REVIEW

Management of Long Term Sickness Absence: A Systematic Realist Review

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Abstract *Purpose* The increasing impact and costs of long term sickness absence have been well documented. However, the diversity and complexity of interventions and of the contexts in which these take place makes a traditional review problematic. Therefore, we undertook a systematic realist review to identify the dominant programme theories underlying best practice, to assess the evidence for these theories, and to throw light on important enabling or disabling contextual factors. *Method* A search of the scholarly literature from 1950 to 2011 identified 5,576 articles, of which 269 formed the basis of the review. *Results* We found that the dominant programme theories in relation to effective management related to: early intervention or referral by employers; having proactive organisational procedures; good communication and cooperation between stakeholders; and workplace-based occupational rehabilitation. Significant contextual factors were identified as the level of support for interventions from top management, the size and structure of the organisation, the level of financial and organisational investment in the management of long-term sickness absence, and the quality of relationships between managers and staff. *Conclusions* Consequently, those with responsibility for managing absence should bear in mind the contextual factors that are likely to have an impact on interventions, and do what they can to ensure stakeholders have at least a mutual understanding (if not a common purpose) in relation to their perceptions of interventions, goals, culture and practice in the management of long term sickness absence.

Keywords Sickness absence · Occupational health · Management · Organisations

Introduction

Sickness absence management remains high on the agenda of governments and industries, mainly due to rising direct and indirect costs to companies and the wider economies [1]. High levels of sickness absence have been directly associated with negative effects on productivity, profitability, competitiveness and customer service [2]. In the United Kingdom (UK) current levels of sickness absence in the public sector are estimated to equate to 190 million days lost per annum [3]. As a result, in recent decades many UK employers have placed more emphasis on sickness absence control procedures, especially where this a need to cut costs due to increased competition in the private sector and financial constraints in the public sector [4]. The UK government has also placed greater emphasis on reducing long-term sickness absence (LTSA) due to the ever increasing costs associated with people of working age claiming incapacity benefits in the UK [5]. However, despite increased efforts, the average absence figures have indicated only limited improvement over the past 20 years and paradoxically the costs of sickness absence have actually risen significantly [3]. A recent report [5] on the health of Britain's working age population commissioned by the Department of Work and Pensions (DWP) reported that the economic costs of sickness absence and worklessness due to ill health amounted to over £100 billion a year, which is greater than the annual budget of the National Health Service (NHS).

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Defining LTSA

Within many empirical studies the definition of what constitutes LTSA varies greatly, ranging anywhere from 20 to 90 days or longer. The guidance on LTSA from the National Institute for Health and Clinical Excellence (NICE) in the UK acknowledged that there was no universal definition of short or long term sickness absence but, following a comprehensive review of the evidence, they defined short term as up to 4 weeks and long term as 4 weeks and above [6].

The Causes of LTSA

The two most significant reasons for medically certified LTSA globally and throughout different sectors are musculoskeletal disorders (MSD) and stress related ill health [7–8]. However, the correlation between diagnosis and LTSA is not a simple one. There are many compounding factors that affect the likelihood of an individual taking LTSA, including their physical and psychological condition, the availability of primary healthcare, perceived and actual job demands, as well as management attitudes [9–10]. It has also been argued that the length of LTSA cannot easily be predicted by diagnosis alone, as many other psychosocial, economic and cultural factors impact on the decision to return to work [11].

Much of the earlier research focused on how absence behaviour was affected by individual personal characteristics such as age, gender, tenure, level of job satisfaction and socioeconomic status [12]. However, in recent decades research has increasingly examined the correlation between absence behaviour and organisational factors such as, organisational size, absence culture, organisational change and job demands and controls [10]. Numerous other barriers to workplace attendance have also been identified including family or caring responsibilities, economic factors such as occupational sick pay or disability benefits and cultural elements, such as perceived tolerance of sickness absence within the organisation [13–14]. Notwithstanding, it must be emphasised that there will always be the necessity for longer periods of sickness absence due to episodes of ill-health; and improvements in occupational sick pay arrangements have helped ensure that staff who are unwell have adequate time to physically and psychologically recovery from their illness, to a stage where they are fit for a modified or full return to work duties [15–16].

