

Scientist-worker alliance to study work injury

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Research Excellence
Advancing Employee Health

A unique research alliance of injured workers and scientists has received a prestigious \$1 million funding award from a federal research program. The Institute for Work & Health is involved as a partner.

Over the next five years, the Community-University Research Alliance on the Consequences of Work Injury will look at the long-term impacts of work injury.

"We see the effects of injury, such as unemployment and depression, in the large number of workers we help, but we don't know what the scope of the problem is," says Steve Mantis, the alliance's community lead, who volunteers at the Thunder Bay and District Injured Workers' Support Group. "For some time, injured workers' groups have been seeking information on the long-term effects of work injury on a broader scale."

As part of their research, the alliance will explore how legislation, policies and programs affect injured workers after an injury and over time. The researchers will also study injured workers' long-term financial security, work situations, health and well-being. Another theme of the alliance is to research the history of injured workers and their role in political activism.

Every year in Ontario, approximately 350,000 workers are injured in the workplace, including 13,000 who experience a permanent impairment, according to data from the Workplace Safety & Insurance Board.

The alliance hopes the research results will help develop evidence-informed policy and also increase knowledge about the situation of injured workers.



The CURA on Work Injury Steering Committee:
Top row: Ellen MacEachen, Marion Endicott,
Pat Vienneau, Steve Mantis, Alice de Wolff
Bottom row: Bonnie Kirsch, Emile Tompa,
Alina Gildiner. Missing: Robert Storey, Sabrina
Pacini, Basil Boolis, Bobby O'Regan

"We are including policy-makers in the earliest stages of the project," says Emile Tompa, a Scientist at the Institute and the alliance's academic lead.

The alliance came together in December 2003 at a meeting of injured workers, researchers and community representatives. The group decided to apply for funding through a federal research program called the Community-University Research Alliance (CURA). Out of more than 100 applications, it became one of 12 projects selected for funding earlier this year.

The alliance is also unique because it aims to equip injured workers with the skills to continue their involvement in conducting research, disseminating evidence and influencing policy. The initiative is comprised of nine community organizations and eight university/academic organizations. All participants in the initiative share decision-making, power, resources and opportunities.

(continued on page 3)

The Institute for Work & Health is an independent, not-for-profit organization whose mission is to conduct and share research with workers, labour, employers, clinicians and policy-makers to promote, protect and improve the health of working people.

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At Work is published by **Institute for Work & Health**
481 University Ave., Suite 800, Toronto, ON Canada M5G 2E9
To be notified by e-mail when a new issue of *At Work* is published
and available on our web site, send your e-mail address to
atwork@iwh.on.ca. Our web site address is www.iwh.on.ca
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Issue #45 Summer 2006 ISSN # 1261-5148
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**The Institute for Work & Health operates with
the support of the Ontario Workplace Safety
& Insurance Board.**



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contre les accidents du travail



What researchers mean by...

generalizability

The goal of scientific research is to increase our understanding of the world around us. At the Institute for Work & Health, that means understanding how work and health interact.

To explore these interactions, researchers study different groups of people or populations. These populations can be as small as a few individuals from one workplace or as large as thousands of people representing a cross-section of Canadian society. The results of this research often provide insights into how work and health interact in those groups. But how do we know if a study's results can be applied to another group or population?

To answer this question, we first need to understand the concept of generalizability.

In its simplest form, generalizability can be described as making predictions based on past observations.

In other words, if something has often happened in the past, it will likely occur in the future. In studies, once researchers have collected enough data to support a hypothesis, they can develop a premise to predict the outcome in similar circumstances with a certain degree of accuracy.

Two aspects of generalizability

Generalizing to a population. Sometimes when scientists talk about generalizability, they are applying results from a study sample to the larger population from which the sample was selected. For instance, consider the question, "What percentage of the Canadian population supports the Liberal party?" In this case, it would be important for researchers to survey people who represent the population at large. Therefore they must ensure that the survey respondents include relevant groups from the larger population in the correct proportions. Examples of relevant groups could be based on race, gender or age group.

