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## Workplace-based occupational rehabilitation in New South Wales, Australia

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### 1. Introduction

Occupational health and safety and workers' compensation legislation underwent major changes in the 1980s in Australia. This was largely due to skyrocketing costs associated with workers' compensation overwhelming business and industry. Between 1974 and 1984 workers' compensation costs increased 480%, whilst wage and salary costs increased 250% (Office of the Commissioner for Employee Compensation, 1986, cited in Kenny, 1994). The period 1977–1978 to 1985–1986 saw workers' compensation costs in Australia double per employee, even after adjustment for inflation (Emmett, 1992). In New South Wales (NSW) claims were \$349 million in 1980, rising to \$838 million in 1985 (Williamson, 1990) and \$1000 million by 1988 (WorkCover Authority, 1990).

As a response to these spiralling costs the New South Wales Occupational Health and Safety Act was enacted in 1983, with 1987 seeing radical reforms to the workers' compensation system, and the enactment of the NSW Workers' Compensation Act (WorkCover) in July of that year. Prevention of injury was highlighted in both these pieces of legislation, with the workers' compensation legislation also incorporating the concept of rehabilitation.

The workers' compensation system changed from an adversarial and litigation focussed situation, to one which had rehabilitation of injured workers as a central feature. The concept of workplace-based rehabilitation was introduced in the WorkCover Scheme (the workers' compensation system in New South Wales) as it was in various other workers' compensation systems throughout Australia.

The impact of these changes in approach to employment injuries and injured workers which have been supported by legislation, has been significant. In NSW during the period 1991–1992 there were over 51 000 employment injuries, which comprised of workplace injuries, non-workplace injuries and occupational diseases (WorkCover, 1993b). This is an 11% decrease in the incidence of employment injuries and a 16% decrease in the actual number of injuries over 3 years when compared to 1989–1990 (WorkCover, 1993b).

In this paper the principles and guidelines for the workplace-based rehabilitation of injured workers which have supported this significant reduction in employment injuries and workers' compensation costs in New South Wales are discussed. The efficacy of workplace-based programs developed by rehabilitation providers and rehabil-

itation coordinators and the factors influencing success will also be presented.

## 2. Principles of occupational rehabilitation

'Occupational rehabilitation' is defined as

"the restoration of...injured worker(s) to the fullest physical, psychological, social, vocational and economic usefulness of which they are capable, consistent with pre-injury status. It is a managed process aimed at maintaining injured or ill workers in or returning them to suitable employment. It involves early intervention with appropriate, adequate and timely services based on assessment of the injured worker's needs" (WorkCover Authority, 1993a, p. 9).

The underlying principle of workplace-based rehabilitation is that "the workplace, and not a medical institution or the home, may be the most appropriate and effective place to rehabilitate the majority of injured workers" (WorkCover Authority, 1993a, p. 8). Another principle is that all parties involved in the workplace, including the worker, worker's family, employer, co-workers, union, insurer, rehabilitation provider and other health professionals, benefit socially and economically by an individual's safe and speedy return to work following a work-related injury or illness.

It should also be recognised that not every injured worker will require rehabilitative services, however, early assessment of the need for rehabilitation is necessary (WorkCover Authority, 1993a, p. 8). The WorkCover Authority estimates that in NSW, only 6% of injured workers actually require referral to a rehabilitation provider (Yates, 1992).

The acknowledgment of the importance of occupational rehabilitation has resulted in the development of general principles of occupational rehabilitation and the essential elements of a workplace-based rehabilitation program. The purpose of these principles and guidelines is to produce a workplace which has been described as a "rehabilitating environment" (Remenyi, 1992).

The principles of occupational rehabilitation outlined by WorkCover (1993a) are that:

- *Early intervention results in the maximum gains from rehabilitation.* The earlier injured workers receive appropriate intervention following an injury, the more likely they are to return to work (Strautins and Hall, 1989).
- *There must be a commitment by all parties to the rehabilitation of the injured worker* — this includes not only the worker and the rehabilitation provider, but also the employer, unions, insurance companies, doctors and other health providers. Commitment by various stakeholders is seen to be critical in the success of occupational rehabilitation programs. The employer in particular is seen to be a crucial player in this process (Cornally, 1987; Ferguson and Talbot, 1992).
- *Absences due to work-related injuries incur costs to the worker and the employer, both 'hidden' and actual costs.* Indirect costs are generally considered to be 4–8 times greater than direct costs of work injuries (Ganora and Wright, 1987).
- *Rehabilitation provision is an essential component in ensuring the health and productivity of the work force.* This last principle is almost seen as a basic assumption for any work-oriented rehabilitation program, whether it be clinic- or workplace-based. The fact that the rehabilitation program occurs in the workplace, however, creates a strongly identified link and has been shown to greatly reduce costs (Ganora and Wright, 1987).

