Australian Rehabilitation Providers Association

Submission

Productivity Commission Inquiry into National Workers Compensation and Occupational Health & Safety Frameworks

22 August 2003

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Introduction

The Australian Rehabilitation Providers Association (ARPA) welcomes this opportunity to lodge formal submissions to the Productivity Commission Inquiry into National Workers Compensation and Occupational Health & Safety Frameworks and expresses appreciation for the additional time afforded to ARPA for preparation.

This submission incorporates concerns raised by the affiliate members of ARPA, namely the representative organisations for rehabilitation providers to each workers compensation scheme in Australia. These include:

ARPPS – Assoc. of Rehabilitation Providers in the Private Sector (NSW)

ARPPS (ACT chapter) Incorporated

VCORP – Victorian Council of Occupational Rehabilitation Providers

RPA (WA) – Rehabilitation Providers Association of Western Australia

TAVRP – Tasmanian Association of Vocational Rehabilitation Providers

NTARP - Northern Territory Association of Rehabilitation Providers

SARPA - South Australian Rehabilitation Providers Association

QRPA – Queensland Rehabilitation Provider Association

A survey of the views of representatives of our affiliate members has been conducted dealing with each of the Terms of Reference with an emphasis on rehabilitation issues. This submission sets out the findings of that survey.

The submission also provides positions on key issues, specifically drawing on experience under each regime, that affect all rehabilitation providers across Australia. These positions should be considered in

conjunction with submissions and hearing transcripts from rehabilitation agencies and by the associations listed above.

About ARPA

ARPA through its member associations represents some 1000 rehabilitation providers employed by some 300 companies in Australia. Across the nation there are 467 accredited Occupational Rehabilitation Providers. Rehabilitation Providers within Australia include single operators, small to medium business as well as national companies.

ARPA has been in operation for just two years and grew from recognition of the need for a peak body to represent the interests of the State and Territory Rehabilitation Provider Associations at a national level. The Objects of ARPA are:

i. To be the national representative body for Rehabilitation Providers in Australia

ii. To develop and implement a national code of practice for professional standards and ethics in line with individual State and Territory requirements and international best practice.

iii. To initiate and facilitate research and development to support the aims and objectives of ARPA.

iv. To increase the awareness and profile of the rehabilitation industry.

v. To promote national consistency in rehabilitation service provision.

To date, ARPA has progressed these objectives through the development of a National Data Base including rehabilitation processes, timeframes, costs and outcomes; development of a Code of Practice for Rehabilitation Providers; and preparation for the convening of a national conference to

be held in March 2004. ARPA has developed an Australian Occupational Rehabilitation Providers Comparison Table. This table is regularly updated as changes occur within the different jurisdictions. See Attachment.

ARPA Core Position

Early and effective Occupational Rehabilitation delivered by appropriately qualified Rehabilitation Providers is critical to minimisation of the financial, social and personal costs of work-related injury and illness. The impacts of effective rehabilitation outcome are as follows: (please refer to the attached document 'Cost Effective Rehabilitation Framework'.)

Rehabilitation Outcomes

REHABILITATION IMPACTS

Best practical levels of psychological and physical recovery

Restoration to the community

Return to work

Independence

CLIENT IMPACTS

Increased capacity

Improved independence

Community Participation

Self esteem

EMPLOYER CUSTOMER IMPACTS

Reduced overheads / on costs

Improved OHS&W

Improved work environment

Improved productivity

SCHEME IMPACTS

Objects met

Liability reduced/ Scheme viability

STATE IMPACTS

Reduced disabled dependency

Increased productivity

Reduced overheads/ on cost to business

Social benefits

State competitiveness

ARPA considers that the rehabilitation industry in Australia is at a critical point. It must move to a self-regulation model incorporating industry-based accreditation, free market pricing, industry based complaint handling, accountability to regulators based on outcome based performance monitoring and a general withdrawal of regulators from the role of operational supervisors. The consequences of no change at this time will be a steady increase in the population of workers that could have been effectively returned to work and to competency as members of the community; but now are forced to fall under social security and lifetimes of impaired potential.

In particular ARPA takes the view that the heavy handed, inconsistent and constantly changing mechanisms used by some regulators disrupt early and targeted intervention to the detriment of injured workers. In contrast the employees of self-insured organisations usually enjoy timely and effective rehabilitation services and consequently a far higher chance of returning to work of any kind.

This failure of understanding of the professional issues involved in rehabilitation and return to work permeates all levels of the regimes, resulting in mediocre policy development and poor outcomes. Comprehensive training for insurers, regime staff, and other stakeholders is necessary and at the very least those in claims-decision-making positions should have some formal qualifications.

Too frequently, ARPA observes throughout Australia, that the decision-making over the delivery of complex professional rehabilitation services is in the hands of inadequately qualified and skilled insurance staff. The results are deferred rehabilitation action, delayed recovery and return to work, additional costs, increased litigation, worker feeling disenfranchised, and more workers on social security after they have been

rejected from the scheme. There is also a trend to the introduction of programs where workers are deemed ready for work after perfunctory fixed fee rehabilitation 'programs' without adequate review of rehabilitation needs. There are now high disputation rates as workers object and with decreasing actual return to work rates (as against 'work ready rates'), which are largely a product of these trends.

In respect of the Terms of reference of the Review, ARPA takes the view that there is a clear need for:

- Consistent **Rehabilitation Provider accreditation** requirements to achieve highest standards of professional conduct across the nation. This may be achieved most effectively through the development of an Industry Code of Conduct and self-regulation.

- Regular **monitoring of claims handling and rehabilitation processes** within each scheme to assess and maintain desired standards and outcomes.

- Current regulation in many jurisdictions is not supported by best practice research. There is now a considerable body of research related to claims and injury management in workers' compensation (we have referred to some of these results in Attachment B of this submission). A requirement for jurisdictions to adhere to **best practice guidance materials** may ensure more effective processes are implemented.

- The relationship and responsibilities of **employer and employee** to each other must become the dominant feature of workers compensation in Australia. Too often in current regimes, the employer is not involved in claim management decision-making and the employee is kept from the workplace for an unnecessary period of time.

- ARPA supports a scheme that is subject to **competition through market forces**. Competition encourages businesses to be innovative, improve efficiencies and achieve quality service standards with

ultimate benefit to consumers. We do not support the concept of fee setting by regulators.

- Guidelines for all jurisdictions to implement evidence-based strategies to achieve **early intervention**.

- **Training** of all parties regarding issues that are specific to the achievement of successful outcomes in Injury Management and Return to Work.

- **Decision-making** regarding rehabilitation interventions should not be in the hands of unqualified insurance claims officers. In most circumstances the recommendations made by an Accredited Rehabilitation Provider has been formulated with the benefit of professional knowledge and experience. These recommendations should not be rejected by insurers, agencies or regulators without a clear process of investigation and collaboration with stakeholders. The growing trend for the employment of Injury Management Advisors by insurers is encouraging. However clarity of role is essential. IMA's should not be providing rehabilitation services.

About the survey

The survey was conducted during July 2003 and represents the views of representatives of each of the affiliate associations. It is evident that each jurisdiction has created different issues for our members due to variations in Workers' Compensation law and its administration. It is equally evident that there are common concerns for Rehabilitation Providers across the nation.

Various issues raised in past submissions to the various regimes are also included. (Detailed survey responses may be found in the Attachments.)

Layout of remainder of submission

The remainder of this submission follows the layout of the issues paper – the full results of the survey may be found in the attachments.

National frameworks

ARPA considers that rehabilitation underpins the success of modern workers compensation schemes. Around Australia few regimes make optimal use of rehabilitation. In many instances, rehabilitation is subject to over-regulation of cost structures and a high level of uninformed interference in decisions properly the subject of professional discretion. Moves by regimes to suppress costs are short sighted and result in excessive claims costs. Rehabilitation should be largely directed to removing the barriers to return to work - this can involve facilitating medical treatment, workplace reintegration and in most instances the myriad adjustments required to overcome injury.

Rehabilitation used properly cuts regimes claims costs and adds considerable value to the community.

