



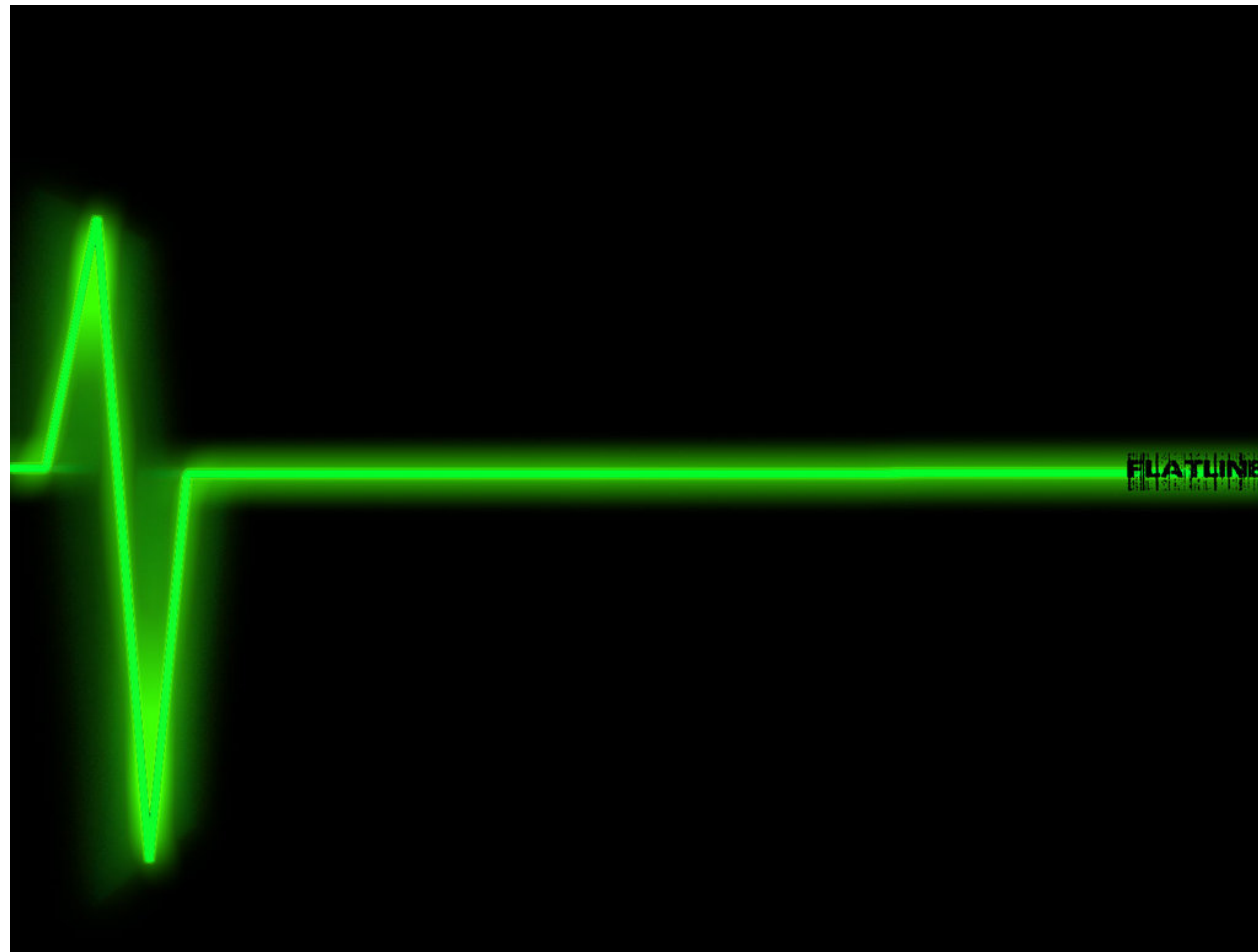
# Why workers compensation schemes will become purveyors of wellness

