Opportunities, barriers and facilitators of an indicated prevention strategy to prevent future long-term sickness absence in SMEs

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Opportunities, barriers and facilitators of an indicated prevention strategy to prevent future long-term sickness absence in SMEs: A qualitative study

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Abstract.
BACKGROUND: The efficacy of an indicated prevention strategy for long-term absence due to sickness has been demonstrated and is implemented in multinational companies. Such a strategy may also be beneficial for small and medium-sized enterprises (SMEs). However, due to the different contexts, adoption, and implementation of this strategy in SMEs may be quite different.
OBJECTIVE: This study aims to investigate the opportunities, barriers, and facilitators for adoption and implementation of this preventive strategy, as anticipated by employers and employees of SMEs.
METHODS: A qualitative needs assessment was conducted using semi-structured interviews with higher managers ($n = 15$) and a focus group with employees ($n = 8$). Purposive sampling was used, and data were analyzed using content analysis.
RESULTS: Employers had positive expectations concerning the gains of the preventive strategy, whereas employees had more reservations. Anticipated gains and intentions to implement the preventive strategy were rooted in underlying conceptions of the causes of sickness absence and the responsibilities of stakeholders. One key barrier shared across employers and employees concerned the potential lack of confidentiality. For employees, the role of the occupational health professional in the prevention of sickness absence was perceived as uncommon. Employers stressed lack of capacity and resources as a barrier, whereas employees stressed lack of follow-up by the employer as a barrier.
CONCLUSIONS: SMEs are considerably receptive to the implementation of an indicated prevention strategy for long-term absence. Insight into the barriers and facilitators gives clues for wider and optimal implementation across a wider range of organizational settings.

Keywords: Absenteeism, early intervention, preventive policies

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1. Introduction

Long-term absence due to sickness (hereafter: long-term absence), often defined as absence from work longer than six months due to sickness [1], remains an important concern given that long-term absence is highly costly to employers, employees, and society at large [2–4]. In the Netherlands, in 2016, about 1.6% of all employees were sick-listed for a long period, which was an increase of 32% compared to the rate of 2013 (1.2%) [5]. Previous studies have shown that long-term absence may be a pathway to future work disability, early retirement, and unemployment [6], which is at odds with European Union (EU)-wide efforts directed at increasing the workforce participation of all working-age people [7]. For employers, long-term absence may cause a disruption involving financial and operational implications like productivity loss, costs for replacing employees, increased insurance premiums and may also affect overall levels of job satisfaction and turnover among employees [8]. The financial ramifications of long-term absence may be particularly high for employers in countries like the Netherlands, where employers are held responsible for paying the salary of employees on sick leave for a period (at least 70% for a maximum period of two years in the Netherlands). So employers have an important stake in preventing long-term absence among their personnel.

Prevention of long-term absence has been covered by either universal preventive actions focused on health protection and promotion targeting health and work-related factors of all employees [9], or by designing workplace-based policies to facilitate return to work of workers on absence [10]. Yet, although substantial research has focused on the effectiveness of such programs, only a few (high-quality) workplace-based return to work programs have demonstrated their effectiveness [11]. Against this background, an indicated prevention strategy that focuses on employees with a high risk for future long-term absence may be a viable alternative [12, 13]. When employees have a high risk for a presumable future encounter of an episode of long-term absence, they are subject to early intervention [14]. In this sense, "early" refers to intervening before actual sick leave has occurred. Several indicated prevention strategies have proven to be effective for predicting and preventing future absence [15, 16]. Such a strategy has also been developed earlier by Maastricht University jointly with the Occupational Health Service "Beter." This strategy comprises two elements: (1) screening based on a validated screening questionnaire—the Balansmeter—which enables identification of employees with a high risk of future long-term absence [17, 18] and (2) subsequently providing the high-risk workers with an early consultation with their occupational physician or another occupational health professional. The questionnaire comprises questions on the work environment (e.g., working conditions and psychological job demands), characteristics of employees' private situation (mental), health status, demographic factors, and absence history, and it is protected by medical confidentiality. Questions are predictive for future sick leave. Using a specific algorithm, employees' individual risks for future long-term sick leave, here defined as a consecutive period of more than 28 days of absenteeism, are calculated. Employees at high risk for future long-term sick leave are invited for extensive, one-to-one consultation with an occupational physician or another occupational health professional. The structured early consultation involves several steps, during which the results of the screening questionnaire are discussed and a broad range of additional anamneses can be performed to consider options for treatment or guidance. Although the efficacy of this preventive strategy has been demonstrated in two large randomized experiments in a multinational organization [12, 19, 20], the preventive strategy has not been applied across different organizational settings, like those of small and medium-sized enterprises (SMEs), or companies with 250 employees or less. Yet, SMEs have a share of about 70% in the total employment level in the Netherlands [21] and could benefit substantially from this preventive strategy. Before effectiveness can be demonstrated in this setting, adequate adoption and implementation of this strategy are imperative. As multiple stakeholders like employers, employees, and occupational health professionals are involved and need to align their interests and collaborate, recent research has been concerned with identifying the factors for successful adoption and implementation of this preventive strategy [22, 23], but only for multinational companies.

Compared to multinational companies, the long-term absence of employees with key expertise may pose a direct threat to the business of SMEs, as internal successors for those positions are often lacking, or difficult to find in the external labor market. In addition, SMEs tend to have fewer options to adapt working requirements and circumstances to ease their return to work [24]. Also, financial responsibilities related to the continuation of salaries, and the hir-

ing of external replacements tend to be a burden on the company's total wage sum. Simultaneously, SMEs generally possess fewer resources to organize the protection of occupational health for their personnel [25]. They are more frequently characterized by a "structure of vulnerabilities" [26–28], implying less knowledge and resources to manage the work environment properly for record-keeping and inventorying costs, and a lack of experience due to the shorter life cycle of SMEs compared with larger companies [29, 30]. Hence, potentially, there is a strong business case for an indicated prevention strategy in SMEs. Yet, to date, it remains unclear whether SMEs would perceive such a strategy as a viable option and what they might anticipate as possible barriers and facilitators to implementation in an SME context.

First, SMEs tend to have a more defensive attitude toward buying-in external preventive services, and also make less use of publicly available preventive services in general [26, 27, 31–33]. Specifically, concerning SMEs' decision-making process on whether to take precautionary actions to combat absenteeism, research has shown that such a decision largely depends on the degree to which SMEs regard absenteeism as related to working conditions [34]. In general, occupational health and safety issues tend to be seen as an individual rather than an organizational issue in SMEs [25]. This externalization of organizational responsibility may therefore be considered a specific barrier for the implementation of the indicated prevention strategy earlier introduced, as the preventive strategy also implies the shared responsibility of the employee and the employer. Also, barriers and facilitators in a multinational setting, such as having a culture of health and conceptions about the responsibilities of both employers and employees [23], may not be generalizable to the setting of SMEs. Barriers in SMEs may have to do with issues like defensiveness because of the strong identification of employers with their business. Moreover, guaranteeing the privacy of participation in such interventions may be challenging because in SMEs, the employee–employer relationship is more informal [32]. Despite differences, there may also be similarities with larger companies; for instance, facilitators of implementation may concern anticipated positive consequences for workers' wellbeing or reduction of absence related costs [35, 36]. Generally speaking, practical solutions that can be easily integrated into the workflow without any major costs are considered more acceptable for SMEs [25, 33].