Cultural, Political and Organisational Complexity

It is evident from the discussion above that investigations into the causes of sickness absence, and evaluation of interventions to manage it, cannot be isolated from the cultural, political and organisational contexts in which sickness absence occurs. For example, significant differences have been highlighted in governmental and legislative approaches to sickness absence management across various countries [17]. It has been argued that the wide variations in the mechanisms at work across different nationalities make the generalisation of study findings from diverse countries very difficult [18].

Theoretical Background to Realist Review

The diversity and complexity of interventions to manage LTSA and of the contexts in which these take place makes a traditional systematic review and meta-analysis problematic. This partly is the result of technical issues, namely a 30 year history of inaccurate and inconsistent measurement of absenteeism, making it almost impossible to benchmark across or even within countries [7, 19]. However, there is an even more profound problem, which is the heavy reliance of most systematic reviews on randomised controlled trials (RCTs). The rigorous standardisation of interventions and measurements that make an RCT so powerful in demonstrating the efficacy of interventions also contribute to its limitations in relation to generalisability. Interventions in everyday practice are not controlled by trial protocols. Rather, they are open systems, in which many factors additional to the intervention itself, including those relating to organisational structure, and the interpretations and actions of the individuals involved, will all affect the effectiveness of the intervention [20].

This diversity and complexity in the literature on the management of LTSA underpins our rationale for undertaking a realist review of the literature. As a guide for this process we have broadly followed the systematic approach recommended by Pawson and colleagues [21]. Realist reviews draw on the ideas of critical realism, which seeks to take the complexity of causal relations into account when explaining social interactions. Specifically, we espouse the insights of realistic evaluation [22]. This operationalises the causal ontology of critical realism in the evaluation of interventions by seeking to explain the processes involved between the introduction of interventions (in this case those intended to manage LTSA) and the outcomes that are produced. The characteristics of the intervention are only part of the story: the interaction of the intervention with its social and organizational context must also be understood in order to explain the pattern of outcomes observed [23]. An intervention is thought of as embodying a theory about what will work to achieve the desired outcomes; and it works by providing reasons or resources for the people involved to change their behaviour [21]. Consequently, the aim of a realist review of the

literature is not simply to answer the question: 'Does this intervention work?' but to answer a more complex series of questions: 'What is it about this intervention that works?' 'In what circumstances does this intervention work or fail to work?' 'For whom does the intervention work?' A realist review does this by seeking to explicate the theories embedded in descriptions of interventions, and by looking for the impact of context on the effectiveness of interventions. This raises the question of what we mean by 'context.' In their seminal work, *Realistic Evaluation*, Pawson and Tilley define the social context as "the spatial or geographical or institutional location into which programs are embedded…" and "the prior set of rules, norms, values, and interrelationships gathered in these places…" [22, p70]. However, there is a lack of commonality in the interpretation of the concept of 'context' within research literature [24–25]. Consequently, investigating an agreed set of variables representing the main attributes of contextual factors which can be used across various research domains has been advocated [21]. We have chosen to use a conceptual model of the organisational factors influencing the successful implementation of healthcare interventions outlined by Greenhalgh et al. [26] as it is based on a wide ranging review of the relevant literature, and recommended by the authors for use as an explanatory model within the rubric of the realistic evaluation approach. The model outlines the effects of organisational factors such as structure, size, resources, leadership and vision, communication and relationships, and internal and external socio political climate, in relation to the outcomes and likelihood of an intervention being successfully introduced and sustained. We have used this model to guide our assessment of the literature, particularly when seeking to identify contextual factors that may have an impact on the success of interventions intended to manage LTSA. A review of this sort is more likely to produce evidence in a form that can be readily understood and used by policymakers, in that it seeks to identify the policy options and explain the main considerations that should be taken into account when choosing between them. Knowledge transfer is more likely when it is in a form that helps those using it make sense of how initiatives may work in their own context, and indicates what to aim for and what to avoid when implementing a given intervention [21].

