

Not Quite a Win–Win: The Corporate Agenda of the Stay at Work/Return to Work Project

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Abstract

The idea that efforts are necessary to transform the dominant framework of workplace safety and health in the United States, from one of compensation and disability to one of stay at work/return to work (SAW/RTW) for workers injured or made ill on the job, has become increasingly widespread. SAW/RTW advocates argue that everyone “wins” when unnecessary disability is reduced. Toward this end, advocates have put forward a program and implemented a strategy with strong proponents among a coalition of corporate-connected professionals. The seemingly obvious conclusions of their arguments bear closer critical scrutiny, however. Addressing key questions—why injured workers do not SAW/RTW, who the coalition of SAW/RTW proponents includes, and what the coalition proposes—reveals that the SAW/RTW approach mainly benefits employers and the corporate-connected advocates. These assertions are detailed, and principles of an alternative approach that will serve the needs of injured workers are outlined.

Keywords

return to work, work-related disability, workers’ compensation reform, vocational rehabilitation

Introduction

There is an effort afoot with an avowed aim to end, or at least greatly reduce, “unnecessary disability” among workers injured or made ill on the job.

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By “unnecessary disability,” the movement’s proponents are referring to injured workers who can work, but are not working. In their view, this group constitutes the vast majority of disabled workers. Everyone suffers in this state of affairs as injured workers must access benefits paid for by employers, insurance carriers, and taxpayers, and businesses lose productive workers. The goal of the developing movement is to find ways to get injured workers to stay at work or return to work (SAW/RTW).^{1,2}

From an injured worker’s point of view, working is clearly preferable to not working, assuming the work is not going to worsen his/her health condition. Injured workers suffer greatly when they are forced to leave their jobs due to injury or illness. Major and sometimes devastating financial impacts are typical, with long-term consequences for injured workers and the families and others who depend upon them. There is typically an emotional price to pay as well. Work is powerfully tied to one’s core identity, and when it is lost, an injured worker loses a large piece of him/herself. An injury or illness can wipe out years of hard work, training, and experience. Pride in one’s achievement, self-sufficiency, and ability to support a family can be transformed into dependency in an instant by an injury. Depression, anxiety, frustration, and anger often follow as a matter of course.³⁻⁵ An SAW/RTW movement, then, should be something everyone—employers, insurance carriers, policy makers, and injured workers—can celebrate. Before jumping to this conclusion, though, a few questions require exploration:

1. Why do not injured workers SAW/RTW?
2. What is the composition and nature of the people and groups advocating for SAW/RTW?
3. What are the proposals the SAW/RTW movement is putting forward, and how are they affecting—and how will they affect—injured workers?
4. Are there alternatives to the SAW/RTW approach that will better serve the interests of injured workers?

As these questions imply, I will contend that a healthy dose of skepticism is necessary before accepting the claims of SAW/RTW advocates at face value. A closer look at who SAW/RTW proponents are and what specifically they are advocating reveals an agenda much more likely to benefit corporate interests than injured workers. Injured workers and their advocates should take note, however, that the SAW/RTW movement has developed considerable momentum in the United States and the United Kingdom with potentially far-reaching impact. Analysis and response are necessary to reshape debate and policy in ways that truly benefit injured workers.

Why Do Not Injured Workers SAW/RTW?

There is little argument about two fundamental assertions of the SAW/RTW movement:

1. The burden of disability in developed countries is tremendous.
2. Much of the disability burden is unnecessary in the sense that most disabled people are physically capable of some type of work.

One widely quoted estimate is that 20.5 percent of adults aged fifty-one to sixty-one years in the United States “have a health problem that limits the amount or kind of work they can do,” and 36.3 percent of these individuals believe that work caused their disability.⁶

The idea of “unnecessary” disability has long been emphasized by advocates for the disabled, including the disabled themselves. Despite their physical or mental limitations, people maintain capacities for work. The problem is, from this perspective, that the world of work is not organized to accept or accommodate people with limitations. The Americans with Disabilities Act, passed in 1990, is an example of policy that accepted the premise that many disabled workers could work if appropriate workplace changes were made. The remedy sought under the law was to compel employers to make significant efforts to change workplace conditions to accommodate disabled workers, instead of just automatically excluding them from work.

