Submission
No 169

INQUIRY INTO NSW WORKERS COMPENSATION SCHEME

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Joint Select Committee on the NSW Workers Compensation Scheme
Parliament House
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Dear Sir/Madam

This is a joint submission on behalf of **Professor Michael Nicholas** (Pain Management Research Institute, University of Sydney/Royal North Shore Hospital); **Professor Chris Maher** (Musculoskeletal Division, George Institute/University of Sydney); **Associate Professor Fiona Blyth** (Pain Management Research Institute, University of Sydney/Royal North Shore Hospital); and **Dr Garry Pearce** (Director, Rehabilitation Services/STAHS, previously from Concord Hospital).

We fully support the seven reform principles in the terms of reference document and would like to take the opportunity to make the following suggestions to best deliver those reforms.

1. Change the name of the scheme so that it highlights the primary aims

These schemes should be about promotion of workers' health and wellness, injury prevention and effective rehabilitation so that workers can stay actively engaged and productive at the workplace. Unfortunately, for some workers the scheme fails and they suffer a catastrophic injury that prevents return to work; and compensation is a fair expectation. However, the vast majority of injured workers suffer relatively minor (soft-tissue) injuries. Yet a small but significant proportion of these workers become long-term disabled and contribute disproportionately to the costs of the scheme. Our submission is concerned with proposals to help this group achieve earlier and sustained return to work. Associated with this goal we would recommend that the term 'compensation' be removed from the scheme's title and it be replaced with words that more accurately reflect its aims (eg. 'rehabilitation' or 'disability prevention').

It has always struck us as questionable that the scheme's name focuses on failure and loss rather than focusing on the clear positives that the scheme is primarily aiming to achieve for the worker and employer. Some would say that there is nothing substantive in a name but we would disagree. In our view, so long as WorkCover continues to name the scheme a 'compensation scheme' they risk overlooking the key positive messages of the scheme

2. Innovation requires investment in research and development

For WorkCover to achieve innovation it will need to invest in research and development and have a culture that values R&D. Most large businesses in

Australian invest in research and development but our experience is that this has not been a priority for WorkCover in the last decade.

A concrete example of this relates to the fifth reform principle that concerns supporting less seriously injured workers to recover and regain their financial independence. There is growing evidence that psychological (personal) and environmental (work-place) factors make a more significant contribution to delayed RTW and disability than physical symptoms in those with soft tissue (minor) injuries (Chou et al., 2010; Mallen at al., 2007). Yet, these aspects appear rarely assessed and even less rarely addressed by primary care practitioners in NSW (see WorkCover report on *Barriers in Returning to Work*, 2005; Cohen et al., 2000; Williams et al., 2010).

Nevertheless, there is growing evidence that if these personal and environmental factors are identified and addressed in the first few weeks after initial injury, then improved RTW (and reduced costs) can be achieved (Nicholas et al., 2011; Whitfill et al., 2010). Let us illustrate with a local example:

