

Rehabilitation and return to work: Analysis report on EU and Member States policies, strategies and programmes

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Abbreviations

AUVA	Austrian Social Insurance for Occupational Risks
DGUV	German Statutory Accident Insurance
ECB	European Central Bank
EFTA	European Free Trade Association
ENWHP	European Network for Workplace Health Promotion
EU	European Union
EU-28	28 Member States of the European Union
EU-OSHA	European Agency for Safety and Health at Work
Eurofound	European Foundation for the Improvement of Living and Working Conditions
GP	general practitioner
HR	human resources
ICF	International Classification of Functioning, Disability and Health
ILO	International Labour Organization
ISSA	International Social Security Association
KELA	Social Insurance Institution of Finland
MSDs	musculoskeletal disorders
NAV	Norwegian Labour and Welfare Administration
OADR	old-age dependency ratio
OECD	Organisation for Economic Co-operation and Development
OHS	occupational health service
OSH	occupational safety and health
RTW	return to work
UN	United Nations
WHO	World Health Organization

Executive summary

This study¹ investigates the systems for rehabilitation/return to work in place in the 28 European Union (EU) Member States, along with the four European Free Trade Association (EFTA) countries. It analyses what factors play a role in the development and implementation of a rehabilitation/return-to-work system. Finally, it identifies a number of elements of rehabilitation/return-to-work systems in European countries that could be considered as success factors.

Systems for rehabilitating sick and injured workers are increasingly viewed as important elements of national policy approaches towards the ageing workforce. Between 2002 and 2013, life expectancy in the EU-28 increased by 2.9 years, from 77.7 to 80.6 years (Eurostat, 2015a). In parallel, the proportion of 55- to 64-year-olds in the total working-age population rose strongly between 2000 and 2015 (from 16 % to 20 %) and is expected to reach 21 % in 2020 (Fotakis and Peschner, 2015). Ageing is accompanied by a higher risk of developing (chronic) health disorders, such as depression, chronic bronchitis, cardiovascular disease and musculoskeletal disorders. In 2013, 33.4 % of the older employed population (55–64 years) in the EU-28 suffered from a long-standing illness or health problem compared with 14.6 % of the younger employed population (16–44 years) (Eurostat, 2015b). This ageing of the European workforce, combined with the stagnation of healthy life years and the prevalence of long-standing illness in older age groups, is compelling workplaces and national social security systems to improve the management of sickness absence and adapt work to chronic conditions and mild disabilities. Long-term sickness absence often leads to unemployment and is a major predictor for all types of exit from the labour market, including disability pension (OECD, 2010) and early retirement (Aranki and Macchiarelli, 2013), which are all major financial burdens for Member States, the workplace and society.

Actions aimed at prevention — that is, at avoiding sickness — both at the workplace (occupational safety and health (OSH) interventions) and outside the workplace (public health interventions) are clearly important. But if sickness occurs, measures focusing on *rehabilitation* and *return to work* are also important in avoiding or minimising sickness absence leading to disability.

Rehabilitation — understood as the process of recovering ‘optimal physical, sensory, intellectual, psychological and social functional levels’ (WHO, 2016) — consists of three different aspects. *Medical rehabilitation* aims to restore the functional or mental ability and quality of life of people with physical or mental impairments or disabilities; *vocational (or occupational) rehabilitation* aims to enable persons with physical or mental impairments or disabilities to overcome barriers to accessing, maintaining or returning to employment or other useful occupation; and *social rehabilitation* aims to facilitate the participation of people with disabilities in social life. While exploring the linkages between the three types of rehabilitation, this study focuses in particular on the second category.

Return to work is a concept encompassing all procedures and initiatives intended to facilitate the workplace reintegration of persons who experience a reduction in work capacity or capability, whether this is due to invalidity, illness or ageing (ISSA, 2013). The return-to-work concept fits well in the current political context of maintaining the sustainability of social security systems and reducing the economic impact of sickness absence and mismanaged return to work leading to unemployment, disability pensions or early retirement.

This report analyses the systems in place for rehabilitation and return to work in the 28 EU Member States and the four EFTA countries. It also incorporates the evidence gathered through case studies describing return-to-work programmes in nine Member States and the results of expert workshops held in 10 Member States. The country studies were drafted by national experts in the field of health and safety at work between September 2013 and June 2014 and, therefore, this report does not include new policies or initiatives that countries might have introduced afterwards.

¹ This report forms part of the activities carried out to support a three-year pilot project initiated by the European Parliament and managed by EU-OSHA on the occupational health and safety (OSH) of older workers and the rehabilitation of sick and injured workers in Europe. The project aims to assess the prerequisites for OSH strategies and systems within different European Union Member States to take account of an ageing workforce and ensure better prevention for all throughout the working life.

Rehabilitation and return-to-work policies and systems in European countries

The analysis of the national systems in place in 32 European countries (the EU Member States and EFTA countries) highlighted a great diversity of contexts, policies and stakeholders involved. On the basis of the investigation and analysis, the countries have been grouped according to their rehabilitation/return-to-work systems. The criteria for the categories included the obligations of employers regarding rehabilitation and return-to work, access to vocational rehabilitation, the country's approach to disability, the timing of intervention and the focus on prevention, the coordination of stakeholders and/or multidisciplinary teams in the rehabilitation process and the level of external support provided to employers.

Two main trends emerged from the analysis. First, in some countries, the focus is on the implementation of antidiscrimination and equality in employment policies, mainly targeting people with disability. In these countries, the system focuses more on the promotion of access of people with disability to the labour market than the actual reintegration process following a long-term sickness absence that has led to disability. Second, other countries address rehabilitation with the more general perspective of ensuring the sustainability of social security systems. In these countries, the system targets all workers and focuses more on early sickness absence management and the prevention of exclusion from the labour market. From these overall trends, four groups of countries were identified:²

- The first group of countries consists of Austria, Denmark, Finland, Germany, the Netherlands, Norway and Sweden. Among the main characteristics of these countries are the inclusiveness of their rehabilitation system (all workers are entitled to rehabilitation), their focus on prevention and early intervention, the broad responsibility of the employer in the return-to-work process, the effective coordination of multidisciplinary teams and the case-management approach. The rehabilitation of workers is generally supported by an integrated policy framework for the promotion of sustainable working lives or the prevention of exclusion from the labour market.
- The second group of countries consists of Belgium, France, Iceland, Italy, Luxembourg, Switzerland and the UK. These countries have well-developed frameworks for rehabilitation and return to work, but coordination across the different steps of the return-to-work process, from medical and vocational rehabilitation to reintegration at the workplace, remains limited. As a result, return-to-work considerations are generally dealt with only at the end of the sickness absence, with limited room for early intervention. Two countries, however, stand out. Recent policy developments in France and the UK indicate a shift towards more comprehensive and integrated approaches to rehabilitation and return to work.
- The third group consists of Bulgaria, Estonia, Ireland, Spain, Lithuania, Hungary, Portugal and Romania. In general, these countries do not have coordinated approaches and only limited institutional support for the return to work of workers after sickness absence. However, some ad hoc initiatives on the part of governmental agencies and non-governmental organisations were identified. Vocational rehabilitation services and support for the return-to-work process are generally available to people with disabilities. In most cases, rehabilitation can also be accessed by workers returning to work after an occupational accident or disease or while suffering from a long-term/chronic affection or partial incapacity to work.
- The fourth group consists of the Czech Republic, Greece, Croatia, Cyprus, Latvia, Malta, Poland, Slovenia and Slovakia. Countries in this group have a limited framework in place for rehabilitation and return to work. Rehabilitation support for workers exists essentially only for people with disability, and aims at promoting their access to the labour market. Likewise, support to employers only targets the hiring or reintegration of people with disabilities.

Determinants of rehabilitation/return-to-work systems

A comparative analysis of national systems highlighted a number of factors that play a role in the development of a rehabilitation/return-to-work system. A common driver for all European countries is that the costs of sickness absence and disability benefit schemes contribute to a substantial part of

² The information provided on Liechtenstein was too limited to allow its inclusion in any of the groups.

expenditure on social welfare and therefore are a target of public spending reforms. In many countries, the entry point for the question of return to work at policy level is the lack of sustainability of social security systems and the need to reform the management of sickness absence and disability.

The evolution of the narrative on rehabilitation/return to work and the recommendations of supranational organisations, such as the Organisation for Economic Co-operation and Development (OECD) or the International Social Security Association (ISSA), have highlighted the need for holistic approaches to return to work, individualised interventions with the active participation of the persons concerned, and improved coordination and cooperation of the different actors. Awareness of these elements accompanied a progressive shift in Member States from a focus on providing rehabilitation services to integrate people with disability into the labour market to a focus on return-to-work strategies intervening early to avoid people leaving the labour market because of a reduced capability to work.

While the influence of EU policy frameworks for employment, OSH and public health on the development of national systems has been rather limited — as one of the main areas of intervention for the development of return-to-work systems is social security — the EU has had an important impact on the development of national policies on antidiscrimination in employment and adaptation of workplaces to the needs of people with disabilities.

At the national level, two main factors influence the effectiveness of the rehabilitation/return-to-work systems: (1) the scope of the systems and (2) the presence of coordination mechanisms. In countries that approach the question of rehabilitation and return to work by focusing on the needs of people with disabilities for (vocational) rehabilitation, the scope of the system is relatively narrow and focuses on people with officially recognised reduced working capacity or on people who suffer from certified occupational accidents or diseases. In countries that focus on sickness absence management and approach the topic through the angle of return to work, of which rehabilitation is only one component, all workers going on medium- or long-term sickness absence are entitled to rehabilitation and are supported in their return to work.

Where they exist, coordination mechanisms for rehabilitation and return to work may be inscribed in the law or defined in a policy framework, instituted at national level or left to the appreciation of workplace actors, developed around a leading institution or formed as a network of several players, institutional or not. Coordination mechanisms intervene at different stages of the return-to-work process, starting at the very beginning of the process, when medical treatment is taking place, between medical doctors and the workplace (employer or occupational health services). Coordination between rehabilitation service providers and the workplace (and occupational health services when they exist) is also key to defining an individual rehabilitation plan and supporting the employer in deciding on workplace adaptations. Finally, coordination between the employer and human resources (HR) departments and, when they exist, occupational health services is also needed when the worker is reintegrated into the workplace.

The role of the employer is critical in the return-to-work process and varies a lot from one country to another in Europe. In general, the level of involvement of the employer in the process depends on the national legal framework and the nature of the responsibilities given to the employer with regard to sickness absence management. In some countries, employers have to pay for sickness absence compensation for a relatively long time (up to two years in the Netherlands), giving them a strong and immediate incentive to put in place effective return-to-work procedures. In other countries, this obligation is shorter in time but is accompanied by other responsibilities, from making workplace adaptations (in most European countries) to preparing an individual work plan (for instance, in Germany).

Factors for a successful rehabilitation/return-to-work system

The legal, institutional and policy frameworks of successful return-to-work systems have a number of common elements that contribute to their effectiveness at national and workplace levels:

- *Cohesive legal frameworks:* A legal framework that covers all aspects of the process is necessary for a successful return-to-work system, either by regulating all the steps of the return-to-work process under a single legal act or by defining in the law clear coordination mechanisms across these different steps.