This study aims to investigate the opportunities, barriers, and facilitators, as anticipated by management and employees, to implement the specific preventive strategy regarding SMEs. The perspective of employees in addition to that of management is of importance in SMEs, as employee involvement is more direct (less unionization) and relationships in small workplaces occur on a more personal basis [37]. Hence, a qualitative needs assessment was conducted to inventory anticipated opportunities of this strategy, barriers, and facilitators of its implementation and underlying existing conceptions on the causes of absence and the responsibilities of the stakeholders involved (management and employees). As SMEs employ 67% of all workers in the EU [38], insights gathered in this study may provide clues for a wider and optimal implementation of a scientifically proven strategy on indicated prevention for long-term absence. Hence, this study also aims to follow up on calls for more attention to preventive policies aimed at maintaining and promoting labor force participation [39].

2. Methods

2.1. Study design

For this study, a qualitative approach encompassing semi-structured interviews with higher management representatives of SMEs was combined with a focus group of employees of one of those SMEs. The concrete case of the preventive strategy as discussed above was the starting point of all interviews and the focus group. This preventive strategy was not (yet) implemented in any of the organizations the respondents worked for.

2.1.1. Samples and procedures

SMEs are a heterogeneous group of companies. This study focused on companies ($N = 10$) active in the province of Limburg, the Netherlands, with a minimum of 50 to a maximum of 250 employees, supplemented by some ($N = 5$) smaller companies (25–50 employees). The upper limit of 250 employees agrees with the EU definition of SMEs; the lower limit of 25 is chosen so that companies have at least a systematic prevention and personnel policy in practice (i.e., risk assessment and evaluation are mandatory for companies with 25 employees or more according to the Occupational Health and Safety Act

in the Netherlands). This research therefore does not focus on self-employed workers or so-called "micro-enterprises," but on SMEs with a certain scale to implement prevention and personnel policies in which the preventive strategy could potentially be embedded. In addition to independent companies, participation in this study was also open to SMEs that have ties with a larger holding or group or have partnerships with other SMEs. All participating companies in this study had strong authority to shape their local prevention and absenteeism policies, bore the financial consequences of absence, and reaped the benefits of investments in prevention policies. Companies were purposively sampled through a regional network of SMEs to which the researchers had access to. All management respondents were contacted via telephone and invited for a face-to-face interview. The aim of the study and ethical standards related to confidentiality and data use and storage were thoroughly explained at first contact. During recruitment, the representation of various typical industries for the region (e.g., transportation, agriculture, and industry) was considered. The participating companies ($N = 15$) were active in various sectors, including transport and logistics ($N = 1$), industry ($N = 6$), agriculture, forestry, and fishing ($N = 3$), construction industry ($N = 1$), retail trade ($N = 1$), hospitality ($N = 1$), and specialist business services ($N = 2$). All respondents provided informed consent in advance of the interview.

Insight in the perception of employees was gained through a focus group meeting in one of the participating companies (industry sector and with a workforce in the range of 50 to 250 employees). The chosen company allowed the gathering of a heterogeneous group of employees (regarding type of jobs) without mutual direct authority relationships among members. A written description (flyer) of the research was provided to a company representative, who distributed the flyer among employees. Participation in this study was voluntary, and the flyer explained the confidentiality of the collected data. All eight participants gave their informed consent prior to the focus group meeting.

Incentives for participation in this study were not provided either for employers or employees.

2.1.2. Data collection

Face-to-face interviews with management of the participating SMEs took place between March and September 2018. All interviews were conducted at respondents' workplaces in Dutch by the first author (DS). The interview was guided by a topic list based on literature insights, important general issues like viewpoints on the responsibility for employees' health and absence, and the extent to which these could be influenced by company policies. Thereafter, the interviewer introduced the preventive strategy in a similar (but brief) way to all respondents, as described earlier in the methods section of this study. Specific issues relating to the preventive strategy on the topic list were addressed, encompassing the anticipated benefits of the preventive strategy, its anticipated potential barriers (e.g., lack of financial resources, organizational capacity, and privacy), and facilitators (e.g., feedback). We also probed whether employers would consider the deployment of such a strategy ("Would you consider implementing it?"). This approach allowed the researcher flexibility both in probing for further information or in switching between issues depending on the course of the interview. The interviews were recorded digitally and took on average 40 minutes. All interviews were transcribed fully in Dutch by a professional transcriber.

The focus group meeting (of 90 minutes) was held in October 2018 in a private meeting room in the selected company and led by a moderator (DS) and one additional researcher. The focus group was organized around the same topics as those central in the semi-structured interviews with management. Yet, adaptations were made in two ways: (1) additional topics like possible stigmatization due to the screening questionnaire were discussed and (2) issues were framed from the perspective of employees (e.g., possible costs) instead of employers. The preventive strategy was also briefly explained at the start of the focus group in a similar way as in the semi-structured interviews. Afterwards, all participants were asked to answer the following three questions on paper: 1) "What is/would be the most important reason for you to participate in this preventive approach?" (answer options: "Health benefits;" "Prevention of absence;" "Prevention of income loss due to absence;" "Insight in my own situation (work, health, private life);" or specify "Other"), 2) "What is/would be the most important reason for you not to participate in this preventive approach?" (answer options: "No confidence;" "Privacy;" "Stigmatization;" and "Costs;" or specify "Other"), and 3) "All in all, would you participate in this preventive approach?" (answer options: "Yes" or "No"). The discussion was taped (only audio) and transcribed fully in Dutch by a professional transcriber.

2.1.3. Data analysis

The transcripts of the interviews and focus group were analyzed independently of each other using content analysis [40, 41]. First, the transcripts of the interviews were read and coded in an open way. As the semi-structured interviews and focus group were guided by a topic list, founded in literature, data was coded with labels following the (sub)topics on the topic list (e.g. 'barrier'). During this first phase *in-vivo* labels were given (e.g. barrier 'employers' lack of capacity to change the work environment'). In the next phase, after all interviews were coded, all codes with accompanying text fragments were read again, and adjustments were made either by grouping text fragments with similar meaning together, or establishing new categories when differences in meaning were discovered. In the third phase, after all data was categorized, categories were ordered in a structure with general and subcategories that gave insight in the multifaceted reasoning of stakeholders on the opportunities, barriers and facilitators of the preventive strategy (section 3.1–3.3). An overview of the coding structure and frequencies is given in Table 1. Next, by combining categorized answers in employers, patterns were explored in their narratives (section 3.4). One researcher coded the semi-structured interviews and the group interview (DS), and four other researchers (IJK, LvA, NJ, and IH) assessed the coding phase. The coding labels were frequently discussed and adjusted, or coding themes were added with the help of the same researchers who acted as peer reviewers throughout the data analysis (IJK, LvA, NJ, and IH). Also, the translation of the coding themes and quotes to English, as presented here, were discussed by the research team.

