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Shaping return to work policy: the role of industrial relations at national and company level

Country report for Estonia

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

Estonia is a post-socialist country with a population of 1.3 million.

Employment

The duration of working life in Estonia is among the longest in the EU: in 2019, it was 39 years while the EU-28 average was 36.4 years.[1] The number of employed people aged 15-74 has been increasing over time, from 568,000 in 2010 to 671,000 in 2019[2] (an increase of 18%) despite the population staying at 1.3 million.[3] The share of 65-74-year-olds among the working population has been between 3% (2010) and 6% (2019). In absolute numbers, it has varied from 19,800 in 2010 to 37,200 in 2019.[4] The share of 65-74-year-olds in the total population has remained roughly the same, at 10%.[5] The number of elderly workers has almost doubled and in percentage terms increased from 15% to 27%.

Health

In 2016, the self-rated health condition of the Estonian population was relatively poor, as health was assessed as good or very good by 53% of the population against 68% of the EU-28 average.[6] In 2018, the number of healthy years at birth in Estonia was 53.9, which was the second lowest figure among EU countries and 10 years below the EU-28 average of 63.9 years.[7] Life expectancy at birth in 2018 was 78 years in Estonia and 81 years in the EU.[8] Hence, the number of expected healthy years constituted 69% of life expectancy at birth in Estonia, while it was 79% in the EU. In 2015, life expectancy at birth was the same – 78 years – placing Estonia 9th from bottom among European countries. Over the period 2000 to 2015, Estonia had the largest increase in life expectancy in the EU.[9] Yet, this positive trend was broken between 2015 and 2018, when life expectancy at birth did not improve in Estonia while it improved in most other low-ranking EU countries.

The chronic morbidity rate in Estonia is not clear. Based on EU information, the rate significantly exceeds that of the EU average. Compared with OECD data, chronic morbidity rates have been comparatively low in Estonia as the percentage of people living with two or more chronic diseases was 25.9% in 2014 against 31.3% of the OECD average (Figure 1). Among people aged 65 or older, the percentage was slightly above 50% while it was close to 60% in OECD countries on average. Type I and II diabetes was detected in 4% of the population in Estonia and 6.4% in OECD countries on average in 2017.[10]

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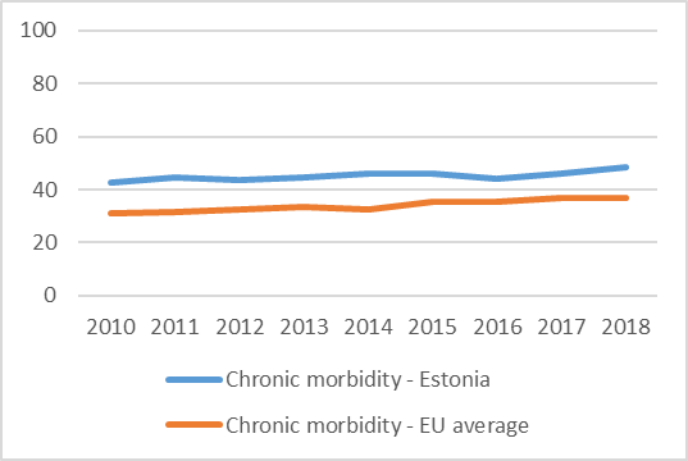
[1] Eurostat (2020a), Table LFSI_DWL_A, https://ec.europa.eu/eurostat/databrowser/view/lfsi_dwl_a/default/table?lang=en.
[2] Statistics Estonia (2020), Table TT0202.
[3] Statistics Estonia (2020), Table RV021.
[4] Statistics Estonia (2020a), Statistical data on labour market, https://tooturg.stat.ee/.
[5] Statistics Estonia (2020b), Table RV021.
[6] OECD/EU (2018), *Health at a Glance: Europe 2018: State of Health in the EU Cycle*, OECD Publishing, Paris. https://doi.org/10.1787/health_glance_eur-2018-en, p. 99.
[7] Eurostat (2020a) Healthy life years at birth by sex (online data code: TPS00150).
[8] The World Bank 2020a. Life expectancy at birth. https://data.worldbank.org/indicator/SP.DYN.LE00.IN, visited 13.11.2020.
[9] OECD/European Observatory on Health Systems and Policies 2017 Estonia: Country Health Profile 2017, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels. http://dx.doi.org/10.1787/9789264283350-en.
[10] OECD (2019), Health at Glance 2019: Health Indicators, Chronic disease morbidity, https://www.oecd-ilibrary.org/sites/5101558b-en/index.html?itemId=/content/component/5101558b-en.

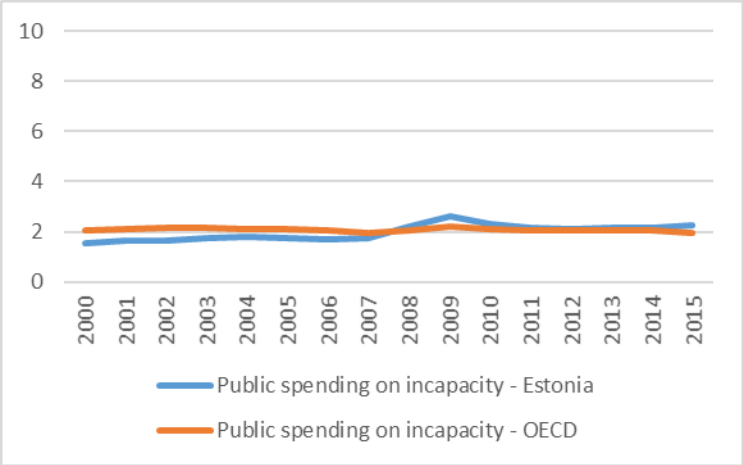
Figure 1. Chronic morbidity (people with long-standing illness or health problems)



Source: Eurostat.

Public spending on incapacity[11] was below the OECD country average until the Great Recession but since 2008, it has been equal to or above the OECD average (Figure 2).

Figure 2. Public spending on incapacity (% GDP)



Source: OECD.

In 2017, Estonia spent 2.3% of GDP on incapacity while the OECD average was 1.9%.[12] From 2000 to 2018, the number of days per year and per person compensated because of absence from work due to illness

[11] Public spending on incapacity refers to spending due to sickness, disability and occupational injury. It includes disability cash benefits that are comprised of cash payments on account of complete or partial inability to participate gainfully in the labour market due to disability, https://data.oecd.org/socialexp/public-spending-on-incapacity.htm.
[12] OECD, Public spending on incapacity, https://data.oecd.org/socialexp/public-spending-on-incapacity.htm.

was higher in the OECD on average: in the OECD, the number was 12 while in Estonia it fluctuated between 7.3 and 11.3.[13]

The comparatively poor health condition of the population is a recognised public policy challenge in Estonia. The following policy documents define health and healthcare challenges to a large extent in relation to labour market participation:

- Population health development plan 2009-2020 (Rahvastiku tervise arengukava 2009-2020);[14]
- Well-being development plan 2016-2023 (Heaolu arengukava 2016-2023).[15] Health condition is seen as a relatively significant impediment to the labour market participation of the older population as well as the long-term unemployed and people with reduced work capability in general; and
- a proposal for a population health development plan 2020-2030 (Rahvastiku tervise arengukava 2020-2030 koostamise ettepanek)[16] defines the public health problem through the ageing of the population, with older age groups being more vulnerable to chronic diseases.

It seems fair to conclude that the rate of chronic morbidity in Estonia is probably not too high among the population in general. However, the low number of healthy years suggests that older age groups likely suffer disproportionately more from chronic illnesses. The employment rate has been increasing among the older population, indicating that relatively many of them work despite having a chronic illness. Older people need to work because their pension income is too low to make ends meet, as indicated by the steadily growing share of older people living below or at risk of falling below the poverty line.

Employment of people with reduced work capability

In Estonia, public policy discussions and issues surrounding return to work with a chronic condition fall mainly into the area of regulating and supporting the employment and economic activity of people with work capability of less than 100%. This condition may be temporary or permanent; it may be induced by work-related circumstances but that is not necessarily so. In general, there are three reasons for reduced work capability:

- disability, which a person has been living with since before the start of that person's working life, probably but not necessarily since birth;
- disease – occupational, work-related or not[17] – which has led to a temporary or permanent condition of reduced work capability; and
- injury – occupational, work-related or not – which has led to a temporary or permanent condition of reduced work capability.

[13] OECD.Stat. Health Status: absence from work due to illness, https://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#.

[14] The Government of Estonia, https://www.valitsus.ee/sites/default/files/content-editors/arengukavad/rahvastiku_tervise_arengukava_2009-2020_taiendatud_2012.pdf.

[15] Ministry of Social Affairs. Heaolu arengukava 2016-2023, https://www.valitsus.ee/sites/default/files/content-editors/arengukavad/heaolu_arengukava_2016-2023.pdf, visited 13.11.2020.

[16] https://www.valitsus.ee/sites/default/files/content-editors/arengukavad/rahvastiku_tervise_arengukava_2020-2030_koostamise_ettepanek.pdf.

[17] As per Estonian regulations, three conditions are distinguished: occupational diseases, work induced diseases and conditions that are not occupational diseases and diseases and conditions not related to work.

Until 2016, treatment of these conditions was only on a case-by-case basis. But this was not perceived as a satisfactory solution for the labour market participation of people with disability, illness or injury and in 2016, the work ability reform was launched. The goal of the reform was to bring together all the labour market participation, employment-related services and transfers under one institution – the Estonian Unemployment Insurance Fund (EUIF). Since mid-2016, when the work ability reform was launched, work capability has also been assessed by the EUIF.[18] The number of new people with partial work capability in Estonia, as per work-capability assessment decisions, was 29,044 in 2017 (2,420 per month on average), 27,515 in 2018 (2,293) and 26,504 in 2019 (2,209).[19] The number of decisions on partial work capability has been decreasing over time.[20] The number of decisions attributing a lack of work capability to individuals was lower but still considerable: 13,086 in 2017, 15,173 in 2018 and 13,609 in 2019.[21] From early 2017 to early 2020, the EUIF allocated work-capability allowances to approximately 3,500 people per month. A considerable number of people recover over time and regain full work capability. The number who quit receiving the work ability allowances has been rising gradually, starting from approximately 100 per month in early 2017 to approximately 3,000 per month in 2020. The predominant reason for ending receipt of the allowance is the end of the period of reduced work capability (72%); other reasons include an exit from employment or unemployment (12%), attainment of retirement age (8%) and death (6%).[22]

The state was only partially prepared to implement the new work capability-based policies before the launch of the reform in 2016.[23] Although during the first couple of years of implementing the new support system for work capability the labour market participation of people with reduced work capability did increase, there is not enough evidence to support the statement that this was caused by the policy reform and not by a sound economy and economic growth.[24]

Social partners in Estonia

In Estonia, industrial relations are mostly developed at the national level, and much less so at the sectoral or company level.[25] Negotiations over the minimum wage, the main issue in social dialogue in Estonia, are held by the Estonian Trade Union Confederation and the **Estonian Employers' Confederation** (EEC). As of 1 November 2020, the EEC was among 23 sectoral employers' organisations and 127 individual companies

[18] Estonian Unemployment Insurance Fund, https://www.tootukassa.ee/eng/content/work-ability-reforms.

[19] Ibid., https://www.tootukassa.ee/content/tootukassast/toovoime-hindamine, visited 18.11.2020.

[20] An extrapolation based on the figures from earlier years returned an estimate of 20,653 for 2020 (1,721), which again is lower than in previous years. However, the year 2020 was a fairly uncommon year until November so that using earlier patterns may not be justified fully.

[21] An extrapolation based on the figures from earlier years returned an estimate of 10,285 for 2020 (1,721), which again is lower than in previous years. However, the year 2020 was a fairly uncommon year until November so that using earlier patterns may not be justified fully.

[22] Ibid., https://www.tootukassa.ee/content/tootukassast/toovoimetoetus, visited 18.11.2020.

[23] National Audit Office (2017), *Riigi tegevus töövõimereformi ettevalmistamisel. Kas riik on valmis töövõime toetamise uue süsteemi käivitamiseks ja töös hoidmiseks?* Riigikontrolli aruanne Riigikogule, https://www.riigikontroll.ee/Suhtedavalikkusega/Pressiteated/tabid/168/557GetPage/1/557Year/1/ItemId/950/amid/557/language/en-US/Default.aspx.

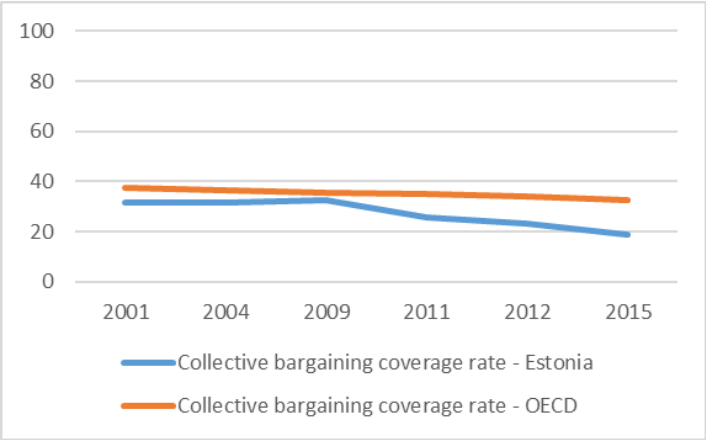
[24] Masso, M., Nuiamäe, M., Michelson, A., Murasov, M., Melesk, K., Laurimäe, M., Kadarik, I. (2019), Töövõime toetamise skeemi loomise ja juurutamise vahehindamine. Poliitikauuringute Keskus Praxis; ISBN 978-9949-662-17-3 (pdf), http://www.praxis.ee/wp-content/uploads/2019/05/TVH-RAPORT.pdf.

[25] For further discussion of trade unions in Estonia, see Kall, K. (2020) Fighting marginalization with innovation: turn to transnational organizing by private sector trade unions in post-2008 Estonia, PhD dissertation, Tallinn University, https://www.etera.ee/zoom/84474/.

from all economic sectors.[26] The EEC is actively involved in 23 management committees of public organisations and working groups with relevance for the labour market in Estonia, including the Health Insurance Fund and Unemployment Insurance Fund. It is actively involved internationally too.[27] The **Estonian Chamber of Commerce and Industry** (ECCI) is the oldest and largest Estonian representative organisation of entrepreneurs, with over 3,300 members.[28] Its activities are more business-oriented than those of the EEC.[29] The **Estonian Association of SMEs** (EAS) had 5,217 member SMEs as of 1 November 2020.[30] Altogether, this means a rather small share of Estonian enterprises have become members of such representative associations.

The **Estonian Trade Union Confederation** has 17 sectoral trade unions as its members.[31] In Estonia, only a small fraction of employees and workers are trade union members. Trade union density has dropped significantly since 1990 and nowadays Estonia is characterised as a country with the lowest union density rates in Europe, declining from 94% in 1992 to 15% in 2000 and 4% in 2017.[32] Some sectors have been practically union-free, and sector-level collective agreements are rarely concluded. Therefore, the collective bargaining coverage, at about 20%, is significantly lower than the OECD average (**Figure 3**) and much lower than that in the countries with the highest coverage; this has been decreasing over time even since 2010.

Figure 3. Collective bargaining coverage (%)



Sources: OECD.

Despite low levels of trade union membership, there is generally quite a large consensus about the need for trade unions in society (see Table 1): in 2015, 72% tended to agree that workers need trade unions, and while the share is larger among union members (84%), it is also high among those who have never

[26] Estonian Employers' Confederation homepage, https://www.employers.ee/meist-2/liikmed/, visited on 1 November 2020.
[27] Ibid., https://www.employers.ee/meist-2/osaleme/, visited on 1 November 2020.
[28] Estonian Chamber of Commerce and Industry homepage, https://www.koda.ee/en/about-chamber, visited on 1 November 2020.
[29] Ibid., https://www.koda.ee/en/services/our-services, visited on 1 November 2020.
[30] Homepage of Estonian Association of SME's, https://evea.ee/, visited on 1 November 2020.
[31] Homepage of Estonian Trade Union Confederation, https://www.eakl.ee/meist, visited on 1 November 2020.
[32] Visser, J. (2019), ICTWSS Database. Version 6.0. May 2019, Amsterdam, Amsterdam Institute for Advanced Labour Studies, University of Amsterdam http://www.uva-aias.net/en/ictwss.

joined a trade union (65%). On the other hand, only 7% of the population agreed with the statement "trade unions are bad for the economy", which is as low as just 2% among trade union members.

Table 1. Perceived relevance of trade unions in Estonia by trade union membership, 2015 (%)

	Total	*Current trade union member*	*Used to be a trade union member*	*Never been a trade union member*
	N=1,100 (100%)	N=46 (4%)	N=535 (50%)	N=489 (46%)
Strong trade unions bad for economy	7	2	7	7
Workers need trade unions	72	84	79	65

Source: International Social Survey Programme[33] 2015 work orientations survey, own calculations.

Exploring trust in trade unions over time since the 1990s (Table 2), one notices that the level of complete distrust did not increase between 2008 and 2017, staying at 12%. But the extent of strong confidence steadily increased: from 27% in 1990 to 32% in 1999, 43% in 2008 and 50% in 2017. Although this does not seem to be reflected in union membership, some further understanding of unions is emerging among the public.

Table 2. Level of confidence in trade unions in Estonia, 1990-2017 (%)

	1990	*1999*	*2008*	*2017*
A great deal	3	3	5	7
Quite a lot	24	29	38	43
None at all	**18**	**20**	**12**	**12**

Source: European Values Study,[34] own calculations.

A cross-European representative survey by Eurobarometer[35] has also been measuring popular opinion on trade unions. According to this survey (see Table 3), the number of respondents for whom trade unions brought to mind something "very or fairly positive" dropped significantly from 90% in 2009 to 80% in 2015 and was just above 50% in 2016 and 2019. It also seems (from the data for 2007 and 2009) that respondents were much less optimistic about the extent of general trust in unions than their own level of trust.

