WORKERS' COMPENSATION AND MOTOR ACCIDENT INSURANCE

AIM:

To explain the difference between no-fault and fault based third party insurance. To explain the benefits of no-fault rehabilitation and insurance underwritten by government and industry, but which is competitively delivered by the private sector.

WORKERS' COMPENSATION: A NO-FAULT SYSTEM OF INSURANCE

Insurance is a purchase which people have historically made to lessen the harmful effects of any unplanned catastrophe, including legal suit. It may perhaps be best understood as a private sector alternative to the taxation that governments undertake to provide people with health and related support if they cannot support themselves as a result of physical injury or financial loss. The origin of Australia's ten major systems of workers' compensation legislation is the Employers' Liability Act introduced in Britain in 1883. The Act provided for weekly benefits for injured workers. Employers were required to finance this through purchasing workers' compensation insurance. This legislative approach was taken because common law suit, which required an injured worker to sue their employer for negligence, was failing to meet workers' needs. At that time, the employer generally argued successfully in the courts that in doing the work the employee had also voluntarily assumed its risks. The Employers' Liability Act sought to overcome this problem by providing injured workers with regular, reliable benefits, paid for through insurance contributions by all employers. Thus insurance was transformed from its primary purpose of protecting the premium purchaser from the economic risk of negligence suit, into a social welfare scheme to support the injured, paid for by employers. The fact that an injured worker does not have to prove fault in order to be entitled to benefits makes workers' compensation insurance a no-fault scheme. It is also a third-party scheme, because the insurance cover is for a different person than the one who purchased the premium.

Australian state workers' compensation acts were developed during the early part of this century, in isolation from the highly detailed, prescriptive yet limited occupational health and safety (OHS) legislation, such as state factories, shops and industries acts, which had been established slightly earlier. It was only recently, during the 1980s, that state OHS acts first introduced the general **duty of care** approach to legislation. The requirements of this are consistent with quality management. Under OHS legislation all Australian employers must provide a safe place of work and all workers must work safely. Employers are required to identify and control workplace risks in consultation with workers who are provided with information and training. A few years after passing OHS acts, all states introduced rehabilitation requirements for injured workers into their workers' compensation acts. As a result, all Australian employers are also required to develop an organisational rehabilitation program in consultation with workers and their unions. In workplaces with more than twenty workers the employer must also nominate someone as a rehabilitation coordinator.

Since the passage of OHS acts and rehabilitation requirements in workers compensation acts, there is a clear requirement for workplaces in any industry to take a **quality management/risk management** approach to identifying and controlling hazards related to work. Workers' compensation and other injury related data is ideally used to drive a continuous cycle of performance improvement in injury prevention and rehabilitation. Quality management requires reliable outcome data from all relevant service providers to be available to consumers, industry and government. An integrated management approach should be taken to the identification and control of other production risks, such as harm to consumers or harm to the environment.

However, there is still some distance to go before obtaining all of this in Australia. Problems related to the lack of an effective risk management culture at the workplace, and the effects on rehabilitation of the adversarial system of justice will be discussed later. The importance of high quality health and other service outcome data is discussed in many of these lectures.

THE PROCESS FOLLOWING INJURY AT WORK

A person injured at work must make sure this is recorded in the workplace injury book. They see their doctor and, if time off work is needed, they will be provided with a WorkCover medical certificate. The worker's employer forwards the certificate, along with a workers' compensation claim form, to their insurer. The employer of an injured worker must not dismiss a worker wholly or mainly because of work related injury within six months of the date they first became unfit for work. An injured worker must not unreasonably refuse to participate in rehabilitation and must be prepared to seek suitable employment with another employer if the original employer cannot provide it. The workplace based, rehabilitation coordinator's role is to do whatever possible to promote effective and speedy rehabilitation. As early as possible after injury they should liaise with the injured worker, insurer, doctor and people in the workplace to assist return to work. Rehabilitation providers are also established by workers compensation legislation. These are teams of accredited health professionals who may:

