

# Coordination of return-to-work stakeholders in a changing welfare system

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# Linköping University, Sweden

Students	25 000
Research students	1 300
Employees	3 500



# Who am I?

- PhD student at the National Centre for Work & Rehabilitation, Linköping University, Sweden
- The centre is a multidisciplinary research group focusing on return-to-work, rehabilitation, health promotion and workplace learning
  - Sociology
  - Psychology
  - Public Health
  - Pedagogics

# Today's talk

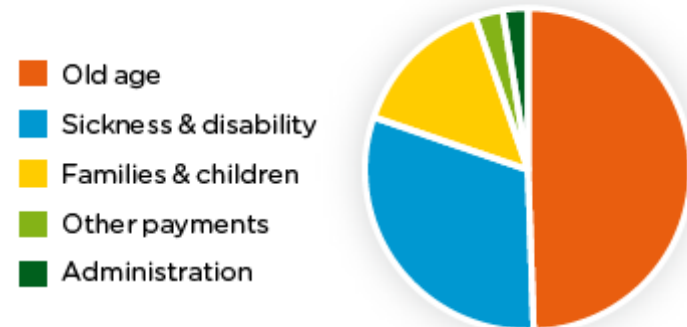
- A brief introduction to the Swedish social security system and how it is changing
- A stakeholder perspective: who's responsible for what?
- Stakeholder cooperation in return-to-work and work reintegration
- Organizational perspective on cooperation
  - Managers
  - Staff

# Welfare systems

- The liberal welfare regime
  - Strong market-orientation, low benefits, often means-tested
  - USA, UK, Australia, Canada
- The corporatist welfare regime
  - Close interrelationship between eligibility and social position on the labour market, strong focus on family structures
  - Germany, France, Italy, Austria
- The social-democratic welfare regime
  - Based on universalism, often high benefits, little means-testing
  - The Scandinavian countries

# The Swedish social insurance system

- A comprehensive system that covers everyone who lives or works in Sweden
- The Social Insurance Agency administrates most of the system
- Pays out pensions, allowances and benefits
- In 2007, the amount paid out was SEK 436 billions (approx. 67 billion CAD)
- Approx. 15 % of Sweden's GDP



# Swedish work life legislation

- Regulation for work disability prevention is primarily set by:
  - ✓ the Work Environment Act  
to ensure a good working life with well-functioning employment conditions and a good and stimulating working environment
  - ✓ the National Insurance Act  
to provide financial security at every stage of life, from birth to retirement e.g. for those who are ill, disabled, parents and pensioners

