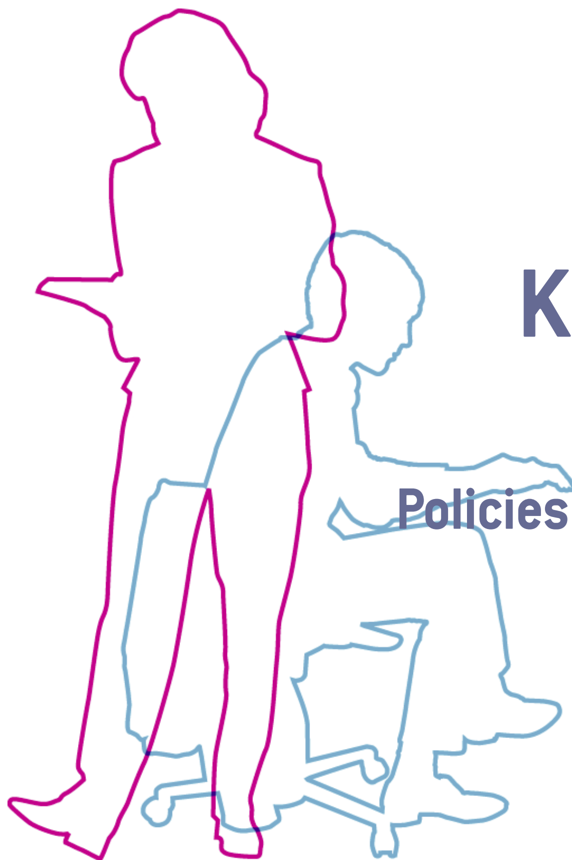
eurogip

03/2014
Ref. EUROGIP-85/E



Keeping people at work in Europe and Canada

Policies for rehabilitation and return-to-work

Proceedings of the EUROGIP Discussions on 19 March 2013 (Paris)

eurogip

comprendre les risques professionnels en Europe
understanding occupational risks in Europe

Conference Programme 19 March 2013

Keeping people at work in Europe and Canada

Policies for rehabilitation and return-to-work

Opening session

- **Raphaël HAEFLINGER**, Director of EUROGIP

The potential implications of retention in employment

- **Dominique MARTIN,** Occupational risk Director, French National Health Insurance Fund for Employees (CNAMTS), France
- **François ATGER**, Director of Communications, in charge of International Relations, Association for management of the fund for integration of disabled persons (Agefiph), France
- **Stéphane PIMBERT**, Director General, National Research and Safety Institute for the prevention of accidents at work and occupational diseases (INRS), France
- **Laurent VOGEL**, Researcher, Working Conditions, Health and Safety Department, European Trade Union Institute (ETUI)

National policies to manage disability, job retention, rehabilitation

- **Philippe CALATAYUD**, Responsible for Insurance benefits for Swiss Romandie and Ticino, Suva, Switzerland
- **Doris HABEKOST**, Responsible for Participation in Job market / Disability management Unit, Insurance and Benefits Department, German Social Accident Insurance (DGUV), Germany
- **Vigdís JÓNSDÓTTIR**, Director, Icelandic Rehabilitation Fund (VIRK), Iceland
- **Therese KARLBERG**, Manager, Division for Early retirement, Disability benefits and Occupational injuries, Swedish Social Insurance Agency (Försäkringskassan), Sweden
- **Claude SICARD**, Vice-President, Occupational Health and safety Commission (CSST), Canada
- **Glen WINZOR**, Director of Research Coordination, Forskningscenter for Arbejdsmiljø (National Research Centre for the Working Environment), Denmark

European project "Promoting healthy work for workers with chronic illnesses"

- **Nettie VAN DER AUWERA**, Project coordinator, European Network for Workplace Health Promotion (ENWHP)

Mobilization around enterprises

- **Jean-Michel BACHELOT**, Consulting Engineer on prevention of occupational risks, Retirement and Occupational Health Insurance Fund CARSAT) Pays de la Loire, France
- **Pascal CORBINEAU**, Occupational physician, Airbus Nantes, France
- **Katrien BRUYNINX**, Project Manager, Prevent, Belgium
- **Annette GÄSSLER**, Specialist in Occupational Medicine, Germany
- **Juha MIKKOLA**, Managing Director, Finnish Insurance Rehabilitation Association (VKK), Finland
- **Zinta PODNIECE**, Project Manager, Prevention and Research Unit, European Agency for Safety and Health at Work (EU-OSHA)
- **Joy REYMOND**, Head of Rehabilitation & Health Management Services, Unum, Director of the Vocational Rehabilitation Association and the UK Rehabilitation Council, Great Britain

Moderation of the Discussions:
Régis de CLOSETS, Journalist

Introduction

To supplement the succinct information given by the speakers on the insurance context of the country in question, we invite the reader to look up Eurogip's publications or the Web links relating to the following countries:

- Statistical review of occupational injuries **GERMANY** - 2009-2010 data
  http://www.eurogip.fr/images/publications/Eurogip_Point_stat_GER0910_71EN.pdf
- Statistical review of occupational injuries **BELGIUM** - 2008 data
  http://www.eurogip.fr/images/publications/Eurogip_Point_stat_Bel08_56EN.pdf
- Statistical review of occupational injuries **DENMARK** - 2004-2010 data
  http://www.eurogip.fr/images/publications/Eurogip_Point_stat_Dan0410_67EN.pdf
- Statistical review of occupational injuries **FINLAND** - 2008 data
  http://www.eurogip.fr/images/publications/Eurogip_point_stat_FI08_66E.pdf
- Statistical review of occupational injuries **FRANCE** - 2012 data
  http://www.eurogip.fr/images/documents/3597/Eurogip_90EN.pdf
- Statistical review of occupational injuries **GREAT-BRITAIN** - 2008-2009 data
  http://www.eurogip.fr/images/publications/Eurogip_Point_stat_GB08_09EN.pdf
- Statistical review of occupational injuries **SWEDEN** 2008-2009 data
  http://www.eurogip.fr/images/publications/Eurogip_Point_stat_Sweden_08_09EN.pdf
- "L'assurance contre les risques professionnels en **SUISSE**" (2012) - in French only
  http://www.eurogip.fr/images/documents/3480/Eurogip_ATMP_Suisse_80FR.pdf
- Useful websites in the field of occupational risk insurance and prevention
  http://www.eurogip.fr/en/useful-links

Les Débats d' eurogip
19.03.2013 Paris

Opening session

Raphaël HAEFLINGER, Director of EUROGIP

Welcome to the Eurogip Discussions, this year devoted to retention in employment in Europe and Canada. A large number of you take part in this annual event that Eurogip organizes on a topical issue relating to occupational risks in Europe.

Today, we shall present to you the policies applied for people suffering from a health problem, especially one of work-related origin. This choice owes nothing to chance, but is related in particular to the programme to which France has committed itself, about which Dominique Martin will speak to you straightaway.

Eurogip's mission is to observe foreign systems and encourage exchanges of experience. Retention in employment and the prevention of occupational desintegration have long been priorities in several foreign countries represented here today. The measures for retention in employment existing outside France are often intrinsically linked to the occupational risk insurance systems. Retention in employment and the medical rehabilitation of occupational injury and disease victims form an integral part of the insurer's services. Accordingly, these services sometimes precede compensation payments.

At the Community level, the Strategy 2007-2012 on health and safety at work encouraged Member States to include in their national policy specific measures to improve the rehabilitation and reintegration of workers excluded from the labour market following an occupational disease or injury.

Today we shall look at foreign experience regarding the early detection of risks of occupational desintegration; medical and social rehabilitation of victims; retention in employment within the enterprise, through adaptation of the work station or assignment to a new job; retention in employment, i.e. reintegration outside the enterprise in a job that is not necessarily the same; and the organization of case management by occupational injury insurance organizations.

We should like everyone to assimilate the experience of the other countries and be able to understand both the foreign approach to social insurance and foreign practices, while becoming aware of the difficulties of managing occupational rehabilitation.

I would remind those who do not know us that Eurogip was founded 20 years ago in the form of a public interest grouping by the Occupational Risks Department of the French insurer for employees and private-sector firms, CNAMTS, and by the French national research and safety institute for occupational injury and disease prevention, INRS. Eurogip is a small structure governed by an equi-representational Board of Directors.

In addition to this annual event, the Discussions, Eurogip performs research and surveys concerning occupational risks in Europe. The latest report, produced in conjunction with ten foreign insurance organizations, covers the recognition of work-related mental illnesses(1) as occupational injuries or diseases.

Eurogip also collaborates on projects of Community interest, notably in close cooperation with the European Agency for Safety and Health at Work (EU-OSHA in Bilbao), which disseminates information and good practices relating to occupational risks. The Group also replies to invitations to tender from the European Commission. For example, it has drawn up guidelines for the application of occupational health and safety directives, and recently it collaborated on a project relating to occupational health systems in Europe(2).

Lastly, Eurogip keeps a daily watch on occupational risks in Europe. This monitoring service inputs data in particular for the newsletters available on our website (www.eurogip.fr), in French and English.

Eurogip also has two more technical activities:

- Coordination of a network of experts of the Occupational Injuries Branch, who take part in the production of European and international standards in the area of health and safety at work;

- Coordination of the Notified Bodies for the regulatory certification of machinery and personal protective equipment at the French level, under the authority of the Ministries of Labour and Agriculture; on the European level, for machinery, under a contract with the European Commission.

Régis de Closets will moderate the Discussions, as he has done for the past two years. I thank the speakers and the participants, some of whom have been faithful to us for several years now.

(1) Ref. Eurogip-81/E at http://www.eurogip.fr/images/publications/Eurogip_recognition_of_work_related_mental_disorders_81EN.pdf

(2) http://ec.europa.eu/social/BlobServlet?docId=9982&langId=en

Les Débats d' eurogip 19.03.2013 Paris

The potential implications of retention in employment

Régis de CLOSETS

The aspects we are going to talk about during the first round table discussion will serve as a main theme. They are especially important in that we are faced with the twofold phenomenon of population ageing, which is reflected by the fact that retention in employment will be a problem for a growing number of people, and the growing complexity of cases of retention in employment, notably due to the increasing prevalence of MSDs, psychosocial disorders, etc.

I should like to establish a general framework for the day with Dominique Martin. In your opinion, why is the issue of retention in employment especially topical at present?

Dominique MARTIN, Occupational risks Director, French National Health Insurance Fund for Employees (CNAMTS), France

Everything depends on the viewpoint adopted. I shall speak from the French perspective regarding current developments in France.

We are at present visiting several European countries to analyse their models, which in some cases have already undergone changes. In France, priority is traditionally given to primary prevention. The process of access to medical stabilization seems relatively quick, so that compensation is guaranteed within a fairly short time. The period that elapses between the injury and determining permanent disability is therefore brief, while reflection on rehabilitation and reintegration has not been developed.

The situation has been changing in the past few years, however, following the refocussing of the Occupational Injuries Branch on its mission as supportive insurer, which can be seen clearly in the guidelines of the social partners who manage the branch. This refocussing is reflected in particular by allowance for risk management, which combines the frequency of injuries, that primary prevention must limit, and the cost of the most serious injuries on which it is also important to take action. Such injuries are above all personal tragedies, but they also have significant social and economic consequences, because they prevent companies from carrying out their work and they entail costs for the Occupational Injuries Branch. 10% of the most serious injuries account for 60% to 70% of the costs incurred by the Branch.

That is why it is important to develop in France a specific, personalized approach to the most serious injuries. But, I would emphasize that risk management is not merely a matter of economic concern. It is above all a matter of human and social concern. Experiments have already been carried out in France. Stéphane Pimbert will discuss the "Cadre vert" approach to OH&S. Moreover, we are endeavouring, with the support of the social partners, to develop the prevention of occupational desintegration, which is currently unsatisfactory in France.

Generally, France is currently changing direction. This change is based on foreign experience. We have met our Swiss, German, Spanish and Danish counterparts, in particular. Our analysis is that "case management" policies, i.e. personalized follow-up of people who find themselves in the most complex situations, are effective policies that should be established. We are therefore in a building phase. The benchmarking stage is ending and our objective is to prepare a programme of the case management type by the end of 2013. Although this programme will be based on foreign experience, it will take into account the special features of the French system. We plan its widespread adoption in all of France in the medium term.

Régis de CLOSETS

Stéphane Pimbert, does retention in employment contribute to therapeutic success?

