

# **EVALUATION OF REHABILITATION SERVICES PROVIDED TO QUEENSLAND DEPARTMENT OF EDUCATION'S INJURED OR ILL EMPLOYEES WITHIN THE WIDE BAY REGION IN THE 1995/96 FINANCIAL YEAR**

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This paper was selected for publication because it provides some useful insights into aspects of organizational learning through a case study analysis. The paper was a requirement for the unit GSN215. While it is based on some observations with a particular organization, the arguments do not necessarily reflect or represent the views of that organisation.

## **ABSTRACT**

This research evaluates rehabilitation services provided by the Wide Bay Region of Queensland Department of Education in the 1995/96 financial year.

Workers' compensation payments, leave records, case-management data and client perceptions were used to complete an economic analysis and evaluate case-management practices against Best Practice Principles.

With a salary budget of \$112 million, an annual investment of \$82,050 in salaries yielded estimated savings of \$3.844 million by the second year of operation. While the return to work rate was lower than recommended, other factors indicate rehabilitation practices were effective. Client perceptions strongly indicated that Best Practice principles were followed.

Further research is suggested to determine the causes of separations within specific age and employee groups and whether correlations exist between the level of support in rehabilitation interventions and i) reducing periods of sick leave; and ii) separations. An evaluation of the current model's 1999 services would permit an equivalent comparison with this evaluation.

## **INTRODUCTION**

An evaluation of a rehabilitation program is determined by the goals and objectives of the evaluator. If the goals are chiefly economic, the evaluation concentrates on costs and benefits. Although literature indicates that economic analysis is necessary, rehabilitation programs provide more than economic benefits. When dealing with interpersonal processes, evaluations should consider the effectiveness of interpersonal communications.

The *National Occupational Health and Safety Council* established a task force (see Appendix 1 for membership) which generated a set of principles for Best Practice in occupational rehabilitation (Appendix 2). As a result, a set of guidance notes were published in 1995 which provided principles for rehabilitation case managers as a recommended approach to providing rehabilitation services.

*WorkCover Queensland* uses these principles as the basis for training occupational rehabilitation co-ordinators, who are the employers' primary contact when an employee suffers a workplace injury or illness. Because of this strong influence, Best Practice principles were used as the basis for evaluating the rehabilitation practices.

The hypotheses are:

*Hypothesis 1: Rehabilitation services in the Wide Bay Region of Queensland Department of Education were not cost effective in the 1995/96 financial year;*

and

*Hypothesis 2: Injured or ill workers supported by Wide Bay Region's rehabilitation programs from the 1994 calendar year to 1996/97 financial year feel that Best Practice principles were not reflected in case-management practices.*

## **BACKGROUND INFORMATION**

In this evaluation, the 1995/96 financial year will be referred to as 'the period' and Wide Bay Region will be referred to as 'the region'.

Queensland Department of Education's administrative structure comprised a central office and eleven regions. Wide Bay was one of those regions. The geographic area of the region and workforce composition are detailed in appendices 3 and 4 respectively.

An Employee Advisor managed a number of rehabilitation cases in 1994. The Public Sector Management Commission recognised that rehabilitation could reduce escalating workers' compensation costs and provided support to employ a rehabilitation co-ordinator. This initiative led to an Employee Relations Unit (ERU) being established in the 1995/96 financial year. Each of four co-ordinators in the unit shared responsibility for the region's rehabilitation caseload.

*WorkCover Queensland* manages the workers' compensation monopoly in Queensland. Similar to other Australian states, workers' compensation legislation previously focussed on compensating workers for lost wages rather than rehabilitating injured workers (Kenny 1994, p. 158).

With the introduction of the *WorkCover Queensland Act 1996*, the legislative focus changed to a non-adversarial system (Richardson 1997, p. 42). Under Section 245, employers are required to provide rehabilitation for injured workers for the period the worker is entitled to compensation (*WorkCover Queensland Act*, p. 146). The region's program exceeded this requirement by supporting both compensable and non-compensable injuries and illnesses.

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The need for legislative change was already identified by researchers, for example Buys' (1993, p. 7) statement that insurance organisations viewed rehabilitation "... as a claims driven process aimed at reducing the insurance carrier's exposure rather than being one whose primary aim is the ... restoration of the injured worker back into employment ..."

With organisational re-structuring in mid-1997 and the introduction of the *WorkCover Queensland Act*, the service delivery model changed when co-ordinators were appointed to schools with thirty or more employees.

## LITERATURE REVIEW

Literature suggests that evaluating rehabilitation programs should focus on an economic analysis and inter-actions between parties to the rehabilitation process (*Worksafe Australia*, 1996).

Four measures were used to complete the economic analysis — cost-benefit analysis, average days absent, return to work rate and average intervention period. These will be discussed in greater depth in the section on methods.

Yates (1992, p. 494) supports economic analysis, but qualifies his statement by noting that while costs are the principal concern of management, economic analysis should not be regarded as the sole measure, as this may lead to inappropriately managing rehabilitation. Dean (1996) argues that it is a mistake to evaluate rehabilitation programs solely from a cost-benefit perspective because it only measures a small part of the global effects of a program. Cottone and Emener (1990, p. 99) propose that relationships should be the focus. An evaluation of rehabilitation in Telecom used cost-benefit analysis and qualitative data to determine "...[stakeholders'] acceptability of [the] process ..." (Hocking et al. 1992, p. 25).

This evaluation of interactions in the rehabilitation process is based on Best Practice principles. Readings and Best Practice principles reflect, to a greater depth, four major themes for effective rehabilitation programs: early intervention; communication; participative decision-making; and providing quality alternative programs (Strautins & Hall 1989; Timson 1997; Gardener 1987; Pati 1985; Shrey 1993; Kenny 1995a, 1995b, 1995c, 1996; Tenner & De Tors 1992; Wooden 1991; James & Brownlea 1994; Wright 1992; Kregel 1992).

The time between injury or illness and referral to a co-ordinator is an important factor in the success of rehabilitation. Strautins and Hall's (1989) finding — that the chance of returning an injured worker decreases the longer the time between injury and referral to rehabilitation — is receiving growing support (Gardener 1987; Pati 1985; Shrey 1993). Timson (1997, p. 27) states one of two key issues in effective rehabilitation is immediate intervention with regular client contact. Other researchers make similar assertions (Wojcik 1994; Fletcher 1992; Flynn 1994; and Yates 1992). This theme, which is reflected in Best Practice principles a) and d), will be evaluated by calculating the average intervention period.

A second theme was communication between the parties and maintaining information flows. Kenny has assessed rehabilitation processes from several perspectives: a cross-section of injured workers (Kenny 1995a); long-term injured (Kenny 1995b); failures in occupational rehabilitation (Kenny 1995c); and the employer (Kenny 1996). Kenny found common themes, including breakdowns in communication and information flows (Kenny 1995a, pp. 62-70).

Kenny also proposed that, when the rate of disagreement between parties reaches a critical point, logic is forgotten and the practical focus of helping the injured worker ceases (Kenny 1995a, p. 74). Leutgeb and Hagelberg (1997, p. 51), in redesigning Gillette Children's Speciality Healthcare's rehabilitation process, involved the patient and family in discussions. Colledge and Johnson (1997, p. 57) support a team approach to eliminate communication barriers. Harty (1992, p. 23) states that success "... depends largely on a well-planned communications effort ...". Other researchers have written about the need for open communication (Timson 1997; Wojcik 1994; Parkins & Parsons 1995; Flynn 1994; Pelland 1997; Heine 1994). This theme is reflected in Best Practice principles b), e), f), g) and h).

