ARPA
Australian Rehabilitation
Providers Association

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Commissioner
National Workers' Compensation and OHS Inquiry
Productivity Commission
PO Box 80
Belconnen ACT 2616

Dear Mr Woods,

The Australian Rehabilitation Providers Association (ARPA) is pleased to have the opportunity to provide this additional submission to the Commission in relation to the National Workers' Compensation and OHS Inquiry. In particular we wish to respond to requests from the Commissioners that arose during our attendance at the hearing in Canberra on 8 December 2003.

As discussed in earlier submissions, "rehabilitation" and "compensation" have formed the basis of all of the Australian schemes for people injured at work since the mid 1980's. To date this has been partially successful through adding rehabilitation components to existing claims focused schemes. The key to the future is how to bring rehabilitation up to the level of partnership whilst delivering scheme and claims outcomes cost-effectively. ARPA sees the potential to achieve this through:

- The use of evidence based rehabilitation strategies for recovery and restoration
- The application of the most suitable pricing model
- Correctly allocating authority with accountability
- Continuous measurement and improvement, and
- Quality assurance systems

National and international studies over the past 20 or so years have regularly concluded that Vocational Rehabilitation (VR) services, when delivered within an appropriate framework, are the most effective vehicle for achieving high rates of durable return to work, managing many of the major scheme costs and improving the overall injury management experience for injured workers and their employers (Atkinson 1982, Spitz 1982, Schmidt 1995, Frank 1998). There is no doubting the contribution of the rehabilitation discipline to a smooth running system, however maintaining the current focus of minimising rehabilitation services by experienced professionals outside of the compensating authority is sure to lead the scheme further into the realm of poor performance.

131 Canberra Avenue, Griffith ACT 2603
Secretary, Pam Garton - (08) 8941 3211 - pam(a-)ntrehab.com.au President,

George Hallwood - (08) 8362 3600 - george(o¯)effective. net. au
www.arpa.org.au

Research has suggested that delays in recovery and return to work (and therefore rising claim costs) are more likely to be due to a multitude of barriers other than medical, or issues of physical capacity alone (Pimentel 1999, Johnson and Fry, 2002, 2, Pickette, 2002, 14, Marhold et al, 2002, 65, Franche et al, 2002, 233, Crook et al, 277). The types of non-medical barriers that typically delay recovery and return to work include, industrial, environmental, psychosocial and litigation factors, which can all interrelate with and confuse medical issues.

Evidence Based Strategies

The use of evidence based rehabilitation strategies for recovery and restoration will achieve better return to work rates, lower continuance rates and generate significant savings for a national scheme. They will also improve personal and social benefits that are not so easily measured financially.

International research in the field of Occupational Rehabilitation has regularly stated that a successful rehabilitation and return to work model possesses the following characteristics:

- Early claim determination
- Early assessment of the need for Rehabilitation services
- Early intervention
- Worksite based services
- Return to work is focussed with the pre injury employer
- Professional autonomy
- A degree of Provider discretion
- Vocational Rehabilitation services independent of and external to the claims management process
- Removal of identified triggers which lead to litigation
- Removal of process based inefficiencies that discourage rehabilitation and return to work outcomes
- Introduction of efficiencies and simplified processes to motivate timely rehabilitation and return to work.
- Appropriate measurement of rehabilitation services.

These are additional to the three positive characteristics of a sound claims management model that are:

- Rapid claim determination (and payment of entitlements)
- Open, respectful communication including provision of information about rights and responsibilities, and
- Minimisation of dispute triggers

Both national and international research demonstrates that the opportunity to improve return to work rates, reduce overall claims costs, increase productivity, and enhance the recovery and return to work experience for workers and their employers, is most assured when return to work models contain these characteristics centrally as key tenets.

Early Claim Determination

Johnson and Fry (2002, 4) found that timely agent claim acceptance has the effect of reducing claim durations by approximately 6.5% for all claimants,. Anecdotal evidence also suggests that the ability to assist an injured worker to rehabilitate and resume productive employment, is more likely to be delayed as a result of lengthy delays with claim determination. The associated economic hardship and uncertainty, along with the disenfranchisement often experienced with the stigma of a delayed acceptance, are powerful barriers that hamper return to work efforts, even once the claim is eventually accepted. The worker can become so conditioned to having to "live the injury" to justify their need for compensation during a lengthy determination phase, that sometimes they find it difficult to break out of the negative spiral. Efforts to rehabilitate them back into their work environment can be much harder in these cases, and all due to a nonmedical issue that was never the basis for the claim in the first place.