Stéphane PIMBERT, Director General, National Research and Safety Institute for the prevention of accidents at work and occupational diseases (INRS), France

Schematically, it can be said that, in the 1970s and '80s, lumbago was treated with analgesics, which caused the pain to disappear. From the 1990s, there appeared, especially in Canada, the Netherlands, Germany and Finland, policies of putting sufferers back to work in a suitable framework, with a suitable work pace and organization, so that they were no longer doomed to stay at home.

In France, the average duration of sick leaves following a lumbago is 340 days, which means quasi-desocialization. Apart from the transition from primary prevention, which is not abandoned, to secondary prevention, there is growing awareness that the most favourable solutions should be found for retention in employment, even in adapted conditions. Accordingly, the Board of Directors of the INRS, which is an equi-representational body, has set five priorities for the coming years, including retention in employment.

Régis de CLOSETS

François Atger, you do a lot of work with companies via services to support disabled workers and keep them on

Les Débats d'eurogip 19.03.2013 Paris

the job (SAMETH). How have issues relating to retention in employment evolved in recent years from the employers' viewpoint?

François ATGER, Director of Communications, in charge of International Relations, Association for management of the fund for integration of disabled persons (Agefiph), France

The national association for management of the fund for integration of disabled persons (Association de gestion du fonds pour l'insertion des personnes handicapées: Agefiph) is administered by representatives of the employers and employees, and associations for disabled persons.

We note that the number of disability decisions has increased from 70,000 to 150,000 in the space of 10 years. So it has more than doubled. At the same time, in the past year, unemployment among disabled persons increased by 20%, compared with 10% in the labour force as a whole. These figures show the great importance of the retention in employment issue.

That is why the Board of Directors of Agefiph have decided to launch an information campaign targeting employers and employees, around the theme of "keeping your job to avoid losing it". This slogan illustrates the change in perceptions of retention in employment. A few years ago, those suffering from the occurrence or worsening of a disability found themselves temporarily excluded from the job market before being redeployed, rehabilitated and reintegrated. The present trend is both to replace the prefix "re" in "reintegration", "redeployment" and "rehabilitation" with "retention in employment" and ensure the continuity of the employment contract and retention of those concerned in their work community, while complying with periods for healthcare.

Régis de CLOSETS

Do you link this change to the changing profile of disabled workers? Only 20% of these workers now have disabilities that are classified as "visible". Do you also link it to employers' growing allowance for employees' skills?

François ATGER

The Act for obligatory employment of disabled workers dates from 1987. It is therefore more than 25 years' old, which is sufficiently long for assessment. It is currently estimated that 80% of disabilities are not visible. We are dealing above all with motor disabilities that are not visible, MSDs, psychiatric conditions, respiratory disorders, etc. The image of the disabled worker has therefore changed: they are no longer necessarily someone in a wheelchair or who moves about with a white stick.

Régis de CLOSETS

Are employers also concerned to maintain the skills of their employees?

François ATGER

I shall reply to you based on the work of the 'SAMETH'. There are 106 of these services, handling about 22,000 cases per year, of which almost 19,000 end with successful retention in employment. It is mainly ageing workers who benefit from the services of the 'SAMETH', due to longer working lives and the fact that age often goes hand-in-hand with the appearance of disabilities.

Régis de CLOSETS

Laurent Vogel, what can we learn from the Community regulations and the legislation of the Member States regarding retention in employment?

Laurent VOGEL, Researcher, Working Conditions, Health and Safety Department, European Trade Union Institute (ETUI)

There is no common legislation and each country has its own regulations. The European legislation is very inexplicit.

In all the national standards, there are four aspects which are present to varying degrees and which form an equation, as it were. The first is compensation for work disability, which is one of the foundations of the European social model. This is a positive factor for us, in contrast with the United States and the BRICS [Brazil, Russia, India, China and South Africa - editor's note].

I consider that this aspect should be maintained.

On the other hand, I consider that the activist policies carried out by the social security system are negative, especially when they result in increased responsibility of employees, who become guilty. They take the form of a reduction in benefits and the concept of "suitable employment", a bureaucratic construction which is often unrelated to what the employee does.

There are also two unknowns. The first is the obligation to adapt work, which appears in the framework directive and which has been carried over into national legislation systems. Although I consider this excellent in principle, I have doubts regarding its application. The second unknown is the principle of non-discrimination on the basis of disability or health, which is present in legislation at the Community and national levels. These two principles, however useful, are not sufficient to answer all questions.

Moreover, I should like to emphasize that the damage that work causes to health, i.e. a lack of primary prevention, goes far beyond occupational injuries and diseases. The great majority of diseases caused by work are not diseases recognized as work-related and hence compensated as such. For example, it is well known that working conditions play an important role in the occurrence of MSD and burn-out. MSD are very unevenly recognized as occupa-

Les Débats d' eurogip 19.03.2013 Paris

tional diseases in Europe, while cases of burn-out are practically never recognized, as shown by the Eurogip report [editor's note: "What recognition of work-related mental illnesses? Study of ten European countries" at http://eurogip.fr/]. Likewise, ageing is not merely a biological concept: it is a sociobiological concept. The ageing process is more or less early and accelerated depending on the work performed, which raises the question of social inequalities. The retention in employment of an engineer does not pose the same problems as for a checkout operator, for example. It is therefore essential to avoid developing systems which would result in an increase in social inequalities and which would work satisfactorily for scarce and skilled jobs, but not for repetitive work requiring no specific skills.

Régis de CLOSETS

So the systems established must be suitable for all occupational groups. Another potential problem is their suitability for SMEs.

I should like us to discuss the secondary prevention strategy again with you, Dominique Martin. Could you tell us what is a "case manager"? Could you tell us what foreign experience has taught you?

Dominique MARTIN

Before starting, I should say that I am not the best placed to define the role of the case manager, which does not yet exist in France. Our foreign colleagues present in the room will talk to you about it better than me.

Moreover, in reply to the preceding statement, I emphasize that the aim is not to replace primary prevention, which we consider essential, with secondary prevention; we are not speaking of changing the compensation and reparation policy that exists in France, and which is of a generally high level. On the contrary, the aim is to enhance the system by adding to it a rehabilitation and reintegration component, which is currently lacking in France, and provide personalized assistance to help the persons in greatest difficulty return to the workplace.

Case management is characterized by the presence of a staff member who follows up individually the persons in greatest difficulty in their path to return to the workplace, and who represents as it were their twin with respect to the numerous systems already existing. The difficulty for the persons concerned lies in dealing with the complex circuits.

The French system for prevention of occupational desintegration is undergoing evaluation. It appears that it is very complex and that this complexity detracts from its efficiency. It should therefore be simplified, and case management aspects should be included in it. The case manager provides personal follow-up for a group of people in great difficulty and acts as an intermediary between the latter and the environment so that those concerned may be able to return to the workplace in the best possible conditions. It is clear that the hierarchy of values is as follows: the individual is positioned above his (her) social dimension, which outweighs the economic dimension. It is the personalization of the process that interests us, to supplement what already exists and which must undergo coordination, especially for the most complex cases.

Régis de CLOSETS

You emphasize the management of complex cases. How can they be detected? How can personalized treatment then be put in place for those cases?

Dominique MARTIN

You have mentioned two issues: action as early as possible and the comprehensive approach. It is indeed essential to take action as soon as possible.

At the same time, the approach must be comprehensive and must go beyond the strictly medical framework. For the person to regain all their capabilities, they must first be assisted in our healthcare system, excellent but complex, in order to ensure the best possible healthcare process. But a social and psychological approach must also be adopted. An occupational injury represents a violent disruption and can result in spells of depression which must be taken into account. Human support, personalized and warm, therefore seems to me essential. The return to the workplace requires multi-disciplinary teams for which coordination must be provided. It is therefore the role of the case manager to take charge of this coordination work on behalf of the victim, with the primary goal of a return to the workplace in the best possible conditions. All the person's capabilities must be restored: physical, mental, relational, etc.

Régis de CLOSETS

This implies the creation of a new job, that of case manager.

Dominique MARTIN

Indeed. That is why this new process is included in the guidelines of the social partners and in the contract that we signed with the government for 2013. The system will appear in the contract that we shall sign with the government for the coming years. It will be a system based on the foreign models, but which will be adapted to allow for specific French features.

We plan to design the system before the end of 2013, to carry out pilot experiments from the start of 2014 and to bring these measures into general use in 2017, within the framework of the multi-year contract on objectives and resources covering the period 2014-2017. We have also learned from foreign experience that these procedures must undergo continual improvements and that they cannot be put in place permanently in the space of a few years.

Les Débats d' eurogip 19.03.2013 Paris

Moreover, an evaluation of the satisfaction of the persons concerned and the potential benefits for companies should be provided for, not to mention measuring the return on investment, because these are costly operations.

François ATGER

The question of coordination is to my mind essential. This is the main difficulty that we faced when we designed the SAMETH organizations. The employment contract ties the employee and his (her) employer, who have mutual obligations. When the industrial doctor issues a disability decision, the employer has a certain period of time to mobilize all possible means to maintain the employee in his (her) job, but without having an absolute obligation. It is then that the Agefiph teams take action.

When an employee enters proceedings for the recognition of his (her) disability, the SAMETH comes into action to propose all the solutions that come within the competence of neither the industrial doctor nor the pension and occupational health insurance funds [CARSAT]. The SAMETH suggests training measures and organizational and ergonomic solutions.

It also ensures that retention in employment becomes a collective issue. Many players are involved in this process, which starts with detection and continues with medical stabilization and the return to a job compatible with the disability. However, it is hard to see a player emerging spontaneously to take responsibility for coordination of the whole.

Régis de CLOSETS

Does that mean that a single player can cause a blockage of the entire system?

François ATGER

In some cases, yes. In the absence of a player who would provide coordination for the entire chain, there should be a reference system which makes it possible to establish a professional consensus.

Régis de CLOSETS

Laurent Vogel, what do you think of the case management process, more individualized and more coordinated?

Laurent VOGEL

I have the impression that reform of the occupational health services has been the main subject of discussion for years. In my opinion this reform is incomplete. It still arouses questions, especially regarding the independence and resources of these services. I therefore express doubts. I believe that it could be appropriate to think about the development of the occupational health services, which have been assigned responsibility for performing secondary prevention tasks, and consider cooperation between these services and the other healthcare players. Many interesting aspects have been emphasized, but contradictions have appeared: it is indeed essential to focus on the person, but also on the work station, because it is impossible to separate the two.

Régis de CLOSETS

Case management systems are means available to the services in charge of secondary prevention.

Laurent VOGEL

True. And yet I wonder. Should the number of players be increased or should we start by strengthening and improving the existing systems? I am thinking in particular of issues of multi-disciplinarity, independence and resources. I feel that a socialized approach independent of the company manager should also be considered. Lastly, there are the CHSWCs (committees for health, safety and working conditions). If these have access to expertise, this will create a social momentum that will be able to resolve the situation. Conversely, no social momentum will appear if the CHSWCs are kept out of the process.

Régis de CLOSETS

Dominique Martin, how do you react to these statements? Are we not adding a layer, can we not give the CHSWCs more resources so that they may take charge of these actions?

Dominique MARTIN

In France, the occupational health services are not attached to the Occupational Injuries Branch. However, we work together within the framework of contractual arrangements. So I am not competent to discuss issues relating to the role and independence of the industrial doctor.

Regarding case management, I do not think that it represents an additional layer. On the contrary, it is an effort of organization and coordination. Moreover, nothing will be done without the cooperation of the social partners. The process carried out by the Occupational Injuries Branch is completely in line with social dialogue.

Régis de CLOSETS

Stéphane Pimbert, you have said to us that retention in employment was one of the strategic goals of the INRS for the coming years. You are supporting it as of now with pilot projects, the “cadres verts”, which involve defining conditions acceptable for employees resuming work after a spell of acute lumbago. Can you tell us about the planned arrangements? Are they temporary or permanent?

Stéphane PIMBERT

I repeat that retention in employment is a priority set

Les Débats d' eurogip 19.03.2013 Paris

by the INRS Board for the coming years and that this does not mean leaving aside primary prevention.

The "cadre vert" approach arose from an initiative by the INRS. It should enable companies to help employees suffering from lumbago to return to work as soon as possible. To achieve this, the work must be adapted and conditions organized for their reception in the company. The approach involves all the players in the company: the employer, managers, the occupational health service, the employee, the process engineering department where applicable, and the social partners. In the weeks following the employee's return to the workplace, either the work station of the person concerned should be adapted, or they should be found a suitable job position. This is not a method, because the approach should be adapted both to the company and the victims of lumbago problems.

