

Recovery at Work: A New Way of Thinking About Work Injuries



Strategic Roundtable • Sydney, 5 May 2016

Global Access Partners
NSW Family & Community Services
State Insurance Regulatory Authority (NSW)
Insurance & Care NSW (icare)
WorkSafe Victoria



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Cover Photo: GAP Roundtable participants in the Strangers Dining Room, NSW Parliament House
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Recovery at Work: A New Way of Thinking About Work Injuries

A Strategic Roundtable presented by Global Access Partners

Thursday, 5 May 2016

NSW Parliament House, Sydney

Organised by Global Access Partners and supported by the NSW Department of Family and Community Services, the State Insurance Regulatory Authority (SIRA), Insurance and Care NSW (icare) and WorkSafe Victoria, the Roundtable discussed strategies to encourage recovery at work after soft tissue injuries.

Seventy six participants from academia, government agencies, the health service, employers, insurers and industry associations engaged with workplace rehabilitation specialists in an open and constructive debate of issues raised by the recent return-to-work studies in NSW and Victoria.

Attendees were welcomed by **The Hon. John Ajaka** MLC, the Minister for Ageing, Disability Services and Multiculturalism in the NSW Government. The discussion was facilitated by **Dr Norman Swan**, host of *The Health Report* on ABC Radio National.

Speakers included **Helen Rogers**, Executive Director of the Participation and Inclusion Directorate at NSW Family and Community Services, **Prof Michael Nicholas** of the Pain Management Research Institute at Royal North Shore Hospital and The University of Sydney, **Dr Alex Gyani** of the Behavioural Insights Unit at NSW Premier and Cabinet, **Carmel Donnelly**, Executive Director of Workers and Home Building Compensation Regulation at the State Insurance Regulatory Authority (NSW), **Dr Anne Daly**, Clinical Consultant at WorkSafe Victoria, and **Eugene McGarrell**, General Manager of Community and Health Engagement at icare NSW.

Disclaimer

This document represents a diverse range of views and interests of the individuals and organisations involved in the Roundtable. They are personal opinions that do not necessarily reflect those of the organisers and sponsors of the event. Given the different perspectives of participating individuals, it should not be assumed that every participant would agree with every argument or recommendation in full.

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Executive Summary

- Workers and their families, employers, insurers, government, health and social services all benefit from workers' faster recovery and earlier return to work after injury. Employment supports physical health and psychological wellbeing, while long-term absence from work can lead to personal poverty, family stress and increased medical and social security costs.
- Evidence-based guidelines for the treatment of soft tissue injuries were released by WorkCover NSW over a decade ago¹, and most employees return to work in good time with little extra support. Unfortunately, many vulnerable people are still hampered by delays in identification and treatment.
- Behavioural insights can suggest practical ways to reduce institutional barriers and improve results. The EAST ('Easy, Attractive, Social and Timely') framework, published in 2014 by the Behavioural Insights Team,² can help develop user-friendly solutions. Simplifying and aligning recovery-at-work processes in pursuit of workers' goals, securing personal commitments, focusing on 'a return to work', rather than 'managing the injury', and testing new approaches to identify and overcome problems are the keys to stakeholder acceptance.
- WorkSafe Victoria and the Transport Accident Commission (TAC) offer pain education to chronic sufferers and online health advice to the public, and are consulting health professionals on certification practices.
- The recent Work Injury Screening and Early intervention (WISE) study³ in NSW public hospitals proves that outcomes for workers at risk of poor recovery can be improved by early identification and coordinated physical and psychological treatment. These workers were identified within days of their injury through a brief questionnaire, and prompt and coordinated application of treatment reduced the average recovery time from 53 days to 29. The protocol implemented the existing guidelines much sooner and more rigorously than is customary, rather than offering novel treatments or therapies. Successful implementation relied on close cooperation and consultation between all the clinicians, the employer and the insurance claims manager involved.
- In line with SIRA's approach, efforts to roll-out return-to-work protocols should be collaborative, consultative and constructive to ensure broad stakeholder acceptance. New programmes should be risk-based, data-driven and customer-centric, with their outcomes evaluated, to ensure the improvements seen in initial studies are maintained.
- Further GAP roundtables will discuss implementation of return-to-work protocols with a network of 'early adopters' to lead their wider adoption.

Welcome from the Chair of the GAP Taskforce on Productive Ageing

Helen Rogers

Executive Director
Participation and Inclusion Directorate
NSW Family and Community Services

Helen Rogers acknowledged the traditional custodians of the land and thanked the sponsors and organisers of the Roundtable. Ms Rogers chairs the GAP Taskforce on Productive Ageing, a multidisciplinary group which supports the NSW Ageing Strategy⁴ by discussing and suggesting policy proposals.



Since its establishment in June 2014, the Taskforce has considered the needs of older and injured workers, and agrees that return to work can be fostered by early identification of at-risk workers and holistic medical and psychological support.

Workplace absence through injury impacts workers, their families and employers, and the broader community. Ms Rogers praised attendees for their commitment to keeping employees 'healthy, happy and engaged' and expressed the hope that the Roundtable would be the first step in rolling out the WISE study more widely.

Introduction

Dr Norman Swan

Host of *The Health Report*
ABC National Radio



Dr Norman Swan noted that the attitudes and actions of employers, managers, general practitioners (GPs) and occupational health and safety specialists shape the trajectory of injured workers for good or ill.

As an example, he referred to a randomised trial of Boeing workers with back pain⁵ which proved that expectations set in an initial medical consultation can set a patient's course towards chronic pain or full recovery. He also noted that a recent conference in Tokyo⁶ had encouraged GPs to play a stronger role in helping people return to the workplace.

The debate around return to work is more often driven by the beliefs of various stakeholders, rather than objective evidence, with each believing their approach to be the best. Dr Swan challenged attendees to embrace evidence-based, transformative thinking to improve the system, as most workers do not want to be disabled or leave their jobs. An inability to work often leads to poverty; work maintains the economic and social wellbeing of the nation as well as individuals.

Employers, regulators, insurers and workers all share an interest in improving the current system, and the Roundtable's speakers will offer evidence, ideas and strategies to improve outcomes. Rather than blame particular professionals or workers for delays, all stakeholders must collaborate to help people recover and get back to their jobs.

Dr Swan then introduced Professor Michael Nicholas, head of the Sydney WISE study.

For Better Return to Work Outcomes, Knowledge is not Enough: Lessons from an Early Intervention Trial



Professor Michael Nicholas

Pain Management Research Institute
Royal North Shore Hospital
The University of Sydney

Prof Michael Nicholas thanked his collaborators and fellow researchers⁷ and agreed that all stakeholders share the same goal of reducing recovery times. While most workers overcome soft tissue injuries without extra support, the system fails the minority who require more help, but slip through the net. The treatment they require is well understood, but the problem has been identifying and treating injured workers quickly enough to change their trajectory.

Implementation research offers insights into improving system performance. The recently completed WISE study in NSW public hospitals conclusively demonstrates that better results can be achieved by using existing resources more effectively. Knowledge is not enough to deliver better outcomes; it must be accepted and implemented by all practitioners to achieve its full impact.

Turning Research into Reality

History offers many instances of clinicians being slow to adopt simple and effective practices which are now taken for granted. Hungarian physician Dr Ignaz Semmelweis (1818-65) called for hospital doctors to wash their hands, like midwives, between attending expectant mothers, to stop babies contracting and dying from puerperal fever, but was ignored, dismissed as a madman and died in a mental hospital⁸. While doctors, like most healthcare workers, can be reluctant to change their ways, it is also incumbent on researchers to press for reforms and encourage implementation if their trials are successful.

Work has long been acknowledged as beneficial for people's health. Dame Carol Black's Review⁹ of the health of British workers and the Australasian Faculty of Occupational and Environmental Medicine¹⁰ agree that safe work is generally good for health and wellbeing, while long-term work absence, work disability and unemployment have negative impacts.

Rates of Return after Injury

Most people who sustain back or other soft tissue injuries return to work in good time. A Sydney study of 900 people with recent onset back pain, undertaken by a physiotherapist completing a PhD¹¹, found the vast majority resumed work without issue, but that few returned after more than three months away. Many studies confirm that the longer an injured worker is away from work, the lower their chances of returning. Data from Melbourne¹² shows that 70% of people absent for 20 days will return, but only half of those away for 45 days, and just 35% of people on medical leave after 70 days will resume employment.

“Soft tissue injuries accounted for 53% of work injuries across NSW in 2011-12, and 69% of work injuries for NSW Health in 2011-12. Workers compensation premiums for NSW Health rose by \$24m (15%) to \$181m in 2012-13.”

A 2013 survey by the Australian Bureau of Statistics (ABS) found¹³ that 85% of injured workers continued to work in the job where their injury occurred, while 7% had changed jobs and 8% were not employed when surveyed. Fifty to fifty-four-year-olds had the highest rates of work-related injury or illness and suffered the greatest financial and social penalties.

Research¹⁴ by Professor Deborah Schofield, a health economist at the University of Sydney, shows back pain to be a major cause of early retirement for Australians in their fifties and enumerates the financial problems they, along with the community in general, face as a result.

Soft tissue injuries accounted for 53% of work injuries across NSW in 2011-12, and 69% of work injuries for NSW Health in 2011-12. Workers compensation premiums for NSW Health rose by \$24m (15%) to \$181m in 2012-13. The rise in premiums was mainly driven by workers' increasing time away from work. Despite consensus around the value of work and the costs of absence, outcomes for workers who do not return quickly have not improved, despite the availability of knowledge of how to help them.

Rather than look for novel treatments, one solution may be to implement existing guidelines more effectively by identifying workers at risk of delayed return early enough to alter their trajectory. While they select themselves after six months off work, it is then too late to help them effectively, especially if they have lost their jobs. Many health professionals and claims managers believe they can predict which people will struggle to recover, but the evidence suggests they fail to do so, and a more objective and reliable method is required.

Problems with Delayed Returns to Work

“Rather than look for novel treatments, one solution may be to implement existing guidelines more effectively by identifying workers at risk of delayed return early enough to alter their trajectory.”

Evidence suggests a range of risk factors¹⁵ for delayed return to work. Some, such as serious injuries requiring surgery, are ‘red flags’ which must be treated in a timely way, but, fortunately, these are a relatively small proportion of cases. The major risk factors for delayed RTW are psychological and social/environmental factors. The psychological factors include depression, post-traumatic stress disorder, emotional distress, avoidant coping strategies such as excessive resting, and a passive role in recovery.

The social/environmental factors include job dissatisfaction and the perception by the injured workers that they are unsupported or overburdened in the workplace. The legislative criteria for compensation and the extent of heavy physical labour involved can also affect outcomes. While it is difficult to amend legislation or remedy severe medical problems quickly, the social and personal factors can be addressed and changed and thereby greatly improve the chances of successful and sustained RTW.

Well-Established Treatment Options

Evidence-based treatment options which improve returns to work are well understood and widely acknowledged. For example, five major reports on the management of acute nonspecific lower back pain, published between 1994 and 2004¹⁶, all endorsed a similar range of strategies, including:

- The exclusion of ‘red flag’ conditions;
- Reassuring the worker they have not suffered a major injury;
- Encouraging the worker to play an active role in their recovery, including early movement and exercise, after very limited rest;
- The use of simple analgesics (only) to manage short-term pain;
- The review of psychosocial ‘yellow flags’ if recovery is not progressing.

Reflecting this knowledge, and faced with rising premiums, WorkCover NSW issued evidence-based guidelines for the treatment of soft tissue injuries in 2003 (updated in 2008)¹⁷ to encourage an ‘early, safe and durable’ return to work. These guidelines stressed the importance of independence, education and activity, urged stakeholders to work towards common goals, and called for regular reviews of progress and risk factors. The guidelines recommended that ‘yellow flags’ be checked between three to six weeks after injury, and intervention to follow after four to twelve weeks as required.

Systemic Failure to Follow Guidelines

Unfortunately, the practical implementation of these guidelines has often suffered from undue delays and a lack of coordination over the last decade. Many workers who are failing to recovery are not identified until 12 weeks (or longer) after their injury and develop chronic pain and associated disability as a result, and this means they become far less likely to respond to treatment. Worker reviews, when they finally take place, are usually conducted by physiotherapists who do not necessarily share the information with other stakeholders.

