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***Negotiating Return to Work in the Age of Demographic Change through Industrial Relations (REWIR)***

***Project No. VS/2019/0075***

**WP 1: Return to Work Policies and the Role of Industrial Relations: Literature Review and Conceptual Framework**

**Deliverable 1.1: Working paper presenting a literature review on return to work policies and the role that industrial relations play in facilitating return to work at the EU, national and sub-national levels**

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**Contents**

[1. Introduction 1](#_Toc39050828)

[2. Research questions and project scope 2](#_Toc39050829)

[3. General overview of return to work policies for chronic diseases 5](#_Toc39050830)

[3.1 Data illustrating the burden of chronic illnesses in the workplace 5](#_Toc39050831)

[3.2 EU regulations and guidelines 6](#_Toc39050832)

[3.3 Concept of return to work 6](#_Toc39050833)

[4. Industrial relations systems and their interaction with diverse policy frameworks on return to work across the EU 18](#_Toc39050834)

[5. Analytical framework 19](#_Toc39050835)

[5.1 Institutional context 19](#_Toc39050836)

[5.2 Relevant actors 20](#_Toc39050837)

[5.3 Mode of actors’ interaction 21](#_Toc39050838)

[5.4 Result 23](#_Toc39050839)

[6. Methodological framework 23](#_Toc39050840)

[6.1 Country case studies 23](#_Toc39050841)

[6.2 Sectors 26](#_Toc39050842)

[6.3 Data collection 27](#_Toc39050843)

[6.3.1 EU-wide survey 27](#_Toc39050844)

[6.3.2 Interviews with European level stakeholders 27](#_Toc39050845)

[6.3.3 Interviews with national stakeholders 27](#_Toc39050846)

[6.3.4 Survey of companies 28](#_Toc39050847)

[6.3.5 Survey of workers 28](#_Toc39050848)

[6.4 National reports and templates 28](#_Toc39050849)

[7. References 30](#_Toc39050850)

[8. Annex – Survey questionnaires and Interview Guides for data collection 35](#_Toc39050851)

**List of Figures and Tables**

[Figure 1. Analytical framework – actors, their strategies and modes of interaction in given RTW policy contexts and characteristics of industrial relations systems 20](#_Toc39050852)

[Table 1. Summary of the four categories of countries regarding policies for RTW and rehabilitation after chronic conditions 9](#_Toc39050853)

[Table 2. Country clusters and industrial relations systems across EU 19](#_Toc39050854)

[Table 3. Actors in our study 21](#_Toc39050855)

[Table 4. Justification of country selection 24](#_Toc39050856)

# Introduction

Demographic change and population ageing have a profound impact on labour markets across the EU and have been identified as major societal challenges that call for a policy response, as both put pressure on the fiscal sustainability of the welfare states and the capacity of healthcare systems and raise issues of intergenerational fairness and the welfare of the older population (European Commission 2014). In an attempt to tackle these challenges, member states have adopted measures to extend working lives, such as increasing the retirement age and the (re-)integration of vulnerable groups into the labour market, including individuals who became inactive due to illness or disability.

In the context of demographic and technological change, this project **Negotiating Return to Work in the Age of Demographic Change through Industrial Relations (REWIR)** studies the role that industrial relations at the EU level, national level and company level play in these efforts of work retention and integration of vulnerable groups into the labour market after exposure to chronic diseases. We understand chronic diseases as diseases of long duration and generally slow progression, which can be divided into several types: cardiovascular diseases (CVD), cancers, diabetes, chronic respiratory diseases, musculoskeletal diseases (MSD) and mental diseases. These categories are selected because they produce a considerable burden on the workforce and are the main cause of morbidity and mortality in the EU (Guazzi et al. 2014). Mortality from CVD is associated with more than one long sickness absence per year, which yields negative consequences upon work (Vahtera, Pentti, and Kivimäki 2004).

As the labour force ages and working lives are extended, an increasing number of workers will be faced with chronic diseases and subsequent reintegration into the labour market in case of a longer absence. Recent evidence demonstrates that chronic diseases are a leading cause of mortality and morbidity in Europe, and bear significant economic and labour consequences (e.g. lower wages or labour force participation) (WHO 2010). In turn, healthy ageing practices and good health standards more generally became EU priorities within the Europe 2020 agenda and the EU Health Programme 2014-2020. In addition, the European Observatory on Health Systems and Policies regards tackling chronic diseases as a priority for better and healthier ageing (WHO 2010).

Workplace support measures, in the form of adjustment strategies, together with legislation, are preconditions to facilitate the integration into the labour market of individuals with chronic illnesses (Amir et al. 2010). Although the European Pillar of Social Rights asserts that “*people with disabilities (chronic conditions) have the rights to... services that enable them to participate in the labour market ..., and a work environment adapted to their needs”*, it remains an open question to what extent such services and policies have been implemented and what stakeholders play a key role in facilitating return to work (RTW).

Since industrial relations play a key role in shaping the work environment and striking a balance between the needs of employers and workers, the REWIR project studies opportunities for interest representation structures of workers and employers across the EU to facilitate RTW. In addition, we aim to rethink how industrial relations play a role in the (re)definition of conceptsof ‘*intergenerational fairness*’, ‘*longer labour market involvement’*, *’job performance’*, ‘*presence at work’*, and *’fitness for work’* (some of which are priorities of Europe 2020) by raising awareness on transformations in the world of work flowing from technological, organisational, and demographic changes. The project’s focus is motivated by the fact that little is known about how representatives of governments, employers and employees approach the issue of RTW in social dialogue, and how they support workers in their work retention and labour market (re-)integration efforts following chronic diseases and longer absences (Tiedtke et al. 2013).

In the remainder of this working paper we operationalise our approach to studying the role of industrial relations for facilitating RTW at three levels: the EU level, national level and company level. The next section summarises the project’s research questions, followed by an overview of RTW policies across the EU member states in Section 3 and an overview of industrial relations systems in Section 4. Section 5 explains our analytical framework by focusing on the role of particular stakeholders in overlapping institutional contexts of (a) RTW policy frameworks and (b) industrial relations systems. In Section 6 we elaborate our methodological approach for data collection and analysis that will guide the empirical part of this research project.

# Research questions and project scope

The research questions within the REWIR project evolve around the approach of different industrial relations systems to RTW policies and their implementation, and vice versa, questions concerning how similar RTW policy frameworks are designed and implemented in countries with radically different industrial relations. We are interested in uncovering how relevant industrial relations stakeholders deal with RTW policies and practice in different industrial relations systems. These aims are operationalised in the following research questions:

1. How do relevant **EU-level social partners** participate in the implementation of particular targets of Europe **2020**, such as the agenda of promoting a healthier Europe and active and healthy ageing? How do they contribute to RTW policy making and policy implementation at the EU level?
2. What role do **trade unions and employers’ associations in particular national contexts** play in the current practice of RTW policy implementation across the EU?
3. In a **comparative perspective**, what opportunities emerge for trade unions, employer’s associations, governments and other stakeholders to negotiate a better creation and implementation of RTW policies across different industrial relations systems and different RTW policy frameworks?
4. How do **company-level** interactions between employers and employee representatives enhance RTW of people having experienced chronic diseases through information, consultation and co-determinationacross six EU member states with different industrial relations systems and different RTW policy frameworks?
5. How do **workers** facing chronic health conditions and undergoing RTW perceive the relevance (or role) of social partners to help **preventing their risk of marginalisation, discrimination and the threat of poverty**?
6. How does the documented and potential **role of industrial relations help the (re)definition of** **concepts prioritised in the Europe 2020 agenda**, including ‘*intergenerational fairness*’, ‘*longer labour market involvement’*, *’job performance’*, ‘*presence at work’*, and *’fitness for work’?*

In order to answer the above questions, the project scope embraces several levels of analysis covering all EU member states as well as the EU-level representative bodies. At the **EU level**, we will conduct 15 **interviews** with employers’ representatives and trade union representatives in the European social dialogue committees (ESD) and European sectoral social dialogue committees (ESSD) on the actual and perceived role of social dialogue in shaping RTW policies as part of the Europe 2020 agenda (**Research Question 1**).

To analyse the role of trade unions and employers’ associations in facilitating RTW in nationally specific contexts of RTW policies and industrial relations systems, we will implement an **EU-wide survey among national-level social partners in 27 EU member states. This will be an online survey to be distributed to a pre-defined list of social partners** to gather data on their approaches to and experiences of shaping and implementing EU-level and country-specific policies aiming to facilitate return to work. Data collected via the survey will be used in the analysis to respond to **Research Question 2**.

To deepen the analysis of industrial relations actors in facilitating RTW in nationally specific contexts of industrial relations and RTW policies, in addition to the EU-wide survey of national social partners we will collect in-depth qualitative evidence in six selected EU member states (namely, Belgium, Estonia, Ireland, Italy, Romania, and Slovakia). In these countries, we will conduct 25-30 (in total) **interviews with governments and national-level stakeholders** and as well as other relevant national-level stakeholders (5-6 interviews per country).Respondents include government representatives, patients’ organisations, employment offices, social security authorities, NGOs and charities that participate in shaping and/or implementing return to work policies. This evidence will supplement the survey findings and help responding to **Research Questions 2 and 3**.

