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Australasian Faculty of
Occupational and Environmental Medicine

It Pays to Care

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

An imperative for change and call to action

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About the Royal Australasian College of Physicians (RACP)

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

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

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

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Preface

Over the past decade, the evidence on the impact of psychosocial factors on occupational health has grown substantially. New-found knowledge has revealed new opportunities to assist our patients, reduce costs and secure benefits for Australian and Aotearoa New Zealand taxpayers, businesses and the broader community. These opportunities are present in the workplace, in case management approaches, in overarching workers' compensation arrangements and in healthcare.

In recent years, media has drawn attention to the human and economic costs of work injury scheme dysfunction, highlighting the pressing case for change.[1,2] There is widespread appetite for workers' compensation systems that are fair and promote health and recovery for injured workers, but important questions remain. These questions concern the specific changes needed to secure better outcomes and the systems required to enable, implement and sustain these changes.

This evidence-informed paper summarises the growing body of research on the psychosocial factors that influence recovery from work injury and illness and highlights current gaps between evidence and practice. It does so in a constructive way, aiming to present the evidence as it stands but also to seek input from other stakeholders. Workers' compensation systems are complex; a collaborative approach will secure meaningful improvements.

The main message of this paper is that two major reforms are required.

1. Change to systematically capture psychosocial information for individual claims and proactively manage psychosocial risks by providing injured workers, workplaces and treatment providers with timely support according to need.
2. Change to ensure that scheme cultures, systems and processes do not create unnecessary barriers to recovery, but instead encourage positive psychosocial factors (those known to assist recovery and return to work (RTW) – e.g. self-efficacy), whilst reducing negative psychosocial factors (those known to slow recovery and RTW – e.g. perceptions of unfairness).

This paper explores the evidence regarding psychosocial factors as barriers to RTW and how these barriers can be lowered. Key aspects of evidence-informed practice are examined, current practices are compared, and the barriers to improvements reviewed. Scheme delivery is explored through four work injury domains: 1) leadership and regulation, 2) case management, 3) the workplace, and 4) health care; though many issues are relevant across multiple domains. Specific improvements under the 'action areas' are noted and key elements necessary to secure better outcomes are listed.

This paper has incorporated constructive feedback from policymakers, medical and healthcare bodies, and people involved in research and rehabilitation. Several groups expressed their wish for improvements to the work injury schemes and a willingness to be actively involved in advocating for changes that will assist injured workers and Australian and Aotearoa New Zealand businesses.

Many of the issues discussed in this paper are applicable to other systems, such as motor accident insurance and income protection insurance. The improvements to case management, regulation and healthcare suggested here may also be of benefit to those insurance schemes.

It is hoped that this policy paper will be used as a tool to influence attitudes and practices in each of the relevant domains: healthcare, case management, the workplace and regulation. Occupational physicians may use it to advocate for evidence-informed healthcare. Case managers may use it to advocate for improved case management practices. Workers may use it to advocate for greater transparency and fairness in workplace injury management and workers' compensation systems. Workplaces may use it to advocate for more engagement with insurance claims management, and so on.

RTW practices needs all players 'on side'. Better results are achieved collaboratively. Arguably, the same applies to scheme improvements. All work injury stakeholders stand to benefit from action in the areas suggested in this paper, and contributions from all are needed to achieve the improvements suggested.

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Acronyms

ACC	Accident Compensation Corporation [Aotearoa New Zealand]
AFOEM	Australasian Faculty of Occupational and Environmental Medicine
ARC	Australian Research Council
CBT	Cognitive Behavioural Therapy
COHE	Centers of Occupational Health and Education [Washington State, US]
CT	Computed tomography
IME	Independent medical examination
IPS	Individual placement support
IWHG	Insurance Work and Health Group [Monash University]
KPI	Key Performance Indicator
NHMRC	National Health and Medical Research Council
OEM	Occupational and environmental medicine
PREM	Patient reported experience measure
PROM	Patient reported outcome measure
PSC	Psychosocial safety climate [survey]
PTSD	Post-traumatic stress disorder
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCT	Randomised controlled trial
RTW	Return to work
SIRA	State Insurance Regulatory Authority

Key terms

Jurisdiction – A scheme operating with its own laws, rules, or legal decisions. In this paper, referring to state/territory-based schemes (e.g. Victoria, Western Australia) or federal systems such as Comcare.

