European Foundation for the Improvement of Living and Working Conditions

Employment and disability: Back to work strategies

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Foreword

Causes of unemployment and exclusion from the workplace are manifold but a number of trends and social changes, not least the ageing of the European workforce, have increasingly placed the spotlight on issues of chronic illness and disability.

The issue of how people with chronic illnesses become excluded from the workplace is a complex one. Access to work is associated with higher levels of income, autonomy, health and well-being, and social networking. Without targeted measures to address the problem, chronic illness greatly inhibits employment possibilities, resulting in consequent costs for the individual and family, the workplace and for society as a whole. Yet, in most EU Member States, the numbers of people receiving disability benefits or leaving work permanently for health reasons are similar to, or indeed exceed, the numbers of people unemployed for other reasons.

This report addresses this knowledge gap by gathering information on relevant initiatives in this area in seven Member States. It proposes a new model for understanding the nature of the problem; develops an assessment tool for new initiatives in the area; and makes recommendations on how best to promote social inclusion for people with chronic illnesses.

We trust this report will provide a timely contribution to promoting the debate among the key stakeholders on this important issue.

Willy Buschak
Acting Director

List of abbreviations

BG	Berufsgenossenshaften
DWP	Department of Work and Pensions (Britain)
ENWHP	European Network for Workplace Health Promotion
GDP	gross domestic product
GNP	gross national product
GP	general practitioner
ICF	International Classification of Functioning, Health and Disability
ILO	International Labour Organisation
INAIL	National Institute for Work-accident Insurance (Italy)
INPS	National Institute for Social Insurance (Italy)
ISPESL	Higher Institute for Accident Prevention and Safety at Work (Italy)
ISSA	International Social Security Association
KELA	Social Insurance Institution (Finland)
LMA	Labour Market Authority (Sweden)
LOZO	Limburg Representative Organisation for Small Enterprises (Netherlands)
NAPs	National action plans
NGO	non-governmental organisation
NHS	National Health Service (Britain)
NIDMAR	National Institute of Disability Management and Research (Canada)
OECD	Organisation for Economic Cooperation and Development
OHS	Occupational health and safety
SME	small and medium-sized enterprise
TUC	Trade Union Congress (Britain)
UNSR	United Nations standard rules for equalisation of opportunities for people with disabilities
WHO	World Health Organisation

Contents

Introduction

This report examines social exclusion through illness, specifically the processes whereby people who develop chronic illnesses are excluded from the workforce. In particular, it reports on the project carried out by the European Foundation for the Improvement of Living and Working Conditions: 'Illness and inclusion – maintaining people with chronic illness and disabilities in employment'.

Among the motives for the study was the European Year of People with Disabilities in 2003. The Foundation responded by producing a report on disability and social inclusion (Grammenos, 2003). A clear distinction emerged between measures to combat the exclusion of people with disabilities who were unemployed or economically inactive, and those needed to respond to workers who developed a chronic illness that affected their work.

The report for the Barcelona Summit (2002) highlighted ill health as a barrier to employment, as did the *Joint report on social exclusion* and the Disability Communication of the Commission. While the distinction between disability and chronic illness is implicit in the structure of many national systems, the concerns and challenges facing people as a result of disability and chronic illness are similar in many ways. Responding early to conditions such as back pain or stress-related disorders can prevent people from becoming disabled and unemployed.

However, designated authorities, such as social insurance providers, employment services or health services, are often inconsistent in legislating or intervening when an employee develops a progressive illness or a disability. This study complements the Foundation report on disability and inclusion by focusing on policy and initiatives in job retention and reintegration of ill and injured employees. Its emphasis is not on employment equity measures responding to people with disabilities who are unemployed or economically inactive.

The processes involved in maintaining people with chronic illness or disability in work, or reintegrating them to work, are complex and require coordinated, focused system responses from the company and the designated authorities. Responsibility to protect and support chronically ill employees lies with both the employer and the state. But this responsibility is ambiguous in terms of the extent to which the employer should protect the employability of currently ill workers, and which designated authorities should provide rehabilitation, support and other reintegration interventions. It demands a more coherent and consistent approach based on analysis of the system level factors (i.e. the actions of the benefits, health and employment service providers) that enhance or inhibit the likelihood of retaining employment.

By providing such an analysis, the study aims to promote the employment and social inclusion of people with chronic illness or disability. It describes measures and initiatives in a number of European Union (EU) Member States to encourage job retention and reintegration. The report sets out to inform policymakers, social partners and relevant non-governmental organisations (NGOs) of positive initiatives and policy measures. It recommends improvements to system level measures including: more focused policies; more targeted mediating mechanisms such as services, supports and incentives; more clearly delineated responsibility for interventions; and more effective monitoring of the impact of actions.

The study identifies and assesses a range of initiatives and policy measures that encourage job retention and reintegration in relation to the expectations and needs of employees, companies and

public authorities. The recommendations take into account the cost and benefit implications for the main stakeholders. The report also considers emerging issues highlighted by the Lisbon objectives, particularly the ageing European workforce.

Overview of the study

The main tasks of the study were to generate:

- a framework to address social exclusion as a result of illness, particularly for people in employment;
- a policy assessment tool to evaluate policies and initiatives on social exclusion through illness;
- case studies of policies and initiatives to combat social exclusion through illness;
- policy level recommendations and proposals for innovative approaches.

The work took place in seven of the EU Member States – Finland, Germany, Ireland, Italy, the Netherlands, Sweden and the UK. Using the assessment tool, the study examined relevant policies and initiatives in each country. Some case studies of new and interesting actions to combat exclusion from employment as a result of illness illustrate innovative approaches to the problem.

Chapter 1 describes the policy and statistical context of exclusion from employment through chronic illness and factors that can exacerbate the process. It provides an overview of the incidence and costs of disability and illness at EU and national level, and describes a range of current EU policies that can impact on illness and social exclusion. Chapter 2 elaborates the relationship between functioning, health, disability and restricted participation in the labour market and wider society. It also proposes a four-level model as the basis for the study.

Chapter 3 describes a set of initiatives and measures developed in the target countries and beyond, which demonstrate useful and effective approaches. These range from company level actions to sectoral actions, to changes in policy and practice by some of the major actors.

Chapter 4 describes the aims and dimensions of the national level tool for assessing policy initiatives in social exclusion through illness. Chapters 5-11 describe its application to the policies and initiatives in each of the seven countries. Each chapter presents an overview of national context, and reviews measures and initiatives relevant to job retention and reintegration for workers at risk of exclusion from employment through chronic illness or disability. They describe measures for social protection, workplace health management, rehabilitation and reintegration, anti-discrimination and, where relevant, other health and disability issues. The country studies also present a system profile, based on the assessment tool, with examples of innovative policy approaches or sectoral initiatives. Each national case study ends with a summary and conclusions drawn from the analysis.

Chapter 12 attempts to synthesise the conclusions in terms of a more general European strategy to respond to chronic illness and social exclusion, particularly in job retention and reintegration. It makes recommendations for changes to policy emphasis and more targeted measures in relation to the workplace, the individual and designated authorities.

Some key issues

A number of important issues need to be addressed before reporting on the main work of the project, including gender, mental health and the meaning of the word 'disability'.

The meaning of disability is more than a semantic issue as there are a number of misconceptions and misunderstandings associated with it. Firstly, it is often assumed that most persons with disabilities have acquired them either at birth or very early in life, and that most disabilities involve visible physical impairments. Neither of these assumptions is true – most disabilities develop during adult life and many are not visible. For example, the greatest single cause of long-term absenteeism in many countries is now stress-related disorders, and many of the other causes relate to medical conditions such as cardiovascular and respiratory complaints. Chapters 1 and 2 consider definitions in more detail.

These are important points, since they highlight the need for changes in perceptions among the major actors involved with disability and also perhaps changes in services for people with these conditions. Essentially, the major causes of disability are moving away from either congenital conditions or accident traumas to medical or psychiatric conditions.

Mental health is a more significant cause of disability and is attracting greater policy attention in recent years. However, despite this rise in interest, there is relatively little solid material on effective interventions to prevent mental health problems leading to disability. The study strongly emphasises the need to address mental health, and includes a number of case studies which shed useful light on how best to manage mental health problems at work.

It might be expected that gender plays an important role in social exclusion and chronic illness, since there is much evidence about gender differences in many aspects of employment, e.g. participation rates, income, grade, short-term absenteeism and health status. However, one of the surprises of the study was the extent to which gender either did not appear to be addressed or to be a major factor in chronic illness, long-term absenteeism and social exclusion. No conclusions could be drawn on this, though, where findings are available, the report refers to them; there appears to be a need for more systematic research in this area.

Policy and statistical background 1

Overview

This chapter brings together what is known about the problem of social exclusion through chronic illness from the perspectives of current EU policy and publicly available statistics. Central to this are people who lose their jobs through illness or injury. This concept underpinned the search for relevant measures, initiatives and facts. The main conclusion of the study is that this group is not well served by the current EU policy framework.

EU policy often refers to the important role of employment and health in exclusion. However, policy is generally focused on unemployed and economically inactive jobseekers rather than those currently employed and at risk of early retirement or long-term work disability as a result of chronic illness (Council of the European Union, 2003; European Commission, 2001; European Commission, 2002).

The Framework Directive on Equal Treatment and Employment (2000) and the Madrid Declaration (2002) focus on 'people with disabilities' as though they were a clearly delineated and stable group. In reality, disability is a dynamic process that increases with age and affects many people with chronic illness. These are in effect a hidden group within disability policy in that they are, in administrative terms, 'not yet disabled'.

From a work and health perspective, EU policy documents tend to emphasise occupational health and safety measures within the workplace (see, for example, the work of Directorate General for Health and Consumer Affairs (DG Sanco) and the European Agency for Occupational Health and Safety). The new Public Health Strategy of DG Sanco (European Commission, DG Sanco, 2003) makes little mention of the workplace as a setting for public health initiatives and no mention of chronic illness or disability. In fact, public health policy is largely seen as being concerned with medical or health issues with almost no connection to social circumstances or consequences. These policies and measures, while indirectly relevant, do not respond directly to the needs of those who return to work after an illness that has reduced their work capacity.

It is difficult to obtain a clear demographic and statistical focus on the group central to this report. Firstly, while over 50% of those who reported a long-standing health problem or disability indicated that it was as a result of non-work related diseases (Dupre and Karjalainen, 2003), the majority of absence data available relate specifically to work-related accidents and diseases (European Social Statistics: *Accidents at work and work-related health problems 2002*). Secondly, while the people who are the focus for this report are often in receipt of social protection payments, data are generally incorporated into the categories of those receiving early retirement or disability payments (Social situation in the European Union 2003). While the relationships between age and enhanced risk of chronic illness or disability, and age and economic inactivity are well documented (*Social situation in the European Union 2003*; *Joint report on social inclusion 2002*; *Employment in Europe 2003*; Dupre and Karjalainen, 2003), the majority of data relate to older people at work or older people who are unemployed and economically inactive. It is not possible to distinguish the number of older people currently exiting the labour market as a result of chronic illness through long-term absence.

An important contributor to the lack of appropriate statistics arises from an inconsistency in definitions (Bolderson, 2002/European Commission, 2002). To focus properly on people at risk of

losing their jobs from illness or injury, it is necessary to differentiate between short-term and long-term disability. EU figures are not easy to obtain. People experiencing chronic illness, regardless of the cause, may have reduced capacity to work but may not be considered 'disabled' either under social protection regulations or discrimination legislation. Nevertheless, without timely and appropriate reintegration, they are less likely to return to work. The term 'work disability' has been used to describe non-return to work after illness or injury (Krause, Frank, Dasinger et al, 2001; Shaw and Polatajko, 2002).

'Work disability' in this report refers to the failure to return to work after illness or injury, regardless of the cause. It can be considered as being the opposite of a return to work outcome. A different term used in generating statistics throughout the EU – 'long-standing health problem or disability' (Dupre and Karjalainen, 2003) – does not make such distinctions. Nevertheless, the Eurostat figures based on the latter definition are probably the most relevant to the focus of this report. This is particularly so because the ad hoc module from which the data were derived was based on self-report rather than administrative definitions and included many categories of long-standing health problems or disability that could be termed chronic illness.

Despite the lack of clarity of focus within EU policy and statistics, a number of critical implications for the European social model arise from loss of work due to illness or injury leading to social exclusion. These include:

- *the ageing of the workforce.* The growing number of older workers is the subject of much policy debate and many policy initiatives in recent years. The issue has been approached largely from the perspective of the labour market where the main concern is to ensure an adequate labour supply for Europe in the future. There has been relatively little policy concern on the health aspects of ageing in relation to older workers and the implications for job loss, though initiatives such as the maintenance of work ability in Finland are an exception.
- *the pensions crisis.* The European population is living longer, the length of the so-called third age is extending, and the underfunding of state and private pension schemes has attracted increasing policy attention in recent years. This has led to a number of initiatives mainly concerned with altering the financial conditions and eligibility for pensions, rather than addressing the health-related reasons for early retirement, despite poor health being a major contributor to early exit from the labour force.
- *the rise of stress and mental health problems.* The causes of illness in the working population are changing. A greater proportion of illnesses now relate to stress and mental health problems, a trend that poses special difficulties when retaining such people at work.
- *the increase in rates of work disability.* In many countries, there have been recent and unsustainable rises (from the perspective of costs) in work disability. The causes relate to a complex mix of an ageing workforce, changes in eligibility criteria, interactions between social insurance schemes for disability and unemployment, and perhaps also the changing nature of the illnesses which give rise to disability claims.
- *anti-discrimination measures.* A substantial part of EU social inclusion strategy relies on measures and initiatives to combat discrimination on a number of grounds, including disability and age. There is a major emphasis on measures to combat discrimination in employment, in particular, recruitment and selection of jobseekers. The framework does not address the needs of an older employee with chronic illness with sufficient clarity.

These related trends have not given rise to a general concern across policy areas to prevent social exclusion by maintaining people with illness in the workplace. In part, this may be because the competence to address this complex issue does not reside solely at EU level (e.g. the EU does not have a clear policy brief in relation to social protection). It may also be due to the fact that an effective response requires policy initiatives that cross traditionally separate policy areas. For example, there appears to be a contradiction between social policy and employment measures. The process that creates work disability, regardless of the cause, begins and progresses within an employment, rather than unemployment, context. Thus, responsibility lies among employers, worker representatives and statutory health, employment and social protection agencies. This fragmentation of responsibility may well contribute to the lack of an effective policy focus.

Nature of the problem

Exit from the labour force is simply the transition from active to inactive life, as defined in *Employment in Europe 2003*. It can happen to anyone at any age who develops a health condition which impacts on work capacity. However, age is significantly associated with chronic illness, disability and economic inactivity, and the EU population is ageing (*Disability and social participation in Europe 2001*; *Social situation in the European Union 2003*). Some 24% of the working age population (15-64 years old) are older workers. This is likely to grow to 27% by 2010. Only 38.6% of the EU population between 55 and 64 were in employment in 2001. The employment rate for the EU as a whole was 64%, and 73% for 46-55 year olds in the same year. Within the EU, the average age at which people left the labour market was 59.9 years.

Given that employment is closely linked to income, this has important consequences for social exclusion. An ageing population puts pressure on healthcare systems. The relationship between age and long-standing health problems or disability is almost linear and accelerates in older workers. Less than 7% of people in the 16-24 age range reported a long-standing health problem or disability (EU25). The corresponding figure for 55-64 year olds was close to 30% (Dupre and Karjalainen, 2003). Equally, having a moderate to severe long-standing health problem or disability increases the likelihood that a person will be economically inactive, i.e. between 20-46% participation in the labour force compared with 68% of those without a condition. The interaction between age, long-standing health problems or disability, and economic inactivity is clearly evident in the figures.

These high rates of work disability pose particular problems for social insurance and employment systems, both in relation to the costs of funding disability and early retirement pensions, and also in the provision of services to maintain disabled employees in work or to facilitate their return to work. In addition, the human and financial costs of work-related disability to the individual worker can be very high and include loss of self-esteem and self-efficacy, loss of work-related skills, and a range of psychological outcomes. There is also disruption to relationships with the individual's family and social networks.

The nature of illnesses leading to work disability is changing. The main work-related health problems are musculoskeletal, stress, pulmonary and cardiovascular disorders (*Social situation in the European Union 2003*; *Employment in Europe 2003*). There is a growing incidence of chronic illnesses, and illnesses related to stress, such as depression, anxiety and burnout, are increasingly

the cause of long-term absence from work (European Working Conditions Survey 2000/2001). These chronic illnesses are an important focus for the study.

A number of major factors are associated with this emerging problem. Perhaps the most important relates to an ageing population and workforce – a situation that has been well documented (Foundation, 1999; Ilmarinen, 1999). This demonstrates that older workers (more than 50 years old) exit the workforce early for a variety of reasons related to health, discrimination and, in some cases, generous benefits packages. Low activity rates on the part of older workers put pressure on social protection through an unfavourable dependency ratio. Older workers represent 10% of those in employment but 33% of all those who are inactive (*Employment in Europe 2003*).

While not all early retirement is due to health reasons, there is ample evidence to suggest that health issues make a significant contribution. In particular, illnesses relating to lifestyle, injuries from accidents and, increasingly, stress and mental health problems all play a role.

Many of the systemic responses to disability deal primarily with persons with a congenital disability or those who have acquired a disability through injury. These systems are not always the same in terms of eligibility criteria, benefits or the type of services offered. However, when it comes to rehabilitating people who develop chronic illness, most systems struggle to cope. In particular, rehabilitation and reintegration are difficult to achieve for people with mental illness (Thompson et al, 2003). As a result, chronic illness can, and often does, lead to social exclusion in particular through exit from the workplace and the labour market generally.

Long-term absence and exclusion

Definitions of long-term absence vary according to differences in regulations and administrative requirements within a particular Member State, and can range from six to 36 weeks. The move to long-term absence is a critical step in the process of exclusion for many employees who experience illness, injury or impairment. Over 85% of unemployed and inactive older workers had previously worked (*Employment in Europe 2003*). It should, therefore, offer an important focus for targeting job retention and return to work, especially given its possible consequences for European social welfare systems, private insurers, employers and workers in Europe.

The main reasons older workers gave for leaving work were retirement (both early and at normal age), and illness or disability. Income maintenance for people who are disabled remains the third largest item of EU social protection expenditure at 8% coming after health care and old age pensions, but before unemployment (*Social situation in the European Union 2003*). This probably underestimates social protection costs, given that chronic illness or disability can also result in early retirement rather than disability. Out of work income maintenance/support and early retirement account for almost 63% of 15 EU states' social protection expenditure, while 15.6% of expenditure on labour market policies is targeted at integration of disabled people.

The underlying causes are complex and exist at national, company and individual levels. European social welfare systems have traditionally focused on ensuring the social maintenance of disabled people and, as a result, access to services often depends on inflexible disability registration procedures. Some people, while ill, injured or impaired as a result of a complex set of factors, do not clearly fit within either the work or welfare system.

A significant proportion of economically inactive persons, who have left employment for health reasons and want to work again, are not actively seeking a job. The risk of losing disability benefit, or not being able to reclaim it if the job does not last due to disability reasons, affects decisions to seek employment even if people wish to work (Grammenos, 2003). Non-employed older people may be passive, discouraged, retired, or ill and disabled (*Employment in Europe 2003*). This indicates a contradiction between social policy and employment measures, and very few countries have systems in place to react early enough to prevent the risk of an employee with a disability exiting employment on a long-term or permanent basis.

Many national and international reports recognise the challenge of long-term absence (Gladnet/ILO, 1998; Thornton and Lunt, 1997) and statistics, though incomplete, support the need for change (Grundemann and Van Vurren, 1997; Bloch and Prins, 2001). It is also likely that an ageing workforce will increase the numbers exiting the labour market as a result of impairment and long-term absence (European Commission, 2002).

Prevalence and costs of long-term absence and disability

Unfortunately, there is no readily available and comparable set of EU statistics on the incidence of long-term absence. The statistics available are out of date and derive from research studies rather than official sources. There is a distinct lack of comparable data available on people in receipt of different benefits, which makes it difficult to assess the numbers on short-term sickness or disability benefits (*Social protection in Europe 2001*). However, the available statistics indicate the size and scale of the problems associated with long-term absence.

The impact of accidents and work-related health problems in absence terms was somewhere in the region of 500 million lost work days in the EU in 1998/1999 (*Social situation in the European Union 2003*). From another perspective, this may well represent less than half the actual numbers as over 50% of people reporting a long-standing health problem or disability indicated that it was not work-related (Dupre and Karjalainen, 2003). Large increases in the number of work days lost are a distinct possibility, given Europe's ageing workforce (*Employment in Europe 2003*).

It is also important to note that 29% of those who left work early did so through early retirement and 15% as a result of their illness or disability. In addition, 4% left because of personal or family responsibilities, which could relate to a partner's illness or disability. Short-term projections suggest that employment and activity rates for 55-64 year olds will remain at 41% and 43% respectively. These are almost half the level for the total workforce (*Employment in Europe 2003*).

Fourteen percent of the working age population (EU15) report a long-standing health problem or disability. The rate is much more prevalent in older people (63% of people with disabilities are older than 45 years). Only 6% of illness absence is attributed to accidents at work (Paoli and Merllié, 2001). This pattern is mainly due to individuals' health conditions deteriorating with age and many impairments being acquired during a person's life (European expert group on the employment situation of people with disabilities, 2001).

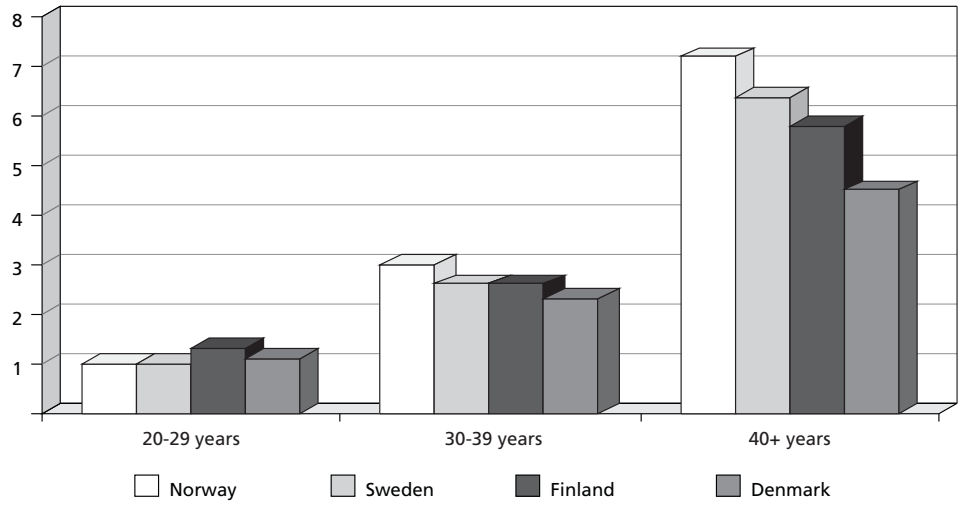
The link between sick leave and exclusion from the labour market is evident in figures from the Danish Ministry of Employment (2003). In 2001, an estimated 116,000 employees in Denmark

were absent from work due to illness and 46% of these are long-term absent. In the UK, 176 million days were lost as a result of absence in 2001, and 7.5% of the working population were in receipt of incapacity benefits (James, 2003). In Germany, data based on the 11 million members of the largest statutory health insurer revealed an overall reduction in absence to 3.6% in 2003, but a 74% increase in psychological illness since 1995, making it the fourth most frequent cause of absence through illness (Foundation, 8 March 2004). The average number of days lost per worker as a result of non-work related health problems was more than twice that for work-related accidents or health problems (Foundation, 2000, 2001). Absence rates also increase with age. In a study covering eight EU Member States, from 1983 to 2001, the average sickness absence rate for 60-64 year olds was 4.1% in comparison to an overall average of 2.1% (Bergendorff, 2003).

Levels of work disability in Finland are relatively high, with approximately 10% of the labour force claiming disability pension in 1996 (Ilmarinen, 1999). This has been rising slowly in recent years, with 320,000 claims for sickness absence of more than nine days compensated by the Social Insurance Institution in 1997, and 380,000 such claims in 2002 (Joensuu et al, 2003).

Ilmarinen (1999) provides data from Finland and the Scandinavian countries for 1996 which also illustrate the increasing rates of work-related disability with age (see Figure 1). There are between five- and seven-fold differences in disability rates between the 20-29 year age group and the group aged over 40.

Figure 1 Disability rates by age for the Nordic countries in 1996



Source: Ilmarinen, 1999

A recent study by the Organisation for Economic Cooperation and Development (OECD) demonstrates that employment rates for working-age disabled people appear to be significantly lower than for working-age non-disabled people (OECD, 2003). Employment varies with the severity of the disability – employment rates for moderately disabled people average around 70% of non-disabled people. Employment rates for the severely disabled are only about 30% of non-disabled people, varying across countries. The number of people classified as disabled and receiving social protection payments also varies by country. (Grammenos, 2003) These differences

are likely to be associated with variations in legal and regulatory systems, culture and social contexts, definitions of disability and the economic situation. Cross-country variation is less for those classified as severely disabled than for moderately disabled people (OECD, 2003).

The burden of chronic illness most obviously falls on the individual and their family, but there is increasing concern about the impact on social insurance systems, both in terms of the costs associated with illness and the need for more appropriate services. Currently, costs are high and rising with relatively weak return to work impacts. It is difficult to assess the costs of chronic illness and exclusion as it is not possible to disaggregate data in relation to sickness and disability benefits for those of working age and those in receipt of early retirement benefits as a result of ill health. Nevertheless, by exploring the costs of absence, as a precursor to exclusion, and the costs of disability and early retirement, as a consequence of exclusion, it is possible to get some estimate of the substantial costs associated with illness for the state, the employer and the individual worker.

In the UK, the cost of absence alone was more than €17.5 billion in 2001, approximately €633 per worker, and expenditure on incapacity benefits amounted to €9.5 billion (James, 2003). Healthcare costs can also be substantial: for instance, people with mental health problems, a key area, tend to have higher physical morbidity compared with society generally. Mental health problems are estimated to account for at least 3% of GNP in the EU. Not only serious mental health problems, but also common problems, such as stress and depression, are major causes of disability, lost employment and early retirement. Again, studies indicate that these are often the single greatest contributor to costs (Patel et al, 2002; Rice et al, 1992). One Canadian study conservatively reported that the lost productivity costs alone due to all forms of disability accounted for more than 5% of total GDP (Moore et al, 1998).

OECD countries spend at least twice as much on disability-related programmes as on unemployment programmes. Combined sickness and disability benefits on average account for about 12% of total social spending (*Social protection in Europe 2001*), while in the Netherlands they amount to as much as 20% of social expenditure. In spite of high spending levels, disability-related economic inactivity and unemployment rates remain stubbornly high in all countries and, in most, people who enter disability-related programmes remain beneficiaries until retirement. On average, only 1.5% of benefit recipients leave the system each year (OECD, 2003).

While the impact on the state is substantial, at company level, employers also bear the burden of chronic illness and long-term absence. Even though in Europe social insurance agencies carry many of the income replacement costs, the employer incurs direct costs in sick pay, overtime for existing staff and replacement costs, and indirectly in terms of higher personnel turnover, reduced productivity, low staff morale, loss of experience and higher insurance premiums in some systems. One recent study estimated that musculoskeletal disorders alone cost employers more than €24.5 billion in Germany (Thiehoff, 2002), making it the single greatest contributor to lost productivity. The annual cost to German employers of the first six weeks of absence is estimated at €33 billion (James, 2003).

There are moves in some countries to change the benefits systems so that employers become responsible for a greater portion of costs (e.g. RETURN, 2000; Brenninkmeijer et al, 2003). In the

Netherlands, from 2004, employers bear the costs of the first two years of absence – an initiative designed to promote better and earlier return to work.

The ill or injured employee remaining at home on long-term absence can pay a substantial price in increased personal costs and ultimately employment loss and disability. Individual costs associated with work disability include social isolation, reduced quality of life, lost educational opportunities, damaged long-term career prospects, and lower final pensions. There may also be costs incurred by family members if they have to give up work or leisure time to provide care. There can be a high degree of stigma associated with many types of disability, and individuals may be effectively discriminated against not only within the labour market but also across all aspects of daily life.