The survey indicated very strong support for the proposition that:

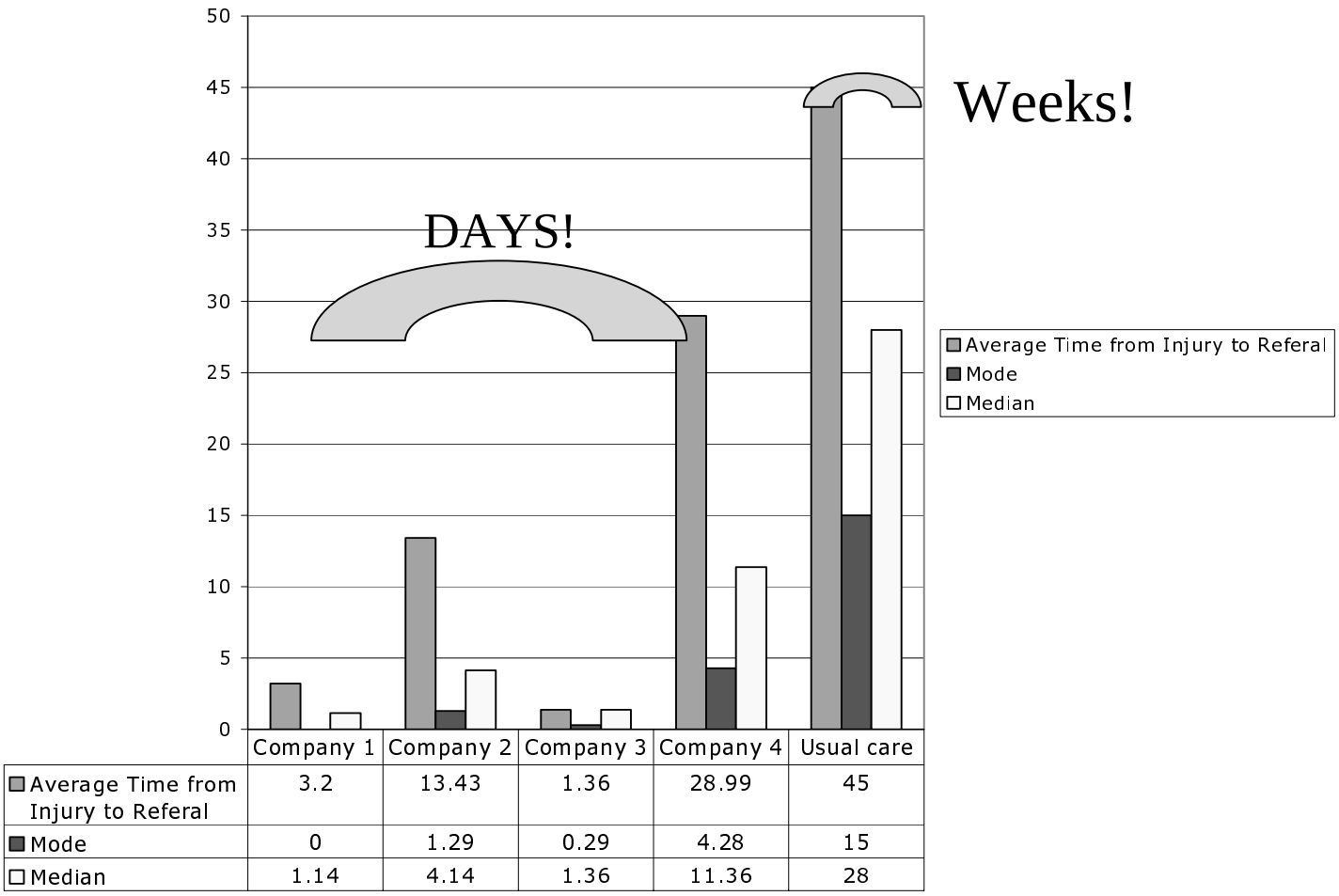
- **'Rehabilitation is not being used to its full potential in most Australian workers compensation regimes. In this most workers compensation regimes lag behind privately insured employers and other clients.'**

Member comments – National frameworks

The graph (provided by VCORP) on the next page shows the difference in outcome between self-insurer results and regime results with out-sourced private insurers and an input management approach. The 'usual care' group refers to cases managed through a state regime – the other 3 companies are national self-insurers.

The impact of the timing of cases is shown by the next graph – early intervention delivers lower claims costs.

Figure 1 – Impact of 'red tape' on early intervention

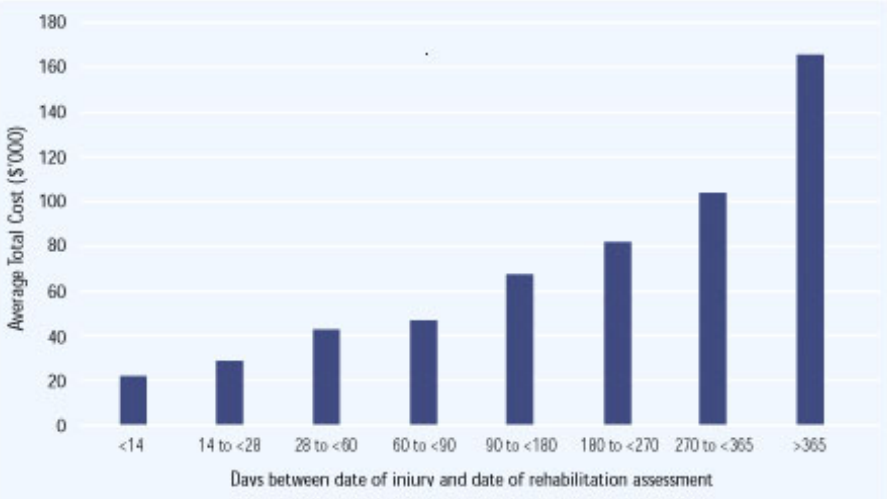


	Company 1	Company 2	Company 3	Company 4	Usual care
Average Time from Injury to Referal	3.2	13.43	1.36	28.99	45
Mode	0	1.29	0.29	4.28	15
Median	1.14	4.14	1.36	11.36	28

Note: The right hand columns - 'usual care'- indicate the number of **weeks** compared with the columns to the left that show the number of **days**. (N = 300). The 'red tape' comprising of written and communicated approvals by a claims officer for each unit of expenditure (hour) on the case ensures that delays are built in and endemic.

Fig 2 – Relationship of early intervention to claims costs

GRAPH 10: Effect of Early Intervention on Average Claim Costs



Graph taken without alteration from the Comcare 1998/1999 Annual Report

This graph shows the relationship between the timing of intervention and eventual claims costs, i.e. weekly benefit payments and medical and other expenses associated with the claim. Research supporting this direct relationship and discounting other factors may be found in the Attachment B.

"*The RPA (WA) strongly agrees that rehabilitation is not being used to its full potential. A key example of this is that the current delay to referral for rehabilitation in WA is 285 days; the RPA is endeavouring to build into legislation or regulations a mandatory referral at four weeks for rehabilitation assessment. Unfortunately, both the government and the WorkCover Authority fail to see the value of early intervention and the need for there to be legislative requirement for this"*

"Different insurers use rehabilitation services and are proactive to varying degrees. The use of IMA's, (Injury Management Advisors) based within insurance company offices, generally provides better education of claims officers and encourages early intervention.

Costs of multiple jurisdictions

Multiple jurisdictions pose additional costs and restraints for rehabilitation companies. The main problems arising from the current arrangements are:

- Inconsistent approval processes and criteria
- Inconsistent training requirements
- Inconsistent fee-setting or intrusive fee arrangements
- Inconsistent compliance arrangements
- Inconsistent 'best practice' approaches
- Inconsistent data collection processes

The survey indicated –

- **Strong support for the propositions:**

  'National rehabilitation companies face significant administrative costs and associated compliance costs due to multiple regimes.'

  'Most regimes are not competent in setting reasonable and effective standards or compliance systems.'

Member comments – Cost of multiple jurisdictions

'The RPA (WA) members that have multiple state offices believe national companies do face significant administrative costs with data collection requirements, performance monitoring, multiple licences required within each state, and service delivery to workers. This manifests in an inconsistent service delivery to workers with so much professional time being wasted on administrative tasks'.

'National rehabilitation companies are required to allocate resources solely to cope with administering services in multiple jurisdictions'.

Member comments – Regulator Competency

'In general Regulators are not competent in ensuring consistent and effective management of workers comp schemes'.

'The RPA (WA) has had ongoing issues with the WA WorkCover Authority over many years regarding their setting of effective standards and compliance systems. An independent analysis of the WA system by Australia's leading statistician quoted "in the absence of adequate sample sizes, documentation of the setting of targets and the adjustment of external factors, I am not able to have any confidence in the existing process. Indeed, the danger that the variation between providers is little more than randomness strongly suggests that it would be very unwise to discriminate between providers or to act upon current performance measures

Preferred framework

ARPA representatives considered the various models proposed by the Inquiry. Briefly they are:

1. A cooperative model - Status quo on OH&S
2. A mutual recognition model - Recognition by all schemes or subscription to one model.
3. An expanded Comcare model - Capacity to subscribe to Comcare self-insurance and benefits across Australia
4. A uniform template legislation model - mirror legislation by all states
5. An extended financial sector regulation model - ASIC & APRA regulation
6. A new national regime - a new national WorkCover scheme.

