Report

February 2005

Gender, Workplace Injury *and* Return to Work:

A South Australian perspective

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- Verna Blewett, New Horizon Consulting, Representative of Working Women's Centre SA Inc Management Committee.
- Lucy D'Aloia, WorkCover Corporation Access and Equity Unit to May 2004, and then Suzanna Meier and Emily Petering (April 2004 – January 2005) from the same Unit.
- Barbara Pocock, University of Adelaide.
- Michelle Hogan, Dale Street Women's Health Centre to May 2004, then replaced by Cheryl Baxter, Women's Health Statewide.
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WorkCover CORPORATION

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Disclaimer Statement

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Report Summary

1. Aims and Approach

The **Gender, Workplace Injury and Return to Work Research Project** was conducted in South Australia from August 2003 to July 2004. The project was funded by a WorkCover grant and under the auspices of the Working Women's Centre on behalf of WorkCover's Access and Equity Women's Focus Group. The project team was guided by a steering committee representative of key stakeholders in the area of workplace injury and return to work.

The project aimed to explore the following issues:

- people's experiences of workplace injury and rehabilitation
- whether the issues are the same for men and women
- what helps and hinders people during rehabilitation and return to work – both in the workplace and in the workers rehabilitation and compensation system
- whether available statistics and research adequately consider gender and broader psychosocial issues
- strategies that represent best practice for assisting workers' rehabilitation and return to work.

The views of a range of groups were canvassed, including: employers, managers, OHS/Rehabilitation coordinators, unions, health and safety representatives and trainers, claims agents and case managers, rehabilitation consultants and providers, as well as workers who have, or have had, a lost time injury.

The project's methodology had both qualitative and quantitative components, but its priority was to give a voice to injured workers, a perspective that has been recognised internationally as under-researched. Data was collected through surveys, interviews and group discussions and was informed by a literature review of relevant Australian and international research.

The key components of the research were as follows:

- Review of relevant Australian and international literature and statistical data
- Injured Workers' survey
- Health and Safety Representatives' (HSRs) survey
- Employers' survey
- Interviews with injured workers
- Interviews with other key stakeholders
- Attendance at relevant meetings and focus groups.

2. Key findings from the project

2.1 Overview

The different paradigms underpinning the South Australian Workers Rehabilitation and Compensation scheme ('the system') are frequently in collision. On the one hand there are the values of Insurance Companies (Claims Agents) and their need to be commercially profitable. On the other, there are the values of health, welfare and rehabilitation. Injured workers typically feel that the emphasis is on profit, rather than on their wellbeing – both in the workplace and in their dealings with Claims Agents.

Overwhelmingly, workers found dealing with the 'system' (and sometimes the workplace as well) to be the most difficult part of the whole experience of work injury.

The view of the 'scheme' that has emerged in this study is of a system that is fragmented, complicated and often slow to engage. It is an impersonal system that can negatively impact on its clients.

Those with the greatest power in making decisions that affect the lives of injured workers are often their case managers. Some case managers do not have access to appropriate and adequate ongoing training. There is a tendency for some to display less than positive attitudes towards injured workers.

The way the system functions frequently sets up adversarial relationships early in the process which act against the best interests of employers and injured workers.

There are undoubtedly always going to be some situations that will prove extremely difficult or impossible to resolve. However there are a significant number of 'cases' which could be resolved with far better outcomes for workers, the scheme and employers.

There are some relatively simple changes outlined in the strategies for change, some of which are mooted in recent strategies for reform, which could make a significant impact on the functioning of the scheme.

Injured workers often experience a lack of respect and agency. For many injured workers their injury and rehabilitation it is a whole-of-life experience and current practice takes little account of this.

2.2 Injured workers' perspectives

The following themes repeatedly arose during interviews with injured workers and were often reinforced by survey comments:

The system

- The system is basically fair, but the ways in which it is implemented are not fair.
- The process of claims determination can be extremely slow, sometimes creating delays in appropriate intervention, diagnosis and treatment.
- There were often delays in reimbursement for costs incurred.
- The system created limbo periods followed by sudden and a sometimes overwhelming number of obligations (appointments, treatments).

- The system and its processes triggered adversarial responses.
- The system was seen to be compromised by Insurance companies being the pay masters of allied health professionals.

Information and communication

- Injured workers were often unclear about what to expect, what they were entitled to, what rights and obligations they had.
- There was often little or no consultation with the injured worker about possible and best options for sustainable return to work.
- There was little collaborative consultation (or communication) between key players involved in the injured worker's case.
- Workers found that it was difficult to get clear information from Claims Agents about retraining policy and processes.

Implementation of the scheme

- The implementation of the scheme reflected a mechanistic outlook rather than a personal holistic approach.
- The welfare component of the scheme was not evident to injured workers.
- Many staff involved in implementation of the scheme (especially Claims Agents) did not demonstrate appropriate communication skills, knowledge of workplace realities or knowledge of the legislation.
- Workers felt that their Return to Work (RTW) Plans were generic rather than individualised.

Psychosocial issues

- Injured workers felt that there was no one who was 'on their side' to help them through.
- Participants felt a loss of agency in their own 'case'
- Both women and men reported that their psychosocial needs were not usually taken into account, even though such issues accounted for most difficulties in rehabilitation and return to work.
- Where key players did take account of an individual's needs and feelings it had enormous positive impact on attitude and motivation.
- Work injury had a significant impact on identity and self esteem. It was often a "whole of life" issue.
- There were commonly held assumptions about women's role in the home and expectations that housework and childcare would continue to be taken care of despite a work injury.
- Many participants reported that their home responsibilities had not been understood by people implementing the scheme.

Workplace issues

- Workplace responses to injured workers were often negative – both from management and co workers.
- The injury sometimes seemed to be a catalyst for workplace bullying (eg. name calling, snide remarks, punitive shift allocations).
- Appropriate alternative duties were often not available.
- There was little or no information about work task opportunities eg. no log book or register of available work.

What injured workers want
Injured workers were asked in various ways to offer positive suggestions for improved outcomes. Their answers clustered around the following themes:

- Better communication and information.
- More transparency in the system.
- Consultation, compassion and respect.
- To be believed. Assume that the injury is genuine – rather than that it isn't.
- Require (and check) that case managers/administrators and rehabilitation providers are appropriately qualified.
- Ensure that doctors do not have a conflict of interest.
- Make sure rehabilitation providers are independent.
- Create a better system of finding alternative duties.
- Provide meaningful retraining and equitable opportunities for it.
- Improve timeliness of responses to their injury.
- Improve adequacy of treatment.
- Improve employer ethics and investigation of employers' bad practices.
- More assistance at home.
- Awareness that work place bullying is common.

2.3 Employer perspectives

The following findings emerged from the employer's survey and interviews with managers:

- Many employers saw the system as unfair or favouring the injured worker. Only a few thought the system was unequivocally fair.
- There should be a balance between protecting vulnerable workers and providing workers with incentives to return to work.
- Several employers suggested there were *too many grey areas* and that there was *too much room for interpretation* in the legislation, and that the claims process was *too open ended*.
- Employers frequently mentioned difficulties in finding meaningful alternative duties. A number emphasised the need for more flexibility regarding Section 58B of the Act concerning the employer's duty to provide work and also regarding eligibility for RISE (the Re-employment Incentive Scheme for Employers)
- They complained of the costs involved in providing supplementary assistance while workers resume full duties.
- Employers were strongly critical of the role of General Practitioners (GPs) in injured workers' rehabilitation. Specifically, they criticised their lack of knowledge of workplaces; their too ready support for workers to 'remain off work'; and their willingness to declare all injuries as work related.
- Employers identified good communication and positive approaches and attitudes as key factors helping timely and sustainable return to work. Overcoming isolation was a big issue for subcontracting agencies whose employees worked alone on shifts at many different sites.
- Employers acknowledged the importance of early intervention and early return to work.
- Negative employee attitudes were seen as hindering return to work. Employer attitudes (adversarial, lack of understanding for worker) were also identified as hindrances, as were unhelpful GPs and differing medical opinions.

- Some employers/managers saw work injuries as a trigger for pre-existing injuries. A number spoke of their difficulties with an ageing workforce, many of whom are 'menopausal women' with degenerative conditions.
- Employers agreed that the workplace culture is important and most referred to the attitudes of co-workers as being significant. The most common word used to describe a good workplace culture was *supportive.* The stigma of being 'on workers compensation' was acknowledged.
- Suggestions for changing the workplace culture mainly centred on the need for training and awareness generally, for both management and the workforce.
- Many responses recognised that the impact of a work injury on home life is huge and that sometimes this impact comes from having to comply at home, as well as work, with restrictions on physical activities.

2.4 Health and Safety Representatives' perspectives

Key findings from the Health and Safety Representatives' (HSRs) survey were:

- HSRs regard their work sites' initial response to injury as extremely good, especially in terms of compliance with the regulations.
- Information about work place injury, rehabilitation and return to work was identified as an issue in need of further action.
- They consistently reported that generally, workers were ill informed about the processes and dynamics of rehabilitation and return to work. There was some feeling expressed that available information was incomplete in that it explained responsibilities and obligations – but not rights.
- HSR training and development was seen as invaluable and they wanted more – not only about the legislation, but also at a practical level, for example responding to an injured worker's depression.
- The role of HSRs could be expanded and more broadly defined. This would involve training about the ways an injury affects a range of issues beyond the physical. However, for such training to be meaningful, there would also need to be support from management, including acceptance of the idea that psycho/social issues relating to workplace health and safety are important.
- Training, especially about attitudes and communication skills, emerged as a priority to support HSRs to undertake their role effectively. However there may also need to be further clarification about expectations of their role. It appears that this can be understood differently by different stakeholders, eg. Union, employer, worker and the HSRs themselves.
- Consistently, HSRs identified return to work of an injured worker as a time that was a potential trigger for harassment, bullying, derision, victimisation and negative or abusive labelling. Underpinning these problems were co-worker and supervisor assumptions about the legitimacy of the need for modified or alternative duties and often a lack of understanding about the effects of injury and rehabilitation needs.

2.5 Contesting points of view

Two major differences of opinion repeatedly emerged in the surveys and interviews. These concerned the role of General Practitioners (GPs) and perceptions of the genuineness of work injuries.

The role of GPs

Employers and some Claims Agents conveyed frustration with the role of GPs in the implementation of the scheme. They were often described as 'the weak link' and seen to be too ready to give blanket 'unfit' certificates, and reluctant to understand the requirements of the workplace or to assist early sustainable (perhaps modified) return to work.

Injured workers, on the other hand, often felt that their GP was the *only* player in the whole scenario, who knew them and was working in the best interests of their health within the context of their whole of life circumstances.

This is clearly a trigger point for colliding paradigms to play out. (It is also possible to imagine how the GP could be 'caught' between them).

The genuineness of work injuries

Employers and claims agents talked in terms of the importance of support for 'genuine' cases, and of the feelings of frustration with those who are seen as not genuine. They often said that 'common sense' and 'experience' equipped them to know when someone was abusing the system and they responded accordingly.

On the other hand many injured workers felt that they were being treated as criminals – as one put it: *"guilty until proven innocent*". It was also common to hear that 'blood on the floor' injuries were supported, but muscular skeletal injuries (invisible) injuries, were always potentially under some doubt. This sense of 'not being believed' had devastating emotional consequences for some participants, and was, for example, central to the feelings of several participants who discussed their suicidal thoughts.

It is interesting to note that in several responses to questions, HSRs also frequently referred to the legitimacy of the case. For example, in an answer about co-workers' attitudes to the injured person, it was fairly common for them to answer that it depended on the person and whether they were genuine or seen as genuine.

Both of the contested issues highlighted above reinforce the importance of the psychosocial component of injury, rehabilitation and return to work and the importance of front line workers having appropriate qualifications, skills and information with which to make appropriate judgements

Key Recommendations and their Rationales

Central objectives of the *Workers Rehabilitation and Compensation Act, 1986,* are to establish a fair scheme that provides for the effective rehabilitation of injured workers and their early return to work – and to reduce adversarial contests as much as possible. Rehabilitation programs are established with the object of achieving the best practicable levels of physical and mental recovery and where possible restore workers who have a 'compensable disability' to the workforce and the community. There is a broad range of rehabilitative and assistance options that WorkCover may utilise, including an open-ended option to do anything else that may assist in the rehabilitation of workers. We interpret this broadly to encompass a 'whole of life' response to the impact of work injury.

In the spirit of these objectives we present here a small number of primary recommendations regarding Gender, Psycho-Social issues and Data collection and reporting. Each set of recommendations is preceded by a brief rationale gathered from our own and related research. Other more detailed 'secondary' recommendations can be found later in the report in Chapter 7.

Gender

Rationale

Responses to work injury management, rehabilitation and return to work do not adequately take into account gender issues and the pressures of balancing work, domestic and community life. The realities involved in the combination of paid and unpaid work are not recognised at a systems level. In Australia generally, women typically undertake almost twice as much domestic and caring work as men. When injured workers require significant time off work for rehabilitation, assumptions are often made about family members or friends taking on additional housework or child-care.

Many injured workers in this study had no knowledge of the existence of home support services or how to access them. Key players involved in responding to work injury may be inadequately trained in understanding the different needs of men and women. There is strong gender segregation in the labour market and women are more likely to be employed in part time and casual jobs. This makes it less likely that they report and resolve injury matters and less likely that related issues are understood and researched. Another issue that has particular implications for women is the fear that may be evoked by the use of surveillance.

It is recommended that

1. WorkCover's future planning, programs, policy and contractual arrangements reflect appropriate understanding of and response to gender issues and the pressures involved in balancing work and home life.
2. WorkCover's new Rehabilitation and RTW model adopts a gender-based analysis and any major reviews should take account of work, gender, domestic and community life.

3. WorkCover devises appropriate strategies for ensuring that all relevant people involved in work injury claims management and rehabilitation are adequately trained in gender and work/home life issues and that this is demonstrated and continuously monitored. Specific strategies could include:
    - Training for managers, claims agents, rehabilitation providers and Health and Safety Representatives incorporating awareness of gender and work/home life issues
    - Monitoring of the recognition of gender and work/home life issues at all stages of an injured worker's compensation and rehabilitation process – eg. in checklists, pro-formas and in the performance standards of claims agents.
4. WorkCover's Access and Equity's Women's Focus Group support a research project to establish and pilot a best practice model for the equitable and effective accessing of home support services, in terms of improved outcomes for workers, employers and the scheme.
5. In relation to RTW;
    - The format for RTW Plans be revised to ensure they are written in appropriate and
      accessible language and in various formats.
    - Training for rehabilitation consultants adequately addresses the whole-of-life impact of injury, pain and disability on injured workers and their families.
    - Rehabilitation providers can ensure provision and/or referral of injured workers for counselling to address whole-of-life impacts of injury, pain and disability.
    - In the longer term review the legislation so that it can take account of the whole-of-life impacts of injury, pain and disability.

Psycho/social issues

Rationale

Injured workers in this study overwhelmingly reported that dealing with the 'system' (and sometimes the workplace as well) was the most difficult part of the whole experience of work injury. They felt that the whole-of-life impacts of injury, pain and disability were often not adequately considered and that they were often not treated with sufficient compassion or respect. Specifically, many felt that the process was demeaning because they were not believed. They also felt inadequately consulted and informed and generally wanted clearer, more respectful communication.

The research suggests that the solution to this identified need lies in ensuring that the scheme's implementation has a clearer customer focus. This can be achieved through a range of strategies, include appropriate staff training and recruitment, viable case loads for case managers, explicit recognition of the benefits to all of psychologically as well as physically safe workplaces, and accessible, timely and comprehensive information to be disseminated more consistently.

It is recommended that:

6. Key players who contribute to the compensation and rehabilitation of injured workers are trained in, and demonstrate, respectful communication skills and an understanding of psycho/social issues related to workplace injury.
7. Case-managers' case loads take into account risk categories and differing levels of complexity, and ensure that case managers have the time to communicate adequately with all clients and address their psycho/social needs.
8. The rehabilitation and return to work model gives more consideration to the concept of return to the community as an appropriate outcome for injured workers who will not realistically return to paid employment.
9. That the concept and benefits of a psychologically safe work site should be widely promoted, including a recognition that returning to work on modified duties can be a trigger for hostility or bullying.
10. That WorkCover review its information dissemination services and materials to ensure that all injured workers routinely receive timely, comprehensive and accessible information about: the scheme and its operations the rights and obligations of all key players, including employer, claims agent, rehabilitation provider, medical provider and the injured worker available services and support for which workers may be eligible, including transport, childcare, cleaning and other home support and re-training opportunities.
11. The Access and Equity Unit undertakes to monitor performance to ensure that the information needs of injured workers from identified equity groups (women, Aboriginal and Torres Strait Islanders, people from culturally and linguistically diverse backgrounds and workers with disabilities) are met.

Data collection and reporting

Rationale

Women and men have different patterns of employment and are clustered within different industries and occupational tasks within industries. There are also differences between workers in employment arrangements, for example, permanent, casual, contractual, full time and part time, fixed and flexible shifts. Women make up the major component of the part time work force and they account for 85% of lone parent households with dependent (and non-dependent) children. It appears that an increasingly lower proportion of women are returning to work after an injury involving lost time, and that if they do return to work, the duration of their claim is longer.

Analysis of data therefore needs to identify the impact of these factors, especially in relation to understanding the dimensions of gender differences and work injury. Currently, WorkCover data is claims-based and difficult to relate to workforce data. Occupational data to match the categories used by WorkCover is not available and definitional differences make information difficult to interpret. There are also significant differences between data held for exempt employers and non-exempt employers in relation to rehabilitation and return to work. There is therefore, a challenge to be addressed in data collection and reporting, namely, to present meaningful data relating to small sub sets of workers and to disaggregate the data by occupation and gender.

It is recommended that:

12. WorkCover provides the following information about work injury claims, relating to both exempt and non-exempt employers, and that the information be broken down by occupation and gender:
    - number and cost of claims
    - number and cost of claims relating to lost time injuries
    - number of claims where rehabilitation services are provided
    - average cost of rehabilitation services and what this money is spent on
    - number of claims where home assistance is provided
    - average cost of home assistance services and what this money is spent on
    - number of claims where re-training is provided and information on the nature of that re-training
    - rehabilitation and injury outcomes, including whether the worker returns to the same work and the same hours of work and whether return to work is sustained over time.

13. The current multi-variant analysis project should be completed and the findings published.

The primary recommendations above are prioritised as major issues to be addressed in order to improve rehabilitation and return to work outcomes for injured workers. Other key issues concern early reporting, return to work plans, alternative duties, re-training guidelines, the responsibilities of case managers and rehab providers, the role of Health and Safety Representatives and occupational health and safety committees, workplace training and the role of doctors. Best practice about all of these issues and suggested strategies for improvement are canvassed in the discussion of research themes in Chapter Four.

A complete list of recommendations including specific secondary recommendations about these issues is provided in Chapter Seven. It should be noted that some recommendations are within WorkCover's sphere of influence and responsibility and others need to be taken up by appropriate agencies and stakeholder groups, including employers.

Summary of Best Practice and Strategies for improvement (more detail in Chapter four)

Issue	Best Practice	Strategies for improvement	Reference in main report
Gender	• Rehabilitation and return to work policies and practices will take account of work, domestic and community life and gender. • Front line workers (anyone who responds to an injured worker as part of their job) demonstrate respectful communication skills and a social awareness of relevant psycho social issues surrounding workplace injury. They are trained to be appropriately responsive in this domain. • Awareness of and sensitivity to gender and work/home life issues become a performance standard required of claims agents contracted by WorkCover. • Home circumstances and needs are discussed with every injured worker. Assumptions about others (such as friends or family members) taking on additional responsibilities should not be made without establishing the viability of the proposition with the worker concerned. • WorkCover's information collection is disaggregated by gender and other diversity factors and this information is accurate, current and readily available. • All programs and policies are assessed according to their potential to either exacerbate or counteract gender inequality. Programs should be analysed and evaluated from a gender perspective.	• WorkCover's future planning, programs, policy and contractual arrangements should reflect appropriate understanding of and response to gender issues and the pressures involved in balancing work and home life. • WorkCover's new Rehabilitation and RTW model should adopt a gender-based analysis and any major reviews should take account of work, gender, domestic and community life. • WorkCover should devise appropriate strategies for ensuring that all relevant people involved in work injury claims management and rehabilitation are adequately trained in gender and work/home life issues and that this is demonstrated and continuously monitored. Specific strategies could include: • *training for managers, claims agents, rehabilitation providers and health and safety representatives incorporating awareness of gender and work/home life issues* • *Monitoring of the recognition of gender and work/home life issues at all stages of an injured worker's compensation and rehabilitation process – eg. in checklists, pro-formas and in the performance standards of claims agents*. • WorkCover's Access and Equity's Women's Focus Group supports a research project to establish and pilot a best practice model for the equitable and effective accessing of home support services, in terms of improved outcomes for workers, employers and the scheme.	**4.2**

Issue	Best Practice	Strategies for improvement	Reference in main report
Information	• Information is readily available in plain English and other languages about: ▪ overall parameters of the scheme and how it operates. ▪ rights and obligations of all key players, including employer, claims agent, rehabilitation provider, medical provider and the injured worker ▪ Available services and support for which workers may be eligible, including transport, childcare, cleaning and other home support • Information provided is up-to-date, consistent and timely and provided in a variety of formats • Major players in the system and Health and Safety Reps refer workers to this source of information. • Rehabilitation providers/consultants, Health and Safety Reps and unions have a role in ensuring that their clients/injured colleagues understand the information provided.	• That WorkCover review its information dissemination services and materials to ensure that all injured workers routinely receive timely, comprehensive and accessible information about: o the scheme and its operations o the rights and obligations of all key players, including employer, claims agent, rehabilitation provider, medical provider and the injured worker o available services and support for which workers may be eligible, including transport, childcare, cleaning and other home support and re-training opportunities. • The Access and Equity Unit undertakes to monitor performance to ensure that the information needs of injured workers from identified equity groups (women, Aboriginal and Torres Strait Islanders, people from culturally and linguistically diverse backgrounds and workers with disabilities) are met.	4.6
Early Reporting	A workplace environment, supported by employers, managers, HSRs, OHS Committee and unions, which expects and supports prompt reporting of workplace injury and disease.	• An information campaign is developed for employers, unions, HSRs, workers and the community regarding the benefits of early reporting and early intervention regarding workplace injuries. • Ensuring management, union and HSR training addresses the benefits of early reporting and early intervention. • Development of employer incentives for prompt reporting and/or disincentives for delayed reporting. WorkCover's current bonus/penalty scheme extends not only to OHSW but also to early reporting and effective return to work and rehabilitation processes to encourage employers to get more actively involved in the workers compensation and rehabilitation system. • Promotion of the Early Claim procedure to workers, employers and HSRs.	4.7

Issue	Best Practice	Strategies for improvement	Reference in main report
Early Determination and intervention	• Workers and employers understand the benefits of early intervention and timely and sustainable return to work. • There are appropriate incentives in place to support early intervention – for employers, workers, claims agents and rehabilitation providers.	• Access and Equity Unit's Women's Focus Group consider further research into investigating who should be eligible for 'return to the community' and when and what are the likely costs and benefits to the injured worker and the scheme of extending eligibility. Please also refer to **Section 4.7.3**, *Early Reporting Strategies.*	4.8
Return to work plans	• The scope and purpose of the RTW Plan is focused on rehabilitation and restoration and is clearly directed to achieving the best outcome for the worker, taking into account the work and home environment. • The worker and the employer are actively engaged in developing, and agree to, a realistic plan which takes into account the worker's physical and emotional capability; employer/management capability and workplace culture. • RTW Plans are in plain English, easy to understand and concise. • RTW Plans can be varied to meet changing needs and circumstances of the injured worker.	• Revise the format for RTW Plans to ensure they are written in appropriate and accessible language and in various formats. • Ensure training for rehabilitation consultants adequately addresses the whole-of-life impact of injury, pain and disability on injured workers and their families. • Ensure that rehabilitation providers can provide and/or refer injured workers for counselling to address whole-of-life impacts of injury, pain and disability. In the longer term possible review of the legislation so that it can take account of the whole-of-life impacts of injury, pain and disability.	4.9

Issue	Best Practice	Strategies for improvement	Reference in main report
Home support	• Injured workers are fully informed of the potential range of services available to support their effective rehabilitation and return to work. • Injured workers know about and can access home support services.	• Ensure that injured workers are provided with information about home support services, along with other information about the scheme and the process. • WorkCover's Access and Equity's Women's Focus Group supports a research project to establish and pilot a best practice model for home support services, in terms of improved outcomes for workers, employers and the scheme.	4.10
Alternative duties	• Workers and employers/managers are actively engaged in planning early and sustainable return to work. They take account of the worker's prior family commitments where possible, matching tasks and jobs to the capabilities of the injured worker and developing strategies to ensure that the worker can return to normal duties as soon as possible. • Job/task registers are developed and available in workplaces to support better matching of injured workers' skills and capabilities and alternative duties. • In industries, businesses or occupations where suitable alternative duties are not available alternative arrangements are in place, to enable the injured worker to obtain work within their capability and in a timely manner.	• WorkCover policy and practice supports workers and employers being actively engaged in planning early and sustainable return to work. • WorkCover supports development of job registers in workplaces. • WorkCover responds promptly and works with employers to find workable solutions to the lack of availability of suitable light duties in some industries, businesses or occupations. • WorkCover receives early Section 58B referrals when alternative duties are not available and responds appropriately. • Workers receive appropriate job training/support from their employer if alternative duties are not available eg. language and literacy classes for workers of Culturally and Linguistically Diverse backgrounds. **See also** Section 4.12.3 Re-training**, following.**	4.11

Issue	Best Practice	Strategies for improvement	Reference in main report
Retraining	• Re-training of injured workers to enable them to take up alternative job opportunities is properly considered and realistic options are assessed and offered.	• It is understood that reforms under consideration are likely to ensure that re-training opportunities are made more available in the future. This policy shift is supported. • WorkCover develops clear and transparent guidelines regarding access to re-training. • It may well be appropriate for the Access and Equity Unit to monitor performance in this area to ensure reasonable equity in access to such opportunities.	4.12
Rehab providers and case managers	• The rehabilitation role has higher autonomy to give expert advice without pressure based on short term cost control approaches. • That case managers and rehab providers are more proactive in the interest of workers' rehabilitation and RTW. • Appropriate workloads for claims officers/managers. • Qualified, well trained and compassionate case managers. • Less change/turnover in claims managers and rehab providers.	• Support proposed reforms which give greater autonomy to rehabilitation providers • WorkCover standards and contracts ensure claims agents employ adequately skilled and trained case managers who respond to injured workers with greater understanding and respect. • WorkCover standards and contracts ensure rehabilitation providers employ adequately skilled and trained rehabilitation consultants. • Claims managers/officers are selected to reflect their client base. • Severity of injury/injury type are matched with skill set of claims agents. • WorkCover initiates a project to research and address high claims manager/rehab provider turnover	4.13

Issue	Best Practice	Strategies for improvement	Reference in main report

HSRs and OHS committees	• All workplaces have at least one Occupational HSR and workplaces with twenty or more workers have an OHS Committee.
	• Where an injured worker consents, s/he is actively supported by the HSRs and OHS Committees in their return to work
	• HSRs and OHS Committees influence workplace culture to better support workers returning to work after an injury and, where the injured worker agrees, co-workers are informed about the nature of the injury and how best to support the worker in their return to work..
		• The Workplace Liaison Unit continues to actively encourage the election of HSRs, especially in any industry, occupation or geographical areas where there are evident gaps.
		• WorkCover Health and Safety Consultants, Unions and Business SA, in consultation with Workplace Liaison Unit, actively explore alternative models for provision of HSR and OHS Committee functions for small and very small businesses in metropolitan Adelaide and for regional SA.
		• Workplace Liaison Unit, in consultation with Unions and Business SA, articulates the role of HSRs and OHS Committees in relation to RRTW.
		• Workplace Liaison Unit works with training providers to develop and introduce extended training opportunities for HSRs and OHS Committees to address:
		  • the role of HSRs and OHS Committees in RRTW
		  • employee and employer rights and responsibilities in relation to RRTW and scheme procedures and processes
		  • workplace culture and attitudes to injured workers
		impact on injured workers and self-esteem issues for workers returning to work
			4.14

Doctors	• Meeting and collaboration between rehabilitation providers, doctors, injured worker and employer to ascertain best options and potential outcomes. • Doctors are aware of relevant workplace tasks and understand the legislation. • Doctors' judgements would reflect thoughtful consideration of the capabilities of injured workers to participate in alternative duties in the workplace • Employers and Claims Agents are respectful of doctor's judgements about a patient's psycho /social needs as well as physical ones.	• Rehabilitation and return to work could become a specialist competency for some doctors • Doctors visit workplaces to enable them to make appropriate recommendations re alternative duties and return to work • Doctors are consulted and approve the RTW plan before it is agreed by all parties • Interested doctors are involved in workplace training about the health impact of toxic work cultures • WorkCover initiate research about alternative models of practice involvement for doctors eg. overseas examples.	4.15

Chapter One: Introduction

1.1 Project aims

The Gender, Workplace Injury and Return to Work Research Project was conducted in South Australia from August 2003 to July 2004. It aimed to explore:

- people's experiences of workplace injury and rehabilitation
- whether the issues are the same for men and women
- what helps and hinders people during rehabilitation and return to work – both in the workplace and in the workers rehabilitation and compensation system
- strategies that represent best practice for assisting workers' rehabilitation and return to work.

The views of a range of groups were canvassed, including: employers, managers, OHS/Rehabilitation coordinators, unions, health and safety representatives and trainers, claims agents and case managers, rehabilitation consultants and providers, as well as workers who have, or have had, a lost time injury. Data was collected through surveys, interviews and group discussions and was informed by a literature review of relevant Australian and international research.

The project had both quantitative and qualitative components, but its priority was to give a voice to injured workers, a perspective that has been recognised internationally as under-researched. A particular focus of the research was to explore any gendered differences in workers' work injury experiences, to consider whether available statistics and research adequately consider gender and broader psycho-social issues, and to recommend strategies that improve rehabilitation and return to work.

1.2 History of the project

The project proposal was initiated by the Working Women's Centre representative on WorkCover's Access and Equity Unit's Women's Focus Group[1]. The impetus for the research was twofold. It arose both from stories South Australian women workers were telling about their experience of occupational health and safety and the Workers Rehabilitation and Compensation scheme and from a growing body of international research suggesting that gender is a significant variable in these areas. WorkCover's Access and Equity Unit's Women's Focus Group has had rehabilitation and return to work on its agenda for some time. Some of the issues being raised were around injured female workers experiencing difficulties relating to their role

[1] The Women's Focus Group includes representatives from United Trades & Labor Council, Working Women's Centre, Office for Women, Australian Manufacturing Workers Union, Business SA, Equal Opportunity Commission, Dale Street Women's Health Service, Migrant Women's Lobby Group and a Community representative.

in the home as housekeepers and primary carers (especially as mothers); lack of awareness regarding entitlements, including entitlement to home support and lack of awareness about workplace occupational health and safety and the workers rehabilitation and compensation system.

The Access and Equity Women's Focus Group submitted a project proposal to the WorkCover Grants program and was successful in securing funding. The project timeframe was from August 2003 to July 2004. The project was conducted under the auspices of the Working Women's Centre Inc on behalf of the Women's Focus Group.

The research team selected to undertake the project was Jocelyn Auer, Joan Cunningham and Karen Jennings. They were appointed in July 2003 and work commenced in September 2003.

1.3 Gender hypotheses

Anecdotal evidence has suggested that there are differences in experience and outcomes between men and women in relation to Occupational Health, Safety and Welfare (OHSW) and injury management. The differences are in the nature and experience of work for many women and the effects of the 'double-day' with working women continuing to have primary responsibility for home and children. In terms of the nature of work, more women today work part-time and/or are in casual employment. To some small extent, women are moving to what are often considered the traditionally male dominated industries. A significant factor in the South Australian context, and elsewhere, is also the increasing age of the workforce, including the female workforce.

Indications from WorkCover Corporation are that these factors may all impact on recovery and return to work figures in South Australia. The 2004 Operational Review maintains that, compared to the national average, South Australian workers:

- take longer to return to work;
- are more likely to return to different duties; and
- take longer to return to normal duties.[2]

Although these figures are contested by some, it does appear that an increasingly lower proportion of South Australian women than men are returning to work, and that if they do the duration of their claims is longer. One hypothesis the project aimed to explore, therefore, was whether the South Australian Injury management system had recognised and responded to the changing roles of women at work, the multiple roles they have in society and the factors which may hinder or delay early and sustainable return to work. Is it the case here, as was found in a NSW study[3], that women are likely to face particular difficulties in reporting and resolving their health and safety concerns because of workplace arrangements such as part-time work, casual work and/or because of the nature of the industry or occupation in which they work?

This NSW research did not address whether gender differences associated with women's role in the home, as well as work segmentation and work arrangements, may also contribute to women experiencing greater difficulty in returning to work.

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[2] South Australian WorkCover, Operational Review, May 2004, p.24.

[3] *Gender Differences in OHS&W experiences of NSW workers: A summary of a WorkCover study of the injury and illness experiences of men and women*, Data Analysis and research Unit. WorkCover Authority of NSW. Feb 1998.

1.4 Project outcomes

Consistent with the project's aims, the principal outcome of the project was to identify factors impacting on rehabilitation and return to work and make strategic recommendations for best practice to assist workers' timely and sustainable rehabilitation and return to work.

Specifically, the outcomes to be delivered by the project were:

- A series of quarterly progress reports
- A final project report and recommendations
- A short article on the project and its key findings suitable for newsletters
- An article suitable for journals
- Notes and overheads/slides suitable for a conference presentation
- A strategic plan of action based on report recommendations.

1.5 Project Management

The project was managed by a Steering Committee with the following members:

- Verna Blewett, New Horizon Consulting, Representative of Working Women's Centre SA Inc Management Committee.
- Lucy D'Aloia, WorkCover Corporation Access and Equity Unit to May 2004, and then Suzanna Meier and Emily Petering (April 2004 – Jauary 2005) from the same Unit.
- Barbara Pocock, University of Adelaide.
- Michelle Hogan, Dale Street Women's Health Centre to May 2004, then replaced by Cheryl Baxter, Women's Health Statewide.
- Ruth McEwin, Business SA. Proxy: Andy Tascione.
- Kevin Phelan, Occupational Health and Safety Representative Trainer.
- Emmy Fonteyn, Workplace Services
- Andrea Costa, Costa Pericles Consultancy.
- Sandra Dann, Director Working Women's Centre.

The Committee met regularly throughout the project to receive project updates from the researchers, and to discuss and resolve any major issues or dilemmas raised in the course of implementing the initial research design. This support was invaluable for the researchers in undertaking their work. Committee meetings were held more frequently during the early stages of the project to provide guidance in finalising the research design and in identifying ways of accessing participants. Individual Committee members also provided information and feedback as required throughout the project.

The Workers Rehabilitation and Compensation System

1.6 The scheme and its key players

The Workers Rehabilitation and Compensation Scheme is a no fault scheme with the aim of rehabilitating and facilitating the safe return to work of an injured or ill employee.

The money to fund the Scheme is collected from employers in the form of a levy. The levy is calculated as a percentage of remuneration paid to workers by an employer. WorkCover is required to ensure that sufficient funds are collected to pay for current and future liabilities, administration and other costs. These funds also support initiatives and improvements in workplace health and safety for South Australian workers.

Diagram 1 on the following page represents the key players in the South Australian Workers Rehabilitation and Compensation scheme. The bold arrows indicate relationships which are normally involved when an injured worker makes a claim. The dotted lines indicate relationships which *may* be made for example an injured worker may contact WorkCover directly, or may see a lawyer or consult the Employee Advocate Unit or a support group. WorkCover may deal directly with medical providers. The research found that injured workers often perceive a lack of communication between these various players.