At the individual level, there is insufficient emphasis on the link between poverty and disability. The personal income of an unemployed person with a disability, on average, comes to barely half the income of an employee with a disability, and there are differences in earnings between disabled and non-disabled persons. In most countries, the work incomes of people with disabilities are on average lower than those of other wage earners, with the gap in earnings between the two categories ranging between 5% and 15% (OECD, 2003).

Given these substantial costs, much more needs to be done to understand the barriers and facilitators to increasing reintegration outcomes for chronically ill and absent workers. Without such an understanding, it is difficult to design and develop appropriate and transferable interventions and approaches.

Responses to illness and exclusion

There is broad agreement on the need to reduce absence, disability and early retirement costs but, within the EU, little consensus on the most appropriate way to do this. Procedural and administrative solutions tend to dominate, such as increased monitoring and assessment, changes in eligibility criteria, and reducing replacement ratios between net incomes and benefits. For example, the Danish government has acknowledged the need to address exclusion early and has launched a national action plan on sick leave. However, the plan appears to focus on procedural responses such as reporting, monitoring and assessment, rather than active reintegration (Foundation, 2004). Nevertheless, there is a need to address financial disincentives (e.g. taxation or poverty traps) to return to work. In some situations, working can actually reduce the overall household income (Larmurseau and Lelie, 2001). Some schemes address this problem for people with disabilities and could be equally relevant to long-term absent workers. For example, reintegrated workers could keep some of their disability benefits, although the amount received would reduce with increased productivity.

While evaluating the effects of legislative and policy strategies, it is also necessary to take into account personal, sectoral and social factors that affect job retention and reintegration of people with chronic health conditions. This demands insight into the processes by which long-term absent workers move to inactivity and exclusion at the macro, micro and individual levels, in order to stimulate durable, high-quality labour participation and to evaluate strategies to maintain their participation.

At the macro level, inappropriate and/or ineffective policies can be a substantial barrier to improved job retention and reintegration. One example is the inherent contradiction between attempts to reduce unemployment among people with disabilities while, at the same time, subsidising the withdrawal from work of people who suffer an illness or injury. While such policies are patently counter-productive, parallel and competing systems of support and services are common in many countries. One way in which these policies affect decisions to stay at work or leave the workforce is through the replacement ratio (Grammenos, 2003), i.e. the ratio of expected disability benefits to net wage earnings. This was highlighted in a recent cross-national study of return to work by the International Social Security Association (ISSA) (Bloch and Prins, 2001), and is of particular concern within the current EU employment guidelines (Council Decision 22 July 2003). This policy is more likely to impact on older than younger workers, who see their limited potential to increase future earnings. It is unclear whether low wages or high benefits induce people to leave the workforce for this reason. However, raising disability benefits increases the inflow of claims for disability allowances, but decreasing benefits does not have the same impact in deterring people from continuing to claim them.

At the micro and individual levels, safe and timely interventions are an important element to ensure more effective reintegration outcomes for long-term absent workers (Shrey and Hursch, 1999). Such systematic approaches are only in the early stages of development and not widely available in most Member States (RETURN, 2000). Relatively few EU states operate targeted job retention and reintegration services for those with chronic illnesses which are not work-related; and such individual interventions, at least in the case of back pain, are inconsistently and sometimes negatively associated with return to work in the ISSA study (Bloch and Prins, 2001).

Nevertheless, the level of a person's support needs are an important predictor of return to work; 47.7% of non-working persons with a long-standing health problem or disability who faced work restriction considered they needed some form of assistance to work (Dupre and Karjalainen, 2003). In contrast, only 16% of those at work received assistance. This suggests that a number of these are inactive not because their condition is more severe but because they are not offered the necessary services, supports, work adaptations or technical aids. Many of those who were currently inactive but had previously worked (85% of non-working respondents) could have remained at work if offered suitable reintegration services at the appropriate time.

There are lessons to be learned from measures to promote the labour market participation of people with disabilities. In contrast to responses to long-term absent workers, all countries provide social inclusion, vocational training and rehabilitation specifically targeting people with disabilities who are economically inactive. Approaches differ significantly across countries and relatively little has been documented about the impact of measures on the future work history and well-being of recipients. These appear to be linked to differences in policymaking, systems of provision and incentive design, and may illustrate some best-practice approaches.

Many of the incentives and supports for people with disabilities could be very helpful to someone wishing to return to work after illness. For example, the requirement that employers make 'reasonable accommodation' could be a step towards job retention and reintegration. Also positive would be increasing employment access for people with disabilities, along with employers' grants for workplace adaptations and aids for people with disabilities. Policies can undoubtedly help to

change existing attitudes to chronic illness, long-term absence and disability by providing incentives and even imposing requirements on individuals, employers and significant other parties.

A more targeted approach based on the factors influencing the decisions of employers and chronically ill workers will enhance the effectiveness of system design and more relevant mediating mechanisms. However, no matter how well designed a policy framework may be for promoting employment access for people with disabilities or reintegration for long-term absent workers, it requires profound behaviour changes, especially on the part of employers and workers. For example, many employers, particularly in small and medium enterprises, are unaware of the relevant grants (Foundation, 1998). It is not sufficient merely to have a policy in place – those whom the policy is aimed at should be aware of its existence.

If encouraging employment among people with disabilities who are able to work can result in important welfare gains and improved social and economic outcomes for the employer and the worker, preventing work disability outcomes for people who are chronically ill could actually be more cost effective. A shift towards an employment-oriented policy reflects the belief that many recipients of absence benefits *want* to return to work and *can* do so with the proper encouragement and assistance. These individuals, and also the companies and society, would benefit from their safe and timely return to work.

Policy context

In EU policy documents and statistics, there are no explicit references to the group of workers who are the primary focus of this report. They are at the intersection of social inclusion, employment, health, disability, active ageing and social protection policies, but not adequately covered by any one strand. From a statistical perspective, many are older workers, some classified as disabled, some seeking early retirement, others are unemployed, many are absent from work but all were previously in active work and, with appropriate assistance, have the capacity to return to work. They are already on the pathway to social exclusion. They are employees at risk of losing their jobs as a result of illness or injury regardless of the cause.

EU social policy acknowledges the need for better synergies between health and other policies, including those that affect socio-economic determinants of health (*Social situation in the European Union 2003*). Investment in health should be properly targeted and health and health care recognised at the intersection between the European employment strategy and efforts to modernise social protection. Thus, social inclusion is linked inextricably to health and employment. Equally, better health leads to less disability. Age is closely associated with increased chronic illness and disability.

The health agenda involves a 'global approach to well-being at work' and focuses mainly on preventive measures in health and safety, but there is no evidence which recognises the need for reintegration services. A positive correlation between unemployment and illness or disability is taken to imply that bad health is the result of unemployment rather than, what is equally likely to be the case, poor health results in job loss (*Social situation in the European Union 2003*).

From a social protection perspective, the emphasis of EU policy tends to be on modernising the European social model and investing in people as a way to improve economic performance.

Mechanisms include measures to address the needs of those who are at risk of poverty and social exclusion. They include developing an inclusive labour market and promoting employment as a right and opportunity for all, with a guarantee of equal access to, and investment in, high quality services such as health (*Social protection in Europe 2001*). However, social inclusion policies mainly tend to help people find jobs and increase their employability with no mention of job retention and reintegration.

Early retirement places a substantial drain on social protection systems. The growth in the numbers withdrawing from the labour force before the official retirement age has been a marked feature of the labour market. In many countries, those retiring early are sometimes supported by disability benefits, which are used as a substitute for unemployment benefits (*Social protection in Europe 2001*). However, the response to this is mainly focused on administrative and procedural changes to payment systems and active labour market measures for those already out of the workforce. The key strategy proposed is to adjust payment levels to reduce exit from work rather than trying to encourage people to return to their jobs.

These concerns are echoed in the *Joint report on social inclusion* (2002). The use of national action plans (NAPs) is an important element in progressing the European social agenda and complementing the objectives of the European employment strategy. A challenge for the next phase of social inclusion is the cost effectiveness and efficiency of policies to tackle poverty and social exclusion. NAPs can improve the impact of social inclusion policies in many fields relevant to the people who are the focus of this report, i.e. social protection, employment and health.

The *Joint report* aspires to a positive and dynamic interaction of economic, employment and social policies, and acknowledges the key role of employment participation in social inclusion. It links unemployment with poverty, poor health and disability, and stresses that the risk factors interact and accumulate over time. It might therefore be expected that the report would address chronic illness and return to work as an inclusive labour market issue, and support employment promotion as a right and opportunity for all with improvements in delivery of services. However, despite the apparent clarity of focus, there is no explicit reference to workers at risk of exiting employment as a result of chronic illness or disability.

The *Joint report* recommends a strategic and integrated approach that incorporates social inclusion measures, health measures, active ageing and employment of older workers, and employment of people with disabilities. It acknowledges that NAPs can increase employment through active and preventive policies. However, it is clear that the focus is solely on those who have already exited the labour market or who are inactive rather than those who require reintegration.

The *Joint report* covers long-term unemployment, disability and poor health but does not directly address the dynamic interaction between these three factors in job loss. It promotes employment equity for economically inactive people rather than job retention and reintegration for workers. As a result, it is not clear that a recommended guarantee of equal access to quality services, including health services and social services, applies to early or vocational rehabilitation.

Social inclusion guidelines can incorporate vocational rehabilitation and reintegration early in the absence process. There is an explicit reference to prevent exclusion from work by improved

employability through human resource management, the organisation of work, and lifelong learning. Retaining people with reduced work capacity in the labour market is explicit, although strategies to achieve this are not well described. The report acknowledges that prevention and early intervention are important to prevent people losing contact with the labour market although this is mediated by the concern that schemes do not 'cream off those who are most easily reintegrated' (*Joint report on social inclusion*, 2002, p. 35). In this regard, sub-targets from most vulnerable groups are proposed.

Within this, there is scant recognition that vocational rehabilitation and reintegration can contribute significantly to fighting poverty and social exclusion, by participation in employment and reducing exclusion risks, i.e. job loss, and helping the most vulnerable workers. Despite these potential benefits, the current NAPs in most Member States do not address employees at risk of early retirement, disability and inactivity as a result of a chronic health condition.

There is a clear commitment in EU disability policies to improve the employment position of disabled people (Council Resolution 2003/C 175/01), supported by programmes and policies. The EU addresses disability through social inclusion, anti-discrimination, active social protection and labour market measures. However, increased labour market participation of people with disabilities is difficult to achieve (Dupre and Karjalainen, 2003). Other developed economies have had similar difficulties achieving a tangible response to system measures and interventions (Statistics Canada, 2001).

One key instrument in meeting this challenge is the Council Directive 2000/78/EC establishing a general framework for equal treatment in employment and occupation. Only two EU Member States (France and Italy) had passed this Directive fully into their national legislation within the three year deadline of December 2003. The remaining states can take up to three additional years to implement it. This lack of progress prompted the Employment and Social Affairs Commissioner to propose a disability specific directive. National politicians, social partners and disability advocacy groups across Europe strongly promote the priorities of the framework on non-discrimination of people with disabilities. However, there is little documentation about the strategy's impact on job retention or reintegration into work of people with disabilities arising from chronic illness.

A major element of EU social policy is the European employment strategy and, in particular, the employment guidelines produced each year (*Employment guidelines 2003*). The main aim is to improve employment among Europeans of working age. Through the open method of coordination, they are one of the principal means to implement the European employment strategy, and provide a good estimate of current EU thinking on employment and social inclusion. The approach of developing national employment action plans has been in place for over seven years and includes a specific reference to people with disabilities. The current guidelines include strategies aimed at integrating people at a disadvantage in the labour market and combating discrimination. They also include a new target relating to age: 50% of older workers (55-64) to be in employment by 2010.

After the Lisbon Economic Council, a new target was set to raise the employment rate for people with disabilities to that of those without disabilities by 2010 (Van Lin, Prins and de Kok, 2003). Thus, persons with disabilities are an important target group to foster participation and

employment, especially in countries with a high incidence of non-employment among those who are moderately disabled.

The employment guidelines favour active and preventive policies and a balance between flexibility and security in pursuit of three complementary and mutually supportive objectives: full employment; quality and productivity at work; and social cohesion and inclusion. However, they focus primarily on unemployed people and integrating those who are inactive or at a disadvantage into the labour market.

The introduction acknowledges employment as a key means to social inclusion, and recommends preventing exclusion of people from work but the guidelines do not refer to rehabilitation or reintegration as recommended by the European expert group on the employment situation of people with disabilities (2001). Instead, they refer to health and safety, reduction in accidents and occupational diseases, and emphasise training and active ageing, fostering working conditions conducive to job retention, and eliminating incentives for early exit by adjusting social protection to eliminate inactivity traps.

There is agreement among most EU Member States on setting targets for employment participation for people with disabilities, with measures to achieve those targets and progress monitoring mechanisms (UNSR – UN standard rules for equalisation of opportunities for people with disabilities, 1996). However, to date, there is no systematic and compatible means to measure achievements in the UNSR employment rules or the employment guidelines. The number of countries involved and differences in the way disability is defined or self-reported curtail efforts to compare various EU states (Bolderson, 2002/European Commission, 2002; Dupre and Karjalainen, 2003). There is even little emphasis on how to retain people with disabilities in employment (*Employment situation of people with disabilities*, European expert group on the employment situation of people with disabilities, 2001).

A related area of policy concern for the Commission and national governments is the growing focus on ageing and older workers. The Commission has shown concern about the ageing European population since the late 1980s (Von Nordheim, 2004) but it was not until the 1999 employment guidelines that it focused on older workers. The 1999 Commission Communication 'Towards a Europe for all ages' identified increasing employment of older workers as an important element of the policy response. In the latter half of 1999, a major theme of the Finnish Presidency concerned active strategies for an ageing workforce. The employment agreement at the Helsinki Summit identified the age gap in employment rates for older workers (Diamantopolou, 1999).

The Lisbon Summit in 2000 took the Commission's and Member States' concerns further through the Lisbon Strategy which set a goal of full employment by 2010. While maintaining Europe's social protection, the Commission launched policy initiatives such as: adopting a specific employment guideline on active ageing from 2001 (European Commission, 2001); agreement at the Stockholm Summit (2001) on a target of 50% employment rates for workers aged 55-64 by 2010; the March 2002 *Joint report on labour force participation and active ageing* (European Commission, 2002); and the March 2002 Barcelona European Council agreement to raise retirement age by five years by 2010 (Presidency conclusions, 2002).

The European employment strategy thus acknowledges ageing and the labour supply of older workers (*Employment in Europe 2003*), and recognises that exit from the labour force is the transition from active to inactive life, within the terms of the labour market. It relates this to advancing age, although the transition can occur to anyone who develops a health condition that affects work capacity at any age. The employment strategy also points to the cost of social protection systems for older workers and increasing pressures on the system as a result of the dependency ratio. It recognises the low employment rates for older workers and early withdrawals, and suggests that, to reach the Stockholm and Barcelona targets for 2010, the numbers of people aged 55-64 in employment need to increase by almost one million each year. This requires about two-thirds of the 46-55 age group remaining in employment until 2010. It also acknowledges that work-related health problems increase with age and relate mainly to musculoskeletal conditions and stress.

The recommendations promote active ageing and aim to eliminate incentives for early exit and early retirement. They also propose better work-related health conditions, flexible working time and retraining older workers. What is not explicit in the strategy, however, is that early vocational rehabilitation and reintegration can help substantially to maintain the health of older employees and their ability to work, even though disabled people in active labour market programmes tend to be younger (European expert group on the employment situation of people with disabilities, 2001).

Early intervention, vocational rehabilitation and reintegration can contribute substantially to both the Stockholm and Barcelona targets through the health, social and economic gain of older workers whose ill health leads to reduced work capacity. Such services should be available at all ages within the workplace as, without appropriate intervention, many conditions become chronic over time.

Despite this focus, most – if not all – of these policy initiatives fail to target older people at work who risk losing their jobs from illness or injury. The most closely related interventions proposed focus firmly on altering tax and benefits, and introducing active labour market measures to boost target group employment levels. There is an apparent assumption that workers in this, or any, age group with a chronic health condition do not need help to remain in, or return to, work.

This is surprising given that a suitable international policy framework emphasises job retention, early intervention, referral to appropriate services, redeployment, the use of adaptations and adjustments, and gradual return to work. The International Labour Organisation (ILO) code of practice, *Managing disability in the workplace* (ILO, 2002), has the advantage of reflecting a tripartite view of the job retention process in terms of the state, worker representatives and employers.

The code recommends adjustments to work organisation, the environment or work content, redeployment, training or retraining, the use of devices or appliances, and the right to access other supports. In parallel, it recommends that 'competent authorities' provide guidance, services and incentives to employers to retain people and to encourage employees to resume work speedily. Suitable measures include individual counselling, individual rehabilitation plans, job retention programmes, assessments of ability and work experience of workers who undergo reduced job capacity, and encouraging workers to remain economically active through vocational retraining and reintegration programmes. The code also states that social security systems can help workers

retain their job and return to work through high quality, well coordinated and promptly available services.

Another relevant EU policy area, which could impact on the employment prospects of people with chronic illness or disability, is public health. The *Social protection in Europe* report (2001) recommends a focus on illness prevention and health protection as the best way to tackle health problems, reduce costs and promote healthier lifestyles. A public health strategy endorsed by the Commission (DG Sanco 2002) sets out three strands of activity: better public health information systems; developing Europe's capacity to respond to major disease outbreaks; and health promotion, i.e. addressing the determining causes of disease. There is no formal mention of chronic illness or disability. Moreover, the health promotion strand fails to mention the workplace, or any other setting, as a venue to undertake health promotion, unlike the previous public health programme which ended in 2002. Despite this, the European Network for Workplace Health Promotion (scheduled for July 2004), funded under the health promotion strand of the public health programme, deals with the health of an ageing workforce.

The EU does not have competence over all policy areas relating to social exclusion through illness. National governments determine social insurance and social welfare and health policies, especially concerning welfare system design, levels of benefits, eligibility criteria, training and retraining systems, and workplace health systems.

Changes and proposals for changes have been introduced in these areas in some countries, with popular protests taking place in countries such as Austria, Germany and Italy. These changes are occurring for many reasons, including the perceived need to make labour markets more flexible, to reduce unemployment and the costs of disability pensions (for example, the Dutch government has set a target of reducing the numbers claiming long-term disability benefit by 75%), and to reduce the costs of public pensions.

Whatever the motivation for these changes, it seems clear that the challenges from a combination of high and rising disability rates and an ageing workforce will lead to more profound changes. Chapters 5-11 of this report deal with these trends at national level for seven EU countries.

In summary, the policy background to social exclusion through chronic illness or injury points to a number of conclusions:

- There appears to be relatively little focus on chronic illness and employment in the major EU policy areas.
- The responsibility and competence for all relevant policy areas to combat social exclusion from chronic illness do not reside at EU level.
- There is concern about how relevant policies relate to one another – in employment, health, social security and equality, there needs to be an explicit goal to prevent social exclusion at EU and national levels.
- There appear to be major gaps in prominent policy areas, e.g. EU initiatives on ageing do not emphasise preventing exclusion from the labour market through chronic illness; and public health policy does not refer to work or maintaining workers with chronic illness in the workplace.

2 Process of social exclusion through illness

Pathways to social exclusion

The path to exclusion for people who develop chronic illness begins when the condition impacts on their capacity to do their job. At this point, the response of the immediate supervisor, general manager, human resource staff, occupational health personnel, and their own general practitioner can increase or reduce the likelihood of extended absence from work. The methods available to employers can help workers continue and can contribute significantly to preventing them entering the process of social exclusion. Unfortunately, not all employers intervene positively and, in many cases, the individual must leave work for a long time. At this point, the path from long-term absence to long-term unemployment, economic inactivity and social exclusion is well documented. It is widely accepted that 80% of those who are long-term absent for six weeks or more need some assistance to return to work (RETURN, 2002). The probability of returning to work for those absent between three and six months is less than 50%. For those absent more than 12 months, the probability is less than 20% (NIDMAR, 1995).

This period, starting when a person crosses from employment into absence and finishing when they make the transition into early retirement, disability pension, dependency or long-term unemployment, is the critical phase in the exclusion process. Although it is more likely to occur for certain groups such as older workers or those with low qualifications, at any one time between 10% and 30% of the working population are at risk of long-term absence as a result of chronic illness or disability. On the other hand, many people with reduced capacity from chronic illness or disability do not forfeit their employment. In fact, in an Irish survey, over 50% of people with disabilities who were employed were not disabled when recruited. Thus, job maintenance and reintegration mechanisms prevent progressive social exclusion (National Rehabilitation Board, 1996).

It is not difficult to grasp the implications of moving from being a productive worker to long-term absence. Apart from the distressing experience of having developed an illness or disability, the altered status of long-term absence brings with it reduced income, negative self-esteem and confidence, stigma (particularly in relation to mental health conditions), disengagement from work, and a loss of skills and knowledge within a job role or occupation. There are also exclusionary impacts on the person's family, particularly if there are dependents. On a broader scale, chronic illness and work disability have impacts on the community, colleagues in the workplace, and the wider society. Many of these can be described in economic or financial terms, but there are also repercussions for quality of life and social marginalisation.

Over the past five years, an increasing trend in both policy and research terms has been the focus on safe and timely intervention for individuals at risk of unemployment from chronic illness or disability. This focus has led to a clearer perception of the contributors to extended long-term absence and the progression to economic inactivity and exclusion. It is now abundantly clear that system factors are equally if not more important than a person's characteristics or health condition in the cycle of absence and exclusion. The lack of coordinated, safe and timely interventions (i.e. from three days post-absence to six weeks and beyond) is an important factor in the relatively high numbers of people exiting work as a result of illness.

The difficulties in accessing safe and timely interventions vary from country to country. In many cases, the speed of response, or lack of it, is down to bureaucratic systems of administration,

eligibility, financing and provision. There are often intervention delays in deciding which agency is responsible for the costs. In some jurisdictions, there is a complete unawareness of the need for safe and timely interventions from employers, trade unions, service providers and authorities. This can result in parallel and sometimes competing systems of social protection and rehabilitation. Social welfare policy and practice operate to maintain people in social protection, either through passive income support measures or tax and poverty traps; while, at the same time, substantial active labour force and employment equity measures support people going back to work. In most systems, there are fragmented and uncoordinated responses to the individual, the possibility of being excluded from services through ineligibility (due e.g. to their employed status), and ambiguous responsibility for financing interventions.

Workplace factors can also enhance or lessen a person's likelihood of social exclusion. Lack of contact with the workplace post-absence, lack of appropriate work–life balance within a company, lack of policies and procedures for managing disability in the workplace, and a company's culture can all contribute to the likelihood that someone will fail to return to work. In addition, a person's non-work context – their family and community involvement – can act positively or negatively in relation to return to work.

Modelling job maintenance and return to work

There is sustained attention to the link between illness, absence, disability and unemployment in the EU and in other jurisdictions e.g. US, Australia, New Zealand. This has produced a knowledge base on system characteristics that may act as inhibitors or enhancers of early return to work. Other results include good practice guidelines for companies (ILO, NIDMAR, RETURN), and identifying systems elements that need to be improved to achieve more effective impacts on unemployment and the labour market.

There is a need for a coherent description of systems to build on this knowledge base. This description should be able to support trans-national comparisons of initiatives either solely or together. In particular, a model is needed which describes the potential impact of initiatives on how employees, employers and other actors perform with regard to maintaining jobs or reintegrating into work. A conceptual understanding of the processes involved will provide the basis for future system design, and advice and guidance to policymakers, employers and workers.

This undertaking requires a number of elements including:

- a coherent model of the exclusionary process and the interactive impact of system, personal and health factors on reintegration, or transition to economic inactivity. The model must help clarify terminology across countries and disciplines.
- a methodology and conceptual framework to highlight potentially relevant initiatives specific to the immediate post-absence/early return to work period, taking into account jurisdiction and company level policies, procedures and culture. It should generate a system profile of strengths and weaknesses, and recommend strategies for change and intervention.
- a focus on results. In particular, the effectiveness of changes in jurisdictional or company policy, measures or strategies should be specified in terms of approach and monitoring in order to support decision-making, learning and innovation.

The four-part model described in this chapter seeks to support a proactive and value driven approach. The aims of each part of the model are:

- to describe the relationship between health conditions and social exclusion, using a widely accepted terminology and model;
- to produce an explanatory mechanism for the impact of macro and micro level factors on an individual's decisions to remain in or return to work, and the employer's decisions on retention and reintegration;
- to characterise the transition from work to disability, unemployment and inactivity at a system level, not simply in descriptive but in structural terms to support the policy recommendations;
- to produce a model of good practice in service provision, leading to jurisdiction and company recommendations.

Disability: a dynamic interaction between person and environment

Over the past 20 years, there has been a gradual shift in perspective from structures and provisions developed on the basis of a 'medical' model of disability. This model suggests that a person's physical or mental condition provides sufficient explanation for the negative consequences and exclusion experienced. More recent thinking proposes a 'social' model of disability, which focuses on the responsibility of the system for creating negative consequences for people who differ in some personal characteristic from a societal norm, often as a result of a difference in functional capacity.

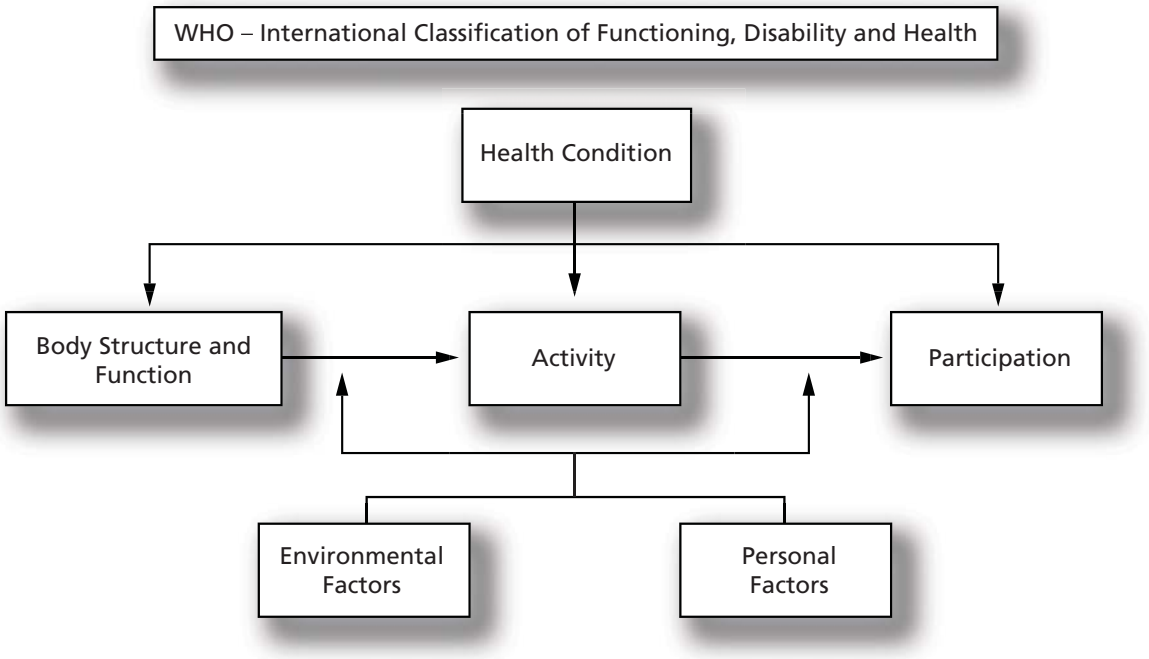
Current systems tend to reflect their origins within either model. For example, many jurisdictions allocate resources to disability services through structures that reflect a categorical or medical concept of disability. Categories such as physical and sensory disability, learning disabilities and psychiatric disabilities determine funding. Individuals who require these resources must accept a category label in order to avail of supports and interventions. These systems contrast with equality legislation, underpinned by Article 13 of the Amsterdam Treaty, which outlaws all discrimination on the basis of disability. While there is general acceptance of the concept of an inclusive society based on the social model, existing health, labour and social protection measures still reflect a medical model of disability. This results in an often inconsistent, ambiguous and incoherent response to individuals with chronic illness or disability.

