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Swedish Rehabilitation Professionals' Perspectives on Work Ability Assessments in a Changing Sickness Insurance System

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Running head: Work Ability Assessments

Abstract

Purpose: Changes in the Swedish sickness insurance system shifts focus from return-to-work to labour market reintegration. This article analyses Swedish rehabilitation professionals' perspectives on how the changed regulations affect practice, with a special focus on work ability assessments.

Methods: Two groups of representatives ($n=15$) from organizations involved in rehabilitation and return-to-work met at seven occasions. The groups worked with a tutor with a problem-based approach to discuss how their practice is influenced by the changed regulations. The material was analysed inductively using qualitative content analysis.

Results: The new regulations requires developed cooperation between insurance, health care, employers and occupational health care; however, these demands are not met in practice. In work ability assessments, several flaws regarding competence and cooperation are identified. An increasing number of people previously assessed as work disabled are required to participate in labour market reintegration, which puts demands on professionals to engage in motivational activities, although this is perceived as hopeless due to the group's lack of employability.

Conclusions: The possibility for employers to sidestep their responsibility has increased with changed regulations. The overall lack of cooperation between relevant actors and the lack of relevant competence undermine the ambitions of activation and reintegration in the reform.

Introduction

In recent decades, policy development on disability and sickness insurance has converged in most European countries, and there has been a shift of focus from passive compensation to active work reintegration (1), a development actively promoted by international actors such as the European Union (EU) and the Organisation for Economic Co-Operation and Development (OECD) (2-5). As a consequence, the concept of work ability has become increasingly important, because the criteria for eligibility for sickness benefits are commonly related to remaining abilities rather than diagnoses. However, there are a variety of methods for assessing work ability in the different national settings, and there are differences in who is responsible for the assessments and the criteria for making assessments (6).

To be eligible for sickness benefits from Swedish sickness insurance, a person must have a medical condition that implies work disability. After an initial waiting day, the employer is responsible for paying sick-pay for the first two weeks, whereafter the cost is taken over by the Social insurance Agency. The agency assesses the worker's work ability based on a medical certificate issued by a physician, most commonly in primary health care.

In 2008, the government introduced several changes to the sickness insurance system. The most prominent feature of the reform involve a fixed time schedule for work ability assessments (the Rehabilitation Chain) which describes how work ability should be assessed in increasingly broader terms as time passes (see table 1), which affect eligibility for sickness benefits. After 180 days, the process is shifted away from the employer to the labour market at large, i.e. from return-to-work to labour market reintegration. At this stage, the Public Employment Service assists the sick-listed worker with vocational guidance. An ending-point to sickness benefits was also introduced, where benefits after 365 days are only to be granted in cases of severe illness. Further, a system of temporary disability pension for people with

more long-term diseases was abolished to direct the sickness insurance system more towards labour market reintegration. Sickness benefits have also been reduced from 80% to 77,6% of wages¹.

[Table 1 about here]

The new time schedule have changed the conditions for sick-listing, and in particular work ability assessments. Before the changes, there were no set time limits in the system. A more narrow time perspective put higher demands of purposeful cooperation between relevant actors in the processes of rehabilitation and return-to-work. Therefore, it is of interest to study how officials (i.e. the gatekeepers) within the authorities that are responsible for these processes perceive that the changes affect their practice.

Aim

The aim of this study is to explore how officials from different organizations involved in rehabilitation perceive that the changes in sick-listing regulations affect their practice and cooperation, with a special focus on work ability assessments. The study aims to answer the following questions:

- What factors are taken into account when work ability is assessed?
- How do the representatives perceive that the new sickness insurance regulations affect their cooperation in work ability assessments?

¹ This was done through lowering the income from which benefits are calculated from 100% to 97% of wages. The result is a reduction of benefits with 2,4%.

- How do the representatives perceive that the new sickness insurance regulations affect return-to-work and labour market reintegration?

