The European way(s) back to work

International Conference, 28 – 29 June 2007, Lucerne

Thoughts and comments of an observer at the Conference

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The Conference of the European Forum of insurances entitled “The European way(s) back to work”

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I. Introduction

1. The short film shown at the start of my comments is a SUVA TV commercial about occupational (re-)integration. It shows how construction workers are taken back to work after recovery in a stretch limousine and meet with a rapturous welcome. The film fits in superbly with what has been the central theme of your talks: that the insured person who has suffered an accident is the focal point of reintegration. Although this statement sounds like a platitude, in fact it is not: as HANSPETER GMÜNDER commented in his talk, the only nuisance factors in the original operating procedures at his clinic were the patients … Putting the focus squarely on the insuree means having *confidence* in this person and the other persons involved. However, confidence is the basis for the entire integration process[1].

2. I would like to explain my “Thoughts and comments” as follows:
   - In an initial step, I will summarize what you yourself, in your talks, consider to be more or less the basic principles for a successful back-to-work (q.v. II ff.).
   - In a second step, I intend to sum up the problems you have in common that you encounter in your work (q.v. III ff.).
   - In conclusion, I will make a (single) opinion-based observation and ask just one question.

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* As far as possible, the text keeps to the spoken word. Gender-specific references have been dispensed with to improve readability.

1 E.g. ELLEN MACEACHEN, JUDY CLARKE, RENÉE-LOUISE FRANCHE, EMMA IRVIN, et al., Systematic review of the qualitative literature on return to work after injury, in: SCAND J WORK ENVIRON HEALTH 2006, Vol. 32, no. 4, P. 261 f.

II. Common principles for a successful "back-to-work strategy"

1. Overview

a. As I see it, almost all the talks formulated both explicitly and implicitly no fewer than *five principles* as indispensable requirements for a successful back-to-work strategy:

- *Principle of confidence* in the relationship between the person to be rehabilitated and those people who are involved with him, whereby this confidence presupposes, in particular, transparency and professionalism on the part of the insurers.
- *Principle of speedy action.*
- *Principle of the subtle organization of the rehabilitation process,* including consistent *coordination* between those involved, with particular emphasis on employers, too.
- *Principle of a multi-disciplinary approach* instead of placing excessive emphasis on the medical aspect.
- Principle of "*proactive financial investment"* instead of an "administrative cost approach".

b. It did not escape my notice that you see these principles as having an *inner connectivity*. In fact, to give just one example: what would people think of a declared wish for transparency if an insurer did not implement this in actual fact by means of organizational detailed and hard work?

2. The basic principles in detail

a. Principle of confidence

The person in need of rehabilitation must have confidence in the doctors, case managers, insurance legal experts, etc. In the final analysis, they are demanding from him the most precious thing he can offer: his own will to return to work. In the end, it is only the insuree himself - and not them - who goes back to work. Without confidence, this decisive step would not be taken at all or only with hesitation.

However, confidence is only the end product in a series of very different but mutually dependent factors that the insurer can influence more or less specifically and must also influence.

For example, the people involved must make an effort to be *objective* and act thoroughly *professionally* and *ethically*. Specifically, this also means among other things the training and further training of the staff involved including legal issues, as FRANÇOISE QUILICHINI has emphasized. Only in this way will those accompanying the patient gain his confidence in their abilities. Objectivity and professionalism - doing the right thing and also making demands of the person being rehabilitated - will have a more lasting effect than moralizing and smothering.

Transparency is thus particularly at the heart of building trust. Every important step must not only be "insightful" for the insuree but also "well-defined". The accident victim should be repeatedly kept informed about the status of the case, about the next step and the interim goals. I was very interested to learn how, according to ANNE RYSLINGE,

an attempt is being made in Denmark to establish this transparency using the most up-to-date and apparently very expensive means.

b. Principle of speedy action

More or less every speaker emphasized the key importance of *speedy* action: for example, this action should not be too "legalistic" (MORGER), any necessary in-patient treatment should be implemented immediately, in rehabilitation - even during the recovery stage - occupational reintegration should be the goal and with the original employer if at all possible as well as other insurance companies and other involved parties should be promptly included, etc.

