## PEER REVIEW HISTORY



## ARTICLE DETAILS

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| **TITLE (PROVISIONAL)** | The transition between work, sickness absence and pension in a cohort of Danish colorectal cancer survivors |
| **AUTHORS** | Carlsen, Kathrine; Harling, Henrik; Pedersen, Jacob; Christensen, Karl; Osler, Merete |

## VERSION 1 - REVIEW

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| **REVIEWER** | Alv A. Dahl, MD, PhD<br>Senior Research Consultant<br>Oslo University Hospital, Radiumhospitalet<br>Oslo, Norway |
| **REVIEW RETURNED** | 10-Nov-2012 |

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| **GENERAL COMMENTS** | This Danish register-based cohort study concerns colorectal cancer survivors and their movements between work, sickness absence and pension. Although the opportunities for such studies are excellent in Denmark, I have several concerns about the present manuscript:<br><br>**Major concerns**<br><br>1) *Lack of cancer-free matched controls.* Based on unique person numbers matched controls for the cases could reasonably have been drawn, and such data would have increased the perspectives of the study. I urge the authors to explain why they did not choose such a design.<br><br>2) *Lack of explanation of the Danish National Insurance Scheme.* In order to understand the movements in relation to work life, the Danish rules for sick-leave, rehabilitation and unemployment support as well as disability pension have to be spelled out. Closely related to such information, is the issue of external validity. To what extent can these findings based on Danish rules and regulations be generalized to countries with other Insurance Schemes? The answer determines the international value of the paper.<br><br>3) *Choice of statistical model.* Though I am not a statistician, I have considerable statistical knowledge, but still I find the statistics section hard to understand. Partly it has to do with language and expressions like (bottom page 7): “If a person received a transfer payment that did not fit any of the four states (i.e. education) the time was censored but the person was allowed |

back into the model if he afterwards received a transfer payment fitting one of the four states." Since "transfer payment" is nowhere defined, this is hard to understand. And their definition of "in work" is no better: "In work was defined as not receiving any social transfer payments for six consecutive weeks" – why six weeks by the way? Is "transfer income" the same as "transfer payment" – if so why use two expressions?

The authors state that a multistate model was use and refer to Pedersen et al (ref #28). In order to become wiser; I looked into that paper. They present the "flexicurity model" just cursory mentioned by the present authors on the top of page 7 which is "The general understanding of the consequences lies in the flow between different states such as work, unemployment, sickness absence, and disability pension." So is the present paper describing the "flexicurity model" applied to colorectal cancer patients? The multistate model described by Pedersen et al. seems to stem from the Norwegian SA Lie (Scand J Pub Health 2008;36:279-86), not mentioned in the reference list of the present manuscript.

Both Pedersen et al and Øyeflaten et al (BMC Public Health 2012,12:748) use Lie's multistate model, but they both explain the models and the various states much better than the present authors. I also think the authors should present a figure like Figure 1 of Øyeflaten et al.

Other ways of using Cox proportional hazard models for change of status over time

are presented by Gjesdal et al. (Nord J Psychiatry 2008;62:294) and Hauglann et al (J Cancer Surviv 2012;6:3459) and should be considered by the authors.

Sickness absence, work, unemployment and retirement are interrelated which should call for interaction analyses, that are not mentioned.

The editor is recommended to let an expert statistician evaluate the methods used by these authors and their way of presenting it.

4) *Lack of description of covariates.* The ASA score is not explained, nor what is meant by postoperative complications. The information collected from the IDA has to be specified and operationalized. Concerning co-morbidities it is unclear how the Charlson index was calculated and what the basis for dichotomization was? If the study concerns individuals who get cancer between 2001 and 2009, why then is data from the DREAM register "since 1991 until week 13 in 2001" relevant?