In this article, the term cooperation is primarily used to indicate cooperation between professionals from different organizations, e.g. cooperation between health care workers and social insurance officials. The term is thus to be understood as referring to interorganizational cooperation rather than cooperation between professionals within a specific organization.

Methods

This is a qualitative explorative study in which the experiences and attitudes of representatives of officials from different public services are investigated.

Study participants

Two groups of officials from the Social Insurance Agency, the Employment Service, primary health care and municipal rehabilitation services met seven times to discuss how the changes in policy affect their practice. These actors have the main responsibility for the return-to-work and labour market reintegration processes in the Swedish system. The groups were located in two different municipalities in eastern Sweden. The selection of participants was made through discussions with coordinators in the two municipalities. The criteria for inclusion were that all the relevant public actors involved in rehabilitation and return-to-work should be represented, and that all participants had experience of everyday work with clients. The ambition was to also include employers into the study, and in one of the groups a municipal human resource manager represented this perspective. A similar request was made in the

other municipality, but no employer representative was available for participation. The study was carried out in collaboration with two municipalities, health care, the Social Insurance Agency and the Public Employment Service, which made participation possible although it demanded a fair amount of the participants' time. Private employers, occupational health services and unions were not included in the study due to these constraints. The participants in the groups are listed in Table 2.

[Table 2 about here.]

Data collection: introducing a problem-based approach

The groups met for approximately two hours on seven occasions each, with the first meeting extended by one hour to introduce the participants to the study and to the principles of problem-based learning (7-8). This approach involves that the participants will contribute in setting the agenda, which involves posing questions they want to work on, based on their own experiences. Problem-based learning was used as a pedagogical tool to structure the meetings, where the educational goal for the participants was to develop cooperative strategies across organizational borders. A tutor was assigned to the groups to help them to structure the meetings and to function as a facilitator in the discussions. One researcher also attended the group meetings, primarily as an observer but at some points also as a resource person providing information about research in the rehabilitation field.

At the first meeting, the participants were asked to choose from a selection of newspaper articles about the recent changes in the Swedish sickness insurance system to provide a starting point for their discussions. At subsequent meetings, no such starting points were introduced; instead, the groups ended each meeting by posing a question for discussion at the next meeting. The discussions dealt with a multitude of topics over time, such as the consequences of policy changes; the relationship between sickness insurance and labour

market policies; work ability assessments; the participants' working conditions and relationship with managers; and cooperation within and between organizations.

The groups met from February to May 2009. All group meetings were documented in several ways: all meetings were recorded and transcribed verbatim; notes were taken by both the participants and the researcher, both during and after the meetings; whiteboards were used during meetings, and then photographed and sent out to the groups; all group members were also given a notebook for their personal reflections, which on some occasions were used as input for discussions.

There were several reasons for the use of problem-based learning. Firstly, this was done in order to give the participants a purpose for the meetings; the idea was that they would benefit from meeting and working with other professionals in a structured way. Using problem-based learning as a method for professional development contributes to illuminating and systematizing informal and tacit knowledge (9), and since the scenarios used are often not very structured (such as discussing a newspaper article), the method is suitable for learning to handle equally unstructured problems in practice (8).

As a research method, problem-based group meetings result in a rich material that is open for analyses at several levels and from different disciplinary perspectives. Since the groups meet several times, a process perspective is also added, providing the opportunity to study group development and learning. Compared with focus groups or group interviews, this method provides less static and more in-depth knowledge about the participants' reality. Further, the approach enables the participants to develop practical knowledge from participating in the study (10).

Analysis

The analysis was performed according to the principles of qualitative content analysis (11). Since the study involves a rich material, a broad variety of issues was covered with several possible paths for analysis. The first step was thus to make a preliminary categorization of recurrent issues in the material (i.e. open coding (12)). This was done manually, using highlighters in different colours, and cutting and pasting. The comprehensive documentation (the researcher's and participants' notes, photographs of whiteboards etc.) facilitated the reading of the lengthy transcripts from the group meetings and was used to form questions to guide the categorization.

