

Potential contributing factors, such as communication difficulties and cultural issues (for women and care providers) will be discussed.

Risk factors for infant deaths among singleton babies born at term in England, 2005–07

Nirupa Dattani

N Dattani, AJ Macfarlane, P Datta-Nemdharry
City University London, United Kingdom
Contact: n.dattani.1@city.ac.uk

Introduction

Over 90 per cent of the live singleton births that occur in England are born at term 37–41 weeks. Although the infant mortality rate for this group of babies is only 1.8 per 1000 live births compared with the overall infant mortality rate 4.9 per 1,000 live births, they account for 40 per cent of infant deaths among live singleton births. Ethnic origin is not recorded at registration. Therefore all analyses to date based on national data have used the mother's country of birth. But with the introduction of a central system for allocating the National Health Service Number for Babies (NN4B) in 2002, it was possible to access information on ethnicity and gestational age for all births. Information on parity is collected on a separate hospital admission system. Therefore selected data items from both of these systems were linked to birth and infant death registration records in England to enable analysis of infant deaths by gestation, birthweight, ethnicity, parity, mother's age, marital status and area deprivation score.

Method

All records of singleton live births linked to NN4B and hospital records in England for 2005 to 2007, for babies born at term and for babies whose ethnic group ethnic group was recorded as White British, Pakistani, Bangladeshi, Indian, Black African and Black Caribbean were used. Odds ratios and p-values for the univariate and multivariate analysis were derived from logistic regression in SPSS.

Results

There were 2,798 infant deaths among 1,510,376 singleton live births in England from 2005 to 2007, giving a rate of 1.85 per 1,000 live births. Infant mortality for babies of Pakistani ethnicity was significantly higher at 5.14 per 1,000 live births compared to white British, Indian, Bangladeshi, black Caribbean and black African babies. The odds ratio remained significantly higher at 2.54 after controlling for mothers age, birthweight, sex, parity, marital status and area deprivation score.

Conclusion

Infant mortality for babies of Pakistani ethnicity remains high at term compared to all other ethnic groups in England, after controlling for socio-demographic factors and area deprivation score. These babies have high mortality rates due to congenital anomalies and these may be attributed to autosomal recessive inheritance.

What are the social, economic and general health costs and benefits of consanguinity? the Born in Bradford Birth Cohort Study

Raj Bhopal

R Bhopal¹, E Petherick², L Fairley², N Small³, J Wright²

¹Ethnicity and Health Research Group, Centre for Population Health Sciences, the University of Edinburgh, Edinburgh, United Kingdom

²Bradford Inst for Health Research, Bradford Teaching Hospitals NHS Foundation Trust, Bradford, United Kingdom

³The University of Bradford, Bradford, United Kingdom
Contact: raj.bhopal@ed.ac.uk

Background

More than 1 billion people are reportedly in consanguineous marriages, which have small but important risks of genetic defects in offspring. While counterbalancing benefits are claimed, the evidence is sparse and qualitative.

Objective

To examine, quantitatively, a range of putative associated social, economic; lifestyle and general health benefits (excluding genetic outcomes) in women and their offspring in consanguineous marriages.

Setting

City of Bradford, England-Born in Bradford (BiB) Study

Design/Methods

BiB is a prospective birth cohort study where 13,776 women were recruited at about 26–28 weeks gestation between 2007–2010 with follow up to birth, and beyond that through linkage to health records and actual follow up of subsets. At recruitment women completed a questionnaire including whether they were related to the father of the baby before marriage. Ethnic group was self-assigned based on the Census England 2001 question. We compared Pakistani and Other Non-British groups in, and not in, consanguineous marriages. For reference we used White British mothers not in consanguineous marriages.

Results

Consanguinity was common in the Pakistani group (59%, 37.4% with first cousins), less common in the Other ethnic groups (7%) and rare in the White British group. Mothers in consanguineous relationships were, objectively, comparatively socially and economically disadvantaged. Yet, in every respect their lives were no worse or better than women in non-consanguineous marriages. For example women in consanguineous relationships were less likely to be employed, or have higher education than their non-CR counterparts. They were no different in financial matters including paying bills, or in the marital relationship e.g. the security and warmth of their relationship. Women in CRs were less likely to divorce, smoke cigarettes, or drink alcohol.

Conclusion

Consanguineous relationships are associated with benefits that need to be offset against genetic risks to offspring. In evaluating consanguinity a broader scientific perspective than hitherto is essential.

L.5. Workshop: Diagnosis-specific sickness certification guidelines/recommendations: their background and implications

Chair: Kristina Alexanderson, Sweden

Organiser: EUPHA Section of Social Security and Health

Every day, physicians write medical certificates for thousands of patients regarding their sickness absence. Different studies have identified great variations in sickness absence certification patterns, also in patients with similar diagnoses and work capacity. Moreover, there is evidence from several studies that physicians find sickness certification a problematic task. To aid

physicians, insurance agencies, and case managers and to assure a patient's right to fair and more equal treatment, different sets of diagnosis-driven recommendations or "guidelines" have been developed and implemented in different countries.

The aims of this workshop is to provide an overview of such sickness certification recommendations or "guidelines", currently used in Europe and the United States, and to initiate a discussion about them, from a scientific point of view.

Five different sets of recommendations or “guidelines” will be presented, two from Europe (Sweden and the UK) and three from the United States, regarding their underlying principles, intended use, and evaluation. In addition, the basis for the development of new return-to-work guidelines for patients in cardiac rehabilitation programmes in The Netherlands will be presented.

