Changing business behaviour - would bearing the true cost of poor health and safety performance make a difference?

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Changing business behaviour - would bearing the true cost of poor health and safety performance make a difference?

Michael Wright and Sara Marsden
Greenstreet Berman Ltd
First Base
Gillette Way
Reading
Berkshire RG2 0BP

Previous research demonstrates that the cost of occupational ill-health and injuries and, specifically, the cost of employers' liability insurance does not motivate UK employers. Also, rehabilitation has a relatively low status. The Health and Safety Commission's Revitalising Health and Safety strategy (RHS) states that the "compensation, benefits and insurance system must motivate employers…" and "The Government sees a case for reforming the arrangements for employers' liability insurance..". This study has found that workers' compensation arrangements in other countries positively motivate health and safety management and, in some cases, rehabilitation. This is achieved by integrating rehabilitation into the compensation process, including a greater proportion of ill-health and injury costs into a single no fault insurance scheme and linking premiums to performance. There are also examples of innovative ways of helping smaller firms. UK insurers indicate that, notwithstanding examples of good practice, they are constrained by the Employers' Liability Regulations and competitive pressures. UK employers indicate that, notwithstanding some reservations, they would improve standards of health and safety and rehabilitation, in response to new arrangements. The introduction of new insurance arrangements could contribute significantly to RHS objectives. It is recommended that the options in this report be elaborated and assessed.

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EXECUTIVE SUMMARY

A key aim of the Revitalising Health and Safety strategy is to motivate employers to improve their health and safety performance. Item (v) in the 10-point Strategy Statement notes that:

> "The compensation, benefits and insurance system must motivate employers to improve their health and safety performance, in particular by securing a better balance in the distribution of the costs of health and safety failures. When things do go wrong, employers must also be motivated to rehabilitate injured workers so as to maximise their future employability. The Government sees a case for reforming the arrangements for employers' liability insurance in pursuit of these goals." (p 18, RHS 2000)

In addition, Action Point 5 notes that many consultees suggested that the insurance industry could do more to promote health and safety standards. It mentions the use of auditable management standards, loading and discounting premiums and offering free advice on risk management together with consultancy services. It is suggested that further consideration should be given to how the current practice of adjusting premiums and giving advice to larger firms could be transferred to lower hazard sectors and smaller firms.

There are currently two main forms of insurance, namely Employers' Liability insurance under which employees may receive damages via tort, and Industrial Injuries Disablement Benefit that provides no fault state benefits. Academic researchers have indicated that the Industrial Injuries Disablement Benefit scheme offers no incentive for companies to improve their safety records. As elaborated in this report, there is little evidence that Employers' Liability insurance provides UK firms with an incentive to improve occupational health and safety.

Review of overseas experience

We reviewed the Canadian, USA, German and Australian occupational insurance systems (termed workers' compensation) as they meet the following criteria:

- They relate the costs of injury and ill-health to the safety performance of firms;
- They apply the costs of ill-health and injury to employers;
- Information is available on the design and operation of the scheme;
- The country is similar in economic development to Great Britain, and;
- Information is available on the impact of the scheme on the behaviour of employers.

In all cases employers pay for insurance that covers employees' (and dependents in case of death) costs and lost earnings, and, in some cases, pain and suffering. In this way, workers' compensation is an employer-funded form of insurance, analogous to UK employers paying for employees' private health and disablement (loss of earnings) insurance. In this sense the issue of "fault" is not relevant. This is in contrast to Employers' Liability insurance which provides funds to the employer to cover the costs they incur arising from employees' litigation. The main conclusions from the review of overseas experience with accident insurance are summarised below.

Overseas experience: Can work related injury and ill-health insurance encourage higher standards of health and safety?

On balance the research indicates that premium discounts, premium modification and rebate schemes can positively influence the management of occupational health and safety. It appears that for an experience-rating scheme to have a significant positive impact:

- The cost of insurance needs to be perceived to be high in absolute terms – rates above 1% or 2% of payroll appear to motivate employers;
- When the national average rate exceeds 3% of payroll it appears that employers challenge the affordability and legitimacy of the cost of insurance;
- The value of discounts or rebates needs to be perceived to be high in either absolute terms or relative to the firms overall turnover /profit – typically ***at least*** 25% of the normal premium;
- Rebates / discounts need to be received within 1 to 3 years to influence firms;
- If rates vary greatly from one year to another this can cause business concern, and;
- The extent to which annual premiums can be adjusted to reflect annual claims needs to be moderated by the retention of funds to cover long tail claims.

Small firms and firms in lower risk sectors are less likely to be influenced by these schemes, especially in those cases where premiums for small firms are based on occupational class alone. However, there are a few examples where insurance costs are related to the performance of a group of small firms. These schemes appear to have a positive on influence health and safety management, including positive peer pressure for better safety.

Overseas experience: What can be done to facilitate the link between insurance and safety performance?

The provision of low cost advice and support appears to an important factor in encouraging and enabling firms, especially small firms, to realise the offer of reduced premiums / rebates. Such advice is often provided by employer financed insurance boards / societies rather than government bodies.

On the other hand, the motivational impact of experience rating can be diluted by factors such as competition between insurers which can result in insurers offering lower rates to firms regardless of actual claims. It is also pertinent to note that the link between premiums and employer performance is weaker in the case of diseases with long onsets since the claims, and so the adjustment in premiums, lag behind the exposure.

In addition, the link between premiums and performance can be reduced by "technical" problems. In particular, schemes have become unbalanced, with payments exceeding contributions due to factors such as competition and regulation of premiums. This can lead to the need to keep a proportion of firms' premiums at a constant level to bring the scheme back into balance.

However, these negative mediating factors do not appear to have overridden the potential positive impact of these schemes when national statistics are considered.

Overseas experience: What is given priority – rehabilitation or compensation?

Rehabilitation and return to work programs are awarded greater importance in these systems, compared to the UK, due to the link between the cost of claims and the duration of absence. The costs of rehabilitation and return to work are borne by insurance and viewed as an integral part of a system in some schemes. This is particularly so where the goal of rehabilitation and return to work is prioritised above compensation, such as in Germany where compensation is decided after completion of a rehabilitation process. Indeed, a requirement for employers to provide rehabilitation and return to work support is viewed as being an integral part of ensuring the employer bears the cost of work related injury and ill-health.

It has been noted in some countries such as Australia that a conflict can arise between the goals of rehabilitation and compensation, especially where an adversarial system exists for awarding compensation. This leads to pressure to mandate rehabilitation and / or link insurance premiums more clearly to uptake of rehabilitation.

Overseas experience: Can the cost of compensation be de-motivating?

Employers in some of the countries surveyed have reacted negatively to workers' compensation when the cost starts to exceed a certain level, typically an average of about 3% of payroll. (Note that an average cost of 3% across all firms can encompass rates of 8% for higher risk sectors such as construction.) The costs are then characterised by employers as unaffordable. Reactions may include seeking relocation, contesting a higher proportion of claims and lobbying for a change in rules. This has led to reforms in countries such as Australia including reducing benefit levels, limiting the range of conditions that are compensated, restricting access to legal procedures, and tightening rules for establishing if a condition is work related.

Comparison of UK and overseas arrangements

It should be noted that the purpose of schemes in other countries differs from the UK in several respects, namely:

- UK arrangements were designed to ensure employers have funds to meet costs arising from employees' litigation for compensation, and were not designed to motivate health and safety or rehabilitation;
- The US, Canadian, Australian and German schemes explicitly aim to provide a financial motivation for employers to reduce the number and severity of injuries and cases of ill-health – particularly by the use of experience rating and ensuring all (recognised) costs are funded by a single benefits scheme;
- Germany appears to prioritise rehabilitation over compensation, limiting compensation to loss of earnings after rehabilitation and vocational retraining, and makes provision of prevention services an integral element of insurer activity;
- The US, Canadian and Australian schemes aim to reduce the uncertainty about compensation costs and the level of legal costs by operating a "no fault" scheme with capped benefit levels;
- Canadian, Australian and German schemes have been designed to increase the level of health and safety advice available to SMEs as an integral part of insurer activity;

- Overseas schemes aim to cover all work related injuries, often including road traffic accidents, and hence place a different boundary on "work". This in part reflects a simple difference in demarcating the scope of each form of accident insurance;
- The cost of employers' liability in the UK cannot be compared with the cost of overseas schemes, as the cost of injury and ill-health in the UK is spread across a number of state benefits and insurance schemes whilst overseas insurance schemes are more integrated;
- Workers' compensation is conceived as a form of insurance that covers the costs and lost earnings caused by injury – in the same way that other (non-occupational) insurances aim to cover the consequences of (say) ill-health from natural causes.

It is also pertinent to note that some schemes are conceived as a "bill payment" or "pay as you go" system whereby premiums are "simply" based on current claim related costs. The level of contributions is calculated to cover the previous year's total claims (from all firms) and total related costs, although premiums may be "smoothed" across years to avoid sudden changes in premiums. Such schemes are operated at an "industry" level rather than on a company-by-company basis. This may be contrasted with the principle (current in the UK) of insurers providing unlimited cover for claims arising from any one year (up to a limit per claim) via premiums charged in that year.

The cost of workers' compensation is in the range of 1.5% to 3% of payroll, depending on which country you consider. The cost of employers' liability is approximately 0.23% of the total salary bill in the UK. We have identified current estimates of the costs of ill-health and injury in the UK. After excluding non-injury costs, such as equipment damage, the costs of injury and ill-health in the UK are about:

- 1% of payroll if only tangible costs are included, i.e. excluding pain and suffering,
- 2.5% of payroll if pain and suffering are included.

Thus, the cost of workers' compensation in other countries is comparable to the actual cost of work related ill-health and injury in the UK.

UK insurers' opinions

Consultation with insurers indicates that they believe they already operate many of the mechanisms suggested by the review of overseas practices, as far as is possible within the limits of commercial and legal requirements in the UK. It is apparent that practices vary and that there are examples of "good practice" that could be applied more widely. In particular, there is scope for the following practices to be more widely applied:

- Adopting a de facto "no fault" approach to claims, and;
- Promoting the role of rehabilitation prior to the settlement of claims.

In order for insurance to be a more effective vehicle for promoting health and safety, significant changes are required in Employers' Liability Regulations. Whilst some insurers accept that an increase in employers' liability (EL) premiums may provide employers with an incentive to improve health and safety, the increased commercial risk posed to insurers by unprofitable EL would need to be addressed. Also, reform of

employers' liability should consider how it influences the uptake and timing of rehabilitation, and the balance between compensating and rehabilitating claimants. It appears that insurers would welcome reforms that placed a greater priority on rehabilitation. This would offer both potential reduction or containment of compensation costs and the creation of a scheme that presents improved injury/illness recovery chances and that is a better vehicle for improving health and safety performance.

Survey of UK employers

A survey of UK employers has been completed to inform the discussion of whether potential changes to insurance arrangements may prompt changes in employer behaviour. The main conclusions are set out below.

The significance of EL costs

- Employers' Liability is perceived to be a significant business expense that relates to the size of the organisation and, to a lesser extent, to the risk category of firms.
- The majority of large and medium sized firms report that they are trying to reduce the cost of employers' liability. Only a minority of small firms state this view.

Employers' perceived control of health and safety

- Employers believe they control health and safety in their organisation but only half believe that the cost of EL is related to their standard of management.
- There is a clear association between company size and the perceived link between their health and safety performance and the cost of EL. Whilst the majority of large and medium sized firms believe that the cost of EL is related to their performance, only a small minority of small firms share this belief.

Employers' access to health and safety and rehabilitation services

- The vast majority of organisations have access to some health and safety expertise.
- A minority of employers are familiar with how to get access to rehabilitation services. Small and medium size employers are least aware of how to get access to rehabilitation services.

Employer awareness of IIDB

- The majority of employers are unfamiliar with the Industrial Injuries Disablement Benefit (IIDB) scheme, particularly small and medium size employers.

Employer attitudes towards the balance of rehabilitation and compensation

- Employers do on the whole agree that injured employees should have rehabilitation before compensation is settled, with a small majority agreeing that compensation should be withheld if the employee refuses suitable rehabilitation.
- About half of firms agree that employers should pay for rehabilitation, and that they would prefer to insure against the costs of rehabilitation.
- The attitude towards rehabilitation does not appear to vary according to company size, except on the question of whether employers should pay for rehabilitation. Small firms are less likely to agree with this proposition.

Acceptance of a cost increase to pay for health and safety support

- A small minority of firms would accept a 20% increase in the cost of EL to pay for improved health and safety services. This appears to be related to company size with far fewer large firms accepting a cost increase than smaller firms.

Interest in joining a club

- About a third of firms of all sizes express an interest in becoming members of a "club" wherein improved performance would be rewarded by reduced premiums.

Perceived impact of a no fault scheme

- The majority of firms of all sizes agree that a no fault scheme would lead to increased claims, increased cost and fraud without reducing legal costs and without being fairer for employees.

What is "a lot"?

- The vast majority of firms believe that 0.25% to 3% of payroll is "a lot"; with over 50% falling in the range 0.25% to 1%.

Employers' anticipated response to an increase in EL costs

- If the cost of EL were to increase significantly the majority of firms would attempt to improve health and safety, contest claims, improve rehabilitation, and avoid the recruitment of previously injured persons. About half would consider changing insurers to reduce costs.

Motivational impact of a 50% surcharge/rebate

- The majority of firms indicate that they would be motivated by the prospect of a 50% surcharge or rebate to try to improve health and safety.

Options for change

We have outlined three options, namely:

1. Voluntary "best practice" initiatives that do not require any regulatory changes – as per Action Point 5 of the HSC's Revitalising Health and Safety Strategy;
2. Reforms to Employers' Liability and IIDB schemes that would require regulatory change, and;
3. Replacement of Employers' Liability Regulations and IIDB with an entirely new form of employee occupational injury and ill-health insurance, drawing on overseas experience.

An implicit aspect of the options is that part of the "cost" of injury and ill health can be borne by employers by increasing the level of rehabilitation (assuming that the additional cost is indeed borne by employers).

Conclusions

Our research indicates that UK employers would be motivated to improve occupational health and safety and rehabilitation if the cost of insurance increased and they believed there was a link between their performance and the cost of insurance. Employers would need to believe that their premiums would fall significantly if they improved their health and safety performance. Research from other countries indicates that the operation of a scheme with performance related premiums has led to significant reductions in serious injuries. The impact of such schemes is dependent on their design.

It would be sufficient to integrate "tangible" costs of ill-health and injury into a single insurance scheme for the cost (at about 1% of payroll) to be a motivator. If the subjective value of pain and suffering were included this would raise the cost to a level that the vast majority of firms perceive to be a lot (at about 3% of payroll) and would approach the level that overseas employers have (on occasion) objected to.

Notwithstanding employers' fears about an increase in claims, the feedback from insurers and the Department of Works and Pensions suggests that there is already a very high level of awareness of the right to compensation and the "no win no fee" legal schemes probably mean most casualties already enter claims. Thus, it could be that a no fault scheme would not lead to a significant increase in claims in the UK.

It is suggested that Option 3 (replacing EL with a no fault scheme) would have the greatest impact on employer behaviour because it would facilitate the greatest "transfer" of costs to employers. Nonetheless, Option 2 would also have a significant impact in our opinion, especially if the regulatory requirements for rehabilitation and "responsible" pricing of EL were introduced. It is uncertain whether the voluntary initiatives of Option 1 would have the same influence, as the cost of EL may not be influential.

Recommendations

The evidence available to this study indicates that a reformed UK insurance process would provide a significant motivation to employers to improve health and safety and rehabilitation. It is therefore recommended that the ideas emerging from this study be taken forward and awarded appropriate weight by the HSE and HSC.

In the first instance, it is recommended that employers' liability and rehabilitation "best practices" be drawn together into a "best practice model" that is then promoted as an industry standard. A number of insurers have developed schemes that aim to encourage better health and safety and to integrate rehabilitation into the claims process. Given the availability of such examples in the UK and overseas it should be possible for such a model to be developed within a relatively short time, such as one year.

Secondly, studies and consultations should be carried out to elaborate how current regulations could be reformed or replaced, as per Options 2 and 3 in this report. Therefore, it is recommended that a study, involving consultation with key stakeholders, be launched in the short term to explore and identify practical ways forward for the reform of the UK occupational injury and ill-health insurance arrangements.

1 INTRODUCTION

1.1 BACKGROUND

A key aim of the Revitalising Health and Safety strategy is to motivate employers to improve their health and safety performance. Various approaches are noted, such as the provision of a ready reckoner to help drive home the benefits, new challenges on annual reporting, and commitments to legislate to 'make the punishment fit the crime'. Item (v) in the 10-point Strategy Statement notes that:

> "The compensation, benefits and insurance system must motivate employers to improve their health and safety performance, in particular by securing a better balance in the distribution of the costs of health and safety failures. When things do go wrong, employers must also be motivated to rehabilitate injured workers so as to maximise their future employability. The Government sees a case for reforming the arrangements for employers' liability insurance in pursuit of these goals." (p 18, RHS 2000)

In addition, Action Point 5 notes that many consultees suggested that the insurance industry could do more to promote health and safety standards. It mentions the use of auditable management standards, loading and discounting premiums and offering free advice on risk management together with consultancy services. It is suggested that further consideration should be given to how the current practice of adjusting premiums and giving advice to larger firms could be transferred to lower hazard sectors and smaller firms.

There are currently two main forms of insurance, namely Employers' Liability insurance under which employees may receive damages via tort, and Industrial Injuries Disablement Benefit that provides no fault state benefits. Academic researchers have indicated that the Industrial Injuries Disablement Benefit scheme offers no incentive for companies to improve their safety records and implicitly entails low risk sectors subsidising higher risk sectors. As elaborated later in this report, there is little evidence that the costs of Employer Liability insurance or the manner in which Employer Liability operates, currently provides firms with an incentive to improve occupational health and safety.

The possibility of revising these schemes has been the subject of debate as part of the Government's programme of welfare reform. Indeed, House of Commons research (e.g. Research paper 98/51) has noted criticisms of the current tort based arrangements, such as its liability oriented adversarial nature and focus on defendant culpability as opposed to the needs of the plaintiff. The 1998 research paper notes that other countries have introduced alternative no fault arrangements. It is the Government's aim to provide better protection from the risks and consequences of occupational disablement by improving incentives for prevention and rehabilitation, and realising the link between prevention, rehabilitation and compensation.

Therefore, this study aims to explore how changes to the way in which the financial costs of health and safety failures are distributed, and in particular insurance changes such that businesses cannot shelter from some of the costs, could provide an incentive to firms to improve health and safety performance. Currently employers can rely on insurance to shelter from many of the costs of poor safety performance. Also, many costs are borne by the state and are therefore not reflected in employer liability or other company insurance premiums. This study focuses on how current employers' liability and other forms of insurance can act inadvertently to reduce the focus on improving H&S, and to consider what changes might engender a greater business focus on these issues.

The study aims to address a number of specific issues. First, it is important to understand to what extent would increased insurance costs promote improvements, and what financial thresholds would be required? Secondly, it is important to consider the relative strengths and weaknesses of alternative schemes. Thirdly, it aims to explore how such changes might be introduced in the UK.

It might be inappropriate to look at ways merely of transferring those costs more fully to businesses, unless it can be shown that businesses have sufficient control over them that the good ones can avoid the financial penalty that might ensue. Thus, this research also looks at how changes in the way that costs are borne by industry might influence business behaviour such that it leads to improved performance. If it can be shown that by transferring certain costs, businesses may start to behave more safely, and hence that the net cost to business (and thereby to society) would reduce, then the net benefit justifies the change. For example, if transferring to business some of the societal costs (e.g. hospital treatment) simply resulted in increased insurance premiums, this might not lead to changes in behaviour. However, if premiums were increased as a consequence of claims history, such that poor businesses carried more of the costs directly, this might motivate them to improve their performance, and thereby reduce costs.

1.2 SCOPE OF THIS PROJECT

The study comprised has six stages of work, as follows:

- Stage 1: Background and literature survey

This entailed the collation and review of existing knowledge and research on the financial motivators for improved health and safety performance. The results were used to develop a framework for considering financial motivators.

- Stage 2: Review schemes in other countries

Various systems exist in other countries for passing the costs of poor health and safety on to the employer. These include hospital and other welfare costs that are borne by the state in the UK. This stage entailed the survey of four systems. Specific consideration has been given to how they attempt to relate costs to firms' performance. The information is used to identify evidence for whether such arrangements promote higher standards, and the factors that affect whether this is so. The results were combined with

the results of Stage 1, to develop a framework for a survey of UK insurers and businesses and draw out lessons learnt for the UK.

- Stage 3: Survey of UK insurers

UK insurers have already looked to some extent at how changes in the insurance arrangements would affect the risks that they cover. The Association of British Insurers (ABI) has considered the impacts of potential changes to Employers' Liability Insurance, in its response to the Consultation Document on the Draft Employers' Liability (Compulsory Insurance) General Regulations, issued by the DETR.

The views of the insurance industry were sought concerning the potential approaches available to make businesses shoulder directly a greater proportion of the costs of poor H&S performance. Specifically, their views have been sought about the feasibility of different approaches, the likelihood that they will lead to changes in business behaviour, and the viability of options for change – both within the current regulatory framework and if these regulations were to change.

- Stage 4: Survey of businesses

A postal survey of organisations was conducted to ascertain their self-reported perception of how potential changes to insurance arrangements would impact their view of the costs of health and safety and their motivation to make improvements.

- Stage 5: Develop conclusions

Conclusions have been drawn about how insurance arrangements could best be developed to motivate employers to improve occupational health and safety. Some initial options are outlined and their advantages and disadvantages are noted.

- Stage 6: Reporting

This entails developing a report appropriate for publication, i.e. the current report.

2 THE UK POSITION

2.1 INTRODUCTION

The aims of this section are to:

- Summarise the current arrangements for providing financial compensation and benefits for persons suffering occupational injury or ill-health;
- Provide an approximation of the cost of occupational injury and ill-health insurance if all of the tangible and intangible costs were borne by a single "integrated" insurance policy;
- Summarise previous research that directly or indirectly indicates to what extent UK employers are motivated to improve health and safety management by the wish to reduce the cost of Employers' Liability insurance, and;
- Identify examples of other forms of accident related insurance in the UK that aim to provide a link between organisational performance and premiums.

The findings of this section on the position in the UK are compared with a similar summary of schemes and research in other countries in section 3 of this report.

2.2 CURRENT EMPLOYERS' LIABILITY AND INDUSTRIAL INJURY BENEFITS

It is reasonable to say that the UK currently operates a two-track approach to occupational injury and disease insurance. On the one hand, there is "no fault" access to limited state benefits and, on the other hand, litigation based access to damages under Employers' Liability insurance. Indeed, it is pertinent to note that the cost of Industrial Injuries Disablement Benefit at £728m in 1998/99 is close to the cost of employers' liability at £872m in 2000.

2.2.1 Industrial injuries benefit

There are a number of benefit schemes that apply to industrial accidents and diseases, namely:

- Industrial Injuries Disablement Benefit (IIDB): Covers disablement as a result of an accident at work or a disease caused by work. The amount payable is dependent on how serious the disablement is, with a minimum qualifying disability of 14%.
- Statutory Sick Pay: Paid for periods of sick leave between 4 days and 28 weeks.
- Industrial Death Benefit: Paid to surviving dependants. (This benefit is being phased out and no new claims are now allowed)
- Income Support: This may apply where a person on a low income does not sign on at the Job Centre.
- Reduced Earnings Allowance (REA): Also being phased out, this is only available to persons who suffered an accident before 1990 and as a result cannot do their usual job or work with similar pay.

- The Pneumoconiosis etc (Workers' compensation) Act 1979. An employee is entitled to claim a lump sum payment under this act if they are unable to recover damages against an employer for prescribed asbestos related diseases. Negligence need not be proven.

As at 1998/99 the expenditure on these benefits in cash prices was:

- IIDB: £710 m
- Industrial Death Benefit: £49m
- Other industrial injuries benefits: £2m.

The IIDB scheme therefore appears to account for the largest proportion of identifiable benefit costs arising from work related injury and ill-health.

Industrial Injuries Disablement Benefit

An individual can apply for a decision that their injury results from an industrial accident or disease. A medical examination advises the level of disability and expected duration. If a work related condition is established and meets certain time limited criteria (such as contact with asthma causing substances within previous 10 years) the claim can be met. The Industrial Injuries Advisory Council advises on a schedule of prescribed diseases, with an ongoing review.

IIDB is not paid if you were self-employed when the accident happened. IIDB provides for:

- Disablement pension allowance, linked to degree of disability;
- Constant Attendance Allowance (CAA), paid at four different rates;
- Unemployability Supplement, and;
- Exceptionally Severe Disablement Allowance (ESDA) paid when disablement is judged to be 100%.

No IIDB benefits are paid for the first 90 days after an accident.

Disability allowances are set at fixed weekly amounts, such as £79.03 for 70% disablement versus £33.87 for 30% disablement for persons over 18. Similarly, CAA is set at fixed amounts such as £90.40 for Exceptional Rate versus £22.60 for Part -Time Rate. Unemployability supplement is £69.75 (basic rate) with additions for early incapacity.

Whilst the DSS do not *instruct* individuals to seek compensation through the courts, the Compensation Recovery Unit recovers the cost of social security benefits paid as a result of an accident, injury or disease where compensation has been paid. Benefits are repaid by the compensator, namely the insurer. The compensator, i.e. the insurer, can reduce the amount of damages by the amount of benefit the person has already received. The unit recovered benefits in 30,000 cases in 1995/96.

2.2.2 Employers' liability in the UK

The aims of this section are to:

- Summarise how Employers' Liability (EL) currently operates in the UK, and;
- Indicate some typical EL annual premiums for firms in the UK.

There are two pieces of legislation that govern Employers' Liability insurance, namely:

- The Employers' Liability (Compulsory Insurance) Act 1969
- The Employers' Liability (Compulsory Insurance) Regulations 1998.

The Act requires employers to insure against their liability for personal injury to their employees hence ensuring that an employer has at least a minimum level of insurance to cover a claim. The regulations state that the amount of insurance cover that an employer has to provide should not be less that £5 million for each employee involved in any accident. There are also some other legal requirements with regard to certification, employees abroad, and relatives of the employer for example.

Cover provided under an EL policy indemnifies the employer against their legal liability for damages including legal costs resulting from: accidental death, bodily injury, illness and disease. The injured person must sue the firm for damages through litigation and must demonstrate a degree of negligence on the part of the employer, although most cases are settled without court action. The employer may in turn reject liability or claim contributory negligence on the part of the employee. The level of damages is intended to cover loss of earnings and health care costs in full, although they may be reduced if contributory negligence can be established, and an element for pain and suffering. For example, in Mary Watkin vs Birmingham City Council £20,000 of the £200,000 award was for pain and suffering.

There has been an increase in the cost of insurance premiums due to the increasing number of claims and hence the total cost of claims. Between 1981 and 1991 the number of claims almost doubled and between 1986 and 1990 the number of claims arising from accidents increased by a third. The number of claims relating to occupational disease trebled, particularly in relation of noise induced hearing loss, asbestosis, occupational asthma and cancer. Disease accounts for 50% of the claims made. It is thought that much of the increase in the number of claims is due to a greater employee awareness of their ability to claim against their employers' insurance.

Notwithstanding this, the cost of EL is still only approximately 0.23% of the total salary bill in the UK. The UK total salary bill is estimated to be £380 billion (1997-98) and the total cost of employers' liability insurance in 2000 is estimated to be £872 million.

In most cases the premium cost is based upon a percentage of the company salary bill, taking into account the industry sector. Premiums are intended to reflect the potential for future claims of the future, as well as recent and past experience.

Wrightson (1996) also comments that many insurance companies requires a company to provide and maintain a good standard of health and safety with the intention of

preventing accident and exposure to harmful agents, in order to minimise/prevent claims of negligence. Wrightson also notes that the companies' claims experience is taken into account in some cases. Eagle Star Insurance Company Limited, for example, is reported to offer financial rewards to employers whose successful health and safety management system has minimised the number of claims made. The company offers an 'optional renewal bonus scheme' which provides a bonus on a sliding scheme of up to 25% on the premium for a claim free history.

2.2.3 Cost of "integrated" occupational injury and disease insurance

As discussed later in this report, other countries aim to cover all work related injuries and ill-health under a single insurance regime. Some of these schemes also make payments for pain and suffering, whilst others are restricted to loss of earnings and additional expenses. Therefore, this section:

- Identifies those injury and ill-health costs that are currently in the UK covered by individuals, the state and EL, such as medical costs, sick pay and loss of welfare, and;
- Provides an estimate of the total of these costs.

This estimate is used for a number of purposes, including:

- To provide an indication of what the total cost of an "integrated" work related injury and ill-health insurance might be;
- To provide a comparison with costs covered by accident insurance in other countries;
- For use in surveying UK employers' reaction to the total cost of an integrated insurance scheme.

As part of this we have reviewed previous studies of the costs of ill-health and injury. In particular, we have used the HSE's report 'The cost to Britain of workplace accidents and work related ill health in 1995/6' and statistics from the Department of Social Security (DSS) on IIDB cash payments. The HSE report draws upon information collected from a number of surveys including:

- The Labour Force Survey 1995/6 (LFS);
- Self-reported Work Related Illness in 1995 survey (SWI95), and;
- 1995/96 Family Resources Survey (FRS).

We have identified costs such as loss of company production, costs of temporary staff and so on, that would not fall within an industrial injuries insurance scheme and excluded them from the estimate. These costs may be pertinent to other types of insurance and include:

- Damage to plant and equipment;
- Loss of output;
- Loss of reputation and good will with employees, customers and the local communities;

- Extra expenditure including administration, management and rescheduling to recover production, and;
- Recruitment of replacement staff

However, it is possible that a new insurance arrangement would lead to changes in claims practices and payment rules. Therefore, we have also sought to identify key variables that may significantly alter the cost.

From reviewing the literature regarding the costs of accidents and ill-health it is possible to identify both the costs that could be included in an "integrated" insurance and those that should not. These are summarised in Table 1.

The main "tangible costs" are:

- Individuals' loss of income (the difference between sick pay, part pay etc and "normal" income;
- Salaries paid to employees whilst absent from work due to injury or ill-health;
- Employers' Liability premiums;
- NHS costs, and;
- Industrial Injury Disablement Benefits.

One cost that is at present borne by individuals and families is that of pain suffering and grief. This had been converted to monetary terms by the HSE and is estimated at a nominal £5.5 billion per annum (in 1995). However, this is a very difficult and subjective process. In addition, it is not certain that payments would be included in an "integrated" insurance regime. Therefore, we have considered the potential total cost of insurance with and without an allowance for pain and suffering.

Table 1: The costs that could be included in "integrated" insurance

Who currently bears the costs?	Costs that could be included	Estimated Cost (1995/6)
Individuals (employees) and their families	Loss of Income (in one year when absent)	£558m
	Extra Expenditure ▪ Medicine ▪ Additional Travel ▪ Additional Shopping expenses	 £11m £6.4-10.1m £2m
	Sub-total Loss	*£577.4-£581m*
Employers	Compensation and insurance (calculated from £720m of claims with additional 15% for insurance company admin and profit)	£828m
	Sick Pay	£56m
	Salary paid whilst employee off work	£1,100m
	Sub-total	*£1,984m*
Society	Costs borne by the taxpayer: ▪ Medical treatment ▪ Cost of accident investigation by HSE/LA ▪ DSS administration ▪ Industrial Injuries Disablement Benefits	 £181-676m £11m £117m £731m (1995/6)
	Sub-total	*£1,040m to £1,535m*
Total tangible costs		£3,601m-£4,100m
Loss of welfare, pain and suffering		£5,500m

Table 2 compares the cost of an "integrated" insurance scheme (if it bore all of the costs of injuries and ill-health noted in Table 1) with the costs currently included within EL. We have provided two comparisons, one with and one without an allowance for payments for pain and suffering.

Table 2: Potential cost of an "integrated" insurance

Cost of EL (Late 1990's)	£828m	Factor increase
Tangible costs	£3,601m-£4,100m	4.5 to 5
Including pain & suffering etc.	£9,100m-£9,600m	11to 11.5

Potential Inflationary/ deflationary factors

The latter cost estimate of an "integrated" insurance is based on adding together estimates of current costs. These estimates do not take account of potential "inflationary" and "deflationary" factors. Also, it is not certain that current estimates capture all of the costs associated with ill-health and injury. For example, it is unclear what proportion of casualties fail to claim or receive compensation because they are unable to prove fault on the part on employer. In addition, the scheme could be designed so as to include or exclude some of the costs noted in Table 1. In particular:

- Employers' payment of salaries to absent staff might not be covered by such a scheme – employers might pay these directly rather than have employees claim them under insurance;
- Individuals might not receive 100% compensation for loss of earnings (some other countries pay less than 100%).

Similarly, there are choices about:

- The range of dependants/beneficiaries who may receive compensation – such as parents, grandparents or other family members;
- The number of components of a claim a claimant could receive compensation for, for example their increased shopping costs or transportation costs.

Moreover, the current approach to EL claims is based on tort, with full compensation for loss of earnings, whilst IIDB is based on a schedule of benefits rather than a percentage of the individual pre-injury earnings. The "no fault" systems in many other countries provide medical / care expenses and only a proportion of loss of earnings, without compensating pain and suffering. Indeed, some schemes cap benefits according to average wages rather than relating loss of earnings to the individual's actual salary. Thus, the cost of each claim would vary according to whether payments were not made for pain and suffering and according to which formula was used for loss of earnings.

Therefore, it needs to be recognised that the actual cost of an "integrated" insurance scheme would depend on its design.

Also, current claims costs include the legal costs incurred by a tort based system (about 30% of EL costs). These costs might be averted or reduced if the integrated scheme operated on a no fault scheme, although some other countries allow limited access to tort within a "no fault" scheme. On the other hand, a no fault scheme may lead to an increase in the number of successful claims. In addition, the scheme could include a requirement to provide and accept rehabilitation services. Thus, costs could be increased by the following:

- A no fault system where employees can claim for any injury/illness so long as they can show that it can be attributed to work activities. Drawing on overseas experience, the number of claims could increase by a factor of 2 to 10 if all persons suffering harm entered a claim for compensation.
- Replacing scheduled benefits paid under IIDB by a proportion of loss of earnings.
- A requirement to cover the cost of rehabilitation, vocational retraining and return to work.

At the same time claims may rise due to reasons unconnected to the scheme. Currently, as Wrightson (1996) discusses, there is a significant increase in the number of claims for work related ill health and injury (a 33% increase in injury claims between 1986 and 1990). He attributes this to a greater awareness of the rights of individuals to claim for compensation.

Finally, some current costs may have been omitted from Table 1, such as income support and housing benefit. If an integrated scheme aimed to cover all income requirements, these could also add to the estimated cost.

On the other hand, costs could be reduced by the aforementioned means, including:

- Only paying a proportion of loss of earnings and (all) health care costs – without paying for pain and suffering as per some EL claims;
- Reduced legal costs;
- Reduced injury severity (due to better rehabilitation), and;
- Fewer claims (due to employers' health and safety improvements).

Notwithstanding the latter provisos and uncertainties, the costs of an integrated scheme would be about:

- 1% of payroll if only tangible costs in Table 1 excluding pain and suffering are included, and;
- 2.5% of payroll if all costs including pain and suffering are included from Table 1

In considering these values it should be noted that the 1% value is based on costs that are already incurred by the state, employers or individuals. These estimates are based on a UK salary bill of £380 billion (1997-98).

These values can be compared with costs in other developed countries, as elaborated in section 3. In the USA, Canada and Australia workers' compensation/employers' liability as a percentage of the total salary bill is in the order of 2% to 3% on average. The continental European systems typically cost about 1.3% to 3% of payroll. The systems in Germany, Canada and America do not, as a rule, cover, pain and suffering, although the Australian and some continental systems do. Thus, the higher cost of these systems is accounted for in part by the number of compensated claims and the cost of lost earnings, health care, rehabilitation etc. It is also pertinent to note that the level of rehabilitation is regulated in some other countries and hence may be provided at a higher level than in the UK. It should also be noted, as discussed below, that many schemes in other countries include work-related travel and commuting within the scope of work accident insurance. This makes direct comparison of occupational accident insurance costs difficult.

2.2.4 Work Related Road Traffic Accidents

A number of overseas systems include work related traffic accidents (RTAs), and sometimes commuting, within the scope of workers' compensation. Accordingly we have considered the potential cost of including these within an "integrated" insurance scheme.

It is estimated that out of the 3,500 deaths caused by roads traffic accidents, 1,000 involve drivers and passengers who are engaged in work related travel. However this is only an estimation as current data on RTAs in the UK does not include information about journey purpose. However, research commissioned by the Work-related Road Safety Task Group confirms that "between a quarter and a third of all road traffic incidents involved someone who was at work at the time". The Task Group also asked HSE economists to estimate the costs of work related road traffic accidents. They estimated a figure of £2.2bn for insurance/damage cost in the UK (Work-related Road Safety Task Group 2001).

The addition of about £2billion to the cost of an "integrated" insurance scheme would increase "tangible" costs to up to about 1.7% of payroll, from about 1% if they were excluded. In considering this estimate, it should be noted that these costs are already incurred and would simply comprise a transfer between fleet and employers' liability insurance policies, and some switching from employees to employers' insurance policies. In addition, only a proportion of this cost would relate to injury as a proportion would be related to vehicle and other damage.

2.3 RESEARCH ON EMPLOYERS' MOTIVATION IN THE UK

2.3.1 Introduction

The aims of this section are to:

- Summarise research regarding the extent to which UK firms are motivated by financial factors to manage occupational health and safety, and;
- Pick out any research that indicates the extent to which insurance, particularly EL, influences employers' attitudes towards occupational health and safety.

It is pertinent to note that the Industrial Injuries Disablement Benefit scheme is not cited in any research as a motivator of employers. In this way it is noticeable by its absence. This is unsurprising given that IIDB is just one of a number of state benefits covered by general taxation and has no tangible link to employer costs or health and safety performance.

There has been one large scale study of employers' motivation in the UK, namely the Evaluation of the Good Health is Good Business Campaign, a number of industry specific studies and a review of various case study and small scale survey studies.

2.3.2 Factors motivating proactive health and safety management

Wright (1998) reviewed the UK and overseas research on the factors that motivate employers to manage health and safety. It should be noted that this review covered work for the period prior to the conclusion of the HSE's Good Health is Good Business Campaign.

The review found that the avoidance of the costs associated with work related ill-health and injuries is not a motivator amongst UK employers with the exception of high risk high profile firms, although it is in the USA under certain conditions. Avoiding the costs of ill-health and injuries was similarly reported to not be a key factor in Israel, Norway and Australia. Based on a subjective review of UK research, the report ranked the avoidance of ill-health and injury costs as 5th out of 6 motivators in the UK. The main motivators are reported to be a fear of loss of corporate credibility and a belief that it is necessary and morally correct to comply with health and safety regulations.

The review ascribed this finding, in part, to the differences in insurance and compensation costs between the UK and the USA. In the UK research available at the time of reporting indicated that employers bore no more than 30% of the cost of ill-health and injury (if the subjective cost of well being is ignored). Indeed, it is reported that:

> "The EL premium is unlikely to be a significant proportion of the total insurance spend an so the underwriter has little or no leverage to, for example, secure a sound relationship …."

Insurance companies generally do not have any influence on health and safety performance; say on hearing conservation activity – as an example.

In the USA, where most employees have health insurance arranged as part of their employment package, compensation and health care can account for 8% to 12% of labour costs. However, cost avoidance / reduction only operates as a factor in the USA under certain conditions, namely:

- The costs are regarded to be high;
- The costs are under the influence of the organisation;
- The company is large enough to have the resources to implement interventions;
- There are no operational barriers to change, such as cyclical workloads, and;
- Benefits can be realised within a few years.

