Gert Lindenger: ‘In some cases return to work is the treatment’

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Gert Lindenger (1954) is chairman of EUMASS/UEMASS. As he was attending the VG-dagen in Almere early November, TBV took the opportunity to meet and talk. An update on past, present and future of European Insurance Medicine.

Can you tell us something about yourself?

I’m married, we have four children, one still at home. We live just outside Göteborg. About 60% of my work is in Göteborg, the rest is in Stockholm, on the east coast, or abroad for EUMASS. I started as an economist, in a bank. At 25, I decided to apply for Medical School, and to my great surprise I was admitted. In the early 90’s, having completed my specialisation, I became a GP, but was recruited as a Medical Advisor in 1992, by Sven-Olof Krafft, a rehabilitation doctor in Borås who was also a Medical Advisor. The job title back then was *förtroende läkare* (letterlijk *vertrouwensdokter* – red.). In ‘93 it was changed to *försäkringsläkare* (*verzekeringsarts* – red.) and then in 2008 to Medical Advisor, or *medicinsk rådgivare* in Swedish.

When I started in the mid-90’s, there was a big project where physicians and insurance agencies were looking to improve co-operation. A number of new ideas came out of that. Some could be done locally, but quite a few would require a nation-wide approach. So I decided to go to Stockholm to raise the issue there. And I ended up being employed by the National Board of Social Security.

From about ‘98 to 2003, the amount of people on sick leave in Sweden had doubled, and so the government wanted to do something about that. Up until then, you would only need a medical certificate from any type of physician, stating whether or not you were fit to work; criteria then were very vague. One of the new ideas was that we should have a second statement from professionals who were specialized to assess fitness for work. Around that time, the World Health Organisation had just introduced the ICF. We decided to use ICF to assess whether or not a claimant’s disease would be a disability, i.e. an impairment to function at work. That’s how we still work today, but the assessing methods have been improved.

Did you get a formal training to become an insurance physician?

No. When I started, it was learning on the job. Things have changed though. Medical universities, Karolinska in Stockholm and Göteborg University, have an introduction programme in Insurance Medicine for the last ten years now, there are several courses, and we have a programme equivalent to 22½ Bologna University points – so it’s not quite a Master’s programme, but close to that. If you want to become a Medical Advisor, that programme is recommended. More and more professionals do have it. If you work as a medicinsk rådgivare, your employers will encourage you to get it. But it’s not mandatory.

Is the specialisation funded by the government or the employer?

Medical Advisor isn’t a formal medical speciality in Sweden, nor in most EU countries. Italy, the Netherlands, Belgium and Romania are the exceptions. But to answer your question, the training programme is funded by our national social insurance agency, and it’s open to everyone. If you work for the national social insurance agency, you are allowed to do the training in working hours.

Does Sweden have only one national social insurance agency, like in the Netherlands?

Yes. It’s a state authority. Historically, we had a lot of different institutes, the *sjukkassan* (letterlijk: *ziekenfondsen* – red.). They merged, over many years, to become 21 different semi-national organisations in 1955, each with their own board of directors; that was the basis for our social insurance institute. In 2005, they were all nationalised into one nation-wide institute. Nearly all insurance doctors in Sweden have the same employer. There are a few who are employed by private companies, but they don’t cover the basic insurance. We have around 40 different types of insurances in Sweden; in thirteen of them, some form of certification from a physician may be necessary. For us, sick leave and disability pension are the two major fields, but together they only take 43 Medical Advisor man-years. Then there’s work injuries, for about ten to fifteen MA-man-years. By comparison: the national

social insurance agency employs about thirteen to fourteen thousand people. Sick leave has about five thousand social security officers. And these officers decide upon the majority of all claims by themselves, they request help from us only for a small proportion of the total claims.

How did you get involved with EUMASS?

In 2004, one of the two Swedish representatives in EUMASS left, and they thought it would be nice if his replacement would be able to speak some French. EUMASS/UEMASS is bilingual. English is the dominant language but we do need to keep French as well. And I'd had some French in school, so it looked like an opportunity to improve (laughs).

In the beginning it took me some time to find out what everybody was doing, because there's such a wide variety in backgrounds. Then Sweden was asked to organise the bi-annual EUMASS congress. That's a huge undertaking, hence the national representative of the congress host traditionally becomes vice-president. That's how I became a board member. Søren Brage from Norway was president at the time. When he turned 67 he decided to retire partially. So I was asked to become president.

What is the challenge for you?

I'm lazy by nature, both physically and mentally, but I do like to develop. That's my challenge (laughs).

You must have had an idea of what you wanted to achieve?

EUMASS is about exchanging ideas and experience between medical advisors from different European countries and organisations. Trying to overcome the differences is no simple task, but we have a lot of common interests as well. Our profession is a complex marriage between insurance and medicine. Medicine is the same throughout the western world, but insurance varies a lot, due to the different history and legislation in each country.