Behind this is an awareness that too long a procedure can even make people ill or lead to chronification of the accident's consequences[2]! The *medical aspects at all levels, including the courts, must (at long last) be seen in combination with the course of the process* and its multifaceted non-medical influences. Studies show that even a 30- to 40-day absence from gainful employment makes the return to work that much more difficult or even make it impossible[3]. This also explains the major importance of a legal stipulation such as §84 para. 1 of the IXth German Code of Social Law (SGB) that FRIEDRICH MEHRHOFF referred to: legislators force employers to look after employees suffering from health impairments (or frequently other problems, in reality) after only six weeks of incapacity for work.

In short: the speakers taught us not to view the term "occupational rehabilitation" within such close confines *in terms of time*: the "way back" already starts as early as the recovery period. In individual cases, it can become imperative that the insuree returns to work even before the healing process is complete[4]. MARTIN MÜLLER goes even further when he asserts: "the return to work process starts even before the working world has been left behind". With this paradox, he is also addressing *prevention* that is also significant in this context.

c. Principle of subtle organization including consistent coordination

Rehabilitation is apparently an exceptionally complex procedure due not only to the multifaceted needs of the insuree who has been thrown off track, but also of those people working on his behalf. The consequence is that, logically, the organizational aspects of rehabilitation must necessarily be equally complex and subtle in their design. The necessity of being responsive to *individual* aspects can go as far as specific occupational groups having their own insurance companies and setting up their own rehabilitation systems as HANS-JÜRGEN SAUER described, taking German farmers as an example, and PALMIARA PETROCELLI with her example of Italian sailors. Organizational subtlety also includes major *coordination as well as cooperation and information efforts*. JUKKA KIVEKÄS even goes so far as to view the close coordination between the *"claim handlers"* and the *"rehabilitation handlers"* as the most important single element in a successful rehabilitation organization. The keywords are: coordination

- between insurers according to the Federal law on accident insurance (UVG) and family physicians as well as consultant physicians,
- between insurers according to the Federal law on accident insurance (UVG) and other insurers involved, not forgetting the liability insurers,

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2 Instead of many, International Social Security Association: People who return to work and why; findings and effects of a study on incapacity for work and reintegration for politics (summary), Geneva 2002, P. 16.

3 This statement can also be viewed as what is generally experienced by rehabilitation specialists.

4 MACEACHEN et al. quoted in Fn 1, P. 257.

- between the accident insurer and the employer (which FRIEDRICH MEHRHOFF also particularly emphasized),
- as well as coordination between the various parties involved *at the insurance institution*.

d. Principle of a multi-disciplinary approach

WILLI MORGER, as well as FRIEDRICH MEHRHOFF and FRANÇOISE QUILICHINI, and, from the field of medicine, OLIVIER DÉRIAZ, CHRISTIAN LUDWIG and HANSPETER GMÜNDER clearly emphasized the major role played in complex cases by *non-medical* factors. For MORGER, the three key words were the insuree's personality structure, background and occupational setting. This can only meet with agreement[5]. The success achieved so far with the SUVA concept is largely attributable to this awareness. According to MORGER and based on experience, the non-medical factors are frequently *more decisive* than the medical ones! I will return to this key problem in more detail later on[6]. A truly *radical rethink* is necessary in this connection. However, there is no question that we must always also medically address these complex cases without any cutbacks. This is, however, no longer sufficient. We (legal practitioners, including judges, in particular) are still thinking *far too monocausally*. Rehabilitation should not just be placed in the hands of the medical practitioners, a finding that medical practitioners would be the first to agree with[7]. Right from the very start - in synchrony with the medical practitioners as it were - we are dependent on the input of various non-medical specialists. *Multi-disciplinarity* is needed. It is therefore not by chance that the rehabilitation teams at INAIL play a central role, as *Piero Giorgini* explained. This is, in fact, the result of the "nature" of complex cases; however, medical care will naturally always take centre stage for the most severe physical and mental injuries.

e. Principle of "proactive investment" in rehabilitation

As was expressed in various talks, rehabilitation costs a lot,. It is my impression that, in this connection, insurance companies let themselves be guided by the thought that an investment is being made in the future of each individual insuree and not simply the financing of an administrative process. The people responsible in the insurance institutions know that, initially, a lot of money must be available and the upper echelons must be convinced before the successes (which are by no means assured) gained by reintegration can generate any savings. The extent of the return on such investments is documented by SUVA'S impressive initial figures.