The approach has been adopted in some companies, especially for checkout operators in supermarket chains, which have created specific work stations, allowing the persons concerned to not be excluded. So this is a measure aimed at job positions of a relatively low level.

Régis de CLOSETS

Do the arrangements also concern working conditions?

Stéphane PIMBERT

The "cadre vert" approach aims to adapt the work station according to companies' specific features. In some cases, it can therefore entail a change in working hours if necessary.

Régis de CLOSETS

Are these temporary work stations created according to needs, or permanent work stations held in turn by employees resuming their work?

Stéphane PIMBERT

The experiment in a supermarket chain that I referred to involved creating three "cadre vert" work stations in a store employing 100 people. These work stations are located at the reception and in the departments that are least demanding from the physical viewpoint. These are work stations classified permanently as "cadre vert" and held in turn by people suffering from lumbago pains.

Régis de CLOSETS

What is the situation concerning the financing and deployment of this type of work station for the coming years?

Stéphane PIMBERT

I have no information regarding the financing. As regards deployment, companies should be encouraged to adopt such an approach. At present the experiment is limited to about fifty companies, generally large. An evaluation is in progress and we should like to address SMEs, which represent 90% of French companies.

Régis de CLOSETS

François Atger, the SAMETHs have adopted an approach of advisory services, training and deployment of expertise to promote the readaptation of work stations. What initiatives are you carrying out in this regard?

François ATGER

The disability decision ascertains an established fact, whereas retention in employment represents work on an overall situation. This work includes ergonomic adaptation of the work station to the residual capacity, a possible transfer, which implies the acquisition of new skills, and the organization of the work area in particular.

I would add that our Board of Directors recently established an aid package making it possible to maintain the entire salary of workers aged more than 55 whose working hours are reduced on medical prescription due to a disability.

As regards assistance, the SAMETHs can call upon service providers financed by the Agefiph specialized in the five major disabilities (motor, auditory, visual, mental, intellectual deficiency) to assist the company and the person.

When these various resources are employed, the CHSWC is informed. But it must also be ensured that the workforce, and not only the employee representatives, be kept informed. It is not sufficient merely to provide technical solutions.

Régis de CLOSETS

This allows the employees' colleagues in a situation of return to the workplace to know how the persons concerned work. Moreover, some adaptations could benefit all the personnel.

François ATGER

This is a general assertion in the case of a disability. For example, "kerb ramps" on footpaths are appreciated by mothers wheeling prams. Likewise, the remote controls of television sets were initially designed for people who are bedridden. At work, screens adapted for persons with visual deficiencies are sometimes requested by workers having excellent eyesight. The response to the specific concerns of disabled persons can therefore benefit all of a company's personnel.

Régis de CLOSETS

Laurent Vogel, you spoke of the importance of working conditions. How do you view these examples and what, in your opinion, are the difficulties in adapting the work sta-

Les Débats d' eurogip 19.03.2013 Paris

tions of persons in a situation of return to the workplace?

Laurent VOGEL

I can see two difficulties. The first lies in ergonomics, which has not yet been spoken of and which should be developed as one of the competencies of the occupational health services. I would add that ergonomics does not concern just adapted work stations but all jobs. Thought should therefore be given to the position assigned to ergonomics in occupational health services.

The second is due to the dominant management cultures. Numerous work stations that could be held by employees in the rehabilitation phase have been eliminated because the corresponding functions have been outsourced.
Counterforces must therefore be established to offset the dominant cultures of just-in-time in every field, including corporate organization and the breakdown between tasks performed internally and outsourced functions. We are not just speaking of theoretical thinking;
it is important to give the CHSWC more powers and resources so that it may be able to discuss all the options selected by the company, including choices of outsourcing and changes in the work pace and working hours. I consider that the increase in certain health problems among checkout operators is not inevitable, but that it is due solely to working conditions (carrying heavy loads, postural stresses, etc.).

Régis de CLOSETS

In other words, the company must want to work on the subject and see an interest in retention in employment. This brings us back to the link between secondary prevention and primary prevention. Dominique Martin, do you not think that one should avoid developing secondary prevention alone, isolated from primary prevention?

Dominique MARTIN

Everyone has said so. It is essential to first create conditions contributing to occupational injury prevention. This is our first task. And this is the historical role of the Occupational Injuries Branch. The process of case management, which is a complementary activity, implies personalized assistance for the people in greatest difficulty, for example after an occupational injury. I would like to emphasize the concept of equilibrium included in risk management, which is an approach focused on the person but which also includes a concern for economics, including for the branch as a whole, which, I remind you, posts a deficit in France. Risk management means improving control of spending while endeavouring to enable employees to regain maximum autonomy. It is the link between these two factors that creates an equilibrium central to risk management. This equilibrium is an essential aspect of the equi-representational functioning of the branch, in which every process implies reaching a consensus between the employer party and the employee party.

DISCUSSION WITH THE AUDIENCE

Bertrand LIBERT (AMETIF)

At present, the various players work each at their level and I wonder about the usefulness of adding another. I should nevertheless like rather to emphasize the systemic aspects mentioned by Laurent Vogel, and especially two specific French features. The first is the suspension of the employment contract during the period of healthcare and the resultant isolation of the employee, since any initiative toward the person concerned is then considered as an intrusion into their private life. The second is the unfitness announced by the industrial doctor. This measure, supposed to protect the employee, is in practice a factor of exclusion. I wonder whether it would not be a good idea to act on these structural problems.

Dominique MARTIN

I repeat that the case management process that we have mentioned is not an additional process. It involves introducing a system of coordination in a complex and rich environment, from a balanced perspective, focused on the person and including an economic concern.

As Occupational Risk Director of the CNAMTS, I have to promote cooperation between the occupational health services and government services, but I cannot give my opinion on aspects relating to occupational health services when they are completely independent of the Occupational Injuries Branch.

An occupational doctor

I should like to tell you of my experience. You were speaking of coordination. I add the word “anticipation”, which seems to me essential. It is hard to reintegrate employees who have been on sick leave for three or four months. I joined a multi-disciplinary team in the cardiac rehabilitation centre of Grenoble Hospital. In this framework, the industrial doctor identifies the probabilities of a resumption of work on the eighth day after a heart attack or after a heart operation. Then, in relation with the social worker and the SAMETHs, the person is directed toward the appropriate structures. Anticipation is a favourable factor for a resumption of work. I regret that hospital doctors merely treat patients, as though the ultimate objective of reintegration in working life did not exist. I feel that industrial doctors can usefully take part in reintegration procedures by collaborating with hospital medical teams.

Stéphanie JULIEN (nurse)

I would like to react to the elimination of small “light-

Les Débats d' eurogip 19.03.2013 Paris

ened" work stations. In our company, there was a department called a "hospital", which grouped together employees for whom there was a need for redeployment. This department has disappeared and this resulted in general thinking on all work stations, "lightened" or not. I consider that this development is positive, because it obliged the employer to perform this thinking.

Stéphane PIMBERT

I agree with this comment. The "cadre vert" approach aims precisely at bringing together the employer, the occupational health service, the employee and the process engineering department so that they may all think about changes to existing work stations that could temporarily receive employees before they resume a normal work activity.

François ATGER

The temporary adaptation of certain work stations is necessary, but one should take care not to create discrimination at work and not to confine persons in difficulty to certain work stations considered as secondary.

Samuel LIBGOT (Ergonomist)

I work in a rehabilitation centre co-financed by the Agefiph which does everything that has been spoken about: early approach to integration, by mentioning work as of the treatment period, combating the boundary between the Social Security Code and the Labour Code, and collaboration with industrial doctors. There already exist tools, such as the occupational re-education contract, which involve the company in the re-education process.

I have heard two paradoxes this morning. The first is that of rehabilitation, which requires substantial resources and multi-disciplinarity, which are available in aftercare centres. The purpose of rehabilitation is reintegration into society. But society does not offer the same coordination as that existing in the centres. How to go from health to health at work? Work issues should not be medicalized. The second paradox is that of the disability, which requires a transformation of the world. The magnifying effect obtained by observing the working conditions of people having a deficiency makes it possible to investigate the working conditions of everyone.

Les Débats d' eurogip 19.03.2013 Paris

National policies to manage disability, job retention, rehabilitation

Régis de CLOSETS

We shall start with German experience. The DGUV federates the injury insurance organizations. It is in charge of all aspects of rehabilitation: social, psychological, occupational, etc. The original principle on which the German system is based is "Reha vor Rente", which means "rehab before pension". Could you tell us about this and explain to us the reasons for this choice of giving priority to rehabilitation?

Doris HABEKOST, Responsible for Participation in Job market / Disability management Unit, Insurance and Benefits Department, German Social Accident Insurance (DGUV), Germany

I have thought about what for us is an obvious principle that rehabilitation must prevail over compensation. Formerly, I worked on pensions. At the start of the last century, we realized that compensation could pose a huge problem. After the First World War, it was considered important for the numerous casualties to find a job again. Moreover, in Germany, we are defined by our occupations. When we first meet someone, we ask them where they come from and what is their occupation. Work represents an essential part of social status. This is possibly a specific feature of Germany.

When an employee is on occupational disability leave for a long period of time, the health insurance organization may invite them to file a pension application, and the insurance company concerned checks whether a process of rehabilitation can be carried out. The DGUV is competent for compensation, but it applies the principle of "rehabilitation before pension". We are in close relations with enterprises. Employees suffering an occupational injury continue to have an employer and a job, and the primary objective is to maintain that job. If that is not possible, we try to adapt the work station, e.g. using technical systems. If such adaptations are impossible, we try to find a suitable work station in the enterprise, possibly after the person concerned has followed a training course. If that is not possible either, a change of employer should be considered.

Régis de CLOSETS

The D-Arzt, i.e. the coordinating doctor, plays an important role in the system. What is his profile? What role does he play in the rehabilitation procedure?

Doris HABEKOST

These doctors are employed by the injury insurance funds. Generally, they are orthopaedists or injury surgeons. The DGUV is subdivided into six regional unions, which accredit and train the coordinating doctors. We organize specific training courses, which include rehabilitation management.

There are about 3,500 doctors in charge of coordinating the entire medical process. Some work in a private practice and are in charge of ambulatory treatment. The others work in hospitals accredited by the injury insurance organization and are in charge of ambulatory and stationary treatment. Note that the German injury insurance organization has about ten clinics which are specialized in treatment of the victims of occupational injuries and diseases.

When an employee suffers an occupational or commuting injury, he must be examined by a coordinating doctor if he is in one of the following cases:

- He has not regained his working capacity the day after the injury;
- Medical treatment is likely to last more than a week;
- Medicines or healthcare must be prescribed for him;
- He has suffered a relapse after being treated for an occupational or commuting injury.

The coordinating doctor then decides whether monitoring by the general practitioner is sufficient or whether a special treatment should be provided for, in one of these clinics I spoke of. He also decides whether the person concerned needs ambulatory treatment or whether they should be taken care of in an institution. He is the only one who can prescribe medical rehabilitation, the case manager cannot do so. To take his decisions, the coordinating doctor must have all the information, that he must then forward to the injury insurance fund. He is in charge of follow-up appointments. He plays an essential role in the rehabilitation process. It is he who establishes the diagnostic, which is something that a case manager cannot do. He contributes to rehabilitation planning with regard to measures of a medical nature, which a case manager cannot do either. A case manager can, on the other hand, decide whether the costs are covered by the injury insurance organization.

We plan to perfect this system and make various minor adjustments. In Germany, there are admittedly rules which oblige orthopaedists and injury surgeons to undergo training throughout their career, but we would like the coordinating doctors to have the broadest possible range of experience regarding injuries. That is why we want to increase to 250 the minimum number of patients handled by a coordinating doctor over a period of five years.

Les Débats d' eurogip
19.03.2013 Paris

Régis de CLOSETS

You have spoken of the "case managers" who work in the funds that come under the DGUV. What is their role and how will their job evolve?

Doris HABEKOST

For a long time now we have had "professional auxiliaries" (Berufshelfer) who traditionally provide services when an adaptation of the work station seems necessary. This generally takes place after medical rehabilitation. The presence of these auxiliaries is provided for by the national insurance code.

The various injury insurance funds have agreed on handling of the occupational aspect of health problems as early as possible. It is against this background that the process of rehabilitation management was introduced. With a view to coordination and uniformization, the funds have agreed to define the role of the professional auxiliaries. We should like it to be the same with the case managers, who coordinate the process.