- *Integrated policy frameworks:* Integrating the return-to-work system in a comprehensive policy framework, which covers all relevant policy areas, helps define coherent objectives and set goals for its implementation and provides a foundation for the designation of clear coordination mechanisms.
- *Effective coordination mechanisms:* Coordination across relevant policy areas is a critical success factor in the development of effective return-to-work systems. This includes coordination of policy formulation across employment, public health, OSH and social security areas. It also means coordinating stakeholders, as many can be involved in return-to-work systems.
- *Scope of the system:* Approaching the question of rehabilitation/return to work through the perspective of the right to equality of people with disability is too limited to effectively address the issue of return to work. An inclusive system targeting all workers with a health problem is needed.
- *Early intervention:* Intervention at an early stage of the sickness absence increases the chance of the worker to get back to work quickly. The longer workers stay off work, the lower their chances to reintegrate easily into the labour market.
- *Tailored intervention:* Successful return-to-work interventions are tailored to the worker's needs and abilities. They involve the creation of individual plans with adapted measures for rehabilitation/return to work and the active participation of the worker. This also calls for the use of an interdisciplinary approach in order to cover the whole return-to-work process. Thus, medical and non-medical professions need to work together.
- *Case management:* Case managers help the worker through the different steps of the rehabilitation process and facilitate their interactions with various stakeholders, including the employer. A case-management approach is based on the principles of cooperation and coordination of all relevant parties to the benefit of the individual worker.
- *Incentives:* Incentive-based systems can increase the participation of employers and workers in the system without using binding instruments. Incentives for employers include increasing the employer's responsibility for compensation of sickness absence (negative) and the provision of financial support to deal with a person's return to work (positive). For workers, it includes aligning the allocation of disability benefits with the execution of rehabilitation programmes, or encouraging part-time return to work while still receiving sickness benefits.
- *Support activities:* Support activities from institutional and non-institutional actors can help employers to develop individual action plans and put reintegration measures in place for people returning to work following sickness absence. Support can be financial (e.g. for adaptations of the work environment to the needs of people with reduced work capability) or technical (provision of guidance documents for the reintegration of a person with a specific health problem, support from consultants to make ergonomics assessments and adjustments). Support can be provided by national and regional governmental organisations as well as by other intermediary organisations that have an easier access and dialogue with workplaces and workers, including work insurance and pension organisations, OSH advisory services, local employment agencies, healthcare facilities, business and trade union organisations.

Policy-relevant findings

A number of policy-relevant findings have been identified with regard to the prerequisites of a national system to address the issue of rehabilitation/return to work.

Holistic systems

The majority of European countries do not sufficiently consider the needs of people on medium- and long-term sickness absence returning to work with a reduced work capacity — where the person is able to do the same job but less of it — or reduced work capability — where the person is unable to perform the same tasks. Broadening the scope of the systems to all workers has two main benefits:

- It supports *early intervention*, as the worker enters the system during the sickness absence, rather than once he/she has been recognised as disabled. How early a worker should enter the system is still under investigation.
- An early inclusion system for all workers after a defined duration of sickness absence allows for a *stepped-care approach*. Here, workers are provided with different types of services and support depending on the nature of their health problem, its severity and the duration of their sickness absence.

Integration within a broader policy framework

The return-to-work system should be inscribed in a broader holistic and integrated policy framework for sustainable working lives. This requires coordination across all relevant policy areas: employment, public health, OSH, social security, fundamental rights and vocational education. It also requires the establishment of common goals and a commitment to a shared agenda across policy areas (e.g. employment and health). Joined-up budgeting across the different policy areas can also reinforce coordinated activity and increase resource efficiency.

Cross-policy coordination is particularly important in the context of reforms of social security systems, in particular health and disability benefit schemes. These reforms should be coordinated with a support system for rehabilitation and return to work. With adequate support mechanisms, adapted working conditions and an occupation suited to the person's condition, remaining at work need not affect health stability.

At EU level, mainstreaming the issue of rehabilitation/return to work in different policy areas could be considered. Further action could build on the Commission's commitment to launch a Communication on the health of the workforce to implement cooperation mechanisms between relevant actors in employment, social protection and public health fields. This study has shown repeatedly the importance of considering return to work as an outcome of medical treatment.

Coordinated systems

In many European countries, a lack of coordination between medical doctors, vocational rehabilitation providers and the workplace impedes or delays return to work. Returning to work after a medium- to long-term sickness absence is a complex process, requiring a number of steps to be followed and the combined action of different professions that are not necessarily used to working together. The workplace should be the central point of focus of return-to-work systems.

Knowledge exchange and transfer of practices from countries that have established such coordination structures would be beneficial. Considering the multidisciplinary nature of this topic, the sharing of good practice is also necessary among all professional communities involved, including medical and paramedical professionals, occupational health specialists, employment and HR experts, social security experts and antidiscrimination experts, as well as the scientific and professional community, and policy-makers.

Financial and technical support

For workplaces, returning to work can be a complicated process, involving budget considerations, HR, OSH, etc. For small and micro companies, the process can become particularly complex, especially if they do not have an internal OSH or HR department or staff member. External technical and/or financial support can, therefore, help employers to develop individual action plans and establish reintegration measures for people returning to work following a sickness absence. Intermediary actors, such as work and pension insurance organisations or OSH external services, play an important role in the provision of this support or at least in relaying, at the workplace level, the type of support available at national level.

Raising awareness

Raising the awareness of those involved in the development and implementation of a rehabilitation/return-to-work system is a major challenge, as their interests, needs and roles differ considerably. It is, however, a critical success factor. Company culture plays an important role in the return to work of someone after a medium- or long-term absence. Intermediary actors also have a

critical role to play in raising awareness at workplace level on the opportunities and the challenges of return to work, in particular for small and micro companies.

Research gaps

Finally, while research efforts should continue to focus on the analysis of workplaces to identify and eliminate or mitigate factors contributing to occupational ill-health, additional research is also needed in the following areas:

- the practical implementation of existing national return-to-work systems to evaluate, among other things, their impact, feasibility and cost-effectiveness;
- evidence on the effectiveness and applicability of return-to-work models in small and micro companies;
- evidence on the impact of the organisational culture on health at work, including cooperation with colleagues and management, team cultures and political organisation of workers' interests;
- the specific needs of older workers, women, people on long-term sickness absence (i.e. more than one year) and people suffering from mental health disorders in the return-to-work process;
- the need for more harmonised statistical data, including better accounting for differences in definitions and interpretations across EU countries in relation to, inter alia, rates of sickness absence, rates of return to work after a sickness absence, transfers from sickness absence benefit schemes to other income-support schemes, and people working with a chronic or long-term health problem.

1 Introduction

1.1 The ‘Safer and Healthier Work at Any Age’ project

This report is part of a pilot project initiated by the European Parliament and is based on the findings of the Parliament study on new forms of physical and psychosocial health risks at work. This three-year pilot project, ‘Safer and healthier work at any age’, began in June 2013 after the European Commission and the European Agency for Safety and Health at Work (EU-OSHA) concluded a delegation agreement. Project activities were directed and managed by EU-OSHA and carried out by a consortium led by Milieu Ltd. Other consortium partners include COWI A/S, the Institute of Occupational Medicine (IOM), IDEWE, Forschungs- und Beratungsstelle Arbeitswelt (FORBA), GfK and the Nofer Institute of Occupational Medicine (NIOM).

The project aims to assess the prerequisites for occupational safety and health (OSH) strategies and systems within different European Union (EU) Member States to take account of an ageing workforce and ensure better prevention for all throughout the working life. The results of the project will assist policy development by providing examples of successful and innovative practices. In doing so, the work aims to highlight what works well and what needs to be done or prioritised, and to identify the main drivers and obstacles to effective implementation of policy initiatives in this area.

More specifically, the project aims to:

- review current knowledge in relation to OSH and older workers;
- investigate EU and Member States’ policies and strategies in relation to the challenges of an ageing workforce, in particular in relation to OSH;
- investigate EU and Member States’ policies and systems in relation to rehabilitation and return to work;
- gain knowledge of successful and innovative practices in workplaces for safer and healthier work at any age; and
- raise awareness on the topic and receive feedback from stakeholders.

1.2 Objective, structure and methodology

The present report aims to identify and analyse the different approaches in Europe to rehabilitation and return to work by comparing the different components of the national systems for return to work in the 28 EU Member States (EU-28), with a view to identifying the main success factors and support needs in the different systems. In addition, it looks at systems in countries belonging to the European Free Trade Association (EFTA), namely Iceland, Liechtenstein, Norway and Switzerland.

To this end, the report analyses the combined findings from a number of deliverables produced as part of the project, which include:

- a state-of-the-art review of knowledge and recommendations on rehabilitation and return-to-work systems, specifically looking at the effectiveness of rehabilitation/return-to-work interventions and success factors for long-term reintegration and sustainable return to work;
- descriptions of the systems in place for rehabilitation and return to work in the 28 EU Member States and the four EFTA countries (Iceland, Liechtenstein, Norway and Switzerland);
- in-depth descriptions (case studies) of return-to-work programmes or interventions implemented in nine Member States (Belgium, Denmark, Germany, France, the Netherlands, Austria, Finland, Sweden and the UK); and
- the results from qualitative research between March and June 2014, collecting the views of stakeholders on the topic of rehabilitation and return to work in 10 Member States (Belgium, Denmark, Germany, Greece, France, the Netherlands, Austria, Poland, Finland and the UK).

The report has five main chapters:

- Chapter 2, 'Setting the scene: why rehabilitation and return to work are important', provides general background information on trends related to health and disability in the context of an ageing workforce and introduces the concepts of rehabilitation and return to work.
- Chapter 3, 'Approaches of European countries to rehabilitation and return to work in the context of an ageing workforce', describes the various components of the national systems for rehabilitation/return to work and proposes a grouping of countries according to the approach they follow.
- Chapter 4, 'Determinants of a rehabilitation/return-to-work system', identifies contextual information related to the supranational and EU context, the social and economic contexts, the regulatory and institutional frameworks for health and safety at work and social welfare, and other factors that determine why countries are following a certain approach to rehabilitation/return to work.
- Chapter 5, 'Factors for a successful rehabilitation/return-to-work system', provides an account of some of the factors that can explain the successful implementation of rehabilitation/return-to-work systems and programmes, at country and workplace level, and the obstacles that countries and workplaces can face when implementing these systems and programmes, based on the identification of good practices.
- Chapter 6, 'Policy-relevant findings', sets forth the prerequisites of a national system to assist effective rehabilitation and return to work and to highlight the challenges and support needs of European countries in relation to improve their existing systems.

The report's grouping of countries is based on the information included in national reports, as well as additional sources of information at European and international level. Considering the current level of activity in the fields of OSH, employment and public health in relation to demographic changes and sustainability of social security systems, new initiatives may have emerged at national level since June 2014. At the time of drafting the present analysis report, major new national developments on the issue of rehabilitation and return to work have been considered, but it is possible that smaller, more ad hoc, initiatives have not been taken into account.

In Chapter 4, the report examines some of the supranational and national determinants that can explain differences in national approaches. These are embedded in wider economic, regulatory, cultural and political contexts at national as well as international and European level that are also constantly evolving. The determinants were selected based on the Consortium's own expertise and on discussions with EU-OSHA.

Throughout, the report also considers how recommendations from international organisations, such as the International Social Security Association (ISSA) or the Organisation for Economic Co-operation and Development (OECD), and the theoretical models for return to work are being implemented in practice. It discusses success factors in the implementation of rehabilitation/return-to-work policies systems and concludes by providing policy pointers on rehabilitation and return to work in the context of an ageing workforce.