The advantage to Occupational Rehabilitation providers of a cooperative model is that a national external body would set compliance standards and this would attract some uniformity across the country. There may be disadvantage in that control of the implementation of these standards will

remain with the regimes. ARPA considers that this is a clear situation in which industry self-regulation would achieve the highest of professional standards and in the most cost-effective
manner. Occupational Rehabilitation Providers are supportive of a mutual recognition model. This in combination with the external standard setting body (preferably self-regulation) of the cooperative model is preferable.

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The survey indicated – Strong support for the proposition:

- **'We support a model that allows choice of compliance regime, national application; external standard setting, performance monitoring and auditing; aligns with competition policy in pricing and which is accountable to regulatory efficiency principles.**

"We see the benefit in a nationally consistent framework, but do not wish to see a Comcare-type model, which appears to be process rather than outcome driven." NTARP

Lessons from existing approaches

- Any new model should incorporate the following principles that have been drawn from members experience over the past 15 years.
- Early and strategic intervention is critical to achieving outcomes.
- High-level professional discretion must be supported early to determine RTW plans and appropriate treatment regimes; insurers have limited training, and doctors are often not confident in dealing with the compensation environment.
- The role of Occupational Rehabilitation providers as facilitators to manage the complex issues for Return to Work (RTW) must be recognised in any new functional model.
- The role of the Occupational Rehabilitation Providers must be clearly defined and known by all Stakeholders to optimise outcomes.
- A fostering of partnership between insurer, employer, worker, treatment providers and Occupational Rehabilitation Provider produces the best outcomes.
- Recognition of the particular needs of regional clients and hence regional service providers is required to ensure that services are accessible to all. This may also be a Resource issue for some States and Territories.

Self insurance and rehabilitation

Rehabilitation companies deal with national businesses that may be self-insured in some states and not in others. Generally rehabilitation is more effective for self-insurers as the red tape that complicates the provision of services in WorkCover style regimes is absent. Accordingly rehabilitation companies have some difficulties in offering similar service standards across the country. Inevitably fresh negotiations have to be undertaken with local WorkCover agents in each state. This seems to be a largely redundant activity and an added cost to the rehabilitation provider. Acceptance of the status of contracts agreed to in one regime should extend automatically to all regimes. (See mutual recognition below).

The survey indicated –

- **Strong support for the proposition that OR Providers should be able to offer contracts across borders to companies that are self-insured in one state and not in others without restriction**

Member comments – Self insurers and rehabilitation providers

"Any rehabilitation provider, whether they are based nationally or within one state, should be able to offer contracts across borders. Often, rehabilitation providers are requested to do work from another state or jurisdiction, and the compliance requirements for this are onerous on systems and administration."

Reducing the regulatory burden and compliance costs

Approvals to provide rehabilitation services

Rehabilitation Providers in all regimes are subject to approval processes to operate what are effectively licenses dispensed by the workers compensation agency to deliver and be paid for services. These approval processes are largely consistent; however take different forms - regulation, contractual agreement, committee decisions, and gazetted outcomes. (See attached details for each state and territory). Approval processes vary. In all regimes approvals seek to mandate staff qualifications and service standards. Other states attempt to use performance indicators as criteria for continuation of approvals. For all sizes of business the current approval processes are problematic - it imposes anti-competitive controls on innovation and sets artificial deadlines for re-approval.

ARPA proposes that approval criteria should be based on a rigorous national accreditation process that requires evidence of appropriate qualifications, experience and continuing education. The Australian Association of Occupational Therapists has implemented an exemplary accreditation model, which would be suitable for this purpose.

As per recommendations of the ACCC, ARPA supports the concept that ‘effective codes of conduct deliver real benefits to businesses and consumers with the least possible compliance cost placed on either’. Professional standards can raise consumer’s knowledge of, and confidence in, the quality of professional services. The development of a national accreditation scheme will resolve many issue related to the achievement of highly professional service delivery across the nation.

The survey indicated –

- **Mixed support for the proposition that Approval in one state should automatically mean approval in all states, however**
- **Stronger support with some disagreement to the propositions that approval criteria should consist of capacity to deliver on performance initially and then according to agreed performance standards thereafter , and**
- **Very strong universal support for the proposition that approval criteria should include staff experience.**

Member comments – Mutual recognition & staff experience

"RPA (WA) proposes that mutual recognition should be applied to approvals. Approval criteria should be based on performance and less intrusive requirements.

"While differences between state rules exist, it is reasonable for providers to have to demonstrate their understanding to the regulator of the state rules. VCORP supports consideration be given to industry self regulation. Uniformity across states would enable more efficient handling of cross border provider applications."

"The risk of automatic accreditation across Australia increases the risk of rapidly expanding operators establishing sole consultants in many locations with little or no supervision and infrastructure to ensure quality service provision."NTARP

"VCORP (Vic) supports approval criteria based on capacity to deliver results and is against cumbersome administrative requirements".

"RPA (WA) believes agreed performance standards should exist from day one and be enforced on an ongoing basis."

"We strongly agree that this should be the case. Unsupported new graduates become disillusioned and burn out quickly. They also leave industry early and therefore we lose professionals from the field. Also create a high risk of poor service to clients and customers". NTARP

"VCORP supports inclusion of staff qualifications for delivery of specific services requiring specific expertise, as well as allowing provider discretion to employ staff with required competencies and experience to deliver other services e.g. Job Seeking Assistance services".

"VCORP supports including staff experience in guidelines for providers applying to undertake OR. However VCORP recommends that providers have ultimate discretion to determine an appropriate mix of experience within their organisation. If schemes are structured on measuring outcomes, providers who do not employ sufficiently experienced and qualified staff will not be viable."

"Competencies and / or qualifications should be a part of the approval process" – SARPA.

Pricing structures and fee-setting

Various regimes adopt different pricing structures and fee-setting procedures. Most use an hourly rate system, which generates intensive lobbying and negotiation over the amount of the rate on a periodic basis. No standard rate exists across Australia. There is also little consistency in the processes to set fees.

Current regulation and fee setting in some jurisdictions amounts to nothing more than 'heavy handed' regulation with no real benefit to either service providers or consumers.

Monopoly or market dominant buyers, as well as those that can set rates legislatively, often set rates from the perspective of rehabilitation being a cost driver to the scheme. This results in rates that are insufficient to provide the services and professionalism required by the schemes, injured workers, employers, and other stakeholders. The rates also reflect a risk management approach that ignores the social expectations of the legislation.

The artificial containment of rates ignores many increasing service demands including increased qualifications, service standards, reporting requirements, facilities, accreditation and training as well as the following implications:

- An inability to pay competitive remuneration to Rehabilitation Consultants and to retain the services of quality human resources.
- A disincentive for Rehabilitation Providers to make medium and long-term investments, such as advancements in rehabilitation techniques, specialised programs and support for professional development and quality assurance.
- Limiting the integration of new technologies such as email, the Internet and advancements in payment and reporting systems.
- A disincentive for providers to deliver service to regional areas and small employers. The additional cost of maintaining regional offices has discouraged providers from locating themselves in these areas and the increased cost of educating smaller employers is a disincentive to work with them.

The survey indicated –

- **Mixed views for the proposition that pricing should be undertaken by independent remuneration committees, and similarly for the proposition that fees should be uniform across Australia with variations according to Australian Bureau of Statistic capital city relativities.**
- **There was however much stronger support for the allowance under a national framework of fixed cost arrangements, and private contracting for high cost differentiated services**

Member comments – Fees

NTARP believes pricing should be market driven in all jurisdictions. If fees are set then ORP businesses employ the least expensive / least qualified staff in order to meet costs. Fee setting results in erosion of service quality. The market drives ORP services in the NT, as long as there is an effective Accreditation process this works well. We do not want set fees across Australia given the variation in costs of running business in different locations such as rural and remote service provision. Recruitment costs to NT employers are high particularly to attract allied health professionals, as we have limited courses in NT e.g. no full OT and physiotherapy training in NT.

"We strongly support market driven, non-regulated pricing. Also, we feel that Occupational Rehabilitation Providers should be the ones to set standards in relation to services provided.

In Victoria, flexible cost arrangements already exist and are working well within the self-insured and private market e.g. delivering of pre-claim injury management services.

The RPA WA believes that private contracting negotiated directly with the company should be allowed.

"South Australia went for eight and a half years without a review or change of rates through stalling tactics by the scheme. Even now there is only an interim rate approved with an interim contract nine years from the last rate review."

Cost sharing and cost fixing - Fixed fees and risk sharing

Various regimes are seeking to defray the risk of obtaining return to work outcomes in a reducing job market by introducing fixed fee services. These effectively move the risk and additional cost to rehabilitation providers.

Rehabilitation Providers should be paid an hourly rate for professional services provided.

Many submissions have been made over the years on fee for outcome and the potential for the scheme to risk shift, the potential for those most experienced picking the cream of the referrals, also the potential to adjust the numbers, minimising services to those workers likely to recover anyway and those unlikely to deliver an outcome, while maximising services to the group likely to make the most difference to financial returns.