It is important to identify the cases that are covered by this rehabilitation process. Guidelines have been produced for this purpose. When the coordinating doctor estimates that the work disability will exceed 112 days, i.e. 16 weeks, it is theoretically necessary to employ the rehabilitation management system. It is possible to use this system in other situations: when the condition prevents performing work, and - something more difficult that has already been emphasized this morning - when the social and work environment of the person concerned is likely to be an obstacle on the path of a return to the workplace. In some circumstances, an injury that is not serious prevents a return to the workplace. This is especially difficult to detect early in that the insured must feel at ease to discuss the problems he (she) is faced with (e.g. psychological problems). We endeavour to collect a maximum of information on this aspect by means of questionnaires. This is part of the work of the case managers.

The main task of the latter is to have all the stakeholders (doctors, physiotherapists, etc.) cooperate in the interest of the insured. No rehabilitation plan can succeed without the support of the person concerned. Some auxiliaries formerly achieved success in a rather authoritarian manner, but such methods are no longer conceivable. It is important that the insured be kept informed of progress on the plan, which is signed by the insured, the doctor and the injury insurance fund. Rehabilitation management concerns only 2.5% to 3% of cases. These are the cases which are dealt with in rehabilitation clinics.

Régis de CLOSETS

How do the coordinating doctor and the case manager work together?

Doris HABEKOST

As I have said, some prerogatives are specific to the doctor, prescriptions in particular. The coordinating doctors willingly work with the case managers, who have the power of decision based on the proposals made by the doctors.

Régis de CLOSETS

You mentioned an agreement signed by both parties. What happens if the insured does not comply with it?

Doris HABEKOST

Each has rights and obligations. In the rehabilitation plan, it must be ensured that each party identifies when the process ceases to take place as planned. It is then checked whether the insured complies with the plan, whether other measures should be taken, whether a new condition has appeared, etc. The purpose is not to punish someone who does not cooperate perfectly. Allowance must be made for the fact that the insured often have psychological problems. The plan is more a guideline document which is designed to make the persons concerned feel secure. This is important, because confidence is necessary for cooperation.

Régis de CLOSETS

In Switzerland, you have also adopted a case management system for the most complex cases. The SUVA is an independent public enterprise, which was founded at the start of the twentieth century. Until 1984, it had a monopoly in the area of injury insurance. Its activity is threefold: prevention, compensation and rehabilitation. What are the requirements for a disability pension to be paid?

Philippe CALATAYUD, Responsible for Insurance benefits for Swiss Romandie and Ticino, Suva, Switzerland

In Switzerland, disability is not a medical concept but an economic one. The disability rate is determined by comparing the earnings that would have been obtained in the absence of an injury to the insured and the earnings that can be made despite the injury sequels.

Régis de CLOSETS

In the original enterprise, or more generally?

Philippe CALATAYUD

In the enterprise, whether it be at the initial work station or in a more appropriate work station, if the person concerned works again, then the calculation corresponds to the real situation. Otherwise, a theoretical calculation is performed based on the job that he could find again, taking into account his condition, in a balanced job market.

Régis de CLOSETS

The return to the workplace is subject to a rehabilitation

Les Débats d' eurogip 19.03.2013 Paris

process, which evolved in the early 2000s, with the establishment of a coordinated approach and the case manager. So why was the Swiss system reformed?

Philippe CALATAYUD

At the end of the 1990s, quality surveys highlighted the growing demands of the insured with regard to the provision of services. It appeared that the insured appreciated the benefits and the prevention work performed by the SUVA, but regretted a certain lack of support in the procedure for return to the workplace.

Among the cases handled by the SUVA, a distinction could be made between injuries not causing any work disability and other injuries. All the latter were treated in almost the same way, irrespective of the scale and duration of the disability. An in-depth study was therefore carried out based on several cases in which the initial damage seemed minor and which had ended in major disabilities or serious social situations.

In all these cases, where the SUVA had performed its role thoroughly (providing the right service at the right time), it was possible to show that although the initial injury admittedly played an essential role at the outset, the success of the occupational rehabilitation process depended above all on the patient's personality and especially on their work and social environment. The consequences of a given injury are largely related to the branch of activity and the social environment. For example, a study carried out in one of the SUVA's clinics shows that in patients who are guaranteed to find their job again and who are in a favourable social environment, lumbagos become chronic in 15% of cases. However, the proportion increases to 85% for patients who suffer from work-related uncertainties and/or experience social problems.

It is based on this observation that the SUVA decided to make the human factor and the entire follow-up of the injured person - and no longer merely the medical aspect - the focus of its injury management process, which thus changed radically from "deny and defend" to "accept and assist".

Régis de CLOSETS

This therefore means ceasing to examine merely the medical aspects, which raises the question of detection.

Philippe CALATAYUD

The case managers, of whom there are currently 115, intervene only in complex cases, for which there is a real problem of occupational rehabilitation, either due to serious injuries, or because of a combination of unfavourable factors. In such cases provision must be made for adaptation of the work station or an occupational conversion. As regards the hypothesis of a combination of unfavourable factors, we recognize only 5% of cases at the time of injury reporting. This is why special tools have been developed to facilitate early identification of such cases. When the dossier manager detects an abnormal development and assumes that the person concerned will be unable to return to their original work station, he immediately transfers the matter to the case manager, who contacts the accident victim as soon as possible.

In case of alert, the case manager is obliged to contact the insured very quickly, if possible within a week. The meeting usually takes place at the home of the insured or in a healthcare establishment. No appointment is organized in the offices of the SUVA. During this first meeting, the case manager explains his role: in particular, general advice and coordination of the various players. The case manager assists the insured with the numerous formalities (with the medical world, with the employer, etc.) in order to achieve optimal medical and occupational rehabilitation.

Régis de CLOSETS

The role of the case manager is therefore twofold: he evaluates all aspects of the case (medical, family, social, etc.) before establishing an agreement on objectives concerning treatment. How is the agreement on objectives defined?

Philippe CALATAYUD

Following an initial contact between the case manager and the insured, it is important for the latter to accept the plan that is submitted to him. The case manager decides nothing by himself, he acts merely as a facilitator. It is the insured, possibly with his or her close relatives, who decides. A refusal by the insured of such an offer of assistance has no consequences on the services provided for him (her).

Based on the patient's written authorization, the case manager performs a detailed examination of the case: job, possibility of rehabilitation in the enterprise, social and family environment, accommodation, medical situation, etc. The SUVA has a medical service competent for all areas of traumatology (orthopaedics, neurology, psychiatry, etc.), so that the case manager can work in tandem with a doctor.

The analysis performed by the case manager and the solutions that can be worked out in the medium and short term are then presented to the patient, who can accept them or not. These measures form a real medical and occupational plan which should enable a return to employment as early as possible if the state of health of the person concerned so permits. The plan includes therapeutic objectives, but also personal and behavioural objectives. It may, for example, involve taking the children to school on certain days of the week.

The agreement does not set objectives for the insured

Les Débats d' eurogip 19.03.2013 Paris

alone. The case manager also has objectives: for example, solving a particular problem within a given deadline by suitably activating one or other of his network partners.

Régis de CLOSETS

When does the agreement end? When is rehabilitation considered to be completed?

Philippe CALATAYUD

Ideally, when medical treatment has been completed or can no longer provide improvements and when work has been resumed, either in the original company or in another company, or else when occupational rehabilitation measures have been completed, resulting in no disability or a disability slighter than that which might initially have been feared. However, case management can be suspended if the insured does not comply with the terms of the agreement. Moreover, it can and must always be adapted, for example due to an unexpected change in the insured's state of health or because in the end the employer no longer wants to keep his employee. No deadline is set beforehand.

Régis de CLOSETS

What is your evaluation of this system, which has existed for about 10 years now?

Philippe CALATAYUD

Our first objective, which was to place the insured back in the centre of the system, has been achieved, as shown by our regular satisfaction surveys. Furthermore, both the number and the annual cost of the disability pensions allocated in these complex cases, representing about 2% of the 500,000 or so accidents reported each year but slightly more two-thirds of the costs, have decreased by more than half since 1 January 2003.

Régis de CLOSETS

What difficulties remain? For which pathologies?

Philippe CALATAYUD

The difficulties are not related to the pathologies. For a given pathology, the situation varies for each personality, notably depending on the family and work environment. At present, the main difficulties result from tensions in the labour market and hence the difficulty of finding new employment for people whose physical or psychological integrity has been harmed. In Switzerland, however, many companies "play the game", or even specialize in recruiting people who, although disabled following an accident, nevertheless often have great know-how.

Régis de CLOSETS

We shall now look at Iceland. You manage the occupational rehabilitation fund (VIRK), which was set up in 2008. It is estimated that 8% of employees are faced with health problems which prevent them from working. Can you describe the Icelandic compensation system to us?

Vigdís JÓNSDÓTTIR, Director, Icelandic Rehabilitation Fund (VIRK), Iceland

In Iceland, employees on sick leave continue to receive their wages for a period of variable duration, which may be as much as twelve months in some sectors. The health insurance organization, managed by the trade unions and with employers contributing to its financing, takes over the baton during a period ranging from 6 to 9 months. 80% of employees are trade union members. Subsequently, it is possible to receive a government allocation. Finally, a disability pension is paid by the government and by the pension fund, which is financed by employees and employers.

Régis de CLOSETS

This is therefore a system on three levels. In 2008, the disability management system was reformed. The VIRK, to which 0.39% of the payroll is allocated, was created. Since 2009, 4,200 people, representing 2.5% of the working population, have benefited from this. Each year, 0.9% of the working population contacts the VIRK. Why did Iceland decide in 2008 to take action on this issue?

Vigdís JÓNSDÓTTIR

This was the result of negotiations between the employees' trade unions, employers and the government. The creation of the fund was seen as a sort of investment, because everyone was aware of the cost of disability pensions and the cost of the wages that employers had to continue to pay. In Iceland, there are a large number of SMEs. In fact, it is the social partners who exerted pressure on the government for the fund to be created.

Régis de CLOSETS

2008, the year of the VIRK's creation, was also the year of the crisis in Iceland. The fund survived the crisis. It currently employs about sixty people and has benefited 4,200 employees. Could you give us the characteristics of these beneficiaries?

Vigdís JÓNSDÓTTIR

42% suffer musculoskeletal disorders and 37% psychological problems. The others represent a large range of pathologies, because the system is very open.

Régis de CLOSETS

Like in Germany and Switzerland, you have established case managers. There are 40 of them, who cooperate with the trade unions' regional representatives. How are the cases that should be handled by the case managers identified?

Les Débats d' eurogip 19.03.2013 Paris

Vigdís JÓNSDÓTTIR

Employees who receive health insurance benefits are informed of the fund's existence. They receive brochures. It is explained to them that they should contact the VIRK if they are absent for 4 to 6 weeks and have difficulties resuming work. It's not an obligation, but the employees are encouraged to establish contact with us. It is when they apply for the award of a disability pension that the fund that pays the pension asks them to contact us first. We are developing our relations with the players of the social welfare system.

We have worked out a rehabilitation process which is based on three factors: standard evaluation, special evaluation and re-evaluation. Initially, during the standard evaluation period, the employee and the case manager try to work out a solution allowing a return to the workplace. If this is not sufficient, several specialists play a role, so that the issue may be dealt with more comprehensively. At this stage, we use the International Classification of Functioning, Disability and Health (ICF).

We started from the experience of other countries: Denmark, Norway, Netherlands, etc. Our tool was built based on the ICF, which allows for various perspectives. Before taking the decision to pay a disability pension, we check that every attempt has been made for the person concerned to find a job again.

Régis de CLOSETS

You have mentioned difficulties of coordination between the rehabilitation system and the disability pension system. Could you expand on this aspect?

Vigdís JÓNSDÓTTIR

We attempt to influence the disability pension system, which does not function satisfactorily. Employees are not encouraged to resume work. For example, for single parents who receive both a disability pension and family benefits, it is not in their interest to look for a job.

Régis de CLOSETS

Along what lines would you like the system to evolve?

Vigdís JÓNSDÓTTIR

We do not have the slightest authority to make changes in it.

Régis de CLOSETS

Another important aspect: how are case managers recruited?

Vigdís JÓNSDÓTTIR

They are healthcare system professionals: nurses, physiotherapists, occupational therapists, etc. The difficulty lies in the fact that they are more concerned by what accident victims cannot do than by what they can do, whereas we focus on the latter aspect. We therefore try to train them.

Régis de CLOSETS

Do your have the same difficulties with Swiss case managers?

