Focusing the equity lens: from context to consequences of return to work interventions

Campbell Collaboration Colloquium, Oslo, 19\textsuperscript{th} May 2009

Professor Margaret Whitehead

WHO Collaborating Centre for Policy Research on Social Determinants of Health, University of Liverpool, UK

Three key issues covered in this talk:

- Why are return to work policies and interventions pressing public health and health inequalities issues as well as a social welfare issue?

- What extraordinary conceptual and methodological challenges are thrown up for evidence synthesis of return to work policies and interventions?

- How is research community starting to deal with the challenges and finding a new way forward?
What is the public health and equity issue?

Employment is an important determinant of health and social inclusion in our societies:

“Work is the glue that sticks our society together”

- Employment rates for disabled people low compared with the rates for people without disability: OECD average is 40% compared with 75% for people without disability. Conversely, unemployment rates typically twice as high for disabled people compared with people without disability

- People with health problems much more likely to experience poverty – poverty causes further ill-health

- Differential consequences: disabled people who have less skills and lower social position have lower employment rates - pathway to health inequalities

What is the policy issue for public health and social welfare?
OECD: People with disability are at greater risk of poverty—but marked differences between countries

Source: OECD 2009 Sickness disability and work background paper
Adverse consequences for society

- 6% of OECD working-age population on disability benefits in 2007; spending on disability benefits amounts to 1.2% of GDP on average; 4-5% of GDP in some countries if include sickness benefits

- Pressing policy issue in OECD countries, getting worse with worldwide recession
UK: Rise in numbers of working-age people on long-term Incapacity benefits 1979 – 2005: 2.6 million (7% of pop)

Message from high-level forum of Ministers from 15 OECD countries, Stockholm, 15 May 2009:

“Governments must do more to help most vulnerable amid rising unemployment….much more can and must be done to help people with reduced work capacity caused by illness or disability….those people, among the groups being hard hit by the jobs crisis, already find it harder to get work and therefore are more likely to live in poverty…Ministers warned against repeating mistakes of the past...”

Source: OECD press release 15/05/09
The big questions asked by policy-makers:

- What can we do?!

- What policies and interventions help chronically ill and disabled people return to work?

- Which ones help reduce social inequalities in return to work chances?

What works for people?
What are the extraordinary challenges for the research community in answering the policy-makers’ questions?

The range of influences on employment chances on chronically ill and disabled people include:

- Macro-economic cycle and state of economy
- Population-wide social welfare and labour market policies influence employment chances for everyone, but might also have a differential effect on disabled people and for different social groups
- Focussed interventions aimed specifically at helping chronically ill and disabled people return to work – might also have differential effects by gender and by socio-economic group
- How to capture/disentangling these diverse impacts?
1. The challenge of capturing the influence of macro-economic and policy CONTEXT
Need for:

- Evaluation studies to report macro-context of intervention and take into account in interpretation – currently very rare
- Include observational trend data, and qualitative studies in process of interpretation of results
- Make more use of cross-country comparative analysis with natural policy experiments – but with understanding of policy context

Use contrasting macro-level policies in different welfare systems as natural policy experiments

- Experiments in flexibility of the labour market
- Contrasts in social security provision/‘de-commodification’
- Contrasts in active labour market policies
2. The challenge of understanding policy context in interpreting impacts of focussed interventions

Country social welfare policy context influences....

- Who is on welfare and who gets a welfare-to-work intervention (e.g. selection into programmes; universal versus selective)
- What type of intervention is likely to be offered (e.g. incentives or disincentives)
- What the consequences are for individuals of participating in the intervention versus not participating (e.g. welfare cut off versus income maintenance)
Understanding policy context when interpreting impact results

- Some interventions may appear to be counterproductive – Swedish study of different forms of rehabilitation found that educational rehab worsened chances of re-employment compared with no rehabilitation.

- Need to understand country context to interpret above finding – individuals with bad sickness record, having exhausted other forms of rehab, end up in educational rehab as last stage before disability pension. Stigma may also play a part (employers know sickness profile of participants).

- Value of policy analysis and qualitative studies for interpretation.

Extra pitfalls in standard review methods?

