Causes and Effects

A personal opinion on the South Australian workers compensation scheme

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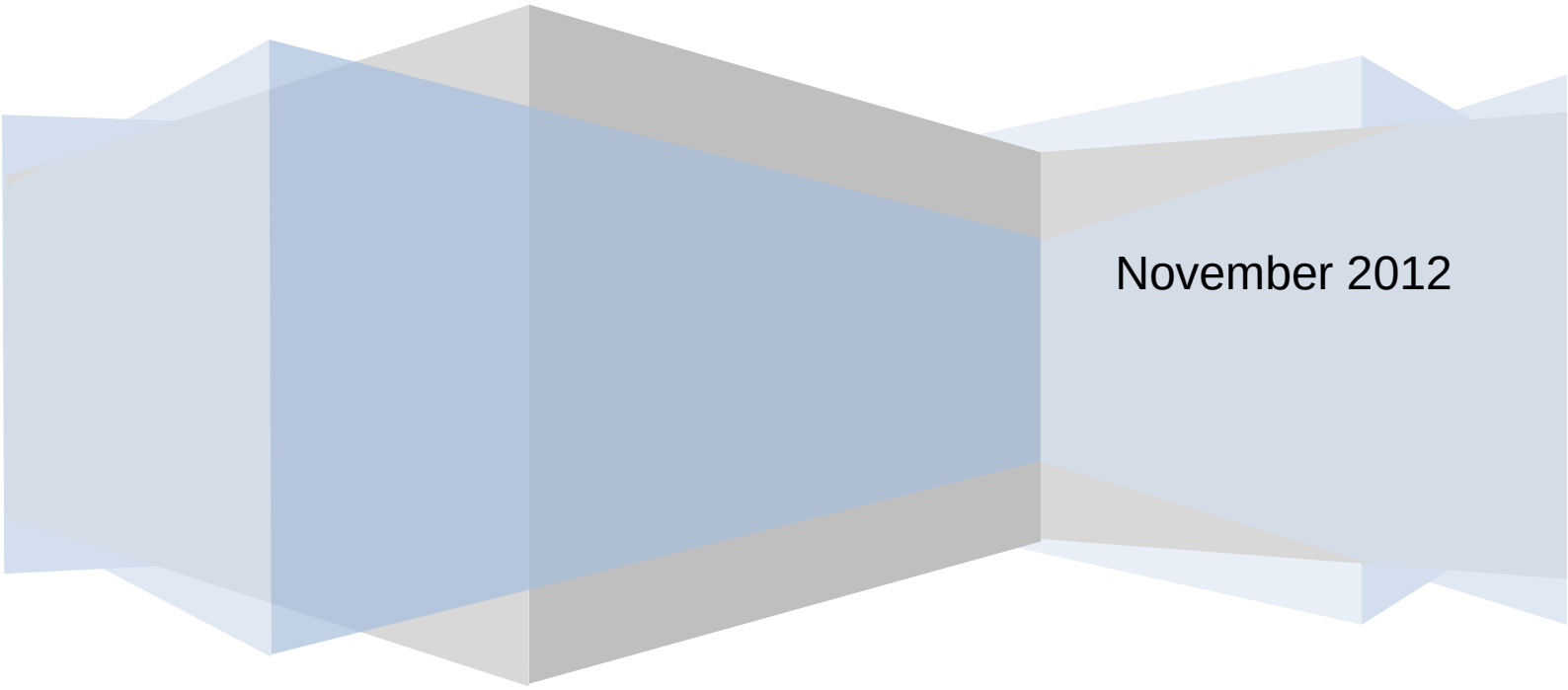

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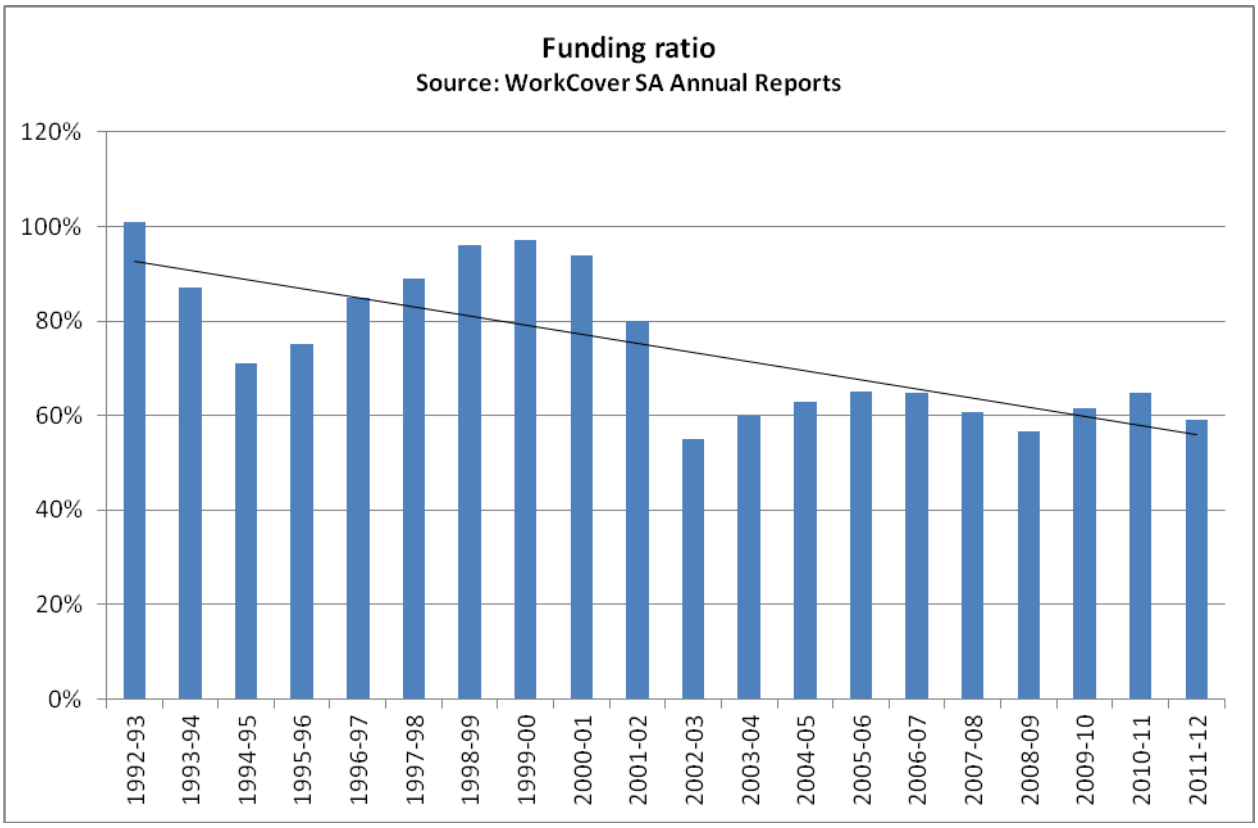
The opinions expressed in this paper are entirely personal and do not purport to represent the views of any other person or organisation. They are based on the author's own experience in the SA workers compensation system in a range of roles over a number of years.

Contents

Executive Summary

The two parts of this paper address what I see as the two root causes of the long-term funding problems of the South Australian workers compensation scheme. Part 1 describes a flaw in the Act that has existed since its inception. Part 2 deals with shortcomings in delivery that have existed since the creation of regulated workers compensation systems.

That the problems are long-term and remain unresolved is to me beyond doubt. A long view of funding trends bears this out:



Part 1 - Statutory defects

Legislation is usually developed through negotiation and compromise, and loss of clarity of intent can be the result. This is never more the case than in workers compensation.

Unclear law and political gestures have delivered a continuous thread of statutory and funding failure to the South Australian workers compensation scheme in one critical aspect– the income maintenance duration provisions.

Millhouse J of the Supreme Court of SA wrote in 1992 about this problem:

…reading section 35 it has all the indications of a section, drafted probably hastily and under pressure, agreed as a compromise at a conference of managers of the two Houses of Parliament… Hasty drafting does not make any difference of course to the responsibility to try to work out what Parliament intended - just makes the job a bit harder![1]

[1] *Workers Rehabilitation and Compensation Corporation v. James* LSJS 164 Judgment No. S3360 April 1992, p.143

Since its inception, the SA scheme has developed a 'tail' – a small percentage of long-duration claims that carry a large percentage of scheme liabilities. It is the continuous thread through the scheme that can be traced to the political compromise of the original Act. No rhetoric, restructuring, management reform, outsourcing, in-sourcing, change of Government or marketing can alter this defect, since it is statutory in nature.

In 2008 there was an attempt to rush a set of changes to the scheme, one of which was the replacement of section 35. This paper argues that while the intent was appropriate, the execution of it was poor and probably doomed it to failure from the start.

The question is this - was this scheme *ever* intended to pay long-term pensions to people who are not permanently incapacitated for work to any large degree, but are unemployed? I will show that the answer to that is a definite 'no' by examining two crucial documents that formed the blueprint for the 1986 Act – the Byrne Report[2] and the 1985 White Paper[3].

The Byrne Report suggested that long-duration payments should be provided after a decision on the *permanence* of incapacity. It also advocated the settlement by lump sum of pensions involving up to 20% permanent incapacity. Payments should be based on the degree of incapacity applied to 100% of average weekly earnings. The report inferred a time limit of one year in most circumstances prior to the decision on permanence and the deeming of earnings in accordance with capacity for work. Two assumptions appear to have been made by the report's authors:

- That permanent incapacity could be quantified quickly and simply; and
- A return to work would follow successful rehabilitation as a matter of course.

The 1985 White Paper retained the Byrne Report recommendation that payments would be at 100% of weekly earnings until a decision on permanence of incapacity was made, and a pension rate fixed by deeming earnings in line with assessed capacity for work. A major difference was the inclusion of the 'partial deemed total' concept from the 1971 Act.

We can summarise the primary design features of income maintenance entitlements as envisaged by the scheme's architects as follows, (using the White Paper):

1. Temporary weekly payments at 100% of pre-injury earnings for a maximum of 2 years or up to the time that the disability is determined to be permanent (whichever is sooner).
2. Where a disability is determined to be permanent, entitlement would switch to a pension rate of 85% of pre-injury earnings less what the worker is assessed as being capable of earning.
3. Partial incapacity would be deemed to be total incapacity for a maximum of 2 years where the worker is unable to secure employment, with discretion by the regulator to extend in appropriate circumstances.

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[2] *A Workers Rehabilitation and Compensation Board for South Australia: The key to rapid rehabilitation & equitable compensation for those injured at work*, Report of the Tripartite Committee on the Rehabilitation and Compensation of Persons Injured at Work, September 1980.

[3] *South Australian Proposals for Workers Compensation Reform*, August 1985.

The regulator was to have clear powers to set and pay entitlements over defined periods. The onus was to be on the worker to establish that his or her entitlements were at law different to those determined by the Corporation.

What emerged from Parliament in 1986 was so badly expressed that this intent was not just lost, it was practically reversed, as was articulated in the James Case.

Until 2008, what were known as the 'second year review' provisions were dysfunctional, and entitlement to weekly payments at 80% of average weekly earnings was indefinite for those who could demonstrate any degree of ongoing incapacity and who were not working.

This is the statutory (but not the only) root cause of the claims liability problem for the South Australian workers compensation scheme – the inability to deem earnings by reference to the worker's capacity for work. This ensured that the scheme could not deliver on the design intent that high levels of long term entitlements would be delivered only to those who suffered high levels of permanent incapacity for work.

There is another statutory feature that is linked with the duration defect – redemption. There are two aspects of income maintenance redemption that need exploring:

1. Their intended purpose; and
2. How they were used out of context, and why.

The original intent was to redeem the liability to make small residual payments over a long period through the payment of a lump sum. But over time, redemption gained another purpose which had, at best, a shaky legal basis.

As the claims tail grew, the Corporation sought an alternate means to curb its income maintenance liabilities. Redemption was the chosen course. Workers were selectively offered redemption lump sums in exchange for a voluntary cessation of weekly payments. The theory was that the lump sums represented significant savings in liabilities, as they may well have done if they also terminated the claims being redeemed.

So entrenched did this practice become that the completion of a redemption came to be equated with a legal claim discharge. This was not the case. The offer of a redemption could not require a worker to waive entitlements under the Act – it was *not* a legal discharge.

There was however some published actuarial evidence to suggest that this redemption campaign had yielded some improvement in the scheme's claims liability. The ending of the redemption campaign in 2009 and the later ban on redemptions were intended to be offset by the revival of assessing work capacity as the basis for curtailing income maintenance entitlements under the new sections 35-35C. We are yet to see any results from this.

To my mind, it is rash to assume that every claim has a return to work outcome at the end of it. For a small number of cases representing a large liability, the scheme needs to either:

- Equitably (and legally) finalise matters with the worker where the situation cannot yield another solution; or
- Legally end entitlements for the small number of people who will not voluntarily do the right thing.

At the moment, the scheme can do neither. It can't even purport to do the former under existing provisions due to a self-imposed 'no redemption' policy.

Part 2 – How things change while staying the same

This part deals with the service delivery problems facing the scheme. The question of outsourcing of claims management is a distraction from the actual problem. The evidence shows that outsourcing has delivered none of the benefits expected of it since 1995.

What the outsourcing debate conceals, however, is the fact that to a large extent, outsourcing was just a different look to the same thing. Workers compensation claims are still managed by a group of administrators in an office receiving, determining and managing claims based on paperwork, phone calls and so on. It is a model suited to types of insurance where all claims are broadly similar and will fit within a fixed linear process.

When one looks at claims management outsourcing since 1995, we can see that the same product has been on offer. It may be dressed differently, but in the end we still have rows of people in an office managing claims in accordance with written procedures in an environment largely remote from the actuality of the workplace and the worker.

The question is why we continue to be tied to a model that is so ill-suited to personal injury when the evidence is clear that schemes are gravely damaged by the exceptions that it generates. Mass-management abhors exceptions, yet that is exactly what a personal injury compensation claims administrator is likely to encounter. Part of the problem lies in how we articulate our scheme.

A no-fault workers compensation scheme has a statutory structure that usually links an entitlement to services or compensation with events or elapsed time, cost or some other defined point in a linear progression. Paradoxically, this process-based legislation, which is intended to differentiate workers compensation from other forms of insurance and to create and protect the rights and obligations of scheme participants, will often generate a process culture not well suited to personal injury management.

This is not an argument that there should be no statutory structure, but it is an argument that the effects of the statutory structure might be improved through smarter management.

The key point is that in any mass-management model, exceptions are managed retrospectively. The undetected risks are usually apparent after the event. But prior to the exception becoming manifest it is not obvious because the mass-management system collects broadly the same information in respect of every person's claim.

Priority should be placed on ensuring that only the seriously incapacitated workers, for whom long term support is a part of scheme design, move into the tail. So the differentiation of claims by risk at the time of initiation ought to intuitively be the preferred approach.

If the claims management system is to learn to reliably detect and manage human risks before they become exceptions, it must understand the issues and know how and when to respond to them. Here is a short, but not comprehensive, list of potential risks:

1. Pre-existing socio-economic and demographic factors, personal traits and behaviour.

2. Industrial relations issues bearing on job sustainability and satisfaction.
3. System error – mistakes that adversely impact on the worker.
4. System (or decision) generated hostility.

1 and 2 above require diligent and sophisticated information-gathering during the earliest contacts. 3 and 4 above are about:

- The style, method and quality of communication
- The calibre and profile of the person making the decisions and communicating them
- The system support and resources that are available to that person
- The speed and extent to which policy and procedure can be unilaterally adapted by that person to suit individual needs; and so on.

The challenge is to detect the cases with evidence of risk, decide if that will have implications for the worker's progress and if so, direct the right resources to them at the right time. It sounds hard and expensive, and it would be. It involves letting go of an element of control and trusting others who have a better view. In short, it requires major changes to a century-old, entrenched model of business and the assumptions that support it.

The problems outlined in Parts 1 and 2 tend to exacerbate each other. If fewer exceptions were generated, the 'tail' would be of more manageable proportions and the flawed legislation that inflates duration would be a less pressing issue. If the legislation functioned in the way intended by the scheme designers, tail claim duration would be less of a problem and would make exceptions less critical.

This interplay of flaws is, to my mind, the root cause of the problems of the South Australian workers compensation scheme. Slogans such as 'improving the return to work rate' are just euphemism to cover these harder matters. These issues have existed and continue to exist like an unbroken thread since 1986.

For a thoroughgoing result, both the laws and their application have to be right. Without clear laws there is no clear understanding of what a person's rights and obligations are. Without intelligent application of the laws, there is no guarantee that those rights and obligations, and the limitations on them, will be delivered.

Part 1 - When the words don't match the intent: statutory defects

Foreword

Pens are most dangerous tools, more sharp by odds

Than swords, and cut more keen than whips or rods.

John Taylor, *News from Hell, Hull and Halifax*, 1639

This is an essay about words as much as anything else. While my primary target is a small part of a large and complex piece of legislation, the essence of the issue I will pursue lies in words. After all, what is legislation other than a sequence of words that, in a perfect world, would clearly express the intent of those who made it law?

We must recognise that absolute clarity of statute law is at present about as attainable as the speed of light. Were we to attain absolute clarity, we would have no need for our courts to guide us on the intent and meaning of our laws; they would only need to apply them. Anyone who doubts that courts prefer to apply clearly worded laws rather than try to distil the intent of Parliament from unclear legislation need only refer to the words of the late Justice John Perry on page 6 of this paper.

The reality is that our legislation is developed in a political environment, often through negotiation and compromise between competing interests. When the language of complex legislation such as workers compensation is settled by compromise, loss of clarity and breakdown of intent can all too often be the result.

On top of that is the very nature of politics itself - the slogan, the gesture, the pose, the media impact of being *seen* to act in response to a problem is often as high a priority, (if not more so), than the actual and lasting effects of the action. I still shudder when I hear those words 'legislation is being rushed into Parliament'. Even when legislative language is not settled by compromise, if it is rushed, the result is often the same, as those who work within the South Australian workers compensation scheme know only too well.

