Continuing at work
Long-term illness, return to work schemes and the role of industrial relations

Edited by
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Introduction
Returning to work after chronic illness: elevating the role of the social partners

Mehtap Akgüç
With contributions by Ziv Amir and Paula Franklin

1. Context

Demographic change, including ageing and longevity, together with the transforming world of labour, have implications for the proper functioning of labour markets across European countries. According to recent estimates, one-third of the population in Europe is expected to be aged 65 or older by 2070 (compared to one-fifth in 2019), while life expectancy is expected to increase to 86 for men and 90 for women by the same date.[1] As the population gets older and working lives increase, it may be expected that a growing number of workers will face health conditions that might lead to their absence from work or to them working on while ill (EU-OSHA 2016).

In the meantime, demographic change is likely to create societal challenges such as a shrinking workforce or the sustainability of social security systems, calling for policy action to sustain economic growth while ensuring inclusive and prosperous European economies. Some policy measures include extending working lives via increases in the retirement age, or active ageing, as well as promoting the return to work and the reintegration and retention of individuals who have been absent from work due to chronic health conditions or disability. Other workplace support and adjustment measures, alongside underlying legislation, are preconditions for facilitating the reintegration of individuals with chronic illnesses (or disabilities) into the labour market (Amir *et al.* 2010). It is this notion of the return to work that is at the core of this book.

In relation to this, Principle 17 of the European Pillar of Social Rights specifically states that 'people with disabilities have the right to income support that ensures living in dignity, services that enable them to participate in the labour market and in society, and a work environment adapted to their needs.[2] While the Pillar refers to disabled people, the dividing line between chronic illnesses and disability is blurred and long-term sickness absence is often a precursor of disability (OECD 2010). In either case, the extent to which policies are implemented or relevant services put in place to facilitate the return to work, or reintegrate workers with chronic diseases or disabilities which limit their abilities to perform their work, is an open question.

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1. For more detail, see the dedicated website on the impact of demographic change in Europe: https://ec.europa.eu/info/strategy/priorities-2019-2024/new-push-european-democracy/impact-demographic-change-europe_en
2. https://ec.europa.eu/info/sites/info/files/social-summit-european-pillar-social-rights-booklet_en.pdf

Meanwhile industrial relations structures and actors, representing the interests of workers and employers, constitute key components of labour markets contributing to their smooth functioning and improving the working environment. Since industrial actors aim to strike a balance between the needs of employers and workers, the involvement of the social partners in tackling the implications of demographic change in the workplace and dealing with the return to work calls for in-depth investigation.

In this context, this book brings together two strands of research, one on the return to work and the other on industrial relations, with the objective of developing our expertise on the role which industrial relations structures and actors play at EU level and in member states in addressing and facilitating the return to work and retaining workers experiencing chronic illness in the workplace.

1.1 Chronic diseases and illness

Centers for Disease Control and Prevention, a US agency, defines chronic diseases broadly as 'conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both.'[3] Chronic diseases are the leading causes of death and disability worldwide and are understood as those of long duration (with or without a cure) and slow progression. Prominent examples include cardiovascular diseases, cancer, diabetes, musculoskeletal diseases and mental illnesses. The World Health Organization states that most chronic diseases are linked by common biological risk factors – notably high blood pressure, high blood cholesterol and obesity – and are preventable with policies that address the determinants of the related behavioural risk factors (e.g. unhealthy diet, physical inactivity and tobacco use).[4] Such diseases imply a significant burden on the health and well-being of the workforce; constitute the main cause of mortality and morbidity in the EU (Guazzi *et al.* 2014); and have considerable economic consequences for individuals, such as lower pay or rates of labour force participation (Busse *et al.* 2010), and for national economies through reduced labour supply and outputs (e.g. absenteeism), lower tax revenues and lower returns on human capital investments.[5]

Eurofound (2019) states that over a quarter of the working population of the EU reports living with a chronic disease and that the prevalence of chronic diseases has increased over the last few years for all age groups but particularly for older individuals. Research has indeed shown that older workers are more prone to develop chronic diseases; for example, Eurofound (2019) reports that workers over the age of 50 are more than twice as likely to have a chronic disease compared to workers below the age of 35.

Mental health issues related to various psychosocial factors such as stress and/or anxiety, musculoskeletal disorders, cancers, cardiovascular diseases, respiratory

3. www.cdc.gov https://bit.ly/3qRsH46
4. https://www.who.int/chp/chronic_disease_report/media/Factsheet1.pdf
5. https://ec.europa.eu/jrc/en/health-knowledge-gateway/societal-impacts/costs

problems and diabetes have been among the most prevalent chronic diseases in Europe (European Commission 2017). While work-related cardiovascular diseases are responsible for nearly one-quarter of deaths globally (Takala *et al.* 2014), the impact of musculoskeletal disorders on work is also considerable as they decrease productivity and increase sickness absence (EU-OSHA 2007), causing almost half of all absences from work lasting three days or longer in the EU as well as 60 per cent of permanent work incapacity (Bevan *et al.* 2013). It may be hard to identify the main cause of chronic diseases, as a number of factors such as work environment, genetic predisposition or other individual factors could be jointly at play; however, in some cases, chronic diseases could be made worse because of work.

Health and disease intersect with gender; in the EU, while men have lower life expectancies than women, women more often report 'bad' or 'very bad' general health and have higher rates of chronic disease (Franklin *et al.* 2021). Women and men also differ in terms of the diseases they are more likely to develop; for example, diabetes and smoking have a greater weight as risk factors in men than in women. Obesity rates are slightly higher in men than in women, but women are disproportionately affected by obesity-related cancers (Franklin *et al.* 2021).

Furthermore, occupational health data show that women in Europe report more occupationally-related diseases than men (Casse and De Troyer 2021). The issue of musculoskeletal disorders is notably more likely to affect women. This is linked to the kind of workplace roles that women occupy which exposes them to risks regarding biomechanical stress (e.g. repetitive work, lifting people) but also to them having very little room for manoeuvre and autonomy in their work; that they experience physical burdens in both their professional and (non-paid) domestic work; and that their physiology makes them more susceptible to developing certain pathologies (carpal tunnel syndrome, for example). They are also often exposed to psychosocial risks, notably in the personal assistance, care and service professions (Casse and De Troyer 2021).

1.2 Chronic diseases and Covid-19

There are several linkages between chronic disease and Covid-19. First, research has so far shown that having a chronic disease increases the likelihood of experiencing more severe consequences of Covid-19 (e.g. hospitalisation, a stay in an intensive care unit or even death).[6] Second, the recent pandemic appears to have played a negative role in preventive medicine, impeding the advanced detection of chronic diseases that would have been monitored or diagnosed early in normal times. For example, lockdown restrictions and the strain put on health systems due to Covid-19 have implied that cancer care services have been severely disrupted across Europe (and globally), significantly delaying early diagnosis and treatment, and having a direct impact on

6. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medicaal-conditions.html

the chances of the cure or survival of many cancer patients.[7] According to the Belgian Cancer Registry, an estimated 5 000 expected new cancer diagnoses were not made due to the Covid-19 pandemic during 2020;[8] this is most likely a result of the decreased availability of medical staff for care services in hospitals other than for Covid-19.

Moreover, lockdowns have proved particularly challenging for mental health, with concerns expressed by medical professionals from across Europe about the impact of extended isolation and lack of social contact. This is exacerbated by rising financial insecurity and poverty – which is likely to have a disproportionate impact on women given that, on average, women have lower incomes and are more often in precarious employment (Bambra *et al.* 2021). The mental health impacts are also likely to be stronger for women as school closures have led to increased childcare pressures. This is particularly challenging for people who already have mental ill-health and given that women are more likely to suffer from anxiety and depression; it is possible that women's psychological well-being has suffered excessively as a result of lockdown (Bambra *et al.* 2021).

The Covid-19 pandemic is an evolving situation, but it is becoming evident that the new disease can have long-lasting health impacts. Current estimates are that 5-10 per cent of people who get Covid-19 will develop so-called 'Long Covid', in which the signs and symptoms continue for more than 12 weeks.[9] Long Covid is associated with many different symptoms that can fluctuate over time ranging from fatigue and headache to shortness of breath and neurological problems.

Among a sample of over 20 000 study participants who tested positive for Covid-19 in the UK, 14.7 per cent of women reported symptoms at 12 weeks compared to 12.7 per cent of men. This was also highest among those aged 25 to 34.[10] A study by Longfonds, the Dutch Lung Foundation, in conjunction with the universities of Maastricht and Hasselt found that, six months after infection, nine out of ten people suffered from more than one symptom and less than 5 per cent were symptom-free. The vast majority of respondents to the study (94 per cent) were not hospitalised because of Covid-19 but were 'mild' cases. These were relatively young patients with an average age of 48. By far the largest group (86 per cent) said their health was good before the virus infection and 61 per cent had no underlying condition.[11] We also know that over half of those who experience symptoms for more than six months go on to have memory deficits in month seven and new diagnoses may also be developed including diabetes, heart disease and liver disease.[12]

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7. https://www.euro.who.int/en/media-centre/sections/statements/2021/statement-catastrophic-impact-of-covid-19-on-cancer-care
8. https://kankerregister.org/Publications
9. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/962830/s1079-ons-update-on-long-covid-prevalence-estimate.pdf
10. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/evalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/1april2021
11. https://coronalongplein.nl/informatie/zorg-en-onderzoek/six-months-after-infection-almost-all-patients-study-group-still-have-symptoms
12. https://www.independentsage.org/wp-content/uploads/2021/01/Long-COVID_FINAL.pdf

2. The concept of the return to work

The International Social Security Association (ISSA 2013) defines the return to work as 'a concept encompassing all procedures and initiatives intended to facilitate the workplace integration of persons who experience a reduction in work capacity or capability, whether this is due to invalidity, illness or ageing.' The World Health Organization defines rehabilitation as the process of 'recovering optimal physical, sensory, intellectual, psychological and social functional levels' and it consists of medical, vocational and social aspects (EU-OSHA 2016). All in all, the return to work is considered to be 'a complex process, unfolding in time, with many stakeholders and factors shaping it' (Akgüç *et al.* 2019b).

With the increasing age of retirement, many workers are likely to experience longer working lives but also to face an increased probability of falling ill during their career. A part of these workers will succeed in returning to work after the proper management of their disease and recovery. Resuming work can result in significant economic and social benefits in addition to personal benefits as the worker might feel valued or less isolated after returning to work. However the process of returning is also complex, involving many actors, and it could be marked by multiple challenges ranging from limited access to (or lack of) a workplace and workload adjustments to interactions with colleagues after disease and the risk of stigmatisation or discrimination as a result of it. For instance, evidence suggests that 55 per cent of people with mental health problems make unsuccessful attempts to return to work and, of those who return, 68 per cent have less responsibility, work fewer hours and are paid less than before.[13]

Therefore, a relevant policy framework for returning to work and a successful implementation of this at establishment level are vital in assuring the occupational reintegration of workers after or with chronic illness. It is also important that the strategies, polices and actions are gender-sensitive because of the gender differences in the prevalence of chronic diseases and implied precariousness.

2.1 Return to work in the Covid-19 context

Some guidance is starting to be issued on the return to work for workers recovering from Covid-19, for example for health and safety professionals[14] and, in respect of Long Covid, for healthcare professionals.[15] The importance of developing rehabilitation services has also been acknowledged.[16] It is clear that occupational health and safety protection in respect of the return to work will (and should) be further developed as part of the pandemic response. Here, an analysis of prolonged Covid-19 symptoms in a survey by a patient-led research team found that one of the reasons for people

13. https://ec.europa.eu/health/sites/health/files/mental_health/docs/compass_2017workplace_en.pdf
14. https://www.som.org.uk/COVID-19_return_to_work_guide_for_recovering_workers.pdf
15. https://www.fom.ac.uk/wp-content/uploads/longCOVID_guidance_03_small.pdf
16. https://www.sll.se/verksamhet/halsa-och-vard/nyheter-halsa-och-vard/2021/03/sa-ska-patienter-med-post-covid-fa-vard/

not sharing their personal stories was the fear of being stigmatised, especially in the workplace, linking the issue directly to equal opportunities and discrimination.[17]

All in all, the impact of Covid-19 on the return to work operates in countervailing ways. On the one hand, the pandemic-related expansion of telework and the flexibility that this entails might offer new possibilities for returning to work for workers experiencing particular chronic diseases. On the other hand, as individuals with chronic disease are more prone to suffer from Covid-19 severely, and might even experience long-term scars as a result of it (e.g. Long Covid), returning to work might be more compromised than it otherwise would have been had the pandemic not occurred. Therefore, issues around employment and occupational rehabilitation are of great importance for people affected by Covid-19. Evidence derived from the current study might be relevant for this new population.

2.2 Industrial relations systems and their role in the return to work

European social dialogue is host to different industrial relations systems with different traditions across member states, each of which might have different priorities and mechanisms that can enable (or not) the efficient application and creation of new policies, including those on returning to work. According to Bechter *et al.* (2012), we can distinguish between the following industrial relations systems in the EU: Nordic organised corporatism (Denmark, Finland, Sweden); western liberal pluralism (Cyprus, Ireland, Malta); southern state-centred industrial relations (France, Greece, Italy, Portugal, Spain); central-western social partnership (Austria, Belgium, Germany, Luxembourg, the Netherlands, Slovenia); and a mixed central-eastern European system (Bulgaria, Croatia, Czechia, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia).[18]

While deviations possibly exist, industrial relations arrangements in most European countries have historically relied on at least one of four institutional pillars:

(i) strong or reasonably established social partners;
(ii) negotiated wage setting via sectoral or higher-level collective bargaining;
(iii) a fairly generalised arrangement of information, consultation and co-determination at company level;
(iv) institutionalised practice of tripartite policy-making and involvement of the social partners in tripartite policy arrangements (Akgüç *et al.* 2019a; European Commission 2009; Streeck 1992; Visser 2006).

These pillars remain relevant in the context of return to work and related policy implementation.

17. https://patientresearchcovid19.com/research/report-1/

18. We note that the countries of central and eastern Europe actually have diverse industrial relations systems within their group and that there could be at least two sub-groups: those with an embedded neoliberal system (Croatia, Czechia, Hungary, Poland and Slovakia); and those with a neoliberal system (Bulgaria, Estonia, Latvia, Lithuania, Romania). For more detail see Akgüç *et al.* (2019b).

Against this background, Scharpf's `actor-centred institutionalism' is taken as the underlying framework underpinning this study of how industrial relations actors facilitate the return to work at EU and national levels across countries. In this framework, 'social phenomena can be explained as the outcomes of interactions among actors, acknowledging that such interactions are structured and that outcomes are shaped by the characteristics of the institutional setting in which they occur' (Scharpf 1997; Akgüç *et al.* 2019b).

As a result, this book adopts an actor-oriented perspective in which the perceptions and experiences of industrial relations actors, as well as their interactions with other relevant stakeholders in given institutional settings, industrial relations systems and return to work policy contexts, are placed at the core of the analysis.

3. Research questions and methodology

The key research questions which the book aims to address revolve around the approaches of different industrial relations stakeholders to return to work policies in practice and their implementation at supranational (EU), national and company level across different industrial relations systems in Europe. So far little is known about how representatives of governments, employers and employees approach the issue of the return to work within the framework of industrial relations and how these stakeholders support workers in work retention and labour market reintegration following chronic illness.

While the focus is on the roles of trade unions and employer associations in the return to work process and policy-making across Europe, the role of additional stakeholders such as NGOs, campaigning and patient support organisations or occupational doctors are also investigated to evaluate the emerging opportunities to negotiate or improve the implementation of return to work policies across different industrial relations systems and national legislative and policy frameworks.

After an overview of existing national policies and relevant legislation on the return to work, the book addresses the issues at a more granular level, looking at company-level interactions between employer and employee representatives to see whether these support individuals through information, consultation or co-determination of the processes under which they return to work. Specifically, the perspectives and experiences of company-level stakeholders are investigated to evaluate their role in dealing with the implementation of the return to work at establishment level.

The company-level analysis is complemented with an analysis of the perspectives of workers facing chronic health conditions and undergoing returns to work (or who are likely to undergo a return to work after the diagnosis of a chronic condition) to shed light on how they perceive the relevance or role of the industrial relations actors, especially trade unions, in supporting and accompanying them during the return to work process and in helping to prevent the risk of marginalisation, discrimination and the threat of poverty.

3.1 Scope of the analysis

A recent EU-OSHA report (2016) provides a comprehensive assessment and overview of return to work policies across European countries, categorising them into four groups based on different approaches:

(i) **Group 1 – comprehensive approach:** in this group, countries usually have a developed framework on the return to work, oriented towards inclusiveness, with features such as emphasis on early intervention as well as progressive and planned returns. Examples include Austria, Denmark, Finland, Germany, the Netherlands, Norway and Sweden.
(ii) **Group 2 – stepwise approach:** in this group, countries have a developed framework for the return to work with emphasis on early intervention but with limited coordination between stakeholders. Examples include Belgium, France, Iceland, Italy, Luxembourg, Switzerland and the UK.
(iii) **Group 3 – ad hoc approach:** in this group, countries are characterised by a less-developed framework for the return to work with limited (or missing) coordination between stakeholders and room for ad hoc initiatives implemented by various actors. Examples include Bulgaria, Estonia, Hungary, Ireland, Lithuania, Portugal, Romania and Spain.
(iv) **Group 4 – limited approach:** in this group, countries generally offer rehabilitation only for people with disability status, with no formalised or planned measures to facilitate the return to work for individuals with specific chronic diseases. Examples include Czechia, Greece, Croatia, Cyprus, Latvia, Malta, Poland, Slovenia and Slovakia.

This book provides an in-depth analysis of six countries – Belgium, Estonia, Ireland, Italy, Romania and Slovakia. While the selection of countries reflects diverse approaches to the return to work and different systems of industrial relations, they are not always representative of dominant policies in Europe. Countries have differing rates of return to work depending on the legislative tools and practices in place. With this in mind, the following box provides a brief snapshot of three countries from Groups 1 and 2 above, which are larger than those covered in the book, to provide a benchmark.

Benchmarking: the return to work experience in France, the Netherlands and the UK

This benchmarking exercise aims to expand the study sample by briefly describing the return to work experience from three large countries: France, the Netherlands and the UK. These countries have exercised significant influence on EU-level policies (as for the UK, prior to Brexit) and have well-developed and comprehensive return to work frameworks. Yet they differ in their industrial relations systems and particular approaches through which the return to work after chronic illness is facilitated.

Return to work policies and frameworks are strongly developed, comprehensive and integrated in all three countries. The Netherlands has the most inclusive policy framework while eligibility criteria determine workers' access to return to work policies in France and the UK. The policies focus on minimising the duration of work absences due to chronic illness. However, the elements of prevention, early intervention and maintenance of work abilities during sick leave,

next to a well-functioning coordination of the roles of various stakeholders, are most prominent in the Netherlands. In France and the UK, work reintegration is mostly dealt with towards the end of sick leave, with moderate coordination between the stakeholders involved and between the steps of the work reintegration process.

Existing coordination mechanisms among the various national stakeholders are the main factors contributing to the effectiveness of the return to work process in these countries. Nevertheless, the role of the social partners differs: while employers are fully integrated into return to work processes in all three countries, only the Netherlands has achieved a high level of social partner collaboration, based on definitions of the responsibilities of each stakeholder involved. Compared to the Netherlands, the UK and France lack an encompassing and coordinated return to work policy framework. In the UK, the National Health Service mainly focuses on the medical aspects of the return to work while France's strategy in the occupational health plan for 2016-2020 introduced a greater role for social dialogue in supporting health promotion measures. This attempt at simplifying legislation and at connecting health and safety with the quality of working life represents the first step in France's transition towards a more comprehensive return to work policy.

Although employers are at the core of the return to work process in all three countries, the incentives offered to employers within the policy framework are different: only in the Netherlands are employers offered risk-free insurance for the retention in work of people who have experienced a chronic illness while such motivation for employers is non-existent in the UK. In France, employers receive a limited financial incentive to reintegrate workers after chronic illness.

As regards the role of collective bargaining in addressing long-term sickness absence and return to work, a few differences may be identified in how bargaining is undertaken in the three countries. Bargaining in the Netherlands and the UK covers a wide range of topics, including those related to disability. In contrast, in France, bargaining relevant in this context is restricted to pay issues and occupational health and safety measures within the social and economic committees which have operated in the workplace since 2018. Nevertheless, collective bargaining and agreements are significant factors affecting national policies in these countries even though the return to work and vocational rehabilitation are not always covered by negotiations.

3.2 Methodology and data collection

The methodology used in the chapters is based on a mixed-method approach relying largely on qualitative tools such as literature reviews and policy analysis. The chapters also benefit from an empirical analysis of primary data collected via three online surveys distributed to national social partners (targeted at ten social partners per country) across the EU (25 countries), and to company representatives such as human resources or line managers (targeted at 60 responses per country) and workers (targeted at 50 responses per country) in six EU member states.[19] Data collection through interviews and surveys

19. The surveys were distributed in the context of the REWIR project, established to study negotiation of the return to work in an era of demographic change. This book is, however, entirely separate from the REWIR project and has been independently developed. Response rates to the REWIR surveys show variance across the individual surveys and between member states and the samples are non-representative of the overall populations in the respective countries; the results presented in the following chapters should be read with these limitations in mind. More detail on the survey results per country as well as the survey questionnaires can be found in various reports accessed via the following link: https://www.celsi.sk/en/projects/detail/64/

took place between June 2019 and May 2020 with the majority concluded prior to the outbreak of Covid-19 in Europe which went on to disrupt survey response rates.

In addition to desk research of academic and policy documents, a total of 16 semi-structured interviews were conducted at EU level with representatives of European-level social partners and European institutions as well as academics and campaigning and patient support organisations or other relevant civil society organisations given their involvement in the issues of return to work and chronic illness. At national level, 54 interviews in total were organised across the six member states with government representatives and relevant stakeholders including campaigning and patient support organisations, employment offices, social security authorities, medical practitioners, academia, NGOs and charities participating in shaping and/or implementing return to work policies.

Beyond data collection through semi-structured interviews with stakeholders or the online surveys distributed to various actors, a number of events were organised to garner further insights and understand the perspectives of the range of actors involved in return to work processes at national and company levels. These events included six roundtable discussions with national stakeholders as well as twelve stakeholder discussion groups with representatives of companies and workers at company level in the six member states. This process resulted in strong engagement with key stakeholders (e.g. social partners, company representatives, government officials and campaigning and patient support organisations) on issues raised by the return to work as well as more broadly of the role of occupational health and safety at national and company levels.

All the information and insights collected during these events and in the various data collection phases have been consolidated, analysed and fed into the respective country chapters. All interview information has been anonymised and, in some chapters, anonymised quotes from interviews are included to help illustrate the analysis.

4. Structure of the book

The rest of the book is divided into three main parts. The first begins at EU level and provides an overview of the existing or relevant EU-level policy framework on the return to work. It then describes the involvement and experience of EU-level stakeholders from a broader set of industrial relations actors on return to work issues after chronic disease or with chronic illness.

In the second part, the EU-level framework is followed by country chapters including national-level analysis which explores not only the national legislative and policy framework but also goes deeper to look at company-level and worker-level perspectives in the selected member states. This national-level analysis provides perspectives and experiences from each of the six member states, each of which has their own specific legislative settings and policy frameworks for dealing with return to work, summarised here in turn.

In Belgium, the return to work after sick leave has become an important issue on the political and social agenda since the 2010s as an increasing number of incidences of absence due to chronic illness have come hand-in-hand with soaring social security expenditure. As governments have sought to address this issue by means of new activation policies, the social partners have participated in the design of a new formal reintegration procedure targeted at employees seeking to return to their former occupational activity. The social partners have been able to influence the legislation by putting forward some key principles and procedures around the role of the occupational health specialist and of the health and safety committee at company level, but they remain critical of the effectiveness of the new procedure and the implementation questions raised by it.

In Estonia, there is good policy provision in support of the return to work but this lacks implementation. The majority of interventions supporting the return to work belong to the category of active labour market policies which assist employers as well as employees directly or by offering relevant know-how. A lack of employer-level strategies discourages the reporting of illness while low expectations regarding managerial support make the smallest adjustments seem satisfactory to workers with chronic diseases, even if it probably comes nowhere near to meeting their needs. However, there is no complaining: trade unions are weak and have other priorities; campaigning and patient support organisations are focused on patient rights; and employer organisations feel their ad hoc solutions are sufficient. Building awareness about access to support measures needs to gain attention.

In Ireland, the main chronic diseases facing workers are musculoskeletal disorders, cancer and cardiovascular disease. Early intervention, timely and proactive use of organisational procedures, communication between key stakeholders and multidisciplinary coordination across government departments and agencies and at workplace level emerge as the most important factors in managing the return to work after chronic illness. A key finding in the chapter is that there is no `one size fits all' formula for workers' return to work after chronic illness. However, there is broad agreement on ending the existing fragmented approaches and creating a national return to work framework through social dialogue and the introduction of a statutory sick pay scheme for all workers.

The chapter on Italy sheds light on a fragmented legal and contractual framework on return to work, with many provisions applying to people with chronic illness only where they are affected by disabilities and with scant knowledge and interest in the topic being demonstrated by the social partners amidst their own limited role in policy-making. Nonetheless, there are a few positive experiences at local and company level resulting from collaboration between the social partners and other stakeholders, and these are highlighted.

Despite generous provision regarding sick leave duration and benefit, returning to work after chronic illness is insufficiently regulated by law in Romania. Research indicates that, among the industrial relations actors, it is the state that has the most substantial role in designing return to work policies: employers and trade unions are

either not active or are not involved in this process to their full potential. The same can be said about policy implementation as current legislation stipulates a rather minor formal role for the social partners. Yet the chapter highlights that there is space for improvement for all industrial relations actors even in the absence of a dedicated and specific return to work policy.

In the context of economic growth and labour shortages in Slovakia prior to 2020, the reintegration into work of people after chronic illness has become increasingly important. Nevertheless there is little evidence of return to work after chronic illness, especially of workers without formal disability status. This chapter argues that trade unions and employer organisations do not yet use their full potential in engaging in return to work policy-making and in the actual facilitation of return to work processes, but there is interest in closer stakeholder cooperation both at national and workplace levels.

In the third part, the closing chapter takes stock of EU-level and national experiences in understanding the role being played by industrial relations actors and relevant stakeholders dealing with and facilitating returns to work. It provides concluding remarks and discusses policy options and the way forward.

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Chapter 1
The EU-level policy framework and stakeholder perspectives on returning to work after chronic illness

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1. Introduction

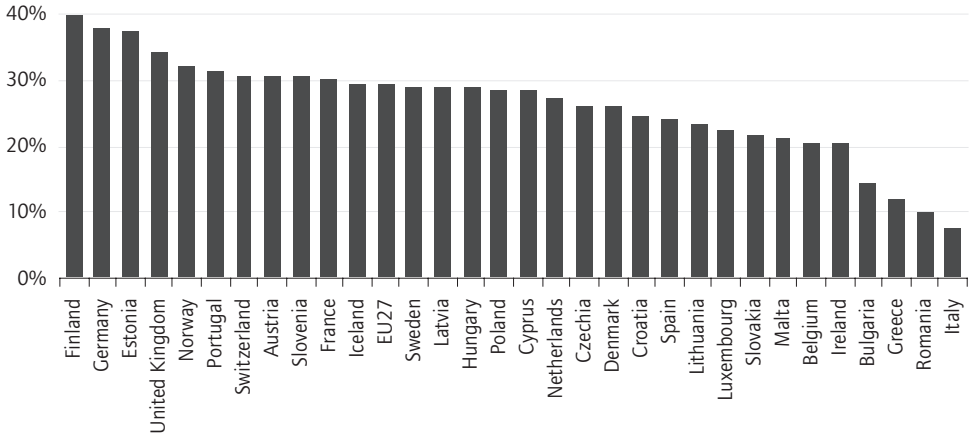
Labour markets have undergone significant transformation due to demographic changes such as longevity and declining birth rates. Policies to extend working lives and promote labour market inclusion are essential for ensuring the sustainability of European social security systems and the functioning of labour markets. In this context, measures to facilitate the return to work of individuals after chronic illness are a key policy instrument. As described in the introductory chapter of this book, chronic diseases are understood as those of long duration and slow progression, examples of which include cancer, cardiovascular diseases, diabetes, musculoskeletal disorders (MSDs) and some mental disorders (Akgüç *et al.* 2020). These diseases represent a considerable burden on labour markets and are the main cause of morbidity and mortality in the EU (Guazzi *et al.* 2014). For instance, while it can be difficult to isolate the precise factors behind the disease, cancer has been identified as a primary cause of work-related deaths in the EU (European Commission 2017).

The prevalence of chronic disease is a significant issue in Europe. Various studies have shown that older workers are more prone to develop chronic diseases. According to EU-OSHA (2016), work-related health problems are more prevalent in older age groups. Therefore, with the ageing of overall populations and longer working lives, it is expected that more working age people will have chronic conditions in the years to come. Indeed, between 2010 and 2018 the proportion of working age individuals (between 16-64) reporting a longstanding illness or health problem increased from 24.8 per cent to 29.3 per cent across EU-27 countries.[1] The incidence of chronic morbidity varies across European countries, as illustrated in Figure 1.

The concept of chronic illness is closely related to that of disability where a disabled person is understood as 'an individual whose prospects of securing, retaining and advancing in suitable employment are substantially reduced as a result of a duly recognised physical or mental impairment.'[2] Long-term sickness absence can often be a precursor of disability (OECD 2010) and the line between chronic illness and disability can be blurry. Accordingly the European Court of Justice has made several rulings suggesting that some chronic diseases may be included in the definition of disability (Eurofound 2019).

1. Source: Eurostat, hlth_silc_04, extracted on 10 November 2020.
2. https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C159

Figure 1 **Proportion of population suffering from a longstanding illness or health problem, 2018**



Source: Eurostat, hlth_silc_04, extracted on 10 November 2020. Data for individuals aged 16-64.

The prevalence of chronic illness is a significant challenge to labour market integration. In EU-27 countries, almost 30 million individuals are limited in the amount of work they can do due to longstanding health problems or difficulties in performing basic activities.[3] Chronic illness increases the likelihood that an individual will withdraw from the labour market either temporarily or permanently through disability, long-term unemployment or early retirement (Eurofound 2019; EU-OSHA 2016). According to the OECD (2016) 'the employment rate of people who have one or more chronic conditions, and particularly people aged 50-59, is much lower than those who do not suffer from any disease.' In addition to absence from work, chronic illness is also associated with presenteeism at work; that is, the inability of the worker to function fully due to illness or other medical conditions. Presenteeism is estimated to cut individual productivity by one-third or more (Hemp 2004).

Reduced individual productivity and potential loss of employment have negative consequences at individual and societal levels. For employees with a chronic illness, work is important as it allows them to be financially independent, develop social contacts and contribute to society (Vooijs *et al.* 2018). As such, the loss of work is associated with negative financial and mental health consequences. Moreover, there is a further impact on caregivers, often women, that may also be forced to drop out of the labour market to assume caring responsibilities (European Parliament 2018). Negative employment impacts are particularly relevant for women of pre-retirement age (50-64 years) of whom only 48 per cent providing long-term care are in employment. Informal caring duties can also lead to early retirement for older carers, particularly women.[4]

3. Source: Eurostat, hlth_dlm150, extracted 16 November 2020.
4. https://eige.europa.eu/publications/gender-equality-index-2019-report/informal-care-older-people-people-disabilities-and-long-term-care-services

Furthermore, the return to work can be a challenging process for businesses, particularly for micro and small companies with lower worker turnover and difficulties in adjusting workflow (European Commission 2017). On a macroeconomic level, significant productivity losses may be incurred due to foregone labour force potential. For instance, recent estimates suggest that, while the direct costs of work-related cancer in terms of healthcare, sickness and disability benefits and productivity losses amount to €4-7 billion, the indirect costs can reach up to €350 billion annually (European Commission 2017).

Against this background, this chapter has two key objectives. First, it provides a policy framework as well as analysis on the return to work after chronic illness at EU level by overviewing the existing legislative and non-legislative structures and relevant policy instruments. Second, by analysing primary data collected from key stakeholders including EU-level social partners as well as representatives of European institutions, campaigning and patient support organisations and academia, it focuses on the role of EU-level industrial relations structures and actors in addressing the return to work after chronic illness.

2. Returning to work after chronic illness in the EU: existing policy framework and tools

Facilitating a return to work for individuals who have suffered from chronic illness aligns closely with the core principles of the European Union. Article 26 of the Charter of Fundamental Rights of the EU[5] emphasises the 'right of persons with disabilities to benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community'. While this does not directly refer to individuals who experience chronic illness, there can be a significant overlap between individuals with certain chronic diseases and those who are disabled. More recently the European Pillar of Social Rights (2017)[6] stresses the right to equal opportunity in the workplace, active support in employment and a healthy, safe and well-adapted working environment.

As there is no specific EU legislation or regulation addressing return to work, and as most social and employment policies remain a primary competence of member states due to the subsidiarity principle, the EU does not directly intervene in specific return to work policies in member states. Nevertheless, the EU can influence return to work policy through the establishment of minimum standards in occupational health and safety, providing guiding principles and serving as a platform for the exchange of best practice. Moreover, while the EU approach in this context is fragmented, reflecting the diversity of policies and practices across member states, there are two key EU policy areas that are relevant for addressing the return to work: occupational health and safety policy; and social inclusion policies with particular reference to equal

5. https://www.europarl.europa.eu/charter/pdf/text_en.pdf
6. For more details on the principles of the European Pillar of Social Rights, see https://ec.europa.eu/info/strategy/priorities-2019-2024/economy-works-people/jobs-growth-and-investment/european-pillar-social-rights/european-pillar-social-rights-20-principles_en

opportunities and the treatment of disabled individuals in the labour market (EU-OSHA 2016; Eurofound 2019). In what follows, we address these policy areas in turn.

2.1 Occupational health and safety policy

Within the field of employment and social affairs, health and safety at work is one of the most developed aspects of EU policy. In this context, return to work is a relevant issue. For instance, the 2007 Community Strategy on Health and Safety at Work envisioned that national and EU-level policies should aim to create working environments that enable workers to contribute to their jobs until they reach old age (European Commission 2007). In particular, the Strategy encouraged member states to develop measures to support the reintegration and rehabilitation of workers excluded from the workplace for a long period of time due to accident, occupational illness or disability.

On the legislative side, EU policy action within the realm of occupational health and safety tends to focus on the prevention of occupational accidents and diseases rather than the return to work. The Framework Directive 89/391/EEC on the introduction of measures to encourage improvements in the health and safety of workers at work and the 23 subsequent individual directives constitute the EU's occupational health and safety *acquis*.[7] This delivers generalised provisions to improve health and safety in the workplace as well as sector-, worker- and hazard-specific requirements to ensure protective working environments. A recent evaluation of the *acquis* concludes that, while it remains relevant today, it requires modernisation in the face of transformed labour markets and emerging risks (European Commission 2015). For instance, recommended measures include stepping up the fight against occupational cancer, psychosocial risk prevention and assisting businesses, particularly micro and small enterprises, to comply with occupational health and safety rules (European Commission 2017).

Overall, occupational health and safety directives relate to the return to work and integration in that they protect workers against risks and promote measures that contribute to accident prevention. However, the reintegration of workers after chronic illness is not specifically addressed in EU legislation. As such, the return to work may also be addressed through non-legislative EU action. In recent EU policy documents, returning to work after chronic illness is acknowledged as a significant issue in the area of occupational health and safety. Specifically, the EU Strategic Framework on Health and Safety 2014-2020 emphasises the importance of adapting workplaces and work organisation to the needs of ageing workers and identifies reintegration and rehabilitation measures as key to avoiding the permanent labour market exclusion of workers (European Commission 2014; Eurofound 2019).

Building on the previous framework, the European Commission published the renewed Strategic Framework on Health and Safety 2021-2027 in June 2021, following

7. For the full list of directives in occupational health and safety, see Table 1-1 in European Commission (2015).

stakeholder contributions to the consultation on the Framework.[8] For instance, the position statement of the European Trade Union Congress (ETUC 2019) highlights the need to address the situation of workers who return to work after sick leave and calls for the Framework to promote occupational health services enabling workers with long-term illnesses to retain employment; encourage the development of an action plan on returning to work; facilitate analysis of the current state of play in member states; and establish best practice and concrete tools to enable workers to return to work. As a result, the Strategic Framework includes guidance on securing health and safety at work as well as highlights the role of 'vocational rehabilitation schemes for people experiencing chronic diseases or people who have been the victim of accidents.' There is also an emphasis on actively supporting reintegration, non-discrimination and adaptation of working conditions of workers experiencing cancer.

2.2 Social inclusion and disability policy

In addition to occupational health and safety policy, a further policy field that is relevant to the return to work is social inclusion and disability policy. Individuals with chronic illnesses tend not to be specifically targeted by EU legislation but rather included in policies focusing on the employment of disabled people. Indeed, chronic illness often leads to limited working capacity as well as potential degrees of disability. Accordingly the European Court of Justice has, in some cases, ruled that chronic illness can be included in the definition of disability (Eurofound 2019). However, from this legal perspective, the definition of disability does not automatically include the concept of (chronic) illness and legal rulings on this issue diverge (Eurofound 2019). This implies that the inclusion of workers with chronic illnesses in disability policies is not legally guaranteed.

Internationally, organisations such as the United Nations (UN), International Labour Organization (ILO), World Health Organization (WHO) and the Organisation for Economic Co-operation and Development (OECD) have all worked on the subject of the return to work in recent decades with the objective of promoting the social inclusion of disabled individuals (EU-OSHA 2016). The ILO defines a disabled person as 'an individual whose prospects of securing, retaining and advancing in suitable employment are substantially reduced as a result of a duly recognised physical or mental impairment.' ILO Convention No. 159 on Vocational Rehabilitation and Employment (Disabled Persons), adopted in 1983, foresees the inclusion of financial incentives for employers to improve and adapt workplaces and work organisation to increase employment opportunities for disabled individuals (EU-OSHA 2016).[9] In addition, the UN Convention on the Rights of Persons with Disabilities (UN 2006),[10] to which the EU has been party since 2011, forms the international framework for the rehabilitation of disabled people (EU-OSHA 2016) and encompasses general principles of rehabilitation

8. For more information, see: https://ec.europa.eu/info/law/better-regulation/have-your-say/initiatives/12673-EU-Strategic-Framework-on-Health-and-Safety-at-Work-2021-2027-

9. https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C159

10. https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

and career protection. Finally, the OECD has produced a number of studies promoting the participation of disabled individuals in social and economic life (OECD 2003; OECD 2010). In particular, it provides policy recommendations for member states on the development of effective return to work strategies for people with disabilities and/or chronic conditions, emphasising the importance of better coordination between different actors including employers, medical staff, social security agencies and the social partners (OECD 2010).

Against this international background, the EU has taken legislative action on disability and inclusion. In particular, it adopted Directive 2000/78/EC[11] establishing a general framework for equal treatment in employment and occupation (the Employment Equality Directive), specifically covering disability. The directive requires employers to make 'reasonable adjustments to accommodate disabled people.' These are relevant for workers returning to work after chronic illness, especially where that leads to disability or impairment resulting in the limitation of work capacity and capability. However, these provisions do not specifically cover workers returning to work after chronic illness where this does not result in the individual having explicit disability status (EU-OSHA 2016).

Another relevant piece of EU legislation is the Work-Life Balance Directive[12] that entered into force in August 2019. While the main focus of this directive is on improving access to family leave, it also has several elements pertaining to flexible work arrangements that could be relevant for the employment protection of caregivers of workers experiencing chronic illness.

In addition, the European Commission has been active in the development of strategies for improving the rights of disabled people. The 2010-2020 Disability Strategy[13] identified eight main areas for action, including employment and health, specifying that the EU would support national efforts to analyse and improve the labour market situation of disabled people, reduce the risks that might exacerbate disabilities in the workplace and support their reintegration into work. An evaluation of the 2010-2020 Disability Strategy highlighted employment as one of the most important topics to be addressed in the future (European Commission 2020). In particular, position papers on the continuation of the disability strategy by the ETUC (ETUC 2020) and by the European Disability Forum (EDF 2020), as well as a resolution by the European Parliament (European Parliament 2020), highlight the importance of reintegration measures and guidelines on reasonable accommodation for the labour market inclusion and reintegration of disabled people. The European Parliament specifically sought to ensure that the new strategy should address the lack of clarity regarding the inclusion of chronic illness within the definition of disability and pay attention to the needs of individuals suffering from chronic illness, including targeted measures on employment activation.

