Disease oriented work ability assessment in social insurance medicine
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Chapter 1

General Introduction
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Introduction

A large number of people stop working before they reach the age of 65\textsuperscript{1,2}. An important reason to discontinue working before the age of 65 is when the development or acquisition of a disease diminishes the functional capacities to such an extent that work demands cannot be fulfilled\textsuperscript{2,3}. This results in one becoming work disabled.

In most Western countries drain out of the workforce due to ill health is substantial\textsuperscript{4,5,6} and the financial consequences are insured under social security\textsuperscript{7,8}. The concerned employees can therefore claim a disability pension.

Generally speaking, before disease-related restriction results in a disability pension, a process of diminished functional capacities resulting in presenteeism and/or absenteeism\textsuperscript{9,10,11,12} occurs. In addition, attempts to return to work\textsuperscript{13,14} without counter-balancing the reduced functional capacities can be observed. This process takes time, and, before possibly disability pensions are granted, most social security systems impose a waiting period\textsuperscript{7}. A failure to return to work within an allotted time does not mean that the incapacitated employee is unable to participate in their work. This can be illustrated by the facts that disease-related retirement appears to vary between organisations\textsuperscript{15,16} and countries\textsuperscript{17}, employees may return to work after disability pensions have been granted\textsuperscript{18}, and the management of ill health retirement varies in practice\textsuperscript{7,19}.

The assessment of work ability of incapacitated employees who claim disability pensions may therefore vary with the perspective of the assessor. Since returning to work is thought to be associated with subjective well-being and life satisfaction\textsuperscript{20,21}, and because labour shortages are predicted in the future\textsuperscript{22}, the assessment of the work ability of the incapacitated employee is an important subject for study. Consequently, work disability should not simply be accepted, and high-quality criteria in the input, process, output and outcome of the work ability assessment process\textsuperscript{7} are needed. In practice, this implies skilled assessors, inter-collegial consultation, continuous education, coaching, working according to guidelines and protocols, and performing reliable and valid work ability assessments\textsuperscript{7}.
1.1 Aspects of work ability

In the assessment of work ability, the capacity to participate in work is determined. In the International Classification of Functioning, Disability and Health (ICF) model of the World Health Organisation (WHO)\textsuperscript{23}, aspects of work ability can be categorised by six components: (1) disease and disorder, (2) structures and functions, (3) activities, (4) participation, (5) environmental factors and (6) personal factors. In this classification, the capacity to participate in work can be conceptualised as the result of mutually interacting aspects\textsuperscript{23}. Due to the fact that participation in work also needs to be stable in terms of hours per day and days per year, the assessment of work ability should be described by aspects of work ability that are prognostic for future participation in a given occupation.

Many theoretical predictors for returning to work, as covered by the components of the ICF model, have been described\textsuperscript{24}. Those factors, however, are predominantly based on cross-sectional research and do not address the situations in which as many as 21 months have passed since sick-listing, as is the case in the Netherlands for the assessment of work ability intended for social security purposes. Furthermore, the described factors are mainly not disease-specific. Examples of these factors include age, gender, nature of work and social support\textsuperscript{24}, suggesting that the type of disease is less relevant. Counter-arguments against this suggestion are that disease-specific patterns of presenteeism or absenteeism\textsuperscript{11,25} are known, that return to work measures for certain diseases have been designed\textsuperscript{26}, and that disease-specific guidelines to assess work ability have already been developed\textsuperscript{27,28,29,30}. Furthermore, medical support for the disabled employee is oriented in a disease-specific manner in most countries. The central argument for assessing work ability in a disease-specific manner in work ability assessment is when the complains fit the diagnoses of a patient to appraise the gathered aspects of work ability that are related to participation in work. For example, chest pain during walking in patients with coronary heart disease is a valid reason for slowing down the work pace, while chest pain in patients with psoriasis is thought to be unrelated to the disease. Therefore, it seems reasonable that, in assessing work ability, not only non-disease-specific, but also disease-specific factors for work ability should be considered. A disease-specific approach of work ability assessment does not exclude the relevance of any non-disease-specific aspects.
1.2 Quality improvement