I suppose this is the price we pay for our invaluable democracy – Governments usually have much shorter lives than the laws they make. This could not be any truer than it is in the context of workers compensation schemes, which can take years or decades to mature and to respond to any substantial statutory change. Politics demands quick fixes in an area of law and finance that simply does not yield quickly to normal types of statutory change[4].

The central theme of Part 1 of this paper is that compromised language, unclear intent and political gestures have delivered a continuous thread of statutory and funding failure to the South Australian workers compensation scheme since 1986 in one critical aspect of the entitlement structure.

If any proof was needed for the implications of compromised and rushed statutory language, this is what Millhouse J, sitting as a member of the Full Court of the Supreme Court of SA

[4] By 'normal' I mean statutory change with no far-reaching retrospectivity.

wrote in 1992 in the judgement of one of the landmark cases in the history of the current South Australian workers compensation scheme:

I must say that reading section 35 it has all the indications of a section, drafted probably hastily and under pressure, agreed as a compromise at a conference of managers of the two Houses of Parliament.

Otherwise, for example, why should two different but similar phrases such as "suitable employment that the worker has a reasonable prospect of obtaining" and "suitable employment for which the worker is fit is reasonably available" have been used? Why not use the same phrase in both places? Even one phrase would be difficult enough to construe!

When I looked in Hansard I found I was right. There had been disagreement on the clause between the Houses: it did go to a conference.

Hasty drafting does not make any difference of course to the responsibility to try to work out what Parliament intended - just makes the job a bit harder![5]

I have at times wondered if His Honour used the words 'a bit harder' with tongue in cheek. The extent and the impact of what became known simply as 'the James case' suggests in fact that the Full Court found itself having to almost divine what the intent of that aspect of the workers compensation laws actually was, so unclear was the wording.

I make mention of the James case because it is an ideal jumping-off point for this document. It addressed, especially in Millhouse J's incisive words, what I would term a life-threatening defect in the 1986 workers compensation laws; a defect that created the claim duration issue that, in spite of Parliamentary intervention since, continues to threaten the scheme.

No amount of rhetoric, restructuring, management reform, outsourcing, in-sourcing, change of Government or marketing can alter this defect, since it is statutory in nature. Talk of improving return to work rates or improving rehabilitation, lowering costs, improving satisfaction rates or stiffening accountabilities, is all just euphemism for one thing and one thing only. Since its inception, the SA scheme has had a proclivity to develop what is known in the industry as a 'tail' – a relatively small percentage of long-duration claims that carry a large percentage of scheme liabilities. It is the continuous thread through the story of the scheme that can be traced, as Millhouse J did, to the political compromise of the original Act. That this is a chronic issue is indicated by the fact that the scheme has had a funding surplus just once in its entire history, in 1992-93:

[5] *Workers Rehabilitation and Compensation Corporation v. James* LSJS 164 Judgment No. S3360 April 1992, p.143

Figure 1

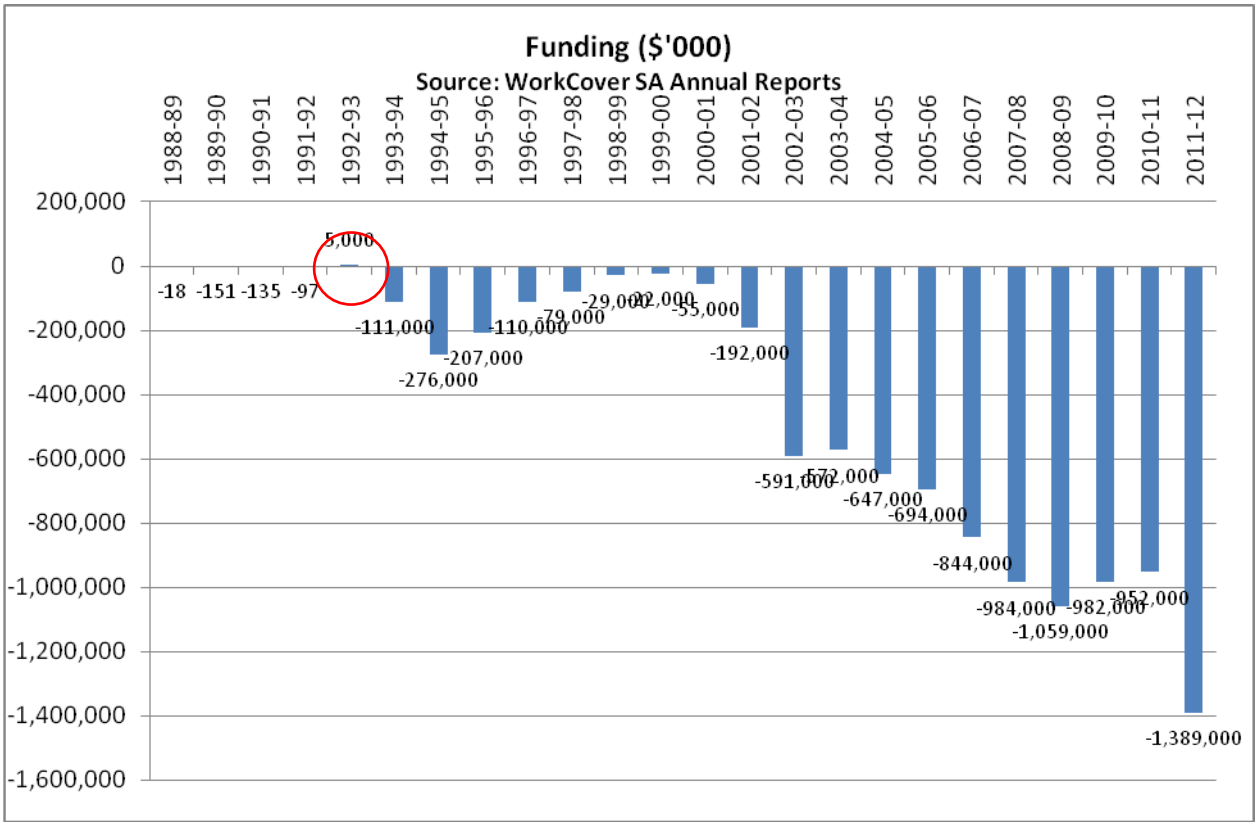


Figure 1 has the influence of investment performance built in, which is not entirely within WorkCover's control. However, a comparison of funding trends with outstanding claim liabilities demonstrates that the outstanding claims liability has a distinct inverse correlation with scheme funding which investment performance only mutes to some extent:

Figure 2

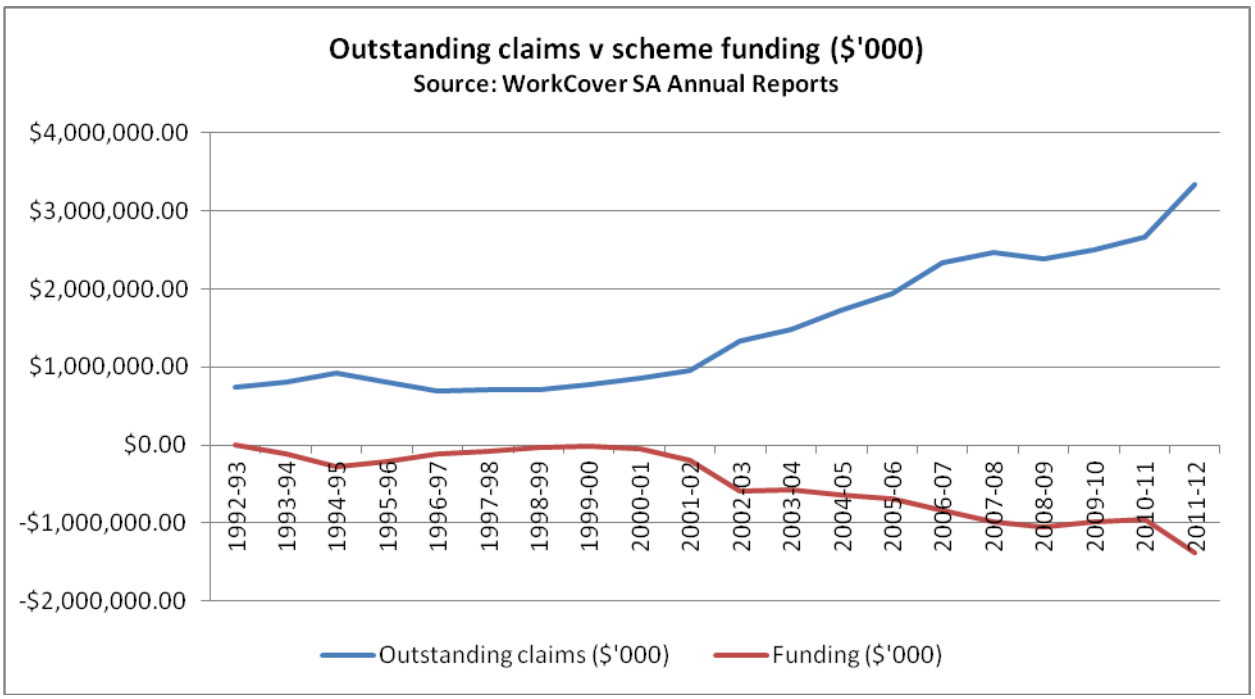
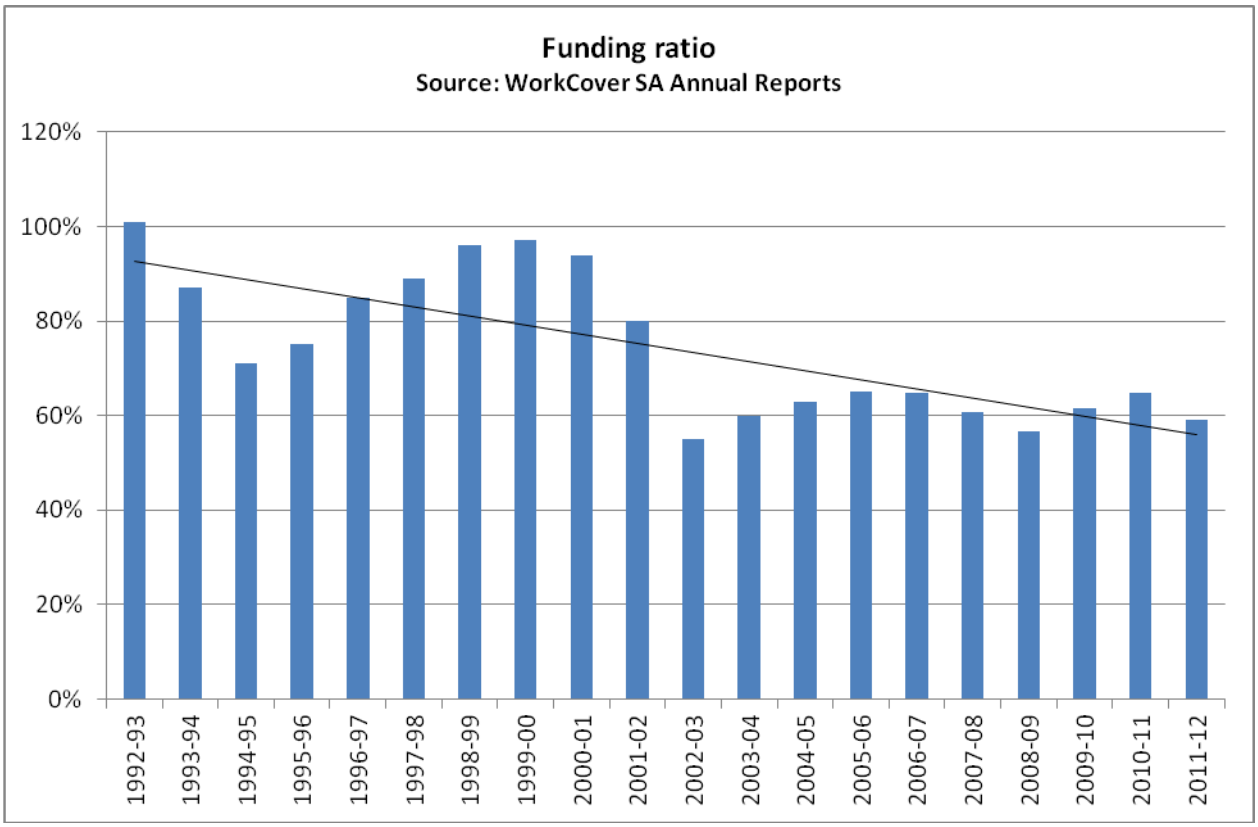


Figure 2 shows that where goes the claims liability, also arguably goes scheme funding. So an in-built weakness in the legislation that inflates claim liabilities is going to directly impact scheme funding.

To see how the scheme's funding is behaving in the long term, one need only look at the linear funding trend since the one and only time the scheme was fully funded (Figure 3).

Figure 3



If any long-term trend is of concern, it should be this; not just because the trend shows an inexorable downward drift over time despite efforts to reverse it, but because the flaw in the scheme of the Act that is driving the deterioration remains unrepaired after it was first formally identified in cases such as James some 20 years ago.

I do not intend to suggest that the wording of the law is all there is to it. Quality of management of the human aspects of workplace injury and disease is often the proximate cause behind many of the small percentage of long duration claims I mentioned. Inflexibility of management, distance from the realities of the parties to a workplace injury and a perverse obsession with cash-flow and day to day cost control do indeed bring cases (and the people whose lives they represent) undone and make early resolution next to impossible.

But these things are fixable at the policy level, had we the wit and the will to do so[6]. My argument in this Part goes to bedrock issues of original intent. I ask the question – was this scheme *ever* designed or intended to pay long-term pensions to people who are not permanently incapacitated for work to any large degree, but whose primary issue is unemployment? I intend to show that the answer to that is a definite no.

[6] These qualitative issues are reviewed in Part 2 of this paper.

In the mean time, while we observe the fixing of what isn't broken and consider the effects of previous unsuccessful attempts to fix what *is* broken, it is timely to remind ourselves of a quote I used in 2008 during that year's ill-considered attempts to reform the legislation:

Those who cannot remember the past are condemned to repeat it.

George Santayana, *The Life of Reason, Vol 1,* 1905

Santayana was saying that history does not repeat itself; people do.

It will take a long succession of far better results to reverse the trend illustrated by Figure 3, and the funding history suggests that this is unlikely as things stand. Perhaps this is the most revealing of all of the data and of the need to go deeper into the scheme's statutory DNA when considering the future of the SA workers compensation scheme. If we do not, the hidden problem will remain, the Figure 3 trend will remain and we will indeed repeat past errors.

The problem statement – when the words don't match the intent

In the 1992 case previously quoted, *Workers Rehabilitation and Compensation Corporation v. James*, Legoe J, at page 136, said of the terms of section 35 of the Act as it then was:

Counsel for the appellant submitted to this court that it was never intended that the 1986 legislation be a substitute for unemployment benefits or sickness benefits or any other kind of quite proper community Social Service benefits…

In my judgment it is apparent that the factors to be considered by the authority making the determination…are those set out in sub-section (2)(b). However, they are not the only factors…

Counsel for the appellant submitted that the phrase in section 35(1)(b)(ii) "that the worker has a reasonable prospect of obtaining" has a different meaning to the words "reasonably available" in sub-section (2)(a)…The phrase "reasonably available" speaks of the present and the other of the future and not necessarily the immediate future. The distinction may be correct, but… it does not assist in the resolution of the problem.

If the Court were to answer this question in the affirmative, I am of the opinion that the provisions of section 35(1)(b)(ii) would be unduly narrowly construed and assessments would be made contrary to the general principles of interpretation. The plain and ordinary meaning of the words in the context of the section and division IV itself are in my opinion clear.

His Honour effectively stated that regardless of whether or not we think the scheme was *designed* to provide compensation for unemployment or other forms of social support, in his view, the wording settled by Parliament said that it clearly did. I will look at the original design of the scheme shortly, but I want to continue this theme of interpretive issues for a short while longer, as it speaks volumes about the conflict between intent and interpretation that has in effect given the SA scheme a split personality since its inception.

The sheer difficulty of making sense of the duration aspects of the income maintenance entitlement elements of the Act as it stood in 1994 was eloquently expressed in the judgment

of *Martha Pashalis v The Workcover Corporation* [SCGRG 94/26 Judgement No. 4803 (1994) SASC 5188. Perry J at 55 said:

I cannot…refrain from observing that this Court has been plagued over the years since the enactment of the Workers Rehabilitation and Compensation Act 1986 with appeals which turn upon questions of construction of the Act. In almost every case, the Court has been obliged to… surmount problems occasioned by poor drafting. There is a limit, however, to the extent to which this Court can torture words towards a meaning which they cannot reasonably bear. A situation will occasionally arise where it is necessary for the legislature to return to the task of drafting the relevant provisions so that they give effect to Parliament's intention. In my opinion, this is one such situation.

To paraphrase His Honour, 'if you think the scheme should be able to deal with certain things in certain ways, you need laws that say so. At the moment, they don't say so'.

It seems clear that recognition of the flaws in the legislation was not limited to the judiciary:

You also have the other situation of people with a 5 per cent to 10 per cent disability staying in the scheme because of their age, and they are purely and simply using the scheme with a very minor disability to maintain an 80 per cent pension. All I am saying is that, if we genuinely are serious about having a benefit system that is fair and gives long-term benefits to the majority of employees who deserve to get it because they are injured at work, we have to get rid of the nonsense in this tail.

Any person who genuinely sits down to study the scheme should not look at it from the political ramifications point of view…If you genuinely look at the scheme you will see a lot of anomalies in this long tail that could easily be fixed, and you would get a much better return to work and have less…people staying in the scheme.

I will give another example of what is wrong with the scheme at the moment. Recently a company closed because it was no longer profitable, and the majority of employees, because they had previous injury claims with WorkCover, automatically came back into the WorkCover scheme and were able to use it as a pension scheme, getting more payment than they would if they were on social security.