Since RTW implementation is extensively bound to the working lives of particular individuals and their particular workplaces, we extend our EU-wide and national-level data with a company-level perspective. First, we will implement **stakeholder group discussions across 6 countries** (Belgium, Estonia, Ireland, Italy, Romania, and Slovakia). In each country, we will conduct one group discussion with selected employers and one with selected company-level trade union representatives (6-8 representatives from companies with developed company-level bargaining). The aim of these discussions is to identify topics relevant for employers and unions in maintaining employment through a negotiated implementation of RTW policies. Second, an online **survey at company level** (target is 60 responses per country) aims to collect data in order to analyse how company-level industrial relations (can) facilitate RTW, and whether the attitudes, priorities and experiences of social partners on return to work issues differ across various levels of study. Evidence collected at the company level in six countries will be used for responding to **Research Question 4.**

For evaluating how the perspectives of EU-level and national-level policy makers and social partners meet the implementation of the priorities of Europe 2020 agenda, we will implement a **web-based survey among individual workers** to collect evidence on the perceptions and experience of individual workers facing RTW after chronic health conditions with help received from their employer, from trade unions, from other stakeholders as well as barriers faced due to a legislative and policy framework in the workers’ respective country. The web survey is to be distributed through the national WageIndicator websites (by associated organisation WageIndicator Foundation). The target is 50 responses per country. The survey will be advertised using search engine optimisation and its findings will help responding to **Research Questions 4 and 5**.

Finally, **Research Question 6** will be answered by integrating evidence from all of the above data collection methods as well as the elaboration of three benchmark case studies on France, the Netherlands, and the UK as countries with advanced RTW policy frameworks and implementation practices. The purpose of these benchmark case studies is to expand our sample, by adding countries that have a significant impact on the EU-level policy agenda, diverse industrial relations systems and developed institutionalised return to work frameworks, and investigate where EU-level policy preferences in RTW originate from, and how they influence social partners’ attitudes.

# General overview of return to work policies for chronic diseases

In this project, we combine the EU-wide diversity in RTW policies for workers having experienced chronic diseases with diversity of industrial relations systems and seek to understand how industrial relations actors help facilitating RTW in particular institutional contexts for RTW policies. To achieve this objective, we first review the RTW concept as well as country-specific RTW policy framework across the EU.

The chronic illnesses represent a significant and growing burden among the working population of Europe. With an increasing retirement age, many employees will have to expect longer working lives and a greater probability to fall ill during their career. Part of these employees will eventually return to work following a good management of their disease and recovery. Resuming work can result in significant economic and social benefits. Yet, the process of returning to work is complex, involving many actors and marked by multiple difficulties. Therefore, policies for returning to work are vital for assuring the professional reintegration of workers after chronic diseases. International bodies such as the European Agency for Safety and Health at Work (EU-OSHA) and OECD have advised on both the importance of returning to work and the importance of adequate policies to facilitate this process. Little can be done about the non-modifiable prognostic factors for return to work, such as age, sex or disease characteristics, yet the research shows there are also modifiable factors, related to work or the interventions available, which is essential to target through specific policies (Cancelliere et al. 2016).

## Data illustrating the burden of chronic illnesses in the workplace

Four categories of illnesses affect in a great extent the working population in Europe: cardiovascular diseases (CVD), cancers, musculoskeletal diseases (MSD) and mental conditions. Besides these, chronic respiratory diseases and diabetes produce an extra burden, with considerable morbidity and mortality rates. Taken together, all these six categories produce a considerable burden on the workforce. Although incidence and prevalence for CVD is decreasing, they still represent the main cause of morbidity and mortality in EU (Guazzi et al. 2014). Work-related CVD amount for 23% of the deaths globally (Takala et al. 2014). In the workplace, mortality from CVD is associated with more than one long sickness absence per year, indicating negative consequences upon work (Vahtera, Pentti, and Kivimäki 2004).

The impact of MSD on work is considerable, as they decrease productivity and increase sickness absence (EU-OSHA 2007). MSD cause almost 50% of all absences from work lasting three days or longer in the EU and 60% of permanent work incapacity (Bevan 2013). Here too, we might expect that the impact on work performance is significant, since 3.15 million days are lost to MSD each year in Romania, 1.02 million days are lost in Estonia and 7 million in Ireland (Bevan 2013). In a systematic review, over half of the studies included were related to MSD, whilst the other half were related to mental problems, cardiovascular diseases, stroke, cancer etc., thus reflecting the high burden of MSD in the workplace (Mols et al. 2009).

Cancer is another condition dramatically affecting the labour force. Being diagnosed with cancer results in work changes related to the employment status and the work ability (Mols et al. 2009) and physical and psychological problems after returning to work (Tamminga et al. 2012). A cancer diagnosis often implies long and frequent sickness absence episodes in the workplace (C. Roelen et al. 2008).

Finally, mental disorders are highly prevalent among the working population. They produce frequent and/or long-term sick leave spells and result in a lower employment rate of workers diagnosed, compared with healthy people (OSHWiki 2018). Mental health is considered a priority challenge for the labour market as is the case with the mental health (OECD 2012).

## EU regulations and guidelines

Several EU regulations and guidelines draw a general framework for health and safety in the workplace. Thus, a number of sector specific regulations are proposed. among which – relevant for this project – are the ones for the healthcare sector (e.g. sharp injuries in hospitals) and industry (e.g. mineral-extracting, drilling and construction) (EU-OSHAa 2019). Moreover, sector-specific guidelines (non-binding) are proposed in the healthcare sector for occupational health and safety risks and also for sharp injuries, and in the construction sector for implementing the minimum of safety and health requirements (EU-OSHAb 2019). Besides this, the European Commission is raising awareness about some conditions/ diseases, by considering them as priorities. For example, fighting occupational cancer is a key action in the EU Strategic Framework on Health and Safety at Work 2014-2020 (European Commission 2018). Additionally, an initiative for recognising and managing stress and psychosocial risks at work was implemented in 2014-2015 (EU-OSHA 2013).

As part of supporting the ageing workforce, the European Commission through the EU-OSHA is dedicated to facilitating the RTW after long-term sickness. Two extensive reports synthetise the state-of-the-art, the initiatives and policies of EU member states for MSD (EU-OSHA 2007) and for rehabilitation and return to work in general (Belin et al. 2016).

## Concept of return to work

RTW refers to procedures and initiatives aimed at facilitating the workplace reintegration of persons who experience a reduction in work capacity or capability, whether this is due to invalidity, illness or ageing (International Social Security Association 2012). Return to work must be understood as a complex process, unfolding in time, with many stakeholders and factors shaping it, a process engrained in many societal levels. Due to its complexity, a rich literature was devoted to understand the role of the actors involved, the relationship between them and the mechanisms of return to work. Return to work is not only a fascinating concept to study, but a real and an indispensable solution to extend the working lives of people, thus providing the workforce for the labour market and alleviating the burden on the social security systems.

Resuming work after a chronic illness which caused a long-term absence from work is not simple and straightforward, but rather a process marked by barriers of different nature. Different countries have significantly diverse rates of RTW, pointing to the idea that many factors, including policies, influence sustainable RTW. Thus, in the case of sickness absence for back pain, the RTW rate at two years of follow-up is 22% in Germany and 62% in Netherlands (Anema et al. 2009), whilst in case of cancer 60% to 90% of cancer survivors return to work after a sickness absence of up to 2 years (Roelen et al. 2011; Tiedtke et al. 2015). The importance of work interventions, which are usually made compulsory through policies, shows that RTW after disability or illness is rather a socio-political problem and less a medical one (Hansson and Hansson 2000; Anema et al. 2009). The policies have a crucial role in planning the actions required and drawing the directions for the key stakeholders to follow a successful return to work process. This section will examine the policies for RTW after chronic illness at EU level. An additional aim is to focus on the policies of six countries (Belgium, Estonia, Ireland, Italy, Romania and Slovakia) in order to evaluate the diversity in the responses given to the challenge of reintegrating the workers recovering after chronic illness back into the labour market.

An EU-OSHA comprehensive report (EU-OSHA 2018) was dedicated to summarising the situation regarding the policies for RTW in the EU countries. After an in-depth analysis based on several criteria, a classification with four categories is proposed (summarised in Table 1). This report and classification will inform the present paper as a foundation for undertaking the literature review. The four categories of countries differ not only with regards to their systems of RTW, but also in relation to the amount of research that has been done in this respect. A very rich literature exists mostly for the first, but also for the second group, whilst the RTW literature is scarce for the third group and almost non-existing for the fourth one.

The **first group** of countries (**Austria, Denmark, Finland, Germany, the Netherlands, Norway** and **Sweden**) has a comprehensive approach on RTW, oriented towards inclusiveness, i.e. all workers are entitled to rehabilitation, early intervention and progressive and planned RTW. Countries in this group illustrate most extensively the seven principles of RTW developed by the Institute for Work and Health (IWH) in their practice (Institute for Work and Health 2014).

One key feature of this category is the focus on prevention and early intervention. The literature shows the importance of considering RTW for chronic pain as a treatment objective to be accomplished as early as possible (Hamer et al. 2013; Sullivan and Hyman 2014). Early intervention including early diagnosis and referral, but also workplace adjustments, is a key feature for work reintegration in the case of musculoskeletal disorders (Bevan 2013). In almost all countries in this group, the RTW process starts early, from one to three months after the start of the sickness absence (Belin et al. 2016; International Social Security Association 2002).

Once the sickness absence begins, several mechanisms are put in place: offering job protection, gradual and planned RTW, the employer’s responsibility, providing incentives for RTW and assuring coordination between the actors. The principle behind these mechanisms is the multidisciplinary intervention, i.e. the involvement of professionals from multiple disciplines, which has been shown to support RTW in both physical and psychological disorders (Hoefsmit, Houkes and Nijhuis 2012).