Early intervention

The concept of early intervention within the Work Injury Model of Rehabilitation contains two basic philosophies:

- Early referral for an initial assessment of the need for vocational rehabilitation assistance (and for outcome focussed services to continue beyond the initial assessment when required)
- A standard measurable timeframe and criteria applicable to all claims

Early referral

Schemes that combine early claim determination with early referral to rehabilitation achieve the best results despite other scheme faults. Large exempt type schemes, of which Comcare is the largest example in Australia, tend to have strict standards that ensure early intervention. These strict standards are the only way to guarantee early referrals. The 2002/03 Australia & New Zealand Return To Work Monitor indicates significantly better return to work rates than other Australian schemes (Western Australia and the Northern Territory do not participate in this survey).

Most research in the field of rehabilitation, both nationally and internationally, illustrates that the longer an injured worker is away from work, the less likely they are likely to return (Wyman 1999, 1, Pimentel, 1999). Toran (2002) writes," Early intervention ... can greatly improve disability outcomes and decrease the time it takes employees to return to work". Frank (1998), in a review of intervention studies for related low back pain, found that return to work plans implemented within 3-12 weeks of the onset of pain, has shown reductions in the amount of time lost from work of between 20 and 50%.

The Worker's Compensation Board of British Columbia (2002) states that:

"Vocational Rehabilitation should be initiated without delay", and

"Vocational Rehabilitation services are to provide quality interventions and services to assist workers in achieving early and safe return to work and other appropriate rehabilitation outcomes".

And even more specifically, in relation to the concept of early intervention:

"Vocational Rehabilitation assistance should be provided as soon as the worker is medically able to participate in his or her own vocational future".

Delaying the referral for rehabilitation assistance will not minimise rehabilitation and return to work costs, because involvement will need to operate longer to achieve a result once referral has occurred. Delayed assistance with return to work also increases other costs such as income maintenance, medical costs and other indirect costs (lost production, overloading other staff, replacement staff, retraining etc) as workers fail to recover and return to work.

Interestingly, the New South Wales scheme in the 1990's faced problems of scheme performance and a major reason for this was attributed to slow referral for rehabilitation assistance. The Grellman Report in the late 1990s, led to a shift in emphasis by NSW WorkCover and a redefinition of the early intervention concept. Initial assessment and reports within 14 days from date of injury were instigated, along with interventions based on professional discretion and simplified processes.

Services are *work place based*

For return to work rates to increase, rehabilitation efforts should be focussed on interactions with the key parties within the worker's employment environment. When combining this approach with early intervention, time losses per claim can be reduced by up to 30% (Frank 1998). Simply put, keeping the focus on the workplace will return workers to work earlier. The potential for cost savings, increased productivity, and improving the experience for workers and employers by resourcing rehabilitation services to the extent that interventions occur at the workplace cannot be overstated. People move toward what they think about. If all that you see are medical treatment providers, then you will focus on incapacity and more treatment. Work becomes secondary.

Pimentel (1999) categorically states: "any broad based medical treatment effort that does not include a return to work plan will only be partly successful .....work should be part of therapy". Similarly, Matheson and Brophy (1997, 111) emphasise rehabilitation models that achieve "immediate intervention and early return to work in transitional light duty work". Many other studies (Margoshes and Webster in Mayer et al 1997, 214) and Toran (2002, 46), demonstrate worksite based rehabilitation services are the most likely medium in which to achieve a viable, more rapid and complete recovery from injury.

Return to work is focussed with the pre injury employer

To follow on from the concept of work place based rehabilitation the ultimate return to work outcome remains with the pre injury employer. Legislation should be quite clear in placing the responsibility of Injury Management with the employer and for good reason. All Work Injury rehabilitation services support this as it can be demonstrated that cost savings and increased

productivity do occur when an appropriate outcome with the pre injury employer is identifiable and achievable.

