7 Rehabilitation programs and benefits

7.1 The terms of reference require an examination of *the adequacy, appropriateness and practicability of rehabilitation programs and their benefits.* There is a general acceptance that early access to rehabilitation and injury management, and return to work, leads to improved outcomes for the injured worker and the workers' compensation system.

7.2 The key elements for effective rehabilitation and return to work scheme design have been identified nationally in the *Promoting Excellence* report.[1] There remains, however, significant concern at the lack of comparability across schemes in determining outcomes and benefits, due to the different arrangements. This information would enhance the analysis of current trends and assist in the identification and monitoring of best practice.

7.3 This chapter outlines the practice of rehabilitation and return to work in Australia, with perspectives provided by and on employees, employers, service providers and insurers.

Definition of rehabilitation

7.4 The National Occupational Health and Safety Commission (NOHSC), defines occupational rehabilitation as a managed process involving early intervention with appropriate, adequate and timely services based on assessed needs, and which is aimed at maintaining injured or ill employees in, or returning them to, suitable employment.[2]

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1 Heads of Workers' Compensation Authorities, *Promoting Excellence: National Consistency in Australian Workers' Compensation*, Final and Interim Reports to the Labour Ministers' Council, Melbourne, May 1997 cited in Comcare, Submission No. 32, pp. 43-44.

2 Uniform Guidelines for Accreditation of Rehabilitation Providers [NOHSC:7032(1995)]; http://www.nohsc.gov.au/PDF/Standards/Guidelines/AccreditRehabilitation.pdf

7.5 Much of the evidence received highlights the varying expectations that different parties hold in terms of what is adequate, appropriate and practicable. The Committee clarifies the terms of reference in the following way:

- adequacy: sufficient and satisfactory rehabilitation to meet the needs of the injured worker to return to work;
- appropriateness: suitable rehabilitation designed to meet the longer term needs of injured workers and employers; and
- practicability: rehabilitation programs that are feasible and are cost effective in relation to desired outcomes.

7.6 Occupational rehabilitation providers involve many professions such as occupational therapists, physiotherapists, ergonomists and psychologists and social workers. They operate with those backgrounds in delivery of occupational rehabilitation.

Occupational rehabilitation in Australia

7.7 The systems of operation of Commonwealth, State and Territory occupational rehabilitation (OR) vary significantly. The Return to Work Monitor published by the Heads of Workplace Safety and Compensation Authorities provides a comparison of injured workers' participation in rehabilitation and the costs for each jurisdiction.[3]

7.8 The 2001-02 Return to Work Monitor indicates that 35 per cent of injured workers participated in rehabilitation during 2001-02 with an average cost of rehabilitation of $1 360.[4] Across jurisdictions there is considerable variation in the average cost of rehabilitation, with the ACT costs highest ($2 156) and South Australian costs being the lowest at $639.[5]

7.9 However, given that the benefits available under each scheme differ significantly, the comparisons are limited. The lack of comparable measurement undermines the management of effective rehabilitation

3 The Heads of Workplace Safety and Compensation Authorities, *2001/2002 Australia & New Zealand Return to Work Monitor,* August 2002.

4 The Heads of Workplace Safety and Compensation Authorities, *2001/2002 Australia & New Zealand Return to Work Monitor,* August 2002, pp. 52-53.

5 The fifth annual *Return to Work Monitor* includes all Australian jurisdictions and New Zealand except Western Australia and the Northern Territory.

Australia wide.[6] This inability to compare system characteristics restricts the analysis of system effects on outcomes. The Australian Rehabilitation Providers Association suggested that there should be increased emphasis on national data gathering and statistical analysis.[7]

7.10 In addition, the manner in which rehabilitation providers are involved in the system vary. The schemes differ, for example, in terms of:

- accreditation of occupational rehabilitation providers;
- fee regulation;
- services provided;
- insurance system; and
- referral sources.

7.11 The Department of Employment and Workplace Relations (DEWR) provided an indication of the variation across jurisdictions comparing rehabilitation and return to work provisions.[8] To varying degrees, Australian workers' compensation systems encourage employers to implement best practice workplace rehabilitation. Firstly, each system incorporates statutory rehabilitation obligations for employers (which may be supported by financial penalties for non-compliance). Secondly, employers' claim experience and return to work performance effects insurance costs.

7.12 Currently there is concern that:

> the workers' compensation system is plagued by monitoring, delays and waiting. This waiting costs money and it costs injured workers proper rehabilitation.[9]

Elements of best practice

7.13 In 1997 the Labour Ministers' Council adopted a strategy for continuing workers' compensation reform nationally, noting five key principles of Australian workers' compensation scheme design. The principles were

6 Department of Employment and Workplace Relations, Submission No. 48, p.54; Master Cleaners Guild of Western Australia Inc, Submission No. 59, p. 7; Australian Rehabilitation Providers Association, Submission No. 17, p. 3.

7 Australian Rehabilitation Providers Association, Submission No. 17, p. 5.

8 See Department of Employment and Workplace Relations, Submission No. 48, Attachment E.

9 Dr Paul Pers, Transcript of evidence, 26 November 2002, p.361.

identified by the Heads of Workers' Compensation Authorities (HWCA) in the report, *Promoting Excellence.*[10]

7.14 The *Promoting Excellence* report also identified seven elements of best practice scheme design in relation to rehabilitation and return to work arrangements, often described as total injury management. These total injury management elements are:

- in a workers' compensation system, early return to work is the expected outcome of occupational rehabilitation intervention. Occupational rehabilitation should be workplace based with services aimed at the maintenance or restoration of a worker to appropriate employment;
- the employer should be responsible for assisting in the occupational rehabilitation of injured workers, as well as keeping the job available for a reasonable period;
- occupational rehabilitation services are not required for all injured workers, but where necessary to achieve a return to work, services are most effective when delivered as soon as possible after injury, and subject to regular assessment for relevance, effectiveness and results;
- workers' compensation systems should provide an environment where an early return to work is seen by the injured worker as the most appropriate outcome. This involves an obligation on the injured workers to participate positively in the occupational rehabilitation program and return to work plan;
- insurers and managed fund agents should ensure that there is a clear focus on occupational rehabilitation and return to work as part of the workers' compensation claims management process;
- occupational rehabilitation is most effective when the employee, workers, medical and rehabilitation providers (where involved) jointly develop, implement and show a commitment to return to work programs; and
- the workers' compensation system regulator should have a responsibility to develop and foster a culture that supports and reinforces the expectation of return to work as the normal outcome for any work related injury or disease. The regulator's role should be to develop, communicate, promote and enforce the legislative framework

10 Heads of Workers' Compensation Authorities, *Promoting Excellence: National Consistency in Australian Workers' Compensation*, Final and Interim Reports to the Labour Ministers' Council, Melbourne, May 1997 cited in Comcare, Submission No. 32, pp. 43-44.

required to achieve a return to work and the provision of occupational rehabilitation.

In practice

7.15 The Australian Rehabilitation Providers Association suggested that increasing control and regulation does not necessarily lead to better outcomes. The Association cites Tasmania as an example, having a higher than Australian average durable Return to Work (RTW) rate (79 per cent for 2001-02), with no accreditation procedures, fee setting or other operational controls.[11]

7.16 While specialist intervention is very effective in certain cases, the Western Australian Government commented that it is not always required or appropriate. The cost effectiveness and performance of specialised occupational rehabilitation services needs to be examined.[12] Rehabilitation providers such as ARPA support more comprehensive data collection. Employer groups also identify the need for performance measurement:

> Whilst calls for performance measurement will no doubt result in re-examination of current quantitative outputs it is important that some focus begins to evolve on appropriate qualitative evaluation of the system cultures that underpin operations or as some would say, undermine the various schemes operational around Australia.[13]

7.17 DEWR endorses the elements of total injury management identified in *Promoting Excellence*, however, does not accept the principle of the HWCA model that the cost of an injury to an employee should be shared between the employer, the worker and the community through social welfare programs.