Judicial systems tend to look at things in an old-fashioned way. The basic Swedish social legislation was created in the 40's from a strictly biomedical point of view. But things have developed. With the advent of ICF, we are now talking more and more about a biopsychosocial model. It took me quite some time to realise what that means: in the western parts of the EU, sick leave is not only determined by disease, but also affected by personal, social and cultural factors, disregard if we like it or not. And judicial systems do not realise the impact of that.

Judicial systems do not realise the impact of the biopsychosocial model

Sick leave starts out with a disability and a medical diagnose. After some months to a year, the medical condition most often gets better and then other factors get a stronger influence. Research by Mansel Aylward, presented at VG-dagen 2013, shows that several months into sick leave, psychological and cognitive factors are a hindrance to return to work of up to 38%; work factors 32%, social factors 17%, economical factors 7%; and disability a mere 3%. This is what we need to address in the western EU-countries.

Now look at other parts of Europe: in Russia – still part of Europe – sick leave on mental grounds is simply not done! I was in Poland recently, and we happened to look at some of the questions that one needs to answer in order to get a medical certificate. One was: is the claimant bed-ridden or can he or she be up standing? You're looking at a completely different culture.

Up until the 60's we had a similar mentality in Sweden and I'm sure in most of northwestern Europe: mental non-well-being was not regarded as a valid reason for sick leave, instead a common complaint was lower back pain. So one of EUMASS's challenges is: how do we address these other factors in a fair way? We have a diagnose, a

functioning impairment, and a disability, but the disability is interpreted differently depending on personal factors. If the claimant believes that it is dangerous to return to work before he has fully recovered, then it will be difficult to convince him otherwise. Especially so if the social debate, in the media and by politicians, is about jobs being harmful in general.

If the social debate is about jobs being harmful, the claimant believes it's dangerous to return to work

In Sweden we're facing an increase in sick leave due to mental non-well-being. So the government has asked universities to find out what causes these stressful, harmful conditions. That led to a number of reports. But there is no counterweight to show that work, for the vast majority of people, is beneficial for health. There's a study in the UK, by Gordon Waddel and Kim Burton, *Is work good for your health and well-being?*, but that's about all we have. Politicians and media have drawn too much attention to the problem, so the public opinion is that "work is bad for you", but that's blown up out of proportion. In fact for the vast majority, work is good for you!

In the Netherlands, over the last two decades or so, General Practitioners and Medical Specialists have shifted from being lenient with the patient to stay at home, towards encouraging the patient to return to work. How is that in Sweden?

We have seen the same shift. For example, in the 80's, a myocardial infarction meant you should wait six months before you let the patient do an exercise ECG. Nowadays you do it on the last day before the patient leaves the hospital. Similar with lower back pain.
But with the new diseases, the not-well-defined mental non-well-being, it's different: fibromyalgia, chronic fatigue, and so on. There's been quite a debate in Sweden about burn-out. In 2006, our Board of Health and Welfare decided to have a separate diagnosis 'exhaustion-depression'. In this area, there's a lot of discussion on whether you should encourage patients to return to work, or let them stay on sick leave. The official guideline is very unspecific, so people can stay on sick leave for anything from six months to several years for this particular condition. The phenomenon I see is like a comet: a bright centre with patients who are truly exhausted, perhaps with cognitive problems and the like. But the criteria are so diffuse that the comet has a long tail with people who've had an acute stress-situation, their lives have been upside-down for a short period of time. They often get the same diagnose, so they too may stay at home for years, but that might actually be detrimental for their health. Waddel and Burton (again), in their report *Concepts of rehabilitation for the management of common health problems*, say that return to work *is* the treatment[1], in some cases. But that idea is not well-established in medical practice in Sweden.

In the Netherlands, medical specialists, GP's and insurance physicians work more and more together to make protocols and guidelines. How is that in Sweden?

We have no protocols, we do have guidelines about medical treatment, but they don't deal with return to work. Instead there are separate guidelines resembling the MDA (medical disability advisor), stating a reasonable average time for return to work for certain groups of patients. If the claimant needs a longer than average sick leave, the physician must explain why. And for M-diagnoses, apart from pain, this works quite well.
The medical statistics in Sweden differentiate between M-diagnoses, for muscular-skeletal problems, and F-diagnoses for mental disorders. Statistically, both of these groups vary up and down in magnitude. But in the M-group, fractures do not vary, nor do psychoses vary in the F-group. What does vary in the F-group are the not-well-defined problems that I mentioned, and in the M-group it's pain. And I think, to a large extent you're looking at the same thing. If you don't feel well, you have increased anxiety, with anxiety comes tension and with tension comes pain.