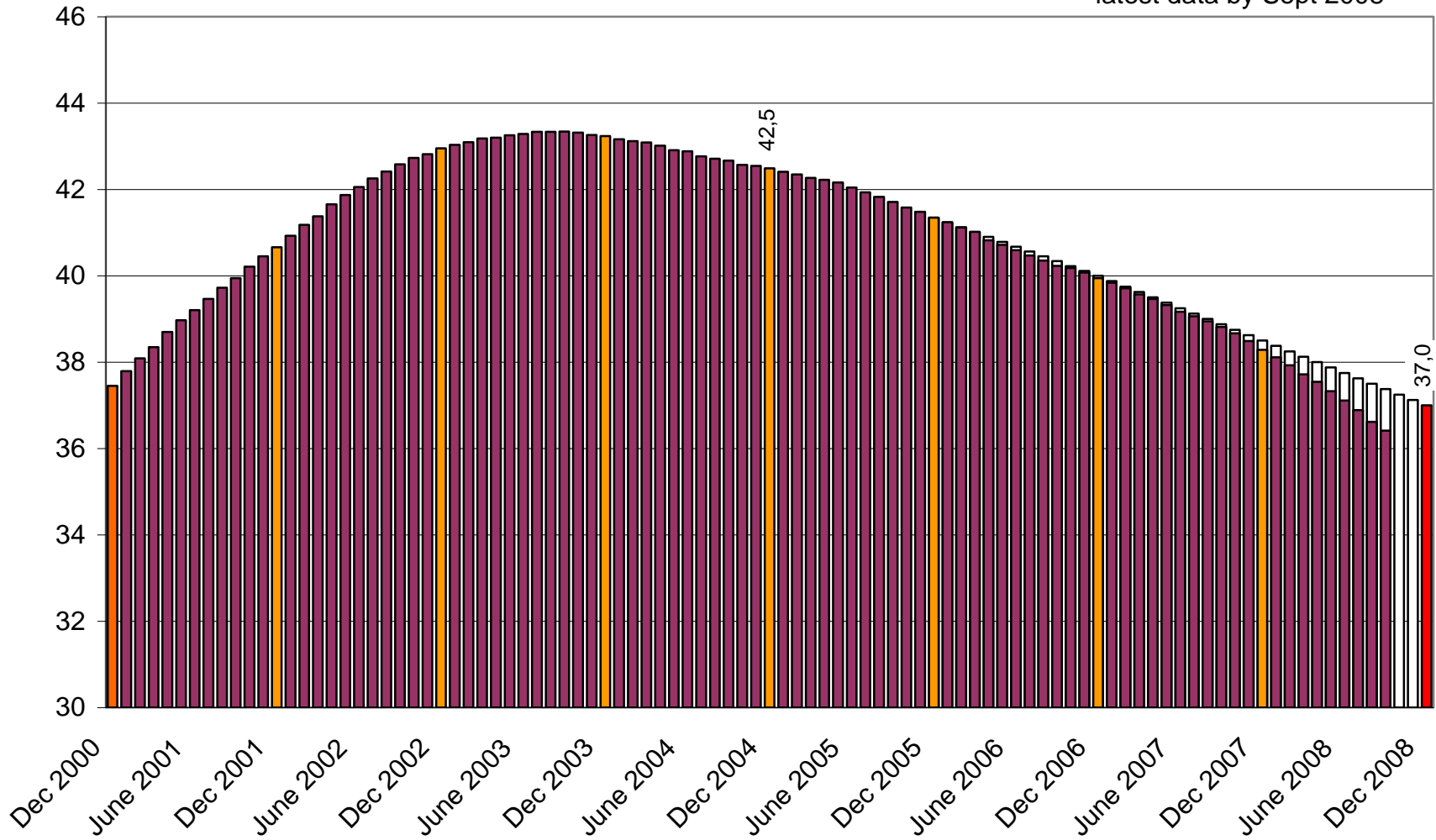
# The Swedish sickness insurance system

- Sickness benefits are 80 % of salaries, up to a ceiling
- The first two weeks are paid by the employer, then by the Social Insurance Agency
- No difference whether disease is caused by work or not
- Criteria for eligibility is decreased work ability caused by medical reasons (disease or injury)
- An additional work injury insurance covers loss of income and costs for treatment and medication when applicable
- Sickness compensation (disability pension) when work disabled for life, 64 % of salaries