Service provider – Groups or organisations that provide services to work injury schemes. This includes treating and independent medical practitioners and other health professionals, workplace rehabilitation providers, and legal practitioners.

Stakeholder – Refers to all involved in work injury schemes. The worker and their employer are stakeholders; other scheme participants are service providers.

Work injury insurance – In this paper the term ‘work injury insurance’ is used throughout; an alternative is ‘injury insurance scheme’. In Aotearoa New Zealand, the Accident Compensation Corporation (ACC) scheme covers all people who have had an injury. Many of the principles in this paper apply to other schemes that include wage replacement, such as motor vehicle insurance schemes, veterans’ affairs and social security.

Worker – In this paper the term ‘worker’ is used to denote a person who has experienced a work injury. This person may also be a patient, claimant or injured worker.

EXECUTIVE SUMMARY

Workers' compensation systems were established to benefit injured and ill workers and businesses. Generally, benefits for both groups are greatest when recovery and return to work (RTW) are timely, durable and efficient.

However, health outcomes are actually worse for people who claim compensation than for those who don't claim.[3,4] In fact, the chance of a poor health outcome for a compensated surgical condition is about four times that for the same condition in a non-compensable setting.[3,5,6] The increased risk of a poor health outcome is even greater for workers who claim for psychological injury.[7]

Most people RTW after an injury without difficulty. However, a significant minority struggle and remain off work longer than expected for their medical condition. Research has established that workers exposed to high levels of psychosocial risk have over three times the amount of time off work as low-risk workers.[8] The more psychosocial risk factors present, the more likely it is that recovery will be delayed. As the number of psychosocial risks increase, so does the cumulative probability that a worker will not recover from their injury or illness.

Some people never return to the workforce, an outcome with immense human and financial costs. Those who remain out of the workforce long term have poorer physical and psychological health and report financial distress. Intergenerational impacts have also been established: the children of the long-term unemployed have higher rates of distress and poorer mental health than their peers.[9]

These problems are longstanding, but awareness of the need for change has grown in recent years. Reviews of compensation scheme operations in two large Australian jurisdictions have highlighted that failures of implementation can have strong negative impacts on workers and businesses.[10,11] Moreover, there is now clear evidence that system approaches which prevent or lessen psychosocial factors can reduce work disability and its associated costs by 25–50%.[8,12,13] To improve patient outcomes, psychosocial barriers for individual cases must be proactively managed, whilst also reducing the psychosocial obstacles raised by current systems, processes and cultures.

This paper aims to further the discussion about psychosocial risks and encourage work injury stakeholders to collaboratively:

- Reduce system-induced barriers to recovery and RTW.
- Improve the way psychosocial risk factors for prolonged work disability are identified and managed in work injury schemes.

Biopsychosocial care

The biopsychosocial model of healthcare recognises that health is influenced by biological, psychological and social factors.[14] The biopsychosocial approach acknowledges that each of these three components may present barriers to, as well as enablers of, recovery, and that there are interrelationships between the components.

In workers' compensation, biopsychosocial influences emerge in the domains of scheme regulation, case management, the workplace and healthcare, and within individual injured workers. Each of these domains may influence the others. For instance, scheme factors, such as delays and disputes, perceptions of fairness and bureaucratic processes, can result in reduced motivation and distress in an individual worker, leading to poorer recovery and delayed RTW.

The employer's response to injury has a notable bearing on whether someone resumes their role: the nature of workplace encounters, levels of supervisor support, workplace culture before and after the injury, and attitudes of co-workers all make a meaningful difference to wellbeing and recovery.

Individual factors such as poor or passive coping, unhelpful beliefs about pain and injury, poor recovery expectations, adverse life experiences, anxiety and mood disorders can all contribute to delayed recovery and RTW. Importantly, however, many of these biopsychosocial factors are modifiable.