- **The survey indicated very strong support for the proposition that: Rehabilitation Providers should not be expected to carry the risk of fluctuating employment markets and only being paid on Return to Work (RTW) results.**

Member comments – Outcome based payments

"Current WA legislation requires the demonstration for capacity of work, not successful return to work.

"We agree with "Rehabilitation Providers should not be expected to carry the risk of fluctuating employment markets" and do not feel that providers should be paid on RTW results. We should be paid on an hourly basis for work performed (same as lawyers and other professions)."

"If fee for outcome is used, Rehabilitation Providers should be paid on a number of KPI's that are relevant to the workers market - they should be aligned with the insurer KPI's with the ability to share in the bonuses (SARPA)"

Data collection for regimes

Data collection is an increasing burden in most regimes. While insurers are being squeezed in WorkCover states, the data processing tasks required of them are being passed to Rehabilitation Providers. No compensation is paid for this work and insurers rely on market power over referrals. Data that is provided does not reappear in usable form for either insurers or rehabilitation providers. The key problem is that while insurers can pass this work on, its efficacy in the regime is unlikely to be questioned.

Rehabilitation Providers should not be expected to absorb the costs of the collection of data and maintenance of paperwork for insurers. Data requirements should be subject to external expert committees or regulatory efficiency scrutiny before being introduced. Data collections should be a separate function that is fully costed and paid for by regime administrators. National consistency in data collection should be an important goal of any framework changes.

- **The survey indicated very strong support for the proposition that:**

  'Data collection should be paid for if performed for insurers or for regimes.' and for

Member comments – data collection for regimes

"RPA (WA) members are currently expected to absorb all costs for the collection of data and maintenance of paperwork for WorkCover WA. Data collections should be a separate function that is fully costed and paid for by regime administrators. Providers in the WA system collect more data for the Authority than any other scheme, however the data that is provided back from the Authority does not appear in a usable form for any stakeholders in the system, and often tends to be manipulated to suit the scheme administrators position. Note: in comparison to the WorkCover Authority, insurers within WA do not place onerous data requests on providers. Failure to meet data collection requirements can result in a provider losing their accreditation.

The RPA (WA) agrees strongly with the proposition that external scrutiny is needed. As previously stated, the data collection requirements for providers are onerous and much of the data required has little relevance to the outcome of the scheme performance. In addition, WorkCover WA often feeds back requirements for data clean up, with many cases listed not belonging to the provider in question, i.e., the error rate is high. We feel that the data collected should be consistent across jurisdictions."

Early intervention, rehabilitation and return to work

Early Intervention

Early intervention by rehabilitation providers improves continuance rates and offers the best chance of early return to work. While this is accepted in the literature and research (see attachments), and has been supported by Comcare data, the predominant regime response is delay and red-tape. This is largely driven by concern that allowing rehabilitation providers early access would result in high provider costs. Accordingly, the decision to call in rehabilitation has variously been passed between employer, insurer and treating doctor, or a combination of all three. These approaches ignore the fact that rehabilitation is a specialist role and uninformed referral points hinder return to work and actually drive up costs. This tendency to shy away from intensive, specialist early intervention is a consistent characteristic of workers compensation regimes.

Early intervention is fully supported. It is best delivered where there is either a pre-existing relationship between the OR Provider and the workplace (possible to achieve through premium incentives), or where safety net systems operate. These latter schemes call in rehabilitation assessments by default after a certain period of time lapses after the claim is lodged. ARPA favours a system where by all accepted and deferred claims are immediately screened for risk factors indicating the potential for a high level of incapacity or high cost (several evidence-based screening tools are available), with moderate to high risk claims being immediately referred to a rehabilitation provider for assessment, recommendations and coordination of rehabilitation.

- **The survey indicated mixed views for the proposition that:**

  'Early intervention is not effective because of regime hurdles in our jurisdiction; however there was strong support for the view that early intervention operated best for self insurers in each of the jurisdictions.

- **Insurers were the most appropriate referral points for rehabilitation services ahead of employers and doctors.**

Member comments – early intervention

VCORP made extensive submissions to the House of Representatives Inquiry last year – a copy of the relevant submission is attached. The key points in that submission are that the research shows categorically that early intervention is a pre-condition to high rates of effective return to work. There is an inverse relationship between the likelihood of success and the delay between the first contact of a rehabilitation coordinator and the date of injury and claim.

Members were asked to provide their own statistics to a "Showcase Forum' to the VWA in September 2002. (The results may be found at http://www.transformation.com.au/transformation/LIBDOCS/StrainSprain/showcase.asp)

"Early intervention in WA is simply not occurring because of regime hurdles. (See previously cited delay to referral in results published by WorkCover WA). In WA, early intervention by rehabilitation providers is reduced cost to the system, and has offered the best chance for workers to return to work. The RPA (WA) supports early intervention,

"We do not feel that the jurisdictional requirements in the NT interfere with early intervention framework."

Member comments – referral points to rehabilitation

"Recommendations from doctors re referral to OR should be ratified promptly. However doctors should not be the only gatekeepers of services."

"The RPA (WA) does not believe doctors are the most appropriate referral point for rehabilitation. Doctors can be flagged as one of the potential referral sources, but should not be the main point of referral

Insurers are currently the best placed facilitators of early referral for rehabilitation in the WA system. Whilst employers are the best positioned for this, over 50% of the business in WA relates to small business employers, and they do not have the systems in place to facilitate rehabilitation referral."

"We feel that all of these parties are appropriate referrers, however a lack of training and education regarding rehabilitation prevents them from being well utilised in this respect. NT."

"Employers can be a good point for referral, however should not be the only point. Agents (insurers) are in theory appropriate referral points for rehab; however in practice Agents are not effective in early and / or appropriate referrals. Recommendations from doctors re referral to OR should be ratified promptly. However doctors should not be the only gatekeepers of services. (Vic)"

"We feel that all of these parties are appropriate referrers, however a lack of training and education regarding rehabilitation prevents them from being well utilised in this respect. (NT)"

"In general self insurers are more proactive and effective in early intervention with the exception of poorly performing self insurers"

"The lack of bureaucratic red tape allows early intervention with self insurers. Unfortunately in WA, the referral process is significantly impeded by the requirement for tri-party agreement on referral between the doctor, worker and employer"

"Of course there are exceptions to those referral practices that we disagree with, and which could be appropriate if operating within the right framework. (SA)"

Insurer-owned rehabilitation providers

The *Back on the Job Report* describes concerns that have been raised in relation to insurer-owned rehabilitation providers. These concerns typically are that - conflicts of interest between the interests of the insurer to reduce claims costs and to keep treatment and return to work costs down will result in less than optimal rehabilitation services for injured workers. There is also a view that insurers will refer to their own in-house providers in preference to other more qualified providers in particular those that the worker or employer may prefer.

There are mixed views both within and between jurisdictions about vertical integration. ARPA has no data to support the perception that insurer owned providers demonstrate any conflict of interest. Data that is publicly available in some jurisdictions demonstrates that there are no issues concerning the quality of the performance of insurer owned providers.

The quantity of referrals to one rehabilitation agency does not cause concern to ARPA. ARPA's focus is to ensure that all consumers are provided fair and objective rehabilitation intervention by suitably qualified professionals.

ARPA believes that all Occupational Rehabilitation Providers should be subject to the same accreditation process and performance indicators.

ARPA believes that there are currently many forms of vertical integration that exist within the workers compensation scheme. Within the rehabilitation context as long as key performance indicators such as return to work rates, timeliness and unit service cost are met then the issue of vertical integration should not present a problem. It is imperative that all jurisdictions move to setting key performance indicators, where full disclosure and transparency of data is available to ensure that conflict does not exist. Currently variations exist between jurisdictions regarding transparency. ARPA considers it essential that all schemes ensure disclosure processes as well as service standards.

- **The survey indicated support for the proposition that:**
- **'Insurer owned rehabilitation providers appear to be favoured with more referrals by their insurers than other providers'**

And little support for

- **'Insurer owned rehabilitation providers appear to operate similarly to other providers and compete for work on equal terms'.**

Member comments – insurer owned rehabilitation providers

Availability of transparent data would enable clarification of this issue. (Vic)

"There is no objective evidence that highlights that such cross referrals from partly or wholly owned subsidiaries do in fact compromise the quality of service delivery and outcome. Rather SARPA would propose that within a business context and according to the Corporation requirements for the delivery of rehabilitation services, any organization should be able to provide such services as long as all requirements for service delivery are met.

SARPA acknowledges that in order for there to be an effective outcome in rehabilitation, service delivery must be independent. If there is any bias towards one party involved the likelihood of a successful and durable return to work is significantly diminished. The ownership of a

rehabilitation organization alone would not impact on its ability to maintain independence or on quality of service delivery.

