The integrated education of mildly disabled children creates the foundations of the successful social integration of the disabled. This practice promotes the tolerance of sound people, and helps to pull down their prejudices. The social integration of the disabled might meet similar problems in the countries of Central-East Europe.

A systematic review of studies on sickness absence and disability pension: Workshop of the EUPHA Section on Social Security and Health

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Introduction

The Swedish Council on Technology Assessment in Health Care has done a systematic and critical review of the scientific literature on sickness absence and disability pension. The aim of the project was to:

- Assess the scientific evidence about positive and negative consequences of being sickness absent.
- Review the research in sickness absence and disability pension, current knowledge of its causes and on sickness-certification practices of physicians.
- Identify areas where further research is needed.

A broad search for studies was done, using literature databases (Medline, PsychINFO, SSCI), reference lists, and personal contacts. Found publications were judged according to relevance, quality (according to set criteria) and the scientific evidence they provided. Studies addressing the following seven topics were reviewed:

- Reasons for sickness absence in general, irrespective of diagnoses.
- Souses of sickness absence with back or neck disorders.
- Sick leave and psychiatric diagnoses.
- Sick leave following stroke, MI, and certain heart procedures.
- Consequences of sick leave.
- 'Sickness presence'.
- Sickness-certification practices of physicians.

The following persons conducted the review: *Alexanderson K[1], Allebeck P[1,2], Hansson T[2], Hensing G[2], Jensen I[1], Mastekaasa A[3], Norlund A[4], Perk J[5], Wahlström R[1], Vingård E[1].*

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Aim

The aim of this workshop is to report results from the review and discuss consequences of this for future research and international research cooperation.

Presentations

- Risk factors for sick leave – a systematic review of general studies. *Arne Mastekaasa*, professor, Oslo, Norway
- Sick listing and its consequences, sickness presenteeism, and sick listing because of low back and neck/shoulder disorders and pain. *Eva Vingård*, professor, Stockholm, Sweden
- Towards evidence based knowledge on sickness absence, psychiatric disorders and alcohol problems – a systematic literature review. *Gunnel Hensing*, Ass prof, Gothenburg, Sweden.
- Studies on return to work after stroke and MI, and on sickness certification practises of physicians. *Kristina Alexanderson*, professor, Stockholm, Sweden

Risk factors for sick leave – a systematic review of general studies

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This paper provides a narrative review of the empirical literature on risk factors for sick leave and disability pension. The purpose of the review was: (1 to provide an overview of the field, focussing in particular on the identification of under-researched areas; 2) to evaluate the evidence on the effects of specific risk factors. After scrutinizing more than 600 publications found in bibliographic databases and in reference lists, 188 relevant publications were identified. 97 of these were found to be of sufficient quality with regard to design, response rate, statistical methods, etc.

Not unexpectedly, the importance of working conditions has received the most attention in sick-leave research. Also, the importance of family structure (marriage and children) and lifestyle factors have been studied rather extensively. Some relatively neglected areas are: the causes of demographic differences in sick leave (gender, age, social class), employee attitudes and workplace cultures, and insurance/compensation schemes. Also, there are in general few studies on the causes underlying disability pensioning.

Regarding the family, we found no satisfactory evidence that marital status and children living at home were associated with sickness absence. However, we found limited scientific evidence for an effect of divorce. As for work-related factors, there is some evidence for effects of physically stressful work and work autonomy. There seems to be a correlation in time between unemployment and sickness absence, but there is little on the causes of the association. There was moderate scientific evidence that the amount of sickness absence is influenced by the design of the social insurance system, but insufficient evidence on the magnitude of change required to influence the level of sickness absence.

With regard to disability pension, the number of studies was small. However, we found moderate scientific evidence for the effects of socio-economic status, which could be explained partly by exposures during childhood.

Sick listing and its consequences, sickness presenteeism, and sick listing because of low back and neck/shoulder disorders and pain

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Sick listing is frequently used but its consequences are not very well described. Possible consequences can be measured at different levels; here consequences for the sick-listed person were focused. Sick listing might have both positive and negative effects, for example on disease development, health, work, social life, and life style. Some of these factors are investigated in single studies, but evidence of any consequences are lacking due to few studies.

When a person has an impaired work capacity because of a disease but still works the term sickness presenteeism is used. A problem with this terminology is that it implies that being at work when not perfectly healthy is an exceptional status. However, most persons with a diagnosed disorder or disease are not sick listed but working. Sickness presenteeism is therefore not a good term to use in a scientific context. Investigations have shown that sickness presenteeism is frequent but no evidence on the consequences for the individual or the work place can be stated.

Sick listing because of low back and neck/shoulder disorders is frequent but the scientific knowledge about causes for sick listing because of these common diagnoses are rare. Few studies exist and most of them are investigating men working in industry. Studies on women, white collar worker, and employees in the public sector are lacking. However, there was a scientific evidence for that the following factors were related to sick listing with these diagnoses: High physical workload, forward bending, working in awkward positions, and low job satisfaction were associated with both short- and long-time sick listing. A specific back or neck diagnosis and earlier sick listing because of that were associated with both short- and long-time sick listing. Self-reported pain and disability were associated with long-term sick listing. Long duration of the present employment reduced the risk of short-time sick listing.

Towards evidence based knowledge on sickness absence, psychiatric disorders and alcohol problems – a systematic literature review

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Background and aim

The aim of this presentation is to report the results of a review of

evidence based knowledge on sickness absence, psychiatric disorders and alcohol problems.