“In light of new evidence, it may also be time to revise the guidelines themselves. The system must be changed if we are to get better outcomes.”

Physiotherapists also lack the confidence and skills required to address the psychosocial factors¹⁸ inhibiting physical recovery, and they do not see themselves as psychologists.

Psychologists are therefore not used early or often enough to address problems they are trained to address and, when they are consulted, they also rarely collaborate or share information with the workplace or other healthcare providers, such as GPs. Taken together, the delayed access to potentially effective interventions, coupled with the lack of coordinated support, leaves many vulnerable workers in pain and off work much longer than necessary. The longer this situation persists, the less likely successful outcomes become.

As in other areas of medicine, knowledge of best practice and the publication of treatment guidelines is no guarantee that patients will receive them. Doctors around the world are often reluctant to follow such protocols. An Australian study¹⁹ found that back pain specialists tended to ignore published evidence-based guidelines because they believed they knew better, and several studies in the UK²⁰ and Sweden²¹ show that while the importance of early intervention is always acknowledged in theory, it often falls short in practice. A succession of delays, a lack of collaboration, a shortage of skills, differences in beliefs and system errors have undermined the effectiveness of the WorkCover NSW guidelines as a result. But in light of new evidence, it may also be time to revise the guidelines themselves.

The motor accident insurance industry faces a similar problem, in that injured people may not be brought to their attention until six months after their injury. In summary, a major problem is not a lack of effective treatment options, but the failure to use them in a timely, targeted and concerted manner. Health professionals often know what to do but, for a range of reasons, fail to do it or are prevented from doing it, and so it is more of a system problem than an injury or treatment problem. Essentially, the system must be changed if we are to get better outcomes.

Implementation Science

The new field of ‘implementation science’ offers a way to encourage the systematic uptake of evidence-based interventions into policy and practice²². A strategy for complex workplace applications²³ should be considered to improve the current situation, with one such framework, known as the Consolidated Framework for Implementation Research (CFIR), outlining five domains that need to be considered:

1. Intervention characteristics (treatments)
2. Outer context (workers compensation legislation, regulations)
3. Inner context (relationships within the workplace)
4. Characteristics of the individuals involved (professionals as well as workers)
5. Process of implementation (at multi-levels)

Any improved protocol must address all levels of stakeholder involvement, rather than merely focus on the injury itself, to be successful.

The WISE Study

Planning

Encouraged by results from a small pilot study of changes in rehabilitation procedures at Concord Hospital²⁴, Professor Nicholas’s research group approached a range of sponsors to fund a larger trial. In 2012, funding for a controlled trial of early intervention measures based on the Concord prototype was granted by a consortium of stakeholders, including the NSW Self Insurance Corporation, or SICorp (since relabelled as Insurance and Care NSW, or icare), NSW Health and Employers Mutual Insurance (EML). Research expertise and project management was provided by Prof Nicholas’ team at the Pain Management Research Institute at The University of Sydney’s Northern Medical School at the Royal North Shore Hospital. The trial was also supported by leading workplace injury researchers from the USA, Great Britain and Sweden, as well as some leading Australian musculoskeletal injury researchers. Reflecting the central elements of the project, it was called the Work Injury Screening and Early intervention (WISE) study.

Mirroring the CFIR Model²⁵, the agreed WISE protocol, its components and responsibilities evolved from a series of meetings between the key stakeholders (icare, NSW Health, EML, and the University of Sydney). ‘Outer context’ involved achieving agreement with the NSW workers compensation scheme’s regulator (SIRA) and funding body (icare), and a range of health professionals who agreed to follow the prescribed protocol for managing the participating injured workers.

EML, the insurance agent, provided formal and informal connections between the claims managers, the workplace coordinators, the treatment providers, and the injured workers. The 'inner context' of the workplace included agreement for providing a supportive workplace culture that was facilitated by the return-to-work coordinators at each workplace and the injured workers' supervisors. The workplace managers and chief executive officers all agreed to support the protocol. Ethics approval was granted by the University of Sydney, Concord Hospital, and each of the participating hospitals.

Methodology

The study recruited health workers with significant work-related soft tissue injuries. These injuries were severe enough to force a week off work with medical approval, but did not require surgery, and the workers' insurance claim had been accepted by EML. Participation was voluntary, with the injured worker agreeing to participate after the terms of the study were explained to them by their claims manager within seven days of their injury.²⁶ Those who agreed to participate were then asked (over the phone) questions from the 10-item Orebro Musculoskeletal Screening Questionnaire (OMPSQ-SF). This is a shortened version of the one recommended by WorkCover NSW for soft tissue injuries and is intended to identify the strength of the common psychological risk factors for delayed recovery. Those who scored more than $\geq 50/100$ were flagged as at-risk for delayed RTW.²⁷ This meant that the determination of at-risk cases was more objective and less subject to bias compared to judgements made by clinicians or claims managers.

The WISE study involved 17 hospitals across Sydney and adjacent regions. Six hospitals were designated as Control hospitals, and eleven were designated as Intervention hospitals. The hospitals were selected by reference to their geographical distribution and for their history of workplace injury claims in the previous two years. The intention was to balance inner city and outer suburban hospitals, size of hospitals, and a likelihood that claims for the study period would be roughly similar between Intervention and Control hospitals. Low-risk individuals at the Intervention hospitals and both low- and high-risk individuals at the Control hospitals were given standard care, while high-risk individuals at the Intervention hospitals were managed according to the intervention (WISE) protocol.

The protocol specified that high-risk cases should meet face to face with the RTW Coordinator (within a week of notification) at their hospital where the next steps in the protocol were explained to them. Given their high distress scores on the OMPSQ, they were offered the opportunity to see a selected psychologist to assess their concerns and undertake brief psychological treatment if indicated. The psychologists were asked to see the injured workers within two weeks; if treating them, to do this on a weekly basis for up to six sessions; and to liaise with the

workplace and nominated treating doctor at least every two weeks to promote collaboration between the treatment providers and workplace. Addressing any workplace issues was the responsibility of the RTW Coordinators.

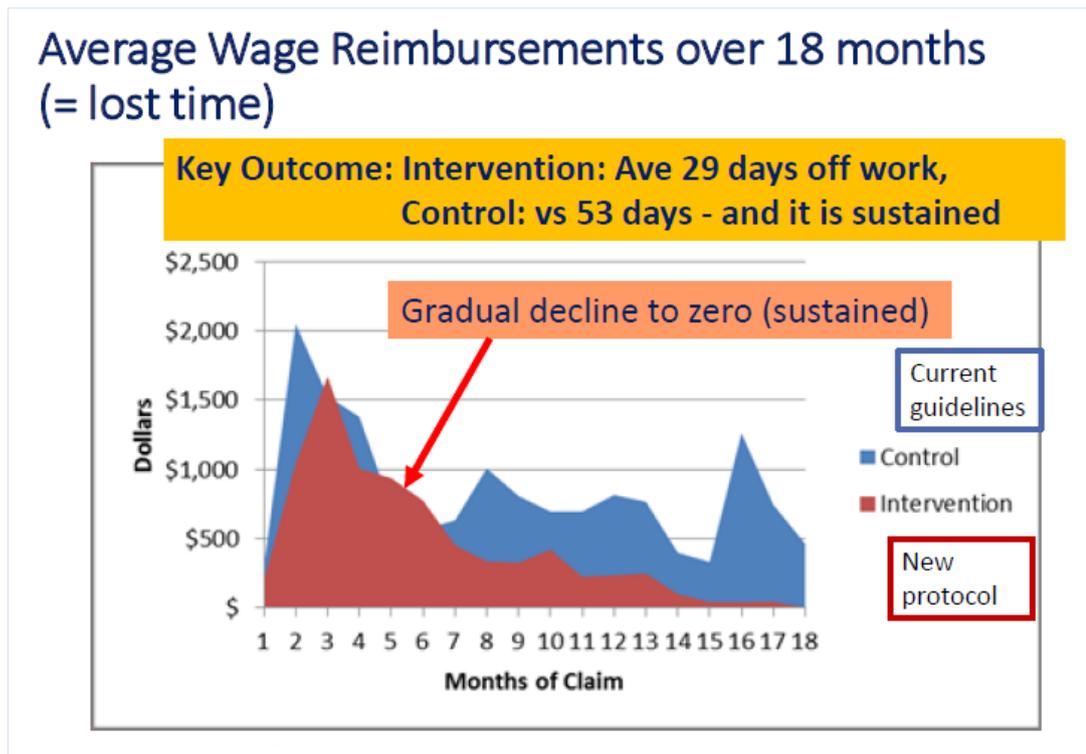
An independent medical assessment by a qualified occupational physician was arranged for the injured workers about four to eight weeks following entry into the study. This was intended to confirm the diagnosis of soft tissue injury and to reassure the injured worker and nominated treating doctor (GP) that the worker should recover quickly and that early return to work, even if symptoms were persisting, was appropriate. If an injured worker was also being treated by a physiotherapist and a second series of eight sessions was requested, an independent physiotherapist was asked to review the need for this and speak with the physiotherapist concerned. A workplace case conference could also be offered if a worker had not returned to work by 8-9 weeks. Throughout this time, the management of each worker in the high-risk group was monitored by the Research Manager and Claims Managers to ensure that the WISE protocol was being implemented as agreed. The Research Manager and Research leader provided additional training and problem-solving assistance for the RTW Coordinators and Claims teams as required. The RTW Coordinators also met with the research team on a quarterly basis throughout the study to provide additional support for the implementation process.

The primary outcomes were the cost of the claims and the amount of time off work (lost time) over a year following the injury. New legislation for workers compensation injuries was introduced in NSW just before the study started, and this reduced the number of new claims by 30% below the estimated recruitment rate (which had been based on the injury rates over the previous two years). Nevertheless, this affected both Intervention and Control hospitals equally. The steering committee managing the study extended the recruitment period to compensate for this.

Study Outcomes

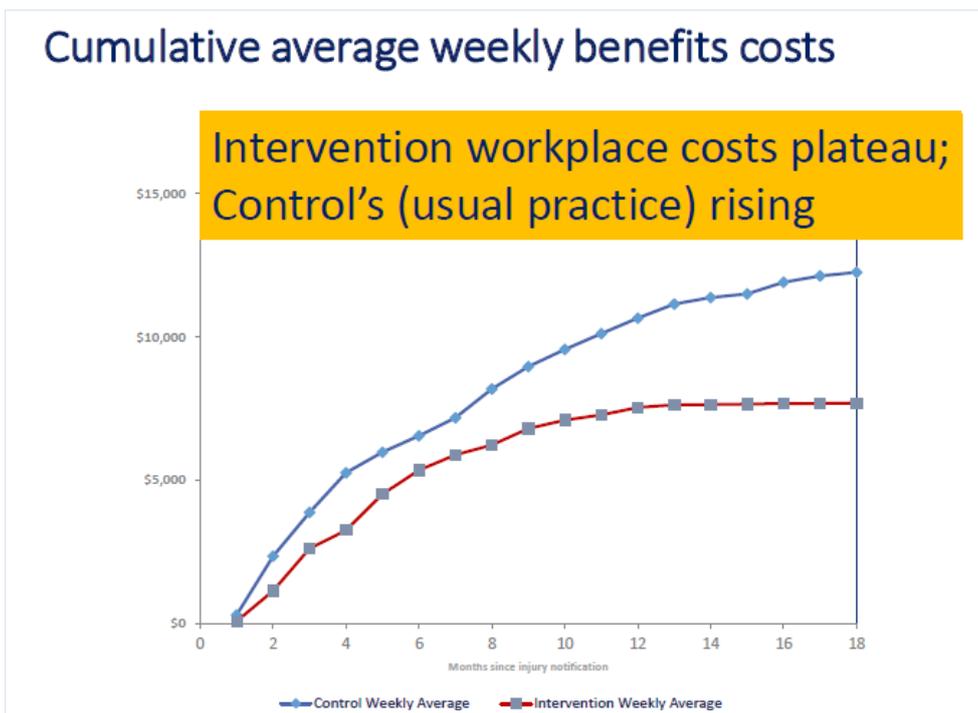
“The WISE study demonstrates that costs can be reduced and worker outcomes improved by taking a whole person / job approach, rather than focusing too much on a worker’s injury.”