Table 1. Summary of the four categories of countries regarding policies for RTW and rehabilitation after chronic conditions

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| **Groups of countries**  **Countries in our study**  **Criteria** | **Group 1**  **(comprehensive approach)** | **Group 2**  **(step-wise approach) Belgium, Italy** | **Group 3**  **(ad hoc approach) Estonia, Ireland, Romania** | **Group 4**  **(limited approach) Slovakia** |
| Target groups for rehabilitation and RTW | Inclusiveness of the system targeting people with chronic/long-term condition but also people with disabilities and occupational injury or disease. All workers are targeted for reintegration and return to work process. | In theory, all workers are targeted for general reintegration procedures, but not all are targeted for supported RTW measures. Some interventions and benefits are conditioned by the dis-abled status or by having an occupational accident or disease. | Workers with disabilities and occupational conditions or injuries are the target groups. In some countries of the group the workers with chronic diseases are also included. | Only workers with disabilities (either occupational or not) are entitled for rehabilitation and RTW measures. |
| Actors involved | *Institutional actors:* Social insurance and social security institutions, local authorities, pension organisations, agencies for occupational diseases and accidents, employment services.  *Non-institutional actors:* employers | *Institutional actors:* National bodies for sickness and work accidents insurance, vocational rehabilitation bodies, invalidity insurance bodies or agencies.  *Non-institutional actors:* charities,foundations, employers. | *Institutional actors*: national agencies which assess the work ability and recommend rehabilitation and adaptations of the workplace. Internal or external occupational health services.  *Non-institutional actors*: employers, charities, foundations, workers. | *Institutional actors:* Social insurance and social security agencies, employment agencies, other organisations.  *Non-institutional actors*: employers, charities, foundations, workers. |
| Prevention of exclusion and early intervention | Occupational and safety health policies to strengthen prevention of exclusion. RTW and rehabilitation planned and implemented early. | The policies are oriented towards the prevention of exclusion, but not to early intervention. | The policies do not prescribe concrete measures towards the prevention of exclusion, although a generic legislation exists in some countries. No early intervention. | The policies are oriented neither towards the prevention of exclusion nor to early intervention. |
| Programmes for RTW | Such programmes exist | Such programmes exist, usually delivered by statutory actors | No statutory programmes for RTW. | No statutory programmes for RTW. |
| Progressive and planned RTW | Gradual RTW with job training (“therapeutic” work resumption), based on a plan which is done by the employers in almost all countries in the group | Actors do not have the formal responsibility to plan RTW and to make sure the reintegration is done progressively. | Not planned or progressive RTW. RTW is achieved based on ad hoc measures, at the end of the sickness absence. | Not planned or progressive RTW. RTW depends on the employers’ willingness to re-accommodate the employee. |
| Employer’s responsibility | Broad responsibility. Employers are full partners in the RTW process, in all the stages, having prescribed formal responsibilities. | Employers are not obliged to reintegrate sick or injured workers. They collaborate in the process in most countries. | Obligation of the employers to follow the recommendations of the official bodies or specialists regarding work adaptations. No formal responsibility. | The disability and anti-discrimination law obliges employer to hire and to maintain in employment the workers with disabilities. No formal responsibilities exist for RTW. |
| Incentives for RTW | Broad variety of such incentives: part-time jobs, jobs with flexible arrangements etc. | Limited financial support to incentivise employers to adapt workplace and reintegrate employees. Incentives exist in some countries for workers to RTW early. | Financial support for employers to reintegrate employees with reduced work capacity (due to disability or occupational condition).  No incentives for the workers. | Financial incentives for employers to hire workers with disabilities and for people with disabilities for rehabilitation and re-training. |

Source: Authors’ adaptation and summarisation based on EU-OSHA Report (2018).

Regarding *job protection*, the Netherlands and Germany offer protection against dismissal for long fixed period (Loisel and Anema 2013). In Denmark and Sweden dismissal is allowed, but only for several categories of workers and under certain conditions (International Social Security Association 2002). The *RTW is done gradually* and following a plan which, in almost all countries in the group, is created by the employer (Tiedtke et al. 2017). The gradual RTW, for fewer hours a week and after a job training is known as “therapeutic” work resumption (International Social Security Association 2002). Achieving RTW in a planned way was established to be effective in conditions with physical complaints (Weiler et al. 2009; Hoefsmit, Houkes, and Nijhuis 2012).

*The employer* fully participates in the whole RTW process and has a broad responsibility in RTW which includes several tasks: the first visit to the worker for assessing the work capacity, finding the best support options and discussing the next steps; in all countries in the group except Austria, building individualised reintegration plans which, in Denmark, Norway and Sweden, are a condition for entering vocational rehabilitation; supporting RTW early by providing support regarding the work environment, the working hours or the work career of the employee (Belin et al. 2016). Another mechanism is *offering incentives* for workers to encourage them to resume work as early as possible, incentives which are usually part of the active labour market policies (OECD 2015). These incentives can take the form of part-time sickness benefits in Denmark, Finland, Norway and Sweden, working part-time while still receiving the benefits, or flexible work arrangements (Lindsay et al. 2015). Successful RTW is about providing proper policies and services as well as a*ssuring coordination between the actors* involved.Usually this is done by coordination bodies which exist in all countries in the group, except the Netherlands. These bodies can be social security organisations, insurance and pension organisations or local authorities. Not only do they provide a link between various fields (medical, work and social security) and various stakeholders, but they also offer integrated support, i.e. from one place, thus simplifying the effort for the workers. The most important step in this coordination is the link with the workplace and the employer for actual support for RTW (Belin et al. 2016).

Another key element is the case management approach which assures an intervention tailored to the worker’s needs. Research shows that case management interventions taken at the beginning of the sickness absence have a strong impact on RTW to the pre-illness employer (Høgelund and Holm 2006). Workplace intervention including case management with all stakeholders significantly reduces the time until RTW for lower back pain (Anema et al. 2007). Case management and individualised care are indispensable since research shows that providing generic interventions, i.e. for all workers irrespective of their disease and characteristics, proves to not be effective for RTW (Hoefsmit, Houkes, and Nijhuis 2012).

The **second group** of countries, including **Belgium, France, Iceland, Italy, Luxembourg, Switzerland** and **UK,** has a developed framework for RTW, but with limited coordination and early intervention (see Table 1).

Some of the key features of the previous group are not present in this cluster of countries. First, reintegration in the workplace is considered mostly at the end of the sickness absence period, which means that early intervention is not necessarily a focus, despite being highlighted as essential for cancer, adjustments disorders (mental health) and MSD (Hoefsmit, Houkes and Nijhuis 2012; Désiron et al. 2015). Second, the inclusiveness of the system is not as broad as in the first group. In policy, all workers may be part of rehabilitation and reintegration programs, yet in practice some conditionalities are present. Some initiatives, programmes or benefits are conditioned by the disability status, or by having an occupational disease or accident. Third, there is limited involvement of employers in the RTW process. However, employers in some countries (France, Luxembourg and Italy) manage the RTW process together with the occupational physicians; therefore, they have high responsibility in the process. Employers are involved in the process, yet their role does not prescribe detailed responsibilities in planning and assuring a progressive reintegration. Fourth, these countries do not have a coordinated approach between the stakeholders involved, which is a major challenge mostly for those with a long absence from work (Watson et al. 2004). The lack of coordination means that in almost all countries in this group, except for Iceland, the RTW process is not managed by a single institution or body. In compensation, in some countries platforms are available for integrating all the stakeholders involved, as for example in Belgium. Other technical support is also available, such as training courses for employers or services for workers. In most of these countries, there are statutory institutions delivering pilot or continuous programmes for vocational reintegration. Finally, the incentives for the employers and employees to return on the labour market are limited and conditioned. In some countries, incentives are offered to employers, but only for disabled workers.