1.3 Limitations

This report aims to explain differences in policy approaches and frameworks put in place by European countries for rehabilitation and return to work. While a wide range of sources were consulted, the results of the study should be seen in the light of some uncertainties inherent in the methodology used, the availability of data and the timing of the analysis.

Firstly, the key resources for this report were national country inventories on policies, programmes and initiatives for rehabilitation/return to work, which were compiled by national experts in health and safety at work. While the national reports aim to present data and describe factual information, a level of subjectivity in how the information is presented by the expert is inevitable. EU-OSHA's national focal points had the opportunity to review the reports. This should nevertheless be considered an expert

perspective rather than an evidence-based analysis. The description of the programmes and initiatives constitutes an overview of key activities implemented at the time the reports were drafted (between September 2013 and June 2014). It should be noted that the reports investigate in only a limited manner the actual degree of implementation of the system in place. Implementation was discussed in more details in the countries where qualitative research was carried out.

Secondly, there are several limitations to the quantitative data used in Chapters 2 and 4. Apart from a few exceptions, data were used only where they were available across the EU-28 and EFTA countries and when they had been collected and processed in a harmonised way. Most of the quantitative data therefore comes from different surveys and statistics (such as the EU Labour Force Survey, the Statistics on Social Protection Expenditures, health statistics, and others) processed by Eurostat; from the European Working Conditions Survey (EWCS) carried out by the European Foundation for the Improvement of Living and Working Conditions (Eurofound); from the OECD (statistics on retirement ages); and from the Survey on Health, Ageing and Retirement in Europe (SHARE), which was not carried out in all EU countries. While the sources mentioned above follow high standards to allow for cross-country comparisons, they nevertheless have limitations and there is a lack of data for certain countries and years.

The outcomes of this report should therefore be considered within the scope of the above-mentioned uncertainties.

2 Setting the scene: why rehabilitation and return to work are important

2.1 The consequences of an ageing workforce on sickness absence and disability

Populations across the world have been ageing significantly during the past decades because of rising life expectancy and declining birth rates. Similar trends can be observed in Europe, where people aged 65 years and above are projected to account for nearly 30 % of the total EU-28 population by 2080 (compared with 18.6 % in 2013) (Eurostat, 2014a).

The ageing of the overall population is resulting in parallel ageing of the workforce. The age composition of the working-age population (15–64 years) has changed over the past decade and will keep changing. The proportion of the oldest age group (65 years and above) of the total population will have doubled in 2080 compared with 1990 and will make up almost one-third of the total population. In parallel, the proportion of the 'younger' working-age population (15–54 years) will have decreased to 51 % by 2020 and to 46 % by 2040 compared with 56 % in 1990. In 2080, this group will make up less than half of the population (Eurostat, 2014b, 2015c).

In addition, since 2000, the average age of exit from the labour market has risen (OECD, 2016), further increasing the proportion of older workers in the workforce over the past 15 years. The employment rate among people aged 55–64 in the EU has grown by more than 12 percentage points between 2000 and 2013, at a faster pace than any other age group (although large differences exist among European countries) (Eurostat, 2015d).

Increased risks of sickness and disability

While life expectancy has been increasing in Europe over the past decades, these extra years of life are not necessarily spent in good health. In fact, since 2005, 'healthy life years'³ expectancy has remained stable for men and decreased for women (EC, 2009). In 2012, people aged 65 years could, on average, expect to spend less than half (44 %) of their remaining life in good health.

Ageing is accompanied by an increased risk of developing (chronic) health disorders. Health problems that are increasingly prevalent among older people include chronic diseases such as depression, chronic bronchitis, cardiovascular disease, musculoskeletal disorders (MSDs) and multimorbidity, namely the co-occurrence of two or more chronic medical conditions in one person (Varekamp and van Dijk, 2010). Because the workforce in Europe is ageing, the risk of developing health problems while still being at work is also increasing. The relationship between age and long-standing health problems or disability is almost linear, but accelerates among older workers. According to the EU Statistics on Income and Living Conditions (EU SILC) data, in 2013, 14.6 % of the younger employed population (16- to 44-year-olds) in the EU-28 reported to suffer from a *long-standing illness or health problem* compared with 33.4 % of the employed population aged 55–64 years (Eurostat, 2015b).

While the development of health problems among workers has an impact on sickness absence rates, it can also lead to presenteeism, which occurs when 'workers go to work when ill and are unable to perform effectively due to their ill health' (Gervais, 2013). Studies have estimated that presenteeism can be more costly to organisations than short-term sickness absence and that it actually increases the likelihood of going on long-term sickness absence (Huver et al., 2012). Looking at the factors associated with presenteeism, it has been shown that older employees are more likely to attend work while sick (Huver et al., 2012).

This increased risk of developing a health problem while at work affects the rates of exit from the labour market because of health problems. While not all early retirement is due to health reasons, there is ample evidence to suggest that health issues make a significant contribution. MSDs and mental ill-

³ The EU indicator 'healthy life years' is a disability-free indicator of life expectancy, which indicates the number of remaining years that a person is expected to live without any severe or moderate health problems. For more information, see EC (2016).

health are the primary diagnostic causes for disability retirement. On average, around 6 % of the working-age population rely on disability benefits, which increases to 10–12 % in some Northern and Eastern European countries. The number of beneficiaries of disability benefits is highest among older workers aged between 50 and 64, with average rates of 10–15 %, increasing to over 20 % in Sweden, Norway and Hungary. Many workers leave the labour market permanently as a result of health problems or disability, and too few people with reduced work capacity (i.e. the person is able to do the same job but less of it) or reduced work capability (i.e. the person is not able to perform the same tasks) manage to remain in employment (OECD, 2010).

Costs to the individual and society

Long-term sickness absence and early retirement because of reduced ability to work are both major burdens for the individual, the workplace and society. Workers have to face a loss of income and bear the emotional and physical costs of ill-health. Employers are responsible for (1) sick pay (depending on the country), (2) costs because of staff turnover, (3) time spent on managing the sickness absence, and (4) providing occupational health services (OHSs), whenever offered. The state bears the costs of sickness benefits, foregone taxes and extra health care (Black and Frost, 2011). Although no data on the costs of sickness absence management exist at EU level, UK estimates show that sickness absence costs GBP 9 billion (approximately EUR 12.2 billion) to employers in sick pay and other indirect costs and GBP 15 billion (approximately EUR 20.4 billion) to society, mainly in lost output (Black and Frost, 2011).

In addition, early disability retirement and long-term sickness absence lead to high expenditures on disability and sickness benefits. This has become a large burden on public finances in most OECD countries, subsequently influencing their economic growth (OECD, 2010). In 2007, among all the OECD countries, the average public spending on disability and sickness benefits amounted to 2 % of the gross domestic product (GDP), except for in Norway, the Netherlands and Sweden, where it was more than twice as high (4–5 %).

Many chronic diseases can be prevented or managed and adjustments can be put in place within the work environment to accommodate resultant restrictions in capability. Incidences of long-term sickness absence, work disability or early retirement could be reduced if appropriate measures were taken to facilitate return to work, rehabilitation and reintegration. It is therefore crucial to organise work and to design workplaces to prevent the emergence (or aggravation) of illnesses and to enable more employees to return to work and stay active until retirement age.

2.2 The concepts of rehabilitation and return to work

This section introduces the two concepts that constitute the focus of this report: rehabilitation and return to work. Although both terms are brought together many times in this report, rehabilitation and return to work are two different concepts. The return-to-work process is an overarching process, which begins when the worker starts their sickness absence and ends with the sustainable reintegration of the worker at their previous workplace or in a different workplace. Rehabilitation (medical, vocational or social) is only one component of the return-to-work process.

Rehabilitation

The International Labour Organization (ILO) issued its first recommendation on rehabilitation (ILO, 1955) in 1955 in relation to people with disability. The World Health Organization (WHO) explains that the 'rehabilitation of people with disabilities is a process aimed at enabling them to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels' (WHO, 2016). The 2006 United Nations Convention on the Rights of Persons with Disabilities (UN Convention) talks about 'habilitation and rehabilitation services and programmes' as measures 'to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life' (UN, 2006).

Rehabilitation, understood in the sense of rehabilitating someone with a disability or with health problems into an active life, can be split into three different types:

- *Medical (physical or psychological) rehabilitation* aims to restore the functional or mental ability and quality of life of those with physical or mental impairments or disabilities.
- *Vocational (or occupational) rehabilitation* aims to enable persons with physical or mental impairments or disabilities to overcome barriers to accessing, maintaining or returning to employment or other useful occupation. ILO Convention No 159 notes that the purpose of vocational rehabilitation should be to 'enable a disabled person to secure, retain and advance in suitable employment and thereby to further such person's integration or reintegration into society', while, according to the OECD, it aims to 'increase the productivity of people with disability by restoring and developing their skills and capabilities so they can participate in the general workforce' (OECD, 2010).
- *Social rehabilitation* aims to facilitate the participation of people with disabilities in social life.

This study has focused particularly on the second category, vocational (or occupational) rehabilitation, although it has also investigated the links between medical rehabilitation and vocational rehabilitation.

While the international organisations mentioned above discuss rehabilitation mostly in the context of people with disabilities, this study has a wider perspective on rehabilitation. It encompasses all workers who are potentially at risk of exclusion from the labour market because of a health problem, and not only people with an officially recognised disability. In a broad understanding, this includes all previously healthy workers who take medium- to long-term sickness absence or regular shorter sickness absences (because of chronic diseases), and who need support to go back to work, either at their previous workplace or in a different workplace, even if they have not been formally recognised as disabled.

The return-to-work concept

Only since the 1990s have scientists and policy-makers been paying attention to the return-to-work concept. According to the ISSA, 'return-to-work programmes facilitate the workplace reintegration of persons who experience a reduction in work capacity or capability, whether due to invalidity, illness or ageing' (ISSA, 2013).

Views concerning the return-to-work process have changed over the years. In the more traditional *biomedical perspective*, individuals who are unable to work are considered to have a medically determined diagnosis, and their illness is connected to a physical pathology (Schultz et al., 2007). The treatment focuses on the restoration of lost work ability by attempting to overcome, adapt or compensate for this loss. Physicians set the diagnosis and treatment plan, regardless of factors such as the personal situation of the individual. This approach has been criticised for neglecting the contextual factors of illness and disability, such as the individual's personal/psychological situation and any external socio-economic factors (Waddell and Burton, 2005).

The more recent *biopsychosocial model* integrates the biomedical with the psychosocial perspectives (Schultz, 2008). This model views the return-to-work process as an interaction between biological, psychological and social factors, which together enable an individual to work. The *case-management model*, in line with the biopsychosocial model, also symbolises this shift from personal disease/biomedical models towards person/environment models (Loisel et al., 2009). The responsibility for rehabilitation outcomes shifts from the healthcare provider–patient relationship to a multi-player system, which may involve interactions with different professional, legal, administrative and cultural (societal) professionals (Loisel et al., 2005).

The underlying idea of this evolution is that the return-to-work process is affected by many determinants. Consequently, this process should be understood as involving interplay between the macro-system (societal context, culture and politics), the meso-system (workplace, health care, legislative and insurance system) and the micro-system (the worker). An increasing number of national systems for rehabilitation/return to work are based on this case-management model, as illustrated in the next chapters of this report. This approach recognises that several actors are involved in the return-to-work process, and each of these actors has his/her own understanding of return to work and what

outcomes they expect (Schultz et al., 2007).