Five hundred and eighty workers were studied in total, 214 at the six Control hospitals and 366 at the eleven Intervention hospitals. Overall, 141 (24.4%) injured workers were assessed as high risk, their ages ranging from 23 to 75, with a mean of 45. Four-fifths were women, reflecting the nature of the health workforce. Thirty-five per cent of the injuries affected the back, 30% the arms, 20% the legs, and 5% the neck and upper back, with problems affecting the head, trunk and other areas accounting for the remainder.



As can be seen in the above graph, the Intervention group consistently outperformed the Control group of at-risk workers in their lost-time rates. The Intervention group averaged 29 days off work, compared to 53 days for the Control cohort. The cost of wage reimbursements for the Intervention group declined to zero after 15 months, indicating they had all returned to work, while the costs continued to fluctuate in the Control group, indicating they were still having time off throughout the 18-month study period.

The cumulative costs, presented in the figure below, indicates that these have plateaued in the Intervention group at \$7,000 after twelve weeks, as the workers had returned to their posts. In contrast, costs in the Control group had risen to over \$11,000 by that stage and continued to climb.



Conclusion

“Employers, as much as clinicians, must be actively involved in the programme for it to succeed.”

The WISE study demonstrates that costs can be reduced and worker outcomes improved by taking a whole person/job approach, rather than focusing too much on a worker’s injury. Although simple in concept, it is challenging to implement in practice.

Fundamentally, the protocol used in the WISE study was quite consistent with existing WorkCover NSW guidelines, but it prescribed much earlier identification of those at risk of delayed recovery, and taking active steps to deal with this group before they became a problem, rather than waiting until they appeared to be having trouble. The approach also prescribed clear roles for relevant providers, claims managers and the workplace, and emphasised the importance of their collaboration to assist the injured workers in returning to work.

The early engagement of skilled psychologists in helping the high-risk workers to overcome their psychological barriers for early return to work approach was a key departure from general current practice, but the skills of the RTW Coordinators at the workplaces, supported by the Claims Managers, were also critical to the successful implementation of the protocol. The WISE study has clear implications for the management of injured workers generally, whether compensable or not. This applies especially to older workers who have been identified as likely to be at risk of leaving the workforce entirely due to musculoskeletal injuries.

The Importance of Stakeholder Commitment

Merely including the workplace in return-to-work programmes does not guarantee success. A similar study in the UK²⁸ in 2006 failed to demonstrate significant benefits because staff within the chosen workplace had not committed to the idea and internal policies and practices of the workplace had not been modified to support the aims of the program.

In contrast, in the WISE study, the workplace management provided strong support for the protocol.

Employers must do more than simply sign up on paper, they must believe in the approach and devote resources to it. Employers, as much as clinicians, must be actively involved in the programme for it to succeed.

The broader implications of the recovery-at-work approach for all older workers should be considered, as should its application regardless of age or compensation status. It will be a challenge to roll out the approach more widely, but if Australian employers are to retain workers in their fifties, it will make social and economic sense to do so, as the population ages overall.

Dr Swan agreed that theoretical knowledge does not always guarantee its use or change professional behaviour. He welcomed **Dr Alex Gyani** to the stage and asked him to explain the use of behavioural economics in the UK and its power to understand the human drivers and motivations which undermine or encourage the adoption of new techniques and policies.

“The broader implications of the RTW approach for all older workers should be considered, as should its application regardless of age or compensation status.”

Applying Behavioural Insights to Return to Work

Dr Alex Gyani

Principal Advisor
Behavioural Insights Unit
NSW Premier and Cabinet



Behavioural Insights

Public policy is put into practice through tools such as education, legislation, incentives and penalties, but these 'levers' often seem detached from the public or professionals they are supposed to influence.

Policy makers must therefore understand the people their policies affect, if they want those policies to be more successful. Observing and analysing how humans actually behave can improve the design and implementation of return-to-work services. Behavioural insights do not replace other policy tools, but can make them more effective.

Issuing evidence-based guidelines will not ensure their use. Studies show that individual guidelines are often ignored because their users are overwhelmed by the number of guidelines overall²⁹. Clinicians complain there is too much academic evidence for them to deal with and so tend to fall back on their clinical judgement, which is often subject to certain biases³⁰.

The EAST Approach

The EAST framework was published by the UK Behavioural Insights Team in 2014. It argues that policy changes should ensure that the behaviours policymakers want others to undertake are 'Easy, Attractive, Social and Timely' for service providers and clients alike. The EAST principles³¹ should make back-to-work services easier and more pleasant for people to use, and more effective for the agencies delivering them.

- **Easy**

Policy makers should make it as easy as possible for people to change their behaviour. Although it is deceptively difficult to make things as easy as possible for others, the effort is repaid with results. Service providers should use defaults to shape behaviour, for example, as most people do not bother to change a pre-set option. They should ease the process of joining and using a service to increase uptake and response rates. Participation rates rose from 61% to 83% in the first six months, after British employees in large firms were automatically enrolled into pension schemes.

Messages should be sharpened to their essence and emphasise a call to action. Clarifying a message increases understanding, and complex goals should be broken down into simpler, discrete tasks.

“Service providers should use defaults to shape behaviour, as most people do not bother to change a pre-set option.”

- **Attractive**

Information should be presented in an attractive, user-friendly manner, using images, colour and personalisation to engage its target audience. Reams of dense information will be not read by an injured worker, but a diagram or list of bullet points are more likely to inspire the desired action.

Agencies can also offer rewards and threaten sanctions for maximum effect. Financial incentives can be highly effective, but alternatives such as lotteries also work well and often cost less. When letters to British car owners who had failed to pay the compulsory road tax included a picture of the offending vehicle, payment rates rose from 40% to 49%.

- **Social**

Human beings are social creatures, embedded in networks at home, at work and online. People take their behavioural cues from those around them, and so describing what most people do in a particular situation encourages others to do the same. Tax payment rates in Britain rose by 5% when people were sent letters from the tax office saying that most people pay their taxes on time. Similarly, public information should avoid inadvertently reinforcing a problematic behaviour by warning how common it is.

Networks and social relationships can be harnessed to empower collective action, provide mutual support, and encourage the spread of positive behaviour peer-to-peer. Effective schemes also encourage people to make concrete commitments to themselves and others. People often use commitment devices to voluntarily lock themselves into actions in advance, and social pressure to honour them makes them more likely to be fulfilled.

- **Timely**

Deadlines can prompt action, but constant nagging can provoke counter-productive reactions, and the same offer made at different times can have drastically different results. Service providers should therefore pick the right time to contact people to have the greatest impact, usually when the issue is most relevant to their immediate personal interest. Text messages sent to people who had failed to pay court fines in the UK ten days before the bailiffs were due doubled the sum of payments made without further intervention.

Service providers should consider the immediate costs and benefits of engagement to their clients. People are more influenced by short-term, rather than long-term, affects, even though the latter are more significant. Upfront costs and benefits should therefore be adjusted to increase their initial impact in pursuit of long-term goals.

People should be helped to plan their response to events, as there is often a substantial gap between people's best intentions and their actual behaviour. A person's behaviour is usually easier to change when their habits have already been disrupted by major life events. Recovering workers could be prompted to identify the barriers they feel are preventing a return and to develop a specific plan to address them in partnership with their support team.

Applying the EAST Framework in Context

“Messages which settle for ‘managing the injury’ should be replaced by steps to ‘help you return to work’. Information which stresses or even implies the chronic nature of an injury sets the tone for the ultimate outcome.”

However clear its principles, service providers cannot properly apply the EAST framework to particular problems without understanding the specific circumstances of each case and talking to the people it will affect. Such conversations should also help identify the behaviours they wish to influence and the outcomes they seek. Implementation must also include robust methods of measurement to allow assessment and fine-tuning over time.

The scale of improvement required to make a change worthwhile, and the length of time it will take to achieve, should also be balanced against the project's costs in terms of time and resources. Pilot schemes should then be run to test the ideas in action, preferably in randomised trials, and alterations made as required before they are rolled out more widely.

The Behavioural Insights Team found that in order to lodge a claim, claimants in British Job Centres had to sign nine pieces of paper, including one to provide a specimen signature. Successive pieces of legislation had each called for their own signature without regard to the cumulative administrative burden. The interview which job seekers had with their work coach involved the coach accepting or rejecting a list of activities the client had completed in the previous fortnight, but as this process was unpleasant and unproductive for both parties, the Behavioural Insights Team focused it on what the job seeker could do next. This fostered a more cooperative and positive approach, and a randomised controlled trial found that these clients were 10% more likely to be in work three months later. These apparently minor administrative changes can have a significant impact on government finances and individuals' lives.

Attempts to apply this approach across the UK showed that staff required comprehensive training in the new approach and easy access to support and advice if they were struggling.

The NSW Behavioural Insights Unit later worked with the UK Behavioural Insights Team, the NSW Department of Education and Allianz Insurance on improving returns to work for absent staff. As in the UK, it found the initial claims procedure to be cumbersome and recommended the process and the information sent to applications be streamlined. An additional letter sent to workers after a period off work telling them they were officially 'significantly injured' was sent based on an interpretation of the legislation, but served to terrify its recipients who feared their doctors had informed the authorities about medical problems kept hidden from them. The letter undermined the injured workers' mental state, and so affected their physical recovery, and exemplifies the counter-productive potential of activities which are not considered from the client's point of view. A cohort study found that employees returned to work 27% more quickly under the reformed protocol.³²

Behavioural insights can result from empathy with the client's needs, drivers and perceptions. Service providers must be clear on the behaviours they are trying to encourage, and support and empower their clients to achieve them. This can be done by simplifying and aligning processes and ensuring that everyone shares the same goal, encouraging clients to make a personal commitment to a shared vision of success and, in this case, focusing on the return to work as the central goal. Messages which settle for 'managing the injury' should be replaced by steps to 'help you return to work'. Information which stresses or even implies the chronic nature of an injury sets the tone for the ultimate outcome.

Dr Gyani underlined the need to test new processes in pilot schemes to assess their effects and ensure that wider roll-outs retain their integrity to maintain their impact. Merely taking a finding from research and plugging it into public policy without attention to detail or particular circumstances can have counter-productive effects, or no effect at all. Testing and review is a prerequisite to maximise their impact on the public purse and people's lives.

Dr Swan criticised the poor record of many GPs in managing back pain, citing a *Four Corners* programme which revealed the vast sums wasted on unnecessary imaging and the referrals and treatments such scans generate. These investigations merely confirm a client's 'chronic' status, rather than doing anything to help them recover. He then introduced Ms Carmel Donnelly to offer a regulator's point of view.

The Health Benefits of Good Work – A Regulator’s Perspective



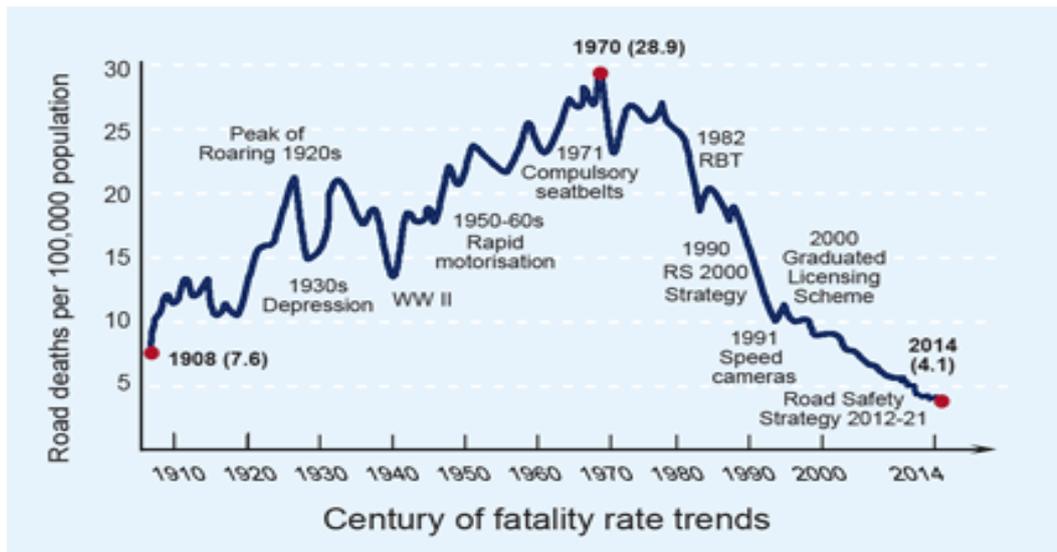
Carmel Donnelly

Executive Director
 Workers and Home Building
 Compensation Regulation
 State Insurance Regulatory Authority (SIRA) NSW

Ms Donnelly agreed that work has demonstrable health benefits and emphasised SIRA’s commitment to helping injured workers return to work.