It is frustrating for a person with a disability to negotiate through such fragmented and uncoordinated responses. An additional dilemma faces people who develop a chronic illness as they may not meet the eligibility criteria for services based on a medical construction of disability, nor qualify for protection under anti-discrimination measures. The dichotomous nature of both approaches can inhibit appropriate, safe and timely access to services, supports and mediation. A more dynamic concept of the disabling process is required in order to plan an effective and proactive system response.

The World Health Organisation provides a potential framework in its International Classification of Functioning, Health and Disability (ICF, WHO, 2001). The ICF began in the mid 1990s, when the World Health Organisation and Disabled Persons' International began discussions on revising the 1980 International Classification of Impairment, Disabilities and Handicaps to reflect more

accurately the social model of disability. With extensive effort, an agreed classification appeared in 2001. The ICF is termed a 'hybrid' and a 'universal' model of disability in that it attempts to encapsulate the wide range of conditions from very minor to severe within its remit. Figure 2 illustrates the elements of the ICF.

Figure 2 The ICF classification



The ICF has a detailed system to classify a person's functioning, activity limitations and participation restriction, and the health, environmental and personal factors that influence these. It also provides a conceptual way to describe the dynamic interaction between states and factors within the model. It gives a paradigm for describing the impact of system level initiatives (as environmental factors) on a person's residual capacity post-illness or injury. It also helps describe how they operate to influence a person's activity potential and participation in the community.

A key concept of the ICF is the discontinuity between states, i.e. a person's level of functioning, activity limitations and participation restrictions. It is possible for someone to have a relatively minor reduction in their physical, sensory, cognitive or psycho-emotional functioning and yet be limited in their activities. This may result from the impact of environmental factors such as regulatory requirements, or personal factors like age, gender or educational qualifications. On the other hand, a person whose activities are very limited can, as a result of environmental or personal factors, participate very effectively socially, culturally and economically e.g. in employment.

A number of examples illustrate the dynamic nature of the ICF and, in particular, the discontinuity between functioning, activity and participation. One often cited example relates to short-sightedness. In countries where corrective lenses are available, only minor limitations to a person's activities may result. However, in a country where such lenses are not available, this can substantially limit a person's activity. Equally, if an individual has a minor capacity reduction but

cannot access appropriate, safe and timely interventions, the person may experience more serious activity limitations than indicated by the original incapacity. This arises regularly within mainstream education, training centres and workplaces in all countries.

Accessible communications, transport and workplace environments illustrate the discontinuity between activity limitation and restriction in participation. For example, if a person has difficulty negotiating steps reaching above a certain height, participation can be severely restricted by level changes in the built environment that are not ramped, or by storing items on stacked shelves out of the reach of someone who cannot use a ladder. Similarly, someone who has difficulty understanding the 24-hour clock can be severely restricted by needlessly complex transport and work schedules.

Unemployment or economic inactivity resulting from a chronic illness or disability restricts a person's participation in a valued economic life activity. While both environmental and personal factors greatly influence activity and participation for people with a reduction in capacity due to health conditions, the main focus of the current study is on the environment. In particular, the focus is on the measures operating within specific jurisdictions and the initiatives within a sector or enterprises.

The key focus of the study is on macro-environmental factors such as laws and regulations and mediating mechanisms such as supports and incentives, fiscal constraints and administrative procedures. A further focus is on micro-environmental factors at the level of the employing organisation, for example, culture and attitudes, policies and how these are put into practice, the resources the company allocates and how it prioritises retention and return to work, and the knowledge base within the company. This can characterise initiatives in terms of their potential impact on the employer's retention and reintegration decisions; the worker's decision in relation to remaining in or returning to work; and the decisions of agencies to provide or withhold appropriate supports and protection in legislation, services and eligibility for financial or procedural incentives.

Threshold model

Figure 3 below illustrates the process whereby workers can become socially excluded (i.e. long-term or permanently absent from work) due to chronic illness.

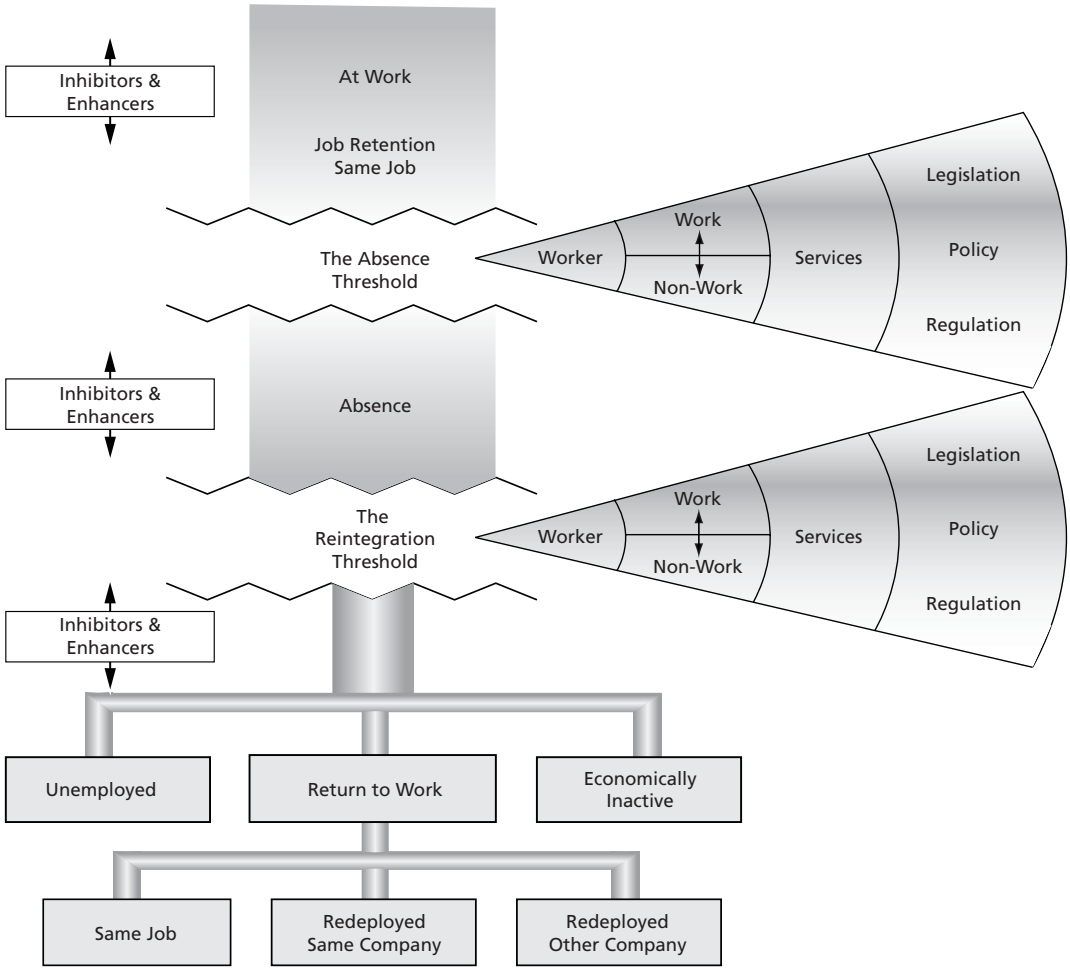
There are a number of key elements and concepts to this model:

- *retention* – the processes and activities whereby an ill or injured worker is kept in the workplace;
- *reintegration* – the process whereby an ill or injured worker who is absent (long or short-term absence) rejoins the workplace. This can be to the worker's original job, a different job within the organisation, or a new job with a different employer;
- *thresholds* – the idea that a set of factors act as a barrier to changing the employment status of an ill or injured worker, i.e. from employment to absence, or from absence to employment, unemployment or to becoming economically inactive. There are two key thresholds of interest: the retention or absence threshold, whereby the ill or injured worker is absent from work, and the reintegration threshold, where the employee returns to work.

- *outcomes* – the worker will experience one of three types of outcome following long-term absence: return to work, unemployment, or becoming economically inactive.

The key concept in the model is threshold. Thresholds consist of a range of interacting factors at the individual level, the level of the workplace, the family or personal social context of the individual ('non-work', as it is labelled in the figure), the services available to the individual, and the broad area of policy which affects the career prospects of the ill or injured worker.

Figure 3 The threshold model



At the individual level, factors such as the nature of the illness, individual motivation, age and gender all influence the transition from work to absence. For example, older workers are more likely to cross the threshold to absence due to illness, workers with chronic illness are more likely to become long-term absent (compared with those who experience acute illness), and women are more likely than men to remain out of work as a result of long-term absence.

In the workplace, retention and reintegration policies, supportive services such as occupational safety and health (OSH), disability management, training and retraining, and the availability of alternative work all contribute to increasing the likelihood that an ill or injured worker will remain in work. Conversely, the absence of such factors lowers the absence threshold and raises the return to work threshold.

Factors outside the workplace such as personal and social circumstances also influence absence and return to work thresholds, as do personal finances and the support available to the worker.

Important services include rehabilitation, training and retraining, and disability management. Welfare services and benefits systems also raise or lower the absence and return to work thresholds. A key issue concerns the level of service coordination and the strength of the services' relationship with the workplace.

Finally, public policy in retention and reintegration also greatly influences thresholds. Relevant policy areas include social insurance, equality, social inclusion, vocational training, levels of benefits and their accessibility for the ill or injured worker. A key question is the extent to which they actually focus on retaining and reintegrating chronically ill or disabled workers. Public policy often has confusing and conflicting objectives, for example, where benefits may be seen solely as income replacement rather than reintegration resources. The complexity of policy and benefits may also militate against a smooth reintegration, thereby raising the threshold for people returning to work.

Gap between work and welfare

The adoption of the ICF, and in particular its emphasis on the dynamic interaction between the person and the environment, leads to the conclusion that neither chronic illness nor disability need inevitably result in job loss and unemployment. This leads to a closer examination of the exclusion process. Figure 4 (RETURN, 2001) illustrates how two parallel systems operate in most countries, and locates long-term absence as a result of chronic illness in this context.

In the workplace, a range of work-based strategies respond to the individual needs of employees and prevent illness or injury. These include human resources policies and strategies, equal opportunities, health and safety, risk management, occupational health and health promotion, including employee assistance programmes and private health insurance. The welfare sector, on the other hand, mainly focuses on people who are short-term unemployed, registered as disabled, or economically inactive. Those who are eligible can access employment services, vocational rehabilitation, general health services, income maintenance, and other social inclusion measures.

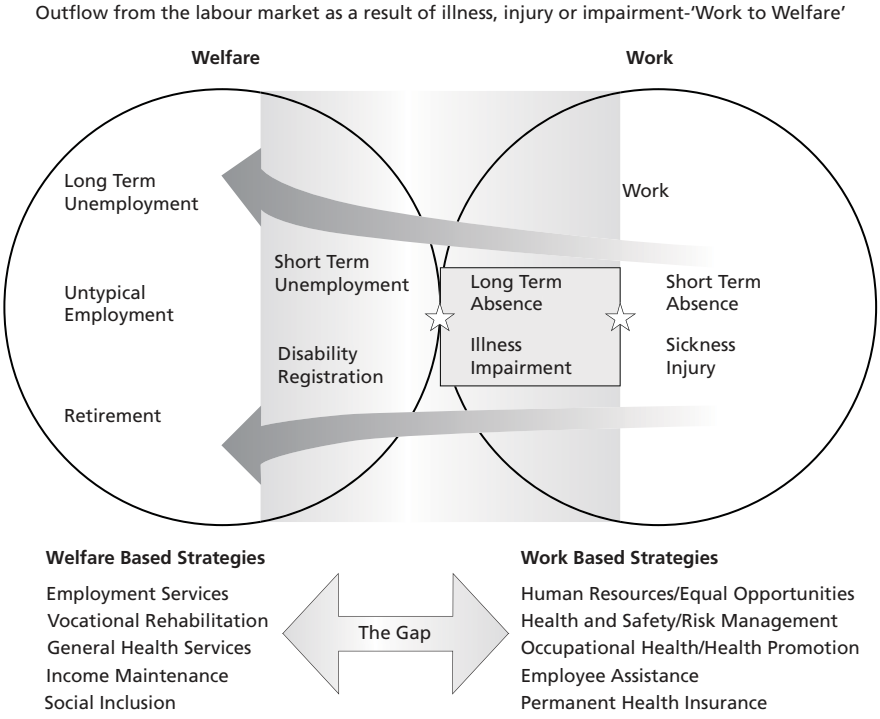
This study focuses on long-term absent people who are ineligible for services that require disability or unemployed status, and who do not wish to exit into short-term unemployment. In other words, they aspire to reintegrate into their previous job, or in an adapted position with their original employer, but do not yet qualify for active supports under social inclusion or equality measures.

The RETURN project set out to specify the gap between work-based strategies and welfare-based interventions. One major conclusion was that many services for people in continued employment are relevant to those on long-term absence but were inaccessible. Conversely, many potentially useful services within the welfare sector were denied to long-term absent employees on eligibility grounds, either because they did not or could not register as disabled or they were unwilling to accept unemployment.

The figure represents the outflow from the workplace of people experiencing chronic illness or impairment, and the ineffective or in many cases non-existent responses to employees at risk of,

or experiencing, long-term absence. This gap will inevitably result in a substantial proportion of these losing their jobs, registering as disabled, unemployed or taking early retirement, and ultimately requiring long-term social protection measures. The impact on society and the social costs of this essentially undocumented outflow are most serious. The constraints that rising social protection costs can place on the European social model are clear. The progressive exclusion of individuals on long-term absence as a result of chronic illness or impairment is a key element in this equation, and has implications for solidarity, social cohesion, equality objectives and the engagement of citizens in society.

Figure 4 Work to welfare gap



Disability management model

The previous models detailed how employees cross the absence and reintegration thresholds as a process taking place over time. The disability management model is concerned more with the types of intervention at organisational and system level to increase the possibility of job retention (not crossing the absence threshold) and reintegration (easing the employee's passage across the reintegration threshold). An active strategy known as disability management is the best practice in this area.

The concept of disability management evolved within the Workers' Compensation Boards systems in North America. An important motivating factor was that the employer, regardless of fault, was responsible for the rehabilitation and support of the injured employee as long as the condition was work related. In such cases, the compensation boards had to provide rehabilitation and insurance protection. They attempted to recoup these costs through increased premiums to employers on the basis of the occupational injuries and absence levels of the company over the previous three years. Conventionally, disability management was conceived as an internal company strategy for

reducing long-term absence and job loss as a result of injuries suffered in the workplace, and thus reducing premiums and other costs of long-term absence. It consisted of four main pillars or processes:

- promoting employee health to create a healthy working environment;
- managing identified risks through proactive responses to emerging conditions;
- intervening early when an employee suffered an injury;
- case managing or coordinating return to work for long-term absent employees.

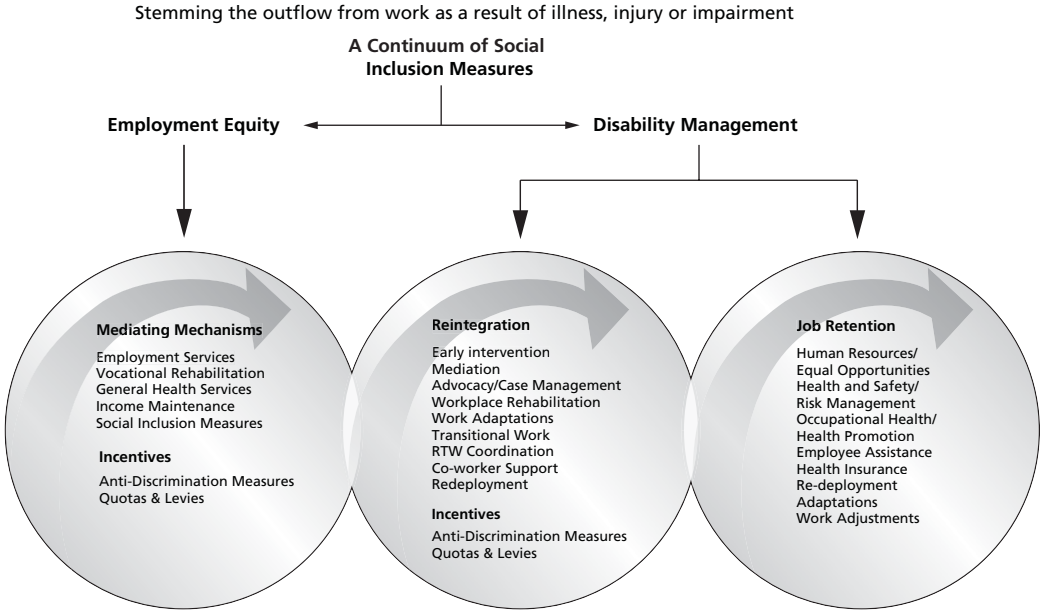
Within a workers' compensation insurance system, the extent to which 'bonus-malus' operates tends to influence the effort invested by an employer in disability management systems and strategies. Bonus-malus rewards companies that have lower accident or illness rates by reducing their insurance contributions, while penalising companies with higher rates by increasing their contributions. While disability management was developed for work-related illness or injury, the approach is equally applicable to workers with illness or injury from any source. Thus, disability management strategies have the potential to benefit all employees at risk of long-term absence and ultimately social exclusion.

This study proposes that disability management need not solely be an enterprise-based approach but can equally be applied to a system level analysis. It is possible to evaluate system initiatives in terms of the extent to which they motivate and facilitate a disability management approach for the company or the employee. From a system perspective, there are two main pillars of a disability management approach. The first relates to retaining the employee who is chronically ill or impaired within the company. In other words, prior to an employee opting for long-term absence, the employer can take a range of steps to prevent such a decision. These include risk management, health and safety initiatives, occupational health services, workplace health promotion, the adoption of work–life balance policies, absence management, diversity management, and redeployment.

Once an individual has exited active work, they acquire long-term absence status. At that point, reintegration requires early monitoring and intervention, mediation, advocacy and awareness raising, case management, work-based rehabilitation, work adaptations, and transitional work. In addition, other supports are needed, including return to work coordination, co-worker awareness raising, and redeployment. The reintegration pillar needs to be distinguished from employment equity measures available to the economically inactive. Figure 5 illustrates the distinctions between employment equity and disability management systems and, within the disability management process, distinguishes between job retention and reintegration.

The conceptual framework applied in this study attempts to capture the extent to which measures and initiatives focus on employment equity or disability management, and the extent to which disability management measures focus on job retention or reintegration. There is an inherent assumption within this report that systems in which there is a substantial bias towards either job retention or employment equity measures alone will inevitably 'disable' or 'exclude' employees who are long-term absent as a result of a reduction in function from chronic illness. Such systems will, for example, create problems regarding eligibility and access to services which may be available only to specific groups such as long-term unemployed people, even though persons with disabilities could also benefit.

Figure 5 Disability management model



New initiatives in retaining jobs and return to work

3

Introduction

The case studies in this chapter come from seven countries and represent responses to long-term absenteeism from a wide range of settings and systems. They illustrate certain elements of good practice in preventing employees from crossing the absence threshold, i.e. preventive activities in the workplace which seek to maintain the employee in work. Some of the case studies also address the return to work threshold, i.e. how employees who have become long-term absent from work may return in a safe and timely manner.

The initiatives described in this chapter are:

- Novo Nordisk (Denmark)
- Volkswagen (Germany)
- Ford Motor Company (Germany)
- Frozen food manufacturer (UK)
- HealthyReturn Job Pilot (UK)
- PAIMM (Spain)
- Initiative on workplace safety (Ireland)
- Employers' Forum on Disability (UK)
- MKB Benefits (Netherlands)
- The adoption of disability management as a framework for workers' compensation (Germany)
- Maintenance of work ability (Finland)

The chapter describes each initiative briefly, giving an account of the main activities. There then follows a commentary to illustrate how company activities and practices can be assessed in relation to good practice. Of particular concern here is how these initiatives address elements of both the absence and return to work thresholds.

Selecting company initiatives

The process of identifying company initiatives involved a literature search, and asking contacts in the participating countries for information about examples of good practice by organisations. The authors were also aware of a number of interesting initiatives from other work they have undertaken. However, these avenues did not identify a large number of initiatives. Indeed, it was very difficult to find suitable projects in many of the countries of interest in this report.

There are several reasons for this apparently low level of company activity. It may be in part because of failures in the search mechanisms used but there are other factors.

Perhaps the most important reason relates to the structure of the national systems to promote the maintenance and return to work of people who have illness problems. Most national systems in Europe (with the exception of the Netherlands) locate responsibility outside the workplace with a range of service providers in rehabilitation, training, employment and social insurance. It is seen as the job of the state; and companies, while subject to regulation and legislation in the area, are not generally responsible for ensuring maintenance in work and return to work. Most systems, for

example, do not have any or a significant level of bonus-malus with little incentive for employers to undertake such initiatives.

Because most national systems provide the services to ensure return to work, there is often little expertise within companies and organisations. This is especially true of small and medium-sized enterprises (SMEs) and micro-enterprises, where the specialised functions for good practice often do not exist.

Many national systems have begun to address the need to change current arrangements for rehabilitation and social insurance. While the reasons for these changes are complex (they are dealt with in some detail in each of the national chapters), most are relatively recent and have not filtered down to changes in practice at enterprise level. In some cases, these changes are not targeted at companies and appear to have little impact on company practice.

The search for company-level initiatives did identify a number at a higher level analysis. In some cases these were geographical or regional initiatives, in others they were at sectoral level, or even at the level of a single occupation. These initiatives all refer to multiple enterprises rather than single organisations. Their emergence is understandable in terms of national systems for rehabilitation and return to work. As most services are external, it is consistent that initiatives take place outside the organisation.

Dimensions of good practice

Before outlining company initiatives, it is necessary to consider what is good practice at company level. Dimensions of good practice have been described elsewhere based on work carried out in Canada by the National Institute of Disability Management and Research (NIDMAR, 1999) and the RETURN project (RETURN, 2002b). In addition, the authors have consulted other work by Wynne, O'Brien and Grundemann (2000), McAnaney et al (2001), Thorne et al (2002), and Thomson et al (2003).

Most of this work has addressed constructing a company-level audit tool to assess the quality of policies and practices for returning ill or injured workers to work. NIDMAR developed a tool for use with companies in the Canadian Workers' Compensation system. The RETURN project adapted the NIDMAR tool for use within the European context (it was field tested in six EU countries).

Good practice in the area of return to work includes three main types of workplace health activity:

- meeting statutory requirements on occupational health and safety – essentially a preventive strategy with regard to occupational illness and injury;
- undertaking workplace health promotion – not generally a statutory activity, this is targeted at improving the health and well-being of the employee;
- implementing active early intervention policies and practice – these come into use when an employee is ill or injured, and aim to return the employee to work in a safe and timely manner.

Thus, good disability management practice requires a proactive, designed set of policies that focus not only on the activities which must take place when an employee becomes chronically ill or injured, but also on the adoption of preventive and promotion practices in relation to worker health. These policies should be integrated in relation to each other and also to the general company operation and management. The perspective of good practice is that retention and reintegration are the norm and worker health is a mainstream consideration of how the company operates.

Occupational health and safety is primarily a preventive, risk management activity but should also assess the fitness or employability of staff for their work. It can and ought to play a central role in the reintegration process when an ill employee is about to return to work, especially with regard to health status and work.

Workplace health promotion primarily aims to improve or maintain the health and well-being of the worker. It takes an integrated approach and seeks to address general issues, unlike occupational health and safety which focuses on the management of occupational risks to health and well-being. In Europe, much practice draws on the Luxembourg Declaration (ENWHP, 1996), which outlines a set of aims for the practice of workplace health promotion. (Details of the approach can found on the ENWHP website – www.enwhp.org.)

The dimensions of the company assessment tool from the RETURN project (RETURN, 2002b) are outlined below. These may be used as criteria against which the company-level initiatives can be assessed.

- Joint labour–management support and company culture – levels of support for the goals of job retention and reintegration by both management and trade unions;
- Responsibility and accountability – clear lines in terms of management and implementation;
- Internal and external communications – active communications management is necessary between the company and outside agencies; and also between the relevant departments;
- Benefits – types and nature of incentives (deliberate and unwitting) which a company may operate in relation to health-related absenteeism;
- Knowledge and skills in the workplace – staff with appropriate training and experience in managing and implementing retention and reintegration policies;
- Accident prevention and safety programmes – the presence and quality of appropriate measures to prevent disability or injury occurring;
- Occupational health programme – the quality of the programme and its capacity to prevent disability or injury;
- Workplace health promotion – the quality of the programme, i.e. interventions which improve the general, rather than the occupational, health of the workforce. Such programmes can help prevent disability or injury;
- Occupational ergonomics – both as a preventive intervention and to alter the work environment for ill or disabled employees;

- Management information systems of injury, illness and lost time patterns – the quality of such systems, and using the information to plan and implement appropriate disability management practices;
- Early intervention and case management – making early interventions when a worker is absent due to illness or injury. Proactive case management involves assigning the ill or injured worker to an individual to ensure reintegration occurs in an efficient, safe manner;
- Transitional work programme and retraining – the opportunities for a gradual return to work and the possibilities for training and retraining where the worker has a different job;
- Vocational rehabilitation and redeployment – the opportunities for being rehabilitated into the workplace and for being repositioned to another job within the company if needed.

Company level initiatives

Good practice based on the RETURN tool has influenced the choice of company case studies below. These dimensions are not applied rigidly to the case studies but help to identify innovative elements when dealing with employees' illness.

Case 1 describes the approach of Novo Nordisk, a Danish pharmaceutical company with a long history of a proactive and innovative approach to managing illness and disability among its workforce.

Case 1 Novo Nordisk (Denmark)

Novo Nordisk is a major producer of insulin, diabetes care and other pharmaceutical products, and employs over 14,000 people, 9,500 of whom are in Denmark.

Since 1992, the company has had a rehabilitation policy which provides guidelines and defines roles and responsibilities. Proper rehabilitation increases the employability of ill or injured employees, adding occupational competencies or remodelling the working environment. By 1 January 2000, Novo Nordisk had processed 691 cases of illness or injury. Of those, 55% resulted in job retention, 39% received a disability pension, and 6% left the company.

In Novo Nordisk, rehabilitation focuses on sustainable solutions to give employees the best opportunities to return to work. The endpoint is not always inside Novo Nordisk, but may involve placing the employee in a job with another employer. When an employee becomes ill or injured, it is important to intervene early. Both the manager and the employee have a responsibility to identify a rehabilitation solution as soon as possible and to contact the social advisor, OSH or human resource department. Many cases are solved in the employee's own department through redeployment or by generating a job for the individual with some adaptations. OSH expertise is almost always involved in rehabilitation.

Novo Nordisk illustrates the importance of a comprehensive and proactive policy in return to work. This company's policy sets out clear responsibilities for employer and the employee. It emphasises the importance of early intervention, assessing the functional capacity of the returning worker, and adapting the work environment and work organisation to try to ensure the employee's safe return. The company also seeks to outplace employees when there is no adapted work solution.

Cases 2 and 3 below illustrate recent changes made by two car manufacturing companies in Germany with more proactive policies and procedures to respond to employees who have developed health conditions that impact on their work. Case 2 describes Volkswagen's return to work policy and Case 3 describes the initiative of Ford Motors in Germany.

Case 2 Volkswagen (Germany)

Recently, Volkswagen published a description of its approach to job retention and reintegration of employees. A joint labour–management approach encourages intervention and support, viewing workplace health management as a set of multidisciplinary and participative processes, aided by external specialists and providers. Volkswagen has introduced a graded set of responses incorporating a range of mechanisms to promote healthy living and working behaviours in the workplace. For example, it has implemented the Health Circle approach to general health and to working conditions. The strategy aims to prevent employees developing or acquiring disabling conditions through effective risk management and health and safety measures with targeted responses to workers who are at risk. A range of options enhance the potential of long-term absent employees to return to work either in their current job or through redeployment. Transitional work and supervised work-based rehabilitation are among the possible interventions.

The Volkswagen Health Circle approach seeks to improve the work environment in health and safety terms and to design general health promotion interventions in the workplace. This policy-driven and systematic approach conforms to the principles of disability management as outlined in the RETURN protocol/NIDMAR code of practice. Of particular interest are the return to work options available – with a range of adapted work environments and supervised work rehabilitation. Also of note is the participative approach to the policy which is firmly rooted in agreements between management and labour representatives.