Table 3. Image and perceived image of trade unions in Estonia, 2004-19 (%)

	2004	*2007*	*2009*	*2014*	*2015*	*2016*	*2018*	*2019*
'People tend to trust in unions'	63	62	55[1]					
'Trade unions bring to mind something very or fairly positive'		89	81	79	81	52	58	54

[1] Data from year 2010.

Source: European Values Study,[36] own calculations.

Still, the trust level of around 50% seems to be roughly in line with the level of confidence in 2017 (about 50%), which we observed in Table 2. Since the belief that workers need trade unions is strong even among

[33] International Social Survey Programme, www.issp.org.
[34] European Values Study, https://europeanvaluesstudy.eu/.
[35] Eurobarometer, https://ec.europa.eu/commfrontoffice/publicopinion/index.cfm.
[36] European Values Study, https://europeanvaluesstudy.eu/.

those who are not trade union members (as we observed in Table 1), this reflects a certain potential for recognition of trade union activity, especially in putting new matters on the agenda of collective agreements, such as those related to institutionalising basic income, fighting unequal treatment and the gender pay gap, and perhaps also negotiations on return to work after chronic illness.

This might be a sign of perceived changes in trade union strategies and, therefore, their efficiency in negotiations. It is worth noticing that the national-level discussions – which are crucial in representing workers in industrial relations – are, indeed, highly visible to the public, as they get media exposure. Moreover, when only national (and sometimes also sector-level) trade union organisations engage in negotiations, there is a higher likelihood that they have enough qualified human resources to secure both expertise and media coverage. Thus, focusing social dialogue on the national level, instead of the sectoral or company level, might have even more potential to change policies on return to work after chronic illness.

Sources of data

This report is based on the following data sources:

- REWIR online survey among workers in Estonia (details in Table 5);
- REWIR online survey among company managers in Estonia (details in Table 6);
- REWIR survey among social partners in Estonia (details in Table 7);
- interviews with relevant national stakeholders;
- a roundtable discussion with key stakeholders;
- group discussions with employers and trade unions; and
- relevant documents, such as legislative acts, research reports, policy plans and reports, and mass media.

Table 4. Overview of REWIR Estonian survey samples and respondent identification

Survey and target group	Total number of responses	Number of relevant responses
Workers' survey	49	25
Managers' survey	16	16
Social partners' survey	4	4

Source: REWIR surveys in Estonia 2020, own calculations.

Note: The total number of responses refers to the overall data intake for Estonia, within the period of data collection. The number of relevant responses refers to the number of completed surveys for the social partners and the company survey. For the workers' survey, the number of relevant cases refers to responses where the respondent selected 'Yes' for Question 6 – *Have you experienced a chronic disease in your working life?*

Table 5. REWIR workers' survey in Estonia: details

Workers' survey – structure of responses	% based on valid responses and the number of responses (in brackets)
Gender (Q1)	
Male	20% (5)
Female	80% (20)
Mean age in years (Q3)	47 years
Mean length of working life in years (Q4)	28 years
Level of education (Q2)	
Low-qualified (up to lower secondary)	16% (4)
Medium-qualified (up to post-secondary vocational)	24% (6)
High-qualified (up to university education)	60% (15)
Type of organisation where the respondent worked prior to diagnosis/treatment (Q14a, b)	
Domestic (14a)	80% (5)
Foreign owned (14a)	0% (0)
Don't know (14a)	20% (1)
Type of organisation where the respondent worked prior to diagnosis/treatment (Q14a, b)	
Private sector (14b)	50% (3)
Public sector (14b)	50% (3)
Trade union membership (Q9)	
Yes	0%
No	100% (6)
Trade union presence at the workplace (Q11)	
Yes	50% (3)
No	50% (3)
Type of job (Q16)	
Intellectual	100% (5)
Manual	100% (1)
Indoor	100% (5)
Outdoor	0% (0)
Intensive physical activity	0% (0)
Intensive emotional stress	100% (4)
Company size (Q13)	
Below 20	33% (2)
20-50	0%
50-500	50% (3)
500-1,000	16% (1)
Above 1,000	0%
Currently on sick leave (Q17)	
Yes	0%
No	100% (6)
Three most frequently reported diseases (Q7)	
1. Chronic respiratory disease	100% (1)
2. Cardiovascular disease	100% (1)
3. Other, epilepsy	100% (1)

Source: REWIR workers' survey in Estonia 2020, own calculations; number of respondents: total 53, but 26 of them had ever been diagnosed with a chronic disease – 6 of them recently and 20 sometime earlier.

Out of the twenty-five respondents who responded 'yes' to the Question 6 – whether they had been diagnosed with a chronic disease – only six reported having a job before the diagnosis.

Out of these six, five reported that they were doing an intellectual job indoors, and four of them said they had a lot of emotional stress. More specifically, two of them belonged to the group of information and communications technology professionals, one was a teacher, one belonged to the group of legal, social, cultural and related associate professionals, and one was in the wider category of research and education. The respondent who reported having had a manual job specified further belonging to the group of customer service clerks. Sector-wise, two reported working at a public sector organisation and two at a private sector organisation.

Table 6. REWIR managers' survey in Estonia: details

Structure of responses	% responses, number of responses in brackets
Ownership type (Q4)	
Domestic (public)	36% (6)
Domestic (private)	32% (5)
Foreign (private)	32% (5)
Organisation size (Q2)	
0-9	6% (1)
10-49	38% (6)
50-249	25% (4)
Above 250	31% (5)
Predominant types of workers (Q7)	
1. Highly skilled specialists (e.g. doctors, engineers, kindergarten and schoolteachers)	38% (6)
2. Low-skilled manual workers (e.g. line operators with simple tasks)	31% (5)
3. Service workers – private services (e.g. business services, tourism and catering, personal services)	19% (3)
Three most commonly reported economic sectors represented (Q6)	
1. Wholesale	25% (4)
2. Manufacturing	25% (4)
3. Education, research	25% (4)
Presence of trade union or other form or workers' representation (Q22)	
Yes	58% (7)
No	42% (5)

Source: REWIR employers' survey in Estonia 2020, own calculations; number of respondents: 16.

For the employer-level survey among managers, sixteen questionnaires were filled in. These represent different ownership types rather well: six were from public organisations, ten from private companies and of the latter, five were of domestic origin and five of foreign origin. While the general numbers are low, they still provide good grounds for comparative insight. The same could be said about the degree of trade union presence at the organisations: 58% of the organisations have a trade union, while 40% of them do not; it will be interesting to see if there are any systematic differences in their experience and work arrangements relating to return to work.

The three most commonly reported economic sectors, again, show equal representation of types of sectors that are as varied as manufacturing (four organisations), wholesale (four), and education & research (four). Thus, the report can attempt to provide an initial comparison of return-to-work policies and experiences in the production sector, service sector and knowledge sector, representing three different branches of the economy. Similarly, nearly 40% of the employers said that the predominant group of employees in their organisation was highly skilled specialists, 30% had mainly lower-skilled manual workers and 20% had service workers.

In the social partners' survey, only the national-level associations participated, and with one employer association and three trade union associations represented (see further details in Table 7).

Table 7. REWIR social partners' survey in Estonia: details

Structure of responses	% responses, number of responses in brackets
Type of organisation (Q2)	
Employers' associations	25% (1)
Trade unions	75% (3)
Other	0%
Level of social dialogue engagement (Q4)	
National	100% (4)
Sub-national (territorial)	0% (0)
Sectoral	0% (0)
All three	0% (0)
Other	0% (0)

Source: REWIR social partners' survey in Estonia 2020, own calculations; number of respondents: 4.

Considering the low levels of trade union participation and the fact that industrial relations in Estonia are more likely to be effective at the national level, this is an important outcome but also reflects the pattern whereby these topics are often not a priority in sector-level negotiations. The sub-national level is not as relevant for trade unions (partly owing to the small size of the country, but even more so to low membership) and likewise for employers the sub-national level initiatives are of less importance than the possibility to have their voices represented at the national level. However, it must be noted that employer associations usually only represent a small number of (larger) employers; sector-level associations are different, but this also reflects their agenda, which is even less likely to include topics related to return to work after illness.

A note on data quality

The three surveys were carried out as online surveys. The **specialised platform** Wageindicator, which was used for the survey of workers, is not commonly known in Estonia; thus, the chance of noticing the invitation to participate in the survey just in passing was extremely unlikely. Additional efforts were made to distribute information about the survey, though this might have increased potential bias, especially compared with other countries where the web platform is more widely visited. In the future, we would recommend that project-level, prior arrangements with institutional partners present in specific country contexts or joint social media campaigns are coordinated centrally to gain better visibility.

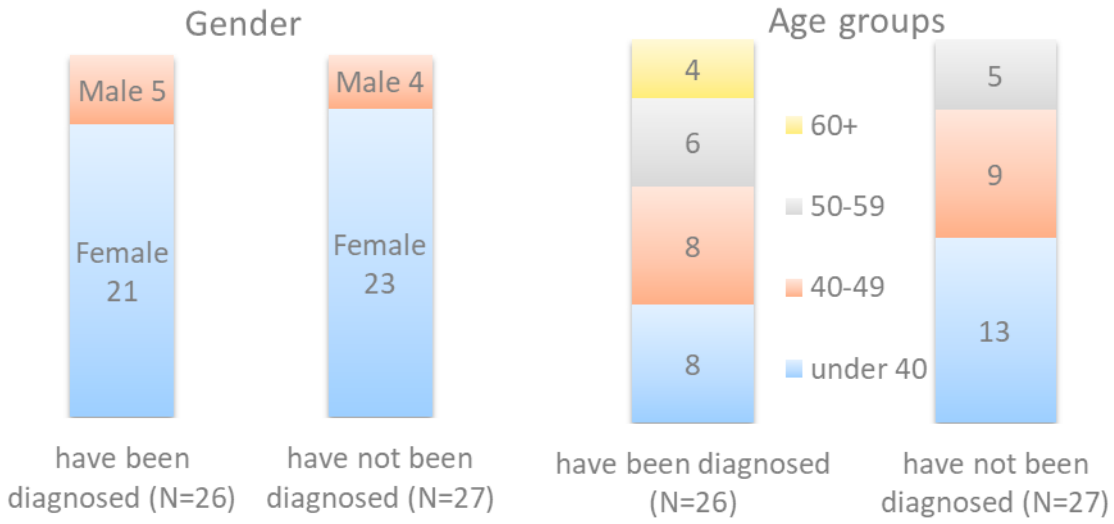
Lack of awareness as well as interest in the specific topic in Estonia manifested itself in these surveys as well as in group discussions and individual interviews carried out earlier within the REWIR project. The problem with interest is really twofold: in terms of trade unions, the low coverage makes it unlikely that

individuals have experience with them and hence cannot imagine their potential role; in terms of health issues and return to work, this is considered a private and individual matter that is not seen as something that can be solved, because of the low level of visibility of positive examples in the public sphere. For this reason, and also because of the **small size of the difficult-to-reach target population** to be surveyed within a country with such a small population overall, it turned out to be impossible to reach a sufficient number of respondents despite additional efforts. This too explains the low numbers of questionnaire respondents as well as the poor representativeness of the composition of the groups.

We also acknowledge that for some target populations, online surveys on the topic evidently were **not an appropriate choice for data collection** as they required access to the online questionnaire. We can assume that this kind of easy access is probably not that widely available to manual workers, for example. That, at least partly, explains the low numbers of responses as well as poorly filled-out questionnaires.

In addition, such online surveys always suffer heavily from **self-selection** in the survey. But the effect of self-selection on the sample characteristics cannot be assessed well because of poorly completed questionnaires. In terms of the worker survey, acknowledging the self-selection effect we decided to check how the subsamples of those with some chronic illness differed from participants who did not have this experience of illness and thus stopped filling in the survey. The aspects that we could include in such a comparison were gender, age, level of education and years in employment. That allowed us to draw the following conclusions. First, even though the sample is heavily biased towards women's perspectives, it is not because men dropped out of the survey more as they had not been diagnosed with any chronic illness but rather because of the initial self-selection for the online survey on this topic. It might be important to remember here that while men are usually considered a less easy target for any survey, they are sometimes considered more likely to participate in an online survey, but we assume the relevance of the topic seemed even lower for them than for women.

Figure 4. Sample distribution by gender and age and being diagnosed with chronic illness



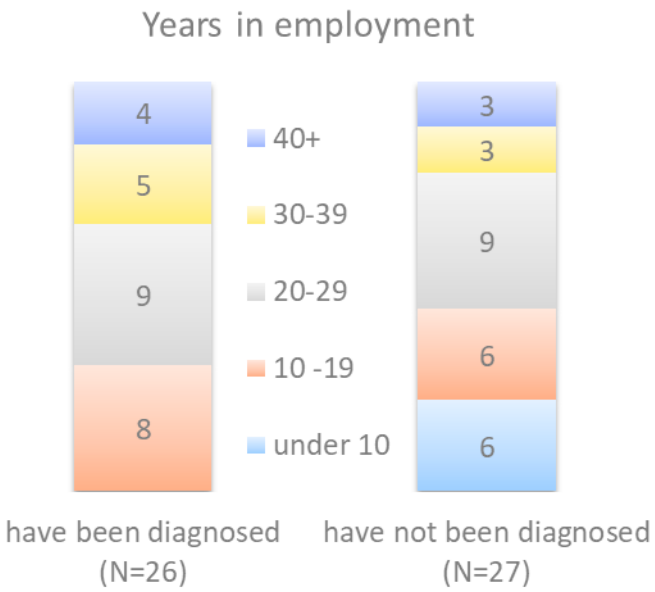
Source: REWIR workers' survey in Estonia 2020, own calculations; number of respondents: 53.

In terms of age groups, the effective sample had more individuals in the older age groups, whereby there were more people under age 40 among those participants who had not been diagnosed with an illness. On the one hand, this illustrates well the increased likelihood of experiencing health-related issues at

older ages but could also point to the fact that online surveys are more likely to be noticed by younger audiences, unless there is a dedicated survey on the topic that seems personally relevant. In any case, everyone older than 60 who opened the survey admitted being diagnosed with a chronic illness, compared with just about half of those between the ages of 41 and 59 and less than 40% of those under 40. Nevertheless, this still shows that such online surveys are a good tool for gathering opinions from younger people in the target group who might otherwise be harder to reach.

The next aspect we compared for the two subgroups was work experience, measured by years in employment.

Figure 5. Sample distribution by years in employment and being diagnosed with chronic illness

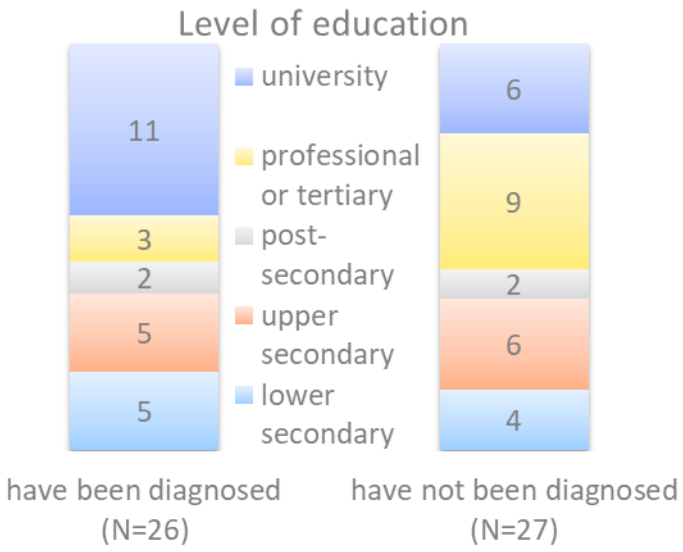


Source: REWIR workers' survey in Estonia 2020, own calculations; number of respondents: 53.

Considering that the age distribution was skewed towards younger people in the group who did not have experience with a diagnosis of chronic illness, it is also logical that there were more people in this group with work experience of less than 10 years. At the same time, since there were also individuals under age 40 in the effective sample of those with a serious illness, it is important to note that none of them had work experience of less than 10 years. For the older groups, there seemed to be more people who had entered the labour market later or who had left earlier or taken breaks – but there were people with more than 40 years of working life experience in both groups.

With this in mind, it appears that later entrance into labour market might be related to years in education: among those with experience of illness there were a disproportionate number who were university educated, while those who terminated the questionnaire early as they had no experience with chronic illness were more likely to have completed professional or tertiary education. Groups representing other educational levels were of comparable size.

Figure 6. Sample distribution by level of education and being diagnosed with chronic illness



Source: REWIR workers' survey in Estonia 2020, own calculations; number of respondents: 53.

Comparing the two groups – those who had ever been diagnosed with a chronic illness and those who had not – we realised the **questionnaire design could be improved** to take this into account. We suggest that for future surveys of this kind, even if the individual who starts answering the questionnaire ends up not being among the main target group, there should still be some questions related to awareness, attitude or opinion. This could help gather some indications of the general atmosphere around the theme. It could be especially relevant for a study like this, to reveal attention and even support by colleagues who themselves do not have such experience or perhaps are even not directly affected by the employees' lower labour market attachment.

2 The policy framework on return to work in Estonia

Relying on earlier analysis[37] of institutional frameworks for return-to-work policies and systems across the countries, it has been suggested[38] in the REWIR concept note that Estonia has a poorly developed framework for RTW, with very limited (or lack of) coordination between stakeholders, limited institutional support, but with ad hoc initiatives implemented by various actors. The system in Estonia resembles neoliberal industrial-relations system common in Central and Eastern European (CEE) countries. This provides the background context in which the respondents to the REWIR survey participated and provided their answers.

