

## Commentary

# Integration and Return to Work of Workers with Disabilities: A New Paradigm

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## Introduction

Occupational Health (OH) has gone through a shift in focus that extends the classical emphasis on workplace hazards to include: the medical aspects of prevention and reduction of occupational disability, managing prolonged absences from work and the integration of disabled workers in the workforce. This paradigm shift poses new challenges to the field that requires the OH practitioners to adopt new working strategies and to improve their competencies. This is in order to anticipate the risk of labor market withdrawal of their patients, and enhance job retention and to encourage return to work practices for patients with disabilities.

Employees who experience the onset of long-lasting or permanent disabling health conditions (whether from occupational or non-occupational causes), that challenge their ability to work, may be at risk for exclusion from society and employment. Detachment from the work environment as a possible consequence of disability is detrimental for the worker's physical and mental wellbeing, and may increase socio-economic pressures as the worker becomes dependent on social benefits [1-3].

## Epidemiology

People with disability consist about 15% of the world's population, which amounts to more than a billion persons [4]. The rate of self-reported disability in the OECD countries ranges from 5% to 20% of the working age population [5]. Over the years, disability rates have been increasing, concurrent with the increasing inflow into disability social welfare plans. This inflow is of people of working age acquiring new criteria for determining disability that exempt them, partially or fully, from the workforce. Of all new disability benefit claimants in the OECD, one-half to three-quarters were previously employed [5]. Morbidity from mental and musculoskeletal disorders are reported as leading causes for disability among working age populations around the world [6]. In developed countries, the disability benefit inflow is

predominantly due to mental health problems [7], while low back pain is the number one cause of disability globally, and is the primary reason for work loss in middle and low income countries [8]. The increase in working age disability worldwide is partially explained by the aging of the population, the later retirement age, the prolonged life expectancy among people with chronic diseases and the changes in disability entitlements and legislation [9, 10]. Work disability contributes a considerable economic burden on society with a global cost that exceeds one trillion US dollars, representing around 4% to 5% of the American gross domestic product (GDP) [11]. The employment rate of people with disabilities is much lower than people without disabilities (44% vs.75% in OECD countries) [5]. These low employment rates for people with disabilities coupled with the substantial growth in disability beneficiary rates over the past two decades are concerns for policy-makers. To address to this concern, many governments have introduced policies and programs to promote employment opportunities for job-seekers with disabilities, job retention by people who acquire a disability while in employment, and return to work after prolonged sick leaves [12,13]. Over 130 countries have ratified the UN Convention on the Rights of Persons with Disabilities aimed at promoting, protecting and ensuring human rights for people with disabilities and local legislation has been enacted in many countries [14].

### **Terminology of Disability**

The definition of “people with disabilities” is broad, and includes various types of classifications (physical vs. mental, acquired vs. congenital, severe vs. mild, temporary vs. permanent) depending on the perspective of the policy makers.

1. Disability income support definition - administrative definitions that enable eligibility for disability benefits, rehabilitation programs, etc. Traditionally, physicians evaluating the medico-legal (“forensic”) perspective, which translates the disability from degree and type of impairment, claiming that pathology leading to impairment

gives rise to functional limitations that result in work disability [15]. However, low reliability and high variability between evaluators requires a more complex relationship between impairment and work disability [16,17]. Hence, the biopsychosocial approach, which perceives disability as a dynamic interaction between the clinical, personal, psychological and social factors as well as the work environment, is gradually being adopted worldwide [10].

2. Legislative definition - this definition is based on impairment but is wider than merely the receipt of benefits, and defines disability as “a physical or mental impairment that substantially limits one or more major life activities” [18,19].

3. Perceived disability – the self-evaluation of people reporting having disabilities. This subjective assessment is usually used in epidemiological surveys and based on answers to questions concerning the existence of long-lasting health problems or a disability that limits daily life activities [20]. This broader definition may include workers who do not receive a disability benefit but encounter difficulties due to their disability in their daily functioning. This definition also includes people with perceived disabilities that are no longer in the labor force, but do not receive any disability allowance or any other benefit, which accounts for 10% of the disabled persons in the OECD [5].