Any such proposed changes would also have a direct negative impact on both exempt employers and The Crown. Both currently operate and provide rehabilitation services to injured workers from an in house perspective. Whilst clearly there is a direct relationship, systems and processes have been implemented to ensure that independence and quality of service delivery is not compromised. - (SA)".

NOHSC Guidelines on rehabilitation

The Back to the Job Report proposed implementation of NOHSC Guidelines. While written in 1995, these Guidelines have little status or penetration outside Comcare. Most regimes have developed similar guidelines and the ARPA is working on a national code of practice and standards.

A single set of standards of Guidelines would be preferable across Australia; however this would require greater consistency between the regimes than is currently the case. The NOHSC Guidelines serve as a useful template, however they are limited in coverage of the breadth of matters related to rehabilitation. Therefore additional guidelines will need to be developed to address all relevant claim handling and injury management matters.

The survey indicated support for the proposition that:

- **'NOHSC Guidelines should be adopted nationally under a consistent set of regimes or national framework, and**
- **NOHSC Guidelines should be adopted (in a national framework) with variations debated and agreed by representative stakeholders.**

Member comments – National Guidelines

"We agree that nationally consistent guidelines would be useful; however consultation and review of the NOHSC guidelines would be necessary prior to acceptance as there are significant gaps relating to the way professional rehabilitation services are delivered."

Dispute resolution

Litigation and rehabilitation

The Back to the Job Report describes concerns over workers having little incentive to commit to rehabilitation while litigation is on foot. This is either because they are instructed by lawyers to show no improvement to obtain higher awards; or because they see the lump sum as solving their livelihood issues above and beyond any rehabilitation attempts. The Report suggests education and financial advice for workers as one remedy.

Rehabilitation Providers take the view that common law litigation interferes with rehabilitation. The problem is stark where Providers are expected to deliver RTW outcomes despite the non-cooperation of workers. Most Providers collect data to delineate these cases. Delays in litigation processes exacerbate the problem and hinder early intervention. The better regimes overcome this problem with swift conciliation services and no access to common law.

The survey indicated strong support for the propositions that:

- **Litigation with the prospect of lump sum payments interferes with effective rehabilitation in all circumstances, and that**
- **Conciliation services can overcome this problem and facilitate rehabilitation.**

"In WA, a Common Law system operates in conjunction with a privately insured workers' compensation system. Litigation can affect significantly a workers' potential to return to work, however, this can be largely offset by early referral mechanisms, as litigation often does not impact until 6-12 months post injury."

"We do not agree this is the case in all circumstances. We feel that the option of some form of settlement can assist rehabilitation (e.g. Self-employment following redemption / commutation payment). NT does not have common law and we certainly believe this encourages focus on rehabilitation and return to work."

"In theory Conciliation has the potential to overcome problems with participation in rehabilitation when lump sum payments are under legal consideration. However in practice there is little evidence of this being effective. (Vic")

"Conciliation approaches are effective providing that the Conciliation and Review Directorate work in conjunction with rehabilitation providers and support rehabilitation providers in the process. Far too often in WA, the Directorate officers have not taken a hard line on workers' failure to participate in rehabilitation programmes, and simply referred workers back for further rehabilitation if the entitlement is not exhausted."(WA)

"The removal of litigation triggers is the optimal approach" SA

The role of private Insurers in workers compensation schemes

Market power and recognition of rehabilitation provider expertise

Private insurers are the main source of referrals for rehabilitation providers in most regimes. This gives them inordinate market power, particularly where small self-insurance markets are available.

In regimes where the number of insurers has been reduced, this can cause problems for the business survival of rehabilitation providers and the industry as a whole. The cycle begins with fewer insurers and a homogenisation of practices. The benefits arising from insurers' so-called competitive practices are largely lost as regulators driven by cost move to increasingly interfere in how insurers manage claims. In the worst instances regulators will seek to move rehabilitation provider roles to lower paid insurance staff.

Rehabilitation providers find that they are less able to deliver excellent outcomes in these conditions, however are pressured for better results at lower costs. The extent of this type of pressure is inversely proportionate to the number of insurers providing referrals.

However, in regimes where the relationships with private insurers are largely unfettered, results can be vastly improved for workers and employers. The pay-off is in lower claims costs and lower continuance rates.

Without exception these results are achieved in situations where the expertise of the provider is recognised, valued and appropriately remunerated. This factor more than potential for abuse of market power is the most crucial to better outcomes. Its predominance is borne out in the results of monopoly government schemes take on the private insurer's role.

The survey indicated strong support for the propositions that:

- **Private insurers achieve poorer results if they can use market power to force lower prices and lower standards from rehabilitation providers.**

Member comments – market power

Unregulated fees and a free market environment support effective rehabilitation outcomes. In the NT this works well.

A. Supporting Documents.

1. ARPA Affiliate Member Documents

The State and Territory Rehabilitation Provider Associations have, over many years, represented the views of their members to State and Territory workers' compensation regulatory authorities. Representatives have appeared before review committees and submissions have been prepared for legislative reviews or regulatory changes, or in response to yet another recommended change to service requirements or fee setting. ARPA is currently compiling a collection of submission documents that have been prepared by our affiliate member bodies over the past 2 years and these documents will be provided to the Productivity Commission if required.

2. Cost Effective Rehabilitation Framework

This graph summarises the rehabilitation process and the impacts of injury and services and current issues at each stage of the process. This graph is attached to the final page of this document.

B. Vocational Rehabilitation Research Summary

The information below is a summary of some research carried out throughout the world that has identified the benefits of occupational rehabilitation in workers compensation claims, along with the benefits of 'early intervention' of rehabilitation with focus on return to work. It is not exhaustive of the research conducted, but provides an overview supporting ARPA's submission.

Numerous studies have found that the key factor influencing the outcome of Vocational Rehabilitation programs is early referral to a rehabilitation provider. Although some of this research is more than 20 years old, the principle of early intervention remains the same, and the result of delayed intervention can still be seen.

1. In the United States, Spitz (1982) found the following return to work rates for Vocational Rehabilitation referral within:

3 months of injury:	47% RTW
4-6 months post injury:	33% RTW
1 year post injury:	18% RTW

2. Atkinson (1982) undertook a study of closed Minnesota rehabilitation services cases. At the time of the study, Minnesota State law required the employer to refer injured workers to rehabilitation services within 30 days of medical notification of inability to return to work.

   The study found that 82% of all workers returned to work at some time. That of the 18% that did not return to work 75% received Vocational Rehabilitation referral 150 days or more post-injury.

   A further finding was that average cost of cases increased as the **time between injury and Vocational Rehabilitation** referrals was prolonged.

3. A study by the California Workers Compensation Institute in 1983 found that the average cost per case was directly related to the length of time between the **date of injury** and **referral to Vocational Rehabilitation**.

   Cost of Vocational Rehabilitation services with referrals made within:

90 days	$ 5186 (average)
6-12 months	$ 8732
> 18 months	$ 9735

***4. Vocational Rehabilitation and Workers Compensation* (1998)**

This study, undertaken by the Association of Workers Compensation Boards of Canada, examined the experiences of several Workers Compensation Boards that had adopted a wage loss system to compensate for permanent partial disabilities. In this model compensation amounts are based on the difference between pre and post injury earning capacity. Income supplements are provided for earnings shortfalls, but there are no continuing benefits if there is no earnings loss. The study found that:

- Vocational rehabilitation can be a key factor in reducing costs of workplace accidents
- employment found at or near the pre-injury level leads to lower costs.

5. Kenny (1995), Professor of Psychology, University of Sydney, found that "Worker characteristics, the timing and the meaning of the injury to individual workers and conflicting and unstated agendas in the occupational rehabilitation process, were all identified as critical factors which impact on return to work outcomes**." i.e. the real agendas held by workers related to work site issues and stress rather than the injury claimed.**

6. Kenny (1998) found that employers operating with improved OHS, providing **better information** to workers and disputing claims less experienced better return to work rates. Similarly, a Towers Perrin (1993) survey of 1050 employers found that employers who **communicate with workers** on workers compensation experienced reduced costs of litigation.

7. Frank (1998) in a review of intervention studies for work-related low back pain between 1994 and 1998 found that return to work programs implemented in the sub-acute stage (**3-4 weeks to 12 weeks** after the onset of pain) have shown reductions in the amount of time lost from work **by 20-50%**. A secondary finding was that employers who promptly offer **appropriate modified duties** can reduce time lost per episode by at least **30%**. The researchers recommended a coordinated approach utilising: **guidelines**; **return to work programs** at the 3 to 12 weeks stage; and prompt offers of **modified duties** to maximise reduction in return to work rates.