3. Results

3.1. Employer perceived benefits

During the interviews, three possible outcomes of the preventive strategy were discussed with the employers: absenteeism, health, and care consumption by employees.

3.1.1. Absenteeism

Most employers (12/15) anticipated that the preventive strategy could lower absence in their organization. Five employers argued that the preventive strategy and, in particular, the screening questionnaire would enable them (as employers) to be informed sooner about possible (hidden) problems leading to possible absenteeism and act upon it. As one respondent quoted:

> *I think there are more. Perhaps someone is in a difficult home situation, which we do not know. It could well be a marriage crisis, as a result of which, there is the risk of long-term absence. What you probably could tackle more easily at an early stage before it escalates completely. So I think there are more things that we may not know at all.*

To a similar extent, it was noted by employers (5/15) that the preventive strategy, in particular, the screening questionnaire, could raise awareness among employees of possible problems ("*I think that raising awareness for the employee does have an effect on absenteeism. So I also think it has to be done early.*"). When this signaling function to employees was mentioned by respondents, "health behavior" issues were often highlighted as the major cause underlying possible absence, which needed appropriate action or change on behalf of the employee. As an example:

> *Awareness and that people intervene earlier in situations too, for example, adapt their behavior or change of lifestyle. Often, these are determining factors for absence in the longer term. So I think shaking it up, shaking it up, that might be important. And with that, absenteeism during the later phase of their working life becomes reduced.*

Some employers (3/15) referred to both reasons when addressing the possible benefits of the strategy in preventing absenteeism. Emphasis on all these narratives was often put on issues in an employee's private life. Surprisingly, issues in the working environment, such as poor working conditions, were not explicitly referred to in these narratives. Two employers explained the anticipated effectiveness of the strategy in preventing absenteeism differently: one employer argued that using the strategy could be seen as a gesture of organizational support, and another respondent expected a lot of bringing in an independent external professional as part of the preventive strategy, as employers either lack the expertise or cannot provide confidentiality as professionals do.

In total, three employers anticipated no benefits of the preventive strategy regarding preventing absence when asked. They provided multiple explanations for this:

Table 1
Structure and frequencies of coding categories

Employer perceived benefits			
	Absence		
		Employer informed sooner (15)	
		Employee awareness (10)	
		Help by occupational health professional (1)	
		Organizational support (1)	
		Incapacity for employees to change (6)	
		Unwillingness of employees to participate (5)	
		Incapacity of employers to change (2)	
		Uncontrollable nature of the causes of long-term absence (1)	
	Health		
		No or little health benefits (6)	
		No reason specified (2)	
		Signal for employees (11)	
		Signal for employers (15)	
	Care consumption		
		Decrease over time (16)	
		Unclear (8)	
		Increase (4)	
Employer perceived barriers			
	At the level of employers		
		Lack of capacity	
			Time and people (13)
			Company scale (5)
			Replacement of employees (3)
			Change work environment (1)
			High cost (10)
			Return on investment (1)
		Lack of confidence in the occupational health professional	
			Too slow (3)
			Not active and solution oriented (5)
			Focused on invoicing (4)
			No customization (1)
			Lack of competencies (3)
		Lack of confidence in the method	
			Role of work overestimated (2)
			Unintended consequences (6)
		Unclear	
			Cost-benefit balance (7)
			Benefits (6)
			Timing of benefits (3)
			Beneficiary of benefits (1)
			Link to the workplace (1)
			Effectiveness (6)
			Company's role (2)
	At the level of employees		
		Lack of ability	
			No time perspective (3)
			Lack of understanding (4)
			Lack of skills to complete questionnaire (7)
		Low readiness	
			Make changes (3)
			Reflect on functioning (3)
		Low motivation	
			No purpose (1)
			No confidence (1)
			Private issue (3)
			No need (3)
			Fear of being 'high risk' (2)
			Fear of consequences of being 'high risk' (2)

(*Continued*)

Table 1
(*Continued*)

	Lack of trust in the method	
		Confidentiality (19)
		Anonymity (5)
		Infringement in private life (4)
		Misuse of information (9)
		Disclosure by follow-up action (3)
		Occupational physician (1)
	Lack of trust in the work environment	
		Lack of openness (2)
		Lack of support (2)
Employer perceived facilitators		
At the level of employers		
	Information or confidence in advance	
		Return on investment (16)
		Benefits (3)
		Business case example (3)
		Price-quality (2)
		Expertise of occupational health professional (5)
	Post-hoc feedback	
		Impact on organization (3)
		Individual employees (8)
		Subgroups of employees (3)
		Trends (2)
		Percentage of 'high risk' (1)
		Experiences of employees (1)
		Unsuccessful interventions (1)
		Overall climate (1)
		Process (2)
		Non-responders (1)
	Context	
		Stability on the organization (1)
	Financial support	
		No cure no pay policy (1)
		Financial support from government or industry (3)
		Financial reward by insurance company (1)
At the level of employees		
	Trust and confidence	
		Culture of trust (13)
		Anonymity (4)
		Trustworthiness of occupational health professional (6)
		Benefits (7)
		Voluntary nature (1)
		Expertise of occupational health professional (6)
		Feedback and follow-up measures (5)
	Method specific	
		Straightforward worded questionnaire (2)
		Online screening questionnaire (2)
		Attention for the work-environment (2)
	Support and communication	
		Support by line-managers (4)
		Communication by management (3)
		Enthusiast management (6)
		Spread success mouth-to-mouth (2)
Employer intention to implement the preventive strategy		
No intention (2)		
Weak to moderate intention and conditional (8)		
Moderate to strong intention (7)		
Employer perceived responsibility for employee health		
Employer for work-related causes (17)		

(*Continued*)

Table 1
(*Continued*)

	Employer and beyond work-related causes (12)
	Employees, life style causes (7)
Employer perceived responsibility for absence	
	Primarily employee (14)
	Employer but constrained to what can be influenced (15)
	Employer overall (2)
Employer perceived culture of health	
	Present and concerned with in policy (6)
	To a limited extent (14)
	No culture of health (12)
Employer influence on absence	
	Moderate impact (14)
	Strong impact (5)

