

Aligning SB/IB with ACC approaches

This paper considers the option of aligning SB/IB with ACC approaches, or to put it another way the implications of placing SB/IB target groups on a scheme akin to ACC.

Context

Current welfare arrangements

SB/IB are the main instruments for providing benefits to working age people who are unable to work for reason of sickness or invalidity. They do not cover those who are unable to work because of injury – those are covered by ACC.

Both SB and IB are predicated on the principles of **social assistance** in that they provide a basic level of income adequacy with prescribed entitlements. They are funded on a pay as you go basis from the tax system and administered by a Government department. Related health and other services are provided separately through the public health system.

There are currently around 65,700 Sickness Beneficiaries. They enter SB from a variety of sources including other benefits. They have a wide range of illnesses but musculo-skeletal, psychological and psychiatric and substance abuse conditions predominate. Those on SB tend to be on for moderate to long periods of duration and there is considerable churn.

There are currently around 95,700 Invalids Beneficiaries. IB is for those who are determined through medical assessments to have permanent severe incapacity. There are no work test requirements. Over half of new entrants come onto IB off SB. A large number of cases have cardio-vascular conditions, intellectual disabilities, musculo-skeletal disorders and psychological or psychiatric conditions. In contrast to SB, there are very long periods of duration with relatively low churn.

Economic costs

A range of economic costs pertain to having an individual on SB or IB that need to be considered in any reform:

- for an individual who would otherwise be in work, lost productivity to the economy.
- direct cost to the Crown of providing the benefit
- health and disability costs, for the duration, borne by the Crown and the individual
- lost quality of life to the individual and his/her family
- broader social costs.

The ACC scheme

Key features

In contrast to SB/IB, ACC is an insurance-based scheme and is different to social assistance schemes in a number of important respects.

Rather than basic income adequacy, it provides **income compensation** for earners, at the rate of 80% of lost earnings, up to a cap. The maximum compensation payable is currently \$1,341.31 a week. This feature is an essential quid pro quo for the loss of the right to sue. It also provides entitlement to treatment and rehabilitation services which are purchased by ACC. ACC also provides a lump sum on permanent impairment.

The ACC scheme is **fully funded** by **levies** on employers, earners, and motor vehicle owners and a Crown appropriation for non-earners. The combination of full funding and levies¹ results in transparency about costs and performance, with the cost of the scheme explicit, but means that most participants pay a levy in addition to tax.

The levy is subject to risk pricing on the work² and motor vehicle accounts. For example, those employers in industries that have a higher cost of accidents (ie taking into account accident rate and actual cost per accident) pay a higher levy. In allocating the cost of workplace injuries to employers, the scheme **allocates costs to those best able to control them**. In principle this provides incentives on employers to prevent injuries and support workplace-based rehabilitation. In practice, for most employers these incentives are blunt, but ACC is currently considering improvements to the risk weighting arrangements and the introduction of experience rating.

While entitlements are prescribed, ACC has considerable **discretion as to the level of investment in treatment and vocational and social rehabilitation services**, taking into account their effectiveness. ACC also purchases such services itself. This contrasts with SB/IB where the overall level of investment in specific case management is set as part of the (MSD) budget process in competition with other government priorities and health services are provided by the wider public health system independently of MSD's case management.

In consequence of these arrangements, ACC has strong incentives to manage the scheme in a way that minimises overall costs consistent with entitlement. It also has the tools to do so. This is because the arrangement of fully funding via a levy gives high profile to the costs of the scheme. ACC also has a greater flexibility than MSD does in the case of SB/IB to determine investment in treatment and rehabilitation services.

The Accredited Employers Scheme

Within the Work Account of the ACC scheme, there is provision for some employers to self-insure. The Accident Compensation Act provides for regulation to define the framework for this. Larger employers are able to join the Accredited Employers Scheme, which means a high degree of self insurance. This provides strong incentives to avoid workplace injuries and

¹ Note that in designing a scheme, decisions regarding full funding and levies are separate – it is possible to have full funding other than through levies, and levy based pay as you go.

² The Work Account receives levies from employers and funds costs relating to workplace injuries.

support vocational rehabilitation. A recent study for the ACC Stocktake shows these incentives are effective.

