Roshana May
Lawyer

R. May: 2025 SCLJ 21 May 2025

The Chair, Mr Greg Donnelly
Standing Committee on Law & Justice
Legislative Council
Parliament of NSW

Dear Chair

STANDING COMMITTEE ON LAW AND JUSTICE INQUIRY
PROPOSED CHANGES TO LIABILITY AND ENTITLEMENTS FOR PSYCHOLOGICAL INJURY IN NEW SOUTH WALES - Question on Notice to Roshana May Page 71 uncorrected Transcript

I thank the Committee for the opportunity to provide further material to assist with the Inquiry.

Transcript of the QON

The Hon. BOB NANVA: I will just ask one question, perhaps to you, Ms May. I hope you'll forgive me if I refer to an article which you co-authored in 2014, *Principles of an effective workers' compensation scheme*, which I found fascinating. You talk about the compensation effect on health and wellbeing—
The Hon. MARK LATHAM: And you found it yourself?
The Hon. BOB NANVA: I did, actually.
The Hon. MARK LATHAM: Good on you.
The Hon. BOB NANVA: With the compensation effect on health and wellbeing, you look at the two broad categories of secondary gain and secondary victimisation. You conclude: Taking this evidence together, effort is required to minimise system-generated stressors and to improve scheme design so that people are supported to exit the schemes as quickly as possible. With that lens, what are your reflections on the scheme as it exists and the reforms proposed? If you had your hands on the levers, what would you do with that in mind?

ANSWER:

Thank you for the question which is an important one. Unfortunately, there is insufficient time for me to give the answer the proper attention it deserves. This serves as the best answer I can provide in the time permitted noting the urgency of the Committee's considerations and the shortness of the Committee's timeframes for deliberations and reporting. I am also conscious of the Government's intention to enter a Bill into the parliament very soon.

I **attach** the article co-authored with Dr Petrina Casey in 2014 in order to give the context to the question(s) posed by the Member. I ask the Committee to note that I do not support the initial premise of the paper advocating harmonisation of workers compensation systems in Australia.

The concepts of 'secondary gain' and 'secondary victimisation' are referenced in a Dutch article authored in 2011 which involves a study of participants who were individuals injured

in traffic accidents and involved in a compensation process in the Netherlands. The final outcome would be an award of damages paid in one lump sum. That is not the context in which I am asked to examine psychological injuries here.

The article emphasises the health benefits of work, now universally accepted, and the consensus that:

> *"long-term work absence, work disability and unemployment all have a negative impact on health and wellbeing; that work must be safe so far as is reasonably practicable; and that work practices, workplace culture, work-life balance, injury management programs and relationships within workplaces are key determinants, not only of whether people feel valued and supported in their work roles, but also of their individual health, wellbeing and productivity."*

Reflections on the existing scheme(s)

I refer to my submission and what I consider the fundamental principle of workers compensation: A worker who has received an injury shall receive compensation from the worker's employer. Injury is defined as personal injury arising out of or in the course of employment (see section 4 1987 Act).

Psychological injury is not a new phenomenon. It was first recognised by the NSW workers compensation system in 1995 with the introduction of section 11A to the 1987 Act in response to a growing number of teacher stress cases in the preceding years. The section contained the first mention of psychological injury in the Act and included the definition of psychological injury and the 'reasonable management action' defence, that **no** compensation was payable for psychological injury "*if the injury was wholly or predominantly caused by reasonable action taken or proposed to be taken by or on behalf of the employer with respect to transfer, demotion, promotion, performance appraisal, discipline, retrenchment or dismissal of workers or provision of employment benefits to workers.*"

Section 11A(3) provided that psychological injury is a "*psychological or psychiatric disorder. The term extends to include the physiological effect of such a disorder on the nervous system*".

In 2001, assessment of impairment arising from psychological injury was introduced with the implementation of the whole person impairment assessment rating and adoption of the AMAV Guides. Section 65A was inserted prescribing that only impairment arising from a *primary* psychological injury could give rise to a claim for lump sum compensation and setting a threshold impairment of "at least 15%". Section 151H relating to the threshold for work injury damages claims was amended to include provisions restricting such claims to *primary* psychological injuries and imposing a threshold degree of permanent impairment of at least 15% for all injuries.

In 2012, the system changed significantly shifting the focus to the 'capacity' of a worker from 'incapacity'.

There has been a gradual fragmenting of the application of the legislation since 2001 such that the 1995 amendments apply to all New South Wales workers (including coalminers). The 2001 amendments only apply to 'non-coalminer workers'. The significant 2012 amendments only apply to workers not exempted from the changes (dubbed Non-Exempt workers).

Workers exempted from the 2012 amendments are dubbed 'Exempt Workers'[1], generally understood as active police officers, paramedics, and firefighters.

For each 'cohort' of workers the NSW workers compensation system provides a slightly different statutory no fault benefits scheme where benefits are paid as they accrue. Benefits fall roughly into the following types: Weekly payments (income replacement or support), medical and treatment expenses, and a lump sum for permanent impairment. The scheme also gives access to common law damages ("work injury damages" - modified common law damages - for exempt and non-exempt workers).

Each benefit regime is subject to regulation and a specific set of Guidelines.

The present legislative framework is extremely complex and difficult to navigate. It is virtually impossible for any NSW worker to understand their rights and obligations under the legislation without assistance.

The current framework generally provides adequate coverage and benefits although for non-exempt workers access to benefits is complicated and restricted by the imposition of multiple impairment thresholds across all benefit types.

The system objectives can be read as "to restore the (mental) health of a worker, provide income and other supports and return them to meaningful and gainful employment as promptly as possible".

In my opinion psychological injury claims made by **non-exempt workers**[2] are not optimally managed by the system due to a number of factors, including:

- Delays in notification by workers due to stigma attached to mental ill health and fear of reprisal
- Confusing and complex claims processes
- Insufficient early access to medical, social and vocational supports for workers who with psychological injuries
- Little or no early intervention
- Avoidance of ***provisional liability*** (up to 13 weeks weekly payments) by "reasonable excuse" (see *Workers Compensation Guidelines)*, typically "insufficient medical evidence" or "The injury is not work related"
- Absence of a dedicated 'short term' benefits and supports 'regime' to provide early treatments, assistance and income support to facilitate an early return to work (a form of 'provisional liability without eligibility rules for workers with psychological injuries)
- Underutilisation of work capacity assessments and work capacity decisions (incentive measures) by insurers (resulting in long duration of weekly payments and time off work)

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[1] Workers covered by: Schedule 6, Part 19H, cl.25, 1987 Act (police officers, paramedics, or firefighters), Schedule 6, Part 19H, cl.4, 1987 Act and the *Workers Compensation (Bush Fire, Emergency and Rescue Services) Act 1987* (volunteer bush firefighters, lifesavers, and emergency services personnel), or The *Police Regulation (Superannuation) Act 1906* (PRS Act) (which applies to NSW police officers who were attested prior to 1 April 1988 and who contributed to the Police Superannuation Fund).

[2] The Exposure Draft Bill does not contain reference to amendment of the prior savings and transitional provisions. For example, exempt workers are not subject to work capacity decisions, a current 260 week cessation of weekly payments, or limitations on medical and treatment expenses under section 59A 1987 Act.

- Poor appreciation and understanding by employers of their primary duty of care under work health and safety laws[3] with respect to ensuring the health and safety of workers while at work and minimising risks to the health and safety of workers from work
- Perverse and inappropriately targeted incentives including marrying benefit duration to impairment thresholds and theoretical and unrealistic definitions (e.g. suitable employment)
- Delayed outcomes and perceived injustice
- Little education of key service providers about the concept of 'capacity' for work
- No measures aimed at prevention of injury
- Difficulties within the current legislation (not addressed by the exposure draft Bill)[4]

Reflections on the reforms proposed in the exposure draft

In my submission to the Inquiry, I have attempted to identify and explain the effects of the reforms proposed on non-exempt workers. Without the benefit of clearly articulated reasons for the reforms I conclude the proposed reforms concerning psychological injuries will have serious consequences including immediately severing access to compensation benefits and recognition of psychological injury except in the most extreme circumstances or as a consequence of the most egregious of behaviours ("bullying" and "harassment"). At best they will result in a carve out another cohort of workers creating further system complexity and inequality. The impact of the reform proposals will be negative for both workers and employers.

Some of the reform proposals are not restricted to psychological injuries and affect the rights and entitlements arising from *any injury*. I remain unclear as to why such major reforms have been included in the exposure draft Bill where no evidence has been made available justifying change and there has been no consultation or discussion with stakeholders.

I have identified which of the reform proposals deliver system wide assistance to workers and will improve outcomes, and I identify those which won't. Even the beneficial proposals require consideration before implementation to ensure that the desired effect is achieved.

Without fully understanding the extent of the problems and the intent of the reforms I am at this point unable to provide any further answer.

If I had my hand on the levers, what would I do?

The workers compensation system is extremely complex. The problems/issues with psychological injuries have not been properly articulated to the extent that any sensible proposal could be put forward at this time and at such short notice.

The reforms in the exposure draft Bill are significant and extend well beyond addressing psychological injury claims. They require careful thought, expert input, and more information than is currently publicly available.

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[3] Section 19, *Work Health and Safety Act 2011* NSW

[4] Refer to the *Parkes Inquiry 2014-2015*, Workers Compensation Independent Review Office, in which stakeholders identified key areas within the legislation for consideration and attention and issued a unanimous Statement of Principles and Recommendations for consideration by government. refer to previous Law & Justice Committee review of the NSW workers compensation schemes.

In due course, if the opportunity arises I would like to be involved in ongoing conversations and consultations with decision makers, external stakeholders and local and international experts in the field about the status and operation of the system and the potential for reform.

For the benefit of the Committee, I **attach** the following:

ACOEM Guideline: Preventing Needless Work Disability by Helping People stay employed. Journal of the American College of Occupational and Environmental Medicine 2006 pages 972 – 987

The Role of Incentive Measures in Workers' Compensation Schemes, Prepared by Peter Hardy, Ben Knight and Ben Edwards for the Institute of Actuaries of Australia 2011 Accident Compensation Seminar.

A How-To Guide for Injury and Work Disability Prevention 01/22/2021, An Issues paper of the International Association of Industrial Accident Boards and Commissions (IAIABC) (an organisation which empowers, educates, and connects the global workers' compensation community to reduce harm and aid recovery from work injuries and illnesses.)

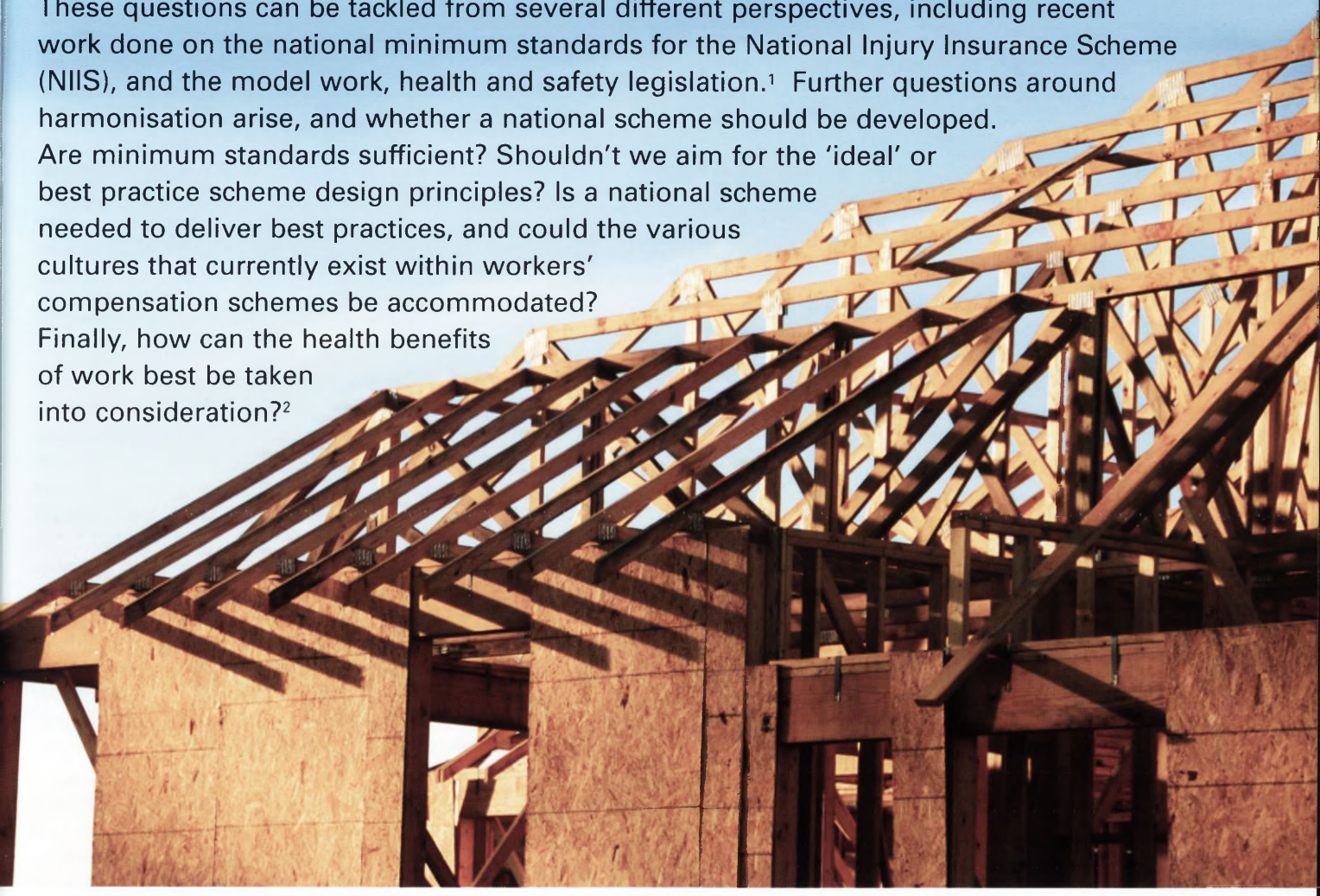
Yours faithfully

Roshana May

By Roshana May and Petrina Casey

Principles of an effective workers' compensation system

What might 'national minimum standards' for workers' compensation look like? How should they be set and implemented in the context of workers' compensation schemes? These questions can be tackled from several different perspectives, including recent work done on the national minimum standards for the National Injury Insurance Scheme (NIIS), and the model work, health and safety legislation.[1] Further questions around harmonisation arise, and whether a national scheme should be developed. Are minimum standards sufficient? Shouldn't we aim for the 'ideal' or best practice scheme design principles? Is a national scheme needed to deliver best practices, and could the various cultures that currently exist within workers' compensation schemes be accommodated? Finally, how can the health benefits of work best be taken into consideration?[2]



THE AUSTRALIAN WAY

The workers' compensation landscape in Australia is perhaps best described as a patchwork of arrangements. Internationally, Australia is somewhat unique, being one of only three countries where workers' compensation schemes are organised at state level (the other two being Canada and the US). Most European countries have schemes that are integrated with their social security systems, while New Zealand and the Scandinavian countries have schemes that provide national coverage for all injuries (national schemes).

The 11 distinct Australian workers' compensation schemes (including the three Commonwealth Schemes: Comcare, Seafarers and Military) have evolved largely in isolation from one another, with significant variations in key areas of scheme design, including eligibility and benefit entitlements.

Because of this 'patchwork' of schemes, the debate continues about the virtues or otherwise of a national scheme or of harmonising workers' compensation arrangements. Proponents of harmonisation argue that state-based schemes lead to inequitable treatment of workers; >>

increased administrative complexity and inefficiencies for participants; burdensome compliance frameworks; sub-optimal outcomes for workers and employers; and perhaps even a 'race to the bottom' or 'lowest common dominator' as states compete to have the lowest premiums. On the other hand, proponents of the current state-based arrangements contend that they promote interstate rivalry or competitive federalism, stimulating scheme innovation. As states compete for business investment attracted by lower premiums, they can recognise the local needs and conditions; and there is the potential to develop closer relationships with stakeholders, such as workers, employers, unions and providers. However, with the exception of a few areas of scheme 'design' – for example, cross-border legislative provisions, claim form requirements, accreditation standards for workplace rehabilitation-providers and discrete national self-insurance harmonisation projects[3] – there has been little tangible progress towards fulfilment of the harmonisation 'project' commenced in 2010.[4]

Another recurring theme discussed and debated in the many scheme reviews conducted over the past 30 years is the relevance of 'fault' in determining access to compensation benefits, and the merits or otherwise of 'no-fault' arrangements compared with 'common law/fault-based' arrangements.[5] Generally, workers' compensation schemes have evolved from the 'no-fault' principle. However, over time, many have introduced elements of common law so that what in fact exists today is a mixture of no-fault and fault-based elements.

From a health policy perspective, there is evidence that no-fault scheme arrangements are associated with improved health outcomes.[6] There is, however, evidence – particularly from the US – that no-fault schemes can be more expensive.[7] One of the main factors contributing to higher costs is the difficulty in containing lifetime medical costs.[8] There is also a higher propensity for claimants in 'no-fault' arrangements to access medical treatments at higher rates, leading to a significantly greater medical cost.[9]

From a legal viewpoint, common law is seen as an effective means of policing occupational or workplace health and safety regulation and ensuring that employers employ best practice and systems in their workplaces. It is also viewed as the best mechanism for adequately 'compensating' an injured person for the wrongs of another and as an opportunity for the injured to 'take control' of their futures.

However, no-fault and common law are rarely mutually exclusive, with most workers' compensation schemes being a 'hybrid' of the two, adding to the complexity of compensation schemes. The Productivity Commission (PC) in its 2011 review, *Disability Care and Support*, focused on the insurance arrangements for injury and the impact of compensation on health outcomes and recovery,[10] particularly for the catastrophically injured. For the catastrophically injured, the PC recommended the formation of the National Injury Insurance Scheme (NIIS), reflecting its findings that existing fault-based insurance arrangements do not meet people's care costs efficiently.[11]

It is worth noting that Australia almost introduced a national no-fault scheme in 1974 following the National Committee of Inquiry into Compensation and Rehabilitation Australia, chaired by Justice Woodhouse. The government of the time had intended to enact legislation, as outlined in the National Compensation Bill 1974 but, following a change of government, the Bill was not enacted.

SCHEME REVIEW AND DESIGN

While the circumstances that typically lead to the review of individual schemes differ, they are generally driven by political imperatives to control premiums, or unfunded liabilities, usually resulting in benefit reductions or decreased access. The other driver for change, albeit less frequent, is scheme profitability, resulting in premium reductions and increased access to benefits.[12] Rarely is there an opportunity to design from a blank canvas. The existing scheme design, the culture, the political, social and economic environment all influence the scheme design review process.

Policy discussions of the merits or otherwise of state-based scheme arrangements and of common law arrangements will undoubtedly continue, and inevitably many of the current scheme arrangements will be reviewed to accommodate the NIIS. However, these are not prerequisites to implementing ideal scheme principles where the aim is scheme sustainability and optimising injured workers' outcomes. In addition, there is a broader evidence base emerging that needs to be considered when designing schemes and establishing benchmarks, including the effects of the compensation system (or elements of the system) on its participants and the health benefits of work.

The 'compensation effect' on health and wellbeing

Notwithstanding the difficulties in conducting research in this area,[13] and noting that not all researchers agree,[14] a growing body of evidence suggests that compensation status has a negative effect on the injured person's health and that people with 'compensable' injuries may have poorer health outcomes than those with similar but 'non-compensable' injuries.[15] Prolonged exposure or the 'time taken to deal with a claim' is associated with stresses that may hinder recovery.[16] Additionally, scheme participants report significant stressors in the compensation process: numerous assessments, situations where claimants are confronted with the traumatic history of the injury event, delayed funds and financial risks.[17]

This so-called 'compensation effect'[18] generally falls into one of two broad categories: 'secondary gain' and 'secondary victimisation'.[19] The 'secondary gain' theory proposes that being involved in a compensation process creates an unconscious incentive for the injured person to remain unwell. In contrast, the 'secondary victimisation' theory proposes that being involved in the compensation process is complex and stressful and that it gives rise to renewed victimisation for the injured person.[20]

Taking this evidence together, effort is required to minimise system-generated stressors and to improve scheme design so that people are supported to exit the schemes as quickly as possible.

The health benefits of work

It is widely recognised by all the Australian compensation regulators, and by numerous medical colleges and faculties, that work is generally good for health and wellbeing. The Consensus Statement of the Health Benefits of Work[21] endorses the view that long-term work absence, work disability and unemployment all have a negative impact on health and wellbeing; that work must be safe so far as is reasonably practicable; and that work practices, workplace culture, work-life balance, injury management programs and relationships within workplaces are key determinants, not only of whether people feel valued and supported in their work roles, but also of their individual health, wellbeing and productivity.

Scheme design to date has focused on 'incapacity' rather than 'work capacity', thereby placing emphasis on work absence. Work absence is the major determinant for the receipt of compensation benefits. Work absence is, in most cases, discretionary – at the worker's, their doctor's or their employer's discretion – in that there is no *medical* requirement that the worker remain absent from work.[22] Culture around sickness or illness certification requires a major shift to focus on capacity, together with community recognition of the positive impact of work on health. Scheme design must accommodate consistent language, positive incentives and support around the health benefits of work.

In line with this evidence, workers need to be supported where possible to recover at work by ensuring the support and interventions provided are work-focused and co-ordinated within the workplace.[23] Fundamentally, workers' compensation schemes are (or should be) about supporting people to stay at, recover at, or return to work. If return to work is not the focus, then workers should be supported through active community participation to gain independence in other areas of their life.

If return to work (optimised work outcomes) is the primary objective of workers' compensation schemes, how do we design a scheme to deliver that objective while providing financial, medical and social support to the injured worker? While this may be simplistic, we know this must be done in an affordable and sustainable way and must account for people injured at work who will not return to the workplace. If agreement could be reached on the primary objectives of workers' compensation schemes, perhaps agreement could then be reached on the best practice scheme design principles to deliver those objectives? Surely minimum standards should be best practices?

SCHEME OBJECTIVES AND ACHIEVING NATIONAL CONSISTENCY

Given that each state has its own workers' compensation system and culture, evolved through many decades and influenced by the different motivations and imperatives of different stakeholders, change will always be difficult. In the absence of a national scheme, which is unlikely in the short or medium term, there is still scope for greater harmonisation or uniformity, with minimum standards for delivery of workers' compensation insurance benefits across the nation.

In response to the PC's 2004 report into health and safety and workers' compensation,[24] the states, territories and Commonwealth, through the 'Heads of Workers Compensation Authorities' (HWCA), embarked on a number of activities to achieve the vision of promoting and implementing best practice in workers' compensation arrangements in Australia and New Zealand in the areas of policy and legislative matters, regulation and scheme administration.[25]

The HCWA strategy[26] outlined key activities to be undertaken in the area of 'harmonisation' including streamlining of processes, data collection and setting of minimum benchmarks for scheme design and scheme objectives. Since 2010, little more than a streamlined claim form has been achieved. Activities slowed and seemingly came to a halt in or around 2012. However, since then, there has been substantial scheme reform in several states – NSW, QLD, SA – and reform is underway in the Commonwealth, driven by 'financial instability' (premium increases and reducing funding ratios). The impetus and goal underpinning this tranche of reform has been scheme sustainability and stability.

The state schemes have similar visions, purpose and objectives, typified by the NSW workers' compensation system:[27]

- To secure the health, safety and welfare of workers by prevention of work-related injury.

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- To provide prompt, effective and proactive treatment and management of injuries.
- To provide and pay for necessary medical and vocational rehabilitation following injury to assist in and promote early return to work.
- To provide income support to workers and their dependants during incapacity.
- To provide payment for permanent impairment or death and payment of reasonable medical and other related expenses.
- To be fair, affordable and financially viable, ensuring employer contributions are commensurate with risk.

It is clear that while the primary objective of the schemes is to provide necessary support and assistance to achieve optimal restoration to health and work outcomes (while at work), the secondary objective is to provide this within an affordable and sustainable environment. Another stated objective is to assist in optimising work outcomes in a way that protects the safety, health and wellbeing of Australian workers.

Principles of an effective workers' compensation system

To achieve national consistency, the fundamental principles of effective workers' compensation scheme design would include:

- **Scheme stability and predictability:** a fully funded scheme, with stable and predictable performance, which allows the scheme to be sustainable without legislative change for a substantial period (in excess of five to seven years).
- **Affordability:** premiums are affordable by those required to pay them.
- **Work outcomes are optimised:** The health benefits of work are recognised and all stakeholders – employers, employees, doctors, health-providers, insurers/claims agents – are focused on recovering at, or returning to safe work depending on the injured worker's capacity.
- **Fair and just compensation:** ensuring injured workers are fairly and consistently compensated for the injuries they sustain, with a focus on those who have suffered severe or catastrophic injury.
- **Scheme efficiency:** that the majority of premiums collected is returned to injured people and administrative costs associated with running the scheme are kept to a minimum, while keeping system-generated stressors to a minimum.
- **Scheme adaptability:** the capacity to respond to changes in economic and social climates and the efficient collation and analysis of data to measure scheme outcomes and performance (recognised by the PC as a 'core feature' of a national disability insurance scheme).

THE SEVERELY INJURED – CATASTROPHIC INJURIES, THE NIIS AND MINIMUM BENCHMARKS

For catastrophic work injuries, the PC proposed the NIIS – a federation of no-fault workers' compensation schemes, drawing on best practice arrangements already in place around Australia. Identifying catastrophic injuries as major acquired brain injuries, spinal cord injuries, burns and multiple amputations, the PC said: 'In most instances, people need lifelong supports and, particularly in the initial post-injury phase, have intensive clinical needs and require post-treatment supports, early interventions and rehabilitation.'[28]

State and territory governments are encouraged to transfer the care and support of catastrophic workplace claims to the NIIS through a contractual arrangement with their respective workers' compensation schemes. It is anticipated that all jurisdictions will endeavour to agree minimum benchmarks[29] to provide no-fault lifetime care and support for people 'catastrophically injured through workplace accidents' by as early as July 2016.[30]

It is imperative that all states and territories modify their existing scheme arrangements to achieve minimum benchmarks for workplace accidents, as clause 115 of the 'Intergovernmental Agreement on NDIS Launch' contemplates that the states will carry 100 per cent of the cost of participants in the National Disability Insurance Scheme (NDIS) who are in the NDIS 'because they are not covered by an existing or new injury insurance scheme that meets the minimum benchmarks for workplace accidents'.

Minimum benchmarks have not yet been published. And given the variance in the duration and quantum of benefits across jurisdictions, significant work will be required by some states to meet whatever minimum benchmarks are set. The benchmarks must, as a minimum, address the following:

- **Coverage and eligibility:** For example, consistency in the *definitions* of worker, employee, contractor, workplace accident to ensure equitable access to scheme benefits and supports.
- **Assessment criteria:** An objective, injury-based criteria such as that used by the NSW Lifetime Care and Support (LTCS) model[31] to determine catastrophic injury (excluding those long-term benefit recipients whose injuries are not 'catastrophic').[32] Consistency in applying impairment measures (for example, national guidelines for permanent impairment threshold measurement).
- **National cross-border/cross-jurisdiction** arrangements across all states and territories (as to which NIIS scheme applies and in what circumstances).
- **Coverage** for those industries with separate compensation schemes: for example, NSW coalminers, NSW police, firefighters and paramedics, seafarers and military.
- **Alignment** with state motor accident schemes, especially in relation to journey claims.
- **Access to appropriate rehabilitation** and/or education and vocational training for the life of the injury.
- **Benefits:** lifetime support for medical treatment, rehabilitation, attendant care services, domestic assistance, aids and appliances and artificial members (or other body parts), home and transport modification (mimicking the Agreed Minimum Benchmarks for Motor Vehicle Accidents).[33]
- **Income support.**

CONCLUSION

Minimum standards for workers' compensation schemes in Australia must be considered within the context of the ideal scheme design principles and as part of a national harmonisation program subscribed to by the coalition of all workers' compensation regulators.

The primary focus must be on the injured worker and the restoration of their health at work and improvement in work capacity. This will necessarily result in consideration of better return-to-work options, leading to improved return-to-work outcomes. As a natural corollary, the evidence of the health impacts of compensation scheme design must be given greater weight than at present. The health benefits of work must be used as a tool in scheme design, again focused on achieving better outcomes for injured workers.

The HWCA should continue to work towards the objectives outlined in its 2010-2013 strategy. However, harmonisation or a national scheme are not prerequisites to the agreement and implementation of the principles of effective scheme design across the various workers' compensation jurisdictions. Minimum standards in terms of benefit delivery, outcomes for injured workers, funding ratios and premium standards are achievable and should be pursued in line with the principles outlined. ■

Notes: **1** http://www.safeworkaustralia.gov.au/sites/SWA/about/Publications/Documents/598/Model_Work_Health_and_Safety_Bill_23_June_2011.pdf. **2** Australasian Faculty of Occupational & Environmental Medicine Position Statement, *Realising the Health Benefits of Work*, October 2011, The Royal College of Physicians. **3** HWCA, *Harmonisation Activities*, www.hwca.org.au/harmonisation_activities.phpdate, accessed 23 September 2014: http://www.hwca.org.au/harmonisation_activities.php. **4** http://www.safeworkaustralia.gov.au/sites/SWA/about/Publications/Documents/566/ NationalWorkersCompensationActionPlan2010_2013.pdf. **5** Productivity Commission, *Disability Care and Support*, 2011. Chapter 17, Insurance Arrangements, discusses the strengths and weaknesses of common law versus no-fault insurance arrangements, **6** JD Cassidy, LJ Carroll, P Cote, M Lemstra, A Berglund, A Nygren, 2000, 'Effect of eliminating compensation for pain and suffering on the outcome of insurance claims for whiplash injury', *New England Journal of Medicine*, Vol. 342, No. 16, pp1179-86. See also I Cameron, D Rebbeck, T Sindhusake, D Rubin, G Feyer, AM Walsh, WN Schofield, 2008, 'Legislative change is associated with improved health status in people with whiplash', *Spine*, Vol. 33, No. 3, pp250-4. **7** JM Anderson, P Heaton, and SJ Carroll, 2010, *The US Experience with No-Fault Automobile Insurance: A Retrospective*, Santa Monica, CA: RAND Corporation. **8** JM Anderson, P Heaton, and SJ Carroll, 2010, *The US Experience with No-Fault Automobile Insurance: A Retrospective*, Santa Monica, CA: RAND Corporation. **9** G Atkins, 2013, 'Sustainability of Common Law – Presented to the Actuaries Institute Injury Schemes Seminar', 10-12 November 2013, Finity Consulting http://www.finity.com.au/publication/injury-schemes-seminar-2013-sustainability-of-common-law/. **10** Appendix J, Productivity Commission, see note 5 above. **11** *Ibid*, Chapter 17, p789ff. **12** For example, the NSW Scheme: *see Media Release, Review of WorkCover Authority of NSW Final Report for immediate release*, 17 September 2014. **13** G Grant, and DM Studdert, *Poisoned Chalice:* 'A Critical Analysis of the Evidence Linking Personal Injury Compensation Processes with Adverse Health Outcomes', *Melb UL Rev*, 2009. 33: p865. **14** NM Spearing, and LB Connelly, '*Is compensation "bad for health"? A systematic meta-review*', *Injury-International Journal of the Care of the Injured*, 2010, 41(7), p683-92. **15** Australasian Faculty of Occupational Medicine and Royal Australasian College of Physicians (AFOM), 2001, *Compensable injuries and health outcomes*, Sydney: RACP, 2001. See also: I Harris, J Mulford, M Solomon, J van Gelder, JY Young, 2005, 'Association between compensation status and outcome after surgery: A meta-analysis', *JAMA*, Vol. 293, No. 13, pp1644-52; Cameron, Rebbeck, Sindhusake, Rubin, Feyer, Walsh, and Schofield, from note 6 above; M Sterling, J Hendrikz, J Kenardy, 2010, 'Compensation claim lodgement and health outcome development trajectories following whiplash injury: a prospective study', *Pain*, vol. 150, pp22-8; DF Murgatroyd, ID Cameron and IA Harris, 2011, 'Understanding the effect of compensation on recovery from severe motor vehicle crash injuries: A qualitative study', *Injury Prevention*, Vol. 17, No. 4, pp222-7. **16** GM Grant, ML O'Donnell, MJ Spittal, M Creamer and DM Studdert (2014), 'Relationship between stressfulness of claiming for injury compensation and long-term recovery: A prospective cohort study', *JAMA psychiatry* 71(4), pp446-53. **17** N Elbers, L Hulst, P Cuijpers, A Akkermans and D Bruinvels, 'Do compensation processes impair mental health? 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ACOEM GUIDELINE

Preventing Needless Work Disability by Helping People Stay Employed

Stay-at-Work and Return-to-Work Process Improvement Committee

Introduction/Background

Each year, millions of American workers develop health problems that may temporarily or permanently prevent them from reentering the workforce. In most cases, employees are able to stay at work or return to work after a brief recovery period. However, approximately 10% of these workers incur significant work absences and/or life disruptions that can lead to prolonged or permanent withdrawal from the workforce. During this nonworking period, these individuals are described as "disabled," and many become involved in one or more of the existing disability benefit systems and laws, eg, sick leave, workers' compensation, short-term disability, long-term disability, Social Security Disability Insurance, the Family Medical Leave Act, or the Americans with Disabilities Act (ADA). The estimated total annual cost of disability benefits paid under all these systems exceeds $100 billion.