- Provide worker and workplace assessments to identify suitable duties
- Monitor work upgrading programs
- Advise on job modification or retraining
- Assist in arranging vocational re-education or training

The no-fault benefits under state workers compensation legislation normally include:

- Hospital and medical expenses
- Physiotherapy and other ancillary treatment specified in the legislation
- Modification to a workplace, home or vehicle under a doctor's direction
- Care of a person in their home under a doctor's direction
- 26 weeks of payment at current award or enterprise agreement rate followed by the statutory rate
- Retraining and re-employment assistance
- Make-up pay if the worker is re-employed on 'suitable duties' or is unemployed and undertaking retraining or seeking work
- A lump sum for any permanent disability plus an award for pain and suffering
- Rights to reinstatement in former employment if fully recovered within two years

In some states or territories, injured workers also retain the right to sue their employer at common law. In NSW, which has a third of the Australian population, only seriously injured workers may do this. If they take a common law route they must forfeit access to all statutory (outlined in law/statute) benefits.

About a third of all new workers compensation injuries each year are related to sprain and strain injury, sometimes of gradual onset or unknown origin. Experts have indicated that when workers experience back injury or similar pain, they should be warned of the potential bad effects of excessive bed-rest or overmedication. In the absence of strong pre-operative indications they should be advised against surgery as a last resort for pain. They should also be told about the

importance of appropriate exercise and stress reduction techniques. Since slow return to work correlates highly with personal work dissatisfaction, injured workers should be asked about any psychosocial problems at work or home that may lead to delayed return to work. Ways to evaluate the injured person's personal resources in order to bolster them should also be explored. Ergonomic and other knowledge of the workplace should be used to minimise or lessen stress on the worker, to avoid re-injury.

The insurer may dispute a claim if the injury is thought not to be work related. Alternatively, an insurer may cut off benefits because of the view that return to work should have already occurred. When their claim is disputed, the injured person may go onto another form of Commonwealth social security payment such as unemployment benefits or the disability support pension. The NSW government recently introduced compulsory conciliation of disputes assisted by independent health experts. Until this occurred, people were expected to go, at their solicitor's hands, through the adversarial workers' compensation court, if they had not returned to work. During the court process they would be assessed for their level of 'permanent disability', in order to reach a settlement between the employer's insurer and the injured worker. Although workers' compensation is supposedly a no-fault system, if a person goes to the compensation court, their level of incapacity is decided in an adversarial context. There is no logical reason why a person's level of injury should be treated as a matter of dispute. The adversarial process undermines rehabilitation and is expensive because of the fees of opposing medical and related experts.

MOTOR ACCIDENT: A FAULT BASED INSURANCE SYSTEM

Third party insurance structures, such as workers' compensation and motor accident insurance, are state based systems which vary across Australia. This makes their administration confusing, costly and liable to be challenged. While all workers' compensations systems are no-fault systems, third party motor accident systems are likely to be fault based. The owner of a car must take out third party motor accident insurance in case they injure somebody on the road. Usually, a road accident victim must then be able to prove in court that the third party premium holder was at fault in order to be provided with a lump sum for life, to compensate them for:

- 'reasonable and necessary' hospital, medical and rehabilitation benefits
- compensation for loss of income and loss of ability to earn future income
- pain and suffering

It has been estimated that in NSW each year between 250 and 300 people are so catastrophically injured on the roads that they will require a high level of care for the rest of their lives. Claims data from the Motor Accidents Authority indicates that about 240 people sustain severe brain injury each year. Of these about 135 make a claim and 25% of them are rejected. This leaves a motor accident insurance coverage rate of 42% of the severely brain injured. Less than half of the victims of spinal chord injury are able to claim successfully.