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| **Belgium**  In the Belgian health care system, the primary focus has been on the treatment of acute diseases and on care in hospital settings until recently. However, in 2008 a national strategy for chronic diseases has been introduced. This national programme is called “Priority to chronic patients!” and is published by the Ministry of Public Health and Social Affairs in 2008. As summarised by Paulus, Van Den Heede, and Mertens (2012), the programme includes the main domains such as (i) information to the patient, (ii) measures to improve the accessibility to care for chronic patients, (iii) improved financial accessibility, transport, physiotherapy and so on, (iv) set-up of an observatory for chronic diseases within the National Institute for Health and Disability Insurance (NIHDI), and (v) integration of chronic patients in the society. The latter item includes elements such as a minimum wage for patients with a chronic disease and further help to go back to work.  There are also other initiatives for chronic care patients at the federal level stemming from the Federal Public Service Health, Food Chain Safety and Environment, Sickness Funds and National Institute for Health and Disability Insurance. A position paper published by the Belgian Health Care Knowledge Centre (KCE) authored by Paulus, Van Den Heede, and Mertens (2012) provides a comprehensive analysis of the benchmark national programme for chronic diseases and the other initiatives. Following this position paper and some other evaluation reports of the national programme and some initiatives, chronic diseases inter-cabinets workgroup developed an orientation note “An integrated vision on care for chronically ill in Belgium” and consequently a joint plan “Integrated Care for a better health” is developed and approved by the Federal and Federated Ministers of Public Health in 2015 (Devos 2019). The main objective of this plan is “to promote and develop an integrated and person-centred care system with a focus on people with a chronic disease” (Devos 2019).  Most of the aforementioned pilot programs of reintegration are run under the Integrated Care Plan action (approved in 2015) aiming to provide an integrated and holistic care approach to individuals with chronic diseases. These projects include the following components of integrated care (among others) as regards work reintegration: empowerment of the patient, socio-professional reintegration (i.e. return to work), prevention, and multidisciplinary guidelines.  In Belgium, the work incapacity consists of two periods: the primary incapacity for work and the period of invalidity. The employers initially pay a compensation (guaranteed salary) for a month during the sickness absence. Then the insurance takes over. Primary incapacity for work lasts maximum one year and starts at the beginning of the incapacity for work, during which period a worker is paid 60% of the salary from the insurance institution. The invalidity period starts after the primary incapacity for work (which lasts one year). This second phase depends on the evaluation of the invalidity by the Medical Invalidity Council of the NIHDI on the basis of a report by the advising physician of the insurance institution. The end period is also determined by the advising physician. A worker with dependents is entitled to an indemnity rate of 65% of the lost income.  On top of the national strategy on chronic diseases, there is a recently passed national legislation (Royal Decree of 28 October 2016) in Belgium that reintegrates people back to work. This is meant to gradually support workers with a disease of long duration to come back to work at their available capacity. The system is voluntary in nature, meaning that there is no obligation (nor sanctions to) by employers to push for the reintegration. This legislation provides a tailored reintegration route, accompanying the workers with long-term incapacity for work to suitable work or other work on a temporary or permanent basis. The initial focus is to continue the work with the own employer, allowing the worker to work in the environment that he/she is used to work and possibly has established relationships, which might increase the chances of successful reintegration. The occupational physician plays a key role during this process serving as an intermediary between the employer and the worker. The prevention counsellor/occupational physician is also part of the multidisciplinary team within the internal and external prevention department. The legislation foresees a collective framework of reintegration policy to be developed at the enterprise level. The success of the legislation is to be seen in the years to come with the availability of evaluation studies that are currently under way.  There is also an action plan called “Back to Work” initiated by NIHDI with the vision to develop a Disability Management across the country. This plan trains “Disability Managers”, whose training is coordinated by NIHDI and subsidised by the state. The objective is to train these disability managers in a multidisciplinary way so that they could support the RTW process at the company level (a local approach). These people might be existing human resources managers, who could receive such a training to be better equipped to provide support in RTW cases. |

The positive features of this category of countries are the significant role the occupational physician plays in the RTW process and the multitude of programmes of work reintegration offered by service providers, research centres and social partners. In France, Luxembourg, Italy and Belgium, the role of the occupational physician is prescribed in policy. This role consists of providing a work ability assessment after a long period of sickness absence, in working closely with the employer for reintegrating the worker and providing the suitable work adaptations. A bulk of literature shows how important the support for RTW offered by the occupational physicians is in case of cancer, and that this kind of support should be part of the structural interventions within the healthcare services (Désiron et al. 2015; Bains et al. 2012; Muijen et al. 2013). Yet, the current situation is that the occupational physician is not consulted during the sick leave period (Tiedtke et al. 2012). These countries implement a variety of work reintegration programmes such as the programme led by IDEWE (Belgium) of adapting the theoretical model of RTW for the Belgium context, the programmes of the Work Foundation in UK or the ones of the League Against Cancer in France (Belin et al. 2016).

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| **Italy**  Two national strategies are in place, one for chronic diseases and one for diabetes, both with few references on work and employment, which concerns the impact of certain conditions on the working life, raising co-workers awareness on emergency situations, productivity losses and social costs of absenteeism. Although chronic illnesses tend to be assimilated to disability, the country has some provisions which target or facilitates return to work at least indirectly: the provisions related to smart-working, i.e. the use of technology in work, which allows the possibility to work from anywhere. The most important ones are the opportunity to work part-time in the case of employees with cancer and other severe chronic conditions and the permission granted for workers with certified medical conditions to not work in night shifts. A host of provisions concern the employees with disabilities: thus, the formal support for RTW offered for workers with work-related disabilities, the right to have free days for treatment during the year, providing reasonable accommodation for disabled workers and the employers’ obligation to hire disabled people (Tiraboschi, 2015).  The sick leave period can be for a maximum of 18 months, with a compensation proportional to the normal wage, which progressively decreases from the 10th month to the 18th month of absence. The sick leave provisions are general, not specific to the chronic disease. Workers with disabilities (including those who acquired their disability through chronic illness) who have total and permanent work inability can apply for incapacity pension. There is also a provision of civil invalidity pension, which is general for people who are unable to work. Economic incentives are offered to the employers who hire disabled people. Several NGOs and research projects aim at protecting the rights of people with chronic illnesses, identifying their difficulties related to work and offering information (e.g. CnAMC, AIMAC, MaCro@Work). Also, some regional initiatives are available for people with disabilities such as employment services, programmes for facilitating the labour market participation. The law allows regional funds to be established for the employment of people with disabilities.  Provisions for chronic diseases can be found in collective bargaining, such as protection against dismissal and flexibility at work. |

The **third group** of countries, comprising **Bulgaria, Estonia, Hungary, Ireland, Lithuania, Portugal, Romania** and **Spain**, have an even less developed framework for RTW, with very limited or lack of coordination between stakeholders, but with ad hoc initiatives implemented by various actors. The countries in this group are also not so homogenous as the ones in the previous groups.

Three large categories are targeted for some type of rehabilitation services and RTW support: workers with disabilities, workers with occupational diseases and injuries and workers with chronic conditions. The situation differs from country to country, with some of them having a better situation than others. Thus, positive features similar to the best practices in the first two groups of countries can be found such as the obligation for the employer to adapt the workplace for employees with chronic conditions (Portugal), individualised rehabilitation plans including for those chronic sufferers (Estonia), or the financial incentives for employers to retain workers (Ireland) (Belin et al. 2016). At the same time, several deficiencies are present: offering alternative options for employers to the obligation of hiring disabled people and thus failing to reintegrate (Romania), or stating only the general principles for reintegration after chronic conditions and not the specific procedures, also in Romania (Popa and Popa 2019), or not having formal mechanism for employers to support RTW (Bulgaria, Spain, Lithuania and Hungary).

The support is offered either externally by a national agency or an occupational service or internally by the occupational physician. The first case is specific for Bulgaria, Spain, Lithuania and Hungary. The national agency recommends work adaptations or changing the job based on a work assessment of the employee’s ability to resume work. Recommendations are done also for vocational rehabilitation, which is also supported financially by the agency. The second case is found in Romania, Spain and Portugal, where the work assessment after long sickness absence is done by an occupational health service/physician (Belin et al. 2016).

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| **Estonia**  There are two national level policy documents that address chronic diseases and control of chronic diseases: (a) the Disease Prevention Development Plan 2016-2019[[1]](#footnote-1) and (b) the National Health Development Plan 2020-2030,[[2]](#footnote-2) which contains chronic diseases as a separate category. Chronic diseases are not addressed specifically but as a part of wider disease control plan. Aspects of employment, including return to work after chronic illness, are regulated by the Employment Contracts Act[[3]](#footnote-3), the Health Insurance Act[[4]](#footnote-4), and the Occupational Health and Safety Act[[5]](#footnote-5).  An important institution in the landscape of labour and health is Estonian Unemployment Insurance Fund (EUIF). Unemployment Insurance Fund implements significant aspects of labour market policy in Estonia and also offers a range of measures to employees who need support at workplace because of their health condition; the EUIF offers a range of measures on health-related issues also to employers. In an organisation, health and workplace related issues are addressed also by work environment commissioner.  There are no specific measures for RTW for workers with chronic illness. 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, the doctor will issue a certificate for sick leave to prove it. Based on this certificate, the employer and the Health Insurance Fund will pay to the person the benefit for temporary incapacity to work. The employee will not be compensated for the first three days of illness (this includes also quarantine, domestic or traffic injuries). The employer will pay the benefit from the fourth day of illness until the eighth day of illness. The Health Insurance Fund starts paying the benefit from the ninth day of disease. The sickness benefit is paid at the rate of 70% of daily income. The sickness benefit is subject to income tax. An insured person has the right to receive the sickness benefit for 182 consecutive calendar days and 240 consecutive days in case of tuberculosis. If necessary, a doctor may issue a certificate for sick leave for a longer time, but the person will not receive any benefit for that time.[[6]](#footnote-6) Although sickness benefit is paid for 182 consecutive days (six months) (240 days, eight months in the case of tuberculosis), employment protection lasts only for four months.  There are no obligations to hire or retain workers with chronic illnesses. The Estonian Unemployment Insurance Fund does support hiring people with reduced work capability; this group may include also people with chronic disease. The Fund offers both benefits and services to employers and employees in general. |