This report focuses on the large number of people who, due to a medical condition that should normally result in only a few days of work absence, end up withdrawing from work either permanently or for prolonged periods. For many of these workers, their conditions began as a common problem (eg, a sprain, strain, depression, or anxiety) but escalated, resulting in short-term, long-term, or permanent disability. This potentially preventable disability absence has unfortunate consequences for both the employer and the employee.

The fundamental reason for most medically-related lost workdays and lost jobs is not medical necessity, but the nonmedical decision making involved in and the poor functioning of a little known but fundamental practice used by U.S. and Canadian disability benefits systems: the stay-at-work/return-to-work (SAW/RTW) process. This process determines whether a worker stays at work despite a medical condition or whether, when, and how a worker returns to work during or after recovery. The SAW/RTW process presently focuses on "managing" or "evaluating" a disability rather than preventing it. This report describes the SAW/RTW process, presents recommendations to improve the process, and provides information on current best practices and initiatives.

What Is the Stay-at-Work/Return-to-Work Process?

The usual steps included in the SAW/RTW process are as follows:

1. The SAW/RTW process is triggered when a medical condition or another precipitating event occurs—in this example, a worker with a badly infected cut on his or her foot—raising the question whether the worker can or should do his or her usual job today.
2. The worker's current ability to work is assessed on three important dimensions:
   a. Functional capacity—what can he or she do today? Has the infection made him or her so sick he or she simply cannot function at all? If not, what can he or she do in his or her current condition?
   b. Functional impairments or limitations—what can the worker not do now that he or she normally could? The acute pain makes it uncomfortable to wear regular shoes and conduct activities that require being on one's feet.
   c. Medically based restrictions—what he or she should not do lest specific medical harm occur? Would walking, standing, and being on his or her feet all day actually worsen the infection or delay healing?
3. Next, the demands of the usual job and/or available temporary alternative tasks are compared with the worker's current functional capacity, limitations, and medical restrictions.
   a. To make this comparison, the functional demands of the tasks or job must be known, including what knowledge, skills, and abilities—physical, cognitive, and social—are required.
   b. Specific medical qualification standards (such as those for airline pilots), legal requirements (such as those for truck drivers and crane operators), company policies, or concerns about the safety of coworkers, the public, or the business may also apply.
4. Finally, the actions necessary to resolve the situation and return the worker to work are identified.
   a. If the worker can be safe and comfortable doing his or her usual job or can independently make any necessary modifica-

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TABLE 1
The Stay-at-Work/Return-to-Work Process Escalation Levels

Escalation Level	Who Is Involved?	How Is Current Work Capacity Determined?	How Are Job Demands Determined (both usual job and alternatives)?	What Triggers the Actual Return to Work?
0	Worker	Personal knowledge	Personal knowledge	Personal decision
1	Worker and supervisor	Discussion	Discussion	Discussion
	Worker and physician	Discussion Return-to-work note from physician	Verbal description of usual job	Discussion
2	Worker Physician Claims adjuster/case manager	Formal inquiry Simple physical capacities form completed by doctor	List of job's functional demands	Discussion
	Worker Physician Claims adjuster/case manager	Objective testing Functional capacity evaluation	Video of job Ergonomic analysis of job	Written offer of employment Formal return to work plan Sign off by all parties
	Physical therapist Ergonomist or vocational consultant Independent medical examiner Union steward	Independent medical opinion	On-site workplace visit	
3	Lawyer			

tions, he or she should be able to return to work.

b. If the worker is only able to do temporary alternative work that requires the cooperation of others, or if permanent modifications to the job must be made, the employer must make arrangements and implement them. If that happens, the worker can go to work.
c. If not, the worker remains out of work until either the medical condition resolves or the situation changes.

If the job does not demand too much use of the impaired body part or function, the medical condition is minor, and the worker wants to go to work, the preceding steps are accomplished rapidly. However, some situations do not resolve as quickly and require additional steps. At this stage, the SAW/RTW process evolves into a negotiation between the employee (and his or her advisors) and the employer (and its advisors) regarding whether the employee can return to work. Therefore, steps 2 through 4 may need to be repeated at each level. During each repetition, more participants tend to become involved and the situation can escalate with progressively more opinions, data, resources, and time being required to decide when and if the employee can return to work.

For example, in more difficult situations, successive passes require additional assistance from more specialists such as a nurse case manager, physical therapist, an occupational medicine physician, an independent medical examiner, a lawyer, and/or other experts. Functional capacity evaluations may be required to document work capacity. Job analyses may need to be done to document the job demands. The additional effort and resources often produce a paradoxic effect of clouding the situation rather than clarifying it by obscuring basic issues, causing confusion, hardening positions, and polarizing participants.

Table 1 displays the escalation levels of the SAW/RTW process moving from simplest to most complex. The process ends when a definitive answer is reached—the worker will or will not return to work. However, the three basic questions requiring factual answers always remain the same:

1. What are the worker's current work capacity, medical restrictions, and functional limitations?
2. What are the functional demands of the intended job?
3. If the worker's functional capacity matches the functional demands, what is required to affect an actual return to work?

Medical conditions vary considerably as do their impact on work. Table 2 provides examples of the circumstances under which the SAW/RTW process takes place.

The SAW/RTW process does not occur in isolation. Although it has been overlooked because of the incorrect assumption that if the medical condition is promptly and properly treated, the worker will naturally return to work, the process occurs in parallel or is influenced by four other well-known processes (Table 3):

1. Personal adjustment process deals with the disruption resulting from the illness or injury.
2. If the medical situation calls for treatment, the SAW/RTW process occurs in parallel with the

TABLE 2
Examples of the Variability of Medical Conditions and Their Impact on Work

Medical condition	A 'cold' or acute food poisoning	Sprained ankle or influenza or asthma attack	Femur fracture or abdominal surgery or treatable cancer or major depression	Bipolar disorder or multiple sclerosis or congestive heart failure
Length of time away from work	None/days	Days	Weeks	Weeks/months
Biologic impairment	Trivial isolated episodes	Minor isolated episode	Moderate isolated episode; may recur	Moderate/severe; chronic/ recurring; may be progressive
Medical care required	None	Single provider 1–2 visits	Several providers; several curative visits/service; relapse prevention may be necessary	Multiple providers; ongoing services; relapse prevention required
Likelihood of full resolution	Always	Always	Usually some residual impairment possible	Unlikely; fluctuation in functional ability common
Time course of the illness/condition	Days	Days	Weeks	Months/year
Career impact	None	Irrelevant	Significant temporary impact (residual but stable permanent impairment may affect ability to perform essential job functions)	Progressive impairment often affects ability to perform essential job functions long term
Number of other professionals involved	0 – 1	0 –2	0–3	Multiple
Stay-at-work/return-to-work information exchanges required	0–1	0 –1	0–3	Multiple

medical care process comprising diagnosis and treatment.

3. If the initial SAW/RTW process results in the worker staying home and if coverage under one or more disability benefit programs is possible, the disability benefits administration process begins operating in parallel with SAW/RTW.
4. If permanent or long-term alteration of work capacity occurs, the ADA "reasonable accommodation" process might be triggered. It operates in parallel with SAW/RTW. If ADA applies, it will heavily influence what occurs in SAW/RTW.

The outcomes produced by the SAW/RTW process profoundly impact the overall health and well-being of patients, their families, employers, and communities by determining whether people stay engaged in or withdraw from work and all the consequences that derive from that decision. However, the SAW/RTW process has been hidden by complex technical, financial, and legal details of multiple disability benefit programs. This little studied and underresourced process has enormous personal and economic consequences for millions of people and deserves attention.

Observations and Recommendations

The following portion of this report, grouped under four general recommendations, discusses 16 specific areas in which the SAW/RTW process can be improved:

1. Adopt a disability prevention model;
2. Address behavioral and circumstantial realities that create and prolong work disability;
3. Acknowledge the contribution of motivation on outcomes and make changes to improve incentive alignment; and
4. Invest in system and infrastructure improvements.

For each of the 16 parts, specific recommendations for achieving optimal outcomes are described and ways to implement these recommendations

TABLE 3
Five Parallel Processes Triggered by a Health Event That Affects Ability to Function

	Personal Adjustment Process	SAW/RTW Process	Medical Care Process	Disability Benefits Administration Process	ADA Act Reasonable Accommodation Process
Fundamental issues	Dealing with life disruption: ● Physical ● Logistic ● Financial ● Social ● Psychologic ● Can I cope with this life challenge? Am I healthy or sick? Am I in charge here? What does this mean for my future?	Will this person recover on the job? When is it medically safe to resume normal activity? What adjustments to the usual job will be required and for how long? Will this person ever return to the same job/employer/vocation?	What is the diagnosis and prognosis? Is this curable or treatable? What treatment is warranted?	Does this episode qualify under the rules of our plan? Is this person eligible for benefits? How much benefit is due? Is there any evidence of benefit fraud?	Will this change in work capacity be longstanding? Does this person qualify for protection under the ADA law? Is there an accommodation that can make full productivity possible? Is it "reasonable"?
Participants (leader is in italics)	*Employee*	*Employer* *Employee treating clinician* Benefit or claims agent	*Treating clinician* Employee	*Benefit or claims agent* Employee Healthcare provider	*Employee* *Employer*
Activities	Thinking, feeling, reacting, talking, coping, adapting	(see Table 1) Fact finding; negotiation; making arrangements	Delivery of medical care services	Fact-finding; data-gathering; claim processing; calculation	Fact-finding; data-gathering; negotiations
Results	Interpretation; decisions/strategies; possible change in self-concept (identity)	Staying home; staying at work; going back to work; new job	Healing; symptom resolution; failure to improve; monitoring	Benefit decisions and exchange of money; claim closure	Employment decision

SAW/RTW indicates stay-at-work/return-to-work; ADA, Americans with Disabilities Act.

suggested. When possible, concrete examples are provided of existing improvement initiatives or of programs that achieve better than average results by using best practices.

Adopt a Disability Prevention Model

Increase Awareness of How Rarely Disability is Medically Required

Only a small fraction of medically excused days off work is medically required, meaning work of any kind is medically contraindicated. The remaining days off work result from a variety of nonmedical factors such as administrative delays of treatment and specialty referral, lack of transitional work, ineffective communications, lax management, and logistic problems. These days off are based on nonmedical decisions and are either discretionary or clearly unnecessary. Participants in the disability benefits system seem largely unaware that so much disability is not medically required. Absence from work is "excused" and benefits are generally awarded based on a physician's decision confirming that a medical condition exists. This implies that a diagnosis creates disability.

However, from a strictly medical point of view, people can generally work at something productive as soon as there is no specific medical condition to keep them from working (see Table 4). The key question is, "What kind of work?" Many obstacles that appear to be medical are really situation-specific. For example, an employee with a cast on the right foot cannot drive a forklift but can perform other tasks until the cast is removed. A person recovering from surgery may not be able to work a full day in the office but could work half days. In fact, people often sit home collecting benefits because their employers do not take advantage of their available work capacity. Today, these decisions gen-

TABLE 4
When is a Disability Medically Required, Medically Discretionary, or Medically Unnecessary?

Medically Required	Medically Discretionary	Medically Unnecessary
Absence is medically required when: • Attendance is required at a place of care (hospital, physician's office, physical therapy) • Recovery (or quarantine) requires confinement to bed or home • Being in the workplace or traveling to work is medically contraindicated (poses a specific hazard to the public, coworkers, or to the worker personally, ie, risks damage to tissues or delays healing)	Medically discretionary disability is time away from work at the discretion of a patient or employer that is: • Associated with a diagnosable medical condition that may have created some functional impairment but left other functional abilities still intact. • Most commonly due to a patient's or employer's decision not to make the extra effort required to find a way for the patient to stay at work during illness or recovery	Medically unnecessary disability occurs whenever a person stays away from work because of nonmedical issues such as: • The perception that a diagnosis alone (without demonstrable functional impairment) justifies work absence • Other problems that masquerade as medical issues, eg, job dissatisfaction, anger, fear, or other psychosocial factors • Poor information flow or inadequate communications • Administrative or procedural delay

Source: Cornerstones of disability prevention and management. *ACOEM Practice Guidelines*, 2nd ed. pp 80–82.

erally are misclassified as "medical" and, as such, are not examined.

Recommendation. Stop assuming that absence from work is medically required and that only correct medical diagnosis and treatment can reduce disability. Pay attention to the nonmedical causes that underlie discretionary and unnecessary disability. Reduce discretionary disability by increasing the likelihood that employers will provide on-the-job recovery. Reduce unnecessary disability by removing administrative delays and bureaucratic obstacles, strengthening flabby management, and by following other recommendations in this report. Instruct all participants about the nature and extent of preventable disability. Educate employers about their powerful role in determining SAW/RTW results.

Current Initiatives/Best Practices. Clinicians, employers, and insurers can now use the following criteria (see Table 4) to determine whether a disability is medically required, discretionary, or unnecessary. If all parties use these definitions, clearer communication and better decision-making will result. In particular, physicians will no longer have to make employment decisions, and employers will stop misclassifying business decisions as medical decisions.

Urgency Is Required Because Prolonged Time Away From Work Is Harmful

Unnecessary prolonged work absence work can cause needless but significant harm to a person's well-being. While on extended disability, many patients lose social relationships with coworkers, self-respect that comes from earning a living, and their major identity component— what they do for a living. Many key players in the SAW/RTW process do not fully realize the potential harm that prolonged medically excused time away from work can cause. Many think that being away from work reduces stress or allows healing and do not consider that the worker's daily life has been disrupted. With these attitudes, system-induced disability becomes a significant risk.

An article by Harris in the *Journal of the American Medical Association* reconfirmed that workers receiving disability benefits recover less quickly and have poorer clinical outcomes than those with the same medical conditions who do not receive disability benefits. The researchers reported that 175 of the 211 studies meeting their inclusion criteria reported worse surgical outcomes for patients on workers' compensation or involved in litigation. (Only one study reported better outcomes in compensated patients; 35 studies reported no difference.) Of the 86 studies that excluded patients in litigation, the odds of an unsatisfactory outcome were nearly four times higher for the patients on workers' compensation than for those not receiving compensation. These findings are similar to those of other studies, including two previous meta-analyses of outcomes studies, one for workers with chronic pain and the other for closed head injuries.

Early intervention is the key to preventing disability. Research confirms that people who never lose time from work have better outcomes than people who lose some time from work. Studies have shown that the odds for return to full employment drop to 50/50 after 6 months of absence. Even less encouraging is the finding that the odds of a worker ever returning to work drop 50% by just the 12th week. The current practice of focusing disability management effort on those who are already out of work rarely succeeds.

Recommendation. Shift the focus from "managing" disability to "preventing" it and shorten the response time. Revamp disability benefits systems to reflect the reality that resolving disability episodes is an urgent matter given the short window of opportunity to renormalize life. Empha-

size preventing or immediately ending unnecessary time away from work, thus preventing development of the disabled mindset, and disseminate an educational campaign supporting this position. Whenever possible, incorporate mechanisms into the SAW/RTW process that prevent or minimize withdrawal from work. On the individual level, the healthcare team should keep patients' lives as normal as possible during illness and recovery while establishing treatments that allow for the fastest possible return to function and resumption of the fullest possible participation in life.

Current Initiatives/Best Practices. Many employers and some insurers now begin return-to-work efforts on the first day of absence or within 72 hours of being notified of a claim. One large workers' compensation insurer established a group of "preinjury consultants" to help employers prepare to respond from the moment of injury to avert needless lost workdays. Attempts are also underway to detect workers with preexisting risk factors for prolonged disability to manage them more intensively from the onset. Colledge et al developed a Disability Apgar test, which evaluates a situation and assigns a risk score. The State Fund of California recently completed a pilot program that assesses risk factors at claim intake and makes suggestions for claim management. A workers' compensation insurer in Australia uses an evidence-based assessment questionnaire at claim intake and again at specific intervals to speed detection (and intervention) on claims showing signs of delayed recovery.

Address Behavioral and Circumstantial Realities That Create and Prolong Work Disability

Acknowledging and Dealing With Normal Human Reactions

Injuries and illnesses disrupt lives. Even a minor injury may seem like a major occurrence because it is different. People may fear getting into trouble, the need for surgery, or that the injury may end their career. Frequently, they also must learn to deal with unfamiliar workers' compensation and/or disability benefits systems and rules. Employers and insurers often neglect to inform injured or ill employees know about how their disability benefit programs work, what to expect, and how to make the process work smoothly. Physicians often fail to tell their patients much about their condition and what they can do to achieve the best possible result.

Many injured or ill workers experience stress because coping with these uncertainties can be difficult. The amount of stress a specific individual experiences in a specific situation will vary widely based on factors such as the magnitude of the medical problem, the personal and family situation at the time, and the job situation.

According to medical anthropologists, patients take on the "sick role" and the "dependent patient role" after becoming ill or injured. To recover, they must relinquish these roles. The sick role exempts people from their normal responsibilities while giving them the right to receive care from others and be free of fault. Those who have trouble coping with their circumstances are likely to resist relinquishing those roles, using them instead to feel good about themselves and ensure their future security.

The ability to function and deal with life's problems varies from individual to individual. When people are under stress, they function less well and are more susceptible to illness or injury. If the demands of a situation exceed an individual's ability to cope and no assistance is provided, the personal adjustment process will stall and recovery and return to work will be delayed. Experience shows that the current processes do not acknowledge these emotional realities. Workers are typically left alone to cope regardless of their situation and their coping skills. Little effort has been devoted to reducing uncertainty and other sources of stress. Individuals caught up in stress that they cannot handle alone are not identified.

Even when SAW/RTW process participants recognize emotional factors, effective assistance is not usually available. Because benefit programs do not cover medical treatment costs, paying for supportive services that will help nonoccupational disability patients recover and return to work is usually not considered. In workers' compensation, claims adjusters are reluctant to acknowledge these issues and authorize mental health services, fearing that doing so will lead to claim for a psychologic illness and drastically increased claim cost. However, most of these sick or injured people do not need psychiatric care. They need the education, minor supportive counseling, and reassurance that a friend, family member, social worker, or employee assistance program can provide. Treating physicians could remove much uncertainty and stress by clearly pointing out the functional aspects of medical conditions, options, and length of treatment, thus empowering people to cope on their own.

Recommendation. Encourage all participants to expand their SAW/RTW model to include appropriate handling of the normal human emotional reactions that accompany temporary disability to prevent it becoming permanent. Encourage payers to devise methods to provide these services or pay for them.

Current Initiatives/Best Practices. Some U.S. employers are creating links between their disability benefit programs (workers' compensation, short- and long-term disability), their employee assistance programs, and/or their disease management programs to assure that employees know they can tap into existing support services. A New Jersey insurance agency makes immediate solicitous inquiries after a work-related injury occurs, ensuring that injured workers feel cared for and their questions are answered.

Investigate and Address Social and Workplace Realities

Research shows that an individual's social connection to the workplace af-

fects the occurrence of injury and illness as well as the outcome of the SAW/RTW process. Does the worker like his or her job? How much pressure and decision latitude does the employee have at work? Does the worker get along with his supervisor? These types of factors can play a major role in a person's willingness to return to work, especially when coupled with the emotional adjustment issues. Job dissatisfaction has been shown to be one of the strongest statistical predictors of disability. Home/family considerations may also pose problems for the worker entering the SAW/RTW process. The worker may be tempted to resolve such problems by prolonging disability benefits.

Although many players in the SAW/RTW process acknowledge the importance of these factors, little has been done to effectively address them. Employers and workers often use the disability benefit system to sidestep difficult workplace issues that are obvious to them but not disclosed to outside parties, ie, physicians, insurance adjusters. Unless these parties exert a significant effort to discover the underlying facts, interventions to address the real issues are seldom attempted. When key parties to the SAW/RTW process do not know what is actually happening because they lack "inside information," any effort expended on SAW/RTW may be misguided or futile and a waste of resources and time.

Recommendation. The SAW/RTW process should routinely involve inquiry into and articulation of workplace and social realities; establish better communication between SAW/RTW parties; develop and disseminate screening instruments that flag workplace and social issues for investigation; and conduct pilot programs to discover the effectiveness of various interventions.

Current Initiatives/Best Practices. An innovative program that is now being used successfully by several employers and insurers, particularly in Canada, involves a trained facilitator conducting face-to-face discussions between the employee and the first-line supervisor. Each session focuses on "what part of your job can you do today?" All other parties become resources and advisors for the two key participants as they work to resolve the situation. Substantial increases in both employee and supervisor satisfaction with the way these situations are handled and the near total demedicalization of the SAW/RTW process are among this program's benefits.

Find a Way to Effectively Address Psychiatric Conditions

When a person with underlying psychiatric illness incurs a potentially disabling physical illness or injury, the risk of permanent disability increases unless the psychiatric problem is treated. A significant psychiatric disorder becomes symptomatic during a period of serious medical illness in more than 50% of cases, especially those with a history of a major psychiatric disorder. Many more previously undiagnosed workers also are vulnerable to developing their first episode of anxiety or depression when sick or injured. In these cases, the physical illness or injury precipitates the psychiatric episode.

Mental health treatment is required for these cases because the patient's mental condition significantly affects his or her reaction to the illness, adherence to medical treatment, the course of illness, its impact on function, and functional recovery from the physical condition. Psychiatric factors can contribute significantly to permanent disability unless treatment is active and effective. However, the current SAW/RTW process often ignores or does not detect or address psychiatric issues. The reluctance of treating physicians to make a psychiatric diagnosis comes primarily from lack of awareness and stigma. Patients often do not want these diagnoses.

Even when a psychiatric diagnosis is made, treatment is often inadequate or inappropriate. Limited benefits coverage and shortages of skilled mental health professionals often mean that expert treatment is unavailable. Although all healthcare professionals understand the need to protect and foster role functioning in personal relationships, they often overlook the importance of role functioning at work. Faced with a patient who describes stress due to difficulties at work, leaving work is often seen as the solution.

Dramatic improvements in psychiatric diagnosis and treatment have occurred during the past 15 years. Although some employers know that psychiatric treatments are potentially cost-effective, they also have spent considerable sums on ineffective, expensive therapy. They correctly believe that many mental health providers do not focus on functional recovery but continue with treatments that show no apparent benefit. Payers have not conditioned access and payment on providers' adherence to current treatment principles. As with other chronic conditions, psychiatric disorders may require intermittent intensive early treatment of new episodes as well as long-term, low-level treatment to prevent recurrence.

Recommendation. Adopt effective means to acknowledge and treat psychiatric comorbidities; teach SAW/RTW participants about the interaction of psychiatric and physical problems and better prepare them to deal with these problems; perform psychiatric assessments of people with slower-than-expected recoveries: routine; and make payment for psychiatric treatment dependent on evidence-based, cost-effective treatments of demonstrated effectiveness.

Current Initiatives/Best Practices. The Washington State Department of Labor and Industries pioneered an innovative program that provides psychiatric services to injured workers. The agency handles all workers' compensation claims and pays all benefits for the state's insured employers. The agency reached agreement with the state medical association to pay for up to 90 days of psychiatric treatment "as an aid to cure" a physical work-related injury if the initial evaluation, treatment plan, and progress report notes

meet certain specifications. Showing a clear connection between the diagnosis and specific barriers to resume working is essential as is a connection between the treatment plan and removal of those barriers. As long as progress is documented, payment continues for up to 90 days.

Reduce Distortion of the Medical Treatment Process by Hidden Financial Agendas

In disability cases, the medical treatment process is often distorted by nonmedical factors with patients often seeking particular diagnoses or treatments to obtain or maximize benefits. Distortion also occurs when employers or benefits claims administrators ask naive physicians precise questions and elicit particular language that later becomes the basis for benefit, claim, or employment determinations.

One cause is the complex and differing sets of rules for eligibility and benefit determination in the various disability benefit programs. With thousands of different disability benefit plan designs, few physicians can accurately determine the impact their actions may have on a given patient's benefit payments or where hidden agendas may lie. Physicians are uncomfortable when they suspect patients, employers, or payers of making requests based on hidden agendas. They often practice "don't ask, don't tell" in such situations, knowing they will not be paid for time spent investigating specifics.

Recommendation. Develop effective ways and best practices for dealing with these situations. Instruct clinicians on how to respond when they sense hidden agendas. Educate providers about financial aspects that could distort the process. Procedures meant to ensure independence of medical caregivers should not keep the physician "above it all" and in the dark about the actual factors at work. Limited, nonadversarial participation by impartial physicians may be helpful. For example, ask an occupational medicine physician to brief the treating clinician. When possible, reduce the differences between benefit programs that create incentives to distort. Employers are in a better position to do this than other payers.

Current Initiatives/Best Practices. Many employers examine their benefit programs to determine whether they create unwanted incentives for employees to behave in a certain way. For example, some employers have set up paid time off banks in lieu of sick leave to decrease abuse and increase the predictability of employee absence. Others have redesigned their short-term disability program benefits to more closely match the workers' compensation benefit and vice versa. An increasing number of employers are expanding their workers' compensation return-to-work programs to cover nonoccupational conditions as well.

Acknowledge the Contribution of Motivation on Outcomes and Make Changes to Improve Incentive Alignment

Pay Physicians for Disability Prevention Work to Increase Their Professional Commitment

Physicians seldom receive extra compensation for their time and effort in the disability prevention and management aspects of the SAW/RTW process. As a result, they may give those aspects low priority, believing they have no market value. In more complex situations that could benefit from the physician's initiative or active participation, the monetary disincentive reflected by lack of payment often deters the physician from responding quickly or making the extra effort, often delaying SAW/RTW.

Because most physicians do not consider disability prevention their responsibility, their passivity does not represent a failure to carry out their perceived duty. Although employers and insurers may assert that disability management should be included in the price of the medical visit, such assertions have little impact on physician behavior.

Recommendation. Develop ways to compensate physicians for the cognitive work and time spent evaluating patients and providing needed information to employer and insurers as well as on resolving SAW/RTW issues. ACOEM developed a proposal for new multilevel Current Procedural Terminology codes for disability management that reveals the variety and extent of the intellectual work physicians must do in performing this task. Adopting a new Current Procedural Terminology code (and payment schema) for functionally assessing and triaging patients could achieve similar goals. Payers may be understandably reluctant to pay all physicians new fees for disability management because of reasonable concerns about billing abuses—extra costs without improvement in outcomes. Make billing for these services a privilege, not a right, for providers and make that privilege contingent on completion of training and an ongoing pattern of evidence-based care and good faith effort to achieve optimal functional outcomes.

Current Initiatives and Best Practices. An innovative Australian operation builds relationships between selected local providers and employers. Instead of contracting for discounted fees, the employer customers agree to pay full fees in exchange for the selected providers' agreement to learn about the employer's programs and collaborate and communicate promptly. The selected providers are also paid additional fees for the extra effort spent on communications.

A workers' compensation insurer in Massachusetts selected and trained a network of primary occupational medicine providers and asked them to help manage the situation caused by the injury or illness. The insurer paid these providers their full fee schedule rates for medical care plus a modest fixed fee for "situation management" for every case they handled. Half of the new fee was held back and paid as a bonus if the pattern of care revealed good overall results—appropriate medical costs, pa-

tient and employer satisfaction, and low disability rates. The program taught employers to channel to the providers; many channeled more than 85%. Workers' compensation injuries that became lost time injuries decreased between 6% and 8% when the treating physician was a provider.

Support Appropriate Patient Advocacy by Getting Treating Physicians Out of a Loyalties Bind

Government agencies, insurers, and employers expect physicians to provide unbiased information that verifies what their claimants/employees have said about their medical conditions and ability to work. Some of this information will be used to validate claims and manage attendance and may be used to award or deny benefits or as the basis for personnel actions. Physicians are often made aware of this by their patients. The medical profession does not acknowledge any duty to play this role as corroborator of fact for third parties, especially because negative financial consequences for patients may result. In fact, the physician must advocate for the patient and consider the patient's interest first.

However, many physicians have not thought carefully about patient advocacy in the context of SAW/RTW. Frequently, being a patient's health and safety advocate means promoting employment and full social participation. However, the scope of "patient advocacy" varies from physician to physician with some using their role as physician to advocate for whatever their patient wants. Historically, employers and insurers have dealt with this primarily through the independent medical examination process.

Recommendation. The SAW/RTW process should recognize the treating physician's allegiance; reinforce the primary commitment to the patient/employee's health and safety, and avoid putting the treating physician in a conflict of interest situation; focus on reducing split loyalties and avoid breaches of confidentiality; use simpler, less adversarial means to obtain corroborative information; and develop creative ways for treating physicians to participate in SAW/RTW without compromising their loyalty to their patients.

Current Initiatives/Best Practices. Employers and insurers who get the best return-to-work results and have the lowest disability rates:

- Take charge of the process from the start and never let it appear that the physician is in charge of making employment decisions;
- Inform treating physicians that the employer has a temporary transitional work program and that most workers are expected to recover on the job;
- Make it clear that they can provide work within a wide range of functional abilities and will carefully abide by any guidelines the physician sets;
- Stop asking physicians to set return-to-work dates, asking them instead to provide functional capacities, restrictions, and limitations; and
- Use metrics such as workdays lost per 100 injury/illness episodes to track the effectiveness of their programs.

Increase 'Real-Time' Availability of On-the-Job Recovery, Transitional Work Programs, and Permanent Job Modifications

Allowing workers to recover on the job is a cornerstone of disability prevention. This often takes the form of transitional work programs (also known as temporary modified work, alternative duties, or light duty) that allow workers return to work at partial capacity while they recuperate. On-the-job recovery usually involves a temporary change in job tasks, work schedule, or work environment; and often requires reduced performance expectations for the limited duration of the assignment, generally not more than 90 days. Workers in on-the-job recovery programs are expected to return to their usual jobs, with or without permanent accommodations, once they have completed the temporary assignment.

Permanent job modifications such as task redesign or switching to ergonomically designed tools may also allow for recovery on the job. Permanent modifications usually enable employees to continue working their usual jobs without interruption while meeting that job's regular performance expectations.

Currently, there are three problems that can prevent workers from recovering on the job:

1. Failure to provide temporary modified work. Many employers still refuse to provide temporarily modified work and many labor agreements prohibit it. Insurers offering discounts to employers who claim to have transitional work programs typically fail to confirm that such programs are actually used. Few employers provide financial incentives to supervisors to make arrangements for on-the-job recovery by subsidizing the labor cost of transitional work programs. Few also appropriately allocate the cost of disability benefits to the operating units whose failure to keep workers safe or provide transitional work created the lost workdays.
2. The bad reputation of "light duty." Based on past experience, employers and workers may see light duty as a dead end for favored or aging workers who can no longer keep up. Others view it as a punishment and resist it for fear they will be given meaningless or no work or will be isolated or harassed.
3. Long lag times. Many companies do not use their return-to-work programs promptly. When one of their workers becomes ill or injured, they wait for the physician to write restrictions or the physical therapist to recommend job modifications rather than anticipating the need for transitional work assignments.

Recommendation. Encourage or require employers to use transitional work programs; adopt clearly written policies and procedures that instruct and direct people in carrying out their responsibilities; hold supervisors accountable for the cost of benefits if temporary transitional work is not available to their injured/ill employees; consult with unions to design on-the-job recovery programs; require worker participation with ombudsman services available to guard against abuse; and make ongoing expert resources available to employers to help them implement and manage these programs.

Current Initiatives/Best Practices. Successful transitional work programs are now in place in many well-managed organizations. As a result, these organizations experienced significant reductions in costs and absenteeism. The Ohio Bureau of Workers' Compensation's statewide Transitional Work Program makes employers eligible for a state-funded grant of up to $5200 to develop a Transitional Work Program. California's recent workers' compensation reform legislation includes a program to reimburse small employers up to $2500 for purchasing adaptive equipment or otherwise modifying jobs for injured workers. An employer consortium, sponsored by the occupational medicine program at a clinic in Illinois, provides guidance and support to local employers in setting up and running their transitional work programs. The Australian state of New South Wales requires all employers with more than 200 employees to appoint an in-house injury manager, who is responsible for creating return-to-work plans.

Be Rigorous Yet Fair to Reduce Minor Abuses and Cynicism

The disability benefit system is often used inappropriately to solve other problems, for example, taking sick leave to stay home and care for a child. Rules also are stretched to receive benefits without medical justification. If these minor abuses continue unchecked, more people assume everyone engages in such behavior. Eventually, anyone filing a claim is treated with cynicism or suspicion. Those with legitimate needs may be treated unkindly, and the SAW/RTW process may become unpleasant for them. Additionally, if transitional work programs are allowed to become permanent havens for nonproductive workers, both employees and supervisors lose enthusiasm for them. If used to demean, harass, or ostracize workers, light-duty programs may become counterproductive.

Recommendation. Encourage programs that allow employees take time off without requiring a medical excuse; learn more about the negative effect of ignoring inappropriate use of disability benefit programs; discourage petty corruption by consistent, rigorous program administration; develop and use methods to reduce management and worker cynicism for disability benefit programs; train all parties to face situations without becoming adversaries; and be fair and kind to workers in the SAW/RTW process.