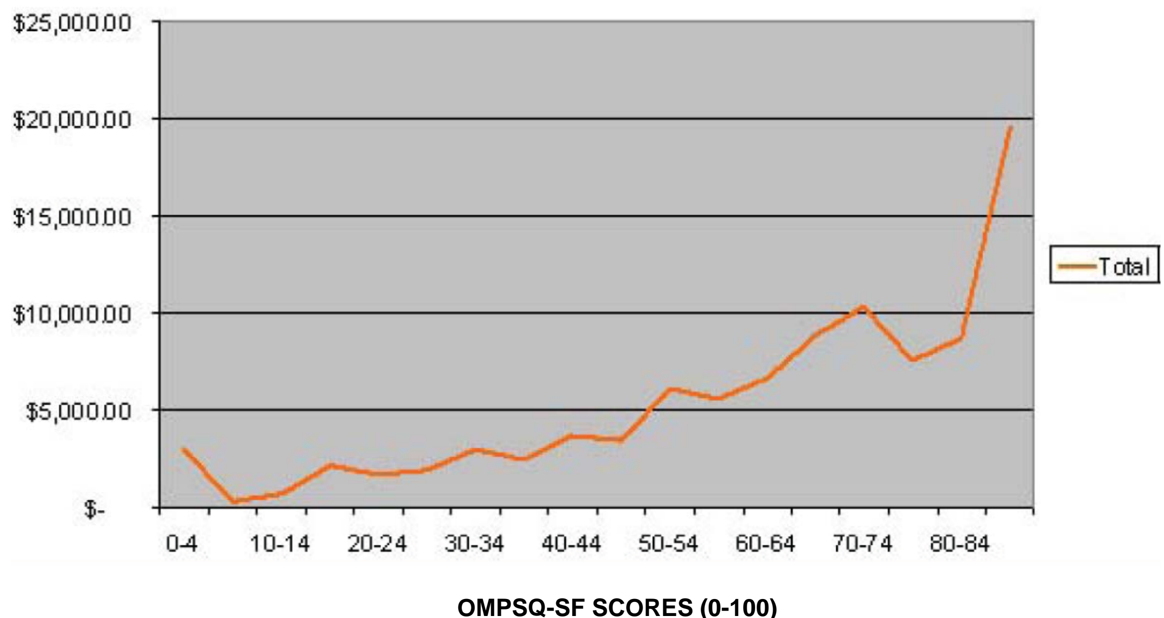
Retention of the health workforce is a major problem for the Ministry of Health. A pilot study (with 160 injured hospital workers) completed at Concord Hospital 4 years ago demonstrated that most of those at high risk of delayed RTW could be identified with a brief screening instrument within 48 hours of the initial injury, and when a brief, protocol-based intervention/management plan was instituted the costs of these high risk cases were reduced by 25% within the first year after injury (Pearce et al., 2008). This finding was consistent with overseas' evidence, but needed to be evaluated locally.

Subsequent to this 'proof of concept' study, a consortium of researchers (led by our group) applied to WorkCover NSW in 2009 to fund a rigorous randomized controlled trial to scale up the approach used at Concord Hospital to a larger population in collaboration with the insurance agent (EML) and the employer (NSW Health). The Insurer agreed to participate and to put up half the funds (roughly $140,000); NSW Health agreed to participate; and so did WorkCover management (Injury Management Division) (verbally), but almost 3 years later WorkCover has still not provided their share of funding for the project. The Insurer (EML) and NSW Health are still willing to participate but WorkCover has been silent – despite several meetings and enquiries.

If that research project had been supported by WorkCover in 2009 the results would now be available and we could have good local evidence for (or against) this approach. Instead, we will have to rely on overseas' evidence and the original pilot project at Concord Hospital. The cost of this project is very modest and the Concord Hospital pilot indicated the savings from a successful trial could be rapidly recovered anyway, not to mention the savings made by avoiding more long-term claims.

Most recently, one of our group (Professor Nicholas) has been assisting one of the current NSW WorkCover Scheme agents (Xchanging) to conduct a pilot project aimed at confirming these overseas' findings. Initial data from just under 500 cases assessed over the telephone by claims staff (trained by Nicholas) using a brief psychosocial risk scale (the OMPSQ: Linton et al., 2011) within 3-5 days of notification (of claim) reveal that by 6 months those with higher scores (over 60/100) cost the scheme substantially more than those with scores under 60/100. Figure 1 illustrates this trend.

Figure 1: Mean total costs of claims (at 6 months from injury) with increasing scores on baseline OMPSQ-SF with 498 claimants with soft tissue injuries (Xchanging, 2012)



OMPSQ-SF SCORES (0-100)

The costs measured relate primarily to lost time and medical treatments. The key point is that these data can be readily obtained within days of an injury being reported and they reflect factors such as beliefs, fears, level of distress and pain – all of which are amenable to change (as has been demonstrated – see Nicholas et al., 2011). To the extent that these factors are delaying RTW and driving up costs, it means, with appropriate interventions, these higher costs should be avoidable (as was demonstrated at Concord Hospital).