On page 8 I have trouble understanding the statement: "Besides the covariates concerning gender, age, etc each record included three variables that was processed during follow up and was both time and state dependent. Each of the processed time and state dependent covariates did hold the present number of times the person had experienced work, sick-

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| | listing or unemployment counted from start to follow up" Here the "number of times" are used, while a few lines later "the duration of weeks" are mentioned. Were both these variables used or what?<br><br>*5) What is the study population?* Under this heading on page 7 is written: The study population comprised 31.570 persons diagnosed with colorectal cancer between 2001 and 2009. Of these we included 4.343 persons aged 18-63 years, who were part of the workforce and survived the first postoperative year." In my view the study population is 4.343 persons not 31.570. I do not think we need Figure 2 to state this. And why were not those not surviving the first postoperative year included?<br><br>6) *The conclusion is strange.* The same statement is given both in the Abstract and in the Conclusion. After description of the transitions the authors state: "This leads to an increased focus on early detection of colorectal cancer, and the importance of avoidance of post-operative complication. But such detection and avoidance are general medical principles which are not geared by transitions, which is a consequence. Please, rephrase this.<br><br>**Minor concerns:**<br><br>1) *Lack of aims and hypotheses.* These should be stated. "To look more in depth" is not a scientific term.<br><br>*2) Why was not chemotherapy included?* So far as I can see the study included only surgery, so why was chemotherapy excluded?<br><br>*3) Is rehabilitation/work training part of the unemployment state?* This should be explained.<br><br>*4) Table 1. Why present the two excluded populations?* And is there any meaning in testing statistical differences between these groups when it is not an aim or mentioned in the discussion.<br><br>*5) What is the meaning of ** in Table 3 and 4?*<br><br>*6) Several references are incomplete.* #3, 17, 20, 24, 28. |

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| **REVIEWER** | Sjovall, Katarina<br>Lund University |

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| | No competing Interests |
| **REVIEW RETURNED** | 21-Nov-2012 |

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| **THE STUDY** | Clarify if the outcome retirement is equal to early retirement. What is the age of retirement in Denmark? 63 or 65?<br>It is not clear from where data on retirement is obtained.<br><br>It is nor clear how follow-up time differ in the subpopulations in different diagnosis years<br><br>What about own-business holders, are they included in the social security system?<br><br>Abbreviations in text and tables should be clarified (SES, SEP...) |
| **REPORTING & ETHICS** | Ethical considerations not included |

## VERSION 1 – AUTHOR RESPONSE

Reviewer: Alv A. Dahl, MD, PhD
Senior Research Consultant
Oslo University Hospital, Radiumhospitalet
Oslo, Norway

This Danish register-based cohort study concerns colorectal cancer survivors and their movements between work, sickness absence and pension. Although the opportunities for such studies are excellent in Denmark, I have several concerns about the present manuscript:

Major concerns

1) Lack of cancer-free matched controls. Based on unique person numbers matched controls for the cases could reasonably have been drawn, and such data would have increased the perspectives of the study. I urge the authors to explain why they did not choose such a design.

Answer: We do fully understand the concern about the lack of a cancer-free control group, but the aim of the study was not to find out whether persons diagnosed with colorectal cancer had an increased risk for early retirement pension or sickness leave compared to a cancer-free control group neither was the intention to find out if the risk factors for sick leave or pension differed between cancer survivors and the background population. The aim of the present study was to analyze the impact of both socioeconomic factors and clinical factors on the transitions between different stages and to test for interaction between clinical factors and socioeconomic factors.

In two previous studies we have compared cancer patients with a cancer free control group. In the first study 1 we found no effect of colorectal cancer on the risk for unemployment compared to the cancer free control group and observed that the risk factors for unemployment during follow up were the same among cancer survivors and the cancer free control group. In the other study 2 we found an increased risk for early retirement pension among both men and women diagnosed with colorectal cancer compared to the cancer free control group. This point's towards different mechanisms with regard to the pathway from diagnosis and treatment to early retirement and unemployment. In the present study our intention was to get more into depth with the risk factors for the transitions between the different stages and this has been cleared in the last two paragraphs of the introduction.

Page 4 line 20:

'In order to get a better understanding of the occupational consequences of colorectal cancer it is important to take both socioeconomic and health related factors into account and to differentiate more specifically between the different reasons for not working. In the majority of studies the outcome is

‘not returning to work’ which is a mix-up of different reasons for not working, i.e. unemployment, sickness absence or disability pension and the transition from a cancer diagnosis to one of these outcomes could very well differ according to different risk factors.’

Page 5 line 11:
‘….a cohort of colorectal cancer survivors and to test for interaction between clinical and socioeconomic factors.’

In addition, in the result section we have specified that we did not find any interaction between socioeconomic factors and factors related to the disease:
Page 11 line 10: ‘Finally, we analyzed for effect modification by adding an interaction in the logistic model between disposal income as the strongest socioeconomic predictor and type of cancer, stage of disease, type of operation and post-operative complications. We did not find any significant effect modification between socioeconomic factors and disease related factors (Data not shown).’