Methods

Realist review differs from a traditional systematic review in that it entails no methodological limitations on the type of research eligible for the review; and has a focus on the programme theories embodied by interventions. The approach is systematic but, unlike a traditional review, it is

an iterative process: first interrogating the literature to discover programme theories; then returning to the literature to look for the most frequently cited theories, which we have called dominant programme theories (DPTs); and finally assessing the evidence to support the DPTs and to highlight the main contextual factors impacting on outcomes. Pawson refers to this as "reviewing official expectations against actual practice". [21, p.15].

The Scope and Purpose of the Review

This is a review of organisational approaches to the management of LTSA, which is defined as absence of 4 weeks or more [6] attributed by the employee to illness or injury and accepted as such by the employer [15]. The purpose of the review is to identify the underlying mechanisms embodied by interventions to manage LTSA, as well as contextual factors that work to support or hinder these interventions.

Search Strategy

Identifying Programme Theories

We carried out an initial search of the literature in a number of databases. The search strategy for Medline is presented in Table 1. This was modified for use in the British Nursing Index, CINAHL, EMBASE, and Health Management Information Consortium. The social sciences

Table 1 Search strategy for Medline, 1950 to September 2011

1. Absenteeism.mp. or absenteeism/
2. Sickness absence.mp. or sickness absence/
3. Sickness absence.mp.
4. Long term sickness absence.mp.
5. Sick$.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
6. ill$.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
7. 5 or 6
8. Leave.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
9. Absen$.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
10. 7 and 8
11. 7 and 9
12. 1 or 2 or 3 or 4 or 10 or 11
13. Manage$.ti.
14. Occupational health.mp. or occupational health/
15. 13 or 14
16. 12 and 15

and management databases (ABI Inform, Emerald, Sage, Swetswise and Science Direct) were searched using the search terms 'absenteeism', 'sickness absence', 'sick leave' and 'sickness absence management.' This literature was reviewed by AH looking for interventions to manage LTSA and to identify contextual factors that were thought to have an impact on the interventions. AH also searched the reference lists of included papers looking for further studies, as well as conducting internet searches for published guidance and policies. Contextual factors were identified and mapped to the model proposed by Greenhalgh et al. [26] using NVivo software. AH then drew up a long list of programme theories which were discussed by AH, PO and SP in the light of the literature, then condensed into an agreed short list of dominant programme theories.

Assessing the Evidence for Dominant Programme Theories

We searched within this literature for empirical research to assess the strength of the evidence base for the dominant programme theories, as well as contextual factors relating to the adoption and sustainability of interventions. In the interests of rigour empirical studies were assessed, guided by critical appraisal tools as low, medium or high quality. However, unlike traditional reviews, studies were not excluded on the grounds of quality criteria alone but were included due to their relevance to the pertinent DPT's. Notwithstanding, the methodological strength of empirical studies was still taken into account when considering the weight given to their outcomes in the findings of the review.

Results

The initial searches indentified 5,576 papers. Titles and abstracts were reviewed for inclusion on the basis of their relevance to the scope and purpose of the review. This yielded a total of 372 articles, comprising 348 research papers and 24 articles from the grey literature. The full text of these articles was reviewed and a further 103 were excluded as repetitive, irrelevant or lacking rigour, leaving 269 papers to form the basis of the review.

Data Synthesis

The next step was to synthesise the data, initially by populating the conceptual model [26] then comparing and contrasting findings from different studies in order to refine our conceptualisation of the mechanisms and to identify contextual factors that work to support or hinder these programmes. We also identified unexpected benefits of

sickness absence and unintended consequences of interventions designed to manage sickness absence. At this stage we focused on material relevant to the DPTs [21]. Each of these theories has been highlighted repeatedly throughout the main body of literature as being imperative to the effective management of LTSA management. The four main DPTs are outlined below:

Early Intervention

Early intervention, whether in the form of early contact by employers or early referral to occupational health and rehabilitation services, is important in facilitating an earlier return to work [6, 10].