An overview of the main aspects of policies on RTW and rehabilitation after chronic conditions in countries like Estonia is presented in Table 8.

Table 8. Summary of policies for RTW and rehabilitation after chronic conditions

Target groups for rehabilitation and RTW	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.
Actors involved	*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.
Prevention of exclusion and early intervention	The policies do not prescribe concrete measures towards the prevention of exclusion, although generic legislation exists in some countries; no early intervention.
Programmes for RTW	No statutory programmes for RTW.
Progressive and planned RTW	No planned or progressive RTW; RTW is achieved based on ad hoc measures, at the end of the sickness absence.
Employer's responsibility	Obligation of the employers to follow the recommendations of the official bodies or specialists regarding work adaptations; no formal responsibility.
Incentives for RTW	Financial support for employers to reintegrate employees with reduced work capacity (due to disability or occupational condition); no incentives for the workers.

Source: Modified from Akgüç, Kahancová and Popa (2019).

The message delivered in the report probably adequately describes the situation in Estonia if one is looking at an explicit framework for return to work after a serious illness and/or with a chronic condition and presumes there is a specialised field of public policy devoted to supporting return to work. If one takes a slightly diverging point of view, one might arrive at a somewhat different position. In Estonia, return to work is supported by a mix of several sectoral policies: healthcare, employment relationships, active labor market policies, social welfare and social care. The report gives an overview of the public policy measures supporting return to work and of opinions about supporting return-to-work policies.

[37] EU-OSHA Report (2018), Rehabilitation and Return to Work: Analysis Report on EU Policies, Strategies and Programmes, Office for Official Publications of the European Communities, Luxembourg.

[38] Akgüç, M., Kahancová, M. and A. Popa (2019), REWIR 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, REWIR literature review and conceptual framework. Available: REWIR consortium.

The main legal acts that frame employment, illness, sick leave and return to work after treatment include the following ones:

- Employment Contracts Act[39]
- Health Insurance Act[40]
- Work Ability Allowance Act[41]
- Occupational Health and Safety Act.[42]

In addition, there is a range of other legislative acts that regulate aspects of employment contracts.[43]

There are two national-level policy documents that address chronic diseases and their prevention: (a) the Disease Prevention Development Plan 2016-19[44] and (b) the National Health Development Plan 2020-30,[45] which lists chronic diseases as a separate category. Chronic diseases are not addressed specifically but as a part of wider disease prevention plan. Aspects of employment, including return to work after chronic illness, are regulated by the Employment Contracts Act,[46] the Health Insurance Act,[47] and the Occupational Health and Safety Act.[48]

The legislative act that regulates employment when an employee falls ill or gets injured is the Employment Contracts Act.[49] As per the act, the employer may cancel the employment contract extraordinarily when an employee is not able to perform the duties of the job due to the employee's state of health for more than four months (para. 88). However, before the cancellation of an employment contract, in particular on the basis of a health condition, the employer must offer other work to the employee, which includes organising, if necessary, the employee's in-service training, adapting the workplace or changing the employee's working conditions if such changes do not incur disproportionately high costs for the employer and the offer of other work may, considering the circumstances, be reasonably expected.

The Health Insurance Act[50] defines the categories of insured persons. All employed and self-employed people are covered by the insurance, plus a range of other groups.

[39] Employment Contracts Act, https://www.riigiteataja.ee/en/eli/502042014001/consolide. State Gazette 2009, 5, 35.
[40] Health Insurance Act, https://www.riigiteataja.ee/en/eli/ee/504062020003/consolide/current, State Gazette 2002, 62, 377.
[41] Work Ability Allowance Act, https://www.riigiteataja.ee/en/eli/530042020009/consolide State Gazette 13.12.2014, 1.
[42] Occupational Health and Safety Act, https://www.riigiteataja.ee/en/eli/ee/527052014007/consolide/current. State Gazette, 1999, 60, 616.
[43] Check the respective section of the Labor Inspectorate homepage, https://www.ti.ee/et/tookeskkond-toosuhted/oigusaktid-viited.
[44] https://www.haigekassa.ee/sites/default/files/uuringud_aruanded/ennetuse-arengukava_2016-2019.pdf.
[45] https://www.valitsus.ee/sites/default/files/content-editors/arengukavad/rahvastiku_tervise_arengukava_2020-2030_koostamise_ettepanek.pdf.
[46] https://www.riigiteataja.ee/en/eli/509052019005/consolide.
[47] https://www.riigiteataja.ee/en/eli/523052019005/consolide.
[48] https://www.riigiteataja.ee/en/eli/ee/527052014007/consolide/current.
[49] Employment Contracts Act.
[50] Health Insurance Act.

The Work Ability Allowance Act[51] defines the access to employment of people with reduced work ability caused by long-term health damage and ensures an income for them under the conditions and to the extent provided by law.

The Occupational Health and Safety Act[52] frames the area of occupational health and defines the role of medical professionals in occupational health, such as occupational health doctors, occupational health nurses and other medical professionals.

An overview of the legal provisions discussed above is provided in Table 9.

Table 9. Sickness absence eligibility in Estonia

Eligibility	One can claim sickness benefit in the case of • illness; • an accident at work; • traffic injury; or • personal injury. 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 following categories are covered: • an employee; • a civil servant; • a person receiving remuneration or service fees on the basis of a contract under the law of obligations; • a member of the management or controlling body of a legal person; • a self-employed person; and • a spouse participating in the activities of a self-employed person. Sickness benefit is paid if the person does not receive income, subject to being individually registered for social taxes, due to a temporary release from their duties or economic or professional activities.[53]
Duration	An insured person has the right to receive the sickness benefit for 182 consecutive calendar days (240 consecutive days in the 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.
Source of payment	The first three days of sickness leave are own responsibility of the employee meaning that neither the employer nor the EHIF covers the costs. However, they may be covered from a private insurance contract if that has been concluded earlier. The employer will pay the benefit from the fourth day of illness. The Health Insurance Fund starts paying the benefit from the ninth day of illness.
Level of benefits	The employer calculates the amount of the sickness benefit on the basis of the average wage in the last six months. The Health Insurance Fund calculates the benefits for incapacity to work based on social tax data (received from the Tax and Customs Board) calculated or paid for the beneficiary

[51] Work Ability Allowance Act.

[52] Occupational Health and Safety Act.

[53] Homepage of the Estonian Health Insurance Fund, https://www.haigekassa.ee/en/people/benefits/sickness-benefit, visited on 1 November 2020.

	in the calendar year preceding the start date of the incapacity to work indicated in the incapacity certificate. Both the employer and the Health Insurance Fund calculate the employee's average daily wage based on the above data. The sickness benefit is paid at the rate of 70% of daily income. The sickness benefit is subject to income tax.
Timing of RTW consider-ations	There are minimal or no specific considerations for returning to the same job or workplace. The legislation does not place any special obligations on employers and does not give any special rights to employees to leave a position temporarily because of illness or to return after treatment. The legislation envisages that the employer must adjust working conditions at the workplace according to the employee's needs in the case of reduced work capability. This requirement holds equally when an employee loses partial work ability while working at a job and when a person with partial work capability starts working at a job. Work ability may be reduced as a result of (occupational) disease, (occupational) injury or disability. In both cases, the employer has to adjust the workplace so that the needs of the employee arising from that person's reduced work capability are met.
Procedure to return to work	Employing a person with reduced work ability is a company-level decision and process. The employment of a person with reduced work ability is supported by services offered by the Estonia Unemployment Insurance Fund, the Social Insurance Board and potentially also by social workers (municipal level). To receive the services, both the (prospective) employee and employer need to contact the Unemployment Insurance Fund.
Type of source for these provisions	• Employment Contracts Act[54] • Health Insurance Act[55] • Work Ability Allowance Act[56] • Occupational Health and Safety Act[57] • Other legislative acts regulating aspects of employment contracts[58] • Work Capability reform[59]
Any other aspect relevant for the country	In Estonia, two distinct patterns can be pointed out. First, if an employee loses partial work ability, then the employer may adjust that person's workplace, tasks and working hours to meet the person's needs arising from a health condition without terminating the employment contract. The person may or may not stop working temporarily. Second, if an employee falls ill, the employment contract is terminated on those grounds. The employer has no legal obligation and the employee has no legal right to restart the employment contract after treatment, when the employee returns to the labour market. However, many employers employ people with reduced work capability and adjust the workplace, tasks and working hours to meet the needs arising from the employee's health

[54] Employment Contracts Act.
[55] Health Insurance Act.
[56] Work Ability Allowance Act.
[57] Occupational Health and Safety Act.
[58] Check the respective section of the Labor Inspectorate homepage, https://www.ti.ee/et/tookeskkond-toosuhted/oigusaktid-viited.
[59] Check the respective section of the Estonian Unemployment Insurance Fund homepage, https://www.tootukassa.ee/eng/content/work-ability-reforms.

	condition. There are different reasons why an employee's work capability may be reduced: (occupational) illness, (occupational) injury or disability from birth. People whose work ability is assessed at less than 100% are entitled to a range of supportive policy measures, which can be in cash (benefits and subsidies), in kind (publicly funded support services) and in time (reduced and constrained working time). Since 2016, work ability has been assessed by the Estonian Unemployment Insurance Fund. The fund administers the in-cash and in-kind measures to support working with reduced work capability. In-time measures are envisaged in the legislative acts. Ensuring the implementation of all support measures is the duty of the Labour Inspectorate.

As a key institution in the landscape of labour and health, the EUIF implements significant aspects of labour market policy in Estonia. It also offers a range of measures to employees who need support at the workplace because of their health condition. The EUIF also offers a range of measures on health-related issues to employers. As a public institution, the board of the EUIF consists of six members: according to the law, two members are named by the national government, two members by the national employers' organisation and one member each by the two national-level trade union confederations. The tripartite nature of this body means that the issues the EUIF regulates (including those related to return to work) are the object of national-level social dialogue.

In every organisation, health- and workplace-related issues are addressed by a work environment commissioner. It is required by law that every organisation with more than 150 employees (and in others if the Labour Inspectorate so requires) establishes a working environment council with the responsibility to ensure occupational health and safety. Such a council needs to consist of representatives of management as well as representatives of employees. A **working environment representative**, to be elected by employees, has a mandate on occupational health and safety issues. Compulsory committees like that are meant to foster industrial dialogue and are likely set by law with the understanding that trade unions are not present in every organisation. In fact, occupational health and safety is one of the rare themes on which the state has made social dialogue compulsory. This does not mean it works very well across the organisations, and often the illusion of industrial relations is created with this framework rather than actual social dialogue (see also Ost (2000)),[60] on the emergence of *illusionary corporatism* in the CEE).

While the company-level dialogue is not always efficient, there are rather good conditions set in the legal regulations for employees to apply for workplace accommodation. Yet, there are still no specific measures for RTW for workers with chronic illness. Additionally, with the exception of tuberculosis, there are no specific provisions for different kinds of diseases. In general, when an employed person falls ill and needs to be away from work, a doctor will issue a certificate for sick leave to validate it. Based on this certificate, the employer and the Health Insurance Fund will have to pay to the person the benefit for temporary incapacity to work. The Health Insurance Fund starts paying the benefit from the ninth day of illness. The sickness benefit is paid at the rate of 70% of daily income, and the benefit is subject to income tax. Although sickness benefit is paid for 182 consecutive days (six months) (240 days, eight months in the case of tuberculosis), employment protection lasts for only four months. It is possible that better conditions are agreed upon at the company level, but most sectors definitely do not have any provisions of this kind in sector-level collective agreements.

[60] Ost, D. (2000), Illusory Corporatism in Eastern Europe: Neoliberal Tripartism and Postcommunist Class Identities, Politics & Society, 28(4), 503-530, https://doi.org/10.1177/0032329200028004004.

Thus, we can conclude that there are no obligations to hire or retain workers with chronic illnesses. The EUIF, with its national-level body of tripartite social dialogue, does support hiring people with reduced work capability, which may also include people with chronic disease. The EUIF offers both benefits and services to employers and employees in general.

In the context of a system of limited institutional support for RTW and ad hoc policy initiatives, and due to low union density and the priorities of employee representatives around fundamental issues of membership growth and improved legitimacy,[61] RTW topics remain less relevant. We expect that REWIR research will reveal rather atomised initiatives negotiated at the company level by unions or other employee representatives and employers.

We will now turn to explore the REWIR research results.

[61] Kall, K. and Samaluk, B. (2021), Innovative trade union project-based organisations in Central and Eastern Europe: The Case of Slovenia and Estonia, European Journal of Industrial Relations.

3 Involvement of social partners in shaping return-to-work policy at the national level: REWIR research results

3.1 Actors and stakeholders in RTW policy

RTW in Estonia is best understood as an integrated policy field that comprises measures in the following areas contributing to return to work after a serious illness or with a chronic condition:

- labour market legislation, such as the Employment Contracts Act and adjacent documents;
- medical services to treat a disease, offered by medical professionals such as general practitioners, occupational health practitioners, specialist doctors, physiotherapists, psychotherapists and/or other medical professionals within the healthcare system of the country. This sphere is regulated by respective legislative acts and financed by the Estonian Health Insurance Fund, the purpose and activities of which are regulated by the Estonian Health Insurance Fund Act;
- rehabilitation services that support reintegration into society in the event of serious injuries and illnesses that significantly impair the ability to cope with daily activities, including working; and
- social security/welfare measures, such as income replacement during periods of inability to work and allowances in the event of reduced work ability, along with social welfare services (social work).

RTW is one aspect of a more general policy mix of interventions that seek to identify a medical problem, cure it and help the person to return to daily life, including going back to work. Serious and/or chronic illnesses, such as cancer and diabetes, appear as one target but not the only one as also injuries and disabilities are addressed within this framework. Occupation-related health, diseases and injuries constitute a separate category of conditions that too are addressed in this framework.

It is also perceived differently by various stakeholders. A representative of the Estonian Chamber of Commerce and Industry perceived RTW as belonging to the field of social heterogeneity and helping people with reduced work ability to find a job that suits them and benefits the employer.

A trade union representative thought of RTW as an additional area of social security for workers, which potentially could contribute to their (material) well-being. The representative tended to think in financial terms – how much it would cost employers and the state to institute another form of insurance and what it would mean in terms of new taxes or tax rates, and noted that employees as well as employers were more interested and motivated to discuss and agree the level of (minimum) income rather than occupational health, disease or injury problems.

Representatives of the Ministry of Social Affairs as well as the Estonian Unemployment Insurance Fund tended to think of RTW as a field in the wider area of policy measures that target occupational health issues within an overall framework of employment and social heterogeneity. They also viewed potential advances in RTW from a longitudinal perspective – measures that evolve together with other policy measures on social security and well-being.

The EUIF representative described concrete measures available to people with reduced work ability that were linked to the **2016 work ability reform**.

Such a situation may develop when there has not been much communication on the issue between stakeholders. This hypothesis finds quite a lot of empirical support: there has been little interest in the

topic, it was repeatedly mentioned that there have not been any significant debates on the topic and participants used different frames of reference. Another potential explanation could be that each stakeholder sticks to an understanding and is not ready to step back from it, although this hypothesis finds little if any support in interviews, discussions and documents.

RTW policy has not been a distinct topic in social dialogue (except as part of jointly operating the EUIF). Hence, it is hard to describe the involvement of actors in discussions solely about RTW policies. The involvement of stakeholders has been based on other topics of social dialogue.

The issues of health, occupational health and support for people with reduced work ability have also been addressed at the ministerial level. The approach has been broader than just RTW, and RTW alone has not been the topic of policy discussions. On health, medical care and support measures, representatives of relevant stakeholder groups have been involved in the related discussions, such as doctors' organisations, nurses' organisations, occupational health doctors, patients' organisations, the Health Insurance Fund and the Unemployment Insurance Fund.

3.2 Views and level of involvement of industrial relations actors in RTW policy

The social partners' survey suggests that the involvement of stakeholders in European-level social dialogue structures is probably sufficient, as all responses were in agreement.

As mentioned, RTW has not been seen as a distinct topic in social dialogue. Thus, the involvement of actors in return-to-work issues and policies can be assessed based on their involvement in social dialogue in general. None of interviewees said that they have been involved in social dialogue to an insufficient degree. Indeed, assuring stakeholder participation in policy processes is among the core principles of public administration in Estonia and it is hardly possible that any significant stakeholder has been left out of the process. Social dialogue on labour relations and employment in general has been organised and carried out by the Ministry of Social Affairs. All significant discussions have taken place with the attendance and active involvement of trade unions, employers' organisations, medical doctors' organisations, organisations for people with reduced work ability and representatives of national organisations responsible for relevant support services, such as the Estonian Unemployment Insurance Fund, Estonian Health Insurance Fund and Social Insurance Board.

The stakeholders' survey showed that all of the respondents had participated in EU-level social dialogue structures. But all of them said that they were unaware of European-level RTW policies. On the question of whether the EU-level agenda should embrace RTW policies more actively in the form of non-binding recommendations for member states, two respondents said they did not know and the other two agreed. Three respondents held the opinion that EU-level social dialogue should embrace return-to-work policies more actively on the agenda, while only one said return-to-work issues should not be a priority of EU-level social dialogue committees and the current extent to which they are addressed is adequate. These responses give some support to the statement that stakeholders expect somewhat more initiative from the side of the EU when it comes to developing return-to-work policies.

Regarding awareness of national return-to-work policies and measures in Estonia, three national stakeholder respondents said they were aware of such policies. Two national stakeholders held the opinion that Estonia had an elaborate policy framework, one considered it insufficient and one was undecided.