Standard practices include undertaking an organisational analysis to determine what is required in regard to; training, equipment, workplace modification and/or job redesign. Further to this rehabilitation services identify issues for consideration at the workplace to accommodate a Work Injured person,

However not all Work Injured people can achieve a return to their pre-injury employer and the claims management process needs to give greater recognition to recommendations made by rehabilitation providers and medical practitioners when it is clear that pursuit of a return to work with a pre injury employer is likely to lead to deterioration or further injury to a worker. Too often workers suffer significant damage because alternative return to work goals are not given suitable or timely recognition. Parallel goals can also improve workplace options and return to work outcomes in some cases.

Separation of functions for quality and independence

Other less supported models of claims management suggest that the rehabilitation and claims management process can combine together to manage cost management as well as the rehabilitation needs of the injured worker. The expectation that Case Manager, Injury Management Co-ordinator, or Rehabilitation Provider for that matter can successfully wear both hats is foolish. Firstly the primary focus of claims handling and administration required for successful case management has differing goals and outcome expectations to those needed for successful recovery and restoration. Secondly, the policing role necessary in managing claims cannot be successfully tied to the supporter and counselling role of the provider. Thirdly, worker and employer perceptions and confidence in providers can be difficult to maintain, even when the provider is completely independent. Fourthly, in instances of state underwritten/ agent administered schemes,the difficulty in aligning Agent action with regulator wishes described as being at the heart of the "principal/agent" issue in economic theory are amplified further when rehabilitation is included as part of the regulatory state fund model (Clayton 2002 p45). The use of professional providers with specialist training, specific understanding of workplace injury, rehabilitation, and systems necessary to achieve appropriate return to work outcomes should be an expectation of a national scheme.

In order to ensure that the worker and employer receive the services that are required, vocational rehabilitation must be managed independently outside the Agent setting. Combining the two roles is seen as adversarial to the basic philosophy of rehabilitating injured workers.

The experience, systems and training unique to the rehabilitation profession are directed at recovery and restoration. With scheme based rehabilitation decision making, workers and employers would have a right to feel that they will only receive the insurance company line, which seeks to manage the claim rather than rehabilitate. The separation of rehabilitation service delivery from the claims management function is critical to ensure that services are provided on the basis of need, not whether cost containment philosophies allow the expenditure. Role confusion will only lead to further watering down of responsibility identification, degradation of confidence in providers, and conflict over decisions. It is well documented that conflict leads to disputation and higher rates of disputes traditionally delay return to work, and increase claims costs as well as frustrating injured workers and their employers (Johnson and Fry 2002, 8).

Professional Discretion

Strong anecdotal evidence has shown that over the years, a provider's inability to make an "on the spot" decision about the provision of, for example, a $300 ergonomic chair, or a $50 antifatigue mat without Case Manager approval directly increases timeframes for recovery and return to work and has a number of indirect impacts. Some workers continue to work in an environment that may suit someone without a disability but does not suit them, leading to further deterioration in their condition. The injured worker often feels that their rehabilitation provider is unable to assist them if they have to get approval for a small cost item, and mistrusts the intent of the scheme at the same time. Workers feel that the scheme ill considers them and the provider is powerless in the mix. Employers are often frustrated that the scheme that they are paying levies into is unable to quickly respond to the needs of their injured employee.

It is also likely that a degree of professional discretion will keep disputes about the provision of equipment to a lower level, as some claimants have chosen to review an Agent's decision not to approve equipment after the rehabilitation provider has raised it as a consideration.

Capping the total expenditure under automatic approval, together with purchasing guidelines will mean that costs are kept to minimal levels and will produce maximum increase in return towork rates as well as other stakeholder benefits.

Removal of other litigation triggers

Professional discretion advances as detailed above will also reduce the types of litigation triggers and will reduce cases moving into dispute. This is another aspect of a smooth functioning rehabilitation model focussed on improving return to work rates.

There are of course many other litigation triggers, such as claim determination, calculating notional weekly earnings particularly because of overtime disputes, and decisions made in executing the legislation. A potential solution to this problem is the introduction of a scheme hotline where issues can be identified and followed through by informed and independent officers. This "hotline" could be run by the scheme administrator, by the legislative authority, or by the courts and would seek to diffuse situations by having the hotline operator call the Case Manager or Provider to ensure that actions or intent will actually assist to resolve the claim rather than throw the claim into dispute. The hotline could also counsel workers and employers about their approach, in the event that an unreasonable approach threatens to derail return to work progress, reduce productivity, and increase claim costs. Complaints could also be tracked for trends so that further training could be identified for Case Managers and Providers where difficulties continue to arise.