11. https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32000L0078
12. https://data.consilium.europa.eu/doc/document/PE-20-2019-INIT/en/pdf
13. https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM%3A2010%3A0636%3AFIN%3Aen%3APDF

The new Strategy for the Rights of Persons with Disabilities 2021-2030 was published by the European Commission in March 2021.[14] The Strategy highlights employment policy as one of the key areas in which action may be taken to improve the rights of people living with disabilities and emphasises measures promoting reasonable accommodation in the workplace for disabled people. In particular, it announces a flagship initiative to improve the labour market outcomes of disabled people, to be presented in 2022. This initiative is set to include guidance and support for member states in a variety of areas including vocational rehabilitation schemes in the case of chronic illness or serious accidents. The new disability rights strategy thus represents a step forward in taking policy action at EU level regarding the return to work. However, there is relatively little elaboration in terms of how far individuals with chronic illness are included in the definition of disability and, therefore, whether these policies apply to them specifically.

Focusing more specifically on workers with chronic illness, the Committee on Employment and Social Affairs of the European Parliament published a comprehensive report in 2018 on pathways for the reintegration of workers recovering from injury and illness into quality employment (European Parliament 2018). The report calls on the European Commission and member states to develop guidelines on best practice and to draw up advice for employers on how to develop reintegration plans, ensuring dialogue between the social partners and facilitating exchange between member states and other stakeholders.

In addition, in February 2021, the European Commission released the 'Europe's Beating Cancer' Plan,[15] a comprehensive action plan against cancer. The plan emphasises issues that cancer survivors have in returning to work and proposes a variety of actions, including the promotion of up- and re-skilling programmes for cancer survivors and the launch of a new study in 2022 focusing on the return to work of cancer survivors. This initiative represents an example of an initial concrete EU policy action on the topic of the return to work after chronic illness.

In summary, concrete legislation or other policy action on the return to work after chronic illness has been comparatively scarce at EU level. Policy areas such as occupational health and safety and social inclusion and disability are relevant to the issue of returning to work after chronic illness but policy action remains underdeveloped. Moreover, chronic illness tends to be addressed within the category of disability and suffers from a lack of specific policy recommendations or the recognition that such a framework may not be appropriate for all chronic illnesses. Some actions have been taken to address the issue of returning to work after chronic illness, such as the 'Beating Cancer' Plan, but specific policies on chronic illness that comprehensively address the issue of the return to work are still lacking.

14. https://ec.europa.eu/commission/presscorner/detail/en/qanda_21_813
15. https://ec.europa.eu/health/sites/health/files/non_communicable_diseases/docs/eu_cancer-plan_en.pdf

3. Returning to work and the EU policy framework: the role of social dialogue

In order to explore further the EU policy-making process on the return to work, as well as the potential role of social dialogue in this, 16 semi-structured interviews with EU-level stakeholders – covering EU social partners as well as European institutions, non-governmental organisations (NGOs), campaigning and patient support organisations and academics – were conducted between December 2019 and May 2020.[16] Table 1 summarises the interviewee types.

Table 1 **Summary of stakeholder interviews**

Type of organisation	Count
European social partners (total)	7
- Trade unions	5
- Employer organisations	2
European institutions	2
NGOs, campaigning and patient support organisations	6
Academia	1
Total	**16**

The diversity of organisations interviewed reflects the multidisciplinary characteristic of the return to work. While not all these actors are part of formal EU social dialogue channels, they belong to a *tripartite plus* industrial relations setting and are highly relevant in the overall return to work context. All actors interviewed closely interact with policy-makers and have engaged in research, policy or advocacy work in the field.

In what follows, we first briefly describe the functioning of EU-level social dialogue, embedding the diverse industrial relations systems operating in it. We then turn to the various actors involved in EU-level return to work policy and describe their level of involvement in it. Subsequently, we analyse the nature of the interactions between the various stakeholders before finally providing some perspectives on forward-looking actions and future policy options at EU level on the return to work.

3.1 Brief overview of EU-level social dialogue

Social dialogue plays an important role in the European policy-making process. The role of national collective bargaining systems has been emphasised in terms of improved labour market performance (among others, OECD 2018). At EU level, bipartite and tripartite social dialogue has contributed to improved working environments through the interest representation of workers and businesses over recent decades. In addition to formal social dialogue platforms, open consultation with stakeholders is key to

16. Interview data was collected before some of the recent policy developments referenced in section 2, particularly the publication of the recent Disability Rights Strategy and the 'Beating Cancer' Plan.

the development of EU-level legislation and binding tools (e.g. directives) as well as other non-legislative tools such as recommendations and guidelines. Here, there are both cross-sectoral and sectoral social dialogue committees where the social partners come together to discuss, negotiate and sometimes reach consensus on diverse issues relevant to the proper functioning of labour markets and workplaces.[17] Several EU-level social partner organisations – including, for instance, the ETUC and Business Europe – participate in EU cross-sectoral social dialogue committees addressing a variety of labour market issues. EU sectoral social dialogue includes social partners representing trade unions and employer organisations from all member states. There are currently 43 EU-level sectoral social dialogue committees representing more than 80 per cent of the EU workforce (Kerckhofs 2019).

Various EU policies and strategies put an emphasis on social dialogue. For example, as part of the *Fair Working Conditions* chapter of the European Pillar of Social Rights, Principle 8 on social dialogue and the involvement of workers states the following:

> 'The social partners shall be consulted on the design and implementation of economic, employment and social policies according to national practices. They shall be encouraged to negotiate and conclude collective agreements in matters relevant to them, while respecting their autonomy and the right to collective action. When appropriate, agreements concluded between the social partners shall be implemented at the level of the Union and its Member States.'

Previous EU strategy also referred specifically to the role of social partners in promoting and implementing the European occupational health and safety framework, as stated in the following (European Commission 2017):

> 'Social dialogue has made a huge contribution to improving health and safety, at EU, national, sectorial and company level. It has not lost any of its relevance in today's context. On the contrary, social dialogue will be crucial in implementing the actions contained in this Communication.'

Meanwhile, Europe is host to a diverse set of industrial relations systems, as summarised in various studies (among others, Bechter *et al.* 2012; Akgüç *et al.* 2019b, 2020). This diversity of regimes is to the benefit of European industrial systems but it can also constitute a challenge to the setting of minimum standards in an environment where reaching agreements can take a longer time as a result of this diversity and the different processes, tools and national practices. This is also why most of the EU-level social dialogue agreements or outcomes tend to remain rather general in nature, leaving room for member states to implement a tailored version in view of their national and sectoral contexts.

17. For more detailed analysis of European social dialogue at cross-sectoral level, see Akgüç *et al.* (2019a).

3.2 EU-level stakeholder engagement in the return to work

Turning next to interview data on the issue of the return to work after chronic illness, all the EU-level stakeholders perceived returning to work and reintegration as a relevant topic in the face of demographic change and the prevalence of chronic illness in the EU. Inactivity among workers who have suffered from a chronic disease implies a large pool of wasted talent. In addition, it was highlighted that the return to work is not only an issue of economic productivity but also of inclusion. Despite its broad relevance, however, the specific topic of the return to work does not always appear at the top of the agenda of EU-level stakeholders while the level of involvement differs strongly between the different types of stakeholder.

From the side of the European institutions, the level of engagement with return to work policy has been limited. Beside the European Commission and Parliament, the main bodies dealing with the return to work are the European Agency for Safety and Health at Work (EU-OSHA) and the European Foundation for the Improvement of Living and Working Conditions (Eurofound). In particular, EU-OSHA has been working on return to work issues over the last decade, focusing research on return to work after MSDs and cancer, considering that work should not make existing health conditions worse but that, at the same time, it can promote health and well-being. In most of these projects, health and safety is considered within a multidisciplinary framework and the idea is to look for best practice in adapting workplaces for people with chronic conditions. These projects are coordinated and promoted jointly with the European Commission and Parliament. As regards the work of the European Commission, the bulk of its policy development work has focused on the prevention of accidents at work and, more recently, on work-related diseases. Nevertheless, there is a growing interest in the return to work, particularly in the context of MSDs, psychosocial risks and demographic change in Europe. Overall, the main role of the European institutions in return to work policy has been limited to information sharing, dissemination of research and awareness-raising in the EU, as well as providing a platform for the exchange of information and best practice.

Turning to the role of the EU-level social partners, the issue of the return to work after chronic illness is considered to be relevant in the face of demographic change such as ageing, or labour market developments such as labour and skill shortages, but the issue is not on the agenda of the social partners as yet. In some cases, this is due to limited resources while in others it is an issue of prioritisation with the main focus of work being on the prevention side of occupational health and safety, as is the case for other European institutions. While prevention has traditionally been concerned with occupational accidents, there has been a shift over time towards an emphasis on work-related diseases. In parallel to prevention, risk assessment and the promotion of healthy workplaces are also within the focus of social partners. For instance, the cross-sectoral social partners attempted to address the issues of active ageing and workplace accommodation in the Autonomous Framework Agreement on Active Ageing and an Inter-Generational Approach (Business Europe *et al.* 2017). Furthermore, European

social partner agreements, such as the framework agreements on work-related stress[18] and harassment and violence at work[19] might well have some relevance to people with chronic illnesses even though neither specifically addresses the return to work.

However, there is also a perception that returning to work and chronic illness will become more relevant on the social dialogue agenda in the near future, particularly in certain sectors such as construction and woodwork that are more deeply affected by work-related diseases. Sectoral trade union representatives highlighted unfavourable working conditions, bad work posture and ergonomics, the manipulation of heavy loads, stress and exposure to chemicals as leading factors in MSDs and cancer in some particular sectors with, latterly, a rising prevalence of chronic conditions.

Despite this increasing trend, nor is the return to work high on the agenda of the sectoral social partners at EU level yet. One way for this to change might be to consider working conditions and their relation to the prevalence of chronic diseases from a different angle. For instance, night shifts are common in sectors such as cleaning and studies have shown a link between night shifts and cancer. Thus, one way to draw attention to the prevalence of chronic illness and the related return to work issues among social dialogue committees would be through the working time dimension. Another example of the health impact of poor working conditions is stress in the workplace, which is shown to be linked to chronic conditions;[20] around one-half of European workers consider workplace stress to be common, contributing overall to almost one-half of all lost working days.[21] An emphasis on workplace stress could thus be another way to address the subject of chronic illness in social dialogue.

In some cases, employers would prefer to dismiss employees with chronic illness. Trade unions are, however, able to influence the employer side through social dialogue and, where the issues of chronic illness and the return to work appear on the agenda of social dialogue committees, this might represent a way of avoiding such outcomes. Additionally, lobbying European institutions to make sure these issues are put high on agendas also works: once the European institutions place importance on an agenda item, it tends as a consequence to get discussed by the social partners.

Campaigning and patient support organisations and NGOs are key stakeholders in EU-level return to work policy. They invest resources in raising awareness about people experiencing chronic illness and provide a mapping of the prevalence of such conditions; they also acknowledge the impact that chronic illness has on economic and health systems. Their belief is that effective policy requires a shift in mindset to focus on a person's abilities rather than their limitations, considering that inactive people with a disability or a limiting illness constitute an untapped reserve of talent and skills. Some organisations prefer to advocate disability angle in policy-making on the return to work, pushing for a collective effort behind the full implementation of the UN

18. https://www.etui.org/sites/default/files/ez_import/Framework%20agreeement%20on%20work-related%20stress.pdf
19. https://www.etuc.org/en/framework-agreement-harassment-and-violence-work
20. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5877081/
21. https://osha.europa.eu/en/themes/psychosocial-risks-and-stress

Convention on Disabled Persons, with particular reference to Article 27 on reasonable accommodation in the workplace. All in all, these stakeholders mainly focus on the health side of the issue but they value exchanges with policy-makers, social partners and other campaigning and patient support organisations to discuss other dimensions such as employment and social policies.

The possible challenges faced by micro-enterprises and SMEs compared to larger companies in the context of the return to work is also worthy of mention. A major obstacle for these companies when dealing with the return to work is that it is often the case that no two employees have the same tasks; thus, reorganisation can be very difficult to allow the possibility for a worker, absent for a long time due to chronic illness, to come back. Moreover, most SMEs do not have the financial capacity and human resources to adapt the workplace to accommodate and facilitate the return to work of workers following chronic illness. In larger companies, there is often a more established human resources management structure, and hence a return to work is more likely, but some chronic diseases (e.g. chronic headaches) are not always recognised even there as an issue to be addressed.

3.3 Interactions between industrial relations actors and other stakeholders in return to work policy

Generally, while the nature of interactions between the social partners can sometimes be adversarial, they frequently cooperate on health and safety issues. Common ground can often be found here as a healthy workforce and well-functioning labour markets are in everyone's interests. It is also acknowledged by most social partners that trade unions are generally more in favour of legislative solutions while employers are rather reluctant when it comes to binding agreements. In interactions between the two there has not, however, been any specific discussion of the return to work as this issue is not present on the agenda of EU social partners.

This is also the case for interactions on the issue between EU-level social partners and the European institutions. The social partners are part of the tripartite Advisory Board on Health and Safety at Work and, as such, they are regularly consulted by the European Commission to provide opinions on topics related to health and safety. In addition, they are part of the tripartite governing board of EU-OSHA which must draw up its work programme through consensus. In these interactions, an atmosphere of cooperation usually prevails as they are based on knowledge exchange and the search for joint actions and compromises. Nevertheless, the return to work is not addressed specifically.

Turning to interactions between campaigning and patient support organisations and the social partners, engagement has also been limited. While the campaign organisations state that they are seeking opportunities to cooperate with the social partners on the return to work, they have had limited success so far as the social partners are more focused on issues relating to prevention. Where there has been some form of interaction, this appears not to have resulted in any particular policy action on the return to work. The

limited interest of the social partners may result from trade unions seeking to advance conditions for all workers whereas the specific needs of individual workers, or those who are inactive, cannot always be collectivised; while employer organisations might have greater awareness of the issues but lack knowledge about potential adjustments and are focused on cost. The reason why both are hesitant on this issue might also be due to not wanting to put at risk the terms of existing collective agreements.

Involving the social partners in return to work policy would increase the legitimacy accorded to this topic in discussions with policy-makers. Consequently there is significant interest from campaigning and patient support organisations in further exchanges with the social partners in terms of educating them about medical facts and the importance of the issue, convincing employers that adjustments are not always costly and discussing their policy recommendations openly with both sides. However, greater flexibility and openness from the social partners might be needed to increase fruitful exchanges between social partners and NGOs on the return to work issue. Due to their limited success at engaging with the social partners, campaigning and patient support organisations and NGOs are therefore more focused on interactions among themselves and with European institutions where there is more active cooperation, in particular with the Commission and the Parliament, including discussions with policy-makers and the organisation of joint events.

3.4 Future potential for EU action and social dialogue on the return to work

The data collected in these interviews suggests that the EU does have a future role in return to work issues, both in developing policies and in raising general awareness. However, its role here is distinct from that of national member states as employment and social policies are national prerogatives in the context of subsidiarity. Given the large variation in national labour market and social policy systems, specific legislation on the return to work should perhaps be developed on a more disaggregated basis comprised of national, sector and company levels. In contrast, the EU could provide at least an overarching policy framework on the return to work. There also appears to be room for the industrial relations actors to take part, subject to all sides being willing.

One of the key added value aspects at EU level is indeed the potential development of a European charter on the return to work and chronic illness, collecting good practice and creating minimum standards and common guidance in particular for member states and employers. Diversity in handling return to work issues in member states means that having European standards as a practical guide could serve those member states who lag behind. In addition, having practical guidance approved at EU-level can lend legitimacy to the issue and encourage further action in member states. Employers would also benefit from this as most are not sure of how to deal with the issue, taking sector-specific considerations also into account. In this context, one of the key transmission mechanisms could be the amount of interaction such a charter would generate between the EU and the national social partners. Achieving a level playing field across all member states might not be possible but convergence in facilitating the return to work can perhaps be aimed at.

An additional and potentially useful EU policy tool is the European Semester process. As a benchmarking tool, this process could be useful in terms of the collection of further data on the return to work since the absence of data can lead to an underestimation of the scale of the problem. Furthermore, greater emphasis could be put on health and safety topics in country-specific recommendations as part of the national reform process. For example, there are existing EU instruments that address the long-term unemployed. One idea could be to add an annex to such instruments to include people who are absent from work because of a chronic illness (or disability). There is also room for the social partners to participate in the European Semester. Even though there are divergences in the extent of actual experience with the process thus far (Akgüç *et al.* 2019a), the social partners have started to be involved in the process and can contribute their perspectives on the return to work as part of it. The roles of the European Social Funds and the European Structural and Investment Funds are also a means of supporting member states and employers to adjust workplaces and facilitate return to work arrangements.

Another area where EU action is relevant is EU-funded research projects and programmes, such as Horizon 2020. These joint research and innovation activities contribute to our understanding on chronic diseases and the societal challenge of demographic change, and they inform policy-makers drafting initiatives and strategies on employment and health policies. There is also an EU budget line for the social partners to participate in various projects to improve expertise on industrial relations and on the specific challenges which wider society faces. All such EU activities are considered to be valuable in engaging the various actors and advancing knowledge in relation to the return to work after chronic illness.

The social partners are relevant at all levels but there is a need to differentiate the roles that they play. At the level of the EU, the focus of the social partners is the generation and co-ordination of overall policy. In contrast, national social partners can address return to work issues through legislation or collective bargaining within member states, considering the context of national legislation and social security systems. Furthermore, the sectoral social partners can address specific industry-wide issues as returning to work does require a more tailored consideration in some sectors (e.g. construction, cleaning or the chemical industry). Finally, interest representation at company level is also important as the success of any return to work policy elaborated at higher levels boils down to practical implementation in enterprises where representatives can serve as intermediaries between workers and the company.

The main role of the EU-level social partners in contributing to policy development on the return to work therefore lies in providing information and exchanging best practice, thus raising awareness among their members at national level, and capacity building. In addition, they can lobby the European institutions in order to bring the issue higher up the European policy agenda which would also result in making it more prominent in the European social dialogue. The social partners have an important role to play in making sure that issues related to health and safety and to employment enter the relevant European and national strategies. Here, the return to work tends to be addressed through disparate policy angles such as health and safety, employment and

social inclusion with the result that different policy fields dealing with the issue, such as ageing, discrimination, disability and occupational health and safety, are at times disconnected. One of the roles of the EU-level social partners could be to bring these different policy angles together to promote a more holistic and joined-up approach.

In addition to awareness-raising and information exchange, the EU-level social partners could also include the return to work in formal social dialogue negotiation. However, EU-level regulations on this issue are not necessarily desirable as their outcomes tend to remain rather general in nature. It is rather the national-sectoral level of social dialogue – perhaps the most influential channel to achieve binding agreements in view of the centrality of national legal frameworks, industrial relations settings and sector-specific risks and conditions – which is arguably the most important.

4. Conclusion

In the context of demographic and economic change, the labour market integration of individuals who are returning to work after chronic illness is a significant social and economic challenge. This chapter has sought to elucidate the EU policy framework on return to work and the contributions to it of the EU-level social partners, as well as stakeholders' views on current and future EU return to work policy. As set out in this chapter, EU-level initiatives and industrial relations actions on the return to work have, so far, been limited but there are several relevant actions that are worth acknowledging.

At EU level, there have as yet been no concrete policy agreements on the return to work although some EU agencies, such as EU-OSHA, have conducted research on it. The return to work is relevant to several EU policy fields, the most prominent among which is health and safety, and social inclusion and disability. Within the health and safety policy nexus, however, the focus of policy up to now has been on the prevention of occupational accidents and occupational diseases. The new EU Strategic Framework on Health and Safety at Work for 2021-2027 addresses the return to work more explicitly by highlighting the importance of vocational rehabilitation of people with chronic illnesses. As regards the field of social inclusion, chronic diseases tend to be subsumed under the heading of disability. On the legislative side, the most significant development in this regard is the Employment Equality Directive and its proposition for reasonable accommodation to be made in the workplace for employees suffering from a disability. Generally, chronic illness tends not to be specifically addressed in EU policy documents but the recently-released Strategy for the Rights of Persons with Disabilities 2021-2030 does include a specific reference to workplace rehabilitation for workers who suffer from chronic illness. In addition, the EU 'Beating Cancer' Plan is a first concrete initiative that addresses the return to work of individuals with cancer. Hence, the topic appears to have started to attract more attention on the European policy agenda.

The EU-level social partners have, so far, engaged with the topic of the return to work after chronic illness only to a very limited extent. While autonomous framework agreements, such as those on active ageing or work-related stress, address concepts

relevant to workplace rehabilitation, specific policy engagement with the return to work concept has, up to now, been lacking. Our research suggests that the return to work could become more prominent on the agenda of the EU-level social partners in the future, with the stakeholders interviewed agreeing that the social partners have a key role to play in developing return to work policy at EU level.

In particular, there are several ways in which the social dialogue actors might function at EU level to address the return to work. One of the main ones here is to raise awareness, share information with national members and engage in capacity building. Such efforts could be further enhanced by increased cooperation with other actors such as campaigning and patient support organisations. The EU-level social partners could also influence European institutions to help the development of a more coordinated and holistic European strategy on the return to work.

While the return to work may be discussed in both cross-sectoral and sectoral social dialogue committees, the conclusion of binding agreements at EU level on the return to work may be less appropriate. In other words, one of the common messages is that social dialogue at European level should mainly have an awareness-raising role, providing general information on the topic, but that all the practicalities should rather be left to the member states and particularly to the sectoral actors due to national competence and the diversity of legal and industrial relations settings. Rather than new legislation at EU level, a better interpretation of the existing legislation, as well as more practical guidance for member states, could provide a more functional way forward. Here it is the national-sectoral level which appears to be the one most appropriate for specific social dialogue outcomes to be agreed on return to work issues while, going one step further, the enterprise level is the one where the practical and day-to-day management decisions on the ground are taken in relation to return to work matters.

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Chapter 2
Shaping an evolving framework on return to work: the role of the social partners in Belgium

Mehtap Akgüç, Nina Lopez Uroz and Leonie Westhoff

1. Introduction: chronic illness and employment in Belgium

Belgium faces longlasting challenges regarding the labour market activation of vulnerable groups, including sick and disabled people, notably due to persistent inactivity traps (Hufkens *et al.* 2017). Only three out of four people of working age (20-64) are active in the labour market (74.5 per cent), below the EU average of 78.7 per cent in 2019 (European Commission 2019). Meanwhile, before the Covid-19 pandemic, labour market shortages had become more acute, creating skills shortages and impeding the smooth functioning of the labour market especially in Flanders (European Commission 2019). Sickness and disability have become significant reasons for inactivity: the share of inactive people not seeking employment due to their own illness or disability increased from 10.7 per cent in 2007 to 19.1 per cent in 2019.[1] Furthermore, the share of private sector salaried employees[2] absent from work as a result of long-term illness increased significantly between 2008 and 2015, and has been continuing more recently albeit at a slower rate (Securex 2018). Population ageing and the related alignment of the statutory retirement age, as well as increased female participation in the labour market and the associated higher eligibility for benefits, seem to explain an important part of the increase in invalidity benefit claimants (Saks 2017).[3]

Associated with the extension of working lives, the incidence of chronic illness among the working population poses important challenges for the proper functioning of the labour market in Belgium. Chronic illness is associated with stigma and taboos, and often leads to social exclusion thereby producing a considerable burden on the workforce. Musculoskeletal and mental health problems are the primary causes of absenteeism, explaining about two-thirds of the significant increase in long-term sick leave and representing 67.3 per cent of sickness and disability insurance beneficiaries (Mutualités Libres 2019b). According to a study conducted between 2013 and 2017 by health insurer Mutualités Libres (2019c), over half of 'new' disability insurance beneficiaries already suffer from at least one chronic illness, depression being the most frequent. On the other hand the incidence of other types of chronic conditions, such as cardiovascular illness and cancer, has decreased (Saks 2017).

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1. Source: Eurostat, lfsa_igar, extracted 15 December 2020.
2. This figure only includes firms with less than 1 000 employees. Long-term illness refers to absences of more than one year (Securex 2018).
3. There is also evidence showing that women have a higher rate of reported poor health (Franklin *et al.* 2021).

This situation became more acute with the Covid-19 pandemic in early 2020 as Belgium reached its highest number of invalidity benefit recipients.[4] Covid-19 is estimated as likely to cause long-term health issues for 10 to 20 per cent of infected people (WHO 2020), leading to significant alterations in patients' ability to work and raising important issues of rehabilitation and reasonable accommodation in the workplace for those experiencing Long Covid. More broadly, the pandemic has made the return to work more difficult for people suffering from chronic illness as they face higher chances of developing severe complications from Covid-19. At the same time, however, the spread of remote working due to the pandemic might have eased the reintegration of some workers returning from sick leave.

Nevertheless, people suffering from a chronic condition in Belgium tend to face significant difficulties in terms of integration into the labour market and with their well-being. The gap for those at risk of poverty or social exclusion for people with and without disabilities amounts to 17.7 per cent, significantly higher than the EU average of 9.7 per cent (European Commission 2018). Only in February 2018 did a Belgian court apply, for the first time, the principle of non-discrimination based on disability and the associated duty on employers to make reasonable accommodation for people with chronic illness, as stated in the jurisprudence of the European Court of Justice (Eurofound 2019; CSC 2019). It should be noted here that Belgian legislation uses the concept of invalidity more than disability (CNT 2015).

Perceived as a threat to the sustainability of the social security system, this evolution is reflected in the Belgian government's increasing concern over the risk of incapacity for work. Increased awareness of this issue has been noticed over the past decade, while the switch from welfare to workfare has also been experienced in the area of incapacity (Houwing and Vandaele 2011). The increasing incidence of long-term incapacity for work has led to mounting social security costs as spending on disability increased from 1.9 per cent of GDP in 2005 to 2.6 per cent in 2016 (Pacolet 2019). In 2018 the combined spending on disability and sickness benefits exceeded for the first time the expenditure on unemployment benefits, probably due to a 'communicating vessels' effect between the various schemes for early withdrawal from the labour market (Pacolet 2019). The government has, since 2015, been seeking to address the economic impact of sickness absence and the mismanagement of the return to work leading to unemployment, disability pensions or early retirement. Notably the *mutuelles/mutualiteits* (insurance providers) are being encouraged to increase the rate of employment of the beneficiaries of long-term sickness insurance and to provide incentives for them to return to work. New pieces of legislation on work reintegration also address the challenge of supporting the return to work, where feasible, of workers with a chronic illness (i.e. where they are 'able' and have the 'capacity' to get back to work) (Securex 2018).

This context makes Belgium a relevant case study in understanding the role that industrial relations actors can play in designing and implementing return to work

4. Source: La Libre, 18/11/2020, L. Gérard, 'Invalidité: Le Covid peut faire exploser la casserole à pression en 2021-2022' https://www.lalibre.be/belgique/societe/invalidite-le-covid-peut-faire-exploser-la-casserole-a-pression-en-2021-2022-5fb427307b50a6525b6661c6

policies, even more so given the country's industrial relations and welfare state regime. Belgium has a strong tradition of a Bismarckian continental welfare system, corporatist arrangements and social pacts as solutions in the case of social conflict (Houwing and Vandaele 2011). The Belgian industrial relations system is characterised by a strong role for the social partners, a high union density rate and significant collective bargaining coverage. Dialogue with the state also plays an important role in the social dialogue process and unions are involved in social security management and in the development of social and employment policy at federal and regional levels.

This chapter first outlines the policy framework on the return to work in Belgium. It then evaluates how the social partners shape and view policy on the return to work at national level and at company level, consolidating and analysing the data collected through interviews with relevant stakeholders, at stakeholder events and via online surveys distributed to social partners, managers in companies and workers.

2. Policy framework on the return to work in Belgium

According to a typology of rehabilitation and return to work systems in Europe, Belgium is classified by EU-OSHA (2016) as part of the group of 'European' countries, together with France, Iceland, Italy, Luxembourg, Switzerland and the United Kingdom. These countries are characterised by well-developed frameworks for rehabilitation and the return to work but with limited coordination between the different stakeholders. The return to work is considered as the period of sickness absence comes to an end and with only limited possibilities for early intervention. Nevertheless recent policy developments have shifted the Belgian approach to the return to work.

2.1 Sickness and the invalidity benefit system

Belgium has a 'pillarised' social security system composed of separate regimes for salaried workers (sometimes differentiated by blue collar and white collar workers), self-employed and civil servants (Pacolet 2019). Trade unions, insurance providers and employer organisations co-decide various aspects of these social security regimes. Each regime has a different framework and coverage regarding sickness, disability insurance and the return to work. Different regimes also exist depending on the cause of the illness. While *Agence fédérale des risques professionnels/Federaal agentschap voor beroepsrisico's* (Federal Agency for Occupational Risks; FEDRIS) manages benefits in relation to occupational accidents and diseases, it is the federal institution *Institut national d'assurance maladie-invalidité/Rijksinstituut voor ziekte- en invaliditeitsverzekering* (National Institute for Health and Disability Insurance; INAMI/RIZIV) which is responsible for non-occupational illness. As the coordinator of the sickness and disability insurance benefit system, INAMI/RIZIV works in collaboration with the accredited insurance providers who act as intermediaries with the insured and as key gatekeepers in terms of access to sickness and disability benefits (OECD 2013). This chapter focuses on the schemes coordinated by INAMI/RIZIV for salaried workers.

Unlike in most other countries within the OECD, sickness and disability benefits in Belgium are integrated into one single system managed by INAMI/RIZIV. To be eligible for incapacity benefits, the employee must have fulfilled several contributory requirements. Work incapacity is divided into two periods: *incapacité de travail primaire/primaire ongeschiktheid* (primary work incapacity), corresponding to sickness benefits during the first year of sickness; and *invalidité/invaliditeit* (the period of invalidity), corresponding to the disability benefits which are applicable after one year of incapacity. An employee on sickness leave receives a guaranteed salary during the first month of absence (or 15 days for blue collar workers), paid by his or her employer. Following the first month, INAMI/RIZIV takes over the management of incapacity benefits, covering 60 per cent of the worker's salary up to a certain maximum annual amount. After one year of incapacity, the period of invalidity may be prolonged by a decision of the *Conseil médical de l'invalidité/Geneeskundige raad voor invaliditeit* (the Invalidity Medical Council of INAMI/RIZIV) on the basis of a medical report written by a physician from the insurance provider. The payment of invalidity benefits can continue until retirement, depending on how the employee's health condition evolves. During the period of incapacity, the beneficiary is not allowed to work unless the insurance provider's occupational physician authorises part-time work.

In 2018 incapacity benefits amounted to €1.8 billion and invalidity benefits to €5.8 billion. Between 2013 and 2018, invalidity benefits increased by 7.8 per cent per year on average (Mutualités Libres 2019b, based on INAMI/RIZIV data).

2.2 Provisions for rehabilitation and return to work support

The Belgian incapacity and invalidity benefit system encompasses several pathways into work based on activation and vocational rehabilitation. The federal and regional governments have focused over the last few years on increasing fitness for work among workers on long-term sickness leave and improving the incentive structure for the return to work. The policy framework on the return to work applies to several legislative areas, including legislation on social security, labour market regulations, well-being at work and disability (CNT 2015). It forms a major part of the *Code du bien-être au travail/ Codex over het welzijn op het werk* (1996 Act on Well-being at Work, as amended) which extended the concept of health and safety at work to cover all aspects of well-being in the work environment. This put a legal obligation on the employer to take all necessary measures to protect employee well-being such as risk assessments and medical check-ups conducted by external or internal prevention services. In addition the Law of 3 July 1978 on employment contracts included important provisions on the consequences for the employment contract of work incapacity, partial return to work and permanent work incapacity; while the Law of 14 July 1994 on compulsory health-care and indemnity insurance also included provisions on invalidity and incapacity benefits which can have an impact on the return to work. Furthermore the Anti-discrimination Law also encourages an employer to make reasonable accommodation for a disabled worker as advised by the occupational physician and forbids any employment-related discrimination due to health or disability status.

Returning to work gradually while keeping partial invalidity or incapacity benefits has been possible since 1996. The insurance provider's occupational physician must first authorise medical part-time status or adjustments to the workload (Mutualités Libres 2019a) and this is dependent on two conditions: that incapacity remains at least 50 per cent; and that the job does not jeopardise the person's health. The physician also decides on the intensity and duration of part-time work which can be gradually increased until the beneficiary is ready for regular or full-time work. Adjustments can be related to working hours (longer breaks, shorter week, fewer hours per day); work organisation (telework, slower work pace, change in tasks); workspace and equipment; the provision of specific training; and putting in place support by a coach, colleague or line manager. Benefits are adjusted according to the number of hours worked in a week. The medical part-time option was rarely used in the past but the number of authorisations of a partial return to work is now on the increase (OECD 2013; Mutualités Libres 2019b).

A new *trajet de réintégration/re-integratietraject* (formal return to work/reintegration procedure) was implemented in 2016 as a new chapter of the 1996 Act.[5] Informal dispositions regarding the return to work existed before this reform, such as the *visite de pré-reprise du travail/bezoek voorafgaand aan de werkhervatting* (voluntary medical appointment) with the occupational physician, implemented in 2004 (SPF Emploi 2018). However, the 2016 legislation added a formal procedure for the return to work, requiring physicians from insurance providers to assess the possibilities for the return to work within the first two months of sickness absence. Beyond systematising early intervention and individual case management, thereby strengthening the insurance providers' role in sickness monitoring, the reform provided a series of steps to follow for voluntary, gradual and adapted return to work.

The goal of the new procedure is to reintegrate the worker with an employment contract within the same company so that he or she can return to a familiar environment. The procedure outlines a sharing of responsibilities between the main stakeholders on a practical level and foresees a collective framework for the return to work after sick leave to be developed at company level, for example by the *Comité pour la prévention et la protection au travail/Comité voor Preventie en Bescherming op het Werk* (health and safety committee). It also clarifies the use of 'medical *force majeure*' to terminate an employment contract which can now be invoked only where the employee has gone through a formal return to work procedure. In 2016, 4 801 formal return to work procedures were initiated with 5 015 being undertaken in 2017 (Mutualités Libres 2019b, based on INAMI/RIZIV numbers).

Réinsertion ou réhabilitation socio-professionnelle/socioprofessionele re-integratie (occupational rehabilitation) is targeted at workers declared unfit to return to their former company as well as at unemployed or self-employed workers (Mutualités Libres 2019a). This enables the individual to attend a training or rehabilitation programme to update their skills or acquire new ones. INAMI/RIZIV cooperates with several regional public employment services on this matter as they are responsible for labour market activation policies and training. Regional agencies specialised in vocational

5. Royal Decree of 20 December 2016 amending the Royal Decree of 28 May 2003.

rehabilitation for disabled workers (e.g. GTB - *Gespecialiseerd Team Bemiddeling*; Service PHARE - *Personne Handicapée Autonomie Recherchée*; AViQ - *Agence pour une Vie de Qualité*) are also involved. Financial incentives are attached to this procedure: participation fees are covered by INAMI/RIZIV and participants receive a lump-sum payment of €500 at the end of the training. However, participants can lose their entitlement to disability benefits within six months of the training which can act as a disincentive. Furthermore in 2018 the federal government introduced in its *Deal pour l'Emploi/Arbeidsdeal* (Job Deal) the right to an outplacement payment of up to €1 800 paid by the employer in cases where the latter has invoked medical *force majeure* to terminate the employment contract.

Some financial and technical support is available for employers at regional level in the case of an employee's recognised permanent functional limitation (e.g. the *Vlaamse ondersteuningspremie* in Flanders; SPF Emploi 2018). Regional financial support also includes adjustments to the work environment, the coverage of work and living expenses, paid interpreters in the case of hearing impairment and a premium for companies offering mentoring support to a returning disabled worker. In 2014 INAMI/RIZIV created a training course for 'disability managers', subsidised by the state but paid for by the company, to support the return to work process at company level (INAMI 2019). This is based on disability management methodology aimed at maintaining employment and facilitating a quick and adapted return to work. Additionally, INAMI/RIZIV also runs pilot programmes, such as the Individual Placement and Support programme for people suffering from mental health issues. This follows a 'place then train' model and consists of the provision of early and continuous support for the return to work, including after the start of the job. Depending on the results of the pilot programme, this model could be implemented as an alternative to existing rehabilitation schemes.

3. Involvement of the social partners in shaping return to work policy at national level

3.1 Industrial relations structures and return to work policy

This section focuses on the involvement of the social partners in the design and implementation of return to work policies at national level. The analysis relies on interviews with key stakeholders and the survey targeted at national social partners referred to in the Introduction as well as a literature and policy review.

Belgium is characterised by a strong social dialogue tradition involving established industrial relations structures and actors.[6] The country has a relatively high unionisation rate amounting to more than 50 per cent while collective bargaining covers approximately 90 per cent of employees. At national level, workers are mainly

6. For a brief overview of the industrial relations system in Belgium, see www.worker-participation.eu/National-Industrial-Relations/Countries/Belgium/Trade-Unions provided by the European Trade Union Institute (ETUI) (last updated in 2016).

represented by three large trade union confederations: *ACV/CSC* (Confederation of Christian Trade Unions); *FGTB/ABVV* (General Federation of Belgian Labour); and *CGSLB/ACLVB* (Confederation of Liberal Trade Unions of Belgium). On the employer side, the main national association for employers is *FEB/VBO* (Federation of Belgian Enterprises). In addition, craft and trade sector employers, the self-employed and small and medium enterprises are represented by *UNIZO* in the Flemish-speaking region and *UCM* in the French-speaking region. The membership rate of employer organisations in Belgium is above 80 per cent (ETUI 2016).

National social dialogue takes place within thematic advisory bodies: *Conseil National du Travail/Nationale Arbeidsraad* (National Labour Council; CNT/NA); *Conseil Central de l'Economie/Centrale Raad voor het Bedrijfsleven* (Central Council of the Economy); and *Conseil Supérieur pour la Prévention et la Protection au Travail/Hoge Raad voor Preventie en Bescherming op het Werk* (High Council for Prevention and Protection at Work), an advisory body focused on matters related to the well-being at work legislation (ETUI 2016). The CNT/NA has a cross-sectoral remit extending to the whole of Belgium and covering all companies and sectors, with a composition divided equally between representatives of the main employer associations and trade unions. Its principal functions are to provide advice and deliver opinions to a minister or the two chambers of the legislature (upon request or on its own initiative) on general issues of a social nature. It also provides a platform for collective bargaining agreements and performs an important role in policy evaluation.

Since the beginning of the 2010s, the CNT/NA has been working on the topic of the return to work. It has followed a coordination role as a 'Platform for consultation between the actors involved in the process of the voluntary return to work of people with health problems' (CNT 2015). This platform on the return to work was set up as a structural consultation framework bringing together the social partners and the other institutions (e.g. INAMI/RIZIV, Ministry of Labour, FEDRIS) involved in the process of the voluntary return to work. Its goal was to develop an integrated approach to the return to work after chronic illness, considering the social security aspects as well as employment and health and safety issues, gathering all the institutions involved in the issue. As regards the government, the Ministry of Labour and the Ministry of Social Affairs have been involved in the issue of the return to work and were jointly responsible for the Royal Decree of 2016 on the new return to work procedure. Discussion and negotiation with the social partners in preparing legislation at federal level is of key importance to the wider process.

Before the start of the CNT/NA's consultation platform, the focus of the social partners was mainly on prevention in terms of health-related issues in the workplace. Since then, the return to work has been rather high on trade union agendas. This was accentuated when the social partners noticed the adverse social consequences of the 2016 reform, notably the sharp increase in the number of contract terminations due to medical *force majeure* (CNT 2018c). However, it is still taking time for them to incorporate this issue fully into their programmes. The social partner survey noted that nearly two-thirds of social partners had only marginal and ad hoc involvement in return to work policy-making or policy implementation but would like to have a more active involvement.

This additionally suggests that the initiative to come up with a policy on the return to work was taken by other bodies (rather than the social partners themselves), such as the government.

A key role for the national social partners is to inform and support their local members in understanding how the new procedure works, for example via study days and training courses or booklets (CSC 2019; FGTB 2019). Indeed, company-level industrial relations structures matter in facilitating the implementation of national legislation at a more local level since they serve as intermediaries between the high-level decision-making bodies and the regions and companies where policies are implemented. Equally they are responsible for collating the issues observed at local levels and raising them for discussion and negotiation at national level. This important bottom-up function follows the pyramidal structure of trade unions: local branches are in contact with company-level union members and run the regional social rights offices (*Office régional de droits sociaux)*, providing legal and strategic support to workers facing problems with their employers. Information and complaints can then be channelled to the sectoral and cross-sectoral levels. Regional stakeholders share information with national stakeholders, enabling them to negotiate on legitimate grounds.

