Return-to-work: The importance of human interactions and organizational structures[1]

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The purpose of this study was to gain insight into stakeholder perspectives on barriers and facilitators for return-to-work (RTW). Qualitative methodology with purposive sampling was employed. A total of 55 participants, representing a wide spectrum of stakeholders and industry, were interviewed in individual or group format. Interview transcripts were coded, categorized according to themes, and placed within a framework which reflected the dynamic interaction of individuals and the structural systems or context of those individuals.

Findings indicated that perceived barriers to RTW included delays of all types in processing or delivery of information or treatment, and ineffective communication among stakeholders. Facilitators to RTW included establishment of RTW programs in the workplace, effective communication and teamwork, as well as trust and credibility among stakeholders. The interdependence of organizational structures and human interactions was evident in successful RTW programs which emphasized teamwork, early intervention, and communication. Differing stakeholder perspectives, however, especially on issues such as worker attitudes and participation, must be acknowledged and addressed if more injured workers are to be successful in returning to full employment.

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1. Introduction

Return-to-work (RTW) following soft tissue injuries such as low back pain and repetitive strain injuries has become a critical issue for employers as well as for insurers, due to the high costs associated with disability resulting from these injuries [4,10,18]. Soft tissue injuries are the most common cause of workers' disability and compensation claims in North America, accounting for 50% or greater of all lost-time claims [2,40]. Campolieti and Lavis [4] report that workers' compensation costs in Canada grew at a rate of 6.2% per year between the years 1970 to 1994. In 1998, the Workers' Compensation Boards in Canada accepted 375,360 time-loss injury claims and paid $3.6 billion in benefits to workers [2]. Based on the statistics from Manitoba, approximately 40–50% of the claims are likely to be soft tissue musculoskeletal injuries [44]. The 1998 annual report of the Manitoba Workers' Compensation Board reports a total of nearly 40,000 injury claims with an average time-loss of 37 days. Direct costs attributed to soft tissue injuries were approximately $75 million; indirect costs to the workplace were estimated to be triple this amount [24]. Less tangible (in terms of actual dollars) are costs of a personal and social nature such as self-esteem or the impact on community and family responsibilities and roles.

2. Background

Return-to-work following injury is a complex process which requires action on the part of workers to

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do their best to recover [32], an assessment by one or more health professionals to pronounce the worker fit to work, and commitment from the insurer to pay benefits and offer vocational rehabilitation services as needed [44,46]. As well, the employer is expected to keep a job open for the worker or to make accommodations for a worker who is permanently disabled [44].

Success in returning injured workers to their jobs is influenced by numerous factors including characteristics of the worker [3,36], the job [7,48], and the workplace [29].

Research has shown that predictors for RTW include worker demographic factors such as gender, age and previous injury [3], disability factors such as perception of pain or disability [6] and psychological illness such as the presence of depression [1]. Employment factors such as seniority in the workplace or availability of employment [26] are important, as are workplace factors such as the presence of an active RTW program and a people-oriented work culture [19]. Factors within the legislative or insurance systems such as complex rules and structures resulting in worker dis-empowerment are also important [12,33,39].

In addition, organizational factors such as the presence and effectiveness of joint management and labour committees in health and safety [24,30], organizational climate [22], and control over one's job demands [21] have been cited as important both in preventing injury as well as in reducing the costs related to time-loss claims. It is apparent that responsibility for safety and prevention of injuries as well as management of workplace injury are increasingly viewed as the responsibility of many stakeholders and do not have single-stakeholder solutions [34,40,46].

Sinclair et al. [36] and Frank et al. [10] emphasized that RTW for injured workers was most likely to be successful if all the stakeholders would coordinate their efforts, recognizing that multiple factors within several systems impact on the success of RTW. These interrelated factors include medical, rehabilitation, insurance, and workplace systems as well as factors concerning the worker.

Various models have been proposed for successful RTW such as case management [13,40], work hardening [6,20], temporary 'reassignment' to an alternate job or to modified work [17,20], ergonomic interventions in the workplace [29,31], and workplace based multi-component interventions [48].