Differences in Context for ACC compared with SB/IB

Before moving to consideration of how SB/IB could be placed on a scheme similar to ACC, it is worth noting some important differences:

- As noted, the ACC scheme **replaces the right to sue**. As a result, a necessary feature of the scheme is that it provides real compensation for loss of income for a potentially unlimited period. In contrast, any welfare scheme for sickness and incapacity not resulting from an accident does not necessarily have to provide for income replacement, only income adequacy. Furthermore, all cases of social insurance schemes we have identified in OECD countries only provide income replacement for a limited period (usually between 6 months and 2 years) before claimants revert to an income adequacy regime.
- ACC has a clear **role in accident reduction**. The scheme places incentives on employers to reduce the incidence and cost of accidents, and it places incentives on the scheme's managers to support other accident reduction activities such as social marketing campaigns. This is economically efficient. While it might be that an analogous scheme could usefully create incentives to avoid ill-health, consideration would need to be given as to whether this would lead to an improvement in the overall prioritisation of public health expenditure. Admittedly, this difference is one of degree rather than absolute.

Outcomes and Issues

Outcomes sought

In considering an ACC-type approach to managing those of working age unable to work for sickness and invalidity reasons, the following outcomes would be sought:

- **Reduction in the economic costs** including costs of lost production and the direct cost of income replacement. This includes:
 - Reducing the incidence of sickness in the first place
 - Achieving quick and lasting return to work or independence by those affected by acute sickness events or chronic illness or disease.
- **Income protection** for individuals' loss of income resulting from sickness or chronic illness. Note that this is different to the basic income adequacy provided by current SB/IB. Schemes providing income protection typically exist in addition to schemes to provide family income adequacy for those not covered.
- Overall **affordability** including cost of entitlements and administration.

Other design considerations

In meeting these outcomes, a scheme needs to consider:

- How to maintain labour market attachment through creating incentives on employers and employees to maintain the employment relationship in some form, and strengthening incentives on beneficiaries to return to work
- How to purchase the right bundle of health, vocational, counselling and other interventions (at the right time) to support fast and lasting return to work and independence

- Minimising dead weight costs
- Ensuring the right incentives and decision-making rights for efficient scheme administration
- The incentive effects on sickness prevention.

Scheme Design Choices

In designing a scheme there are a number of critical design choices as follows:

Design Choice	Comment
<p>High level scheme design - a combined sickness / invalids scheme v continuing with two separate schemes?</p> <p>Relationship to the unemployment, DPB and accident schemes?</p> <p>Relationship to the health system?</p>	<p>Costs of invalids scheme can be considered the long tail costs of sickness</p> <p>What are the expectations of return to work / independence for persons off work because of sickness v invalids?</p> <p>Would persons be allowed to migrate between schemes, say from the UB to the sickness / invalids scheme?</p>
<p>Level and structure of compensation for lost income</p> <ul style="list-style-type: none"> • flat v income related • stand downs • step downs • time limits / cut-offs • reciprocal obligations 	<p>A large number of sickness events result in short periods away from work, with only a few resulting in long periods of dependency. Current benefit levels are not income-related and do not provide adequate protection to medium / high income earners. By contrast, ACC pays 80% weekly compensation up to a maximum cap. EQC requires a homeowner to have in place private insurance arrangements, under which EQC pays up to an initial \$100,000</p> <p>A high level of income compensation could be a disincentive on individuals to return to work / independence to return to work</p> <p>Employers currently have obligations to provide some sick leave</p>
<p>Related benefits</p> <ul style="list-style-type: none"> • treatment and health services • social and vocational rehabilitation • other <p>Relationship to the public health system</p>	<p>Timely and appropriate provision of treatment and rehabilitation services is essential to achieving fast and sustainable return to work and independence</p> <ul style="list-style-type: none"> • Who makes decisions on the provision of these services? • Who pays for these services? <p>Should the costs and provision of these services be met and managed by the scheme?</p> <p>ACC can directly purchase treatment and other services outside of the public system</p> <p>What would be the implications of allowing the sickness / invalids scheme to also do this?</p>

<p>Level of funding - full v pay-as-you-go</p>	<p>Full funding results in increased transparency</p> <p>Full funding can provide for a more effective performance framework – where performance is measured against scheme solvency</p> <p>Full funding would require recognition of any unfunded liability on the Crown balance sheet</p>
<p>Means of funding - tax v levy / premium funded</p>	<p>A levy would provide for a direct relationship with the insured and for premiums to be risk-rated</p>
<p>Who pays – employer or employee?</p>	<p>The employee is the primary beneficiary and has control over lifestyle and some contributory factors. Employers can influence workplace health (as well as safety)</p> <p>Employer funding could result in increased incentives on employers to keep jobs open and support rehabilitation</p>
<p>Institutional arrangements</p> <ul style="list-style-type: none"> • Private v public v mixed • Organisational form of a public provider 	<p>ACC and MSD provide two quite different approaches, and EQC a third</p> <p>Competition can be structured round the underwriting risk, service delivery or both</p>
<p>Implementation and transition</p>	<p>If an insurance-based scheme was introduced, it would apply to events from the date of introduction</p> <p>How would existing claims and claimants be managed?</p>

Options for a scheme

Taking into account the above parameters, we have prepared two options.