Devise Better Strategies to Deal with Bad Faith Behavior

Employees and their families, supervisors, employer management, treating clinician(s), insurance carriers, benefits administrators, case managers, union representatives, and lawyers are involved in the disability benefits system. Some individuals in each group manipulate the SAW/RTW process to the point of serious abuse or clearly fraudulent activity. For example, an employer pressures a worker not to report a work-related injury. Employers and insurers expend considerable effort identifying and dealing with employees who take advantage of the system and, to a lesser extent, with physicians who do the same. In comparison, little attention has been paid to the harm done to injured or ill employees when their claims adjuster or employer gives them poor service or behaves inappropriately or illegally.

Often, a lawyer is the only recourse available to the injured worker. Most workers seeking counsel do so only after a problem arises. People who feel they have been ill-served and retain lawyers get involved in an adversarial system that hardens and polarizes positions, prolongs needless disability, and increases the likelihood of poor functional outcomes. One multistate insurer's analysis shows that the median cost of workers' compensation claims of those with legal representation is approximately $30,000 more than those without representation. The median cost of represented claims ranges between 10 and 20 times higher than the median cost of unrepresented ones.

Recommendation. Devote more effort to identifying and dealing with employers or insurers that use SAW/RTW efforts unfairly and show no respect for the legitimate needs of employees with a medical condition; and make a complaint investigation and resolution service—an ombudsman, for example—available to employees who feel they received poor service or unfair treatment.

Invest in System and Infrastructure Improvements

Educate Physicians on 'Why' and 'How' to Play a Role in Preventing Disability

Few physicians, except those in occupational medicine and physiatry, ever receive training in disability prevention and management. Although function is now acknowledged as having a greater impact on quality of life than serious illness, most medical schools have not integrated evaluation of function into their curricula. Yet the average physician who treats working-aged adults usually signs five or more work-related letters or notes to employers and payers per week and is by definition a regular participant in SAW/RTW. As a result, he or she may allow workers to return to work who should not and disable those who could be working.

Recommendation. Educate all treating physicians in basic disability prevention/management and their role in the SAW/RTW process; provide advanced training using the most effective methods; make appropriate privileges and reimbursements available to trained physicians; focus attention on treatment guidelines where adequate supporting medical evidence exists; and make the knowledge and skills to be taught consistent with current recommendations that medicine shift to a proactive health-oriented paradigm from a reactive, disease-oriented paradigm.

Current Initiatives/Best Practices. ACOEM and the American Academy of Orthopedic Surgeons have active educational efforts underway with courses on disability-related topics at all annual conferences. Several employers in West Virginia and Idaho award quality points toward bonuses to those local physicians who attend a training session or take a short, web-based course in disability prevention and return-to-work communications. Two workers' compensation health-care provider networks in California and Florida strongly encourage their physicians to take a course in disability prevention. Other networks are developing similar programs. The State Compensation Insurance Fund of California recently made disability management training a requirement for key clinicians in its medical provider network.

Disseminate Medical Evidence Regarding Recovery Benefits of Staying at Work and Being Active

Strong evidence suggests that activity hastens optimal recovery, whereas inactivity delays it. Moreover, simple aerobic physical activity has been shown to be an effective treatment for chronic pain, fibromyalgia, and chronic fatigue syndrome. Other evidence indicates that remaining at or promptly returning to some form of productive work improves clinical outcomes as compared with passive medical rehabilitation programs. The ACOEM *Occupational Medicine Practice Guidelines* recommend exercise, active self-care, and the earliest possible safe return to work. Despite this evidence, inactivity, work avoidance, and passive medical rehabilitation programs are often prescribed as treatment.

Recommendation. Undertake large-scale educational efforts so that activity recommendations become a routine part of medical treatment plans and treating clinicians prescribe inactivity only when medically required; specify that medical care must be consistent with current medical best practices; or preferably, adopt an evidence-based guideline as the standard of care.

Current Initiatives/Best Practices. California recently adopted ACOEM's Practice Guidelines as the best available evidence-based standard of care for new workers' compensation injuries. California law says that the Guidelines shall be "presumptively correct on the issue of extent and scope of medical treatment." Colorado also developed evidence-based treatment guidelines and requires those who perform independent medical evaluations to take a rigorous state-sponsored training course. Their opinions must conform to state standards.

Simplify/Standardize Information Exchange Methods Between Employers/Payers and Medical Offices

Although physicians play an important role in the SAW/RTW process, they are typically given too little information to act effectively. Employees often are the physicians' only source of information because employers usually do not send any information to the physician about an employee's functional job requirements, their SAW/RTW programs, their commitment (or lack of it) to employee well-being, and how to quickly answer questions or address problems.

Claim administrators often request information from the physician to help in managing their claim. They tend to use a generic approach that does not match the information requested with the simplicity or complexity of the situation. Questions often seem designed to determine eligibility for benefits rather than to find a way to help the worker return to work. Discussion of patient functionality, which is not subject to confidentiality restrictions, lacks sufficient focus. Employers and claims administrators often find it easier and more efficient to send volumes of material to the physician instead of reducing it to the essential questions for the physician's convenience.

Many physicians seem unaware of employers' and benefit administrators' needs for information. When physicians receive poorly conceived requests for guidance or opinions, they have little tolerance or time to review irrelevant or redundant information to find the few useful pieces of data. Many physicians simply do not know how their delays or inadequate responses impact optimal functional outcomes for their patients. Both sides are exasperated by the enormous variability in the other's paper forms.

Recommendation. Encourage employers, insurers, and benefits administrators to use communication methods that respect physicians' time; spend time digesting, excerpting, and highlighting key information so physicians can quickly spot the most important issues and meet the need for prompt, pertinent information; and encourage all parties to learn to discuss the issues—verbally and in writing—in functional terms and mutually seek ways to eliminate obstacles.

Current Initiatives/Best Practices. Training can increase awareness among employer and insurer staff members about the practical realities of the physician's office and teach them how to make more successful information requests that match these realities. Successful case managers often fax a single page to the physician's office the day before a patient's appointment. It should contain one or more questions or options accompanied by checkboxes the physician can use to answer them. Several new companies

are seeking to link medical provider offices with employers and insurers using various business models to help make the process valuable for all participants.

Improve/Standardize Methods and Tools That Provide Data for Stay-at-Work/Return-to-Work Decision-Making

Everyone involved in a worker's SAW/RTW process needs data about work capacity and job demands to make informed decisions. Considering their impact on thousands of work disability episodes per year, existing methods and tools for obtaining and analyzing data are nonstandard and often crude.

In the time-pressured setting of patient care, treating physicians typically make educated guesses to determine work capacity, medical restrictions, and functional limitations. Similarly, employees and employers typically make educated guesses to describe the functional demands of workplace tasks, a method that seems to work well most of the time. However, whenever ability to work is uncertain or disputed, everyone—especially the courts—develops an appetite for "hard facts" and data. The private sector developed most of the proprietary methods and technologies currently used to determine work capacity.

Although almost all commercial methods/machines claim to have been scientifically tested, very little high-quality research has been published in rigorously peer-reviewed scientific journals. One major study showed that functional capacity evaluations (FCEs) were worse than no testing to facilitate appropriate job placement. In that study, a group of patients underwent functional capacity evaluations. Those whose physicians used data from the FCEs as the basis for their return-to-work advice did worse than those whose physicians ignored the FCE results and simply reassured and returned the workers to their usual jobs. Another major study showed that patients who had FCEs to facilitate appropriate job placement fared worse than those whose physicians ignored the FCE results and simply returned the workers to their usual jobs.

Table 5 provides examples of the methods physicians commonly use to obtain the data needed for SAW/RTW decision-making. For each question or issue to be resolved, the table shows the low-cost or simple method typically used in an everyday medical office visit compared with a high-cost or complex method typically used in a complex or litigated situation. The table indicates the wide range in technical sophistication, time required, and cost. However, one important reference has not yet been developed. Physicians looking for authoritative information have no resource for the occupational implications of various specific medical conditions or descriptions of patient-specific or task-specific considerations that would generate the need for specific medical restrictions.

Recommendation. Help physicians participate more effectively in the SAW/RTW process by standardizing key information and processes; persuade employers to prepare accurate, up-to-date functional job descriptions (focused on the job's maximum demands) in advance and keep them at the benefits administrator's facility; send them to physicians at the onset of disability; teach physicians practical methods to determine and document functional capacity; and require purveyors of functional capacity evaluation methods and machines to provide published evidence in high-quality, peer-reviewed trials comparing their adequacy to other methods.

Current Best Practices/Initiatives. Many occupational medicine physicians ask workers carefully designed questions about everyday activities or observe them while they perform a simple set of office-based maneuvers to quickly obtain objective information on which to base their opinions. Occupational medicine specialists commonly tour the plants of their industrial clients to familiarize themselves with the physical work environment and the tasks of specific jobs. Many employers have developed detailed functional job descriptions as part of their ADA compliance program. Some have modified their claim intake process to include mailing the worker's job description to the treating physician. Some large companies are developing a computerized database of all tasks, including each task's critical (most difficult) functional demands. A few companies use job-specific functional testing at time of hire as well as at routine intervals after injury or illness to assure that workers are assigned tasks within their capabilities. Both vendors and purchasers of evaluation methodologies are beginning to understand the need to demonstrate validity and reliability in well-designed and controlled peer-reviewed trials.

Increase the Study of and Knowledge About Stay-at-Work/Return-to-Work

The SAW/RTW process has not been systematically and formally studied in sufficient detail. Little solid methodological foundation or medical evidence exists to support or improve commonly used methods and tools. Although millions of dollars have been spent studying the adequacy of healthcare services, very little funding or research has addressed outcomes for those covered by the workers' compensation system. Like with workers' compensation, the failure to address these issues may point to a need for federal agenda.

Recommendation. Complete and distribute a description of the SAW/RTW process with recommendations on how best to achieve desired results in disability outcomes; establish and fund industry-specific, broad-based research programs, perhaps in the form of independent institutes or as enhanced university programs; collect, analyze, and publish existing research; formulate research to better understand current practices and outcomes, determine best practices, and test alternative solutions to problems; develop a way to effectively communicate the find-

TABLE 5
Methods of Obtaining Data for the Stay-at-Work/Return-to-Work Decision-Making Process

Question/Issue to Be Resolved	Low-Cost and/or Simple Method	High-Cost and/or Complex Method
What are the functional demands of the worker's usual job?	Physician asks the worker what he or /she usually does at work	Physician relies on data from a job analysis; physician reads a multipage comprehensive functional job description possibly with digital photos/video; the report has been prepared by a trained expert hired by the employer or insurer; the expert did a formal job analysis, including making actual measurements at the worksite
What is the worker's current work capacity and functional limitations?	Physician asks what the worker cannot do; observes the worker's behavior in the examination room; performs a physical examination and then mentally projects those answers and observations into likely workplace activities	Physician uses data from tests such as treadmill testing (aerobic exercise capacity), functional capacity evaluation (musculoskeletal work capacity), or neuropsychologic testing (cognitive ability); tests of other capacities are available but much more rarely used; physician reads a report of the worker's visit to a special testing facility, in which he or she performed a set of maneuvers to ascertain the worker's maximum work capacity
Is there a medical reason why the worker should be removed from work? Is there any specific activity/exposure the worker should avoid for medical reasons?	Physician uses his or her own knowledge of workplaces and jobs, then thinks about potential situations that might pose a risk to the health/safety of the worker or others and writes medical restrictions to avoid them	Other than disability duration guidelines that specify the length of time people are typically absent from work for various conditions, no clinical resource is available; we are unaware of any reference that systematically reviews the occupational implications (medical concerns and functional issues) of various medical conditions; neither a consensus-based encyclopedic reference nor a systematic and comprehensive review of evidence-based medical literature exists yet
Can this worker with this functional capacity and these medical restrictions do this particular job?	Make an informed guess; the physician uses whatever information is available to decide whether the worker's current capabilities match with the job demands; *OR* the employer or insurer looks for a match, they compare the employee's abilities as portrayed in a physician's note with the demands of available jobs	Physician relies on data from functional testing; using information about a particular job, a testing facility devises a set of maneuvers that duplicate the maximum functional demands required by the tasks of that particular job; then the worker attempts to perform those critical tasks; the areas of mismatch are the tasks that the worker cannot perform
Ways of modifying jobs/making accommodations	The physician makes a suggestion based on his or her previous life and practice experience; the employer may seek advice from a consulting physician with occupational medicine expertise	Physician relies on data in a report written by a vocational counselor or similarly trained and qualified professional who has evaluated the situation in detail and made recommendations

ings of completed research to all decision-makers; and solicit needs for future research.

A sampling of research topics of interest might include:

- Develop screening tools to accurately predict relative risk of long-term functional disability and provide a basis for therapeutic interventions;
- Document the long-term history of prolonged absence or withdrawal from work;
- Design controlled trials of various claims and clinical interventions for improving medical and functional outcomes;
- Assess and catalog the functional implications and occupational considerations related to the 300+ medical conditions that cause most disability;
- Compare ways to assess work ability capacity;
- Devise ways to standardize and increase the availability and usability of functional job descriptions;
- Study physician behavior in dealing with role conflict;
- Develop controlled trials to compare different methods for training physicians in disability prevention and assessing the impact of that training on clinical, functional, and financial outcomes;
- Discover ways to increase the recognition and effective treatment of psychiatric comorbidities;
- Develop effective ways to streamline communications between participants in SAW/RTW; and
- Compare different methods to reward physicians for active participation in the SAW/RTW process.

Conclusion

Although most injured or ill people can cope with their problem and make either temporary or permanent life and

work adjustments, a large minority cannot. This minority does not recover successfully, adopts a disabled self-concept, and experiences either a needlessly prolonged absence or a permanent withdrawal from work. In problematic situations, the SAW/RTW process is usually inadequate and ill-suited to detect and effectively address the most important issues related to the outcome. It also accounts for the majority of needless expenditures for disability benefits. Because this minority accounts for such a large portion of all disability program costs, a 1% reduction in cases with prolonged disability should generate a substantially larger reduction in overall system cost. Therefore, the focus of the SAW/RTW process should shift away from "managing" or "evaluating" disability to preventing it. The fundamental reason for most lost workdays/lost jobs is not medical necessity, but the nonmedical decision making and poor functioning of the SAW/RTW process.

Employers, insurance carriers, and government agencies currently burdened by the costs of preventable disability, and worried about the future implications of the aging workforce, should consider underwriting efforts to more effectively prevent disability. Recommendations to improve the SAW/RTW process will require:

- A sense of urgency;
- Attention and priority;
- Research;
- Experimentation with new methods and interventions;
- Infrastructure development;
- Policy revision;
- Methodological improvement and dissemination;
- Education and training;
- Incentive alignment; and
- Funding.

Common sense evidence abounds that keeping people productively employed is good for them and for society. Avoiding the unfortunate outcome of iatrogenic or system-induced disability is worthwhile. Improving the appropriateness and usefulness of services available to people coping with illness and injury is also of value. It also is sensible, if not urgent, to curtail needlessly using resources and losing personal and industrial productivity.

Improving the SAW/RTW process will require sustained attention and effort as well as a willingness to explore new approaches. This report will, perhaps, stimulate thinking and begin a regular dialogue with other stakeholders to explore this topic in progressively greater depth.

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The Role of Incentive Measures in Workers' Compensation Schemes

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Abstract

Workers' Compensation Schemes have a large number of participants, including injured workers, employers, administrators and external service providers. The behaviours of these participants have a significant impact on the outcomes achieved and costs incurred by the scheme. Incentive Measures are one way schemes can influence participant behaviour.

For each participant in a Workers' Compensation Scheme, in the context of specific scheme outcomes, we summarise key participant behaviours and the factors which influence those behaviours, with a focus on Incentive Measures. We draw on examples from both the Australian and international environments.

We propose an Incentive Measure management framework that describes the establishment and management of incentives. We then discuss challenges such as the potential for gaming, barriers to optimal decisions, measurement of success and getting buy-in from participants.

Keywords: Incentives, Outcomes, Accident Compensation, Scheme Design, Workers' Compensation

The Role of Incentive Measures in Workers' Compensation Schemes

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1. Introduction

1.1. A Working Definition of "Incentives"

Incentives are widely used in society today and come in many different shapes and forms. Incentives can be defined as:

> "*any factor (financial or non-financial) that enables or motivates a particular course of action, or counts as a reason for preferring one choice to the alternatives. It is an expectation that encourages people to behave in a certain way*."[1]

Incentives arise in many different situations and have many different structures in order to influence behaviours. Incentives may be *reward* incentives or *fear of penalty* incentives.

Some examples of non-workers' compensation incentive schemes that have been used or proposed within Australia include:

- Reward schemes are now commonplace in Australian society[2], where buyers are incentivised for their purchasing loyalty to a company or group of companies through the accrual of rewards.
- The Home Insulation Program[3] was introduced in February 2009 to incentivise homes to install ceiling insulation in an effort to reduce future carbon emissions.
- The First Home Owner Grant was introduced in 1 July 2000 to offset the effect of the Goods and Services Tax on home ownership in an attempt to incentivise new home building behaviours of first home buyers.
- The Australian Government's plan to introduce a Carbon Tax[4] is aimed at incentivising investment in clean and renewable energy sources.

These incentives are well known within Australia and each scheme has had, or is likely to have, behavioural impacts on our society.

1.2. Roadmap for the Paper

This paper focuses on incentives used in workers' compensation schemes. Incentives have been used as a part of scheme design for many years to influence scheme participant behaviours. There is a wide array of literature that has analysed the success, or otherwise, of these incentives. Many principles discussed in this paper may be suitably transposed for use within other accident compensation schemes, while other principles remain specific to workers' compensation schemes. Where appropriate, we draw on examples from sources other than workers' compensation.

The rest of this paper is structured as follows:

- Section 2 describes incentives in a workers' compensation context.
- Section 3 introduces a framework for managing incentives.
- Sections 4 and 5 describe incentives used in Australian and overseas workers' compensation schemes respectively.
- Section 6 discusses some challenges in managing incentives.
- Section 7 provides a summary of the key conclusions.

2. Incentives in a Workers' Compensation Context

Workers' compensation insurance provides wage replacement and medical and rehabilitation benefits for employees who suffer from workplace injury or disease. Each state in Australia has some form of compulsory workers' compensation, although the benefit structure and operational model varies between jurisdictions.

Two key objectives of these schemes are generally: the prevention of workplace injury and disease through the provision of safer workplaces, and ensuring a timely return to work after injury. We discuss this further in Sections 2.3 and 2.4.

Perhaps ironically, the existence of an insurance based workers' compensation benefits system can create a number of perverse incentives which may act counter to these scheme objectives. This occurs through the creation of moral hazards, for example:

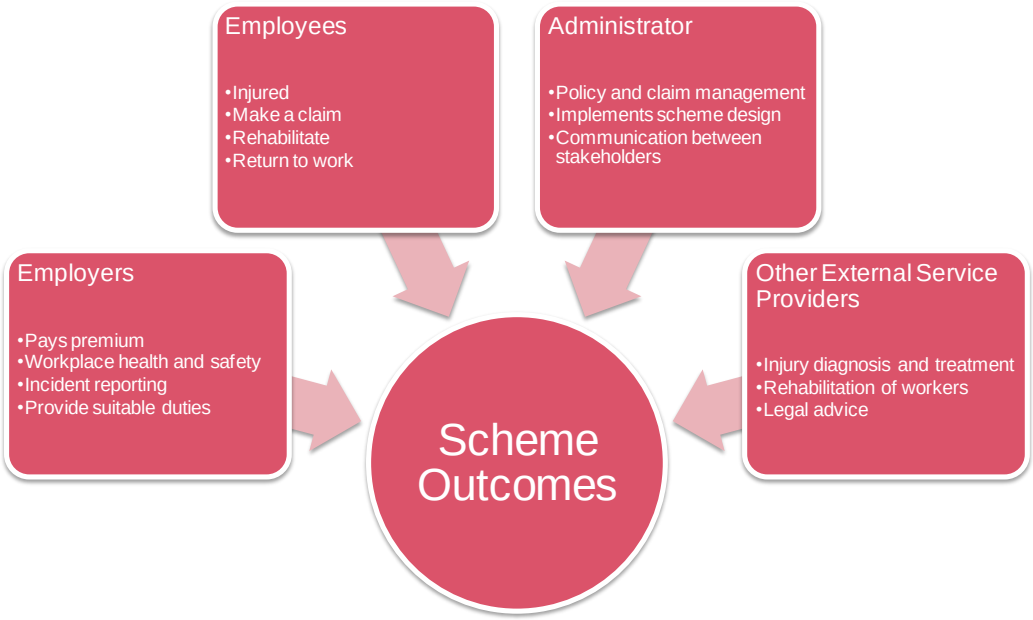
- Employers may pay less attention to workplace safety if they know that they are covered by insurance in circumstances of workplace injury or disease
- Once a worker is on compensation benefits there may be a reduced incentive to return to work if the insurance benefits are overly generous
- Workers may have a financial incentive to falsely report non-work related injuries as workers' compensation claims

There are a number of ways for schemes to counteract these perverse incentives, and the use of incentives to influence participant behaviours is one possible response.

2.1. Who are the Scheme Participants we need to Incentivise?

There are a number of key participants in a workers' compensation scheme with differing roles in the prevention of injuries and the recovery of injured workers. The following diagram shows some of these participants and their roles within a workers' compensation scheme.

Figure 1- Participant Roles in a Workers' Compensation Scheme



We note that private sector insurers may be active participants in the scheme in a number of different capacities, including being the primary providers of insurance (in the case of private

sector schemes) or as administrators (in the case of public sector schemes that outsource their administration functions).

The behaviours that participants demonstrate while performing their roles has a large influence on scheme outcomes. The design of appropriate incentives should encourage participant behaviours that are aligned with the schemes objectives.

2.2. What is an "Incentive Measure"?

In this paper we refer to an "Incentive Measure" as a component of a workers' compensation scheme's design that rewards or penalises a participant for certain behaviours or outcomes. Incentive Measures may be used to influence a variety of different types of behaviour. The most commonly used Incentive Measures in workers' compensation schemes target improved workplace injury and disease outcomes, and these are the focus of this paper.

For an Incentive Measure to be effective in improving injury and disease outcomes it should be successful in either the:

i. Prevention of injuries or illnesses - by improving the safety of the surrounding workplace environment; or

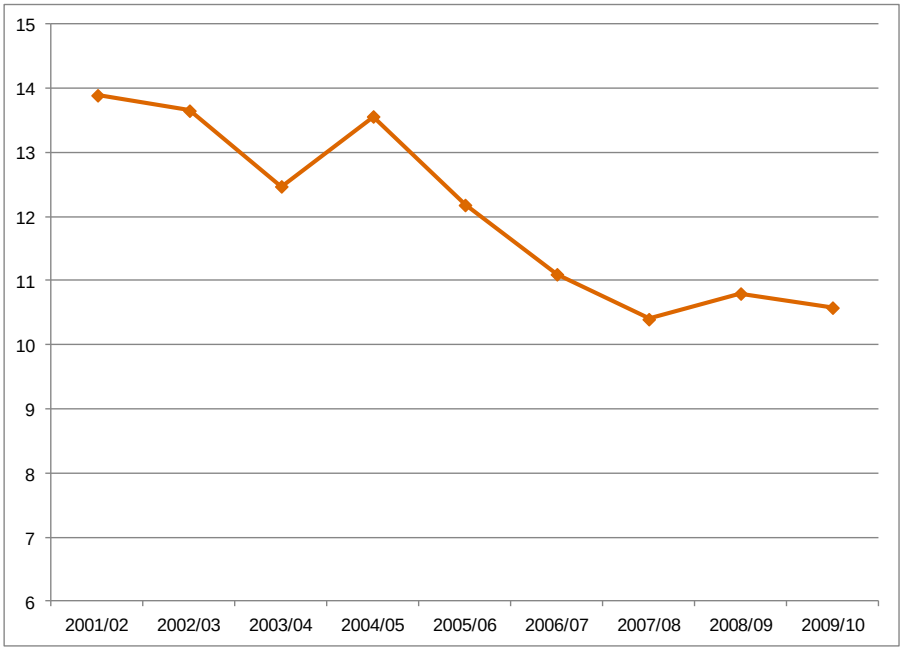
ii. Optimisation of longer term injury recovery or disease management once an injury has already occurred – this may be achieved by either improved recovery outcomes or reduced costs for a similar outcome.

Other types of Incentive Measures may also exist within workers' compensation schemes to achieve other scheme objectives or to support broader social initiatives.[5]

2.3. Prevention of Workplace Injuries or Illnesses

There have been significant reductions in scheme incidence rates over the last two decades. For example, the following chart shows the reduction in claim frequency per 1,000 workers within the WorkSafe Victoria Scheme over the last 9 years.

Figure 2- WorkSafe Victoria Claims per 1,000 Workers over Time



Source: WorkSafe Victoria Annual Reports

The WorkCover NSW 2009/10 Annual Report notes a 38% reduction in major workplace injuries since 1999/00 and a 58% reduction in work related fatalities incidence rate since the scheme commenced.[6]

What is less clear is the attribution of the causes of these improvements. Much of the improvements are likely due to improved Occupational Health and Safety (OHS) regulations, technological advances, employers taking a more active interest in workplace safety and a changing industry mix.

However, part of this improvement is likely to be due to the use of Incentive Measures. As this paper highlights in Sections 4 and 5, the use of Incentive Measures to change the behaviour of scheme participants is common and can be a powerful tool in pursuing scheme objectives.

We now describe some of the forces that influence workplace safety.

2.3.1. Labour Market Forces

Economic theory suggests that the labour market will act as an OHS regulator over time. The employer has an incentive to improve OHS when the marginal cost of making jobs safer outweighs the cost of increased remuneration that is required to be paid to employees for the perceived risks of the job. One way they may do this is by utilising safer technologies. This incentive is most obvious in highly hazardous industries where the risk of injury can be a real consideration in whether to accept a job. As a result, high risk occupations may require large increases in remuneration to attract labour. This theory is discussed in more detail in many other papers.[7]

There are some obvious limitations to this theory:

- There is an assumption that employees are able to accurately assess the level of occupational risks. It may be difficult for employees to adequately assess occupational risks, especially for disease related risks.
- There is an assumption of the perfect transferability of employment. In practice there are significant frictional costs associated with changing employment.

Nonetheless, labour market forces may be regarded as a form of Incentive Measure that should gradually improve OHS practices over time.

2.3.2. Regulation

Governments can legislate OHS requirements through their regulatory framework. There is a strong incentive to comply with these OHS regulations because it is the law. Non-compliance is breaking the law and can lead to severe financial penalties or, in more extreme cases, lead to a company going out of business. There are also reputational risks associated with non-compliance.

The use of regulation can be an effective way to manage known and important risks. Some good examples of regulations that have worked well in targeting specific known risks can be found within the Compulsory Third Party (CTP) environment. Regulation has been effective in helping to reduce risks associated with speeding, drink driving and traffic light infringements. Further, the success of these regulations has been influential in changing general societal attitudes to some of these risks, as a result of both the "fear of penalty" and through targeted media education campaigns over sustained periods of time.

Similarly, regulation has been successful in Workers' Compensation schemes. For example, McInnes et al (2009) describes some of the major reasons for the reduction in the NSW claim incidence experience over the last 20 years. A large proportion of this improvement is

attributed to the creation of safer workplaces that have been achieved within the policy framework created by the *Occupational, Health and Safety Act* 1983.

There are some limitations to the effectiveness of regulation:

- It may be difficult to efficiently enforce regulations and pick up non compliance. Workplace audits, for example, can be both time consuming and expensive.
- Regulations are not firm specific and may not take into account important variations in work practices, for example technological variations between employers.
- Employers may need to spend time and energy in compliance rather than responding to underlying safety issues.
- The threat of penalty may not be sufficient incentive to improve OHS practices unless there is a high enough probability of inspection.
- Regulation can respond well to known risks but can be less effective in managing emerging risks.

The regulatory approach can be enhanced through the use of financial disincentives such as fines or other penalties, to the extent that these are significant enough to incentivise behaviours. In any case, it makes good business sense for employers to comply with regulations because it leads to safer workplaces (and hence lower injury and disease rates within the workplace), satisfies employer's moral responsibilities and can be used to enhance an employer's brand as an employer of choice.

2.3.3. The Use of Incentives Measures in OHS

Incentives are another tool that can be used to provide continuous improvement to both known and emerging risks. This is one of the key advantages of using incentives rather than direct regulation, which generally only prescribes a minimum standard of OHS. A well set up and managed set of Incentive Measures can be used to promote better practice OHS risk management.

2.4. Optimising Injury Outcomes through Return to Work

Once an injury or disease has been sustained, the management of the injury or disease is of great importance. There is a growing acceptance that early intervention in an injury, appropriate treatment and early return to work is crucial in ensuring an optimal outcome for the injured worker.

There are a number of challenges in optimising injury outcomes as a result of a worker's compensation scheme. These include:

- There may be a perverse incentive for employees to remain off work and access additional compensation benefits. For example, there are various time and impairment thresholds that may need to be attained to access certain lump sum benefits, and weekly compensation may be seen as an attractive remuneration substitute while off work.
- There is a need to balance long term outcomes against short term costs. There may be the temptation to minimise short term treatment costs, however this may not be in the best long term interests of the worker. Thus, the trade-off between bulk billed standardised treatments versus more tailored and potentially more expensive approaches needs to be considered. Long term sustained recurrence of injury can be a major scheme cost.
- The interaction of a workers' compensation scheme with other social security systems needs to be considered. For example, Selander (2006) discusses the

disincentive for some cohorts of Swedish workers to return to work. This is because once workers' compensation benefits are considered in conjunction with other social security benefits, some workers may be just as well off financially whether they are at work or not.

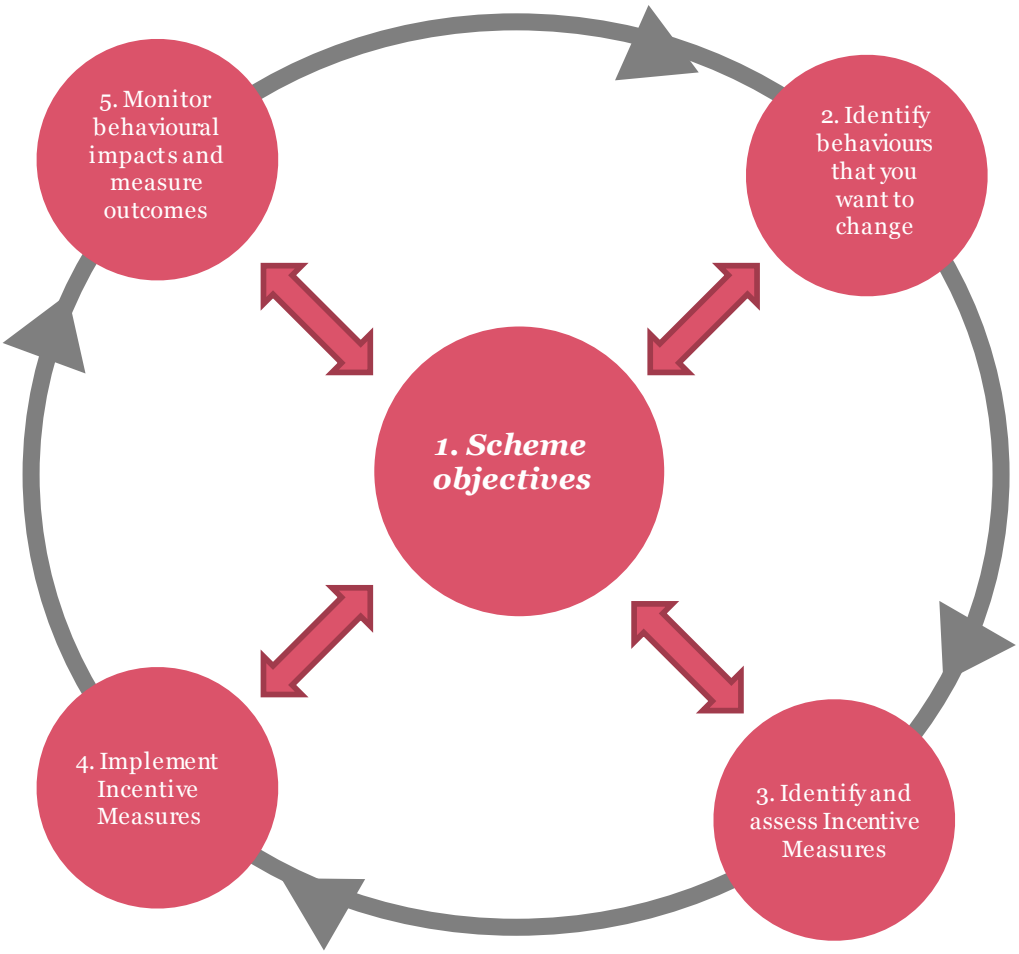
These challenges can lead to undesired behaviours by the scheme participants and can work against the return to work goals of the scheme. Incentive Measures can be used to address these behaviours and achieve better injury recovery outcomes.