Other workers cannot do that. That is a flaw in the scheme. It is not a rort; it is a flaw. You can hardly blame someone for wanting to do it, but it is not right. You should not be able to come back into the scheme after 18 months of not being in the scheme. Those sorts of issues are causing massive blowouts in the scheme.[7]

Despite a range of things happening in the years following *Pashalis*, little really changed[8]. Gilchrist J of the Workers Compensation Tribunal, in his address to the *Both Sides of the Fence* conference in Adelaide in 2007 said of potential legislative changes:

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[7] Hon G.A Ingerson MP, Minister for Industrial Relations, in a statement to Estimates Committee B, SA Parliamentary Hansard 13th September 1994 p.37.

[8] For example, the *Warren* decision of 1998 was expected to yield some improvement, but it did little to help, probably because it dealt narrowly with only components of the flawed wording. *WorkCover Corporation of South Australia v Bradley Warren SCGRG-97-1239 Judgment No. 6761 [1998] SASC 7224*

"…if as predicted, change is imminent, I urge those responsible to take care to ensure that any re-working of the Act does not evoke criticisms such as those expressed in Pashalis. I also urge caution before replacing tried and tested concepts that now form that body of precedents that is making such a significant contribution to the efficiency of the dispute resolution process. To use an old adage: If they ain't broke don't fix them…"

Again, to paraphrase His Honour, the intent of the laws we had at the time of *Pashalis* might have been initially, (and perhaps unforgivably), unclear, but with the passage of time, at least had had sufficient testing in the courts to allow an understanding of the *presumed* intent. A degree of certainty is better than none, and we discard that certainty at our peril. I mention this not to suggest that the laws were not at the time defective – in fact my thesis is that that they were, always had been, and still are defective. However, if we are going to persist in failing to fix the core problem, the laws we know are better than the ones we don't. Discarding all of the section 35 precedent would be predictably dangerous for the scheme if the laws that replaced section 35 were not clear and workable.

Yet, that is exactly what happened in 2008. The income maintenance entitlement sections of the Act that had been so extensively tested were not simply adjusted so as to clarify intent. They were excised from the Act altogether and replaced with a new, complex and legally vulnerable scheme of income maintenance entitlement of a quite different character, copied almost word for word from the Victorian Act. I earlier described this as an ill-considered effort, and I will next explore what I think are the reasons for that.

Why was the 2008 reform attempt so ham-fisted?

I see two main reasons for the use of such heavy-handed tactics in forcing through the hastily constructed *Workers Rehabilitation & Compensation (Scheme Review) Amendment Bill 2008*. The first is what I mentioned in the foreword – the ham-fisted bit came from a political desire to be seen to act decisively to rapidly respond to a deteriorating funding trend, regardless of actual outcomes. The timing of elections also probably had a role. The 2008 amendments to the workers compensation scheme even made it on to the 2011 list of achievements of the Rann-Foley years, even though we are still waiting to see any concrete evidence that any of the amendments have made even a small difference at the whole-of-scheme level[9]. Rapid passage of the Bill may indeed have been a political achievement, but one without any visible result for the rest of us, so far anyway.

The second reason was lack of intellectual property. By 2008, there were few, if any, in positions of influence who would have remembered the chequered history of the now repealed section 35 and the defect it had carried from day one. There was insufficient knowledge among decision-makers to allow a focused surgical solution. Instead of finesse, they opted for the big-bang approach, aided greatly in their thinking, no doubt, by the political urge to make a quick, large splash. It could fairly be termed the 'hammer and tongs' method of making law.

[9] The Cossey Review of 2011 didn't find any, but asserted that after 3 years, it was still too soon. *Review* of *the Impact* of *the Workers Rehabilitation and Compensation (Scheme Review) Amendment Act 2008*, Bill Cossey AM & Chris Latham, May 2011.

I suspect there were third and fourth reasons as well. One of them might explain why we transplanted such a large slab of alien legislation without testing for unintended consequences, with all the very obvious risks that that entailed, rather than drafting our own. By 2008, the Corporation had developed what looked to us outsiders as an inferiority complex. Other schemes seemed to be prospering; ours was struggling. It seemed to follow, in the minds of the decision-makers, that what the other schemes were doing had to be better than what we were doing, so let's just copy them. Their logic was, in effect, *anything* else had to be better than this[10]. South Australia seemed to have concluded that it lacked the smarts and the will to find its own answers driven by its own needs and knowledge of its own scheme.

The fourth reason was probably shortage of time. Absurd time pressure was put on the development of the Bill. Insufficient time was allowed to carefully consider the Clayton-Walsh recommendations[11] - the amending Bill was tabled in Parliament just 2 days after the Clayton-Walsh report was released to the public. The authors of the Bill were given, I was told by an insider shortly after the Bill was passed, about 3 weeks to draft a Bill of 83 often complex clauses and 2 Schedules, the whole covering some 77 pages. Rushing it was practically a guarantee of a host of unintended consequences, and that is exactly what happened[12].

One might argue that the way it was done was less important than the substance of what was done. I would counter by saying that this wholly unnecessary haste was one of the main reasons for the failure of the Bill to cure what really ailed the scheme – the substance was not in fact there.

I also say there was a deeper, (if perhaps unwitting), reason for the amputation and replacement of section 35 that has its roots in original scheme design – an effort to fix a 1986 defect that defeated one crucial aspect of that original design. To illuminate that, we need to review some history.

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[10] The current major funding troubles of the NSW scheme are evidence of the short-sightedness and naïveté of this approach. In 2008, that scheme looked healthy on the strength of good investment returns. In 2012, its internal flaws have been exposed by receding investments and an unfunded liability approaching $4 billion, a repeat of the experience of the early 2000s.

[11] *Review of the South Australian Workers' Compensation System*, Bracton Consulting & PricewaterhouseCoopers, December 2007, generally referred to as the Clayton-Walsh Review. It seems likely to me that unreasonable time pressure was also placed on Clayton & Walsh, which, if true, makes the 2008 exercise even more questionable.

[12] *"Make no mistake about it: this legislation is a mess...We will be back here during the term of this parliament to fix up mistakes that could easily have been fixed up in the committee stage of this bill".* Hon Mark Parnell (G) SA Legislative Council Hansard 5/6/08 p.3232. "*We have not had adequate discussion, and the rate at which we dealt with amendments this afternoon in order to get this through on the timetable the government wants was really quite disgraceful".* Hon Sandra Kanck (Dem), SA Legislative Council Hansard 5/6/08 p.3233.

Scheme design – what was it *supposed* to do?

The Byrne Report (1980)

We usually trace the history of the 1986 Act back to the so-called Byrne Report[13] of 1980. The Byrne Report was submitted to a Liberal Minister for Industrial Relations (Hon Dean Brown MP). However, the Report is often connected to a previous Labor Government Minister for Labour and Industry, Hon Jack Wright MP, under whose leadership the Tripartite Committee had commenced its inquiry. Mr Wright was later Minister of Labour from 1982-1985, when the findings of the Byrne Report were being revived and translated into a blueprint for a new scheme.

Here is what the Byrne Report said at p.62 about what we now refer to as income maintenance:

Once categorised as permanently disabled (totally or partially) a Worker's Compensation Pension should not be affected by subsequent earnings.

The pension scheme would apply to workers who are totally permanently incapacitated or partially permanently incapacitated would [sic] *receive the compensable wage after the injury while absent from work and while undertaking a rehabilitation program. If the worker recovers and the rehabilitation process is successful, a return to work would result. If, however, in the Board's judgement the worker has a permanent incapacity, the Board must make a decision on the payment of a pension. The Board would be required to make its decision within one year with the option of a longer period under exceptional circumstances.*

When the worker's condition has stabilized [sic] *the Board must make its decision on the pension. The Totally Permanently Incapacitated pension should be calculated as a proportion of the compensable wage with a set maximum, using the Australian Bureau of Statistics figure for Average Weekly Earnings for South Australia. Pension payments would thus be indexed annually on an acceptable basis. The Partial Permanently Incapacitated Pension would be calculated by the percentage of disability multiplied by the Totally Permanently Incapacitated Pension for the injured worker.*

After the Board's decision on the pension both the worker and the employer would have the right to appeal. A person with an income greater than the ABS figure for Average Weekly Earnings would have the pension calculated using the ABS figure, although the compensable wage, until the Board has made its decision, would be calculated on the wage at the time of the accident.

Persons receiving a pension from the Board would be permitted to apply for re-assessment of their pension rate should their condition have deteriorated.

The Board would also have the power to initiate its own re-assessment on the basis of new evidence becoming available.

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[13] *A Workers Rehabilitation and Compensation Board for South Australia: The key to rapid rehabilitation & equitable compensation for those injured at work*, Report of the Tripartite Committee on the Rehabilitation and Compensation of Persons Injured at Work, September 1980.

The Board would have discretionary powers to adjust the level of pension payments to juniors or part-time workers. In the case where the percentage disability is below 10% the Board would automatically settle by a once only payment.

Where percentage disability is between 10% and 20% the worker should have the right to opt for a lump sum payment. As the proposed pensions would be payable until the age of qualification for the Age Pension the matter could be the subject of negotiations between the South Australian and Commonwealth Governments regarding savings to the Social Security system by the payment of these regular pensions.

The suggested changes would be beneficial to the injured worker by encouraging rapid rehabilitation, and in serious cases where it is not possible for a worker to gain employment, they would provide a secure income in the form of a compensation pension. This type of system has been operating in Canada with success for many years. Comparative costs in Canada are much cheaper than our present scheme…

In short, the Tripartite Committee considered that long-duration payments should be provided after an administrative decision is made on the *permanence* of incapacity. Further, it advocated the settlement by lump sum of pensions involving up to 20% permanent incapacity. Payments should be based on the degree of incapacity applied to 100% of average weekly earnings. The report appears to state that payments prior to an administrative decision on the permanence of incapacity should be at the 100% rate with an inferred time limit of one year in most circumstances prior to the decision on permanence and the deeming of earnings in accordance with capacity for work. Two crucial assumptions appear to have been made by the report's authors:

- That permanent incapacity could be quantified quickly and in a straightforward manner; and
- A return to work would automatically follow successful rehabilitation as a matter of course.

The White Paper (1985)

The next key stage in the evolution of the scheme came with the so-called White Paper of 1985[14], which was drafted under the leadership of Hon Frank Blevins MP, who had by then succeeded Jack Wright as Minister of Labour. Here is how that paper developed the Byrne recommendations on income maintenance:

Insofar as the compensation for loss of earnings is concerned the following broad package of benefits is proposed:-

For temporary incapacity weekly benefits will be determined broadly on the same basis as they are payable under the current Act, ie on the basis of 100% compensation for loss of earnings in ordinary hours (but subject to some reassessment where work is regularly performed outside ordinary hours).

Benefits at this rate will be payable until such time as the worker's disability is assessed as permanent or for up to two years whichever is the sooner.

[14] *South Australian Proposals for Workers Compensation Reform*, August 1985.

Where the worker's disability has been assessed as permanent or after a worker has been in receipt of weekly benefits for two years, if that is sooner, further benefits will become payable by way of a pension. The pension will be calculated on the basis of the difference (or "make up") between the worker's assessed earning capacity (if any) and 85% of the worker's pre-injury earnings rate.

Thus if a worker is totally permanently incapacitated the pension will represent 85% of the worker's normal average weekly earnings and will be continued until such time as the worker becomes entitled to age pension benefits.

Pensions will, however, be reviewed on an annual basis and will be reduced where the total of the pension paid and the amount the worker is able to earn exceeds the level of the worker's pre-injury earnings (adjusted in current terms).

In such cases the pension will only be reduced by the amount of the excess earnings and will thus provide some incentive for rehabilitation. Pensions may also be increased at any time where the worker suffers a deterioration in his or her medical condition that further reduces the worker's ability to earn.

Where a worker is partially incapacitated (ie is capable of earning some degree of income) but is unable to obtain suitable employment the current concept of partial deemed total will apply for twelve months from the date of medical stabilisation of the disability or from two years after the commencement of benefits if that is sooner. At the expiration of the 12 month period the Corporation will have the discretion to extend the partial deemed total assessment for a further twelve month period where special circumstances exist.

Thus the 1985 White Paper retained the Byrne Report recommendation that payments would be at 100% of weekly earnings until a decision on permanence of incapacity was made and a pension rate fixed by deeming earnings in line with assessed capacity for work. A major difference was the inclusion of the 'partial deemed total' concept from the 1971 Act[15], in which an inability to secure employment while partially incapacitated for work (note - not unwillingness to accept, or unavailability for, employment) was deemed to be total incapacity for a maximum of 2 years. So the White Paper appears to have recognised the dangers of the second of the two crucial Byrne Report assumptions, (that a return to work would automatically follow successful rehabilitation as a matter of course), and attempted to mitigate it, albeit in a way that would demand crystal-clear legislation if the principle of 'partial deemed total' were to be limited to two years.

But once again there was a presumption that incapacity for work could be quickly and clearly quantified for the purposes of fixing the pension rate. Another departure from the Byrne Report principles was the stepping-down of the pre-injury earnings rate to 85% for the purposes of fixing the pension rate. Things seemed to be getting more complicated even before legislation was drafted.

So, we can summarise the primary features of the income maintenance entitlement structure as originally envisaged by the scheme's architects as follows, (using the White Paper):

[15] *Workers Compensation Act 1971*, s.67.

1. Temporary weekly payments at 100% of pre-injury earnings for a maximum of 2 years or up to the time that the disability is determined to be permanent (whichever is sooner).
2. Where a disability is determined to be permanent, entitlement would switch to a pension rate of 85% of pre-injury earnings less what the worker is assessed as being capable of earning.
3. Partial incapacity would be deemed to be total incapacity for a maximum of 2 years where the worker is unable to secure employment, with discretion by the regulator to extend in appropriate circumstances.

The key point is that these provisions were intended to provide the regulator (the Corporation) with clear powers to set and pay entitlements over clearly delineated periods of entitlement. The onus was *supposed* to be placed on the worker to establish, via a system of appeal, that his or her entitlements were at law different to those determined by the Corporation. The intent was to this extent quite clear.

What emerged from Parliament was so badly expressed that this seemingly clear intent was not just lost from the first moment, it practically reversed the intent.

The Act as it actually developed

The *Workers Rehabilitation and Compensation Act 1986* (WRCA) received assent on 24th December 1986. Most of the Act commenced on 16th April 1987. Since then, there have been 20 primary amending Acts and 11 others that made consequential changes to the WRCA. In total, these have involved hundreds of changes.

I will focus on section 35 (as it was before the 2008 amendments) and the post-2008 sections 35 to 35C. The original section 35 was amended in various ways no fewer than 14 times until it was repealed and replaced in 2008. It would not be practical to list and explain every amendment, nor would they all be germane to the question of duration of entitlements. However, an example will illustrate the loss of the original intent through compromised wording.

It was mentioned above that the White Paper proposed that the 'partial deemed total' concept would apply for up to two years with discretion for the Corporation to extend. Here is how the 'partial deemed total' provision of section 35(2) the Act actually stood as at late 1994 (after the James case):

(a) a partial incapacity for work over a particular period shall be treated as a total incapacity for work over that period <u>unless the Corporation establishes</u> [my emphasis] *that suitable employment for which the worker is fit is reasonably available to the worker in respect of that period (but where the period of incapacity extends beyond a period of two years, this paragraph does not apply to a period commencing after, or extending beyond, the end of the second year of incapacity)…*

The point that many miss is the shift in onus. Where the scheme's designers intended the onus to be on the worker to *prove* ongoing entitlement where the Corporation had determined otherwise, this sort of wording placed the onus on the Corporation to *disprove* the worker's asserted entitlement. The Corporation was put on the back foot, and the earlier quotes from the James case illustrate just what a difficult burden that was to prove.

What was equally critical in the 1986 Act as it emerged is the loss of the intended linkage between the determination of permanent impairment and the entitlement to ongoing weekly payments. The Act treated weekly payments and permanent incapacity as separate matters with no statutory linkage between them other than the establishment of compensability. In effect, the entitlement to weekly payments was made a 'stand alone' issue, with legal arguments quite separate to those of the permanence of incapacity. To maintain the entitlement to ongoing weekly payments, a worker only needed to demonstrate *any* degree of incapacity without needing to satisfy any test of permanence or extent.

By 2008, duration-driven claims liability issues were, not for the first time, severely affecting scheme funding, as is ever the case when investment returns evaporate and expose the claims liability, just like a receding tide exposes rocks.

Despite further amendment, what had become section 35(2) of the Act prior to the 2008 Bill was as confusing as ever:

(*b) for the first two years of the period of incapacity, partial incapacity for work is treated as total incapacity unless the Corporation establishes that suitable employment is reasonably available to the worker; and*

(c) after the end of the first two years of the period of incapacity, if—

> *(i) suitable employment is in fact not available to the worker; and*
>
> *(ii) the worker establishes that the worker is, in effect, unemployable because employment of the relevant kind is not commonly available for a person in the worker's circumstances irrespective of the state of the labour market, partial incapacity for work will also be treated as total incapacity, but otherwise an assessment of the weekly earnings the worker could earn in suitable employment after the end of the first two years of the period of incapacity must be made on the basis that employment of the relevant kind is available to the worker.*

In short, the worker receives the full 'pension' (as the scheme's designers called it) indefinitely if the worker could show that employment is not 'commonly available'.

The concept of entitlement had drastically altered over the years to become practically the direct opposite of the original design. The Byrne Report recommended that income maintenance entitlement quantum and duration be defined by the degree and permanence or otherwise of incapacity for work and nothing else, with the onus on the worker to prove ongoing entitlement in excess of that determined by the Corporation.