Professor Niki Ellis

11 November 2013, Gold Coast



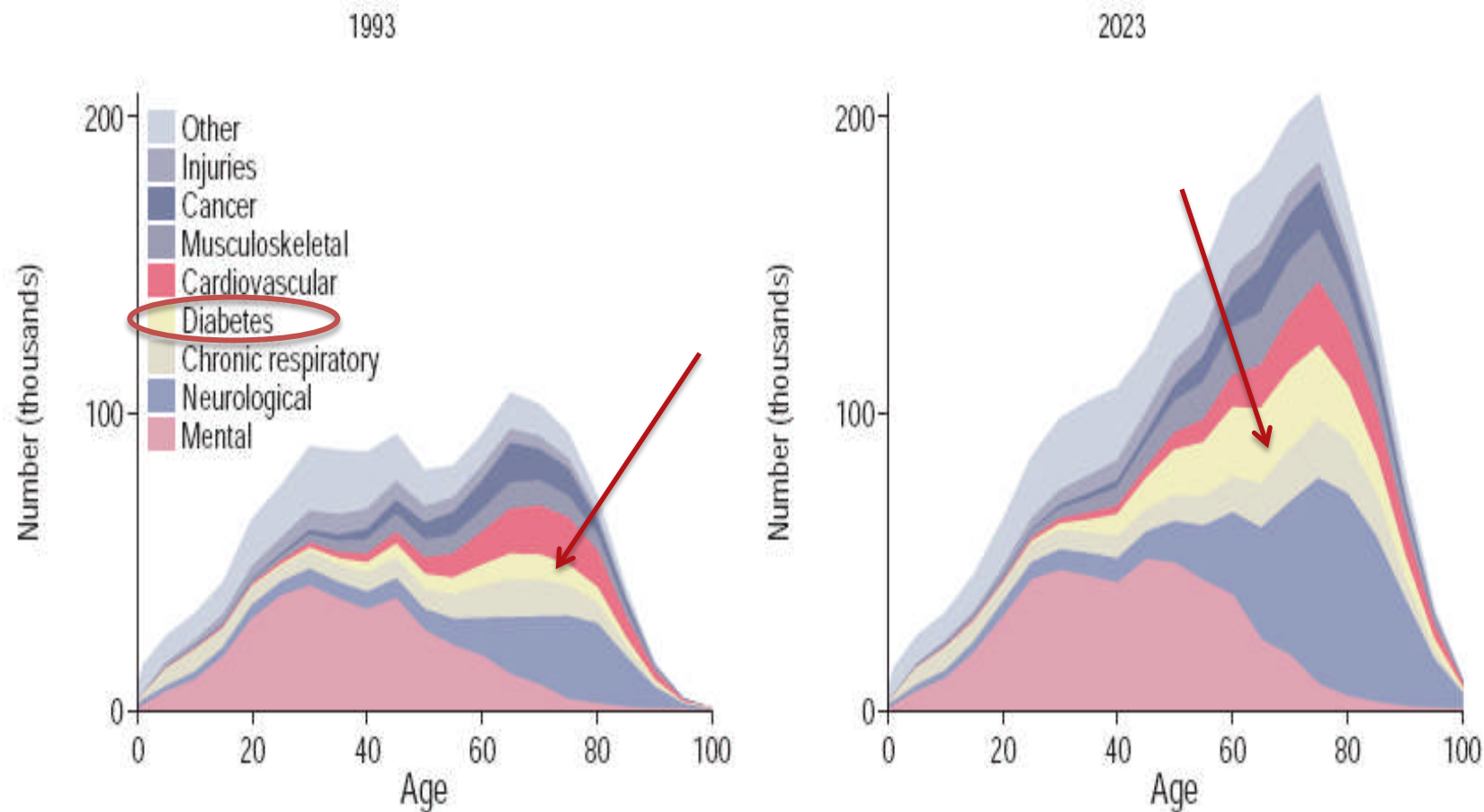
# Workers compensation performance has flat-lined over the past decade





# Age-related trends are changing:

Prevalence of disability (PYLD) due to selected broad cause groups for both sexes combined by age, Australia, 1993 and 2023