Generalizing to a theory. More broadly, the concept of generalizability deals with moving from observations to scientific theories or hypotheses. This type of generalization amounts to taking time- and place- specific observations to create a universal hypothesis or theory. For instance, in the 1940s and 1950s, British researchers Richard Doll and

Bradford Hill found that 647 out of 649 lung cancer patients in London hospitals were smokers. This led to many more research studies, with increasing sample sizes, with differing groups of people, with differing amounts of smoking and so on. When the results were found to be consistent across person, time and place, the observations were generalized into a theory: "cigarette smoking causes lung cancer."

Requirements for generalizability

For generalizability we require a study sample that represents some population of interest – but we also need to understand the contexts in which the studies are done and how those might influence the results.

Suppose you read an article about a Swedish study of a new exercise program for male workers with back pain. The study was performed on male workers from fitness centres. Researchers compared two approaches. Half of the participants got a pamphlet on exercise from their therapist, and half were put on an exercise program led by a former Olympic athlete. The study findings showed that workers in the exercise group returned to work more quickly than workers who received the pamphlet.

Assuming the study was well conducted, with a strong design and rigorous reporting, we can trust the results. But to what populations could you generalize these results?

Some factors that need to be considered include: How important is it to have an Olympian delivering the exercise program? Would the exercise program work if delivered by an unknown therapist? Would the program work if delivered by the same Olympian but in a country where he or she is not well known? Would the results apply to employees of other workplaces that differ from fitness centres? Would women respond the same way to the exercise program?

To increase our confidence in the generalizability of the study, it would have to be repeated with the same exercise program but with different providers in different settings (either worksites or countries) and yield the same results.

Understanding workplace needs shapes IWH's research agenda

As the demand for innovative, high-quality evidence increases in the work-health field, deciding what research to undertake is important.

At the Institute for Work & Health, more than 60 research staff from various disciplines collaborate on occupational health and safety research. Each year the Institute establishes a research agenda that sets its key priorities for the year. So what exactly drives the Institute's research?

It's a combination of researcher curiosity, meeting our stakeholders' needs and aligning with our partners, explains IWH Chief Scientist Dr. Tony Culyer.

"We use a process of formal and informal consultations with our stakeholders and other interested parties," says Culyer. "We work with them to identify their needs in the workplace, and to gain a better understanding of the context in which the research results are likely to be used."

Based on these needs, the Institute has internal discussions to ensure its research priorities are consistent with the IWH's mission and current portfolio of work, adds Culyer.

How does the IWH engage its stakeholders when setting its research priorities? "We use our extensive knowledge transfer and exchange (KTE) channels to communicate with our stakeholders," explains Culyer. This communication



"We use a process of formal and informal consultations with our stakeholders and other interested parties..."

— Tony Culyer, Chief Scientist

provides input to IWH about the usefulness and accessibility of our research.

One example is our networks of "educationally influential" (EI) clinicians. "These networks provide ongoing exchange as we bring new research knowledge to them and they share their experience and ideas with us," says Rhoda Reardon, an IWH Knowledge Transfer Associate. "We also ask them about their views on research priorities." For example, occupational therapist EIs recently identified the need for research on mental health, specifically on methods to accommodate workers returning after a mental health-related absence.

In addition to engaging stakeholders, the IWH also receives guidance from its primary funder, the Workplace Safety & Insurance Board (WSIB). In 2005, the WSIB released a strategic document entitled *The Road Ahead*, which describes its focus over the next five years.

Two of their fundamentals, "health and safety" and "return to work" are strongly aligned with the Institute's expertise, explains Kelly Grover, Manager of External Relations and Corporate Development. For example, current Institute research focuses on understanding the health risks in young

and immigrant workers. Another study involving 600 injured workers will examine the factors that contribute to successful return to work.