The initial categorization was then discussed with the co-authors until agreement was reached on a thematic structure that was well grounded in the empirical material and that showed satisfactory internal homogeneity and external heterogeneity (i.e. the themes were well defined and did not overlap) (11). After this, specific themes were chosen for in-depth analysis (i.e. selective coding, (12)). For this article, the specific themes chosen focuses how representatives from different public rehabilitation actors experience cooperation in work ability assessments and how they perceive that the recent policy changes have affected their practical work.

The analysis was conducted primarily through an inductive approach in which the group discussions were interpreted without using a predetermined theoretical framework. The theoretical perspectives used in the article were consulted after identifying central themes in the material, where literature on the concept of work ability was used as a relevant framework.

The results were later presented to the study participants and to the managers from the organizations represented to ensure the validity of the conclusions.

Results

The participants' discussions in this study concerns two distinct phases in the sickness insurance system: the early return-to-work oriented phase, and the later labour market reintegration phase.

The return-to-work phase: work ability assessments as a public affair

Because work ability is a central concept for decisions on eligibility for sickness benefits, these assessments must be performed accurately. However, there are several ways of assessing a person's work ability, incorporating a different number of factors (e.g. medical, psychological or social). Work ability assessments are performed by health care and the Social Insurance Agency, and different definitions of the concept may prevail.

At the initial phase of a sickness insurance case, a physician assesses the individual's functional ability, most commonly in primary health care. In the medical certificate, the physician also suggests whether the functional disability will decrease the person's work ability, for which the physician needs to have an idea of the characteristics of the person's work tasks. The following quote illustrates how this may be complicated, because one occupation may have very different working conditions.

Health care coordinator: That there is someone on the person's surroundings who asks "describe your work, how is it done", because you are surprised. We had one; this guy who filled a hundred kilos a day, and that was his only task as a painter. "What do you do as a painter?" "I fill." And he filled this sand fill, a hundred kilos a day, and he had such terrible pain in his shoulder. Another guy who was a painter, "what do you do when you paint", and "I only paint bases". He was on his knees all day painting bases. Well, of course your knees hurt.

This example illustrates how difficult it is for health care workers to assess whether a person is able to continue their work or not, based only on a short visit to a health care centre. Because the health care workers cannot observe the individual at work, the assessment is dependent on their ability to ask the right questions, and that they can trust the individual's description of their working conditions.

In a strict sense, health care is only supposed to assess the individual's level of functioning, which is then formally transferred into an assessment of work ability by the Social Insurance Agency. However, the physician's medical certificate is the basis for this assessment. It is thus interesting to ask who has the competence to assess work ability. The following quote indicates that the Social Insurance Agency officials do not consider that they have enough competence to do so.

Social insurance official: We have to translate this certificate to what work ability it generates. And it's not sure that the physician, it's not the physician's task to describe that, it's us who are supposed to consider on the basis of the certificate if there is a work ability or not. And it's not easy for us laypersons to do.

The official in the quote speaks of herself as a layperson in assessing work ability, and yet it is this person who has the formal task of performing this assessment. Apparently, the officials at the Social Insurance Agency are given a task they do not feel competent enough to fulfil.

Social insurance official: As an official, I'm not supposed to ask the physician if the person has a work ability. I'm only supposed to ask, "what is the functional ability?". Then it's my role – because it says so in our profession – to assess on the basis of the physician's description how it decreases the work ability. And it becomes, it gets ambiguous. Because I don't really have the competence to assess work ability.

More specifically, the officials at the Social Insurance Agency state as problematic their lack of knowledge of working conditions and how the different factors that limit work ability can and should be weighed. According to the regulations, the officials are to limit their

assessment to medical factors as the only valid cause for limitations, although there may be other, more socially oriented factors that influence an individual's situation. Since physicians in general tend to include a broader set of factors in their certificates, the Social Insurance Agency officials have to deal with sorting out the factors that permit or deny eligibility to sickness benefits. In doing so, they may consult insurance medicine counsellors, but they are in turn even further detached from the individual's working conditions because they do not meet the individual.