Regarding implementation of Directive 2000/78/EC on establishing a general framework for equal treatment in employment and occupation, the work capability reform that was launched in 2016 was highlighted as especially important. The reform focused on transferring all employment-related support

services to one institution – the Estonian Unemployment Insurance Fund. All support services to people who had lost part of their work ability have been part of the EUIF since 2016, and this includes support measures for people suffering from a chronic disease. It needs be emphasised that the EUIF only manages interventions at the crossroads of (returning to) the labour market and health issues. For supporting people with 0% work ability, either permanently or temporarily, other social policy measures are in place. These include medical services to treat people with an illness, benefits and services to disabled and/or ill people, and social welfare benefits and social work services for those in need.

Three trade union respondents expected trade unions to be more active in RTW policy processes. The representative of an employers' organisation expressed satisfaction with trade unions' current extent of involvement. Interestingly, assessing the role of employers' associations in return-to-work policy was a harder task, as two trade union representatives said they could not evaluate their role. The representative of the employers' organisation, however, considered employers sufficiently active. Still, one of the trade union representatives expected employers to be more active on RTW policies.

A set of three out of the four stakeholders were aware of at least one specific measure in Estonia that would facilitate the implementation of return-to-work policies. This set included the employers' organisation and two trade unions. One trade union representative remained undecided.

When asked to indicate the extent to which the respondent's organisation was involved in creating RTW policies in Estonia, the responses ranged equally from one extreme to another, from having been actively involved and regularly consulted on RTW policymaking to not involved at all. The position of the employers' organisation was that it was involved occasionally, with trade unions being represented at both ends of the scale. The important if not central role of the state and EU is revealed in responses to the question of upon whose initiative the stakeholders became involved in RTW policy development. Only one (a trade union) got involved upon the initiative of the organisation. Two of the stakeholders got involved upon the EU's initiative and one through governmental priorities and agendas. Half of the respondents were satisfied with their extent of involvement in RTW policies and half wanted to be involved more actively. None said that RTW policies were not their priority and they wanted to decrease their involvement. Regarding the most important obstacles to organisations' involvement in RTW policymaking, these are unique, as each reported a different reason. They included blocking by other social partners, RTW not being considered important by other social partners and finally, not seeing the topic of RTW as important for the organisation (employers' organisation), among other reasons.

When it comes to applying RTW policies, the organisations have been involved in RTW policy implementation in Estonia either occasionally (two responses) or on ad hoc bases only and marginally (two responses). None said they were actively involved. Regarding concrete forms of involvement in implementation, three checked the box that they monitored how RTW policy was implemented at the national level and one respondent said they monitored how it was implemented at the company level. While one of the organisations would like to increase its involvement in putting RTW policies into practice, another did not expect any changes in involvement and two organisations did not know if they wanted to change their involvement in RTW policy implementation.

Hence, the organisations surveyed displayed a slightly stronger inclination towards involvement in the development of RTW policies than in the implementation of them. With caution, this could be interpreted as a sign that they are dissatisfied, at least to some degree, with the current state of affairs.

As to the perceived role of national industrial relations in RTW, the representatives of two trade unions expressed the opinion that trade unions should be more active in RTW policy implementation at the national level. The third trade union representative thought that RTW implementation should be a priority

for trade unions at the company level. Thus, all the trade union representatives alluded to the idea that trade unions should be more actively involved in implementing RTW policies. The employers' organisation representative refrained from expressing an opinion on the question. Interestingly, when it comes to assessing the role of employers' organisations, all the trade union representatives chose the option "don't know, cannot evaluate any of the above". The representative of the employers' organisation stuck to the view that employers' associations are active on the issue of RTW policy implementation and that their current extent of involvement is satisfactory. One of the trade unions and the employers' organisation had been involved in lobbying for RTW policy development in Estonia. The finding that both the trade unions and employers' organisation refrained from assessing one another's role in RTW policies leads to the interpretation that together that have not been involved in the development and implementation of RTW policies. Rather, they have been involved separately. This suggests that one of the aspects of the Estonian system is the significant role of the state as a mediator – or rather the initiator – of policies in RTW. Such a configuration looks natural in the national institutional setup whereby employers have managed to establish several umbrella organisations that cover virtually all employers and enterprises and only a small fraction of employees are members of trade unions.

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

Lack of cooperation between stakeholders is evident in the responses to the question in which stakeholders assessed cooperation in developing RTW policies, as two said they could not assess it and two said it could potentially be beneficial but there are obstacles. Roughly the same holds for the assessment of implementation of RTW policies, with the difference that three respondents checked the box that there are obstacles and one could not assess the situation. Is this again referring to the lack of communication and collaboration specifically between trade unions and employers' organisations? Probably not, as the question featured a list of organisations that also included others such as government, labour market institutions, medical organisations, rehabilitation centres and NGOs. Hence, this is an indication of a bigger challenge of cooperation between stakeholders. Interviews revealed that such a wide spectrum of stakeholders is represented only in processes that are initiated and facilitated by the state administration. In line with Estonian governance standards, all stakeholder organisations must have a say in matters that involve them. Problems of occupational health, health insurance and return to work are not put on the table in the regular social dialogue when negotiations focus on minimal income. In the stakeholders' survey, when asked to evaluate the cooperation between stakeholders in *shaping RTW policy* in Estonia, the two trade union federation representatives seemed to find there is already vital cooperation between stakeholders to facilitate a sustainable and feasible RTW policy framework; however, a third one, alongside the representative of the employers' association, suggested that such a cooperation would potentially be important, but there are obstacles. It is unclear if the obstacles were not felt by the other two trade union representatives or if they simply treated obstacles as an inevitable part of any such cooperation. Clearly, though, none said this cooperation is not relevant, thus reflecting understanding and agreement in this regard. Yet, when asked to evaluate the cooperation between stakeholders in RTW policy implementation in Estonia, none of them said such a cooperation is not relevant at all but nor did any say that it is vital. The representative of the employers' association as well as two representatives of trade union federations instead found the cooperation *potentially important* for facilitating sustainable and feasible RTW policy implementation, but there are other obstacles, and one trade union representative refrained from evaluation with "don't know". As these questions distinguish between policymaking and policy implementation, it seems that cooperation between stakeholders is likely viewed by trade unions as vital in shaping policy but only *potentially important* in policy implementation, whereas for the employers' association, cooperation might offer some potential

for both. Thus, there is no fierce opposition to the idea, but instead a clear need to better explain how the relevance of stakeholder cooperation in policymaking, and even more so in policy implementation, could be manifested. This might reflect the role that social partners see for stakeholder cooperation across the other themes that they negotiate about – *potentially important* or already *vital*, depending on which stage of policymaking is discussed.

3.4 Outcomes of social dialogue with regard to RTW policy

Regarding the role of trade unions in shaping RTW policies in Estonia, the employers' organisation respondent was satisfied with their role and level of activism while all three trade union respondents said that trade unions should be more active in RTW policymaking. The answer expresses the prospect that the employers' representative might not be interested in trade unions becoming more active, but trade unions want to be more involved. Assessing the role of employers' associations was a harder task, as two trade unions said they could not evaluate the role. The representative of the employers' organisation considered them sufficiently active and one trade union respondent expected them to be more active on RTW policies. Thus, it could be concluded that employers' organisations felt no need for more involvement on their or the trade unions' part, whereas trade unions wanted the cooperation to be more active on both sides.

Does this indecisiveness result from poor contacts and collaboration? Lack of cooperation is evident in the responses to the question where stakeholders assessed cooperation between stakeholders in developing RTW policies, as two said they could not assess it and two said cooperation could potentially be beneficial but there are obstacles to it. Therefore, this probably is not a problem of *poor* cooperation. Rather it is a problem of *lack of initiative* in this area from both sides – the trade unions and employers' organisations.

Representatives of trade union representatives alluded to the idea that trade unions should be more actively involved in implementing RTW policies: two trade unions, expressed the opinion that trade unions should be more active in RTW policy implementation at the national level while the third trade union representative expected RTW implementation to be a priority for trade unions at the company level. . The employers' organisation representative refrained from expressing an opinion on the question. When it comes to assessing the role of employers' organisations, all the trade union representatives chose the option "don't know, cannot evaluate any of the above" while the representative of the employers' organisations expressed the view that employers' associations are active and that their current extent of involvement in RTW was satisfactory. It appeared that one of the trade unions and the employers' organisation had been involved in lobbying for the development of RTW policy in Estonia, but none had provided assistance to individual workers, engaged in collective bargaining or raised workers' awareness of their rights in terms of RTW through an information campaign; thus, many ordinary tools are still to be discovered where RTW policies are concerned. Indeed, two of the trade union representatives admitted that they would like more active involvement in RTW policymaking, whereas one was happy with it as is and did not expect changes, which was also the position expressed by the employers' representative.

Social dialogue – negotiations between trade unions and employers' organisations – has instead been revolving around other themes and topics than RTW issues. The main topic has been the wage level, and in most sectors it has been the minimum wage. Occupational health matters have been advanced mainly on the initiative of the Ministry of Social Affairs, using participatory policy processes but outside the format of the social dialogue between trade unions and employers. One of the RTW-related topics that potentially could make its way to the negotiation table is occupational injury insurance, which would cover only those health problems resulting from work accidents. Therefore, it is narrower than the area of

occupational health and disease. In any case, there is not much interest in bringing this topic to the table by either employees or employers. Employers are not interested in bringing it to the negotiation table as it would probably lead to an increase of expenses for them. Employees are not interested because there are other issues that concern them more, such as agreements on wages and the minimum wage.

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

Two of the four organisations surveyed had an opinion on their current and future level of involvement in RTW policy and two said they did not know. One of the two organisations with an opinion ticked the option of wanting increased involvement in RTW implementation while the other was content with the current situation; both responses came from trade union representatives. As the best example of involvement in RTW implementation, being a member of the supervisory board of the institution implementing RTW policies was given. Indeed, RTW policy is not normally part of social dialogue. Instead, RTW policy and discussions are advanced as a specific topic of social involvement and health issues by the Ministry of Social Affairs, which is responsible for organising health services, occupational health and safety.

The potential for future action on RTW measures in Estonia remains bleak at the moment. None of the interviewees mentioned significant interest in pushing the theme, nor were there any concrete ideas put forward in focus group discussions. The trade union representative mentioned the long-standing general interest in making progress on the issue but added that there was no real interest in doing so because of more active attention elsewhere. According to the employers' representative, employers had already taken the initiative of addressing the situation of people with reduced work capability – they saw that RTW policies could be part of a workforce diversity approach. They acknowledged the fact that not all employees and workers were equal and that some needed specific support. The employers' representative interviewed framed the RTW theme primarily as a workforce-diversity issue rather than a health issue. Within that framework, health condition is just one factor that needs employers' attention as well as that of organisations that provide support services for reduced work capability.

What needs bringing forward is the central role of the state administration in the process of supporting the employment of people with a chronic disease. Returning to work is one strand of action on the wider agenda of interventions aimed at supporting people with reduced work capability. The Ministry of Social Affairs, Estonian Unemployment Insurance Fund and Social Insurance Board are the central players in this respect. Trade unions seem interested in being more involved, but employers' organisations are quite happy with how things are.

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

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

The disease reported by the highest number of respondents to the workers' survey was cardiovascular disease, which was mentioned by four and also rated the most serious disease by four. It was followed by other serious diseases such as cancer, mental disorders and musculoskeletal disease.

Table 10. Diseases reported by survey respondents who experienced RTW

	Diagnosed	Most serious disease	Concerned about return to work?	
			Yes	No
Cardiovascular disease	4	4	3	1
Oncological disease	3	2	1	1
Mental disorder	2	2	2	1
Musculoskeletal disease	2	1	1	1
Chronic respiratory disease	2	0	1	
Diabetes	2	0	1	1
I do not wish to specify my disease	3	0	2	
Other	4	1		
Radiculitis	1	0		
Celiac disease	1	0		
Epilepsy	1	1		1
TOTAL	22	10	9	4

Source: REWIR survey, own calculations; number of respondents: 13.

A majority of workers and employees in this situation – ten respondents – were concerned about their return to work, and this did not differ systematically based on the type of illness reported. Several respondents named more than one concern (in one case up to five). From the survey data, two major types of fears could be distinguished. One was associated with not being able to meet productivity standards after illness, and the other was associated with being left without adequate or any support. There were also concerns about the employer's unwillingness to adjust working conditions after illness – with fears not only of workplace and financial discrimination but also of the need to work long hours, of being required to jump in at full productivity and of there being nobody to support employees in the event of problems with productivity – evidently suggesting that the returning employee expects to face problems in being understood, noticed and supported.

One could suggest that concern about RTW is more likely dependent on the organisation type or some specific features of the job. It appears, though, that among those five who had not been concerned about their RTW, the aspects that were common included:

(1) having an intellectual job; (along with)

(2) working indoors, in an office;

(3) working as a professional (although in different fields); and

(4) ending up being satisfied or very satisfied with the support they received from their employers.

Their employer was either a very small (fewer than 20 employees) or sizable (50-500 employees) private sector (and in one case, public sector) organisation, thus showing that security in the arrangement does not really depend on the type or size of the organisation. At the same time, the small private sector organisation felt less scary in the case of a respondent with epilepsy – a disease that does not always show, until it does – whereas other respondents from small organisations with various illnesses (oncological disease, cardiovascular disease and mental disorder) were rather concerned, probably illustrating awareness of the fact that in small organisations, everyone has to be at their full productivity all the time. Indeed, the fears that those from smaller organisations voiced more likely included being afraid there is need to jump in at once while their productivity is (still) less than before, with no support in the event of problems occurring in this regard. Those from larger organisations (50-500, 500-1,000) were a bit more likely to fear that their employer is not willing to adjust the working conditions upon RTW, but also that they will be left without support when they need it. It seems then that those from smaller organisations worry because they feel obliged to start at full power upon RTW (but feel they might be unable to), while those in larger organisations tend to be more aware that the working conditions could be adjusted, yet their employer might be not willing to follow suit. Perhaps related to this is the level of satisfaction with the help and support received upon RTW? Notably, in smaller organisations the respondents tended to have had a more negative experience, being only moderately satisfied with the employer's support and either moderately or even partly satisfied with the support by the trade union (including when they were not union members). In organisations with 50 and more employees, the experience was more likely to be satisfactory, with respondents ranging from partly satisfied to satisfied and very satisfied; here again, there were those who were happy with trade union support and those who were moderately satisfied. There were two exceptions: a public sector organisation with 50-500 employees, where the returning employee was not satisfied at all with the support from the employer or from trade union; and a public sector organisation with 500-1,000 employees where the returning employee was not satisfied at all with the support from the employer, but partly satisfied with the support from the trade union.

Among those who had only recently been diagnosed, five respondents said they did not intend to take time off from work because of their illness. Employers' reactions to the information that an employee needs sickness leave, according to the employees' survey, have not been supportive. This is evidenced by the survey finding that only one respondent said that it had been supportive, and one said it had just been indifferent (not negative). Further, three said they had not disclosed their illness to the employer out of fear of losing their job and one said that the employer always panics when presented with such information. Altogether, these responses paint a grim picture of unsupportive employers. Returning to the same job after illness seems to be a working practice, while three respondents reported they did not plan to stop working during the illness and had set up an arrangement to return. In addition, two more said they intended to return to the same job after the illness. Five said they had an arrangement with their current employer to return to the same work position after treatment. When thinking of real-life experience, then, actually six had returned to the same job while three had not.

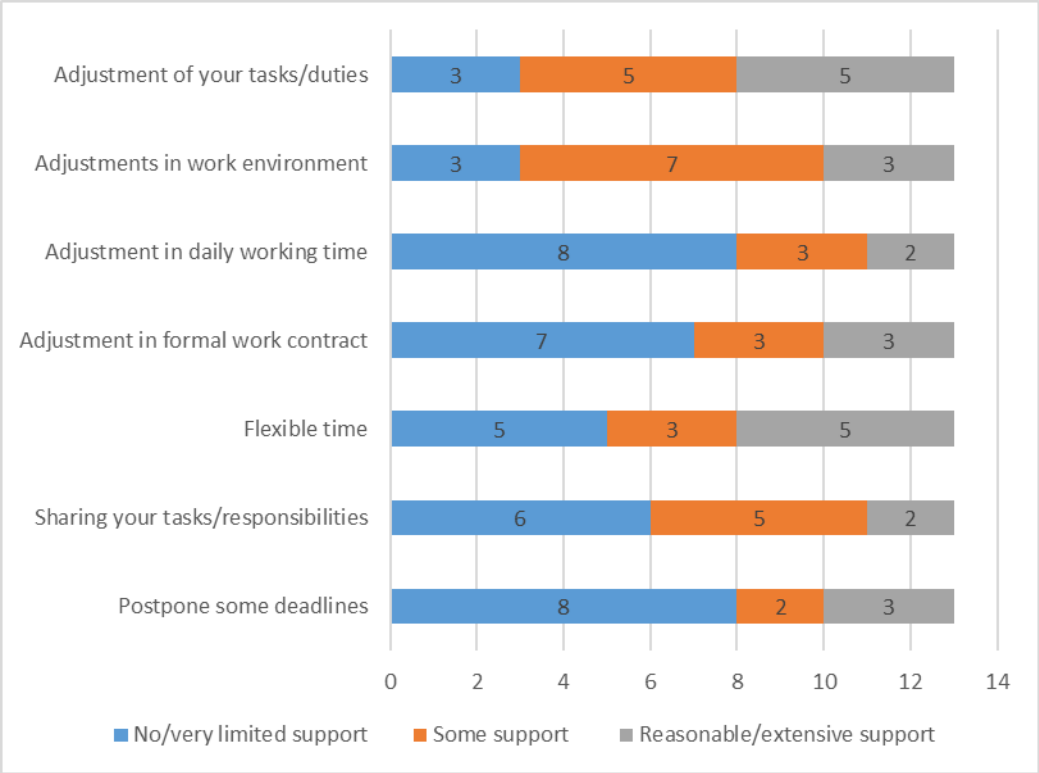
Those facing the situation of return to work held the opinion that their team leader/line manager was the most important person for supporting the respondents' return to work, as mentioned by four respondents. A psychologist was mentioned by one respondent and another said no help from any of them was needed. Two respondents reported that they will contact their team leader/line manager, while one said they will contact the human resources department and one intended to seek help from an

external psychologist. Two said they had decided not to seek any help. When it comes to concrete support actions, there too the team leader/line manager was considered to be the most important person to support returning to work – eleven respondents had this opinion. A rehabilitation institute, human resource department and a professional association working with patients were mentioned far less often, and the same applies to a psychologist/professional therapist. The least popular were the boss of the company, trade unions and labour authority. Indeed, when talking of personal experience, the biggest number of respondents had been in contact with their colleagues (eight respondents) and/or with their direct manager (seven respondents). The general manager/HR department and trade union were mentioned by one. And one respondent reported not being in contact with anyone. In all, this suggests a very scattered picture with no certainty and more reliance on informal relationships (with one's colleagues, for example) than a standard procedure that would be followed with the involvement of human resource professionals, therapists or indeed, trade unions.