3.2 Interaction between industrial relations actors and other stakeholders in return to work policy

The nature of the interaction between the key industrial relations actors is generally reported as cooperative while discussions on return to work policy tend to be constructive. All the opinions issued by the CNT/NA have been unanimous, showing the social partners' willingness to display a 'united front' to give strength to their recommendations so as to influence the government. They especially agree on the need to ensure that the return to work is a voluntary process and happens early, to change mindsets on the issue and to give a key role to the occupational physician in the process. Even so, there have been several disagreements between the social partners, one example being the financial responsibility carried by the employer: trade unions asked that they cover the salary for the first two months of sick leave but employers opposed this as it would place small and medium-sized enterprises (SMEs) in a difficult situation.

There has also been some disagreement between the social partners and the government, which intensified after the disclosure of figures on the increase in contract termination due to medical *force majeure*. Trade unions condemned these adverse social consequences in the media and the issue became increasingly debated in the public sphere. Furthermore it is a matter of regret for the social partners that none of their recommendations have been implemented, a situation partly related to the political stalemate that Belgium encountered until the formation of the De Croo government in September 2020. Up to that point, the government had mainly taken responsibility only for current affairs (*Gouvernement d'affaires courantes/Regering in lopende zaken*) and had limited competence in diverse policy areas. Another bone of contention was the government's draft legislative proposal in May 2018 which

planned to impose financial sanctions where employers and employees had failed to fulfil their responsibilities regarding the new return to work procedure. The proposal was strongly rejected by the CNT/NA (CNT 2018b). The CNT/NA was also critical of the introduction, as part of the Job Deal in 2018, of a new general compensation measure for employees declared unfit to return to their former job. This measure was seen as insufficiently individualised and lacking in tailored support from the regional employment services (CNT 2018d).

Interactions on the return to work in Belgium can become complex due to Belgium's multilevel governance. Return to work issues cut across policy areas which are assigned either to the federal (social security) or the regional (active labour market policy) levels. Designing a comprehensive common policy framework can thus be a challenge. There is a major need to increase cooperation between the various stakeholders so as to facilitate the implementation of legislation on the return to work following chronic illness.

3.3 Outcomes of social dialogue regarding return to work policy

One of the main outcomes of social dialogue at national level on the return to work was the key role played by the CNT/NA in supporting the overhaul of legislation on the matter via the forum it established on the return to work. The overhaul of the policy framework originated around 2010 when INAMI/RIZIV put the issue of the return to work on the agenda following the sharp increase in the number of long-term sickness insurance beneficiaries. In doing so, the Institute called for a more active approach towards workers on sickness leave who are able to perform some level of occupational activity, on the grounds that this would be beneficial for their recovery prospects as well as for the sustainability of the Belgian social security system. In 2015 the CNT/NA published a report on the results of the forum's work, laying down some basic principles for legislation which embodied the need for a collective approach to the return to work, concrete incentives, a voluntary procedure, clarification on the use of medical *force majeure* and identifying the key role of the occupational physician. These discussions and agreements were later adopted as part of the Royal Decree in 2016.[7] By subsequently consulting experts and civil society stakeholders during its evaluation of the 2016 legislation, the CNT/NA also gathered relevant information on return to work policy and the potential gaps that needed to be addressed. However, it is unclear whether and how the 2016 legislation will be modified following the CNT/NA's evaluation (as well as that performed by a group of academics).[8]

Beyond influencing the legislation, it is clear that the Belgian social partners could do more on the topic of the return to work such as issuing common practical guidelines for health and safety committees, employers and union representatives on how to

7. For more details on the Royal Decree, see the legal documentation (in French): www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2016102808&table_name=loi
8. For more information on the evaluation conducted by researchers from KU-Leuven and ULB: https://emploi.belgique.be/fr/projets-de-recherche/2018-evaluation-de-limpact-de-la-nouvelle-reglementation-sur-la-reintegration

implement a company-level return to work policy. The social partners could also work at sectoral or cross-sectoral levels on collective bargaining agreements specifically on the return to work which has not happened so far.

However, the outcomes of social dialogue at sectoral level are more difficult to determine. Sectors follow divergent approaches on the return to work as they face different prospects in finding adjustments in terms of the tasks which may be carried out by workers experiencing chronic illness. In this respect, the presence of a diversity of tasks within a sector may actually act as a facilitator in the return to work. For instance, firms in the construction sector tend to have well-established procedures on the return to work and the potential for adjustments in task allocation. Here, a progressive return to work into the workplace is possible, for example, by allocating fewer physically demanding tasks to a worker returning after sickness absence. Other sectors face more difficulties in proceeding to reasonable accommodation such as the voucher-based parts of the service sector (including cleaning and homecare services), which is characterised by a high incidence of musculoskeletal diseases. Trade union representatives here have tried to react to the negative consequences of the return to work procedure by putting the issue on the sectoral negotiation agenda.

3.4 Views of the industrial relations actors on the policy framework for the return to work

Returning to work after (or indeed with) chronic illness is evidently a salient issue in Belgium. A clear formal return to work procedure is welcome on the basis that stakeholders tend to agree that action is needed in the face of the high prevalence of chronic illness and the scale of long-term sickness absence and rising expenditure linked to sickness and disability benefits. However, there is also consensus that a more thorough *ex ante* impact assessment should have been conducted and that the procedure should be revised.

Trade unions and employers share the view that informal procedures offer a more efficient and flexible approach to the return to work in which the occupational physician can give advice instead of making binding decisions. Moreover, informal procedures allow for a case-by-case approach, taking into account sectoral and company-level considerations as well as those specific to the worker's health and preferences. Formal procedures might then only come to be used where other informal options have been explored or if there is a conflict between the employee and the employer. Employers are also prone to criticise the return to work procedure as too cumbersome in terms of administration as well as over-formalised and slow. Together, the social partners also underline the primary importance of prioritising prevention in company-level social dialogue so as to avoid chronic diseases such as mental and musculoskeletal disorders.

Another common criticism relates to the frequency with which formal return to work procedures lead to a contract termination for medical reasons; these can result from a decision by the occupational physician that the employee is permanently unfit to return

to the former job (i.e. a category C or D decision, as designated in the legislation).[9] Such criticism is particularly offered by trade union representatives who describe the legislation as having been drafted without having considered the potential unforeseen impacts of the procedure for contract termination. Consequently trade unions sometimes advise their members not to engage in the formal procedure. This aspect was also referred to in one of the CNT/NA's unanimous opinions (2018b). Available data from 2018 (CNT 2018c) shows that the large majority of decisions taken by occupational physicians were category D decisions (68 per cent), i.e. that the worker is definitively unfit to return to work in the same company. There is no systematic support provided to this type of worker and little is known about their situation after dismissal. Support measures and procedures exist for them, such as initiatives by INAMI/RIZIV and the regional employment services, but the social partners underline the need for a coordinated and systematic approach to raise awareness on this aspect.

The lack of public, reliable data on the return to work after chronic illness has also been raised by the social partners as it renders evaluation of the new policy more difficult (CNT 2018c). This is partly a reflection of the lack of data on the situation of former employees who have been dismissed for medical reasons following a category D decision. However, the lack of consistent data also hampers an analysis of the situation of employees who have been reintegrated into their company, for example regarding adaptations in terms of workload, working time and work tasks. Better data availability would allow a measurement of the impact of the return to work on the careers of employees whether or not they return to the same company. It would also enable a better understanding of the gendered implications of the return to work, as some female-dominated sectors tend to allow for less flexibility in terms of tasks and display more atypical and precarious forms of employment, such as the cleaning sector.

It is also clear that the public debate tends to be over-focused on sanctions and the assignment of responsibilities and insufficiently on incentivising employers and employees to engage actively in the return to work. Stakeholders from both trade unions and employer organisations also regret the absence of support mechanisms to accompany stakeholders or guide them along the return to work process, including inside the firm. The cost of return to work procedures can be a burden on employers, especially on SMEs who often lack the human resources required to implement a return to work procedure and reorganise a team where the returning employee does so on a medical part-time basis. Another issue highlighted by trade unions is that employers are not strongly incentivised to invest in prevention or create opportunities for adapted work in the company given the short duration of the guaranteed salary period. One avenue suggested by the social partners is to revise the legislation to make specific provision for SMEs and to provide them with further support to implement reasonable adaptations.

9. As part of the work ability assessment, the occupational physician declares whether the employee is temporarily unfit or permanently unfit to perform his or her former job. If the employee is declared fit, the doctor then evaluates whether an adapted job can be performed in the meantime within the company (category A decision) or not (category B decision). If the employee is declared permanently unfit to perform his or her former job, the doctor also evaluates if an adapted job or another job can be performed in the meantime within the company (category C decision) or not (category D decision). A Category E decision means that the employee is not yet ready for a return to work and will be re-examined every two months.

The social partners in the CNT/NA are also agreed on several recommendations for modifications (CNT 2018c). They argue for more consultation with stakeholders before the occupational physician takes a category C or D decision and for the provision of support from a trade union representative or a member of the company's health and safety committee during the procedure. In addition the social partners have asked for a change in the timing of the procedure, which currently leaves either too much or too little time for dialogue and consultation, while asking that the occupational physician better underlines the remaining capabilities of the employee in the work ability assessment. The social partners also tend to agree with campaigning and patient support organisations on the lack of centralised access to information for employers and employees.

Furthermore there is evidently a need to enhance cooperation between doctors. Multiple specialists are involved in examining a worker's medical file, including occupational physicians, medical experts from the insurance providers and the general practitioner treating the worker. In most cases, decisions on the fitness of the worker to go back to work are not coordinated between these specialists as a result of confidentiality reasons, data sharing constraints and the lack of time. Therefore, the social partners have requested the creation of a digital tool that could help with data sharing and coordinated follow-up between the different health professionals and institutions involved in the return to work process. In parallel, pilot projects such as the 'Trio groups' project have been implemented by professional medical associations to address this lack of multidisciplinary collaboration between the three professions. This is a means to the organisation of common training events and dialogue (Lenoir 2017).

Finally there is a need for cultural change to avoid the stigma around the return to work. There is a growing consensus that going back to work following chronic illness can be good for the health of the worker and can prevent social exclusion. This, however, requires a shift in mindset towards focusing on and building on the remaining abilities of the worker. Therefore, the social partners – via the CNT/NA – have underlined that the 'disability case manager' training organised by INAMI/RIZIV should be more widely promoted among firms (CNT 2018c). This would help raise awareness within HR services about good practice regarding absenteeism and the return to work.

4. The return to work process at company level and the involvement of the social partners

4.1 Workers' experiences of the return to work process

Analysis of the survey and interview data helps us obtain a fuller assessment of the role of the social partners in shaping the return to work in Belgium, their involvement at company level and their impact on the return to work experience of employees within the firm. However, it is important to acknowledge the limitations of the survey data given the small size of the sample.

From the perspective of workers returning to work following chronic illness, support from and the involvement of their boss, colleagues and health professionals appear to play important roles. Family seems to do likewise, but only in combination with these other actors. Workers indicated, however, that trade union or employee representatives, rehabilitation institutes and NGOs play only a minor role in facilitating the return to work after sickness leave.[10]

There is thus a mixed picture as regards the role of trade unions in facilitating the return to work at company level. Trade unions emphasise the central role of their local representatives but others, including employer organisations, state that the role of trade unions at company level is rather weak on the basis that the return to work is more of an individual than a collective issue. More than half of respondents in the worker survey were trade union members, with almost two-thirds stating that they had access to a trade union or other employee representative in their workplace. Nevertheless workers are generally not satisfied with the support offered by trade unions in their return to work and only one in five receive the expected level of advice or guidance from their trade union. Accordingly trade union representatives are generally not regarded by workers as important in the return to work process.

One explanation for this limited role is that personal health matters are seen to be too sensitive to be handled through social dialogue. Local representatives often do not have access to information on employees struggling with return to work issues unless they are directly approached, given both the confidentiality concerns and that the employer has no obligation to communicate with union representatives on this matter.

Most workers state that they did have concerns about returning to work. These include the potential lack of employer support where productivity or concentration levels did not fully meet managers' expectations, the unwillingness of the employer to adjust working conditions post-illness and an expectation that they would continue to work long hours, as they had done previously, immediately upon returning to work. Although some employees have positive experiences, the majority express feeling left alone in the return to work process with a lack of support from their employer but also from the trade union. Several employees report that, ultimately, they changed their job after resuming work. Some also express frustration with the regulations governing the return to work process.

The majority of surveyed workers benefited from few adjustments upon returning to their jobs. The most common adjustments were made in the formal work contract (e.g. from full-time to part-time work) together with the offer of flexibility to facilitate medical appointments, but only about one-third of workers received reasonable or extensive support on this. The postponement of work deadlines seemed to happen only in a few cases. The clear majority of respondents (60 per cent) receive limited or no support in adjusting their work environment, their daily working time (in terms of long or night shifts) or their tasks so as to share responsibilities with colleagues.

10. More detailed analysis of the survey results can be found here: http://www.celsi.sk/en/projects/detail/64/

4.2 Perspectives of company actors on the return to work process at company level

Most companies indicate that employee absence does have an effect on the organisation. In particular, the worker might not be replaced in the first instance but workflow has to be rearranged and job tasks divided between other employees. Such adjustments are, as we have reported already, especially difficult for SMEs which lack the capacity to redirect workflow. During the return to work process, companies consider certain resources to be helpful, specifically legal advice during sickness leave and external counselling from doctors or therapists as well as professional associations. However, external counselling, information on workplace adjustments and guidance on financial strategies in dealing with sickness leave are sadly lacking.

The work culture in Belgium and the continuing stigma around workers with chronic illness does influence workers' ability successfully to return to work and many employers are indeed unwilling to adjust tasks for returning employees. Employers do not perceive workers to be less committed after being diagnosed with a chronic illness but they do feel that an employee returning to work on reduced duties would increase the workload of colleagues and a majority disagree that workers should have the right to a gradual return to work on full pay. However, employers also regard that workers should be entitled to adjusted working duties at the organisation's discretion (70 per cent) or as a legal entitlement (55 per cent). Moreover, most agree that staying in touch with an employee during their absence was important (89 per cent) while most also believe that returning to work during treatment should be encouraged wherever possible.

Return to work is addressed in company-level collective agreements in only a minority of companies (20 per cent), but 60 per cent confirm that they consult on their organisation's return to work issues with trade unions or employee representatives. In most cases, these interactions are of a regular nature with a trade union representative being part of a health and safety committee that discussed return to work. Praised outcomes from interactions with union representatives on the matter include training sessions for managers on interacting with chronically ill employees and informal agreements on the role of employee representatives in supporting the management of the return to work process. Specific return to work provisions in collective agreements are also seen as beneficial outcomes of interaction with union representatives.

4.3 Interactions between employer and employee in facilitating the return to work

From a worker's perspective, it seems that experience of the return to work process is quite individualised with little being coordinated at company level. Most employees declare that adjustments in their tasks or responsibilities are not negotiated between their trade union or employee representatives and their employer. Therefore, negotiations at company level do not seem to play an important role in the return to work process. Employees are also rather critical of the degree of coordination between

health professionals and employers as well of the preparedness of their company to make reasonable adaptations upon their return. Although half feel welcome at their workplace, only a few receive guidance or mentoring from their employer (26 per cent) or their trade union (13 per cent) during their return to work.

Reflecting on these results, while procedures do exist at company level they are often not well implemented and can be difficult to understand for the worker. In addition, the creation of a welcoming social environment in the company, while crucial, can be challenging particularly as colleagues might be sceptical of reintegration given that the reorganisation of workflow may well increase the burden on them.

Most managers say they have regular interactions with workers on sick leave (70 per cent) and in an informal setting, i.e. via phone calls, friendly conversations or indirect information via colleagues (77 per cent). Similarly, qualitative data emphasises the importance of informally keeping in touch with workers in facilitating their return to work although employers clearly have to be careful not to give the impression of 'harassing' the employee. A majority of managers in the survey declare that, during sick leave, the company generally keeps employees informed about work-related issues but does not involve them in work-related planning and decisions.

Informal coordination between the employee and employer is the preferred way of dealing with the return to work after sick leave. This entails thorough discussion and planning of reintegration before the employee's return to work, from which to develop a joint strategy, as well as cooperation with external organisations on occupational health and safety. Managers perceive that ad hoc adjustments in working time and flexibility in workload are quite widespread and that, in general, they are understanding, declaring that they do not expect workers to come back to their pre-illness productivity levels. Measures implemented less often include common standard procedures and a defined adjustment plan for each employee discussed in the health and safety committee – even though it is now mandatory in medium and large companies to have a company-level policy on employees' return to work. Medical returns are, however, only rarely discussed by health and safety committees in practice.

Overall, the results from the company survey are somewhat at odds with those from the interviews and discussions with social partners and other key stakeholders, with the latter reporting that many companies struggle to offer substantial adjustments to employees and that employers often expect full productivity upon return especially since they lacked the incentives to offer adjustments given the current legislation. This may be due to selection bias in that those companies which are more interested in the issue of the return to work, and more committed to facilitating it for their employees, are more likely to participate in a survey and contribute to research on the topic.

4.4 Views on the future potential for social dialogue to support the creation and implementation of return to work policies at company level

As regards the future role of social dialogue to support return to work policy at company level, employees favour a stronger role for trade unions, agreeing that trade unions should continue to be involved in health-related issues and that the return to work should be part of the agenda for social dialogue negotiations. Employees seem, however, to prefer the negotiation of binding agreements with the employer on making reasonable accommodation during the return to work and tend to be indifferent to individual consultation with trade unions.

On the one hand, results from the social partner survey indicate that trade union representatives strive for more active involvement in the implementation of return to work policy in Belgium. On the other hand, representatives of employer associations are more split on their preferred level of involvement: a quarter are satisfied with the current situation although another quarter wish for greater involvement. Employer organisations similarly tend to see return to work as an individual rather than a collective matter, where unions only play a limited role; while trade unions emphasise the potential for social dialogue at company level to influence return to work processes.

According to managers, there are a few elements that should change in their companies regarding the return to work such as better interpersonal relations with employees to deal directly with employee reintegration, and better cooperation with health professionals and campaigning and patient support organisations to facilitate the return to work process. Managers also tend to agree that organisational policies should be improved. One avenue for improved organisational policies is the development of a return to work strategy in health and safety committees, as already mandated by national legislation since 2016, where the social partners can be involved in the process of discussion. Managers do, however, report a sceptical outlook on the current legislation which none regard as providing good guidelines for company-level action. At the same time, managers do not wish for more specific legislative provisions on company-level return to work policies; instead they prefer flexibility.

5. Discussion of research findings and conclusion

This chapter has analysed the role of social partners in Belgium in the design and implementation of policies on return to work for workers after, or with, chronic illness. This became an important issue on the political agenda in Belgium in the 2010s with an increasing number of cases of sick leave due to chronic illness and soaring social security expenditures. The current Covid-19 pandemic appears to have added further challenges on the return to work, causing health complications for chronically ill workers. Faced with increasing concern over incapacity for work, absenteeism (mainly due to mental health and musculoskeletal illnesses) and the financial sustainability of the Belgian welfare state, governments have sought to address the economic impact of sickness absence by means of activation policies, i.e. by offering more opportunities to previously sick employees to come back to work. This resonates with the objectives of

the Europe 2020 strategy which is aimed at a gradual increase in the presence at work and fitness for work of previously ill employees, facilitating their longer involvement in the labour market.

The analysis in this chapter has shown that the social partners assume a significant and multi-faceted role in the development and implementation of return to work policies in Belgium. Social dialogue has helped substantially in developing a new framework for the return to work, even though this has important limitations. After INAMI/RIZIV put on the agenda the need to improve the reintegration of employees suffering from chronic illness, the social partners – via the CNT/NA – participated in the design of a new return to work procedure targeted at employees seeking to return to their former occupational activity. The social partners were able to influence the legislation by putting forward some key principles, such as the concept of a voluntary return to work process, the key role to be occupied by the occupational physician and the need for both collective return to work and concrete incentives. However, the 2016 reform's unforeseen consequences have also been criticised, especially by trade unions, mostly regarding the issue of contract termination for medical reasons.

Since EU-OSHA established its typology of systems in the return to work (2016), our findings show that the Belgian policy framework has evolved towards early intervention and a case management approach. This is exemplified by the new obligation on health insurance providers to assess, at the start of the period of invalidity, options for the return to work based on the employee's medical condition. While the financial incentives for employers to engage in early planning of the return to work have not been substantially changed, employers now have clearer responsibilities regarding the creation of an individualised return to work plan for the employee and of a company policy on return to work. Employees can benefit from transitional work options based on the work ability assessment performed by the occupational physician. However, there are still coordination problems between health professionals and the stakeholders involved at company level.

Effective social dialogue can certainly help with the return to work, but sectoral and firm characteristics play a more important role in determining the success of the return to work itself. Also, return to work following chronic illness can be difficult to tackle via social dialogue, given its sensitive and private nature, while it also involves workers shifted to the margins of traditional social dialogue as they are excluded from occupational life during the period of their illness. However, employers can play a key role at firm level, beyond human resources and occupational health services, in ensuring smooth reintegration for example by involving colleagues and line managers in the process. Some instruments and legal dispositions are in place, such as the obligation to discuss annually within the health and safety committees a company procedure on the return to work. However, these dispositions are not well implemented on the ground. Similarly, trade union or employee representatives are accorded an important role in the new legislation (CSC 2019). They can perform important functions such as offering emotional support during the return to work process and providing legal advice to the employee in the case of conflict with the employer as well as strategic guidance on the complexity of the procedure and during negotiations with the employer on the

reintegration plan. Additionally they can act as a mediator between HR and the employer as well as with colleagues. Trade union representatives can also put return to work on the agenda of health and safety committees which have the capacity to assess company return to work policies based on the quantitative and qualitative evaluations provided by the occupational physician. As part of these committees, trade union representatives can also contribute to the evaluation of the company policy and its implementation on the ground. However, there is substantial room for improvement in this area especially due to a lack of information on the part of union representatives and employees, as well as because of the sensitive nature of people returning to work with chronic illness.

Our findings highlight that a tailored company-level approach tends to be more efficient when combined with a broad national framework enforcing basic rights and requirements regarding return to work procedures. Informal procedures are often praised as a more efficient and flexible approach to the return to work in which the occupational physician can give advice instead of making binding decisions. In parallel, social partners at the federal level could coordinate via the CNT/NA to issue guidelines based on best practice as a means of helping companies and local union representatives design company-level return to work procedures. Return to work after sick leave could also be tackled at sectoral or cross-sectoral level in a similar approach to that used by the social partners in addressing burnout (CNT 2018a). Ultimately, however, gathering reliable and systematic data on the outcomes of the return to work and the situation of chronically ill employees is the issue that needs to be prioritised most of all.

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Chapter 3
Why do individualised industrial relations mean the underutilisation of policy tools? Workers who fall ill in Estonia

Marti Taru and Triin Roosalu

1. Introduction

Estonia is a small, post-socialist country with a population of 1.3 million. People have a longer working life than in most other European countries: the duration of working life in Estonia in 2019 was 39 years compared to an EU-28 average of 36.4.[1] Moreover, the number of employed people aged 15-74 has been increasing over time, from 568 000 in 2010 to 671 000 in 2019 (an increase of 18 per cent),[2] despite the population staying relatively stable.[3] While the share of those aged 65-74 in the total population has remained roughly the same, at 10 per cent,[4] the share of 'elderly workers' between these ages has increased from 15 per cent to 27 per cent. The unemployment rate in Estonia has also been relatively low, at 5 per cent or below between 2015 and 2019.

Longer working life comes from the increased employment of elderly people who also are likely to suffer from chronic conditions. In 2016, the self-rated health condition of the Estonian population was relatively poor in general, with health being assessed as good or very good by 53 per cent of the population compared to an average of 68 per cent across the EU-28 (OECD and European Commission 2018). In relation, the number of expected healthy years in 2018 in Estonia was notably lower than in the EU on average, meaning that a relatively high share of elderly employees had some kind of health problem. The chronic morbidity rate in Estonia significantly exceeds that of the EU average at around 50 per cent in Estonia in 2018 compared to lower than 40 per cent in the EU. All these imply that more people of working age are likely to face health problems during their career, making the return to work – or reintegration – a relevant issue in Estonia. Additionally the relatively low unemployment rate implies that companies have a strong interest in hiring or retaining people including those with reduced work capability arising from health conditions.

Despite the relatively poor condition of health, the number of days per year and per person compensated because of absence from work due to illness was, between 2000 and 2018, lower on average in Estonia than in the OECD, fluctuating between 7.3 and 11.3 days in the former but averaging 12 days in the latter.[5] Public spending on incapacity, which refers to spending due to sickness, disability and occupational injury,

1. Eurostat. Table LFSI_DWL_A. Duration of working life - annual data.
2. Statistics Estonia. Table TT0202. Employed persons by age group and economic activity (1989-2019).
3. Statistics Estonia. Table RV021. Population by sex and age group, 1 January.
4. Statistics Estonia. Table RV021. Population by sex and age group, 1 January.
5. OECD.Stat. Health Status: absence from work due to illness, https://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#.

was around 2 per cent (close to the OECD average) between 2010 and 2017.[6] People not taking more days off work, even if they need to, is likely to be a sign of workers' weak labour market position.

Estonia has a poorly developed framework for the return to work with very limited (or a lack of) coordination between stakeholders and a restricted amount of institutional support but with ad hoc initiatives implemented by various actors. In this chapter we demonstrate that the return to work in Estonia is best understood as an integrated policy field that comprises measures in several areas including medical, labour market, social welfare and rehabilitation services. In terms of policy provision, there is greater visibility of the healthcare dimension. Although a reasonably solid institutional support system has been developed in respect of measures to ease labour market integration and specifically the return to work, employers and employees do not seem to have enough information about this and thus no faith that such support would actually exist in practice. Based on our analysis this seems to translate into rather meagre workplace level provision when it comes to return to work arrangements and, at least in part, this owes to an unsupportive organisational culture and a lack of organisation-level trade union activity.

The discussion in this chapter is based on desktop research of relevant documents such as legislative acts, research reports, policy plans and reports, and the mass media. Empirical fieldwork was also conducted based on interviews and roundtable discussions held with relevant national stakeholders, group discussions with employers and trade unions and three online surveys distributed to social partners, workers and company managers in Estonia.[7]

The chapter is structured as follows: in the next section, we introduce the policy framework on the return to work before exploring more closely the involvement of the social partners in shaping return to work policy at national level, thereafter discussing the issue at company level. The last section provides concluding remarks.

2. Policy framework for the return to work in Estonia

In Estonia, public policy discussions and issues surrounding the return to work following chronic illness fall mainly into the area of regulating and supporting the employment and economic activity of people with a work capability lower than 100 per cent. Such a condition may be temporary or permanent and it may be induced by work-related circumstances although not necessarily so. In general there are three reasons for reduced work capability:

— disability, which a person has been living with since before the start of that person's working life, probably but not necessarily since birth;

6. OECD. Public spending on incapacity, https://data.oecd.org/socialexp/public-spending-on-incapacity.htm.
7. For a more in-depth overview, see the Estonia country report by Taru and Roosalu (2021).

— occupational illness which has led to a temporary or permanent condition of reduced work capability; and
— occupational injury which has led to a temporary or permanent condition of reduced work capability.

Return to work is supported by a mix of several sectoral policies: healthcare; employment relationships; active labour market policies; social welfare; and social care policies. The main legal acts that frame employment, illness, sickness leave and the return to work after treatment include the Employment Contracts Act,[8] the Health Insurance Act,[9] the Work Ability Allowance Act[10] and the Occupational Health and Safety Act.[11] In addition a range of other legislative acts regulate various aspects of employment contracts.[12] Meanwhile, there are two national-level policy documents that address chronic diseases and their prevention:

— the Disease Prevention Development Plan 2016-19 (from the Estonian Health Insurance Fund); and
— the National Health Development Plan 2020-30 (Ministry of Social Affairs, now in the process of development), listing chronic diseases as a separate category within the wider disease prevention plan.

The legislative act that regulates employment when an employee falls ill or is injured is the Employment Contracts Act. This allows an employer to terminate an employment contract extraordinarily where the employee has not been able to perform the duties of the job, due to his or her state of health, for more than four months (para. 88). However, before the termination of the employment contract, in particular on the basis of a health condition, the employer must offer other work to the employee. This includes organising, if necessary, in-service training, adapting the workplace or changing the employee's working conditions where such changes do not incur disproportionately high costs for the employer and where the offer of other work may, considering the circumstances, be reasonably expected.

The Health Insurance Act defines the categories of insured persons. All employed and self-employed people are covered by insurance. The Work Ability Allowance Act defines the access to employment of people with reduced work capability caused by long-term health damage and ensures an income for them under the conditions and to the extent provided by law. The Occupational Health and Safety Act frames the area of occupational health and defines the role of medical professionals such as occupational health doctors, occupational health nurses and other medical professionals which are relevant actors in the return to work context.

8. Employment Contracts Act, https://www.riigiteataja.ee/en/eli/ee/Riigikogu/act/529122020003/consolide. State Gazette 2009, 5, 35.
9. Health Insurance Act, https://www.riigiteataja.ee/en/eli/ee/504062020003/consolide/current, State Gazette 19.06.2002, 62, 377.
10. Work Ability Allowance Act, https://www.riigiteataja.ee/en/eli/530042020009/consolide State Gazette 13.12.2014, 1.
11. Occupational Health and Safety Act, https://www.riigiteataja.ee/en/eli/ee/527052014007/consolide/current. State Gazette, 1999, 60, 616.
12. Labour inspectorate homepage, https://www.ti.ee/et/tookeskkond-toosuhted/oigusaktid-viited.

In 2016, the work ability reform[13] was launched bringing together all labour market participation and employment-related services and transfers under one institution – *Eesti Töötukassa* (the Estonian Unemployment Insurance Fund; ET). Since mid-2016, work capability has also been assessed by the ET. The reform was rooted in the excessive financial burden on the public budget arising from state-paid pensions to disabled persons and to people with permanent partial or full loss of work capability, as well as in the finding that a considerable percentage of those with a medical condition did not benefit from state support. An audit carried out by the National Audit Office of Estonia in 2010 showed that the number of the disabled and reduced capacity pensions had been increasing since 2004, rising to over 200 000 by 2010 (Uder 2010) in a country of 568 000 economically active people.

Expenditure on disability had been increasing at a relatively high pace, from €56 million in 2000 to €279 million by 2010. This was a nearly five-fold increase and a disproportionally high one as two other large areas of social benefits had increased less: expenditure on old age pensions had increased 2.5 times and that on healthcare by a factor of three. Expenditure on disability had reached 12 per cent of all social benefit expenditure by 2013, a doubling of the 6.6 per cent which was the case in 2000.[14] This was alarming and commanded policy-makers' attention.

Veldre *et al.* (2012) established that the Estonian regulations and policies meant to support people with reduced work capability due to medical condition were comparatively inefficient and needed significant amendment. The main problem was that the focus until then had been on health loss instead of a person's capacity for work. Furthermore the assessment of work capacity needed to be prospective and to include recommendations of appropriate support measures that would help the person get back into the labour market. Essentially, this meant a transition from the previous system, in which a person with a loss of health was seen as a passive beneficiary of state aid, to one in which a person with reduced work capacity, as well as that person's employer, were seen as active agents supported by state services. Additionally the assessment of health condition, work capability, employment opportunities and support measures was regarded as in need of better coordination with each other in order to be effective; hence the aim of co-locating all these services in one institution instead of several as had been the situation until then. Preparation of the reform took several years but, in 2016, it was ready to be launched.

As the key institution in the landscape of labour and health, ET implements significant aspects of labour market policy in Estonia. It offers a range of measures to employees who need support at the workplace because of their health condition as well as to employers on health-related issues. As a public institution, the ET board consists of six members: according to the law, two members are named by the national government, two by the national employer organisation and one each by the two national-level trade

13. For more on the work ability reforms see the homepage of the Estonian Unemployment Insurance Fund, https://www.tootukassa.ee/eng/content/work-ability-reforms; and that of the Ministry of Social Affairs, https://www.sm.ee/en/new-working-ability-support-system.

14. Statistics Estonia, table SKK02: Expenditure on Social Benefits by Indicator, Function and Year.

union confederations. The tripartite nature of this body means that the issues that ET regulates (including those related to the return to work) are the object of national-level social dialogue.

At establishment level, health and workplace-related issues are addressed by *töökeskkonna volinik* (working environment commissioners). By law, every organisation with more than 150 employees (and in others if the labour inspectorate so requires) should establish a working environment committee with the responsibility of ensuring occupational health and safety. Such a council needs to consist of representatives of management as well as those of employees. The working environment commissioners elected by employees have a responsibility for all occupational health and safety issues. Such mandatory committees are meant to foster social dialogue and are legally comprehended on the basis of an understanding that trade unions are not present in every organisation.

Occupational health and safety is thus one of the rare themes on which the state has made social dialogue compulsory. This does not mean that it works very well across all organisations and frequently it is the illusion of industrial relations which has been created under this framework rather than actual social dialogue (see also Ost (2000) on the emergence of illusionary corporatism in central and eastern Europe). The election of mandatory representatives creates an image of worker representation but, where there are no trade unions, the infrastructure for those representatives to engage meaningfully with workers to establish common grounds for what to negotiate with the employer is lacking. Thus every elected representative approaches the role foreseen by the law as they please – and, in the case that they are too busy with other tasks, the return to work may be not among their priorities; while, if their role is less valued by workers than by the management, this further decreases their chances of being efficient either bargaining or in consultation (see Kallaste *et al.* 2007).

While company-level dialogue is not always efficient, the legal regulations set down quite decent conditions for employees to apply for workplace adaptations. Yet there are still no specific measures on the return to work for workers with chronic illness. Additionally, with the exception of tuberculosis, there are no specific provisions for different kinds of diseases. In general, when an employed person falls ill and needs to be away from work, a doctor will issue a certificate for sickness leave to validate it. Based on this certificate, the employer and *Eesti Haigekassa* (the Estonian Health Insurance Fund; EH) pay benefits for temporary incapacity for work, commencing on the ninth day of illness. Sickness benefit is paid at a rate of 70 per cent of daily income and is subject to income tax. Although sickness benefit is paid for 182 consecutive days (240 days in the case of tuberculosis), employment protection lasts for only four months. It is possible that better terms may be agreed upon at company level, but most sectors do not have any provisions of this kind in sector-level collective agreements.

Thus we can conclude that there is no legal obligation to hire or retain workers with chronic illnesses. ET, with its national-level tripartite social dialogue and its offer of both benefits and services to employers and employees in general, does support hiring people with reduced work capacity which may encompass those with chronic illnesses.

At organisational level, the law foresees a position to be responsible for addressing health- and workplace-related issues – the working environment commissioner. However, low trade union density and the priorities of employee representatives around fundamental issues of membership growth and improved legitimacy (Kall 2020) mean that return to work issues occupy a rather lower level of priority.

3. Involvement of the social partners in shaping return to work policy at national level

In terms of its industrial relations structure, Estonia belongs to the neoliberal industrial relations system common to central and eastern European countries (EU OSHA 2016; Akgüç *et al.* 2019). Industrial relations are mostly developed at national level and much less so at the sectoral or company level (Kall 2020) while only a small fraction of workers are trade union members: Estonia has the lowest union density rates in Europe, declining from 94 per cent in 1992 to 4 per cent in 2017 (Visser 2019). Collective bargaining coverage, at about 20 per cent, is significantly lower than the OECD average and far lower than in those countries which have the highest coverage.

Negotiations on the minimum wage, the main issue in social dialogue in Estonia, are held by *Eesti Ametiühingute Keskliit* (the Estonian Trade Union Confederation; EAKL) and *Eesti Tööandjate Keskliit* (the Estonian Employers' Confederation, ETK). EAKL has 17 sectoral trade unions as its members; while, as of 1 November 2020, ETK has 23 sectoral employer organisations and 127 individual companies as members, from all economic sectors.[15] ETK is actively involved in public policy processes including those which fall within the remit of ET and EH.

Our research highlights that the return to work in Estonia is best understood as an integrated policy field comprising measures in a range of areas including medical, labour market, social welfare and rehabilitation services. Being such a fairly complex field, public policies related to the return to work are, however, perceived differently by the various stakeholders.

A representative of the Estonian Chamber of Commerce and Industry perceives the return to work as belonging to the domain of workforce diversity, acknowledging that a considerable part of employees either have a medical condition or other reasons why they can work only under restricted conditions and who may need support to be able to work; and that helping people with reduced work ability find a job suits them and benefits the employer. A trade union representative thinks of return to work as an additional area of social security for workers which could potentially contribute to their (material) well-being. However, such thought processes are couched in financial terms – how much it would cost employers and the state to institute another form of insurance and what it would mean in terms of new taxes or tax rates – while the representative notes that employees as well as employers are more interested in discussing the level of (minimum) wages rather than occupational health, disease or injury problems.

15. https://www.employers.ee/meist-2/liikmed/

Representatives of the Ministry of Social Affairs, as well as ET, tend to think of return to work as a field within the wider area of policy measures targeting occupational health as part of the overall framework of employment and social heterogeneity. They also view potential advances in the return to work from a longitudinal perspective – measures that evolve together with other policy measures on social security and well-being – while also observing the importance of the context set down by the 2016 work ability reform.

Return to work policy has not been a distinct topic in social dialogue (except as part of the joint operation of ET). This is most likely to be the result of a lack of communication on the issue between stakeholders. Hence it is hard to describe the involvement of the actors in discussions which are focused solely on return to work policies; the involvement of stakeholders is based on other topics of social dialogue (where representatives agree that they are sufficiently involved). The main reason behind such a level of involvement has been that stakeholder participation in policy processes is one of the core principles of public administration in Estonia. In particular, one of the aspects of the Estonian system is the significant role of the state as a mediator – or rather the initiator – of policies in the return to work. Social dialogue on labour relations and employment in general is organised and carried out by the Ministry of Social Affairs which assures that trade unions, employer organisations, medical doctor organisations, organisations for people with reduced work capability and representatives of the national organisations responsible for relevant support services, such as ET, EH and the Social Insurance Board, are involved.

However, social dialogue in Estonia has tended to revolve around other themes and issues than the return to work. The main topic is wages and, in most sectors, this means the minimum wage. Occupational health matters are advanced mainly at the initiative of the Ministry of Social Affairs using participatory policy processes but outside the format of regular social dialogue between trade unions and employers. Awareness of the national-level return to work policies and measures in Estonia is, nevertheless, considerable and they are considered for the most part as quite elaborate although stakeholders had expected trade unions to be more active in return to work policy, an expectation that was not imposed similarly on employer organisations.

The involvement of stakeholders in EU-level social dialogue structures can be considered as sufficient: all of our interview partners had participated in EU-level social dialogue structures. Despite this involvement, the awareness of specific EU-level return to work policies is very low. At the same time, stakeholders had expected somewhat more initiatives from the EU when it came to the development of return to work policies at national level.

Return to work policies within Estonia are thus developed with a varying degree of involvement of the different social dialogue partners. The social partners see the role of the state (and the EU) as important, if not central, to policy development on the return to work, considering such policies to be of low priority for them. Their reasons for not being involved more intensely in policy processes are quite organisation specific. When it comes to applying return to work policies, organisations have been involved in

implementation only occasionally and are not planning on increasing their involvement. Hence those organisations that are involved in social dialogue are inclined towards involvement in policy development issues rather than in practical implementation.

There is an evident lack of cooperation between stakeholders, with the existence of several obstacles being reported during the research. Likewise, the implementation of return to work policies does not always go smoothly. This is an indication of the presence of bigger challenges to cooperation, not merely that of communication, with problems of occupational health, health insurance and return to work not being put on the table in regular social dialogue. There is no fierce opposition to stakeholder cooperation but, instead, a clear need to explain better its relevance to policy-making and even more so to policy implementation.

Our research indicates the need for a more active approach in return to work policy-making among both trade unions and employer organisations even though the latter do seem to have been relatively more involved. The same holds for involvement in implementing return to work policies. Such a configuration looks natural in the context of a national institutional set-up in which employers have managed to establish several umbrella organisations covering virtually all employers and enterprises while only a tiny number of employees are trade union members. While lobbying as a policy tool has been utilised, other options such as providing assistance to individual workers, engaging in collective bargaining or raising workers' awareness of their return to work rights through information campaigns have, however, also been deployed.

The lack of activism seems rather to be a problem of a lack of initiative in this particular policy area from both sides. Consequently the potential for future action on return to work measures in Estonia remains bleak. Trade unions have longstanding general interest in making progress on the issue but there is no profound interest in doing so as a result of other issues occupying a more active priority. Even so, trade unions could potentially pick up the issue of occupational injury insurance, covering those health problems which result from work accidents. Meanwhile employers are not interested in bringing return to work to the negotiation table as it would lead to an increase in their costs. Employers see that they have already taken the initiative of addressing the situation of people with reduced work capability. They see that return to work policies could be part of a workforce diversity approach and they acknowledge that not all workers are equal and that some require specific support. For employers, the return to work theme is thus primarily a workforce diversity issue rather than a health issue. Within that framework, health conditions are just one factor requiring attention.