It should also be noted that the USA figures relate to all employee health care costs, which includes non-work related health care costs that are often met via health care insurance provided by the employer. In addition, the cost of health care insurance rose significantly in the USA due to a general increase in the cost of health care and there was an increase in the proportion of employers providing health care insurance as part of the employment package during the 1980's. Accordingly, the comparison with the USA position needs to take account of the differences in health care (including non-work related ill-health) insurance arrangements and costs. The discussion of the USA insurance process is continued later in this report.

Nonetheless, the review goes on to suggest that the conditions in the UK do not currently prompt an accurate balancing of the costs and benefits of health and safety amongst employers because:

- Firms do not bear the full cost of harm;
- The mechanism for allocating cost to responsible organisations does not reflect organisation specific performance;
- The actual financial costs dot not reflect the loss of well being incurred by people, such as pain;
- Accounting methods fail to identify all costs, such as early retirement;
- Many costs are hard to quantify;
- Many firms are not aware of the risks arising from their operations, and;
- Demands for services may be inelastic, such that firm's commercial fortunes may not be sensitive to its health and safety performance.

Under these conditions, the degree of cost that a profit maximising firm can justify on the grounds of averting consequential loss is unlikely to reflect the true level of harm incurred by society. The review indicates that a socially optimal balance of costs and benefits is currently sought by the process of regulation in the UK.

The exception to this is high-hazard firms who are reportedly driven to a greater extent by commercial concerns and fears of catastrophic loss. In this case, firms fear the

tangible and intangible consequences of a major incident in terms of direct loss, consequential regulator attention and reputational damage.

The review concludes by suggesting that changes in the UK's insurance system could act as a trigger for firms. This would need to increase the share of costs of injury and ill health borne by the responsible organisation and link premiums to the experience of the organisations. This may have the effect of giving firms an intrinsic reason to improve health and safety management, namely their own commercial fortune.

However, for this to work other conditions need to be in place, including

- Ensuring costs of compliance are not viewed as an obstacle, i.e. is it affordable?
- Ensuring firms understand how to better manage health and safety.

The review notes that there are mediating factors that moderate employers' motivation to manage health and safety, including their awareness of risk and cost of improvements. Thus, firms need to be aware of their risks and feel capable of making improvements as well as believing they have good cause to do so.

It should also be noted that this review reported research that indicated that many small employers do not prioritise profit, placing autonomy and achievement above financial rewards. This suggests that the variable level of profit motive may further reduce the business motivation for improving occupational health and safety.

Also, the report concludes that, given that firms may have a number of alternative ways of reducing costs or increasing income and only limited resources to pursue them, they may overlook the potential benefits of reduced injury and ill-health costs in favour of other strategies. Accordingly, the impact of changes in insurance arrangements may be mediated by other factors.

2.3.3 Evaluation of the Good Health is Good Business Campaign

Wright et al (2000) completed a survey of 1800 UK employers on behalf of the HSE regarding the factors motivating them to manage occupational health. The survey supported the view that very few firms in the UK are currently prompted to make improvements due to the potential business impacts of work related ill-health. Only 8% of respondents indicated that they are prompted to make improvements due to business impacts /bad PR /customer pressure. Only 1% of those respondents who had made improvements to occupational health management had been prompted primarily by employers' liability claims, with 4% citing employers' liability claims as a secondary prompt. The majority of respondents are prompted by regulations, awareness of hazards and moral duties. In addition, only 17% of respondents believed that work related ill health cost their firms "a lot". The majority of respondents report that work related ill-health costs them between "a little" and "nothing significant" whilst the costs and benefits of managing occupational health are slightly in favour of their management.

The survey also found that few firms, just 10%, would anticipate that evidence of business impacts would prompt them to do more to manage work related ill-health, with other factors such as a better understanding, seeing an incident or more regulations being reported as more likely reasons for doing more. Only 3% of the 1800 respondents

indicated that an increase in employers' liability premiums would act as a prompt to further improve occupational health This can be interpreted as indicating that UK employers do not currently expect business impacts to act as a driver for occupational health improvements. This is despite 29% of those respondents who were aware of the HSE's Good Health is Good Business campaign reporting that the campaign had improved their awareness of business impacts of ill-health.

On the other hand, a second part of the survey that involved interviewing face to face 120 employers, found that a small proportion of employers (15 out of 120) believed that a change in insurance premiums or liability claims could act as a prompt for employers to better manage occupational health.

This work supports the view that neither employers' liability insurance costs nor wider business / financial impacts of work related ill-health currently prompt employers to better manage occupational health. Few employers anticipate that this position will change but some do believe that changes in employers' liability insurance could act as a prompt.

2.3.4 Industry specific studies

Construction health and safety for the new millennium

Brabazon et al (2000) surveyed 89 respondents from the UK construction sector. The survey addressed, amongst many other points, the role of insurance in construction health and safety and the factors motivating construction sector firms to manage health and safety. It reported contrasting findings. On the one hand, the majority of construction sector firms see health and safety performance to be important to commercial success due to its impact on tendering and their reputation. However, the short-term nature of construction business inhibits investment in health and safety. On the matter of insurance, interviews indicated that insurance premiums are not linked to safety management and performance, except for large projects. Rather premiums are based on knowledge of risks in the industry in general.

It is also reported that the extent of price competition in the construction sector means that "Either there must be commercial advantage in good standards of health and safety or there are to be commercial disadvantages from poor performance" (p 87). Accordingly, it was noted that "Interviewees feel insurance premiums could be a financial incentive to increase the focus on health and safety. Insurance requirements are considered to have a large influence over health and safety" (p 52). The report recommends that greater penalties are imposed for poor health and safety performance.

This finding is consistent with the former research, i.e. that employers' liabilities for the costs of ill-health and injury could act as a motivator if they were to become a significant commercial factor.

The costs of accidents and work-related ill-health to a cheque clearing department of a financial services organisation

Monnery (1999) adapted the HSEs method of calculating the cost of accidents and ill health to collect data in a cheque-clearing department. The study collected data over a three-month period and allowed calculations of the total costs, both insured and uninsured costs and costs that were attributable to ill heath and injury. They found that in this particular office environment that the total costs of £81,362 to the company were equivalent to approximately 0.5% of the annual salary bill (~£16,272,400) and hence not a substantial loss to the business. The company was found to pay EL insurance to the sum of £4,650 for the department, which is approximately 0.03% of the total salary bill. There were approximately 1000 employees in the department.

The study drew the conclusion that "the total cost of accidents and work related ill health was not regarded as substantial and unlikely to be a key motivating factor for improving health and safety management within a cheque clearing department of a financial services organisation" (p68)

Costs of Construction Accidents to Employers

Leopold & Leonard (1987) administered a postal questionnaire to employers of workers who were known to have had an occupational accident. They found that small firms (with a turnover of less than £100,000) paid an average premium of £604. One large firm with a turnover of £25 to £50 million was considered in more detail. Its EL insurance premium was £70,000, i.e. no more than 0.3% of turnover. It was found that less than one percent of construction companies employed 80 staff and 80% of construction firms employed less than 14 people. £83.1 million was spent on EL insurance by 115,186 firms in construction in 1987, approximately £721 per firm.

The study concluded that, because of the relatively low premium that small firms pay, they couldn't hope to significantly influence the size of their premium through better health and safety performance. Also, as small firms make up 80% of the market it was concluded that changing the structure of the system would not have a massive impact as small firms are unlikely to be influenced.

2.4 OTHER UK INSURANCE SCHEMES

2.4.1 Introduction

The aims of this section are to:

- Identify examples of how other forms of "accident" related insurance have taken account of safety management standards in organisations;
- Summarise any available research on the impact of these insurance schemes on organisational behaviour, and;
- Summarise lessons for changes to the EL system.

2.4.2 The Clinical Negligence Scheme for Trusts (CNST)

The CNST scheme is of interest to this study because it links insurance discounts to achievement of audited risk management standards rather than "claims experience". The background and operation of the scheme is summarised below. Whilst it is reasonable to suggest that trusts have sought to achieve these standards it should be noted that many other factors have had a bearing on trusts risk management activity since the early 1990's. Accordingly the increase in Trusts risk management cannot be ascribed solely to the CNST. Nonetheless the scheme is also of interest as a rare example of linking discounts to risk management standards rather than just claims experience.

Crown indemnity for clinical negligence was introduced in 1990, through which the NHS assumed all liability for clinical negligence in NHS trusts instead of requiring doctors to have their own professional liability insurance (which had previously been supplied by the Medical Protection Society (MPS)). Unsurprisingly, since the early 1990's the Department of Health has endorsed risk management and encouraged NHS trusts to take the issue more seriously. By 1994 many Trusts had initiated some risk management activities, which essentially involved risk assessments by themselves or bringing in external risk management consultants to help. At this time there were no direct incentives for Trusts to invest in risk management and few Trusts had appointed dedicated risk management personnel, due to lack of funding.

The DoH ruled that NHS trusts should not seek commercial insurance for clinical negligence, as it was considered an expensive route. Consequently, proposals were drawn up for a national risk pooling arrangement, the Clinical Negligence Scheme for Trusts (CNST). This scheme would involve NHS trusts joining and paying a subscription based on their size and the clinical areas in which they worked. In return most of the costs of the claims for clinical negligence above a certain threshold (their "excess") would be met by the CNST. The subscriptions would be set each year at a level that covered the costs of claims met and administration for that year. To ensure that the scheme meets members' needs, the Medical Protection Society Ltd and Willis Corroon Ltd, were awarded the contract to design and implement the scheme. The CNST was established in 1995.

The scheme is a 'pay as you go' type of scheme. It is estimated what will happen in the coming year and premiums are based on this estimation. A further factor that is influential in setting the premium is how much risk the trust wishes to carry. Discussions are then held between the trust and the insurer to determine the level of cover that the trust want to pay for, and a premium is set.

The CNST scheme also aimed to improve the quality of patient care and to promote best practice in risk management. Trusts wishing to join the scheme were asked to meet a set of risk management criteria which allowed them to receive a discount on their subscription. CNST assessors would assess each trust against risk management standards. Increasing subscription discounts (up to 25%) would reward trusts that achieved higher level standards. Essentially the CNST had created a national set of risk management standards that NHS trusts were strongly encouraged to follow, and they put in place financial incentives for good risk management. These standards are shown

in Box 1. For each main standard there was an accompanying series of statements and explanations in the standards manual. Each statement was categorised at either Level 1 (the minimum standard for risk management), level 2 (a little more demanding, requiring more action by the Trust) or level 3 (highest level).

With subscriptions expected to increase to £1m per year for large acute trusts it was expected that discounts of up 25% would act as an incentive. If the trust has attained level 1 standards they get a 10% discount on their subscription, for a level 2 attainment a 20% discount is given and a 25% discount for level 3. However it is not believed that many of the participating trusts have achieved level 2 or level 3 and this has been attributed to a lack of knowledge of how to move between the levels.

Box 1: Summary of CNST Risk Management Standards (Hickey, 1995)

- The Board has a written risk management strategy that makes their commitment to managing clinical risk explicit.
- An executive director of the Board is charged with responsibility for clinical risk management.
- The responsibility for management and co-ordination of clinical risk is clear.
- The clinical incident reporting system is operated in all medical specialties and clinical support depts.
- There is a policy for the rapid follow-up of major clinical incidents.
- An agreed system of managing complaints is in place.
- Appropriate information is provided to patients on the risks and benefits of the proposed treatment or investigation, and the alternatives, before a signature on a consent form is sought.
- A comprehensive system for the completion, use, storage and retrieval of medical records is in place; record-keeping standards are monitored through the clinical audit process.
- There is an induction/orientation programme for all new clinical staff.
- A clinical risk management system is in place.
- There is a clear documented system for management and communication throughout the key stages of maternity care.

The CNST risk management standards are not particularly demanding at level 1, but in the first 2 years of the scheme, just over 50% of NHS trusts joining the scheme were able to comply with them. Although all trusts joining the Scheme were required to undergo an assessment, those who did not meet the standard still remained as members. However, as a consequence of failing to reach level 1 they received no discount on their subscription. There is no requirement on any Trust to bring their arrangements for risk management in line with the standards in a prescribed period, or to undergo further assessment, unless they wish to do so. A team of auditors visit and assess what level of standard the Trust has achieved.

The CNST standards only apply to English trusts and not to primary care. The Welsh Risk Pool was set-up a couple of years ago to provide a similar service as the CNST to Welsh hospitals. Their standards are similar, but not identical. All but one English trust has joined the voluntary CNST scheme.

It is believed that the CNST has been a catalyst for risk management within the NHS. Bringing its importance to the forefront encourages the trusts to establish risk management teams and employ professional risk managers. However there has not been any research (empirical or anecdotal) to show the level of impact the scheme has had. Efforts are being made to 'link' trusts of similar characteristics to promote organisational learning within the NHS.

2.4.3 Fleet insurance

Many of the motorcars involved in road traffic accidents are part of a fleet owned by private companies. It is therefore important as part of this study to consider how the insurance of these motor cars is administered; how the hazards are being managed in order to reduce the risks and how premiums are related to claims experience.

It is a legal requirement that all motor vehicles are insured before they are allowed to travel on the road. Fleet insurance arose because it was found that where companies owned and managed a fleet of cars, it was more economically viable for them to insure them all under the same policy and pay one premium. It is the private insurance companies (for example Cornhill Insurance Ltd., CGU and Norwich Union) who underwrite private motor vehicle insurance that provide fleet insurance for companies and organisations.

In order to set a premium, the insurer receives a 'presentation' of the company requiring the insurance from the broker. The insurer will then assess this presentation considering, for example, the claims experience of the company in the previous 3 to 5 years, taking into account the type and number of claims that have been made. They also consider the vehicle schedule, i.e. the make and model of the cars and whether they are high performance cars.

The coverage of the insurance will depend on the insurer but typically provides:

- Indemnity to principles against legal liability for the acts of employees;
- Loss and damage cover;
- Replacement and repair of motor vehicles;
- Medical expenses (limited amount), and;
- Personal accident cover.

There are many articles in the literature that discuss the increasing interest of insurers in risk management in order to control and minimise the risk to all parties involved. According to Gordon (2001) insurers see the risk management approach as a way of saving clients money and maintaining their profits. Freebody (2000) considers that if there is an increase in the insurance premium of £50,000 for a company operating at 5% profit they will have to generate a £1million increase in turnover to cover the additional cost. The point being, is it easier to reduce the cost of the premium or to generate the extra turnover?

Many insurers are positively advocating the risk management approach and providing the expertise to help companies to reduce the risk. One particular intervention that is well documented in the literature is advanced driver training. Insurers such as CGU and Norwich Union are offering discounts on the premium of £50 per driver who had been trained in the first year and £25 discount in the second year (Cronin 1999). In some cases operators run fleets of thousands of cars thus the discount can mount up. Some insurers have negotiated special rates on such courses for its policyholders, therefore reducing the cost further. However Freebody (2000) warns that insurers and fleet owners cannot rely on this intervention alone and that other risk management practices are needed. Fanning (2000) discusses some of the technology that many insurers and fleet operators are taking advantage of including: vehicle reversing safety systems, accident data recorders, electronic monitoring systems and fleet command systems. Other interventions are behavioural workshops, CD-ROMS, videos, auditing and management training.

Newman (2000) considers the issues of motivation and culture. A marketing manager for a large insurer is quoted, suggesting that the management culture is just as important as the claims experience. It is acknowledged that fleet operators give different weights to the different benefits for applying risk management systems, for example to reduce premiums or to run a more efficient and safe fleet. Thus insurers must assess and consider the motivation of the client and incorporate this into the management system they advocate.

2.4.4 Public liability

Public Liability insurance like EL insurance protects companies against claims from third parties (in this case from the general public) for negligently causing injury/illness/disease to the claimant. It also covers loss and damage to the claimant's property. The insurance provides cover against a claim providing that the incident occurs during the course of business.

There are three common levels of indemnity, £1 million, £2 million and £5 million and the level that the company insures for is dependent upon the business needs and activities. This limit of indemnity applies to all claims made under a single incident. Thus, if a company is insured for £1 million and 50 people make a claim for injury in one incident, there will be £1million of funds available to cover the claims of the 50 people.

The insured company under the insurance gets cover for legal fees incurred and other costs and expenses such as representation at a coroner's court, fatal accident enquiry or other court hearing as well as claimant compensation.

3 THE OVERSEAS POSITION

3.1 INTRODUCTION

The aims of this section are to:

- Identify worker insurance / compensation schemes in other countries that apply a greater proportion of costs to the employer and/or aim to relate costs to organisational safety performance;
- Summarise these systems;
- Identify and review any research into how these schemes influence organisational behaviour, and;
- Learn the lessons for potential changes in the UK's EL system.

This entails:

- Screening countries using publicly available information on their systems;
- Selecting four for closer review;
- Collecting publicly available information and research on their systems, and;
- Reviewing the latter material.

3.2 SELECTION PROCESS

Other countries have been selected for review by applying the following criteria:

- They aim to relate the costs of injury and ill-health to the safety performance of firms;
- They aim to apply the costs of ill-health and injury to employers;
- Information is available on the design and operation of the scheme;
- They operate in a country that is similar in economic development to Great Britain, and;
- Information is available on the impact of the scheme on the behaviour of employers.

After completing a literature search the following countries have been identified:

- USA
- Germany
- Canada
- Australia

We have also reviewed a number of schemes in continental Europe to lesser extents, namely France, Belgium and Italy.

In all cases employers pay for insurance that covers employees' (and dependents in case of death) costs and lost earnings, and, in some cases, pain and suffering. In this way, workers' compensation is an employer-funded form of insurance, analogous to UK employers paying for employees' private health and disablement (loss of earnings)

insurance. This is in contrast to Employers' Liability insurance which provides funds to the employer to cover the costs they incur arising from employees' litigation.

3.3 USA

3.3.1 Introduction

In the USA 97% of all workers covered by the state unemployment insurance programs are covered by workers' compensation programs. The Federal Employment Compensation Act provides workers' compensation for non-military federal employees, which works in much the same way as state schemes. Whilst workers' compensation schemes have operated for most of this century in the USA, the 1972 National Commission on State Workmen's Compensation Laws made a series of recommendations regarding state schemes to ensure that each state scheme was adequate. It was perceived that benefit levels were inadequate at that time. Thus, whilst schemes vary from state to state they do share some common features. For example, the National Commission recommended that the maximum weekly benefits for temporary total disablement should be at least 100% of the state's average weekly wage by 1975. Only 10 of the 50 states had benefits above 66.67% of average weekly wage at that time. This was followed by revision of the Model Act in 1974 to make the proposed statutory language consistent with the recommendations on the National Commission. The subsequent changes in arrangements, including an increase in benefit levels, was followed by insurance premiums rising at more than 40% per year on average in the 1970's in the case of California.

Workers' compensation is provided if four conditions are met, namely:

1. There must be a personal injury;
2. The injury must result from an accident;
3. The accident must arise out of employment, and;
4. The accident must occur during the course of employment.

Whilst most work related injuries meet these tests, there are exceptions particularly regarding work related diseases. The exact terms of schemes and benefit levels differ between states, with some states excluding injuries that develop over a long time. It is also pertinent to note that US employers challenge about 10% of occupational injury claims and about 60% of chronic disease claims (Barth and Hunt, 1980). This is reported to combine with difficulties in establishing the work relatedness of many diseases, such as the long latencies between exposure and disease, uncertainties about the cause of illness and the multifactorial causes, to reduce the tendency of employees to file illness related compensation claims. Whilst accidental injuries need only to arise out of or in connection with the course of employment there must be a greater risk of contracting a specific occupational disease as a result of employment. In addition to illnesses such as asbestos related cancer, conditions such as osteoarthritis (for which prior joint injury is the single greatest cause) have been noted as often falling outside of the coverage of workers' compensation.

Workers' compensation provides for the following:

- Medical benefits, including medical rehabilitation. There are no statutory limits on medical care in most states.
- Cash benefits varied according to the extent of disability and the duration of disability. The most common is Total Temporary Disability (TTD) at two-thirds of pre-injury wages in most states. But Permanent Partial Disability (PPD) accounts for the greatest share of payments, for persons with (for example) loss of an arm or back injury. PPD are based on schedule and non-scheduled benefit levels set by states. Permanent Total Disability and Death Benefits (DB) are also paid, with benefits being paid to dependants.
- Some states provide vocational rehabilitation for workers seeking reemployment and/ or require employers to fund (via premiums) vocational rehabilitation and job placement services.

Thus, benefits aim to compensate the injured worker or dependants to some degree for loss of earnings and fully cover medical costs. Benefits are typically based on 2/3 of average wage although there are large variations between states. For example, expected fatal injury compensation ranged in 1997 from $53,025 to $1,55,182 between Mississippi and Connecticut. In 1998 TTD claims cost $1,327 on average, PTD claims cost $301,536 and PPD claims cost $26,580 on average across the USA (Thomason T and Burton, J. 2000)

It is also interesting to note that every employer subject to workers' compensation paying $5,000 or more in premiums or who is self-insured is required to have an annual safety inspection. Some workers' compensation agencies provide safety services free of charge.

The schemes are operated on a "no fault" basis. To qualify for benefits the employee only has to show that the injury is work related, not that the employer was negligent. The schemes offer a high level of limited liability for employers, as they are insulated from negligence suits. This does not eliminate legal proceedings, as the attribution to work of a condition can be challenged as can the severity of injury.

The "no fault" principles arose from experience in the 19th century and early part of the 20th century where employees had to sue their employer for negligence. Employees seldom won the lawsuits but when they did employers had to pay out large cash awards. This was regarded as unsatisfactory because employers faced large and uncertain financial risks whilst employees faced destitution.

Workers' compensation sought to provide a balance between employees and employers by providing employees with a no fault means of compensation in exchange for limited benefits, thereby reducing employer risk. Workers gave up their right to file civil or "tort" actions in return for a no fault system which provided limited benefits. Thus, the level of benefits is not designed to fully cover loss of earnings or loss of welfare. Rather, the no fault nature of the system is balanced by limited benefits. In most cases the injury only has to have arisen during employment or in connection with employment. Boards in the first place make decisions on the work attribution of

conditions with court rulings regarding disputed cases also setting precedents. Work only has to contribute to or exacerbate a condition (including pre-existing conditions) for the injury to be compensable, in most states, although the eligibility standards vary between states. In particular, many states require that work was the primary contributor to a disease or mental condition.

Finally, although workers' compensation is a no fault system, legal action can be required to resolve disputes, such as the degree of disability and the contribution of work in the case of disease and mental conditions. Indeed, with the increase in workers' compensation claims, an adjudicative and tribunal process has developed to resolve employers' appeals against claims and workers claims for entitlement. The US National Council of Compensation Insurance reports that 53% of mental stress claims, 8% of physical injury claims and 36% of occupational disease claims involve attorneys. Thus, litigation remains a feature of workers' compensation. Also, if the employer fails to provide required safety equipment or procedures the worker may be entitled to extra indemnity pay (benefit) that is paid by the employer rather than the insurer, at least in some states.

3.3.2 How premiums are set

Historically, the price of workers' compensation insurance (i.e. premiums) have been regulated by state insurance commissions, due to a fear that excessive competition between insurers would lead to premiums being too low and hence causing insurer insolvency and /or excessive insurer profits. In addition, many states set up state workers' compensation schemes, some of which acted as state monopolies to ensure a stable source of insurance coverage. Rating bureaus collected historical data on losses to construct rates including a provision for profits. At their discretion state insurance commissions could reject the bureau's rate and substitute another. This position changed in the 1980's with an increasing level of deregulation of rates and increased number of private insurers, in response to cost pressures and underfunding of schemes.

The rate setting process begins with the calculation of *pure premiums rates* that are the expected losses per $100 of payroll for employers in an insurance class. The pure premium rate covers benefits, medical costs and rehabilitation along with costs incurred in claims- adjustment. The pure rate is adjusted to cover insurance carrier expenses and profits to give a *manual rate*. Manual rates are adjusted by the experience modification rating for larger firms to give a *standard earned premium excluding constants*. The latter rate may be adjusted by addition of flat charges assessed on a per policy basis. These flat charges may include a charge for the minimum cost of issuing and servicing a policy and a loss constant to compensate for inferior safety performance of small businesses. This gives the *standard earned premium including constants*. Larger firms may then get a discount for economies of scale. Finally, some firms offer a deviation rating that allows a firm's premium to be further adjusted to reflect subjectively evaluated factors such as an employer's loss control programs. This gives a *net earned premium*.

Whilst the average premium was about $3 per $100 payroll in the mid-1990s, the claims rate varies by a factor of 6 between industries and by a factor of 10 within industries in 1986 (Hunt et al 1993).

3.3.3 The experience modification rating

As noted above, part of the USA workers' compensation system entails applying an Experience Modification Rating. The premium charged is experience-rated in two ways. Firstly, every employer is assigned to an occupational insurance classification. Secondly, medium (with more than 10 employees) and large employers are eligible for firm-level experience rating, which means their premium varies relative to other firms in the same occupation according to their claims, calculated on the past 3 years performance. The extent of experience rating varies according to company size. Small firms are not experience rated. Medium sized firms are partly experienced rated, with a premium reflecting their claims and a weighted industry average. Large firms are fully experience rated. If a large firm's claims are 80% of expected claims the EMR is 80% and premiums are adjusted accordingly.

EMR's are reported to range from 35% to 260%. The impact of the EMR was demonstrated in the context of large construction projects. The compensation premium for a $500m project varied by $8.2m, a saving of 5.46% of project labour costs.

After reviewing all of the empirical evidence available at the time of their report, Burton and Chelius (1997) concluded that experience rating "has had at least some role in improving safety for large firms". Also, Kralj 2000 quotes eight studies that found experience rating was associated with a reduced injury rate, with only one failing to find an effect. Some of these studies found that the effect of EMR was greatest for more serious / fatal injuries, which should be less prone to benefit levels, reporting and claims management practices. Also, three US studies indicate that experience rating reduces claim duration (Chelius and Kavanaugh 1988, Krueger 1990, Cheadle et al 1994). Indeed, it has been reported that workers' compensation became the prime motivating factor for safety in US construction firms.

One study by Ruser (1992) suggested a $50 increase in weekly benefits and hence costs to the employer (in 1989) could be associated with a 15% to 30% fall in fatal injuries. Indeed, Krajl concludes that US evidence suggests that the effect of workers' compensation EMR on safety was much greater than the direct controls, fines and inspections carried out by OSHA (although it should be noted that OSHA's highly prescriptive approach has been seriously criticised as being ineffectual). Moore and Viscusi (1990) go so far as to indicate that in the absence of workers' compensation the fatality rates in America could rise by over 40%. They also provide a model of the relationship between benefit rates and fatality risk. The model indicates that a $10 increase in benefits (in 1998 prices) results in a 0.13 per 100,000 workers fall in fatality risks.

The one study noted by Kralj that did not find an EMR affect was completed by Chelius and Smith (1993) using 1979-82 data. They compared small firms in Washington with small firms in other states because Washington experience rates all firms. They did not any difference in injury rates. They suggested that this was due to:

- The time delay between improved safety and reduced insurance premiums (two years);
- The complexity of the EMR calculation;

- The relatively small value of reduced workers' compensation costs (e.g. a 30% discount off a 2% payroll premium gives a 0.6% reduction in payroll costs), and;
- Insurance firms view EMR as a procedure for rating equity rather than a reward for safety.

A difficulty that can arise in evaluating the impact of EMR is that benefit levels influence reporting rates, and hence may mediate the effect of EMR, i.e. reporting rates would vary according to benefit levels rather than EMR. Indeed, a number of studies (Butler and Worrall 1991) have found a positive relationship between benefit levels, claims rates and severity. Kniesner and Leeth (1989) estimated that a doubling of benefits leads to a 27% increase in claims. Moore and Viscusi (1989) completed one study that avoided this potential confounding. They related benefit levels to fatality rates and found a negative relationship between the two. If it is assumed that fatality rates are not affected by benefit levels (and hence premiums), it can be inferred that EMR and the cost of premiums do positively influence employers.
However, it appears that the EMR has had a variable impact due to a number of factors. Also, whilst there is evidence that it is associated with reduce injury frequencies, there is little evidence from the USA of its impact on workplace safety.

The mediating factors include

- Rates vary according to the insurance cycle, with rate suppression when the market hardens;
- Benefits levels vary between states, with more claims in states with higher benefits;
- The EMR is not applied to small firms;
- State regulation of premiums may suppress increases in rates;
- The number of claims tends to increase in periods of recession;
- The period (typically 3 to 4 years) on which the EMR is based does not always prompt employers to link safety improvement with cost savings;
- The absolute cost of compensation varies between occupational class, with much lower rates for low risk sectors, hence reducing financial incentive.

It has also been reported that state regulation of rates may have suppressed or delayed the modification of rates in response to changes in claims, and thereby reduced the link between claims and employer premiums.

Health insurance

A number of research papers regarding the USA position with regard to health care insurance were reviewed as part of the 1998 study (Wright, 1998). The study cited research that indicates a majority of medium – large firms commenced health improvement programmes at least in part to reduce health care costs. Given the general nature of health care insurance it is perhaps unsurprising that these programs focused on promoting matters such as smoking cessation and drug / alcohol control.

It should be noted that there appears to a size effect in the case of both health care and workers' compensation. Firstly, the workers' compensation premium for a firm with less than 10 employees are based on occupational class risk calculated annually based

on the state's injury experience. Secondly, the proportion of firms paying for (for example) smoking cessation programmes increased with the size of firms.

In addition, it is pertinent to note that many USA firms did not introduce health care schemes in response to the increased costs. It is reported that this was related to a number of factors, including:

- Visibility – many costs are "hidden" in accounts as pension and sick pay;
- Relevance – the ratio of employee costs to other costs such as equipment varies, with operating costs low in some capital-intensive activities, and;
- Controllability – can the costs be controlled in the time period of concern? Can financial objectives be met by other means?

Consequently, the impact of workers' compensation and health care costs varied between firms. It should also be noted that many US state systems omits a large number of workers, including:

- Self employed people, who are not usually covered by workers' compensation;
- Firms with less than 5 or 3 employees are excluded in many states, and;
- Domestic staff, farm owners and workers are often omitted.

This appears to combine with the lack of experience rating for small firms to reduce the impact of workers' compensation on the motivation of small firms to better manage health and safety.

3.3.4 Recent developments

The workers' compensation system came under scrutiny for three reasons in the late 1980's and 1990's. Firstly, the cost of workers' compensation rose over the 1970's through to the 1990's to a level that generated a high level of concern amongst employers and a high level of political attention. The average employers' costs of workers' compensation rose from 0.95% of payroll in 1975 to 2.97% in 1995, having peaked at 3.5% in 1993 (Thomason, 2001). However, it should be noted that the premium varied by at least a factor of two between occupations, such that some occupations had rates in the order of 7% of payroll before the application of the EMR. Given that the EMR can vary the premium by a factor of 2 to 3, the workers' compensation premium could in theory account for over 10% of payroll.

Secondly, there were reports of private insurers being unable to cover claims by premium increases due to regulated rates. This prompted withdrawal of insurers from some states and underfunding of schemes. Thirdly, the interstate cost differences widened to a level that were perceived to encourage movement of employers between states. It has been reported that the average payroll cost was $5.39 in Montana versus $1.41 per $100 payroll in Indiana, in 1995. This translated into an average weekly cost of $21.41 per employee in Montana compared to $6.04 per employee in Indiana, against a national average of $13.08 per employee per week.

The increase in cost and the projected increase in future years had become a headline newspaper issue. This is illustrated by the Rhode Island case in Box 2 and the headline below:

"Worker's Comp Costs: Out of Control", Nation's Business.

Whilst this concern and the projected potential increase in compensation costs reported in the media was not necessarily accurate, it was indicative of the general attitude amongst employers towards workers' compensation costs in the 1990's. This in turn led to statutory reductions in workers' compensation benefits, tightened eligibility standards and some deregulation of workers' compensation schemes (to allow insurers to match costs with premium revenues). For example, Oregon restricted eligibility to injuries where work was the major cause whilst previously an injury was compensable even if the work injury contributed to or exacerbated a pre-existing condition. Indeed, some states have enacted legislation that allows firms to opt out of workers' compensation system, although this does enable workers to seek redress via tort. The costs of workers' compensation were $20 billion in 1979 and $55.2 billion in 1991. However, by 1998 they had fallen to $52.1 billion.

Box 2: The Rhode Island case

The events surrounding the Rhode Island program, where 90% of employers were in the state's assigned risk pool, illustrate the extent to which the cost of workers' compensation had become an issue in the late 1980's and 1990's. State regulated compensation costs had been held responsible for highly publisized departures of business from the state, such as a truck body manufacturer that claimed it could save $500,000 by moving state. This dissatisfaction led to a protest march by the Rhode Island Chamber of Commerce on the statehouse. At the same time insurers were leaving the Rhode Island market claiming that premium rates were inadequate, with incurred losses in excess of revenues of $56.2million in 1988. In 1989 insurers sought a 139% increase in rates and were granted a 32% increase. Notwithstanding the state's contention of that rates were adequate, a series of changes were subsequently agreed, namely;

- Premium rates were frozen;
- The appeals process was streamlined;
- Benefit levels were reduced;
- A fraud prevention unit was established;
- Restrictions on medical expenditures, and;
- A guarantee that employers must rehire injured workers whose benefits had expired and increased benefits for total disablement /death.

Within two years injury rates and severity fell significantly, large insurers returned to the state and by 1998 there had been three premium rate reductions

From Thomason et al 2001

Whilst the tightening of eligibility standards and reduction in benefits appears to have contained the cost of workers' compensation, it is thought that the reduced protection afforded workers could increase the likelihood of workers resorting to tort liability. This has led to an ongoing legal and legislative debate. The debate focused on the issue of whether the worker should have the right to file tort actions if workers' compensation is not available for a "work related" condition. This debate is ongoing at the time of reporting although courts in some US states hold that an employee can sue an employer if they are unable to meet heightened causation standards for workers' compensation.

3.3.5 Health care cost differentials

It has also been reported that the costs of care in workers' compensation are higher than in other health insurance plans for similar illnesses and injuries. The reasons for this have been the subject of debate and some research (Leigh and Ward 1997, Ramsey and Rosenstock, 1994). The postulated reasons include:

- Health care providers upgrading procedures to codes that pay more generously;
- Workers' compensation patients receive better services that enable workers to return to work sooner and thus reduce indemnity costs;
- The chance of litigation motivates physicians to require extra procedures;
- Physicians compensate for a high level of paperwork and potential legal duties (that have a fee cap) associated with workers' compensation.

It has also been suggested that there is no incentive to contain costs by limiting the number of visits and diagnostic tests. The length of disability and the time the employee can and should return to work is controlled by the physician and the injured employee has a free choice of physician, although an employer can request an independent examination. This combines with a lack of standardisation of care protocols to lead to a high level of variation in the treatment of similar injuries.

However, it should also be noted that many funds place a priority on rehabilitation and treatment with state of the art facilities for returning injured employees to the work force. These can include facilities for physical rehabilitation, vocational evaluation, counselling and job placement services.

Whilst the reasons for the relatively higher cost of health care provided under workers' compensation are not certain, the differential pricing of care was estimated to account for $6 billion of workers' compensation costs (Ramsey and Rosenstock, 1994), i.e. about 10% of the total cost.

3.3.6 Product liability

It is possible to seek redress for work related injury / ill-health outside of the Workers' Compensation system. Although the worker cannot sue the employer, a third party can be sued, such as the producer of equipment or provider of services at a workplace. Thus, a forklift driver can sue the forklift manufacturer as well as the employer. This is particularly important in the case of asbestos related cancer for which it can be difficult to collect compensation benefits. Subsequently many disabled workers filed product liability lawsuits against the asbestos manufacturers under the law of strict liability to

warn of hazards. The high cost of such lawsuits required innovative changes to law, limiting the cost of claims and associated insurance premiums that posed a threat to business viability. For example, the Risk Retention Act that enabled businesses to form insurance co-operatives to share product liability and purchase insurance at lower rates.

In addition, an employer or insurer, after settling a workers' compensation claim, can seek reimbursement from the producer of products used in the workplace that caused the injury.

3.4 CANADA

3.4.1 Introduction

There are at least two pertinent schemes in Canada, namely;

- Disability management programs , also called return to work programs, that provide safe return to work for employees and short-term and long-term disability benefits, and;
- A no fault workers' compensation system financed by a payroll tax levied on employers and operated by Canadian provincial agencies.

A survey of 305 Canadian employers (Watson Wyatt Worldwide 1997) found that the average cost of these programs equals 5.6% of payroll.

The balance of these systems differ between jurisdictions. Ontario uses a form of wage loss compensation for permanent disabilities whilst British Columbia pays a pension based on disability. 70% of workers in Ontario are covered by workers' compensation. Persons such as casual workers, domestic workers, banks staff and clergy are excluded.

As with the USA, workers' compensation represents a compromise whereby workers give up the right to tort and accept lower compensation in return for a “no fault” system. Under the tort system that preceded workers' compensation damages covered non-pecuniary losses, such as pain and suffering, and could extend to exemplary damages. However, the worker had to demonstrate employer negligence via the uncertain tort process. Workers' compensation only covers pecuniary losses and costs, such as health care and a proportion of lost earnings, although some Canadian provinces have begun to make awards for non-pecuniary loss in cases of permanent disability.

This does not eliminate disputes, as employers can contest the compensability of a condition. This is particularly relevant in the case of mental injury where mental disability is often appealed and contested. In contrast, in the case of Lower Back Pain (LBP) almost all claims are automatically met because it is difficult to determine which cases are not associated with work.

As with the USA, Canadian workers' compensation was designed to provide health care and wage loss indemnity coverage for workers with work related injuries and illnesses. The criteria for establishing work attribution allow claims for chronic conditions such as Low back pain to be made. In these cases, exposure to causal factors at work is sufficient for a claim for accepted LBP to be met, despite the fact that 95% of LBP

cases do not display any testable pathological abnormalities. Currently an adjudication process exists in Canada that declares certain conditions to be work related and others not to be work related, with osteoarthritis falling into the latter category.

In 1996 workers' compensation costs for Ontario were allocated as follows:

- 56% for permanent disability benefits;
- 16.5 rehabilitation expenses;
- 11.5% health care costs;
- 9.3% short term disability;
- 6.1% survivor benefits.

Disability benefits are intended to partly cover wage loss. For example, British Columbia pay 75% of gross earnings as its compensation rate. In the case of back injury the maximum level of impairment is 51%. So a worker can expect approximately 50% to 75% of pre-injury wages. For a 35-year-old worker with pre-injury earnings of $4000 per month a permanent back injury could have an award of up to $540,000 (not applying inflation) for a expected life expectancy of another 30 years, paid as a monthly pension. The award would be higher if it is found that the worker's future earning capacity is reduced by more than the value of the pension by the injury.

Workers' compensation is also intended to minimise transaction costs by applying statutorily defined formulas to benefit levels rather than requiring individual loss adjustment. Whilst this sacrifices full compensation, it minimises transaction cost that would otherwise be high in a tort system. Legal obligations and administration account for 4% and 11% of rates in Ontario in 1996.

As with the USA, the terms of workers' compensation varies between Canadian provinces. For example, in 1997 expected fatal injury compensation varies from $106,585 to $1,021,132 between Quebec and Yukon provinces. These inter province differences are significant. For example, the Ontario benefit costs were 2.5 times those of Prince Edward Island.