For those in the disability rights movement, the main reasons that individuals fail to SAW/RTW are economic, political, and social. Employers are primarily interested in maximum productivity, which is necessary for maximum profitability. In their view, workers without limitations are most likely to help them reach their goals. Limitations, whether physical or mental, pose a risk of decreasing productivity. Disability rights advocates have contested this perspective by arguing that workplace accommodations would allow many disabled people not only to work but also to work productively.⁷

SAW/RTW advocates agree that employers share some responsibility for the failure to get many disabled individuals back to work. They extend their analysis, however, to include other causes. Physicians who treat injured workers are one group whose behavior has been closely scrutinized by SAW/RTW advocates. According to these advocates, treating physicians suffer from a lack of training which makes them unable to accurately assess disability. In addition, they argue that the role of the treating physician creates an inherent conflict of interest. As treating physicians, they are advocates for their patients and have an interest in maintaining good relations with their patients. As a consequence, they are apt to just go along with what the patient wants or says, rather than detaching themselves sufficiently to try to more accurately determine independently a

patient's disability level and workplace needs. In addition, physicians are paid to be productive, meaning there is a time pressure for doctors to see as many patients in as short a time period as possible. Disability assessment takes time and is not commensurately reimbursed, giving physicians an incentive to either avoid performing assessments or to do them as quickly as possible without too much thought.^{8,9}

Another area of concern for SAW/RTW advocates is the inefficient way that disability issues are handled administratively. Citing research that shows that the longer injured workers are out of work, the higher the likelihood that they will never go back, SAW/RTW advocates have identified delays in the ways disability claims are handled as a key issue to be addressed.¹⁰ If these delays can be shortened or eliminated, then a significant portion of disability could also be eliminated. The culprits in this process include physicians, employers, injured workers, and insurers. In addition, lawyers appear in this analysis as adding nothing other than an adversarial presence that gets in the way of effective communication, thus prolonging the process.¹¹

It is the physician's job to determine whether the worker/patient's capacities match the functional demands of the job. In order to answer this question, the physician must have an accurate assessment of the job demands. One aspect of the communication breakdown, as SAW/RTW advocates see it, is that physicians are not routinely in contact with employers, who are the source of an accurate job/exposure assessment. Without the employer's input, the doctor relies upon the patient, and whatever ideas the physician has developed on his/her own.¹¹

Perhaps the major impediment, in the eyes of SAW/RTW advocates, to an injured worker staying at or returning to work is the injured worker him/herself. Inordinate fear is seen as a common problem, as injured workers are overly worried about reinjury. Other issues impeding return to work include negative feelings toward the employer or a specific supervisor, and dislike of the job itself. The injured worker may see the employer/supervisor as uncaring and interested primarily in the bottom line of productivity. In that situation, an injured worker may feel that if he/she takes a risk to stay at or return to work, there will be no effort on the employer's part to try to prevent reinjury. In addition, the injured worker may feel the employer will not honor work restrictions and will force the worker to do things that will put him/her at risk of reinjury. Alternatively, workers may be depressed by an injury, decreasing their motivation and ability to make the necessary effort to recover and return to work.¹²⁻¹⁵

"Bad faith" is another problem identified by SAW/RTW advocates as impeding workers from staying at or returning to work. Bad faith may be on the part of the injured worker who is motivated to exaggerate the severity or duration of a disability to maximize or prolong benefits. SAW/RTW advocates also recognize potential bad faith among the other participants in the process: the employer who wants to terminate an injured worker, or an insurance carrier that is trying to deny appropriate benefits.¹¹

The major assumption underlying SAW/RTW advocates' approach is that all participants in the injury/disability process have an overriding common interest in keeping an injured worker working or returning an injured worker to his/her job. But is this assumption warranted? To answer this question requires more attention to the political economic context.

Over the last thirty-five years, working people in the United States and internationally have faced a sustained attack. To maintain profitability, the corporate class has relentlessly sought policy and workplace changes that would allow them to capture more of the surplus produced. In general, this has included efforts to decrease corporate taxes, eliminate regulations on business, increase the mobility of capital, and remove unions and any other sources of working-class power.^{16,17} The latest crisis has greatly exacerbated these long-term trends, and the past few years have seen struggles nationally and in many states over imposed austerity measures, and efforts to break the power of public-sector unions in addition to the pursuit of their other goals.¹⁸

