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Linköping University Post Print

N.B.: When citing this work, cite the original article.

The original publication is available at www.springerlink.com:

Kerstin Ekberg, Charlotte Wåhlin, Jan Persson, Lars Bernfort and Birgitta Öberg, Is Mobility in the Labor Market a Solution to Sustainable Return to Work for Some Sick Listed Persons?, 2011, Journal of occupational rehabilitation, (21), 3, 355-365.

http://dx.doi.org/10.1007/s10926-011-9322-4

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http://www.springerlink.com/

Postprint available at: Linköping University Electronic Press http://urn.kb.se/resolve?urn=urn:nbn:se:liu:diva-70023 Is Mobility in the Labor Market a Solution to Sustainable Return to Work for some sicklisted persons?

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Running head: Mobility in the labor market and return to work

Abstract

Aim: The study aims to identify characteristics associated with long-term expectations of professional stability or mobility among recently sick-listed workers, and to study whether expectations of professional mobility and turnover intentions were associated with duration of sick leave. Methods: A cross-sectional study was performed on baseline measures in a prospective cohort study of patients who were granted sick leave due to musculoskeletal (MSD) or mental (MD) disorders. A total of 1375 individuals fulfilled the inclusion criteria. A baseline questionnaire was sent by mail within 3 weeks of their first day of certified medical sickness; 962 individuals responded (70%). The main diagnosis was MSD in 595 (62%) individuals and MD in 367 (38%). Results: Expectations of ability to remain in the present profession in 2 years was associated with better health and health-related resources, younger age, higher education, and better effort - reward balance. Effort-reward imbalance, MD, high burnout scores, and better educational and occupational position were associated with turnover intentions. Low expectations of ability to remain in the present profession defined two vulnerable groups with regard to RTW, those with no turnover intentions were older, had lower personal resources, often MSD, and slower RTW rate. Those with turnover intentions had a clear effort-reward imbalance and high burnout scores. Conclusions: The results of this explorative study underline the importance of differentiating RTW- interventions based on knowledge about the sick-listed person's resources in relation to the labor market and the work place, and their expectations of future employment and employability.

Keywords Return to work; Expectations; Job stability; Turnover intention, Return to work, Survival curves

Introduction

Interventions to promote return to work after sick leave commonly aim for return to the specific job from which the individual was sick listed. A number of studies have shown how interventions at the workplace contribute to return to the original job [1–4]. These interventions are appropriate for many workers, and contribute to the fact that most people on sick leave resume work within a limited amount of time.

In a recent study [5], about 20% of a population seeking occupational health services for mental disorders (MD) or musculoskeletal disorders (MSD) were assessed by rehabilitation professionals and found to need a new job in order to be able to return to work. The specific jurisdiction and social insurance regulations and practices in different countries may hinder return to the original job after longer sick leave, and in most welfare systems there is no direct path from sick leave to a new job. Some countries give the employer the opportunity to fire employees on sick leave after a specified duration of sick leave (after 6 – 12 months in Sweden), independent of diagnosis. In practice, this regulation gives the employer the freedom to choose which employees on sick leave they support in return to work by implementing work place accommodations, for example.

Evidence-based knowledge is still lacking, in particular for persons on long-term sick leave due to poor mental health, on prognostic factors of long-term disability and return to work [6]. Several contributing reasons have been suggested, not only medical, to why about 20% of those on sick leave have difficulties in returning to their original job. MacEachen et al. [7] identified 5 potential explanations for long-term sick leave, including health problems and the individuals' ability to cope with these symptoms, interaction with inefficient health care systems, problematic relationships between the worker and the workplace, rigidity in rehabilitation welfare systems, and lack of knowledge among sick-listed individuals about their rights and responsibilities. Deficits in the

welfare system mean that some people on long-term sick leave may experience a combination of these factors. [8]. Such deficits was labeled by MacEachen et al. [7] as "a toxic dose of system problems". As suggested by Schaufeli et al. [9] for burnout patients, imbalance or deficits in interactions may lead to individual resource loss over time. Shirom et al. [10](p.289, ref. in [9]) described this process as an escalating spiral of losses. This reasoning may be extended to sick-listed individuals in general in relation to rehabilitation stakeholders, deficits in the communication and coordination of rehabilitation measures may result in a cumulative depletion of self-efficacy and mental resources for sick-listed individuals, with negative effects on expectations and motivation to return to work.

