

**Workshop of the EUPHA Section on Social Security and Health, Graz 2005**  
**Preliminary program (three presenters are yet to be included)**

**Cooperation between different actors regarding promotion of return to work of sickness absentees**

In managing sickness-absence cases a promotion of return to work among absentees often cooperation between different actors, such as health care, employer, occupational health care, sickness insurance, and/or unemployment offices, are warranted. In many countries different projects have been launched to promote such cooperation, however, they are seldom scientifically evaluated. There are different types of obstacles, at different structural levels, to such cooperation.

**The aim** of this workshop is to initiate a discussion on the following aspects:

- Cases that requires cooperation
- Determinants of cooperation
- Obstacles to cooperation
- Problems in cooperation
- Methods to promote cooperation
- Methods to study effects of such interventions
- Theories and models that are useful in this research area
- Differences between countries with regard to the above aspects

Presentations from four different countries will be made as an introduction to the discussion.

**Chairperson:** MD, Wout de Boer, TNO, The Netherlands

**Organiser:** Prof Kristina Alexanderson, Department of Clinical Neuroscience, Karolinska Institutet, Stockholm, Sweden

**Presentations**

1. **Problems in cooperation between social insurance and occupational health care in Belgium**, Professor Peter Donceel, Dr. Katrien Mortelmans, Dept of Occupational, Environmental and Insurance Medicine, Leuven, Belgium
2. ... **A theoretical model for cooperation in public health settings**. de Rijk A, van Raak, A & van der Made, J Department of Health Organisation, Policy and Economics, Maastricht University, Maastricht, The Netherlands.
3. **Co-financed collaboration between welfare services -Effects on staff and patients with musculoskeletal disorders**. Eva-Lisa Hultberg, Department of Social Medicine, Sahlgrenska Academy, Gothenburg, Sweden.
4. **Health, Work and Inactivity: Current context and developing solutions. A UK Perspective**. Professor Mansel Aylward and Professor Gordon Waddell, UnumProvident Centre for Psychosocial and Disability Research, United Kingdom

**1. Problems in cooperation between social insurance and occupational health care in Belgium**

Peter Donceel, MD, PhD, Dr. Katrien Mortelmans, Department of Occupational, Environmental and Insurance Medicine, Kapucijnenvoer 35/5 B-3000 Leuven, Belgium

In the Bismarckian social security system, which we have in Belgium and in a lot of European states, there is a strict separation between the world of work and the world of social insurance. Either a person is at work and then occupational health care workers guide his health, or he is unable to work and in that case social insurance authorities evaluate his condition. The logic behind this separation is not compatible with an integrated counselling and activation of the worker with a health problem.

Occupational physicians have knowledge of the practical situation in the company with regard to the possibilities for job modification, work accommodation, and the presence of alternative tasks. These and other company-related factors can be very helpful for early reintegration and prevention of long-term work incapacity.

Insurance physicians receive detailed information about the medical situation of a sick-listed employee in order to assess his functional capacities. Furthermore they are acquainted with the legal criteria and procedures for partial or progressive return to work and can consult with the treating physician about optimal medical treatment and rehabilitation.

If all information about practical possibilities at the workplace is combined with data of the medical functional assessment and treatment, this could theoretically result in an improved and early reintegration.

In an intervention study we tried to establish a systematic information exchange between the occupational physician (world of work) and the medical adviser (social insurance). But this standardised communication did not result in a decline of the mean duration of work incapacity and a decrease of the number of patients on long-term invalidity.

The mere fact of enhancing communication apparently was not sufficient to create a real change in the attitudes and collaboration practices of occupational and social insurance physicians.

By means of a questionnaire we have explored the impediments in the process of collaboration and in the achievement of better reintegration results. We will present and discuss the results of these questionnaires.

**2 A theoretical model for cooperation in public health settings.** de Rijk A, van Raak, A & van der Made, J Department of Health Organisation, Policy and Economics, Maastricht University, Maastricht, The Netherlands.

Cooperation between actors is believed to be important in many public health settings. However, the determinants of cooperation are hardly understood. Two sociological theories, Resource Dependence theory and New Institutional theory, led to the development of the Resource Dependence Institutional Cooperation (RDIC)- model for understanding cooperation. Factors include: goals, interdependence, resources, legislation, perceptions, willingness and ability to co-operate. The aim was to test the validity of the RDIC-model in two different networks: (1) professionals involved in sickness absence guidance of employees; (2) representatives of employers and employees responsible for developing sickness absence policy in organisations.