The 1985 White Paper weakened the Byrne position by recommending limited retention of the concept of 'partial deemed total'. The process continued through the iterations of section 35 and the James case, ending with the above version of section 35(2), which as much as stated that unemployment is itself compensable under the workers compensation scheme with the onus on the Corporation to prove otherwise.

Through most of the life of the scheme as it was until 2008, what became known as the 'second year review' provisions were largely dysfunctional and for the most part, entitlement to weekly payments at 80% of average weekly earnings was indefinite for those who could demonstrate any degree of ongoing incapacity and who were not in employment.

This is what I assert is the statutory (but not the only) root cause of the claims liability problem for the South Australian workers compensation scheme. It is what I call the main defect – the inability to deem earnings by reference to the worker's capacity for work at a certain point in the life of a claim. The flaw ensured that the scheme could not deliver on the clear intent that high levels of long term entitlements would be delivered only to those who suffered high levels of permanent incapacity for work.

Badly-worded law allowed many more cases into the post-2 year pension 'tail' than the designers intended. Although these days the preference seems to be to mask the cause and effect of this flaw with the euphemistic term 'return to work' (or a lack thereof in describing the claims 'tail'), the fundamental problem seems to be well enough understood. In 2006, WorkCover SA said in a consultation paper leading up to the 2008 amendments, *"The recommendations made in the Byrne Report, compared with the performance of the current-day Scheme in returning injured workers to work and its financial position, demonstrate a divergence between the application of the legislation and its original intent"*[16].

What started out as an unintended consequence became a feature of the scheme, and to some, an entitlement that ought not be changed. Over 20 years of passive acceptance of this miscarried *status quo* guaranteed that any attempted fix would receive a hostile reception from many quarters.

That brings us to the current situation.

The 2008 amendments and beyond

I have stated elsewhere, publicly and privately, that the 2008 income maintenance and redemption amendments to the Act were ill-considered and probably doomed to failure. But I will stick up for the *intent* behind one sub-set of the amendments, even if the intent was defeated by dreadful wording, just as it was in 1986 and since.

Sections 35-35C

Whatever else one says about the repeal of the old section 35 and its replacement with sections 35-35C, one thing is clear to me. These particular amendments clearly sought to reverse the onus of proof in disputes over ongoing income maintenance entitlements and to at least partially restore the connection between permanent incapacity and ongoing weekly payment entitlements. Observe the language, firstly of the current section 35B:

(*1) Subject to section 35C (and to the other provisions of this Act), a worker's entitlement to weekly payments under this Division ceases at the end of the third entitlement period under section 35A (unless brought to an end before this time) unless the worker is assessed by the Corporation as—*

(a) having no current work capacity; and

(b) likely to continue indefinitely to have no current work capacity.

And section 35C:

[16] *Proposed legislative change to the South Australian workers rehabilitation and compensation scheme*, WorkCover SA November 2006 p.6.

(*1) Subject to this Act, a worker who is, or has been, entitled to weekly payments under section 35A(3)(b) or 35B, may apply to the Corporation in accordance with this section for a determination that the worker's entitlement to weekly payments under this Division does not cease at the end of the third entitlement period under section 35A or at the expiry of an entitlement under section 35B (as the case may be).*

Note also that for the first time in the history of this Act, the 'partial deemed total' concept is not expressly stated, though one can argue that it is implied by sections 35 and 35A.

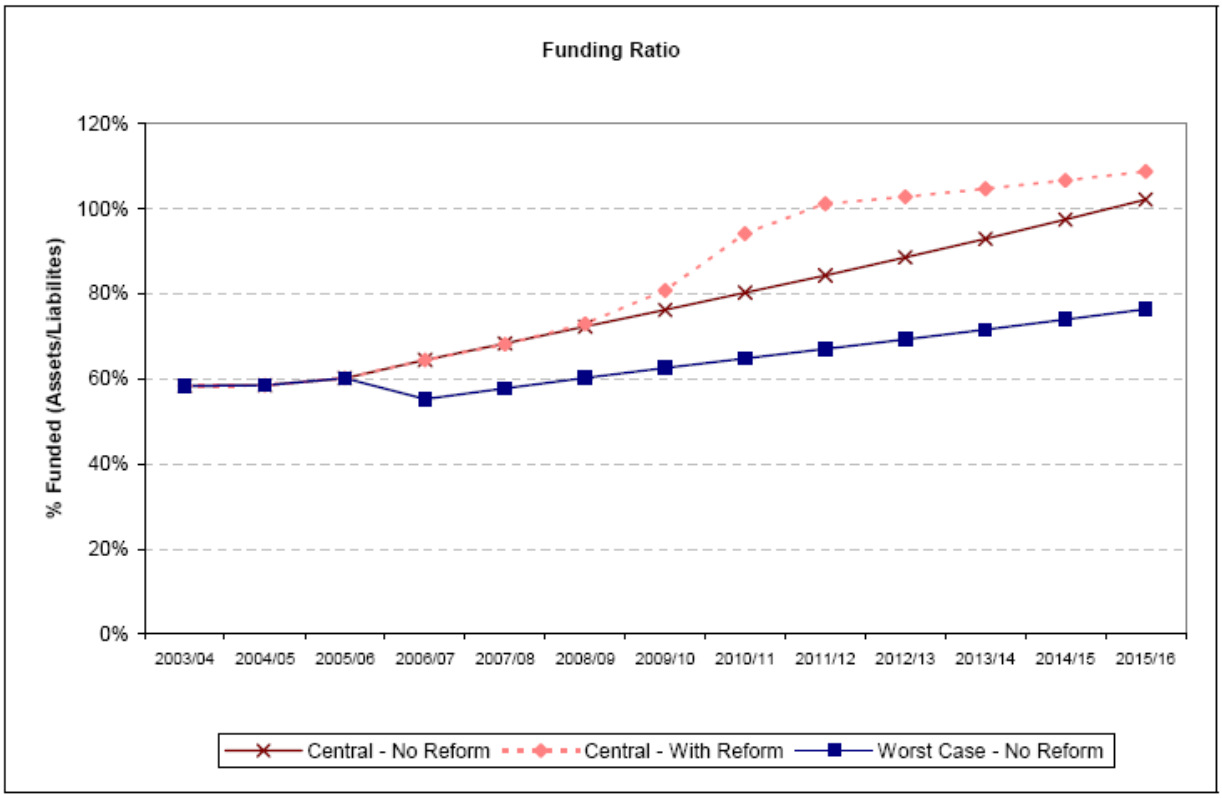
In my view, the intent of these amendments was to return the scheme design of entitlement duration to the first principles set out by the Tripartite Committee in the Byrne Report - the Corporation makes a decision authorised by legislation, on ongoing entitlement based on capacity for work, and the onus is on the worker to make a different case.

While the intent is one thing, the actuality is very much another. Others far more qualified than me have stated that the wording of sections 35-35C is unworkable[17]. The history of disputes before the Workers Compensation Tribunal so far suggests that the range of technical and policy challenges faced by the administrators of these new sections is formidable. It seems to me that we have replaced one set of dysfunctional provisions with another set of dysfunctional provisions. And so the defect remains.

The fact of the failure of the 2008 amendments to deliver as forecast is clear enough. In 2006, WorkCover published the following actuarial modelling of scheme funding with and without the amendments:

[17] For example, Gilchrist J in a talk to the SISA seminar *Closing the Loop*, Adelaide, July 2011, in which His Honour stated that he found these sections incomprehensible due to convoluted language, double-negatives and so on.

Figure 6: Funding ratio scenarios



Had all gone according to plan, the scheme would have been fully funded by now (2011-12)[18]. Instead we have seen a steady succession of liability releases so small they have been easily overtaken by economic factors, leading to adverse funding outcomes.

But there is another statutory feature that is inextricably linked with the duration defect – redemption or, as it was briefly known, commutation. It, too, has had a role in the way the scheme has behaved.

Redemption and the problem of not legally settling claims

Redemption, in various forms, has been a feature of South Australian workers compensation arrangements since 1911[19]. There are two aspects of income maintenance redemption that need exploring:

3. Their intended purpose; and
4. How they were used out of context, and why.

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[18] *Proposed legislative change to the South Australian workers rehabilitation and compensation scheme*, WorkCover SA November 2006 p.15. At p.16, that paper also forecast a required average premium rate of 2%-2.2% by 2011-12.

[19] The 1st Schedule to the *Workmen's Compensation Act 1911* is the first reference to redemption I have been able to find. That Act was subsumed and repealed by the *Workmen's Compensation Act 1932*, wherein conditional redemption was allowed for in section 28. S.72 of the *Workers Compensation Act 1971*, which succeeded the 1932 Act, also made redemption available at the discretion of the insurer or a Court, and this set the pattern for commutation, later re-named redemption, under the current Act.

For this we need another short piece of history.

In the extract from the Byrne Report quoted earlier appeared the following words in relation to pension payments:

In the case where the percentage disability is below 10% the Board would automatically settle by a once only payment.

Where percentage disability is between 10% and 20% the worker should have the right to opt for a lump sum payment.

The 1985 White Paper was less explicit, stating only that 'The Corporation shall have the discretion to commute small pensions to a lump sum' (page 15).

So, whatever we call it, (commutation, redemption), the original intent was for this sort of payment to settle the liability to make small residual payments over a long period through the payment of a lump sum. But the Act as it evolved gave commutation, (a term changed in the 1990s to redemption), a whole other purpose which had, at best, a shaky legal basis.

As the problem with the claims tail grew through the late 1990s and early 2000s (due primarily to the dysfunctional section 35), the Corporation sought an alternate means to curb its income maintenance liabilities. Redemption was the chosen course. (Note that under WorkCover SA internal policy at the time, no claim could be redeemed less than 2 years after the date of first incapacity). Claims were selectively offered redemption lump sums under section 42 in exchange for a voluntary cessation of weekly payments under section 36. The theory was that the lump sums represented significant savings in liabilities for the Corporation, as they may well have done if they also terminated the claims being redeemed.

So entrenched did this practice become that the completion of a redemption seemed to be equated with a legal claim discharge. This in fact was not legally the case, regardless of the intent. Section 119 of the Act is explicit:

(2) Any purported waiver of a right conferred by or under this Act is void and of no effect.

(3) Any person—

> *(a) who enters into any agreement or arrangement with intent either directly or indirectly to defeat, evade or prevent the operation of this Act; or*
>
> *(b) who attempts to induce a person to waive a right or benefit conferred by or under this Act,*

is guilty of an offence.

The offering of a redemption lump sum could not require a worker to waive other entitlements under the Act – it was *not* a global, legal discharge for the Corporation. It is likely that many workers who received redemption payments later revived their residual entitlements, be that rehabilitation, medical or partial weekly earnings (where the terms of the redemption permitted).

Legalities notwithstanding, there was a period of some years prior to and after the implementation of the 2008 amendments during which redemption was heavily (and

according to some commentators, aggressively) used[20]. There was some published actuarial evidence to suggest that this redemption campaign had yielded some improvement in the scheme's claims liability[21]. Yet perversely, the 2008 amending Bill curtailed the use of section 42, followed soon after by an administrative decision by the Corporation to cease redemption payments altogether[22].

It is probably worth noting at this point that the so-called redemption strategy did nothing to stem the flow of claims *into* the tail, thus regenerating the tail almost as quickly as it was supposed to be reduced by redemption. The front end of the scheme continued to create the risk, which goes some way to explaining why the wholesale use of redemption had a relatively muted effect on scheme funding.

The ending of what was locally called the 'redemption fire sale' in 2009 was intended to be offset in actuarial terms by the revival of assessing work capacity as the basis for curtailing income maintenance entitlements under the new sections 35-35C. As mentioned earlier, we are yet to see any results from this over 3 years later and I suspect we won't until the Corporation has the use of legislation that is clear in its language and intent.

As an aside, here I choose to by-pass the more rhetorical aspects of this debate. I have no doubt that 'improving return to work rates' is an issue that must be addressed as soon as 'return to work' can be defined and measured. Indeed, if every worker who could work did actually return to work after injury, one of the presumptive conditions underpinning the Byrne Report would be met. But that is not the reality, yet scheme managers continue to talk like it is their primary mission to somehow work around the faults in the legislation, (if indeed they recognise them), rather than making a case to fix the root cause[23].

To my mind, it is rash to assume that every injury and every claim has a return to work outcome at the end of it. For a small number of cases representing a large liability, the scheme needs to either:

- Equitably (and legally) finalise matters with the worker where the situation cannot yield another solution due to issues outside the control of the parties and/or the scope of the scheme; or

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[20] It is ironic that one of the 2008 amendments on which so much store was placed was the limitation of redemption payments based on the theory that they promoted a lump sum mentality among workers that made them stay on the scheme longer. That inferred that the pattern of redemption and claim duration in preceding years was somehow worker-driven. Nothing could have been further from the truth in my view – the frequency and size of redemption payments was largely driven by deliberate Corporation policy.

[21] See *Summary of the Scheme Actuarial Review as at 30 June 2010* by Finity Consulting, 24/9/10 page 11 (published on the WorkCover SA website www.workcover.com).

[22] The decision to amend s.42 in 2008 remains a mysterious one. Redemption remains a discretionary power for the Corporation. An administrative decision or a Ministerial Direction would have been just as legally sustainable and effective without closing out future options by amending the legislation.

[23] For an indication that the root cause of scheme funding problems remains, after 25 years, the same one that the 1986 Act was intended to resolve, see Postscript 1. For examples of how decision makers have rhetorically skirted around the root cause, see Postscript 2.

- Legally end entitlements for that very small proportion of people who will not voluntarily do the right thing.

At the moment, the scheme can do neither. It can't even purport to do the former under existing provisions due to a self-imposed 'no redemption' policy.

Fixing what is broken

Income maintenance duration

The primary assertion of Part 1 of this paper is that the scheme's claims liability problems primarily arise from legislation that is supposed to limit the quantum and/or duration of income maintenance entitlements based on capacity for work, but has failed to do so since 1987, despite more than one attempt to rectify the fault. That has to be fixed. No scheme can afford to pay 80% of inflation-proofed average weekly earnings for more than 2 years to any more than the small number of workers who are heavily or totally permanently incapacitated.

The main problem facing Parliament is not the language of statute, challenging as that may be. The fact is that, through its structural faults, the scheme has paid the 80% rate to 5% or more of workers in excess of two years for most of its history. This has been the case for so long that it has been assimilated into expectations as an *intended* feature of the scheme. The new sections 35-35C were predictably criticised as a 'slashing' of injured worker entitlements. But these sections were actually intended, for better or for worse, to return the scheme to its original design principles. The intent was there, but the words failed.

Getting a clear and workable fix is essential, but it will require considerable skill and fortitude.

Settling claims

Without arguing the merits or otherwise of redemption and the (to me) unprovable theory of the 'lump sum mentality', there is no doubt in my mind that all schemes involving periodic statutory compensation should have a well-marked and well supervised exit.

After all the years of amendment, what the scheme still lacks is a clear *imprimatur* to finalise claims. I am not referring to common law as people tend to perceive it – but something that has a similar legal outcome in the sense of closure.

Common law in the context of tort action is in my opinion a red herring in the South Australian workers compensation scheme[24]. Proving negligence is not the core issue, since, as a State, we have long since decided on a no-fault compensation scheme and a separate work health & safety regulatory regime that takes care of matters related to negligent

[24] This should not be taken to mean that I think common law is anathema to a scheme. SA is one of only 2 Australian schemes that has no common law (NT is the other), yet it tends to have the most volatile and negative funding. On the other hand, the current travails of the NSW scheme largely stem from common law, and there are signs that similar problems are arising in Victoria. Provided the notion of tort action based on negligence is excluded as part of having a no-fault scheme, what is termed 'common law' in other schemes is really just another statutory entitlement and/or a mechanism to settle claims, which is exactly what I advocate here. I choose not to use the words 'common law' both because it is probably not the right legal description and because of the unthinking emotive response the words tend to receive in SA.

breaches of workplace safety laws. However, having an exit from the compensation system via a settling of liabilities is very much the issue. It is to me obvious that not every claim ends with the ideal 'return to work'. The reality is that sometimes, the scheme and a worker are better off parting company long before the claim reaches some other end-point. The trick is in identifying which workers have a genuine need in this regard.

The current s.119 actively precludes agreements in which a worker purports to waive rights under the Act. Yet for years, the scheme regularly negotiated redemption agreements that were treated as *de facto* finalisations of claims even though they were no such thing at law. It is arguable that the scheme for years practiced what the Act in theory still does not condone.

Such finalisations could, if they were openly countenanced by the Act, be achieved within the current entitlement structure without reference to some other set of financial or legal remedies. Access thresholds are also normally associated with the classic version of common law and always attract both disputation and debate. A position on this would need to be carefully considered if settlement provisions are to be drafted.

Self insurers can already achieve finalisations because they are both the compensating authority and the employer. They are able to negotiate finalisations and they can do it within the confines of broader industrial relations arrangements, even if they are fettered by s.119 in the same way. It makes sense that most self insurers generally have few claim duration or long term liability problems.

Section 119 should be amended to remove the bar on voluntarily settling claims, but retain what I think is its original intent, which is to protect workers from being coerced or hoodwinked into waiving their rights. Such an amendment should be complemented by the insertion of a Division that expressly permits the structured settlement of claims in specific circumstances via the existing entitlement structure, including redemption. Such a power should be discretionary for the compensating authority (as redemption has been in the past), and it should include a legal waiver of workers' further rights under the claim or claims being settled with mechanisms available to ensure that settlements are purely voluntary for all parties.

Summary of Part 1

The scheme was originally designed to limit the quantum and duration of income maintenance entitlements by reference solely to the extent and permanence of incapacity for work. This intent was lost in the sequence of drafting, Parliamentary debate, judicial review and amendment that followed.

Duration of income maintenance entitlements has been the key statutory defect in the current South Australian workers compensation scheme since its inception. All attempts to rectify the defect have failed and it remains the main distortion of scheme funding to this day.

The 2008 amendments removed one flawed set of income maintenance provisions and replaced them with another flawed set.