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| **Ireland**  In Ireland, the national strategy called the *Comprehensive Employment Strategy for People with Disabilities 2015-2024* is targeting both people with disabilities and long-term illnesses. The report *Make Work Pay* (2017), issued by the Ireland Government, provides specific recommendations for returning to work after chronic illness and disability. An important feature of Ireland’s legislation is that the paid or unpaid sickness leave is not provisioned in the national legislation, but in collective agreements and employment contracts. Thus, an employee can benefit from paid or unpaid sick leave after a chronic disease only if this is provided in the work contract with the employer, in the terms and conditions of employment, or in a collective agreement.  Although this feature can be considered a limitation, there are other accommodating provisions available for employees suffering from chronic illnesses who return to work, or for their employers. First, employees with long-term conditions can still receive a percentage of their Illness Benefit or Invalidity Pension while working, in case they apply for Partial Capacity Benefit. This scheme is voluntary and offered only for workers with moderate, severe, or profound restriction on their work capacity (not mild). Second, financial support is provided by the Department of Employment Affairs and Social Protection (DEASP) for employers who facilitate the RTW of employees with chronic disease. Thus, the private sector employers receive wage subsidies if they employ people with disabilities. Other examples are the types of support available under the Reasonable Accommodation Fund scheme, such as the Employee Retention Grant, Workplace Adaptation Grant, the Personal Reader Grant or the Disability Awareness Support Scheme. However, employers are allowed to end the employees’ contract if they are unable, unfit or incapacitated to fulfil the job they were hired for.  Regarding sick leave, as outlined above, there is no national legislation binding employers regarding the duration and the financial benefit offered. Therefore, a wide variety of situations are possible depending on the sector (public or private). Yet, employers must provide clear information or the duration and entitlement of the sick leave in collective agreements or terms of employment. In addition, all employees can apply for the Illness Benefit which is offered for a maximum of two years. If they cannot return to work after that period, they can apply for Invalidity Pension or Disability Allowance.  Other schemes are offered at the community level or by organisations other than the Government. The Community Employment Programme, the Rural Social Scheme or the Youth Employment Support Scheme, all for recipients of Disability Allowance, are such examples. Through the EmployAbility programme, dedicated job coach support as well as pre-employment and in-employment assistance is offered for jobseekers with a disability or long-term illness. Even more interesting, the Intreo Service provided by the DEASP represents a single point of contact for all jobseekers (including those with disabilities or long-term conditions), which gathers all employment and income supports available. A case officer is appointed for agreeing with the jobseeker a suitable personal progression plan and for accessing the full range of employment supports available. |

The **fourth group** of countries (**Czechia, Greece, Croatia, Cyprus, Latvia, Malta, Poland, Slovenia** and **Slovakia**) offer rehabilitation only for people with disability and return to work support in non-formalised and non-planned ways.

Rehabilitation support seems to be better than RTW support in these countries. People with disabilities are assisted in finding or maintaining a job and benefit from a range of rehabilitation services, both medical and vocational. Social security agencies (in Latvia and Slovakia), employment agencies (Czechia, Malta, Slovenia) or organisations (institutional or non-institutional) assess the work ability of the employees with disabilities and/or provide vocational rehabilitation. Some countries have a better situation than others; for example, in Slovenia employers have to provide vocational rehabilitation to all their workers who become disabled (Belin et al. 2016).

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| **Romania**  The Romanian Ministry of Health through the National Fund of Health Insurance is currently running many national health programmes, amongst which relevant for this project are The National Programme for Oncology, The National Programme for Cardiovascular diseases, The National Programmes for Diabetes and the National Programme for Mental Health. These programmes created the necessary legal framework for implementing crucial health measures, yet frequent difficulties hindered and sometimes blocked their implementation. For example, The National Programme for Oncology is dealing mostly with covering treatment for insured patients and some measures for early detection, but fails to address essential issues such as cancer surveillance and control, cancer research or cancer prevention. Work and survivorship are not mentioned in any way in this programme (Popa, 2017).  In relation to work and the labour market, Romania has policies for chronic illnesses and disabilities and also some cancer-specific provisions. Most of the Romanian legislation which is relevant for work regards people with disabilities. Chronically ill patients can obtain a disability certificate in some cases. The interdiction of discrimination based on disability, the concepts of “assisted employment”, “special medical surveillance” and “groups sensitive to risks” and the sheltered units and jobs are the provisions for workers with chronic illnesses and disabilities. Another provision requires that employers with more than 50 employees must hire employees with disabilities, as many as to be proportional with the number of employees.  The sick leave for employees with cancer, tuberculosis, schizophrenia and HIV/AIDS can be for a maximum of 12 months with the possibility to extend it to 18 months. The financial compensation is 100% of the previous salary. The invalidity pension is granted to workers who lost at least half of their work capacity from various causes, including neoplasms. Workers with cancer are entitled to an invalidity pension after 18 months of sick leave if they have not recovered and are not able to return to work. The invalidity pension is granted for a maximum of 5 years and is conditioned by the obligation of the beneficiaries to enrol in a physical rehabilitation program planned by an expert physician of social insurance.  In case of a conditional ability to work (diagnosed by the occupational physician), the policy binds the employer to offer work adjustments according to the worker’s capacity or, when not possible, to refer the employee to the local labour force agency to obtain a new job. The only work accommodation provisioned for workers with conditional ability to work is the part-time job. Other accommodations, such as flexible working hours, progressive return to work or providing work adaptations to fit the worker’s capacity, are not bound by law; they depend on the employers’ benevolence. If an employee is assessed as permanently unable to work, the employer has the obligation to offer another position in the same organisation, compatible with the work capacity, and if this is not possible, to refer the worker to the local labour force agency. After these two conditions have been met, the employer is allowed to fire the employee (Popa and Popa 2019).  The Romanian policies offer generous compensation (duration of sick leave and benefit) in case of disease, but there are almost no measures for activation, i.e. stimulating workers with conditional ability to work to return on the labour market. |

Compared to the other categories of countries, where a host of measures are employed by multiple actors with clear responsibilities, in this category most of the responsibility for RTW is placed on the employer, which is both overwhelming and difficult to manage. Two challenges follow from this situation. First, employers find themselves alone in this process, as they have no support from the state or other institutions. Apart from the financial support they receive for hiring workers with disabilities or maintaining them on the job, there is no network of support available to employers. Second, there are no formal and coordinated procedures for reintegrating employees back at work. When an employer is willing to help a worker accommodate at the job after disability or long sickness absence s/he will have to devise the best ways to accomplish this. Not having formal and planned procedures for RTW can allow for a certain degree of freedom in decision and choices and also permits to adapt the process to that particular organisation. However, on the negative side, as research in other countries with similar problems shows (Tiedtke et al. 2013), the lack of formal guidelines is paired with a lack of knowledge and resources, creating dilemmas and uncertainty for employers. Moreover, not having a formal structure allows the RTW process to be affected by organisational factors, as well as employer and employee factors.

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| **Slovakia**  The key document coordinating the public health efforts in Slovakia is the National Health Promotion Program. Several prevention programmes ran in the last years, such as Slovakia Circulatory Diseases Prevention Program, the Cancer Prevention Program, or the National Program on Mental Health (Kapalla, Kapallová, and Turecký 2010). Similar to other Eastern European countries, no unitary strategy exists for return to work after chronic diseases or disabilities, but rather a series of legislative measures which seem to be only partially coordinated. Almost all these measures address the needs of people with disabilities and one also applies for workers with occupational diseases or injured at work. Several types of allowances are used for incentivising the work (re-)integration of people with disabilities: allowance for keeping employees with disabilities at work, allowance for self-employed disabled workers, allowance for having a work assistance. Other measures regard the social enterprises, sheltered workshop and workplaces or the benefit for the injured workers and sufferers of occupational diseases.  The sick leave can be for a maximum of one year, with the first ten days payed by the employer and the rest by the Social Insurance Agency. The employee is protected from dismissal during the sick leave. People with disabilities can apply for disability pension which can be received even if the person is working. A disabled employee can be dismissed by the employer only with the prior consent of the competent Labour Office.  A measure to stimulate work integration of people with disabilities is the obligation of employers in companies with more than 20 employees to have 3.2% people with disabilities of the total number of workers. Yet, employers can avoid this obligation by paying a tax, which is more convenient for most of them.  Other initiatives for RTW of workers with chronic diseases are included for example in the Supported Wage System, which is a tool to engage people with serious forms of disability in the open labour market. Also, scattered initiatives of integration of people with chronic disease can be found at company level, but there is no coordinated policy measure at regional or local level. Comparable with other countries in this region of Europe, a coordinated and unitary approach for RTW is lacking. There is a strong need for a strategy which is enforced at the national level and involves all relevant stakeholders. |

# Industrial relations systems and their interaction with diverse policy frameworks on return to work across the EU

EU member states not only differ in their policy frameworks for RTW, but also in their industrial relations systems. Existing literature maintains that industrial relations arrangements in most Western European states have historically rested on at least one of **four institutional pillars**: strong or reasonably established social partners (in particular, trade unions); negotiated wage setting via sectoral or higher-level collective bargaining; a fairly generalised arrangement of information, consultation, and even co-determination at the company level; and institutionalised or routinised practice of tripartite policy making and involvement of social partners in tripartite policy arrangements (European Commission, 2008; Streeck, 1992; Traxler, 2002; Visser, 2006). Although the diversity of industrial relations systems has further increased after each EU enlargement, these pillars are still valid to embrace indicators of differences in social partners’ structures, institutional resources, access to policy making and the practice of collective bargaining.

Understanding differences in industrial relations systems is important for the purpose of the REWIR project, because different national industrial relations systems have different priorities and mechanisms that can enable (or hinder) the efficient application and creation of new policies, including RTW policies. In other words, particular country traditions and modes of interaction between industrial relations actors are a crucial factor for analysing the (potential) role of industrial relations for facilitating RTW.