The third theme is ensuring the injured employee's active participation in decision-making. James and Brownlea (1994, p. 89), who indicate that client participation is a significant factor influencing the scale of the impact of injury, measured participation by:

- choice of services;
- greater independence and empowerment;
- the injured worker identifying care and support needs; and
- the injured worker prioritising the order of services (James & Brownlea 1994, p. 89).
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Wright (1992, p. 4) states that "... rehabilitation is intended to help ... individuals to help themselves ...". Kregel (1992, pp. 56-60) predicted that programs would be judged on their ability to promote consumer choice and self-determination. The theme of actively involving clients in rehabilitation decision-making processes is reflected in Best Practice principles b), e), f) and g).

The fourth theme was providing meaningful alternative duties. James and Brownlea (1994, p 91) concluded that the level of impact is not always related to the injury severity — serious injury can have little impact when appropriate, alternative duties are available. They also stated that their research had "... profound implications for planning and program development if white-collar workers alone design and implement programs, because [their] perceptions were clearly not typical of the working population" (James & Brownlea 1994, p 91). Timson (1997, p. 27) states that a key issue in effective rehabilitation is providing quality, interesting alternative duties. Other researchers (Heine 1994; Wojcik 1994; and Fletcher 1992) support this theme which is reflected in Best Practice principles j), k) and l). The theme will be evaluated through clients' perceptions of the co-ordinator's and medical practitioner's support for alternative duties and the meaningfulness of alternative duties undertaken in the return to work program.

Consequently, the research considers the effectiveness of rehabilitation services provided by members of the ERU from both economic and interpersonal perspectives.

## **METHOD**

The different foci reflect the types of data collected. For the economic evaluation an example of the quantitative data is the salary component of workers' compensation payments, while qualitative data was collected through the clients' perceptions of case-management practices.

The economic evaluation uses cost-benefit analysis, average days absent (or lost time), return to work (or success) rate and average intervention period. *Worksafe Australia* (1996) suggest using the success rate, lost time and statistical information for evaluation purposes.

## QUANTITATIVE DATA

The cost-benefit analysis considers the major portion of the program's costs and benefits, namely:

- costs — an estimation of the relevant proportion of co-ordinators' annual salaries; and
- benefits — annual salary component of workers' compensation payments and savings from reduced sick leave.

Excluded expenses are discussed in Appendix 5.

Major concerns with cost-benefit analysis are the difficulty of calculating non-salary costs and costing direct and indirect benefits, for example, savings from employees' earlier return to work, morale, productivity and commitment.

The average days absent is the mean length of absence due to injury or illness (Allen & Eritzel 1997, p. 25). Teacher absences were used as the sample for this instrument because 80 percent of rehabilitation cases were teachers (Table 3). Absences of less than twenty days were excluded to nullify the effect of numerous, smaller periods of sick leave and because, when leave for an injury or illness reached twenty days, the rehabilitation process was initiated.

The return to work rate is calculated as the percentage of closed rehabilitation cases resulting in a full return to their previous position (Yates 1992, p. 494). Considered alone, this rate gives no indication of long-term outcomes, or whether a return to work was inappropriate because of the severity of the medical condition. Long term rates, supported by Butler et al (1995), indicate whether the client has maintained work or changed employment as a result of continuing difficulties. This longitudinal study was not feasible in this research.

The average intervention period is the mean time between when clients commenced leave as a result of an injury or illness and the date a co-ordinator initiated contact with the client to discuss the client's medical situation. This instrument assesses early intervention strategies by indicating responsiveness to potential rehabilitation cases.

The concern with this instrument is that external factors may cause delays, for example, applying for long service or recreation leave, rather than sick leave without pay; not immediately applying for leave; or absences remaining unadvised. As case-management data is incomplete, periods exceeding 100 days have been excluded because they are less likely to originate from extended average intervention periods than data omission or were incurred before rehabilitation was initiated.

Sources of quantitative data to calculate these instruments are provided in appendix 6. Examples of excluded quantitative methods and reasons for their exclusion are detailed in appendix 7.

## QUALITATIVE DATA

Qualitative data was collected through a survey of clients entered on the region's database for managing rehabilitation cases, *Employees under case management* (Department of Education). 'Clients' are employees taking leave greater than twenty working days and considered by the ERU as potentially requiring support. Appendix 8 is the letter and questions provided to the sample of clients and appendix 9 a *Table of Responses*.

Two questions were formulated for each of the three themes. The questions were randomly numbered then asked in the numbered order. Likert scales were used to measure responses because they are less laborious; correlate well with more complex scales (Oppenheim, 1992, p. 195); are simplistic; reduce survey completion time; and simplify analysis. Provision was made for respondents to make comments to clarify each of their responses.

The population of the survey is 276 employees who were rehabilitation clients of the Wide Bay Region in the period from the 1994 calendar year to 1996/7 financial year. A sample of twenty-one clients who received questionnaires were randomly selected after extracting employees who were deceased, not recent cases, or considered to be vulnerable. Of the survey recipients, one had died, two were unable to be contacted, one did not respond and seventeen responded.

Other qualitative measures have been used in evaluating rehabilitation programs, but these methods require qualified specialists — for example, the attitudinal evaluations performed by Althoff and Andruss (1996).

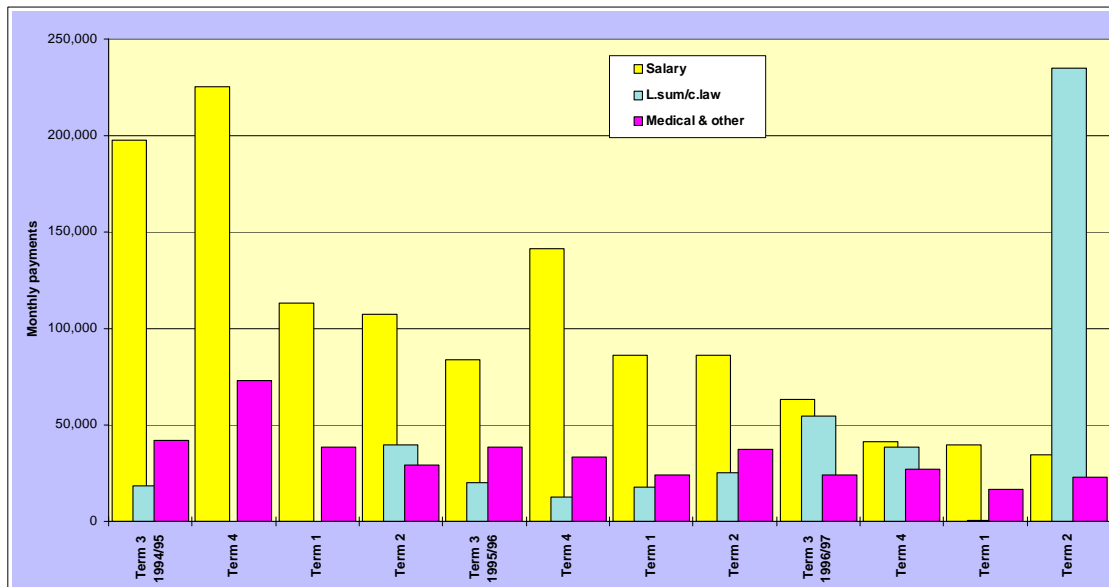
## RESULTS

Complete data was not collected for all clients, for example, the date of making initial contact, because of continuing development of the *Employees under case management* (Department of Education) database. Where necessary, samples with complete information have been extracted to maintain the integrity of the analysis.