Campbell Collaboration review of welfare-to-work interventions: no restriction on country, but tight inclusion criteria of RCTs, quasi-randomised trials and cluster randomised trials (Smedslund et al, 2006):

- 46 trials identified, 44 of which from USA, 2 from Canada, none outside North America.

- Impact: welfare-to-work programmes in USA have shown small but consistent effects on moving welfare recipients into work, increasing earnings, and lowering welfare payments. Unclear if they reduce the proportion receiving welfare.

- Authors conclude that results cannot be generalised to Europe or anywhere else – because stark differences between welfare system in USA and rest mean characteristics of welfare recipients different, nature of interventions different, relationship of welfare recipients to employers and to wider employment policies different.

- ……………….But politicians and policy advisers generalise from USA all the time!
Why do SRs of welfare-to-work interventions identify RCTs almost exclusively from USA?

- Having a randomly allocated control group is sometimes a condition of receiving funding to evaluate a welfare-to-work programme in the USA.

- Randomisation was sometimes a US Federal stipulation for a proposed intervention to be allowed to go ahead in the first place (Smedslund et al, 2006, p. 30).

- In European countries, not only is there no such requirement for RCTs, but randomisation sometimes discouraged on ethical and methodological grounds (universal policy applied to whole population) (Whitehead et al, 2009).

- Calls for more randomisation in Europe not the entire answer - need more creative methods appropriate for assessment of impacts of universal welfare systems.

3. Making sense of results when no two interventions are exactly the same - the need for a typology.
Typology of focussed interventions

<table>
<thead>
<tr>
<th>Focus</th>
<th>Perceived problem</th>
<th>Intervention Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENVIRONMENT</td>
<td>1. Employers discriminate against disabled/chronically ill in recruitment and retention of staff</td>
<td>Legislation against discrimination</td>
</tr>
<tr>
<td>ENVIRONMENT</td>
<td>2. Employment and workplace inaccessibility creates significant barriers to employment</td>
<td>Legislation and Support to improve employment and workplace accessibility</td>
</tr>
<tr>
<td>ENVIRONMENT</td>
<td>3. Few appropriate employment opportunities available for the disabled/chronically ill or employers perceive disabled/chronically ill workers to be less productive</td>
<td>Financial and other incentives to employers to take on disabled workers</td>
</tr>
<tr>
<td>ENVIRONMENT</td>
<td>4. Loss of contact with work culture leads to sick-listed individuals moving into long-term sick/economically inactive category. Poor coordination of services hinders the process.</td>
<td>Enhanced return-to-work planning and requirements</td>
</tr>
<tr>
<td>INDIVIDUAL</td>
<td>5. Welfare system creates disincentives to moving into employment</td>
<td>Financial incentives to disabled people to support return to work, or reductions in generosity of their benefits</td>
</tr>
<tr>
<td>INDIVIDUAL</td>
<td>6. Time outside the labour market means loss of skills in locating and obtaining appropriate work</td>
<td>Individual case management and job search assistance</td>
</tr>
<tr>
<td>INDIVIDUAL</td>
<td>7. Individuals lack appropriate skills, education or training for available work</td>
<td>Education, vocational training and work trial</td>
</tr>
<tr>
<td>INDIVIDUAL</td>
<td>8. Individual’s health condition creates limitations on ability to perform job</td>
<td>Medical rehabilitation and health management advice to reduce impairment</td>
</tr>
</tbody>
</table>

To sum up....

- Need in-depth understanding of macro-level context and intervention context within specific welfare system to make sense of measured impacts

- There ARE policies and interventions that help employment chances of chronically ill and disabled in each context, but many efforts struggling against formidable odds
Focusing the equity lens

- Above all, there is a glaring gap in evidence to answer the equity question: what works to reduce social inequalities in return-to-work chances for disabled people?

- We urgently need studies (existing as well as new) to identify differential impacts of both wider macro-policies and focussed interventions to inform future policy - more pressing than ever as we enter the economic downturn.

- The papers in this session illustrate the ways in which one multi-country project has started to address these major challenges.

“How thoughtful…a layoff notice in braille.”
How equitable is vocational rehabilitation in Sweden?
Bo Burström, Lotta Nylén, Stephen Clayton, Margaret Whitehead

Background

- Increasing health-related exclusion from the labour market
- Especially low-educated/low skilled persons
- High costs to society – adverse social and economic consequences for individual
- Social inequalities in health – mechanism?
- Several nation-wide policy initiatives to improve return-to-work in Sweden
- Equity focus of policies?