Philippe CALATAYUD

The case managers should be specialists of the social welfare system, and in particular the injury insurance organization. They should also have psychosocial skills and be capable of coordinating the work of several people, like orchestra conductors. The labour market does not offer such profiles. So the SUVA has made a major effort at training.

Doris HABEKOST

In Germany, usually the injury insurance funds recruit internally, so that the persons concerned know the insurance rules. However, they must undergo training. We have defined a case manager profile (empathy, ability to work in a team, etc.), which was published last year. We are very satisfied with our case managers and we are currently preparing a questionnaire designed to check the level of satisfaction of our insured.

Régis de CLOSETS

This first overview of Europe has enabled us to observe that there are several models of coordination around the case manager and that this expression has various meanings. It has also enabled us to note the problems common to all countries: detection of difficult cases as early as possible so as to take action effectively, coordination of medical expertise and various initiatives around the case manager, and follow-up of the rehabilitation plan.

The three experiences that we shall speak of now focused especially on these three aspects.

I suggest that we begin with Canada, where occupational health comes under the authority of the provinces. A committee deals with both compensation and rehabilitation, as well as risk prevention.

In Quebec, the employer is obliged to guarantee a return to an equivalent work station, and a worker injured at work or suffering from an occupational disease keeps a priority right to his job. This right can be exercised during two years in companies with more than 20 employees and during one year in other companies. Beyond this period, the return to the workplace is based on negotiations between the parties. The case management of rehabilitation is handled by the family doctor. The provincial authority can define personalized plans for return to the workplace.

What did these personalized plans consist of and why did they not always work well with regard to prevention of chronicity factors?

Claude SICARD, Vice-President, Commission de la santé et de la sécurité au travail (CSST), Canada

In recent years, we have recorded a reduction of about

Les Débats d' eurogip 19.03.2013 Paris

40% in the number of minor occupational injuries. At the same time, the average length of absences has increased. An examination of our work methods convinced us of the passiveness of our chronicity management, with chronicity factors not being detected early enough. It was not uncommon for transfer of the dossiers to the teams in charge of rehabilitation to take place 120 days after the injury, whereas chronicity factors set in after 80 to 90 days. Moreover, it became apparent that the link with employment was permanently lost in about 2% of cases. In such cases, compensation is limited: the pension is determined by the difference between the previous income and the income that it would be possible to obtain from a "suitable job" in view of the state of health of the person concerned. It is therefore important that these people return to work, hence the idea of a more proactive management of chronicity.

Régis de CLOSETS

The continuous approach to chronicity prevention is the key feature of the Synchro system established as of 2011. The detection of chronicity factors therefore appears of fundamental importance. When and how can they be identified?

Claude SICARD

We must first verify the validity of the dossier, i.e. make sure that the injury (or disease) is work-related. The patient then receives the planned compensation. Between days 30 and 40, an interview is organized with the worker so that chronicity factors may be identified with the help of a specific guide. When the interview takes place, the date of return to the workplace is usually already scheduled. About 65% of cases are settled within a period of 60 days.

If the interview shows no chronicity factor, the person is handled by a compensation officer, who ensures that the person concerned actually receives the compensation to which they are entitled and benefits from appropriate medical treatment.

Otherwise, they are guided toward a tandem consisting of a compensation officer and a rehabilitation adviser. It is the latter who takes the initiative, by checking that the person concerned receives their benefits. He also works out a plan for return to the workplace. Employees are subdivided into five categories according to their profile (e.g. existence of job ties or not). The rehabilitation advisers are generally trained in the social sciences (sociology, psychology, etc.).

Régis de CLOSETS

Regarding detection, you have put in place the «Detect tot» tool. In this context, some questions must mandatorily be put to the insured, while others are optional. There are 12 mandatory questions which make it possible to detect chronicity factors: nature of the pains, morale of the person concerned, perception of return to the workplace, etc. Can you give us other examples of questions? How did you choose them?

Claude SICARD

We made a review of the literature which enabled us to identify the various chronicity factors. These were adapted to the reality of Quebec. Some factors concern the conditions of medical monitoring. Doctors can have a more or less proactive management of chronicity. Stress is also a chronicity factor, as well as neurological symptoms in the case of sufferers from back aches or relapses. The worker's perception of his working conditions and his return to the workplace should not be neglected either. Other questions concern the perception of the employer and personal characteristics.

Régis de CLOSETS

There are also optional questions, which correspond to passive adaptation strategies, such as the tendency to dramatize, to pray, to hope, etc., which you say contribute to chronic disability and are responsible for 50% of the chronicity at twelve months. How can one evaluate these passive strategies? Are you not entering the field of subjectivity?

Claude SICARD

The aim is to determine the personality of the insured. It is obvious that a strong tendency to dramatize hinders a return to the workplace. We must therefore try to bring the persons concerned to adopt a more positive view.

The new approach represents a major change for the personnel of the CSST. Previously we worked from a perspective of reparation and we must now adopt a perspective of prevention. In the first year, several members of the personnel experienced difficulties. The change is now well accepted, notably thanks to the major training efforts that were undertaken.

Régis de CLOSETS

The benefit of the new approach lies in early detection and the relation between this and rehabilitation. You spoke of five categories. Does this mean that rehabilitation depends on the chronicity profile and that the healthcare services are specially adapted to the patients?

Claude SICARD

The aim is indeed to guide the persons concerned toward specialist teams which establish appropriate plans for return to the workplace. For the insurer, this approach is more costly than the traditional approach, but we have wagered that the amount of compensation would decrease. After two years, we have already noted that the length of the compensation period has decreased. As yet it is hard to say whether this development is attributable exclusively to

Les Débats d' eurogip 19.03.2013 Paris

this new approach.

Régis de CLOSETS

Do improved case management of the insured and allowance for their personal psychological problems help to improve the motivation of the insured?

Claude SICARD

The insured appreciate the additional service offered to them. The new system also enables the CSST to work better with its partners, especially with the rehabilitation centres to which the insured are sent earlier and judiciously, and with family doctors.

Régis de CLOSETS

In Denmark, the employer pays compensation to victims of occupational injuries and diseases for four weeks. Then, the local bodies take over the baton for 52 weeks. Then, the persons concerned are generally covered by another system, usually early retirement.

Between 2004 and 2008, you recorded a sharp increase in the number of absences for chronic illness. That is why you adopted a new policy designed to improve the rehabilitation system. Before we analyse the new measures, could you explain to us the main shortcomings of the old system?

Glen WINZOR, Director of Research Coordination, Forskningscenter for Arbejdsmiljø (NFA, National Research Centre for the Working Environment), Denmark

First of all I should emphasize the minor role of the insurance organizations in the return to the workplace. It is the local bodies that play the main role. This is a major difference by comparison with the other countries mentioned. I think that it is coordination that was lacking in the previous system. Several of the speakers have emphasized the complexity of the process of return to the workplace and the resulting need for coordination.

Régis de CLOSETS

The new TTA (Tilbage til Arbejdsmarkedet) system, i.e. a system for "Return to the labour market", has been tested in 21 municipalities. It represents a major investment: €41m. Cases are handled by a task force consisting of industrial doctors, specialists, psychologists, ergonomists, etc. In the smallest municipalities there is only one task force, but in the largest ones there are several of them. For the system to function efficiently, it is important that cases be submitted to the task force at an early stage. What instrument do you use for detection?

Glen WINZOR

Many things have already been said about early detection. In this regard, we are faced with the same obstacles as the other countries, because a given injury does not have the same consequences for all the insured. This is a complex problem and there's no question of adopting merely a single criterion to implement the major process of return to the workplace. As part of the TTA plan (which is not yet a reform), we proceed more or less like the Canadian speaker has just explained for Synchro. We have produced an interview guide and an interpretation manual which is based on the international literature relating to the return to the workplace. This enables us to assess the capability of workers to return to employment. However, this procedure does not completely eliminate subjectivity.

Régis de CLOSETS

One of the difficulties of the TTA plan lies in your will to handle a large number of cases.

Glen WINZOR

That's true. In Denmark, persons who are on long-term sick leave are covered by the local bodies. They must collaborate with the doctors and employers. We have wanted to include in the TTA plan people of diverse profiles, especially with regard to the pathology. The procedure for return to the workplace which employs a large number of professionals is costly, and the aim is to know in what cases it should be applied.

Unlike what usually happens, the TTA plan foresees that the team of professionals should analyse precisely to what extent the person concerned can work again. This is a multi-disciplinary team, so that numerous viewpoints are represented there and various aspects of the worker's case are analysed.

Régis de CLOSETS

What difficulties do the members of the multi-disciplinary teams face in working together?

Glen WINZOR

This plan represents a new way of working for the members of the municipal social services. Before its launch, we asked them to follow special training for three weeks concerning the return to the workplace, and they learned to work together. Since the project began, two organization consultants have helped the local bodies taking part to implement the new measures. It is true that bringing a rehabilitation officer, a psychologist, a labour market specialist and an industrial doctor together around a table is a real challenge for the simple reason that these different people do not have the same references. One doctor, for example, may be interested only in the diagnostic, whereas another will focus on the person's residual capacities. Moreover, in the case of this project, we gave priority to the latter aspect.

Les Débats d' eurogip 19.03.2013 Paris

Régis de CLOSETS

The project, which began in the spring of 2012, is currently being evaluated. How do you proceed and what results surprised you?

Glen WINZOR

In fact, three evaluations - equally important - have been made. The first one concerned the process and the organizational changes implemented in the municipalities, the second concerned the impact of the measures regarding return to the workplace, and the third concerned the permanence of the returns to the workplace achieved.

The first evaluation, of an economic nature, surprised me due to the differences between the results of the various municipalities. That shows precisely the need to perform evaluations. Without such evaluations, we would be incapable of saying why some municipalities succeeded and others not. 60% of the municipalities implemented the TTA programme in accordance with the instructions and they obtained good results, unlike the others. We were surprised to note that, despite the training and assistance provided for the consultants, some municipalities did not carry out the programme properly.

Régis de CLOSETS

Regarding rehabilitation, it is also important to evaluate the residual working capacity and measure the improvement provided by the procedures in this respect. This is a subject on which you do a lot of work in Sweden. Could you, in a few words, describe the system to us?

Therese KARLBERG, Manager, Division for Early retirement, Disability benefits and Occupational injuries, Swedish Social Insurance Agency (Försäkringskassan), Sweden

I can only agree with my Danish colleague. I believe it is important to focus on early detection and on individual cases. This is precisely what Sweden did by adopting the new legislation, in 2008. On that occasion we introduced strict deadlines. It seems to me that no one has spoken of this yet.

Until 2008, there were a growing number of premature retirements, a growing number of people on long-term sick leave, etc. There are several explanations for this phenomenon, which also affected young people; they include a lack of appropriate tools and specific skills possessed by the doctors working for the insurance organizations. The situation came to a head in 2003, at which date changes began.

The major change took place in 2008. During the first 14 days, it is the employer who pays sick leave benefits. Then, the national insurance organizations take over the baton until the 90th day, provided that the person concerned is not in a condition to return to his job. Between days 91 and 180, benefits are subject to the inability of the insured to work for his (her) employer, which creates pressure on the latter to adapt the work station or find another. Then, and until day 364, it's rather complicated. Moreover, this has been the subject of discussions in the media. Let's say that if the insured is capable of working, although necessarily in his original company, he ceases to receive compensation. However, this rule is not applied if the national insurance organizations consider that the person concerned could return to their job before the end of the 364-day period.

Régis de CLOSETS

So it is the working capacity of the insured that is the basis of the compensation system: capacity for resuming their job between days 14 and 90, for working for their employer between days 91 and 180, or quite simply working from day 181. Who evaluates the residual working capacity? On what basis?

Therese KARLBERG

There is a case manager who supervises the dossier and the medical certificate provides assessment criteria. The certificate does not indicate whether the person concerned is or is not entitled to sick leave benefits. It is the national insurance organizations that decide based on the information contained in the medical certificate. The doctor is obliged to specify the following items: diagnostic, disability and resulting reduction in working capacity.

Régis de CLOSETS

The doctors who draw up these certificates are therefore the doctors of the insured, and not those employed by the national insurance organizations. What collaboration is there between the two?

Therese KARLBERG

Some doctors dispute the strict deadlines we have established. Generally, doctors would like compensation to be paid for long periods of time. So we work in close cooperation with them. We have developed information campaigns. We have also established a call platform for doctors and a website, where they can find all the information they need. In conjunction with the Healthcare Agency, we have worked out instructions to help them in their prescription of sick leaves. The corresponding lists include 120 different diagnostics. There are also financial incentives. The government has created a specific overall allocation, that we call the “sick leave billion”. Roughly, the sums allocated to doctors out of this overall allocation depend on the quality and degree of detail of their medical certificate.