Recently, the development of a number of operational models, such as the Sherbrooke model⁴ (Loisel et al., 1997) or the recommendations of the Black and Frost's review (Black and Frost, 2011)⁵, have helped put in place programmes or practices aiming at an *early return to work* through the integration of the workplace in the treatment programme. Evidence now indicates that this type of workplace-based intervention is more effective than usual healthcare interventions for reducing sickness absence and for preventing work disability among workers with MSDs (Schultz et al., 2007).

Return-to-work systems as safeguards of the sustainability of socio-economic systems

In order to guarantee the sustainability of our social security systems, European countries have been implementing policies to extend the duration of the working life. They have done so primarily by raising statutory retirement age and limiting access to early retirement benefits but also through policies aiming to maintain people's work ability and employability throughout the working life⁶. Rehabilitation and return-to-work systems are part of this process, as they aim to maintain or restore people's work ability and prevent the exclusion of people from the labour market because of a reduction in work capacities due to their health.

There is growing evidence that work can help people in recovering from sickness or dealing with physical or mental impairment. Being able to continue working helps build confidence and self-esteem (MacMillan Cancer Support, 2013; Taskila et al., 2013). There is a broad consensus across disciplines that returning to work after, or even while, being sick generally has a positive effect on health and well-being (Waddell and Burton, 2006). In 2012, 28 % of economically inactive people aged 50–69 years who received a pension (including old-age and disability) reported that they would have preferred to stay longer in employment (Eurostat, 2014c).

However, coming back to work with a disease or an impairment is likely to require adaptations to the working environment to suit the changed abilities of the worker and, where appropriate, to avoid relapses due to unsuitable working conditions or a workload that is too heavy. This is where OSH policies and measures matter. For example, a patient returning to work after an injury with lower back pain may need a temporary or permanent adaptation of his/her tasks and workload and an adjustment of his/her workstation (such as the provision of lifting/handling aids) to avoid aggravating the pain and this may even contribute to the healing process.

The vision of adapted work as an asset in the treatment of a disease is a relatively new concept, which is only starting to permeate the current national systems for sickness absence and disability management, as illustrated in the following chapters.

⁴ The Sherbrooke model is an early intervention model for patients suffering from lower back pain. It consists of an occupational intervention starting after six weeks of absence from work — including a workplace assessment by the occupational health physician and a visit to the workplace by an ergonomist to anticipate workplace adaptations — and a clinical intervention starting after eight weeks of absence from work including specialist medical assessment and a multidisciplinary rehabilitation intervention (McGee et al., 2009).

⁵ Black and Frost recommend that an independent assessment service be created, to which general practitioners could refer for an expert assessment of workers' capacities after four weeks of sick leave. This service would be complemented with measures to enhance support from the employer to the sick workers and a job-brokering service to support workers with reduced capacities to return to work (Black and Frost, 2011).

⁶ For more information on this, see the 'Analysis report on policies, strategies and actions' produced in the context of the 'Safer and Healthier Work at Any Age' project.

3 Approaches of European countries to rehabilitation and return to work in the context of an ageing workforce

A major part of this study of rehabilitation/return to work in Europe involved analysing the systems in place in 32 European countries. The study investigates the different elements that constitute a return-to-work system in the 28 EU Member States and in the four EFTA countries.

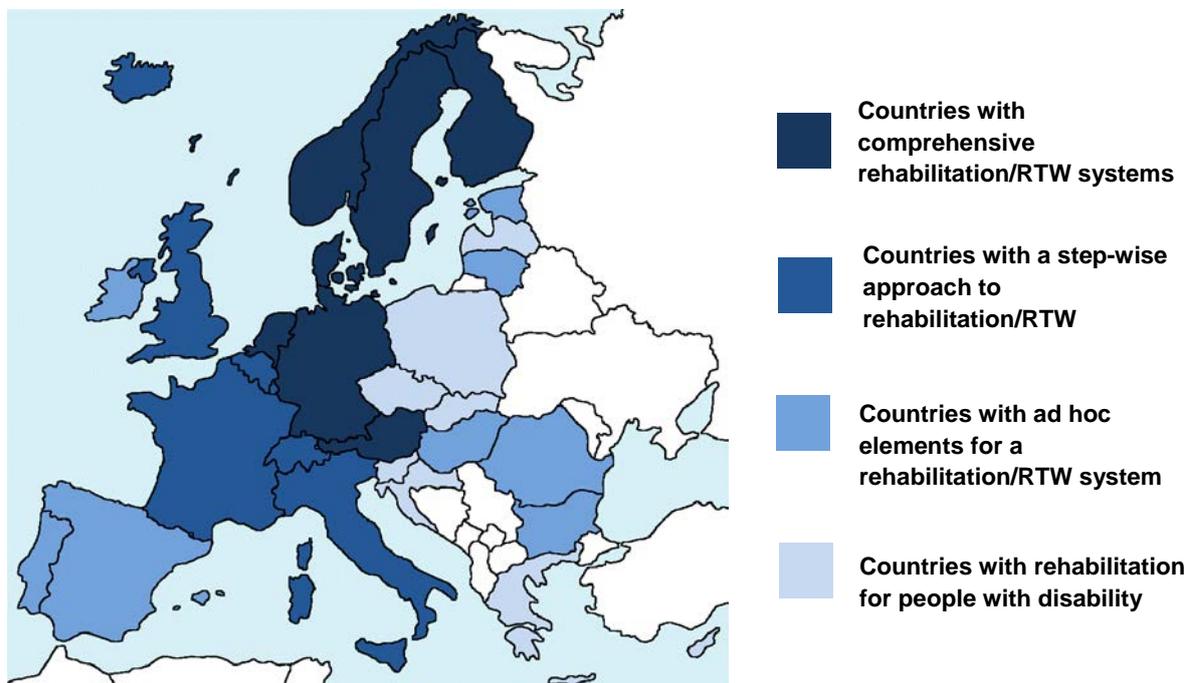
These elements include, among others, the procedures for medical and vocational rehabilitation (with an emphasis on vocational rehabilitation), the obligations of employers with regard to the reintegration of workers following a sickness absence and supporting measures provided to employers, and the procedures for compensation of sickness absence and allocation of disability benefits. At the same time, it examines the roles and responsibilities of different actors and the coordination mechanisms in place to create integrated systems.

3.1 Introduction and methodology

Four different profiles, reflecting the different national approaches to rehabilitation and return to work, have been identified through an in-depth analysis of national systems. The information collected for each country is presented in national reports published in the framework of the 'Safer and Healthier Work at Any Age' project. The countries covered in the grouping include the 28 EU Member States and Iceland, Norway and Switzerland. The information provided on Liechtenstein was too limited to allow its inclusion in any of the groups.

The four groups are presented in Figure 1.

Figure 1: Four types of national profiles based on approaches to rehabilitation and return to work (RTW)



The analysis is based on a number of selected criteria, such as the obligations of employers regarding rehabilitation and return to work, access to vocational rehabilitation, the country's approach to disability, the timing of intervention and the focus on prevention, the coordination of stakeholders and/or multidisciplinary teams in the rehabilitation process, and the level of external support provided

to employers. The detailed matrix of indicators used for the grouping is presented in the Annex of this report. The grouping was also refined by taking into account similarities identified within groups of countries and differences from other groups. These similarities and differences can be explained by a number of factors, such as a country's traditions and legal and institutional frameworks. These factors, or determinants, are analysed in the next chapter (Chapter 4).

The countries with the darkest colour (dark blue) have a comprehensive and mature framework for rehabilitation and return to work, targeting all workers and valuing early intervention and individualised approaches. They have recognised the need to address the issue of long-term sickness absence leading to permanent exclusion from the labour market and have developed appropriate regulations, policies, programmes and institutions to deal with it. They do not all necessarily follow the same approach, but a number of features, identified as essential to successful return-to-work systems, can be found across all countries: holistic, multidisciplinary and individualised approaches; coordinated mechanisms with involvement of all relevant stakeholders and in particular the workplace; and early intervention and prevention to retain workers with health problems at work.

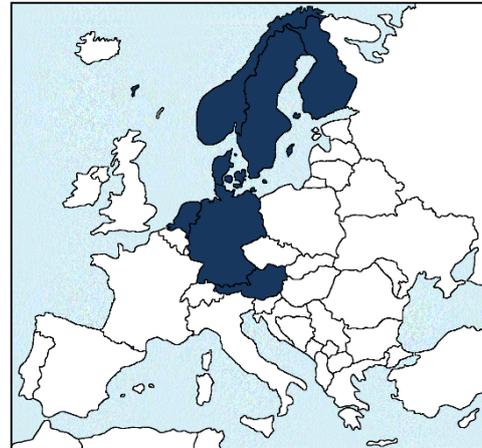
The next group of countries presents a number of interesting and innovative characteristics for rehabilitation/return to work. They have well-developed legal and/or institutional frameworks for rehabilitation and return to work, but coordination across the different steps of the return-to-work process, from medical rehabilitation to reintegration at the workplace, is limited. As a result, return-to-work considerations are generally only dealt with in a targeted manner at the end of the sickness absence, with limited provisions for early intervention. The level of development of integrated return-to-work systems is uneven across the countries, with some countries, such as the UK and France, making recent progress towards more comprehensive frameworks, while other countries, in particular Italy and Luxembourg, do not show signs of such evolution.

The third group is made up of countries with varied profiles but presenting a number of common characteristics that justify their inclusion in this group. Activities related to rehabilitation and return to work mostly focus on people with disabilities or, in certain cases, people who have suffered from an occupational accident or disease. These countries have a less developed framework for rehabilitation and return to work, with a general lack of coordination to ensure the return to work of workers from sickness absence. However, they do have relevant institutional approaches to rehabilitation or, as a minimum, an initiative from non-institutional organisations presenting interesting features. They demonstrate signs of a developing discussion related to the need to deal with sickness absence and return to work.

Finally, the last group, coloured lightest (light blue), consists of those countries that have a limited framework for rehabilitation and return to work. Rehabilitation support (medical, vocational and social) exists for people with disability, aiming to promote their access to the labour market, although disability policy is more compensation oriented than rehabilitation oriented. In addition, most of these countries have adopted rules for the employer to adapt the workplace to the needs of people with reduced work capacity, which means that efforts for the reintegration of workers coming back from sickness absence with a reduced working capacity are employer driven.

3.2 Comprehensive approach to rehabilitation and return to work in the context of an ageing workforce

Seven countries in Europe can be considered to have a comprehensive framework for prevention and rehabilitation, targeting all workers and valuing early intervention and individualised approaches. These are **Austria, Denmark, Finland, Germany, the Netherlands, Norway and Sweden**.



Among the main characteristics of these countries is the inclusiveness of their rehabilitation system. All workers are entitled to rehabilitation, both medical and vocational, whatever the cause of their health problem and without any requirement to be recognised as disabled.

