It Pays to Care

Bringing evidence-informed practice to work injury schemes helps workers and their workplaces

A values and principles based approach

April 2022

145 Macquarie Street, Sydney NSW 2000, Australia

Telephone +61 2 9256 5444 | Facsimile +61 2 9251 7476 | Email afoem@racp.edu.au

Contents

About the Royal Australasian College of Physicians (RACP) ... 2
About the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) ... 2
Introduction ... 3
- The need for change ... 4
- Unmanaged psychosocial risks drive poor health and return to work outcomes ... 5
- Psychosocial barriers to recovery and return to work are modifiable ... 6
- Our shared challenges ... 7

What are the principles of healthy injury insurance schemes? ... 8
- Leadership ... 8
- A culture of collaboration ... 8
- Fairness ... 9
- Health of workers is the priority ... 10
- Active and responsive management of individual cases ... 10
- Effective communication ... 11
- Long-term thinking ... 11

References ... 13

About the Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of physicians and trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

About the Australasian Faculty of Occupational and Environmental Medicine (AFOEM)

The AFOEM is a Faculty of the RACP that represents and connects Occupational and Environmental Medicine Fellows and trainees in Australia and Aotearoa New Zealand through its Council and committees. The AFOEM are committed to establishing and maintaining a high standard of training and practice in Occupational and Environmental Medicine in Australia and New Zealand through the training and continuing professional development of members and advocating on their behalf to shape the future of healthcare.

Introduction

> We now have clear evidence that system approaches which address modifiable psychosocial determinants of health can achieve substantial improvements in work disability and its associated costs, in the region of 20-40%.
>
> Recent reviews of scheme operations in two large Australian jurisdictions have highlighted how failures of implementation have strong, negative impacts on both injured workers and businesses.[1,2]

Injury insurance schemes exist to help people in times of need. However, health and return to work (RTW) outcomes are worse for people who receive compensation than for those who do not.[3] Systems that are designed to assist people at a time of need can actually make matters worse.

A strong body of evidence indicates that *modifiable* determinants of health are responsible for much compensation-related stress, unnecessary work disability and suffering. Many of these modifiable determinants of health are not biological or mechanical but social and psychological (psychosocial). Some psychosocial factors are inherent in people, others are introduced by external factors, including work injury insurance schemes themselves.

Over the last decade an increasing body of research has shown that proactively managing psychosocial issues and transitioning to systems that don't themselves erect barriers to recovery substantially improves outcomes and reduces costs.

We are calling for a collective conversation about the need to reconnect injury insurance schemes with the values commonly shared by people – honesty, respect, fairness, compassion and collaboration.

Evidence shows that values matter. Injury insurance systems that are fair, respectful, engaging, transparent and collaborative support recovery and RTW. Systems that are not founded on these values, or not designed and resourced in a way that enables the implementation of these values, jeopardise recovery and RTW. We seek to build a coalition to tackle this public health problem.

This document offers a values-based summary of why "it pays to care" and introduces the principles of 'healthy' insurance schemes. The longer companion document, *It Pays to Care: An evidence-based discussion paper*, presents the supporting evidence, canvasses the gaps between current and evidence-informed practices and outlines suggestions for improvements.

The need for change

Most people RTW after injury or illness with little difficulty. However, a significant minority struggle to recover, remaining off work for longer than expected for their medical condition. Some will never return to the workforce. The human and financial costs are immense.

Health outcomes are worse. When an injury or medical condition occurs in a compensation setting the chance of a poor health outcome is about four times that of the same condition without compensation.[3,4] This holds for all health conditions studied: back strain, a disc prolapse requiring surgery, a rotator cuff shoulder tear, carpal tunnel, tennis elbow etc. The increased risk of a poor health outcome is even greater for workers who have claimed for psychological injury.[5]

Psychological distress is widespread. Around one in four people (28%) claiming compensation for injury or illness report moderate psychological distress and around one in eight (14%) report severe psychological distress.[6] This is close to three times the rates of psychological distress in the general community.