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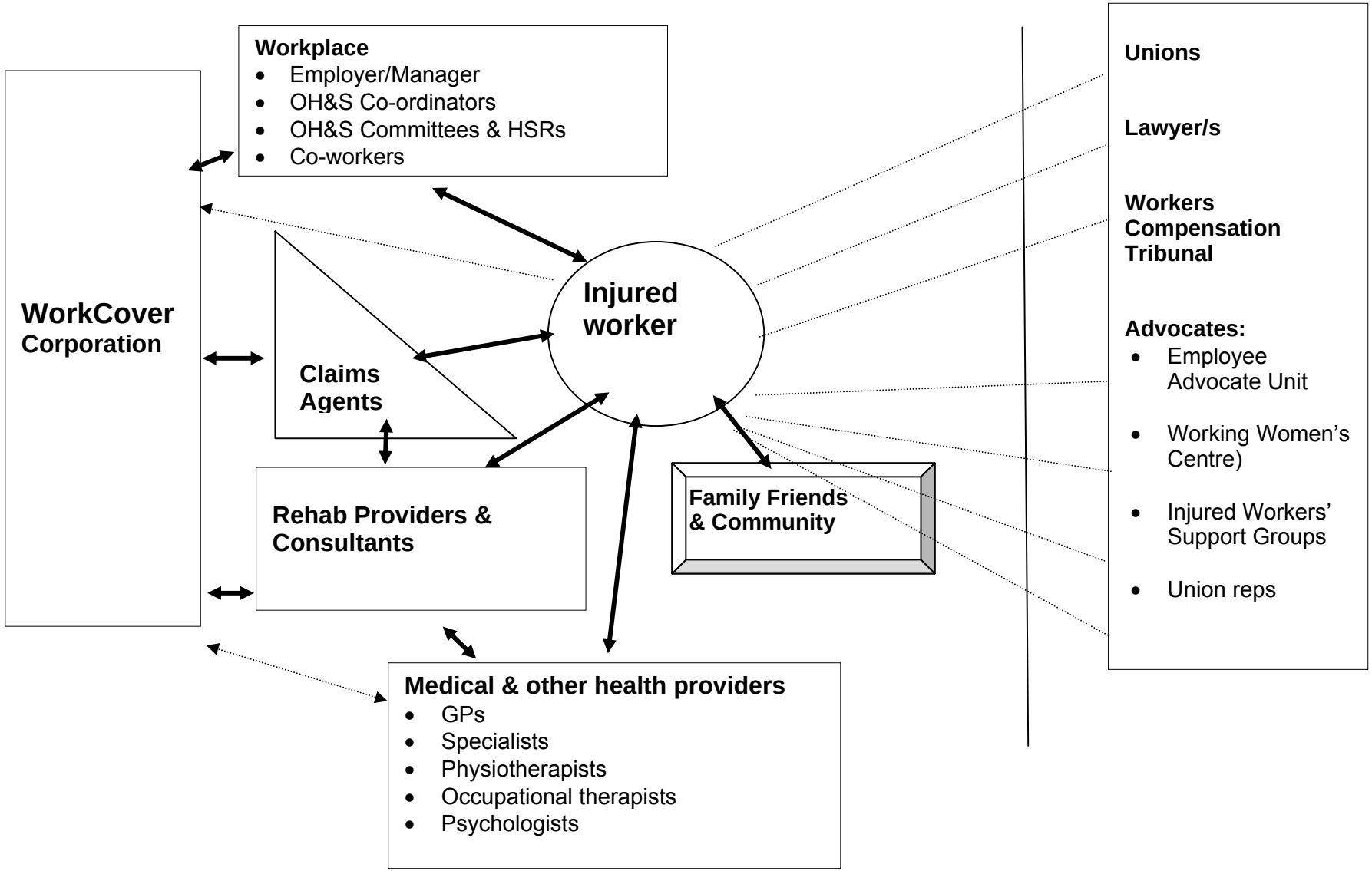
Diagram 1

The Workers Rehabilitation and Compensation Scheme
Non-Exempt employers



Currently:

- WorkCover Corporation out-sources claims management to four claims agents (insurance companies) under contractual arrangements outlining its requirements and terms and conditions
- A claims agent determines if claims are eligible for compensation and then manages these claims; coordinates the rehabilitation and return to work of an injured worker; and provides advice to employers and workers on rehabilitation and compensation.
- Employers choose or are allocated a claims agent with whom they will deal, and they may change this arrangement each financial year if they so choose.
- The claims agent may appoint a rehabilitation provider to assist the injured worker to return to work. WorkCover has contracted a number of providers to deliver these services.
- In some instances the injured worker may select her/his own rehabilitation provider.
- Employers who maintain lower claims costs through safe work practices and by providing suitable alternative employment for injured workers may be rewarded with a reduced levy through a bonus/penalty scheme.
- Injured workers generally choose their own medical provider or they may go to a doctor or work clinic recommended by their employer.
- In some instances injured workers who dispute a decision made in relation to their claim may seek the support of Unions, the Employee Advocate Unit or other support or advocacy groups, or they may seek legal representation.
- Most disputed decisions in relation to workers' compensation claims may be taken to the Workers Compensation Tribunal for review.

From the worker's perspective the system is extremely complex, with a large number of players with competing interests and goals. It may seem like a maze with a series of hoops to be jumped through. Workers frequently have little knowledge of the system until they are injured and it may be quite difficult to come to terms with these complexities at a time when they are already under a great deal of stress.

1.7 'Contending Parties'

Alan Clayton, in his commissioned paper for the Stanley Review, argues that the nature of workers compensation schemes in the different states in Australia are greatly influenced by the relative strength of 'contending parties', with a 'business friendly' group of contenders pressuring for changes leading to lower premiums, and trade unions and other groups taking a 'social justice perspective'[4]. The tensions inherent in this situation are reflected at both policy and operational levels of the scheme.

In SA, in the early years following the introduction of the 1986 *Workers Rehabilitation and Compensation Act*, there appears to have been a strong focus on worker rehabilitation with a key role for rehabilitation providers. Decision-making supported short term expenditure to achieve longer term benefits for workers and the scheme.

Then the pendulum swung in the other direction and the mid 1990s saw the beginning of an increasing emphasis on short term cost control measures such as constraining access to rehabilitation services, framing of benefit structures to limit access and entitlement, and redemption strategies directed towards the overall financial management of the scheme rather than the welfare of workers[5].

[4] Alan Clayton "Current Issues in Australian Workers' Compensation" in Brian Stanley, Frances Meredith, and Rod Bishop *Review of Workers Compensation and Occupational Health, Safety and Welfare Systems in South Australian Report* Volume 1 December 2002. p2

[5] Ibid pp.3-4. See also Volume 2 of the Report p 51 where the authors note that "The objectives of the South Australian scheme have certainly shifted from long term ongoing support for all claimants to be *restored to employment*, to one which is characteristic of Australian and North American schemes, where for all but the seriously injured, the obligation is

These changes coincided with other changes including outsourcing of claims and rehabilitation management.

The tensions inherent in the scheme and shifts in policy direction and operations have contributed added layers of complexity to an already complex system. There are multiple and competing players with a range of different priorities. In undertaking this research it was frequently difficult to see just where and how these come together to achieve the best possible outcomes for workers and the scheme.

1.8 Is it an adversarial system?

The workers compensation process has multiple decision and review points. This means that there are many opportunities for employers or workers to exercise their rights. However, there are also potentially many trigger points of frustration and disagreement, creating opportunities for the development of adversarial relationships between the players.

These decision points include:

- Will the claim be accepted/rejected?
- Will treatment options offered to the worker be appropriate and timely?
- Will alternative duties be offered if needed and will they be suitable and timely?
- Will the employer be supportive?
- Will rehabilitation services be offered and, if so, when?
- Will home assistance be offered and, if so, when?
- Will the injured worker be able to return to work?
- Will retraining be offered and, if so, when?
- Will a redemption be offered and, if so, when?

While our findings confirmed that there is great potential for the escalation of adversarial relationships, it is also true that conflicts may be avoided or ameliorated by prompt intervention, good communication and respectful negotiation.

Recent reform initiatives

The workers compensation scheme and operational aspects of WorkCover Corporation have been under a process of review and change. At the time of writing this report, the consideration and implementation of some recommendations may be underway. This section provides an outline of key proposals for change identified in the Stanley Review, the Operational Review and other reports relevant to this research. This research project seeks to place its recommendations in the context of these ongoing developments.

1.9 The Stanley Review

In 2002 SA undertook a major review of its Workers Compensation and Occupational Health, Safety and Welfare Systems. The Review Report, frequently referred to as the Stanley Report, was released in December 2002[6].

The Workers Compensation part of the Review made major recommendations concerning access to compensation; entitlements – including rehabilitation and return to work entitlements; provision of high level policy and legislative advice; structural arrangements for claims management; and restructuring of the dispute resolution system, as well as a number of other matters[7].

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to restore the claimant to a condition of 'employability' within a specified period (see Clayton). In South Australia that is currently two years. "

[6] Brian Stanley, Frances Meredith and Rod Bishop, *Review of Workers Compensation and Occupational Health, Safety and Welfare Systems in South Australia,* Vols 1,2 & 3 December 2002

[7] Stanley, Meredith and Bishop Vol 1 pp. 3-5

The rehabilitation and return to work section highlights a number of factors[8], many of which also emerged in our research. These include:

- Competing interests between the welfare of the injured worker and the needs and preferences of the employer.
- Emphasis on early intervention and early provision of rehabilitation.
- Issues with Return to Work plans, return to suitable duties and piecemeal approaches to rehabilitation.
- The importance of the professional autonomy of rehabilitation providers.

The Occupational Health Safety and Welfare part of the Review recommended the establishment of a SafeWork SA Authority as an independent statutory body, supported by an agency, Workplace Services, employing specialist occupational health and safety expertise and bringing together the roles, responsibilities and functions of workplace health and safety into one organisation. The Review considered consultation and participation processes. Its recommendations include provision of wider and more flexible options for advanced training of health and safety representatives; and increased training opportunities for health and safety committees, responsible officers, managers and supervisors and others with responsibilities for occupational health and safety. Further recommendations addressed protection of people in the so-called 'new labour market', workplace bullying and valuing diversity in the workplace[9].

A number of these recommendations align with our own findings and conclusions.

1.10 Further developments

Following the Stanley Review, WorkCover commenced a range of internal projects including: development of a model for improved Rehabilitation and Return to Work (2003); development of draft Vocational Rehabilitation Principles of Service Delivery (2004); Category A standards for claims agents (2004); and a Review of the scheme's operational and administrative performance (May 2004).

1.10.1 An improved Rehabilitation and Return to Work model

The model for improved Rehabilitation and Return to Work[10] is built on an understanding that instead of trying to 'bend' the injured workers and employer to fit an administrative system, the system should pro-actively adapt to each case. The Paper proposes a new model which has:

- A focus on the injured worker and the employer rather than the claim process
- Early reporting of claims and early face-to-face intervention
- Early risk assessment, including RTW and psycho-social risks
- Coordinated, constructive and frequent communication between all parties
- Establishment of common goals and targets, understood by all (p.3)

1.10.2 Category A standards

Category A standards are part of performance measurement in the contract between WorkCover and agents. They focus on ensuring early intervention in the management of claims with the aim of sustainable return to work. The Operational Review, see below, suggests there are some problems with some of the standards, in that they may be subjecting workers to low value 'sausage machine' plans and programs to comply with process deadlines, rather than focusing on outcomes.

[8] Stanley, Meredith and Bishop Vol 2 pp. 33-46
[9] Stanley, Meredith and Bishop Vol 1 pp 5-9
[10] WorkCover Corporation Stakeholder Discussion Paper *Towards an Improved Rehabilitation and Return to Work Model in South Australia* December 2003

1.10.3 Operational Review

The *WorkCover Operational Review*[11] was initiated to look at the scheme's performance, WorkCover's role in administering and directing the scheme, the performance of claims agents and the robustness of WorkCover's information and business systems. The Review Report was released in June 2004, just prior to the completion of this research project.

The review team identified a failure in all key relationships in the claims management model – ie. between WorkCover and claims agents and between claims agents and medical and rehab providers (p 31-36).

The publicly released report presentation highlights the importance of the relationship between WorkCover and claims agents and the need for WorkCover to strengthen its contract management to ensure a stronger focus on outcomes and accountability. Other report recommendations relate to:

- Prioritising (triaging) claims to focus efforts on higher risk claims
- More individually tailored return to work (RTW) plans for injured workers
- More timely use of Section 58B powers to require pre-injury employers to provide alternative employment
- More effective and coordinated enforcement of the review of entitlements when a claim reaches two years duration
- Removal of the use of lump-sum payments (redemptions) to close-off claims
- The need to overhaul current levy-setting arrangements.

Finally, there is a large scale review of Exempt Employers in the pipeline. This will look at some issues regarding standards of practice and monitor these. This work was reported to the WorkCover Board in August 2004.

Implications for this project

This small research project sits, therefore, in the midst of a great deal of complexity and change.

To address these factors we have:

- put some clear boundaries around our project (for example, we have concentrated on claims, rehabilitation and return to work, rather than the broader issue of occupational health and safety).
- recognised that it is a work in progress rather than a definitive piece of research.
- Fore-grounded the experience and voices of injured workers.
- sought to develop our recommendations in the context of new directions and initiatives.

[11] Bill Mountford and Chris McEwan *South Australian WorkCover Restoring Claims Management Excellence – Final Report* May 2004

Chapter Two: Methodology

The research methodology for this project evolved over time in response to information gleaned from the literature review, the availability of meaningful statistical data and logistical issues of access to injured workers and dissemination of surveys. However, some features remained constant. These were:

- The central focus of the project was on the experience of the injured worker.
- The experience of the injured worker was situated on a broader canvas drawn from perspectives of a range of other key stakeholders. These included employers, health and safety/rehabilitation coordinators, claims agents, unions, health and safety reps and trainers, rehab providers/consultants, injured workers' support groups, WorkCover employees and members of the project's steering committee.
- There was a mix of quantitative and qualitative methods, but there was a primary emphasis on qualitative data. This data was derived from interviews, open ended response opportunities in surveys and a literature review.
- The experiences of both men and women were sought to understand both the commonalities of their experience as well as to identify any gendered differences.

2.1 Key components

The key components of the research undertaken were as follows:

- Injured Workers' survey
- Health and Safety Representatives' survey
- Employers' survey
- Interviews with injured workers (mainly face to face, but a few by phone)
- Interviews with other key stakeholders (see above)
- Attendance at relevant meetings and focus groups
- Review of relevant Australian and international literature
- Review of available statistical data.

2.2 Research principles and understandings

The following principles and assumptions informed the conduct of this research project:

- Qualitative and quantitative research methods each have their limitations and strengths and are both important components of this project
- Quantitative research is effective for indicating patterns and trends and broad generalities.
- Qualitative research is effective for probing beneath the statistics to identify motivations, emotions, effects and preferences.
- The stories people tell are important – they put flesh on the bones of larger scale quantitative data collection.
- Qualitative research emphasises the socially constructed nature of reality and asks questions that explore how the world is seen by the respondents

within the context of everyday life. This approach is especially important in exploring women's experiences, needs and views which have traditionally been under-represented or 'washed out' in analyses which ignore the frequently gendered nature of social relations.

- Multiple interpretations of the same circumstances or 'event' are possible and 'colliding paradigms' may be used to explain and justify different points of view. These must all be taken into account in describing the bigger picture.
- There must be critical reflection about the interaction and impact of the researcher and the research process on the findings and conclusions.
- There must be sensitivity to contradictions ie. data that does not 'fit' into the preconceptions of the research design. Similarly, there needs to be sensitivity to silences ie. issues that are not spoken.

2.3 The injured workers' survey

620 surveys were distributed to injured workers as follows:

- 200 by WorkCover,
- 150 by a large union,
- 158 by four large metropolitan and two smaller rural employers (several Aged Care and Disability Services agencies, a large cleaning contractor and an apprentice training organisation)
- 97 by two injured workers' support groups, and
- 5 people responded to advertisements placed in a Union newsletter and *Newslink* [12]

With a few exceptions, the survey was distributed to workers who'd had a claim (closed or ongoing) in the last 5 years and which was, initially at least, based primarily on a physical musculoskeletal injury. There was a mix of gender, age, occupation, ethnicity, claim status and people who had partially, fully or never returned to work. Most of the surveys went to people who had more than 10 days lost time and the responses had a good mix of shorter and longer-term injuries.

The survey was distributed to people across a range of industries and also incorporated a cohort of aged care/disability workers.

Surveys were distributed with a covering letter from the Working Women's Centre and returned anonymously to the Centre in a reply paid envelope. The research team did not have access to the names or any other details of those receiving the surveys.

The survey focused on injured workers' perceptions of the quality of help received, workplace responses and the WorkCover process. It comprised 28 multiple choice questions using a 5 -point scale (with an invitation for additional comments) and five open-ended questions. In addition there were four YES/NO questions specifically for people whose first language is not English. The Survey and covering participants' letter are attached as **Appendix A.**

[12] *Newslink,* November 2003 (WorkCover's newsletter for Large Workplaces and Health and Safety representatives). These advertisements were informing readers about the project and inviting interested people to be interviewed. Five of these people also requested the survey.

Returns
123 responses were received – a response rate of 34.3%. 60 of these responses were from women, 56 from men and 7 from people whose gender was not stated. See **Chapter Six** for a more detailed description of the sample.

2.4 Health and Safety Representatives' survey

The survey was designed in consultation with Sally Mitchell, (Workplace Liaison Officer, WorkCover), and members of the project Steering Committee. It canvassed health and safety reps' perceptions of workplace policies and practices relating to work injury and rehabilitation, the role of HSRs in the workplace, training for HSRs and other strategies for improving return to work outcomes for injured workers. There were 12 multiple choice questions using a 5-point scale (with an invitation for additional comments) and three open-ended questions. (The Survey and covering letter are attached as **Appendix B**.
One hundred surveys were distributed by the Workplace Liaison Unit – 58 at meetings in metropolitan Adelaide and 42 in Ceduna and Port Augusta. 20 responses were received – a return rate of 20%. As with the Injured Workers' Survey, surveys were returned anonymously in reply paid envelopes to the Working Women's Centre.

2.5 Employers' Survey

We also surveyed employers to supplement information we had from interviews with employer organisations, management and OH&S coordinators. Fifty medium and large non-exempt employers across a range of industries were chosen from Business SA's database, with surveys being returned anonymously to the Working Women's Centre. The research team did not have access to the names or any other details of those receiving the surveys. The survey canvassed views on the fairness of the Workers Rehabilitation and Compensation system and legislation in SA, the factors that most help and hinder sustainable return to work, workplace cultures, difficulties facing employers and desired reforms. It comprised 11 open-ended questions. Nine responses were received, an 18% return rate.

This survey is attached as **Appendix C.**

2.6 Interviews with injured workers

Twenty two injured workers (11 male and 11 female) were interviewed, with most interviews lasting about an hour and a half. Four interviews were conducted by phone and the remaining eighteen were face to face.
Interviewees were found in a fairly opportunistic manner – some through injured workers' support groups, some in response to invitations in newsletter notices, some via employers and some were people who had been selected for surveying (see 2.3 above) and took up the invitation to be interviewed. It is probable that all those who agreed to be interviewed felt strongly about the topic and to some extent the sample may therefore have had a bias towards people who felt aggrieved. This bias is acknowledged. However, the researchers also felt that it was important to give a voice to these people who felt the system had let them down. It is also likely that those referred by employers probably counter-balanced the sample to some extent, in that they were unlikely to select people known to be strongly dissatisfied with their employers or the system.

Workers interviewed were from a range of industries including a small cohort of aged care/disability workers. All had lost time due to their injury and several had been unable to return to work at all. Several had taken redemptions. Most had back, shoulder and muscle strain injuries. Some had been with the same employer for years, some for a shorter term; most had been permanent employees, while a few had been on contracts. Their ages ranged from the 20s through to the 60s, with most being in their 30s and 40s.

Questions covered the experience of being an injured worker, focussing on home life, issues surrounding self-esteem and relationships, workplace practices and the rehabilitation and return to work system. Two questions probed negative and positive aspects of their experience. See **Appendix D** for the questions used as the basis of the interviews with injured workers.

2.7 Interviews with key stakeholders

In addition the following key stakeholders were interviewed:

- Quality & OHS Coordinator from a large cleaning contractor
- Injury Manager, large cleaning contractor
- A Union organiser and members of this Union's campaign committee
- Industrial Officer & three shop stewards from another large Union
- Union officials from another Union
- Two advocates from different Injured Workers' support groups
- Consultant at Business SA
- Executive Officer of an Industry Committee, Business SA
- An OHS coordinator from an apprentice training organisation
- An Injury Management Adviser from one of the claims agents contracted by WorkCover
- Senior Injury Claims Consultant from one of the claims agents contracted by WorkCover
- A technical adviser from one of the claims agents contracted by WorkCover
- An admin support staff member from one of the claims agents contracted by WorkCover
- Injury management coordinator from Disability services organisation
- OHS Coordinator from another Disability Services organisation
- Rehabilitation/OHS Coordinators from three large Aged Care organisations
- Workplace Liaison officer, WorkCover
- Two WorkCover OHS consultants
- Two consultants from WorkCover's Access and Equity Unit
- Two staff from WorkCover's Scheme Liability Unit
- General Manager, Scheme regulation and Compliance, WorkCover
- Manager Employee Advocate Unit, WorkCover
- Senior Rehabilitation consultant & marketing manager from a large Rehabilitation provider
- An independent Rehabilitation consultant
- OHS Manager from a manufacturing industry
- A Health and Safety Trainer responsible for training health and safety reps
- Representative from Rehabilitation Providers Association
- Conciliation and Arbitration Officer, Workers Compensation Tribunal.
- Director of the Working Women's Centre.

Interview approach

Appropriate information about the project was given to the interviewees in advance. Confidentiality was assured. While the interviews were semi structured (ie. the researchers had defined in advance areas of interest), they also included a number of open ended questions and prompts which invited participants to explore their own avenues of experience and perception. Participants were asked if there were any issues that they felt were relevant that had not been raised during the discussion. Injured workers were given a small gesture of appreciation of their co-operation (a movie ticket or chocolates) and were entered into a draw for a $50 department store voucher. Interviews with injured workers were generally conducted in the Working Women Centre or the worker's home.

It was decided it was not realistic to try to 'cover the waterfront' in interviews, nor to replicate information that was available elsewhere. Rather, it was decided to be focussed and thorough in exploring at length certain emergent themes.

2.8 Attendance at meetings and focus groups

In the early days of the project the research team attended the following meetings and focus groups largely as an orientation to the key issues and stakeholders and as a way of establishing further useful leads to pursue. These meetings were invaluable in providing the 'lay of the land'.

- WorkCover Scheme Liability Group forum
- SAfer Industries consultants meeting
- Injured Workers focus group
- Rehabilitation and Return to Work consultants and claims agents focus group
- Women's Focus group
- Working Women's Centre Management Group
- Aged Care Industry OHS Working Party meeting.

2.9 Review of literature

The research team reviewed relevant Australian and international literature. This included research reports and reviews, conference papers, websites, articles and books. The literature specifically on return to work is very limited and the material on women and rehabilitation and return to work even more so. There was very little contemporary Australian material exploring psycho/social issues associated with work injury and return to work. On occasion, our review extended beyond rehabilitation and return to work to encompass broader gender and work and occupational health and safety issues, when these seemed as if they might illuminate our research question. However, we did not do a comprehensive review of these related areas. For a summary of our literature review, see **Chapter Three and Appendix E.**

2.10 Review of available statistical data.

We reviewed available statistical information from the National Occupational Health and Safety Commission, WorkCover's Statistical review, and other sources such as the *Statistical Profile of Women in South Australia*. WorkCover also generated some additional statistical information for us. We were able to make use of some relevant statistical data from New South Wales. For a fuller discussion of the statistics that informed our project, see **Chapter Three.**

Chapter Three: Context

This chapter describes the available information, both statistical data and qualitative research, which helped to shape our project design and inform our conclusions and recommendations. It was felt that this would provide a good contextual framework for our findings from surveys and interviews.

3.1 Statistical information

The project team reviewed available South Australian data to identify any patterns or trends to inform our understanding of work injury, rehabilitation and return to work and any differences and similarities between men and women in these areas.

However, we found that this exercise was fraught with difficulty, because of limitations of the data available in the public domain and the relatively unsophisticated level of statistical analysis applied to such data.

This section of the report briefly outlines the information we have gathered; it discusses some of the difficulties in interpreting such data without more sophisticated analyses; it notes some current promising developments and makes recommendations in support of these.

3.1.1 Workforce participation, paid and unpaid work

ABS 2001 workforce data[13] provided a useful national backdrop to our research questions and findings. There were three major points of particular relevance to us, underscoring the need to be aware of a range of factors that impact on the health of workers. These were:

- Since Oct 1991, the number of persons employed part time increased by 51%. (2.6million in Oct 2001)
- Female workers account for the majority – 71% of the supply of part-time labour.
- Women aged 25 –54 account for almost half of part-time workers.

The recently released *Statistical Profile - Women in South Australia*[14] provides a wealth of information relating to the social and economic position of women in SA. It tells us that women make up just over 50% of the population (2001) and that this is an ageing population.

A significant number of both men and women live in lone person households. In South Australia women make up the majority of these households (82% in 2001) and they account for 85% of lone parent households with dependent and non-dependent children. As discussed later in this chapter the literature suggests that people living in such households are more vulnerable when they experience an illness or injury because of the lack of home/family support. According to national ABS data, in one parent families with children 57% of parents are employed.[15]

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[13] An ABS Labour Force Australia Special Article – *Full time and part –time employment* (Oct 2001)

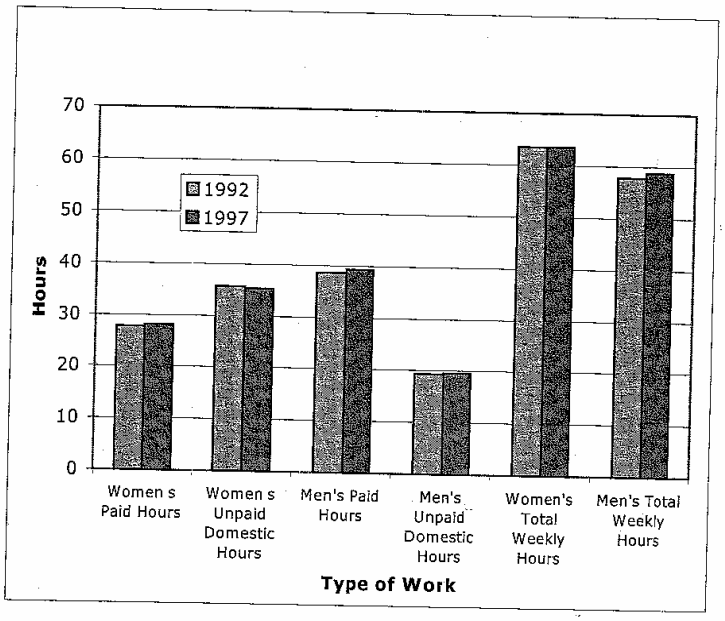
[14] *Statistical Profile – Women in South Australia* Premier's Council for Women SA Government 2004. Figures presented in this Profile are drawn from ABS Census of Population and Housing 1991, 1996, 2001 as well as other ABS surveys and various government reports.

[15] Pocock, B. 2003, *The Work/Life Collision,* The Federation Press, p.28.

In 1997, 90% of women participated in housework activities (cooking, laundry and other cleaning) compared to 63% of men, and women spent 154 minutes a day on housework compared to 62 minutes for men.[16] There is no information readily available on other household activities such as home and garden maintenance. However, such activities are generally more episodic, more often occurring on a weekly or monthly basis rather than daily. Barbara Pocock draws on national ABS data to graphically illustrate this pattern:

Men's and Women's Paid and Unpaid Hours of Work, 1992, 1997[17].

Figure 2.4 Men's and Women's Paid and Unpaid Hours of Work, 1992, 1997



Source: Computed from data in ABS Cat No 4153.0 and 6291.0.40.001(June 1992 and 1997) applying average male and female patterns of working hours. Unpaid work includes domestic work, childcare, shopping and voluntary work and care

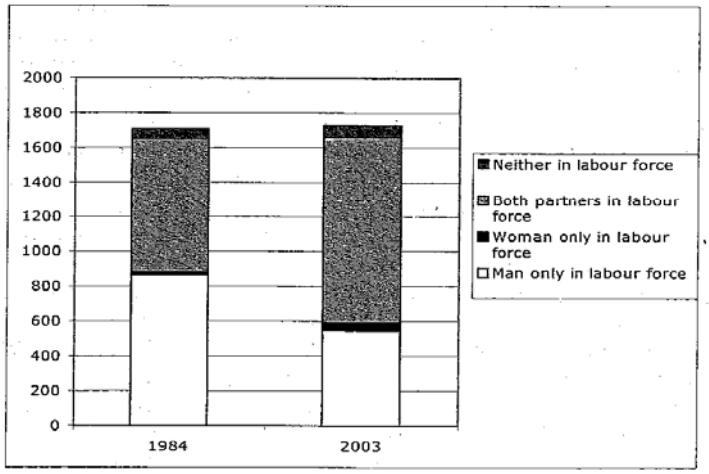
As Pocock concludes from this data, women typically undertake "almost twice as much domestic and caring work as men", and "this imbalance has barely changed between 1992 and 1997 and the segmentation of unpaid tasks remain highly gendered".[18]

There is also a growing trend for both partners in couple families with dependants to be in the labour force. "The traditional male breadwinner family with dependants has been overtaken by the dual income family" (Pocock, 2003, p.28), as the following graph indicates:

[16] *Statistical profile – Women in South Australia*, op cit. p.23.
[17] ibid, p.25.
[18] ibid p.25

Labour Force Participation in Couple Families with Children, 1984 and 2003[19]

Figure 2.5 Labour Force Participation in Couple Families with Children, 1984 and 2003 ('000 families)



Source: ABS Cat No 6203.0 February 2003 and ABS Labour Force Survey data on microfiche for 1984.

In 2001-2002 women made up 44.3% of the South Australian workforce and 32.9% of those people employed full-time. In April 2003 women made up 73.1% of persons employed part time and 57% of casual workers (i.e. workers without holiday and sick leave entitlements). Working women are concentrated in health and community services, the retail trade, education and property and business services. Working men are heavily concentrated in manufacturing, with significant numbers also employed in the retail trade, property and business services and construction (*Statistical Profile*, p.27). The *Statistical Profile* does not present figures with a break-down by occupation.

These figures all highlight that women continue to carry the major burden of unpaid housework and child care, in addition to an increased rate of participation in the paid labour force. This data is a factor to be taken into account in effecting socially responsive rehabilitation and early and sustainable return to work.

3.1.2 Relevant WorkCover statistics

A snapshot

The number of claims in 2000-2001 incurred by males employed by exempt/self-insured employers was 8,550 and by non-exempt employers was 21,580. For females in that year the figures were 5,140 and 7,400 respectively. Figures are not published on the numbers of males and females employed by exempt and non-exempt employers[20].

[19] ibid.p.29

[20] These and other figures on injuries and claims are taken from WorkCover Corporation *Statistical Review 2001-2002*, unless otherwise footnoted.

The numbers of income maintenance claims in 2000-2001 incurred by males employed by exempt employers was 1,230 and by non-exempt employers was 3,690. For females in that year the figures were 950 and 1,700 respectively.

One of the interesting questions arising from these figures relates to the relatively higher proportion of women injured and with lost time injuries who were employed by exempt employers. This correlates with the high concentration of women employed in the health and community services industry – particularly as enrolled or registered nurses or care workers. For non-exempt employers, lost time injury claims for females are concentrated in occupations such as commercial cleaner, personal care assistant and aged or disabled person carer.

In 2000-2001 the main nature of injury/disease as a percentage of total claims and total claims cost was sprains and strains for both males and females.

The WorkCover *Statistical Review 2001 – 2002* looks at expenditure on rehabilitation and the proportion of income claims receiving rehabilitation, but it does not break these down for males and females. However, WorkCover did provide us with this information and also with figures on home assistance claims.

Below Figure provides an overview of differences between males and females, drawn from these sources.

WorkCover claims and services for men and women over a five year period

	Incurred number of claims[21]		**Income maintenance claims**		**Claims with rehab[22]**		**Home assistance claims**	
	M	F	M	F	M	F	M	F
1999/2000	23,330	7,730	3,841	1,987	2,609	1,450	246	225
2000/01	21,580	7,400	4,111	2,078	2,791	1,534	282	248
2001/02	20,380	7,180	4,364	2,208	3,062	1,656	368	297
2002/03	18,930	6,730	4,402	2.275	3,097	1,760	449	381

These figures indicate that, overall, women incur approximately 25% of claims; 34% of income maintenance claims; 35-36% of claims where rehabilitation was involved; and 45-49% of home assistance services, with the proportion of home assistance for women declining over time. It is important to remember when looking at these figures that women make up more than 40% of the workforce[23].

As it stands this Table presents a limited and potentially misleading picture. It raises more questions than it answers. For example, why do females incur proportionally less claims? Are the rates influenced by the fact that women are concentrated in particular industries and occupations that have less injuries or do not report injuries, or that they comprise a higher proportion of casual

[21] WorkCover *Statistical Review 2001-2002*

[22] WorkCover provided the figures for a 5 year period, giving a male/female break-down, on:

- Expenditure on rehabilitation services (financial year)
- Number of income maintenance claims and claims with rehabilitation services (point in time 31/12)
- Number of claims, number of services and cost of home assistance services (financial year).

[23] *Statistical Profile – Women in South Australia,* p. 19.

workers who may not be aware of their entitlements? Are there age-related variables?

The disproportionate number of home assistance claims for females makes sense, however, because as mentioned before, it is women who are primarily responsible for household activities.

3.1.3 Issues relating to the data

This brings us then to issues relating to the data. Clearly there are gaps and inadequacies.

- WorkCover data is all claims-based and this is therefore hard to relate to workforce data.
- Occupational data to match the occupation categories used by WorkCover is not available.
- There are issues of data reliability and definition which make it difficult to interpret. This is particularly so when it comes to rehabilitation and return to work.
- There are significant differences between data held for exempt employers and non-exempt employers, again notably in relation to rehabilitation and return to work.
- There is a statistical challenge, which remains to be addressed in published statistics, in presenting meaningful data relating to small sub-sets of people.

These points suggest firstly the need for comparable workforce data so that it is possible to look at rates, rather then just numbers, and secondly, more sophisticated methods of analysis that can take account of multiple variables. So, for example, in analysing figures such as those presented in Figure 3.3 above, it becomes possible to tease out the compounding impact of variables such as occupation, industry, employer size, nature of injury and gender, and to isolate the impact of gender.

It is our understanding that WorkCover is currently undertaking a project to do just this, using multi-variant analysis. This sounds like a very worthwhile and interesting piece of work and it will be good to see the report in the public arena.

However, it should be noted that a 'problem' with multi-variant analysis may be that in controlling for all variables but one, you end up with a useful but rather blunt picture. You might be able to say something like "if women were working in the same occupations as men then their injury rates would be no different". But a key point is that women *are* clustered in different occupations, and even within occupations they often get the more repetitive tasks, and often they have less power in the workplace. This all adds up to a gender difference which needs to be considered and addressed.

So you need both sorts of analysis to get a more reliable/accurate picture of what's happening in relation to the injury and rehabilitation outcomes for males and females as well as a gendered analysis which examines the picture presented by the key variables themselves.

In relation to rehabilitation and return to work, there is another important potential source of information and that is the data collected by the rehabilitation providers, of which WorkCover utilises a small sub-set. One provider indicated, for example, that it collects data on job placement for males and females, including the outcome rate, median costs and median duration of employment. Another provider referred to the establishment of a national minimum data set on rehabilitation provision which could prove an invaluable data resource in the

future. It will be important that this database provides and reports on a male/female break-down of data collected.

3.2 Literature review

As discussed in the previous section, the research instruments used to provide current local data about gender in relation to injury, rehabilitation and return to work do not provide a well defined picture of the multiple variables involved in the issue.

In addition to the important issue of the need for good local statistical information, it is also the case that much more research is needed about gender and work generally and specifically about workplace health, injury and return to work. Analyses from Europe, the USA and recent work in Australia indicate that gender and the work/life balance is under-researched and constitutes a significant gap in current knowledge about the impact of gender on workplace safety and welfare.

The following is a snapshot of the findings from the literature which most informed the work of this project: A detailed review of the literature which informed our project is provided in **Appendix E**.

- Research in the field to date has placed little emphasis on the processes and interventions that sustain return to work and participation in the workforce (Franche & Krause 2002).
- Physical and injury factors are determining predictors of disability in the acute phase. However, psychosocial factors have stronger predictive values in the subacute and chronic phases of disability (Franche & Krause 2002).
- Characteristics of the work environment, health care and the insurance system all have a significant influence on return to work outcomes – independent of the underlying medical condition and other risk factors (Franche & Krause 2002).
- 'Traditional families' often foster the belief that it is the women's' job to attend to family needs – even when she is in recovery. Multiple role strain may hinder recovery. Social roles and number of dependants need to be taken into account in terms of further research and compensation decisions (Franche & Krause 2002).
- Any analysis of occupational health needs to take account of the relationship between paid and unpaid work (Vogel 2003).
- In Australia, women typically undertake 'almost twice as much domestic and caring work as men', and 'this imbalance has barely changed between 1992 and 1997 and the segmentation of unpaid tasks remain highly gendered (Pocock 2003).
- Injury at work can result in change in jobs or employers, unemployment, or withdrawal from the labour force. Substantial life changes occur, often mediated by the initial attempt to return to employment (Strunin & Boden 2000).
- Paths of re entry to the workforce after injury are of major significance. On a *welcome back* path, workers feel valued by their pre-injury employers. There is a positive effect, even for those who are unable to resume work because of their injuries. On other paths workers feel undervalued, discarded or like

damaged goods. Hostility and resentment is generated (Strunin & Boden 2000).