Research shows that mortality more than doubles for long-term sick-listed people

Dutch psychiatrists acknowledge that the regularity of a job, and the self-confidence that you get from work, are beneficial to certain groups of patients.

Yes. By the same token, people on sick leave are at greater risk. A study by Kristina Alexanderson's group[2] shows that mortality more than doubles for sick-listed people after one year. Letting someone stay on sick leave if it's not necessary, may be harmful. We do need more research in this area, though. It raises all sorts of other issues, like who is responsible if the social insurance, by being too lenient, causes claimants to reach early mortality?

You mentioned 'return to work is the treatment', in some cases. Can EUMASS help spread this type of knowledge among EU members, in the medical world as a whole, and throughout society?

As for spreading knowledge on a broader scale in the medical world and in society in general, I'm not quite sure. Traditionally, EUMASS works by having congresses. By means of discussions and benchmarking, we aim to help build consensus about how things really work. But we can't enforce anything. We could offer some conclusions as recommendations, but we can't be too imperative. We don't want to invoke resistance.

EUMASS congresses also aim, of course, to encourage spreading scientific knowledge and good practices within the law. But law is deep-frozen politics, not an evidence-based science. So the tric is to merge those two approaches in a fair manner. The congress offers a forum to present this, and debate about it. In the board, we've been talking about whether we should still keep parallel sessions with smaller groups discussing more specialised subjects. It was the late Peter Donceel who pointed out that we should have both broad and narrow topics, although narrow topic may be of great interest only to some members.

We have the Babylon project. It's intended to help solve misunderstandings induced by different judicial backgrounds. Let's say a medical advisor from Slovenia wants to discuss something. He does that in English, and he chooses his terminology from his own judicial system's background. I listen to him, but I interpret his words against my background and so the outcome may be different.

The Babylon project aims to help solve misunderstandings induced by different judicial backgrounds

So the Babylon project aims to facilitate better understanding by defining a core set of English terminology for insurance medicine. Since English is the common language, we do that with the help of our British colleagues. Nerys Williams, our former UK-representative, has done a tremendous job there. So now we have this growing list of terms and definitions. Local EUMASS-members review it, and add their local context in comments. The result should be a common vocabulary for benchmarking and abstracts.

Where should EUMASS be five years from now?

EUMASS is a low-budget organisation, we depend a lot on voluntary work from council and board members. So what can we do with these limited resources? One is a well-working website, to show results and share information and perhaps use as a discussion forum. We can only meet one another in person maybe two or three times a year, so we should work online more. We also need a generic website to help organise and present congresses. Up to now, every congress got its own website, so we've been re-inventing the wheel over and over again there, which is a waste of resources. We also have a process framework to help us organise congresses. In general, we want to become more professional.

Are you trying to get more funding from governments?

We've been scratching our heads over that one for a long time. Our congresses usually break even or better, but some don't, so there's an economic risk there. I do believe we need to become more professional in achieving things, and in presenting our added value, so we can show our governments that we deliver good return on investment. But as for fund-raising, I'm open to suggestions.

The EUMASS core set was presented ten years ago. Are there any new developments in the area of the ICF?

Certainly! We've had a lot of suggestions from EUMASS-members to add ICF-codes for assessing permanent incapacity. That turned into a list of 172 different items. So we voted to identify the twenty most essential activity levels; that shortlist has been used in some countries, modified to fit the local context. The next step is to not only regard it as being essential for working capacity, but we also need to fit them with descriptors. That's one of the tasks within our ICF working group.

There's also an interesting new development from Evelyn Aaviksoo's group in Estonia: they've been using the EUMASS core set in a new and rather ingenious way. From the activity and participation chapter, they defined seven domains of activities, and a small set of easily understandable key activities for each domain; with this, they assess each key activity based on ICF logic, i.e. no, mild, moderate, severe or total impairment (from 1 to 5). But they use weighted ratings, depending on whether an activity is easy or complex. For example, a moderate impairment can get score 1 or 2 if the task is easy, but 3 if the task is complex; they put the cut-off point at 4. They achieved good results from this new method. So we can learn from this.[4]

At the moment, ICF is the best we have, but it has its limitations: it acknowledges that a personal situation has an impact, but doesn't assess that impact. In Germany, they are working on an instrument that does assess the

personal situation. In the Netherlands you have the MOI-system (*methodisch ondersteuningsinstrument* – red.). There's a lot going on about assessment aids and instruments.

Do you have a message for our readers?

Our profession deals with long-lasting disease and injury, so it might be regarded as negative. But I think that Europeans are lucky to have an insurance cover that works relatively well. In other parts of the world, they can only dream about having what we have. Globalisation, with different cultures and different morale, puts our system to the test. Our challenge is to keep making it work in a just and fair manner, in order to safeguard it for the future.

Literatuur

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