- The incapacity of employees to change something (e.g., "*But some also make the choice, this and this came from that test, but I don't do anything with it. So they bury their head in the sand a little bit*")
- The expected unwillingness of employees to participate in the preventive strategy (e.g., "*because do people really want to share their difficulties with others?*")
- The incapacity of employers to do something about the working conditions (e.g., "*Can we remove that? No, here, we can only ensure that someone has a decent break, a good workplace, concentration, training, optimizing the process, which has all happened. But still people may experience pressure, and then it* [taking measures] *kind of ends for us as employer*").
- The uncontrollable nature of the causes of long-term absence (e.g., "*You cannot expect anything else in the life of someone that if his son, his daughter, one of his relatives dies, causing so much pressure, so severe that they will drop out completely.*")

3.1.2. Health

During the interviews, the majority of employers (11/15) also anticipated that using this preventive strategy could be beneficial for employees' health. Some also elaborated on how the overall approach could contribute to their employees' health. A respondent described it as follows:

> *Yes of course. If you are helped early with discovering the signals, like hey, this will not go well in the future. Then you can also respond preventively. And preventively means that health, sustainable employability, can only get better.*

Yet, three employers argued against possible health benefits and one employer only anticipated little health benefits. Interestingly, in their argument, they all reframed "health" as health behavior and further indicated that changing employee behavior is too difficult and/or not the responsibility of the employer. The quote below is prototypical for this argument.

> *And I only think a real serious wake-up call, cardiac arrest, myocardial infarction, cerebral infarction, really something extreme, can make people change and even then, it is still difficult, I think. But to quit smoking? So I think it's very hard to change a certain habit of people after so many years, I think it's impossible, with a few exceptions.*

Among those responding affirmatively regarding the health benefits, the prevention rationale was explicitly mentioned by several respondents. Furthermore, some of these employers anticipated that the screening part of the preventive strategy could function as a mirror to employees, potentially signaling unhealthy lifestyles and its consequences. For example:

> *But I do think that if you are talking about that tool, indeed, you will be confronted with the fact that this is my lifestyle. And that causes this. So if you feel certain things and you see them on paper, okay. Of course, I also smoke two packs of cigarettes a day. And when I get up in the morning, I feel dizzy. Well, okay. With a little common sense, you know how to link one to the other.*

Other employers rather emphasized the signaling value of the strategy to the employer, as it may indicate that "something" is wrong either at work or in their private life, which could be potentially addressed by the employer. In these narratives, refer-

ence was not only made to both mental and somatic heath but also to health as regards functioning in a working environment and how the preventive strategy could safeguard it. The following quote is exemplary:

> *Yes, that's what it's about. So how do you stay physically and mentally healthy? [. . .] You have a seasonal peak. And then there is enormous pressure that the work must all be finished. [...] And to guide that process, I think that's difficult. But you notice a number of employees, okay, the season is coming, then, they are very irritable. Will it all be alright this year? Everything has to be restarted and so I think that something can be done preventively.*

3.1.3. Care consumption

Although nine employers argued that the preventive strategy could lower consumption of (occupational health) care among employees (e.g., "*A healthy person normally has to go to the doctor less often, right? So the situation then requires less healthcare*"), a potential increase in consumption of care, especially during working time, was a concern among employers. Among those nine, only two anticipated a decrease in care consumption over time, after a first period of increases in care consumption ("*Well no, I think maybe more in the beginning and in the end, it should be less*"). Four employers were undecided but saw an increase in care consumption as a serious risk for the daily functioning of their business. Their argument was that a positive screening test may set off all kinds of medical interventions and/or bureaucratic processes, which may actually make the situation worse than before and could be highly costly for the employer. One respondent stated his concern about "medicalization" as follows:

> *Yes, look, what I said earlier, there is also the risk that certain things will become medicalized. And then that goes to the curative sector, I have a high-risk and then a battery of investigations is released and because of that investigation, someone starts calling in sick.*

In total, two employers expected that consumption of care would increase, as a demand for more care is stimulated. One respondent formulated it as follows:

> *Yes, I think you'll get more demand because now, they don't do anything, but then, they want to get rid of smoking and then that is seen as a risk and then oh yes, I have to do it anyway. Well, come on. Let's do it. Course here, course there. Well, failed. Once again, again. So yes, more is coming.*

Only one respondent anticipated none of the anticipated gains. Overall, these findings suggest that adoption could be high in our sample of respondents, and that only a few employers perceived reasons to revoke from implementation of the preventive strategy. As adoption is also to be determined by perceived barriers and facilitators, these are discussed next.

3.2. Employer perceived barriers

Management mentioned barriers at the level of the employers and employees (Table 2). Concerning barriers at the level of employers, analyses led to a categorization of perceived employer barriers that have to do with either their (lack of) capacity to implement, their confidence in the approach, or anticipated unclear issues tied to the strategy.

Lack of capacity is the most important employer-related barrier, as almost half of the employers believed that either the cost associated with the use of the preventive strategy may be too high or that it may deploy too many non-financial resources (e.g., time and personnel). To a lesser extent, some employers also perceived barriers that have to do with lack of confidence. Lack of confidence was first discussed regarding the role of the occupational health professional in the preventive strategy. These were based on their earlier experiences that had nothing to do with the preventive strategy, although only a minority of employers foresaw the specific issues were deeply rooted. Lack of confidence was also discussed regarding the method of the preventive strategy. Some employers anticipated unintended consequences like the method would overidentify workers as "*I have something, so I'm sick,*" or would "*open a can of worms*" after a positive screening, or that it would just be used by employees to channel their overall frustrations with the company. Yet, it should be noted that the majority (11 out of 15) of employers explicitly expressed their confidence in the method. Finally, many employers also identified several issues concerning the preventive strategy, mainly regarding the potential benefits that they found unclear (i.e., what, when, for whom), how these can be demonstrated, and outweigh investments.