- "Governments must do more to help most vulnerable amid rising unemployment"
- "To improve outcomes, it is necessary to promote a culture of inclusiveness"
- "Incentives for all actors to keep people in or bring them back to work must be strengthened"
- "Complementary institutional and workplace reforms can make policy work"

Review questions

- Is there evidence of differential access to the vocational rehabilitation (VR) programmes provided in Sweden?

- For those who gain access to VR programmes, is there evidence of differential outcomes?
Methods

- Literature search for vocational rehabilitation studies 1990-2007
  - 11 electronic databases
  - 15 websites, grey literature and other sources
- 3348 titles identified
- 54 studies retrieved
- 10 studies selected for detailed analysis

Q1. Differential access to VR – inclusion/exclusion criteria

- 6 studies
  - Observational studies of population-based or employee-based registers of sick-listed individuals, if socioeconomic, demographic, health characteristics recorded/analysed
- 1 study
  - Other studies if examining informants’ knowledge of bias in selection
Q2. Differential outcomes of VR – inclusion/exclusion criteria

- **1 study**
  - Evaluations of VR programmes – return to work (RTW) outcome, socio-demographic characteristics included
- **1 study**
  - Before/after studies of VR programmes – RTW outcome
- **4 studies**
  - Observational studies over time - registers of sick-listed who received VR and RTW

Q1. Differential access to VR? Yes.

- Biased selection
  - *male sex; younger age; type of health condition; long-term sick leave; lower income; employed*
- Selection may affect outcome
  - *type of VR is important*
- Access to rehabilitation investigation
  - *important for access to VR*
Q2. Differential outcomes of VR? Yes

- Differential impact
  - better results for men, younger, employed, with shorter sick-leave, with higher income
  - depending on VR measure - work training best

- Effects of selection into VR - impact on outcome
- Success depends also on labour market

Discussion

- Few studies
- Inherent methodological problems
- Context-dependent results
- Other influences on success/failure
  - labour market/business cycles
  - workplace adjustment
  - specific diagnosis
Conclusions

- Few studies have assessed differential access to and differential outcome of VR
- Patchy evidence of biased selection into and differential outcome of VR
- Studies must consider selection into VR for adequate interpretation of impact results
- May be appropriate to have different interventions (if based on sound reasoning)
- Evaluations not fatally flawed if biased selection
- Need for equity analysis of population-wide policies
Impact of macroeconomic and policy contexts: international and social inequalities in employment consequences of long term illness

Campbell Collaboration Session on Return-to-work Interventions

Oslo 18-20 May 2009
Espen Dahl
Professor
Oslo University College

Helping chronically ill or disabled people into work: what can we learn from international comparative analyses?

University of Liverpool team: Margaret Whitehead (Pl.), Stephen Clayton, Paula Holland, Frances Drever, and Public Health Specialist Registrars Ben Barr and Rachael Gosling.

Norway: Professor Espen Dahl and Kjetil Arne Van Der Wel, Oslo University College, Oslo; Professor Steinar Westin, Norwegian University of Science and Technology, Trondheim.

Sweden: Professor Bo Burström and Lotta Nylen, Karolinska Institute, Stockholm. Professor Olle Lundberg, Centre for Health Equity Studies (CHESS), Stockholm.

Denmark: Professor Finn Diderichsen and Dr Karsten Thielen, University of Copenhagen, Copenhagen.

Canada: Drs Edward Ng, Sharanjit Uppal and Web-Hao Chen, Statistics Canada, Ottawa.
Three dimensions of health (‘‘DIS-triade’’)

- **“Disease”** (The biomedical dimension)
  - Organism
  - Physiological observations, laboratory tests
  - Malfunctioning, infection, degeneration

- **“Illness”** (The psychological dimension)
  - Personal level
  - Interviews of individuals
  - Subjective experiences, feelings, symptoms

- **“Sickness”** (The sociological dimension)
  - Social system, role capacity
  - Health status as defined by “others”
  - Reduced activity, sickness absence

Questions

Q 1: Are there differences across countries in the employment differentials between healthy and chronically ill?