# The time has come to put the H back in OHS

**O H S**

# We have always neglected disease in compensation

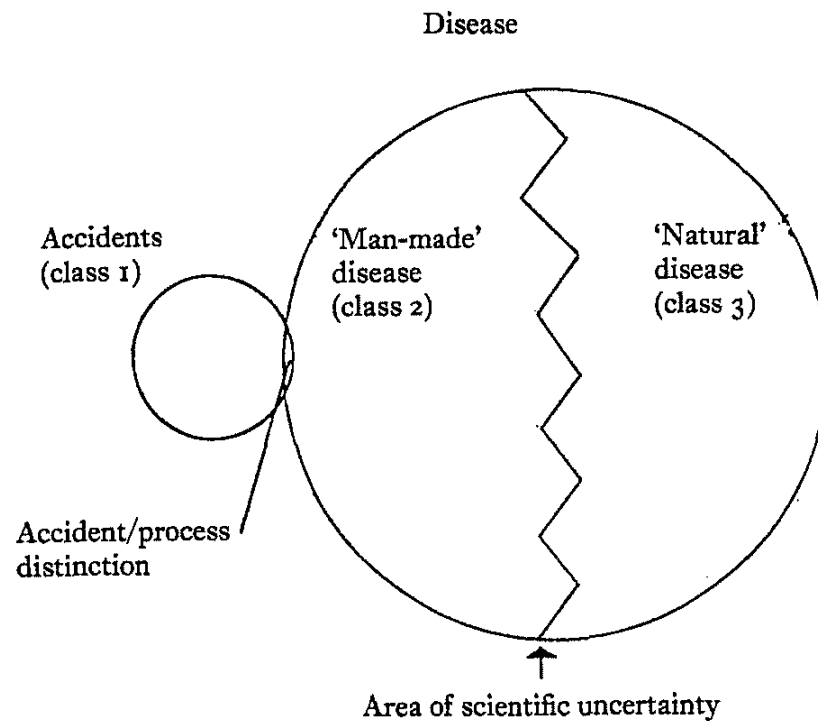
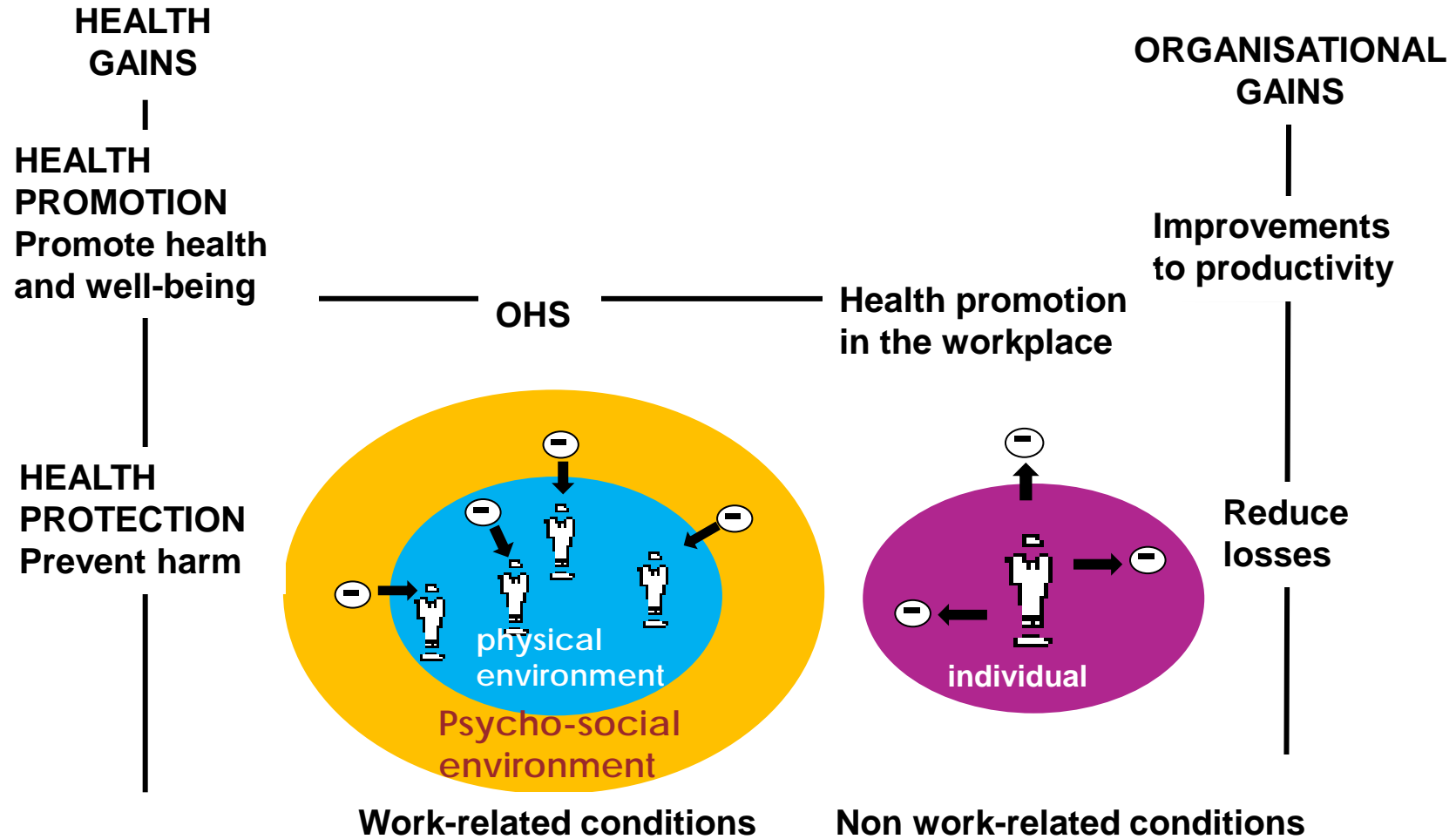


Figure 1. Classes of disablement.

Source: Jane Stapleton, *Compensating Victims of Disease*, *Oxford Journal of Legal Studies*, 1985



# Traditional OHS: Injury prevention





# Futures studies rationale



*...most decision makers at all levels simply want information that can justify their pre-understandings of past, present and future....*

*Sohail Inayatullah, 1990*



## Medical ethnologists divide causation theories into:

- ‘Ordinary activities gone wrong’  
OR
- ‘Harm wreaked by a human or superhuman agency’

‘Early beliefs ascribed special prominence to social or supernatural causes; illness was thus *injury*, and was linked to aggression’