Process inefficiencies and technological improvements

The following points will also enhance the delivery of return to work services within the Work Injury Model of Rehabilitation:

There must be a shift away from input and process control on rehabilitation to free up resources for more support at the worksite.

• Sound outcome measurement is what is required to guarantee the focus is targeted toward scheme improvement.
- An industry body with a code of conduct, self audit policy and standards regarding service deliverables and timeframes can effectively ensure professional service delivery, without the need for compliance checks that restrict the focus on outcomes.

A **Suitable Pricing Model**

Many approaches to pricing have been tried in the various Australian schemes with little research done on outcomes of models or their impacts on behaviours by providers or scheme agents. We also have the advantage of having seen varieties of pricing models in related environments such as the hospital systems and the Job Network.

Often pricing models are introduced at times when costs are the only consideration. These approaches inevitably fail because either benefits are ill considered, or the risk is shifted leading to the collapse of the entity that is meant to provide the solution. It is important that any consideration of price is driven by cost/benefit rather than just cost.

Typically in Australia rehabilitation has been paid for using an hourly rate. This rate varies greatly between jurisdictions and is set by the scheme administrator in some, and influenced largely in others. While this approach has been reasonably fair for the schemes and the industry in most cases, there have been notable exceptions where the scheme monopoly or cartel has determined a rate too low for sustainable delivery of quality services. The hourly rate model in itself has also done little to influence behaviour, which has been directed in most instances by outcome expectations and standards imposed by the scheme administrators. The Service agreement model anecdotally has worked better than other approaches.

Incentive models have typically performed badly in Australia as finding the right outcome to deliver incentives for, and discouraging the variety of "cherry picking" and triaging has been too complex a challenge to overcome.

Two tiered systems have faced the challenges of incentive models and have been overlaid with the variation in claim types that has plagued this approach between scheme administrators and Agents.

The "diagnostic related groups" approach required years of research before being introduced to the hospital system and is still not fully developed for non-clinical environments although this approach does seem to be most suited to rehabilitation services in the long run.

Overall it is most likely that the hourly rate model will deliver the best outcomes as long as performance standards are developed that align with best practice and are built into service agreements. The Comcare approach is probably the closest to this model.

Through the actions of our Association, ARPA has demonstrated our commitment to the development of consistent, fair and effective workers' compensation systems across Australia. We believe our collective expertise in rehabilitation across jurisdictions is unique and therefore consider that we will be able to continue to offer the Australian Government advice regarding

scheme design, standards development and monitoring of performance, that will be integral to the successful development of a national scheme.

Allocating Authority with Accountability

The introduction of evidence based improvements and in particular; professional autonomy, a degree of Provider discretion, and Vocational Rehabilitation services independent of and external to the claims management process will enable rehabilitation providers and claims officers to be held more accountable for their separate roles in the scheme. A database that measures with integrity is also a basic requirement for the allocation of responsibility and the accountability for outcomes needed for scheme improvement management. Again, the Comcare approach is the closest to this model, however there are currently no approaches that are recommended as adequate.

Continuous Measurement and Improvement

ARPA commissioned Transformation Services to develop a database capable of receiving data from all rehabilitation providers throughout Australia and of comparing common factors across jurisdictions. The aim is to deliver robust, nationally comparable, useful data in order to measure outcomes and costs as well as real time trends when changes are made to scheme legislation or application. This has been a very complex process given the significant difference between jurisdictions regarding timeframes, services, terminology etc. and yet has been expertly executed by Transformation Services. Our data now allows some comparison of the effects of scheme features on rehabilitation intervention and outcomes. ARPA will be demonstrating this database to Scott Austin of the Commission on the 29th of January 2004.

The ARPA database is still in its infancy in relation to data collection and has been developed on a tight budget, which has prohibited us from employing a coordinator to provide constant helpdesk service to rehabilitation providers to ease the uploading of data. Once this next step is achieved we will then have access to a large volume of data from a wide distribution. We expect to have reliable and valid comparisons across jurisdictions of factors such as referral time, injury types, program costs and outcomes available within the next 3-month period.