A well-established predictor of future health and return to work is the sick-listed person's own expectation of future return to work [11-14]. In a systematic review, Mondloch et al. [15] found consistent associations between patients' recovery expectations and health outcomes. Previous experience, vicarious learning, verbal persuasion, and social support are, according to Mondloch et al. [15], all thought to contribute to recovery expectations and may emanate from how interactions with the welfare and health care systems, and the work place have been. Self-efficacy [16] seems to be central for expectancies to return to work, as also found by Shaw et al. [17]. In their study hesitation about return to work after sick leave for low back pain was due not only to pain and reinjury but also the perceived ability to perform job tasks, meet role expectations, obtain workplace support, and maintain financial and job security. As shown by Tjulin et al. [18] attitudes and behaviors at the work place may be more or less supportive of return to work of an injured worker, supervisory competence and involvement is crucial [19-21] and may thus also influence expectations of return to work.

In interventions aiming to promote return to work, it thus seems plausible to consider whether the worker on sick leave is expecting to be able to return to the original job. Changing job may be health promoting for people who are not satisfied with their present job or suffer from ill health due to their job [22, 23, 24]. Not being able to change job despite wanting to do so has been labeled a locked-in position [23], and is associated with increased risk for ill health [23,25].

Expectations about remaining in the same profession may be an important determinant for openness to job mobility. Janzen et al. [26] suggested that beliefs and experiences are antecedents of expectancies, whereas attitudes, behavior, and cognitive processing are consequences of expectancies and important for the individual's actual ability to work. Experiences of pain, exhaustion, or dissatisfaction with work conditions may influence expectations of ability to work, and willingness to change job. Seeking another job while on sick leave may however be perceived as strenuous and risky from a financial and job security perspective, although it may be important for improving health. Expectation about changing job or profession among sick listed persons has not been studied, but may be important for how intervention programs aiming to promote work ability and return to work are designed.

The aim of this study was to identify characteristics associated with long-term expectations of health-related ability to stay in the same profession among workers recently sick listed due MSD or MD. A second aim was to study whether these expectations of professional stability, and turnover intentions (desire to change job) were associated with duration of sick leave. The underlying hypothesis was that sick listed persons with expectations of professional instability and with turnover intentions, i.e. those with lower attachment to the work place, are less motivated to return to work and have longer sick leave duration.

Research Design and Methods

This study was a cross-sectional study performed on baseline measures in a prospective cohort study. Cases were patients who were granted sick leave due to musculoskeletal (MSD) or mental (MD) disorders at 39 primary health care centers and 4 occupational health care centers in the county of Östergötland, Sweden. Östergötland has about 450,000 inhabitants and is representative of Sweden socioeconomically. Patients seeking primary health care are representative of the study population in general.

Subjects were recruited consecutively from June 2008 to December 2009, and their sick leave records were followed for 1 year after inclusion. The research team recruited patients by scanning the computerized case records of all patients who obtained a sick-leave certificate at the health care centers. Inclusion was based on the ICD-10 diagnosis in the sickness certificate issued by the physician. Each individual was then recruited by telephone. All patients were given written and verbal information about the study before giving their consent to participate.

The inclusion criteria for participation in the study were age between 18 and 65 years, ability to communicate in Swedish, and on sick leave due to a main diagnosis of MSD or MD, including depression. Exclusion criteria were sick leave for the same diagnosis in the previous month or sick leave due to a psychiatric diagnosis such as schizophrenia and psychotic disorders, neurologic disorders, rheumatic disease, fracture, or pregnancy.

The study was approved by the Regional Ethics Committee in Linköping.