III. Common problems

Various talks referred to the *problems* of more or less the same type encountered in most of the countries. In the first instance and in particular, these are masked by the principles summarized earlier, which are nothing more than the *correct conclusions drawn from the problems recognized*. The most important key words are: too little transparency and a lack of professionalism, a bureaucratic approach, tardiness in addressing rehabilitation, wide-

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5 Q.v. ERWIN MURER, The failed legal treatment of "insurance cases of unclear causality" and their effects on the rise in pension claims in disability insurance, in: ERWIN MURER (ed.), Die 5. IVG-Revision: Kann sie die Rentenexplosion stoppen?, Berne 2004, S. 19ff.

6 Q.v. IV. 1. c.

7 Q.v. IV. 1. d.

ranging shortcomings in coordination (whereby it is frequently only the legislators who can redress this)[8], an approach that is too heavily slanted towards medical aspects, a shortage of case managers, too little knowledge of the social and occupational background of insurees, etc.

I thought that the references to *new problems,* which resulted from applying even the most up-to-date rehabilitation methods, were particularly interesting. For example, the comment made by CHRISTIAN LUDWIG that the use of case managers produces, in some circumstances, an *additional demand for medical services* and that *new interfaces* such as between them and the medical practitioners are created. In short, that they (and this is perfectly normal) are developing a new dynamism in many ways that can also have a downside. References were also made to a fact that I consider important, namely that older insurees and those with a background of migration make special demands.

IV. Opinion-based observation and the question

In conclusion, I would like to share an *opinion-based observation* with you and I would like to ask just *one question*.

1. Opinion-based observation:

a. In my estimation, we could have - particularly on the first day - discussed the references made by various speakers to the *causes* of complex cases in greater depth. Every successful *back-to-work strategy* presupposes a tidy analysis of the causes even if worked out on a trial and error basis, especially since complex cases make up the lion's share of expenditure. According to MORGER, the most expensive 5% of cases at SUVA account for 80% of insurance benefits paid out, a figure that is basically hard to believe. The causes should be more or less the same in most countries - this was my immediate assumption, at any rate.

b. However, I am perhaps only judging this from the Swiss angle. Perhaps we have causes that do not exist in other countries or at least not to the same extent. For example, in Germany and Switzerland, a comparatively large number of accidents involving *whiplash injury* (distortion trauma of the cervical spine) are reported: yet while these cases lead to exceptionally high social and liability insurance benefits in our country (cumulated disability pensions from disability insurance and from accident insurance or, possibly, occupational pension funds), the benefits are by comparison very low in Germany (which I personally prefer)[9].

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[8] This was also acknowledged by legislators within the framework of the 5th revision of the Swiss Federal Law on Disability Insurance: for the first time, it forces other branches of social insurance, and in some cases also private insurance companies (life insurance, daily benefits insurance) to cooperate with the Disability Insurance.

[9] Nowadays, there are plausible “alternative” explanations for the alleged medically related causality between grade 1 and 2 whiplash injuries and disability (the possible occurrence of temporary incapacity for work is not disputed), with the result that disability cases would have to fail on the level of proof of predominant plausibility that applies in social insurance law: q.v. ERWIN MURER, Die Institution Sozialversicherung als Ursache des Risikoeintritts? on the possible interdependence between the risk of disability and the procedure to determine its occurrence, in: *Schweizerische Zeitschrift für Sozialversicherung und Berufliche Vorsorge* 2006 H. 7, particularly P. 656 ff.

The difference can easily amount to fifty times or more! It can thus be assumed that the rehabilitation of whiplash victims is organized differently in Switzerland than in Germany or *should be* organized differently. Whatever the case: this example proves that different national rehabilitation processes must also take *specific national conditions* into account and must therefore also be assessed differently.