We recommend that the implementation of a national scheme be supported by a methodology that ensures adequate planning, reflection and modification. This risk management control cycle is of course used in a variety of formats in the introduction of change. For example the Department of Health and Ageing promote the use of the collaborative model (incorporating PDSA - Plan, Do, Study, Act) in the implementation of funded care programs to ensure informed evidence-based approaches to care and service delivery allowing for continuous quality improvement.

The collection of appropriate and meaningful data will be critical to the effective study of the impact of changes accompanying a new scheme. We anticipate that the data available from the ARPA national database will be able to contribute significantly to scheme monitoring and development.

Quality Assurance

ARPA is currently developing a Code of Practice to ensure that professional standards of Rehabilitation Providers will optimise the likelihood of achieving effective rehabilitation outcomes within the constraints of the scheme. This will require rehabilitation providers to not only meet requirements as per their individual professions but will also require training specific to workers' compensation insurance. The purpose of this is to ensure that rehabilitation providers fully understand the cost factors involved in workers compensation injury management as well as their responsibility to focus on the most cost effective means to achieve the desired rehabilitation and scheme outcomes.

Limitations with the Current Claims Management Approach to Rehabilitation

Rehabilitation only became a component of the management of workers compensation claims in the 1980's. At that time it was generally believed that injured workers would recover as per the Medical Model of Illness (World Health Organisation 1975), which states that symptoms can be relieved by targeting the underlying cause of tissue pathology. The corollary is that if recovery is not achieved then there is either permanent impairment (which will be detectible and measurable) and therefore the injured worker will be financially compensated, or there is malingering, 'functional overlay' or some other psychological cause of disability not related to the physical injury, and therefore liability will be terminated.

This has resulted in adversity, and has contributed to an increase in the incidence of chronic pain and disability in Australia. (Blyth et al 2003).

As an alternative to the Medical Model, The Biopsychosocial Model was originally described by G. Engel in 1981 and further developed by Dennis Turk in 1996, it acknowledges that pain and ongoing disability is dependent on many biological, psychological, environmental and social factors. Evidence to support this model is now beginning to revolutionise the management of chronic pain and disability. This model is particularly applicable to injured workers because of the complexity of factors that impact on their injury, their recovery and their capacity to return to work.

The emphasis of biopsychosocial management is on the normalization of cognitive, behavioural and physical function leading to the reduction of disability, and ensuring individuals take an active role in the development of self-management skills.

Accepting the guidance of this model ensures that the critical factors for each individual are identified and addressed in the earliest stages of rehabilitation allowing for the implementation of the correct intervention at the correct time. This is most effectively achieved if the rehabilitation needs of injured workers is managed by health professionals with a multidisciplinary approach and workplace focus to ensure appropriate utilization of pain management, counselling, adjustment to injury, restoration of function and meaningful and sustainable employment.

Claims Management Initiatives

Throughout Australia, scheme improvement initiatives have focused on claims management tools and processes. There is little evidence that these have achieved long term effective, costcontained claims management, or outcomes that rate the return of the worker to meaningful and

sustainable work as the primary goal. For example, Comcare introduced a claims management model to determine and manage claims for stress related injury. We understand that after 2 years the overall costs of these claims have doubled due to poor claims decisions. We believe an audit of decision-making in claims management in any jurisdiction will pinpoint this as the major cost driver in workers' compensation in Australia.

Claim Coordinators do not have the skills to independently identify and make effective decisions to resolve the complex issue of injury, pain, psychological distress, employment and industrial issues.

An effective Workers' Compensation model will ensure that each decision is made by the party most qualified to make that decision. Those with qualifications in insurance should make insurance decisions; medical decisions are the prerogative of medical practitioners; and rehabilitation decisions should be the responsibility of qualified rehabilitation providers.

There is a clear and essential role for claims coordinators and there is an equally clear role for rehabilitation providers with specialist training and expertise in particular aspects of rehabilitation. We strongly recommend that the relationship between rehabilitation providers and claims coordinators be redefined and that rehabilitation providers are granted responsibility for rehabilitation related expenditure.

Conclusion

We have touched on some of the factors that will contribute to effective delivery of services by the insurer and rehabilitation provider. With the application of the use of evidence based rehabilitation strategies for recovery and restoration, the application of the most suitable pricing model, correctly allocating authority with accountability, continuous measurement and improvement, and the use of adequate quality assurance systems, a national scheme will deliver outcomes unheard of before in Australian schemes and probably unmatched in the world.

Yours Sincerely,
George Hallwood
President

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