Study Population

A total of 1375 sick-listed individuals fulfilled the criteria and agreed to participate. A baseline questionnaire was sent by mail to all participants and 962 individuals responded to the questionnaire

(70%). The average age was 46 years (SD 11 years), 262 (30%) were men and 621 (70%) were women, 20% had attended mandatory schooling, and 26% had a university education. In total, 595 (62%) had a musculoskeletal condition as the main diagnosis and 367 (38%) had a mental condition as the main diagnosis. White-collar professions were more common in the group with MD (43% vs 16%), pink-collar professions were equally distributed between the 2 groups (MD 42%, MSD 40%), and blue-collar professions were more common among those with MSD (43% vs 15%). In the present analyses, only participants with employment on the inclusion date (*n*=849) were included.

Non-response Analysis

Those included in the cohort were compared with the 413 non-responders for the parameters that were accessible. There was no significant difference in the distribution of diagnoses between the cohort members and the non-responders, but there was a tendency to a better response rate among those with MSD (p=.071). The 2 groups differed in age (p<.001); non-responders were younger (mean 42 years, SD 11 years) than respondents (mean 46 years, SD 11 years) with a higher proportion of non-responders among those younger than 39 years of age; the proportion above 50 years of age was higher among respondents. The proportion of men was higher among non-responders (35%) than among respondents (29%) (p<.014). There was no difference between respondents and non-responders in return to work rate during the 1-year follow-up period (p=.807).

Data Collection

Data for the present analyses was collected from the patient questionnaires and register data on sick leave from the Social Insurance Office.

Questionnaires

All cohort members responded to a baseline questionnaire within 3 weeks of their first day of certified medical sickness, which in practice means that they had been on sick leave for about 4 weeks, as the first week on sick leave does not require a doctor's certificate in Sweden. The baseline questionnaire comprised questions on demographic data, employment situation, and socioeconomic status. Questions on lifestyle, health, work ability, coping, work conditions, and prospects for future work were also included.

Expectations of Health-Related Professional Stability

Expectation of professional stability was measured using one item in the Work Ability Index (WAI) [27]: "Considering your health, do you think you can work in your present profession in two years?"

Turnover Intention

Turnover intention was measured using the exit subscale of the EVLN instrument (28). This scale consists of 6 items (e.g., "Consider possibilities to change job") and the response scale is a 7-point Likert scale. The instrument was validated by [28] and the psychometric properties were found to be satisfactory in a Swedish context [29]. Liljegren et al. [24] found a significant association between turnover intentions measured with the exit scale and actual exit behavior. Individuals having an average score of at least 4.5 on the 7-step exit scale were regarded in the analyses as having turnover intentions.

Health

Generic health-related quality of life (HRQL) was measured using the self-administered instrument EuroQol (EQ-5D) [30, 31]. It consists of 5 dimensions that describe HRQL in terms of mobility, self-care, usual activity, pain or discomfort, and anxiety or depression. Each dimension is divided into 3

levels: no problems, some problems, and severe problems. A global score, ranging from 0.59 (worst imaginable state) to 1.0 (perfect health) (zero corresponds to being dead) can be assigned to the 243 different states attainable from the EQ-5D. Global scores are assigned using a tariff based on a general population study in the United Kingdom [32].

Self-rated health was measured with the EuroQol visual analogue scale (EQ-VAS) [30]. The purpose of the self-rating scale is to measure overall health; the respondents rate their current physical and mental health state on a scale ranging from the worst state you can imagine (0) to the best state you can imagine (100).

The Shirom Melamed Burnout Questionnaire (SMBQ) has 22 items graded from 1 to 7 measuring symptoms such as physical fatigue, tension, emotional exhaustion, listlessness, and cognitive difficulties [33]. High scores indicate more symptoms. The overall burnout index (SMBQ-Global) was used when summarizing the score. High level of burnout on the SMBQ has been defined as a mean value \geq 3.75 and a low degree of burnout as a mean value \leq 2.75.

The Pearlin Mastery Scale [34] is a 7-item scale of self-concept and refers to the extent to which individuals perceive themselves in control of forces that significantly affect their lives. Each item is a statement regarding the respondent's perception of self, and respondents are asked how strongly they agree or disagree with each statement. Four response categories are allowed from strongly disagree to strongly agree. The overall index was calculated by summarizing the score.