The biggest number of respondents had returned to work on their own initiative – eight respondents said so. Six respondents pointed out the significant role of medical doctors in making this decision and four emphasised the role of their family. Colleagues and the boss were mentioned by only one respondent, implying that these decisions were made outside of workplace relationships. A doctor was the first contact to discuss returning to work after illness for the highest number of respondents (six) and family was mentioned by three. Friends, colleagues and the boss were mentioned by one. This pattern gives the impression of a lack of active interest on the part of the workplace.

The workers' experience reveals that adjustments of tasks and duties, probably reduced workload and part-time work as well as adjustments in the work environment were the most common changes after illness.

Figure 7. Adjustments received by workers when returning to work after a long-term illness

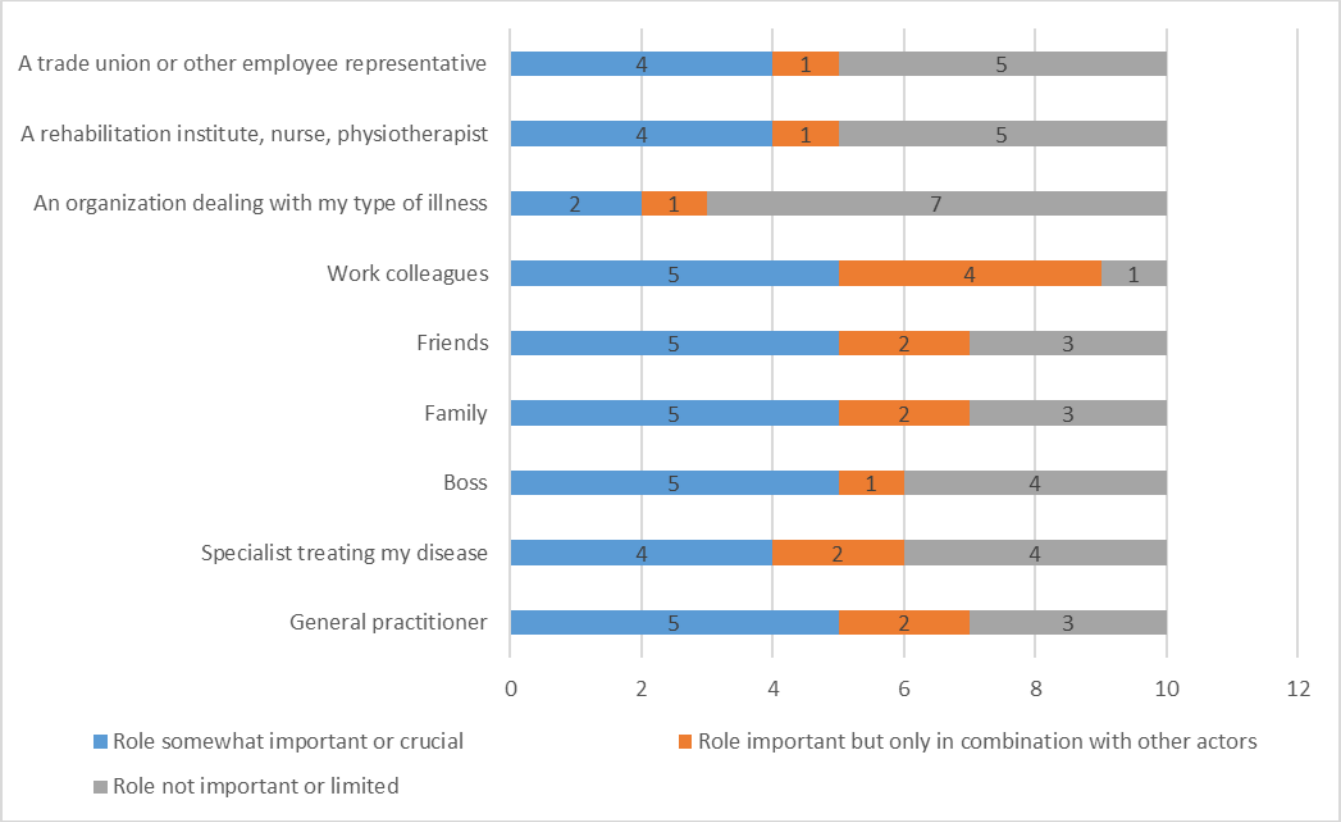


Source: REWIR survey, own calculations. Number of respondents: 13

The least occurring adjustments have been postponement of deadlines and also adjustment in daily working time.

Colleagues have had important role in facilitating return to work after illness by the biggest number of respondents. Friends, family and general practitioner too were rated highly too. The least useful were organisations dealing with the respondents' types of illnesses. This suggests that other medical professionals did not take any responsibility in supporting RTW. The role of bosses as well as trade unions were rated as small as well, which is, of course, much more problematic given the context.

Figure 8. Workers' evaluation of the role of different actors in facilitating return to work after sickness leave



Source: REWIR survey, own calculations; number of respondents: 10.

Hence, the role of people at the workplace with whom a respondent gets in touch was cited as the most important even though none of them had any role in adjusting workloads, working conditions or providing specific support devices. But they might be an important facilitating factor in making these work.

When assessing their experiences during return to work, a majority of respondents said they were either not satisfied at all (two) or were partly (four) or moderately satisfied (four). Only two said they had received the advice and support they expected or that the advice and support had even exceeded their expectations. When assessing the help and support from the trade union, a similar picture emerges: eleven respondents were not satisfied at all or were partly or moderately satisfied, two said they had received the advice and support they expected or that the advice and support had even exceeded their

expectations. When assessing the activities of employers, four did not agree that the employer had been prepared for their return and two held the opinion that the employer had been well prepared. Still, five did not receive mentoring from their company and six did not receive it from the trade union. All nine disagreed with the statement that their return was well coordinated. Hence, employees' overall satisfaction with their return-to-work process was low. This nonetheless needs be separated from the feeling of being back at work. Most people felt welcome when returning to work after illness (six agreed, two disagreed).

In terms of the role of and expectations of trade unions in the RTW process, based on the survey, it is fair to say that none of the respondents received help or support from trade unions when they reported their health situation, the need for treatment and sick leave. One respondent had thought of joining a trade union since a recent diagnosis in order to support or facilitate return to work after treatment while twelve respondents said they had not thought of joining trade union. The reason for that could be that they did not see how a trade union could help them in this process. Indeed, all of the respondents said that they knew of no cases where a trade union had supported the return-to-work process. According to the survey, three respondents had been working in an organisation where there was a trade union while twelve came from an organisation without one. Under such conditions, the support of trade unions was hard to notice. Two respondents said there had been negotiations between the employer and trade union/employee representatives about adjustments in their work tasks and responsibilities after returning to work. Five said there had been no negotiations and two did not know whether such negotiations had taken place. Twelve respondents reported that they were not aware of any cases where a trade union proved helpful in facilitating return to work. None volunteered that they were aware of such cases. The attitude towards trade unions was characterised by responses to the question of whether respondents had considered joining trade union – eleven said they had not thought of joining, while one had been thinking of that.

These survey findings about the activities and the role of trade unions in RTW are in stark contrast with employees' and workers' vision of what it potentially could be (see the table).

Table 11. Opinions about trade unions

	Agree
The trade union should always be ready to address health-related issues of workers	9
Support for RTW should be an important element on the agenda of negotiations between the trade unions and the employer	10
The form of support by the union is sufficient in offering individual consultations	4
The preferred form of support by unions is negotiating binding agreements with the employer, e.g. for reducing working hours, stress and workload for people after long sickness leave	7
Trade unions are not powerful enough to facilitate RTW in my country	4

Source: REWIR survey, own calculations.

Ten respondents said that support for RTW should be an important element on the agenda of negotiations between the trade unions and the employer, and nine that the trade union should always be ready to address the health-related issues of workers. The preferred form of support by unions was negotiating binding agreements with the employer, e.g. for reducing the working hours, stress and workload of people after long sickness leave, as reflected in the opinion of seven respondents. Only four did not see that trade unions could do more and four held the opinion that trade unions were not powerful enough.

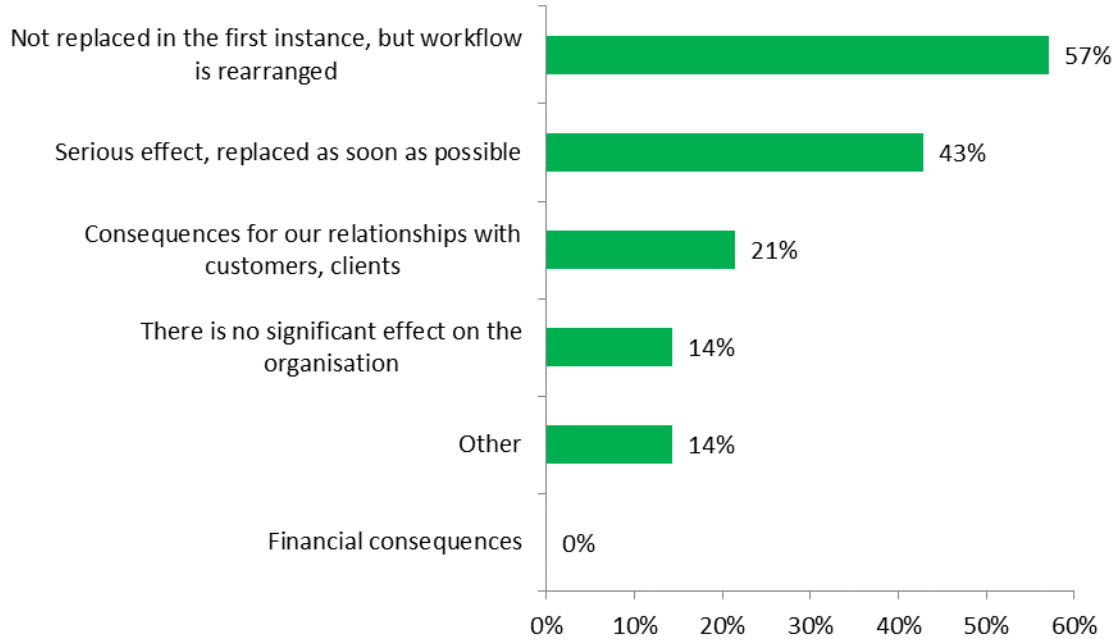
Evidently expectations do not match the reality. While there are hopes that trade unions offer support in RTW, in real life few have experienced help from trade unions. In fact, nobody reported a concrete and supportive response from a trade union when announcing the need for treatment and sick leave, as one

respondent did not respond at all, two did not receive an expected response and three said there was no trade union at their workplace.

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

According to company managers, an employee with a serious illness would cause significant problems for company operations. That employee would not be replaced immediately (eight responses) but still, if the employee could not fulfil the job duties, that individual would be replaced (six). Only two said that there would be no significant effects on the organisation. Importantly though, none expected financial consequences.

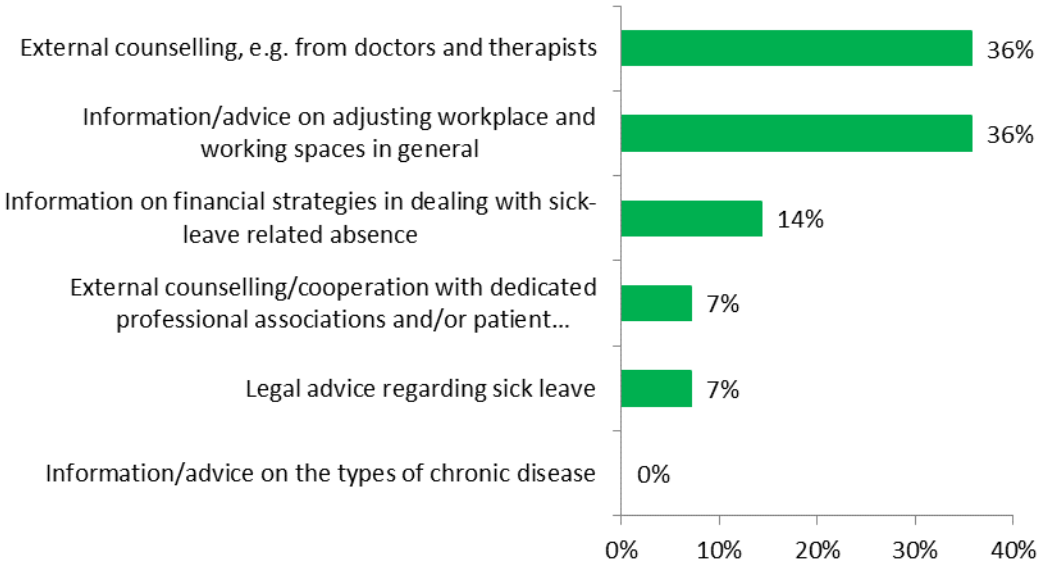
Figure 9. Perceived effect of an employee absence on the organisation



Source: REWIR survey, own calculations; number of respondents: 14.

Among organisations' managers, information/advice on adjusting the workplace and working spaces in general as well as external counselling, e.g. from doctors and therapists, were considered to be supportive resources when dealing with the sick leave of workers (both mentioned by five). Information on financial strategies in dealing with sick leave-related absences was mentioned by two. Legal advice as well as external counselling/cooperation with dedicated professional associations and/or patient organisations were mentioned by one and information on chronic diseases by none. Managers felt that they would need more information on financial strategies in dealing with sick leave-related absences (mentioned by four respondents) when dealing with workers on sick leave. Three respondents mentioned a lack of information on the types of chronic diseases as well as on adjusting the workplace and working spaces in general.

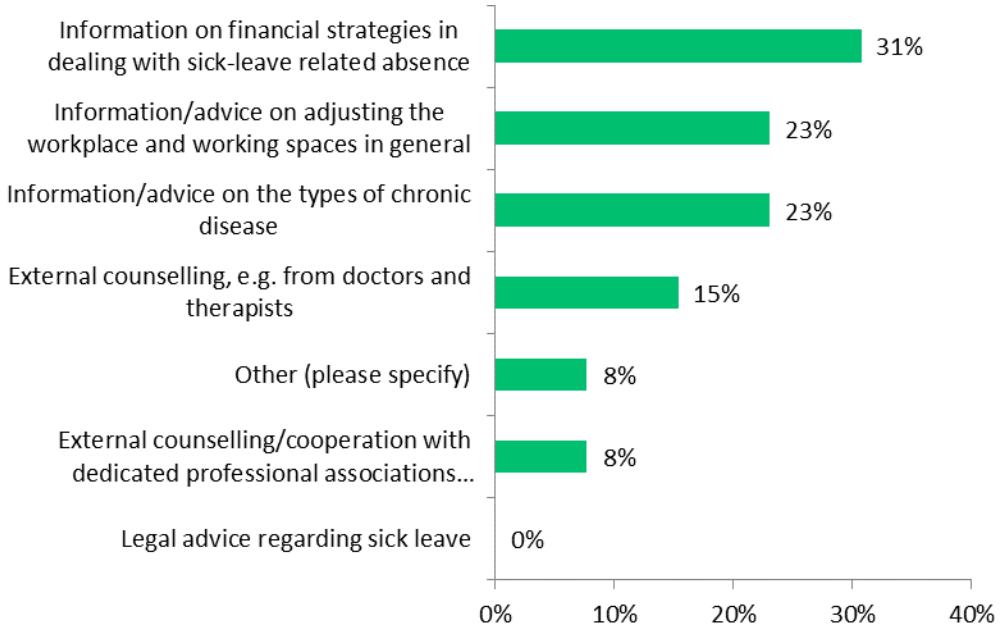
Figure 10. Resources that organisations consider supportive when dealing with workers on sick leave



Source: REWIR survey, own calculations; number of respondents: 14.

Lack of external counselling (such as from doctors and therapists) was mentioned by two and one mentioned the lack of external counselling/cooperation with dedicated professional associations and/or patient organisations. None mentioned the lack of legal advice.