- Understanding the experience of job re-entry from the perspective of injured workers themselves may help in designing policies that better accomplish the social goal of minimising the substantial economic and non-economic costs of workplace injuries. (Strunin & Boden 2000)
- There is a need for a greater focus on the 'demand side' as well as the 'supply side' of return to work. Information systems are too focused on increasing monitoring of health care providers and financial incentives focused on the RTW process – rather than on outcomes for workers. There is a need to better understand some of the differences between different groups of employees (Gardner & Butler 1998).
- Communication is most important – employers must communicate their need and desire to return employees to productive activity as soon as possible (Gardner & Butler 1998).
- Workforce segmentation is a key factor in claims differences (WorkCover NSW, 1998).
- Part time and casual work makes it less likely that women will report and resolve OH&S concerns. Women are less likely to be represented on committees. Therefore issues that concern women are less known and are consequently under researched (WorkCover NSW, 1998).
- There is strong gender segregation in the labour market. Gender analysis should therefore be built into all monitoring and research on work injury and return to work, and data needs to consider hours worked and the specific tasks and activities associated with the work, rather than simply using job titles (European Agency for Safety and Health at Work, 2004).
- Successful return to work after injury for women of Non English Speaking background may be adversely affected by factors such as stereotypical attitudes, poor communication and inadequate cultural awareness training by those dealing with claims (Mercantile Mutual, 1997).

Chapter Four: Recurring themes: Adding insult to injury?

4.1 Introduction

This chapter summarises some of the key recurring themes which emerged from interviews we conducted with 22 injured workers and a number of other key stakeholders. Many of these themes also emerged in data from our three surveys of injured workers, health and safety representatives and employers. The discussion of themes therefore draws from all of these sources, although, consistent with our central focus on the experiences of the injured worker it primarily draws on interviews with these people. Detailed findings from the surveys are outlined in **Chapter 5** and fully described in **Chapter 6.**

22 Injured workers (11 male and 11 female) were interviewed, with most interviews lasting about an hour and a half. Interviewees were from a range of industries including a small cohort of aged care/disability workers. All had lost time due to their injury and several had been unable to return to work at all. Several had taken redemptions. Most had back, shoulder and muscle strain injuries. Their ages ranged from the 20s through to the 60s, with most being in their 30s and 40s.

The approach used was to ask a set of structured, but open-ended questions about a range of issues relating to injury, rehabilitation and return to work (See **Appendix D** for the questions used as the basis of interviews). Questions covered the experience of being an injured worker, focussing on home life, issues surrounding self-esteem and relationships, workplace practices and the rehabilitation and return to work system. Two questions probed negative and positive aspects of their experience. This method allowed participants to 'tell their story' in their own ways and to give as much or little emphasis to a particular answer as they wanted to.

The injured worker interviewees were 'self selected' in that they chose to respond to invitations to meet with us (see Methodology, **Chapter 2**). This almost certainly means that dissatisfied clients were more likely to want to tell their story than those who have had a successful RTW outcome. We do not therefore, claim that the following issues represent the whole cohort of injured workers and WorkCover clients. However, what is worthy of attention, is that for the people for whom the system has **not** worked well, there are high levels of consistency in reported experience about what went wrong.

Gardner & Butler (1998) have argued that there is often a research focus on providers and financial incentives in the RTW process, yet it is important to understand the 'demand' side of the equation as well as the 'supply' side. With this in mind, they advocate the need to understand more about outcomes for employees. During conversations with participants we had the opportunity to explore the feelings and meanings that people attributed to their experiences of work injury, rehabilitation and return to work. In this context, many different facets of experience were raised.

In terms of understanding more about the dynamics of an unsuccessful process, these accounts are invaluable. They signal possible directions for improving interactions, structures and outcomes. And they offer insights for potentially reducing

the number of long term, unresolved cases. Put simply, if there is to be a customer focus in this area, the 'dissatisfied customer' may well have a vitally important contribution to make about what would constitute better customer service.
In addition to describing recurring themes, this Chapter also identifies Best Practice and Strategies for Improvement related to each theme.

4.2 Putting gender on the agenda

4.2.1 Assumptions about gender

The researchers noted that gender tended to be thought of and spoken about in particular ways. It was common, for example, for people to assume a taken-for-granted knowledge about women having the major responsibility for housework and childcare. And in the same way, there was often a taken-for-granted knowledge about differences in the jobs regarded as men's and women's within the workplace.

Gender was often an unspoken concept and yet its implications were implicit in the experiences being described. One example of this dynamic was highlighted in a worker's description of the ways in which an injured worker returning to work could be humiliated (and, as he saw it, punished). He described, *being put onto the women's work in the factory*. And he felt that this was not only degrading, but also deliberately setting him up for the derision of his (male) workmates.

4.2.2 Women's experiences

Several women who were interviewed mentioned their concern that if they were seen as 'difficult' by their supervisor, they would be given impossible shifts. Uniformly, 'impossible shifts' meant that they could not arrange child-care around them. It was implied that at one factory in particular that shift allocation was a common form of social control over women workers. Further, when participants were invited to describe what they meant by *being difficult,* their answers often revolved around their attempts to negotiate, question, or make suggestions about shift arrangements or possible modified duties that they could undertake.

It was typical in the lives of women interviewees that they had multiple responsibilities at home. These involved children and facilitating the children's busy lives, dealing with adolescent crises, taking the overall responsibility for cleaning and cooking and often caring for a parent or parent-in-law as well. Some had supportive partners, some rarely saw their partners because of different work shifts, some had partners who had minimal involvement with household and child related work, some lived alone, some were dealing with access and/or violence issues and some were single parents. Apart from one interviewee who had decided that she and her husband could manage on his pension, all needed paid work to meet their financial commitments.

In addition to these busy lives, people's actual work duties were often described as intense or pressured and the expectations of what could be achieved seemed to be constantly increasing. (See Barbara Pocock, 2003, on long hours and family unfriendliness[24]). Several women in the course of their answers talked about the importance of feeling part of a group at work. One interviewee explained for

[24] Barbara Pocock, *The Work/Life Collision,* The Federation Press, 2003, Chapter 6.

example, that being with her work mates *was great* because, *you've all got the same sorts of things to deal with and you can have a talk or a laugh about it*. Another made a similar point in describing two different line managers. One of them *didn't mind you having a chat as long as we got the work done - and we'd even sing sometimes.* Yet the next manager *stopped all of that* and assumed that everyone was bludging – *he'd even time our toilet breaks*.

What emerges in these descriptions is that when the workplace represents a form of community and is supportive and trusting, it is an extremely important and affirming aspect of women's lives and sense of contribution. This may be especially so given that social changes in recent years have led to diminished community life in the old sense of the word. Pocock (2003) describes this transformation as 'a shift of community from the street to the workplace' (p.3).

For many of the women interviewed, the idea of connection with others in both their home and paid working lives was an important issue for them. Creating human connection was a valuable contribution that they made in both their home and work spheres. It is this process that Eva Cox refers to as 'providing the social glue in human relations'. Yet this aspect of lived experience does not appear to be defined or regarded as part of workers' health and safety that is recognised or addressed in many of the work sites of the people involved in this project.

On the contrary, some participants were devastated that it was the event of their injury that made them realise how little they mattered to their employer – except as a unit of labour. In the women's stories it often appeared that what started as a physical problem (the injury) had a domino effect, dislodging the fine balance they had worked hard to maintain between their work, domestic, social and community lives. This not only impacted on them physically, but also emotionally and psychologically – sometimes raising issues about their whole identity, role and worth.

> *It's just awful having to sit while my husband does everything. And, he has to do it after a long day at work. It's not right and it puts a strain on the relationship too*.

> *Let's face it, some men have changed, but women still take care of things at home. I love my husband, but realistically, I think I'm doing well if he shifts a carton of milk to get his own beer out of the fridge!*

Such comments are also echoed in the survey results, with 60% of women saying that their home situation was not well understood by people dealing with their case. In addition, only 12% of survey recipients were aware that home support services were available. This is of particular concern given that the inability to care for children and keep their homes clean was one of the most frequent concerns of injured women workers. We also question here the basis on which clients are told, or not, about home assistance possibilities.

4.2.3 Men's experiences

When men described their experiences in the workplace around their injury and rehabilitation it was often in terms of their feelings of loss of identity. It was difficult, for example, if an important part of someone's self concept was in their strength and ability to achieve demanding physical tasks, to find that they could no longer 'be that person'. They felt humiliated when the modified tasks that were allocated seemed to be *Mickey Mouse – not a real man's work.* Similarly, many work hardening options were seen as degrading work. Packing pigs ears for dog treats was one example given.

One interviewee, a factory hand in his fifties, wept as he described not being able to pick up his grand daughter when she ran towards him with her arms open. Another male maintenance worker in his forties described the ways in which his relationship with his teenage daughters had declined since his injury. He felt that pre-injury he had represented their tower of strength – the person who could get things done. But that post-injury he had become *useless* – and difficult to live with because of constant pain.

A particularly distressing interview took place with a worker in the car manufacturing industry. He was in his fifties and revealed after a lengthy discussion that he seriously thought about suicide every single day because he felt so useless and lacking in any hope for his working future. When the interviewer asked whether she could assist in arranging some crisis help, he answered: *No, it's OK, because my religious beliefs stop me from actually doing it, although I've come close.*

4.2.4 Work injury and identity

There is a significant way in which a workplace injury becomes for some people an event that challenges what they thought of as strong working relationships and confronts the ways in which they had established a sense of identity and purpose. Dealing with the injury, as well as these new perspectives about their role, abilities and usefulness, created high levels of vulnerability and uncertainty about the future for many participants.

Conversely, in accounts of workplace experiences that were positive, the descriptions were of the caring nature and responses of colleagues and managers. This was particularly appreciated when there was an interest and concern about how things were going at home and when there was genuine consultation about what would work best on return to work.

One Injury Management Coordinator in a large organisation offered an important insight into this theme of personal engagement with injured workers when she said:

> *The legislation seems blokey to me. Its wording seems to relate to the mechanical side of health and safety – rather than the whole welfare part… what is involved in a person's welfare is just as important, and needs some re thinking.*

4.2.5 Gender Best Practice

- Rehabilitation and return to work policies and practices will take account of work, domestic and community life and gender.
- Front line workers (anyone who responds to an injured worker as part of their job) demonstrate respectful communication skills and a social awareness of relevant psycho social issues surrounding workplace injury. They are trained to be appropriately responsive in this domain.
- Awareness of and sensitivity to gender and work/home life issues become a performance standard required of claims agents contracted by WorkCover.
- Home circumstances and needs are discussed with every injured worker. Assumptions about others (such as friends or family members) taking on additional responsibilities should not be made without establishing the viability of the proposition with the worker concerned.
- WorkCover's information collection is disaggregated by gender and other diversity factors and this information is accurate, current and readily available.
- All programs and policies are assessed according to their potential to either exacerbate or counteract gender inequality. Programs should be analysed and evaluated from a gender perspective.

4.2.6 Strategies for improvement - Gender

- WorkCover's future planning, programs, policy and contractual arrangements should reflect appropriate understanding of and response to gender issues and the pressures involved in balancing work and home life.
- WorkCover's new Rehabilitation and RTW model should adopt a gender-based analysis and any major reviews should take account of work, gender, domestic and community life.
- WorkCover should devise appropriate strategies for ensuring that all relevant people involved in work injury claims management and rehabilitation are adequately trained in gender and work/home life issues and that this is demonstrated and continuously monitored. Specific strategies could include:
    - Training for managers, claims agents, rehabilitation providers and health and safety representatives incorporating awareness of gender and work/home life issues
    - Monitoring of the recognition of gender and work/home life issues at all stages of an injured worker's compensation and rehabilitation process – eg. in checklists, pro-formas and in the performance standards of claims agents.

- WorkCover's Access and Equity's Women's Focus Group supports a research project to establish and pilot a best practice model for the equitable and effective accessing of home support services, in terms of improved outcomes for workers, employers and the scheme.

4.3 Psycho/social issues

Many of our findings related to the psycho /social impact of the workplace injury and these warrant some particular discussion and analysis.

4.3.1 The most difficult thing

One striking theme emerged early in interviews in response to the question: *What was the most difficult thing about the whole experience*? In almost all cases, people's answers related to the psycho/social domain of their experience – rather than to the injury itself.

Overwhelmingly, participants found dealing with the 'system' (and sometimes the workplace as well) to be the most difficult part of the experience.

There was a range of specific issues raised – many of which are also reflected in the injured worker's survey data. (See **Chapter 6**) They included:

- Feeling that your life had been taken over
- Feeling as if you were a criminal – and not believed about anything
- Not being consulted
- Being treated rudely and without respect
- Endless waiting time for things to be processed and determined and then suddenly being told to *jump and keep jumping*
- Confusion about how the system worked and what could/should be expected
- Experiencing the stigma of being 'on WorkCover'
- Experiencing harassment and bullying in the workplace as a result of being 'on WorkCover.'

Often, accounts included a hostile boss or one that would prefer to be rid of them altogether. And sometimes they also included the experience of resentful work mates who may have had to pick up an extra workload – or who may simply regard the injured worker as having it 'jammy' because of alternative duties. In situations such as these the injury was sometimes a trigger for workplace bullying. One interviewee, for example, was given alternative duties that would otherwise have been overtime work for another 'section' of the workplace. He was seen as stealing their opportunity for additional pay, and as he described it, he *was given hell for it.*

Dealing with these sorts of issues as well as an injury and the changes it created in their lives was an extremely stressful experience – and arguably, contributed to poor outcomes in terms of sustainable rehabilitation and return to work.

4.3.2 Intensity of feelings

Some participants were intensely distressed during interviews. They wanted to talk about their experiences - but at the same time, doing so often brought to the surface issues that were extremely painful and difficult to talk about.[25] Many people said things like: *You are the first person that has ever asked me how I felt about it.*

Even more troubling was the number of people who talked about suicide, either their persistent thoughts of it or the times that they had come close to it. One participant, for example, told a researcher that he stood for hours on the curb, watching the trucks drive past – thinking about what it would be like to jump underneath one. His religious beliefs prohibited suicide but he had spent a lot of time reflecting on whether 'falling under the truck' would 'count' as suicide in God's eyes. And he then thought of how terrible it would be for the driver of the truck, and so on, all of which tells us how extensive and preoccupying the thinking was. It is important to note here

[25] Note that the team and steering committee took steps to ensure that crisis assistance was available if needed.

that this interviewee had not told anyone within the rehabilitation and return to work system of his level of distress.

Similarly, advocates in injured workers' support groups told us of several incidents of actual and potential suicides that they believed had resulted from the never ending spiral of despair and conflict that their cases involved some people in.

Although such responses obviously represent the extreme end of the spectrum of WorkCover claimants, they nonetheless clearly signpost the fact that an injury is not simply a physical event that can be dealt with in isolation from the rest of an individual's social and emotional life and context.

In fact, in some cases, it seemed plausible that if the communication strategies and responses had been better, quicker and more personal in the first place, the worker may well not have adopted an adversarial stance at all.

4.3.3 Fight or flight?

Another dynamic observed was that some injured workers had been so alienated by 'the system' and sometimes by the workplace as well, that they reacted in distinctive ways.

One reaction was of withdrawal, depression and passivity – doing what was required perhaps, but taking little part in imagining any possible, positive, future outcomes. Conversely, other people were consumed by anger at the ways in which they had been treated and were determined to fight back.

A more collaborative, personal and respectful process would assist in reducing these responses – both of which regard 'the system' as something to be dealt with, rather than something to work with. Several participants told us that it would have helped enormously if someone early in the piece had met with them and said something like: *We are sorry you are injured and aware of the difficulties it is causing. What do you think would be helpful for your recovery?*

Others expressed similar thoughts with the recommendation that there needed to be some sort of roundtable discussion to work out best possibilities and options, with key players focussed on the worker's injury and rehabilitation as the central issue. All of these statements reflected the feeling that there was no one who was personally involved in their case, and that even when their case was being discussed, it had little to do with their welfare. This theme is also taken up in **Section 4.4,** below.

4.3.4 Just another brick in the wall

One trigger point of negativity for many interviewees was the impression they had that the values attached to the workers compensation and rehabilitation system were about costs and getting them off the books quickly – rather than values of care and welfare. Several participants explicitly commented that the legislation was OK – but the way it was put into practice was terrible.

This sense of being of no importance as a human being was sometimes exacerbated when their manager's attitudes towards them were also cost driven (eg. concerns about the levy or productivity). For some people, realising how little they seemed to matter was a devastating and confronting experience.

4.3.5 Good communication

People often described feelings of isolation. They found themselves cut off from their usual working contacts and unable to be involved in their usual household responsibilities, relationships and leisure activities. This could be especially difficult in regional situations. Extended periods of this way of living were described as very depressing – and as one worker put it: *a nightmare that seems as if it's not going to end.*

It is useful to mention here that any front line worker within the system, ie. anyone who has a role in responding to an injured worker, is influential in contributing to the injured worker's perception of the whole system. A disinterested telephone manner, or lack of information about someone's case when that information had been previously conveyed, caused extremely high levels of frustration and resentment. *Don't these people ever talk to each other?* was a typical remark, for instance. Participants were also particularly scathing about people whom they dealt with in claims agencies who didn't seem to know much about the WorkCover area. They also very much resented what they described as 'power plays', eg. comments like: *You will only get what I say you can have.*

4.3.6 Self belief and the belief of others

Various issues contributed to a diminished sense of self-esteem for injured workers. Some of these are discussed in the gender section, for example, the ways in which identity associated with gender roles and status can be disrupted by the event of an injury and its consequent implications for ways of functioning.

The ways in which others perceived them were very significant to injured workers. It was extremely difficult for people who had a muscular skeletal injury (invisible) when they were either not believed or not taken seriously. This was a particular problem when their rehabilitation was slower than it 'should be'.

Many participants told us that they felt that they were treated like they were frauds by the system and by their workplace even though medical evidence supported their claim. One participant described being told by her supervisor, that: *everyone has a back problem – you just have to get on with it – no pain – no gain.*

In several cases what began as a set of physiological problems developed into stress and depression issues. And such developments seem to contribute to the cynicism and disbelief of other stakeholders.

One interviewee, for example, who was speaking on behalf of employers, saw it in this way:

> *It's not that they necessarily set out to be fraudulent – it's that they become systematised – and everything is supposed to be fixed by the system instead of them taking responsibility.*

Several employers in their survey responses expressed support for the 'genuine' cases, but great frustration with what they saw as rorting, or, as one employer expressed it: *using the system as a welfare system or an opportunity for a career change.*

These views exemplify one aspect of the colliding paradigms that are in play in the arena of rehabilitation and return to work. Undoubtedly, as with all systems, there will be a minority of 'cheats'. However, it seems that this explanation is applied by some Claims Agents' staff and some employers' claimants whose rehabilitation outcomes do not match hopes and expectations. As many injured workers pointed out, this situation is not helped by the sort of 'beat up' stories that appear in the media from time to time.

Injured workers who experience distrust or disbelief can have their self-esteem and sense of identity so disrupted that mental health issues arise. One interviewee, a forty year old production worker, explained: *I felt I was going mad, I couldn't stop crying.* For her, one of the biggest difficulties, on top of the frustration of the (neck) injury, was that she felt people were suddenly now suspicious of her. People who she thought respected and trusted her might now say something like: *Oh yeah, we saw you at the pub the other night.* She thought that having a workers compensation claim was about as socially acceptable as *having leprosy*.

4.3.7 Best Practice for responding to psycho/social issues

- More supportive attitudes towards injured workers are actively encouraged and demonstrated by Claims Agents and within workplaces.
- The loads of case-workers are reduced, enabling more personal responses.
- Key players who contribute to the rehabilitation of injured workers are appropriately trained and have good communication skills.
- The system has a customer focus.
- The system becomes efficient and collaborative.

4.3.8 Strategies for improvement in the psycho/social domain

- Key players who contribute to the compensation and rehabilitation of injured workers are trained in, and demonstrate, respectful communication skills and an understanding of psycho/social issues related to workplace injury.
- Case-managers' case loads take into account risk categories and differing levels of complexity, and ensure that case managers have the time to communicate adequately with all clients and address their psycho/social needs.
- The rehabilitation and return to work model gives more consideration to the concept of return to the community as an appropriate outcome for injured workers who will not realistically return to paid employment.
- That the concept and benefits of a psychologically safe work site should be widely promoted, including recognition that returning to work on modified duties can be a trigger for hostility or bullying.
- The Access and Equity Unit undertakes to monitor performance to ensure that the information needs of injured workers from identified equity groups (women, Aboriginal and Torres Strait Islanders, people from culturally and linguistically diverse backgrounds and workers with disabilities) are met.

Case study 1

Janet: Health care worker, aged 36.

The hardest thing for Janet has been the impact on her home life and her family. When helping to lift an elderly patient, Janet suffered a severe shoulder injury, which resulted in an operation, ongoing severe disability and pain. This experience completely changed her life.

Janet describes herself before the work accident as someone who was assertive, very fit and active and with heaps of energy. She is a mother of three young children and had been involved in their school sporting and other activities. She had worked as an enrolled nurse four days a week. She ran the household, organising everyone, paying bills, cooking and cleaning. She looked after a large garden – her pride and joy – engaged in an active social life with her husband and was involved in fund raising for charity. At weekends the whole family often went to a local horse-riding club where she and her husband could go off riding and there were supervised activities for the children.

Janet was living a busy, rewarding and fulfilled life. And all that changed. Her world was turned on its head. She entered a cycle of drugs, pain and lack of sleep.

Janet talks about how she felt like she was a different person, someone who was always sitting down and who was grumpy, snarly and snappy or always apologizing. She describes her loss of self-confidence and self-respect, the breakdown in the household organisation, the frustration and disappointment of her children when she could no longer engage in kicking the footy or help them with homework. She didn't want them bringing friends home to play.

She says how hard it is to see the house in disarray and the garden neglected – to overhear disparaging comments from neighbours. Janet describes how hard it is to give over the managing of her jobs to someone else and the battle she has with herself to let others help. She doesn't want her husband to have to do 'her work'. Janet talks about the pressures on her husband and the huge impact on all aspects of their relationship. She says she is amazed that her marriage has survived.

On top of all this there is the problem of managing the pain and the pain medication – the drowsiness, not being able to drive while on medication, and worrying about addiction. Her colleagues and friends have inferred that she is emotionally disturbed because the pain hasn't gone away.

Janet has struggled on now for some three years. She is back at work on a very part-time basis. She has attended the Pain Clinic at Flinders Medical Centre and this has been a turning point. She controls her medication, makes time for meditation and focuses on getting through just one day at a time. She has taken on board a key lesson from the Pain Clinic – trying not to push too hard. Janet is rethinking her life. She says she can now take some positives from the negatives. She is a more reclusive, but much stronger person. Her husband and children can acknowledge her bravery.

Janet has now taken a pay out, even though didn't want it – she says she just couldn't 'hack it any more'. She is still coming to terms with needing to completely reframe her view of herself and her life and is finding this a really hard and challenging thing to do.

4.4 Colliding paradigms

Many people in the field have talked to us about the mismatch of paradigms that underpin the injury, rehabilitation and return to work scheme. On one hand there are the values of commercial profits. On the other, there are the values of health, welfare and rehabilitation. As the Operational Review has noted this has not worked well in practice. In particular, the differences have played out in the area of short term action rather than longer term planning and thinking. There are instances of different paradigms at work that undermine the intention and spirit of the Workers Rehabilitation and Compensation Act. One such example was of a female worker in her thirties, who being keen on fitness and on doing what she could to strengthen her injury, began to do some gentle rowing activity. This had been suggested by a physiotherapist. However, when she met with her lawyer in relation to the case, he was horrified that video evidence existed of her rowing activity – which would 'not be helpful to her case'. He advised that she should stop any such rehabilitative effort immediately.

See Diagram 2 on the following page for a representation of the often competing and complex issues for the key players involved in work injury. Diagram 3 illuminates these issues by encapsulating them in a series of 'typical' responses by key players to work injury. *Note:* Inevitably these comments cannot represent the range of different views expressed. They are, however, indicative of common recurring themes.

4.5 Workplace culture

It was clear in our findings – and especially emphasised during interview discussions, that the workplace culture made an enormous difference to workers' rehabilitation and return to work experience. When bosses or managers had been supportive and flexible – particularly if they had taken a personal interest in how things were progressing – workers felt hugely encouraged. Similarly, if co-workers were accepting of work 'accommodations', the injured worker seemed to be able to sustain their sense of being a valued part of the group, despite their injury. They were certainly motivated to achieve a successful outcome.

Two interviewees, who happened to work in the same aged care organisation, could not speak highly enough of their workplace and of a particular OHS coordinator within it. The fact that he had rung them at home to ask whether they needed any help was a point that they both independently reported as being really special. Accounts such as these, highlighted how important it is for people to feel that they matter.

> *He [OHS Co-ordinator] was a sounding board and always willing to give answers. He always knew what to do. He was accessible. A soon as he had all the forms he rang me to see how I was. My immediate managers also rang me to enquire about my welfare.*

Key Issues and Competing Interests

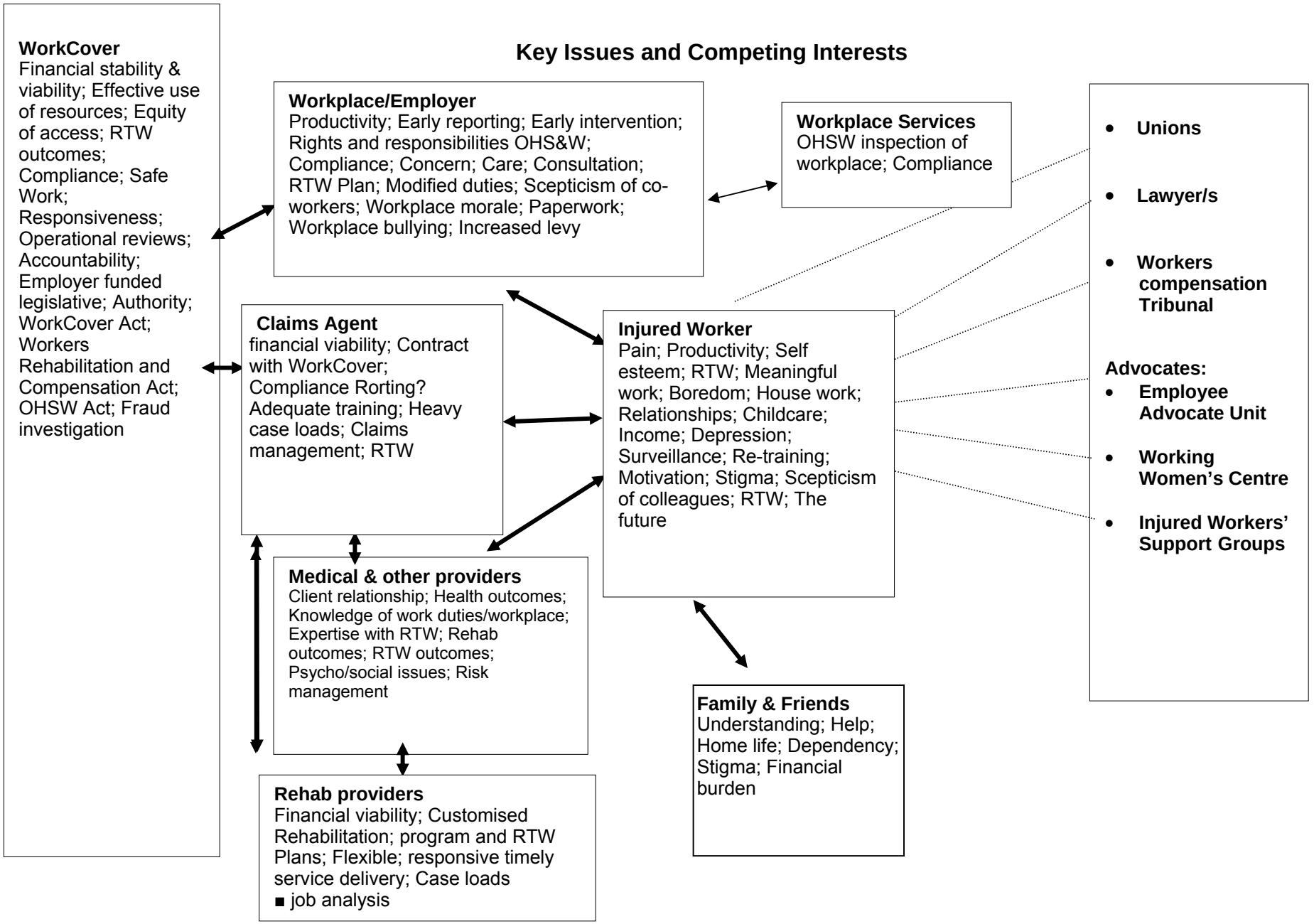


Diagram: Colliding Voices

Injured worker: What is this going to mean for the future? How do I handle all this – pain, future, family responsibilities, money…it feels overwhelming.

Employer: How will we manage the gap without interrupting productivity? I wish the paper work wasn't so time consuming. We'll have to think about what alternative duties we can offer and who might take on the existing workload?

GP: What are this patient's presenting issues? What does s/he most need for his/her overall health at the moment? How can I assist?

Rehabilitation providers: What is likely to be the most effective treatment to get this worker back to work as soon as possible?

Claims Agent: Is this a straightforward claim or are there likely to be complications? What is the most efficient way to move it along?

Workplace Services: What sort of record does this company have in relation to the occupational health and wellbeing of its workers?

Tribunal conciliators: If only some of these issues could have been effectively addressed months ago, we might well have avoided some of these complexities – now they've compounded.

Co workers: It's all very well treating the WorkCover people with kid gloves – but we're the ones carrying the load.

Support Group: I can't tell you how frustrating it is to see people being so ground down by the whole process. Often, they simply need respect, support and to be listened to. Yet so often they feel as if they're being treated like criminals.

Union: Is this a case that needs our intervention? Is this worker a member?

Employee Advocate Unit: Does this injured worker meet our criteria? Can we fit him/her into our caseload?

WorkCover: Are we achieving the goals of the legislation in the most efficient and appropriate ways? Which aspects of the system need attention?

WorkCover's Access and Equity Unit: Are we confident that everyone is able to access the system equitably? Are employers and service providers sufficiently aware of the diverse needs of people from different cultural and social groups?

On the other side of the coin, there were several accounts of what can only be described as ‘toxic workplaces’. Descriptions of what goes on in them indicated a climate of mistrust, gossip, ‘us versus them’ thinking, harassment, threats, bullying and abusive behaviour – and no interest whatsoever in the whole-of-life issues facing any individual worker. This in turn tended to produce anxiety on the part of workers about being seen to ‘step out of line’, or antagonism about the whole enterprise of work and those managing it.

It seems common sense that it is in everyone’s interests to establish positive and collaborative environments and approaches. It is encouraging that work is now being done on what is needed to create more effective work/life social health balances. Barbara Pocock’s work (see **Chapter 3**) contributes to this debate, as does the extensive social commentary of Eva Cox on attributes of a civil society, eg. in her Boyer Lecture on this topic. Taking an holistic approach to a worker’s life is one that the European Trade Union Technical Bureau [for Health and Safety] is also taking very seriously in its agenda for workplace reform. All of this indicates that legitimate space is being created in this area for interested stakeholders.

4.6 Information

4.6.1 Issues

Timely access to clear independent information about the Workers Rehabilitation and Compensation scheme and the claimant’s and employer’s rights and obligations was a recurring theme emerging from interviews with injured workers and supported by the survey findings. Nearly all interviewed workers saw the lack of information as contributing to a feeling of powerlessness and frustration.

Injured workers wanted a sense of the overall parameters of the scheme and how it operates, including what is intended by the legislation. Several indicated they would have liked to have a picture of what options might be available in the future and their likely possible consequences.

They wanted to understand their entitlements and the specifics of these. For example, one worker wanted to know whether she was eligible for a refund on chemist bills and how to claim these. Another indicated she didn’t know she could have received reimbursement for some transport in the period following major surgery when she was unable to drive. Few of the workers interviewed knew about the availability of any home support services. Some eventually received information about home support – but it was often by chance, or some years down the track.

Although there are excellent brochures produced by WorkCover, in many cases these do not seem to have been given to injured workers. A particular gap in information seems to be the services and support, other than medical, that workers may be entitled to.

Few of the workers interviewed voiced an interest in better understanding the different roles of different players. However, the researchers believe it could be helpful for this information to be available, in order to give workers some greater clarity what they can expect from different people they encounter in the process of their claim.

There are some injured workers who have detailed and extensive knowledge of the scheme. This knowledge has often been gained from bitter, hard-won experience and personal research over time. It is not necessarily the information that injured workers want up-front.

Workers wanted information in simple written form and they wanted it early on in the process. Difficulties in accessing information are exacerbated for workers employed in small business, especially for those in regional SA, and also by workers from non English speaking backgrounds.

Our survey data confirmed that NESB workers had particular difficulties with understanding information about their claims, with three quarters of those who responded to this question saying that the information was difficult to understand, and a similar proportion saying that their cultural and language needs had not been well considered by their case manager.

Survey responses from HSRs indicated that they believed workers received adequate information, however. This could indicate that in workplaces where there are HSRs, injured workers do receive timely and adequate information, or there may be a discrepancy between the perceptions of HSRs and injured workers. (The role of HSRs and OH&S Committees is discussed in more detail later in this section.)

Interviewed rehabilitation providers referred to great variability in workers' access to information about the system/scheme and inconsistency in information given. It appeared from their responses that it was very much a matter of an individual's personal judgement as to whether an injured worker was informed about home support options, for example.

The relatively few comments from management supported provision of information to injured workers on their rights and their obligations. Several noted that injured workers found the system difficult to understand. A number of comments suggested that while workers were given information they didn't necessarily digest it. This was confirmed by one of our survey respondents, a woman of Non English speaking background, who said: *It was explained but because of my health I was unable to remember.*

In summary, this is a key issue. It's an issue for women and for men, and it needs urgent attention.

4.6.2 Best practice: Information

- Information is readily available in plain English and other languages about:
  - overall parameters of the scheme and how it operates.
  - rights and obligations of all key players, including employer, claims agent, rehabilitation provider, medical provider and the injured worker
  - Available services and support for which workers may be eligible, including transport, childcare, cleaning and other home support
- Information provided is up-to-date, consistent and timely and provided in a variety of formats
- Major players in the system and Health and Safety Reps refer workers to this source of information.

- Rehabilitation providers/consultants, Health and Safety Reps and unions have a role in ensuring that their clients/injured colleagues understand the information provided.

4.6.3 Strategies for improvement: Information

- That WorkCover review its information dissemination services and materials to ensure that all injured workers routinely receive timely, comprehensive and accessible information about:
    - the scheme and its operations
    - the rights and obligations of all key players, including employer, claims agent, rehabilitation provider, medical provider and the injured worker
    - available services and support for which workers may be eligible, including transport, childcare, cleaning and other home support and re-training opportunities.
- The Access and Equity Unit undertakes to monitor performance to ensure that the information needs of injured workers from identified equity groups (women, Aboriginal and Torres Strait Islanders, people from culturally and linguistically diverse backgrounds and workers with disabilities) are met.

4.7 Early Reporting

4.7.1 Issues

Feedback from injured workers suggests that a key issue in achieving early reporting is the stigma associated with 'being on WorkCover'. Nearly all these workers referred to negative attitudes held by co-workers and the general public.

Some workers also found their employer obstructive and slow-to-proceed. Several injured workers commented that their bosses were markedly reluctant to lodge paperwork regarding their claims. This meant delays in accessing entitlements and some resentment against their employers because of this. One saw his employer as fearful of an increase in levy costs.

> One worker with a severe back injury said he delayed reporting the injury, hoping his back would just get better. Nigel (trade assistant engineer in his 40's) said *I just kept trying to do my job and my boss kept pushing me, until I just couldn't manage to lift.* Nigel reported leaving the job when he felt he just couldn't continue. He says he went to see a lawyer because there was no-one else to give him information or to help him. He believed his situation was more difficult because he lived and worked in a country town.

On the other hand, some workers reported very supportive bosses who acted promptly and demonstrated concern for the injured worker.

Claims agents and rehabilitation providers commented that delayed reporting was a significant issue which must be addressed in order to achieve better outcomes for

workers and the scheme. Some noted that delayed reporting is especially evident where workers are casual or seasonal.

We cannot comment on the size of this problem – and it may not be extensive. However, it would seem that this could be costly for workers, employers and the scheme, where it results in late intervention and the creation of adversarial relationships between injured workers and other parties.

It is therefore important to address what appear to be the two biggest obstacles to early reporting – worker reluctance to report because of workplace and community stigma and employer reluctance to report because of anticipated costs.

4.7.2 Best practice: Early reporting

A workplace environment, supported by employers, managers, HSRs, OHS Committee and unions, which expects and supports prompt reporting of workplace injury and disease.

4.7.3 Strategies for improvement: Early reporting

- An information campaign is developed for employers, unions, HSRs, workers and the community regarding the benefits of early reporting and early intervention regarding workplace injuries.
- Ensuring management, union and HSR training addresses the benefits of early reporting and early intervention.
- Development of employer incentives for prompt reporting and/or disincentives for delayed reporting. WorkCover's current bonus/penalty scheme extends not only to OHSW but also to early reporting and effective return to work and rehabilitation processes to encourage employers to get more actively involved in the workers compensation and rehabilitation system.
- Promotion of the Early Claim procedure to workers, employers and HSRs.