Delayed recovery and RTW can lead to long-term worklessness. Barriers to prompt recovery can have long-term consequences: the longer a person is away from work, the less likely it becomes they will ever return. In the position statement *Realising the Health Benefits of Work*[7], the substantial negative impacts of long-term worklessness, including poorer physical and psychological health, financial distress and higher rates of many health conditions are outlined.

Negative intergenerational and community impacts. Over time, a difficult workers compensation claim may instigate a negative cascade in the life of the worker. Isolation, frustration, and strained or broken relationships are common amongst people who get 'stuck' in the system. The children of people experiencing persistent worklessness have higher rates of distress and poorer mental health than children in the general population. With longer term claims, there is often family breakdown, financial distress, and lives significantly impacted.[7]

Financial costs for employers and taxpayers. The costs of work injury schemes are borne by the worker and their family, employer and the community. The major cost driver within a scheme is wage replacement for time off work. Employer insurance premiums and the financial health of schemes are directly linked to the health and RTW outcomes of workers. Many of those who remain out of work long term transition to other schemes: unemployment benefits or the disability support pension, or income maintenance or permanent disability via the life insurance sector. Costs are not just borne by compensation schemes.

Health inequities. Healthcare systems that only focus on the typical 'disease model' do not address social determinants of health adequately. Health equity is the absence of

systematic disparities in the determinants of health between different social groups who have different levels of underlying social advantage/disadvantage.[8] This is often missing in work injury management.

These problems are long standing. Occupational and Environmental Physicians have sought change for over two decades, with publications such as *Compensable Injuries and Health Outcomes,*[8] *Realising the Health Benefits of Work,*[7] *and Employment, Poverty and Health.*[9,10] However, as the evidence-base has grown, the need for change has accelerated.

Unmanaged psychosocial risks drive poor health and return to work outcomes

A strong body of evidence links the relatively poor health outcomes seen in workers compensation systems to poorly managed psychosocial influences.

> One unmanaged psychosocial risk may proliferate.
>
> For instance, an injured worker may tell their treating practitioner that they heard their workplace supervisor verbally humiliate people certified fit for work on modified duties.
>
> Wanting to protect their patient, the treating practitioner may opt to certify time off work rather than recovery at work.
>
> Later, a case manager may question this decision and refer the injured worker to an Independent Medical Examiner – an experience the injured worker may find stressful and disempowering.
>
> Now the injured worker has less confidence in their ability to manage their recovery, and the treating practitioner (who was offended to have their professional judgement questioned) has little interest in collaborating with the case manager or the employer.

Workers exposed to high levels of psychosocial risk have over three times as many days off work as those exposed to low risk.[11]

Regarding return to work, the more psychosocial risk factors a worker is exposed to, the more likely recovery will be delayed. As the number of psychosocial risks increase, so too does the cumulative probability that a worker will not recover from their injury or illness.[11]

Psychosocial risks include:

- Personal psychosocial factors, e.g., low coping ability, fear of re-injury, other health conditions.
- Systemic psychosocial factors, e.g., real or perceived interaction with a system that is experienced as unfair, poor stakeholder engagement.
- Case management psychosocial factors, e.g., delays, poor communication.
- Workplace psychosocial factors, e.g., lack of supportive contact with injured worker, poorly managed modified duties.
- Healthcare psychosocial factors, e.g., lack of engagement with work issues and RTW, non-collaborative approach.

Medical practitioners have heard the message that being out of work is bad for health. Yet the rate of certifying an individual unfit for work has increased over the last decade.[12] Medical practitioners may rightly be wary of certifying work capacity if they perceive a lack of workplace support or other psychosocial stressors around the compensation process will do their patient harm.

Psychosocial barriers to recovery and return to work are modifiable

Evidence shows that injured people are healthier and more likely to have durable and timely RTW when injury insurance systems systematically identify and manage psychosocial risks.[13-16]

Risk management can be targeted at the individual (e.g., providing pain management education for a person with chronic pain), the workplace (e.g., training supervisors in the importance of social support for injured workers), health care (e.g., paying treating practitioners to consult with other claims stakeholders), case management systems (e.g., ensuring case managers have appropriate caseloads) and at the overarching system (e.g., fair and transparent dispute resolution processes).