A modified version of the Zung Self-Rating Depression Scale (ZSDS) measures the current severity of depressive symptoms [35]. The scale covers affective, psychological, and somatic symptoms. The 23 items have a 4-point range where 1 is equal to "some" and 4 is "most of the time", and a total score of 0–69, with 0 representing no signs of depression. The overall index was calculated by summarizing the score.

The first item of the WAI, "current work ability compared with life-time best", was used to analyze the employees' self-rated work ability [27]. Several studies have shown that this item has predictive ability for sick leave [36, 37].

Work Conditions

Effort-reward imbalance (ERI) at work was measured using 3 scales [38, 39]. Effort is based on 6 items dealing with aspects of the work environment that are perceived as demanding. The scores range from 5 to 25, with high scores indicating high effort. The reward scale is based on 11 items measuring esteem, salary/promotion, and job security. The score ranges from 11 to 55; the lower the reward score the lesser the perceived reward at work. The ratio of effort/reward indicates imbalance at work when the ERI quota is ≥1 [38]. Over commitment (OC) was assessed by 6 items measuring patterns of coping with work demands. The total score for OC varies from 6 to 24, where a high score indicates that the subject is likely to experience OC at work [38, 40, 41].

Profession was coded according to the Swedish standard for occupational classification (Statistics Sweden) with 9 occupational groups categorized into white collar (managers, academics, etc.), pink collar (care, service, salespersons, etc.), and blue collar (industry, etc.).

Register Data on Sick Leave

Sick leave for each individual was recorded at the Social Insurance Office. This register was established for administrative purposes and not for research. For each individual, the dates for the start and end of sick leave were registered during the 1-year follow-up period. Duration of sick leave was computed as the number of calendar days of absence due to sickness within 1 year from inclusion in the study until first return to work.

Statistical Analyses

Descriptive statistics are presented as mean and standard deviation for continuous variables and proportions for categorical variables, to describe the characteristics of the outcome and explanatory variables. Group comparisons on categorical variables were analyzed using Pearson's χ^2 -test. Student's *t*-test, and ANOVA or ANCOVA was used to analyze group differences on continuous variables.

Survival analysis was performed based on Kaplan-Meier plots and Cox´ multivariate regression analysis with time to first RTW, full or partial, as the dependent variable. Data was censored at 365 days. Potential confounders were entered and removed in the regression model using a forward stepwise procedure. All *p*-values were two-sided and considered to be statistically significant if <.05. All analyses were performed using the statistical software package SPSS (version 17.0; SPSS Inc., Chicago, IL).

Results

Expectations of Remaining in the Same Profession in 2 Years

A total of 412 participants (59%) expected to remain in their present profession in 2 years. This group were on average younger (p<.001), had a higher education (p<.001), white-collar occupations were more prevalent (p=.006), and they experienced less economic strain (p<.001) compared with those who did not expect to remain in their present profession. It was more common among subjects with MD compared with MSD to expect to remain in their present profession (p=.05). The characteristics of the 2 groups are presented in Table I.

/Table I/

Mean ratings for work conditions, health, and turnover intentions are presented in Table II. Generic HRQL (EQ-5D) and individual resources, measured with mastery and self-efficacy, were significantly better in the group who expected to remain in their present profession (p<.001), and burnout scores measured with SMBQ and depression measured with ZSDS were lower in this group (p<.001). There was no difference between the groups in self-rated work ability (p=.27).

Those who expected to remain in their present profession had a lower ERI index, indicating less job stress (p<.001), and they had lower average ratings on the OC scale (p<.001), indicating less emotional strain due to the job. There was no difference between the 2 groups in turnover intentions (p=.27).

/Table II/

Expectations of Remaining in the Same Profession and Turnover Intentions

Expectations of health-related ability to stay in the same profession in 2 years and turnover intentions were analyzed by cross-tabulation of the 2 variables, rendering 4 groups: expecting to remain in the same profession and with no turnover intention (A, Stable) or with turnover intention (B, Mobile), expectation of not remaining in the same profession with no turnover intention (C, Insecure) or with turnover intention (D, Locked-in). The univariate distribution of demographic, health and work variables among the 4 groups are presented in Table III.