2) Lack of explanation of the Danish National Insurance Scheme. In order to understand the movements in relation to work life, the Danish rules for sick-leave, rehabilitation and unemployment support as well as disability pension have to be spelled out. Closely related to such information, is the issue of external validity. To what extent can these findings based on Danish rules and regulations be generalized to countries with other Insurance Schemes? The answer determines the international value of the paper.
Answer: We agree that a short description of the Danish National Insurance Scheme makes the understanding of the transitions between the different stages more clear and that the sentence on page 7 ‘The Danish labor market is characterized as a flexicurity system’ need to be clarified. We have therefore included the following sentence in the manuscript:

Page 7 line 22:
‘The Danish labor market is characterized as a flexicurity system with a high degree of economic compensation in case of unemployment or reduced work ability (security) but also with a high turnover rate (flexible). Unemployed persons are warranted economic compensation if they are actively seeking job. During the study period it was possible to receive a maximum of four years of unemployment benefit. After the end of these four years or if a person is not qualified for unemployment benefit (i.e. not member of a union) it is possible to receive social income. If a person is unable to work due to illness or disability it is possible to receive sickness benefit for a maximum of 52 weeks during a period of two years or apply for early retirement if the work ability is reduced to a level where it is not possible to hold a job.’

In addition we have included the following sentence in the discussion under the headline ‘Strengths and limitations’:
Page 14 line 7:
‘The present study is conducted in a Nordic welfare system with high turnover rates on the labour market, high rates of participation and high degrees of social security. Despite the fact that the expenditures to social protection in the Nordic countries including Denmark is higher compared to the rest of the European Union and countries as US and Canada they all have some degree of social welfare systems and universal health care. The size of economic compensation and duration of sickness absence might have an impact on the consequence of a chronic disease but the risk factors and reasons for being on sickness absence or return to work is not influenced by the political context.
’

3) Choice of statistical model. Though I am not a statistician, I have considerable statistical knowledge, but still I find the statistics section hard to understand. Partly it has to do with language and expressions like (bottom page 7): “If a person received a transfer payment that did not fit any of the four states (i.e. education) the time was censored but the person was allowed back into the model if he afterwards received a transfer payment fitting one of the four states.” Since “transfer payment” is nowhere defined, this is hard to understand. And their definition of “in work” is no better: “In work was defined as not receiving any social transfer payments for six consecutive weeks” – why six weeks by the way? Is “transfer income” the same as “transfer payment” – if so why use two expressions? The authors state that a multistate model was use and refer to Pedersen et al (ref #28). In order to become wiser; I looked into that paper. They present the “flexicurity model” just cursory mentioned by the present authors on the top of page 7 which is “The general understanding of the consequences lies in the flow between different states such as work, unemployment, sickness absence, and disability pension.” So is the present paper describing the “flexicurity model” applied to colorectal cancer patients? The multistate model described by Pedersen et al. seems to stem from the Norwegian SA Lie (Scand J Pub Health 2008;36:279-86), not mentioned in the reference list of the present manuscript.
Both Pedersen et al and Øyeflaten et al (BMC Public Health 2012,12:748) use Lie’s multistate model, but they both explain the models and the various states much better than the present authors. I also think the authors should present a figure like Figure 1 of Øyeflaten et al.
Other ways of using Cox proportional hazard models for change of status over time
are presented by Gjesdal et al. (Nord J Psychiatry 2008;62:294) and Hauglann et al (J Cancer Surviv 2012;6:3459) and should be considered by the authors.
Sickness absence, work, unemployment and retirement are interrelated which should call for interaction analyses, that are not mentioned.
The editor is recommended to let an expert statistician evaluate the methods used by these authors and their way of presenting it.
Answer: We agree in your comments and acknowledge that this section could have been formulated more clearly. A total rewriting of it has therefore been made by a biostatistician (Karl Bang Christensen) who has many years of experience in working with these models.

The paragraph statistical analysis has been changed to:
Page 9 line 10:
‘Descriptive analysis by use of chi2 and t-tests was conducted in order to examine the characteristics of the sample. The outcome data was recoded and for each person time spent in one of the four states was registered. Furthermore it was registered if a transition to another state occurred at the end of the persons stay in the state, and, if so, what state the person shifted to. The time spent in the state was censored if the person died, emigrated, or shifted to a social transfer payment that did not fit any of the four states.