What does need bringing forward is the central role of the state administration in the process of supporting the employment of people with chronic illness. Returning to work is one strand of action on a wider agenda of interventions aimed at supporting people with reduced work capacity. Here, it is the Ministry of Social Affairs, ET and the Social Insurance Board which are the central players in this respect. Trade unions do seem interested in being more involved but the employer organisations are quite happy with how things are.

4. The return to work process and the involvement of the social partners at workplace level

4.1 Workers' experiences with the return to work process

A majority of workers with chronic illness are concerned about their return to work. This does not differ systematically based on the type of illness reported. Two major types of fear can be distinguished: one associated with not being able to meet productivity standards after illness; the other associated with being left without adequate, or indeed any, support. The most common chronic disease reported by respondents is cardiovascular disease followed by other chronic diseases such as cancer, mental disorders and musculoskeletal diseases.

Among those who are only recently diagnosed, a sizable share of workers do not intend to take time off from work because of their illness. One of the reasons for this is where employers' reactions to employees' sickness leave had not been supportive. Nevertheless the majority of employees with a recent diagnosis of a chronic illness did have an arrangement with their current employer to return to the same position after treatment and, indeed, many of those with more longstanding conditions had actually been able to return to the same job.

In general, the team leader/line manager is considered to be the most important person in supporting a worker's return to work and is also the primary point of contact when support measures come under discussion. Company management, trade unions and the relevant labour inspectorate are far less usual in this respect. Indeed, people returning to work had mostly been in contact with their colleagues and/or with their line manager. In all, this suggests a very scattered picture with no certainty and more reliance on informal relationships (with one's colleagues, for example) than a standard procedure followed with the involvement of human resource professionals, therapists or trade union representatives.

While workers mostly return to work on their own initiative, the role of medical doctors in the making of this decision is important as is that of their family. This pattern gives the impression of a lack of active interest on the part of the workplace. Workers' experiences reveal that adjustments to tasks and duties, probably in terms of reduced workload and part-time work as well as modifications in the working environment, are the most common changes after illness while those which occur least are the postponement of deadlines as well as adjustments in daily working time. However, once a decision is taken, colleagues also have an important role in facilitating return to work after illness together with friends, family and the general practitioner. The role of management as well as trade unions in supporting the return to work is reported to be small and there are deficiencies in advice and support from the employer as well as from the trade union.

Regarding the role of trade unions in the return to work, this is in in stark contrast with workers' vision of the potential. Trade unions are expected to be ready to address the health-related issues of workers and to support the return to work by negotiating

binding agreements with the employer, e.g. in terms of reducing working hours, stress and workload for people after long periods of sickness leave. Evidently expectations do not match the reality and very few workers have experienced help from their trade unions.

In general, the overall experience of returning to work is moderately satisfactory. Despite a level of dissatisfaction with the process, most people feel welcome when returning to work after chronic illness.

4.2 Perspectives of managers on the return to work process

Managers are in agreement that an employee with a serious illness is likely to cause significant problems for company operations. They underline that such an individual would be replaced, perhaps not immediately but certainly were the problems to persist, and that that this would be done before serious financial consequences had emerged for the organisation.

Meanwhile managers consider information/advice on adapting the workplace and working spaces in general, as well as specialist direct advice, e.g. from doctors and therapists, to be useful when dealing with workers' sickness leave. Information on the financial strategies to deal with absences related to sickness leave, legal advice and external counselling/cooperation with dedicated professional associations and/or patient organisations are options mentioned less frequently. When it comes to making arrangements to support the return to work, three ideas are highlighted by managers:

— the worker should be entitled to the adjustment of their working duties (working time and workload) but at the organisation's discretion;
— workers should be entitled to a phased return to work on full pay;
— the worker should be legally entitled to adjustments to working duties (working time and workload).

The adjustment of working time and workload is perceived to be effective by the largest number of managers. These actions were also among the most frequent offers to employees returning to work. There certainly are many managers who do accept working part-time and the possibility of unexpected interruptions, but it turns out that not all managers accept such arrangements in practice. However, relatively few line managers and team leaders hold the opinion that the employment of a person with reduced work capability would bring about additional challenges associated with the reorganisation of workflow. The main challenges that were mentioned, however, are:

— taking time off;
— a lack of recognition of the difficulties that lower-level managers face in connection with workers' absence;
— that a worker returning to work with reduced duties increases the workload of other colleagues;
— staying in touch with the worker during that person's absence.

Very few managers believe that a person returning to work after illness and treatment will be less valuable than other workers. In general, managers are quite supportive and prepared to adapt the working conditions of people returning to work with a chronic condition. However, most managers are unaware of organisational practice in terms of supporting the return to work.

Moreover return to work issues are not addressed in company-level collective agreements. In this vein, managements do not have regular contact with the trade union regarding the return to work and further difficulties are caused by the lack of organised representation on the health and safety committee responsible for dealing with return to work issues.

4.3 Interactions between employer and employee in facilitating the return to work

Employees generally do feel welcome at work when they return after illness. However, there are no other major positive experiences: employees do not perceive their companies to be well-prepared to accommodate the necessary adjustments; the returning employee does not receive extensive mentoring and guidance from the trade union or the employer; and the return to work is often not well organised.

Employees do recognise that their employers are not fully unprepared: the two most common offers to people returning to work are the possibility of a phased return process and the establishment of a formal procedure for managing the situation. Here, companies may offer adjustments to work tasks and working time, along with informal procedures, a thorough discussion and individualised plan, workplace adaptations and training for the returning worker.

A somewhat different picture emerges from the managerial point of view. Here, half of managers say that contact with the worker on sickness leave is regular although a similar number say it is irregular and, in one case, there was a confession of no contact. One could thus conclude that there are some companies where there is some regularity in interactions between the management and employees on sickness leave while in others such contacts are irregular. In any case, such contact as does exist tends to be rather informal. Regarding the content of communications, for the most part this is reported as being designed to keep the worker informed of work-related issues.

4.4 Experiences in facilitating the return to work

Over the entire 2015-19 period, the unemployment rate in Estonia was 5 per cent or below. This means that companies have had a strong interest in retaining people and this also holds for people with reduced work capacity: in a tight labour market situation, companies have an interest in providing employees with support so that they can work.

However, there is not a lot of information available on good practice in the return to work. Making use of national-level policy measures should be listed among these, since there is not much beyond that offered by individual employers – and, often, even existing policy measures are not considered despite the availability by law of a range of in-cash, in-kind and on-demand measures. Awareness of these measures, and then consequently of how to take advantage of them in practice, is low. The claim has been made that employers, especially managers, have little awareness of the possibilities available in supporting the return to work and that they may also suffer from a lack of research time.

Given the paucity of evidence of good practice, we have extracted some examples. We define a good experience as a situation in which an employee has experienced a supportive employer environment when returning to work after chronic illness or with a chronic disease and encountered no problems in this regard. An example of good practice is where an employer (i.e. manager) is able to discuss existing cooperation with a trade union in the return to work context and expresses a preference to access more support. We describe below the experiences of workers who have returned to work as well as those who had as yet no practical experience of this but who had nevertheless been diagnosed with a chronic illness.

Considering workers who had been diagnosed only recently and who thus did not yet have return to work experience, we examined the responses they received from the employer and from the trade union representative when they announced their treatment and the need for a period of sickness leave. The following pattern appears:

— The best return to work experience: upon announcing the need for treatment and sickness leave, there was a generally supportive response from the employer and from the trade union, even though no help or support might have been offered during the period of sickness leave. Where the employee was not a trade union member, he or she reported that they had thought about joining the union since their diagnosis in order to get proper support when returning to work.
— Trade-union supported return to work: there was a generally supportive response from the trade union (even though no help or support might have been offered during the period of leave) but an indifferent response from the employer with the company, in the worker's view, only caring for its business and not for the well-being of employees.
— Unsupported return to work: in this case, the employee either did not plan to take extended leave and/or did not feel confident enough even to announce the need for long-term absence to the employer as they feared losing their job. One worker volunteered in response to an open-ended question: 'Anything like that always makes the employer panic'. In such cases, either there was no trade union representative at the workplace to whom the employee could turn or, alternatively, the employee did not tell the representative of the need for long-term absence.

In the most supportive return to work model, people would contact the human resources department of the company for support while, in the trade union-supported model, the contact point might, instead, be a psychologist or occupational therapist from outside

the company who would assume the role of most important person to support their return to work. This highlights that support may well rely on professional suggestions from people outside an organisation.

Among workers who do have a personal return to work experience, in terms of evaluating the level of satisfaction with the help and support received from the employer and from the trade union, approximately half are satisfied while the other half feel that the support that they had received was insufficient. The key aspect that most distinguishes the best return to work experiences – where the employee is satisfied with both the employer and with the trade union – seems to be being made to feel welcome upon returning. Among other determinants of good return experiences is the employee actually having relatively low expectations: since employer support for adjustments upon the return to work appears mostly to be rather weak, this might contribute to the avoidance of disappointment. Another more important factor for defining a good return experience is that the employee did not feel worried about their return. This can be related to the kind of illness experienced but also to their position in the organisation being more secure.

4.5 Views on the future potential for social dialogue to support the development and implementation of return to work policies at company level

Employer organisations' preferred way of organising the return to work, based on the perceived need for improvement at organisational level, can be divided into two groups. One group seems to prefer better cooperation with external stakeholders (medical doctors, therapists, patient organisations and so on) in facilitating returns, perhaps accompanied with (even) better legislative and institutional support. This group suggests that they have already done everything they can at company level and thus need external insight, or perhaps a push, to go a step further. The second group seems to be interested in looking for internally-oriented solutions on the return to work, some of them more informal ones (better interpersonal relations between managers and employees, leading to a better handling of workers returning from long-term sickness leave) and some more formalised ones (better organisation-wide policies and activities).

The main benefits of cooperation between management and trade unions, seen from the point of view of managers, are training sessions for managers directly exposed to interaction with workers with chronic illness, input from trade unions in company internal policies, informal agreement on the role of employee representatives in supporting the management of return to work processes and specific return to work provisions in collective agreements.

Managers overall perceive the legislation to be too general to be useful to an organisation. The legislation may set out a general framework but it does not specify the arrangements that need to be undertaken by an organisation. It thus appears that managers do not regard the legislation in Estonia to be particularly helpful in arranging return to work adjustments or in regard to the development of their company policies. Some managers

would welcome more specific provisions to guide their organisation in its approach to the return to work. However this is not a general perception as a small subset of managers do think that the legislation provides quite sound guidelines for company-level actions. We are also aware that some managers would prefer the legislation to be more flexible and leave more space for company-level managerial decisions on return to work issues while another group think it sufficient that the return to work is contextualised as part of a broader set of policies on the labour market integration of people with chronic illnesses.

Thus there are some companies that perceive the legislation to be sufficient, as they would like to arrange return to work matters at their company themselves; while there are others that would prefer to receive more specific indications about what they should do to arrange return to work after chronic illness.

From a workers' perspective, trade unions should be occupying a significant role in the process. A large share believe that support for the return to work needs to be an important element on the agenda of negotiations between trade unions and employers; while a similar share think that the unions need always to be ready to address the health-related issues of workers. The preferred form of support from unions is the negotiation of binding agreements with the employer, e.g. in terms of reducing working hours, stress and workload for people after long periods of sickness leave. Only a small subset of workers think that their unions could not do more or hold the opinion that their unions were simply not powerful enough. Unfortunately none were able to identify any good examples of how a trade union had been helpful in the return to work process.

Hence from the employee side the prevailing view is that trade unions should be doing more than they have been doing. Ultimately, however, the perception of workers about the role of the union in facilitating the return to work is dependent on whether the actual return experience was one that had been supported by the employer or the trade union.

Workers with an employer-supported return to work experience in which trade unions were absent and who had initially been more concerned about their return agree that unions should be prepared to address health-related issues. This implies a need to empower trade unions as a precondition for them being able to adopt a greater role in the return to work process. However, those who were initially not concerned about their return – implying that they were more confident about making their own arrangements with their employer – suggested that trade unions could already start to work on facilitating returns in Estonia without first needing to accrue more power.

In the case of people with a union-supported return to work experience, this might have led the individual to disagree that trade unions in Estonia were insufficiently powerful to facilitate the return to work. They are able to assert that unions could facilitate returns, preferably by negotiating binding agreements with the employer but also by offering individual consultation. These workers also somewhat agree that trade unions should always be ready to address the health-related issues of workers and that support for the return to work should be an important element on the negotiations agenda.

5. Conclusions

This chapter provides evidence of how the return to work after chronic illness is supported in Estonia. Estonia is characterised by an open labour market – it is relatively easy to lose a job as well as to gain a new one – which frames the situation in which illness forces one to stop working. Against such a background, the employment contract is often, although not always, terminated by the employer. Small companies, which constitute the absolute majority of enterprises in Estonia, cannot redistribute work tasks among other workers and thus need to hire a new person so that these may be continued. There is no obligation to re-employ a worker after medical treatment. After treatment, individuals returning to the labour market may find their personal work capacity is reduced as serious illness and/or a chronic condition is one of the reasons why a person loses work capability. It is primarily this situation that is being addressed by public policies which seek to support the finding and retention of a job for a person with reduced work capability. Covid-19 offers a window of opportunity to emphasise return to work issues but this is yet to emerge on the policy agenda amidst all the others; thus far, the existing return policy measures have neither been discussed nor reformed and nor have any new initiatives yet been put forward for discussion.

The employment of people with reduced capacity for work is supported by a range of policy measures. Institutionally the central role in developing and implementing policies with relevance for the return process has been played by the Ministry of Social Affairs (specifically the Work and Pensions Department) and its associated organisations. Since 2016, when the work ability reform was launched, implementation of all the benefits and services supporting people with reduced work capacity has come under the remit of the ET while oversight of the subsequent legally-binding regulations is provided by the labour inspectorate, an agency of the Ministry of Social Affairs dealing with the area of governance. The current policy mix addressing people returning to work after illness or with a chronic condition has been developed at the initiative of the same ministry. Its Work and Pensions Department has been behind the policy processes in which all stakeholders have had an opportunity to have a say on the topics and themes related to the return to work after serious illness and/or with a chronic condition.

Currently there is a wide range of support measures which are offered both to employees with reduced capacity for work and to the companies that employ them. The mix includes support in terms of time (boundaries on working time and shifts), in-kind assistance (various support services, consultations for employees and employers as well as job training programmes) and cash benefits (for both employees and companies that employ people with reduced capacity for work). A very important milestone in the evolution of the policy mix is the work ability reform which saw all support measures transferred to ET so that the assessment of a person's degree of work capability, the planning and offer of support measures, the review of the effectiveness of the measures offered and all other related activities are carried out by a single organisation.

Neither trade unions nor the employer organisations have taken much initiative in these policy processes. Trade unions have not focused on return to work or occupational health

because of a more significant interest in wages, expressly the level of the minimum wage. Given that return to work policy is rather scattered between different fields, as well as the rather low unionisation rate and the weak state of sectoral social dialogue, trade unions and employer organisations are mainly mobilised by the Ministry of Social Affairs since the social partners' own interest in engagement is relatively low: they do not feel notable dissatisfaction with the present situation; they have stronger interests elsewhere; and they feel that they have made their contribution already. While national employer and employee associations are represented on international discussion forums, the debates seem not to have managed to initiate spill-over effect to local levels via the usual policy trails. Analysis suggests that income will probably continue to be the central concern for trade unions. Unions might consider raising the issue of occupational injury insurance but the likelihood of even that taking place is not high. For their part, the employer associations have developed a different frame of reference for addressing people with reduced work capability – the workforce diversity approach. From this point of view, people with reduced capacity for work because of a health condition constitute one category of the diversified workforce. Returning to work after a serious illness and/or with a chronic condition is one of the processes that, among others, needs to be approached appropriately. Employers do feel that they are doing enough to employ and support people with reduced capacity.

Overall, the social partners in Estonia consider the current state of public policy affairs to be quite satisfactory and they do not perceive that there is a need for considerable changes. Neither trade unions nor employer associations have clearly-defined goals and agendas in the area of return to work and they do not express a wish to set them. Although the state has put in place rather generous regulations and support measures, there may well be problems with following these through in daily practice. Employees as well as employers lack information about their rights and duties and the available support measures. Relatively many employees in the situation of returning to work after an illness and/or with a chronic condition do not feel confident about turning to their employers to discuss support measures or to contact other institutions. Employees expect trade unions to be more active in occupational health and return to work matters. Yet trade unions in Estonia are generally weak and present only in a handful of sectors.

Employees did not express any significant amount of open discontent with the functioning of the return to work system in recent years. There might be two explanations for this. First, it might be that the majority is, to a large degree, content with the existing system and services. Indeed, the state has been allocating a good deal of resources to support people in going back to work with reduced capability. The system of labour market benefits and services has been growing and improving substantially in the last two decades while the work ability reform signals a general trend towards greater agency on the part of employees (as well as employers). Second, employees might fear losing their jobs. Although the Estonian labour market is flexible and open, the situation might be complicated for certain categories of people such as those with reduced capacity for work who might experience more hardship in finding a new job than the average worker.

The findings of the chapter suggest that the way things are now arranged is likely to persist without major change. This means that the central role of the public sector in policies relevant to the return to work will continue and that the social partners – trade unions, employers and other players – will continue with their limited role, participating in policy processes mostly initiated by the Ministry of Social Affairs without their own clear goals and agenda. It is worth noticing, however, that national-level discussions – which are crucial in representing workers in industrial relations – are particularly visible to the public as they attract media exposure. Moreover, when only national (and sometimes also sector-level) trade union organisations engage in negotiations, there is a higher likelihood that they have sufficient qualified human resources to secure both expertise and media coverage. Focusing social dialogue on the national level, instead of the sectoral or company level, might thus have even greater potential to change policies on the return to work after, or with, chronic illness. This might both compensate for the lack of company-level trade union activity around these issues and support such discussions being developed. With Covid-19 making the issues related to the return to work much more prominent in everyone's social reality as well as on the policy agenda, more attention could be expected in reconciling the interests of the social partners in this regard.

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Chapter 4
In search of a coordinated national framework: opportunities and challenges for returning to work after chronic illness in Ireland

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1. Introduction

The prevalence of chronic diseases has been growing in Ireland over the past few decades. The main work-related health problems are musculoskeletal disorders, cancer and cardiovascular disease. Cardiovascular disease is the most common cause of death, accounting for 36 per cent of all deaths (Turner *et al.* 2018) followed by cancer. There is also a growing incidence of mental health disorders, with depressive mental illnesses projected to be the leading cause of chronic illness in high income countries by 2030 (WHO 2008). This rise in chronic illness, in the context of an ageing population, has a significant impact on labour supply in terms of workforce participation, turnover and early retirement.

There is no specific legal framework in Ireland for employees with chronic illness as the regulations concerning people with disabilities generally cover their rights as well as the obligations of employers. In 2015 the government launched its ten-year Comprehensive Employment Strategy for People with Disabilities 2015-2024 (CES) to increase the proportion of people with disabilities in employment. The National Disability Authority[1] (2005) reported that people with disabilities were two and a half times less likely to be in work than those without disabilities while 85 per cent of working-age people with a disability or chronic illness had acquired their condition while employed, thereby highlighting the importance of effectively managing retention in employment. A strategic priority of CES was the promotion of job retention, with strategies for intervention in the early stages of absence from work due to acquired disability. Ireland has a long way to go to achieving its target: in 2017 it had one of the lowest employment rates for people with disabilities in the EU (26 per cent) and one of the highest gaps in employment between people with and without disabilities in employment (45 percentage points) (European Commission 2019).

Healthcare systems are critical in addressing the management of individuals with chronic illness. Health spending per capita in Ireland is higher than in most other EU countries: in 2015 Ireland spent €3 939 per head on healthcare compared to the EU average of €2 797 (OECD 2019). Even so, only around 70 per cent of health spending is publicly funded, which is well below the EU average. The Irish healthcare system has a complex dual-tiered system of both public-funded and private health insurance schemes; 46 per cent of the Irish population has some form of private health insurance.

1. This is the independent statutory body that provides information and advice to the government on policy and practice relevant to the lives of people with disabilities.

This dual system does not provide equitable access either to primary or acute hospital care or to a universal healthcare in which patients are treated based on need rather than ability to pay (Connolly and Wren 2019). The need to adopt a chronic care model has been recommended (Darker *et al.* 2015), which should seek to incorporate patient, provider and system-level interventions focusing on both the prevention and management of chronic illness through investment in primary care – a critical factor in ensuring successful re-integration into the workplace; but there has been little progress.

This chapter examines the barriers to, and facilitators of, employees returning to work after experiencing chronic or long-term debilitating illness within Ireland's voluntary industrial relations system. The discussion is drawn from primary and secondary data. The primary sources consist both of qualitative data (semi-structured interviews with key national stakeholders and two stakeholder discussion groups) and quantitative data (surveys of workers, managers and social partners).

The rest of the chapter is structured as follows: background information and national policy frameworks are presented in the next section before proceeding to discuss the role of the social partners in shaping such policy at national level. Finally it examines the role of actors at enterprise level who seek to facilitate the return to work of employees with chronic illness.

2. Policy framework on the return to work in Ireland

There is no overarching policy on rehabilitation and the return to work in Ireland. However, an exploration of policy frameworks indicates four distinct areas, administered separately and mostly uncoordinated, that are relevant in the context:

(i) occupational sick pay schemes;
(ii) the sickness and invalidity benefit system;
(iii) managing disability; and
(iv) provisions for rehabilitation and support for the return to work.

2.1 Occupational sick pay schemes

Ireland is one of only five EU countries in which there is no statutory entitlement to an occupational sick pay scheme, except when provided for in a contract of employment or negotiated by collective agreement. Otherwise the duration and level of sick pay is at the discretion of the employer. The Covid-19 pandemic has prompted the Irish government to launch a public consultation on the need to introduce occupational sick pay schemes. Many employees, particularly those who are on low incomes, have no legal right to sick pay, a fact highlighted by the National Public Health Emergency Team and the acting Chief Medical Officer as 'a problem in controlling outbreaks' of Covid-19 (Wall 2020).

Public sector and semi-state employments all provide some form of employee sick pay, although most of these were reduced in scope during the three years of the Troika Programme.[2] The Public Service Sick Leave Scheme was introduced in March 2014 in the majority of sectors in the public service and in September 2014 in education. It standardised, for the first time, paid sick leave arrangements across the generality of public services but effectively halved paid leave, the cost of which had been perceived as unsustainable, while also introducing a provision for extended leave in the case of critical illness or injury. Most public sector sickness schemes now consist of payment for a maximum of 13 weeks (92 days) on full pay in a rolling one-year period, followed by a maximum of a further 13 weeks (91 days) on half pay in a rolling one-year period. In total, sick pay is subject to a maximum of 183 days paid sickness leave in a rolling four-year period.

Two processes were key to this new scheme, namely Temporary Rehabilitation Remuneration and the Critical Illness Protocol. Temporary Rehabilitation Remuneration is a non-pensionable discretionary payment that can be paid to public servants who have exhausted access to sick leave at full and half pay and who are likely to be able to resume work. The Critical Illness Protocol defines eligibility criteria for the granting of extended sick leave for critical illnesses, while leaving the decision to award extended leave to the HR manager following consultation with the occupational health physician.

The development of the scheme was carried out in consultation with the Public Services Committee of the Irish Congress of Trade Unions (ICTU). However, one consequence of the contraction of public sector sick pay schemes in the wake of the Troika Programme has been the increase in public sector employees taking out private insurance policies to cover long-term illness and income continuity while sick.

In the private sector there is a wide range of sick pay schemes in operation ranging from full pay for 12 working days in the retail sector up to a maximum of 12 weeks identified in the manufacturing sector. A survey by the Chartered Institute of Personnel Development (CIPD 2019) reported that 44 per cent of private sector companies who participated in the survey did have some form of sick pay scheme, confirming thereby that the majority do not offer a company scheme leaving their employees solely reliant on the state for sick pay.

2.2 Sickness and invalidity benefit system

Under the Social Welfare Consolidation Act 2005, all working people in Ireland have an entitlement to some social benefits (social welfare) from the state while absent from work or if they are experiencing chronic illness. The various schemes are administered by the Department of Social Protection,[3] with eligibility being dependent on having

2. On 28 November 2010, the European Commission, European Central Bank and the International Monetary Fund, colloquially called the European Troika, agreed with the Irish government a three-year financial aid programme in order to cut government expenditure.

3. In Ireland, government departments can be, and are, re-organised to cover different administrative functions according to the priorities of the government at the time. The Department of Social Protection (DSP) was previously known as the Department of Employment Affairs and Social Protection.

paid sufficient national insurance contributions. The applicable rate in 2020 was €190.55 per week which may be paid continuously for up to two consecutive years in one claim, except for certain diseases such as tuberculosis where the duration is unlimited. Employees who do not qualify for this benefit are assessed for a Supplementary Welfare Payment, which is a discretionary scheme. In addition there is a state welfare payment called the Occupational Injuries Benefit Scheme for those who do not get paid from a company sick pay scheme. This is available for people who have had an accident at or going to work. The scheme also covers people who have contracted an illness or a disease as a result of the type of work they do.

2.3 Managing disability

Irish policy frameworks do not necessarily address chronic illnesses specifically but instead incorporate it into the 'disability' category. The CES 2015 strategy outlined six priorities:

(i) build skills, capacity and independence;
(ii) provide bridges and support into work;
(iii) make work pay;
(iv) promote job retention and re-entry into work;
(v) provide coordinated and seamless support; and
(vi) engage employers.

The only strategic priority to focus on people already in employment was the promotion of job retention and re-entry into work, with the key actions detailed in the report in support of this priority extended to the following:

— develop guidelines to promote intervention in the early stages of absence from work;
— pilot new approaches to integrating work into the recovery model for mental health integration, including job coaches in mental health teams;
— a continuing programme to train trade union 'disability champions' to support colleagues returning to work following the onset of disability.

To support this strategy, a number of initiatives have been introduced. Firstly the government funded a new online service for employers, entitled Employers Disability Information Service, which began as a three-year pilot in 2016.[4] This service was managed by a consortium of employer organisations including Chambers Ireland, the Irish Business and Employers Confederation (IBEC) and Irish Small and Medium Enterprises, and was funded through the National Disability Authority. The purpose of the Service was to provide employers with advice and information on employing and retaining staff with disabilities, and to provide a network to encourage best practice. The National Disability Authority, in collaboration with the Institute of Occupational

4. See more information at http://www.employerdisabilityinfo.ie/

Safety and Health, was tasked to disseminate guidance for employers and employees on job retention and re-entry into work.

Secondly ICTU, under the Disability Activation Project,[5] was selected to develop training programmes for 'disability champions': trade union representatives and shop stewards intended to assist employers support employees with a chronic illness in the return to work.

Thirdly a report was commissioned by the National Disability Authority examining good practice in organising national vocational rehabilitation services across a number of jurisdictions (McAnaney and Wynne 2017).

The final strategic action focused on promoting and supporting strategies for intervention in the early stages of absence from work due to acquired disability, based on coordination between the Health Service Executive[6] (HSE) and the Department of Social Protection.

Whilst a number of these actions have proceeded, a key criticism is that no single government department is leading on the delivery of the CES. Furthermore, the resources which have been made available for the implementation of the strategy are perceived to be insufficient.

Other significant developments in the Irish policy landscape focusing on chronic illness and disability include The National Disability Inclusion Strategy 2017-2021 that sets out a whole-government approach to improving the lives of people with disabilities (Department of Justice and Equality 2017). This identified a number of key areas including education, employment and the need for joined-up policies and public services. A key area was employment and for people who acquire a disability to be given the support needed to remain in or return to work. Some of the actions set out in this strategy document have been achieved. Since it was developed, reforms have been made to the Partial Capacity Benefit Scheme. Other actions are in progress to address access to, or the affordability of, the necessary aids, appliances or assistive technologies required for everyday living for those people with disabilities whose entry to, retention in or return to work could be jeopardised due to unaffordability.

2.4 Provisions for rehabilitation and return to work support

In Irish employment law, chronic illness is encompassed within the definition of disability. The main legal instruments in the area of rehabilitation and return to work are the Employment Equality Acts and the health and safety legislation. The

5. In 2012 the Minister for Social Protection announced funding of just over €7 million for a range of projects under the Disability Activation Project. Their aim was to increase the capacity and potential of people receiving Department of Social Protection disability or illness welfare payments to participate in the labour market. Funding for these projects ceased in 2015, much to the disappointment of key NGO groups such as Inclusion Ireland.

6. The HSE provides all of Ireland's public health services in hospitals and communities across the country.

Employment Equality Acts include disability and obliges employers to make reasonable accommodation for people with disabilities. For an employee returning to work after long-term illness, an employer must take 'appropriate measures' to meet the needs of that person. Meanwhile the Safety, Health and Welfare at Work Act obliges employers to create a safe and healthy workplace.

There are a number of government funding initiatives available to organisations to support an employee's return to work. One is the Employee Retention Grant Scheme that aims to help private sector employers keep employees who acquire an illness, condition or impairment (occupational or otherwise) that affects their ability to carry out their job. Another is the Reasonable Accommodation Fund for the employment of people with disabilities which includes workplace equipment and adaptation. Other initiatives include financial assistance schemes to encourage employers to employ people with disabilities including the Disability Awareness Support Scheme and the Wage Subsidy Scheme.

In addition to workplace regulation, there is a range of uncoordinated voluntary activities being undertaken by trade unions, employers and non-governmental organisations (NGOs), including information and awareness-raising campaigns; employee well-being programmes; work-life balance programmes; employee assistance schemes; and some family friendly policy initiatives.

Overall, the policy framework in Ireland can be characterised as fragmented compared to other EU states. Provisions relating to long-term absence have evolved but can still be seen as overly complex, partly because long-term absence procedures occur at the intersection of different sectoral responsibilities and government departments: employment; health and disability; and equality and social inclusion (McAnaney and Wynne 2017). Any initiatives introduced (e.g. the Employers Disability Information Service or the Disability Activation Project) are often short-term projects: indeed, neither were still in operation as of 2020.

Social protection agencies in Ireland focus on the unemployed or economically inactive rather than those who are absent from work due to a chronic illness. There is little evidence of state-funded and state-run occupational rehabilitation services which support the return to work of employed people with chronic illness. A number of pilot programmes have taken place, however, driven by campaigning and patient support organisations under the now-defunct Disability Activation Project (co-funded by the European Social Fund and the Department of Social Protection) to support workers' return to work after long-term absence due to chronic illness. These include the Working with Arthritis: Strategies and Solutions programme developed by Arthritis Ireland; and Work4You by the Peter Bradley Foundation, in conjunction with Acquired Brain Injury Ireland, which set up three vocational assessment teams to support people with Acquired Brain Injury to remain in or re-enter the workforce (McAnaney and Wynne 2017).

The view of NGOs is that many of the strategic actions outlined in government policies are often left to them to implement without adequate government funding.

3. Social partner involvement at national level

3.1 Demise of social partnership and consequences for the return to work

Social partnership was a formal process of dialogue that began life in 1987 as a form of corporatist pay/income tax bargaining arrangement. It ran consecutively for over 20 years and produced seven national agreements. Premised on voluntary dialogue between the state and multiple stakeholders, many elements of the national agreements went, in the latter stages, beyond pure fiscal matters to encompass a wide range of social policy areas. However, social partnership extinguished itself during, and as a direct consequence of, the global financial crisis (for an overview, see McDonough and Dundon 2010). As a consequence there has been no national-level process of social dialogue since 2009 except for the continued existence of two cross-industry advisory bodies: the National Economic and Social Council; and the National Competitiveness Council. Some bilateral engagements have, however, taken place in that IBEC, ICTU and NGOs lobby the government on specific areas of concern at the time of the annual budget or as part of the law- and policy-making process. Return to work procedures have continued to play out in the workplace and at individual level, as explored later, rather than through collaborative policy development at national level.

In October 2016, the Irish government re-established a limited form of national-level social dialogue entitled the Labour Employer Economic Forum which brought together employers, trade unions and the government to discuss views and policies over matters of mutual concern. With the emergence of important national issues such as Brexit and Covid-19, they have met weekly and even daily in many instances as high-level stakeholder forums to agree on approaches and policies, e.g. the Return to Work Safety Protocol: Covid-19 Specific National Protocol for Employers and Workers (Government of Ireland 2020).

Nonetheless, IBEC and ICTU officers felt that the ending of social partnership deprived them of access to national social dialogue on important issues. For many, social dialogue was viewed more broadly than just a wage bargaining device but as one which should encompass a range of societal issues such as the return to work following chronic illness. Instead what now exists are sporadic issue-specific events highlighting a particular deficiency or failure in response to which a government department will establish a committee of inquiry and seek public views on the matter, or a government minister will amend an existing programme or measure of support. By and large it is the activities of NGOs in lobbying and publicising issues that have brought about change in the area of the return to work which, in effect, means that measures are developed in a piecemeal and uncoordinated fashion.

3.2 Subsequent stakeholder activity

Union officers would welcome social dialogue on establishing a national return to work framework and, in its absence, have frequently lobbied the government individually

on the issues which it raises. One union officer expressed to us a common theme articulated by many:

> 'In an ideal situation all union workplaces would have extensive collective bargaining agreements and provide for RTW policies and the like, but employers just will not engage with us on new agreements.'

NGOs and patient groups could be a critical pillar in social dialogue on the return to work, although NGOs report that they do not have a strategy to engage with other social partners, particularly the government, on such issues. The primary reason for this is resource constraints. Many groups work directly, albeit on an ad hoc basis, with employer groups, unions and health services to raise awareness of chronic illness and patient needs. NGOs such as the cancer charity, the Marie Keating Foundation (2019), have produced a guide for employers and employees on returning to work after cancer, in partnership with Chambers Ireland. Arthritis Ireland, together with Fit for Work,[7] has developed a guide for employers that provides practical information and guidance to help them understand arthritis and musculoskeletal disorders, the effects on employees and the support they need. Another example is the Pocket Guide to Returning to the Workplace (SEE Change 2020) on returning to work after or with mental health issues due to Covid-19, produced by SEE Change and Mental Health Ireland. IBEC has also partnered with SEE Change to produce a guide for line managers on mental health and well-being as part of their KeepWell programme.

Both IBEC and the ICTU pinpoint examples of the input they have had in policy development at national level, particularly regarding the Comprehensive Employment Strategy. Each acknowledge that they would often engage on topics jointly, for example in the area of mental health, working together on awareness-raising activities such as the Reasonable Accommodation Passport (ICTU 2019). The aim of the Passport is to allow structured conversations about the impact of disability and chronic illness and to ensure that the necessary employee and workplace supports are facilitated. The Fit for Work coalition, spearheaded by Arthritis Ireland and facilitated by the ICTU, IBEC and Irish Small and Medium Enterprises, along with key health stakeholders, is seeking better alignment of the work and health agendas in Ireland. Guideline documents for both employees and employers have been developed by this coalition for key stakeholders.

3.3 The potential for future action

There is an appetite among all stakeholders to examine the topic of return to work, but there is a lack of consensus on what needs to be done. In the Fit for Work coalition, debate has arisen around replacing the sickness certificate supplied by medical doctors to employees to give to their employers a 'fit to work' note similar to that in the UK, but

7. Fit for Work Ireland is a coalition of patients, physicians, health professionals, employer associations, trade unions and policy-makers working to improve the early detection, prevention and management of musculoskeletal disorders (MSDs) in the workplace.

no agreement has been reached. Employers fear that other stakeholders (e.g. unions and government) want employers to meet the costs associated with the return to work, e.g. of rehabilitation and providing sick pay.

Brexit and especially Covid-19 has prompted some dialogue regarding national (governmental) economic, social and health policies. Evidence has emerged that return to work has become a priority for industrial relations actors, with one employer association claiming it was 'pushing an open door' on the topic. It is also clear that there is an understanding among the social partners that comprehensive return to work policies and architecture are absent in the Irish health and social protection systems but could be developed as part of the activities of the Labour Employer Economic Forum. Therefore the potential does exist for a comprehensive approach through social dialogue for more strategic and coordinated return to work policies in Ireland.

4. At the level of the enterprise

Evidence cited in this chapter[8] shows that return to work processes at company level occur generally as part of a company's absence and attendance management policies. In some organisations, line managers are responsible for implementing absence and sickness leave policies; in others, line managers and human resources (HR) departments work together to support employees who are on extended leave and to support them in returning to work. Managers do acknowledge the increasing occurrence, as well as the importance, of employees on long-term sickness leave. Some indicate that their organisations hold occupational health insurance, in which the insurance company becomes the case manager during illness-related absence from work, working with HR throughout the process.

Some additional detail regarding the worker experience, management perspectives and the level of interaction between each of these are explored below.

4.1 The worker experience

The major chronic illnesses reported by workers in our survey are cancer (27 per cent), cardiovascular, musculoskeletal and mental illnesses (15 per cent each) and other (23 per cent). The majority report they had already returned to work after chronic illness, with only a small share indicating they had been diagnosed recently and that their treatment had either just started or was about to start shortly.

Among workers who had already returned to work, a large majority report feeling concerned about their return. Campaigning and patient support organisations highlight major concerns: the unknown expectations of an employer; a fear of acceptance back

8. For further details on this study, please refer to the REWIR Ireland report here: https://www.celsi.sk/media/datasource/National_Report_Ireland_merged.pdf

into the workforce; and that the employer would not understand their particular circumstances. Workers' major concern is focused on the need to return to work at full productivity with no adjustment period (45 per cent), closely followed by a fear that there would be nobody available to support them if they experienced work problems due to recent treatment and sickness leave. The absence of adjustments to work conditions and working hours are also reported as key concerns (each by 30 per cent).

Two-thirds of workers return to the same job while one-third receive adjustments to daily working time and formal work contracts. Adjustments to tasks and the postponement of deadlines are, however, reported as receiving limited or no attention.

We can clearly highlight the importance of providing reasonable accommodation for individuals returning to work such as redesigning a job description; redeployment or the reassignment of duties; flexible working; job sharing; and modified workstations or adaptation of buildings. The Reasonable Accommodation Passport (developed by ICTU and IBEC) evidently provides important guidance in terms of structuring what could be a difficult conversation. This guidance assists in the method and organisation of conversations between workers and employers to ensure that adjustments are put in place which help them fulfil their role in a way that works both with them and for them.

More than two-thirds of workers who had returned to work report that they had been in touch with a general manager or HR department during their absence. Slightly less than half were in touch with work colleagues, followed closely by a line manager (more than one-third). Over 80 per cent indicate that they had returned on their own initiative, with one in five reporting that this had been initiated by medical professionals. When we examine experiences with the return to work, over half of workers report not being satisfied, or being only partially satisfied, with the support they had received while nearly two-thirds report dissatisfaction with the help and support received from their trade union.

Workers pinpoint medical actors (e.g. a general practitioner or specialist) as the most important contributor in return to work processes, closely followed by family, friends and work colleagues. The importance of social interaction with colleagues is an important theme in the return to work process in the sense of considering how the group will reintegrate a returning worker (Tjulin *et al.* 2011), yet trade unions have little formal involvement in the process. Communication is usually between the HR department (or line manager) and the employee, with no information being shared with union representatives on an employee's health problems or return to work. A union would only become involved if an employee approached them directly, or if a situation escalated and disciplinary proceedings were being introduced due to absence or performance issues. Even a worker's manager is rated as less important than work colleagues in the return to work, although the manager is identified as important in successful reintegration, in combination with other actors.

In the majority of instances, the HR department manages cases on a day-to-day basis while the relevant line manager deals with the granular detail. Many managers, however, do not wish to deal with the sickness leave process, leaving it to HR to manage

through regular 'check-ins' with employees, etc. and then through working in tandem with healthcare professionals to facilitate the return to work. Indeed, 70 per cent of workers report liaising with their HR department during their treatment and absence, followed by work colleagues (48 per cent) and the line manager (40 per cent). Healthcare professionals, such as occupational therapists, are seen by many stakeholders as being the linchpin of a successful return to work due to their proactivity in setting out a roadmap for returning, checking on individuals' readiness, thinking about the practicalities, liaising with the employer on adjustments and motivating individuals to go back to work.

Return to work policies tend to be developed at the level of the individual enterprise. The more successful approach often lay in being able to persuade a local line or HR manager to:

> 'See the need for compassion for an employee. It is not an ideal situation that relies on hard cases and compassion and not an agreed process for all.'

Evidently line and HR managers do, for the most part, have the ability to grant flexibility to employees with a serious illness but it does underscore the broad situation in Irish workplaces that, without a national scheme or framework on the return to work, many employees have to rely on the decency and pastoral care of individual managers.