Based on institutional and structural indicators of industrial relations along the above pillars, Bechter et al. (2012) and Eurofound (2018) distinguish between **several industrial relations systems** in the EU: **Nordic organised corporatism**, **Western liberal pluralism**, **Southern state-centred industrial relations system**, **Central-Western social partnership** and a **mixed Central-Eastern European (CEE) system**. We use this clustering for analysing the opportunities and practices for social partners to help facilitating RTW via policy access at the national level as well as the actual RTW experience for individuals at the company level. The only difference we introduce to the above clustering is replacing the mixed CEE cluster from Bechter et al. (2012) with a more detailed categorisation by Bohle and Greskovits (2012). In total, a combination of both categorisations yields six country clusters of industrial relations systems as summarised in Table 2. More justification on the selected countries for the REWIR project and expectations regarding these countries’ RTW approaches are included in Section 6.1.

Table 2. Country clusters and industrial relations systems across EU

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| --- | --- | --- | --- | --- | --- | --- |
| **National industrial relations systems** | **Organised corporatism (Nordic)** | **Liberal pluralism (West)** | **State-centred (Southern)** | **Social partnership (Central-West)** | **Embedded neoliberal (Central-East)** | **Neoliberal**  **(North-East, South-East)** |
| **Countries** | DK, FI,  SE | CY, IE,  MT, UK | ES, FR, GR,  IT, PT | AT, BE, DE,  LU, NL, SI | CZ, HR, HU,  PL, SK | BG, EE, LV,  LT RO |

Source: Authors’ classification based on Bechter et al. (2012), Eurofound (2018), Bohle and Greskovits (2012), European Commission (2009: 49-50).

# Analytical framework

The analytical framework underpinning the study of how industrial relations actors (may) facilitate RTW policy formation at the EU and national levels and its implementation at the workplace across various countries is based on the framework of **actor-centred institutionalism** (Scharpf 1997). In this framework, the baseline is that 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). In the context of REWIR, this means focusing on understanding the rational action of trade unions and employers in facilitating and contributing to RTW practice through negotiated interactions with each other and with other relevant stakeholders in given institutional contexts of RTW policy frameworks and country-specific industrial relations systems. By adopting an actor-oriented perspective, REWIR, therefore, puts industrial relations actors and their perceptions, experiences and interactions with other relevant stakeholders in given institutional (industrial relations) and RTW policy contexts at the core of the project.

The operationalisation of this framework for the purpose of the REWIR project embraces the following steps, as shown in Figure 1. After identifying the ‘problem’, in this case facilitation of RTW policies and practice, we define which actors are relevant in our analysis, what their strategies towards the ‘problem’ are, how their interactions with other actors evolve regarding the ‘problem’, and finally whether they contribute to solving the ‘problem’, which in our case is facilitation of RTW policies and practices.

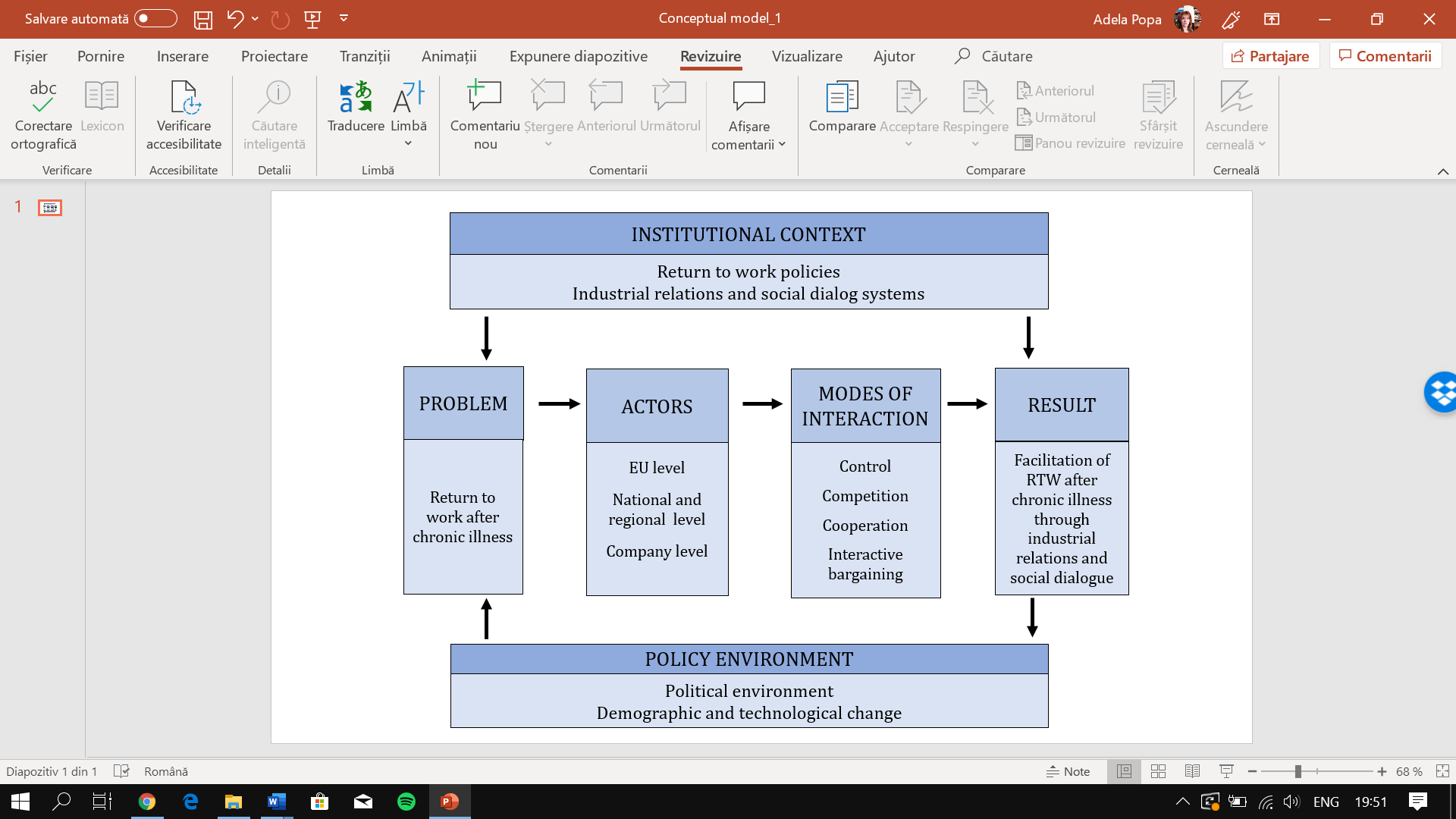
## Institutional context

The first step in our approach is identifying the institutional context in which actors operate. This context embraces the EU-level and national-level RTW policy framework as well as national specificities of industrial relations. Both contextual variables have been described in Sections 3 and 4 of this study. The institutional context on RTW policies at the EU-level context and the national context embraces

* Policies and regulations on RTW after chronic illness
* Policies/legislation on sickness absence and/or disability
* Recommendations for RTW, work reintegration, work retention.

The institutional context for industrial relations and social dialogue embraces the different roles of social partners, their access to policy making and practices of interaction, collective bargaining and information, consultation and co-determination of rights at company level (see Section 4). In addition, these policy frameworks are part of a broader political and policy environment responding to demographic and technological change differently across different EU member states.

Figure 1. Analytical framework – actors, their strategies and modes of interaction in given RTW policy contexts and characteristics of industrial relations systems



## Relevant actors

While our core focus is on the role of social partners – trade unions and employers’ associations (EU and national level) and trade unions and/or employee representatives and employers (company level), it is important to identify all relevant individual and corporate stakeholders which are actually involved in the policy process and whose choices will inform the strategies and actions of unions and employers and thus ultimately shape the outcome (c.f. Scharpf 1997: 43). Table 3 lists the relevant actors for our study.

Existing literature points at various resources that inform the strategies of actions of unions, employers and other actors. Institutional resources refer to support for particular action through relevant legislation and social compromises agreed upon in the past, such as policy influence through participation in tripartite social dialogue (Levesque and Murray 2002). A strong underpinning of actors’ strategies via institutional resources equips them with higher bargaining

Table 3. Actors in our study

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| EU level | European Commission  Official regulatory bodies (EU-OSHA and others if relevant)  EU-level social partners, cross-sectoral/Sectoral social dialogue committees |
| National and regional level | Governments  Ministries  Trade unions at national/sectoral/regional level (whichever relevant for particular countries)  Employers’ organisations at national/sectoral/regional levels (whichever relevant for particular countries)  Patients organisations  Health providers – only at aggregate level, e.g. chamber of doctors  Labour force agencies (public/private), case workers  Social security authorities/insurance companies (public/private, country-specific)  NGOs – any organization that has a role for facilitating RTW and chance of interaction with other actors, most importantly trade unions and employers |
| Company level | Employers (through a web-based survey among managers in 6 countries and through focus group interviews)  Company-level trade unions  Workers (only through a web-based workers’ survey in 6 countries)  Works councils, workers’ committees, European works councils (for multinationals only and if relevant in specific countries and survey responses) |

power and thus a greater potential for policy influence if they decide to act on RTW policies. *Structural resources* derive from the workforce’s strategic position in the labour market (ibid.). In tight labour markets facing labour shortages, unions and employers may be more prone to seizing opportunities to raise employment through implementation of RTW policies while agreeing on granting adjusted working conditions to people with chronic diseases. Finally, actors can utilise their *organisational resources*, including leadership, legitimacy and organising capacity (Hunt et al. 1994; Hyman 1997; Hyman 2010; Ost 2009; Visser 1995). Leadership refers to an organisation’s ability to provide a vision, define goals and engage in action (Ost 2009; Visser 1995). Identity helps shaping perceptions of opportunities and risks from greater involvement in RTW policy and practice and make choices regarding RTW in relations to these (Hunt et al. 1994; Hyman 2010). Legitimacy refers to externally perceived compatibility of actors’ interests with the interests of those they represent and the general public (Hyman 1997). In the original actor-centred institutionalist framework, Scharpf (1997) refers to actors being equipped with certain *capabilities* and *orientations*. *Capabilities (or abilities)* are all action resources that allow an actor to influence an outcome in certain respects and to a certain degree (social capital, money, influence, political power etc.). *Orientations* are perceptions and preferences which are relatively stable towards a particular problem. For our understanding, capabilities and orientations are part of organisational resources that inform actors’ choices, strategies and actions.