# Days with Sickness Cash Benefit and Disability Pension per insured person

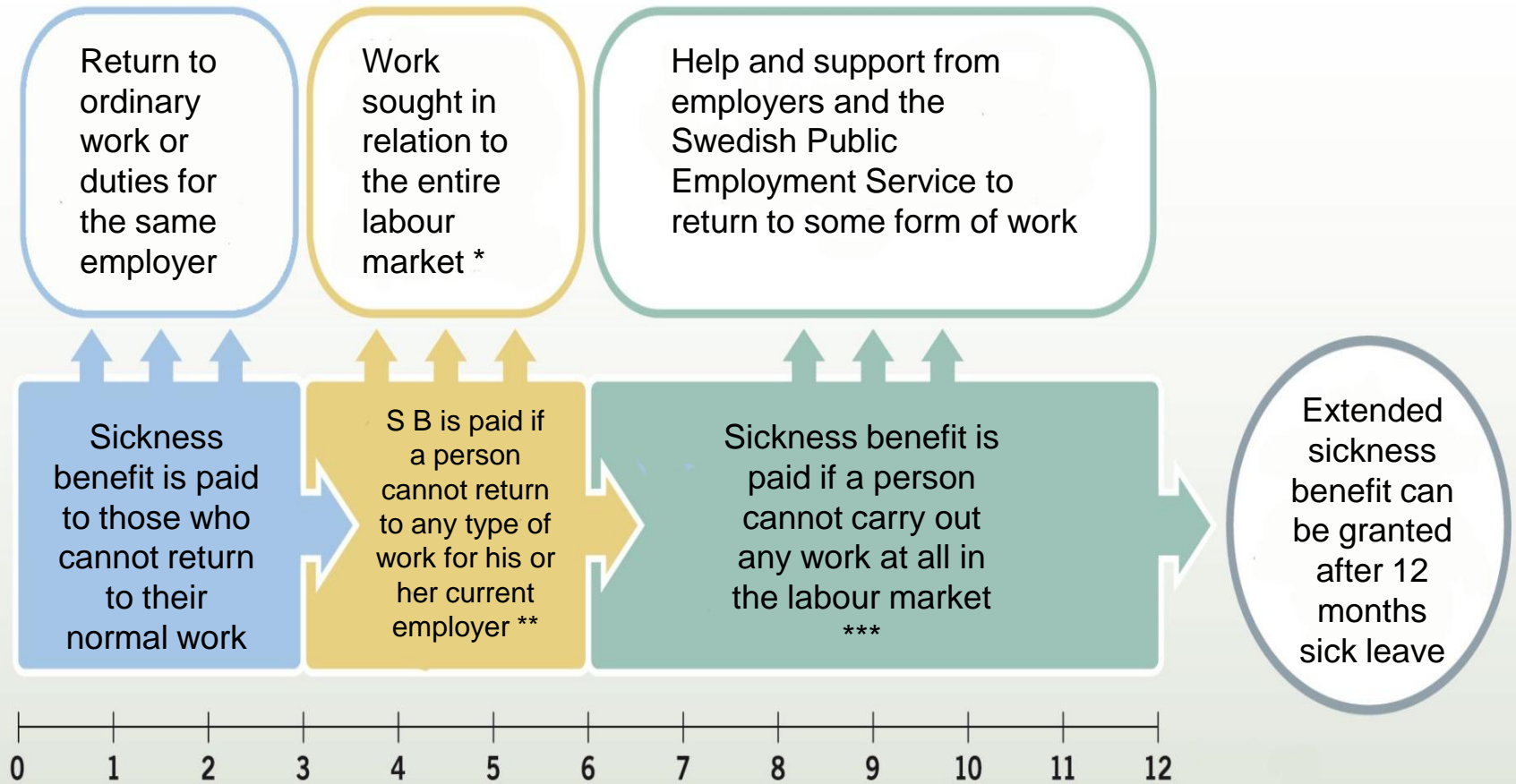
latest data by Sept 2008



# Changing regulations

- In 2006, 700 000 people were long-term sick-listed (>3 months) or received disability pension in Sweden (total population approx. 9 000 000)
- In 2008, several changes were introduced into the Swedish sickness insurance system
- A one year time limit in sickness insurance has been introduced and the RTW process has been shortened
- Temporary disability pensions has been abolished, concerning approx. 111 000 people
- These people will either receive permanent disability pension or return to work