In 1996 the Standing Committee on Law and Justice of the NSW Parliament undertook an inquiry into the NSW motor accidents scheme. Representatives of injured people and health professionals argued that the necessity for road injury victims to prove fault in order to gain compensation leads to many of those most likely to be severely injured on the roads also being least likely to be able to claim successfully. For example, young drivers and children are more likely than many other groups to be involved in serious road accidents. If their immaturity caused or substantially contributed to the accident, as is often the case, they will not be able to mount an effective negligence claim. The effect of this is that there are many claims for minor injuries, but that

people with horrific injuries may either be unable to claim, or will face years of uncertainty and difficulty before they hear the outcome of their case.

Over two thirds of motor accident victims end up unable to mount effective claims. Early rehabilitation treatment may be denied by an insurer who will not accept payment for services before fault had been established, which could take years. The period after release from hospital is an extremely difficult time for injured people, particularly if liability is not recognised. The injured persons and their carers are generally housebound and without the funds to allow installation of ramps, modification of vehicles, doorways, or bathrooms. The typical accident matter takes years from the date of the accident to be resolved. Advocates of injured people and health professionals commonly agreed that linking court awards to the concept of 'the most extreme case' provides disincentives to a positive mental attitude to rehabilitation. For years on end claimants are faced with conflicting needs. On one hand, they need to maximise their chances of physical recovery. On the other, they need to maximise their disability to maximise the court award.

Road injury victims often report feeling under the control of others, and that the insurer and the system are against them. This is not surprising. They are not protected by the Insurance Contracts Act which aims to promote fair dealings and open communication between the parties to a contract, because the person with the contractual relationship with the insurer is the claimant's adversary. The adversarial, judicial process is overwhelming, especially when combined with the need to adjust to spinal chord or other serious injury. It may artificially force friends or members of the same family into bitter dispute if one of them is required to be the subject of a claim by the other. Those with brain injuries as a result of their accident face extra stress as a result of cross-questioning.

Rehabilitation is inhibited by an adversarial process which subjects the claimant to repeated medical examinations which may bear little relation to the timely provision of the kind of objective, open and sympathetic medical treatment which is most likely to build confidence and a positive attitude to potential for recovery. Injured people will probably be given no immediate information about the outcome of numerous medical examinations by the insurer's doctors that they are nevertheless required by law to undertake. They may then be made upset and angry by the sharply opposing views of their medical condition which they subsequently hear in court. The income of the medical experts used in court normally depends on the requirements of the lawyer who hires them. This may also produce 'junk science' as expert witnesses are grilled according to the ancient adversarial rules of lawyers, rather than the more normal and open questioning methods of the scientific community.

A related major problem is that the judicial estimation of levels of impairment cannot be undertaken adequately when doctors presenting medical reports are acting for adversarial lawyers. At the opening of a public seminar to discuss the motor accident scheme in NSW the Attorney General noted that:

> 'One important basis upon which any compensation is determined is, of course, the medical report. Trial judges have remarked to the Motor Accidents Authority that in some cases the differences between the medico-legal reports tendered by the parties are so great as to cast doubt as to whether they are related to the same person.'

It is also impossible to determine an appropriate lump sum to meet an unknown future need. If the claimant was a young actor, for example, is it reasonable to assume they would spend most of their life out of work, or in starring roles? How long might they reasonably be expected to live?

Successful claimants may face the stress of managing a large award which is supposed to maintain them for the rest of their life, but which is nevertheless inadequate, particularly after it has been reduced by taxation and legal costs. Their future welfare may depend overwhelmingly on the competence and goodwill of those who manage their lump sum. This may also be a cause of considerable stress and conflict. The research generally indicates that the inadequacy of lump sum payments reduces quality of life for lump sum recipients and their carers and also leads to cost shifting and double dipping, with injured people using the public health system for care costs which should have been covered by their compensation payment. Health professionals repeatedly make the point that there is a lack of effective services in the community, particularly in relation to accommodation for brain-injured people. This social deficit cannot be compensated for by the provision of money to individual claimants.