A wealth of evidence suggests many scheme and workplace barriers can be lowered by modifying the way systems and workplaces interact with injured workers. Barriers arise because of unhelpful relationships, cultures, processes, and system characteristics, including in systems intended to help.

Workers with personal psychosocial barriers to recovery can benefit from individually focused interventions, such as programs designed to improve self-efficacy. Support for individuals can assist them to identify and deal with their own barriers to recovery. Workers asked about biopsychosocial factors, and supported to address these factors, express satisfaction with the care they receive and have reduced work disability.[15]

While the biopsychosocial model of care has been discussed for decades,[16] recent evidence shows that systematic application of the model can contribute to significant improvements in both worker health and scheme costs.

The shared challenge is twofold:

1. Ensure that scheme cultures, systems and processes do not create unnecessary barriers to recovery, but instead encourage factors known to assist recovery and RTW, whilst reducing negative factors that slow recovery and RTW.

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

Regulation and policymakers

Regulators and insurers – particularly monopoly statutory government insurers – influence the culture, attitudes and behaviour of work injury schemes via their approaches, communication styles, and policies and procedures. Regulators set standards through their policies and expectations and through their approach to enforcement. Insurers' policies regarding case management, as well as their interactions with scheme participants, also influence scheme culture. Regulators can influence the behaviour of insurers, businesses, healthcare providers and injured workers through encouragement and education, and to a lesser extent, enforcement.

Collaboration and cooperation are needed for disparate groups to work together. Yet these are lacking in many everyday interactions: case managers express frustration about general practitioners' (GPs) certifying practices; whilst GPs express distrust about workplaces adhering to restrictions and so on. This has consequences for recovery and RTW outcomes.

When all players work towards a shared goal, RTW is more likely. A group will achieve more if group members trust each other to cooperate. A high level of trust, or social capital, results in fewer disagreements and disputes, streamlined communication, reduced requirements for written or legal documents, and better engagement.

A scheme regulator can improve collaboration and cooperation by enhancing workforce skills and scheme interactions. Persuasion, incentivisation, education, evaluation, performance monitoring, information provision and encouragement of good behaviour can all contribute.

Methods to encourage positive behaviours, trust and cooperation include:

- Stated principles and expectations of standards of service[17,18], such as being fair, treating others with respect, and being reasonable, efficient, proactive, responsive, transparent and accountable.

- Measurement of claimants' experiences, including factors that influence recovery and RTW.
- Measurement of scheme culture and levels of trust between participants.
- Clear and consistent focus on worker recovery and RTW.
- Active regulation, through monitoring and awareness of scheme factors that contribute to delayed recovery.
- Transparent sharing of scheme data.
- Explicit focus on engagement via an explicit stakeholder strategy, outreach, conferences or meetings that bring different scheme participants together.
- Avoidance of unnecessary delays, particularly with initial claim notifications and unnecessary disputes.

Minor abuses within work injury schemes by workers or employers, insurers or service providers have an outsized impact on trust and cooperation. Effective regulators have systems in place to identify and resolve such issues early and efficiently.

Large statutory insurers influence outcomes through their approach to case management and, by setting standards for third-party claims, agents contracted to undertake insurance case management. The systems, style of management (e.g. control versus partnership), financial arrangements and standards setting all have a material impact on how claims are managed and how the scheme operates.

All policymakers must recognise the importance of trust and cooperation in work injury schemes. The level of leadership in setting standards seems to vary between jurisdictions. Active endeavours to improve levels of fairness, trust and collaboration must be supported.

Case management

Workers who report positive interactions with their case manager have higher rates of RTW,[19] report less pain, greater perceived health, quicker recovery and improved quality of life.

The case manager operates within an environment that may enhance or hamper their ability to be effective. High turnover of staff, inadequate training, inadequate emotional support, high caseloads, burdensome administrative requirements, unclear expectations, cumbersome claims software and funding limitations can all play a role in limiting an individual case manager's ability to support and engage workers. Focusing on short-term fixes via key performance indicators (KPIs) or other performance targets can result in unintended consequences, with poorer outcomes for workers and schemes.