The benefits of such programs can be "described in psychological terms..., social terms..., and in economic and employment terms" (Remenyi, 1992, p. 5) for both the employer and employee. These benefits include reduction of both direct and indirect costs of injury to the employer, and substantial benefits, such as improved independence, function and fitness, and reduced reliance on health services, medications, aids and appliances, for the worker (Ganora and Wright, 1987). Returning to work has a positive

effect on the individual's self-esteem and on family relationships (Bammer et al., 1994). Oxenburgh (1991) also cites improvement in overall productivity, quality control, workplace morale and a reduction of sick leave as some of the productivity, health and safety gains which can be achieved through successful occupational rehabilitation programs.

Guidelines for the establishment of workplace-based rehabilitation programs have been developed and consist of a number of essential elements (WorkCover Authority, 1993a). These elements include demonstrated commitments to:

- *Prevention of occupational injuries and illness.* This commitment incorporates the occupational health and safety legislation into the workers' compensation legislation. The emphasis in the workplace should be a proactive approach to the prevention of injuries and illness, rather than a reactive approach to manage the injury once it has occurred. The prevention of injuries is always preferable to the rehabilitation of an injured worker, both economically and socially. Injury prevention may consist of changes or modifications to plant and equipment, the work environment, job design, policies and procedures or the individual worker (Innes, 1988). This latter component may include education and training for employees prior to injuries occurring.
- *Early commencement of occupational rehabilitation* to minimise time off work and ensure that the worker role is maintained. The goals of return-to-work programs include the prevention of loss of identity as a worker, and prevention of secondary deficits such as occur with deconditioning due to prolonged periods of inactivity (Schwartz, 1993).
- *Ensuring that a return to work as soon as possible is a normal expectation* in the workplace from top level management to factory floor workers. Graded return to work programs are a preferred option to injured workers remaining off work when they are not able to perform their pre-injury duties for the usual period of time.
- *Provision of suitable duties / employment where*

*practicable, for an injured worker as an integral part of the rehabilitation process.* Suitable duties have regard for the employee's current abilities, rehabilitation plan and pre-injury employment, as well as the individual's education, skills and work experience. It does not include work which is demeaning or of a token nature. The term 'light duties' is avoided as it implies that the work performed is of an easier or lesser nature than 'normal duties'. 'Suitable duties', indicating that the nature of the work is suitable for the individual, is the preferred term used.

Many employers require assistance from either rehabilitation providers or in-house rehabilitation coordinators with health professional backgrounds to identify suitable duties for individual injured workers. It is not possible, and in fact highly undesirable, to identify one or two positions which are deemed to be the 'light-duty' jobs to which all injured workers return regardless of injury incurred.

- *Consultation with workers and, where applicable, any industrial union of employees representing those workers.* An open communication policy which seeks the views of interested parties is always advisable. It is a legal requirement for employers to consult with workers and any industrial union representing them when developing a workplace-based rehabilitation program. While the employer may select a rehabilitation provider or providers for the workplace, the injured worker retains the right to nominate any accredited provider to conduct his/her rehabilitation program (WorkCover Authority, 1993a).
- Australian society is multicultural and many workers do not have English as their first language. The use of interpreters, and written information available in a wide variety of community languages is encouraged.
- *Participation in a rehabilitation program will not, of itself, prejudice an injured worker.* A worker should not be disadvantaged in the

course of employment by undertaking rehabilitation. If a worker refuses to be involved in a rehabilitation program which is deemed to be necessary, however, then benefits may be effected.

### **3. Rehabilitation coordinators**

All employers in NSW who employ over 20 people must have a person nominated to be the rehabilitation coordinator to manage and oversee the rehabilitation of injured workers. In large companies this position is often filled by professionals with health backgrounds, predominantly occupational therapists, occupational health nurses, physiotherapists and rehabilitation counsellors. In smaller organisations, however, this is not always the case, with the role being performed by a variety of individuals, including workers' compensation clerks, payroll officers and safety officers from technical rather than health backgrounds.

The role of the in-house rehabilitation coordinator includes the development and coordination of rehabilitation programs, consultation and liaison with injured workers, rehabilitation providers, unions, management, insurers, general practitioners and other health professionals (Kelly and Tasker, 1989). The rehabilitation coordinator "becomes the focal point for all contact, liaison and review, particularly with the injured worker, his/her union, his/her treating doctor and the rehabilitation provider(s)" (WorkCover Authority, 1993a, p. 17).