3. Managing Incentive Measures

We have reviewed an array of literature that discusses the use of incentives within workers' compensation schemes, as described in Sections 4 and 5 of this paper. This review has led us to observe certain themes and trends which appear to influence the success or otherwise of Incentive Measures.

This section proposes a framework to assist in the successful design, implementation, assessment and management of an effective Incentive Measure. The following diagram is a summary of this framework.

Figure 3- Incentive Measure Management Framework



3.1. Scheme Objectives

No two workers' compensation schemes are the same. Each scheme has its own objectives, its own strategies to align the direction of the scheme with those objectives and its own execution challenges. The first step in the proposed framework is to establish the objectives of the scheme and express them as a number of measurable targets.

Table 1 provides hypothetical examples of the opportunities that could be targeted by a scheme to progress with its objectives.

Table 1: Examples of Targeted Opportunities

Scheme Objectives	Targeted Opportunities
Reduce the number of workplace injuries or disease	• Reduce claim frequency for musculoskeletal injuries • Reduce agricultural industry claim rates to comparable levels with other jurisdictions • Reduce claim frequencies for smaller employers • Target reduced deafness claims using preventative measures
Improve the return to work rates of injured workers	• Reduce the delay between injury and first medical treatment to allow early intervention in treatment of injuries • Improve the rates of redeployment of injured blue-collar workers to white collar roles • Respond to the increasing emergence of newer injury claim types, such as stress claims
Provide a fair level of compensation and support, proportionate with the level of impairment	• Improve the effective management of lifetime care and support claimants to comparable benchmark schemes • Reduce the utilisation of common law or lump sum benefits

Targeted opportunities can exist at a number of different levels. Table 1 gives examples of opportunities for specific injury types and industry groups, as well as scheme wide opportunities (e.g. common law utilisation).

There are likely to be a number of good starting points for identifying these opportunities, such as:

- Scheme monitoring reports
- The findings of targeted claim file reviews
- The commentary contained in actuarial valuation reports
- Data mining and other statistical analysis
- Benchmarking experience with comparable schemes

It is important for the scheme to establish targets for each opportunity, and use Key Performance Indicators (KPI's) to monitor the success, or otherwise, of the Incentive Measure. These targets can be short or long term in duration, but should represent the end outcome that is desired. These targets should be established prior to implementing an Incentive Measure and be SMART, that is (S)pecific, (M)easurable, (A)chievable, (R)ealistic and (T)imebound.[8]

Table 2 gives examples of setting a KPI for two example opportunities.

Table 2: Example of SMART Target

Targeted Opportunity	SMART Target
Reduce the claim frequency for small employers	Frequency, defined as claim numbers from small employers divided by wages to fall by 10% over two years. Quarterly reductions in the observed claims frequency of 1.25%.
Improve the rates of redeployment of injured blue-collar workers to white collar roles	Reduce the average return to work duration for the most recent accident year by 5%, compared to the previous year, measured at a one year development period

3.2. Identify Behaviours that you want to Change

Once targeted opportunities to improve scheme performance have been identified, the next step is to determine the stakeholder behaviours that might limit the success of these opportunities. Thus, the relevant stakeholders that will play a role in the targeted opportunity need to be identified, and then the behaviours that you need to overcome in order for the strategy to work need to be listed. We give an example in Table 3.

Table 3: Identification of Behaviours that are Inconsistent with Scheme Objectives

Targeted Opportunity	Relevant Stakeholder	Adverse or Inconsistent Behaviour(s)
Improve the rates of redeployment of injured blue-collar workers to white collar roles	Employers	• Not cost effective to hire a worker with an injury history. Retraining is costly and there is a risk of re-injury that could result in higher workers' compensation premiums, excess costs and disruption to the business.
	Injured workers	• A reluctance to change from blue collar to white collar roles. • Do not have the skills for the new role and it requires significant effort to develop them.

Identification of the stakeholders' behaviours that are inconsistent with scheme objectives is a crucial part of the framework, as it is these behaviours that the introduced Incentive Measures will need to change.

A good example of the successful targeting of specific behaviours that are inconsistent with scheme objectives has been in the CTP industry where drink driving behaviours were a significant contributor to road fatalities. The introduction in the late 1980's of various mass media campaigns acted as a moral incentive to change behaviours. This was also supplemented by significant financial penalties, potential loss of licence and an increase in the enforcement of these penalties through the introduction of booze buses and other breath testing equipment. These initiatives have contributed to almost halving the fatalities on the road in Victoria from these causes between 1989 and 2007.[9] This has also been successful in changing many societal attitudes towards drink driving and it is now more common to have designated non-drinking drivers within drinking groups or to make it more acceptable to take public transport or taxis when under the influence of alcohol. This is not to say that these campaigns and penalties have been fully successful, and while these reductions are significant

there are still ongoing campaigns that target specific drink driving behaviours, such as drink driving of those near the legal limit.

3.3. Identify and Assess Appropriate Incentive Measures

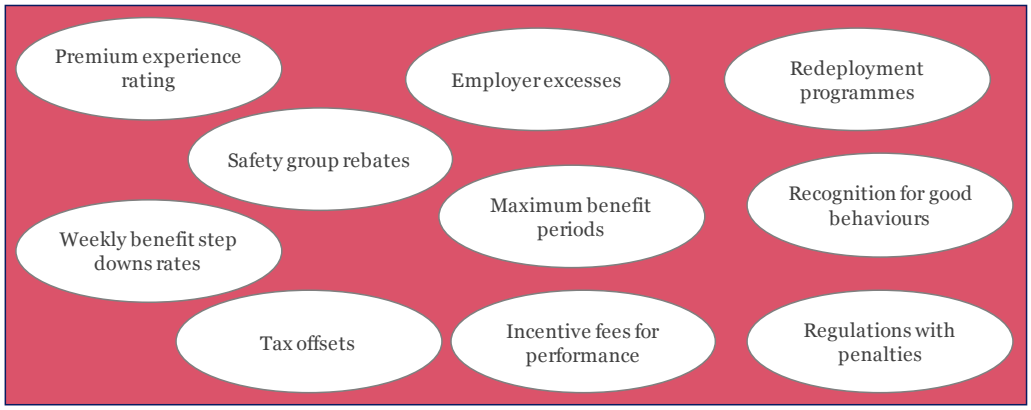
Incentive Measures are one tool that can be used to change the behaviours of individuals and organisations. This section discusses how to select the Incentive Measure that will best suit the opportunities that the scheme is pursuing.

We recognise that there are many ways to change behaviours, and there may be other non-incentive responses that can be used. Here we consider the options in those cases where Incentive Measures are considered the most appropriate course of action.

3.3.1. Types of Incentive Measures

There are many different ways to incentivise behaviours. Sections 4 and 5 of this paper highlight a range of Incentive Measures that are used locally and overseas. The following diagram shows a summary of some of these types of incentives.

Figure 4- Types of Incentives



Selecting an Incentive Measure that best contributes to the scheme's objectives requires a number of considerations. The following section looks at the common characteristics that effective Incentive Measures share.

3.3.2. Characteristics of Effective Incentive Measures

Table 4 summarises the authors' thoughts on the design characteristics of effective Incentive Measures. Whilst some of these features are relatively straightforward, others are considered in greater detail below.

Table 4: Design Characteristics of Effective Incentive Measures

Specific Outcomes	• The Incentive Measure should relate to a specific tangible objective or outcome that has a high upside benefit. • The reward or penalty provided by the Incentive Measure should be strong enough to change the targeted participant behaviour.
Simple	• The incentive should be simple to understand and implement. For example, can the Incentive Measure be explained and understood in less than a minute? • It should not pose a significant administrative burden on either the scheme or the stakeholder, otherwise stakeholders may be unlikely to invest the time to understand the system, and hence to change behaviours.
Cost and Benefit Analysis	• The gain from the Incentive Measure should be commensurate with the cost of implementing it. • The gains should be consistent with the KPI's set prior to implementing the Incentive Measure.
Alignment with Other Incentives	• The Incentive Measure should not detract from other Incentive Measures currently being used. • The Incentive Measure should consider behavioural responses from all stakeholders, not just the targeted stakeholder – for example injured workers, employers, claim managers, administrators, medical providers, rehabilitators and solicitors.
Support Innovation	• The Incentive Measure should not necessarily constrain stakeholders to only deal with a problem in a certain way. • The Incentive Measure should enable innovative strategies which lead to better outcomes to continue.
Evidence Based	• As far as possible, Incentive Measures should be designed using evidence based approaches.

3.3.3. Cost and Benefit Analysis

One of the more challenging aspects of making sure that an Incentive Measure is effective is measuring the costs and benefits of implementing it. Here we list some of the key issues that a scheme should consider.

Measuring the Cost

There will generally be a cost associated with the introduction of an Incentive Measure and this should be affordable and sustainable. The assessment should include all costs associated with the Incentive Measure, and this may include:

- Education and communication costs associated with implementing the Incentive Measure.
- Up-front capital costs such as Incentive Measure development and Information Technology (IT) costs associated with managing the Incentive Measure.
- Ongoing administration costs including IT costs and reporting costs.
- Any expected future payments that would be paid to stakeholders as financial incentives.

Measuring the Benefits

The anticipated benefits of the Incentive Measure should be direct and substantial. There are a number of challenges when assessing the benefits of introducing Incentive Measures and we provide a more thorough discussion of these in Section 6.2.

The starting point to measuring the expected benefits is to make sure the projections are consistent with the KPI targets you have set for the Incentive Measure.

For public sector schemes a broader societal perspective may be justified when assessing benefits. That is, benefits need not only be measured from a "premiums" or "claims costs" perspective but from potential gains in other publicly run "systems", such as reduced public medical costs and reduced unemployment costs.

3.4. Implement Incentive Measure

There are a number of issues to consider before implementing an Incentive Measure.

3.4.1. Testing of Incentive Measure

It may be appropriate to trial the expected outcomes of the Incentive Measure on a subset of the scheme. This may be achieved through a number of different ways:

- The scheme could undertake a stakeholder consultation process with targeted workshops to test how stakeholders intend to change their behaviours in response to the Incentive Measure. Both intended and unintended consequences of the Incentive Measure need to be tested for and considered, including the potential for gaming, and any third party behavioural impacts.
- Pilot schemes are an effective way to test an Incentive Measure, although it is acknowledged that it can be difficult to evaluate pilot schemes in cases where there are long lead times between implementation and outcome.

These actions may enable the scheme to better understand which aspects of the Incentive Measure require further refinement. Should the Incentive Measure not perform as expected then a costly roll out to the entire scheme can be avoided.

3.4.2. Education and Buy-in

Stakeholders who are impacted by the Incentive Measure need to be educated in advance of the Incentive Measure becoming "live". Stakeholders need to trust and understand the Incentive Measure will react in the right way in order to commit to changes in behaviour.

Allowing voluntary participation in an Incentive Measure can help improve buy-in from stakeholders. In this case, the educative process is more important as stakeholders need to be aware of the initiative so that they can participate and adjust their behaviours accordingly.

Where the Incentive Measure is voluntary, the challenge is ensuring that there is sufficient uptake of the Incentive Measure to warrant implementation.

3.4.3. Administration

The preparation of administration and monitoring systems should be completed so that the Incentive Measure can be implemented in a timely fashion. It may require time and money to set up appropriate IT systems or other infrastructure, such as audit capabilities or measurement capability.

3.5. Monitor Behavioural Impacts and Measure Outcomes

Once an Incentive Measure has been implemented it is important to understand and be able to objectively evaluate the impact that the Incentive Measure has had. A scheme should monitor the outcomes resulting from the Incentive Measure and reassess its effectiveness periodically:

- The behavioural impacts of the Incentive Measure on stakeholders should be monitored against the KPI targets following implementation. This is important to ensure that the anticipated behavioural responses are occurring and there is appropriate stakeholder engagement.
- The coverage or uptake of the Incentive Measure should be assessed, especially for any voluntary Incentive Measures. It may be useful to gauge stakeholder engagement through surveys or discussions with stakeholders to understand how they view the Incentive Measure according to criteria such as:
    - knowledge of the existence of the Incentive Measure
    - understanding of how the Incentive Measure works
    - trust that the Incentive Measure will reward appropriate behaviours.
- Audits may be required to make sure that the Incentive Measure is being implemented correctly and as anticipated. This is especially important for Incentive Measures that require OHS hurdles to be satisfied to get rebates, subsidies or offsets.
- The emergence of any unintended behaviours should be considered. This can occur when the Incentive Measure creates perverse incentives that reward scheme participants for undesired behaviours. These behaviours may emerge from participants not directly targeted by the Incentive Measure.
- It is also useful to identify any indirect benefits in any cost and benefit analysis. This may include putting a benefit on absenteeism and "presenteeism[10]" A societal view of cost and benefits may also provide a different view to valuing stakeholder benefits. This would more completely measure the outcomes associated with improved OHS conditions, such as the lower reliance on other medical treatments that may arise from wellness programs.

This monitoring makes it possible to improve the effectiveness of the Incentive Measure by addressing any identified shortcomings of the Incentive Measure. The effectiveness of Incentive Measures should be retested over time, as each initiative may have a limited life span, as stakeholders better understand, and potentially game, the Incentive Measures, and as technological, social, and legislative conditions change. For example:

- The Incentive Measure may lose its appeal to stakeholders if the requirements (such as paperwork) become too onerous. The Incentive Measure may be too routine over time and become an expectation rather than being earned.
- Changing injury types, such as lower prevalence of acute trauma and higher incidence of musculoskeletal injuries, may require different strategies.

- Changing industry mix within a scheme may require different industries to be targeted over different periods of time.

3.5.1. Exit Strategy / Useful Life

Incentive Measures which have lost their effectiveness in changing stakeholder behaviour, whether through flaws in design or changes to the environment, should be removed.

Implementing an Incentive Measure without a planned exit strategy can result in discontent for the stakeholders who benefited from the incentive once it is removed. This can make future incentives more difficult to implement as trust has been lost.

3.6. Conclusion

The use of Incentive Measures is becoming more widespread within workers' compensation schemes to influence a range of stakeholder behaviours. An effective framework that assists in the design, implementation and management of these Incentive Measures, such as that proposed in this section of the paper, is important in ensuring that sound governance is maintained when managing these tools.

Our proposed framework covers the following key aspects:

1. Identify opportunities with SMART targets that are consistent with scheme objectives.
2. Identify the behaviours that you want to change that align with these opportunities.
3. Identify appropriate Incentive Measures to change these behaviours and ensure an adequate assessment of costs and benefits is performed.
4. Ensure that appropriate testing of the Incentive Measure is completed and that stakeholders are educated, with appropriate systems put in place prior to implementation.
5. Monitor the impacts of the Incentive Measure to ensure that it is having the correct behavioural impacts and remains appropriate for the times.

4. Workers' Compensation Incentive Measures Used in Australia

In this section we give a description of some of the main Incentive Measures used in Australia today. For each scheme participant, we list the Incentive Measures and behaviours they are most likely to impact. We have also subjectively rated the relationship between the Incentive Measure and the behaviour using the following symbols:

Symbol	Impact on behaviour
✓	Weak
✓✓	Strong
×	Perverse

There are a variety of operating models used within Australia's workers' compensation schemes and this has influenced the types of Incentive Measures that are used to change stakeholder behaviours. For example:

- **Private Sector versus Public Sector Schemes**

  Privately underwritten schemes typically involve a competitive environment where a number of insurers provide workers' compensation insurance. The insurers are generally motivated by profit and market share, to maximise their shareholders' value. This motivation may not necessarily align with better workplace safety outcomes. The use of workplace safety incentives outside of the workers' compensation scheme through a higher use of regulation may therefore be required.

  Public schemes generally operate as a monopoly and may be able to take a broader approach. Their motivations may therefore be better aligned with wider societal outcomes, such as improving longer term health outcomes, in addition to any direct scheme benefits.

- **Scheme Administration**

  The use of outsourced policy and/or claims administration providers, such as is currently used in NSW and Victoria, is another example of scheme structure that may require different incentive approaches. Care is needed to ensure that the motivation of these third party Agents are aligned with broader scheme objectives.

4.1. Employer

A workers' compensation scheme offers insurance coverage for an employer's workers on the occurrence of workplace injury or disease. The scheme coverage may also include self employed workers and contracted workers.

As discussed in the introduction of Section 2, the existence of an insurance scheme can create perverse incentives for employers and promote behavioural changes detrimental to OHS. An employer may have a limited incentive to improve OHS if covered by insurance in circumstances of workplace injury or disease.

Incentive Measures exist to counteract the perverse incentives created through the introduction of a worker's compensation scheme. It is important for Incentive Measures to

promote the right behaviours and limit the ability for participants to "game" or "cheat" the system.

The following table summarises some of the main employer Incentive Measures used in Australia today and the behaviours they are trying to change. We follow with discussion on each of these Incentive Measures.

Table 5: Incentive Measures for Employers

	Targeted behaviour				
Incentive Measure	Operational Health & Safety	Provision of Suitable Duties	Timeliness of incident reporting	Payment of Premium	Healthier workforce
Experience Rating	✓	✓			
Employer Excess	✓	✓	✓		
Return to Work		✓✓			
OHS inspections	✓✓				
Premium Discounts	✓				
Early claim reporting			✓✓		
Timeliness of premium payment				✓✓	
Internal Employer Incentives	✓	✓	✓	✓	✓
Workplace wellness	✓				✓✓

4.1.1. Experience Rating

Experience rating is a premium rating process where the claims experience of an employer is used in setting the premium paid by that employer. Most jurisdictions in Australia have a form of experience rating, with the form depending on both the operating structure of the scheme and the history behind the development of the scheme.

Experience rating may take several forms and different components may include:

- Future or historic employer claim performance may be included in the premium calculation.
- The period of claims experience assessment may vary, for example it may be the year the premium relates to or an average over previous years.
- The level of credibility given to an employer's experience will generally vary by employer size according to a credibility formula.
- There may be caps and limits applied on individual claims cost contributing to the experience rating to limit the impact of random large claims.
- The assessment of claims cost generally requires open claims to be increased for future expected claims development and the method used to do this may vary.
- There may be limits on the overall experience discounts or surcharges applied to the premium.

Behaviours Targeted

There are three main justifications for the use of experience rating:

1. Claims cost can be more equitably allocated between employers, enabling those industries and employers with higher risks to pay a premium appropriate to their size and risk.
2. Allows greater competition between insurers in a competitive workers' compensation market.
3. Acts as an incentive to improve an employer's claim outcomes, indirectly incentivising employers to improve their OHS and return workers to employment sooner.

The last point is of significance to this paper, as experience rating tries to incentivise employers to provide safer workplaces and more effective return to work options. This should minimise both claim occurrences and the claims cost once injuries have occurred.

General Discussion

There are mixed views on the ability of experience rating to improve OHS. There is a wide body of literature that contests the notion that experience rating significantly improves OHS.[11] There are also other significant limitations of experience rating. These include:

- Experience rating is only suitable for larger employers because smaller employers are subject to statistical fluctuation of claim outcomes, meaning that good luck rather than good management can lead to favourable claim outcomes.
- Even for larger employers the claim cost outcomes may reflect random injury outcomes in both the type of injury and the severity of the injury sustained. For this reason most experience rating programs will limit the contribution from large losses.
- The structure of the experience rating formula may result in significant lags between the outcome of the claims experience and the incentive result.
- There is some evidence that better "claim outcomes" can be achieved through experience rating. Although claims can be used as a proxy for OHS, there is no direct link between the two.
- Perhaps one of the greatest criticisms of experience rating is the perverse incentive of claims suppression and potential adverse behaviours for return to work:
    - The operation of experience rating may lead to claim suppression and this may lead to worse longer term outcomes where early injury intervention is not provided.
    - Employers may focus on the rewards of the experience rating rather than aiming to improve OHS and /or optimise injury or disease outcomes.
    - For industrial disease there may be no clear link to experience as the latency period may be upwards of ten years, providing a weak incentive to undertake preventative measures.
    - Once a worker is injured, an experience rating program may incentivise employers to either bring workers back to work too early or to have an adversarial relationship with injured workers due to the impact that additional claim cost may have on the employer's workers' compensation premium.

In summary, literature reviews of studies show moderate evidence that a well constructed experience rating scheme may lead to better claim outcomes. However, whether this incentivises behavioural changes that lead to safer workplaces is not clear.

4.1.2. Employer Excesses

Employer excesses operate by the employer bearing the initial cost of each claim up to a specified limit. This commonly operates as either a fixed dollar amount or a fixed number of days compensation since the injury has occurred. Each jurisdiction in Australia has different levels of excesses[12].

Behaviours Targeted

Justifications for employer excesses may include:

- Like experience rating, employer excesses provide an incentive for employers to improve OHS and prevent injuries from occurring, as part of the initial injury cost is borne by the employer. The excess represents the financial cost that the employer has for each claim and acts to counteract one part of the perverse incentives of the existence of the insurance scheme.
- They prevent small claims from entering the main scheme. These claims can be frequent and relatively costly to administer. Any improvements in OHS in response to better managing the frequency of small claims can have flow in impacts by also reducing the frequency of larger claims.

General Discussion

The selected level of excess should balance the goals of being high enough that improvements in OHS are worthwhile to reduce the cost of claims, but not so high that small employers can get into financial difficulties as a result of a reasonable number of claims reaching the excess.

One of the potential problems with employer excesses is that if small claims are not reported then they may not receive appropriate medical treatment. They may develop into more serious injuries than if they had received the proper medical treatments in the first place.

We are not aware of any quantitative research into the relative effectiveness of different levels of employer excess, although we note that some literature exists on large deductible schemes available in the US.

4.1.3. Return to Work Employer Incentives

Return to Work Employer Incentives recognise that a swift return to work following recovery from injury is in the best interests of both the scheme and the injured worker. Employers play a key role in this process by providing a suitable position for the injured worker to return to.

Return to work incentives are typically financial incentives such as payments or discounts to an employer for a timely return to work for their employee. Non-financial incentives are also possible however, such as:

- Occupational rehabilitation support to assist the employer in preparing for the return of the injured worker (such WorkSafe Victoria's Original Employer Services[13]).
- Recognition of employers with good return to work experience, which can have a positive impact on their brand or reputation. This may be through Safe Work Awards which exist in many Australian states.

Incentives may exist for both the original employer, and new employers.

Behaviours Targeted

Justifications for return to work incentives include:

- Reduced cost to the scheme as full income replacement benefits are not required once the injured worker has returned to work.

- Alignment of employers interests with that of the scheme and worker.

General Discussion

For original employers, there are often obligations to provide a suitable position for an injured worker. This regulation approach can be coupled with free occupational rehabilitation advice for the employer in order to make the transition back to work as smooth as possible for both employer and employee.

Some employers, typically smaller ones with limited alternative duties, may be unable to provide a suitable position for the injured worker. The injured worker may, however, be able to find work with another employer, and incentives may be paid to encourage these new employers to take on previously injured workers – such workers typically have a higher likelihood of requiring workers' compensation benefits in the future.

The Re-employment Incentive Scheme for Employers (RISE)[14] in South Australia is an example of this. The key elements of this incentive package are:

- reimbursement of 40% of the injured employees wages for their first year of employment with the new employer;
- consideration of payments for minor workspace modifications and equipment; and
- any aggravation of the previous injury is recorded against the original employer, not the new employer.

4.1.4. Operational Health and Safety Inspections

OHS refers to the conditions workers face in their workplace environment. Whilst good OHS will be reflected in improved workers' compensation claims experience, OHS is a much broader concept, and has many benefits beyond workers' compensation claims.

OHS inspectors are employed by schemes to enforce the regulated OHS requirements. The inspectors may have the ability to issue citations or penalties for workplaces that do not comply with the standards. The fear of inspection and penalty provides in incentive to employers to maintain minimum safety standards.

Behaviours Targeted

The justification for OHS inspections is that it can lead to improved safety in the workplace, which can lead to lower frequency and severity of claims (among other benefits).

General Discussion

Studies such as Tompa et al (2007) have shown that specific deterrence (firms that get a penalty) is more effective in changing claim frequency and severity than general deterrence (existence of a penalty).

Employer behaviour is also dependant on the size of any penalty and the frequency of inspections. A small penalty may be insignificant compared to the cost of improving OHS, limiting the impact of the incentive. Very infrequent inspections may lead employers to 'take the risk' and not comply, knowing they are unlikely to be caught out.

4.1.5. Premium Discounts and Exemptions

Premium discounts and exemptions can be used to reward almost any behaviour, as they are essentially a cash payment.

We consider two examples of premium discounts / exemptions. The first is the Apprentice Incentive Scheme in NSW[15] which exempts Apprentices from the workers' compensation costs of an employer.

The second example is the Premium Discount Scheme in NSW, which rewarded employers who met certain workplace safety thresholds.

Behaviours Targeted

For the two examples we consider the behaviours targeted are:

- Apprentice incentive scheme: encourage employers to hire apprentices
- Premium Discount Scheme: improve OHS

General Discussion

The Apprentice Incentive Scheme is an interesting example, as there is no direct benefit to the scheme by exempting apprentices from workers' compensation premiums. There are however other benefits of more apprentices from a societal perspective, such as improved productivity, jobs for young workers, skilled workforce, etc. This example shows how incentive schemes may consider wider impacts on behaviour than those measured directly through claims costs.

The Premium Discount Scheme (PDS) in NSW was a voluntary scheme, started in 2001, that provided premium reductions to employers who implemented workplace safety programs and return to work strategies for injured workers. The PDS was closed after 3 years, as there was mixed reaction from stakeholders regarding its ongoing value.

One of the difficulties faced by Incentive Measures which rely on the achievement of specific OHS hurdles is ensuring a rigorous audit of employer performance. If the audit process does not sufficiently differentiate between employers who commit to the program and those who do not, the incentive to change behaviour may be lost.

4.1.6. Incentives to Improve Reporting Speed

Incentives to improve reporting speed may provide a benefit, such as reduced employer excess, for employers who report claims promptly.

Behaviours Targeted

The justifications for incentives to improve report speed are:

- Reduced claims suppression
- Earlier treatment of claims leading to improved return to work outcomes
- More complete data on which to identify emerging trends

General Discussion

Early reporting incentives are not new, however little literature exists on the effectiveness of reporting speed improvements in improving claim outcomes, or reducing claims suppression.

WorkCover SA runs an *Incentive for early reporting of injuries (Waiver of employer excess)*[16]. This incentive waives the two week employers' excess on weekly benefits for claims reported to WorkCover SA within 2 business days of the employer being notified.

4.1.7. Prompt Payment of Premium

To incentivise prompt payment of premium, schemes may impose penalties for late payment, or discounts for early payment. WorkCover Queensland, for example, offers a 3% premium discount for early payment, and imposes a 5% penalty for late payment.

4.1.8. Internal Employer Incentives

There are a number of incentives which employers can create for themselves, particularly for larger employers or self insurers. These include:

- Linking remunerations (such as bonuses) for internal OHS staff to improvements in claims experience.
- Safety jackpot lotteries or other incentives to encourage safety awareness.
- Internal programs to provide suitable alternative duties in other departments

These incentives are very important to the successful operation of the scheme. They can be thought of as the actions which underlie the more general 'improve OHS' incentives, however they are not the focus of this paper.

4.1.9. Workplace Wellness Incentives

Society is exhibiting increasing trends in the prevalence of chronic diseases and mental health.[17] Some of these chronic diseases are preventable, for example type 2 diabetes and heart disease. Risk factors linked to these diseases include poor diet, stress, obesity, and a sedentary lifestyle.

There is growing evidence that the presence of chronic diseases and mental stress can both increase the risk of workplace injury and slow rehabilitation and recovery from an injury.[18] It also leads to other costs for employers such as absenteeism and "presenteeism" (not fully functioning at work when unwell). This therefore creates an opportunity to incentivise employers to promote wellness initiatives to improve the health of employees. Improved wellness amongst employees can also indirectly increase staff retention which would have other indirect benefits to employers.

Victoria has offered WorkHealth checks through their WorkHealth[19] initiative where free health checks are provided to employees. They have also introduced Workplace health promotion grants where employers can access a grant to fund health and wellbeing activities for their workers, if they have previously offered health checks to the majority of their employees.

Behaviours Targeted

Workplace wellness incentives encourage employers to improve the health of their workforce.

General Discussion

There are some difficulties in providing these types of programs, especially within a worker's compensation scheme. These include:

- There can often be a long lag time between the program initiatives to the subsequent change in behaviours to the final benefit outcomes.
- It may be difficult to measure the benefits, although the monitoring of key performance indicators such as absence rates, retention rates, employee health indexes, OHS claim rates and staff satisfaction ratings can all be useful measures.
- The initiatives can be costly and / or time consuming to administer, with the best solutions often requiring to be tailored to individual organisations or industries.
- Some of the benefits will not directly impact the employer or workers' compensation scheme. For example, many of the benefits arise from improved longer term health outcomes associated with the prevention of chronic diseases and hence benefit society in general.

More service providers are offering such initiatives, either tailored or off-the-shelf, making these more accessible to a range of employers (for example, Medibank, BUPA etc.).

These types of initiatives may be well suited to larger self insurers.

4.2. Injured Worker

Workers' compensation schemes provide a range of support for employees injured in the workplace, including compensation for lost income and / or impairment, medical and rehabilitation benefits and access to common law. The existence of this support may provide a disincentive for the injured worker to return to work.

In order to balance the need to provide fair compensation with the need to have a financially sustainable scheme, Incentive Measures are needed to encourage injured workers return to work as soon as they are able to.

Table 6: Incentive Measures for Injured Workers

	Targeted behaviour			
Incentive Measure	Safety awareness	Propensity to Claim	Return to work	Fraud
Evidence of initial injury		✓✓		✓✓
Replacement ratio		✓✓	✓✓	✓
Maximum benefit periods			✓✓	✓
Existence of lump sums	×	×	×	
Advertising and awareness	✓✓			

Whilst workers' compensation legislation in each jurisdiction establishes workers rights to compensation as a result of a workplace injury, there is a social stigma of being 'on benefits' that provides a natural incentive for return to work or a disincentive to lodge a claim.

The effectiveness of this natural incentive can vary for a range of reasons:

- There may be a weaker incentive to pursue workers' compensation benefits during periods of economic downturn.[20]
- The influence of lawyers in schemes with common law access can reduce the effect of this social stigma as claimants are made fully aware of their right to compensation.

4.2.1. Evidence of Initial Injury

Establishing a process to discourage false or fraudulent claims is common across all workers' compensation jurisdictions. It is important to ensure that the process isn't overly bureaucratic or time consuming for genuine claims, but discourages the lodgement of false claims. Enforcing sign off from the worker's treating doctor and the employee's safety officer are common practice and widely used.

4.2.2. Weekly Benefit Replacement ratio

The primary mechanism for compensating injured workers for their loss of income in Australia is through weekly benefits. The level of weekly benefits varies by scheme, but most

schemes pay weekly benefits as a fixed percentage of the workers' pre-injury earnings or the average weekly earnings of the State.

A common feature of workers' compensation schemes is that the level of weekly benefits claimants are entitled to receive reduces the longer the claimant is off-work. The purpose of these "weekly step downs" is to incentivise return to work through a direct financial penalty.

The primary challenge with this Incentive Measure is establishing step down rates that incentivise return to work while still providing a reasonable weekly benefit to claimants with longer term injuries.

The scheme will also need to be aware of external influences that may reduce the effectiveness of this Incentive Measure. Some examples include:

- The interaction of weekly benefits with other social security benefits received by the claimant.
- In some cases, employers may have workplace agreements with particular employee groups to "top up" weekly benefits to 100% of the pre-injury earnings in the event that the worker is injured.
- Death and disability schemes provided to workers performing dangerous public service such as Police and Fire Fighters often provide additional benefits to workers and their families.[21]
- Other societal factors such as the cost of child care compared to receiving less than 100% of pre-injury earnings.

4.2.3. Maximum Benefit Periods

A common feature in a number of the State schemes is the cessation of income replacement benefits at a certain time if claimants have a capacity to work. The cessation of benefits provides an incentive to return to work because claimants who do not return to work beyond this point are forced to rely on other forms of welfare in order to generate an income. This income is likely to be significantly less generous than the benefits available under workers' compensation.

For example, WorkCover SA apply "Work Capacity Reviews[22]" for all claims that reach 130 weeks on benefits. This review determines the injured workers capacity for work, and may lead to cessation of weekly benefits if the worker is found to have capacity to work.

4.2.4. Existence of Lump sum Benefits

Access to common law or lump sum benefits is available in some form in most Australian workers' compensation jurisdictions.

- Claimants with injuries causing permanent impairment and pain and suffering are entitled to lump sum compensation in a number of States.
- Several States offer claimants, with some restrictions, the ability to commute future benefits in lump sum form.
- Access to pursue common law damages is also widely available, although often with restrictions on access to ensure only the more severely incapacitated claimants are able to pursue these benefits. Commonly used restrictions are:
    - Access thresholds based on impairment assessments.
    - Minimum periods on weekly benefits before access is permitted.