Case management should be procedurally fair, timely, proactive and supportive. Well-trained and adequately resourced case managers can help individual workers overcome obstacles, offer support, provide relevant information about rights and responsibilities, and influence other scheme participants, such as the employer or treating practitioner.[12] This is particularly important for workers at higher risk of prolonged work disability.

From a biopsychosocial perspective, attributes of case managers that enable positive outcomes include interpersonal skills (e.g., the ability to deal with people in difficult circumstances), communication and influence skills, knowledge of and ability to manage key RTW factors, and problem-solving and conflict resolution skills.[20-23]

Enabling attributes of case management systems include a systematic approach to early identification of the needs and risks of workers, fair and timely decision-making systems, and regular communication that provides guidance and support for workers, the workplace and treatment providers. Minimising bureaucratic requirements aids case managers, workers and other scheme participants, enhancing cooperation.

Some workers may have unmet needs, such as Māori and Aboriginal and Torres Strait Islander peoples, individuals from non-English speaking backgrounds, individuals with low self-efficacy and individuals with psychological injuries. A case manager with a high caseload and few supports may not have sufficient time or resources to meet these needs.

Evidence indicates that a systematic approach to identifying workers in need of extra support through early screening for biopsychosocial barriers is required. Claims management organisations need systematic approaches to providing the extra supports required via the healthcare system, referral pathways, rehabilitation counselling or additional workplace supports.

Improvements to case management systems will be facilitated by:

- Acknowledgement of case managers' influence on recovery and RTW outcomes.
- Systems that support case manager *effectiveness*, including staff selection, training and mentorship, appropriate caseloads and career path options.
- Systems that support case manager *retention*, including through attractive pay and conditions, recognition of the emotional labour of case managers, and recognition of their ability to embody the important values of fairness, respect, quality, and collaboration.
- Consistency of case managers over the life of a claim.
- National standards, such as agreed principles of practice for insurer case management.

- A common management approach across systems, such as work injury, motor vehicle accident and life insurance.
- Transparent reporting of case management systems, including turnover rates, case managers' perceptions of their effectiveness, caseloads and costs.

The workplace

Workplace psychosocial factors are a major influence on RTW outcomes, with workers indicating that, of all the domains, the workplace wields the greatest influence. Australian research shows that workers around the country who consider their employer's response to injury to be fair and constructive have, on average, considerably higher RTW rates than those who don't: 43% higher for physical and 52% higher for psychological injury claims.[19]

Key figures involved in workplace injury management are the injured worker, their supervisor, the RTW coordinator, and – through their influence on workplace culture and priority setting – senior management.

RTW rates are affected by the timeliness of injury reporting, the provision of suitable duties, RTW planning, the quality of communication, the stress of interactions with key workplace figures, support from co-workers, and the workplace culture before and after injury.

Improving workplace management of work injuries offers significant opportunities to enhance worker wellbeing and workplace productivity. RTW coordinators want and deserve more comprehensive training and skills development. Supervisor training improves confidence in managing work injuries and aids workers. Senior managers who receive reports about injuries and work injury management are more engaged and influential in this space.

Several jurisdictions are now seeking to address problems with workplace culture through the measurement and management of psychosocial hazards at work. These efforts should be applauded. Insurers may also be well placed to upskill employers in evidence-informed practices, though they would need sufficient time, training and motivation to undertake such initiatives.

Healthcare

Medical/healthcare influences on recovery and RTW include the nature and expected progression of the injury/illness, certification practices, treatment effects (which may be helpful or detrimental) and the level of coordination between the treatment provider and the workplace.

The biopsychosocial model recognises that an individual's psychosocial responses influence their neurobiology and can increase pain, distress and disability. Evidence shows that

measuring personal psychosocial responses and then offering tailored education and self-help coaching can help people manage pain and improve their ability to cope, thereby assisting recovery and RTW.