It is pertinent to note that Canadian labour and human rights statutes protect injured workers from dismissal based on disability. For example, in Ontario larger employers are required to re-employ injured workers who attempt to return to work within two years of work related injury. Re-employment must be provided to the workers former or comparable job if the worker is medically capable, or to the first suitable job available, if the worker is not so capable.

As with the USA, a condition needs to be attributed to work for it to be compensable. This has led to some disputes and possible inconsistencies, whereby some soft tissue conditions are compensable but others are not. For example, conditions such as cardiovascular disease and osteoarthritis of the knee and hip are not currently compensable despite researchers indicating that these conditions can be work related. This is, at least in part, due to the need to meet a standard of proof of work attribution. Thus, whilst the no fault system eliminates the need to establishment negligence, an

adjudication system is still used to adjust claims, hear appeals regarding entitlement, that may entail the involvement of legal representatives.

Typical rates

Whilst Canada applies an EMR like the US it has a simpler approach to rate setting, compared to the 11 step US approach. In Canada, after assigning a firm to a class, it is assigned a Base Assessment Rate (similar to US manual rates) that reflects losses (benefit paid to injured workers) and administrative costs. In most Canadian jurisdictions these base rates are adjusted by an EMR, although Ontario applies an expense constant. Otherwise no further adjustment is made.

It is pertinent to note that:

- The average rate of 3% of payroll was similar to the average USA rate;
- The rate varied from $1.32 to $8.44 per $100 payroll between industries in Ontario in 1995.

The rate for large firms also varies according to an experience modification rating. Thus, the highest rate could exceed $8.44 per $100 payroll in the construction sector.

Table 3: Ontario, 1995

Industry	Lost time injury rate	Assessment rate (cost per $100 payroll)
Forest products	2.91	4.56
Mining and related	2.32	6.92
Other primary	4.5	5.23
Manufacturing	3.48	3.4
Transport and storage	5.99	6.49
Retail and wholesale	2.43	2.2
Construction	3.88	8.44
Government	2.09	1.32
Other services	2.21	1.94
Total	2.88	3.00

It should be noted though that the Ontario scheme was underfunded in earlier years, with assets covering just 43% of future benefit liabilities. Therefore, $0.89 of the average rate of $3.00 was for unfunded liabilities. In the case of construction, $2.50 of the $8.44 was for unfunded liabilities.

The surcharge per industry does not fully cover the deficits in high hazard sectors. Thus, some sectors are being "subsidised" by others, for the sake of affordability. Clearly this reduces the link between sector safety performance and cost. Also, as new firms are also charged the surcharge, new firms are effectively contributing to the cost of old firms' liabilities.

3.4.2 Experience modification rating

Although EMRs have been in operation since 1917, the schemes were subject to serious criticism. The earlier schemes, including the Voluntary Plan that operated into the 1980s, penalised firms with favourable accident experience, provided insufficient refunds and surcharges to provide meaningful incentives and placed inadequate emphasis on rehabilitation. For example, the EMR operated over a six-year period in Quebec. The Ontario system's approach to adjudication was said to be arbitrary, opaque and unresponsive to the growing number of claims.

It was not until the 1980's that the current schemes came into effect. These schemes and associated reformed appeals processes made the adjudication process transparent whilst increasing the link between firm's claims and their EMR. The increased role of EMR was intended to counter employers' concerns about rising costs, by allowing them to reduce their premiums by means of accident prevention. Firms with below average claims could get refunds in the order of hundreds of thousands or, for larger firms, millions of dollars.

There has also been an increased requirement for rehabilitation, with the aim of minimising disabled workers loss of earning capacity. Also, injured employees had extended rights for re-employment, even if this requires workplace adjustment, with the aim of reducing benefit costs.

Even then, due to a lack of consensus within industry, two plans emerged, the Council's Amended Draft-7 (CAD-7) and New Experimental Experience Rating plans. The CAD-7 plan applies only to construction firms. The CAD-7 and NEER plans differ significantly. CAD-7 has an accident frequency component that accounts for half the refund /surcharge a firm receives. The frequency is based on the prior two years, comparing the firm's experience with the industry average. The NEER does not directly use injury frequency to determine refunds/ surcharges.

These schemes are discussed below drawing on the experience of Ontario.

CAD-7

CAD-7 is a prevention incentive program for employers in the construction sector and is for those employers who pay more than $25,000 in annual workers' compensation premiums. Refunds are made on the premium for firms that maintain a good health and safety record. Surcharges can be enforced if a poor level of health and safety is maintained.

Each company is categorised into a rate group according to the type of work they undertake, such as heavy civil construction. Along with the company size, the number and cost of the companies' claims over the past five years are compared to the average for the rate group. If the frequency and cost of the claims are lower than would be expected for a company of that type they are awarded a rebate. If, however, the claims are higher than expected then the company is charged extra.

Claims for chronic ill health, such as asbestosis and noise induced hearing loss, are not counted in the calculation in order to not penalise for long term hazards.

There is a strong incentive for larger companies to maintain a good standard of health and safety as the plan can adjust premiums by 100% for companies with more than 100,000 working hours (i.e. about 50 or more staff). For small companies, i.e. companies with less than 21,000 working hours (i.e. less than 10 staff), the premium can be adjusted by no more than 15%, thereby protecting companies from random fluctuations in claims.

A number of concerns have been raised about CAD-7 experience rating, namely that:

- It may encourage under-reporting of claims;
- Inappropriate next day return to work programs (converting a lost time injury into a none lost time injury), and;
- It encourages reporting new injuries as re-occurrences of conditions caused by past injuries.

Also the CAD-7 system does not distinguish between minor and serious injuries. A three-day lost-time injury and a thirty-day lost time injury receive the same weighting.

NEER - New Experimental Experience Rating Plan

The NEER uses predicted lifetime costs of a claim, with future costs estimated by applying special reserve factors, whilst CAD-7 uses only actual costs in its calculations. Also, the NEER is more "aggressive". The absolute value of the refund/ surcharge is higher for the NEER than CAD-7. The average NEER surcharge exceeds the average refund by 300% compared to 60% for CAD-7.

However, the NEER off balance (i.e. its deficit) increased greatly since 1991, reaching $260m by 1996, compared to $13.5m for CAD-7. Indeed, the CAD-7 off balance fell between 1990 and 1996 whilst the NEER off balance increased in this period.

This scheme encourages employers to invest time and money into making their workplace safer, with the aim of reducing accidents. However when an accident does happen the scheme encourages early and safe return to work programmes. There is a financial incentive to improve safety performance through premium refunds and surcharges. These are calculated by comparing the actual claim cost of a company with the expected claims cost (derived from the rate group average for firms of similar size). In calculating the cost of the claims they factor in the payments already made for health care, temporary disability loss of earnings, administration fees and possible future costs on the claim. Also taken into account is the type of disability and age of the claim. Due to the time lag between hazard exposure and chronic ill health, claims of this nature and their costs are not included in the experience rating.

A refund or surcharge is based on a proportion of the difference between the actual and expected costs and may range between 25% and 90%. The smaller the firm the lower the percentage as they are less able to absorb large surcharges. Hence it provides a 'greater collective liability insurance protection' for small firms.

A company is protected from the full extent of a large claim or bad accident through:

- A limit placed on the maximum cost that can be used for NEER for any one claim. Namely four times the maximum insurable earnings;

- A limit placed on the accumulated amount of individual claims, namely three times the expected costs for that year, and;

- A limit placed on the degree to which the employer is held financially accountable for claims under NEER i.e. depending on the size of the firm the employer is only liable for a portion (the rating factor) of the difference between the expected and actual costs. The smaller the premium, the lower the rating factor and the lower the degree to which the employer is held liable.

Refunds and surcharges are calculated on the basis of retrospective rating, data is collected about payments made on a claim and estimates for future payments and a refund or surcharge is awarded yearly. Only the costs accrued in the three years following the claim are counted for the purpose of surcharges / refunds. The costs incurred following this period are not used when assessing surcharge / refunds. This is intended to give an incentive for the employer to rehabilitate the worker to an early and safe return to work, as these employers are unable to gain refunds on costs incurred after the initial three-year period.

The impact of EMR

USA studies of the impact of EMR are hampered by the lack of a direct measure of the degree of experience rating employed by insurers. Accordingly, US studies have tended to assume that larger firms have more experience rating than smaller firms. Thus, it was difficult to compare experience rated with non-experience rated firms of the same size.

Canada offered the possibility of comparing pre and post experience rating because the majority of provinces have only introduced EMR in the past decade, and not all firms are experience rated. In one study by Bruce and Atkins (1993) of forestry and construction in Ontario 1951-89, they found EMR was associated with decreased fatality rates. This study was based on before and after tests to gauge the impact of the introduction of EMR. Thomason (2000) concludes that "there is substantial evidence indicating that experience rating is, in fact, associated with a decline in the occupational injury rate and, in particular the fatal injury rate" (p 286). The efficacy of the EMR was evaluated as part of a report to a Royal Commission on workers' compensation in British Columbia, which confirmed this finding (Hyatt and Thomason, 1998).

However, there are conflicting views. For example, Lanoie (1992) found, in an assessment of all interventions (inspections, fines, safety committees, right of refusal and workers' compensation) that only the frequency of inspections gave a statistically significant association with reduced injury frequency. However, Lanoie's study was based on 1982-87 Quebec data, which precedes the more recent EMR systems. Nonetheless, Boden (1995) states, after a review of literature, that "We cannot conclude that workers' compensation premiums provide effective incentives to reduce workplace hazards. Moreover, where workers' compensation costs are high, employers engage in

loss prevention activities that limit the availability of compensation for injured workers, distort employment policies, and lead to socially inefficient expenditures to identify 'accident-prone' workers and fraudulent claims". Ison (1986) who argued that economic incentives in the form of lost production and damage already exist supports this view. Similarly, organised labour has traditionally opposed EMR on the grounds that it encourages firms to challenge workers' claims rather than improve safety.

There are mixed findings on this matter. A 1995 study by Hyatt and Kralj found that experience rated firms are more likely to appeal a claim than a non-EMR firm. This effect was greatest for larger firms. However, a 1996 study by Hyatt and Kralj found that there was no relationship between experience rating and the likelihood of an appeal against a claim being successful.

Three Canadian studies sought evidence of the impact of EMR on employer safety behaviour. Kralj (1994) found that EMR led to more emphasis on both claims management and accident prevention, although the effect on claims management was greater. Kahley and Sornberger (1994) found in a telephone survey of 150 mid-sized Illinois employers that EMR did increase employers' concern for workplace safety, as opposed to claims management. More recently, Thomason and Pozzebon (2000) found that increased experience rating led to increased employer efforts to address workplace safety as well as more aggressive claims management. They surveyed 400 Quebec manufacturing firms and collected data on the extent of experience rating, safety and claims management practices, health and safety training and workers' compensation disputes. They controlled for factors such as union status and average wage in their assessment. They also found that the extent to which firms seek to reduce workers' compensation claims was related positively to average wage, but no such relationship existed for claims management, i.e. higher wages are associated with more emphasis on accident prevention.

Finally, in contrast to the USA studies, two Canadians studies indicate that experience rating was associated with increased duration of disability benefits (Krlj 1995 and Lanoie 1992). However, a more recent study by Campolieti (1999) applied a different statistical treatment to the data. Campolieti found that the duration of disability was not as sensitive to benefit levels as previously suggested. A 10% increase in benefit levels was associated with a 0.154 to 0.158 increase in expected duration.

Workers' "moral hazard"

Whilst there is some evidence of workers claiming for non-work related injuries, higher benefits tend to have greater effect on reporting of injuries, i.e. people are more likely to report work related injuries in the case of higher benefits. This is termed "workers' moral hazard" That is, workers are more likely to claim if higher benefits are available. Thomason expresses this as follows;

> "Almost every study examining the issue has found that benefits are positively related to injury or compensation claims rate". (Thomason, 2000, p286)

This is not the case for fatality benefits, where the fatal injury rate is negatively related to benefit levels, confirming that fatal injury rates are not influenced by worker moral hazard.

3.4.3 Concerns about workers' compensation in Canada

The cost of Canadian workers' compensation has come under scrutiny for a number of reasons. These include:

- Allegations that the cost of workers' compensation, due to overly generous benefits impaired the competitiveness of Canada relative to America, following the increase in north-south trade associated with NAFTA in 1992;
- An increase in unfunded liabilities (off balances) during the 1980's and 1990's, and;
- Increased cost to employers during a period of recession, due to increased number of accepted claims, benefit indexation and rehabilitation costs.

Inter-state cost differentials

As regards cost-differentials, Thomason and Burton (2000) found, after controlling for differences in industrial compositions and other factors, that average Canadian and US rates were not significantly different. This is despite:

- The indexation of Ontario benefits in 1984 led to a doubling in benefits;
- Ontario benefits were 6 times higher than U.S.A. statutory benefits from 1984 onwards, whilst British Columbia's were 5 times higher.
- Canadian benefits have been index linked, whilst US benefits are not commonly indexed.

The apparent lack of differences in average costs, despite the latter factors that would inflate Canadian costs, may be explained by:

- Non-profit provinces run the Canadian system;
- Higher health care cost in the USA. The per capita health care costs are half as great in Canada as in the USA. Health care costs account for 26% of Canadian benefits vs 41% for US programs, and;
- The possibility that less extensive coverage for non-occupational illness and injuries in the USA leads to cost-shifting onto workers' compensation.

Thus, whilst Canadian benefits being more generous, US health care costs are higher, US insurance costs include a profit margin and there may be more workers' compensation costs in the US due to the relatively low level of benefits for non-occupational injuries and illness.

Unfunded liabilities

According to Gunderson and Hyatt (2000) the total unfunded liability for Ontario in 1996 was $10.5 billion, equivalent to $3362 per worker covered by workers' compensation. This can be compared with an average of $838 premium per worker in 1996. Workers' compensation costs were $2.9billion in 1996 compared to revenues of $3.3billion. Thus, the 1996 surplus accounted for 5% of the funds future liabilities.

The underfunding of schemes is even greater when specific sectors are considered. For example, the construction sector unfunded liability was the equivalent of $23,000 per worker in Ontario 1996.

Expenses peaked in the early 1990's and thereafter have come down, allowing some reduction in unfunded liabilities. 30% of rates comprise a surcharge to cover unfunded liabilities.

The off balances appear to have arisen for a number of reasons. Unfunded liabilities in the Canadian workers' compensation system arose in the 1980's because insufficient reserves were set aside to cover future expenses associated with workers who are permanently disabled. Long-term permanent disability payments are the largest expense associated with workers' compensation, accounting for about 60% of expenses. In the case of Ontario, that had the greatest off balances, the introduction of a Future Economic Loss factor in awards (that allows for reduction in future earning increases) generated unexpected cost increases.

90% of NEER firms receive a refund as do 75% of CAD-7 firms, causing an overall off-balance. The experience rating off balances contributed to the overall unfunded liabilities. Thus, whilst individual surcharges tend to exceed refunds, by a factor of 2 to 3, the majority of firms receive a refund, thereby causing an off balance.

Unlike the USA where most insurance is provided by private carriers who do not carry losses over a sustained period, the Canadian state-run funds clearly accepted increasing deficits for a number of years.

Increased cost to employers

Up until the 1980's workers' compensation did not comprise a significant cost for employers, as a proportion of payroll. The introduction of the NEER system and a widening of its application amongst firms, along with a reformed appeals process and free advocacy (in Ontario from 1985) combined with escalating assessments, indexation of benefits and increased rehabilitation requirements to give significant increases in workers' compensation costs.

While the absolute number of claims and the workplace accepted lost time injury frequency rate has been declining over the past ten years, costs per claim have increased. Indeed, the accepted lost time injuries frequency rate fell from a peak of 57 per 1,000 workers in 1986 to just under 35 per 1,000 workers in 1997.

The increase in costs occurred at the same time as a recession in Canada. Economic growth fell to minus 10% in 1991 with unemployment doubling to 10% between 1988 and 1991. It is suggested that workers in declining industries tended to use the workers' compensation system more, thereby increasing workers' compensation costs in those sectors experiencing the greatest economic pressure. One consequence of this was an increase in employer appeals, particularly against re-employment, although 99% of claims are not appealed.

3.4.4 Recent developments

In recent years Ontario has sought to contain workers' compensation costs by;

- Benefit reduction;
- A curtailment of long term wage loss awards;
- The exclusion of chronic stress, and;
- Reduction of allowances for chronic pain.

At the same time Ontario and Quebec have led the way in innovative reforms of workers' compensation. In 1996 Ontario proposed initiatives aimed at improving EMR and eliminating technical problems that lead to off balances. This includes simplifying the EMR. In addition, the review proposed separate programs aimed at encouraging workplace health and safety for smaller workplaces as NEER has not been effective in motivating smaller firms. One such scheme is Safe Communities Incentive Program (SCIP), which is discussed at length in the next section of this report. Also, a scheme called MAP, also summarised below, has been developed for smaller firms.

The concern about affordability continues, focusing more recently on the impact of new knowledge about chronic conditions on the sustainability of workers' compensation. The ongoing debate in Canada is how to balance fairness, sustainability and entitlement with a growing knowledge of work-related injury and disease. Much of this debate focuses on occupational disease and mental injury, including chronic and acute mental stress. Work is ongoing regarding how to provide entitlement for mental injury without threatening the sustainability of workers' compensation.

These debates are of growing importance due to the change in employment from “traditional” manufacturing trades to service activities, which is being accompanied by a change in the pattern of injuries from the “clear-cut” acute injury to the soft tissue and mental strain associated with service sectors. Options under debate include:

- Covering all work related conditions under workers' compensation, although doubt is expressed about the financial sustainability of this option;
- Providing a social welfare net (sick pay and state disability benefits) for disability arising out of work related conditions such as osteoarthritis, to avoid the risk of burdening workers' compensation with long term chronic conditions, and;
- Limiting eligibility for LBP and heart disease to cases arising out of or involving acute events such as lower back impacts or heart attacks.

Thus, the debate is one of juggling “no-fault” welfare payment with workers' compensation in such as way as to provide a sustainable system that provides individuals with a fair level of protection.

3.4.5 MAP - Merit Adjusted Premium Plan for Small Businesses

This plan came into effect at the beginning of 1998 and is tailor made for small companies in Ontario who pay a yearly average premium between $1,000 and $25,000. The companies who are involved in the scheme are non-construction industries and the company must comply with the reporting requirements of the Worker Safety Insurance

Board (WSIB) and be in continuous operation for the duration of the review period. The aim of the scheme is to give small companies a financial incentive to increase injury prevention.

The incentive to maintain a high level of health and safety comes from the premium being decreased or increased according to performance. For example, if a company has a fatality or if a claim exceeds $5,000 there is an instant premium increase of 25%. The MAP plan applies a percentage adjustment rate to the employer's basic premium rate that creates an individual premium rate. This rate is based on the workplace injury performance.

The company's health and safety record is measured according to the number and severity of new claims that a company makes (only claims over $500 are counted) within the three-year review period. For example, the premium was set in 2000 based on data between 1996-1998. Should a decrease in premium be awarded it will not be applied until the company has been in continuous operation for three years, yet an increase can be applied within three years if a sufficient number of claims have been made. This is so that employers are encouraged to consider health and safety as a priority.

3.4.6 (Alberta) Partners in Injury Reduction Program

The Partners in Injury Reduction (PIR) system of Alberta aims to encourage injury prevention and the development of effective health, safety and disability management systems. Participation in the scheme is advantageous to employers as they can earn up to a 20% reduction in their workers' compensation premium through three alternative mechanisms as discussed below.

Achieving or maintaining a Certificate of Recognition

A Certificate of Recognition (COR) is awarded to an employer when they have been assessed and audited to show their successful implementation of a H&S management system. This then allows them to qualify for the PIR systems and for other Workers Compensation Board premium refunds. In the first year of trying to improve their company's health and safety performance, if they achieve an improvement but not a COR then they can still be awarded a discount on the premium. By the end of the next year they will have to have made such an improvement that they are awarded a COR – if they do not they no longer receive the premium discount. If a company attains their COR in the first year of registration they are eligible for a 5% industry rate discount.

Improving performance

If a company's 'Improving Your Performance' measure compares favourably to the company's historical record they are eligible for discounts of between 1% and 20%. An industry rate discount of 1% is given for every 1% improvement up to maximum of 20%.

Maintaining industry leadership

A 10 to 20% discount can be earned for 'Maintaining Industry Leadership'. This is a measure of claims experience compared to the average of the industry's rate group over the same period. However, to obtain a discount in this way, the company needs to have

a COR and have claim costs that are 50% lower than the industry average for two consecutive years. To get a 20% discount the claims costs have to be 90% lower than the industry average.

In order to improve health, safety and disability performance and to achieve COR status, each participating company of the scheme has a Certifying Partner who is a safety association/training service that helps in the audit process of a company and assists in the awarding of COR's.

3.4.7 Safe Communities Incentive Program

The Safe Communities Incentive Program (SCIP) is a three-year pilot program run by the Worker Safety and Insurance Board in Ontario Canada in 1997-1999. The program was evaluated in 1999 (WSIB, 1999).

SCIP is a community based incentive scheme for participating groups of small employers (less than $90,000 in premiums). The scheme has two main elements, namely a process of safety improvement and a refund facility. Participating firms share proportionately in a 75% refund of any savings realised in a community's claim cost with the WSIB. The share is in proportion to the firm's premium. The WSIB retains the other 25% of any savings. The saving is based on the difference between expected (no change in claims) claims for the period and actual claims.

SCIP provides training, worksite evaluations and access to mentoring and coaching to assist in the development of an action plan for improving health and safety in the workplace.

The scheme involved a number of organisations, including:

- WSIB;
- Ministry of Labour;
- Good Neighbours;
- Safe Workplace Associations;
- SCIP Leaders, and;
- Safe Communities Foundation.

Thus, the scheme aimed to develop employer competence and provide access to low cost support.

The evaluation focused on three communities (sets of towns) with a total of 616 firms registering for the scheme. The evaluation included:

- A comparison of injury rates between participating firms and a control group of firms;
- A questionnaire survey of employees, and;
- Case studies of participating firms.

Evaluation findings

The main findings are:

Injury rates

- SCIP lost time injury rates fell more quickly than a comparison group;
- For two out of the three communities "no lost time" injuries also fell more quickly than a comparison group;
- Injury rates fell by between 20 and 50% in the three year period.

It is interesting to note that the injury rates in participating firms started higher than the comparison group but that the lost time injury rates were almost the same by the end of three years.

The case studies cited examples of physical improvements, such as replacing ladders with scaffolding, new conveyor belts, PPE and upgrading first aid. Some firms also introduced return to work programs.

Employees' view

The study reports that:

- 67% of workers stated that they or a co-worker reported hazards and incidents more;
- 46% stated their supervisors track near-misses more;
- 75% reported safer workplaces;
- 75% of workers were more aware of safety;
- 67% said safety representatives were more available;
- 63% said their workplace was checked more often for safety hazards.

These statistical results were consistent with the subjective feedback from case study firms.

Motivation for joining

The majority of employers were prompted to join SCIP by the potential for financial savings and to learn more about health and safety and how to prevent accidents and the availability of low cost training. Some firms had recently had an incident or a Work Well audit.

Reasons for withdrawal

10% of firms withdrew in the first two years. The reasons were:

- not enough savings on premiums, and;
- not enough time for the training process.

Profile of SCIP firms

40% of firms had less than 10 people compared to 87% in the comparison group. The majority had 10 to 100 people. There was also a bias towards manufacturing firms. SCIP firms also tended to have above average injury rates.

Difficulties

Employers cited a number of other concerns. These were:

- Employers expressed concern about "poor performers" not being held accountable whilst still sharing in the community rebate;
- WSIB being soft on unsafe workers and soft claims.

Discussion

The evaluation noted that whilst many firms were prompted to join SCIP by the potential cost savings the training led to a shift in attitude towards "doing the right thing". Also firms indicated that compensation costs were secondary to the cost of not having employees on the job. In addition, firms indicated that the wish to appear professional and gain a tendering advantage were also significant reasons for improving safety. Indeed, the rebate was of little significance for very small employers as the refund is proportionate to company premiums.

Accordingly, it is reasonable to suggest that whilst the potential rebate helped to prompt firms to register along with low cost training, they subsequently developed a broader motivation to improve health and safety.

It is also reasonable to suggest that the training and coaching was a integral part of the scheme and the reduction in accident rates has to be ascribed to this support along with the financial rewards.

The findings of this evaluation are consistent with the findings of UK research, such as the Evaluation of the Good Health is Good Business campaign, which indicates that:

- Firms need to increase their competence and have low cost support as well as a reason for improving health and safety, and;
- Firms are motivated by a mixture of moral, legal and financial factors to improve safety.

Finally, the evaluation highlighted the importance of local consultancy support being provided by local Safe Workplace Associations rather than the WSIB. The WSIB was perceived as unapproachable.

In conclusion, it appears that SCIP was a successful pilot that demonstrates the potential benefits of combining financial rewards with lost cost support for small and medium sized firms.

Lessons learnt

The lessons learnt include:

- SCIP avoided the problem of low incident rates in individual firms by basing the scheme on communities of firms. This enabled a statistically meaningful assessment of injury rates to be made for small firms;
- The provision of low cost training and support from non-statutory organisations enabled firms to make improvements, and;
- The rebate was of sufficient value to act as an inducement for many firms, even if it subsequently proved to be a secondary factor.

3.5 CONTINENTAL EUROPE

3.5.1 Introduction

This section first provides an overview of occupational health and safety insurance arrangements in a number of continental European countries, particularly Germany, Italy, France and Belgium. It then provides a more detailed explanation of arrangements for Germany and reviews the trends in German claims and costs. The Italian scheme has been in operation since 1999. We are unaware of any research to date regarding the impact of the scheme on employers' attitudes towards occupational health and safety. Information was not available at the time of reporting on the causes of trends in France and Belgium.

3.5.2 Overview of arrangements

Many of the continental systems have three equal goals, namely:

- Prevention;
- Rehabilitation, and;
- Compensation.

It is noticeable that as much attention is awarded to the rehabilitation aspects of these systems as the compensation and prevention elements in many (but not all) European countries. The focus on rehabilitation reflects the desire to minimise the cost of injury (to society) and the social goal of keeping people productive. France, Germany, Italy and Switzerland all operate an extensive rehabilitation and vocational programme as an integral part of the insurance system. The German system is based on the idea of lower compensation but higher costs for rehabilitation and return to work. The objective is to secure return to work rather than financial compensation of the damage suffered. It is reported that:

- In Germany, 80% of cases with vocational training result in vocational rehabilitation;
- In France, 67% of all disabled persons who underwent vocational training find a job in a year.

The aim of the Swedish system is that employers should re-establish the working capacity of the injured person within one year.

Similarly, most insurance firms or associations have set up accident prevention services and departments. Many of these focus on assisting SMEs. They tend to undertake accident analysis to identify causes and types of injuries, develop prevention strategies and assist in their implementation. In Germany the Insurance Ordinance imposes on trade associations, as carriers of statutory accident insurance, a duty to guard against accidents at work, to rehabilitate victims and to provide them or their dependants with pensions. All firms are required to belong to the trade associations and pay a percentage of wages to the association. Germany has 4,000 experts who provide consultancy to firms and verify their implementation.

It is also pertinent to note that many of the continental schemes include work related travel, including commuting, within the scope of occupational insurance schemes. This includes, France, Austria and Italy.

Insurance cover

Insurance tends to cover:

- the cost of compensation (loss of earnings);
- rehabilitation, and;
- accident prevention services.

In some cases compensation covers loss of social function, as in Italy, as well as loss of earnings. Until recently Italy paid a monthly pension calculated on the basis of the insured monthly wage and degree of disability. The pension was awarded for disability with a level equal to greater than 11%. Since 1999 indemnities cover damage of more than 5% affecting the mental and physical integrity of the worker, even if the injuries do not result in loss of earnings, on the basis that a persons' mental and physical health is a right. Therefore, any damage that diminishes the ability of a person to express their personality through emotional, social, political, sport etc are indemnified. For damage of 6% to 15% a lump sum is paid, although the sum may be raised if health worsens. For 16% + impairment the lump sum is paid as a monthly pension for life. The pension may be raised if health worsens. The indemnity is proportional to the degree of impairment and age of the injured party, but ignores earnings unless impairment exceeds 15%.

These schemes are operated on a no fault basis. France and Belgium had previously operated litigation-based systems. Belgium has established the principle of employer immunity.

Average costs

The average cost of premiums varies greatly, as shown below. It should be noted that the scope of schemes varies, such as in the inclusion / exclusion of commuting accidents and the inclusion of rehabilitation and the levels of benefits.

Table 4: Summary of contribution rates

Country	Contribution rates 1999 (% of payroll)
Italy	3
France	2.25
Spain	2
Finland	1.4
Germany*	1.4
Austria	1.4
Sweden	1.35

*1.33% of total wages were paid into the funds in 1999.

Financial incentives

France, Germany, Italy and Switzerland provide financial incentives within their schemes, whilst the Netherlands and Austria do not. The premiums are related to company size and sector and:

- Costs incurred because of accidents;
- Points given to specific types of accidents according to their severity, or;
- Frequency rate and accident severity.

In France, firms with less than 10 employees have a flat rate. Most employers pay contributions to the state controlled National Accident Insurance Association. Firms with more than 300 employees, contributions can be adjusted to take account of performance, as defined by accident rates over the past 3 years. Medium size firms (10 to 199 workers) have rates based partly on the collective data (for a risk category) and individual firm's claims. The premium is based on a % of payroll. If there is evidence of negligence an employer may be required to reimburse the fund for compensation paid to the worker. There are two types of insurance cover for ill-health, both compulsory;

- Employers pay into a scheme that pays employees a pension if they become ill due to work activities, and;
- Employees pay into a personal pension that pays out if they become ill due to non-work related causes.

In Germany, each professional institution of accident insurance has freedom to design its own incentives schemes. It is reported that:

- 46% apply reductions only;
- 31% apply reductions and increases, and;
- 24% apply increases only.

Variations in premiums tend to range between –25% and +25% of the average for a risk category (sector), although some associations have wider bands. Rates can remain in force for 6 years.

In the case of the sugar industry the rebate / surcharge is calculated as follows:

- First one takes the percentage by which the number of accidents in a firm differs from the average number for all firms in the past 3 years.
- Then one takes the percentage by which the accidents in the firm differ in severity from the average in all firms (severity being measured by the disbursements);
- Award twice as much weight to severity as to the number of accidents:
- Split the difference between the two weighted percentages to give the result.

The adjustment was capped to 50% surcharge / rebate.

In Belgium, any deficits in premiums by one firm are shared amongst other employers.

With the exception of Germany information was not available on the impact of such arrangements on employer behaviour. However, Klen (1989) conducted a study of large forestry firms in Finland and collected data with regard to the costs of accidents not only to employers but also society and employees. It was found that 60% of the total cost of accidents was paid for by the employer and includes uninsured losses, 30% absorbed by public administration and 10% by employees. The research also revealed that the surveyed companies pay for their share of the accidents themselves and the insurance company only pays for the administration of compensation and other practical tasks. This is typical of all large companies in Finland. The research concluded that there is a financial incentive for those companies to decrease their insurance premium by being more proactive in health and safety management.

3.5.3 Germany

An explanation of accident insurance arrangements in Germany is given in Hoffman (1994). Further information was acquired by correspondence with Hauptverband der gewerblichen Berufsgenossenschaften, the industrial statutory accident insurance body.

The Berufsgenossenschaften

In Germany the Berufsgenossenschaften carry out the functions of prevention, physical and mental rehabilitation and the provision of compensation for occupational accidents and diseases. These constitute an element of indirect state administration and are public law bodies, with government supervision. Employees and employers are represented in equal numbers. Berufsgenossenschaften are structured according to sectors of industry.
The Berufsgenossenschaften have a statutory duty to use all appropriate means to prevent occupational accidents and disease, provide effective first aid, ensure the best possible medical, occupational and social rehabilitation and to pay benefits to the injured, sick and surviving dependants.

Insurance cover is guaranteed whether or not the employer has paid contributions. When claims that meet the criteria for admittance of an accident arise the statutory accident insurance Berufsgenossenschaften accepts liability on behalf of the employer.

In special cases the Berufsgenossenschaften may have recourse to the employer if the employer acted with negligence or with intent.

Basis of contributions

Contributions are levied to retrospectively cover costs, i.e. it is a "pay as you go" system. In 1994 the compulsory levy on companies was 1.45% of wages and salaries, which at DM 566 per full worker is about £176 per worker per year. The annual contribution to be paid by a company depends on:

- Sector of industry;
- Risk class;
- Size of payroll, and
- Number and severity of accidents.

In fixing contributions a distinction is made within a company between the production and commercial / administrative sections. This ensures that workplaces posing comparable risks are rated equally.

There is a statutory requirement for rebates to be granted or supplementary contributions imposed where ever appropriate. The contribution will be increased or reduced depending on the severity and/or the number and/or the costs of accidents that actually occurred in the previous period. This arrangement is designed to give employers a real financial incentive to make the workplace safer.

Scope of coverage

The following types of accidents are covered:

- Occupational accidents;
- Commuting accidents, and;
- Occupational disease.

Commuting accidents and occupational disease are treated as occupational accidents for the purpose of compensation. A list of conditions is used to guide decisions on which injuries can be admitted.

The Berufsgenossenschaften have a general duty to prevent all work-related accidents and ill-health by all appropriate means. Compensation is only paid if the condition is on the statutory list of conditions.

Key aims of Berufsgenossenschaften

A key principle is "rehabilitation before pension". All appropriate means are used to achieve as complete a rehabilitation as possible before the insured person receives a pension. To this end a "curative system" has been developed that is designed to guarantee comprehensive and first class medical care, with referral to hospital or accident clinics. Alongside medical rehabilitation runs vocational services that provide career resettlement and additional rehabilitation. The aim is to reintroduce the injured

person into working life in accordance with their performance potential and, whenever possible, on a permanent basis. The vocational services includes:

- Grants to retain or find a job;
- Vocational reorientation, aptitude tests and vocational preparation;
- Career adjustment and advanced training, and;
- Domestic mobility and driving benefits.

As part of the preventative medical work, an insured person may be advised to cease a hazardous work activity, with loss of earnings compensated by transitional benefit.

Benefits

Compensation is intended to cover loss of earning. Payment is made by health insurance agencies on behalf of the Berufsgenossenschaften. Individuals do not receive any compensation for pain, suffering, loss of psychological or social capabilities. The level of benefit varies according to the period of rehabilitation / post rehabilitation state, as follows:

- Curative treatment: For the period of curative treatment an injured person receives an injury benefit set at 80% of regular gross net earnings (once sick pay or wages have ceased). When vocational reintegration is underway the person receives transitional allowance of 70 to 80% of the injury benefit.
- Transitional benefit: If a person gives up a job to prevent an occupational disease arising, recurring or worsening, they get transitional benefit for 5 years.
- Reduced earnings: If a person has a reduced earnings capacity for longer than 13 weeks after the injury, and if this is at least 20%, they get an injury pension. This pension generally begins when medical and vocational rehabilitation has ended and the individual is fit for work again.
- Permanent incapacitation: Where earning capacity has fallen 100% a full pension is granted, calculated at two thirds of the earnings from work received in the year prior to the accident. In the case of a partial reduction, the pension is calculated according to the degree of loss of their earning capacity.
- Survivors pension: In the event of death the dependants receive a Survivors Pension.

The reduced earnings pension is calculated on annual earnings in the year preceding the accident and the degree of reduction in earning capacity. Thus, a 20% incapacitation gives a pension equivalent to 20% of last years' earnings. For reduction in earnings to be compensated the reduction in earnings must be at least 20% beyond the 13th week after the accident. If a person suffers more than one accident the reduction in earnings need only be 10%.

Impact of arrangements

It is reported that both accident rates and financial contribution rates have been falling. The average contribution in 1994 was 1.45% of wages and salaries, compared to 1.7% in 1950 and 1.5% in 1960. Thus, the cost has declined despite an expansion of duties and services over the same period, especially in rehabilitation and prevention. 80% of contributions are spent on "pensions" and rehabilitation. At the same time reported

injury rates have fallen by 3% and 7% per annum for different grades of injury since 1960, (although the reunification with East Germany was associated with an increase in the 1990's).

The reduction in costs and claims is attributed to:

- The benefits of a joint employer – employee approach;
- The trade / sector specific nature of Berufsgenossenschaften;
- The financial incentives;
- The onus on involvement of doctors, safety delegates, safety engineers/ officers in company safety management of all firms (with small firms able to access training), and;
- An extensive body of safety regulation and preventive occupational medical examinations.

Whilst it is recognised that there has been a shift in industrial structure, with a reduction in traditional hazardous work, it is asserted that the reduction in claims exceeds the falls attributed to industrial change. The rate of occupational accidents has fallen by 75% since 1960, of which only 15% can be attributed to changing industrial structures. The cost of workers' compensation in Germany has declined from 5.8% of social security costs to 3.1% despite increasing medical and pension costs.

One very interesting study was completed in the German sugar industry covering the period before and after they introduced the financial incentives (Kotz and Schafer, 1993). The study sought to test theory that economic incentives affect employers' conduct. Until 1963 the firms' contribution was unrelated to its accident experience, with the same rate being applied to all firms within an association. A 1963 law required trade associations to establish "contribution adjustment procedures" whereby firms' contributions varied by surcharges or rebates according to the number, severity or cost of accidents. Kotz and Schafer selected the sugar industry as an example as it applied an adjustment procedure in 1966 with especially high surcharges and rebates. A 50% surcharge or rebate could be charged. The sugar industry of 80 firms also formed a homogenous group producing a single product with no sudden changes in production methods in the period of study (1955 to 1980).

After controlling for the prevention work of the trade association, the level of production and weather (that affects activity levels) they plotted accident trends before and after the introduction of the scheme. They found that:

- There was a sudden and sustained drop in accidents after the surcharge /rebate scheme was introduced;
- The accident rate fell from about 140 per 1,000 workers in the 1950's to 80 in 1980.

It was also noted that the cost of accidents rose steeply in the 1950's and early 1960's (more than doubled) due to the increased coverage of statutory accident insurance, but that the accident rate remained level during this period. It was not until the introduction of surcharges and rebates that the accident rate fell. Moreover, the cost of accidents levelled off after the rebates / surcharges were introduced.

They went on to produce a model of the relationship between the value of rebates / surcharges and accident rates. They also looked at the correlation with expenditure on prevention by the association. They were able to derive statistically robust associations that predicted that:

- Every 50,000 DM in rebates and surcharges meant one less accident per 1,000 workers;
- Every 10,000 DM spent on accident prevention led to a 0.61 reduction in accidents per 1,000 workers.

They were also able to assess the impact of underreporting of claims by use of data on unreported accidents (those less than 4 days). The decline in reported accidents could not be attributed to reduced reporting.

Finally, they found that whilst the scheme was associated with a reduction in accidents, there was no fall in the average severity of accidents. They note that the rebate system under weights severity because it only accounts for 2 years of disbursements. Accordingly, they report that the scheme appeared to motivate a reduction in the number of accident alone.

They conclude that the system of rebates /surcharges induced managers of firms to take measures to prevent accidents which resulted in fewer accidents.

3.6 AUSTRALIA

3.6.1 Introduction

As in Canada and America, workers' compensation arrangements are designed at the state level in Australia, with a Federal scheme covering public sector employment. The Australian system originated in the first quarter of the 20th century. Employers were required to pay insurance for their employees to licensed and regulated insurers. The workers' compensation laws provided liability without fault and a schedule of benefits. However, employees could claim damages under common law if they considered the workers' compensation benefits insufficient or if the injury was due to negligence. The employer could argue for contributory negligence as a defence. Thus, litigation remained a feature of the system, including litigation regarding the determination of benefits. Until the 1980's firms were charged premiums based on the industry average risk and company size.