An inability to fix the duration problem at a statutory level led to the use of income maintenance redemption as a work-around in a way it was never designed for, and with

legally faulty results. Even so, the work-around did nothing to halt the influx of claims to the income maintenance 'tail', meaning that the funding impact of mass redemption was at best muted.

Then redemption was halted altogether on the dubious grounds that they inflated scheme liabilities by prolonging claims and created an expectation of a 'payout'.

So now we have the paradox of a scheme that seeks ways to end income maintenance claims yet denies itself an important tool (redemption) and is in any case statute-barred by its own Act from discharging claims by settlement.

Instead, we have the now entrenched euphemism of 'return to work' that is used as humanising cover for what the financial performance of the scheme really needs – fewer claims in receipt of high levels of long term income maintenance. If the latter can be achieved by better return to work results, (even if they could be defined and measured), then so much the better. But the terms of sections 35-35C as they were inserted in 2008 show that, euphemism to one side, income maintenance duration remains the real *statutory* target.

After all, we should always bear in mind that talk of 'return to work rates' being better or worse is potentially misleading, (quite aside from my argument that the scheme can't at present define or measure return to work anyway). The scheme has a continuance problem with a small percentage of claims. There can be a tendency to turn this into a sort of ritual self-flagellation in which the entire scheme's return to work performance is deemed to be poor. In reality, the other 95% actually did pretty well at getting back to work, it seems. Where the scheme fails is in not spotting the 5% early enough and acting on them. The lack of clear law on how to deal with the smaller percentage of intractable cases within the 5% by deeming earnings in line with capacity for work is at the heart of the recurring funding problem.

A final point of clarification – even if we can find our way through to a solution for the legislation, what then? There will still be an existing 'tail' of claims that will need to be dealt with under the laws that existed at the time those workers were injured. Changing the laws (without complete retrospectivity) is not an instant fix to scheme funding. Managing the tail will be an entirely different challenge and beyond the scope of this paper.

Part 2 – Déjà vu in service delivery: how things change while staying the same

The more things change, the more they stay the same. (Plus ça change, plus c'est la même chose)

Jean-Baptiste Alphonse Karr, January 1849

This part deals with the non-statutory, service delivery problems facing the scheme. I suggest that they are every bit as important as the legislation in terms of influence on scheme funding. These are business policy issues that, in theory at least, should have administrative solutions. Despite that, it seems that like the flaws in the legislation, the delivery mechanisms have had ingrained design faults that have existed far longer than the scheme has.

In-house or out-sourced – is that the real question?

An essential first step in reviewing the service delivery issues faced by the South Australian workers compensation scheme is to work through what I see as a distorting influence in the discussion of key issues – outsourcing of claims management. I call it a distorting influence because outsourcing has generated a layer of debate that has tended to lure thinking away from challenging the actual fundamentals of delivery. In effect, debating outsourcing is debating the 'who' rather than the 'what' and the 'how'. In this part I hope to make a case that if a claims manager gets the 'what' and the 'how' right, it does not matter whose logo is on the letterhead.

A brief history of outsourced claims management in SA

The structural evolution of outsourced claims management in South Australia is summarised in Appendix 1. It was initiated under the leadership of Hon Graeme Ingerson MP, Minister for Industrial Relations[25]. The legislation that authorised it was contained in the *WorkCover Corporation Act 1994*, which, among other things, reconstituted the WorkCover Corporation and re-defined its powers and degree of independence.

After passage of that Bill, a tender was undertaken that resulted in the selection of 10 insurance companies that would manage claims from 1st August 1995 on a fee-for-service basis. Insurance industry consolidation reduced that number to 9 by the time of commencement, and this process would, over subsequent years, steadily reduce the number of agents, but increase the size of insurers willing to undertake the role.

One of the governing principles of the 1995 agent arrangements was the then-popular concept of 'partnering'. Under this approach, the contractual arrangement was almost that of equals, with significant policy and procedural latitude afforded to the agents and limited capacity for WorkCover to direct agents[26].

[25] I will not go into the rationale under which outsourcing was undertaken. The purpose is only to review its history and influence.

[26] So important was this thought to be that a firm of partnering consultants was engaged to manage this aspect of the tender and contract development.

By 1997, it was clear that the first contracts[27] needed improvement, particularly a stiffening of agent accountabilities (including the introduction of penalties for financial errors), restructuring of performance requirements, fees and incentives as well as a more flexible contract structure that allowed for operational variation as scheme needs altered. There was also a view that 9 agents may have been too many for a market the size of South Australia, though changing the number of agents was not a declared objective of the 1997-98 selection process.

Above all, it was by 1997 clear that 'partnering' as a management model was unsatisfactory for claims management given the risks. The new contract needed to be between WorkCover as the principal and the agents as service providers working under pre-set conditions of engagement[28].

From 1st July 1998, a smaller panel of 5 agents (including one new one) commenced under a significantly amended contract[29].

Apart from consolidation, the next major change was the appointment of a sole agent in 2006 to replace the multi-agent panel.

Through most of the life of the multi-agent format, the following basic principles applied:

- Base remuneration, set at a break-even value for agents, was based on market share (or, to put it another way, the number of employers and the remuneration they represented in each agent's portfolio).
- Performance fees (intended to be the profit margin for agents) were based on a range of performance indicators ranging from service-related items, through legislative compliance, transactional accuracy, to liability-related matters such as claim duration. (The balance between these things sometimes shifted according to operational requirements).
- Employers had a periodic right to change agents.
- No tight controls over market share.
- Cyclical evaluation of agent performance and compliance was undertaken by WorkCover.

The critique of outsourced claims management

Over the years since 1995, the private sector management of claims on behalf of WorkCover SA has attracted its fair share of usually polarised discussion, much of which has tended to blur the key points. For example:

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[27] Which borrowed heavily from the form of the contemporary Victorian agent contract. The forms of the 1995 and 1998 contracts were both published as regulations in the SA Government Gazette and debated in Parliament. This practice ceased in 2006.

[28] The author managed the 1997-98 selection and contract development process for WorkCover.

[29] It is ironic that the very same process of initiating a claims management contract as a partnership and later abandonment of that form of relationship in contract revisions appears to have been repeated in 2006 and the years after. The lessons of only 10 years before seem to have been forgotten or ignored. Reasons for this can be suggested but they are not germane here.

By any objective standard the outsourcing of WorkCover's claims' administration functions has been a failure. The benefits claimed for outsourcing have simply not materialised. On the contrary, administration costs have increased significantly, employer choice in any meaningful sense was never achieved, and service delivery to injured workers in key areas has been compromised. Most importantly, the performance of the scheme has deteriorated and the funding position of the scheme has never been at such a low level as has been the case under outsourcing.

Accordingly, the recommendation of the Stanley Review that the scheme's claims administration should be insourced [sic] *needs to be revisited as a matter of priority…*[30]

In this summary statement and elsewhere in his paper, Dr Purse has asserted that outsourced multi-agent claims management:

1. Failed to achieve its objectives.
2. Was adversely linked to the state of the scheme's funding.
3. Delivered its services in an unbalanced manner that favoured employers.

I will provide a brief comment on each point.

Did outsourcing fail to achieve its objectives?

In 1995 during debate in Parliament, the then Attorney-General, representing the Minister for Industrial Relations in the Legislative Council, said:

We are confident as a Government that outsourcing of the claims management will produce… cost savings to the scheme. The board has resolved independently of Government that at least $5.4 million per year in cost savings can be achieved by improving return to work rates through competitive outsourcing of claims management.[31]

The actual result over the following 5 years:

	1995-96	1996-97	1997-98	1998-99	1999-00
Fees ($'000)	$17,003	$18,529	$17,306	$15,875	$20,038
Annual % change		9%	-7%	-8%	26%
5 year variation					18%
Outstanding claims ($'000)	$806,244	$695,015	$709,815	$710,316	$780,702
Annual % change		-14%	2%	0%	10%
5 year variation					-3%

In short, claims management costs increased by 18% in the 5 years after this statement, while the outstanding claims liability decreased by just 3%.

10 years later, we were presented with a remarkably similar statement:

[30] Dr Kevin Purse, *The Outsourcing of Workers' Compensation Claims Management in South Australia*, submission to the Parliamentary Statutory Authorities Review Committee written for the Public Service Association of SA January 2008 p.13

[31] Hon K.T. Griffin, Attorney General to the Legislative Council, SA Parliamentary Hansard 5th April 1995 p.1752.

'On 18 January 2006, the Board appointed Employers Mutual as sole provider of injury and claims management services for WorkCover… Appointing Employers Mutual as sole agent provided better overall value, including savings for WorkCover of almost $5 million a year in agent fees… they expect to reduce WorkCover's claims liability by more than $100 million a year after only two years of operation…'[32]

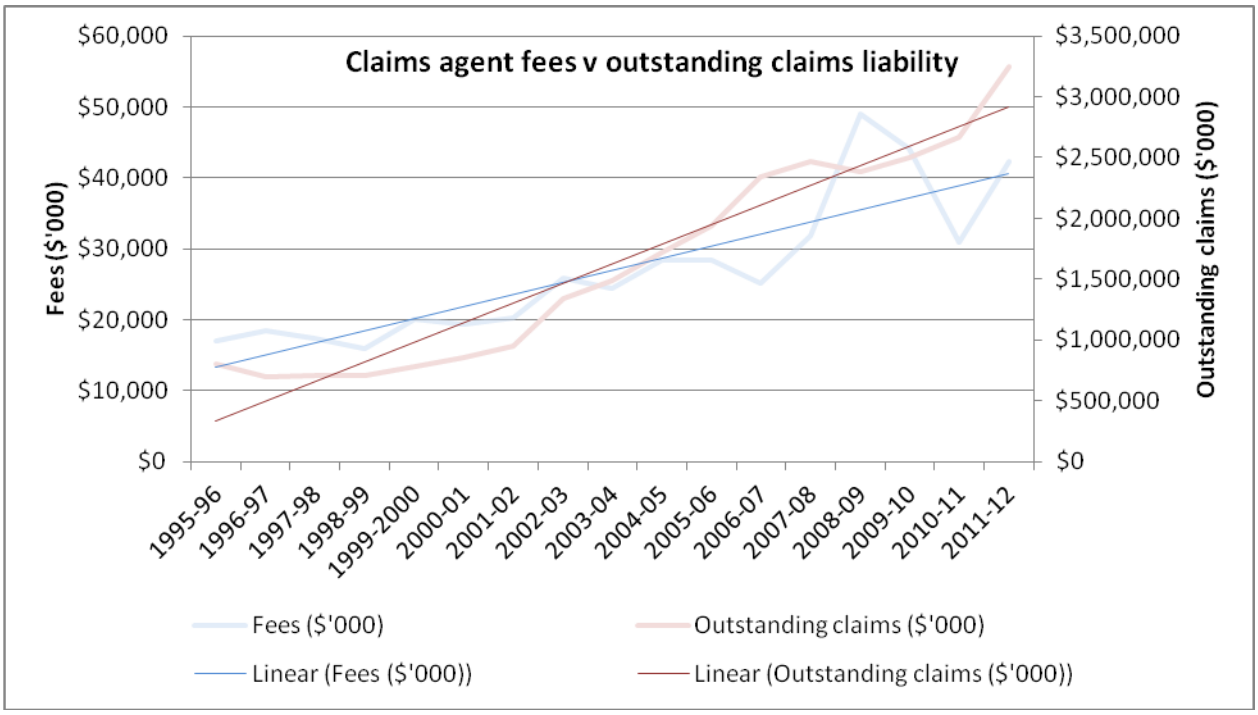
The actual result over the following 5 years:

	2006-07	2007-08	2008-09	2009-10	2010-11
Fees ($'000)	$25,124	$31,773	$48,930	$44,154	$30,935
Annual % change		26%	54%	-10%	-30%
Overall variation					23%
Outstanding claims ($'000)	$2,344,042	$2,464,987	$2,384,999	$2,497,741	$2,663,521
Annual $ change		-$120,945	$79,988	-$112,742	-$165,780
Annual % change		5%	-3%	5%	7%
Overall variation					14%

In other words:

- Agent fees increased by 23% over the subsequent 5 years
- The outstanding claims liability increased by 14% over same period.

Seen in broader terms, the one thing that has inflated faster than claims management fees since 1995 has been the outstanding claims liability:



Other assertions have been made about the objectives of outsourcing including the improvement of service to employers and workers, the introduction of choice for employers (which was obviously discarded at the appointment of a single agent, but may be making a

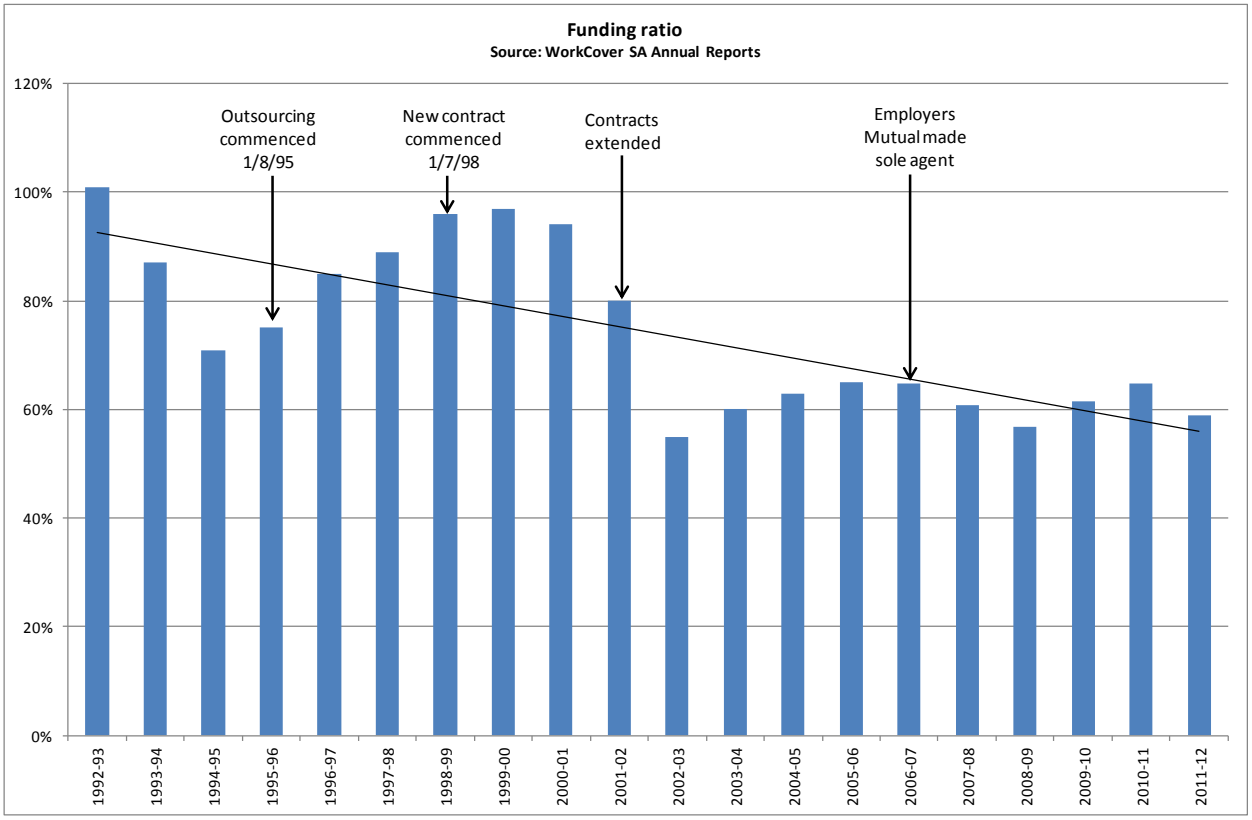
[32] WorkCover Annual Report 2005-06

return in 2012) and greater efficiency. There is evidence to be had on these matters as well, including that set out in the paper by Dr Kevin Purse cited earlier, which I will not repeat.

My conclusion is that Dr Purse was correct – outsourcing delivered none of its declared objectives in the 17 years since it commenced.

Was outsourcing adversely linked to the state of the scheme's funding?

The evolution of outsourced claims management does not seem to have an identifiable connection with scheme funding, which has had a declining trend since before the advent of outsourcing, arguably right back to the scheme's first years:



It would be correct to say that outsourcing is adversely linked to scheme funding *if* it can be demonstrated that the agent/s had a high level of control over the outstanding claims liability[33]. The views on the statutory driver of the outstanding claims liability put forward in Part 1 of this paper, that is to say a defect in the income maintenance duration provisions in the Act that has existed since the scheme commenced, is relevant here. I suggest that this defect ensures that no claims manager, in-house or outsourced, has that level of control.

I conclude that Dr Purse's inferred connection between outsourcing and scheme funding should be modified. Outsourcing has failed to affect scheme funding not entirely because claims agents have failed to control the outstanding claims liability. It has failed because the various claims agents have proved no more able than WorkCover to overcome the effects of the statutory defect described in Part 1 of this paper. In real terms, the agents brought nothing new to the scheme in liability management terms.

[33] Figure 2 in Part 1 of this paper shows the close inverse relationship between the outstanding claims liability and scheme funding.

Did outsourcing deliver its services in a manner that favoured employers?

I think the unequivocal answer to this is yes. But that is not to say that being pro-employer is an inherent characteristic of outsourced claims management. The behaviour of claims agents will always be shaped by 2 things in order of importance:

1. Fee structures; and
2. Contract conditions.

Throughout the multi-agent experience, base fees were allocated by market share. The larger the market share, the larger the base fee and, in theory at least, the more economies of scale available to the agents. Since market share was determined by employer choice, it was commercially necessary for agents to attract employers. Aside from various corollary product offerings and other marketing ploys, the obvious way to attract employers was with a style of service delivery that they found attractive. Agents were driven to pro-employer behaviour by the terms of their contracts, in particular, the basis of their fees. Since the terms of the agent contracts were written by WorkCover, the accountability for the behaviour of the agents must also be WorkCover's.