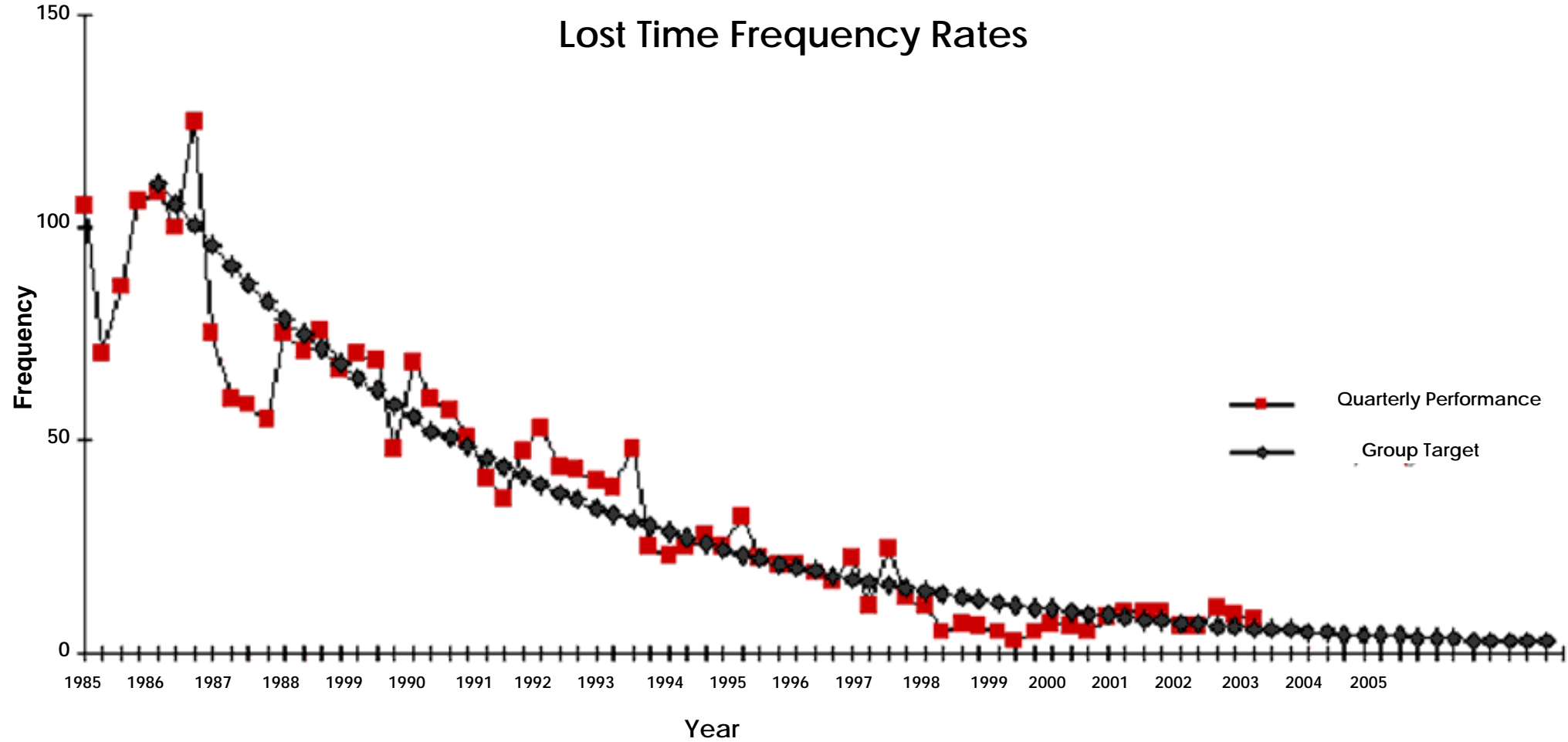
Roy Porter, *The Greatest Benefit to Mankind*, 1997, p 302