# The Rehabilitation Chain



\*The person on sick leave is entitled to time off to try out other work

\*\*Where there are special grounds this may apply for more than 6 months

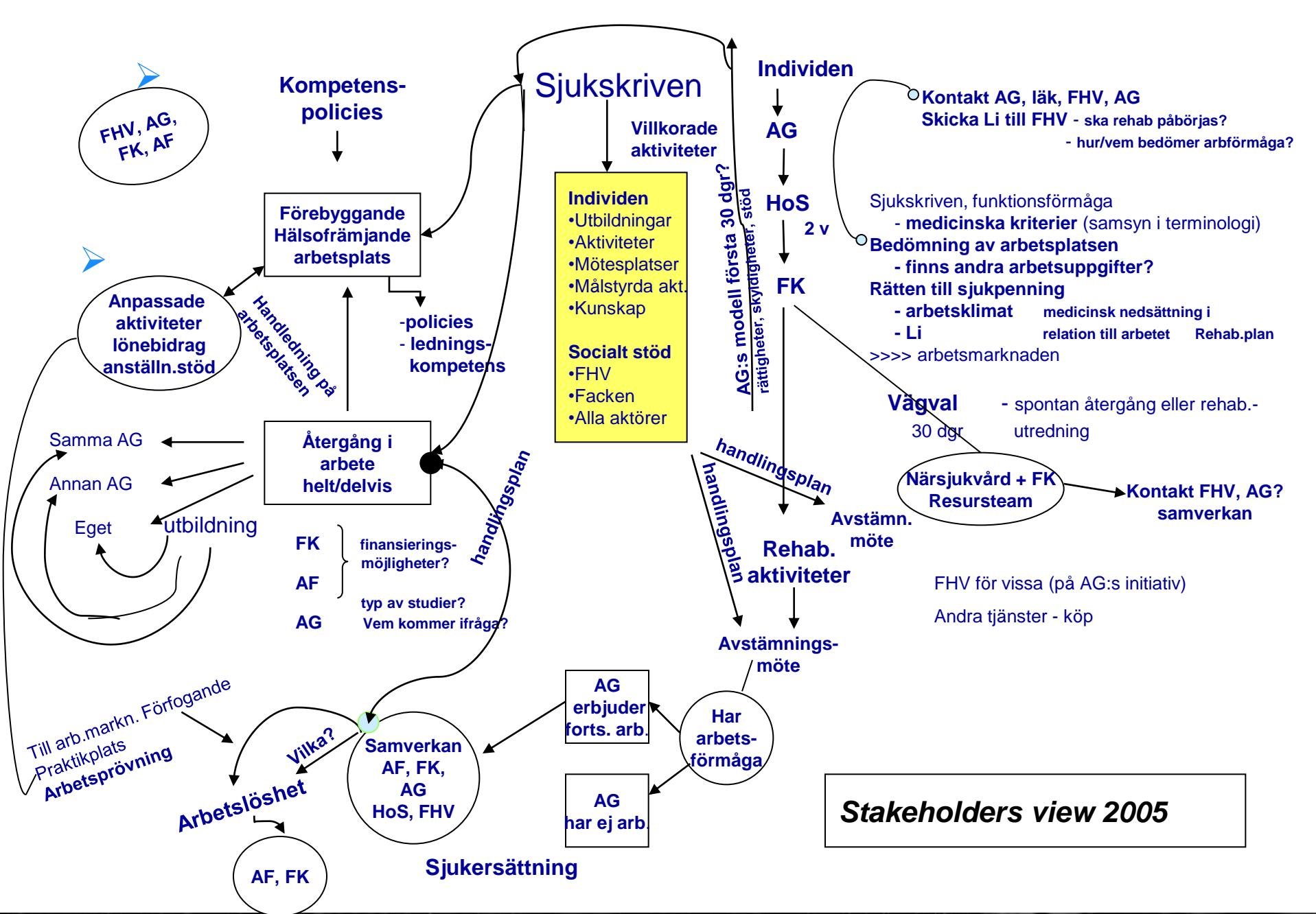
\*\*\*In the case of serious illness, sickness benefit is paid for longer than 12 months