The presence of lump sum compensation can act as a perverse incentive for claimants to avoid or delay returning to work. Whilst the impairment thresholds go some way to

minimising this behaviour, there are situations where these may not work as intended. By way of example, claimants with impairment levels below the impairment thresholds may be able to establish a higher degree of impairment over time. Another example observed in some schemes has been the emergence of secondary injuries which emerge as a result of the primary injury. (i.e. secondary psychological injuries, damage to the digestive system as a side effect of prescribed medication for the primary injury).

4.2.5. Advertising and Awareness Campaigns

While the responsibility of providing a safe workplace lies with employers, personal safety is a priority that all workers should practice.

Advertising aimed at safety awareness has been used in a number of schemes to reduce the number of injuries. These campaigns range in form from television and radio advertisements, workplace posters to sponsorship of sports and athletic teams. In NSW, these campaigns have recently focused on the consequences to the worker and their families in the event of a workplace accident.

These campaigns can be thought of as moral incentives as they are a way of influencing employee behaviour. The campaigns make employees aware of the potential consequences of a workplace accident, and fear of such consequences can influence behaviours.

4.3. Medical and Rehabilitation Providers

Workers' compensation schemes include medical and rehabilitation benefits for injured workers, consistent with the goals of the scheme. The provision of these benefits is commonly outsourced to third party providers whose motivations may differ from that of the scheme, such as an objective to grow their businesses and maximise profit. As a result, provider behaviour may not necessarily align with the objectives of workers' compensation schemes, for example:

- Providers may service injured workers beyond the level required by the injured worker in order to return to work. Or, in the case that the provider represents the insurer or scheme, encouragement to return to work before the worker is sufficiently recovered.
- Providers may focus on rehabilitation as the end objective, with less focus on return to work than is consistent with the scheme objectives.
- There is the potential for the provision of inappropriate treatment and inaccurate invoicing, as providers seek to maximise profits.

Incentive Measures are one way to encourage provider behaviours which are better aligned to the objectives of the scheme. Some examples of these are provided below.

Table 7: Incentive Measures of Medical and Rehabilitation Providers

	Targeted behaviour			
Incentive Measure	Treatment of difficult cases	Over-servicing	Focus on return to work	Inappropriate treatment or billing
Fee for outcomes	×	✓✓	✓✓	✓✓
Performance benchmarking	×	✓✓	✓✓	
Regulation	✓	✓	✓	✓

4.3.1. Fee for Outcomes

A "fee for outcomes" arrangement is an approach to align the medical and rehabilitation fees paid with the objectives of the scheme. These arrangements differ from the standard convention of paying fixed fees for service and hourly rates. Rather, service providers are remunerated based on the rehabilitation or return to work outcomes of the claimants they treat. It is becoming an increasingly popular mechanism for incentivising quality improvement globally.[23]

Behaviours Targeted

Accordingly, this Incentive Measure directly addresses provider over-servicing and appropriateness of treatment as well as promoting return to work.

General Discussion

The primary concern with this is that it can create a perverse incentive for service providers to avoid difficult cases and focus on providing service to injured workers with easily achieved rehabilitation and return to work outcomes. There are other challenges with this type of incentive including the difficulty defining appropriate outcomes and the costs associated with measuring these outcomes.

In practice, fee for outcomes arrangements are generally blended with fixed fee and hourly rate arrangements. To support this kind of arrangement, the scheme also needs to develop a suitable framework for monitoring provider success at achieving claimant outcomes. This should also be supported by a claims triage model to ensure that claimants are passed on to case managers with the right qualifications and experience to manage these providers.

One example in Australia is WorkSafe Victoria's Original Employer Services[24] incentive, which provides an incentive payment (in additional to prescribed fee for service payments) when an injured worker achieves sustained return to work outcomes.

4.3.2. Performance Benchmarking

Benchmarking can be used as an indirect measure to incentivise desired behaviours in the scheme's service providers. Medical and rehabilitation practitioners rely on their reputation in order to receive ongoing business and future referrals. Public acknowledgment of their success in achieving the desired outcomes of the scheme can enhance this.

Behaviours Targeted

The behaviour targeted is specific to the criteria used to compare the performance of the providers. Typically the criteria will be an outcome measure (such as proportion of injured workers returning to work) coupled with a cost measure (such as average rehabilitation spend per worker). The behaviours targeted are generally:

- a focus on return to work through the outcome measure
- a reduction in over servicing through the cost measure.

General Discussion

The success of a good provider benchmarking system relies on the results being transparent and easily accessed by the scheme's users. The measured benchmarks also need to be consistent with the scheme's objectives and the opportunity for gaming by the providers should also be tested.

Q-Comp's "Return to Work Awards"[25], for example, have a "Health Provider Achievement Award" which can recognise good performing occupational rehabilitation providers. These awards have been used by provider firms on their websites which shows providers are aware of the positive impact such awards can have on their perception by the public.

4.3.3. Regulation

The regulation of service providers can be an effective tool to ensure that providers meet minimum standards with respect to pursuing the schemes objectives. There are a variety of approaches to regulating service providers:

- One approach is to only allow providers which meet specific accreditation standards to operate within the scheme. Accreditation incentivises providers to meet a minimum standard, with the incentive being a penalty of exclusion from providing services should standards not be met.

  WorkCover WA, for example, adopt the "Nationally Consistent Approval Framework for Workplace Rehabilitation Providers"[26], along with some additional requirements relating to performance and data entry.

- Expert panels may adjudicate where there is a difference of opinion between two providers, possibly one acting for the scheme, and one for the injured worker. The intention of the medical panel is to be a source of a consistent expert opinion, and the existence of this can be a useful incentive to encourage best practice among providers.

  One example of an expert panel is Medical Panels SA which is specifically set-up to deal with workers' compensation medical disputes arising from the WorkCover SA scheme.

- Guidelines for the treatment of an injured worker are common, and are useful to provide a consistent framework for providers to work from. An injured worker should expect to receive a quality service regardless of the provider used. Communication of the recommended course of action outlined in the guidelines also helps claimants understand the reasoning for the recommended treatment.

  One specific example is NSW WorkCover's "Treatment Principles For The Provision Of Psychological And Counselling Services"[27], which promotes evidence based practice and the use of objective functional outcome measurement in clinical practice.

Regulation attempts to increase the overall quality of providers in the scheme. As a result, its impacts can be less focussed than other Incentive Measures. However, a good regulatory framework can lead to provider behaviours that are more in line with scheme objectives.

4.4. Scheme Agents

Table 8: Incentive Measures of Scheme Agents

	Targeted behaviour		
Incentive Measure	Focus on return to work	Treatment of difficult cases	Gaming
Performance linked remuneration	✓✓	✓✓	×

4.4.1. Performance Linked Remuneration

Some workers' compensation schemes in Australia have appointed third party administrators to provide ongoing management of policies and to manage claims.[28] These "Scheme Agents" receive remuneration in exchange for the provision of these services. These remuneration arrangements, like many other outsourced underwriting arrangements, require careful thought in order to provide incentives that align administration practices with scheme objectives.

In some instances the Scheme Agents may be private insurers. They may have existing insurance relationships with the employers covered under the workers' compensation policies being administered. Some behaviour's of the Scheme Agents may be related to ensuring that their existing relationships are catered for, rather than optimising the workers' compensation scheme outcomes.

Remuneration arrangements in these situations are generally structured to provide incentives to the Scheme Agents to achieve scheme objectives. This may be achieved by linking remuneration to:

- Achievement of KPI targets, which are typically quality gates to incentivise Scheme Agents to perform quality work. Audits are usually completed to make sure these quality gates are adhered to.
- Linking remuneration to claim outcomes, such as a return to work measure or estimated claim liability assessment. A baseline measure may be established according to which favourable assessments would receive higher levels of remuneration.

There are a number of challenges with implementing and managing these types of arrangements:

- The Incentive Measure needs to be objective and understandable. Assessment either needs to be over long periods of time or performed in a manner that is trusted and accepted by Scheme Agents. Scheme Agents need to believe that they'll be adequately remunerated for better claim outcomes.
- Measurement of outcomes may be difficult. Ongoing assessment needs to be consistent over time and the operation of different investment conditions and identification of assessment measure requires careful thought. For example:
    - If a return to work measure is implemented then careful thought needs to be given to the definition used to assess performance.
    - Assessment of claim performance may be problematic because of the long tail nature of many of these liabilities. Assessment of future liabilities needs to be simple enough to be understood by Scheme Agents to drive the correct behaviours, but responsive enough to capture subtleties in changes in claim management initiatives that lead to better outcomes.

- If the remuneration is based on the number of claims settled then there is little incentive for Scheme Agents to spend appropriate amounts of time on the treatment of difficult or complex cases.
- It may be costly to administer the remuneration arrangements and assessment of incentive fees or KPI-related fees. For example, the assessment of return to work measures, claim measures and file quality reviews can be both costly and time consuming.
- If the scheme is performing poorly, perhaps from circumstances that are either fully or partially outside of the Scheme Agents control, and their incentive remuneration becomes small and difficult to improve then it may be difficult to incentivise Scheme Agents to improve performance.
- The remuneration arrangements need to be structured to limit the potential for gaming. This may happen under a number of circumstances including:
    - A Scheme Agent may believe that they can optimise their remuneration by trading off any incentive based remuneration with the number of staff that they use to administer the portfolio. Quality KPI's are therefore important inputs in ensuring that quality administration is maintained.
    - In other cases Scheme Agents may attempt to administer claims to maximise their own remuneration rather than to achieve the best outcomes.

A further incentive for the Scheme Agents may be the threat of the loss of market share if the Scheme Agent is performing poorly. If a poor job is being performed by a Scheme Agent then the Scheme may transfer all or part of their administrative function to another provider. Healthy competition in this area makes this a credible Incentive Measure.

4.5. Legal Providers

Aligning the behaviours of legal providers with the objectives of a workers' compensation scheme is a challenging task. Legal providers have a responsibility to ensure their client receives fair compensation for the injury they have suffered. Schemes however, are generally focused on ensuring that injured workers receive the best return to work and injury rehabilitation outcome. There can be conflict in the pursuit of these two objectives, as demonstrating ongoing incapacity can be difficult if the worker has returned to their job.

Regulation is the tool most commonly adopted by schemes to change the behaviours of the participating legal providers. Here are a few examples:

- Workers' compensation schemes in some states have scheduled rates that lawyers are able to charge at different stages of a claimant's progression through the common law and lump sum processes. These rates can act as a disincentive for lawyers to pursue some types of claims, particularly those with likely return to work capacity. The introduction of a minimum impairment threshold that claimants are required to meet before pursuing common law can produce a similar outcome.
- In 2003 the Compensation Court of NSW was replaced by the Workers' Compensation Commission. As part of this change, determination of statutory lump sum benefits was changed from being a negotiation process between lawyers based on the table of maims, to a more objective, medical assessment of impairment. There were also changes to the fees that legal providers could charge. Incidentally, prior to the closure of the Compensation Court there was a significant spike in the number of S66 payments.

While each of these examples has been widely used across the states, the extent to which the legislation has withstood the test of time is often debatable. Scheduled rates may not work if claimants and lawyers enter private agreements to pass on a percentage of the claimants

awards to the providers. Impairment thresholds may not survive in the long run as loop holes are exposed by case precedence.

5. Some Incentive Measures Used Overseas

It is valuable to learn lessons from other countries to see what Incentive Measures are working and which are not working well. We have included some background on Incentive Measures used in European and North American countries. We have restricted our commentary to Incentive Measures which are not commonly used in Australia.

It is important to understand that some of these schemes are comparable to Australia while other countries have very different workers' compensation structures. For example, some countries overseas do not have specific workers' compensation schemes. This results in many incentives being provided outside of any workers' compensation scheme. These Incentive Measures may operate through separate government mechanisms that may include:

- **Funding schemes:** for example, subsidies or grants for a range of practices that support improved OHS such as for materials, tools or OHS management systems.
- **Matching funds:** the government may match funds for OHS related improvement initiatives.
- **Tax reductions:** where investment is made in OHS activities.

The insurance and OHS functions may either be the same body or a separate body, depending on the jurisdiction. This may also influence the choice of Incentive Measures. Where it is part of the same body then the premium system may be more easily used for Incentive Measures, while for external bodies other Incentive Measures may need to be implemented.

5.1. North America

There are many similarities in some aspects of operational structure between Australian and some North American workers' compensation schemes. There are also some slightly different and interesting approaches that are being taken in regard to the design of Incentive Measures for some of these North American schemes.

One of the authors recently accompanied WorkSafe Victoria on a premiums research tour of Canada. On this trip we were able to speak to the management of some of the Canadian schemes about their premium systems and, in particular, Incentive Measures that are being used or developed within these schemes. This section therefore contains some information arising from these discussions, with a particular bias on premium incentives.

5.1.1. Voluntary Prevention Programs

Some workers' compensation boards in North America have a specific injury and illness prevention mandate.[29] This has seen the introduction of a number of voluntary prevention incentive programs. These programs typically provide a premium participation rebate which is payable after an employer achieves specific OHS objectives, sometimes in tandem with specific claim experience outcomes. This may be seen as an "advance" on experience rating, especially for those where it may be hard for employers to otherwise invest in improved OHS.

In addition, the employer may also be recognised through the issue of a Certificate of Recognition (CoR[30]). This may only be available to employers in good standing with the Authority. The program may be supported and partly administered through an independent Safety Group.

While the Incentive Measure is generally marketed as the premium rebate, other benefits of the programs are also marketed, to increase the incentive for employers to participate, such as lower absenteeism, higher employee retention and helping to lower operating costs from improved OHS.

We now discuss some of the key aspects of these programs in more detail.

Safety Groups

A number of jurisdictions in North America have voluntary industry-focused safety associations responsible for driving OHS initiatives specific to their industry. These Safety Groups are in the business of prevention (supporting OHS) but may also have a secondary function to support return to work and injury management. They often prepare their own documentation, and have their own training courses and awareness programs.

The premise of Safety Groups is for the individual industries to develop tools to enable both risk identification and risk mitigation. The groups develop OHS programs around the key risks specific to their industry. Some programs are specifically designed to cater to the needs of small to medium employers or newer employers.

They may be funded by an additional premium rate collection on top of the normal workers' compensation premium. These fees are invested in areas of OHS initiatives that are considered appropriate for their industry.

While a rigorous statistical comparison of experience for employers participating in these schemes compared to those not participating does not appear to have been prepared to date, the reductions in claim rates of participants appears to indicate some very strong benefits. What is not clear is whether there is an element of self selection in that those employers that participate in Safety Programs would have had significant reductions in any case.

Certificate of Recognition

Employers who are able to complete OHS courses or meet pre-requisite OHS standards may be eligible to receive a CoR. The employer generally needs to be certified through an audit process. Most programs tailor an appropriate level of scrutiny for different sizes of employer. One of the main challenges is keeping the cost affordable, especially for smaller employers. Different jurisdictions have different operating models. Some use external auditors while others have specific attendance criteria for OHS workshops, often operated through industry groups.

One of the most promising aspects of these programs is that in some provinces in Canada we have been told that it is influencing behaviours outside of the workers' compensation scheme:

- A CoR is being used in some industries (for example, oil, mining and construction) as a requirement for employers to tender for specific contract works. The CoR demonstrates that the employer is in good standing with the workers' compensation board, has good OHS standards and may be viewed as a general good moral indicator.
- Some private insurers are using the CoR as a rating factor for some forms of insurance (e.g. public liability).

Example 1 - Voluntary Prevention Program: Ontario

In Ontario the Safe Communities Incentive Program (SCIP[31]) is a two-part health and safety incentive program for small business. The first part of the program targets newer employers who will typically be facing many challenges associated with starting up a new business. These initial challenges include:

1) Management of assets and capital
2) Talent acquisition and retention
3) Legislation compliance.

SCIP contains material on each of the above topics and also includes material on the importance of OHS. The OHS course gives employers an introduction on how to identify and manage risks. We have been told that one of the key challenges of the program is in targeting

the right amount of time for smaller employers to be able to participate in already busy business schedules.

Ontario also has Safety Group Programs (SGP) for larger employers.

Example 2 - Voluntary Prevention Program: Alberta

Alberta enables an industry to voluntarily determine the aggressiveness of industry rating through its "Industry Custom Pricing" (ICP[32]) option. This program applies where an industry collectively wants to vary the responsiveness of experience rating according to an industries risk tolerance and preferences. An industry participates through polling of industry if 50% of payroll agrees.

The two main ICP options are:

- Experience rating option preferences can be changed to control the limits and aggressiveness of experience rating to enable the opportunity to receive greater discounts or surcharges. The preferences provide flexibility and can react differently to different sized employers.
- Cost relief option for claims due to aggravation of a pre-existing condition. Employers are able to takes claims off their own experience record and these are then applied to the industry as a whole. The intention is to promote RTW for these cases. The biggest issue is the potential for gaming by classifying more and more claims as having aggravation of pre-existing injuries.

5.1.2. Additional Employer Premium Surcharges

Many Canadian schemes have employer premium surcharges for those employers that have claim cost outcomes consistently worse than their industry peers. The premium surcharge generally operates over and above any standard experience rating.

The surcharges are quite aggressive, often being a multiple of the base premium. The scheme will generally communicate the expectation of a surcharge well before it is due to be charged, often a year or more prior to the premium surcharge applying. This provides an incentive for the employer to enact OHS changes in response.

Some schemes meet with employers flagged for future premium surcharges to better understand the cost pressures for each individual employer. There may be different cohorts of employers in these surcharge schemes:

- Employers may have poor OHS that is contributing to poor claims experience and they may require help in implementing change.
- Employers may not fit well into their relatively blunt industry classification in which case the surcharge may be appropriate but no OHS changes are required.

The intent is to drive behavioural changes to get employers out of the surcharge scheme over time. One scheme mentioned that having the size of the premium surcharge high enough to incentivise improved OHS behaviours was a key factor in the success of the program.

5.1.3. Small Employer Premium Incentives

Small Employer Discounts

Some North American schemes have introduced small employer discounts for employers that have been claim free over specified time periods. More complex systems have also been developed which have discounts or surcharges based on a table of claims versus employer size.[33]

We are not aware of any research to indicate that that these discounts lead to improved workplace safety. However, anecdotally it does act as an effective panacea to "keep employers happy" with the insurance process. Smaller employers are familiar with the operation of no claim bonus discounts that may be used in other forms of personal insurance.

Some considerations arising from these types of Incentive Measures are:

- Some schemes have experienced problems arising from the blending of employers who change programs, from small employer programs (generally simpler) to large employer programs (generally more complex) as their premium rate may change significantly.
- It is generally acknowledged that there is no real science to the calibration of these models, as luck probably contributes as much towards the employer discount or surcharge as does the underlying risk. It is also generally acknowledged that there is no evidence that these Incentive Measures directly improve OHS.
- These Incentive Measures can introduce cross subsidies into the scheme from large to small employers because of the skewed distribution of possible claim outcomes and the undesirability of using harsh penalties, given the volatile experience of small employers.

Small Employer Group rating

Small employers by themselves may not have statistically credible claims experience due to the volatility of their own experience. One way to experience-rate smaller employers is to aggregate the claims experience of smaller employers. This has been tried in a couple of states in the US[34], although some have had significant issues in implementing them successfully.

There are several issues to consider prior to introducing a group rating programme:

- This type of structure can lead to significant gaming issues unless the structure is well thought out. For example, we are aware of one instance where groups of good performing smaller employers banded together to attract significant premium reductions, and then pressured any employers with deteriorating experience over time to leave the group.
- There may be significant brokerage and frictional costs involved with setting up the small employer groups and this should be compared to the potential benefits of group rating.
- Consideration should be given to whether the rebates are allocated directly to an employer, or to the third party administrator of the group. It is possible that the administrator may only pass back discounts to some employers, and not all.

5.1.4. Large Deductible Plans

Some states within the US have used the concept of large deductible schemes as an Incentive Measure.[35] Under these schemes, large employers self insure the cost of each claim up to their deductible, which can be set at a high level. This therefore has an element of self-insurance to its structure, with the scheme acting as a reinsurer for the employers.

Anecdotally we have been told that in some cases this has had unintended behavioural consequences where the behaviour of the firm to the individual claimant has changed once the threshold has been reached. For example, in some cases an adversarial relationship ensues as the employers may encourage employees to quit or take severance pay so that their experience does not impact future employer premiums.

The large deductible plans were found to improve claim rates and average claim sizes in Shields et al, 1999. However, the potential for unintended consequences mentioned above needs to be offset against the potential gains.

5.1.5. Other North American Incentives

Safety Consultation

Ohio takes the approach of safety consultation rather than enforcement. The types of services they offer include air quality testing, ergonomics, and safety culture programs. The Safety Intervention Grant Program allows employers who want to purchase equipment that substantially reduces or eliminates the risk of injuries and illnesses to apply for financial assistance. Successful employers can receive up to a 2-to-1 matching grant. We have been told that there have been significant reductions in claim frequency following safety grants made to some employers. However, it is acknowledged that these types of programs can be expensive to monitor and administer.

5.2. Europe

The scheme structure of many systems in Europe is different to Australia. A summary of economic incentives used in Europe is documented in *Economic incentives to improve occupational safety and health: a review from the European perspective* issued by the European Agency for Safety and Health at Work in 2010.

Many of the Incentive Measures in Europe work outside of the workers' compensation schemes and some countries don't operate a workers' compensation scheme. Some of the key findings of the paper were:

- Funding schemes are commonly used in Europe. Subsidies or grants are available to be used for a range of practices that contribute towards improved OHS. This may include the purchase of new OHS materials, safety tools or OHS management systems. The schemes are generally managed by public bodies. Subsidy schemes can be good at promoting innovative solutions for specific OHS areas.
- Tax reductions are not commonly used but are seen as a potentially good incentive to promote employer financial investment in OHS initiatives. However, there are limitations to this approach because it does not motivate those who do not pay tax (for example not for profit organisations or unprofitable organisations).
- Matching fund programs where governments provide funds in proportion to the organisational OHS spend are also seen as promising, although they are generally associated with high administration costs.
- OHS regulations should be supported by appropriate incentives to make them effective. Direct measures to ensure compliance with legislation are generally considered the best way to achieve this through inspection and penalties, such as fines for non-adherence. This therefore requires linking OHS to audits to ensure that the risk of getting caught for non adherence is not trivial. It is noted that there are limits to regulations because they are not employer workplace specific and do not respond well to emerging risks. Increasing the probability of inspection is generally seen as a more effective incentive than increasing the size of penalty.
- For smaller employers the availability of free training and OHS materials is seen to be an effective way to change OHS behaviours. Trust is also an important aspect of the relationship between the employer and the regulator that works well in being able to influence behaviours.
- Insurance strategies, such as experience rating, are seen as providing moderate success in reducing claim frequency, but require careful consideration in structure

and design. There are some good case studies available that show where insurance rating has improved outcomes, such as for the German butchery industry, which used a simple, focussed impact, and targeted approach to achieve some good outcomes, primarily some reductions in skin disease.

- Employer led wellness schemes can be successful in preventing workplace injuries. The mix of effectiveness, efficiency and political feasibility, as well as the choice of instruments, are seen as important considerations.

6. Specific Incentive Challenges in Workers' Compensation

There are a number of challenges in managing Incentive Measures within workers' compensation schemes and we discuss some of the main ones below.

6.1. Perverse Incentives and Unintended Consequences

While an Incentive Measure may be designed to address specific unwanted behaviours, the implementation of the Incentive Measure can result in the participants behaving in unintended ways. There are many examples of changes in behaviour in response to incentives that proved to be either counter-productive to the original goal of the incentive or resulted in behaviours that were not fully anticipated.

A non workers' compensation example is the Home Insulation Program. This had the goal of incentivising homes to install ceiling insulation to reduce the reliance on home heating and cooling which was expected to reduce future carbon emissions. The introduction of the Home Insulation Program saw a rapid increase in consumer demand and, in some cases, the operation of illegal or inexperienced operators which led to significant fire hazards and exposure to serious safety issues from installers.[36] The unintended consequences from this program were the tragic death of four young installation workers by electrocution or heat stroke and many roof fires. This prompted the establishment of the Home Insulation Safety Program in order to address some of these unintended adverse outcomes.

This example highlights the need to have adequate controls governing the operation and design of incentives. These controls should be maintained over time as behavioural responses may change.

Sections 4 and 5 of this paper give a number of workers' compensation examples where perverse incentives have been created from the implementation of Incentive Measures. In some circumstances these perverse incentives are created as a result of scheme participants attempting to "game" the Incentive Measure.

"Gaming" occurs when scheme participants change their behaviours (in response to the Incentive Measure) in order to meet their targets, but not in a way that is consistent with the objectives of the scheme. This may occur when the Incentive Measure targets issued to scheme participants are poorly constructed.

The following table gives some examples of unintended behaviours that could emerge from poorly constructed Incentive Measures.

Table 9: Examples of Unintended Behaviours from Poorly Constructed Incentive Measures

Targeted Behaviour	Incentive Measure	Unintended Behaviour
Reluctance of employers to employ previously injured workers because of fear of recurrence of existing injuries	Remove second injury claim payments from employer experience rating	Participants spend a disproportionate amount of time seeking to prove existence of secondary injury
Improve OHS for larger employers	Introduce employer claims experience rating based on number of claims	Employer suppresses claims to maximise experience rebate payments
Reduce over-servicing arising from fee for service medical providers	Introduce a fee for outcome arrangement	Avoidance of treatment of difficult cases
Faster treatment of claims by Scheme Agent	Scheme Agent remuneration is based on the number of claims finalised	Claims finalised too quickly and claimants return to work too quickly, leading to a high number of reopened claims

These simple examples illustrate some potential unintended behaviours and consequences that could emerge as a result of poorly constructed Incentive Measures. Workshopping these issues with scheme participants may help to establish more robust Incentive Measures.

6.2. Measurement of Benefits

One of the key aspects of our proposed Incentive Measure management framework is to periodically compare the costs of an Incentive Measure against the benefits arising from the Incentive Measure being in place. The end result may be placing a dollar value on the impact to the scheme if the Incentive Measure were included or excluded.

We acknowledge that some forms of subjective assessment may be needed in the measurement process. However, the measurement process is an important step in understanding the impacts that Incentive Measures are having on scheme outcomes and the Incentive Measure should be evidence based as much as possible. Estimating this benefit has a number of challenges.

Normalising for Other Influences

Scheme outcomes will generally emerge as a result of the combined impact of a number of different influences. The attribution of benefits arising from each influence (an Incentive Measure being one such influence) can be problematic. For example, improved scheme outcomes may be the combined result of the introduction of new OHS regulations, changing societal attitudes towards OHS, technological advancements or from a change in industry mix of business. While some of these factors may be normalised for, it can be problematic to normalise results for other factors.

There are ways that the Incentive Measure may be implemented to help mitigate some of these measurement issues. It may be appropriate to have pilot programmes or voluntary trials that test the Incentive Measure over a limited cohort of the scheme. Where this occurs it may be easier to normalise results for other influences. For example, a sample of "good performing" and "poor performing" employers within a specific industry could be selected prior to the implementation of a new Incentive Measure, where the distinction between "good" and "poor" is based on a specific KPI result. The success of the Incentive Measure could be measured by looking at the resultant KPI's for each of the cohorts separately (and in particular the "poor performing" employers) compared to those not participating in the incentive program.

Estimation of Long Term Benefits

It may be difficult to measure scheme outcomes due to the long term nature of some workers' compensation benefits. Depending on the scheme, income replacement benefits may be payable up to retirement age and other medical costs may be payable for life. This can make it difficult to estimate the value of any improvements in scheme outcomes, as the final benefit may not manifest itself for a long period of time.

In circumstances where improvements in claim durations are impacted, there is also the chance for recurrence of existing injuries and a reopening of existing claims. This may be significant in some circumstances and should be considered as a potential offset to improvements in existing claim results if claims are finalised too quickly.

The measurement of benefits arising from OHS incentives that target disease mitigation are also difficult to quantify given that latency periods may be of a significant duration.

Dead Weight Loss

Even well constructed implementation programs may suffer from the issue of identifying "dead weight" loss. This may occur where voluntary programs are taken up by employers who would probably have implemented OHS systems regardless of the Incentive Measure.

Measurement of this "dead weight" loss is important for proper evaluation of the Incentive Measure to understand the net change in behaviours.

6.3. Specific Design Challenges for Small and Medium Sized Employers

It can be difficult to incentivise small and medium sized employers (SME's). Workplace accidents, and hence claims, may not necessarily be expected over shorter periods and luck may have as much a role as good OHS in claims occurring.

SME's typically have claims experience that is worse than that of comparable larger employers. It is important to understand the reasons for this different experience so that appropriate responses can be formulated. Data mining techniques may be used to better understand any key differences that may be present for SME's versus larger employers.

Some particular challenges for SME's include:

- Some SME's may view workers' compensation premiums as an additional tax and OHS may not be a high priority within their business. They may fear the high cost and extra work involved with any specific Incentive Measure. Therefore the Incentive Measures need to be simple to understand, easy to respond to and focus on key risks and outcomes.
- If a particular Incentive Measure is voluntary, then incentivising SME's may be difficult if they are not made aware of the particular incentive. It is therefore important to ensure that there is adequate promotion of the existence of the Incentive Measure for SME's.
- SME's may not be aware of the potential benefits of an Incentive Measure. The scheme can take a proactive approach here by actively marketing the up-side benefits associated with the Incentive Measure. For example, there may be direct benefits (perhaps in the form of subsidies, insurance premium rebates or tax offsets), but there may also be large indirect benefits associated with improved staff retention, lower injuries, and less absenteeism. In circumstances where the direct benefits may be very small, it is the promotion of these indirect benefits that can be effective in improving stakeholder engagement. Acknowledgement of these benefits may often be required to justify employers joining voluntary groups, especially for smaller employers where the premium rebate of itself may provide little incentive.

Europe is responding to some of these design challenges through the use of subsidised OHS systems, workshops, education, project funds (subsidies), tax offsets, and safety management systems based on continuous improvement principles. For example, Austria has introduced subsidies so that companies are able to better access low cost consulting advice on OHS.[37]

The involvement of professional unions, industry bodies or other interest groups can also help to maximise participation and understanding of the benefits of Incentive Measures.

6.4. Getting Buy-in from Scheme Participants

The presence of a financial incentive alone may not be enough to encourage buy-in from participants when an Incentive Measure is introduced. Employers, employees and external service providers need to understand the Incentive Measure. A complex system can act as a barrier to participant take up. Educating participants in the details of the Incentive Measure can reduce this barrier, but implementing a simple and easy to understand Incentive Measure may be more effective.

Successful implementation of Incentive Measures often requires co-operation between employers, employees and external service providers. In particular there needs to be a certain element of trust established between the various stakeholders. This trust and co-operation can be one of the main factors in the success or failure of an Incentive Measure.

Consultation with the schemes participants when designing the Incentive Measure can help in this regard. The benefit of allowing participants to contribute to the design of the Incentive Measure is two-fold. Firstly, the consultation process can engender trust between the scheme and its participants. The feedback provided by the participants may also help identify the strengths or weaknesses or the proposed Incentive Measure. Difficulties can emerge however, when the consultation process becomes adversarial. This can result in the premature demise of an Incentive Measure before it is introduced into the scheme.

Schemes will also be challenged by ensuring that participants continue to be engaged in the behavioural changes encouraged under the Incentive Measure. Providing clear and transparent monitoring to stakeholders can assist in this regard, particularly when the incentive is a financial reward. This can be more challenging when participants reach the extremes of the incentive. By way of example, it is difficult to encourage further improvement from a participant who is receiving the maximum financial reward under an Incentive Measure.

6.5. Interactions with Other Systems

Workers' compensation systems do not operate in isolation from the other systems used by individuals and organisations in our society. In reality, the participants of the workers' compensation schemes may also interact with other schemes or systems that shape their behaviour. It can therefore be difficult to predict the behaviours of the schemes participants based only on the incentives presented in the workers' compensation scheme.

A good example of this is the Death and Disability Schemes that provide benefits to workers injured performing dangerous public services such as policing and fire fighting[38]. In some circumstances, these schemes top-up the weekly benefits provided to claimants to be 100% of pre-injury earnings. In this example there is little financial incentive for the claimant to return to work when their situation is considered from more than just the workers' compensation point of view.

If a scheme was to consider introducing a fee for outcome arrangement with its medical and rehabilitation providers, it would need to consider that injured workers are just one of many sources where medical and rehabilitation providers generate an income. Care would be needed to ensure that the rates paid are still competitive enough to prevent providers from overlooking workers' compensation claims and focusing on patients from other systems.

7. Conclusion & Summary

Incentives can be a powerful tool used to influence behaviours and they are relatively commonplace in our society today.

There is a need to use incentives in workers' compensation schemes to counteract some of the perverse incentives created from the introduction of workers' compensation schemes and to help achieve scheme objectives. Labour market forces and regulations enforced with penalties can also be viewed as forms of incentives.

While the design of effective incentives is achievable, there are many examples of incentives that have led to undesirable outcomes and behaviours. It is for this reason that a sound governance framework needs to be applied to effectively manage incentives. We therefore present an Incentive Measure management framework, which has the following steps:

1. Identify opportunities with SMART targets that are consistent with scheme objectives.
2. Identify the behaviours that you want to change that align with these opportunities.
3. Identify appropriate Incentive Measures to change these behaviours and ensure that an adequate assessment of costs and benefits is performed.
4. Ensure that appropriate testing of the Incentive Measure is completed and that stakeholders are educated, with appropriate systems put in place prior to implementation.
5. Monitor the impacts of the Incentive Measure to ensure that it is having the correct behavioural impacts and remains appropriate for the times.