Figure 11. Resources that organisations consider lacking when dealing with workers on sick leave



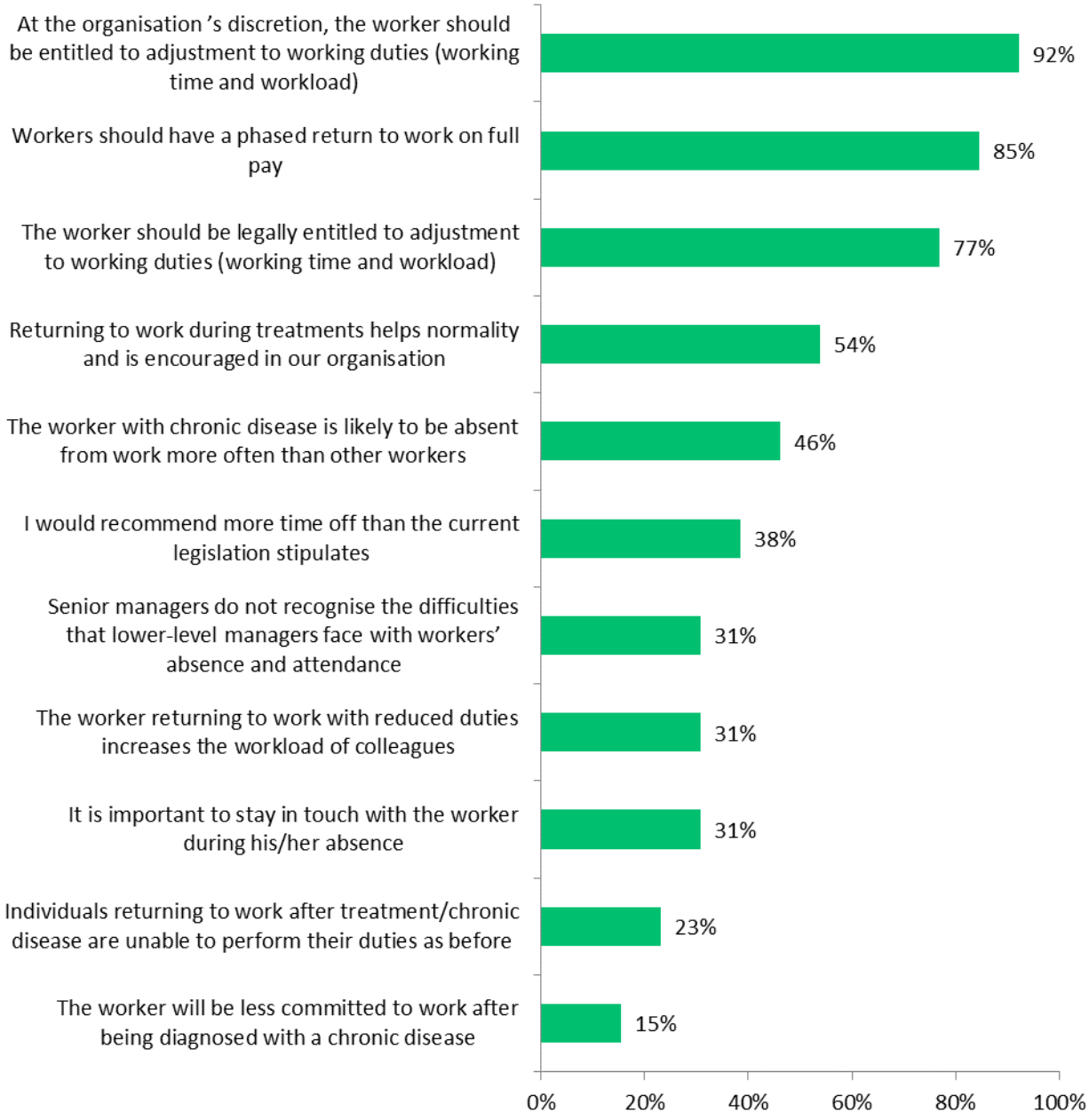
Source: REWIR survey, own calculations; number of respondents: 14.

When it comes to making arrangements to support return to work, three ideas were most popular among managers:

- At the organisation's discretion, the worker should be entitled to adjustment to working duties (working time and workload) (checked by twelve respondents).

- Workers should have a phased return to work on full pay (eleven respondents).
- The worker should be legally entitled to adjustments to working duties (working time and workload) (ten respondents).

Figure 12. Employers' opinions about statements on return to work



Source: REWIR survey, own calculations; number of respondents: 13.

In sum, the adjustment of working time and workload is perceived to be effective by the largest number of managers. These actions were also among the most frequent offers to employees returning to work.

Approximately half of the respondents checked the following two options:

- Returning to work during treatments helps normality and is encouraged at our organisation (seven respondents).
- A worker with chronic disease is likely to be absent from work more often than other workers (six respondents).

In general, these responses indicate that managers accept working part-time and the possibility of unexpected interruptions. However, the relatively low number suggests this might be not accepted by all.

Relatively few line managers and team leaders held the opinion that the employment of a person with reduced work capability will bring about some additional challenges, associated with a reorganisation of workflow:

- I would recommend more time off than the current legislation stipulates (five).
- Senior managers do not recognise the difficulties that lower-level managers face with workers' absence and attendance (four).
- The worker returning to work with reduced duties increases the workload of colleagues (four).
- It is important to stay in touch with the worker during that person's absence (four).

Surprisingly, only very few managers believed that the person returning to work after illness and treatment will be less worthy than other workers:

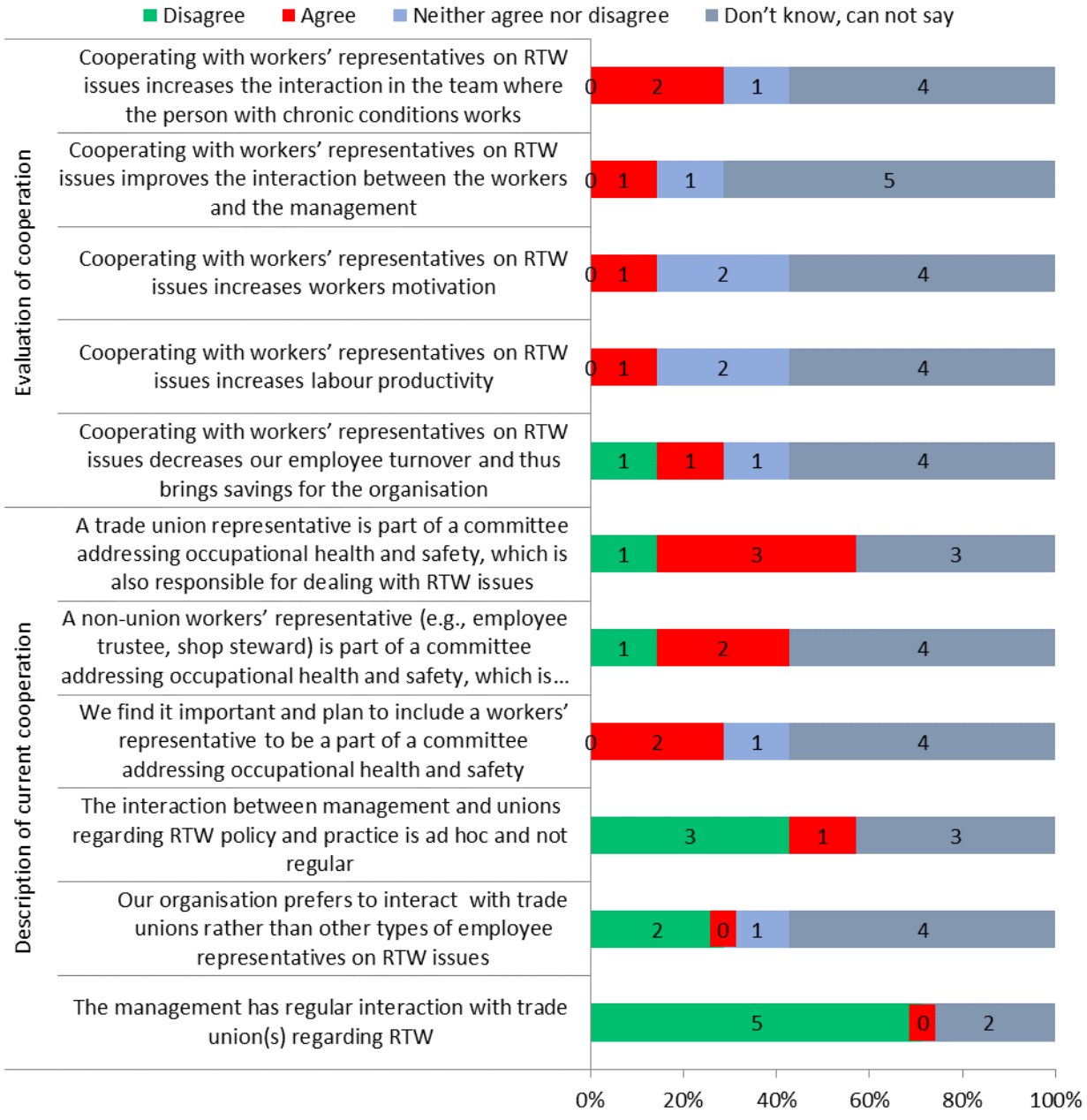
- Individuals returning to work after treatment/chronic disease are unable to perform their duties as before (three).
- The worker will be less committed to work after being diagnosed with a chronic disease (two).

These responses leave the impression that managers are quite supportive and ready to change the working conditions of people returning to work with a chronic condition.

In the survey, seven managers said that a trade union was present at their organisation and five said it was not. Six respondents said that less than 50% of workers were unionised and one did not know how many had joined the union. None of the respondents said that return-to-work issues were addressed in company-level collective agreements. Five said it was not addressed and two that they did not know. Six respondents said they did not with discuss return-to-work issues with the trade union, but one did.

Regarding organisational practices on supporting return to work, the most significant finding is that most of the respondents did not know about them, as "don't know" was the most common response to eight questions out of eleven. The option ticked by the largest number of respondents (five) disagreed that management has had regular contact with a trade union regarding return to work. At the same time, three respondents disagreed with the statement that management has had irregular contact with a trade union regarding return-to-work policy and practice. Not surprisingly, three respondents agreed with this statement. Further, three respondents agreed that a trade union representative was part of the committee which was also responsible for dealing with return-to-work issues. Two respondents agreed that a non-trade union workers' representative was part of the committee which was also responsible for dealing with return-to-work issues and two with the statement that the company planned to include a workers' representative on a committee addressing occupational health and safety.

Figure 13. Organisational practices on return to work



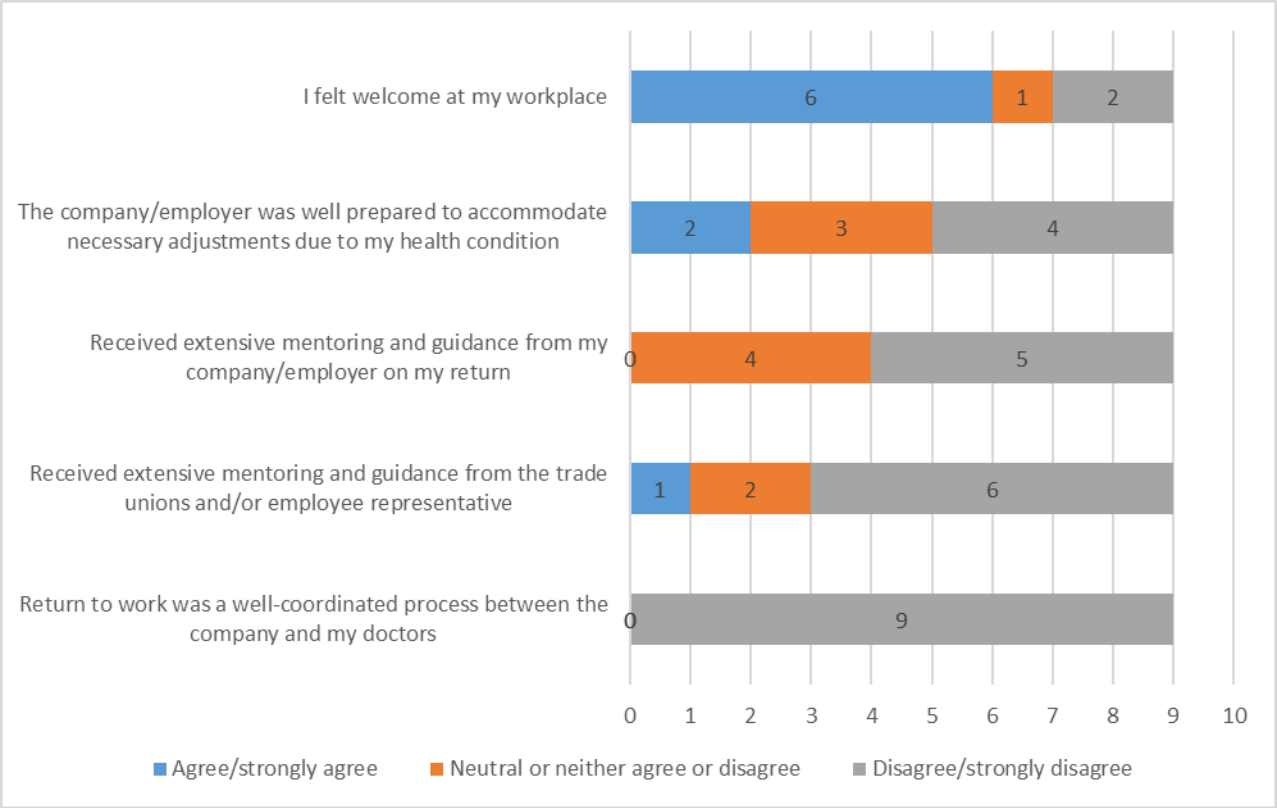
Source: REWIR survey, own calculations; number of respondents N=7.

It also must be noted that more than half of the survey participants skipped the question – thus indicating either their unwillingness to share, or more likely their lack of preparedness to describe or furthermore evaluate the current level of cooperation with the trade union. It is indeed revealing that the respondents lacked information about cooperation practices: did they think it was possible that these might exist, even if they themselves had heard nothing of them?

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

Among the employees, six respondents ticked the response option that they felt welcome at work. Despite this generally positive view, other opinions were less positive, but this was the only statement where there were more positive responses than negative ones. Positive sentiment was also revealed in the statement that the company was well prepared to accommodate necessary adjustments (two positive responses) and the statement that the returning employee received extensive mentoring and guidance from the trade union and employer (one response). However, as noted, the number of negative responses exceeded the number of positive ones. The statement that the return was well organised only generated disagreement. From the employee side, a slight negativity frames returning to work and relations with the employer.

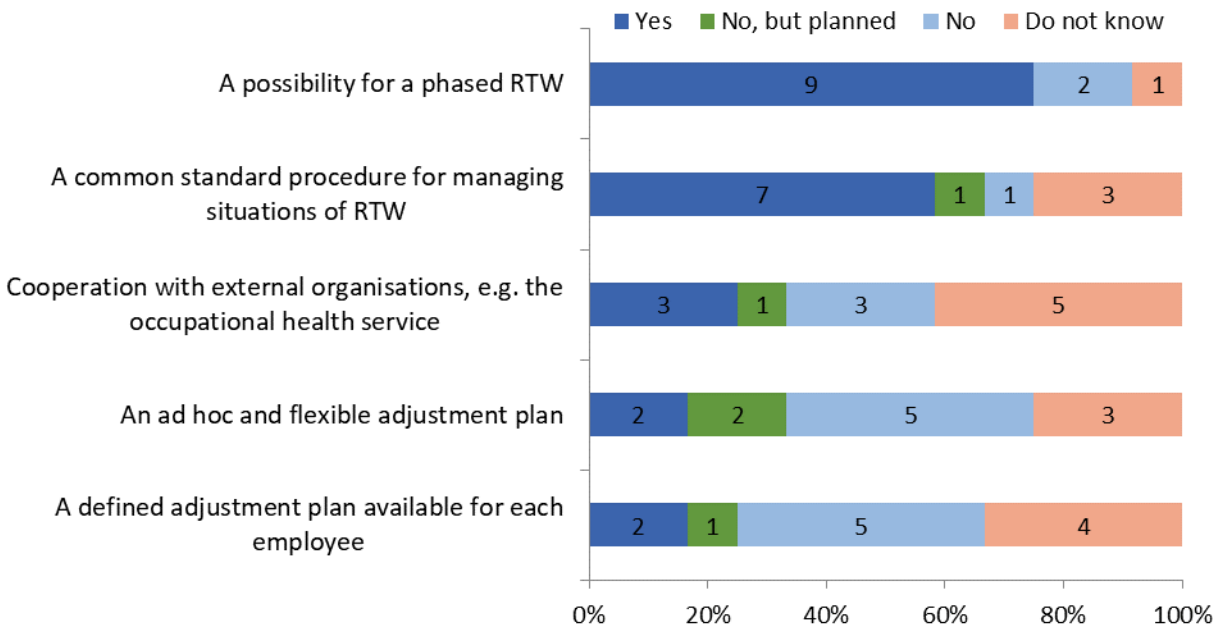
Figure 14. Workers' experience with the return-to-work process



Source: REWIR survey, own calculations; number of respondents: 9.

Management has undertaken actions to adjust work for people returning to work from sick leave. From the management perspective, the two most common offers to people returning to work are the possibility of a phased return to work (nine responses) and an organisational procedure for managing such situations (seven responses). An adjustment plan was available at two places and not available at five. Again, the percentage of "don't know" responses was high – 27% of all responses given by managers (who could be expected to be aware of organisational practices).

Figure 15. Availability of return-to-work procedures at the organisation



Source: REWIR survey, own calculations; number of respondents: 12.

