ARPA NSW submission to the regulatory requirements for workplace rehabilitation service provision in NSW personal injury schemes

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Developed by the ARPA NSW Council

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1. Introduction

The NSW Council of the Australian Rehabilitation Providers Association (ARPA NSW) appreciates the opportunity to contribute to the consultation paper on regulatory requirements for workplace rehabilitation service provision in NSW personal injury schemes developed by SIRA.

People with injuries need varying degrees of medical and treatment care. Some very little and others with more complex presentations, much more. Those same people with injuries who require more medical and treatment support, are those that have historically been referred to workplace rehabilitation (WR) providers. Amongst other services, WR providers ensure medical assessment and treatment services are coordinated, goal driven, evidence-based and timely, therefore ensuring care and spend is effective. By working closely with employers, WR providers additionally ensure that workers with injuries return to work (RTW) to duties that are safe, medically, psychologically and functionally appropriate, and that are ultimately sustainable for the long term.

2. Who is ARPA?

ARPA is the industry voice for the Australian workplace rehabilitation industry, representing the majority of independent WR provider organisations in Australia. With strong industry and government links and affiliations, ARPA is dedicated to promoting and protecting the professional interests of our member organisations and through them, the sustainability of a purpose driven, socially impactful industry.

ARPA, its members, and the rehabilitation consultants they employ are committed to facilitating the personal, social, occupational and economic independence of individuals with injuries or disabilities. In fulfilling this commitment, rehabilitation consultants work with individuals, employers, insurers, and other medical and health professionals, in a variety of service delivery systems, in order to achieve the best possible outcomes for their clients, including those who may be suffering from a mental health illness or episode in the workplace.

3. What is a workplace rehabilitation provider?

A WR provider is comprised of tertiary qualified health professionals that specialise in the complex needs of workers and employers to achieve timely and sustainable RTW outcomes following injury or illness, be it either a physical or psychology injury or illness. Like treating health professionals, they are independent of other stakeholders and strive for a safe and sustainable RTW for workers with an injury, in consultation with their treating medical practitioners. WR providers can be relied on to provide expert opinion and solutions to resolving workplace injury, illness and disease and to

manage the relationship between the worker and their employer where attempts to RTW has broken down.

Every workplace insurance policy in NSW includes the right to an accredited WR provider. These services are vital in helping a worker (and their employer) safely stay and recover at work, or transition back to work after an injury, accident, illness or disease.

All WR providers in NSW are aligned to the HWCA Principles of Practice for Workplace Rehabilitation Providers, which is designed to ensure minimum standards are consistently met in the delivery of services to workers and employers. The WR providers are assessed and audited against the framework and approval principles by the State Insurance Regulatory Authority (SIRA).

In addition, rehabilitation consultants are each required to maintain their own registration with their relevant allied health professional authorities. This includes mandatory professional development to accrue CPD points which would include courses to access updated research and guidelines.

ARPA NSW believes that this framework and the regulatory oversight accompanying the framework, ensures that all providers of workplace rehabilitation services in NSW provide consistently high quality and evidence-based services, however as you will see from our submission there are many areas where we believe significant improvements can be made, which should see improved RTW rates in NSW and reduced premiums for NSW businesses.

4. Current RTW performance

As SIRA correctly points out, in recent years trends show a major decline in RTW performance in NSW, however at the same time the proportion of WC claims receiving WR services is decreasing and it is ARPA NSW's assertion that the reduction in referrals has had a direct effect on the decreasing RTW rate in NSW.

As is well understood, poor RTW rates not only cost the employer in premiums, but the community and NSW economy. The impact for workers with injuries extending to long term work absence includes a profound and negative effect on their health, relationships, financial position and can exacerbate underlying mental health conditions.

During the time that the RTW rates have decreased, ARPA NSW was aware of many instances of employers requesting assistance from icare and its Scheme Agents for referrals to WR services and not receiving any communication for weeks. There have been numerous occurrences of employers attempting to engage rehabilitation to facilitate an early RTW, however, these have often been stymied by the Scheme Agent or have taken weeks to enact.

Furthermore, many employers had been advised that they do not need WR provider assistance and that they should use internal resources to manage the RTW themselves. As pointed out above, the WC policy includes access to WR provider for workers and employers to support RTW, yet ARPA NSW believes that it had been denied on a wide-scale basis.

The Nominal Insurer has acknowledged these issues and reportedly worked more directly with their Scheme Agents to ensure these bottlenecks are overcome, so that employers and workers are able to access early rehabilitation intervention to support recovery at work, however issues persist.

Previous scheme reviews have identified the need for the employer to increase their literacy and capability in managing RTW following injury. This has been poorly interpreted as an opportunity to shift the responsibility to the employer to manage all aspects of RTW when clearly this is not within the capability for most employers within NSW.

Conversely, the scheme, the employer and the worker all benefit from the unique health intervention that comes from WR intervention, as is intended in the relevant legislation.

Objective criteria should be applied to remove any subjective decision making in respect of access to WR intervention. The employer and the worker are entitled to and need the quality health support that only comes from an accredited WR provider. For a range of reasons, not least of which the financial cost benefits to the scheme, the Nominal Insurer should be engaging WR services more often and earlier in the life of a claim.

Investment in WR has a mitigating benefit against medical treatment costs. The savings generated by reducing investment in WR have been eclipsed by the increase in medical treatment costs, with the compounding factor of deteriorating RTW rates.

Suggestions that the increase in medical spend has been driven by higher case complexity or surgical rates is out of step with comparative experience outside of the managed fund. A reduction in avoidable medical costs is a facilitatory by-product of good WR intervention which only further enhances the value of investment in these services. WR reduces medical and treatment costs by:

- coordinating treatment to aligned goals
- ensuring treatment is medically and functionally beneficial (i.e. treatment providers are held accountable to outcomes of intervention rather than ceaselessly being provided additional treatment sessions without results)
- ensuring communication is clearly directed to recovery at work and gains in functional and psychological tolerances
- engaging treatment and medical providers in the worker's return to work plan
- ensuring appointments are scheduled and attended at appropriate milestones to ensure worker assessment and progression through recovery.

This reduction in spend on WR services (due to the assumption that WR services are superfluous to the scheme) had previously been touted as a positive improvement by previous management of icare, before RTW rates started to decline as a result. However, what is clear is that this reduction in spend on WR services is resulting in:

- a massive decline in RTW rates for 4, 13, 26 and 52 week measures
- enormous social and health impacts on workers and their families
- pressure on employer premiums
- increases in medical and treatment spend
- reductions in the scheme funding ratio which is attributable to these factors
- GPs / specialists becoming the contact point for the worker by default, who often have little time and impact on the workplace or other treating parties, also leading to the overmedicalisation of injuries and the rehabilitation process.

5. Best practice in WR

ARPA NSW believes that a lack of early intervention and infrequent use of WR is central to the deterioration in evidence-based healthcare in NSW. SIRA has found that increased (medical) service utilisation is a driver for burgeoning medical and treatment costs. This correlates directly to a reduction in WR service usage.

The HWCA Principle Based Framework for WRP has evolved positively from the previous framework and has attempted to address some of the concerns that we have outlined in our response. This framework should be considered with our response. Particular areas that are positive are the need to build capability in professionals and the widening of the scope of services (though this needs to go further).

Medical and treatment providers have consistently demonstrated a lack of contemporary knowledge of the mechanisms operating within personal injury schemes. That is not to impart blame, but merely underscores the fact that WC and personal injury components of caseloads for health professionals and doctors is a smaller component over their overall workload profile. Without the oversight, support, review and collaboration with accredited WR providers, medical and treatment providers' quality and evidence base is severely eroded.

A critical factor impacting RTW rates has universally been the number of days taken from the time of significant or high-risk injury presentation, to a referral being made to the WR (delay to referral).

Over the last few years, the delay to referral (more time taken) has deteriorated to alarming levels, which is having a direct impact on RTW rates, which in turn leads to premium increases. The data surrounding delay to referral has not been shared, however ARPA member feedback has uncovered that the average delay to referral has blown out to nearly 170 days (delay from date of injury to date of referral to WR – for all ongoing rehabilitation services).

Further, the delay to referral data will not capture the increasing number of claims that should, but have not been referred to WR, which has an even larger impact on RTW rates.

Key factors that need to be addressed for workers with injuries and illnesses to receive high quality care include:

- assessment and management of worker risk factors for long term chronicity, including psychosocial risks
- identification and confirmation of worker return to work goals
- coordination of worker recovery and RTW timeframes (especially with difficult RTW programs, aiming to RTW to the same employer rather than having a worker displaced)
- coordination and accountability of treatment provider outcomes
- alignment of treatment outcomes to work capacity
- accountability on the efficacy of treatment and medical intervention
- engagement with employers and identification of suitable duties
- workplace relationship management and return to work facilitation
- worker and employer support for claims and scheme navigation.

More consistent use of WR for those who need it, coupled with early referral, will significantly enhance the quality and efficacy of medical and treatment provision within the NSW WC scheme. This ensures NSW workers with injuries and illness receive the best and most effective care and recover at, or return to, work sooner.

Furthermore, ARPA NSW strongly recommends that Scheme Agents should provide services within their expertise only. Over the last few years there has been a clear attempt to bring services in-house that are not within the remit or expertise of the Scheme Agent and are conflicted. This includes:

- recover at work services, including return to work planning, return to work plan development & management
- job seeking services & monitoring
- treating doctor / treater case conferencing
- mobile case management.

There are a number of issues with this trend:

- independence and objectivity are compromised
- the inherent conflict of interest jeopardises the validity of Scheme Agent claims decisions which would have precedent setting and reverberating impacts across the scheme
- there is no oversight by SIRA on these services
- services are being provided by a non-accredited WR provider and, in many cases, by non-allied health qualified or experienced personnel
- this has been undertaken to seek more revenue for the Scheme Agent, rather than acting in the best interests of the injured person and employer.

To ensure best practice in WR in NSW, ARPA NSW recommends:

- allowing an automatic approval and funding for employer or treating doctor directed rehabilitation referrals in recognition of the employer's commitment to facilitating recovery at work
- mandating early referral for workplace rehabilitation at 2 weeks (where the worker is likely to be off work for greater than 4 weeks)
- directing scheme agents to immediately approve referrals from employers, workers or treating doctors
- ensuring that training manuals, information and support available to agents and their team of case managers accurately represents early intervention and the benefits of same
- training case managers on the effective use of workplace rehabilitation services, in particular on the benefits of early referral to workplace rehabilitation
- non-accredited providers of workplace rehabilitation should be banned from providing them or are subject to the same level of oversight that WR providers are.

We have included the ISCCR report on the value and effectiveness of workplace rehabilitation that has recently been released (Appendix B). While centred in Victoria we note that the consistency of the conclusions with our submission that identifies:

- WR intervention has a significant positive impact on claim outcomes
- early referral improves the effectiveness of WR intervention and claim outcomes
- service delivery model design can have positive but also unintended negative consequences.

Additionally, we anticipate that a current project underway in conjunction with SIRA will provide further data and conclusions that will add additional value to this analysis and this review.

6. Emerging challenges

Since the onset of the COVID-19 pandemic, ARPA and its members have been well prepared to help businesses operate safely and assist businesses remained positively connected to employees.

As an essential service, ARPA member organisations, were well prepared with strategies to keep their staff, clients and the community safe. Technology has enabled continuity of services and a ready transition to online support. Many ARPA members readily shifted to work being undertaken from home or remotely during the COVID-19 lockdown period. Of course, providing face to face support to workplaces and workers with injuries continues, with strict adherence to health guidelines and safe practices.

During this period, WR was deemed more important than ever for ensuring not just recovery or RTW, but also ensuring work readiness, maintained capacity and connection to the world of work. By ensuring that the WR industry is the key '*Partner to Recovery*' during the COVID-19 pandemic, ARPA members have helped ensure that workers with an injury remain connected to their workplace, returned to work in a safe and timely manner, at a time when WC scheme costs and premiums were under pressure.

Of critical importance, ARPA members continue to play a major role in ensuring that workers with injuries, regardless of the status of their employment, remain connected to the world of work, through accessing vocational education and redeployment programs, and utilising their extensive skills in vocational counselling and support to achieve positive health and RTW outcomes.

Going forward, WR will be more important than ever, as helping people remain meaningfully engaged and providing specialised services to facilitate the RTW in what is a difficult labour market will continue to be instrumental in minimising the impact of the pandemic for individuals, businesses and the greater community.

ARPA knows that the provision of WR services should be provided in the workplace or face to face wherever possible, however we recognise that in some instances, due to the success in providing services remotely during the COVID-19 lockdown, some services could be provided remotely by using technology to leverage knowledge, skills of the consultants and their associated relationships with stakeholders.

In regards to the rising prevalence of mental health claims, ARPA NSW believes that targeted intervention from an independent 3rd party (such as WR providers) with appropriate knowledge in the workplace to facilitate the support mechanism and the relationship between the worker and their employer has proven benefits for the employer and also for the worker. The most significant drivers of prolonged work absence are psychosocial factors and therefore psychosocially targeted assistance to support the employer and in turn the worker through a workplace-based intervention will produce the greatest results.

7. ARPA's response to SIRA questions

A. In the current landscape, are there aspects of the WC or CTP schemes that should be extended to the other scheme to optimise WR service provision?

ARPA NSW believes that the guiding principles that govern WR service provision in the NSW WC system should be extended to the NSW CTP scheme, where appropriate. The workers compensation service delivery benefits greatly from consistency through: regulated qualifications and guidelines; quality and continuous improvement frameworks; consistency of data; and clear objectives for service delivery. By ensuring minimum standards in the CTP scheme, will help

ensure that all providers of WR services in the CTP scheme will provide consistently high quality and evidence-based services.

Workers insurance has a stronger focus on RTW rather than independent living and this may greatly benefit the road users insurance scheme. Doing more to preserve the relationship between the worker and the employer will greatly enhance RTW outcomes in this scheme. Generally, there remains good will between the employer and the road user and the employer is often willing to bring the person back to work through a sense of obligation and benevolence, providing the risk can be minimised. Often this opportunity is lost however. If approaches from workplace rehabilitation in workers insurance can be adopted within CTP then the potential for greater RTW and life and a reduction in scheme liability will be achieved.

Research says many people living with disability would love the opportunity to work if they were able. More seriously injured road users are often pigeon holed into worklessness from a scheme which historically discouraged RTW due to the lump sum compensation. The legislative changes now better support RTW yet these have been poorly realised. A more active approach to RTW is certainly warranted.

Conversely there are learnings from the CTP scheme that may benefit workers insurance. Traditionally within CTP the engagement of WRP was not limited only to services that directly related to a RTW goal due to many factors, particularly that claimants tended to have more severe injuries and that many were not working pre-accident. Pre-vocational and social outcomes that all build to independence are considered goals for service provision. These have an indirect relationship with work as they are the basis upon which a person is then able to manage and consider the requirements of working in the future. Workers insurance has suffered in recent years as the narrow scope of the approval framework has not allowed WRP to provide services that more broadly support RTW. We can learn from this opportunity. Non regulated providers have emerged in workers compensation as a consequence. Allowing WRP to provide services that indirectly support RTW would be consistent with the evidence and allow for more person specific intervention. This builds much greater cooperation in the more severely injured workers that often contribute the greatest costs to the scheme.

B. Do we have the breadth of WR services, interventions and supports required for optimal recovery and RTW outcomes for injured people in NSW?

Old school thinking is still applied to many schemes by not allowing WR providers to expand interventions into prevocational or psychosocial interventions that would follow the biopsychosocial approach. Aside from the enormous benefits that can be achieved through enhancing the relationship with the WRP that eventually translates to RTW, this will better steer the pathway to work before this

comes off the rails. Often workers are delayed far too long from exploring RTW options before they are certified with capacity to RTW. WRP have a very skilled and capable workforce who would be well placed to direct more interventions to building capacity in workers to get them to the base level to consider RTW options. All too often workers remain unfit for extraordinary periods of time when WRP could have provided intervention that will have built capacity. Our approval framework has tended to stop engagement of WRP services early in the life of a claim for fear that money will be spent before the worker is ready to work. This has paralysed progression in many instances where progress is slow or has stagnated. Widening the scope of services to include early intervention services that build capacity and capability on a pathway to RTW would greatly enhance what benefit we could bring to the scheme.

Innovation has been continually touted as the future to the scheme to deliver better than average RTW rates. Unfortunately, the focus on this has actually seen the opposite effect with a departure from the evidence and a tendency to throw support and resources by new ideas in the hope to hitch the wagon to the next big thing. This has been an abject failure. We have seen extensive resources pumped into innovation projects that are not regulated, have not delivered outcomes, are not subject to scrutiny, and have damaged the scheme and WRP as they have dragged investment away from the evidence-based practice for RTW. If we had just continued to operate the way we were operating there would be thousands more workers back at work. WRP have not been invited into such projects as our framework has been too narrow and we have been considered old school. Allowing the widening of the scope of services that we can provide would offer the scheme a more attuned and safer pair of hands to explore ways to improve outcomes. While we recommend this be included in a new framework, presently a return to the basics and the evidence will deliver the results drastically required by the scheme.

ARPA NSW also recommends that WR providers staff who are allied health professionals are approved and capable and should be encouraged to use their clinical judgement and expertise. This will help move the NSW WC system from being a heavily driven process scheme.

C. What would be the best approach to building capability in WR service provision?

i) Gazetted rates are introduced for WR services

Earlier this year ARPA NSW undertook a review of the current rates paid for WR services within all Australian WC schemes and compared them to the current rates paid for allied health services (namely OT, physiotherapy and psychology services) and for NDIS services.

The purpose of this undertaking was to highlight the growing disparity between the rate paid by the NDIS and those of the NSW WC scheme for similar services

provided by WR providers. This disparity is now having a detrimental effect on the market for these highly skilled services and it is anticipated that the growing inequality in rates may lead to inferior RTW service provision for workers injured in NSW which is in turn likely to adversely impact scheme RTW rates.

Health professionals within WR providers have higher demands and expectations placed upon them in comparison to other health sectors and as such a comparable rate is required in wages, at a minimum to attract and retain staff.

NSW WC insurance runs the risk of not being able to maintain quality service provision at a time where WR provider expertise is more important than ever.

WR providers that employ allied health personnel can no longer compete with wages and conditions of employment elsewhere. For the first time ever, WR providers are reporting the loss of allied health staff to the aged care and home based sectors which were previously at the lower end of the scale for wages, with comparatively less challenging professional demands on qualified professionals.

ARPA NSW recommends that WR service rates are gazetted by SIRA at commercially viable rates, bringing WR services into line with comparable allied health services, and comparable markets. This will bring consistency across services and ensure that rates are indexed annually and are able to be adjusted responsive to market conditions. Workers insurance has fallen behind other sectors for service rates, with many of those other sectors being seen as easier and more rewarding. For example, the NDIS represents the largest consumer of health services nationally at higher service rates and much lower levels of service provider dissatisfaction. Further, when determining appropriate rates for services consideration be given to the additional complexities of operating as an approved WRP compared to other allied health practitioners which add to our cost of operation. These include but are not limited to: WRP are not able to gain the same efficiencies as other health practitioners in respect of service delivery; the costs required to attain and maintain WRP provider approval on top of all individual requirements to maintain registration as a health practitioner; the need to deliver a workplace based service means that services are often provided in the workplace, home or other areas of the community (the provider travel rate only covers the WRP time and not the cost of the travel itself).

Separately, a gazetted rate will address the unfair market power position held by the nominal insurer in this circumstance that can be seen to have negatively influenced scheme outcomes in the past. Indirectly the power held by the insurer in this market is a deterrent to some health practitioners wanting to enter this industry as there is an abundance of negative experience in respect of this market power and the experience of health professionals both still practicing and who have left the industry. The WRP industry has to counter the negative image problem if we are to attract and retain the necessary talent required to support the scheme in meeting its objectives.

Consideration needs to be given to providing a secondary tier for specialist WRP services provided by those with appropriate levels of expertise. Presently all services are paid at a base rate for a health practitioner. Should the industry wish to retain those with high levels of skill and expertise then a second greater remuneration tier at a higher rate should be implemented. This will help support the industry to retain more skilled professionals with experience rather than losing them to other sectors. It is important to note that this does not mean reducing the base rate to provide a lift in the second tier as this will spell certain disaster for the industry contrary to interests of SIRA and the scheme.

ii) The pool of available talent and the list of allowable qualifications should be expanded

Aligned with the issue of payment rates for WR services, ARPA NSW strongly recommends that more needs to be done within the market to address the decline in the core professions entering the sector (OT; PT; EP; RC and Psych). Positive changes and promotion are needed to lift the number of key allied health professionals that view WRP as a suitable career pathway. ARPA and SIRA need to work together on strategies to improve the experience of those working in WRP and the external image that is portrayed. SIRA should take a positive promotional view in conjunction with industry partners like ARPA to promote the workers' insurance industry. This promotion needs to be supported by real changes that improve the experience of those working in the sector so once again WRP and the workers' insurance industry more broadly can be seen as a positive career move and the negative image of the sector can be repaired. This needs to be supplemented with advocacy for greater numbers of university placements to meet demand and real programs in conjunction with the federal government that remove the red tape from fostering entry for overseas qualified health professionals.

