THE DANISH NATIONAL RETURN-TO-WORK PROGRAMME: DENMARK

1. Organisations involved

- National Research Centre for the Working Environment (research institution)
- Danish Institute of Governmental Research (research institution)
- Twenty-two Danish municipalities
- CABI (a knowledge centre focusing on employment and corporate social responsibility)
- CAF (occupational rehabilitation unit)
- Psykiatrifonden (humanitarian organisation)
- PP Clinic (psychiatric clinic)
- Incita (centre for occupational rehabilitation)
- KIApro (centre for health, working life and rehabilitation)

2. Description of the case

2.1. Introduction

Sickness absence and work disability put a considerable strain on public finances. Denmark, like many other Western countries, is increasingly concerned about sick leave. Associated direct reimbursement costs were in the region of €5 billion, excluding healthcare costs and loss of productivity. In 2008, the Danish government initiated a tripartite agreement on reduction of sickness absence. The agreement included 39 initiatives including the Danish National Return-to-Work Programme.

This multidisciplinary programme was aimed to address the complexities of returning to work after a long period of sickness. Successful return is influenced by personal and workplace characteristics, as well as the individual’s health. Research shows that, the longer someone stays off work, the less likely they are to return. This programme, therefore, took an early intervention approach, tailoring its solutions to the needs to the individual worker. It also aimed to enhance collaboration among healthcare and social insurance systems, employers and unions, to increase the chances of success.

2.1.1. Sick-leave management in Denmark

Sickness benefit in Denmark is paid by the municipal sickness benefit offices, except for the first 30 days, which, since January 2012, are paid by the employer. These offices assess eligibility for sickness benefit, and may choose to ask for a medical certificate. Officers within these institutions, therefore, are the key coordinators of sickness benefit and return to work, with little input from employers.

The sickness benefit offices are obliged to perform an initial assessment of all sick-leave beneficiaries. As part of the assessment, the officer must categorise the beneficiary into one of the following three categories:

- **category 1**: likely to return to work within 3 months;
- **category 2**: not likely to return to work within 3 months, but able to participate in return-to-work activities or gradual return to work;
- **category 3**: not likely to return to work within 3 months and not able to participate in return-to-work activities.

The sickness benefit offices use this categorisation to allocate time and resources to those beneficiaries most in need of help. It also requires them to conduct regular follow-up consultations with each beneficiary. More specifically, the officers must follow up on all beneficiaries in category 2 every 4 weeks and all beneficiaries in categories 1 and 3 every 8 weeks.
Sickness benefit officers are also obliged to develop a return-to-work plan that includes activities and return-to-work goals (for instance setting a date for the expected return) for the beneficiaries. Activities can include stress or pain management, gradual return to work or work accommodations. These last, however, also depend on the employer, and the sickness benefit law strongly urges the officers to coordinate efforts with external stakeholders such as employers and general practitioners. However, these practices vary considerably from municipality to municipality (Aust et al., 2012).

2.2. Aims

The National Return-to-Work Programme aimed to establish an early, multidisciplinary and coordinated intervention to promote return to work within the existing sickness benefit system in the municipal sickness benefit offices.

2.3. What was done, and how?

The programme included all sickness benefit beneficiaries at high risk of becoming excluded from the labour market (those in category 2 as described in section 2.1.1). Thus, the programme comprised a diverse group, including beneficiaries suffering from mental health problems and musculoskeletal disorders, as well as beneficiaries sick-listed from self-employment, unemployment and employment. Implementation was planned in different municipalities of different sizes covering different regions of the country.

2.3.1. Core elements of the programme

The programme consisted of three core elements that aimed to change the organisation and procedures of the sickness absence management. These elements are:

- establishment of multidisciplinary teams in the municipalities;
- introduction of standardised work ability assessments and sickness absence management procedures;
- a comprehensive return-to-work training course for all multidisciplinary team members prior to the programme.

2.3.2. Establishment of the multidisciplinary team

Each municipality had to establish multidisciplinary teams consisting of a municipal sickness benefit officer, a physiotherapist, a psychologist, a physician specialised in general, social or occupational health and a psychiatrist. The number of professionals involved depended on the size of the municipality. The teams could be located at the job centre or in an office outside the sickness benefit offices.

The sickness absence officer had primary responsibility for coordination efforts with the other team members and for coordinating efforts with external stakeholders, such as general practitioners and employers.