In addition, employers also anticipated employee-related barriers for the successful implementation of the preventive strategy (Table 2). Analysis of the interview transcripts led to a categorization of per-

Table 2
Barriers at the level of employers and employees as perceived by employers for adoption and implementation of an indicated prevention strategy

Barriers at the level of employers
Lack of capacity:
– to direct resources like time and people to successfully implement the preventive strategy ($n = 7$)
– regarding company scale/size to make the preventive strategy worthwhile ($n = 4$)
– to handle replacing employees that would be temporarily unavailable as a consequence of making use of the preventive strategy (e.g., filling in the screening questionnaire, having a consultation with an occupational health professional) ($n = 2$)
– to change the work environment, in case that would be indicated using the preventive strategy ($n = 1$)
– to bear high costs to buy in the preventive strategy ($n = 7$)
– to miss out on earlier made investments in case employees would leave the organization ($n = 1$)
Lack of confidence:
In the occupational health professional because they . . .
– work too slow ($n = 2$)
– do not have an active solution-oriented approach ($n = 2$)
– are eager to invoice ($n = 2$)
– are unable to tailor an approach to the individual employee ($n = 1$)
– lack competencies (i.e., to tune in on the employee) ($n = 1$)
In the method because . . .
– other similar instruments on the market available or the role of work is overestimated ($n = 2$)
– the preventive strategy may incur unintended consequences ($n = 3$)
Unclear . . .
– how the cost-benefit balance looks like ($n = 6$)
– what the precise benefits are ($n = 5$)
– what the timing of the benefits is ($n = 3$)
– to whom the benefits accrue ($n = 1$)
– how the information can be linked to the workplace ($n = 1$)
– how effectiveness can be inferred ($n = 4$)
– what the company's role is in the preventive strategy ($n = 1$)
Barriers at the level of employees
Lack of ability: employees have . . .
– no time perspective to see the value of the preventive strategy in a broader career perspective ($n = 3$)
– lack of skills to understand the purpose of the preventive strategy and/ or screening questions ($n = 3$)
– lack of skills to complete the online screening questionnaire ($n = 3$)
Low readiness: employees are not ready . . .
– to act upon outcome of online screening questionnaire and make necessary changes ($n = 2$)
– to reflect on their functioning as implied by the use of the preventive strategy ($n = 1$)
Low motivation: because employees . . .
– do not see the purpose of the preventive strategy ($n = 1$)
– have no confidence in the effectiveness of the preventive strategy ($n = 1$)
– regard the central focus of the preventive strategy as private issue ($n = 3$)
– do not have a need to participate in the preventive strategy because they are/feel currently healthy ($n = 3$)
– are afraid of bad news following the screening questionnaire ($n = 2$)
– do not want to think about the possible consequences in case they are on indication of "high risk" ($n = 2$)
Lack of trust:
In the method as employees . . .
– do not trust the confidentiality of data ($n = 11$)
– do not trust anonymity of data ($n = 4$)
– regard the preventive strategy as an infringement of the employer in private life ($n = 3$)
– anticipate misuse of sensitive information ($n = 5$)
– are afraid of indirect disclosure by follow-up action on indication of "high risk" ($n = 3$)
– do not trust the occupational physician ($n = 1$)
In the work environment as employees . . .
– anticipate lack of openness on psychological issues (taboo) ($n = 1$)
– anticipate lack of support and understanding of colleagues in case they are on indication of "high risk" ($n = 1$)

ceived employee-related barriers that have to do with either the employees' (lack of) ability, readiness, motivation, and trust to fully participate and engage with the preventive strategy.

Barriers related to the (lack of) ability of employees and their low readiness to participate in the preventive strategy were overall not that often reported. In cases where these were mentioned, they were often

Table 3
Facilitators at the level of employers and employees as perceived by employers for adoption and implementation of an indicated prevention strategy

Facilitators at the level of employers
Information or confidence in advance
– return on investment calculation ($n = 10$)
– more insight on advantages to employers ($n = 3$)
– have a clear business-case example ($n = 2$)
– overview of price-quality ($n = 1$)
– confidence in the expertise of the occupational health professional ($n = 3$)
Post-hoc feedback on
– the impact of the preventive strategy on the organization (preferably with benchmark) ($n = 5$)
– the situation of individual employees ($n = 5$)
– relevant subgroups of employees (e.g., departments) ($n = 2$)
– trends over time ($n = 2$)
– percentage of employees on indication of "high risk" ($n = 1$)
– experiences of employees with the preventive strategy ($n = 1$)
– unsuccessful interventions ($n = 1$)
– overall climate in the organization ($n = 1$)
– the process ($n = 2$)
– the non-responders ($n = 1$)
Context
– stability in the organization (e.g., no reorganization) ($n = 1$)
Financial support
– no cure, no pay policy ($n = 1$)
– receive financial support from government or industry ($n = 2$)
– financially rewarded by insurance company in case the preventive strategy is used ($n = 1$)
Facilitators at the level of employees
Trust and confidence
– culture of trust in the organization ($n = 6$)
– guarantee anonymity ($n = 3$)
– confidence in the trustworthiness of occupational health professional ($n = 4$)
– point out advantages to employees ($n = 4$)
– stress participation of employees as voluntary ($n = 1$)
– confidence in the expertise of the occupational health professional ($n = 2$)
– reassure feedback is given and follow-up measures are taken ($n = 2$)
Method-specific
– straightforward wording of questions in the screening questionnaire ($n = 1$)
– online screening questionnaire ($n = 2$)
– attention to the role of the work environment in the preventive strategy ($n = 1$)
Support and communication
– supportive role of line manager ($n = 1$)
– clear communication by management ($n = 2$)
– express enthusiasm and confidence by higher management ($n = 3$)
– start locally so success and participation can spread mouth-to-mouth throughout the organization ($n = 1$)

attributed to the low educational level of employees. Motivation-related barriers were also anticipated by employers. Several reasons were mentioned, but no specific cause of low motivation could be identified as of primary importance. Employers perceived the salience of trust-related issues of more importance. Almost all employers raised their concern that employees may not believe that the gathered information would be treated anonymously or as confidential. One third of the employers believed that employees would anticipate bearing the negative consequences when information is misused for other personnel-related decisions. To a lesser extent, employers also mentioned that the employees would also have trust issues with the working environment in which the preventive strategy would be implemented.

3.3. Employer perceived facilitators

Throughout the interview, employers also formulated in a "positive" way conditions (facilitators), which may overcome the anticipated barriers (Table 3). Respondents mentioned facilitators at the level of the employer and employees.

Concerning facilitators at the level of employers, employers named receiving more information in

advance to come to a decision on using the preventive strategy and post-hoc feedback after deployment as an important facilitator. Remarkably, one third of the employers also favored having information about high-risk employees, although during the short presentation on the preventive strategy, it was stated that gathered information on employees is protected by medical confidentiality. In addition, some employers aspired more insight into the potential benefits of the preventive strategy. Some employers also mentioned that to overcome financial hurdles, financial support from the industry or government, a "no cure, no pay" policy, or a financial reward by the insurance company would favor them adopting the preventive strategy.

Concerning facilitators at the level of employees, trust-related facilitators were most often mentioned by employers as important prerequisites for adopting the preventive strategy by employees. About one third of all employers stressed the importance of a "culture of trust," which implied mutual openness ("*to disclose,*" "*to value everyone,*" "*an open atmosphere*") and confidence between employees and employer as an important facilitator ("*everyone is confident that there will be no abuse of the results,*" "*high standards to be confidential with people and their data*"). Related to confidence, reference was made by the employers to the trustworthiness of the involved occupational health professional, the anonymity of the data gathered, the voluntary nature of the preventive strategy, providing feedback and follow-up, and more overall to the importance of stressing out the advantages to employees to participate in the preventive strategy. To a minor extent, method-specific issues were named (e.g., importance of using straightforward questions in the screening questionnaire) or facilitators that relate to providing support and communication directed to employees concerning the preventive strategy (e.g., supportive role of the line manager).