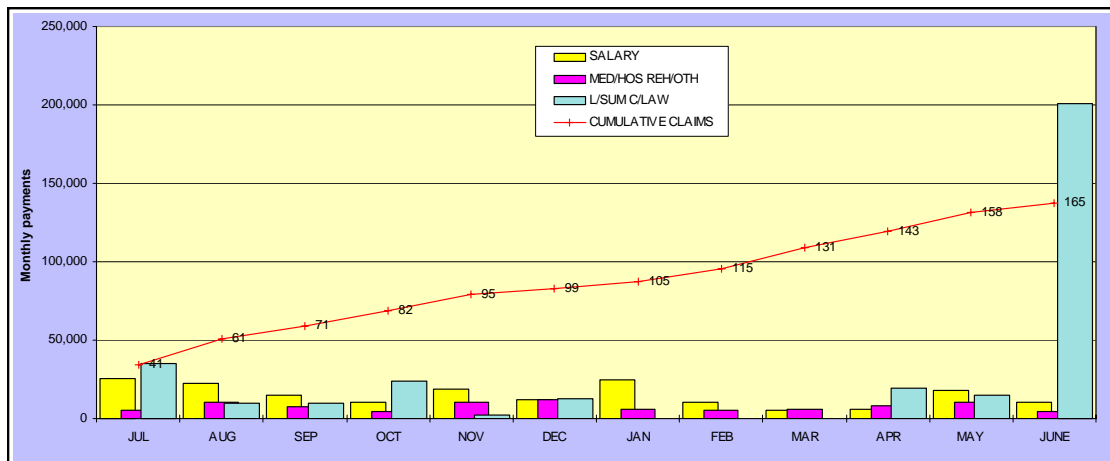
## QUANTITATIVE DATA

In calculating the cost-benefit analysis, Figure 1 graphs the components of compensation payments for 1994/95 to 1996/97 financial years and Figure 2 separates 1996/97 data to show payment components against claim numbers. The reduction in the salary component of workers compensation payments between 1995/96 and 1996/97 financial years was \$246,160 making a saving of \$164,110. It should be noted that this reduction occurred despite increasing numbers of claims. Rehabilitation Co-ordinator salary costs were estimated at \$82,050 (Table 1).

**Figure 1**  
**Components of workers compensation costs 1994/95 to 1996/97 financial years**



**Figure 2**  
**Workers compensation costs and numbers of claims 1996/97 financial year**



**Table 1**  
**Estimated salary costs for rehabilitation co-ordinators**

ERU officers	Salary 1995	%	Amount
1	\$48,891	30	\$14,667
2	\$48,891	30	\$14,667
3	\$48,891	45	\$22,000
4	\$43,188	40	\$17,275
5 (Administrative support)	\$26,880	50	\$13,440
		<b>Total</b>	<b>\$82,050</b>

During the period, the workers' compensation premium was not adjusted despite continuing reductions in compensation costs. It was not until the 1997/98 financial year that the statewide premium reduced by approximately \$6 million from \$18 million (Fitzpatrick 1998, pers. comm., 11 August). This averages to a reduction of \$0.5 million in each of the eleven regions. The reduction is considered to be a savings generated by rehabilitation interventions, but it has been excluded from these calculations because the reduction did not occur in the period.

Appendix 5 details other costs excluded from the calculations. These are balanced by omitted savings from indirect and intangible benefits, for example, increased productivity from improved morale and commitment.

As indicated by the instrument measuring the average days absent, savings of approximately \$3.68 million occurred through rehabilitation interventions reducing periods of sick leave. Another future saving from rehabilitation is reduced common law payments which Kinzie and Holyoke estimate mature after two years (1996, p. 42).

The average days absent was calculated from data obtained from *EdPERS<sup>II</sup>* and excludes workers' compensation leave (Table 2).

**Table 2**  
**Average days absent (Only teacher absences exceeding twenty working days).**

Prior to 1995/96 financial year	1995/96 financial year
95.20 working days	92.09 working days

Source: EdPERS<sup>II</sup>, Department of Education.

The region's 1995/96 annual budget for teacher salaries was \$112,580,895. The reduction of 3.27 percent represents a savings of approximately \$3,681,000 in the year.

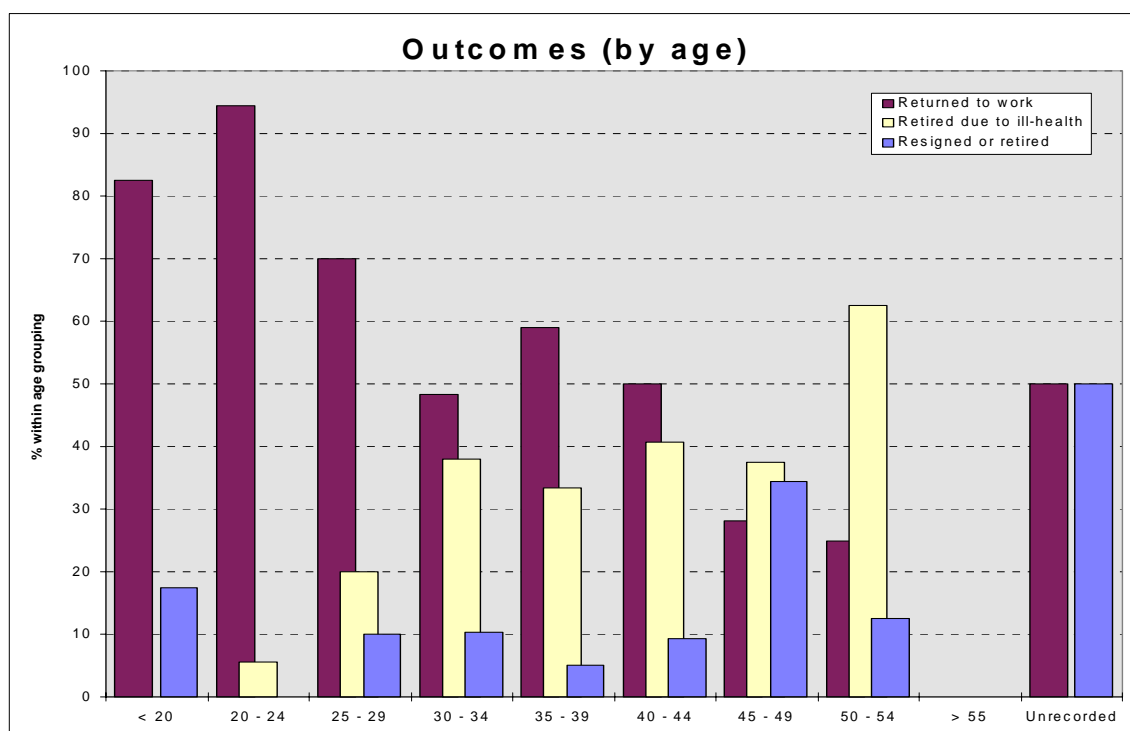
The return to work rate, dissected into age groupings, calculated from the population of clients of the region in the 1994/95 to 1996/97 financial years is shown in Table 3 and Figure 3.

**Table 3**  
**Rehabilitation outcomes based on age groupings (population)**

Age	Returned to work	Retired ill-health	Resigned or retired	Other	Total
	n	n	n	n	n
< 20	19	0	4	0	<b>23</b>
20 - 24	17	1	0	0	<b>18</b>
25 - 29	14	4	2	0	<b>20</b>
30 - 34	14	11	3	1	<b>29</b>
35 - 39	23	13	2	1	<b>39</b>
40 - 44	16	13	3	0	<b>32</b>
45 - 49	9	12	11	0	<b>32</b>
50 - 54	2	5	1	0	<b>8</b>
> 54	0	0	0	0	<b>0</b>
Unrecorded	2	0	2	0	<b>4</b>
Current cases					<b>71</b>
<b>Total</b>	<b>116</b>	<b>59</b>	<b>28</b>	<b>2</b>	<b>276</b>

Source: *Employees under case management*, Department of Education.

**Figure 3**  
**Rehabilitation outcomes for closed cases (dissected into age groups)**



Source: *Employees under case management*, Department of Education.

The resulting return to work rate is 56.6 percent, based on 116 interventions resulting in a return to work from 205 closed cases.

