Peer Review Integrated Services in the Field of Rehabilitation

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1. Introduction

There is no doubt that people with sickness or disability face a variety of issues which make them more likely to lose their jobs; less likely to find new jobs; and less likely to get paid as much as those who are neither sick nor disabled when they finally get a job. For example:

- Their physical or mental capabilities may be restricted so they cannot fulfil the requirements for some jobs at all, and only parts of others;
- Their health condition may make them less adaptable to meet the demands of an employer, and so less attractive for an employer who values adaptability;
- Limitations may have to be imposed on the workplace or the tasks they can be expected to do, leading to friction with line managers and other staff;
- Their sickness absence may be higher raising the unit cost of the work they actually do;
- Their education and training may have been reduced by ill health or disability;
- They may face stigma and discrimination.

1.1 Service Integration

Overcoming the precise barriers to work an individual experiences may therefore mean harnessing a variety of skills including those normally found in services dealing with the unemployed; those of services assessing and managing benefit claims for sickness or disability; health care providers; and providers of social care. There are various possible mechanisms which can include:

- Merging services, for example 'Centrelink' in Australia, 'Work and Income' in New Zealand and 'Jobcentre Plus' in the UK which merged services for the unemployed jobseeker and those on incapacity benefits. Centrelink also contains what was the Commonwealth Rehabilitation Service;
- Commissioning across boundaries, such as the UK 'Pathways to Work' pilots where the social security authorities specified, commissioned and funded specialised interventions from the UK National Health Service aimed at getting disabled people back to work;
- Setting out a legal responsibility for ensuring co-operation and legal responsibilities for co-operating with a single leader. This seems to have been part of the Swedish approach.
- Giving individuals a budget (or a voucher as in the Netherlands 'personal reintegration budget') allowing them to buy services from a wide range of providers.

A number of models have been tried internationally to do what DELTA has aimed to do.

1.2 Health and Work

There is good evidence that most people are healthier if they are in good jobs, and that includes people with the common mental health problems which are now the predominant health causes of workless-

ness (musculo-skeletal problems, back pain and anxiety and depression). Most disabled people demand the right to participate in society, and that includes working. Most countries face an ageing workforce, and disability increases with age so that means a workforce in which disability is becoming increasingly commonplace. And most countries face pension deficits which mean workers will need to work longer, and employers will want them to do so. All these drivers force the issue of helping disabled people to work onto the social policy agenda.

Creating mechanisms which promote co-operation between the service providers set out in paragraph 1.1 has become a priority for many countries, including the UK. As DELTA is one method of tackling this issue, it is relevant to UK social policy.

2. The Swedish Project

2.1 The Model in Hisingen

The nature of the project seems to have changed over the years it has operated. First, some projects already in existence were incorporated at the original launch in 1997 and 'further projects were added in succeeding years'. This implies a relatively slow start-up phase, and this is confirmed by suggestions that 1997 'was devoted entirely to disseminating information and getting the project securely anchored'. In 1998, 'the collaborating authorities recognised the need for expert resources' and appointed staff to provide it. In 2000, 'financial follow-up, information/communication and implementation, were strengthened in the autumn'. The Financial Coordination of Rehabilitation Measures Act came into force on 1st January 2004, but the extra powers were not used in Hisingen until 1st January 2005 when the county labour board formally joined DELTA (though it seems to have been involved informally before). There also seem to have been major differences between the projects in different areas, the Ministry noting that some projects restricted their activities to particular client groups. This means that meta-analysis of the impacts of the different schemes to gauge overall impact is likely to be problematic.

The development of the Hisingen service seems to have been incremental and probably only reached stability in about 2001. It may have changed significantly after 1st January 2005. Given the problems of evaluating such a complex situation, and of finding valid comparators, it seems inherently unlikely that a robust evaluation could have been mounted easily.

2.2 The Model and Its Applicability to the UK

The Swedish paper sets out the organisation of the various services brought together under the DELTA programme, and it seems clear that they share a de-centralised approach, but with local units which are normally not co-terminous. It is not entirely clear how this applies to the island of Hisingen and whether the fact that it is an island affected the possibility of a programme like DELTA being mounted. In the UK, rather more services are currently supplied centrally though there is a tendency to de-centralise which could make the DELTA model more applicable to the UK.

The model could not be applied to the UK as it stands because of differing service organisation, notably the National Health Service. But, it could be more applicable in the future. Its success or failure is therefore a helpful guide for the UK.

2.3 Swedish Information Relevant to UK Social Policy

The main issue therefore becomes what evidence exists of what the model actually does, and whether it works. We are particularly sensitised to this question in the UK, having mounted the largest randomised trial of its type ever done to look at the value of boosting early interventions to prevent sickness becoming long term, the Job Retention and Rehabilitation Pilot. It cost approaching £20m. The bottom line was that both the contractors who provided services and those subjects who received them generally supported the programme and valued it. But, there was no overall impact on return to work, and indeed those with mental health problems were (if anything) less likely to return to work quickly after an intervention. Interestingly, providers remain convinced of the value of what they did, and a number have made major changes to their personal careers to reflect what they see as positive, valuable lessons from the initiative. Nevertheless, there is no suggestion that the government will provide services like those in the trial.

Positive perceptions of providers and customers for services, although desirable, do not show that they work and would not of themselves persuade the UK government to provide services.

2.4 The Impact of the Model in Hisingen

The first evaluation covered the period before 2004, the second was published in 2005 so presumably could not have picked up the effects of the new act of 2004. The second evaluation compared Hisingen to 'control centres' but there is no description of how these were selected and how they compared to Hisingen. At any rate, the comparison showed no changes in Hisingen outcomes, though Hisingen processes did differ as 'patients at DELTA centres were treated more often, particularly with regard to physiotherapy'. On the face of it, Hisingen costs per individual were higher and the outcomes were unchanged.

The Ministry paper also refers to a 'national evaluation of the pilot between 1997 and 2004 [showing]. favourable results in Hisingen and other places in terms of sickness benefit costs, social security benefit costs and long-term sick leave trends'. There is no clearer description of the methodology used in this evaluation, and of any cost-benefit comparison made in it. It seems inherently unlikely that this wider evaluation would have identified results which would have been missed by Hultberg who appears to have had the opportunity to select areas to match Hisingen.

Whilst participants have enjoyed the DELTA project, there is no firm evidence that it succeeded in reducing benefit costs or helping people to return to work sooner. If anything, it confirms the findings of the UK Job Rehabilitation and Retention Pilot, though with a less robust evaluation.

2.5 Possible Lessons from Hisingen

This does not mean that lessons could not be learned from the project which it would be helpful to discuss. They could include:

- At what stage of their absence subjects entered DELTA;
- Their health and social status at that point and the barriers to their returning to work;
- The national and local labour market, any legal protection for those off work sick and their influences on the project;

- What the intervention programmes were aiming to do and whether there is any possibility of disaggregating their evaluation;
- Whether those programmes did cover the needs of the individuals, or whether the professional liaison showed gaps in them;
- Whether the project did boost or expedite health care provision and whether this did help individuals even if group activities were not successful;
- What links to employers and their ability work to allow or expedite return to work were achieved (given the legal requirements on employers described by the Ministry). If they were not achieved (as Hultberg reports that no extra workplace visits were carried out in Hisingen) the reasons for this situation;
- How DELTA reacts to the findings of no real impact.

This might help persuade the UK to mount a further pilot in this vital area of social policy.