Submission to the Senate Inquiry into Australia Post's Treatment of Injured and Ill Workers

Submitted by:

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Prevention Wellness Rehabilitation Health Consultants Inc.

Supporting People, Protecting Society

Dr. Ian Holland
Secretary
Senate Standing Committee on Environment, Communications and the Arts
Australian Senate Inquiry into Australia Post's Treatment of Injured and Ill Workers
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Canberra, Australia

Dear Dr. Holland and Senators:

I congratulate the Australian Senate for undertaking this Inquiry. My reasons for writing to your Inquiry are:

1. **To *acknowledge your leadership* in actively listening to the experiences of workers and their families. (These issues are just as relevant in Canada.)**
2. **To *share what I learned from the my experience* with the Ontario Round Table Project (1998-2005), (**see Round Table Project**,** A Common Language, A Common Policy for Safe and Timely Return to Function, Return to Work attached**) in which 16 sectors involved in the return to work process were able to agree on a common policy. The policy was based on the World Health Organization International Classification on Health, Disability and Functioning (ICF) 2001, a new framework for disability.**
3. **To share my current observations regarding patients who present with significant health outcomes as a result of going through the compensation process.**
4. **To identify the power of individual/community activism in driving change.**

After many years of working to improve the system by integrating Return To Function, Return To Work into Ontario Primary Care Reform, by helping develop the Ontario Medical Association (1994) and Canadian Medical Association's policy on RTF and RTW (1997), and by initiating a project on educating physicians in Ontario on return to function, return to work issues, I now again work directly with patients. Every day I see patients' adverse functional and health outcomes due directly to the failure of current policies and processes. Patients are *still* falling through cracks of the system and are *still* prevented from becoming functional due to multiple barriers that are not addressed by the system. Failure of leadership to admit the deep seated problems is the key element in a failed return to work process. The health outcomes of the flawed compensation process/return to work process in Canada that I am aware of, *in addition* to the original injury, include these examples:

- Suicides,
- Death due to a gastric hemorrhage – stress related,
- Post traumatic stress disorder,
- Major depressive disorder
- Cardiac arrhythmias
- Teeth grinding.

If causes of health outcomes such as those listed above are not captured and are not identified for what they are (outcomes of the structural determinants of health such as government policies), then the cause of the causes can never be identified and corrected. (see work of Sir Michael Marmot, Chair of World Heath Organization Committee on the Social Determinants of Health). The goals of employers, insurers, bureaucrats and researchers are vastly different than the daily goals of the individuals and their families who need assistance to return to optimal function and then to work. Not only should we focus on functional outcomes but we must provide for accountability for the attitudes and practices of everyone who is involved in the return to work processes.

My patients in my office frequently tell me in these exact words, “I want to function. I want to work.” Too often “guidelines” do not focus on functional outcomes, the environmental barriers or on improving the process in a significant way. Working directly with patients teaches us that we must start where the patient is.

I refer to John E. Walsh’s description of the Australian accident compensation system, with particular emphasis on its process of impairment classification assessment, and entitlement to damages. He argues that the process is fundamentally flawed, and suggests that the framework provided by the ICF may provide a starting point for future development. I agree with his statements.

Recognition that significant change must occur, is happening slowly; however, current changes are not being driven by patients’ needs but too often by the needs of governments (more statistics), insurers (reduce costs), companies, unions or research institutes (money for new research projects).

During the process of driving change in the system, the individual patients’ needs be central. We must actively listen to *their* experiences. Easy to say. It is not so easy to do, as many sectors try to jockey for control of the process and push out the voices of those whose lives we are trying to improve.

In 1914, as a result of the Meredith Commission, workers gave up the right to sue employers in exchange for “a process to turn them to function”, In Ontario ‘return to function’ has come to mean

only 'return to work'. The two are not the same. That approach is mistaken. The first issue must be return to function. When the individual can return to function, ***then*** physicians can focus on a timely return to work. This difference was recognized in the revised Ontario Medical Association Policy, (The Role of the Primary Care Physician in Timely Return to Work, Ontario Medical Association, and December 2008).

In Ontario the return to work concept has also changed from 'safe and timely return to work' to 'safe and early return work' to in some cases 'early return to work' or ERTW and now timely Return to Work. I want to emphasize that *words matter because policy is developed based on them.*

Physicians are also frustrated by the current system. The administrative burden of filling out insurance forms has been estimated to be 18% of a physician's time. (see The Role of the Primary Care Physician in Timely Return to Work, Ontario Medical Association, December 2008) Some physicians in Ontario refused to see patients on workers' compensation because of their frustration with the process. The result was that the College of Physicians and Surgeons in Ontario in 2008 had to develop a policy in view of the human rights issue involved to ensure that physicians complied with the requirement of not discriminating against the disabled.

My recommendation is that a two pronged approach is required for the change that is needed:

1. Continue the ongoing overarching work of transformation of all sectors involved in the return to function, return to work process and, and *at the same time*,
2. Develop an immediate strategy to improve and provide appropriate care *now*, for injured and ill working people and their families.

Research does not address the reality of the need for immediate care of working people and their families. The current trend amongst bureaucrats of "no policy without evidence" is flawed as a standard approach. Patients are individuals. Evidence must reflect the uniqueness of individuals and their circumstances now. If for example a working parent is depressed because they cannot get appropriate help for their disabled child, medications prescribed will not decrease symptoms until appropriate care arrangements for the child are provided. There are seldom any simple fixes to complex cases.

