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Reducing sickness absenteeism at the workplace—what to do and how?

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Reducing sickness absenteeism at the workplace—what to do and how?

Sickness absenteeism is a significant problem both for employees and for employers. Sometimes the discussion is more directed towards the economic consequences than the individual suffering caused by disabling diseases. Another relevant issue is the extra burden to supervisors and colleagues when lacking resources are being replaced. All of these factors have prompted many workplaces to create their own procedures to diminish lost worktime due to sick leaves.

The European Foundation for the Improvement of Living and Working Conditions has published a model for sickness absenteeism (1). It presents two crucial steps in the process, the “absenteeism barrier” between work and taking sick leave, and the “reintegration barrier” between sick leave and return to work.

When an individual makes the decision of whether to take sick leave or to stay at work despite illness, the severity of the symptoms is only one factor in the decision-making process. In order to clarify this step, Johansson & Lundberg introduced an “illness flexibility model” (2), which was later expanded in an article by Hansson et al (3).

The negative consequences of absence for the disabled employee, colleagues, or customers, as well as the high level of adjustment latitude at work (providing opportunities for an employee to continue to work despite illness) might prevent sickness absence. In addition, incentives for staying at work (eg, perceived stimulation, social support) or at home (eg, time with relatives, more rewarding domestic activities) have an impact on the final decision. Finally, the decision might depend on the absence requirements, referring to the negative consequences of staying at work while ill (eg, fear of transmitting an infection or not being wanted at work).

The second step in the model for sickness absenteeism, “reintegration barrier”, has been the focus of intense return-to-work research. In their recent review (4), Hlobil and his colleagues, confirmed that return-to-work interventions are equal or more effective than usual care regarding absence from work due to subacute low-back pain. The recommendation of the authors, as supported by Loisel in his editorial (5), was to open the “black box” of return-to-work interventions in order to understand which are the most important components to shorten work absenteeism.

The magnitude of the problem indicates that better policies and procedures are urgently needed to return temporarily or permanently disabled employees to work more safely and efficiently. This need has been addressed in the systematic review written by MacEachen and her co-workers (6) in the present issue of the *Scandinavian Journal of Work, Environment & Health* with its focus on the results of qualitative return-to-work research literature.

The same research group has also participated in the previously published systematic review of quantitative literature on workplace-based return-to-work interventions (7). According to this review, there is strong evidence that work disability duration is significantly reduced by work accommodation offers and contact between the health care provider and the workplace. Moderate evidence was found for the effectiveness of early contact with the worker by the workplace, ergonomic worksite visits, and the presence of a return-to-work coordinator.

The previous review of quantitative studies receives substantial support from the systematic review of MacEachen et al (6), which aims at a better understanding of the dimensions, processes, and practices of return to work. The qualitative methods used in the included studies focus on discovering the key elements of successful return-to-work interventions and, at the same time, on describing the

related possibilities and threats. Instead of asking what should be done, they give extensive guidance on what could lead to the best return-to-work practices.

From the workplace point of view, both quantitative and qualitative information is needed. The former helps to invest in interventions that have proved to be effective. The latter deepens the insight into the various aspects of collaboration and social networks.

In the 13 eligible articles, the review found eight key concepts to be relevant in relation to successful return to work. It is evident that no intervention as such is successful without sufficient commitment of those involved. Consequently, the main finding of MacEachen et al is that "goodwill and trust" form the overarching condition to return-to-work arrangements. As intangible as these concepts are, the authors give some practical examples of their components, one of the most relevant being the willingness of the employer to invest time and effort in the return-to-work process (eg, organizing accommodating work).

Another finding that is relevant to real-life situations is the timing, nature, and contents of the contacts between various stakeholders in order to assist the absentee's earlier return to work. Contact of the workplace with the absent employee can include much encouragement, but it can also be perceived negatively if not properly planned and if performed by supervisors without sufficient training and support.

It has already been shown in everyday life that conveying relevant information on the employee's health condition from the physician to the workplace is really a challenge in order to facilitate adequate adjustment. Because MacEachen et al also show that individual workers can easily get lost in the complexity of various systems related to disability, the benefits of a return-to-work coordinator are easy to see. In countries like Finland, with its high coverage of occupational health services, the situation creates an ideal opportunity for occupational health professionals to play a crucial role as return-to-work coordinators.

MacEachen et al also discuss the role of unions and colleagues, as well as that of supervisors, in the return-to-work process, especially in relation to modified work. It seems that the same prerequisite of goodwill and trust among all stakeholders in the workplace is the key to successful collaboration. This situation is reflected by the attitude of other employees towards the disabled colleague with reduced workload, by the role of the supervisor in managing daily social relations and physical conditions in the work environment, and, finally, the ability of union representatives to participate constructively in return-to-work activities.

Finally, but not of the least importance, MacEachen et al list the organizational environment as one of the key elements. Once again, the goodwill and trust of the workplace are needed to maintain humane values, even in the midst of financial constraints. If the company wants to show social responsibility, the commitment must not change according to the market situation. In order to "walk the talk", practical procedures must be created to give credibility to the company's commitments. Goodwill and trust are reflected by the participation of all stakeholders in the process of creating the disability management system for the workplaces, and respecting each other's expectations and their fulfillment.

Most of the studies MacEachen et al included in their review originated from North America and Australia. In the future, more research is needed from other countries to verify the results in other social security systems. Another urgent need is to widen the scope of return-to-work interventions to disabling mental disorders, which were excluded by MacEachen et al.

The review by MacEachen et al offers scientific guidance on how to construct effective return-to-work practices in the workplace. When the conclusions of the review are considered, it can be presumed that the same key elements lowering the "reintegration barrier" also have an effect on the "absenteeism barrier" by modifying adjustment latitude, attendance incentives, and absence requirements through improved communication between different stakeholders. This improved communication reinforces the positive effect of evidence-based return-to-work practices on sickness absenteeism.

Once this kind of systematic evidence is available, one can only hope that all of the stakeholders at workplaces are made aware of these results and that evidence-based principles will be applied as widely as possible in practice.

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