Rising costs [2,4], changes in both workplace and workforce [15], and the changing nature of injury claims [38] all add to the urgency of implementing strategies which will lead to successful RTW. Although evidence exists as to what constitutes successful disability management [11], costs and time-loss injury claims continue to rise and it is not clear why only a few workplaces appear able to implement and sustain a successful RTW program. A review of the literature showed that stakeholders' perspectives on why or how RTW was effective were unknown. Therefore a qualitative study was designed which would invite participation of stakeholders in order to develop a greater understanding of the challenges associated with RTW. The Manitoba Work-Ready study was part of a multi-disciplinary applied research project involving researchers in occupational health and rehabilitation in three Canadian provinces, Ontario, Quebec and Manitoba. Work-Ready researchers were brought together under the auspices of HEALNet (the Health Evidence Application and Linkage Network), a National Centre of Excellence funded by the Canadian government.

The purpose of this paper is to describe a portion of the Work-Ready study, the objective of which was to gather multiple stakeholders' perspectives which would add to the understanding of the complex issues in RTW. This paper is limited to the Manitoba Work-Ready study; results for Ontario [5] and Quebec [37] are being published elsewhere.

3. Methods

3.1. Study design

Focused ethnography [28] was chosen as the most appropriate methodology for assessing stakeholders' perspectives on RTW. Broad questions were asked and followed up with probing in order to elicit detailed and rich descriptions.

3.2. Study participants

Participants were chosen purposefully to be the individuals best able to answer the research question [8, 28]. An initial list of potential workplaces and participants was generated by asking occupational health professionals for contact names and workplaces. From this list, more workplaces and participants were added by using snowball sampling [28]. Potential participants were contacted and selected on the basis of their knowledge, experience or importance in the work injury field and the RTW process within the workplace. They included a range of individuals or groups who have an in-

Table 1
Description of participants

Workplace	
Managers	11
Union/worker representatives	4
Occupational health professionals (nurses and physicians)	11
Workers	12
Other groups	
Professional regulatory agency	1
Government departments	
– Workplace safety and health	3
– Labour education	1
Workers' advocacy groups	2
Professional groups	
WCB vocational rehabilitation coordinators	5
Occupational therapists	4
Total number of participants	55

terest and/or involvement in RTW, called stakeholders in this study. Stakeholders include workplace owners, managers and employees, physicians, other health professionals, vocational rehabilitation specialists, workers, union members, advocacy and educational groups, government departments such as workplace health and safety, and regulatory bodies for health professionals. Workplace managers include department managers of human resources or occupational health, supervisors of work groups, or senior managers in charge of large sections of the workplace. Physicians include both family physicians, occupational physicians as well as other physicians with treating responsibilities for injured workers. All participants were given written information about the study and the opportunity to consent or refuse to participate.

A total of 55 individuals agreed to participate, either in one-on-one encounters or in small groups (Table 1). Because the aim of the study was to interview a wide variety of stakeholders with a wide range of perspectives, participants came from ten workplaces (five unionized, five non-unionized), two government departments, one professional regulatory agency, one advocacy group, and two professional groups representing practitioners who work with injured workers. The spectrum of workplaces represented health services, public services, construction, retail, manufacturing and hydro-electric services. Workplaces ranged in size from fewer than 100 employees to more than 5000 employees.

3.3. Procedures

A semi-structured interview with two guiding questions was used:

What are the barriers to successful RTW after injury?
What has been or would be helpful for workers to RTW after injury?

Twenty-seven participants were interviewed individually, nineteen in small groups of two or three, and nine in focus groups. Focus groups differed from the small groups in that they were planned groups with a facilitator and observer to record responses, and took place in a seminar room. The small groups usually took place at the workplace where participants requested that they be interviewed as a group rather than individually. Where it was possible and permission was given, interviews were audio-taped. In all cases, extensive field notes were taken to record participants' responses as accurately as possible.

3.4. Analysis: Coding and theme development

Audiotapes and field notes were transcribed and labeled to remove any identifying information. Interview data were initially coded into two major categories: facilitators – things which people said were helpful in returning the injured worker to the job, and barriers – things which were unhelpful in the process. Issues were often raised which could be interpreted in either way; for example, the presence of a workplace or worker characteristic was identified as a facilitator while its absence was perceived as a barrier to successful RTW. Speakers of the comments were identified generally as to the type of stakeholder, i.e. manager, worker, health professional. Using ATLAS.ti,[2] a qualitative research analysis software tool, comments were further categorized by common themes such as "attitudes" or "initiative". Issues, themes, and relationships between themes were identified after further reading and analysis.