8. Schmidt (1995), in a follow up of outpatients treated in the Netherlands between 1984 and 1987, found that there were **two factors** that had a significant positive impact on employment after work related injury: **vocational rehabilitation** and commencing **work on a trial basis**. The researchers recommend adoption of rehabilitation programs that aim specifically at promoting employment for people with disabilities.

Operating Models of Vocational Rehabilitation

In **Holland** physicians in conjunction with rehabilitation workers are called upon to rate a worker's capacity, both mental and physical, to return to work on a 38-point scale. The rehabilitation provider has powers to provide wage subsidies, adapt jobs, provide transportation allowances and many other things: Berkowitz (1990)

Germany has long used a program of providing vocational rehabilitation rather than permanent disability pensions. Rehabilitation and return-to work assistance is provided through a coordinated system of employment, accident and health insurance and pension funds. Results demonstrate between 80-90% return-to-work using vocational retraining and upgrading of vocational skills: Hursh et al (1999)

C. Australian Occupational Rehabilitation Provider Comparison Table

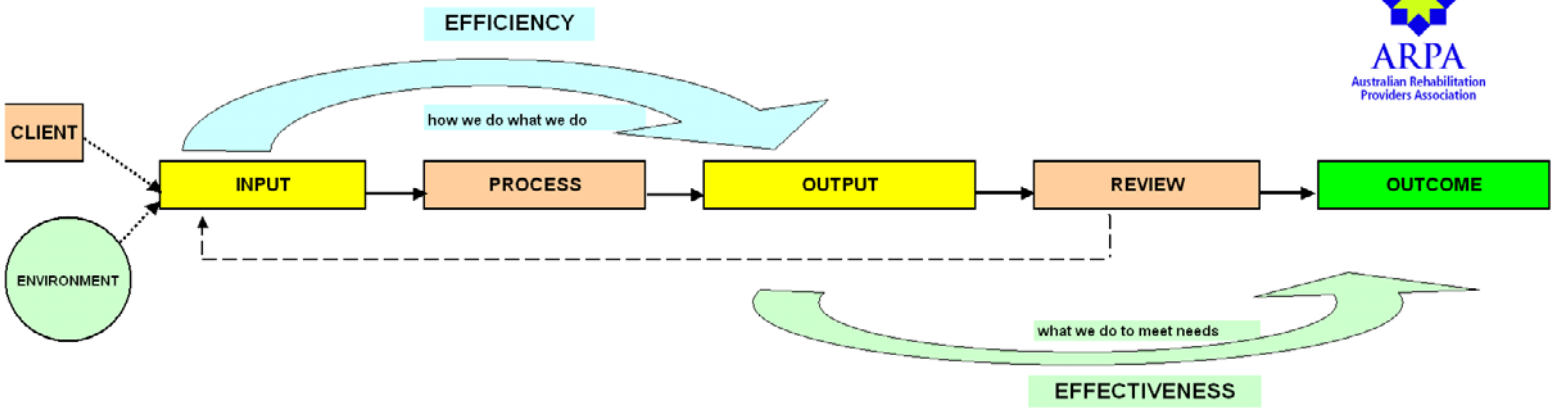
This table is compiled and currency maintained by the Australian Association of Rehabilitation Providers. It provides a summary comparison of the

Occupational Rehabilitation process as currently occurs in each State and

D. Survey results

http://www.transformation.com.au/members/report/rptSurveyGraphShort.asp?surveyID=26&clientID=6

Cost Effective Rehabilitation Framework



ARPA
Australian Rehabilitation Providers Association

injury
disability
potential -psychological
-social
-industrial
issues
work environment
home environment
predispositions

SKILLS
KNOWLEDGE
TECHNOLOGY
GEOGRAPHICAL LOCATION
AVAILABILITY
INFRASTRUCTURE

Current Issues

TERTIARY QUALIFICATIONS
REHAB QUALIFICATIONS
INDUCTION
SUPERVISION PROGRAMS
PROFESSIONAL DEVELOPMENT
RESOURCING SMALL BUSINESS
RESOURCING COUNTRY
ACCESS & EQUITY
TECHNOLOGY UNFRIENDLY
RESTRICTED COMPETITION
ACCREDITATION
INDUSTRY UNCERTAINTY

EVALUATION SERVICES
PLANNING SERVICES
COUNSELLING SERVICES
COORDINATION SERVICES
SUPPORT SERVICES
RETRAINING
ACCOMMODATION IN WORKPLACE
ADL ASSISTANCE
MATCHING SERVICES
RTW MANAGEMENT SERVICES

Current Issues

QUALITY STANDARDS
BEST PRACTICE
CONFIDENCE code of ethics
EARLY INTERVENTION
WORKPLACE BASED
MANAGEMENT SUPPORT
PAY TO ADDRESS NEEDS
MULTI-DISCIPLINARY APPROACH
PRODUCT DEFINITION
INEFFICIENT PROCESSES
PROFESSIONAL DISCRETION
CODE OF CONDUCT

SUITABLE WORK
IMPROVED CAPACITY
REDUCED PAIN
IMPROVED WORKPLACE
IMPROVED WORK HABITS
SUPPORT STRUCTURES
ADJUSTMENT AND REINTEGRATION
KNOWLEDGE TO AVOID RE-INJURY
APPROPRIATE WORKPLACE BEHAVIOUR
APPROPRIATE AIDS, EQUIPMENT, FACILITIES

Current Issues

QUALITY
VALUE
TIMELINESS
SUSTAINABILITY
TIMING OF NEW EMPLOYER FOCUS

ASSESS OUTPUT
DETERMINE OUTCOME ACHIEVEMENT
REVIEW OUTCOME VALIDITY
DETERMINE COST EFFECTIVENESS

Current Issues

BOUNDARIES
COST
COMPLIANCE
RISK SHIFTING
POOR OUTCOME MEASURES
POOR DATA MANAGEMENT
PROCESS MEASUREMENT
Not matched to delivery
Used for outcomes

REHABILITATION IMPACTS

Best practical levels of psychological and physical recovery

Restoration to the community
Return to work
Independence

CLIENT IMPACTS

Increased capacity
Improved independence
Community participation
Self esteem

EMPLOYER CUSTOMER IMPACTS

Reduced overheads / oncosts
Improved OHS&W
Improved work environment
Improved productivity

SCHEME IMPACTS

Objects met
Liability reduced/ Scheme viability

STATE IMPACTS

Reduced disabled dependency
Increased productivity
Reduced overheads/ oncost to business
Social benefits
State competetiveness

Current Issues

LIMITED FOCUS
OUTCOME CONFLICTS
REWARD COMPLEXITIES
RISK SHIFTING

Occupational Rehabilitation Provider Comparisons within Australia – Table 1 ***July 2003***

QUESTIONS	NT	WA	SA	VIC
1. Accreditation				
a) Is there a system of Accreditation of ORP's	Yes	Yes	Yes	Yes
b) Who is responsible for the process?	N.T. Worksafe	WorkCover WA	WorkCover sets the minimum qualification and experience levels. Provider Companies are responsible for ensuring services are provided by qualified professionals although WorkCover will not issue a provider number unless they are also satisfied.	VWA (Victorian WorkCover Authority)
c) Level of accreditation	Single Provider, Agency Employer based provider	Single provider Agency	Agency Agreement as per Act	Agency
d) Requirements for initial accreditation				Service delivery list includes: ▪ years of O.R. experience ▪ qualification ▪ services/individual
Qualifications	▪ Allied Health ▪ Appropriate tertiary	▪ Allied Health	▪ Allied Health ▪ Behavioral Science ▪ Experience Based	
Experience	Completion of questionnaire	▪ 5 years	Experience years from 1 (including supervision program) to 5 depending on service and qualification level	Service provision standards
Supervision		▪ Yes	Undefined supervision program	
Training		No, demonstrated performance Evidence of legislation and rehabilitation process knowledge - Detailed application form plus interview		
Administration Requirements	▪ Quality Assurance ▪ Data management ▪ Financial arrangements Comcare accreditation	▪ Quality Assurance ▪ Data management ▪ Financial arrangements Comcare accreditation	Standards for Agents and WorkCover ▪ Quality Assurance ▪ Data management ▪ Financial arrangements	
e) Is accreditation general or for specific/restricted services?	General ORP	General ORP	General ORP	General ORP
f) How is accreditation maintained? License/Accreditation review Performance Standards Outcome Standards Audit Process	Annual review completion of staff details only. Potential for audit of performance standards.	▪ 12 monthly Performance standards ▪ Duration ▪ Response time ▪ Reporting standard ▪ file management	Only when Agreement is changed (Nearly 5 years since last agreement for Rehabilitation Counsellors, more frequently for OT's, Psychologists, and Physiotherapists)	License/ Accreditation review Currently 4 year licence period - expires mid 2004. All providers need to re-apply at the end of that period.