### **4. Rehabilitation providers**

Rehabilitation providers are usually multidisciplinary teams which are able to provide occupational rehabilitation services. The rehabilitation provider team may consist of an occupational therapist, physiotherapist, psychologist and doctor specialising in rehabilitation or occupational medicine. Depending on the services provided, rehabilitation counsellors, occupational health nurses, and other health professionals may also

be included. The rehabilitation provider assists with the assessment of workers and workplaces, and treatment of injured workers, as well as developing return to work programs in consultation with the rehabilitation coordinator.

Occupational rehabilitation services include functional and vocational assessments, workplace assessments and job analyses to determine job requirements, advice on job modification, functional education, rehabilitation counselling, development of rehabilitation plans which incorporate workplace-based programs to enable workers to meet job demands, work conditioning (also known as work hardening) and supervision and upgrading of duties at the worksite, and advice or assistance concerning job-seeking and in arranging vocational re-education (WorkCover Authority, 1992b).

Workers are now facilitated to remain at work through individual rehabilitation programs, possibly on a part-time basis, and engage in appropriate duties which match their post-injury abilities. This avoids injured workers taking extended periods of time off work because they are unable to cope with a full time work load, or because some of the duties of their job are inappropriate. These workplace-based rehabilitation programs are gradually upgraded by increasing time at work and also the reintroduction of pre-injury duties. It is not unusual for injured workers to return to work for 2, 3 or 4 h/day and gradually increase this to full-time duties. Where this is not possible or feasible, long term plans regarding the retraining or permanent redeployment of the injured worker are developed.

### **5. Success of workplace-based rehabilitation programs**

The overall return to work rate for rehabilitation provider-managed cases from September 1989 to November 1991 was 65%, with the average duration of rehabilitation being 131 days, and costing an average of AUD \$929 per case for rehabilitation only (this does not include other costs such as wages, medical, etc.) (WorkCover Authority, 1992a).

Factors such as early notification of the injury, immediate involvement of the rehabilitation coordinator, early appropriate intervention, cooperation from all parties involved, and frequent monitoring and evaluation of progress, are viewed to contribute to the overall success of workplace-based occupational rehabilitation programs (WorkCover, 1991).

Workplace-based occupational rehabilitation programs developed and managed by health professionals demonstrate above average return to work rates. Return to work rates range from 74.5 (Yates, 1992), to 94 (Ferguson and Talbot, 1992) and 98% (Johnson, 1993) for occupational rehabilitation programs in area health services and motor vehicle assembly plants. These cases represent situations in which health professionals, in these cases occupational therapists, were functioning as both rehabilitation coordinators (Ferguson and Talbot, 1992; Yates, 1992), and rehabilitation providers (Johnson, 1993).

The reasons for these high levels of success have been attributed to management commitment to the program (Cornally, 1987; Ferguson and Talbot, 1992; Kelly and Tasker, 1989), site ownership, availability of qualified health professionals to provide advice (Ferguson and Talbot, 1992), and the ability for individuals to have a high degree of control over the rehabilitation process (Bammer et al., 1994). Ongoing education to all levels of staff and marketing of the program also assist in establishing an expectation that rehabilitation is a normal part of managing a work-related injury (Ferguson and Talbot, 1992). A clear demonstration of a management's commitment to creating a safe workplace can be through channelling managed fund savings back into other occupational health and safety projects (Ferguson and Talbot, 1992).

The nature and value of the work performed is a crucial factor in successful occupational rehabilitation programs. Bammer et al. (1994) indicate the real need for meaningful and mentally stimulating work. The selection of appropriate duties for individuals unable to return to their normal duties goes hand-in-hand with the responsibility health professionals have to listen to the injured worker.

Emphasis on the need for rehabilitation to address all the roles an individual fulfils, rather than only the worker role has been stressed in a recent study (Bammer et al., 1994). This requires consideration of not only the work requirements and environment, but also the home, social and leisure aspects of an individual's lifestyle. The arbitrary isolation of a single aspect of a person's life and focus on the worker role alone, has the effect of devaluing and failing to acknowledge the impact and interplay which occurs between the various roles and activities performed by individuals within their own environments.

Multiple factors obviously influence the effectiveness of workplace-based rehabilitation programs. The key factors appear to be early and appropriate referral for rehabilitation services, ready access to the work site enabling on-site supervision and support, on going support in the workplace from the rehabilitation coordinator and demonstrated commitment on the part of management.

## 6. Summary

The principles and guidelines developed for workplace-based rehabilitation provide a sound basis from which effective and innovative return-to-work programs have developed in New South Wales. The return to work rates reported for these workplace-based programs compare very favourably with more traditional clinic-based work hardening programs. While workplace-based rehabilitation programs do not meet the needs of all injured workers, the concept of injured workers returning to work, performing suitable duties which are matched to their capacities as soon as is safe and practical, should be strongly supported.

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