Techniques were used to ensure the credibility and trustworthiness of the data [23]. Transcribed interviews along with a brief summary of initial barriers and facilitators were reviewed by participants to ensure accuracy of data. Any changes in the data suggested by participants were incorporated into further analysis. Triangulation, a means of establishing different patterns of agreement based on more than one method of observation, information gathering, or more than one data source was used to establish credibility [14, 16,23]. In this study, data were collected by way of

[2] Scolari Sage Publications Software, Thousand Oaks, CA.

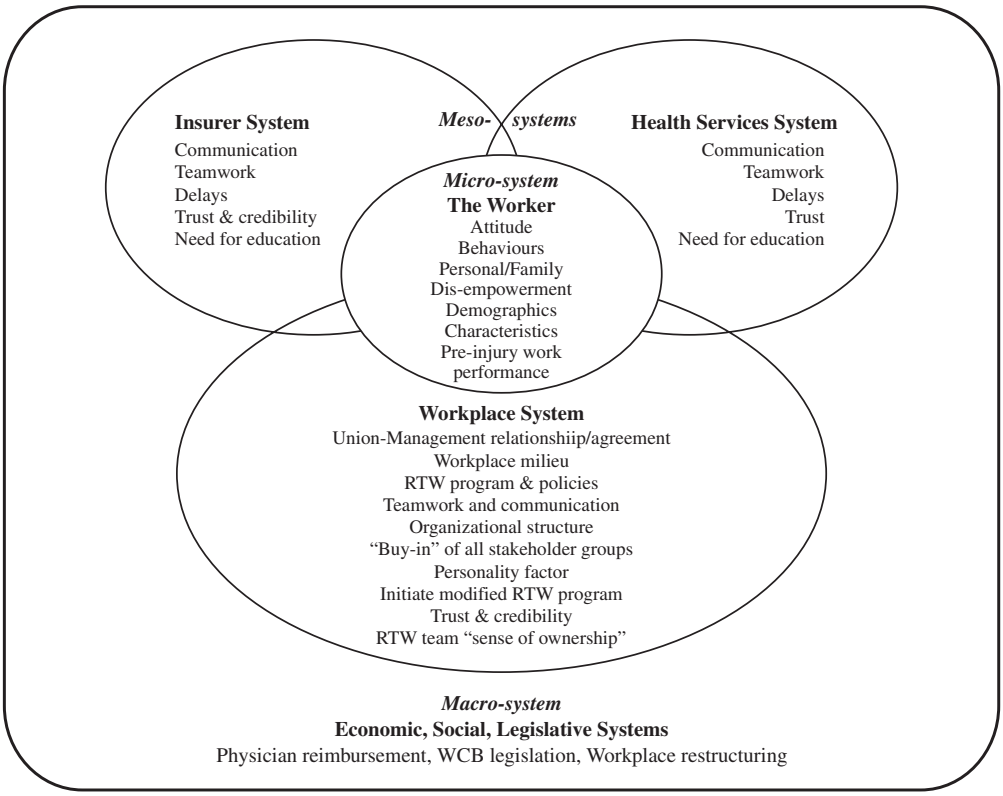

Fig. 1. Stakeholders' perceptions of barriers and facilitators for return-to-work.

one-on-one interviews, small group interviews and focus groups. Data were gathered from varied sources including workers, managers and individuals from advocacy, government, and professional agencies. Each piece of data, when added to previous data, strengthened or confirmed previous information; triangulation of the data, in this way, reinforced and enhanced the trustworthiness of the information obtained [14].

4. Results

As themes related to the categories of barriers and facilitators for RTW emerged, they appeared to fit into three levels of systems which encapsulated the contexts of organizations and interpersonal dynamics. A conceptual model consisting of micro-, meso-, and macro-systems was developed based on the themes and relationships found in the data (Fig. 1). Use of this conceptual model enabled the researchers to draw some significant conclusions about the importance of human interactions and organizational structures within the RTW process (Fig. 2). The micro-system consists of the worker's characteristics and demographic characteristics or learned skills and behaviours. The meso-systems consist of the workplace, insurer and health care systems; these are the interactions and organizational structures within the workplace which may influence the RTW process as well as the interactions and structures involving stakeholders external to the workplace. The macro-system reflects the broad context of social, economic and regulatory environment.

4.1. Micro-system themes

4.1.1. The worker

4.1.1.1. Worker attitudes and behaviours

All stakeholders agreed that workers' attitudes, motivations and behaviours could be facilitators or barriers to RTW. Workers acknowledged that a positive attitude to both life and work was important. A worker's pre-injury work performance as well as level of skill or education could influence the success or failure of RTW. Several workers commented that their own attitude toward the injury and recovery was important, and this was often reflective of their general attitude toward life.