Stakeholders generally appear to believe that no-fault accident compensation schemes are better than fault based ones in their rehabilitation, compensation and return to work outcomes. A report to the Commonwealth Department of Social Security pointed out that contributory negligence results in around 50% of all motor accident victims receiving no benefits or having them reduced. It described motor accident insurance schemes as inferior to workers' compensation schemes in regard to health outcome, because there is no direct link to employment in the former, and comparatively little attention is paid to rehabilitation. The delay in getting lump sum payments was reported to be very much greater for motor accident victims than for people injured at work, and it appeared that lump sums are often inadequate. Injured people often found both of these systems confusing and also felt that it was difficult to obtain clear information or advice. The inquiry into the NSW Motor Accident scheme called for the development of a range of performance indicators for the scheme and the development of a model for the provision of long term care on a no-fault basis. Better forms of case management were also recommended.

INSURANCE DESIGN TO PROMOTE BETTER MANAGEMENT

In Australia, workers' compensation insurance schemes have operated in a variety of ways. However, there is now commitment to national uniformity, which is increasingly based on the NSW WorkCover managed fund model of service delivery. This insurance system, which also involves integrated management of OHS legislation, was introduced in 1987 by a Labor government. A Victorian Liberal government later adopted it. Prior to the introduction of the managed fund model, employers had tended to support insurance paid to private sector insurance companies which competed on premium price. Trade unions had tended to support the government acting as a monopoly administrator which collects funds from employers and pays benefits to injured claimants. In the former model, a range of competing private insurance companies owned the premium funds and could invest them on behalf of the company. In the latter model the funding pool was more like a taxation system.

Under the motor accidents insurance system private sector insurance companies compete on premium price and underwrite the business. This means they own the premium pool and bear the risk) of the cost of claims. In contrast, under the managed fund model of workers compensation insurance, the government establishes the appropriate level of premiums and benefits. It also licenses thirteen insurance companies to collect premiums, administer claims, invest funds, and despatch data to state WorkCover Authorities and the National Occupational Health and Safety Commission (NOHSC) on its behalf. The insurers are paid to perform these services for government and industry. Government and industry also underwrite the scheme. Because insurers cannot compete on premium price, the system should promote insurer competition on services to reduce the employer's premium through more effective workplace injury prevention

and rehabilitation performance. In addition, since government and industry are the owners of the insurance fund, returns on its investment belong to them, rather than to the private sector insurers.

This is an excellent system design because it provides Australian businesses with a comparatively stable yet competitive environment, plus the additional benefits of fund investment and returns, at comparatively low administrative cost. On the other hand, private sector insurer underwriting and competition on premium price may become a recipe for disaster through insurer failure. This has occurred repeatedly in Australia, and most recently in the case of HIH, which insured builders and housing consumers against catastrophe, and also insured doctors against medical negligence claims. Before the advent of the NSW WorkCover system over forty insurance companies competed to underwrite workers' compensation business. Competition between insurers led to pricing wars and to the reserves of some insurers running low. At the same time, courts were making increasing lump sum payments to injured workers whose claims had been denied. There were five insurance company insolvencies in NSW in the mid 1980s. Employers have paid, through a levy on their premiums, for the failure of these insurers to meet their ongoing obligations to injured workers.

The WorkCover Review Committee was established to evaluate the WorkCover structure when the Greiner Liberal coalition government was elected in 1989. Employer organizations, unions, the medical profession, the Bar Association, the Law Society, the Attorney General's Department, and the Insurance Council of Australia were all represented on the Committee. The legal profession and the Insurance Council favoured a return to a system underwritten by private sector insurers in preference to a managed fund. The legal profession representatives noted that 'no amount of control by bureaucracy can substitute for the management that comes into play when insurers' own funds are at risk'. The Insurance Council indicated that insurers would like to resume underwriting by the end of 1991, or earlier. The legal profession advocated the reintroduction of common law and jury trials for certain situations. The Attorney General's Department thought that 'all disputes, at all stages, should be a matter for the Compensation Court'. Such views reflect the interests of the service providers, rather than the public interest. Employers and unions wanted the managed fund retained, although the NSW Labor Council indicated it wanted common law reintroduced if benefits were not increased. Re-introduction of limited access to common law for the severely injured occurred in 1989 and 1990.