> DEWR considers that the primary responsibility for the cost of a workplace injury, including rehabilitation rests with the employer (via the insurance coverage an employer is required to have with a scheme) and not taxpayer funded social welfare programmes.[14]

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11 Australian Rehabilitation Providers Association, Submission No. 17, p. 5; See also the Heads of Workplace Safety and Compensation Authorities, *2001/2002 Australia & New Zealand Return to Work Monitor,* August 2002.

12 Western Australian Government, Submission No. 36, p. 3; See also Chamber of Commerce and Industry of Western Australia, Submission No. 21, p. 10.

13 Masters Cleaners Guild of Western Australia Inc, Submission No. 59, p. 7.

14 Department of Employment and Workplace Relations, Submission No. 48, p. 51.

The environment

7.18 Management culture and competence play a significant role in determining the rates of injury, workplace disruption and claims cost and level of premium. Workplace change such as downsizing and the significant trend towards more contractor, subcontractor and casual employment relationships have implications for the duty of care to employees by employers.[15]

> The factors outlined above which contribute to higher or lower levels of workplace injury, also directly impact on the effectiveness of OR [Occupational Rehabilitation]. Workplaces that place a high emphasis on care for employee health and safety correlate highly with a management culture that accepts responsibility for employee rehabilitation. Such workplaces participate positively, creatively and constructively in return-to-work programs, and achieve higher return-to-work rates and lower associated costs. Workplaces with low commitment on these measures achieve poorer outcomes.[16]

7.19 The way in which that supportive environment is maintained is important. Anything that undermines the credibility of workers' compensation and rehabilitation schemes will reduce their effectiveness.

> One [indirect cost] is the poor credibility of workers compensation schemes from time to time with employers. That creates risks for injury management. Employers have a very profound responsibility in relation to workers compensation to make sure that they contribute what they can to an injured worker's recovery through offering them alternative duties where they are available to offering a supportive environment et cetera. To the extent that there is fraud in a scheme, that jaundices or prejudices employers' views about the legitimacy of that role, and I think that should not be underestimated.[17]

7.20 The chapter will now provide details of evidence that the Committee received in respect to adequacy, appropriateness and practicability.

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15 Master Cleaners Guild of Western Australia Inc, Submission No. 59, p. 6.

16 Victorian Council of Occupational Rehabilitation Providers, Submission No. 46, p. 2.

17 Mr Mark Goodsell, Australian Industry Group, Transcript of Evidence, 18 October 2002, p. 54.

Adequacy

7.21 The adequacy of rehabilitation requires that it is sufficient and satisfactory to the needs of the injured worker, enabling a return to work. The view of the Australian Manufacturing Workers' Union, Injuries Australia and the Victorian Council of Occupational Rehabilitation Providers was that the practical application of occupational rehabilitation falls well short of the original intent of the legislation.[18]

7.22 Ms Anita Grindlay, following a recent review of 1000 workers' compensation claims commented that:

> a lot of poor return to work outcomes are due to the fact that employers are often acting to the letter of the legislation without necessarily to the spirit.[19]

7.23 Injured workers' support groups are more broadly critical of rehabilitation and rehabilitation providers. They have concerns about timeliness, the amount of worker control in relation to decisions made, the professionalism of the rehabilitation and whether any rehabilitation is provided at all.[20]

7.24 The Australian Nursing Federation (ANF) reports that rehabilitation is not taken seriously by either employers or insurers. The ANF lists problems including:

- injured workers having difficulty accessing rehabilitation or information about available services, and little support from management; and
- the employer not providing alternate duties, or if not possible to return to pre-injury then opportunities for retraining are extremely limited.[21]

7.25 Unions are committed to rehabilitation and return to work as an essential part of the workers' compensation system and to providing justice to workers and long term savings to the system.[22]

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18 Australian Manufacturing Workers' Union; Submission No. 35, p. 13; Injuries Australia Ltd, Submission No. 27, p. 6; Victorian Council of Occupational Rehabilitation Providers, Submission No. 46, p. 3.

19 Ms Anita Grindlay, Transcript of Evidence, 26 November 2002, p. 355.

20 Workers' Compensation Support Network, Submission No. 5, p. 5; Mr Ian Trinne, Injured Workers Association, Transcript of Evidence, 21 November 2002, p. 278; Injuries Australia Ltd, Submission No. 27 p. 6; Mr B C Glover, Submission No. 44, pp. 1-3; Mrs Margaret Pursey, Injured Persons Action and Support Association, Transcript of Evidence, 12 February 2003, p. 442.

21 Australian Nursing Federation, Submission No. 67, p. 8.

22 Community and Public Sector Union, Submission No. 42, p. 3.

Employer perspectives

7.26 A number of employer groups described their commitment to rehabilitation and return to work. Employer groups such as those in the automotive industry are often challenged to find alternative duties that are meaningful and suitable, especially where there may be language, literacy and/or numeracy issues. They suggested that simpler rehabilitation and return to work obligations be implemented.[23] Small businesses echoed these concerns, citing similar problems and requesting simplification.[24]

7.27 Greater success is achieved when an injured worker is able to return in some capacity to pre-injury duties. In 1997 a review of rehabilitation by the Workers' Compensation and Rehabilitation Commission of Western Australia recommended that the major responsibility of injury management and rehabilitation rests with the employer and the injured worker, in consultation with the medical practitioner. Difficulties arise when this cannot occur, because of the unavailability of alternate duties, poor relationships between the employer and worker and/or the medical practitioner.[25]

7.28 The 80-20 *pareto principle* was mentioned by a number of witnesses. Eighty per cent of people who have an injury get back to work with little assistance required, but 20 per cent of the claims become long term and make up 80 per cent of the costs. It is these 20 per cent of claims that need to be better managed not processed.[26] This could be facilitated by a move to exception-based reporting and management.[27]

7.29 Where an injury occurs in manual or labouring trades other employment opportunities are often limited, unless workers have specific skills.[28] This is especially debilitating for younger workers.

7.30 Small business organisations recognise the difficulty with return to work and cited their difficulty in having spare capacity to offer alternative duties which are suitable.[29] They suggested that a pooling arrangement may be helpful to increase the possible supply of available suitable positions.

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23 Victorian Automobile Chamber of Commerce, Submission No. 65, pp. 9-10.

24 Council of Small Business Organisations of Australia, Submission No. 49, pp. 2-3.

25 See also Dr Sherryl Catchpole, Workers' Medical Centre, Transcript of Evidence, 22 November 2002, p. 342.

26 Ms Anita Grindlay, Transcript of Evidence, 26 November 2002, p. 355; Mr Kim Mettam, Charles Taylor Consulting, Transcript of Evidence, 20 November 2002, p. 241.

27 Ms Anita Grindlay, Transcript of Evidence, 26 November 2002, p. 360.

28 Dr Peter Shannon, Submission No. 3, p. 5.

29 Mr Michael Potter, Council of Small Business Organisation of Australia, Transcript of Evidence, 4 December 2002, p. 418.