## Mode of actors’ interaction

Drawing on the above resources in given institutional contexts, it is then the actors’ strategies and mutual interactions between actors that account for particular outcomes i.e., in terms of facilitating the creation and implementation of RTW policies at the European and national levels, and in terms of facilitating RTW practices at the company level. Since these strategy formations and actors’ interactions evolve in diverse RTW policy frameworks (see Section 3) and diverse industrial relations systems (see Section 4), we expect to find differences in how actors approach RTW policy and practice, how they interact about RTW with other actors, and how they actually facilitate or remain outside of RTW practice implementation at company level.

To capture various forms of interaction between actors in facilitating RTW, we distinguish between the following modes of interaction (Akgüç et al. 2019):

**Interaction in form of control** refers to economic or legal power of an actor to make decisions and impose these on others (Netherlands Bureau for Economic Policy Analysis 1997: 57). In this case, unions and employers actions would be subordinated to political decisions of other actors in RTW policy making. This implies a high degree of power asymmetry towards decision making bodies. Control may apply also at an employer-driven RTW agenda at the company level, where weak trade unions lack organisational, structural and institutional resources to influence the employers’ agenda and, therefore, are subordinated to the employer discretion over facilitating RTW practices.

The second mode of actors’ interaction is **competition**, referring to rivalry between actors that strive for resources that not all can obtain (Netherlands Bureau for Economic Policy Analysis 1997: 56). Competition is commonly found between the actors at the same hierarchical level, or among those not being dependent on each other (Akgüç et al. 2019). This situation is thus also relevant for social partners at the EU and national levels, e.g. when one EU-level social partner organisation strives to reach an agreement regarding RTW policies while another EU-level social partner with equal powers is opposing it. While this form of social interaction might result in identification of the most efficient outcome, however, actors may lack a rationale to implement it. The actual intention to influence some issues will then depend on other power resources such as social capital (in form of lobbying), financial resources (organising campaigns in media) or organisational resources (ability to protest) (ibid.).

**Cooperation** based on shared values is the third mode of interaction between actors. Cooperation develops on the basis of a congruent set of preferences between involved actors (Netherlands Bureau for Economic Policy Analysis 1997: 57). In this case actors share interests regarding RTW policies and practice and are able to identify a common agenda and pursue its implementation unless a more powerful actor is blocking it due to institutional rules.

Finally, interaction in form of **interactive bargaining** expects consultation between actors with different interests (Netherlands Bureau for Economic Policy Analysis 1997: 58). At the EU level, it would mean a constructive social dialogue among employers’ representatives and trade unions, or between unions, employers’ organisations and the European Commission and other EU-level agencies with a key role in RTW (such as EU-OSHA). This form of interaction decreases power asymmetry between the actors, or these power asymmetries even become irrelevant. In contrast to competition, this form of interaction results in an agreement with commitment to effectively implement it. Such implementation may occur e.g. at company level via adopting a company-specific code of conduct on RTW, or embracing RTW provisions in company collective agreements. Given the shared commitment of unions and employers to implement these provisions, no external enforcement is needed.

## Result

The final step in our analytical framework is identifying the result of actors’ strategic decisions and their mode of interaction in a given institutional and policy environment. We will evaluate to what extent actors’ interactions result in facilitating RTW through (a) improvement of RTW policies via policy access at the EU-level and national levels, and through (b) improvement of implementation of these policies and thus improving the RTW practice at the company level across six countries.

# Methodological framework

The methodological framework of the REWIR project embraces both all-European and country-specific case evidence, evidence across sectors and occupations, and across different levels of industrial relations.

## Country case studies

As far as the selected EU member states from the REWIR project are concerned, in our sample, **Ireland** represents a **liberal pluralist**, or Anglophone, industrial relations system, with a voluntarist approach of social partners and little state intervention (after recent changes in the Irish system following the economic crisis). The **Southern industrial relations system cluster** is represented by **Italy**. Rather than state-dominated, industrial relations in Italy emerge as characterised by an abstention of law and a high level of voluntarism, giving rise to phenomena such as union pluralism, multiplication of collective agreements, and a lack of collective bargaining governability (Leonardi 2017, Leonardi et al. 2017).

Belgium brings the **negotiated social partnership system** perspective where the state tends to formulate and implement policies in close cooperation with certain ‘privileged’ societal actors. A CEE n**eoliberal industrial relations system** ischaracterised by weakly established or enforced tripartite institutions. In our sample, **Romania** enjoys a strong labour movement, but recently witnessed a state-led bargaining decentralisation, while the **Estonian** labour movement is weak and fragmented and bargaining is limited to the company level, if existing at all. Finally, countries within an **embedded neoliberal industrial relations system**, including **Slovakia** in our sample, have a strongly entrenched tripartism and formally granted access of social partners to national policy making, while experiencing plummeting union density, decentralization of collective bargaining and a weak bargaining coverage.

On top of these six member states, for which REWIR will produce detailed country case studies with various data collection activities, the project will also produce benchmark case studies for **France**, the **Netherlands** and the **UK**. Thus, all in all, this country selection offers a balanced sample of large and small member states, located in various geographical areas of the EU. Especially for CEE countries, there is little in-depth knowledge on particular industrial relations practices in relation to occupational health. In addition to industrial relations diversity, the selection of countries according to RTW policy frameworks and industrial relations systems yields an interesting selection of cases that aim to capture the European diversity along both dimensions of RTW policies and industrial relations systems (see Table 4).

Table 4. Justification of country selection

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Industrial relations system** | **Frameworks for return to work policies and systems** | | | |
| Inclusive system, effective policy coordination | Developed policies but limited policy coordination | Limited institutional support and ad hoc policy initiatives | Generally limited return to work framework for promoting labour market access |
| **Liberal/Anglo-Saxon/Anglophone** |  | (UK) | Ireland |  |
| **Southern** |  | Italy  (France) |  |  |
| **Negotiated social partnership** | (Netherlands) | Belgium |  |  |
| **CEE neoliberal** |  |  | Estonia, Romania |  |
| **CEE embedded neoliberal** |  |  |  | Slovakia |

Source: Authors’ elaboration based on the RTW policy frameworks (Section 3) and industrial relations systems (Section 4).

Table 4 shows a justification of the country scope of our research. From the country cluster with developed RTW policies but limited policy coordination, our research covers **Italy** with an industrial relations system with high level of voluntarism and abstention of the legal rule, and **Belgium** with a negotiated social partnership industrial relations system. Based on these two factors, in **Italy** due to the high degree of voluntarism and the traditional confrontational approach to industrial relations, we expect a lack of coordination among the practices initiated by social partners and the difficulty to engage all actors (employers, trade union organisations, patient organisations, NGOs, etc.) in joint projects. Given the scant diffusion of company-level collective bargaining, still limited to large companies in industrial sectors, we would expect to detect collectively-shaped RTW policies predominantly in these contexts: moreover, these companies should also have more organisational and economic capacities than SMEs to adopt adjustments to working time and workplace that favour RTW. As legislation does not expressly promote the role of collective bargaining in RTW policies, we expect that good collectively-agreed experiences at company level could be made possible by the commitment of individual employers and workers’ representatives. Union pluralism and the large number of National Collective Labour Agreements (NCLAs) also suggest the possible multiplication of uncoordinated initiatives across sectors and territories. Given the fragmentation of legislative and contractual provisions in this field, we should also expect social partners particularly involved in awareness-raising campaigns and consultancy services targeted to workers, their workplace-level representatives and employers. Finally, due to the irregular involvement of social partners in public policy formation, we should expect social partners scantly involved in public policy making and more engaged in public policy implementation, collective bargaining and lobbying activities.