In 1990 the Insurance Council of Australia met with the new Liberal Premier, and in 1991 an independent actuary was engaged by the WorkCover Authority to report on the likely effects of privatisation of the scheme. The report did not support the Insurance Council of Australia's stated view, which was unaccompanied by any evidence, that the private sector insurer is necessarily more efficient than the public sector one. The evaluation concluded that there did not appear to be any compelling argument for greater administrative efficiency in the private sector than in the public sector. In 1993 the Industry Commissions inquiry into workers compensation came to a similar conclusion. It argued that market structure within jurisdictions is not of itself critical to good performance. Other factors, including quality of scheme administration, are more critical.

The actuarial report provided to WorkCover's board argued that when insurance is underwritten by the private sector, an underwriting cycle exists which follows the economic cycle, creating great fluctuations in insurance industry profitability and therefore in premium rate setting. For example, between 1978 and 1989 in NSW, insurance industry profitability fluctuated between -47% and +6%. The practice of competing for clients with the offer of premium discounts is integral to the development of the underwriting cycle. This also increases the likelihood of fluctuations in premium rates leading to insurer insolvency as the cycle develops. In periods of the cycle when insurer profits are high, the temptation for insurers is to increasingly discount

premiums. At other stages of the cycle, low profit levels lead to the setting of higher premium rates, but also to increased risk of insurer insolvency. A related problem is that the underwriting cycle creates an environment of volatile premium rates which makes general business planning and operation much more difficult and uncertain.

The actuarial review showed that a return to private sector insurance underwriting and competition on premium price would be likely to increase general administrative costs of the scheme by around 12%. These additional administrative costs would arise partly because of the cost of re-insurance, which insurers would have to purchase if the large pool of all industry funds were broken up for underwriting by numerous insurance competitors. Without reinsurance a single disaster might send an insurer broke. Re-insurance is an international system, and Australian premium holders may find their premium costs rising as a result of disasters in foreign parts over which they have no control. In an international insurance system, where insurers compete on premium price, Australian government would also need to support and promote high levels of insurer profit as insolvency margins. In addition, a multiplicity of insurers competing on premium price would mean the inevitable return of brokers into the system. This would add additional regulatory difficulties and costs.

LESSONS FROM THE MOTOR ACCIDENTS SCHEME

Clear, reliable information is crucial in order to effectively estimate insurer performance. This is always more difficult to achieve with private sector underwriting. Information on scheme performance is comparatively readily available to the WorkCover Authority, which administers workers' compensation and OHS legislation. This can be contrasted with the position of the Motor Accidents Authority which overlooks a third party accident insurance scheme where insurers underwrite the business. The Motor Accidents Authority told the NSW Standing Committee on Law and Justice, that there are no specific compulsory third party (CTP) funds because CTP premiums are not distinguished in any way from other general insurance funds. The Authority therefore has no basis on which to exercise the powers of financial monitoring which are provided in its legislation. Speaking of motor accident insurance the Deputy Chief Executive of the Insurance Council of Australia noted that:

> '....as we have tried so often to explain, the complications of a fully funded actuarially based scheme are difficult to understand. Attempts at simplification could lead to undesirable misunderstandings of both a political and social nature!.....The system does maintain fairness, and we do not believe further disclosure of results to the public would be beneficial.'