Referrals

7.31 Much of the discussion of rehabilitation has focused on the time lapse between the injury and the worker's involvement in rehabilitation programs. Often much of the focus of rehabilitation is on acute medical treatment immediately following the injury and for a relatively short time period.[30] However, access to other rehabilitation services is often delayed. For example, where all parties must agree to a referral to a rehabilitation provider this can lead to significant delays. Delays of up to 240 days have been quoted by the Australian Rehabilitation Providers Association (ARPA). ARPA suggests that removing systemic barriers to early referral should be a priority.[31]

7.32 Other examples have also been given where no rehabilitation or ongoing support was provided.[32] In these examples psychological or mental injury was the reason for seeking workers' compensation. There is criticism that any system that takes into account physical problems but ignores the psychological aspects is only a partial system.[33]

7.33 A number of submissions suggested that educating employers about injury management of their own employees would lead to significant improvements in injured workers' rehabilitation.[34] ARPA also suggested that for smaller employers rehabilitation of injured workers' could be helped by insurers at claims management level referring injured workers to occupational rehabilitation services.[35]

7.34 ARPA stated that often the best results for rehabilitation occur in larger organisations and worksites, and that often these are self-insured. Such organisations usually have in-house expertise and the commitment to manage the rehabilitation closely, using internal and external rehabilitation resources. Most small or medium sized employers have limited experience or resources to devote to rehabilitation. ARPA suggested that:

> Achieving early referral and streaming injured workers into appropriate occupational rehabilitation services is the biggest

30 MAXNetwork Pty Ltd, Submission No. 4, p. 2.

31 Australian Rehabilitation Providers Association, Submission No. 17, Appendix 1, p. 5; See also Master Cleaners Guild of Western Australia Inc, Submission No. 59, p. 7.

32 Mr Stig Hellsing, Transcript of Evidence, 16 October 2002, p. 45; Ms Heather McLean, Submission No. 15, p. 3.

33 Dr Peter Shannon, Transcript of Evidence, 20 November 2002, p. 197.

34 For example Australian Industry Group, Submission No. 53, pp. 25-26.

35 Australian Rehabilitation Providers Association, Submission No. 17, p. 4.

> challenge confronting the workers compensation OR [occupational rehabilitation] system today.[36]

7.35 DEWR recommended that more emphasis on early intervention should be on resolving issues at the workplace rather than requiring further regulation.[37] ARPA were also of the view that the most effective occupational rehabilitation is workplace based.[38] The Queensland Government is examining workplace rehabilitation accreditation and factoring in organisational size and risk factors, plus incentives for early intervention and employer reporting.[39]

7.36 The Chamber of Commerce and Industry of Western Australia questioned the efficacy of externally provided rehabilitation. Using Western Australia as an example the Chamber cited a 1997 rehabilitation review:

> 'the utilisation of vocational rehabilitation as a strategy to assist injured workers return to work was associated with an increase in the return to work rate for closed cases from 59% in 1993/94 to 64% in 1994/95'. It also found that the referral to external vocational rehabilitation increased by 39% in the first two years and the cost in the first three years by 186%. Since 1995 the return to work rate has remained reasonably stable.[40]

7.37 Evidence was received of delays in referral leading to reduced likelihood of return to work, reduced worker confidence and higher costs to the schemes. The Committee received evidence that in one state the occupational providers are under significant pressure to assess claimants as having work capacity, not necessarily leading to redeployment assistance but rather to termination strategies if the claimant is reaching the 104 weeks time limit.[41]

Return to work

7.38 Return to work (RTW) refers to an injured worker returning to any paid employment, with the pre-injury employer or with another employer.

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36 Australian Rehabilitation Providers Association, Submission No. 17, p. 4.
37 Department of Employment and Workplace Relations, Submission No. 48, p. 54.
38 Australian Rehabilitation Providers Association, Submission No. 17, pp. 6-7.
39 Queensland Government, Submission No. 30, pp. 9-10.
40 Chamber of Commerce and Industry of Western Australia, Submission 21, p. 8.
41 Victorian Council of Occupational Rehabilitation Providers, Submission No. 46, p. 6.

7.39 The Australia and New Zealand Return to Work Monitor provides an indication of jurisdictional performance.[42] In 2001-2002, 83 per cent of injured workers in Australia had returned to work for some period just over six months after submitting a claim. However this rate has fallen over the last three years, as has the durable RTW rate. Ten per cent of injured workers had attempted to return to work but were not able to sustain employment. This fall in RTW is associated with a rise in average number of days compensation paid per claim, and an increase in national average claim cost to $9 708.[43]

7.40 Other concerns from injured workers involve instances where workers have had their claims for compensation rejected, and then miss out on rehabilitation, thereby reducing their ability to return to work.[44]

7.41 The Australian Manufacturing Workers' Union cited a range of concerns with rehabilitation programs and their administration. In general the AMWU believes that injured workers, especially those with musculoskeletal disorders or psychological injury are discriminated against during return to work or retraining. This includes:

- the lack of provision of suitable duties;
- the lack of or inappropriate vocational retraining;
- the dismissal of injured employees; and
- workers being treated differently through redundancy processes.[45]

7.42 The Recruitment and Consulting Services Association outlined the difficulties in determining obligations for on-hired service providers and host organisations with return to work for injured workers.[46] The assessment of the AMWU is that:

> The lack of suitable duties for people who are employed under labour hire arrangements is appalling. Basically, what happens is that you are injured, you do not get rehab.[47]

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42 The Heads of Workplace Safety and Compensation Authorities, *2001/2002 Australia & New Zealand Return to Work Monitor,* August 2002.

43 The Heads of Workplace Safety and Compensation Authorities, *2001/2002 Australia & New Zealand Return to Work Monitor,* August 2002, pp ii, vi; see also Figure 2, 4, 64.

44 Ms Muriel Dekker, Workers' Compensation Support Network, Transcript of Evidence, 22 November 2002, p. 349.

45 Australian Manufacturing Workers' Union, Submission No. 35, pp. 13 -16.

46 Ms Charles Cameron, Recruitment and Consulting Services Association, Transcript of Evidence, 4 December 2002, p. 430.

47 Dr Deborah Vallance, Australian Manufacturing Workers' Union, Transcript of Evidence, 26 November 2002, p. 383.

7.43 Injured workers involved with intensive redeployment efforts can have success but many become de-motivated as discussed above, and alternative strategies need to be found.[48] In addition, injury can lead to declining self esteem and identity problems. In some cases poor decisions relating to the difficulties in returning to work tragically lead to suicide.[49]

7.44 Significant concerns were raised on the substantial loss of income to workers who are injured at work. For example, in a survey of injured nurses in Victoria, for those that were to return to some form of work, 46 per cent were receiving less income compared to their pre-injury earnings and only 48 per cent were able to work at their pre-injury job or hours.[50] Therefore, the effect of work injury is significant also in financial terms.

7.45 Where there is successful return to work, either to their previous job or alternative employment, then the worker exits the workers' compensation scheme. In some cases this does not occur and the injured worker then seeks other economic compensation where possible, or access to commonwealth benefits schemes.