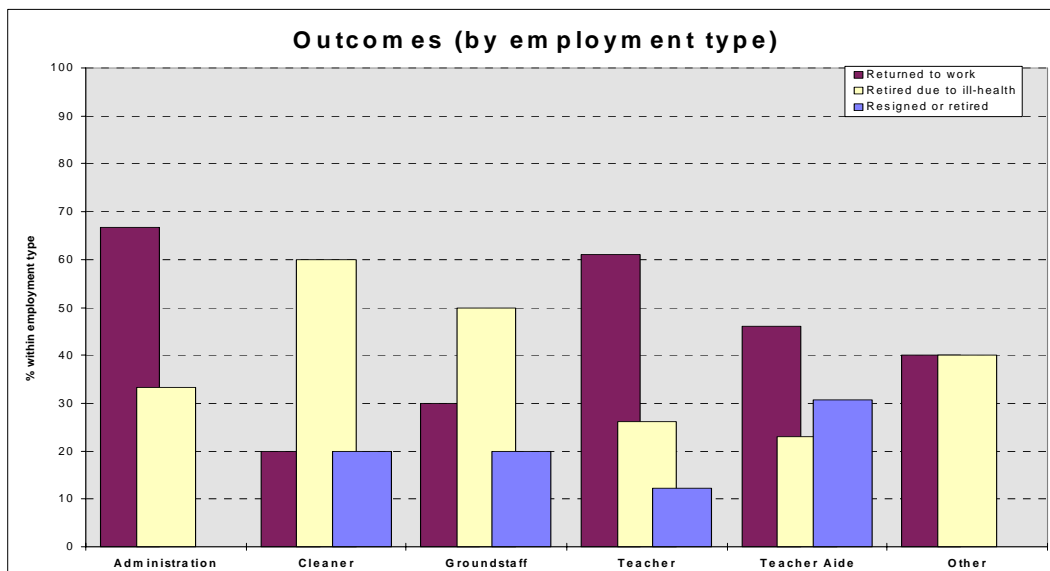
Rehabilitation outcomes within employment categories are detailed in Table 4 and Figure 4.

**Table 4**  
**Rehabilitation outcomes for closed cases (% within employment category) based on employment categories (population)**

Category of employment	Returned to work	Retired ill-health	Resigned or retired	Other	Total
	%	%	%	%	n
Administration	66.7	33.3	0	0	<b>3</b>
Cleaner	20	60	20	0	<b>10</b>
Groundstaff	30	50	20	0	<b>10</b>
Teacher	61	26.2	12.2	0.6	<b>164</b>
Teacher Aide	46	23	31	0	<b>13</b>
Other	40	40	0	20	<b>5</b>
<b>Numbers of cases:</b>					
Current cases					<b>71</b>
<b>Total</b>	<b>115</b>	<b>60</b>	<b>28</b>	<b>2</b>	<b>276</b>

Source: *Employees under case management*, Department of Education.

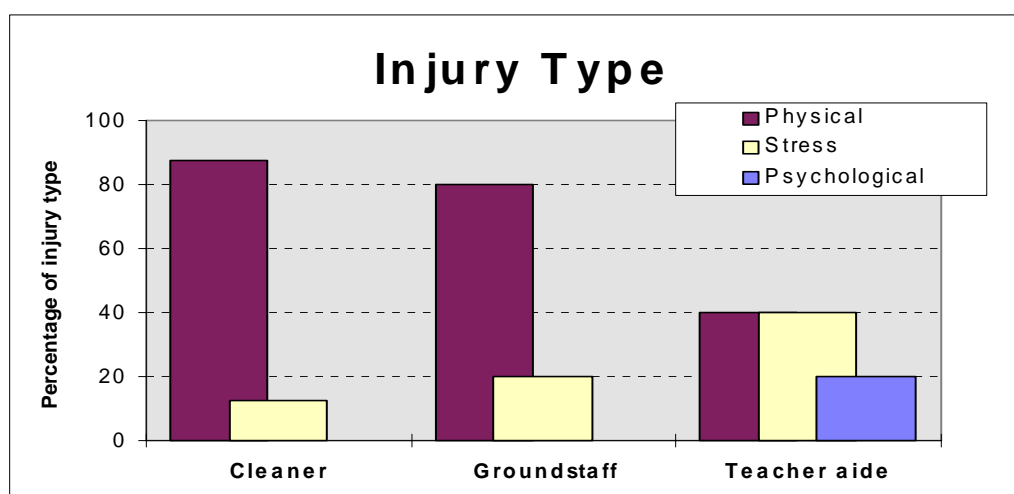
**Figure 4**  
**Rehabilitation outcomes for closed cases (dissected into employment types)**



Source: *Employees under case management*, Department of Education.

A more detailed analysis of the injury types for a sample of twenty-three cleaners, groundstaff and teacher aides is given in Figure 5.

**Figure 5**  
**Injury types for Client Cleaners, Groundstaff and Teacher Aides who separated from employment.**



Within these employee groups, approximately 80 percent of clients suffered physical injuries which resulted in separating from employment through ill-health retirement or resignation.

From the analysis of employees separating from employment, divided into age groups, the following is noted:

- 82 percent of clients in the age groups to 29 years were returned to work;
- 53 percent of clients in the age groups from 30 to 44 returned to work;
- 27.5 percent of clients in the 45 to 54 year age group returned to work; and
- no employee over 54 became a rehabilitation client.

The **average intervention period** is presented as a sample of 26 employees in Table 5.

**Table 5**  
**Rehabilitation outcomes (based on days before initial contact established)**

Contacted made (calendar days)	Work		IHR		Employment Terminated		Total n
	n	Note 1	n	Note 1	n	Note 1	
Within 14 days	8	89%	1	11%	0	0%	<b>9</b>
Within 28 days	6	100%	0	0%	0	0%	<b>6</b>
Within 42 days	3	75%	1	25%	0	0%	<b>4</b>
Within 56 days	2	33%	3	50%	1	17%	<b>6</b>
56 days and over		0%	1	100%	0	0%	<b>1</b>
<b>Totals</b>	<b>19</b>		<b>6</b>		<b>1</b>		<b>26</b>

Note 1. Percentage of outcomes within the number of days contacted

**QUALITATIVE DATA**

Responses from the survey were collated into tables displaying responses for each theme (Tables 6 to 9). The maximum possible tally for each question is 17.

**Table 6**  
**Communication**

Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	12	4	1		
6	7	8	2		

Sixteen respondents at least agreed that their dignity was respected. Fifteen respondents strongly agreed or agreed that they were continually informed in the process.

**Table 7**  
**Participation**

Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	9	6		2	
8	1	2			

Question 8 was not applicable: 14

Fifteen respondents at least agreed that they participated in decision-making. The three respondents who ceased employment felt the co-ordinator accepted that rehabilitation was not the best option. Fourteen respondents stated the question was not applicable because they did not separate from employment.

**Table 8**  
**Supportive of Return to work program**

Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
2	9	5	3		
3	8	5	1	2	1

Neutral — not considered due to medical condition

Fourteen responses at least agreed that the rehabilitation co-ordinator was genuine in offering alternative duties. Thirteen respondents indicated that medical practitioners were committed to their rehabilitation. One respondent strongly disagreed with a medical practitioner because of the practitioner's medical assessment of their condition.

**Table 9**  
**Meaningful alternative duties**

Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
4	6	5	4	2	
7	11	6			

Three respondents were unable to accept alternative duties because of their medical condition. Their response was recorded as neutral. Eleven of the remaining twelve respondents capable of accepting alternative duties at least agreed that alternative duties were meaningful. All respondents at least agreed that rehabilitation was beneficial.

Indicative comments from the questionnaires are provided in Appendix 10.

## DISCUSSION

### Quantitative data

The cost-benefit analysis revealed that annual savings of more than \$3.844 million were generated by a rehabilitation program costing \$82,050 per annum. However, the reduction in the salary component of worker's compensation may have been influenced by other factors, especially changes in workers' compensation legislation. These changes were intended to strengthen assessment criteria and exclude marginal compensation claims.

Claim numbers from Figure 2 (page 15) indicate that 13.75 applications for workers' compensation were approved each month in the 1996/97 financial year. Despite these increasing numbers, compensation payments reduced by \$164,110 during the period. Apart from return to work programs, this may have been due to the individual's commitment to duties; the medical condition not requiring an absence from duty; employees having a greater awareness of their right to lodge an application, doing so for reference purposes only; or because the initial co-ordinator's contact persuaded employees to return to duties.