4.8 Early determination and early intervention

4.8.1 Issues

A number of injured workers commented on slow determination of their claims and the stress and strain this placed on them. For some, this was the point at which the adversarial tenor of the whole proceedings was established.

Several workers also reported that they found punitive the expense of reimbursement arrangements, whereby they were often battling over entitlements and/or waiting months for reimbursement of travel, chemist and other costs. This can act as another point in the establishment of an adversarial relationship between a worker and the scheme.

Feedback from injured workers made it clear that if 'early intervention' means 'early/timely engagement of rehabilitation providers', then this doesn't always happen.

Certainly in several of the long-term cases it appeared that engagement of a rehabilitation provider occurred 'down the track'. One worker, who commented very

positively on the rehabilitation role, said this service was *too long coming. It was more than 12 months after the claim*. One of the rehabilitation providers interviewed indicated that some people were not being seen until two years into the period of the claim.

Over the period of a claim stretching for some 2-3 years a worker frequently sees 3-4 different rehabilitation providers. Workers generally experience these changeovers as disruptive. While in some instances, a new provider brought new information and/or a quite different perspective to a claimant, these differences suggest a degree of inconsistency in approach between providers which may be undesirable. Claims agents and rehabilitation providers, especially, agreed that early intervention is the key for sustainable return to work. The majority view is that current arrangements and strategies for achieving this are not adequate. One respondent commented that *the longer the delay, the more the worker feels unheard, not believed, leading to their being less likely to cooperate*.

In some instances, there appears to be a slide in emphasis from early intervention to early return to work. The two terms become synonymous. The key point here, one emphasised by some of the rehabilitation providers, is that appropriate and effective early intervention will result in timely and sustainable return to work.

It is noteworthy that several injured workers (all women) reported active pressuring from their employers to accept an early return to work, only to find that this return was unsustainable. This finding reinforces the point made above. Case managers and rehabilitation providers should be cognisant of this and ensure that the goals for workers in relation to return to work are feasible and sustainable.

A quite different point was touched on by some injured workers and rehabilitation providers relating to the complex issue of return to the community vis a vis return to work. This was not an issue explored by the project but it appears that there are different views on how ‘return to the community’ should be interpreted.

It appears to be generally understood by most stakeholder groups engaged in workers’ compensation that ‘return to the community’ is a goal associated with severe/stable injury where return to the paid workforce is absolutely not achievable in the short or long term. However, some injured workers’ support groups were adamant that there was a need for a broader interpretation of this term. The concern of these groups was that some injured workers suffer unnecessary hardship and duress because they are being forced back to work when they are not able.

If the recommendation of the 2004 Operational Review regarding withdrawal of the redemptions option under the Workers Compensation scheme is adopted, the scope of the definition of ‘return to the community’ may become more of a pressure point in the system.

Few managers/employers referred to early intervention and early return to work. This could be because they see responsibility for this resting with the claims agent/case manager.

It may be that managers/employers and injured workers need more information regarding research findings in these areas.

4.8.2 Best practice: Early determination and Intervention

- Workers and employers understand the benefits of early intervention and timely and sustainable return to work.
- There are appropriate incentives in place to support early intervention – for employers, workers, claims agents and rehabilitation providers.

4.8.3 Strategies for improvement: Early determination and Intervention

- Access and Equity Unit's Women's Focus Group consider further research into investigating who should be eligible for 'return to the community' and when and what are the likely costs and benefits to the injured worker and the scheme of extending eligibility.

Please also refer to **Section 4.7.3** above, *Early Reporting Strategies.*

4.9 The Rehabilitation and Return to Work Plan

4.9.1 Issues

A key element in an early intervention strategy is the Return to Work (RTW) Plan. The development of the Plan has the potential to actively engage the injured worker in the return to work process.

However, many of the workers interviewed for this project felt that their RTW plan was not tailored to their particular needs at all and that they had not had anything to do with its design. Some commented that categories of injury were regarded as *all the same* and needing exactly the same treatment. Others saw their plans as *just pieces of paper.* These comments are consistent with the findings of the Operational Review, which describes the current formulaic production of these plans as *the sausage machine approach.*

Some workers commented that the Plans were inflexible and unable to reflect changing situations and needs. These workers saw the Plans as documents that worked against them, not for them. There was no evidence that Plans engage the worker as an active and responsible player.

As a female assembly line worker of Non English Speaking Background said:

> *An injured worker knows what they are capable or doing or not doing. They must be listened to, not made to work with force. Some understanding of fears needed.*

One rehabilitation provider referred to Plans being 'full of jargon' with workers finding them hard to understand. Some providers reported that women particularly 'sometimes forget that their injury goes home with them' and that the restrictions in the RTW Plans 'apply 24/7'. Others commented that the Plans had become 'invoices for services' and documents primarily directed towards compliance and identifying breaches – that is, designed to catch the worker out. Where this is the case Plans become one more plank in the formation of adversarial relationships between the worker and the scheme.

Several rehabilitation providers expressed a clear view that the primary focus of the Plans should be rehabilitation, restoration and, where appropriate, sustainable return to work, rather than early return to work at minimum cost in the short term.

It is apparent that while some aspects of a Plan may apply to work and home life they do not address whole-of-life concerns even when these may be foremost in the mind of the injured worker. This is a challenging issue but one that needs to be addressed.

4.9.2 Best practice: RTW Plans

- The scope and purpose of the RTW Plan is focused on rehabilitation and restoration and is clearly directed to achieving the best outcome for the worker, taking into account the work and home environment.
- The worker and the employer are actively engaged in developing, and agree to, a realistic plan which takes into account the worker's physical and emotional capability; employer/management capability and workplace culture.
- RTW Plans are in plain English, easy to understand and concise.
- RTW Plans can be varied to meet changing needs and circumstances of the injured worker.

4.9.3 Strategies for improvement: RTW Plans

- Revise the format for RTW Plans to ensure they are written in appropriate and accessible language and in various formats.
- Ensure training for rehabilitation consultants adequately addresses the whole-of-life impact of injury, pain and disability on injured workers and their families.
- Ensure that rehabilitation providers can provide and/or refer injured workers for counselling to address whole-of-life impacts of injury, pain and disability.

In the longer term possible review of the legislation so that it can take account of the whole-of-life impacts of injury, pain and disability.

Case study 2

John: Machinist, aged 37.

The worst thing was they thought I was pulling a bodgie.

After regularly being required to work on a machine he had not been trained to operate, John suffered a lower back disc bulge which has impinged on the nerve root and left him unable to return to normal duties 12 months after the injury. He had worked for his employer for many years and had often complained of back pain after using this machine. He felt that the problem could have been addressed with adequate on-the-job training, but that this was an expense the company was unwilling to incur.

John describes the last 12 months as like being on an *emotional rollercoaster.* He has been fighting not only recurring pain, but also boredom. He was totally incapacitated for two months and housebound. This was particularly difficult because he lives alone. Being unable to work has left him demoralised, lacking in direction, feeling useless and at times suicidal.

When the first symptoms appeared John had private chiropractic treatment and when he did not respond to this he was referred for X-rays, a CT scan and an MRI scan. It was only after these tests that he put in a WorkCover claim. He subsequently discovered that his employer had held onto the forms for two months before lodging them.

After the acute phase of his injury was over, John felt that he was capable of partial return to work with modified duties. He very much wanted this for both financial reasons and his self esteem. However John says his employer wouldn't agree to an acceptable RTW Plan.

John feels he has been *stuffed around* by the whole system. The worst part of the whole experience has been not being believed by his boss, by the WorkCover doctor and by the Claims agent – *having someone's else's bullshit accepted over my truth.* In particular, the work-related causes of his injuries were questioned, being attributed to recreational activities. John strongly contests this, claiming that he had always been exceptionally fit. In any case, his Union lawyer has assured him that he has a legitimate claim even if the medical opinion was that his condition was aggravated by pre-existing injuries.

While John's friends have been helpful, John has found coping with his domestic situation very difficult. For many weeks he lived on *Vita-Brits and vegemite sandwiches* because he was unable to go shopping for fresh food for himself (or for his cat). As someone who takes a pride in his home, John has found it very depressing that he has been unable to do housework. He was not at any time offered home assistance and was in fact, totally unaware of its existence until our interview.

John was an active sportsman before his injury, regularly playing cricket and going ten pin bowling. He has been unable to maintain these interests and his social life has been very limited. This has contributed to feelings of depression and loss of confidence.

John did not receive any information at work about the Rehabilitation and Compensation scheme or process. Nor did he receive a brochure or any other information from WorkCover or from his Union. His GP gave him the only information he had. At the time of the interview he had appealed the WorkCover decision and was scheduled for mediation and conciliation. He had very little knowledge of what to expect and did not know of the existence of support groups.

John can't envisage going back to the same employer. He would ideally like a redundancy payout and to be re-employed elsewhere. He would also like back pay for the period when he was living on holiday pay and reimbursement of his medical expenses. In the meantime he awaits the outcome of the Tribunal decision.

4.10 Home support

4.10.1 Issues

The great majority of injured workers interviewed and surveyed for this study reported that they were unaware that home support services were potentially available to them. Several indicated that they heard about these services months after their claim and generally past the time when such assistance would have been most helpful.

This lack of awareness by injured workers regarding availability of home help was also reflected in comments from Health and Safety Representatives and unions.

Rehabilitation providers noted that home help is often not offered and some commented further that they made a judgement themselves about whether or not there were family members who could do the work at home, before raising this option. Their responses are perhaps reflected in the statement: *Some people don't ask for anything, some ask for everything.*

Where workers did receive some home support this was most likely to be for home duties for women and for garden and home maintenance for men. We were not able to explore whether this sort of distinction still applied if a woman or man was living alone or was a single parent. And this may be a useful area for further research.

Several women commented that they thought themselves 'lucky' to have a supportive family. Some women said that husbands were too busy with their work to be able to take on additional home duties, especially where there were added financial pressures because of reduced or lost income over time.

In general, women resented outsider assessment that some other member of the family should take on home support responsibilities.

> One worker who did eventually receive home support waited more than 12 months after the injury. Jane (enrolled nurse in her 30s) has a shoulder injury with nerve damage and severe pain. She has two children. She said her rehabilitation provider negotiated for her to have someone come in to clean the floors, and although this seemed a really good idea at the time, it didn't help as much as she hoped because she, Jane, still had to pick up and tidy first and this was extremely taxing. This, plus the financial strain of paying up-front for services and then waiting 6 or more weeks for reimbursement led her to discontinue the support.

The most evident gap in support services was for childcare. For some the key question was lack of access to support to cover childcare. For other women what they most wanted was a more amenable employer/manager – one who could adapt light duties to fit within the workers normal hours of duty. For example, one woman, Alice (nurse attendant in her early 40s), who had gone to considerable lengths to organise her pre-injury working life around caring for her children and getting them to and from school and other activities etc. found changed shifts/hours of work incredibly disruptive and hurtful.

A complicating factor in identifying what might be best practice in provision of home support for women is the impact on how best to support them in their role as mothers. It is apparent, and not surprising, to find that women who experienced injuries which severely impacted on how they fulfilled their role as mothers, suffered at least as much from this loss, as from any other impact of the injury.

While several male injured workers indicated that having home support for garden and home maintenance would have been greatly appreciated, it seemed a less pressing issue than for women (See **Chapter 3**. Section 3.1.1).

Rehabilitation providers presented a range of views regarding availability of home support and its utilisation. With regard to gender differences, one provider commented that men were generally more willing to accept offers of home help than

women. Several others referred to family pressures and expectations that the woman will do the housework pretty much 'whatever happens' as a factor in women refusing home support. This was seen to be especially the case if the woman had 'an invisible overuse injury'.

Other providers thought that the women themselves were often unwilling to use services, because they were embarrassed that their partners were not helpful. As one provider noted:

> *Generally women continue with the role of being responsible for home duties and child care and this can impact on priorities regarding returning to work. Self esteem can be compromised when some women are seen, or see themselves, as not caring for their family.'*

One consultant commented that she would see women struggle at times with balancing home duties, childcare and returning to work and that greater access to support services would help. For this consultant the claims agents were the barrier because they see services like this as 'cost drivers'.

However, in general, providers maintained that there were no differences between men and women in relation to utilisation of home support services, except in the different nature of the work done at home.

It was recognised by some providers that there would be implications for this component of the rehabilitation service should there be greater recognition of a whole-of-life focus.

4.10.2 Best practice: home support

- Injured workers are fully informed of the potential range of services available to support their effective rehabilitation and return to work.
- Injured workers know about and can access home support services.

4.10.3 Strategies for improvement: home support

- Ensure that injured workers are provided with information about home support services, along with other information about the scheme and the process.
- WorkCover's Access and Equity's Women's Focus Group supports a research project to establish and pilot a best practice model for home support services, in terms of improved outcomes for workers, employers and the scheme.

Case study 3

Erma, Service Industry worker

Erma is in her early fifties and worked in a service industry. Part of her job was handling the laundry of towels sheets and blankets. She was lifting some heavy damp blankets into a commercial drier when she injured her shoulder.

Erma enjoyed working – not so much because of the actual work tasks, but because of the relationships and camaraderie she had *with the other girls.* She felt that they respected her and that she took them under her wing sometimes. One example of this was that when she heard one of them *bad mouthing* another worker, she took her aside and said:

*Now how would **you** feel if someone was saying those sorts of things about you? It's not good when people at work get into that sort of thing, because it just spreads and makes everyone unhappy in the end.*

Erma went on to explain that she had held a managerial role back in Europe, so she understood things about keeping a work team happy.

Her rehabilitation progressed well and she was gradually able to begin resuming her duties. What she found was that even when she had made good progress, her shoulder could only cope with a couple of days of physical work before it started to become very painful again.

She suggested to her boss that if she could work on Mondays and Tuesdays and then take Wednesday off, then work again on Thursdays and Fridays, followed by the weekend off, it would mean that she could give four days without re-injuring herself. She was told that shift arrangements were not for her to arrange just to suit herself and that if she couldn't work four days straight she was 'no use' to him.

Erma thought that she'd have a good case if she wanted to report him – but at about that time her husband was due to retire with a reasonable pension and they decided: *Who needs to put up with that sort of grief, we'll manage without them.*

Although this anecdote has a 'happy ending' in that Erma and her husband were enjoying life and could manage financially, it is an example of the ways in which valuable contributions to the workplace can be completely overlooked and disregarded. As far as Erma could see, there was no logic behind the demand for 'four straight days'. She added: *Perhaps he thought he could get someone younger and stronger.*

4.11 Alternative duties

4.11.1 Issues

The findings of the study reflect what appears to be common knowledge – that for both workers and employers there are significant difficulties relating to provision of alternative duties.

Some injured workers reported that alternative or light duties have not been available, either because the employer was unwilling to identify suitable tasks or because of the nature of the business. In some instances work offered and taken up was unsuitable in that it was not adequately assessed against worker capabilities and led to a second injury.

Several workers said they experienced the alternative duties offered to them as boring and inappropriate. In a few instances workers commented that they believed that their employer/manager deliberately provided work that was 'punishing' in that it was totally isolated from other workers or unnecessarily mindless and repetitive.

One worker on 'light duties', Alice, (nurse attendant), was occasionally placed on a normal shift as a relief worker. Alice said that on these occasions the manager would tell other staff that they would have to work extra hard because she (Alice) wouldn't carry her share of the workload. Alice said that prior to the injury she had been regarded as a very good worker and she found this treatment humiliating.

For workers who have been on shift work, there are often added complications when light duties entail different working arrangements such as different hours of work. Some women with young children reported finding changed hours extremely difficult to manage.

A theme which ran through many responses on this matter related to the workers' sense of powerlessness in being able to have any influence of what they did and when.

Jenny (Service Industry worker in her 50s) said her return to work 'worked really well at first. I worked Mondays and Tuesdays, then had Wednesday off. Then I worked Thursdays and Fridays and had the weekend off. That meant that after two days work I could give it a rest. But the boss wouldn't keep this up, he wanted four days straight from me, and my shoulder couldn't take it. The production manager said 'No pain, no gain'. … When I tried four days straight I was back to square one.'

Ian's (process operator in his 50s) story illustrates the impact on the worker of returning to meaningless, less skilled tasks and the loss of self-respect this entails. It draws attention to a best practice approach, instigated and supported by the employer.

Ian's employer had responded to his injury promptly and effectively in ensuring he received necessary medical and other treatment and an early return to light duties that were identified as suitable to his capacity. However Ian reported that he was depressed during this period, he felt he was doing 'useless work'. Ian said he was eventually referred to a local injury clinic and a work site visit and assessment of his normal job was arranged. This resulted in Ian's employer purchasing a truck to assist him with lifting and in Ian then being able to return to his original job.

Reflecting on this experience Ian said, *the real boost for me came from having someone take me seriously and take an interest in me.* The assessment focused on making recommendations on the best ways to solve lifting problems to help him get better and to be able to do his job. He said*, I felt this was a real turning point for me, things were moving forward at last*. Ian felt that if this demonstration of interest was there at the start, he could have been much better, sooner.

Rehabilitation providers, employers/managers, union representatives and others all referred to situations where alternative duties were not available and the difficulties associated with this. Small businesses, cleaning contractors, labour hire firms and the Aged Care industry were all cited as examples.

Several individuals from these groups commented that some workplaces allow 'Mickey Mouse' jobs that were perceived as deliberately soul destroying. Others indicated awareness that changes in work arrangements such as changed shifts could have a significant impact on workers' lives in general.

Some rehabilitation consultants and OHS Managers noted that alternative duties could cause problems at both points of change. It was difficult for some workers to adjust to new hours of work for light duties, and it could be just as difficult for the worker to adjust back again to previous hours of work. They cited examples where women with carer responsibilities experienced just such difficulties and commented that in some instances they believed this disruption factor was an active deterrent to return to normal duties at work.

Some union representatives noted that there may be special issues for men in blue collar jobs in undertaking 'office job' light duties - jobs which are identified as 'women's work'.

Several rehabilitation consultants and OHS Coordinators referred to innovative approaches in developing job registers to facilitate better matching of jobs and injured workers' capabilities. The intention here is to enable workers to be back at work in a safe environment as soon as possible. As one OHS Coordinator indicated, this sort of approach could provide benefits by 'better matching skills and capability to ensure modified work fits and has dignity.'

Good examples of this approach were provided by two businesses visited for this study, whereby jobs or tasks were analysed, assessed and an illustrated register or log established to enable this matching of injured worker and suitable tasks or jobs.

4.11.2 Best practice: Alternative duties

- Workers and employers/managers are actively engaged in planning early and sustainable return to work. They take account of the worker's prior family commitments where possible, matching tasks and jobs to the capabilities of the injured worker and developing strategies to ensure that the worker can return to normal duties as soon as possible.
- Job/task registers are developed and available in workplaces to support better matching of injured workers' skills and capabilities and alternative duties.
- In industries, businesses or occupations where suitable alternative duties are not available alternative arrangements are in place, to enable the injured worker to obtain work within their capability and in a timely manner.

4.11.3 Strategies for improvement: Alternative duties

- WorkCover policy and practice supports workers and employers being actively engaged in planning early and sustainable return to work.

- WorkCover supports development of job registers in workplaces.
- WorkCover responds promptly and works with employers to find workable solutions to the lack of availability of suitable light duties in some industries, businesses or occupations.
- WorkCover receives early Section 58B referrals when alternative duties are not available and responds appropriately.
- Workers receive appropriate job training/support from their employer if alternative duties are not available eg. language and literacy classes for workers of Culturally and Linguistically Diverse backgrounds.

See also Section 4.12.3 Re-training**, following.**

4.12 Re-training

4.12.1 Issues

The study did not specifically seek information on this topic. However, it was apparent that few injured workers interviewed received re-training. A few workers commented that re-training was discussed and their views sought on possible new careers. However, in several instances this offer was withdrawn and re-training was not offered. One worker was particularly upset about the lack of transparency in the policy and processes of the claims agent in relation to decisions about whether his retraining requests were deemed to be reasonable or not.

One rehabilitation provider noted that re-training was not a realistic option for some workers, especially those in blue-collar jobs. Again the policy guiding such assessments is not clear.

It appears there has been a WorkCover policy preference under the scheme to limit any offers for effective re-training, and instead to 'persuade' workers that a 'pay-out' was the best alternative for them.

> Irene, a worker who undertook re-training tests and a psychological evaluation to assess her suitability for counselling training, said she was then told that the re-training was *too expensive.* Irene said: *After this I felt I had nowhere to go, there were no rehabilitation options open to me and I was not wanted back at work*. She added: *I'm a determined person and I really wanted to continue to work, but eventually I couldn't take it any more and I took a pay-out.*

4.12.2 Best Practice: Re-training

- Re-training of injured workers to enable them to take up alternative job opportunities is properly considered and realistic options are assessed and offered.

4.12.3 Strategies for improvement: Re-training

- It is understood that reforms under consideration are likely to ensure that re-training opportunities are made more available in the future. This policy shift is supported.
- WorkCover develops clear and transparent guidelines regarding access to re-training.
- It may well be appropriate for the Access and Equity Unit to monitor performance in this area to ensure reasonable equity in access to such opportunities.

4.13 Case managers and rehabilitation providers

4.13.1 Issues

Rehabilitation providers

Overall, there was limited comment from injured workers about rehabilitation providers and their role. Those who did comment were mostly positive, with one worker saying that this person did try to help and 'she treated me with respect'.

> Another worker, Ann (aged care worker in her late 30s), said she valued her good relationship with the rehabilitation person and that this good relationship was possible, *because this person knew I was trying*. Ann's impression however was that *she was powerless to act on my behalf. All the power she seemed to have was to write up a report every three months.*

A few workers reported that their rehabilitation provider actively encouraged them to *throw it all in*, to recognise that given the active antagonism of their employer and/or the employer's inability or unwillingness to provide alternative duties they would be better off aiming for a pay-out.

Rehabilitation providers themselves saw their role as being greatly constrained by WorkCover policy decisions which effectively prioritised short term cost control and focused on providers as 'cost drivers' in the system. In general these providers saw their lack of authority and the level of control held by case managers as frequently detrimental to best possible outcomes for injured workers and, in the longer term, for the scheme.

Several responses suggested that there is increasing variability in approach and level of training and expertise among rehabilitation providers and that this variability is particularly evident where complex cases require flexibility in response and careful consideration of the whole-of-life situation of the injured worker.

Case Managers

Responses from workers about case managers were generally negative, reporting them as cold and distant, disbelieving and/or not returning calls. Several workers reported 'not being believed' and/or 'not being listened to' as the hardest thing they experienced.

One worker said he felt harangued – *Why didn't he do this? Why didn't he do that?* Another commented that on one occasion when he went to the physio without asking, when he was in great pain, he *got hauled over the coals*. Ann (nurse attendant), remarked that: *case managers need to have more compassion and understanding and less judgement.*

Rehabilitation providers and others commented on claims agents and case managers having a high level of control over outcomes and as being driven by short-term cost control. They are seen as the gatekeepers to resources, without necessarily having the knowledge to support this role. Considerable variability in practice and the relative lack of training for case managers received frequent adverse comment.

It appears that the case manager's headset is often miles away from the issues that affect workers. For example, one stakeholder explained:

> *If you think of a building site worker with a back injury having a hard time because he is used to being physically strong and his idea of masculinity comes from this. And he's worried about the future and money and the way his relationship with his kids has changed. The case managers are just not equipped to deal with this. They are expected by their boss to keep costs down. They often assume the worker is conning.*

An adversarial relationship between the worker and the scheme can be quickly and irreversibly established from this experience, especially as we found that often workers do not distinguish between WorkCover staff, case managers/agents and rehabilitation providers/consultants, but see them all essentially as part of WorkCover.

In our interviews with workers in one Claims Agency, it was apparent that case managers were working under enormous pressure. They had very big caseloads and were working to challenging performance management benchmarks. They also had to respond to claimants whose issues were often multifaceted and complex, as well as to some individuals who were expressing a whole range of emotional responses towards the system. In addition, they had to deal with a great deal of paperwork and ensure that appropriate documentation from GPs was on track. This involved many telephone queries and discussions.

As they described their working life it was clear that they were often working under great stress, including time pressure, to try to keep their case work up to date. It came as no surprise to hear that there was a high turnover in case-workers. Variations in their work histories may also be relevant here. There seemed to be no requirement, for example, for tertiary qualifications in the human relations or health related fields. Yet these workers were expected to make judgements (and routinely did) about the legitimacy of claimants' stated needs, and, for example, whether claimants would be given information about all support services available.

During these interviews it was clear that some staff were sensitive to the needs of all the different stakeholders and were doing their absolute best to accommodate them

all. However, there was also a widely shared belief that, as one senior staff member put it:

> *…lots of them [injured workers] don't want to go back [to work]. It's often about conflict at work rather than anything being wrong with them. A lot of it is psychological.*

He was referring here to claims that were ongoing after a year or so, rather than to all claimants. But it was a view that strongly influenced how claimants were regarded within the agency.

It appears that once a claimant is viewed as having the 'wrong attitude', there is a great deal of cynicism about that person's needs and requests for support. We were told of a couple of extreme examples of claimants 'trying it on' – and these examples were so 'over the top' as to be amusing. For example, one claimant requested to have the whole house painted and the garden cleared and landscaped.

It is understandable that pressured case-workers would feel frustrated about unreasonable claims such as the one identified above. However one could also question whether subjective 'common sense' judgements about the legitimacy of people's claims are sometimes made by people who may not have all the relevant information with which to make such a judgement. This is a particular trigger point of conflict within the system and especially significant because, as mentioned above, injured workers consistently report that one of the worst things of all is 'not being believed.'

4.13.2 Best practice: Rehab providers and Case Managers

- The rehabilitation role has higher autonomy to give expert advice without pressure based on short term cost control approaches.
- That case managers and rehab providers are more proactive in the interest of workers' rehabilitation and RTW.
- Appropriate workloads for claims officers/managers.
- Qualified, well trained and compassionate case managers.
- Less change/turnover in claims managers and rehab providers.

4.13.3 Strategies for improvement: Rehab providers and Case Managers

- Support proposed reforms which give greater autonomy to rehabilitation providers
- WorkCover standards and contracts ensure claims agents employ adequately skilled and trained case managers who respond to injured workers with greater understanding and respect.
- WorkCover standards and contracts ensure rehabilitation providers employ adequately skilled and trained rehabilitation consultants.
- Claims managers/officers are selected to reflect their client base.
- Severity of injury/injury type are matched with skill set of claims agents.
- WorkCover initiates a project to research and address high claims manager/rehab provider turnover

4.14 Health and Safety Representatives and Occupational Health and Safety Committees

Under the legislation, all businesses with twenty workers or more are required to ensure a process for the election of a workgroup HSR if they are requested to do so, and they are required to establish an OHS Committee if requested to do so. Businesses with less than twenty workers do not have to respond to such requests.

There are over 6,000 HSRs in SA and approximately half of these are women. Representatives are concentrated in medium to large businesses across the public and private sectors and exempt and non-exempt employers. While the great majority of HSRs are located in the metropolitan area, there is fair coverage in regional SA. Nevertheless there are gaps in coverage, particularly in relation to small and very small businesses.

OHS Committees are less widespread, particularly in smaller workplaces.

4.14.1 Issues

Workers interviewed for the project had few comments relevant to the role of HSRs and OHS Committees, and little to say about unions and their role.

It was evident that many of them were in workplaces where HSRs and OHS Committees were not present or not particularly visible or active on RTW matters. This matches gaps in cover (especially for workplaces with less than 20 workers). Feedback from the survey of HSRs and interviews with trainers and others indicated that in practice generally, neither HSRs nor OHS Committees play much of a role in relation to rehabilitation and return to work of injured workers. This role is not spelt out in the Act.

Survey findings suggest that these HSRs are interested in seeing a strengthened role for representatives and committees in the rehabilitation and return to work of injured workers. They believe they could have a significant role in influencing workplace culture to better support workers returning to work after an injury. In particular, there was quite a lot of support for representatives and/or committees being informed about returning workers duties so that they could communicate this to workers – recognising that there are issues of confidentiality and privacy and that the injured worker has to be agreeable to this. Some HSRs commented that they (and the OHS Committee) could help ensure that RTW Plans were adhered to by managers and to reduce co-worker attitudes detrimental to the rehabilitation process.

HSR survey responses were strongly in favour of further training to support this role – for HSRs and others in the workplace, including managers and supervisors. They identified training needs in several areas:

- the role of HSRs and OHS Committees in RRTW;
- employee and employer rights and responsibilities in relation to RRTW and scheme procedures and processes;
- workplace culture and attitudes to injured workers;
- impact on injured workers and self-esteem issues for workers returning to work; and
- depression and how to deal with this in the workplace.

The survey responses also indicated that these HSRs generally see their employers/managers as doing their best. They would like to see WorkCover being more proactive in instances where the employer is not cooperating.

Country areas were identified as needing more support.

The key issues which emerge are the importance of continuing to expand the coverage of HSRs and OHS Committees; articulating and encouraging a more active role for HSRs and OHS Committees in RRTW; and extending training opportunities.

This study did not explore the role of unions in RRTW. It was however evident that where workers were union members they generally sought advice and/or support from that union at some point. Responses from injured workers suggested that in some instances they found this response satisfactory, while in others the response was most unsatisfactory.

4.14.2 Best practice: HSRs and OHS Committees

- All workplaces have at least one Occupational HSR and workplaces with twenty or more workers have an OHS Committee.
- Where an injured worker consents, s/he is actively supported by the HSRs and OHS Committees in their return to work
- HSRs and OHS Committees influence workplace culture to better support workers returning to work after an injury and, where the injured worker agrees, co-workers are informed about the nature of the injury and how best to support the worker in their return to work..

4.14.3 Strategies for improvement: HSRs and OHS Committees

- The Workplace Liaison Unit continues to actively encourage the election of HSRs, especially in any industry, occupation or geographical areas where there are evident gaps.
- WorkCover Health and Safety Consultants, Unions and Business SA, in consultation with Workplace Liaison Unit, actively explore alternative models for provision of HSR and OHS Committee functions for small and very small businesses in metropolitan Adelaide and for regional SA.
- Workplace Liaison Unit, in consultation with Unions and Business SA, articulates the role of HSRs and OHS Committees in relation to RRTW.
- Workplace Liaison Unit works with training providers to develop and introduce extended training opportunities for HSRs and OHS Committees to address:
    - the role of HSRs and OHS Committees in RRTW
    - employee and employer rights and responsibilities in relation to RRTW and scheme procedures and processes
    - workplace culture and attitudes to injured workers
    - impact on injured workers and self-esteem issues for workers returning to work
    - depression and how to deal with this in the workplace.

4.15 Doctors

4.15.1 Issues

Employers and claims agents often reported General Practitioners as problematic in their role within the Workers Rehabilitation and Compensation scheme. More than one interviewee referred to them as *the weak link in the chain*. The most common criticisms were that:

- They did not understand the RTW scheme and legislation
- They were often ill informed about the nature and scope of work tasks relating to their patient's employment
- They tend to give a 'blanket' Prescribed Medical Certificate (PMC) of unfit to work, rather than identifying specific limitations
- They tend to be over generous in the time off work that they prescribe. As one Claims Manager saw it: *they'll often give ten days, when two or three would do it*
- They are too ready to declare an injury as work-related
- And, as one manager put it: *They know the person's 'baggage history' and have empathy with that – this can be a barrier to early return.*

These issues, and perhaps especially the last one, raise broader questions about the underpinning philosophy, practices and priorities of different stakeholders in the system. Injured workers for example, frequently reported that their GP was the **only** one who cared, understood and had their best interests at heart. Yet this is precisely a phenomenon that is experienced as potentially problematic by other stakeholders – as illustrated by the comment in the last dot point.

This paradox highlights again a colliding paradigm in play. If we assume that a GP is making decisions in the best interests of the patient, it is quite likely that psycho/social issues may be a legitimate factor in the health equation and diagnosis. Yet the Workers Compensation and Rehabilitation scheme requires claims to be reliably attributable, clearly measurable, and reasonably predictable in terms of resumed productivity in the work place.
Perhaps this is what one Injury Management Coordinator was referring to, when she said that the legislation was *blokey* and only concerned with the mechanics of the process rather than the welfare side of things.
As discussed in the literature review, this socially constructed work/life separation may not be the most helpful way of thinking about the health of workers and the factors that would encourage the most successful and sustainable return to work. There is clearly room for further debate about these bigger picture issues for future practice directions.
Another comment from some injured workers was that they felt that some doctors and medical specialists were 'in the pay' of the Claims Agent. Clearly we are not able to comment on such a statement. But it is worth noting that there are contested views about who in fact is the client in the whole system.

4.15.2 Best Practice: Doctors

- Meeting and collaboration between rehabilitation providers, doctors, injured worker and employer to ascertain best options and potential outcomes.
- Doctors are aware of relevant workplace tasks and understand the legislation.
- Doctors' judgements would reflect thoughtful consideration of the capabilities of injured workers to participate in alternative duties in the workplace
- Employers and Claims Agents are respectful of doctor's judgements about a patient's psycho /social needs as well as physical ones.

4.15.3 Strategies for improvement: Doctors

- Rehabilitation and return to work could become a specialist competency for some doctors
- Doctors visit workplaces to enable them to make appropriate recommendations re alternative duties and return to work
- Doctors are consulted and approve the RTW plan before it is agreed by all parties
- Interested doctors are involved in workplace training about the health impact of toxic work cultures
- WorkCover initiate research about alternative models of practice involvement for doctors eg. overseas examples.

4.16 Concluding comments

The view of the scheme which emerged in this study is of a system that is fragmented, complicated and often slow to engage. It is an impersonal system that can negatively impact on its clients.

Those with the greatest power in making decisions which affect the lives of injured workers are often case managers, some of whom have little training and may have negative attitudes to the workers they deal with.

Injured workers often experience a lack of respect and complete lack of agency.

The way the system functions frequently sets up adversarial relationships early in the process which act against the best interests of employers and injured workers.

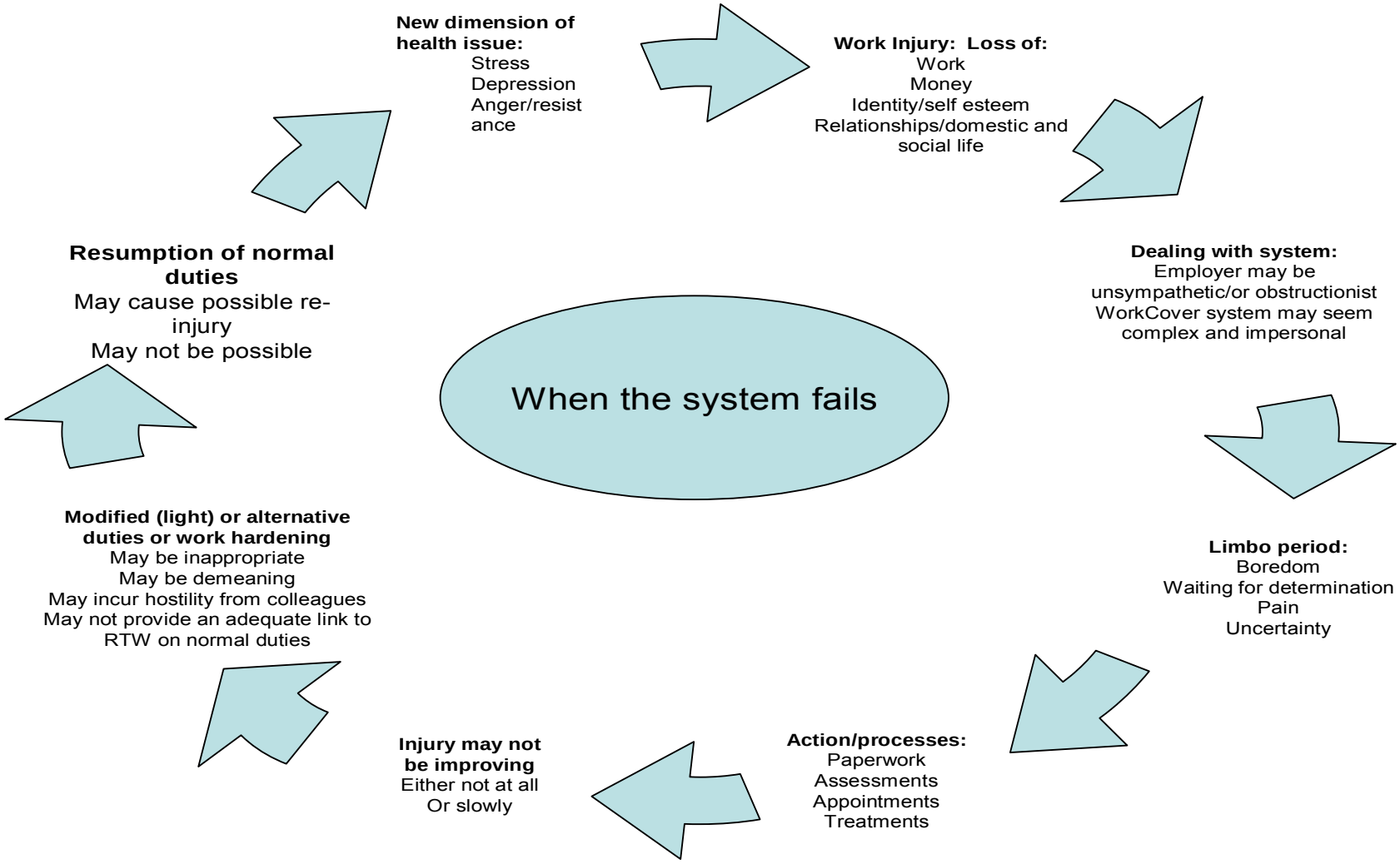
There are undoubtedly always going to be some situations that will prove extremely difficult or impossible to resolve. However, it is our view that the scheme could be significantly improved, and that there are a significant number of ‘cases’ which could be resolved with far better outcomes for workers, the scheme and employers.