Clinical practice guidelines have been defined as “systematically developed statements to assist practitioners’ and patients’ decisions about appropriate health care for specific clinical circumstances”. Such guidelines should be based on scientific evidence. However, due to the limited research on sickness absence, and especially regarding sickness absence due to specific diagnoses, the extent to which sickness certification recommendations are science-based is very limited. Nevertheless, every day physicians discuss the pros and cons of being absent from work with their patients and write sickness certificates indicating the ‘correct’ or optimal duration for sickness absence.

Some of the questions to be discussed in the workshop are: What are the incentives for introducing diagnoses-specific sickness certification recommendations or “guidelines”? What are the pros and the cons of using such guidelines, from the perspective of patients, physicians, employers, insurance companies, and politicians? How should studies best be designed to gain more knowledge about this?

Comparative overview of disability guidelines in the United States

George Delclos

GL Delclos^{1,2}

¹The Center for Research in Occupational Health, Pompeu Fabra University, Barcelona, Spain

²The University of Texas School of Public Health, Houston, Texas USA

In this presentation, we will provide a comparative overview of three comprehensive resources frequently used in the United States by clinicians and case managers to help guide the management of sickness absence: 1) the Official Disability Guidelines, published by the Work Loss Data Institute, 2) the Medical Disability (or ‘MD’) Guidelines, published by the Reed Group, and 3) the Occupational Medicine Practice Guidelines, published by the American College of Occupational and Environmental Medicine. Topics addressed by these guidelines include anticipated time to return to work, evidence-based treatment guidelines and work modifications. In addition to comparing these three guidelines, some practical examples of their use will be provided during the session.

Return-to-work guidance in the Dutch Multidisciplinary Guideline for Cardiac Rehabilitation 2011

Angelique de Rijk

A de Rijk

Department Social Medicine, Maastricht University, Maastricht, The Netherlands

Introduction

In 2011, the new Dutch Multidisciplinary Guideline for Cardiac Rehabilitation has been launched. The guideline includes recommendations regarding return to work for cardiac rehabilitation teams, general practitioners and occupational physicians.

Methods

Three systematic reviews were done on 1) the effectiveness of return-to-work interventions for cardiac patients; 2) risk factors in the workplace for cardiac patients and 3) factors that prolonged sickness absence in cardiac patients. The scientific evidence from these reviews was discussed with representatives of 11 scientific societies of professions involved in cardiac rehabilitation and the patient’s association during

11 meetings over a period of 18 months. Recommendations were formulated, checklists were developed and pilot-tested and schemes to improve communication.

Results

The following number of studies with sufficient quality was found: 14 studies on return-to-work interventions for cardiac patients; 32 studies on psychosocial risk factors were of sufficient quality; 24 on factors that prolonged sickness absence in cardiac patients. Positive effects of interventions were found for the more complex interventions. Four major psychosocial risk factors were found and 14 barriers to successful return to work. Key recommendations were: start of (part-time) return-to-work during cardiac rehabilitation; tailor-made support; communication between the cardiac rehabilitation team and occupational physician. To facilitate tailor-made support a checklist for screening on risk-factors in the workplace and barriers for return to work was developed and pilot-tested in one hospital. In addition to the checklist a matrix with risk-factors/barriers and possible interventions was developed to guide professionals in offering tailor-made support.

Conclusions

Return-to-work guidance should be part of cardiac rehabilitation in order not to delay return to work and offer the patient tailor-made support. Next step is implementation of the guideline.

‘Healthy Working UK’: A website for work and health in the UK

Debbie Cohen

D Cohen

Centre of Psychosocial and Disability Research, Cardiff University, Wales, United Kingdom

Background

Dame Carol Black’s report (2009) highlights the evidence that work is good for health and wellbeing as well as the therapeutic nature of work. Studies have highlighted that GPs and hospital doctors feel they lack both knowledge and confidence in managing work and health related issues in their consultations. In the UK this has led to the development of interventions and training, to shift health practitioners’ behaviour about the importance of addressing health and work issues with their patients. Central to these developments is the “Healthy Working UK” website. The website is endorsed by The Royal College of General Practitioners, The Faculty of Occupational Medicine, and The Society of Occupational Medicine.

Method

The website was developed in 2008 using experts, GPs and occupational health practitioners. Data was collected to understand GPs’ views on a ‘health and work’ website. In 2009, the site was evaluated across Wales. In 2010, the site was expanded to cover the whole of the UK. The site includes information and leaflets for patients and doctors including guidelines about return to work, access to e learning for both hospital doctors and GPs and links to face-to-face training events. The site includes ‘aids’ to support the completion of new ‘fit note’ and a newsletter.

Results

The website has slowly gained membership over the last three years. Between April 2011–December 2011 there had been 9615 visits to the site; 6445 individual visitors and an average 1000 visitors per month, viewing on average 3 pages. The ‘home page’, ‘learning resources’, and ‘websites and leaflets’ were the most viewed areas. Our results show that the site has enhanced GP learning with now 3500 GPs attending face-to-face training since June 2009. 394 GPs and 60 hospital doctors have downloaded the e-learning training from the site during this time period.

Discussion

The website is central to the on-going UK work stream to engage health practitioners, employers, and individuals with the work-and-health agenda and bring about a change in