The sickness benefit officers were expected to successfully manage about 50% of all sickness absence cases without including the other team members. In more complex cases, the other team members would be called in to consult, with physicians expected to become involved in about 25% of cases.

2.3.3. Training for the multidisciplinary team

To facilitate the implementation of the programme, all multidisciplinary teams were obliged to participate in a 3-week return-to-work training course before the onset of the programme (with the physicians required to participate in selected elements only). The training course prepared the multidisciplinary team members for the implementation of the programme by focusing on sick-leave legislation, the biopsychosocial understanding of health and the different tools (see below) that had been developed for the programme. The training format was based on a combination of lectures, discussions and practical group assignments. During the programme, two consultants from the National Research Centre for the Working Environment (NRCWE) visited all municipalities to discuss problems, challenges and strengths in the multidisciplinary team work (Aust et al., 2012).
• The dialogue guide and communication tools

The municipal sickness benefit officers used a comprehensive dialogue guide for first consultation with the sick-leave beneficiary. The first consultation established trust and included an extensive initial assessment of the beneficiary. During this first consultation, the officer also screened beneficiaries for mental illness using a clinical assessment tool. After the first consultation it was up to the officers to decide whether or not it was necessary to include other members of the team. To facilitate knowledge sharing, the team members were obliged to note down their observations of the beneficiaries in standardised output logs.

• Weekly multidisciplinary team meetings

These meetings were the cornerstone of the multidisciplinary efforts. Together, the team developed an individual and relevant return-to-work plan for each beneficiary based on a multidisciplinary assessment. The team meetings also addressed the progress and follow-up on the sickness absence beneficiaries and adjusted the initial plan if needed.

• Programme activities

The physiotherapists and psychologists initiated return-to-work activities for the sick-listed beneficiaries. These activities could be courses in pain and/or stress management and could be organised as individual sessions or group activities. These activities were coordinated with existing activities in the municipality, and supplemented where needed.

• Coordination with external actors

A central part of the programme was to coordinate return-to-work efforts with employers and other external stakeholders such as the beneficiary's general practitioner. However, the frequency of and motivation for such coordination were not specified; rather, it was based on an assessment by the multidisciplinary team and depended on whether the beneficiary was employed or not.

• Evaluation

The NRCWE was contracted to conduct a comprehensive process-and-effect evaluation. In addition, the Danish Institute of Governmental Research conducted an economic evaluation. The main aim of the evaluations was to assess:

- the feasibility of the programme;
- the effects on sickness absence and return to work;
- the costs and benefits of the programme.

2.4. What was achieved?

The programme ran between April 2010 and April 2012, but was extended to September 2012, during which time most of the municipalities participated. The NRCWE published an initial report in November 2012. A more comprehensive analysis of the entire data set is still ongoing, the results of which will be published in the coming years.

The following section presents preliminary results based on the 2012 report and on scientific articles that have been published on aspects of the data set. As part of the evaluation, 31 anonymous interviews were conducted with the beneficiaries in the programme. Of these 31 interviewees, five were unemployed, 22 were employees and four were self-employed; 13 were sick-listed for mental health problems, 11 because of musculoskeletal problems and seven for other health problems. The duration of their involvement in the programme varied.

2.4.1. Implementation of the programme

The evaluation showed that implementation was possible, with successful implementation in 60% of the municipalities. The presence of clear and dedicated management in the sickness benefit offices
was a key driver, as was the willingness of multidisciplinary team members to change their manner of working (see Success factors below).

Implementation steps varied for the different participants, as the programme was tailored to individual needs. All participants, however, took part in an individual consultation with the sickness benefit officers within 8 weeks of absence. At this meeting the officer used a standardised assessment tool to identify resources for and barriers to return to work related to physical and mental health and work. In more complex situations, the sickness benefit officer referred the beneficiary to the other team members. All beneficiaries also received an individual return-to-work plan.

2.4.2. Effects and costs and benefits of the programme

- Statistical results
The effect on sick leave and return to work varied significantly among the municipalities. Results from a randomised controlled trial conducted in three municipalities showed that the programme caused a statistically significant reduction of time on sick leave in one municipality, while there was an adverse effect in the second municipality. The programme had no effect in the third municipality (Poulsen et al., 2013). Likewise, the programme had a positive effect on return to work in one municipality, a negative effect in the second and no effect in the third municipality (Nielsen et al., 2014). In the two municipalities with a statistically significantly positive effect and a positive tendency that was not statistically significant, the cost–benefit analysis showed that the programme was economically beneficial for the municipality, for the public sector taken together and for society (NRCWE, 2012).