Consideration should be given to widening the scope of qualifications allowable to provide WRP services beyond the current core group. This would need to be done with careful consideration and include a competency-based skill acquisition pathway to address the differences between the core allied health degrees and those listed. We recommend that competency-based assessment for workers insurance RTW SE/NE as a core module; and possible modules in workplace assessment, functional assessment and vocational assessment be explored. The program and assessment process could be managed independently by ARPA to ensure that this program could be delivered reliably, independently and with specificity. We note this course is likely to be of benefit to core professions entering the industry also and could be voluntary for that group. Non-core allied health professions that may be considered for addition to the approval framework include:

- osteopaths, chiropractors and paramedics (which have been approved by WorkSafe Victoria to be allowed to provide WR services from 1 July 2021)

- podiatrists and orthotists/prosthetists
- provisionally registered psychologists (more specifically clarified to remove the current ambiguity)
- ASORC Affiliate Members be allowed to provide WRP services under a supervision plan.

NOTE: from 1 July 2020 WorkCoverWA will recognise:

- provisionally registered psychologists and rehabilitation counsellors with associate membership of ASORC
- rehabilitation counsellors with affiliate membership of ASORC, with supervision

under the Heads of Workers' Compensation Authorities' Principles of Practice for Workplace Rehabilitation Providers.

iii) A similar approach as has been taken by HWCA in respect of building capability be adopted or expanded

The HWCA principles based framework directly addresses the need for WRP to build capability within the industry. This is very positive and should be adopted by SIRA. This should be a shared responsibility with all stakeholders and not just WRP. Joint approaches should be considered including the proposal by ARPA to provide competency based training and assessment.

D. How do we support WR service provision to achieve optimal outcomes?

i) Mandatory referral to workplace rehabilitation

The risks to long term scheme viability by reluctance, refusal, inability or inaction to engage WR providers in early intervention support of workers and employers are real and evident in the independent (SIRA) statistics. ARPA NSW recommends that there is mandatory referral to workplace rehabilitation for workers not anticipated to RTW within four weeks.

Earlier referral to focused workplace rehabilitation would save NSW at least $38 million each year (see Appendix A & B) and WR has a proven track record of delivering quality care and offers a return on investment between $28-$32 for every $1 invested (see Appendix C).

Early referral will minimise delay to support; delays of RTW and the associated wages recorded on the claim. Further, it will significantly improve the employer's experience and the worker's experience by allowing the worker to RTW earlier, stay engaged with work and recover at work. The impact of delays can also contribute to a breakdown in the relationship between the worker and the employer and the heightened development of secondary psychosocial factors that directly impact on an individual's recovery timeframes.

Ensuring that workers with an injury are able to get earlier referral to an independent WR provider will help address this significant increase for employers and help achieve scheme sustainability, as was evidenced prior to the enormous structural changes undertaken following icare's introduction.

ii) SIRA to develop guidelines to ensure WR services are not interrupted

Across the NSW WC scheme, there has been a trend of having:

- funding requests in rehabilitation plans reduced with often no or little reasoning
- case managers who have no relevant qualifications and little rehabilitation knowledge, who are responsible for reducing, cutting, denying WR requests, often without any explanation or legitimate justification.

which significantly reduces the ability to provide necessary and tailored services to injured workers.

As Scheme Agent case managers are not required to be tertiary allied health qualified, are not subject to professional health standards, are not routinely audited and monitored and are not required to have knowledge of, or to even reference, evidence-based strategies for the provision of health care, there can be no doubt that not all people with injuries are receiving high quality or evidence-based healthcare.

It also means these case managers are not able to make clinical and best practice judgments which can impact on workers getting appropriate treatment. This may also lead to an increase in cost, longer durations, and a distrust of all parties within the scheme, with workers becoming very distrustful.

ARPA NSW recommends that SIRA develops a comprehensive set of guidelines which clearly articulates when a Scheme Agent can or cannot reduce, cut or deny WR service requests. ARPA NSW would be very happy to work with SIRA to develop these guidelines.

iii) SIRA to consider adopting responsibility for provider performance

Presently the responsibility for monitoring provider performance and WRP market share rests with the nominal insurer and other scheme providers. While the agent is responsible for provider performance, the agent determines what optimal performance looks like. This raises a conflict. We have seen WRP performance diverge at times from the approval framework due to the nature of this relationship. Mandated referral processes in conjunction with SIRA being responsible for performance management may alleviate this conflict.

iv) SIRA to consider adopting responsibility for scheme data

We have experience inconsistent data across the scheme and there is often difficulty determining who actually holds the true data. ARPA supports one consistent dataset held by the singular authority being SIRA.

E. How do we promote best practice and continued innovation in WR service provision in NSW?

i) Non-accredited providers should either be banned or subject to the same rules

There has been an emergence of non-accredited providers of various guises providing services within the NSW WC scheme. This includes social prescribing agencies who have been allowed by the Nominal Insurer to provide programs to workers with an injury to help get them 'work ready'.

There is no transparency on the skills, qualifications, care or capability of these organisations or their staff to work with workers who are vulnerable due to injury or illness.

There is no accountability to the scheme funders (employers), no measures of RTW outcomes nor is there any recognition that the scheme already possesses the qualified skills, accreditation and expertise to get workers with an injury job ready through evidence-based, best practice approaches (via WR providers).

In addition, these service providers may not be equipped to deal with the vulnerable and psychologically impacted worker who requires trained and experienced personnel to ensure they are providing best practice treatment. Furthermore, WR providers have a known network of appropriate service providers who are fluent in WC and rehabilitation, allowing workers to benefit from this expertise (as do employers and insurers).

ARPA NSW believes that this is inappropriate as:

- they are non-accredited as a workplace provider, yet providing WR services
- there are serious concerns regarding conflicts of interest
- they lack experience, mandated qualifications and an understanding of working with workers with injuries and the impact of disability, injury/illness
- there is a lack of appropriate support tailored to the needs of those works with injuries
- there is a lack of understanding of the Health Benefits of Good Work
- there is no oversight by SIRA
- there is no accountability on their outcomes, value or methods of service delivery – that exposes the scheme and workers to wasted funds, at risk behaviours and unqualified personnel delivering services
- this represents an early erosion of the structure that is evidence based and has been shown to work

- we have already seen the impact of declining RTW rates as similar concept projects have been trialled under a culture of wanting to discover the next big thing, rather than actually administer the scheme in the way in which it was designed and has been shown to work effectively.

ARPA NSW would strongly recommend that either these providers are either banned from the scheme or are covered by the WR provider framework.

ii) Practices inconsistent with scheme principles should be banned

There are numerous examples of practices that are inconsistent with or otherwise contradict the ambitions of the NSW WC scheme and the intent of the legislation within which all stakeholders and administrators operate. A brief summary of concerning and contrary practices are listed below:

- There is evidence within the scheme of not referring to a WR provider if a worker with an injury is certified unfit for work, with no work capacity. This is clearly contrary to best practice and must be immediately addressed and WR provider engagement actively facilitated. This leaves workers without direction, support or assistance and can escalate tensions between a worker and their employer and can result in the employer(s) paying higher premiums for their insurance.
- There is evidence within the scheme of preventing, discouraging, delaying and redirecting employers who have initiated a referral to their preferred WR provider. As with the point above, this is clearly contrary to best practice, as well as disregarding an employer's obligation to nominate a preferred WR provider as part of their RTW plans. This must be stopped and rectified.
- There is evidence within the scheme of directing employers to NOT attend a treating doctor case conference due to privacy issues. Encouraging and maintaining relationships between employers and workers is essential to good outcomes. This is contrary to good injury management practices.
- There is evidence within the scheme of directing a WR provider to avoid keeping the pre-injury employer informed of the different employer RTW programs. ARPA NSW believes that this is at odds with collaborative problem solving, an employer's rights and supporting the best outcome for a worker.

ARPA NSW recommends that these practices are banned and that SIRA are provided with appropriate power and resources to effectively monitor, manage and to stamp out these practices when reported.

iii) Mental health injury claims to be referred to WR ASAP

With the increasing prevalence of reported mental health injury, and the increased acknowledgement of underlying mental health, industrial relations, and litigious factors hindering a successful RTW from physical injury, this cohort is growing and becoming more complex every day.

Targeted intervention from an independent 3rd party (such as WR providers) with appropriate knowledge in the workplace to facilitate the support mechanism and the relationship between the worker and their employer, has proven benefits for the employer and also for the worker with a mental health issue.

The most significant drivers of prolonged work absence are psychosocial factors and therefore psychosocially targeted assistance to support the employer and in turn the worker through a workplace-based intervention will produce the greatest results.

ARPA NSW recommends that it is imperative that these cohorts should be referred for workplace rehabilitation services as soon as practicable.

F. How do we most effectively measure outcomes associated with WR?

ARPA NSW are very keen to ensure that WR services in NSW are highly valued, regarded and deemed to be excellent value for money. However, as has been previously raised by ARPA NSW, there are several data issues in the NSW scheme as it relates to return to work and WR providers, as SIRA and the Nominal Insurer have been at odds over the accuracy of scheme data.

Data is an important driver of transparency and enables monitoring of performance and performance improvement activities. It is ARPA's recommendation that SIRA, as the independent regulatory authority actively collects, manages accuracy, reports upon and distributes data about scheme performance.

Included in the data set should be the effectiveness of WR services - including RTW outcomes, the reduction in benefits paid, costs and durations for the claims in which they are involved in the provision of RTW services. The measurement of the change in benefit status will help place a value on each RTW outcome especially with respect of partial RTW and the definition of suitable employment. Ideally, ARPA would like SIRA to validate and communicate the return on investment of $1 spent on WR services in the NSW workers' compensation scheme with savings in wages, medical and other claims costs.

The impact of savings from engaging rehabilitation at the right time on the right claims has been measured in other schemes and jurisdictions, it is appropriate that the same be done in NSW.

Clear and informative measures are absolutely critical to the capture of return to work outcomes and stakeholder performance. Measures require very clear descriptors to ensure data accurately reflects true status, and further capturing the status of workers at the commencement of their claim and through their claim journey to their claim conclusion.

ARPA NSW recommends that until these data issues have been rectified and that there is strong trust in the data between all stakeholders, that the development of measurement of outcomes for WR be delayed.

G. How can we drive value – as articulated in the SIRA Health Outcomes Framework - for WR in NSW personal injury schemes?

ARPA NSW recommends the incorporation of WRPs as part of SIRA's Health Outcomes Framework, due to the many reasons already stated in our earlier submission to the Health Outcomes Framework. ARPA NSW firmly believes that a framework around medical and treatment costs cannot, in and of itself, expect to produce outcomes or value-based healthcare without WRP support to guide, support and monitor it. ARPA NSW also considers that the Deeds / SLAs within insurers need to be aligned with SIRA's Health Outcomes Framework so that both Insurer and WRPs are working together towards a common goal, rather than being inhibited by compliance driven SLAs which do not allow whole person centred WR services to achieve an outcome.

A focus on early intervention is key to improving health outcomes and reducing overall claims costs and outcomes. ARPA NSW believe that for the framework to be successful and to improve overall RTW rates and health outcomes for the scheme, early intervention needs to be mandated across all insurers, as detailed previously in this submission.

We note the following which was outlined in our response to the HOF:

- incorporate workplace rehabilitation providers (WRPs) as part of the framework, due to many of the reasons already stated in our earlier submission (see previous submission attached). ARPA believes that a framework around medical and treatment costs cannot, in and of itself, expect to produce outcomes or value-based healthcare without WRP support to guide, support and monitor it
- have a whole person focus (within reason)
- consider issues such as the regulation of providers, the impact of deeds/SLAs etc. with insurers etc. as it is difficult to see how the HOF will work in the way that it is hoped, as there are multiple factors that may impact its success
- consider WRPs to be the allied health experts if this framework is to be accepted and integrated, as without the coordination and input from a WRP, we believe that the framework will not work as SIRA believes it will
- focus on early intervention and ARPA would like to see evidence of how the HOF supports an early intervention model
- ensure that only accredited and experienced staff are eligible to provide services and that non-accredited parties are removed from delivering accredited service in NSW

- ensure that oversight of providers is less prescriptive in nature and that less micromanagement is provided by scheme managers, with an assumption within the schemes that providers will deliver services that are fair and reasonable
- align (wherever possible) with the National Safety and Quality Health Service (NSQHS) Standards which have been developed by the Australian Commission on Safety and Quality in Health Care.

Separately we have referred to value already in this submission. In particular we believe it is hard to 'drive value' when no one can actually determine what is the value of WRP presently. The value of WRP has not been quantified and is not easily articulated. We commend SIRA on embarking on a project to determine the value of WRP to the scheme in financial terms as this has remained a barrier to mainstream acceptance by insurers to engaging RTW support services. The scheme is well designed to support workers and employers when administered correctly. Defining exactly what the value of WRP actually is will greatly help move past the need to constantly explain and justify engagement even though the evidence has been accepted long ago. The project to determine the value of WRP is critical to then be able to drive that value further, or even simply capitalise on what is already there.

H. What elements does a policy framework need to drive quality, innovation, capability and outcomes in WR in NSW?

ARPA NSW recommends that SIRA consider what has already been outlined in the HWCA principles-based framework for WRP as much of these elements are already there. Beyond that however we have already referred to other factors within this response such as: flexibility; data consistency; early referral and triage mechanisms; commercial competitiveness; continuous improvement and quality provisions; avoidance of red tape; defined objectives and outcomes; among others. One area we have not touched upon is however the right element of trust. Our industry remains proud that throughout many, many years we have remained true to our values and have demonstrated that we are a trusted partner within the scheme. The policy framework should consider the inherent value and responsibility that comes with trust and consider how this could be harnessed by design.

8. Appendices:

A. ARPA Case for mandated referral
B. Actuarial Edge Occupational Rehabilitation Financial Benefits Report
C. SwisseRE Rehabilitation Watch 2014 – Australia
D. ISCRR - Institute for Safety, Compensation and Recovery Research, Recommendations Report 211, June 2018
E. Letter of support from ASORC

ARPA NSW

July 2019

Policy paper: the case for compulsory referral to workplace rehabilitation in NSW

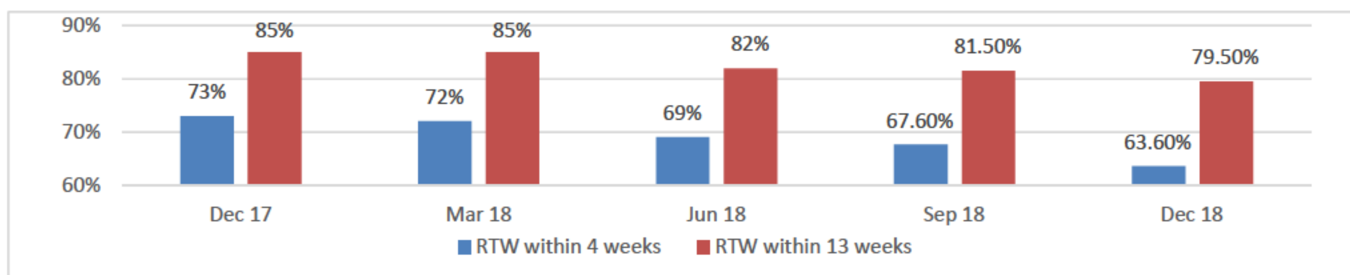
With return to work rates in NSW continuing to plummet (15% reduction over 12 months), the Australian Rehabilitation Providers Association (ARPA) calls for the NSW government to mandate referral to workplace rehabilitation for workers not anticipated to return to work within **four weeks**. Earlier referral to focused rehabilitation would save NSW at least **$38 million each year**[1].

ARPA is the peak body for the Australian workplace rehabilitation industry, representing thousands of independent workplace rehabilitation providers and allied health professionals. Our industry has a proven track record of delivering quality care and offers a return on investment between $28-$32 for every $1 invested.[2]

THE PROBLEM

- More than **560,000 Australians** suffer work-related injuries or illnesses every year[3], costing an estimated **$61.8 billion annually**[4] (extrapolated to be 160,000 New South Welshmen, at a cost of $20 billion).
- Nearly one in five of the state's workers[5] are employed in industries with the highest rates of serious claims - **agriculture, forestry and fishing; manufacturing** and **construction.**[5]
- The state's **700,000+ businesses** (ABS 8165.0 published 21 Feb 2019) are legally required to hold workers' compensation insurance, costing them more than **$2.3 billion every year.**[6]
- **Return to work (RTW) rates are in dramatic decline in NSW.** More than 2,800 or 36.4% of injured workers have not returned to work within four weeks (up from just over 1,800 or 27% of injured workers in just 12 months)[7]. Poor RTW rates cost the worker, their family, the employer, the community and the economy.[8] Reduced referrals to workplace rehabilitation are correlated directly to reduced return to work rates.
- Many employers have poor claims management practices, causing lengthy **delays in workers receiving necessary medical and rehabilitation services.** Premiums are calculated on the time it takes to return an injured employee to the workplace; these delays are unfairly inflating insurance costs.
- Workers' compensation claims costs incurred by employers in NSW have increased dramatically, rising nearly **17% from 2017 to 2018.**[6] Ensuring workers with an injury are able to get earlier and a mandated referral to an independent workplace rehabilitation provider will help address this significant increase.[1]
- The state's peak business organisation, the NSW Business Chamber, recently called upon a review of the NSW workers' compensation system to address the **serious concerns** raised by businesses across NSW. The Chamber said the system "is not working properly and is negatively impacting both employers and employees."[9]

Chart 1: NSW workers' compensation system return to work rates (December 2017 to December 2018)[7]



1 ActuarialEdge Occupational Rehabilitation Financial Benefits Report, NSW, January 2019
2 SwisseRe Rehabilitation Watch 2014
3 ABS 6324.0 - Work-Related Injuries, Australia, Jul 2017 to Jun 2018
4 SafeWork Australia, The Cost of Work-related Injury and Illness for Australian Employers, Workers and the Community: 2012–13
5 SafeWork Australia, Australian Workers' Compensation Statistics Report 2015/16
6 icare 2017/18 Annual Report
7 SIRA – NSW workers compensation dashboard, Dec 2017 - Dec 2018
8 The Royal Australian College of Physicians: Realising the health benefits of work – An evidence update November 2015
9 NSW Business Chamber https://www.nswbusinesschamber com au/Media-Centre/Latest-News/December-2018/URGENT-REVIEW-NEEDED-OF-WORKERS-COMPENSATION-IN-NS

Policy paper: the case for compulsory referral to workplace rehabilitation in NSW

July 2019

MANDATED REFERRAL: HOW WILL IT WORK?

Where any worker is likely to be off work for more than **four weeks**, the case manager must refer them to accredited WRP for an independent rehabilitation assessment. This must happen within **three working days** of the triaging outcome. A mandated referral to an accredited workplace rehabilitation provider means workers who are at risk of remaining off work long-term, are provided expert, impartial and informed support to get them back to work as quickly and safely as possible.

THE BENEFITS OF MANDATED REFERRAL TO EMPLOYEES, EMPLOYERS & THE SCHEME

Workplace rehabilitation helps a worker with an injury recover, stay at, or, return to work following an injury or illness. Accredited workplace rehabilitation providers address physical, psychological and social risk factors that affect a worker's ability to recover at, or return to work.

Every workplace insurance policy includes access to a workplace rehabilitation provider. This service is vital in helping a worker and their employer safely stay at work, or, transition back to work after an injury, accident, illness or disease. But more people with an injury in NSW are staying out of the workforce longer than they need to. This comes at an enormous personal, social, health and economic cost to them, their employers and the workers' compensation scheme in NSW.

Australasian and international empirical evidence shows that good work is beneficial to people's health and wellbeing.[10] Conversely, long-term work absence, work disability and unemployment have a negative impact on a person's health and can exacerbate underlying mental health conditions.

Workplace rehabilitation providers are approved, accredited, audited and measured by the State Insurance Regulatory Authority (SIRA) and the Australian Health Practitioner Regulation Agency (AHPRA), so employers and workers with an injury are guaranteed high levels of service, independence and the application of regulated health standards. Accredited workplace rehabilitation providers are the key resource providing expertise across these areas and more.

RAISING THE STANDARD OF SERVICE

ARPA is committed to improving the standard and the quality of service within the workplace rehabilitation industry. To help ensure mandated referral to rehabilitation is a cost-effective and consistent service, ARPA proposes that all consultants who work for workplace rehabilitation providers in NSW should complete a new and mandatory online training program.

This training program would:

- be competency based, which is training that is designed to allow the learner to demonstrate their ability
- outline the skills and attributes required to provide early, consistent and efficient workplace rehabilitation services in the NSW scheme
- be delivered by ARPA
- require an undertaking of no more than a few hours.

10 ARPA National - WRPs: Getting people back to work, back to health and back to life

ARPA NSW

July 2019

Policy paper: the case for compulsory referral to workplace rehabilitation in NSW

CASE STUDIES

The following case studies demonstrate the significant difference in cost between an early and late referral to an independent workplace rehabilitation provider for NSW employers and the scheme. In this instance, the employer whose worker was **not** referred to an independent rehabilitation provider soon after their injury has incurred wage costs more than **980%** of the employer whose worker (with the same injury) was referred to an independent rehabilitation provider within four days of their injury **($304,640** compared to **$26,160** in estimated wage costs over the life of the claim*).