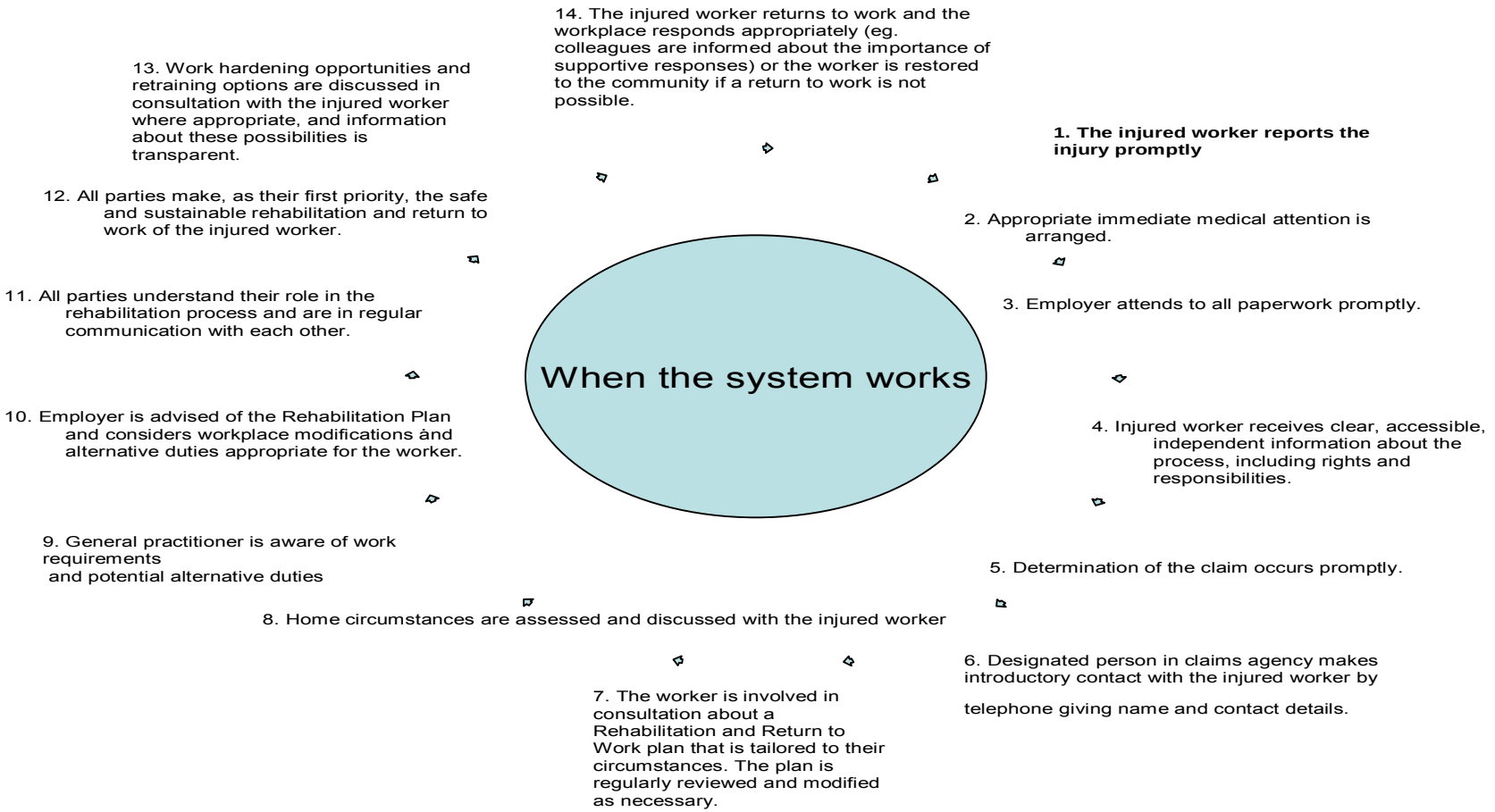
There are some relatively simple changes outlined in the strategies for change, some of which are mooted in recent strategies for reform, which could make a significant impact on the functioning of the scheme.

The material in this section also supports a key theme discussed elsewhere in this report – that is that for many injured workers their injury and rehabilitation it is a whole-of-life experience and current legislation takes no account of this.

Our study and the work of other researchers, eg the European Agency for Safety and Health at Work (2004) argues that this issue is an extremely important one to address.

Our study found a number of examples of good practice. From our interviews with injured workers and key stakeholders we were able to identify what happens when the system works well and what happens when it fails. It became apparent that the system itself was not fundamentally flawed. In theory it is workable and equitable, although there are some areas in which it could be improved. Where the system failed was in its implementation rather than its inherent principles. The following two diagrams summarise what happens when the system works well, and what happens when it fails.


When the system fails
New dimension of health issue:
Stress
Depression
Anger/resistance
Work Injury: Loss of:
Work
Money
Identity/self esteem
Relationships/domestic and social life
Dealing with system:
Employer may be unsympathetic/or obstructionist
WorkCover system may seem complex and impersonal
Limbo period:
Boredom
Waiting for determination
Pain
Uncertainty
Action/processes:
Paperwork
Assessments
Appointments
Treatments
Injury may not be improving
Either not at all
Or slowly
Modified (light) or alternative duties or work hardening
May be inappropriate
May be demeaning
May incur hostility from colleagues
May not provide an adequate link to RTW on normal duties
Resumption of normal duties
May cause possible re-injury
May not be possible



As an underpinning concept, the system works when: *The injured worker experiences support, respectful and clear communication, appropriate information and is consulted about their rehabilitation and return to work process. Simple but important questions are asked of the injured worker, such as, How are you feeling and coping? There is a focus on rehabilitation and a demonstrated awareness of psychosocial issues as well as awareness of the injury.*

Chapter Five: Survey findings at a glance

This Chapter summarises key findings from the three surveys:

5.1 Injured Workers' Survey
5.2 Health and Safety Representatives' Survey
5.3 Employers' Survey.

A more detailed analysis and description of the samples and findings is provided in **Chapter Six.**

5.1 Injured Workers' Survey

5.1.1 Helpfulness of various people/groups

- Comments revealed a strong reliance on **family and friends** for housework, transport, and emotional support, with over three quarters of the whole sample categorising them as *helpful* or *extremely helpful* in assisting their rehabilitation and return to work.
- By contrast, over half the sample rated their **employers** to be *unhelpful* or *extremely unhelpful.*
- Of those who had experience/knowledge of **health and safety representatives** (and many appeared not to) there was a significant level of dissatisfaction with the assistance provided, with almost 45% of the sample regarding them as *unhelpful* or *extremely unhelpful*.
- Respondents were generally quite positive about their treating **doctors**, with over 70% of the sample regarding them as *helpful* or *extremely helpful*. For injured workers their own GPs, especially, were ranked very highly, with many seeing them as the only person outside their family and friends who had their interests at heart.
- Over 45% of the sample characterised their **case managers** as *unhelpful* or *extremely unhelpful* and under a third of the sample saw them as *helpful* or *extremely helpful*.
- **Rehab providers** were assessed slightly more positively by the sample, with almost 40% rating them as *helpful* or *extremely helpful*.
- The sample was fairly evenly divided in their rankings of the helpfulness or otherwise of **co-workers.** The scepticism or hostility of co-workers may contribute to a workplace culture which is unsupportive of injured workers' rehabilitation or self esteem.
- Many injured workers had either not contacted **support groups** or did not know of their existence.

5.1.2 Workplace

- The most telling feature of responses in this section was that 56.1% of the whole sample rated their company's response to their injury as *bad* or *not very good.*
- Reasons for this included: employers' tardiness in registering claims; lack of support or communication after the initial injury; disbelief or scepticism about workers' injuries; failure to pay costs or wages; failure to rectify unsafe work practices; lack of care or understanding; and failure to provide alternative duties.

- A large percentage of the positive comments about employers were from staff of Aged Care or Disability organisations.
- Over a third of the sample felt that other workers' responses to their injury had been poor. It appears that the return to work of an injured worker is a time that is a potential catalyst for harassment, bullying or victimisation.

5.1.3 WorkCover process

- Less than a quarter of the whole sample were satisfied with their case manager's handling of their case, with almost half categorising it as *bad* or *not very good.*
- The following issues had influenced perceptions of case managers' performance: lack of continuity/high turnover; variable competence/care; difficulty in contacting them; beliefs that they were 'on the employer's side'
- There was generally a low level of satisfaction with the timeliness of responses to workers' claims.
- There were high levels of dissatisfaction with RTW Plans. Respondents complained of: meaningless plans to comply with the paperwork requirements; lack of implementation; inflexible strategies; unavailability of recommended duties; and inappropriate duties.
- A little over a third of the sample felt that the rehabilitation and return to work process had not been explained well to them.
- Over half the sample characterised the communication between the people involved in their case as poor, with only 23% regarding it as very good or excellent.
- Almost 59% of the sample felt that their needs and views had not been adequately considered, with under 20% of men and under 30% of women being satisfied on this score. Many of the comments revealed perceptions that return to work and the profit motive outweighed any consideration of injured workers' needs. Workers reported a loss of agency in the process.
- Overall, 57.7 % of the sample characterised their experience of the WorkCover process as *bad* or *not very good*, with only 20.3 % suggesting it was very *good* or *excellent*. Recurring themes in the added comments were about financial loss; stress, despair, depression and suicidal thoughts; slowness of the process; and a degrading loss of agency.

5.1.4 Home situation

- Almost 60% of the women were concerned that their home situation was not well understood by people dealing with their case. Many men felt this also, but the trend was less emphatic (46%).
- Over three quarters of the sample had no awareness of the availability of home support services and were not offered any.
- A significant majority of workers (67.5%) felt that they were not able to undertake their domestic jobs as usual, without needing extra help. This is one of the questions where women expressed a higher level of dissatisfaction than men.
- Over three quarters of the sample agreed or strongly agreed that their injuries were made worse by housework.
- A majority (65%) of respondents relied on family and friends for help with jobs or child care.
- A high 66.7% of the sample felt that their injury had had a damaging effect on their family relationships.

5.1.5 What injured workers want

To get them back to work more successfully, injured workers wanted:

- better communication and information
- consultation and respect
- a better system of finding alternative duties
- meaningful retraining
- timeliness of responses to their injury
- adequacy of treatment
- improved employer ethics and investigation of bad practices
- more assistance at home.

5.1.6 Summary

Almost all of the responses reflect feelings that the workers rehabilitation and compensation system makes life even more difficult and complicated than it already is with the injury. These comments mostly relate to bad experiences with employers and claims agents and a failure to adopt a 'whole of life' response to rehabilitation and return to work.

It seems clear (and is reinforced in discussion with other stakeholders) that currently the WorkCover system is perceived as adversarial rather than collaborative.

Although this group of respondents may well represent the most dissatisfied end of the client group, their perceptions of an adversarial rather than a collaborative system are so uniform that they offer clear and valuable messages for the improvement of customer relations generally.

5.2 Health and Safety Representatives' survey

- The HSRs felt that the initial response of their work sites to injury is extremely good, especially in terms of compliance with the regulations.
- Information about work place injury rehabilitation and return to work was identified as an issue in need of further action. Health and Safety reps found training and development invaluable and wanted more – not only about the legislation, but also at a practical level about responding to issues such as an injured worker's depression. They consistently reported that generally, workers were ill informed about the processes and dynamics of rehabilitation and return to work. There was some feeling expressed that available information was incomplete in that it explained responsibilities and obligations – but not rights.
- The role of H&S reps could be expanded and more broadly defined. This would involve training about the ways an injury affects a range of issues beyond the physical. However, for such training to be meaningful, there would also need to be support from management, including acceptance of the idea that psycho/social issues relating to workplace health and safety are important.
- Training, especially about attitudes and communication skills, emerges as an important issue to support Health and Safety representatives to undertake their role effectively. However there may also need to be further clarification about expectations of their role. It appears that this can be understood differently by different stakeholders, ie. union, employer, worker and the Health and Safety Representatives themselves.
- Consistently, Health and Safety reps identified return to work of an injured worker as a time that was a potential trigger for harassment, bullying,

derision, victimisation and negative or abusive labelling. Underpinning these problems were co-worker and supervisor assumptions about the legitimacy of the need for modified or alternative duties and often a lack of understanding about the effects of injury and rehabilitation needs.

- The responses of the Health and Safety reps reveal as much about the psychological health of the organisational culture as they do about the particular needs of injured workers. These issues are extremely important for future work and action, which could include audits of workplace practices and cultures, including measuring qualities like openness and trust and the incidence of practices such as harassment and bullying.

5.3 Employers' survey

- Many employers saw the system as unfair or favouring the injured worker. Only a few thought the system was unequivocally fair.
- Several suggested there were *too many grey areas* and that there was *too much room for interpretation* in the legislation
- The two most frequently mentioned difficulties with rehabilitation and return to work were finding meaningful alternative duties and problems with GPs.
- Employers were strongly critical of GPs' role in injured workers' rehabilitation. Specifically, they criticised their lack of knowledge of workplaces; their too ready support for workers to 'remain off work'; their willingness to declare all injuries as work related.
- Employers identified good communication and positive approaches and attitudes as key factors helping timely and sustainable return to work. Early intervention and early return to work were also mentioned. This is particularly important as employers, injured workers and providers agree early intervention is important in effective return to work.
- Negative employee attitudes were seen as hindering return to work. Employer attitudes (adversarial, lack of understanding for worker) were also identified as hindrances, as were unhelpful GPs and differing medical opinions.
- All agreed that the workplace culture is important and most referred to the attitudes of co-workers as being significant. The most common word used to describe a good workplace culture was *supportive.* It was acknowledged that there can be a stigma attached to receiving workers compensation.
- Suggestions for changing the workplace culture mainly centred on the need for training and awareness generally, for both management and the workforce.
- Many responses recognised that the impact of a work injury on home life is huge and that sometimes this impact comes from having to comply at home, as well as work, with restrictions on physical activities.
- Respondents were fairly evenly divided on whether there were gendered differences in the impact on home life, with one suggesting the greater effect of ethno-cultural differences.
- The most frequently mentioned reform identified related to improved responsibility and accountability of doctors.

Chapter Six: The Survey Findings in Detail

6.1 Injured Workers' Survey

The sample: 123 responses were received from 618 surveys distributed.

Note: Where percentages (when listed) do not add up to 100%, this is either due to rounding off or some respondents not recording an answer to this question.

Gender and return to work status

	Number	Returned to work %	Not returned to work %
Whole sample	123	69%	29%
Women	60 (49%)	76%	23%
Men	56 (46%)	66%	34%
Gender not specified	7 (6%)	43%	43%

Of those who had returned to work 39% responded that they were doing the same work.

Age and Gender

	Whole sample	Women	Men	Gender not specified
Under 26	4 (3%)	3 (5%)	1 (2%)	1 (14%)
26-40	38 (31%)	19 (32%)	18 (32%)	1 (14%)
41-55	55 (45%)	28 (47%)	23 (41%)	4 (57%)
Over 55	23 (19%)	9 (15%)	14 (25%)	-
Age not specified	3 (2%)	1 (2%)		1 (14%)
Total	123	60	56	7

Occupation

	Women	Men	**Gender unspecified**
Community Services	28** (47%)	10 (18%)	**3 (43%)**
Manufacturing	13 (22%)	21* (38%)	**2 (29%)**
Recreation/Personal Services	2 (3%)		
Wholesale/Retail	4 (7%)	1 (2%)	
Transport/Storage	1 (2%)	11 (20%)	**1 (14%)**
Public Service/ Administration	2 (3%)	1 (2%)	
Cleaners	5 (8%)	1 (2%)	
Agriculture/fishing		3 (5%)	
Construction		4 (7%)	
Mining		1 (2%)	
Finance		1 (2%)	
Not specified	5 (8%)	2 (4%)	**1 (14%)**
Total (n=123)	60	56	**7**

*13 of these men (23.2% of male sample) were in the automotive industry.
** 19 of these women (31.7% of female sample) worked in Aged Care or Disability services.

Nature of injuries

The vast majority of injuries were musculoskeletal (88% of the women's injuries and 70% of the men's injuries were of this type). These were mainly back, neck and shoulder injuries. Other injuries included fractures, crushed limbs, open wounds, and dermatitis. Some injuries were multiple in nature and included secondary stress and depression.

6.2 The findings

Note: *Except where otherwise indicated the following figures are percentages. Where percentages do not add up to 100%, this is either due to rounding off or some respondents not recording an answer to this question. Averaged rankings out of 5 do not include those who did not respond.*

Section A: Help

1. How do you rate the following people or groups in helping your rehab and return to work?

a. Family and friends

	1 % Extremely unhelpful	**2** % Unhelpful	**3** % OK	**4** %Helpful	**5** %Extreme helpful	**0** % No response	**Total**	**Average score out of 5**
Women (n=60)	**1.7**	**5**	**13.3**	**16.7**	**60**	**3.3**		**4.3**
Men (n=56)	**1.8**	**7.1**	**10.7**	**23.2**	**57.1**	**0**		**4.3**
Gender not specified (n=7)	**0**	**0**	**57.1**	**14.3**	**28.6**	**0**		**3.7**
Total sample (n=123)	**1.6**	**5.7**	**14.6**	**19.5**	**56.9**	**1.6**	**99.9%**	**4.3**

Over three quarters of the whole sample considered that their family and friends had been *helpful* or *extremely helpful* in assisting their rehab and return to work. It is notable that this positive assessment of the helpful role of families contrasts markedly with most of the other groups about whom responses were sought.

Comments revealed a strong reliance on family and friends for housework, transport, and emotional support. A number of workers also nominated family members and friends as the source of information about the WorkCover process. Several women acknowledged their families and friends as their *support system*, their *rocks*. *Without them I wouldn't be here*. However there was also acknowledgement that family help was inevitably restricted due to ill health, work and other commitments. As one woman said: *they did the best they could but my mother is very ill.*

In only 7.3% of cases were family and friends assessed as unhelpful or extremely unhelpful. One man commented that his family *were supportive but unable to grasp the pressure.* Another said *they are too busy when help is needed.* One man commented that *my wife is unhappy about me being on*

WorkCover, alluding to the stigma which we found widely reported elsewhere in the research. Several workers mentioned that they had lost friends because they were unable to maintain social commitments.

b. Employer

	1 % Extremely unhelpful	**2** % Unhelpful	**3** % OK	**4** %Helpful	**5** %Extreme helpful	**0** % No response	**Total**	**Average score out of 5**
Women (n=60)	**28.3**	**11.7**	**20**	**20**	**18.3**	**1.7**		**2.9**
Men (n=56)	**50**	**10.7**	**14.3**	**16.1**	**1.8**	**7.1**		**2.0**
Gender not specified (n=7)	**42.9**	**14.3**	**14.3**	**14.3**	**14.3**	**0**		**2.4**
Total sample (n=123)	**39.0**	**11.4**	**17.1**	**17.9**	**10.6**	**4.1**	**100.1%**	**2.5**

Over half the sample rated their employers as *unhelpful* or *extremely unhelpful*, with only 28.5% regarding them as *helpful* or *extremely helpful*. The negative responses from just over 60% of the men in the sample are particularly striking. The women sampled were more positive, with 38.3% giving a positive assessment.

There are many possible reasons for this gender discrepancy and these merit further research. One possible contributory factor might be that approximately 47% of the women in the sample were from female dominated Community Services industries, with over two thirds of these women working in Aged Care or Disability Services. By contrast, 37% of the men worked in manufacturing, many of them in the automotive industry. There may be something about the workplace culture of factory work and the effects of male dominance in such industries, which has resulted in less satisfactory rehabilitation and return to work policies, practices and experiences. It may also be the case that Aged Care/Disability services have been working hard to develop models of good practice, a speculation which was lent some credence in several interviews we did with rehabilitation coordinators from these industries.

It is also possible that women were better able to negotiate a satisfactory outcome with their employers, or with their HSRs. It may also be that women still do not define themselves as strongly as members of the paid workforce and may therefore have lower expectations of workplace procedures. It may also be that women are less likely to complain or more likely to positively re-frame experiences, than men. These are all issues which merit further research.

Some of the negative responses were supported with comments such as: *They simply did not want to know me* (from a young female cleaner who had not been able to return to work after 5 years).

They didn't want to take responsibility for my injuries (a female assembly line worker who was off work for 10 months with carpal tunnel injuries to both hands)
Once damaged you are disposed of (a female carer in an Aged Care home who had shoulder and neck injuries).

A number of people commented that their employers were only interested in the financial implications of their injury:
He [employer] said things like: When will you be right to work? Do you know my WorkCover premiums have gone up?
Employer not interested in my rehab – only cost of rehab."
He [employer] was a liar – too worried about levy."
In the beginning would not submit claim – then terminated position soon after going on WorkCover.

On the other hand a registered nurse in a public hospital spoke of a *supportive manager who maintained regular contact*. One female carer in aged care said she had received *excellent, very professional support,* and another said: *My employer was extremely helpful with all aspects of my recovery.*

Some were aware that there were difficulties inherent in the situation for the employer. For example one man, an electronics assembler with RSI commented: *It was not the employer's fault there was no suitable work available.* A woman who had sustained shoulder and wrist injuries from operating a pneumatic screw driver acknowledged *Sometimes he try to help…but sometimes I was given wrong jobs.*

c. Supervisor or Manager

	1 % Extremely unhelpful	**2** % Unhelpful	**3** % OK	**4** %Helpful	**5** %Extreme helpful	**0** % No response	**Total**	**Average score out of 5**
Women (n=60)	**33.3**	**10**	**21.7**	**16.7**	**16.7**	**1.7**		**2.7**
Men (n=56)	**37.5**	**19.6**	**19.6**	**10.7**	**7.1**	**5.4**		**2.3**
Gender not specified (n=7)	**42.9**	**0**	**28.6**	**28.6**	**0**	**0**		**2.4**
Total sample (n=123)	**35.8**	**13.8**	**21.1**	**14.6**	**11.4**	**3.2**	**99.9%**	**2.5**

These figures are also very concerning with almost half the sample expressing dissatisfaction with the role of their supervisors or managers. A number of workers felt that their needs were not adequately considered and that their supervisor's priorities were more to do with productivity than the welfare of their staff. As one female carer in the disability sector put it: *Immediate supervisor was very pushy in gaining return to normal duties or doing menial tasks.*

Such comments underscore an inherent systemic conflict between the welfare of workers and cost effective management practice. Worksite managers, like claims agents' case managers, may well feel they are 'between a rock and a hard place' in this respect. Some workers reported that they felt pressured not to put in claims. Others spoke of *lies to WorkCover* and supervisors *aiding and abetting employers.* One automotive assembly line worker described his manager as having a *care factor of zero.* A storeman/packer in the same industry, who had a lower back injury, said of his supervisors: *Most treat you like you have a contagious disease.*

d. Health & Safety representative

	1 % Extremely unhelpful	**2** % Unhelpful	**3** % OK	**4** %Helpful	**5** %Extreme helpful	**0** % No response	**Total**	**Average score out of 5**
Women (n=60)	**23.3**	**23.3**	**13.3**	**6.7**	**15**	**18.3**		**2.6**
Men (n=56)	**25**	**16.1**	**19.6**	**10.7**	**5.4**	**23.2**		**2.4**
Gender not specified (n=7)	**57.1**	**0**	**0**	**14.3**	**14.3**	**14.3**		**2.2**
Total sample (n=123)	**26.0**	**18.7**	**15.4**	**8.9**	**10.6**	**20.3**	**99.9%**	**2.5**

The high non response rate for this question probably indicates that many work sites did not have HSRs, or that workers are unaware of their existence if they do. This is most likely to be the case in small worksites. However there was also an unfortunately high level of dissatisfaction with the assistance provided by HSRs, with almost 45% of the sample regarding them as unhelpful or extremely unhelpful. Many respondents reported that that they had had no contact with their HSRs and that they played no role or that HSRs were not included in meetings. Several claimed that the HSRs *didn't care*, or that they *turned a blind eye* to work injuries. One woman claimed that the HSR listened to the employer and supervisor but did not consult with her. A male technician in the submarine industry said *Might as well not have one* and a male Aged Carer said: *She's scared of her job.*

There are important implications here for HSR training and for a clearer role definition within worksites. These points are reinforced in the findings of our HSRs survey, where both training and role clarification and consequent expectations emerged as important issues. It appears that the role of the HSR can be understood differently by different stakeholders, eg. unions, employers, workers and HSRs individually.

e. Health & Safety Co-ordinator

	1 %Extremely unhelpful	2 % Unhelpful	3 % OK	4 %Helpful	5 %Extremely helpful	0 % No response	Total	Average score out of 5
Women (n=60)	**21.7**	**21.7**	**15**	**5**	**20**	**16.7**		**2.8**
Men (n=56)	**33.9**	**14.3**	**12.5**	**5.4**	**5.4**	**28.6**		**2.1**
Gender not specified (n=7)	**57.1**	**0**	**0**	**14.3**	**14.3**	**14.3**		**2.2**
Total sample (n=123)	**29.3**	**17.1**	**13.0**	**5.7**	**13.0**	**21.9**	**100%**	**2.4**

Again, a significant nil response here, suggesting perhaps that many worksites do not have health and safety coordinators. Many injured workers' comments confirmed this speculation. One man, a printer machinist, simply added *Who?* Another man, a process welder in the automotive industry, said: *What health and safety co-ordinator?* A production engineer in the automotive industry described his health and safety coordinator as *rude, arrogant, pigheaded and did not comply with doctors' orders.* A process worker in a manufacturing industry saw her health and safety coordinator as being constrained by the company's definition of the role: *If they were allowed to do more things they would be better. They have to go through the workers' comp manager first.*

f. Union

	1 %Extremely unhelpful	2 % Unhelpful	3 % OK	4 %Helpful	5 %Extremely helpful	0 % No response	Total	Average score out of 5
Women (n=60)	**10**	**13.3**	**11.7**	**5**	**18.3**	**41.7**		**3.1**
Men (n=56)	**19.6**	**19.6**	**10.7**	**16.1**	**10.7**	**23.2**		**2.7**
Gender not specified (n=7)	**42.9**	**0**	**14.3**	**0**	**0**	**42.9**		**1.5**
Total sample (n=123)	**16.3**	**15.4**	**11.4**	**9.8**	**13.8**	**33.3**	**100%**	**2.8**

It is likely from the responses that many people in our sample were either not members of unions or had not bothered to contact them. However, it was also evident, both from the survey and interviews, that many injured workers who were union members, felt unhappy with their union's role (23% of women and 39% of men found the unions *unhelpful* or *extremely unhelpful*). While some unions (for example The LHMU) provide an excellent little handbook about work injury and compensation, others appear to provide little information and to be reluctant to get involved in work injury claims. For a number of part time workers (for example cleaners) flat rate union fees which were not discounted pro rata were regarded as prohibitive.

g. Treating doctor/s

	1 %Extremely unhelpful	**2** %Unhelpful	**3** % OK	**4** %Helpful	**5** %Extremely helpful	**0** % No response	**Total**	**Average score out of 5**
Women (n=60)	**1.7**	**3.3**	**13.3**	**21.7**	**53.3**	**6.7**		**4.3**
Men (n=56)	**3.6**	**3.6**	**19.6**	**28.6**	**41.1**	**3.6**		**4.0**
Gender not specified (n=7)	**0**	**14.3**	**0**	**28.6**	**42.9**	**14.3**		**4.2**
Total sample (n=123)	**2.4**	**4.1**	**15.4**	**25.2**	**47.1**	**5.7**	**99.9%**	**4.2**

Respondents were generally quite positive about their treating doctors, with over 70% of the sample regarding them as *helpful* or *extremely helpful*. In fact, this group was viewed almost as favourably as family and friends. For injured workers their own GPs, especially, were ranked very highly. However, there were less positive comments about employers' doctors. For example: *I was getting no results with work doctor so I went to my own* (female process worker). Young female cleaner: *My doctors tried but were just as hindered by the system as I was.*

It is significant, however, that doctors were seen as a problem by a number of employers we surveyed and also by health and safety co-ordinators we spoke to. In a number of interviews with such people it was suggested that doctors were unfamiliar with work injuries, that they rarely visited work sites and were ignorant about work duties, that they were not sufficiently committed to early return to work, or that their relationship with their clients predisposed them to too readily give medical certificates for time off rather than suggesting modified duties or return to normal work. On the other hand injured workers often saw their doctor or specialist as the only person outside their family and friends who had their interests at heart. A clerical worker in the manufacturing industry described her doctor as *my lifeline.* Others used words and phrases like *supportive*, *excellent*, *understanding*, *providing full help and support*.

h. Case manager/s (and their staff)

	1 %Extremely unhelpful	2 % Unhelpful	3 % OK	4 %Helpful	5 %Extremely helpful	0 % No response	Total	Average score out of 5
Women (n=60)	**28.3**	**13.3**	**20**	**11.7**	**23.3**	**3.3**		**2.9**
Men (n=56)	**33.9**	**17.9**	**19.6**	**10.7**	**8.9**	**8.9**		**2.4**
Gender not specified (n=7)	**14.3**	**14.3**	**14.3**	**28.6**	**28.6**	**0**		**3.4**
Total sample (n=123)	**30.1**	**15.4**	**19.5**	**12.2**	**17.1**	**5.7**	**100%**	**2.7**

These findings once again reveal a very high level of dissatisfaction with 52% of men and 41% of women characterising case managers as *unhelpful* or *extremely unhelpful* and under a third of the sample seeing them as *helpful* or *extremely helpful*. A number of respondents referred to the difficulties of having minimal contact with busy case managers and having to deal with too many different ones. These issues of excessive caseloads and high turnover (and possibly burnout) had also been raised with us in our interviews with rehab consultants, OHS coordinators and case managers themselves. Comments from workers included:

I had so many different case managers, it was ridiculous (A female store person, off work for 5 months)
They do not communicate (had 8 case managers) – interested only in return to work (A driver operator in waste management, off work for 2 $^{1/2}$ years so far with hand and back injuries).

While two workers described their case managers as *understanding*, and a couple were ambivalent (*Some were OK – others were extremely hindering. Sometimes excellent – sometimes I feel like I'm a burden),* the majority of comments were very negative. Comments included:
These people don't return calls, and they categorise injured people (female aged care worker)
I dared to want to get my life back – that was not on the agenda (young female cleaner with a broken AC joint, who has not been able to return to work).

Other comments included accusations of lying, breaches of confidentiality, laziness, controlling behaviour, and scepticism: *The Case Manager holds my claims to be fraudulent, frivolous, vexatious and antagonistic.*

i. Rehabilitation providers

	1 %Extremely unhelpful	2 % Unhelpful	3 % OK	4 %Helpful	5 %Extremely helpful	0 % No response	Total	Average score out of 5
Women (n=60)	**20**	**8.3**	**23.3**	**15**	**30**	**3.3**		**3.3**
Men (n=56)	**26.8**	**12.5**	**14.3**	**17.9**	**12.5**	**16.1**		**2.7**
Gender not specified (n=7)	**14.3**	**0**	**14.3**	**14.3**	**42.9**	**14.3**		**3.8**
Total sample (n=123)	**22.8**	**9.7**	**18.7**	**16.3**	**22.8**	**9.7**	**100%**	**3.1**

Rehab providers were assessed relatively more positively by the sample, with almost 40% rating them as *helpful* or *extremely helpful*. Most of the additional comments, however, tended to be negative, with quite a few people suggesting they were a waste of money or ineffectual. The most negative expression of this view was that they *are the parasites of the WorkCover system.* A recurring complaint was that they had a conflict of interest. There were comments like: *Works for case manager, not me* (male construction worker); *Changed things to suit the employer* (male production engineer); *Only concerned with employer* (female clerical work in manufacturing industry).

j. Co-workers

	1 %Extremely unhelpful	2 % Unhelpful	3 % OK	4 %Helpful	5 %Extremely helpful	0 % No response	Total	Average score out of 5
Women (n=60)	**18.3**	**10**	**31.7**	**20**	**15**	**5**		**3.0**
Men (n=56)	**16.1**	**23.2**	**25.0**	**19.6**	**5.4**	**10.7**		**2.7**
Gender not specified (n=7)	**14.3**	**0**	**14.3**	**42.9**	**14.3**	**14.3**		**3.5**
Total sample (n=123)	**17.1**	**15.4**	**27.6**	**21.1**	**10.6**	**8.1**	**99.9%**	**2.9**

The sample was fairly evenly divided in their rankings of the helpfulness or otherwise of co-workers. The opportunity to add comments elicited more negative than positive comments, however. It was apparent from this data, as

well as from information received from other sources such as HSRs and interviews with health and safety coordinators that the scepticism or hostility of co-workers can be a significant problem for injured workers, contributing to a workplace culture which does little to support their rehabilitation or self esteem. Perceptions of colleagues' responses ranged from disbelief/scepticism to ostracism to outright antagonism and undermining behaviours. Comments included:

Don't care – reckon I'm having a paid holiday (male construction worker with back injury)
Want little to do with me (a male greaser in the chemical industry)
Give you a hard time (female process worker).
See where you have been placed and avoid you like the plague (male storeman/packer in the car industry).
As soon as I signed the WorkCover form I was treated like a leper by my boss, supervisors and most co-workers (female process worker in the metals industry).
I became known as the WorkCover technician (a male technician)
[They] undermined my return to work light duties (male quality assurance trainer).

It has become clear that co-workers are much more likely to be sympathetic to injured colleagues if they themselves have experienced an injury. As one said: *Most support obtained from others with similar problems.* Several of our interviewees confirmed this view, in particular noting that younger workers who had not experienced injury, tended to be the most sceptical, especially of invisible injuries such as back pain.

k. Injured workers' network or support group

	1 %Extremely unhelpful	**2** % Unhelpful	**3** % OK	**4** %Helpful	**5** %Extremely helpful	**0** % No response	**Total**	**Average score out of 5**
Women (n=60)	**3.3**	**5**	**10**	**8.3**	**13.3**	**60**		**3.6**
Men (n=56)	**5.4**	**5.4**	**7.1**	**14.3**	**14.3**	**53.6**		**3.6**
Gender not specified (n=7)	**0**	**0**	**0**	**14.3**	**28.6**	**57.1**		**4.7**
Total sample (n=123)	**4.1**	**4.9**	**8.1**	**11.4**	**14.6**	**56.9**	**100%**	**3.6**

We assume that the high non response rate to this question suggests that some injured workers had either not contacted support groups and/or did not know of their existence, with a number of comments like these being added: *Around that time I didn't know of such help*. *Would have been very helpful.* Or: *Good, but did not find out about them for years.*

Of the ten respondents who added comments about their experience of these groups, the views, with one exception, were very positive. Comments included:

The Work Injured Resource Connection (WIRC) were the only people to give me support (Male Quality Assurance trainer)
You can talk to people who know what you are talking about (Male carpenter, with back and knee injuries)
Could not have done it without them (female public servant)
My second support system (female clerical worker).