This context has significant implications for workers' health. The relentless search for profit maximization in a recession and anemic recovery has exacerbated corner-cutting to reduce costs, the squeezing of maximum productivity out of workers, and the socialization of the costs of workplace-related illnesses and injuries.^{19,20} As workers are driven harder to produce in workplaces made more dangerous by cost-cutting measures, increased risk and incidence of injuries and illnesses are inevitable. With unemployment high and plenty of workers waiting for a job opportunity, workers are less likely to resist toughened and even dangerous working conditions. With employers strenuously resisting any effort to make them shoulder more of the economic burden of occupational injuries and illness, and little political power in opposition, the socialization of costs accelerates.¹⁷⁻²³ For example, workers' compensation is a major arena for struggle over the costs of occupational injury and illness. The reform efforts that have swept through workers' compensation systems in many states over the last twenty years can be read as employer-based campaigns to increase the socialization of costs.^{24,25}

In this context, the prospects for successful SAW/RTW for injured workers become even more dismal. An injury to a worker that reduces his/her work capacities also reduces productivity. That is a problem for the employer. To maintain productivity, the employer may have other employees, or temporary workers, fill in for the injured worker. If the worker's injury is not severe and he/she returns to work at full capacity in a relatively short period of time, the employer's problem is minimized. However, if the worker's injury is more serious, necessitating a longer period out of work, or a long-term or permanent reduction in ability to work, the employer is confronted with a more serious dilemma. He/she could elect to accommodate the injured worker with lighter duty or changes in the job that would allow for return. Alternatively, the

employer could say it is too much hassle and expense to keep the injured worker around—better to just hire a fully able-bodied replacement.²⁶

What would keep employers from using this strategy of simply replacing injured workers? The main incentive is expense. However, a large share of the costs of workplace injuries and illnesses is borne by injured workers themselves, their families, and taxpayers rather than employers.^{27,28} The expense for employers comes in the form of workers' compensation premiums and the costs of hiring and training replacement workers. Workers' compensation has not proven to be an effective tool in imposing significant enough costs on employers to alter their behavior toward preventing workplace injuries and illnesses or toward injured workers.^{29–33} The costs of replacing injured workers will vary depending on the skill and experience that a given job requires. But many employers treat workers as interchangeable parts of the production process. When one wears out, it is easiest to just replace him/her with another.

Instead of focusing on the prevention of occupational injuries and disease through workplace changes and controls, insurance carriers have chosen to unite with employers in a sustained campaign to limit liability even further through workers' compensation reform. Over the last twenty years, states across the country have enacted workers' compensation reform laws at the behest of business and the insurance industry, who have complained over costs. They have limited the types of conditions deemed to be work-related, forced workers into managed medical care networks selected by their employers, and severely limited the length of time injured workers who are “permanently” but partially disabled can collect benefits.^{25,34–37}

These and other measures encourage employers and insurers to fight workers' compensation claims. The dynamic of the workers' compensation process discourages injured workers from staying at or returning to work. As the employer and insurer expend their energy fighting the claim, they offer the injured worker one option: admit the claim and/or the disability they are claiming is bogus or exaggerated and get back to work. Faced with this adversarial stance, the injured worker feels his/her integrity being attacked and will respond by expending his/her energy proving his/her condition is serious and real. Injured workers also often feel that their employer did not care enough about the workers' health and safety to take the necessary precautions, and now, once a worker is injured, has the gall to call the worker's credibility into question instead of accepting responsibility. This dynamic is the opposite of the cooperation necessary to facilitate return to work.^{26,37–41}

Injured workers who cannot return to work at the firm where they were injured face additional obstacles to successfully gaining employment with other businesses. They typically report being treated by prospective employers as “damaged goods”—either not capable of being fully productive at the job or carrying a risk of reinjury and liability for the company. Injured workers face the bind of revealing their injuries and limitations to the employer, which routinely

results in a job denial, or hiding their limitations, exposing them to reinjury and possible legal difficulties.⁴²

My discussions with injured workers suggest that the overwhelming majority want to stay at work or find new jobs, but they want those jobs to be safe. If they return to work under conditions that are unchanged or similar to those under which they were injured in the first place, it is reasonable, contrary to the assertions of SAW/RTW proponents, to think that there is an increased risk of those same conditions causing a reinjury or aggravating an already existing condition. In the current context, there is even less reason to believe employers will spend the money to improve conditions and reduce exposures, making workers' fears even more rational.