Q 2: Does gender and education modify the association between illness and employment?

Q 3: Do countries differ in terms of how gender and education exert this modifying effect?
Three expectations

Active labour market policies including vocational rehabilitation might draw workers with reduced work ability more actively back into the labour force after periods of sickness, and might in particular be beneficial for disadvantaged groups.

Policies with high levels of de-commodification, with universal coverage and replacement rates, make it possible for labour with reduced work ability to leave the labour force without serious economic consequences.

Flexible/deregulated labour markets with low employment protection will make it easier for individuals with reduced work ability to get employment and work experience (although it will leave the labour force more unprotected against the macroeconomic forces).

<table>
<thead>
<tr>
<th></th>
<th>Canada</th>
<th>Denmark</th>
<th>Norway</th>
<th>Sweden</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Reduction 1990-2005 in proportion employed in industry of all employed</td>
<td>-5.1</td>
<td>-15.0</td>
<td>-11.8</td>
<td>-22.8</td>
<td>-13.6</td>
</tr>
<tr>
<td>Range of unemployment rates 1990-2005</td>
<td>6.8-11.4</td>
<td>4.8-10.4</td>
<td>3.2-6.6</td>
<td>1.7-8.2</td>
<td>4.8-10.4</td>
</tr>
<tr>
<td>Employment protection legislation index 2003</td>
<td>1.13</td>
<td>1.83</td>
<td>2.62</td>
<td>2.62</td>
<td>1.10</td>
</tr>
<tr>
<td>Decommodification index (incl. unemployment insurance and sickpay)</td>
<td>17.8</td>
<td>24.4</td>
<td>22.7</td>
<td>25.1</td>
<td>15.9</td>
</tr>
<tr>
<td>Active labour market policy (spending in % of GDP 2004)</td>
<td>0.36</td>
<td>1.85</td>
<td>0.78</td>
<td>1.22</td>
<td>0.46</td>
</tr>
</tbody>
</table>

Sources: OECD-data 2008 and Hox et al 2006.
Key messages from Table 1:

- UK and Canada (The liberal welfare state regime) cluster together.

- Denmark, Norway and Sweden (The social democratic welfare state regime) cluster together.

Table 2 Employment rates among healthy and limiting illness. Age standardized 25-59 years in 2005. (Canada 2001).

<table>
<thead>
<tr>
<th></th>
<th>Canada</th>
<th>Denmark</th>
<th>Norway</th>
<th>Sweden</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy men</td>
<td>86.4</td>
<td>90.6</td>
<td>93.2</td>
<td>93.3</td>
<td>92.9</td>
</tr>
<tr>
<td>Men with limiting illness</td>
<td>62.7</td>
<td>70.5</td>
<td>70.6</td>
<td>62.6</td>
<td>58.9</td>
</tr>
<tr>
<td>Healthy women</td>
<td>74.7</td>
<td>83.3</td>
<td>88.6</td>
<td>88.4</td>
<td>79.8</td>
</tr>
<tr>
<td>Women with limiting illness</td>
<td>53.6</td>
<td>56.0</td>
<td>64.3</td>
<td>64.9</td>
<td>49.9</td>
</tr>
</tbody>
</table>
Key messages from Table 2:

- Employment among men and women with limiting illness are consistently lower than among healthy in all five countries.
- UK have lower employment among both men and women with limiting illness.

Table 5.4: Adjusted rate differences and excess risk due to interaction (linear regression coefficient and Confidence intervals (CI) in brackets) of not being employed by limiting illness, country and education. *Men and women 2001-06.*