In my current role I treat only complex cases. I see patients who recover from injury or illness, but then find that on their return to work they regress due to the lack of flexibility and understanding on the part of the employer, the union, the insurers, in house physicians or all of the above.

We need to address *all* the complex systems in all the sectors involved in return to work. Every sector involved in return to work presents barriers and every sector must *focus on functional outcomes for the injured or ill individual*. In our attempts to improve the system in Ontario through the work of The Round Table Project (which was funded by Human Resources Development Canada – Ontario Region), we were unable to identify innovative or creative ways to fund the ongoing coordinating work of transformational change of the system. The federal government was willing at that juncture to fund the change process if they could get a 10 per cent partnership with even one of the provincial sectors. None of them would partner with the federal government to fund the change process. Individuals working on the project demonstrated that they had the strong commitment needed (contribution was estimated to be proximately two million dollars) but the sector organizations did not, due to their wish to be able to control the process. The project ended. The lesson learned is partnerships are fragile unless support is provided.

We must ***all*** remember to ask this --- what is the purpose of this work? We are doing this work *to improve and maximize functional outcomes for the individual*. IF we maximize functional outcomes for the individual, then outcomes for the workplace, and ultimately society are also improved. That might seem to be obvious but it is all too frequently *not* obvious to many participants in the return to function, return to work process. Barriers to return to function, return to work are found in every sector of the system.

One of the purposes of The Round Table Project in Ontario was to identify every sector involved in return to work, and then to be able to work and learn together as our knowledge evolved. Graham Lowe, Professor Emeritus of University of Alberta and a leading Canadian expert on workplace issues evaluated The Round Table Project in a report on the work of the Project and noted.

> "The overriding goal of the Round Table Project (RTP) has been the creation of a better system for helping individuals who are disabled, ill or injured return to function and return to work (RTW/RTF). The RTP approach to disability prevention is multi-stakeholder, multi-disciplinary and multi-dimensional. The hallmark of the RTP's contribution so far is greater efficacy through improved coordination and integration."

Dr. Lowe's recommendations continue below:

"Based on this evaluation of the Round Table Project, we recommend that the following actions be taken:

1. A consistent theme in the RTP forums is the need for strong government leadership. This is role the federal government should continue to play through the partnerships forged in the RTP. This will help develop a pan-Canadian approach for RTF/RTW.

2. Lack of stable and predictable funding has hampered the RTP. Furthermore, shifts in thinking and practice of the magnitude proposed by RTP require long-term efforts and resources. HRSDC therefore should make a 5-year funding commitment to the RTP, for half of its projected financial needs based on a detailed business plan. This will strengthen partnerships and accountability by requiring the RTP to raise the remaining funds required.

3. The RTP should collaborate with HRSDC to create a 5-year business plan that will be the basis for this funding and serve as an accountability and reporting framework for tracking outcomes.

4. To build momentum from the work of the RTP it is essential to move quickly to capitalize on the high readiness for change to improve the system among stakeholders. This is a fragile creation and the social capital – basically, the capacity for cooperation among a disparate network – the RTP has developed will quickly diminish. A lot of people have invested time, expertise and leadership into the RTP. Rebuilding this foundation at some future date would be far more costly than maintaining the RTP. Therefore, future funding must be put in place quickly.

5. Within the next five years, the RTP should be transformed from a project into a formal non-profit institution, either as a stand-alone institute or hosted as a discrete entity within an appropriate existing structure. If the latter approach is taken, it is important to preserve the independence of the RTP and not link it too closely with an existing stakeholder's interests. Another important consideration is finding an institutional model which enables effective fund-raising.

6. The December 2004 Forum report to HRSDC is evidence-based, presenting a framework for a disability prevention model that meets stakeholders' needs in Ontario. Within the next five years, the Round Table Project should develop a systematic plan for replicating this work in selected jurisdictions across Canada, contingent on readiness and resources within a jurisdiction.

7. The RTP should give priority in future initiatives to engaging employers, insurers and the legal profession. These groups are key stakeholders in the RTF/RTW process, as well as potential sources of support and resources for pilot projects and related initiatives.

8. The RTP should give priority to developing its integrated planning tool, a useful resource that can guide the pilot projects developed by the RTP, as well as future actions. Pilot projects provide the feedback loop needed to refine the planning tool.

9. As the RPT initiates pilot projects involving individuals in transition to work, it should apply rigorous cost-benefit evaluations to these interventions. Tools should include but not be limited to quality-adjusted life years, the cost of disability, and the contribution made by the RTP towards returning people to function and work.

10. The RTP should use every opportunity to pilot and refine its integrative RTF/RTW model so that it is able to guide action in a wide range of settings and meet the needs of diverse groups of persons with disabilities."

My hope is that you will consider Dr. Lowe's words as they relate to changing your return to function return to work systems.

My best wishes to you all as *you* work and learn together while you attempt to bring transformational change to your systems. *It is an extraordinarily challenging task.*

Many of us in Canada look forward to the results of your Inquiry. I've enclosed my CV only so that you can relate my experience and background to these issues.

I thank my patients for teaching me what is needed to improve the system and my long time co-worker/editor, Irene Clark Wolfson for putting what I've learned into appropriate words.

Sincerely,

signed copy will arrive by courier

Dr. Lisa M. Doupe

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