The Institute also conducts systematic reviews of prevention measures for the WSIB. In this case, there is an extensive ongoing consultation about research priorities, which lead to recommendations for the Institute to consider.

The IWH also aligns with its institutional partners, such as the Occupational Health and Safety Council of Ontario, to ensure the research is relevant to the key priorities of this stakeholder group. For example:

- Institute researchers are involved with the High Risk Firm Initiative, a Ministry of Labour program that targets firms with the poorest health and safety performances.
- Associate Scientist Lynda Robson is leading a project that measures and evaluates the performance of injury and prevention strategies in Ontario.
- Several projects focus on the prevention of work-related musculoskeletal injuries, which are responsible for a majority of lost-time compensation claims.

The Institute's research priorities will also be examined next year as part of a five-year external review. A review panel will look back at the past five years to assess research productivity, quality and impact. The review will also look ahead to the years 2007-2011.

For more information on the Institute's research projects visit <http://www.iwh.on.ca/research>.

Scientist-worker alliance to study work injury (continued from page 1)

CURA is part of the Social Sciences and Humanities Research Council of Canada (SSHRC). The CURA award was augmented by funds provided by McMaster University, the Institute for Work & Health, the University of Toronto, and in-kind funds from several community organizations and other Ontario universities. The grant is administered through McMaster University.

In Brief ...

A combination of three factors – meeting stakeholder needs, aligning with partners and researcher curiosity – shapes the Institute's research priorities.

Why wealth doesn't always equal health

Dr Robert Evans delivered the final lecture of the Population Health Lecture Series of the Canadian Institute for Advanced Research. The series was co-sponsored by the University of Toronto and the Institute for Work & Health. Below is a brief overview of his talk on May 16, 2006. For a more detailed description, visit www.iwh.on.ca/about/ciar_evans.php

The idea that “wealth equals health” doesn’t appear to be true in North America today, says Dr. Robert Evans, one of Canada’s leading health economists.

People’s health generally improves as they make more money, according to many research studies. In North America, the trend has been toward weakening social safety nets, which leads to more poverty and greater economic inequality.

Yet this doesn’t seem to be leading to widening differences in health, said

Evans. He is Associate Director, Senior Faculty at the Centre for Health Services and Policy Research and Professor of Economics at the University of British Columbia.

To explain this dilemma, Evans first looked at income inequality. In the United States, the gap between rich and poor has widened substantially in the past 20 years.

The trend is similar in the U.K., but Americans are much less healthy, said Evans. A 2006 study in the *Journal of the American Medical Association* shows that Americans – even the richest ones – have higher rates of diseases such as diabetes, heart disease and cancer. In large U.S. cities, income inequality is associated

with poorer health, but this finding doesn’t hold true in Canada, said Evans, citing a study by Nancy Ross in the *British Medical Journal*.

So what explains the differences in health? Evans said there may be important factors in the social environment. One example might be an individual’s stress levels, which can affect health. Another factor is that in countries such as Canada, there are more public supports to buffer market inequalities.

All this suggests the idea that wealth equals health is too simple. Social contexts and inequality also need to be considered, Evans said. “There really is such a thing as more or less livable societies.”

Grant Round-up

Grant Round-up: In addition to the Institute’s core funding from the WSIB, Institute scientists receive grants and awards from funding agencies. These funds help to support research on work and health issues and the transfer of research messages. The following grants were awarded in 2005 and to date in 2006.