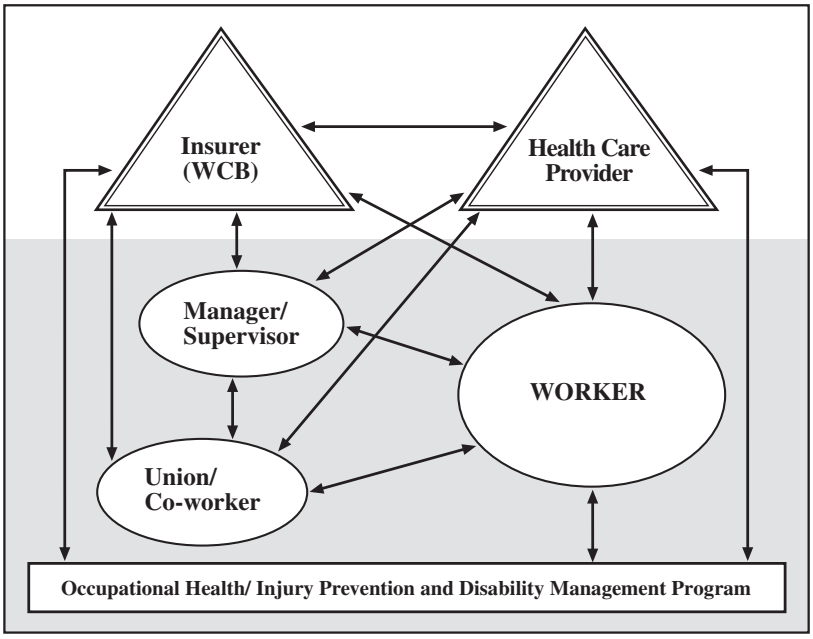

Fig. 2. System and human interactions in return-to-work.

> "Half of it's attitude [getting back to work, getting better]. It [illness, injury] sucks a lot out of your real life – real life is playing with your kids, wrestling with my son – the worst thing is dying. I enjoy living. I'm a little more careful." WR08B210

Health professionals and employers, however, referred most often to the need for workers to be motivated to RTW, and to take responsibility for their own well-being. Some comments implied that only the workers who exhibited the appropriate attitudes and behaviour really deserved their help. A human resources manager, although very supportive of RTW programs, acknowledged that there were some workers who presented difficulties, for example:

> "Some employees try to manipulate the system and take advantage of the good will of the company . . . People who are in denial about their poor performance sometimes need a drastic "reality check" such as being called into the human resources manager's office." HR03H310

4.1.1.2. Worker participation

Closely allied with worker attitude was the concept of worker participation, involvement, control or choice. Therapists within one focus group were articulate about the need to closely involve the worker in the RTW process:

> "Let the worker know the plan is flexible and encourage [him/her] to try things . . . involve the client in the process . . . give them choice or alternatives especially in things like equipment modification . . . [it is helpful] if worker has say in scheduling RTW." AG02N410

Some participants spoke about 'dis-empowerment' or imbalance of power between the worker and the insurance system, or between the worker and the health care or the workplace system. This sense of disempowerment appeared to be tied up with the sense of being unable to understand "the system" or to "negotiate the system", a concept consistent with work done by Frankcom [12] and Tief and Donelson [41]. One worker stated:

> "You know you have to be careful, 60% salary is better than 0% and they have the money – you're dealing with the system. They always act as though it is their money – it's not, it's my money – I paid for the insurance. The whole system is intimidating. They want you to apply for CPP but then you get taken off the disability benefit." WR08B210

Workers expressed the need to be persistent, to ask questions, and to be their own case manager:

> "You have to be persistent and ask a lot of questions . . . I've learned how to do that." WR14W110

4.2. Meso-system themes

4.2.1. Workplace system

4.2.1.1. Workplace organization

Organizational structures within the workplace, including the style of management whether authoritarian or participative, the general milieu among workers and supervisors, and the presence of formal RTW policies and programs, all appeared to affect the success or failure of RTW. One workplace RTW coordinator explained the impact of organizational structure:

> "We work with cell leaders very closely; often workers come up with a good idea re: a RTW plan. Co-workers are a strong point within each cell. A cell is a style of management, it promotes a sense of knowing who each worker is. It helps to socialize workers, either at the beginning of employment or if people have been off for too long." OH08S900