Social insurance official: ... it's tricky. Then you hope to get help from the insurance physician, the insurance medicine counsellor to clear it up, to help you find out what's what.

Tutor: Is that where you go for advice?

Social insurance official: Exactly, when I want to get to the bottom of it, the medical and to be able to decide what to do.

Tutor: Help with not seeing all the other things?

Social insurance official: Exactly, yes.

Cooperation needs in the return-to-work phase

Since the sickness insurance system only focus on return to the previous workplace during the first 180 days, cooperation with employers and occupational health care is an important issue to make return-to-work possible within this time frame. However, these actors are perceived as disinterested as long as the public system cannot offer financial incentives for participation. There is a general view among the participants that employers can easily escape their responsibility for rehabilitation. Employers only need to state that they have no possibilities of returning their employee to work, after which there are no further opportunities for the Social Insurance Agency to act.

Social insurance official: ...it's enough [for an employer] to state in a meeting that they've done what they can and that there's nothing else, and then we can submit a note and that's enough for us.

Health care coordinator: So the employer doesn't need to declare what they've done?

Social insurance official: No, well, they probably do in the meeting, but they don't have to. [...]

Employment service official: My take on that is that it's too easy for employers to get rid of people. You need a clearer, deeper account of what actually has been done to save someone's job.

Tutor: Are there too little demands on the employers?

Employment service official: That's my experience.

Lack of cooperation between the public authorities and employers is perceived as the weak link in the process of rehabilitation and return-to-work, and possibilities of workplace adjustments are easily missed due to communication failures. Similarly, there is a lack of communication between primary health care and occupational health services, where secrecy is perceived as a hindrance for cooperation.

Health care coordinator: The problem is that the occupational health services don't have physicians in the way they used to. If they [people on sick leave] have their certificates from [the occupational health service], then we [in primary healthcare] don't have any information on them. And we're also supposed to take those who come from psychiatry, and we have to refer them back since we don't have access to their journals. There's a level of secrecy that we cannot get around.

In addition, all employees do not have access to occupational health services, which means that they most likely will be sick-listed by physicians in primary health care, who generally do not have knowledge about the working conditions of the workplace. The participants in this study also claim that the communication between primary health care and occupational health services is limited.

Tutor: So there's no assessment of the work task on site?

Health care coordinator: Not from health care, no. Then you're referred to the occupational health services. And we in health care, if we see that it's a work-related problem, we try to refer the patient to occupational health. But there are also limitations, for instance how much the employer buys from the

occupational health services. They may not buy that the physician shall write sickness certificates, for instance. It's hard. And we as coordinators have a large role in trying to create a dialogue, but it's not easy.

The occupational therapists in primary health care claim that they are not allowed to – or are not supposed to – visit workplaces, since this falls under the responsibility of occupational health services. However, when an individual is sick-listed in primary health care and there are no occupational health services, this implies that there is no professional in the system who observes the individual at the workplace.

Occupational therapist: It's quite tragic that we in primary health care are not allowed to do workplace visits. Me and two other occupational therapists got the opportunity to take a course on analysis of work demands, and we almost out of mercy were allowed to test it on a few patients, to go out to the workplaces and test, and I mean, it brings you so much.

Psychiatry: But why aren't you allowed to do that? [...]

Occupational therapist: Well, it's different you know, it's the occupational health services... [...] It's a big difference what's the occupational health's role and what's my role is when I do an analysis of work demands. My role isn't to look at what accommodations that we could do for a person, because that's the occupational health service's role. My role is to look at what demands this job puts on a person and to put that in relation to the person's functional ability and medical problems; does this work together?