Of course, returning to or staying at work requires that there are jobs to return to or stay at. With the developed world struggling to recover from the worst downturn since the Great Depression, unemployment and underemployment are high, making competition for jobs tough and allowing employers to pick and choose from a large applicant pool. In this situation, the disadvantage already conferred by an injury to a worker looking for a job is amplified.⁴³

To summarize, injured workers face serious barriers to staying at or returning to work. SAW/RTW advocates do not exactly ignore the social nature of the major barriers, but they emphasize the personal and behavioral characteristics of individual injured workers and their physicians and see changes in behavior as the key to positive change. This may stem partially from a pragmatic approach that leads to the conclusion that these are the things that are most amenable to change. However, an unspoken but implied worldview is probably more basic to their approach. Jennifer Christian, a leader in the SAW/RTW movement, puts her fundamental belief this way: "Even in a bad economy, there are opportunities and people with spunk can find them."⁴⁴ In this worldview, the burden of returning to or staying at work after an injury or illness is clearly the responsibility of the worker.

A Grassroots Movement?

Who exactly are SAW/RTW proponents? For the most part, they are professionals from a variety of fields involved with one or more facets of disability assessment, treatment, or policy. For the most part, they provide their services to employers as consultants, direct service providers, or corporate employees. Occupational groups involved include those providing health care (physicians, nurses, psychologists, physical therapists), vocational rehabilitation services, human resources, loss prevention and other administrative functions, and disability insurance companies.

These groups have coalesced into a larger group that seeks to marshal its collective strength to work effectively toward common goals. Toward that end, its activities have encompassed a multilevel strategy. Proponents have

constructed a common agenda through various forums such as conferences and Web-based discussion groups. They have attempted to legitimate their agenda through publications in peer-reviewed journals and through the various professional organizations that represent the spectrum of professions participating in the coalition. For example, in the United States, the American College of Occupational and Environmental Medicine (ACOEM), the official professional organization representing occupational medicine specialists, has played a major role in developing an SAW/RTW agenda and action plan. SAW/RTW ideas have also penetrated medical specialties beyond occupational medicine with, for example, supportive articles in the *Journal of the American Medical Association*, and a policy statement from the *American Academy of Family Physicians*.^{11,45-47}

Armed with the policy statements of the professional societies and peer-reviewed research, individual physicians can pursue SAW/RTW strategies, and consultants and corporate employees can convince their employers of the virtues of corporate policies that promote SAW/RTW. Change at the level both of the individual health-care practitioner and of the company is one major goal of SAW/RTW proponents.

However, the proponents' agenda is more ambitious than change on the individual or company level. They recognize the need for policy change and have sought to pursue this goal on a state level across the country. One vehicle they have developed toward this end is the 60 Summits group.⁴⁸ The group includes some of the physicians who play a role in ACOEM but has a broader inter-professional composition including all of the groups described earlier. The intent of 60 Summits is to bring the SAW/RTW discussion to every state via a kickoff conference followed by the development of committees that will implement an action plan meant to impact policy and practice in the state.

Groups like 60 Summits and The Work Fitness and Disability listserv bring together a multidisciplinary group to share information and resolve issues ranging from individual cases to broad policy initiatives. They provide support for individuals seeking to put the SAW/RTW agenda into practice.

Proponents of SAW/RTW have been dubbed by observers a "grassroots" group, suggesting that participants are professionals involved in disability matters, who may be consultants to employers and insurers, or may be employed by a business or insurer, but are not speaking as official representatives of those businesses. In fact, SAW/RTW talk is rife with the need to convince insurers and employers of the justness of their cause. Independence, expertise, and objectivity are common themes invoked by SAW/RTW proponents when describing themselves.^{49,50}

It is also of interest to note who the SAW/RTW coalition does *not* include. Injured workers, who can be expected to have a major interest in this issue, appear in SAW/RTW discussions as the objects of attention rather than as subjects with their own voices and legitimate opinions. From the SAW/RTW viewpoint, the "good" injured worker has the "gumption" described earlier by

Jennifer Christian. He/she is willing to listen to the “reason” of the expert professionals and has the energy and initiative to actively follow their advice. Conversely, the “bad” injured worker persists in lamenting his/her fate as a victim and refuses to engage with the SAW/RTW process. Worse is the worker who seeks help from an attorney or union, as this is unnecessarily adversarial. And worst of all are those workers who are actively, and falsely, seeking disability status to shirk work while still getting paid. From the SAW/RTW perspective, injured workers are to be “managed,” either collaboratively or confrontationally, depending on the attitude of the injured worker.⁵¹⁻⁵⁵