<table>
<thead>
<tr>
<th></th>
<th>United Kingdom</th>
<th>Canada</th>
<th>Denmark</th>
<th>Norway</th>
<th>Sweden</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Limiting Illness</strong> (LI)</td>
<td>0.15 (0.13-0.17)</td>
<td>0.16 (0.16-0.17)</td>
<td>0.17 (0.08-0.25)</td>
<td>0.05 (0.00-0.10)</td>
<td>0.17 (0.11-0.24)</td>
</tr>
<tr>
<td><strong>Country interaction with LI</strong></td>
<td>-0.01 (-0.02-0.00)</td>
<td>0.05 (0.05-0.06)</td>
<td>Ref</td>
<td>Ref</td>
<td>Ref</td>
</tr>
<tr>
<td><strong>Low education</strong> (LE)</td>
<td>0.03 (0.02-0.03)</td>
<td>0.07 (0.06-0.07)</td>
<td>0.10 (0.09-0.11)</td>
<td>0.08 (-0.03-0.12)</td>
<td>0.20 (0.14-0.26)</td>
</tr>
<tr>
<td><strong>Country interaction with LE</strong></td>
<td>0.23 (0.24-0.25)</td>
<td>0.16 (0.15-0.17)</td>
<td>0.12 (0.06-0.18)</td>
<td>0.03 (0.02-0.04)</td>
<td>0.12 (0.07-0.19)</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Limiting Illness</strong> (LI)</td>
<td>0.16 (0.12-0.16)</td>
<td>0.15 (0.15-0.15)</td>
<td>0.12 (0.06-0.18)</td>
<td>0.14 (0.08-0.19)</td>
<td>0.13 (0.07-0.19)</td>
</tr>
<tr>
<td><strong>Country interaction with LI</strong></td>
<td>0.02 (0.01-0.03)</td>
<td>0.09 (0.08-0.10)</td>
<td>Ref</td>
<td>Ref</td>
<td>Ref</td>
</tr>
<tr>
<td><strong>Low education</strong> (LE)</td>
<td>0.05 (0.01-0.06)</td>
<td>-0.03 (-0.07-0.00)</td>
<td>Ref</td>
<td>-0.08 (-0.12-0.04)</td>
<td>-0.08 (-0.12-0.03)</td>
</tr>
<tr>
<td><strong>Country interaction with LE</strong></td>
<td>0.10 (0.11-0.12)</td>
<td>0.14 (0.14-0.14)</td>
<td>0.05 (0.01-0.07)</td>
<td>0.07 (0.05-0.09)</td>
<td>0.03 (0.01-0.05)</td>
</tr>
</tbody>
</table>

*Extrapolated for country and sex, adjusted for age and education
**Extrapolated for country and sex, adjusted for age and educate
* Use UK definition 1 of limiting long-standing illness (including work plus daily activity limitations)

Note: Figures in Table 5.4 are regression coefficients and the figures labeled “interaction” denote the excess risk due to interaction.
Key messages from Table 3

- Differences in employment between unhealthy and healthy is about the same in all countries.

- People with illness tend to have lower participation rates in UK than in the other countries.

- Interaction between education and illness is found in all countries, except among Danish men. Although uncertain, UK interaction terms tend to be higher than those of the other countries.

Answers:

Q 1: Are there differences across countries in the employment differentials between healthy and chronically ill?

No, but people with illness have lower participation rates in the UK than in the other countries.

Q 2: Does gender and education modify the association between illness and employment?

For both genders in most countries there is an interaction effect between illness and education with respect to employment. (exception = danish men).

Q 3: Do countries differ in terms of how gender and education exert this modifying effect?

UK seems to depart from the other four countries in that the interaction effect is larger here.
Are the theoretical expectations supported?

Tentative conclusions:

- An active labour market policy hypothesis is not weakened.
  - Den, No and Swe do well, but so does Can

- The “de-commodification” hypothesis is not supported.
  - Den, No and Swe do well

- The positive effect of an unregulated/flexible labour market hypothesis is not supported.
  - UK and Can do not perform better than Den, No and Swe

Thank you for your attention!
Current state of knowledge: View I

“We also found no evidence for systematically smaller inequalities in health in countries in northern Europe. .... Our results suggest that although a reasonable level of social security and public services may be a necessary condition for smaller inequalities in health, it is not sufficient.”

(Mackenbach et al. 2008:2479)

Current state of knowledge: View II

“In relative terms, inequalities between social groups are not smaller in the Nordic countries than in other European nations, but in terms of absolute levels of mortality among manual workers in Norway and Sweden are faring better than in most other countries”

(Lundberg et al. 2008a:II)

“The Nordic experiences of welfare states and public health suggest that the general principles adopted for policy programmes, as well as their levels of generosity, have relevance for public health. Hence, social policies are very important for how we can understand and tackle the social determinants of health”.