7.46 Evidence to the Committee stated that rarely is the initial claims manager made accountable for the long term consequences of the inability to return an injured worker to employment. Injured workers' support groups view inadequate rehabilitation efforts and ceasing payments as cost savings to the State and insurers. This is then followed by a cost burden to the Commonwealth, possibly accounting for part of the increase in people receiving a Disability Support Pension.[51] DEWR also raised the issue that allowing claimants to redeem their benefits in a lump sum or a common law settlement rather than return to work may or may not be in the long term best interest of the claimant.[52]

7.47 In relation to outcomes and comparative data there is also criticism of the lack of measurement where a return to work is not achieved. The Victorian Automobile Chamber of Commerce suggested more regular file reviews where there are unsatisfactory delays in an early return to work.[53] Occupational provider groups have criticized the current national measurement of return to work outcomes:

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48 Australian Rehabilitation Providers Association, Submission No. 17, p. 5.

49 Injuries Australia Ltd; Submission No. 27, p. 6.

50 Australian Nursing Federation, Submission No. 67, p. 9.

51 Injuries Australia Ltd; Submission No. 27, p. 7; Injured Workers Association, Submission No. 29, p. 6.

52 Department of Employment and Workplace Relations, Submission No. 48, p. 53.

53 Victorian Automobile Chamber of Commerce, Submission No. 65, p. 8.

> the Campbell survey [Return to Work Monitor], is not an appropriate measure of occupational rehabilitation effectiveness, as occupational rehabilitation is only involved in a minority of open claims.[54]

7.48 Insurers play a crucial role in encouraging rehabilitation and ongoing management. Representatives of the Association of Risk and Insurance Managers of Australasia suggested that schemes discourage recovery because financial incentives mitigate against quick recoveries.[55] The adversarial environment of many workers' compensation schemes does not focus the motivation and commitment on the earliest possible return to work.

Terminations - Discontinuances

7.49 Matching a worker's capabilities and achieving meaningful work should be a key outcome of rehabilitation. However, injured workers are dissatisfied with the 'find a job, any job' approach of some insurers who simply want the workers 'off the books'[56]. Injuries Australia referred to bonuses that insurers or their agents receive in closing cases, rather than effectively managing the rehabilitation of injured workers. It raises the need for appropriate performance measures and incentives for insurers or vocational employment providers.[57] It has been suggested that there needs to be a refocus from short term to long term claims cost thinking.[58]

7.50 The Queensland Government acknowledges the complexity of trying to measure the outcome of rehabilitation once a claim has been closed. WorkCover Queensland has commissioned research to investigate rehabilitation and return to work outcomes.[59] Similarly, the NSW Government through its regulatory authority, WorkCover, has also commissioned research in these areas on health, social and economic outcomes.[60] In particular, the South Australian WorkCover Corporation has been investigating the incidence of suicide, as depression is a significant issue for injured workers.[61]

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54 Ms Jane Barnett, Victorian Council of Occupational Rehabilitation Providers, Transcript of Evidence, 26 November 2002, p. 393.

55 Association of Risk and Insurance Managers of Australasia, Submission No. 11, p. 3.

56 Ms Julia Mourant, Submission No. 12, p. 1.

57 Injuries Australia Ltd, Submission No. 27, p. 6.

58 Comcare, Submission No. 32, p. 45.

59 Queensland Government, Submission No. 30, p. 9.

60 Labor Council of New South Wales, Submission No. 52, p. 3.

61 Ms Gwyneth Regione, Australian Manufacturing Workers' Union, Transcript of Evidence, 26 November 2002, p. 381.

Appropriateness

7.51 The appropriateness of rehabilitation refers to suitable rehabilitation designed to meet the longer term needs of injured workers and employers.

7.52 The RSI and Overuse Injury Association of the ACT suggested a more cautious approach to rehabilitation and return to work dependant on the injury type. The assumption that all injured workers need to return to work as quickly as possible after injury does not hold for workers with occupational overuse syndrome. The Association submitted that if they are returned to previous duties, this approach jeopardises recovery. OOS recovery is recognised as needing months rather than weeks to improve.[62] Suitable duties and appropriate equipment and training need to be provided in a timely manner, for example in the use of voice-operated software or telephone headsets. Research conducted by the AMWU also noted that a significant number of workers were pressured by management to return to work before they were ready.[63]

7.53 Greater flexibility from insurers is also sought in treatment to meet the current needs of the injured worker to enable more control over their rehabilitation.

> At the moment, if you make any changes to the type of treatment you have, it is also assumed that there may be fraud involved. One of the problems with RSI is that it is cumulative in the sense that it depends what you have done that week how bad your condition is and what you might have done to actually flare up the condition. For example, with massage treatment, you get to a stage where you may not need it every week but, if you change that at all, Comcare—I have experience only with Comcare—get a bit strange about changing your treatment regime. I think a lot of people feel like they do not have very much control. I feel there is a lot of money wasted as well because either the doctor makes the decision about what treatment you have or it is an ongoing thing.[64]

Support for changes to career or employment options

7.54 If early return to work is not achieved workers' compensation schemes may not have the requisite longer term skills to assist injured workers make significant changes in their career or employment options. These

62 The RSI and Overuse Injury Association of ACT, Submission No. 24, pp. 2-3.

63 Australian Manufacturing Workers' Union, Submission No. 35, p. 13.

64 Ms Kate Beckett, RSI and Overuse Injury Association of the ACT, Transcript of Evidence, 16 October 2002, p. 30.

required skills may include those most usually displayed in welfare and employment programs; for example, skills facilitating attitudinal and behavioural change to overcome longer term and multiple barriers to employment.[65] This suggests that the programs for longer term injured workers should be re-examined to determine if they are effectively meeting the workers' needs.

7.55 Where retraining and other skills are provided there also needs to be alignment between the injured worker and realistic job expectations. It was reported that the need for retraining is not very well dealt with.[66] In evidence to the Committee, an injured worker cited his frustration with his retraining process. Mr Graham Stewart, previously a truck driver, said:

> They put me in a computer class with 18 women. As I said, I left school halfway through my second year of high school, with very minimal English ability as far as spelling and that. They put me in a room with 18 women to learn a computer. I could not even type therefore I could not keep up with the course, and after about five weeks I dropped out because I could not do it.[67]

7.56 In another case, a production worker with carpel tunnel injuries from repetitive assembly work was provided a word processing course by her insurer. Keyboard work is a significant risk factor for that type of injury.[68] Similarly in other industries, the National Farmers' Federation suggests that rehabilitation services need to have a wider scope with a need for training and retraining services.[69]

7.57 Where it has been identified that injuries sustained by the worker are unlikely to enable return to work, then alternatives to continuing rehabilitation for work purposes should be provided. It was suggested that there would be benefits in allowing greater flexibility in how this is managed rather than pursuing rehabilitation where there is very minimal improvement. Continuing from this point ARPA suggested that schemes should maintain a capacity to settle claims where no positive occupational rehabilitation outcome is realistic.[70]

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65 MaxNetwork Pty Ltd, Submission No. 4, p. 2.