This is not a view shared by all. In December 2002, the report of the Stanley Review focused on the commercial aspects without considering the underpinning contract and fee influences. The report commented that:

Many submissions and some of the consultations undertaken by the Review - from workers, unions, worker support groups, medical and rehabilitation provider associations and individual practitioners, as well as legal practitioners - drew critical attention to the insurer-employer relationship. Many times it was quite explicitly stated that the insurer was looking after the employer's interests and not those of the worker. Some submissions raised the issue indirectly through the account of the problems encountered. In dispute resolution this is particularly apparent to participants, with insurer solicitors commonly acknowledged as representing employers. Some of the promotional marketing material of some insurers sighted by the Review certainly gives that impression.

In the opinion of the Review, this is a serious problem. The commercial arrangements between insurers and employers clearly have the potential to affect the claims management and rehabilitation functions. While it is appropriate and reasonable for claims managers to brief, consult and involve an injured worker's employer in important aspects of the claim, particularly rehabilitation and return to work, agents for the compensating authority…are expected to decide matters in an impartial manner according to the legislative prescriptions and other guidelines without being influenced by commercial arrangements[34]*.*

The report went on to recommend that claims management be returned to WorkCover and the legislation authorising outsourcing be repealed. With respect to the reviewers, I suggest that the pro-employer bias shown by the agents at the time should have been looked at as a symptom of the underlying contract and fee issues that could have been addressed, rather

[34] Stanley, Meredith & Bishop, *Review of Workers Compensation and Occupational Health, Safety and Welfare Systems in South Australia*, Report Vol 2 December 2002 p. 80. This is the report mentioned in Kevin Purse's paper quoted earlier. The Review used the misnomer 'insurer' when referring to claims agents. The actual insurer was (and still is) WorkCover SA.

than a fixed and unchangeable feature of outsourced claims management necessitating its cessation.

Furthermore, it should not be concluded that pro-employer behaviour was always to the scheme's advantage. Sometimes the reverse was the case. For example, shortly after outsourced operations commenced, WorkCover noted a steady increase in the number of claims being coded secondary[35].

So, I suggest that Dr Purse was correct in identifying pro-employer behaviour. But it was not an inherent feature of outsourcing. Had the agent contracts, and in particular the fees, been structured differently, the behaviour would have been different. All the agents did was follow the commercial line of least resistance, as would be expected given that the reason for their presence in the scheme was commercial rather than altruistic.

Observations and conclusions on outsourcing of claims management

Here are some observations on outsourcing based on experience:

1. Outsourcing will be more expensive due to the need to build in agent profit margins, unless more than that is saved in cost and liability (which has not been the case in SA). This assumes that it costs roughly the same to manage claims regardless of who does it. The problem with proving this theory is that there are too many greater and lesser variables that constantly affect scheme performance to isolate the actual effect of outsourcing at a scheme level. But I still believe that this is a valid observation, even if it is intuitive.
2. Outsourcing claims management is not outsourcing risk or accountability. Statutory accountability rests with WorkCover. It is for this reason that partnership-based approaches are inappropriate. There is no actual equality in the accountability for the results, since the agent/s have far less skin in the game than the regulator.
3. Statements that claims management is not core business for a workers compensation insurance regulatory authority should be rejected as hindsight justification of continued outsourcing in the face of poor scheme results. If an insurer does not receive and manage claims, what does it do other than collect revenue? The alternate argument is that the regulator is not the same thing as the insurer, and claims management is not a regulator's core business. That would be credible if the functions were split as suggested in the postscript to this paper. However, as long as the functions of insurer and regulator remain in the one organisation, claims management is indeed core business for the insurer, and while outsourcing might place an artificial distance between the insurer and the claims shop-front, it all remains, at law and in fact, a single statutory and business system.
4. Outsourcing introduces issues of control risk. Contract terms, performance criteria, market share incentives and other things directly controlled by WorkCover will govern agent behaviour. Malicious compliance, 'gaming', internal cost-cutting for improved

[35] By being coded secondary, the costs of claims were excluded from the employer's claims experience under the Bonus-Penalty scheme, meaning that WorkCover was unable to recover claim costs incurred by employers in excess of their industry averages.

margins and lower service standards are all risky behaviours that will be manifested if the contract terms permit them. In effect, agents will go where the money is.

5. Miscast performance criterion will allow agents to gain performance payments while the scheme's performance is deteriorating. This principle is exacerbated by the flawed legislation that drastically curtails the ability of any party to adequately control the claims liability.
6. In managing claims, agents are spending someone else's money, which in turn can lead to less than diligent internal practices. For example, it was not until the advent of the 1998 contract that WorkCover gained the right to recover duplicate invoice payments and overpayments from the agents, which could then elect to recover from the party they paid in error at their own expense. Payment accuracy predictably improved after this provision was invoked[36].
7. The cost of surveillance of agent operations in terms of auditing, data-matching, performance management and contract management can all too easily over-match any monetary benefit attributable to outsourcing. In most outsourcing cycles, these costs start out low while trust and confidence in the contract terms are high. Over time, as flaws in the arrangements emerge, the level of surveillance and active direction of agents increases, along with the internal cost of outsourcing.
8. Agent fees in the SA scheme have an unbroken history of escalating at a rate well beyond any known inflation factor, regardless of how the scheme itself is performing. The tables on pages 22 and 23 are very clear on that. This says something about the difficulty of tying fees to measurable factors that are genuine indicators of scheme health without losing the focus on day-to-day quality.

The case a few years ago in Victoria where an agent was allegedly falsifying data to improve its fee payments was a salutary lesson in outsourcing risk[37].

My conclusion about outsourcing is that it is more risky from a control standpoint without a corresponding decrease in system risk. This may change if the flaws in the legislation are finally repaired and system risk is reduced accordingly.

To my mind, there is no firm evidence that either the in-house or outsourced models have so far made a demonstrable difference in the face of the lack of control over liabilities conferred by the statutory defects.

But that is not all there is to it. We are still discussing the 'who'. I have asserted that the 'what' and the 'how' are made very difficult by unclear legislation. But there is another layer that makes the statutory problem much worse. Changing the logo over the claims management desk has not made and will not make a difference because too much else that

[36] The author recalls serving an invoice for $30,000 for incorrect payments on one agent in 1998-99. The impact on that agent's internal procedures was clear. While the cost of the data-matching and auditing required for this system might at times have exceeded the value of the recoveries, the improvement in agents' internal business disciplines arguably made the system a success.

[37] *Investigation into record keeping failures by WorkSafe agents*, Victorian Ombudsman May 2011 p.35. This report explored the risks of agent manipulation of performance fee data in the Victorian scheme at some length.

is not statutory in nature has stayed the same throughout the history of the scheme, and that is my next theme.

Compassion v compulsion, sympathy v statute – changing while staying the same

Not all it cracked up to be – everything old is new again

Everywhere I have looked, workers compensation claims are managed on an insurance model – what I call the mass-management of claims. A group of administrators, (case managers or whatever title is used), sits in an office and receives, determines and manages claims based on the paperwork received, phone calls and the like. It is a very efficient model for material-loss claims such as motor vehicle damage, home insurance and the like, where the sole job is to ensure that claimed losses are genuine and fall within policy terms, make a payment and close the file. In short, it is a model well suited to throughput types of insurance where all claims are broadly similar and will fit within a fixed linear process.

When one looks past the marketing and spin of the various exercises in claims management outsourcing since 1995, it is not hard to see that the same mass management product has been on offer, (and sometimes delivered by the same people wearing different badges). It may be dressed differently, and it may be accompanied by any number of slogans, promises, declarations of a new standard of diligence and service delivery undertakings and the like. In the end we still have rows of people in an office managing claims in accordance with written procedures in an environment largely remote from the actuality of the workplace and the worker. The question is why, as an industry, we continue to be tied to a model that is so ill-suited to the world of personal injury when the evidence is clear that schemes are gravely damaged by the exceptions that the mass-management model generates, however few they may be.

It probably goes without saying that personal injury claims are not at all similar in nature to those in other classes of insurance. This was recognised in the 19th century by the enactment of statutory rights to compensation for sufferers of personal injuries and diseases sustained in the workplace[38]. Where contractual or policy terms for most other classes of insurance have remained a transaction between purchaser and vendor with the principle of *caveat emptor* limited only by modern consumer rights laws and broad industry regulation, we have for over 100 years recognised how different and more complex personal injury compensation insurance is and defined it in workers compensation and compulsory third party insurance legislation.

Yet we have persisted in managing the statutory insurance schemes (that we originally sought to differentiate) in the same way we manage other insurance classes – by the mass-management model. In the context of the current South Australian workers compensation scheme, the mass-management model has remained in place since the scheme

[38] SA was one of the first in Australia, with the *Workmen's Compensation Act 1900*. That Act was limited to occupations that were "…dangerous or injurious to health or dangerous to life or limb…" (section 3) and allowed workers to opt for compensation under the Act or to pursue damages in a court. It also allowed employers to 'contract out' of the Act in certain circumstances – a forerunner of self insurance.

commenced in 1986 – as mentioned earlier, outsourcing has not altered that in any meaningful way.

The mass-management model relies on economies of scale and process flow – it needs every case to be as similar to all others as it can be made to be for the model to run smoothly. The model is therefore not good at dealing with the notion that 'claims' are actually 'people', whose needs and personal characteristics might differ from case to case. Mass-management abhors exceptions, yet that is exactly what a personal injury compensation claims administrator is likely to encounter. In the next section I will suggest why this apparent paradox exists before looking at some possible avenues to resolve it.

The curse of the statutory structure

Any no-fault workers compensation scheme has a statutory structure that usually links entitlement to services or compensation with events or elapsed time, total claim cost or some other defined point in a linear progression. Paradoxically, this process-based legislation, which is intended to differentiate workers compensation from other forms of insurance, to make directions with regard to liability and to create and protect the rights and obligations of scheme participants, will often generate a process culture best suited to mass-management but not well suited to personal injury management. Legislative compliance becomes the dominant factor, supported by sometimes rigid or overbearing regulatory practice that tends to erode flexible thinking at the point of contact between the system and those it is supposed to serve. It is here that most of the exceptions are created.

For example, step-downs in income replacement entitlements are normally fixed by statute at a point in elapsed time. There are workers whose injuries, despite their best efforts, continue to preclude a full return to work as that point in time is exceeded. Yet they are subjected to the step-down anyway even though these cases do not fit the statutory presumption that at a particular point in time, a worker needs a goad[39].

The paradox created by the tension between statutory structures and flexible thinking is not limited in scope to the injured worker. Unlike many other forms of insurance, a workers compensation scheme's income stream has statutory certainty. Regulators have extensive statutory powers to both set their premium rates and collect the revenue from employers, including the punishment of non-compliance. This guaranteed income tends to move the employers that finance the scheme into the operational background and places the primary focus of the regulator on expenditure and liability control. The operational focus is on the worker and the cost[40]. I would argue that this is one reason why the role of the employer and the workplace in workers compensation has historically been a relatively passive one in

[39] I should note in passing that in SA, application of step-downs is not mandated by the Act but is at the discretion of the compensating authority, since the Act only establishes a minimum entitlement for the worker. The mass-management model tends to compel the universal application of step-downs despite the obvious damage they can do in some cases. They have in the past even been integrated as a business rule into the computer systems used to manage claims so that the step-down is automatically applied. It may even be the case that claims managers have forgotten or might not even be aware that applying step-downs is not mandatory; such is the force of process normalisation.

[40] Evidence of this is to be found in WorkCover annual reports. Whole chapters are dedicated to the various abstract aspects of revenue, expenditure and liability management, return to work and so on. The employers that finance the scheme and their role in the scheme tend to get passing mention.

which the employer is simply expected to comply and cooperate without taking any leading or managing role in managing the employee's situation[41]. The other reason for this historically subordinate role definition of the employer has been the relatively authoritarian and centralised approach to management that is the natural consequence of the mass-management model. It is a system of central control that does not comfortably co-exist with the notion of decision-making by others closer to events who might be more attuned to risks and needs.

It is only in relatively recent times that workplace-based management (as distinct from employer compliance, cooperation and participation) has been formally recognised as a key ingredient in good outcomes. The advent of Rehabilitation and Return to Work Coordinators is one form of recognition. In Victoria, employers are obliged to draw up return to work plans for their injured employees. The demonstrable balance-sheet success of the self insurance model, where *all* decisions are made by the employer at the workplace, is perhaps the ultimate expression of this principle[42].

To summarise this part, I suggest that the very existence of a statutory structure that bases access to workers compensation entitlements on linear development, be that time or some other thing, contributes to the innate tendency to organise schemes by the mass-management model that creates exceptions that it is ill-equipped to deal with. This is certainly not an argument that there should be no statutory structure, but it is an argument that the effects of the statutory structure might be improved through smarter management systems.

Exceptions in the mass-management model

To be clear, the term 'exception' as I use it here refers to injured workers whose cases do not fit the 'norm' for some reason. In South Australia, due to a combination of statutory shortcomings (described in Part 1) and lack of up-front risk management, exceptions often result in worker distress, extended claim duration and mounting liability, even if the triggering issue was not of major dimensions. It is a situation with no winners.

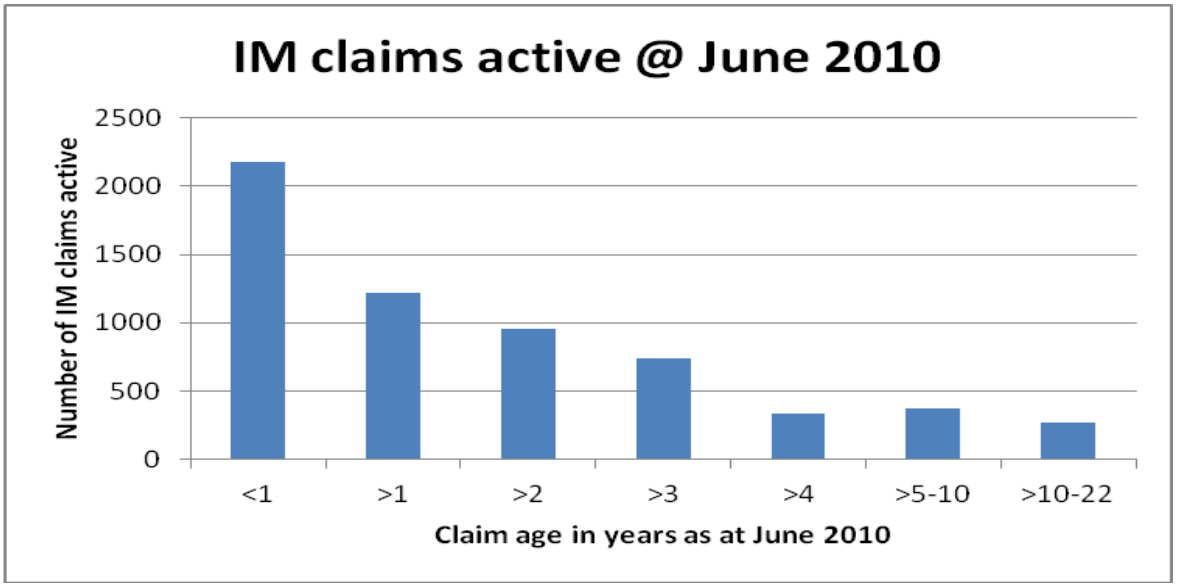
The key point is that in any mass-management model, exceptions are managed retrospectively. The undetected risks that gave rise to the exceptions are usually apparent after the event. But prior to the exception becoming manifest it is not obvious because the mass-management system collects broadly the same information in respect of every claim. A review of a claim form shows that the required information is directed to determining the statutory issues of compensability and access to entitlements – what happened, when did it happen, how did it happen, why did it happen, what were you doing, who is your employer, what is your weekly wage, have you had any other similar injuries, and so on. This is information that has to be collected, but it says little or nothing about human issues and latent risks, such as what is the state of the employment relationship, how is your health other than the claimed injury, what is your level of job satisfaction, do you want to return to

[41] This is not to say that many enlightened employers do not do this spontaneously anyway.

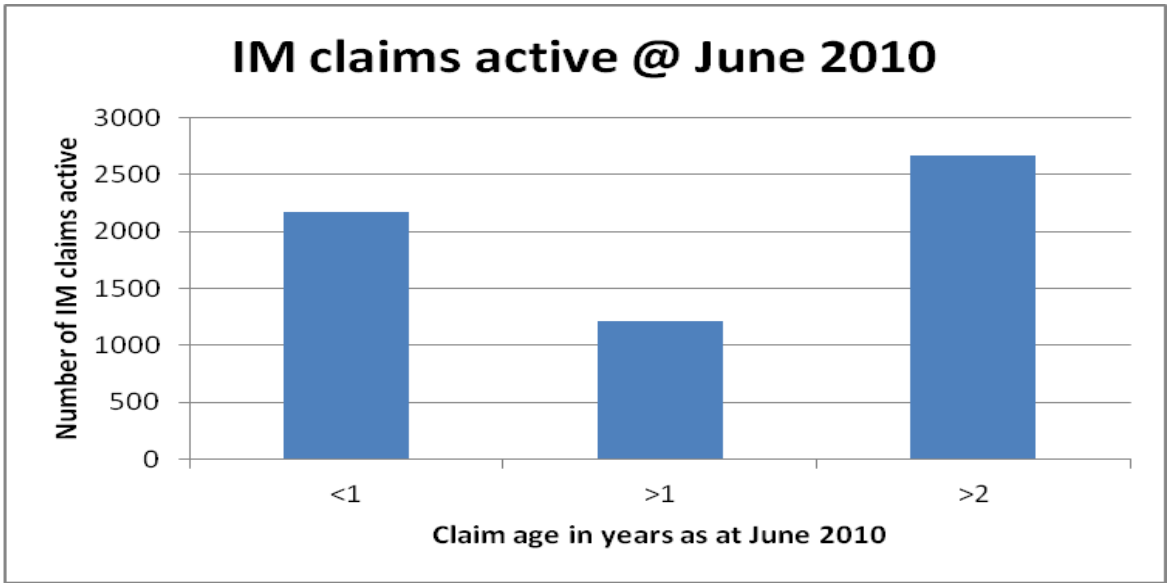
[42] I estimate that at the time of writing, self insurers represented about 36% of the SA scheme by remuneration but carried only about 17% of the State's total outstanding claims liability.

that job – background information that has a large bearing on how well a worker will progress.