Case details	Late referral to workplace rehabilitation	Early referral to workplace rehabilitation
Date of Injury (DOI)	14 January 2016	4 September 2016
Date of Referral	5 March 2018	9 September 2016
Delay to Referral (days)	781 days	4 days
Nature of Injury	Lower back disc bulge L4/L5 disc bulge	Lower back disc bulge L4/L5 disc bulge
Summary	Worker was referred 781 days after the injury, which was managed internally by an employer representative. Intervention required: • Exercise Physiology Program (moving from passive to active treatment) to increase functional capability to increase hours and duties within the workplace • Intensive support to worker and employee to ensure maintenance of relationship given duration of injury and strain between both parties • Identification and facilitation of investigation into pathology of injury • Facilitation of additional treatment for compensable condition including cortisone injections.	Worker was referred four days after injury for RTW services following L4/L5 disc bulge. Intervention required: • Treatment facilitated and commenced by 22/09/16 • Employer able to offer suitable duties reduced hours / tasks in the interim • Graded RTW Program commenced alongside treatment recommendations increasing hours and duties accordingly • Worker able to return to pre-injury duties within **11 weeks as a result of early referral**; early treatment; supportive employer and graded RTW plan alongside AHRR (treatment plan).
Outcome	Working same employer pre-injury duties	Working same employer pre-injury duties
Date of Closure (DOC)	7 September 2018	30 November 2016
Duration to outcome	26.42 weeks	11.7 weeks
Rehabilitation cost paid by the scheme	$8,344 incl GST	$4,782 incl GST
Estimated wages cost during rehabilitation*	$42,272	$18,720
Estimated wages cost from DOI to DOC*	**$304,640**	**$28,160**

* Estimated using NSW Average Weekly Ordinary Time Earnings (6302.0 - Average Weekly Earnings, Australia, May 2018)

Actuarial EDGE

OCCUPATIONAL REHABILITATION FINANCIAL BENEFITS REPORT

NEW SOUTH WALES

Executive Summary

The Australian Rehabilitation Providers Association (ARPA) is the peak professional body for the workplace health, return to work and rehabilitation industry. Representing thousands of independent workplace rehabilitation providers and allied health professionals, our industry has a proven track record of delivering quality care and offer a return on investment between $28-$32 for every $1 invested.

More than 500,000 Australians suffer work-related injuries or illnesses in Australia every year, costing the national economy an estimated $62 billion. More than three-quarters of the cost is attributed to indirect costs to workers, such as lost productivity, loss of current and future earnings, and loss of quality of life.

That is because more people with an injury staying out of the workforce longer than they need to. Australasian and international evidence shows that good work is beneficial to people's health and wellbeing. Conversely, long-term work absence, work disability and unemployment generally have a negative impact on a person's health and can exacerbate underlying mental health conditions.

Workers' needs in New South Wales and across the country are changing. Increasing rates of mental health injury and our inability to create psychologically safe workplaces are possible threats to a worker's successful return to work. However, we can reduce the burden of lost productivity. The following report, commissioned by ARPA and conducted by Actuarial Edge, analyses the financial benefits of using occupational rehabilitation services.

It concludes:

"If occupational rehabilitation referrals occur one month faster than is currently the case, resulting in improved return to work outcomes, Insurance & Care NSW's (icare) breakeven premium (BEP) could decrease by approximately $38 million per annum (0.023 per cent of remuneration) and the scheme's claims liability would decrease by approximately $17 million (0.15 per cent of the liability)."

New South Wales could save $38 million per annum through earlier referral to occupational rehabilitation.

ARPA members consider greater collaboration between icare and independent rehabilitation providers would mean more efficient and earlier referrals with the ultimate goal of returning people to work. icare can partner with ARPA members to reduce scheme liabilities and bring about greater benefits for the workers of NSW, their employers and the economy.

Getting people back to work is a priority and building a better workplace rehabilitation industry is a key part of the solution.

ARPA National

Actuarial Edge Report

Methodology

ARPA has commissioned this report to determine the financial benefits of utilising occupational rehabilitation (OR) services within workers' compensation schemes across various jurisdictions in Australia. The initial focus is on New South Wales, which is managed by Insurance & Care NSW (icare).

Several research materials were used in preparing this report:

- A 2013 research paper by Casey, Guy and Cameron[1] (the 2013 research paper), examines RTW outcomes for individuals receiving OR services in the NSW workers' compensation scheme;
- High level data to 2010 from WorkCover NSW (WorkCover data) summarising OR referrals, outcomes and total spend;
- High level data to 2016 from the State Insurance Regulatory Authority (SIRA data) summarising OR referrals, outcomes and total spend.

Actuarial Edge was engaged to:

- Identify key findings from the 2013 research paper and the WorkCover and SIRA data;
- Use the findings from the WorkCover and SIRA data as a reference check against the findings from the 2013 research paper;
- Translate the findings from the 2013 research paper into financial benefits for icare, including:
  - reductions in break-even premium;
  - reductions in scheme liabilities; and
  - improvements in return to work rates.

Actuarial Edge initially conducted this analysis in July 2017 and it was updated in 2018 to reflect more recent icare financial and claims statistics, available in icare's 2016-17 Annual Report and Financial Statements and Safework's Comparative Performance Monitoring Report, 19th edition.

[1] P. Casey, L. Guy and I. Cameron 2013 "Determining return to work in a compensation setting: A review of New South Wales workplace rehabilitation service provider referrals over 5 years"

Actuarial EDGE

Summary of Findings

A key finding of the 2013 research paper was that "for every 3 month increase in the duration of disability the odds of achieving a RTW upgrade decreased by 3%."

We used various sources of data available to us, including data underlying the 2013 research paper, Safework Australia's Comparative Performance Monitoring report and icare annual reports and financial statements to translate this finding into the following:

"If all OR referrals occur 1 month faster than is currently the case, resulting in improved RTW outcomes, we estimate that icare's breakeven premium (BEP) would decrease by approximately $38m p.a (0.023% of remuneration) and the scheme's claims liability would decrease by approximately $17m (0.15% of the liability)."

This finding relied on a number of key assumptions, including:

- RTW outcomes observed at different delays to referral are due to the different delay times, rather than due to any other factors impacting RTW outcomes (such as injured worker cohort characteristics);
- It is possible to speed up OR referrals by 1 month;
- Approximately 1,135 injured workers receive income replacement for at least 2 years (based on the assumption that 50% of those receiving income replacement for at least 1 year will continue to receive income replacement for at least 2 years);
- Approximately 115 injured workers receive income replacement for at least 5 years (based on the assumption that 10% of those receiving income replacement for at least 2 years will continue to receive income replacement for at least 5 years).
- 11% of all injured workers are referred to OR providers for RTW services.

It was not possible to test the validity of these key assumptions based on the data available. We therefore ran scenarios to test the sensitivity of the results to these assumptions. Output from scenario testing suggests that the financial impact to icare of speeding up OR referrals by 1 month is in the range of a 0.003% to 0.077% decrease in BEP (expressed as a % of remuneration).

Further Detail

Key Findings from 2013 Research Paper

A key finding of the 2013 research paper was that "duration of disability[2] is a significant determinant in achieving a positive RTW outcome". The paper concluded that "for every 3 month increase in the duration of disability the odds of achieving a RTW upgrade decreased by 3%."

We were provided with the data underlying the 2013 research paper and used this to further analyse the relationship between delay to OR referral and RTW outcome, as summarised in Table 1.

Table 1 - RTW outcomes at various delays to OR referral

Delay to OR Referral (Months)	Average RTW	Weighted Ave Change in RTW (1 mth faster)
0	45%	
3	57%	-3.6%
6	52%	2.1%
12	43%	1.2%
24	40%	0.2%
60	35%	0.1%

Table 1 suggests that:

- RTW outcomes are highest at lower delays to OR[3].
- The impact on RTW outcomes of speeding up OR referrals by 1 month is strongest at earlier durations. For example,
  - referrals made between 3 and 6 months post injury achieve an average 2.1% improvement in RTW outcome for a 1 month faster referral; whereas
  - referrals made between 12 and 24 months post injury achieve an average 0.2% improvement in RTW outcome for a 1 month faster referral.

In interpreting our analysis in the above way, we made a key assumption that different RTW outcomes achieved at different delays to referral are due to the different delay times, rather than due to any other factors impacting RTW outcomes (such as injured worker cohort characteristics). As noted in the 2013 research paper, this analysis also does not assess or allow for:

- The sustainability of RTW outcomes achieved
- Any previous episodes of RTW assistance
- Variation in service intensity, duration and content amongst providers

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[2] Measured as the time elapsed between injury date and date of referral to OR

[3] We note the exception to this rule for referrals made in the same month of injury (month 0), which exhibit a lower RTW rate (45%) than referrals made up to 6 months after injury (52%-57%). We have assumed this anomaly is due to certain characteristics of claims referred immediately after injury and have therefore ignored this effect when analysing the impact on RTW outcomes of faster referral to OR.

Key findings from and comparison to WorkCover and SIRA data

WorkCover and SIRA data (provided to us by ARPA), contained information such as:

- Referral numbers
- RTW outcomes
- OR payments; and
- Delay to referral (WorkCover data only).

In many cases, this information was available separately for Same Employer and Different Employer services. The WorkCover data covered the period from 2006 to 2010, while the SIRA data covered the period 2012 to 2016.

While the WorkCover and SIRA data didn't contain any "key findings" as such, it did allow a comparison to the data underlying the 2013 research paper, as summarised in Table 2[4].

Table 2 - Comparison of Research, WorkCover and SIRA data

Item	Research data (2010)	WorkCover data (2010)	SIRA data (2012)
Total Rehab Costs ($m p.a)	62	96	95
Rehab Referrals (p.a)	16,394	47,917	20,012
RTW rate	52%	46%	58%
RTW rate Same Employer	57%	n/a	79%
RTW rate Different Employer	46%	n/a	34%
Median delay to referral (months)	12	10	n/a
Average delay to referral (months)	29	19	n/a

[4] We note that WorkCover data was available until 2010 and SIRA data was available from 2012, hence a like with like comparison between the three sources was not possible.

We note the following from Table 2:

- The research data represents approximately 65% to 80% of total OR referrals in a year (not all OR providers chose to participate in the 2013 research[5]).
- the overall RTW rate from the research data falls in the middle of the rates reported in the WorkCover (2010) and SIRA (2012) data, although the difference in rates for Same and Different employers suggests the use of different definitions/calculation methodologies between the 2013 research data and SIRA data.
- Median delay to referral from the research data (12 months) is reasonably consistent with the WorkCover data (10 months), although the average delay to referral is significantly higher in the research data (29 months v 19 months respectively).

It would be useful to conduct further investigations into the differences between these data sources. In particular, as suggested in the 2013 research paper, it would be useful to find ways to increase the consistency, accuracy and reliability of data available from OR providers, to increase the pool of referrals available for analysis.

Translation of findings

The first step in translating the 2013 research findings into financial benefits for icare was to answer the following question: "If all OR referrals are made 1 month faster, resulting in improved RTW outcomes as set out in Table 1, what impact will that have on the number of injured workers receiving income replacement at different durations after injury"?

It is not clear from the research findings whether the extra RTW outcomes achieved were for individuals who would otherwise have remained on income replacement for more than 5 years after injury. We have therefore examined two extreme scenarios:

- Scenario 1 (Faster RTW): no additional RTW outcomes - the faster referrals result in faster RTW outcomes for those workers who would otherwise have ceased entitlement to income replacement and returned to work 5 years after injury;
- Scenario 2 (More RTW): all additional RTW outcomes - the faster referrals result in more injured workers achieving RTW outcomes. These workers would otherwise have continued on income replacement beyond 5 years.

[5] Referrals in the WorkCover data includes all claims with an OR payment in 2010. This overestimates actual referral numbers, as it double counts claims with OR payments occurring across multiple years.

Table 3 sets out our estimate of the impact under these two scenarios:

Table 3 - Impact of faster referrals on claim numbers at different durations[6]

Summary of Financial Benefits			
Weeks	Number of claims reaching milestone (base)	Change in claims reaching milestone (faster RTW)	Change in claims reaching milestone (more RTW)
0	61,221	0	0
1	32,404	0	0
6	13,610	0	0
13	8,425	0	0
26	4,213	-19	-19
52	2,268	-25	-25
104	1,134	-26	-26
260	113	0	-26
1144	0	0	0

Under the Faster RTW scenario, 26 injured workers achieve a faster RTW outcome (and therefore have a shorter period of income replacement paid to them). However, there is no change in the total number of injured workers remaining on income replacement beyond 5 years/260 weeks (113).

Under the More RTW scenario, 26 injured workers, who would otherwise have continued to receive income replacement more than 5 years after injury, achieve a RTW outcome prior to 5 years post injury.

These scenarios could result in the following financial impacts for the icare scheme:

- Reduction in the number of weeks of income replacement paid
- Reduction in the amount of medical costs for these injured workers
- A lower propensity to claim lump sum payments from the scheme such as in the form of permanent impairment benefits or common law damages.

[6] Source of number of claims reaching various milestones is Safework's Comparative Performance Monitoring Report, 19th edition, adjusted for the growth in overall claim numbers between 2015/16 and 2016/17, as reported by icare in their Annual Reports. Assumptions were applied to these statistics to estimate the number of claims at 52 weeks reaching 104 weeks and 260 weeks.

The estimated financial impact of each of the above changes is summarised in Table 4.

Table 4 - Estimated Financial Impact for icare[7]

	Base	Faster RTW	Central	More RTW
Weekly BEP ($m)	552	-3	-12	-20
Medical BEP ($m)	362	-2	-8	-13
Lump Sum BEP ($m)	324	0	-18	-37
Other BEP ($m)	800	0	0	0
Total BEP ($m)	**2,038**	**-6**	**-38**	**-70**
Total BEP (%rem)	**1.240%**	**-0.003%**	**-0.023%**	**-0.043%**
Total gross liability ($m)	**11,320**	**-2**	**-17**	**-32**
% of liability		**-0.02%**	**-0.15%**	**-0.28%**

The Faster RTW scenario is expected to reduce icare's Breakeven Premium (BEP) by $6m p.a (0.003% of remuneration), whereas the More RTW scenario is expected to have a much greater impact on BEP ($70m reduction or 0.043% of remuneration).

As the Faster RTW and More RTW scenarios represent two extreme scenarios (ie none/all of the additional RTW outcomes were for injured workers who would have remained on income replacement beyond 5 years), we have selected the average of these two scenarios as our central estimate.

Therefore, if all OR referrals occur 1 month faster than is currently the case, resulting in improved RTW outcomes, we estimate that icare's claims costs would decrease by approximately $38m p.a (0.023% of remuneration). We estimate this would decrease the scheme's claims liability by approximately $17m (0.15% of liabilities).

The estimated change is expected to have only a small impact on overall RTW rates for the scheme (26 additional RTW outcomes out of 32,400 injured workers receiving some income replacement would increase RTW rates by approximately 0.1%).

Sensitivity testing

In estimating the impact of faster OR referrals on icare's financial results, we had to make a number of key assumptions, due to the limited data available to us about icare's claims experience and financial structure. These key assumptions related to:

- The percentage of all injured workers referred to OR for RTW services
- The flow-on impact of higher RTW outcomes on an individual's propensity to claim lump sums
- The number of claims staying on income replacement between 52 and 104 weeks and between 104 weeks and 5 years after injury

[7] We note that the "Base" BEP figures in Table 4 are estimates only, as icare's actual BEP amounts were not available.

- The inflation and discount factors used by the scheme when calculating BEP and liabilities
- The average length of income replacement, particularly for those injured workers entitled beyond 5 years.

We ran a number of scenarios to test the sensitivity of our findings to each of these key assumptions. The outcome of these scenarios is shown in Table 5.

Table 5 - Results of Scenario Testing

Scenario	Base	Scenario	Change in Premium (% remuneration) Faster RTW	Central	More RTW	Key Assumption?
Base			-0.003%	-0.023%	-0.043%	
Workers receiving OR (RTW)	11%	14%	-0.004%	-0.029%	-0.054%	Y
		20%	-0.006%	-0.041%	-0.077%	
Lump Sum impact	50%	25%	-0.004%	-0.017%	-0.031%	
		75%	-0.004%	-0.029%	-0.054%	
52 week claims reaching 104 weeks	50%	20%	-0.004%	-0.035%	-0.066%	Y
		60%	-0.004%	-0.022%	-0.040%	
104 week claims reaching 5 years	10%	5%	-0.004%	-0.033%	-0.062%	Y
		20%	-0.004%	-0.018%	-0.032%	
inflation factor	116%	107%	-0.003%	-0.020%	-0.037%	
		124%	-0.004%	-0.026%	-0.048%	
discount factor	74%	86%	-0.004%	-0.025%	-0.046%	
		64%	-0.003%	-0.021%	-0.039%	
break-even premium buffer (% rem)	0.11%	0.01%	-0.004%	-0.023%	-0.042%	
		0.50%	-0.004%	-0.023%	-0.042%	
average weeks for those > 5 years	967	790	-0.004%	-0.021%	-0.038%	
		702	-0.004%	-0.020%	-0.036%	

As shown in Table 5, this scenario testing suggests that the financial impact to icare of speeding up OR referrals by 1 month is in the range of a 0.003% to 0.077% decrease in BEP (expressed as a % of remuneration).

The results are most sensitive to the following assumptions:

- The proportion of injured workers receiving OR RTW services

The number of injured workers remaining on income replacement for more than 2 and 5 years

Reliances and Limitations

The findings contained in this letter rely on the accuracy and completeness of the information provided by ARPA. Where possible, we have checked for consistency between the various sources, including a comparison of 2013 research data to data provided by WorkCover NSW and SIRA. However, we have not conducted a comprehensive, independent review of the information.

We note that the 2013 research paper listed a number of limitations on the research, including:

- only 40% of RTW cases collected in the data set were included, due to issues with consistency, accuracy and reliability of the underlying data
- it did not account for many possible explanatory variables of a non RTW outcome
- it did not measure sustainability of RTW outcomes over time
- it did not consider any previous episodes of RTW assistance
- it did not allow for variation in service intensity, duration and content amongst providers

In estimating the financial impact on icare, we have made various assumptions, particularly as we had limited claims experience and financial information for icare. As with any estimation involving uncertainty, it is unlikely that the actual financial impact will be exactly as expected.

We have examined the uncertainty in our modelled outcomes by conducting scenario testing to understand the impact of changing our key assumptions. In conducting our scenario testing, we chose a range of what we consider to be plausible assumptions. This highlighted a number of key assumptions which could be further explored at a later date to reduce the uncertainty contained in our estimates.

Swiss Re

Rehabilitation Watch 2014 – Australia

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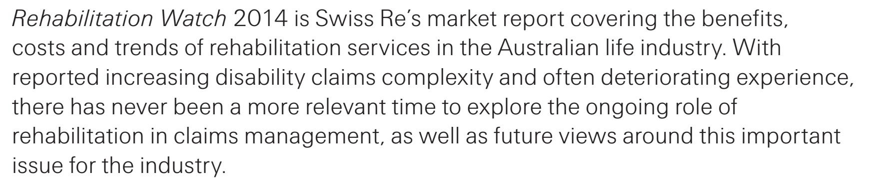
Disclaimer: All companies that participated in Rehabilitation Watch 2014 agreed that any and all results gleaned from this survey would not and will not be used for commercial or other public purposes, without the prior written permission of Swiss Re. Specifically, the results and analysis herein will not be used in business marketing, sales materials or as part of any sales activities by the participants. Swiss Re Life and Health Australia Ltd assumes no responsibility for the accuracy of data submitted by participating companies, nor for any action or results arising out of the use of the survey. Swiss Re reserves the right to publish high-level overviews and analyses of any key survey results findings. The information and opinions contained in Rehabilitation Watch 2014 are provided as of the date of publication and are subject to change without notice. Swiss Re does not accept any responsibility for the accuracy or comprehensiveness of the data and/or details given. All liability for the accuracy and completeness thereof or for any damage or loss resulting from the use of the information contained in this publication is expressly excluded. Under no circumstances shall Swiss Re or its Group companies be liable for any financial or consequential loss relating to this publication.

Welcome to our first *Rehabilitation Watch* report for the Australian market. This report covers trends and topical issues for life and health claims from a rehabilitation perspective – on individual and group business.


Rehabilitation Watch 2014 is Swiss Re's market report covering the benefits, costs and trends of rehabilitation services in the Australian life industry. With reported increasing disability claims complexity and often deteriorating experience, there has never been a more relevant time to explore the ongoing role of rehabilitation in claims management, as well as future views around this important issue for the industry.

We would like to thank everyone who has participated in this first edition. We look forward to meeting with each of you to discuss these findings in more detail. We are keen to explore areas where we can work together on initiatives to benefit both you, our clients, and your customers.

Your local *Rehabilitation Watch* contacts

To discuss any aspect of this publication or the related issues, please contact:

Executive summary

Claims rehabilitation has been a topic of growing interest in the Australian life insurance market, with insurers either starting or growing their investment in in-house rehabilitation staff. From an industry level, we have seen the Life Rehabilitation Forum increase in size by 700% over the past five years, and recruitment continues. As an industry we have a cognisance that rehabilitation can offer many benefits, to many parties but how can we demonstrate this, both from an objective and qualitative standpoint?

Nine of Australia's major life insurance companies provided data and commentary for this study, including those who offer individual and/or group insurance as well as multiple product lines. In undertaking our first *Rehabilitation Watch* study, we sought to explore what rehabilitation means to the market, the associated costs and benefits, and to consider what place rehabilitation might have in the future disability insurance environment.