There seems to be a divide between the Social Insurance Agency and primary health care on the one hand and the employers and the occupational health services on the other. There are no routines for cooperation across this divide. This in combination with policies in primary health care against workplace visits leads to limited workplace rehabilitation and on-site assessments.

The labour market reintegration phase

After 180 days on sick leave, the worker's work ability is to be assessed in relation to the labour market at large, which implies that the focus is shifted from return-to-work to labour

market reintegration. In this phase, the earlier assessment of work ability may prove to have little in common with employers' demands. Basically, this may be seen as a transfer from work ability to employability: employers may not want to hire a person, even though he or she has been assessed as able to work, if the person lacks relevant competence. Both these concepts are highly interrelated to the situation on the labour market; in bad times, there are fewer jobs, which makes the competition tougher.

Health care coordinator: And then the development on the labour market. I'm thinking about those I've met who had been odd-jobbers more or less, in a workplace, sweeping the floors, carrying mail, watering flowers, this and that. And the social competence was perhaps not the best. But it worked there, in that small family business where you believed in them. But as soon as they got kicked out of there they were toast, because in our groups where we were to test their work ability, they really made a mess. [...]

Employment service official: Yeah, I'm thinking about this with employability. I mean, it takes – an important thing is that there is an employer who is willing to pay for what this person can do. I think that's where it's at. If someone's willing to pay me for standing on the street playing my lip, well then I guess I'm employable for that.

Employability is a context-bound concept, depending on what employers need at a certain place at a certain point in time. This has little to do with how the Social Insurance Agency assesses work ability: when assessing work ability after 180 days, social insurance officials are expected only to consider the medical function and are not allowed to take age, education, place of residence or working life experience into account.

The ultimate goal for the rehabilitation process, according to policy, is that the individual shall return to work with full work ability within the time frame of the Rehabilitation Chain. However, the participants in this study expressed concerns about whether this is feasible for all individuals. Those who are not able to finish their rehabilitation in time lose their sickness benefits and are transferred to the Public Employment Service where they have to compete with people with full work ability. In addition, the policy changes were introduced shortly before the financial crisis of 2008, which resulted in a dramatically deteriorated labour market

with increasingly tough competition over jobs. This situation causes the participants in the study to question the goal of the rehabilitation process.

Social welfare official: ...if there's no job for this ability, then I feel that we're fooling people, to fire them up and be positive and work with them, and then there's no possibilities.

The participants see few practical possibilities and no actual end point for rehabilitation of the more complex cases. In the quote above, the participant expresses that it feels like they are fooling the individual when arguing for a goal that is not possible to accomplish. This involves the risk of backlash, where the individual falls back into sickness.

Health care coordinator: I have a man with a troublesome past, a drug addict who prior to that worked as a welder for twenty years and got a disk displacement, went to sick leave, alcohol abuse, depression following that. Then in some way he changed his life, got off his addictions and has found a 75% work ability. And he's so proud of his job, he's a wood worker, and enjoys it. So he's really succeeded. But then there's no employer to hire him, and what will happen to him? The last thing he told me was "the social welfare office, I'll never set my foot there". It was humiliating for him when being assessed as having a 75% work ability; he has no unemployment insurance, what will happen to him? He can tip back over night.

Employment service official: That's a great example. That's the biggest dilemma we have to face. [...] There's something missing, a "what happens next?". [...] When you come to this, when you've worked up an ability and motivation to pull from and you're so close to the goal, you're finally "normal". Finally, but too bad. So close, but there was no employer to hire you.

Most participants expressed that there are no alternatives for those who are not able to cope with the competition on the labour market. For instance, those who due to the changed regulations have had their temporary disability pension withdrawn generally have decreased work ability. The participants express a wish for more alternative employment structures, such as sheltered workshops or other forms of subsidized employment. The participants generally claim that the availability of these alternative forms of employment have decreased considerably in recent years.