Systems of work injury management were developed in the 1980s, with a biomedical model[1] as the framework. Over the last 40 years research on psychosocial factors has progressed from models, or ways of thinking about psychosocial factors, to studies that aim to predict those at risk of long-term disability, to studies that have shown the clear link between psychosocial barriers and prolonged disability.

There is now clear evidence that systematically identifying and managing psychosocial factors, and at the same time minimising system-induced factors, can have an important positive impact on individuals' wellbeing and RTW.

[1] Under the biomedical model health conditions are attributed to physiological deviations from the norm.

- ✓ Having a positive claims experience is strongly associated with having returned to work after accounting for injury, worker, claim and employer factors.
- ✓ Early workplace support is associated with substantially higher rates of RTW.
- ✓ Non-stressful interactions with healthcare providers are associated with higher odds of RTW.

Our shared challenges

- **To ensure that scheme cultures, systems and processes do not create unnecessary barriers to recovery**, but instead encourage positive psychosocial factors (those known to assist recovery and RTW) whilst reducing negative psychosocial factors (those known to slow recovery and RTW).[17]

  There is clear evidence this can be achieved by systems that are based on constructive engagement, collaboration, fairness and respect, caring for the whole person, individual and organisational responsibility and up-to-date evidence-informed healthcare. Further, the functioning of schemes improves where there is shared, reciprocal practice, so stakeholders at all levels can exert ethical influence in any direction.

- **To systematically capture psychosocial information for individual claims and proactively manage psychosocial risk** by providing claimants, workplaces and healthcare practitioners with timely support according to need.

We do not need to ask *if* scheme finances and the societal goal of aiding workers at a time of need can coexist. We need to ask *how* the community that makes up work injury schemes can do things effectively, efficiently, responsibly and collaboratively across Australia and Aotearoa New Zealand.

We know what to do – the challenge is implementation. This needs to be at multiple levels across all aspects of the system.

Scheme arrangements vary across Australia and Aotearoa New Zealand. In many systems there is already a high standard of care. We acknowledge those schemes that have focused on delivering evidence-informed services. We also respect the high standard of service offered across all jurisdictions by proactive case managers and enlightened employers, and treatment providers.

What are the principles of healthy injury insurance schemes?

Leadership

Regulators and insurers set the tone and standard for schemes. Policymakers have the capacity to promote positive psychosocial influence on claims at the level of legislation, standards, culture, scheme oversight, and delivery and dispute systems.

Regulators and policymakers in evidence informed schemes:

- Are seen to be independent from the insurer they are regulating.
- Recognise they set the tone and the culture of the scheme. Clarity of purpose and a strong sense of values underpin cooperation.
- Scheme participants are actively engaged in the shared goal of worker wellbeing and RTW, working to enhance positive collaboration between scheme participants.
- Are consultative, open and transparent, such that scheme participants consider their feedback and input will be heeded. Formal and informal feedback from workers and scheme participants about how the system is operating is encouraged.

Scheme approaches that foster trust are actively pursued by scheme leaders, including:

- Fair application of the rules.
- Prompt identification and resolution of abuses of the scheme (whether by workers, employers or service providers), safeguard stakeholder trust in the integrity of the scheme.

At the workplace, senior managers set the tone and culture of workplaces. Senior managers can lead within their organisation to achieve better RTW results.

To lead, senior managers benefit from reports that outline and monitor progress, line manager engagement and being available for problem solving. They also benefit from an understanding of workplace psychosocial factors and the impact of organisational culture on RTW (and many other facets of employee wellbeing and workplace productivity).

A culture of collaboration

When all players are onside, RTW is more likely. A group will achieve more if group members trust each other to cooperate. A high level of trust, or social capital,[2] results in less disagreement and fewer disputes, streamlined communication, reduced requirements for

[2] *Social capital refers to the collective value of social networks, and is based on trust, reciprocity, information and collaboration, including the social and financial benefits that ensue when people are connected and cooperative.*

written or legal documents and a higher level of engagement. Many have low levels of trust in compensable systems.