4.2 Managerial perspectives

More than half of managers indicate that they would not replace an absent employee due to illness but would rearrange workflow and job tasks. Some report absence having a serious impact on the business (25 per cent), leading to financial consequences (25 per cent) or having other effects on clients and/or customer relationships (25 per cent). Employer associations highlight that the business impact of an employee absent from work for a prolonged period is particularly pertinent in respect of small and medium-sized enterprises due to limited resources and competitive pressures.

Managers perceive information and advice on adjusting workplaces and workspaces, financial strategies in dealing with sickness absence and external counselling, e.g. from doctors and therapists, to be the most valuable resources in supporting workers returning to work after chronic illness. A key barrier noted among campaigning and patient support organisations and occupational therapists is, however, insufficient knowledge of workplaces and specific illnesses, leading to a lack of clarity about who takes responsibility and which healthcare professional should start the discussion on the return to work. The absence of a national vocational rehabilitation service or framework available to all workers on sickness leave due to chronic illness is a major problem. Research consistently shows that timely access to related support services, or a framework available to all, is critical in a successful return process for people diagnosed with chronic illness. Lund *et al.* (2008) established that the longer the duration of absence due to illness, the greater the future risk of receiving a disability pension and of permanent exclusion from the labour market.

The attitudes of managers towards workers with chronic illness have been highlighted in previous research as having a significant impact on a successful return to work (Amir *et al.* 2008). Most of the managers we spoke to disagree that workers with chronic illnesses were less committed to their work. More than half believed that employees, at the employers' discretion, should be entitled to an adjustment to their working duties due to chronic illness, although only a small share are in favour of a legal entitlement to this. However, they also report that having a worker with a chronic illness did lead to an increase in the workloads of their colleagues. Most managers also stress the importance of staying in touch with a worker on sick leave while, interestingly, half believe that senior managers in their organisation do not recognise the difficulties faced by lower-level managers in managing a worker's absence and attendance.

Managers believe that it should be the HR department that formally deals with absence management and long-term sickness leave, together with the return procedure, leaving the line manager to be mainly responsible for handling the actual return process. This does not always happen, however. Fearful attitudes, the burden on line managers and poor relationships are significant barriers explaining why a manager may not become involved in the return to work process. Fearful attitudes encompass both a fear of discussing the illness and of how the employee might respond as well as a fear of being misinterpreted, with the latter being particularly pertinent during communications with an employee absent from work; for example, a 'check-in' phone call might be interpreted as putting pressure on an individual to return to work. The burden on line managers includes the additional demands placed on them in managing the tensions between providing support for employees who are ill while fulfilling statutory and company procedural requirements; furthermore, this is often reinforced by a lack of training and limited HR support.

4.3 Employer-employee engagement and outcomes

The return to work following chronic illness is a complex process with no 'one size fits all' formula. It can be impeded by a number of factors: organisational; personal; medical; and the timely access to related support services.

A large majority of managers believe that a common standard procedure is needed to manage the return to work for all employees. Here, an absence management policy is vital as it gives clarity to everyone about the process. Some organisations do indeed have a specific sickness absence management policy and procedures which clearly set out what happens when an employee is absent through illness. Where such a policy exists, it typically sets out:

(i) detail of the sick pay scheme and the income continuity plan (if one exists);
(ii) notification and certification requirements; and
(iii) the requirement to attend a doctor nominated by the employer for medical assessment, and guidelines for the return to work.

Return to work policy is perceived as an important part of the employee's rehabilitation process (Higgins *et al.* 2012). However, the way in which sickness absence is managed could be seen as punitive. Taylor *et al.* (2010: 274) argue that a shift in sickness absence management must be seen against the background of decades of neoliberalism 'which has unambiguously strengthened managerial prerogative'.

Most managers highlight the potential in their organisations for a phased return with the close cooperation of other external organisations e.g. occupational health services. In terms of the improvements which could be made to this process, more than one-half of managers cite better interpersonal relations between the managers and employees dealing with the return to work and better cooperation with the external stakeholders (e.g. doctors and occupational therapists) involved in facilitating returns.

External stakeholders are indeed critical in the return to work process at company level. In this respect, an income protection policy is vital under which an employee unable to work due to an identifiable illness is paid until they return to work or reach retirement. These insurers, such as Irish Life, take on the case after a number of weeks, assess the claim and work on rehabilitation and return to work programmes. The return to work process is thus moved outside the organisation, with the insurance company managing the case.

In the view of managers themselves, interactions between managers and workers on sick leave happen quite regularly (both formally and informally). More than half of managers indicate that they keep the worker informed about work-related issues although only one in five report involving the worker in actual decisions. This may be due to a fear that contact could be misinterpreted as pressurising the employee to re-connect with work.

Having no clear workplace procedures can lead to perceptions of unfairness and a lack of transparency, compounded by a lack of consistency in the implementation of sickness leave and return policies even within an organisation. van den Bos and Lind (2002) argue that workers pay greater attention to fairness during times of uncertainty such as when on sick leave or returning after, or with, a chronic illness. It follows that interventions that yield reductions in perceived injustice for the returning worker should be associated with more positive outcomes. A national framework on the return to work is one such intervention which may set clear procedural rules for managing the return process.

Communication in the return to work – ensuring a thorough discussion with the worker and putting in place a prior plan for their return – is clearly important. Discussions with occupational therapists and consultants working in this area reinforce the importance of agreeing an individual plan before the employee returns. The plan should include any adjustments to workload or work patterns that might be needed. Over half of companies do offer some form of adjustments in working time, work tasks, workload and workspaces. Few, however, offer training to co-workers in how to treat a colleague returning to work after long-term illness. One rare example is provided by a cancer patient organisation which had been approached by a manager requesting training on how to support a key employee returning after cancer treatment.

The introduction of the General Data Protection Regulation (GDPR) in 2018 is a new, complicating issue in facilitating the return to work. For an employer, the processing of a medical report is necessary to ensure they deal with sick pay or can assess fitness to return, identify reasonable accommodations for the returning employee and ensure they adhere to employment law. GDPR, however, places constraints on the processing of data which means that employers can only insist on the following information from a doctor or occupational health physician: that the employee is unfit to work; how long they will be unfit for; and when they are medically fit to return. Some managers think that this has a negative impact on their ability to work with the employee to support a successful transition back into work as they do not have full details of the illness and cannot plan for reasonable adjustments to workload or the workplace. Occupational specialists also express concern about this; communication and cooperation between healthcare professionals and employers are clear facilitators in the planning of a successful return, but knowledge of the chronic illness is a requirement to implement such a plan. Campaigning and patient support organisations highlight, however, how individuals are different and that many do not want to be labelled or stigmatised due to their illness. For some employees, this results in uncertainty regarding the disclosure of their illness to their employers. A consequent challenge lies in balancing the needs of the worker and those of the employer by ensuring confidentiality for the worker and then looking to facilitate adaptations and allow others to understand the workplace difficulties that may occur.

A number of managers and employer representatives raise the issue of sickness certification, required in Ireland to confirm that an individual is ill. A study by King *et al.* (2016) found that Irish general practitioners report significant difficulties in relation to sickness certification. Over half the respondents in their study indicated a preference for introducing a 'fit to work' note as the current system had an excessive focus on disability. In their view, a key strength of the 'fit note' is thus its shift away from disability towards empowering sick patients to go back to work.

The nature of an employee's illness is a concern both for employers as well as for employees, illnesses having both visible and invisible elements. For example, a stroke patient returning to work may have visible changes such as mobility issues. However, cognitive changes such as difficulties with memory, data processing and language, in turn causing fatigue and anxiety, are less visible. Many interviewees report mental health illness to be the most complex illness, entailing a fear on the part of the employer of how to manage it and on the part of the employee with regard to being stigmatised or considered less valuable as a worker.

4.4 Identification of good practice

The coordination of the return to work requires an understanding both of the worker with an illness and of the work environment as well as the presence of an individual work plan. There is some evidence of organisations (both public and private sector) which provide employees with appropriate plans and accommodation. Here, however, having a good understanding of the chronic illness in question and its side effects is

critical. If the return to work is to be effective, it must be seen as a process not just an event. Such a perspective allows for clarity in the management of expectations on how quickly an employee could 'return to normal' and also facilitates the discussion about any necessary adjustments. The needs of workers with chronic illnesses vary according to the type of illness: cancer survivors might well have different needs and require different adaptations than those experiencing a stroke or mental illness.

A second point of good practice emerges in connection with communicating with the employee at various points in the process. One campaigning and patient support organisation stresses that:

> 'It is really important to signpost for people… [so that they] Know where to go and ask questions. What resources are available.'

Clearly outlined and agreed communications should begin at the point of diagnosis and/or the start of sickness leave and continue both in its duration and prior to the return to work in terms of planning how and when the employee will return. Employees suggest that conversations should also take place after their return in order to review their return process and the effectiveness of any adjustments made for them in the workplace. One manager commented to us on the importance of relationships within the organisation, too:

> 'These processes depend largely on how workers get along with the team, and the manager's human practices and thinking.'

Beatty and Joffe (2006) highlighted that an understanding and supportive supervisor is the most significant factor contributing to a successful return to work experience.

The importance of a work plan is particularly critical. Best practice examples show that there should be a meeting six weeks in advance to work out a phased return. This meeting should agree on a number of issues such as the targets to be met, hours to be worked, etc. and with a clear discussion of capabilities and adjustments, and full disclosure about medical appointments during work hours. It is, however, acknowledged that such best practice could constitute an onerous cost for small and medium-sized enterprises who generally do not have extensive HR expertise, especially in managing an employee absent due to chronic illness. Challenges are also acknowledged around the capacity of a small and medium-sized enterprise to accommodate a phased return or redeployment to other work tasks. Operational factors may additionally limit the extent to which employers can make reasonable work plan adjustments in working hours and/or job content. High risk settings are particularly problematic in situations, for example, of high temperatures, electromagnetic activity, toilet facilities on higher floors or an absence of the availability of lighter duties.

The public sector may well be better equipped to demonstrate best practice and there are a number of examples of public bodies providing reasonable accommodations to employees with chronic illness. The Health Service Executive (HSE) has published a recent update of its Rehabilitation of Employees Back to Work After Illness or Injury

Policy & Procedure in order to bring it 'in line with international evidence-based best practice in the area of workplace rehabilitation' (HSE 2020). In some public sector organisations, disability liaison officers or occupational therapists are responsible for supervising the provision of reasonable accommodations.

4.5 The future potential of social dialogue in the return to work

The creation of cooperation between stakeholders is certainly critical in facilitating the implementation of return to work programmes. However at company level there is a lack of consensus around the role of trade unions in the return to work. Workers point to limited engagement by trade unions, although over 60 per cent of respondents in the study were not union members. Even so, almost nine in ten stated they had not thought about joining a trade union in search of support for their return to work since their diagnosis. More than three-quarters nevertheless agree that support for the return to work should be an important element in negotiations between trade unions and employers, followed closely by trade unions being ready to address the health-related issues of workers.

Some managers told us that, despite their companies being unionised, there are no return to work provisions in collective agreements. A report by the European Agency for Safety and Health at Work (EU-OSHA 2016) claims that the implementation of collective agreements regulating the reintegration of workers following sickness absence can be as effective as a national integrated framework for the return to work. Some evidence of this can be found amidst the consensus that enterprises with longstanding collective bargaining agreements, in manufacturing and financial services, provided the best arrangements in dealing with chronic illness and the return to work. One example is Baxter Healthcare, a pharmaceuticals manufacturer, where an agreement was made in 2018 to expand sick pay entitlement to eight weeks at full pay and six weeks at 75 per cent pay. One officer from the Services, Industrial, Professional and Technical Union (SIPTU) stressed that Baxter could afford extra sick pay and was willing to do so but that many other, and smaller, firms in Ireland did not have the ability to pay. One trade union officer related that, outside of the big supermarket chains:

> 'Many retail workers did not have any form of sick pay scheme and had to rely on State benefits.'

In instances where a collective bargaining agreement does not have return to work provisions, return thus usually becomes an 'individualised' issue. In these circumstances, union officers represent an employee with an HR manager and seek a personal agreement for the union member to have paid time off for treatment or adaptations on their return. One SIPTU officer reported:

> 'When the collective bargaining agreement, if it exists at all, does not cover how to deal with employees with serious illness, we have to make individual without prejudice agreements with companies for individual union members that cannot be applied in other instances.'

In such instances, however, the presence of collective agreements at workplace level means that the actors involved in the return to work process — employer, workers, HR and trade union representatives — are more easily able to reach consensus since they are familiar with collaborating on issues related to well-being at work.

Turning to attitudes towards the role of trade unions in the return to work, more than half the managers we interviewed indicated the presence of a trade union or some form of employee representation. Among those who are unionised, however, return to work is not an issue addressed commonly in company-level agreements. A little less than one-half of managers do not consult with trade unions on these sorts of issues although one-third report that the committee addressing occupational health and safety (and which is also responsible for dealing with return to work issues) contains a union member. Over half report that cooperating with unions or employee representatives had previously led to additional requests being attached to return to work stipulations.

There appears to be consensus among managers that the current Irish legislation is sufficient; one manager declared to us:

> 'We have a very successful return to work practice which is very employee centric. Current legislation is also highly adequate in preserving workers' rights in this area and in fact places a big burden on organisations which may not have the same resources as ours to manage such a difficult situation.'

However, the lack of specificity over the stages of the return to work process is highlighted as an issue in a further comment that:

> 'It would be helpful to look at this from an employer perspective and develop an innovative set of provisions that can allow employers to more easily manage long-term illness cover for their organisation and bring some more certainty in supports and plans for their business while still retaining adequate supports to employees. A big ask, I know.'

4.6 Return to work and Covid-19

The Covid-19 pandemic has had a significant impact on workers with chronic illness. Beyond the employment-related issues, it has had major implications for their access to healthcare, particularly primary care, in seeking to manage chronic illness. Many organisations providing essential follow-up care are Section 38 and 39 NGOs[9] and voluntary groups established with the support of charitable donations. Fundraising has collapsed during Covid-19 and many charities report their finances to be uncertain

9. The HSE has arrangements with other organisations to manage and deliver health and personal social services. The HSE provides annual funding for the delivery of a range of services to agencies (known as Section 38 agencies) and organisations. Section 38 arrangements involve organisations funded to provide a defined level of service on behalf of the HSE, while under Section 39 the HSE grant aids a wide range of organisations to a greater or lesser extent.

or in difficulty. A survey by The Wheel found that 82 per cent of charities are 'very concerned' about whether they will have sufficient funds to provide their services in 2021 (The Wheel 2021). This also shines a light on how reliant the state is on such organisations to provide critical services including cancer support, mental health services and stroke rehabilitation.

More broadly this disruption in health services due to Covid-19 has paused work in many parts of Irish Health provision[10] and patients are either not getting diagnosis or treatment or are postponing or avoiding attending hospitals or family doctors. For example, the Irish Cancer Society estimate that 450 cancers and 1400 pre-cancers were not detected in Ireland up to July 2020 due to Covid-19. This suggests a 'Covid hangover' in terms of delayed diagnosis and treatments that may have significant short-term and long-term impacts on the health of Irish workers.

Covid-19 poses significant challenges in particular for people with chronic illness and concerning their ability to work. However, several initiatives and policies emerged in the early stages of the outbreak in 2020. In May 2020, the Department of Enterprise, Trade and Employment published a Return to Work protocol developed through social dialogue, which was a significant and positive development. This protocol allows everybody to work from home wherever possible; and it gives individuals with health conditions guidance to remain at home where practical, that accommodations will have to be introduced to keep them safe (2m distance at minimum) on their return to work and that they would be the last group of workers returning to the workplace. All employees are, prior to returning, required to complete a Covid-19 Pre-Return To Work form at least three days in advance of their physical return. Individuals are asked on the form if they have any concerns around their return to work. Anecdotally it is reported that this has raised concerns for both employers and workers. For workers, it raises the problem of disclosure: people who may have an underlying health problem are worried about Covid-19 and returning to work in that, up to now, they may have been managing without disclosing their condition to their employer. For the employer, this forced disclosure requires them to acknowledge and manage what has then been reported.

A major question raised by the Covid crisis concerns the assumptions which underpin policy-making in the area of work. Covid-19 has amplified the structural inequality that exists in the labour force. As mentioned in section 2, Ireland is an EU outlier in that it does not have a statutory sick pay scheme. This lack of statutory sick pay has emerged as a significant topic of public interest during Covid-19. Due to its absence, many workers who were sick went to work, as did those who should have quarantined due to being a close contact. The government has promised to introduce legislation by the end of 2021 and consultations are taking place with unions and employers.

10. For example, the national cervical screening programme was paused for over three months from March to July 2020.

5. Conclusion

There is no national framework in Ireland which guides the reintegration of employees with chronic illness back into the workplace. Largely this is due to Ireland traditionally taking a voluntarist and decentralised approach to the regulation of employment terms and conditions. Instead there are a number of important, albeit relevant, ad hoc initiatives from government and other state bodies, trade unions, employer associations and campaigning and patient support organisations. Unlike in other countries, the passive welfare approach to social protection, mainly through income replacement or financial benefit, has been adopted in Ireland. Employees not covered by a collective agreement or as part of an employment contract have no statutory right to an occupational sick pay scheme.

The evidence gathered for this chapter suggests that chronic illness is an important issue at national level. It does seem that supporting people with chronic illness in Ireland is focused on the preventative and medical care aspects rather than on the mechanisms supporting the return to work. Where chronic illness is captured in a work context, it typically tends to come under the umbrella of disability. Non-traditional industrial relations actors, like campaigning and patient support organisations, play an important role in the development of return to work policies and guidelines. They have their own distinct focus on a singular chronic illness and therefore have different needs and priorities. The strength of patient support groups is their knowledge of the needs of workers with specific health problems. However, they face barriers due to the lack of resources, most of which come from voluntary donations, although there are some cases of organisations being funded by the government. This has placed a critical limitation on their ability to provide services and advocate on behalf of their patient cohort.

Overall, Irish social partners report strong awareness of the importance of the return to work. However, there is no evidence of national social partner involvement in return to work policy except in the public sector where there is evidence of negotiation with unions on the Public Service Sick Leave Scheme. Whilst we did find evidence of social dialogue, it was ad hoc and fragmented and often short-term due to the lack of funding. Our findings show that the company level is where return to work procedures are developed but there is limited evidence of trade union involvement in the implementation of return to work policy.

A number of key barriers and facilitators relating to the return to work emerge from the research. The Irish benefits system as a whole is seen as a complex system to navigate, especially when simultaneously dealing with a chronic illness. At different points in the process, workers must engage with multiple government departments and bodies, many of whom do not coordinate with each other. Having a clearly signposted policy around the return to work is critical to the re-entry process and to workers' subsequent adaptation. Effective return procedures require a high level of workplace coordination and communication as well as coordination with external services including medical services, rehabilitation providers, etc. Interactions with HR and line managers in particular surface as critical in a successful return to work process.

When discussing reasonable accommodations, organisations need to communicate their policies and procedures on this effectively so that all employees understand them and are able to navigate the process. Organisations also need a process for regularly reviewing reasonable accommodations as the employee's needs, their environment or their work duties change. These challenges – of navigating benefits, communicating between stakeholders and negotiating accommodations before the return to work – were identified by Hoefsmit *et al.* (2013) as bottlenecks that can hamper the return to work.

This chapter has set out the Irish national framework and experience of various actors on the return to work. A major finding is that the majority of stakeholders accept that returning to work with, or after, chronic illness is an important issue. Early intervention, the timely and proactive use of organisational procedures, communication between key stakeholders and multidisciplinary coordination across government departments and agencies and at workplace level emerge as the most important factors in managing the return to work after chronic illness. Furthermore there is no 'one size fits all' formula for such workers: ultimately, it is the needs of workers, as influenced by their illnesses, that are the most important consideration.

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Chapter 5
Over-expectation and underprovision: overcoming the voluntarist and irregular approach of Italian social partners to the return to work

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1. Introduction

In line with the majority of European countries, Italy is experiencing a slow, though quite steady, increase in the percentage of people affected by chronic illness.[2] In 2019, 40.9 per cent of Italian residents (compared to 38.6 per cent in 2010) said they had been suffering from at least one chronic disease. Chronic-degenerative pathologies are more frequent in older age groups: 54.1 per cent of Italian people aged 55-59 already experience chronic illness and, among the over-75s, the share reaches 85.4 per cent.[3] Projections indicate that, by 2030, the number of patients with a chronic disease will rise above 26.5 million while those with more than one will number 14.6 million (Università Cattolica Sacro Cuore, Istituto Sanità Pubblica 2020).

As regards the interplay between chronic illness and work, the share of the Italian working population affected by at least one chronic disease increased from 30.1 per cent in 2009 to 34 per cent in 2019. That same year, 78.3 per cent of Italians experiencing at least one chronic disease left the labour market, a total significantly higher than for people in good health (38.7 per cent). These data seem to confirm for Italy a trend which has been registered in many countries, i.e. an increase in the proportion of people requesting sick leave, taking early retirement and living on long-term disability allowances (EuroHealthNet 2017; Tiraboschi 2015).

In this scenario, the long-term effects of the Covid-19 pandemic must also be carefully monitored. In a survey conducted by *Fondazione Policlinico Universitario Agostino Gemelli IRCCS* on 143 patients in Rome who had recovered from Covid-19, 87.4 per cent of those interviewed (on average 60.3 days after the onset of the first symptoms) had at least one persisting symptom, particularly fatigue (53.1 per cent) and shortness of breath (43.4 per cent) (Carfi *et al.* 2020). It is reasonable therefore to expect that the delayed return to usual health for Covid-19 patients may lead to a protracted absence from everyday life, including work.

1. The authors thank Dr. Margherita Roiatti and Dr. Pietro Manzella for their valuable comments and language revision, and Dr. Mehtap Akgüç and all the participants in the European project 'Negotiating Return to Work in the Age of Demographic Change through Industrial Relations' (REWIR) for coordination and feedback. This chapter is dedicated to Dr. Lorenzo Maria Pelusi who passed away prematurely in August 2020.

2. Eurostat, People having a long-standing illness or health problem, by sex, age and labour status [hlth_silc_04], http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_silc_04&lang=en [Accessed on 30.12.2020].

3. Istat, Aspetti della vita quotidiana: Stato di salute – età dettaglio, http://dati.istat.it/Index.aspx?QueryId=15448# [Accessed on 30.12.2020].

These trends need to be adequately addressed since the participation of people affected by chronic illness in the labour market is considered important for a number of reasons. In the first place this is expected to reduce the impact on patients and help them successfully manage their condition in everyday life, thus fostering functional capacity, psychological well-being and even recovery (EuroHealthNet 2017). It is therefore no wonder that, according to different surveys on cancer (La Stampa 2011; Istituto Piepoli 2008), most Italian patients themselves consider work as a fundamental means of facing up to illness. The return to work of people with chronic illness is also essential in tackling the decline in labour supply (given the decrease in birth rates) and shortages of skilled labour, as well as combating the pressures on public health and pension systems induced by the dramatic ageing of the workforce (Tiraboschi 2015; OECD 2009). Moreover, workplace accommodation of the needs of workers with chronic illness can have a positive impact on the quality of work produced and its sustainability through lower levels of work intensity and stress, as well as better work-life balance (Vargas Llave *et al.* 2019).

The social partners are, as key players in labour markets, required to play a highly important role in activating flexible solutions and favouring return to work processes (Tiraboschi 2015). However, their contribution in this field, also with specific reference to the Italian case, is largely neglected in the literature.

Italy, which belongs to the 'southern' cluster of industrial relations in Europe (Caprile *et al.* 2017), boasts quite positive and steady values in collective bargaining coverage (80 per cent in 2016)[4] and in trade union density (34.4 per cent in 2018).[5] Even so, Italy is also characterised by an irregular involvement of the social partners in public policy formation, a scant development of employee representation in the workplace (Caprile *et al.* 2017), a generalised abstention of the law and a high degree of voluntarism in industrial relations (Leonardi 2017; Leonardi *et al.* 2017). The latter conditions have progressively made larger organisations subject to pressure and opposition; this tends to compromise the development of cooperative industrial relations and has paved the way for the growth of independent autonomous unions (Colombo and Regalia 2016) and the multiplication of national collective labour agreements (NCLAs) (CNEL 2019). These are the features which make up the institutional framework for industrial relations in Italy and which potentially have an impact on their role in return to work processes.

This chapter relies on information and data gathered via various tools, including documentary research, surveys with workers, managers and social partners, semi-structured interviews with national stakeholders and group discussions with employers and workers' representatives at company level as well as a roundtable with stakeholders.

4. OECD.Stat, Collective bargaining coverage, https://stats.oecd.org/Index.aspx?DataSetCode=CBC [Accessed on 03.06.2020].
5. OECD.Stat, Trade union density, https://stats.oecd.org/Index.aspx?DataSetCode=TUD [Accessed on 3.06. 2020].

2. Legal policy framework on the return to work

The Italian legislation supporting people with chronic illness in returning to work is neither homogeneous nor specifically targeted. This is mainly due to the Italian system lacking a clear definition of chronic disease in legal terms and there is a trend, both in literature and case law, to equate illness with 'disability' (Fernandez Martinez 2017). Even though workers with chronic illness are generally not given specific rights, there are some provisions on the return to work and some protections which derive from being recognised as disabled. However, even this has taken different forms in the Italian legal system according to the objectives pursued from time to time by the legislator. As a result, there is an overlap in this field between various notions which have different meanings (e.g. 'handicapped[6] people', 'unfitness', 'disability', etc.) and their related pieces of legislation. Furthermore, the traditional influence of biomedical evaluations (focused on a person's condition and need for healthcare) has given rise to a number of legal provisions almost exclusively devoted to ensuring assistance and protection (e.g. through paid leave and benefits) to people falling within these specific categories (Bono 2020). It is only with Legislative Decree No. 216/2003, the Italian transposition of Council Directive 2000/78/EC, that a broader, more dynamic and inclusive notion of disability has entered the legal system, paving the way for jurisprudential guidelines supporting the principles of social justice and non-discrimination at work (with an important role to be played by the employer in terms of the (re-)integration of disabled people) regardless of the specific causes of the disability.

2.1 Sickness and invalidity benefit system

Paid sickness leave for workers is met by the employer during the first three days of absence and thereafter by *Istituto Nazionale Previdenza Sociale* (National Institute for Social Security; INPS) up to the 180th day. It is proportional to the normal wage but progressively decreases. This compensation is provided to workers experiencing illness and who cannot perform their job tasks.[7]

Important rules concern the calculation of the length of the so-called protected period, made up of the overall number of days of absence from work during which employees cannot be dismissed. These rules are either established by law (for white collar workers) or set in NCLAs at sectoral level (for blue collar workers). Many NCLAs extend the duration of the protected period in the case of certain illnesses.

When chronic illness leads to disability or an inability to work, as ascertained by public healthcare and the social security authorities, people are provided with an incapacity benefit (where there is an absolute and permanent impossibility of performing any work activity) or a civil invalidity benefit. In addition to the latter, a further mobility allowance is provided to those who cannot move about independently.

6. We are using the word as it appears in the Italian law.
7. INPS does not pay sickness compensation for certain categories of worker, including white collar workers in industrial sectors and managers in the industrial and craft sectors; in these cases it is the employer that pays the compensation.

In addition, occupational insurance for work-related accidents and occupational diseases, potentially applying also to workers with chronic illness, is financed through contributions paid mandatorily by employers to *Istituto Nazionale per l'Assicurazione contro gli Infortuni sul Lavoro* (National Institute for Insurance against Accidents at Work; INAIL) in respect of all employees and *lavoratori parasubordinati* (project-based contract workers). INAIL's assistance measures include: a daily allowance for temporary absolute inability, targeted at people injured at work or affected by an occupational illness if they are unable to work for a period of time; compensation for functional impairments; and an allowance for people with mesothelioma contracted after exposure to asbestos, regardless of whether this was at work or elsewhere.

INAIL has also been entrusted by Law No. 190/2014 with the task of supporting the return process for workers with occupational illnesses. In 2016 INAIL therefore adopted a regulation on the return to work of people with work-related disabilities through which it launches public calls to finance work integration projects for disabled or unfit workers following an accident at work or an occupational illness. In addition to notifying INAIL of their availability to participate in these processes, employers can directly present projects of their own and apply for funding. However, trade unionists have pointed to procedural issues which inhibit access to these funds and a lack of knowledge in companies about the availability of finance for return to work projects, leading to the resources being little used.

INAIL also finances and conducts research on health and safety at work in collaboration with the social partners and, according to Budget Law 2019, it may fund projects presented by the social partners for informing and training workers and employers as regards the return to work of people affected by work-related disability.

2.2 Provisions for rehabilitation and return to work support

In addition to INAIL's role in respect of work-related illnesses, the return to work is favoured by a number of legislative provisions. The most important of these, specifically targeted at people with 'severe chronic and degenerative pathologies', is the right to switch the employment relationship from full-time to part-time (Legislative Decree No. 81/2015).

Other relevant opportunities derive from the potential for collective bargaining to complement and adapt certain legislative provisions in response to specific situations. For instance, 'smart working', regulated by Legislative Decree No. 81/2017, allows people to perform their job from home or other locations after signing an individual agreement.[8] Moreover, Legislative Decree No. 151/2015 introduces the possibility for

8. During the Covid-19 pandemic, the Italian government introduced a new right to work from home for disabled or immunosuppressed workers, as well as for those with a disabled or immunosuppressed person in their family. This right is meant to be temporary, up to the end of the health emergency, and is also dependent on whether this way of working is compatible with the characteristics of the activity being carried out. In addition, workers suffering from serious and proven diseases and who have reduced working capacity must be offered the possibility of working from home as a priority comparative to other workers.

workers to give some of their accrued but unused time-off to colleagues who need to take care of disabled or ill children. The above statutory provisions are frequently complemented by collective bargaining which sometimes expands their scope to people with chronic illness.

Those workers who are disabled (under the definition of Council Directive 2000/78/EC) also have the right to reasonable accommodation in the workplace in order to ensure they have working conditions equal to those of other employees (Legislative Decree No. 216/2003).

Further opportunities may apply to people with chronic illness as far as their condition fits the legal notions of 'disability' (here interpreted in a narrow sense and essentially based on biomedical evaluation), 'unfitness' and 'handicap', that have to be ascertained by the healthcare and social care authorities. These include the right for workers with disabilities amounting to more than 50 per cent of capacity to 30 days leave per year for treatment (Legislative Decree No. 119/2011); the obligation on the employer to assign a worker who has been assessed as unfit to perform a specific task by the occupational physician to an equivalent, or lower-level, task without loss of remuneration (Legislative Decree No. 81/2008); the right for a worker with health problems to refuse night shifts (Legislative Decree No. 66/2003); the right for 'handicapped' workers to paid leave of two hours per day or three days per month and, supplementarily, the right to choose (or be transferred to) a workplace closer to their home (Law No. 104/1992).

Financial incentives apply to employers in the public and private sectors who hire disabled people on open-ended contracts (Law No. 68/1999), while the same law also establishes a legal obligation for employers to hire and retain disabled workers in a number proportionate to the dimensions of their enterprise (from one in companies with 15-35 workers to 7 per cent of the workforce in companies with more than 50 workers). The employer can comply with these provisions by hiring temporary agency workers as long as their contract duration is at least 12 months (Legislative Decree No. 151/2015) or, on the basis of the rules established in specific regional agreements signed by public job centres, trade unions and employer associations (Article 14 of Legislative Decree No. 276/2003), by contracting out certain activities to social cooperatives pursuing the integration of disadvantaged people.

One policy slowly spreading in larger companies is the creation within HR departments of a 'disability manager' specifically devoted to inclusion and the management of disabilities at work. The role of a person 'responsible for the inclusion at work' of disabled people is envisaged by Legislative Decree No. 151/2015[9] and the related costs may be partially reimbursed through funds established in each Italian region for the

9. As regards private workplaces, precise guidelines for the job placement of disabled people, based on a set of important principles including the promotion of an ad hoc professional figure, should have been designated within 180 days of the adoption of Legislative Decree No. 151/2015, but these remain missing. In public administrations with more than 200 employees, the introduction of a professional figure for the inclusion at work of disabled people has been made compulsory (Legislative Decree No. 165/2001, as modified by Legislative Decree No. 75/2017).

employment of disabled people.[10] In addition, these funds may partially reimburse the expenses incurred by companies making reasonable workplace adjustments for workers whose level of incapacity exceeds 50 per cent.

Competences in terms of labour policy are also attributed to Italy's regions and autonomous provinces in the light of which, on top of these national provisions, there are some regional or more local activities which are relevant to the return to work. Examples include the SIL 22 job integration service in Verona, aimed at promoting the employment of disabled people by offering information, vocational training, career planning, job matching and placement, and other services; and the EMERGO plan, a programme promoted by the municipal authorities in Milan for disabled people aimed at facilitating their labour market participation through services supporting training or other return to work activities.

3. Involvement of the social partners in shaping return to work policy at national, local and company level

3.1 Industrial relations actors and return to work policy

Return to work policies for people with chronic illness may involve a great number of actors including public authorities, employer associations, trade unions, campaigning and patient support organisations, public job centres and private employment agencies, research organisations and companies.

By and large, the industrial relations actors are perceived as very important in the return to work by most of the stakeholders involved, especially considering the fragmented legislative framework and workers' needs for assistance and representation during their return process. Here, trade union representatives act as more or less a link between the worker with chronic illness and the other relevant stakeholders in accompanying the worker throughout the process. Moreover, both trade unions and employer associations provide support to workers and companies in the return to work and also collaborate with each other (mainly through collective bargaining at national, regional or company level) to establish solutions that facilitate return to work processes.

The social partners are becoming increasingly aware of the importance of returning to work for people experiencing chronic illness. However, there is a long way to go, since 75 per cent of trade union and employer representatives responding to our survey declare they have no knowledge of any national policy in this field. Neither are return to work issues perceived as a priority by many: while they acknowledge that they have only limited involvement in policy-making and implementation, representatives

10. The obligation for Italian regions to establish a fund for the employment of disabled people was firstly introduced via Law No. 68/1999 and then slightly modified by Legislative Decree No. 151/2015. Each fund is financed out of the fines paid by companies not complying with the rules on the mandatory hiring of disabled people, contributions from companies not subject to the rules, private donations, etc.

exhibit a rather ambivalent attitude concerning their possible greater engagement, some wanting to focus mainly on other issues of interest representation although 50 per cent do strive for a more active stance. Overall, the impression is that employer associations are largely indifferent towards these issues whereas, in some cases, trade union officials display a rather greater interest.

At workplace level, employers tend to regard workers with chronic illness as no longer efficient or productive which could lead some to violate or circumvent certain of their obligations. In turn, this could contribute to endorsing the perception, which is widespread among HR and line managers, that the legislative framework in this field is more of a limitation than an opportunity. Furthermore, some important legislative provisions, including those referring to reasonable adaptation, seem to be unknown by many employers and HR managers. The inclination of small companies to implement organisational solutions for return to work processes is further jeopardised by a lack of economic resource compared to larger companies. Furthermore, in some SMEs, workers' relocation to other tasks is more difficult given the scarcity of available alternative activities. At the same time, local trade unionists and workers' representatives are regarded by some HR managers as lacking specific knowledge on different chronic pathologies that affect workers in various ways depending on age, contractual relationship and the personal characteristics of the worker. Therefore, worker representatives are regarded as applying rather generalised solutions and simply focus on helping people receive the benefits which are appropriate for their level of incapacity. Overall a reactive, rather than a proactive and preventive, approach to the issue seems to prevail within both companies and trade unions.

Training and awareness-raising initiatives are advocated as a means of overcoming these problems and boosting the involvement of the industrial relations actors, while better dialogue and cooperation between all the stakeholders involved are well-regarded in terms of further spreading, improving and coordinating return to work practices. However, it is worth specifying that these sorts of belief are shared mainly among those who are actively engaged in return to work processes, whereas most of the representatives of the social partners who had no direct experience to report in this field were generally apathetic towards the potential for multi-stakeholder cooperation to facilitate the return to work.

3.2 Interactions between industrial relations actors and other stakeholders in return to work policy

Examples of how multi-stakeholder cooperation can overcome prejudices and the information gaps constraining the return to work are provided in the positive impact that public job centres and private employment agencies may have on employers dealing with the return to work of workers experiencing chronic illness. Companies are often unprepared for the requirements of Law No. 68/1999 which obliges the hiring of a certain percentage of disabled workers according to the size of the enterprise and often look to employment agencies for help and assistance. Employment agencies do not only recruit workers for the employer but (especially when equipped with personnel

specialised in the workplace inclusion of disadvantaged people) they can support the employer in the implementation of organisational solutions, working time flexibilities and the necessary task adjustments to ensure a worker's successful (re-)integration. One professional from a private employment agency told us:

> 'Our work consists of discussing with the company and trying to erase preconceptions, by proving that certain limits can be overcome thanks, for instance, to the allocation of the worker to a different position. It happens very often that diseases described as unbearable by companies can actually be handled.'

Another example is provided by Mestieri Lombardia Bergamo, an employment agency specialised in the job placement of disadvantaged people. This is a non-profit entity which, by participating in the local consortium Sol.Co Città Aperta, has become a benchmark for other cooperatives in the consortium in dealing with a disabled person or a worker with chronic illness: if a return to the workplace is not possible, Mestieri Lombardia Bergamo helps identify entities both within and outside the consortium that may be available to offer opportunities to the worker.

In contrast, the collaboration between industrial relations actors and campaigning and patient support organisations is still underdeveloped. It is not by chance that two in three representatives from private employment agencies underline the need for patient support organisations to be further engaged in return to work policies as many are essentially concentrated on aspects related to treatment. In this sense *Associazione Italiana Sclerosi Multipla* (Italian Multiple Sclerosis Association; AISM) represents a positive exception as it has cooperated both with Merck Serono (a pharmaceutical company) and Prioritalia (a trade union foundation) in the organisation of different training courses. It has also reached a local partnership agreement with the employer association Unindustria of Rome, the ASPHI Foundation (which promotes the inclusion of disabled people through digital technologies), Merck Serono and local trade union organisations FILCTEM-CGIL, FEMCA-CISL and UILTEC-UIL with the aim of facilitating the recruitment of workers affected by multiple sclerosis at Merck Serono's Rome site. Another positive example is represented by the PROJOB initiative launched by *Associazione Italiana Malati di Cancro* (Italian Association of Cancer Patients, Relatives and Friends; AIMAC) in 2012. AIMAC professionals offer training for HR managers, line managers and colleagues, consultancy for employers on legal and contractual solutions for a better work-life balance and psychological support for workers with chronic illness and those caring for ill relatives.

Research organisations focused on chronic illness seem to experience even lesser chances of interaction with the industrial relations players. Indeed, these occasions are largely limited to the collection of information required by research projects in which researchers conduct interviews with managers and trade unionists or workers' representatives; or, occasionally, to the workplace training programmes that some such organisations, for example *Fondazione IRCCS Istituto Neurologico Carlo Besta*, have developed on disability management.

Regional and local public authorities and INAIL also interact with industrial relations stakeholders. Aside from the involvement of the social partners in *Consiglio di Indirizzo e Vigilanza* (INAIL's Orientation and Oversight Committee; CIV),[11] an important example is represented by the Memorandum of Understanding signed in January 2020 by the Lazio regional directorate of INAIL on behalf of local trade unions, employer organisations and several associations for disabled people. The Memorandum concerns the use of INAIL funds for carrying out, with the support of the public employment centre, return to work projects for disabled people involving the breaking down of architectural barriers, the adaptation of workstations and the organisation of training. Another case is provided by the project *Insieme per il Lavoro*, resulting from a collaboration between the Municipality of Bologna and the Archdiocese of Bologna, aimed at facilitating the job placement of people experiencing social and economic vulnerability. The project was launched in 2017 and has developed thanks to interaction with local trade unions and employer associations as well as with a network of enterprises available to integrate such workers.

Even so, these important experiences seem quite rare in the Italian landscape and are often focused on broad categories of disabled or disadvantaged workers which may encompass, though do not specifically refer to, people with chronic illness.

According to a director of the Ministry of Labour and Social Policies, trade unions and employer associations are in steady and permanent dialogue with the legislator concerning labour and industrial relations issues and, with specific regard to return to work policy, have been consulted prior to the introduction of some legislative provisions. However, the social partners offered us a quite different picture with most trade union and employer representatives declaring that they were not involved in policy-making on this issue.