The rehabilitation of workers is generally supported by a comprehensive policy framework aiming to maintain work ability or prevent exclusion from the labour market. This policy framework for prevention promotes a holistic approach to rehabilitation rather than an approach centred on workers with disability or occupational diseases and accidents. This approach aims to intervene sufficiently early to avoid long-term or repeated absence from work and permanent work incapacity. It is based on the concept of work ability and well-being at work in **Finland**, the prevention of exclusion from the labour market in **Denmark**, the concept of sustainable employability in the **Netherlands** or the need to ensure the sustainability of social security systems in **Germany, Sweden and Austria**. These policy frameworks usually cover the different policy areas that are relevant for the implementation of rehabilitation/return-to-work systems, such as employment, OSH, public health and social welfare.

Approach to disability

In general, these countries have in general a positive and work-oriented approach to disability, focusing on an individual's remaining capacities and the adaptation of the workplace. This approach reflects the recommendations made by international organisations, such as the WHO (2011) or the European Network for Workplace Health Promotion (ENWHP, 2011). The assessment carried out before starting a rehabilitation and return-to-work programme usually evaluates a worker's degree of incapacity or invalidity. But it also aims to determine the degree of the person's remaining capacity, taking into account the person's occupational profile and socio-economic situation in addition to examining their physical and mental functional abilities. This is in line with the biopsychosocial model used by the WHO to classify the determinants of health, functioning, disability and health.

In the **Netherlands**, the Occupational Disability Act of 2005 shifted the focus from an assessment of workers' disabilities to an assessment of their remaining capabilities. The assessment can help determine if work adaptations or vocational rehabilitation services are needed in order to reintegrate the worker quickly. The focus on 'remaining work abilities/capabilities' rather than on disability or invalidity gives a more positive outlook to the procedure. The earlier this assessment is carried out, the more likely it is that the person will return to work, either at their previous work or at another job. Early intervention is therefore a key factor common to the seven countries forming this group.

Prevention and early intervention

Intervention as early as possible is one of the main recommendations for successful return-to-work systems from international organisations, such as the OECD (2010) and ISSA (2013). Early interventions aim to bring employees back to work even before they have made a full medical recovery, when medically appropriate to do so, in recognition of the value of work for a person's recovery process.

In this group of countries, return to work is planned at an early stage, from four weeks to three months after the beginning of the sickness absence. In **Denmark**, the employer must arrange a discussion

with the worker on their return to work within four weeks of the worker's first sick day, while rehabilitation starts after eight weeks of sickness absence. In **Norway** and **Sweden**, a follow-up plan is drawn up by the employer after four weeks of sickness absence; in **Germany** after six weeks; in the **Netherlands** after a maximum of eight weeks; and in **Finland** after 90 days. An interesting feature of the system in Finland is that these 90 days can be either continuous or over a period of two years, which would cover workers suffering from 'lighter' but chronic health problems. In **Austria**, the 'fit2work' services have the potential for early intervention but require an action from the worker and/or the employer to be activated. As a result of the early intervention of the employer and rehabilitation services, medical and vocational rehabilitation are usually arranged together.

In addition, OSH policies in these countries have, for decades, been aiming to strengthen prevention and avoid the occurrence of work-related health problems. More recently, OSH policies have also emphasised the need to enhance health at the workplace, for instance through workplace health promotion programmes or regular health screening, in order to prevent the occurrence of health problems, whether work-related or not. The 'fit2work' programme in **Austria** has a strong prevention component, as it offers employers the opportunity to make an assessment of the health status of their workforce if they suspect that health problems are common or likely among their employees. In **Finland**, the Social Insurance Institution (KELA) has a programme called 'vocationally oriented medical rehabilitation', which intervenes in workplaces where workers are subjected to considerable physical, mental or social strain that can lead to health problems and a deterioration of work capacity or capability.

Employer responsibility

In most of these countries, the employer has a broad responsibility in the return-to-work process including the responsibility to investigate sickness absences. Usually, the employer is supported by internal OHS and human resources (HR) departments in this task.

The procedure typically starts with a meeting/visit organised between the sick worker and whoever at the workplace is in charge of the reintegration process, namely the employer or the OHSs/occupational physician. As mentioned before, the question of the timing of this meeting is a key factor regarding how early in the sickness absence the worker receives support for their reintegration. The objective of this first contact is typically to assess the work capacity of the sick/injured worker, how best to support the worker to promote their return to work in conditions adapted to their health and abilities, and to decide upon the steps to be taken before their return to work. As a follow-up to this meeting, most of the seven countries require employers to draw up individual action plans (variously known as 'reintegration action plan', 'retention plan' or 'follow-up plan'), where decisions made during the meeting regarding adaptations and potential needs for rehabilitation are recorded. The fully individualised plan can also contain objectives for the worker, for example in terms of rehabilitative steps to be taken to aid recovery.

In **Denmark**, **Norway** and **Sweden**, the coordinating body in charge of rehabilitation/return to work — that is, the municipality in Denmark, the Norwegian Labour and Welfare Administration (NAV) and the Social Insurance Agency in Sweden (see below) — will request the worker's reintegration plan before starting any vocational rehabilitation. This has three main benefits: (1) it ensures that any external vocational rehabilitation support provided is adapted to the worker's future work tasks; (2) it ensures that the worker will have the necessary support and adaptations upon their return to work; and (3) it is a way of engaging the employer in the worker's return-to-work process before the worker actually comes back. In the **Netherlands** and **Germany**, the plan is not required by any coordinating authority but is part of the employer's legal obligations with regard to the reintegration of the worker. In **Finland**, adaptation measures are defined by the employer with the help of occupational services but do not require a formal plan, although it is likely that the outcomes of the meeting with the worker will be recorded. **Austria** is the only country out of the seven where the employer does not have such obligations.

The measures that can be implemented at the workplace to favour the reintegration of sick/injured workers vary widely. They can relate to:

- the working environment, for instance by adapting workstations or providing new technical equipment to help the worker in their tasks;
- the working time, for instance by allowing the worker to come back part-time for a while, or adapting working hours to their treatment needs;
- the worker's career, for instance providing training for professional reconversion within the company to avoid tasks that are not adapted to their abilities.

Compared with other countries, adaptation measures are defined earlier in the process, sometimes while medical treatment is still taking place, and the link with the workplace is maintained during the sickness absence.

In these countries, there has been a shift in recent years towards increasing the level of responsibility of the employer in the return-to-work process. Employers are full participants in the return-to-work process from the start and are part of the decision-making process. This helps to ensure that they do not regard the reintegration process as a burden, for which they would need compensation and incentives, but as an opportunity to recover their worker and their skills, competences and experience. The guidance and technical support they need — in particular in small and micro enterprises with limited experience in rehabilitation measures or with no OHS or HR departments — is (theoretically) provided to them throughout the process through coordination with the external body or bodies in charge of vocational rehabilitation. In **Sweden**, for instance, the drawing up of the reintegration plan is done by the employer in coordination with the Social Insurance Agency.

External support

In most of the countries in the group, employers can receive technical support to define adaptation measures beyond the support they receive from their internal OHS/HR departments. Such technical support can include the provision of guidance documents for the reintegration of a person with a specific health problem; the support from consultants to make an ergonomic assessment prior to the return to work of the person with reduced work capacity; and the provision of a personal helper to support the person at work with a disability. In the **Netherlands**, private enterprises or 're-integration bureaus', specialised in assisting reintegration, can provide advice and coaching to employers on how to develop and implement a reintegration plan. In **Austria**, the innovative 'fit2work' services, which can be requested by an individual worker or by a company, support workers whose jobs are threatened because of health problems, helping them to reintegrate back into their workplace or the labour market. In **Finland**, KELA administers a 'work ability helpdesk', which can be used by workers but also companies' OHS departments to receive advice on a range of issues to ensure the rapid return to work of an individual.

Employers also receive financial support to adapt the workplace for workers returning to work or can benefit from financial incentives to maintain in employment people with reduced working capacity. In the **Netherlands**, employers can benefit, over a five-year period, from a 'no-risk insurance' policy (*noriskpolis*) from the Employee Insurance Agency for employees on health or disability benefits. During that time, if the person gets sick, the Agency, rather than the employer, will pay for sickness benefits. In addition, the Employee Insurance Agency provides subsidies for necessary workplace adjustments related to the reintegration of sick employees or employees with disabilities. In **Finland**, KELA can financially support the acquisition of the necessary equipment for the worker to return to work. In **Sweden**, although the employer pays for rehabilitation, the Social Insurance Agency can provide financial support for work aid or workplace adaptations. In **Germany**, the German statutory accident insurance (DGUV) grants financial support to employers for the return to work of employees, including a three-month employment trial which allows the employer to assess the work ability and capacity of the worker and their adaptation needs. Finally, **Denmark** has put in place an interesting incentive to encourage employers to hire people at risk of regular health-related absences from work, in particular people with chronic conditions. As per the Act on Benefits in the Event of Illness or Childbirth (paragraph 56), the employer hiring a worker with an increased risk of absence can be reimbursed for the first 21 days of sickness absence every time the worker is off work because of their condition.

Incentives for workers

In order to encourage the swift return to work of sick or injured workers, a number of countries have also put in place incentives to encourage the worker to go back to work early, in particular flexible working arrangements, such as part-time work. In **Denmark**, the municipality can grant part-time sickness benefits⁷ if the worker is able to work some days a week during their recovery period. Similar schemes exist in **Finland**, **Norway** and **Sweden**, where sickness benefit insurers — KELA, NAV and the Social Insurance Agency — provide part-time sickness benefits during a definite period to help the worker get back to work. Some countries are proposing flexible work arrangements for workers with reduced working capacities. For example, Danish municipalities provide adapted ‘flexible jobs’ (*fleksjobs*) to workers whose working capacities have been significantly reduced by an accident or a disease. Workers in these jobs benefit from reduced working hours and/or reduced work speed.

Finally, in **Denmark**, **Germany**, **Norway** and **Finland**, the possibility exists for workers to work part-time while still receiving disability benefits⁸. This allows the worker to view disability benefits as a temporary form of income support while continuing to undergo rehabilitation to either recuperate their work capacity or find appropriate work arrangements that allow a return to full-time work. The allocation of disability benefits is no longer seen as a permanent state of dependency on benefits but potentially a transition to a different form of employment. Two countries have adopted an even more innovative approach. **Austria** has recently reformed its disability benefit system and people under the age of 50 are no longer eligible for disability benefits but receive financial support for rehabilitation. Similarly, in **Sweden**, disability benefits no longer exist but people with a permanent reduction in work capacity can receive sickness compensation benefits, re-evaluated every three years, after all rehabilitation options have been exhausted.

Coordination of stakeholders

A high level of coordination of stakeholders can support workers and employers in the return-to-work process. This group of countries has achieved this by setting in place clear definitions of the responsibilities of the different actors involved in the process, as recommended by the ISSA (2013). With the exception of the **Netherlands**, all of these countries have one or several coordinating bodies supporting the process. These bodies can be state social security institutions, for example the NAV in **Norway**, the Social Insurance Agency in **Sweden** and KELA in **Finland**. They can also be insurance and pension organisations, for example the Austrian Social Insurance for Occupational Risks (AUVA) in **Austria** for occupational diseases and accidents, and the statutory accident insurance (DGUV) and statutory pension insurance (DRV) schemes in **Germany**, or they can be local authorities, for example municipalities in **Denmark**. They coordinate by making the link between medical, vocational and social rehabilitation (when needed), and the actual return to work. These organisations act as a ‘one-stop-shop’ for workers, who may otherwise get lost in the diversity of steps, actors and services provided and lose precious time before obtaining the service they need to return to work.