66 Dr Peter Shannon, Transcript of Evidence, 20 November 2002, p. 198.

67 Mr Graham Stewart, Injuries Australia Ltd, Transcript of Evidence, 18 October 2002, p. 94.

68 Australian Manufacturing Workers' Union, Submission No. 35, p. 14.

69 National Farmers' Federation, Submission No. 19, p. 13.

70 Australian Rehabilitation Providers Association, Submission No. 17, pp. 5-7.

Practicability

Compliance

7.58 With respect to workers meeting their obligations, the National Meat Association of Australia (NMAA) raised concerns about injured workers not participating in rehabilitation, and suggested that workers' compensation authorities appear reluctant to take actions against workers.[71] The NMAA claimed that there is little incentive for a worker to return to work.[72] Evidence from reviewing claim files also indicated examples of claimants not turning up for medical appointments and not meeting their rehabilitation conditions after receiving numerous letters outlining their obligations, but the payments do not always cease.[73]

7.59 Evidence from the Victorian Trades Hall Council cited Victorian WorkCover Authority statistics that employers need to meet their legislative responsibilities, and that dismissal of injured workers needs to be further investigated.[74]

> 26% of injured workers do not return to work due to 'loss of job attachment'. 9% are dismissed or retrenched, 7% resign or retire and 10% find that work is no longer available due to its nature (seasonal) or the employer close down.[75]

7.60 Australian jurisdictions have legislative provisions and sanctions which can be imposed on employers for failing to find suitable employment.[76] However, it was suggested that enforcement of non-compliance is scant.[77] The Queensland Government is further investigating and/or developing a trial of a compliance strategy.[78]

7.61 The Victorian Government cited a campaign in April 2002 of distributing CD-ROMs to 180 000 employers, plus advertisements outlining employers' return to work obligations to ensure that injured workers receive

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71 National Meat Association of Australia, Submission No. 41, pp. 18, 25, 34, 55-56.

72 National Meat Association of Australia, Submission No. 41, pp. 39, 53-56.

73 Ms Anita Grindlay, Transcript of Evidence, 26 November 2002, p. 361.

74 Victorian Trades Hall Council, Submission No. 26, p. 3; See also Labor Council of New South Wales, Submission No. 52, p. 3.

75 *The Case for Change*, Victorian WorkCover Authority, 2001, p.14 cited in Victorian Trades Hall Council, Submission No. 26, p.3.

76 See for example, Australian Capital Territory Government, Submission No. 45, pp.4-5.

77 Australian Plaintiff Lawyers Association, Submission No. 39, p. 18; Australian Manufacturing Workers' Union, Submission No. 35, p. 14.

78 Queensland Government, Submission No. 30, pp. 9-10.

appropriate support.[79] Improving return to work outcomes is a major focus of the Victorian WorkCover Authority's new claims management model. Where a claim is identified as high risk the case manager must undertake three-point contact with the employer, the worker and the treating practitioner to establish expectations and clarify obligations in the return to work process. The Australian Capital Territory introduced amendments effective from 1 July 2002, to its Workers' Compensation Act with similar three point contacts and clearer obligations, and personal injury plans, and significant increases in penalties to encourage scheme compliance.[80]

Rural workers

7.62 Injured rural workers have specific needs associated with the high incidence of injury[81] and their frequent remoteness from many services. Injured workers in rural areas also have limited redeployment opportunities, as many work opportunities in agriculture require manual labour. This leads in part to the high cost of claims in the farming sector.[82] Similarly, in the meat industry there are few light duties for return to work programs.[83] The National Farmers' Federation believes that more support is required for rural and regional areas in respect to rehabilitation, return to work and alternative work options. Access to medical specialists, rehabilitation providers, government authorities and claims officers is more difficult and expensive due to travelling time and limited access.[84]

7.63 In Western Australia WorkCover commented on the rural issues:

> There are, particularly in Western Australia, significant issues relating to injured workers being able to receive specialist vocational rehabilitation in country areas. Six vocational rehabilitation providers have country offices and the Commonwealth Rehabilitation Service services most major centres, but that does not detract from the problem for injured workers. If they are injured in a country location, part of vocational rehabilitation is to try to place them in other jobs when they are not able to go back to their existing jobs, and the availability of appropriate employment is a major issue for country people. I am not sure that putting more vocational

79 Victorian Government, Submission No. 37, pp. 14-15.

80 Australian Capital Territory Government, Submission No. 45, Attachment 1.

81 Ms Mary Yaagar, Labour Council of New South Wales, Transcript of Evidence, 18 October 2002, p. 120.

82 National Farmers' Federation, Submission No. 19, p. 11.

83 National Meat Association of Australia, Submission No. 41, p. 34.

84 National Farmers' Federation, Submission No. 19, p. 12.

> rehabilitation people into the country areas would overcome that. It is certainly a major issue.[85]

7.64 The Recruitment and Consulting Services Association voiced their members' concerns on rehabilitation and redeployment. Some employers state that they do not have suitable alternate duties required for rehabilitation and assisting in return to work. They also indicated that there was a fear by some employers of taking on 'someone else's liability' in cases of redeployment.[86]

State arrangements

7.65 Workers' compensation arrangements in relation to rehabilitation vary across the states, as described previously. This has consequences for the rehabilitation and return to work of injured workers employed in other jurisdictions. Employees who move to a different state after becoming injured can have difficulties in receiving the full range of assistance that is normally available to help them achieve a return to work.[87]

> For example, WorkCover New South Wales makes available to New South Wales employers a range of financial and other benefits to encourage them to employ a worker who has been injured while working for another employer in that state. While this is a good initiative, not all of these incentives are made available to an interstate employer who takes on a worker injured in New South Wales.[88]

Service providers

7.66 Interested parties in the rehabilitation and return to work process provided a range of views to the inquiry. Some comments were supportive of rehabilitation service providers,[89] and another publication, the Return to Work Monitor, provides more detailed feedback on the helpfulness of sources of assistance with return to work.[90] However, other comments

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85 Mr Harry Neesham, WorkCover Western Australia, Transcript of Evidence, 20 November 2002, p. 180.

86 Recruitment and Consulting Services Association, Submission No. 20, pp. 8-9.

87 Mr George Smit, Submission No. 61, p. 9.

88 Mr Rex Hoy, Department of Employment and Workplace Relations, Transcript of Evidence, 25 September 2002, p. 15.

89 For example Dr Sherryl Catchpole, Workers' Medical Centre, Submission No. 14a, p. 3; Mr Simon Cocker, Community and Public Sector Union, Transcript of Evidence, 26 November 2002, p. 372.

90 The Heads of Workplace Safety and Compensation Authorities, *2001/2002 Australia & New Zealand Return to Work Monitor*, August 2002, pp. 37-48.

were more critical of the services provided. The number of providers may vary depending on the state arrangements and the severity and the needs of the injured worker. However, it is clear that better communication and cooperation are required to improve services. Depending on the scheme the involvement of claims/case/ and workplace rehabilitation coordinators may be required, and the roles of each are not clearly defined. However, in all schemes the medical practitioner plays a key role.

Medical practitioners

7.67 A number of submissions indicated the pivotal role of the medical practitioner in rehabilitation and early return to work.[91] The need to provide a medical certificate to initiate workers' compensation processes and to recommend suitable duties indicates their pivotal role. Many rehabilitation providers and others have been critical of the performance of medical practitioners, due to limited consultation with the employer, limited demonstration of evidence based care for rehabilitation[92] and limited willingness to participate actively in the injury management and return to work.[93] The need for medical education of practitioners was suggested as necessary to address some of the above concerns.[94]

Third party interest

7.68 Other submissions also outlined possible concerns about medical practitioners, where other providers in the rehabilitation process wish to be involved and affect the outcome of a medical consultation. This raises the topic of partnerships in injury management which will be discussed later in the chapter and are discussed in Chapter 4. Examples of the perceived need for greater involvement in the RTW process were given where rehabilitation providers or return to work practitioners request to be present during medical practitioner interviews or examinations. Workers suggest that this interferes with the doctor/patient relationship.[95]

7.69 Some employer groups state that they are a legitimate third party in the interaction and outcome.

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91 The RiskNet Group, Submission No. 10, p. 10; Chamber of Commerce and Industry of Western Australia, Submission No. 21, p. 9.