In contrast, in **Belgium**, due to greater embeddedness of negotiations and social partnership, we expect more coordination among industrial relations actors in facilitating RTW, and a greater alignment between national-level RTW policies and activities of trade unions, works councils and employers at the company level for facilitating RTW. The country cluster with limited institutional support and ad hoc RTW policy initiatives is represented in our sample by **Ireland** with a decentralised, liberal industrial relations system, and **Estonia** and **Romania** with CEE neoliberal decentralised industrial relations systems. In **Ireland,** we expect to find less national-level influence of coordinated industrial relations impact on RTW policies. At the company level, in Ireland we expect to find positive examples of negotiated RTW with involvement of industrial relations actors, but lack of coordination of such initiatives across companies, sectors, or regions. In contrast, in **Estonia** we expect lack of atomised company-level negotiated initiatives by unions, other employee representatives and employers due to low union density and priorities of employee representatives around fundamental issues of membership gain and improved legitimacy (Kall and Samaluk 2019). In **Romania**, we expect a revival of company-level initiatives of trade unions after a state-centred attack on the coordinated system of collective bargaining (Trif 2013). The abolition of the national collective bargaining, through the reform of social dialogue legislation in 2011, brought severe barriers to how trade unions were formed and functioned. As a result, collective bargaining coverage declined from 100% in 2010 to approximately 35% several years after (Stoiciu 2016), being among the lowest within the European countries (Visser et al. 2017). Thus, the responsibility for bargaining moved to the company-level actors. So far, the expectations that employers and employee representatives will take over bargaining in an effective way at the company level, including on aspects such as RTW facilitation, were generally not met. Therefore, there is little influence of trade unions at company level on health and RTW issues. Where this exists, it is done on ad hoc and case-to-case bases. We expect little policy influence of industrial relations actors at the national level given the general situation of national-level industrial relations including its slow remaking after 2015 (ibid). Finally, the country cluster with a generally limited RTW policy framework for promoting labour market access of people with chronic health conditions is in our sample represented by **Slovakia**, a country with an embedded neoliberal industrial relations system. In **Slovakia**, social partners enjoy reasonable access to policy making via a functioning tripartite concertation (Kahancova et. al. 2019). In some sectors, sectoral social dialogue and collective bargaining is also vital and regularly taking place, but it addresses more fundamental issues of working conditions; therefore, we do not expect a significant involvement of sectoral social partners in facilitating RTW. At the national level, the impact of policy influence is decent, however, since Slovakia belongs to countries with limited RTW policy frameworks we expect a lack of opportunities for social partner involvement due to a general lack of attention of policymakers to the RTW issue. At the company level, similar to countries with decentralised neoliberal industrial relations systems, we expect to find scattered evidence of some companies where industrial relations could have a potential for facilitating individual RTW practices. The actual evidence on such cases depends on particular initiatives of individual persons and their prioritisation of RTW among other negotiated company-level issues.

## Sectors

Within REWIR’s analytical framework and as part of data collection and analysis in the next stages of the research and to keep a focused approach, we keep in mind the diversity of the sectors (and specific occupations) to include in the country case studies. We consider the following criteria to help us select the occupations and sectors within REWIR research: (i) the strength and relevance of industrial relations and social dialogue, (ii) the prevalence of chronic diseases, (iii) possible labour shortages implying the relevance of RTW in these sectors. Taking into account these dimensions, we propose to include the following occupations and corresponding sectors covering actors both from white collar and blue collar segments:

* Education – teachers (white collar)
* Health – nurses (white collar)
* Clerical workers (white collar)
* Machinery/car/electronics industry (blue collar)
* Construction (blue collar)
* Transportation (blue collar)

## Data collection

The REWIR project is based on a multitude of data collection methods, combining survey methodology, qualitative face-to-face interviews, desk research, stakeholder group discussions and roundtable discussions. The data collection is fundamentally divided along the following lines:

* Data collection covering all EU member states vs. country-specific data collection,
* Qualitative vs. quantitative data collection.

In addition, data will be collected for benchmark case studies covering France, the Netherlands, and the UK. The purpose of these case studies is to expand our sample, by adding countries that have a significant impact on the EU-level policy agenda, diverse industrial relations systems and developed institutionalised return to work frameworks, and investigate where EU-level policy preferences in return to work originate from, and how they influence social partners’ attitudes. Data will be collected via desk research.

### EU-wide survey

At the national level, the REWIR team will implement an EU-wide survey among national-level social partners, in order to study the approaches to and experiences of national employers’ associations and trade unions in shaping and implementing EU-level and country specific policies aiming to facilitate return to work. The target is to obtain responses from at least 5 most relevant national-level social partner organisation from each EU member state.

### Interviews with European level stakeholders

At the EU level, the REWIR research team will conduct 15 interviews with employers’ representatives and trade union representatives in European social dialogue committees (ESD) and European sectoral social dialogue committees (ESSD) on the actual and perceived role of social dialogue in shaping return to work policies. We will also conduct interviews with other key stakeholders from international organisations (or agencies), academia, patients’ organisations, and NGOs.

### Interviews with national stakeholders

25-30 Interviews in total with governments and other relevant national-level stakeholders will be conducted to supplement the EU-wide survey. The expected number is 5-6 interviews per country that are covered as part of REWIR project. Respondents include government representatives, patients’ organisations, employment offices, social security authorities, NGOs and charities that participate in shaping and/or implementing return to work policies.

### Survey of companies

The survey at company level serves the purpose to analyse how company-level industrial relations (can) facilitate return to work, and whether the attitudes, priorities and experiences of social partners on return to work issues differ across various levels of study. The survey is online, distributed via the REWIR research partners in the respective countries. The aim is to collect at least 60 responses per country. In addition, stakeholder group discussions organised in each of the six countries inform the design of this survey and/or validate the results, depending on when these are organised in each country. Each partner will conduct one group discussion with selected employers and one with selected company-level trade union representatives (6-8 representatives from companies with developed company-level bargaining). The aim of these discussions is to identify topics relevant for employers and unions in maintaining employment through return to work policies.

### Survey of workers

This is a web-based survey among individual workers to collect evidence on the perceptions of individual workers returning to work after long-term illness. The web survey is distributed through the national WageIndicator websites (by associated organisation WageIndicator Foundation). Target is at least 50 responses per country. The survey is advertised using search engine optimisation, but also via promotion and dissemination activities of the REWIR research team in each of the covered countries.

## National reports and templates

The six national reports, which will be produced within the REWIR project, will use the same structure, in order to allow their comparability:

**1 Introduction (incl. methodology)**

Summarise the country’s key characteristics in terms of employment, registered incidence of chronic illnesses (if data available), research questions and scope. Suggestion of existing public data data to be used in reports: e.g. OECD public spending on incapacity; incidence of chronic diseases, share of employment for above 64 years old, health and long-term care expenditure (OECD) compared to OECD average etc.

List also the **sources of data collected as part of REWIR project** for analysis in this report: Workers’ survey in the particular country, Company managers’ survey in the particular country, stakeholders’ survey in the particular country, interviews with relevant national stakeholders (mostly policy makers and organizations not covered in the social partners’ survey), roundtable discussion with key stakeholders, group discussions with employers and trade unions, media and other relevant sources.

**2 The policy framework on return to work in the particular country**

🡪 based on desk research and info emerged through all types of data collection

Complete this table (same as for benchmark case studies)

|  |  |
| --- | --- |
|  | Country |
| Eligibility |  |
| Duration |  |
| Source of Payment |  |
| Level of Benefits |  |
| Timing of RTW Considerations |  |
| Procedure to return to work |  |
| Type of source for these provisions (e.g. law (dedicated or general), collective agreement, other) |  |
| Any other aspect relevant for the country |  |

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

🡪 based on interviews with stakeholders, roundtables and stakeholders group discussions (if relevant) + insights from the stakeholders survey (if relevant)

3.1 Actors and stakeholders in RTW policy

3.2 Views and level of involvement of industrial relations actors (trade unions, employers and employers’ associations, representatives of the government that normally engage in social dialogue, e.g. the Ministry of Labour) in RTW policy

3.3 The nature of interactions between industrial relations actors and other stakeholders in RTW policy

3.4 Outcomes of social dialogue with regard to RTW policy (covering national and if relevant sectoral/regional social dialogue)

3.5 Views on future potential for action on RTW and the contribution of industrial relations actors

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

🡪 based on workers survey and company manager survey + stakeholder group discussions (if relevant) + interviews (if relevant)

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

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

4.3 Interactions between employer and employee in facilitating return to work

4.3 Role of national-level social dialogue and industrial relations at company level in implementing return to work at company level

4.4 Experience with and good practices in facilitating return to work at company level

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

**5 Conclusions**

🡪 summarise the main findings from all sources of data collection

🡪 answer the research questions specified in the analytical framework with respect to the country studied

🡪 draw lessons from these findings for (a) policy implications, (b) action that needs attention at the EU level, (c) relevant aspects for a comparative cross-country study, (d) relevant theoretical/conceptual considerations, based on the country-specific findings, for analysing RTW in academic literature

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# Annex – Survey questionnaires and Interview Guides for data collection

The English master version of all questionnaires are available in a separate document (Deliverable: D1.2):

* Workers’ survey – Masterfile in English language
* Managers’ survey – Masterfile in English language
* Stakeholder survey – Masterfile in English language

Guides for interviews at the national and at the European level are available separate document (Deliverable: D1.2).

1. <https://www.haigekassa.ee/sites/default/files/uuringud_aruanded/ennetuse-arengukava_2016-2019.pdf> [↑](#footnote-ref-1)
2. <https://www.valitsus.ee/sites/default/files/content-editors/arengukavad/rahvastiku_tervise_arengukava_2020-2030_koostamise_ettepanek.pdf> [↑](#footnote-ref-2)
3. <https://www.riigiteataja.ee/en/eli/509052019005/consolide> [↑](#footnote-ref-3)
4. <https://www.riigiteataja.ee/en/eli/523052019005/consolide> [↑](#footnote-ref-4)
5. <https://www.riigiteataja.ee/en/eli/ee/527052014007/consolide/current> [↑](#footnote-ref-5)
6. Estonian Health Insurance Fund, <https://www.haigekassa.ee/en/people/benefits/sickness-benefit>, visited 30.10.2019. [↑](#footnote-ref-6)