The negative comment was from a male machinist in the vehicle industry who said: *I was treated like I was exaggerating my disability.*

I. Other (please specify)

	1 %Extremely unhelpful	**2** % Unhelpful	**3** % OK	**4** %Helpful	**5** %Extremely helpful	**0** % No response	**Total**
Women (n=60)	**1.7**	**0**	**1.7**	**3.3**	**8.3**	**85**	
Men (n=56)	**3.6**	**1.8**	**1.8**	**1.8**	**3.6**	**87.5**	
Gender not specified (n=7)	**0**	**0**	**0**	**0**	**14.3**	**0**	
Total sample (n=123)	**2.4**	**0.8**	**1.6**	**2.4**	**6.5**	**86.2**	**99.9%**

A small number of respondents chose to specify other people or groups who had been helpful or otherwise. Those mentioned positively were a physiotherapist, an occupational health and safety consultant, a psychologist and a doctor. The doctor was said to be: *Not frightened by WorkCover or case manager – will not be intimidated although threatened by WorkCover and Case Manager.*

There were two negative comments about WorkCover's Employee Advocate Unit (eg. *they were useless and gave wrong information*), one about a lawyer (*dragging feet after nearly 4 years*), one about a claims agent (*Insurance company suxs!)* and one about an employer (*Very poor there were several positions I could have been placed in, but the behind the scene policy is to terminate the injured worker so it won't happen again.)*

Section B: Workplace

2. How would you generally rate your company's responses to your injury?

	1.Bad %	2.Not very good %	3.OK %	4.Very good %	5.Excellent %	Total	Average score out of 5
Women (n=60)	**28.3**	**18.3**	**20.0**	**11.7.**	**21.7**		**2.8**
Men (n=56)	**50.0**	**17.8**	**16.1**	**12.5**	**3.6**		**2.0**
Gender not specified (n=7)	**0**	**42.9**	**28.6**	**28.6**	**0**		**2.4**
Total sample (n=123)	**36.6**	**19.5**	**18.6**	**13.0**	**12.2**	**99.9%**	**2.4**

The most telling feature of responses to this question is that 56.1% of the whole sample rated their company's response to their injury as *bad* or *not very good.*

This level of dissatisfaction was particularly noticeable with men, with almost 68% feeling negatively about this issue, and only 16.1% of men giving a rating of very good or excellent, compared to 33.2% of women. Because the question measures perceptions this difference is difficult to interpret. It could be that men have higher expectations of their employer's responses and are therefore less satisfied. Or women may be less likely to complain than men. Or women may in fact have had better experiences, either because of the nature of their injury, the way in which they communicated their needs to management, or the quality of management responses in the particular industries in which women worked. See the analysis of the responses to Question 1b earlier.
This question elicited large numbers of additional comments. The negative comments centred around the following themes:

- Employers' tardiness in registering claims (eg. *Did not register my claim for two months*. *Slow to make changes, slow to offer alternative duties, company have made me feel guilty for injuries*
- Lack of support or communication after the initial injury (*Not bad at time of injury but no contact since*)
- Disbelief/scepticism (*At first they didn't believe me which to me was totally disgusting. I was just a waste of space throughout the whole process* (male metal trades engineer). *Half hearted attempts to accommodate my needs. Poor attitude and disbelief that I was badly injured -- cannot see a back injury.* (female community support worker).
- Failure to pay costs or wages
- Failure to rectify unsafe work practices *Company was only interested in covering up negligence on faulty equipment and inadequate procedures!* (male driver/operator in waste management)

- Lack of care or understanding: *They don't care at all. They hate people on WorkCover so they treat you like shit, so you will leave. Case closed.* (female process worker).
- Failure to provide alternative or light duties (*Pressure to do things unable to do, not understanding or caring about injury, terminated employment when unable to increase hours* (male aged care worker). *They sent me home saying they had no work to suit my condition. When there was a job that no one wanted that I could easily have been trained to do* (male test technician in submarine industry). *When injury first reported then accused me of doing it outside my work. After operation I was on light duties, but on full shift without help, covering normal production* (fitter and turner in the dairy industry).
- Dishonesty. *Lied - gave false statement on ERF form - to investigator - forced me into litigation and 'folded' during arbitration when lies were exposed* (female clerical officer). *Try to change doctors' comments to suit themselves* (male production engineer in the car industry).

Positive comments

A large number of the positive comments in our survey were from staff of Aged Care or Disability organisations. Almost half of the women in our sample were from such organisations, which, as discussed earlier, may be a major factor in their more positive assessments of their employers. Because our surveys were anonymous we are unable to identify which specific agencies these workers came from. However it is perhaps significant that these positive comments align with what we have described elsewhere in this report as good policy and practice, on the basis of information derived from a number of interviews with health and safety/rehabilitation co-ordinators in several of these agencies. Comments included:

My first employer couldn't get me out the door fast enough. The second is trying to work through the problems with me (Male material handler in the automotive industry).
X (large aged care organisation) has been very supportive, even when the injury has had to have some more treatment after return to pre injury duties (Female kitchen worker).
Health/Safety rep was wonderful. He put me on to the necessary doctor (Female Community support worker in Disability sector).
Agency understands my injury because nurses are prone to back injuries (Female carer in Aged Care home).
Assisted me with everything. Helped physically and mentally with me, always supported me (Female Community support worker in Disability sector).

3. *How would you generally rate other workers' responses to your injury?*

	1.Bad %	2.Not very good %	3.OK %	4.Very good %	5.Excellent %	Total	Average score out of 5
Women (n=60)	**8.3**	**26.7**	**33.3**	**18.3**	**10.0**		**2.9**
Men (n=56)	**10.7**	**25.0**	**39.3**	**19.6**	**1.8**		**2.8**
Gender unknown (n=7)	**14.3**	**14.3**	**42.9**	**28.6**	**0**		**2.9**
Total sample (n=123)	**9.8**	**25.2**	**36.6**	**19.5**	**5.7**	**96.8%** (3.3% no response)	**2.9**

Over a third of the sample felt that other workers' responses to their injury had been poor, with less than a third experiencing *very good* or *excellent* responses. Once again men's experiences were more negative than women's. This finding is consistent with the qualitative data from both the survey and the interviews which revealed that co-workers were often either hostile to injured colleagues or sceptical about their injuries and that consequently injured workers feel that there is a stigma attached to going on WorkCover.

The finding underscores the need for workplace training about occupational health and safety and work injuries and transparency of communication when workers are injured. The majority of injured workers in our sample had 'invisible' musculoskeletal injuries, many of them back injuries, which are frequently regarded as fraudulent or exaggerated, especially by people who haven't experienced severe long term back pain. In fact, a registered nurse with chronic dermatitis on her hands explained why she was treated quite well: *My injury was visible and they were able to see that it was 'real'.* A machinist in the vehicle industry seemed to suggest that attitudes were better today than in the past: *In the 70s bad back claims were generally treated with disbelief and distaste by employers.* However, other perceptions were that these attitudes still prevailed.

This finding suggests there needs to be more workplace education for employees and management, specifically about back care and back pain, especially in industries such as aged care, cleaning and other industries which involve lifting, bending or other activities likely to lead to back injuries. A management issue of relevance here is the fact that other workers, especially in small worksites, often have to take on extra duties when colleagues are injured.

These conclusions are supported by findings from both our HSRs survey and our Employers' survey. The reps spoke of the ways in which subjective views about an individual worker can influence how seriously a worker's injury is taken

or whether they are believed at all. And they identified the return to work of an injured worker as a time that was a potential trigger for harassment, bullying or victimisation. Employers also emphasised the importance of the workplace culture and the attitudes of co-workers.

Comments revealed mixed feelings and affirmed that a number of different factors and experiences influence colleagues' attitudes including their own workloads and remuneration. Some obviously saw the issue as a matter of management versus workers.

My first lot of co-workers feared being with me. The second have been very supportive (Young female cleaner).
Other workers that have NOT had injuries do not really understand and sometimes do not believe that the victim is in a lot of pain. This I have experienced – when it happens to them they might 'chew' their words (Female carer, Aged Care).
*Most co-workers are understanding but can't help much or their bonuses will be upset (*Female pneumatic screw driver).
They thought I was having a holiday!! (Female process worker in metal industry).
A few who where there supported management at time – just wanted to get rid of me, as did the supervisor who injured me. Result was I was forced back on line, more injury made permanent, workplace bullying and harassment, mental, emotional and physical abuse. Rest of workers gave abuse to keep in good books (Female assembly line worker in automotive industry).
Lack of understanding and feeling inadequate as injuries made it impossible to do tasks. The co-workers gave the impression you weren't carrying your load (Female housemaid in hospitality industry)
Very hurtful, Question me a lot, make me feel that I'm faking (Female process worker).

Section C: WorkCover Process

4. *How do you rate your case manager's handling of your case?*

	Bad %	Not very good %	OK %	Very good %	Excellent %	Total	Average score out of 5
Women (n=60)	**21.6**	**20.0**	**26.7**	**13.3**	**16.7**		**2.8**
Men (n=56)	**37.5**	**14.2**	**28.6**	**14.3**	**1.8**		**2.3**
Gender unknown (n=7)	**28.6**	**14.3**	**14.3**	**28.6**	**14.3**		**2.9**
Total sample (n=123)	**29.3**	**17.1**	**26.8**	**14.6**	**9.8**	**97.6 %** 2.4% no response	**2.6**

Less than a quarter of the whole sample was satisfied with their case manager's handling of their case, with almost half categorising it as *bad* or *not very good.* Comments elaborated that the following issues had influenced their rankings:

- High turnover: too many case managers, loss of continuity
- Variable competence/care by different case managers
- Difficulty in contacting them
- Perceptions that they were on the employer's side.

It is evident from our surveys, interviews and from the WorkCover Operational Review of May 2004, that the issue of case managers and their excessive caseloads is one in need of urgent reform.

Comments included:

Too many case managers to keep count of (Female cleaner).
All different from bad to OK. Had 5 in 3 years. (Carpenter in construction industry)
The first was great, then it got progressively worse as they changed. (Male Mining contractor)
They only work to their assigned parameters (Male material handler in automotive industry)
*Collusion with employer. Breach of confidentiality. Arrogant, nasty. (*Female clerical worker)
I would have had more luck getting hold of the Queen of England. Phone calls unreturned, contempt and disdain (Female aged care worker).
My case was never managed. I was lied to, denied help, no retraining, constant threats (Male weed control operator)
If they were allowed to work on employee side and not one handed to company… sometimes their hands are tied. (Female process worker).

5. ***How do you rate the promptness of responses to your claim?***

	Bad %	Not very good %	OK %	Very good %	Excellent %	Total	Average score out of 5
Women (n=60)	**20.0**	**16.7**	**28.3**	**15.0**	**18.3**		**2.9**
Men (n=56)	**37.5**	**17.9**	**26.8**	**12.5**	**3.6**		**2.3**
Gender unknown (n=7)	**14.3**	**14.3**	**57.1**	**14.3**	**0**		**2.7**
% of Total sample (n=123)	**27.6**	**17.1**	**29.3**	**13.8**	**10.6**	**98.4%** 1.6% no esponse	**2.6**

There was generally a low level of satisfaction with the timeliness of responses to workers' claims. Almost 45% of the sample (55% of men and 37% of women) was dissatisfied. It is widely acknowledged that early reporting and early intervention are key factors in early and sustainable return to work. This issue is complex because the delays occurred at various stages in the process from the employer's lodging of the forms, claims agents' reimbursements of expenses, through to Tribunal decisions. It is apparent that the problems that injured workers experience are almost certainly exacerbated by such delays, and may become intractable by the time matters go to mediation. This issue is one which therefore needs urgent attention and lateral thinking across the board.

Of the 30 comments added to this question, only 2 were positive. One man said he was *pleasantly surprised* (assembly line worker with shoulder injury). The rest of the comments were extremely negative, emphasising delays, lack of information about progress, and being out of pocket for expenses incurred.

Comments included:

[Employer] delayed as long as possible (Storeman/packer in the automotive industry)
Took 6 weeks without pay to reject the claim (Male process welder in automotive industry)
3 months to accept claim (Truck driver)
My claim for depression is still undetermined 7 months later! (Process worker in metal industry)
Had to fight to get claim lodged. In the end went direct to WorkCover (Female clerical worker)
I always had to chase info. Never let me know what was happening (Female Child care Manager)
Continually out of pocket (Female Aged Care worker)
It dragged on. It was a constant battle. I was constantly lied to (Weed control operator).

6. *How do you rate your Rehab and Return to Work Plan?*

	Bad %	Not very good %	OK %	Very good %	Excellent %	Total	Average score out of 5
Women (n=60)	**16.7**	**21.7**	**25.0**	**13.3**	**20.0**		**3.0**
Men (n=56)	**28.6**	**8.9**	**35.7**	**16.1**	**1.8**		**2.5**
Gender unknown (n=7)	**14.3**	**28.6**	**14.3**	**42.9**	**0**		**2.9**
Total sample (n=123)	**21.9**	**16.3**	**29.3**	**16.3**	**10.6**	**94.4%** (5.7% no response)	**2.8**

Again, there were high levels of dissatisfaction with this issue. Respondents complained of meaningless plans to comply with the paperwork requirements, lack of implementation, inflexible strategies, unavailability of recommended duties, and inappropriate duties. It is significant that one of the Operational Review's identified areas for reform was "more individually tailored RTW plans for injured workers needing them" and "more timely and strategic use of the S58 powers to require the pre-injury employer to provide employment" (2004, p. 3).

Comments included:

It was meaningless (Female Registered nurse)
Doctors etc have made suggestions but nothing has been implemented by my work (Male gardener in Aged Care)
Could not return to work until I could do all work (Female disability worker)
Rehab makes more money pushing me from place to place as free labour (Male construction worker)
Duties on plan often not available (Female pneumatic screw driver)
No return to work plan employer won't accept liability for return (Female process worker)
Forced back on line to do jobs that made injury worse (Female assembly line worker)
So long as it looks nice on paper (Female aged care worker).

7. *How well was the rehab and return to work process explained to you?*

	Bad %	Not very good %	OK %	Very good %	Excellent %	Total	Average score out of 5
Women (n=60)	**15.0**	**18.3**	**25.0**	**20.0**	**18.3**		**3.1**
Men (n=56)	**23.2**	**16.1**	**26.8**	**21.4**	**7.1**		**2.7**
Gender unknown (n=7)	**14.3**	**14.3**	**28.6**	**42.9**	**0**		**3.0**
Total sample (n=123)	**18.7**	**17.1**	**26.0**	**22.0**	**12.2**	**96.0%(4** 1% no response)	**2.9**

This is another area in which there is a significant perceived need for much improvement. A little over a third of the sample felt that the process was explained poorly to them. As with other findings it underscores the absolute priority of good communication and information dissemination. See Chapter Four for a fuller discussion of this point.

8. *How good was the communication between people involved in your case?*

	Bad %	Not very good %	OK %	Very good %	Excellent %	Total	Average score out of 5
Women (n=60)	**16.7**	**30.0**	**20.0**	**18.3**	**15.0**		**2.8**
Men (n=56)	**37.5**	**23.2**	**25.0**	**12.5**	**1.8**		**2.2**
Gender unknown (n=7)	**42.9**	**14.3**	**28.6**	**14.3**	**0**		**2.1**
Total sample (n=123)	**27.6**	**26.0**	**22.8**	**15.4**	**8.1**	**99.9%**	**2.5**

Over half the sample characterised the communication as poor, and only 23% regarded it as very good or excellent. There were few positive comments about this issue. One female public servant responded with irony: *You mean they had to talk to each other!!* The most common theme was that the injured workers themselves had to be the go-betweens facilitating any communication. On this theme there were comments such as:

Most communication initiated by myself (Male truck driver)
Unless I chased them nothing happened (Female cleaner)
I had to play messenger otherwise treating doctors didn't know what the other was doing (Female child care manager)

Others reported conflicting and confusing views and collusion:
Case manager and rehab provider in conflict - very confusing (Female cleaner in a nursing home).
Every consultant had a different view and different plans (Female store person in transport industry).
Very good collusion between Case Manager and employer to deny me my rights (Housemaid in hospitality).

Consistent with these findings a 2003 WorkCover Discussion Paper recommended 'coordinated, constructive and frequent communication between all parties'.[26]

9. *How well do you think your needs and views have been considered?*

	Bad %	Not very good %	OK %	Very good %	Excellent %	Total	Average score out of 5
Women (n=60)	**26.7**	**21.7**	**23.3**	**8.3**	**20.0**		**2.7**
Men (n=56)	**48.2**	**23.2**	**17.9**	**7.1**	**3.6**		**1.9**
Gender unknown (n=7)	**28.6**	**14.3**	**28.6**	**28.6**	**0**		**2.6**
% of Total sample (n=123)	**36.6**	**22.0**	**21.1**	**8.9**	**11.4**	**100%**	**2.3**

Almost 59% of the sample felt that their needs and views had not been adequately considered, with under 20% of men and under 30% of women being satisfied on this score. Many of the comments emphasised the ways in which return to work and the profit motive outweighed any consideration of their needs. Workers reported a loss of agency in the process, seeing themselves as a statistic or a drone, whose views and needs were irrelevant. There were very few positive comments. Views expressed were similar to those in a 2003 WorkCover Discussion paper *Towards an Improved Rehabilitation and Return to Work Model in South Australia,* which suggested the need for 'a focus on the person rather than the claim process' and for 'putting "a human face" on rehabilitation and administering the legislation'.

[26] *Towards an Improved Rehabilitation& Return to Work Model in South Australia,* 2003.

Comments included:

Never asked me or didn't listen to what I said (Male Carpenter)
My needs views and rights were NEVER considered (Female clerical worker)
My need or medical injuries where never an issue – always return to work!! (Male driver operator in
waste management)
My needs were never considered - it was all money and how to cut costs and save money (Male weed control operator).
I felt that I was a 'honey maker' for the industry (Male Quality Assurance Manager)
I am a money machine for rehabs and lawyers (Male construction worker)
Did not see me as person but as a headcount so no needs met (female assembly line worker)
Varied over the years but mostly not very good (Female Community services worker)
Getting better (I hope) (Female pneumatic screw driver)
I explain things what I can and can't do. May as well be talking to a wall most of the time (Female process worker).

10. *Overall, how good has the WorkCover process been for you?*

	Bad %	Not very good %	OK %	Very good %	Excellent %	Total	Average score out of 5
Women (n=60)	**35**	**13.3**	**25**	**3.3**	**23.3**		**2.7**
Men (n=56)	**46.4**	**25**	**14.3**	**8.9**	**3.6**		**2.0**
Gender unknown (n=7)	**14.3**	**14.3**	**14.3**	**28.6**	**28.6**		**2.0**
% of Total sample (n=123)	**39.0**	**18.7**	**19.5**	**7.3**	**13.0**	**99.9%**	**2.4**

Overall, 57.7 % of whole sample said that they had experienced the WorkCover process as bad or not very good, with only 20.3 % suggesting it was very good or excellent. Men were more negative about the process than women, giving it a satisfaction ranking of only 2.0 on a 5 point scale. See the earlier discussion of questions 1(b) and 2 for some possible explanations for this difference.
Common negative themes in the added comments were:

- Financial loss
- Stress/despair/depression/suicidal thoughts
- Slowness of the process
- Degrading loss of agency.

Some of the more disturbing comments were:

I have become a disposable commodity, demoralised, dehumanised, disillusioned. NO JUSTICE!! (Female clerical worker)
It has left me ill; financially worse and wary of lawyers. (Male quality assurance trainer)
Totally dissatisfying. Emotionally destroying (Male truck driver)
Contemplated suicide over it (Another male truck driver)
Makes you feel you don't care if you live or die (Male aged care worker)
The 3 year process was the worst 3 years of my life and still continues to be even now I'm off WorkCover (details unknown)
Frustrating and degrading to be an adult and have to answer to others and not make own decisions (Female cleaner)
Rather be dead (Male storeman/packer)
*Made me much more sick and stressed (*Male driver/operator*)*
Soul destroying (Female aged care worker).

Those who were positive or had mixed feelings rarely added extra comments. One referred to the benefit of having wages and medical expenses paid. Several referred to final good outcomes after frustrating processes along the way:
It took away my life, my advocate got it back (Male carpenter)
End result was good but the journey wasn't (Female nurse in public hospital).

11. *During rehabilitation my home situation was well understood by people dealing with my case*

	1 %Strongly disagree	**2** %Disagree	**3** %Undecid	**4** %Agree	**5** %Strongly agree	**Total**	**Average score out of 5**
Women (n=60)	**33.3**	**25.0**	**10.0**	**21.7**	**10.00**		**2.5**
Men (n=56)	**25.0**	**21.4**	**16.1**	**23.2**	**7.1**		**2.6**
Gender unknown (n=7)	**28.6**	**14.3**	**14.3**	**28.6**	**14.3**		**2.9**
Total sample (n=123)	**29.3**	**22.8**	**13.0**	**22.8**	**8.9**	**96.8%** (3.2% no esponse	**2.6**

Almost 60% of women were concerned that their home situation was not well understood by people dealing with their case. Many men felt this too but the trend was less emphatic (46%).

This is a very significant gender finding, aligning with other research (eg. Barbara Pocock's) which indicates the importance of home life for women and the difficult juggling act they have in balancing work and home life. It indicates the necessity for a broader definition of a worker's general welfare to be adopted by all of those involved in dealing with a worker's rehabilitation and

return to work, and an acknowledgement of the very significant (and unpaid) work that women do in the home to support husbands and children (See Chapters 3 and 4).While workers typically report that they receive great assistance from friends and family, such support obviously should not be assumed when considering the home situation. Nor should it be used as a pretext for not offering assistance.

There were numerous comments along the lines of: *They don't care. They were not interested in my home situation. No one cared. Nobody asked me about my home situation. No one asked or cared.*

Some other comments included:

The interest was more with the treatment, rehab and return to work plan, and part of myself thought that was all that WorkCover was about (Woman, 41-55, working in Aged Care kitchen)
My family was used against me when I asked for help (young female cleaner)
Didn't care – left my wife to do everything (Construction worker aged 26-40 with back and knee injury)
It was explained that problems at home were 'too bad' (Male process welder with back injury)
Was never asked by anyone except my own doctor. Employer would have no idea (Female process worker, aged 26-40).
Having a work injury and being a housewife with 3 kids is very difficult (female nurse in Aged Care with a wrist injury).
Understanding and supported by my wife, not Work Cover (male truck driver with neck and back injury)

12. *I was given information about the range of possible support services available to me in the home*

	1 %Strongly disagree	**2** %Disagree	**3** %Undecid	**4** %Agree	**5** % Strongly agree	**Total**	**Average score out of 5**
Women (n=60)	**51.7**	**26.7**	**6.7**	**8.3**	**3.3**		**1.8**
Men (n=56)	**55.4**	**19.6**	**7.1**	**8.9**	**3.6**		**1.8**
Gender unknown (n=7)	**57.1**	**14.3**	**14.3**	**14.3**	**0**		**1.9**
Total sample (n=123)	**53.6**	**22.8**	**7.3**	**8.9**	**3.2**	**95.8%** (4.1% no response)	**1.8**

It was apparent from both this survey and also from our interviews that many injured workers had no awareness of the availability of home support services and were not offered any. Over three quarters of the sample disagreed or strongly disagreed that they were given such information, with only about 12% agreeing. Typical comments included: *Nothing of the sort. Nothing was ever offered or produced. None was suggested and I felt that I would do the best I could. Was given no such information. I didn't know I could have had any help. Wasn't told or offered anything.*

Many relayed stories of debilitating injuries which prohibited simple household tasks like hanging washing on the line. Several talked of not being able to move from the floor or the couch for lengthy periods. While the inability to do housework was apparently felt more strongly by women, for whom housework was an expected duty and something in which they invested some pride, it was also the case that some men, especially those who lived alone, felt very keenly their inability to do simple household cleaning and shopping.

It was evident that family assistance was assumed, although it is not clear whether this was by employers, rehabilitation coordinators, case managers or WorkCover. As a female Service Manager in the Disability sector commented: *I had family support – therefore I did not need other services.* A carpenter in the construction industry said: *I was told my son could mow the lawn. He is two years old!!* A female assembly line worker in the automotive industry said: *No services were offered. The RTW officer was supposed to visit home to see what was needed, but never turned up – I was forgotten.*

A number of injured workers found out about home support from friends, colleagues, rehab consultants or their lawyers. One public servant said she found out 'by default'. It is evident that such information was not routinely offered by case managers and that there was considerable variation between how different insurance companies handled providing this information. Several workers said that they had to make the first approach, or that they only found out after ringing WorkCover to make enquiries.

13. I was able to undertake my domestic jobs as usual, without needing extra help

	1 %Strongly disagree	**2** %Disagree	**3** %Undecide	**4** %Agree	**5** %Strongly agree	**Total**	**Average score out of 5**
Women (n=60)	**50.0**	**21.7**	**3.3**	**11.7**	**11.7**		**2.1**
Men (n=56)	**33.9**	**28.6**	**12.5**	**16.1**	**5.4**		**2.3**
Gender unknown (n=7)	**57.1**	**14.3**	**0**	**28.6**	**0**		**2.0**
Total sample (n=123)	**43.1**	**24.4**	**7.3**	**14.6**	**8.1**	**97.5%** (2.4% no response)	**2.2**

These figures reveal that a significant majority of workers (67.5%) felt that they were unable to undertake their domestic jobs as usual, without extra help. It is also one of the answers where women expressed a higher level of dissatisfaction than men. This is likely to be due to the fact that more women than men participate in housework activities and that women spend significantly more time than men on such unpaid work (see *Statistical profile: Women in South Australia*, p.23). For a fuller discussion of this point, see the discussion of psycho social and gender issues in Chapter 4. This point also emerged strongly in interviews with injured workers, where women revealed that the inability to keep their homes clean and care for children and other family members was one of the most difficult consequences of their work injury. Seen in conjunction with the responses to questions 11 and 12, above, this finding points to the necessity for workers' injuries and rehabilitation to be approached within the broader social context of family and community wellbeing and for rehabilitation and work plans and support services to take on board the crucial role that women assume in doing unpaid childcare and housework. Workers' compensation schemes do not exist in a social vacuum. It is essential that the system is responsive to prevailing social arrangements, in particular the highly gendered division of labour in contemporary Australia.

Additional comments can be clustered in the following themes:

- Limitations or total incapacity for household tasks
- Reliance on partners or children, or the rearrangement of household tasks within the family
- Reliance on paid (self funded) help or the postponement of home maintenance
- The lack of choice about housework, especially for those living alone
- Ongoing problems with pain and the reliance on medication to permit ongoing housework.

Comments included:

Could not do thing about house (male aged care worker with lower back injury)
I had no choice …just took more tablets (female aged care worker with shoulder injury)
Had no choice – I live alone (male printer with lower back injury)
Delayed maintenance or paid others (male electrical technician)
Family members – 14 year old daughter has had to take over a lot of duties (female process worker with repetitive strain injury)
Tasks that took a weekend to complete now take about six weekends (male technician in submarine industry with neck injury)
Every day is an effort. I am never pain free (female clerical worker with musculoskeletal injuries and subsequent depression)

14. Sometimes my injury was made worse by doing jobs at home

	1 %Strongly disagree	2 %Disagree	3 %Undecided	4 %Agree	5 %Strongly agree	Total	Average score out of 5
Women (n=60)	**8.3**	**11.7**	**1.7**	**33.3**	**43.3**		**3.9**
Men (n=56)	**7.1**	**3.6**	**10.7**	**30.4**	**42.9**		**4.0**
Gender unknown (n=7)	**0**	**0**	**0**	**42.9**	**57.1**		**4.6**
Total sample (n=123)	**7.3**	**7.3**	**5.7**	**32.5**	**43.9**	**96.7%** (3.3% no response)	**4.0**

Over three quarters of the sample agreed or strongly agreed that their injuries were made worse by housework. As with the previous question, women were more likely to feel this way than men, presumably a reflection of the amount of housework they were still attempting to do (See discussion of previous question).

Recurring themes in the comments centred around:

- Issues of lowered self esteem: *You still try to do things so you don't feel useless* (male truck driver)

- Resignation to the necessity of housework and associated pain: *Had to try or they just did not get done* (male aged care worker). *My injury is aggravated daily at work and home – have to live with it* (female assembly line worker, with bursitis in shoulders and stress related to bullying)

- Pain with even simple tasks: *Even drying myself after shower caused pain* (female aged care worker with back injury). *Always – food shopping is excruciating still* (female aged care worker)

- A general feeling of defeat about the home situation: *I'm stuffed now and my wife is worn out* (male construction worker, under 40, with back and knee injuries). *Many jobs are still to be done because of the constant pain* (male weed control operator).

Complications arising from re-injury: *I try to do things and hurt myself and therefore sometimes over medicate* (female clerical worker with multiple physical injuries and depression).

15. There were family/friends who I could rely on to help with jobs or with child care at home

	1 Strongly disagree	2 Disagree	3 Undecided	4 Agree	5 Strongly agree	Total	Average score out of 5
Women (n=60)	**8.3**	**13.3**	**1.7**	**43.3**	**28.3**		**3.7**
Men (n=56)	**3.6**	**14.3**	**12.5**	**41.1**	**19.6**		**3.6**
Gender unknown (n=7)	**0**	**42.9**	**0**	**42.9**	**0**		**3.0**
Total sample (n=123)	**5.7**	**15.4**	**6.5**	**42.3**	**22.8**	**92.7%** (7.3% no response)	**3.7**

Consistent with the responses to Question 1, which revealed that family and friends were extremely important and helpful to injured workers, a majority (65%) of respondents to this question agreed or strongly agreed that they relied on family and friends for help with jobs or child care. This response was more likely to come from women (71.6%) than men (60.7%), which could reflect that women are more likely to have strong networks of friends. There were obviously particular problems for people living alone and those without strong friendship networks. Many reported that only their spouses had been helpful and that the constraints of time limited the ability of friends and family to help.

Comments included:

Home help was at times restricted due to spouse unwell and son works fulltime (Female kitchen hand in Aged Care)
Although my family/friends were very helpful they do not have the time to do my tasks. (Male working in submarine construction)

16. My injury and rehabilitation had a damaging effect on my family relationships

	1 Strongly disagree	2 Disagree	3 Undecided	4 Agree	5 Strongly agree	Total	Average score out of 5
Women (n=60)	**13.3**	**16.7**	**8.3**	**26.7**	**35**		**3.5**
Men (n=56)	**7.1**	**10.7**	**8.9**	**17.9**	**51.8**		**4.0**
Gender unknown (n=7)	**0**	**14.3**	**0**	**42.9**	**42.9**		**4.1**
Total sample (n=123)	**9.8**	**13.8**	**8.1**	**23.6**	**43.1**	**98.4%** 1.6% no response	**3.8**

A high 66.7% of the sample felt that their injury had had a damaging effect on their family relationships. While a few respondents spoke of understanding partners and children and strong support, other comments comprised a sad catalogue of relationship breakdown, stress, loss of self esteem and intolerable burdens placed on other family members. While many of these responses relate to the injury and not necessarily the rehabilitation process, they nonetheless highlight the need for a holistic approach which takes into account the impact of injury on workers' domestic situations and relationships, as well as their capacity for work.
Comments included:

The mental stress on my marriage was unfair and unbearable, lucky to survive (truck driver with neck and back injuries)
Separation and eventual divorce (electronic assembler with RSI)
My partner left. Teenage sons moved out eventually because they did not understand what had happened to their mother (public servant, with back injuries and subjected to workplace bullying)
It made me a miserable show of my former self (male aged care worker with lower back injury)
Sex life crashed and burnt (metal trades engineer with knee and back injury)
While I share my home it was assumed they would do all plus work full time as well (Female carer in Disability sector)
Constantly being stressed and in pain is taking its toll on my family (female clerical worker)
I have a understanding partner, but not everyone does (female process worker)

Section D: Open ended questions)

17. *Is there anything that could have happened, or could be happening now, to get you back to work earlier or more successfully?*

There were 92 out of a possible 103 written responses to this question and the answers clustered into seven major themes. They are discussed in the order of the most frequently identified. These themes were:

- Better communication, respect and negotiation (in relation to workplace and case management)
- Better system of finding modified tasks and retraining
- Timeliness of responses to injury
- Adequacy of treatment
- More and better quality information
- Improved employer ethics and investigation of bad practices
- More assistance at home.

Better communication

This was the issue most frequently raised, both in terms of the work place and the case manager or rehabilitation provider. Consistently, respondents felt that their own views about what would be most effective for them were not considered by anyone. They felt that the injury had created a situation in which they had lost personal agency and that other people (who may or may not have their interests at heart), were now making decisions about their life. Their only role was to comply with processes whether they understood or agreed with them or not.

As well as this feeling of being, as one worker described it, *just a pawn in the game,* many respondents described experiencing extremely poor communication skills from the people they had to deal with as a direct result of their injury. They felt that people in the insurance companies were much more interested in cost saving than in health and welfare and that representatives of these companies often adopted an inappropriate interpersonal stance. This stance was often described as hostile, ill-informed (about both WorkCover rules and workplace reality) as well as lacking in recognition that not everyone responds in the same ways to the 'same' injury.

In the workplace, people wanted a more respectful, consultative and supportive attitude, especially from supervisors. They wanted an open process of information and negotiation about what jobs and/or tasks were available and possible. They wanted to contribute to the process of working out shifts and work locations. And, as one worker plaintively put it: *I would have really liked the opportunity to write a 'victim statement' so that there could have been some acknowledgment of what I had been through* (41-55 yr old female community support worker).

Respondents often referred to wanting 'real consultation,' implying that what passed as consultation was inadequate. One registered nurse for example, explained that although she had achieved a successful return to work, she found the whole process *extremely frustrating* because poor communication led

to misunderstandings. She felt sure that a more open communication and consultative style could have avoided a great deal of strain and pressure.

Some participants feel that their reliability and workplace efforts have counted for nothing once they are injured, and that the injury, by definition, creates doubts about their personal integrity and work ethic. One worker offered the suggestion: *Don't hassle people into thinking they are criminals for having hurt themselves.*

These comments about communication and poor interpersonal responses were consistent with issues that were raised by injured workers in our interviews. The levels of intensity of comment varied of course, for example, from a worker who simply said: *I just **wish** they would listen,* through to a couple of workers who said that they had been made to feel so terrible that they had seriously considered suicide.

Several respondents made the explicit point that they (claims agents) care much more about bottom lines and costs than they do about people.

The issue of the quality of communication skills of people who work with and respond to injured workers is an area in need of attention. And, given the complexity of issues and responses surrounding workplace injury it appears that there need to be much higher levels of awareness of related psycho/social issues.

Information

Some workers identified a desire for understandable information. They were confused about how the system works and their role and rights. In terms of receiving good information, a lot of workers expressed a wish for a person who understood their case and needs, who could support them through the experience. This need reinforces the idea of establishing an injured workers' information service. There is also a need for user-friendly information in appropriate language forms including FAQs (Frequently Asked Questions).

Modified tasks and retraining

Many injured workers felt that the process of deciding what tasks they would undertake during work hardening and rehabilitation was not adequately considered and/or that they had not been adequately consulted about possibilities. There is a problem of injured workers being in limbo while possible work tasks are being found. These times of limbo that seem to occur frequently in the experiences of injured workers, add to their personal feelings of depression and resentment against 'the system'.

Injured workers involved in this project would prefer suitable job options or retraining opportunities to be found (and negotiated) more promptly. Some respondents were also confused about what the 'rules' were about retraining – for example, they questioned whether they have any say in this option and the criteria by which retraining is considered. (It is interesting to note here, that a couple of employers in their survey responses, thought that some injured workers were using their injury as a way of making a career change). This points to the adversarial climate and highlights what an important part personal

perceptions play in the dynamics surrounding work place injury.Timeliness of responses

The issue of promptness frequently arose in response to this question. Waiting for responses, either in terms of decisions about their case, or treatment – especially when referred to a specialist – or waiting for appropriate modified duties to be found, all added to feelings that the system was impossible to penetrate. One example given by an injured fitter and turner was that he 'knew' that the two months of physiotherapy weren't doing any good – but he had to go through that because it's what the generic plan dictated for that injury. After the two months had been completed, he then had appropriate surgery. His comment was: *It [the physio treatment] did nothing, except delay things and cost money.*

Adequacy of treatment

The main theme in relation to adequacy of treatment was that injured workers felt that there was a formula for the injury they had received – rather than a plan tailored to their needs. This was not only seen as inflexible and non-consultative but occasionally as counter-productive as well. These views were reinforced in interviews with injured workers and also in WorkCover's *Operational Review* (May 2004) with its recommendation of 'more individually tailored RTW Plans' (p.3).

One aged care worker for example, described appointments that actively *stirred up* her condition but believed that attendance at them was important, or otherwise she might be viewed as non-compliant. Comments such as these continually underscored how little involvement some injured workers felt in their own rehabilitation. It appears that their feelings of exclusion from decisions that centrally affect their well being may well contribute either to passivity and depression or hostility and resentment. Either way, the response is not conducive to early and sustainable return to work.

Many participants felt that within the whole range of players whom they had to deal with, their own GP was the only person who was concerned about their health. This is another point at which the opinions of stakeholders collide. In interviews with case managers, some OHS coordinators, and with employers for example, General Practitioners were seen as problematic. The concerns expressed about them have been discussed in Chapter 4 and are also addressed in section 6.3, later.

Improved employer practices

A few injured workers identified some extremely poor employer practices and felt that employers didn't come under the same sort of scrutiny that injured workers do. Obviously employers differ, as do workers. But another potential 'trigger point' of colliding views is apparent here. It is important that conflict is minimised where possible in the best interests of all stakeholders and this would indicate that attention should be paid to improving some employer practices. In an interview, for example, one worker described how her boss made her go into the factory every morning to clock on and then let her go home again, rather than have an injury report lodged. Another had been 'threatened' with a shift that was impossible in terms of child-care arrangements if she did not return to full time non-modified work.

Support at home

Some respondents wanted '*more support at home*'. What this means may well be different in each case and was not elaborated on the survey form. However, a common message is that consultation about needs is seen as vital.

18. *If you could recommend anything that would improve the rehab and return to work system for other injured workers what would it be?*

There were 98 responses to this question which are listed below (Some recommendations have been paraphrased without altering their intended meaning).

Develop a more caring system

- Create a system that cares and is supportive in an ongoing way
- Create a system that cares about people, their lives and their rehabilitation. Listen more.
- Get the system to understand that it is a whole of life issue – not just a workplace one
- Assume that the injury is genuine rather than assume that it isn't
- Include a victim impact statement
- Make the whole system user friendly
- Employ people who've been through the system so that they know what it's like
- Set up a support system
- Listen to the injured worker.