Treating practitioners, such as GPs, can set worker expectations by providing timeframes for RTW, which evidence shows leads to better RTW outcomes. Other work-focused communication strategies, such as identifying capabilities and discussing re-injury prevention, may also be effective when the worker trusts their treating healthcare practitioner.[24] There is strong evidence that a lack of positive communication and cooperation between the healthcare system and other relevant stakeholders (e.g. the employer and the compensation system) is an obstacle to work participation.[25]

Numerous challenges and frustrations, for both healthcare providers and case or claims managers, limit communication and cooperation. Not all health care offered to injured workers is high-value care – care that secures benefits important to patients (such as increases in functional capacity or comfort, relief from suffering or calm, or the ability to live normally) in a cost-effective way. Most injury claims are for common musculoskeletal conditions such as back pain, neck pain, and shoulder and knee problems. For these conditions, low-value health care, such as overdiagnosis and overtreatment, is common and associated with poorer outcomes. Low-value care can prevent a person gaining a comprehensive or correct understanding of their condition, reduce self-efficacy and delay recovery, wasting resources without securing positive outcomes.

Best practice treatment for work injury is work-focused, psychosocially informed, and evidence-informed. It is also collaborative. Time lost from work is significantly reduced by interventions that involve integration between two of the three domains of healthcare, workplace accommodation and case management.[26] Improving treatment alone is not an effective approach.

Action areas for better healthcare include:

- Developing systematic approaches for addressing psychosocial influences at the patient level. While people who may benefit from support in tackling psychosocial barriers to work may be identified through claims managers, the workplace or rehabilitation providers, the central point of coordination is often the GP. Therefore, GPs must actively tackle psychosocial risks.
- Providing evidence-, biopsychosocially-informed health care. The Clinical Framework for the Delivery of Health Services[27] outlines the importance of a biopsychosocial model and the need for effective treatment and fostering self-management. In particular, the Clinical Framework recommends the following principles:
    - Measure and demonstrate the effectiveness of treatment,

    - Adopt a biopsychosocial approach,
    - Empower the injured person to manage their injury,
    - Implement goals focused on optimising function, participation and RTW, and
    - Base treatment on the best available research evidence.
- Embedding the principles of the Clinical Framework within healthcare will help to ensure a systematic approach to biopsychosocial care.
- Adopting and promoting the Australian *Principles on the role of the GP in supporting work participation*[28] to guide GPs to foster worker empowerment, communication with other stakeholders, team-based care, the health benefits of good work, and appropriate certification. As the principles declare, this approach needs support from other scheme participants so that employers, insurers and policymakers can overcome the broader barriers to work participation. The development of a similar model may assist GPs in Aotearoa New Zealand.
- Creating easy pathways to high-value health care that informs and empowers workers. A focus on health care outcomes is important. Training of healthcare providers is sought by many in the industry, though has shown no or marginal benefit when studied. Universal education of healthcare practitioners through undergraduate and postgraduate training may assist.
- Incentivising evidence-informed, high-value care. The fee-for-service model encourages shorter, more frequent medical contacts. Higher rates of remuneration for interventions and surgery may incentivise these practices, leading to situations in which they are recommended to patients who would do better with less invasive treatment. There is a need to incentivise high-value health care, focusing on the provision of appropriate advice and explanations, grounded in a biopsychosocial approach.
- Improving work certification practices that support timely RTW to promote recovery. High rates of ‘unfit’ certificates are a barrier to work participation, with some workers who have work capacity certified instead as ‘unfit for work’. The Collaborative Partnership has partnered with GPs to develop the *Principles on the role of the GP in supporting work participation*,[28] and should be supported by schemes in the rollout of the guide. This may assist in improving certification practices. Occupational physicians are willing to partner with the Royal Australian College of General Practitioners (RACGP), the Collaborative Partnership and work injury schemes in this endeavour.

INTRODUCTION

Most people (70-80%) return to work (RTW) after a work injury with minimal difficulty and usually without any long-term consequences. The remainder find themselves in a more challenging situation. These individuals have extended time off work, frequently more than is medically necessary; some may never RTW.

In this paper, the focus is on how systems deal with workers who have experienced a work injury.[29] This is not to diminish the importance of primary injury prevention, which remains a priority. Indeed, we applaud Safe Work Australia and other organisations seeking to prevent and manage psychosocial hazards at work.[30] Primary, secondary and tertiary prevention measures are all necessary to reduce the harm that may flow from physical and mental health conditions.