/Table III/

Groups A and B, i.e. those who did expect to remain in the same profession in 2 years, but differed in turnover intentions, differed in age, educational level, work conditions, degree of burnout, and diagnosis. The participants in group A (Stable), who had no turnover intentions, were older, about one fourth had a university education and the majority were sick-listed due to MSD. In group B

(Mobile) the majority were sick listed with MD, almost half were university graduates. Burnout scores were higher in group B, high ERI scores, and high OC were more prevalent in this group.

Groups C (Insecure) and D (Locked-in) did not expect to remain in their present profession in 2 years. Participants in group C, with no turnover intentions, were older than the other groups, one third had only mandatory schooling, and pink- and blue collar occupations were most common. The prevalence of MSD was high. The D group with turnover intentions were younger and had worse work conditions in terms of high ERI scores and a high prevalence of OC. The D group scored high on burnout, in the other health-related measures were the C and D groups similar, with scores indicating ill health in several measures. The D group was similar to the A group in educational and occupational variables, but economic worries were more prevalent in the D group.

To sum up the complex table, the groups with long-term expectations of health-related ability to stay in the same profession had in general better health-related scores than those with no such expectations. Worse work conditions, MD, high burnout scores, and better education and occupational position were associated with turnover intentions. The two groups with no long-term expectations of health-related ability to stay in the same profession differed in age, and with regard to work conditions, older age was associated with no turnover intention and worse work conditions were associated with turnover intentions. In all health measures except burnout were these two groups similar at levels indicating ill health.

Time until return to work was significantly longer for group C (Insecure), (hazard ratio [HR] 0.69, 95% CI 0.50–0.96). The D (locked in) group tended to have a faster RTW rate but did not differ significantly from the A and B groups (Figure 1).

/Figure 1/

Significant confounders were blue-collar profession (HR 1.54, 95% CI 1.17–2.02), self-rated health (EQ-VAS, HR 1.01, 95% CI 1.00–1.02) and self-rated work ability (HR 1.08, 95% CI 1.04–1.12), worse scores contributing to a later return to work (Table IV).

/Table IV/

Discussion

One aim of the study was to identify which factors were associated with long-term health-related expectations of professional stability or mobility among workers recently sick listed due to MSD or MD. An assumption was that interventions to promote return to work in some cases may benefit from early analyses and discussions of the sick-listed employee's opportunity and motivation to return to the same profession.

Somewhat surprisingly, as many as 41% of those recently sick listed had negative expectations about remaining in their present profession in 2 years. The single WAI-item separated the study population into two groups who differed in socioeconomic resources, in health and health-related resources and in work conditions. It is not possible to determine, from this cross-sectional analysis, which came first, bad work conditions or ill health. The results however show that better job fit and control over the personal economy were associated with expectations of staying in the profession. Recent changes in the Swedish sickness and disability benefit policy, based on an activation strategy for the individual and limited obligations for the employer may have contributed to the high prevalence of expectations not to remain in the present profession. If sick leave exceeds 6 months, the employer may initiate a process to terminate the employment, which forces people on sick leave to seek a new job on the labor market. For most people on sick leave, economic security prospects

are of major importance [17], and trying to find a new job or profession may be a less attractive strategy when on sick leave. The policy may contribute to feelings of economic insecurity among those on long term sick leave, and among those with lower resources to compete on the labor market.

Leaving employment or a profession to search for a new job may be a difficult step to take when on sick leave, particularly when the prospects for gaining new employment in Sweden are limited for individuals attempting to return to the labor market after long-term sick leave. Only 7% of employers in Sweden would consider employing individuals who are sick listed from another job, according to an interview study with over 1800 Swedish managers [44]. Kaye et al [45] found similar attitudes among managers in the USA. Expectations of not being able to remain in the present profession due to health may, as suggested by Mondloch et al [15], have its origin in experiences at the workplace, or in the interaction with inefficient health care and welfare systems [7], involving a threat to job and financial security. It was expected that sick listed persons with low attachment to the workplace, i.e. having turn over intentions, would have a slower RTW rate. The results rather show that negative expectations of job stability, combined with limited resources to compete on the labor market, seem to lead to longer sick leave, possibly due to a gradual depletion of personal resources due to problematic interactions with rehabilitation stakeholders or limited support from the work place [7].