Social capital operates on a systemic level. When one person's, or group's, trust is broken, they are less likely to be cooperative, leading others to lose trust in them. Work injury schemes operate more smoothly and RTW is more likely when parties have a level of trust in each other.[18]

Case management systems underpinned by positive communication between stakeholders improve RTW outcomes and reduce costs.[14] The same applies to the workplace. When the worker considers their employer's response to their injury is constructive, RTW is over 40% more likely than when the worker considers their employer's response unhelpful. In psychological injury cases RTW is over 50% more likely where there is a positive employer response.[19]

Disability prevention is an organisation-wide responsibility. Employees and supervisors are the two key groups involved with RTW. RTW coordinators, unions, unit/department managers, human resources, co-workers and senior staff are part of the workplace team. When employees and management work together, outcomes are improved.

Fairness

Workers who perceive they have been dealt with fairly have better health outcomes.[20-22] These include faster recovery, improved self-related quality of life, better physical and psychological health, less pain, less disability and reduced use of healthcare services.

Workers who perceive they are treated fairly by the work injury system are around 25% more likely to RTW.[19] Perceptions of justice are also associated with reduced distress and reduced mental ill-health.[23] Fairness is greater when the following processes are adopted:

Quality decision-making. Decisions are made based on all relevant information, are collaborative, the worker has input into the decision-making process and can voice concerns, and the decision is communicated empathically in an understandable format.

Fair processes. This include advice about how decisions will be made, timeframes for decision-making, and that the person will have an opportunity for input into the process and understands what steps they can take if unhappy with the decision.

A person who receives an unfavourable outcome is more satisfied with and more likely to accept that outcome if they feel that they've been treated fairly throughout the process.[24] When the process is perceived to be fair, the person is less likely to be disenfranchised and dispute the decision, and they are more likely to be cooperative.

Fairness across the scheme. Fairness extends beyond the individual worker. Fairness is important for employers, treating practitioners and scheme participants more generally.

When scheme participants have a sense that the scheme is fair, they are more likely to act cooperatively and collaboratively.

Health of workers is the priority

Foster evidence-informed health care. Evidence-informed principles of management for work injury healthcare include:

- Treatment is evidence-based. Workers have access to appropriate, timely high-quality care. Workers have reliable information about the pros and cons of treatment options.
- Self-management is fostered. Workers are encouraged to take primary responsibility for their health.
- Healthcare practitioners routinely seek to identify psychosocial barriers to RTW, particularly before interventions and in situations where there is delayed RTW.
- Treating practitioners have a range of providers they can refer to for management of identified psychosocial barriers to working.
- Treating practitioners have sufficient time to focus on advice and explanation. Treating general practitioners (GPs) may coordinate all a worker's needs in the context of work incapacity or adopt a medical management role with another health provider or case manager coordinating RTW. Treating GPs have access to Occupational Medicine support to assist with the more complex cases.
- Cultural factors and belief systems are taken into account.
- Treating practitioners consider their role is clear and their opinion is respected.
- Care is holistic, taking into account cultural aspects of those receiving treatment.

Active and responsive management of individual cases

Case management is procedurally fair, timely, proactive and supportive. Evidence informed case management is associated with higher levels of worker perceived fairness/justice, reduced work disability, less distress and less secondary mental ill-health.[4,19,20,22,23,25,26]

Quality case management includes early supportive communication with the worker and the employer. Case management that aids RTW includes:

- Timely claims determination, implementation of wage replacement and decisions regarding provision of treatments.
- Early identification of risks, including psychosocial barriers to RTW.
- Responsive monitoring, tracking the worker's progress and identifying psychosocial barriers that may develop as the claim progresses.
- Regular effective communication includes empathy and support and provision of relevant information.
- Fairness in reviews, such as independent medical examinations, decision-making, and communication between scheme participants.