Régis de CLOSETS

The system began in 2008. What difficulties did you

Les Débats d' eurogip 19.03.2013 Paris

face? What limitations do you perceive?

Therese KARLBERG

The system works well in the case of short leaves. In other cases, on the other hand, we still lack tools to define the residual working capacity. When the persons concerned no longer receive sick leave benefits, it is the employment agency that provides coverage for them. It frequently occurs that its services consider that people are not capable of working, which does not correspond to our viewpoint. That is why the national insurance organizations and the employment agency services are trying to work out jointly tools making it possible to define working capacity. Moreover, the system is complicated for everyone: for the insured, for doctors, etc. All this explains the keen debate, of a more or less satisfactory level, moreover, which is spreading in the media on this subject.

Régis de CLOSETS

In Denmark, have you tried to evaluate capacity for return to the workplace?

Glen WINZOR

Yes, evaluation of the residual capacity for return to the workplace plays an essential role in Denmark, and it is especially in this respect that the Danish and Swedish systems resemble one another and differ from systems based on insurance organizations.

Régis de CLOSETS

And in Canada, have you tried to obtain real markers of capacity to return to the workplace and make compensation subject to the residual capacity?

Claude SICARD

Yes, this capacity must be evaluated. Doctors have guidelines produced by the occupational health and safety research institute.

However, we have noted that the rehabilitation programmes were designed for workers with permanent damage. Now, it is increasingly apparent that simple injuries are likely to evolve and hinder a return to the workplace. Our system is insufficiently attentive to these cases of simple injuries.

DISCUSSION WITH THE AUDIENCE

Daniel BOGUET (UPA)

The Eurogip Discussions are definitely a source of good ideas, but I wonder about the appropriateness of the thoughts and the proposed solutions for small enterprises. Consider, for example, the industrial relations tribunal hearing which I attended yesterday. The single employee of a small limited company (EURL) attacked her employer because she had not been retained in employment. Obviously the head of such a company has no way of retaining his employees on the job.

Glen WINZOR

I believe that the way of dealing with these issues depends on the economic context and the legislative framework. The Danish flexicurity system makes staff layoffs much easier. It is SMEs that benefit most from the system of return to the workplace in Denmark. They do not have sufficient resources to manage their human resources and handle legal issues.

Claude SICARD

Admittedly, it is difficult for a very small enterprise to reintegrate its employees. That is why we have established an incentivizing financial mechanism: if the employee is not able to fully take charge of his work, the national insurance organizations temporarily pay a supplement. Moreover, small enterprises in Quebec group together so as to mutualize not only risks but also solutions to reintegrate employees who have lost part of their working capacity.

Gaëlle POSTIC (CARSAT Rhône-Alpes)

I wonder about the role of the employer in the agreements on objectives signed between the insured and the case managers.

Philippe CALATAYUD

You have to start by identifying the obstacles to reintegration. If no resumption of activity in the enterprise is foreseeable eventually, the possibility is discarded. If, on the other hand, there is a possibility of adapting the work station or finding another one, the employer is involved. He does not strictly have to accept the objectives himself, but he is involved in their preparation and must accept the measures that they entail. For example, he may be led to authorize the insured to visit the workshop several times each week, not to work, but to be informed of what is happening there. In any case, no occupational rehabilitation is foreseeable without the cooperation of the employer.

Glen WINZOR

I agree with what has been said. A return to the workplace requires a coordinated, early effort involving the employer, but it takes time.

Therese KARLBERG

I agree, too. The role of the employer is essential. I should like to mention the case of SMEs, for which the adaptation of work stations represents a difficulty. In Sweden, however, it is SMEs that are the most closely

Les Débats d' eurogip 19.03.2013 Paris

involved in the employment of disabled persons. The argument can therefore be used both ways.

Régis de CLOSETS

In Quebec, the employer must retain the work station during one or two years, as we saw. He is therefore included in the process. Is this measure conducive to a return to the workplace or does it represent a constraint?

Claude SICARD

It is in the interest of the employer to reintegrate the employee, if only because of financial regulations. In some sectors such as construction, the problem is harder to solve; the adaptation of work stations there is more complex. Employers are therefore less open to solutions for a return to the workplace. However, this is a sector that is economically important and in which there are many accidents.

Pascal JACQUETIN (CNAMTS)

My question is for Doris Habekost. When the return to the workplace requires carrying out special measures, I suppose that decisions must sometimes be taken shortly after the accident. In such cases, how do you manage to rapidly involve the coordinating doctor or the case manager? I mean in terms of organization.

Doris HABEKOST

You wonder how we detect these cases rapidly. I have tried to explain that it is sometimes difficult, as emphasized by our Swiss colleague, to identify cases that are apparently benign but which could evolve unfavourably. We have no contextual information necessary for this assessment immediately after the accident. Moreover, at this stage of the procedure, a relationship of trust has not yet been established between the case manager and the accident victim. Generally we assume that it is the most serious cases that require case management. In the week following the accident, even before putting in place case management, the injury insurance organization sends one of its representatives to visit the accident victim. This is not necessarily the person who follows up the dossier, but this representative is nevertheless able to discuss with the case manager and provide him with important information.

A participant (lawyer)

I wonder about the thinking currently being carried out to improve the communication of information relating to working conditions between employers and the occupational medicine services. I note that this communication currently takes place in conditions which do not facilitate occupational redeployment.

Dominique MARTIN (CNAMTS)

Industrial doctors, whether they be employed by the company or by an inter-company service, are obliged to comply with medical secrecy, which does not rule out discussions on working capacity. The occupational health services should undoubtedly abandon a strictly medical viewpoint and adopt a more comprehensive approach. I mentioned earlier the establishment of contracts between occupational health services, the social security system and the state to organize competencies and coordination between these three players. I think that the industrial doctors present in the room are better placed than me to reply.

Arielle BAHAUT (occupational doctor)

I am a coordinating doctor in the occupational health division of the CNAMTS. I also take part in a working group on disabled persons, which brings together representatives of the occupational health division, members of CHSWCs and also volunteer disabled workers. I should like to reply to the previous participant. Industrial doctors can provide answers to the requests of the employer, but they cannot take part in lawsuits because they are bound by medical secrecy.

Our working group has thought about questions of vocabulary: we prefer the “a” of “anticipate”, “adapt”, “arrange” to the “re” of “readaptation”, “rehabilitation”, etc.

Finally, I should like to emphasize the negative connotation of the word “handicap” (disability). Moreover, people who suffer from a disability have the unpleasant impression of being filed, even when their disability is not visible, as is often the case. If the disability comes with unfitness, the situation is even more difficult for the persons concerned. Why not eliminate the fitness assessment, as has been done in Finland, where the problems are discussed directly with the employer and the industrial doctor?

Philippe CALATAYUD

Regarding the relationship between the employer and the industrial doctor, this is precisely one of the questions that the case manager can solve. I give a reminder here that the industrial doctor is present in Switzerland only in large firms. Generally, the doctor who reports the unfitness ignores the occupational situation of the person concerned before the introduction of case management. Now, the case manager, in the investigation phase, establishes a link between the employer and the doctor: when he meets the latter, he has the profile of the work station, and can, in particular, explain its constraints, etc. He does the same work with the employer, notably discussing the possibilities for a return to work in special conditions, without ever betraying medical secrecy.

Patrick LE TANNO (occupational doctor)

I simply wanted to make an observation regarding the role of the industrial doctor. I consider that his main role is

Les Débats d' eurogip 19.03.2013 Paris

to be as close as possible to the work situation and that unfitness should be reported only based on precise circumstances. Any excessively general unfitness is likely to adversely affect the employee. On the contrary, the industrial doctor must discuss with the employer to agree on work station adaptations.

Jean-Michel BACHELOT (CARSAT Pays de la Loire)

Can Dominique Martin explain to us why the social services of the CARSAT funds cannot become case managers? It seems to me that they already form the link between the employee, the medical consultant, the industrial doctor, etc. They perform this role notably in the departmental units for the prevention of occupational desintegration. Also, I have the impression that the SAMETHs could easily become case managers for disabled employees.

Dominique MARTIN (CNAMTS)

The presentations that we have heard show us that the processes of return to the workplace are complex and must be viewed in their context. In France, we are currently in an observation phase. Today's seminar is especially interesting in this regard. We do not have the slightest preconception regarding the system we are going to establish. We know that all the factors mentioned will have to be taken into account: early detection, comprehensive support, coordination of numerous procedures, allowance for psychological aspects, etc. Organizational choices will also have to be made between the national level and the regional level of the Occupational Injuries Branch. These choices will be made once the purpose of the system has been thoroughly defined. The processes will be built in cooperation with the social partners and with the entire network of the Occupational Injuries Branch. It is obvious that the regional level, which is in contact with the enterprise, will be involved. The main question mark concerns the coordination of the existing structures. The main contribution of case management approaches is due to coordination by a person who is more or less the twin of the person who is in difficulty. Above all, the competencies and systems that already exist should be exploited. The Occupational Injuries Branch must create a coordination service offering.

A participant (PhD student in ergonomics)

I am surprised by the role assigned to ergonomics in the case of a return to the workplace. I have the impression that the ergonomist is considered as the person who provides technical solutions. But ergonomists, when faced with an issue of retention in employment, establish contact with all the stakeholders. They analyse the employee's life and environment, etc. They therefore take into account the overall situation.

Glen WINZOR

The concepts of handicap and disability always refer to what the person concerned cannot do, and the idea of compensation. I suggest that we adopt a more positive expression and that we use the word "employability".

The European project entitled “Healthy work for workers suffering from a chronic illness”

Régis de CLOSETS

The ENWHP, a European network for the promotion of health at work, brings together occupational health and safety institutes, health promotion organizations and social security funds of various European countries. It recently carried out an awareness raising campaign on chronic illnesses.

Nettie VAN DER AUWERA, Project coordinator, European Network for Workplace Health Promotion (ENWHP)

I shall describe to you a European project underway relating to protection of the work station and the return to the workplace for employees suffering from chronic illnesses.

As Régis told you, the ENWHP is an informal network bringing together various organizations from 28 different countries.

The ENWHP has endeavoured to promote health at work since 1996. It has done everything to ensure that the European social agenda includes this subject. Its main activities are to conduct awareness raising campaigns, draw up recommendations for European employers and stakeholders, and highlight good practices.

The current initiative, “Work. Adapted for all”, is the ninth such initiative of the network since its creation; 17 Member States are taking part. It relates to chronic illnesses, whether or not they be of work-related origin.

This project is the third in the “Move Europe” series on the theme of promoting health at work. Before this, there were projects on:

- “Healthy lifestyles in the working environment” over the period 2007-2009, which aimed at promoting behaviour conducive to good health. It focused on four aspects: food, physical activity, prevention of nicotinism and mental health.

- “Work in tune with life”, over the period 2009-2010, which was focused more on mental health.

In the current project, we are trying to convince enterprises to allow for the promotion of health at work in both their general policy and their daily practices. We do so via awareness raising campaigns in the project's partner countries, but also by providing them with various tools. Prevent, a Belgian occupational health and safety organization, is in charge of coordinating the European project.

The main objective of the project is to invest in sustainable employability, i.e. to retain employees in employment, in the interest of the latter, but also of the company and of society in general. The project is supported by the European Union. It benefits from the funds of the 2008-2013 health programme as part of the European Health Strategy. We are endeavouring to contribute to the implementation of the Europe 2020 strategy for intelligent, sustainable and inclusive growth, which asserts the need to retain employees in employment and reintegrate them in the event of an illness.

The aim therefore is to develop and disseminate good practices for the promotion of health at work in the case of employees suffering from chronic illnesses, so that they are not pushed into an early retirement or disability scheme. For this purpose, we must identify good practices, provide advice to employers, organize knowledge transfer between experts and shareholders, draw up recommendations targeted on a return to the workplace, and develop awareness raising.

Our campaign primarily targets companies with more than 50 employees, their shareholders, employees and their families. The tools that we produce are distributed in the 17 countries taking part in the project. Some are intended for the authorities in charge of the public policies in question, and others for employers. The major tool for companies is the Good Practice Guide including a six-point action plan (identifying who needs help, establishing contact, initial interview, examination of the case, working out the programme for return to the workplace and regular re-examination of the plan). There is also the checklist for managers.