This view was not shared by the Insurance and Superannuation Commission (ISC). This is the Commonwealth body which administers the Insurance Act, the primary legislation for the prudential supervision of general insurers in Australia. The ISC representative pointed out that there is a lack of public information about the insurance sector and, as a consequence, market disciplines which encourage effective competition have less force. According to the ISC, information disclosure enhances the natural workings of the market and is less intrusive than other regulatory measures. Disclosure is seen as 'having the capacity to unleash powerful market forces which enhance consumer choice, stimulate genuine competition, and reduce socially wasteful expenditure on excessive product differentiation and inefficient distribution systems'. Whether it is ever possible for government to effectively achieve disclosure and monitoring when insurers underwrite the business is a moot question.

PREMIUM SETTING SHOULD ENCOURAGE RISK REDUCTION

Under the WorkCover system employers pay premiums according to one or more of 100 risk rated premium classifications in around 18 premium pools. Supposedly there is no cross subsidy under the scheme and each industry is assigned the premium rate that best reflects its claims experience. This is more equitable than risk cross subsidy and also provides industries with collective incentives for improving their risk management performance. Employers whose base premium exceeds $3000 have their premium adjusted according to their individual experience so those with good claims performance will pay reduced premiums while those with poor experience will face higher rates. This maximises incentives for the employer to undertake effective risk management and rehabilitation. Small employers are not risk rated on their claims performance.

The Industry Commission inquiry into workers compensation in Australia discussed bonus and penalty schemes which might provide small businesses with premium incentives for good safety performance. Rewarding small businesses for good performance is problematic because over 90% of them do not have a claim during the year. In many cases this is probably due more to good luck than good management. If no-claim bonuses were paid this might reward the unsafe employer along with the safe one, and also place a heavy and unjustified administrative burden on the scheme. No claim bonuses might also provide an incentive to employers to seek to understate injury levels. It would be more beneficial to provide bonuses to small businesses that can show that they have put effective safety management and rehabilitation programs and training systems in place. People should not be given economic rewards for undertaking what they are required to do by law. On the other hand, training cost subsidy, perhaps by way of premium reduction, might be a successful and legitimate means of promoting health, safety and rehabilitation.

Organizations employing at least 1000 workers may become self-insurers under the WorkCover system. Private and public sector organizations must operate according to the same requirements. In 1993 there were 52 licensed self-insurers in NSW, including many large businesses, state government departments, statutory authorities and local councils. The NSW Treasury Managed Fund acts as a self-insurer for state government inner budget sector organizations in a range of insurance matters including workers' compensation. Outer budget sector organizations, which operate in a more commercial environment, may become self-insurers with WorkCover in their own right, or be included under the umbrella of the Treasury Managed Fund. Self-insurers must prepare and lodge a full set of audited annual accounts with the Authority. They must be able to demonstrate a fully professional standard of claims management and administration, which cannot be delegated to a third party. A self-insurer must also demonstrate that its rehabilitation and OHS practices comply with relevant legislative requirements, including provision of health facilities to treat injured workers promptly. They must provide a history of their claims experience and any convictions under the OHS Act. Evidence must also be provided of ongoing consultation with workers. Self-insurers must provide this and related data to the WorkCover Authority, and comply with all other statutory requirements set down in their licences.

While risk rated premium setting is usually most equitable, its effects on prevention should not be overestimated. For example, driving is a comparatively dangerous activity. Approximately 15% of work related road traffic accidents end in death or permanent disability, compared with 10% for all workplace injuries. However, public education and supporting enforcement of safe working and driving principles are likely to have a much more beneficial effect on motorists than premium incentives will. For example, NSW has a road fatality rate lower than most comparable countries, except for Japan and Great Britain. A very rapid decline in road death took place between 1988 and 1993 because of the introduction of a series of well executed safety campaigns

promoting the use of seat belts, and the avoidance of drink driving, speeding and driving when tired. A contribution was also made to the reduction of the road toll by building safer roads, the identification and targeting of black spot programs, and improvements in car design. Alcohol remains a major cause of death. Fifty percent of fatal crashes which take place between 9pm and 3am each day and between 3 am to 9am on Saturday and Sunday involve a driver with an illegal level of alcohol. It is highly unlikely that consideration of the effects of an accident on their premium costs would alter an individual's drinking and driving behaviour. However, greater awareness of risk, peer pressure, or fear of a fine or worse, will probably have an effect.