The spread and containment of Legionnaire’s disease in Louisiana in 1989³³ and road traffic deaths in NSW³⁴ exemplify the ‘epidemic curve’ which public health problems, such as work injuries, tend to follow. Hazards grow and spread through the population before reaching a plateau and declining as public health measures take hold.

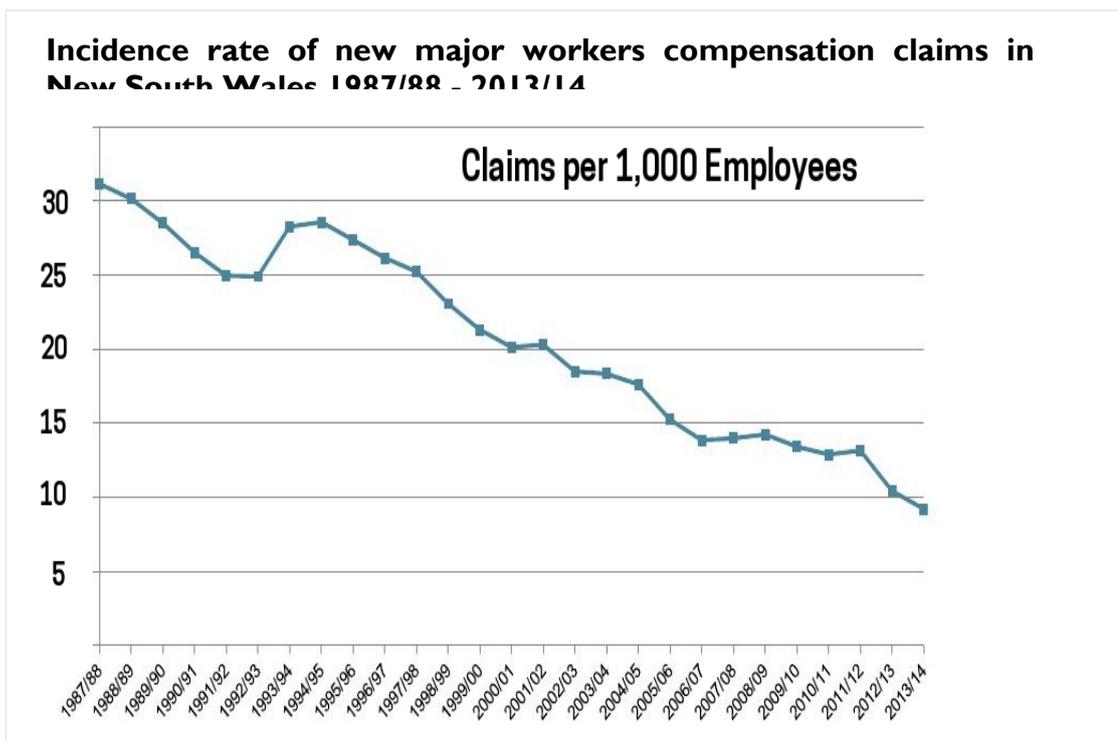
Fatality Trends (Centre for Road Safety, Transport for NSW)



Hazards or diseases tend to emerge and grow, provoking the community to demand preventative measures. In issues such as worker injury claims, common law remedies are then pursued and insurance products emerge. Calls for mandatory insurance lead to ‘one size fits all’ measures which reduce the social costs of negligence.

“Legislation is only part of the picture and better results will continue to rest on closer cooperation between workers, employers, clinicians and service providers.”

However, risks in real life are not evenly distributed, and blanket measures become less effective over time. Mandatory fire alarms save lives across the population, for example, but heavily medicated people living in rented accommodation are still disproportionately vulnerable to fires and smoke inhalation. Risk-based innovations and customer-centric services should therefore be developed to drive down the numbers of cases and improve the experience and outcomes for injured people.



Work injury compensation claims in NSW have grown, plateaued and declined over the past 25 years in the face of tightened legislation. Prevention and recovery are now termed forms of ‘tertiary prevention’ in public health, with certain groups, such as those suffering co-morbidities, more likely to recover more slowly. Psychological factors influence the recovery of people with similar physical injuries, while the generosity of compensation systems is a factor in recovery times.

SIRA is willing to consult and work with medical professionals and other stakeholders to improve recovery outcomes. Launched in September 2015, SIRA is still developing its regulatory approach and will tailor compensation systems to maximise the public good. However, legislation is only part of the picture and better results will continue to rest on closer cooperation between workers, employers, clinicians and service providers.

Dr Swan welcomed the willingness of SIRA to shape its approach through consultations with others, and invited **Dr Anne Daly** to explain WorkSafe Victoria's approach.

Worker-Centred Approaches to Return to Work and Pain Management



Dr Anne Daly

Physiotherapy and Pain Management Consultant
Health and Disability Strategy Group
Transport Accident Commission (TAC) and
WorkSafe Victoria
Senior Clinician, Austin Health Pain Service

WorkSafe Victoria and the Transport Accident Commission's Health and Disability Strategy Group place the worker at the centre of their strategies. They use the National Clinical Framework for the Delivery of Health Services³⁵ to unite stakeholder activities, as it offers a shared set of principles in 'practical, common sense' language. The framework calls for policy to influence and engage 'the system' at every level, build evidence of effective action in particular environments, and challenge unhelpful beliefs wherever they occur.

WorkSafe Victoria and the TAC also draw upon the work of others, demonstrated in the National Pain Strategy³⁶, the Health Benefits of (Safe) Work consensus statement³⁷, the Electronic Persistent Pain Outcome Collaboration³⁸ (ePPOC) and The High Price of Pain³⁹, a report on the economic impact of persistent pain published in 2007.

WorkSafe Victoria and the TAC have partnered with some public pain services to offer a 10-hour pain education programme to compensable clients which explains evidence-based treatment options and the limits of a biomedical approach. It covers a range of treatment options and emphasises that acute and chronic pain cannot be successfully managed by the same methods.

The Victorian Government's Better Health Channel⁴⁰ receives 50 million unique visits a year, with back pain as the most common search topic. The website is currently being upgraded with relevant, evidence-based information on pain from clinical panel physiotherapists and psychologists presented in user-friendly language, with help from Arthritis Victoria (recently rebadged 'Move').

These 'fact sheets' present return to work as part of the rehabilitation process, rather than its end result. They emphasise that it is safe for people to remain in, or return to, work with some degree of pain and to manage their activities accordingly.

“GPs are most people’s first point of contact with the health system, but are often under-informed about compensation regimes.”

Claims management staff on the frontline of the compensation system are often new to the healthcare environment, and efforts to educate them on modern attitudes to mental health and persistent pain issues are underway. This gives staff an opportunity to reflect on and reframe their beliefs where appropriate, as personal attitudes can shape their management of clients and their claims.

GPs are most people’s first point of contact with the health system, but are often under-informed about compensation regimes. Victorian GPs are therefore offered personal education on persistent pain issues and the health benefits of safe work with clinical panellists working in the field. Clinical panel doctors now phone or visit GP to advise on certification practices. Thirty practices will have been visited by June 2016, and high-volume providers will receive a report contrasting their certification outcomes with their peers. Information and education is offered to the public and GPs in a range of user-friendly methods, from webinars and e-learning modules to public awareness campaigns.

Physiotherapists spend significant time with recovering workers and are also being contacted by clinical panellists regarding their certification practices. This has increased the numbers of physiotherapists willing to write certificates and is backed by the Australian Physiotherapy Association. About 1,300 physiotherapists have enrolled in WorkSafe Victoria’s Early Intervention Physiotherapy Framework⁴¹ to receive three hours of online training in return for increased remuneration, and have agreed to engage with the clinical panel and follow treatment guidelines.

Several surveys have noted the effectiveness of multidisciplinary pain programmes in treating chronic pain. A 2012 evaluation of workers who had been off work for an average of 1.9 years found that 41% of people certified as unfit before joining a Network Pain Management programme were reclassified as fit for some hours and duties, while half of those who were already back at work increased their hours or range of activities. The evaluation also found that Network Pain Management programmes helped five of them to return to work after five years out of the workforce, effectively paying for 500 clients to complete these programmes. An evaluation of the programme in 2015 found that workers were accessing pain management programmes earlier (an average of 1.5 years after injury), and there is an expectation that this should continue to fall further in the future.

Pain specialists have also been encouraged to adopt a set of standardised outcome measures based on ePPOC when undertaking Spinal Cord Stimulator Trials. These encourage providers to consider the value of this invasive intervention in improving the patient’s wellbeing and readiness for work.

WorkSafe Victoria and the TAC are working diligently to make progress, but acknowledge that much remains to be done. They recognise the need to collaborate with all stakeholders, while keeping workers at the heart of its activities. They will develop a wider range of deeper partnerships, emphasise the importance of staying at work, promote health literacy, expand the scope of physiotherapists, engage more closely with psychologists, increase the use of online platforms, and trial screening tools with hospitals and workers, in addition to their ongoing work with Victoria's employers.

Panel Questions

Dr Swan invited attendees to question the speakers under the Chatham House rule of non-attribution.

WISE Cost/Benefits

Although the WISE programme of early identification and early physical and psychological support may appear expensive, its overall costs are lower than current standard practice, as injured workers take less time off work and are less likely to require ongoing treatment. During the study, workers received an average of five consultations with a psychologist, costing just over \$1,000, with a similar sum spent on medical specialists, but the protocol saved over \$4,000 compared to current usual practice – whose costs were still rising after costs of the Intervention group had plateaued.

The Timing of WorkSafe Victoria's Interventions

WorkSafe Victoria's support for injured workers covers the full arc of their recovery, but more attention is being paid to earlier identification and action. Pain management is introduced later than it could be, and pain education should begin as soon as workers at risk are identified, rather than being reserved for chronic cases. The system has not succeeded if such cases develop, regardless of how effective pain management becomes. While there are many complex issues which can lead to chronic pain, some of which exist before the workplace injury, multiple failures in the system exacerbate these chronic cases.

Encouraging Best Clinical Practice

Changing the behaviour of medical professionals is as important as improving the attitudes of at-risk workers. Delayed, uncoordinated or unhelpful treatment regimens can impede, rather than foster, a patient's recovery. While sound clinical guidelines exist for most activities, the sheer number of them means that many are ignored by clinicians. However, while it is easy to blame GPs for these problems, they are extremely busy people beset by any number of lobby groups claiming their particular issue should be prioritised. The solution is to make it easier for GPs to follow the appropriate evidence-based protocol, just as information and recovery plans should be made easier for patients to understand. After UK Job Centres created 'commitment booklets' to record job seekers' plans and activities, plastic wallets were trialled in one centre to protect them from inclement weather. Unfortunately, the plastic covers were difficult to remove, wasting 30 seconds of every four-minute appointment. The covers were abandoned as a result, and millions of pounds would have been wasted if they had been introduced more widely without that trial. GPs are under even greater time pressure, and administrative duties should be minimised to ensure they are accepted and undertaken.



Engaging the Workplace

Workplaces as well as workers must be engaged. Sixty per cent of workplaces may need some alterations in practice or equipment to allow a worker with chronic pain to return. Companies, such as BMW in Germany, have altered their factories in small ways, such as providing stools and mats, to retain older workers, allowing them to share their engineering experience with younger employees. Existing SIRA workers compensation guidelines acknowledge the importance of the workplace, and the outcomes generated by the WISE study should encourage more employers to take steps to retain older workers and encourage the return of injured employees.

The costs of shop floor or office alterations will vary by circumstance, but workplace culture must always embrace and encourage a return to work for the programme to be effective. Workers living with a degree of pain or other symptoms must be welcomed and accommodated to create a 'win-win' situation for worker welfare and corporate productivity. Workplaces and workers alike must accept that they should not wait until their convalescence is complete before resuming their duties, as a 100% recovery can prove elusive. Employers are naturally concerned about their potential legal liability if workers reinjure themselves, but the WISE study proves that progress can be made on this issue.

Flexibility within Fidelity

“The right balance must be struck between freedom of action and fidelity to evidence-based protocols. If guidelines allow too much individual variation in operation, then the outcomes generated by the proven principles which underpin them will be lost.”