Relationships between union and management, as well as positive communication and teamwork were mentioned frequently as being important to the RTW process. One worker expressed frustration at the lack of help she felt she was getting from her union and placed the responsibility on poor communication between unions and employer:

> "There's two unions – my union doesn't have light duties and there's a dispute between management and union. But there's nothing in the contract that would help me. I've paid my union dues . . . but they're not fighting for us." WR09V600

Another worker was grateful that the union was able to give support at a critical time:

> "Finally . . . I phoned the union and said this is enough . . . The [insurer] backed off after the union intervened." WR08B210

Although the union did not appear to be a leader in establishing RTW policies, several stakeholders expressed that the process was most effective when the unions were cooperative and involved in the process of establishing RTW policy:

> "Get the union involved in policy development; get them to participate and cooperate. Use negotiated contract language to facilitate RTW. You must have rapport with the unions." HR01W110

Union representatives also endorsed the importance of their involvement to the team approach to RTW:

> "The process is that there is a rehab team meeting where the RTW plan is designed, present are the worker representative, the worker, the occupational health nurse, the workers' compensation adjudicator and any other involved team members such as the occupational therapist." WP03B210

4.2.1.2. Trust and credibility

Many stakeholders spoke of the need to establish "trust" and "credibility" of all stakeholders within the workplace as well as between the micro- and meso-system stakeholders. Both themes indicate the importance of good communication and positive relationships. Establishing credibility of the RTW program among employees was a high priority for the RTW program coordinators. Several mentioned that they worked very hard to gain trust of the employees by treating all workers fairly.

4.2.1.3. Communication and positive relationships

Good relationships, regular communication and teamwork among all the involved parties were perceived by all the stakeholders to be very important. This included communication and relationships with the insurance company, the workplace manager, injured worker, occupational health professionals, and family physicians. A therapist involved in RTW rehabilitation stated that:

> "Attitudes and communication among all parties is absolutely imperative." AG02N410

One worker representative felt that the most important facilitator in RTW was:

> ". . . to have an open-door policy with easy access [i.e. to RTW manager], approachable, and have ongoing education with health and safety coordinator." WP02P100

A manager prided himself on fostering good relationships:

> "It [i.e. success of RTW] all depends on the relationships I have in the plant or the office or WCB." MG01P100

Initiating early communication, follow-up calls, and fostering relationships with the injured workers was seen by one company to be a factor in its success rate in early RTW:

> "Workers respond positively to follow-up phone calls; we have kept good rapport with workers so we know who is over-estimating their ability to come back to work and those who might be off for a very long time." HR04S900

A union representative was emphatic that teamwork was the only way to be successful in implementing a RTW program:

> "Real case management happens when the whole team meets to make a decision and pulls together." WP01W110

"Sell the program" was a term used by several RTW teams – the occupational health nurse, human resources representative and the union representative spoke about the need to market the concept of RTW and their particular program to upper management, union members (workers), and to direct line supervisors within their place of employment. This marketing of the RTW program helped to establish credibility:

> "We have to sell our program to management and to employees . . . Over the past ten years we have worked very hard at building up trust with employees." OH08S900

Another human resources representative, when asked about facilitators for RTW, stated emphatically:

> "Trust and Credibility and Integrity . . . It takes time to facilitate the process; it's taken ten years to develop this." HR01W110

The same human resource department also spoke about the need to market the RTW program and advocated the use of training and education sessions to accomplish this. The training would be tailored to the audience, whether managers, supervisors, or board members:

> "We market the process using different types of training, using one perspective with the Board of Commissioners and another perspective with supervisors of departments." HR02W110

4.2.1.4. Workplace initiative

The workplace appeared to be an important "initiator" of an effective RTW program. Whether unionized or non-unionized, those workplaces which took the initiative to develop a policy (formal or informal) on RTW, established a modified RTW program, and took responsibility to contact the worker, the insurer, and the physician early in the process of RTW, stated that they had lowered their injury costs. There also appeared to be satisfaction among both workers and managers in those workplaces. Workplace stakeholders, especially those who were directly involved in the RTW process, frequently displayed a sense of ownership and pride in RTW program. These workplaces did not wait for the insurer, the health professional or the worker to arrange for their employee to return to the job. As expressed by an occupational health nurse:

> "We don't wait for [insurance] agencies to contact us – we get a plan in place and then call them to say what we're doing." OH08S900