Data for average days absent indicate the potential for savings in salaries associated with rehabilitating employees with a non-work injury and illness. The reduction of 3.27 percent occurred over two consecutive financial years and so reduces the possibility of being influenced by time-related factors. The legislative changes which may have reduced workers' compensation premiums would not have reduced the average days absent because the leave is not associated with work-related medical conditions. While the magnitude of the reduction is partly attributable to the size of the payroll, the potential benefit of extending rehabilitation support to non-compensable medical conditions is supported by these figures. The data supports research indicating that rehabilitation programs are financially beneficial.

The return to work rate compares unfavourably with 67 percent for *Workcover Authority* and a suggested performance standard of 84.3 percent (Yates 1992, p. 494). A more detailed analysis indicated that the rate was particularly poor for specific age groups and employee groups. Of these trends, the most concerning is the number of clients separating from the department above the age of 29. This is a concern because these employees represent a loss of experience and investment in employee development and, therefore, future management potential. It is a further concern because these employees represent a significant proportion of the department's workforce. The increasing percentage of separations as age increased further amplifies the need to explore causes.

Cleaners, groundstaff and teacher aide separations were significantly higher than other employee groups. In a majority of cleaner and groundstaff cases the separation resulted from a physical injury. A possible inference is that, when cleaners or groundstaff commence sick leave, the extent of the injury or illness is so severe that the condition significantly reduces their ability to return to work. This might result from a cultural trait of persisting to work despite high levels of discomfort for fear of being labelled as abusing the system; financial pressures to remain at work; or low awareness of compensation or rehabilitation processes. The department should determine if the pattern is widespread and, if so, analyse the contributing factors. Potentially, cultural changes may be required to reduce these separations. Although the sample of teacher aides is very small, equal physical and stress conditions were

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noted. Physical strain may result from more labour intensive duties, for example, moving play equipment twice each day in preschools, or supporting special needs students in the special sector. Emotional stress might be experienced by teacher aides who are providing a high level of support to teachers and students, but not having tertiary training or coping skills of tertiary trained teachers.

### **Qualitative data**

When assessing the inter-personal communications in the rehabilitation process, the evaluation considers four themes — early intervention, communication, participation and meaningful alternative duties.

The data on early intervention supports Strautins and Hall's findings (1989) that early intervention increases the likelihood of returning employees to work. A greater percentage of employees returned to work when initial contacts were made within 28 days and, when contact was made after 43 days, the percentage ceasing employment increased. Despite broad research, no indicators or standards were discovered to compare with this research's rate.

Qualitative data indicated that clients perceived co-ordinators' communication and information flows were appropriate. All but one respondent indicated that communication processes were at least agreeable. This indicates that client communication and information needs were met by parties in the rehabilitation process.

Clients perceived that they were actively involved in determining the course of the rehabilitation process. Responses indicate that the co-ordinators' practices included participative decision-making processes, even when considering ill-health retirement.

Literature and Best Practice principles indicate that a key element of successful rehabilitation programs is the provision of quality alternative duties. This element was measured by the willingness of parties in the rehabilitation process to provide alternative duties and whether the duties offered were meaningful to the client. Clients had passionate recollections when meaningful duties were not arranged, for example:

- “Done in haste ...”
- “After I was left feeling I was only another [employee type] ... there wasn't anything useful I could do.”
- “I left the first time because [the school] didn't support me ...”

However, the research data strongly supports that co-ordinators were perceived as genuinely supporting the return to work program by negotiating meaningful alternative duties. These meaningful duties could only be made possible with the cooperation of the region's schools. Additionally, responses indicate that the duties undertaken by clients in the rehabilitation process were perceived by clients as being meaningful. This indicates that meaningful alternative duties were negotiated by co-ordinators in accordance with Best Practice principles.

It is interesting to note that three clients who separated from employment despite rehabilitation support disagreed that the medical practitioner was committed to assisting in the rehabilitation program and two disagreed that the return to work provided meaningful duties.

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The causes of this might also be that other parties considered that there was little chance of a successful return to work because of medical concerns; other parties did not adequately consider the client's perspective; or the client's disposition to return to work was inappropriate. In these instances, improving the client's perception of the intervention might focus on the client's acceptance of their situation. Therefore, co-ordinators should genuinely seek meaningful alternative duties or assist their client's understanding of their medical situation through appropriate referrals, for example, a psychologist.

## CONCLUSIONS AND RECOMMENDATIONS

### *Hypothesis 1:*

Despite the *return to work rate* being lower than either the *WorkCover Authority's* rate or the suggested rate (Yates 1992, p. 494), the economic analysis indicates significant savings were generated by the rehabilitation intervention and that these savings will attract future benefits including reduced premiums and common law claims.

*The first hypothesis, that rehabilitation services in the Wide Bay Region of Queensland Department of Education were not cost effective in the 1995/96 financial year, is rejected.*

### *Hypothesis 2:*

Of the seventeen surveyed respondents, no client indicated overall disagreement with case-management practices. The one response indicating strong disagreement related to a medical practitioner's assessment. All the respondents agreed or strongly agreed that the co-ordinator's practices reflected Best Practices principles.

*The hypothesis, that injured or ill workers supported by Wide Bay Region's rehabilitation programs from 1994 to 1996/97 financial year feel that Best Practice principles were not reflected in case-management practices, is rejected.*

It is recommended that further research be conducted to determine the cause of separations:

- of employees aged over twenty-nine years; and
- of cleaners and groundstaff.

A longitudinal survey should be conducted to ascertain whether a correlation exists between the provision of rehabilitation services for non-compensable conditions and reduced sick leave.

It is further recommended that researchers determine whether a correlation exists between rehabilitation clients not returning to work and the level of support provided by co-ordinators and medical practitioners. If a correlation is established, providing appropriately skilled co-ordinators is essential and developing a list of recommended medical practitioners is highly desirable. In view of the long-term effects of rehabilitation on common law, compensation premiums and sick leave, it is recommended that the department evaluate case-management practices under the current model.

It is recommended that employers provide rehabilitation support for both work and non-work related medical conditions because, regardless of the source of the injury or illness, the effects on the employment relationship and potential benefits are similar.

**BIBLIOGRAPHY**

- Allen, R. & Eritzel, D. 1997, 'An Injury and Cost Assessment of a Coal Mining Company's Return to Work Program', *Professional Safety*, Volume 42, Number 9, pp. 24-26.
- Althoff, J. & Andruss, M. 1996, 'Study Finds Attitude Does Affect Return to Work', *National Underwriter Property and Casualty/Risk and Benefit Management*, Volume 100, Number 12, pp. 15 and 37.
- Anonymous 1994, 'The Merit Bonus Scheme Review — What Do The Proposed Changes Mean?', *Safenews*, Mar/Apr, Volume 24, Number 2, pp. 4-5.
- Butler, R. J., Johnson, W. G. & Baldwin, M. L. 1995, 'Managing Work Disability: Why First Return to Work is Not a Measure of Success', *Industrial and Labour Relations Review*, April, Volume 48, Number 3, pp. 452-469.
- CEDVET*, Department of Education.
- Ceniceros, R. 1997, 'Return to Work Plan Under Fire', *Business Insurance*, September 22, Volume 31, Number 38, pp. 2, 13 and 14.
- Colledge, A. & Johnson, H. 1992, 'Teaming Up Against Workplace Injuries', *Risk Management*, Volume 39, Number 10, pp. 47-51.
- Cottone, R. R. & Emener, W. G. 1990, 'The Psychomedical Paradigm of Vocational Rehabilitation and Its Alternatives', *Rehabilitation Counselling Bulletin*, Volume 34, Number 2, pp. 91-102.
- Dean, D. 1996, 'Examining the Efficacy of Vocational Rehabilitation: The Early Returns for the "Project Network" Experiment in Virginia', *National Conference of the Australian Society of Rehabilitation Counsellors*, Sydney.
- Dean, D. H. & Dolan, R. C. 1991, 'Fixed-Effects Estimates of Earnings Impacts for the Vocational Rehabilitation Program', *The Journal of Human Resources*, Spring, Volume XXVI, Number 2, pp. 380-391.
- EdPERS<sup>II</sup>*, Department of Education.
- Employees under case management*, Department of Education.
- Fletcher, M. 1992, 'Safety Diligence Protects Profits as Well as Workers', *Business Insurance*, Volume 26, Number 32, p. 12.
- Flynn, G. 1994, 'Rehab Makes Good Business Sense', *Personnel Journal*, Volume 73, Number 9, pp. 18-20.
- Gardner, J. A., 1987, 'Vocational Rehabilitation: Lessons for Employers', *Business and Health*, March, pp. 20 and 24.
- Gice, J. H. and Tompkins, K. 1988, 'Cutting Costs with Return to Work Programs', *Risk Management*, Volume 35, Number 4, pp. 62-65.
-