92 Evidence based medicine is the use of the best available evidence from the international literature in making decisions about the care of individual patients. Dr Paul Pers, Transcript of Evidence, 26 November 2002, p. 357.

93 National Meat Association of Australia, Submission No. 41, p.44; Master Cleaners Guild of Western Australia Inc, Submission No. 59, p. 7; Mr Mark Goodsell, Australian Industry Group, Transcript of Evidence, 18 October 2002, p. 57.

94 Queensland Government, Submission No. 30, pp. 9-10;

95 Australian Manufacturing Workers' Union, Submission No. 35, pp. 15-16.

> The general point we make is that the medical profession seem to bring to workers compensation their traditional private practice / private patient model of treatment. … The question we are really asking is: is that entirely appropriate for a scheme where there is a legitimate third-party interest in how that patient presents and what is done about that injury?[96]

7.70 The Australian Industry Group recommends education campaigns and performance monitoring of medical practitioners involved in occupational medicine to ensure that appropriate return to work rates are achieved. Claims that are likely to have longer term effects could be dealt with by more specifically trained occupational medical practitioners.[97] In addition, the education of medical practitioners needs to tie in more closely with community needs, rather than the hospital training model.[98]

7.71 Positive work is being done in various jurisdictions in this area. WorkCover in Queensland has a medical unit with a qualified doctor who visits various regions to assist in complaints resolution and develop relationships with doctors in rural towns.[99] Tasmania has a system of accreditation of medical practitioners, and a former chief commissioner of the Workers Rehabilitation and Compensation Tribunal in Tasmania commented that:

> unless medical practitioners are properly trained, know workplaces and understand workplaces, rehabilitation is going to be difficult.[100]

Rehabilitation providers

7.72 Industry groups had differing views on the role of external occupational rehabilitation providers. Overall, submissions from employer groups supported the early intervention and rehabilitation of workplace injuries.[101] However, the Chamber of Commerce and Industry (WA) were more critical of the role of external rehabilitation providers, calling for the cost and performance of vocational rehabilitation to be measured nationally.[102]

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96 Mr Mark Goodsell, Australian Industry Group, Transcript of Evidence, 18 October 2002, p. 56.

97 Mr Mark Goodsell, Australian Industry Group, Transcript of Evidence, 18 October 2002, p. 67.

98 Dr Paul Pers, Transcript of Evidence, 26 November 2002, p. 361.

99 Ms Evron McMahon, WorkCover Queensland, Transcript of Evidence, 22 November 2002, p. 331.

100 Mr Andrew Hemming, HEMSEM, Transcript of Evidence, 13 November 2002, p. 174.

101 Australian Industry Group, Submission No. 53, p. 23.

102 Chamber of Commerce and Industry of Western Australia, Submission No. 21, pp. 9-10.

7.73 The problems Australian Industry Group members experience with rehabilitation providers, though generally not as often, are usually similar to those they face with medical practitioners in the type of patient-provider relationship that is developed, which can exclude the employer from being involved in the development of a rehabilitation plan. Two additional problems were provided when utilising rehabilitation providers:

- There is no check or balance on over-servicing.[103] A third party is funding the patient. There is no financial incentive for the patient to rehabilitate to a point where they either reduce or cease treatment. In Victoria, providers are paid on an hourly rate, and their outcomes are not measured.[104] The Australian Rehabilitation Providers Association suggests a fee-for-service provision, and that outcome focussed performance standards should be introduced to address issues of over-servicing.[105] The Committee was concerned that this partial fee-for-service may be an additional cost burden to injured workers' who may already be on lower incomes following their injury.
- There is a tendency for some employees to begin to believe that rehabilitation treatment is a substitute for an actual return to work strategy. Australian Industry Group suggested that outcomes in workers' compensation need to be linked to work based outcomes rather than general improvements in the injured workers welfare.[106] The Australian Industry Group also advocate increased regulation of rehabilitation providers to ensure better outcome of service.

Rehabilitation and return to work managers

7.74 The roles of a workplace rehabilitation coordinator and a case manager are often similar, depending on the jurisdiction. For example in a publication explaining to injured workers the role of the case manager:

> A case manager's role may include:
>
> - assessing your need for occupational rehabilitation;
> - contracting a (Comcare) approved provider of rehabilitation services;
> - consulting with you and your treating medical practitioner;

103 Australian Industry Group, Submission No. 53, p. 11-12. See also Moreton Exhibitions and Events, Submission No. 63, p. 3; Victorian Automobile Chamber of Commerce, Submission No. 65, p. 8.

104 Ms Anita Grindlay, Transcript of Evidence, 26 November 2002, p. 356.

105 Australian Rehabilitation Providers Association, Submission No. 17, p. 7. See also Australian Industry Group, Submission No. 53, p. 25

106 Australian Industry Group, Submission No. 53, pp. 12, 25.

- negotiating with you and your managers on suitable duties for your return to work;
- the processing of all relevant forms; and
- liaison with you and (Comcare).[107]

7.75 Workplace Rehabilitation Coordinators are a requirement of some States' legislation, with approved training and annual audits to meet legislative requirements.[108] However, examples were given where co-ordinators were appointed with little experience or background in rehabilitation.[109] In this situation, training and education need to be provided. Comcare provided an example of the training that they can provide for case managers, and the need for approved rehabilitation providers.[110]

Insurers

Claims managers

7.76 Claims managers and staff are responsible for the management of a worker's claim, which includes determination of liability and benefit payment.[111] Workers' compensation authorities and claims agents acting on behalf of governments employ claims managers to liaise with the stakeholders and process claims. Much of the success for the injured worker's rehabilitation rests on the effectiveness of the claims manager in promptly processing claims and organising injury management. However, a dilemma frequently arises between expediently processing the worker's compensation claim in financial terms for the insurer and ensuring the best possible long-term outcome for the injured worker.[112]

7.77 Claims staff at insurers are often inexperienced and have enormous case loads. In Victoria they are supposed to have about eighty cases but average about 120. They are lucky to get through the processing let alone manage the claim. The Australian Rehabilitation Providers Association suggested that insurers should be encouraged to increase their in-house occupational rehabilitation expertise to better manage claims.[113]

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107 Comcare, *All about Workers' Compensation. a guide for employees*, sourced 4 February 2003 http://www.comcare.gov.au/publications/wc-employees/contents.html.

108 Queensland Government, Submission No. 30, p. 9.

109 Workers Medical Centre, Submission No. 14a, p. 3.

110 Comcare, Submission No. 32, p. 8.

111 Australian National Audit Office, *Better Practice Guide – Return to Work*, 1996.

112 Dr Christine Roberts-Yates, *The dilemma of the case manager in workers' compensation, Exhibit No. 80*; See also Queensland Government, Submission No. 30, p. 9.