3.3 Outcomes of social dialogue and collective bargaining with regard to return to work policy at national and local levels

At national level, it does seem that social dialogue processes have resulted in the introduction of legislative provisions seeking to facilitate the return to work; while some important bipartite or multipartite social dialogue activities have been conducted at regional or local level. On top of the aforementioned 2020 Memorandum signed in Lazio, agreements were signed in July 2015 by the Municipality of Alessandria and local trade union confederations; and in November 2011 by the Municipality of Pomezia, the social consortium Coin and local trade unions. Both are aimed at the placement into work of disabled people, thus extending potentially to people with chronic illness. A local collective agreement was signed among social cooperatives in the area of Bologna in April 2018 delivering information and consultation with workers' representatives concerning people 'with functional limitations' and the health and safety measures being put in place in individual cooperatives; furthermore, it also focused on possible

11. This body is charged with defining the programmes, guidelines and strategic multi-year objectives of INAIL as well as monitoring the proper management of the Institute's economic resources.

relocation opportunities to be implemented in conjunction with social consortia and local cooperatives specifically devoted to the workplace inclusion of disadvantaged people. This process is coordinated and supported by a regional bilateral committee.

As regards national-level collective bargaining, most of the NCLAs signed by the most representative trade unions (i.e. those affiliated to the major confederations *Confederazione Generale Italiana del Lavoro*, *Confederazione Italiana Sindacati Lavoratori* and *Unione Italiana del Lavoro*) provide measures that ensure work continuity for people affected by serious illnesses requiring periodic treatment. Many NCLAs (such as those for the food industry, the electrical sector, professional services firms, environmental services and social cooperatives), ensure that periods of hospitalisation and absence related to the need for life-saving therapies and long-term treatment are not considered in the calculation of when the protected period ends for workers affected by certified chronic illnesses (including cancers, HIV, multiple sclerosis and muscular dystrophy). Similarly, some NCLAs (such as those for the banking sector, chemical and pharmaceutical sectors, glass industry, apparel industry and stone materials) increase the length of the protected period, as far as 32-36 months, for workers affected by chronic illness. Moreover, once the protected period is over, NCLAs can provide ill workers with the possibility of benefiting from unpaid leave of absence that can last for four, six or twelve months depending on the sector.

Other agreements, such as the NCLA for the metalworking sector as well as that for retail, specify that absences related to chronic illness are not a reason for wage reductions; while the NCLA for the food industry grants workers affected by serious pathologies or medical necessities the opportunity to obtain a severance payment in advance.

Clauses in other collective agreements concern working time such as the right to change the employment relationship from full-time to part-time (confirming the rights laid down in the law); paid time-off (also in compliance with Law No. 104/1992); other forms of working time flexibility (e.g. the banking sector agreement provides workers affected by cancers and degenerative diseases with greater flexibility on entry to and exit from work); and the exclusion of chronically ill workers from certain work shifts (e.g. on Sundays). The NCLA for the banking sector considers telework a suitable tool to facilitate the return to work of disabled people.

Some NCLAs also establish funds supplementing the essential health provisions offered by the public system and thus improving access to treatment for workers. These funds are financed out of the contributions paid by employers (and, in some cases, also by workers) operating in the sectors concerned. These funds can offer the reimbursement of expenses related to surgical operations, specialist examinations, diagnostic tests (in the metalworking and food sectors), treatment and rehabilitative therapies for cancers (in the banking sector) as well as medical consultancy and assistance (in the apparel industry).

The sorts of measures set down in NCLAs are generally aimed at guaranteeing job protection, economic support, work-care-life balance and enhanced access to healthcare for workers affected by disabilities or chronic illness. Less attention,

however, is paid to the procedural and infrastructural elements (such as ad hoc training activities for managers and workers' representatives, targeted information and consultation processes and guidelines for company-level bargaining on return to work processes) whose use may potentially sustain the actual application of national-level provisions that are indeed not always known and implemented at company level. Relevant provisions in this sense can, however, be detected in the NCLAs in the chemical and pharmaceutical and the banking sectors. Moreover, unlike local social dialogue, NCLAs do not generally cast attention to active labour policies and tend to concentrate on securing jobs and making them more sustainable for disabled or sick workers rather than empowering workers themselves in the labour market. Only the NCLA for agency workers (probably because of its cross-sectoral nature) seems to acknowledge and sustain possible occupational transitions for disabled workers by supporting vocational training and job placement paths for these workers.

3.4 The return to work process at company level and the involvement of the social partners

3.4.1 Workers' experiences with the return to work process

Considering the type of illness, our worker survey reveals that cancers are the ones most often diagnosed while other frequent diseases with an impact on work include: musculoskeletal disorders; chronic respiratory, cardiovascular and mental illnesses; arthritis; and diabetes.

More than two in three workers are concerned about their return to work, most often on the grounds that the employer might not be willing to adjust working conditions to their post-illness situation. Workers also fear being left without support from the employer if their subsequent productivity, concentration and work performance do not fully meet the employer's expectations. Other reasons for concern are the risk of being required to return to work at full productivity right after treatment and without any adjustment period, as well as the possible need to work long hours shortly after long-term absence. Discrimination by colleagues and unequal financial treatment, in the sense that workers may not get bonuses due to their lowered productivity, constitute additional grounds of concern.

With reference to workers' actual return experiences, in a majority of cases the initiative to return had been made by the workers themselves although almost one in four identifies that the triggering role here was played by the specialists treating them. Indeed, the first actor with whom workers discuss their return to work is their medical specialist (38 per cent), followed by the general practitioner (29 per cent), the family (21 per cent) and trade unions to a lesser extent. It is thus no wonder that a crucial role in facilitating the return to work is played by both the medical specialists and the family. The role attributed to rehabilitation institutes, nurses and physiotherapists (considered as crucial by 20 per cent of workers), as well as general practitioners and colleagues (their role is important in combination with other actors for one in four workers), is also relevant although less important is the contribution of NGOs or similar organisations

and trade unions or other employee representatives (60 per cent of workers deem them to be unimportant).

With specific reference to the help provided by trade unions, almost half of workers declare that they are not satisfied, although one in four are very pleased, receiving the expected advice and support. More than eight in ten workers have not had the wish to join trade unions as a means of better facilitating their return to work after treatment, even though at least one trade union operates in most of the workplaces where respondents are employed. Moreover, although the vast majority of workers think that 'the trade union should always be ready to address the health-related issues of workers' and that 'support for the return to work should be an important element on the negotiations agenda between trade unions and the employer', only a small minority declare that there have been actual negotiations between their employer and workers' representatives about adjustments to their work tasks and responsibilities after the return to work. Only one in four workers knows of other cases where a trade union proved to be helpful in facilitating the return to work.

Neither are workers satisfied with the support received from their employer: more than one in four are not satisfied at all and just 16 per cent report that they were very happy.

Turning to the specific characteristics of the return to work process, respondents are equally divided between those who, after chronic illness, had returned to the same job position and those who had not done so. The majority (57 per cent) receive either no support or only limited help with regard to tasks or duties while, as for adjustments in the work environment and in the type of employment, almost one-half are not provided with any support. Similar results concern the opportunity to postpone deadlines although less negative findings emerge with reference to adjustments in daily working time (offered, to an extensive or reasonable degree, to 34 per cent of workers), flexible working time solutions to facilitate medical examinations or treatments (extensive or reasonable support for 43 per cent of workers) and the reassignment of some original tasks and responsibilities (extensive or reasonable support for 39 per cent of workers). However, at least two out of five workers receive either no support or limited assistance in all these areas.

3.4.2 Perspectives of HR, line managers and other relevant company actors on return to work processes

The importance of regular contact with workers during absence is largely acknowledged by HR and line managers. Indeed, despite them working mainly in large enterprises with more than 250 employees, they are generally informed of the employee's specific chronic illness directly and there were relatively few cases of where they had instead been informed by the employee's own occupational physicians or the company's medical specialist. Regular contact with workers during absence are not always ensured through formal channels (such as standard HR requests for medical updates) but sometimes via informal phone calls and friendly conversations. On these occasions, workers are generally notified of work-related issues and, albeit in fewer instances, also engaged in decision-making and planning processes on work-related topics.

During sickness leave, three in four managers say they are forced to implement important organisational measures generally implying a rearrangement of workflow and a redistribution of job tasks among other workers as well as, to a rather lesser extent, the replacement of the sick worker. One in ten undergo financial difficulties. It is thus no wonder that most (70 per cent) declare that they encourage processes for the return to work during treatment. While dealing with workers on sick leave, HR and line managers find it useful to receive consultancy advice from an external expert or campaigning and patient support organisation, as well as information or advice on the specific chronic illness and proper adjustments which may be implemented in the workplace. We pointed earlier to the important support given by private employment agencies to companies, although managers frequently identify that this is missing, along with legal advice on sickness leave and external counselling.

Managers report that return to work processes are generally initiated by workers (56 per cent) or managers or employers (38 per cent) and anticipated either by a thorough discussion or informal conversation between workers and managers, allowing for a shared planning of specific return to work paths. A small majority of companies provide workers with a phased return to work, even though this is largely not written in any specific document or adaptable to individual situations. Return to work processes tend therefore to take the form of 'one size fits all' solutions, indivisibly addressed to all workers, and managed mostly by HR managers even though the role of line managers and team supervisors is conceived as equally important. Meanwhile, less responsibility is attributed to dedicated health and safety committees. The prevailing approach to the return to work seems to be essentially reactive when facing a specific situation, although there is a need for collaboration between HR managers and other business departments as regards the adoption of a preventive and proactive attitude which could result in the reconfiguration of workstations in such a way that they are suitable both for healthy workers as well as disabled or sick ones.

In the large majority of cases, companies do cooperate with external stakeholders when handling return to work situations. Indeed, such collaboration, as well as the relationships between the managers and those employees affected by chronic illness, are considered as pivotal in these processes and many respondents declare that both aspects should be further improved.

As regards the content of return to work processes, adjustments to working duties are perceived as relevant and, according to most, should be binding in law (74 per cent) rather than simply subject to managerial discretion (53 per cent). One in four managers think that individuals returning to work after chronic illness will not be able to perform the same duties as before, while there is also evidence that HR and line managers also believe that such workers are less committed to work. In this respect, the vast majority think that ill workers are likely to be absent from work more often than their colleagues (76 per cent). This, in turn, may be perceived as increasing the workload of colleagues. Subsequently, adjustments to working time, work tasks or workload are deemed necessary by the vast majority of respondents. In about half of cases, training for employees returning to work after chronic illness is offered, although it is far less common also to find training initiatives targeted at other workers on how to deal

with colleagues returning to work (around 28 per cent). There is a level of support for converting training from being merely an adaptive measure for upskilling or reskilling a worker after a long period of absence into a more proactive process that gives value to the new health conditions and personal skills developed by the worker as a result of their illness.

These results are, however, sometimes at odds with the degree of satisfaction in these fields perceived by workers. Workers' experiences with the return to work process are complex and, in the majority of cases, they do not see their companies as being prepared to put in place the necessary adjustments required by their health condition. They also perceive there to be a lack of coordination between companies and doctors during the process. Moreover, workers underline the weak support received from companies and trade unions during the process with specific reference to mentoring and guidance practices. Given this context, it is no surprise that less than one-half of workers declare that they felt welcome when they returned to the workplace.

Finally, we should not lose sight of the finding that a considerable share of managers expect workers to return to their previous productivity level with no need for adjustment (around one in three) or that about the same proportion had no clear opinion on this point. Confusion around this issue potentially hints at the current definitions and assessments of labour productivity being inadequate when it comes to workers affected by chronic illness: these methodologies are rather abstract and standardised. More particularly, there is no consideration of individuals' health and mental conditions at work and the various organisational and adjustment measures which should not be neglected when assessing the work performance (and its sustainability) of people with chronic illnesses in a given context (Tiraboschi 2015).

3.4.3 Experience of (and good practice in) facilitating the return to work at company level and the role of industrial relations

Return to work policies for workers following chronic illness do not constitute a prominent topic for company-level collective bargaining in Italy.[12] Indeed, although managers find it important to include a worker representative on the committee addressing occupational health and safety, and that cooperation with workers' representatives is widely considered to be helpful in increasing workers' motivation and improving the quality of relationships between workers and managers, regular interaction with workers' representatives does not always appear to be an attractive option for HR and line managers. Interaction takes a long time and is less flexible than unilateral decision-making; it also entails the risk of additional requests being made by the workers' side. The result is that, when these issues are tackled in collective agreements at company or workplace level, this mainly stems from where managers are sensitive to workers' problems and from a willingness to share commitment with

12. The scope of the analysis is represented by the ADAPT database of company-level collective agreements which has gathered together approximately 3 000 collective agreements. The findings from the database accord with the views of workers in our survey in which 82 per cent of the latter say there are no negotiations between their employer and trade union/employee representatives about adjustments in work tasks and responsibilities after returning to work.

workers' representatives. Another relevant prerequisite for negotiations over these topics is constituted by an awareness among worker representatives of the issues at stake and an inclination to deal actively with them.

By and large, not all the steps in a return to work process are formalised in a collective agreement: there are some reasonable adjustments that may imply significant investments by the company in new technical facilities and equipment and that are not included in collective agreements. Moreover, individual processes of return can be managed by the social partners totally outside the regulatory framework of collective agreements. For example, the relocation of a worker to different activities within a social cooperative has not been written down in any agreement even though it has been handled by both employer and trade union representatives. Consequently HR and line managers tend to see that the most beneficial results of the involvement of workers' representatives in this field are not only binding collective agreements but also training sessions organised for managers and workers' representatives, information leaflets distributed to workers and inputs made from the labour side on how to improve company return to work policies internally.

Employers occasionally do consult workers' representatives, but they still prefer to activate and implement return to work processes unilaterally, albeit sometimes in collaboration with external experts and organisations. Important examples in this sense are from the banking group Unicredit, which has organised awareness-raising initiatives on disability (e.g. online courses, days dedicated to disability management, focus groups, etc.) as well as training and professional mobility paths for deaf and blind people (Stefanovichj 2017). In recent years, return to work initiatives have also been promoted by the energy group Eni and AIMAC, with the participation of INPS, the Sodalitas Foundation and *l'Ordine Provinciale dei Consulenti del Lavoro* (Provincial Association of Labour Consultants) in Milan. Their project is entitled *Una rete solidale per attuare le norme a tutela dei lavoratori malati di cancro sui luoghi di lavoro* (Solidarity network to implement the norms protecting cancer patients in workplaces) and is aimed at identifying regulatory solutions for Eni workers who have had various cancers. The project also focuses on raising workers' and managers' awareness of these problems so as to promote better job integration policies. The digital platform 'Know and Believe', built in partnership with AIMAC and addressed to enterprises and health funds for the organisation of awareness-raising campaigns, collaborative events, online training courses and other initiatives to boost the prevention of cancer, is also worth mentioning in this respect.

In addition to these activities carried out by companies mainly outside the sphere of industrial relations, company-level collective bargaining can offer a normative framework for HR managers and workers' representatives when dealing with return to work processes as it makes available organisational solutions and tools that can be used in specific cases.

Among the different company-level collective agreements that do address this issue, the most significant clauses regard the increase in the length of the protected period or a job retention guarantee being offered until the complete recovery of a worker

affected by cancer. Further norms that have been established in this way concern work-life balance and, notably, the provision of unpaid sickness leave and additional paid time-off to undergo medical examinations and treatment (sometimes reserved explicitly to workers with chronic illnesses); and the possibility for certain categories of worker (including disabled workers and ones experiencing chronic illness) to benefit from the unused time-off accrued to individual workers but voluntarily transferred to a 'Solidarity Working Time Account' (introduced by Legislative Decree No. 151/2015[13]). Other company-level solutions which have been collectively agreed as regards workers with chronic illness include an exemption from working on weekends or on certain shifts, priority access to remote work and the possibility to be transferred to sites closer to home or allocated to different tasks where they are unfit for their previous activities (also in compliance with Legislative Decree No. 81/2008).

Specific attention is also paid to wage protection during periods of absence, particularly in the form of the return to work at up to the full amount of the normal wage and the guarantee of full performance-related pay (excepting the various days of absence from work).

Other provisions, found somewhat less frequently in company-level collective agreements, concern dedicated training courses for workers after long periods of absence and campaigns for the promotion of healthy lifestyles, often in collaboration with external experts and organisations. Welfare measures potentially targeted at workers with chronic illness may also be encompassed by the direct provision or reimbursement of expenses for medical examinations, tests and check-ups as well as of contributions to health funds and for insurance policies against the risk of not being able to support oneself or of developing serious illnesses (Tiraboschi 2019). By and large, however, these solutions are primarily devoted to increasing access to healthcare for workers from the perspective both of the prevention of serious diseases and their proper treatment rather than the direct facilitation of return to work policies.

Finally, it is worth mentioning the experiences of those companies (largely concentrated in the chemicals and pharmaceutical and the banking sectors) that have established, via collective agreement, the professional figure of a 'disability manager' and/or joint labour-management observatories or committees on disability, entrusted with the task of activating awareness-raising campaigns targeted at all workers and the design of welfare, training and organisational solutions for the effective return to work of disabled people. Following the setting-up of these roles and bodies, and despite the term 'disability' being potentially misleading as it seems to exclude many chronic illnesses, some companies have reached collective agreements regarding the launch, in partnership with campaigning and patient support organisations, of specific projects for the workplace inclusion of people affected by chronic illnesses at work (e.g. the local partnership agreement signed by Merck Serono referred to in section 3.2). Another example is the 2018 agreement signed by banking group Intesa San Paolo

13. Legislative Decree No. 151/2015 formally includes the possibility of workers transferring, on solidarity grounds, unused time-off solely to workers who need to assist their sick children. However, collective bargaining has expanded the scope of this measure.

which envisages a project for the inclusion of autistic workers, in collaboration with a specialist association, as well as an alternative training path for mentally disabled students. Funding for the initiatives at Intesa San Paolo comes from the sectoral bilateral employment fund and the solidarity company account financed by the employer and by workers voluntarily giving up a small percentage of their salaries for this purpose.

4. Conclusions

The Italian legislation on chronic illness and labour rights generally does not attribute functions and competences to industrial relations specialists, and the social partners themselves argue that policy-making processes in respect of the return to work provide rather poorly for their involvement. The legal framework on the return to work after chronic illness in Italy is also significantly fragmented and this compromises local players' thorough knowledge of it and their ability to implement it properly. Furthermore both employers and social partners frequently lack this legal expertise while being usually somewhat disinterested in these topics, preferring to focus their action on more traditional issues.

It is thus no wonder that the role of collective bargaining in this area is rather limited, being mainly focused on generalised responses to disability or chronic illness. Most NCLAs, indeed, tend to provide workers who have chronic illnesses with employment and wage security, a fair work-life balance and, thanks to supplementary health funds, with better or additional healthcare services. Although the measures agreed in this field mainly relate to these social areas, some differences can be detected across different sectoral NCLAs as regards the scope and generosity of these solutions and their main targets (e.g. either disabled workers, workers with chronic illness, workers affected by cancers and degenerative diseases, workers in need of life-saving therapies, etc.). In particular it has been reported that there is a lack, across different NCLAs, of clear and homogeneous definitions of the worker categories which are intended to be the beneficiaries of return to work measures and other forms of protection (Osservatorio AISM 2017). This has led to great confusion in their application and, consequently, to the risk of unequal treatment across companies and economic sectors.

It is in the light of these considerations that we can agree with and further advance AISM's suggestion that the social partners overcome the disparities in protection standards caused by the varying beneficiaries identified in different NCLAs and extend the rights and prerogatives to more comprehensive and less compartmentalised worker categories (Osservatorio AISM 2017). The potential wide and generalising effect of this approach must not, however, overlook the specific characteristics of each condition and the particular needs of every single person with chronic illness, in respect of whom each return to work plan needs to tailor its measures carefully.

With reference to decentralised industrial relations, it is worth pointing out that local and company-level bargaining on the return to work after chronic illness is largely underdeveloped and reliant on the mutual willingness of individual trade unions, employer representatives and managers. As a consequence, when it does take place,

company-level bargaining is essentially limited to large and well-structured companies (generally equipped with the necessary financial and technical resources to address return to work processes), that are mainly concentrated in specific sectors such as the chemical and pharmaceutical, energy and banking sectors.

As observed from the sectoral level, collective company-level solutions are usually aimed at providing workers with protection within their existing employment relationship and do not support, nor cover, any possible employment transitions. In contrast, active labour market policies and return to work programmes are found to be more frequently designed and implemented at regional level, where the social partners often engage with other relevant stakeholders in joint initiatives and projects. At company level, employers and workers' representatives may sometimes be found to cooperate with each other in return to work processes even outside the framework of formal collective agreements. As a result, the processes of return for workers experiencing chronic illness in Italy still seem to be largely managed on an informal and individual basis. In companies, these processes are mostly addressed unilaterally by company managers – at best, with the support of a few external experts – whilst the involvement of workers' representatives is quite rare. This situation is likely to jeopardise worker voice in return to work processes, thus explaining the already-polarised views of workers on the amount of support received from their employers. The situation also explains surveyed workers' largely negative perceptions on workplace adaptations after long-term absence and the role of labour representatives in these dynamics.

In partial contribution to the prevailing informality of the management of these issues, as well as the lack of a homogeneous, widespread commitment among the social partners to return to work processes, is the absence of any form of coordination and promotion starting from national industrial relations levels. Exceptions can be found in the NCLAs for the chemical and pharmaceutical and the banking sectors, where trade unions and employer associations have emphasised certain procedural aspects (e.g. ad hoc training activities for managers and worker representatives and targeted information and consultation rights), enabling local negotiating parties to put in place informed and site-specific solutions. Moreover, these NCLAs have sought to enhance the role of a national bilateral observatory in promoting and coordinating active labour market projects at local level, as well as encouraging companies to adopt disability management plans. It is thus not by chance that the most relevant collective return to work solutions have been implemented in companies operating in these sectors. However, both these agreements suffer from the lack of a clear provision of a monitoring system aimed at checking the implementation in practice of the suggested measures.

In the light of these findings, it is desirable that the social partners at national level take action to foster the role of local actors on this topic and improve their competencies at doing so. Successful results can be achieved especially when social partners collaborate with research institutes, campaigning and patient support organisations, public institutions and other relevant stakeholders in this field. However, these interactions, which are all the more important in this area given the multidimensionality of the issue (affecting the worker primarily as a person and a member of a family and a social community), seem limited to certain contexts and situations stemming from the availability and interest of

particular individuals. Major efforts should thus be oriented towards deepening social partner knowledge of the existing legal framework, strengthening multi-stakeholder cooperation and coordination across different levels and promoting a preventive and proactive approach to the return to work. This ought to have been done prior to the emergence of a critical health situation, and not in response to one, by redesigning work environments to make them more inclusive and sustainable for all and by rethinking notions of productivity, work performance, task fulfilment and suitability for work, inter alia, concerning their more appropriate adaptation to the needs of workers experiencing chronic illness (Tiraboschi 2015). This is even more urgent considering that workers undergoing a return to work are largely worried about not being able to keep up their usual levels of productivity and performance, and that a considerable portion of managers expect workers to be back at their previous pace with no adjustments.

Ultimately, as collective agreements mainly provide protections for workers within their existing employment relationship, greater attention should be paid by the social partners to the periods of transition (such as periods of absence from work due to treatment and periods of transition to a different job), within which workers may feel lost and in need of the external support which, today, is largely being sourced from relatives, physicians, colleagues and professionals from campaigning and patient support organisations. It is in this area that, given the many personal changes and events (e.g. disease, maternity, caregiving, etc.) which potentially have an impact on individuals' careers, the maturity, innovativeness and readiness of industrial relations actors and institutions will be measured.

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Chapter 6
Missing a framework for returning to work: the role of the social partners in Romania

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1. Introduction

Population ageing and the increasing prevalence of chronic illness constitute demographic developments which are influencing labour markets across the European Union with a likely higher impact on those countries, such as Romania, where welfare and healthcare systems are already challenged. The Romanian case is interesting as it has a specific profile among other countries in Europe: poorer labour market and health indicators compared to the EU average and a weak and ineffective trade union movement. We detail these three aspects below; for a more detailed presentation, see Popa *et al.* 2021).

First, labour market indicators have improved in the last few years, but there remain ongoing difficulties. After the employment rate reached its lowest point of 63.5 per cent of the working age population in 2009, it increased slowly but steadily to 66.7 per cent in 2019 (Eurostat and Trading Economics 2020). Despite this upward trend, Romania is still slightly below the mean employment rate for the EU-27 (73.1 per cent in 2019). Moreover the duration of working life in Romania was 35.9 years in 2019, below the EU-28 average of 36.4 (Eurostat 2020), while the activity rate (the labour force as a percentage of the country's total population) was, at 72.3 per cent in 2017 (European Commission 2019), also behind that of the EU-28. The unemployment rate reached its lowest level in December 2018 (3.8 per cent), while the long-term unemployment rate (those unemployed for more than 12 months) is low compared to other European countries – 1.6 per cent in 2019 (Eurostat and Trading Economics 2019). However, a good share of this category either remain unemployed (73.2 per cent) or become inactive (13.2 per cent).

Second, the healthcare system in Romania has, since 2017, been based on social and health insurance contributions paid by the employed population out of their salaries. Before 2017, such contributions were shared equally with the employer. The state pays the contributions for several vulnerable social categories (the unemployed, pensioners with low retirement incomes, people receiving social benefits) while coverage for other categories (including disabled people and those with chronic illness) is provided out of the contributions of employed people. Despite the neoliberal policies which have been implemented in the healthcare system during the last decade, it remains both chronically underfinanced – 4.7 per cent of GDP went on health expenditure in 2018 (Eurostat 2018b) – and centralised. Romania also has problems with healthcare outcomes (high infant deaths, low cancer survival rates, a high number of deaths before age 65) and it faces problems in prevention and the range and reach of the healthcare services provided (Björnberg and Phang 2019).

The main cause of morbidity and mortality in Romania is represented by cardiovascular diseases. The mortality rate from ischaemic heart disease is three times higher than the EU average (OECD/European Observatory on Health Systems and Policies 2019). Another relevant, although indirect, indicator of the prevalence of chronic illness in Romania is given by hospital discharge rates. Romania is discharging patients with diseases of the circulatory system, which are among the most prevalent chronic illnesses in the country (Eurostat 2018a), at an increasing rate and here it ranks eighth among EU countries. Romania has a standardised death rate around 2.5 times higher than the EU average (Eurostat 2017). Cancer is the second cause of morbidity and mortality, with lung cancer being the most frequent cause of death in this category (National Institute of Statistics 2020).

Furthermore, around 46 per cent of people beyond the age of 65 suffer from at least one chronic illness, women being more affected than men. It is additionally estimated that more than 3 per cent of the country's population suffers from one form or another of rheumatic disorder with the active population being significantly affected. More than half of absenteeism in the workplace and around 60 per cent of permanent incapacity for work are caused by musculoskeletal diseases in Romania (Dorobantu 2018). Thus, besides the pressure on the healthcare system, such diseases are having an important socioeconomic impact upon the labour market and the welfare state.

In the last year, the Covid-19 pandemic represented an extra burden for all workers including those with chronic illnesses. In January 2021 the number of Covid-19 cases diagnosed since the beginning of the pandemic stood at 728 743 among which there were 674 594 cured cases while 106 196 people had been immunised through vaccine *(Covid-19. Date la zi* 2021). The peak number of cases was in November 2020 (around 10 000 a day). No official data is currently available in Romania regarding the return to work after Covid-19 or about its longlasting health effects which can lead to further absence from the labour market. Even though some employer associations and federations of trade unions are involved in making sure that preventive measures are taken in the workplace or in advocating the benefits of teleworking, there is no data available which allows us to draw conclusions on their impact.

Third, the type of industrial relations system in Romania may be described as central and eastern European neoliberal and decentralised (Bechter *et al.* 2012; Bohle and Greskovits 2012). Traditionally Romania had a strong trade union movement and a coordinated system of collective bargaining until the reform of social dialogue legislation in 2011. This legislation changed how trade unions were established and how they functioned. The result has been a decrease in collective bargaining from 100 per cent (in 2010) to around 35 per cent (Stoiciu 2016), a figure which contemporary sources also support (ETUI 2020). According to the same data source, the trade union membership rate is 33 per cent but the numbers vary depending on the source. At present, social dialogue is weak and largely ineffective as responsibility for bargaining is placed at company level and actors in the companies have not fully assumed their role. Of all the issues addressed by trade unions, their influence on health issues is rather limited.

The rest of the chapter is structured as follows: section 2 describes the Romanian policy framework for the return to work after chronic illness; section 3 provides analysis regarding the involvement of the social partners in the return to work at national level; section 4 analyses the same issues at company level; and section 5 provides concluding remarks.

2. The policy framework on the return to work in Romania

This section summarises the policy framework for sickness, invalidity and the return to work in Romania.[1] Data were collected initially by desk research and then compared with information from individual interviews with health and social security experts. Of the four groups of countries described by Belin *et al.* (2016), Romania belongs to the third group with an ad hoc approach, i.e. not planned and supervised but usually determined on a case-by-case basis. The main target groups are disabled workers and those with occupational conditions or injuries and, in respect of some provisions, workers with chronic illnesses. Few actors are formally mentioned as having a role in the return to work and there are no statutory programmes for it.

2.1 The sickness and invalidity system in Romania

The Romanian social security system is based on social insurance (which pays for invalidity benefit) and health insurance (which pays for sickness leave). Different government departments formulate the criteria and supervise the requirements for sickness leave and invalidity benefit: *Ministerul Sănătăţii* (Ministry of Health) is responsible for the sickness leave provisions, named temporary work incapacity in Romanian law, while *Ministerul Muncii şi Protecţiei Sociale* (Ministry of Labour and Social Protection; MMPS) is responsible for invalidity benefit, disability benefit (since 2019) and other related payments. The provisions for sickness absence and invalidity are established in law and thus the system is rather centralised with the state having the key role while other actors, including employers, trade unions and employer associations, make a less significant contribution to how these systems function and how policies are shaped.

Different measures are established for accidents at work and occupational diseases compared to diseases not related to the workplace.

2.1.1 Sickness leave provisions

All workers are eligible for temporary work incapacity on a conditional basis, i.e. if they are insured by the public social insurance system, have a contribution record of

1. The analysis here focuses on several pieces of legislation: Law 19/2000 (public pension system); Law 263/2010 (the unitary system of public pensions); Emergency Ordinance 158/2005 (temporary work incapacity and social security); the Labour Code (53/2003); Government Decision 355/2007 (employee health monitoring); Law 448/2006 (protection and promotion of the rights of disabled people); Law 319/2006 (security and health at the workplace); and Government Ordinance 137/2000 (preventing and sanctioning all forms of discrimination).

at least one month and can provide a medical certificate. The duration of incapacity is a maximum of 183 days (six months) in one year and workers cannot be fired during this period. After an initial period of 90 days, the period of incapacity can be extended up to the 183-day limit with the approval of an expert social security physician. For several specific diseases (such as tuberculosis, some cardiovascular diseases, AIDS and cancer), the duration can be longer than six months.

Temporary work allowance is generally paid by the employer for the first five days of sickness leave and then out of the public social insurance budget (*Fondul Naţional Unic de Asigurări Sociale de Sănătate*; National Fund for Social Health Insurance; FNUASS) until the end of the period of incapacity. Generally the level of benefit is 75 per cent of average monthly income earned in the six months prior to the month when the illness occurred; however, it is 100 per cent when the illness occurred through an accident at work or an occupational disease or if the illness is tuberculosis, HIV/AIDS or cancer.

The timing of the considerations about the return to work is the end of the period of sickness leave. The sole early intervention is an obligation on workers with sickness leave longer than 90 days to follow a medical rehabilitation programme which is set out in the following sections. The return to work is usually done informally, it is not planned and is rarely phased (part-time work then full-time work). When resuming work, the occupational physician must give an assessment but is not really involved in the return to work process.

2.1.2 Invalidity benefit provisions

Workers who are assessed as having lost more than one-half of their work capacity due to accidents at work or occupational diseases, tumours, HIV/AIDS, schizophrenia or accidents and diseases not related to work can apply for invalidity benefit provided they have completed the required contribution period (also related to the age of the worker). There are three degrees of invalidity. The first degree means a total loss of work capacity and self-care ability; the second degree represents a total loss of work capacity while preserving self-care capacity; and the third degree represents the loss of at least half of work capacity (the worker can work corresponding to a maximum of one-half of normal working time). The assessment of work capacity is carried out by expert social insurance physicians from *Casa Naţională de Pensii Publice* (the National House of Pensions; CNPP) which is a part of MMPS. Invalidity benefit, which is paid by CNPP, can be extended up to retirement but every 1-3 years the person is reassessed by an expert social insurance physician. Several situations may halt benefit payment. The contributors to this fund are salaried workers, employers and the self-employed. Invalidity benefit can vary as it is calculated based on gross salary and the contribution period.

During the period of invalidity, beneficiaries must follow a medical rehabilitation programme recommended by the expert social insurance physician; benefit will be stopped if the beneficiary does not comply. After the invalidity benefit ends, the worker must usually find another job. Here, too, the occupational physician must give an assessment but is not really involved in the return to work process.

2.2 Policies on the return to work in Romania

The Romanian legislation thus makes several stipulations for sick leave and invalidity which are indirectly related to the return to work. In addition, there are other provisions which can also be indirectly related to this issue. These provisions are general, indicating broad principles rather than specific actions designed to facilitate the return to work. No specific measure, procedure or intervention is provided by law after the period of sickness leave ends and the return to work is not specifically planned although employers may allow a worker to resume work on a part-time schedule initially (depending on the type of job). Specific roles in the return to work process are, however, allocated to the treating physician, the employer, the occupational physician and the local public employment agency. No other actors have a role, while that of the employer is marginal. Furthermore no active labour market policies targeting workers who have been on sickness leave are in place.

2.2.1 Sickness leave

No specific procedure in respect of the return to work which involves either the employer or an occupational physician is set down for this period. However, there are several stipulations regarding the recovery of work capacity which must be followed during the period of leave. Thus, to achieve the recovery of work capacity, workers who are on sickness leave for more than 90 days can benefit from medical and spa treatment of 15-21 days for recuperation, following an individual plan provided by the treating physician and approved by the expert social security physician. Individual medical rehabilitation plans are phased and mandatory and paid by FNUASS.

2.2.2 Resuming work

Workers who return to work after sickness leave of more than three months, or who change jobs, must obtain a medical certificate (fit note) from the occupational physician. The fit note can have four outcomes: able to work; conditionally able to work; temporarily unable to work; and permanently unable to work. Based on the fit note, measures for work adaptation can be established by the employer.

If a worker lacks work capacity (validated by the expert social security physician), the employer has to offer another role compatible with the skills and/or work capacity of the worker. The worker has three days in which to inform the employer whether or not the new role is accepted. If the employer does not have vacant positions to offer, the employer must refer the worker to the local employment agency which will offer guidance on obtaining a new job according to the worker's skills and capacity. The employer can dismiss the worker only if that person does not respond in three days to the proposal of an alternative role or only after referral to the local employment agency. If dismissed in this situation, the worker may receive compensation according to the individual work contract or the collective labour contract.

2.2.3 Provisions for disabled people

Some workers who have chronic illnesses have a disability certificate issued by *Serviciul de Evaluare Complexa a Persoanelor Adulte cu Dizabilitati* (Authority for the Complex Assessment of Disabled Adults; SECPAD) which is also part of MMPS. There are several provisions for people with such a certificate if they want to (re-) integrate into work. Public authorities have the obligation to establish and maintain sheltered units and sheltered jobs and to initiate measures to incentivise employers to hire and maintain disabled people in work. Public authorities must also offer social services and counselling for disabled people and their families as well as for employers.

Employers with at least 50 employees have the obligation to hire disabled workers (a minimum of 4 per cent of the total number of employees) but alternative options are available for employers who cannot meet this requirement. Employers who hire disabled workers may benefit fiscally in many ways, including the deduction of their expenditure on workplace adaptation and in respect of vocational rehabilitation and guidance.

Disabled workers have the right to benefit from reasonable accommodation in the workplace, counselling and work mediation, the possibility to work fewer than eight hours daily (on advice from SECPAD) and exemption from payroll taxes. Employers have the obligation to adapt the workplace according to the needs of 'groups sensitive to risks' as set out in the law.

Other general provisions include the outlawing of discrimination based on chronic non-communicable diseases in the workplace and the concept of special medical supervision which refers to the assessment of the work capacity of workers with chronic illness carried out by occupational physicians.

3. Involvement of the social partners in shaping return to work policies at national level

This section presents findings from our survey of the social partners, the roundtable discussion, two separate discussion groups with employers and with trade unions and from interviews with national stakeholders.

3.1 Actors and stakeholders in return to work policies

A major characteristic of the Romanian policy-making system is its centralised nature. In the context of the return to work, the state plays the main role while the involvement of the social partners and other stakeholders is rather limited. Traditionally, and even more so since 2011, the practice of social dialogue in Romania has been weak.

At national level, tripartite social dialogue is coordinated through institutional structures. At government level, *Consiliul Național Tripartit pentru Dialog Social* (the National Tripartite Social Dialogue Council) is composed of members of trade

unions and employer associations and members of the government (Ministerul Muncii şi Protecţiei Sociale 2020). The technical secretariat role is carried out by *Comisia de Dialog Social* (Social Dialogue Commission) which functions within MMPS. Also at national level there are consultations between the government and *Consiliul Economic şi Social* (the Economic and Social Council), a civic dialogue body composed of civil society representatives.

Besides these actors, there are five trade union confederations with representation at national level and with a more significant membership density in industry (75-85 per cent) than in public administration (30 per cent) (ETUI 2020). Since 2011 collective agreements are no longer negotiated at national level, only at industry or sector level, company level or for groups of companies. Negotiations are regulated by the law on the social dialogue under which only trade unions (and employer associations) that represent at least 7 per cent of employees (10 per cent of employers) in a sector of activity can negotiate at that level. When it comes to the company level, only one trade union can be representative of employee interests. In companies with more than 20 employees and no trade union, employee representatives can be elected (ETUI 2020). All companies with more than 10 employees should elect health and safety representatives, although their responsibilities are rather general in maintaining workplace health and safety. Concerning to whom companies turn when they need information on health and safety, Romanian companies turn mostly to labour inspectorates (in 82 per cent of organisations) and much less to employer associations (27 per cent) or to trade unions (11 per cent) (Irastorza *et al.* 2016).

Since the 2011 reform of the social dialogue (Law 62/2011), social dialogue has been weak and ineffective. According to the results of our research study the provisions of Law 62/2011 are very restrictive as regards trade unions while favouring employers. The number of collective agreements negotiated at company level has dropped significantly and social dialogue has been reduced to focus only on a few points based on the minimal requirements of the labour code. Trade unions have been dealing mostly with financial issues and working conditions while health and safety issues, including the return to work, remain under-regulated.

Another institutional actor is *Agenţia Naţională pentru Ocuparea Forţei de Muncă* (Public Employment Agency; ANOFM), alongside its regional agencies, but it deals mostly with unemployed people in good health and has only a formal and marginal role regarding workers returning to work after sickness or disability.

Civil society is also characterised by having little involvement in shaping return to work policies. For example, among the 135 associations and 33 foundations active in the field of cancer, only nine associations and one foundation are engaged in explicit activity facilitating work reintegration (Popa *et al.* 2016). Some initiatives could be undertaken by researchers active in this field as a result of the projects they carry out, but communication with the upper political layer is usually limited as there are no formal bottom-up ways to propose policies, or changes in policy, and public consultations are rarely organised as well as ineffective and usually non-transparent when they are.

Discussions with stakeholders confirm that they are not directly involved in shaping policy at national level on the return to work following chronic illness. Employer participants in these discussions agree that the state (as the most important actor), employers (especially HR departments) and workers should all be involved more while some stress that specialist physicians should have greater involvement. Trade unions are only marginally involved and their involvement is usually restricted to financial issues. For their part, trade union participants also agree that the state is the most important actor, followed by trade unions, employers and the College of Physicians. Even so, all the participants see themselves as passive actors regarding their influence in shaping policies, acknowledging that they merely act within the context of the law. Here, a lack of initiative in shaping policy is explainable by a lack of mechanisms which strengthen cooperation between the political actors and stakeholders at lower levels.

Half the social partners agree that, although marked by obstacles, cooperation between them and other stakeholders (government, members of labour market institutions, medical organisations, rehabilitation centres, NGOs, psychologists, therapists and other professionals) is vital in facilitating policy creation and implementation concerning the return to work.

3.2 Views and level of involvement of industrial relations actors in return to work policies

Seven Romanian social partner organisations participated in the research (including three employer associations and three trade unions), all involved in tripartite national social dialogue. Here, we supplement the responses with data from the roundtable discussion, stakeholder discussion groups and interviews with the social partners.