# Consequences of the changes

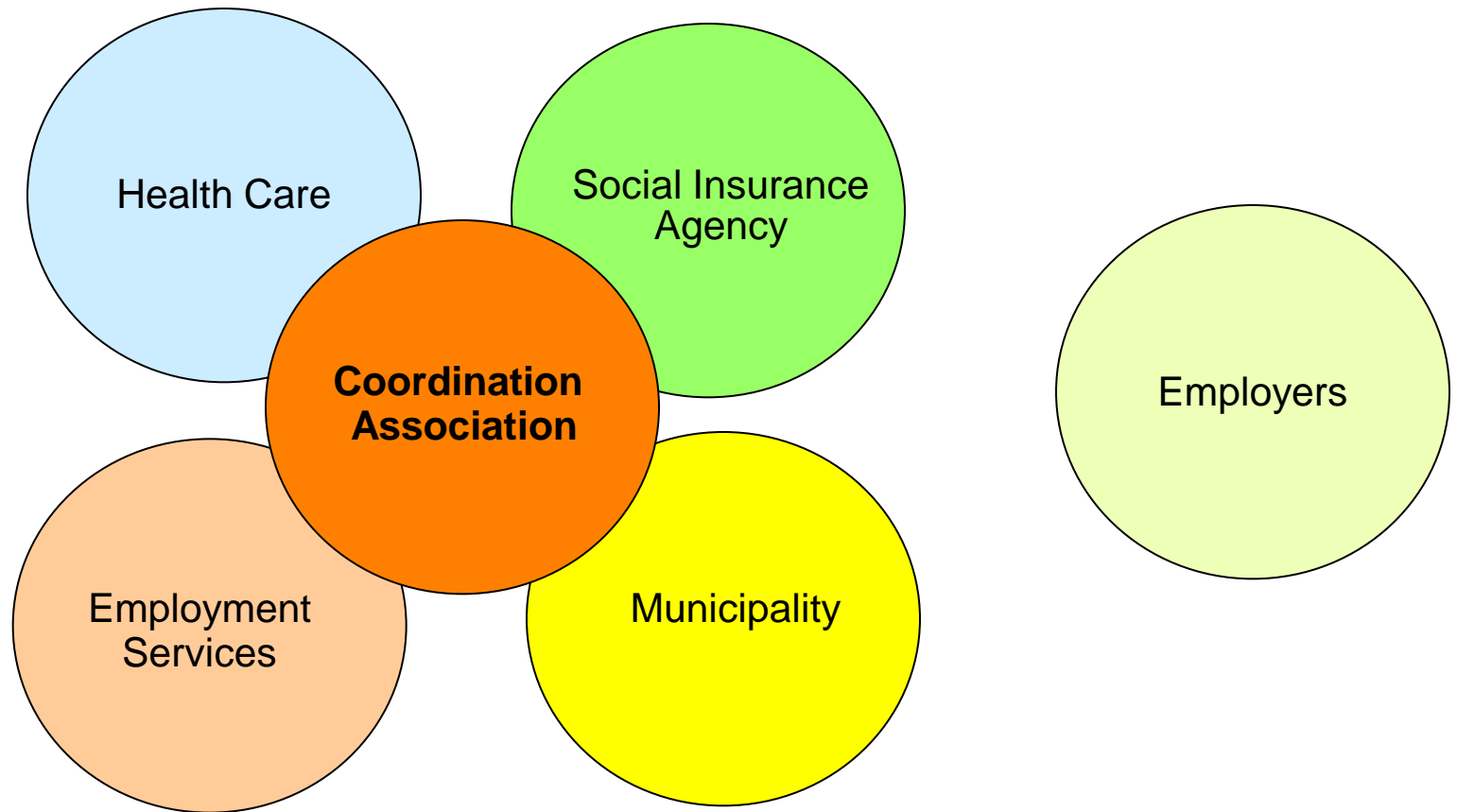
- Less eligible for disability pension
- Less sick-listed due to time limit, transfer to:
  - Unemployment insurance, if possible
  - Social welfare office
- Work injury insurance may become more attractive, since it does not have a time limit
  - An increasing importance of whether a condition is work related or not?
  - More litigation?
- The changes are just beginning to come into effect
  - Wait and see!

# Stakeholders in Swedish return-to-work

- Health Care
  - Assessment of individuals' functioning
  - Responsible for the medical rehabilitation
- Social Insurance Agency
  - Assessment of individuals' work ability
  - Administrates sickness benefits and disability pensions
  - Responsible for the coordination of the RTW process
- Public Employment Service
  - Responsible for vocational rehabilitation for unemployed
- Municipalities
  - Responsible for social rehabilitation
  - Overall social responsibility for citizens
- Employers
  - Workplace rehabilitation
  - Pays for the first two weeks of sick-leave



# Stakeholder cooperation in RTW



# Coordination Associations (CAs)

- The structure of the CAs is regulated by a voluntary legislation
- CAs are governed politically by a local board in each CA, consisting of representatives from the participating stakeholders
- An operative group consisting of managers from the stakeholders has the responsibility for implementing the decisions of the boards in practice
- A coordinator in every CA administrates and supports the boards and operative groups in their work
- Common coordination budget



# Coordination Associations (CAs)

- The aims of the Coordination Associations are to:
  - Facilitate return-to-work and work reintegration
  - Restore or enhance work ability
  - Improve cooperation structures between stakeholders
  - Reduce costs for society
- Examples of new work forms to enhance cooperation:
  - Interdisciplinary rehabilitation teams between authorities to promote return-to-work
  - Cooperation teams between all stakeholders for unemployed with complex needs
  - Individual coaching
  - Psychosocial teams