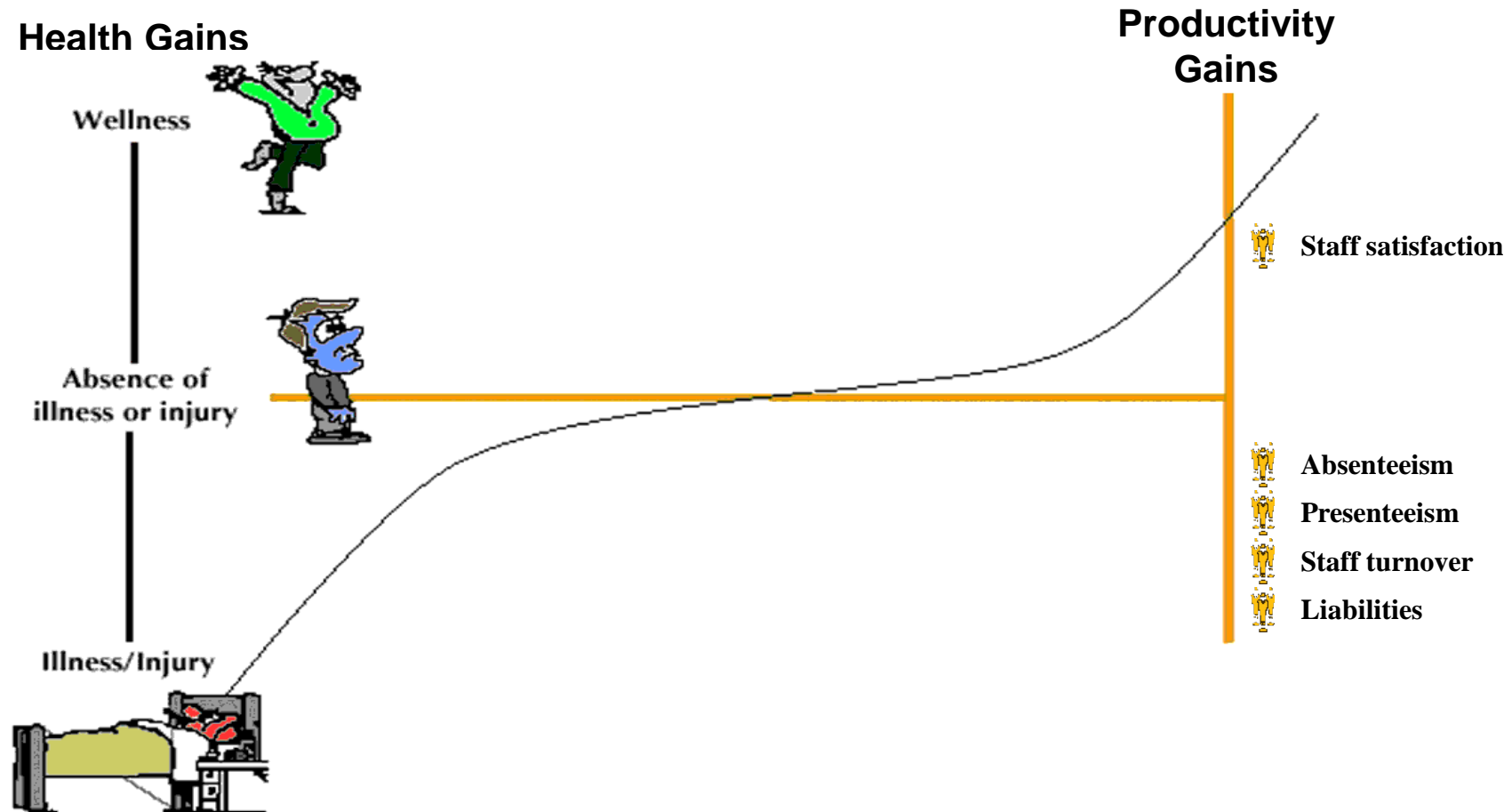
# Theiss Australia

## Lost Time Frequency Rates



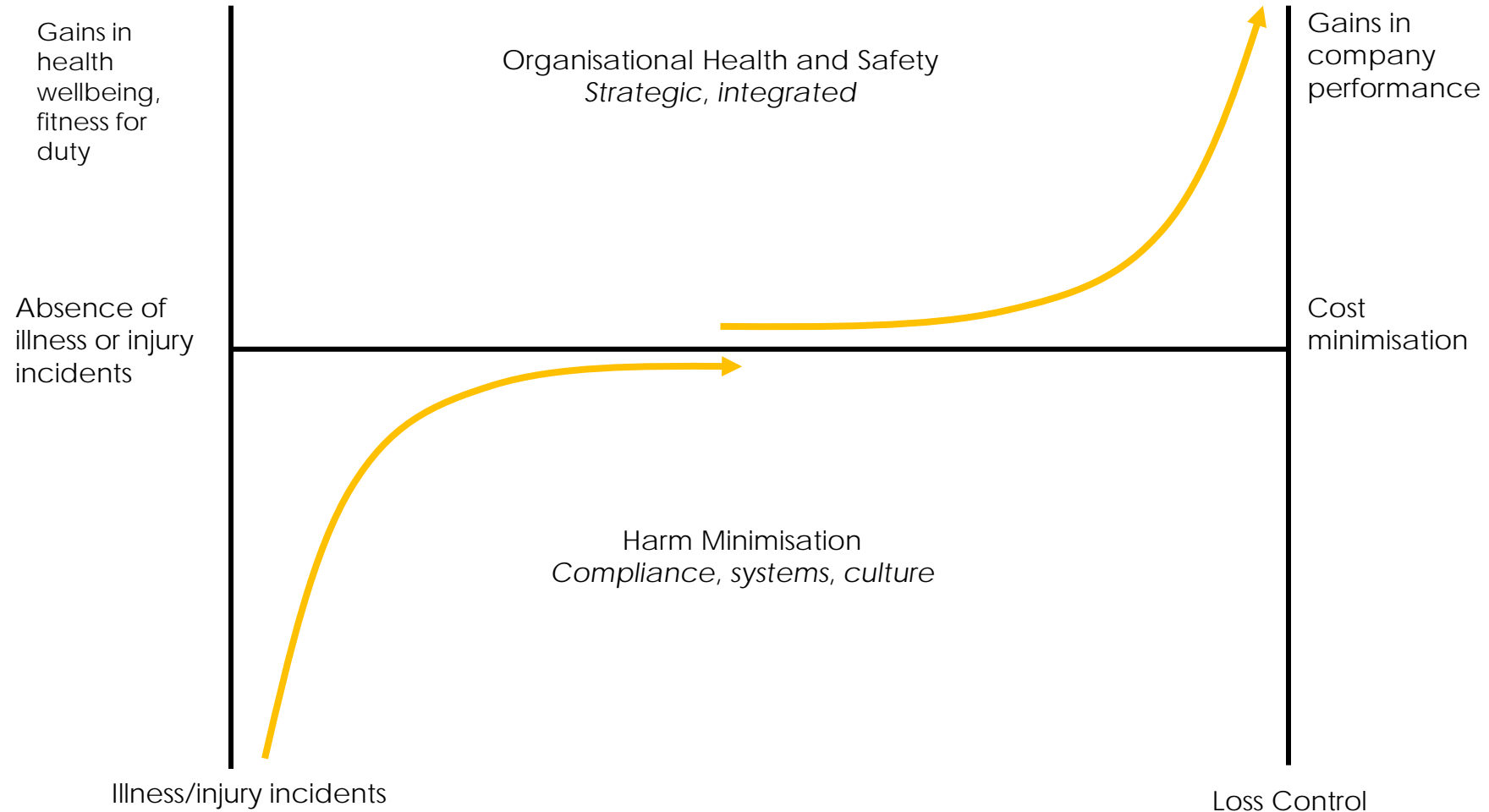


# Potential Shape of Gains from Organisational Health and Safety





## Occupational Health in the 21<sup>st</sup> century.... An expanded value chain goes beyond absence of injury





# Worker obesity shown to increase risk of workplace injuries

- Musculoskeletal disorders
- Heat stress
- Transport accidents
- Vibration-induced injuries



Source: AIHW, 2012



# Obesity and workplace injury risk - AIHW

- Obese injured patients have a significantly longer average length of stay in hospital
- Obese injured patients are more likely to suffer complications of care in hospital following injury
- PPE may be less likely to be worn by/less suitable for obese workers



Source: AIHW, 2012



# Health co-morbidities associated with...

Increased risk  
of injury

Prolonged  
hospitalisation  
& rehab

Higher  
treatment  
costs

Increased time off  
work due to  
treatment & rehab  
complications

Higher risk of  
becoming  
permanently  
unable to work

Co-morbidities include: asthma, chronic obstructive pulmonary disease, ischaemic heart disease, heart failure, diabetes mellitus, mental health condition (depression, bipolar, anxiety, schizophrenia), cancer diagnosis (lung, breast, colon, cervix, prostate), osteoarthritis

*Source: Gribben & Wren, 2012*



## Presence of 1/ + health co-morbidities showed...

28% more claims

346% higher lump sum  
payments

59% higher medical  
treatment costs

39% more weekly  
compensation costs

Overall 59% more total  
ACC costs across all cost  
categories

10.7% of total ACC  
expenditure per annum  
directly attributed to the  
presence of the most  
common co-morbidities  
(\$276m NZD 2011)

*Source: Gribben & Wren, 2012*



# Impact of injury type, hospitalisations and pre-existing chronic conditions on age differences in absence from work following a work injury in British Columbia