The existing literature, both locally and overseas, contains a number of examples where Incentive Measures have been successful and other instances where they have not achieved their goals. Some key learnings from this literature review include:

- A mix of different Incentive Measure strategies can work best for different opportunities and to target different stakeholders.
- There are many examples of Incentive Measures gone wrong indicating that it is important to have a strong governance framework around design, implementation and ongoing management.
- It is important to engage with, and get buy-in from, stakeholders so that they understand the Incentive Measure and trust that favourable outcomes will be rewarded.
- For regulations to effectively drive behaviours, there should be a non-trivial chance of being investigated, and the penalties or rewards need to be large enough to encourage compliance.
- Trust remains an important factor in Incentive Measures and more complex Incentive Measures can erode trust, especially for SMEs.
- There is a growing trend for more voluntary Incentive Measures, especially in North America, to help engender a more trusting relationship between scheme and stakeholders.

There are many challenges associated with managing Incentive Measures successfully. However, the potential rewards arising from the successful implementation of Incentive Measures can be significant and there is a growing trend to explore a wider range of options. An effective framework, such as that proposed in this paper, can make a significant difference to the overall scheme outcomes achieved.

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[1] Source: Wikipedia - http://en.wikipedia.org/wiki/Incentive

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[3] The Australian Government provided assistance of up to $1,600 to allow homeowners and tenants to have ceiling insulation installed in their homes. The $1,600 should cover the cost of insulating an average home, so most people will not need to pay anything.

[4] Source: Clean Energy Australia

http://www.cleanenergyfuture.gov.au/clean-energy-future/our-plan/clean-energy-australia/

[5] For example, the NSW WorkCover scheme incentivises employers to hire more apprenticeship employees by providing a premium reduction for NSW employers of apprentices.

[6] Page 2 of the 2009/10 NSW WorkCover Annual Report

[7] This concept is discussed more fully in sources such as Clayton (2002) and EASHW (2010).

[8] SMART / SMARTER is a mnemonic used to set objectives, for example for project management, employee performance management and personal development.

http://en.wikipedia.org/wiki/SMART_criteria

[9] Drink Drive Campaign History - In 1989, the year that the TAC commenced its campaigns, 114 drivers and riders died in road crashes with an illegal blood alcohol concentration. This figure had dropped to 62 in 2007. http://www.tacsafety.com.au

[10] This concept is described in many places including NERA Economic Consulting (2006). Presenteeism refers to where the employer has additional costs associated with absence from injury and illness or has lower productivity from employees returning to work in an unwell state where further treatment may provide a better long term outcome.

[11] Much has been written about some of the perverse incentives that can result from Incentive Measures. This is especially the case in terms of experience rating. For example, Carter, Clayton and Walsh (1996) contests the notion that experience rating is effective in improving OHS. Many other sources acknowledge an improvement in claim experience although there is limited evidence that this relates to improved OHS.

[12] The current arrangements are described in the latest Comparison of Workers' Compensation Arrangements in Australia and New Zealand issued by Safe Work Australia dated March 2011.

[13] More detail on WorkSafe Victoria's Original Employer Services can be found on their website http://www.worksafe.vic.gov.au

[14]Further information is available on the WorkCover SA website at the following link http://www.workcover.com/site/employer/contactsother_useful_information/rise_reemployment_incentive_scheme_for_employers.aspx

[15]Further information is available on the NSW WorkCover website at the following link http://www.workcover.nsw.gov.au/insurancepremiums/premiums/Calculatingpremiums/Pages/Apprenticeincentivescheme.aspx

[16] Further details may be found on the WorkCover SA website at the following link http://www.workcover.com/site/employer/contactsother_useful_information/incentive_for_early_reporting_of_injuries_waiver_of_employer_excess.aspx

[17] "Workplace wellness in Australia Aligning action with aims: Optimising the benefits of workplace wellness" 2010 discusses some of these trends as \a result of both aging population and lifestyle changes.

[18] "Workplace wellness in Australia Aligning action with aims: Optimising the benefits of workplace wellness" 2010 discusses some references to obesity and alcohol consumption associated with increased workplace injury, while the presence of chronic conditions can slow rehabilitation and injury recovery.

[19] More detail on the WorkHealth initiative is shown in the following website link. http://www.worksafe.vic.gov.au/wps/wcm/connect/WorkHealth%20Internet%20Content/workhealth-internet/home

[20] A summary of this research was provided by Lisa Simpson at the 2010 Personal Injury Education Seminar in her presentation titled "Personal Injury Compensation Schemes and the GFC "

[21] A summary of the benefits paid under the NSW Police Death and Disability scheme is shown here:

http://bourkelove.com.au/wp-content/uploads/2011/07/Link-3-Police-Death-Disability-Award-2005.pdf

[22] Further details may be found on the WorkCover SA website at the following link http://www.workcover.com/site/treat_home/the_workcover_system/work_capacity_reviews.aspx

[23] Many examples of paying for performance in both the UK and US are described in PricewaterhouseCoopers (2008), "Paying for Performance – Incentives and the English Health System".

[24] See end note 13

[25] Further details on the Q-Comp Awards may be found at the following link http://www.qcompconference.com.au/awards.aspx

[26] Further details may be found on the WorkCover WA website at the following link http://www.workcover.wa.gov.au/Service+Providers/Workplace+rehabilitation+providers/Default.htm

[27] Further details may be found on the WorkCover NSW website at the following link http://www.workcover.nsw.gov.au/formspublications/publications/Documents/treatment_principles_provision_psychological_counselling_2292.pdf

[28] For example NSW and Victoria both have appointed a mix of insurers and other administrators to manage claims and to provide general policy administration.

[29] For example WorkSafeBC has a specific mandate that requires the scheme "To promote the prevention of workplace injury, illness, and disease." In other states in North America this specific mandate may lie outside of the workers compensation authority.

[30] For example, WorkSafe British Columbia and the Workers' Compensation Board of Alberta issue Certificates of Recognition.

[31] SCIP and other Safety Group programs are described in more detail within the Workplace Safety & Insurance Board website http://www.wsib.on.ca.

[32] ICP and other incentive programs are described in more detail within Alberta's Workers' Compensation Board website http://www.wcb.ab.ca.

[33] For example, Ontario has a Merit Adjustment Program (MAP) that has a table of rebates or surcharges based on the average premium of the employer and the number of non-trivial claims over a three year period. There are also adjustments for employers that have had a fatal injury claim.

[34] Ohio's Bureau of Workers' Compensation (BWC) has used a number of different forms of group rating programs. Washington State also has a group rating program under the Department of Labor & Industries.

[35] Many states within the US introduced the concept of workers' compensation deductibles in the early 1990's. For example Ohio's BWC currently has a voluntary deductible program and BWC's website contains the current arrangements in more detail https://www.ohiobwc.com

[36] Australian Government Department of Climate Change and Energy Efficiency website http://www.climatechange.gov.au/government/programs-and-rebates/hisp.aspx

[37] This initiative is explained in more detail in Section 4.3.3 of the European Agency for Safety and Health at Work (2010).

[38] See end note 21.

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ISSUE PAPER

A How-To Guide for Injury and Work Disability Prevention

Author
Disability Management and Return to Work Committee

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Executive Summary

In April 2016, the Disability Management and Return to Work Committee published “Return to Work: A Foundational Approach to Return to Function.” The 2016 paper provides international, shared perspectives regarding the various stakeholders in workers’ compensation: regulators, employers, employees/unions, caregivers, attorneys, and insurers, and what they each have to gain by taking responsibility for their role in return to work.

While the 2016 paper provided some tools, the work here represents the Committee members’ commitment to effective return to work programs in systems around the globe by expanding on steps each of these stakeholder groups can take in their jurisdictions. In other words, it is a “how-to” guide for return to work.

But, first, it’s important for readers to understand the concepts of work disability, how it’s a separate condition from the worker’s medical issues, and why the most effective program or system includes a worker-centric approach to return to work.

Shifting the Way We Think About Disability

The current trends in work and medical disability as a result of injury or illness are quite alarming. After decades of talk about early intervention and integrated disability management, worklessness continues to be an issue for organizations, governments, workers, and society. Workplace disability costs continue to rise despite a steady decline in the incidence of accidents due to better workplace safety and accident prevention initiatives. The National Public Radio (NPR) report, "Unfit for Work. The startling rise of disability in America" (2013) paints a bleak picture of the prevalence and impact of disability in the United States. Similar reports have been done about the cost and impact of disability in other countries.

According to the Integrated Benefits Institute, the total cost of disability in the U.S. is $576 billion. This number includes wage replacement (both non-occupational and occupational injury/illness), treatment, and lost productivity. This roughly amounts to 3.6% of the U.S. GDP. The U.S. is not alone. A Conference Board of Canada report from 2013 estimates the direct cost of absenteeism to the Canadian economy was $16.6 billion.[1] In Australia, the estimated the total economic impact of work-related injuires was $61.8 billion, or 4.1% of GDP for the 2012-2013 financial year.[2] The United Kingdom has similar numbers to Canada and the U.S.

For years historical industry practices have focused on disability management. While this has drawn attention to the need to assist people with injuries and illness back into the workplace, it has not resulted in a substantial reduction in the costs associated with disability. Why? Perhaps because we

[1] The Conference Board of Canada. (2013). *Missing in Action: Absenteeism Trends in Canadian Organizations.* https://www.conferenceboard.ca/e-library/abstract.aspx?did=5780&AspxAutoDetectCookieSupport=1
[2] Safe Work Australia. (2015). *The Cost of Work-related Injury and Illness for Australian Employers, Workers and the Community: 2012-13.* https://www.safeworkaustralia.gov.au/system/files/documents/1702/cost-of-work-related-injury-and-disease-2012-13.docx.pdf

have resigned ourselves to accept disability - which compels us to passively manage it instead of focusing on preventing work disabilty through evidence-informed best practices. Again, there has not been an overall reduction in the human, social, and economic costs of unnecessary work disability.

WHAT IS WORK DISABILITY?

The Handbook of Work Disability (Loisel and Anema, 2013) states, "Work disability has become a worldwide major public health problem."

Simply put, if a person is unable to stay at work, resume working, or return to work due to an illness or injury they are considered disabled from working, or in other words, "work disabled." *The Handbook of Work Disability* goes on to say:

> "Work disability is the result of a decision by a worker who for potential physical, psychological, social, administrative, or cultural reasons does not return to work. While the worker may want to return to work, he or she feels incapable of returning to normal working life. Therefore, after the triggering accident or disease has activated a work absence, various determinants can influence some workers to remain temporarily out of the workplace, while others return, and others may finally not return to work at all."[3]

It is well accepted that the biomedical model doesn't fully explain whether a person becomes unnecessarily work disabled or not. In essence, the medical (i.e., the diagnosis) does not predict duration of work disability and clinical severity does not predict whether the person will remain work disabled.

It is helpful to describe work disability as a separate condition. Work disability prevention should avoid linking interventions or actions to specific medical diagnoses and, instead, address the work disability determinants.

Known and well-accepted work disability determinants are:

1. Worker's concerns
2. Worker's perceptions/expectations
3. Workplace conditions
4. Stakeholder attitudes (i.e., medical providers, employers, attorneys, unions, spouses, etc.)
5. Medical factors such as co-morbid conditions, non-evidence based treatment, poor access to treatment options, etc.

None of this means that a person doesn't require treatment. If they have a shoulder injury that requires surgery, physical therapy, and/or graded exercise, then they should have access to it. What it doesn't predict, or explain, is when the worker will choose to return to work and if the employer is willing to offer return to work options. It doesn't fully explain why they are still not at work and/or

[3] Loisel, P., & Anema, J. R. (2014). *Handbook of work disability: Prevention and management*. New York: Springer.

returning. In addition, medical treatment is often ineffective in improving return to work outcomes once acute conditions have stabilized. More treatment has the increased potential to create worse outcomes (Campbell, Wright, Moseley, Chilvers, Richarcs & Stabb, 2007).[4]

We now recognize that work disability is developmental in nature, and has its own unique set of causes that require unique and individualized interventions. The actual diagnosis is not a very good predictor of whether a person will be able to stay at work when they will return to work, or whether they will return at all.

Long-term, unnecessary work disability is harmful and has been linked to 2-3 times the increased risk of developing mental health conditions, 2-3 times the risk of developing co-morbid conditions, and a 20% increase risk of mortality not to mention the social and economic costs that go along with it.[5] [6] The focus of work disability prevention is helping workers stay productive at work or return to a healthy productive work-life regardless of the ongoing impairment or severity of the medical condition.

Work Disability Prevention After an Injury or Illness Has Occurred.

In a prevention model, there are three levels of prevention; primary, secondary, and tertiary. While primary prevention (the provision of a safe work environment, effective safety policies and training, among other things), our focus here concerns secondary and tertiary prevention. Once an injury/illness occurs the purpose of a work disability prevention model is to minimize medically discretionary and medically unnecessary disability. The focus is on secondary and tertiary prevention measures to reverse the onset of unnecessary work disability or substantially reduce the human, social, and economic costs associated with the development of unnecessary work disability by finding ways to help people stay in or re-enter the workforce.

There are four principles of preventing the development of unnecessary work disability.[7]

1. **Preventing Unnecessary Delays** – Unnecessary delays are often caused by system problems. Unnecessary delays often translate to Unnecessary Duration.
2. **Preventing Unnecessary Duration** – Unnecessary duration is often caused by medically discretionary and unnecessary disability which usually manifest as non-clinical risk factors.
3. **Preventing a Confusing Process** – A confusing process creates uncertainty in the mind of the worker. The process of being ill and/or injured can be very overwhelming for them and can impact their engagement in the claim process and return to work.
4. **Preventing Unclear Return to Work Plans** – There is clear evidence that a perceived lack of control is at the center of the "Web of Disability" (Aurbach, 2014)[8] and in particular when there is

[4] Campbell, J., Wright, C., Moseley, A., Chilvers, R., Richards, S., Stabb, L. (2007). Avoiding long-term incapacity for work: developing an early intervention in primary care. Peninsula Medical School, Universities of Exeter and Plymouth, Exeter.
[5] Kivimaki, M., Head, J., Ferrie, J.E., et al. (2003). Sickness absence as a global measure of health: Evidence from mortality in the Whitehall II prospective cohort study. *British Medical Journal, 327: 364-368.*
[6] Waddell, G., & Burton, A.K. (2006). *Is work good for your health & well-being?* The Stationery Office.
[7] Courtesy of Centrix Work Disability Services and Jason Parker.
[8] Aurbach, R. (2014). Breaking the web of needless disability. *Work, 48*(4), 591-607

no clear path or plan to return to work.

Return to work is not something we do to a worker but something we do with them. When it comes to return to work, an approach that is evidence-informed, behaviorally focused, and worker-centric is the best practice. Ensuring work disability prevention programs have the four principles above as the foundation will provide a solid base for the secondary and tertiary prevention of unnecessary work disability.

An article, "Work Disability Prevention Research: Current and Future Prospects" states, "Work disability prevention has evolved from being a component of disease outcomes studies, to a separate and growing research discipline. In part, this is due to recognition that work outcomes often do not correlate with other health outcomes; the causes of work disability are multiple, complex, and often distinct from associated health conditions or treatments; and that work disability creates an important personal, economic and social burden that is often preventable." [9]

WHY WORKER-CENTRIC?

Remember that "work disability is the result of a decision by a worker." So how can the stakeholders in a workers' compensation system influence that decision? We believe the most effective method is through a worker-centric approach. Put simply, worker-centric means we:

- Put the worker in the lead role and make it easy for them to choose to return to work;
- Engage and activate the worker based on what they think needs to happen through goal planning and attainment to enable them to successfully return to work or progress through the process; and
- Develop a relationship and trust with the worker to help identify their motivations, concerns, and risks with returning to work.

In a worker-centric model, questions from insurers, employers, caregivers and other stakeholders are different: rather than asking, "When are you coming back to work?" which often elicits responses such as, "I'm not ready!" or "I'm in too much pain!", the worker-centric question might be: "Why is return to work important to you?" or "What needs to happen for you to return to work?" These questions are designed to help workers connect with their goal of return to work (if that is their goal), and to get them to begin thinking about return to work. The answer to these questions can provide insights into next steps that will move the worker through the claims and treatment process and closer to their decision to return to work.

In the end, integrated work disability prevention is a multi-dimensional, worker-centric, prevention-oriented, evidence-based, function- and outcome-focused process. The concept of preventing work disability relies on an outcome of the person working and this makes stay at work and return to work a strategic initiative for all stakeholders.

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[9] Pransky, G. S., Loisel, P., & Anema, J. R. (2011). Work disability prevention research: current and future prospects. *Journal of Occuoational Rehabilitation.* p. 287-2920

The Caregiver

Objective: Caregivers should be an advocate for functional and vocational recovery, and promote return to work as an essential element of healing and as a critical component of preventing work disability.

This section addresses caregivers as medical providers (medical doctor) and vocational professionals. These two specialties are discussed below.

Summary on the Medical Provider

To help ensure an early return to work compatible with their patient's health and safety, a provider's duties include:

1. Examination, diagnosis, and treatment thoroughly documented in the medical record. The record must include return to work goals and a method for objectively evaluating functional improvement. Consider whether there is a specific reason that poses a risk of harm or is unsafe for the injured worker patient to remain in or return to the workplace.
2. Communication and education is another element of the provider's activities. This includes not only education and shared decision-making with the patient, but also working with the employer and other caregivers such as physical therapists, rehabilitation centers, and vocational providers.
3. Documentation is an essential portion of the medical provider's role so that personnel involved in the patient's care and return to work can clearly understand the provider's work restrictions and functional goals.

Unfortunately, providers who do not work primarily in a workers' compensation or occupational medicine system or with physical medicine and rehabilitation are usually not aware of the elements required to effectively engage and activate workers toward functional and return to work goals. In part, this is because the medical system traditionally has focused only on making an accurate diagnosis and providing the appropriate treatment to cure the disease. The majority of the conditions causing needless time off work in the U.S. are related to musculoskeletal conditions, such as low back pain, and/or mental health conditions, while the underlying contributing factors to work disability are preventable yet remain largely unaddressed. While the scientific evidence supporting quality treatment relies almost exclusively on validated functional tools, the current electronic health records provide virtually no assistance with recording the patient's function as part of the usual medical record. In addition, there is minimal information in most electronic health records regarding the patient's occupational title or job duties. This lack of alignment between the electronic health record and the actual goals of treatment is a significant gap for all of the parties in the workers' compensation system.

MEDICAL PROVIDER'S ROLE IN PREVENTION

Treatment of patients injured on the job should be directed at obtaining optimal functional improvement while actively returning to work. Many workers' compensation systems rely on the legal concept of maximum medical improvement (MMI); this is defined as the point at which it is unlikely there will be further functional improvement even with continued medical treatment or physical rehabilitation. To support functional improvement, providers need to ask about functional impact at every visit and aim treatment at approaches that will improve function.

Clinical providers caring for injured workers in the workers' compensation system need to address more than the usual medical care decisions to have optimal functional outcomes. Ideally, medical care will address multiple domains, engaging the injured worker and the employer in the recovery plan to determine the underlying non-medical factors of the work disability problem. This requires mindfulness around the patient's and employer's expectations and motivations towards returning to work while addressing any signs of fear and avoidance behaviors. A useful acronym to remind providers about these multiple domains is TRACK:

Treatment: What diagnostic testing, medication, procedures are indicated?
Referrals: What help is needed from other professionals?
Activities: What can your patient safely do at home and at work while healing? What should your patient do at home and at work to speed recovery?
Communication: Who needs to know what? How will the provider communicate critical information to stakeholders?
Knowledge: What are the employee's knowledge gaps related to the condition, recovery, and treatment options? What patient education is needed?

TREATMENT

1. **Follow evidence-based guidelines.**
   Many states have adopted evidence-based treatment guidelines for work injuries. For example, there is strong evidence that specific guidance is appropriate to avoid opioid prescriptions for musculoskeletal injury conditions, especially nonspecific low back pain, and to avoid early imaging (including X-ray and MRI) for back conditions without clinical red flags.

   Care that does not follow evidence-based medicine (EBM), such as the examples above, leads to worse outcomes, while growing evidence shows that adherence to guidelines improves patient outcomes and saves money.

   For instance, the time lost from work for low back injuries, as measured in weeks of temporary disability, ranged from 6 to 10 times longer than the temporary disability durations anticipated by the ACOEM evidence base.[10]

[10] Harris, J.S., Swedlow, A (February 2004). Evidence-Based Medicine & The California Workers' Compensation System. *CWCI A Report to the Industry*.

In "A New Method of Assessing the Impact of Evidence-Based Medicine on Claim Outcomes,"[11] Dr. Dan Hunt and colleagues developed a methodology to evaluate adherence to evidence-based treatment guidelines and found that when all levels of medical complexity are considered, those claims in the low compliance group had a 13.2% increase in claim duration and a 37.9% increase in medical incurred costs when compared with claims in the high compliance group.

2. **Practice quaternary prevention.**
   Quaternary Prevention is defined as: "Action taken to identify patient at risk of overmedicalization, to protect him from new medical invasion, and to suggest to him interventions, which are ethically acceptable." Another way to think of it is: "action taken to protect individuals (persons/patients) from medical interventions that are likely to cause more harm than good." [12] Although there are no research studies using this term as applied to workers' compensation, the concept fits notions such as avoiding imaging for non-specific low back pain, because the risk of both the test (unnecessary radiation exposure) and of procedures that often follow the identification of pathology that is not responsible for the patient's complaints. Such testing has been described as "low-value care."[13]

3. **Schedule follow-ups appropriate for promoting advancement in work activities.**
   When scheduling follow-up visits with patients treated for work injuries, consider both expected healing time (anticipated clinical changes that should be accompanied by progression of work duties) and patient psychosocial risk for delayed recovery. Patients with pain catastrophization, disability beliefs or behavior, fear/avoidance, perceived injustice, or other identified work disability risk factors should be monitored more closely, with more frequent follow-up to proactively manage expectations and progress activities.

REFERRALS

1. **Choose your team of external experts consciously.**
   If you need to refer your patient to other professionals, make sure you know (or find out) whether your referral resources have values and approaches that align with best practices. Pay attention to the outcomes in patients you refer. Referral sources should also follow and report functional status and improvements to demonstrate effectiveness.

2. **Continue to coordinate care and return to work efforts – don't "refer out."**
   Make it clear to your patient, to those you refer your patient to, and to the workers' compensation team that you will continue to coordinate care while evaluating when return to work no longer poses a risk to the patient or others. It makes a positive difference if a single provider continues to manage the patient's care, as a trusted advisor and care coordinator. When you refer to other professionals, consider them expert advisors whose assistance you need in preventing work disability. Consider meeting with both the patient and expert advisors, such as vocational

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[11] Hunt, D. L., Tower, J., Artuso, R. D., White, J. A., Bilinski, C., Rademacher, J., Bernacki, E. J. (2016). A New Method of Assessing the Impact of Evidence-Based Medicine on Claim Outcomes. *Journal of Occupational and Environmental Medicine*, 58(5), 519-524.
[12] Martins, C., Godycki-Cwirko, M., Heleno, B., & Brodersen, J. (2018). Quaternary prevention: Reviewing the concept. *European Journal of General Practice*, 24(1), 106-111. .
[13] Schwartz, A. L., Landon, B. E., Elshaug, A. G., Chernew, M. E., & Mcwilliams, J. M. (2014). Measuring Low-Value Care in Medicare. *JAMA Internal Medicine*, 174(7), 1067.

professionals, to avoid unclear roles, delays, a confusing process, and unclear return to work expectations and plans.

Referring to pain management specialists can be tempting in cases of delayed recovery but may do more harm than good. There is a wide range of expertise and practice approaches among providers who consider themselves experts in pain management. A recent online search for pain management specialists using Vitals.com led to this explanation of such expertise: "Pain management specialists are primarily trained as anesthesiologists, physiatrists, interventional radiologists, neurologists, osteopaths, or primary care physicians." Bernacki and colleagues measured the costs of claims involving pain management specialists and found both medical and indemnity costs to be significantly higher than cases managed by occupational medicine physicians.[14] Pain management physicians focusing on interventions or medication management are less likely to be attentive to functional outcomes, including work, than those managing pain in the context of functional restoration programs. If patients need pain management interventions, you can refer for procedures while maintaining authority for care coordination. Depending on the jurisdiction and system, you may need to communicate with the claim adjuster about maintaining such care coordination control.

3. **Refer to mental health therapists who deliver "work-focused" Cognitive Behavioral Therapy.**
   When mental health conditions interfere with recovery and return to work, treatment by mental health therapists may be needed. A recent systematic literature review by Cullen and colleagues from the Institute for Work and Health in Canada, ascertained that a specific type of Cognitive Behavioral Therapy (CBT) focused on work-relevant solutions for mental health conditions was most effective in reducing lost time and costs associated with work disability. There was also evidence that these work-focused CBT programs had a positive effect on work functioning after return to work.[15] Ensure integration of "work focused" CBT with other work disability prevention interventions to maximize effectiveness.

ACTIVITIES

1. **Recognize that activity is an important part of recovery.**
   For working-age adults, the fullest possible participation in life via medically appropriate activity and work promotes positive health and overall life outcomes. Encouragement by the physician to remain active and productively engaged in life is beneficial for the patient and his or her family.[16]

2. **Base your recommendations about activity on clinical reality.**
   Ask yourself what recommendations you would make about safely working if your patient and the employer were asking for your help in accommodating the medical condition at work. Put in writing

[14] Bernacki, E. J., Tao, X., & Yuspeh, L. (2010). The Impact of Cost Intensive Physicians on Workers' Compensation. *Journal of Occupational and Environmental Medicine*, 52(1), 22-28.
[15] Cullen, K. L., Irvin, E., Collie, A., Clay, F., Gensby, U., Jennings, P. A., Amick, B. C. (2017). Effectiveness of Workplace Interventions in Return to work for Musculoskeletal, Pain-Related and Mental Health Conditions: An Update of the Evidence and Messages for Practitioners. *Journal of Occupational Rehabilitation*, 28(1), 1-15. .
[16] Jurisic, M., Bean, M., Harbaugh, J., Cloeren, M., Hardy, S., Liu, H., Christian, J. (2017). The Personal Physician's Role in Helping Patients With Medical Conditions Stay at Work or Return-to-Work. *Journal of Occupational and Environmental Medicine*, 59(6).

what the patient can safely do and should do from an activity standpoint to promote recovery. This may put the employer in a better position to proose solutions to help your patient with their transition back to work. If the employer cannot (or will not) provide appropriate work, then the off-work status will belong to the employer, not the treating provider. Consider a call to the employer (with the patient a present and participating in the conversation) if not prohibited by the jurisdiction to discuss modified duty options.

3. **Use a graded activity approach.**
   Several research studies have shown effectiveness of using a graded activity approach – titrating activity recommendations with frequent patient follow-up for progression in work tasks or hours (Cullen et al., 2017). Follow the patient closely to advance activities. Do this even if the patient has not returned to work, emphasizing non-work activities that will promote recovery and eventual return to full duty work capacity. If appropriate under the rules of the jurisdiction, consider recommending participation in volunteer activities as a substitute for work if the employer is unable to address the risk of harm or safety concerns through modified duty available, to keep your patient active and participating in a productive way in society.

COMMUNICATION

1. **Communicate the value of work to health to the patient at each encounter.**
   Learn more about the importance of work to human life and well-being, so you can share this knowledge with your patients. Work adds meaning and purpose to life and is an important source of individual identity. Studies show that worklessness (lack of work) increases morbidity and mortality and results in decreases in mental, family, social, and economic well-being (Jurisic et al., 2017).[17] Asking patients why it is important for them to get back to work can be an effective question based on motivational interviewing principles, which can help patients think about and formulate their own statement about the value of work to them.

2. **Make return to work/maximal function an explicit element of the treatment plan.**
   Work should be addressed as an explicit element in the treatment plan, not an afterthought. Your patient management plan should routinely include discussions about return to work, working together on plans for return to work, including need for restrictions, duration of limitations, and activities that will promote functional improvements to reassure your patient that steps can be taken to keep them safe while at work. Use a template that prompts you to include work recommendations as part of the treatment plan.

3. **Communicate recommendations about work capacity, activities, and limitations in writing.**
   It can be helpful to frame your recommendations in terms of capacity (current physical abilities), risk (activities that may cause harm to a recovering part of the body), and tolerance (limitations related to pain while an injury heals).[18]

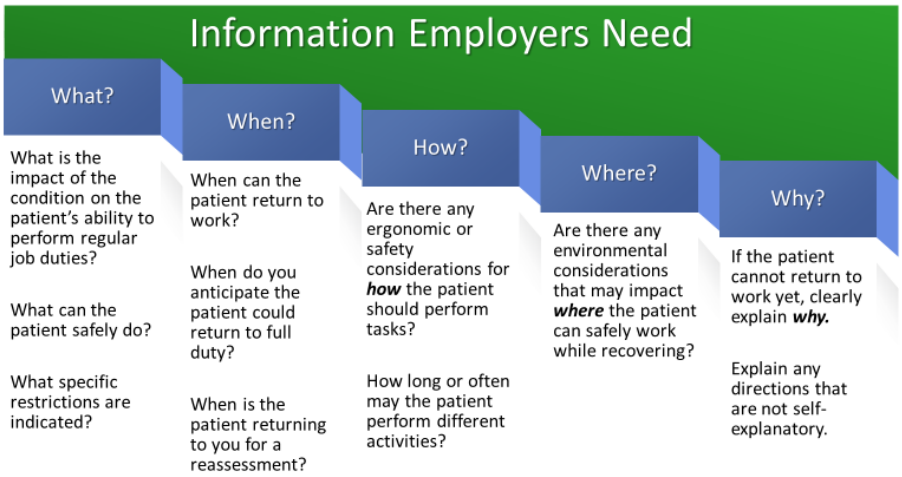
[17] Waddell, G., & Burton, A.K. (2006). *Is work good for your health & well-being?* The Stationery Office.
[18] Talmage, J. B., & Melhorn, J. M. (2005). *A Physician's Guide to Return-to-Work*. Chicago, IL: American Medical Association AMA Press.

When addressing activities, include discussion of those outside of work (home, recreation, hobbies) that are impacted by the patient's condition. Consider the psychological impact of framing your recommendations in terms of positives (what the patient can or should do), e.g. "lift up to 10 pounds, up to once per hour" rather than negatives, e.g. "no lifting over 10 pounds." Also include recommendations for activities that will help the patient recover, e.g. regular walking when recovering from a back injury.

4. **Use written activity prescriptions.**
   Several research studies have shown that recommending activities in writing, in the form of a prescription, is more effective than simply advising a patient verbally about exercise recommendations.[19,20,21,22] This may be especially helpful for patients who exhibit fear/avoidant behavior.

5. **Consider which stakeholders need to know what.**
   Employers and insurers need to understand the impact of the patient's condition on the ability to perform work tasks. Helping these stakeholders anticipate recovery time, and understand the reasoning behind your recommendations will foster cooperation with your patient-centered work disability prevention plan.

Figure 1. Information Employers Need



Source: Dr. Marianne Cloeren (paper author)

[19] Babwah, T., Roopchan, V., Baptiste, B., Ali, A., Dwarika, K. (2018). Exercise prescriptions given by GPs to sedentary patients attending chronic disease clinics in health centres – The effect of a very brief intervention to change exercise behavior. *Journal of Family Medicine and Primary Care*, 7(6), 1446.
[20] Fowles, J. R., O'Brien, M. W., Solmundson, K., Oh, P. I., & Shields, C. A. (2018). Exercise is Medicine Canada physical activity counselling and exercise prescription training improves counselling, prescription, and referral practices among physicians across Canada. *Applied Physiology, Nutrition, and Metabolism*, 43(5), 535-539.
[21] Swinburn, B. A., Walter, L. G., Arroll, B., Tilyard, M. W., & Russell, D. G. (1998). The green prescription study: A randomized controlled trial of written exercise advice provided by general practitioners. American Journal of Public Health, 88(2), 288-291.
[22] Pedersen, B. K., Saltin, B. (2015). Exercise as medicine - evidence for prescribing exercise as therapy in 26 different chronic diseases. *Scandinavian Journal of Medicine & Science in Sports*, 25, 1-72.

6. **Learn how to be an effective persuasive communicator with the patient.**
   Effective communication is an important way to earn the trust of patients. When patients trust their providers, they are comfortable discussing return to work planning, and such discussions do not harm satisfaction scores.[23] There are a variety of doctor-patient communication courses available. Consider training in Motivational Interviewing, which can be used to help a patient who is ambivalent about returning to work identify and move toward such goals.[24] [25] Shared (or informed) decision making is a best practice way to engage the patient in both treatment and other management decisions, by providing good quality information about options and discussing the decision together.[26]

KNOWLEDGE

1. **Identify and address patient knowledge gaps with education.**
   What does the patient need to understand more about, to become an active and effective participant in recovery and returning to work? Most providers have on hand a wide collection of patient education materials that address the clinical conditions they commonly treat – education about causes, pathology and treatment options. But few clinical offices keep education materials on hand about the importance of work and activity in recovery from injury or illness. Providers of workers' compensation care should collect or produce a range of patient educational materials about the health benefits of work and activity.[27]

2. **Prescribe education and follow up with the patient to reinforce.**
   Directing patients to websites that offer high quality education with messages targeted to self-care for recovery can be very effective.[28] Including discussion of this information at follow-up visits can both reinforce the new knowledge and emphasize the importance of this to the treatment plan.