- 
- Guidance Note for Best Practice Rehabilitation Management of Occupational Injuries and Disease [NOHC:3021(1995)] 1995, Australian Government Publishing Service, Canberra.
- Harty, S. J. 1992, 'Return to Work Plans Boost Bottom Lines', *Business Insurance*, Volume 26, Number 15, p. 23.
- Heine, A. 1994, 'Killing Two Birds with One Stone', *Business Insurance*, Volume 28, Number 20, pp. 33-34.
- Hintzman, D. & Farrell, C. 1997, 'The Benefits of a Partnership Approach to Disability Management', *Benefits Quarterly*, Fourth Quarter, Volume 13, Number 4, pp. 14-18.
- Hocking, B., Kasperczyk, R., Savage, C. & Gordon, I. 1992, 'An Evaluation of Occupational Rehabilitation in Telecom', *Journal of Occupational Health and Safety*, Volume 9, Number 1, pp. 17-30.
- James, C. & Brownlea A. 1994, 'Work-related Injury: Managing the Impact', *Asia Pacific Journal of Human Resources*, Volume 32, Number 3, pp. 80-96.
- Kenny, D. 1994, 'The Relationship Between Worker's Compensation and Occupational Health and Safety', *Journal of Occupational Health and Safety*, Volume 10, Number 2, pp. 157-164.
- Kenny, D. 1996, 'The Roles, Functions and Effectiveness of Treating Doctors in the Management of Occupational Injury: Perceptions of Key Stakeholders', *Australian Journal of Rehabilitation Counselling*, Volume 2, Number 2, pp. 86-98.
- Kenny, D. 1995b, 'Barriers to Occupational Rehabilitation: An Exploratory Study of Long Term Injured Workers', *Journal of Occupational Health and Safety*, Volume 11, Number 3, pp. 249-256.
- Kenny, D. T. 1995a, 'Common Themes, Different Perspectives: A Systemic Analysis of Employer-employee Experiences of Occupational Rehabilitation', *Rehabilitation Counselling Bulletin*, Number 39, pp. 54-77.
- Kenny, D. T. 1995c. 'Failures in Occupational Rehabilitation: A Case Study Analysis', *Australian Journal of Rehabilitation Counselling*, Volume 1, Number 1, pp. 33-45.
- Kinzie, P. & Holyoke, P. 1996, 'Untangling Ontario's Rehab Maze', *Canadian Underwriter*, Volume 63, Number 2, p. 42.
- Kuhn, L. 1994, 'A Return to Work Profile', *Small Business Report*, Volume 19, Number 8, p.16.
- Leutgeb, V. & Hagelberg, R. 1997, 'Systems Redesign in Rehabilitation', *Nursing Management*, Volume 28, Number 10, pp. 51-52.
- Oppenheim, A. N. 1992, *Questionnaire Design, Interviewing and Attitude Measurement*, New Edition, Pinter Publishers, London.
- Parkin, K. & Parsons, T. 1995, 'Automation: Rehab-style', *Canadian Underwriter*, Volume 62, Number 5, p. 34.
-

- Pati, G. C., 1985, 'Economics of Rehabilitation in the Workplace', *Journal of Rehabilitation*, October/November/December, pp. 22-30.
- Pelland, D. 1997, 'Applying Managed Care to Workers' Compensation: Integrated Approach', *Risk Management*, Volume 44, Number 11, p. 14.
- Richardson, B. 1997, 'Reforming Workers' Compensation', *Australian Safety News*, Volume 68, Number 7, pp. 36-45.
- Shrey, D. 1993, 'Workplace Based Disability Management', *Proceedings of the second National Rehabilitation Conference*, Sydney, pp. 27-36.
- Smith, S. L. 1991, 'Returning to Health: Getting Injured Workers Back on the Job', *Occupational Hazards*, Volume 53, Number 2, pp. 37-40.
- Snyder, N. M. 1995, 'Organisational Culture and Management Capacity in a Social Welfare Organisation: A Case Study of Kansas', *Public Administration Quarterly*, Summer, Volume 19, Number 2, pp. 243-264.
- Strautins, P. and Hall, W., 1989, 'Does Early Intervention to an on-site Rehabilitation Program Predict an Early Return to Work?', *Journal of Occupational Health and Safety — Australia/New Zealand*, Volume 5, Number 2, pp. 137-143.
- Taylor, T. 1998, 'Working Around Workers' Injuries', *Nation's Business*, Volume 76, Number 7, pp. 39-40.
- Timson, L. 1997, 'Rehabilitation Helps Cut Costs', *Business Queensland*, May 19, p. 27.
- Wojcik, J. 1994, 'Return to Work Plan's Allure: Works Better and Costs Less', *Business Insurance*, Volume 28, Number 42, pp. 3, 4 and 6.
- Wooden, M. 1991, 'Employee Participation: A Practical Guide' in *Readings In Human Resource Management*, ed R. Stone, John Wiley & Sons, Milton.
- WorkCover Queensland Act 1996*, 1997, Queensland Government Printer, Brisbane.
- Worksafe Australia* (1996) Evaluation of Internal Rehabilitation Programs, [On line] URL <http://www.worksafe.gov.au/worksafe/FULLTEXT/DOCS/H5/932.htm>, [Accessed 10 October, 1998].
- Wright, G. N. 1992, *Total Rehabilitation*, Brown & Co., Boston.
- Yates, S. 1992, 'Measuring the Effectiveness of Workplace Rehabilitation', *Journal of Occupational Health and Safety*, Volume 8, Number 6, p. 493-496.
-

## **Appendix 1**

### **MEMBERSHIP OF TASK FORCE WHICH DEVELOPED 'BEST PRACTICE' PRINCIPLES FOR REHABILITATION MANAGEMENT**

The guidance note for Best Practice Rehabilitation Management of Occupational Injuries and Disease [NOHC:3021(1995)] was produced by the Rehabilitation Task Group which included representatives from:

- Victorian WorkCover Authority;
- Workers' Compensation Board of Tasmania;
- WorkCover Corporation of South Australia;
- Work Health Authority of the Northern Territory;
- Workers' Compensation Board of Queensland;
- WorkCover Western Australia;
- Australian Chamber of Commerce and Industry;
- Australian Council of Trade Unions;
- Comcare Australia;
- Commonwealth Rehabilitation Service; and
- Victorian Employers' Chamber of Commerce and Industry.