Case 3 Ford (Germany)

The Ford Motor Company in Germany has adopted what it describes as a paradigm shift in prevention and rehabilitation interventions to enable workers with disabilities to contribute productively and to retain their valuable experience and expertise. There was an initial test involving 500 employees assigned to what is termed a 'disabled workshop' in the company. This pilot was successful and the company has since deployed the approach throughout its occupational health services in Germany. The basis for the project was an analysis of medical leave and associated costs which identified the need to achieve more healthy and productive outcomes, and also to prevent the annual inflow of workers into the disabled category, a process likely to be exacerbated by the ageing of the workforce.

The promoters proposed a shift away from the perspective that workers with disabilities were a nuisance element arising from Ford's requirement to meet quota obligations, to the view that integrating workers with disabilities and older workers into the core production process made good business sense. The disability management strategy used prevention and rehabilitation to reduce the numbers requiring 'easy workstations'. An important principle was that workers currently considered part of a healthy workforce could develop medical restrictions with the possibility of becoming disabled. Thus, prevention and rehabilitation were the mechanisms to increase productivity and ensure a healthy work environment.

The starting point was to describe employees' abilities rather than their limitations. These ability profiles were then matched to detailed analyses of job requirements. The approach

involved all levels of staff, including plant management, personnel, works council, supervisors, the internal Ford occupational health and medical team, and external support specialists. The German Federal Ministry for Labour and Social Affairs supported the project, and a multidisciplinary team involving psychology (University of Siegen), health professionals (IQPR) and occupational science (MUNDA) implemented it. An important ability assessment tool was a computer-based analysis – *Integration von Menschen mit Behinderungen in die Arbeitswelt* (IMBA). IMBA allows the team to match an individual's abilities to job requirements along nine main dimensions including physical and information demands, environmental influences, occupational safety, and work organisation, with 70 detailed characteristics.

IMBA can also incorporate other personal and environmental factors such as family influence, social environment, educational qualifications, colleagues and supervisors. The results of the job–person match specified potential interventions, including ergonomic improvements, appropriate placement and rehabilitation or medical interventions. IMBA does not replace a team approach to decision-making and problem-solving but provides the information for the team, including the worker, to make an informed decision.

The results of the project included the placement of 267 employees in the workshop into integrated positions in normal production. Of these, only seven were out-placed to other employers while 13 were retired or given long-term medical leave. The benefits in the medium to longer term include cost reduction, reduced absence, improved early identification of employees at risk, fewer people developing disabilities, enhanced motivation of employees, and increased productivity of workers with disabilities.

This initiative demonstrates that a disability management approach can work not only for employees with recent or emerging health conditions but also those with established disabilities. It also illustrates the importance of changing company culture as a prerequisite for effective disability management interventions. The use of job matching technology is innovative within an EU context although such systems have been in operation in the US for many years.

Another key characteristic is the cooperation between in-company personnel and external providers to achieve a coordinated approach focused on the individual abilities of the worker and the employment resources of the company. Finally, this initiative may well represent a useful way forward in bringing in-company practice into line with the recently introduced provisions of the Social Code described in Chapter 6. The challenge for the German Social Code is to impact more effectively on in-company culture, policy and practice given that the locus of responsibility for action and intervention tends to be placed with external agencies and authorities.

It is no coincidence that both these companies and the Berufsgenossenschaften (Workers' Compensation Boards) have fully embraced disability management. In fact, a workers' compensation insurance approach may strongly support the adoption of such a model. The challenge for the EU is to adapt the disability management model to the current contexts where employers do not bear the costs of long-term absence, either through sick pay or premiums, but can 'export' employees who are chronically ill or disabled to the welfare system to be funded by general taxation. In such circumstances, the business case for proactive employer policies and strategies may seem less compelling but it certainly highlights the need for more proactive social protection measures.

A recent UK study (Thompson et al, 2003) addressed reintegration practices for workers with mental health or stress-related problems, a well-recognised special challenge for the workplace and the employee (e.g. Anderson and Wynne, 2004). People with psychiatric health problems often find the link between the workplace and the welfare system to be very weak. These difficulties are compounded in work-related stress breakdown since, unlike rehabilitation for many people with physical impairments, the worker will go back to the environment which may have caused the breakdown in the first place. The assessment of work environments and work organisation, as well as the impairments associated with stress, is perhaps a less exact practice than for physical impairment.

The Thomson et al study set out to identify best practice in relation to return to work for people with stress-related disorders. It illustrated 12 case studies of varying size UK organisations from a range of sectors. Best practice was defined largely in terms of the elements of good disability management practice. Case 4 below gives an account of best practice in one case study.

Case 4 Frozen food manufacturer (United Kingdom)

The aim of this company-level case study was to characterise practice in rehabilitation and reintegration of workers absent due to work-related stress. Best practice in this context referred to actions taken after a worker became absent, and also ongoing policy and structural features of the enterprise. A set of expert interviews defined the elements of best practice.

None of the case study organisations met all of the best practice criteria, but many met most of them. The elements of best practice in the frozen food manufacturer were:

- Early intervention – making contact within three weeks and responsibility moving from occupational health to line management;
- Early health assessment – health assessment after four weeks;
- Quality of health assessment – very accurate and supportive of appropriate interventions, the key issue often being the level of detail supplied in the assessment;
- Availability of therapeutic interventions – made available by the company with access to cognitive behavioural therapy;
- Work adaptation and adjustment – this return to work measure was available;
- Written policy and guidelines – the company has a written policy on return to work with a case management system to oversee reintegration;
- Role integration – refers to how well the various aspects of the return to work process were integrated. In this company, occupational health and case management were integrated;
- Awareness of return to work and rehabilitation policy – awareness was high and recognised as a key factor in successful rehabilitation.

This case study points to a number of elements that are vital to ensure early and timely return to work. Early intervention, precise assessment of the health problem and the availability of appropriate therapeutic interventions are particularly important in stress-related disorders. Otherwise, many elements of good practice are similar to those that might be applied to physical illness or injury.

Sectoral and other group initiatives

Among the case studies were a number of sectoral-level initiatives undertaken by a wide range of actors with differing objectives. However, they all demonstrate a new approach to improving the reintegration of workers with long-term illnesses or injuries.

These initiatives vary in terms of organisation, focus and objectives. They include sectoral and regional initiatives as well as actions by insurers, governments and voluntary initiatives by the social partners.

Case 5 The Healthy Return job retention pilot (Scotland)

To be eligible for HealthyReturn, people must have been either employed or self-employed, working full or part-time and currently off work for between six weeks and six months due to an illness, injury or disability. In addition, they should want to get healthy, get back to work, and be living and working within selected postcode areas in Glasgow. People who think they may be eligible can call a freephone number to participate.

At the initial call, a trained operator assesses eligibility to take part in the study. Those eligible have their details sent (via secure, confidential means) to a central point where each individual is placed into one of four pathways.

1. Health care: This offers a variety of treatments from physiotherapy to psychotherapy, depending on an individual's needs. Importantly, clients are consulted on the treatments most suited to them and no decision is taken without their agreement. Treatment is normally offered within a week of the first appointment and provided by fully qualified specialists.
2. Workplace care: Senior occupational therapists from the Department of Occupational Therapy at Glasgow Caledonian University and a consultant occupational physician provide this care. Health and safety advice is also available free of charge from qualified practitioners. Any contact with the employer only comes after employees have given absolute consent. Types of treatment range from ergonomic assessments of the client's workstation to discussing a possible stepped approach back to work.
3. Combined health and workplace care.
4. Control group: The control group is told by letter from a central point that they have been placed at random into this particular group and there will be no contact between these clients and HealthyReturn staff. Future contact only takes place between the individual and the independent evaluators.

Case managers from a variety of backgrounds, ranging from counselling to physiotherapy, coordinate the job retention process. They welcome each client into the project on day one and continue to be an advocate for that client until they return to work. The medical director decides this in consultation with any relevant specialist providers and, importantly, with the client's consent. Ongoing treatment is reviewed regularly.

The case managers are fully trained to deal with all manner of issues, but it is not their role to diagnose an individual client's problems, nor to prescribe any specialist treatment. A specialist provider does this with the client's consent, immediately following the first meeting, and reviewing it regularly with the client as their progress continues.

Case 5 describes one of the UK national job retention pilot projects. The pilot sites are in six locations: Glasgow, Teeside, Tyneside, Birmingham, Sheffield and Kent. HealthyReturn in Glasgow is one example from this two-year national study. It aims to test what, if any, benefit there is to offering additional help to people currently signed off work to assist them back to health and to their job.

The importance of these pilots is that they are testing a model of packaging return to work services using a scientific methodology. If the results are sufficiently positive, the appropriate services will be available on a national basis and the results will help define the most effective interventions to promote early and timely return to work.

The sectoral level example below from Spain describes a healthcare initiative for medical and other healthcare personnel in coping with stress and burnout, recognised as a major cause of long-term absenteeism. It outlines a set of interventions that are very successful in promoting return to work among a group of workers who suffer high stress levels.

Case 6 Integrated intervention for ill medical staff – PAIMM (Spain)

A regional example from the private sector in Spain is *Programa d'atenció integral al metge malalt* (PAIMM - Integrated intervention programme for ill medical staff). Doctors, along with everyone else, need diagnosis and treatment of their illnesses. As an occupational group, they have the fifth highest incidence of psychological morbidity in Spain. A professional body, the *Consell de Collegis de Metges de Catalunya* (Catalonian Council Medical Association), recognised that occupational stress was taking its toll on the profession and on individual members. Furthermore, patients were exposed to what might be a secondary risk: doctors were continuing to practise despite health conditions which could impair their judgement and competence.

PAIMM seeks to help doctors who suffer psychological problems or addictive behaviours that can interfere with their professional practice. Experience shows that early intervention can facilitate the doctor, even while in treatment, to stay at work. From 1999 to June 2000, PAIMM considered 179 cases and accepted 170 of these. According to preliminary results, among the 72 doctors treated, 98% are stable or abstinent during the first seven months after treatment. (US estimates report rehabilitation at around 80% two years later.)

Voluntary initiatives by employers, often on a social partner basis, take place for various reasons. A common feature is that they provide services or take positions on issues which go beyond legislative requirements. Cases 7-9 describe three such initiatives – the Workplace safety initiative from Ireland (with trade union participation), the UK Employers' Forum on Disability, and MKB Benefits from the Netherlands.

The initiative described in Case 7 is significant in a number of respects. Firstly, it specifies that return to work is a goal of employers and unions, a relatively new development in the Irish context. Secondly, it seeks to promote early return to work on a voluntary basis, notwithstanding the fact that Ireland operates a fault-based (and therefore litigation-based) compensation system. However, the agreement as currently drafted only deals with occupational illness or injury, though there are moves to extend it to all illnesses and injuries.

Case 7 The workplace safety initiative (Ireland)

The Irish Business and Employers' Confederation (IBEC) and the Irish Congress of Trade Unions (ICTU) established the Initiative on Workplace Safety Group in cooperation with the Department of Enterprise, Trade and Employment, and the Health and Safety Authority. The initial aim was to produce a voluntary code operated by social partners nationally and at local level. The group focused on the Code to ensure that, when injuries occurred, they were dealt with in the best way possible and the employee received every assistance to return to work. The model for the Code is that it specifies the most appropriate path for return to work for an injured employee. Its importance does not lie simply in its approach to job retention and reintegration but in the attempt to expand the remit of the health and safety brief beyond traditional concerns to include retaining employees who have developed an injury. While the Code itself is adapted to the Irish context, its spirit and approach are of potential relevance in all countries. The Code also addresses a particular aspect of the Irish context: the requirement for an employee to take legal action against an employer to gain financial compensation for an injury. The Code attempts to plot a pathway back to employment even in such difficult circumstances.

The initial section of the Code specifies the normal responsibilities in relation to health and safety for employers and employees. The second part provides a flow chart model outlining the priority of securing appropriate first aid, medical treatment and, where necessary, rehabilitation so that an employee can resume work as soon as possible. It also describes the various outcomes that might arise following accidents and proposes options for resolving them. Medical intervention is a means of ensuring speedy and appropriate health interventions, treatments and rehabilitation.

The Code recommends that, when an employee requires further treatment, the employer should bear the cost of this. It recommends that when parties reach an agreement, actions taken and costs met by the employer are without admission (or implication) of liability. It also recommends that ex gratia financial settlements be exempt from taxation. The Code covers traumatic injury or latent injuries that develop as a result of work practices. One of its strengths is that it covers minor as well as permanent injuries, and plots alternative pathways back to work in each case.

Case 8 describes a voluntary UK initiative – the Employers' Forum on Disability – which focuses on developing policy and practice in employing people with disabilities, and also the return to work of people with potentially disabling conditions. Like the Irish example above, it operates within a fault-based system and its philosophy of treating all cases of long-term absence as potentially the subject of anti-discrimination proceedings both encourages good practice and reduces employers' potential liabilities.

The Netherlands has made major social insurance changes in recent years. A critical element of these changes has been the shifting responsibility for financing long-term absence from social insurance to employers who are now responsible for paying employees for the first two years. Recent legislative changes oblige employers to manage the rehabilitation and reintegration of the absent worker.

Case 8 Employers' Forum on Disability (UK)

Established in 1986 by a small number of companies as an apolitical, not for profit employers' body, the Forum has over 375 member organisations employing approximately 20% of the UK workforce. Members come from retail, financial services, media, manufacturing, government departments, local authorities, NHS Trusts, and universities and colleges.

The members' subscriptions fund the Forum and its mission is to promote the business advantages of embracing diversity and equal opportunities. Member organisations regard the Forum as a self-help club bringing them together to share best practice on disability. The Forum organises events at both a regional and national level where members can meet, share best practice and keep up to date with disability issues. Additionally, members benefit from a dedicated information line to help them understand and manage legislation and a best practice approach to disability.

The Forum has published documents and briefing papers for its members including a Disability Communication Guide with practical advice on how to meet, greet and interview people with disabilities; a guide for front line staff on serving customers with disabilities; and briefing guides on employment adjustments for people with disabilities (including visual impairment, hearing loss, dyslexia, mental health problems, progressive and fluctuating conditions such as multiple sclerosis and repetitive strain injury). Recent publications of particular relevance are the *Unlocking Potential* series which argues that employing disabled people can bring both operational and longer-term strategic business gains, particularly in the light of changing demographics and the new economy. It summarises the case for making disability a strategic business priority.

The Forum supports the need for legislation that is credible for both employers and disabled individuals. The members supported the Disability Discrimination Act 1995 and continue to advise on its improvement and development. The Forum also helps members to understand the implications and encourages them to think ahead to the final stage of the act in 2004, when the physical access to buildings legislation comes into force. The Forum hopes to work in partnership with the UK Disability Rights Commission to ensure the employers' voice is heard.

The Forum advises members to treat every case where an employee develops a disabling condition as though it could become a disability discrimination issue. In doing so, it attempts to link equality legislation to job retention and reintegration interventions without the need for employees taking legal action. It recommends that employers consider providing reasonable accommodation and job retention support as early as possible. In its advice to line managers, human resource personnel, and health and safety officers, it encourages proactive interventions to prevent long-term absence and to encourage workers to return to work. The Forum approach enhances the impact of equality and non-discrimination legislation on return to work of chronically ill and disabled employees.

Case 9 below provides an example of how employers have reacted to these changes. It describes a programme of support services provided by a regional employers' organisation. The services aim to ensure good rehabilitation and reintegration and effective preventive activities within enterprises. Client companies are all either SMEs or micro-enterprises, a sector which is difficult to involve in workplace health-related activities. This initiative provides a clear illustration of how changing incentives can lead to major behaviour changes.

Case 9 MKB Benefits (Netherlands)

MKB Benefits is a Dutch company in the Limburg region that provides insurance, reintegration and prevention services for its membership of c. 500 firms. It is a commercial and self-sufficient offshoot of the Limburg regional representative organisation for small enterprises (LOZO). The services provided are:

- health insurance brokerage for sickness absence;
- insurance brokerage for disability benefits;
- prevention, rehabilitation and reintegration services brokerage.

Context
As noted, employers are responsible (from 2004) for paying workers for the first two years of absence. If they do not take appropriate rehabilitation and reintegration actions within the period, they are subject to financial penalties. These penalties apply after four, six, nine and 12 months:

- at four months – if the employee is still absent;
- at six months – if there has been an inappropriate or insufficient return to work, or incorrect estimates of working capacity;
- at nine months – if no reintegration activities have taken place;
- at 12 months – if there has been a failure to act on recommendations of reintegration report.

LOZO represents 3,000 small enterprises in Limburg. Its services include occupational health services and insurance for employers against the costs of sickness absence and work-related disability. Since 2002, its subsidiary, MKB Benefits carries out these functions.

Employers are required to intervene early when employees are absent for health reasons. However, small businesses often do not have the in-house expertise to do this and must seek outside help. The Dutch system of occupational health, which requires all employers to have a contract with an Arbodienst (Occupational Health Service), might seem an appropriate agent for such services. In practice, though, it has a narrow remit in occupational health risks and does not seem to provide reintegration or rehabilitation. MKB Benefits began its operations to meet demand for such services from employers.

MKB Benefits estimates that the direct cost to an employer for an incapacitated employee earning €25,000 per annum will be in the region of €77,000 if appropriate steps are not taken.

These costs are difficult to bear for larger employers; for smaller employers, they are potentially catastrophic. Hence the value of insurance brokerage for the membership. There is now a growing demand for services in rehabilitation, reintegration and prevention, which MKB Benefits has begun to meet.

Approach
As the impact of legislative changes became clearer, companies realised the costs of health-related absenteeism were not only the insurance premiums paid to cover the wages of absent workers. They also included considerable expenses in penalties, replacement costs and a range of other indirect costs. Yet, there was no single service to provide an integrated approach to disability management.

Using a panel of specialist service suppliers, MKB Benefits adapted its insurance model to include brokerage for the full range of actions needed for effective reintegration to the workplace of ill or injured workers. Feedback from client companies monitors the quality of services and unsatisfactory service suppliers are dropped from the list.

MKB Benefits also plans to set up Internet-based job placements for employees with a significant impairment who cannot go back to their job and for companies which cannot redeploy them. This service will not only develop a labour market for people with illness or injury, but will also include workers who are unemployed. Employers can thus access a flexible labour pool to help meet legal reintegration requirements.

The MKB Benefits' approach is both flexible and participative. It seeks to meet the needs of the client company in case management, health and safety, health promotion or insurance. It works with key personnel to ensure all staff are aware of and involved in the process, demanding a high level of commitment to the programme before accepting client companies.

There is an international move towards increasing employer responsibilities for reducing long-term sick leave. Other countries are following the lead of the Dutch and have either made such changes (e.g. Germany) or plan to do so. The changes proposed or implemented are usually less dramatic than those in the Netherlands, but any move towards changes in responsibilities generates some opposition.

A consistent theme is the need for a proactive approach best developed in relation to disability management, which has now gained some currency in Europe at company and policy level. Case 10 below describes recent developments in Germany in the Workers' Compensation Scheme.

Case 10 Disability management as a framework for workers' compensation (Germany)

An important international collaboration in disability management is that between the German *Hauptverband der gewerblichen Berufsgenossenschaften* (BGs), the Workers' Compensation Insurance Boards, and the Canadian National Institute of Disability Management and Research (NIDMAR). The informal exchange of knowledge and information has resulted in a number of important developments, including the adoption of Rehadat, a database of disability relevant information for the Canadian situation.

A formal partnership agreement commits BGs to adopt the NIDMAR approach to disability management and promote it as the standard for BGs throughout Germany. This agreement sets a number of important precedents, particularly the fact that, while other countries have adopted elements of the NIDMAR approach, the German Workers' Compensation Boards have assumed not only the principles and approach, but also the codes, standards, audit tool and qualification criteria developed by NIDMAR. This is evidence that the disability management approach has international relevance, at least within workers' compensation systems.

NIDMAR emphasises a consensus-based approach to disability management programmes in company and social partnership agreements. Thus, joint labour–management agreements stand at the heart of the NIDMAR approach. This can form the basis of a paradigm that is compatible with the European social model. A survey of Canadian employers particularly within the manufacturing sector, e.g. Ontario Power Generation, BC Hydro and Norske Canada, indicated that companies adopting it reported 30-50% lower disability-related costs and 30-60% fewer long-term disability cases.

The key elements of the NIDMAR/BGs agreement are a code of practice, the NIDMAR audit framework, and the occupational standards for certified return to work coordinators and disability management professionals.

The code of practice is compatible with European health and safety systems such as the safe and productive employment of workers with disabilities, safe and healthy work, the reduced occurrence and impact of illness and injury due to work; and consensus among government, labour and management on achieving these values. The objective of the code is to promote workplace disability management systems. Management, unions and the individual workers should agree on these and the coordination of work accommodation, health care and rehabilitation interventions, with the support of external voluntary and statutory service providers.

The code of practice is relevant to all those affected by chronic illness or disability, regardless of its cause, type, or nature, who have the ability to obtain, return to, or retain employment. It applies to all private sector employers regardless of company size, location, nature of work relationship, or type of work, and all levels of government and statutory agencies and their employees. The framework within which the code operates incorporates:

- protection for the person with a disability;
- support for return to work programmes;
- prohibition of discrimination;
- income support system compatible to a return to work;
- support of senior business, government and labour leaders;
- effective health and safety regulations;
- incentives towards participation;
- effective enforcement of compliance with core values and objectives;
- access to dispute resolution and support services.

An audit framework supports the code of practice and evaluates company policies and practices. The RETURN protocol (RETURN, 2002b) has adapted this tool to EU systems.

Finally, the NIDMAR system includes occupational standards in disability management for certified return to work coordinators and disability management professionals. The standards are based on a survey of working professionals and other stakeholders. Certified coordinators work internally or externally, offering a full range of services for workers with disabilities. The disability management professionals may additionally provide higher-level executive functions.

The NIDMAR/BGs agreement is one element of an initiative by NIDMAR to internationalise disability management. Other elements include an agreement between the International Labour Organisation (ILO), NIDMAR, and the Canadian government to develop consensus-based occupational standards defining education, competencies, experience and values of practitioners and professionals in return to work/disability management, and a code of practice defining the process, roles and responsibilities. The ILO Code on Managing Disability incorporates many of the principles promoted by NIDMAR. More recently, an International Disability Management Standards Council has adopted the code of practice and occupational standards to ensure the ongoing development and relevance of the approach internationally.

Finland has developed one of the earliest and most coherent approaches to both disability prevention and the return to work of people with long-term illness or disability. It was developed

in the early 1990s as a response to a combination of factors that resulted in high levels of claimants for long-term disability payments. The social partners created a programme called Maintenance of Work Ability (Tyokyky-ohjelma). This consists of interventions targeted at improving both the health and well-being, and the occupational knowledge and skills of the individual worker. Interventions also improve the physical and psychosocial work environment. These focus on more than traditional health and safety, also including an element of organisational development. Thus, there are potential direct benefits for both employee and employer. A major aim of the programme is to ensure that long-term absent workers return to work in a safe and timely manner.

Case 11 outlines how the Maintenance of Work Ability programme operates. Part of the national implementation programme involved focusing on SMEs. A large-scale programme specifically targeted at SMEs is described below.

In practice, many of the Maintenance of Work Ability programme interventions aim to raise the absence threshold. In the case of older workers, this may also be seen as raising the retirement threshold. Work and work practices are adapted more closely to the abilities of the worker, while upgrading the worker's health and well-being and job-related skills to promote employability. Though these types of interventions are essentially preventive, the same kinds of procedures apply to workers overcoming the return to work threshold.

Case 11 Maintenance of work ability in SMEs (Finland)

In the Finnish national programme of the European Social Fund, a specific target offered financial support for organisations to arrange activities, training and consultation in SMEs. Municipalities can apply for support and 100 separate programmes started during 1995-1999. Some programmes were small (a health circle for 20 individual entrepreneurs), while some were large scale (Small Workplace Programme of Finnish Institute of Occupational Health with more than 300 companies and 10,000 employees).

The Ministry of Labour through its local offices and the Ministry of Health and Social Affairs coordinated individual projects with a project coordinator as the contact person to the individual SME. There was financial support for needs-based health interventions (physical fitness, mental well-being, rehabilitation), work environment interventions (health and safety improvements, ergonomic improvements), work organisation interventions (team building, leadership training, balancing human factors), and educational interventions (applied computers, vocational skills training). Business focused activities were also included.

Needs-based programmes imply the assessment of workplace and employee needs rather than expert-driven services. The individual projects combined all of these types of interventions. In each SME, the interventions were based on perceived needs and, as a result, there was considerable variation between companies in the type of interventions undertaken.

The nature of the activities depended on both the demand from individual SMEs and the ability and capacity of service providers to meet these demands. The emphasis was on meeting the needs of an SME which had generally committed a considerable level of resources to the project, usually about 30% of total costs in the form of working time. The European funding (about 30%) enabled the project coordinating institutes to subcontract the required services, making the programme more multidisciplinary.

Conclusions

There are many lessons to be learned from these case studies. They may seem difficult to compare, given their different scale and focus, and coming from different countries. However, there are a number of common features that point to general lessons.

- There is a trend towards changing responsibilities for reintegration. It may be argued that some of the reasons for the comparative failure of return to work strategies relate to dividing responsibilities between different agencies and locating the responsibility with the wrong agency. The examples from Ireland, the Netherlands, and the UK show that there are moves to relocate responsibilities towards the workplace stakeholders. This is producing a more coherent response to absence and encouraging a more proactive approach to return to work.
- Joint initiatives to combat long-term absence are becoming more common. Effective responses require a coordinated approach among the main stakeholders. This is based on the need to develop more integrated service provision, and on the need (especially in the UK and Irish legal systems) for unified approaches which set return to work as a normative goal for people who become long-term absent.
- Proactive approaches must be developed. Early intervention is a keystone of good practice in return to work. This demands a proactive approach on the part of the company (see the Danish and Spanish examples), and from the service providers and the social partners (see the Dutch example).
- The disability management approach is becoming more widespread. The examples from Germany show how this proactive approach can be adapted to European systems and companies.
- There is a need for integrated approaches to address the absence threshold. The Finnish Maintenance of Work Ability programme is a good example of such an approach with its emphasis on a range of health and non-health related preventive measures. In addition, there is also an emphasis on promoting good working conditions and health and well-being as an incentive to remain at work.

4 Analysing national approaches to illness and disability

Aims of the tool

On the basis that accident and illness prevention and occupational health promotion were already well documented elsewhere (Wynne and Kuhn, 2001), the framework for the current study is designed to focus particularly on measures and initiatives that impact on job retention and reintegration.

A previous study, RETURN (2001), set out to map legal, policy, financing and service systems that impacted on the return to work of long-term absent employees in six countries. The approach of the RETURN study was to create maps of each national system from the perspective of an individual who developed an illness or disability that resulted in long-term absence (McAnaney et al, 2001). These maps had a timeline from the point an individual left work and followed the absence process until the person either returned to work, became unemployed, or became economically inactive and classified as disabled. Even a cursory examination of the national system maps revealed the extent of diversity and lack of congruence, and the need for a comprehensive, coordinated and systematic approach. A number of conclusions provide an important basis for the approach adopted in the current study.

The RETURN study confirmed that going back to work is a cross-sectoral issue that involves interaction between a number of key policy sectors and measures, including employment, health and rehabilitation, disability, equality and social insurance/welfare. Responsibility for the return to work of long-term absent employees is distributed differently in different national systems. Each cultural and political context influences the systems concerned. It was possible to identify three core approaches that differed in detail depending on national context.

The first was the Workers' Compensation in Germany and Austria where illness and injuries arising from work, or during travel to work, came under 'no fault' insurance which funded income continuance and rehabilitation and reintegration measures. A second social insurance system covered non-occupational illnesses and injuries.

Some EU states adopted a welfare approach where the costs of absence and return to work measures came from general taxation. Welfare approaches differed substantially between Member States alongside other aspects that could inhibit return to work. For example, in Ireland and the UK, an employee who suffered an injury at work must prove employer negligence to obtain compensation.

The third approach, for example, the Netherlands, placed responsibility on the employer and thus created a private insurance market to fund income continuance. However, in some cases, the state also provided substantial resources for return to work measures.

Systems differ in more than income provision. They also differed in the range, availability and responsibility for return to work services. In some, these are primarily the responsibility of the social insurance agencies, in others they are unclear and lie between agencies, while in others there is increasing recognition that employers should bear more responsibility.