As might be expected from the preceding, unions and attorneys are also not usually counted among SAW/RTW advocates. They are seen by SAW/RTW proponents as impediments to direct communication among expert/professional, injured worker, and employer/insurer. According to this perspective, unions and attorneys often have agendas that are inimical to getting injured workers back to work. Lawyers are characterized as having a financial interest in maximizing and prolonging disability, as this will bring in the most benefits to the injured worker and fees to the attorney. Like most employers, SAW/RTW advocates view unions as unnecessary. In their view, employers and professionals are capable of judging injured workers’ needs and the benefits to which they may be entitled. Union representation simply introduces a mediator insisting on rules and processes that stand in the way of rapid and just resolution of issues. Unions are interested only in perpetuating their own power, and their defense of union members reflects that interest rather than a necessary defense of members’ rights.⁴⁸

Treating physicians play a major role in SAW/RTW advocates’ discussions but are not well represented in coalition activities. As noted earlier, treating physicians are objects of criticism for their patient advocacy. In this disability arena, advocacy is defined as being willing to take and keep injured workers out of work unnecessarily. This is because the treating physician is only getting, or taking into account, one side of the story: that of the injured worker.

While it is true that top corporate managers are not visible as public proponents of the SAW/RTW agenda, calling SAW/RTW advocates a “grassroots movement” is a mischaracterization. Given the makeup of the group, a more accurate description would be a corporate-connected technocratic or professionally driven coalition.

The overriding goal of SAW/RTW advocates is to carve out a niche, based upon recognition of themselves as the exclusive possessors of the expertise and objectivity necessary to effectively design and implement SAW/RTW policies and programs. Participants for the most part either work directly for companies or insurers or depend upon them through contracts. This financial dependency seriously compromises any claim to independence and objectivity, as another crucial goal inevitably becomes the protection of their corporate relationships.^{56,57}

With these goals, SAW/RTW advocates at best propose and pursue policies and programs that tinker with the edges of the disability problem while remaining relatively uncritical of the corporate interests and dynamics that create and sustain the major reasons injured workers have such a hard time returning to or staying at work. At worst, advocates are merely carrying out a corporate agenda under a guise of expert or scientific neutrality.

Solutions Proposed by SAW/RTW Advocates

As would be expected, the solutions proposed by SAW/RTW advocates flow from their analysis of the problem and the composition of the individuals and organizations involved. Solutions involve both a theory (what needs to be done) and a practice (how to accomplish defined goals).

SAW/RTW theory is reflected in the United States in the document authored by the ACOEM entitled “Preventing Needless Work Disability by Helping People Stay Employed” and in the United Kingdom by a report commissioned by the British government and authored by Dame Carol Black (a rheumatologist) entitled “Working for a Healthier Tomorrow”. These documents provide a framework that SAW/RTW proponents seek to put into practice.^{11,58}

Much of the focus in the documents is on the treating physician. According to SAW/RTW proponents, treating physicians need training to:

- convince them of the need to get injured workers back to work; and
- educate them on the proper methods to accurately assess work capacity.^{48,59}

In addition to training, physicians need routine and easy ways to communicate with employers and insurers. Communication is necessary for physicians to understand the working conditions of their patients, as well as the opportunities that exist for injured workers to stay at or return to work. In addition, insurers need communication from the physician to understand what diagnostic testing and treatment options should be pursued. Employers need to know what the injured worker’s work capacities are, so that they can offer appropriate work.⁶⁰

Ensuring a rapid response is a major preoccupation of SAW/RTW proponents, and their proposals emphasize the development of communication channels that activate immediately following the diagnosis of a work-related injury or illness. Improved communication is seen as critical to facilitating a rapid response.

SAW/RTW proponents also advocate a reduced role for treating physicians in the disability process, by limiting them to determining work capacity (as opposed to work limitations) and barring them from participation in employment decisions. The employer would receive a note from the physician stating what the injured worker is capable of doing, and the employer would then be responsible for determining what jobs are appropriate or what job modifications

could be made. SAW/RTW advocates see this as a way of “freeing” the physician from the constraints of being a patient advocate, as the physician can tell patients that he/she is only supplying objective information to the employer. Job placement and benefits decisions are consequently the responsibility of the employer, and any problems that arise should be taken up with him/her.¹¹

Injured workers also receive a significant amount of attention in ACOEM’s and Dame Black’s recommendations. Invoking the biopsychosocial model, SAW/RTW advocates emphasize the role of psychological factors in impeding the injured worker’s work abilities. Depression, fear, and anger are among the emotional states exhibited by injured workers that require attention and treatment. In addition, injured workers often need help developing coping mechanisms for chronic pain. SAW/RTW advocates seek to deal with these issues by explicitly identifying them early on in the diagnostic and treatment process and offering treatment that would be covered by insurance.⁶¹