Firstly, coordination may be needed during the *medical rehabilitation* process. Medical rehabilitation may range from consultations with a general practitioner (GP) and a few specialists, for example physiotherapists, psychiatrists, to more complex medical rehabilitation requiring the worker to enter a (public or private) specialised rehabilitation centre. In some cases, the coordinating institution provides occupationally oriented medical rehabilitation or at least ensures that work is considered a treatment outcome in the medical rehabilitation process. In **Germany**, the statutory pension insurance scheme (DRV) has set up a programme called ‘medical-occupational oriented rehabilitation’, which tailors medical rehabilitation to the worker’s work-related needs. Therapy in this case not only focuses on the physical or mental illness but also considers the worker’s occupation and provides advice on how to deal with the illness at the workplace. In the **Netherlands**, the Society of Occupational Medicine (NVAB) has produced multidisciplinary clinical guidelines for the integration of work-related aspects in the medical rehabilitation process (VGI et al., 2010).

⁷ Sickness benefits (or sickness allowance) are daily/weekly/monthly cash or in-kind benefits provided to a person who is absent from work because of health-related issues for a certain period of time (usually decided in national legislation).

⁸ Disability benefits are daily/weekly/monthly cash or in-kind benefits provided to a person who has a disability or a long-term/chronic illness (depending on the scope of the national system).

Secondly, coordination is important for supporting the *vocational rehabilitation* of the sick or injured worker. The type of vocational rehabilitation provided depends on the health problem, the degree of work incapacity and the occupational profile of the worker involved. Before providing vocational rehabilitation and following medical treatment, the coordinating body will most likely assess remaining work capacities in order to identify the most appropriate rehabilitation and return-to-work options. Vocational rehabilitation may consist only of providing advice on possible workplace adaptation, but it can also involve courses on adaptation to new levels of workability, that is, learning to do the same job with different physical or mental abilities, or training to acquire new skills and start a new occupation.

The coordinating institution can itself offer the services or it can coordinate with external service providers for vocational rehabilitation. KELA in **Finland** provides a number of occupational rehabilitation courses adapted to different illnesses and impairments, while the AUVA in **Austria** coordinates with the Public Employment Service (AMS) to provide re-training and advice for workplace reintegration. In **Denmark**, municipalities coordinate with external private providers of vocational training. Another vocational rehabilitation measure that these countries have in common is called 'work training'. It is offered, for instance, by the **Swedish** Social Insurance Agency or KELA in **Finland**. Work training consists of getting the sick or injured worker to test their work capability in an actual working environment in order to determine what they can do, what they cannot do and what they could possibly do with additional rehabilitation measures or workplace adaptations. This training is a way of testing the rehabilitation programme put in place with the coordinating institution. It can be carried out at the worker's previous workplace, if the employer agrees, or in a different work setting, or, in some cases, in specialised work clinics and rehabilitation units.

Thirdly, the coordinating body can also support the actual *return-to-work process* and coordinate with the workplace. The municipality in **Denmark** and the Social Insurance Agency in **Sweden** coordinate with the employer for the work ability assessment and the implementation of rehabilitation and/or workplace adaptation measures to facilitate the worker's return to work. In **Norway**, the NAV requires the employer to report on the activities undertaken at the workplace, including the follow-up plan. The NAV will start rehabilitation measures only after receiving the follow-up plan containing evidence that measures taken to enable the worker to return to work have failed and that they need to be complemented with other measures to help the worker's transition to another job. In **Austria**, the 'fit2work' case manager in charge of a worker's return to work coordinates the implementation of individualised rehabilitation measures — for instance, flexible working hours — with the employer. It is less evident in **Germany** and **Finland** how closely the bodies responsible for rehabilitation and returning to work coordinate with the employer.

Case-management and multidisciplinary approaches

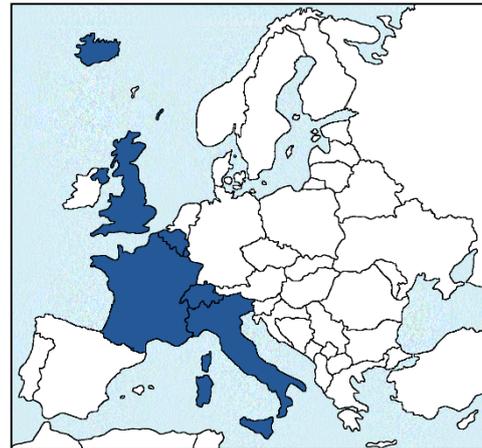
One of the characteristics of most of the return-to-work programmes implemented by these coordinating organisations is their individualised or 'case-management' approach. This approach reflects the WHO recommendation that rehabilitation services should be tailored to the individual's needs and avoid the 'one-size-fits-all' approach (WHO, 2011). At the start of the return-to-work process, the worker is allocated a coordinator or case manager who is then in charge of helping the worker to navigate the different services needed for successful return to work and ensuring that the services proposed to the worker correspond to their needs. The coordinator typically starts by making an assessment with the worker of their work capacity, taking into account the worker's social and professional history and environment in addition to their functional abilities. Based on the principles of the biopsychosocial theoretical model, this assessment is likely to be done with the help of a multidisciplinary team, including medical, physical and mental health doctors and therapists, but also social officers, vocational rehabilitation and employment specialists. Following this assessment, the coordinator is responsible for developing an action plan containing all the measures and steps to be taken for the successful reintegration of the worker, along with a clear timeline and milestones. The plan can also include recommendations for the workplace and action points for the employer and/or occupational physician.

In **Denmark**, return-to-work coordinators or 'social insurance officers' are social workers from the municipal job centres. In **Austria**, workers supported by the programme 'fit2work' are allocated a fit2work case manager who assists the worker personally in implementing their return-to-work plan. In

Finland, discussions have been launched by social partners on appointing a ‘work ability coordinator’ to workers with partial disability returning to work. The coordinator’s task would be to tailor an individual solution for the worker. In **Germany**, the regional branches of the German statutory pension insurance scheme (DRV) are increasingly taking up a case-management approach to rehabilitation, as demonstrated by the project ‘Integrationsprojekt RehaFuturReal®’ launched in 2011 by the Westphalian branch of the DRV.

3.3 Step-wise approach to rehabilitation and return to work

The countries belonging to this group have a well-developed framework for rehabilitation and return to work, but coordination across the different steps of the return-to-work process, from medical and vocational rehabilitation to reintegration at the workplace, is limited. As a result, return-to-work considerations are generally dealt with only at the end of the sickness absence, with limited room for early intervention. **Belgium, France, Iceland, Italy, Luxembourg, Switzerland** and the **UK** are in this group.



In the **UK**, the new ‘Fit for Work’ service opened in December 2014, based on the recommendations from the Black and Frost review of sickness absence. It is part of the initiative ‘Health, Work and Well-being’ of the British government. This new system aims to organise the return-to-work process of sick or injured workers through the development of a ‘return-to-work plan’ after a month of sickness absence. This system, based on a case-management and multidisciplinary approach, should lead the UK to a more comprehensive rehabilitation/return-to-work system than it has had previously.

Both **Iceland** and **Switzerland** have advanced return-to-work programmes in place. In Iceland, the system coordinated by the Vocational Rehabilitation Fund (VIRK) is based on a case-management approach and the establishment of an individualised rehabilitation plan. In Switzerland, the services offered by the Swiss Accident Insurance Agency (SUVA) for the reduction of sickness absence and those offered by Invalidity Insurance (IV) for the return to work of people with disability mean that the issue of the return to work of people suffering from health problems is increasingly being addressed. However, the return-to-work systems in Iceland and Switzerland are not fully comprehensive in that the employer is not obliged to reintegrate the sick or injured workers.

Scope of the systems

In all seven countries of these countries, all workers are theoretically entitled to rehabilitation and to go through the return-to-work process, regardless of the cause of their health problem, without being recognised as disabled. However, some of the financial and technical benefits to employers are only available to workers having the status of disabled workers and some initiatives or programmes are only offered to victims of occupational accidents or workers affected by a specific disease. In **France**, for instance, the National Sickness Insurance Fund for Employees has recently started a new pilot programme to establish a case-management system to deal with the return to work of victims of serious occupational accidents (see below). While the approach proposed by the French institution can be considered innovative, it is for the moment restricted in its scope.

Reinstatement procedures at the workplace

France, Luxembourg and **Italy** are characterised by a strong involvement of an occupational physician, who has a legally defined role in the return-to-work process, and stricter obligations of the employer towards workplace adaptations. The return-to-work process is essentially managed in these countries by the employer and the occupational physician, unless the worker needs to be re-employed outside his/her former company, in which case the national employment agency may take over the re-

employment procedure. In **Belgium**, the occupational physician is involved only after the worker returns to the workplace. Before the worker's return, the occupational physician is not allowed, by law, to get in touch with the worker, except to establish if the condition causing the absence could be work related.

Return to work is structured around the work ability assessment, undertaken at a reinstatement visit with the occupational physician. This visit is compulsory after an absence from work of at least 30 days (or four weeks) in **France** and **Belgium**, of six weeks in **Luxembourg** and of 60 days in **Italy**. The reinstatement visit is performed at the end of the sickness absence, prior to return to work. It is crucial in the return-to-work process, as the occupational physician decides, or provides a reasoned opinion on, whether the worker can perform their former tasks, potentially with some adaptations, or needs to be re-employed in a more suitable position. In **France**, **Belgium** and **Italy**, the occupational physician decides whether the worker is fit or unfit to take up their former tasks; in **Luxembourg**, the occupational physician does not take the final decision but issues a reasoned opinion to the Joint Commission of Social Security, which then decides whether or not to start a reclassification procedure.

In these four countries, the occupational physician provides direct support to the employer for any necessary adaptations of the workplace, of tasks and of the work schedule. The occupational physician also advises the worker on how to manage their condition to remain at work. In **France**, a 'pre-reinstatement visit', that is, a visit with the occupational physician before the end of the sick leave, can be requested by the GP or the worker but is, in fact, underused. In **Luxembourg**, the Joint Commission of the Social Security coordinates this re-employment procedure.

Institutional actors involved in return to work

These countries do not have unique bodies coordinating the overall rehabilitation/return-to-work process, except for Iceland. However, there are active national institutions that have initiated vocational rehabilitation programmes or vocationally oriented medical rehabilitation programmes.

In **France**, the National Sickness Insurance Fund for Employees has recently put in place two programmes that are relevant for rehabilitation/return to work. The first, on prevention against professional exclusion (*prévention de la désinsertion professionnelle*), targets insured workers at risk of losing their job because of their health problems or reduced working capacity. It provides counselling to help workers understand their rights and what support they can get, through a case-management approach. The second programme (still in pilot phase) also uses case management but targets only those who have been victims of serious occupational accidents. It aims to return the worker to work through early intervention and coordination with the services needed by the worker. Both programmes propose individualised support to workers at an early stage — during their sickness absence — and link medical and vocational rehabilitation. In France, the prevention of professional exclusion has been included as an objective of the new Health at Work Plan (national OSH strategy) and, if implemented on a larger scale and given the appropriate resources, could lead France towards a comprehensive approach to return to work.

In **Italy**, the National Institute for Insurance against Accidents at Work proposes individual support to victims of occupational accidents, focused on medical and social rehabilitation. Support is provided by a multidisciplinary team including a medical director, a social assistant and an administrative officer. In **Belgium**, in 2005, the fund for compensation of occupational diseases launched a programme to promote the early return to work of people suffering from chronic lower back pain.