The overall impression from the RETURN study was of systems and processes that emerged in an ad hoc fashion, where the long-term absent employee and the employer faced complex procedures and fragmented provision, responsibility for return to work was poorly specified, and substantial gaps and discontinuities existed. In most systems, potentially positive measures were inaccessible to long-term absent employees on the basis of eligibility. Access to some services required an individual to be unemployed, meaning that the employee would have to lose their job to access return to work services. In other systems, the distinction between occupational and non-occupational illness or injury resulted in delays in the delivery of services, while establishing responsibility between different agencies.

An expert consultation on the RETURN analysis resulted in a number of conclusions. Of particular relevance was the view that prevention approaches to maintaining people at work were insufficient, demanding a more systematic approach to return to work, and that there was a lack of structure to return processes in all countries. Systems suffered poor coordination, and current approaches were ineffective. The expert group concluded that the current social and cultural climate was not conducive to facilitating the return to work of long-term absent employees.

The RETURN study adopted a 'bottom up' approach in that it attempted to characterise systems and provisions rather than compare them. It was useful to draw attention to the diverse and unique elements of each national system, but systematic cross national comparisons were difficult to make.

A subsequent study, *Stress impact* (2003), adopted a more 'top down' approach, identifying all measures with potential relevance to return to work and then establishing whether they applied to employees on long-term absence as a result of stress. This significantly reduced the number of measures and initiatives for analysis. The study evaluated each relevant measure from a return to work perspective on the basis of its approach and scope.

The current study has adapted this approach but changed the focus to chronic illness and disability. The starting point for the analysis of national measures and initiatives is the return to work threshold, i.e. the possible reintegration measures. The approach involves the following steps:

1. The identification of all measures with potential relevance to the return to work threshold.
2. The review of each measure in terms of:
   a) What is it intended to do, e.g. to maintain a person's income, promote health or promote employment?
   b) For which aspect of the labour force is it intended, e.g. those who are at work, unemployed, economically inactive or long-term absent?
   c) Which groups are the intended recipients or beneficiaries of the measure, e.g. those at risk of exclusion, discrimination or unemployment, disabled people or the labour force in general?
   d) How does the measure set out to achieve its intended impact, e.g. is it a policy measure, does it provide for interventions at the level of the individual or workplace, is it based on an incentive system?
   e) Who has responsibility for putting the measure into practice, e.g. the employer or an agency external to the workplace?

f) To what extent is the impact of the measure monitored, e.g. are trend statistics available to assist in the review of the impact?

On the basis of these descriptions, it is possible to evaluate the extent to which system measures, relevant to the return to work threshold, are comprehensive, systematic, coordinated, resourced and properly deployed.

Dimensions of the tool

As an example, all EU Member States have health and safety legislation and regulations. Clearly, health and safety are important to maintain employees at work by ensuring that risks are properly managed and the work environment is conducive to protecting the health and welfare of the employee. Using the approach set out in the analysis tool, health and safety legislation has the following characteristics:

a) The *purpose* is to ensure that employees stay in their current jobs while protecting their health.

b) The *focus* is on people who are at work.

c) The *scope* includes all workers but it is particularly relevant to those at risk of illness or injury resulting from occupational conditions.

d) It operates at a *policy* level by setting out regulations for all employers, it operates at the *workplace* level in work organisation and the work environment, and it includes *negative incentives* in that employers who do not comply can be prosecuted.

e) Generally, it places *responsibility* for implementing systems within the company.

f) The impact is fully *monitored* and most Member States publish regular statistics documenting progress in reducing accidents in the workplace and occupational illnesses.

The framework is designed to apply across all sectors with potential impact on the return to work threshold. All employment, health, disability, equality and social insurance measures, and sectoral initiatives must be subject to the analysis. The framework attempts to address the key contributors to reduce the threshold to return to work at the policy, individual and workplace levels. The framework presented in Table 1 includes health improvements, income maintenance, interventions, work place adaptations, financial and service supports, legal protection and incentives.

The framework has six core elements, elaborated in a number of sub-categories. Three refer to the extent to which a particular measure or sectoral initiative is relevant to employees with chronic illness or disability who are long-term absent. The other three describe the approach adopted by a measure or sectoral initiative, and the extent to which its impact is actively monitored.

Purpose: This refers to the intention of the measure or sectoral initiative aimed at achieving a range of outcomes for the chronically ill or disabled employee. Health improvement includes general medical services and specific post-acute health interventions such as pain management. Measures to promote the recruitment of people with chronic illness and disability aim to enhance people's potential to compete on an equal basis within the labour market through support in recruitment and selection.

Table 1 Components of the national level analysis

Purpose	Focus	Scope	Approach	Responsibility	Monitoring
Health interventions	**Economically inactive**	**Generic**	**Policy**	**In-company**	**Full**
Income support	**Unemployed**	**Specific** at risk OSH		**External**	**Partial**
Recruitment	**Employed** At work	Physical and sensory Psychological Social exclusion Discrimination	**Individual level**		**None**
Job retention Same job Redeployment	Long-term absent		Interventions Medical Vocational Other		
Reintegration Same job Redeployment		**Chronic illness** Physical and sensory Psychological	Supports Finance Services		
			Workplace level Organisation or conditions Environment Supports Finance Services		
			Incentives + Financial + Procedural - Financial - Procedural		

Retention aims to ensure people at work maintain their ability to work with the support of health promotion, risk management, and occupational health and safety activities. Particularly relevant job retention measures aim to redeploy employees who can no longer do the same job as a result of chronic illness or disability within the same company. Reintegration aims to assist a long-term absent individual to re-enter the workforce either by safe and timely return to their original job, or assistance towards redeployment either within the company or another one.

Focus: This refers to the target labour force for the measure or initiative. Measures can focus on the economically inactive, e.g. the long-term unemployed and those on long-term disability income support or other social security payments. Initiatives aimed at people who are unemployed tend to focus on the active labour market and assist job search through employment services, guidance and counselling, training and job integration. Measures that focus on the employed can be divided into those aimed at people currently at work or those out of work on long-term absence but who still have employed status.

Scope: This refers to the intended recipients or beneficiaries of a particular measure or sectoral initiative. In some cases, the scope will be generic, covering all people, employed or unemployed, disabled or not. For example, the scope of employment equality legislation covers everyone seeking work as well as the employed. It is also particularly relevant to those at risk of discrimination. Certain measures and initiatives can target particular at risk groups, in terms of occupational

health and safety factors that can result in physical injury or psychological illness. Other groups include those at risk of social exclusion, e.g. substance misusers, ex-offenders, refugees or people with disabilities, and those at risk of discrimination on the grounds of ethnicity, age, marital or family status, sexual orientation, gender or disability. Finally, the scope of a measure can specify membership of a particular group such as physical and sensory disability or psychological illness. An important distinction is between those measures that include within their scope those at risk of physical or psychological illness/disability, and those for whom the scope is defined as actually being disabled.

Approach: This refers to the intended impact of a measure or sectoral initiative, i.e. the level at which it intervenes and the method adopted. Measures can operate on a number of different levels simultaneously, either through legal and regulatory instruments that specify the way in which systems must operate or through agreement guidelines for the social partners and agencies. At the individual level, measures specify the medical, vocational or other interventions for which long-term absent employees are eligible. They can include medical and vocational rehabilitation, retraining, or guidance and counselling. Also specified are financial supports for those attempting to return to work or support services such as job coaching and case management.

Measures can also operate at the workplace level by specifying ways to adapt work organisation and employment terms and conditions to accommodate the long-term absent employee. Adaptations can involve altering working conditions or the workplace to make it accessible. Workplace interventions can also include financial or service support to the employer to facilitate the return to work of the long-term absent employee. Financial support can include resources to purchase equipment, or to adapt the workplace physically to support the employee.

Workplace services can also include disability awareness training for supervisors and colleagues, and creating incentives for the long-term absent employee or the employer to achieve successful return to work outcomes. Incentives can be positive, such as extra benefits to the employer or the employee through financial subsidies or other rewards like exemption from some regulatory requirements or retaining secondary benefits such as free travel. Negative incentives specify implications if actions are not taken or outcomes are adverse, and may include levies or requiring the employer to pay the salary of a long-term absent employee. Negative procedural incentives can include legal action by the state or increased regulatory requirements.

Responsibility: This refers to implementing the measure or sectoral initiative mainly within the employing company or externally by private or statutory agencies.

Monitoring: This refers to the degree of monitoring and reporting of a particular measure or sectoral initiative. For purposes of policy assessment and formation, the data available on the impact of a particular measure indicate how well it is being used nationally.

A measure or sectoral initiative needs to meet a number of criteria to be considered relevant to maintaining people with chronic illness or disability in employment. The key characteristics are:

- the purpose should be to intervene before long-term absence in terms of retention and redeployment; or after long-term absence in terms of return to work in the same job or redeployment to another employer;

- the focus should explicitly target long-term absence;
- the scope should include chronic illness and disability.

For a system to be coordinated and coherent, certain elements need to be in place and working effectively. First, it should be possible to identify legal and policy instruments that explicitly incorporate job retention and return to work for long-term absent employees. Secondly, measures should be in place to ensure individuals who are long-term absent from work can access interventions and services to enhance their potential to return to work. Thirdly, measures should be in place to promote workplace adaptations and provide services and supports to the employer. Alongside these requirements, incentive systems can operate to magnify the impact of the other elements of the system.

Policies and initiatives in Finland 5

Context

In Finland, expenditure on health care was 6.6% of GDP in 2000, relatively low compared with other EU countries, while social protection expenditure was 25.2% (InfoBase, 2001). Disability-related spending accounted for 13.9% of GDP, the highest of the seven countries examined. Unemployment in 2002 at 10.5% was high (EU, 2003), with 15.1% of that figure due to illness. The proportion of those aged 55-64 reporting a long-standing health problem or disability was 52-66%, compared with 32.2% for the total population and 22.9% for the working age population. These are the highest numbers of the seven countries under study but, in 2003, the employment rate of older workers (55-64) was 48%, inactivity was 48%, and average age of retirement was 61.6 years, higher than the EU average (*Social situation in the European Union 2003*).

The Social Insurance Institution (KELA) administers old age national pensions and disability-related pensions for non-workers. Its main funding comes from the insured: employees (12%), employers (22%) and the state (55%). The Finnish Centre for Pensions and state regulated insurance companies oversee other pensions. These companies provide most disability pensions for workers.

Work-related disability in Finland is high, with 10% of the labour force claiming a disability pension in 1996 (Ilmarinen, 1999). Absence is rising, with 320,000 compensation claims for absence over nine days in 1997, increasing to 380,000 in 2002 (Joensuu et al, 2003).

The main health reasons are musculoskeletal problems, 34% of all claims in 2002. Mental disorders as a cause of absence are growing: 15% of claims over nine days, and exceeding musculoskeletal disorders in 2001 for disability and early retirement (Joensuu et al, 2003). Joensuu et al indicate that there are 29 laws for sickness absence and return to work.

Finland has a long history of collective bargaining and social dialogue, and agreements often include workplace health. The current national agreement includes improved well-being at work and maintaining ability to work.

Social protection

Two main acts cover social protection of sickness absence – the Sickness Insurance Act and the Government Decree on Sickness Insurance. There is no qualifying period for entitlement but the minimum absence is nine days. If it reaches 60 days, KELA requires a rehabilitation assessment and may assess the worker's capability. After 150 days, KELA asks the worker about possible rehabilitation or moving to long-term sickness benefits. Short-term benefits are available regardless of the cause of illness or injury and are not linked to fault assessment.

Employees who suffer work-related accidents or illness can claim income replacement. For occupational accidents and some occupational diseases, compensation is available through insurance which is funded by employers, with premiums subject to a bonus-malus system. In 2003, the Ministry of Social Affairs and Health considered extending the Occupational Illness Act to cover mental illness from workplace stress, concluding that it is a genuine occupational disease.

Workplace health management

Four acts cover workplace health management: on safety, health care, health care professionals, and a decree on principles of good health practice.

Finland has the most developed workplace health management approach of the seven countries studied. Legislation requires employers to: provide a safe and healthy workplace; undertake medical examinations if a job poses special health hazards; provide occupational health services for employees; and monitor the ability of disabled workers to work. Employers and occupational health professionals must draft a healthcare plan, including preventive measures and maintenance of work ability actions, and employees can request an assessment of their mental and physical workload.

Finland's occupational health provision is probably the most comprehensive in Europe and seen as part of the public health services, with more than 5,500 professionals in 2000. In 2000, occupational health services covered 76% of the labour force and 85% of employees (Rasanen, 2000).

The Maintenance of Work Ability programme in the 1990s (described in Chapter 3) was a major change in the provision of occupational health services. The programme responded to an economic downturn, high work-related disability and health-related early retirements. It uses a proactive and integrated approach, emphasising a good physical and social environment and promoting the employee's health and skills.

The programme raised retirement age by two years, from 57 to 59. Average retirement age is now estimated to be 61.6 years. The social partners are committed to this, and national agreements now include targets for maintaining work ability.

There is some debate about psychosocial issues, with evidence of increased mental illness as a cause of work absence. Sectoral agreements also address workplace health, such as how long an employer pays for sick leave.

The major stakeholders support the VETO programme for 2003–2007 to maintain people in work, promote work ability and rehabilitation, prolong working life and reduce sickness absence.

Rehabilitation and reintegration

Complex legislation covers rehabilitation and many parties have a stake in rehabilitating ill or injured workers, including KELA, pension institutes, occupational health services, and health service providers. Rehabilitation services have developed semi-independently in different sectors and do not always function coherently.

There are seven rehabilitation providers: insurance companies, work pension institutes, the Social Security Institution, Labour Administration, occupational health services, public health services, and social welfare agencies. They provide a mix of medical, vocational and social rehabilitation. The main distinctions relate to the rehabilitation offered and target groups. The Labour Administration targets unemployed people, insurance companies target those ill or injured at work,

while the social insurance and public health agencies work with general health problems among employed or unemployed people.

Six rehabilitation laws specify a range of entitlements and responsibilities. They promote developing employees' work capacity and specify the right to income compensation and rehabilitation during return to work. The law defines the main actors' role in rehabilitation and the types of services available.

Rehabilitation is seen as complex and difficult to negotiate (Joensuu et al, 2003), requiring a response to three key questions: the type of rehabilitation required, the appropriate funding agency, and where it can be obtained. The multiplicity of providers, different legislation for each service and the distribution of services can lead to confusion. Complexity can lead to flexibility and tailored solutions but it also delays service delivery.

The legislative instruments are under review and due for update in 2004. New laws will allow preventive rehabilitation where a worker's capability to work is under threat and part-time rehabilitation allowance for those working part time.

Maintenance of Work Ability emphasises early return to work. A specific example of improved rehabilitation is the *Project on rehabilitation and work capacity evaluation network 2000–2002*, run by the Finnish Pension Alliance and the Institute for Occupational Health. It discussed early and preventive rehabilitation with service providers and aimed to develop disability risk indicators.

Anti-discrimination and disability legislation

The constitution now includes an anti-discrimination clause. Equal treatment is guaranteed and it is illegal to discriminate on health or disability. Employers cannot place any impediment on employees or potential employees for reasons of health or disability, provided they can do the job.

The inclusion of health in anti-discrimination measures is unique compared with other countries in this study. Generally, health is a subsidiary to disability and people with chronic illness have an extra hurdle before the law protects them. But it is not clear how far this impacts on reintegration into employment.

System profile

Table 2 below applies the framework to Finnish legislation and regulation. It is a complex system involving occupational health, social insurance, pensions and public health in addition to constitutional provisions.

A reintegration analysis indicates that the legislation covers workers' needs well. Many laws provide for income support during return to work, rehabilitation and reintegration with vocational training.

The law requires employers to provide a safe and healthy workplace. Their social insurance premiums must cover all the costs of sickness absence, unemployment, some life insurance,

occupational accidents and disease, disability and old age pensions. These premiums are subject to a bonus-malus provision. Employers must also be involved in drawing up rehabilitation plans for ill employees.

The Finnish system is even more complex in service provision with many agencies involved. Their responsibilities depend on factors such as the cause of the illness or injury, whether it is as a result of workplace factors, and eligibility for income support. This complexity can be both positive and negative. It may provide flexible solutions to sickness absence and between agencies but it can lead to disputes about responsibilities that may delay key interventions at an early stage in the job loss process.

Services are concentrated in high population areas; and are more difficult to access in remoter areas. Occupational health services come within the public health sector which has responsibility for rehabilitation and reintegration. In theory, this sector is ideally situated to liaise between workplace and the service providers. However, the fact that the state rather than the employer must organise early intervention and rehabilitation may delay early and effective responses to health conditions and chronic illness.

Summary and conclusions

The main conclusions are:

- There is an explicit acknowledgement of the importance of early intervention and reintegration.
- A continuum of provision, from health and safety, risk management, health promotion to reintegration measures, informs the system framework.
- Legislation, the constitution and social partner agreements provide a comprehensive framework to support the individual and employer in reintegration.
- A large number of agencies provide services, making the system both complex and flexible; navigating it can be confusing.
- Levels of service appear high in comparison to elsewhere (especially in occupational health services) though the geographical spread may be problematic.
- Support for rehabilitation and reintegration among the social partners is high.

Table 2 Overview of the Finnish system

Measures	Purpose							Focus				Scope							Approach															Resp		Monitor mechanisms		
	Health	Income support	Recruitment	Retention (pre long-term absence)		Reintegration (post long-term absence)		Econ. inactive	Unemployed	Employed		Generic	Specific categories						Policy	Individual					Workplace				Incentives				In-company	External	Fully	Partially	None
				Same job	Redeploy	Same job	Redeploy			At work	Long-term absent		OSH at risk		Social exclusion	Discrimination	Chronic illness / Disability			Intervention			Supports		Org or Conds.	Environment	Supports		Positive		Negative						
													Physical	Psych.			Phys /Sen.	Psych.		Medical	Vocational	Other	Finance	Services			Finance	Services	Finance	Procedure	Finance	Procedure					
Social protection		X			X	X	X				X		X	X			X	X		X	X		X						X		X			X	X		
General health						X	X				X						X	X		X			X	X										X	X		
Occupational health	X			X	X	X	X			X	X		X	X			X	X	X	X	X				X	X	X	X	X		X		X	X	X		
Employment/labour market																																					
Health and safety	X				X					X		X	X	X					X						X	X		X					X		X		
Equality/non-discrimination																																					
Other – national agreements	X			X	X	X	X		X	X	X	X							X																		
Other – constitution	X		X	X	X	X	X	X		X	X	X																									

Policies and initiatives in Germany 6

Context

The unemployment rate in Germany in 2002 was 8.6% and the proportion of inactive or unemployed people due to illness was 4%. Expenditure on social protection measures was 29.5% of GDP compared with 10.6% for health care (2000) and 7.8% on disability-related social protection expenditure. The proportion of people aged 55-64 years reporting a long-standing health problem or disability was 21%, compared with 11% for the total population. The employment rate of older workers (55-64) in 2003 was 38%, inactivity was 57% and the average age of retirement was higher than the EU average at 60.7 years.

The Social Code has revised the German approach to health and disability, focusing on occupational health and safety, social protection, insurance, employer and worker rights and responsibilities, and employing older people. It deals specifically with part-time employment, social care insurance and the need for safety devices for older workers, as well as social security, sick pay and other health-related payments.

Employer and employee jointly fund health and labour insurance and pensions on a 50:50 basis. Health insurance contributions depend on salary and are obligatory from employees earning €35,000-€40,000, beyond which they can contribute to private insurance companies. 7% of salary goes to the health insurance fund, 3% to the labour insurance fund and 5% to the pension fund. The employer matches these payments and must also provide accident insurance, amounting to 2% of the employee's salary.

Only the accident insurance funds operate an incentive scheme, with a premium reduction for employers with good practice in occupational health and safety. Premium reductions of 10-30% have applied to those who practise effective disability management (reintegration and prevention), and there is an award for good practice in early intervention as an incentive to adopt more comprehensive disability management.

Social protection

The employer pays for the first six weeks' absence, regardless of company size. Health insurance companies fund medical treatment and rehabilitation. After the six-week period, insurance companies cover the costs. The continuing income is generally 80% of the last wage and based on employee contributions, though there is no payment limit for private insurers. Within the statutory health insurance, funded jointly by employer and the employee, the ceiling is between €35,000 and €40,000. Health insurance does not generally cover vocational rehabilitation.

The Berufsgenossenschaften (BG) organisations cover occupational injury or illness, providing all services and income maintenance from the first day of absence. The BG consists of 35 sectoral organisations and an umbrella body with responsibility for occupational illnesses and work site injuries, including those travelling to work. It provides measures in occupational health and safety, workplace health, early intervention, rehabilitation and compensation. It is BG policy that individuals will be visited within one week of absence even if they are in hospital. The BGs cover all associated costs of intervention and provide income maintenance up to 80% of salary.

The health and social insurance funds cover long-term absence from non-occupational illnesses and injuries. A work capacity assessment takes place after rehabilitation to determine pension level. This depends on age and the number of contributions made. A pension can be up to 70% of salary although the average is 30-40% of previous income. Those with less than two years' contributions come under the responsibility of the Labour Office.

The social rehabilitation organisations, funded from local taxes with some federal support, provide a basic income and rehabilitation. They focus on individuals with developmental disabilities or those not covered by any other insurance fund or who are ineligible for support from the Labour Office.

The BG organisations provide long-term support for occupational illnesses and injuries. Compensation is based on the extent of lost function, whether employees can return to the same workplace, and the possibility of another job. Compensation begins in the forty-second week of absence and individuals can keep this payment after return to work.

Workplace health management

Occupational health and safety are covered by the Arbeitschutzgesetz, which specifies employer responsibility for a safe and healthy workplace. The local authority implements the law, and monitors and audits minimum standards in health, safety and hygiene. The BGs also coordinate rules agreed by the social partners on a sector basis.

Statutory health insurance companies engage in workplace health promotion. In addition to BG and health insurance company initiatives, companies can also implement corporate programmes with trade unions. These are not regulated or covered under any measure.

Rehabilitation and reintegration

The German system is a 'dual' system in that legislation has two groups in mind: the general population with disabilities, and those who become ill or injured at work. For the latter, there is a distinction between occupational and non-occupational illness and injuries.

Rehabilitation can fall on the Bundesanstaltfurarbeit or the pension funds. The Labour Office operates vocational rehabilitation and workplace supports mainly for the unemployed or economically inactive, while the pension funds provide a pension. This statutory fund operates at federal level for white-collar workers and at sectoral level for blue-collar workers. The pension fund offers vocational and social rehabilitation to those who have made sufficient contributions. Otherwise, the Labour Office becomes involved.

For occupational injuries or illnesses, the BG system covers interventions to reintegrate the person into work and society. These measures may include acute medical care, medical rehabilitation, vocational and social rehabilitation with home care and housing. Recently, the BGs agreed with the Canadian National Institute of Disability Management and Research (NIDMAR) to implement a comprehensive approach to disability management involving in-company standards, an audit system, and accreditation of disability managers and return to work coordinators. This initiative is described in detail in Chapter 3.

A wide range of medical, social and vocational rehabilitation options are available from 28 Berufsfurderungwerke and specialist rehabilitation centres. The primary goal of each rehabilitation phase is to return the participant to the original job or another position in the company. Rehabilitation has three phases:

- post-acute or primary rehabilitation aims to restore functional capacity;
- medico-social rehabilitation focuses on a smooth transition to employment or vocational rehabilitation;
- vocational rehabilitation involves training in specialist centres, generally targeted at individuals who are economically inactive or unemployed as a result of disability.

Work-based rehabilitation and transitional work options can be at the employer's discretion and are generally negotiated by the social insurance provider. Functional capacity and job demands analysis often determine workplace adaptations and appropriate aids or assistive technology. There may be extra for funding if the company has an 'extraordinary difficulty' employing a particularly disabled person. Examples include the use of work assistants in the workplace to support disabled employees, assistance in travel to work, and adaptations to the person's home.

In-plant integration agreements between the company and the social partners aim to improve work opportunities and conditions for employees with disabilities. Employers should develop an integration plan with specific goals and responsibilities for action. An agreement can cover human resource policies, workplace design, work organisation, working hours and work environment, as well as absence management and return to work incentives, as part of an employee's contract. These agreements are at an early stage and the extent of their use and their content are not yet clear.

In consultation with national disability organisations and through the Social Code amendment, the German government has begun to transfer obligations on the participation of people with disabilities from state and/or social insurance to employers. This move does not seek to decrease public resources for integration and social inclusion, as the government and social security agencies must still provide counselling, planning and assistance. The change is primarily about who has to start the process and who is responsible for coordinating necessary action.

There are two target groups: an employee whose health affects their work performance and may threaten their employment; and an applicant with a disability who meets the job requirements and whose employment prospects would be enhanced by the rehabilitation agencies.

Where problems arise after recruitment, this measure aims to provide technical workplace aids and adaptations without cost, and to monitor the employment relationship of a worker with all necessary prevention, rehabilitation and environmental interventions.

Disability legislation

SGB IX covers the basic rules relating to people with disabilities and the payments available, with flexibility in the way the funds operate through the Social Code. The quota levy system applies to companies with over 20 employees and is set at 5% of the workforce; the levy for not meeting this

quota can be 6% of the company's wage bill. Funds are collected locally and a percentage goes to the federal government for reintegration measures such as workplace adaptations. Federal resources pay for sheltered workshops, research projects and accessible environments. There are no rewards for good practice in employing people with disabilities although this is under consideration.

System profile

Table 3 below applies the national level tool to the German system. The role and function of social insurance funds are clear, and a comprehensive approach to health, income support, retention and reintegration are evident. Pre- and post-absence are within the remit of the funds and, overall, the system is an integrated and graduated approach to people with a health condition which affects their work.

Distinctions exist between occupational conditions and other causes, and the Workers' Compensation Boards and social insurance funds can respond to a range of issues for an employee at risk of unemployment from a chronic illness or disability.

The goals of social insurance funds clearly focus on maintaining people in employment, with some support from the Labour Office and disability measures. Where a person is eligible, financial support or employment protection is possible from the quota levy system, and also from the Labour Office if it appears that an individual is likely to become unemployed.

The German system includes economically inactive, unemployed and employed people, in particular the long-term absent who need intervention and support. Physical, sensory and mental health difficulties fall within the scope of the German system for social protection, employment and disability measures. There is no discrimination or employment equality legislation although the quota levy system does provide job protection.

The German policy framework is comprehensive and systematic, aiming to return people to employment through rehabilitation prior to considering pension eligibility. Medical, vocational and rehabilitation interventions are an important pillar of retention, and financial supports and services are available to individuals at risk of unemployment as a result of a health condition.

Employer and workplace supports and services are also available, such as work adaptations and workplace conditions. Where a person has a severe disability, the quota levy system offers incentives to retain the employee.

In general, responsibility lies with external agencies and authorities rather than the employer but legal changes aim to give employers greater control of the absence threshold. Determining responsibility can cause delays, particularly where it is not clear if a condition arises from an occupational or other cause. Employer responsibility mainly relates to insurance payments but there are attempts to redress this. It is too early to assess how current measures will empower a well-structured, conceptually coherent and clearly focused system.

The overall effectiveness of the system is not fully monitored and it is difficult to assess its impact on job retention and return to work.

Summary and conclusions

An overview of the German system suggests that it includes all the ingredients for effective responses to health-related absence. The main conclusions are as follows:

- It is a strongly policy driven approach yet effectively deployed for the individual and the company. This is clear in the BGs' initiative on a disability management code of practice and promoting disability management strategies.
- Workers' compensation systems are clearly compatible with disability management but the response is limited to occupational illnesses and injuries.
- A two tier system may develop where employees with non-occupational conditions are less well served, and the divided responsibility between agencies may cause delays in early intervention.
- As the German system is unlikely to change its organisation, it may be more feasible for other funds and agencies responsible for non-occupational illnesses and injuries to adopt the disability management approach.
- The systematic approach of the Social Code requires not only acceptance in principle but also operational strategies, including professional training, and raising awareness among company staff of the need for a more coordinated, coherent approach.
- An inhibiting factor has been placing rehabilitation and reintegration responsibility on external agencies rather than employers.