Each of the nine possible transitions shown in Figure 1 was analysed using the Cox proportional hazards model in SAS (The PHREG procedure, SAS version 9.2). The time scale used was duration of stay in current state.
The variables education, disposal income, job type, type of cancer, cancer stage, comorbidity, ASA score, curative operation, type of operation, post-operative complications were included as time constant covariates. Three time dependent covariates were also included: number of times the person been employed, had been sick-listed, or unemployment since the start of follow up.’
Because the baseline hazard for each state was allowed to vary freely, the covariate relied on the assumption of proportionality.

In addition we have included a paragraph describing the outcome data:
Page 9 line 2:
‘Outcome data

For every person in the study population labour market status was recorded on a weekly basis until the person reached the age limit of 63 years, emigrated, died, or until the end of follow-up whichever came first. Labour market status was categorized in four different 'states': work, sickness absence, unemployment, and disability. The multi-state model is a model for the nine possible transitions between these four states (Figure 1). '

Finally we have included a section in the introduction in order to give some background information about the model including the references mentioned by you.
Page 5 line 3:
'These transitions between different states (e.g. from sickness absence to work, or from sickness absence to disability) can be modeled by using multi-state models3. Multi-state models are well-known statistical models used for event history analysis, e.g. the study of survival. The application of statistical models for survival analysis in the analysis of sickness absence is relatively new4;5 and the use of multi-state models is mainly due to Lie et al6 , but multi-state models have also been applied by other researchers7;8.'

4) Lack of description of covariates. The ASA score is not explained, nor what is meant by postoperative complications. The information collected from the IDA has to be specified and operationalized. Concerning co-morbidities it is unclear how the Charlson index was calculated and what the basis for dichotomization was? If the study concerns individuals who get cancer between 2001 and 2009, why then is data from the DREAM register "since 1991 until week 13 in 2001" relevant?

Answer: We have changed the description of the covariates according to your suggestions:
Page 6 line 4:
'Health status at time of surgery was measured by ASA score (according to the American Society of Anesthesiologists) where patients are categorized into five subgroups by preoperative physical fitness reaching from I - A completely healthy patient to V - A moribund patient who is not expected to live 24 hours with or without surgery. ASA score III-V was collapsed into one group of patients with severe systemic diseases. Postoperative complications were grouped as no complications or one or more complications. The latter group included postoperative bleeding, problems with the ostomy, intra-abdominal infections or infections in the wound, lack of passage through the intestine, leak from the intestine or postoperative rupture of the wound.
'
Page 6 line 17:
'From IDA we had information about country of origin (grouped as born in Denmark or born outside Denmark) and marital status (married or cohabiting, single including widows and unknown). Education was classified according to length of study (primary school 9-12 years of education, vocational and short education 13-15 years, medium and long education more than 16 years and unknown). Job type was classified as management and knowledge work (e.g. leaders, doctors and teachers at high school), office and sale (e.g. secretary, police and nurses) and manual work (e.g. farmers, craftsmen and social and health care assistants). In order to obtain information on disposal income for the family we also identified partners and their income. Disposal income was calculated as the average of the family income three years before the year of diagnosis and was deflated according to the 2000 value of the Danish kroner.
Education, job type and disposal income were combined under the heading socioeconomic status (SES).'
Page 7 line 16:
'Co-morbidity preceding five years before the year of diagnosis was obtained from NPR and RMPS. As comorbidity we included cardiovascular disease, chronic obstructive pulmonary disease, diabetes and liver, kidney or connective tissue diseases – diseases which are all part of the Charlson index. Comorbidity was stated if one or more of these diseases were present at time of diagnosis.'

We are sorry for the typing error it should have been 2010 and not 2001. We have changed the sentence in order to clarify the included years.
Page 8 line 5:
'DREAM covers all residents in Denmark who have received social transfer payments from the state 9 in any given week since 1991. In the present study we included data from DREAM from week 1 in 2001 until week 13 in 2011.'

On page 8 I have trouble understanding the statement: "Besides the covariates concerning gender, age, etc each record included three variables that was processed during follow up and was both time and state dependent. Each of the processed time and state dependent covariates did hold the present number of times the person had experienced work, sick-listing or unemployment counted from start to follow up" Here the "number of times" are used, while a few lines later "the duration of weeks" are mentioned. Were both these variables used or what?
Answer: As we have circumscribed the paragraph Statistical analysis this point should be more clear now.