c. Regarding the core issue*: What are the causes of the complexity in these cases?* It is easy to answer for those complex cases that involve the most severe physical (and in some cases, subsequent) mental injuries. But not for the others. However, I am in complete agreement with WILLI MORGER and various other speakers who stated that *non-medical* elements were increasingly occurring in their work. I call such cases *"insurance cases of unclear causality*", which not only occur within the framework of accident insurance but also in other branches of insurance, particularly, for example, in Swiss disability insurance. "Unclear causality" for these cases is because it is exceptionally difficult to determine whether incapacity for work or even gainful employment following an accident or disease is actually attributable to a legally relevant extent to a *medical* element or to non-medical factors (MORGER terms these personal, social and/or occupational situations). The *medical cause in itself* is frequently unclear and attributing it is correspondingly unclear[10]. In other words, the problem is already created "at source", with the circumstance that the accident or the disease or their effects on the body or mind ex ante *cannot be verified or barely so* (or in medical terms are inexplicable or barely explicable)[11]. Thus these unclear cases, which have occurred *"en masse"* over the last twenty years or so, make up the lion's share of pensions in Swiss disability insurance[12]. In this connection, a total of two clinical pictures predominate: *mental-health problems* (whereby these are not classic illnesses such as schizophrenia, severe depression and similar, but adjustment disorders and the like) and disorders involving the *musculoskeletal system* such as *low back pain*. The two other health impairments that are similarly insured under accident insurance make up the approximately 20% remainder: *psychogenic disorders following accidents* as well as accidents resulting in *whiplash injury* of light and moderate severity[13].

d. The viewpoint that complex cases are largely caused less by the medical element than we assume is supported by increasing scientific literature, particularly in the English-speaking world: in this connection, I am thinking of BARKER, FUREDI, LUCIRE, MALLESON, RUDOLF, SHORTER, TRIMBLE[14]. Major importance is therefore frequently attached to contextual *personal, educational level, family, economic,*

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[10] In all countries, only one health impairment can and may legally be the cause of facts of relevance for benefits. For example, the legal definition of incapacity to earn an income according to Art. 7 of the Federal Law on the General Part of the Social Security Law (ATSG) reads as follows: "The inability to earn an income is the residual whole or partial loss of earning opportunity in a regulated job market that can be considered as caused by an impairment of physical, intellectual or mental health that remains after appropriate treatment and reintegration". According to Art. 8 of the ATSG, disability is "…the anticipated remaining and long-lasting whole or partial inability to earn a living" in the sense quoted above in Art. 7 of the ATSG.

[11] Q.v. the numerous authors who wrote contributions on this topic for the Freiburg Sozialrechtstage in 2006: ERWIN MURER (ed.), Nichtobjektivierbare Gesundheitsbeeinträchtigungen: Ein Grundproblem des öffentlichen und privaten Versicherungsrechts sowie des Haftpflichtrechts, Berne 2006.

[12] In 2004, these two categories accounted for no less than 64% of all new pensions: statistics of the Federal Social Insurance Office 2004, Berne 2004.

[13] Severity grades 3 and even 4 are extremely rare: ANDREW MALLESON, Whiplash and other useful illnesses, Montreal/London/Ithaca, 2002, P. 15 f.

[14] KRISTIN BARKER, The Fibromyalgia Story. Medical authority and women's worlds of pain, Philadelphia 2005; FRANK FUREDI, Therapy Culture. Cultivating Vulnerability in an Uncertain Age, London/New York 2004; YOLANDE LUCIRE, Constructing RSI. Belief and Desire, Sydney 2003; ANDREW MALLESON (quoted in Fn 13); GERD RUDOLF, Individuelle und soziokulturelle Einflüsse auf die Entwicklung somatoformer Schmerzstörungen, in: RAINER SANDWEG, Chronischer Schmerz und Zivilisation. Organstörungen, psychische Prozesse und gesellschaftliche Bedingtheiten, Göttingen 2004, P. 87 f..; EDWARD SHORTER, From Paralysis to Fatigue. A History of Psychosomatic Illnesses in the Modern Era, New York 1992 (German version published by Rowohlt in 1994 entitled: *Moderne Leiden. Zur Geschichte der psychosomatischen Krankheiten*); MICHAEL TRIMBLE, Somatoform Disorders - A Medico Legal Guide, Cambridge University Press 2004.