On the other hand, workers were often away from their jobs for long periods of time when no modified work was available. A worker representative felt that a key barrier to RTW was that workplaces were too rigid and therefore reluctant to implement modified work strategies:

> "It depends on how RTW is structured; a workplace is sometimes too rigid, they want a job done a certain way. They should look at the best interests of the worker over the long haul." AG01N410

A worker commented on the lack of modified work opportunities:

> "I would have been able to come back to work sooner if the company had identified light work." WR04V100

Sometimes the RTW policy was part of the collective agreement or policy established by management with written procedures. In these instances, the process might be more formal:

> "We have a new contract . . . with a clause on 'duty to accommodate' . . . we have a hierarchy of accommodation – the person's own job, then within their job classification, then within the bargaining unit. The health and safety committee can recommend an ergonomist and do a job demands analysis." WP04V800

Sometimes it was described as being an informal policy or practice which:

> "It was sort of serendipitous developing the program . . ." OH08S900

4.2.2. Health and insurer systems

The major themes within these systems emphasized the need for regular and positive communication among all stakeholders within and between each of the three meso-systems and one micro-system. Delays due to administrative controls or other factors were always perceived as being a barrier to the RTW process. The need for education about job demands, modified work, and accommodation for workers with disabilities was mentioned by several groups.

4.2.2.1. Communication

Although communication within the workplace was clearly identified as important, lack of communication with or between stakeholders outside the workplace was seen as the major external barrier to successfully arranging RTW. Workers experienced barriers to RTW when there was little or poor communication between the treating physician and the workplace, between the

insurance company and the workplace, between the insurance company and the physician, or when any of these did not communicate fully with the worker. Employers also expressed the frustration of poor communication among any of the key participants in the RTW program.

> "The [insurer] never has the information at hand ... it's always hard for them to find the file." MG04W710

Workers frequently expressed frustration that they had inadequate information although this also seemed bound up with a sense of frustration with "the system":

> "You're not told what benefits you're eligible for, everyone plays cards close to their chest because if you know what you really have a right to, it's going to cost more money; people aren't aware of what's available to them." WR13S300

Occupational health personnel in one company were frustrated when they attempted to get further information from the worker or the workers' family physician:

> "Follow-up calls might be viewed as harassment; we have to walk a fine balance."
> "We don't have any access to the treating doctors' reports." OH02V800

Some physicians expressed frustration with the lack of effective communication and delays in working with the insurer:

> "How [insurer] works seems to be a mystery; there are long delays; I don't know who to contact to get something done by [insurer]."

4.2.2.2. Delays

Delays occurred in areas such as processing the claim, conveying forms or other information between physician and employer, physician and insurer, insurer and employer, as is indicated by the following comment by an occupational health nurse:

> "Delays often occur with physician forms for WCB and getting the initial adjudication done; why do workers stay at home when they could be doing at least 1–2 hours per day?" OH01S700

A delay in getting appropriate medical intervention also contributed to increased time away from the job:

> "Cases which get into trouble are those in which they wander from specialist to specialist; it's not the worker's fault, they may not be getting an answer which they understand." OH06N410

4.2.2.3. Need for education

Some worker representatives and some managers felt the family physicians needed to be educated on job demands and the potential benefit of modified work:

> "Community physicians have a lack of knowledge about the injured worker's job." OH03W110
> "Treating physicians are not aggressive in involving therapies or getting people back to modified work." OH02V800

One agency indicated that workers, employers and unions should be educated on the role of occupational physicians:

> "A facilitator for RTW would be for the union/workers/employer to understand the place of occupational health; a physician's job is to state that the person can or cannot do the job safely; all other information is confidential." AG04N410

Some worker advocates indicated that, although the Manitoba Federation of Labour had recently adopted a policy on job accommodation for workers with disabilities, many union members still needed to be educated on the benefits for all workers on such a policy:

> "I developed some training for supervisors and coworkers, this has gone over quite well once workers understand what is going on and they know that this [injured worker] could be them tomorrow." WP01W110

4.3. Macro-system themes

The major themes and issues relating to the macrosystem included physician reimbursement patterns and economic and political constraints which resulted in downsizing workplaces, often eliminating the potential for developing modified work within the workplace. Several physicians commented:

> "The MMA [Manitoba Medical Association] statement on early RTW is a great idea, but physicians never have time to follow it. And for what benefit do we spend the extra time; there is no incentive to take time to really understand the patient." OH07H310