3.4. Intent to implement and its connections with underlying beliefs

When employers were asked whether they would consider the implementation of the preventive strategy, the majority responded affirmative. Two employers had no intention to implement the preventive strategy, eight employers had a weak to moderate intention to implement the preventive strategy of which seven made their decision contingent upon the fulfillment of specific conditions ($n = 7$, further labeled as the "conditional implementers") and one employer argued, "*I don't know why I wouldn't* [implement it]," while simultaneously, this person addressed that one should not expect much from the effectiveness of the preventive strategy ("*You should not make it heavier than it is, because you will not solve it* [preventing absenteeism] *for the majority*"). Five employers had a moderate to strong intention without any reservations when addressing the question (further labeled as the "implementer" group).

In the "implementer" group, the degree of adoption was notably higher, as all these employers anticipated three benefits (lower absenteeism, improve health, and lower care consumption) of the preventive strategy without any exception. In the other groups, consistency in the expected gains was clearly lacking across employers.

When considering the perceived barriers among the two employers that had no intention to implement the preventive strategy, both named lack of capacity as an important employer-related barrier. As one employer stated it:

> *There I had written down the workload. Whoever that is, is often HR, yes, I don't want to say it's the first point, but it often starts there, who has to manage people, check others, have you done that? I think the workload in HR will increase.*

Both employers also shared the concern that employees may not believe that the gathered information would be treated anonymously or as confidential. For example:

> *I think half of the people, but that is my opinion, if that is actually the case, I do not know, still thinks, it will probably not be anonymous. The company will be able to see that and then I have to log in online and I wonder where that ends up, yes, people still think like that.*

The group of "conditional implementers" referred to specific conditions when addressing the question on implementation: allocation of resources (i.e., personnel and time), better informed about the role of the company, a proactive approach from the occupational health professionals involved, growth in organizational size and/or professionalize ($n = 2$), and learn more from the results and experiences of other companies with the preventive strategy ($n = 2$). Because these prerequisites were tied to their answers regarding their implementation intentions, these can be seen as facilitators with high priority for these respondents.

When exploring the more general underlying issues, such as viewpoints on the responsibility of employers for employees' health and absence within these groups, we found some remarkable patterns. Typical for the "implementer" group was that they all acknowledged that employers have an important responsibility regarding employees' health and absence. When discussing how far their responsibilities have gone, one of these employers made it clear by turning it around, and said: "*For everything that affects the work. And actually that's everything. Actually, that's everything.*"

All other employers in the "implementer" group stressed their responsibility for the absence among their employees by acknowledging the role of work-related factors in the etiology of absence in some way. One employer gave a clear example related to absenteeism:

> *Look, that could be related to workload, for example, if we have too much workload in a certain department or with certain people. That is, of course, an indirect consequence of the policy we pursue. And, well, then we have to look, can we solve it in another way by accommodating the pressure. So I certainly feel responsible for that.*

Also, related to health, another employer within the "implementer" group clearly linked the work environment to the health of their employees and stated:

> *I think you have a shared responsibility as an employer. It is not the case that you can shift all responsibilities to the employer, but that you also include the employee that you expect he also treats his health well, and as an employer, I think that you are responsible for a good working atmosphere and a good climate, and I mean both physically and mentally, within the company.*

All employers in the "implementer" group also indicated that employees have a responsibility for health and absence (often, the term "*shared responsibility*" was used), but a remarkable difference in their narratives compared to the other employers is that none of the employers allocated the responsibility solely or primarily to the individual employee. "Blaming" the employee and/or his personal situation was more often seen among the other groups of employers. For instance, one respondent stressed a person's private situation as the primary cause of absence as follows:

> *How's your family doing? How is the atmosphere at home? How are the children doing at school? Do you have any hobbies? All those factors that determine how someone is and I think those factors outweigh the factor 'work.' Because you can just get out of here and go to another job. You cannot pick up things and move on to another family for example. Do you understand? So I think that we make the factor, 'work,' way more important in the Netherlands than it actually is.*

Also, in the non- "implementer" groups, impaired health was more often explained as a consequence of a poor lifestyle, for which primarily the employee was held responsible. One employer stated it as follows:

> *I am convinced that everyone should be responsible for it [health] themselves, but in practice, you notice that this is not enough, because I just see people walking around who still smoke, because I see that there are still people who weigh hundred kilos, because I see that there are still people who come to work by car. So you would like to give that responsibility to everyone and you also think that everyone should get it, but in practice, I think that people actually handle it very badly, themselves.*

The extent to which employers believed they were able to influence (prevent) the absence of employees and the extent to which employee health was already valued and shared at the workplace ("culture") was also explored. Yet, no clear patterns emerged from the data, as the beliefs or opinions of employers regarding these issues were distributed equally across groups.

3.5. Employee perspective

Employees in the focus group were generally reserved regarding the anticipated benefits of the preventive strategy. An often-heard response was: "*I think it could*" lower absenteeism "*but only if applied well.*" Also, concerning the gains for employee health, benefits were seen, but only conditional upon an employee's openness to the preventive strategy, e.g., "*If you are open to it, then it can help you.*" Awareness and making a subsequent change in one's lifestyle were also mentioned as the primary mechanisms through which the preventive strategy could contribute to employees' health. Concerning consumption of care, employees anticipated

an increase in preventive care or care in the short term, but "*with the idea of consuming less care over time.*"