PREVENT ADVERSARIALISM THROUGH BETTER WORKPLACE MANAGEMENT

The case that the adversarial court process is detrimental to rehabilitation is not new. In 1973 the Commonwealth government established a National Committee of Inquiry into Compensation and Rehabilitation chaired by Justice Woodhouse. He had earlier headed an inquiry in New Zealand, which led to the introduction of a comprehensive accident scheme providing rehabilitation and income support to injured people regardless of fault. The Australian committee marshalled a great deal of evidence on the capricious and selective results, and the poor effects upon rehabilitation, of the practice of linking benefits to suit for negligence. It recommended a similar scheme to the New Zealand model, funded by levies on employers and on motor vehicle registrations, with supplementation from government revenue. The government lost office for a variety of reasons, and the plan was never implemented. Since that time, over ten major inquiries into workers' compensation in Australia have come to the conclusion that negligence suit is detrimental to rehabilitation.

The NSW motor accident insurance scheme is now being re-designed to achieve greater consistency with the NSW WorkCover system. However, in 1997, Grellman found major workers' compensation cost increases were still occurring in NSW as a result of lack of effective risk management at the workplace, especially in relation to back and other musculoskeletal injuries. These account for a third of newly reported injuries. Primary cost drivers of the scheme were found to be court payments for permanent impairment and pain and suffering awards; long term duration on weekly benefits; and the cost of commutation, disputes and litigation

After Grellman's findings, the NSW government introduced compulsory conciliation of disputes. A recommendation for victim impact statements to be issued in conjunction with prosecutions under the NSW OHS Act was also made recently. If an injured person could receive economic support as a result of an OHS prosecution, this could provide them with help soon after injury. It would eliminate the many disincentives to rehabilitation and work return which are inherent in adversarial processes. These link the size of lump sum awards to the severity of injury, and deliver the award only after the injury has supposedly stabilised, often years later. The 1998 Workplace and Injury Management Act established an Industry Advisory Council in NSW, and thirteen industry reference groups composed of employer and worker representatives. The stage is now set for development of industry based risk and fund management. For this to succeed, national consistency, comparability and transparency are crucial. Effective risk management incentives for small businesses whose premiums are not risk rated are also necessary. One means of achieving this would be to set lower premiums if approved auditors find the business has established effective workplace consultation, education, and risk management procedures.

OTHER REHABILITATION OR DISABILITY RELATED SUPPORT SERVICES

There needs to be a consistent, equitable and effectively coordinated administration of entitlements to injured people, however they have been injured. The potential for this increased

in 1986 when the Commonwealth Disability Services Act established professional health teams to undertake aged care assessment and doubled funds available under the home and community care program. Such measures seek to avoid institutional care and improve the quality of life for people with disabilities, whatever their age. Services provided include housekeeping and personal care, community nursing and paramedical services, meals on wheels and other food services, respite care, community transport, home maintenance and modifications, neighbour aid programs and other community options. An attendant care scheme helps people in nursing homes or hospitals move into the community through providing assistance with personal care services.

The Commonwealth/State Disability agreement of 1991 outlined the responsibility of the states for accommodation support services, and stated the Commonwealth would assume responsibility for employment related services for people with disabilities. The Commonwealth Disability Discrimination Act of 1992 placed a new onus on employers to make 'reasonable adjustment' to workplaces and job design to accommodate injured workers, no matter how their injury occurred. This is provided as a result of recommendation from a doctor. Related rehabilitation and training assistance may also be available. Transport assistance may be provided for people with a disability who are working, in training or doing voluntary work for at least eight hours per week and who are unable to use public transport without substantial assistance.