Evidence informed schemes acknowledge the skills and time commitment of quality case management. The attributes and skills of an effective case manager include:

- Interpersonal skills that enable positive interactions with people in difficult situations.
- Ability to influence multiple scheme participants through verbal and written communication.
- RTW focus and attitude and facilitation skills, including problem solving and conflict resolution.
- Organisational and administrative skills.

Case managers need strong systems to enable them to be effective. Support structures that enable effective case management include:

- A caseload that enables case managers to communicate with relevant parties in a timely fashion.
- Appropriate training, importantly including soft skills such as active listening and effective communication.
- Low staff turnover, which supports continuity of the relationship between the worker and the case manager.
- Effective IT systems that are easy to operate and foster reminders to streamline care.
- Subject matter experts who can provide advice and assistance as needed to case managers.

Effective communication

Evidence has demonstrated that communication approaches have a measurable impact on recovery and RTW. Case management systems underpinned by positive communication between stakeholders improve RTW outcomes and reduce costs.

Timely access to clear and appropriately presented information about processes, rights and responsibilities can increase the perceived fairness of the system and may reduce claimants' drive to seek legal advice.[27] Communication that is respectful, relevant and regular is key.[28]

Helpful practices include user-friendly written material in language that is clear and appropriate for the worker's literacy or familiarity with English and the culture, two-way communication with active listening, early and regular contact with the worker, and responsive communication.

Long-term thinking

Longer term objectives enable broader and deeper thinking and a focus on evidence informed practice. Focusing on key performance indicators (KPIs) or short-term financial results is more likely to skew decisions and increase the risk of unethical decision-making.

Valuing a skilled workforce. The skills and experience of scheme participants impact worker wellbeing and RTW. Developing a stable workforce with the experience to guide and support workers is vital.

- **Case managers**. Case managers trained in soft skills, effective case management approaches and jurisdictional legislative requirements are more effective.
- **Supervisors**. Trained supervisors report greater levels of job satisfaction and have improved RTW results.
- **RTW coordinators**. Workers who report stressful encounters with their RTW coordinator are less likely to RTW. RTW coordinators are provided with basic and advanced training, particularly in soft skills.
- **Medical and treating practitioners**. Doctors and allied health practitioners trained in the health benefits of good work and how they can support workers during undergraduate and postgraduate training are in a better position to assist with recovery and RTW.

Innovation. Encourages system changes over time based on evidence and research.

Research. Difficulties with implementation are a core barrier to the improvement of injury insurance schemes. Implementation research can help identify how systems can be more effective and efficient in delivery of services.