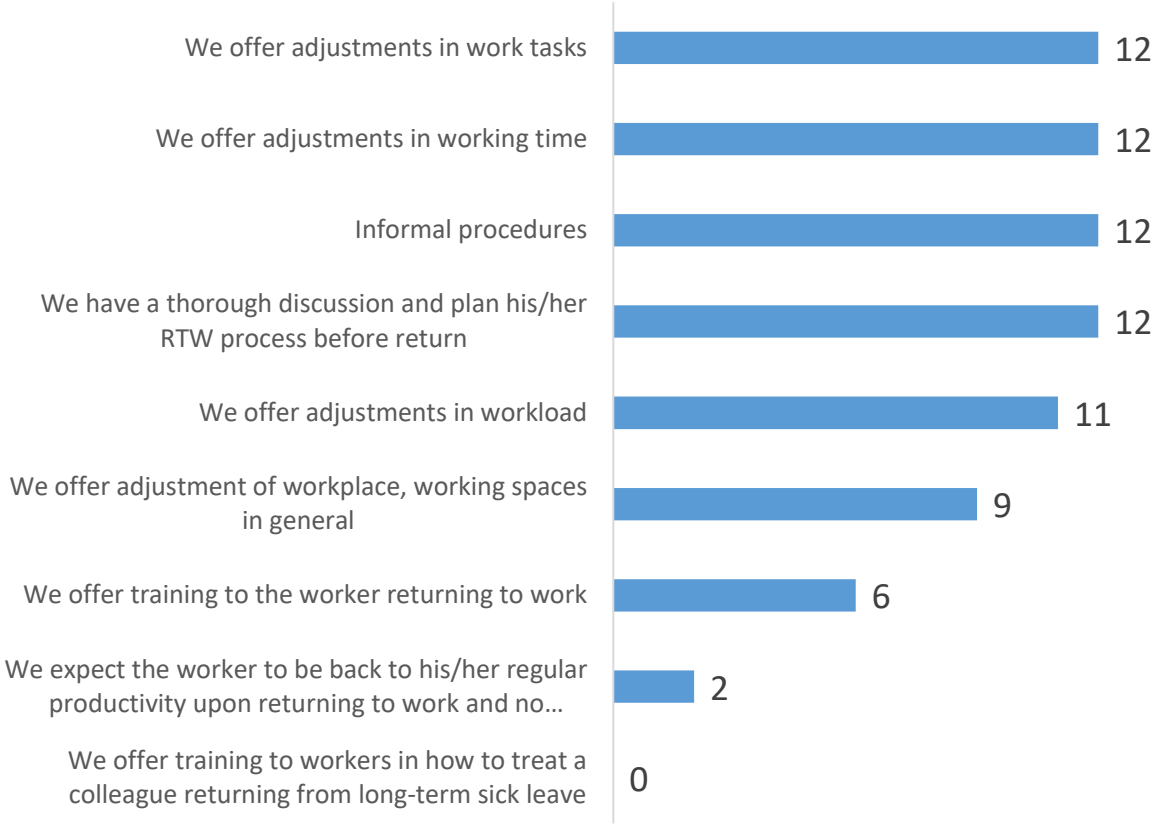
When it comes to concrete support measures offered by companies, twelve managers said their company offered adjustments to work tasks and working time, along with informal procedures, a thorough discussion and individualised plan; eleven said their company offers adjustments in workload. An adjustment of the workplace was offered at nine companies and training for the returning worker at six companies. Two respondents said their company expected employees to be back at their regular productivity upon return. This gives an impression of management's supportive attitude towards people retuning to work after illness.

These adjustments and arrangements are most likely offered outside the activities undertaken by the trade union, as five respondents said there had been no negotiations about adjustments to work tasks and responsibilities between the employer and the trade union and two said they did not know of such negotiations. Yet, two said there had been such negotiations.

Lack of cooperation between workers and employers is evident in the responses to the question in which stakeholders assessed the implementation of return-to-work policies.

Regarding the smoothness of implementation, three respondents checked the box that there were obstacles along the way and one could not assess the situation. In spite of that, the survey indicates that the team leader/line manager was considered to be the most important person in supporting respondents' return to work, mentioned by four respondents. A psychologist was mentioned by one and one respondent said no help from any of them was needed. The significance of the immediate manager is further corroborated by the finding that two respondents reported they will contact their team leader/line manager, while one will contact the human resources department and one intended to seek help from an external psychologist. Two said they have decided not to seek any help. A rehabilitation institute, human resource department and a professional association working with patients were far less popular, as was a psychologist/professional therapist.

Figure 16. Support offered by the company to the employee returning to work (agree/strongly agree)



Source: REWIR survey, own calculations; number of respondents: 13.

The least popular were the boss of the company, trade unions and the labour authority. Indeed, the biggest number of respondents had been in contact with their colleagues (eight respondents) and/or with their direct manager (seven respondents). The general manager/HR department and trade union were mentioned by one. One respondent had not been in contact with anybody. Eight respondents said they had returned to the work on their own initiative, six pointed out the significant role of medical doctors and four their family. Colleagues and the boss were mentioned by only one respondent. When assessing the role the first contact to discuss returning to work after illness, then a doctor was mentioned by six, family by three and friends, colleagues and the boss were mentioned by one. This pattern gives the impression of a lack of active interest on the part of workplace. When it comes to returning to work and related activities, it appears that colleagues have had important role in facilitating return to work after illness for the largest number of respondents. Friends, family and a general practitioner were also rated highly by relatively many. The least useful were the organisations dealing with the respondents' types of illnesses. The role of bosses as well as trade unions were rated low too.

To sum up, the decision to return to work was taken by the individual returning to work and supported by people within a close circle – medical staff and family members. Also, colleagues may play some role, but this seems not to be too significant. Still, when it comes to concrete arrangements, the direct manager becomes the most important person.

When assessing the experiences that the respondents faced upon their return to work, a majority of them said they were either not satisfied at all (two), were partly (four) or moderately satisfied (four). Only two said they had received the advice and support they expected or the advice and support had even exceeded their expectations. Most people felt welcome when returning to work after illness (six agreed, two disagreed). Two agreed that the employer was prepared for the employee's return even if four did not agree. Five did not receive mentoring from their company and six did not receive it from the trade union. All nine disagreed with the statement that their return was well coordinated. Moreover, five respondents said there had been no negotiations about adjustments to work tasks and responsibilities between the employer and the trade union and two said they did not know. By contrast, two said there had been such negotiations. Despite the absence of such negotiations, the workers' experience reveals that adjustments of tasks and duties, probably reduced workload and part-time work, as well as adjustments in the work environment were the most common changes after illness. The least common adjustments were the postponement of deadlines and adjustments in daily working time.

A somewhat **different picture** emerges from the managers' point of view. Half of the respondents to the managers' survey said that contact with the worker on sick leave was regular (seven respondents) and the same number of respondents said it was irregular; one said there was no contact. Based on this pattern of responses, one could conclude that there are some companies where there is some regularity in interactions between the management and employees on sick leave. And there are other kinds of companies where there such contacts were irregular. In any case, such contacts probably are rather informal, as fourteen respondents said the contact was informal, while one respondent said it was formal. Regarding the content of the communications, twelve managers said it was about keeping the worker informed of work-related issues (two said they do not do that) and seven said that they involve the worker in work-related issues (seven said they did not do that).

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

Over the period 2015-19, the unemployment rate in Estonia was 5% or below that. This means companies have had strong interest in hiring people and this also holds for people with reduced work capability. Companies have an interest in providing employees and workers with support so that they can work.

Among good practices, we can list the proper usage of policy measures. There are a range of in-cash, in-kind and on-demand measures available. But awareness of these measures and then consequently effective usage of them is low. The claim was made during the roundtable discussion as well as the interviews that employers, especially managers, have little awareness of the possibilities for supporting RTW, and may also lack time.

Given the scarcity of evidence of good practice, we have extracted some examples of good experience from the survey. A **good experience** is a situation whereby an employee has experienced a supportive employer environment when returning to work after an illness or with a chronic disease or expects no problems in this regard. **An example of good practice** is that where an employer (manager) is able to discuss existing cooperation with a trade union in the RTW context and expresses preference for more support.

Considering the six respondents who had been diagnosed only recently and who thus did not yet have RTW experience, we looked at the responses they received from the employer and from the trade union

representative when they announced their treatment and need for sick leave. The following pattern appears:

1. **The best RTW experience.** Upon announcing the need for treatment and sick leave, there was a generally supportive response from the employer as well as a generally supportive response from the trade union, but no help or support was offered during the sick leave (one respondent). Even if the employee was not a trade union member, the employee reportedly thought about joining a trade union since the recent diagnosis in order to support returning to work.

2. **Trade-union supported RTW.** There was a generally supportive response from the trade union (though no help or support offered during the sickness leave) but an indifferent response from the employer, as the company only cared for its business and not for the well-being of employees, according to one respondent.

3. **Unsupported RTW.** In this case, the workers either did not plan to take extended leave, and/or did not feel confident enough to even announce the need for a long-term absence to the employer, as they feared losing their job. One volunteered in an open answer: "Anything like that always makes the employer panic".

   In those cases, either there was no union at the workplace to which the respondent could turn or the respondent did not announce the need for a long-term absence to the union representative. Altogether, in our sample there were four examples of such cases.

It is important to note here that none of these respondents were trade union members. It should also be noted that perhaps even in the case of the 'best RTW experience', no help was offered to support the workers during their sickness leave. Thus, what makes it special is the *generally supportive response*, which sets it apart from the 'union-supported RTW' where the company was perceived as not caring for employees' well-being. This is even more problematic when one considers that in fact, the employees in question either did not intend to be absent from work or did not know as yet how long they needed to be away. Given their types of reported illnesses – oncological disease, cardiovascular disease, chronic respiratory disease and epilepsy – the fear of even informing the employer of the chronic illness might be really counterproductive for the employers in the long run. The fear of losing one's job or that the employer would start panicking or otherwise not take a caring approach applied to both public and private sector organisations, confirming the point that public sector employers are not necessarily setting a good example in the field.

Regardless of the type of RTW support received, the respondents maintained their intention to return to their current job after treatment, and they had an arrangement with their current employer for this. Also, despite their RTW support pattern, they were of the opinion that their team leader/line manager was the most important person to support their return to work – or they indicated that they would not contact anyone as they felt (or hoped?) that they would not need support. Yet, in the **most supportive RTW model**, the respondent said they would instead contact the HR department of the company for support, and in the **trade union-supported RTW** model, the contact point would be a psychologist/occupational therapist outside the company, who would be the most important person to support their RTW.

Among those workers with RTW experience (N=11), when evaluating the satisfaction level with the help and support received from the employer and from the trade union, the following patterns seem important to note.

Two were satisfied or very satisfied with the support from the trade union (but only one of them was a trade union member), four were only partly satisfied, reporting that they had received only limited support (none had a trade union at the workplace) and five admitted that although the support was not extensive, they had not expected more (two of them had a trade union at their workplace and one of them was a member, but the other was not). Five were satisfied or very satisfied with the support from the employer, two felt they had received too little support, and four said the support was not enough but they had not had expectations of more. If we regard experiences with limited support as rather negative, and cases of "not extensive but I did not expect more" support as not positive, the following positive models emerge:

1. **The best RTW experience.** The respondent was satisfied with the employer and satisfied with the trade union (just one case) but in fact was not a trade union member and there is no trade union presence at the individual's workplace.

2. **Employer-supported RTW.** The respondents were satisfied with the employer and had not expected or received much from the trade union (four cases). In two of these cases, there was a trade union at the workplace, and one respondent was a union member. In the open answer the latter actually volunteered the following:

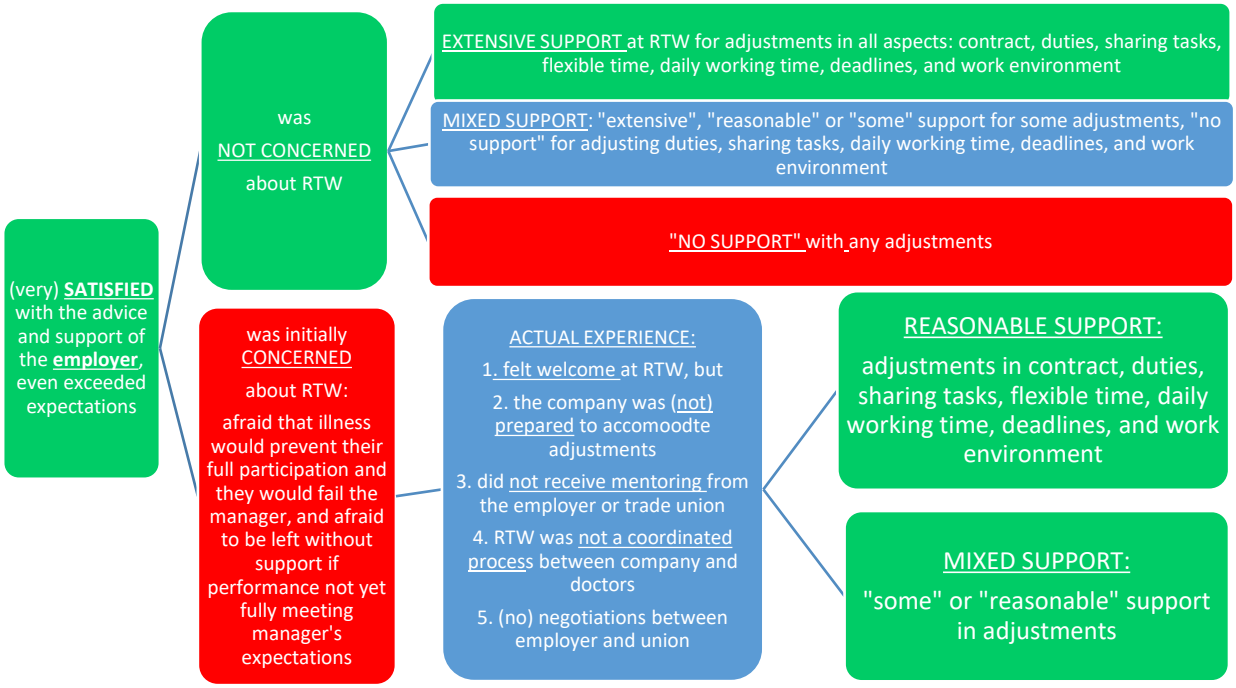
   > My work was of enormous support for me emotionally in healing and rehabilitation. Thus, support by [the] trade union as such was not especially necessary. Still, it gave me the sense of belonging, and I felt that I was needed.

3. **Trade union-supported RTW.** The respondent was satisfied with the trade union support, and had not expected or received much support from the employer in one of the two cases where there was a trade union and the respondent was a trade union member.

4. **Unsupported RTW.** The respondents were not satisfied, even if not expecting much, with either (in five cases). In one case, the respondent had been thinking of joining a union since the latest diagnosis, even though there is no trade union at the respondent's workplace.

Given that in the 'best RTW experience' there was no active involvement from the trade union as there was no trade union presence at the workplace, this in fact should be collapsed together with the category of 'employer-supported RTW'. In what follows, we analyse the characteristics of the best RTW experience, exploring the experience with employer-supported RTW (five episodes) and with union-supported RTW (one episode), and will no longer focus on the other cases.

Figure 17. Best experiences with RTW in Estonia from the employee perspective: employer-supported RTW



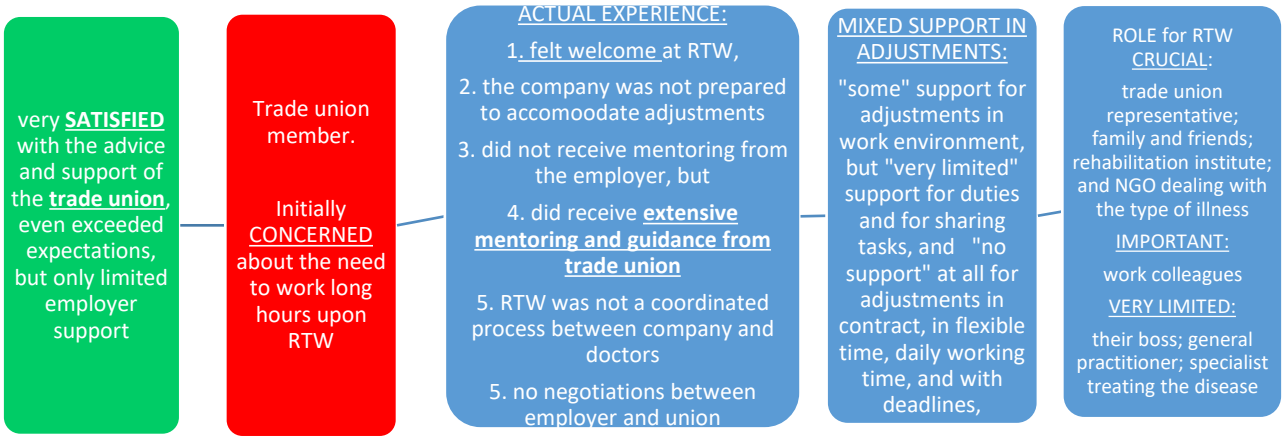
Source: REWIR survey, own analysis.

Note: Green fields = positive, supportive for RTW, red fields = problematic for RTW, blue = not clearly positive or negative.

Among those who were satisfied with their RTW experience, no one actively disagreed with any of the statements about the possible role that trade unions could play in terms of RTW. However, those who were initially more **concerned** about their RTW agreed that *unions should be ready to address health-related issues*, and *RTW support should be important for negotiations between trade unions and employers*, but *trade unions are not powerful enough to facilitate RTW in Estonia.* In addition, they either agreed or remained indifferent in terms of the best strategies for unions – either *offering individual consultations is a sufficient form of union support,* or *binding agreements with employers to reduce hours, workload and stress upon RTW would be the preferred form of union support.* In turn, those who were initially **not concerned** about their RTW – meaning they were more confident about it – were quite indifferent about the two strategies (thus opposed none). But they were not sure that *unions are not powerful enough to facilitate RTW* in Estonia, thus suggesting that the trade unions could already work on this topic, without needing to accrue more power first. They were of more mixed opinion regarding the other two statements: though they did not disagree with them, they either agreed or remained indifferent if asked *whether trade unions should be ready to address health-related issues* or *whether RTW should be an important topic for negotiations between trade unions and employers.* Therefore, it seems both of those aspects are more or less acceptable to them.

Union-supported RTW is the second case that we look into here.

Figure 18. Experiences with RTW in Estonia from the employee perspective: union-supported RTW



Source: REWIR survey, own analysis.

Note: Green fields = positive, supportive for RTW, red fields = problematic for RTW, blue = not clearly positive or negative.

