Return to work in the first year of sickness absence

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Summary

Since the introduction of the Work Incapacity Act (WAO) in 1967 a large number of employees has applied for a disability pension. In the 1990s this led to major changes in the social security legislation, including the introduction of a bonus/malus system, limitation of the duration and level of the disability pension, tightening of the admission criteria and privatisation of the Sickness Insurance Act (ZW).

The employer became responsible for the reintegration of employees in the first year of sickness absence. In the second year of absence this responsibility shifted to the public sector. To ensure that this transition flowed smoothly, the gatekeeper model was introduced. However, this system did not function well which led to the introduction of the Gatekeeper Improvement Act (Wvp) in 2002. The main aims are to stimulate reintegration in the first year of sickness absence, to strengthen the responsibility of both employer and employee, and to improve the cooperation between the private and the public sector. Within the Wvp-system, the occupational health service (OHS) has to draw up a problem analysis within six weeks after the employee reporting ill. Subsequently, employer and employee have to formulate an action plan. Furthermore, employer, employee and OHS keep in regular contact in order to monitor the reintegration process. At the end of the first year of sickness absence the employee can apply for a disability pension.

In the 1990s there were also some developments in the occupational health care system. The assistance of employees on sickness absence by an OHS became obligatory. Furthermore, the government allowed for the establishment of commercial OHSs. Both developments had consequences for the relations between employer, employee and OHS. Against this background, the present study focuses on return to work (RTW) in the first year of sickness absence with an emphasis on the relationship between employee and OHS. The study aims to provide insight into several aspects of RTW in the first year of sickness absence within the framework of the Wvp. The research questions are:

1a. Which work-related determinants predict return to work (RTW) of employees who resort under the Wvp?
1b. Which self-rated health determinants predict RTW of employees who resort under the Wvp?
2. To what extent are the time and complaint contingent approaches towards treatment and RTW supported by empirical data?

*From January 2004 this period has been extended to the first two years of sickness absence.*
3a. How does the reintegration process according to the Wvp actually function in practice?
3b. To what extent do employees who returned to work differ from employees who did not return to work?
4. Which factors, related to the reintegration process according to the Wvp and to client satisfaction, predict the way employees judge the support provided by the OHS with regard to RTW?

Work-related determinants are the focus of chapter 2. The study is based on a sample of 926 employees on sickness absence who were followed until the tenth month after listing sick. Through Cox proportional hazards regression analyses three factors are identified which can predict RTW of employees on long-term sickness absence: vocational sector, supervisor support and co-worker support. Employees from the sectors construction, public administration, financial and commercial services, transport and education all have a worse prognosis for RTW compared to employees from the health care and welfare services sector which form the reference group. However, employees from the sector education have the highest risk for a longer duration of sickness absence. The results with regard to supervisor support are unexpected as low supervisor support is associated with a higher RTW rate. Low co-worker support is associated with a longer duration of sickness absence. Several explanations for the findings are presented with regard to the association between supervisor support and RTW.

Chapter 3 focuses on the health-related determinants of RTW. This study is based on a sample of 862 employees who have been listed sick with musculoskeletal, other physical or psychological complaints. They were followed until the tenth month of listing sick. Again, Cox proportional hazards regression analyses are used to identify which factors can predict RTW. First, regression analyses are executed for the study population as a whole. Employees on long-term sickness absence with psychological complaints have a relatively low RTW rate, followed by employees with other physical health problems while employees with musculoskeletal problems are the first to be able to work again. Subsequently, regression analyses were executed for each of the three complaint groups, musculoskeletal complaints, other physical health complaints and psychological complaints. For employees with musculoskeletal complaints the physical aspects of functional status (physical functioning and physical role problems) as well as mental health and health change are important predictors for RTW. Better self-rated health on these aspects is associated with earlier RTW. The model for employees with other physical health problems is more complex. Subjective severity of complaints, physical and social functioning, general health perception and health change are all predictive of RTW. Determinants of RTW for employees with psychological complaints are mental health and general health perception. In order to use self-rated health as a predictor of RTW at the individual level more research is needed.

In the Netherlands a time contingent approach towards treatment and RTW is advocated in the professional guidelines for occupational physicians (OPs). Chapter 4 describes the LISREL modelling of both the time contingent and the more traditional complaint contingent approach. The study is based on a sample of 489 employees with physical health
complaints. When modelled separately, both the time and the complaint contingent approach fit the data well. However, when the two approaches are combined into one full model, only the solutions for the relationships between the latent variables for the complaint contingent approach remain significant, indicating that the complaint contingent approach is best supported by the empirical data. We conclude that in practice the way in which employees return to work is based more on the complaint contingent approach than on the time contingent approach. Probably, many OPs do not treat employees according to the time contingent approach or do not implement this approach correctly. However, it is also possible that the attitude of the employees towards their ability to return to work can explain these findings or that the model presented in chapter 4 is too simplistic to capture the reality of time contingency.

Chapter 5 describes the reintegration process of the Wvp as experienced by the employees and investigates the differences in the reintegration process between employees who returned to work and those who did not. The study is based on a sample of 870 on sickness absence. The sample is divided into three groups: 'early RTW', 'RTW', and 'no RTW'. Both the problem analysis and the action plan are often not formulated within the time limits as dictated by the Wvp. The time limits are only reached for employees who returned to work within 13 weeks after listing sick, the group 'early RTW'. However, the OHS can deviate from the time limit for formulating a problem analysis if necessary. In the problem analysis the OHS often predicts that employees can fully return to their own job. This holds also true for employees who did not return to work during the study period. It is not clear why this group did not return to work despite the favourable prognosis. It seems that the duration of sickness absence itself is a risk factor for a permanent work disability.

The employees' perception of the support provided by the OHS during the reintegration process is the focus of chapter 6. The study is based on a sample of 935 employees on sickness absence. An ordinal regression analysis is performed to model the way in which the employees perceive the support provided by the occupational health service. Factors related to the Wvp process and to satisfaction with the consultation of the OP are entered into the analyses as predictors for the employees' overall perception of the support provided by the OHS. Several factors from both the Wvp process and the satisfaction with the consultation of the OP remain in the final model: approval of the advice on the endterms of the reintegration process, presence of advice on reintegration activities, and four aspects of satisfaction with occupational health care, namely satisfaction with the advice given by the occupational physician, with the expertise regarding the complaints, with handling confidential information, and with the time available for the client. We conclude that the perception is based on three aspects of occupational health care: advice, professional attitude of the OP and the way the consultation with the OP has been organised.

In the general discussion (chapter 7) the main findings, the methodological considerations, future research and the practical implications are addressed. This study has several strengths, such as the longitudinal design with a large study population, no selection of type of complaint and the distribution of the respondents over various parts of the country. There are also some important methodological limitations, being the fact that the study took place within the setting of only one OHS and the high level of non-response.
Future research should concentrate on RTW within the sector education and on the development of a self-rated health questionnaire which can be used at the individual level. Furthermore, more research is needed in the areas of time contingency and the quality of care by the OHS.

Chapter 7 points out several practical implications. OPs can use the determinants of RTW this study identified for their prognosis with regard to RTW. Especially the factors sector, type of complaint and earlier sickness absence can be used for this purpose. The results with regard to the time contingent approach indicate the need for OPs to discuss time contingency with the employee during the consultation hour. OPs should maybe be offered a training with regard to the advantages of the time contingent approach, the correct implementation of this approach and on the best way to achieve compliance by the employee. Finally, this study points out the importance of the consultancy function of the OHS.