This year's survey found that insurers are confident that the advantages of offering and administering rehabilitation benefits still outweigh the challenges. Reaping the benefits of rehabilitation comes with its caveats – having an understanding of and an action plan for these caveats very much determines whether rehabilitation intervention is likely to be successful and cost-effective.

Evidence-based literature reinforces the importance of intervening early and as an industry, we acknowledge there is much room for improvement. We observed an average timeframe for implementing rehabilitation programs in excess of 12 months from the date of disability, however, there are signs that the market is pressing forward with earlier intervention and engagement, with some insurers offering rehabilitation assistance within the waiting period and potentially prior to claims being lodged.

Encouragingly, when rehabilitation services are being implemented – either by in-house rehabilitation consultants, or provided externally – most insurers are able to provide evidence of a return on investment (ROI). *Rehabilitation Watch* 2014 found that for every $1 spent on rehabilitation services, insurers saved between $24 and $39 on income protection claims costs. Conversely though, insurers may not be tapping into the full ROI potential with only 5-6% of income protection claimants participating in rehabilitation programs in the 2013 calendar year.

The inability to provide comprehensive rehabilitation-specific data was an overarching finding from the survey. Insurers remarked that through the completion of the survey tool came the realisation of the need to improve the quality and span of data captured. With many participants developing new claims management platforms, Swiss Re envisages that future survey editions will lead to more meaningful, reliable and compelling metrics.

Our intention in future editions of *Rehabilitation Watch* will be to use the data from this first edition to make comparisons and to develop richness to the commentary around the trends observed. Swiss Re's UK office has undertaken a similar study and we hope to be able to provide comparisons, not only in the Australian market in future editions, but also from a global standpoint.

Rehabilitation Watch 2014 left us with some encouraging messages for our industry. Not only have insurers started to realise the positive financial impact rehabilitation can have, more widely the market is focused on promoting the intrinsic value of rehabilitation in assisting people to make a recovery and a return to health and work.

Key takeaways

Claimants' attitude and motivation	The key determinant to the success of rehabilitation intervention.
5–6%	Income protection claimants engaged in rehabilitation services.
12 months	Average time after the date of notification or date of disability that insurers are initiating rehabilitation programs. As an industry we need to work at expanding the opportunity to intervene earlier.
$24–$39	Amount saved by insurers on claims costs for every $1 spent on rehabilitation services – demonstrating the cost-benefit
Communication	Required to improve engagement with the market. The degree of stakeholder engagement is clearly linked to the level of knowledge and understanding of the purpose of rehabilitation services.
100%	Participants who agreed that rehabilitation would play more of a role in the future Australian life insurance market.

Methodology

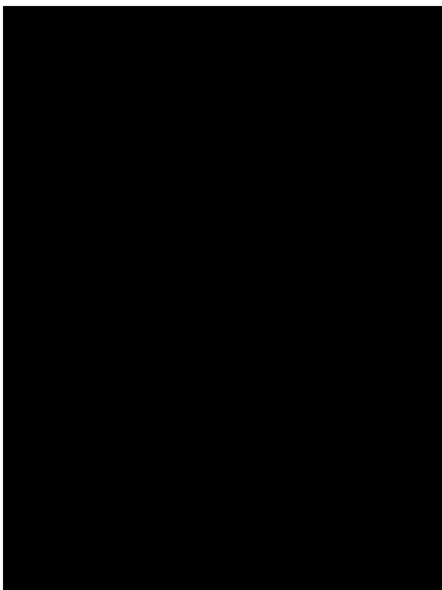
The information presented in *Rehabilitation Watch* is derived from data submitted by nine participating insurance companies (participants), based on claims received and managed in the 2013 calendar year.

Not all companies supplied data for every question and this has been acknowledged throughout the report. The findings are anonymous[1] and companies are listed in no particular order. Quotes included in this report have been provided by participants.

For survey questions requiring data submission, participants were asked to assign a data confidence rating. All confidence ratings referred to throughout this report were scored on a scale of 1 to 5, where 1 = educated guess and 5 = very sound data provided. The overall data confidence rating for *Rehabilitation Watch* 2014 was 3.24.

Throughout this report, we have used some assumed terms and abbreviations to keep it as concise as possible. The appendix contains a guide of these terms and abbreviations to take into account when reading *Rehabilitation Watch* 2014.

Author:



has worked in the insurance industry for more than 10 years in a variety of injury/illness management and rehabilitation roles in both Australia and the UK. She joined Swiss Re in 2011 as Claims Medical Specialist.

has had extensive experience in the occupational rehabilitation field and across various disciplines including workers compensation, CTP and income protection/disability insurance. She holds a Bachelor of Applied Science, Cert IV OH&S and is a Certified Disability Management Practitioner (IDMSC).

As an integral part of Swiss Re's Life and Health Claims team, provides clinical consultancy and training to our clients. In 2012, she was awarded the Turks Legal-ALUCA (Australasian Life Underwriting and Claims Association) Scholarship for her research paper on the benefits of early intervention in claims management. plays a key role in promoting best practice and quality rehabilitation service provision for those absent from work due to injury or illness.

Rehabilitation – the advantages and challenges

Advantages
In line with the increasing utilisation of rehabilitation services within the life insurance market there has been an increase in awareness of the benefits that the provision of these services can have. Importantly, it is not just about the benefits to the insurer. Through this survey we were able to capture thoughts about the benefits to all key stakeholders – and this is where we will start. The tables below reflect statements made by the participants for *Rehabilitation Watch* 2014.

Foremost, participants stated that return to work (RTW) was the standout advantage fuelled by the provision of rehabilitation services. Returning a claimant to work is a benefit for all parties. For the insurer it means claims can be finalised and reserves managed accordingly but for the claimant, a RTW is hugely important for reasons that extend beyond just the financial incentives of getting back to 100% pre-disability income. The health benefits of work are widely recognised (Australasian Faculty of Occupational & Environmental Medicine, 2011) and promoting these health benefits is just a small part of the role of rehabilitation professionals in any injury/illness compensation jurisdiction.

"Under our rehabilitation benefit, we will consider almost anything to help a customer, if we can link it to a return to work."

Advantages of rehabilitation services – claims management

Return to work (RTW)

- Facilitation of a quicker and more sustainable RTW
- Early RTW → reduction in monthly benefit and reserve, claim finalisation
- Focused on evidence-based treatment and ensuring RTW is considered part of the 'treatment plan'
- Raises awareness that a RTW outcome is in the best interests of all parties
- Assisting RTW through retraining

Claims strategy

- Ensuring appropriate strategies are in place and that appropriate treatment is being provided
- Facilitating reduced claim durations and improved termination rates
- A way to connect medical aspects of the claim to the occupational factors
- Provision of useful information for other areas of the business such as medical and investigation
- Enhancing robustness of the TPD decision making process

Advantages of rehabilitation services – key stakeholders

Customers (claimants)

- Assisting people to become fit for work and RTW
  - Helping people get back to good health and gaining confidence to be able to RTW
  - Assists a return to gainful employment through a supportive and gradual approach
  - Workplace RTW assistance (employers tend only to offer this on workers compensation claims)
- Improving quality of life through education and help with 'living aids'
  - Improved customer experience through enhancing coping strategies and functional abilities
  - Understanding the customer's circumstances from day one of the claim

Employers (group insurance), Fund and Advisors/Brokers

- Value added service
  - 'Peace of mind' and 'confidence' that their employees have access to an expert team of internal staff and external providers
  - Stronger service offering through reliance on a rehabilitation service delivering qualitative and quantitative outcomes
- Employers retain employees and minimise lost productivity, at no cost to them
  - RTW is in the best interest of the employer (premium management)

Insurers

- Marketing advantage through improving the customer experience
  - Delivering more than just a monthly benefit
  - Role of rehabilitation in overall service proposition
- Enhanced knowledge and expertise of claims assessors
  - Behavioural and technical upskilling of claims teams around duration and RTW case management
  - Improving claims capability in rehabilitation and disability management
- Claims management impacts (strategy and RTW) – see above table

From the survey results, it is clear that implementing rehabilitation services can provide many benefits to the key stakeholders, however, the question has historically been, and still is – how do we measure and demonstrate these benefits? We will cover rehabilitation outcome metrics later in this report.

Lastly, it would be remiss not to report any drawbacks to providing rehabilitation services to claimants, as the very nature of managing claims means that we will face challenges and obstacles along the way. Most insurers were of the opinion that while there are few disadvantages to funding rehabilitation, it must be prefaced with ensuring rehabilitation is part of a clear strategy engaging all stakeholders. Instead of 'disadvantages' to rehabilitation, we will term the negative influences or factors for consideration as 'challenges'.

Challenges

The largest and most frequently reported challenge faced when offering rehabilitation services to claimants is motivation. Motivation is defined as the desire or willingness to do something; enthusiasm (Oxford University Press, 2014). Almost all insurers made the observation that unless the claimant is engaged, willing to participate and ultimately motivated to RTW, rehabilitation intervention is unlikely to be successful.

Therefore, a key facet of determining suitability for rehabilitation intervention is to gather an impression of the claimant's level of motivation and what is driving this. Examples of motivation drivers include solicitor involvement and concurrent claims (workers compensation, TPD etc.) – where these drivers are negative, we can draw the conclusion that the claimant may be motivated by secondary gain to remain off work and therefore may be unlikely to engage in or benefit from rehabilitation intervention.

Secondly, unlike rehabilitation in workers compensation, claimants are not obligated (by legislation or otherwise) to participate in rehabilitation services to help them RTW. Thus, given the absence of any negative consequences for non-participation, success and engagement in rehabilitation services is really reliant on the claimant's motivation.

The presence of an 'entitlement mentality' is another barrier to implementing rehabilitation strategies on claims. Insurers reported that this mentality works in two ways – if a claimant wants rehabilitation assistance just because they feel 'entitled', this may be reflected in an unenthusiastic approach to recovery and RTW. Conversely, insurers often see claimants remain off work and unengaged because they are 'entitled' to their monthly benefit. In more extreme examples, claimants can present unrealistic expectations of their rehabilitation benefit entitlements, for example wanting a career change or funding for tertiary education when change is not required for medical/health reasons.

Turning attention to the challenges faced within insurance companies when implementing rehabilitation services, participating organisations reported that there needs to be a collaborative focus as opposed to an 'us and them' (rehabilitation consultants (RCs) versus claims assessors (CAs)) mentality. By solely owning recovery and RTW strategies, rehabilitation teams can run the risk of disassociating CAs from these key aspects of claims management.

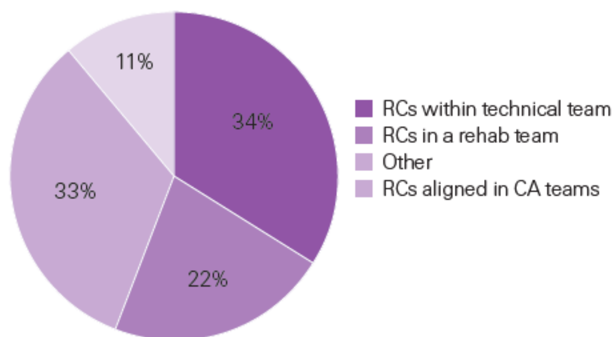
Finally, one of the biggest challenges reported by participants pertains to external rehabilitation provider referrals. In particular, where insurers do not have an internal rehabilitation team and refer most cases out, the success of intervention is very much reliant on the external provider. In this study, insurers with and without in-house rehabilitation teams both agreed that this challenge extends further when CAs make referrals and are responsible for directing strategy with the provider. Often due to CA inexperience and/or workload there can be a tendency to 'blindly follow' what the provider recommends. When this has occurred, insurers said they experienced escalating rehabilitation costs and at times longer durations and poorer outcomes. For RCs participating in *Rehabilitation Watch* 2014, this final challenge is actually viewed as an opportunity and a proof point to the value that in-house rehabilitation teams can bring.

Structure and role of in-house rehabilitation consultants

At the time of data submission for *Rehabilitation Watch* 2014, there were a total of 43.8 full time equivalent (FTE) RCs working in-house at participating organisations. This number continues to increase and is estimated to have increased almost tenfold over the past five years.

Turning our attention to how participants align their in-house RCs in the claims operation, we presented the following options:
1. RCs sit within their own rehabilitation team (typically with a designated Rehabilitation Manager)
2. RCs sit within the claims teams (typically reporting through to Team Managers or the Head of Claims)
3. RCs sit within the insurer's team of technical specialists
4. Other/a combination of the above options.

Figure 1: In-house RC alignment within the claims operation



Interestingly, there was a somewhat even distribution of how the participants align their RCs within the business. Many indicated 'other', explaining that their organisation combines alignment options – for example, RCs report to a manager of rehabilitation services (organisational reporting line), however, each RC sits within a claims team and is responsible for providing rehabilitation services to that team. Some insurers also provided feedback around national coverage; whereby their organisation may have offices in multiple states or countries such as New Zealand. RCs may be located in one office, however, provide rehabilitation assistance to all other offices/locations.

Most insurers advised that they have tried and tested various alignment models and found that a key consideration when deciding on structure is to ensure that the RCs are not isolated from the claims teams.

"We've found that since sitting together as a rehab team, there's generally less case discussion with the assessors because we're not next to them."

As always, there are pros and cons to any alignment model. Some additional pros derived from the feedback included:

RCs aligned within claims teams

- Grow and maintain collaborative relationships with CAs
- Provides opportunity for CA education, knowledge and training transfer
- Observe CA behaviour – coach and mentor skills such as telephonic case management
- RCs can learn from CAs – close proximity allows RCs to be privy to broader issues impacting the claims environment
- Team has a single point of contact – fosters stronger strategy and ideas
- Ensures rehabilitation is "visible", easy to approach

RCs in a rehabilitation team

- Sitting together encourages collaboration and idea generation – with an array of RC backgrounds, skill and expertise can be shared
- Allows RCs to work across all products facilitating greater job variety, satisfaction and opportunity as well as ensuring the ability to cross-skill
- Having a rehabilitation manager is an opportunity to provide direction, professional guidance and support – promotes quality and consistency

RCs in a team of technical specialists

- Rehabilitation is viewed as another "specialist tool" to assist effective claims management
- RCs benefit from technical claims advice and collaborative strategy setting
- RCs have the opportunity to work across all claim types – group and retail IP/GSC and TPD
- Facilitates management of service provider panels similarly to legal and factual investigation

Staff ratios

The question of rehabilitation staffing ratios within insurers is always sought-after information. How many RCs do we need to implement cost-effective rehabilitation intervention? We need more staff, how can I substantiate my business case?

So, what is the 'magic' number? The average ratio of CAs to RCs for group business was one RC to every 18 CAs. Within the retail business at participants, the average ratio was one RC to every 13 CAs.

Group Life

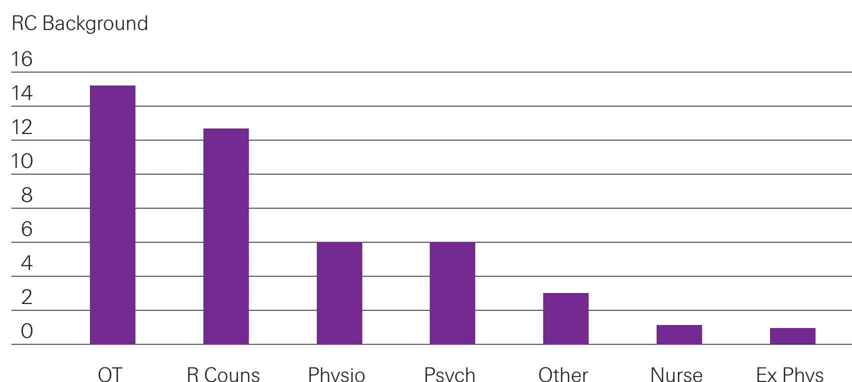
Retail Life

A wealth of experience

There was a diverse rehabilitation skill set and capability across the participating insurers. While the RC staff background is still dominated by occupational therapists, there are now many more rehabilitation counsellors and psychologists joining the life insurance sector. In order to attract this diverse skill set, we are seeing the industry move towards partnerships with specialist bodies such as ASORC (the Australian Society of Rehabilitation Counsellors) and offering seminars to university graduates to promote career path opportunities.

Other skills and expertise of participants' RCs included nursing, exercise physiology and physiotherapy, occupational health and safety, naturopathy and counselling.

Figure 2: Rehabilitation Consultant staff background experience/qualifications



“Having a multidisciplinary team, with varied specialties, ensures that we can *support* each other to best manage the *needs of the claimant,* and *understand* the treatment and injury management protocols for a wide range of groups.”

Not only do RCs come from a multitude of different backgrounds, the level of experience either in the life insurance (or wider insurance) sector and/or in clinical rehabilitation is typically a minimum of five years and ranges to more than 20 years' experience.

Encouragingly, given the increase in claim numbers for mental illness, both for disability insurance and for TPD, we are seeing the life insurance market recruiting psychologists and counsellors to help support effective claims management and to educate CAs on best practice rehabilitation.

Finally, some participants said they are currently utilising external contractors to assist their core rehabilitation team to deliver on objectives and meet workload demands. While in most cases this is seen as a stopgap measure, there are other associated benefits including capacity to provide training to claims staff and deriving (rehabilitation) market information from the 'coal face'.

Rehabilitation services and interventions

Policy inclusions and wordings vary across all life insurers and consequently, we expect insurers to report different services that are included under the banner of 'rehabilitation'. Table 1 shows the percentage of the participants that consider each service as 'rehabilitation' and would therefore expect their RCs to undertake, refer out and where applicable, fund.

Table 1: Considered rehabilitation services

Rehabilitation service	% of Insurers
Initial rehabilitation needs assessment	100%
Case management, planning and graded RTW	100%
Vocational rehabilitation counselling and job seeking	100%
One-off assessments (e.g. workplace and employability assessments)	100%
Adjustments to job role, aids and equipment	100%
Early intervention services	100%
Clinical/rehabilitation advice to Claim Assessors	89%
Business coaching	78%
Functional capacity evaluations	67%
IME referrals and/or input	67%
Funding non-Medicare services	56%
Other services	33%
Signposting to Government/charity support agencies	22%

'Other services' insurers reported included external training courses, work conditioning (work-related activity programs, supervised exercise programs), work trials and employer mediation services.

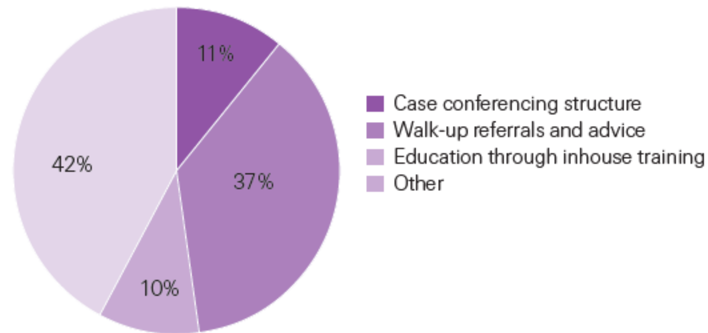
Many of the services that now fall under the banner of 'rehabilitation' are focused towards a model of engagement. The industry is embracing a multidisciplinary approach to claims rehabilitation through strategies such as case conferencing – both in-house and externally, over the phone and face-to-face. We are seeing insurers sending RCs and/or CAs out to meet with claimants and in some cases, doctors/GP's and other allied health professionals, with the goal of assisting effective case management and RTW.

Structuring in-house rehabilitation

Given variation in staffing ratios and business lines, we asked the participants to comment on how they structured the services that in-house RCs provide within the claims operation. Some had difficulty answering this question, with 42% indicating that their operating model fell under 'other' – commenting that this included a combination of the options presented and typically a more formalised referral process such as allocation of cases by a rehabilitation manager (see Figure 3).

Interestingly, most participants agreed that in-house rehabilitation was predominantly case-management focused as opposed to a more holistic embedding of rehabilitation and RTW philosophy at a high level (e.g. through the delivery of in-house training and consultancy). Given different interpretations of the survey question, insurers estimated the time spent delivering education through in-house training comprised an average 10% of their working time.

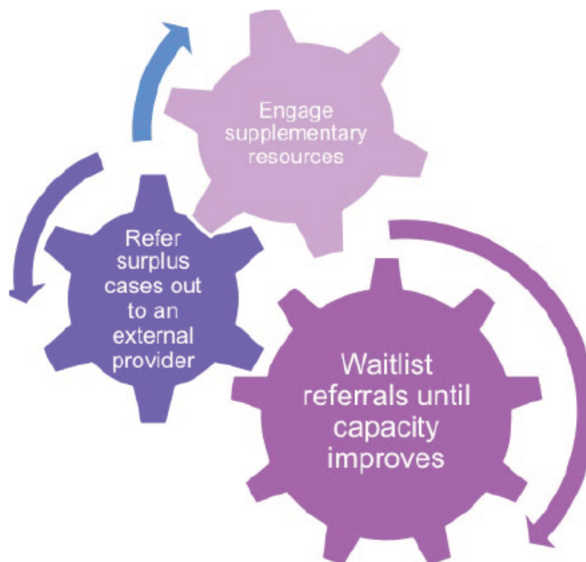
Figure 3: In-house rehabilitation models of operation



Of the nine participants, five indicated that their RCs carry their own case load. Across these five insurers, the average case load size was 58.6 claims. Again, the reliability of this figure is low given that the rehabilitation services offered for each claim varies by claim type (IP or TPD), business line and from company to company.