One worker representative commented on the effects of the economy and downsizing strategies of the employers:

> "There's a lack of jobs and loss of job positions, usually entry-level jobs. This means that the workers are not qualified to bump other workers in positions because they're not qualified to do those other jobs. And because there's a lack of jobs, the [em-

ployer] will not allow us to shield injured workers during the bumping process, nor will they create jobs in order to accommodate the injured worker." WP03H310

5. Discussion

Popular opinion might suggest that stakeholders representing management and those representing workers would polarize over some issues such as worker attitudes or job accommodation. Findings in this study, however, suggest that there is considerable agreement by the various stakeholder groups over what are the barriers and what are the facilitators for RTW. Common barriers were delays of all types and ineffective communication. Common facilitators were workplace initiative to establish a RTW program, effective communication and teamwork, as well as trust and credibility. Some barriers or facilitators were identified as such based on a particular situation or viewpoint.

Within and between all systems, the interplay of organizational structures and human interactions was evident, suggesting that successful RTW cannot be the result of positive relationships nor formal policies alone. Consistent with the review by Frank et al. [10], this study confirmed that RTW is influenced by multiple factors and systems. No system is isolated; an action on the part of one person, or a policy developed within one system, has an impact which often influences the responses of people within another system.

5.1. Micro-system – the worker

It was evident from the data that worker behaviours and attitudes were expressed within the context of an organization or system structure and/or in response to the type of relationships and interactions influenced by the employer, the insurance representative or the health professional. A worker's attitude, for example, was viewed quite differently by the workers themselves in comparison to perceptions of other stakeholders, including managers, supervisors, union representatives, and health professionals. This suggests that it is important for individuals within the other systems to listen to the workers and try to understand their behaviour from their personal perspective as well as from the supervisor's or manager's perspective. This has important implications for the workers' motivation and self-efficacy in recovery and RTW [33,42,43].

Human interactions and structures which allow for and encourage worker participation and empowerment in the RTW process are vital to the well-being of the worker and his or her ultimate RTW. This is consistent with findings from other studies [9,27,33,42]. The worker's sense of dis-empowerment appeared to be tied up with the sense of being unable to understand or to negotiate "the system". The "system" in this context usually referred to the numerous organizational and bureaucratic structures within the meso-systems which were involved in assisting the injured worker. It also referred to the multiple and complex human interactions within those structures which were necessary to facilitate successful RTW. The workers appeared to indicate that they needed an entirely new or different set of skills in order to understand and to balance the demands of the workplace, the insurer and the health professional during the process of recovery and trying to RTW. This finding may suggest that all workers could and should learn the skills necessary to find their way through the various systems, or equally, it may suggest that the policies and actions of people within the systems need to change in order to provide less of a barrier to the workers. Some authors suggest that there has been an over-emphasis on the need for change within the workers and it is now important for the organizational systems to institute change in their attitude and practices rather than requiring the worker to learn new skills [12,41].

5.2. Meso-system – workplace structure and human interactions

All stakeholder groups agreed that "positive relationships", "good communication" and "working together" were important to success in a RTW program. The results also highlighted the importance of the workplace in initiating and establishing a RTW program. Both structure (having a RTW program) and relationships (communication and trust) were perceived as vital in successful RTW, evidenced by workers returning to their jobs and by lower injury costs. This finding is consistent with recent studies which indicate that workplaces which have a strong "safety culture" also have a lower work injury rate [25,34,35]. In this study, some workplaces had established formal policies and procedures for RTW programming while others indicated that their RTW program was informal in the sense that there was no written policy, and the program was based primarily on personal relationships and communication. In both types of settings, there appeared to

be some success in getting workers back to work more quickly and in reducing overall costs related to injury. There was a suggestion that some workplaces which had few written policies and no collective bargaining agreements had an enhanced ability to facilitate earlier RTW because the process was simplified by having fewer people or organizations involved in the RTW plan for a worker. However, at least one workplace which had multiple unions involved had developed a very active and successful RTW program; they reported that they relied heavily on positive relationships which included early contact with the worker and on frequent and comprehensive communication with all the relevant stakeholders.