The Xchanging pilot project applies the Concord Hospital approach in a different setting, and demonstrates that it is viable for relatively little cost to identify injured workers at higher risk of delayed recovery (and higher costs) due to psychosocial factors. Xchanging, with input from Professor Nicholas, is currently implementing the next stage of this pilot given the significance of the data collected so far. Preliminary results will be available in August 2012.

The critical step after that, of course, is to test a scaled-up version of the Concord protocol to confirm the pilot study's findings and guide its broader application across the scheme. The insurer can also contribute to this process and Xchanging has just commenced a trial of a pilot protocol on its own management approach to this end.

3. Innovation requires the translation of research findings into practice, and a practice-informed research agenda.

We outline some of the challenges that WorkCover faces in achieving progress towards the seven reform principles that can only be overcome by a commitment to R&D and its application to practice,

There is a lack of research translation at the primary prevention level

The first reform principle appropriately encourages injury prevention but this is a little more complex than it first seems. For example with back pain, a very common workplace injury, the traditional prevention approaches probably don't work but new methods do. The Cochrane reviews of workplace interventions (van Oostrom et al 2009) and lumbar supports (van Duijvenbode et al 2008) have failed to support these traditional LBP prevention approaches. In contrast the Cochrane review of exercise (Choi et al 2010) concluded that exercise can prevent low back pain. This provides a good example of the importance of fresh thinking, informed by research.

Key measures of primary outcomes are lacking

The third reform principle is to promote recovery and the health benefits of returning to work but at the moment WorkCover does not routinely measure either 'recovery' or 'health' for claimants and has very poor measures of work status so it will be very difficult to measure progress against this reform principle. An efficient method to measure health, recovery and work status needs to be developed so that the effects of policies and practices designed to improve these outcomes can be established.

There is a lack of research translation at the care provider level

The seventh reform principle is to strongly discourage payments, treatments and services that do not contribute to recovery and return to work. At the moment the gatekeeper to the system is the GP but surveys of practice show that Australian GPs typically deliver care that departs substantially from best practice. For example in a survey of the care provided by GPs to 3533 patients with a new episode of low back pain (Williams et al 2010), most of the patients did not get the best practice care recommended by Australia's National Health and Medical Research Council. This finding corroborates those from a similar study from Victoria (Buchbinder et al., 2009), and together they point to significant problems in knowledge of evidence-based best practice in this key group. Accordingly, we recommend that attention is given to ways of improving knowledge and practice amongst all healthcare providers involved in the management of injured workers, especially those with soft-tissue injuries at risk of poor return to work outcomes.

The seventh reform principle should also be applied to those with ongoing claims - the so-called 'tail claims'. Australasian work injury data on those who have not returned to work by 6-months post-injury indicate that 84% of those who do not feel ready to RTW relate this to their injury/pain (Campbell Research & Consulting. 2005/06). At this point ongoing treatments that might help pain in the first week or two after an injury are unlikely to help (Goucke, 2004; Waddell and Burton, 2005). Yet, these ineffective interventions continue to be prescribed and funded. Waiting for recovery (and pain relief) from these treatments is unlikely to achieve RTW. In fact, it can greatly reduce the chances of successful RTW (Waddell and Burton, 2005). Instead, the injured worker has to learn to effectively manage their pain and to resume normal activities despite their pain if RTW is to be a realistic possibility (Airaksinen et al., 2006). But, as is commonly the case, if the worker has become dependent on medication, fearful of re-injury, depressed and significantly disabled, s/he not only has to learn to manage their pain, but also to overcome these additional obstacles, further delaying RTW.