Medical professionals can resist evidence-based protocols which appear to restrict or undermine their professional judgement, and so protocols which permit ‘flexibility within fidelity’ tend to receive a warmer welcome.⁴² Small businesses could also be allowed leeway within the protocol to achieve its goals by means more appropriate to their circumstances.

Guidelines which set certain parameters within which individuals have some freedom of action are more likely to be adhered to, ensuring the principles which underlie them are retained.

The right balance must be struck between freedom of action and fidelity to evidence-based protocols. Evidence from behavioural therapy suggests that experienced psychologists have poorer patient outcomes than newly qualified practitioners because they increasingly ignore protocols in favour of their own judgement. If guidelines allow too much individual variation in operation, then the outcomes generated by the proven principles which underpin them will be lost. Guidelines must allow clinicians to retain their sense of clinical judgement within firm parameters with a strong evidence base. This can be difficult to achieve, but it is important to try.

Small Businesses

While large companies can devote adequate resources to accommodating older or injured workers, NSW’s 680,000 small businesses⁴³ may be less willing or able to do so. Small business associations and peak bodies, such as Farmers NSW, should be engaged and educated on the benefits of return-to-work protocols, but many small businesses have not encountered this issue, or do so most infrequently. It is important for government agencies to reach out to small businesses to explain the guidelines to ensure their cooperation with service providers and medical professionals in encouraging a return to work.

User-Friendly Information

Up-to-date, evidence-based, intelligible information on mental health and persistent pain should be tailored for employers of different sizes and workers of different educational experience. Such information is more likely to be seen as credible if it comes from independent, expert medical groups, such as the Royal Australasian College of General Practitioners, rather than compensation agencies.

Behavioural Insights in NSW Health

The WISE study improved outcomes through encouraging cultural change, rather than using new treatment methods. NSW Health is adopting the scheme across all its public hospitals and is applying behavioural insight principles in an examination of the system. The recovery team will meet the worker and their supervisor in person within 24 hours of the injury, be it at home or in the workplace, to plan their 'recovery at work', rather than a 'return to work' as before. Frontline supervisors are being trained to help them manage the worker, as many are nurses or clinicians with little prior knowledge of the compensation system.

The WISE protocol works best through a close relationship between the injured worker and their recovery-at-work coordinator and by engaging all stakeholders in the process. While lip service is commonly paid to the importance of patient-centred care across the whole of medicine, in reality the system is still controlled by medical professionals and administrators who defend their own interests as a result.

Helping Injured Workers

Most workers return to work in good time after soft tissue injuries and require little or no extra support. The changes required to help the minority at risk of poor recovery demand a change of focus, rather than extra spending or resources. People who stay off work for long periods generate significant costs for medical services and employers, but the WISE study proves that early identification and coordinated support reduces overall expenditure rather than incurring it, by encouraging an early return to work. It is vital that the workplace takes an individualised and personal approach to each injured worker – for example, meeting with the injured worker face to face, rather using formalised letters or phone calls that can easily be seen as potentially intimidating by injured workers. Such behavioural insights will help NSW Health drive improvements by making the process more personal to the workers at risk.

Incentives

The savings which early intervention and coordinated treatment can generate for employers were all possible before the WISE study, but for a range of reasons, including a tendency inherent in the workers compensation system to focus too much on the injury rather than the worker who had the injury (and their workplace), it tended not to occur. Further incentives may therefore be required for the WISE study to find wider acceptance.

Small businesses in NSW have not taken advantage of a government subsidy to help fund a temporary worker to allow an injured worker to return to lighter duties or shorter hours at first, and such packages should be assessed for their effectiveness and attraction. Small business owners can see their employees as 'family', and so non-financial incentives may prove more effective.

It could also be argued that the general health and psychological benefits of work have only been appreciated relatively recently, meaning that some workers and GPs may still believe that longer periods of rest are required. Blunt financial incentives rewarding higher performance may also backfire, as children in the USA did not achieve higher grades when offered money as they did not know how to achieve them.⁴⁴ Offering rewards for positive steps, such as reading books which helped achieve the final goal of higher grades, were more successful. Incentives for activities which lead to returns to work may be more effective than rewarding the return to work itself.

The Power of Social Norms

Medical professionals were more willing to join the Network Pain Management programmes run by WorkSafe Victoria and the TAC when their power to help patients was demonstrated. Clinicians want to be part of successful programmes, and this social pressure can encourage them to engage. Pain management was unfashionable in the past, but is increasingly part of the mainstream. There is little benchmarking of clinical effectiveness in private practice, but WorkSafe Victoria and the TAC's efforts to assess individual performance and compare professionals with their peers has encouraged improvement. Clinicians with poor outcomes may well be unaware of their shortcomings and can be eager to improve, once made aware of their standing among their contemporaries.

Nudging individual behaviour by highlighting social norms has proved successful in the UK. As noted, a letter from HMRC⁴⁵ explaining that nine out of ten people pay their taxes on time generated £50 million of extra revenue in the UK, as more people paid on time, rather than being pursued through the courts. Although large companies, such as Google, still exploit complex international arrangements to avoid paying tax, social pressure can be brought to bear at all levels. Comparing and benchmarking clinicians has potential, given that data sharing and transparency are key to overall success. Data on waiting times and outcomes in London mental health services, for example, highlighted major discrepancies between adjacent and apparently similar areas, and publishing such figures would encourage consumers to switch to better providers and force laggards to improve. Patients should have the information they need to make informed decisions about which clinician to use, and competition should be encouraged to improve the medical marketplace.

The Employer's Incentive to Fire Injured Workers

The Injured Workers Support Network is contacted on a weekly basis by at least four former employees who have been fired following their injury. Many employers want an injured worker to leave their job, rather than help them return to work. Such employers would rather hire a new worker than spend time and money supporting injured employees, or altering working conditions to accommodate their post-injury needs. Employers are allowed to fire a worker after six months off work, and many choose to do so, rather than invest effort in

encouraging an earlier return. While early identification and support is vital for physical recovery, legislation in Victoria delays claims for medical support until 21 days after the injury. Steps to reduce this delay are required to permit the early intervention proposed by the WISE study.

Clarifying the Legislation

The WISE study initially found significant delays in the timely referral to psychologists by the injured workers' GPs. This referral pathway has been standard practice under current legislation, but as these delays threatened the viability of the project, the former WorkCover NSW agreed to allow the workplace to facilitate the process. This aspect of the legislation should be clarified and, if necessary, modified to ensure that early intervention by registered psychologists is made as straightforward as possible.

“SIRA will examine the regulations which stand in the way of better practice and will continue to consult broadly to discuss this and other issues.”

This does not diminish the importance of the GPs' role, as they remain the Nominated Treating Doctor, but their close and cooperative liaison with the psychologist and workplace could be facilitated by clearer legislative support, as demonstrated in the WISE study.

SIRA will examine the regulations which stand in the way of better practice and will continue to consult broadly to discuss this and other issues. While some employers have undoubtedly replaced injured workers, these cases can be handled by enforcing current employment laws. While most stakeholders agree that transparent performance monitoring and disclosure is required, opinions should be sought on the precise metrics which should be recorded and compared.

WorkSafe Victoria acknowledges the legislative barriers in their jurisdiction to early intervention and will find ways to work around them in the short term, given the difficulty of amending or removing unhelpful legislation. These measures could include accepting excess payments from employers or permitting direct referrals to specialist support from the workplace.

Encouraging Bureaucratic Risk-Taking

A strong evidence base must be assembled to prompt legislative change, as agreeing to such changes creates a great deal of work. Ways must be found to alter the risk/benefit calculation for public servants to encourage flexibility and to pressure politicians to pursue reform.

Health Data Analytics

Health data analytics companies have the information which would help patients make informed choices about the best services to use. One large company puts the consumer – rather than ‘patient’ or ‘injured worker’ - at the centre of its approach and proceeds from the assumption that such individuals should own their own data. Agencies and providers must collaborate to help their shared clients, particularly if clients suffer comorbidities or other family or life issues, but there is little sign of this occurring.

Improving Coordination

Workers compensation organisations, such as icare, are attempting to understand patient journeys and pursue coordination to improve them. Practical issues, such as a lack of transport to appointments, can hamper a worker’s compliance or recovery and can be eased by inter-agency cooperation. Customer surveys and focus groups conducted by icare in the lead-up to the 2015 NSW workers compensation legislation reforms⁴⁶ generated insights into the needs of both employers and employees, and should be extended. While coordination across agencies and stakeholders is often difficult, the consumer is often best placed to report on their own needs, and agencies must find ways to disseminate and share this information more effectively.

Patient-Reported Outcome Measures (PROMs)

Smart phones enable data gathering on a scale and with an ease unprecedented in human history. It is trivial to ask people how they are doing and receive their feedback, but agencies show little interest in gathering or using this information. Patient-reported outcome measures can provide detailed data about patients’ attitudes and their experience of the system they are navigating. They are appreciated by patients, who welcome the opportunity to report on their progress and have their voice heard, but are dismissed by most medical professionals as a mere ‘box ticking’ exercise. These clinicians see little value in contributing to or acting on such reports, and ways must be found to disseminate this information in ways which clinicians will find useful.

PROMs are widely used and generally accepted in the persistent pain sector. ePPOC has amassed 15,000 reports which will inform future activities and offer information about people in the workplace. Mobile apps are an obvious way to increase access and convenience, as more people now own phones and use them more confidently than home computers.

PROMs were also employed in the WISE study with positive results. Patient feedback demonstrated the success of the WISE approach and was supported by ePOCC measurements. The reports offer a useful way of holding health professionals to account for their treatment standards and can demonstrate the successful implementation of change.

The Role of Coordinator

As emphasised throughout the Roundtable's proceedings, stakeholder collaboration is required to stop injured workers 'falling through the net'. While most people recover and return to work without additional support, the minority of at-risk workers have been failed by the unwillingness of services and health professionals to share information and pursue common goals in the past. The WISE study found that a research manager based at the insurance company was required to oversee every case and discuss activities with claims managers, return-to-work coordinators and other stakeholders to maintain the protocol's integrity.

While doctors at a recent meeting discussing traffic accident claims maintained they could and should be responsible for providing the necessary coordination, the evidence strongly suggests that others can more effectively fulfil this role. The coordinator need not come from any particular speciality or agency, but must take individual responsibility for driving outcomes and be respected by the services and medical professionals involved. If clinicians are too busy to play this role in practice, and insurance staff can lack confidence in dealing with clinicians, the employer seems better placed to coordinate activities, given their close contact with their employee and direct financial interest in accelerating a return to work.

Welcome from the Hosting Minister



The Hon. John Ajaka MLC

Minister for Ageing
Minister for Disability Services
Minister for Multiculturalism
NSW Government

Dr Swan welcomed the Minister and summarised the morning's discussion. Returns to work can be improved by focusing on the worker's recovery, rather than their injury, but substantial efforts are required to integrate different service providers to make the existing system work more effectively. Injured workers need the system to foster collaboration between clinicians, the workplace and the worker, and more flexibility must be found in existing legislation to make it happen. New pain management programmes in Victoria have allowed some long-term sufferers of chronic pain to return to work, but the emphasis in NSW is to identify workers with psychosocial complications as quickly as possible to stop such problems developing.

Minister Ajaka welcomed attendees to the NSW Parliament and acknowledged the traditional custodians of the land. He thanked Global Access Partners for organising the Roundtable and was heartened to see so many familiar faces for all sectors in attendance.

Employees can suffer a significant financial impact when they are forced out of their workplace by injury. The Minister began his legal career in workers compensation and third party liability and witnessed at first hand the effects of injuries on workers and their families. The financial toll is particularly damaging for older Australians nearing the end of their working lives, while injuries for younger families can severely strain their budget. The loss of a worker from a business or government agency can also triggers a negative domino effect throughout the organisation, as vital experience is lost and colleagues are forced to shoulder an extra burden, or inexperienced temporary workers are brought in.

The impact of injury is not only felt in the wallet, but also at an emotional level. A person's job is more than just their pay cheque. A job is, for better or worse, a huge part of what we are. People are often introduced to each other in terms of where they are from and what they do. The first thing which people with disability tell the Minister is that they want a job, with one young man 'living for the day' he can pay income tax and so play his part in the general community.

Getting people back into work is not only important for a person's finances, but for their spirit and their mind.