Unnecessarily prolonged work disability comes at a high cost to individuals, families, employers and society as a whole. Some of these costs are visible in workers' compensation schemes (e.g. in the form of costly long-tail claims and slower RTW), while others sit outside them. Examples of external costs include lost productivity, injured workers relying on other forms of income support (e.g. socially funded disability benefits[31]) and negative impacts on children whose parents experience long-term worklessness.[32]

An increasing and strong body of evidence points to the importance of psychosocial factors in determining which workers recover and RTW in a timely way, and which struggle. Importantly, many psychosocial factors are modifiable.

However, work and accident injury schemes continue to revolve around the biological model of health care, missing the opportunity to remove psychosocial barriers to recovery and RTW. Decades of awareness of the importance of psychosocial factors have not led to material changes in practice.

Psychosocial risk factors are not systematically identified and addressed in work injury schemes. In fact, the way systems and schemes operate can increase both the frequency and impact of psychosocial barriers to RTW. As highlighted in recent reviews of two large jurisdictions, failures of implementation can have strong negative impacts on workers and businesses.[10,11]

In the *It Pays to Care: Values and Principles Based Approach* companion paper the core principles of work injury schemes are outlined, which align with the values expected within a social insurance policy framework – fairness, respect, engagement, transparency, collaboration and support; describing what is needed for work injury schemes to operate according to evidence-informed practice.

The principles of injury management that foster RTW are straightforward and well understood. However, implementation is challenging. Drawing on a compelling evidence base and the expertise of specialist occupational and environmental physicians, this paper seeks to encourage public debate on potential improvements to the design, implementation and management of workers' compensation schemes in Australia and Aotearoa New Zealand. This paper describes the impact of psychosocial factors on recovery and RTW, and points to opportunities to reduce psychosocial risk in four key domains of work injury management: leadership and regulation, case management, the workplace, and healthcare.

The challenges of translating evidence-informed research into practice have long been recognised.[33] Passive dissemination of information is generally ineffective. However, modern healthcare includes systems that foster uptake, most commonly within hospital settings, in which relevant medical specialists can adopt a leadership role.

Barriers to translating research into practice may be professional, political, institutional, managerial and in some cases, personal.[34] Professionals in sufficient numbers need to be persuaded of the value of an intervention; institutions need to be persuaded that it is affordable and deliverable; planning and commissioning need to be coordinated; and everyone needs to understand the value of the change and want it. Embedded practices often pull back to familiar practices and create webs of inertia.

If these problems lay only within healthcare, specialist occupational and environmental medicine (OEM) physicians could use the now solid base of evidence on psychosocial factors to lead a healthcare focused implementation strategy. However, healthcare is only one component of the problem; there is a need to work with scheme designers and other scheme participants to see real improvements.

The Australasian Faculty of Occupational and Environmental Medicine (AFOEM) acknowledges the breadth of expertise, research and real-life experiences that must be utilised to properly manage psychosocial risk. OEM physicians see how regulation, case management and system design issues affect patients (workers) across Australia and Aotearoa New Zealand. In this paper, system barriers are explored from the OEM physician perspective, acknowledging that other relevant perspectives need to be considered. Evidence is presented, including what works from a health and medical perspective, and suggestions for change are made.

This paper outlines the results of a narrative review, which is a useful approach for obtaining a broad perspective on a topic. It differs from a systematic review, in which all relevant publications are identified systematically, the quality of each study is assessed, and the results of studies deemed to be of sufficient quality are summarised. The main drawback of

a narrative review is that it is open to bias; its main advantage is the ability to bring together diverse material.

The suggestions in this paper remain works in progress. They are not intended as definitive, one-size-fits-all solutions to the challenges faced, which vary from jurisdiction to jurisdiction. In the 'action areas' under each domain (policymakers, case management, the workplace, and healthcare), the context for important areas ripe for change are provided. The 'Key elements for better outcomes' section outlines the important elements of evidence-informed practice. The intention is to provoke constructive collaborative discussions between those involved in work injury insurance schemes.