Important barriers that were more intensively discussed by the employees during the focus group were the perceived distance toward the occupational health professional, lack of confidentiality, lack of follow-up by the employer, the potential unintended consequences, the wording of questions in the screening questionnaire, and the financial costs. First, the occupational health professional (often coined by respondents as the occupational physician) was regarded as someone too distal to appropriately deal with employee's personal or work-related problems. Respondents did not seem to associate the occupational physician with prevention of absenteeism or early intervention, but rather later in a trajectory: "*an occupational physician, that is, actually, in my opinion, if there is really something wrong and if you go into sickness for a long time and reintegration.*" Also, concerns related to the neutrality of the occupational physician were raised incidentally: "*The company doctor is paid by the employer, so I can imagine that he—who's . . . .*" It was also noted by respondents that in big companies, an occupational physician is better placed and known, but not in a small company, and that initiatives launched by an occupational health care professional could even deter people. Although not all respondents agreed on this last issue, for some, it would add to their sense of confidentiality. A second barrier for the employees in the focus group was lack of confidentiality. Respondents stressed its importance as: "*It should actually be confidential, that it is not misused,*" and also clearly discussed the implications they foresaw in case confidentiality was not provided: "*Oh wait, high-risk, I have to get rid of that person now.*" It was also mentioned by respondents that lack of confidentiality would lead to dishonest answers on the screening questionnaire. Confidentiality was seen by respondents as something that would also be difficult or even undesirable to establish: "*But in our situation, could such a thing be possible, could we? Then everything should be arranged first, I suppose?*" or "*But if he* [occupational health professional] *does not provide feedback, the employer cannot do anything. Because he doesn't know anything*" [to address work-related issues]. A third important anticipated barrier for employees was lack of follow-up by the employer. One employee stated it as: "*For me, the number one is feedback that something happens with it. And I have my big doubts about that in general,*" a concern that was shared by all. According to another respondent, it was typical for SMEs (and not only for their company) that initiatives like this are launched enthusiastically but "*it disappears somewhere in a drawer and you will never hear about it again*" and is taken over by a next initiative: "*Next time, we will invent something else and we will start enthusiastically.*" This was considered by employees as a serious let-down, undermining their participation. A fourth barrier of the preventive strategy was the potential unintended consequences. Employees suggested that the screening questionnaire could potentially lead to overreporting "*. . . thinking that he has something, when he actually has nothing. Are you not triggering the wrong thoughts?*" may even cause absenteeism after employees are inventoried as high-risk: "*If you are unlucky, they immediately report sick,*" psychological distress in case people cannot do anything about their situation "*If you are told that you have something you cannot do anything about, then that might start to work psychologically,*" or stigma "*If you are the only one who happens to be picked out, then you feel a bit watched.*" A fifth barrier that employees anticipated was the wording of the questions in the screening questionnaire. Reference was made to earlier experiences they had with surveys in general: the use of language (i.e., too abstract, too scientifically), open to all kinds of interpretations, requires reading comprehension, or is experienced as threatening: "*Well, if I read that question and I know if I answer this... Then I know what the conclusion is.*" Finally, costs associated with the use of the preventive strategy were not only a reported concern ("*And costs and people, people and costs, that's a very difficult combination*"), but also the possible costs when interventions are needed. Employees also felt that if employers want to deploy the preventive strategy "*then the employer must be prepared to invest in it,*" or costs should be covered by an insurance policy. In their view, it would also matter if the encountered "problem" would be work-related or personal. As one respondent put it, "*You also have to ask yourself, should the employer pay if you have private problems?*" Simultaneously, respondents also noted that the cost for employers, especially for SMEs, may be difficult to bear. And concerning investments of employers in a preventive strategy of absence, it was mentioned that in general SMEs: "*do what we can do. And we accept that if one* [employee] *falls out, it is just like that,*" and "*And then we'll see how we will solve that. I think that's kind of how SMEs deal with that.*"

Two important facilitators mentioned by employees were feedback and transparent communication by the company. Concerning feedback, employees felt a need to also know why they would be marked as high-risk in the screening questionnaire, in which area their problem could be situated (work-related or personal), personal advice upon completion, and information to further seek advice. Several of their concerns, such as lack of confidentiality and the unclear role of the occupational health professional, could be handled, according to respondents, if the employer would first communicate clear the "what" and "why" of the preventive strategy.

After the discussion rounds, all participants—when asked individually on paper—indicated to be willing to participate in the preventive strategy. Insight in one's own situation was reported most frequently ($n = 5$), followed by anticipated health benefits ($n = 4$) and prevention of absence ($n = 4$) as the most important reasons to participate in this preventive approach. For the most important reason to refrain from participating in this preventive approach, costs ($n = 4$), lack of confidence ($n = 2$), and privacy ($n = 1$) were mentioned. Two employees explicitly indicated lack of follow-up by the employer as the most important reason.

When exploring the more general underlying issues, such as viewpoints on the responsibility of employers and employees for employees' health and absence, employees attributed the responsibility of employee health to an important extent to the employee (e.g., "*Well, I think that the employee is basically responsible for his own health in the first instance,*" or "*I think that 90% of the responsibility lies with the employee himself.*" Also, ill health was in the minds of employees primarily associated with (poor) lifestyle (e.g., fitness, diet, smoking) and/or the busy lives of people (e.g., always online, endless choice-options). Absence was, according to our respondents, a shared responsibility of both the employee and employer, "*So that's about work, and I think they have fifty-fifty, both equally, responsibility,*" or somewhat more of the employer "*The responsibility for absenteeism, I think that that balance scale leans more toward the employer.*" In their narratives, reference was most often put on working conditions (e.g., high-work pressure) and poor ergonomics of the workplace as the causes for absenteeism. In turn, they also indicated that employees have to be open concerning the problems they may encounter, make appropriate use of the tools provided by the employer, and care for their own health.

4. Discussion

This study aimed to identify the facilitators and barriers for the adoption and implementation of an evidence-based indicated preventive strategy for the reduction of future long-term absence regarding SMEs. Recent studies have been concerned with identifying the factors for successful adoption and implementation of this preventive strategy [22, 23] in large international companies, but not in SMEs.

Overall, the results indicate that employers in our study had positive expectations concerning the gains of the preventive strategy. Employees were somewhat more reserved as they emphasized fulfillment of several conditions for the gains to occur. In general, respondents had a favorable reception of the preventive strategy, earlier unknown to them, as only two employers had no intention to implement the preventive strategy and none of the participating employees would refute participation upon invitation. These findings corroborate with earlier research that SMEs are also sensitive to the positive consequences like workers' wellbeing or reduction of absence-related costs when considering the implementation of strategies in the area of employee health and absence [35]. Compared to multinational companies, SMEs often lack a "culture of health" (characterized by values and activities directed to employee health) [23]. Yet, important drivers enabling the success of initiatives like the preventive strategy are, according to respondents, primarily based on shared responsibility and trust.

One key barrier widely shared across employers and employees concerned lack of confidentiality. This was also a concern for multinational companies in previous studies [22, 23], maybe even more in SMEs given the personal ties employers and employees have. Also, some employees questioned whether confidentiality would be feasible as regards SMEs, which probably relates to the more informal modes of employer–employee exchanges that they are acquainted with [32]. This barrier is likely to have ties to other barriers, such as unintended consequences of which stigmatization and discrimination following being screened as high-risk for long-term absence. An important addition from the employee focus group was the role of the occupational health professional. A minority of employers had concerns regarding occupational health professionals' lack of proactivity or ability to tune in on employees, whereas employees in general did not associate an actor like the occupational physician with the prevention of

absenteeism or early intervention. Clearly, there is a difference in expectations between employees and employers on the role of occupational health professionals like the occupational physician. Also, the role of the occupational physician is seemingly received more critically in SMEs than in multinational companies [22, 23]. An implication for the successful implementation of the preventive strategy is that the role of the occupational health professional in the prevention of absence should also be well clarified to all stakeholders. Nevertheless, concerns regarding the independent role of the occupational health professional are to be taken seriously, as they may be based on earlier experiences and/or have to do with the intertwining of interests like income insurance and occupational health care in SMEs.