Given that many RCs working in-house carry their own case load or work via a referral allocation model, we asked participants to rank process preference for what happens when internal referrals hit capacity. Six participants described an internal order of process preference as outlined in Figure 4.

Figure 4: Adopted method at referral capacity point



The preferred process when at maximum capacity was to waitlist rehabilitation referrals (either formally or informally) until RC capacity improved, or to refer the surplus cases out to an external provider. The second most preferred option when at capacity was to engage extra rehabilitation resources – this may be achieved through engaging contractors or by utilising reinsurer rehabilitation specialists.

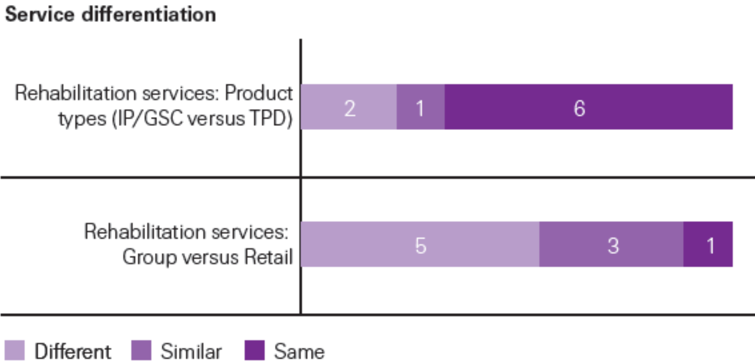
"A 'full' caseload consistently without relief means that key rehabilitation projects and initiatives generally suffer."

“Should the trajectory of increased use of rehabilitation continue in the future, *increased resources* will be needed to manage rehabilitation effectively.”

None of the insurers supplying data for this metric opted to have their CAs manage rehabilitation for the surplus cases. They reported that their rationale for this approach was to ensure that rehabilitation strategy and expenditure was controlled by having rehabilitation ‘peers’ oversee referrals and provider case management. Additionally, the transfer of cases from RCs to CAs can be more time consuming and have the potential to impact the quality of outcomes.

Variances by scheme and by product

Figure 5: Differentiating services by product type and line of business



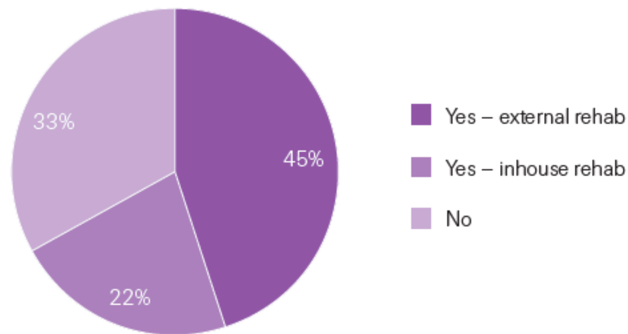
Given the variances in product offerings (including rehabilitation benefits) and lines of business, we expected to see differences in the services offered by each insurer. Eighty-nine per cent of respondents indicated that their company offered the same or similar services for their group (wholesale) and retail (individual) schemes. Looking at rehabilitation services offered for group or retail, the factors determining service differentiation centred on the profile of the claimant – for example, in retail lines there is typically more emphasis on re-training and business coaching.

When comparing rehabilitation services offered by product type – IP/GSC and TPD – most insurers (67%) reported offering different services. There was consistency in the commentary, with most insurers reporting that rehabilitation services for TPD were more likely to be “one-off” assessments or opinions aimed at determining whether the claimant is totally and permanently disabled. “One-off” assessments reported for TPD claims included employability assessments, transferrable skills assessments and labour market research.

Early rehabilitation

In recent years, life insurers have started to see the value of intervening early in terms of managing claims durations (IP/GSC). This concept was reinforced in the survey responses, with only 33% of insurers reporting that they did not offer some form of rehabilitation service to claimants in the policy waiting period (Figure 6).

Figure 6: Percentages of insurers offering rehabilitation assistance in the waiting period



Referring back to Table 1 (Rehabilitation Services), 100% of participants felt that early intervention services fell under the banner of rehabilitation. However, from this we see there is still room for improvement, with 67% of respondents providing early rehabilitation in the waiting period. Given the momentum of early intervention philosophy within the industry, we expect to see the trend of engagement increasing and the timeframe for intervening becoming even earlier, likely even at pre-claim stage.

Determining suitable cases for referral

Early identification of claims that have potential for rehabilitation services to impact duration and outcome is now widely accepted as best practice. The participants in this study used a variety of methods to determine 'suitable' claims.

Despite adopting a variety of methods, all insurers indicated that they relied on standard criteria (most commonly, biopsychosocial (BPS) profiling) or claim considerations and in-house procedural guidelines to direct rehabilitation referral. Company-specific procedures tended to involve the use of a screening tool and for some insurers, the procedure is timeframe-based (e.g. all new claims undergo rehabilitation screening within x weeks of notification).

In-house screening by the rehabilitation team and tele-interviewing screening by CAs were the next most utilised methods of identifying 'suitable' cases. One insurer's team structure lends itself to having a dedicated team of trained staff to undertake tele-claims, which encompasses rehabilitation screening. Other insurers screen all claims of a certain claim cause (e.g. mental illness or musculoskeletal injury) to determine potential for early rehabilitation intervention.

Interestingly, given the current market investment in IT services and platforms, the least adopted method for identifying 'rehabilitation suitable' claims was an automated triage based on key indicators (such as type of benefit/period). Presumably use of an automated triage would be the most cost-effective way of identifying appropriate claims. The relatively low utilisation of this method seems to point towards a lag in IT system development and/or a commitment to focus on a more individualised approach to rehabilitation involvement at this point in time.

Finally, the debate between rehabilitation proactivity versus reactivity was noted in the survey responses. Some insurers reported relying somewhat on reacting to certain triggers, including only initiating rehabilitation services when a claimant asks for assistance. Conversely, some insurers are proactively offering rehabilitation services to all claimants at assessment stage as part of their standard claims assessment procedure.

Key indicators
Delving into the key indicators for rehabilitation, the survey showed some commonality behind approaches. Almost all of the participants agreed that the key determinant to the success of rehabilitation intervention is the claimants attitude and motivation.

Claimant motivation and other BPS profiling factors are typically not understood through automated triage methodologies and hence a combination of approaches to deciding 'suitable' cases is applied.

Aside from gathering more of an understanding on the claimant's motivation to participate in rehabilitation and RTW strategies, insurers reported relatively consistent data indicators. The level of sophistication of an insurer's claims data system very much governs the key indicators that can be screened for.

In Figure 7, the indicators under Tier 1 are widely used as baseline/automated rehabilitation triggers. Those factors in Tier 2 and Tier 3 can be more difficult to screen – again dependent on the insurer's data collection/IT platform and management information, as well as information collected and recorded at claim assessment (including via tele-interviewing).

Figure 7: Indicators for rehabilitation screening

Tier 1	Tier 2	Tier 3
Claimant age	Injury/illness type or complexity	Employer RTW program support
Length of benefit period	Exceeded predicted duration	Change in definition
Sum insured	High risk occupation	Deterioration in status or condition
Reserve held	Demographics (claimant location)	Concurrent claims and/ or co-morbid conditions
Time lapsed since DLW	Job attached/ detached	

Timeliness of rehabilitation intervention

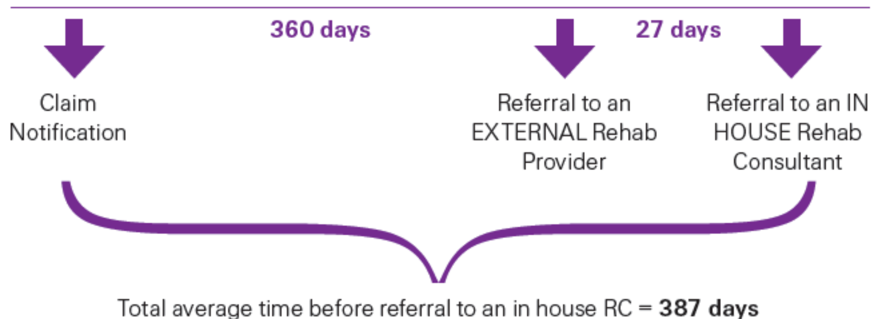
Throughout *Rehabilitation Watch* 2014, we have referred to the importance of intervening early in terms of demonstrating cost-effective and sustainable outcomes. Almost all the insurers echoed sentiments around the value of intervening early and through this survey, we were able to gain a truer understanding of the timeliness of intervention that insurers are offering.

Excluding outlier data, five insurers were able to estimate the average time in days for intervention. It is important to note that by 'intervention' we mean referral for a rehabilitation program as opposed to in-house RCs undertaking a one-off screening service. The data confidence average for these survey questions was lower – estimated at 60% confidence.

The timelines illustrated in Figure 8 depict the results using the start dates:
a) date of claim notification, and b) date of disability or loss.

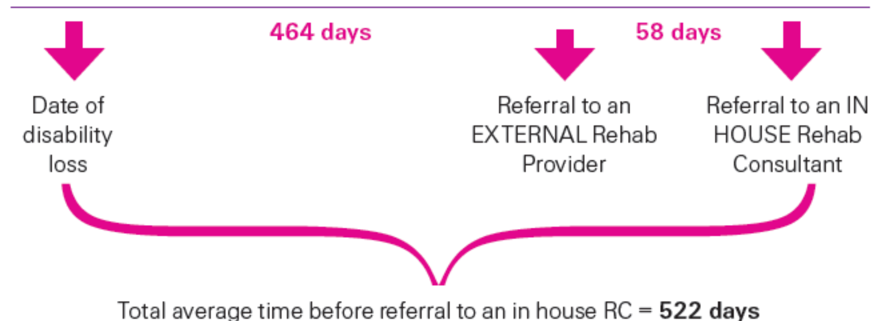
Figure 8: Timelines for rehabilitation intervention

(a) Date of claim notification



Total average time before referral to an in house RC = **387 days**

(b) Date of disability or loss



Total average time before referral to an in house RC = **522 days**

Due to lower data confidence and difficulty obtaining the data for the timeliness questions, we should exercise caution when interpreting the findings. Factors influencing data confidence included claims moving between teams (e.g. short-term to long-term claims) and claims being 'touched' by RCs during screening as opposed to referrals for rehabilitation intervention.

The data unexpectedly showed that the average timeframe for referral to an in-house RC was slightly longer than for referral to an external rehabilitation provider. While this result could be attributed to inaccuracy or inability to capture time-related data, we may assume other factors have impacted the result – such as RC case load size versus smaller percentages of cases referred externally and provision of other value-add services such as training.

Regardless of the noted data difficulties, it is important that as an industry we gain a better understanding of the timeliness of rehabilitation to ensure we align intervention strategies with the evidence base. Implementing a rehabilitation/RTW program after 12 to 18 months of absence (disability) is counterintuitive according to early intervention evidence, and often an uphill battle in terms of cost-benefit. This also speaks to the observed market trend of late claims notification and therefore why, as an industry, we need to proactively influence earlier notification of claims.

Utilisation of rehabilitation services

Given the increasing number of rehabilitation staff within life insurance companies in Australia, we sought to understand the percentage of claimants that had been offered rehabilitation services in 2013. As this is the first *Rehabilitation Watch*, the figures should serve as a benchmark to understand future trends.

In terms of in-house rehabilitation services, the proportion of disability insurance claimants undertaking rehabilitation ranged from one to 16%. Seven of the nine participants were able to provide data[2] for this question, giving an average proportion of 6.1% of claimants engaging in in-house rehabilitation services.

Looking at engagement in external rehabilitation services, the proportion range was similar – between one and 15%. Only five insurers were able to confidently (rating of 4.4) provide this data, giving an average proportion of 5.8% of claimants engaging in externally delivered rehabilitation services.

Figure 9: Percentage of claimants participating in rehabilitation services

How does the life insurance market compare to other personal injury claims settings? In 2013, a published RTW survey indicated that nationally, under workers compensation jurisdictions, between six and 16% of injured workers had received the assistance of an occupational rehabilitation provider to RTW (Safe Work Australia, 2013).

The utilisation of rehabilitation services in claims management is influenced by many factors including the availability of benefits under each policy and more prominently, the absence of legislation to influence participation. Most life insurers who participated in *Rehabilitation Watch* 2014 reported that utilisation numbers are lower than expected, however, attributed this finding to claimants not taking up the offer of rehabilitation support.

Given the increases observed in the number of new IP claims and similarly in in-house rehabilitation staff, it may be that the proportion of claimants undertaking rehabilitation programs delivered via in-house RCs has not increased or decreased. However, it is our belief that as an industry, being able to demonstrate the cost-benefit of rehabilitation should drive our focus to think innovatively about how we are able to increase utilisation and continue to deliver cost-effective claims outcomes.

[2] Claims data is for disability insurance (income protection claims) with an average data confidence rating = 3.7

External provider utilisation and expense investment
The occupational rehabilitation provider industry in Australia has historically been geared towards the provision of legislated services to workers compensation insurers. More recently we have seen these providers starting to tailor services to suit life insurance products and claim profiles, and the emergence of smaller, boutique providers who only offer life insurance-specific services. *Rehabilitation Watch* 2014 sought to understand more about the factors driving external rehabilitation provider selection at participanting insurers.

The location of the provider was the key factor driving selection for all participants. After location, and equally ranked, were the factors of skill set and background of the provider consultant, past good experience and provider recommendations from a colleague or through the Life Rehabilitation Forum (LRF). Most of the insurers who participated in the study indicated that they had a preferred provider listing; however, only two insurers operate a service provider panel (i.e. a more formalised arrangement with service level agreements).

Despite only seeing a low proportion of claimants undertaking externally delivered rehabilitation programs, we sought a deeper understanding on how much insurers are spending on these programs. Data was obtained using the below calculation over the12-month period:

$$\text{Average spend} = \frac{\text{Total external rehab provider spend (\$)}}{\text{Total number of claims where external costs incurred}}$$

Seven insurers were able to provide an average external spend per claim referred. The average spend per claim across these insurers was $3,035[3].

Of the insurers able to estimate the average file spend for external rehabilitation expenses, only half were then able to break down expenses by claim type:
i. IP and/or GSC claims rehabilitation services (such as RTW programs, case management etc), and
ii. TPD claims rehabilitation services (such as employability and labour market assessments etc).

Figure 10: Average external rehabilitation provider file spend by claim type

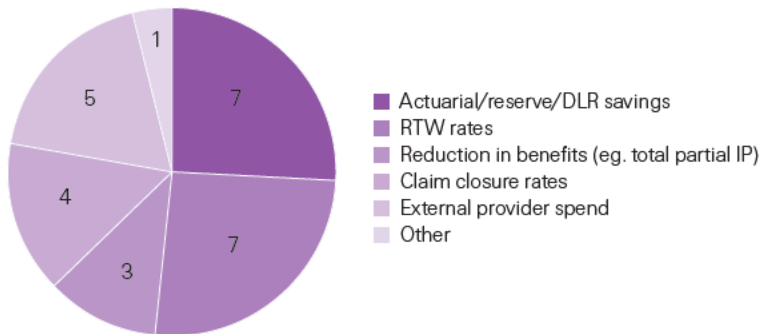
These results were in line with our expectations given that referrals for IP/GSC claims are characteristically more for rehabilitation programs where ongoing involvement, case management and liaison with key stakeholders can be required. Rehabilitation services for TPD claims are more typically one-off assessments intended to assist CAs to make evidence-based decisions.

[3] Average data confidence rating = 3.4

Measuring the impact of rehabilitation

Income protection
Given that rehabilitation services are a relatively recent addition to the claims management offering for life insurance, it was expected that insurers would measure success in different ways, using a combination of metrics. Figure 11 shows the distribution of different metrics utilised by participants to measure claims outcomes within their operations, noting that many insurers adopt a variety of the stated measures.

Figure 11: Numbers of insurers using outcome metrics to measure rehabilitation impact[4]



It is promising to see that the persisting question of the cost-benefit of claims rehabilitation is now starting to be quantified. Seventy eight per cent of participants are now able to report actuarial or reserve/DLR (disabled life reserve) savings and/or RTW rates. Where in the past we had only seen the capture of rehabilitation data in a cost context (expenses), encouragingly insurers are now gathering data on the benefits – capturing the financial savings realised through achieving RTW (or claim) outcomes.

Return on investment
The majority of insurers are able to capture return on investment (ROI) data using reserve or actuarial savings for income protection claims. There is, however, some inconsistency in this measurement formula, with some insurers using reserves gross of reinsurance, others using reserves net of reinsurance and some taking partial reserve savings into consideration. We also sought to understand whether insurers were able to compare ROI by external rehabilitation expenses versus ROI by in-house RC involvement.

In an attempt to calculate a consistent ROI average for *Rehabilitation Watch* 2014, we asked participants to use the following calculation:

$$\textbf{ROI} = \frac{\text{Reserve Release (gross of reinsurance) less External Rehab Expenses}}{\text{External Rehab Expenses}}$$

NB: for in-house RC expenses, we substituted 'external rehab expenses' for ' in-house RC staff salaries'.

Looking firstly at the ROI for external rehabilitation service provision, five insurers were able to provide data. For every $1 spent on external rehabilitation services, they reported an average ROI of $39[5] (range $16 to $72). Due to data limitations, only two insurers were able to further break down the external rehabilitation ROI for group and retail business lines.

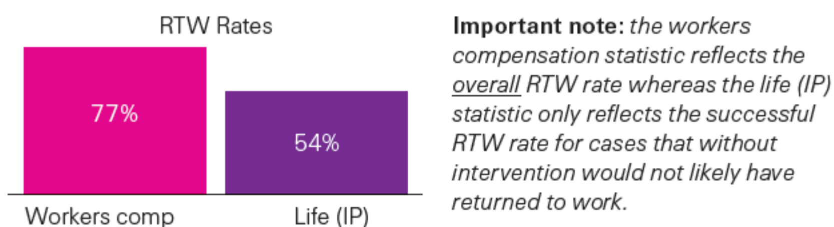
[4] 'Other' represents metrics such as TPD claims decisions/outcomes
[5] Average data confidence from the 5 respondents = 4. ROI was calculated using reserves for IP claims only and encompasses gross and net reserves.

Return on investment when calculated using in-house RC staff salaries was an average $24 for every $1 spent (range $14 to $35). It is important to note that ROI for in-house RC services encompasses not just individual rehabilitation case management, but all other value-added services that RC's provide, such as monitoring of external providers, training, IME referrals (refer to Table 1).

Return to work rates
As part of *Rehabilitation Watch* 2014, we asked participants to specify whether their outcome metrics were objective (measured or quantified data) or qualitative (based on quality or characteristic). Two of the seven insurers using the metric of RTW rates[6] classify it is a qualitative measure and the remaining five reported low to moderate data confidence in their measurement. The average RTW rate for these five insurers was 54% following rehabilitation intervention (in-house or external provider services).

In order to incorporate an industry comparison, we have included workers compensation claims RTW rates. Nationally, the 2013 workers compensation RTW rate was 77% (Safe Work Australia, 2013). It should be noted that the workers compensation RTW rate is a reflection of overall claims management outcomes as opposed to our *Rehabilitation Watch* measure: the percentage of IP claimants who had made a RTW after receiving rehabilitation support. Although the life RTW rate is somewhat lower, we understand it to reflect a positive outcome of more than 50% of claimants able to RTW who might otherwise not have without rehabilitation intervention.

Figure 12: RTW rates comparison - workers compensation and income protection



Important note: *the workers compensation statistic reflects the overall RTW rate whereas the life (IP) statistic only reflects the successful RTW rate for cases that without intervention would not likely have returned to work.*

Being able to confidently report on RTW rates is a metric that the life insurance industry needs to improve on. In a market where lapse rates are increasing and group IP cover is not a compulsory offering from employers, we need to promote the availability of support to RTW, in line with the Health Benefits of Work position statement (Australasian Faculty of Occupational & Environmental Medicine, 2011).

Data confidence was similarly low when insurers were asked to calculate the number of IP/GSC claims that ceased following a successful RTW (or outcome achieved) over the 12-month period where some level of rehabilitation intervention was provided. Because rehabilitation intervention is just one strategy or tool to assist duration management, to solely attribute outcome achievement to rehabilitation intervention is difficult and often not appropriate. Sending a message to the wider community about the importance of helping people return to health and work is, however. As a collective of the seven insurers who provided data, rehabilitation teams helped more than 641 people achieve a RTW in 2013.

[6] The measurement of RTW rate in this survey incorporated both a return to full or part-time work.

Total and permanent disability
Insurers are now starting to capture information on how rehabilitation involvement can assist in the management of TPD claims. For the most part, this data reflects the percentage and reserve savings for claims where rehabilitation intervention (either in-house or referral to an external provider) has assisted in identifying suitable employment options.

We asked insurers to provide information on:
1. The number of notified TPD claims in 2013[7]
2. The number of these claims that had rehabilitation involvement (in-house or external assessment) and if possible
3. Any reserve savings realised (ie. claims not paid due to a suitable job being identified within education, training, experience or similar definition).

Only three insurers were able to provide limited data for rehabilitation involvement for TPD, however, due to variation in claim numbers, sums insured and categorisation, these figures need to be interpreted with caution:
- The average percentage of notified TPD claims that were referred to a rehabilitation provider and/or actioned by an in-house RC was 13%
- Of those TPD claims referred for some form of rehabilitation (in-house or external assessment), at least 25% of claims were not paid due to a suitable job/s being identified (i.e. the RC was able to identify that the claimant was not totally and permanently disabled to work within their education, training and experience).