Psychological and social demands have increased in working life and work conditions are characterized by increased intensity and higher work pace associated with new knowledge and technologies. New organizational principles may also involve increasing decentralization of responsibility. These changes have led to new and rapidly changing demands on employees, such as demands on continuous development of competence, interpersonal skills, flexibility, and adaptability [53]. Given this development, it seems reasonable that sick-listed individuals, with lower economic resources, low education, and worse health, perceive themselves as vulnerable with regard to future

employment if being at risk to be dismissed from their present job. In the cross-tabulation of expectations to remain in the present profession and turnover intentions, the characteristics of the 4 groups provided some insights into the various types of support that might be needed to facilitate sustainable employment and work ability.

From a labor market perspective, there were 2 vulnerable groups, defined by having no expectations of remaining in their present profession in 2 years. The locked in group (D) did not expect to remain in their present profession in 2 years and had turnover intentions. This group had the worst work conditions, most worries about their economic status and comparably poor self-rated health in several measures. In a recent study by Fahlen et al. [25], high ERI quota and being locked-in were associated with long-term sick leave. Other studies have shown associations between high ERI quota and different health problems [23, 42]. Changes in the labor market in the last few decades have reduced the possibilities for permanent jobs. As a consequence, many stay in undesired work situations. This situation corresponds to that described by Siegrist [54], when individuals have to stay in non-desirable situations because of few alternatives on the labor market and are at risk of being laid off or facing downward mobility. For this group, interventions to promote sustainable work ability may gain from incorporating support for the prospect of changing profession or job to promote work ability in a long term pespective.

The insecure group (C) was dominated by sick listed in MSD, they had higher average age, low education, low HRQL (EQ-5D), and low self-rated health (EQ-VAS). Blue-collar jobs were common. This type of employee is a common care-seeker in primary health care and in occupational health care, and most commonly they only get symptom-oriented treatment. In Sweden, the demands on the employer to implement necessary work place adjustments are low and the risk of becoming dismissed in a long-term perspective is probably higher for this group compared with the other

groups. Their higher average age and worse health may, in the context of the welfare regulations in Sweden, contribute to their expectations of not being able to remain in their present profession in 2 years. To prevent unemployment, return to work interventions directed at return to the previous job may however be most relevant, as their resources to meet new labor market demands are limited. The Cox regression analysis showed that this group had the slowest return to work, which may indicate that this group are the victims of system problems as described by McEachen [7]. Return to work interventions for this group in all likelihood should involve multimodal and coordinated interventions with work place adjustments.

Those who expected to remain in the present profession in 2 years, the stable group (A) and the mobile group (B) differed with regard to work conditions and prevalence of MD. The mobile group (B) had turnover intentions and they had a higher prevalence of strenuous work conditions, measured with ERI, and a higher prevalence of OC. Expectations of professional stability or mobility may be two-edged, involving positive expectations of career development or negative expectations of downward mobility and limited possibilities to leave the present job or profession for a better one. High turnover intentions among employees has been associated with strenuous work conditions, such as high work load [46], low advancement possibilities [47], low skill variety [48], low social support [49], low autonomy and feedback [50, 51]. Several studies [42, 43] have shown positive effects of mobility from jobs that do not fit the individual's competence or abilities. This may be applicable for group B who had good personal resources, but a bad job fit. For this group would support to active job seeking be relevant if the employer is unwilling to implement work place adjustments. For employers, high mobility has in general been seen as a problem, as it involves disruption of activities or production. High mobility may also impoverish the organization as competence and human capital investment disappear with employees who quit [52]. The results thus give support to the common

finding that employer engagement involving support and work place adjustments for sick-listed workers may facilitate health and work ability [2, 4, 23].

The similarity between 3 of the groups in return to work rate may partly be explained by the strict regulations in Sweden concerning duration of sick leave. After 90 days on sick leave, the employer has the authority to transfer the sick-listed employee to another job, and after 180 days on sick leave the employee may be laid off. The regulations enforce return to work to secure the individual's economic situation.

