SWEDISH NATIONAL AUDIT OFFICE

REPORT NUMBER: RIR 2015:19
DATE: 27 OCTOBER 2015

Summary:
The rehabilitation guarantee is not working – rethink or discontinue

Mental health is the main reason for sickness absence today.[1] In addition, mental ill health is the most common reason that individuals of working age are outside the labour market in the OECD.[2] In Sweden diagnoses of mild to moderate mental illness or disorder account for about 40 per cent of all ongoing sick leave reimbursed by the Swedish Social Insurance Agency. This entails major costs. The cost of mental ill health in Sweden is approximately SEK 70 billion per year.[3]

Audit background

To tackle the increase in sick leave for mental ill health the Government and the Swedish Association of Local Authorities and Regions entered into a first agreement on a rehabilitation guarantee in 2008. Continued agreements have since been signed annually. The purpose of the rehabilitation guarantee was to provide county councils[4] with incentive funds so that people with mild to moderate mental ill health could be offered specific treatment methods that would promote a return to work and prevent sick leave.[5] The county councils lacked access to a sufficient number of registered psychologists and registered psychotherapists, which meant that the requirement that treatment providers

[1] Henderson, M. et al. (2011), *Work and common psychiatric disorders. J R Soc Med* 104(5):198–207.

[2] OECD (2013), *Mental Health and Work Sweden.*

[3] Ibid. p. 20.

[4] The term county councils also refers to regions.

[5] *Agreement between central government and the Swedish Association of Local Authorities and Regions on a rehabilitation guarantee* (2008).

should be registered psychologists or psychotherapists was not covered by the rehabilitation guarantee.[6]

The rehabilitation guarantee was formulated and introduced quickly, and the Government decided on several evaluations and investigations to develop and improve the agreements subsequently. The agreements stated that treatment should be given in accordance with the latest evidence and that the agreements should continually admit new knowledge and take into account the findings of evaluations and investigations.[7] None of the evaluations commissioned has shown with certainty that the rate of return to work for people with mild to moderate mental ill health has increased.[8]

The Swedish NAO carried out an audit of what in the design and implementation of the rehabilitation guarantee prevents achievement of the objective of a return to work for people with mental ill health. The audit covers the agreements signed from 2008 to 2015. The audit was conducted by means of a document analysis of the evaluations and investigations covering the rehabilitation guarantee, a qualitative interview study with primary care treatment providers and a quantitative examination of how county councils have allocated the rehabilitation guarantee funds. The county councils can allocate funds as they consider appropriate. It is nevertheless relevant to investigate how the county councils have used funds, since the rehabilitation guarantee has shown poor achievement of objectives and it is a matter of incentive funds for a specific target group: people with mild to moderate mental ill health who are to be treated in primary care.

Audit conclusions

The Swedish NAO considers that a series of factors in the design and implementation of the rehabilitation guarantee have hindered achievement of its objective.

Too much focus on treatment method

In the opinion of the Swedish NAO the Government has not formulated and revised the agreements on the basis of existing knowledge of the rehabilitation guarantee and its effects. The Government has not continually developed the agreements on the basis of

[6] Interviews 35 and 36.

[7] *Agreement between central government and the Swedish Association of Local Authorities and Regions on a rehabilitation guarantee (2011).*

[8] See Karolinska Institutet (2011), *En nationell utvärdering av rehabiliteringsgarantins effekter på sjukfrånvaro och hälsa. Final report part I*; Institutet för arbetsmarknads- och utbildningspolitisk utvärdering (2012), *Rehabiliteringsgarantin*. Institute for Labour Market Policy Evaluation, Report 2012:26, p. 37–40.

the current state of knowledge and on the basis of the findings of commissioned evaluations.

The fact that the Government from the start has steered towards promoting evidence-based treatment methods in primary care has directed focus specifically to the treatment methods, which has hampered development of the rehabilitation guarantee. Instead, an explicit focus on returning to work should have been given priority when introducing the rehabilitation guarantee.

An initial qualified assessment is important but is not always carried out

In many cases the patient is not given any initial qualified psychological assessment by a registered psychologist or registered psychotherapist. This means that it not possible either to determine whether the patient has the right potential to be helped by the treatment covered by the rehabilitation guarantee or to exclude the possibility that the patient is suffering from another mental problem.

Patients do not always receive treatment fast enough

An important focus for the rehabilitation guarantee is to achieve fast treatment. Instead the waiting period before starting treatment is often long. The number of qualified treatment providers is not sufficient to meet the needs. Some county councils have a waiting list of about four months, some even up to a year.

If the treatment providers are to comply with all the requirements of the agreement their waiting times grow. Nor do all patients need as many treatments as the rehabilitation guarantee assumes. For some patients suffering mild or moderate mental ill health fewer treatment sessions may be sufficient.

Lack of systematic patient follow-up

Another problem is that it is not possible to say whether the patients are helped by the treatment. The reason is that the rehabilitation guarantee does not include any patient follow-up requirements. This means that the treatment providers themselves do not know if patients receiving treatment as part of the rehabilitation guarantee receive more effective help than patients being treated with methods other than those specified in the rehabilitation guarantee.

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There is no focus on actively promoting a return to work

In primary care the treatment providers usually do not know how they should tackle returning to work and they are not reimbursed for going to meetings with employers or for familiarising themselves with various treatment methods aimed at increasing the return to work rate. Nor has the intended collaboration with occupational health services become a reality, which is a problem since in some cases the occupational health services are the initial contact for patients suffering mental ill health. Instead, coordination is often carried out by a rehab-coordinator who plays a central role in the patient's rehabilitation. Another important aspect for making work on mental ill health in primary care effective is an operational manager who gives priority to mental ill health and the professions that work with psycho-social issues.

County councils have dealt with the funds in different ways

In some county councils a considerable percentage of incentive funds go to psychiatry, which does not necessarily treat the target group for the rehabilitation guarantee. Some county councils have kept the funds at central level. The money may go to relevant projects, but the projects may also be outside the rehabilitation guarantee objectives. One reason that county councils have decided to retain the funds at central level is the lack of long-term perspective in the agreements, and the fact that they are signed so late in the year makes the county councils' planning more difficult. The same applies to the extra funds allocated to the county councils to enable them, among other things, to improve the qualifications of treatment providers to registered psychotherapists, which have only in a few cases been used to raise the qualification from treatment provider with basic qualifications in cognitive behavioural therapy to registered psychotherapists. There is still a great need for registered psychologists and registered psychotherapists in primary care.

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Recommendations

The Swedish NAO makes the following recommendations to the Government:

- The Government should consider whether the rehabilitation guarantee should be redesigned or abolished. The guarantee has not clearly succeeded in achieving the return-to-work objective and primary care is not fully equipped to work towards such an objective. Steering towards specific treatment methods has been ineffective in achieving the objective of increased return to work and restricted professional assessment.
- The Government should assess how it can prevent sick leave and increase focus on return to work by means of structured formal collaboration between the Ministry of Health and Social Affairs and the Ministry of Employment and the Swedish Social Insurance Agency and the Swedish Public Employment Service. This collaboration may entail financing a larger number of rehab coordinators (independent of the 'sick leave billion') to be responsible for coordination of patient contacts with care-providers and employers.
- To provide the conditions for fast and early initiatives for people with mild to moderate mental ill health the Government should consider whether it should finance registered psychologists and psychotherapists who can make psychological assessments of the target group. There is inspiration to be found in the design of the rehab coordinators.
- The Government should again consider whether the competence of the occupational health services can be better utilised.