3.2.1 Social partners' perceptions of EU-level return to work policies

Over half affirm that their organisations participate in EU-level social dialogue structures and that they have knowledge of EU-level policies supporting the return to work following chronic illness. Most trade union representatives agree that the agenda in this field should be part of an EU strategy and that the EU-level agenda should be more energised on this issue to the point of making binding recommendations for member states. Others also disagree with the idea that the EU-level agenda addresses policies appropriately and that no changes are needed, as well as that the return to work should feature more highly on the agenda of EU-level social dialogue. EU-level policies on the return to work should serve as the basis of a framework for national policies; while cooperation at EU level is considered both necessary and relevant.

3.2.2 Social partners' perceptions of national return to work policies

The main problem in Romania appears not to be the absence of an elaborate policy framework but the lack of proper implementation and enforcement, although almost all respondents agree that trade unions and employer associations should be more active in addressing the policy-making process in this area. Most respondents say they know

of the existence of national policies and measures in this area, even though Directive 2000/78/EC establishing a general framework for equal treatment in employment and occupation is not a well-known measure, while two-thirds know of specific measures facilitating the implementation of return to work policies.

The majority are occasionally involved and consulted in policy-making on the return to work yet respondents do strive for more active participation. Half of those involved assert that they take the initiative on the issue with the other half acknowledging that the initiative is driven by external factors (such as at national or EU level). Participants identify two important barriers to their involvement in shaping policy: governments who disregard their initiatives; and not being recognised as a relevant partner for policy-making in the area.

One-third have occasional involvement in policy implementation while the rest have limited, ad hoc or marginal involvement. The cause of this lower level of involvement in policy implementation is the lack of a national strategy or legislative framework to facilitate engagement. Half monitor how return to work policy is implemented at company level while one-third monitor it at national level.

As highlighted in part by our own previous research (Popa and Popa 2019), participants in the stakeholder discussion groups identify several positive aspects of the current legislation on sickness leave, invalidity and the return to work. These include the labour code (considered as a good policy); sickness leave being generous and fully-paid in respect of some illnesses; the impossibility of dismissing a worker during sickness leave; and the stipulations on occupational diseases (some of them being chronic illnesses). On the negative side, participants highlighted the insufficient regulation of the phased return to work and working time flexibility; the non-existent counselling services; the insufficiency of rehabilitation services and the low degree of their accessibility; that sickness leave is granted only on a month-by-month basis, thus challenging the employer's need to make long-term replacement plans; and the lack of facilities to help employers accommodate an employee's return after chronic illness since the system is sanctions-based.

In sum, the stakeholders are rather poorly involved in policy-making. They lack the proper means to participate and have somewhat withdrawn from this process in the context of the state being deemed to have the most significant responsibility. On the other hand, the social partners agree that the policy stipulations that are in place in this area are not specific enough. Here, they mention the need for a legal framework, reflecting EU-level strategy, with clear procedures for employers and other stakeholders supporting the return process. The social partners agree they should be more active but consider their power of influence to be limited.

3.2.3 Social partners' perceptions of the role of national industrial relations in returning to work

The social partners are involved mostly in activities related to collective bargaining and less so in raising workers' awareness of their rights, lobbying public institutions and providing assistance to individual workers.

All stakeholders consider that the trade union role could extend to negotiations on health funds and bonuses for workers with chronic illness. Industrial relations are judged as important in the return to work; yet the framework within which the actors could function effectively is missing. Stakeholders also agree on the importance of all the social partners, at all levels, in shaping and implementing policy through social dialogue. However, they see the main objective of their involvement in the context of improving the policy proposals of MMPS, as the main actor.

3.3 Outcomes of social dialogue regarding return to work policies

Our findings suggest that, overall, the outcomes of social dialogue on the return to work are poor. Interviews with various stakeholders pointed to the presence of little cooperation with industrial relations actors. Where such cooperation does exist, it is mostly with trade unions although, even then, it is only limited. An individual (tailored) approach at company level is considered more useful and using collective bargaining is common practice. An example was offered in which the trade union had negotiated that a worker would receive a lump sum of two years' salary before being made redundant following the loss of work capacity. More often, however, trade unions help employees financially with their treatment and offer informal support and encouragement for the return to work.

3.4 Views on the potential for action on the return to work and the contribution of the industrial relations actors

The very few examples of best practice which the social partners were able to offer concerning return to work policies were rather abstract. Several measures were proposed as a means of improving social dialogue co-operation: to elaborate better legislation; to offer fiscal advantages for employers supporting an appropriate environment for employees with chronic illnesses; to include return to work on the collective bargaining agenda; and to build a culture at company level based on the argument that organisations with good performance take care of their human resources.

Our evidence confirms that current approaches are based on informal action and the employer's willingness and good intentions, similar to the findings of other studies (Tiedtke *et al.* 2012; Stepanikova *et al.* 2016). There is, however, a need for clear strategy and procedures from national legislative level to company level. Here, our interview participants make two notable suggestions. The first is to change the law to include an option to allow a phased return to work of 2-4 hours (at present, if a worker wants to return to work for 4 hours, sick leave is suspended). The second is to introduce a reintegration incentive (a financial incentive for those who go back to work earlier). Both suggestions are similar to those that apply to maternity leave. Another important recommendation is to establish an agency, or at least a virtual platform, where workers could access all services needed for the return to work in one place – rehabilitation, counselling, legal advice and medical advice. Such a service could function as a 'safety

net' for people who fall between the different systems (i.e. medical, employment and social security).

Participants also identify that employer associations should have a more active role in the return to work and there should be training for employers and employees in raising awareness about health, disease prevention and work-related issues. Another suggestion is to give small companies special attention and support in that they might have other priorities because of the high burden of legal obligations and taxes.

Based on the level of cooperation between trade unions and employer associations, one participant advanced the view that trade union representatives are less involved and less open to cooperation and dialogue since their expectations had developed exclusively around possible benefits and ready-to-go solutions rather than in active participation. Instead, cooperation with employee representatives was better as they engaged more actively in negotiation with employers and were less conflictual and more flexible than trade union representatives.[2]

Stakeholders nevertheless stress that trade unions and employers should play an active role in improving rehabilitation and the return to work. Here, cooperation between the occupational physician and the HR specialist is considered essential if the return is to be successful. One expert social insurance physician explained that most workers on long-term sickness leave following chronic illness preferred to go for retirement even if they still had some capacity for work. In his opinion, this preference could be explained via the lack of available counselling and vocational support and a lack of support from the employer as well as through the inflexibility of the provisions for part-time work. Instead, the return to work for those with a low level of employability (workers with only half of their work capacity left, i.e. the third degree of invalidity) could be facilitated by cooperation between three actors: ANOFM; occupational physicians; and the expert social security physicians. There is, additionally, a lack of cooperation between the expert social insurance physicians and social workers even though this is essential for an accurate assessment of work capacity. Capacity is therefore evaluated based only on medical documents and patient declarations and not on a social investigation carried out by a social worker within the patient's own environment, which can negatively influence the correct assessment. Another suggestion is that there could be financial incentives for employers to hire workers with reduced work capacity following chronic illness, perhaps akin to the incentives for taking on unemployed people.

Stakeholders agree that the greater involvement of ANOFM is necessary although the Agency itself points out that each career counsellor usually works with 3 000 unemployed people and that the serious shortage of career counsellors is responsible for their low involvement in return to work issues. ANOFM has no targeted programmes for workers with chronic illness looking for job reorientation.

2. Trade union and employee representatives are distinct entities in the Romanian social dialogue law. In organisations which do not have a trade union, employees can elect a representative who has the same rights as the trade union representative.

4. The return to work process at company level and the involvement of the social partners

Following this analysis, we turn next to information describing the current situation concerning the company-level return to work process and the involvement of the social partners.

4.1 Workers' experiences with return to work at company level

The most prevalent diseases reported to us by Romanian workers are cancers (61.1 per cent) followed at some distance by cardiovascular disease, musculoskeletal disease and diabetes.[3] A majority say they had been concerned about their return to work, the biggest concern being that nobody would offer support followed by the fear of being left without any support from the employer. Otherwise, workers are concerned about pay gaps, worry that they need to return at full productivity right after treatment and that their employer would not be willing to adjust working conditions to their capacity for work.

Workers see the most important actors in offering support for their return to work as the HR department, the team leader or line manager and the head of the company while less frequent responses concern the external psychologist or occupational therapist, rehabilitation institutes and the trade union. Almost half of workers state that they were not at all, or only partly, satisfied with the help and support they received from the employer while just over half were not at all, or only partly, satisfied with the help and support offered by trade unions.

Studies have shown that keeping in contact with manager and colleagues is important for a successful return to work (McKay *et al.* 2013; Isaksson *et al.* 2016). Four out of five workers in our sample were in touch with their colleagues during treatment while 40 per cent were in touch with their direct manager and 20 per cent with the head of the company or HR department. Only a small share of respondents say they kept in touch with their trade union representative. The initiative on returning to work seems not to be work-driven since most workers say it was their personal initiative followed by that of the specialist treating their disease and then their family or the head of the company.

Workers most often see the family as playing the most crucial role in enabling their return to work followed by the specialist physician and work colleagues. At the other end of the scale, workers do not consider that NGOs, rehabilitation centres or nurses or their trade union representative play an important role in this area.

High percentages of workers receive no support in making adjustments to their work contract (63 per cent), in postponing deadlines, in making changes to daily working

3. For more details, see the Romanian country report on the REWIR project website: https://www.celsi.sk/en/projects/detail/64/

time or in sharing tasks and responsibilities with colleagues. On the other hand, they were more likely to receive reasonable and extensive support in the work environment mostly in the form of time being made flexible to allow for medical appointments.

4.2 Perspectives of HR representatives, line managers and other relevant company actors in the return to work process at company level

Regarding the consequences that a worker's absence has on the company, two-thirds of managers would choose not to replace the worker but to rearrange workflow and divide tasks between other employees. Slightly more than one in five thought that there would actually be no significant effect on the organisation.

In terms of the resources needed to support workers on sickness leave, managers value external counselling from doctors and therapists; being able to obtain information and advice on the types of chronic illness; external counselling and cooperation with dedicated professional and/or campaigning and patient support organisations; and information on adjusting the workplace and workstations in general.

Company representatives disagree that individuals returning to work after chronic illness are unable to perform their duties as before or that workers will be less committed to work. Quite a large percentage agree, however, that a worker returning to work with reduced duties would increase the workload of colleagues while more than half agreed that a worker with chronic illness is likely to be absent from work more often than other workers. Even so, strong majorities agree that a worker should be entitled to adjustments to working duties (in terms of working time and workload) either at the organisation's discretion (63 per cent) or in terms of legal entitlement (68 per cent). A slim majority agree that workers should have the right to a phased return to work on full pay; two-thirds think it important to stay in touch with the worker during absence; and a small majority believe that returning to work during treatment helps with the return to normality and is encouraged in their organisation.

The return to work process is managed mostly by HR and, in a small number of cases, by the line manager or team leader or by general management. Respondents viewed this situation as adequate but one-third favoured the idea that, besides HR and line or team managers, a dedicated health and safety committee should manage this process.

Company representatives tend to report that there is no defined adjustment plan available for each employee returning after a long illness and neither is there a common standard procedure for managing the return to work nor an ad hoc and flexible adjustment plan. Companies do, however, cooperate with other external organisations (for example, the occupational health service) when managing return to work situations. One key participant with extensive experience regarding the return to work after occupational diseases and accidents at work, gained from participating in organisational health and safety committees, stated that some employers do refuse to make necessary adjustments in order to avoid creating precedents for other employees.

When asked what would improve the return process in their organisation, most point to better interpersonal relations between managers and workers returning from long-term sickness leave, the organisation's own policies being more progressive, legislative and institutional support coming into existence and clearer paths to cooperation with external stakeholders.

A majority of company respondents indicate that there is a trade union or other form of employee representation in their organisation. However, the return to work is addressed by fewer than one in five collective agreements although around one in three managers think that this is a suitable matter to be addressed in a collective agreement. In more than two-thirds of companies, over half of employees are unionised, yet only one in five company respondents agree that there is regular interaction between managers and trade unions on return to work issues. In a clear majority of companies, however, a trade union representative is part of the committee addressing occupational health and safety, with managers agreeing that this is important.

4.3 Interactions between employers and employees in facilitating the return to work

The experience of returning workers and their interaction with their employer is no better than neutral and, in some cases, draws a rather negative picture. The shares of workers agreeing, disagreeing or being neutral to the statement that they felt welcome at their workplace are almost equal (around 30 per cent in each case). Regarding how well-prepared the employer was to accommodate the worker, more than two in five either disagree or are neutral. Most do not receive extensive mentoring or guidance from their employer and an even higher proportion (some two-thirds) do not receive mentoring or guidance from the trade union. Half do not consider their return to have been a process that had been well-coordinated between the company and their doctors. Three-quarters, however, are able to return to the same job position.

Regarding their return to work experience, when prompted by an open question, workers tend to describe negative or mildly negative experiences. Some of the more negative experiences are as follows:

> 'I had a horrible experience [at] my former job, so I had to look for another.'
> 'My employer, which is a public one, did not care about my disease, so after my return I have worked as much as the other employees. Nowadays, with Covid-19, my employer abuses and discriminates against me after I had the audacity to say that he was endangering my life and exposing me to this virus.'
> 'I did not receive [the] salary rise that all the other colleagues received. They [i.e. the employer] said to me that I [had] lost this opportunity.'
> 'I did not have the opportunity to return to the same position. They totally refused this.'

Among the more mildly negative experiences were returning to work but having to deal with extreme fatigue and exhaustion; returning to work without being physically fit

simply because the sickness leave period had expired; and returning to work without receiving any form of support.

Turning to the perspective of managers, a considerable share do have contact with workers absent on sickness leave (regular or irregular) and only a small percentage has no such contact. During absences, most managers say they keep workers informed of work-related issues or involve them in these (such as asking for opinion, advice, involvement in planning and in decision-making, etc.)

Romanian companies do not usually have common standard procedures for the return to work but do plan to introduce them. The most common practice is cooperation with external organisations such as public employment agencies and occupational physicians. A lack of company-level procedures for the return to work is compensated by other ways of facilitating the workplace reintegration of workers following chronic illness. Thus, a majority of managers discuss the return with the worker in a meeting which is usually informal. Company-level actors also report that they offer adjustments, mostly as regards work tasks and workload, although less than one-half offer adjustments in working time. Half do offer adaptations of the workplace but only around one in three offer training to workers as well as to colleagues to prepare for the worker's return. These results support the findings from another study carried out on Romanian employers (Popa *et al.* 2020).

Managers acknowledge that the most difficult workers to accommodate back into work are those with mental health illnesses (including alcohol and drug addictions and depression), some citing stories of return to work failures for workers with mental health disorders who were prone to violent behaviour. They tend to agree, however, that managers in general have to make a shift from being too focused on what returning workers cannot do in the company to focusing on what they can do.

In terms of good practice, managers point to maintaining contact with employees during sickness leave, being aware of employees' real needs, encouraging the return to work by letting workers know they are valued and adjusting working conditions. Other good practices are represented by the prevention of dismissal during workers' sickness leave, the obligation to keep jobs open until they come back, a generous period of fully-paid sick leave in respect of some illnesses and good legislation on occupational diseases.

At the same time, an important deficiency in the legislation, which was the subject of intense discussion by our employer representatives, is the situation in which an employer cannot provide a new or adjusted job position for a worker who has received a 'conditionally able to work' assessment from an occupational physician. In such a case, the employer is legally required to refer the worker to the local employment agency before dismissing them. The problem here is that there are workers who have lost their jobs and are no longer patients but are too young to retire. Scarce and over-long vocational rehabilitation programmes subsequently block them from the timely acquisition of new skills for a new job. Many of the employers we spoke to had such workers and it was a matter of regret to them that they could not find viable solutions.

4.4 Views on the potential for social dialogue to support the creation and implementation of return to work policies at company level

Over three-quarters of workers say they had not given thought to joining a trade union after a recent diagnosis in order to support or facilitate their return to work after treatment, although in half of the cases there was no trade union or any other form of employee representation in the workplace. Furthermore, the overwhelming majority of workers say that no negotiations took place between their employer and trade union or employee representatives about adjusting their work tasks and responsibilities.

Looking at the role of trade unions in this process, most workers agree that trade unions should address health-related issues and that the return to work should be on the trade union agenda. Overall, the views about social partners are mixed in that most workers think this issue should be addressed through binding agreements with the employer, yet slightly more than one-half consider that trade unions are not powerful enough to facilitate the return to work. Moreover, most are not aware of other cases in which a trade union proved to be helpful in facilitating a return to work.

At company level and regarding what possible beneficial outcomes could result from cooperation with trade unions, company representatives highlight the following elements: the inclusion of specific provisions in binding collective agreements; training sessions for managers and team leaders directly exposed to interaction with workers with chronic illnesses; input from employee representatives on internal policies; informal agreement on the role of employee representatives in supporting the management of the return to work process; trade union involvement on the health and safety committee; training sessions for unions and employee representatives on issues connected with the return to work; and being able to have individual consultations between workers and trade unions.

The most prevalent opinion at stakeholder level is that general legislation on the return to work is available, and capable of serving as a framework, but that it lacks specific recommendations for organisations actually facilitating returns. This opinion, coupled with the perception that the legislation is too general, indicates an important need of Romanian organisations – to have more specific policy recommendations with which to approach workers with chronic illnesses. Managers thus argue that the current legislation needs to be revised. Some participants gave examples of initiatives in connection with other areas than the return to work (for example, those related to maternity leave) through which they had tried to fill the gaps in the legislation. They suggested that such initiatives could be disseminated as examples of good practice and, later, generalised through state programmes.

Consistent with this, a large share of respondents in the company survey would welcome more specific provisions in law to guide the approach to the return to work at company level. For example, around one-quarter wish for more flexible legislation that would leave greater space for company-level decisions. However, none of the responding managers here would opt for legislation which stipulated binding regulations for the return to work and only a small group considered any change in the current legislation to be necessary.

5. Discussion of research findings and conclusions

The main results from analysing the data converge towards the idea that returning to work is an issue insufficiently regulated by law and which does not generate sufficient involvement by stakeholders. Romania has a general policy framework on sickness leave, invalidity and disability, mostly concerning benefits and conditionality of access, but, turning to the social dialogue, it is evident that the state has the most substantial role with employers and trade unions occupying only rather minor ones.

The relevant policy framework for sickness leave, invalidity and disability provides only general guidelines mostly in relation to benefits, eligibility and period of entitlement. The policy does not contain specific measures or interventions for making the return to work easier when the sickness leave or invalidity period is over, although some provisions do concern and facilitate this to some extent (e.g. the provisions on rehabilitation targeting the recovery of work capacity). The social security system is based on social insurance and health insurance and is coordinated by two ministries and several lower-level agencies and services. Several pieces of law regulate these issues and the process of applying for benefits is characterised by a considerable amount of bureaucracy. One positive aspect of the legislation, however, is a generous period of fully-paid sickness leave.

Overall, the return process after sickness leave or invalidity is not planned, rarely phased and entails formal obligations for the specialist physician, the occupational physician and the local public employment agency, but only a marginal role for the employer. No active labour market policies specifically targeting the return to work after chronic illness are in place; and the existing law provides only general stipulations for resuming work.

Institutional actors at state level play the most important role in the return to work process. Based on our research data, the social partners are not currently involved in this to their full potential and see themselves as rather passive players, especially in terms of shaping policy, tending also to be content with the situation that the state should be the main actor.

Romania does not have a dedicated return to work policy in the case of chronic illness, but more than half the social partners in our sample evaluated the policy framework as being sufficiently well elaborated but lacking in proper implementation and enforcement. They agree that the EU-level strategy should be reflected in this framework and that there is a lot of work ahead on policy implementation. Even so, trade unions and employer associations feel that they do not have sufficient power or instruments to shape policy. Our findings also highlight that the preferred way of approaching the return to work entails a more focused legislation which should also be flexible and give space for companies to implement tailored measures and initiatives for the workers affected.

All agree that trade unions and employee representatives should make an important contribution to the return to work. At present, however, there is little involvement of

trade unions, alongside reduced cooperation with other industrial relations actors, while the level of involvement that they do have tends to be limited to negotiating financially worthwhile outcomes for workers in difficult situations. Participants agree that employee representatives and trade unions could become more active opinion makers that could raise awareness of the issues related to the return to work process.

Workers have rather negative experiences of returning to work and they express dissatisfaction with the level of support they receive from both employer and trade unions. This support can be described as inconsistent, as other studies also highlight (Mak *et al.* 2014; Robinson *et al.* 2015). Most keep in contact with their colleagues at work but less do so with their direct or general manager. Workers' families and their physicians are the two key actors offering support and influencing the success of their return. In terms of adjustments, they report receiving reasonable and extensive support mostly in terms of the flexibilisation of working time as well as some adjustments regarding the working environment and in their tasks and duties. However, their open feedback regarding their experience is largely negative, disclosing a continuum of adverse situations from indifference and lack of support to discrimination and abuse.

In conclusion, other than for the government and its subordinate institutions (ANOFM, the regional work inspectorates and the regional CNPP offices), the other actors (trade unions, employers and NGOs) believe that they have a passive role in the return to work and that not much can be done to change this situation. Their ideas for improvement relate more to the state and the legislation and less to their own potential involvement. The best way to improve occupational reintegration following chronic illness would indeed be to have specific legislation with defined roles, steps and outcomes. However, even in the absence of such legislation there are ways to move things forward.

First, the role of trade unions and employer associations is essential as they can be the 'voice' of workers with chronic illnesses and of their employers. Thus, one opportunity for change regards the constant efforts of trade unions and employer associations to raise awareness of return to work issues, even when a change in policy is not immediately forthcoming.

Second, a possible improvement for these workers could be accomplished by including return to work issues in collective agreements negotiated at company level. Yet, as trade union participants told us, only about a third of Romanian companies now have collective agreements and, among these, only approximately 5 per cent are negotiated in the company, the rest having a simulacrum of a collective agreement which is usually very brief. This situation is a consequence of the social dialogue reform in 2011 which dramatically decreased collective bargaining in Romania.

Third, the interactions between employers and trade unions and employee representatives could be intensified; currently there is little consultation with them on issues related to the return to work. Workers with chronic health conditions mostly trust their employers to offer support for their return to work but they do expect greater involvement from the trade unions.

Fourth, opportunities for policy change in this area might also develop from initiatives of researchers in the field who can indicate, based on their studies, the most effective ways of bringing about improvement. In Romania, studies in this area have started to accumulate only recently. It is essential for these studies to continue in order to gain knowledge about the return to work in specific policy and social contexts and to ensure that policy-making is informed by an evidence base.

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Chapter 7
Return to work practice in Slovakia: matching best practice with the scope of social partner activity

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1. Introduction

The labour market integration of disabled people has received increasing policy attention not only at EU level but also in particular EU member states, including Slovakia. In the context of labour shortages prior to the Covid-19 crisis, measures pertaining to a longer working life and quick (re)integration into work have become increasingly important. There are, of course, several contextual issues surrounding these policy debates.

Slovakia's 'Country Health Profile 2019' (OECD 2019) summarises that life expectancy in Slovakia has increased but that, at 77.3 years, it still remains among the lowest in the EU, where average life expectancy stood at 80.9 years in 2019. We should remember that, although life expectancy has increased, about 40 per cent of people aged 65 still report having at least one chronic disease. In general, access to healthcare in Slovakia has attained a decent level at which only 2.4 per cent of the population reported unmet medical needs in 2017 – the remaining percentage is likely to be related to ethnic divides and regional inequalities and not directly to chronic illness. Meanwhile the OECD's data on public spending due to incapacity show that Slovakia spent 1.86 per cent of its GDP in 2015 on disability cash benefits (payments made in respect of complete or partial inability to participate gainfully in the labour market due to disability). This is close to the OECD average, but significantly less than those countries which are spending more than 3 per cent of their GDP on this type of benefit (e.g. the Netherlands, Finland, Sweden and Norway).

After Slovakia's political and constitutional crisis in 1998, the employment rate rose from a nadir of 56.3 per cent in 2000 and saw continual growth in the years after 2014 to reach the EU average of 68.4 per cent in 2019.[1] At the same time, the employment rate of people with health conditions stood at just 16.6 per cent in 2015 (Ondrušová *et al.* 2017). Among the reported reasons for absence from work since 2006, the percentages of people citing chronic illness and disability as the main cause have oscillated between 7 per cent and 45 per cent.[2] Most of the policy attention has targeted people with formally-attained disability status, but there is a pool of people of working age who have faced chronic illness and long-term absence from work who do not have this status. In the context of pre Covid-19 labour shortages in the Slovak

1. Eurostat: Employment and activity by sex and age - annual data; online data code: LFSI_EMP_A; https://ec.europa.eu/eurostat/databrowser/view/LFSI_EMP_A__custom_697052/default/table?lang=en
2. Eurostat, Absence from work by main reason, sex and age group - quarterly data[lfsi_abs_q]; https://data.europa.eu/data/datasets/hvwzmlvgj18dxi5l5baaw?locale=en

labour market, the return to work of this group of people has become more important than ever before.

Research into the labour market integration of disabled people in Slovakia is, overall, rather scarce but the return to work after, or with, chronic illness of people who do not have formal disability status has been even less studied. The return to work is a complex process requiring the interaction of various stakeholders at various levels of policy-making and implementation, including workers and employers but also rehabilitation centres, health professionals, workers' representatives, the higher-level social partners as well as policy-makers. Policy areas which have an effect on the return to work encompass sickness, disability and employment. Despite the relevance in a labour market perspective of the return to work of people experiencing chronic illness, little is therefore known about how this process has evolved in Slovakia and how the distinct actors can play a facilitating role therein.

With this aim in mind, the chapter aims to identify (a) the role that is played by the industrial relations actors in shaping return to work policies and facilitating the returns process at workplace level; and (b) the opportunities and challenges which exist for strengthening social dialogue and industrial relations in Slovakia through greater involvement of the social partners in return to work policy and implementation. The analysis of these questions is set in the context both of Slovakia's healthcare system and its structures of industrial relations.

From an industrial relations perspective, Slovakia is an interesting case because it has a stable structure of bargaining partners and a detailed legislative system supporting their roles in collective bargaining, yet there is little vertical coordination between bargaining at the sectoral and the company levels (Kahancová *et al.* 2019). In the past 30 years of its post-socialist history, Slovakia's industrial relations has evolved into an embedded neoliberal system (Bohle and Greskovits 2012), with a key feature being a trade-off between trade union access to policy-making in the early 1990s and social peace (Bohle and Greskovits 2012). In turn, trade unions have formally gained access to tripartism although their membership has gradually declined. In response, unions are increasingly seeking new opportunities to strengthen their voice both at national and at workplace levels. It is thus interesting to explore the extent to which the return to work, a topic with outreach to both these levels and which closely concerns working conditions, yields opportunities for union involvement and bargaining.

Several original sources of data have been used for the analysis, including roundtable discussions and face-to-face interviews with relevant national stakeholders from government agencies, campaigning and patient support organisations, trade unions and employer associations. Moreover, online surveys have also been launched to collect responses from workers and managers; however, response rates were significantly influenced by the Covid-19 pandemic and the related economic and employment protection measures.

The remainder of this chapter is structured as follows. Section 2 introduces the policy framework for return to work policies in Slovakia while section 3 analyses the

involvement of the social partners in shaping these policies and their implementation at national level. Section 4 focuses on the company level and analyses the views of managers and workers while Section 5 summarises the main findings, responds to the research questions and formulates several policy recommendations related to the policy agenda.

2. Policy frameworks on the return to work in Slovakia

Slovakia is among those countries with a limited framework for the return to work in which rehabilitation support essentially exists only for people with formal disability status and where government bodies are the main actors in terms of policy formulation.

There are two basic categories in the Slovak system as regards the workplace integration of people experiencing health-related disadvantages: recipients of invalidity benefit; and severely disabled people. A person receiving invalidity benefit must not be recognised as severely disabled and vice versa.

Invalidity benefit is backed by disability insurance and its acquisition is overseen by *Sociálna poisťovňa* (Social Insurance Agency; SP) based on a medical assessment. The purpose of the benefit, which is called an invalidity pension in Slovakia, is to provide the insured person with an income in the case of a decline in the ability to perform work activity because of the insured person's long-term unfavourable health condition. The following categories of worker are eligible for invalidity pension:

(i) disabled people;
(ii) those who have acquired the requisite number of years of pension insurance (which is determined by age); and
(iii) those who, on the day of their invalidity, did not meet the conditions for entitlement to a retirement pension or who have not been granted an early retirement pension.

The origin and duration of the disability are assessed in line with the benefit procedure by a social insurance physician. The calculation of the amount of the disability pension is complex and depends on the period of pension insurance which the insured person had acquired on the day of becoming entitled to invalidity pension. Subsequently, the 'accrued period' is the period from the origin of the right to an invalidity pension to the day of reaching retirement age.

While the receipt of invalidity benefit encapsulates the view that the person receiving it has reduced work capacity, severe disability is seen as the reduced ability to lead an active life which does not necessarily imply a reduced capacity for work. Thus, unlike a person in receipt of invalidity benefit, someone who is severely disabled does not receive wage compensation from SP but a benefit to compensate for the social impact of the health disadvantage.

In the absence of specific return to work policies in Slovakia, people with chronic illnesses are supported only by the sickness benefit system. Sickness benefit must be

provided to an insured person who has been recognised as temporarily incapacitated from work as a result of sickness or an accident or who is obliged to respect a quarantine measure (hereinafter 'temporary work incapacity'). The following categories are eligible for sickness benefit:

(i) employees;
(ii) self-employed people with compulsory sickness insurance;
(iii) people with voluntary sickness insurance; and
(iv) people who have become temporarily incapacitated after the termination of sickness insurance within the protected period.

Sickness benefit is paid by the employer for the first ten days and then by the public budget (via social insurance) until the end of temporary work incapacity. From the first to the third day, the benefit is 25 per cent of the daily assessment basis; from the fourth to the tenth day it is 55 per cent of it (this may differ as a result of collective bargaining and it can go up to 80 per cent). After ten days the level is calculated as 55 per cent of the daily assessment basis. The maximum duration of temporary work incapacity is set at 52 weeks. The expiry of this period does not lead to the termination of temporary work incapacity status where this can be justified by the individual's state of health continuing to be unfavourable. It does mean, however, that the insured individual is no longer entitled to sickness benefit.

We have said already that there are no coherent and detailed return to work policies in Slovakia and neither, consequently, is there much of a focus on people returning to work after long-term sickness or who are seeking reintegration into the labour market. It is not only this, however. It is also the case that Slovakia does not have any definition of these categories of people and we do not even know their number. Furthermore there are no studies that concentrate on this group. However, it is worth mentioning one measure in particular as well as some more general legal provisions of the Labour Code which may be supportive of a return to work process.

This measure is vocational rehabilitation (Act on Social Insurance § 95). This is a benefit that can be provided by accident insurance and is intended to support the worker's efforts in returning to work and with social reintegration. There is no legal right to rehabilitation, but it may be provided after an assessment of the medical fitness of an injured worker who, because of an accident at work or an occupational disease, has experienced a decline in work capacity. This is carried out by a medical assessor from social insurance and is made in particular view of the possibility of getting the injured worker back to work. The maximum duration of vocational rehabilitation is six months. In justified cases – in which it can be assumed that the injured worker will acquire the ability to work at his or her previous level of activity – benefit can be extended by another six months. The problem is, however, that this tool is little used and that some people appear to be ashamed to seek it; while counselling on the issue is also insufficient.

There are three legal stipulations in the Labour Code that are relevant in a return to work context. The first is the job guarantee provided under Labour Code § 157 – when a

worker returns after temporary work incapacity, the employer is obliged to assign him or her back to the original work they were undertaking and to their original workplace. Where such reassignment is not possible, the employer is obliged to assign the worker to different work which corresponds to the contract of employment.

The second stipulation, under Labour Code § 64, is a prohibition on notice which guarantees that the worker cannot be fired during the period of temporary work incapacity (sickness leave). There is also a general provision in § 2 of the Anti-discrimination Act which states that '[a]dherence to the principle of equal treatment shall lay in the prohibition of discrimination on the grounds of sex, religion or belief, race, nationality or ethnic origin, disability…' and that (in § 7):

> 'In order to apply the principle of equal treatment employers shall take appropriate measures to enable a person with a disability to have access to employment, to work of a certain type, to promotion or access to vocational training; except if the adoption of such measures would impose a disproportionate burden on the employer.'

The third stipulation refers to job assignment (§ 55). This obliges the employer to reassign the worker to another job if, because of a medical condition, he or she has lost the long-term ability to continue carrying out the previous work, if he or she is not allowed to do so due to an occupational disease or if he or she has reached the maximum permissible exposure at the workplace determined by a decision of the competent public health authority. The medical report must show that the worker has lost the ability to continue to perform the work done to date; such an opinion could be issued by a physician, specialist doctor or a medical facility. Where such a medical report has been issued, the worker must submit this to the employer and request a transfer to another job.

We should also note that some collective agreements do exist that partially stipulate provisions on the return to work. Some establish an employer's obligation to the worker in the form of financial compensation if he or she develops an occupational disease or work-related injury or receives a one-off financial sum during long-term incapacity for work due to health problems. Workers with an occupational disease are sometimes, based on a provision in the collective agreement, protected against the termination of employment in the event of organisational change.[3] Furthermore some large companies, such as Volkswagen Slovakia, have developed internal policies that seek to take preventive action so that people do not end up being absent due to sickness.

The increased labour market protections available for people with health conditions is presented as a blanket statement in several strategic documents that set out the reasons and tools to support the work integration of vulnerable people. Several laws, allowances and measures help such people integrate into the labour market and, in respect of this, there exists a number of stipulations including increased labour law

3. In this context, it is notable that the employer has a general legal obligation to ensure health and safety at work and that this has a preventive aspect concerning the emergence of various occupational diseases and injuries.

protection, active labour market policies, mandatory quotas for the employment of people with disabilities and vocational guidance services. There are, in addition, sheltered workshops and, since 2018, social enterprises for work integration as well as several NGOs dealing with this issue. However, where someone returns to work following a chronic illness that did not lead to the acquisition of formal disability status, sickness leave is the basic tool and there are almost no other options (measures, procedures or interventions) available in the Slovak legislation to help these people get back to work.

Therefore we conclude that, generally, the legislative framework on the return to work is limited in Slovakia. Currently the actual returns process is largely discretionary, resulting from the interaction between the relevant actors and company-level policies, and lacking a strict anchoring in dedicated legislation.

3. Involvement of the social partners in shaping return to work policy at national level

As summarised earlier, the existence of return to work policies, measures and policy implementation is tied up with people having formal disability status or decreased work capacity. This connection is firmly embedded in the perceptions of the social partners and other stakeholders, e.g. campaigning and patient support organisations supporting disabled people. Policies on the return to work therefore rarely relate to people with or after chronic illness in the absence of formal disability status or eligibility for invalidity benefit.

This perception of the return to work concept needs to be kept strongly in mind and provides the backdrop to our analysis which exploits three sources of data: a survey of the social partners[4] and interviews and roundtable discussions with stakeholders.

3.1 Key actors in return to work policy

Government bodies are the main actors in terms of the formulation of policies on the return to work. *Ministerstvo práce, sociálnych vecí* a *rodiny* (the Ministry of Labour, Social Affairs and Family) designs the legislative framework and determines the conditions applying to work assistance for disabled people and other supportive measures. The creation of return to work policies and the monitoring of their implementation is the job of a specialist department in the ministry. An important role is also attributed to Ústredie *práce, sociálnych vecí* a *rodiny* (Central Office of Labour, Social Affairs and Family; *ÚPS*VaR), the central labour market authority in Slovakia. This is an umbrella labour market organisation with a broad regional structure of 46 local labour offices which manage a database of jobseekers, including jobseekers with reduced work capacity.

4. The sample used for the analysis is rather small; therefore the findings need to be taken as indicative rather than representative of the opinions of the social partners in Slovakia. More details can be found here: https://www.celsi.sk/en/projects/detail/64/

Return to work is not a key issue that ranks high on the trade union agenda. This is more the result of a lack of resource and a shortage of expertise than any absence of a willingness to be more active. On the employer side, associations act based on the demands of their members which are not interested in greater activity on the issue of the return to work.

Other relevant actors are the health insurance agencies which possess the most detailed evidence of people experiencing chronic illness and disability. *Agentúry podporovaného zamestnávania* (the Supported Employment Agencies) and occupational health physicians are additional actors with the potential to influence return to work policies. Campaigning and patient support organisations perceive their contribution as indirect in the sense that they provide personal support services (targeting courage and self-confidence) so that such workers can be better integrated into the work process.

3.2 Views and level of involvement of industrial relations actors

The social partners perceive EU-level return to work policies as relevant and call for greater action, citing that EU-level social dialogue should adopt binding recommendations for the member states in this area. Despite this, more than half are not aware of any EU-level policies that support the return to work for workers after treatment for chronic illness.

In contrast to the low awareness of EU-level policies, the social partners are conscious of national policies and measures in this area. They believe that Slovakia has, in general, an elaborate policy framework and that it properly implements and enforces return to work practices. As established earlier, however, these are predominantly associated with disability and are not ones comprehending the return of workers after treatment for chronic illness. Indeed, our interviewees among the social partners confirm that a standardised policy on the return to work following chronic illness is absent at national level.

Consequently the involvement of the social partners in shaping return to work policies after chronic illness is limited. Research shows that they are currently working on, or actively involved in, neither policy creation nor its implementation.

This low commitment to being more involved in policy direction is supported by a relatively high level of satisfaction with the current extent of their involvement. Employer associations are more satisfied with this than are trade unions which acknowledge that they should be more active in this area. However, the involvement of the social partners here is mostly conditioned by external factors, i.e. the national government's priorities or agenda in national social dialogue. Moreover, the reasons for non-involvement relate to the internal organisational structures of the social partner organisations: the social partners do not consider involvement in return to work policy-making as a key priority on their agendas and, therefore, are not actively taking initiatives to increase their participation in policy development.

Considering policy implementation, most social partners have an awareness of specific measures that facilitate the application of return to work policies and are actively involved at this stage, more at company level and using an informal, case-by-case approach. This is conditioned by the presence of a committed representative of trade unions or employer associations within the company who is actively engaged in policy implementation on the issue.

Trade unions are mostly involved in collective bargaining and providing individual assistance to workers (e.g. by assisting them with the bureaucratic procedures of applying for benefits or helping them voice their problems to the employer). The type of collective bargaining related to the return to work that trade unions have been involved in has occurred solely at national level.

The employer association is in a position to submit various proposals concerning return to work policies, and to get these on the agenda, since it is a member of the national tripartite council. However, it is basically against any regulation, including on the return to work, and does not see any demand coming from its members. On the other hand, it does welcome any measure which supports the flexibilisation of work which might also be relevant to people returning to work after a long illness or with a disability. It sees employers' views on return to work policies not only as an economic matter but also as a matter of social responsibility:

> 'We as employers want to act like those who are not only interested in profit but want to be perceived by the public as those who are also interested in people who are not at their best in terms of the ability to work.'

3.3 The nature of interactions between industrial relations actors and other stakeholders in return to work policy

Most social partners evaluate the degree of cooperation between stakeholders (trade unions, employer associations, government, labour market institutions, medical organisations, rehabilitation centres and NGOs) as potentially important in facilitating a sustainable and feasible return to work policy framework, but they do see obstacles in it. However, the majority repeatedly confirm that there is a lack of cooperation in terms of return to work policy-making and implementation. The social partners generally agree that more intensive interaction between stakeholders is essential and also that trade unions and employer associations should both be more active in return to work policy implementation at national level. At the moment, cooperation works only partially and between some actors, but an overall umbrella mechanism at national level is also missing. For example, attempts to initiate systemic cooperation to promote the enforcement of the UN Convention on the Rights of Persons with Disabilities, which would bring together all relevant actors, failed due to insufficient political support.

Some campaigning and patient support organisations express strong dissatisfaction with the amount of cooperation with employment offices as well as with their unwillingness to assist the return to work in individual cases. Meanwhile government

bodies claim that they do cooperate with trade unions at sectoral or company level where a trade union organisation has been established.

The most relevant platform for cooperation is the Committee for Disabled People which joins representatives of government and public regional administrations with campaigning and patient support organisations. This Committee is the place to discuss urgent problems and to initiate or prevent a change in the legislation that might damage the interests of disabled people. The Committee also consults on particular cases of alleged discrimination against disabled people and drafts recommendations for improvement although it only rarely proposes policy documents, focusing more on various initiatives. Trade unions and employer associations are either not present on the Committee or are present but not active.