Notwithstanding the developments described below, several states introduced incentives in the 1980's, in the form of experience based premiums. The aim was to encourage employers to reduce injury and disease by means of variable workers' compensation premiums. This reflected the norm of achieving social ends, namely fewer injuries, through market forces (i.e. economic incentives) rather than exclusively by government intervention. It also reflected the realisation that injury rates were influenced by employer behaviour, a notion not previously widely acknowledged. These changes were, as discussed below, also aimed at reducing workers' compensation costs.

The average workers' compensation premium in Australia is summarised in Table 5, as a percent of payroll. Because of the state based nature of Australia's system the rates vary significantly. However, when considering the inter-state differences in rates, note should be taken of the fact that other welfare arrangements also differ between states. Thus, it is possible that each state has a different balance between social welfare and workers' compensation.

Table 5: Summary of Australian workers' compensation premium rates as a % of payroll (1998/99)

State	Queensland	Northern Territories	Victoria	ACT	Tasmania	New South Wales	South Australia	Western Australia
Average premium	1.85	1.9	1.9	2.12	2.7	2.8	2.86	3.44

Workers' compensation in Australia aims to cover loss of earnings, non-economic loss and health care. The duration of entitlement and provision for lump sums varies between states. The Comcare scheme for employees of the ACT Government provides:

- Medical expenses;
- Travel benefits for medical treatment;
- Weekly benefits – 100% of normal earnings for the first 45 weeks (perhaps with a top up to cover difference between normal earnings and potential earnings) and 75% to 100% thereafter depending on capacity to work;
- Household services;
- Attendant care services;
- Alterations, modifications, aids and appliances required to home, office or vehicle due to compensable condition;
- Lump sums for permanent impairment (>10% of the whole person). This does not affect other entitlements. This covers non-economic loss, such as pain and suffering, loss of expectation of life or loss of the amenities or enjoyment of life.
- Payments on death of lump sum and weekly benefits to dependants.

Claimants with over 10% permanent impairment and dependants of deceased may elect to sue for damages as an alternative to an award from Comcare.

Some examples of the New South Wales WorkCover scheme benefits (for period 1995 to 2001) include:

- $262,250 lump sum to dependants of deceased workers and $82.40 weekly benefits for dependant children;
- A maximum of $100,000 lump sum for permanent injury (lower amounts for lesser injuries), rising to $121,000 for multiple injuries plus (a maximum) $50,000 for pain and suffering;
- The maximum weekly benefit is $1,237 in the first 26 weeks, falling to $291 for persons with no spouse or dependants. A rising scale of benefits of $345.9, $413.80 etc apply to persons with one, two etc dependants, with higher benefits for persons with a dependent spouse.

Medical costs are governed by scheduled allowable maximum treatment costs.

However, it should also be noted that the workers' compensation system is designed to provide equal emphasis on prevention in an integrated manner. Indeed, WorkCover was established in 1990 to simultaneously manage workers' compensation and provide advice and support on prevention. The constitution of a single organisation to cover these two roles was intentionally aimed at better promoting prevention and ensuring an integrated approach is taken to workplace health and safety. WorkCover roles include:

- Set premiums for insurers and manage workers' compensation;
- Manage occupational rehabilitation;
- Monitor the conduct of insurers on point such as financial viability, and;
- Encourage prevention and rehabilitation.

The WorkCover organisaton is funded by a 4% levy on workers' compensation policies.

More recently, as elaborated below, there have been attempts to shift the balance away from workers' compensation and prevention towards rehabilitation and return to work, prompted by concern in the early 1990's about low rates of return to work. It was felt that this was due to the adversarial nature of workers' compensation and the financial disincentives associated with workers' compensation, and the general low priority awarded rehabilitation. This led to the introduction of rehabilitation regulations and duties, such as a requirement for employers to keep a job open for an injured employee for a prescribed period and to provide suitable rehabilitation and vocational resettlement assistance. Although this regulation appears to have increased the level of rehabilitation available, there is ongoing debate about how best to align workers' compensation and rehabilitation systems for the purpose of maximising return to work rates and adequately compensating injured workers.

3.6.2 Recent debates

The Australian system has been the subject of much debate and change in the past two decades. Indeed, it is reported that there have been a "seemingly endless series of Government inquiries that have been conducted during this period and in the dramatic changes in workers' compensation that have almost invariably accompanied changes in the political complexion of state governments" (Purse, 2000). There have been 17 official inquiries in two decades. Workers' compensation is a controversial industrial relations and public policy issue in Australia. This is illustrated by the Queensland example summarised in Box 3.

Similarly, New South Wales businesses threatened inter state relocation due to the costs of workers' compensation (Kenny, 1994). The cost of workers' compensation was thought to have become a burden on business. Workers' compensation payments rose by 479.7% between 1974 and 1984 compared to a 249.6% increase in wage and salary costs. Ore (1992) found that compensation costs were a significant factor in the New South Wales construction sector, where they account for about 3% of building cost and 4.23% of the industries total labour cost in the mid 1980's. At the same time a premium discounting "war" between insurers in the 1980's led to some insurers being unable to cover payouts and losing their licenses.

Box 3: The Queensland Government reaction

The political sensitivity surrounding workers' compensation is illustrated by the events in Queensland. The adequacy of the workers' compensation system was a campaign issue, centering on whether it was a fair system for employers. WorkCover defends, on a non-profit basis, common law claims on behalf of an employer if their insurer sues them for negligence. The cost of this common law claim affects the employer's premium. Initially WorkCover used estimates of claims when calculating premiums due to the long time to settle, without then adjusting these estimates upon settlement. Employers question this practice and the affordability of "sudden hikes" in premiums.

This system was the subject of political debate. Upon election of a new state government, the system was changed such that:

- A two year premium cap was applied such that rates could not rise beyond twice the industry average;
- A premium adjustment could only be made once, at the time of the annual review;
- Premiums would be adjusted to take account of differences between estimate and actual common law settlements;
- Factors used to scale up current claims were reduced;
- Premiums rates were set a year in advance to allow employers to plan for these costs.

These changes resulted in the average premium falling from 1.85% to 1.75%, although the rate varied according to the safety record of individual firms.

The political significance of this issue is illustrated by the comment:

"Despite outrageous and misleading attempts by Mr Santoro and his supporters to sabotage WorkCover reforms, Queensland employers now have an average premium rate up to half that of other Australian employers" Mr Braddy, (Queensland Employment, Training and Industrial Relations Minister)

It is thought that a number of factors contributed to the increased cost of workers' compensation in Australia, including:

- No financial incentives for individual employers to prevent injuries (rates were based on industry averages);
- Operating costs grew to account for 40 cents of every 100 cents paid out, due to administrative arrangements;
- During the 1980's there was an expansion of compensation entitlement from circumscribed temporal and monetary limits to one that could continue until retirement in the event of ongoing disability;
- The number of injury and disease claims rose;
- The time lag involved in occupational disease created a delayed financial demand on the system, and;

- Increased legal costs were the largest single cost of the New South Wales compensation system as result of the emphasis on substantiating claims, and;
- Indexation of benefits against pay commenced in 1978 in New South Wales.

It has also been suggested that employees resisted rehabilitation so as to maximise benefits. On the other hand, long delays arose in receiving claims for serious injuries due to common law disputes. Also, many insurers opted for payment of lump sum compensation as this was cheaper than weekly benefits. However, lumps sums tended to over compensate minor injuries and under compensate more serious injuries. Also, private insurers held premiums paid by firms. It was thought that this created a conflict of interest with the need to provide for injured workers, i.e. private insurers were reluctant to meet claims.

3.6.3 Recent developments

There have been a number of developments in Australia focusing on the balance between employer affordability with equity and the alignment of workers' compensation and rehabilitation systems. Whilst the Australian system is state based there have been a number of common trends.

Rehabilitation

Until the 1970's the Australian schemes did not consider the rehabilitation of injured workers. Since then worker rehabilitation has developed in importance to the point that it became a dominant feature in the 1990's. This is illustrated by the title of authorities such as the Western Australian "Workers' Compensation and Rehabilitation Commission". Worker rehabilitation was supported by statutory requirements in respect of employers holding jobs open and proscribing the dismissal of injured workers. For example, in 1987 New South Wales introduced compulsory rehabilitation. This included:

- Provision of suitable duties for injured employees;
- A system of early reporting and referral to rehabilitation;
- Treatment by a multi-disciplinary team;
- Graduated return to work programs with modified workplace or job tasks for seriously injured workers;
- Vocational assessment and retraining.

It also became an offence to dismiss incapacitated workers within 26 weeks of injury. On the other hand, employees lost their right to benefits if they refused to participate in rehabilitation.

Even more recently, the Heads of Workers' Compensation Authorities completed a review of workers' compensation arrangements across Australia (1997). Amongst many other issues the report addressed the issue of avoiding dependency on benefits, especially amongst long-term claimants, and providing financial incentives for employers to adopt rehabilitation. The report was advisory with implementation of ideas left to individual jurisdictions. It suggested that the following ideas be considered:

- Having a reduced benefit level after a certain period of time, such as 13 weeks, so as to reduce the incentive to remain on benefits - for example, reducing benefits to 70% of earnings after 13 weeks;
- Developing a non-adversarial approach to workers' compensation and rehabilitation, so as to avoid perverse incentives to avoid a return to work;
- Recognising employers' rehabilitation and return to work practices within workers' compensation premiums, so as to provide a clear financial advantage for rehabilitation, and;
- Placing an obligation on injured persons to participate in return to work processes, for instance by linking benefits to participation in rehabilitation.

This work demonstrated the clear recognition that workers' compensation and rehabilitation and accident prevention need to be addressed in an integrated manner. Indeed, they refer to "Total Injury Management" wherein rehabilitation is seen as a component of a broader injury prevention and management process actively linked to return to work goals.

Incentives

There have also been moves to contain the increasing cost of workers' compensation. These include providing better incentives for accident prevention and restricting entitlement. The improvement in incentives entailed increasing the link between premiums and firms' experience, in the form of experience based rating.

The first new incentive system was introduced in New South Wales in 1987. For firms with less than 3 full time employees a standard rate applied. For firms with 3 to 130 employees, the premium was capped so that it could not rise above twice the industry average. For larger firms there was no limitation to the EMR. However, to ensure the premium was not affected by a few large claims, any claim above $100,000 was treated as $100,000 for the purpose of rate calculation.

In Victoria, a new system was introduced in 1988. The scheme placed absolute limits on the extent of penalties /bonus. Initially, rates could be reduced by 56.25% on the industry average or increased by 25%. These limits were progressively raised to75% and 37.5% respectively. A similar scheme was introduced in South Australia in 1990.

Reduced access to common law

The Australian system has previously allowed access to common law action for damages for workplace injuries and disease. Some states have recently abrogated access to common law entirely or subjected it to threshold entitlement criteria and /or caps upon awards and settlement. However, New South Wales restored limited entitlement for access to common law for seriously injured workers in 1989.

On the other hand, the recent 1997 review by Heads of Workers' compensation Authorities suggested the option of ceasing no fault benefits after 5 years but providing access to common law damages thereafter with uncapped economic loss. This was set alongside an alternative option of eliminating common law damages whilst providing

capped economic and non-economic loss compensations. Clearly, there is an ongoing debate regarding the operation of workers' compensation in Australia.

Reduced scope of workers' compensation and benefits.

Benefits structures were altered. Also, some states have removed injuries incurred whilst travelling from one's place of abode to the place of employment from the scope of workers' compensation or placed additional conditions on their compensability. Most jurisdictions have instituted rigorous criteria and investigative processes and introduced clauses that require that work must be " a significant contributing factor" or "the major contributing factor" to injuries, with the aim of reducing liability to conditions such as stress and musculoskeletal injuries.

3.6.4 The impact of EMR

Hopkins 1994

In a review of evidence available at the time of reporting Hopkins (1994) concluded that there was no compelling evidence that EMR incentives were working as intended.
Hopkins compares changes in claims rates across a number of states. He notes that:

- In South Australia a drop in the number of lost time injuries immediately followed the introduction of a new incentive scheme;
- In New South Wales a decline in injuries occurred two years after the scheme was introduced;
- In Victoria the decline began one year before the new scheme was introduced – although this was probably simply a reflection of a decline in employment, especially in manufacturing, and;
- In Western Australia claims declined although no such incentive scheme was in place. The authorities attribute the fall to the effectiveness of their prevention strategies.

This clearly presents an ambiguous picture.

He notes that due to the introduction of a number of changes to workers' compensation it is difficult to pinpoint the effect of introducing incentives. For example, in the case of New South Wales, the average premium fell from 3.8% to 1.8% within 4 to 5 years of introducing financial incentives. However, this coincided with:

- Abolishment of common law entitlements;
- Reduced extent of benefits;
- The introduction of compulsory rehabilitation, and;
- A new law making it an offence to dismiss incapacitated employees within 26 weeks of the injury.

Similarly, the progressive introduction of penalties / bonus in Victoria coincided with declining employment especially in manufacturing. Thus, it is difficult to establish the association of reduced claims in Victoria with the introduction of incentives. However, in the case of South Australia, WorkCover found evidence of a link between the new incentive scheme and a 20% fall in claims. The fall in claims preceded the recession. It

is interesting to note that the South Australia scheme offered lower bonus / penalties (30% and 50% for bonus / penalty respectively) than Victoria but still showed a positive outcome.

Hopkins (1994) also suggest that the introduction of incentives may have led to claims "suppression", where employers either scrutinise claims more carefully or discourage claims. He points to the case of Victoria where there was no fall in the number of fatalities or serious injuries after the introduction of the bonus /penalty scheme, but there was a fall in minor injuries. Although he does not report evidence regarding the cause of these trends, he suggests that anecdotal reports support the possibility of claims suppression.

Hopkins 1995

Hopkins has completed a series of studies of employer occupational health and safety behaviour, the main finings of which are summarised in Hopkins (1995). His research provides a rich explanation of a range of organisational responses to workers' compensation and some of the mediating factors. These findings are summarised below. In summary Hopkins reports that workers' compensation can generate pressure to improve safety and rehabilitation, and cites examples of this. However, there are situations where the link between injury and ill-health and compensation costs may be lost, thereby removing any such incentive. In addition, firms may seek to reduce claims by less legitimate methods. Thus, he reports a complex picture of variable effects of workers' compensation.

He concludes from this work that whilst workers' compensation does function as intended at times, it fails in a host of ways. He concludes from this that financial incentives alone are not enough to assure safety, and asserts the need for government regulation.

Organisational responses to experience rating

Hopkins reviews a range of evidence regarding the impact of experience rating on injury (claims) rates.

Hopkins uses first hand information from specific firms to illustrate the range of responses to experience rating. These responses range from safety improvements through claims management to suppression and contesting of claims. These responses are not necessarily exclusive, as some firms may combine tighter claims management with safety improvements to reduce the duration and number of injuries. He reports a number of examples where experience rating clearly influenced firms. With regard to examples of safety improvements he notes that:

- Repco implemented a series of improvements, including job rotation and exercise programs in response to increase premiums due to RSI claims;
- An abattoir implemented a preventive vaccination program against Q fever after noting that the cost of the program were outweighed by the potential workers' compensation costs (if an outbreak were to occur), and;
- NSW Forestry Commission implemented a back care program including manual handling training and hazard control.

Thus, as in the second example above, the threat of a large compensation claim can by itself prompt firms to take preventive action.

He also notes examples of firms implementing rehabilitation and return to work programs, in order to reduce the duration and hence the cost of claims. This includes providing keyboard staff with voice-activated terminals in the event that they get RSI. He notes that as long-term claimants contribute disproportionately to total costs, management can be motivated to introduce a claims management policy, including rehabilitation.

Whilst some firms focus on long-term claimants, Hopkins notes that Australian research also indicates that some firms seek to reduce lost time claims by introducing light duties and first aid for minor injuries. This has the effect of converting what would have been a lost time injury (3+ days) into a non-lost time injury, which no longer counts towards recorded claims.

Hopkins goes on to note some examples of less legitimate responses to experience rating, including:

- Negative attitudes towards employees who report injuries;
- Keeping people at work despite on "light duties" despite their injuries preventing them doing any productive work;
- Encouraging injured employees to take sick leave instead of making a claim;
- Using pre-employment medicals to screen out and refuse employment to people with problems that may recur;
- Employers illegally encouraging employees to make a claim for a minor injury, so that all future (real) claims could be attributed to this same injury and excluded from the experience rating calculation, and;
- Contesting claims such as RSI as medically unproven,

He concludes by arguing that there are a number of situations where compensation costs cannot act as a safety incentive.

1. Distribution of premiums in large firms

Hopkins notes examples of where large organizations have paid premiums centrally but distributed the cost to individual business units on the basis of the number of employees per unit. This is reported to have had the effect of removing the link between premiums and business unit performance. In another example a hospital would use any workers' compensation rebate to cover budget over runs in other areas, again removing the link between departmental safety performance and finance. In this way the structure of large organizations can nullify the incentive aspect of experience rating, although Hopkins notes that this is only the case where the overall premium is not high enough to attract senior management attention.

Similarly, in the case of construction, the premium is typically charged to the state head office based on the number of directly employed workers. The premium may be

recharged to each project manager based on the number of people per site. This again removes the link between individual site performance and premiums.

2. Long onset diseases

Hopkins argues that as cancer is rarely compensated, work induced cancer deaths are not reflected in workers' compensation. Subsequently, workers' compensation and the experience rating scheme would presumably have little direct impact on employers' attitude towards occupational health. He cites the example of the asbestos related cancer, mesothelioma, where due to the long onset time there is no financial incentive for an employer during the period of time when workers are exposed. In addition, as cancers and lung disorder may be a product of both occupational and domestic behaviours, such as smoking, their work relatedness may be contested. He cites the case of asbestos mining as an example of a failure to prove occupational causation.

3. Small firms

In the case of small firms he argues that workers' compensation and experience rating will not act as an incentive for two reasons. As the probability of an accident in any one small firm is low, simply as a result of its size, a small business may go for years without a claim. As a result an accident is a rare and unpredictable event from an employers' perspective. For these small employers, Hopkins asserts that workers' compensation is simply a form of insurance against a chance event. In addition, most (Australian) workers' compensation schemes are designed such that small employers' premiums are determined mainly by the nature of their work and number of employees, and only minimally by actual claims experience. He contests that workers' compensation provides little if any incentive to small employers, even in theory.

4. Self-employed

As self-employed persons are, for the most part, not covered by workers' compensation, he argues that it does not provide a role in promoting the safety of these workers (although many may be covered by personal injury insurnce). He cites the case of farming where the majority of tractor accident deaths involved self-employed people not covered by workers' compensation.

5. Rare but catastrophic events

Hopkins argues that:

> "Where injury is frequent and compensated, the costs may well generate pressures to improve workplace safety. But where death and injury are rare, even though perhaps widespread when they do occur, they do not provide ongoing financial incentives to focus n safety" (p53).

He cites the example of lift cables. There has never been a fatal accident due to lift cable failure in Australia, and hence no compensation costs.

6. Subcontracting

Hopkins argues, citing construction as an example, that whilst the main contractor may have primary control over workplace safety, it will not be liable for workers' compensation costs. Accordingly, they are unlikely to be directly motivated by subcontractors' compensation costs in respect of occupational health and safety.

Workers' compensation and rehabilitation

A number of studies have also been conducted into the impact of workers' compensation and associated rehabilitation requirements on return to work practices. Some earlier studies found that the wage replacement component of workers' compensation has often been cited as a disincentive to return to work (Walker, 1992). Compensation payments do not cease until the injured worker returns to work. It was also noted that as the worker is reliant on the employer or rehabilitation provider to locate suitable employment they are not compelled to seek alternative employment options. This inaction may be reinforced by medical advice not to return to work until *completely fit*.

These concerns led to a strengthening of rehabilitation requirements, such as the 1995 Workers' compensation Workplace Rehabilitation Programmes Regulation. This regulation placed a legal obligation on employers to provide rehabilitation for workers. More recent research has indicated that many employers have adopted a "compliance" reaction to this regulation, rather than perceiving it as a cost-effective means of reducing workers' compensation costs (Kenny, 1996, 1999). Few employers perceived a cost benefit from rehabilitation, with the exception of larger firms who are guardedly positive about the financial benefits. This research also indicated that there were many practical rehabilitation difficulties, especially in small firms, such as locating suitable alternative employment and lack of competent rehabilitation personnel.

Other research indicated that the success of rehabilitation is clearly related to the attachment of the individual to work and their wish to return to work (WorkCover WA 1998). In addition, it has been noted that the adversarial workers' compensation system is still detrimental to the return to work process (O'Donnel, 2000), as is the uncoordinated work of insurers, employers, medical people and so on, each of whom pursue an alternative agenda (Kendall, 2000).

These findings indicate that the regulatory rehabilitation initiatives, whilst promoting a higher level of rehabilitation, did not provide a financial incentive for employers.

3.7 DISCUSSION OF UK AND OVERSEAS RESEARCH

3.7.1 Introduction

This section of the report addresses three issues:

- What conclusions can be drawn from overseas experience regarding the extent to which insurance can act as a motivator for better health and safety?
- How can the current UK approach to insurance be contrasted with other countries?
- What options and ideas does overseas experience suggest for the UK?

3.7.2 The motivational impact on employers of schemes

The main conclusions from the review of overseas experience with accident insurance are summarised below.

Can work related injury and ill-health insurance encourage higher standards of health and safety?

On balance the research indicates that premium discounts, premium modification and rebate schemes can positively influence the management of occupational health and safety. The evidence from overseas indicates that the combination of no fault schemes with experience rating leads to the cost of work related injury and ill-health becoming a significant and tangible issue for employers. This is particularly so where new conditions are recognised, such as lower back pain, and benefit levels are designed to fully compensate employees.

Previous research indicates that the extent to which experience-rating schemes give firms an incentive depends on a number of factors, including:

- The absolute cost of insurance;
- The value of the rebate / surcharge;
- The time period in which the discount or rebate may be received, and;
- Firms' perception of their ability to improve standards;

It appears that for a scheme to have a significant positive impact that:

- The cost of insurance needs to be perceived to be high in absolute terms – rates above 1% or 2% of payroll appear to draw the attention of employers;
- When the national average rate exceeds 3% of payroll it appears that employers challenge the affordability and legitimacy of the cost of insurance;
- The value of discounts or rebate needs to be perceived to be high in either absolute terms or relative to the firms overall turnover /profit – typically at least 25% of the normal premium;
- Rebates / discounts need to be received within 1 to 3 years to influence firms;
- If rates vary greatly from one year to another this can cause business concern due to the impact of financial management, and;
- The extent to which annual premiums can be adjusted to reflect annual claims needs to be moderated by the retention of funds to cover long tail claims, such as asbestos etc.

Small firms and firms in lower risk sectors are less likely to be influenced by these schemes, especially in those cases where premiums for small firms are based on occupational class alone. However, there are a few examples of relating insurance costs to the performance of a group of small firms. These schemes appear to have a positive influence on health and safety management.

It is pertinent to note that there is a possible link between the value of compensation, the claims rate and the cost of insurance. That is, the number of claims can be positively correlated to the value of benefits, such as what percentage of earnings is awarded and whether payments are made for pain and suffering. As the number and value of claims increase, so does the premium and hence the extent to which it draws employers' attention. Similarly, the number of claims is also related to the range of conditions deemed to be compensatable. This again influences the absolute cost of the scheme and hence the likelihood that it will draw employers' attention.

What needs to be done to facilitate the link between insurance and safety performance?

The provision of low cost advice and support appears to an important factor in encouraging and enabling firms, especially small firms, to realise the offer of reduced premiums / rebates. Such advice is often provided by employer financed insurance boards / societies rather than government bodies.

On the other hand, the motivational impact of experience rating can be diluted by:

- Competition between insurers – offering lower rates to firms regardless of actual claims;
- Claims suppression by employers, and;
- Organisational factors, such as large organisations paying premiums centrally or failing to distribute rebates to local departments.

It is also pertinent to note that the link between premiums and employer performance is less in the case of diseases with long onsets, as the claims and hence the adjustment in premiums lags behind the exposure.

In addition, the link between premiums and performance can be reduced by "technical" problems. In particular, schemes have become unbalanced, with payments exceeding contributions due to factors such as competition and regulation of premiums. This can lead to the need to keep a proportion of firms' premiums at a constant level to bring the scheme back into balance. This has the effect of reducing the extent to which premiums can be linked to current claims experience.

However, these negative mediating factors do not appear to have overridden the positive impact of experience when national statistics are considered. Also, legal protection regarding discrimination against persons on the grounds of health and employment protection (i.e. right to retain a job) are often in place. This helps to ensure that employees do not seek to reduce claims costs by screening out employees at the point of recruitment and / or ceasing a person's employment on the grounds of health risk.

What is given priority – rehabilitation or compensation?

Rehabilitation and return to work programs are awarded greater importance in these systems, compared to the UK, due to the link between the cost of claims and the duration of absence. The costs of rehabilitation and return to work can be borne by insurance and viewed as an integral part of a system. This is particularly so where the goal of rehabilitation and return to work is prioritised above compensation, such as in Germany where compensation is decided after completion of a rehabilitation process.

Indeed, a requirement for employers to provide rehabilitation and return to work support is viewed as being an integral part of ensuring the employer bears the cost of work related injury and ill-health. The employer bears the cost of rehabilitation as opposed to "allowing" persons to become unemployed due to their impairment.

It has been noted in some countries such as Australia that a conflict can arise between the goals of rehabilitation and compensation, especially where an adversarial system exists for awarding compensation. This leads to pressure to mandate rehabilitation and / or link insurance premiums more clearly to uptake of rehabilitation.

Can the cost of compensation be de-motivating?

Employers have reacted negatively to accident compensation when the cost starts to exceed a certain level, typically an average of about 3% of payroll. An average cost of 3% across all firms can encompass rates of 8% for higher risk sectors such as construction. The costs are characterised as unaffordable and unmanageable. Reactions may include seeking relocation, contesting a higher proportion of claims and lobbying for a change in rules. This has led to reforms including reducing benefit levels, limiting the range of conditions that are compensated, restricting access to legal procedures, and tightening rules for establishing if a condition is work related.

3.7.3 Comparison of UK and overseas arrangements

Key points of comparison in the design and intent of work related accident and ill-health insurance between the UK and selected other countries are given in Table 6. It should be noted that the purpose of schemes in other countries differs from the UK. For example;

- UK arrangements were designed to ensure employers have funds to meet costs arising from employees' litigation for compensation, and were not designed to motivate health and safety or rehabilitation;
- The US, Canadian, Australian and German schemes explicitly aim to provide a financial motivation for employers to reduce the number and severity of injuries and cases of ill-health – particularly by the use of experience rating and ensuring all (recognised) costs are funded by a single benefits scheme;
- Germany appears to prioritise rehabilitation over compensation, limiting compensation to loss of earnings after rehabilitation and vocational retraining, and makes provision of prevention services an integral element of "insurer" activity;
- The US, Canadian and Australian schemes aim to reduce the uncertainty about compensation costs and the level of legal costs by operating a "no fault" scheme with capped benefit levels;
- Canadian, Australian and German schemes have been designed to increase the level of health and safety advice available to SMEs as an integral part of insurer activity;
- Overseas schemes aim to cover all work related injuries, often including road traffic accidents, and hence place different boundary on "work". This in part reflects a simple difference in demarcating the scope of each form of accident insurance;
- The cost of employers' liability in the UK cannot be compared with the cost of overseas schemes, as the cost of injury and ill-health in the UK is spread across a number of state benefits and insurance schemes whilst overseas insurance schemes are more integrated;

- Workers' compensation is conceived as a form of insurance that covers the costs and lost earnings caused by injury – in the same way that other (non-occupational) insurances aim to cover the consequences of (say) ill-health from natural causes.

It is also pertinent to note that some schemes are conceived as a "bill payment" or "pay as you go" system, whereby premiums are "simply" based on current claim related costs. The level of contributions is calculated to cover the previous year's total claims (from all firms) and total related costs, although premiums maybe "smoothed" across years to avoid sudden changes in premiums. Such schemes are operated at an "industry" level rather than on a company-by-company basis. This may be contrasted with the current UK practice of insurers providing unlimited cover for claims arising from any one year (up to a limit per claim) via premiums charged in that year.

Table 6: Comparison of arrangements in UK and selected other developed countries

Issue	UK	Other countries
Priority awarded rehabilitation	Rehabilitation is not an element of Industrial Injuries Disablement Benefit. The provision of rehabilitation is a variable & discretionary element of EL insurer activity	**Germany:** Victims proceed through a rehabilitation & vocational resettlement process before settling compensation. **Australia:** rehabilitation and vocational duties are mandated. **US and Canada:** Rehabilitation is a priority insurer activity to reduce claims costs.
Prevention services	The provision of prevention support is a variable & discretionary element of EL insurer activity. HSE acts as regulator. Discretionary use of consultants.	**Germany:** Prevention work is an integral aspect of "insurer" activity. **Australia:** prevention services are paid for by levy applied to workers' compensation. **US:** Prevention is a priority insurer activity to reduce claims costs. **Canada:** some rebate schemes are linked to acceptance of prevention advice.
Absolute cost	Employers do not perceive cost of employers' liability as significant. The cost is spread between EL, IIDB and other benefits. Cost of IIDB not directly linked to employers.	Cost of workers' compensation is perceived to be significant and draws employers' attention, especially in US, Canada and Australia. Most costs are borne by a single insurance scheme.
Experience rating	IIDB is not linked to employer performance /claims. Experience rating is a variable & discretionary element of EL policies, usually limited to larger firms.	All schemes include experience rating, with less weight awarded claims records in small firms. Some innovative schemes in Canada for small firms.
Fault vs no fault	A mix of no fault state benefits and "fault" based Employers' Liability (but with many insurers operating "as if" it was no fault).	Mostly "no fault" but with limited scope for litigation in certain cases, such as asbestos claims against suppliers in US and dispute of work relatedness in US/Australia.

Issue	UK	Other countries
Tariff schedules vs case specific awards	IIDB operates on prescribed benefits whilst EL offers unlimited compensation for loss of earnings, pain and suffering.	**Germany, Canada and US:** Prescribed benefit levels based on either average wage (eg in the state) or a % of current earnings linked to degree of disability. Minimal allowance for pain and suffering. **Australia:** Loss of earnings and pain and suffering, linked to degree of disability.
Application of schedules of work related conditions	Industrial Injuries Advisory Council advises on list of work related conditions. Court based judgement of which conditions are work related for purpose of settling EL claims.	All schemes operate with an advisory body defining which conditions are work related.
Are RTAs covered?	Whilst work related RTAs can be claimed in theory, it is necessary to demonstrate employer negligence, which is rare.	Work related RTAs are included, as well as commuting accidents in some countries.

3.7.4 Options prompted by overseas review

The review of overseas practices suggests a range of options for re-aligning insurance arrangements in the UK. These include:

Reform the IIDB scheme

The IIDB could be reformed independently of EL, for example by:

- Placing all benefit and medical / care costs related to work related injury and ill-health in a single benefit scheme rather than splitting them across a range of benefits and un-recouped NHS costs;
- Demarcating the cost of IIDB explicitly within employers' national insurance / other tax payments, and linking payments to the claims records of industrial sectors / individual firms;
- Requiring all claimants to have received legal advice on the opportunity to seek compensation under EL before their IIDB claim is considered;
- Requiring all claimants to have gone through a "standard" rehabilitation and vocational resettlement process before the long term claim is settled, and;
- Creating a unit that reviews all IIDB claims for potential legal redress, and thereafter advising / directing claimant regarding their right to legal redress.

The current National Insurance (NI) arrangements could be modified so that, as in Germany, accident insurance is separate from other forms of state benefits. Thus, all unemployment/ disability / income support etc claims and medical / care costs

associated with work related injury and ill-health would be identified and paid for by a work related injury/ill-health element of National Insurance. This could be operated on a no fault basis but with scheduled benefits, or (say) a % of the average wage, or a % of final (pre-injury) salary. The NI contribution could be charged to employers (and / or employees) and separately denoted from other elements of NI. The actual amount could then be varied according to industry sector and the number of claims per firm – i.e. a class and firm based experience modification factor. Claimants could be required to take up rehabilitation and vocational retraining, paid for by the NI contribution, as a condition of receiving benefits.

Merging IIDB and EL

The two schemes could be merged on either a fault or no fault basis, and with or without scheduled benefits.

A variation on this option is for employees to retain the option to sue employers under current Employers' Liability laws for compensation and care costs where they judge that "scheduled" benefits are inadequate. Employers could defend such claims. The right to sue could be limited to claims of a certain size or duration, such as injuries causing >10% permanent disability or lasting more than 5 years (as per the current Australian option). In this scenario, the scheme would operate on an either / or basis, i.e. you either get limited state benefits / care on a no fault basis or compensation from litigation (falling back on state benefits in the event of failure).

This option is discussed further later on in this report.

Replace EL with a reformed IIDB scheme

Employers' liability could be eliminated and replaced by a reformed Industrial Injuries Disablement Benefits scheme operated as described above. Such a scheme could be operated by the state or by private insurers.

Reform of EL

The options for relating insurance to performance include:

- Requiring firms to recompense insurance / compensation funds for claims arising due to their negligence - as per the French system;
- Offering firms a rebate /surcharge based on the difference between expected claims and actual claims for the proceeding 1 to 3 year period – with the rebate / surcharge in proportion to the difference;
- Reducing / increasing premiums for forthcoming years based on the difference between expected claims and actual claims for the proceeding 1 to 3 year period – with the discount / increase in proportion to the difference. This can lead to a factor of 5 to 10 variation in rates between firms (with all other things being equal);
- The assessment of premiums and discounts / rebates for small firms by reference to a "community" of firms appears to avoid the problem of individual small firms lacking a measurable claims experience.

In some cases, chronic illnesses that cannot reliably be attributed to a single employer are excluded from these schemes, with costs covered by a separately funded scheme on

a no-fault basis. Some countries maintain health surveillance records for 40 years (as in America) that move with the employee whilst some countries carry out annual medical checks (as in France). This should make it easier to attribute illness to work /employers.

Some schemes operate as if they are "bill payment" schemes, whereby premiums are set to reflect the past years claims. This may be compared with the UK "occurrence system" where the premiums from one year are intended to cover the costs of all claims arising from that year regardless of when the claims materialise.

Rehabilitation and vocational resettlement

Rehabilitation and vocational resettlement could be:

- Made a requirement for employees as part of their claim for IIDB;
- Encouraged as part of EL;
- A regulated duty of employers – with cost covered by EL.

It is important that compensation and rehabilitation schemes are integrated to ensure costs are contained and that effective (early) rehabilitation is encouraged.

Work related road traffic accidents

Insurance for <u>all</u> work related road traffic accidents (including those involving private vehicles) could be transferred to employer / public liability insurance or business travel / fleet policies.

Other issues

Other issues that arise in considering these options, include:

- To what extent should compensation cover pain and suffering and loss of psychological /social capacity?
- Should compensation cover total loss of earnings or just a proportion? Some systems offer a reduced level of benefits in return for a no fault system;
- How is the validity of claims established in the event that a no fault system is adopted (without court based arbitration)?
- How is the level of compensation set in the event that a no fault system is applied (without court based arbitration)?
- Should limits be placed on the degree of premium variation or rebate /surcharge, so as to avoid unaffordable changes in premiums?

It is important to recognise that the financial viability and commercial risk associated borne by insurers are key issues. If the absolute cost is considered unaffordable or the risk of claim costs exceeding premiums is considered high, it is possible that employers and insurers would oppose the scheme rather than be motivated to improve health and safety. Also, if a system operates with a deficit, the subsequent need to maintain higher premiums to re-balance the scheme reduces the link between premiums and performance, thereby undermining the motivational aims of the scheme.

No fault systems are usually supported by lists of compensable injuries / disease and scheduled levels of benefits. An adjudication process is usually also in place, sometimes with limited access to civil law in the case that there is a dispute over compensation. The provision of a benefits schedule and independent means of verifying claims is regarded to be essential aspects of cost containment.

The provision of health and safety advice and training is often provided as an integral part of schemes, with the cost covered by a levy imposed as part of the insurance premium. The provision of such support is reported to be an important element of the strategy for improving standards and containing costs. Thus, the possibility of including such support in a UK system warrants consideration.

Finally, no fault systems are usually accompanied by a change in law, restricting employees' ability to sue employers for negligence. This would require a change in UK law. Similarly, the requirement to provide rehabilitation and return to work support and employment protection (to guard against discrimination) may require legal changes.

3.7.5 Options arising from other UK insurance instruments

Consideration of other insurance policies suggests that it is also possible to:

- Vary the "excess", with better firms accepting a higher excess (with a reduced premium) on the basis of self-confidence in their performance (although this is not currently allowed under UK law);
- Offer firms a "no claims discount" based on the previous 1 to 3 years claims experience;
- Offer lower premiums for firms who have in place a defined set of "above standard" health and safety management arrangements - as per the Clinical Negligence scheme and some fleet policies.

4 CONSULTATION WITH UK INSURERS

4.1 INTRODUCTION

There were two phases of consultation with UK insurers. The aim of the initial consultation with UK insurers, as reported in this section of the report, is to explore their views as to how insurance arrangements could be used to motivate better health and safety. Accordingly discussions have been held with representatives of those insurers and brokers who hold the majority of the EL market in the UK, and the Association of British Insurers. Discussions were guided by a set of open-ended questions, as per appendix A. The discussions had three parts, namely:

- How do insurers currently try to use EL as a means for promoting better health and safety?
- What more can be done within the current legislative framework?
- What is the insurers view of some of the ideas suggested by the review of overseas practices?

The summary is structured to reflect these three points. Some additional points were also raised and these are also summarised below.

There is a reasonable level of consistency in the opinions expressed by insurers. Accordingly, we have provided an integrated summary of their opinions. Any major differences in opinion and practices are highlighted.

A second phase of consultation, as reported in section 7 of this report, sought insurers views on the feasibility of changes suggested by our survey of UK employers and our review of options.

4.2 SUMMARY OF CONSULTATION RESPONSES

4.2.1 What is already done?

To what extent do firms already provide EL schemes that offer some of the features noted in section 3?

The ABI belief is that in a competitive environment insurers will be innovative and insurers already do what they can within the confines of the current legal framework. Although practices vary between firms, many insurers already operate premium discount / surcharge schemes, promote rehabilitation, operate “as if” it was a no fault scheme, and offer health and safety advice services. A summary of current practices is given below.

Experience Rating

There are currently two ways that an insurer calculates the premium.

1. Book Rating

Prices are-pre determined and are quoted directly from the list. These prices are derived from statistics reflecting claims experiences of companies within a sector. There are eight main industrial sectors in the country, each with a number of sub-sectors, and statistics are compiled according to these sectors.

UK insurers do not 'pool' companies in the same way that overseas insures do. That is, they would not necessarily penalise all companies within a group due to changes in the group's performance. For example, if, in their judgement a particular company had maintained its performance its premium would not be increased in line with the pooled rate. However they would pool the statistics that may influence the book rates of all firms in the group.

2. Experience Rating

The insurer looks at the company's claims experience in order to determine the price, offering discounts and loadings according to the risk. Some of the insurers interviewed are using other indicators of performance alongside claims experience, including management systems, management attitudes, ISO 9001 and Investors in People. One insurer provides a 'low claims discount' of up to 20% on a sliding scale. Another insurer authorises individual branches to give clients up to 65% discount to customers who are, in their judgement a 'good risk'. There is no limit on loading.