At a time when the industry is seeing record numbers of new TPD claims being notified and Australians receiving compulsory cover under superannuation funds (including MySuper), we need a more robust way of measuring the impact of specialised rehabilitation assessments on soundly-based decision making.

The questions asked in the survey provided a good foundation for future discussion in measuring rehabilitation impact on TPD – particularly around the message we send to the industry. Collectively, we do not want the message to the market to centre on rehabilitation as a tool to decline TPD claims, nor to have TPD decline rates as a reflection of rehabilitation effectiveness. Insurers want to reinforce that they are utilising rehabilitation services (and predominantly one-off assessments) as an evidence-based means of ensuring that correct claims decisions are being made and individuals are being assisted to identify RTW options.

As we look to the future impact of rehabilitation, insurers are now calling on RCs to provide input into product design and policy wording to ensure the focus remains on a sustainable market, which continues to promote the health benefits of work.

Rehabilitation teams helped over *641 people achieve a return to work* in 2013.

[7] Number of TPD claims notified in 2013 – the metrics are unlikely to reflect true decision ratios due to the typical duration of TPD claim assessment being greater than 12 months.

Involvement with key stakeholders

For rehabilitation strategies to be effective we need to ensure engagement with all key stakeholders; however, the degree of stakeholder involvement can either help or hinder strategy. We asked participants to comment on the degree of involvement with two of the key stakeholders: employers and brokers/financial advisors.

Looking first at engagement with employers, all insurers agreed that this was crucial to facilitating RTW strategies in group insurance – especially from an early intervention perspective to try to retain the same job/same employer relationship. Most insurers indicated that the predominant method of employer engagement was via the phone with some face-to-face case conferencing starting to take place. Insurers reported that they rely on external rehabilitation providers to undertake much of the interaction given the geographical spread of employers and workplaces, and in cases where consent to contact employers has not been provided by the claimant or fund. Some insurers also noted that there still remains the difficulty of facilitating graduated RTW programs with employers given the lack of obligation for accommodation of medical/functional restrictions and some employers' '100% fit' policies.

Participants reported a more inconsistent level of engagement with advisors in facilitating rehabilitation and RTW support. The factor driving this inconsistency was thought to be the advisor's knowledge and understanding of the purpose of rehabilitation services. This response varies from advisors being quite positive and welcoming of such support for their client (the claimant), through to negativity and resistance to rehabilitation.

Engagement of key stakeholders can be jeopardised when parties lack understanding about what is included under policy rehabilitation benefits, often requesting funding or coverage for medical treatment. In addition, some insurers noted that they face barriers in managing claims (particularly individual/retail) when advisors have sold or promoted the insurance product as a means to retire if one cannot return to his or her own occupation.

Feedback from participants indicated that advisor resistance can be driven by the perception that rehabilitation is a mechanism to force their clients back to work. This mindset is also demonstrated when advisors (and now more commonly, claimant solicitors) block participation due to the fact that their clients are not obligated to participate under the policy.

Despite the presence of negative opinions on rehabilitation benefits among some key stakeholders, all participants agreed on the importance of education in order for rehabilitation intervention to be successful. Survey participants advised that they develop and distribute marketing and promotional material designed to change perceptions and improve the understanding of the benefits of rehabilitation involvement. This message needs to come not only from rehabilitation teams, but also from business development and claims managers – regularly communicating the value of rehabilitation support in assisting people to recover and return to health and work, stakeholders can welcome the opportunity to learn more and receive support when they feel it is being offered for the right reason.

The future of rehabilitation in the Australian market

Throughout this study we have looked at current rehabilitation practice in the Australian life market. Insurers are striving to adopt and embed best practice into the future. When asked what role rehabilitation would play in the management of life claims over the next two to five years, 100% of participants agreed that rehabilitation would play more of a role.

Delving deeper into the future of rehabilitation, participants tended to agree that the industry will continue to focus on embedding principles of early intervention – where RCs will remain the driving force behind implementing early intervention framework, including risk profiling and claims data mining – and intervening at the earliest point possible, potentially even pre-claim.

"Rehabilitation needs to lead a cultural and procedural shift towards true end to end duration management."

Insurers anticipate that the observed growth in numbers of RCs working in-house will continue to increase and, as their title suggests, possibly shift to more of a consultancy or advisory function. There is now more recognition around rehabilitation as part of an insurer's 'value proposition', requiring RCs to take a more strategic view and contribute more cross-functionally – including contribution to product development and design. Some insurers are looking to future rehabilitation practices as a key differentiator, a competitive advantage in a mature claims environment.

"Stakeholder expectations are changing ... rehabilitation is starting to be seen as an essential part of a fully functioning claims team."

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Appendix

Table 2: Assumed terms used for *Rehabilitation Watch* 2014

Assumed terms
Claimant: is the person who has submitted a claim. This covers members, cases, clients.
Group business: is also known as wholesale and includes corporate. Individual business is also known as retail or adviser-led.
Disability insurance: includes income protection and group salary continuance insurance.
Total and permanent disability: includes permanently unable to work insurance.
Cases 'suitable' for rehabilitation: are those cases that participating organisations have identified to have the potential to benefit from rehabilitation intervention.
Rehabilitation program: refers to a case-managed approach whereby the claimant undergoes an assessment, has goals/ timeframes/ milestones set and agreed to by all parties. A program constitutes ongoing involvement as opposed to a one-off assessment only.
Claim or rehabilitation outcome: refers to the achievement of a return to work outcome (full, partial, different job; work fitness/ functional capacity achieved; claim declined etc).

Table 3: Abbreviations used for *Rehabilitation Watch* 2014

Abbreviation descriptors	
ANZ = Australia and New Zealand	**GSC** = Group Salary Continuance
BPS = Biopsychosocial	**IME** = Independent Medical Examination
CA = Claims Assessor	**IP** = Income Protection
DI = Disability Insurance	**RC** = Rehabilitation Consultant
DLW = Date Last Worked	**ROI** = Return on Investment
DOD = Date of Disability (injury and illness)	**RTW** = Return to Work
DON = Date of Notification	**SLA** = Service Level Agreement
Govt = Government	**TPD** = Total and Permanent Disability

Swiss Re Life & Health Australia Ltd
Level 29, 363 George Street
Sydney NSW 2000
Australia

Telephone +61 2 8295 9500
Fax +61 2 8295 9600
www.swissre.com

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JUNE 2018

RECOMMENDATIONS REPORT 211

ISCRR

Institute for Safety, Compensation and Recovery Research

Occupational Rehabilitation Review

Recommendations Report

Synthesis of research findings and recommendations arising from *ISCRR Project 211: Occupational Rehabilitation Review*

A joint initiative of

WorkSafe Victoria TAC Transport Accident Commission MONASH University

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1. EXECUTIVE SUMMARY

This report summarised the findings from the four studies undertaken as part of the ISCRR Occupational Rehabilitation Review (ISCRR Project 211) and identified cross cutting themes.

Project key findings

Findings from the evidence review

- The evidence review found moderate to strong evidence that OR interventions are effective at improving RTW outcomes, particularly for musculoskeletal injuries
- Occupational rehabilitation achieves the best outcomes when delivered early (2-4 weeks of injury)

Findings from the environmental scan

- There was significant variation in the approaches to providing OR services, including within WSV
- Measures and incentives are a major influencer of behaviour in the current system
- A number of challenges in the provision of OR services exist in the current model, including the lack of ability for OR consultants to provide recommendations, turnover of OR consultants, the injured workers' capacity, capability and motivation to RTW, stigma of clients, unintended consequences of performance measures and incentives and the employers' capacity, capability and motivation

Findings from the data analysis

- Over the time period studied (2007–2016), the data analysis found that OR service use increased
- In the study period, improvements in the time to commencement of OR services as well as OR outcomes including time to placement and sustainability were observed, however, as the analysis only reviewed claims that had received OR services it is unclear as to whether this was as a result of the OR services provided

Findings from the qualitative interviews

- Both positive and negative experiences were reported in the management, delivery and receipt of OR services in Victoria
- For recipients of OR services, positive experiences were associated with perceptions that OR consultants were helpful, supportive, listened and tailored services to their needs while negative experiences were associated with perceptions of unrealistic expectations of RTW on the injured worker, communication challenges and services that did not match needs

Cross cutting themes

Over all of the research pieces, five key themes emerged which require attention to improve the management, delivery and receipt of OR services in Victoria:

- Performance measures and incentive structures
- Early and targeted referral of injured workers
- Information flow and communication between stakeholders
- Flexibility and ability to involve injured workers
- Stigma towards injured workers and people with mental injury

Recommendations are provided based on the cross cutting themes identified.

Recommendations

The following is recommended to improve occupational rehabilitation services for injured workers.

Performance measures and incentive structures

1. Review current system measures and benchmarks for both Agents and OR providers to ensure they are driving behaviours that maximise client RTW outcomes.
2. Consider measures and incentives that fairly reward OR consultants for case complexity and encourage professional growth.
3. Align measures used by WorkSafe and Agents to measure OR provider performance.

Early and targeted referral

4. Facilitate early referral to OR services with a focus on improving case management.
5. Consider the development of client screening approaches to identify the injured workers most likely to benefit from OR services.
6. Review eligibility and referral requirements for NES services, particularly for mental health claims.

Information flow and communication between stakeholders

7. Promote initiatives that enable the sharing of information between stakeholders such as case conferencing.
8. Explore opportunities to provide information to injured workers through channels other than formal letters.

Flexibility and ability to involve injured workers

9. Enable OR consultants to provide recommendations on the services and treatments delivered to their clients.
10. Explore opportunities for greater engagement with injured workers in the OR assessment process.

Stigma towards injured workers

11. Invest in activities and programs aimed at reducing stigma associated with accessing workers' compensation.

2. BACKGROUND AND APPROACH

2.1 Background

Occupational rehabilitation (OR), also referred to as vocational rehabilitation or workplace rehabilitation is a suite of activities and interventions which aim to facilitate employment. In the context of the Workers' Compensation System in Victoria, OR services aim to support injured workers to return to work (RTW) following workplace injury or illness.[1] OR services include workplace assessments, occupational therapy, worksite visits, on-site management, vocational guidance, occupational health services, work hardening, work modification, job accommodation, work adjustments, work reintegration plans, or ergonomic interventions.

The primary goal of OR is to support injured workers to RTW at either their original employer or a new employer. Services delivered to facilitate RTW to the original employer are termed Original Employer Services (OES) and services aiming to find a different employer, New Employer Services (NES).

Although not restricted to work-related injuries, occupational rehabilitation is a key component of the approach to workplace injury in Australia and is guided by the relevant state-based workers' compensation legislation.[2]

In 2015/16, 14,887 WorkSafe Victoria claims were referred to occupational rehabilitation, managed by WorkSafe Victoria's Insurance Agents.[3] Despite the increased investment in these services in recent years, results in return to work rates have not seen significant improvements.[4]

WorkSafe Victoria is reviewing their current approach to the provision of occupational rehabilitation services to identify areas for improvement in service delivery and RTW outcomes. To support this process WorkSafe commissioned a strategic review through ISCRR (Project 211).

2.1.1 Stakeholders in occupational rehabilitation services

In Victoria and other jurisdictions, the strategic review identified a range of stakeholders involved in occupational rehabilitation:

- **Management of OR services** includes WorkSafe Victoria through the set-up of standards, procedures and contracts, Insurance Agents through determination and decision making regarding which injured workers receive OR services and OR providers who distribute referrals to consultants.
- **Delivery of services** includes OR consultants who deliver OR programs and undertake OR servicing on claims, healthcare providers who provide treatment and recovery including fitness certification and employers through providing workplace accommodations and alternative duties.
- **Receipt of services** includes the injured workers who had been assigned OR services to support their recovery and return to work.

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2.2 About this project

This report has been prepared for WorkSafe Victoria to synthesise the evidence generated through ISCRR Project 211: *Occupational rehabilitation strategic review*. The project delivered the following outputs:

- An evidence review of effective occupational rehabilitation interventions in the scientific literature
- An environmental scan of current and emerging practice in occupational rehabilitation
- A quality improvement review involving qualitative interviews with a number of stakeholders involved in the delivery of occupational rehabilitation services in Victoria
- A data analysis of trends and outcomes in the delivery and receipt of occupational rehabilitation services in Victoria.

This program of work aimed to answer the following questions:

1. How well are existing Victorian occupational rehabilitation approaches working?
2. What models and initiatives are being used in other jurisdictions?
3. What occupational rehabilitation initiatives have been shown to be effective in improving return to work outcomes?
4. How do the proposed initiatives compare with what is evidence-based and being implemented elsewhere?
5. What are the evidence-based recommendations for future approaches?

This synthesis presents the major cross-cutting themes which emerged across all the research activities undertaken. It provides evidence-based recommendations with the aim of improving the efficiency of OR services and maximising return to work outcomes for clients.

2.3 Approach

The approach taken for the four primary study components and the synthesis are described below.

2.3.1 Evidence review

A systematic search of the scientific literature for systematic reviews and primary studies that tested occupational rehabilitation interventions was conducted in July and August 2017. The review aimed to answer the following questions:

1. What occupational rehabilitation interventions for injured workers have been shown to impact return to work and health outcomes?
2. What are the characteristics of effective interventions, in particular:
   - 2.1. What are the differential effects across worker, employer and injury characteristics?
   - 2.2. How are they implemented?

The search found 24 systematic reviews and primary studies that met the eligibility criteria. Data from these reviews were extracted and synthesised into the following intervention themes: 1) occupational/vocational; 2) physical; 3) psychological; 4) multicomponent; and 5) recovery and return to work coordination.

2.3.2 Environmental scan

An environmental scan was conducted to provide an industry-wide snapshot of current and emerging practice in providing occupational rehabilitation services to clients. Specifically it aimed to identify:

1. Approaches and models for occupational rehabilitation that currently support people with injury, illness or disability to return to work
2. The emerging approaches for occupational rehabilitation that are being developed or recently being trialled to support people with injury, illness or disability to return to work.

The scan involved desktop scanning of publicly available information and interviews with key informants. A total of 23 organisations participated in the scan ranging from workers' compensation authorities, insurance agents, Federal Government agencies, occupational rehabilitation providers, industry associations and one managed care consortium. Participating organisations were based in Australia and internationally. Cross-organisational findings were presented as well as case studies identifying emerging best practice.

2.3.3 Quality improvement review

This study adopted a multi-component design which involved a survey, targeted stakeholder interviews, survey data collection and subsequent data analyses. It aimed to answer the following research questions:

1. What are stakeholders' experiences of return to work processes that include OR approaches?
2. Based on their experience, which aspects of the existing Victorian OR approach to return to work are effective and which are less effective?

The data from previous surveys conducted by WorkSafe Victoria, which evaluated OR providers from the perspective of employers and injured workers was analysed in line with the study questions. Additional semi-structured interviews were conducted with 20 injured workers and 11 employers to explore the experience, barriers and facilitators for OR approaches to return to work. A survey for OR consultants was developed and delivered to 20 participants, in addition to 11 semi-structured interviews with OR consultants. Finally, semi-structured interviews were conducted with representatives from all five WorkSafe Agents. All data was synthesised and the findings presented as they related to the management, delivery and receipt of OR services.

2.3.4 Data analysis

This study analysed WorkSafe claims data held by ISCRR in the Compensation Research Database (CRD). The study aims were to:

1. Examine OR service utilisation in Victoria between 2007 and 2016
2. Identify any patterns in OR service use
3. Examine OR service outcomes and their sustainability
4. Identify factors associated with return to work placement and sustainable work outcomes for Original Employer Services and New Employer Services.

Data analysed were claims, service and payment data on standard time loss claims where a WorkSafe client was provided with OR services between July 2007 and December 2016. Data were extracted from the CRD and the following analyses were performed:

1. Descriptive statistics and data visualisation to examine trends in the provision of OR services
2. Duration analysis to examine claim characteristics, such as time to return to work
3. Logistic regression to identify any relationships between individual client and claim characteristics and claim outcomes
4. Logistic regression to identify any relationship between claim characteristics and return to work placement, as well as characteristics the positively influence return to work outcomes.

2.3.5 Evidence synthesis

The four primary output reports in the project were reviewed to identify themes consistent across the evidence gathered in the project. Authors of the primary output reports were also consulted to provide feedback on the synthesis findings. Recommendations were devised in areas where sufficient evidence was identified.

2.4 Report structure

The report's findings are presented under the following cross-cutting themes:

1. Summary of project key findings
2. Overview of findings against proposed WorkSafe Victoria initiatives
3. Identified focus areas for improvement
4. Thematic synthesis and recommendations
5. Insights

3. SUMMARY OF PROJECT KEY FINDINGS

This section provides a summary of the key findings from the four components of the Occupational Rehabilitation Review (ISCRR Project 211).

3.1 Evidence review

3.1.1 Key findings

The review of scientific evidence identified a variety of occupational rehabilitation interventions which were effective at improving return to work outcomes.

The key findings were that:

- **Coordination of recovery and RTW** in interventions incorporating early contact and referral, functional and biopsychosocial assessment, employer engagement, collaborative service coordination and individualised planning improved early return to work, function and well-being for injured workers with musculoskeletal (MSK) or pain-related conditions.
- **Multicomponent and multidisciplinary interventions** that involved early contact with the worker and the employer were effective in improving the likelihood of return to work and improved function and pain outcomes for workers with a MSK injury.
- **Work-directed vocational interventions** effectively reduced the time to return to work (by as much as half) and increased the likelihood of return to work for workers with a MSK injury.
- **Physical and psychological interventions** that involve the workplace are effective for reducing time to return to work and sickness absence.

From the evidence we drew the following conclusions:

- There is **strong** evidence that **coordination of recovery and RTW** can reduce the time to RTW for workers with musculoskeletal injury.
- There is **strong** evidence that **multicomponent and multidisciplinary interventions** that include early contact and employer engagement can significantly improve RTW and health outcomes for workers with musculoskeletal injury.
- There is **moderate** evidence that **workplace based vocational interventions** that include employer engagement can reduce the number of sick leave days.
- There is **moderate** evidence that **psychotherapy interventions** that are work focused and include employer engagement can reduce sick leave duration and time to RTW for workers with musculoskeletal injury and mental health conditions.
- There is **mixed** evidence that **psychotherapy interventions** are effective in facilitating RTW for workers with mental health conditions.

3.1.2 Implications

Post injury or illness process

- Consider an approach that provides injured workers with a primary contact person (e.g. coordinator), to assist in navigating the system and to achieve timely referrals and service appointments.
- Undertake early (<2 to 4 weeks after discharge from hospital or soon after claim lodgement) functional and biopsychosocial assessment to identify injured workers' needs, occupational status and work readiness.
- Refer to occupational rehabilitation provider/consultant as early as possible.

Post referral to OR provider process

- Work collaboratively with occupational rehabilitation providers/consultants, injured workers, health service providers, and employers to develop a tailored return to work plan. A return to work plan should incorporate periodic case conferences for ongoing assessment of progress.
- Offer workplace based and work focused multicomponent interventions that are tailored for physical and mental health conditions.
- Align intervention intensity and duration with the complexity of the return to work process for individual injured workers to achieve optimal employment and health outcomes.

New employment services

- Individual placement and support programs can effectively result in competitive employment for individuals of working age with severe and long term physical and mental illness.
- Currently there is insufficient evidence of effectiveness of new job placement and support programs for individuals with back pain on disability pension and unemployed individuals with musculoskeletal injuries.

Future enquiry

- There is insufficient evidence on the effectiveness of voluntary work, motivational interviewing and telephonic interventions for promoting occupational re-integration and improving RTW outcomes.
- Further evidence of the effectiveness of structured individual placement and support programs for injured workers unable to return to the same job and the same employer is required.
- Trials of work focused motivational interviewing, voluntary work, retraining to improve work readiness and telephonic interventions are recommended to strengthen the evidence base.
- The applicability of established RTW processes for workers with musculoskeletal injury cannot currently be directly translated to mental health conditions in the workplace.

3.2 Environmental scan

Findings from the Environmental Scan comprised desktop scanning of 23 organisations involved in the management and delivery of OR services and semi-structured interviews with 21 of these organisations.

3.2.1 Key findings

Approaches and models for occupational rehabilitation

- There was considerable variation in the role, use and governance of OR providers by agencies providing OR services to clients with injury, illness or disability.
- Outsourcing of occupational rehabilitation services to external OR providers was the standard practice across the vast majority of organisations examined, with the exception of two who had brought services in house.
- Multiple compensation authorities reported increasing their control of OR service delivery in recent times. Examples of ways this was done included limiting the number of OR providers, introducing stronger performance monitoring approaches, and new payment models such as outcomes-based incentive payments and package payment approaches to encourage outcome-driven behaviour.
- Only limited evaluation of OR provider initiatives was available, with only two organisations having reviewed their OR frameworks in recent years.
- A noticeable focus on moving from general OR service provision to delivering client-centric approaches was observed in the scan, including increasing attention on the provision of support for mental injury.