3. **Follow health literacy best practices if you develop your own patient education materials.**
   You may decide to develop your own patient education materials. The U.S. Centers for Disease Control and Prevention (CDC) have developed very useful guidelines for developing materials to increase health literacy among patients. The CDC recommends paying attention to the "3 A's" – materials should be Accurate (based on best scientific knowledge but presented in a way patients can understand), Accessible (consider issues such as reading levels, language, legibility, patient

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[23] Radosevich, D. M., Mcgrail, M. P., Lohman, W. H., Gorman, R., Parker, D., & Calasanz, M. (2001). Relationship of Disability Prevention to Patient Health Status and Satisfaction With Primary Care Provider. *Journal of Occupational and Environmental Medicine*, 43(8), 706-712.
[24] Gross, D. P., Park, J., Rayani, F., Norris, C. M., & Esmail, S. (2017). Motivational Interviewing Improves Sustainable Return-to-work in Injured Workers After Rehabilitation: A Cluster Randomized Controlled Trial. *Archives of Physical Medicine and Rehabilitation*, 98(12), 2355-2363.
[25]Park, J., Esmail, S., Rayani, F., Norris, C. M., & Gross, D. P. (2018). Motivational Interviewing for Workers with Disabling Musculoskeletal Disorders: Results of a Cluster Randomized Control Trial. *Journal of occupational rehabilitatio*n, 28(2), 252–264..
[26] Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., Cording, E., Tomson, D., Dodd, C., Rollnick, S., Edwards, A., & Barry, M. (2012). Shared decision making: a model for clinical practice. *Journal of General Internal Medicine*, 27(10), 1361–1367.
[27] *http://www.webility.md/az-cme/Patient%20Instructions-%20How%20to%20Cope%202011-10-12a.pdf*
[28] Clesham, K., Galbraith, J. G., Kearns, S. R., & O' Sullivan, M. E. (2018). Fracture Patients' Attitudes towards Online Health Information & a 'Prescribed' Fracture Website. *Irish Medical Journal*, 111(4), 732.

access to internet, etc.), and Actionable (offering specific recommendations for what the patent should do).[29]

WHAT IS WORK DISABILITY?

Work disability occurs "when a worker is unable to stay at work or return to work because of an injury or disease. Work disability is the result of a decision made by a worker who for potential physical, psychological, social, administrative, or cultural reasons does not return to work. While the worker may want to return to work, he or she feels incapable of returning to normal working life. Therefore, after the triggering accident or disease has activated a work absence, various determinants can influence some workers to remain temporarily out of the workplace, while others return, and others may finally not return to work at all." *(Loisel & Anema, 2014)*

VOCATIONAL PROFESSIONALS' ROLE IN PREVENTING DISABILITY

In the original paper, *Return to Work: A Foundational Approach to Return to Function,* the caregiver section was limited to a discussion of the role of the medical provider. However, credentialed vocational professionals are also service providers who can provide worker-centric work disability prevention interventions while positively impacting outcomes for a worker and the duration of disability which, in turn, reduce claim costs for the employer and insurer.

For those who are not familiar with workers' compensation systems, the term Vocational Rehabilitation Counselor (VRC) can be mystifying. To some, the term VRC suggests a profession associated with helping people return to work. For others, the term may conjure up thoughts of a counselor helping students identify what they want to be when they grow up. Yet others may think VRCs help the unemployed find jobs. All of these assumptions are true to a higher or lesser degree. Credentialed VRCs are used in a multitude of ways in workers' compensation systems with a great degree of variance across jurisdictions. Some jurisdictions use credentialed VRCs only when it's clear a worker needs to be retrained. Other jurisdictions use credentialed VRCs to support legal arguments pertaining to benefit eligibility or settlements. And some jurisdictions don't even recognize the profession, while others have changed how, or even if, vocational professionals have a role in their systems.

Washington State has taken a different approach; they are shifting the involvement of credentialed VRCs to occur much earlier in the life of a claim so their skills and training are better utilized to motivate, engage, and activate workers through best practices based on a worker-centric model aimed at preventing needless work disability. Prior to this change, Washington utilized credentialed vocational providers primarily to assess a worker's employability while producing a defensible outcome that routed the claim to closure, retraining, or total permanent disability consideration. This system-centric approach, focused on the adjudication of benefits, happened very late in the claims process, generally after maximum medical improvement was achieved.

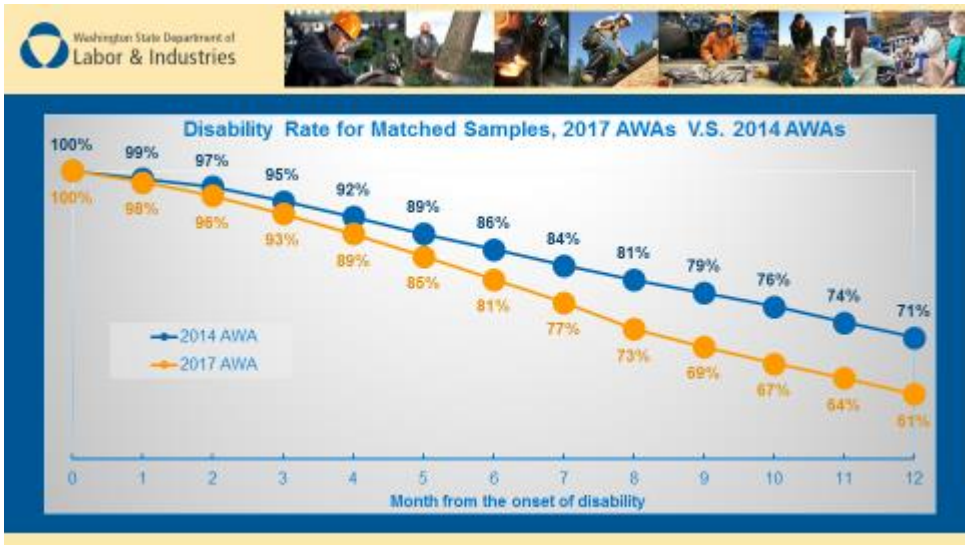
[29] See *https://www.cdc.gov/healthliteracy/developmaterials/index.html*

Under Washington's emerging model, VRCs are asked to partner with the claim manager early - when the case has as little as 20 days lost time paid (the median lost time days to referral was 42 as of July 2020). This compares to referrals made at a median of 212 days in 2012. By changing the timing of the VRCs' initial engagement, return to work outcomes have improved by about 125%.

Researchers with Washington's Department of Labor and Industries (which administers the State Fund, along with overseeing the provision of benefits by self-insured employers) performed an analysis to determine the return on investment for vocational services, particularly given the improved return to work outcomes. The research identified treated subjects to find similar claims (all observed covariates balanced) in order to compare differences in disability rates and resulting costs over the entire follow-up period of 2014 through 2017 using 2012-13 as the baseline.

The research found markedly improved disability rates; Figure 2 for 2017 is provided as an example.

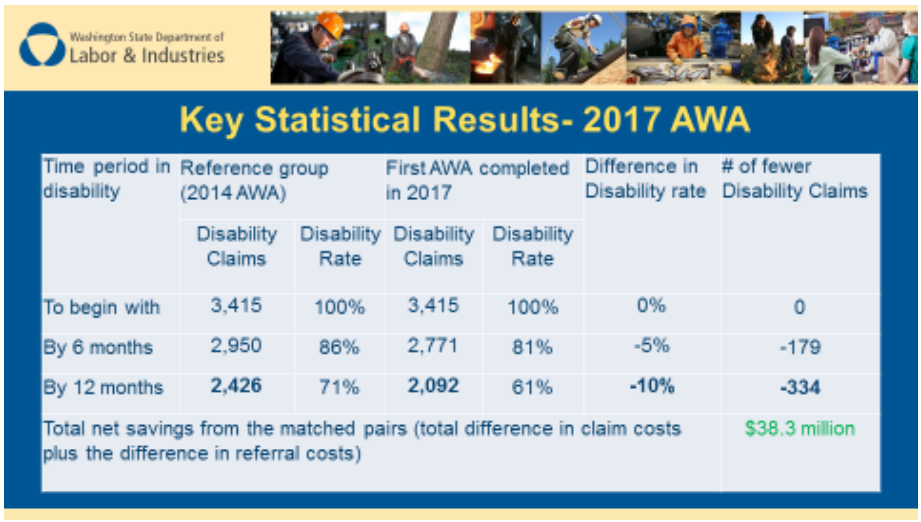
Figure 2. Disability Rate for Matched Samples, 2017 AWAs V.S> 2014 AWAs



Source: Washington State Department of Labor and Industries

Table 1 shows the key statistical results for 2017. (2017 had the greatest improvement, perhaps due to improved timeliness and consistency in referrals as the new process for claim managers matured.) The total savings of $38.3 million is net of the cost of vocational services for the 4,112 matched pairs only. (Washington's State Fund refers about 7,000 new claims each year for vocational services.)

Table 1. Key Statistical Results- 2017 AWA



Source: Washington State Department of Labor and Industries

GERMANY'S REHABILITATION MANAGEMENT MODEL

In Germany, based upon a rehabilitation plan drawn up jointly with the affected individuals, and with the involvement of all stakeholders in the process, the case managers co-ordinate and supervise medical rehabilitation and the benefits for participation.

The rehabilitation process is supported by ad-hoc team meetings between the insured individual, physician, and case manager. These meetings are held whenever the targets of individual measures are attained or if rehabilitation as a whole appears in jeopardy, for example owing to substantial changes in the conditions or the emergence of conflicts. With the insured individual's consent, employers' representatives are to be involved in the meetings.

PRIORITIZING THE WORKER

First and foremost, insurers and jurisdictions need to ask themselves some critical questions related to work disability and the role of vocational providers within their respective systems. For example, what is most important and what is a priority? If helping injured workers return to work is a top priority, and if they fully understand and embrace a worker-centric approach aimed at preventing needless work disability, then they will benefit from continuing to read. Also, insurers and jurisdictions should analyze the stated goals of vocational services in their systems and ask themselves if those goals align with a worker-centric work disability prevention model.

The "worker-centric" approach is likely a significant shift for many U.S. systems, but significantly important to address work disability (remember that work disability is a "decision made by a worker") as a separate condition requiring specialized interventions. For example, the worker has historically

been left out of modified or light-duty job return to work discussions and, as a result, return to work happens “to” them, rather than “by/with” them. This example demonstrates how systems can very easily and inadvertently create a sense of loss of control from the workers perspective thus triggering psychosocial barriers to return to work - such as a sense of injustice and/or catastrophic thinking. Triggering or exacerbating these psychosocial risk factors can amplify the work disability condition thus costing needless human suffering at a heavy cost to insurers.

Washington identified worker-centric best practices through a search of available scholarly literature. They restricted their research to evidence published in the last ten years that focused on non-medical interventions. More than 80 articles and collections were identified. The most frequently cited publications can be found in the *Handbook of Return to work*, edited by Izabela Z. Shultz and Robert J. Gatchel, 2016 and the *Handbook of Work Disability Prevention and Management*, edited by Patrick Loisel and Johannes R. Anema, 2014. Additional insights and guidance can be gathered from *The AMA Guides to the Evaluation of Work Ability and Return to Work*, Second Edition, Talmage MD, Melhorn MD and Hyman, MD, 2011 and ACOEM’s *Stay-at-Work and Return to work Guideline*, 2006.

Several best practices help address the work disability problem via a worker-centric approach. The three most prominent that can be employed by vocational professionals (and some claim adjusters/managers) in any system include:

- Return to Work Management. This means engaging a worker to identify their motivations (gains/losses) and expectations as they are related to returning to work.
- Return to Work Planning. This means planning what needs to happen next, driven by the worker, for the worker to be successfully returning to work through goal identification, goal setting/re-setting, and ultimately goal attainment.

Job modifications are first developed in collaboration with the worker and employer then include the medical professional (if the jurisdiction requires physician input for release to return to work).

In addition to best practices related to injured worker motivations, engagement, and activation, Washington is identifying and testing those practices that relate to employers and medical providers as well. These are likely to include:

- Helping employers understand the value of return to work and providing return to work incentives;
- Assisting employers with understanding work disability from a prevention standpoint and making it clear that prevention starts in the hiring and onboarding process;
- Helping employers understand their role and how to respond to a worker, who has been injured, as it relates to long-term disability risk exposure and how this correlates to engaging (or lack thereof) their worker immediately after a claim and all the way through the return to work process;
- Assisting employers with tools to more effectively communicate with medical providers thus demonstrating their willingness to make good-faith efforts to return workers to physically appropriate job duties as soon as possible;
- Ensuring medical providers are engaged in the return to work discussions at the correct point during the life of the claim; and
- Ensuring medical providers are asked the correct questions related to safely returning a worker to work vs. relying on subjective estimates of tolerance and capacities.

The Employee, Union, and Employee Attorney

Objective: Employees and their advocates (union representatives and attorneys) need to be actively involved in the progression of the employee's return to function and proactively pursue early return to work to maintain or increase earning capacity and improve quality of life.

Pre-Injury

Workplace Safety

We would be remiss if we didn't first state the obvious - that the best workers' compensation claim is the one that never happens. One of the most important steps for any employee is to become familiar with their employer's safety policies and accident prevention program (APP). APPs are required by the federal Occupational Safety and Health Administration (OSHA) and by those states that administer their own state-OSHA plan (these 28 states are listed in the appendix).

If your employer does not have a plan, work with them to create one. Don't assume your company is intentionally ignoring the requirements - they have many to follow and regulations can change at any time. Rather, use your state resources to help. Some examples are provided by OSHA directly.[30]

You can also become an active employee member of your employer's safety committee, required by federal OSHA for employers with at least 11 employees. This gives you a chance to be an advocate for safety, and the voice of the worker for safety policies.

Employer Claim Procedures and Return to work Programs

In states where new workers' compensation claims are initiated by the employer, the employers have claim-reporting policies and requirements. In states where the claim may be filed by either the worker or medical provider, the employer likely still requires you to notify your supervisor or human resources person of the accident and injury. Know your employer's expectations and follow them as quickly as possible. This gets your claim started, minimizes gaps or delays in your benefits, and allows you to quickly take advantage of any "modified or transitional" work your employer may have available if you are hurt on the job.

Modified or transitional work means assigning lighter duty tasks, fewer hours, or other adjustments in your regular job or another job so that you are able to perform the work while you continue to heal. A modified or transitional job or tasks are consistent with limitations from your doctor. For example, your job generally requires you to lift 50 pounds or more, and your doctor says it's unsafe or poses a risk of harm if you lift more than 30 pounds until he releases you to your regular duties. Your employer could

[30] Go to www.osha.gov and search "state plans" or search for "OSHA State Plans" in a general search engine.

modify your job by providing you with a buddy to do the lifting, or by breaking the loads in half so that each lift is 25 pounds. If you feel you can lift more, considering talking to your doctor about it and whether it's safe to do so.

Some employers have created return to work programs to ensure they are able to keep their workers active and involved with their peers after an injury. Meet with your supervisor to learn whether your company has a program, and how it works. Questions you should ask include:

- What is the process for participating in a modified or transitional job? Who would you contact to start the process? Your supervisor or someone else?
- What are the expectations of the employee while working a modified or transitional job? This is particularly important if the job is with another department, or if your state allows (and your employer participates in) temporary work at non-profit or other organizations separate from your employer's job sites.

THE UNION'S ROLE

Labor unions often assist injured workers in navigating the workers' compensation system and engaging with their employer and claim manager, once an injury has occurred. There are several steps they can also take to support their members before injuries happen:[31] [32]

- Educate your members about the human, social, and economic harm that unnecessary work disability can cause.
- Meet with employers to learn about their return to work program so you can assist and support your members. Identify any potential conflicts with the collective bargaining agreement(s) or opportunities to coordinate with other unions.
- Advocate for return to work programs and important elements (pay, duration) to be included in collective bargaining agreements.
- Get involved and support government efforts to improve the services to the labor community. These services should be aimed at preventing disability and retaining a viable labor force to include those with impairments from disabling incidents, whether work-related or not. For more information, see the section on Government/Regulators.

POST-INJURY

CLAIM AND RETURN TO WORK PROCESSES

Once an accident and injury have occurred, use the knowledge you have from preparing yourself with a good understanding of your employer or workers' compensation insurer's policies and processes. Start with reporting your accident immediately and asking your supervisor to assist you in getting medical attention.

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[31] Kivimaki, M., Head, J., Ferrie, J. E, et al. (2003). Sickness absence as a global measure of health: Evidence from mortality in the Whitehall II prospective cohort study. *British Medical Journal* , *327* : 364–368.
[32] Waddell, G., & Burton, A. K. (2006). *Is work good for your health and well-being?* The Stationery Office.

Once you've received initial medical treatment and it's clear you may be unable to work your regular job for even a few days, begin to be your own proactive advocate:

- As quickly as possible (the day of injury or next day), call your supervisor or designee such as a human resources staff member about modified or transitional return to work options. Ask for a copy of the job description outlining the available modified or transitional duty work.
- Take the modified or transitional duty job description to your doctor immediately (schedule an appointment if you do not already have one). If allowed by your jurisdiction's rules, ask your supervisor/designee to attend the appointment with you or be available by phone to answer any questions the doctor may have about the modified or transitional duty work tasks and expectations to help him/her consider whether the work poses any risks considering your injury.
- Let the doctor know you are interested in going back to work and the steps you'll take to avoid re-injury while you heal. Ask your doctor what you CAN do.
- Don't be afraid to contact your claim manager.
- Ask about the claims process, make sure you understand your role and expectations and the roles and expectations of others. Keep good records, including any communications you receive from your insurer, doctor and employer.
- Understand what your worker's compensation insurance covers, including wage replacement and medical coverage, and when these coverages begin and end.
- Communicate!
    - Notify your claim manager if you're going to miss an appointment or have returned to work.
    - Let your supervisor know how you are tolerating the modified or transitional tasks. Be sure the tasks you are performing are consistent with the job description and the level of activity prescribed by your physician. Keep your claim manager informed about any changes that are necessary.
- Ask your doctor questions so you understand the treatment plan
    - Ask about alternatives to opioids – are they really necessary?
    - Ask for more information about procedures such as surgeries – what does the evidence say about expected outcomes? Don't be afraid to ask for clarification or a second opinion.
- Stay in touch with your co-workers, if you're not able to get back to work right away.
- Make sure your family members and spouse know how they might support your return to work and recovery efforts.

*A CASE STUDY OF WORKER SELF-ADVOCACY**

**This is a true claim of an injured worker, with the worker's name changed for privacy/confidentiality reasons.*

Mr. Hernandez frequented his local grocery store and was greeted by the store manager one day. The store manager asked him if he was still out of work because of his claim. Mr. Hernandez stated that his treatment was wrapping up, but he'd been unable to return to work with his employer. Mr. Hernandez was interested in working at the local grocery store, and expressed this to the store manager.

Mr. Hernandez was working with a vocational professional who was assisting him with employment options, a resume, and contact with local workforce and employment organizations. He relayed his conversation and interest to the vocational provider, who went to the grocery store (with Mr. Hernandez's permission) and spoke to the store manager. As Mr. Hernandez had mentioned the workers' compensation return to work incentives available in their state to the store manager, the vocational provider explained the details of these benefits (see the Government/Regulator section for more details about state incentive programs). The store manager responded that they had an opening and would definitely consider Mr. Hernandez for the job. Mr. Hernandez returned to work in a lead position with less physical demands than his prior job and making higher wages than he earned at the time he was injured. The store received reimbursements from the available incentive program for some of their costs of employing Mr. Hernandez.

As an added outcome, the vocational provider developed a job analysis for the employer as a first step in the employer's development of a return to work program for their employees!

SUMMARY STEPS FOR EMPLOYEE

WorkSafe Victoria (Australia) provides ten tips that summarize well the important steps for workers. The following is available on their website[33]: "The earlier you start planning your return to work, the more likely you are to get back to work quickly. While a work-related injury or illness can have a big impact on your life, research has shown that getting back to work is important for your health and wellbeing."

1. Act early. Don't wait till you are 100% recovered to return to work.
2. Understand that the most important person in your recovery is you.
3. After your injury try to keep positive and motivated – focus on what you can do rather than what you can't.
4. Work actively and cooperatively with those involved in your return to work.
5. Raise issues or concerns immediately with the appropriate people.
6. Talk regularly with people involved about your progress and return to work planning. This may include your GP (attending medical provider), your return to work coordinator, your manager/supervisor and your agent case manager – help them to help you get back to work.
7. Regularly review your return to work arrangements.
8. Incorporate work into your recovery. Remember, you don't have to be 100% to get back to work.
9. Ask for help/information when you need it.

ENGAGING THE WORKER'S ATTORNEY IN RETURN TO WORK

As a representative of the injured worker, the primary role of the attorney is sometimes perceived to maximize the benefits the worker receives from the workers' compensation system. Usually, the focus is on making sure that appropriate medical care is provided, that wage replacement or temporary disability benefits are accurate and paid on time, and that all permanent disability is identified and

[33] See: https://www.worksafe.vic.gov.au/10-tips-help-you-get-back-work

awarded. In most jurisdictions, the attorney fees are somewhat based on the awarded permanent disability.

For the injured worker, the most catastrophic result from a workplace injury event is failure to return to work. Studies have shown that not returning to work results in lifetime income loss and shortened life expectancy. Failure to return to work can also be a factor in damaged relationships and destabilized marriages.

Attorneys have an ethical obligation to represent their client's best interests. Unfortunately, many are not aware of the impact that failure to return to work has on their clients. As a result, they may not spend time or effort ensuring their client gets back to work. This can be further aggravated by reliance on consulting physicians who may maximize the disability, rather than focusing on return to work.

Returning to work has proven to be the best emotional therapy and physical recovery method from most injuries. Studies have shown that every day off work adds to the likelihood of never returning to work. Ironically, the severity of the injury has little to do with the likelihood of the worker returning to work. Major factors limiting return to work are low expectations or value of returning to work, the employer / employee relationship, fear of re-injury (by both the employer and employee), opioid use, psycho-social issues, co-morbidities, age, and the distance between the employer and the employee residence.

SOLUTIONS

Worker attorneys can (and should be) a force in helping injured workers return to work. They have the trust and respect of their clients. They also have access to insight (from their clients) into barriers which may hinder return to work.

The following is a list of positive actions attorneys can take to help their client return to work:

- Educate themselves on the return to work process and how failure can negatively impact workers.
- Early in the relationship, educate the worker on the importance of returning to work. Help them understand that workers' compensation is a safety net until they return to work, it is not designed to be a retirement program.
- Make sure to set the goal with the worker to get back to work as quickly as possible. Never underestimate the power of setting return to work goals.
- Consult with physicians who understand the importance of return to work and who will support the employee to return to work. The physician should have an accurate physical job description, make return to work decisions based on risk of harm to self or others, and understand the impacts of limiting an employee from returning to work due to medically discretionary or medically unnecessary reasons.
- Carefully listen to the worker to discern any obstacles in the way of a successful return to work. The obstacles can be low expectations or value of returning to work, psycho-social, physical, or a combination of all of the above.
- When appropriate, leverage the defense attorney to help make sure the employee gets back to work as quickly as possible.

THE EMPLOYER

Objective: Employers must proactively focus on the safe and early return to work of an injured worker as a part of the worker's healing process, thereby achieving better outcomes for them and the worker.

PRIMARY PREVENTION

The main goal of injury and illness prevention programs is to prevent workplace injuries, illnesses, and deaths, the suffering these events cause workers, and the financial hardship they cause both workers and employers.

An injury and illness prevention program is a proactive process to help employers find and fix workplace hazards before workers are hurt. These programs can be effective at reducing injuries, illnesses, and fatalities. Many workplaces have already adopted such approaches, for example as part of the U.S. federal Occupational Safety and Health Administration (OSHA) cooperative programs. Not only do these employers experience dramatic decreases in workplace injuries, but they often report a transformed workplace culture that can lead to higher productivity and quality, reduced turnover, reduced costs, and greater employee satisfaction.

A quality injury/illness and work disability prevention program can achieve the following goals:

- Reduced workers' compensation claims and costs (direct and indirect)
- Decreased absenteeism and presentism
- Improved employee performance
- Increased motivation and production
- Increased employee engagement and morale
- Decreased employee premiums
- Improved external image and brand

OSHA-implemented research into the positive results that a primary prevention program can provide to employers is outlined below.[34]

Key highlights from this research show a significant reduction in workplace injury and illness rates in states with a required prevention program. OSHA estimates that implementation of injury and illness prevention programs will reduce injuries by 15 to 35 percent for employers who do not now have safety and health programs. At the15 percent program effectiveness level, this saves $9 billion per year in workers' compensation costs; at the 35 percent effectiveness level the savings are $23 billion per year.

Your workers' compensation carrier, jurisdictional and occupational safety staff, and your jurisdiction's workers' compensation agency can assist in developing a primary prevention plan.

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[34] OSHA (2012). *Injury and Illness Prevention Programs, White Paper* accessible at: https://www.osha.gov/dsg/topics/safetyhealth/OSHAwhite-paper-january2012sm.pdf

U.S. OSHA SAFETY PROGRAMS

OSHA's On-Site Consultation Program offers no-cost and confidential occupational safety and health services to small- and medium-sized businesses in all 50 states, the District of Columbia, and several U.S. territories, with priority given to high-hazard worksites. On-Site Consultation services are separate from enforcement and do not result in penalties or citations. Consultants from state agencies or universities work with employers to identify workplace hazards, provide advice for compliance with OSHA standards, and assist in establishing and improving safety and health programs.[35]

Through the Alliance Program [36], OSHA works with groups committed to worker safety and health to prevent workplace fatalities, injuries, and illnesses. These groups include unions, consulates, trade or professional organizations, businesses, faith- and community-based organizations, and educational institutions. OSHA and the groups work together to develop compliance assistance tools and resources, share information with workers and employers, and educate workers and employers about their rights and responsibilities.[37]

EMPLOYEE ENGAGEMENT

Corporate culture and employee engagement in safety plans create a collaborative environment where everyone is engaged in the prevention of injury/illness.[38]

PRIMARY PREVENTION: GERMANY

German Social Accident Insurance (DGUV) is one of the five pillars of the German Social Security System. It is compulsory insurance provided at the federal level and funded by employer contributions. It provides indemnification against employer liaibility, and supports prevention before rehabilitation and rehabilitation before compensation.

The German legislature has accorded the DGUV a strong and broadly formulated prevention mandate. It is legally empowered to use all suitable means to assure the prevention of occupational accidents, occupational diseases and work-related health hazards. The DGUV offers a wide range of mutually complementary prevention services which extend far beyond the traditional task of inspection. They include training, research, and consultancy. The objective is “Vision Zero,” since every single occupational accident and disease could and should be prevented.

Prevention is more than inspection, but without inspection prevention is a paper tiger

The DGUV labor inspectors inspect companies and provide comprehensive advice. Inspection generally begins with a preliminary meeting, inspection of the site, and a post-inspection meeting.

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[35] Learn more at https://www.osha.gov/smallbusiness/
[36] Learn more at https://www.osha.gov/alliances/
[37] Find an OSHA Plan: https://www.osha.gov/
[38] For a case study on how workplace safety and employee engagement can have positive outcomes, see Philips,D, Workplace Safety and Employee Engagement, Georgia Institute of Technology, Atlanta, Georgia, accessible at: https://pdfs.semanticscholar.org/d5b4/0c5e060e8324403f63c7db1c37a9ddb82d05.pdf

Deficits in the organization of occupational safety and health or technical deficits are noted and must be rectified by the company.

Consultation with companies is a key pillar of prevention activity

The DGUV has the statutory mandate not only of inspecting occupational safety and health in companies, but also of providing advice. A wide range of consultancy services are available for companies. The prevention experts can also be contacted with specific questions.

Legislation is the same for all companies, but differences exist in its implementation

The legislature has mandated the DGUV to issue accident prevention regulations of its own for companies. In addition, the DGUV can develop rules and informative publications that are geared to the particular requirements of certain sectors, small and medium enterprises (SMEs), or target groups (such as experts or insured individuals). Tailored prevention products are the solutions of choice. The objective is to support the companies with these rules and informative publications as they implement the OSH legislation and regulations.

Certification of products keeps producers and users safe

DGUV Test is a certification system maintained by the DGUV and includes 17 test and certification bodies that are specialized in particular sectors or product areas. The products are tested and certified in order to verify their compliance with the health and safety requirements before they are used in companies.

Information and communication ensure that knowledge is available right where it is needed: in the companies

Modern prevention involves providing companies and their internal and external OSH experts with information on developments which are relevant to the safety and health of the companies' employees. Communication of risks at an early stage is an important element by which acceptance can be generated for new technologies.

The aim of prevention research is to be better tomorrow than today

Research helps us to understand the causal relationships between work-related risks and exposures and their effect on individuals' safety and health. This allows us to interrupt this causality in the future. With research we ensure that we take evidence-based decisions and that our prevention measures are effective.

Training and education empowers people

Education is key for a culture of prevention and creates a positive attitude towards occupational safety and health at the very beginning of a career. In numerous seminars DGUV offers training for employees with responsibility for OSH within companies.

PRIMARY PREVENTION: ONTARIO

Health and Safety Excellence Program

The Workplace Safety and Insurance Board's (WSIB, Ontario) Health and Safety Excellence Program provides a clear roadmap to improve safety in the workplace, whether you are just getting started or want to improve systems and processes already in place. The program connects businesses of all sizes with WSIB-approved providers to help develop a customized action plan to address and prioritize health and safety gaps. .

Benefits include:

- Pandemic readiness materials, to help businesses meet the challenges of operating safely and helping people who have been injured at work return to work during a pandemic
- Support and guidance from an experienced provider to develop health and safety competencies
- Reduced risk of hazards and an improved health and safety culture in their workplace
- Rebates on premiums for successful implementation of topics from their action plan and further potential savings by improving their health and safety experience
- Non-financial recognition to show employees, customers, and investors their commitment to health and safety and increased profile for investing in health and safety
- Opportunities to network and share best practices with other like-minded businesses

The program has three levels – foundations, intermediate and advanced. There are 36 topics spread across the three levels.[39]

1. Foundations: Essential topics to start building their health and safety program. Examples of topics in foundations include: first aid, health and safety responsibilities and control of hazards.
2. Intermediate: Topics to build and customize their health and safety program or management system. Examples of intermediate topics include: emergency prevention and preparedness, return to work roles and responsibilities, and corrective action.
3. Advanced: Topics to integrate and optimize their health and safety management system. Examples of topics include: change management and procurement, health and safety continual improvement planning and external audit.

Businesses that successfully implement these topics will be positioned to apply for the Chief Prevention Officer's Supporting Ontario's Safe Employer's program (accreditation). .

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[39] *Health and Safety Excellence Program: Health and safety topics guide* (October 2019). Toronto, Ontario: Workplace Safety & Insurance Board (WSIB). Found at: https://www.wsib.ca/sites/default/files/2019-10/health_and_safety_topics_guide_oct-2019.pdf

Safety Incentives

The WSIB offers rebates and recognition to businesses of the Province of Ontario who join the Health and Safety Excellence Program and have worked hard to complete their health and safety topics.

Rebates

The Health and Safety Excellence program fits with the premium rate-setting model. Businesses with less ability to impact their rates (i.e. small business) will receive a 2 percent rebate per topic against total premiums. Businesses (medium to large) with more ability to impact their rates will receive a 1.4 percent rebate per topic. This is because these businesses will see greater reductions in their premium rates as their health and safety experience improves. Rebates are based on annual WSIB premiums. For small businesses, the WSIB offers a minimum rebate of $1,000 per completed topic. Larger businesses with high premiums are capped at $50,000 per topic.

Recognition

Aside from the financial rebate, businesses can also receive recognition badges to use on their website, email signatures and advertisements, to show others their commitment to workplace health and safety. Their badges will also show up on their business profile on the WSIB website (Safety Check) when people search for safety stats. In addition, there is an annual small business award recognizing the top three small businesses that commit to health and safety. There is a COVID-19 connection in 2020.

Employer Safety Councils

The WSIB works with a list of approved health and safety providers, within the province of Ontario, to offer the Health and Safety Excellence Program**.** Providers are private health and safety companies, health and safety associations and business associations approved by the WSIB to deliver the program to support workplaces in improving their health and safety. The Ministry of Labour, Training, and Skills Development (MLTSD) has a Prevention Council to provide advice to the Chief Prevention Officer (CPO) and Minister. The WSIB oversees the Health and Safety Excellence Program. The mandate for prevention is with the MLTSD.