social and *cultural* factors - logically also in rehabilitation. These cases must therefore be approached just as much "non-medically" as medically. Since the initial facts on which rehabilitation is to be based are very frequently *mixed facts*, representing *ex ante* a mixture of medical factors (which, in some instances, may be little more than an unspecific ailment) and non-medical factors, whereby the latter frequently predominate. Behind the outdated, one-sided medical approach is the supposition dominating the current process both inside and outside insurance companies, of "*hidden diseases"* and "hidden consequences of accidents", that are to the forefront for the injured parties and published opinions: *it might just be,* people speculate, that there is a hidden health impairment, even if it cannot be seen or proved. Thus, driven by the insuree and his lawyer, the insurer often feels obliged to *look for* what is hidden by using every imaginable medical investigation method. While the "hidden disease" has not been found, the clarification and immediate tackling of *non*-medical factors are left by the wayside. In other words: a lot of valuable time is lost in rehabilitation, particularly when years of dispute are spent in court involved in a nebulous medical cause or its actual and supposed effects (whereby it is usually the medical expert who actually settles the dispute, which finds expression in the fact that many cases initially revolve around the expert who is "right"[15]). Generally speaking, we are dealing with a *medicalization of non-medical factors* that is not without its dangers for a welfare state, a process that has long been described, particularly in the English-speaking world.

e. Whatever the case: at least in Switzerland - and, in my opinion, the efforts and initial successes at SUVA cannot be prized highly enough - we must pay far greater attention to this stealthy process than we have done in the past, particularly in the field of health insurance or disability resulting from diseases.

f. The multi-disciplinary approach demanded here has major consequences *for the process*. In particular, right from the start this must be directed towards clarifying both the medical and non-medical aspects with equal priority and analyzing them in their interdependence. Where the bio-psycho-social concept of disease is concerned, the standpoint represented here leads to the conclusion that non-medical specialists should also be called in to clarify the *social* element in the bio-psycho-social concept of disease; only in this way can we guarantee that the medical conclusions are drawn based on a comprehensive picture[16].

2. The question

The question: *Is it disadvantageous for rehabilitation if high social insurance and possibly legal liability benefits are the prospects for the insuree?* At present, this question cannot be answered conclusively but I can well imagine that it will finally be answered in the affirmative. The development of social insurance, in Switzerland at any rate, is going increasingly in the direction of as high a level of compensation as possible; with the legislation on social insurance and on liability increasingly adjusting to each other in relation to the level of benefits. The economic consequences of accidents as well as of diseases are - in contrast to the original plan[17] - to be increasingly seamlessly compensated for. However, compensation

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[15] These cases are *disputed in medical circles themselves*, with the result that the corresponding interested party wishes to prevent the expert who is a "devotee" or "opponent" of the health impairment in question. The phenomenon (that is due to the welfare state) that nowadays almost every medical benefit must be compensated for frequently leads to, in the end, the courts taking on the role of referee in medical disputes, which can lead to lastingly bad consequences, as in Switzerland when the Federal Court relied on bad medical theories.

[16] Q.v. ERWIN MURER, „Entmedizinalisierung" der Versicherungsfälle unklarer Kausalität als Voraussetzung für nachhaltige Lösungen, in: ERWIN MURER, quoted in Fn 11, P. 253 ff.

[17] A look back at history shows that, initially, low benefits were foreseen: q.v. for example the contributions in: Un siècle de sécurité sociale 1881 bis 1981. L'évolution en Allemagne, France, Grande-Bretagne, Autriche et Suisse, edited by PETER A. KOEHLER and HANS F. ZACHER, with the collaboration of PHILIPPE-JEAN HESSE, Munich 1982.

is *“conservative-backward-looking”* while reintegration points *towards the future*. Compensation is thus, at least in theory, the adversary of rehabilitation: it aims to benefit an incapacity for work in monetary terms “by looking back” while rehabilitation wishes just the opposite - to avoid claims. At best, this is what applies: the higher the prospective benefits are, the greater the negative effect on the conscious and subconscious behaviour of the insuree in rehabilitation (*Moral Hazard*[18]). If this were true, then legislators would have to set some milestones of relevance for rehabilitation. Whatever happens: this is some *“food for thought”* to mull over on your way home. Have a safe journey!

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[18] Q.v. on this ERWIN MURER, Moral Hazard und die Versicherungsfälle unklarer Kausalität, unter besonderer Berücksichtigung der psychogenen Störungen nach Unfällen sowie des sog. “Schleudertraumas”, in: Schweizerische Zeitschrift für Sozialversicherung und Berufliche Vorsorge 2006 H. 3, P. 248 ff. with references.