Barriers and enablers for occupational rehabilitation service delivery

- Barriers and enablers to the effectiveness of OR services were identified across the system and included:
  - Level of employer capability, capacity and motivation for enabling RTW
  - Level of worker/client capability capacity and motivation for work
  - Negative stigma of compensation claimants and mental injury, making employers and workers unwilling to work with the system and/or compensable clients
  - OR consultants, including their skills and the level of turnover
  - Relationships and trust within the system, with positive relationships supporting RTW and negative relationships impeding RTW.
- In the Victorian system, the measures applied to the sector were identified as a key driver for the provision and behaviours regarding delivery of OR services to clients. Measures were reported to be driving an increase in service referrals in an effort to meet benchmarks as well as driving OR Provider behaviour such as cherry picking cases to receive outcome incentives.
- Several organisations had worked to minimise identified barriers in the system including consultant turnover though stepped payment models, stigma through incentive payments and relationships and trust through mobile case management.

3.2.2 Implications

Occupational rehabilitation provides valuable services to clients to support RTW processes. The scan identified a number of current and emerging trends in the provision of OR services, as well as key challenges and opportunities in the current WorkSafe Victoria system.

Currently, significant effort is expended on assessments of the client, including their functional capacity and capability, as well as their work-related capability including transferrable skills. It was

unclear from the scan as to how the assessments link to OR service delivery and discussions with insurance agents in the WSV system identified a lack of ability to understand when OR servicing should continue and when it should cease.

The scan also identified a number of challenges and opportunities in the current system, and the ways these have been addressed where possible. Key challenges included:

- Relationships and trust between stakeholders
- The ability to recruit and keep OR consultants
- The client's capability, capacity and motivation for work
- The employer capability, capacity and motivation to both return the worker to work and/or hire workers with illness, injury or disability
- Stigma associated with both workers' compensation and mental health
- Discrepancy between the measures and indicators used to measure OR services between stakeholders.

The measures used to track and monitor OR provider performance within the workers' compensation system in Victoria were frequently referred to by providers and agents as influencing and driving behaviours. In particular, the Back @ Work measure that Agents are required to meet, whereby the worker is back at work in some capacity at 26 weeks, was frequently referred to as driving OR services. This resulted in providing OR services on claims as a means of attempting to meet this measure, rather than as a means of improving outcomes for clients. Decisions regarding providing OR services in Victoria were also characterised by a need to have face-to-face representation and intervention, particularly in more remote areas of the State.

There was a strong sentiment from providers of wanting to work with WorkSafe Victoria and Agents to develop solutions to problems identified in this report. Approaches such as those used to develop WorkSafe Victoria's new employer service were appreciated and further engagement with providers would be welcomed. A new model that builds on existing engagement practices such as those used to develop WorkSafe Victoria's new employer service is likely to both yield both better outcomes and improved relationships.

The provision of payment to providers with outcome-based measures and incentives was overall seen as a positive, however, despite their intent, the incentives for consultants sometimes created a divide between experienced and less experiences consultants. This resulted in a situation in which experienced consultants were more likely to be allocated complex cases, and as a result, receive fewer incentive payments. Consideration of consultant incentives could support providers to keep trained consultants in the system and further support delivery of services for workers.

Another area for further exploration was the prioritisation of services delivered to injured workers. Currently, RTW to the worker's original employer is the top priority in the Victoria Workers' Compensation system, with new employment services initiated only after workers fail to RTW at their original employer. OR providers reported that this approach is restrictive and, in some cases, not in the worker's interest. Several examples were given where consultants had identified early on that a worker was unlikely to return to their original employer but the consultant was unable to move them into new employer services until much later than they would recommend due to the current legislative environment requiring employers and consultants to meet their RTW obligations.

Of note was discussion around incentives for employers and the insights provided around the poor adoption of incentives by employers. Providers noted that the stigma associated with being on workers' compensation or having a mental health condition often prevented workers from wanting to disclose their status as a compensation client. In addition, a strong theme around employer reluctance to hire workers with mental injury was noted. Based on the findings from this scan, incentive payments are unlikely to resolve this issue.

In light of these findings, the following considerations were highlighted to inform future models for the provision of OR services:

- Collaboration with key stakeholders including OR providers for the development and implementation of services
- Re-consider the usefulness of incentive payments in relation to improving client outcomes
- Consider mechanisms of rewarding experienced OR consultants
- Align insurer and provider performance measures for assessing success
- Provide tailored services to injured workers that respond to their needs and motivation for work, particularly for those who are unlikely to return to their original employer
- Provide capacity building for employers to build skills for RTW planning and understanding RTW obligations in the system.

3.3 Quality improvement review

Findings from the Quality Improvement Review comprised data from previous surveys conducted by WorkSafe Victoria, which evaluated OR providers from the perspective of employers and injured workers, semi-structured interviews with 20 injured workers and 11 employers, a survey completed by 20 OR consultants and 11 semi-structured interviews with OR consultants. Semi-structured interviews were also conducted with representatives from all five WorkSafe Agents.

3.3.1 Key findings

Roles and responsibilities in the management, delivery and receipt of OR services

Occupational rehabilitation is a service provided by WorkSafe though insurance agents when agents determine that a claim would benefit from OR services. Decision-making processes across agencies in determining claims for OR services varied, with some agents reporting undertaking early case conferences and others using screening approaches to identify barriers for RTW. In the Victorian system, injured workers are given 3 OR providers to select from at the start of their claim, usually within the acceptance package. Providers are selected using different approaches including location, availability, provider performance and service type.

Once a claim is referred to an OR provider, the provider then assigns the claim to an OR consultant. Insurance agents reported that all claims started in OES, and only when all options had been exhausted and evidence supporting the employer's inability to provide suitable duties and/or the workers incapacity for a role within their original employer, was the worker referred to NES.

The role of the OR consultant was described relatively consistently across the stakeholders included in this study. Insurance agents were also described consistently by stakeholders involved in the management and delivery of services, however, there appeared to be some confusion between the role of OR consultants and mobile case managers. This could result from the reported use of OR consultants for cases where a need for face-to-face intervention was the main driver for the service provision.

Further, the role of the employer was less clear, with some stakeholders in the system reporting that the employers supported the delivery of OR services by providing suitable employment tasks for injured workers, workplace accommodations and by actively participating in service delivery. Agents, however reported that one driver for providing OR services was to support employers with limited capability and capacity for RTW planning and that in some cases, employers were the ones requesting OR services.

Stakeholder experiences with OR approaches were characterised by their role in OR in the Victorian Workers' Compensation System, specifically whether stakeholders were involved in managing OR services, delivering OR services and/or treatments and receiving OR services, as outlined below:

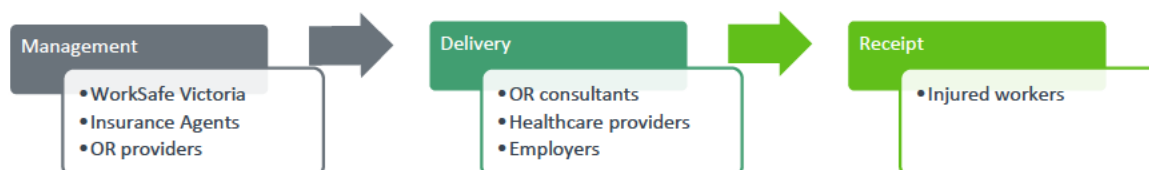


Fig 1. Stakeholder roles in the management, delivery and receipt of OR services in the Victorian Workers' Compensation setting

Agencies involved in the management of OR services included:

- **WorkSafe Victoria** – through the establishment of standards, regulation and enforcement of associated legislation, and development of procedures and contracts with OR providers
- **Insurance Agents** – WorkSafe's five insurance agents provide management through determination and decision making regarding which injured workers receive OR services, as well as undertaking claims management processes, including payment
- **OR Providers** – OR providers support the management of serivces by distributing referrals to consultants and providing reporting and compliance.

Agencies involved in the delivery of OR services included:

- **OR Consultants** – who deliver OR programs and undertake OR servicing of claims
- **Healthcare providers** – who provide treatment and recovery including fitness certification
- **Employers** – through providing workplace accommodations and alternative duties.

Stakeholders receiving services appeared to be exclusively the injured workers who had been assigned OR services to support their recovery and return to work. WorkSafe Agents reported the level of knowledge and skill of the employer in relation to RTW planning as a key determinant for the assignment of services for injured workers.

Some cross-cutting themes emerged as issues for stakeholders managing, delivering and receiving OR services including:

- **Discrimination** – discrimination was reported against injured workers who had made a claim. Agents, consultants and injured workers all reported that the stigma associated with being on workers' compensation was a key issue and barrier in the successful delivery of OR providers and, in some cases, led to discrimination and prevented workers from returning to thieir original employer or finding new employment after injury.
- **Communication and transparency** – all stakeholders in the system reported instances where they were unaware of progress or issues in the claim. A desire for improved knowledge transfer and exhange across stakeholders was a strong theme in the review.

Experiences in the management of OR services

Experiences in the management of OR services provided below were captured from the perspective of WorkSafe's insurance agents. Perspectives from WorkSafe and OR Providers who also manage OR services are not included in the following analysis as they were not included in this report.

Overall, WorkSafe's insurance agents indicated that OR services did improve RTW outcomes for injured workers and that these services provide a critical function for the injured worker. Insurance agents reported that positive OR outcomes occurred when:

- Injured workers and employers were willing to participate in the RTW process
- OR services were provided at the right time for the right purpose
- There was good communication and collaboration between and amongst case managers OR consultants and healthcare providers.

Agents also noted that the implementation of Mobile Case Management is providing face time to more injured workers and employers, which is reducing barriers to RTW and improving coordination between stakeholders. Many believed that these changes will assist in achieving better RTW outcomes.

Reported challenges in the system in relation to the management of OR services were largely associated with a lack of flexibility in the system, competing success measures, unwillingness of healthcare providers/employers/injured workers to participate in RTW processes and the individual skills of the OR consultant.

Overall, agent representatives suggested that the following aspects of the system be reviewed:

- Enable OR consultants to provide suggestions regarding treatment to the injured workers and practitioners.
- Review current system success measures (e.g. Back @ Work and RTW measure) for both agents and OR providers as current measures do not consider the multiple barriers beyond agent/consultant control that may prevent injured workers' RTW.
- Review data inputs for reporting; particularly the suspension code to enable accurate reporting of active/suspended services.
- Provide guidance around length of OR service provision and when treatments should cease.

Experiences in the delivery of OR services

Experiences in the delivery of OR services were captured from the perspectives of OR consultants and employers. Perspectives from healthcare providers who also deliver/support the delivery of OR services are not included in the following analysis as they were not involved in this review.

Employer experiences with OR consultants were largely positive, with employers stating that when consultants were knowledgeable, proactive and communicative, the process was smooth, easy to understand and easy to participate in. Of those who reported negative experiences, a lack of communication, knowledge and the employer having to follow up providers were reported as the main reasons.

Employers reported that barriers to the effectiveness of OR service provision included:

- Injured worker barriers, including their skill level, training and willingness to take on roles within the organisation
- Employer barriers, including their inability to provide suitable duties
- Healthcare provider barriers, including their certification practices and willingness to recommend work
- Insurance agent barriers, including poor communication, delays in approvals and case manager change processes.

OR consultants reported barriers to providing OR services at the insurance agent level (inappropriate timing of referrals for services), injured worker level (attitudes and skills), with healthcare providers (unwillingness to participate in the process), and with employers (ability to provide duties and system barriers including the measures and payments applied for services).

Conversely, OR consultants' experiences indicated that they achieved better RTW outcomes when:

- The injured workers were content with the treatment and the WorkCover claim process and were participative in the RTW plan
- Employers participated in the RTW plan process
- OR consultants had good communication exchange with health care providers and case managers.

Overall, representatives from stakeholders involved in the delivery of OR services suggested that the following aspects of the system be reviewed:

- Communication and information about OR services
- Provide OR consultants more flexibility from the system, the ability to provide treatment recommendations, reduction in administration and faster approvals
- Review measures used for payments of both agents and OR providers, which were driving referrals from agents at inappropriate times and enabling behaviours such as using OR services as a means to measure compliance
- Pathways to referral with a focus on supporting early referral mechanisms

- Provide education and skills to the injured workers, employers and healthcare providers involved in OR claims so that they understand their obligation and cooperate with OR consultants
- Recognise and work to abolish the stigma associated with WorkCover claimants
- Approval, payments and processing times for services
- Handover practices when claims managers change to minimise the impact on the injured worker and ensure stakeholders are informed of changes.

Experiences in the receipt of OR services

Injured workers' experiences with receiving OR services were mixed. Positive experiences with OR consultants were associated with perceptions that OR consultants were helpful, supportive, listened to them and provided services tailored to their needs. Negative experiences were associated with perceptions of unrealistic expectations of RTW on the injured worker, communication challenges and mismatched services.

Injured workers' experiences with insurance agents were also mixed with positive experiences associated with swift approval processes, support of the treatment recommendations and clear and transparent communications. Negative experiences were associated with delayed approvals and/or denials of services and poor communication.

Injured workers reported multiple factors that they believed affected the OR service delivery, including:

- Case management processes – current practice provides limited personalised communication to the injured workers regarding the WorkCover claim process as well as frequent change in case managers with poor handover practices
- Employer barriers – unwillingness to provide alternative duties or participate in the process
- OR consultants – some injured workers reported that their consultants placed unrealistic expectations on them and pressured them to RTW.

Injured workers who had been able to successfully RTW after their injury reported that they were able to RTW because:

- They worked in organisations where the injury management systems were in place
- They did not find the claim process complicated
- Their employers were accommodating
- They were eager to return to work
- The OR consultants were supportive and did not pressure them to RTW.

Overall, representatives from injured workers who had received OR services suggested that the following aspects of the system be reviewed:

- Provide more tailored services from the system and enable informed decision making from the injured worker
- Recognise that their injury and the challenges associated with having an injury that they perceived were not their fault
- Guide and audit employers to provide safe and accommodative work environment (e.g. mental injury – bullying)
- Simplify and streamline claims management processes to enable decisions related to treatment and/or course requests without delay
- Minimise pressure on the injured worker to RTW.

3.4 Data analysis

The data analysis looked to identify trends in standard time loss claims where a WorkSafe client was provided with OR services between July 2007 and December 2016. The findings are described as they related to use of the Original Employer Services (OES), direct referral the New Employer Services (NES) and NES after OES.

3.4.1 Key findings

Trends in occupational rehabilitation service use

- The **number of OR claims increased** from 2007–2008 (11,434 claims) to 2015–2016 (14,887 claims), with **increases in both OES and NES** during that period. The number and proportion of direct NES claims increased over the period.
- In regards to timing of services:
  - OES was primarily delivered in the first year from claim approval (73% of claims), and by 3 years for 98% of claims
  - Only 25% of NES services were delivered in the first year after claim approval and 85% of NES services had been delivered within 3 years.

Patterns of occupational rehabilitation service provision

OES

- Claims that **achieved OES placement had a shorter commencement time** (15 weeks) than claims that did not (19 weeks). This was seen when all claims were analysed together and across all Insurance Agents and OR Providers.
- **Time to first OES placement decreased** from 2008 (11 weeks) to 2016 (8 weeks).
- The **time to a sustainable OES outcome increased** from 2008 to 2016 for clients who were not at work at OES commencement (23 to 28 weeks), as well as for clients at work at the time of commencement (19 to 21 weeks).

NES

- The **time to commencement was considerably shorter for direct NES than NES following OES**, regardless of year (in 2016, an average of 91 weeks compared to 131 weeks).
- There was an **increase in time to commencement for direct NES services** each year, increasing from an average of 36 weeks in 2008 to 91 weeks in 2016.
- **Time to commencement increased** between 2008 and 2016 for both direct NES and NES following OES for all but one Agent and for all but one OR Provider.
- **Time from commencement to sustainable outcome increased for both direct NES and NES following OES** for all Agents and all Providers between 2008 and 2016. Overall the increase was 40% for Direct NES (44 weeks in 2016) and 31% for NES following OES (42 weeks in 2016).

OR outcomes: client placement and sustainability

OES

- The proportion of clients who **achieved placement** increased from 55% in 2008 to 77% in 2015.
- The largest proportion of clients who **achieved placement** went through gradual OES placement and achieved 100% pre-injury hours (PIH) (about 30-40%).
- The largest proportion of clients who RTW through OES placements do so **within 3 months** after commencing OES, regardless of the year in which they began using OES. The proportion of clients who RTW in under 3 months through OES almost doubled from 36% to 63% from 2008 to 2015, respectively.

- Clients who commenced OES in **later years** such as 2015 took a **shorter time** to achieve their first OES **placement** relative to earlier years.
- Clients who RTW through gradual 100% PIH placements took a **shorter time** to achieve their first OES placement compared to those who RTW using 100% PIH placements directly.
- The total proportion of clients who achieved **placement sustainability** increased from 44% in 2008 to 59% in 2015.
- Placements were more likely to be **sustainable** where there was a shorter time to commencement, a shorter time to first placement, and placement type was gradual or directly 100% pre-injury hours.
- Over 90% of clients who achieved gradual 100% PIH and direct 100% PIH placements attained **sustainability**.

NES

- 32% of clients who used NES services from 2008 to 2015 achieved **placement with a new employer** and 26% achieved **placement sustainability**.
- A higher proportion of clients who commenced using NES in more recent years (2014–2015) took a shorter time to achieve both their **first NES placement** and **sustainable placement** compared to those who commenced using NES in earlier years (2008–2009).
- Clients who used **retraining services** were slightly (1.13 times) more likely to achieve NES **placement**, compared to clients who did not use retraining services.
    - Of the clients who achieved placement with NES, 45% were retrained and of these 77.5% attained sustainable placements.
    - Of the clients who did not achieve NES placements, 41.5% were retrained.
- Clients who were **directly referred to NES** were slightly more likely to achieve **placement** (1.11 times) and **sustainability** (1.15 times), then those who were referred to NES following OES.

Factors associated with occupational rehabilitation service outcomes

OES

- The most important factors in achieving **OES placement** were: lack of use of psychiatric or psychological services, type of injury, location on body, and cause of injury.
- The most important factors in achieving **OES sustainability** were similar: lack of use of psychiatric or psychological services, location on body, type of injury, and hospital admission
- Regardless of type of injury (any physical or mental), the use of psychiatric or psychological services was strongly negatively associated with OES placement and sustainability.
- Characteristics of the injury (i.e. type, location and cause) were also very important for OES clients.

Direct NES

- Factors determined to be statistically associated with achieving **both placement and sustainability** for direct NES clients were age group, time to commencement, occupation and cause of injury.
- Clients with **mental injuries** were more likely to achieve **placement and sustainability** with direct NES compared to other types of injuries.
- The other most significant factor in determining NES placement and sustainability was **client age**. Time to commencement and occupation were also important.

NES following OES

- Factors significantly associated with achieving **both placement and sustainability** for NES following OES clients were age group, time to NES commencement, location on body and type of injury.

- Clients with **mental injuries** were more likely to achieve **placement and sustainability** with NES following OES compared to other types of injuries.
- The same factors appear important in determining placement for NES, regardless of whether the client had previously used OES: client age and time to commencement.

3.4.2 Implications

This report provided extensive analysis of WorkSafe claims with occupational rehabilitation services over a ten-year period. A number of findings demonstrate positive trends in OR service provision. These included an increase in OR services utilisation, an improvement in OR service timelines (including a reduction in time to commencement and time to first placement), and improvements in placement outcomes and their sustainability. Injured workers who commenced OR services more recently were not only more likely to find a placement, but were also more likely to find a placement in a shorter time. There was also reduced variation between WorkSafe Agents' performances in recent years, with data showing a more consistent and uniform approach to OR services provision over time.

Original employer services (OES) were the largest proportion of claims, and 73% of these are delivered in the first year after claim approval. **Claims that achieved OES placement had a shorter commencement time than claims that did not.** This was seen when all claims were analysed together and across all Insurance Agents and OR Providers. Therefore this is an important implication from this work.

- The faster OR services commenced, the better the outcomes for clients.

Over the study period, the average time to first OES placement decreased from 11 to 8 weeks, and the proportion of clients who achieved placement increased from 55% to 77%. **The largest proportion of clients who RTW through OES placements did so within 3 months after commencing OES and through gradual OES placement and achieved 100% pre-injury hours (PIH).** Clients who commenced OES in later years such as 2015 took a shorter time to achieve their first OES placement relative to earlier years.

By 2015, the proportion of OES clients who achieved placement sustainability had increased to 59%. However, there was an increase in the time it was taking to achieve sustainability. Placements were more likely to be sustainable where there was a shorter time to commencement, a shorter time to first placement, and placement type was gradual or directly 100% pre-injury hours. The successful and increasing use of gradual return to work may be related to the finding of increased time taken to achieve sustainability.

NES clients took longer to commence compared to OES clients (in 2016 time to commence was 91 weeks for direct NES and 131 weeks for NES following OES; compared to about 15 weeks for OES) and only a quarter of the NES services are provided in the first year. The time to commencement for both direct NES services and NES following OES had increased over the study period. The time from commencement to sustainable outcome also increased for both direct NES and NES following OES between 2008 and 2016. There is a clear need to reduce the time to commence NES services and provide support to achieve sustainability.

The bulk of OR services are delivered as OES. OES achieved successful outcomes (placement and sustainable placement) for two-thirds of clients. This was considerably more than for NES (either direct or following OES) where only one third of clients achieved successful outcomes.

Analysis of claims' factors associated with OR outcomes showed that claims' factors that were most significant for OES outcomes were the lack of use of psychiatric or psychological services, and injury related such as type of injury, location on body and severity shown by hospital admissions, while

factors most significant for NES outcomes were characteristics such as age, occupation and time to NES services commencement.