Throughout Europe, the assessment of work ability of long-term sick-listed employees is performed by medical advisors on authority of the national institutes of social security. In such settings, and according to Hofstee (1999), qualified assessors should be exchangeable. This implies that the relevant characteristics for the assessment of work ability and methods to assess these should be known among all assessors. However, work ability is ill-defined, and there is an inconsistency in the assessment of work ability between medical advisors. Guidelines and training to handle these inconsistencies can be assumed not to be applicable in this context because it is not yet known what aspects of work ability should be addressed. Consequently, identifying relevant aspects for the assessment of work ability, and subsequently developing useful instruments to measure them, is a real need in this area. When this endeavour is directed at diseases for which disability pensions are frequently granted, the improvement in quality for the institutes of social medicine, on whose authority work ability is assessed, is understood to be substantial. Identifying relevant aspects for the assessment of work ability and subsequently developing the appropriate instruments should, therefore, first be aimed at diseases for which disability pensions are frequently granted. The figures from the Dutch National Institute of Benefit Schemes show that, of the assessments performed in the Netherlands, approximately one-third concern musculoskeletal diseases, approximately one-third concern psychiatric diseases, and approximately one-third concern all of the remaining diseases. Major Depressive Disorder (MDD), chronic Low Back Pain (cLBP) and Myocardial Infarction (MI) are diseases for which disability pensions are often granted. In addition, MDD is the diagnosis for which the majority of disability pensions are granted in the Netherlands.

1.3 Assessment of work ability in the Netherlands

In the Netherlands, medical assessments for work disability are conducted by Insurance Physicians (IPs). Around 1000 IPs work on a daily basis at the Dutch National Institute of Benefit Schemes. IPs are physicians who received four years of post-academic training, including on-the-job training, complemented by theoretical education for one day a week during these four years. After completing the training and their study, they are officially registered as medical specialists in social insurance medicine.
The main duties of IPs in cases where an applicant claims a disability pension are to assess the social-medical history of the claimant, the current work ability of the claimant in their own or another job, the prognosis of the work ability of the claimant, and the possibility for further treatment and/or support. Schematically, the assessment of work ability in the Netherlands is presented in Figure 1.

Before the assessment of work ability is performed, the sick-listed employee is typically on sick leave for a minimum of 21 months. During this period, the patient is usually counselled by an occupational physician and/or treating doctor. After 21 months of sick leave, if the return to work is not (yet fully) achieved, the assessment of work ability is then performed by an accredited IP.

IPs base their assessment of work ability on the social-medical history, an interview, and, when necessary, an examination of the claimant, conducted in consultation with the other medical professionals concerned. As professionals, the IPs are obliged to use guidelines, disease-specific protocols, appropriate interview methods, and disease-specific illustrative case histories to help in assessing work ability of the claimant. The regulations stipulate that information should be gathered and that work ability should be preferably conceptualised according to the ICF model. However, specific criteria for what information should be gathered and how to appraise the gathered information to assess work ability are in many cases missing or incomplete and often not evidence based.

The assessment for the ability to work is noted now in a pre-structured functional ability list in which activities that the claimant is able to perform are described. In this list, the work conditions that should be met before a claimant can safely work, according to the IP, are also listed. This list, in addition to the employee report made by the IP, makes up the base of the administrative process. In this process, a labour expert decides if a client can return to work or if, and to what extent, a disability pension should be granted based on the financial loss of income.