(Lundberg et al. 2008b:1639)
The impact of return to work interventions in well-developed welfare systems: what we know and what we need to know?

Stephen Clayton
Division of Public Health
University of Liverpool
UK

Review questions:

What are the employment effects of return to work interventions for people with long standing limiting illnesses and disabilities across five OECD countries: Canada, Denmark, Norway, Sweden and the UK?

Are there differential effects by gender and socio-economic position?
Key inclusion/exclusion criteria

- Empirical evaluations of effectiveness of major ‘welfare-to-work’ and ‘return to work’ programmes and their constituent elements to improve the employment chances of long-term limiting ill or disabled people of working age in the five countries

- Included qualitative studies of the views of participants and process evaluations looking at how the interventions were implemented

- Excluded short-term sickness absence initiatives, sheltered work initiatives

Search strategy

Population - Disability, long term-sickness etc.
+ Intervention – rehabilitation interventions/programmes
+ Outcome - Employment/unemployment

16 electronic databases (+ 11 Swedish)

Grey literature searches on 111 governmental and organisational websites in the five countries

Hand searched bibliographies and contacted 30 key researchers in the field
### Number of included papers

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>86</td>
</tr>
<tr>
<td>Electronic databases</td>
<td>26</td>
</tr>
<tr>
<td>“Grey” literature</td>
<td>60</td>
</tr>
<tr>
<td>Canada</td>
<td>8</td>
</tr>
<tr>
<td>Denmark</td>
<td>6</td>
</tr>
<tr>
<td>Norway</td>
<td>6</td>
</tr>
<tr>
<td>Sweden</td>
<td>25</td>
</tr>
<tr>
<td>UK</td>
<td>41</td>
</tr>
</tbody>
</table>

### Reviewed papers by study design (some report on same study or follow up)

<table>
<thead>
<tr>
<th>Study Design</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systematic review</td>
<td>1</td>
</tr>
<tr>
<td>RCT</td>
<td>5</td>
</tr>
<tr>
<td>Cohort</td>
<td>12 (7 controlled)</td>
</tr>
<tr>
<td>Case control</td>
<td>8</td>
</tr>
<tr>
<td>Econometric</td>
<td>11</td>
</tr>
<tr>
<td>Ecological</td>
<td>3</td>
</tr>
<tr>
<td>Longitudinal panel data</td>
<td>2</td>
</tr>
<tr>
<td>Cross sectional with repeat or follow up</td>
<td>5</td>
</tr>
<tr>
<td>Mixed method*</td>
<td>9</td>
</tr>
<tr>
<td>Qualitative</td>
<td>24</td>
</tr>
<tr>
<td>Longitudinal qualitative</td>
<td>5</td>
</tr>
<tr>
<td>Case review</td>
<td>1</td>
</tr>
</tbody>
</table>

* includes all studies that mixed quantitative and qualitative methods
Reflections on finding evidence

• Substantial gap between the large number of interventions identified and the limited number of evaluations carried out

• RCTs rare, as are robust controlled studies

• Qualitative studies are invaluable for understanding why intervention worked or didn’t work and for gaining greater insight into the limitations of those which are effective

• The majority of studies identified from ‘grey’ literature

What are the studies telling us?

<table>
<thead>
<tr>
<th>INTERVENTION TYPE: Environment</th>
<th>IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Legislation against discrimination</td>
<td>Employment worsened for disabled people with lower skills and mental health problems. QUALITATIVE: employers poor understanding, contradictory attitudes</td>
</tr>
<tr>
<td>B. Workplace and employment accessibility</td>
<td>Flexible schedule and modified work increased employment duration. QUALITATIVE: importance of other workers understanding and accepting adjustment</td>
</tr>
<tr>
<td>C. Financial incentives to employers</td>
<td>UK incentives too low. Danish Flexjobs – generous, but given to ‘healthy’ workers, plus stigma. Norway Active Sick Leave – low take up, RCT showed take up can be increased, but did not improve employment outcomes</td>
</tr>
<tr>
<td>D. Enhanced return-to-work planning</td>
<td>Sweden: Beta, Delta co-operative effective when implemented well – but sometimes badly</td>
</tr>
</tbody>
</table>
### What are the studies telling us?