Long-term inability to work may qualify the person for a disability support pension. People providing full-time personal care to a disabled relative or friend may qualify for a carer pension if they are living in the same house or an adjacent house. Rent assistance may also be available. The need for more community-based accommodation suitable for disabled people remains high. The kind of supported accommodation services which are provided for severely injured people and funded from NSW motor accident insurance are desperately needed more broadly. Their availability for use by people injured at work or through other activities would make sense. However, a nationally and regionally planned expansion of supported accommodation facilities which include residential care for people with disabilities is required, rather than a partial and disorganized approach to service funding, provided through private insurance.

Some ageing workers in poor health may welcome a reduced level of employment demands appropriate to their situation. A disability wage supplement which was introduced into the social security system in 1994 may provide this opportunity. It enables an employer to pay a reduced productivity-based wage if a wage assessment shows this is necessary and the person's disability prevents him or her working at least 30 hours per week at full award wages. The employer pays for the work the employee is able to do, so the worker is paid at less than full award wages in accord with the assessed level of reduced productivity. An employer, a qualified assessor and a union which is party to a relevant award, determine the wage rates and related work required, in cooperation with the injured participant.

To receive the disability wage supplement a person must meet the impairment criteria that apply to the disability support pension. Before the wage agreement is determined the person may undertake a trial period of employment of approximately twelve weeks. After the trial the productivity of the person is assessed against standards within the workplace for that particular job. Each year, the wage assessment is reviewed to ensure that an appropriate wage is being paid. Participants can remain in the system until their productivity indicates that a full award wage is payable. The disability wage supplement ceases only when the person has been receiving full award wages for a period of twelve months. If a person ceases to receive the supplement they automatically qualify for a disability support pension. Other services also exist which may assist partially incapacitated or older people to remain in work at the level of intensity which is appropriate for their health.

In NSW the Guardianship Board, the Office of the Public Guardian and the Office of the Protective Commissioner each operate independently to provide services for people with disabilities aged sixteen years or over who are incapable of making their own decisions and who need a legally appointed substitute decision maker. The Guardianship Board is a legal tribunal which may appoint a family member or friend to this role. Alternatively, it may appoint the Office of the Public Guardian to make decisions on behalf of the disabled person in areas such as accommodation, medical treatment, dental treatment and other services. The Board may also appoint the Office of the Protective Commissioner to provide financial management services for severely disabled people. The decision-making functions of the Protective Commissioner and the Office of the Public Guardian on behalf of people too disabled to exercise their rights are crucial. However, these service have recently been trenchantly criticised by consumers and are the subject of ongoing inquiry. Necessity for such functions may be lessened if people injured as a result of road accident are provided immediately and automatically with no-fault rehabilitation and income replacement benefits, and no-one is burdened with the responsibility for managing large lump sum awards which result from the tortuous process of negligence suit.

CONCLUSION

The problem of work related injury appears to be best dealt with by introducing measures to promote more effective workplace risk management systems, with a view to preventing injury and resolving disputes at the workplace wherever possible. The costs and benefits of the OHS duty of care approach to preventing workplace injury, and also of the WorkCover managed fund insurance design, should be investigated for their relevance in other areas of potential risk. Improved rehabilitation and return to work require the introduction of transparent data gathering in regard to service outcomes by health professionals, conciliators, insurers and other relevant service providers. An adversarial system for estimating a person's level of disability in illogical, undermines their effective rehabilitation and is unnecessarily costly. Health professionals should be contracted to undertake these measures in a non-adversarial context. Injured peoples' chances of access to effective rehabilitation and return to work would probably be greatly improved as a result of such measures, and the system would probably be more cost-effective. If negligence claims were met by providing victims with awards as a result of prosecution under the OHS or similar protective acts, good rehabilitation outcomes would also be promoted more efficiently and cost-effectively than occurs in the present adversarial system.

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