# Aim of my research

- The principal aim of my research is:
  - To analyse Coordination Associations as a tool for improving the cooperation between public rehabilitation stakeholders
- An organizational focus:
  - How representatives from stakeholders on different levels perceive participation in Coordination Associations
  - Effects on practice
  - Perceived implications for the individual
- A welfare theoretical framework:
  - How practice in Coordination Associations is related to the recent changes in the social security system and a changing working-life

# Three perspectives

- A managerial perspective on cooperation, its prerequisites and possibilities
  - Interview study with 35 board members and managers in two Coordination Associations
- Officials' perspectives on the development of cooperation
  - Bases on recurrent group discussions with officials from the Social Insurance Agency, the Employment Service, healthcare and municipal rehabilitation workers in to municipalities
- Strategies for cooperation through Coordination Associations

# The managerial perspective

- Board members and managers are generally positive to the common financing of cooperative projects, which makes it possible to develop and test new work forms
- Representatives have double bindings, since they represent both the CA and their own organization
- The identification with organizational goals (eg. keeping budget) can hinder cooperation
  - "In the board, the most important thing is to see this as a common responsibility, because it's easy that you want payback on your invested money. The big pedagogical question is to always raise your perspective; you're not on the board to only represent your own organization. On the board, you're not only a representative from the SSIA, you also have to see to it that it works as a whole. I cannot look at my figures and say that I want payback." (SSIA)

# Organizational prerequisites

- Internal problems (restructuring, financial problems et cetera) has a negative impact on cooperation
- The Employment Service (a state authority) lacks clarity from the national level on cooperative work
  - "There was no obvious standpoint from our managers on how to react to Coordination Associations. And of course, if it had come from there that this is important, we can use this in our practice and so on, then it would have been different. But since it was like, well, wonder if we're supposed to engage in this? Are we concerned with this at all?" (Employment Service)
- A general problem to implement new work forms into regular practice, both because of budgetary reasons and because of managerial governance of work routines

# Why cooperate?

	Insurance Agency	Employment Service	Healthcare	Municipalities
<b>Primary target group</b>	Work disabled, working-age	Employable, working-age	Sick, ill and/or disabled, all ages	Socially excluded, unemployed, disabled, all ages
<b>Motives for cooperation</b>	RTW for work disabled, efficiency	RTW for unemployed, efficiency	Individual health and quality of life, cooperative work	Self-sufficiency, social security, efficiency
<b>Priority in RTW process</b>	Early-mid	Late	Early	Early-late
<b>Congruence with CA goals</b>	High	Low-medium	Low-medium	High
<b>Experienced benefit/value of participation</b>	High: RTW is a central issue	Low: wants more short-term efforts	Medium: low in RTW, high in cooperative work	Medium-high: wants more long-term efforts
<b>Commitment to the CAs</b>	High	Low	Medium	Medium-high

# What does it take to cooperate?

- Organizational disloyalty?
- No, but **trust** across organizational borders
  - “trust will moderate the relationship between cooperative motives and cooperative behaviour” (Dirks & Ferrin 2001)
- Cooperative motives are essential, but insufficient for cooperation to occur
  - Participants need to expect that others will cooperate
  - If this trust is lacking, cooperative motives will not be translated into cooperative behaviour

# What does it take to cooperate?

- Participants need to identify with common goals
- Since these goals may come in conflict with organizational (financial) goals, a long-term perspective is important
- The coordinators have a central role in balancing these goals and to work out a strategy together with the representatives from the participating organizations



# Officials' perspective: formal and informal cooperation

- *"Municipal rehabilitation worker:* ...that's kind of the idea of having cooperation, that we know about each other, where we can shorten the distances. Picking up the phone or sending an e-mail.
- *SSIA:* Exactly.
- **You do that?**
- *MRW:* Yes, I think we do.
- *Rehabilitation Coordinator:* Yes, I also think so. Much has developed since the rehabilitation teams came, and we were supposed to cooperate.
- *SSIA:* It was not much before that.
- *MRW:* And I think that when we work together, four authorities, you dare more. It's not dangerous to ask. It's been more of this drainpipe thinking."