Table 3 Overview of the German system

Measures	Purpose							Focus				Scope							Approach														Resp		Monitor mechanisms		
	Health	Income support	Recruitment	Retention (pre long-term absence)		Reintegration (post long-term absence)		Econ. inactive	Unemployed	Employed		Generic	Specific categories						Policy	Individual					Workplace				Incentives				In-company	External	Fully	Partially	None
				Same job	Redeploy	Same job	Redeploy			At work	Long-term absent		OSH at risk		Social exclusion	Discrimination	Chronic illness / Disability			Intervention			Supports		Org or Conds.	Environment	Supports		Positive		Negative						
													Physical	Psych.			Phys /Sen.	Psych.		Medical	Vocational	Other	Finance	Services			Finance	Services	Finance	Procedure	Finance	Procedure					
Social protection	X	X	X	X	X	X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X	X	X						X		X	
General health	X	X						X	X	X	X	X							X																	X	
Occupational health	X			X						X		X	X	X					X									X						X			
Employment/labour market			X			X	X	X	X		X						X	X	X	X	X	X	X	X	X	X								X		X	
Health and safety	X			X						X		X	X	X					X																X		
Equality/non-discrimination																																					
Disability legislation			X	X	X	X	X	X	X	X	X						X	X	X					X	X	X	X	X	X		X		X	X	X		
Other																																					

Policies and initiatives in Ireland 7

Context

The unemployment rate in Ireland in 2002 was 4.3% and the proportion of unemployed/inactive people due to illness was 1.8%. Expenditure on social protection measures in 2000 was 14.1% of GDP compared with 8.1% for health care. Disability-related social protection expenditure, at 5.3% of GDP, was relatively low compared with other countries studied. The proportion of those aged 55-64 reporting a long-standing health problem or disability was 22-26%, compared with 11% for the total population. The employment rate of older workers (55-64) in 2003 was 48%, the inactivity rate was 51%, and the average age of retirement was substantially higher than the EU average, at 63.1 years.

Provisions relating to long-term absence in Ireland have evolved over time and it is difficult to discern a planned approach in the layers of regulation and administration. The Social Welfare (Consolidation) Act attempted to rationalise social protection. Despite this, the Irish system is persistently complex, partly because the long-term absence process occurs at the intersection of different sectoral responsibilities: employment, health and disability, equality and social inclusion.

The basis of the philosophy behind health and disability is acute medical care, and health and social care services. Medical services, including post-acute medical rehabilitation, are available to all citizens in a public health framework. The framework consists mainly of community doctors operating alongside public health centres, local and national accident and emergency hospitals, outpatient clinics, general medical and specialist hospitals, including psychiatric hospitals. A number of specialist hospitals deliver medical rehabilitation. Private health insurance operates alongside the public health system, offering cover against sickness disability or injury and mental illness. In health and social care, the current concentration is on day activity, respite care and sheltered occupational services. Social and occupational rehabilitation services come under the health and social care pillar and are generally not available to patients who have yet to register as disabled, i.e. the majority of long-term absent employees.

In 1996, Ireland began a substantial restructuring to respond to disability. A blueprint in a report by the Commission on the Status of People with Disabilities, *A strategy for equality*, made 402 recommendations in all areas including employment. The core elements are the Employment Equality Act, an Equal Status Act, an Education Act, a National Disability Authority to oversee policy, research and standards, and an information, advice and advocacy service, Comhairle. To-date, the new structures have not addressed early intervention and emerging disabling conditions as a result of chronic illness.

Social protection

In general, the welfare approach adopted applies passive measures to social protection, mainly income replacement. Rapid income support is a key productivity criterion in the welfare system and claims processing absorbs most of the front line effort. Whether a person has a genuine cause for absence determines eligibility, based on a medical certificate: this is a medical model. Additional criteria are social insurance contributions, regardless of whether the condition is occupational, and the estimated work absence. There are complex eligibility interdependencies for secondary benefits and means testing for longer term allowances.

Pay-related social insurance and the exchequer (i.e. general taxation) fund all payments, and the employer is not obliged to pay an absent employee sick pay; entitlement depends on the employment contract. In many cases, money from the employer will be minus any benefit from the Department of Social, Community and Family Affairs.

There are seven types of social welfare payments, and eligibility can be complex. Disability benefit is most often used to support absent workers. This is a short-term sickness benefit covering temporary incapacity to work subject to income tax. Almost 20% of those in receipt of it have been out of work for more than 12 months. Those permanently incapable of work who are ineligible for disability benefit receive unemployability supplement, under the occupational injuries scheme.

Injury benefit is paid to those unfit due to an accident at work or travelling to or from work, or who contracted an occupational disease, for example, contact with physical or chemical agents. Anyone in insurable employment (full or part-time) is covered from the first day of employment. Disablement benefit/pension is payable if a person in insurable employment sustains a loss of a physical or mental faculty from a work injury or occupational disease. They may also qualify if injured as a result of a commuter accident.

Those aged 16-66 with a specified disability which results in being 'substantially handicapped' to do a job suitable for a non-disabled person, and who satisfy a means test, receive a disability allowance, usually long term. The invalidity pension and the pension for blind persons are also long term.

The legislation allows payment toward rehabilitation costs for persons entitled to disablement benefit, financed from the social insurance fund. The Department of Social, Community and Family Affairs can promote research into prevention of accidents, injuries and diseases, and the law also provides vocational rehabilitation for those who are occupationally injured, to facilitate early return to work; up to 1999, the Department had not used these powers.

Some pilot projects have responded to absence but mainly at a procedural level i.e. changes in medical assessment and eligibility. The 2003 Renaissance Project assessed social welfare applicants with back pain, using a diagnostic triage. Some applicants were refused sick pay on the basis that early return to work was the more healthy option and that, in certain cases, 'work is the best form of rehabilitation'. The project resulted in a large number of applicants being turned down for income support.

Workplace health management

Workplace – as opposed to general labour market – measures tend to emphasise risk management and prevention to maintain employee health and safety. The main legal instrument is the Safety, Health and Welfare at Work Act whose underlying ethos is that employers (including self-employed) must create a safe and healthy workplace. Employees must behave responsibly to protect the safety and health of all at work. The statutory authority, the Health and Safety Agency, has mainly concentrated on risk management, and health and safety monitoring in the workplace. Reporting mechanisms emphasise the days lost from reportable injuries and the number of fatalities. Once an employee leaves work, the employer has few mandatory responsibilities and need not monitor a return to work.

There are attempts to extend the remit of employers, particularly in relation to occupational injuries. This work has been profiled in Chapter 3. The Initiative on Workplace Safety, from the social partners and the Health and Safety Authority, sets out a protocol for early employer intervention and mediation to facilitate return to work and avoid litigation.

In addition to workplace regulations, there is a range of employer voluntary initiatives, including work–life balance programmes, employee assistance programmes and family friendly policies, many from social partner and sector agreements.

Rehabilitation and reintegration

Most occupational rehabilitation and placement services focus on people with disabilities who are unemployed or inactive. Services are the responsibility of FÁS, the national training agency within the Department of Enterprise, Trade and Employment, or of regional health boards, under the Department of Health and Children. The core services emphasise vocational or rehabilitative training, with a range of assessment, guidance and personal development programmes from voluntary and statutory agencies.

Other return to work initiatives which eligibility criteria make inaccessible are the Supported Employment Scheme with job coaching for unemployed or economically inactive people with disabilities, and the Employment Support Scheme, for those with a substantial disability entering work from unemployment and economic inactivity. The latter subsidises the employer for the disabled worker's lower productivity.

Among recent return to work initiatives is the Employee Retention Grant Scheme, providing €2,500 to assess a long-term absent worker's needs and a further €12,500 for interventions. Both employer and employee must complete several application forms, requiring specialist knowledge and case management skills. Case management is not available through the public sector although the employer can purchase skills using the grant scheme. Unfortunately, most employers will need a specialist case manager to access the grant in the first place.

Employers can also access a disability staff awareness training grant on the same basis as the employee retention grant scheme. Training tends to be focused on the work organisation and environment covering a range of disabilities including mental health. This grant could be part of a return to work package for individuals with chronic illness and disability.

The work adaptation grant funds structural changes to make the workplace more accessible, while the Back to Work Allowance Scheme gives an allowance to a person entering the workforce to ease the transition from unemployment to work; this gradually decreases over three years. Individuals receiving some welfare benefits can also participate in rehabilitative work, limited to 20 hours a week, and a person's earnings may affect this benefit. Thus, what emerges is a system of potentially useful mechanisms to support reintegration operating in a policy vacuum.

The law affects reintegration in Ireland, as in Britain, particularly compensation on the basis of employer negligence. Workers may seek compensation even for minor injuries through the courts, making employers reluctant to reinstate an employee for fear of aggravating their condition. At the

same time, an employee may not want to return to work in case this reduces their compensation. There is a proposal for a Personal Injuries Assessment Board to use mediation to assess compensation claims and remove them from the courts.

Anti-discrimination legislation

The Employment Equality Act (1998) affects job retention and return to work as a non-discrimination measure to redress unequal treatment. The act covers nine grounds of unlawful discrimination: age, gender, sexual orientation, marital status, family status, religious belief, ethnicity, disability, and being a member of the travelling community. The definition of disability is a medical one and depends on being able to determine an enduring condition. It prohibits unequal treatment in recruitment, promotion and retention. Unfair dismissals legislation that is still in place, however, accepts inability to do a job as a result of illness as legitimate grounds for dismissal.

The Equality Authority oversees the Act, monitoring legislation effectiveness, providing advice and guidance to individuals, and producing progress reports. The Director of Equality Investigations is responsible for individual cases.

Disability provision

To complete the disability response programme, two further bills are in preparation: the Education – Persons with Disabilities Bill and a more general Disabilities Bill. It is too early to assess their content or the government's approach but early drafts suggest that they will contain an individual assessment to determine the needs of a person with a disability to participate in society. It remains to be seen if these instruments will be accessible.

The Department of Health and Children is also designing a set of databases to document the service needs of people with disabilities. However, there is a determined effort to ensure their core focus is on health and social services; the physical and sensory disabilities database has had difficulty incorporating chronic illnesses into its coding system.

System profile

Table 4 presents the framework application to the system in Ireland, and shows that it is not well specified at the structural level. It is possible to identify individual mechanisms in social protection, employment, health, disability and equality systems but there is no framework to coordinate these elements. Both the Department of Social, Community and Family Affairs and the Department of Enterprise, Trade and Employment have taken on board this emerging issue.

Although both departments recognise job retention and return to work as important goals, they tend to develop mechanisms independently. A Department of Social, Community and Family Affairs project facilitates early return to work of people with back pain, while the Department of Enterprise, Trade and Employment finances the return to work costs of the long-term absent – without any integration or coordination of the two. The purpose, focus and scope of the Irish system is relevant to chronically ill or disabled people but the impact has been less than effective due to lack of planning and coordination.

The Irish approach includes individual vocational interventions, financial supports and return to work services, subsidies for workplace adaptations, requirements for adjusted work organisation or conditions, and employer services. Nevertheless, a lack of awareness of what is available and an uncoordinated approach militate against effective action or proper monitoring.

Proving employer negligence for compensation delays effective action as it can take up to three years for a case to come to court. During this time, neither employer nor employee may want to consider reintegration.

There is no explicit policy framework for return to work in the Irish system apart from passive income support measures. It does not enable active service measures to encourage return to work, or supports or incentives at the workplace.

Summary and conclusions

These are the main characteristics of the Irish system:

- It has no obvious policy framework and each scheme is administered in its own right, uncoordinated with other elements.
- The analysis confirms a fragmented and uncoordinated system in relation to chronic illness and reintegration.
- Occupational health and safety provisions do not extend beyond risk prevention.
- Employer responsibilities for long-term absent workers are weak.
- A wide range of interventions and incentives exist but focus primarily on the social inclusion of unemployed or inactive people with disabilities.
- The legal requirement to establish employer fault to obtain financial compensation can be an inhibiting factor.
- Recent developments have the potential to improve significantly Ireland's response to people at risk of social exclusion.

Table 4 National profile of legislation in Ireland

Measures	Purpose – Health	Purpose – Income support	Purpose – Recruitment	Purpose – Retention (pre long-term absence) – Same job	Purpose – Retention (pre long-term absence) – Redeploy	Purpose – Reintegration (post long-term absence) – Same job	Purpose – Reintegration (post long-term absence) – Redeploy	Focus – Econ. inactive	Focus – Unemployed	Focus – Employed – At work	Focus – Employed – Long-term absent	Scope – Generic	Scope – Specific categories – OSH at risk – Physical	Scope – Specific categories – OSH at risk – Psych.	Scope – Specific categories – Social exclusion	Scope – Specific categories – Discrimination	Scope – Specific categories – Chronic illness / Disability – Phys /Sen.	Scope – Specific categories – Chronic illness / Disability – Psych.	Approach – Policy	Approach – Individual – Intervention – Medical	Approach – Individual – Intervention – Vocational	Approach – Individual – Intervention – Other	Approach – Individual – Supports – Finance	Approach – Individual – Supports – Services	Approach – Workplace – Org or Conds.	Approach – Workplace – Environment	Approach – Workplace – Supports – Finance	Approach – Workplace – Supports – Services	Approach – Incentives – Positive – Finance	Approach – Incentives – Positive – Procedure	Approach – Incentives – Negative – Finance	Approach – Incentives – Negative – Procedure	Resp – In-company	Resp – External	Monitor mechanisms – Fully	Monitor mechanisms – Partially	Monitor mechanisms – None
Social protection		X	X			X	X	X	X		X				X		X	X	X	X			X											X	X		
General health	X							X	X	X	X	X					X	X	X	X														X		X	
Occupational health																																					
Employment/labour market			X		X	X	X	X	X		X				X	X	X	X			X		X	X	X	X	X						X	X		X	
Health and safety				X						X		X	X	X					X						X	X						X	X		X		
Equality/non-discrimination				X	X	X	X	X	X	X	X	X			X	X	X	X	X													X	X		X		
Disability legislation																																					
Other e.g. Common law				X	X	X	X			X	X	X					X	X														X	X			X	
Other																																					

Policies and initiatives in Italy 8

Context

Italy spends a relatively high proportion of GDP on health care (8.1%), in comparison to the other countries (InfoBase, 2002). Expenditure on social protection was 25.2% of GDP in 2001. A low proportion was spent on disability (6% of GDP) – about half the expenditure of Finland, Sweden or the Netherlands. This correlates with lower numbers for those suffering a long-standing health problem or disability: 6.6% for the total population and 7.8% for the working age population. Unemployment at 6.6% in 2002 was low compared to other EU countries (EU, 2003). The proportion of those aged 55-64 reporting a long-standing health problem or disability was 12-16%, the lowest of the seven countries, but the employment rate for this group and the average age of retirement were also extremely low at 29% and 59.4 years respectively (*Social situation in the European Union 2003*).

The Italian constitution contains work, workplace health, and disability provisions. Italian social security applies only to workers and was originally a mutual insurance fund financed by employers and employees. However, with rising claims costs, the state now tops up the fund. Recent pension reforms have addressed these deficits by shifting funding from an earnings to a contributions-based system, where benefits are paid in relation to contributions made.

Two large social insurance agencies oversee social protection – INAIL (Istituto Nazionale Assicurazione contro gli Infortuni sul Lavoro) and INPS (Istituto Nazionale di Previdenza Sociale). INAIL deals with occupational injuries, illness, reintegration and the social life of work accident victims, while INPS covers general social insurance, e.g. unemployment and invalidity benefits and old age pensions.

Social protection

Sickness absence must be verified by the social insurance agency and, for occupational injuries, the employer must report the injury to INAIL within 48 hours. Employers pay for the first three days, after which INPS takes over.

INPS payments are 50% of the employee's salary for the first 20 days, rising to 66% for up to 180 days a year. After this, employees may move on to permanent invalidity benefit, during which the individual's disability may be assessed.

State nominated medical panels assess a person's ability to work, supported by regional technical committees. These are medical and allied health professional teams, labour market specialists and local authority representatives. This multidisciplinary approach is a major advance on previous arrangements.

The social component was originally part of health and rehabilitation but these functions are now split, and local authorities manage this through a separate organisation and budget. However, most municipalities made agreements with local health agencies, so in effect there was little change.

Recent legal changes have moved from passive support towards a more dynamic, active approach. In assessing disability, for example, even what is termed 'grave' may include a positive assessment of residual abilities so that total disability is not recognised as grounds for inability to work.

It is difficult to assess the success of this approach, since the law only came into force in 2000 but there appear to be many regional variations.

Workplace health management

Workplace health and safety regulations concern equipment, machinery and services, and also work hazards.

The Workers' Statute gave workers an input to workplace health and safety. These regulations were very advanced and led to the establishment of the National Health Service in 1978, covering environmental protection, workers' health conditions, supervision, inspection and regulations. The USLs (Local Health Units) acquired the power to intervene and to verify the application of these regulations at work, and replaced company health systems which existed only in large firms.

ISPESL (Istituto Superiore per la Prevenzione e Sicurezza del Lavoro), a technical agency of the Ministry of Health, has the tasks of research, study, experimentation and ratification of machines, plant components, instruments and personal protection.

Among the hygiene and safety norms are:

- the employer's duty to plan production to meet safety requirements;
- specific instructions for different production sectors;
- grants for small enterprises to adopt safety measures;
- participation of workers in health and safety.

A number of EU directives on workplace safety led to Decree 626/94, a collection of general regulations. The employer must guarantee employees' health and safety by identifying the risks and taking preventive action. The employer also works with an occupational physician who may be an employee, freelance, or employed by a private or government body. To ensure worker participation, the employee prevention and safety representative takes an active part in applying prevention regulations.

Local health agencies are responsible for checking enforcement of health and safety laws, while information and assistance for companies comes from various government departments and other state bodies.

Rehabilitation and reintegration

Italian law requires integration to focus on the individual's needs and the social context. Law no. 104 focuses on the capacities of a person with disabilities, maximising their autonomy in terms of integration into social life and the workplace.

Three laws govern rights and entitlements of people with disabilities in the workplace: Disabled persons' rights to work (68/99); Professional retraining for people injured at work (144/99); and Post-injuries global care and reintegration (38/00).

Law 68/99 affects recruitment of people with disabilities but not reintegration because eligibility criteria require them to be economically inactive or unemployed.

Employers had to meet a proportion quota to employ a certain number of people with disabilities but Law 68/99 lowered the quota and introduced incentives with targeted employment. Employers could opt to provide sheltered workshops instead. People with disabilities could also have a complete functional analysis of their abilities, their employment needs and training.

Law 144/99 focuses on employees' occupational injuries and illness with the same rehabilitation, professional retraining and integration principles but slightly different assessment criteria. INAIL is now responsible for rehabilitation, vocational training and reintegration. INAIL also makes workplaces and the homes of people with disabilities more accessible, provides information and communications training, and outsources better training for people with disabilities. Employment Services for People with Disabilities tries to find work for all unemployed people with disabilities.

The Italian system could be termed 'dual' in that laws appear to have two sectors in mind: people with general disabilities, and those who become ill or injured at work. This is the case in a number of the countries studied. What is not clear is how well the framework responds to the needs of workers with reduced capacity as a result of a chronic illness.

Anti-discrimination legislation

State legislation supports non-discrimination on a number of grounds including disability and age, and is being passed into law at regional level. It is too early to determine its relevance or effectiveness.

System profile

Table 5 provides an overview of Italian law which deals with rehabilitation and reintegration primarily under disability legislation, unlike other countries where they are covered by social protection or occupational health provisions.

Occupational health and safety provisions in Italy do not respond to post-illness or injury absence, and general or public health systems do not focus on return to work.

Legal changes encourage a dynamic response to people with disabilities, recognising their residual work abilities rather than focusing on assessing eligibility for benefits.

There are job retention and reintegration provisions, at least for those who develop occupational injuries or illnesses, although it is unclear how early they start in the absence process. These tend to emphasise vocational training, workplace accessibility, and procedural incentives, i.e. the quota system.

INAIL's training and workplace interventions may apply to those with occupationally related chronic illnesses. Dividing social protection between occupational and non-occupational injury or

illness, and INAIL's distinction between blue and white-collar workers, may well block people with non-occupational illnesses who find it difficult to return to work. They are eligible for INPS services but these do not seem to focus on return to work. The distinction between working classes seems to be limited to how benefits are paid, but may also extend into return to work services.

The regional basis and little data make generalisation difficult though there appear to be considerable regional differences in access.

Nevertheless, the Italian system appears to have adequate chronic illness and reintegration provisions, despite access problems. Specific references to chronic illness and non-occupational health problems were hard to locate. Legislation tends to relate to people who had developed an occupational illness or injury, or those unemployed or inactive as a result of disability.

Summary and conclusions

The main conclusions are drawn from the material available to the project and are tentative.

- The system was, in principle, good but complicated with many changes in social insurance and disability laws. Some changes aim to reduce claims costs and improve contribution levels to social insurance. They also focus on improving services to people with disability.
- The legal changes sought to provide a more dynamic employment access system for people with disabilities.
- Chronic illness is not specifically addressed and administrative differences between occupational and non-occupational injury and illness may lead to access difficulties for people with chronic illness.
- Regional access differences may be a problem for people with any type of illness or injury.
- Employers do not appear to have many obligations to ensure return to work for any type of illness or injury. Any such responsibilities for employing people with disabilities may be transferred into payments to the socially supported employment sector.

Table 5 Overview of the Italian system

Measures						Other – constitution	Other – national agreements	Equality/non-discrimination	Health and safety	Employment/labour market	Occupational health	General health	Social protection
Purpose	Health					×		×	×		×		
	Income support					×		×					×
	Recruitment							×					
	Retention (pre long-term absence)	Same job						×					
		Redeploy						×					×
	Reintegration (post long-term absence)	Same job						×					×
		Redeploy						×					×
Focus	Econ. inactive					×		×					
	Unemployed												×
	Employed	At work											
		Long-term absent						×					×
Scope	Generic							×	×		×		×
	Specific categories	OSH at risk	Physical					×	×		×		×
			Psych.					×	×		×		×
		Social exclusion				×		×					
		Discrimination				×							
		Chronic illness / Disability	Phys /Sen.			×		×					×
			Psych.			×		×					×
Approach	Policy					×		×	×		×		×
	Individual	Intervention	Medical					×					×
			Vocational					×					×
			Other					×					
		Supports	Finance										×
			Services					×					×
	Workplace	Org or Conds.							×		×		
		Environment							×		×		×
		Supports	Finance					×					×
			Services								×		
	Incentives	Positive	Finance										
			Procedure										
		Negative	Finance										
			Procedure										
Resp	In-company								×		×		×
	External							×			×		×
Monitor mechanisms	Fully												
	Partially							×	×		×		
	None												

9 Policies and initiatives in the Netherlands

Context

In the Netherlands, healthcare expenditure as a proportion of GDP in 2000 was 8.1%, and expenditure on social protection was 27.4% of GDP, among the highest in Europe. Expenditure on disability was 11.8%, among the three highest countries reported in this study. The Netherlands had one of the lowest unemployment rates in 2002 (2.6%), but a high proportion were inactive due to illness (11.6%). The Netherlands has a high proportion of working age people reporting a long-standing health problem or disability (EU, 2001): 18.5% of persons aged 16-64. Though not as high as either Finland or the UK, this is 80% higher than Ireland and more than twice that of Italy. The proportion of the 55-64 age group reporting a long-standing health problem or disability was 40-42%, employment of older workers (55-64) in 2003 was 42%, inactivity in this group was 52%, and the average age of retirement slightly higher than the EU average at 60.9 years (*Social situation in the European Union 2003*).

The Dutch social insurance system has changed radically. State-backed social insurance was responsible for income maintenance and rehabilitation and reintegration but, as income maintenance is generous by European standards, the costs were becoming unsustainable and return to work rates were low.

After discussing options (including a quota system for employing people with disabilities), income provision and rehabilitation and reintegration shifted from social insurance to the employers.

There are 15 laws relating to employing people with disabilities, five of which concern social protection and cover most workers.

Social protection

Some five laws govern the first year of sickness absence. Employers are responsible for short and long-term income and organising return to work services. From 2004, it covers the first two years.

Absent workers are entitled to a minimum of 70% of normal wages for a year. Employers need not pay this if the illness or injury was deliberate or the worker refuses an adapted job. Most collective agreements stipulate that employers will make up wages to 100% for a limited period and some employers insure against this. When not entitled to this extra benefit, employees may receive a top-up from the Workers' Insurance Authority.

Previously, employers' insurance premiums dropped with low sickness absence and increased when high, but this ceased when employers argued that they were not responsible for sickness which was not work related.

Four laws cover disability leave of over 52 weeks and all employers pay a basic insurance premium to cover the costs for the first five years. Those with more than 25 employees also pay a premium which varies according to the number of former employees claiming disability benefit.

Disability benefits are available for anyone with an uninterrupted 52 week absence, and for fully or partially incapacitated employees who must have at least 15% reduced earning capacity. The benefits threshold has risen through stricter medical criteria, medical reviews, and broader interpretation of suitable types of work when assessing fitness.

Self-employed people pay a premium to cover the risk of becoming long-term disabled, with disability benefits for people who have been disabled from an early age, i.e. before they began work.

Workplace health management

The social partners also made sectoral collective agreements on aspects of working life, including health. Though not all refer in detail to health, they do include wage supplements during sickness absence. Two thirds of the agreements deal with integration and reintegration but the provisions are usually aspirational and fewer than 10% are binding. They mainly refer to reintegration, company health care, sickness reporting, possible sanctions, medical examinations, resuming work, benefits under the Occupational Disability Insurance Act, and transfer to other jobs.

Arbocoventanten are sectoral agreements governing occupational health and safety. Those between the social partners on health and safety are systematic and based on research and commitment to planned interventions. Work pressure and reintegration are commonly dealt with (21 out 33 covenants), while 24 of the agreements cover sickness absence and early integration. Most set targets for reducing sickness-related absenteeism.

All Dutch workplaces must have a prevention contract with occupational health services. These are independent companies which advise on sickness absence. They determine at six weeks whether the employee is fit for work or needs long-term absence assistance. They must also provide advice on preventing such absence but do not provide case management services, beyond dealing with medical diagnosis.

The Gatekeeper Act of 2002 aims to facilitate proactive responses to sickness absence within the first year. The act has reduced sickness absence though it is too early to be definitive about its effects. In the first half of 2003, applications for occupational disability insurance benefits declined by 26%. However, it may be that a difficult economic situation contributed to this.

Rehabilitation and reintegration

The Act on Vocational Rehabilitation (1998) promotes reintegration to work following disability. Employees have several return to work responsibilities and receive financial assistance once an occupational health doctor has approved a reintegration plan. The allowance can cover training/education, personal assistants, and they can use employment placement services. Employers can apply for financial support for reintegration with financial incentives, such as reduced insurance premiums and subsidies for employing people with long-term disabilities.

System profile

Table 6 below profiles Dutch legislation on return to work for people with chronic illness. The measures aim to alter occupational health services and reduce work-related disability rates, among the highest in Europe.

The main change is a transfer of absence costs from the state to the employer, who must promote reintegration. In theory, employers now have a greater interest in prevention and health promotion, though there are some difficulties with occupational health organisation and practice. There has been a move away from passive towards more active, dynamic measures with positive and negative incentives for employers. The long-term absent now have greater autonomy in rehabilitation and must make every effort towards that aim and reintegrating into the workforce.

The legislation provides for income supplements, focusing largely on people who are short-term and long-term absent from work. It covers chronic illness and disabilities, with its main instrument being financial support and incentives.

Occupational health legislation also sets out a role for professionals in prevention and reintegration. Though confined to individuals, it covers both medical and vocational interventions.

An overview of disability legislation and sectoral agreements indicates that there are few obvious gaps in legislation or services, and it appears that the system caters relatively well for people with chronic illness. Policies and regulations under social protection, occupational health, the disability system and particularly sectoral agreements seem to provide adequate access to reintegration services.

Summary and conclusions

The following conclusions arise from this analysis:

- Dutch legislation and regulation have changed radically to reduce long-term absence from work.
- Responsibility for costs and absence management has shifted from the state to the employer.
- A range of active and dynamic measures targeted at employers and employees seek to reduce absence from work.
- Many changes in policy and practice have been at sub-governmental level, i.e. sectoral agreements between employers and labour representatives.
- The changes may influence the types of organisations offering services and the kinds of services offered.