Inadequate (or the wrong type of) information at the inception of a claim risks the creation of exceptions, which in turn generate the bulk of the claims liability when they become long-term or 'tail' claims through a combination of flawed legislation and poor up-front understanding of the issues that are likely to arise in any given case. The propensity of the South Australian workers compensation scheme to accumulate a 'tail' has been a consistent issue. A snapshot of it was given in 2010 when WorkCover published a summary of its June 2010 actuarial review including a table of active income maintenance claim numbers by injury year[43]. This is summarised as follows:



The picture changes if we adopt the principle that any claim over 2 years is well and truly in the 'tail' and add the number of claims older than 2 years:



[43] *Summary of the Scheme Actuarial Review as at 30 June 2010*, Finity Consulting 24 September 2010 Appendix A.1. Note that this practice of publishing such information has since ceased.

It seems clear that the operational priority should be placed on ensuring that only the seriously incapacitated workers for whom long term support is a part of scheme design move into the tail. So the differentiation of claims by risk factor at the time of initiation ought to intuitively be the preferred approach. Yet the mass-management model and the obsession with compensability, cost and compliance with linear statutory and policy processes actively resist that through their inherent preference for standardised procedures and compliance. I suggest that the mass-management model of claims management adds significantly to the scheme's propensity to accumulate a tail and the liability problem that flows from it. It is a scheme feature that has never changed and seems unlikely to change, despite it being occasionally dressed differently.

Where to from here?

The following quote from nearly 10 years ago goes a long way to summing up what is needed.

Considered in conjunction with the finding that one in ten injured workers have [sic] *an unsuccessful attempt at returning to work, mostly because of their injury, the high proportion of previous claims reinforces the importance of focusing on the injured worker, and not the claim, as the primary unit of analysis for evaluating RTW outcomes*[44].

If the claims management system, (whoever is running it), is to learn to reliably detect and manage human risks before they become exceptions, it must understand the issues and know how and when to respond to them. Here is a short, but not comprehensive, list of factors that a claims manager may need to be aware of when making decisions:

1. Pre-existing issues – these range from broad socio-economic and demographic factors through family situations to individual matters of personal history, physical and mental health status and personality traits such as addictive personality or obsession behaviour.
2. Industrial relations environment – ranging from the economic health of the worker's industry or occupation, through employer-level viability and job sustainability[45] to individual workplace issues bearing on job satisfaction.
3. System error – where the compensation system makes mistakes that adversely impact on the worker, including poor communication. These can include the recovery of overpayments and decisions on access to compensation that are wrong at law or based on incomplete information.
4. System (or decision) generated – a decision might be correct in law but is so adverse to the worker and/or so poorly communicated that active hostility and a tendency to challenge everything is generated.

1 and 2 above require diligent and sophisticated information-gathering during the earliest contacts. There will be obvious sensitivity about some of this information, and consideration must be given as to who would be the appropriate person to collect and consider it.

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[44] *Campbell Research & Consulting Return to Work Monitor*, August 2003 p.iv

[45] Example – the group of long-term claims that emerged when construction of the Adelaide Myer Centre was completed by the Remm Group in the early 1990s. Many of these ran for 10 years or more.

Rehabilitation providers, doctors or other qualified people outside the direct claims administration process might fill this role.

3 and 4 above are about:

- The style, method and quality of communication
- The calibre, experience and psychometric profile of the person making the decisions and communicating them
- The system support and resources that are available to that person
- The speed and extent to which policy and procedure can be unilaterally adapted by that person to suit individual needs; and so on.

The challenge is to detect the cases with evidence of any of the risks listed above, decide if that will have implications for the worker's progress and if so, be able to direct the right resources to them at the right time in response. It sounds hard and expensive, and it would be hard and expensive. It requires an intelligent, layered approach using state of the art tools. It requires information collection and decision making outside the realm of central control, closer to the reality of the worker and the employer. From the mass-management standpoint, it involves letting go of an element of control and instead trusting others who have a better view. In short, it requires major changes to a century-old, heavily entrenched model of business and the assumptions that support it.

Some of the barriers to such a model might be:

- Expense
- Having the right people doing it
- Availability of the right tools for information collection – psycho-social, psychometric, demographic and so on
- Overcoming natural and understandable community resistance to collecting sensitive personal information that does not at first glance appear relevant to a claim for compensation
- Breaking the mass-management mould – putting less distance between the people and the process, for example, by creating mobile high-risk case managers who operate in the field for the identified exceptions
- Breaking the centralised control tendency of the mass-management model and entrusting some decision-making to qualified people who are closer to the realities of workers, workplaces and employers
- The role of the medical profession, in particular the attitude of some sections of the medical community to the compensation system, and workforce design issues involving shortages of doctors, especially in regional and remote areas
- Re-casting the role of vocational rehabilitation. A good start would be to ban the use of rehabilitation providers for purely statutory purposes. In my view, using providers to, for example, gather evidence to sustain a decision to cease a compensation entitlement is not an appropriate use of a profession whose object is to obtain the best possible

restorative and employment outcomes for workers[46]. A corresponding increase in in-house expertise for those statutory functions would be required.

Summary of Part 2

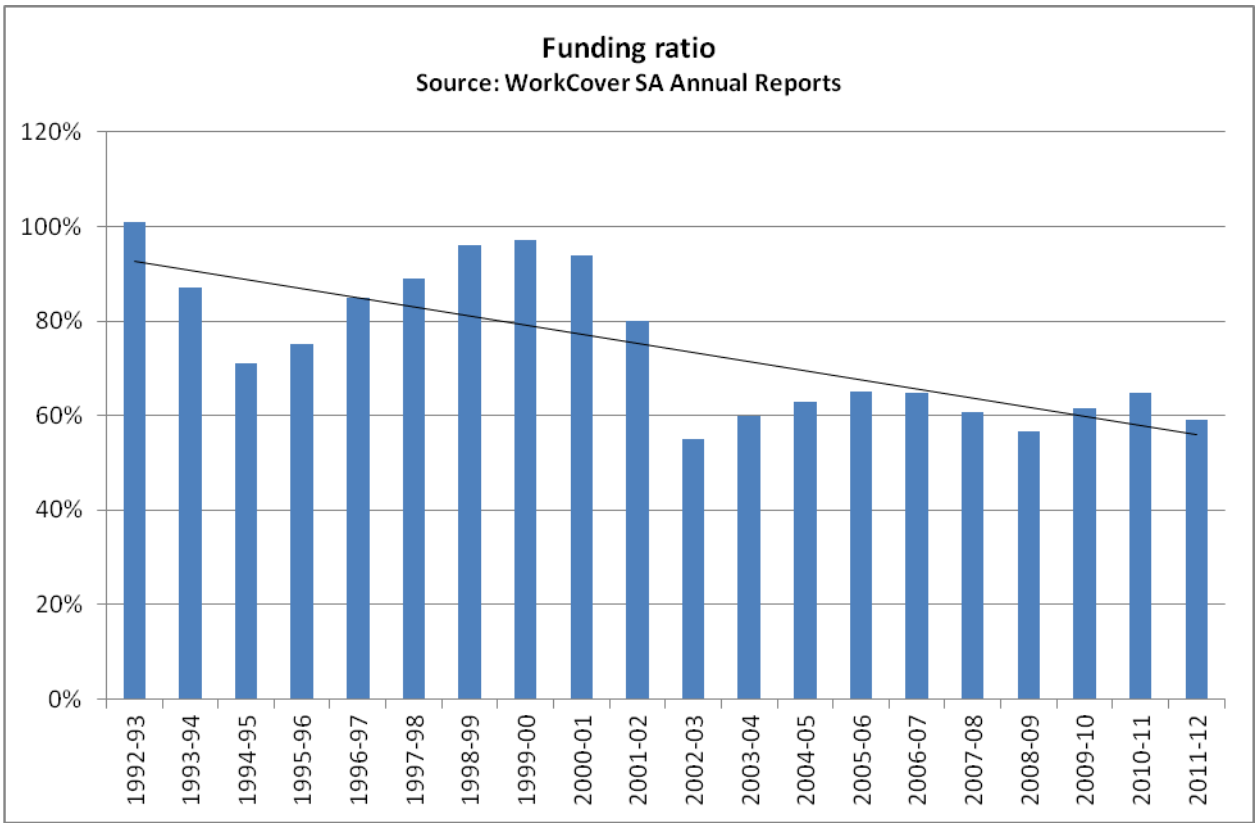
To summarise my views in this Part 2, arguments about whether to outsource claims management or not are at best a distraction from the real questions about how the scheme approaches its task. The approach to statutory compliance and the mass-management of claims are at the heart of the service delivery question. The historical model has been creating exceptions at a rate that needs to be reduced. Flawed legislation as set out in Part 1 allows those exceptions to form a claims 'tail' larger than the scheme was designed to cope with.

[46] Based on my own experience and discussions with providers, I think it is arguable that an appreciable proportion of rehabilitation expenditure has in the past been directed to these statutory (or non-restorative) functions. I also think that while this is the case, any concerns about the level of scheme rehabilitation expenditure compared to outcomes have to be sheeted home to those who direct the providers and approve payments for services.

Summary of Parts 1 and 2

The problems outlined in both parts tend to exacerbate each other. If many fewer exceptions were generated at the claims management level, the 'tail' would be of more manageable proportions and the flawed legislation that inflates duration would be a less pressing issue. If the legislation functioned in the way intended by the scheme designers, tail claim duration would not be the problem that it so clearly is and would make the rate of exceptions less critical.

This interplay of flaws is, to my mind, the root cause of the problems of the South Australian workers compensation scheme. Slogans such as 'improving the return to work rate' are just euphemism to cover these harder matters. These issues have existed and continue to exist like an unbroken thread since 1986. If anyone doubts what this means in the long term, I firstly reproduce the linear trend in scheme funding in Figure 3 from Part 1:



If anyone still doubts the existence or influence of these perennial problems, I recommend that they speak to the injured workers and the employers that the scheme is supposed to serve. From their standpoint, it seems to me that not much has really changed over the long term. For employers, workers compensation and keeping injured employees at work is one of dozens of business challenges to be met. For injured workers, making a claim and seeking access to services and compensation remains pretty much the same process, and the issues and disputes that arise for both parties have a familiar ring.

This is the window through which we should judge how much things are really changing for better or worse. It is not about logos, slogans, business models or corporate communication. Workers compensation is a grudge buy for most that have to participate in it. No amount of dressing it up will make it anything other than a cost to business and a complex and

sometimes difficult system to navigate for workers and employers together. The real customers just want it to be fair, simple, efficient and cost-effective. Easy to say, of course.

It is arguable that solving the challenges in claims management as outlined in part 2 might alleviate the need to correct the flaws in the legislation set out in Part 1. I regard it as a truism that the best laws, if badly applied, will still produce bad outcomes. The worst laws, when applied with intelligence and flexibility, can still generate good outcomes. I use the word 'can' advisedly. We are dealing with *personal* injury, which, as suggested earlier, is necessarily less certain in its human outcomes than other classes of insurance.

For a thoroughgoing result, both the laws and their application have to be right. Without clear laws there is no clear understanding of what a person's rights and obligations are. Without intelligent application of the laws, there is no guarantee that those rights and obligations, and the limitations on them, will be delivered.

Appendix 1 – Summary History of Claims Management Outsourcing

Based on the author's recollection

As selected 1995	**As commenced 1/8/95**	**1998 contract**	**Contracts extended 2001**	**At July 2006**	**From 1 July 2006**	**From 1 January 2013**
C.E. Heath[1]	FAI[2]	Commercial Union[3]	Allianz	Allianz	Employers Mutual	Employers Mutual
CIC[1]	GIO	HIH Winterthur[1]	CGU	CGU		Gallagher Bassett
FAI	Heath-CIC[1]	Mercantile Mutual[4]	HIH[1]	Employers Mutual[7]		
GIO	Mercantile Mutual	MMI[5]	QBE-Mercantile Mutual	HIH		
Mercantile Mutual	MMI	Royal & Sun	Royal & Sun[6]	QBE-Mercantile Mutual		
MMI	NZI[3]					
NZI	Sun & Royal					
Sun & Royal	VACC[3]					
VACC	Zurich[2]					
Zurich						

Notes:
1. Heath acquired CIC after selection, but was required by WorkCover to use both names as a claims agent for the benefit of employers that had selected CIC as their agent. In 1996 Heath-CIC changed its name to HIH Winterthur, and again in 1998 to become HIH Insurance Ltd.
2. Were not selected in 1998 process. FAI attempted restraint of trade litigation in the Federal Court under the then Commonwealth *Trade Practices Act 1974* that was discontinued prior to judgement when FAI was acquired by HIH
3. Brands acquired by what became Insurance Australia Group & operations merged under CGU brand
4. Brand acquired by QBE and traded as QBE-MM until end of contract
5. Brand acquired by Allianz & agency name changed accordingly
6. Brand acquired by Vero & agency name changed accordingly. Withdrew from contract in April 2006.
7 EML reportedly took over the vacated Vero portfolio and elements of the QBEMM portfolio prior to 1/7/06.

Postscript 1 – describing the full circle

Looking at the following quotes, I am pressed to wonder what progress has been made at all in terms of understanding scheme sustainability in the 26 years since the 1971 Act was supplanted by the 1986 Act.

From the evidence presented, there is little wonder that employers have found cause to complain about a system in which increases in benefits, coupled with uncontrolled increases in average time lost per accident and workers' compensation premium insurance rates, have all contributed to the continuing significant increase in the real costs to industry of compensating persons injured at work.

Byrne Report (1980) page 31

Around five years ago most of the [Australian] *schemes had average premium rates in the range 2.5 percent to 3 percent of wages. In the case of the four largest schemes other than South Australia, experience over the past five years has been very favourable...*

Notwithstanding the existence of many of these trends also in South Australia, the scheme is conspicuous in not capitalising on them in overall performance. The South Australian scheme premium rates have stayed at or around 3 percent…

A key failing of the South Australian scheme has been in…return-to-work outcomes…PwC…has compared the experience of South Australia with that of New South Wales and Victoria...This analysis very starkly contrasts the differential performance in South Australia compared with these other two jurisdictions.

Clayton Walsh Report (2008) pages 3-4

These quotes, separated as they are by 28 years and spanning two entirely different South Australian schemes, say the same thing:

- The South Australian workers compensation arrangements are expensive; and
- That is because the scheme has a claim duration problem.

What, then, has actually changed in those 28 years?

Postscript 2 – is there an echo in here?

The following is an illustration of the long-term obsession with trying to say that the post-1986 scheme has a chronic duration problem without actually saying it.

"The past 12 months have seen a deterioration in scheme performance…the Corporation has actively pursued…major cost reduction strategies …namely…reducing claim costs by encouraging earlier return to work.

…we will continue…developing more innovative return to work strategies …and striving for ongoing improvements in customer service.

Unless there is a…significant improvement in the ability to return injured workers to work, the cost of the scheme will remain at about 3%".

1993-94 WorkCover Annual Report

Naturally, it remains essential that we manage the…Scheme wisely and efficiently, to continue meeting the needs of injured workers and assisting them back to work…

This includes:

- *seeking to reduce the number and rate of claims…through a focus on safe work*

- *improving the way in which we manage claims and support injured workers while continuing to strive to manage claims more efficiently*
- *improving the way we do business and focus on the needs of our customers.*

2001-02 WorkCover Annual Report

…we have a joint plan to reduce WorkCover's claims liability, and a joint program of work to align activities to deliver improved return to work outcomes for injured workers…

… a two-pronged approach being necessary to turn around the performance of the Scheme – legislative reform combined with excellent case management …to see sustainable and meaningful change, which translates to better…return to work prospects for workers and the associated benefits for employers and the…positive effects for the Scheme's bottom line…

2008-09 WorkCover Annual Report

…The need to foster a return to work culture, not only within the Scheme but in the broader South Australian community was another key issue for the Scheme.

The South Australian Scheme has often been described as…one where the focus is on payouts rather than returning to work…

…our new Strategic Direction 2011-16…provides the framework for WorkCover to achieve the best outcomes for injured workers, employers and the South Australian community…our role has been defined to better administer and regulate the Scheme and to ensure appropriate claims management and related services are provided…

2010-11 WorkCover Annual Report

Annexure 1 – Comments on the workers compensation premium structure in SA

I have chosen to make comments on premium structures in an annexure because in actuarial terms, most premium and premium management initiatives have at best muted effects on scheme funding. For example:

1. It is well established in South Australia that the extent of self insurance under the current entry criteria has no effect on the scheme average premium rate (and by default, on scheme funding).
2. Experience rating, while it is acknowledged to influence employer behaviour, is reactive and in any case, only redistributes the sourcing of existing premium income, rather than increasing or decreasing it overall, so it too has no substantial short or medium term effect on scheme funding.
3. One of the main complaints I hear about some existing arrangements and the new retro-paid scheme is lack of control on the employer's part when it comes to managing claims. The risks and costs that drive the employer's liability to pay premiums are managed by a third party claims manager. In other words, some employers see themselves as being at risk on premiums as a result of the quality of someone else's claims management.

The concern, then, is the lack of real choices in funding and management models for the employers that pay for the scheme. In most schemes, there is plain vanilla insurance for most, with experience rating for the medium to large employers and, occasionally, a retro-paid scheme for the largest. The only other option is self insurance, but only for the few with the resources to qualify.