Conclusions

Job security for long-term sick-listed individuals is no longer a matter of course in many welfare systems. Globalization and organizational changes in working life have led to new and rapidly changing demands on employees, such as continuous development of competence, interpersonal skills, flexibility, and adaptability, which makes employees with health problems and low educational and personal resources vulnerable with regard to opportunities for return to work. The results suggest that intervention programs to reduce long-term sick leave should include measures to facilitate job mobility for some sick-listed people, while for others return to work interventions should focus on return to the previous job combined with work place adjustments. The results of this explorative study underline the importance of knowledge about the sick-listed person's resources in relation to the labor market and the work place, their expectations of future employment and employability, and their specific needs when developing interventions for return to work.

Acknowledgements

This study was supported by grants from the Swedish Council for Working Life and Social Research (FAS) and from the County Council of Östergötland. We thank Henrik Magnusson for statistical analyses.

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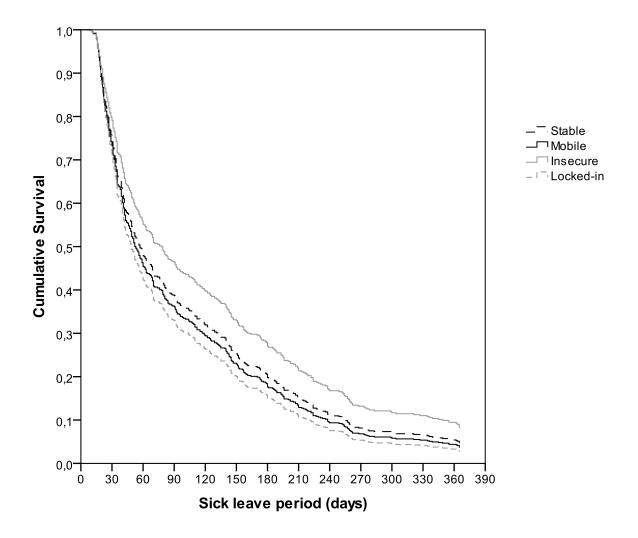


Figure 1: Kaplan Meier survival curves, time until return to work in groups A: Stable, B: Mobile, C: Insecure, D: Locked in

Table I Demographics among those who expected and did not expect to remain in the same profession in 2 years due to health

Variable	Expect to remain in present profession in 2 years					
	Yes		No		-	
	n	%	n	%	- p	
Age (years)						
<29	42	8	31	9		
30–39	115	23	52	15		
40–49	167	33	99	29		
50–59	138	27	101	29		
60–65	43	9	61	18	<.001	
Sex						
Female	295	72	195	68		
Male	117	28	90	32	.366	
Education						
Compulsory	57	14	75	27		
High school	229	56	142	51		
University	121	30	62	22	<.001	
Economic strain						
Yes	87	22	122	44		
No	316	78	157	56	<.001	
Occupational categor	у					
White collar	126	31	61	22		
Pink collar	170	41	116	41		
Blue collar	115	28	107	38	.006	
Diagnosis						
Musculoskeletal	237	58	185	65		
Mental	175	43	100	35	.050	

Table II Mean score and standard deviation for health and work condition variables among those who expected and did not expect to remain in the same profession in 2 years

Yes	SD	No		
Mean	SD			
	שנ	Mean	SD	p
0.50	0.31	0.38	0.30	.001
54.81	19.86	42.48	18.93	.001
3.98	1.50	4.53	1.26	.001
44.07	9.66	47.52	9.16	.001
21.69	3.54	19.57	3.62	.001
137.92	43.58	122.08	41.29	.001
3.40	2.97	3.08	2.56	.128
0.92	0.32	1.11	0.42	.001
12.89	4.64	14.45	4.70	.001
3.50	1.51	3.63	1.56	.267
	54.81 3.98 44.07 21.69 137.92 3.40 0.92 12.89	54.81 19.86 3.98 1.50 44.07 9.66 21.69 3.54 137.92 43.58 3.40 2.97 0.92 0.32 12.89 4.64	54.81 19.86 42.48 3.98 1.50 4.53 44.07 9.66 47.52 21.69 3.54 19.57 137.92 43.58 122.08 3.40 2.97 3.08 0.92 0.32 1.11 12.89 4.64 14.45	54.81 19.86 42.48 18.93 3.98 1.50 4.53 1.26 44.07 9.66 47.52 9.16 21.69 3.54 19.57 3.62 137.92 43.58 122.08 41.29 3.40 2.97 3.08 2.56 0.92 0.32 1.11 0.42 12.89 4.64 14.45 4.70