“Bad faith” is another reason injured workers do not return to work, according to SAW/RTW advocates. Some injured workers manufacture or exaggerate their limitations for financial gain or because they are disgruntled in some way. These injured workers should be dealt with “rigorously,” with their behavior quickly and openly identified and benefits denied or cut off.¹¹

Employers and insurers receive very little attention from ACOEM and Dame Black. The possibility of “bad faith behavior” on the part of insurers and employers is briefly acknowledged. The only solution offered is to “identify and deal with unfair employers and insurers” and to make a complaint/ombudsman service available to employers and insurers.¹¹

The “work disability prevention model” put forward by SAW/RTW advocates begins after the injury or illness occurs. Consequently, there is little to no emphasis on eliminating or reducing workplace hazards to prevent injury and illness. Likewise, there is little attention given to the idea that workplace hazards should be eliminated before sending an injured or ill worker back to work under the same conditions that led to the injury or illness.

In summary, the SAW/RTW approach assumes that workplaces are generally safe and present few health risks and that appropriate jobs are widely available. As a consequence, the onus is on the injured worker and the physician to do a better job of keeping an injured worker at work. Toward this end, employers are encouraged to communicate directly with physicians, and insurance carriers are urged to recognize and provide treatment for the psychosocial factors that hold injured workers back from returning to work. Physicians are urged to recognize their worker/patients’ capabilities rather than their restrictions and to share those with employers so that the employer can appropriately place the worker. In doing so, the physician’s relationship with his/her patient is changed. The physician develops a relationship with the employer, who then shares responsibility for decision-making. The worker’s role as object of treatment (as opposed to subject) is heightened, his/her job becoming the passive following

of instructions issued by experts. In the many situations where safe, healthy work is not readily available, or where employers are not eager to make accommodations, following this strategy is a recipe for the denial and/or cutting of benefits for the injured worker.

In practice, the recommendations of SAW/RTW advocates may be put into place through informal or regulatory mechanisms. Through their exhortations, advocates hope to change the behavior of physicians, injured workers, and employers. Though some physician groups like the American Academy of Family Practitioners have begun propounding similar aims, it is difficult to assess how widely these attitudes and practices have penetrated. A glimpse into how these issues might be regulated, however, can be gleaned from policies that have been initiated in some states, including New York and Washington.

In New York, major workers' compensation reform legislation was passed in 2007. One of the central aspects of the reform was a capping of permanent partial disability awards. To aid injured workers with permanent partial disabilities return to work before their benefits ran out, the New York State Department of Labor was instructed to convene a committee that would make recommendations toward that end. The Commissioner of the Department of Labor was assisted by an advisory council consisting of six representatives, each appointed by a different constituency, including labor, business, both houses of the legislature, and the governor.⁶²

The report on the group's deliberations summarized agreements and disagreements. Review of the report reveals an approach similar to that proposed by SAW/RTW advocates. Education of "all participants in the workers' compensation system on the value of return to work" is recommended, with emphasis on employers and physicians. Better communication between the employer, injured worker, and physician should be facilitated by the Workers' Compensation Board. To encourage participation, physicians, attorneys, and employers should be enticed with financial incentives. Doctors would be paid for time spent evaluating return-to-work capabilities, and lawyers would be paid for representing individuals who require only medical care (and not payment for lost wages). These activities are currently not reimbursed. Employers would be offered incentives to hire workers with restrictions, possibly including subsidies for wages, equipment needed for accommodations, vocational assessment, and rehabilitation. The committee also recommended the development and provision of vocational rehabilitation services to injured workers. Injured workers' benefits would not be cut while they were utilizing these services.⁶²

However, the committee was unable to reach agreement on several key issues. Much of the disagreement centered on who would pay for some of the recommendations, including vocational rehabilitation and the education program for employers. In addition, while there was recognition that some injured workers with permanent partial disabilities may not be able to return to work despite all efforts, there was no agreement on funding a safety net for them.