All these documents are available on www.enwhp.org. The French version of the Good Practice Guide is on http://www.anact.fr/portal/pls/portal/docs/1/12330380.PDF. You will also find a large quantity of information on www.maladie-chronique-travail.eu.

The Good Practice Guide is very general, because it is intended for companies in all the countries of Europe. It was produced on the basis of the policies for return to the workplace adopted in several countries and an analysis of the good practices of 11 countries.

Cases should be identified as early as possible, and it is undoubtedly the HR Manager who is most capable of doing so. Establishing contact should also take place as early as possible. It can take place in the form of a general phone conversation. The initial interview should have as its main subject the solutions, and not the problems, so as to arouse trust and make sure that the person concerned wants to resume work. Examination of the case requires in-depth work by all the stakeholders. The programme for return to the workplace must answer the questions: What, When, Why and How? It must be re-examined regularly and its effectiveness must be verified.

The checklist for management staff lists recommended behaviour toward an employee suffering from a chronic illness.

To end my overview, I inform you that a conference will be held at the end of this project (see the website www.enwhp.org). It will take place in Brussels on 22 and 23 October 2013. There we shall continue our awareness raising campaign and present several examples of good practices.

Mobilization around enterprises

Régis de CLOSETS

Zinta Podniece, you represent EU-OSHA, which in 2007 produced a report on national policies for the return to the workplace of workers suffering from multiple sclerosis. Could you tell us about it?

Zinta PODNIECE, Project Manager, Prevention and Research Unit, European Agency for Safety and Health at Work (EU-OSHA)

Our work involved not only examining the legislation of the Member States. We also analysed practices. Our first conclusion is that the policies of the Member States mainly target sick employees who are not working, and not those who are working and face health problems. Our second conclusion is in line with what was said this morning: it is important to detect problems rapidly and prevent prolonged absence, after which employees have little chance of working again. Multidisciplinary procedures must also be employed involving the occupational medicine and social rehabilitation departments, and coordination of all the stakeholders must be provided for.

Régis de CLOSETS

Do you think that the situation has changed since 2007?

Zinta PODNIECE

I'm sure of that, if only because demographic trends make it necessary to deal with the problem posed by the retention of elderly workers in employment. We shall have more information on this subject in two years' time, because we have just begun a study on elderly workers. As part of this work, we shall examine rehabilitation and the return to the workplace.

Régis de CLOSETS

You have also reviewed the literature on the subject. What conclusions can you draw from this? Are they the same as those we heard this morning?

Zinta PODNIECE

We found hardly any studies except on lumbago. According to the study findings, employees should return to the enterprise as soon as possible, which may require adaptations to the work station. It was also found that the adaptation of working conditions, especially working hours, could be of great help for the return to the workplace, not to mention ergonomic measures.

Régis de CLOSETS

What do you think of risk assessment as an instrument for risk prevention and for promotion of a return to the workplace? How can risk assessment policies facilitate a return to the workplace?

Zinta PODNIECE

In 2008 and 2009, EU-OSHA carried out a campaign on this subject. It took into account the entire labour force, including employees suffering health problems, i.e. the victims of chronic illnesses for whom suitable conditions must be provided, and people returning to the workplace after a long period of illness. If a company foresees new developments, it must take into account the profiles of its employees.

Régis de CLOSETS

The Agency also worked on the concept of well-being at work. What link do you establish between well-being at work and a return to the workplace? What is the difficulty

in acting on well-being at work?

Zinta PODNIECE

We studied how the expression "well-being at work" was understood in the various European countries. We found major differences. As a general rule, however, the concept covers physical, mental and social aspects. There is no doubt that the work environment can not only limit occupational risks, but also be an incentive for a return to the workplace and motivate employees.

Régis de CLOSETS

I turn to Katrien Bruyninx. You work in Belgium for Prevent, an organization that has numerous activities in the field of safety and risk prevention: training, research and publication, etc. Most of your customers are private companies. Can you briefly describe to us the Belgian compensation system?

Katrien BRUYNINX, Project Manager, Prevent, Belgium

In fact, we have several systems: for self-employed workers, for civil servants, for private-sector employees, etc. It is the private-sector scheme that covers the largest number of people. It is subdivided into three systems: one for work-related diseases and injuries, the other for occupational diseases and injuries recognized as such, while the main one is the general regime, which covers other diseases and injuries.

Régis de CLOSETS

You told me that the rehabilitation system was more or less like a lottery: everything depends on the institution where you are received, the doctor, etc. Prevent has worked both on the policies that we saw this morning and on what happens in enterprises. You noted a behavioural deficiency faced with problems, a lack of enthusiasm with regard to rehabilitation and a lack of determination to tackle the issue. How do you explain this? Do you have examples to give us?

Katrien BRUYNINX

I believe that there are many reasons for this. We examined various aspects of the process of return to the workplace, and in particular the behaviour of employers, players in the healthcare system, the social security regime and employees. The lack of a constructive mindframe can be found in each of them. For example, many employers consider that the return to the workplace does not concern them. After one month, employees on sick leave are compensated by the national insurance organizations. They are therefore gradually forgotten by the employers, who have no obligation to stay in contact with them. As regards the healthcare system, we have noted that the rehabilitation centres give priority to the recovery needed for everyday activities (eating, dressing, etc.) and forget that work is one of them. As regards our social security system, it places compensation before rehabilitation, unlike the German system.

I would like to mention the lack of communication between stakeholders, the main problem being the large number of stakeholders involved in the process of return to the workplace. They each make their decisions based on their personal criteria, without having any shared language. For example, general practitioners, industrial doctors and the doctors of the national insurance organizations do not adopt the same definition of a disability. Moreover, only 10% of the people who follow a rehabilitation process have seen their doctor speak to another one.

Régis de CLOSETS

I would like us to talk about your work on the European project DM@work, which aims to offer proactive solutions for return to the workplace targeting certain enterprises in three sectors of activity: the chemicals industry, building and healthcare. What particular problems do these three sectors present regarding a return to the workplace?

Katrien BRUYNINX

The main obstacles common to these sectors are, in particular, the possibility of having an appropriate job, communication and the search for substitute jobs, because enterprises have outsourced numerous functions.

When we look at each sector separately, we note specific problems. For example, building activities are often physical, which hinders a return to the workplace after a period of illness. We have therefore established instruments that enable us to have a better understanding of work-related requirements. In addition, we have prepared forms that the employees submit to their doctor so that he may provide precise information, for example on the number of hours during which the person concerned can work standing, sitting, in difficult conditions, etc. This does not mean filling out a medical certificate, but giving practical information to help find solutions. Another problem is that doctors often recommend a gradual resumption of work, but part-time work is generally incompatible with the timetables of public transport systems.

Regarding the chemicals industry, the problems are due mainly to safety rules, which are very strict. Employees are sometimes capable of doing their job but it is the general safety rules that prevent them from doing so. In such cases, we have endeavoured to find jobs outside the strictly regulated areas. We therefore encouraged enterprises to establish differentiated safety levels.

The project is now completed. We have written four manuals: one for each of the three sectors and a fourth

which applies to all Belgian enterprises and which contains information intended for employees wanting to resume their work after a period of sick leave.

Régis de CLOSETS

Pascal Corbineau, before Airbus, you worked in the construction sector. Did you note particular difficulties in the sector? Do you have the impression that the situation is improving?

Pascal CORBINEAU, Occupational physician, Airbus Nantes, France

I left the construction sector about five years ago. This is a sector of activity in which progress has been made. When I arrived there about twenty years ago, there was no question of either retention in employment or redeployment. Solutions appeared gradually. Employers gradually mobilized to retain their skilled labour. However, in my old position, where I was in charge of about 3,000 employees, I noted 10 to 15 cases of unemployability for medical reasons each year. At Airbus, there is one case of unemployability every two or three years. This major difference can be explained by the physical demands of building trades. In my opinion, the solution lies in mechanization and in retraining some employees to operate machinery.

Régis de CLOSETS

In Finland, the rehabilitation insurance organization VKK, represented by Juha Mikkola, was founded in 1964 by various insurance organizations. VKK is a non-profit organization which assists the members of these founders in the rehabilitation process. VKK has provided various instruments for this purpose: advisers, website, etc. Before speaking about it, could you briefly describe the Finnish compensation system to us and explain to us the reasons why VKK has existed for so long?

Juha MIKKOLA, Managing Director, Finnish Insurance Rehabilitation Association (VKK), Finland

In Finland, compensation is handled by private insurance companies. In 1964, they realized that rehabilitation had to form part of the compensation system. VKK was created to fill this vacuum.

Régis de CLOSETS

VKK employs advisers who cooperate with the insurance companies on rehabilitation cases. How do your advisers work with these companies? How are the cases selected?

Juha MIKKOLA

In fact, it is rare for insurance organizations to have their own experts, so that nearly all the cases are sent to us.

We have about twenty advisers and two psychologists specialized in rehabilitation matters, who provide coaching. The process takes place as follows. The insurance companies send us their reports electronically. We then organize meetings between the insured and the advisers. These meetings enable us to make an initial evaluation in the month following sending of the reports. The rehabilitation plans are then worked out within a period of five months. Each year, we receive about 700 reports, including 100 concerning cases of functional rehabilitation. For the 600 others, in 40% of cases a return to working life is impossible. It is therefore the remaining 60% who enter a rehabilitation programme, and the proportion of insured who actually obtain a job at the end of the procedure can be estimated at 70% or 80%.

Régis de CLOSETS

Something else that is hard for the French to understand is that the rehabilitation plan is not produced by VKK but by the healthcare system, which is public. How do the VKK advisers come into contact with the healthcare system? Is there not a certain competition between the two parties?

Juha MIKKOLA

VKK is perceived as an independent organization and not as an offshoot of the insurance companies. This guarantees us a certain authority.

Régis de CLOSETS

Concretely, what does VKK do regarding the rehabilitation plan?

Juha MIKKOLA

Most Finnish companies are SMEs. They are not capable of managing problems related to a return to the workplace themselves, and most redeployments are achieved thanks to VKK.

As regards case management, we advise, guide and support rehabilitation on a personal basis (needs and aspirations of the individual, circumstances). We cooperate with the authorities and service providers to develop and maintain effective policies. VKK acts as an interpreter between the insurance players and rehabilitation players.

Régis de CLOSETS

Could you tell us about the Internet tool, which facilitates relations between insurance organizations, your advisers and employers?

Juha MIKKOLA

The members of the Internet network for return to the workplace are pension funds and seven service providers. VKK coordinates and maintains this network. We organize

seminars, for example. Regarding compensation, VKK represents the insurance organizations in this network, because they are not members.

Régis de CLOSETS

Joy will now describe to us the UK example of Unum, which offers rehabilitation services to its corporate clients.

Joy REYMOND, Head of Rehabilitation & Health Management Services, Unum, Director of the Vocational Rehabilitation Association and the UK Rehabilitation Council, Great Britain

First, I would like to say that in the United Kingdom this is very complicated and different from what exists elsewhere.

I come from Canada. When I arrived in the United Kingdom, I was surprised by the low level of compensation. The employer can take out insurance for his liability. For their part, employees can take legal action against the employer, although few do so. This represents only a small part of the system. There is also a public system of compensation for conventional occupational diseases.

Above all, there is the universal health insurance system run by the state, which ensures a very limited amount (about £8 per week) for employees on chronic sick leave. During the first 28 weeks, the employer pays illness compensation (statutory sick pay). Then the state takes over. The compensation is roughly the same but the employer can supplement it so that the person concerned keeps their salary. This is the case in many large firms, but not in the smallest ones. Then we come into play, as private insurer.

Régis de CLOSETS

We understand the reason for your services: you help employers handle the most complex cases of rehabilitation. What do the employers request of you?

Joy REYMOND

We are a private insurer. So we make sure to be attractive relative to the competition. We always ask ourselves what we can provide for the client. We have developed three service levels: primary, secondary and tertiary.

On the first level, we provide services enabling employers to avoid chronic absences. We ensure that the salary is maintained once the period of six months has elapsed. You know that after six months it is often too late for employees to return to the workplace. It is therefore in our interest to take action before the six-month period has elapsed and help our clients ensure that their employees work again as soon as possible, even if we do not have the slightest financial liability.

Régis de CLOSETS

So you anticipate and you do so in the interest of the employer. How could this service be used by your clients and how does it interfere with the normal rehabilitation programme?