Return to Work

Even with the best laid plans, a workplace injury may still occur. How your organization prevents needless work disability by utilizing a worker-centric intervention coupled with various supportive return to work tools, can have significant impact on your bottom line. Studies by the Workers Compensation Research Institute on outcomes for injured workers show that regardless of the severity of an injury, the longer an injured worker is away from their employer, the less likely they are to return to their employer at injury.[40] This can increase costs, lead to lower morale, and decrease

[40] See: https://www.wcrinet.org/areas-of-research/outcomes-for-injured-workers-st/#p/?cat1=&cat2=&cat3=82&keyword=&date=0

productivity. Below are a few simple tips to implement:

- Communicate quickly with your injured employee. Show them that you are concerned and that they are a valuable part of your team. Put yourself in their shoes. Your first conversation should not be an 'investigation' into the accident or what or who might be to blame.
- Look for ways to modify the worker's job (more details below).
- Set an expectation that you are confident that your employee can heal or recover while working.
- Stay in touch, even if a modified return to work isn't an immediate option.

In Germany, one of the employer's statutory duties is to conduct in-company integration management. In-company integration management is applicable generally, and not only in the event of an occupational accident or disease. In-company integration management has the purpose of restoring an individual's fitness for work as completely as possible, preventing unfitness for work from recurring, and enabling the affected individual to retain their job. In the wider sense, it has the function of protecting the health of the workforce. In-company integration management is a duty of the employer, and is conducted in the interests of all the company's workers.

Within the WSIB's Health and Safety Excellence Program, there are three topics in Level 2 (Intermediate), related to return to work. Once a business has completed Level 1 (Foundation), they will move onto the Intermediate level, where they will find these return to work topics:

1. Return to work program requirements, forms and tools
2. Return to work roles and responsibilities
3. Accommodation and return to work plans

In addition to the Health and Safety Excellence Program, the WSIB offers return to work and disability resources for businesses, including internal support via our Return to Work Specialists.

Early Return to work

Implementing an early return to work plan can reduce employee turnover, lower lost time and medical costs, and even prevent potential litigation. Early return to work can most swiftly occur by proactively approaching the medical provider with return to work options via functional job descriptions or job analyses, and asking risk-based questions pointed at medical contraindications to safely returning the worker to regular or transitional work. Examples of transitional duty work options are reduced hours, adjustment to regular job duties, temporary projects, and other modifications to assure the worker is working within the temporary work restrictions prescribed by their attending physician

Types of Medical Releases

Temporary Release: A temporary work release provides temporary work restrictions for a set period of time. These work restrictions may be updated throughout the treatment process as the worker's condition improves. Comparing the indicated restrictions to the worker's regular job description can provide you with information from which you can create temporary alternative work for the worker to perform while continuing their treatment.

Permanent Release: A permanent work release is a document from the attending physician that indicates the type of physical activities the worker is able to or prevented from performing on a permanent basis. This type of release is available once the attending physician determines that the worker is medically stationary and further treatment will not improve the worker's condition. This type of release is valuable in determining whether or not the worker is able to return to their job at injury or a new permanent job

CREATING A TEMPORARY ALTERNATIVE/TRANSITIONAL WORK PLAN

A transitional/alternative/temporary work plan, however it may be referred to, keeps an injured worker engaged by offering them "real" duties while they are recovering from their injury. Such a plan has many benefits to you, the employer. It is a significant step in lowering costs during the claims process. It can prevent a medical claim from becoming a lost-time claim. It can help you retain a valuable worker and ultimately can ensure the worker is more likely to transition back to regular duties. Data from the State of Oregon Employer at Injury (EAIP) Program, described in detail in "Return to Work Benefits and Incentives," demonstrates that employers who utilize EAIP for their workforce retain their injured workers at a level equal to or greater than workers with non-disabling claims.[41]

The costs involved with such a plan can be quite minimal. Utilizing the injured worker's skills and knowledge to assist with vital tasks in your workplace can keep the worker productive and engaged. Some states and insurers have programs to assist employers with costs associated with early return to work.

The State of Oregon EAIP, for example, can provide reimbursement for equipment and wage subsidy for time the worker spends performing the transitional work.[42] The State of Washington has very similar incentives available under their Washington Stay at Work Program.

Arkansas Rehabilitation Services offers consultation services for employers to address accommodation questions.[43]

For more resources to assist your organization with return to work, visit the Office of Disability Employment Policy (ODEP) website.[44]

In addition to providing early return to work opportunities, consider other strategies to keep your injured worker engaged and a part of your work process.

1. Provide consistent communication with your injured worker so they feel informed and up to date on the next steps in their return to work.
2. Allow, but don't require, that they listen in on team calls or provide them updates so that they feel part of the organization.
3. Collaborate with them to find appropriate early return to work opportunities.

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[41] See http://www.cbs.state.or.us/external/imd/rasums/2362/14_updates/pdf/chapters/rtw-chapter.pdf
[42] See https://wcd.oregon.gov/rtw/Pages/eaip.aspx
[43] Learn more at https://arcareereducation.org/services/arkansas-rehabilitation-services/access-accommodations/stay-at-work-return-to-work
[44] Learn more at https://www.dol.gov/agencies/odep/program-areas/employers/saw-rtw

4. Conduct post-resolution surveys of injured workers to identify strengths and weaknesses of your return to work process.

Best practices for an early return to work plan:

- Maintain current job descriptions and create transitional work plans in advance. Identify key tasks, equipment needs, and training needs prior to their use. Having a ready plan creates time and cost savings. Your insurer may offer financial incentives for having a transitional work plan for your organization.
- Communicate often with your workers' compensation insurer and injured worker to assure you are current on all medical releases for your worker. Knowing what the worker is released to perform will allow you to be flexible and proactive in providing valuable and productive transitional work.
- Provide open communication with your injured worker to keep them up to date on your plans for their transitional work.

RETURN TO WORK BENEFITS AND INCENTIVES

Effective return to work can benefit an organization with savings related to lower claims costs, decreased absenteeism, and higher production. In addition, there are a number of incentives available to increase the value of a solid return to work plan for the employer at injury. Including recruitment of previously injured workers in your workforce recruitment plans can provide skilled, experienced workers who also bring valuable incentives with them.

Hiring a previously injured worker may provide eligibility for the U.S. Federal Work Opportunity Tax Credit.[45] This credit provides an incentive for hiring individuals from certain target groups who have consistently faced significant barriers to employment. This benefit can be added to other incentives that may be available through state programs.

The State of Oregon Preferred Worker Program may be applicable if the worker's treatment ends without a full release to their job at injury due to permanent work restrictions. This program provides lifetime assistance that can provide permanently modified work and employment incentives for their employer at injury or for new employment.[46] Visit their website to hear from a preferred worker whose injuries required him to seek an entirely different type of employment and how the preferred worker program assisted.

Washington State Department of Labor and Industries also has a Preferred Worker Program that provides premium relief, incentive payment, and some costs of tools, clothing, and equipment the worker needs to do a new permanent job.[47] Visit their website to learn how a veterinary clinic utilized the program to bring on a skilled vet tech.

[45] Learn more at https://www.dol.gov/agencies/eta/wotc
[46] Learn more at https://wcd.oregon.gov/rtw/pages/pwp.aspx
[47] Learn more at https://lni.wa.gov/claims/for-employers/employer-incentives/preferred-worker-program

North Dakota offers a Preferred Worker Program as well.[48] They offer a number of benefits to eligible employers that assist with cost savings and risk reduction related to the hiring of a preferred worker.

Incentive schemes are used by the German Social Accident Insurance (DGUV) to motivate employers to make particular efforts in prevention. The schemes are intended to strengthen employers' motivation by increasing the benefit and reducing the cost. The most important incentive schemes offered by the DGUV include:

- Surcharges and discounts on premiums
- Financial contributions to innovative measures to improve occupational safety and health
- Awards for special prevention activities
- Quality seals and other forms of recognition

Other benefits DGUV offers to employers include:

- Training grants for the performance of in-company training
- Integration grants
- Grants for working aids in the company
- Partial or full reimbursement of the costs of trial employment

LABOR AND MANAGEMENT COLLABORATION IN RETURN TO WORK

Supported by research and literature, labor-management collaboration is an essential feature of successful disability management programs. Employers increase the likelihood of a program's success when they involve unions in the planning, implementation and evaluation of such programs, and in coordinating the return to work of employees. Labor-management collaboration can improve labor relations, improve union and employee buy-in for the program, and reduce the human and financial costs of disability. Employers may use several strategies to secure union cooperation, particularly a joint labor-management committee that oversees the program. Employers who do not involve unions risk grievances based on a failure to meet their legal obligation to accommodate employees, a failure to achieve the buy-in of employees, and increased work disability costs.

Relationships are the means by which the timely and safe return to work of an injured or ill employee to the workplace can be achieved. In order for an employee to be successfully returned to work, collaborative and positive working relationships must exist between the disability management coordinator, the employee, supervisor, union, health care providers, and other internal contacts, to name a few. Work disability prevention involves all parties to support from the beginning of the employer/employee relationship.

An organization's culture must support the relationships in the return to work process. The relationship between management and the union is therefore a critical component in the creation of work disability prevention programs and return to work coordination that are based on ongoing and supportive relationships Joint labor-management collaboration is an essential feature of successful work disability prevention programs. Moreover, employers can use a variety of methods to secure the

[48] Learn more at https://www.workforcesafety.com/return-work/preferred-worker-program

cooperation and collaboration of unions, particularly the use of a joint labor-management advisory or steering committee that oversees the program

If an employer chooses to involve the union, the next choice is what form the involvement will take. The degree of union involvement in work disability prevention and return to work programs ranges from no involvement to involvement in:

- Individual return to work coordination only;
- Choosing a consultant to perform a needs assessment and to develop the program;
- A needs assessment as a precursor to developing the program;
- Selecting the work disability prevention coordinator;
- Providing feedback on a program design and a fully developed set of policies and procedures, already built by the employer;
- Developing the program, including policies and procedures;
- Implementing the program;
- Evaluating the program; or
- Every aspect of the program.

PRACTICAL APPLICATIONS OF LABOR AND MANAGEMENT COLLABORATION

The State of Oregon Management – Labor Advisory Committee (MLAC) provides an effective forum for business and labor to meet, explore, and resolve issues involving the workers' compensation system.[49] Workers' compensation issues are often adversarial, creating uncertainty for both workers and employers. The Oregon Legislature created the committee as part of the reform of the workers' compensation system in 1990.

A jurisdiction may also allow a carve-out. Carve-outs are a process by which union and management agree, through a collective bargaining agreement, to maintain their own medical delivery and dispute resolution process.[50] Through the carve-out program, the participating organizations must at least meet the workers' compensation benefits and standards set by the jurisdiction. .

California's Joint Labor-Management Body

The Commission on Health and Safety and Workers' Compensation (CHSWC) within the California Department of Industrial Relations is a joint labor-management body that conducts a continuing examination of the workers' compensation system and of the state's activities to prevent industrial injuries and occupational illnesses.

Established in 1994, CHSWC serves as a crucial forum for issues, ideas, and recommendations designed to benefit key stakeholders and the economy, it has directed its efforts toward projects and studies to identify opportunities for improvement and to provide an empirical basis for

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[49] Learn more at https://www.oregon.gov/dcbs/mlac/Pages/mlac.aspx
[50] For more information about carve outs, see *How to Create a Workers' Compensation Carve-Out in California: Practical Advice for Unions and Employers* prepared for the California Commission on Health and Safety and Workers' Compenations, 2006 avaialbe at http://lohp.org/wp-content/uploads/2013/10/carveout.pdf

recommendations and/or further investigations. Many individuals and organizations participate in CHSWC meetings and serve on advisory committees to assist CHSWC on projects and studies. [51]

In addition to conducting research and serving as a forum for stakeholders of the workers' compensation and health and safety system, CHSWC administers the statewide Worker Occupational Safety and Health Training and Education program (WOSHTEP).[52] WOSHTEP includes the provision of injury and illness prevention trainings and educational safety materials for both workers and employers. The program's activities and material development are guided by its labor-management advisory board that provides links to the target audience and broadens partnerships with the employer, worker, other members of the health and safety communities. [53]

[51] https://www.dir.ca.gov/chswc/
[52] https://www.dir.ca.gov/chswc/woshtep.html
[53] https://www.dir.ca.gov/chswc/Reports/2019/WOSHTEP_AdvisoryBoardAnnualReport2019.pdf

The Government/Regulator

Objective: Governments, including regulators and legislators, need to support and encourage investments in work disability prevention and return to work through sound public policy, engagement, and collaboration with workers' compensation stakeholders in order to support economic growth and promote a healthy society.

This guide can help both jurisdictions who have implemented work disability prevention and return work programs, as well as those that may not have established programs or strategies.

There are different approaches a jurisdiction may take to implement these programs, ranging from a statewide approach to a program that provides support and resources for individual employers that want to develop work disability prevention and return to work programs for their employees.

For purposes of this guide, "government/regulator" includes all three branches of a jurisdiction's government – executive, legislative, and judicial.

Benefits of Work Disability Prevention and Return to work Programs for Jurisdictions

Work-related injuries impact a jurisdiction in a number of ways:

- Less economic productivity – increased labor costs, disrupted business operations, decreased individual spending.
- Reduced tax base – injured workers are not earning taxable income, or are earning a reduced level of income.
- Impact on other social support programs – injured workers who do not return to work are likely to turn to other programs for support including disability, healthcare, and government assistance.
- The general well-being of the jurisdiction's residents is negatively affected when injured workers do not return to the workplace.

The jurisdiction is in a unique position to be able to bring key stakeholders together and facilitate a dialogue regarding work disability prevention and return to work. In addition to balancing the needs of the injured worker and the employer, by facilitating the development of effective work disability prevention and return to work programs, the jurisdiction can affirmatively work to overcome perceptions of government as impersonal, bureaucratic, and inefficient.

Strategies for Implementation

Listed below are various strategies a jurisdiction may want to explore in the development and support of work disability prevention and return to work programs. Keep these points in mind:

- One size does not fit all. Every jurisdiction is different and every jurisdiction's workers' compensation system is different. The current system and the political and economic climate will influence which strategies may be implemented, to what extent.
- Strategies may need to be adapted to suit the individual characteristics of a particular jurisdiction.
- The strategies may be explored individually. Jurisdictions may want to take a "mix and match" approach, or the strategies may spark entirely new ideas.

DISSEMINATE INFORMATION BEFORE AN INJURY OCCURS

The jurisdiction can disseminate information to key stakeholders about what programs and benefits are available in the event an injury does occur.

LEAD BY EXAMPLE

A jurisdiction that has work disability prevention and return to work programs for public employees can use those programs as models for private employers. It is important to involve public employee unions in program development to ensure the programs adequately consider and balance the interests of employees with the interests of the jurisdiction.

EDUCATE LEGISLATORS

Legislators who will review and vote on any legislative proposals affecting work disability prevention and return to work programs may not be very familiar with the jurisdiction's workers' compensation system or the benefits of returning workers to work. Before any proposals are introduced, to provide context and set the stage, the regulator can offer information to individual legislators or legislative committees about the benefits of reintegrating injured workers into the workplace. Be sure to identify the just cause of work disability prevention and that is to prevent the human, social, and economic harm. Then list the why's of the just cause (i.e. economic growth, increase tax pay base, healthy and productive communities, etc.

LEGISLATIVE POLICY STATEMENT

A legislative package regarding work disability prevention and return to work should include a policy statement that will guide key stakeholders in the development and implementation of said programs and to inform future policymakers of the intent.

REMOVE LEGAL BARRIERS AND ALIGN LAWS

Existing laws outside of workers' compensation may unintentionally create barriers to successful implementation of a return to work program ("bureaugenic" or system-created disability). For example, limitations on the exchange of health information intended to protect a patient, or restrictions on communications between treating physicians and claims administrators, can prevent the exchange of

information between the provider, claims processor, and employer necessary to create a modified job within the worker's medical restrictions, thus compounding the work disability problem. A jurisdiction will want to review its laws for possible barriers and consider proposing exceptions where possible to facilitate the success of a return to work program.

A jurisdiction will want to make sure its laws in the areas of workers' compensation, employment, anti-discrimination, and work disability prevention are aligned to ensure that workers and employers can fully participate in return to work programs without affecting other benefits or having unintended consequences in other areas. .

ADMINISTRATIVE STRATEGIES

Depending on the jurisdiction, strategies that are within the authority of the regulatory agency to implement may be used in the absence of, or in addition to, specific legislation.

- Require claim processors to provide information about return to work to injured workers and employers, including the benefits of return to work, how to access benefits, and how to make the process successful for everyone involved.
- Treat work disability as a separate condition, developmental in nature, that requires unique interventions to address its own unique contributing factors. A worker-centric approach is the recommended evidence-based model.
- Identify the appropriate stakeholders to delivery worker-centric work disability interventions and provide evidence-based/evidence-informed education and practical application training on how to properly apply said interventions.
- Prescribe forms that include necessary information to facilitate communication, such as a Medical Status Form, Return to Work Status Form, or Work Disabilituy Assessment Form, and be sure to include the worker in the discussion.
- Provide timeliness standards for properly-trained claim processors and employers to encourage early contact and interventions with the worker, regular contact with the provider, and required follow-up.
- Establish standards for service providers including qualifications, certification, a code of conduct, and continuing education requirements that align with an evidence-based worker-centric work disability prevention model.
- If dispute resolution becomes necessary, encourage a focus on return to work.
- Require that specific language be provided to the worker about return to work options.
- Encourage collaboration among the parties.
- Don't allow workers to waive rights to return to work benefits.

PUBLIC POLICY

Successful work disability prevention and return to work programs need to consider the interests of workers and employers. Some jurisdictions may consider the injured worker's interest before the employer's interest; others may try to keep both interests in balance. In either situation, the jurisdiction should get input from representatives of both labor and management in the development and implementation of said programs. A standing body that can monitor the system, advise the legislature

and the regulatory agency, and make recommendations for improvement can be an invaluable resource.

If a labor-management committee is in place, a subcommittee can be formed to focus on work disability prevention and return to work issues. Even if a labor-management committee is not formalized, a jurisdiction can seek the advice of labor and management representatives on an ad hoc basis.

INCENTIVE PROGRAMS FOR EMPLOYERS

Many jurisdictions have incentive programs for employers to provide return to work opportunities to their injured employees.

North Dakota's Preferred Worker Program encourages the re-employment of injured workers and offers cost-saving incentives to employers participating in the program. Benefits available include premium exemption; wage reimbursement; claim cost exemption; worksite modification; work search allowance; certification, licensure, or related testing costs; moving expenses; lodging, meals, and travel expenses; tools and equipment; and union dues.

Ohio Bureau of Workers' Compensation (BWC) Transitional Work Grants Program is designed to help employers develop a transitional work program that's right for their business and their employees. Components of the program include company analyses and job analyses of employees' job tasks; labor-management collaboration; policy and procedure development, which includes a community resource directory and training of management, supervisors, and workers; and program evaluation for effectiveness.

Ohio Bureau of Workers' Compensation (BWC) Transitional Work Bonus Program provides eligible state-fund private employers with an approved transitional work plan a bonus for using the plan to return injured workers back to work.

Oregon's Employer-at-Injury Program (EAIP) encourages the early return to work of injured workers by helping lower the employer's return to work costs and claim costs. Incentives include wage subsidy, worksite modification, purchases of tools and equipment, and early return to work purchases.

Oregon's Preferred Worker Program (PWP) helps qualified Oregon workers who have permanent restrictions from on-the-job injuries and who are not able to return to their regular employment because of those injuries. Benefits include premium exemption, claim cost reimbursement, wage subsidy, employment purchases, and worksite modification.

Washington's Preferred Worker Program provides financial incentives when an employer hires a preferred worker for medically-approved, long-term jobs. Incentives include financial protection against subsequent claims, premium relief, incentive payment for continuous employment, wage reimbursement, and the costs of tools, clothing, and equipment needed to do the job

Washington's Stay at Work Program provides incentives to employers who provide temporary, light-duty jobs for injured workers while they heal. Incentives include reimbursement for wages, training, tools, and clothing

OMBUDSMEN

Several jurisdictions, including Florida, Texas (Office of Injured Employee Counsel), Oregon, and New York (Advocate for Injured Workers) have ombudsmen programrs to help workers and employers navigate the workers' compensation and return to work processes.

TRAINING AND OUTREACH

The jurisdiction can provide easy-to-access work disability prevention tools for employers, such as model return to work policies, sample forms, and online toolkits.

A jurisdiction can publish web pages that provide information:

- For workers about why returning to work is beneficial and how to work with their doctor
- For employers describing the benefits and incentives available, how to access them, and dispel myths within the system
- For health care providers
- For vocational professionals
- Video messages
- Online guides
- Posters
- Best practices
- Examples of successful work disability prevention and return to work programs

A jurisdiction can employ technical consultants that are available to provide advice and assistance to employers and workers.

A jurisdiction can actively look for opportunities to speak to stakeholder groups about work disability prevention and return to work by attending conferences or enlisting the assistance of organizations and associations for employers, businesses, providers, unions, attorneys, and insurers.

Germany's "Budget for Training" progam provides benefits for participation in working life. It is granted to disabled persons who are entitled to benefits during the entrance procedure and within the vocational training provision of a sheltered workshop, and whom a private or public-sector employer has offered an apprenticeship subject to social insurance contributions, leading to a recognized or other vocation. The budget comes into effect with the contract governing the apprenticeship. The Budget for Training covers reimbursement of the training allowance and costs for instruction and supervision at the apprenticeship and in the vocational college, where necessitated by the disability.

Collaboration

Collaboration with other agencies within the jurisdiction that provide services to individuals with disabilities and to workers can be beneficial in a number of ways. The agencies may include:

- Workers' compensation
- Employment
- Vocational rehabilitation
- Social services
- Mental health and drug treatment
- Veterans

Someone who is injured at work may interface with one or several of these agencies, depending on the individual's circumstances. To the extent that they provide overlapping or similar services, the agencies should work together to be sure to provide a consistent message, avoid duplication, and make the process as easy as possible for the individual to navigate.

These other agencies may also have programs aimed at their own clientele that can serve as models for programs for injured workers, and vice versa.

Participate in Multi-Jurisdictional Associations

Associations that have a diverse membership of workers' compensation jurisdictions and stakeholders provide a forum for the exchange of information across jurisdictions, including best practices, new ideas, and lessons learned. See the appendix for a list of organizations. For jurisdictions considering work disability prevention and return to work programs, participation in these types of associations can be a great help.

Monitor Performance

The jurisdiction can collect, track, and publish data on work disability prevention and return to work. The data can be used to monitor, evaluate, and adjust efforts to continuously improve outcomes and to share successes with policymakers.

The Insurer

Objective: The insurer is responsible for preventing work disability by coordinating workers' compensation claim services efficiently and effectively to promote safe and early return to work.

Insurer and TPA Interviews: Understanding Return to Work Processes

Insurance carriers and third party administrators (TPAs) were interviewed in an effort to develop a better understanding of their return to work processes. The focus these companies relayed during our interviews was on training, customer service, compliance, state regulations, and best practices. The common thread was delivering exceptional customer service, developing relationships with the employer, and establishing partnerships with vendor partners to achieve optimal outcomes. *NOTE: Customer service should not be viewed as a proxy for worker engagement and activation.*

Training

All the companies interviewed indicated the focus for claims training needed to be centered on communication and collaboration with all stakeholders and adhering to best practices. Best practices incorporate educating claims staff on establishing compensability by completing three-point contacts upon first report, properly reserving the file for exposure, and adhering to state regulations. Some have adopted best practices that employ a worker-centric work disability prevention model. Others apply a worker advocacy model.

Most carriers have the new claims professionals participate in 60 days of intense training. This training consists of claims and disability management or work disability prevention, and medical management including common diagnoses and treatment plans based on evidence-based medicine (EBM) and occupational disability guidelines (ODG). The utilization of comprehensive resources is essential in managing claims to achieve optimal outcomes and mitigate cost. The take away is the importance of not only basic file management but to include medical management, work disability prevention, and resources to be utilized to facilitate return to work.

These resources can consist of utilization of ODG, EBM, Centers of Excellence, Pharmacy Benefit Management programs, and other vendor partners. Several of the carriers interviewed utilize predictive analytics to identify claims with cost drivers that could potentially have a negative impact on the file direction. The file is alerted based on the severity of the work disability condition that is in part based on biopsychosocial history obtained from the injured worker; identifying red and yellow flags, comorbidities, and potential motivation issues. These indicators can predict the trajectory of the claim, absent a worker-centric work disability intervention, with the anticipation that the claim professional can utilize their resources to mitigate cost. These initiatives can realize a timely and medically appropriate return to work and significant cost savings.

Return to Work

The ultimate goal for any workers' compensation system should be achieving return to work. The carriers and TPAs interviewed all handle this differently, some have strong return to work programs in place and, for others, return to work just occurred. To most effectively achieve return to work, insurers

should establish rapport with the employer at the time of the first report of injury, obtain the job description and identify the availability of modified duty. It is important to communicate early in the claim with the worker and employer to identify return to work expectations, values, and concerns. It is also important to assess transitional duties, a retraining program, or learning whether learning a new skill set, etc. is possible. This should be an area of focus in claims handling as work disability prevention strategies and return to work are key in mitigating cost while achieving optimal outcomes for workers and employers.

Some of the insurers interviewed discussed using volunteer programs to transition an employee back to work. This has been successful in motivating injured workers to visualize their ability to return to work as they participate in this volunteer position. The injured worker is functioning daily in a work environment and can be offered progressive return to work as their functional capabilities increase. This can also be effective in obviating the need for work hardening. Vocational rehabilitation can also be used in conjunction to provide worker-centric work disability prevention services and to facilitate return to work when the injured worker is unsure of their expectations, values, concerns, or ability to return to work or when there is a discrepancy between what the employer and injured worker believe the functional requirements of a position entail.

COMMUNICATION

Communication with the provider is crucial. Consideration should be given to field case managers meeting with the injured worker and physician to discuss the functional requirements of the job of injury, or transitional duties, and focusing on what the injured worker can do. Having this conversation with the provider at the first visit is essential in preventing needless work disability.

Most of the companies interviewed are just beginning to utilize social media for education of their clients. A mix of social media and development of a resource library accessible via the client website should be incorporated to reinforce the need for and concepts of a robust return to work program.

Training of the employer is primarily provided by the underwriting team at the time of client initiation. Most claims professionals or claims managers were not able to describe the type of training the employers receive. There was a definite disconnect between the sales, underwriting, and claims divisions. There is a need for these three teams to work together at the time of client initiation, but also, more importantly, as the claims are managed. The benefits of working towards a timely return to work can be stressed by all three teams, and the benefits of coordinating a timely return to work from the financial aspect can be emphasized in real time by the underwriting team.

Insurers should also consider developing a network of “5 star” or “top tier” treating physicians. This approach is becoming a reality with the advent of data analytics. Providing the physician with information regarding the functional requirements of a position, potential alternative positions and commitment to bring the injured worker back to work whenever medically appropriate are essential. Develop a line of communication with each physician office.

CASE MANAGEMENT

Telephonic case management (TCM) can be an effective adjunct to a claim professional’s interventions. Most of the companies interviewed have in-house TCMs with variations noted as to

when the TCM is engaged. A very effective approach seems to be having the TCMs assigned to specific claims teams with access to the claims as they are initiated. The TCM is then able to obtain a biopsychosocial history of the injured worker and develop a care plan appropriate for potential co-morbidities, red flags, and barriers to look for and overcome as needed. The TCM should look at their role as an adviser and resource person for the claims professional.

The TCM should also be cognizant of when it is appropriate to engage the services of a field case manager. In many cases, the TCM can effectively work with a field case manager to provide in-person assessments of the worker, communication with the physician, or meet with the employer. If the TCM works mainly as an advisor for a claims team, then a full field-based case assignment may be the best approach to ensure continuity for complex claims.

Summary

In summary, measure and demonstrate the value of your initiatives and utilization of best practices for each case:

- Track and analyze return to work data. This is essential.
    - Evaluate opportunities for return to work.
    - Document when the physician anticipates return to work.
    - Document when the claims professional might anticipate return to work (per ODG, ACOEM, or similar guidelines).
    - Track the actual return to work dates.
    - Analyze this data, looking for areas of discrepancy and determining if any actions need to be taken to minimize these discrepancies.
- Offer transitional duty if the employer cannot accommodate modified duty.
- Evaluate whether a more effective utilization of case management could minimize these discrepancies.
- Evaluate the cost of treatment, the physician's commitment to return to work and adherence to projected treatment plans. Evaluate and utilize physicians who meet these goals.
- Develop a method of communication between sales, underwriting, and the claims departments to assess opportunities for improving the employers' engagement in the return to work process.

Strategies for Promoting Best Practices in Medical Care

Using the same **TRACK** approach as in the provider section, following are strategies for insurers to use in promoting best practices in medical care.

Treatment

In addition to the approaches outlined above, there are strategies specific to medical providers that can make it easier for them to participate in the workers' compensation system and to ensure their injured worker patients have access to appropriate resources and interventions. These are outlined below:

- Pay for value – permit documentation to follow guidelines emphasizing occupational medicine best care, such as the documentation and coding reforms proposed by ACOEM rather than CMS rules.[54]
- Share information from treatment and disability guidelines EARLY with treating doctors. This information can serve as a guide to assist early in care, to use in considering transitional work opportunities, and at other steps rather than later when things have already gotten off track.

REFERRALS

- Permit concurrent care with primary providers who have demonstrated the willingness and ability to effectively coordinate care and return to work efforts.
- Be accessible and flexible in authorizing unusual referrals if the treating provider supplies good rationale.
- Develop relationships with mental health providers willing to take workers' compensation insurance and provide work-focused treatment.
- Facilitate access to needed referrals – be proactive in noting intent to refer - suggest alternative providers to treating provider when you are aware of practices that get better patient outcomes.

ACTIVITIES

- Share job tasks with the treating provider.
- Assign a case manager, return to work coordinator, or other specialist to intervene with the employer and obtain cooperation with release to return to work.
- Seek help from other experts if needed (e.g. the Job Accommodation Network, an ergonomist).

COMMUNICATION

- Provide templates that are easy to complete to gather needed information from treating providers.
- Pay providers for the time it takes to complete forms with care.
- Communicate clearly with providers about policies and procedures in managing patients, billing, and authorizations.

KNOWLEDGE

- Consider reimbursing for educational materials that cost money (e.g. pain workbooks). Consider providing quality patient educational materials related to common clinical problems (e.g. the Back Book) to preferred providers, for distribution.

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[54] Cloeren, M., Adamo, P., Blink, R., Burress, J., Galloway, L., Glass, L., . . . Peplowski, B. (2016). Defining Documentation Requirements for Coding Quality Care in Workers' Compensation. *Journal of Occupational and Environmental Medicine*, 58(12), 1270-1275.

Appendix A: Additional Resources

General Resources

- ISSA Guidelines: The Return on Work Reintegration. 2017. International Social Security Association. Found at https://ww1.issa.int/guidelines/rtw.

Caregiver Resources

- Consider using some of the content in the patient education pamphlet produced by Washington State Department of Labor & Industries found at www.Lni.wa.gov/go/F200-001-000. The patient handout produced by the 60 Summits project is another good resource for patients.

Employer Resources

- Project: Return to Work Inc. (R2W): https://return2work.org/
- Job Accommodation Network: https://askjan.org/
- Interational Labour Organization, Global Business and Disability Network: http://www.businessanddisability.org/
- State of Oregon Employer-at-Injury Program: The State of Oregon Employer-at-Injury (EAIP) encourages early return to work by enhancing an employer's ability to return an injured worker to their workforce through worksite purchases and wage subsidy.[55] Practical applications of EAIP usage would be a hospital being reimbursed for the cost of a motorized bed mover to allow a nurse to continue assisting patients while being treated for a knee injury, a truck driver who was able to be trained on dispatch software while treating for a shoulder injury that kept him from securing his loads, or a roofer not released to climb ladders having 45% of his wages reimbursed for 66 days while providing site safety monitoring. All of these workers continued to provide value to their employer and receive a paycheck rather than time-loss payments while treating for their injuries. If released back to their job at injury, these workers can resume their regular work and the employer may keep any purchases related to the transitional work for use with future injured workers. https://wcd.oregon.gov/rtw/Pages/eaip.aspx
- WSIB return to work and disability resources: http://www.businessanddisability.org/
- WSIB Health and Safety Excellence program: https://www.wsib.ca/en/healthandsafety
- California Commission on Health and Safety and Workers' Compensation's Worker Occupational Safety and Health Training Education Program (WOSHTEP) provides injury prevention materials for small employers: https://www.dir.ca.gov/chswc/WOSHTEP/iipp/

[55] Learn more at https://wcd.oregon.gov/rtw/Pages/eaip.aspx

GOVERNMENT/REGULATOR RESOURCES

- Participating in multi-jurisdictional associations to facilitate the exchange of information, strategies, and programs can be beneficial to a regulatory agency. Following are several associations to consider (this is not an exhaustive list):
    - International Association of Industrial Accident Boards and Commissions (IAIABC)
    - American Association of State Compensation Insurance Funds (AASCIF)
    - Disability Management Employer Coalition (DMEC)
    - International Social Security Association (ISSA)
    - American Colleage of Occupational and Environmentam Medicine (ACOEM)