<table>
<thead>
<tr>
<th>INTERVENTION TYPE: Individual</th>
<th>IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>E. Financial incentives/disincentives for welfare claimants/long-term sick-listed</td>
<td>Sweden <em>Resting Disability Pension</em> – generous – effective in return to work even after years on pension, but only for higher educated, non-manual. UK Tax Credits and Wage supplements improved but best for ‘job-ready’, low awareness, <em>DWA wanted ‘proper’ jobs</em></td>
</tr>
<tr>
<td>F. Individual case management and job search assistance</td>
<td>Some evidence of increased employment, but evidence limited by selection into programmes</td>
</tr>
<tr>
<td>G. Education, vocational training, and work trial</td>
<td>Indications of improved employment outcomes, but selection bias a problem. Sometimes reduced return to work (artefact) plus hardest cases bias</td>
</tr>
<tr>
<td>H. Medical rehabilitation and health condition management</td>
<td>Nor, Swe effective, but selective, UK QUAL: positive perceptions</td>
</tr>
</tbody>
</table>

### What do we need to know?

- More and better quality studies, both quantitative and qualitative are required to gain clearer insights into what works and how it works.
- Studies needed that report on differential impacts, particularly by gender and socio-economic status.
- Studies need to be adequately controlled for external factors that may affect employment outcomes (e.g., local labour market conditions, macro-economic conditions).
- More understanding of the pathways out of the labour market are needed to inform interventions.
- Most studies undertaken at a time of stable or rising general employment – what happens in the current economic situation?
Thank you!!

The impact of return to work interventions in well-developed welfare systems: what we know and what we need to know?

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⁴Health Sciences and Social Welfare, Oslo University College, Oslo, Norway
Typology of interventions

<table>
<thead>
<tr>
<th>focus</th>
<th>perceived problem</th>
<th>Programme logic</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENVIRONMENT</td>
<td>A. Employers discriminate against disabled/chronically ill in recruitment and retention of staff</td>
<td>Use legislation either to outlaw discrimination in recruitment and employment or to set employment quotas</td>
</tr>
<tr>
<td></td>
<td>B. Employment and workplace inaccessibility creates significant barriers to employment for disabled/chronically ill</td>
<td>Legislate and/or provide support to improve employment and workplace accessibility</td>
</tr>
<tr>
<td></td>
<td>C. Few appropriate employment opportunities available for the disabled/chronically ill or employers perceive disabled/chronically ill workers to be less productive</td>
<td>Increase employ opportunities through job creation or financial incentives to employers to employ disabled and chronically ill</td>
</tr>
<tr>
<td></td>
<td>D. Loss of contact with work culture leads to sick-listed individuals moving into long-term sick/economically inactive category. Poor coordination of services hinders the process.</td>
<td>Require employers and service providers to make provision for planned return to work and cooperation among all actors involved</td>
</tr>
<tr>
<td>INDIVIDUAL</td>
<td>E. Welfare system creates disincentives to moving into employment</td>
<td>Increase motivation to gain employment through provision of financial incentives to disabled people or reducing generosity of benefits</td>
</tr>
<tr>
<td></td>
<td>F. Time outside the labour market means loss of skills in locating and obtaining appropriate work</td>
<td>Provide individualised vocational advice and job search assistance</td>
</tr>
<tr>
<td></td>
<td>G. Individuals lack appropriate skills, education or training for available work</td>
<td>Improve skill, education and training to increase “employability”</td>
</tr>
<tr>
<td></td>
<td>H. Individual’s health condition creating limitations on ability to perform job</td>
<td>Provide medical rehabilitation and/or health management advice to reduce impairment</td>
</tr>
</tbody>
</table>

Systematic review – search and inclusion process international 1990-2007

- Potentially relevant studies identified and screened for retrieval (n = 3628 + 2948*)
- Ineligible studies excluded (e.g. not empirical, not employment intervention) on basis of title and abstract (n = 3572 + 2689)
- Full studies retrieved and evaluated in detail in accordance with the inclusion criteria (n = 56 + 259)
- Studies excluded on basis of full paper (e.g. no employment outcome) (n = 30 + 199)
- Studies that met inclusion and critical appraisal criteria included in the review (n = 26 + 60)
  Total > 86