Employment service official: That's a clash I've been thinking about since last time. When we assess sheltered employment, for instance. There's no such thing. You're put in a queue for something that's not available, because you assess by old rules. Sometimes we get documents where someone has assessed sheltered employment, and the person has been waiting for fifteen years or something. But they will never get there, and we still get these indications to do these assessments, put them in line. It doesn't feel realistic for me to do so.

The participants in the study experience an increasing gap between the sickness insurance system and the labour market, especially concerning those with low work ability who are not work disabled enough to receive a disability pension. The participants expressed concerns that the introduction of the Rehabilitation Chain implies that these individuals will not be able to provide for themselves when they lose their sickness benefits.

The results of this study are summarized in table 3, where the participants' view of the relevant actors, relevant competencies and cooperation needs are described, as well as factors for and obstacles to successful rehabilitation.

[Table 3 about here.]

Discussion

A prominent feature of the reformed sickness insurance regulations is the shift of focus from return-to-work to labour market reintegration. From a political perspective, the idea behind the reform was to speed up the return-to-work process and to promote activation through an earlier focus on job mobility. This study shows that employers are regarded as passive and non-contributing in this process. Employers have through the new regulations gained an opportunity to sidestep their responsibility for returning workers by staying passive for 180 days, after which the system has the full responsibility for the person.

The two phases in the rehabilitation process put different demands on all of the involved actors. The participants in the study raise a number of concerns regarding these two phases, where the most emphasized are the lack of competence to assess work ability, the lack of cooperation with employers and occupational health care, and the limited possibilities for work disabled people to compete on the labour market.

It is notable that the social insurance officials do not feel competent in assessing work ability. It is also notable that the officials do not make contact with employers or occupational health services, who could provide the information that is necessary to make reasonable assessments. Instead, they rely solely on physicians' medical certificates, which are based on medical status rather than working conditions. Thus, the basis for decisions of eligibility for sickness benefits is weak, which is troublesome from a legal perspective.

As the OECD notes in a report, the sick-listing process focuses more on eligibility to benefits than on activation and return-to-work (13). The new policy framework, further, "requires good cooperation and continuous information exchange to continue" (13, p. 42); this study indicates that this is not the case with regard to the assessments in the return-to-work phase of sick leave. According to Loisel et al. (14-15), work disability management need to take into account the situation at the workplace as well as personal and medical factors and the compensation system for the return-to-work process to be purposeful. The sickness insurance reforms have primarily targeted the compensation system in controlling in- and outflow from sickness benefits, while the importance of involving the workplace arena has been disregarded.

What is disregarded in work ability assessments?

In current practice, work ability assessments are based on physicians' initial assessment of functioning in medical certificates. This assessment is in turn based on the definition of functioning in the International Classification of Functioning (ICF) given by the WHO (16), which, as noted elsewhere (17), offers a broader definition than the one used by the Social Insurance Agency. ICF, for instance involves social and contextual factors which the insurance system are not expected to take into consideration. Because the definition of functioning, and subsequently work ability, differs between the actors, this is a possible cause for conflict within the process of assessing work ability.

The broader perspective on work disability suggested by Loisel et al. (14-15) is to a large extent in line with Nordenfelt's analysis of work ability, in which he distinguishes between a number of factors that together make up a person's ability to work on a specific task, such as personal competence, motivation and health status (18). Nordenfelt concluded that a person's work ability needs to be assessed holistically, involving the context of sickness insurance as well as the person's qualifications and the characteristics of the work task. The results of this study suggest that the biomedical perspective prevails in the sickness insurance system, which implies that other factors that may contribute to a person's work ability are disregarded.

When comparing the Swedish sickness insurance regulations to those in other countries, the focus on medical factors for work disability is notable. As Hedborg notes, it is uncommon that a system disregards other factors as thoroughly as the Swedish does (19). The other Nordic countries (i.e. Norway, Denmark and Finland) permits long-term benefits for other reasons than strictly medical, where the possibilities for the individual are taken into account, including factors such as education, working life experience and age (19).