After adjusting for the significant factors, the odds of achieving placement and sustaining that placement were significantly lower if there had been use of psychiatric or psychological services and late hospital admission. This was seen in patients with primary and secondary mental health problems. Specifically for NES, odds of successful outcomes were lower if clients were aged over 55, or worked as intermediate production and transport workers or labourers. For OES, a longer time to commencing OR services, and having a mental injury were also associated with lower the odds of successful placement and sustainability.

The characteristics associated with significantly higher odds of achieving placement and sustaining that placement were younger client age, and no use of psychiatric or psychological services. Specifically for NES, odds for successful outcomes were higher if clients were younger and had a mental injury. A shorter stay in hospital, shorter time to commencing OR services, and working for a large employer were associated with higher odds of placement and sustainability for OES clients.

4. OVERVIEW OF FINDINGS AGAINST PROPOSED WORKSAFE INITIATIVES

From the strategic review several factors were identified that can inform WorkSafe's Victoria's future approach to OR and provide insight into the feasibility and likely success of approaches currently being considered for implementation. An analysis of the findings against key proposed WSV initiatives in terms of the level of support from stakeholders (injured workers, employers, agents and OR providers) and the level of evidence in practice is provided in Table 1. Overall, across the sector there was strong support for re-training, volunteer work, improving agent quality-decision making, early triage referrals as potentially facilitating positive OR and RTW outcomes.

Table 1. Overview of findings against key WorkSafe Victoria initiatives

Initiative	Level of support identified in study	Evidence in practice
OES assessment – splitting into phone initial assessment and workplace intervention/ergonomic assessment	● (dark grey)	● (dark grey)
Phone-based assessment particularly for major injuries	● (dark grey)	● (dark grey)
Early triaging of claims/ earlier identification of RTW and recovery pathways	● (green)	● (green)
Improving agent quality decision-making	● (green)	● (green)
Volunteer work as part of RTW rehabilitation, work trials and worker incentive payments	● (green)	● (green)
Multidisciplinary conferences for motivational interviewing	● (dark grey)	● (dark grey)
Motivational interviewing for RTW by phone	● (dark grey)	● (dark grey)
Facilitated conflict resolution discussion (mediation style)	● (dark grey)	● (orange)
New Employer Service – job-seeking coaching service	● (dark grey)	● (dark grey)
Re-training	● (blue)	● (green)

	Level of support	Description
● (dark grey)	No support for initiative discussed	No evidence of approaches being used in current practice/ issue not discussed
● (dark red)	No support for initiative	Issue discussed but not supported by interviewees/ tested previously and found unsuccessful
● (orange)	Some support for initiative	Some support for the initiative identified through discussion but not universally positive, mixed reports of success/some early application of initiatives into practice but no evidence of success
● (blue)	Medium support	Medium level of support for the initiative identified through discussion, mostly positive/some examples of approaches in practice and some evidence of success
● (green)	Strong support	Strong support for initiatives identified through discussion with all /strong evidence of application of approaches in practice including strong evidence of success

5. IDENTIFIED FOCUS AREAS FOR IMPROVEMENT

Across the strategic review a number of key challenges and areas for improvement were identified in the management, delivery and receipt of OR services. This section provides an overview of these focus areas and Section 6 provides more detailed thematic analysis and recommendations to address these areas.

5.1.1 Management of OR services (WorkSafe Victoria, insurance agents, OR providers)

There were a number of challenges and opportunities identified in the project relating to the management of OR services. As the area where WorkSafe has the most direct influence, the majority of recommendations identified in Section 6 relate to the management level.

As detailed above, the Environmental Scan identified that the Victorian model of outsourcing both claims management and the provision of OR services provides some efficiencies in administration and simplifying the service pathway, however it can also result in challenges for the compensation authority in measuring the effectiveness of services, and limiting the capacity to tailor services for individual clients.

There were challenges identified for worker's compensation authorities and Agents in being able to assess whether the client receiving OR services is benefitting from them or not, or at what point of a claim to discontinue OR services.

A key finding relating to the management of OR services were challenges identified in measuring and assessing the effectiveness of the services. All WorkSafe Agents reported having their own measurement frameworks in place for OR providers, which were in addition to the frameworks applied by WorkSafe. This was recognised as having the potential to create competing or even conflicting goals for providers, as well as increasing the time spent reporting.

Another key challenge identified at the management level were the processes around client referral. The project clearly showed the benefits of early referral in achieving faster return to work outcomes for clients. There are opportunities to streamline referral pathways and to identify the clients which will benefit most from OR services. There were specific challenges identified in referring clients from OES to NES services. OR consultants reported that the referral pathways could be cumbersome and at times they felt that clients who would benefit from direct referral to NES were being disadvantaged by receiving having to receive OES services first.

5.1.2 Delivery of OR services (OR consultants, healthcare providers, employers)

There were some challenges reported relating to the delivery of OR services. WorkSafe does not have direct control over most of these factors, however through changes at the management level they can influence most.

Active participation from employers, healthcare providers and injured workers in the process of occupational rehabilitation was identified as a key factor for the effectiveness of the services. A number of the challenges identified by OR consultants and injured workers related to the flow of information between stakeholders in the system and the willingness to participate in meetings and conferences relating to the injured worker. Employer participation was identified as a key facilitator for return to work, for both OES and NES clients.

OR consultants reported challenges with the current incentives structures for their work, with many believing that current incentives disadvantage senior consultants and inhibit professional development. They believed this may contribute to the high turnover of consultant staff that was identified by a number of stakeholders as a key challenge in ensuring the quality of services.

5.1.3 Receipt of OR services (injured workers)

This project gathered some evidence from injured workers relating to their experiences in receiving OR services. One of the key challenges identified was a perceived lack of flexibility in the services injured workers received. Some reported that the rigidity of the system resulted in the provision of services that did not match their needs. There was mixed feedback from injured workers regarding their experience of OR services, however they reported positive experiences with consultants when they felt they were listened to, supported and offered tailored services that matched their needs.

6. THEMATIC SYNTHESIS AND RECOMMENDATIONS

6.1 Performance measures and incentives

One of the most consistent findings across the Environmental Scan and Quality Improvement Review was that the current performance measures and incentive structures for OR providers and consultants are mismatched with the primary goal of OR services, which is to support injured workers who need extra assistance to return to work as quickly as possible.

The Environmental Scan showed that the majority of compensation authorities interviewed used a full or quasi outcomes-based payment model or were transitioning to this type of model. Responses from WorkSafe Agents and OR providers indicated that both preferred outcome-based funding to fee for service payments, however they reported that there are both positives and negatives to incentive payments.

There were a number of unintended consequences from the current incentives structure reported across the projects. OR consultants reported that they believed workers were being referred to their services at inappropriate times, with the aim of meeting benchmark measures rather than acting in the best interest of the worker. Another unintended consequence reported was that experienced OR consultants were disadvantaged through the incentive structures as they were more likely to take on complex cases that required greater investment in time, and had a lower chance of resulting in sustained RTW. This disincentives professional development for consultants and may be a contributor to the high staff turnover rates reported by OR providers. OR consultants also reported instances where sustained return to work incentives were not paid as a result of a worker choosing to resign their position after being successfully supported to return to work. Consultants reported feeling penalised in these circumstances despite doing their job effectively.

The Environmental Scan presented a case study from the Department of Work and Pensions (DWP) in the United Kingdom, who after an extensive review of payment arrangements introduced in 2011 an outcome-based funding model which took into account the types of services delivered and the complexity of the case. This model resulted in an increase in the proportion of clients achieving a job outcome within 12 months. At the time of publication DWP were considering changing the calculation of client complexity to a more needs-based approach, which is a potential model for WorkSafe to consider.

All Agents reported that they use their own reporting and metrics to measure performance and OR providers described this as challenging, as these measures could contradict WorkSafe measures and create a significant administrative burden. WorkSafe's review of the OR provider service agreement provides an opportunity to standardise the tools used to measure performance.

Summary

- Current performance measures and incentive structures for OR providers and consultants are mismatched with the primary goal of OR services.
- OR consultants reported that they believed workers were being referred to their services at inappropriate times, with the aim of meeting benchmark measures rather than acting in the best interest of the worker.
- Experienced OR consultants were disadvantaged through the incentive structures as they were more likely to take on complex cases that required greater investment in time.
- Agents reported that they use their own reporting and metrics to measure performance and OR providers which could contradict WorkSafe measures and create a significant administrative burden.

Recommendations

1. Review current system measures and benchmarks for both Agents and OR providers to ensure they are driving behaviours that maximise client RTW outcomes.
2. Consider measures and incentives that fairly reward OR consultants for case complexity and encourage professional growth.
3. Align measures used by WorkSafe and Agents to measure OR provider performance.

6.2 Early and targeted referral

Early referral to OR services was identified across all reports in the strategic review as key to facilitating timely return to work. The Evidence Review found support in the scientific literature for early contact (within 2–4 weeks after injury) being a key component of successful return to work interventions. Early referral to OR services was identified as a key facilitator to return to work by Agents, OR providers and consultants. This was also supported by the analysis of WorkSafe claims data which concluded that the faster OR services commenced, the better the outcomes were for the clients.

Mobile case management was identified in the review as an effective strategy for enabling early contact with injured workers. Close to two thirds of OR consultants interviewed noted improvements in the workers' compensation claims process in the previous year, and a number specifically highlighted mobile case management as a key improvement. ReturnToWorkSA also operate a mobile case management approach with early referral (24–48 hours) and reported a reduction in the premium rate paid by employers from 2.75% to 1.95% since this has been implemented. WorkSafe is currently evaluating the effectiveness of its Agent's mobile case management processes and continuing to improve this service is a key facilitator to early referral.

A number of compensation bodies in Australia and internationally are exploring methods of screening clients and providing targeted intervention and this strategic review presented opportunities for WorkSafe to use the findings to enhance their tailoring of OR services. The analysis of WorkSafe claims data identified some of the individual characteristics associated with work placement. The highest percentage of placement was achieved by claimants between 15–24 years of age (79% OES, 40% direct NES and 54% NES after OES). A key finding in the data analysis was that although clients with mental injury had a lower percentage rate of placement using OES (52%) compared to other injury types, they had a higher rate of placement through direct NES (35%) and NES after OES (42%). This is supported by qualitative evidence that indicated workers with mental injury may be unwilling to return to their original employer, particularly when they have experienced bullying and/or harassment, and would likely benefit from direct referral to NES.

Summary

- Early referral to OR services was identified as a key facilitator for return to work.
- Mobile case management was identified in the review as an effective strategy for enabling early contact with injured workers.
- Evidence from the data analysis can be used to inform client screening approaches.
- Although clients with mental injury had a lower percentage rate of placement using OES (52%) compared to other injury types, they had a higher rate of placement through direct NES (35%) and NES after OES (42%).

Recommendations

4. Facilitate early referral to OR services with a focus on improving mobile case management.

5. Consider the development of client screening approaches to identify the injured workers most likely to benefit from OR services.

6. Review eligibility and referral requirements for NES services, particularly for mental health claims.

6.3 Information flow between stakeholders

A key area for potential improvement in the delivery of OR services identified in the research was information flow between stakeholders in the system. The Evidence Review found strong support in the scientific literature for the coordination of recovery and RTW, which was shown to reduce the time to RTW for workers with musculoskeletal injuries. The evidence of its effectiveness in reducing time to RTW for mental injuries was less clear. There was also support in the scientific evidence for a collaborative approach to RTW involving a clear RTW plan and periodic case conferencing.

This evidence aligns well with the qualitative data in the Quality Improvement Review. Agents, employers and injured workers all consistently described the role of OR consultants, particularly the role they play as a coordinating point between the various stakeholders involved in RTW. When OR consultants were engaged they were reported as being "the face of the claim" for a number of stakeholders and this aligned with the scientific evidence that indicated the value of having a primary contact person to assist injured workers with navigating the system.

Despite a recognition of this coordination role, and a willingness to perform it, many OR consultants reported being hindered by disrupted information flow between stakeholders. Consultants reported difficulty in obtaining information from Agents, healthcare providers and employers. More frequent case conferencing was identified in the scientific and qualitative evidence as a potential facilitator for better communication between stakeholders.

Both the evidence in the scientific literature and qualitative data indicated the importance of employer engagement in the success of OR services. Employers reported being generally satisfied with the service received by OR providers and a number reported the value of consultants acting as a buffer between them and the injured worker, and assisting in the implementation of RTW plans.

Evidence also highlighted the value of OR consultants having an allied health background as this was reported to give them greater credibility in their interactions with healthcare providers.

Summary

- Multiple stakeholders involved in the OR services reported being hindered by disrupted information flow.
- More frequent case conferencing was identified in the scientific and qualitative evidence as a potential facilitator for information flow between stakeholders.
- Employer engagement was identified as a key factor for the success of OR services.

Recommendations

7. Promote initiatives that enable the sharing of information between stakeholders such as case conferencing.

8. Explore opportunities to provide information to injured workers through channels other than formal letters.

6.4 Flexibility and injured worker involvement

A lack of flexibility in the delivery of OR services was identified as a challenge for OR providers, consultants and injured workers. Consultants reported they were hindered in their capacity to provide tailored support to clients by restrictive eligibility criteria, particularly for NES referrals. As highlighted above, the qualitative evidence and data analysis suggested benefit in providing greater flexibility in direct referral to NES services for workers with mental injury.

Many consultants reported being overruled by claims managers in service recommendations for their clients. This was a source of considerable frustration for OR consultants who were working closely with injured workers and believed they had a good understanding of what was required for their timely return to work.

The qualitative evidence indicated that in Victoria injured workers are passive recipients of OR services and one of the few choices they are given is the initial choice of provider. It was reported that a lack of injured worker involvement in the delivery of OR services can lead to a mismatch of service to need.

The Environmental Scan found that this can be a particular challenge in OR management models where both the case management and OR service provision are outsourced, as this creates a number of levels of administration between key decision makers and the injured worker. The Environmental Scan highlighted the model of OR assessment operated by the Accident Compensation Corporation (ACC) in New Zealand, which involved extensive engagement with the injured worker and gave them the opportunity to provide feedback on potential job opportunities and their career goals and aspirations. The ACC model was the only one identified where the injured worker was required to formally approve their OR assessment and this has the potential to minimise time loss and the frustration of the injured worker being offered unsuitable or unwanted opportunities.

Summary

- A lack of flexibility in the delivery of OR services was identified as a challenge for OR providers, consultants and injured workers.
- Consultants reported they were hindered in their capacity to provide tailored support to clients by restrictive eligibility criteria, particularly for NES referrals. OR consultants reported frustration at having their client recommendations rejected by Agents.
- Injured workers in Victoria are passive recipients of OR services and their lack of involvement in decision making can lead to a mismatch of service to need.

Recommendations

9. Provide a mechanism for OR consultants to give feedback and recommendations on the services and treatments delivered to their clients.

10. Explore opportunities for greater engagement with injured workers in the OR assessment process.

6.5 Stigma toward injured workers

A clear finding from this project was that there remains considerable stigma toward injured workers who access benefits through workers' compensation, particularly for those with mental injury. Findings from the Quality Improvement Review indicate that the stigma of being on workers' compensation permeates throughout the system, with several injured workers reporting experiencing discrimination with new employers and their existing employers as a result of their claim.

The majority of employers surveyed in the Quality Improvement Review somewhat acknowledged the existence of this stigma and that it may be a barrier to workers achieving new job placement. Injured workers reported this stigma was especially prevalent for those receiving NES. Some injured workers believed they would not be able to get another job because they had a workers' compensation claim and evidence from the Environmental Scan showed workers hiding the fact that they had submitted a claim through workers' compensation, as they thought it would lower their chances of achieving work placement.

Employers who represented small organisations indicated that they would be particularly cautious in hiring who had had a workers' compensation claim. Responses from medium to large employers were more mixed with some pessimistic of the chances of WorkSafe claimants finding new jobs, while others reported that it was dependent on the injury type.

While stigma was reported towards all workers' compensation claimants, it was particularly prevalent toward workers with mental injury. Both the Quality Improvement Review and Environmental Scan reported evidence that employers were reluctant to hire workers with mental injury.

This evidence all suggests that stigma toward compensation claimants continues to be a barrier which impacts the effectiveness of OR services and may be a factor in the lower rate of NES placement shown in the data analysis. There is an opportunity for WorkSafe to continue its efforts to eliminate this kind of stigma and create more employment opportunities for injured workers.

Summary

- There remains considerable stigma toward injured workers who access benefits through WorkCover, particularly for those with mental injury. This stigma can impact the likelihood of workers achieving placement through NES.
- Employers indicated a reluctance to hire workers who had a workers' compensation claim and this may have contributed to the lower rates of NES placement, compared with OES.

Recommendations

11. Invest in programs to target stigma associated with accessing workers' compensation.

7. INSIGHTS

This strategic review identified a range of evidence that supported the use of occupational rehabilitation services to facilitate return to work for injured workers. Key components of successful OR services identified were:

- early and targeted referral
- communication and coordination between stakeholders
- flexibility and tailoring in the delivery of services.

Qualitative evidence and analysis of WorkSafe claims data revealed that a number of components of the system are operating well and there have been improvement in OR service performance in recent years. Of particular note, two thirds of OR consultants also reported improvements in WorkCover claims processes in the previous 12 months, particularly earlier referral as a result of mobile case management approaches.

A key focus area for WorkSafe should be ensuring that the measures and benchmarks set for Agents and OR providers are incentivising behaviour that promotes client RTW outcomes, and do not result in unintended consequences. The strategic review has identified potential models to help inform this approach, with a focus on recognising and rewarding case complexity. An incentive structure which rewards experience and professional development could also improve the current high level of turnover among OR consultants, which was identified as a significant challenge for providers in the review.

WorkSafe's review of OR services also presents an opportunity to align the measures used by WorkSafe and Agents, to ensure they not contradictory or creating unnecessary administrative burden for providers.

Some of the most significant findings in the strategic review related to the management of mental injury claims, which is a key focus of WorkSafe's *Strategy 2030*. Analysis of WorkSafe claims showed that OR consultants would benefit from greater flexibility in their management of clients with mental injury, and that direct referral to NES may be a better option for many of these clients. The qualitative evidence supported these findings, suggesting that workers who have experienced significant stress or bullying and harassment are unlikely to want to return to their original employer. Further evidence suggested a reluctance from employers to hire workers on WorkCover, particularly those with mental injury, indicating that reducing stigma toward compensation claimants remains an important strategy for improve OR outcomes.

Australian Rehabilitation Providers Association (ARPA)
PO Box 429
Cherrybrook NSW 2126

26 November 2020

Dear ,

ASORC Letter of Support for ARPA NSW submission to State Insurance Regulatory Authority (SIRA)

Thank you for bringing to our attention ARPA NSW's submission to State Insurance Regulatory Authority (SIRA) concerning the regulatory requirements for workplace rehabilitation service provision in NSW personal injury schemes.

The Australian Society of Rehabilitation Counsellors Ltd. (ASORC) is pleased to support your submission, particularly aspects that apply to Rehabilitation Counsellors (RCs). However, in doing so we need to point out that ASORC represents individual Rehabilitation Counsellors not organisations or providers per se, although some of our members happen to wear a dual hat in that they are both RCs and providers.

It is the opinion of ASORC that going forward the role of Rehabilitation Counsellors in workplace rehabilitation will be more important than ever. The unique skills Rehabilitation Counsellors possess in helping people remain engaged in meaningful work, as well as facilitating their return to work in this challenging environment will be of critical importance.

In supporting the ARPA submission we draw particular attention to ARPA's comments below in italics:

7 C ii) The list of allowable qualifications should be expanded

- *ASORC (Australian Society of Rehabilitation Counsellors) Full members– who are accepted by SIRA to perform a number of services – as per the SIRA NSW Supplement. Supplement to the Guide: Nationally consistent approval framework for workplace rehabilitation providers should include ASORC Associate members (under the ASORC supervision program).*
- Associate members are currently not able to provide Full member services by SIRA in NSW

7 D i) Mandatory referral to workplace rehabilitation

- *Early referral will minimize delay to support; delays of RTW and the associated wages recorded on the claim. Further, it will significantly improve the employer's experience and the worker's experience by allowing the worker to RTW earlier, stay engaged with work and recover at work.*

7 D ii) SIRA to develop guidelines to ensure WR services are not interrupted

- *ARPA's recommendation that SIRA develops a comprehensive set of guidelines which clearly articulates when a Scheme Agent can or cannot reduce, cut or deny WR service requests.*

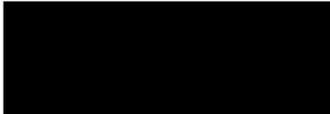
7 E i) Non-accredited providers should either be banned or subject to the same rules

- *ARPA NSW would strongly recommend that either the non-accredited providers are banned from the scheme or are covered by the WR provider framework.*

7 E iii) Mental health injury claims to be referred to WR ASAP

The most significant drivers of prolonged work absence are psychosocial factors and therefore Rehabilitation Counsellors are critical to addressing the *psychosocially targeted assistance to support the employer and in turn the worker through a workplace-based intervention to produce the greatest results.*
ARPA NSW recommends that it is imperative that these cohorts should be referred for workplace rehabilitation services as soon as practicable.

Sincerely,



Australian Society of Rehabilitation Counsellors (ASORC)
Email: admin@asorc.org.au