- Individual results
The positive approach taken by the team members was a key aspect highlighted by the participants, who ‘felt that they understood [them] and that [they were] in good hands’. Establishing trust was therefore important for them to feel safe, to engage in the programme and to return to work again (NRCWE, 2012). Some of the beneficiaries with mental health problems described being treated as an individual person and not as a case (Andersen et al., 2014). Participants who reported high satisfaction with the programme highlighted the importance of being involved in the decision-making process about their case, receiving counselling about the sickness benefit legislation, and the understanding and positivity shown by the sickness benefit officers regarding their situations and the likelihood of their being able to work again in the future (NRCWE, 2012).

The participants highlighted the easy and fast access to the different health professionals in the multidisciplinary teams. From their perspective, the quicker work ability assessment led to a realistic return-to-work plan. Most of the interviewees assessed the return-to-work activities positively. Participants with mental health problems especially highlighted group sessions in stress management and psycho-education. The participants explained that the session was ‘at the appropriate level’ and enabled them to focus on job retention again, because the sessions gave them concrete tools to manage work and daily life (NRCWE, 2012). The beneficiaries explained that these activities helped them to gain knowledge about their symptoms, which facilitated new coping mechanisms. They also highlighted the benefits of group activities as a way of meeting others in the same situation (Andersen, 2014).

2.5. Success factors
Although the final results are not yet available, the report published in 2012 points to a number of factors involved in the successful implementation of multidisciplinary team work:

- Willingness to participate in multidisciplinary teams: Much depended on the team members’ willingness to redefine their role and to work in a different manner from how they used to.
Successful team work is characterised by mutual professional respect and consensus on the programme goals.

- **Dedicated management**: Clear and dedicated management in the sickness benefit offices seems to have been an important driver for successful implementation of the initiative.

- **Respect and trust in the team**: A positive approach amongst the team members was a key aspect highlighted by the participants. Establishing trust was important for them to feel safe, to engage in the programme and to return to work again.

- **Cooperation with employers**: Although cooperation with the employers was modest, interviews showed that employers were, generally, positive about their contact with the team.

- **Appreciation by small companies**: Small companies were more positive than larger companies. This might be because the larger companies have human resource departments, occupational physiotherapists and/or psychologists, and therefore do not need as much counselling.

### 2.6. Challenges

From the interviews with beneficiaries of the programme, the following difficulties were reported (NRCWE, 2012):

- **Lack of clarity in the roles of the team members for patients**: Some of the participants reported that they were confused when they were referred to the health professionals in the teams, as they were unsure of the reason for the referral, and did not understand that the consultations with the health professionals did not include actual treatment.

- **Stigmatisation**: Some of the interviewees felt stigmatised because they were referred to psychiatrists; some felt that they had to prove to the team members that they were sick.

- **Limited help for mental health problems**: Beneficiaries with mental health problems often had problems verbalising their condition and describing their situation. Some therefore felt frustration at the consultations with the professionals (Andersen, 2014).

- **Difficulties for unemployed people**: The high percentage of unemployed beneficiaries was an additional barrier for the implementation of the programme, as there was no employer to coordinate with. The strong focus on return to the labour market made certain participants uncomfortable in these circumstances. Participants were asked early in the process to assess whether or not they were ready to return to the labour market and, for those who had been unemployed for a long time before, this could be a difficult question to answer. Some participants, however, found this focus helpful, as they felt that they were ‘being pushed in the right direction at the right time’ (NRCWE, 2012).

### 2.7. Transferability

The programme included a very broad group of beneficiaries, including employed and unemployed beneficiaries as well as beneficiaries with different types of health problems. Both smaller and larger companies were included, with smaller companies reporting more positive experiences than the larger companies. Caution should be exercised about generalisations from the programme, as the effects differed markedly among the different municipalities.

Different countries have very different rules and ways of organising sick leave and return-to-work efforts, so this multidisciplinary process would need adaptation to the specific contexts of other national systems.

In general, however, the programme offers useful insights into success factors and challenges in the implementation of multidisciplinary teamwork.
2.8. Further information

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3. References and resources