Returning injured workers to employment delivers a triple benefit for the worker and their family, their business and the wider community and state. The Minister hoped attendees would be inspired by the research presented at the Roundtable to help get injured workers back to their jobs sooner and more safely.

The Minister noted that government cannot achieve change on its own, nor should it be expected to. Progress relies on a partnership between governments, non-government organisations and the community in the pursuit of common goals. He looked forward to receiving feedback from the Roundtable and attendee's future activities, and thanked those present for the past, present and future efforts on behalf of injured workers in the state.

Panel Questions

The Cost to Families

A study of the cost of chronic back pain to individuals and their families five years ago found that Australia's out-of-pocket health costs are among the highest in the Organisation for Economic Cooperation and Development.⁴⁷ Back pain can prompt significant personal outlays, but it is unfortunate that many sufferers spend up to \$6,000 on a new bed when rest will only exacerbate their injury. Older people who remain off work tend to run through the assets they have amassed for their retirement, threatening them with poverty later in life. Injuries also impose major psychosocial strain on their families and can wreck marital relationships. Individuals in chronic pain tend to isolate themselves from society and grow depressed as a result. Their inability to even sit in a chair for an hour estranges them from family interactions, and they increasingly withdraw from the world. It is not only the state's social and medical services which bear the costs of chronic pain, there is a crippling financial and psychosocial cost for individuals and their extended families.

The Stigma of Chronic Pain

Pain Australia works with people in chronic pain and has received many complaints from people about their 'distressing experiences' with workers compensation. The issue of stigma has not been raised at the Roundtable until now, but is continuously raised by sufferers with Pain Australia. They feel they are poorly regarded by employers, health professionals and friends and family, and it was hoped protocols such as WISE and the programmes run by WorkSafe Victoria and the TAC would reduce their social opprobrium.

An independent researcher assessing the results of the WISE study after twelve months has received many spontaneous and unsolicited expressions of gratitude from workers who were guided to the care they required at an early stage. Victoria's pain management programmes also receive positive feedback from patients thankful for being 'heard and understood'. The stigma once attached to mental health issues has declined, and it was hoped that persistent pain would follow the same trajectory, although much remains to be done. Reducing the number of sufferers by improving early intervention would be a step in the right direction.

Workers Compensation

A major workers compensation company which handles 75,000 employer policies for icare accepts the need for early intervention, but is hampered by delays in being informed of injuries. Employers often encourage workers to 'work through' physical problems, rather than reporting them, with small businesses unwilling to

encumber themselves with injury claims. Australians tend to be hardy and try to stay at work, but if injuries do not heal themselves, then help is often sought too late to have its full impact. Ways must be found to encourage businesses to recognise and report potentially significant injuries in good time, rather than encouraging employees to take a week off on sick pay and hope for the best. While most injuries do heal themselves, the minority whose condition does not improve are thus denied the early intervention which would have helped them.

Minimising Bureaucracy

Care must also be taken not to over-bureaucratise an occurrence which does not usually require further intervention. The initial screening questionnaire in the WISE protocol acts as risk assessment, triaging the minority who may need additional support, or at least be more closely assessed for such help. It is therefore an integral part of the process, reducing the need for further administration, rather than increasing it. Whilst one of the 'red flags' is the severity of injury received, an injury's physical extent does not correlate closely with the risk of developing chronic pain. Employers must contact their insurance agent as quickly as possible to allow the questionnaire to be delivered, as it will reduce the chances of worker receiving unnecessary treatment or staying longer off work, as well as helping those with psychosocial complications.

The need to understand the psychology of small employers and to avoid creating an unnecessary administrative burden was acknowledged by the panel. At the start of the WISE study, some insurance claims managers were concerned that having injured workers see psychologists risked precipitating secondary claims for psychological injury, but in the event no such claims occurred. Workers who scored below the cut-off on the questionnaire recovered by themselves, but unless high-risk workers are identified immediately, they may not receive help for months, by which time it might be too late, and certainly more expensive.

Attendees were invited to suggest ways to overcome obstacles to identification and treatment without creating unnecessary bureaucracy.

International Insurance Comparisons

Insurance schemes work in different ways in other countries, but the issue of employers pressuring injured workers to stay at work are universal and should be addressed. American and Canadian insurance systems resemble those in Australia, rather than the UK, and also struggle to encourage early intervention. Occupational medicine specialists in the USA believe it would be impossible to run the WISE study in the USA because of organisational and institutional barriers. Australia's smaller population should allow it to be nimbler in tackling the problem.

Chronic Pain at Work

A large number of people suffer chronic pain at work and are struggling to remain in employment. People with persistent pain who lose their jobs tend to erode 80-90% of their savings as a result, and many lack insurance cover for loss of income due to workplace injury. Others suffer injury and chronic pain unrelated to their jobs and are even more vulnerable to financial strain as a result.

Legislation is often more complicated than it needs to be, creating unnecessary barriers and delays, but there are often ways to improve results without taking the complex path of reforming legislation. The WISE programme, for example, did not rely on changes in the law to operate successfully. New approaches can often be found by looking within the existing system, rather than seeking major changes to the system.

People in chronic pain have not only been failed by delays in care, but by receiving treatments which do not work and may even exacerbate their condition. Effective programmes must be made available to patients at a time that is likely to have the most benefit. Once an injured worker loses their job, their chances of successful RTW are much worse. It would be necessary to offer them effective help with their persisting pain before they lose their job. In NSW, this would be before they have been off work for six months. Cutting-edge research into the genetic and molecular basis of pain may offer more effective treatment in the future, and a psychological and molecular approach may be seen as linked and complimentary, rather than incompatible.

Politics of Injured Worker Insurance

The politics of injured worker insurance should also be considered, as surpluses or deficits on workers compensation scheme budgets will inevitably affect how people are assessed and helped. Some employers deal with 16 different workers compensation schemes, and this should be streamlined.

The issue must be approached at the system level across both state and federal jurisdictions. Injured workers should be seen as part of society, rather than isolated individuals within it. The WISE study uncovered more barriers as it progressed. The system should strive to work consistently, rather than relying on a series of ad-hoc decisions made in individual cases by disparate and isolated health professionals acting on their own judgement, instead of following evidence-based protocols in consultation with other stakeholders.

Incentives for Overcoming Barriers

Governments could explore incentives to overcome these barriers. People seeking help in Broadmeadows in Victoria are subject to 21 different assessment forms, and efforts to reduce this number were resisted by agencies determined to cling to their own particular document. The number was reduced over two years, but it has proved impossible to reduce the number of forms to just one.

“Spending on early intervention will reduce long-term medical and social costs.”

Policy makers should appreciate the overall costs and benefits of recovery-at-work programmes and recognise that spending on early intervention will reduce long-term medical and social costs. Regulators should underline the potential of these programmes to improve financial sustainability when discussing them with government. While workers compensation laws are a matter for elected representatives, agencies such as SIRA are committed to working with stakeholders to ensure the system works as smoothly as possible. The plethora of long-standing guidelines should be reviewed for their effectiveness, and Roundtable attendees were invited to suggest particular protocols to re-examine and evidence-based alternatives. Individuals and stakeholders should be willing to work across jurisdictional barriers to improve results.

Implementation: A Framework for Moving Forward

The Roundtable has examined the case for early intervention and noted the drivers and barriers involved, but the success of the WISE study does not mean it will be easy to deploy at scale.

Data should be shared and publicised to identify trends and areas in need of improvement. Workers, their families, their employers, health professionals and government agencies must collaborate to identify and share best practice. Resources are available from public sources if a sound business case can be made. The regulator is keen to move from mere legal compliance to tracking and improving outcomes and working with other stakeholders to achieve clear and agreed goals.

Eugene McGarrell

General Manger
Community and Health Engagement
Insurance and Care NSW (icare)



Mr McGarrell said that stakeholders agree that the problem will only get worse if the same solutions are offered. Australia's population is ageing and so costs incurred by older injured workers will only grow over time. He called for collective action in three areas to improve outcomes.

1. The Workplace

Ways must be found to incentivise workforce wellbeing and encourage positive strategies. Mental health charity beyondblue claim that each dollar invested in mental health returns a dividend of \$2.30⁴⁸, and the benefits of mental health investment should be emphasised to employers as well as government. Primary prevention can save significant sums by preventing injuries in the first place and building resilience so that people recover more quickly.

2. Evidence-Based Care

Evidence-based care must be delivered promptly to workers at risk of poor recovery. The system should give the right people the right treatment in the right place at the right time. Strategies to encourage GPs and other clinicians in NSW to adopt evidence-based practice should be shaped by understanding the reasons they so often ignore it.

3. Reconnecting People with Work

Strategies to reconnect unemployed people with paid employment or voluntary tasks should be pursued by all stakeholders. Unemployed people suffer health, social and justice problems as well as financial hardship which affects themselves, their families and society.

icare will support efforts to build virtual and physical hubs to enable collaborative planning and programmes for all stakeholders willing to work together to improve outcomes. Mr McGarrell invited attendees to contact him to discuss their involvement in the design, development and implementation of such hubs.

Roundtable Discussion

Similar Issues in Other Chronic Health Programmes

A programme funded by private medical insurers to help osteoporosis sufferers lose weight and avoid the need for expensive hip replacements has encountered similar problems to those promoting recovery at work.⁴⁹ It also emphasises the need for clinicians and services to collaborate to offer evidence-based treatments to targeted patients at an early enough stage. Effective treatment strategies are already known and widely accepted, the difficulty lies in ensuring that patients in Dubbo, Orange or Broken Hill have access to them and that protocols are followed properly to maintain their integrity and maximise results.

Lessons must be learned from these related areas to make progress. Return-to-work protocols must be proved in pilot studies, then systematised to ensure their successful delivery does not rely on individual, subjective decision making. The smallest problem can derail the most ambitious programme, and these must be identified and addressed in good time. Schemes can be launched as a 'minimum viable product' to test them at a small scale, before rolling them out more widely.

While politicians often look for instant results, the system is slow to accept new protocols, however strong the case for them. The osteoporosis programme mentioned earlier has struggled for a decade to win wider acceptance, and it is hoped that the WISE team can learn from this experience to shorten their translation time.

Satisfying Consumer Needs

Implementation research shows the right stakeholders must be present at the table for progress to be made. Consumers could be invited to attend future GAP roundtables, given that no injured workers have spoken at this event. Large and successful companies, such as BMW or Kellogg, would view any problem from their consumers' point of view and tailor their solution to their customers' needs. It is hard for the customer to drive change in the public sector than the private, due to the lack of market forces. The customer can also be more difficult to identify in the public sector. However, if the injury was caused by an employer's poor work practices, then it is the workplace whose behaviour is most in need of change.

Tools such as PROMs could be given to consumers to drive reform in the system. Customers need ways to signal their needs and preferences to the system. They should expect it to change to meet their requirements, rather than being forced to adapt to an inflexible bureaucracy. Patients can insist on better service if they are given the information they need to make informed decisions. They often have more understanding of their conditions and circumstances than the medical professions or service providers they encounter. While injured workers are urged

to modify their activity or attitudes to speed their recovery, the behaviour of the clinicians treating them also needs to change. Health professionals must see value in the stories they are told by their patients to take their feedback into account.

Empowering Consumers

The power of online platforms, such as Victoria's Better Health Channel⁵⁰, relies on people knowing they have a problem, knowing that the health channel exists and can be trusted, and then finding, understanding and acting on that information appropriately. Roundtable attendees were challenged to suggest ways to empower consumers to seek the help they require, rather than have services pushed to them.

“While 90% of workers recover by themselves, the small percentage that do not must be encouraged to play a greater and more positive role in their own recovery.”

Evidence-based guidelines emphasise that injured workers must be active players in their own recoveries, rather than passive recipients of care. They must understand their situation, what they can do to improve it, and be motivated to achieve and maintain good health. Pain education is required because sufferers do not understand their condition or the best ways to tackle it. People will always look to medication for relief, but a drug which cures an occasional headache will do little to manage a chronic condition. People may move from one health professional to the next in search of a prescription, but will not find the solution they need.

There must be a partnership between the worker, the workplace and health providers towards a common goal, rather than injured workers being left to choose from a random selection of optional services without an overarching plan. The idea that clinicians or Medicare can offer a complete or immediate cure is often 'magical thinking', and the model of passive patients being administered cures must be abandoned by the medical profession as well as patients, for progress to be made. While 90% of workers recover by themselves, the small percentage that do not must be encouraged to play a greater and more positive role in their own recovery.

