

Introduction

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

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1. Context

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

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

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

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

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

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

1.1 Chronic diseases and illness

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

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

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

3. www.cdc.gov <https://bit.ly/3qRsH46>

4. https://www.who.int/chp/chronic_disease_report/media/Factsheet1.pdf

5. <https://ec.europa.eu/jrc/en/health-knowledge-gateway/societal-impacts/costs>

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

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

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

1.2 Chronic diseases and Covid-19

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

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

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

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

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

Among a sample of over 20 000 study participants who tested positive for Covid-19 in the UK, 14.7 per cent of women reported symptoms at 12 weeks compared to 12.7 per cent of men. This was also highest among those aged 25 to 34.¹⁰ A study by Longfonds, the Dutch Lung Foundation, in conjunction with the universities of Maastricht and Hasselt found that, six months after infection, nine out of ten people suffered from more than one symptom and less than 5 per cent were symptom-free. The vast majority of respondents to the study (94 per cent) were not hospitalised because of Covid-19 but were 'mild' cases. These were relatively young patients with an average age of 48. By far the largest group (86 per cent) said their health was good before the virus infection and 61 per cent had no underlying condition.¹¹ We also know that over half of those who experience symptoms for more than six months go on to have memory deficits in month seven and new diagnoses may also be developed including diabetes, heart disease and liver disease.¹²

7. <https://www.euro.who.int/en/media-centre/sections/statements/2021/statement-catastrophic-impact-of-covid-19-on-cancer-care>

8. <https://kankerregister.org/Publications>

9. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/962830/s1079-ons-update-on-long-covid-prevalence-estimate.pdf

10. <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/evalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/1april2021>

11. <https://coronalongplein.nl/informatie/zorg-en-onderzoek/six-months-after-infection-almost-all-patients-study-group-still-have-symptoms>

12. https://www.independentsage.org/wp-content/uploads/2021/01/Long-COVID_FINAL.pdf

2. The concept of the return to work

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

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

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

2.1 Return to work in the Covid-19 context

Some guidance is starting to be issued on the return to work for workers recovering from Covid-19, for example for health and safety professionals¹⁴ and, in respect of Long Covid, for healthcare professionals.¹⁵ The importance of developing rehabilitation services has also been acknowledged.¹⁶ It is clear that occupational health and safety protection in respect of the return to work will (and should) be further developed as part of the pandemic response. Here, an analysis of prolonged Covid-19 symptoms in a survey by a patient-led research team found that one of the reasons for people

13. https://ec.europa.eu/health/sites/health/files/mental_health/docs/compass_2017workplace_en.pdf

14. https://www.som.org.uk/COVID-19_return_to_work_guide_for_recovering_workers.pdf

15. https://www.fom.ac.uk/wp-content/uploads/longCOVID_guidance_03_small.pdf

16. <https://www.sll.se/verksamhet/halsa-och-varld/nyheter-halsa-och-varld/2021/03/sa-ska-patienter-med-post-covid-fa-varld/>

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

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

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

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

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

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

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

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

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

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

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

3. Research questions and methodology

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

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

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

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

3.1 Scope of the analysis

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

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

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

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

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

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

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

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

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

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

3.2 Methodology and data collection

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

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

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

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

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

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

4. Structure of the book

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

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

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

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

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

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

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

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

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

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

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All links were checked on 28.05.2021.