In the **UK**, the National Health Service (NHS) has also been paying attention to the issue of rehabilitation and return to work, although its activities, for instance the 'Healthy Working UK' initiative, target the role of GPs and other healthcare professionals, thus focusing on the medical aspects of the return-to-work process. The Health and Safety Executive (HSE), on the other hand, has addressed the issue from an OSH perspective, commissioning research to understand the problems faced by employers and their guidance and support needs. It has developed a number of tools and resources on workplace adaptations, available on its website.

In **Switzerland**, both Invalidity Insurance (IV) and the Swiss Accident Insurance Agency (SUVA) have put in place programmes to deal with return to work. IV in particular proposes a number of measures for vocational rehabilitation, such as career advice, re-training and job placements, to people who have

a recognised degree of disability or are at risk of becoming disabled. In **Iceland**, the Vocational Rehabilitation Fund (VIRK) is using a holistic, case-management approach to the return-to-work process, which also includes coordinating with employers for the reintegration of the worker following rehabilitation.

External technical and financial support

In all seven countries, technical support can be provided to the workers, the employers and/or the occupational physician. In **Belgium**, the National Institute for Sickness and Invalidity Insurance (RIZIV/INAMI) is setting up coordination platforms to bring together all stakeholders involved in the return-to-work process together, such as insurance companies, GPs, occupational physicians, employers and employees. It aims to raise the awareness of these groups of return-to-work issues. RIZIV/INAMI also proposes a number of supporting measures for workers who want to go back to work on a part-time basis or need professional reconversion. In **Switzerland**, SUVA provides a number of virtual and non-virtual training courses to employers on managing sickness absence and aims to analyse the situation of a company on the ground before defining an action plan, with measures, roles and responsibilities and the definition of success indicators.

In the **UK**, where OHSs are not always provided in companies, support to the employer on workplace management and adjustments in such cases is provided by the NHS. The 'Fit for Work' service should also provide further guidance to employers and workers for more complex cases. In some cases, this support is earmarked for people with disability and therefore requires that the worker is recognised as disabled for the employer to make use of these services. In **France**, a number of services exist to support the professional reintegration of workers with disability (SAMETH, Cap Emploi, Agefiph).

The countries belonging to this group offer limited financial support for incentivising employers to reintegrate workers on sickness absence. In **France** and **Italy**, financial support exists to adapt working conditions, but to qualify for these incentives requires that the employee is recognised as disabled. In **France**, for instance, the Agefiph — the Association managing the fund for the professional integration of disabled workers — provides funding for ergonomic studies performed by an external specialist prior to the return to work of the worker, with adaptation of the workstation to compensate for their disability, adaptation of the workplace and equipment, personal skill assessments and vocational training, as required.

In these countries, a number of legal measures provide incentives for the worker to return to work early, even while medical treatment is still ongoing. In **France**, **Belgium**, **Luxembourg** and **Italy**, on the recommendation of a doctor, a worker can return to work part-time during a recovery period while still receiving partial sickness benefit. This measure, called 'part-time for medical reasons', allows workers to temporarily work part-time to facilitate their return to work, while still receiving their full salary with the sickness insurance body compensating the partial salary paid by the employer.

Non-institutional actors

Non-institutional actors in this group of countries, such as OSH service providers, social partners, research centres or charities, are also active in the field of rehabilitation and return to work. Some of them have a specific focus on one health condition or disease, such as lower back pain and more generally MSDs, cancer or heart disease, while others have a broader focus on work incapacity and disability.

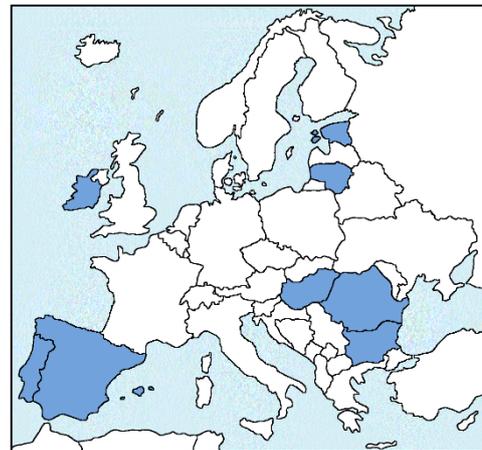
In **Belgium**, the Prevent Foundation has implemented a disability management programme, which supports companies in setting up an internal disability management policy. The programme focuses especially on implementing an individual case-management approach, combining early intervention, an interdisciplinary approach, workplace adaptation and accident prevention at the workplace. Also in **Belgium**, IDEWE, the largest OSH service provider in the country, has led a return-to-work programme that adapts the theoretical return-to-work model known as the Sherbrooke model to the Belgium context through focus groups gathering all stakeholders in the return-to-work process, including the sickness benefits insurers, HR managers of large companies, trade unions, OSH services and disability management experts.

In **Luxembourg**, the Centre for the Prevention of Back Problems ‘Prevendos’ provides training to workers with back problems to adapt to their level of work ability. In the **UK**, a wide range of non-institutional stakeholders, such as health charities and business organisations, provide guidance for patients and employers on sustainability in work and return-to-work issues. In particular, the Work Foundation, through its project ‘Fit for Work Europe’, has greatly contributed to the European-wide discussion on return to work, with a particular focus on people suffering from MSDs. In **France**, in April 2014, the League against Cancer published the third annual report of the Cancer Social Observatory, which presented the results of the Observatory’s research on returning to work after cancer, describing the obstacles faced by cancer patients and the lack of awareness of workplace actors, such as employers, OHSs or HR departments.

While these initiatives may have a relatively limited impact in terms of the number of people they help to reintegrate into the workplace, they contribute to raising the level of awareness in the country on the general question of rehabilitation and return to work. In **France**, for instance, the findings of the report on the return to work of cancer patients were discussed at length in many major French media. They also help to build evidence to support future policies on the matter.

3.4 Ad hoc approach to rehabilitation and return to work

Countries belonging to this group have a less-developed framework for rehabilitation and return to work. They have no coordinated approach and limited institutional support for the return to work of workers in sickness absence. They have, however, relevant ad hoc initiatives from institutional and non-institutional organisations. **Bulgaria, Estonia, Ireland, Spain, Lithuania, Hungary, Portugal** and **Romania** are in this group. Despite some common features, these countries have very different profiles.



Scope of the activities

In these countries, vocational rehabilitation services and support for the return-to-work process are available to people with disabilities and, in most cases, also to workers returning to work after an occupational accident or disease or workers suffering from a long-term/chronic condition or partial incapacity to work. In **Portugal**, for instance, financial support to return to work is provided for reintegrating workers after an occupational accident or disease, and the employer must adapt the working condition for workers with chronic illnesses. In **Estonia**, rehabilitation services offered by the Social Insurance Board — which includes the preparation of an individual rehabilitation plan with medical rehabilitation, psychological support and social workers’ services — can also apply to workers with long-term sickness or permanent health condition (chronic disease). In **Ireland**, financial support is available to employers to retain workers with impairment or illnesses. In **Lithuania** and **Hungary**, the provision of vocational rehabilitation is available only to workers with a work incapacity of at least 40 %.

Support to workers with reduced working capacity

Most of these countries provide external support mechanisms for the rehabilitation and return to work of workers with reduced working capacity.

In **Bulgaria, Spain, Lithuania** and **Hungary**, support is provided by a national agency, which undertakes an assessment of the worker’s ability to return to work after their medical treatment. The assessment aims to define the level of working capacity, evaluate the worker’s career opportunities and, on a case-by-case basis, recommend workplace adaptations or modifications of working conditions. In some of these countries, the focus of this assessment has gradually changed from looking at a worker’s loss of abilities to looking at their remaining capacities taking into account their qualifications, competences and skills, as per the recommendations of the WHO. In **Hungary**, a recent reform in 2012 introduced a shift from looking purely at health impairments to also paying attention to

remaining capacities and capabilities relevant to someone's employability. In **Estonia**, such a reform is upcoming and will include a performance evaluation, which will take into account a person's work and professional competences, as a basis for options on rehabilitation.

Following the assessment, the institution can provide recommendations regarding workplace adaptations or needs for reallocation to a different job in the company or to a different workplace altogether. Although formal coordination mechanisms between the institution and the employer do not seem to be in place, employers have an obligation to follow the recommendations drawn up by these bodies regarding workplace adaptations once a degree of work incapacity has been officially established. In addition, the institution is likely to make recommendations for vocational rehabilitation options in order to train the worker for a different occupation if the reduction in work capacity or capability means that the worker can no longer do the same job as before, even with adaptations. Typically, the institution will provide cash benefits to allow the worker to follow a rehabilitation programme provided by external providers (or by the national employment agency).

In **Lithuania**, for instance, within three days of receiving the conclusions from the assessment of work ability, the worker should apply to the local Labour Exchange for referral to appropriate vocational rehabilitation service providers, where an individual programme is developed. The services offered include assessments of the worker's workplace and needs for adaptations, as well as training and work trials. In **Portugal**, workers with a reduced working capacity because of an occupational disease or accident receive funding from the state to follow vocational rehabilitation programmes at the Institute of Employment and Professional Training.

Support to employers

In most of the eight countries belonging to this group, external financial support is provided to employers for the reintegration of workers with reduced capacity. In some cases, this form of support is earmarked for workers with a recognised degree of disability. In **Hungary**, a 2012 reform has introduced the Rehabilitation Card scheme, whereupon employers of people with reduced working capacity who have a card (and therefore follow a rehabilitation programme) receive tax benefits and wage compensation. In **Ireland**, the Department of Social Protection provides financial support to employers for training and workplace adaptations for workers with reduced working capacity. In **Portugal**, an employer can receive financial support to adapt the workplace to the needs of a worker returning to work after an occupational disease or accident. In **Spain**, employers can receive financial support from the National Institute of Social Security (INSS) to comply with their obligation of making adaptations in line with the needs of workers with disabilities.

Internal support

In Spain, Portugal and Romania, the employer can be supported in the reintegration process by the internal or external OHSs (or occupational physician). In **Romania**, the process is formalised in the law, as the occupational physician has the obligation to carry out a medical examination after an absence of at least 90 days to determine the worker's capabilities and whether workplace adjustments or reassignments are necessary. The employer must follow the recommendations of the occupational physician. In **Spain**, private providers offer multidisciplinary services, also called Employee Assistance Programmes, to employers and workers to assist in the process of reintegration following a period of incapacity. Providers of private insurance, to which employers in Spain have to subscribe to cover risks against occupational accidents and diseases, are increasingly proposing such programmes to employers to reduce the length of sickness absences.

3.5 Rehabilitation limited to people with disabilities

Countries in this group have a limited framework in place for rehabilitation and return to work. Rehabilitation support (medical, vocational and social) exists for people with disability, and aims to promote their access to the labour market. However, as assessed by the OECD, in many of these countries disability policies tend to be more oriented towards compensation than towards rehabilitation (OECD, 2010).