Finally, agreement was not reached on incentives for employers to participate. The common theme in all of the disagreements was employer resistance to paying for any aspect of the proposal and demanding incentives beyond what the labor representatives found reasonable. The ultimate fate of this work is unclear. As of this writing, the recommendations have not been turned into regulations or legislation.⁶²

Washington State has initiated SAW/RTW efforts which bear comparison to New York's effort. Washington relies heavily on employer subsidies to improve SAW/RTW rates. Up to \$10,000 per case is available to compensate the employer while the injured worker is on light duty. Subsidies up to \$5000 per case are available for job modifications that allow accommodations, training during transitional work, vocational assistance, and workers' compensation insurance premium discounts. Washington's Department of Labor and Industries offers extensive assistance to employers beyond subsidies in the form of training, on-site job modification recommendations, and an early-return-to-work team to facilitate the process. Washington has also attempted to upgrade the ways physicians deal with disability and SAW/RTW by giving incentives to doctors treating work-related ailments to meet state-determined standards of care including the use of medical treatment guidelines. In addition, public funds have been used to bolster the capacity and role of six regional specialized occupational health centers. The centers are expected to provide training and expertise to community-based physicians in their region, improving the standard of care, and to provide coordination of care for injured workers requiring services such as vocational rehabilitation and job modifications in order to return to work.^{10,63-66}

Employer participation in Washington's programs is voluntary. The programs are funded via a combination of a portion of insurance carrier premiums and tax revenues. The state has extensively evaluated the medical aspects of the program and shown some reductions in costs and lost workdays for physicians participating in the occupational health program. However, the impacts of efforts to improve SAW/RTW via workplace modifications and vocational rehabilitation have not been formally evaluated, as this aspect of the program is relatively new, having begun in 2011. Discussion with a Washington State Department of Labor and Industries representative revealed a sense that the program has enabled injured workers to return to or stay at work, and optimism that new leadership at the agency will add energy and resources to the program. However, some limitations to the program were noted. It has been very difficult to entice employers into participating, limiting the scope and impact. The role of vocational rehabilitation has been another issue, as in the past, vocational rehabilitation counselors were used primarily for claim adjudication (work capacity, limitations, employability), and physicians have been concerned that sending their patients to vocational rehabilitation would result in benefit cuts rather than a meaningful aid to SAW/RTW.⁶⁷

The experiences in New York and Washington illustrate several key issues. They demonstrate the fundamental role that employers play in the SAW/RTW process. Without employer participation, SAW/RTW efforts will go nowhere. In addition, in contrast to SAW/RTW proponents' claims, substantial subsidies are necessary for employers even to consider participating in SAW/RTW efforts. Many of these subsidies are likely to be taxpayer-financed. To date, Washington State has struggled to persuade employers to participate, despite the lure of subsidies. These experiences conflict with proponents' assertion that SAW/RTW efforts are a win-win for all involved stakeholders. Employers, especially in a difficult economy, are loath to expend financial resources or time on efforts to accommodate injured workers. And finally, experience to date demonstrates a lack of focus on primary and secondary prevention efforts that would control exposures and reduce the incidence of workplace illnesses and injuries. Instead, any action comes only once an injury or illness has already occurred.

In this context, efforts to return injured workers to work, or to keep them at work, are almost certainly going to be ineffective. Physicians can change their communication practices, and workers can be more compliant, but the fact is that if employers are not interested, there will be no accommodations or jobs for injured workers. What is worse is that benefits for injured workers are likely to be cut as they are deemed ready and able to work, but are not able to find jobs.

The experience in New York State and Washington State should not be interpreted as providing evidence of employer/corporate opposition to the SAW/RTW approach overall. They support efforts to get injured workers back to work faster through more efficient or improved medical care and cuts in benefits that effectively coerce workers back to work. What they oppose are measures that would increase responsibilities and costs for themselves, including changes to make the workplace safer, costs associated with accommodating injured workers, and expenses related to vocational retraining for workers who require a change in career path.

Alternative Approaches

In developing an approach to SAW/RTW that offers an alternative to that advocated by professional groups, it is useful to begin by making the underlying assumptions explicit. The principles and strategy of an alternative should flow from the assumptions.