Methods

A systematic literature review was performed on studies published in international, peer reviewed journals. Literature search was done in Medline, PsycINFO and SSCI. The relevance and quality of the studies was assessed by two independent researchers. An evaluation of evidence was made according to international standards. Quality was assessed regarding study design, drop out, bias, analysis and precision. Four evidence levels were established: strong, moderate, limited, and without evidence. Studies on absenteeism where sickness absence could not be identified as a separate unit were excluded.

Results

Abstracts on sickness absence, psychiatric disorders and alcohol problems were identified (n=580). Of these 97 studies were assessed as relevant, only 28 were assessed as being of sufficient scientific quality. No evidence was found for increased sickness absence in general among individuals with psychiatric disorder due to contradictory findings in different studies. Sickness absence with a psychiatric diagnosis on the certification was more common among women. No difference was found for sick-leave days. Studies covered work related factors, socioeconomic factors outside work and psychosocial factors in childhood. No evidence was found due to few studies on each factor. Studies on alcohol consumption were common but only nine had sufficient quality. Four studies showed an association between alcohol diagnoses/problems and increased risk for sickness absence irrespective of certification diagnoses. Due to few studies and limited quality no evidence was reached. No association was found on high alcohol consumption and increased risk for sickness absence.

Conclusion

Selection bias, no or limited reports on drop out, and ill defined sickness absence measures were common methodological limitations. A closer co-operation between sickness absence, psychiatric and alcohol researchers could enhance quality in studies within this area.

Studies on Return to Work after Stroke and MI; and on Physicians' Sickness-Certification Practice

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Although many physicians must make decisions concerning sickness certification, few studies have addressed physicians' practices in this area. We found 28 studies of sufficient quality on this, however, they were on very different topics and could thus only provide evidence on the following two, very broad questions:

There is limited evidence that physicians view the work involved with sick leave (eg, medical and insurance issues) to be difficult or problematic.

There is also limited evidence that the sickness certificates written by the physicians are often incomplete, rendering it more difficult for the insurance office to decide on compensation.

In isolated studies (ie, insufficient basis for drawing conclusions) physicians suggest that their overlapping roles as a representative for the patient and a medical consultant for public authorities (eg, the insurance office) is problematic. It is difficult to assess the patient's working capacity, and physicians perceive their knowledge about the insurance system to be inadequate. Scientific evidence on the practice of prescribing sick leave is also deficient in other respects (eg, studies are of poor quality, too few, or show conflicting results), which does not enable one to draw valid conclusions. Likewise, there is insufficient evidence on the criteria used to assess work capacity.

Disorders of the circulatory system are the third most common cause for disability pension. There is limited evidence that most people of working age return to work following stroke, myocardial infarction, or heart surgery. However, no evidence identifies interventions that can shorten the length of a sick-leave spell. The reasons for the relatively long periods of sick leave that are common in Sweden, eg, after myocardial infarction, are not known.

Injury Prevention

Variance in injury incidence in ten European countries

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Eurocost reference group

Background

Injuries due to accidents are a major public health problem. In order to prevent accidents and injuries, it is important to get a clear picture of the variance in frequencies of injuries in the European Union.

Aim

The objective of the study is to describe and explain the differences in injury incidence in Austria, Denmark, Greece, Ireland, Italy, the Netherlands, Spain, England and Wales.

Methods

Within the framework of a European project we conducted an international comparison of accident data of injury surveillance systems at Emergency Departments (ED-incidence) and hospital registrations with a national coverage (clinical incidence). The first step was to harmonise the data by means of uniform definitions and classifications. A classification of 39 injury groups (ICD-coded) was used to analyse injury patterns. These data were standardised for age and sex according to the direct method using the population of the ten participating countries as a standard. The reference group reached consensus about the new analysis method, which is aimed at reducing the effect of international differences in the surveillance practice and the health care situation on the incidences (per 1,000 inhabitants). To increase the international comparability, the influence of 'registration thresholds' was analysed. The injury incidence for specific injury and accident groups was analysed.

Results

The standardised ED incidence for home and leisure accidents varies from 48-111, while for severe fractures due to home and leisure accidents the incidence varies from 3–14. The standardised clinical incidence for hospital admissions varies from 7–23. For traffic accidents, the ED incidence varies from 5–23, while the incidence for severe injuries varies between 1–6. The clinical incidence for this patientgroup is 1–3.

Conclusions

There is a major difference between the observed injury incidence between countries. Also after correcting for registration effects, considerable differences remain between countries in Europe. Explaining these differences will help to formulate prevention policy.

Interim results of the use of hip protectors at residential care institutions of Oslo

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Issue

Burden of injury as a result of fall is increasing in the ageing population of Oslo. Institutionalised older people are most vulnerable as regards hip fracture.

Description

The Council of City of Oslo has commissioned a procurement of hip protectors in spring 2003 for institutionalised older residents of Oslo in need. 64 residential care institutions are participating. Registration of details on falls occurring in the institutions has been implemented as a monitoring part of the project.

Lessons

260 falls have been registered in a period October 2003 to March 2004 on average. Most falls (55%) happen in the institutions in private room. Almost 40% of falls happen in the afternoon. There was no difference in rate of falls on weekends compared to working days.

578 (34%) falls occurred to the users of hip protectors. 78% of them had hip protectors on hips, while 18% didn't wear hip protector at the time of fall.

There were registered 24 hip fractures as a result of fall. Odds ratio for hip fractures among the users of hip protectors was 1.30 (95% confidence interval 0.4, 4.21) as compared to non-users, indicating no protective effect of hip protectors in non-experimental environment.