In the main, experience rating is applied to larger firms. In one case, premiums are based on individual claims experience for firms that pay premiums of more than £200,000, with book rates applied to firms that pay less than £30,000 in premiums. The handling of firms paying premiums in-between these levels depends on the circumstances.

No Fault

One major insurer said that they 'pay out' on a claim so long as the investigation showed that the injury was sustained in the work place. They did not assign negligence or fault to either the employer or employee. Another insurer noted that they do not believe that demonstration of contributory negligence reduces the cost of claims significantly. However the former insurer was the exception and most would look for contributory negligence and adjust the value of the claim as appropriate. Their reasoning for this was loyalty to the customer.

Non-litigious claims handling

Two of the insurers interviewed positively encouraged non-litigious claims handling. One broker who encouraged its clients to make claims directly to the insurance

company rather than via solicitors. The other insurer has trained investigators whose aim is to avoid litigation through negotiations.

Encouragement of rehabilitation and return to work

Three insurers offer rehabilitation schemes. One company launched a scheme in 1998 that is utilised by more than 200 customers. They aim to provide rehabilitation as a cost-effective solution including the provision of speedy and effective medical care to ensure that recovery time is reduced and, wherever possible, the employee can return to work.

Provision of health and safety information

Most of the insurers see it as their duty to provide their customers with some sort of health and safety information. At the basic level this is a one sentence reminder on the policy renewal notice asking if the company has seen a particular HSE leaflet or they may enclose a HSE leaflet or one produced in house with the notice. They may send out leaflets on different topics to customers throughout the year by means of mail shots. Some also make more extensive safety management guidance available on-line. Information is given verbally through risk managers and investigators visiting the customer's work place. Larger customers have scheduled meetings to discuss the improvements made or those needed within the company, with the insurer. These services are usually provided inclusive of the price of the premium.

Some insurers have a risk management arm of the company which employs a group of risk management consultants. The customer requests their input and they work on a consultancy basis providing health and safety advice and improvement plans as required. This service is funded by the customer separately from the premium cost.

4.2.2 Potential opportunities within current legislative framework

How could the arrangements for settling claims be modified to avoid discouraging injured persons from seeking compensation?

The majority of claims (about 95%) are already settled out of court, although legal costs account for about 30% of EL costs. In the main, insurers accept that if an accident occurred at work the employer is liable. Also, some public sector employers have agreed "no contest" arrangements for certain conditions.

Interviewees report that it is felt throughout the insurance industry that claims could be settled in a more effective way by reducing the involvement of solicitors. It is felt that the majority of genuinely injured employees are already claiming and one insurer believes that unions played a role in this, where they are active in a company. It was expected that with the onset of no-win no-fee legal services that EL claims would rise. However this has not been the case, suggesting that the level of claims is close to the maximum. One insurer thought that lump sum payments should be stopped and a tariff system introduced to make the system fairer although this idea was not advocated by all insurers.

How could employers' liability policies be used to increase the proportion of injured persons entering rehabilitation and return to work schemes?

The ABI view rehabilitation to be a win-win activity as it reduces costs and improves return to work rates. Some insurers share this view and promote rehabilitation wherever it is cost-effective. Many brokers and insurers are adding into their policies provision for rehabilitation and return to work. Some are not so advanced as others, but all respondents saw the value in providing these schemes and planned to offer them in the future. At present the provision of rehabilitation services is a commercial decision on the part of insurers.

Rehabilitation does not benefit all. One insurer asserted that success in these schemes was dependent on the individual case with factors such as injury, medical diagnosis and participation of stakeholders having an influence.

There was some concern that the cost of rehabilitation may exceed the cost of compensation. However, one insurer showed that, where rehabilitation had been successfully implemented, there was a reduced recovery time and a reduction in costs. Two examples were cited;

- Through teamwork, rehabilitation, co-operation and light duties compensation costs were reduced to a negligible level using a £1,200 intervention. It was estimated that the total cost would have been £12,500 on an actual claim. The duration of the 'claim' was also reduced.

- For a hand injury, physiotherapy was used costing a few hundred pounds rather than an estimated £12,000 compensation cost.

However, participants in the survey stressed the point that stakeholders such as employers, employees and employees' representatives need to want to work with the insurer to make a success of rehabilitation. It was thought that the adversarial nature of employers' liability and the litigation process hampers the uptake of rehabilitation and acts as a disincentive for injured persons. Also, rehabilitation is most effective when it is commenced shortly after an injury or condition occurs. As employers and employees may not currently report a case to the insurers for months this currently limits the ability of insurers to encourage effective rehabilitation. In addition, if the employee has to prove fault before they can be recompensed, they may not gain prompt funding for rehabilitation.

Do you think you could operate a scheme that enabled "clubs" of small and/ or medium sized firms to have a pooled claims history for the purpose of granting premium discounts and surcharges?

As regards clubs, many insurers started out as mutual societies that offered cover for specific industries, such as Iron Trades for shippers, with the goal of pooling risks. The National Farmers Union is a remaining example of this.

Risk statistics are pooled but individual companies are not. There would be resistance to doing this because penalised customers may take their business to another company. Insurers would only pool risks if it were made compulsory for them to do so. Statistics are compiled on geographical region and it is known that there are differences in the claims history of different regions. For example construction companies in Northern Ireland claim more than any other construction companies. All insurers interviewed could not see any logic or plausible reason to pool companies based on their region and thought that it would be unreasonable to do so.

Another important consideration is that EL is generally offered as part of a commercial insurance package, covering fire, fleet etc. Indeed, small and medium sized enterprises tend to get a "commercial combined policy" which contains all business insurances. Some insurers calculate one premium for the entire package rather than for each policy. Therefore, it is inappropriate to consider EL "clubs" in isolation of other policies. Notwithstanding this, the general view seems to be that trade-based clubs may be feasible, although geographic ones would not.

Could you provide a higher level of H&S support to firms, paid for by a fraction of the premiums?

Many insurers and brokers already provide health and safety services. Some insurers already offer health and safety advice as part of the EL package and reflect survey costs in the premium, although the firm must be large enough for this to be economic. The provision of such as service is essentially a commercial decision, i.e. is there sufficient demand for such as service. In this way current advisory practices are market led and tends to focus on supporting medium and large firms.

The difficulty in increasing the level of support, via increased premium, is the amount of money and the number of firms involved. Premiums for small companies are in the region of a few hundred pounds with an average of £600. Thus, there would have to be a significant increase in premium to make a significant improvement in health and safety support. A consultant costs at least £350 per day and this would be a high expenditure for small companies. Many small firms may feel unwilling or unable to pay this on top of the premium. In addition, a large insurer may have more than 100,000 holders of employers' liability insurance. The provision of advice and support, particularly by site visits, would require a very large increase in health and safety resources on the part of insurers.

Insurers anticipate that premiums will soon be rising by around 30% (to cover rising costs) and one insurer thought that to provide additional health and safety support an additional 20% increase would be needed. A further concern was that insurers might loose business if they do not offer 'freebies'. Thus, it was considered that whilst larger employers may pay such a fee voluntarily, smaller employers would not.

How do you think it would be possible for the DSS/NHS to recoup a larger proportion of treatment and care costs?

The general view is that this is a matter for government. The NHS can already reclaim NHS costs in the case of Road Traffic Accidents and the DSS reclaim benefits paid to victims who receive compensation.

Most people interviewed thought that it was plausible and appropriate for the government departments to recoup their costs. They saw however several barriers to this.

For example:

- A legislative change would be needed;
- The NHS does not have an adequate administration system for accurately recording treatment costs, and;
- Payment should be subject to legal liability i.e. for a payment to be made the employer whose insurance is being claimed on would have to be liable for causing the injury that results in the treatment costs incurred.

What level of rebate / surcharge or rate variation would you be willing to offer firms for above / below average claims – as a % of normal premium?

Insurers do load rates by 50% and discount by as much as 20% at present – subject to commercial pressures.

Most insurers could not give a specific percentage answer. Currently discounts and loadings are given to individual customers based on the assessment of the risk but there is no fixed formula of discounts/loads given for particular factors such as claims history or safety management systems.

The level of rate variation is restricted by the need to cover the cost of claims arising from past exposure. This means that a proportion of premiums must be set at a "fixed" level to cover the cost of ongoing claims associated with past exposures.

The risk of being refused insurance is regarded a bigger risk to the insured than having their premium loaded. EL is a legal requirement for employers, thus not having EL insurance prevents them from trading. If an insurer refuses insurance, the employer can go to other insurers, but will have to declare that they have been refused insurance.

Would you be willing to offer a firm a different premium rate based on safety management indicators rather than the number of past claims?

To some extent this is already done. Specifically, in the case of larger firms the premium is based on a combination of firm's claims history, the surveyor's report and the class (sector). Most insurers took into account issues such as management attitude, achievement of ISO 9001 or Investors In People. It is less realistic to assess safety standards in the case of smaller firms because:

- They are less likely to have a demonstrable set of safety management arrangements that are readily amenable to audit, and;
- The cost of the survey could lead to premium increases that could exceed the value of any premium variation.

How else could liability insurance be used to motivate employers in H&S?

The scope for using Employers' Liability policies to induce changes in employer behaviour is limited by the requirement for insurers to accept liability regardless of the employer behaviour. This restricts the use of methods such as excesses, policy conditions and so on that may be used on other types of commercial policies. However interviewees had ideas for the improvement of the system, including:

- Moving away from the current 'occurrence system' which makes risk management for occupational health difficult;
- Introducing an excess so that there would be no immediate financial impact on the employer for each claim – this is currently illegal under the EL Act 1969;
- A no fault system to reduce legal fees;
- Improving 'return to work policies' of employers to make them more committed to health and safety management and rehabilitation;
- Allowing large companies to 'self insure'.

Premiums are claims-led at present and any improvements take a long while to be reflected in the premium. Self-insurance can give them a more immediate benefit. Some clients know they have made significant improvements due to investment in loss prevention/control procedures and hence want an immediate reduction in rate (which they could get through self-insurance) but it is illegal for non-exempt companies not to have EL. The insurer is legally obliged to deal with claims. Where the employer does self-insure, the fronting insurer will deal with the claim and pass claim payments through their books as premium before settling the claim. In effect, the claim payment becomes subject to 5% insurance premium tax that can be a disincentive to self-insure.

4.2.3 Impact of major changes to employers' liability arrangements

Do you think that an increased EL premium would cause financial concern to the extent that it would motivate improved health and safety?

The cost of EL at present does not provide an incentive to firms to improve health and safety standards. Employers' liability insurance is often just one part (usually a small proportion) of a combined commercial policy for SMEs, and so many firms may not know how much they pay for employers' liability insurance. It was noted in the ABI memorandum that:

> "Employers' liability premiums can be modest in relation to the overall costs of running a business – a manufacturer with a turnover of £4 – £5 million might pay a premium of around £3,000 per year (1997). It is therefore possible that it would cost more to change business practice than that change would be worth in premium reductions."

Accordingly, at least one interviewee suggested that an increased cost would motivate employers to do more.

However, other interviewees believe that employers will "simply" instruct brokers to find the cheapest quote. It is not thought that this is the way to motivate employers and there are other motivators that would work better. There is a fear that employers would not be able to afford an increase in EL and they would revolt against it rather than improve health and safety.

How do you think UK firms would respond to such an Experience Modification Rating?

Experience rating is already used extensively within the industry (for larger firms particularly) as a method of calculating premiums. They respond by a mixture of improved health and safety management, rehabilitation and better claims management.

Do you believe UK employers would accept or reject a proposal or requirement to take all reasonable steps to rehabilitate and return persons to work?

The insurance companies who already offer rehabilitation believe that it is very well received by those companies whose policies include it, particularly medium to large employers, and those who understand the full costs of accidents. There was a mixed response from the other insurers, one of whom thought that employers would revolt and reject paying out any more money. Another thought that it would depend on the business and the attitude of management, with some thinking of it as an intrusion on the business operation and others responding positively to it. It was thought that making Trade Association membership contingent on having a commitment to rehabilitation and return to work would make employers take it more seriously.

Do you think UK firms would accept a levy on their premiums to pay for health and safety advice, training and related services?

It was thought that for there to be a sufficient increase in premium to provide such as service that this would have to compulsory for all insurers. The concern is that if any one insurer raises premiums unilaterally to cover such costs that they would loose business.

What do you think the general impact of a no fault system would be?

It is thought that a no fault scheme would lead to:

- A mixture of more health and safety prevention, rehabilitation and claims management;
- A premium increase, and;
- Injured employers would benefit from being guaranteed compensation.

The ABI did not discount the option of a no fault system but highlighted the introductory problems that would occur. These include the question of how one would predict future claims at the outset, as current claims history is based on tort based system. There is no UK experience by which to judge the impact of a no fault system on costs.

It was thought that "things would become clearer" with a less adversarial system. It is likely that a tariff system would be needed in a no fault system.

One insurer was not convinced that it would work as an incentive to improve health and safety. Also, overseas experience suggests that there is a risk of cost increases, especially if people retain a right to tort.

Insurers were willing to support a no fault system but only if it would be viable and sustainable for a number of years (at least 10-20). It was acknowledged that the provision of compensation is problematic and there is no system existing in the world at present that satisfied stakeholders due to their different needs of stakeholders. These needs would have to be considered when developing a new system.

Do you believe the option of litigation should be retained within a "no fault" scheme for certain circumstances?

There was a mixed response to this question. Some quotes include:

- "No – insurers don't desire to pay out extra money";
- "Good for reckless employers who are grossly negligent";
- "Would depend on how it would work and the benefits it would yield e.g. level of compensation and if it was adequate enough";
- "Litigation would defeat the 'no fault'. Pricing would be based on a no fault system, but litigation is likely then would have to include this in the cost of the insurance", and;
- "Not if this meant that the cost savings of a no fault scheme are negated."

What aspects of legislation and social security benefits would need to be changed, for such a system to be implemented in the UK?

The legislation regulating EL would certainly need to be changed. This is because it does not encompass many of the modern issues that affect EL, for example stress in the work place. A no fault system would have an impact on the policy holders protection scheme and the financial services compensation scheme. Changes would be needed in:

- Laws of liability;
- Social security claimant rules;
- NHS cost reclamation procedures, and;
- Rehabilitation and employment law.

It was also noted that the adversarial nature of employers' liability claims needs to be reduced for rehabilitation to be effectively applied, particularly the need to demonstrate

fault before rehabilitation is funded. However, it was suggested that it would be difficult to justify reforming the law on tort for the sake of occupational health and safety alone, as tort covers many other areas of litigation.

4.2.4 General points raised in consultation

The acceptance of EL reform needs to take account of the point that EL is not a popular line of business because of the low profitability and the unpredictability of future claims, especially of disease related claims for long-onset conditions. Long-onset diseases would probably have to be put to one side before EL became a more attractive line of business. Another key concern is the risk of retrospective changes to awards formula and the potential for claims arising from past years. Insurers have not covered the cost of potential emergent and rising claims (associated with earlier years) in past premiums. Moreover, there is a general and critical concern about the predictability of claims and the difficulty of ensuring that premiums set for one year cover the claims associated with that year. This problem is exacerbated by the decline in investment returns, which provided secondary income to cover claims costs.

One consequence of these concerns is that an increase in EL costs may be regarded as an increase in the commercial risk posed to insurers by EL. For any changes that lead to increased insurance costs to be welcomed, the problem of matching premiums to claims needs to be addressed.

In addition, it is necessary to recognise that other government departments influence the operations of insurance companies. The Financial Standards Association require that 35% of premium income has to be retained by the insurer as an asset in the event of the company going bankrupt. If premiums were to go up to pay for the provision of health and safety improvement, only 65% of the money could be utilised, thus the premium would have to go up significantly for the insurer to be able to fund the initiative. Stakeholders are resentful of the 35% regulation and hence would not be happy about having to retain any more money with none available for investment. Similarly, the regulations about monopolies and anti competition make it difficult for insurers to work together to improve EL insurance for the benefit of all stakeholders.

Also, as mentioned earlier, insurers often provide EL as part of a wider business insurance package including Public Liability etc. Insurers are conscious of the fact that anything they do to make their EL insurance less attractive to employers may encourage them to transfer to other insurers and take with them other more profitable business.

Notwithstanding these concerns, the prospect of reform is welcomed. Ideally though, reform would “start from scratch” as it is perceived that EL has developed in a piecemeal manner to date. Insurers could also take over some or all of the IIDB scheme.

It is also believed that the litigation process is a barrier to rehabilitation. Solicitors, for example, may dissuade clients from rehabilitation and/or allowing access to their medical records. Insurers would prefer to handle claims directly with the goal of minimising both the severity of harm (via rehabilitation) and legal costs.

However, insurers do not believe that they can motivate employers alone or that it is their job to do it alone. Consideration has to be given to the fact that insurers are in the

business to make a profit on their business activities. Moreover, they do not anticipate that changes to insurance arrangements are likely to play a major role in improving health and safety standards.

They believe that a greater level of involvement is needed from the government particularly through investing more money into the provision of health and safety inspections and health and safety. Many insurers believe that higher standards of health and safety can best be achieved by non-insurance means, such as increased inspection by the HSE and higher fines. Also, other ways of influencing people are available to motivate employers to be more proactive in health and safety. For example:

- People should be educated in health and safety management from school to university, and;
- Trade associations could make membership contingent on commitment to the improvement of health and safety in the workplace.

4.3 CONCLUSIONS

The consultation with insurers indicates that they believe they already operate many of the mechanisms suggested by the review of overseas practices, as far as is possible within the limits of commercial and legal requirements in the UK. It is apparent that practices vary and that there are examples of "good practice" that could be applied more widely. In particular, there is scope for the following practices to be more widely applied within the current system:

- Adopting a de facto "no fault" approach to claims, and;
- Promoting the role of rehabilitation prior to the settlement of claims.

For insurance to be a more effective vehicle for promoting health and safety, significant changes are required in Employers' Liability Regulations. Whilst some insurers accept that an increase in EL premiums may provide employers with an incentive to improve health and safety, the increased commercial risk posed to insurers by unprofitable EL would need to be addressed. Ideally, reform of EL would start from scratch and would take account of the exposure of current insurers to long tail liabilities covered by existing policies and resolve the commercial risk problems posed by the "occurrence system". Reform of employers' liability should consider how it influences the uptake and timing of rehabilitation, and the balance between compensating and rehabilitating claimants. Insurers would appear to welcome reforms that would place a greater priority on rehabilitation.

The UK employers' liability system was not designed to encourage rehabilitation or prevention of injuries and ill-health. Its main aim was to ensure employees received compensation. Therefore, the scheme was designed to ensure insurers paid regardless of the behaviour of employers. In addition, insurers have a perpetual liability for claims arising from the period they cover, regardless of whether they still insure that firm. This is unlike many other forms of insurance when liability for a period ends when the insured firms change insurer. Accordingly, subsequent attempts to introduce motivational mechanisms into the employers' liability system are limited by the (valid) goal of compensating employees, and the risk to insurers is high. It is not suggested that

the goal of ensuring employees are compensated should be changed. However, the current mechanisms for ensuring compensation appear to restrict the opportunity for reforming employers' liability to support latter day goals of prevention and rehabilitation.

5 SURVEY OF UK BUSINESSES

5.1 INTRODUCTION

The aim of this survey is:

- To test employers' views of how potential changes in insurance arrangements may impact their motivation to improve health and safety and rehabilitation;

- To gauge the extent to which employers currently regard the cost of work related injuries and ill-health to be significant;

- To obtain some feedback as to what level of cost (of injury and ill-health) employers would regard to be significant.

A draft questionnaire was piloted with a group of 20 employers via phone, email and face-to-face interviews. A final questionnaire was produced and was sent out to employers (see Appendix B). A cover letter from the HSE requesting a response was sent out with the questionnaires along with a response paid envelope. The response rate was 18%.

5.2 QUESTIONNAIRE DESIGN

The questionnaire has eight main parts. These are summarised and explained below. They have been designed to build upon and test some of the ideas and propositions suggested by the review of UK and overseas experience and research outlined earlier in this report.

1. Background information

This covers:

- The company size (number of employees);
- Sector, and;
- Annual cost of employers' liability.

These questions enabled results to be analysed by company size and sector. The extent to which employers' attitudes are related to the size of the firm and the cost of employers' liability can thus be assessed.

2. Perception of employers' liability and health and safety

Four questions probe whether employers perceive EL to be a significant business expense and whether they believe they can influence this cost by better management of health and safety.

3. Access to advice and awareness of IIDB

Two questions probe whether employers have access to health and safety advice and rehabilitation services whilst a third tests awareness of the IIDB scheme. The first two questions check whether employers have access to H&S advice and rehabilitation. The third aims to test the assumption that employers are not widely aware of IIDB, and hence whether they are likely to be influenced by the cost of IIDB.

4. Attitudes towards rehabilitation

The aim of this section is to explore whether employers believe that rehabilitation should have a greater role within the compensation process, and, if so, how the cost of rehabilitation should be handled.

5. "Club" membership

A single question explores whether employers would be interested in joining a club that offered a potential discount on the cost of employers' liability and low cost health and safety support in return for better performance.

6. Anticipated impact of a no fault scheme

Five questions explore employers' perceptions of whether a no fault approach to employers' liability would impact the level and cost of claims.

7. What is a lot?

A single question probes how much employers' liability would need to cost (as a % of payroll costs) an employer for them to regard it to be "a lot". The aim here is to gauge the level of cost that needs to be reached for employers to be motivated by the desire for cost reduction. The question uses five set points to test this. These have been chosen as follows:

0.25%	The approximate current cost of EL as a percent of total UK employment cost.
1%	The approximate total of all tangible cost of occupational injury and ill-health in the UK (IIDB, NHS, Employers' Liability etc).
3%	The approximate total cost of occupational injury and ill-health in the UK if the subjective value of pain and suffering was included. This value is also close to the cost of workers' compensation in a number of countries that operate no fault schemes (and include all claims within a single scheme rather than separating them between private and state schemes).
6% and 10%	These values can be applied to poorer performers in higher risk sectors in countries that operate a variable rate scheme related to the number of claims.

8. Response to a major increase in the cost of claims.

A series of questions are designed to explore how employers believe they would react to the prospect of a large increase in the cost of insurance. The first explores whether employers would try to prevent accidents and ill-health if they thought that premiums would rise in line with claims. The second question tests whether the prospect of a 50% discount / surcharge would motivate employers. The value of 50% was chosen as experience in Germany and elsewhere suggests that this is a sufficient amount to motivate employers. The final questions explore how employers would seek to reduce the cost of claims if they increased a lot. This includes "legitimate" options such as better health and safety and improved rehabilitation, and less "legitimate" options of avoiding the recruitment of people previously ill or injured.

5.3 SURVEY STRUCTURE

5.3.1 Planned structure

The survey aims to solicit responses from all sizes of firms and a cross-representation of sectors. Therefore, it was decided to:

- Send an equal number of questionnaires to small, medium and large organisations, and;
- Structure the sample in accordance with the number of people employed in each sector.

However, the survey also aimed to acquire approximately equal number of responses from organisations operating in high, medium and low risk sectors. Therefore, sectors were sub-divided according to the rate of injury using RIDDOR and LFS statistics and the sample from each sector was adjusted until an approximately equal number of companies in high, medium and low risk sectors was achieved. Thus, the sample was balanced between sizes of organisations, risk and sectors. The structure of the sample of contacts is shown in Table 7. The sectors are categorised as follows:

High risk (H)

- Construction
- Agriculture
- Utilities
- Telecommunications (post, phone)
- Transport

Medium Risk (M)

- Hotels & catering

- Manufacturing
- Health and social work

Low risk (L)

- Banking, finance, accounts & insurance
- Education
- Other services (laundry, estate agents, Membership organisations etc)
- Local authority / regional government

A total of 3,500 questionnaires were issued. All contacts were acquired from Dunn and Bradstreet, randomly selected according to the sample structure from their database.

All responses received by the cut off date were entered into a database and analysed. The full data set is given in Appendix C.

Table 7: Planned sample structure

SECTOR	Small	Medium	Large	Number per sector & risk category	
Agriculture & forestry	58	70	0	128	H
Banking, finance, accounts or insurance	13	11	56	80	L
Construction	205	211	41	457	H
Education	85	86	19	189	L
Health or social work	106	101	182	389	M
Hotels & catering	63	65	62	190	M
Local authority / regional government	30	29	52	111	L
Manufacturing	169	166	230	565	M
Other services (laundry, estate agents etc)	166	166	67	400	L
Utilities (gas, water, electricity)	1	2	69	72	H
Retail & repairs	114	115	135	364	L
Telecommunications (post, phone)	38	47	83	168	H
Transport	83	70	165	319	H
Membership organisations	23	23	24	70	L
	1153	1162	1185	3500	

5.3.2 Actual sample structure and response rates

The profile of the sample is shown in Figure 1 in terms of the per cent of the sample from each sector. The actual number of responses from each sector is plotted in Figure 2 and given in Table 8 along with the percentage of mailed employers who responded from each sector. It can be noted that:

- The highest response rates are in those sectors commonly regarded to be higher risk, such as agriculture and construction;
- Manufacturing, construction and transport are the three largest sub-sets of responses in Figure 2;
- The overall response rate was 18%.

The response rate of 18% is relatively high for a postal survey, for which it is normal to expect a 10% response rate.

Table 8: Achieved sample structure by sectors

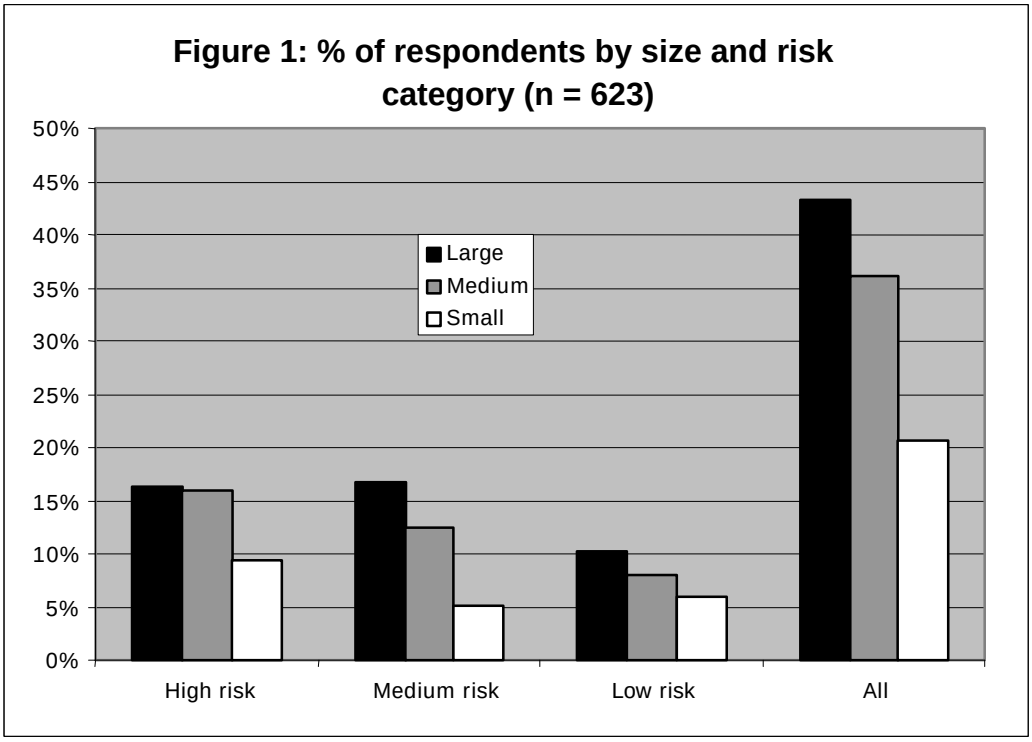
Sector	Risk category	Number of responses	Response rate	% of sample
Agriculture & forestry	H	37	29%	5.7 %
Banking, finance, accounts or insurance	L	11	14%	1.7 %
Construction	H	121	26%	19 %
Education	L	31	16%	4.9 %
Health or social work	M	64	16%	10 %
Hotels & catering	M	29	15%	4.5 %
Local authority / regional government	L	24	22%	3.7 %
Manufacturing	M	132	23%	20.7 %
Other services (laundry, hairdressing, etc)	L	79	17%	12.4 %
Utilities (gas, water, electricity)	H	7	10%	11 %
Retail & repairs	L	32	9%	5 %
Telecommunications (post, phone)	H	9	5%	14 %
Transport	H	62	19%	9.7 %
All		638	18%	

Table 9 provides a summary of the response rates and number of responses by company size and risk category. The total does not equal 638 because the size and risk category of some responses could not be identified. Thus, for example, 23% of large firms responded compared to 11% of small firms.

It is apparent that the response rate varied according to company size and risk category, with much higher response rates for larger firms and firms operating in higher risk sectors.

Table 9: Achieved response rates by risk category and size

	Risk category		
	High risk	Medium risk	Low risk
Response rate	21%	20%	15%
Number of responses	260	213	150
% of all responses	41%	33%	24%
	Company size		
	Large	Medium	Small
Response rate	23%	19%	11%
Number of responses	270	225	128
% of all responses	42%	35%	20%



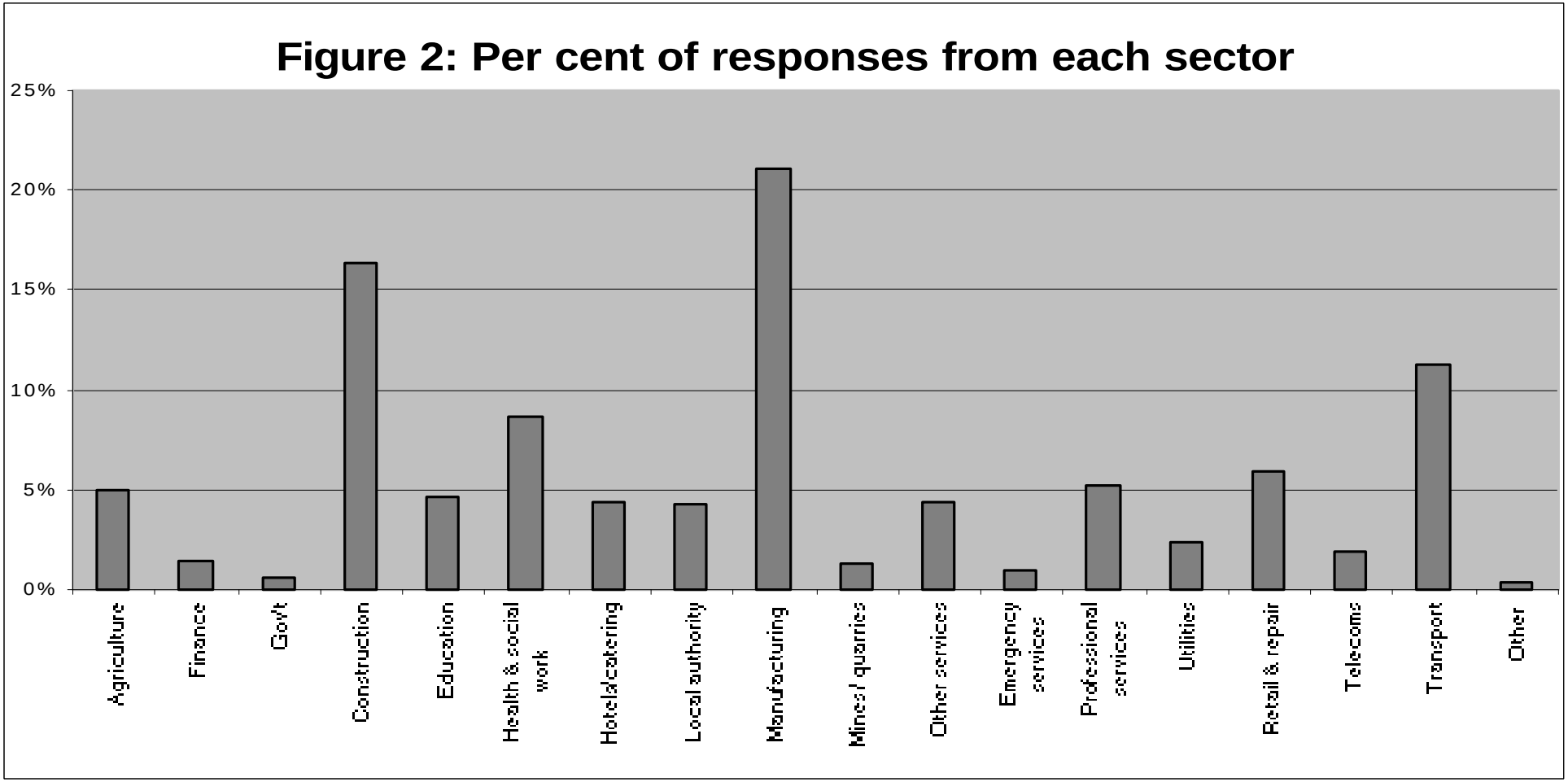


Figure 2: Per cent of responses from each sector
25%
20%
15%
10%
5%
0%
Agriculture
Finance
Govt
Construction
Education
Health & social work
Hotel&catering
Local authority
Manufacturing
Mines/ quarries
Other services
Emergency services
Professional services
Utilities
Retail & repair
Telecoms
Transport
Other

5.3.3 Statistical confidence

As with all sample-based surveys there is a degree of statistical "error" in the results. That is, it is expected that there would be a difference between the responses from a complete census of all employers and the responses from this sample. The range of error associated with any one sample is linked to the sample size and the extent to which respondents provide a common response. Table 10 provides the ranges of error for each part of the sample and the total sample for a number of responses.

Table 10: Ranges of error (95% confidence)

% of respondents giving a response	Range of error (+/-)			
	Large firms (n = 270)	Medium sized firms (n = 225)	Small firms (n = 128)	Total sample (n = 638)
50%	6%	6.7%	9%	4.5%
30% or 70%	5.5%	6%	8.4%	3.8%
10% or 90%	3.6%	4%	5.5%	2.7%

In most cases the percent of respondents who have given the same answer to a question is about 30%, or 70% to 90%. This indicates that there is general agreement amongst respondents and that there is a low degree of error (of about 4%) in the responses for the overall sample. This suggests that confidence can be placed in the statistical reliability of the results for the total sample.

In the case of each sub-group (large, medium and small firms) the degree of error is in the range of 5% or 6% in most cases. This suggests that confidence can be placed, in most cases, in the results for each company size. In those cases where about 50% of small employers give the same response, the "true" result is in the range 41% to 59%.

5.4 OVERVIEW OF MAIN FINDINGS

The main conclusions from the survey of employers are summarised below. There is a low level of variation in responses between firms of different sizes or between firms in higher versus lower risk sectors.

The significance of EL costs

- Employers' Liability is perceived to be a significant business expense. The reported cost of EL relates to the number of employees and, to a lesser extent, to the risk category of firms.
- The majority of large and medium sized firms report that they are trying to reduce the cost of employers' liability. Only a minority of small firms state this view.

Employers' perceived control of health and safety

- Employers believe they control the standard of health and safety in their organisation but only half believe that the cost of EL is related to their standard of management.
- There is a clear association between company size and the perceived link between their health and safety performance and the cost of EL. Whilst the majority of large and medium sized firms believe that the cost of EL is related to their performance, only a small minority of small firms share this belief.

Employers' access to health and safety and rehabilitation services

- The vast majority of organisations have access to health and safety expertise.
- A minority of employers are familiar with how to get access to rehabilitation services. Small and medium size employers are least aware of how to access rehabilitation.

Employer awareness of IIDB

- The majority of employers are unfamiliar with the IIDB scheme, particularly small and medium size employers.

Employer attitudes towards the balance of rehabilitation and compensation

- Employers do on the whole agree that injured employees should have rehabilitation before compensation is settled, with a small majority agreeing that compensation should be withheld if the employee refuses suitable rehabilitation.
- About half of firms agree that employers should pay for rehabilitation, and that they would prefer to insure against the costs of rehabilitation rather than pay out of pocket.
- The attitude towards rehabilitation does not appear to vary according to company size, except on the question of whether employers should pay for rehabilitation in which case small firms are less likely to agree with this proposition.

Acceptance of a cost increase to pay for health and safety support

- A small minority of firms would accept a 20% increase in the cost of EL to pay for improved health and safety services. This appears to be related to company size with far fewer large firms accepting a cost increase than smaller firms.

Interest in joining a club

- About a third of firms of all sizes express an interest in becoming members of a "club" where improved performance would be rewarded by reduced premiums.

Perceived impact of a no fault scheme

- The majority of firms of all sizes agree that a no fault scheme would lead to increased claims, increased cost and fraud without reducing legal costs and without being fairer for employees.

What is "a lot"?

- The vast majority of firms believe that 0.25% to 3% of payroll is "a lot"; with over 50% falling in the range 0.25% to 1%.

Employers' anticipated response to an increase in EL costs

If the cost of EL were to increase significantly the majority of firms would attempt all of the following options:

- Improving health and safety;
- Contesting claims;
- Improving rehabilitation, and;
- Avoiding the recruitment of previously injured persons.

About half would consider changing insurers to reduce costs.

There is little correlation between the size of firms and how they anticipate they would respond to an increase in the cost of EL, other than small firms being less likely to contest claims.

Motivational impact of a 50% surcharge/rebate

- The majority of firms indicate that they would be motivated by the prospect of a 50% surcharge or rebate to try to improve health and safety.

5.5 RESULTS

5.5.1 Introduction

This section provides a graphical summary of the survey results. In most cases graphs are presented of the combined number of respondents who either agreed or strongly agreed with a statement. In those cases where a "Yes/No" question was asked, the graph indicates the percentage that said yes.

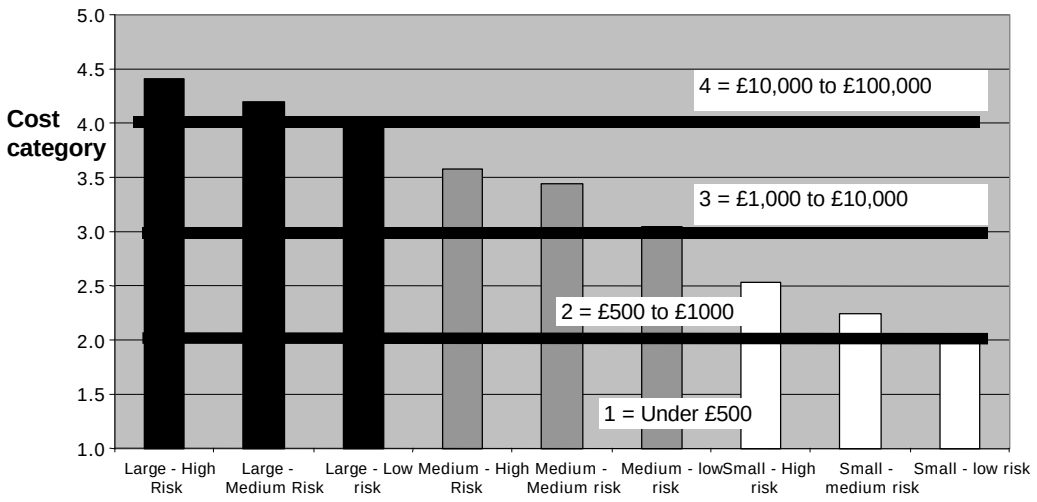
5.5.2 Reported cost and perception of EL

Figure 3 provides a summary of the reported cost of employers' liability premiums, sub-divided by company size and risk category. As expected the cost of employers' liability varies by company size and risk category. For example:

- Large high-risk employers report that they pay £10,000 to £100,000 compared to up to £10,000 for large low risk employers.
- Small high-risk employers pay between £501 and £1,000 compared to under £501 for small low-risk employers.

This indicates that the current approach to setting employers' liability premiums does achieve a link between "risk" and cost.