Operating Grants

PRINCIPAL INVESTIGATOR	TITLE	GRANTING AGENCY	AMOUNT
Dorcas Beaton Claire Bombardier	Disability at work: Measuring the progression of at-work disability and workplace productivity loss	Canadian Arthritis Network 2005-2007	\$270,600
Philip Bigelow Dee Kramer	Exploration of the feasibility of participative interventions to reduce musculoskeletal injuries in the construction sector	CRE-MSD ¹ Seed Grant 2005-2006	\$8,200
Philip Bigelow	Identifying the barriers and facilitators to the adoption of ergonomic innovations in the construction sector	WSIB RAC: Bridging the Gap 2005-2006	\$59,777
Philip Bigelow	Evaluation of an HSA-initiated collaborative partnership to implement participatory ergonomic programs	WSIB RAC 2005-2007	\$292,908
Donald Cole	Developing standard metrics for work disability management – implementation assessment	WSIB RAC: Bridging the Gap 2005-2006	\$59,932
Pierre Côté Vicki Kristman	Occupational mild traumatic brain injury in Ontario: Identification, prognosis and health care utilization	Ontario Neurotrauma Foundations Mild Traumatic Brain Injury/Feasibility Studies 2005-2007	\$76,625
Renée-Louise Franche	Cross-sectoral aspects of mental health in the readiness for RTW injured workers’ cohort	FRSQ ² Team Grant Jan.-June 2006	\$15,800
Renée-Louise Franche	Recurrence and persistence of work absence: Understanding their risk factors and long-term impact on workers’ limitations and non-work role participation	WSIB RAC 2006-2008	\$246,674

Mustard Fellow to study back injury recovery times and treatments

When a person has a back injury requiring time off work, is it possible to predict how quickly he or she will recover and return to work? Are different treatments needed, depending on the expected recovery time?

Dr. Ivan Steenstra, the new Mustard Fellow at the Institute for Work & Health, plans to explore these questions. Steenstra will be conducting studies of patients with low-back pain injuries to see if there is a way to tailor treatment interventions based on a worker's expected recovery time, or prognosis.

If someone's return to work is expected sooner, a clinician might need to do different things than if it is predicted to take longer, says Steenstra, formerly a senior researcher at the Coronel Institute

of Occupational Health in Amsterdam, the Netherlands.

During his two-year fellowship, Steenstra proposes to recruit workers soon after they are injured and file a claim with the Workplace Safety & Insurance Board. He will be working with Institute scientists Pierre Côté and Renée-Louise Franche, but expects to spend a considerable amount of time in the field. He has already published research on this topic.

It might be possible, for instance, to predict a poor prognosis by using a simple questionnaire on the first day of sick leave. Then depending on the prognosis, different interventions can be compared in different groups against the usual

treatment in a randomized, controlled trial, he says.

Steenstra received his PhD in epidemiology from the Vrije University in Amsterdam in 2004. At the Coronel Institute, he was involved in conducting a trial with about 400 government workers to prevent repetitive strain injury.

The trial looked at the use of a newly developed mouse. This mouse vibrates if a worker's hand rests passively on the mouse for longer than 12 seconds, as a reminder to move the hand. The idea is to reduce muscular tension in the shoulders.

The Mustard Fellowship in Work Environment and Health is named in honour of Dr. J. Fraser Mustard, who was the founding Board Chair of the Institute. Its purpose is to develop outstanding researchers in the area of work and health.

Operating Grants

PRINCIPAL INVESTIGATOR	TITLE	GRANTING AGENCY	AMOUNT
Jeremy Grimshaw Claire Bombardier Vickie Pennick (IWH Coordinator)	Knowledge synthesis and translation by the Cochrane Collaboration in Canada (including Cochrane Back Review Group)	CIHR - CCOHTA ³ 2005-2010 Back Review Group	\$7,807,937 \$840,000
Ellen MacEachen	An ethnographic study of injured workers' complex claims experiences	WSIB RAC 2005-2007	\$97,671
Cam Mustard	A systematic review of the effectiveness and cost-effectiveness of social marketing campaigns in occupational injury prevention	Work Safe WCB-BC 2005-2006	\$92,000
Cam Mustard Mickey Kerr	Evaluation of overhead patient lifting devices in Ontario.	Ministry of Health and Long-term Care Dec. 2004-2006	\$1,028,000
Peter Smith Cam Mustard	An examination of the working conditions and risk factors for work-related injuries among immigrant co-workers in Ontario	WSIB RAC 2006-2008	\$101,700
Emile Tompa	CURA: Workers' compensation and the consequences of work injury	SSHRC ⁴ Development funding April 2005-06	\$19,917
Emile Tompa (Grant administered at McMaster University)	CURA: Workers' compensation and the consequences of work injury	SSHRC ⁴ 2006-2011	\$997,322