Table 6 National profile of legislation in the Netherlands

Measures	Purpose: Health	Purpose: Income support	Purpose: Recruitment	Purpose: Retention (pre long-term absence): Same job	Purpose: Retention (pre long-term absence): Redeploy	Purpose: Reintegration (post long-term absence): Same job	Purpose: Reintegration (post long-term absence): Redeploy	Focus: Econ. inactive	Focus: Unemployed	Focus: Employed: At work	Focus: Employed: Long-term absent	Scope: Generic	Scope: Specific categories: OSH at risk: Physical	Scope: Specific categories: OSH at risk: Psych.	Scope: Specific categories: Social exclusion	Scope: Specific categories: Discrimination	Scope: Specific categories: Chronic illness / Disability: Phys /Sen.	Scope: Specific categories: Chronic illness / Disability: Psych.	Approach: Policy	Approach: Individual: Intervention: Medical	Approach: Individual: Intervention: Vocational	Approach: Individual: Intervention: Other	Approach: Individual: Supports: Finance	Approach: Individual: Supports: Services	Approach: Workplace: Org or Conds.	Approach: Workplace: Environment	Approach: Workplace: Supports: Finance	Approach: Workplace: Supports: Services	Approach: Incentives: Positive: Finance	Approach: Incentives: Positive: Procedure	Approach: Incentives: Negative: Finance	Approach: Incentives: Negative: Procedure	Resp: In-company	Resp: External	Monitor mechanisms: Fully	Monitor mechanisms: Partially	Monitor mechanisms: None
Social protection		X									X						X	X		X			X						X		X		X				
General health	X							X	X	X	X	X					X	X		X																	
Occupational health	X			X	X	X	X			X	X	X	X	X			X	X	X	X	X			X	X	X		X		X		X	X			X	
Employment/labour market																																					
Health and safety																																					
Equality/non-discrimination																																					
Disability legislation	X		X	X	X	X	X	X		X	X	X					X	X	X	X	X			X	X				X	X	X		X	X			
Other – Sectoral agreements		X		X	X	X	X				X		X	X			X	X	X	X	X		X								X		X				
Other																																					

Policies and initiatives in Sweden 10

Context

The unemployment rate in Sweden in 2002 was 5%. Social protection expenditure in 2000 was 32.3% of GDP, compared with 7.9% for health care. Disability-related social protection expenditure was 12% of GDP (2000). The proportion of those aged 55-64 reporting a long-standing health problem or disability was approximately 31%, compared with nearly 20% for the total population. The employment rate of older workers (55-64) in 2003 was 68%, by far the highest of the countries studied, and the inactivity rate (29%) for this group was exceptionally low. The average age of retirement at 61.6 years was substantially higher than the EU average. The average sickness leave in Sweden is 42 days.

Responsibility for chronic illness and disability falls between a number of sectors including the Labour Office, the employer, social insurance funds and the Equality Authority. There are nine main Swedish laws relevant to job retention, income support and health, and a number cover employer responsibilities and protecting people with disabilities from discrimination.

Social protection

The National Insurance Board, together with social insurance offices, administers social insurance and is responsible for the greater part of the financial safety net. A pension insurance fund also operates. Four insurance funds provide coverage to those leaving work: the Voluntary Unemployment Insurance Scheme; the Accident / Occupational Disease Insurance Scheme, which also covers burnout; the General Health Insurance Scheme, for health costs; and the Sick Leave Insurance Scheme which covers income continuance.

Three groups are responsible for absence: the employer, the social insurance funds and the Labour Market Authority (LMA) which covers those with insufficient contributions for sick leave insurance.

Reasons for sick leave are: chronic illness; mental health difficulties; and physical and sensory disabilities. Health insurance covers sick leave and the Accident Insurance Fund covers physical impairments from work accidents. The flow between illness and unemployment is complex. There is no national insurance for unemployment but there are voluntary insurance funds managed by the unions. Employees make payments and this type of insurance covers up to 80% of those at work. For those without voluntary unemployment insurance, there is social assistance, paid at a very basic level.

General taxation and employer pay-related social insurance fund health insurance for workers over 18 years, providing income replacement up to 80% of salary or that of a qualified industrial worker, with a ceiling of approximately €28,000. Because income support during sick leave is taxable, an ill or injured employee can return to work part time and earn an income for a limited time.

The LMA offers wage subsidies to assist transition from sick pay, up to 80% of salary, mainly targeted at lower earners. It can also fund part-time sick leave. Company pension agreements can top up benefits and workers can invest in private pension funds linked to chronic illness and disability.

There are no rules to cover interventions for absences of up to 90 days although the social insurance fund pays income continuance after the second week. These funds used to operate independently but have now merged at a national level. The employer pays the first two weeks to decrease state costs, placing responsibility on the manager who is better able to understand a person's needs. It also aims to link the person to the workplace. There is no control on short-term absence until the seventh day when a person must produce a medical certificate. The social insurance funds are not involved at this stage.

Since 2003, there has been a sickness allowance for employees aged 19-29, effectively an activity allowance with support for being active in the workplace.

Workplace health management

Responsibility for occupational health lies with each municipality and is a public health issue. The Health and Environment Board is responsible for community health and the labour inspectorate for workplace health and safety. National responsibility for occupational health and safety lies with the Occupational Health and Safety Board. Health and safety services vary greatly; for example, the hospitality sector operates various advice and guidance services on workplace hygiene, and the Occupational Health and Safety Board issues guidelines on work safety.

While the risk management and prevention requirements of employers are clear, there is no obligation on employers to implement health promotion. Many employers outsource occupational health care and any company services aim to promote health, generally focusing on preventing psychosocial illness or disability. Their main role is to mediate in conflicts between employee and supervisor.

The use of occupational health physicians is relatively rare in the Swedish system. Occupational health centres tend to be involved in research, and some company occupational health facilities operate in larger institutions such as universities, dealing mainly with burnout.

Rehabilitation and reintegration

The Social Insurance Act and the LMA rules make the employer responsible for developing and funding a rehabilitation plan after a 90-day absence, although the social insurance funds can pay for technical aids, retraining and rehabilitation if an employer proves inability to pay. The social insurance funds may become involved but often the person responsible is an administrator and may not be qualified in staff disability management or return to work strategies.

Human resources handle reintegration and generally will implement the employer's responsibility to plan rehabilitation. They may also redeploy staff at risk of unemployment as a result of redundancy or personal illness. This responsibility derives from the Security Foundation Agency which guarantees employees at risk of redundancy that redeployment will be the first option considered.

Sick leave measures focus on the individual's health, leading to income maintenance and acute medical services with post-acute medical rehabilitation financed through the health system. Vocational rehabilitation can form part of a person's plan but return to work services such as

coordination and workplace rehabilitation are not part of it. Supported employment based on medical opinion can be available for a limited time with support split between the social insurance funds and the LMA without a clear delineation.

Under labour market law, the LMA can offer rehabilitation with the social insurance funds, mainly for unemployed and inactive people with disabilities, and can subsidise travel and work participation. This function is not always well resourced and there is no law for reintegration of long-term absent workers so local experience and tradition determine practice.

Being responsible for those not in work, the LMA's involvement, where a person is absent but still employed, is on the basis of the worker's risk of losing the job. It can fund training, technical aids, workplace supports and adaptations, and supported employment, and there is a proposal for it to handle all rehabilitation.

There is confusion as to who pays for interventions on behalf of an individual. A long-term absent employee may attend a rehabilitation planning meeting where the main topic is who should pay for rehabilitation.

Anti-discrimination legislation

A number of acts targeted at working life strengthened the 1991 Swedish equal opportunities strategy, e.g. based on ethnic minorities, gender, and people with disabilities, followed by general anti-discrimination measures.

The Disability Ombudsman handles any cases but it is difficult to estimate the effectiveness of legislation as few people with disabilities have taken discrimination cases. It is hard to evaluate its relevance to people with chronic illness who risk job loss.

Disability legislation

There is little or no disability specific legislation in Sweden except for the blind library, a death law and institutes for special pedagogies. Mainstream legislation covers other disability issues and an independent living fund is available for personal assistants, with direct payment to an individual with multiple disabilities or the family of somebody who is mentally disabled. The municipality pays for the first 20 hours of personal assistance after which the social insurance funds take over.

System profile

Table 7 applies the national level tool to the Swedish system, a substantial body of legislation but not highly regulated. Elements of social protection, employment and equality can include job retention and reintegration of people who acquire health conditions that impact upon their work capacity.

Employment measures engage employers and employees in reintegration and, where eligible, equality legislation can protect a worker with a disability at risk of unemployment. There is little disability specific legislation relevant to job retention and reintegration.

The health system provides post-acute rehabilitation but does not intervene to maintain people at work, and occupational health and safety legislation does not extend beyond protecting those currently employed.

There is a broad focus on economically inactive and unemployed people with disabilities, including the long-term absent. Physical, sensory and mental health conditions fall within the scope of social protection, employment and equality, while some companies cover retaining people with mental health difficulties.

There is no coordinated and comprehensive policy framework in the Swedish system although each area of responsibility has fairly well defined policy guidelines. Social protection and equality emphasise job retention and return to work but this is less explicit in health and employment. On the other hand, the majority of interventions to assist return to work are in the employment system.

Financial support is available through social protection, while vocational rehabilitation comes from either the LMA or the employer. Employer responsibilities and equality legislation support adapting work organisation or conditions, with negative incentives where employers bear the cost of early sick pay.

Social protection, employment and equality measures specify employer responsibility and external support. Services exist in the LMA and insurance agencies but these are usually targeted through the employer.

Social protection outcomes are fully monitored although return to work and job retention figures are not reported separately, and comprehensive absence and return to work figures are not readily available. It is not possible to assess the effectiveness of anti-discrimination measures in job retention and reintegration.

Summary and conclusions

The main conclusions about the Swedish system are:

- Employers carry most responsibility for rehabilitation and reintegration but can receive financial assistance in certain circumstances.
- The social partners and statutory authorities are considering health-related long-term absence. There have been changes to social protection and employer responsibilities with proposals to extend the time for which employers are responsible for sick pay.
- There are active benefits to encourage engagement in rehabilitation and work-related activities.
- Equality legislation may well impact on employers' behaviour and decision-making.
- There is little evidence of a concerted, coordinated approach to acknowledge the needs of the chronically ill.
- Recent initiatives have the potential to increase the effectiveness of the overall Swedish approach.

Table 7 Overview of the Swedish system

Measures	Purpose: Health	Purpose: Income support	Purpose: Recruitment	Purpose: Retention (pre long-term absence): Same job	Purpose: Retention (pre long-term absence): Redeploy	Purpose: Reintegration (post long-term absence): Same job	Purpose: Reintegration (post long-term absence): Redeploy	Focus: Econ. inactive	Focus: Unemployed	Focus: Employed: At work	Focus: Employed: Long-term absent	Scope: Generic	Scope: Specific categories: OSH at risk: Physical	Scope: Specific categories: OSH at risk: Psych.	Scope: Specific categories: Social exclusion	Scope: Specific categories: Discrimination	Scope: Specific categories: Chronic illness / Disability: Phys /Sen.	Scope: Specific categories: Chronic illness / Disability: Psych.	Approach: Policy	Approach: Individual: Intervention: Medical	Approach: Individual: Intervention: Vocational	Approach: Individual: Intervention: Other	Approach: Individual: Supports: Finance	Approach: Individual: Supports: Services	Approach: Workplace: Org or Conds.	Approach: Workplace: Environment	Approach: Workplace: Supports: Finance	Approach: Workplace: Supports: Services	Approach: Incentives: Positive: Finance	Approach: Incentives: Positive: Procedure	Approach: Incentives: Negative: Finance	Approach: Incentives: Negative: Procedure	Resp: In-company	Resp: External	Monitor mechanisms: Fully	Monitor mechanisms: Partially	Monitor mechanisms: None
Social protection		X				X	X	X	X		X				X		X	X	X				X										X	X	X		
General health	X							X	X	X	X	X								X																	X
Occupational health	X			X						X		X	X	X														X									X
Employment/labour market		X			X	X	X	X	X		X		X	X			X	X			X	X		X	X	X	X				X		X			X	
Health and safety	X			X						X		X	X	X					X						X	X						X			X		
Equality/non-discrimination			X	X	X	X	X	X	X	X	X					X	X	X	X						X	X						X	X			X	
Disability legislation								X	X	X	X						X	X				X		X										X		X	
Other																																					

Policies and initiatives in the UK 11

Context

The unemployment rate in Britain (England, Scotland and Wales) in 2002 was 5.1% and the proportion of unemployed/inactive people due to illness was 15.6%. In 2000, social protection spending was 26.8% of GDP and disability-related social protection was 9.5% of GDP. The proportion of those in the 55-64 age group reporting a long-standing health problem or disability was 46-51%, compared with 27.2% for the total population. The employment rate of older workers (55-64) in 2003 was 54%, their inactivity rate was 45%, and the average age of retirement was 62.1 years. These figures for older workers are substantially higher than the EU average and there are marked disparities within and between England, Scotland and Wales.

British estimates for average number of days absent per year for every employee range from 10 to 23 days, and 2% of the workforce is absent on any given day (Barton and Leonard, 2002), amounting to two million working days lost per week (Labour Market Trends, 2002). A company absence rate of 5% of the workforce is equivalent to the cost of two weeks' extra holidays for employees.

According to the Confederation of British Industry (2001), the cost of absence is £10.7 billion for employers and £23 billion for the economy as a whole. A minimum estimate of the cost to employers is £522 per employee and cost of absence estimates range from 2-16% of the salary bill depending on which costs are included.

Long-term absence contributes a substantial amount to these figures: approximately 18% of people account for 40% of time lost. The Department of Work and Pensions (DWP, 2002) concludes that 60% of those absent over five weeks will not return to work nor will over 80% of people on incapacity benefit (available after six months' absence). Mental and behavioural conditions account for 35% of those on invalidity benefit while musculoskeletal conditions account for 22%. Stress or back pain result in 25% of early UK retirements. The Trade Union Congress (TUC, 2003) estimates that the proportion of the long-term absent who return to work is around 15%, compared with 35% in the US. Disabled people make up the majority of the economically inactive and, although the New Deal for Disabled People was intended to address this, it is generally agreed to have been less than effective.

The main elements of the British system that are relevant to chronically ill or disabled employees involve a legal system that strongly underpins health and safety in the workplace, income continuance for the long-term absent, and protection against discrimination for those with disability status. A non-statutory policy, including the social partners, acknowledges the importance of job retention and reintegration for people absent from work as a result of chronic illness or disability (BSRM, 2000; TUC, 2002; DWP, 2003; CIPD, 2002). A number of initiatives, either proposed or beginning, promote job retention and rehabilitation. These include a return to work credit for people on long-term benefits who wish to go back to work, and services and supports in pilot projects.

Social protection

Several laws provide for long-term absence, particularly social protection and income continuance. Underpinning them is the principle that employers must pay those unable to work after four days

up to 28 weeks. Employers can manage sickness payments through contracts and company policies; after 28 weeks, the DWP provides incapacity benefit.

This does not cover the first three days of absence, for which the employer may demand self-certification. Beyond four days, the employer determines the period of incapacity to work and whether to provide statutory sick pay or an in-company occupational sick pay scheme. Statutory sick pay applies to people between 16 and 65 with enough national insurance contributions, although this can be widened. Those ineligible for statutory sick pay can apply for incapacity benefit.

Employees do not need to report in person, or at a specific time on the first day, nor do they need to use a special form or medical certificate. After seven days, there must be records of dates and payments for the employer to claim against the Inland Revenue, often through deductions from national insurance contributions. Employers do not need to collect information on reasons for absence.

An own occupation test determines sick pay eligibility while a personal capacity assessment decides on incapacity benefit, based on assessed ability to carry out everyday activities and work. Those who do not meet this threshold can apply for other benefits, such as disability living allowance.

Those with severe mental illness or paralysis automatically receive incapacity benefit or severe disablement benefit (available to those considered 80% disabled who have made enough national insurance contributions), and 8.5% of the population receive disability living allowance. There are no re-assessment standards nor a time limit for incapacity benefit but claimants must report any improvement in their condition and a medical authority authenticates claims.

Workplace health management

A preventive ethos and health and safety legislation govern workplace health management. The focus is to eliminate factors that can cause illness or result in injury rather than on post-illness or injury intervention. The Health and Safety Executive seeks to reduce risks, and policy recommendations emphasise workplace health promotion. The Health and Safety at Work Act (1974) may provide some basis for post-illness or injury intervention, requiring employers to protect the health and safety of sick employees and others affected by their actions. The Act also proposes a residual duty on employers to incorporate health and safety needs of vulnerable staff within their policy statement and make adjustments to the workplace.

The Health and Safety Executive has published an 'Employer's guide to work-related stress', emphasising prevention over early intervention; and its 'Revitalising health and safety' document proposes that employers should rehabilitate ill or injured workers. The TUC, the Association of British Insurers and the Association of Personal Injury Lawyers have made similar proposals but it appears that the government has dropped this from its current legislative programme.

The National Health Service (NHS Plus 2003) has suggested that GPs and other medical professionals should become involved in occupational health services for employers on a fee-

paying basis. The NHS Plus programme includes sickness absence management, return to work and vocational rehabilitation, but there is little data to evaluate the impact this may have on chronically ill and injured workers.

Rehabilitation and reintegration

Responsibility for rehabilitation and reintegration belongs to a number of sectors including the Departments of Education and Employment, Health, Work and Pensions, and Trade and Industry.

JobCentre Plus and voluntary organisations provide financial supports and services to those on incapacity benefit. The GP has a central role in certifying sick pay and notifies the JobCentre Plus of the need for services and interventions. JobCentre Plus can provide a personal advisor or a disability employment advisor and rehabilitative work with an earnings limit while on sick pay or incapacity benefit. It can also make referrals to a national occupational psychological service.

Job brokerage is available from JobCentre Plus, especially where redeployment is the main option. Its 'One Initiative' is a single benefits gateway, providing claimants with a personal advisor to encourage re-entry to the labour market. A wide range of other vocational rehabilitation initiatives are available (Riddell, 2002), which are more suitable to redeployment or recruiting economically inactive people with disabilities. These include work evaluation, job placement, on the job training, vocational training, job search and job clubs, employer led recruitment campaigns, job matching, supported employment and self-employment options. There is a debate in JobCentre Plus about whether disabled people should use mainstream or specialist services, and whether to target services at specific impairment groups.

Apart from NHS Plus, the sickness absence role of GPs is to decide on sick pay entitlement on the basis of the condition, function limitation and the job's occupational requirements. GPs should take into account clinical guidelines, reasonable adjustments, risk assessment and mediating psychosocial factors as well as work availability, a person's age and other non-work factors. A recent review (Cabinet Office IB 204 2000) found that GPs generally had minimal contact with employers, had no formal training, and reported negative rehabilitation experiences; while employers were unaware of the rules on sickness certificates. Most employers report having policies and strategies relating to sickness absence (CIPD, 2002), regular contact with the absent employee, return to work interviews, flexible hours or changed workloads, referral to occupational health services, stress and employee assistance, return to work training and plans, adapted equipment, working from home options, physiotherapy and private medical care.

The Department of Work and Pensions (DWP) is exploring a more proactive approach to return to work. A Department of Social Security white paper and the DWP's 'Pathways to Work' outline the return to work policy as 'work for those who can, security for those who can't'. The DWP proposes that support for work absentees and return to work measures are a collective responsibility of the government, employers, health professionals and the employee. The paper emphasises rehabilitation and reintegration with planned reforms and occupational health and rehabilitation research. The DWP also published a discussion paper on a possible role for vocational rehabilitation, seeking opinions from interested parties. The paper explores the need for this service as well as its form, content, what represents good practice, and asks what the government can do to encourage vocational rehabilitation.

The Department has adopted evidence-based policy with a pilot job retention and rehabilitation project which focuses on employees out of work for six weeks or more and aims to assist them to return to work and to assist employers to retain valued workers. One of these pilots (Healthy Return) operates in six locations throughout Britain and is featured in Chapter 3.

An important element in reintegration is the legal notion of financial compensation for employers' negligence. A worker can seek compensation through the courts even for minor injuries, making the employer reluctant to reinstate an employee for fear of aggravating the condition. Equally, an employee may not wish to return to work in case this reduces the amount of compensation. This promotes the relatively conservative approaches by the Institute of Directors (2002), the Employers' Organisation and the Confederation of British Industry. The Institute for Employment Studies (2002) acknowledges that employee rehabilitation after long-term illness and the ageing workforce are two major concerns for employers in terms of employee welfare and the numbers exiting through early retirement.

Anti-discrimination legislation

A rights-based approach has been developed, and the Disability Discrimination Act requires employers to accommodate employees with a physical or mental impairment. Any individual whose sickness is prolonged or irrecoverable may be defined as 'disabled' under the Act, with a core concept of reasonable accommodation. This refers to adjustments or duties that do not place an undue burden on the employer. These can include part-time working, adapted work or environmental conditions, reduced work demands, redeployment to another position within the company, and home or teleworking. Other employment rights available to workers who acquire an illness or injury include statutory time off and flexible arrangements such as work–life balance. Recently extended to cover firms with two or more employees, the Act does not specify early rehabilitation or other reintegration interventions but does include a duty not to treat a disabled person less favourably.

There have been disputes about who is considered disabled under the Act and a Disability Rights Commission oversees its protection. Many cases relate to job retention rather than initial recruitment, i.e. individuals who risk losing their job often seek protection under the legislation.

System profile

Table 8 presents the national level assessment using the policy evaluation tool. Job retention and reintegration fall mainly within employment and equality systems, and the social partners and the state agree on a more targeted, proactive approach. Evidence-based policy has resulted in initiatives and discussion papers that may lead to social protection regulation changes, depending on consultations and the national pilot job retention project. As a result, health and income support do not include return to work supports.

Already mentioned is the unique factor in the British and Irish systems of having to prove employer negligence to gain compensation, which can delay a resolution.

While the national health service in Britain promotes health professionals' involvement in occupational health and reintegration, it does not strongly emphasise the issue. Current health and

disability measures do not focus on the return to work of employees at risk of absence or the long-term absent.

Some social protection seeks to promote employment for those on incapacity benefit, targeted more at economically inactive and unemployed people with disabilities or those at risk of social exclusion. The focus of return to work for long-term absent employees comes from employment measures that are not strongly supported by external agencies. There is little incentive to intervene because the employer must pay the first six months' absence and reclaim this cost from the Inland Revenue. Mental health and physical and sensory conditions fall within these terms. Discrimination legislation requires eligibility and people with chronic illness or emerging conditions cannot access such protection, particularly in the early stages.

Various policy positions and documents have restructured systems, such as the learning and skills and social protection sectors, e.g. JobCentre Plus. Work and pensions are now in the same department but the government has yet to incorporate targeted, timely responses to long-term absent workers into its policies. This weakens the overall approach which has a broad focus, wherein long-term absent employees are only a marginal sub-group. Despite the consensus on the need for more proactive measures, the system is an accumulation of uncoordinated measures, including vocational rehabilitation, workplace adaptations, working conditions and subsidies. To qualify, a person needs to be either disabled and unemployed or inactive.

Many supports do not incorporate return to work. While there are monitoring mechanisms, the fact that employers pay the first six months of sick pay rather than the state means that they measure absence, and the DWP does not have accurate estimates of the impact on job retention and return to work.

Summary and conclusions

The main characteristics of the British system are:

- A strong legislative basis exists for workplace health and safety practices.
- Employers pay for absence up to 28 weeks but can recoup costs from social insurance contributions.
- The legal requirement to establish employer fault to obtain compensation can be an inhibiting factor.
- Most statutory funded occupational rehabilitation and job placement services target unemployed and inactive people with disabilities.
- Stakeholders recognise that best practice requires a more active focus on retaining an individual with a chronic illness or injury and reintegrating those who have crossed the absence threshold.
- All stakeholders acknowledge that the key elements are primary health care, graduated return to work and early needs assessment.
- Despite the policy papers recommending rehabilitation and job retention, there is little evidence the British authorities will legislate on rehabilitation or other return to work measures.
- The DWP is unlikely to implement national job retention services until it evaluates the impact of current pilot projects.

Table 8 National profile of legislation in the UK

Measures	Purpose: Health	Purpose: Income support	Purpose: Recruitment	Purpose: Retention (pre long-term absence): Same job	Purpose: Retention (pre long-term absence): Redeploy	Purpose: Reintegration (post long-term absence): Same job	Purpose: Reintegration (post long-term absence): Redeploy	Focus: Econ. inactive	Focus: Unemployed	Focus: Employed: At work	Focus: Employed: Long-term absent	Scope: Generic	Scope: Specific categories: OSH at risk: Physical	Scope: Specific categories: OSH at risk: Psych.	Scope: Specific categories: Social exclusion	Scope: Specific categories: Discrimination	Scope: Specific categories: Chronic illness / Disability: Phys /Sen.	Scope: Specific categories: Chronic illness / Disability: Psych.	Approach: Policy	Approach: Individual: Intervention: Medical	Approach: Individual: Intervention: Vocational	Approach: Individual: Intervention: Other	Approach: Individual: Supports: Finance	Approach: Individual: Supports: Services	Approach: Workplace: Org or Conds.	Approach: Workplace: Environment	Approach: Workplace: Supports: Finance	Approach: Workplace: Supports: Services	Approach: Incentives: Positive: Finance	Approach: Incentives: Positive: Procedure	Approach: Incentives: Negative: Finance	Approach: Incentives: Negative: Procedure	Resp: In-company	Resp: External	Monitor mechanisms: Fully	Monitor mechanisms: Partially	Monitor mechanisms: None
Social protection		X						X	X	X					X		X	X	X				X				X						X	X	X		
General health	X							X	X	X	X	X							X	X														X	X		
Occupational health	X			X						X		X	X	X					X			X						X									X
Employment/labour market			X		X	X	X	X	X	X	X				X		X	X	X		X	X		X	X	X		X						X		X	
Health and safety	X			X	X					X		X	X	X					X						X	X						X	X		X		
Equality/non-discrimination			X	X	X	X	X	X	X	X	X					X	X	X	X						X	X						X	X		X		
Disability legislation																																					
Other e.g. Common law				X	X	X	X			X	X						X	X													X		X			X	
Other																																					

Conclusions and recommendations 12

Introduction

The complexity of most national systems for social insurance, rehabilitation and workplace health means that it is often difficult to obtain a thorough view of their operation, especially for a non-national. However, it is hoped that the systems level analysis tool provides a useful basis for trans-national comparisons. The conclusions drawn from these national examples, and from the case study initiatives outlined in Chapter 3, are necessarily tentative. They form a contribution to an emerging debate on social exclusion, reintegration of people with chronic illness, and maintaining the work ability of such employees.

Informing the analysis of national systems

Dynamic relationship between illness, unemployment and exclusion

The ICF contains useful language to describe social exclusion resulting from an employee's chronic illness, and specifies the key elements of the dynamic process that creates disability. Social exclusion arises when a person's health condition affects capacity to work. However, restricted participation in employment is not an inevitable result of ill health or reduced function. Rather, it is a consequence of environmental and personal factors which limit a person's activity and impact on participation in employment.

Key role of policy and legislative environment

Social exclusion takes place in an environment of laws and regulations, services and supports, workplace policies and practices, alongside professional and managerial resources, and the individual's family and social relations. National analyses show that environmental factors span a number of pillars of statutory responsibility including health, social protection and welfare, employment and social inclusion measures. The ways in which these impact negatively can include lack of appropriate and timely responses, fragmented responsibility for action, lack of clarity or even competing aims in return to work outcomes, lack of awareness of available options by the employer and/or the worker, needlessly restrictive eligibility requirements, or the lack of a coherent policy framework for action.

Critical importance of early intervention

The argument for early intervention incorporates a number of action principles:

- It is not inevitable that a health condition, regardless of its impact on function or activity, results in exit from employment.
- It is better to prevent individuals from losing their job than invest in attempting to return them to work after they become unemployed or inactive.
- Early intervention is the most effective way to achieve job retention and reintegration.
- Early intervention can only be effective if responsibility for action is located in the workplace.
- Coordinated delivery of appropriate services and supports is essential for effective return to work.
- Disability management provides a useful template for effective policy and measures to support job retention and reintegration.