# Rehabilitation coordinators as an increasingly central actor

- When setting up rehabilitation teams, coordinators were employed to administrate team meetings
- In some healthcare centres, the coordinators hold orientating meetings with new sick-listed and follow them through the rehabilitation process
- This helps both the individual and other professionals
  - *SS/A*: I think, the physicians really appreciate the information you collect.
  - *RC*: Yes. They say - it's come that far that they say "no, I don't know, I'll send the person to [the coordinator] so I'll find out what the problem is". And I suppose it's because I have more time to let them describe it.

# Coordinators as disability managers?

- The work of the coordinators have several similarities to how disability managers work in other countries
- Though, the coordinators have not received any training, but developed almost spontaneous through experience
- The coordinators have been left to figure out their own way of working, resulting in a large variety of methods
- Differences in what resources coordinators are given in different healthcare centres

# Cooperation with employers? The case of work ability assessments

- Lack of cooperation with employers and occupational health services in assessing work ability
- Occupational therapists in primary healthcare are not allowed to visit the workplace
  - *OT:* I have, almost out of mercy, been allowed to test it on some patients to go out to the workplace, and I mean, it brings so much.
  - *Psych:* But why aren't you allowed to do that? [...]
  - *OT:* Well, you know, that's supposed to be occupational health service."
- Lacking cooperation between primary healthcare and occupational health services
- This implies that work ability generally is assessed outside the workplace, which makes the assessments less reliable

# Where is the cooperation going?

- In one of the municipalities, there is lot of disappointment regarding the development of cooperation through CAs, since successful projects have been shut down
  - *RC*: What I don't like about it is that walls have been teared down in all our organizations, and now they're being built up again. The CA starts projects and then they say "we'll shut this down, now, you will own the problem". And then the walls have reappeared. Withdrawing Samteamet [a cooperative project] was, well, maybe the category of people that you will have to handle now.
  - *MRW*: That we get instead, yes.
  - *RC*: And you evaluated it and it was proven successful, but nevertheless you shut it down since the organizations, the Employment Service, the Insurance Agency, healthcare don't want to pay. Why should we work then? I think like that sometimes. Perhaps there'll be a new project."

# ”What happens if we do it anyway?”

- The participants feel so frustrated that they are on the verge of mutiny.
  - *Psych*: And then it’s this with projects you talked about before, that you get tired with projects, and I understand that. [...]
  - *OT*: Yes, and now there’s even more talk considering this with multimodal teams that’s the new thing now and - I mean, it will - it feels strange that they are giving up on the resource teams [an interdisciplinary team for planning rehabilitation] since it’s the only multimodal team we have that actually works. Where all the stakeholders are represented.
  - *SSIA*: And that brought so much.
  - *MRW*: What happens if we go there anyway?
  - *OT*: Exactly!
  - *SSIA*: It would be interesting to try.
  - *OT*: Everybody just takes their stuff and go. [laughs]”

# The importance of strategy for cooperation

- Different CAs has chosen different strategies which brings different prerequisites for cooperation
- The CA in Motala chose to finance a long-term cooperative work form (a team) where all stakeholders are engaged, and other services are planned around this central team
- The CA in Norrköping has had more time-limited projects that despite good results has not been possible to implement, since the stakeholders do not want to take over the costs
- Thus, well-functioning work forms get shut down
  - "The effects of cooperative projects seem to vanish when projects are closed down and there is no ground for further cooperation without extra resources. [...] This can become a problem, since the signals become double towards the people that have invested time and engagement into the project. Therefore, a structure for continuity is of need for projects." (Alexandersson et al 2005)

# Summary of the studies

- The CA work forms are much positively experienced by the officials
- The management is positive to the possibilities for development that common financing may bring
- The self-interest of the stakeholders tend to hinder cooperation
- Mutual trust between the stakeholders is crucial for cooperation to work
- Implementation of cooperation needs a long-term strategy and a financial plan to prevent the influence of vested interests
- Cooperation between the public stakeholders and employers and occupational health services is lacking
- CAs are structures for cooperation between public stakeholders and do not include employers



Thank you for your attention!

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