In common with SAW/RTW advocates' approach, an alternative approach begins with the recognition that working is, in general, better than not working and that most workers would rather be working than not. Once beyond this common assumption, the contrasts are stark. In an alternative approach, SAW/RTW issues are embedded in the political and economic context. Specifically, there is an inherent struggle in capitalist societies between business owners and workers over the share of the surplus produced. Over the last thirty-five years

that general inherent tendency has taken the form of a sustained, and largely successful, corporate offensive to weaken labor and claim more of the profits. The globalization of the capitalist system has played a major role in this process. The mobility of capital allows the pitting of worker against worker in a “race to the bottom.” On top of this long-term process, the near collapse of the system in the financial meltdown of 2008 has added a major impetus to efforts to impose austerity on the working class while allowing corporations every opportunity to maximize profits.⁶⁸

In this setting, jobs are hard to find. In addition, employers are under extreme pressure to cut costs, and in the workplace that means cutting corners on safety and health, as well as a resistance to taking on any additional costs. Since much of the expense of occupational diseases and injuries has already been socialized, employers will have no interest in measures that require them to shoulder more of the burden. Instead of looking for ways to accommodate and rehabilitate injured workers, employers will be much more likely to treat them as pieces of machinery: when they get injured or ill, just replace them. In the meantime, they oppose any increase in the provision of benefits to injured workers that requires a contribution from the employer. In this environment, gumption and motivation on the part of the individual injured worker have little chance against a juggernaut.

Given these assumptions, what are the principles of an alternative approach to improving the outlook and results for injured workers staying or returning to work?⁶⁹

1. *Control of hazardous conditions at work should be the primary focus of efforts to return injured workers or keep them at work.* These efforts are critically dependent on the control of workplace hazards and the creation of safer and healthier jobs. In addition, better workplace conditions will reduce the need for SAW/RTW efforts as fewer workers will be injured or made ill at work.
2. *Employers should shoulder the full burden of occupational injuries and illnesses.* It is the responsibility of the employer to maintain a safe and healthy workplace, and it should be the responsibility of the employer to pay for the consequent injuries or illnesses that occur at his/her workplace. The ability of employers to socialize the costs of workplace illnesses and injuries should end, and employers should shoulder the full burden of their responsibility. Toward that end, when a worker gets injured or ill on the job, the employer should be required to maintain the injured worker as an employee, fix the hazard that caused the injury/illness, and accommodate the injured worker. Hopefully, the injured worker could return to his/her original job, but if not, then accommodation in another job would be offered. If it is not possible for the worker to remain with the same employer, then the employer should be responsible for the injured worker’s rehabilitation, including any

necessary retraining. The injured worker's salary and benefits should be maintained at preinjury levels throughout the postinjury process. If the worker must change workplaces due to an inability to accommodate, the employer should be responsible for compensating the worker for any loss of income and/or benefits. This could change the incentives for employers, as it may become cheaper to improve workplace conditions than to compensate injured workers.

3. *Remove all barriers to medical and disability benefits for injured workers.* Benefits for the injured worker should be maintained throughout the recovery process and should continue until successful return to work is accomplished. Benefits should be immediately and fully accessible while causation and benefit determinations are disputed. These benefits should include treatment for mental health sequelae of an occupational injury or illness. Workers should not be penalized for depression, anxiety, or other mental health maladies that play a role in delayed recovery. Benefits should not be cut as the injured worker's condition improves until he/she successfully completes a rehabilitation process and returns to work.
4. *All professionals involved in evaluating and treating injured workers and evaluating workplaces should be independent of employers and insurance carriers.* The financial ties that bind most of the professionals evaluating and giving opinions on injured workers, and workplace hazards need to be severed. Employers should be responsible for paying the costs of medical and workplace evaluations and could do so by a requirement that they all pay into a common fund that is independently administered. Clinicians, industrial hygienists, and vocational rehabilitation specialists would all be paid out of this fund.
5. *Put workers into the process at all levels.* Most importantly, injured workers should be included as subjects playing a central role in every aspect of their recovery and rehabilitation process, the outcome of which will have a profound effect on their lives. In fact, workers in general have a central stake in creating workplace conditions that are safe and healthy and will prevent them from getting sick and injured. Workers also have a central stake in creating policies and programs in the workplace and in the state that will make sure they are adequately taken care of if they become injured or ill on the job.

The specific meaning of injured worker as subject varies depending on the setting. In the medical and disability evaluation process, the worker's voice is expressed in the history given to the clinician. In recent years that history has been devalued as a subjective, biased, and uninformed information source. The search for supposedly objective measures to determine causation and assess disability has been intense, taking the worker's voice right out of the picture. The demand to reinstate that voice in the clinical setting is an important aspect of implementing an alternative agenda.

The workplace and the political arena are the other major spaces where the specifics of worker participation need to be developed. Workers and unions have been on the defensive for a long time and have ceded and/or lost much of their power to employers. To improve workplace conditions and make sure injured workers are treated fairly, workers and unions must be in a position to participate in a wide range of related activities and be powerful enough to influence corporate and political decisions.

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