Methods: Regarding each network, a qualitative, in-depth study was performed. The first included eleven respondents concerned with the sickness absence of four employees. The second concerned fourteen respondents concerned with the development of absence policy in five organisations. Data were gathered by documents (regarding legislation) and semi-structured interviews and analysed with pattern-matching.

Results: The RDIC-model matched with empirical patterns of cooperation in both networks. Regarding the first, particularly mutual perceptions, resources, interdependence and goals

related to cooperation. This could be understood by an influence on willingness to cooperate. Legislation had a limited influence on cooperation. Regarding the second network, legislation appeared to be the most important determinant by influencing the willingness to cooperate.

Conclusions: The RDIC-model appeared valid to understand cooperation in two different networks. Further tests in various public health settings are necessary. We will argue that the RDIC-model is also valuable to make international comparisons and to assist management of cooperation.

### **3. Co-financed collaboration between welfare services -Effects on staff and patients with musculoskeletal disorders.** Eva-Lisa Hultberg, Department of Social Medicine, Sahlgrenska Academy, Gothenburg, Sweden.

The number of individuals in need of help and support simultaneously from different welfare services has increased. Collaboration between professionals and authorities has been seen as a way to improve the efficiency in treatment and rehabilitation. In Sweden, a trial legislation called SOCSAM was introduced in 1994 with an aim to improve collaboration and decrease costs for society through allowing co-financing and joint political steering across welfare services. The main aim of this research project was to assess if co-financed collaboration between primary health care, the social (sickness) insurance offices and social services contributed to improved care and rehabilitation for people with musculoskeletal disorders.

Methods: This research project assessed the effects of a natural experiment. Patients with musculoskeletal disorders attending three health centres with co-financed collaboration (DELTA health centres) were compared to similar patients attending four control health centres not practicing collaboration under the trial legislation. One hundred thirty eight patients were followed prospectively for one year. Information about health status, health care contacts and sick leave were collected through patients' interviews, through medical records, through the Swedish Social Insurance Registry, and through patient diaries.

Results: There were no major differences in baseline characteristics between the two patient groups. No significant differences between patients in the DELTA centres and the controls concerning change in health status between baseline and 12 months follow-up were found. Mean number of sick leave days during the 12-months period after inclusion was 94 for the DELTA patients and 87 for controls. At 12 months follow up, 31% in the DELTA group and 32% in the control group were on sick leave. Patients in the DELTA health centres had more contacts with physiotherapists than the controls, especially during the first months after inclusion. Contacts with social insurance office, social services or hospital did not differ significantly between the groups. The type of treatment the patient received only differed slightly between the groups.

Conclusion: There were no major differences in the care and rehabilitation approaches, or treatments that patients received, between DELTA and control patients. The only clear difference was that DELTA patients received more physiotherapy than controls. There is a weak evidence base for the type of treatments that was received by patients in both groups, which may explain why no significant differences were observed concerning health outcome or sick leave. The studies had some methodological limitations. Since the sample size was small and an observational design was used, the data should be interpreted with caution. This research contributes a small part only of the data required to judge the overall effects of co-financed collaboration under SOCSAM.

**4. Health, Work and Inactivity: Current context and developing solutions. A UK Perspective.** Mansel Aylward and Gordon Waddell, UnumProvident Centre for Psychosocial and Disability Research

In the UK 2.6 million people of working age receive state incapacity benefit (IB) and remain workless as a result of a health condition or disability. This represents a major public health issue. Sickness absence and its management is also a considerable burden on UK business. Most people claiming IB expect to get back to work, yet after 12 months on benefit fewer than a quarter do so. More than two-thirds of benefit recipients have common health problems such as low back pain or report mixed anxiety/depression that should be manageable, but for far too long the separate benefit and employment agencies have undermined efforts at work rehabilitation.

Bio-psychosocial factors aggravate and perpetuate disability and act as obstacles to recovery and barriers to return to work. The UK Government's flagship "Pathways to Work" initiatives provide multidisciplinary condition management which tackle the personal, psychological and social barriers to RTW. The programme's results to date are extremely encouraging returning people to the world of work. Strong scientific evidence indicates that the potential impact of these initiatives could reduce sickness absence and the flow on to chronic illness incapacity by 30-50%.

This programme will be described together with other UK initiatives, including the work at Cardiff University and the Wales Centre for Health, aimed at improving attendance management, health and productivity at work, and addressing key determinants of health inequalities.