5) What is the study population? Under this heading on page 7 is written: The study population comprised 31.570 persons diagnosed with colorectal cancer between 2001 and 2009. Of these we included 4.343 persons aged 18-63 years, who were part of the workforce and survived the first postoperative year." In my view the study population is 4.343 persons not 31.570. I do not think we need Figure 2 to state this. And why were not those not surviving the first postoperative year included?
Answer: We agree that this could have been formulated more clearly, but think the total number of colorectal cancer patients is important in order to get a fully understanding of the population. We have changed the sentence in the manuscript but maintained figure 2:

Page 8 line 19:
'In the years 2001 to 2009 31.570 persons were diagnosed with colorectal cancer in Denmark. The majority of these persons were diagnosed after the age of retirement and the study population consists of 4.343 persons aged 18-63 years, who were part of the workforce and survived the first postoperative year (fig. 2). The follow-up period of this population was between 65 weeks (for persons diagnosed in the last week of 2009) to 535 week (for persons diagnosed in the first week of 2001) leading to 12.569 person years.'

As the outcome under study is the transition between work, sickness absence and early retirement we excluded those persons who died or retired during the first year as it does not make sense to discuss labor market participation in that group. The vast majority of colorectal cancer survivors who retire during the first year are too ill to work and returning to work is out of reach. We have not made any changes in the text regarding this statement.

6) The conclusion is strange. The same statement is given both in the Abstract and in the Conclusion. After description of the transitions the authors state: "This leads to an increased focus on early detection of colorectal cancer, and the importance of avoidance of post-operative complication. But such detection and avoidance are general medical principles which are not geared by transitions, which is a consequence. Please, rephrase this.
Answer: According to your suggestions we have reformulated the conclusion.
Page 14 line 20: 'This leads to an increased focus on the rehabilitation process for the more vulnerable persons who have a history of work related problems with episodes outside the working market. In addition, special attention should be on the impact complications and stage of disease has on the work ability in order to reduce the risk for sickness absence and retirement years after

operation.'

Minor concerns:
1) Lack of aims and hypotheses. These should be stated. "To look more in depth" is not a scientific term.
Answer: We agree and have rewritten the aim of the study.
Page 4 line 20:
'In order to get a better understanding of the occupational consequences of colorectal cancer it is important to take both socioeconomic and health related factors into account and to differentiate more specifically between the different reasons for not working. In the majority of studies the outcome is 'not returning to work' which is a mix-up of different reasons for not working, i.e. unemployment, sickness absence or disability pension and the transition from a cancer diagnosis to one of these outcomes could very well differ according to different risk factors.'

2) Why was not chemotherapy included? So far as I can see the study included only surgery, so why was chemotherapy excluded?
Answer:
Unfortunately we have no information about chemotherapy or other complementary treatments.

3) Is rehabilitation/work training part of the unemployment state? This should be explained.
Answer:
Persons in rehabilitation and work training are excluded from the analysis until they return to 'normal' work, get unemployed receive sickness benefit or get a pension. This has been clarified in the description of the statistical model.

4) Table 1. Why present the two excluded populations? And is there any meaning in testing statistical differences between these groups when it is not an aim or mentioned in the discussion.
Answer: We do fully agree with your comment and have deleted the first column of table 1 (including changed the heading) and have changed the first sentence of the result section:
Page 10 line 5:
'Table 1 shows the baseline characteristics for all patients stratified on those excluded during the first year after diagnosis (N=1689) and the study population (N=4343). Compared to the excluded population the study population was diagnosed with significantly less severe disease and higher SES at time of inclusion.'

5) What is the meaning of ** in Table 3 and 4?
Answer: This is clearly our mistake. We have changed the notes so that ¤ represents a p-value between 0.05 and 0.0001 whereas ¤¤ represents a p-value of <.0001. This has been corrected in tables 3, 4 and 5.

6) Several references are incomplete. #3, 17, 20, 24, 28.
Answer: This has been corrected.