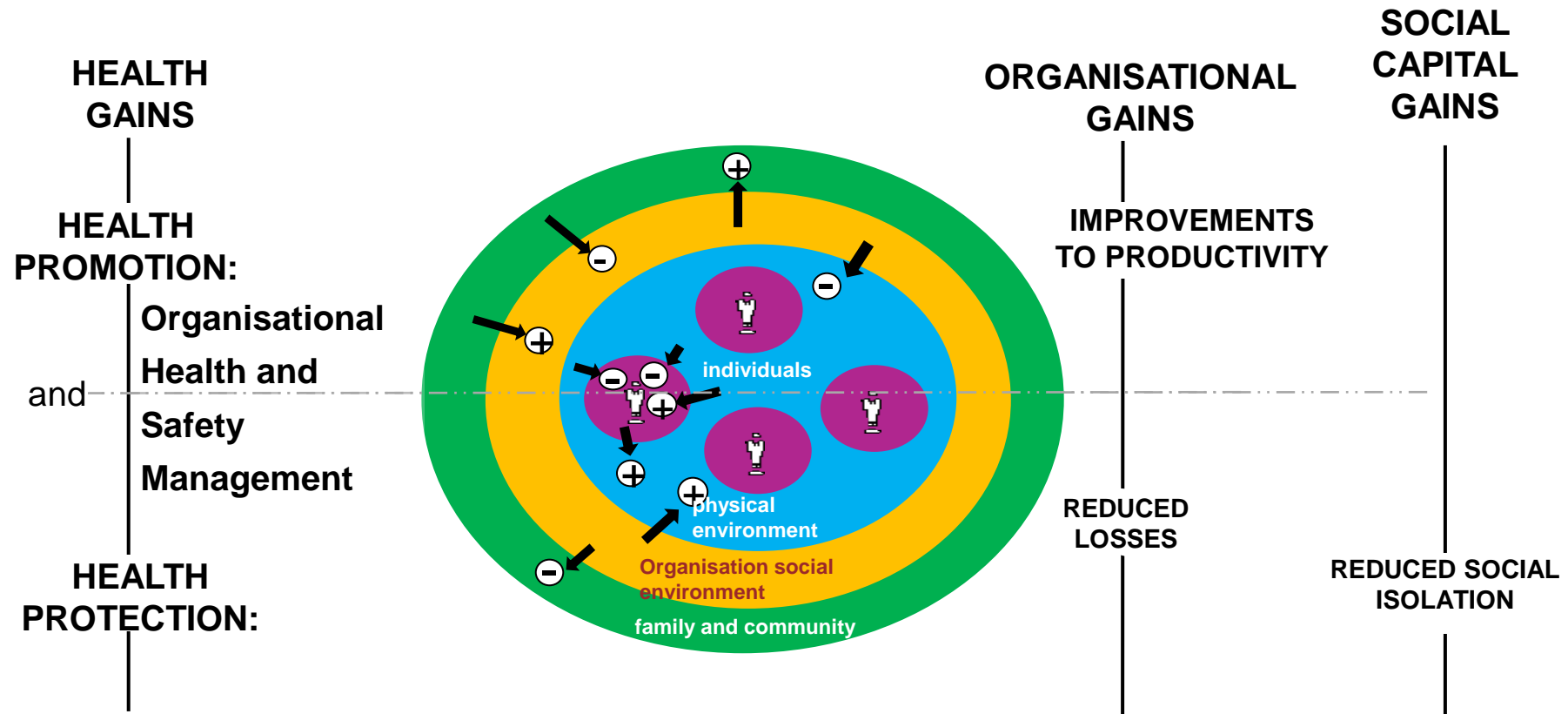
- Chronic conditions, in particular osteoarthritis (OA) and diabetes are associated with an increased risk of work-related injury and greater health care expenditures and days of absence following a work-related injury
- However type of injury and age important relationship
- Mechanism for relationship between chronic conditions and injury not known