This paper is written principally for those involved in work injury insurance scheme design and delivery. However, it is also intended as a tool for workers, employers and other scheme participants. Each has an active role to play in understanding, encouraging and delivering evidence-informed practices within the system.

Work injury insurance scheme arrangements vary across Australia and Aotearoa New Zealand. In many cases there is a high standard of care. We acknowledge those schemes that have focused on delivering evidence-informed services using a person-centred approach. We also respect the high standard of service offered across all jurisdictions by proactive case managers, enlightened employers and treatment providers who provide high-quality care.

The goal is to build a coalition to advance the use of evidence in systems that care for people following a work injury. This paper outlines the evidence and the challenges and provides a platform to work together to press for improvements.

Finally, we acknowledge Safe Work Australia's *National Return to Work Strategy 2020-2030*[35] and Aotearoa New Zealand ACC's *Tauākī Whakamaunga atu Statement of Intent 2021–2025*.[36] *It Pays to Care* is intended to complement these strategies.

SCHEME DESIGN AND DELIVERY: A 20-YEAR CONVERSATION

Workers' compensation is a social insurance policy, designed to benefit workers, businesses and the community at large. In order to secure access to 'no-fault' workers' compensation benefits, workers have given up some rights (e.g. access to many common law actions). Equally, to reduce the chances of being sued, employers have accepted financial responsibility for some of the hazards of employment. Government's shape and oversees this 'grand bargain', as it is often known in the United States, via legislation and regulation.

Australia has 11 main schemes of workers' compensation, most of which were established in the 1980s when biomedical explanations of injury, illness, recovery and RTW predominated. Aotearoa New Zealand has one scheme that provides no-fault personal injury cover to all residents and visitors, including those injured at work, through the Accident Compensation Corporation (ACC).

According to Patrick Loisel and Pierre Côté in the *Handbook of Work Disability*,[37] workers' compensation and sickness benefit insurance systems informed by biomedical explanations typically operate as if work disability can be explained by "the severity of the condition, the effectiveness of healthcare interventions, the strength of economic disincentives, and the effectiveness of the employer's approach to disability management", with some influence exerted by the motivations of the individual worker (e.g. malingering, secondary gain, primary gain). However, this model of operation is not grounded in current empirical evidence, which demonstrates the importance of psychosocial factors; those psychological and social characteristics of individuals, case management approaches, workplaces, health care delivery and compensation systems that determine work disability.

Compelling evidence has established that biomedical approaches do not address many of the causes of work disability, and psychosocial factors exert a strong influence over work and health outcomes. Workers' compensation legislation and practice have been slow to respond to this important body of evidence.

Twenty years ago, OEM physicians developed a forerunner to this present paper. In publishing *Compensable Injuries and Health Outcomes*,[38] OEM physicians sought to bring scheme participants together to tackle the challenging problem of unnecessary work disability. That report highlighted the influence of psychosocial factors in long-term disability, and encouraged medical practitioners, scheme designers, professionals involved with RTW, lawyers and others, to work together to overcome barriers to recovery.

Ten years ago, OEM physicians published *Realising the Health Benefits of Work*,[9] one of a series of position statements on health and good work. That position statement showed

prolonged work absence and worklessness are associated with higher rates of isolation and depression, reduced income and increased rates of multiple health conditions. This message has been widely accepted and promoted. Several jurisdictions have used the position statement to influence GPs and others to support RTW.[39-43]

The *Health Benefits of Good Work* agenda[1] ENREF 44 brought stakeholders together to understand how good work can be part of recovery from injury and illness. However, broader systemic change is still needed. Medical practitioners are more likely to certify RTW if they are confident that employers and the workers' compensation system will manage psychosocial factors well.

[1] Australasian Faculty of Occupational and Environmental Medicine. Health Benefits of Good Work. https://www.racp.edu.au/advocacy/division-faculty-and-chapter-priorities/faculty-of-occupational-environmental-medicine/health-benefits-of-good-work. Accessed August 2020.