Improve performance

- Check and fine exempt employers for poor practice and performance
- Insist on qualifications for rehab providers
- Use doctors who don't have a conflict of interest
- Employ case managers who have integrity
- Make system transparent – give all information about the case to the injured worker
- Check on professional abilities of rehab providers
- Stop the system that rewards insurance companies for getting rid of you quickly and cheaply.
- Make rehab providers independent
- Free up the system to avoid time delays
- Give more home support and assess it more carefully
- Ensure that rehab providers are value for money
- Offer re-training for injured workers.

Check workplace practices

- Ensure no victimisation on return to work – provide support and follow up
- Get other workers to understand that being supportive is important. Educate them
- Have proper workplace assessment and modifications to equipment and environment
- Have better communication between WorkCover, Employer and Insurer
- Address the fact that some people fear reporting an injury – because of stigma and loss of bonuses
- Educate employers about what duty of care really means
- Provide management and workplace training in awareness
- Management, rehab and injured worker should sit down together with genuine interest in the work injury
- Find or create a program of decent work hardening options
- Be aware that work place bullying is common.

Personal advice

- Rest enough
- Don't go back too quickly
- Get a lawyer
- Don't get a lawyer
- Keep all your documentation
- Shoot yourself
- Resign if you can afford to
- Take someone with you to all meetings and appointments
- Ask lots of questions
- Try not to be intimidated
- Try to keep positive
- Consult an injured workers' support group for information
- Don't use employer doctor, don't have a case manager and don't have a rehab consultant
- Don't allow them to push you around.

19. *Would you have any advice for a newly injured worker? If so, what would it be?*

There were 104 responses to this question out of a possible 123. The advice that was offered fell into five general categories (with some overlap between categories). The responses have been paraphrased without loss of essential meaning and message. The categories of response were:

- Finding good information
- Finding the right support
- Handling the system
- Handling the employer
- Survival strategies

Finding good information

It was clear that people felt completely confused and often overwhelmed by the system. Their advice to newly injured workers was to seek advice from *someone you can trust*, ie your union rep, an injured workers' support group, or a lawyer. They actively advised **not** to trust rehab providers or case managers because they were not perceived to have the injured worker's interests as their highest priority. A specific comment (and one that has frequently arisen in other contexts) was: *as soon as a person gets injured there should be a booklet with FAQs given to them.*

Handling the system

Dealing with the system was commonly seen as the issue that was most difficult. This point is reflected in comments such as: *Hard though it will be, don't take the things WorkCover do to you personally. They see the worker as a claim, not a person.*

Advice on this issue ranged from: *Don't make a claim, the system ruins your life,* to specific strategies such as: *Keep a diary. Make sure you've joined the union. Don't sign anything without proper advice.* Consistently, comments reflected the view that dealing with the system is tantamount to going into battle. It requires preparation, assertiveness, support, persistence, determination not to be bullied and wariness about who to trust.

Respondents typically felt that they were not central to the whole process. One respondent advised: *Don't expect a lot of support; don't expect anyone to hurry when they make decisions; always expect that someone else knows better than you.* Another suggested: *Be Strong, try not to get upset, find out as much as possible, and don't let anyone walk all over you.*

Finding the right support

Similarly, the message was clear that injured workers did not see support as something that the system would provide. Comments included: *Go to a support group,* and *Find support from people who don't profit from the system.*

Handling the employer

A common theme in responses to this question was not to rush the healing process and aggravate the injury again, for example: *Don't do what I did and think that the problem won't affect your job. You have to listen, get medical help and be prepared to rest.* And: *Don't let them push you back to work if you know that you are not well enough.* Another theme was that the whole experience of being injured would be significantly affected by the employer's attitude. For example: *Hope that you have an understanding employer.* The other side of this coin was expressed as: *don't put up with 'crap' from employers*, if they were not meeting their obligations. Several respondents urged prompt reporting of the injury. One comment echoed themes that we had heard during interviews, namely: *be prepared to be treated as if you are a liar and a cheat.*

Survival strategies

Strategies mainly centred around possible ways to protect yourself against the system, such as having a witness, recording everything and not signing without advice from someone independent. There was an implied assumption in all of these ideas that the process would inevitably grind you down – and that this was especially hard to take when your life (physical and emotional) was already so disrupted. Many respondents felt that using a personal GP was one way to have someone who had the individual's interests, rather than the system's, at heart.

Summary

Almost all of the responses reflect feelings that the WorkCover system makes life even more difficult and complicated than it already is with the injury. These comments mostly relate to bad experiences with claims agents and employers and a failure to adopt a 'whole of life' response to rehabilitation and return to work.

Suggested strategies for newly injured workers revolve around protecting yourself from the stress that comes with engaging with the system – and asserting your rights and needs because the system is not interested in that dimension of the issue.

It seems clear (and is reinforced in discussion with other stakeholders) that currently the WorkCover system is perceived as adversarial rather than collaborative. The tone of comments made were often similar to this one, made by a 40 yr old female process worker:

Don't trust your rehab or case manager. They don't explain it good and it's a rush job. They just want you back at work straight away because they get paid for it. They get paid for doing nothing to help you.

Although this group of respondents may well represent the most dissatisfied end of the client group, their criticisms are so uniform that they offer clear and valuable messages for the improvement of customer relations generally.

20. *Is there anything about your particular circumstances that has made rehabilitation and return to work especially difficult for you?*

This question was included in case there were any patterns or themes that we had not tapped. We wondered for example, whether ethnicity, age or gender might be raised. We deliberately left the question open so that we would not be suggestive of answers and to allow other circumstances that we may not have considered to be raised. It appears however, that asking what was 'especially difficult', prompted further comments of the sort we had already been given. These included for example:

- *Bad WorkCover officer*
- *Feeling that no one believes me*
- *Poor attitudes to injured workers*
- *The feeling that most contacts are working for someone else, not me.*
- *Depression, anxiety, suicidal thoughts*

- *Claims administrator – rude and not interested*
- *Pain*
- *Attitude of co workers*
- *The length of the process*
- *Being constantly undermined*
- *Knowing that my workplace would rather be rid of me*
- *Being victimised*
- *Being pregnant and also having a toddler*
- *Financial worries*
- *Lack of compassion.*

21. *Is there anything else about rehab and return to work that you would like to tell us?*

This open ended question was included to give participants the opportunity to raise any issue that was of importance to them – and to ensure that we had not omitted any relevant themes. There were 56 comments out of a possible 123.

Most people who commented offered an overview or analysis type of statement. A few people reiterated points already made in order to underscore their importance. And some people added a highly personal comment, such as: *I have had a wonderful experience with [name] from [company name] – previous rehab not really helpful at all.* Comments were directed mainly at the system of WorkCover and the workplace post-injury.

System comments

- *The system is corrupted by the inclusion of insurance companies whose main goal is profit –and who are the 'pay masters' of the allied health professionals. Thus compromising their integrity.*
- *Get some people who have been through the system working in the system. At least they would understand.*
- *It was hard to find out what is available to aid families and who to contact for aids eg. toilet chair.*
- *I felt in the dark a bit.*
- *I found it very depressing and I think psychological counselling should be offered to everyone.*
- *There is very poor communication between employer and Insurer.*
- *Too many chiefs and not enough Indians.*
- *No one from WorkCover has kept in touch on a long term basis – I have felt very isolated.*
- *I did not know my rights.*
- *I did feel very pressured.*
- *The worker should be listened to more.*
- *No wonder WorkCover is broke! Dragging medically proven injuries that will never rehabilitate out for so long is a waste of money.*
- *Personally I think it's a cottage industry where the injured worker is far, far, down in the food chain.*
- *Rehab must be impartial and independent. There is too much conflict of interest.*
- *Rehab providers shouldn't be allowed to organise doctors.*

- *WorkCover don't care about the worker, their aim is to reduce costs.*
- *The actual system isn't bad but I think people must be in it for the wrong reasons and these discourage and degrade injured workers.*
- *Doctors nominated by insurance companies do not help matters with their sneering and aloof attitudes.*

Workplace comments

- *Employer pushed me to do duties and to work faster than what my doctor had advised. I felt guilty if I could not keep up.*
- *Employer wasn't in communication with other parties.*
- *I resigned because of harassment from management – even though that meant I lost WorkCover.*
- *I did try to get back to pre injury duties but the work place wanted me to do normal duties straight away.*
- *I found it very difficult to explain my condition and discomfort particularly to management because they are not listening to me. Their only communication is to tell me that they know because of what the doctor says.*

Summary

It was significant that many participants saw the system, as it is currently organised, as inherently conflicted. This would indicate that their concerns extend beyond the issues relating to the 'front end' of service, to more systemic organisational and structural issues.

6.2 Health and Safety Representatives' survey

Background

One hundred surveys (see **Appendix B**) were distributed to HSRs across a range of industries. Twenty responses were received. See profile of respondents below.

Sample profile

Gender of HSR	Female: 40% Male: 45% Unspecified: 15%
Time in role	From 9 months to 18 years. Average = 6.5 years
Gender of workers represented	30% women 50% men 20% both men and women
Number of employees represented	A range from 9 to 250.

Industries represented	Bulk handling/ ship loading Community services Education Hospitality Manufacturing Health Public Transport Mining Administrative services.

The participants represented:

- a reasonable gender balance
- differences in length of time in the role
- a diversity of industries and organisation size.

In the first twelve questions the survey canvassed views about attitudes, practices and policy within the workplace in relation to injured workers and their rehabilitation and return to work. In these questions respondents were offered a 5 point scale of *Very Poor – Poor – OK – Good – Excellent*, with space for additional comments. The next three questions invited a lengthier response to three open questions:

- *What would assist you to perform your role in relation to injured workers?*
- *In what ways, if any, do men's and women's needs and issues differ in relation to rehabilitation and return to work?*
- *What changes in the rehabilitation and return to work system and/or workplace would improve the situation for injured workers?*

Fifty-eight surveys were distributed in metropolitan Adelaide and the remaining forty-two were distributed in Ceduna and Port Augusta. There was a return rate of 20% and although this was fewer than we had hoped for, respondents were generous in the amount of time and thought they gave to their answers.

This was particularly evident in responses to the three open-ended questions (described above) which invited thoughts, insights and suggestions. It was also apparent in the number of comments added to the questions that asked for a ranking on a five-point scale. It was quite common for people to briefly explain or give an example of why they had ranked in the way that they had. Given this high quality of response, a factor worthy of consideration is that these respondents may represent a group which is especially highly motivated in their work.

Findings

How would you rate your work site in terms of its initial responses to a worker who is injured?

All respondents believed that their worksite management's initial response to the occurrence of a work place injury was *Very good* or *Excellent*. Comments about this question related to the fact that policies were in place and people

were trained to know what to do. First Aid training was cited as an example of this preparation. Some respondents added the point that *a lot depends on the personality of the supervisor.* It would appear that this comment relates to psycho/social responses, rather than to the injury per se. This answer was very similar in relation to management's attitude toward workplace injury. On this issue the theme of genuineness of the injury was raised, ie the response to the worker was positive and supportive if the injury was perceived as genuine.

How would you rate the adequacy and timeliness of information provided to workers about rehab and return to work?

Although many respondents ranked this issue as *OK* or *Good*, several of the comments indicated that it was an area in need of attention. One theme was that there was no information about the process until someone was injured and needed to engage with it. Another theme was that the injured worker learnt what was involved but not other workers on the site, and as one respondent put it, *this doesn't help workplace harmony and morale.* One respondent, who has been a HSR for four years, commented that he *hasn't had any need for this information,* implying that it is seen only as relevant when the issue arises. This raises an interesting question in terms of the role and expectations of HSRs, particularly since a consistent concern reported by injured workers is that there was no one person who could steer them through the experience. One HSR commented that he knew that information existed, *but no time was made available for workers to receive training and development.* Another thought was that the information given *is very one sided and not the whole picture – you don't hear about your rights.*

How would you rate the effectiveness of the work site's OHS Committee in addressing RRTW?

The majority of the respondents ranked the effectiveness of the OHS Committee as 'good'. At the same time, several of the comments relating to this question indicated that the OHS Committee had no connection with individual issues of injured workers and their rehabilitation. Rather, they operated as a policy committee and, seemingly, often at arms length from situations that workers experience on the 'shop floor'. In response to the question about the effectiveness of the committee in relation to rehabilitation and return to work comments included:

- *Mainly just management do it* [deal with injury and return to work]
- *There is non involvement by the OHS committee*
- *So called 'confidentiality' restricts their ability to have a more positive input*
- *It's* [RRTW] *rarely dealt with at committee meetings.*

These sorts of responses mirrored views reported to the researchers in other contexts during the project. A group of union representatives, who met as a focus group for instance, felt that OHS Committees were often helpful if a worker had a positive suggestion to improve safety. However, they were much less responsive to issues such as setting up processes to negotiate alternative duties or shifts. One view expressed in this particular focus group (a view that received unanimous approval of the group) was: *They want the systems to look good, but they don't really give a stuff about injured workers as people. In their*

minds, when one worker is injured, you just go out the back and dig up another one.

In another interview with a trainer of HSRs, a strong view was expressed that there was enormous untapped potential for OHS Committees to become more active in achieving best outcomes for the rehabilitation and return to work for injured workers in their own workplace.

How would you rate your general 'workplace culture' in terms of attitudes/behaviour towards injured workers?

In this question we wanted to find out whether there were any general attitudes in the culture of the workplace in response to worker injury, rehabilitation and return to work. There was a mixed response in terms of the ranking, with 40% thinking the workplace culture was very good or excellent, 25% thinking it was poor and the rest opting for the OK category. It was perhaps a difficult question to make a generalised response to, given that so many variables would affect each situation. However, what emerged as a strong and consistent theme in the comments attached to this question was that worker attitudes to the injured worker strongly related to how that worker was generally perceived. Comments included:

- *Varies from completely supportive to very cynical depending on worker's previous work attitudes and efforts.*
- *With an injured worker, other people have to accept a bigger load. Resentment has flared when that worker has been slack with his light duties. The personality of people has been the biggest factor.*
- *Both sides have poor culture towards injured workers, eg. company and employees see injured workers as not genuine or bludgers on system. Very little sympathy to the injured party.*
- *It's good at the start and then dwindles off.*
- *If they are genuine – fantastic. If they are not a team player or suspect, don't expect the same support.*
- *Depending on the injured party and their attitude.*

It can be expected that different individual workers will provoke different responses from their colleagues. However, what is of interest in these answers is that subjective views about an individual to a large extent determine how seriously a worker's injury is taken, indeed whether they are believed at all. A similar finding was revealed in the survey sent to employers (see Section 6.3, following).
Given that a consistently reported concern of injured workers, in both our survey and in interviews, was that they felt judged and disbelieved, this emerges as an issue for attention.

How would you rate your general 'workplace culture' for its responsiveness to any particular needs, eg. gender or ethnicity?

Respondents ranked their workplaces highly on this question and only one comment was made about the workplace needing to change — *quite a lot,* if it was to be geared to women. However, in our interviews with women workers they raised a range of gender specific issues in relation to their rehabilitation, return to work and home-life balance. The discrepancy between their

experiences and the views of the HSRs is open to interpretation. One possibility is that the HSRs may not be sensitised to a gendered perspective on matters of health, safety and rehabilitation, and that this issue may need to be addressed further in their training.

How would you rate your worksite's practices and policies in relation to rehab and return to work?

All respondents ranked their workplace highly in relation to its policies and practices for injury rehabilitation and return to work, except for one comment that it was *only very average.* The issue of the perception of the worker's genuineness was again raised. The impact of this dynamic is reflected in the comment: *It would do whatever is needed for a person who is positively committed* (implying that it might not if the person were perceived differently). This theme will be discussed more fully later in the report.

How do you respond to the idea of HSRs and/or OHS Committees playing a greater role in actively supporting workplace rehab planning for workers?

This concept was overwhelmingly seen as a positive proposition. Only one respondent commented that she would not be able to leave her post in order to do it. Other comments were:

- *This would help plans being adhered to and reduce co-worker attitudes being detrimental to the rehab process.*
- *I think this would be a very good idea.*
- *I don't want to be involved in formulating plans. However consultation would be good so that problems could be avoided.*
- *The injured party would need to feel comfortable with this too.*
- *We would need appropriate training and backing.*
- *More input from fellow workers on a positive note would be great.*
- *Excellent because it gives a much more experienced and knowledgeable role than 'the professional' who often has a limited knowledge and little experience of other work roles.*

This last point has also been raised in discussions both with workers and union officials. There is a belief that workers' 'hands on' knowledge about work tasks and possibilities for undertaking them is under utilised, or not used at all. One specific recommendation, for example, was that there should be a job register (a listing of every task undertaken in the workplace) and that this should be used and negotiated with injured workers.

How do you respond to the idea of further training for OHS Committees, HSRs or other workers to support a more active role in rehab and return to work?

The response to this proposition was overwhelmingly positive. Apart from general comments of support such as: *I would actively support this move,* there were other comments that indicated that HSRs feel more able to do their job when they are provided with appropriate training. These included comments such as: *Yes, training so that we understand the system and can give the right advice.* And, *I need to know and be able to do the right things.*

Almost all respondents felt that more training for *all* workers would be a good idea. Their comments highlighted a desire for management, supervisors and team leaders to be more informed. And these comments indicated that being better informed related predominantly to psycho/social awareness and skills, rather than policy or legislation. Comments included:

- *Training on issues of depression would be good. Most people haven't got the time or energy to put up with behaviour of depressed injured workers. Need a lot of education there.*
- *All the staff at our site need training about psychological health (unknown word).*
- *Learn co-operation from management, more communication, being open with the injured person.*
- *Upper management fall through the health and safety training net.*
- *Training everyone on site would be good. People just don't realise what it's like to be injured. Because a worker is injured doesn't mean they've got the plague.*

The three open questions

What would assist you to perform your role in relation to rehabilitation and return to work of injured workers?

The responses to this question fell into two categories. The first related to training and the second to the need for information and support from within the organisation. Responses in relation to training reinforced its importance, as described earlier, and were expanded with explanations of how complex the legislation is and how vital sensitive communication skills are in relation to injured workers and their work mates. The stated need for support and information often reflected feelings of being 'out of the loop' in relation to what tasks an injured worker was able to do. Comments included:

- *I'd like information on what a worker's needs are so that I could give genuine assistance.*
- *Being more involved in rehab planning and better informed about the company's processes.*
- *Better support from the company in finding work that will suit the worker.*
- *Better communication and follow-up, especially about the duties allowed.*

These comments would suggest that HSRs would welcome the opportunity to be more involved in the rehabilitation and return to work process. And, importantly, they see themselves as having valuable insights that come from first hand knowledge of 'on the job' experience, something which they sometimes view management and professionals as lacking.

How do men's and women's issues differ in relation to rehabilitation and return to work?

Answers to this question mostly related to the sorts of support that might be required at home. There was an understanding that if a worker has an injury, it will almost certainly affect home life as well. The sorts of comments around this issue were: *Women may need more support in the home because of child care*

and cleaning. And, particular mention was made of single parents who have no options about having to function at home.

One respondent raised the issue of self-esteem, explaining that while the need for self esteem was the same for both sexes, different things provided it for men and for women. Examples given included the affirmation of masculinity that comes from undertaking strong physical labour or the pride that comes with having a clean house.

Another perception offered was that women feel more guilty and responsible for all of the home issues and they push themselves to return to work quickly. Another respondent made the point that each individual's needs were assessed in relation to their workplace capabilities and needs, and that the same sort of plan needed to apply to home because needs and circumstances were so diverse.

Several respondents implied that gender differences exist – but did not expand on their answers. One comment for instance was that: *Women returning to work is complicated by their other responsibilities,* implying some taken-for-granted knowledge about women's lives. Sometimes this taken-for-granted knowledge was made more explicit, for example, in the comment: *Women are still expected to run the household.*

What changes in the rehabilitation and return to work system, and/or in the workplace, would most improve the situation for injured workers?

The responses to this question came as somewhat of a surprise, especially as respondents had been fairly positive in their responses to an earlier question about their perception of attitudes in the workplace culture. However, the comments in this open question consistently referred to the fact that injured workers are not received well by their co-workers (which might well be an indicator of a problematic work place culture). A representative sample of these responses is:

- *There needs to be an understanding of the program and objectives for the injured worker by other workers – whether these injuries are visible or not. It doesn't help workers when they are not believed. I had one case recently where the worker was already thought to be lazy and this didn't help at all when he needed to be on modified duties.*
- *Better understanding from co-workers about their needs and what they can and can't do.*
- *Training of general workers to stop harassment of the injured worker.*
- *Improved information for all and a change of culture about injured workers being rorters or bludgers.*
- *There needs to be more understanding of injured workers especially psychological issues.*
- *A clear statement so that other workers can see what an injured worker can and can't do.*
- *Provided these were great and valued team members before the injury, they should be given every encouragement to continue. When this is not the case an enormous amount of effort can be put in – when the worker doesn't like their team or environment in the first place.*

Summary of key points

- The HSRs felt that their work sites' initial response to injury is extremely good. Most respondents interpreted the question as being solely about compliance with regulations. Only one respondent commented that the experience for the injured worker depended on the 'personality of the manager' – indicating the importance of the interpersonal experiences surrounding the injury.

- Information about work place injury rehabilitation and return to work was identified as an issue in need of further action. HSRs found training and development invaluable and wanted more – not only about the legislation, but also about responding to issues such as an injured worker's depression. They consistently reported that generally, workers were ill informed about the processes and dynamics of rehabilitation and return to work. There was some feeling expressed that available information was incomplete in that it explained responsibilities and obligations – but not rights.

- The role of HSRs could be expanded and more broadly defined. This would involve training about the ways an injury affects a range of issues beyond the physical. However, for such training to be meaningful, there would also need to be support from management, including acceptance of the idea that psycho/social issues relating to workplace health and safety are important.

- Training, especially about attitudes and communication skills, emerges as an important issue to support HSRs to undertake their role effectively. However there may also need to be further clarification about expectations of the role. It appears that this can be understood differently by different stakeholders, ie. union, employer, worker and the HSRs themselves.

- Consistently, HSRs identified the return to work of an injured worker as a time that was a potential trigger for harassment, bullying, derision, victimisation and negative or abusive labelling. Underpinning these problems were co-worker and supervisor assumptions about the legitimacy of the need for modified duties and often a lack of understanding about the effects of injury and rehabilitation needs. It is significant that in our interviews with injured workers, these sorts of attitudes emerged as being more difficult to deal with than the injury itself. They are also attitudes that may well discourage an injured worker from reporting it. A theme that is picked up elsewhere in the report is the subjectivity of judgements that surround the legitimacy of an injured worker's claims.

- The responses of the HSRs reveal as much about the psychological health of the organisational culture as they do about the particular needs of injured workers. These issues are extremely important for future work and action. For example, employers could be encouraged to carry out audits of their workplace practices and cultures, including measuring qualities like openness and trust and the incidence of practices such as harassment and bullying.

6.3 Employers' survey

We surveyed employers to supplement information we had from interviews with employer organisations, management and OHS/Rehabilitation coordinators.

With the co-operation of Business SA, 50 medium and large employers across a range of industries were chosen from Business SA's database. Surveys were returned anonymously to the research team via the Working Women's Centre. The research team did not have access to the names or any other details of those receiving the surveys. The survey canvassed views on the fairness of the Workers Compensation system and legislation in SA, the factors that most help and hinder sustainable return to work, workplace cultures, difficulties facing employers and desired reforms. It comprised 11 open-ended questions.

Nine responses were received, an 18% return rate. Almost all surveys were completed by managers/staff responsible for OHS and/or rehabilitation. Responses came from a range of industries including two from manufacturing, two from healthcare and two from local government. Almost all were large employers, with only one in the 1-25 employee category. Below is a summary of the findings with some selected comments from participants.

In your view is the WorkCover system fair?
There were mixed views here. Many saw the system as unfair or favouring the injured worker. Only a few thought the system was unequivocally fair. Criticisms of the system included that it was a 'no fault system' and that WorkCover made insufficient allowance for the difficulty of finding alternative duties. One comment was:

Where there is a clear injury and workers who wish to be well (including rehabilitation) there are few issues. Where the cause is uncertain and/or there is no desire for rehab, the system is not fair to employers.

In your view is the legislation adequate?
The respondents were divided on this question. Several suggested there were *too many grey areas* and that there was *too much room for interpretation.* Several simply answered *NO.* One negative response included this explanation:

No, there should be provision for medical review of difficult cases to provide clear direction for the parties. The legalistic approach of each party getting medical opinions – then arguing them in court is expensive and not conducive to resolving the situation for either party.

What in your company are the main issues in relation to injured workers and rehabilitation?
A wide range of issues were cited here. Two mentioned problems with doctors (eg. *giving too much time off; not supporting return to work; not communicating adequately about appropriate duties*). Three mentioned the difficulty of finding suitable alternative duties. One small employer mentioned the loss of production and the impact on the morale of the work team. Responses reinforced our perception that 'colliding paradigms' are an integral feature of the whole rehabilitation and return to work picture. Essentially this collision occurred in the tension between productivity and the welfare of the injured worker. One respondent saw the main issue for example, as *people using the*

system as a welfare system. However, two respondents did indicate that they could see these tensions and that a balanced perspective needed to be taken. One such comment was:

Ensuring that the number one paramount concern of the process is return to work. Sometimes this is lost in the management of injury – from both employer and employee positions.

Where there are difficulties with rehabilitation and return to work, what are the main (or most common) reasons for this?

The two most frequently mentioned issues were the difficulty of finding meaningful light duties and problems with GPs (their lack of knowledge of workplaces; their too ready support for workers to 'remain off work'; their willingness to declare all injuries as work related). Other issues raised included the demands of the WorkCover paperwork; unsympathetic colleagues; the need for sensitive management; the need for timely and relevant communication; and psycho-social issues around workplace injuries. One OHS manager in health care avoided polarising the issue with this comment:

Sometimes it is difficult to provide meaningful duties. Care has to be taken that other workers are sympathetic and accept that there are some restrictions. Management has to be careful to not upset delicate situations.

What most a) helps and b) hinders timely and sustainable return to work?

a) Helps

The predominant emphasis here was on the need for good communication and positive approaches. Early intervention and early return to work were also mentioned by several respondents. One singled out employee motivation as the most helpful factor. Several again took the opportunity to stress the need for doctors who were knowledgeable about workplace duties. An OHS coordinator in the Conservation industry summed up the helpful factors as: *communication; early intervention; listening; timeliness.*

b) Hinders

Negative employee attitudes emerged here as hindering return to work but not overwhelmingly so. Employer attitudes (adversarial, lack of understanding for worker) were also identified as hindrances, as were GPs, again, and differing medical opinions. Others mentioned claims taking too long to determine; lack of understanding of WorkCover process by all parties; and the costs associated with light duties. One said the legislation makes it easier for the worker to stay at home.

What are the most difficult issues you as the employer face in dealing with work injuries and return to work (system or other).

Some more insights emerged here about management perceptions of barriers associated with the injured worker – their attitude, impact of other factors in their life, and questions about the sincerity of the injury. GPs were once again a strong theme – mostly relating to their perceived lack of understanding of workers compensation and the workplace, and a belief that they *do just what the worker requests*. Some very negative perception of the legitimacy of workers' claims emerged, with one respondent, a rehab coordinator in the manufacturing industry, citing the greatest difficulty as *people who are after financial gain or a new career path through WorkCover.* By contrast another

person in a similar role in the same industry said that the most difficult issue was *pressure from peers and management on the worker.*

A coordinator in healthcare expressed a view which was also a common theme in our interviews with key stakeholders:

The most difficult cases are where there are other life issues and all problems seem to be focussed on the workplace injury. The bias of the system in favour of the worker then creates an environment of difficulty in RTW and expense in paying for all sorts of issues which may or may not be work related.
Responses to this question highlighted the adversarial nature of the system and the necessity for establishing a culture of collaboration.

a) Do you think that attitudes within the workplace (general workplace culture) influence the rehabilitation of injured workers?
b) And do you have any suggestions in relation to this issue?

All agreed that the workplace culture is important and most referred to the attitudes of co-workers as being significant. The *stigma faced by anyone on workers comp of being a bludger or fraudulent* was acknowledged by one. The most common word used to describe a good workplace culture was *supportive.* Others spoke of the need for it to be *encouraging and sympathetic.* A Workers Compensation Officer in Manufacturing saw management attitudes as crucial: *Yes - If management have a negative attitude it reflects on the injured worker, makes them feel bad and stressed, therefore taking time off, and slowing down rehab.*

Suggestions for changing the workplace culture mainly centred on the need for training and awareness generally, for both management and the workforce. The need for a holistic view of this training was expressed by a production manager in food processing:

Education of the workforce and management of the many issues involved ie. a) cost on business, community, fellow workers and b) mental states of workers; injured worker and management.

A few mentioned the need to ensure that co-workers are aware of modified duties and work restrictions – at the same time recognising the need for confidentiality. This tension is discussed further in **Chapter Four** in the section on communication. A few people didn't respond to this question.

a) Are there particular issues faced by injured workers in relation to their home life?
b) Are these issues different for men and women?

Many responses recognised that the impact of a work injury on home life is huge and that sometimes this impact comes from having to comply at home as well as work with restrictions on physical activities. One local government HR (Human Resources) Manager acknowledged the *lack of independence in terms of maintenance of property, relationships and boredom.*

Respondents were fairly evenly divided on whether there were gendered differences in the impact on home life. A health care safety and quality manager suggested that the differences were likely to be more ethno-cultural than

gendered. Several acknowledged the pivotal role of women in *running the house and looking after the children,* with one of these respondents also suggesting that *men will feel useless because they have to depend on their female partners.*

Does your workplace have an OHS Committee? What is its role? And could it have a more active role in rehabilitation and return to work (RRTW)?

All replied that they have OHS Committees focussed primarily on occupational health, safety and welfare. There was a mixed response to the potential role of such committees in RRTW, with some very firm *NO'*s, particularly around any suggestions of committees getting involved in individual RTW Plans. These responses might flag some likely opposition from employer representatives to any suggestion of an expanded role for OHS Committees. However, some interest was expressed in committees having a workplace education role re RRTW.

Is there anything that you would like to see changed in relation to current rehabilitation and return to work practice or policy?

Again, the predominant emphasis here was on the responsibility and accountability of doctors. As one Manufacturing industry rehab coordinator put it:

Legislation needs to change to make doctors and workers more accountable. Companies should not bear the cost of degenerative diseases or for aggravations of personal non-occupational injury or illness.

Several requested more clarity and certainty. One reiterated his/her suggestion for:

A medical review panel for difficult cases, which could review differing medical opinions and provide clear treatment/RTW capacity advice, would help employers, facilitate RTW and give injured workers a clear guide as to what is expected of them.

Is there anything else you would like to tell us about rehabilitation and return to work?

This open ended question did not generate many answers or much new information. The most expansive answer again emphasised the potential for the system to be rorted, at the same time acknowledging the injustice this produced for genuine cases.

The system needs to be made fairer to those who are sincerely injured. They seem to be the ones who are penalised because of the frauds and injured workers who can't be bothered to return to work. Have shorter waiting times to book any specialist. 3-4 months isn't good enough.

Chapter Seven: Recommendations

A. Primary recommendations

Gender

- WorkCover's future planning, programs, policy and contractual arrangements should reflect appropriate understanding of and response to gender issues and the pressures involved in balancing work and home life.

- WorkCover's new RRTW model should adopt a gender-based analysis and any major reviews should take account of work, gender, domestic and community life.

- WorkCover should devise appropriate strategies for ensuring that all relevant people involved in work injury claims management and rehabilitation are adequately trained in gender and work/home life issues and that this is demonstrated and continuously monitored. Specific strategies could include:

    - Training for managers, claims agents, rehabilitation providers and health and safety representatives incorporating awareness of gender and work/home life issues
    - Monitoring of the recognition of gender and work/home life issues at all stages of an injured worker's compensation and rehabilitation process – eg. in checklists, pro-formas and in the performance standards of claims agents.

- WorkCover's Access and Equity's Women's Focus Group supports a research project

to establish and pilot a best practice model for the equitable and effective accessing of home support services, in terms of improved outcomes for workers, employers and the scheme.

Psycho/social issues

- Key players who contribute to the compensation and rehabilitation of injured workers are trained in, and demonstrate, respectful communication skills and an understanding of psycho/social issues related to workplace injury.

- Case-managers' case loads take into account risk categories and differing levels of complexity, and ensure that case managers have the time to communicate adequately with all clients and address their psycho/social needs.

- The rehabilitation and return to work model gives more consideration to the concept of return to the community as an appropriate outcome for injured workers who will not realistically return to paid employment.

- That the concept and benefits of a psychologically safe work site should be widely promoted, including a recognition that returning to work on modified duties can be a trigger for hostility or bullying.

- That WorkCover review its information dissemination services and materials to ensure that all injured workers routinely receive timely, comprehensive and accessible information about:
    - the scheme and its operations
    - the rights and obligations of all key players, including employer, claims agent, rehabilitation provider, medical provider and the injured worker
    - available services and support for which workers may be eligible, including transport, childcare, cleaning and other home support and re-training opportunities.

- The Access and Equity Unit undertakes to monitor performance to ensure that the information needs of injured workers from identified equity groups (women, Aboriginal and Torres Strait Islanders, people from culturally and linguistically diverse backgrounds and workers with disabilities) are met.

Data collection and reporting

- WorkCover provides the following information about work injury claims, relating to both exempt and non-exempt employers, and that the information be broken down by occupation and gender:

    - number and cost of claims
    - number and cost of claims relating to lost time injuries
    - number of claims where rehabilitation services are provided
    - average cost of rehabilitation services and what this money is spent on
    - number of claims where home assistance is provided
    - average cost of home assistance services and what this money is spent on
    - number of claims where re-training is provided and information on the nature of that re-training
    - rehabilitation and injury outcomes, including whether the worker returns to the same work and the same hours of work and whether return to work is sustained over time.

- The current multi-variant analysis project should be completed and the findings published.

B. Secondary recommendations

Early reporting

- There be an ongoing information campaign for employers, unions, HSRs, workers and the community, regarding the benefits of early reporting and early intervention in workplace injuries.
- Management, union and HSR training address the benefits of early reporting and early intervention.
- There are appropriate incentives in place to support early intervention – for employers, workers, claims agents and rehabilitation providers.

Return to Work (RTW) Plans

- The format for RTW Plans is revised to ensure they are concise, written inaccessible language and that they are flexible enough to respond to the changing needs and circumstances of the injured worker.

Alternative duties

- WorkCover policy and practice supports workers and employers/managers being actively engaged in planning early and sustainable return to work, and in so doing they take account of the worker's prior family commitments, where possible matching tasks and jobs to the capabilities of the injured worker and developing strategies to ensure that the worker can return to normal duties as soon as possible.
- WorkCover supports development of job/task registers by employers to facilitate better matching of injured workers' skills and capabilities and alternative duties.
- WorkCover receives early Section 58B referrals when alternative duties are not available and responds appropriately.
- WorkCover responds promptly and works with employers to find workable solutions to the lack of availability of suitable light duties in some industries, businesses or occupations.
- Workers receive appropriate job training/support from their employer if alternative duties are not available, for example language and literacy classes for workers of Culturally and Linguistically Diverse backgrounds.

Re-training

- WorkCover develops clear and transparent policy and guidelines regarding access to re-training.
- The Access and Equity Unit monitors performance in this area to ensure reasonable equity in access to such opportunities.

Rehab Providers and Case Managers

- Training for rehabilitation providers and case managers adequately addresses the whole-of-life impact of injury, pain and disability on injured workers and their families.
- WorkCover standards and contracts ensure that only such adequately trained and skilled case managers and rehab providers/consultants are employed.
- Workloads are appropriate for claims officers/managers and the complexity of injuries is matched with the skill set of case managers
- Steps are taken to address the high turnover in claims managers and rehab providers.

Health and Safety Representatives and Occupational Health and Safety Committees

- HSRs and OHS Committees influence workplace cultures to better support workers returning to work after an injury and, where the injured worker agrees, co-workers are informed about the nature of the injury and how best to support the worker in their return to work.
- WorkCover Health and Safety Consultants, Unions and Business SA, in consultation with Workplace Liaison Unit, actively explores alternative models for provision of HSR and OHS Committee functions for small and very small businesses in metropolitan Adelaide and for regional SA.
- WorkCover Liaison Unit works with training providers to develop and introduce extended training opportunities for HSRs and OHS Committees to address:
    - the role of HSRs and OHS Committees in RRTW.
    - employee and employer rights and responsibilities in relation to RRTW and scheme procedures and processes.
    - workplace culture and attitudes to injured workers.
    - impact of injuries on workers, including issues such as depression and self-esteem for workers returning to work.

The Workplace

- Workplace training be made available to workers and management about the impact and management of injury (physical and emotional) and appropriate ways of communicating with injured colleagues who are in this situation.

Doctors

- WorkCover initiate research about alternative models of practice involvement for doctors, eg. international models.