Pivotal role of threshold decisions

To create a system that is 'fit for purpose', the starting point must be the decisions of the employee to stay at work and of the employer to retain that person. The whole system should focus clearly on supporting positive job retention and the return to work. Income maintenance, health interventions, rehabilitation, employment protection, non-discrimination measures and disability systems should include early intervention to maintain people at work. These elements must work in unison towards a single purpose and be clearly focused on the target group, i.e. those at risk of unemployment as a result of developing a health condition.

Main themes emerging from the analysis

The countries that were selected for analysis reflect a wide range of approaches to chronic illness, employment and exclusion, and differ significantly in systems and structures. By exploring the purpose, scope and focus of each, the study established how far systems targeted chronic illness, employment and exclusion. The report describes the extent to which systems enhanced or inhibited disability management practice at policy, workplace and individual levels. It also considered the locus of responsibility and the degree of monitoring, identifying a number of dimensions that are helpful in reaching some generalisations.

A major, if obvious, finding was that none of the national systems was originally designed to address chronic illness and exclusion. In most, the state externalised most workforce exclusion costs. Where it existed, service delivery was complex and was not easy to access for those at risk. Of particular note was the lack of integration of EU employment, social protection, occupational health and public health policies. At least two national systems responded actively, albeit in different ways, and the study identified useful developments in other jurisdictions. Some of the most salient are included in the conclusions and recommendations below.

Policy focus

This refers to the extent to which national policy targets chronic illness, job retention and return to work. Both the Netherlands and Germany have a strong policy focus, each with a different approach. Germany operates a highly regulated system based on insurance funds, while the Netherlands has adopted a market-based approach in transferring the costs of illness and long-term absence to the employer. These were the only countries with an explicit disability management policy focus.

In Finland, the focus is on maintaining employees' ability to work: prevention, health promotion and job retention, rather than reintegration of long-term absent workers. Italy and Sweden acknowledge the problem at policy level but in neither country was there evidence of effectively deployed local support and intervention. Employers pay the first two weeks of sick pay in Sweden and have responsibility to develop a rehabilitation plan for ill or disabled employees at risk of exiting work, but the service infrastructure is not well coordinated. In Italy, despite a disability focus in legislation, the regionalised system results in inconsistencies in approach, service infrastructure and employer focus.

While there is strong awareness of the issue in the UK among all stakeholders, particularly the unions, a systematic policy focus on early illness or disability intervention is not fully integrated.

Job retention is the subject of a national study to assess its effectiveness. The approach in Ireland is not policy driven but consists of initiatives to resolve the problem from different perspectives, such as the Personal Injuries' Assessment Board and employers' job retention grants. Ireland and the UK are unique among the country studies in that a fault-based compensation system is a disincentive to reintegration. In both countries, there are initiatives to mediate the impact of compensation. However, current efforts seek to simplify the judicial process rather than change the overall approach.

System inclusiveness

In most of the seven countries, the structure of measures and initiatives is around distinguishing occupational health conditions and other illnesses and disabilities, contributing to a two tier system of services and supports. The result can be complex eligibility systems and delays in accessing services while determining responsibility between agencies and insurance funds. The influence on approach and policy differs mainly in level of emphasis. In Italy and Germany, there is a key distinction between occupational and non-occupational disabilities, with different agencies responsible for each. The Netherlands and Finland have adopted a more inclusive approach, ignoring such distinctions in eligibility for services or income continuance. In the other countries, the distinction was evident in certain aspects of the system.

Externalising responsibility

One of the system dimensions explored was whether responsibility lay within the workplace with the employer or with an external system, e.g. social insurance. There is a strong employer focus in only one Member State, the Netherlands, where the employer pays up to two years' income support for long-term illness or injury absence, regardless of the cause. The German system recently acknowledged employer responsibility to initiate and coordinate support for employees whose ill health affects their work. Other countries have weak and inconsistent approaches to employer focus.

Coordinating interventions

Another distinguishing characteristic of the systems reviewed was the coordination and resourcing of services, supports and interventions. Both Germany and Finland have strong service infrastructures, albeit with significant gaps and discontinuities such as between social insurance and occupational health and safety in Finland. The main fragmentation within the German system is the division of responsibilities between various insurance funds. Generally speaking, the other national systems lack coherent, properly coordinated services and supports, with poorly focused interventions and fragmented responsibilities. None of the systems coordinates occupational health and safety, social protection, employment and public health policies around job retention and reintegration.

Incentivisation

Incentivisation was particularly strong in Germany and the Netherlands, though each approach differed. Germany operates a quota levy system to sanction employers who fail to employ a percentage of people with disabilities in the workforce. While chronically ill and injured workers are clearly within this scope, the focus is broader and includes economically inactive and long-term unemployed people with disabilities. The Netherlands has incentivised employers, transferring the

costs of long-term absence directly to them, with employer and worker entitlements to supports and resources to implement reintegration. Most Member States have equality or non-discrimination legislation and, since the 1990s, people at risk of unemployment from illness or injury have been able to invoke this legislation, but there is little firm evidence that this happens in the countries studied. It is unlikely that equality and non-discrimination legislation will incentivise early intervention on the part of employers and the state, despite strong advocacy from the UK Employers' Forum on Disability.

Monitoring and evaluation

The most evident, and in many ways most significant, area for improvement across all countries studied was the absence of clear and unambiguous data about the size of the problem of long-term absence and associated costs. Although it was possible to identify short-term absence figures and figures for disability in some countries, it is difficult to test and improve effective approaches and measures without the necessary data. It is also possible to contrast approaches in Germany and the Netherlands but, given the data available, not to reach strong conclusions on the effectiveness of either approach. Even in the UK, where evidence-based policy is a priority, information is not easily available about the nature, cause and demographics of the long-term absent after a period of six weeks.

In summary, this review of selected Member States has confirmed the findings of previous studies, including the GLADNET return to work study, the ISSA back pain study, and the RETURN conclusions. It has contributed to a better understanding of the issues and possible areas for future action. In particular, it has highlighted the need for a more clearly focused job retention and reintegration policy. This should include implementation standards, coordinated services and supports, placing responsibility within the workplace, enhanced awareness, knowledge and resources in all Member States. The policy should also remove complexities and disincentives, including fault-based compensation and distinctions between occupational and non-occupational injuries, and, most importantly, it should enable unambiguous impact indicators to evaluate system innovation and benchmarking.

Conclusions

One overarching conclusion is that the drift towards social exclusion, when an employee experiences chronic illness or disability, has serious implications for the European social model. Exit from the labour market can occur through permanent disability benefits, early retirement or long-term unemployment. This increases the social protection burden and reduces the competitiveness of European economies within the global market. Given the size of this problem, it is surprising that there has not been a more substantial and robust response either at European level or in most Member States. There are a number of reasons for this.

At European level, several relevant policy areas can impact on the long-term absence threshold for employers and employees but do not in themselves comprise the complete solution. Despite aspirational statements about integrated approaches and the need for synergies between policy areas, European policy recommendations and initiatives do not address illness and exclusion in a coordinated approach. On the contrary, a departmentalised approach to policy formulation and implementation, which focuses on traditional responses within each area, is a serious barrier to

integrating key policy areas such as occupational health and safety, public health, active ageing, disability, equality, employment, social inclusion and social protection.

On the positive side, the EU has developed an important approach to developing and implementing policy that could easily address fragmentation in a relatively short time. The open method of coordination, used successfully for several years and recently introduced into social inclusion policies, could provide a suitable mechanism. The problem of unemployment and disability as a result of chronic illness is clearly within the sphere of the adaptability pillar of the employment guidelines. Equally, early responses to maintain the health and employability of chronically ill workers concur with social inclusion guidelines and fit well within the remit of public health and social protection.

The European focus on illness and exclusion can be more effectively targeted through open coordination by introducing a reference to the specific target group into the relevant guidelines for Member States. The inevitable resulting effect in national action plans will allow the Commission to examine the relative effectiveness of Member States' actions. Such benchmark activities can help develop more effective and responsive guidelines to target the problem from a policy perspective.

At a national level, each system examined revealed gaps and discontinuities. Most involve static approaches to respond to a dynamic and progressive problem, and two core factors inhibited cross cutting approaches to illness and exclusion.

Firstly, national systems mirror the problem at EU level in that illness and exclusion cut across key government departments including finance, health, employment and social welfare. An effective solution may require changing responsibilities between departments and acknowledging that actions within one department will impact on another. The traditional departmentalised management approach to employment, health and social protection has resulted in rigid boundaries rather than developing integrated approaches. This will require one government department to take the lead in implementing change, a dilemma for policymakers. In most cases, the long-term cost burden falls on the social insurance/social welfare agencies, while employment bodies focus on the workplace. It is likely that the department chosen to lead will vary, depending on systems and structures in each Member State.

Secondly, the fact that social insurance or public health systems carry the costs for the employer and the individual results in a lack of perceived political urgency. The converse is that refocusing costs on the employer or the individual could have significant political fallout for any government courageous enough to attempt it. It may well be that costs should reallocate to where the problem exists, i.e. the workplace, but it also requires that employers take control over costs and access to appropriate resources.

A number of detailed conclusions are possible in relation to social exclusion and system and workplace responses. The categories below are organised to reflect possible broad avenues of intervention addressing a number of important themes. These include the distinction between mental and physical illness, integrated policy and services, the direction and philosophy underpinning policy, and service provision and complexity.

Process of social exclusion

- Work combats social exclusion. The social exclusion process resulting from chronic illness is strongly mediated by access to paid work. The failure of national and workplace systems to rehabilitate and reintegrate the chronically ill employee means that the individual loses income, an important social structure, and self-esteem. Retaining the link between work and chronically ill people is therefore a central means to combat social exclusion.
- Disability problems will probably increase as the European workforce ages, with an increase in mental health problems. Policy discussions in many EU countries to extend working life beyond current retirement mean that preventing work disability and consequent social exclusion will become much more important.
- The consequences of exit from the workplace due to chronic illness are clear. However, there is also a large group of socially excluded people who have never worked because of disability and most countries have, at best, limited success in promoting their entry to the workforce. To reduce social exclusion, it is essential to strengthen entry systems into the labour market and the workplace.

System level responses to chronic illness

- Social protection, rehabilitation and return to work systems were not originally designed to deal with chronic illness, nor to work in an integrated manner. They consist of layers of regulations added to a basic framework and rarely cater adequately for people with chronic illness.
- Most systems have three distinct approaches to illness and disability: occupational, dealing with occupational disease and injury; health, dealing with general health problems and disability; and social, focusing on income continuance. The occupational system generally targets health and safety or compensation for occupational injury or disease and, in a minority of cases, return to work. The health approach also focuses on compensation but generally does not view return to work as a goal; while social protection supports the person out of work. The links between the three systems are often weak.
- People who develop chronic illness for reasons other than work tend to fall between the systems. Occupational systems are of limited relevance, general health systems do not usually aim for return to work, disability systems are inaccessible due to eligibility restrictions, and social protection systems are often passive. Social exclusion then becomes a real possibility.
- Early intervention aims to promote reintegration but is not generally a feature of general health, disability or social protection systems. Chronic illness due to mental health problems poses special difficulties and not enough is known about what constitutes early intervention for people with such illnesses.
- Systems are generally complex, overlapping, sometimes exclusive and often confusing for the person with chronic illness. The complexity may also be a problem for professionals, leading in some instances to competition, or at least lack of communication, between service providers, to the detriment of the individual.
- Responsibility for funding and treatment may be unclear, leading to inadequate services. The eligibility rules often interact in a complex way with the different strands (occupational and general health), denying access to the most appropriate services.

- There is considerable variation in approach to chronic illness and work disability. These relate to the aims of systems dealing with chronic illness, integration levels, assignment of fault in occupational illness or injury and the impact on access to appropriate services, and the presence or absence of bonus-malus elements.
- Reintegration is not always seen as a relevant goal. This is particularly true of income replacement, whether designed to respond to occupational or non-occupational illness or disease, and especially in general health, disability or social protection systems.
- There are many passive aspects to systems which often do not demand action on the part of benefit recipients. Measures to support employers do not have a dynamic element and only rarely are employers responsible for proactive reintegration.
- The problems of chronic illness and work disability are growing and are increasingly the subject of debate, and new legislative and other initiatives. The Netherlands and Germany have made legislative changes, while Finland, Sweden and Ireland have undertaken non-legislative initiatives.
- Mental health problems as a cause of chronic illness are increasing. Most rehabilitative systems have had more success with physical health and have found it difficult to reintegrate people with mental health problems.
- System reform is on the agenda in many countries as implementation costs mount. There is little evidence that current systems achieve high levels of job retention or return to work for people with chronic illness. Some countries have been very active in trying to reduce disability inactivity rates, especially the Netherlands.

Workplace level responses to chronic illness

- The role of the employer in early intervention, job retention and reintegration is often poorly specified and in some cases not effectively communicated. As the employer is usually the first to become aware of the problem, it is essential to integrate that role into policy and system measures.
- Early intervention in chronic illness (especially mental health problems) and case management strategies do not always feature in workplace health practices.
- Mental health problems involve longer work absences, making return to work less likely, and workplaces need greater skills and knowledge to manage staff reintegration more effectively.
- Company reintegration practice varies considerably. Return to work policies often do not exist, awareness of the possibilities for return to work may be low, and the requisite skills may be absent. However, where policies and skills are present, success rates appear to be high.

Recommendations

The recommendations are targeted at three groups:

- policymakers in social insurance, health, rehabilitation and the labour market;
- service providers in these areas;
- employers.

These represent the main actors in return to work and are best placed to improve on current policies and practices.

Recommendations for policymakers

These recommendations are at the intersection of social inclusion, employment, health, disability, active ageing and social protection. It is unlikely that chronic illness and work disability can be adequately covered by addressing them in any one policy strand. Integrated and coordinated policy initiatives must acknowledge the contributions each area can make to an effective solution.

National action plans for employment and inclusion can be part of the strategy, and the health agenda can promote early intervention in health maintenance and the need to prevent job loss as a result of illness. Public health policy could incorporate early interventions and rehabilitation as important contributors to a nation's health. Active ageing policies can incorporate job retention and reintegration to reduce exit from work. The social inclusion guidelines can cover vocational rehabilitation and reintegration early in the absence process to fight poverty and social exclusion. Their role in facilitating employment participation through preventing risks of exclusion or job loss, and helping the most vulnerable workers, concurs with the broad policy objectives.

There is need for a review of the impact of anti-discrimination strategies on retaining jobs or reintegrating people with disabilities into work. The ILO code of practice *Managing disability in the workplace* could provide policymakers with a useful template to plan new approaches and redesign systems.

Whatever the approach to achieve an integrated policy response to the problem, it must include a number of critical strategic elements.

- *Raise awareness of the issue*. Policymakers need to be aware that the problem of chronic illness is growing. Many people who contract chronic illness may face social exclusion, and the problems associated with mental illness are especially serious.
- *Introduce more proactive policies*. All relevant policymakers need to move away from passive towards more active policies for long-term absent workers, assigning rights and responsibilities clearly, and ensuring transparent accountability. Policy needs to support action rather than inaction on the part of the major stakeholders. Adopting disability management as a system paradigm linking the workplace and external interventions to proactive reintegration strategies could assist in producing a system blueprint.
- *Streamline policy towards return to work*. Current policies in many Member States rarely target reintegration. This may be for historical reasons where, for example, income maintenance policies are solely for that purpose. Equally, reintegration is not always the goal of such policies because of different strands of policy and provision. Policymakers should place return to work at the centre of their approach if strategies are to become effective.
- *Remove barriers to services/compensation which depend on employment or disability status*. Some national systems differentiate access to services or compensation depending on whether the person is classified disabled or unemployed. Some also differentiate on the cause of the illness or injury, i.e. occupational as opposed to non-occupational. Where such systems interfere with

reintegration, they should consider streamlining access to funding or services to facilitate return to work.

- *Change expectation norms from welfare to work*. Many national systems do not always have a consistent reintegration agenda. Policymakers need to consider changing perceptions of what should happen when someone becomes chronically ill or injured, so that the norm is that people return to work, rather than survive on welfare payments.
- *Introduce bonus-malus elements to return to work*. Systems should contain financial reintegration incentives for individuals, workplaces or service providers.
- *Specify stakeholders' roles and responsibilities in the return to work process*. Collaboration with service providers is a problem in many countries, with gaps in service provision. Policymakers need to specify the roles of service agencies to eliminate gaps and provide collaboration incentives.
- *Strengthen links between workplace, absent employees and service suppliers*. Reintegration failures are largely due to weak links between the stakeholders. Services and entitlements are often complex, inadequate and difficult to comprehend for the individual and employer. The links between the employee and the workplace are often weak, as are those between service providers and the workplace. These links need to be strengthened to facilitate a successful return to work.
- *Improve data collection and analysis of chronic illness and leaving employment*. The issue of how and how many people exit due to chronic illness is largely hidden. There is an urgent need to improve the collection, analysis and reporting of national and EU data, to monitor the impact of policy and system changes, and to support more sensitive initiatives.

Recommendations for service providers

Service providers have a major role in supporting a person who is long-term absent from work as a result of a health condition. More flexible, responsive interventions, emphasising workplace-based solutions, can significantly improve reintegration. This may require re-engineering existing service models and convincing funding agencies and employers of the benefit of these new approaches.

A substantial challenge for service providers is to create proactive reintegration measures rather than traditional services. This will require changes in the way providers deal with employers, with services to solve the employers' problems as well as the rehabilitation of the ill or injured worker.

A number of strategies can help to modernise current provision and promote more effective outcomes.

- *Encourage collaboration between service suppliers*. A major problem is system complexity, which causes poor collaboration between service suppliers, especially those from different parts of the system. Effective, flexible collaboration between service suppliers, based on a return to work philosophy, is essential for successful reintegration.
- *Apply the disability management model to service suppliers*. Service suppliers could benefit from a disability management model. This would involve proactive management of claimants or

clients, liaison with other stakeholders, and managing the relationship between the individual, the workplace and service suppliers.

- *Enhance and upgrade professional skills*. To support disability management for employers and chronically ill workers, professionals need a wide range of skills and knowledge. They must also have appropriate attitudes to promote disability management among their customers. Continuing professional development and accreditation will enhance the skill base of service providers.
- *Investigate return to work and mental health problems*. There is need for greater knowledge to ensure reintegration of employees with mental health problems. Little is known about the prognosis of various mental health problems, appropriate early intervention, or how these problems reduce working capacity. Research is needed to clarify these issues and provide appropriate reintegration.

Recommendations for employers

Employers have a central role in more effective reintegration for employees who experience reduced work capacity as a result of a health condition. Such problems first manifest themselves in the workplace and thus early intervention is difficult without the proactive, vigilant role of the line manager or supervisor.

Effective reintegration strategies make good business sense. Even where the exchequer carries the burden of sick pay or disability benefits, the employer incurs direct costs in overtime and replacement costs and indirectly in higher personnel turnover, reduced productivity, low staff morale, loss of experience, and higher insurance premiums.

Proactive employers illustrate the benefits of targeted polices and procedures with a well-developed template for how such strategies can work.

- *Workplaces should adopt a disability management approach*. This involves adopting workplace health management interventions. Such measures range from targeted risk management and health promotion to an early intervention and case management approach for an individual with a chronic illness. These should be implemented using appropriate policies and services.
- *Develop policies early*. It is inappropriate to introduce a return to work policy after the individual has developed a health condition. At that stage, interventions, strategies or incentives can appear to victimise the individual by forcing a return to work. The idea of reintegration should be introduced to all workers during their induction phase so it is clear from the outset what will happen if they become chronically ill.
- *Flexible return to work solutions*. Organisations should make available a range of return to work options (e.g. adapted work, part-time work, redeployment, retraining) for people who contract chronic illness. These should be flexible, especially for staff with mental illness, where full recovery is less easy to predict.
- *Assign clear responsibilities for return to work*. Specific staff should be responsible for reintegrating employees with reduced work capacity. They should have the appropriate policies and resources with clear responsibilities and accountabilities.

First steps in implementing change

The costs of social protection for the European workforce are high and rising. The costs of benefits of all kinds (old age, sickness and disability related) are a major element in social expenditure, and it is a policy goal to promote increased labour force participation to control these costs, especially for older workers. However, the main strategy within the social protection debate, particularly early retirement, is to prevent people exiting the workforce by making it less financially attractive to do so.

There are two serious criticisms of this approach. First, preventing people exiting the workplace by cutting benefits does not address the problem of chronic illness and the need for workplace interventions, supports and healthy options. The problem of illness and exclusion remains hidden, only to emerge in potentially epidemic proportions at a later stage as people's health deteriorates. Secondly, reducing benefits can weaken the European social model and solidarity within the system. It is unlikely that simply adjusting existing approaches and policies will resolve the issue. A thorough review of current approaches within each Member State is necessary with a view to redefining entitlements, supports, services and incentives, so that workers with chronic illness and their employers can access appropriate supports at an earlier stage.

Any attempt to re-engineer national systems should have a set of clear multi-layered objectives to reduce the social protection burden, increase productivity, extend working life, improve competitiveness, enhance inclusion and cohesion, and promote health. It should incorporate a number of key principles:

- The strategy must be integral to health and safety, employment, social protection, social inclusion, disability, equality and public health systems.
- The aim must be to change the attitudes and decision-making behaviour of employees and employers when chronic illness threatens a person's employment prospects.
- Work must be seen as the norm for all people regardless of age or health condition.
- No one should be asked to do what they are not capable of achieving and those facing the problem should be given control over it. It is not about shifting costs but refocusing costs and resources to where the problem originates.
- There is need for a fundamental change to redefine system goals and eliminate system dysfunctionality.

Among the key elements of an effective system to respond to illness and exclusion are raising awareness and fostering better understanding of the issues and available solutions. Measures should regulate the process so that employers and workers can make positive job retention and reintegration decisions. Also important are measures that reward job retention and reintegration, and ensure safe and timely access to supports and resources for those who require them.

A useful first step to implement change is to establish a taskforce on job retention and reintegration with these responsibilities:

- prepare statistics on the scale of the problem and associated costs with monitoring mechanisms;

- advocate a higher priority for the issue in national policy and social partnership forums;
- promote greater understanding among those who confront the problem and those with responsibility for action;
- develop and implement flagship projects to test policy initiatives;
- advocate system-wide change particularly for resources, responsibilities, entitlements, incentives and supports;
- review and amend legislation and policy.

Taking into account the national situation, taskforces of this type could come to a true understanding of the nature and size of the problem, and begin designing an appropriate legislative and policy-based approach.

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Appendix:
National legislative measures

The following laws relate to social protection measures in the countries surveyed in the national study chapters.

Finland, Chapter 5

Sickness absence is governed by:

- Sickness Insurance Act (Sairasvakuutuslaki, 364/1963)
- Government Decree on Sickness Insurance (Sairasvakuutusasetus, 473, 1963)

Two laws govern work accidents or illness:

- Tapaturmavakuutuslaki, 608, 1948
- Ammattitautilaki, 1343, 1988

Four main instruments govern workplace health management:

- Occupational safety (Tyoturvallisuuslaki, 738, 2002)
- Occupational health care (Tyoterveyshuoltolaki, 1383, 2001)
- Occupational healthcare professionals (Laki tyoterveyshuollon ammattihen-kiloista 559/1994)
- Decree on the principles of good occupational health practice (1484, 2001)

Germany, Chapter 6

Book I (SGB1- Allgemeiner Teil) contains a general overview of the Social Law and SGB X (Verwaltungs), and the Datenerfassungs und ubermittlungsverordnung.

The following elements of the Social Code are relevant here:

- Entitlement to work (SGB III Arbeitsförderung)
- Consolidated social insurance legislation (SGB IV Gemeinsame Vorschriften fur die Sozialversicherung)
- Statutory Health Insurance Law (SGB V Gesetzliche Krankenversicherung)
- Statutory Accident Insurance Law (SGB VII Gesetzliche Rentenversicherung)
- Law on the rehabilitation and quota for disabled people (SGB IX Rehabilitation und Teilhabe Behinderter Menschen).

SGB XI Soziale Pflegeversicherung und Grundsicherungsgesetz of the Social Code deals with part-time employment, social insurance and safety devices for older workers.

Other relevant elements are:

- Payment of social security (ArEV Arbeitsentgeltverordnung)
- Continuation of wage payments in the event of sickness (Lohnfortzahlungs-gesetz)
- Occupational illness cover (BKV Berufskrankheitenverordnung)
- Other health-related payments (Bundesmantelvertrag and Bundesmantelvertrag: Ärtzte/ Krankenkassen)

Netherlands, Chapter 9

Five social protection laws cover most workers:

- Sickness Benefits Act (Ziektewet, ZW)
- Act on the extension of continued payment of wages in case of sickness (Wet Uitbreiding Loondoorbetaling bij Ziekte, WULBZ)
- Act on reducing incapacity benefits (WetTerugdringing Arbeidsongeschiktheids-volume, TAV)
- Gatekeeper Improvement Act (Wet Verbetering Poortwachter, WVP)
- Act to rescind the malus regulation (Wet Afschaffing Malus en Bevordering Reïntegratie, AMBER).

Two laws govern rehabilitation:

- Act on Vocational Rehabilitation (Wet op de (Re)integratie van Arbeidsge-handicapten, REA)
- Sheltered Employment Act (Wet Sociale Werkvoorziening, WSW).

Five laws govern first year of sickness absence:

- Sickness Benefits Act (ZW)
- Act extending the time period of continued period of wages during sickness (WULBZ)
- Act on reducing incapacity benefits (TAV)
- Act to rescind malus regulation (AMBER)
- Gatekeeper Improvement Act (WVP).

Four laws cover long-term disability:

- Occupational Disability Insurance Act (WAO)
- Disability Claims Reduction Act (TBA)
- Premium Differentiation Work Incapacity Act (PEMBA)
- Self-Employed Persons Disability Act (WAZ)
- Disability Benefits Act for Persons with early Disability (WAJONG)

Sweden, Chapter 10

Five main Swedish laws relate to income support and health:

- National Insurance Act (1962:381)
- Work Injuries Insurance Act (1976:380)
- Partial Pension Insurance Act (1979:84)
- Maintenance Support Act (1996:1030)
- Law (1993:389) on Compensation Assistance

The others cover services and supports:

- Social Services Act (SoL 2001:453), updating Social Services Act (1980:620)
- Law (1993:387) on support and service to some individuals with functional
- disabilities (LSS)
- Law (1998:703) on Disability and Care Allowance
- Health and Medical Care Services Act (1982:763)

The main laws covering employer responsibilities are:

- Employment Protection Act (SFS 1982:80)
- Labour Disputes (Judicial Procedure) Act (SFS 1974:371)
- Employment (Co-determination in the Workplace) Act (SFS 1976:580)
- Public Employment Act (SFS 1994:260)
- Working Hours Act (SFS 1982:673)
- Work Environment Act (SFS 1977:1160)

Labour Market Office responsibilities are set out in:

- Labour Market Policy Programmes Act (2000:625)
- Labour Market Policy Programmes Ordinance (2000:634)
- Activity Support Ordinance (1996:1100)
- Occupationally Disabled Persons (Special Measures) Ordinance (2000:630)

A number of laws specify the rights of people with disabilities:

- Prohibition of Discrimination in Working Life of People with Disability Act (SFS 1999:132)
- Equal Opportunities Act (SFS 1991:433)
- Prohibition of Discrimination Act (SFS 2003:307)

United Kingdom, Chapter 11

The acts governing social protection are:

- Social Security Act (1975)
- Social Security Contributions and Benefits Act (1992)
- Social Security Administration Act (1992)
- Social Security (Incapacity for Work) Act (1994)
- Employment Rights Act (1996)

European Foundation for the Improvement of Living and Working Conditions

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The issue of how people with chronic illnesses become excluded from the workplace is a complex one. Yet, in most Member States, the numbers of people in receipt of disability benefits or who leave work permanently for health reasons are similar to, or exceed, the numbers of people who are unemployed for other reasons.

This report addresses this knowledge gap by gathering information on relevant initiatives in seven Member States. It proposes a new model for understanding the nature of the problem; develops an assessment tool for new initiatives in the area; and makes recommendations on how best to promote social inclusion for people with chronic illnesses.

The European Foundation for the Improvement of Living and Working Conditions is a tripartite EU body, whose role is to provide key actors in social policymaking with findings, knowledge and advice drawn from comparative research. The Foundation was established in 1975 by Council Regulation EEC No. 1365/75 of 26 May 1975.

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