- Option 1: a fully funded insurance approach administered by either an institution analogous to ACC or ACC itself
- Option 2: an actuarial valuation of liabilities in combination with current or revised administrative arrangements.

These two options broadly form two ends of a spectrum of choices, with Option 1 involving the greatest change from present arrangements. Option 2 is a key tool used in insurance, but is not, of itself, a true insurance approach. A range of possible sub-options provide intermediate choices. Option 2 could be combined with a number of other approaches to reform that can be envisaged.

Option 1: A fully funded insurance approach

At a high level, this option is as close to the ACC scheme as can be envisaged. This option comprises a set of proposals for the key design choices set out above. While many variations can be envisaged, it forms the basis for a discussion about the pros and cons of such a scheme.

Parameter	Proposed feature
High level scheme design	<ul style="list-style-type: none"> • Combined sickness and invalids scheme (and potentially injury too) • Cover for loss of income arising from acute or chronic illness - decision required on whether or not persons would be allowed to transfer from other schemes onto this scheme (UB for instance) – and whether there would be transfer from this scheme onto others • Decisions required on whether or not scheme would cover potential loss of earnings for persons that have never entered the work force, and if so who would pay (the ACC scheme does provide such cover and the Crown pays)
Level and structure of compensation for lost income	<ul style="list-style-type: none"> • Initial stand down (2 or 4 weeks) – with employer responsible for paying income over this period • Compensation for initial X months paid at 80% of average weekly earnings for period prior to sickness, paid to a maximum prescribed level of income • Step down after X months to a basic living rate (this differs from ACC) • Reciprocal obligations on beneficiaries to comply with actions agreed during case management interviews with sanctions in form of step downs or cut offs if obligations not met
Related benefits Relationship to the public health system	<ul style="list-style-type: none"> • Related treatment, vocational and social rehabilitation, and other directly related benefits would be included within the ambit of the scheme (similar to ACC) • Scheme administrator would have input into decisions on their provision • Scheme would meet costs of these services • Scheme would be able to purchase services from outside of the public system • Decisions required on co-payments • Decisions required on right of beneficiary to exercise direct decisions on choice and provision of treatment and other services (from their own GP for instance)
Scheme funding	Full funding (for claims cover from date scheme established)
Means of funding - tax V levy / premium funded	Levy funded and related to income covered with provision for risk rating on factors within the control of persons covered (such

	as immunisation, participation in approved fitness programmes, cigarette smoking etc)
Who pays – employer or employee?	Employee pays (employer pays first two or four weeks lost income)
Institutional arrangements	<p>ACC, EQC and off shore social insurance models provide quite different approaches. Competition can be on underwriting, service delivery or both</p> <ul style="list-style-type: none"> • Option 1 – state monopoly administered by a Crown entity (ACC model) • Option 2 – mixed public private delivery (EQC model). A Crown entity would regulate and administer the core components of the scheme. It would provide income support to the level of the basic living rate. Private providers would provide income support over this level • Option 3 – competitively underwritten (Government regulated and privately delivered)
Implementation and transition	<p>If an insurance based scheme was introduced, it would apply to events from the date of introduction</p> <p>How would existing claims and claimants be managed?</p>

Discussion of Option 1

As noted, option 1 is closest to the present ACC scheme. Critically, like the ACC scheme, it has a number of mutually reinforcing elements, notably a strong incentive for scheme performance coupled with flexibility for the scheme's managers regarding rehabilitation services. It also provides for real compensation for lost income.

This arises because overall scheme costs translate into levy rates so there is a strong accountability mechanism. The general arrangements allow the scheme managers considerable discretion in determining overall expenditure on case management.

This contrasts with the weak and indirect accountability mechanisms for the overall level of expenditure on welfare. Benefits are demand driven Crown costs so any change in total expenditure translates only very indirectly into tax rates. It also contrasts with the arrangement that the overall welfare case management expenditure is determined through the national budget process in competition with a range of other priorities. While in principle this takes into account the impact of case management on long-run costs, in practice it does so only weakly.