**Source:** 'Guidance note for best practice rehabilitation management of occupational injuries and disease', 1995, Australian Government Publishing Service, Canberra [NOHC:3021(1995)]

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## Appendix 2

### Best Practice Principles for Rehabilitation Management

Irrespective of the compensation and rehabilitation system or participant role, for example, injured employee, employer, etc, there are essential principles of rehabilitation which can be promoted and maintained by all concerned. These principles are:

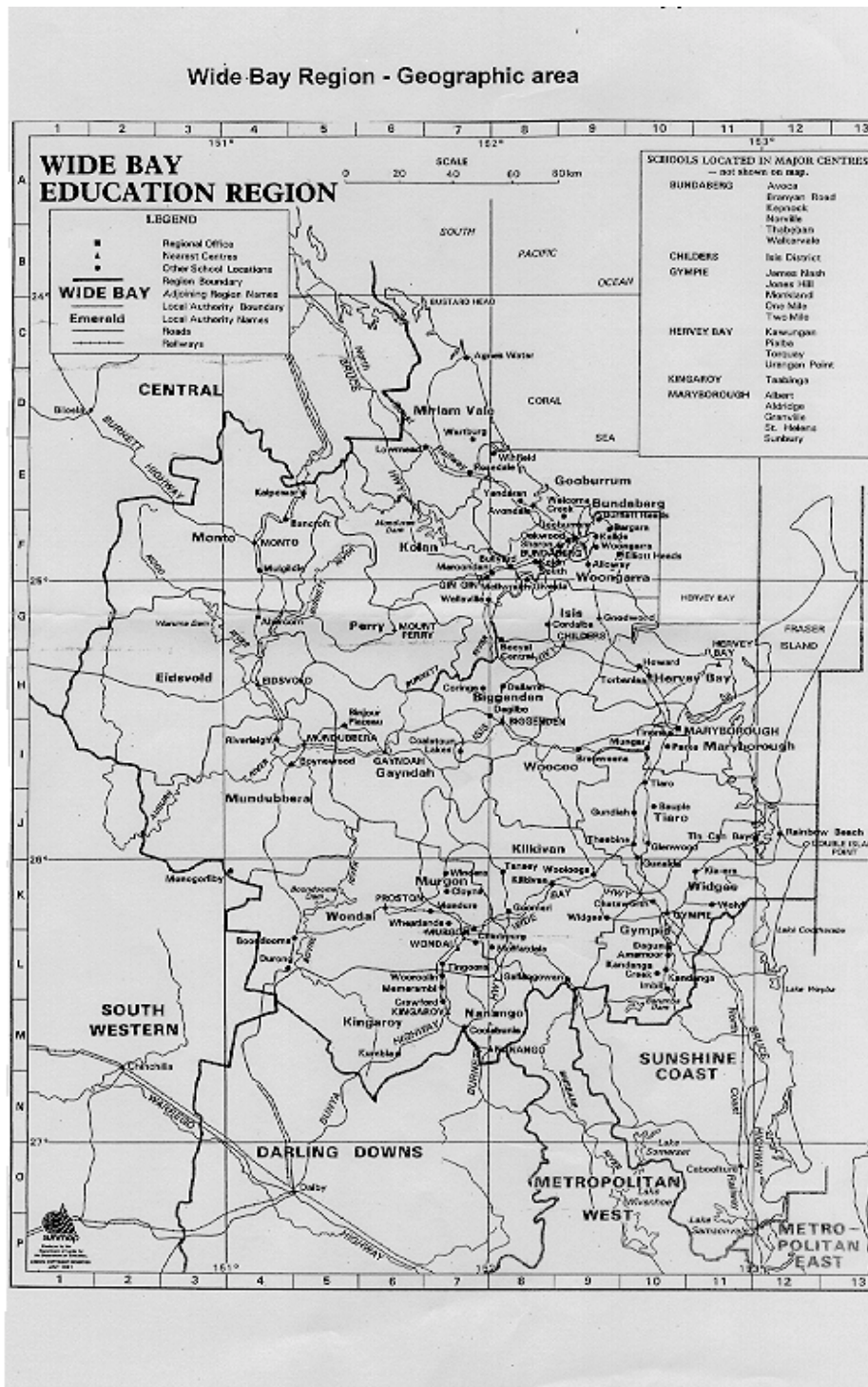
- a) Maintenance at work or early and appropriate return to work is in the best interests of all employees who have suffered a work-related injury or disease and should be the prime goal.
- b) Commitment by all parties to the rehabilitation process is essential for successful outcomes.
- c) Recognition that the workplace is usually the most effective place for rehabilitation to occur.
- d) Rehabilitation should occur at the earliest possible time consistent with medical judgement.
- e) Rehabilitation intervention should ensure that
  - the dignity of employees is retained; and
  - employees participate actively in the process.
- f) Consultation between the employer and employee (and their representatives where appropriate) should occur at all stages of the rehabilitation process.
- g) Employers and employees should be informed of their legislative entitlements and requirements under the relevant workers' compensation system.
- h) Information should be treated confidentially, with sensitivity and used only for the purpose for which it was supplied.
- i) All relevant rehabilitation expenses are to be met by the agent responsible under appropriate legislation.
- j) Return to work programs should aim to return the employee to work in either:
  - same job/same employer;
  - similar job/same employer; or
  - new job/same employer.

These are the first options to be considered when planning and implementing return to work programs. If these are inappropriate, or no position is available with the original employer, then the following apply:

  - same job/new employer;
  - similar job/new employer; or
  - new job/new employer.
- k) Work assigned through the rehabilitation process should be meaningful to the employee.
- l) Graduated return to full time duties, permanent part time work or reduced hours relative to pre-injury hours should be considered when planning and implementing return to work activities.
- m) No injured employee should suffer financial disadvantage by participating in a return to work program.
- n) Rehabilitation is most effective when linked to workplace based occupational health and safety program.

**Source:** "Guidance note for best practice rehabilitation management of occupational injuries and disease", 1995, Australian Government Publishing Service, Canberra [NOHC:3021(1995)]

Appendix 3



**Appendix 4**  
**Workforce composition in July 1995 - Wide Bay Region**

Teachers		2327
Teaching support staff		
	Teacher aides	543
	Others	8
School support staff		
	Registrars/Administration Officers	79
	Scientific Assistants	40
	Groundstaff	88
	Cleaners	433
Regional Office staff		46
<b>Total</b>		<b>3564</b>

Note: Cleaners have been included despite being transferred to the Department of Administrative Services during the period as both the liability for payments for workers compensation and responsibility for cleaners with long-term injury or illness remained with the department.

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## Appendix 5

### Excluded costs associated with managing rehabilitation programs.

**Vehicle running costs** have been excluded because of the minimal amount involved by comparison to other costs, for example salary. Assuming that a vehicle was solely used for rehabilitation purposes for one year, the estimated cost of running the vehicle would be \$3,100 per annum including \$500 registration; \$300 insurance; \$1,000 maintenance and repair (vehicles are under two years old requiring few repairs); and petrol \$1,300 (travelling 20,000 kilometres).

**Travel expenses** would be minimal due to the extremely infrequent travel required to manage cases. It is estimated that a total of no more than four overnight trips would be effected to manage rehabilitation programs during each financial year. A budget of \$960 was allowed for this travel during the 1995/96 financial year.

**Telephone, postage and stationary costs** would be difficult to estimate as each officer was responsible for a rehabilitation caseload as part of their duties, but no officer provided rehabilitation support as their total duties.

Although **Common law** payments are significant, they have been excluded because of the time between injury and payment. Kinzie and Holyoke estimate that full costs do not mature for two years (Kinzie & Holyoke 1996, p. 42). Additionally, under the Merit Bonus Scheme, common law payments are "... not considered representative of employer's efforts to reduce claims ..." and therefore are excluded (Anonymous, p. 4).

Workers' compensation **medical, rehabilitation and other expenses** have not been included due to their insignificance.

Source: Budget and financial information obtained from records within Wide Bay Regional Office, Department of Education, Maryborough.

## **Appendix 6**

### **Sources of quantitative data**

1. *EdPERS<sup>II</sup>*, a database for managing the department's teaching workforce including leave management;
2. *CEDVET*, a database of workers' compensation payments made to injured or ill employees in the period to 1996/97 financial year; and
3. *Employees under case management*, a locally developed database used in the Employee Relations Unit to manage rehabilitation cases.