*Source: Smith et al, 2013*



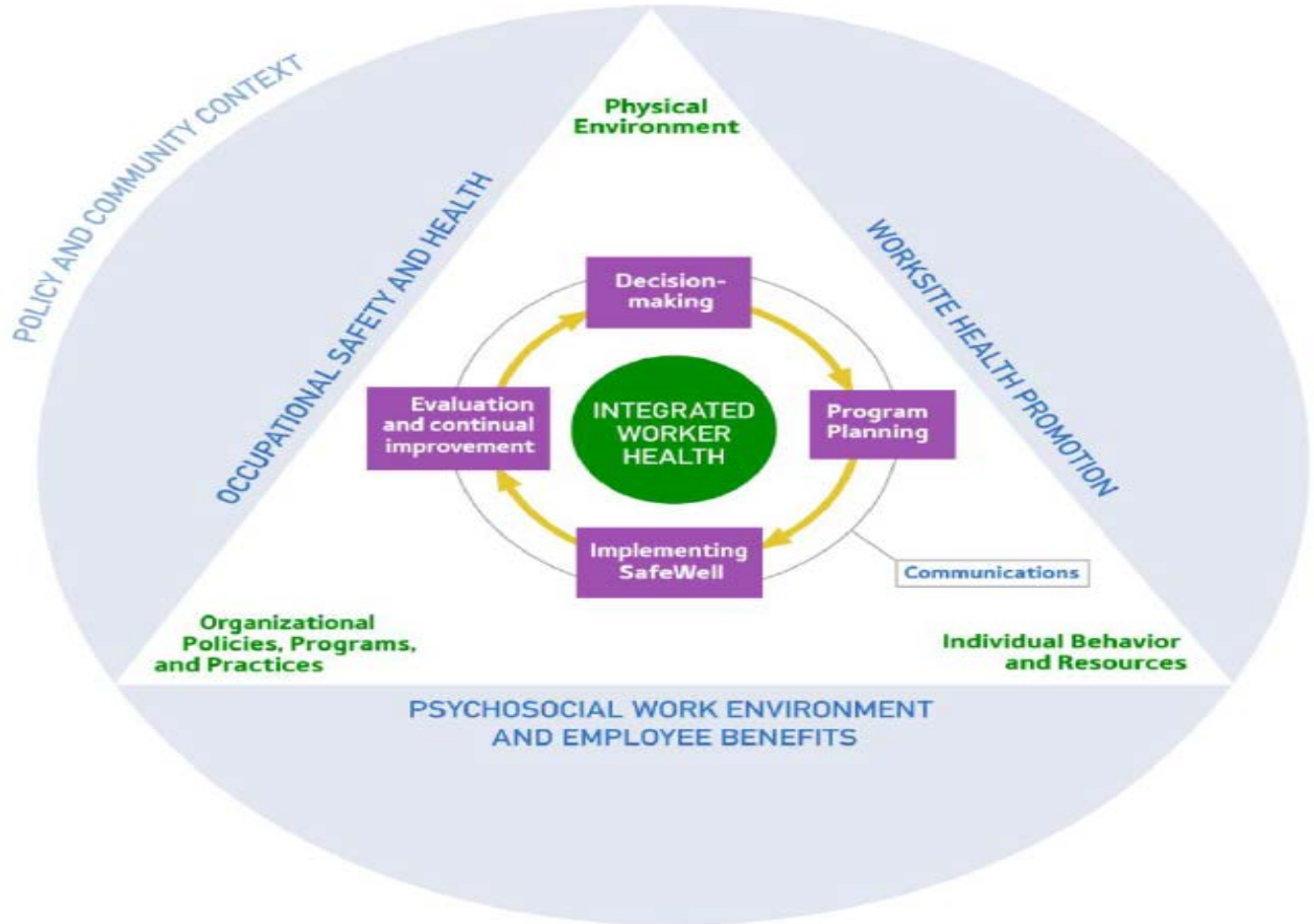


# Integrated approach to OHS





# Integrated Management System for Worker Health






*SafeWell, 2012*







# Case study – WellWorks

## Control group (HP)

-  **Smoke free policies**
-  **Healthful eating policies**
-  **Health education programs**

## Intervention group (OHS/HP)

-  **Smoke free policies**
-  **Healthful eating policies**
-  **Health education programs**
-  ***Occupational risk identification, assessment and control led by industrial hygienist***



## Case study – WellWorks

Possible reasons for greater effect of OHS/HP combined:

- 1 Perception that OHS risks greater threat to health
- 2 Awareness of OHS risks may raise sense of vulnerability
- 3 Addressing OHS risks may give program credibility
- 4 Workers see HP programs alone as futile, but if OHS risks addressed more likely to do their bit too
- 5 OHS interventions require more management engagement – management concern may mitigate fatalism
- 6 Management engagement on OHS may aid HP



# WorkHealth program evaluation

- Modelling using a combination of research data collected and findings available in published literature:
  1. Absenteeism: ↓11% over first two years following WHC, ↓15% for those participating between Jan 1 2012 and June 30 2012 as participation in WorkHealth Coach and Life! Taking action on Diabetes has increased
  2. **Compensable workplace injury/illness: ↓3% for all WHC participants, ↓5% for those participating between Jan 1 2012 and June 30 2012**
  3. Presenteeism: ↓3% for all WHC participants, ↓5% for those participating between Jan 1 2012 and June 30 2012

**Impact highly dependent on participation in health promotion programs**



# Recent evidence review of integrated approaches by ISCRR (unpublished, Oldenburg et al, Nov 2013)

- Consistent support of effectiveness from high-quality studies:
  - Smoking reduction
  - MSDs prevention, reduction and management
  - Stress & mental health
  - ROI
  - Access “hard to reach” populations
- Moderate support for the following:
  - Improving psychosocial job qualities (demand, control etc)
  - Diet, physical activity
  - Organisational “health climate”
  - Mortality



“ A growing body of science supports the effectiveness of combining efforts through workplace interventions that integrate health protection and health promotion programs ”





# Industry Commission Inquiry into Workers' Compensation in Australia, 1994

Work-related injury and illness:

- appropriate for firms to bear costs and pass on
- provides an incentive for prevention by firms

It is not appropriate for firms to bear the costs of consequences of risks over which they have no control, eg journeys to and from work





## Jane Stapleton, 30 years on .....

“Where the initiation of the disease is dose-related and there have been consecutive exposures to an agent or agents that cause the disease one innocent and one tortious ....(because) where the innocent exposure came first, there may be an issue as to whether this was sufficient to trigger the disease or whether the subsequent, tortious exposure contributed to the cause”

*Source: Lord Phillips, cited by Jane Stapleton, 2012*





# Conclusions

1. Compensation systems are designed for traumatic injuries, and have always tolerated a neglect of illness and disease
2. Chronic illness is rising in the working age population and there is growing evidence it is having a negative impact on the incidence, duration and cost of workers compensation claims
3. This effect operates at several points: contribute to increase risk of work injury/illness, recognition of new work-related illness, contribute to delayed recovery and increased medical costs. The mechanism is poorly understood
4. Traditional approaches are not effective for multifactorial conditions (work and non-work related risks) where responsibilities are shared by employers and workers
5. There is good evidence to support the efficaciousness of integrated worker health interventions at the level of workplaces
6. What is not known, is how best to implement them at system level, and what is an appropriate, efficient and effective role for OHS regulators/workers compensation schemes



Alison Wallace, WorkHealth, did the research on health outcome studies for me



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