Proactive Organisational Procedures

Proactive procedures undertaken by organisations in the management of sickness absence (such as implementing sickness absence policies that include flexible working arrangements, trigger points for management action and return to work interviews) are vital for effective management of LTSA [6, 10].

Communication and Co-operation Between Stakeholders

The role of key stakeholders, such as employers, managers, employees, community physicians, general practitioners (GPs) and occupational health, and the level of interaction between them have been highlighted as critical to the effective management of LTSA [27–28].

Multidisciplinary Workplace-Based Occupational Rehabilitation Programmes and Provision of Modified Duties

Workplace-based occupational rehabilitation and modified duties have been extensively researched and identified as an essential part of the successful management of LTSA through facilitation of earlier return to work [10, 29].

Realist Synthesis of Dominant Programme Theories

Before presenting our synthesis of material related to the DPTs, we need to outline two important characteristics of the literature. First, a major difficulty when attempting to evaluate the strength of empirical evidence for interventions to reduce LTSA relates to the fact that many studies evaluate multi-component interventions, making it difficult to ascertain which component, if any, is having an effect [30–31]. Second, the majority of effectiveness studies provide very limited information on any underlying

organisational contextual factors that may have had an impact on the outcomes [32]. Therefore, to endeavour to accumulate as much contextual information as possible it is important to incorporate different sources of evidence within a realist review, including grey literature [21]. Advantageously, realistic review can also accommodate a less than perfect evidence base, which is compatible with the eclectic and variable quality literature relating to sickness absence management [18, 21].

DPT One: Early Intervention Helps Prevent or Reduce the Duration of LTSA

Review of the Evidence

There is strong empirical evidence that the longer the period of LTSA, the less likely an employee will return to work [29]. Consequently, there is major consensus throughout the empirical literature and official guidance documents that early intervention is central to reducing the duration of LTSA and facilitating return to work [29, 33]. Early and regular contact with employees absent through sickness is seen as an important indication that staff members are valued and supported by managers, as well as helping to identify any barriers to an early return to work and to prevent feelings of isolation from the workplace [34]. However, the consensus is not complete. For example, a large prospective cohort study of 632 workers who were on LTSA due to MSD in Ontario, Canada [35] found that although workplace modifications were strongly associated with an earlier return to work, there was no association between early contact by employers and earlier return to work.

Contextual Factors

Delays in the implementation of early intervention initiatives have been attributed to a number of contextual factors, such as long waiting times for medical treatment, non-compliance with organisational procedures, inadequate training of facilitators and poor communication between departments [5, 28]. For example, delays in accessing medical treatment have been cited as a major hindering factor in early intervention and return to work following LTSA [29, 36].

Synthesis of Evidence

Despite the overall consensus about the importance of early intervention, the evidence to support the programme theory that early intervention can reduce the duration of LTSA is inconsistent and inconclusive. There is a growing body of

evidence that the likelihood of more positive outcomes is increased when the early intervention is undertaken within or in close collaboration with the workplace [29] although there are a number of studies which fail to show this effect [37–38]. Ultimately it is very difficult to make generalisations about the effectiveness of early interventions as the time frames for what constitutes 'early' vary significantly across studies [6, 29]. This is exacerbated by the eclectic mix of interventions and referral systems evaluated [18].

DPT Two: Proactive Organisational Procedures Such as Sickness Absence Policies Incorporating Trigger Points for Management Action are Important Factors in the Effective Management of LTSA

Review of the Evidence

Most guidance documents on managing sickness absence emphasise the importance of having robust sickness absence policies with specific trigger points for management action [6, 39]. Numerous qualitative studies have also emphasised that employers believe sickness absence policies are more likely to be effective if they have senior management support, are communicated to all sections of the company, are fully implemented, and are supported by adequate training of managers [36, 40]. Employers often use a combination of preventative measures (e.g. provision of ergonomic assessments and equipment) rewards (e.g. attendance bonuses, flexible working) and sanctions (e.g. disciplinary procedures) to reduce LTSA [3, 15]. However, there is limited empirical evidence for the effectiveness of one approach in comparison to another [38].