The return-to-work phase: is it possible to involve employers and occupational health care?

There is scientific evidence that well-functioning cooperation between health care, employers and the compensation system is effective for shortening the sick-leave period and for facilitating return-to-work (20-21). However, in the Swedish sickness insurance system there is a general lack of clarity regarding the responsibilities of the employers and occupational health services. This study highlights this ambiguity by elucidating flaws in the cooperation between the public system (the Social Insurance Agency and primary health care), employers and occupational health services in return-to-work due to the lack of regulations on employer responsibilities, which leaves them outside the cooperation domain.

According to regulations, the Social Insurance Agency's contact with employers is supposed to take place within the first 90 days of sick leave through a meeting, at which the return to work is discussed. Because this is generally the first contact with the employers – often months after the person's work ability is assessed – the workplace perspective is often absent in work ability assessments. The noted absence of policy and guidelines in securing employer involvement is reinforced by a report from the Swedish National Audit Office, in which it is noted that the Social Insurance Agency does not prioritize employer contacts, and there is a general lack of routine in collecting information from employers (22).

Occupational health services are generally not involved in the return-to-work phase of sick leave, and cooperation with primary health care – where most people go to get medical certificates for sick leave – is lacking (23). In Sweden, 65% of employees state that they have access to occupational health services (24). However, much of these services is directed towards prevention and health promotion, or to rehabilitation in the later phases of return-to-work. In the 1990s, governmental support for occupational health services to participate in rehabilitation was withdrawn, which caused a considerable decline in the use of such services

(25). Further, many workers do not have access to occupational health services because such services are not obligatory for employers. The level of service is therefore dependent on the amount that employers invest in such services.

Employer incentives for participation in rehabilitation and return-to-work are generally low in the Swedish system; employers are often passive in this process, specifically regarding early return-to-work (cf. 26). According to legislation, the Swedish system has structures for ensuring that employers take responsibility for rehabilitation (in the Work Environment Act and the National Insurance Act), but in practice, this responsibility is not observed (27). As this study suggests, the recent change of regulations have further decreased employers' incentives for engaging in rehabilitation.

The results of this study illuminates that there are virtually no cooperation structures in work ability assessments between health care and the Social Insurance Agency on the one hand and employers and occupational health services on the other. Thus, there are few opportunities of involving employers and occupational health care into the return-to-work phase which imply that the possibilities for return-to-work within 180 days are limited, especially for those with complex problems.

The labour market reintegration phase: a Sisyphean task?

As discussed, the current system promote a fast shift of focus from return-to-work to labour market reintegration. In the labour market reintegration phase, the relevant actors change, as does the relevant competencies and needs for cooperation. Where the return-to-work phase required communication with employers and knowledge of working conditions, this later phase put more demands on the officials' therapeutic and motivational skills and their

knowledge in vocational training and guidance. Here, the Public Employment Service replace the employers in trying to bring the sick-listed worker back to the labour market. In this phase, the officials at the Social Insurance Agency are not allowed to take into account the worker's age, education or working life experience when assessing work ability, which implies that most people will be assessed as able to work and hence lose their benefits.

The participants in the study notes how the changed regulations imply that an increasing number of people who previously were considered work disabled now are required to look for jobs on the open labour market. Since the possibilities for placing these people in subsidized or alternative employments are scarce, the task of motivating these people is perceived as hopeless due to their lack of employability. Motivating them to look for jobs is not considered realistic, nor ethical.

One consequence of the changed regulations is that an increasing number of people reaches the new ending point in the sickness insurance system (365 days). In a report on where these people have gone, it is concluded that after six months only 2,5 % have a regular job on the labour market; 7 % have subsidized or supported employments; 41 % returns to sickness insurance after a waiting period, while the rest are either unemployed or not identifiable in the statistics (28). Taking this into consideration, it is reasonable to assume that the disenchantment expressed by the participants is valid.