## **Sickness Absence as a Precursor for Disability and The Role of OH Practitioner in Return to Work (RTW)**

Although most people return to work after a short period of time, a significant portion stay out of work in a prolonged sickness absence. Long-term sickness, translated as a temporary disability, is considered a precursor to permanent disability accompanying labor market detachment. This notion is supported by OECD reports that 50-90% of disability benefit claimants applied after a period of paid sick leave [5]. Increasing rates of long-term sickness absence are, therefore, correlated with increasing disability rates. Sickness absence

can result in permanent disability, sometimes without a severe illness, as patients become depressed, inactive, develop catastrophic beliefs and become fixated on their disability. This is a process seen in many cases of nonspecific low back pain [21]. Once recipients go on disability beneficiary programs they rarely exit them to return to work. This can be due to: cases of a severe health condition, long term detachment from the work environment which erodes working skills, worker's professional identity and feelings of self-efficacy. Limited access to vocational rehabilitation in addition to strong economic disincentives for finding new employment add to the problem [22]. In fact, in many OECD countries, the outflow rate from the beneficiary system to work is about one percent [23]. Therefore, every effort should be made to incorporate timely RTW processes, which can preserve employment continuity of workers whose work capacity was impaired, better utilizing their remaining work capacity and avoiding the long-term sickness absence.

RTW practice is a vocational rehabilitation program that returns the injured or sick employee to work as early as medically feasible, within limits and accommodations as needed [24]. Since clinical treatment alone has little impact on work outcomes [25], an effective vocational rehabilitation depends on work-focused healthcare and accommodating workplaces. Thus highlighting the role of OH practitioners.

Fitness for duty is an evidence-based medical assessment that assists the occupational health physician (OHP) in the evaluation of the work capacity of a disabled employee and enables the physician to advise the employer and the employee on a suitable RTW plan. This includes modification, limitations and adjustments required to successfully re-integrate the employee [18,26]. The physician needs to evaluate the impairment and disability severity while taking into account the job's duties, workplace environment, psychosocial aspects and health and safety considerations. Examples of adjustments that OHP might recommend include: job restructuring, reduce the employee's problematic duties by allocating some to others and/or con-

verting them to less problematic ones, part-time or modified work schedules, reassignment to vacant positions; acquiring or modifying equipment; special training to the employee; creating accessible facilities. Sometimes, a job trial in the workplace with periodic review is the best way to evaluate capacity in the actual work environment, and indicates the extent of modifications needed. The OHP has to comply with disability legislation in making recommendations, and only if a disability jeopardizes health and safety or affects the individual's ability to perform the job and no reasonable adjustments could be made, should the physician recommend dismissal or retirement on grounds of disability.

## Obstacles to a Successful RTW Process

Despite the benefit demonstrated by the RTW process and employee retention following disability, implementing RTW can be sub-optimal due to obstacles from several perspectives:

### Physician's Factors

The competencies essential to carry vocational rehabilitation of disabled workers are unique to the curriculum for the specializations in occupational medicine and rehabilitation; this makes the OHP an essential part of the occupational health team [27]. However, despite a joint initiative by the WHO and ILO that aimed to provide OH globally to all working people, only 5% to 10% of workers in developing countries and 20% to 50% of those in industrialized countries have access to adequate occupational health services [28]. Most OH services are available for large companies and public employers, and predominated by OH physicians [29,30]. Only a few countries maintain access to OH services for all workers; in Israel, for example, occupational medicine services are socialized and accessible to all employees and employers without copayment, as part of the national public health care system [31]. However, this contrasts with many European countries and the United States, where the responsibility for evaluating fitness for RTW often falls upon family physicians and GPs, mainly due to limited accessibility of OH to workers [32-34]. PHC

(Primary Health Care) physician often lacks the education, training, and resources for disability management in workplace, and only occasionally has occupational professional consultant access [35,36]. In addition, returning a worker to the workplace, especially when there is reluctance or workplace adjustments are needed, demands time and effort, which is rarely financially compensated, and may involve patient-doctor conflicts [37]. Challenges faced by OHP during the RTW process: such as concerns over the worker's ability to perform tasks related to the job profile without damaging their own or other's health and safety can tip the scales away from the placement of the worker [38]. Moreover, when work-related activities are likely to be curtailed because of impairment, OHP tend to decide that the worker is unfit for duty and therefore recommend displacement, which may lead to premature removal of these individuals from the labor market. In addition, under-recognition of the biopsychosocial approach to disability can also lead to RTW failure.

### **Patient's Factors**

Diminished motivation to pursue recovery, including RTW, can occur when employees view illness or injury as exempting them from their usual social roles or as protecting them from the demands and stress of their life, including work, or if they have a poor relationship with their employer, especially when there are economic incentives to be absent from work [22,35]. In addition, the worker is sometimes referred to OHP only after a long period of sick leave granted by PHC physician because of lack of knowledge about working conditions. Prolonged sick leave, especially when health care providers discourage the employer to RTW, may lead to suboptimal clinical and workplace management [36,39].

### **Work Place Factors**

Many employers perceive the costs of training a new healthy worker to be lower than the costs of retaining and adjusting in order to maintain productivity with the existing worker with the disability.