Table III Univariate characteristics of the groups according to expectation of remaining in the same profession in 2 years and turnover intentions. Frequencies are proportion within each of the 4 groups: A. stable, B. strenuous work, C. insecure and D. mobile

Variable	Expect to remain in the same profession in 2 years		Expect not to remain in the same profession in 2 years			
	A. Stable (no turnover intention) (<i>n</i> =409)	B.Mobile (turn over intention) (n=96)	C.Insecure (no turnover intention) (<i>n</i> =216)	D.Locked-in (turnover intention) (<i>n</i> =128)	p	Between group comparisons : ≠ indicates sign. diff.
Average age (sd)	45.8 (10.3)	41.5 (9.7)	51.2 (10.0)	41.0 (10.7)	.001	$A \neq B, C, D; C \neq B, D$
Age range	20-64	21-65	23-65	22-63		
Education: (%)	26	43	19	31	.001	
University	26	43	19	31		A, $C \neq B$
High school	59	48	51	53		
Mandatory	15	8	31	16		$A,B\neq C$
Economic worries (%)	21	25	42	47	.001	$A,B \neq C, D$
Occupational group:(%)					.001	
White collar	28	42	18	32		$\mathbf{B} \neq \mathbf{C}$
Pink collar	42	39	43	37		
Blue collar	31	20	39	32		$\mathbf{B} \neq \mathbf{C}$
ERI >1 (%)	30	42	48	68	.001	$A \neq B, C, D; B, C \neq D$
High over commitment (%)	24	42	37	56	.001	$A \neq B, C, D; C \neq D$
Diagnosis: (%)					.001	
Mental	36	63	31	48		A, $C \neq B$
Musculoskeletal	64	38	69	52		A, $C \neq B$
Mean EQ-5D index (sd)	0.48 (.31)	0.55 (.29)	0.37 (.30)	0.41 (.30)	.001	A, B \neq C; B \neq D
Mean EQ-VAS (sd)	55.31 (19.72)	54.42 (19.74)	47.58 (19.54)	47.74 (19.19)	.001	$A \neq C, D; B \neq C$
Mean ZSDS (sd)	43.53 (9.65)	45.98 (9.48)	46.80 (9.52)	49.39 (8.21)	.001	$A \neq C$, D
Mean SMBQ (sd)	3.82 (1.50)	4.52 (1.42)	4.38 (1.31)	4.90 (1.06)	.001	$A \neq B, C, D; C \neq D$
Mean Self-efficacy (sd)	134.91 (43.30)	147.77 (42.99)	120.25 (41.39)	128.29 (39.88)	.001	$A, B \neq C$
Mean Mastery (sd)	21.76 (3.56)	21.48 (3.47)	19.62 (3.80)	19.49 (3.23)	.001	$A \neq C, D$; $B \neq C, D$
Mean Work ability (sd)	3.33 (3.0)	3.87 2.87)	3.07 (2.52)	3.01 2.73)	.11	

Table IV Hazard ratios for early RTW in the groups expecting to remain or not to remain in the same profession in 2 years due to health, and turnover intentions, and confounders.

Variable	HR	95% CI
Group:		
C. Locked in	1.0	
A. Stable	0.86	0.64 - 1.15
B. Mobile	0.92	0.641.31
C. Insecure	0.69	0.50 - 0.96
Occupational group:		
White collar	1.0	
Pink collar	1.24	0.99–1.55
Blue collar	1.54	1.17-2.02
Mental diagnosis	1.11	0.89–1.38
Work ability	1.08	1.04–1.12
Female	0.97	0.77–1.22
Age	0.99	0.98-1.00
Economic worries	0.93	0.75–1.14
Self-efficacy	1.00	1.00-1.00
EQ-VAS	1.01	1.00-1.02