Figure 3: Reported cost of EL per year



Figures 4 and 5 provide a summary of the percent of respondents who either agree or strongly agreed with questions 5a to 5d. Figure 4 provides results sub-divided by company risk category and Figure 5 provides results sub-divided by company size, as well as results for all firms. These questions sought to establish the extent to which employers perceive the cost of employers' liability to be significant, if they are trying to reduce it and if they believe they can control health and safety. The results are presented for the entire sample and for each category of respondents. It can be noted that:

- The majority of high and medium risk respondents perceive the cost of employers' liability to be a significant business expense, but only approximately half of low risk firms share this response;

- Nearly all firms, regardless of risk category, believe they control health and safety standards;

- The majority of high and medium risk firms report that they are trying to reduce the cost of employers' liability, but only a minority of low risk firms report they are trying to reduce this expense;

- Half of all respondents believe that the cost of employers' liability depends on their standard of health and safety, with a minority of low risk firms accepting there is a link between their safety standards and the cost of employers' liability;

- The significance of the cost of EL, the desire to reduce this cost and the perception that EL cost is related to company performance is less amongst smaller firms. Only, a small minority of small firms believe that the cost of EL depends on their health and safety performance.

Figure 4: Respondent's perception of EL (by risk category)

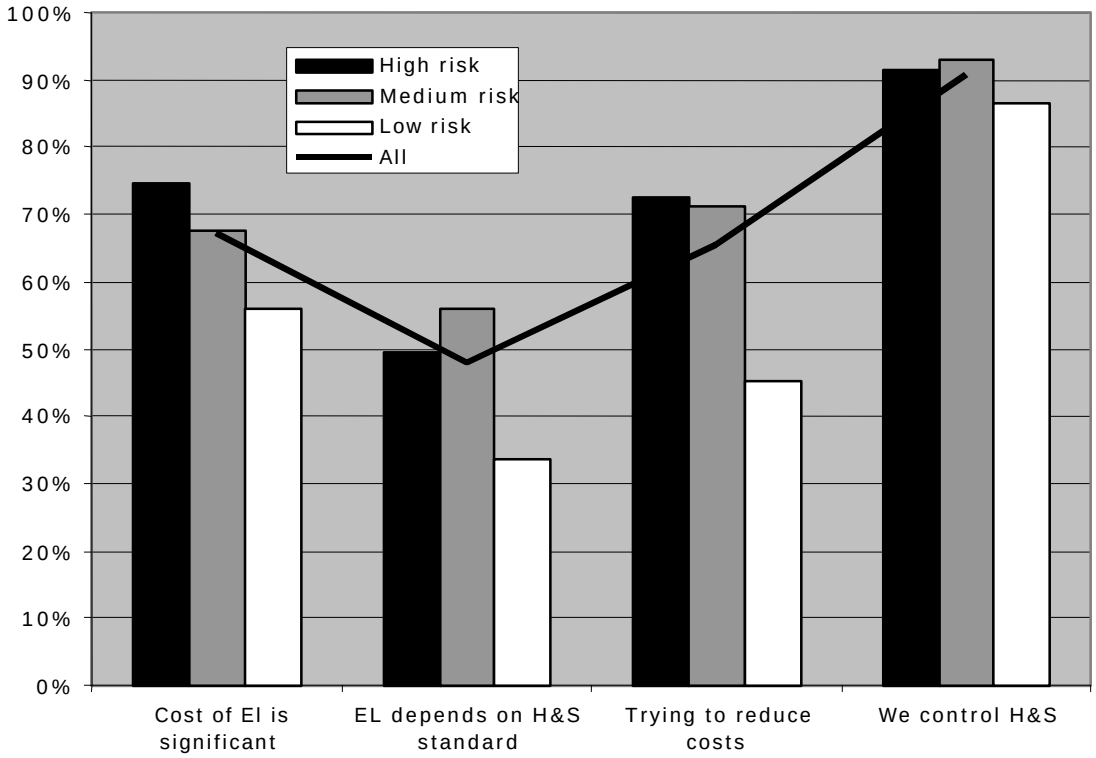
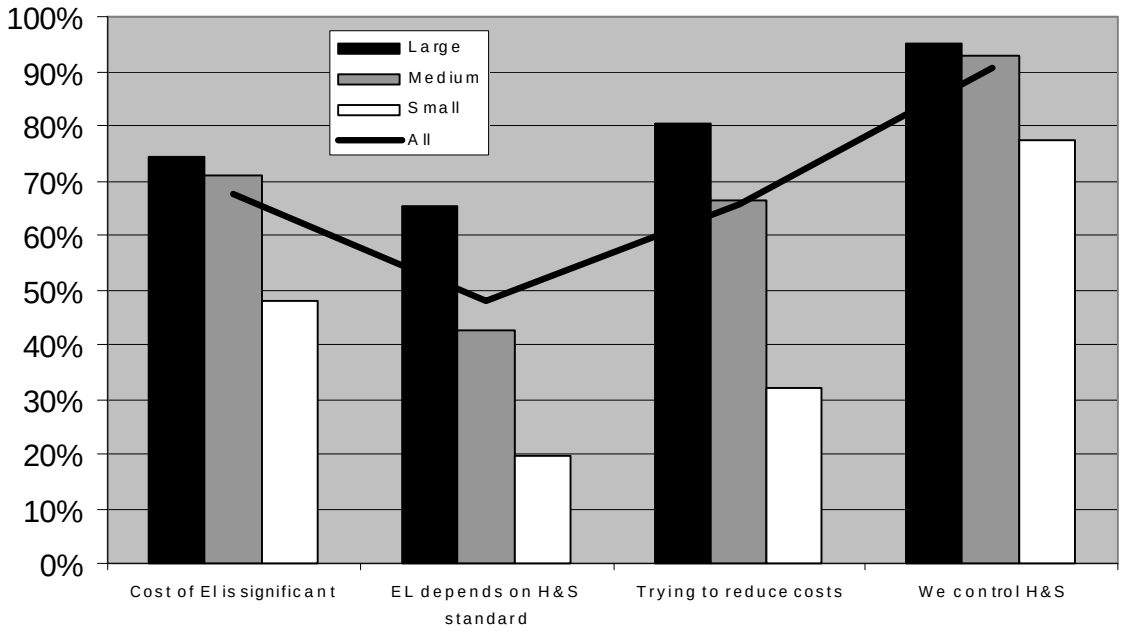


Figure 5: Firms' perception of EL & H&S



5.5.3 Correlation of size and EL cost with responses

Two sets of Pearson product moment correlations have been calculated, namely;

- Correlations between company size and responses to questions 5 to 15, and;
- Correlations between the reported cost of employers' liability and responses to questions 5 to 15.

Company size is represented on a scale of 1 to 5 where:

1 = under 10 employees
2 = 11 to 50
3 = 51 to 200
4 = 251 to 1,000
5 = Over 1,000

The annual cost of employers' liability is represented by a 5 point scale where:

1 = under £501
2 = £501 to £1000
3 = £1,001 to £10,000
4 = £10,000 to £100,000
5 = Over £100,000

All "unsure" responses were excluded from the answers for the cost of employers' liability.

The correlations are shown in Table 5 and Figures 6, 7 and 8.

The statistical significance of these correlations can be judged as follows:

- Those correlations that exceed +/-0.09 are statistically significant at p = 0.05, i.e. there is a 95% confidence that these correlations are statistically significant.

- Those correlations that exceed +/- 0.115 are statistically significant at p = 0.01, i.e. there is a 99% confidence that these correlations are statistically significant.

In Figure 6 to 8 a dotted line is shown that corresponds to a correlation of +/- 0.09. Any of the plotted correlations that fall above or below these dotted lines are considered to be significant.

The strength of these correlations can also be judged by comparison with the following scale:

R	Meaning
0 to 0.19	A very low correlation
0.2 to 0.39	A low correlation
0.4 to 0.69	A modest correlation
0.7 to 0.89	A high correlation
0.9 to 1	A very high correlation

It may be noted that:

- There are low but significant correlations between the number of employees / cost of EL and the perceived significance of the cost of EL, the dependence of EL of H&S standards and attempts to reduce EL costs.

    ⇒ Larger firms and firms with higher EL costs are more likely to report that they are trying to reduce EL costs, that the cost of EL depends on their H&S performance, that EL is a significant expenses and that they control H&S performance.

    ⇒ The strongest correlation is between company size /cost of EL and attempts to reduce the cost of EL. The greater the cost of EL, the more likely that firms are trying to reduce this cost.

- There is a very low (but significant) correlation between the number of employees / cost of EL and the attitude to rehabilitation.

    ⇒ Larger employers are more likely to agree that people should get rehabilitation before compensation and that employers should pay for rehabilitation.

    ⇒ Larger firms are less likely than smaller firms to wish to insure for the cost of rehabilitation or to agree to a 20% increase in EL costs to pay for rehabilitation or H&S advice.

- There are even lower and fewer significant correlations between the number of employees / cost of EL and the perceived impact of a no fault scheme.

    ⇒ Larger employers are less likely to believe a no fault scheme is fairer for employees but they are more likely to believe it will lead to more claims and increased EL costs.

    ⇒ There is no significant correlation between the cost of EL and the perceived impact of a no fault scheme.

    ⇒ There is no significant correlations between the size of a firm and the perceived impact of a no fault scheme on legal costs and fraud.

Table 11: Correlations between cost of EL, company size and responses

	Number of employees	Cost of EL
Perception of cost of EL & control of H&S		
Cost of EL is significant	-0.16**	-0.33**
EL depends on our H&S standard	-0.29**	-0.24**
We're trying to reduce EL costs	-0.38**	-0.43**
We can control H&S	-0.19**	-0.20**
Attitude to rehabilitation		
People should have rehab before compensation	-0.17**	-0.11*
Don't award compensation without rehab	-0.02	0.03
Employers prefer to insure for rehab	0.18**	0.14**
Employers should pay for rehab	-0.17**	-0.09*
We'd accept 20% cost increase for H&S support	0.18**	0.11*
Impact of no fault		
Fairer for employees	0.11*	0.07
More claims	-0.11*	-0.08
Reduce legal costs	-0.03	0.02
More fraud	-0.06	-0.04
Increase El costs	-0.10*	-0.07

Those correlations that have a * are significant at p = 0.05 (i.e. we have 95% confidence that these correlations are significant). These correlations that have ** are significant at p = 0.01 (i.e. we have 99% confidence that these correlations are significant).

Figure 6: Correlations of size & cost to perception of EL & H&S

Negative correlation means as firms increase in size or EL cost, more agree with each statement
Postive correlation means as size or EL cost increases, fewer firms agree with the statement

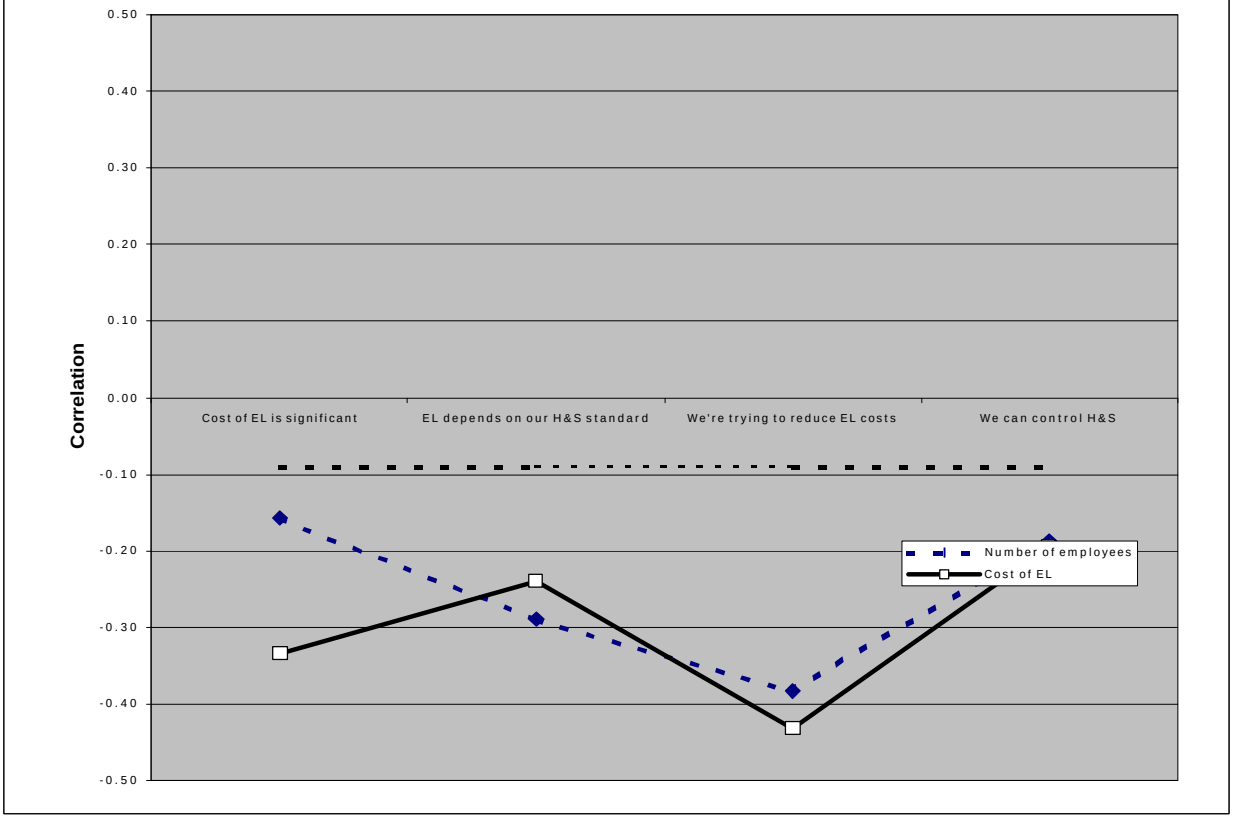
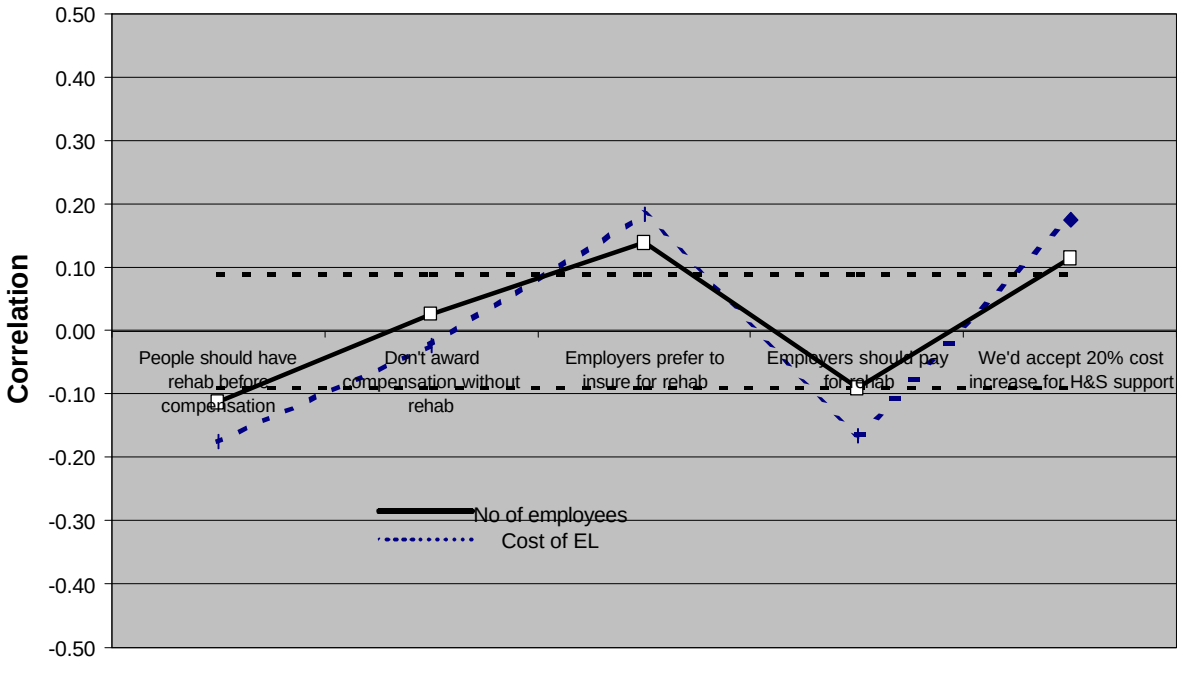
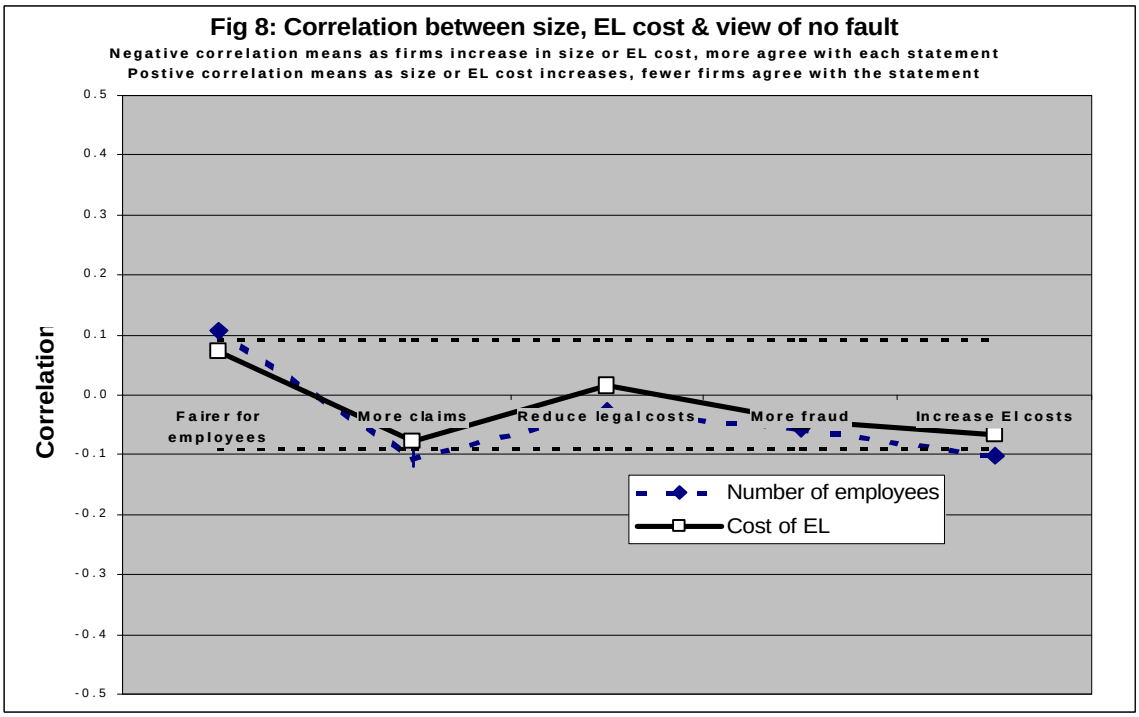


Fig 7:Correlation of size & EL cost to rehabilitation attitude

Negative correlation means as firms increase in size or EL cost, more agree with each statement
Postive correlation means as size or EL cost increases, fewer firms agree with the statement





5.5.4 View of rehabilitation

Figure 9 presents employers' familiarity with IIDB and how to access rehabilitation services. It is apparent that:

- Familiarity with IIDB, how to access rehabilitation services and actual access to health and safety advice is linked to company size – with familiarity and access with familiarity at least twice as high amongst large firms.
- A small minority of small and medium sized employers are familiar with IIDB and how to access rehabilitation services.

Figure 10 presents employers' attitudes towards rehabilitation. It indicates that:

- A majority of employers agree that employees should receive rehabilitation before compensation is agreed and that compensation should be withheld if employees refuse suitable rehabilitation.
- A majority of employers would prefer to insure for the costs of rehabilitation.
- Whilst slightly more than half of all employers agree that they should pay for rehabilitation, less than half of small employers agree that they should pay for rehabilitation.
- Very few employers would accept a 20% cost increase in EL to pay for health and safety advice. Indeed, less than 5% of large employers would accept this.

Figure 9: Firms' familiarity with IIDB and access to rehab / H&S

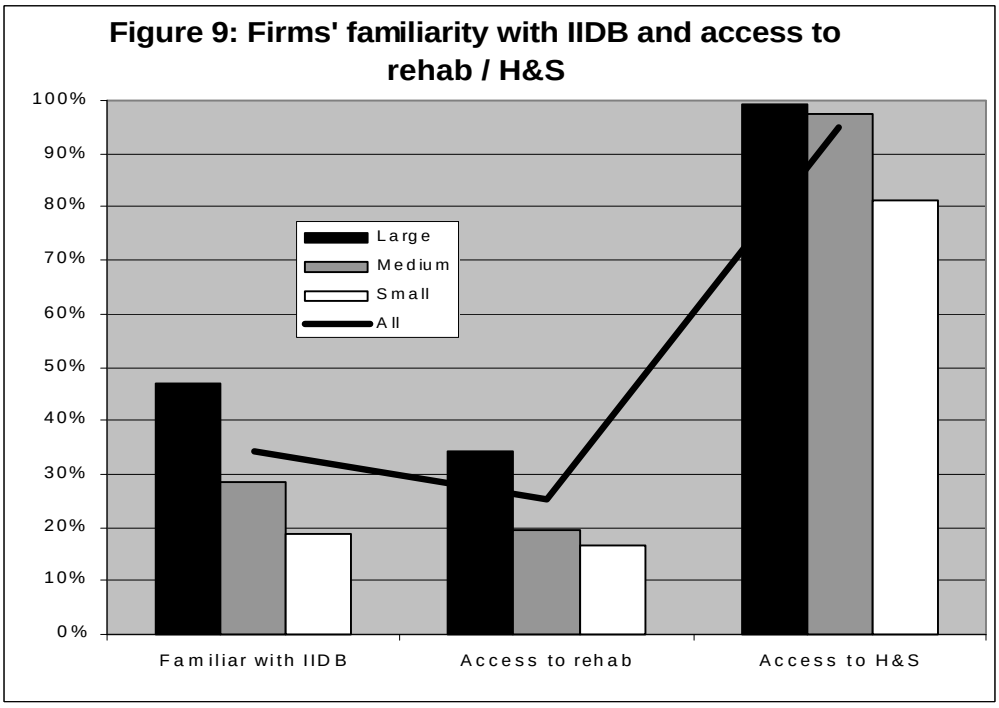
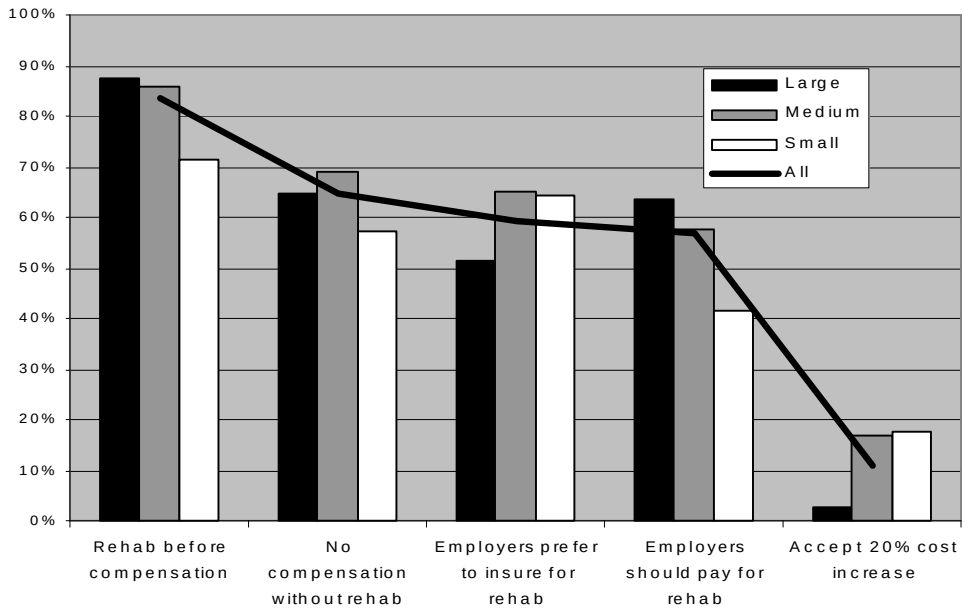
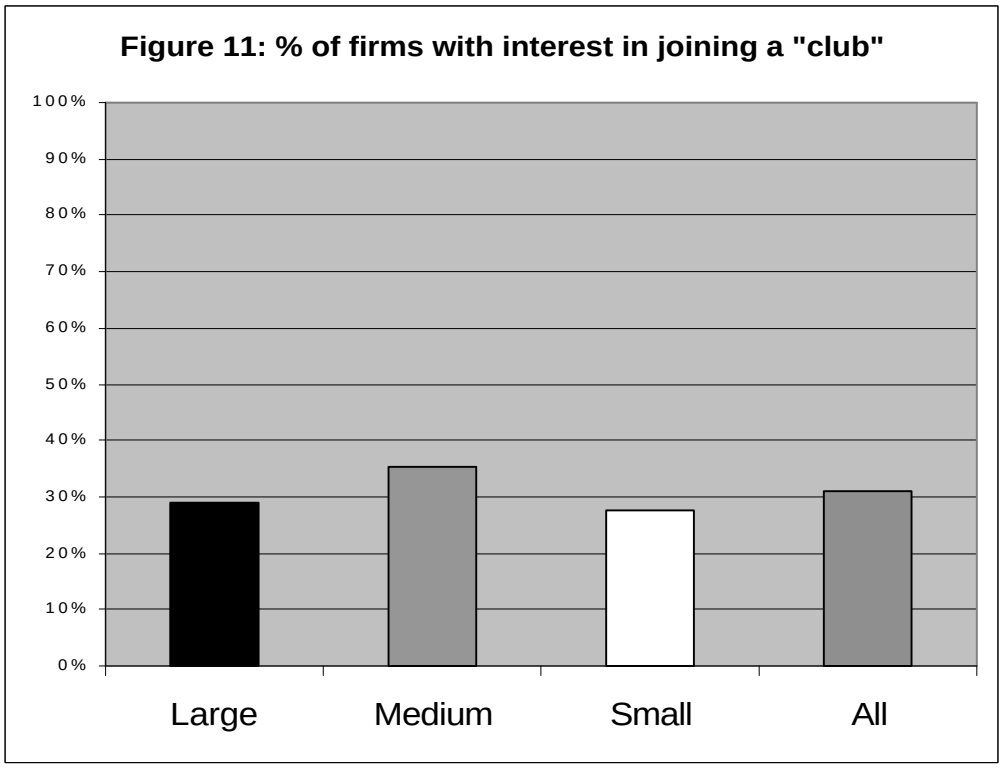


Figure 10: Firms' attitude to rehabilitation



5.5.5 Interest in joining a club

Figure 11 presents the per cent of respondents who say they would be interested in joining a "club" of firms that are in the same line of business who would receive cheaper health and safety support and whose EL premiums would rise or fall in line with the number of claims made by the club. About one third of respondents expressed an interest in joining such a club. There is little variation between sizes of firms.



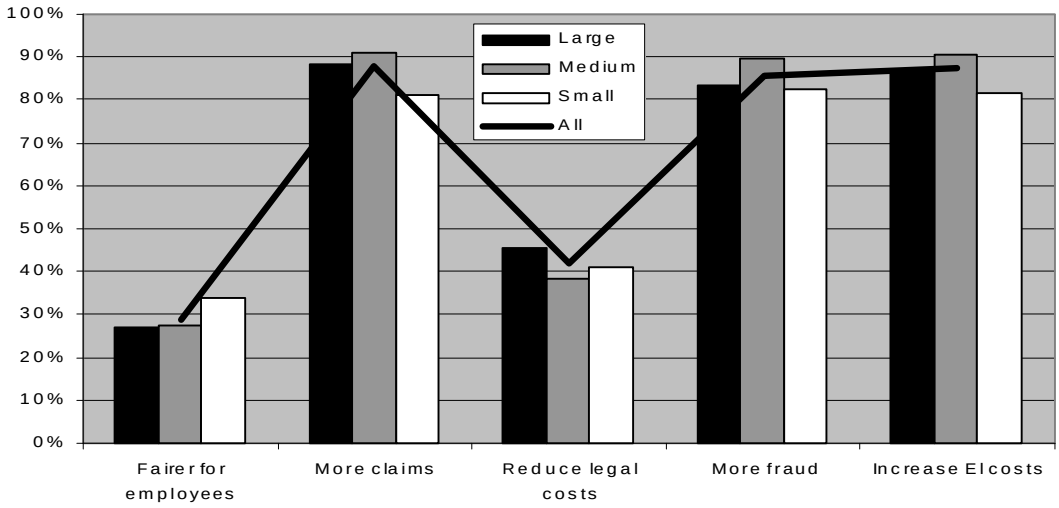
5.5.6 Perception of impact of a no fault scheme

Figure 12 presents employers' anticipation of how a no fault scheme would impact on claims. There is a high level of agreement between employers of all sizes on most questions. They anticipate that a no fault scheme would:

- Lead to more claims, more fraud and increased EL costs, and;
- Not be fairer for employers.

Opinion is split on whether it would reduce legal costs.

Figure 12: Firms perception of impact of a no fault scheme



5.5.7 Response to a large increase in cost

Figure 13 presents employers' reaction to a large increase in the cost of EL and the prospect of a 50% rebate /surcharge. The results indicate that:

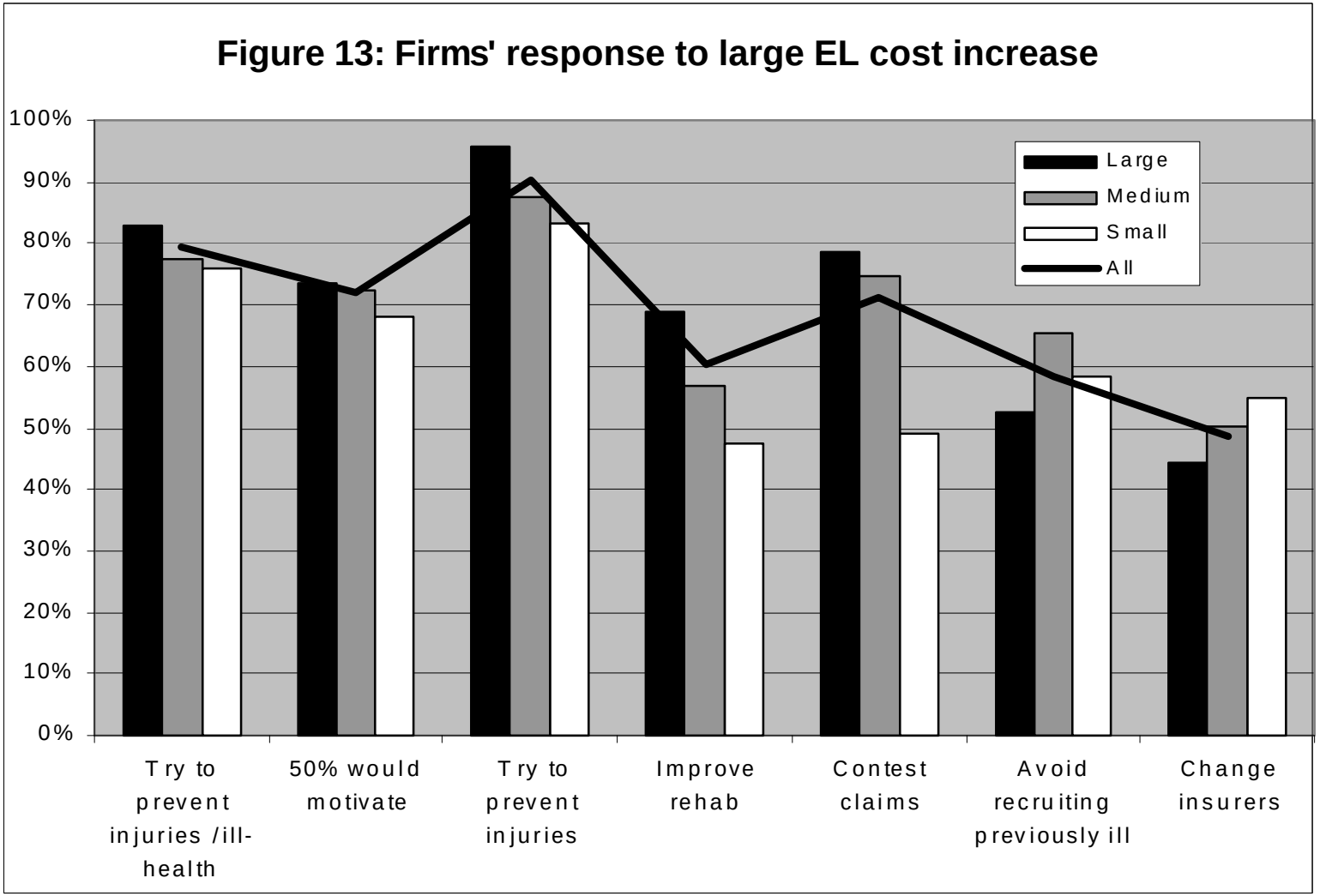
- The vast majority of employers would try to prevent injuries and ill-health if they thought that an increase in claims would lead to a large increase in EL costs;
- The vast majority would be motivated by the prospect of a 50% rebate/surcharge to try to improve health and safety management.

If the cost of EL did increase a lot, the majority of employers would try most of the available options to reduce the cost of claims. These are, in rank order:

1. Try to prevent injury and ill-health;
2. Contest claims;
3. Improve rehabilitation and avoid recruiting people with prior injuries / ill-health;
4. Change insurers.

Small firms are less likely to try to contest claims, whilst small and medium sized firms are less likely to try to improve rehabilitation.

Figure 13: Firms' response to large EL cost increase



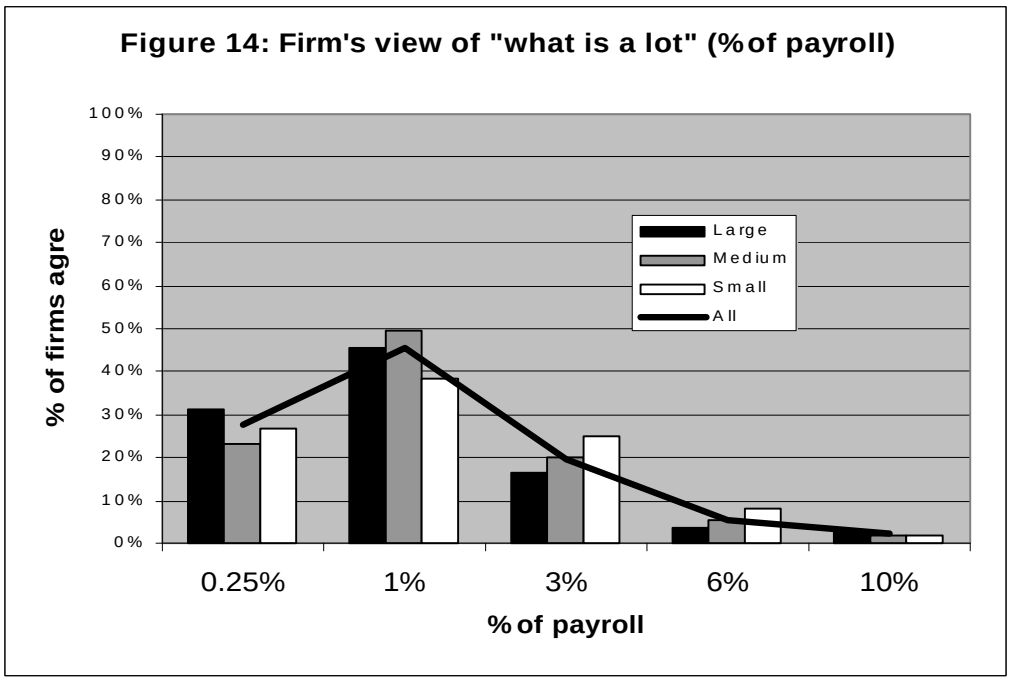
5.5.8 What is perceived to be "a lot"?

Figure 14 presents respondents view of how much EL would need to cost as a percent of payroll for it to be "a lot".

The results indicate that:

- Slightly less than one third think "a lot" as being 0.25% (the current cost of EL);
- Almost half think "a lot" as being 1% (the combined cost of IIDB, NHS costs, EL):
- One fifth think "a lot" as being 3% (the cost of injuries if the subjective value of pain ad suffering is included):
- Less than 10% think "a lot" as being higher values (i.e. 6% or 10%).

Thus, most (about 70%) respondents regard costs of 0.25% to 1% to be a lot, i.e. costs above this are more than "a lot".



6 DISCUSSION OF RESEARCH FINDINGS

6.1 INTRODUCTION

This section of the report provides a comparison of the findings from each part of the research study, namely the review of UK research, review of overseas practices and the survey of UK employers. The aim is to draw out the common findings and thereby provide an indication of the strength of research on each point.

6.2 COMPARISON OF RESEARCH FINDINGS

6.2.1 The importance of employers' liability insurance

The finding that the cost of EL is perceived to be a significant business expense is inconsistent with other studies, none of which report that EL is a driver for health and safety in all but a few firms. Indeed the cost of insurance is rarely mentioned as a driver for health and safety in any respect in studies soliciting unprompted reasons for improving health and safety.

In addition, whilst respondents indicate that they regard the cost to be significant, less than a third regard 0.25% of payroll (the current average cost of EL) to be a lot.

6.2.2 Awareness of IIDB

The low level of awareness of IIDB is consistent with the lack of mention of IIDB in previous research studies on the motivators for health and safety management amongst employers.

6.2.3 Access to rehabilitation

The low level of awareness amongst employers of how to access rehabilitation is consistent with other UK research studies. These studies suggest that rehabilitation is not a priority aspect of occupational health and safety management.

It is also consistent with research that suggests that there is a relatively low level of provision and uptake of rehabilitation in the UK compared to other developed countries.

6.2.4 Reaction to an increase in costs

The finding that employers would pursue a range of strategies to reduce employers' liability costs is consistent with overseas experience and research. That is, overseas research indicates that employers use a combination of "legitimate" strategies such as improving health and safety management, and strategies such as contesting claims. This is consistent with the results of this survey.

The finding that most UK employers regard costs of 3% or more to be “a lot”, also accords with overseas research. That is, overseas research indicates that when the average cost exceeds ~3%, employers on the grounds of fairness and affordability oppose this. This leads to a “reformist” or adversarial response to an increase in cost, whereby employers aim to reduce costs by reforming the system or by contesting claims rather than improving health and safety.

This finding is also consistent with overseas research that suggests that workers’ compensation costs of about 2% to 3% is enough to motivate employers to reduce claims by improving health and safety management.

6.2.5 Impact of a rebate/surcharge

The finding that employers would be attracted by the prospect of a 50% surcharge/ rebate is consistent with overseas experience and research. It is pertinent to note that the amount by which premium can be adjusted varies between countries. In some cases a simple multiplier is applied (relatively to the average number of claims in a class). In other countries the level of adjustment is limited to (for example) 25%. The results of this survey are consistent with the feedback from other countries that a limited surcharge or rebate is adequate to motivate employers.

6.2.6 Encouragement of rehabilitation

There is little overseas research regarding the impact of increased insurance costs on the uptake of rehabilitation. Therefore, it is difficult to judge whether the reported adoption of rehabilitation as part of a cost control strategy has occurred overseas. However, a number of studies report that there is a higher level of rehabilitation in other countries.

6.2.7 Impact of a no fault scheme

The perception that a no fault scheme would increase claims, cost and fraud without reducing legal costs is consistent with the perceptions and experiences of employers in other countries.