QUESTIONS	NT	WA	SA	VIC
Staff experience and qualifications		Outcome standards ▪ Benchmarks in place Audit process ▪ Internal ▪ External Staff experience and qualifications - Needs to be submitted to WorkCover regularly	To date all existing providers are considered to be qualified	Lists of service delivery staff forwarded to VWA quarterly
e) When is accreditation revoked?	Following warning and monitoring	Failure to meet performance standards after warning and probationary period.	Following warning and monitoring - In theory. Not seen in practice	Basically, has to be evidence of reasonably significant level of incompetence or fraud
2. Fees				
a)Are fees regulated?	No	Yes	Yes	Yes. Semi regulated. Base rate (indexed annually), and recommended rate (perceived by insurers as a defacto maximum rate, but it is not a maximum rate)
b) If yes, give current fee level		$108 plus GST		$106.39 (excl. GST) Base rate - to increase on 1 July 03 $115 (excl. GST) Recommended rate
c) Who sets and reviews fees?		WorkCover WA	WorkCover SA	VWA
d) How often are fees reviewed?			This is discipline dependent. No formal review of Rehabilitation Counsellors for 9 years, although an interim rate was introduced after 8 1/2 years after Ministerial intervention	Base rate indexed annually. Recommended rate as part of license renewal.
e) How are fees reviewed?		Set without negotiation	Set without negotiation	Linked to CPI (Base rate only) Increase in Recommended Rate will be negotiated with VWA
f) Are the fees the same for all services provided		Yes	No, Variations based on • Profession • Service Travel is set at a lower rate in the interim package	Yes - Currently. However, VWA intending to introduce a flat fee for job seeking services
g) If fees are not set, what is the range within the state/territory?	$95.00 - $150.00		Set but vary between $90 and $135 depending on Profession for the same services	Up to provider and customer to negotiate whether base rate or recommended rate is used
3. Services Provided				
a)What services are provided as Occupational Rehabilitation services	Initial assessment Case management Workplace assessment	Initial assessment Case management Workplace assessment	Initial assessment Workplace assessment Job analysis	Initial assessment Workplace assessment Job analysis (combined with workplace

QUESTIONS	NT	WA	SA	VIC
	Job analysis Job modification Work conditioning Develop RTW program Monitor RTW Monitoring progress Home/ ADL assessment Prescribing aids and equipment Injury Management Counselling and education FCE Rehabilitation Counselling Vocational assessment Vocational Counselling Job seeking Earning capacity assessment Adjustment to disability Cognitive assessment and rehab Communication assess and rehab Pain management Counselling / education Reports Travel	Job analysis Job modification Work conditioning Develop RTW program Monitor RTW Monitoring progress Home/ ADL assessment Prescribing aids and equipment Injury Management Counselling and education FCE Rehabilitation Counselling Vocational assessment Vocational Counselling Job seeking Earning capacity assessment Adjustment to disability Cognitive assessment and rehab Communication assess and rehab Pain management Counselling / education Reports Travel	Job modification Work conditioning Develop RTW program Monitor RTW Monitoring progress Home/ ADL assessment Prescribing aids and equipment Injury Management counselling and education FCE Rehabilitation Counselling Vocational assessment Vocational counselling Job seeking Earning capacity assessment Adjustment to disability Cognitive assessment and rehab Communication assess and rehab Pain management counselling / education Reports Travel Profession, qualification and experience of individual provider dictate the services they can provide. Earning capacity assessment, while performed by OR's, are not classed as rehabilitation services	assessment) Job modification (combined with workplace assessment) Work conditioning Occ Rehabilitation Counselling Vocational assessment Job seeking Functional Assessment Functional education Advice regarding Voc Re-education
b) What OR recommended services maybe funded?	Retraining Physical conditioning Home help	Retraining Physical conditioning	Retraining Physical conditioning Home help	Retraining Physical conditioning Home Help
c) Are OR services and OR recommended services based in legislation, how	Yes Act	Yes Act	Yes Act A wide range of OR services are built into the Act although this does not guarantee their use	Yes Act
d) What is the process of RTW followed by ORP's 1. Initial assessment(s) 2. Barriers to RTW/upgrading if at work identified 3. RTW goal developed after prognosis clarified 4. RTW goal agreed to by all parties,	This is the usual process. Also referral for specific services only.	This is usual process.	1. Occasionally 2. Yes 3. Yes 4. Yes 5. Yes	This broadly describes the process when we get involved in detailed case management. VIC system is not very form and protocol driven - focuses more on required outcomes. Lots of referrals are for one off, specific services.

QUESTIONS	NT	WA	SA	VIC
5. Plan of recommended OR services to insurer,, including time and costs 6. Plan approved 7. Services delivered with reports monthly on progress towards goal. 8. Case closed when goal achieved or agreed that no further rehab will assist.			6. Yes, sometimes with significant amendment 7. Yes, some programs require fortnightly reporting 8. Sometimes. Often case is kept open at Agents request to ensure compliance unless RTW has been achieved	
d) Have Injury Management Protocols or EBM guidelines been adopted by the state / territory regulator?	No	Yes		No
4. Provider Results				
a) What are the RTW outcome rates?	Not available	Same employer - 90.77% New employer - 54.82%	Same employer - 49% New employer - 16% Changing goals - 11% September quarter 20001 WorkCover data	Not available
b) What are the average plan costs for ORP's	Not available	Same employer - $2715.82 (medium costs - average cost N/A) New employer - $4355.000 (median costs - average cost N/A)	Same employer - 515 New employer - 2280 Overall - N/A Year to September 201 quarter WorkCover data median costs	Not available
5. Referrals				
a) Who can refer to ORP Any party Insurer Employer Medical Practitioner Allied Health	Insurer Employer Medical Practitioner	Insurer Employer Medical Practitioner	Any party	Any party
b) Do referrals need to be approved by a particular party	Insurer	Yes - agreement Insurer Employer Medical Practitioner Worker	Insurer	Insurer
c) Decisions for ongoing service provision	Insurer	Insurer Employer Medical Practitioner	Insurer	Insurer
6. Insurance System				
a) What is the state/territory workers compensation insurance scheme?	Privately underwritten Multiple Insurers	Privately underwritten	Employer Funded The South Australian scheme is a hybrid that is employer funded, underwritten by a government enterprise, with claims management only outsourced to a handful of Agents (all insurance companies)	Multiple insurers Premium pool collected by insurers who are 'Authorised Agents' of VWA. VWA has control of premium fund/central pool or money
b) Is Common Law action available to claimants?	Not available	Unlimited	Not available	Limited

QUESTIONS	NT	WA	SA	VIC
c) What are the legislated outcome options?	Alternative Employer Scheme Limited negotiated settlement Commutation/redemption	Negotiated Settlement Commutation/redemption	Alternative Employer Scheme Commutation/redemption	Alternative Employer Scheme Negotiated Settlement Commutation/redemption To some extent, all three options are available. Alt employer scheme (WISE), is not specifically legislated for
d) Insurer numbers per state/territory.	Private Insurers - Self Insurers -	Private Insurers - 8 Self Insurers - 15	Self Insurers About 40% of South Australian workers are covered by self-insured employers. This includes all the State Government	6 Authorised Agents. Approx. 35 self-insurers. 1 'Insurer of last Resort' - NZI Uninsured and Recoupable
7. Employer Issues				
a) Which employers have RTW/Rehab Coordinators in place	Not a legislative requirement Over 20 employees	Not a legislative requirement	Not a legislative requirement Self insured employers are required to Some larger employers choose to	Determined by size of payroll/remuneration - $1, 000,000 and over
b) Who provides training for employer Rehab Coordinators	Employer	Regulatory Authority Private training Provider	Employer No one is required to	Some provided by insurers and some by employer bodies like VECCI
8. ORP State Body Issues				
a) Name the state/territory body	N.T.A.R.P - Northern Territory Association of Rehabilitation Providers	R.P.A (WA) - Rehabilitation Providers Association of Western Australia	S.A.R.P.A - South Australian Rehabilitation Providers Association	VCORP - Victorian Council of Occupation Rehabilitation Providers Inc
b) How many providers in your state/territory	8	18 agency 11 single providers	About 220. Many are single person operators that provide a few irregular services	Approx. 110
c) How many are members of the State/territory body	7	10 agency 2 single providers	23 Agencies representing 135 providers and more than 80% of the market	Approx. 40
d) Who are members	ORP agencies Also Professional Associations	ORP agencies	ORP Agencies are members Individuals are affiliates	ORP Agencies
e) What fees are paid by:	All agency members	Fee range, determined according to ORP size	Fees are based on full time equivalent ORP's	Paid by company, based on number of EFT service delivery staff
f) What are the membership requirements	Pay fees ORP Accreditation Appropriate qualifications Subscribe to Purposes of Association	Pay fees ORP Accreditation	Pay fees Subscribe to Purposes of Association	Pay fees ORP Accreditation Subscribe to Purposes of Association
9. Provider training				
ORP training offered by:	Not available	Regulatory Authority Provider association	Not available	Regulatory Authority Provider Association VWA has started running 'induction' training for new providers Larger providers also run their own training