Contextual Factors

A number of authors have argued that sickness absence policies and procedures are not a panacea. Rather, multiple contextual factors can impact on sickness levels, such as organisational change, absence culture, terms and conditions of employment; management approach and relations between employers and employees [9, 36]. It has been argued that unionised firms with more elaborate organisational structures and specialist posts assigned to attendance management and employee health protection such as Human Resources, Health & Safety and Occupational Health departments, can provide a more systematic, cohesive approach to the management of sickness absence procedures [1]. Conversely, other research highlights that smaller firms, with single level organisational structures and no collective bargaining, can actually facilitate return to work, due to the smaller number of people involved and the use of simpler processes [36]. Moreover, having robust

sickness absence policies and procedures does not guarantee they will be implemented [41]. For example, strong departmental and professional boundaries can inhibit the dissemination of policies within large, geographically spread out, multi-layered organisations [7].

The importance of the behaviour of line managers in implementing LTSA policies and procedures has been highlighted repeatedly ([7, 27, 40]. Line managers are responsible for day-to-day operation of LTSA policies and procedures but they need to be adequately resourced to fulfil their role [4, 16]. Otherwise, given the normal demands of operational pressures, they are likely to be thwarted by the excessive time given to additional paperwork and sourcing replacement staff [16] or by inadequate investment in training in attendance management procedures [10]. However, it should be noted that there is little evidence that investment in training leads to improvements in LTSA [41].

Synthesis of Evidence

Overall the empirical evidence to support the programme theory that proactive organisational procedures can improve management of LTSA is inconclusive and incomplete and is based on consensus rather than empirical evidence [7, 39]. The majority of literature is comprised of expert opinions, survey and qualitative studies, mainly taken from the employers' perspective [36, 40].

DPT Three: Communication and Co-operation Between Stakeholders is Critical to the Effective Management of LTSA

Review of the Evidence

The importance of good levels of communication and cooperation between stakeholders in effective sickness absence management is highlighted throughout the empirical literature and formal guidance documents [27, 34]. A limited number of studies evaluate a primary intervention focused on improved communication between stakeholders, and the empirical evidence for its overall effectiveness in facilitating an earlier return to work is weak [42] and sometimes contradictory [41].

In an attempt to overcome some of the communication and collaboration difficulties between key stakeholders, many advocate the use of case management approaches to coordinate the management of LTSA. [27, 43] A case manager liaises:

> "…between all the parties involved in a sick or injured employee's care…… to design a plan to help

them return to work." [43, p.41]. However, despite significant investment in multidisciplinary case management there is limited empirical evidence of its effectiveness in facilitating an earlier return to work [29].

Contextual Factors

A number of qualitative studies analysing employers' perspectives reported that when senior management took a lead in sickness absence and occupational rehabilitation there tended to be improved resources and improved communication and collaboration between stakeholders [34]. The literature also emphasises the importance of good, inclusive relations between top management and staff [40] and between trade unions and management [36]. However, despite the emphasis in guidance documents, there is limited empirical evidence specifically relating to the role and input of senior management or trade unions in both qualitative and quantitative primary studies.

Synthesis of Evidence

There is a consensus that successful management of LTSA is vitally influenced by the level of communication and cooperation between stakeholders. However, evidence for the effectiveness of enhanced communication and collaboration between stakeholders, including the case management approach, is limited and the direct association with reduced duration of LTSA is weak [6, 11]. This may be because cooperation is difficult to achieve due to conflicting perspectives, priorities and agendas amongst those involved [33].