Other platforms for cooperation are the employment committees which operate in the state employment offices which are spread widely throughout the regions. Trade unions and employer representatives are involved in these committees and they do discuss the employment of someone with reduced work capacity or with formal disability status. The committees seek to place such a person either in a particular company or in sheltered workshops or workplaces.[5]

This lack of cooperation between all the relevant actors results in the absence of any acknowledgement of the problems as well as a lack of development of the skills associated with how to treat a person returning to work following chronic illness. The need here for a change of approach by the social partners was expressed to us by one representative of a patient support organisation:

> 'I would be interested in the trade unions' response to the extent to which they have mapped the problems of people who find themselves in a chronic disease situation and what they do for them. The people themselves who are to return to work solve many issues, but they will certainly not come to the trade union with a solution. So, instead, proactive detection is needed.'

3.4 Outcomes of social dialogue with regard to return to work policy

Stakeholders consider that incorporating return to work measures into collective agreements might be difficult. Nevertheless social dialogue resulting in specific agreements could be a useful tool for making return to work policy more visible and in terms of raising awareness. There are doubts that it would solve particular cases, but it could be used as a 'reminder' to boost sensitivity towards the people concerned.

5. A sheltered workshop is a workplace where there is more than one job established for a disabled person and where at least 50 per cent of workers are disabled. A sheltered workplace is a workplace where a job for a person with a disability has been established but which is not a sheltered workshop. A workplace where a disabled citizen carries out a self-employed activity is also considered a sheltered workplace. A sheltered workplace can also be set up in the household of a disabled person.

State administration representatives consider that policy guidelines on the return to work are necessary and report that the social partners are, for the most part, involved in commenting on the legislation which has already been drafted. ÚPSVaR could not, however, comment on the state of social dialogue in the return to work area: it is a subordinate agency and acts strictly in terms of the implementation of current legislative measures. It does not possess competencies in social dialogue and cooperates with employers only as far as supporting them in the employment of disabled people.

Trade union representatives challenge the feasibility of a general procedure for social dialogue at national level and warn against unnecessary bureaucracy and impracticalities. Even if a return to work process was anchored in a collective agreement at national level, it would be challenging to implement and oversee. Here, they regard an individual approach at company level to be more useful. Employee representatives at company level similarly prefer an individual, informal approach in specific cases without any anchoring in social dialogue practice at national level. This is in line with findings that the return to work agenda is currently outside the scope of trade union activities which are focused on sectoral and company-level collective bargaining, monitoring processes and in providing assistance to individual workers.

3.5 Views on the future potential for action on return to work and the contribution of industrial relations actors

For some trade union representatives, collective agreements at sectoral or company level are seen as potential and practical tools for extending obligations to employers. NGOs and charities, despite not having experience with collective bargaining, also see an opportunity for social dialogue to include supportive measures for disabled people (or who have chronic illness) at company level. At the same time, there is room to seek improvement in the involvement of labour inspectorates in return to work cases following an accident at work; stakeholders identify that the inspectorates should not just act as an enforcement body but should also provide preventive advice and counselling for disabled people.

Stakeholders also highlight a need for greater flexibility in employment services and better information on vocational training for disabled people and those experiencing chronic illness before entering the labour market. Trade unions need similarly to be better informed about the particular contribution they can make as well as more available for people seeking to return to work.

There is also room for improvements in the legislation. The law on sickness insurance allows only 52 weeks of paid sickness leave and, after one year of this, people have to be granted disability status. Furthermore it is acknowledged that there is space for campaigning and patient support organisations to campaign for people in general to accept illness and to avoid shaming and stigmatising disabled people or those with illnesses.

To sum up, the involvement of the social partners in shaping and implementing return to work policies is limited. One contributory factor here is that the policy framework does not comprehend people returning to work following chronic illness. The absence of a proper policy framework does, however, provide space for an informal and individualised approach by the social partners in terms of their capabilities of providing support in this area. All the actors expect improvements in cooperation and are open to their more systematic involvement in this area, in particular as part of workforce diversity management in the case of employers and as part of collective bargaining in the case of trade unions.

4. The return to work process at company level and the involvement of the social partners

This section focuses on experiences with return to work at company level, i.e. the experiences of workers and managers based on the data and information gathered from our primary research activity.

4.1 Workers' experiences with the return to work process at company level

Regarding individual experiences of returning to work, it is important to note that the number of responses to the survey was quite low and to consider the following statements with a degree of caution.

The most prevalent type of disease in our sample of workers was cancer, followed by cardiovascular disease and musculoskeletal diseases while the rest identified other types of illness or a combination of several. The prevalence of particular illnesses in our sample corresponds to data from the general population according to which the most frequent causes of the hospitalisation of patients in 2018 were circulatory system diseases, digestive system diseases and cancer (NCZI 2018).

Most respondents state that they were not concerned about their return to work. Those who were concerned expressed that were most commonly afraid of the need to jump in at full productivity right after treatment without an adjustment period. Other concerns related to the fear of a lack of support at the workplace and financial discrimination, as well as having no support from the employer and the pressure to work long hours right after recent treatment.

Almost all workers with a prevailing diagnosis intend to return to their current job after treatment and nearly half plan to continue working during treatment, if possible. Most also have an arrangement with their current employer to return to the same work position after treatment and, among those respondents who had already been through the return to work process, more than two-thirds did indeed return to the same position.

A direct team leader or line manager is considered to be the most important person in terms of supporting an individual worker's return, followed by the HR department. Some respondents also mention campaigning and patient support organisations as important in helping to facilitate the return to work. The direct team leader or line manager was likewise listed as the go-to contact in easing the return process in terms of making adjustments to working time, exposure to stress, physical well-being at work and similar aspects, although a smaller number of workers would turn to the company's HR department for help.

During treatment, the people at the workplace with whom respondents are most often in touch are their colleagues and, to a lesser extent, their direct manager. A small share identify that they were not in contact with anyone from their workplace during their sickness leave. Most of the time, respondents return to work on their own initiative, but some had also returned after medical approval, either based on advice from their general practitioner or a specialist treating their illness. Medical staff (specialists as well as the general practitioner) were also among the first to discuss an individual's return to work.

Nearly half of the workers who responded to the question say that had not felt particularly welcome after they had returned to work. Moreover, more than half do not feel that the company was well prepared in terms of making the necessary accommodations as a result of their health condition. In addition, nearly two-thirds say they had not received extensive mentoring and guidance from either their company or employer or the trade union/employee representatives upon their return while the return to work does not seem to have been a process that was particularly well-coordinated between the company and their doctors.

Of all the categories of potential work adjustments, the majority receive no, or only very limited, support in respect of the health conditions they experience due to chronic illness. Where reasonable or extensive support was received, this was mostly in connection with being flexible about time, the sharing of tasks with colleagues and the postponement of some deadlines.

Workers' families and the specialists treating illness play a crucial role in the returns process while the role of the employer in this respect is not considered very important and support from work colleagues or friends is also seen as limited. The vast majority identify that NGOs, organisations for rehabilitation and trade union/employee representatives do not play an important role in their process of returning to work.

Several respondents shared their individual experiences and suggestions for changes to the system. One respondent with cancer suggested increasing the limits on paid visits to the doctor ('sick days'), due to their increased frequency relating to the nature of their illness. Another pointed out that each experience with the return to work is different, influenced by company, supervisor and many other factors. Indeed, several identify the significance of a sector-specific approach: in their experience, sectors such as IT, which regularly has a shortage of workers, appears to have the ability to involve workers with health conditions (after or during sickness leave) more easily than others

due to the nature of IT work. While computer-based work allows for greater flexibility, workers can, for instance, perform smaller tasks or work from home.

Nevertheless, some experiences of workers were rather negative:

> 'After returning to work, one seems to be sitting on an express train. Everyone expects that I will manage the whole amount of work. Nobody talks about surviving the diagnosis and the limitations resulting from it. My work pace is monitored and occasionally corrected by my husband or I try to refuse the work that exceeds normal working hours. I have problems with being on time. I refuse to work unpaid overtime and take my work home for the night.'

> 'After returning to work, I was under pressure from my superiors and colleagues to quit my job and be replaced with a healthy worker.'

It is clear that unions have only limited opportunities to support workers. Of those respondents who discussed their sickness leave with trade union representatives, only one in five confirm a supportive response in terms of the help and support offered to them while an equal proportion report no help or support being offered during sickness leave. Our sample was split into equal groups of unionised and non-unionised workers, but the majority have trade union or employee representatives present in their workplace. Of those respondents who were not union members, most had not thought about joining the trade union in order to support or facilitate the process of their return to work. This confirms that workers do not consider trade unions and employee representatives to be important actors in the return to work.

4.2 Perspectives of HR, line managers and other relevant company actors on the return to work process at company level

Investigating how employee absence due to a long-term medical condition affects the organisation, the vast majority of managers state that the employee is not replaced in the first instance but that the workflow is rearranged and job tasks divided between other employees. Notably, a small share of managers pinpoint that there is no significant effect on the organisation.

Managers consider that legal advice regarding sickness absence plays a supportive role in helping them deal with workers absent on sickness leave. The same is true of external counselling, e.g. from doctors and therapists as well as cooperation with dedicated professional associations and/or campaigning and patient support organisations, such as the League against Cancer. On the other hand, managers also reveal that all the resources that might be potentially supportive in dealing with workers on sickness absence are all equally missing: legal advice regarding sick leave; information on financial strategies in dealing with sickness related absence and external counselling.

Managers mostly agree that a worker should be entitled to an adjustment of their working duties at the organisation's discretion and that it is crucial to stay in touch with the

worker during the period of absence. At the same time, managers mainly disagree that a worker is less committed to work after being diagnosed with a chronic illness. They would not, however, recommend more time-off than the current legislation stipulates.

A majority of managers state that there is trade union or employee representation in the organisation. Even so, company-level collective agreements do not address the return to work. Instead, practices that would best apply to the organisation are: interaction between management and unions regarding return to work policy and practice, as long as this is ad hoc and not regular; and the inclusion of a worker representative on the committee addressed to occupational health and safety. The barriers that managers see in terms of cooperating with trade unions and other employee representatives in facilitating the return to work is that the management of, and responsibility for, the return to work process may become unclear. At the same time, the most prevalent outcomes that they find beneficial as regards engaging with unions/employee representatives on the return to work are training sessions for managers and team leaders directly exposed to interaction with workers with chronic conditions; and training sessions for the union and/or employee representatives who are likewise involved.

4.3 Interaction between employer and employee in facilitating the return to work

4.3.1 Workers' perspectives

Workers feel that their employers were generally supportive after they had announced the need to take sickness leave but, at the same time, did not feel that their employers offered any help or support during their absence. In practice, neither did they benefit from any mentoring or coordination of experience between the company and their doctors.

The level of satisfaction with the help and support received from employers and trade unions at company level shows variance. Most are satisfied with both employers and unions, but more than one-third express strong dissatisfaction with the support and help (or lack thereof) from trade unions. Furthermore over two-thirds state that there were no negotiations between their employer and trade union/employee representatives about adjustments to their work tasks and responsibilities after the return to work.

4.3.2 Managers' perspectives

A majority of managers describe the type of interactions with workers during sickness leave as irregular and mostly informal. The responses here suggest that workers on sickness leave receive no updates on work-related issues during their period of leave: managers admit that, during a worker's sickness absence, they neither keep the worker informed about work-related issues nor involve him or her in work-related matters (such as asking for that person's opinion, advice or involvement in planning or in decisions). According to managers, the return to work is indeed, in line with the responses of workers presented above, initiated mostly by workers themselves.

Regarding return to work procedures that might be available at company level, a few admit that either there are no specific procedures or that they do not know about them. If any return to work procedure is available, then there is the possibility of a phased return to the organisation and/or that the organisation might cooperate in this respect with other external parties, e.g. the occupational health service.

Corresponding to previous findings, the type of support most frequently offered to an employee returning to work is the availability of informal procedures. Another relatively common support is that, before the worker's return, there is a thorough discussion to plan the return process. However, it seems that managers also expect the worker to be back to regular productivity upon returning to work without the need for adjustments.

In the context of the lack of a formalised policy on the return to work at national level beyond disability policies, companies deal with the return to work of their workers individually and behind closed doors. HR departments deal with an individual's return on a case-by-case basis and, most probably, there are no formalised processes or policies at company level. Nevertheless, several good practices and experiences are apparent from our research. For example, in a large automotive manufacturer, trade unions are part of a health and safety committee that treats every return case individually. In another smaller workplace, the informal nature of the interaction between manager and workers had smoothed the return process, as did the level of engagement during the period of sickness leave itself and the need to cope with the employer's various bureaucratic obstacles in order to adjust the workspace to fit the returning worker.

Asking managers about how to improve the return to work process in their organisation revealed that most see the need for better cooperation with external stakeholders, e.g. medical doctors, therapists and campaigning and patient support organisations. Another suggestion for improvement is the demand for better organisation-wide policies and activities. Finally, managers would welcome more specific provisions in the legislation on the return to work to guide the organisational approach, as well as the legislation itself becoming more flexible, leaving more space for company-level management decisions on return to work issues.

4.4 Views on the future potential for social dialogue to support the development and implementation of return to work policies at company level

Nearly nine out of ten workers are unaware of cases in which a trade union had proved helpful in the facilitation of a return to work. Workers' lack of awareness of trade union work, together with their opinion that trade unions should always be ready to address the health-related issues of workers and that support for the return to work should be an element of negotiations between trade unions and the employer, identifies that there is major potential for social dialogue to act as a tool to address return to work processes. Significant issues remain, however: for example, one-third of workers perceive trade unions to be insufficiently powerful to facilitate the return to work in Slovakia while

a quarter are unsure whether the preferred form of support should be to seek binding agreements with employers.

From the employer perspective, although based on a small number of responses, managers prefer to look to training sessions for team leaders who are directly exposed to interaction with workers experiencing chronic conditions. According to managers, the legislation is too general in terms of managing returns to work following chronic illness and thus does not offer sufficient support to companies. Furthermore the legislation has other shortcomings in that it is unclear and creates further burdens, and is thus not particularly helpful.

Overall, the following can be summarised about the return to work process at company level. Employees receive only limited support from their employer in the process of returning to work following chronic illness. The majority return to work on their own initiative and most receive support neither from the employer nor the trade unions at the workplace. Employers, on the other hand, deal with returns to work on an individual basis and without formal rules within the organisation. Managers expect employees to have the same productivity level as before and the availability of adjustments to working conditions is limited.

5. Discussion of research findings and conclusion

In terms of the legislative framework, the legislation in Slovakia is biased towards those people with chronic conditions who acquire formal disability status or who are entitled to invalidity benefit from the state. The vast majority of policies, as well as the policy implementation experience, focuses on this subgroup, leaving those undergoing return to work processes, but without formal disability status, subject to the individual discretion of employers and general sickness benefit policies.

The actors involved in policy-making and implementation relevant to the return to work (and including disability policies) include stakeholders at state level and the social partners as well as NGOs, charities and campaigning and patient support organisations. Among these, return to work policies are identified as among the 'core business' of specialised government and employment offices, patient support organisations, NGOs and charities.

For both trade unions and employer organisations, return to work policies are secondary or even marginal as regards their current agendas. Awareness of EU-level policies on the return to work remains low among the Slovak social partners although they do support more active EU-level policies promoting the return to work in member states. At the same time, some maintain that return to work policies should be addressed exclusively at national level due to the diversity in European policy frameworks and industrial relations systems.

In contrast, the social partners are well aware of national return to work policies (where these are related to formal disability status) but are not actively involved in

policy design as this is not a core priority for their organisations. It is also clear that the social partners lack a coherent national strategy towards the return to work of people following chronic illness. Despite lacking a dedicated framework for national return to work policies which extends beyond disability, most of the social partners think that Slovakia has an elaborate policy framework and properly implements and even enforces practices on the return to work. Regarding policy-making and implementation in this area, employer associations perceive their involvement as sufficient although there is a demand for more active involvement among the trade unions.

At national level, return to work policies are not a priority for trade unions due to low capacity and a priority focus on other, broader, interests of workers. Nevertheless trade unions are involved in commenting and consulting on the relevant legislation and provide legal consultation for their members, when needed. Besides this, trade unions are mostly engaged in providing individual assistance to individual workers at company level, something that is viewed as more beneficial than unions supporting an agenda on the return to work in national-level social dialogue. On the other hand, social dialogue could, where it results in specific agreements, be a valuable tool to make policy on the return to work more visible and to raise awareness among all stakeholders on the potential role that trade unions could play in the return to work process.

Employer associations at the highest level, as regular members of the national tripartite council, can submit various proposals for the amendment of return to work policy. Nevertheless, they do not perceive any demand from their membership base for such activity. Even though the return to work theme is perceived by employers both as an economic issue and as a matter of social responsibility, employers resist stricter regulation and call for greater work flexibilisation in general and for the return to work agenda to be addressed individually at workplace level.

Despite such obstacles, the social partners do see opportunities for their greater involvement in this policy area. Most evaluate the level of cooperation between trade unions, employer associations, government, labour market institutions, medical organisations, rehabilitation centres and NGOs as potentially important in terms of facilitating a sustainable and feasible policy framework on the return to work. Furthermore there is general interest in increasing the participation of the social partners both in policy design and implementation. Suggestions for improving the role of social dialogue include a better integration of the return to work agenda in collective bargaining, more systematic data collection and reform of the present system and of the quotas for employers to employ disabled workers.

All stakeholders agree that cooperation between the various types of actor is, however, lacking and that there is room for improvement. Cooperation could be extended to involve other stakeholders too, such as labour inspectorates or employment promotion agencies, rehabilitation centres and others. At the same time, the level of cooperation that does prevail needs to be intensified and to become a platform for the specific discussion of topics related to the return to work.

Collective bargaining and collective agreements at sectoral or company level are seen as potential practical tools to stipulate obligations for employers in terms of return to work policies. There is also room for the legislative improvement of the present disability policy and its implementation procedure. This includes, for example, an amendment to the legislation on sheltered workplaces for disabled people. While the current allocation to sheltered workplaces does not facilitate an easy transition into regular jobs, a legislative amendment should aim to revisit the role of a sheltered labour market for people with health conditions, In particular, it should propose a mechanism for cooperation between employers and other stakeholders, including unions and NGOs, supporting labour market integration to facilitate an easier and more direct return to regular jobs instead of sheltered ones.

At company level, workers undergoing a return to work process are mostly fearful of a lacking transition period and that they would be expected to resume working at immediate full productivity. Lived experience indeed shows that this is the case on the part of most employers in the absence of a national-level policy on the return to work and since most employers do not normally have even a company-level policy stipulating the exact process that should be followed. In the few cases where concessions are granted, these refer to flexible time arrangements and task sharing with other colleagues. For the most part, no specific return to work procedures are available at company level and, even where they are, managers have little awareness of them. Neither are workers aware of the potential role for trade unions in facilitating their return. Nevertheless several examples of good practice may be identified at company level where employers have successfully managed to integrate workers with health conditions and/or disabilities.

Despite being in touch with colleagues, and occasionally with their line manager, during their treatment, most respondents feel only ambivalently welcome at their workplace after they return. Managers also acknowledge that interactions with workers during their period of sickness leave are irregular and informal. A majority of workers do not think that the company is sufficiently well prepared to accommodate the necessary adjustments required by their health condition. Where adjustments are made, this is mainly in connection with time flexibility, task sharing with colleagues and the postponement of some deadlines.

There is a variation in the level of satisfaction of workers with the help and support they receive from employers and trade unions at company level. Most are satisfied, but one-third express strong dissatisfaction with the support and help they received from trade unions. Overall, the role of trade union/employee representatives is not perceived as an important one in the process of their returning to work. This might, however, be influenced by the relevant respondents not consulting with employee representatives on their need for a long-term period of absence. Furthermore most workers are unaware of cases in which a trade union had proved helpful in terms of facilitating a return to work. Despite some workers regarding trade unions as insufficiently powerful in this respect, they still expected that trade unions would always be ready to address the health-related issues of workers. Workers support the notion that the return to work should be an element of negotiation between trade unions and employers. These opinions, too, highlight the potential for social dialogue as a tool to address return to work processes.

Research into the return to work in Slovakia shows that there is a missing link between EU-wide strategic concepts, their integration into national policies (which are currently restricted to people formally recognised as disabled) and their subsequent implementation in practice at company level. Companies lack policies on workforce diversity and there is an insufficient elaboration of the concepts of an ageing workforce, fitness for work and the overall concept of workforce diversity, extending to workers with health conditions. The connection between EU, national and company-level use of such concepts is currently limited. Better interconnection could be facilitated via the European Semester but also via a better articulation of social partners' interests as regards their own EU-level organisations and social dialogue committees.

Our policy recommendations refer to roles, strategies and particular actors at various levels where return to work policies and their implementation need attention, as well as in terms of a conceptual understanding of the return to work.

First, the study points to the need for more systematic data collection on people with chronic conditions and their working life trajectories. This is currently lacking and thus complicates policy-making and the implementation of return to work policies.

Second, return to work policy should, conceptually, clearly distinguish between people with and without formal disability status. The focus is currently the former and a dedicated policy mix for the latter group is almost non-existent.

Third, given the need for more effective policy implementation on the return to work, closer cooperation between stakeholders is desirable in terms of discussions among expert groups but also in connection with practical steps. The latter should encompass a more coordinated management of the return to work process at national level (e.g. integrating this agenda into a single umbrella organisation rather than decentralising it across various stakeholders that lack cooperation).

Fourth, the greater involvement of trade unions is called for at each of the national, sectoral and company levels. At national level, unions could build on their priority of workforce protection, which is shared by state stakeholders, while opportunities for including return to work provisions in collective bargaining at sectoral and company levels may be explored.

Fifth, at company level, and despite employers' longstanding preference for addressing the return to work on an individual basis, a more systematic approach would be welcome by workers actually undergoing a return to work. This would add to the transparency of employment policies as well as assisting their interaction with national-level policies. Trade union involvement in framing diversity policies at company level more broadly, but also in including stipulations on the return to work, also constitute areas for further exploration and analysis.

Finally, the study has identified a gap between relevant EU-level policies (not only in the narrow sense of the return to work but in the broader sense of an ageing population, fitness for work issues and the labour productivity debate), national-level policies and

the decentralised implementation level. The comparative experience of various EU member states is essential as a means of facilitating better articulation between these levels to address return to work policies within the EU from a multi-level governance perspective.

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Conclusions
Return to work after chronic illness and the way ahead

Mehtap Akgüç

1. Why does the return to work following chronic illness matter?

Demographic developments including ageing and, simultaneously, declining birth rates, resulting in a shrinking workforce, coupled with an increasing prevalence of chronic illness among all age groups – but particularly for older workers – imply that more people of working age are expected to face health problems at some point during their career. Meanwhile, chronic illnesses, usually characterised by a long-term nature and slow progression regardless of whether or not there is a cure, constitute the main reasons for absence from work, as well as presenteeism at work, and could be a precursor for early exit from the labour market. In addition to the effects on health and the personal and professional setbacks to the person at the centre (as well as the indirect costs for caregivers), chronic illness and the related issue of long-term absence from work also pose challenges to employers regarding the continuity of work due to missed workdays or productivity losses. Costs can reach significant amounts when aggregated; for example, while the direct costs of work-related cancer in terms of healthcare and productivity losses can vary between €4-7 billion, the indirect costs can reach nearly €334 billion annually.[1] Furthermore, soaring sickness and disability benefits in many countries, in the face of a declining workforce, is putting further strain on the sustainability of social protection systems in Europe.

For all these reasons and more, the return to work and the occupational reintegration of individuals with chronic illness has become an important element of various policy areas ranging from employment to health and safety policies and to ones focused on social inclusion. Moreover, in addition to addressing the specific challenges faced by individuals with limiting health conditions, their reintegration into work is part of a wider European policy agenda promoting not only a healthier Europe, with active and healthy ageing involving longer working lives, but also establishing inclusive European societies in which various strategies aim at reducing the risk of the marginalisation and poverty of vulnerable individuals, as well as discrimination against them.

In this context, given the importance of the social partners in representing the interests of workers and employers and striking a balance between the two sides in the workplace, the role of industrial relations structures and actors comes to the fore in terms of how far they remain relevant in addressing and facilitating the return to work of individuals following chronic illness. This has been the core task of the book which looks at this issue from several distinct angles.

1. https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52017DC0012&from=EN (page 4).

In particular, various chapters provide a detailed picture of return to work policies and experiences from multiple governance stages, including EU, national and company levels and with a particular focus on the industrial relations actors, and zoom into the perspectives of workers going through return to work or reintegration processes following chronic illness. Six countries – Belgium, Estonia, Ireland, Italy, Romania and Slovakia – are analysed in depth to understand how the return to work is implemented and perceived by national stakeholders, social partners, managers and workers. The evidence base used for the analyses relies on mixed methodologies combining both qualitative approaches, drawing on an overview of the existing academic and policy literature, and quantitative ones exploring primary data collected in a number of online surveys and interviews and at various stakeholder events.

2. EU-level approach to the return to work

The overall analysis suggests that EU-level initiatives and industrial relations actions have, so far, been limited in the specific context of the return to work following chronic illness. This is partly due to the subsidiarity principle as employment and social policies remain a national competence. Nevertheless, a number of actions and strategies from a range of policy fields have been put forward and these have some relevance for the return to work and reintegration of individuals experiencing chronic illness. From a health and safety perspective, while EU policies have mainly focused on the prevention of occupational accidents and work-related diseases, the importance of chronic illness is increasingly acknowledged in the face of its rising prevalence in Europe. However, chronic illness is still frequently subsumed within the disability framework.

At least three recent EU initiatives are worth mentioning with a clear relevance for the return to work. The first is the recently-released Strategy for the Rights of Persons with Disabilities, which specifically refers to the workplace rehabilitation of workers with chronic illness. The second is the EU 'Beating Cancer' Plan that also addresses the return to work of individuals experiencing cancer. Last but not least, the new Strategic Framework on Health and Safety at Work for 2021-2027 has also a role to play in the return to work context.

As regards the involvement of the EU-level social partners in the return to work, the analysis points to limited action at this point. However, the social partners here consider the issue to be highly relevant, even if it is not as yet much on their agenda. It was also largely acknowledged that, in this context, EU-level action could be more appropriate for raising awareness and organising information campaigns as well as supporting national members with more practical guidance on facilitating the return to work at national, sectoral or company levels where more specific actions can be taken.

3. Approaches to and experiences with the return to work in six member states

In most of the countries studied, the existing national policies and legislative framework do not specifically or sufficiently address the return to work and reintegration of individuals with chronic illness; the target is rather those individuals who have disability status, the extent of which is assessed and certified by medical authorities. Individuals with chronic illness usually fall under a certain category of disability status when it is established that their illness has caused a partial or complete loss of work capacity.

Considering the overall policies and approaches to the return to work based on the national analyses, some commonalities may be observed. It emerges that, in most of the countries, other than Belgium which has an elaborate framework for the reintegration to work of people with non-occupational illnesses, there is no specific national policy framework addressing reintegration. Most of the time national polices consist of general sickness leave or disability provisions and quite often constitute a rather fragmented approach to the return to work in which the state usually takes the leading role in policy creation. Consultation and collaboration – let alone co-design – with the social partners or other stakeholders on the return to work or related policies remains limited and the scope for interactions between various actors depends on national legislative structures and industrial relations traditions. At the same time, the return to work lies at the intersection of several policy domains – employment, occupational health and safety, social inclusion and disability – and, as such, policy design and then implementation involve different stakeholders whose priorities might diverge. This might also complicate the coordination of policy-making on the return to work.

In some cases, the existing law accords specific roles to the social partners or other relevant stakeholders to take part in policy-making (e.g. Belgium) while in others consultations are organised in an ad hoc or voluntary manner (e.g. Ireland), if at all (e.g. Estonia or Romania). In Italy, the legal framework on the return to work is somewhat disconnected and often the social partners lack the legal expertise properly to implement the legislation at local levels. A similar situation arises in Ireland, which has a disjointed and complex benefit-setting system that is hard to navigate for workers, especially when dealing with chronic illness.

It also emerges that 'one size fits all' kinds of solutions do not work well in the context of returning to work after or with chronic illness because of sectoral, company and individual specificities that necessitate a more tailored approach on a case-by-case basis. For example, in Slovakia individual assistance to workers at company level is provided by trade unions to facilitate the return to work in the absence of focused and targeted policies. The presence of decentralised and informal channels for dealing with the issue is also common in some countries (e.g. Ireland and Italy). In Romania, the existing law only provides general stipulations as regards work reintegration and no specific measures or interventions exist for easing the return to work, despite a generous duration of fully-paid sickness leave.

The type of disease also matters as workplace or workload adjustments and the needs of individuals with musculoskeletal disorders may well differ from those of individuals with mental health conditions or cancer. In this respect, campaigning and patient support organisations or other relevant NGOs are also considered key actors as they have deeper knowledge on the specificities of particular illnesses and patient experiences and can inform policy-makers and the social partners on the precise needs and priorities of individual workers.

All in all, it is acknowledged that the return to work with chronic illness is a complex subject involving a multitude of actors and stakeholders each of whom might have a specific role to contribute in the facilitation of the overall process.

4. The role of the social partners in the return to work

The overall findings reveal mixed results as regards the role and involvement of the social partners in return to work policies and processes. On the one hand, while they find it relevant, the return to work is not yet a pressing issue for them and hence it is not surprising that their involvement in such issues is limited.

In Estonia, given low union density coupled with weak sectoral social dialogue, neither trade unions nor employer organisations have taken much initiative in return to work matters. In Romania, there is reduced involvement and collaboration, focusing mainly on financial benefits for workers, among the industrial relations actors but their role in raising awareness is also acknowledged. In Italy, regional and company-level collective bargaining on this issue is largely underdeveloped, relying mainly on the mutual willingness of trade unions, employer representatives and managers; when it happens, it is limited to large companies in specific sectors. Ireland's new-traditional social partnership ended following the recent financial crisis in 2009 and, since then, social dialogue has been weakened generally; nevertheless, the high-level social partners were able to make their input into policy development at national level regarding the employment strategy for people with disabilities. In Slovakia, the return to work is not a key topic on the trade union agenda but this is due to low capacity and a shortage of expertise rather than any lack of willingness to be more active in the field.

In contrast to the other countries, the social partners in Belgium have played a key and multifaceted role in the development of a recent dedicated return to work policy framework via the social dialogue. This is in the context of a deeply-established industrial relations setting with high rates of unionisation and collective bargaining coverage. Despite the unforeseen contract termination outcomes (so-called medical *force majeure*) implicit in the framework, the intensive and high level of interaction between government and social partners during the policy design process has put Belgium at the top of the list of the countries studied in this book where the social partners have made an important difference in the return to work.

5. Workers' perspectives and experiences during the return to work

It appears that one of the main challenges for workers in the return to work is a fear of returning without having the right support during the process. Partly this is due to the lack of necessary adaptations in the workplace or other types of (e.g. psychological) support following return. Here, a big part of the responsibility falls on employers who are either too concerned about the costs of adjustments or truly lack the capacity or knowledge to implement existing laws giving certain rights to workers. In either case, it emerges that more education and better informed employers would be more able to understand what their role is in this process and what reasonable accommodations can be made to assist workers.

As regards perspectives on trade unions, workers' rather underwhelming actual experiences during their return to work could possibly be due to workers having very high expectations of what trade unions are able to do for them in this scenario and, perhaps, because workers might consider their trade union representative simply as a means to realise gains on their behalf behind the scenes. A shift in mindsets might be necessary here as more could be achieved. At the same time, trade unions seem to struggle to reach such workers because of the individualised nature of the context of illness and because of privacy concerns, making situations harder to collectivise. Nevertheless trade unions should continue to be proactive by informing workers about their rights and raise awareness about the issues, possibly also by joining forces with other campaigning and patient support organisations.

The other major issue is what the experience of chronic illness makes workers think about going back to work. It is possible that dealing with a chronic illness makes workers realise their vulnerabilities and rethink the importance of time (and life) and thus it can lead to a desire to 'slow down'. This is where policy campaigns to make working lives longer give an uncomfortable message by incentivising workers back to work in the context of the requirement for labour to sustain social security systems. At the same time, working after chronic illness can also be part of the rehabilitation process as it can make workers feel valued despite their vulnerabilities or reduced capacity.

6. Return to work in the Covid-19 context

Here, there are several countervailing effects in play. While the pandemic has added further complications to the return to work process, it might also offer ample opportunities with which to facilitate it.

On the one hand, because of overwhelmed and reduced healthcare services in hospitals during lockdowns, as well as the likely avoidance of medical centres by individuals due to a fear of virus propagation, the pandemic may have delayed the early detection as well as treatment of chronic diseases such as cancer that would otherwise have been monitored and caught. Moreover, recent studies hint at the long-term impacts of Covid-19 on individuals already experiencing chronic conditions and who are at mild to

high risk should they catch Covid-19 (we refer here to Long Covid; for more on this, see the Introduction). Limited social (and professional) contact due to lockdown measures can also extend the recovery process and the reintegration to work of individuals with chronic illness. The pandemic, therefore, might have further compromised the return to work process of individuals with chronic conditions.

On the other hand, mandatory teleworking in certain jobs, where this is possible, and the flexibility that this entails might well offer new possibilities to individuals with chronic conditions in the sense of being able to perform their work from home. Prior to the pandemic, it might have been harder to negotiate this with employers.

In some cases, the pandemic context can also offer the opportunity to rethink existing social security and social protection systems and to consider adapting them to the new context generated by Covid-19. Ireland is a case in point: up to now, there has not been a statutory sickness pay scheme in place in the country but the government has been considering introducing related reforms in a reflection of the devastating health, social and economic circumstances created by the pandemic.

7. Policy considerations and the way forward

Considering the overall involvement and perspectives of the various stakeholders across the different countries analysed, a number of policy considerations come forward.

First and foremost, there is a need to promote a proactive approach to the return to work in which workers are accompanied through effective and transparent communication of policies and procedures which, in turn, help them better navigate what appears to be an already complex process. The overall approach should also take into account the specific needs and priorities of workers, depending on the illness, while accordingly thorough discussions on workload and workplace adjustment, matching the requirements of the reasonable accommodation regulations, would be highly beneficial in facilitating a successful return to work. It would also be helpful if the EU's reasonable accommodation legislation, which currently addresses the needs of disabled workers, could be formally extended to cover workers who are chronically ill. Employers, particularly managers in small and medium enterprises, should also be guided and informed along the way.

Despite the currently limited involvement of the social partners in return to work issues, it is largely believed and expected that effective social dialogue can help to design and facilitate return to work and reintegration policies. As the voice of workers, there is also the important role and responsibility of trade unions to raise awareness on the issues and accompany workers at all levels. However, this requires a deepening of the knowledge of the social partners on the existing legal framework, a strengthening of multi-stakeholder cooperation and coordination across different layers of policy-making and implementation, and an intensification of interactions between the social partners as a means of discussion and exchange on particular aspects of the return to work.

There are also challenges in tackling the return to work through social dialogue because of the private and sensitive nature of the context of illness and since workers away from the workplace as a result of sickness leave are actually on the margins of social dialogue procedures. This is where trade union representatives could play a more proactive role in accompanying and engaging with workers while respecting sickness and recovery periods. Overall, however, experience from the countries studied suggests that having a broad national framework enforcing basic rights and requirements, complemented by a tailored company-level approach, could actually work rather well. In particular, sectoral specificities and company-level characteristics are likely to play an important role in a better targeting of the return to work process. A further possibility could be to push for collective agreements at company level.

It also appears that, once the recovery or recuperation period is over and workers are ready to think about going back to work, the process of return needs to be handled quite 'gently' in a way that allows workers to come back in a gradual and progressive manner – be it in terms of work time and tasks or level of responsibility. Flexibility is also important in cases where individualised accommodations might be necessary, as long as the flexible approach follows from agreed principles (or ones accorded by law) around job security, income security and so on. It is well worth giving these sorts of issues formal consideration either in existing dialogue processes and/or in terms of how legislation responds to the concerns of both workers and employers in this area.

At EU level, the key role continues to lie in awareness-raising on return to work issues as well as providing information and practical guidelines to be transmitted to national, sectoral and company levels. The potential development of a European charter on the return to work, where all relevant information could be gathered, is an option. Another avenue is to incorporate the issue into the European Semester process in which member states would closely monitor the employment and social inclusion of individuals with chronic illness. The social partners could also more proactively participate in this process.

Finally, further multidisciplinary collaborations will be of help in increasing knowledge and expertise on the return to work after or with chronic illness. Such collaborations would allow the exchange of best practice and inform policy-making. Deeper cooperation between the social partners and campaigning and patient support organisations could be especially enriching for both sides. Furthermore increased efforts to collect harmonised data on the return to work and chronic illness will also be needed to allow a proper measurement of the scale of the issues so that informed decisions may be made about them in the future.

List of abbreviations

AIMAC	*Associazione Italiana Malati di Cancro* (Italian Association of Cancer Patients, Relatives and Friends)
AISM	*Associazione Italiana Sclerosi Multipla* (Italian Multiple Sclerosis Association)
ANOFM	*Agenția Națională pentru Ocuparea Forței de Muncă* (Public Employment Agency) (Romania)
CEE	Central and eastern Europe
CES	Comprehensive Employment Strategy (Ireland)
CIPD	Chartered Institute of Personnel Development (Ireland, UK)
CIV	*Consiglio di Indirizzo e Vigilanza* (Orientation and Oversight Committee of INAIL) (Italy)
CNPP	*Casa Națională de Pensii Publice* (National House of Pensions) (Romania)
CNT/NA	*Conseil National du Travail/Nationale Arbeidsraad* (National Labour Council) (Belgium)
EAKL	*Eesti Ametiühingute Keskliit* (Estonian Trade Union Confederation)
EH	*Eesti Haigekassa* (Estonian Health Insurance Fund)
ET	*Eesti Töötukassa* (Estonian Unemployment Insurance Fund)
ETK	*Eesti Tööandjate Keskliit* (Estonian Employers' Confederation)
ETUC	European Trade Union Confederation
EU	European Union
Eurofound	European Foundation for the Improvement of Living and Working Conditions
EU-OSHA	European Agency for Safety and Health at Work
FEDRIS	*Agence fédérale des risques professionnels/Federaal agentschap voor beroepsrisico's* (Federal Agency for Occupational Risks) (Belgium)
FNUASS	*Fondul Național Unic de Asigurări Sociale de Sănătate* (National Fund for Social Health Insurance) (Romania)
GDP	Gross Domestic Product
GDPR	General Data Protection Regulation
HR	Human Resources
HSE	Health Service Executive (Ireland)
IBEC	Irish Business and Employers Confederation
ICTU	Irish Congress of Trade Unions
ILO	International Labour Organization
INAIL	*Istituto Nazionale per l'Assicurazione contro gli Infortuni sul Lavoro* (National Institute for Insurance against Accidents at Work) (Italy)
INAMI/RIZIV	*Institut national d'assurance maladie-invalidité/Rijksinstituut voor ziekte- en invaliditeitsverzekering* (National Institute for Health and Disability Insurance) (Belgium)
INPS	*Istituto Nazionale Previdenza Sociale* (National Institute for Social Security) (Italy)
MMPS	*Ministerul Muncii și Protecției Sociale* (Ministry of Labour and Social Protection) (Romania)
MSD	Musculoskeletal Disorder
NCLA	National collective labour agreement(s)
NGO	Non-governmental Organisation

OECD	Organisation for Economic Cooperation and Development
SECPAD	*Serviciul de Evaluare Complexa a Persoanelor Adulte cu Dizabilitati* (Authority for the Complex Assessment of Disabled Adults) (Romania)
SME	Small and medium-sized enterprise
SP	*Sociálna poisťovňa* (Social Insurance Agency) (Slovakia)
UN	United Nations
ÚPSVaR	*Ústredie práce, sociálnych vecí a rodiny* (Central Office of Labour, Social Affairs and Family) (Slovakia)
WHO	World Health Organization

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Continuing at work
Long-term illness, return to work schemes and the role of industrial relations

Edited by Mehtap Akgüç

This book focuses on the role of industrial relations structures and related actors in terms of how far they remain relevant in addressing and facilitating the return to work of individuals following chronic illness.

While the demographic transition and the transformation of labour markets call for longer working lives and policies on active ageing, the prevalence of chronic health conditions has also increased in ageing societies. This exacerbates issues connected with shrinking workforces and the sustainability of social security systems. Concerns have also been raised about managing the return to work of workers with chronic illness or disabilities, challenging the inclusive workplace and other related social or labour market policies. The Covid-19 pandemic has additionally affected the return to work process in multiple ways, making the issue ever more important in the current public health context.

The chapters display a detailed picture of return to work processes alongside existing legal and policy frameworks and experiences from multiple governance stages (EU, national and company levels) and provide overview perspectives from distinct angles. Six countries – Belgium, Estonia, Ireland, Italy, Romania and Slovakia – are analysed in depth to understand how the return to work is implemented and perceived by national stakeholders, social partners, managers and workers.

The key message emerging from the analysis is that the return to work following chronic illness is a complex subject involving a multitude of actors and stakeholders each of whom might have a specific role to contribute to (the facilitation of) the overall process.

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