Track C5: Workshop: Evaluation of return-to-work interventions for sickness absentees: alternatives to randomized controlled studies

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More and more attempts are made to reduce sickness-absence duration. The variety of interventions to promote return to work (RTW) of sickness absentees is large and their effectiveness often questioned. Researchers should be able to evaluate effectiveness. A Randomized Controlled Trial is regarded as the golden standard for evaluation studies, but it is often hard to meet all the necessary assumptions so the external validity can be discussed. There are different alternative approaches to evaluate RTW interventions; four alternatives are the focus of this workshop. First, alternative randomization procedures are presented. Adequate randomization for allocating patients in an unbiased manner is essential but is often impaired by legislative and organizational rules. Alternatives are randomizing the physicians involved or quasi-experimental designs. Second, another option is to use longitudinal datasets and simulate randomization or adjust for the absence of it, which requires specific statistical tests. Third, interventions can be evaluated at the organizational level, which requires evaluation of the implementation as well. Finally, a qualitative approach that takes the perspectives of stakeholders into account will be presented. This responsive evaluation holds a different definition of the optimal intervention. The aim of the workshop is to present different approaches to evaluate RTW interventions and to discuss limitations, advantages, and applications.

Randomized controlled trials in return-to-work interventions: three variations

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Introduction
In field studies, randomization is hampered by legislation and policy. Alternatives are randomizing the physicians, quasi-experimental designs, or using a strict protocol.

Methods
Three studies to evaluate assessment strategies in the Belgian sickness insurance were conducted. First, a rehabilitation-oriented approach in insurance medicine was compared with traditional assessment. Instead of randomizing the patients, medical advisers were randomly selected and trained. Second, a communication protocol between occupational and social insurance physicians was investigated using a quasi-experimental design. A third study to evaluate an evidence-based protocol for low back pain is currently ongoing. Patients are randomly assigned to two study groups; physicians use strict protocols.

Results
The intervention increased the probability of return to work for patients after lumbar disc herniation surgery. In the second study, no effects of the protocol were found.

Conclusions
If patients cannot be randomized, randomization of physician seems a good alternative.

Causal inference of the effectiveness of a return to work intervention from observational data: the role of selection

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Introduction
Causal inference of intervention effects from observational data is problematic: exchangeability between intervention and control group is not guaranteed. Adjustment for confounding due to non-random selection for interventions makes causal inference possible. We investigated whether and how selection for an intervention by the occupational physician influences the return to work rate of sickness absentees.

Methods
Observational data from 2622 sickness absentees in The Netherlands were used.

Results
Selection for an intervention by the occupational physician is mainly driven by the absentee's labour market position. Occupational physicians are more likely to select sickness absentees with lower chances of return to work. The intervention does not appear to be successful in increasing return to work for these people.

Conclusions
If observational data are used, statistical techniques are needed to adjust for non-random selection for interventions. This clarifies the causal effects of return to work interventions and helps to improve intervention strategies.

Work and health in the processing and engineering industries

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Introduction
In a Swedish multi-centre study, an extensive health and psychosocial intervention is evaluated; outcomes included sick leave.

Methods
Four large workplaces and one reference group were involved between 2000 and 2003 comprising some 5000 employees. Four focus areas were considered: (i) neck and back pain; (ii) cardiovascular diseases; (iii) asthma and chronic obstructive pulmonary disease (COPD); and (iv) hazardous alcohol consumption. The AHA-method is based on three steps: (i) mass screening of employees; (ii) feedback of results at individual and group level; and (iii) intervention (including standardized assessment protocols and evidence-based rehabilitation).

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Results
About 42% of the respondents were 'at risk' and recommended further examination at the occupational health service. About 5% underwent rehabilitation. Implementation processes differed somewhat. Outcomes indicate an advantageous course on sick leave at three of the four companies.
Conclusions
The two companies being most compliant also showed the clearest decrease in sick leave.

Responsive evaluation of an intervention to promote reintegration to work among people on disability pension

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Introduction
Demand-oriented rehabilitation is expected to increase client-involvement and intervention effectiveness. A group-training for people on disability pension with mental problems was evaluated. The training consisted of 10 meetings and aimed at behavioural change. Including client and professional perspectives, we studied how professionals try to work demand-orientation and its consequences for reintegration.
Methods
In-depth interviews were held with eight clients (19–50 years; four males and four females) and eight trainers (28–52 years; three males and five females).
Results
Trainers were not able to increase client-involvement. This relates to the supply-oriented approach during the intake-phase. The training appeared to be successful only for clients able to evaluate themselves in psychological terms. However, these clients become dependent upon the trainers. The other clients are set aside as being 'not motivated' and feel excluded.
Conclusion
This evaluation demonstrated why the intervention was not able to increase client-involvement and return to work.

Track C6: Health services

How community based is general practice?

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Background
One of the potentially strong points of general-practice-based primary care is that it is accessible within local communities. As the arm of clinical medicine with the broadest reach into the community, primary care clinicians are well-positioned to understand local needs and design programmes that address community health. This paper analyses variations in the degree to which general practices indeed work community based. Geographical factors, patient factors, and practice factors are taken into consideration.
Methods
Data are derived from a computerized general practice network (the Dutch National Information Network in general practice for the year 2004 with 349 000 patients in 161 000 households in 86 practices). Patient and practice location are known at 4-digit ZIP-code level. Multilevel analysis is performed at household level (taking in account demographic factors and migration history), ZIP-code level (degree of urbanization), and practice level (GP and practice characteristics).
Results
On average 42% of the GP's practice population lives in the ZIP-code area where the practice is located. The practice covers on average 31% of the total population of that area. In urban areas these percentages are 31 and 11%, respectively. There is significant variation at all levels. On the household level single males and females live farther from the practice. At practice level list size is positively correlated with distance to the practice but group practices are on average closer to their patients.
Conclusions
Especially in urban areas a substantial part of the GP's practice population lives outside the practice's neighbourhood, which makes community-oriented action more difficult. Group practices work more community based than single handed practices. The trend towards more group practices makes prospects for a more community-based primary care favourable.

Does trust in health care influence the use of complementary and alternative medicine by chronically ill patients?

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Background
Patients' trust in health care (professionals) is essential for the effectiveness of health care, especially for chronically ill patients, since chronic diseases are by definition (partly) incurable. Therefore, it may be understandable that the chronically ill turn to complementary and alternative medicine (CAM), often in addition to regular care. The relationship between trust in health care (professionals) and CAM use in chronically ill patients have not been reported until now. In this study, we examine (i) chronically ill patients' trust in health care (professionals), (ii) their use of CAM, and (iii) the relation between trust and CAM use.
Methods
The sample comprises respondents of the nationwide Dutch 'Panel of Patients with Chronic Diseases' (PPCD). Patients were selected by their GPs on the basis of diagnoses of chronic diseases. In total, 1625 chronically ill patients (>25 years) were included. Trust and CAM use were measured by means of a written questionnaire (2003). Statistical analyses used were *t*-tests, Chi-square and one-way analysis of variance, and logistic regression analysis.
Results
The less trust patients have in regular health care in the future the more they will be inclined to use CAM, when controlling for socio-demographic and disease characteristics. Female, young, and higher educated patients are more likely to use CAM, whereas patients suffering from cardiovascular diseases, patients with diabetes, and patients with asthma/COPD are less likely to use CAM.
Conclusions
Trust is an important concept in health care use and a significant issue in CAM use by chronically ill patients. CAM use may increase, at least by chronically ill patients, if the relatively low trust in future health care will stay at the same level.

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