Although all assessments are performed on the authority of the National Institute of Benefit Schemes, IPs have a professional freedom how they assess work ability. The IPs then have to justify and clarify their decisions about work ability to both their professional peers and to the sick-listed patient who was assessed. Therefore, in the judgement of work ability, the perspectives of the sick-listed employee and the IP as a professional are of primary importance.
1.4 The exchangeability of IPs

There are only a few research studies in insurance medicine that concern assessment practices in assessing work ability. The scarce literature that is published shows that different judgement practices exist between IPs in their appraisals of work ability, not only outside the Netherlands\textsuperscript{34,35}, but also within the Netherlands\textsuperscript{42}. According to Boonk et al.\textsuperscript{42}, some IPs assume maximal work ability when health does not interfere, while others take into account gender, anthropometrics or age. Raizenberg\textsuperscript{43} and Kerstholt et al.\textsuperscript{44} showed that experienced IPs more often base their judgements on reported limitations by clients than the less experienced IPs. It appears that the assessment of work ability is associated with the personal preference of the IP and that the starting point to assess work ability is different between individual IPs.
The inter-rater variation among IPs for the assessment of the number of hours a client is assessed to be able to work appears to be substantial. An important quality criterion in work ability assessment, i.e. the exchangeability of the qualified assessors, is therefore violated. Additional studies to examine more evidence regarding this topic are needed. For Figure 1, this means that, in BOX 1, the relevant aspects must be sampled and that using these relevant aspects when assessing work ability results in BOX 2, which is more reproducible.

1.5 Objectives of this thesis

The objectives of this thesis were: (1) to identify aspects of work ability that are relevant for the assessment of work ability in patients with varying diseases after long-term sick leave, including MI, cLBP and MDD according to literature on return to work (RTW) and based on the opinion of IPs or patients; and (2) to test if the use of identified aspects will change variation in work ability assessment by IPs.

In the Netherlands disease-specific protocols prepared by the Dutch Health Council and the Dutch Society of Insurance Medicine are available to support IPs when they assess work ability for long-term sick-listed employees with diseases for which disability pensions are frequently granted. Protocols exist for MDD, MI and cLBP. Although these protocols contain criteria on which diagnoses and treatment can be based, they do not describe evidence on which work ability can be assessed. To develop a scientific basis for the assessment of work ability, this thesis first investigates the literature to identify prognostic factors that can predict work ability of diseased employees who are long-term sick-listed. Thereafter, aspects of work ability relevant to the perspectives of the sick-listed employees and the IP, are investigated. Then it is tested for MDD, which is the disease most frequently associated with disability pensions being granted, if using relevant aspects of work ability by IPs, will change the variation in the assessments of work ability. Four research questions have been formulated:

1. What prognostic factors for work ability have been described in the literature for the three diseases in the Netherlands for which a disability pension is frequently granted: MI, cLBP and MDD?

2. According to IPs, what are relevant aspects of work ability in cases of long-term sick-listed employees with musculoskeletal diseases, psychiatric diseases with a specific emphasis regarding MDD, and other diseases?
According to sick-listed survivors of an Acute Coronary Syndrome (ACS), what are the facilitating and hindering factors in their return to work?

Does variation in work ability assessment change when disease-specific aspects for work ability are used in the assessment of sick-listed patients with MDD?

1.6 Outline of this thesis

The first research question is answered in Chapter 2, in which the results of a systematic literature search for prognostic factors for work ability of sick-listed employees with MDD, CLBP and MI are presented. The second research question is answered in Chapters 3 and 5. In Chapter 3, the results of a semi-structured interview with Dutch IPs are presented, summarizing the aspects they think are most important in cases that they assess for work ability of sick-listed clients with musculoskeletal diseases, psychiatric diseases and remaining diseases. In Chapter 5, the results of a Delphi study in IPs regarding relevant aspects of work ability in sick-listed patients with MDD are given.

The third research question is answered in Chapter 4, in which hindering and facilitating factors are shown for the return to work for sick-listed patients with an ACS.

The fourth research question is answered in Chapter 6, in which the results are described of a study between groups of IPs that do or do not use disease-specific aspects of work ability when assessing work ability of sick-listed employees with MDD. Finally the main conclusions of the studies are discussed in Chapter 7. In this chapter, implications for IPs and policy makers and recommendations for further research are given.
References


Chapter 1
General Introduction


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