Source: Wide Bay Regional Office, Department of Education, Maryborough.

## Appendix 7

### Examples of quantitative evaluation methods not included in this evaluation.

- **Frequency and severity of injuries** (Gice & Tompkins 1988, p. 64) — other data is more relevant to evaluating the effectiveness of the program;
- **In-house referral rate** (Yates 1992, p. 494) — the percentage of compensation claims referred for offer of rehabilitation assistance was considered not to be meaningful as all compensation claims were referred to a rehabilitation co-ordinator; and
- **Value of work** (Allen & Eritzel 1997, p. 25) — other methods are more relevant to the evaluation and the method requires resources which were not available to the researcher to calculate the percentage of work completed by an employee performing a light-duty program.

## **Appendix 8 Survey of Rehabilitation Clients**

Dear

This project is sponsored by the Human Resources Department, University of Southern Queensland, Toowoomba and approved by Education Queensland. The purpose of the survey is to evaluate the effectiveness of rehabilitation services provided under the Wide Bay Region's model which operated during the 1994/5 to 1996/7 financial years. During this period, rehabilitation services were provided by rehabilitation co-ordinators who were based in the Employee Relations Unit of Regional Office.

The survey should benefit employees, rehabilitation co-ordinators and school administrators by improving rehabilitation service delivery. As the survey has academic value, it may also bring benefits to the academic community in general.

You have been randomly selected as one of a sample of employees who were provided with rehabilitation support during the 1994/95 to 1996/97 financial years. **Information will remain strictly confidential** and you are not required to provide identifying information. Only summary information and indicative comments from the questionnaires will be used in the survey.

It would be appreciated if you could complete the survey and return it within one week in an envelope addressed to:

**(Confidential - survey response)**  
Senior Personnel Officer  
Corporate Services  
Education Queensland  
PO Box 3008  
Bundaberg Qld 4670

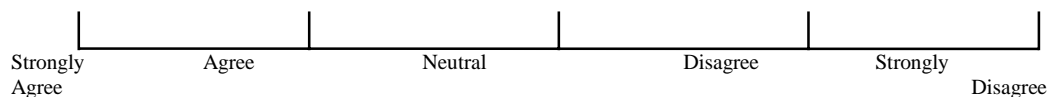
Allowing for comments, **completing the survey takes no more 5 minutes. THANK YOU** in anticipation for taking the time to complete the questionnaire.

Peter Ashby  
Senior Personnel Officer  
Corporate Services  
Education Queensland.

18 September, 1998

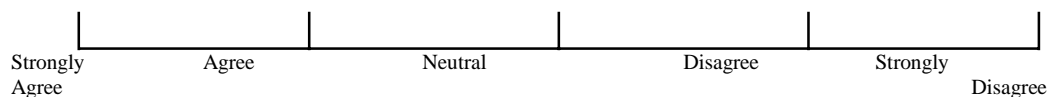
**CONFIDENTIAL**  
**Occupational Rehabilitation Support Survey**

1. The co-ordinator involved me in decisions about duties I could do when I was preparing to return to work.



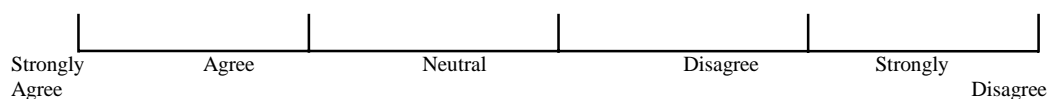
Comments: \_\_\_\_\_  
\_\_\_\_\_

2. When I could not perform my usual duties, the co-ordinator was genuine in providing/discussing options for alternative duties or hours of work.



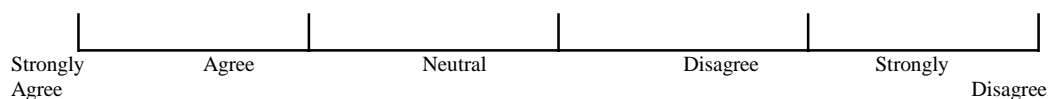
Comments: \_\_\_\_\_  
\_\_\_\_\_

3. The medical practitioner/s involved in my rehabilitation program was/were committed to assisting with my rehabilitation program.



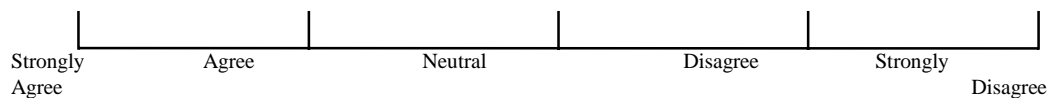
Comments: \_\_\_\_\_  
\_\_\_\_\_

4. The school and rehabilitation co-ordinator were able to offer a meaningful return-to-work program.



Comments: \_\_\_\_\_  
\_\_\_\_\_

5. I felt that my dignity was respected.



Comments: \_\_\_\_\_  
\_\_\_\_\_

6. I was advised of my rights and obligations under the rehabilitation program.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
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Comments: \_\_\_\_\_  
\_\_\_\_\_

7. The rehabilitation program was beneficial.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
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Comments: \_\_\_\_\_  
\_\_\_\_\_

8. When considering retiring as a result of the injury/illness, the co-ordinator acknowledged and accepted that rehabilitation was not the best option.

Not applicable

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
----------------	-------	---------	----------	-------------------

Comments: \_\_\_\_\_  
\_\_\_\_\_

9. Do you have any further comments in relation to rehabilitation services.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If you wish to be advised of the outcome of the survey please ensure that you provide contact details separately to maintain confidentiality (Ph: 07 41540341).**

**THANK YOU** for taking the time to complete the survey. **Please return your response to (fax) 07 41 525698 or post to:**

**(Confidential - survey response)**

Senior Personnel Officer  
Corporate Services  
Education Queensland  
PO Box 3008  
Bundaberg Qld 4670

**Appendix 9**  
**Table of survey responses**

Question number							
1	2	3	4	5	6	7	8
D	N	SA	N	A	SA	A	NA
SA	A	A	SA	SA	SA	SA	NA
A	A	D	N	SA	A	A	A
SA	SA	A	A	SA	SA	SA	NA
D	A	SA	SA	A	N	SA	NA
SA	SA	SA	N	SA	SA	SA	SA
SA	SA	SA	SA	SA	A	SA	NA
A	N	D	D	SA	A	SA	A
SA	SA	SA	SA	SA	SA	SA	NA
SA	SA	SD	SA	SA	A	SA	NA
A	SA	A	A	SA	SA	A	NA
A	A	N	A	SA	A	A	NA
A	A	A	A	A	A	SA	NA
SA	SA	SA	N	A	A	N	NA
SA	SA	SA	A	SA	A	SA	NA
A	A	A	N	N	N	A	NA
SA	SA	SA	SA	SA	SA	SA	NA

## **Appendix 10**

### **Indicative comments from survey responses**

“Often I was left feeling .. there wasn’t anything useful I could do.” “I believe some teachers feel threatened by having another teacher in their room.”

“I left the first time because they [the school] didn’t support me.”

“I found [rehabilitation] was the best thing I’d done. It made me see that [the medical situation] was the normal thing and how to cope with it for the rest of my life.” [The co-ordinator] showed me that I didn’t need to rely on her.” “I don’t know how I would have gone [without the co-ordinator’s support].”

“I have nothing but praise and thanks for all involved in my ‘return to work’ program”

“I just didn’t have the energy at the time to fight.”

“Double strongly agree ... I wouldn’t have got back to work otherwise.” “It was difficult to walk back into the school ... needed someone to help me get back ...” “I felt I was number 1 and I needed that because I was so depressed.”

“The way [the co-ordinator] was ... I really owe her a favour.” “We fought our way through it together”. “Get them over the problem first .. then get back to work ... support was the big thing.”

“I didn’t know what would happen at the school ... rehab was good protection.”

“I was given many options and consulted formally and informally.” “I would have left my profession without the support of this program.” “This is a vital service provided by real people.”