Career Grants (awarded to individuals)

INDIVIDUAL	TITLE	GRANTING AGENCY	TIME COMMITMENT
Heather Scott-Marshall	Career award	SSHRC ⁴	2005-2007

¹CRE-MSD: The Centre of Research Expertise for the Prevention of Musculoskeletal Disorder

²FRSQ: Fonds de recherche en santé du Québec

³CIHR-CCOHTA: Canadian Institutes of Health Research - Canadian Coordinating Office for Health Technology Assessment

⁴SSHRC: Social Sciences and Humanities Research Council of Canada

Is it worth it? Determining the costs and benefits of workplace interventions

Consider this hypothetical scenario at a company that produces telecommunications equipment. Several managers notice that workers on a particular assembly line are taking sick leave more often than other workers. Upon investigating, they learn that the assembly process causes pain in workers' wrists, arms and shoulders. The managers identify two courses of action:

- 1) Bring in an ergonomics consultant to assess the situation and implement an injury prevention program at an estimated cost of \$18,000.
- 2) Rotate workers on different assembly lines to give them a "break" at an estimated cost of \$6,000 for retraining.

Which option should the managers choose? For a business that wants to protect its employees and is also concerned about the bottom line, option two might seem more appealing.

However, this option may not be the best one. It might not be as effective in reducing injury and sick leave as option one. In addition, there may be "hidden costs" that haven't been considered, such as the costs of rescheduling shifts and reduction in product quality. Option one might produce better health outcomes,

but are these benefits large enough to outweigh the incremental costs?

Possibly, the status quo is better than either option one or two when all costs and all benefits of each option are compared.

To make a better decision, the company needs to identify all the relevant alternatives that are available, and assess all the associated costs and benefits. The type of study that considers these issues is called an economic evaluation.

"Economic evaluations are important in any area where you need to make a decision about resource allocation, so that you can answer the question 'Is it worth implementing this alternative rather than another one?'" says Emile Tompa, a Scientist and economist at the Institute for Work & Health. "Many workplace interventions have been evaluated for their effectiveness since the 1980s, but very few of these have included an economic evaluation." The few that do are generally poor in quality, as Institute scientists discovered while conducting a systematic review of workplace intervention studies with economic evaluations (*see sidebar, page 8*).

The Institute is making efforts to advance the use of economic evaluations in occupational health and safety (OHS)

studies to address the need for higher standards in this area. One major project is to develop a book that provides guidance on how to conduct, commission and assess economic evaluations in OHS studies. To this end, the Institute hosted a two-day international workshop in April 2006, which was attended by economists and others with relevant expertise.

"The idea behind the workshop was to give guidance on how best to do economic analyses of OHS interventions," says Dr. Tony Culyer, the Institute's Chief Scientist.

The content of each chapter was discussed at the workshop. Within each chapter, invited authors were asked not only to identify the main barriers to producing high-quality, useful studies, but also to propose solutions. The chapters cover topics such as the perspective from which the study is done, strengthening the workplace-researcher relationship, understanding international differences in labour legislation and policy, and choosing the type of economic analysis (*see sidebar, page 7*).

"We want the book to be very useful for practitioners," says Tompa. The target audience includes OHS practitioners, occupational health clinicians, workplace researchers, applied economists, as well as policy-makers at workers' compensation boards and in ministries of labour. "Readers will need to have some familiarity with economics to appreciate the book's contents, but they don't need to be economists," he says.