Methodological considerations

The results of this study reflects the perceptions of a limited number of professionals. This implies that the results should not be interpreted as generally reflecting the studied organizations. However, there are no reasons to assume that the results from this study are

unique to its participants; they represent authorities and public organizations, and the issues discussed (such as work ability assessments and labour market reintegration) are widespread in a Swedish and an international context. Further, the participants in the two groups expressed similar concerns regarding the changes in regulations, work ability assessments and cooperation needs. It may thus be argued that the results from this study may be transferable to other similar contexts.

The validity of the study was strengthened by allowing the participants to set the agenda for the meeting; this reduces the risk for the researcher influencing the topics discussed. Using a pedagogical approach helped the participants to structure the meetings to focus on topics they observed as relevant for their situation. The continuous group meetings also made it possible to attain a more in-depth discussion that was allowed to evolve over time. The validity was further strengthened by the continuous discussions about the material among the co-authors; by reporting results back to the participants through a meeting where participants from both groups could discuss the findings; and by reporting back and discussing the findings with two groups of managers: one in each participating municipality.

Conclusions

The Swedish sickness insurance system has undergone dramatic changes over the last years, with a shift of focus from return-to-work to labour market reintegration through a fixed time schedule as the most prominent feature. This study highlights how these changes put new demands on cooperation between social insurance, primary health care, occupational health care and employers, and that these demands are not met in practice. Employers are perceived as passive in this process, and the possibility for employers to sidestep their responsibility has increased.

An increasing number of people previously assessed as work disabled are according to the new regulations required to participate in a labour market reintegration process. This puts demands on professionals to engage in motivational and therapeutic activities for this group, although this is perceived as a hopeless task due to the group's lack of employability.

The results of this study also show that officials at the Social Insurance Agency do not consider themselves competent in assessing work ability, which implies that decisions rely heavily on medical certificates issued by physicians. Because of a general lack of communication and cooperation between the public system (the Social Insurance Agency and primary health care), employers and occupational health services, these certificates are based on assumptions rather than actual observations of the individual at work.

In sum, the lack of cooperation between relevant actors and the lack of relevant competence undermine the ambitions of the reform.

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Table 1 Swedish sickness insurance

Time period	Work ability assessed in relation to	Focus of process	Replacement ratio	Cost bearer
2-14 days	N/A	N/A	80%	Employer
15-90 days	Present work task	Return-to-work	77,6%	Social insurance
91-180 days	Alternative work tasks with the same employer	Return-to-work	77,6%	Social insurance
181-365 days	Labour market at large	Labour market reintegration	77,6%	Social insurance

Table 2 Participants' organizational background

Group 1	Group 2
Social insurance official	Social insurance official
Employment service official	Social insurance official
Occupational therapist, primary health care	Social insurance official/cooperation team
Coordinator, primary health care	Employment service official
Psychiatry	Coordinator, primary health care
Social welfare official	Coordinator, primary health care
Municipal rehabilitation service	Social welfare official/cooperation team
Municipal human resource manager	

Table 3 Phases in Return-to-work and Labour market reintegration

	Return-to-work phase (<180 days)	Labour market reintegration phase (>180 days)
Relevant actors	Health care physicians, insurance officials, employers, occupational health services	Insurance officials, employment services, (physicians and paramedics)
Relevant competencies	Medical knowledge, insurance regulations,	Terapeutic and motivational skills, vocational training,

	knowledge of workplace conditions	knowledge about labour market demands
Cooperation needs	Healthcare – insurance – workplace – occupational health services	Insurance – employment service – labour market actors
Factors for successful rehabilitation	Communication with employer, medical condition, work ability, social context	Motivation of the worker, employability, social context, medical condition
Obstacles to successful rehabilitation	Lack of competence in work ability assessments, non-cooperative health care policies, lack of employer incentives, time pressure, lack of occupational health services	Motivation of the worker, unemployment, competitive labour market, lack of alternative employment, financial worries