As such it has the potential to establish an effective framework for the management of those falling out of employment due to sickness or incapacity.

However, option 1 has a number of major implications that the Welfare Working Group should be aware of before it decides to consider this option further.

- Providing scheme administrators flexibility in the prioritisation of health services is a significant change from the current basis of allocation based on clinical need. This could be seen as 'putting beneficiaries at the front of the queue'.
- The scheme provides income replacement for those in employment prior to illness or incapacity³. It could conceivably be extended to others analogous to the ACC non-earners account, funded by a Crown appropriation. However such a funding arrangement does not provide the same performance incentives or accountability. An approach common in jurisdictions with social insurance schemes is to have a complementary social assistance scheme for those not covered.
- In any event a residual social assistance scheme will be needed for those still unable to return to work at the end of the period of income replacement.
- Although the level of income replacement could be set at a range of different levels, it will be higher than current SB/IB levels. As such the initial incentive to go back into work will typically be lower than at present.
- A further consequence of the higher level of income replacement is that the overall cost of the scheme is likely to be higher unless it provides considerably improved return to work outcomes.
- For those currently on SB/IB the levy may increase the EMTRs of a transition into employment because earnings will be reduced by the levy. (This assumes there are no consequential changes to the tax system.)
- The insurance scheme operates at the individual level, whereas the unit of assessment for benefits is the household. This may create issues in designing appropriate treatment for individuals who transition between parts of the welfare system.
- The scheme may not be compatible with present prioritisation criteria based on equity considerations – such as targets based on population groups or duration.

New Zealand and Australia are the only OECD countries whose welfare system is based on social assistance. All other OECD countries have a significant element of social insurance covering unemployment and retirement. If New Zealand were to contemplate moving to a wider social insurance approach, consideration should be given as to whether a partial approach such as proposed here is appropriate or whether, because of the interfaces between individual schemes, wider adoption of social assistance including unemployment and even retirement might be better. (It is unlikely that sole parenthood could be treated as an insurable event.)

Option 2: Actuarial valuation of liabilities

Option 2 is intended to provide the same incentives on the scheme's managers for effective case management without the additional complexity and possible disadvantages of a social insurance approach.

The key design criteria is to create strong incentives for managers to make effective use of case management and a framework for a more dynamic assessment of the overall investment in

³ A study by MSD's Centre for Social Research and Evaluation suggests that only 32% of SB/IB recipients at the end of 2001 came onto SB/IB from employment. See "A Profile of Health and Disability Related Benefit Recipients in New Zealand" in Social Policy Journal of New Zealand • Issue 29 • November 2006.

case management services, including the potential for the direct purchase of health treatment services.

The key features are:

- An actuarial valuation of liabilities based on application periods reported at the end of each year disaggregated by claimant classification
- Accounting for case management time and interventions by claimant year and classification.
- Optionally, provision to purchase treatment and rehabilitation services directly (ie go beyond relying on provision through the health system)

Discussion of Option 2

Option 2 has the potential to increase the incentives on the scheme's managers as it increases transparency of actual costs.

It avoids a number of issues in Option 1 in that:

- It does not affect replacement rates and incentives to go into work
- It does not change the unit of assessment and does not increase the complexity of the system
- It does not of itself significantly add to costs.

However, it does not of itself in the base case provide the scheme's managers with any additional tools, and does not have the mutually reinforcing characteristics provided by the levy mechanism. In the event that provision was made to directly purchase treatment and rehabilitation services, additional tools would be provided, but these raise some of the issues noted above.

Conclusion

The two options presented here have the potential for significant change to the welfare system for some, possibly all, SB/IB clients. Option 1 provides a comprehensive scheme for income protection for those in employment and is open to a wide range of sub-options.

Option 2 avoids some of the drawbacks of Option 1 and could be more readily applied to all SB/IB clients, not just those coming out of employment. However it is best thought of not as a comprehensive scheme, but rather as a tool that could be applied to a variety of other arrangements.

A judgement of whether to proceed with consideration of these options would need to take into account the factors described above and also:

- An assessment of the extent to which current SB/IB issues are due to a lack of incentives on the present scheme's managers
- The extent to which prioritisation of health services based on their potential to reduce the time of those sick and incapacitated spent out of the workforce is acceptable.