The book aims to set a standard in terms of good practice that will be useful for conducting economic evaluations or assessing whether a study's results are applicable to other settings. Several methods books already exist for the evaluation of health-care interventions,



which is further advanced in the use of economic evaluation methods than the OHS arena.

“Ideally economic evaluations should be part of every workplace intervention study,” says Tompa. “Someone with economics expertise needs to be involved at the outset of studies. Questions about the costs and consequences of an intervention should be built into studies of effectiveness at the front end.” For example, the Ontario government is investing \$60 million to install patient lifts in 500 hospitals and nursing homes across the province. Researchers are studying the effectiveness of these lifts in preventing work injuries among health-care workers. An economic evaluation is being conducted at the same time to determine the costs and consequences associated with the lifts.

An economic evaluation can be done from different perspectives. For example, in the case of the telecommunications company, the evaluation could consider the workers’ perspective by focusing on loss of income, out-of-pocket costs, and

decline in health. Or it might look at the workers’ compensation perspective by focusing on claims reductions and related savings in administration and wage-replacement.

While it may seem surprising that a book on this topic doesn’t already exist, there are several reasons for this. First, the workplace arena is complex. It is difficult to assess the full range of costs and consequences, because there are a number of parties who bear the costs. In addition, collecting good data at workplaces can be challenging, particularly because of the amount of time it takes to conduct surveys. Finally, differing and sometimes conflicting priorities make it difficult to quantify all costs and consequences.

In addition, economists with an interest in OHS are relatively few and far flung, Culyer points out. With the presence of several economists at the Institute, including Culyer and Tompa, as well as scientists with expertise in workplace interventions, “We have the beginning of a critical mass,” he says.



“Ideally economic evaluations should be part of every workplace intervention study.”

– Dr. Emile Tompa, Scientist

The deadline for completion of the book is spring 2007. Other activities to promote workplace-based economic evaluations may follow. “One possibility is to develop courses in economic evaluation for those in the occupational health and safety field, similar to those offered in the health-care field,” says Tompa.

What is an economic evaluation?

An economic evaluation is a type of study that can help a decision-maker choose how to allocate resources, such as money, people, time or equipment. It identifies all the options a person might reasonably select. It then compares each one in terms of all the relevant costs and consequences.

There are several types of economic evaluations, which try to answer the questions described below. The examples given are from the health-care field, which is further developed in economic evaluation.

Cost Minimization Analysis – What is the least costly way to get a given result? This approach focuses on costs. It assumes that the consequences are similar for the different options being evaluated. One example from the health-care field is comparing the costs of performing a surgery on an inpatient or outpatient basis.

Cost-Benefit Analysis – What are the costs and benefits associated with different options? This approach measures consequences in monetary terms. For example, this type of analysis might be used to look at the cost of having a universal chicken pox immunization program versus not having one.

Cost-Effectiveness Analysis – What are the costs and health outcomes associated with different options? This approach measures consequences in units that measure natural benefits, such as life-years saved and reduction in disability days. For example, a cost-effectiveness study might compare the costs and reduction in disability days associated with two drugs to treat asthma.

Cost-Utility Analysis – What are the costs and gains associated with different options? This approach measures consequences in terms of improved health or satisfaction gained (utility) /value relative to other

options (value weighted units). The most common type is the Quality Adjusted Life Years (QALYs), which combines the number of years and quality of life gained for each option. For instance, suppose a depression treatment study was comparing drug therapy alone versus a combination of drug therapy and counselling. The researcher might consider measuring consequences – such as improvements in patients’ quality of life – from each option in QALYs.

Deciding which type of analysis to do depends on the question that needs to be answered. It also depends on the perspective taken, such as the worker, company or society. The data and resources that are available to conduct the evaluation are also a factor. If there are good ways to measure outcomes in terms of natural units, but they are difficult to convert to dollars, then the researcher might consider a cost-effectiveness analysis.