113 Australian Rehabilitation Providers Association, Submission No. 17, p. 7.

Other insurer issues

7.78 Evidence presented to the Committee suggests that self insurers manage rehabilitation more effectively because of their longer term interest in the worker and the financial outcome.[114] However, in those cases, some other injured workers feel more pressured to return to work when they are not ready.[115] Where there are difficulties with the case the injured worker may feel resentment to the employer as their manager rather than as an insurer and have difficulty separating those roles.[116]

7.79 Criticism was presented that if the insurers have a vested financial interest in rehabilitation providers, then rehabilitation on an hourly basis would enable increased fees, and there is no incentive to reduce costs or servicing. These greater costs could lead to increased premiums, leading to greater profits for insurance companies, and suggesting a conflict of interest. It was suggested that if this were the case then there would be no incentive for insurers to encourage effective rehabilitation.[117]

7.80 In Victoria, with changes to the incentive structure focussing more on return to work, the Victorian Council of Occupational Rehabilitation Providers commented that they have no indication of unethical practices between rehabilitation providers and insurers occurring.[118] Along similar lines MAXNetwork indicated that a close relationship between all the key stakeholders is a positive thing. The best service for the injured worker was clearly where partnerships produced the best outcome.[119]

Adversarial system effects

7.81 Rehabilitation providers in some jurisdictions were concerned about the effect of common law access on rehabilitation and return to work. The view expressed by APRA was echoed by a number of other submissions and witnesses.[120]

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114 Mr Bruce Ferguson, Association of Risk and Insurance Managers of Australasia, Transcript of evidence, 20 November 2002, p. 249; Mr George Cooper, Injuries Australia Ltd, Transcript of Evidence, 18 October 2002, p. 91.

115 Dr Deborah Vallance, Australian Manufacturing Workers' Union, Transcript of Evidence, 26 November 2002, pp. 376, 379.

116 Dr Sherryl Catchpole, Workers' Medical Centre, Transcript of Evidence, 22 November 2002, p. 343.

117 Injured Persons Action and Support Association, Submission No. 71, p. 7; O'Halloran and Associates, Submission No. 62, pp. 11-12.

118 Mr John Elrington, Victorian Council of Occupational Rehabilitation Providers, Transcript of Evidence, 26 November 2002, p. 396.

119 Mr Paul Stokes, MAXNetwork Pty Ltd, Transcript of Evidence, 22 November 2002, p. 334.

120 For example Mr Douglas Pearce, Insurance Australia Group, Transcript of Evidence, 18 October 2002, p. 71.

> Common law actions focused on negligence generally encourage injured workers and their lawyers to maximise apparent disability in order to achieve the maximum financial settlement of their claims, while insurers and employers conversely seek to minimise apparent disability. Meaningful rehabilitation cannot occur in such a competitive and uncooperative environment.[121]

7.82 Mr Kazimir Kowalski commented that workers' compensation is supposed to be a non-adversarial system, but that it is adversarial, with the concern that WorkCover agencies or similar spend considerable funds on legal advice and representation and little on rehabilitation.[122]

7.83 Limited access to common law has occurred in some jurisdictions; but concerns have been raised by injured workers and their advocates that adequate compensation must remain available for injured workers. From the rehabilitation perspective disputes about liability delay the commencement of rehabilitation, which leads to a lower rate of recovery and return to work. ARPA cited some insurers using occupational rehabilitation services on a 'without prejudice basis' to encourage rehabilitation.

7.84 In response to the trend of people taking more time off work following workplace injuries, insurers are placing greater emphasis on improving rehabilitation strategies.[123]

> In particular, we are working on some strategies to get early intervention operating more effectively in the Commonwealth, even before liability is determined, whether or not a case is compensable.[124]

Rehabilitation costs compared to legal costs

7.85 Associated with the adversarial nature of many workers' compensation schemes, injured workers in part and occupational rehabilitation providers believe that rehabilitation and return to work are considered a secondary concern, and are often overtaken by legal or financial considerations.[125]

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121 Australian Rehabilitation Providers Association, Submission No. 17, p. 5.

122 Mr Kazimir Kowalski, Transcript of Evidence, 21 November 2002, p. 304.

123 Mr Douglas Pearce, Insurance Australia Group, Transcript of Evidence, 18 October 2002, p. 71.

124 Mr Barry Leahy, Comcare, Transcript of Evidence, 18 September 2002, p. 10.

125 Australian Rehabilitation Providers Association, Submission No. 17, p. 6; See also the RSI and Overuse Injury Association of ACT, Submission No. 24, p. 2; Injuries Australia Ltd; Submission No. 27, p. 6.

7.86 Injured workers presented evidence demonstrating the disparity in legal costs compared to rehabilitation costs.[126] An example was provided of approximately $250 000 spent on legal costs and $35 for rehabilitation.[127]

Speed of recovery

7.87 Insurers and employer groups have expressed concern about the slower than expected recovery rate, believing that financial disincentives to return to work play a key role.[128]

7.88 An alternative view is that slower than expected recovery is associated with the stress of the workers' compensation system. This frustration, bitterness and anger is due in part to workers feeling that insurers and providers show no real concern for the injured worker, and the belief that the worker is not being trusted by the employer.[129] It is interesting to note that workers injured in motor vehicle collisions in non-work related accidents do not report similar stress or distrust by their employers and associated parties.[130]

7.89 The amount of control that a person has over their life circumstances impacts on their health outcomes:

> What happens to people in the workers compensation system largely is that they lose control over their lives. They not only lose control over their working lives; they often lose control over their home lives as well because you can no longer help your children and your family in the way that you did previously. That is one reason why workers compensation claimants have poorer outcomes than people with the same injury who are not workers compensation claimants. It is really important to bring this element of control back into workers compensation.[131]

7.90 Research on compensable injuries and health outcomes found that people who are injured and claim compensation for that injury have poorer health outcomes than those who have similar injuries not involved in the compensation process. The findings suggest that a complex interaction is

126 For example Mr Kazimir Kowalski, Submission No. 18, p. 1; Mr Stig Hellsing, Submission No. 33, p. 1.

127 Mr Markham Moore-McQuillan, Submission No. 16, p. 3.

128 Australian Industry Group, Submission No. 53, p. 4; Insurance Australia Group, Submission No. 47, p. 12.

129 Workers' Medical Centre and Queensland Worker's Health Centre, Submission No. 14, pp. 1-2.

130 Injured Workers Association, Submission No. 29, p. 5.

131 Ms Ann Thomson, RSI and Overuse Injury Association of the ACT, Transcript of Evidence, 16 October 2002, p. 39.

present. There is an indication that psychosocial factors play a role and appropriate early intervention can reduce chronicity.[132]

Partnership approach

7.91 The importance of workplace culture in affecting OHS outcomes has been referred to. Similarly, the support from managers and co-workers in rehabilitation is equally important.[133] The Victorian Trades Hall Council outlined the responsibilities of employers in the *Accident Compensation Act 1985 (Vic)*, which relate to ensuring a supportive workplace culture. Employers have a responsibility to ensure that:

- injured workers are treated with respect, compassion and dignity;
- injured workers claims are treated with genuineness and forwarded to claims agents in a timely fashion; and
- injured workers are afforded the opportunity to return to work, when they are able, to their previous position or failing this to an equivalent position agreeable to the worker, their treating medical practitioner and other representatives.[134]

7.92 The Committee received additional evidence on the importance of developing a partnership approach rather than what has been described as an adversarial system. The need for change by all stakeholders in the rehabilitation process has been identified. The claims/injury management and rehabilitation system has been characterised by organisational rigidity and fixed expectations, where a more flexible system is required to minimise the stressors of the system improve communication and outcomes for all concerned in the system.[135]

7.93 This partnership approach underpins Comcare's Return to Work Model:

> The best outcomes in rehabilitation are achieved when the employee, employer, approved rehabilitation provider and treating doctor are all focussed on a common goal – that is, making it possible for an individual to remain in their job or return to productive employment following a work related injury.[136]

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132 The Australasian Faculty of Occupational Medicine, *Compensable Injuries and Health Outcomes*, The Royal Australasian College of Physicians, 2001, p. 12.