6.3 DISCUSSION OF IMPLICATIONS FOR THE UK

6.3.1 Attitudes towards rehabilitation and IIDB

It would appear that employers and insurers are open to the idea of increased rehabilitation and hence that this is an area of potential development, especially as few firms are familiar with how to get rehabilitation.

6.3.2 Impact of an integrated scheme

The results of this survey have clear implications for which costs would need to be included in an integrated scheme for the cost to be perceived to be “a lot” by employers.

It was reported earlier in this report that merging IIDB and EL with NHS and other tangible costs currently incurred would cost about 1% of payroll, whilst adding the cost of pain and suffering would raise this to about 2.5% of payroll. As the majority of employers report that 0.25% or 1% is "a lot" this implies that it might only be necessary to integrate "tangible" costs such as state benefits, NHS costs and EL costs into a single scheme for the cost to act as a driver for most employers. Alternatively, the transfer of work related traffic accident insurance to an integrated scheme would also raise the cost to about the same level. However, these findings suggest that it is unnecessary (from the point of view of motivating employers) to include both the costs of work related traffic accidents and the tangible costs of state benefits etc within an integrated scheme, with respect to raising "headline" costs to "a lot".

The inclusion of the "intangible" value of pain and suffering would raise the cost of employers' liability to a level (about 2.5%) that exceeds what is perceived to be "a lot" by most employers (i.e. 0.25% to 1%). A minority of employers reported that costs exceeding 1% are "a lot", suggesting that this may exceed the level needed to act as a driver for most employers. It is pertinent to note that employers in other countries have challenged the affordability of workers' compensation when it reaches about 2.5% to 3% of payroll. Such concerns have been associated with employer attempts to have the scheme reformed in other countries.

In considering the cost of any scheme it should be noted that if the cost reaches or exceeds "affordable" levels employers may seek alternative ways of reducing costs, such as contesting/suppressing claims and political lobbying for reforming the scheme, rather than trying to improve health and safety. This is lent some support here wherein many employers indicate that they would try to avoid recruiting people who have been previously ill or injured, contest claims and change insurers, as part of their strategy for reducing premiums.

For cost to be a motivator it is clear that employers need to feel that their actions have a major influence over those costs. This means that, for any scheme, it is necessary from a motivational perspective that:

- Costs are related to the safety performance of specific firms, and;
- Changes in costs are not dominated by events beyond the control of the employer, such as trends in employee tendency to claim, rules for allowing claims, changes in levels of compensation for injuries, etc.

This indicates that for a no fault scheme to act as a motivator for employers to improve health and safety, it would be necessary to have administrative controls in place to contain the number and cost of claims.

This also raises the matter of SMEs to the fore as there are practical difficulties in relating claims to their individual safety performance, due to their lack of claims history. Special schemes and arrangements are required in the case of SMEs, such as "clubs".

6.3.3 Would a performance related rebate/surcharge be useful?

It is clear that performance related rebate/surcharges have a significant and broadly positive impact on employer behaviour. In the case of smaller firms, who lack a reliable individual claims history, special arrangements would be needed to allow the operation of a surcharge/rebate.

6.3.4 What if a no fault scheme was to be introduced?

The finding that 1% or more is a lot implies that it is not certain that a no fault scheme is required to facilitate an increase in claims (and hence costs) for the purpose of motivating employers, as the cost of integrating current schemes would reach this threshold. However, the IIDB and EL schemes operate on a no fault and fault basis respectively. This raises the question of whether claims currently entered under each of the two schemes would need to be treated on a "fault" or "no fault" basis.

However, UK employers do fear that a no fault scheme would lead to increased costs, fraud and claims. It is clear from research and experience in other countries with no fault schemes that employers can fear that the cost of claims is related more to changes in the legal system and the tendency for people to claim than their management actions. It has been necessary to "cap" no fault scheme costs for the purpose of maintaining affordability and containing concerns about "out of control" claims costs. The results of this survey reinforce the proposition that cost controls would be required, if a no fault scheme is introduced, to allay employers' fears.

7 INSURERS' FEEDBACK ON FEASIBILITY OF OPTIONS

7.1 INTRODUCTION

This aim of this part of the research was to obtain feedback from insurers and providers of rehabilitation on the feasibility of the emerging options. This section reports the outcome of a second round of interviews with the Association of British Insurers (ABI), representatives from several insurance companies providing employers' liability policies, one provider of case management services for rehabilitation and the Department of Work and Pensions.

As this section pursues options raised earlier in the report, the interviews with insurance companies cover some of the issues discussed in Section 4 (Consultation with UK insurers). However, the focus here is on feasibility and implementation.

The issues discussed were:

- Linking premiums to health and safety
- Clubs
- Rehabilitation
- No fault schemes
- Merging the Industrial Injuries Disablement Benefit Scheme (IIDB) and Employers' Liability (EL)
- Best practice model
- Pay as you go
- Blue sky ideas

Interviewees were asked for their views on the feasibility of these ideas and for some initial ideas on implementation. Occasionally new ideas emerged and these were also taken on board and reported here.

The section begins with some background comments on the context of the interviews, followed by the key points and then an integrated summary of the interviews.

7.2 BACKGROUND COMMENTS

It should be noted that there were a number of reasons for uncertainty in the EL market whilst these interviews were carried out.

There is a general consensus that premiums have been far too low, the business "model" relying heavily on investment returns to cover costs. An acceleration in the drop in investment income has therefore threatened the economic viability of EL as it is currently marketed. This has been exacerbated by aggressively competitive behaviour in this market. There is also a realisation that many liabilities for long-term latent illnesses far exceed the premiums charged at the time diseases were contracted. These pressures have contributed to recent high profile bankruptcies in the industry.

It also pertinent to note that the interviews were carried out during the general post 11 September 2001 uncertainties. Specifically, insurance companies were threatening to exclude terrorist attacks from EL and motor insurance, and so new terms for policies have been delayed. Insurance companies would like to see a model similar to that known as PoolRe provided for property and business interruption caused by terrorist attacks. Under this system insurance companies provide the insurance product. Pool Re is a mutual reinsurance company with whom the government has an agreement to cover peak exposure above the financial resources of the insurance and banking sectors. Concurrently to these interviews therefore discussions about employers' liability between the insurance industry and government were underway.

7.3 KEY POINTS FROM THE INTERVIEWS

General

Everyone agreed that EL needs reforming and all are open to new ideas.

Rehabilitation

All were very supportive of rehabilitation. All felt there was enough evidence in the UK, even if anecdotal, to convince them there was a cost benefit as well as a moral case.

There was a mixed view of whether there was adequate service provision for rehabilitation.

All were open to the idea of rehabilitation being compulsory and paid for from insurance, but suppliers of rehabilitation need to be amenable to this. All felt that employers should have more responsibilities for rehabilitation.

No fault system

All were open to the idea of a no-fault system in particular because it helps with the provision of rehabilitation and reduces legal costs. An excess clause (e.g. 2 weeks salary of the injured person) could be a way to reduce any increase in small claims.

IIDB

There was general agreement that EL and IIDB should be merged, and most felt that if this happened it should be a no-fault scheme.

Ill health

Many occupational ill health conditions are considered to be uninsurable. Several insurers suggested that it could be paid for through a levy on premiums from a separate accident cover.

Linkage to health and safety performance

Larger companies already see the link between their premiums and health and safety performance, but this is hard to achieve for small companies. There are likely to be varying solutions appropriate for any particular firm/sector. Most agreed more could be done to assess performance. Suggestions for improving included:

- Pre contract questionnaire either by telephone interview or self-completion;
- Certification pass/fail by independent assessors;
- Certification/assessment of performance by independent assessors;
- "Clubs" based around new industrial developments;
- EL and state work related injury costs should be made more transparent, including that paid by the state through the NHS and benefits etc.

All agreed that more could and should be done to agree criteria on which to base discounting and management performance assessment.

Competition

All felt that competition reduced opportunity for discounting and surcharging.

Most thought that competition limited voluntary initiatives by industry

Working with others

All were happy to consider working with partners such as the TUC. Several suggested that insurers could do more with HSE, both to assist HSE in achieving its objectives and also to involve HSE in their discussions about reform and rehabilitation.

7.4 SUMMARY OF FEEDBACK

7.4.1 Linking premiums to health and safety performance

Pre insurance questionnaire

Most insurers thought that it would be feasible to develop pre-insurance questionnaires to give improved information on management performance prior to setting premiums. For small firms it would not be cost effective to have health and safety professionals carrying out pre-insurance interviews. However, it was thought that a simple, carefully thought out, telephone questionnaire could elicit useful information. One insurer currently administers a pre-insurance telephone questionnaire to SMEs. On average this takes 7 minutes, and although its focus is not on health and safety it demonstrates that useful information can be gained in a relatively short time. Similarly, a self-completion questionnaire could become part of the contract.

Survey Visits

SMEs' premiums usually mean that survey visits cannot be justified, certainly not at a pre-insurance stage. One insurer specialising in this market does do surveys where they consider the risk more elevated, either because of the industry or because of a poor claims history. This is carried out whilst the policy is in force and its purpose is usually to advise on health and safety, rather than alter premiums. There was scepticism about whether this could be used to alter premiums.

MOT/Certificate of health and safety performance

Several insurance companies were interested in exploring the idea of an independent organisation carrying out an assessment of the business – RoSPA was mentioned as an example. This is in part motivated by the insurance industry's poor public profile. Insurance companies fear that if they impose surcharges on a company this is likely to be perceived as an underhand profit-making device. An independent assessment of performance would militate against this.

The idea was that, like an MoT on cars, businesses should have responsibility to have an approved assessment carried out. One felt it should be a "pass/fail" type assessment but another thought it should be a statement of health and safety management performance. The latter would allow insurance companies to adapt their offer accordingly – either varying the premium or requiring specific health and safety measures to be taken.

Management performance assessment tool

Several insurers suggested a need for a universal tool where the key criteria for management performance assessment are agreed. The weighting of criteria could be varied allowing insurance companies to compete on discounts (or surcharges).

There was general agreement that it would be useful to work on this. Insurers have attempted to develop criteria for specific safety issues (e.g. storage of flammables) and had begun work on a measure for health and safety performance generally, but this initiative has stalled.

Linking premiums to general risk management performance for SMEs

As in the first round of interviews all insurers pointed out that EL is normally contained within a package insurance product for small firms for property, fire theft, etc. EL is usually a small proportion of the total premium for such products. For example a whole package might only cost £1000 a year of which £100 only might be EL. This means both that the premium is a relatively small proportion of business cost, and that the EL premium cost is not actually apparent to the insured. Even a 10% discount wouldn't be noticed.

Given the invisibility of the cost of EL to SMEs one insurer thought that varying the total premium for the package insurance might be more effective in motivating employers than varying EL premiums alone. This would promote a link between premiums and general risk management principles. Another insurer however thought

property liability was often a high proportion of the package cost and so it would become the primary driver, possibly to the detriment of health and safety performance. Should EL premiums rise enough to motivate employers, and the pricing of the package insurance product became more transparent (as most thought was possible to some degree), these problems may be overcome.

Limits on discounts

There was general scepticism about the opportunity to surcharge or to discount on the basis of health and safety performance. One insurer said that the market wouldn't tolerate surcharging, in part because of the poor "profiteering" image of the insurance industry. Another insurer said that both very low profits and the income still required for historic liabilities severely curtailed any opportunity to discount.

The competitive nature of the market also limits the scope for discounting or surcharging. There is a view that there are irresponsible underwriters in the market who will aggressively undercut on poor risks thus undermining any attempts to surcharge for poor performance.

A few insurers suggested that underwriters should be certificated for competence to counter this problem. There are concerns about the competence of underwriters who undercut on poor risks. In the long term they will not survive but the concern is that they distort the market in the meantime and reduce the opportunity for innovative discounts/surcharging based on assessment of risk. Another insurer felt this would have too high an administrative cost.

Another limiting factor restated in these interviews is that a proportion of most premiums are calculated to pay for historic liabilities such as asbestos related diseases. Premiums in the past were not (and could not have been) calculated assuming the risk of then unknown diseases. This limits the proportion of the premium that is available for discounting.

It also takes time for good risk management to lead to changes in behaviour. So, even if an organisation institutes changes as a result of pressure from the insurer, it is hard to financially justify giving a discount until changes have taken effect.

Another problem is the lack of a recognised standard for measuring management performance discussed above.

7.4.2 Clubs

A majority of insurers thought that the idea of forming clubs was interesting. However, there were few clear ideas about how this might be implemented. Two insurers were negative about the idea.

Current "clubs"

Several insurers pointed out that there is already a type of club in the UK related to the old mutual insurance companies. For instance a product is sold specifically for the security industry, premiums being set using claims data entirely from that industry's

record. One insurer selling this product includes requirements to belong to a trade association, and to have a system for vetting employees for criminal records.

One insurer noted that Chambers of Commerce might be considered an example of local clubs, though not linked to insurance.

Health and safety requirements for membership of clubs

Current "clubs" often involve relatively low risk industries and insurers do not normally impose requirements for health and safety performance on members. The rationale for setting up such clubs has been for marketing purposes, and therefore not seen as an opportunity to improve health and safety.

Some previous attempts to set health and safety requirements were reported by one insurer. For a period, some insurers refused employers insurance if pre-defined basics weren't in place, but it was reported that they lost business as a consequence.

What would clubs look like?

Because of the structure of the market in the UK all but one insurer felt that sector specific clubs only would be feasible. Two insurers were fairly negative about the idea. One felt very strongly that it would not be acceptable to have premiums based on pooled group performance with the loss of control over individual contracts that that entails. This interviewee was unable to conceive of any acceptable version of "clubs".

Only one thought that localised clubs might be feasible and they in practice would have to be limited to new industrial developments. This interviewee was previously involved with attempts to introduce localised products such as a product for a high street. To benefit from economies of scale "Members" were encouraged to jointly put in improved security, for instance. This product was not a success because (it was thought) of the difficulty of recruiting enough of a local group of employers into the same insurance product.

Providing health and safety advice to clubs

Most agreed SMEs generally need help with health and safety, but are resistant to paying for it.

Several insurers suggested that the insurance industry could probably do more to promote health and safety. Working in partnership with HSE in particular was mentioned several times by interviewees. Insurers were most interested in supporting HSE's industry specific priorities. Almost all insurers thought that this help should be limited to promotion, believing it impractical to reach small groups of small companies.

However, one insurer that specialises in SMEs is developing distance-learning materials, and does provide a range of surveys (including health and safety advice) even for very small companies where the risk is considered higher. One insurer commented that it may be harder to justify on cost-benefit terms the provision of occupational health support.

7.4.3 Rehabilitation

The case for rehabilitation

As in the first round of interviews, interviewees were unanimous that there is a strong social and moral case for rehabilitation as well as a business case. That it is an ABI priority agreed at the highest level probably reflects this consensus.

As far as those in the insurance industry are concerned, there is no systematic evidence for the benefits of rehabilitation in the UK. There is agreement that there is strong anecdotal evidence that rehabilitation is cost effective overall.

Culture change

Even the most traditional companies are now beginning to consider rehabilitation. But, there was however also strong agreement that there was still much work to be done to change culture both in the insurance industry and amongst policyholders. There has been some movement within the insurance world. However, the idea of providing rehabilitation before establishing fault is not accepted by all stakeholders.

How rehabilitation is paid for

At the moment rehabilitation is paid for in two ways. Normally it is incorporated into claims costs. In general it was said, rehabilitation will occur if the insurer knows there is likely to be a claim, but usually prior to establishing liability. For most companies rehabilitation tends only to be provided for the more serious accidents. Some products have been set up to provide a much broader range of rehabilitation services for all injuries and independently from insurance claims.

The insurer will fund the rehabilitation directly if they consider that this will alleviate the injury. Interviewees all insisted that the primary aim of such intervention is to optimise recovery, rather than reducing cost. However, it is generally thought that, taking all claims together, rehabilitation is likely to reduce the total cost of claims.

Another mechanism for payment for rehabilitation is through insurers' own rehabilitation organisations or in-house services. Rehabilitation is considered an administration cost and so not linked directly to a particular claim, although ultimately premiums do pay for it. This method of payment seems more likely to be applied if rehabilitation is not dependent on there being a claim. An advantage claimed for this is that it takes rehabilitation out of an adversarial context and makes it easier to intervene early and in a less adversarial context.

Availability of service providers in the UK

All but one insurer felt there were not enough providers. With one exception all felt that the numbers of case managers are increasing at an acceptable rate. The Case Managers Society (UK) has recently been set up. One thought that the UK is particularly bad at

spotting where intervention is useful. There may be a lack of people with a broader view of rehabilitation than the medical model.

There are gaps in medical and vocational service providers but as one interviewee pointed out, some rehabilitation will directly reduce the need for treatment by another service. For instance much of the rehabilitation provided already via insurance policies is for the treatment of non-urgent but incapacitating conditions within the private healthcare system, rather than waiting for NHS treatment. Only one company spoken to provided vocational rehabilitation, which they found was very popular. This is a more difficult area requiring much greater input from case managers.

Three respondents felt that services were springing up at an increasing rate and would respond to increased demand. The case management representative said that provision varied both by service (i.e. counselling, physiotherapy etc.) and to some extent by geography.

Aside from the level of provision there are some concerns about ensuring the competence of those providing services. Counselling was mentioned as an example of a service that is increasingly important in combating the rise in incidence of stress-related illness.

IUA/ABI Code of Practice[1]

The insurance industry has developed its own code of practice on carrying out rehabilitation. It covers the duties of the insurer and the claimant's solicitor as well as the rehabilitation assessment process. It is currently under review.

All welcomed this as a start though some commented that it was somewhat cumbersome and not written in a user friendly way. As a result, one respondent felt that it was probably not possible to implement the code in its entirety for any one case.

One respondent commented that there is a role both for employers and for case managers in rehabilitation and so it would be beneficial for those groups to be represented in developing the code of practice.

The ABI has plans to further promote this (see "Solicitors and Judiciary").

Solicitors and Judiciary

All reported that there is often resistance to rehabilitation from solicitors in particular, but that there is a growing awareness of the benefits to the claimant. There is some evidence that judges are starting to ask litigants whether rehabilitation has been considered before deciding on damages. It is thought that there have been cases where damage awards have been reduced because the claimant refused rehabilitation. This is anecdotal information only.

[1] International Underwriting Association and Association of British Insurers "Code of best practice on rehabilitation, early intervention and medical treatment in personal injury claims"

The ABI are planning more work to raise both solicitors' and the Judiciary's awareness of the IUF/ABI Code of Practice on rehabilitation (see above). The theory is that if judges request information about rehabilitation solicitors are more likely to take it seriously.

Ultimately Civil Procedure Rules (Lord Chancellor's Department) could be changed to require consideration of rehabilitation, but one interviewee felt that it could only be implemented successfully if rehabilitation was already widely accepted. Another thought this would only be tinkering with the problem.

Within the fault-based system it is likely that refusal of rehabilitation could only impact on a settlement if it could be shown that rehabilitation would have prevented a worsening of a condition. Even this is likely to be debateable.

Awareness

Everyone agreed that there was a generally low level of awareness of the rehabilitation services available. One company felt that their rehabilitation services were now well understood by their clients (larger firms) in England and solicitors, though they admitted it had been achieved by a lot of specific company targeted promotion work. They felt they had not advanced as far in Scotland where an office has more recently been established.

There was no consensus on what should be done to increase awareness – some felt that there was no point because of the lack of service provision. Another felt that it really shouldn't be down to insurance companies. Others thought that they should indeed be promoting it more and could overcome any difficulties with presentation.

One suggestion was that more should be done to reassure people that the payment for the injury itself cannot be removed by accepting rehabilitation, however successful that rehabilitation turns out to be. Any reduction in compensation is likely to be primarily in reduced loss of earnings payments. This could help increase acceptance and enthusiasm amongst employees/unions etc.

Practical problems

Everyone agreed that early reporting of an injury is key. Currently the main difficulty reported is receiving prompt notice of injuries from the insured. It was felt that this is probably a problem of internal company systems of communication. One insurer has successfully made this part of the contract and linked poor reporting to the premium.

Another practical problem has been all parties' lack of belief in the independence of rehabilitation services. In the adversarial system, there is concern that "the other side" might get information they shouldn't. Even if the company is dealing with both sides and therefore can't be called in court by either side there is still mistrust. This prompted two interviewees to suggest that solicitors should commission rehabilitation services. Insurance companies would still be able to link discounts to recognised rehabilitation services.

There were mixed views about whether more rehabilitation would lead to more claims. This is only likely where rehabilitation was only available when a claim has been made. Some thought that increasing claims was more a reflection of an increasingly litigious society than anything else.

There was no feeling that there would be medical confidentiality issues. The case manager representative said that they do not see medical records. They only receive reports from medical practitioners prepared specifically for them. They are bound by normal medical confidentiality rules as regards those reports. At present they only divulge all information to the injured party's solicitor on request, but have recently been advised that in the event of litigation they will have to divulge to the insurance company as well. The case managers actually felt that this would enhance their status as an independent in the process.

Suggestions for improvements

All agreed that it would help if employers were required to have a policy for rehabilitation. This should encourage better communications between senior and local management. Another advantage of this for insurance companies is that they would not be seen as the main driver for rehabilitation. The insurance industry is very wary of doing anything that makes them vulnerable to accusations of profiteering.

One insurer also suggested that it should be compulsory for the EL insurer to offer rehabilitation. No other interviewee suggested this.

Several commented that it was not necessary to have a direct link to employers' liability insurance. Rehabilitation could be offered as a separate product and benefit. This would detach it completely from the claim and so help distance rehabilitation from the adversarial claims process. Insurance companies could still offer discounts if employers bought a recognised product. It was noted that there is already a model; the company PPP offer such a product for injuries sustained in traffic accidents.

It was generally agreed that there should be some link between rehabilitation and benefit – that if it was refused there should be a reduction in payout for loss of earnings. As discussed this would probably not be possible in a fault-based system.

7.4.4 No fault schemes

All believed that this was a possible way forward but all expressed caution e.g. "it would need to be evolutionary, not revolutionary", "we're open to persuasion", and "detailed work on the costings should be done". There is recognition that there is waste in the system, and that EL should not be looked at in isolation. There is overlap, doubling of administration, doubling of compensation etc.

There was a comment that the no fault question was more a political question than a practical insurance one. All respondents thought that there would need to be a change in the law to accommodate no fault. The right to sue in all circumstances would have to be removed and made the exception in cases of EL; this has political dimensions.

As before, some insurance companies will admit that they tend to pay a majority of accident claims and injuries such as WRULDs (work-related upper limb disorders) without going to court because their experience is that usually the employer is at fault in some way. In effect then many claims are paid as if they were no fault so the role of solicitors is reducing. Insurers believe also that many forward-thinking employers would also welcome the elimination of a substantial portion of the legal costs (around 40% of EL costs).

Structured settlements (i.e. where payments and their timing are structured around the needs over time of the injured party) that can be reviewed should also be incorporated. They have a potential of being much fairer. Currently the lump sum is based on an estimate of how long it will take to recover – this is agreed by negotiation between the solicitor and insurance company at the time of the claim. Ideally the injured person should receive appropriate income for as long as they suffer incapacity caused by the injury in question and structured settlements can provide an opportunity to ensure this.

A no fault system would also help with rehabilitation. Since fault is not an issue, there would be little problem linking benefit to rehabilitation (i.e. no benefit before rehabilitation). Also reduction in adversarial nature of the process is likely to reduce resistance to rehabilitation.

Possible problems

There was general agreement that bringing in a no fault scheme would probably lead to an increase in claims, although there was disagreement about the extent of the increase. Some felt this would merely marginally accelerate a current trend. Most thought that the majority of any increase in claims would come from minor injuries where full recovery is likely within two weeks. It was suggested therefore that such an increase in claims could be mitigated by imposing a "two-week franchise" (i.e. an excess of two weeks of the injured person's salary). Some felt that the savings in legal fees would significantly offset the costs of any extra claims in any case. The cost of EL may therefore not increase and industry would continue to bear most of the tangible cost of these injuries.

The Law Commission published a report in April 1999 which recommended that higher courts should exercise their powers to issue guidelines on increasing damages for pain and suffering (known as "pain, suffering, loss of amenity" or PSLA). In response higher courts have decided that some increases were required. Some insurers commented that the practicality of funding this would need to be considered if a no-fault system was implemented. In general it was thought that there should be some sort of tariff system, though to be fair to claimants it probably would need to have some flexibility built in.

A no fault system will not remove all difficulties, particularly for claimants suffering from diseases with long latency and multiple causes. It can be difficult to prove that some diseases such as stress-related illnesses are work-related. Insurance companies are winning many cases of newer diseases by showing that causes are not work related. Other risks are not yet properly understood such as the use of mobile phones or deep vein thrombosis (DVT) etc.

Although all were enthusiastic that a no-fault scheme should be seriously considered, some insurers pointed out that there would be implementation difficulties. Some had particular concerns about predicting the level of claims likely under a no fault scheme. In contrast, however one insurer was confident that this was unlikely to be a significant problem, suggesting that a study comparing accident book data with actual claims would give insurers adequate information on which to base premiums in the first instance. Lessons could also be learnt from others who have made the transition such as Belgium and Hong Kong.

Another insurer pointed out that in any transition new entrants who had no historic liabilities may have an unfair advantage, and consideration should be given to this.

There was agreement that however simple a new system was, claimants would still need some form of representation. In many cases this need not be a solicitor, but there will be instances where claimants require advice from a solicitor, for example, on the quantum of damages or where the work-related nature of the injury is being challenged.

7.4.5 Merging IIDB & EL?

There was general agreement that there is a significant overlap between IIDB and EL, particularly in administration costs. There is therefore real scope for increasing overall efficiency.

Several insurers also pointed out that the state in effect heavily subsidises employers via IIDB, NHS and emergency services etc. Opinion generally was that employers should be made more aware of this. Several commented that NHS costs could easily be incorporated into claims payments. However it was pointed out that this is likely to be slightly less efficient overall as legal fees are calculated as a percentage of total final awards.

Most insurers thought merging the two systems would address some of these issues. This would require either EL to change to no-fault, or IIDB to change to a fault based system. All thought that the merged scheme ought to be a no-fault system but it was acknowledged that this opinion was based on a view about fairness to IIDB claimants, rather than any practical insurance reasons. IIDB claimants would be disadvantaged if they also had to prove fault.

It was agreed IIDB could also simply be privatised in its current form, but this would not really address any of the problems of duplication etc. On a practical level, insurers would prefer not to pay benefits but rather stick to the EL system for payments.

The ABI position is that they would welcome a debate on how insurance companies could provide IIDB but at present take no position on it.

7.4.6 Best practice model

There was agreement that in the current climate there is a general willingness to work together. What is more, it is thought that a consensus is building amongst stakeholders about the inadequacies of the current system – TUC, Government, insurance companies, employers, providers etc.

Interviewees all felt that a strong government lead would assist the industry to overcome some of the problems of competition and work together to develop its thinking and agree common standards. It should involve all stakeholders but may wish to consider bilateral discussions at first.

One interviewee was sceptical of the possibility of developing a generalised code of practice. He felt that variations within industry sectors would make that very difficult to achieve. He did however concede that it might be possible to agree a broad framework. A barrier to partnership working he also thought may be the perception that common standards reduce competitive opportunity. For instance if rehabilitation were optional this could be a selling point for a company, but if it were compulsory it would be harder to exploit in this manner.

The majority mentioned competition as a barrier to agreeing common standards and several added that the Competition Act would also create difficulties.

7.4.7 Pay as you go

Pay as you go is a system where insurers are responsible for settling claims made in the year of insurance. This certainly reduces the risks to insurance companies, but there was little interest from insurers. Under such a system other arrangements are needed to pay claimants whose claims arise from illness or injury apparent only after their employer has gone out of business. This would have to be dealt with some other way, such as a no fault fund paid for by a levy on premiums.

One insurer thought that there were difficulties with setting premiums on a "claims-made basis" i.e. premiums set based on what has been claimed in the year before. His view was that this would leave insurance companies vulnerable to large payouts for injuries caused in the past, and with no premium income to cover this. It is likely that an insurer would withdraw cover if it could predict large future claims arising from latent diseases.

7.4.8 Blue sky ideas

There were many references to the system in New Zealand (possibly explained by a recent visit to the ABI by representatives from New Zealand). Interviewees were particularly impressed by what a central system could achieve in prevention by having central statistics collection.

One commented that our system ought to reflect being part of Europe with a general preference for workers' compensation systems.

There is consensus that diseases are very difficult to insure. The majority of interviewees felt that long latency, uncertain diseases were not possible to insure.

One interviewee classified diseases into three groups:

1. Identifiable diseases with identifiable legal parameters (e.g. asbestos related diseases nowadays);

2. Identifiable diseases without identifiable legal parameters (e.g. RSI, stress);

3. Unidentifiable diseases (e.g. historically asbestosis).

Respondents thought that planning funding for compensation for the 3rd class of diseases above is very difficult if not impossible. The only suggestion was to build up reserves. However, it was thought that a large reserve for unidentifiable diseases might attract the attention of the Inland Revenue. This however has never been tested and because of the lack of funds in the EL market is not likely to be an issue in the near future.

Several suggested that one option would be to treat accidents and ill health differently for insurance purposes. The industry understands the risks associated with accidents and feels it could effectively insure providing a good service. From the premiums they could pay a premium/levy into a disease fund.

Disease could be no-fault or fault. No-fault would reduce problems of finding companies and apportioning blame. It would be less complex. A model involving government is the PoolRe model (described in the introduction to this section). The industry provides its own reinsurance by building up reserves in a mutual company. The state takes on the excess risk, and is only called upon to contribute if the reinsurance fund becomes exhausted.

A completely different approach suggested by one interviewee was to have insurance following the individual, in a similar way to a pension. The idea was that it would be in 3 parts: Part A covering work risks – paid for by the employer; Part B covering motoring risks – paid for by employer and employee; & Part C covering other non-workplace risks – paid for by both.

8 DISCUSSION OF OPTIONS FOR THE UK

8.1 INTRODUCTION

This section of the report aims to identify options for achieving the ideas arising from this study. At this stage we can only highlight options. The precise design, feasibility and value of these options would require further research. In particular, we have outlined:

1. Voluntary initiatives that do not require any regulatory changes – as per Action Point 5 of the HSC's Revitalising Health and Safety Strategy;
2. Reforms to Employers' Liability and IIDB schemes that would require regulatory change, and;
3. Replacement of Employers' Liability Regulations and IIDB with an entirely new form of employee occupational injury and ill-health insurance.

The third option does not use the current UK arrangements as a starting point. Rather, it aims to satisfy the latter day objectives of occupational injury and ill-health insurance, noting the focus on prevention and rehabilitation as well as compensation. There is an appetite for such a step change amongst stakeholders. This could comprise a "new start" that provided an integrated approach to achieving the goals of rehabilitation, improved health and safety and compensation. Such a scheme would benefit from considering the lessons learnt from our study of overseas systems.

Our ideas focus on how to re-orientate insurance arrangements to encourage improved occupational health and safety. They do not aim to consider issues such as "equity" or reduction in legal costs, except where these issues impact the aim of motivating better occupational health and safety. These issues would need to be awarded closer attention if any of the ideas are taken forward, along with technical and regulatory issues.

8.2 OPTION 1: ENCOURAGE VOLUNTARY INITIATIVES AMONGST INSURERS

8.2.1 A best practice model / approved scheme

Whilst insurers are pursuing a range of voluntary initiatives, there is scope for extension and room within the current regulatory framework for a more consistent approach. The HSE and other pertinent government bodies could, in collaboration with insurers and other stakeholders, develop and promote a "best practice" model for the response to work related injury and ill-health.

This model could be awarded a higher status and profile by operating a Government designed standard equivalent to the "Cheap Accessible Transparent" standard applied to private pensions. In the case of Employers' Liability insurance this could be (say) a "PRIL" standard, as follows:

P **Performance related –** premiums are linked to health and safety performance

R **Rehabilitation** is covered by the policy and is an integral part of the process

R **Responsible premium policy –** premiums cover all costs

I **Information** is provided on health and safety sources and services

L **Low cost** – non-contentious claims are handled without recourse to solicitors

Thus, such a best practice model or approved standard could cover:

- Rehabilitation;
- Claims processes;
- Surcharge/rebate arrangements, and charging transparency, and;
- Access to health and safety support.

It is important that an organisation such as the HSE takes the lead in developing such a model, if only because insurers fear accusations of collusion if they develop a common approach of their own accord. Ideally though, the model should be developed with the input of all key stakeholders, including:

- Insurers and brokers;
- The providers of rehabilitation and health and safety services, such as rehabilitation organisations, Case Management Society (UK), the Department of Health;
- The providers of health and safety services;
- Trade unions and other employee representation organisations;
- The Law Society, Lord Chancellor's Department;
- Employers' organisations, such as the CBI and IOD.

The model would need to be actively promoted by all parties. The promotion of such a model to solicitors, employers and employees would be vital because, as a voluntary model, its uptake would depend on the level of awareness and acceptance of the arrangements.

The possible scope of such a model is discussed below.

8.2.2 Rehabilitation

There are a number of important issues here:

1. To ensure timely rehabilitation;
2. To ensure that the process of seeking financial compensation does not inhibit the uptake of rehabilitation, and that trust is built between the parties;
3. To ensure that the responsible employer bears the cost of rehabilitation;
4. To ensure that the supply of rehabilitation can satisfy increasing demand, and;
5. To ensure that employer implementation of "good" rehabilitation policies is recognised within employers' liability premiums.

The current approach to gaining redress for work related injury and ill-health focuses on acquiring financial compensation for loss of earnings, loss of function and the cost of health care.

The model approach could include:

- An obligation on employers and employees to report injuries at the earliest opportunity to enable their timely assessment and treatment;
- The acceptance (by employers, employees, health professionals and solicitors) that injured parties would seek and accept medical assessment and rehabilitation prior to seeking a "final" financial settlement;
- The cost of rehabilitation being borne by employers as part of their employers' liability insurance premium, or as a separate insurance policy;
- Provision of rehabilitation being independent of there being any claim for compensation;
- Employers' liability premiums being discounted where "good" rehabilitation policies are implemented, and;
- Insurers offering rehabilitation insurance (and services if supplied) at the same time as offering employers' liability insurance and/or renewing EL policies.

Such a model would be assisted by the development of "standard" approaches to the assessment and rehabilitation of injuries and illness, particularly for common conditions such as muscular-skeletal injuries, stress and upper limb disorders. It would probably require an arrangement to be agreed whereby persons who are unable to work are provided with interim payments to cover loss of earnings and health care costs during the period of rehabilitation and prior to agreement or a final settlement. Ideally any injury that entails prolonged time off work would be assessed at the outset to ensure interim payments are agreed and are appropriate. Such a model would assist in the transparency of the process and go a long way to addressing the common concern that rehabilitation threatens the injured person's compensation.

This aspect of the model could be extended to cover the process of vocational resettlement (i.e. helping people gain new employment). This could entail:

- Including a vocational resettlement service within the "insurance" process, such that injured parties have access to a vocational resettlement service funded by insurance, and;
- Allowing for the potential earnings arising from vocational resettlement within the financial compensation settlement.

Such an approach would make compensation a secondary aspect of employers' liability whilst ensuring the responsible employer is liable for the costs of responding to a work related injury or illness.

There is some concern that promotion of rehabilitation by insurance companies will be seen as mere profiteering by the insurance industry. Consideration should be given to more visible and coordinated promotion by other organisations with an interest in

rehabilitation. Current initiatives by stakeholders such as the TUC, the Courts and the Department of Health should be encouraged.

8.2.3 Surcharge / rebates

Whilst many insurers operate surcharge/rebate schemes, they vary between insurers and many entail discretionary decisions by individual insurance representatives. A model approach could include the use of a "standard" and transparent set of surcharge/rebate arrangements.

The results of our survey of employers would suggest an arrangement that enabled a variance of up to 50% in premiums would be adequate. The rebate/surcharge would need to be implemented in a short enough time span to ensure employers recognise how their actions (in the foreseeable future) could influence premiums. A period of 2 to 3 years is suggested.

To address competition concerns, the standard arrangements could incorporate agreed criteria by which health and safety performance will be measured, without necessarily detailing the weighting given to each criteria by a specific insurer. To reach smaller firms information would have to be obtained by simple self-complete or telephone questionnaire. Practical criteria are therefore unlikely to give a very accurate picture for smaller firms, but carefully designed they could give a broad indication of performance.

Another option would be for an independent assessor to certificate an employer's health and safety performance. This would then form a key factor in the assessment of insurance premium. We consider this option to be over burdensome for smaller companies. It may however be possible to offer this as a service linked to insurance.

As regards linking EL premiums to rehabilitation performance, insurers could:

- "Load" premiums for firms without a model rehabilitation policy or access to rehabilitation services;
- Weight the severity (or duration) of injuries more than the number of injuries when assessing claims history.

8.2.4 Responsible premium setting

The model could include the requirement for "responsible" premium setting whereby premiums are set at a level that ensures that EL premiums (and investment income) are adequate in their own right to cover known and expected claims and related costs. The aim here is to ensure that the full cost of claims are passed to employers rather than "suppressed" by unsustainable price competition or "subsidised" by discounting in order to win other insurance policies. It would also avoid the scenario whereby premiums are raised in the future to cover accumulated deficits, with the effect of breaking the link between current performance and EL costs.

8.2.5 De facto no fault agreements

A number of de facto no fault arrangements exist for certain “common” conditions such as upper limb disorders. Also, some insurers work on what is effectively a no fault basis for “common” claims. The model could build these arrangements in for “common” work related injuries (except for exceptional large claims). Such arrangements could be limited to conditions, such as upper limb disorders, that are accepted to be a feature of a particular type of work.

As part of this, arrangements could be devised that minimised legal costs, such as enabling claimants to liaise directly with the insurance firm rather than via solicitors, especially for smaller and non-contentious claims.

Such arrangements would not necessarily eliminate legal proceedings where the extent of injury or size of compensation is disputed. This is not considered to be a problem. Indeed, no fault schemes in other countries allow dispute of the size of claims and whether they are work related (as opposed to related to domestic, personal, natural or other factors). However, legal proceedings are often restricted to claims of a certain size, to ensure that the costs of legal proceedings are proportionate to the claim.

8.2.6 Access to health and safety support

There is a variable approach to promoting occupational health and safety amongst insurers. The model could provide guidelines on the levels of service insurers can provide. This could include:

1. The provision of health and safety advice and support paid for from the insurance premium (appropriately increased to cover the cost of such support);
2. The provision of health and safety advice and support on a “pay as you go” consultancy basis;
3. Active referral to a provider of health and safety advice and support, whereby the insurer passes the employer’s contact details on to a third party (with the employer’s approval);
4. Advice and information from insurers on where and how an employer can acquire health and safety advice and support.

Insurers could declare what level of service they can offer whilst employers could be asked what level of service they require when they take out or renew a policy. Partnerships between insurance companies and other organisations (HSE, Trade Unions, Occupational Health projects, other safety organisations, ROSPA etc.) could be developed to enrich the services available. A minimum level of service, namely referral to a list of service providers, could be part of the model.

8.2.7 Helping smaller firms

Small firms have a number of particular needs. Firstly, due to their size it is difficult to base premiums on their individual claims history. Secondly, the cost of employers’ liability is often hidden when EL premiums are just one part of a “commercial” insurance premium. Thirdly, it is difficult to provide health and safety support at a cost

that is proportionate to the size of the firm and its EL premium (typically under £1,000 per year).