To date, the most cost-effective approach to these essentially psychological and behavioural obstacles is to engage them to some form of targeted cognitive-behavioural pain management. (Nicholas, 2002; Gatchell et al., 2006; Airaksinen et al., 2006). These interventions come in a variety of versions, from a few individual sessions with a psychologist and an activity-based physiotherapy program to a 3-week (115 hour) multidisciplinary pain management program. Typically, the less distressed or less disabled injured workers require less intensive help. Ideally, if injured workers were dealt with effectively in the first few weeks after injury very few would ever need an intensive program. But in the event an injured worker does go to develop chronic problems, the more distressed and disabled are much more likely to return to work after the intensive interventions (a large study by Haldorsen et al., 2002, from Norway, clearly demonstrated this).

Unfortunately, the available data from NSW on treatment for injured workers with back/neck pain (see Cohen et al., 2000, for a NSW study) suggests that the usual approach taken has been to continue trying sequential treatments meant for short-term (acute pain), that are predominantly symptom-focussed (see also Williams et al., 2010 on current practices). These have limited effect on function, especially once pain becomes chronic. At the same time, Cohen et al (2000) found that practitioners delivering usual care seem to ignore the contribution of psychological and environmental factors to the presenting problems, despite the strong evidence for their influence (Waddell and Burton, 2005; Nicholas et al., 2011).

All too frequently, it is our experience at the Royal North Shore Hospital that it takes 2-3 years from the original injury for the nominated treating doctor to refer the injured worker to a pain management clinic for help in managing their pain. By this stage, the worker has usually lost their job and is significantly disabled, demoralised and dependent on medication. Their chances of RTW are close to zero and pain management services are often expected to work miracles in this context. We have long argued (see Nicholas, 2002) that if injured workers have not returned to work within 3 months, despite appropriate treatment and they continue to attribute this to ongoing pain (see Campbell Report, 2005/06), then they should undergo a multidisciplinary pain assessment to identify the contributing factors and options for management, while they still have a job. We

believe, and there is evidence to support this view (Nicholas et al., 2011; Whitfill et al., 2010), if this approach was taken the continuation of unhelpful treatments would be prevented and much improved RTW outcomes would be achieved. This would represent significant benefits in terms of the quality of life for injured workers and their financial security, as well as the costs to the employers and society in general.

There is a lack of research translation at the population level

Of course, the challenges facing the WorkCover system cannot be just the responsibility of the treatment providers. The broader community has a role to play as well. One innovative program, conducted by the Victorian WorkCover Authority in the late 1990's, concerns a public education program to promote more accurate perceptions and expectations of work-related back pain and its management (Buchbinder & Jolley, 2004). This study was estimated to have saved VWA approximately $65M in total, but has never been tried in NSW. Interestingly, Buchbinder and Jolley showed that NSW citizens (chosen at random) as the comparison for Victorians in the study continued to believe that rest and avoidance of activities in case back pain was made worse was the best way to manage it – also contrary to evidence-based guidelines.

So we seem to have a population that generally has unhelpful beliefs about back pain at work and a large proportion of health care providers who concur, and thereby risk promoting greater disability and costs for all. As a follow-up to this point, one of us (Nicholas) has conducted a preliminary survey of the beliefs about back pain management held by NSW workers compensation insurance staff, and this has revealed wide variations, consistent with community surveys, but worrying if we expect this group to implement and support evidence-based interventions (as outlined in Principle 7).

In a system as complex as workers compensation, any improvements are likely to require general agreement on an operating framework or paradigm The evidence we have provided indicates we are still some way from this position. But the merits of the case were outlined by an international group of experts in 2005 (Franche et al, 2005), and we would urge this committee to read that document as part of their deliberations.

In conclusion

While we do not imagine there will be a 'magic bullet' to fix the problems facing work-related injury management in NSW, we are concerned that existing knowledge on best-practices is not being taken up by all stakeholders. That includes all healthcare providers, employers, insurance company staff, WorkCover, and injured workers and their representatives. We would urge this committee to engage in exploring ways of taking up the challenges we have outlined.

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