DPT Four: Workplace-Based Multidisciplinary Occupational Rehabilitation and Provision of Modified Duties Can Facilitate an Earlier Return to Work in LTSA

Review of the Evidence

Evaluation of the evidence is complicated by the fact that there is no universal best practice model for rehabilitation programmes across regions and sectors and the terminology used can vary significantly. Terms such as vocational rehabilitation, occupational rehabilitation; return to work programmes and provision of modified duties are all in use [7]. Occupational rehabilitation processes can include temporarily reduced working hours, changes in work duties, redeployment, physiotherapy, counselling services and ergonomic or health and safety assessments [10, 29].

Australia, Canada, and some Scandinavian countries have placed a legal obligation on employers to implement rehabilitation assessments within the early stages of sickness absence [44]. However, despite this, there is evidence of widespread non-compliance with employers' legal obligation to provide early rehabilitation programmes and in reality it is common for employers to wait for a medical diagnosis from health providers and insurance schemes prior to initiating rehabilitation processes [40, 44].

Recent systematic reviews have found moderate to strong evidence that work-based return to work interventions including the provision of modified duties can facilitate an earlier return to work. However, the evidence is much stronger for musculoskeletal disorders (MSD's) than mental health disorders or other conditions [45] and there are a number of studies that have been unable to demonstrate an effect [28].

Contextual Factors

Managing LTSA through workplace-based rehabilitation and provision of modified duties can be inhibited by a lack of top management commitment; lack of opportunity for alternative duties in smaller organisations; financial constraints; resentment and resistance from co-workers and line managers; and a belief that employees must be completely fit prior to a return to work [7, 44]. Moreover, the facilitation of workplace modifications were found to be influenced by cost implications, the size of an organisation and variety of jobs available [7, 46].

Synthesis of Evidence

Workplace-based occupational rehabilitation and modified duties are the most heavily researched approaches to managing LTSA. However, most of this research relates to MSDs and work related injuries, with limited examples of interventions for other health conditions such as mental health disorders [10, 29]. Nonetheless, the strength of evidence is growing and there is good evidence that links successful outcomes with the provision of rehabilitation programmes carried out within or in close collaboration with the workplace [29]. Finally, it has been argued that the provision of modified duties is one of the most effective return to work interventions; although, considering the weight of literature dedicated to this subject, it must be questioned whether it is the most effective or just the most studied.

Meta-synthesis

The main body of literature pertaining to the management of LTSA is extensive, diverse and of variable quality.

However, a significant proportion of the empirical evidence relates to the impact of occupational rehabilitation on return to work following LTSA due to musculoskeletal injuries. Therefore, there is a distinct gap in the literature surrounding the investigation of workplace interventions and rehabilitation initiatives for other health conditions strongly associated with LTSA, such as mental health disorders [45]. Additionally, despite an emphasis in many guidance documents there is limited empirical evidence specifically addressing the impact of organisational factors (such as sickness absence policies, case management, communication strategies and managerial approach) on the effective management of LTSA [39]. With the exception of workplace-based occupational rehabilitation and modified duties, the majority of DPTs relating to the management of LTSA are based on consensus and custom and practice rather than strong empirical evidence. Moreover, despite the extensive body of literature, the evidence base for the effective management of LTSA is limited by the diverse range of research designs employed and the low number of methodologically strong studies.