*Citations identified by electronic database searching + citations identified from grey literature and other sources.
### Inclusion/exclusion criteria

<table>
<thead>
<tr>
<th>Inclusion/exclusion criteria</th>
<th>Included</th>
<th>Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Geographical coverage</td>
<td>Canada, Danmark, Finland, Norway, Sweden, the UK</td>
<td>All other countries</td>
</tr>
<tr>
<td>(ii) Time coverage</td>
<td>Post-1990</td>
<td>Pre-1990</td>
</tr>
<tr>
<td>(iii) Population of interest</td>
<td>Working age (16-65) population with a long-term limiting illness or disability.</td>
<td>Pre- or post working age population, and working age population without a chronic illness or disability.</td>
</tr>
<tr>
<td>(iv) Studies of interest</td>
<td>1. Empirical evaluations of effectiveness of 'welfare-to-work' and 'long-term sick to work' programmes in terms of employment chances and income. 2. Qualitative studies of the views of participants and process evaluations of the implementation of the included interventions. 3. Systematic reviews of studies in 1 and 2 above</td>
<td>1. Evaluations of 'welfare-to-work' and 'long-term sick to work' programmes that do not include employment or social inclusion (e.g. studies that only evaluate health outcomes). 2. Studies that do not include empirical data or do not review empirical studies. 3. Single cross-sectional studies.</td>
</tr>
<tr>
<td>(v) Type of policy intervention</td>
<td>Major 'welfare-to-work' and 'return to work' programmes and their constituent elements to improve the employment chances of long-term limiting ill or disabled people of working age.</td>
<td>1. Small-scale, local experiments for specific groups of chronically ill or disabled people. 2. 'Sheltered employment' for severely disabled people that would not constitute employment in the general labour market. 3. Major 'welfare to work' programmes for people without a chronic illness or disability. 4. Major programmes to reduce short-term absence rates within the employed population.</td>
</tr>
</tbody>
</table>

### Search terms

<table>
<thead>
<tr>
<th>Population</th>
<th>Outcome</th>
<th>Intervention Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled or disabilit* or chronic ill* or chronic sick* or LLSI or longstanding illness or long-standing illness or long-term sick* or long-term ill* or permanent sickness</td>
<td>Work* or job* or vocation* or labour or labor or unemploy* or employment salary or salari* or income or wages or wage* or earn* or paid or paying or payment*</td>
<td>A) Rehabilitat* or welfare-to-work or back-to-work or welfare-to-work or training or retraining or skills or advice or counselling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B) Disability benefit or disability pension or sick leave or early retirement or mobility allowance or invalidity benefit or long term sickness benefit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C) Quota* or employer subsidy or employer subsidies</td>
</tr>
</tbody>
</table>
What do the reviews tell us

• There is a substantial gap between the large number of interventions identified and the limited number of evaluations carried

• RCTs rare, as are robust controlled studies

• Qualitative studies are invaluable for understanding why intervention worked or didn’t work and for gaining greater insight into the limitations of those which are effective

• The majority of studies are in the grey literature

• Some studies indicate potential improvements in employment chances – Swedish Resting Disability Pension even after several years – but need to understand country context

• Biased selection of participants into many interventions – cream-skimming or struggling with hardest-to-place

What do the reviews tell us

• Some interventions taken up by those for whom they were least intended – crowding out target – Danish Flexjobs?

• Some evaluations measure outcomes too soon or inappropriately – vocational rehabilitation, where time spent on scheme looks like a delay in returning to work

• Some interventions may be counterproductive – Swedish study of different forms of rehabilitation found that educational rehabilitation worsened chances of re-employment compared with no rehabilitation.

• Need to understand country context to interpret above finding – individuals with bad sickness record, having exhausted other forms of rehabilitation, end up in educational rehabilitation as last stage before disability pension. Stigma may also play a part (employers know sickness profile of participants).
What do the reviews tell us (cont.)

- An intervention may show no effect because the problem is misidentified, the theory of change is wrong or the intervention may be having unintended negative effects.

- Some potentially promising interventions have low take up or population coverage, so can’t be expected to have population impact. Norwegian *Active Sick Leave* – 1% of eligible people.

- Potential impact compromised by low level of resources, e.g. UK’s *Access to Work*.

- Very few studies measured differential impact by SES.