They prefer to allow the worker to quit and enroll in publicly or pension-funded income support [5]. This lack of incentive for employers to make employment modifications to retain these workers can lead to a lack of cooperation with the RTW process recommended by OHP [40].

## Recommendations: What Can Be Done?

The OH system according to the emerging biopsychosocial approach should be established under multi-professional teamwork models that include: physiotherapists, psychosocial, rehabilitation, and ergonomic professionals, in addition to the OHP, nurses and hygienist etc. Such teamwork, which exists only in minority of countries [30], can better recognize the psycho-social factors and provide comprehensive treatment regarding these aspects of disability, and promote successful reintegration of disabled workers into the workplace.

OH practitioners should widen their scope and take a more proactive role in promoting comprehensive approaches to health and wellbeing within the workforce, by supporting active management of workers who experience an injury or chronic health conditions, and emphasizing the importance of long term maintenance of their working capacity. Both, the OH professionals and the employer, need to monitor the potentially long-lasting health problems of the compromised worker, at an early stage, while minimizing additional workplace risks for the worker's health and detect reduced work capacity caused by health conditions at the onset. Both these key players should implement strategies and interventions to prevent disability and promote workability, RTW and integration of disabled employees. Such workplace interventions have to take into account occupational, work environment, social and lifestyle determinants of health. PHC physicians as well, should participate in continuing education and training programs that teach disability management strategies, in order to encourage RTW and prevent prolonged sickness absence and possible worker exclusion from the labor market. Both employees and

PHC physicians should be made aware of the adverse effects of not having the worker return after prolonged absence or disability.

Insufficient availability of OH services for workers worldwide, which results in inequities in OH provision, must be addressed by strong legislative and governmental support, and integrate OH within health system reform and funding allocation. OH provision in developing economies, the informal sector of developed economies, within small/medium sized companies, and self-employed must be emphasized. Encouraging physicians and nurses to become professionals in OH by constructing flexible training programs (e.g. e-learning), may offset the current shortage of trained OH professionals. Inclusion of OH topics at the undergraduate levels of health science education is an additional way to gain awareness of the profession. Maintaining a base of academically oriented OH professionals who focus on theoretical and applied research, can advance knowledge and disseminate training. Delegating the responsibilities of OH to PHC practitioners has been proposed as a solution for low OH availability. However, this is unrealistic, as the WHO reports a current shortage of PHC practitioners, who work under high workloads and psychological stress, even without the need to acquire the competencies required for OH practitioners. Therefore, the solution is to establish a professional skilled and trained occupational health system that will meet the needs of the labor market.

## References

1. Anema JR, AJ van der Beek. Medically certified sickness absence. *BMJ: British Medical Journal (Online)*. 2008; 337.
2. Mor S. Disability and the Persistence of Poverty: Reconstructing Disability Allowances. *Nw. JL & Soc. Pol'y*. 2011; 6: 178.
3. Waddell G, AK Burton. *Is work good for your health and well-being?* The Stationery Office. 2006.

4. WHO, World report on disability 2011. World Health Organization. 2011.
5. OECD, *Sickness, Disability and Work: Breaking the Barriers: A Synthesis of Findings across OECD Countries*. Paris: OECD Publishing. 2010.
6. Vos T. Global, regional and national incidence, prevalence, and years lived with disability for 310 diseases and injuries, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015. *The Lancet*. 2016; 388: 1545-1602.
7. Prins R. Mental health problems and disability pensions: trends and measures in a cross-national perspective. *Journal of Public Health*. 2006; 14: 371-375.
8. Hartvigsen J, Hancock MJ, Kongsted A, Louw Q, Ferreira ML, et al. What low back pain is and why we need to pay attention. *The Lancet*. 2018; 391: 2356-2367.
9. García-Gómez P, HM von Gaudecker, M Lindeboom. Health, disability and work: patterns for the working age population. *International Tax and Public Finance*. 2011; 18: 146-165.
10. Rondinelli RD. Changes for the new AMA Guides to impairment ratings, 6th Edition: implications and applications for physician disability evaluations. *PM R*. 2009; 1: 643-656.
11. Loisel P. Developing a new paradigm: Work disability prevention (ICOH 2009). *Occupational Health Southern Africa*. 2009; 15: 56-60.
12. Denne J, G Kettner, Y Ben-Shalom. The Role of the Physician in the Return-to-Work Process Following Disability Onset. *Mathematica Policy Research*. 2015.
13. Westmorland MG, N Buys. A comparison of disability management practices in Australian and Canadian workplaces. *Work*. 2004; 23: 31-41.