We have presented our four DPTs as discrete concepts but of course they overlap in that they are likely to feature to an extent in most organisations. The DPTs are also influenced by a common suite of contextual factors, of which the most important appear to be the level of support for LTSA interventions from top management; the size and structure of the organisation; the level of financial and organisational investment in managing LTSA; and the quality of relationships between managers and staff. All but the last of these are indentified in Greenhalgh et al's [26] conceptual model of the organisational factors influencing the successful implementation of healthcare interventions. The model also draws attention to unanticipated but (un)desirable consequences of interventions, and indeed, these have been evident in our review. For example, sickness absence policies designed to control absenteeism can actually result in increased absence levels due to employees taking longer periods of sickness absence to try and avoid designated short term trigger points within organisational policies [8, 47]. It has also been argued that trigger systems can encourage a certain level of sickness absence that is perceived by the workforce as acceptable, as most organisational policies only mandate action after a certain level of sickness absence, for example, after 10 days or three separate periods of sickness absence within a 12 month period [48]. Additionally, some authors maintain that when sickness absence levels are low it can mask 'presenteeism' (attending work whilst sick) and low levels of morale and job satisfaction [4]. We have also noted certain overarching factors that appear to strongly influence the performance of any given intervention or set of interventions, which we have incorporated into our own
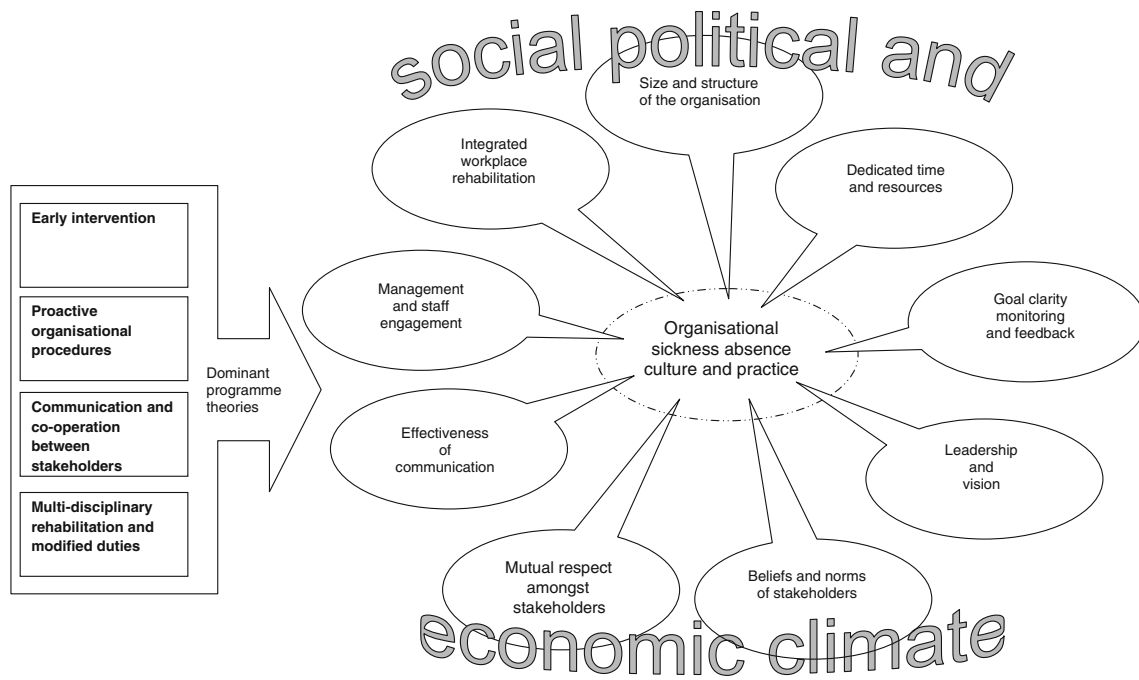
Fig. 1 Factors contributing to the organisational context for managing long-term sickness absence

model of the organisational context for managing LTSA (Fig. 1). Greenhalgh et al. [26] argue that the nature of the 'outer context' (the socio-political climate and external incentives and mandates) can exert a profound effect. This is borne out by research demonstrating that periods of economic recession (with widespread apprehension over rising unemployment) initially are associated with lower levels of self certified short term sickness absence; although the increased pressures on staff often leads eventually to an increase in LTSA [49–50].

Different Perspectives

Just as important as the characteristics of a given intervention is how it is perceived by those involved, including top management and key decision makers in the organisation, in terms of compatibility, complexity and relative advantage [26]. Much of the qualitative literature relating to communication in the management of LTSA concentrates on the different perspectives and goals of the various stakeholders [11, 51]. For example, managers' attitudes have been found to be influenced by the overall corporate approach and perceived tolerance towards sickness absence behaviour [40]; whilst employees perceive their line managers as representing the face and values of the organisation as a whole [34]. An influential systematic review of the international qualitative literature on return to work following injury reported similar findings to this realist review; namely that successful return to work was based not only on improvements in physical functioning but was