In this example of positive RTW experience, the personal experience might have led the individual to disagree with the statement that *trade unions in Estonia are not powerful enough to facilitate RTW*, positing then that the unions could facilitate RTW, preferably by *negotiating binding agreements with the employer*, but also by *offering individual consultations*. The individual also somewhat agreed that *trade unions should always be ready to address the health-related issues of workers* and that *support for RTW should be an important element on the agenda of negotiations between the trade union and the employer*.

Combining the insights from these two phases of RTW – those who had yet not left, so did not have a full RTW experience, and those who had already returned to work, the best possible model of RTW experience in Estonia can be explored.

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

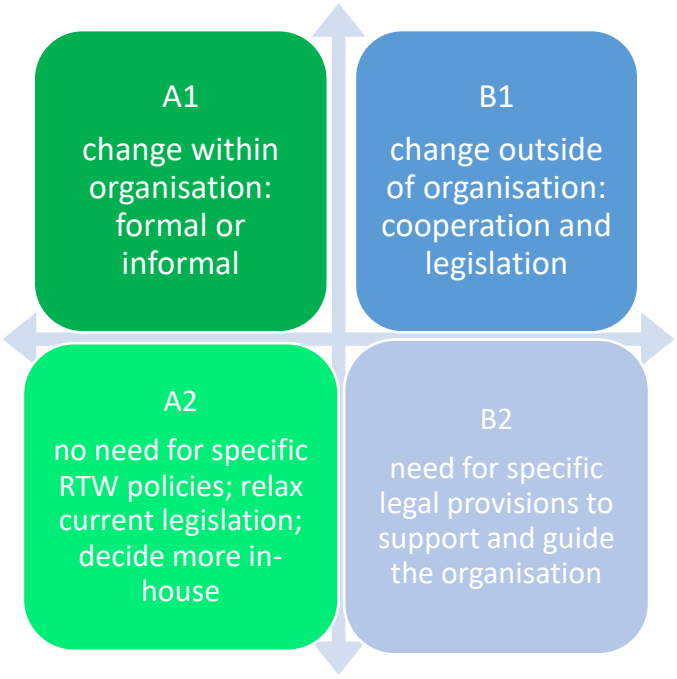
According to the REWIR survey, there are two types of approaches among the employer organisations about their preferred way of organising RTW, considering the perceived need for improvement at the level of the organisation. One group seems to prefer better cooperation with external stakeholders (medical doctors, therapists, patient organisations, etc.) in facilitating RTW, perhaps accompanied with (even) better legislative and institutional support. This group seems to suggest that they have already done everything they can do at the company level and thus need external insight or maybe a push to go beyond it. The second group seems to be interested in looking for internally oriented solutions, some of them more informal (better interpersonal relations between managers and employees dealing with workers returning from long-term sick leave) and some formalising the practices (better organisation-wide policies and activities). There is also one mention of no improvement needed.

In terms of more concrete changes in legislation, again there seems to be distinct strategies: (i) some suggest it is enough that RTW is part of a broader set of policies on integration of people with chronic diseases into the labour market; (ii) another group would welcome stricter, richer and more specific

provisions in legislation to guide organisations in becoming better at their RTW approach; whereas (iii) yet another group would clearly prefer the legislation to become more flexible, leaving space for company-level management decisions, without too much attention on negotiating towards collective agreements.

Any such choice or preference is not universally applicable, not even within one organisation. A specific strategy for each organisation must be sensitive towards adjustments and thus flexible, but there are alternatives.

Figure 19. Strategic preferences (A1, A2, B1, B2) in terms of future potential for implementation of return-to-work policies at the company level: managers' views



Source: REWIR survey.

Based on these four strategies – two pairs of alternatives in terms of expecting internal vs external change – the potential for developing industrial relations by initiating communication and cooperation with trade unions might be envisaged as part of each of them. For example, strategy A1 makes it possible to integrate company-level trade union representatives into the wider picture, developing both formal and informal practices together. In terms of strategy A2, this becomes even more important, since the decision-making is preferably within the organisation, which also requires negotiations with employee representatives, and some discussions could take place at the sector level. Strategy B1 suggests more cooperation would be good outside the organisation, and there is a place for both organised cooperation with trade unions in the sector and developing industrial relations at the national level to secure representation in the legislative process. B2, again, counts less on company- and sector-level discussions, and instead places importance on national-level discussions and agreements.

Was this aspect acknowledged by the survey respondents?

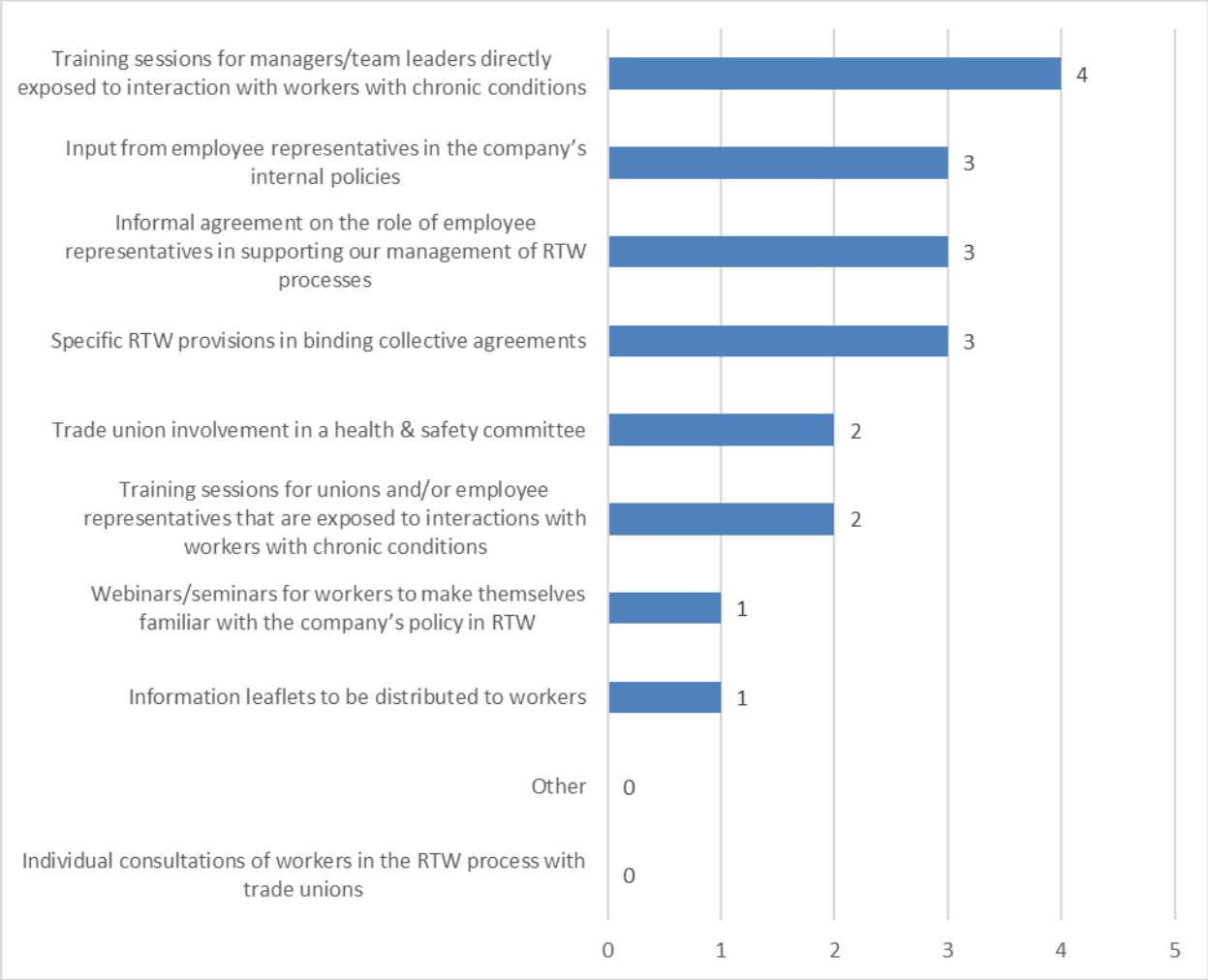
Employees saw that one of the roles trade unions should perform is addressing health issues (eleven responses) and return to work among other health issues (eleven responses). They expected trade unions to act rather powerfully as they thought trade unions should negotiate binding agreements with the employer (eight responses).

Figure 20. Workers' opinion on the role of unions and their dialogue with employers in facilitating return to work

Source: REWIR survey, own calculations; number of respondents: 12.

The main benefits from cooperation between management and trade unions, seen from the position of managers, were training sessions for managers directly exposed to interaction with workers with chronic disease (mentioned by four), input from employee organisations in company internal policies, informal agreement on the role of employee representatives in supporting the management of return-to-work processes and specific return-to-work provisions in collective agreements (all mentioned by three).

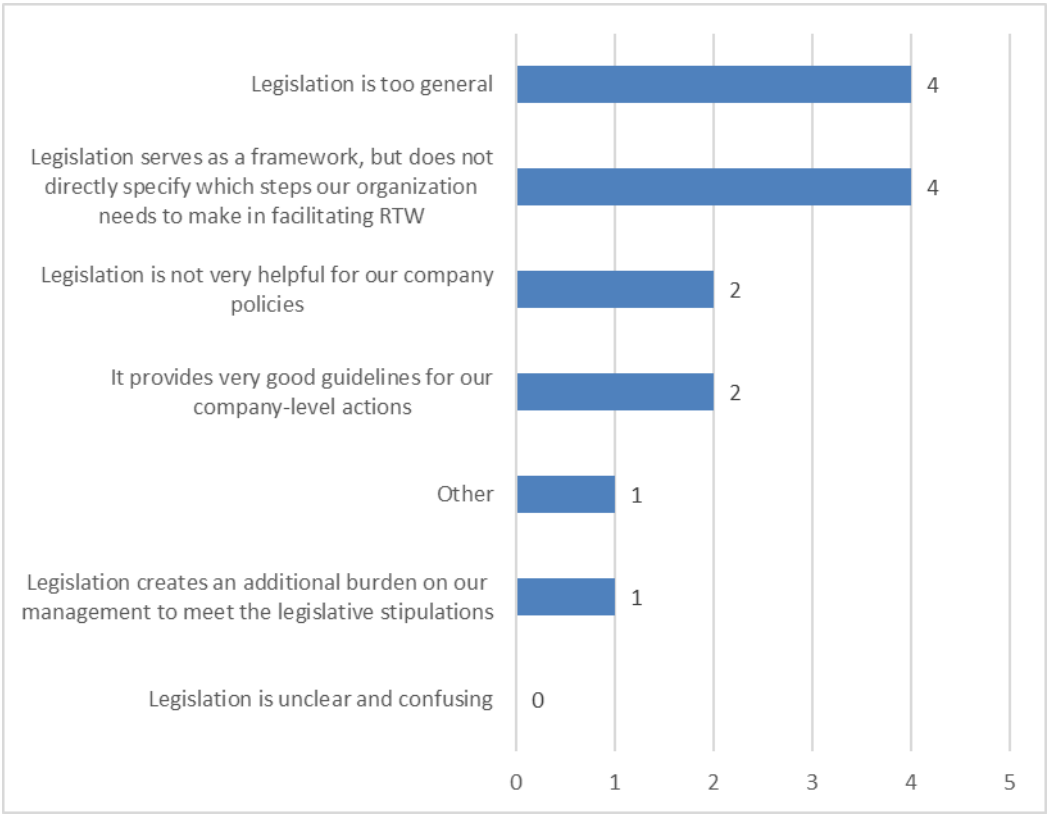
Figure 21. Perceived beneficial outcomes from interaction with unions/employee representatives on return to work



Source: REWIR survey, own calculations; number of respondents: 7.

Currently, the legislation framing return-to-work issues is minimalist (see Table 9). Managers perceived the legislation as being too general for it to be useful to a solid organisation (four responses). Though the legislation sets out a general framework, it does not specify any concrete arrangements for an organisation that need be undertaken (four responses). Based on those responses along with two more that said the legislation was not very helpful for their company policies, it seems that the legislation in Estonia is not regarded by managers as being very helpful in arranging return-to-work adjustments. However, this is probably not a general perception, as two said that the legislation provides very good guidelines for their company-level actions. From the managers' survey we also know that four managers would rather the legislation became more flexible and left more space for company-level management decisions on return-to-work issues, while five said that it is enough that RTW is part of a broader set of policies on the integration of people with chronic diseases into the labour market. Three would welcome more specific provisions to guide their organisation in its return-to-work approach. In sum, the survey provides some bits of information suggesting there are companies that perceive the legislation to be sufficient, as they would like to arrange return-to-work matters at their company, and there are companies which would prefer to get more specific indications about what they should do to arrange return to work after a serious illness.

Figure 22. Perceived support offered by legislation to organisations in managing return to work after chronic illness



Source: REWIR survey, own calculations; number of respondents: 12.

From the workers' perspective, trade unions should have a significant role in the return-to-work process. Ten respondents said that support for RTW should be an important element on the agenda of negotiations between the trade unions and the employer, and nine said that the trade union should always be ready to address the health-related issues of workers. The preferred form of support by unions was negotiating binding agreements with the employer, e.g. for reducing working hours, stress and workload for people after long sickness leave, in the opinion of seven respondents. Only four did not see that trade unions could do more and four held the opinion that trade unions were not powerful enough.

Unfortunately, none was able to bring up any good examples of how a trade union has been helpful in the return-to-work process. Instead we got twelve "no" responses to the question of whether respondents were aware of cases where a trade union proved very helpful in facilitating return to work for someone after treatment of a chronic disease.

Hence, from the employees' side there was the view that trade unions should do more than they have been doing up to the time of the survey, despite the fact the nobody could point to any good examples in return-to-work arrangements.

5 Conclusions

This report dives into how return to work after a serious illness and/or with a chronic condition is supported in Estonia. Estonia is characterised by an open labour market – it is relatively easy to lose a job as well as to get a new job – which frames situations where an illness forces one to stop working. In such situations, oftentimes but not always, the employment contract is terminated by an employer. Small companies, which constitute the absolute majority of enterprises in Estonia, cannot redistribute work tasks among other workers, and thus need to hire a new person to carry on with the tasks. There is no obligation to re-employ the person after medical treatment. After treatment, individuals returning to the labour market may find their personal work capacity has reduced. It is primarily this situation that is addressed by public policies, which seek to support finding and keeping a job for a person with reduced work capability. A serious illness and/or chronic condition is one of the reasons why a person loses some work capability.

The employment of people with reduced work capability is supported by a range of policy measures. Institutionally, the central role in developing and implementing policies with relevance for RTW has been played by the Work and Pensions Department within the Ministry of Social Affairs, and its adjacent organisations. Since 2016, when the work ability reform was launched, implementation of all benefits and services supporting people with reduced work capability have come under the Estonian Unemployment Insurance Fund. Oversight of the subsequent legally binding regulations is provided by the Labour Inspectorate. The Labour Inspectorate is an agency of the Ministry of Social Affairs dealing with the area of governance. The current policy mix addressing people returning to work after illness or with a chronic condition has been developed on the initiative of the ministry. The Work and Pensions Department of the ministry has been behind the policy processes in which all stakeholders have had an opportunity to have a say on the topics and themes related to return to work after serious illness and/or with a chronic condition.

Currently, a wide range of support measures are offered both to employees with reduced work capability and to companies employing them. The mix includes support in terms of time (boundaries on working time and shifts), in-kind assistance (various support services, consultations for employees and employers as well as job training) and cash benefits (for both employees and companies that employ people with reduced work capability). A very important milestone in the evolution of the policy mix was the work ability reform, launched in 2016. With this reform, all support measures were transferred to the EUIF so that assessment of the degree of work capability of a person, plans and offers of support measures, reviews of the effects of the measures and all other related activities are carried out by the EUIF.

Neither trade unions nor employers' organisations have taken initiative in these policy processes. Trade unions have not focused on RTW or occupational health because of greater interest elsewhere – their attention has been mainly on minimum wages. Analysis of the interviews, surveys and documents suggests that it probably will stay there as income is the central concern for trade unions. Trade unions might consider raising the issue of establishing occupational injury insurance but the likelihood of that taking place is not high.

Employers have developed a different frame of reference for addressing people with reduced work capability – the workforce diversity approach. From their point of view, people with reduced work capability because of a health condition constitute one category of the diversified workforce. Returning

to work after a serious illness and/or with a chronic condition is one of the processes among others that needs to be approached appropriately. Employers do feel that they are doing enough to employ and support people with reduced work capability.

Social partners consider the current state of public policy affairs rather satisfactory and do not perceive that there is a need for considerable changes. Neither trade unions nor employers have clearly defined goals and agendas in this area and they did not express a wish to set them.

Although the state has put in place rather generous regulations and support measures, there might be problems with following these in daily practice. Many employees as well as employers lack information about their rights, duties and available support measures. Relatively many employees in the situation of returning to work after an illness and/or a chronic condition do not feel confident about turning to their employers to discuss support measures or to contact other institutions. Employees expect trade unions to be more active in occupational health and RTW matters. Yet, trade unions in general in Estonia are weak and present only in a couple of sectors.

Employees did not express any significant open discontent with the functioning of the RTW system over the last few years. There might be two explanations. First, it might be that the majority of them to a large degree are content with the existing system and services. Indeed, the state has been allocating a lot of resources to support people with reduced work capability going back to work. The labour market benefits and services system has been growing and improving substantially in the last two decades and the work capability reform signals a general trend. Second, they might fear losing their jobs. Although the Estonian labour market is open and it is easy to lose a job as well as to get a job, it is not an uncomplicated situation for the majority of people. Certain categories, such as people with reduced work capability, might experience more hardship in finding a new job than on average.

The findings of the project suggest that the current situation, the way things are arranged in early 2021, is likely to persist without major change. This means that the central role of the public sector in policies relevant for RTW will continue and social partners – trade unions, employers and other players – will continue participating in policy processes initiated by the ministry without their own clear goals and agenda.