But there are so many other models that could be built in. Self-managed retro-paid schemes, group or industry schemes and a form of NZ-style 'semi self insurance'[47] should all be considered.

If regulators and insurers could get over their unfounded fears about loss of premiums and their obsession with regulatory micro-management, any or all of these types of arrangements could add real value for employers and workers (for whom the schemes and regulators exist, after all).

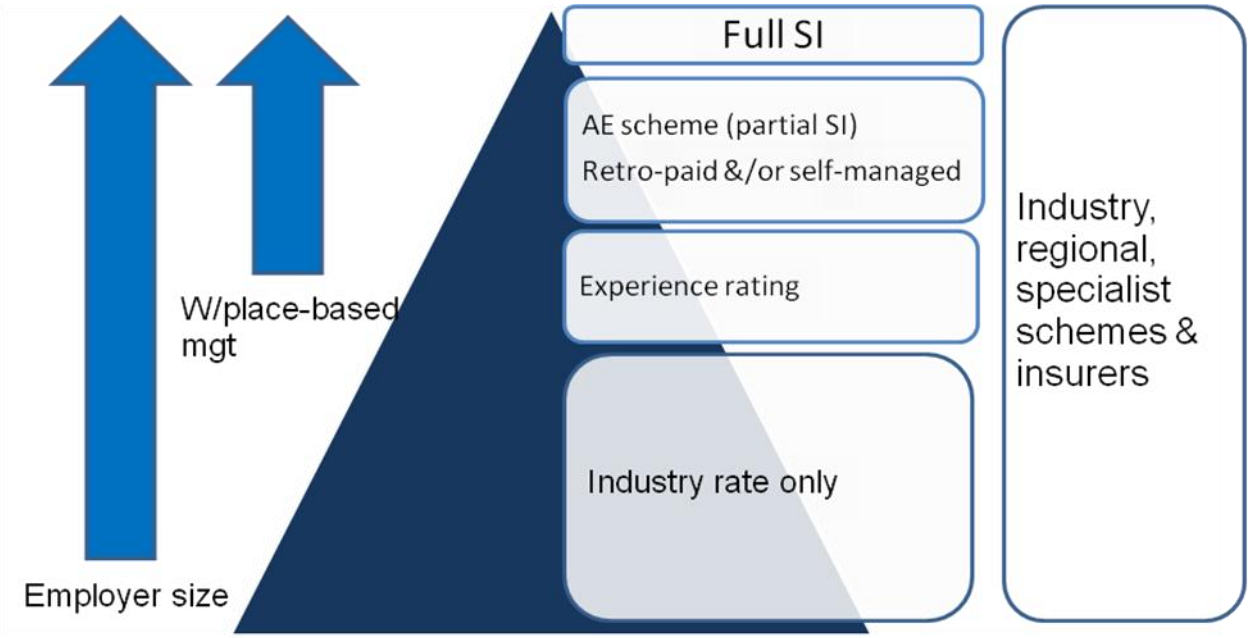
Self insurance is only available to a small sub-set of employers. That does not mean that there are not many others who seek better management and funding options from the schemes they finance.

Quite apart from flexibility of options, many of the options suggested would greatly enhance the influence of what is generally acknowledged as the keystone of successful rehabilitation and return to work – employer and workplace commitment and participation in the process. The success of self insurance supports the notion that the higher the degree of workplace-

[47] The NZ ACC scheme is a 24-hour social security system of which workers compensation is a component. Within that component is the Accredited Employer Programme (AEP), which is a limited-term semi-self insurance, but one which is a component within the ACC scheme that remains tightly controlled by the ACC. What makes the AEP relevant is that the accredited employers fund and manage their own claims at the workplace or via third party administrators for a set period before the claims are handed over to the ACC.

based management, the better the outcome for all, scheme included. If performance at this level is the true objective, (as distinct from preserving premium income and control), Governments and schemes should welcome these sorts of initiatives.

The following diagram is a suggestion for a more diverse premium and management model for workers compensation. As employer size increases, so does the option to increase levels of workplace-based management, ranging from the current Rehabilitation & Return to Work Coordinator type of arrangement, through full self-management[48] and a NZ-style accredited employer (AE) system, culminating in full self insurance. Group schemes, were they to be permitted in SA, (beyond the existing Local Government and Catholic Church arrangements), could cover employers of all sizes based on common factors such as industry, geographic location or association membership.



[48] The SA *WorkCover Corporation Act 1994* section 14(4)(c) still permits a limited SME program of 20 employers.

Annexure 2 – The regulatory structure of the scheme

Like premium structures, regulatory structures don't in my view have a great deal of direct influence on scheme funding. But they can have a substantial macro-level effect on the quality, equity and effectiveness of legislation and schemes of regulation. So again, I have elected to briefly address the issue in an annexure.

As both the regulator and the insurer, WorkCover SA arguably has considerable conflict in its regulatory role. It can, and on occasion, does exercise regulatory powers in an entirely self-interested manner to serve its own view of its insurance needs without reference to alternate cases, external impact or economic imperatives other than the interests of the Compensation Fund it manages[49]. There is no external regulator to assess the fairness and societal aspects of WorkCover's decisions other than the Cabinet (which is heavily reliant of the advice of WorkCover), and Parliament, which may or may not be in a position to do anything about it.

It also cannot be denied that as the regulator, WorkCover SA has a lead role in the drafting of the legislation that it administers. In effect, the insurer also gets to help make the laws. This would be unthinkable if the insurance functions were in the hands of the private sector. Why it is countenanced just because the insurer is a statutory corporation escapes me.

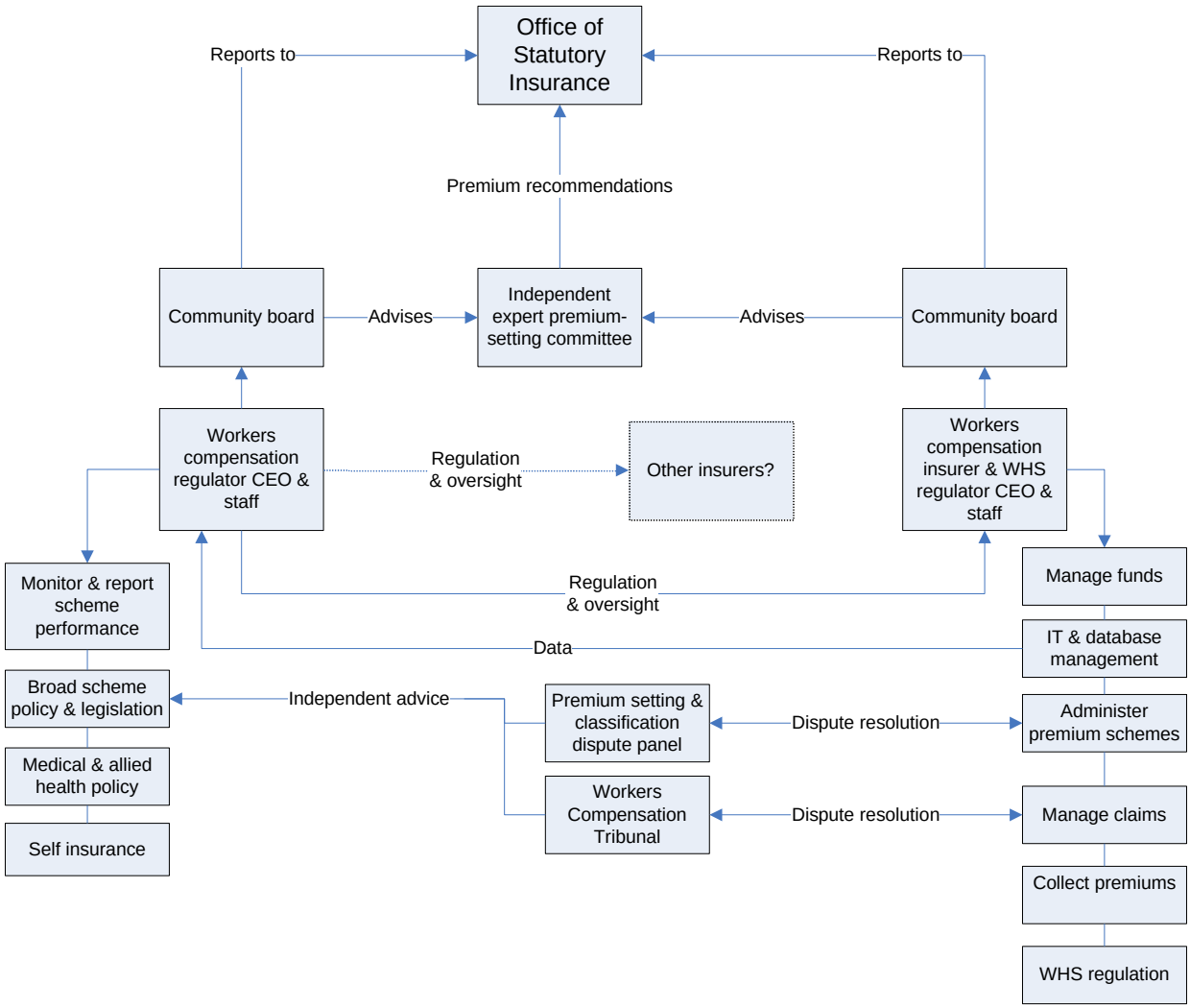
The solution I suggest has precedent. In Queensland some years ago, the decision was made to split the two functions, with regulation going to Q-Comp and insurance going to WorkCover Queensland. The system seems to work pretty well, with the insurer predictably drawing the flak while the regulator is generally well regarded. If we have learned anything from observing the Queensland model, it is to be sure that the functional boundaries between the two and also between regulator, insurer and the relevant Government Department are brightly drawn.

Comcare has something similar, with the Safety, Rehabilitation & Compensation Commission holding some oversight and regulatory functions while Comcare is essentially the scheme's operational arm.

Figure 4 on the next page is one view of how this might work in SA, including the establishment of an independent premium-setting system similar to that of the SA CTP scheme if that is warranted, and a central oversight office for statutory insurance as the following paragraphs explain.

[49] For example, it is this tendency that generates the unwritten but obvious resistance to self insurance. Fears about loss of premium and control as well as external ideological pressures have for years led successive WorkCover Boards to ignore the written advice of 2 successive consulting actuaries and continue to place barriers in the paths of self insurers and companies aspiring to self insurance.

Figure 4

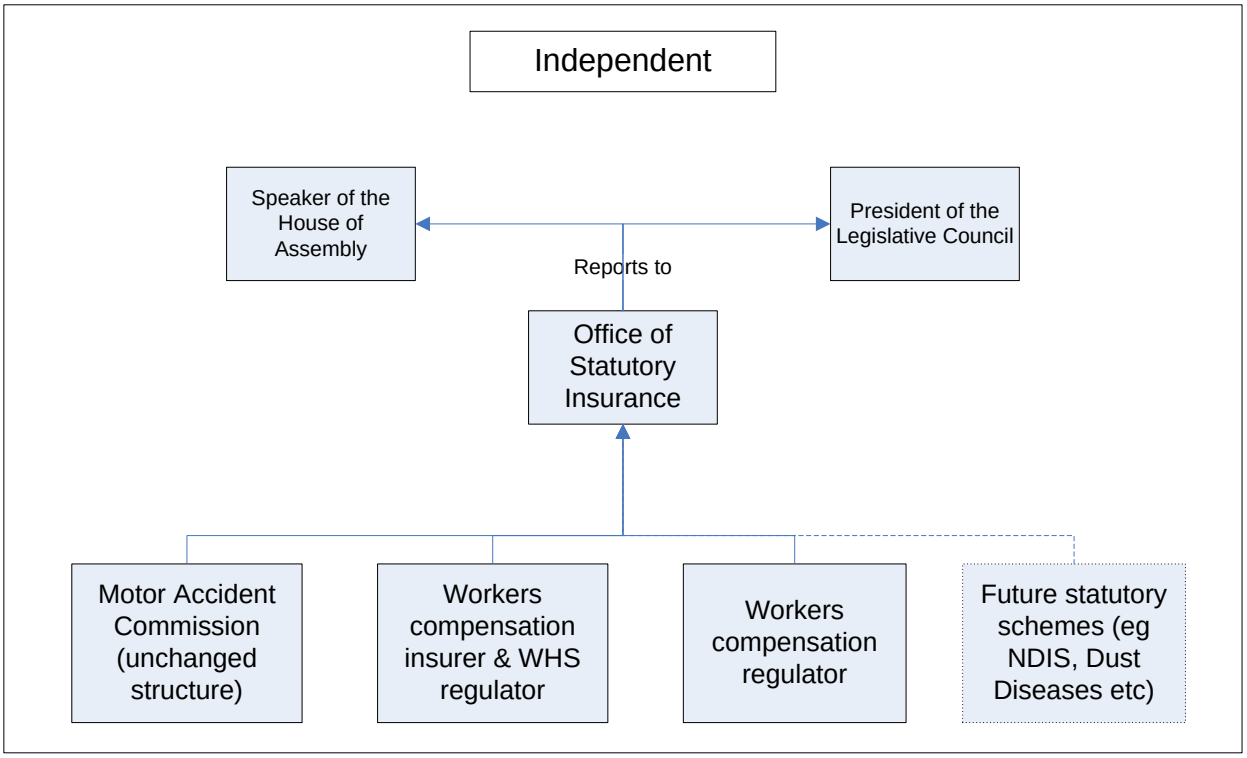


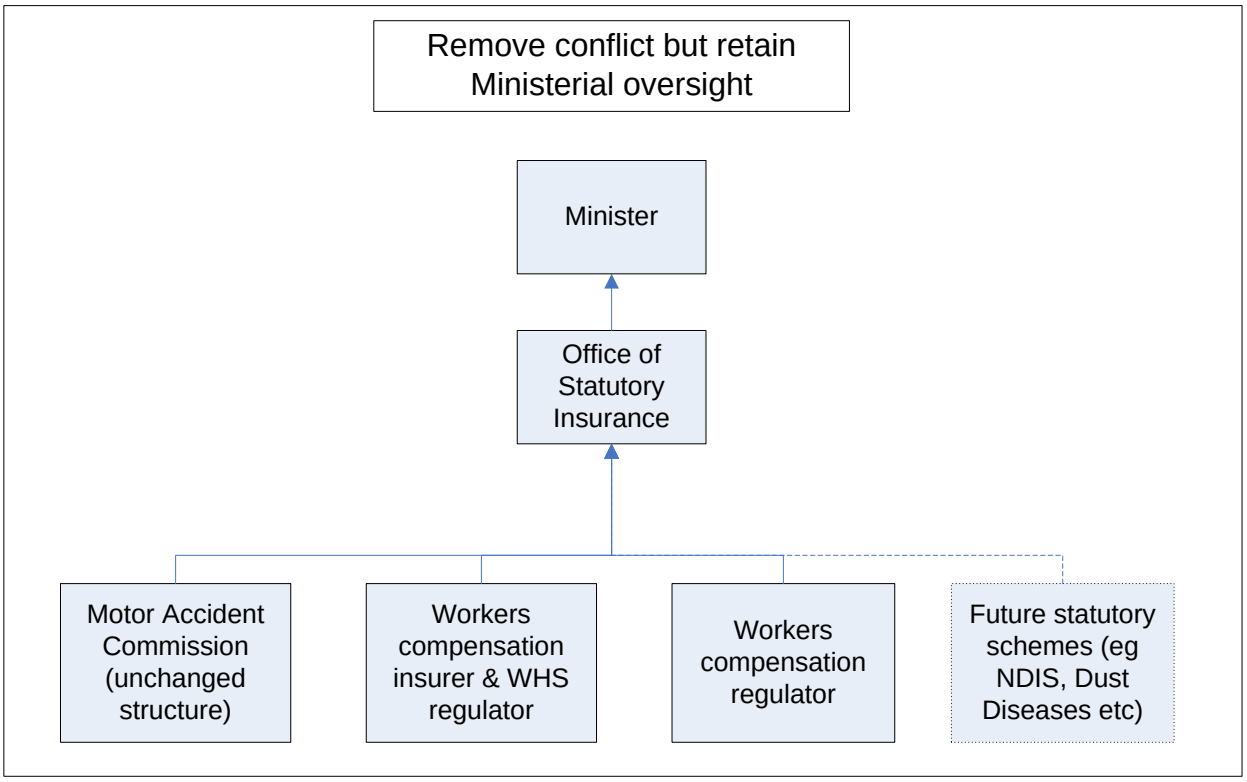
In NSW, all statutory insurance schemes have been gathered together under the Compensation Authorities Staff Division, or CASD. The CASD oversees all 4 NSW statutory schemes and reports to the relevant Minister. Now might be a good time to look at a similar arrangement for SA. While SA currently only has 2 statutory insurance schemes, (CTP and workers compensation), there may well be more in the future for dust diseases, long-term disability and so on. For the purposes of discussion only I have named this postulated organisation the Office of Statutory Insurance (OSI).

Depending on one's point of view, in a perfect world, statutory insurance would be managed free of the influence of narrow interests. I have heard more than one practitioner wish aloud for a way of getting the politics out of workers compensation. Without heavily advocating the idea, I can see how this might be done. The OSI could report to the leaders of the Houses of Parliament under its own legislation in much the same way as the Auditor-General does.

This might be seen as overkill, but I thought it should be put in play anyway. Figure 5 on the next page sets out both models – one as described and the other with the more conventional Ministerial oversight.

Figure 5


Independent
Speaker of the House of Assembly
President of the Legislative Council
Reports to
Office of Statutory Insurance
Motor Accident Commission (unchanged structure)
Workers compensation insurer & WHS regulator
Workers compensation regulator
Future statutory schemes (eg NDIS, Dust Diseases etc)


Remove conflict but retain Ministerial oversight
Minister
Office of Statutory Insurance
Motor Accident Commission (unchanged structure)
Workers compensation insurer & WHS regulator
Workers compensation regulator
Future statutory schemes (eg NDIS, Dust Diseases etc)