Joy REYMOND

The employer can request it at any time. We endeavour to help employers even when employees are still working but suffer from a condition that obliges them to take sick leave and which is likely to force them to cease work in the future. As a general rule, we ask employers to contact us when they have an employee who has been absent for the past four to six weeks. We know from experience that employees take the path back to work naturally and that it can be worse to take action than to do nothing. However, after six weeks the natural process no longer applies in the same way. In that case it is important for the employer to contact us. He can do so by any means (fax, email, telephone, etc.). We then immediately give him some advice and leave him to manage his employee's return by himself. If the situation seems difficult, we take charge of it: one of our advisers visits the employer and then the employee. He then tries to bring them together and examine the obstacles to a return to the workplace. This is an occupational approach and not a medical approach.

In more than 40% of cases, we are dealing with what we call "common mental disorders" (stress, anxiety, depression, etc.), which often have a work-related component. That is why, as part of our risk prevention services, we organize training sessions for HR managers and executives so that they may effectively cope with situations of this type. If the problem has already broken out, we examine what should be done to solve the difficulties. We may then, for example, provide the employer with an ergonomist or a psychologist specialized in cognitive therapy. In practice, however, most of our contribution consists of mediation and negotiation.

When the employers, our clients, are reluctant, we explain to them what is likely to happen if nothing is done. We are an insurer. You know that nothing is free. If the absence is prolonged, we take charge of maintaining the salary, but the employer, for his part, pays the insurance premium. It is therefore very rare for employers not to follow our advice.

Régis de CLOSETS

A legislative reform is planned. As a private player, how do you judge this plan?

Joy REYMOND

The government has agreed to open a credit line of £500,000 to pay for the cost of an independent medical evaluation from which employees would benefit following four weeks of absence. This corresponds precisely to the time when the doctor writes his second sick leave certifi-

cate. I think the principle is excellent. We do not know how it will take place. It could interfere with what we do for our clients if the evaluation is of excellent quality. On the other hand, if it is an evaluation of limited scope, it will not be very useful.

Régis de CLOSETS

There is another important player in the enterprise, the industrial doctor. We shall speak about this with Annette Gässler.

In Germany, there are 3,000 industrial doctors, and they do not perform the same functions as in France: they do not perform regular check-ups, but offer services. You have worked hard in recent years so that the involvement of industrial doctors in the rehabilitation process may be recognized and improved. Why is there not greater participation by industrial doctors in this process in Germany?

Annette GÄSSLER, Specialist in occupational medicine, Germany

It's related to change, which everyone does not want to undertake at the same time. I work in one of the largest family-run companies in Europe, which has 365 plants in 50 countries. This is my work. I also work in the industrial doctors' professional organization. If I look at the last 30 years of my career, formerly I performed 10 medical examinations each day. Around the year 2000, thinking began to take form concerning occupational health and the return to the workplace. Today I perform only 10 medical examinations per month and the rest of my work consists of managing healthcare teams, doing human factors engineering and dealing with the return to the workplace. In future, given population trends, I am certain that the role of medical examinations will further decline but that everything concerning the return to the workplace will expand.

Régis de CLOSETS

Your professional organization has decided to develop the participation by industrial doctors in the process of return to the workplace. This would be done by means of contracts. Could you tell us about it?

Annette GÄSSLER

Most German companies are SMEs. At the level of the Länder, we have prepared framework agreements with the pension funds. These agreements define the role of industrial doctors in the process of return to the workplace. In cooperation with the injury insurance funds, we have developed training programmes intended for industrial doctors. These are sessions that last three days and cover, in particular, labour law and relations with other professions.

Régis de CLOSETS

You are also working on lean management. Can you tell us what this means and how it helps industrial doctors contribute to a return to the workplace?

Annette GÄSSLER

I took part in a lean management project in the aerospace industry. I said to myself that we could work this way in the medical sector, because executives did so. Failing a big bang, we can propose projects, processes, etc. You have to speak the language of management. Lean management means nothing other than having efficient processes and taking action in the event of problems. I therefore consider that the industrial doctor must be present in the workplace every day. He must inspect the enterprise and assess the situation in the field. It is when the iceberg is in the stage of a submerged mass, before absenteeism develops, that we can act extremely effectively.

Régis de CLOSETS

I should like us to consider a French example with Pascal Corbineau, who has been an industrial doctor for several years with Airbus in Nantes, which employs 2,200 people. In the past six months you have taken part in the setting up of "cadre vert" work stations. Before we discuss this point in particular, can you give us some indications on the general context of accident occurrence and redeployment in the enterprise?

Pascal CORBINEAU

We have seen an increase in absenteeism in the past two years. Recognized occupational diseases are rare: only about ten. However, we are faced with problems of medical fitness and resumption of work after sick leave. The seriousness of these problems varies depending on the case. However, the question of redeployment sometimes arises.

Three years ago, we started to look for work stations for a temporary period of three to six months, to allow both parties to acquire a certain visibility regarding the return to the workplace, and adapt the work station with the help of the ergonomist, OH&S personnel, etc. The next stage is redeployment.

Régis de CLOSETS

How did the CARSAT work with Airbus?

Jean-Michel BACHELOT

The Airbus project coincided with the search for enterprises where it seemed possible to experiment the "cadre vert" system.

We were looking for enterprises concerned by lumbago, where the industrial doctor could be a partner, where the employer was aware of both the challenges and the fact that the enterprise was becoming a player in retention in employment, and where the staff representative bodies

were likely to cooperate. Few enterprises met all these criteria.

Régis de CLOSETS

So you identified two enterprises, including Airbus. How did you establish dialogue to convince all the stakeholders (HR Director, social partners, industrial doctor, etc.) to take part in the initiative? What reservations did you encounter?

Jean-Michel BACHELOT, Consulting Engineer on prevention of occupational risks, Retirement and Occupational Health Insurance Fund CARSAT) Pays de la Loire, France

Indeed, you have to convince all the players, especially the employer. First you must identify the view that the enterprise and its manager have of human resource management. If it is mainly an accounting view which considers employees as a cost that must be compressed and reduced, the «cadre vert» approach is not feasible. This project aims to make the enterprise face up to its social responsibility by inviting it to do everything possible to enable a weakened employee to return to the enterprise even when they have not completely recovered. In such cases the enterprise must be aware of the «non-accounting» value of its employees, and it must be prepared to adapt work situations with a view to receiving the employee in order to enable them to gradually resume a normal activity. This general OH&S principle of adapting work to man is unfortunately not prevalent in many enterprises, which, moreover, were not selected for the experiment.

The second stage involved convincing the staff representative bodies. On several occasions we came up against misunderstandings, and hence non-acceptance of the system, on the part of staff representative bodies. The latter view this plan for the early return of an employee before their complete stabilization as a breach of the right to sick leave and suspect a basically accounting solution on the part of the health insurance organization, with the main aim of reducing daily benefits.

Régis de CLOSETS

How does the deployment of experts take place in the field? Do you go on-site to assess the work stations with ergonomists?

Jean-Michel BACHELOT

Acceptance by industrial doctors is easy to obtain. Then you must work in the enterprise with the process engineers to characterize the work stations according to three criteria (biomechanical, cognitive and psychological). However, this evaluation can be performed only in certain enterprises, because it requires special competencies.

Pascal CORBINEAU

We have adapted five temporary work stations located on a production line. They can be held by employees who are suffering from no health problem. When a case of redeployment arises, the industrial doctor asks the line manager if he can receive the person concerned. The latter is trained and assisted during six months by a person who knows the work station well. At the same time, redeployment is scheduled with a view to a return to the permanent work station.

The "cadre vert" work stations are characterized by a high level of protection, especially with regard to the lumbar vertebrae. There are also foreman's positions, where the ergonomic constraint is slighter. Redeployment requires teamwork, involving the ergonomist, OH&S personnel, etc. There is at present high demand for temporary work stations, and there are 27 work stations waited for.

Régis de CLOSETS

How is follow-up performed during three months? At the end of this period, who decides on the assignment of the person concerned?

Pascal CORBINEAU

During the period of employment on a temporary work station, employees must be assisted and informed of their permanent assignment. I see the persons concerned every month and I question the managers concerning their permanent redeployment. It is essential to reassure the employees and check that everything is done for a return to the workplace in satisfactory conditions.

Régis de CLOSETS

What are the limitations of approaches of this type? Do you think that they are suitable for all pathologies?

Pascal CORBINEAU

Every employee can work. The work station need merely be adapted. Working hours must also be adapted.

However, there are psychological limits: returning to the enterprise is not always easy. The doctor has an important role to play in this regard.

Régis de CLOSETS

How is a relationship established with the family doctor?

Jean-Michel BACHELOT

It is sometimes hard to meet the family doctor and convince him of the interest represented by a return to the workplace for the patient. It is necessary to explain and convince him that the work environment is secure and reassuring. However, relations between family doctors and industrial doctors are not institutionalized in France. What

is missing is a case manager who could be the interlocutor who creates this link between the health insurance organization, the employee and the enterprise in order to facilitate the employee's return to the workplace.

Pascal CORBINEAU

Our experience is characterized by profitable collaboration with the CARSAT, which enables us to have access to the medical consultant, who is competent to ask for a check-up before a return to work. This factor should be exploited to facilitate a return to the workplace.

DISCUSSION WITH THE AUDIENCE

Gaëlle POSTIC (CARSAT Rhône-Alpes)

In France, the employment contract is suspended while the employee is on sick leave. Neither the employer nor the industrial doctor is therefore able to come into contact with the employee. This measure prevents the employer becoming a player in the return to the workplace. What are the rules regarding this aspect in other countries?

Joy REYMOND

In the United Kingdom, the employers' charter, available on Internet, allows employers to establish contact with their employees who are on sick leave. In practice, employers are unaware of this provision.

Annette GÄSSLER

In Germany, since 2002, the law obliges the employer to establish contact with employees who have been on sick leave for more than 42 days.

Juha MIKKOLA

In Finland, it is recommended to employers to stay in contact with their employees. The practice varies depending on the enterprise. The question is the subject of debate.

Katrien BRUYNINX

In Belgium, a reform that came into force about one year ago allows employees on sick leave to ask for a visit by an industrial doctor to discuss the possibility of a return to the workplace. Previously, employees saw the industrial doctor only in the first weeks following the resumption of work. Moreover, the employer is obliged to discuss this subject with the employees, but practice varies from one company to another.

Régis de CLOSETS

Do you have the impression that companies are increasingly aware of the potential benefits of a return to the workplace in Germany and the United Kingdom?

Joy REYMOND

In the United Kingdom, this is not the case. We have to explain it to our clients. We must make an effort to provide explanations. At present, the human resource departments do not seem highly motivated.

Annette GÄSSLER

I am convinced that demographic change and the growing proportion of elderly workers will change attitudes.

Régis de CLOSETS

How is the pilot experiment at Airbus made known and relayed within the group?

Pascal CORBINEAU

The experiment is watched with great interest, especially since the senior management is very keen to reduce absenteeism, and the CARSAT plays an important role in this.

Régis de CLOSETS

I shall leave the last word to Raphaël Haeflinger.

Raphaël HAEFLINGER, Director of Eurogip

I should like to thank the speakers, some of whom have come from very far away. I should also like to thank Régis de Closets, the interpreters and the Eurogip teams, especially Isabelle Leleu, who organizes these discussions.

We shall try to define the subject of the next discussions as soon as possible, to be able to keep you informed. See you next year!

www.eurogip.fr

FOUNDED IN 1991, EUROGIP IS A FRENCH ORGANIZATION, WHOSE ACTIVITIES ARE ORGANIZED AROUND FIVE AREAS: ENQUIRIES, EU PROJECTS, INFORMATION-COMMUNICATION, STANDARDIZATION AND COORDINATION OF NOTIFIED BODIES. ALL HAVE IN COMMON EUROPEAN ASPECTS OF THE INSURANCE OR THE PREVENTION OF ACCIDENTS AT WORK AND OCCUPATIONAL DISEASES.

"Keeping people at work in Europe and Canada
Policies for rehabilitation and return to work"
Proceedings of EUROGIP Discussions of 19.03.2013 (Paris)
Réf. Eurogip-85/E
2014 - 30 p. - 21 x 29,7 cm
ISBN 979-10-91290-36-4
Paris: EUROGIP
Director of publication: Raphaël HAEFLINGER
Press contact: Isabelle LELEU

Reproduction rights: EUROGIP reserves the right to grant or refuse permission to reproduce all or part of the results of the present study. In any case, permission is required in advance in writing.

55, rue de la Fédération - F-75015 Paris
Tel. +33 0 1 40 56 30 40
Fax +33 0 1 40 56 36 66