133 The RSI and Overuse Injury Association of ACT, Submission No. 24, pp. 2- 3.

134 Victorian Trades Hall Council, Submission No. 26, p. 2.

135 Dr Christine Roberts-Yates, Submission No. 56, p. 1.

136 Comcare, Submission No. 32, p. 40.

7.94 Dr Christine Roberts-Yates has examined the role of the parties in the South Australian system, identifying the perceptions of all the stakeholders in the system. She argued that a committed partnership would improve most outcomes rather than an adversarial or disrespectful approach. A considerable range of recommendations have been made. The examples provided below highlight the greater need for:

- education of all parties in injury management and return to work processes;
- greater participation by the injured workers in the process with improved communication with all parties; and
- a reduction in case load for case managers.[137]

Recent initiatives

7.95 A number of initiatives were referred to in the course of the inquiry. Examples are the fact that Comcare's future work will focus on workplace culture and a whole of agency approach including:

- leadership and accountability to improve OHS performance recognising the integration of safety, rehabilitation and compensation arrangements;
- claims management – ensuring development of arrangements to address claims that may potentially lead to extended periods off work. This would include stress claims, soft tissue and occupational overuse injuries; and
- return to work – trans-agency mobility of injured employees, and Return to Work publications.[138]

7.96 The Community and Public Sector Union reports positive outcomes working with Commonwealth government agencies such as the Australian Tax Office.[139] Other initiatives which involve participative arrangements include industry based rehabilitation models. The Queensland Government has been involved with the respective unions, employer associations, and larger employers in building and construction, health,

137 Dr Christine Roberts-Yates, Transcript of Evidence, 21 November 2002, pp. 253-256; See also Comcare, Submission No. 32, p. 44; The RSI and Overuse Injury Association of ACT, Submission No. 24, pp. 2-3.

138 Comcare, Submission No. 32, pp. 48 - 50.

139 Mr Simon Cocker, Community and Public Sector Union, Transcript of Evidence, 26 November 2002, pp. 364-365.

and mining. The Queensland Government also aims to involve injured workers.[140]

7.97 A number of witnesses commented on the benefits of second injury funds or re-employment schemes which have been established in some states.[141] The Queensland Government is researching expanding host employment or job placement options.[142]

Re-employment schemes and incentives

7.98 The National Farmers' Federation commented on the lack of incentives to encourage and implement rehabilitation and return to work best practice.[143] They support the fostering of a culture that reinforces the expectation of return to work as a normal outcome. Incentives to rehabilitate would encourage earlier recovery both from perspectives of the injured worker and cost containment.[144]

7.99 Employment schemes such as the WorkCover Incentive Scheme for Employers in Victoria are supported by the Recruitment and Consulting Services Association as strategies to assist return to work.[145]

7.100 Similarly NSW WorkCover operates a JobCover placement program to encourage employers to employ partially incapacitated workers. A range of financial and other incentives are used to encourage employers to participate.[146] Small business representatives suggested the pooling of opportunities to assist injured workers find positions with suitable duties.[147]

7.101 The Australian Rehabilitation Providers Association advocates the development of a national second injury scheme to assist redeployment of injured workers with limited premium protection for the new employer.[148]

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140 Ms Evron McMahon, WorkCover Queensland, Transcript of Evidence, 22 November 2002, p. 325.

141 For example Mr Robert Guthrie, Transcript of Evidence, 20 November 2002, p. 191; Mr Kim Mettam, Charles Taylor Consulting, Transcript of Evidence, 20 November 2002, p. 247.

142 Queensland Government, Submission No. 30, pp. 9-10.

143 National Farmers' Federation, Submission No. 19, pp. 12-13. See also Victorian Automobile Chamber of Commerce, Submission No.65, p. 8.

144 HEMSEM, Submission No. 28, p. 5.

145 Recruitment and Consulting Services Association, Submission No. 20, p. 10.

146 Department of Employment and Workplace Relations, Submission No. 48, p. 53.

147 Mr Michael Potter, Council of Small Business Organisations of Australia, Transcript of Evidence, 4 December 2002, p. 418.

148 Australian Rehabilitation Providers Association, Submission No. 17, pp.6-7. See also Ms Julie Mills, Recruitment and Consulting Services Association, Transcript of Evidence, 4 December 2002, p. 428.

Australian Industry Group cited participation in the NSW Premium Discount Scheme as a positive example of how education combined with incentives can assist employers in getting better workers' compensation outcomes.[149] Chapter 6 included other comments on the effectiveness of financial incentive schemes.

In review

7.102 In 1998 WorkCover Western Australia published the *Report to the Workers Compensation and Rehabilitation Commission - Review of Rehabilitation*.[150] The report presents a number of recommendations which were similar to the evidence received by this Committee. Below is a summary of findings that are consistent with evidence presented to this Committee.

- workers were often reluctant to commit to vocational rehabilitation programs in fear of demonstrating a capacity for work and having weekly entitlements reduced or ceased;
- there is a need for employers to develop and implement vocational rehabilitation policies and to play a more active role in rehabilitating injured workers;
- there is a need for incentives and more assistance for employers to rehabilitate injured workers;
- there is a poor understanding of the compensation and rehabilitation system by medical practitioners and allied health professionals;
- accredited rehabilitation providers need to be more accountable and their performance more closely monitored, assessed and reviewed;
- legislation does not always provide for appropriate action to be taken in cases where it can be substantiated that an injured worker has not reasonably cooperated in or refused to carry out vocational rehabilitation ;
- the opinions, vested interests and roles of the stakeholders and other parties in the system creates tension and conflict to the detriment of vocational rehabilitation; and
- performance indicators are required to evaluate the effectiveness and efficiency of vocational rehabilitation.[151]

149 Australian Industry Group, Submission No. 53, pp. 25-6.

150 Workers' Compensation and Rehabilitation Commission (WA), *Report to the Workers' Compensation and Rehabilitation Commission - Review of Rehabilitation*. 1998.

151 Original list of findings provided by Chamber of Commerce and Industry of Western Australia, Submission No. 21, p. 9.

The Committee's comments

7.103 The Committee notes that a significant proportion of the evidence received by this inquiry on rehabilitation is similar to evidence received by previous inquiries. Although this suggests a validation of findings, it is of concern that in the ten years since the Industry Commission's inquiry into workers' compensation, which included rehabilitation, there has been little movement in injured workers' and employers' concerns.

7.104 The Committee believes that the need for early rehabilitation and for encouraging early safe return to work cannot be underestimated in terms of personal, business and financial costs. However, this needs to occur in a supportive environment, appropriate to the worker's needs, with clear and realistic expectations and suitable meaningful duties.

7.105 The case has been made to the Committee for the need to change the culture away from an adversarial system to a partnership approach. This requires a range of strategies to inform employers, service providers, injured workers and other interested parties of the benefits of such cooperation. The business case has been clearly made for effective rehabilitation. The current restricted data collection and comparison poses some problems. If information was available this would provide greater persuasive evidence to employers. In addition, the need for evidence based treatment and more enthusiastic involvement by medical practitioners is essential.

7.106 Some jurisdictions have introduced additional incentives and broader based re-employment schemes. Both should provide more support to smaller and or regional employers, and to reduce the stigma that injured workers feel they have when applying for re-deployment. However, there also needs to be continued support for legislative compliance to ensure that employees and employers meet their obligations related to rehabilitation and return to work.