Occupational Rehabilitation Provider Comparisons within Australia – Table 2 ***July 2003***

QUESTIONS	TAS	NSW	QLD	ACT
1. Accreditation			To be completed in August	
a) Is there a system of Accreditation of ORP's	No	Yes		Yes
b) Who is responsible for the process?	No-one however TAVRP are working towards developing a system with WorkCover Tasmania Board	WorkCover NSW		Comcare Australia Workcover ACT
c) Level of accreditation	Not yet Determined	Provider Company Choose either or both strands: Pre-injury employer RTW; New employer RTW		Single provider status up to multi-disciplinary groups
d) Requirements for initial accreditation Qualifications Experience Supervision Training Administration Requirements	Not yet Determined	Accreditation requirements: ▪ Staffing, including minimum qualification requirements for workplace assessments, functional assess, vocational assts, case management; and induction and supervision programs ▪ Existence of Organisational Philosophy ▪ Case load management activities, and case management systems ▪ Data collection activities, submission of staffing forms (annually) ▪ Evidence of insurances - PI, PL and W/Comp ▪ Evidence of internal quality assurance mechanisms		• Minimum qualifications are Degree or Diploma in Health Science applicable to work to be undertaken. And membership to an association of that discipline. • Six months vocational rehabilitation or a structured supervision program. • Comcare accredited providers training within 6 months of commencement. • Quality assurance measures as set out in the guidelines for rehabilitation providers
e) Is accreditation general or for specific/restricted services?	Not yet Determined	▪ General ORP ▪ Choice between the strands - RTW old employer v new employer, or both		• General
f) How is accreditation maintained? License/Accreditation review Performance Standards Outcome Standards Audit Process Staff experience and qualifications	Not yet Determined	Achievement of annual RTW rates for either or both accredited strands. Minimum of 12 cases closed per year. Low number of complaints against the company. Provision of annual staffing list updates. A risk management approach. Achieve the RTW rates.		• Every two years. (that is if meet the standard of accreditation under review). Six monthly if new and 1 year if fail to meet the standard but can with improvements in work practices.
g) When is accreditation	Not yet Determined	Failure to meet above criteria		When the performance standards are not

QUESTIONS	TAS	NSW	QLD	ACT
revoked?		Unsatisfactory business operations - warning and monitoring, but no improvement WorkCover will come in and audit operations if felt necessary, against the standards outlined in the accreditation requirements.		achieved. Performance standards are measured over 5 criterion (file review, median cost, timeframe, customer satisfaction [client and referrer] and median duration} The other aspect is if the provider was found to be of ill repute or charged with a criminal offence or if the organisation was bankrupt.
2. Fees				
a)Are fees regulated?	No	No		No, market driven
b) If yes, give current fee level				
c) Who sets and reviews fees?				Each provider organisation
d) How often are fees reviewed?				Every one to two years
e) How are fees reviewed?				Salary demands and
e) Are the fees the same for all services provided?				No
d) If fees are not set, what is the range within the state/territory?	Ranges from approximately $100 -$160 per hour not including GST	Varies from $110 per hour upwards to $150 p/h. Some insurers are setting pries for specific services - FCE Voc Ass		$95 - $166
3. Services Provided				
a)What services are provided as Occupational Rehabilitation services	Initial assessment Case management Workplace assessment Job analysis Job modification Work conditioning Develop RTW program Monitor RTW Monitoring progress Home/ ADL assessment Prescribing aids and equipment Injury Management Counselling and education FCE Rehabilitation Counselling Vocational assessment Vocational Counselling Job seeking Earning capacity assessment Adjustment to disability Cognitive assessment and rehab Communication assess and rehab Pain management Counselling / education Reports Travel	Initial assessment Workplace assessment Job analysis Job modification FCE Rehabilitation Counselling Vocational assessment Vocational Counselling Job seeking Reports Work Conditioning Functional Education Monitoring Aids and Equipment Travel		Initial assessment Case management Workplace assessment Job analysis Job modification Work conditioning Develop RTW program Monitor RTW Monitoring progress Home/ ADL assessment Prescribing aids and equipment Injury Management programs Functional Capacity Assessments Rehabilitation Counselling Vocational assessment Job seeking Travel Driving assessments

QUESTIONS	TAS	NSW	QLD	ACT
b) What OR recommended services maybe funded?	Retraining Physical conditioning Home help	Retraining Aids and Modifications		Retraining/Travel / books / home help/ gardening assistance Aids and appliances
c) Are OR services and OR recommended services based in legislation, how	No	Yes Act and Regulations		Yes
d) What is the process of RTW followed by ORP's 1. Initial assessment(s) 2. Barriers to RTW/upgrading if at work identified 3. RTW goal developed after prognosis clarified 4. RTW goal agreed to by all parties, 5. Plan of recommended OR services to insurer, including time and costs 6. Plan approved 7. Services delivered with reports monthly on progress towards goal. 8. Case closed when goal achieved or agreed that no further rehab will assist.	This is the RTW process	Goals can be changed throughout, but the process is still the same		Basically the same process
d) Have Injury Management Protocols or EBM guidelines been adopted by the state / territory regulator?	No	Injury management process as per Workplace Injury Management Act 1998		Yes new Act to Workcover ACT 2002.
4. Provider Results				
a) What are the RTW outcome rates?	n/a	Same employer - 90% New employer - 64% (figures are 12 months case closures to 31/3/03)		90% return to original employer
b) What are the average plan costs for ORP's	n/a	Same employer - $3715 (median - $2950) New employer - $6651 (median - $6024)		Median cost around $1500
5. Referrals				
a) Who can refer to ORP Any party Insurer Employer Medical Practitioner Allied Health	Any party	Any party		Case manager only (Comcare) Insurer (Workcover)
b) Do referrals need to be approved by a particular party	Insurer Employer - less likely	Insurer Employer (some insurers insist on final approval)		Yes Case manager (Comcare) Insurer (Workcover)

QUESTIONS	TAS	NSW	QLD	ACT
c) Decisions for ongoing service provision	Insurer	Insurer		
6. Insurance System				
a) What is the state/territory workers compensation insurance scheme?	Multiple Insurers - including self insurers	Publicly funded		ACT Workcover
b) Is Common Law action available to claimants?	Limited	Limited access		Yes
c) What are the legislated outcome options?	Alternative Employer Scheme Negotiated Settlement Commutation/redemption	Common law Commutations		Common law Commutations
c) Insurer numbers per state/territory.	8 - Private Insurers 18 - Self Insurers 1 - Specialised insurers	6 - Licensed Insurers (fund managers on behalf of WorkCover) 40 - approx Self Insurers 10 - approx Specialised Insurers		6 Licensed Insurers in ACT
7. Employer Issues				
a) Which employers have RTW/Rehab Coordinators in place	Employers with 50 or more employees - which represents a small percentage in Tasmania	Category 1 employers - those with base tariff premium in excess of $50,000; Self-insured; 'Specialised insurer' and has more than 20 employees - all have a trained RTW Coordinator		Not known
b) Who provides training for employer Rehab Coordinators	Insurer Private training Provider	Training through 'accredited' trainers - those trained by WorkCover to provide 'standard' training package		Training through 'accredited' trainers - those trained by Workcover to provide 'standard' training package
8. ORP State Body Issues				
a) Name the state/territory body	T.A.V.R.P – Tasmanian Association of Vocational Rehabilitation Providers	ARPPS - Association of Rehabilitation Providers in the Private Sector		ARPPS (ACT chapter) Incorp.
b) How many providers in your state/territory	Approximately 80 individuals	Approx 115 companies, but there are approx 190 accredited sites - allowing for companies with multiple sites accredited		
c) How many are members of the State/territory body	Approximately 40	Approximately 72		16
d) Who are members	Individuals	The accredited company		Accredited organisation
d) What fees are paid by:	Individual member Associates $80 Members/Fellows $120	New fee structure being introduced - sliding scale based on FE numbers - currently every company pays $250 pa (+GST). Been that way since 1985		$280 per organisation
e) What are the membership requirements	Appropriate qualifications and experience	Accreditation with WorkCover NSW and/or Comcare		Accreditation with Workcover /or Comcare
9. Provider training				
ORP training offered by:	Not specifically available. Graduate Diploma of Rehabilitation counselling through university of Tasmania	ARPPS about to run out the first of our recently developed Case Management Training program - one for new starters and an advanced for us old timers		ARPPS offer reduced price accredited training for Comcare approved provider courses and Medico legal training. Workcover offer no training at this stage.