influenced by the beliefs and perceptions of the various stakeholders, and the level of goodwill between them [34]. The expectations of outcomes can differ significantly depending on the perceptions and priorities of the stakeholders. For example, whilst an employer's main goal in managing LTSA is typically a sustained return to work, employees' ultimate goals relate to improved health and well-being and quality of life [52]. Different perspectives are also evident when it comes to early intervention and communication between employers and employees. Staff can often feel isolated and undervalued due to the lack of communication from their employers [52] whilst managers are concerned that they may be accused of harassment if they contact staff who are absent [13, 36]. Consequently, it has been argued that the outcomes of early and regular communication are directly related to the relationship between managers and employees, with trust and respect between the parties being perceived as essential to ensure communication is perceived as supportive rather than coercive [36]. This is consistent with two recent systematic reviews of the qualitative evidence surrounding return to work initiatives for LTSA. These found that positive outcomes were often contingent on the degree of trust between employers, workplace advisors and individuals suffering from long-term ill health [34, 53].

Differing perceptions are also evident amongst other stakeholders. For example, GPs saw themselves as the patient's advocate, with the ultimate aim of clinical recovery for their patient, regardless of their employment status [54]; but they may be suspicious that employers have

'hidden agendas', such as trying to terminate employment on the grounds of ill health [14]. Meanwhile, other stakeholders such as human resources, line managers and occupational health services have voiced concern about lengthy absences recommended by GPs, believing that GPs still needed to be convinced that work is itself good for health and that workplace-based occupational rehabilitation and provision of modified duties can help in reaching the ultimate goal of a sustained return to work [29]. Occupational health services are often perceived as having a conflict of interest in the fact that they are paid by employers to provide objective advice on fitness for work but they are also governed by strict codes of ethics and confidentiality which require them to place the interest of their patient (employee) as paramount [55]. However, employees have reported difficulties in trusting occupational health as they are perceived to be acting in the interests of the employer, whereas others welcomed the confirmation from occupational health that they were unfit as it helped to legitimise their period of sickness absence [28]. In contrast, employers have reported frustration that occupational health services consistently place the interests of employees over and above the overriding needs of the business [56]. Ultimately this relates to a lack of understanding of each other's roles. Additionally, to date, there has been limited empirical evidence of the effectiveness and specific cost benefits of the provision of occupational health services, in terms of improved health and well-being and productivity, as well as reduced sickness absence levels. This may be related to the fact that these impacts are often difficult to objectively measure, which in turn is exacerbated by an evidence base that is limited and often of poor quality [57]. Furthermore, there have been numerous references in the literature to very poor levels of communication between occupational health and GP's, which again may be related to potential conflict of interest and lack of understanding of each other's roles [14]. It has been argued that like many other stakeholders, GP's and occupational health have different expectations of outcomes of LTSA. In general, GP's are primarily concerned with clinical diagnosis and effective treatment while occupational health prioritises sustained return to work as well as improved quality of life [58].

Conclusions

It appears that the majority of practitioners, policy makers and researchers concur in seeing early intervention, proactive use of organisational procedures, communication between stakeholders and multidisciplinary workplace-based occupational rehabilitation as being the most important factors in managing LTSA. However, the evidence base for their theories is inconsistent and incomplete. Given the complexity of the problem and the multi-faceted nature of the dominant programme theories, this is unsurprising. What is less often acknowledged, and seldom addressed, is that these factors have a mutually interactive relationship which takes place within the multifarious contexts of particular organisations and societies (Fig. 1). Consequently, those with responsibility for managing absence should bear in mind the contextual factors that are likely to have an impact on interventions. The most significant contextual factors are the level of support for interventions from top management, the size and structure of the organisation, the level of financial and organisational investment in the management of LTSA, and the quality of relationships between managers and staff. They should also do what they can to ensure stakeholders have at least a mutual understanding of (if not a common purpose) in relation to their perceptions of interventions, and the goals, culture and practice of the organisation in relation to absence from work.

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