Whether union – management relationships were perceived as a barrier or a facilitator to RTW was not always clear-cut. Some occupational health professionals found the union to be rigid and obstructive, reporting that the union objected to contact with the worker's treating physician by occupational health professionals, and objected to any regular communication with the worker without having a union representative involved. In this way, the RTW policies established in the collective agreement were rendered less effective. Some workers expressed dissatisfaction with their own union and some worker representatives commented on the need to educate their union members on the benefits of job accommodation. On the other hand, in workplaces where the union representatives had worked closely with management to develop RTW policies and programs and were involved as part of the RTW team, there was often a strong sense of teamwork and satisfaction in working in the best interests of the injured workers. These findings suggest that unions could be involved to a greater degree in supporting injured workers and establishing modified work programs.

5.3. Meso-systems – health and insurer systems

Lengthy delays, although sometimes the responsibility of a single individual, were often a result of systemic factors such as having no process in place to communicate regularly with all stakeholders, whether physician to insurer, or insurer to workplace. Lengthy delays were always viewed as barriers; they were described as being detrimental to the RTW process and as being a factor in the development of secondary disability such as chronic pain syndrome.

Findings of this study suggest that the insurer could play an important role in ensuring that rapid and effective communication strategies were implemented among all the systems – especially to and from the insurer and physician(s), insurer and employer, and insurer and worker. Physicians and other health professionals could do more to educate themselves about the worker's job and the place of modified work as well as initiating and facilitating communication with the other stakeholders within the workplace system to ensure that worker is returned to work as quickly as possible.

5.4. Macro-system – social, economic and regulatory context

In Manitoba, the Workers' Compensation Board (WCB) is primarily an insurance system while injury prevention education is addressed by a government department quite separate from the insurer. Out of twelve workers' compensation jurisdictions in Canada, eight have combined insurance coverage with responsibility for safety and health education [46]. There is, however, no evidence that this strategy has had any positive impact on work injury incidence [2]. The findings of this study support the effectiveness of RTW programs initiated and developed by individual employers. In fact, there was often a sense of ownership and pride when the workplace was able to point to a RTW program that they had developed and that was effective in reducing costs while supporting the dignity of the injured worker. The Manitoba WCB reports that they are encouraging partnerships between workplaces and with the Workplace Safety and Health department in order to improve injury prevention strategies [46]. They are also encouraging workplaces to develop their own disability management programs [45].

Physician reimbursement patterns in Manitoba are such that most family physicians are paid by Manitoba Health on the basis of the numbers of patients they treat. This may result in a physician being pressured to spend less time with each patient and may affect the quality of treatment. Various employers have addressed this issue by employing or contracting with physicians for a set rate, to provide treatment for injured workers within their workplace. In light of our findings that physicians feel they do not have adequate time to address RTW issues in the course of normal treatment, this type of arrangement would benefit both worker and physician. Comments from occupational health professionals and the RTW team within the workplace, both physicians and nurses, expressed satisfaction with this arrangement in two areas. The on-site RTW team expressed the benefits of having a physician easily accessible to the workers, and the physicians expressed the benefits

of gaining greater understanding of the worker's job demands and their relationships to the worker's injury and disability.

6. Conclusions

The emergence of common themes, despite a considerable diversity of participants and workplaces sampled, allows us to have confidence that the relationships and structures underlying the barriers and facilitators for RTW are truly representative of the experience of many Manitoba injured workers and workplaces.

There are, nevertheless, different realities and it would be inaccurate as well as being a disservice to the stakeholders to gloss over the differences in perspectives especially on issues such as worker attitudes and behaviours, and the responsibility for effective communication. By examining these differences, strategies can be planned to address the differing perspectives.

The effectiveness of various models and programs for RTW was not directly addressed within the context of this study. However, the benefits of teamwork and cooperation among all stakeholders was clearly an important issue. It also became clear that, although unions were not often leaders in implementing RTW programs, their support and cooperation was vital to the success of disability management. The design of each RTW program was somewhat unique to each workplace; evaluation of the effectiveness of a RTW program requires a more focused research approach.

Structures which promote communication among all stakeholders are most effective if the individuals involved exercise trust and establish credibility by following through with the formal plans and programs. It appears that improved communication strategies could and should be a goal for many of the stakeholders; especially to and from the insurer. It is recommended that an application of the study findings is to design RTW programs which incorporate as many of the facilitating factors as possible, and involve all the stakeholders in both the planning and the implementation, with a commitment by all stakeholders to the process factors of communication and trust. The WCB of Manitoba has recently published a guide to establishing disability management programs in the workplace which addresses the need for a multi-stakeholder approach to RTW [45]. One outcome of the three-province RTW study is the development of a teaching package on RTW approaches which is being widely distributed to RTW stakeholders [47].

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