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Glossary of acronyms and terms

Acronyms

A&E	**Access and Equity**
ABS	**Australian Bureau of Statistics**
CALD	**Culturally and Linguistically Diverse**
DAIS	**Department of Administrative Services**
GP	**General Practitioner**
HSR	**Health and Safety Representative**
NESB	**Non English Speaking Background**
OHS	**Occupational Health and Safety**
OHSC	**Occupational Health and Safety Committee**
OHSW	**Occupational Health, Safety and Welfare**
PMC	**Prescribed Medical Certificate**
RTW	**Return to Work**
RRTW	**Rehabilitation and Return to Work**
UTLC	**United Trades & Labour Council**

Terms

Access & equity (A&E) – Services and programs are made available to everyone who is entitled to them and should be free of any form of discrimination on the basis of birth, language, culture, race, gender, religion or disability. WorkCover has an Access and Equity Unit.

Alternative/light duties – Duties that are suitable for an injured worker returning to work. For example, an injured worker may be able to work for a part of their normal hours, or do parts of their job but not others, or they may only be able to do different, lighter work. If practicable, employers are obliged to provide suitable duties that the treating doctor has certified the worker is fit to perform

Bonus/Penalty Scheme – WorkCover's reward and penalty system for employers, based on claims performance and applied through a levy (or premium) system.

Case manager – An individual employed by the claims agent to case manage injured workers' claims.

Claims Agents – External organisations (insurance companies) that are contracted by WorkCover to manage claims for work related injuries, illnesses or deaths.

Claims data -Generally refers to 'income compensated' claims, not to all claims. In the WorkCover data **income claims** are claims with more than 10 days lost. These are the claims which are income-compensated.

Department for Administrative and Information Services (DAIS) – It polices the OHS&W Act and is responsible for investigation and prosecution for breaches.

EAU – WorkCover's independent Employee Advocate Unit, which provides free advice and representation to injured workers who do not have legal or union representation.

Employee/worker – The Workers Rehabilitation and Compensation Act 1986 defines a worker as a person working within an employment relationship.

Exempt employers – Also known as self-insurers, exempt employers manage their own claims and are solely responsible for their workers compensation claim costs and liabilities. They are generally large companies. They are still obliged to report on claim incidence and severity.

Gender segmentation - Refers to the distribution of the genders across industry sectors. For example, women dominate in the community service, wholesale and retail trade, and finance sectors while men dominate the mining, manufacturing and construction sectors.

Gender segregation - Refers to the distribution of the genders across different occupations. For example, common occupations for women are clerk, salesperson or personal service worker, whereas common occupations for men are tradesperson, labourer or manager.

Health and safety representative (HSR) – Established under the Occupational Health, Safety and Welfare (OHSW) Act 1986 (SA), HSRs are employees who are elected by co-workers to represent them on health and safety issues in the workplace. The HSR's role is to facilitate communication on health and safety issues between the employer and employees in order to manage the health and safety risks in the organisaton. They are distinct from occupational health and safety officers or co-ordinators (see below).

Large business – More than 100 employees.

Levy (OHSW Levy) – A fee paid by employers to cover the cost of the Workers Rehabilitation and Compensation Scheme, based on an employer's main business activity and charged as a percentage of remuneration (eg. wages and other payments). WorkCover industry levy rates are set, based on a review of the claims experience for the industry as a whole.

Lump sum payment – Payment made to claimants for permanent physical disability (Section 43 of the Workers Rehabilitation and Compensation Act).

Medium business - Employ between 20 and 100 people.

Non-exempt employers – Employers whose workers compensation claims are managed and costs covered by WorkCover through the Workers Rehabilitation and Compensation Scheme. They account for around 60% of workers in SA. They pay a levy contribution to WorkCover.

Occupational Health and Safety Officers/Co-ordinators - Are appointed by management to be responsible for enforcing safe working practices or procedures (some organisations also have Injury management co-ordinators or Rehabilitation co-ordinators) .

Occupational Health and Safety Committees (OHS Committees) - They are a forum for consultation on health and safety issues within the workplace. They are primarily responsible for health and safety issues that affect the organisation as a whole ie. the development and review of organisational policies and procedures. They do not deal with specific health and safety problems unless the problem cannot be resolved between the supervisor and HSR at the workplace. If there are more than 20 employees, an employer must establish a committee if requested by a HSR or any 5 employees.

Occupational Health, Safety and Welfare Act, 1986 – An Act that provides for the health, safety and welfare of people in or visiting work places.

Premium – See levy.

Rehabilitation provider – A company contracted by claims agents to provide rehabilitation services.

Rehabilitation consultant or counsellor – An individual employed by the rehabilitation provider to provide rehabilitation services to injured workers.**RRTW Plan (also RTW Plan) –** If a worker is likely to be off work for more than 3 months, but has some prospect of returning to work, then the case manager must establish a Rehabilitation and return to Work Plan. Both the employee and the employer should be involved in planning and carrying out the RRTW plan. A typical plan involves the worker gradually increasing work tasks and hours of work and the employer making necessary changes to the work environment or equipment.

Small business – Less than 20 employees (ABS definition).

Redemption payments – Lump sum payouts in lieu of weekly payments and medical expenses (Section 42 of the WR&C Act).

Return to work (RTW) – A main aim of SA's workers rehabilitation and compensation system is to return injured workers to safe work.

RISE – WorkCover's Reincentive Employment Scheme for injured workers and employers. The RISE scheme rewards employers who provide opportunities to workers who have suffered work injuries and have been unable to return to work with their pre-injury employer. Certain criteria are applied to determine an employer's eligibility for the RISE scheme.

Safe work – A term coined by WorkCover to cover workplace health, safety and welfare and the philosophy behind engendering cultural change.

SAfer Industries – WorkCover Corporation's key industry partnership strategy for developing safe work approaches and solutions with industry. The program focuses on industries that are responsible for over 60 per cent of the State's claims costs and numbers.

The Scheme – For the purposes of this report, 'the Scheme' refers to South Australia's Workers Rehabilitation and Compensation Scheme.

Section 58B – The section of the Workers Rehabilitation and Compensation Act that covers an Employer's duty to provide work. "If a worker who has been incapacitated for work in consequence of a compensable disability is able to return to work (whether on a full-time or part-time basis and whether or not to his or her previous employment), the employer from whose employment the disability arose must provide suitable employment for the worker (the employment being employment for which the worker is fit and, subject to that qualification, so far as reasonably practicable the same as, or equivalent to, the employment in which the worker was employed immediately before the incapacity).

Self-insured employers – See 'Exempt employers'.

Small business – WorkCover defines small businesses as those that employ up to 20 workers.

The System – The State's regulatory bodies or commercial organisations that, together, administer or enforce the Occupational Health, Safety and Welfare Act 1986 and the Workers Rehabilitation and Compensation Act 1986.

The WorkCover Corporation Act 1994 – The Act under which WorkCover Corporation SA is constituted.

The Workers Rehabilitation and Compensation Act 1986 – This Act of Parliament provides for the rehabilitation and compensation of workers who suffer workplace injuries, illnesses or death.

Workforce employment arrangements - May be full-time, part-time, casual, permanent or other non-permanent.

Work hardening – The process that allows an employee who has been off work for a long period of time to gradually become accustomed to the structure of the work environment. Its goal is to assist the injured/ill employee regain their capacity to return to gainful employment.

Appendices

Appendix A

LOGO
WWC Letterhead
(originals will be inserted)

Workplace Injury and Return to Work Research Project

The research team thanks you for your co-operation in responding to this survey. We hope that it will take no more than 10 or 15 minutes of your time.

Please be aware that it is entirely your choice whether to participate or not. The researchers guarantee that the information gathered is strictly **confidential and anonymous**. Please **do not** write your name on the survey form.

Please return the survey by to:

RTW Project
Working Women's Centre SA Inc
PO Box 8066 Station Arcade
Adelaide SA 5000.

A stamped addressed envelope has been provided for you.

If you would like to make further comments please use the back of this form or feel free to add extra pages.

Please read the whole survey before you start to fill it in.

Your details

Please circle: Male Female

Please circle age range: 25 or under 26 – 40 41 – 55 over 55

What was your job at the time you were injured?
_____

What industry were you were working in?_____

What was the nature of your injury?
_____
_____
_____

Have you returned to work after your injury? YES NO

If YES, is your work the same as your pre-injury work? **YES** **NO**
If NO, please describe the differences

_____
_____
_____

How long were you off work for?

_____
_____

Workplace Injury and Return to Work Research Project

A. Help. *Please tick one box beside each group to indicate how helpful they have been.*

1. How do you rate the following people or groups in helping your rehab and return to work?	**1** Extremely unhelpful	**2** Unhelpful	**3** OK	**4** Helpful	**5** Extremely helpful	**Comment**
a. Family/friends						
b. Employer						
c. Supervisor or Manager						
d. Health & Safety rep						
e. Health & Safety Co-ordinator						
f. Union						
g. Treating doctor/s						
h. Case manager/s (and their staff)						
i. Rehab provider						
j. Co-workers						
k. Injured workers network or support group						
l. Other (please specify)						

B. Workplace: please tick one box beside each question	**1** bad	**2** not very good	**3** OK	**4** very good	**5** excellent	Comment
2. How would you generally rate your company's responses to your injury?						
3. How would you generally rate other workers' responses to your injury?						

C. WorkCover process: *please tick one box beside each question*	**1** bad	**2** not very good	**3** OK	**4** very good	**5** excellent	**Comment**
4. How do you rate your case manager's handling of your case?						
5. How do you rate the promptness of responses to your claim?						
6. How do you rate your Rehab and Return to Work Plan?						
7. How well was the rehab and return to work process explained to you?						
8 How good was the communication between people involved in your case?						

9. How well do you think your needs and views have been considered?						
10. Overall, how good has the WorkCover process been for you?						

D. Home: Indicate with a tick next to each statement how much you disagree or agree with these statements	**1** Strongly disagree	**2** Disagree	**3** Undecided	**4** Agree	**5** Strongly agree	**Comment**
11. During rehabilitation my home situation was well understood by people dealing with my case						
12. I was given information about the range of possible support services available to me in the home						
13. I was able to undertake my domestic jobs as usual, without needing extra help						
14. Sometimes my injury was made worse by doing jobs at home						
15. There were family/friends who I could rely on to help with jobs or with child care at home						
16. My injury and rehabilitation had a damaging effect on my family relationships						

E. General

17. Is there anything that could have happened, or could be happening now, to get you back to work earlier or more successfully?

18. If you could recommend anything that would improve the rehab and return to work system for other injured workers, what would it be?

19. Would you have any advice for a newly injured worker? If so, what would it be?

20. Is there anything about your particular circumstances that has made your rehabilitation and return to work especially difficult for you?

21. Is there anything else about rehab and return to work that is important, that you would like to tell us?

F. For people whose first language is not English

22. Was information about your claim provided to you in your preferred language? YES NO

23. Were you an informed that an interpreter could be arranged for you? YES NO

24. Was information about your claim easy to understand? YES NO

Did you feel that the following people considered your cultural and language needs while managing your claim?

Claims agent/case manager	YES	NO
Rehab provider	YES	NO
Employer	YES	NO
Supervisor or manager	YES	NO
Health & Safety Coordinator	YES	NO
Other (please specify)	YES	NO

Please place your survey form in the attached envelope, seal it and post it back to us.
Thank you very much for your assistance.
The Research Team.

WWC LOGO

Workplace Injury and Return to Work Research Project

Are you, or have you been, an injured worker who has had time off work because of your injury?
Your experiences and views are valuable, and may assist other injured workers in the future.
Would you be willing to fill out a survey and/or talk to us in person?
Please note that your participation is entirely your choice, and that all information is strictly confidential. You are not required to give your name.

The project

We have recently been granted funds to find out about workplace injury, rehabilitation and return to work. In particular, we want to find out:

- What people's experiences of workplace injury and rehabilitation have been
- What helps and hinders people during rehabilitation and return to work – in the workplace and in the WorkCover system.

We are interested in the experiences of both women and men.

As a result of this project we hope to be able to recommend strategies that represent best practice in terms of assisting workers' rehabilitation and return to work. A number of different groups (eg. employers, claims agents, unions, rehab providers), are assisting us by sending the survey out to workers on our behalf.

The Survey

We have attached a survey and a postage paid addressed envelope and hope that you will take the time to fill this in and return it to us by

Please note the following:

- Participation of workers is entirely voluntary and confidential. Survey forms do not include your name.
- The researchers will not be given the full names, addresses or any details about people who are invited to participate, or about their claims.
- If a worker chooses to talk to the researchers, their comments and identity will not be identifiable in anything written about the project.
- Your insurance company will not know who has responded to researchers and who has not.

An interview

We would be delighted if you would also be willing to talk to us in person (absolutely optional). If you would like to speak to us could you please contact us to make arrangements that are suitable for you? People interviewed will be given a small token of appreciation for their participation and entered in a draw for a department store voucher. We would hope to conduct the interviews some time in February or March 2004, and they should take about 30 minutes.

The researchers involved in this project are: Jocelyn Auer, Joan Cunningham and Karen Jennings. They will be happy to answer any questions that you may have. They can be contacted in working hours on 8373 0785 or email: karen@sbwrite.com

In addition, Sandra Dann, who is the Director of the *Working Women's Centre*, would be happy to discuss any aspect of this project with you.

We look forward to hearing from you! The Research team.

Appendix B

Logo

Workplace Injury and Return to Work Research Project

Health and Safety Reps survey

Are you: Male Female (please circle)

How long have you been a H&S Rep? _____

Do you represent (1) mostly women (2) mostly men or (3) a fairly even mix of both? Please circle the number which best represents your situation.

Approximate number of employees at your work site?_____

What type of organisation are you employed in? Please circle one of the following if appropriate: Manufacturing Retail Hospitality Health Community services Industrial services (eg. cleaning).
Other_____ (please specify).

Any other relevant information
_____
_____
_____
_____
_____

Please tick one box beside each question.	Very poor	**Poor**	**OK**	**Good**	**Excellent**	**Comments (**Please use back of sheet if you need more room and indicate question number).
1. How would you rate your work site in terms of its **initial responses** to a worker who is injured?						
2. How would you rate management **attitudes** towards work injury and rehabilitation issues?						

3. How would you rate the **adequacy** of information provided to workers about rehab and return to work?						
4. How would you rate the **timeliness** of information provided to workers about rehab and return to work?						
5. How would you rate the **effectiveness** of the work site's **health and safety committee** in addressing rehab and return to work?						
6. How would you rate your general **'workplace culture'** in terms of attitudes/behaviour towards injured workers?						
7. How would you rate your general 'workplace culture' for its responsiveness to any particular needs, eg. **gender or ethnicity**?						
8. How would you rate the work site's **policies** in relation to rehab & return to work?						
9. How would you rate the work site's **practices** in relation to rehab and return to work?						

10. How do you respond to the idea of HSRs and/or HSCs playing a **greater role** in actively supporting workplace rehab planning for workers?						
11. How do you respond to the idea of **further training** for HSCs and/or HSRs to support a more active role in rehab and return to work?						
12. How do you respond to the idea of further **h&s training for others** in the worksite? (If appropriate, please indicate which groups of people)						

Could you briefly respond to the following questions? Please use the back of the sheet if you need more room – and indicate question number.

13. What would assist you to perform your role in relation to rehabilitation and return to work of injured workers?

14. How do men's and women's needs and issues differ in relation to rehabilitation and return to work? For example, do they face different issues about home responsibilities and family expectations? Are there any special issues for single parents?

15. What 2 or 3 changes in the rehabilitation and return to work system, and/or in the workplace, would most improve the situation for injured workers?

Please return this survey to us

by_____

in the stamped addressed envelope provided.

RTW Project,
Working Women's Centre SA
PO Box 8066 Station Arcade
Adelaide SA 5000.

Workplace Injury and Return to Work Research Project

Health and Safety Reps: We invite your cooperation.

Would you be willing to share your views by filling in a completely confidential survey?

Background

The *Working Women's Centre* works to support and improve conditions for working women. We have recently been granted funds to find out about workplace injury, rehabilitation and return to work. In particular, we want to find out:

- What people's experiences of workplace injury and rehabilitation have been, particularly where there has been time lost from work
- What helps and hinders people during rehabilitation and return to work – in the workplace and in the WorkCover system.

We are interested in the experiences of both women and men.

As a result of this project, we hope to be able to recommend strategies that represent best practice in terms of assisting workers' rehabilitation and return to work.

We plan to talk to a variety of different groups who have an interest in this area, including employers, unions, claims agents, rehabilitation providers, health and safety reps, as well as workers who have had a lost time injury.

We have already sent out a survey to over 500 Injured workers. Now we would like to survey Health and Safety reps such as yourself, to gain the benefits of your valuable experience and insights.

We would very much appreciate it if you would take the time to fill out the attached survey and return it to the Working Women's Centre at PO Box 8066 Station Arcade, Adelaide 5000. We have enclosed a stamped addressed envelope.

Please note the following:

- Participation is entirely voluntary and confidential. Survey forms do not ask for your name (please do not put your name on the form).
- The researchers will not be given the full names, addresses or any details about people who are invited to participate, or any information about them.
- If a participant also wishes to talk to the researchers, their comments and identity will not be identifiable in anything written about the project.

The researchers involved in this project are: Jocelyn Auer, Joan Cunningham and Karen Jennings. They will be happy to answer any questions that you may have. They can be contacted ***in working hours on*** 8373 0785 or email: karen@sbwrite.com

In addition, Sandra Dann, who is the Director of the *Working Women's Centre*, would be happy to discuss any aspect of this project with you.

We look forward to hearing from you!

The Research Team.

Appendix C

Employer Survey

(Please use the back of the sheets if there is not enough room and number your answers to match the questions)

In what industry is your business?_____

What is your position_____

How many employees do you have? (please circle) 1-25 26-100 101+

1 In your view, is the WorkCover system fair?

2 In your view is the legislation adequate?

3 What, in your company, are the main issues in relation to injured workers and rehabilitation?

4 Where there are difficulties with rehabilitation and return to work, what are the main (or most common) reasons for this?

5 What, in your view, most a) helps and b) hinders timely and sustainable RTW?

a)

b)

6 What are the most difficult issues you as the employer face in dealing with work injuries and return to work? (system or other)

7 Do you think that attitudes within the workplace (general workplace culture) influence the rehabilitation of injured workers ? Yes No. (please circle)
If Yes, in what way?

And do you have any suggestions in relation to this issue?

8 Are there particular issues faced by injured workers in relation to their home life?
Yes No If Yes, what are they?

And are these different for men and for women? Yes No
If Yes, how?

9 Does your workplace have an OH&S committee? Yes No
If Yes, what is its role?

And could it have a more active role in rehabilitation and return to work?

If Yes, in what way?

10. Is there anything you would like to see changed in relation to current rehabilitation and return to work practice or policy? (either within the workplace or the system)

11. Is there anything else you'd like to tell us about rehabilitation and return to work?

Appendix D

Interview questions for Injured Workers

Preamble. Thank you's etc Limit of $1^{1/2}$ hours. This interview will focus on some specific issues rather than attempt to cover everything covered in the survey.

Details to get
First name. Age range. Occupation. Nature of injury. Have they resumed work (partly or fully) Phone no or contact address for the draw prize.

Intro
- What for you has been the hardest thing about the whole experience of being an injured worker?

Home
- Are there any differences in the role you take at home since the injury (socially/in community, if appropriate) ?

- Has the experience affected how you feel about yourself?

- Has it affected how others in your life see you?

5. Did you receive any home care support? If not, did you have any knowledge /information about such support?

Workplace
6. Do you think being a man/woman has made any difference in how you have been treated by workers/employers/ supervisors/rehab providers/case managers/anybody?

7. If you have resumed work at any point can you describe what it was like when you first went back (additional prompt: people's reactions – whether you felt welcomed)?

System

8. Surveys have indicated that a lot of people experienced problems about information (eg. Whether they had enough, whether they got it at the right time, whether they understood it etc). Do you have any suggestions about how information could be given more successfully? How should the system and entitlements be explained, in what medium/format, and who should do it?

9. Is there anything at all about the whole experience that has been positive? (Are there any aspects of the system that worked well?)

Appendix E

Literature Review

Some studies which informed our project are summarised briefly below:

- ***Gender Differences in OHS&W experiences of NSW workers: A summary of a WorkCover study of the injury and illness experiences of men and women,*** Data Analysis and research Unit. WorkCover Authority of NSW. 1998.

The information contained in this report can reasonably be assumed to be relevant for the South Australian context. Relevant findings include:

1. Gender segmentation exists in industry areas and different risks are associated with different industries (where gender segmentation applies).
2. Men and women feel differently empowered to report and take action. For example, Health and Safety committees overwhelmingly comprise male representation, 70.5% compared to 29.5%. Employer representatives on these committees are 90.7% males and 9.3% females.
3. Men are four times more likely to suffer work-related disease and twice as likely to be injured.
4. Women are more likely to have severe injuries as measured by duration of absence from work. (In 1994/95 the average time lost for temporary injuries and diseases was 8.4 working weeks for men and 10.8 for women).
5. Women are more likely to have difficulties resolving health and safety concerns through work place committees (large numbers of women working part time is a factor here).
6. 50% of women's disease is repetitive strain and muscular stress compared to 25% of men's.

The analysis concludes that:

- Workforce segmentation is a key factor in claims differences.
- Part time and casual work makes it less likely that women report and resolve OH&S concerns. Women are less likely to be represented on committees. Therefore issues that concern women are less known and are consequently under researched.

Best practice would ensure that all segments are considered, that there are strategies in place for all workers and that research and analysis acknowledges gender differences.

- ***Gender Issues in Safety and Health – A Review***, European Agency for Safety and Heath at Work, January 2004.

This report has its emphasis in health and safety rather than injury and rehabilitation. Its findings however, offer relevant information for the issue of rehabilitation and return to work. In particular it highlights the gaps in knowledge about gender differences in workplace injury and illness. It also reveals the issue of gender segregation in terms of household duties and argues that a whole of life approach needs to be adopted in understanding and appropriately acting on issues of health in the workplace. Significantly it points out that discrimination and harassment -- both related to stress – are experienced much more often by women. The fact that women are also under-represented on

health and safety committees compounds the problem because issues that affect them tend not to get on the agenda.

The report advocates that gender analysis and questions should be built into all monitoring and research and that data needs to be adjusted to hours worked and to specific jobs rather than relying on average figures. It is important, they stress, to have information on the tasks and activities associated with the work, rather than simply using job titles.

- Interestingly, on a broader scale, the **Gender Analysis and Policy Directorate (GAP) of the Canadian Government** (2004) similarly advocates:
    - Considering gender together with other demographic and diversity factors
    - Examining what is being assumed as the norm, and considering whether it takes men's and women's experience into account
    - Considering options according to their potential to either counteract or exacerbate existing gender inequality
    - Considering potentially different impacts of policy on male and female clients
    - Incorporating gender issues into evaluation plans, so that the success of programs in meeting their goals can be studied from a gender perspective.
- See also **http://www.swc-cfc.gc.ca/pubs/gbaguide/gbaguide_e.html#3_4 for a more detailed discussion of these issues in Gender-based Analysis: A Guide for Policy-Making, from the Canadian government's Status of Women office.**
- ***Double Take: The Links between paid and unpaid work.*** Janeen Baxter and Diane Gibson with Mark Lynch-Blosse, AGPS Press. Canberra. 1990.

Although this study is relatively dated, it presented some relevant national statistics about housework and childcare responsibilities with both men and women acknowledging that women do by far the most of both (up to 87%). Barbara Pocock's research and more recent ABS data (see earlier in this Chapter) reveals that contrary to popular opinion, little has changed in this respect.

- ***The Third European Survey on working conditions,*** 2000 (Dublin Foundation).

This work also highlights an unequal gender division of labour in cooking, housework and child rearing responsibilities with women taking 85% of these responsibilities.

► ***The gender workplace health gap in Europe*****,** Laurent Vogel, European Trade Union Technical Bureau for Health and Safety, 2003.

While not specifically about work injury and return to work, this book suggests a way of looking at how embedded gender assumptions affect occupational health. It looks at both knowledge production and policy making and is informed by real-life case studies from nine European countries. The chapter from Belgium on women's unshared burden reveals that women's household duties have not diminished commensurately to their labour force participation. The chapter from Spain on the work-life balance affirms the view that any analysis of occupational health needs to take account of the relationship between paid and unpaid work.

► ***Best Practice Rehabilitation for NESB Women,*** Mercantile Mutual, June 1997.

This was a very useful study, not only because of the important issues it raised, but because it is comparable in size and methodology to our project.

The study highlighted high injury incidence among NESB women, issues around age, ethnicity, English literacy and low skill level, and how these combine to mitigate against successful Return to Work.

The methodology entailed interviews with workers/case managers/employers and rehab providers, as well as ethnic community health workers, medical professionals and a lawyer. There were 56 NESB women with active WorkCover claims at the time of the study.

Issues identified in the study included:

- need to implement strategies to prevent injury
- lack of appropriate alternative duties and inadequate training opportunities
- lack of accurate information for target group
- lack of employer support in RTW
- racial stereotyping.
-

A range of Industrial/communication/cultural issues were also identified, including:

- lack of understanding of rehab provider roles and workers' rights
- racial/stereotypical attitudes
- ignoring of industrial realities
- case manager having little knowledge of individual cases
- little effective communication between various parties
- model of rehabilitation based on assumptions of ideal conditions
- case managers need cultural awareness training and communication skills.

Much of this information is still relevant within the sector, and has been well known for some years. Many of our recommendations replicate those of this study done 7 years ago.

► ***Small – Healthy and Safe? The implications of changing work organisation and reward systems for the health and safety of women workers in small to medium enterprises,*** Verna Blewett & Andrea Shaw, UNSW Studies in Industrial Relations No 42, 2001.

The book is about the strategic choices that small and medium enterprises[27][(SMEs) make in the management of OH&S in times of change. There is a useful section on its case study research methods. Some relevant points included:

- SMEs are an important part of the industry scene in Australia (99% of all workplaces) and they experience a disproportionate number of work-related health problems.

[27]. ABS defines enterprises which employ less than 20 people as small. And those which employ between 20-100 as medium.

- Women's participation in the workforce is increasing but so is the level of casualisation. Contingent workforces in industries where women predominate are also growing.
- Strong gender segmentation and segregation and pay differentials have not changed despite attention to pay equity.
- Women have a different occupational health and disease experience.
- The key importance of "integration of OH&S into general activities in the firm, the degree of autonomy and job control taken by and available to management and employees alike, and the presence of respectful attitudes to others in the workplace". So while the external environment is very important, proactive or reactive enterprises are internally driven – small business plays an active role in making the internal consequences of an environment positive.

➢ ***Gender Issues in Safety and Health — A Review***, European Agency for Safety and Health at Work January 2004.

Although this report does not address rehabilitation and return to work, it does propose an approach which resonates with our project. In this respect it provided some useful pointers for us in putting together our report – particularly in relation to available statistics.

This report claims that health and safety risks of women at work tend to be underestimated and neglected.

It notes the strong occupational gender segregation in the EU labour market – between sectors, between jobs in the same sector, and sometimes segregation of tasks even when men and women have the same job title in the same workplace, and that more women are concentrated in low-paid, precarious work.

It questions the current gender neutral approach which means that gender issues and differences are ignored in policy, strategies and actions and in research.

The report examines:

- gender differences in workplace injury and illness;
- gaps in knowledge; and
- the implications for improving OH&S.

Its findings include:

- Men and women can face significant risks at work.
- Different jobs means different exposure to hazards and different health outcomes in general. Women suffer more from work-related stress, infectious diseases, upper limb disorders, skin diseases as well asthma and allergies, while men suffer more from accidents, back pain and hearing loss.
- Gender segregation at home and unequal sharing of household duties adds to women's workload.
- There are important links between wider issues of discrimination and women's work-related health – eg. issues such as sexual harassment

and discrimination in the workplace are stress factors that women face more than men; women's lower levels of participation in all levels of OH&S consultation and decision-making also contributes to less attention paid to their OH&S needs and poorer risk assessment.

- A gender neutral approach to OHS is contributing to maintenance of gaps in knowledge and less effective prevention.
- Research gaps exist. There is a need to: build gender questions and analysis into monitoring and research; adjust data for hours worked; look at figures relating to specific jobs rather than average figures; include both genders in research and analyse gender differences, rather than 'controlling' for gender; ensure that work-related injuries and ill health relevant to women workers are covered in the statistics; pay attention to previously ignored women's health issues in the occupational setting; improve data collection on links between women's ill health and occupation; do research looking at the real jobs done, not just job titles and descriptions, and involve workers in this data collection; and to target research at risks to women workers and their prevention.

Recommendations from the report include the promotion and facilitation of a gender-sensitive approach in research, policy and prevention practices, to help ensure effective prevention and avoid gender bias in occupational safety and health.

- ***The Work/Life Collision,*** Barbara Pocock, Federation Press, 2003.

As indicated earlier, Barbara Pocock's Australian research was very timely and useful, both for its summary of relevant workforce data and for its rich qualitative material derived from interviews and focus groups, giving a voice to the views of Australian workers, mainly from South Australia, talking about the effects of work on their lives and relationships.

While not dealing explicitly with work injury, it provided an invaluable account of the collision of work and care for contemporary Australian households and the high social costs ensuing from contemporary work trends for mothers, fathers, families and those who want to be both workers and carers. Pocock reveals the hidden costs of how people live and work now – a fallout that can be measured in bedrooms, kitchens, workplaces and streetscapes. She unpacks the 'cover stories' that obscure the complexities and compromises that arise from the work/life collision.

Relevant chapters for our research mapped changing patterns in labour force participation, households and care; the ways in which work is reconfiguring the Australian community; the effects of paid work on motherhood; the effects of long hours and family unfriendly workplaces; issues surrounding part time and casual work; and the gendered quality of caring for dependants.

One point of particular interest was Pocock's argument that with more hours being spent away from home by paid workers in Australia, new forms of community are being made in new locations, especially the workplace. She writes: *Workplaces are places where both bridging and bonding social capital are built; workplaces can be places of solidarity and a sense of group belonging…* (p.50). We were interested to see whether injured workers' experiences of their workplace culture lived up to this potential, or not.

Another point of particular relevance was that:*The double day of household work and paid jobs contributes to physical exhaustion among women in particular, and it carries a high emotional cost as well* (p.107). This has clear implications for considering gender appropriate rehabilitation and return to work plans.

Pocock's view that longer hours in workplaces and the 'pressure to get the job done' may be compromising employers' duty of care to provide safe and healthy workplaces was one which we also took into account.

► ***Who returns to work and why?*** International Social Security Association, (ISSA) 2002.

The WIR (Work Incapacity and Reintegration) Project was undertaken by the International Social Security Association Research programme. It documents a comparative study undertaken in the mid 90s in Denmark, Germany, Israel, the Netherlands, Sweden and the USA. It investigated the effect of:

- duration of work absence
- medical and vocational interventions
- labour market policies and practices
- social/demographic aspects (eg social supports).

The report posed 2 key questions:

Do the various interventions (by social security and health systems) make a difference to work resumption patterns?

And if so, what are the most effective interventions?

While it doesn't cover Australia, there are a number of similarities between South Australia and the Netherlands, and therefore useful issues to explore in our local context.

The ISSA study offers some insights into the reasons why women have a longer rehabilitation and lower return to work rate than their male counterparts, including:

- Some injured women have a working spouse, so don't return to work
- Injured women can't manage paid work **and** housework
- Injured women have fewer skills, so making a transition to new work is more difficult
- There is greater discrimination by employers against injured women.

These findings may well be indicative of circumstances in South Australia and/or signal an area of further research. For a summary paper go to http://www.issa.int/engl/homef.htm

➢ ***'*Paths of Re-entry: Employment Experiences of Injured workers',** Lee Strunin & Leslie Boden, *American Journal of Industrial Medicine,* 38: 373-384, 2000.

This paper is an ethnographic study of 204 injured workers in Florida, USA (all injured workers had back injuries).

A key observation was that an 'injury at work can result in change in jobs or employers, unemployment, or withdrawal from the labour force. Substantial life changes occur, often mediated by the initial attempt to return to employment'.

The study describes three paths to re employment for injured workers and clearly advocates the first.

- The *welcome back* path – workers feel valued by their pre-injury employers. There is a positive effect, even for those who are unable to resume work because of their injuries.
- *Other paths* – workers feel undervalued, discarded or like damaged goods. Hostility and resentment is generated.

The conclusion is relevant to some findings in our own project:

1 Half of the workers in the study experienced employer indifference or hostility in response to their attempts to return to work after an occupational back injury. After injury, there are both commonalities and meaningful disparities in post-injury experiences of White, Black and Hispanic male and female workers.

- Significant that understanding the experience of job re-entry from the perspective of injured workers themselves may help in designing policies that better accomplish the social goal of minimising the substantial economic and non-economic costs of workplace injuries.

- **'Readiness for Return to Work following Injury or Illness: Conceptualizing the Interpersonal Impact of Health Care, Workplace and Insurance Factors',** Franche, R & Krause,N. 2002, *Journal of Occupational Rehabilitation,12, 233-256,* Canada.

The relevant key findings of this paper for our project are that:

- Characteristics of the work environment, health care and the insurance system all have a significant influence on return to work outcomes – independent of the underlying medical condition and other risk factors.

- Research in the field to date has placed little emphasis on the processes and interventions that sustain return to work and participation in the workforce.

- Physical and injury factors are determining predictors of disability in the acute phase. However, psychosocial factors have stronger predictive values in the subacute and chronic phases of disability.

- 'Traditional families' often foster the belief that it is the women's' job to attend to family needs – even when she is in recovery. Multiple role strain may hinder recovery. Social roles and number of dependants need to be taken into account in terms of further research and compensation decisions.

- ***'*Successful Return to Work: Using Worker Specific Analysis',** Harold H. Gardner & Richard J Butler, *The Journal of Workers Compensation* Vol 7 No 4 Summer 1998 pp 19-30.

Gardner and Butler argue for a greater focus on what they call the demand side as well as the supply side of return to work. The article makes a case for a greater focus on the employee. Their findings include:

- Information systems are too focused on increasing monitoring of health care providers and financial incentives focused on the RTW process –

rather than on outcomes for workers. There is a need to better understand some of the differences between different groups of employees.

- Communication is most important – employers must communicate their need and desire to return employees to productive activity as soon as possible.
- Terminology is important – they caution against the use of disability language, for example.
- The first episode is the most important.
- Cumulative trauma claims are different from other claims – in that the origin of the injury is more complex and there is different return to work behaviour. In these instances they found that these claimants were more sensitive to economic incentives and job accommodation and had significantly different post injury employment patterns.

► ***Review of Workers Compensation and Occupational Health, Safety and Welfare Systems in South Australia.*** **Report,** Vols 1-3, Dec 2002: Brian Stanley, Frances Meredith, Rod Bishop.

The workers compensation part of the review is addressed in Vol 2 which covers, among other things:

- access to compensation
- entitlements afforded to workers who have a compensable, work-related disability – access to determination; the determination and adjustment of income maintenance; rehabilitation and return to work; entitlement for longer term partially incapacitated workers; lump sum payments for non-economic loss for those workers who have permanent disabilities.
- structural arrangements for claims management in SA – recommends the return of claims management for all registered employers to WorkCover.
- restructuring of the dispute resolution system to provide for a more effective conciliation process for settlement of disputes and a quality arbitration process that will finalise unresolved disputes.
- other recommendations directed to improving the administration and effectiveness of the workers compensation scheme as a whole including statistics reporting and protocols, data exchange between the Tribunal and WorkCover, and expedited dispute resolution for RRTW disputes [adapted from Exec Summary pp 3-5].

The Occupational Health, Safety and Welfare part of the review is addressed in Vol 3. It identified major themes from submission statements received. Recommendations relevant to our project related to:

- Consultation and participation processes including training of Health and Safety representatives OH&S Committees
- Greater clarity in the legislation to enhance protection for workers and employers – covering inclusion and protection of people who work in the 'new labour market' (ie. workers who work in casual, part-time, seasonal, labour hire type work); workplace bullying; and ensuring minority groups are represented and reflected in actions. [Adapted from Executive Summary pp.5-9].

Some comments of special interest were in a section on Gender Issues in Volume Two.

- The submission from the Office for Women arguing that the Review should adopt a gender-based analysis – to 'help identify the different social experiences, economic circumstances and expectations of men and women and how these things impact upon the workplace and the way that people interact with regulatory systems' (p.5).
- UTLC identifying factors including industry structure, workforce composition and workplace change, which the Council argued, have implications for access to the benefits of compensation for women (p.5).
- The report noted that WorkCover's annual statistics provide data tables by gender in most cases and noted that the 'differences in injury type, duration of incapacity and return to work rates therein confirm the need for such data for the development of access and equity programmes'. (p.5).
- The report noted that 'researchers have used gender based analysis to identify both prevention and compensation issues. This includes factors such as gender segmentation of the labour market and the relative concentration of women workers in the "peripheral' workforce"'. It goes on to say: 'There is little research available to the Review on the differential effects of the compensation system on men and women workers in terms of their experiences and the outcomes. It has been beyond the resources of the Review to do more than acknowledge the importance of these matters here. The Review can only note the obvious interaction between the type of work undertaken, working conditions and wages, family responsibilities most typically assumed by women, and the likely implications of these factors for their access to compensation, level of benefits and rehabilitation and return to work' (vol.2.p.5).