Convergence between employees and employers also shows itself in other barriers, of which parties seem to stress related facets from their perspective. For instance, employers see lack of capacity (i.e., financial and non-financial resources) as the most important employer-related barrier for the preventive strategy. Simultaneously, from the employee perspective, lack of follow-up on behalf of the employer was considered a serious barrier. These findings can probably be linked to the scarcity of resources in SMEs to manage the work environment properly, as compared with larger companies [29, 30], and their orientation to more practical solutions that can be easily fitted in SME's workflow [25, 33]. Also, employees sense such an orientation in their company, i.e., solving problems when they are encountered.

Throughout the interviews, employees and employers mentioned several issues that remained unclear (e.g., the "what," "why," and "when" of the benefits and costs or methodology (e.g., questions in the screening questionnaire), or reporting of feedback), which, if unaddressed, will act as barriers. These issues are likely to be resolved by providing employers and employees with more information, which was, in the context of this study, only provided in a very basic form. Receiving more information was also named by employers as an important facilitator.

More difficult to address are underlying beliefs that have ties to the adoption and implementation of the preventive strategy. Our analysis reveals that employers' viewpoints on their responsibility for employees' health and absence are connected with their intention to implement the preventive strategy. Employers who acknowledged the (shared) responsibility of the employer concerning absence or employee health were also more inclined to implement the preventive strategy, whereas those who were less eager to implement the preventive strategy emphasized the individual employee responsibility. Typically, non-implementers felt that the factor, work, compared to non-work-related causes of absence is overrated and that impaired health was more often explained as a consequence of poor lifestyle choices for which the employee can be held accountable. In contrast, employers who were inclined to implement the preventive strategy all acknowledged the importance of work-related factors for employee health and absence. Simultaneously, employees themselves also felt primarily responsible for their own health. Absence is differently appraised compared to health; employees acknowledge a shared responsibility: the employer is responsible for the working conditions and the employee to appropriately respond to what the employer provides in and one's own health. One implication for the successful implementation of this preventive strategy is that the employer responsibility could be encouraged but without detracting from the personal responsibility that employees experience and value, as also found in other studies on the introduction of work-site health interventions [42]. A second implication for successful implementation is that the dichotomy between the work-and non-work-related roots of employee health and absence should be bridged. This duality does not align with scientific evidence and frameworks like the International Classification of Functioning, Disability and Health (ICF) that propagate the complex interplay of both work-and non-work-related factors regarding an employee's health and functioning [9, 43, 44]. Relatedly, it should also be noted that when it concerns the causes of health and absence, employers and employees stress the physical working environment and lifestyle factors in their narratives. The psychosocial dimension in both the causes and the nature of health and employee functioning remains underexposed in their narratives. These divides could hinder the adoption or implementation of preventive strategies because they may lead to unfruitful discussions, such as making the financial cost of participating in the preventive strategy dependent upon the assumed roots of the "problem" as either work-related or personal. Besides that such beliefs may keep employee barriers relating to the financial aspect vivid, it may also create unrealistic expectations concerning feedback to employees (i.e., whether the problem is work or non-work related). Personal feedback is an important facilitator for employees and employers but

should be realistic and match with what the underlying science can provide.

Concerning feedback, several misconceptions are also noted. Employers preferably would be informed sooner about possible (hidden) problems leading to possible absenteeism and act upon that information. Yet, the screening questionnaire cannot indicate what the specific problem is, nor can the answers of employees be shared with employers, as these are protected by the medical confidentiality of the occupational health professional. In addition, concerns like the unintended consequences of filling in a screening questionnaire (e.g., "*I have something, so I'm sick*") are misconceptions based on the idea that individuals without any clarification by a trained occupational health physician would be informed about their high-risk status. Also, occupational health professionals can address a person's health beliefs or experience of anxiety following a positive test result. Addressing these possible misconceptions in advance by transparent communication to all stakeholders and supporting SMEs in their communication to employees will be a key to the successful implementation of the preventive strategy. A leaflet is unlikely to suffice; potentially, trajectories may kick off with a start-up meeting organized on the premises of a company, open to employees, and involvement of the researchers may be a good start. A related idea was raised during the focus group.

However, this study also has several limitations. We only included employees from one SME and did not incorporate other relevant stakeholders like the occupational health professional in this study. Our primary group of stakeholders was the management of SMEs, as their opinions on opportunities, barriers, and facilitators are the first hurdle to any implementation in practice. For that reason, our primary data concern the 15 interviews with managers, and the focus group with employees should rather be seen as the first complementary exploration of the views of another relevant stakeholder. Currently, insights that stem from the focus group do not give a widespread understanding of employees' perspectives, and future research should investigate this stakeholder group more in-depth. Also, focus groups are different from individual interviews, as deviant personal opinions may be obscured by the majority group. As the information we gave to respondents on the preventive strategy was minimal, we could not always establish whether barriers and facilitators were tied to one of the specific steps of the preventive strategy (i.e., the screening questionnaire or the early intervention), specifically. Also, it may have led to an overreporting of barriers, in particular, concerning unclear issues of the preventive strategy. Participating companies are not representative of SMEs in the Netherlands, or even Limburg, although the representation of various typical industries (e.g., transportation, agriculture, and industry) was sought after. The picture that emerges from this study is likely to give a broad overview of all possible views on the opportunities, barriers, and facilitators linked to the preventive strategy. Concurrently, it is likely that the salience of particular issues may be different in specific sectors. The generalizability of our findings is further limited to countries in which the employer is responsible to pay for sick workers (like Finland and Norway) and has a stake in preventing absence by implementing an indicated prevention strategy. In countries where the responsibility for absence and the costs are shifted solely toward employees and society (like Belgium), employers will probably have no/limited incentive to implement a strategy directed at the prevention of future long-term absence. Also, the role of the occupational physician in the prevention of absence is typical for the context of our study.

5. Conclusion

Overall, this study provides insight into the possible barriers and facilitators that employers and employees of SMEs anticipate when considering the implementation of an indicated prevention strategy to prevent future long-term absence. Furthermore, the detailed picture of possible barriers and facilitators gives clues for a wider and optimal implementation of this scientifically proven strategy from which more employees could benefit. Also, this study has shown that this is unlikely to only constitute quick fixes of loosely coupled barriers and facilitators, as our results also demonstrate how these have roots in beliefs about responsibilities and of the factors responsible for employee health and absence. For future research, it is recommended to study the employee perspective in more depth and to consider other stakeholders, such as occupational health professionals.

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national

research committee and with the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.

Informed consent

Informed consent was obtained from all individual participants included in the study.

Conflict of interest

None of the authors have any conflicts of interest to report.

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