Options include the following:

- Setting up trade based "clubs" of (say) a few hundred regionally based smaller firms wherein a pooled claims history is used to adjust premiums. As part of this, low cost "basic" health and safety support could be provided, perhaps as a condition of being a club member.
- Setting up clubs based on new industrial developments
- Devising a set of safety management indicators amenable to self-reporting that insurers can use to adjust premiums for individual small firms.
- Stating the cost of Employers' Liability insurance within "commercial" insurance packages.
- Extending the insurance industry's effort in general promotion of health and safety. This could include more systematic partnership working between the insurance industry and other stakeholders, such as HSE and the TUC.

The survey of employers indicates that about a third of firms would be interested in joining a club, equivalent to about 9,000 medium and large firms and 350,000 small firms if this held true for all UK firms. If this was matched in any significant way by actual uptake it should provide a large enough "demand" for such clubs to be viable. However, this idea needs to be developed considerably. Insurance companies are sceptical since competition may make it impractical to set such clubs up. There is also some concern amongst insurers about losing control over individual contracts.

The pilot schemes run in Canada could be used as a template for UK schemes on how insurers can help SMEs.

8.2.8 Advantages and disadvantages of voluntary initiatives

The pursuit of voluntary initiatives within the current regulatory framework has the following advantages and disadvantages.

Table 12: Advantages and disadvantages of voluntary initiatives

Advantages	Disadvantages
Does not require any regulatory changes.	Organisations might not participate
It enables new ideas to be "tested" and iterated in a flexible manner – as opposed to being enshrined in a regulation that is difficult to quickly revise.	A low level of uptake would not generate sufficient demand for suppliers to provide services such as rehabilitation.
Enables innovation.	The current proportion of costs borne by employers' liability insurance may not be enough to provide a financial motivator for employers to participate.
A consensus approach would hopefully achieve higher levels of "buy-in".	Success would depend on the level of promotion and acceptance of the approach.

8.2.9 Encourage uptake of legal redress and rehabilitation amongst IIDB claimants

The IIDB scheme currently allows claims for any person who can demonstrate that their disability is work related. Whilst claimants are advised that they may have a right to legal redress against employers, claims are not actively scrutinised. An option is to more actively scrutinise IIDB claims to see if:

- The claimant has a reasonable prospect of legal redress against an employer. If so the claimant could be advised or required to seek legal redress prior to pursuing an IIDB claim.
- The claimants could be asked or required to demonstrate that they have gone through an appropriate rehabilitation and vocational resettlement process, prior to concluding their IIDB claim.

This option would require there to be:

- Ready access to suitable rehabilitation and vocational services, and;
- A means of checking the possibility of seeking legal redress.

The latter could comprise either a unit within the Works and Pensions Department, or a requirement upon claimants to acquire a written legal opinion regarding the prospect of legal redress for their claim.

It is pertinent to note that both insurers and the Department of Work and Pensions believe that there is a high awareness of the right to legal redress due to advertising of "no win no fee" services, and advice given by welfare services such as the Citizens' Advice Bureau. Also, a significant proportion of persons receive IIDB whilst pursuing a compensation claim against an employer, whilst others seek IIDB when they cannot prove that the employer is liable. Finally, the DWP note that their front line benefits advisors already endeavour to advise clients of useful services. Thus, it is uncertain whether there is much scope for "encouraging" more IIDB claimants to seek legal redress.

Also, discussions with the DWP indicate that there can be a significant delay between injury or commencement of ill-health and contact with the DWP. Many IIDB claimants are referred on by their General Practitioner. But they only qualify for IIDB after 90 days absence. This means that the effectiveness of rehabilitation would be reduced, due to the tardiness of intervention.

Table 13: Advantages and disadvantages of IIDB claims scrutiny for legal redress and rehabilitation opportunities

Advantages	Disadvantages
Does not require any regulatory changes.	It is uncertain whether any more IIDB claimants could seek legal redress against employers.
The operation of these arrangements and their design would not be dependent on the co-operation of non-governmental organisations, such as employers or insurers.	It would not address existing long term claimants unless the new "rules" were made retrospective.
The design of new arrangements can be revised in light of experience, rather than depending on regulatory changes.	Incurs a new cost for scrutinising claims.
Potential for increased cost recovery for paid benefit.	Success would depend in part on the level of rehabilitation support available.
	It is uncertain what proportion of cases of injury / illnesses covered by IIDB are amenable to rehabilitation.
	As the benefit system currently operates it is unlikely that rehabilitation would be implemented in good time.

In order for the value of this option to be confirmed it is necessary to establish:

- What types of claims go into IIDB? What proportion of these could be referred to EL?
- How many new claimants are there each year?
- What is the profile of IIDB benefit payments i.e. are they mainly for fixed payments for life or for shorter terms of disability.

8.3 OPTION 2: REFORM OF EL AND IIDB

There are at least four complimentary areas of potential reform.

Firstly, the current Employers' Liability Regulations could be reformed and re-titled as "Vocational Rehabilitation and Employers' Liability Regulation". This new or revised regulation could be modelled on the best practice model described above, whilst retaining fault-based claims processes.

Secondly, Civil Procedure Rules could also be examined for:

- Opportunities for judges to encourage rehabilitation;
- Increasing payments for pain and suffering;
- Reduce the burden of proof (of the employer's liability) required by claimants, and;

- Fast track processing of small or non-contentious claims.

Thirdly, another (or additional) option may be through health and safety legislation, such as including stronger rehabilitation requirements within the Health and Safety at Work etc Act, though primary legislation is likely to be necessary to implement many of the options identified below.

Fourthly, it is reported that EL premiums do not cover the cost of claims and that EL is often discounted to secure other insurances. A regulatory approach (by the Financial Services Authority) could include a "no deficit" requirement that the total EL premiums charged by an insurer cover the full cost of claims, thereby curtailing cost suppression and cross-subsidy of EL whilst allowing variable rates for individual firms. This may also facilitate a higher level of rebate/surcharging as any discounting would need to be balanced by surcharging.

A reformed Employers' Liability regulation could contain a number of pertinent obligations and duties. Obligations and duties could include:

- Make a rehabilitation policy a requirement for employers;
- Make suitable and timely rehabilitation a right and a duty for employees injured or made ill by work;
- Require rehabilitation (as far as is reasonably practicable) to be completed prior to settlement of any claim for compensation, with "standard" interim benefits during this period. (This may also require an alteration in the current right to sue.);
- Require employers to insure for the cost of rehabilitation (and vocational resettlement) in the same way that they must insure against employee compensation claims. This could be part of employers' liability or a separate policy;
- Include involvement with rehabilitation within the definition of contributory negligence, i.e. has the injured person done everything they could to reduce / reverse injury by seeking and following medical advice?
- Make provision of rehabilitation an element of employer negligence, i.e. has the employer done all in their power to reduce / reverse injury by seeking and following medical advice?

The rehabilitation guidance could be made into an Approved Code of Practice, with commensurately greater influence.

Table 14 shows the advantages and disadvantages of pursuing these avenues of reform.

Table 14: Advantages and disadvantages of regulatory reform

Advantages	Disadvantages
Participation would probably be increased due to regulatory status of the new arrangements	Requires regulatory change
A regulated approach would overcome insurers fears about accusations of collusion.	The proportion of costs borne by employers' liability insurance ***may*** not be enough to provide a financial motivation for employers to proactively comply.
Success would not be so dependent on the level of promotion.	It would leave IIDB unchanged.
The profile of a new regulation would probably gain higher levels of awareness and readiness to change practices.	A proportion of casualties may still be unable to claim if they are unable to prove employer liability.
A higher proportion of costs would be transferred to employers, increasing their potential level of motivation.	
A higher level of rebating and surcharging would be achieved.	
May help overcome competition-based constraints on surcharging and discounting.	

8.4 OPTION 3: REPLACEMENT OF EMPLOYERS' LIABILITY REGULATIONS AND IIDB

8.4.1 A new scheme

This option could comprise replacing the current fault based litigation process and accompanying employers' liability insurance, with a no fault "occupational health and insurance" requirement paid for by employers on behalf of employees. This would be equivalent to requiring employers to insure employees for loss of earning and health care costs, but limiting the scope of insurance to work related conditions. Such a regulated insurance requirement could be modelled on the design of workers' compensation schemes in other countries, including:

- No fault;
- Compensation either limited to a proportion of lost earnings, scheduled payments ***or*** including elements for pain and suffering;
- Rehabilitation costs covered within the scheme (with the same duties and obligations as noted above), and;
- Regulated operation of pricing (such as "no deficits" rules).

The exact design of such a scheme would be the subject of a further study of how the schemes operated in other countries would need to be modified to suit UK law and the views of UK stakeholders.

This option is thought to have a number of key advantages, including:

- It should ensure that the proportion of costs borne by employers rises to a level that acts a driver for improved health and safety management;
- It is also believed in some other countries to have reduced legal costs, which currently account for about 40% of the costs of EL;
- It is widely believed that no fault schemes would also reduce resistance to rehabilitation by reducing the adversarial nature of responding to work related injuries and ill-health;
- It would allow the IIDB scheme to be closed, and;
- It would reduce the level of doubt and uncertainty associated with fault based litigation.

The introduction of a no fault liability scheme could facilitate the transfer of claims normally entered under IIDB, and hence its closure. As employees would not need to prove employer negligence, there would be fewer reasons to retain state benefits.

On the other hand, no fault arrangements do not, as previously stated, necessarily eliminate legal or adjudication costs if there is permission to dispute the size of claims and whether they are worked related. Also, experience in other countries does suggest that there is a potential for the number and cost of claims to increase to "controversial" levels. This has led to a series of reforms and schemes to contain costs. Our discussions with UK insurers have suggested some other ways of containing costs, such as an "excess" clause of (say) 2 weeks salary.

In terms of the objective of motivating employers to improve health and safety, care must be taken to ensure that employers continue to believe they have influence over the overall cost of claims if a no fault arrangement was introduced. In particular, if the cost of claims is thought to be determined primarily by societal attitudes (i.e. tendency to enter claims), court rulings, changes in claimant rules (eg advances in medical science attribute more conditions to work), employers may not be motivated by the cost of claims to improve health and safety. Thus, a no fault scheme would increase the need for:

- A surcharge/rebate scheme that works for all organisations (including small ones);
- A cost-effective rehabilitation process (to reduce the size of claims), and;
- Rules that contain the cost of no fault claims, replacing "lump sum" payments with monthly payments (that could be subject to review).

Table 15: Advantages and disadvantages of a replacement scheme

Advantages	Disadvantages
Participation would probably be increased due to regulatory status of the new arrangements.	Requires regulatory change.
Facilitates transfer of greater proportion of costs of ill-health and injury to the employer and therefore have a greater influence on employers' management practices.	May encounter employer fears about increased cost and fraud.
Would probably facilitate transfer of claims normally made under IIDB to employers, i.e. closure of IIDB.	If employers fear costs are "out of control", they may not be motivated to improve health and safety standards.
Would facilitate higher levels of rehabilitation.	Would encounter transition issues.
Casualties should receive rehabilitation and compensation faster and with less uncertainty.	
Would probably reduce legal costs.	
Increased value of insurance would encourage more interest amongst insurers to provide additional services.	

8.4.2 Reduce risk to insurers

The current rules governing employers' liability insurance arrangements are rightly designed to ensure funds are available for employees' claims, although there is serious concern that they do not achieve this goal[2]. However, they reportedly increase the risk to insurers and reduce their profits such that insurers' motivation to engage in novel employers' liability schemes is diminished. These rules could be revised in the light of latter day objectives to facilitate a higher level of engagement amongst insurers, whilst maintaining protection for employees.

A range of options has been identified in this study. In particular, the insurance system could be revised so as to reduce the commercial risk for insurers. This is a particularly technical matter that warrants further work to identify all of the options.

1. Pay as you go

A number of other countries operate on a "pay as you go" basis. That is, the total premiums charged by an insurer are based on the total cost to insurers of claims settled. Thus, for example, premiums in the year 2001 reflect the cost of settled claims in the

[2] "*Asbestos Sufferer*s" Westminster Hall Debate, House of Commons 16/1/02, Hansard Vol No. 378, Part no. 81, Columns 71-91WH

year 2000. With this approach if an employer changes insurers, the insurer is not liable for claims arising in future years. Moreover, the premium can be based on the short-term forecast of claims rather than trying to forecast the totality of claims arising from any one year.

This approach would require an element of a "pool" premium to cover claims from individuals in organisations that have gone out of business. It would also mean that an insurer would be liable for claims arising from the period prior to their agreeing insurance with employers, if such claims are initiated during their period of insurance.

Such an arrangement would probably require regulatory changes to ensure insurers do not have the opportunity to avoid claims by cancelling insurance or delaying claims beyond the period of their insurance agreement. This problem is avoided in other counties by the operation of a single state scheme in each state or province.

2. Separating out occupational injury insurance from occupational health insurance

Another option is to separate occupational accident insurance from occupational health insurance. Many insurers believe that certain occupational ill-health conditions are uninsurable as the risks are not properly understood. Separating out risks that are not currently understood (rather than all ill-health risks) would enable shorter term pricing for occupational accident and ill-health insurance. This could entail:

- A private accident insurance and publicly administered health insurance scheme paid for by a levy on occupational accident insurance premiums, or;
- A private fault based accident insurance and a no fault (pay as you go) privately administered health insurance scheme paid for by a levy on private fault based accident insurance, or;
- A private occupational accident insurance paid for from premiums and a private occupational health insurance scheme paid for by a levy on the private occupational accident insurance – both operated on a no fault basis.

8.4.3 Transition issues

The transition from the current EL arrangements to a no fault scheme as described above would encounter a number of transition issues, including:

- How are claims arising from past exposure managed, especially new asbestos related claims arising from (say) the 1960's, and;
- How are premiums set in the first few years, given that current premiums are based on a claims history in a fault-based system.

Resolution of these issues would require further research. However, it is noted that:

- A number of other countries have made this transition successfully, and;
- Insurers could place funds into a common fund to cover the cost of new claims arising from past exposures (with capped liability) in the same way that Lloyds of London designed Equitas to provide capped funds for past liabilities. The fund could

be operated a no fault basis. Another option is to have the fund "underwritten" by an insurance compensation regulation, which requires insurers to make up any unforeseen deficit in funds.

The exact design of these transitionary arrangements would require consideration of issues such as should funds be based on current court settlements or a proportion of current settlements (to reflect the advantage of no litigation).

It is thought that these and other transition matters could be resolved.

8.5 RECOUPING NHS COSTS

The HSE's cost of accidents and ill-health report indicates that the NHS incurs un-recouped costs in the order of hundreds of millions of pounds per year. An option is to introduce an administrative process to enable a higher proportion of such costs to be identified and claimed from insurers. This would be facilitated by a no fault insurance process, as the NHS would not need to consider whether the employer was liable for their costs.

If the current fault based arrangements are retained, solicitors may be involved in processing such payments through employers' liability claims, and would therefore require some payment for this work. This would therefore be slightly less efficient overall, but would nevertheless transfer more costs to employers.

9 CONCLUSIONS

9.1 THE CURRENT UK POSITION

The current occupational accident and health insurance arrangements do not provide a financial driver for employers to improve occupational health and safety standards. In addition, there is relatively low level of importance attached to occupational rehabilitation and the role this can play in ensuring responsible employers bear the "cost" of ill-health and injury. Few, if any of the stakeholders appear satisfied with the current arrangements.

Our review of previous research and discussions with insurers and our survey of UK employers indicate that:

- UK employers do not cite the cost of work related ill-health and injury as a motivator for improving standards of health and safety management;
- Very few UK employers cite the wish to reduce the cost of insurance premiums (typically about 0.25% of payroll) as a reason for improving standards of health and safety management, even though our survey respondents indicate that they regard the cost to be significant and are trying to reduce it;
- The state run Industrial Injuries Disablement Benefit scheme is not generally mentioned by UK employers as a factor motivating the improvement of occupational health and safety, and our survey reveals that only a minority of employers are familiar with IIDB;
- UK employers only bear a minority of the tangible costs of occupational ill-health and injury through insurance premiums, and an even smaller fraction if non-tangible costs are included;
- Whilst insurance premiums are related to company size and (to a limited extent) risk, small employers do not perceive that their premium is influenced by their health and safety performance;
- Insurance premiums may be suppressed by competitive pressures and "obscured" when included within a "commercial insurance" package;
- Employers currently may or may not opt to cover the cost of rehabilitation within an employers' liability insurance policy;
- Rehabilitation appears to be a secondary aspect of the compensation process in the UK.

It is important to recognise that the Employers' Liability Regulations were designed according to a particular set of priorities in the 1960's, i.e to ensure employers have funds to cover cost of claims. The subsequent design of insurance arrangements and restrictions placed upon insurance policies do not appear to support the achievement of latter day health and safety objectives, such as improved health and safety management or rehabilitation.

9.2 THE POSITION IN OTHER COUNTRIES

On balance, the experience in other countries is that employers are motivated by the occupational insurance scheme to improve standards of occupational health and safety. In some cases, rehabilitation has been awarded primacy in the process of responding to cases, with compensation a secondary feature.

This is achieved by:

- Entering all (or nearly all) cases of ill-health and injury into a single scheme rather than splitting them between a state based and a private insurance scheme;
- Operating on a no fault basis, with varying degrees of access to legal redress regarding the degree of disablement and dispute of whether the condition is work related;
- Requiring claimants and employers to co-operate with a rehabilitation process prior to concluding claims, and / or legislating for an employers' duty for rehabilitation and vocational resettlement;
- Linking the premium paid by individual firms to a measure of their health and safety performance, usually claims experience.

In the case of small firms, schemes exist in some countries, especially Canada, that appear to successfully provide a financial motivation for small firms to embark on health and safety improvements.

The average cost of workers' compensation per firm is in the range of 1% to 3% of payroll. When the cost approaches or exceeds 2% to 3% employers appear more likely to adopt a more adversarial / reformist reaction, seeking to reduce costs by reforming the systems rather than improving health and safety. Such reforms have apparently been successfully enacted in countries where cost concerns have arisen.

9.3 IMPACT OF NEW ARRANGEMENTS

9.3.1 General impact

The introduction of a scheme that transferred the full costs of occupational ill-health and injury to employers would have a major impact on employers. In particular, our research indicates that UK employers would be motivated to improve occupational health and safety and rehabilitation if the cost of insurance increased and they believed there was a link between their performance and the cost of insurance. Also, it could reverse the perception amongst employers that the cost of injury and ill-health (borne by the employer) is not a driver for better health and safety. Research from other countries indicates that the operation of a scheme with variable performance related premiums has led to a reduction in serious injuries in the order of a few tens of per cent.

It would be sufficient to integrate "tangible" costs of ill-health and injury into a single insurance scheme for the cost (at about 1% of payroll) to be a motivator. If the

subjective value of pain and suffering were included this would raise the cost to a level that the vast majority of firms perceive to be a lot (at about 3% of payroll) and would approach the level that overseas employers have (on occasion) objected to. In this scenario, a new scheme could lead to a "dysfunctional" employer reaction, wherein they focus on reforming the system and contesting claims rather than improving health and safety.

Notwithstanding employers' fear about an increase in claims, the feedback from insurers and the DWP suggests that there is already a very high level of awareness of the right to compensation and the "no win no fee" legal schemes probably mean most casualties already enter claims. Thus, it could be that a no fault scheme would not lead to a significant increase in claims in the UK.

9.3.2 Relative strength of each option

It is suggested that Option 3 (replacing EL with a no fault scheme) would have the greatest impact on employer behaviour because it would facilitate the greatest "transfer" of costs to employers. Nonetheless, Option 2 would also have a significant impact in our opinion, especially if the regulatory requirements for rehabilitation and "responsible" pricing of EL were introduced. It is uncertain whether the voluntary initiatives of Option 1 would have the same influence, as the cost of EL may be insufficient to attract participation by insurers and employers.

9.3.3 Impact of change on Revitalising H&S strategy.

The Revitalising Health and Safety Strategy has a number of targets, including:

- Cut death and major injuries by 10% by 2010;
- Reduce work relate ill-health by 20% by 2010;
- Cut working days lost due to health and safety failure by 30% by 2010.

It has been reported that the insurance schemes operated in other countries have contributed to a:

- 15% to 40% decline in injuries in some USA studies;
- 40% decline in injuries in Germany over ~30 years;
- 40% decline in injuries in Canada over 11 years.

In the case of one Canadian scheme, the SCIP scheme, it was reported that there was a 20 to 50% fall in claims in a period of about three years.

The extent to which the insurance arrangements contributed to these falls in injuries cannot be stated with certainty due to the coincidence of other changes, although the researchers claim to have isolated these other factors in some cases. Also, the impact of any new scheme in the UK would depend on its design. Nonetheless, it is concluded that, on the balance of evidence reviewed in this study, that the introduction of new

insurance arrangements would make a significant contribution to the achievement of RHS targets.

9.4 IMPLEMENTATION OF ACTION PLAN POINT V.

Action Point V relates to the encouragement of insurer involvement. It is concluded that insurers are open to the idea of change and would welcome a collaborative approach. This would be best implemented by a third party, such as the HSE, co-ordinating the development and promotion of a best practice model for Employers' Liability insurance. It is concluded that there is a sufficient body of examples of best practice in the UK and overseas to allow such a model to be developed and implemented.

10 RECOMMENDATIONS

The evidence available to this study indicates that a reformed UK insurance process would provide a significant motivation to employers to improve health and safety and rehabilitation. It is therefore recommended that the ideas emerging from this study be taken forward and awarded proportionate weight by the HSE and HSC.

In the first instance, it is recommended that employers' liability and rehabilitation "best practices" be drawn together into a "best practice model" that is then promoted as an industry standard. A number of insurers have developed schemes that aim to encourage better health and safety and to integrate rehabilitation into the claims process. Given the availability of such examples in the UK and overseas it should be possible for such a model to be developed within a relatively short time, such as one year.

Secondly, studies and consultations should be carried to elaborate how current regulations could be reformed or replaced, as per Options 2 and 3 in this report, and to explore the costs and benefits of reform. Therefore, it is recommended that a study, involving consultation with key stakeholders, be launched in the short term to explore and identify practical ways forward for the reform of the UK occupational injury and ill-health insurance arrangements, with the aim of facilitating:

- The achievement of latter-day goals of improved health and safety;
- Improved rehabilitation, and;
- Protection of employees' access to financial compensation.

The ideas and research contained in this report provide a starting point for this study. Such a study should be able to reach clear conclusions regarding how best to reform UK occupational injury and ill-health insurance arrangements.

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Appendix A
Consultation proforma for UK insurers

Introduction

A key aim of the Health and Safety Executive's Revitalising Health and Safety strategy is to motivate employers to improve their health and safety performance. One part of this strategy concerns insurance. As stated in Revitalising Health and Safety "The compensation, benefits and insurance system must motivate employers to improve their health and safety performance, in particular by securing a better balance in the distribution of the costs of health and safety failures". (Action Plan Point V).

It is thought that currently employers can rely on insurance to shelter from many of the costs of poor safety performance. Also, many costs are borne by the state in the form of sick pay and NHS costs and are therefore not reflected in insurance premiums.

Greenstreet Berman has been asked to consider what changes to insurance might best motivate changes in safety performance. The intention is to focus on what changes might engender a greater business focus on these issues. There are three parts to the interview.

Part one will explore how the current insurance system can be used to motivate employers.

We are interested in how the current Employers' Liability arrangements can be used without major legislative changes to achieve the following objectives:

- motivating employers to take preventive actions, increasing physical and vocational rehabilitation;
- ensuring the premiums paid by employers are in proportion to the costs of ill-health and injury arising from their activities;
- reducing the proportion of injured persons relying on state benefits or simply leaving the workforce– despite their having a right to seek compensation.

Part two looks at the impact of possible major changes to employers' liability arrangements. Specifically, your views are sought concerning the likelihood that they will lead to changes in business behaviour.

Some countries operate a no fault system with the provision of health and safety advice and rehabilitation services an integral part of insurers services and a requirement for employers. Benefits and medical costs for work related injuries and ill-health are separated out from other sources of injury and covered by workers' compensation insurance or state social security benefit and funds. Such benefits and medical costs are often set by schedules with adjudication processes for handling disputes, such as the extent of injury or whether the injury is work related. As part of this the employer has immunity from employee litigation for negligence, with a few exceptions. These systems are designed to cover loss of earning, medical and care costs, pension and, in some cases, pain and suffering.

Part three asks for your comments and views you may have on this subject. In particular we welcome any views you have on how insurance services can assist in

employer (health and safety) behaviour modification. For example, could employers be influenced by increased excesses, upper limits on claims, no claims bonus, discounted premiums when certain risk reduction procedures are in place etc?

Appendix B
Questionnaire issued to UK employers

About this survey

The Health and Safety Executive has commissioned this survey.

A key aim of the Health and Safety Executive's Revitalising Health and Safety strategy is to help motivate employers to improve their health and safety performance. One part of this strategy concerns insurance.

> "The compensation, benefits and insurance system must motivate employers to improve their health and safety performance, in particular by securing a better balance in the distribution of the costs of health and safety failures".

Greenstreet Berman Ltd has been asked to consider what changes to insurance might best motivate changes in safety performance. We would like your opinion about work-related accident and illness insurance.

Who should respond

The person responsible for employers' liability insurance and / or health and safety in your organisation should complete the questionnaire. Do not fill in this questionnaire if your organisation does not have Employers' Liability insurance.

Anonymity

We can assure you of complete anonymity. All responses will be aggregated together and none of the raw data will be passed to the HSE. Greenstreet Berman Ltd is an independent research and consultancy organisation. Please visit our website at www.greenstreet.co.uk if you want further information or call Michael Wright on 0118-931-9609.

The questionnaire should take no more than 10 minutes to complete. Please return it in the reply paid envelope provided. Your co-operation would be gratefully received.

Greenstreet Berman Ltd, First Base, Beacontree Plaza, Gillette Way, Reading, RG2 0BP

About you

1. How many people does your company employ?

Tick one box only

Under 10 employees	11 to 50 employees	51 to 250 employees	251 to 1,000 employees	Over 1,000 employees
1	2	3	4	5

2. Please write your job title in the space below:

3. What sector(s) does your organisation work in?

Tick no more than 3 boxes

Agriculture & forestry	1	Mines, quarries	10
Banking, finance, accounts or insurance	2	Other services (laundry, hairdressing, estate agents etc)	11
Civil service / central government	3	Police, fire, ambulance, defence service	12
Construction (inc. decorators, builders, plumbers, etc)	4	Professional services (e.g. legal, consultancy)	13
Education	5	Utilities (gas, water, electricity)	14
Health or social work	6	Retail & repairs	15
Hotels & catering	7	Telecommunications (post, phone)	16
Local authority / regional government	8	Transport	17
Manufacturing	9	Other (please specify below):	18

4. How much does **<u>your organisation</u>** pay for its Employers' Liability insurance **<u>each year</u>**?

Tick one box only

Under £500	£501 to £1,000	£1,001 to £10,000	£10,001 to £100,000	Over £100,000	Not sure
1	2	3	4	5	6

5. To what extent do you agree with each of the following statements:

Tick one box in each row

	Strongly agree	Agree	No opinion	Disagree	Strongly disagree
5a. The cost of Employers' Liability insurance is a significant expense for my organisation	1	2	3	4	5
5b. The amount we pay for Employers' Liability depends on the standard of health & safety management at my organisation	1	2	3	4	5
5c. My organisation is trying to reduce the cost of Employers' Liability insurance	1	2	3	4	5
5d. My organisation can control the standard of its health and safety management	1	2	3	4	5

Tick one box in each row

	Yes	No	Unsure
6. Are you familiar with the Industrial Injuries Disablement Benefit scheme?	1	2	3
7. Do you know how to get rehabilitation support for an injured employee?	1	2	3
8. Do you have access to health and safety advice?	1	2	3

9. To what extent do you agree with the following statements:

Tick one box in each row

	Strongly agree	Agree	No opinion	Disagree	Strongly disagree
9a. Injured employees should have rehabilitation (if medically advised) before compensation is agreed	1	2	3	4	5
9b. People should <u>not</u> be compensated for injuries or illness caused by work if they refuse rehabilitation	1	2	3	4	5
9c. My organisation would prefer to insure for rehabilitation costs, rather than pay directly for rehabilitation	1	2	3	4	5
9d. Employers should pay for the rehabilitation of people injured or made ill by work	1	2	3	4	5
9e. My organisation would accept a 20% increase in the cost of Employers' Liability insurance to pay for occupational health and safety training & advice	1	2	3	4	5

10. Would you be interested in being a member of a "club" of organisations who are in the same line of business - if the club received cheaper health & safety training/advice, & whose employers' liability premiums could rise or fall in line with the number of insurance claims made by the "club"?

Yes	No	Unsure
1	2	3

11. To what extent do you agree that the introduction of a "no fault" insurance scheme (where employees do not have to prove the employer was at fault) for work injuries and illness would:

Tick one box in each row

	Strongly agree	Agree	No opinion	Disagree	Strongly disagree
11a. Be fairer for employees	1	2	3	4	5
11b. Lead to a lot more claims	1	2	3	4	5
11c. Reduce legal costs a lot	1	2	3	4	5
11d. Lead to a lot more fraud / bogus claims	1	2	3	4	5
11e. Increase the cost of employer liability insurance a lot	1	2	3	4	5

12. How much would employers' liability need to cost your organisation (as a % of payroll) for it to be a significant business expense?

	Tick one box
0.25% of payroll	1
1% of payroll	2
3% of payroll	3
6% of payroll	4
10% of payroll	5

For example, if you think that 1% or more of payroll is a significant expense, tick box 2 for 1%. If you think that 6% or more is significant, then tick box 4 for 6%.

13. If you knew that an increase in work accidents and ill-health would lead to a **big** increase in the cost of employers' liability insurance would you try to do more to prevent injuries and / or reduce their severity?

Yes	No	Unsure
1	2	3

14. Would the prospect of a "50% no claims bonus" or 50% rebate motivate you to try to reduce further the number or size of claims?

Yes	No	Unsure
1	2	3

15. If Employers' Liability costs increased a lot, what would you try to do to bring the cost back down:

	Tick one box in each row		
	Yes	No	Unsure
15a. Prevent work injuries & of ill-health	1	2	3
15b. Improve the rehabilitation of injured / ill people	1	2	3
15c. Contest claims	1	2	3
15d. Avoid recruiting people previously injured or ill	1	2	3
15e. Change insurers	1	2	3

Many thanks for your time and help in completing this questionnaire

Appendix C
Employers survey data

C.1 Raw data

		5a	5b	5c	5d	6	7	8
		Cost of El is significant	EL depends on H&S standard	Trying to reduce costs	We control H&S	Familiar with IIDB	Access to rehab	Access to H&S
Large	1	61	37	64	99	125	91	268
	2	136	137	149	156	102	132	2
	3	20	23	30	6	39	43	0
	4	40	57	21	3			
	5	8	13	1	4			
	All	265	267	265	268	266	266	270
Medium	1	38	15	28	60	64	44	219
	2	353	263	353	431	351	426	24
	3	26	42	41	8	38	34	2
	4	35	61	29	8			
	5	4	23	4	0			
	All	456	404	455	507	453	504	245
Small	1	20	1	4	21	24	21	103
	2	40	23	35	75	81	84	16
	3	30	42	41	21	22	22	8
	4	29	40	36	5			
	5	6	16	6	2			
	All	125	122	122	124	127	127	127
All	1	119	53	96	180	213	156	590
	2	296	239	302	377	306	363	22
	3	76	107	112	35	99	99	10
	4	104	158	86	16			
	5	18	52	11	6			
	All	613	609	607	614	618	618	622

		9a	9b	9c	9d	9e	10
		Rehab before compensation	No compensation without rehab	Employers prefer to insure for rehab	Employers should pay for rehab	Accept 20% cost increase	Join a club
Large	1	83	45	13	26	1	77
	2	152	128	123	143	6	108
	3	25	48	99	58	63	82
	4	9	43	29	35	137	
	5	0	4	1	4	58	
	All	269	268	265	266	265	267
Medium	1	60	40	25	16	4	79
	2	400	348	353	347	77	277
	3	27	39	67	46	40	55
	4	5	29	11	42	105	
	5	0	2	0	7	40	
	All	492	458	456	458	266	411
Small	1	16	17	13	9	2	35
	2	74	55	68	43	20	58
	3	29	34	42	42	34	34
	4	7	16	3	22	49	
	5	0	4	0	9	19	
	All	126	126	126	125	124	127
All	1	159	102	51	51	7	191
	2	359	299	312	299	59	256
	3	81	121	208	146	137	171
	4	21	88	43	99	291	
	5	0	10	1	20	117	
	All	620	620	615	615	611	618

		11a	11b	11c	11d	11e
		Fairer for employees	More claims	Reduce legal costs	More fraud	Increase El costs
Large	1	10	129	21	104	124
	2	62	106	100	118	110
	3	49	17	51	35	25
	4	114	12	73	8	8
	5	30	2	21	2	2
	All	265	266	266	267	269
Medium	1	5	94	8	76	85
	2	173	312	253	365	340
	3	34	11	61	14	11
	4	100	9	60	7	9
	5	28	0	16	2	1
	All	340	426	398	464	446
Small	1	12	44	7	40	41
	2	30	58	44	64	61
	3	35	14	30	14	17
	4	39	8	36	5	3
	5	8	2	8	3	3
	All	124	126	125	126	125
All	1	27	267	36	220	250
	2	149	274	221	307	289
	3	118	42	142	63	53
	4	253	29	169	20	20
	5	66	4	45	7	6
	All	613	616	613	617	618

		12	13	14
		Whats a lot	Try to prevent injuries / ill-health	50% would motivate
Large	1	78	221	196
	2	113	30	49
	3	41	16	22
	4	9		
	5	7		
	All	248	267	267
Medium	1	50	170	163
	2	312	78	107
	3	43	21	29
	4	12		
	5	4		
	All	421	269	299
Small	1	31	92	83
	2	44	13	18
	3	29	16	21
	4	9		
	5	2		
	All	115	121	122
All	1	159	483	442
	2	264	72	100
	3	113	53	72
	4	30		
	5	13		
	All	579	608	614

		15a	15b	15c	15d	15e
		Try to prevent injuries	Improve rehab	Contest claims	Avoid recruiting previously ill	Change insurers
Large	1	252	180	204	137	114
	2	5	22	23	71	68
	3	6	60	32	52	75
	All	263	262	259	260	257
Medium	1	194	123	164	143	111
	2	24	69	49	130	135
	3	16	68	44	44	69
	All	234	260	257	317	315
Small	1	99	56	58	70	66
	2	5	12	15	21	16
	3	15	50	45	29	38
	All	119	118	118	120	120
All	1	545	359	426	350	291
	2	22	60	50	124	125
	3	37	178	121	125	182
	All	604	597	597	599	598

C.2 Tabulation of results (per centages)

C.2.1 Sub-divided according to assigned risk category

The per cent of respondents who agree or strongly agree with each statement…

	The cost of EL is a significant business expense	The cost of EL depends on H&S standard	This firm is trying to reduce the cost of EL	We control H&S performance
High risk	75%	50%	73%	91%
Medium risk	67%	56%	71%	93%
Low risk	56%	34%	45%	86%
All	67%	48%	65%	91%

The per cent of respondents who agree or strongly agree with each statement…

	We are familiar with IIDB	We have access to rehab	We have access to H&S
High risk	37%	28%	94%
Medium risk	37%	26%	99%
Low risk	27%	20%	91%
All	35%	26%	95%

The per cent of respondents who agree or strongly agree with each statement…

	People should have rehab before compensation	There should be no compensation without rehab	Employers prefer to insure for rehab	Employers should pay for rehab	We would accept 20% cost increase to pay for H&S advice
High risk	83%	62%	59%	54%	11%
Medium risk	88%	72%	60%	56%	10%
Low risk	79%	59%	59%	63%	13%
All	84%	65%	59%	58%	11%

The per cent of respondents who agree or strongly agree with each statement…

	We would be interested in joining a club
High risk	32%
Medium risk	32%
Low risk	27%
All	31%

The per cent of respondents who agree or strongly agree with each statement…a no fault insurance scheme would …

	Be fairer for employees	Lead to more claims	Reduce legal costs	Lead to more fraud	Increase El costs
High risk	31%	88%	45%	86%	88%
Medium risk	25%	89%	39%	86%	87%
Low risk	30%	86%	41%	84%	86%
All	29%	88%	42%	85%	87%

The per cent of respondents who agree or strongly agree with each statement…if the cost of insurance increased and was linked to our claims we would..

	Try to prevent injuries / ill-health	50% would motivate	Try to prevent injuries	Improve rehab	Contest claims	Avoid recruiting previously ill	Change insurers
High risk	80%	74%	89%	60%	70%	61%	48%
Medium risk	80%	72%	92%	59%	75%	60%	50%
Low risk	78%	68%	89%	62%	68%	51%	47%
All	79%	72%	90%	60%	71%	58%	48%

The per cent of respondents who agree or strongly agree that x% or more of payroll is “a lot”

	% of payroll				
	0.25%	1%	3%	6%	10%
High risk	26.3%	46.1%	22.2%	5.3%	0.0%
Medium risk	27.4%	46.3%	17.9%	5.0%	3.5%
Low risk	29.6%	43.7%	17.0%	5.2%	4.4%
All	28%	45%	19%	5%	2%

C2.2 Sub-divided according to assigned by size

The per cent of respondents who agree or strongly agree with each statement…

	The cost of EL is a significant business expense	The cost of EL depends on H&S standard	This firm is trying to reduce the cost of EL	We control H&S performance
Large	74%	65%	80%	95%
Medium	71%	43%	66%	93%
Small	48%	20%	32%	77%
All	68%	48%	66%	91%

The per cent of respondents who agree or strongly agree with each statement…

	We are familiar with IIDB	We have access to rehab	We have access to H&S
Large	47%	34%	99%
Medium	28%	20%	97%
Small	19%	17%	81%
All	34%	25%	95%

The per cent of respondents who agree or strongly agree with each statement…

	People should have rehab before compensation	There should be no compensation without rehab	Employers prefer to insure for rehab	Employers should pay for rehab	We would accept 20% cost increase to pay for H&S advice
Large	87%	65%	51%	64%	3%
Medium	86%	69%	65%	58	17
Small	71%	57%	64%	42%	18%
All	84%	65%	59%	57%	11%

The per cent of respondents who would join a club

	Join a club
Large	29%
Medium	35%
Small	28%
All	31%

The per cent of respondents who agree or strongly agree with each statement…a no fault insurance scheme would …

	Be fairer for employees	Lead to more claims	Reduce legal costs	Lead to more fraud	Increase El costs
Large	27%	88%	45%	83%	87%
Medium	28%	91%	38%	90%	91%
Small	34%	81%	41%	83%	82%
All	29%	88%	42%	85%	87%

The per cent of respondents who agree or strongly agree with each statement…if the cost of insurance increased and was linked to our claims we would..

	Try to prevent injuries / ill-health	50% would motivate	Try to prevent injuries	Improve rehab	Contest claims	Avoid recruiting previously ill	Change insurers
Large	83%	73%	96%	69%	79%	53%	44%
Medium	77%	72%	87%	57%	75%	65%	50%
Small	76%	68%	83%	47%	49%	58%	55%
All	79%	72%	90%	60%	71%	58%	49%

The per cent of respondents who agree or strongly agree that x% or more of payroll is “a lot”

	% of payroll				
	0.25%	1%	3%	6%	10%
Large	31.5%	45.6%	16.5%	3.6%	2.8%
Medium	23.1%	49.5%	19.9%	5.6%	1.9%
Small	27.0%	38.3%	25.2%	7.8%	1.7%
All	27.5%	45.6%	19.5%	5.2%	2.2%

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