Reviewer: I hereby declare that I have no competing interest in this study.
Katarina Sjövall
Lund University

Clarify if the outcome retirement is equal to early retirement. What is the age of retirement in Denmark? 63 or 65?
Answer: We have clarified this in the sentence page 8 line 8:

‘Transfer income obtained from DREAM was divided into sickness benefit, unemployment benefit and permanent withdrawal from the workforce due to early retirement pension or post-employment benefit, which is an optional withdraw from the workforce not caused by disability.’

And at page 8 line 7 we have included a sentence about the pension age in Denmark.
‘During the study period the retirement age was 64 years of age.’

It is not clear from where data on retirement is obtained.
Answer: This has been stated more clearly on page 8 line 13:
‘Transfer income obtained from DREAM was divided into sickness benefit, unemployment benefit and permanent withdrawal from the workforce due to early retirement pension or post-employment benefit, which is an optional withdraw from the workforce not caused by disability.’

It is nor clear how follow-up time differ in the subpopulations in different diagnosis years
Answer: This has been explained on page 8 line 17:
‘The follow-up period of this population was between 65 weeks (for persons diagnosed in the last week of 2009) to 535 week (for persons diagnosed in the first week of 2001) leading to 12.569 person years.’

What about own-business holders, are they included in the social security system?
Answer: Sickness absence and early retirement pension due to disability is guaranteed to all citizens in Denmark independent of job type. Unemployment benefit requires membership of a union. In the years 2001-2009 the majority of own-business holders was members of a union and could by that receive unemployment benefit.
This has been précised on page 8 line 1:
‘During the study period it was possible to receive a maximum of four years of unemployment benefit. After the end of these four years or if a person is not qualified for unemployment benefit (i.e. not member of a union) it is possible to receive social income. If a person is unable to work due to illness or disability it is possible to receive sickness benefit for a maximum of 52 weeks during a period of two years or apply for early retirement if the work ability is reduced to a level where it is not possible to hold a job. This holds for all Danish citizens independent of job type.’

Abbreviations in text and tables should be clarified (SES, SEP...)
Answer: On page 7 line 3 we have included the following sentence:
‘Education, job type and disposal income were combined under the heading socioeconomic status (SES).’
In table 3 and 4 we have added a footnote ‘§: SES (Socioeconomic status): education, disposal income and job type’

Ethical considerations not included
Answer: We are sorry for that and have in the new manuscript included a paragraph on page 15 line 6:
‘Ethics approval: The study based solely on national and administrative registers and did not require any approval from the ethics committee according to national regulations.’

Reference List

(1) Carlsen K, Dalton SO, Diderichsen F, Johansen C. Risk for unemployment of cancer survivors: A Danish cohort study. Eur J Cancer 2008; 44(13):1866-1874.
(2) Carlsen K, Oksbjerg DS, Frederiksen K, Diderichsen F, Johansen C. Cancer and the risk for taking early retirement pension: a Danish cohort study. Scand J Public Health 2008; 36(2):117-125.

(3) Andersen PK, Keiding N. Multi-state models for event history analysis. Stat Methods Med Res 2002; 11(2):91-115.
(4) Christensen KB, Andersen PK, Smith-Hansen L, Nielsen ML, Kristensen TS. Analyzing sickness absence with statistical models for survival data. Scand J Work Environ Health 2007; 33(3):233-239.
(5) Gjesdal S, Ringdal PR, Haug K, Maeland JG. Long-term sickness absence and disability pension with psychiatric diagnoses: a population-based cohort study. Nord J Psychiatry 2008; 62(4):294-301.
(6) Lie SA, Eriksen HR, Ursin H, Hagen EM. A multi-state model for sick-leave data applied to a randomized control trial study of low back pain. Scand J Public Health 2008; 36(3):279-283.
(7) Pedersen J, Bjorner JB, Burr H, Christensen KB. Transitions between sickness absence, work, unemployment, and disability in Denmark 2004-2008. Scand J Work Environ Health 2012; 38(6):516-526.
(8) Oyeflaten I, Lie SA, Ihlebaek CM, Eriksen HR. Multiple transitions in sick leave, disability benefits, and return to work. - A 4-year follow-up of patients participating in a work-related rehabilitation program. BMC Public Health 2012; 12:748.
(9) Hjollund NH, Larsen FB, Andersen JH. Register-based follow-up of social benefits and other transfer payments: accuracy and degree of completeness in a Danish interdepartmental administrative database compared with a population-based survey. Scand J Public Health 2007; 35(5):497-502.