Media Messaging

Health literacy regarding back injuries, pain management, recovery strategies and the benefits of work should be improved for workplaces, service providers and health professionals as well as workers.

Social media discussion and mainstream media coverage of pain issues has improved public understanding in recent years, and the media could play a similar role in encouraging early intervention and returns to work.

“Social marketing campaigns are often ineffective, and efforts should be targeted towards injured workers at the point when they are ready to act on that advice.”

However, people tend not to consider a problem until it afflicts them personally, and so they can only be mobilised for action at the point. Social marketing campaigns are often ineffective, and efforts should be targeted towards injured workers at the point when they are ready to act on that advice. Spending large amounts on public education campaigns is equally ineffective, and the money should be focused on those in actual and immediate need. Sensationalist media coverage or ill-informed and misleading social media memes can undermine public understanding of an issue, rather than improve it.

Mobile Apps

Consumer-centric healthcare helps healthy people avoid falling ill, as well as helping people to recover and make informed decisions about their options. Today’s powerful and ubiquitous mobile phones offer rich opportunities to gather and share information and, with the technology already in place and available to all, only imagination and will are required to use them to improve public health.

A non-profit information exchange recently launched its ‘Ask Izzy’ app⁵¹ at a Melbourne event attended by the Prime Minister⁵². The app allows homeless people – 80% of whom have mobile phones – to access a database of 350,000 entries to find the closest sources of food, shelter or support to their GPS location. It has proved highly popular and received good testimonies from those it has aided.

Injury Management Consultants

Physicians working as injury management consultants already enable contacts between injured workers, their workplace, insurers, health professionals and service providers and could play that pivotal role in the roll-out of the WISE protocol. Many issues can affect a worker’s return to work, and these should be considered in a wider roll-out. The WISE study involves a wide range of people at an early stage, and care must be taken not to overcomplicate matters or downplay the role of the GP. The use of the questionnaire to identify workers at risk is the key to making it work.

The results of the WISE study are clear and emphasise, rather than undermine, the role of the GP in worker recovery. The existing system is not fit for purpose, and clinicians should not be allowed to maintain their grip on a patient’s care to protect the professional pride or financial interest if that is impeding, rather than facilitating, access to the wider range of services required by slow-to-recover injured workers.

Stakeholder Cooperation and Consumer Segmentation

The existing system works well for the large number of people who recover and return to work quickly. Forty per cent of people who take absence from work and claim benefits return within a month, 80% are back at their jobs within 13 weeks, and 90% have returned after six months. Injured workers cannot be seen as a homogenous group and should be segmented in terms of their needs to allow the targeting of appropriate support at the most vulnerable.

“Injured workers cannot be seen as a homogenous group and should be segmented in terms of their needs to allow the targeting of appropriate support at the most vulnerable.”

Different customers can report very different experiences of the same services, and so the effort must be made to identify and open whatever pathway will best lead a worker to recovery.

Stakeholders should aim beyond mere compliance with the legislation and work together to improve outcomes for every individual. The best option for people with very similar injuries might range from a mobile app to guide the most resilient to a suite of physical and therapy for the most vulnerable. Injury management consultants may have achieved excellent results in many cases, but more clearly needs to be done.

The need to engage people at an early stage to improve outcomes and reduce insurance costs is common to both the WISE study and Prima Health’s work with osteoporosis sufferers. Direct engagement with the health consumer, whether or not it is mediated through a large employer, is necessary for successful outcomes.

The Need for National Standards

A large private healthcare company with over 30,000 employees implemented the NSW soft tissue recovery guidelines across five states 12 years ago and has enjoyed excellent results by actually carrying out the early intervention and holistic treatment strategies they outline. This has allowed the company to reduce insurance premiums, drive very high rates of return to work and reduce the duration and severity of symptoms and injury. Injured workers are captured within 24 hours and treated under the NSW protocol regardless of the state they work in. The company reports that different workers with the same injury will receive starkly contrasting pathologies from doctors in NSW and Victoria, demonstrating the significant effect which different certification rules have on shaping medical outcomes and highlighting the need for national evidence-based standards and protocols. The public and private health sector should do more to share information and experience.

Workers' Rights

Injured workers can help educate the health and service professionals they encounter about their needs and alternative treatment options. However, workers' rights groups must take care to ensure such advice is evidence-based. Although such groups concern themselves with the rights and responsibilities of the injured worker, rather than treatment protocols, they could do more harm than good. During the repetitive strain injury 'pandemic', unions hung alarmist 'lightning bolt' posters on workplace walls which alienated employers and did nothing to inform or help employees.

One workers' rights group is careful to refer workers to doctors or lawyers regarding medical or legal issues, but helps them approach these professionals armed with knowledge of their rights. Empowering workers gives them more control over their situation, and this in turn encourages their recovery.

A union has the right to advocate for the best treatment and support options for its members. Healthcare service providers regularly discuss these issues with the relevant unions, but, in the end, injured workers do not care whose responsibility it is to ensure they receive the proper treatment after injury, merely that they have access to it and can continue to support their families through their salary or benefits.

Employer Perspectives

The Australian Industry Group represents employers of all sizes and is concerned that employers may be held liable for workers whose injuries were sustained beyond their place of work. The WISE study only considered workplace injuries, but the issue of whether injuries were caused by work or non-work activities will become more important if it is rolled out more widely. Small employers are particularly sensitive to costs they may incur for workers who injure themselves outside work, and this may drive the behaviours criticised in the discussion. The concept of provisional liability may offer a partial solution by allowing workers to be screened and receive the early intervention they require for recovery, while not identifying employers as automatically liable for these costs.

Although causation is a significant issue which must be addressed, medicine demands that a patient's condition be adequately assessed before treatment can begin, and delays in diagnosis and care can only delay the worker's recovery. A worker unable to work creates costs for their employer regardless of where or how the injury occurred. Employers and other stakeholders must focus on the worker as a person, rather than the injury in isolation, if progress is to be made.

GPs have resisted using the questionnaire to assess the 'yellow flags' and probable trajectory of their patient at the initial consultation, despite its demonstrable effectiveness. GPs claim they lack the time to do it, despite it saving a great deal of time and effort in the long run, and show little enthusiasm for allowing other staff to deliver the questionnaire while their patient is waiting to be seen, despite the fact that it was delivered by insurance staff in the WISE study with success.

Employers have the most direct vested interest in recovery-at-work protocols and therefore could take the responsibility for delivering the initial questionnaire, given the reluctance of GPs to do so. Legal liabilities can be debated down the track, but the employer will not benefit if concerns about causation delay an injured worker's assessment, diagnosis, treatment and return to their duties.

Summary of Findings and Outcomes

Dr Norman Swan

Attendees were encouraged to consider ways to roll-out effective protocols more widely, while maintaining their effectiveness and targeting them at those in need of additional assistance. Ways must be sought to encourage employers, insurers, clinical groups and other stakeholders to cooperate and implement effective reforms and strategies at scale.

While stakeholders invariably pay lip service to the central importance of the injured worker, their discussions inevitably gravitate towards protecting their own interests or justifying their own activities. All stakeholders agree the pressing need to reform and collaborate, then continue to pursue their habitual activities within their own silos, regardless of their ineffectiveness or expense.

Dr Swan drew the need for partnerships and collaboration, the simplification of unduly complex systems and the use of behavioural insights to reduce barriers in his summary of the Roundtable's debate. Data must be gathered and shared more effectively, and incentives may be required to get all stakeholders on board. Further activities will progress the debate and encourage practical implementation, and Roundtable participants were invited to express their interest in future events.

Progress may be incremental at first, but complex problems cannot be solved overnight, and coalitions of interested parties and early adopters should be formed to scale up the findings of the WISE study across the state. Dr Swan emphasised the need for concrete action to achieve transformative change. Stakeholders cannot rely on changes in legislation, as these are slow to eventuate and may make little difference if the culture of the system is not changed.

Vote of Thanks

Catherine Fritz-Kalish

Co-Founder and Managing Director
Global Access Partners

Catherine Fritz Kalish thanked attendees and confirmed that further events and activities will be undertaken to improve rates of return to work. The Roundtable marks the beginning of a process, rather than its end. The issue was first brought to GAP's attention through the GAP Taskforce on Productive Ageing which, since its creation in June 2014, has worked to help older Australians at work. Ms Fritz-Kalish thanked the speakers, sponsors and steering committee and encouraged attendees to maintain their involvement with GAP and attend the next Roundtable, currently slated for November 2016.

Speakers

Dr Anne Daly

**Physiotherapy & Pain
Management Consultant
Health & Disability Strategy Group
Transport Accident Commission
& WorkSafe Victoria
Senior Clinician, Austin Health
Pain Service**

Dr Daly works as a physiotherapy and pain management advisor to WorkSafe Victoria and the Transport Accident Commission. This involves the provision of peer review to physiotherapists managing compensable clients across Victoria as well as the clinical oversight of a number of programs that form the persistent pain strategy, most notably the Network Pain program. Dr Daly also continues to work in clinical practice in a tertiary public hospital pain service in Melbourne, where she delivers both group based pain education programs as well as individualised pain management and clinical supervision of post graduate students. Dr Daly is the Australian Pain Society's representative on the Management Advisory Group of the electronic persistent pain outcome collaboration (ePPOC). She is also a member of the Victorian Department of Health and Human Services' Musculoskeletal Clinical Leadership Group. The focus of Dr Daly's work is on improving important outcomes for people with persistent pain, such as participation in work and family life, through evidence informed, person centred and accessible interventions.

Carmel Donnelly

**Executive Director Workers
& Home Building
Compensation Regulation
State Insurance Regulatory
Authority (NSW)**

Carmel Donnelly is the Executive Director, Workers and Home Building Compensation Regulation with the newly established State Insurance Regulatory Authority in NSW Government. Prior to her current role, Carmel has held a number of Executive Director and General Manager roles in NSW Government related to public safety, risk and insurance. These include General Manager of the Motor Accidents Authority and Director Strategy and Planning with Fire and Rescue NSW. She was also the Review Director in the NSW Department of Premier and Cabinet and an Associate Director in NSW Health. Carmel holds a Bachelor of Arts with honours in psychology, a Master of Public Health and an Executive Master of Business Administration from the Australian Graduate School of Management. She is a Graduate Member of the Australian Institute of Company Directors and an Associate Fellow of the Australasian College of Health Service Management.

Catherine Fritz-Kalish
Co-Founder &
Managing Director
Global Access Partners

Over the last 16 years, under Catherine's guidance, GAP has grown to be the most influential policy delivery network in Australia, with over 600 active members. It initiates and facilitates high-level discussions at the cutting edge of the most pressing commercial, social and global issues of today. GAP's current initiatives span the industry sectors of Health, Education, Security, Energy and the Environment, and Digital Engagement. Catherine's broader business experience includes coordination of a number of international initiatives as part of the annual programme for the small and medium-sized enterprise unit of the OECD (Organisation of Economic Cooperation and Development), at headquarters in Paris, France; marketing and brand management within all seven divisions of the George Weston Foods Group; and just prior to establishing GAP, working within the TCG Group of companies, particularly in the area of start-up incubator establishment. Catherine sits on the board of social justice charity Stand Up; co-founded *Thread Together* which provides brand new clothing to those in need across Australia, is a member of the Board of the Fritz Family Office; and is part of a significant giving circle which engages whole families in the act of giving to those in need. She holds a Bachelor of Science degree from the University of New South Wales and a Masters of Business in International Marketing from the University of Technology, Sydney.

Dr Alex Gyani
Principal Advisor Behavioural
Insights Team
NSW Premier & Cabinet

Alex is a Principal Advisor with the Behavioural Insights Team. His work with team has predominately focused on getting people back into work, where he has run numerous randomised controlled trials and oversaw the scaling up of Behaviourally Informed Interventions across the UK. He joined the team in March 2012, while he was completing his PhD that focused on encouraging people with anxiety and depression to seek treatment using a mobile phone app, and encouraging psychological therapists to use evidence based treatments. He holds degrees in Psychology from the University of Oxford and the University of Reading. He is currently based in Sydney, based part-time with the NSW Department of Premier and Cabinet and is working on a diverse range of projects in health, employment, rehabilitation, policy evaluation, justice and financial services. He has published in peer reviewed journals in areas as wide ranging as 3D vision, mental health policy and the science practice gap, and is an associate editor for the *Cognitive Therapist*.