References

1. Victorian Ombudsman. WorkSafe 2: Follow-up investigation into the management of complex workers compensation claim 2019.
2. Dore J. Independent reviewer report on the Nominal Insurer of the NSW workers compensation scheme: The State Insurance Regulatory Authority (NSW); 2019.
3. Murgatroyd F, Casey P, Cameron I, Harris I. The effect of financial compensation on health outcomes following musculoskeletal injury: systematic review. PloS One. 2015;10(2):e0117597.
4. Giummarra MJ, Baker KS, Ioannou L, et al. Associations between compensable injury, perceived fault and pain and disability 1 year after injury: a registry-based Australian cohort study. BMJ Open. 2017;7(10):e017350.
5. Wyatt M, Lane TJ, Cotton P. Return to work in psychological injury claims Analysis of the Return to Work Survey results: Safe Work Australia; 2017.
6. Collie A, Sheehan L, Lane TJ, Iles R. Psychological distress in Workers' Compensation claimants: prevalence, predictors and Mental Health Service use. Journal of Occupational Rehabilitation. 2019:1-9.
7. Australasian Faculty of Occupational and Environmental Medicine. Realising the health benefits of work: Royal Australasian College of Physicians; 2011.
8. Australasian Faculty of Occupational Medicine. Compensable injuries and health outcomes. Royal Australasian College of Physicians Health Policy Unit; 2001.
9. Australasian Faculty of Occupational & Environmental Medicine (AFOEM). Employment, poverty and health: A Statement of Principles. Royal Australasian College of Physicians; 2019.
10. Australasian Faculty of Occupational & Environmental Medicine. Employment, poverty and health: Evidence Review: Royal Australasian College of Physicians; 2019.
11. Nicholas M. Early intervention for known risk factors for delayed recovery from work injuries. TMF Conference Sydney 2015.
12. Ruseckaite R, Collie A, Bohensky M, Brijnath B, Kosny A, Mazza D. Trends in sickness certification of injured workers by general practitioners in Victoria, Australia. Journal of Occupational Rehabilitation. 2014;24(3):525-532.
13. Nicholas M, Pearce G, Gleeson M, Pinto R, Costa D. Work Injury Screening and Early Intervention (WISE) Study. Preliminary outcomes. Presentation to Rehabilitation Psychologists' Interest Group. Sydney. 2015;30.
14. Iles RA, Wyatt M, Pransky G. Multi-faceted case management: reducing compensation costs of musculoskeletal work injuries in Australia. Journal of Occupational Rehabilitation. 2012;22(4):478-488.
15. Wickizer T, Franklin G, Fulton-Kehoe D, et al. Improving quality, preventing disability and reducing costs in workers' compensation healthcare: a population-based intervention study. Medical Care. 2011;49(12):1105-1111.
16. Wickizer T, Franklin G, Fulton-Kehoe D. Innovations in Occupational Health Care delivery can prevent entry into permanent disability: 8-year follow-up of the Washington State Centers for Occupational Health and Education. Medical Care. 2018;56(12):1018.
17. Garton P. Submission on the draft Principles of Practice for Workplace Rehabilitation Providers to the Heads of Workers' Compensation Authorities. 2019.
18. Friesen M, Yassi A, Cooper J. Return-to-work: The importance of human interactions and organizational structures. Work. 2001;17(1):11-22.
19. Wyatt M, Lane T. Return to Work: A comparison of psychological and physical injury claims: Analysis of the Return to Work Survey Results: Safe Work Australia; 2017.
20. Giummarra M, Cameron P, Ponsford J, et al. Return to Work after traumatic injury: Increased work-related disability in injured persons receiving financial compensation

is mediated by perceived injustice. Journal of Occupational Rehabilitation. 2017;27(2):173-185.

21. Ioannou LJ, Cameron PA, Gibson SJ et al. Traumatic injury and perceived injustice: Fault attributions matter in a no-fault" compensation state. PLoS One. 2017;12(6):e0178894.
22. Elbers NA, Collie A, Hogg-Johnson S, Lippel K, Lockwood K, Cameron ID. Differences in perceived fairness and health outcomes in two injury compensation systems: a comparative study. 2016(1471-2458 (Electronic)).
23. Elbers NA, Akkermans AJ, Cuijpers P, Bruinvels DJ. Procedural justice and quality of life in compensation processes. Injury. 2013;44(11):1431-1436.
24. Brockner J, Wiesenfeld BM. An integrative framework for explaining reactions to decisions: interactive effects of outcomes and procedures. Psychol Bull. n.d.;120(2):189-208.
25. Grant GM, O'Donnell ML, Spittal MJ, Creamer M, Studdert DM. Relationship between stressfulness of claiming for injury compensation and long-term recovery: a prospective cohort study. JAMA Psychiatry. 2014;71(4):446.
26. Cocker F, Sim M, Kelsall H, Smith P. The association between time taken to report, lodge, and start wage replacement and Return-to-Work outcomes. Journal of Occupational and Environmental Medicine. 2018;60(7):622-630.
27. Ioannou L, Braaf S, Cameron P, et al. Compensation system experience at 12 months after road or workplace injury in Victoria, Australia. Psychological Injury and Law. 2016;9(4):376-389.
28. Kilgour E, Kosny A, McKenzie D, Collie A. Interactions between injured workers and insurers in workers' compensation systems: a systematic review of qualitative research literature. Journal of Occupational Rehabilitation. 2015;25(1):160-181.