Review finds low quality in workplace economic evaluations

Institute scientists are conducting a systematic review to assess the quality and quantity of evidence on economic evaluations of interventions for occupational health and safety (OHS). A pilot review completed in 2005 found only a handful of studies, and the quality was generally quite low.

"Very few occupational health and safety studies have also undertaken an economic analysis," says Emile Tompa, a Scientist and economist at the Institute for Work & Health. After systematically screening a subset of studies in this field, researchers found only 23 relevant studies. Just 11 of the 23 were full economic evaluations that considered both the costs and consequences of the intervention. The rest were partial evaluations that only considered the savings of a given intervention, and not the costs. The interventions included ergonomics,

participatory ergonomics and return-to-work interventions in settings as diverse as offices, warehouses, hospitals and manufacturing companies.

"A lot of the studies were not undertaken by economists," says Claire de Oliveira, a PhD candidate in economics who is involved in the review. This may explain why the studies lacked the depth of a full economic evaluation. In addition, in most studies researchers did not consider multiple viewpoints or question the figures provided to do the analysis. Also, few of the studies lasted long enough to see if the programs could be sustained.

There was also not enough information on the context and on the way things were measured. This made it difficult for researchers to evaluate the quality of the

studies, or for a reader to be able to assess the intervention's applicability in other settings.

As with other systematic reviews, researchers met with stakeholders early in the planning stages to help refine the review questions, search strategy and analysis plan. Stakeholders included individuals from the Workplace Safety & Insurance Board, Workers Health & Safety Centre, Ministry of Labour, Ontario Service Safety Alliance, the University of Waterloo and Dofasco.

"We want to ensure the product is something that they will use," says de Oliveira. Once the review is complete, likely by the fall, stakeholders will meet again to discuss the findings. In addition to preparing a report summarizing their findings, the researchers will produce a document outlining best practices in the use of economic evaluation methods in OHS intervention studies.

IWH News

KTE Community of Practice

Knowledge transfer and exchange (KTE) professionals from the Greater Toronto Area have joined together to form a KTE Community of Practice. The group meets quarterly to network and learn about KTE initiatives at other research, health-care and workplace organizations.

At its second meeting in June, members heard two presentations, one of which was about the Educational Influential project at the Institute for Work & Health. This project facilitates exchange between researchers and practitioners. A second presentation was about the seniors' health research transfer network of the Ontario Ministry of Health and Long-term Care.

The Community of Practice developed following a 2005 workshop organized by knowledge transfer staff from a variety of organizations, including the Institute, the Centre for Addiction and Mental Health, the Hospital for

Sick Children and the Nursing Research Unit at McMaster University. This volunteer-based group is open to anyone in the Greater Toronto Area with an interest in knowledge transfer. For further information, contact Bonnie Heath at bonnie@bonnieheath.com

Conference season

Institute staff participated in several national and international conferences over the summer. The Canadian Association for Research on Work and Health (CARWH) held its 4th annual meeting in St. John's, Newfoundland in June. This conference was a venue for Canadian researchers to share knowledge on research, policy and practice. Institute scientists and staff presented research findings in areas such as precarious employment, occupational health and safety management systems, and work-related musculoskeletal disorders. In addition, they organized roundtable discussions and workshops on topics such as

engaging workplaces in intervention research and transferring theoretical knowledge into practice.

The 7th International Congress on Work Injuries Prevention, Rehabilitation and Compensation, held in Hong Kong in July, had a similar goal of seeking practical ideas on prevention of workplace injury and disease. Institute President Cameron Mustard was invited to present a paper on disability income insurance benefits among Canadian workers.

The International Forum VIII on Primary Care Research on Low Back Pain, held in Amsterdam in June, brought together researchers, clinicians and knowledge transfer associates working in the area of low-back pain. Institute scientists spoke on topics such as the value of observational studies and the challenges of using such studies in systematic reviews. The program also included a meeting of the Cochrane Back Review Group, which co-ordinates systematic reviews in this area.