14. Hendricks A. UN Convention on the Rights of Persons with Disabilities. *Eur. J. Health L.* 2007; 14: 273.
15. Schultz IZ, RJ Gatchel, SR Asih. Handbook of return to work. From research to practice. 2016.
16. Jürgen Barth, Wout E L de Boer, Jason W Busse, Jan L Hoving, Sarah Kedzia, et al. Inter-rater agreement in evaluation of disability: systematic review of reproducibility studies. *BMJ.* 2017; 356.
17. Nagi SZ, RD Burk, HR Potter. Back disorders and rehabilitation achievement. *Journal of Clinical Epidemiology.* 1965; 18: 181-197.
18. Palmer KT, I Brown, J Hobson. *Fitness for Work: the Medical Aspects.* 5th ed. Oxford: Oxford University Press. 2013.
19. Rothstein MA. Innovations of the Americans with Disabilities Act: confronting disability discrimination in employment. *JAMA.* 2015; 313: 2221-2222.
20. Albrecht GL, KD Seelman, M Bury. *Handbook of disability studies.* California: Sage Publications. 2001.
21. Costa-Black KM, Loisel P, Anema JR, Pransky G. Back pain and work. *Best Practice & Research Clinical Rheumatology.* 2010; 24: 227-240.
22. Franche RL, N Krause. Readiness for return to work following injury or illness: conceptualizing the interpersonal impact of health care, workplace, and insurance factors. *Journal of occupational rehabilitation.* 2002; 12: 233-256.
23. Mont D. Disability employment policy (Social Protection Discussion Paper Seroes). The World Bank, Human Development Network, Social Protection Unit. 2004.
24. Krause N, LK Dasinger, F Neuhauser. Modified work and return to work: a review of the literature. *Journal of Occupational Rehabilitation.* 1998; 8: 113-139.

25. Nieuwenhuijsen K, Bültmann U, Neumeyer-Gromen A, Verhoeven AC, Verbeek JH, et al. Interventions to improve occupational health in depressed people. *Cochrane Database of Systematic Reviews*. 2008; CD006237.
26. Tee L, Guidotti, M Suzanne Arnold, David G. Lukcso, Judith Green-McKenzie, Joel Bender, et al. *Occupational health services: A practical approach*. Routledge. 2012.
27. Harrison J, L Dawson. Occupational health: Meeting the challenges of the next 20 years. *Safety and health at work*. 2016; 7: 143-149.
28. Lucchini RG, L London. Global occupational health: current challenges and the need for urgent action. *Annals of global health*. 2014; 80: 251-256.
29. LaDou J. International occupational health. *International journal of hygiene and environmental health*. 2003; 206: 303-313.
30. Jorma Rantanen, Suvi Lehtinen, Antonio Valenti, Sergio Iavicoli. A global survey on occupational health services in selected international commission on occupational health (ICOH) member countries. *BMC public health*. 2017; 17: 787.
31. Rinsky-Halivni L, Y Lerman. Discussion Group Networks in Occupational Medicine: A Tool for Continuing Education to Promote the Integration of Workers with Disabilities. *American journal of industrial medicine*. 2018; 61: 344-350.
32. Beaumont D. Rehabilitation and retention in the workplace—the interaction between general practitioners and occupational health professionals: a consensus statement. *Occupational Medicine*. 2003; 53: 254-255.
33. CMA. *The treating physicians' role in helping patients return to work after an illness or injury*. Ottawa: Canadian Medical Association. 2013.

34. Soklaridis S, Tang G, Cartmill C, Cassidy JD, Andersen J. "Can you go back to work?" Family physicians' experiences with assessing patients' functional ability to return to work. *Canadian Family Physician*, 2011; 57: 202-209.
35. Pransky G, Katz JN, Benjamin K, Himmelstein J. Improving the physician role in evaluating work ability and managing disability: a survey of primary care practitioners. *Disability and rehabilitation*; 2002; 24: 867-874.
36. Sawney P, J Challenor. Poor communication between health professionals is a barrier to rehabilitation. *Occupational Medicine*. 2003; 53: 246-248.
37. ACOEM. Guideline: Preventing needless work disability by helping people stay employed. *Journal of Occupational and Environmental Medicine*. 2006; 48: 972-987.
38. Serra C, Rodriguez MC, Delclos GL, Plana M, Gómez López LI, et al. Criteria and methods used for the assessment of fitness for work: a systematic review. *Occup Environ Med*. 2007; 64: 304-312.
39. Hall JP, MH Fox. What providers and Medicaid policymakers need to know about barriers to employment for people with disabilities. *Journal of health & social policy*. 2004; 19: 37-50.
40. Dionne CE, Bourbonnais R, Frémont P, Rossignol M, Stock SR, et al. Obstacles to and facilitators of return to work after work-disabling back pain: The workers' perspective. *Journal of occupational rehabilitation*. 2013; 23: 280-289.