Eugene McGarrell
**General Manager Community
& Health Engagement
Insurance & Care NSW (icare)**

Joining the public service as a nurse in 1979, Eugene has 36 years' experience working in government health and social services in the UK and Australia with vulnerable people, families and communities. Eugene is experienced in bringing health and social services together, including joint-leading a project that reduced suicide rates by 40% in south west London in 1998. He was directly involved in inter-agency mental health reform in 2005 as Senior Advisor to the Minister for Health, including consultation for the new mental health legislation. In 2013, Eugene started The Collective NSW for Family and Community Services to better connect community, government, non-government and business to break the cycle of disadvantage. He is convinced that the way to achieve this ambitious goal is to create whole-of-system strategies that tackle "wicked problems" and promote wellbeing for all. He is always looking for partners to work with to achieve this goal. Eugene is currently General Manager Health and Community Engagement and is leading the development of an engagement hub to create a better system for injured workers in New South Wales.

Prof Michael Nicholas
**Director of Pain Education &
Pain Management programs
Pain Management Research
Institute, Royal North Shore
Hospital, The University of Sydney**

Professor Michael Nicholas is a Clinical Psychologist and Director of Pain Education and Pain Management programs at the Pain Management Research Institute (PMRI) at the Royal North Shore Hospital. PMRI is part of the Kolling Institute of Medical Research and Northern Clinical School of The University of Sydney. Prof Nicholas has an international reputation in the field of pain management, as a clinician, researcher and educator, with over 150 publications in journals and book chapters. A major focus of his research has involved psychological and environmental factors influencing the development of persistent pain and its impact on quality of life. This work has led him to investigating effective ways of preventing ongoing pain and associated disability. Prof Nicholas was part of the working group with WorkCover that developed the current guidelines for the management of soft tissue injuries at work in 2005 and 2008. He is also a member of an international group of researchers based at the Liberty Mutual Research Centre in Massachusetts (US) and Orebro University (Sweden) and Keele University (UK) who have been addressing the problem of work-related pain and disability, and their management for the last 12 years.

Helen Rogers
Executive Director
Participation & Inclusion
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Helen Rogers is the Executive Director of the Participation and Inclusion Directorate in the Department of Family and Community Services (FACS), which was established on 1 July 2015 when the Office of Communities transferred from the Department of Education and Communities to FACS as part of machinery of government changes. Before commencing work in the Office of Communities in December 2012, Helen had worked in FACS for nine years in various roles including Director Strategic Policy Branch and Director Community Services Program Management Office, which supported the implementation of Keep Them Safe and Out of Home Care reforms. In 2007, Helen was seconded from the Department to work on the Special Commission of Inquiry into Child Protection Services in NSW. Helen began her career in the NSW Public Service in The Cabinet Office and prior to that she had worked for a non-government development agency and as a secondary teacher.

Dr Norman Swan
Medical Doctor
Journalist & Radio Producer
Host of *The Health Report*
ABC Radio National
Host of *Tonic* on ABC News24

Dr Norman Swan hosts *The Health Report* on ABC Radio National, and *Tonic* on ABC News24. The Health Report is the world's longest running health show, and Norman has won many awards for his work including Australia's top prize for journalism, the Gold Walkley. He trained in paediatrics before joining the ABC and has hosted many other programmes, including Life Matters, Late Night Live and Radio National Breakfast, as well as Health Dimensions on ABC Television. He has also been the medical host on Channel Ten's Biggest Loser for the past three seasons. Norman created, wrote and narrated *Invisible Enemies*, a four-part series on disease and civilisation, broadcast on SBS and in 27 countries. He has consulted to the World Health Organisation and co-chaired a global meeting of health ministers in West Africa in 2008.

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Notes and References

- 1 The requirement that employers be involved in the return to work of injured workers was introduced in the Workers Compensation Act 1987. In 1998, the Workplace Injury Management and Workers Compensation Act was proclaimed and introduced the concept of injury management to include treatment, rehabilitation and retraining of injured workers, claims management and employment management practices. In addition, the new law changed the name of a 'rehabilitation program' to a 'return to work program'. Further regulatory changes in 1999 changed the name of the rehabilitation coordinator to return to work coordinator and allowed for shared return to work coordinator arrangements between employers. – Cited from WorkCover NSW (2010), Guidelines for workplace return to work programs, September 2010, https://www.workcover.nsw.gov.au/__data/assets/pdf_file/0017/18305/guidelines_for_workplace_rtw_programs_2872.pdf.
- 2 http://www.behaviouralinsights.co.uk/wp-content/uploads/2015/07/BIT-Publication-EAST_FA_WEB.pdf.
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- 5 Volinn E. et al (2001), The Boeing prospective study and beyond, Spine (Phila Pa 1976). 2001 Jul 15;26(14):1613-22, <http://www.ncbi.nlm.nih.gov/pubmed/11464157>
- 6 A meeting of the Japan Asia Pacific section of the Fit for Work network run by the Work Foundation at the University of Lancaster, 8 April 2014
- 7 Major collaborators included Dr Garry Pearce, Dr Mick Gleeson, Dr Rafael Pinto, Dr Dan Costa, Karen Munk, Tamara Sprod, Rachel Elmes, and claims managers & staff at EML including Robert Lloyd, Susan Rafty, Michele Murphy and Return to Work coordinators at each hospital. International and Australian partners included Steven Linton (Sweden); William Shaw (USA); Chris Main (UK); Rob Smeets (Netherlands); Chris Maher (USyd); James McAuley (UNSW); Fiona Blyth (USyd); Andrew McGarity (NSW Fire).
- 8 Acceptance by the medical profession was hampered because Dr Semmelweis could offer no acceptable scientific explanation for his findings. Although midwives had always washed their hands, and so the babies they delivered suffered much lower rates of infection, physicians only accepted the practice years after Louis Pasteur confirmed the germ theory and Joseph Lister, acting on the French microbiologist's research, practiced and operated using hygienic methods with great success. Dr Semmelweis did not live to see the change, having been committed to an asylum where he died of septicaemia at the age of 47 after a beating by the guards.
- 9 Working for a Healthier Tomorrow. Presented to the British Secretary of State for Health and the Secretary of State for Work and Pensions on 17th March 2008. London. The Stationary Office.
- 10 Australasian Faculty of Occupational & Environmental Medicine (AFOEM) Royal Australasian College of Physicians, Consensus Statement 2011.
- 11 Common Return to Work Rate after Back Injury: Henschke et al, BMJ, 2008.
- 12 Johnson D, Fry T. Factors Affecting Return to Work after Injury: A study for the Victorian WorkCover Authority. Melbourne. Melbourne Institute of Applied Economic and Social Research; 2002.
- 13 Work-Related Injuries, Australia, July 2013 TO June 2014. ABS.
- 14 Major economic implications Schofield, D. et al. Early retirement and the financial assets of individuals with back problems European Spine Journal 2011 20(5): 731-736.
- 15 Main et al., 2008.

- 16 CSAG (UK) (1994), AHCPR (US) (1994), IASP (International) (1995), FOccMed (UK) (2000) and NHMRC (Australia) (2004).
- 17 WorkCover NSW (2010), Guidelines for workplace return to work programs, September 2010, https://www.workcover.nsw.gov.au/__data/assets/pdf_file/0017/18305/guidelines_for_workplace_rtw_programs_2872.pdf.
- 18 Alexanders et al. A systematic review published in *Physiotherapy* 2015.
- 19 Buchbinder et al. *Spine* 2009;34:1218–1226
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- 21 Overmeer et al. Do evidence-based guidelines have an impact in primary care? A cross-sectional study of Swedish physicians and physiotherapists. *Spine* 2004;30:146–151.
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- 23 As proposed by Damshroder et al, 2009.
- 24 Concord General Hospital in Sydney is a self insurer which faced over 300 open claims in 2003-4 including a spate of chronic pain cases. To tackle this problem it changed its rehabilitation policy, developing a database to track workers from notification to finalisation, producing suitable duties lists for a majority of departments and increasing the role of managers in the rehabilitation process. Regular meetings between supervisors and managers in major departments reviewed claims and provided comparative data. As early action appeared key to preventing chronic pain and delayed returns to work, it instigated a rapid assessment and early intervention process, which including an assessment of psychosocial risks (Yellow Flags), to identify high risk cases. This 20% of higher risk workers were not offered novel treatment, but standard treatment at an earlier stage as a result. These 'Yellow Flags' predict the cost of a workers compensation claim within 48 hours regardless of what or where the injury occurs. The hospital found that the provision of an early and aggressive assessment and intervention, led by a trusted GP, can reduce costs in high risk claims. Case Study - Concord General Hospital, Sydney Jul 27th, 2014. <http://centralwestrehab.com.au/news.php?id=227>
- 25 Aarons et al., 2011.
- 26 The use of the questionnaire was not new to the WISE protocol. A 1999-2002 WorkCover study demonstrated the value of early risk screening using the Örebro low-back questionnaire, as suggested by Linton and Hallden in 1998, at the acute stage of a work-related back injury to detect general risks of long-term disability. The findings of the WISE study itself echo those discussed in papers such as 'Work-related back pain study: measuring biopsychosocial risk factors' (Stratin and Swincer), published in July 2012 for WorkCover SA.
- 27 Screening (OMPSQ-10: Linton et al., *Spine* 2011. Cut off scores >50/100.
- 28 McCluskey et al. (UK) (2006)
- 29 Gyani, A., Pumphrey, N., Parker, H., Shafran, R., & Rose, S. (2012). Investigating the use of NICE guidelines and IAPT services in the treatment of depression. *Mental health in family medicine*, 9(3), 149-160; Gyani, A., Shafran, R., Myles, P., & Rose, S. (2014). The gap between science and practice: How therapists make their clinical decisions. *Behavior therapy*, 45(2), 199-211.
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- 33 Suspected Legionnaires 'disease. A Disease Detectives Exercise:
www.cdc.gov/excite/PDF/LegionQ.pdf
- 34 The number of road deaths per 100,000 people in NSW has fallen steeply over the last 40 years from 28.9 in 1970 to 4.1 in 2014. Current figures are the lowest since records began at the start of the 20th century, when, in 1908, there were 7.6 deaths per 100,000 population. This fall is despite the greatly increased traffic on NSW roads. While just 4,000 motor vehicles were registered in 1910, NSW roads carried about 5 million motor vehicles in 2013. Since the start of random breath testing in 1982, road deaths per 100,000 people have dropped from about 23 to 4.1 in 2014. Dr JW Knott - Road traffic accidents in New South Wales, 1881-1991. Australian Economic History Review 1994; 34: 80-116; and NSW Transport authorities.
- 35 http://www.worksafe.vic.gov.au/__data/assets/pdf_file/0006/3885/clinical-framework.pdf
- 36 www.painaustralia.org.au/images/pain_australia/National%20Pain%20Strategy%202011%20Exec%20Summary.pdf
- 37 <https://www.racp.edu.au/docs/default-source/default-document-library/role-of-gps-in-realising-the-health-benefits-of-work.pdf>
- 38 The electronic persistent pain outcome collaboration covers most of the publicly provided pain management programmes in Australian and New Zealand and is increasingly used in the private sector.
- 39 http://www.painaustralia.org.au/images/pain_australia/MBF%20Economic%20Impact.pdf
- 40 <https://www.betterhealth.vic.gov.au/>
- 41 http://www.worksafe.vic.gov.au/__data/assets/pdf_file/0016/130840/290615-EIPF-Policy-WorkSafe-Final.pdf
- 42 Hamilton, J. D., Kendall, P. C., Gosch, E., Furr, J. M., & Sood, E. (2008). Flexibility within fidelity. *Journal of the American Academy of Child & Adolescent Psychiatry*, 47(9), 987-993.
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<http://insurancereforms.nsw.gov.au/>
- 47 AIHW 2012
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- 49 HCF Media release (Feb 2016), Landmark study shows GPs can prescribe weight loss as they would medication to treat osteoarthritis; www.hcf.com.au/about-us/media-releases/2016/2/15/gps-can-prescribe-weight-loss-as-they-would-medication-to-treat-osteoarthritis/
- 50 <https://www.betterhealth.vic.gov.au/>
- 51 <https://askizzy.org.au/>
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