Return to work depends on the employer's willingness and motivation. Belonging to this category are the **Czech Republic, Greece, Croatia, Cyprus, Latvia, Malta, Poland, Slovenia and Slovakia.**



Reintegration at the workplace

The return-to-work system in these countries is entirely employer driven. The transition between sickness absence and return to work relies on the responsibility of the employers. These responsibilities are found mostly in disability and antidiscrimination legislation: employers are obliged to adapt the workplace to disabled workers, to implement measures to favour access to the labour market and to guarantee equal treatment irrespective of disability. In some countries, obligations for employers are laid down in the OSH legislation, stating that employers must adapt the work to the individual's capacities.

More specifically on the management of sickness absence and reintegration into the workplace, in the **Czech Republic** and **Croatia**, the employer must reassign the worker to a different position after a long-term sickness absence if it is considered necessary based on the assessment of their abilities (although in the Czech Republic this obligation is limited to workers who have suffered from an occupational accident or disease). In both **Greece** and **Malta**, although there are no legal obligations to do so, the occupational physician can support the worker coming back to work following a period of sickness absence with regard to their needs for adaptation or reassignment.

Concerning workers with disabilities, some countries have gone beyond the basic obligation of accommodating the workplace to the abilities of the worker. In **Slovenia**, for instance, employers are obliged by law to provide vocational rehabilitation to all employees who are employed in the company when their disability occurs (whether the disability is related to the work or not). Outside these obligations defined in the law, there is no legal or institutional support for workers to return to work.

Rehabilitation services for people with disability

In these nine countries, support mechanisms exist to help workers with disabilities find a job or to help employers retain in employment or hire persons with disabilities. In addition to services for medical rehabilitation, vocational rehabilitation, (including job counselling and training) is also available to workers with disabilities.

In some countries, the main social security body carries the responsibility of assessing a worker's loss of work capability and providing (or coordinating the provision of) rehabilitation services when the worker has a recognised degree of disability. In **Latvia**, the State Social Insurance Agency, based on the recommendations of the State medical commission for expert examination of health and working ability can, on a case-by-case basis, refer people with a reduced working capacity to the Employment Agency, which provides vocational rehabilitation services such as occupational assessments and job simulation tests, assistance in job placement, vocational training, etc. In **Slovakia**, the Social Insurance Agency provides guidance and advice for rehabilitation, but this is limited to medical rehabilitation.

In a few countries, vocational rehabilitation support is provided by employment agencies. In the **Czech Republic**, the Labour Office coordinates the provision of vocational rehabilitation services to people with disabilities, through the development of an individual plan assessing the person's situation and

his/her needs. In some cases, the Labour Office helps coordinate with the employer for work trials. In **Malta**, the Employment and Training Corporation offers programmes to maintain and enhance the employability of people with disabilities. In particular, the programme 'Enhancing employability through training' offers training courses to people who have been outside the labour market for a long time. Although mainly focused on unemployed people, it can also help people who have become inactive because of a health problem. In **Slovenia**, the Employment Service also provides vocational rehabilitation services to people with disabilities registered with the service.

In some countries, vocational rehabilitation for people with disabilities is proposed or coordinated by an organisation (institutional or non-institutional) that is specifically responsible for the reintegration of people with disabilities into the labour market. In **Cyprus**, the Centre for the Vocational Rehabilitation of the Disabled used to provide vocational training and job placement services for people with disability, but it closed in 2013. In **Poland**, the National Fund for the Rehabilitation of the Disabled, in cooperation with the Nofer Institute, has developed guidelines for the design and adaptation of premises and workstations to the specific needs of people with disabilities. In **Slovakia**, the institute for the vocational rehabilitation of people with disabilities in Bratislava ensures the vocational rehabilitation of people with disabilities. In **Slovenia**, the University Rehabilitation Institute is the main provider of vocational rehabilitation services. The services provided are multidisciplinary and coordinated. They are based on an assessment of the person's capacities and are fully individualised to fit the person's needs.

Financial support

Financial support and financial incentives to employers hiring workers with disabilities also exists in more than half of these countries. In **Cyprus**, between 2009 and 2014, an incentive scheme was implemented to encourage employers from the private sector and local authorities to hire people with disabilities. The scheme covered 75 % of the person's wage for 24 months along with additional compensation for adaptation costs. In **Croatia**, the fund for the professional rehabilitation and employment of disabled persons provides financial incentives for employers to hire people with disabilities, such as tax incentives and reduced contributions. In **Latvia**, employers who hire or re-hire individuals with a recognised degree of disability can benefit from tax incentives. In **Poland**, the National Fund for the Rehabilitation of the Disabled provides funding to employers who hire people with disabilities, to pay for wages and adaptations of their workstations. Finally, in **Slovakia**, the Social Insurance Agency offers rehabilitation and re-training cash benefits to people with disabilities.

3.6 Conclusions

This chapter has described four broad types of policy approaches and systems that European countries have put in place in relation to rehabilitation and return to work. The analysis of the national systems highlighted a great diversity of contexts, systems and stakeholders involved. The four categories that were established for the purpose of this report cannot reflect entirely this diversity. While boundaries between different categories are not always clear cut, broad components can be identified that concern either the system's development or its implementation, which allows for a general comparison across the groups of countries. These themes are further described below, and presented in Figure 2.

Figure 2: Four types of national profiles based on rehabilitation and return to work (RTW) and their key characteristics concerning system development and implementation

		Countries with rehabilitation limited to people with disability	Countries with ad hoc approach to rehabilitation/RTW	Countries with targeted approach to rehabilitation/RTW	Countries with a comprehensive system for RTW
SYSTEM DEVELOPMENT	Scope	People with a recognised disability	People with disability, victims of occupational diseases or accidents, people with chronic/long-term conditions	All workers for general reintegration procedures, limited target group for supported RTW programmes	Comprehensive and mature systems based on prevention of exclusion of workers with health problems from labour market, early intervention and maintenance of employability to ensure sustainability of social security systems
	Policy orientation	Focus on antidiscrimination and accommodation of the workplace for people with disabilities	Focus on antidiscrimination and some mention of maintenance of employability	Focus on maintenance of employability and prevention of exclusion	
SYSTEM IMPLEMENTATION	Coordination mechanisms	Employer driven (but limited awareness), no supporting institutional body	Institutional body for rehabilitation but no coordination with workplace Employers have some responsibilities for RTW	Institutional body for rehabilitation with limited coordination with workplace Formal reinstatement procedures for RTW	Combination of multidisciplinary approach supported by a high level of coordination across actors (institutional body, employers, insurance services, rehabilitation providers) and individualised approach focusing on the needs of the worker
	Programmes and initiatives	Vocational rehabilitation programmes for people with disability to promote their access to the labour market	Vocational rehabilitation programmes for people with disability, financial support to employers for reintegration	Numerous relevant programmes and activities to support RTW from institutional and non-institutional actors	

System development

In comparing the policy approaches followed within the four groups, two main trends emerge. On the one hand, many countries focus on antidiscrimination and equality in employment policies, specifically targeting people with disability. On the other hand, a number of countries consider the broader issue of sickness absence management and the prevention of exclusion from the labour market because of health issues, with a view to safeguarding the sustainability of social security systems in the context of an ageing population.

In countries with limited or ad hoc approaches, the rehabilitation/return-to-work system aims to reintegrate into the workplace people with disability or with reduced capacity and, in some cases, workers who have been victims of occupational accidents or diseases. In these countries, the system

focuses more on the promotion of access of people with disability to the labour market than the actual reintegration process following a long-term sickness absence that has led to disability. However, some of these countries have initiated a discussion on the need to deal with sickness absence and return to work.

In countries with step-wise or comprehensive approaches, return to work is dealt with from the more general perspective of ensuring the sustainability of social security systems, in particular taking into account demographic changes. The systems in place in these countries are holistic, meaning that they target all workers, although in most countries, specific programmes also exist to support people with a recognised disability. The systems in place are integrated, meaning that components from different areas relevant for rehabilitation and return to work — that is, employment, OSH, social security, public health and antidiscrimination — are brought together under a single framework with common objectives. They also aim to intervene early, with the general objective of avoiding a progression from sickness to disability and preventing exclusion from the labour market for health reasons. This is particularly true in Denmark, Germany, the Netherlands, Norway and Sweden.

System implementation

The implementation of rehabilitation/return-to-work systems is characterised by two aspects: the coordination mechanisms in place and the availability of programmes and activities to support the worker during their period of sickness absence and during the reintegration process.

Countries with limited or ad hoc approaches have a reintegration process following sickness absence that is mostly employer driven, meaning that the lack of legal and/or institutional support for the management of sickness absence is a driver for employers to put in place their own rules. However, in most countries, the awareness of employers, in particular in small and micro companies, of rehabilitation and return-to-work procedures is limited. Most of the countries in this category have put in place institutional coordination mechanisms for the assessment and recognition of disability or reduced working capacity. Some have also implemented programmes and activities to promote the reintegration of workers with disabilities at the workplace, such as vocational training, job placement and guidelines on workplace adaption.

In countries with step-wise or comprehensive approaches, the reintegration process after sickness absence is formalised and the roles and responsibilities of the various actors involved in the process are clearly established, either in the law or in a policy framework. While the employer always has a proactive and central role in the process, in most countries a coordinating body provides support to both workers and the employer to navigate through the complexities of the process. Coordination mechanisms across the different players are not systematically present. In the countries where they are present, the rehabilitation/return-to-work systems are often implemented through multidisciplinary and individualised approaches. Non-institutional actors (OSH service providers, social partners, research centres or charities) are generally active in implementing programmes and activities in the field of rehabilitation and return to work.

Factors influencing rehabilitation/return-to-work systems

This chapter has demonstrated the existence of a wide spectrum of national approaches, programmes and strategies that have been developed and implemented in Europe during the past decades for rehabilitation and return to work. However, a number of common elements are found across countries, in particular those which have started implementing comprehensive rehabilitation/return-to-work systems.

Similarities and differences across European countries in their approach to rehabilitation and return to work can also be explained by wider determinants and drivers, such as cultural aspects and national traditions, the economic situation, the legal framework and institutional frameworks, which influence national policy development and agenda setting. The following chapter will therefore study further how other factors have had an impact on the development of the rehabilitation/return-to-work frameworks of countries.

4 Determinants of a rehabilitation/return-to-work system

Chapter 3 reviewed the different profiles of rehabilitation and return-to-work systems across European countries. Chapter 4 looks at reasons for these differences and the determinants for implementation of a comprehensive system that helps sick or injured workers return to work as quickly as possible.

This analysis starts by looking at a number of trends related to demography, health, disability and return to work in order to provide an overview of the issue at European level and the differences across countries. It then focuses on what has been happening in relation to rehabilitation and return to work at the international and EU levels to examine whether or not the actions and recommendations of supranational organisations have had an influence on what countries are doing in this area. Finally, it looks at national determinants of a rehabilitation/return-to-work system, starting with national traditions in OSH and legal and policy frameworks, followed by the institutional frameworks for rehabilitation/return-to-work systems and the coordination mechanisms across stakeholders.

The analysis focuses on those aspects of rehabilitation/return-to-work systems that most relate to health and safety at work. However, a comprehensive overview also requires the investigation of aspects related to social security, employment and public health.

4.1 Age, health and disability in a work context

4.1.1 Ageing and health

European countries are confronted with significant and ongoing ageing of their workforce, driven by demographic trends and economic policies promoting longer working lives. This is increasingly a challenge in the workplace as older workers tend to report more work-related health problems and chronic diseases (Eurostat, 2015b). Ageing challenges health at work in general — how to keep older workers at work and prevent loss of capacities — and the return to work of such workers after illness or injury.

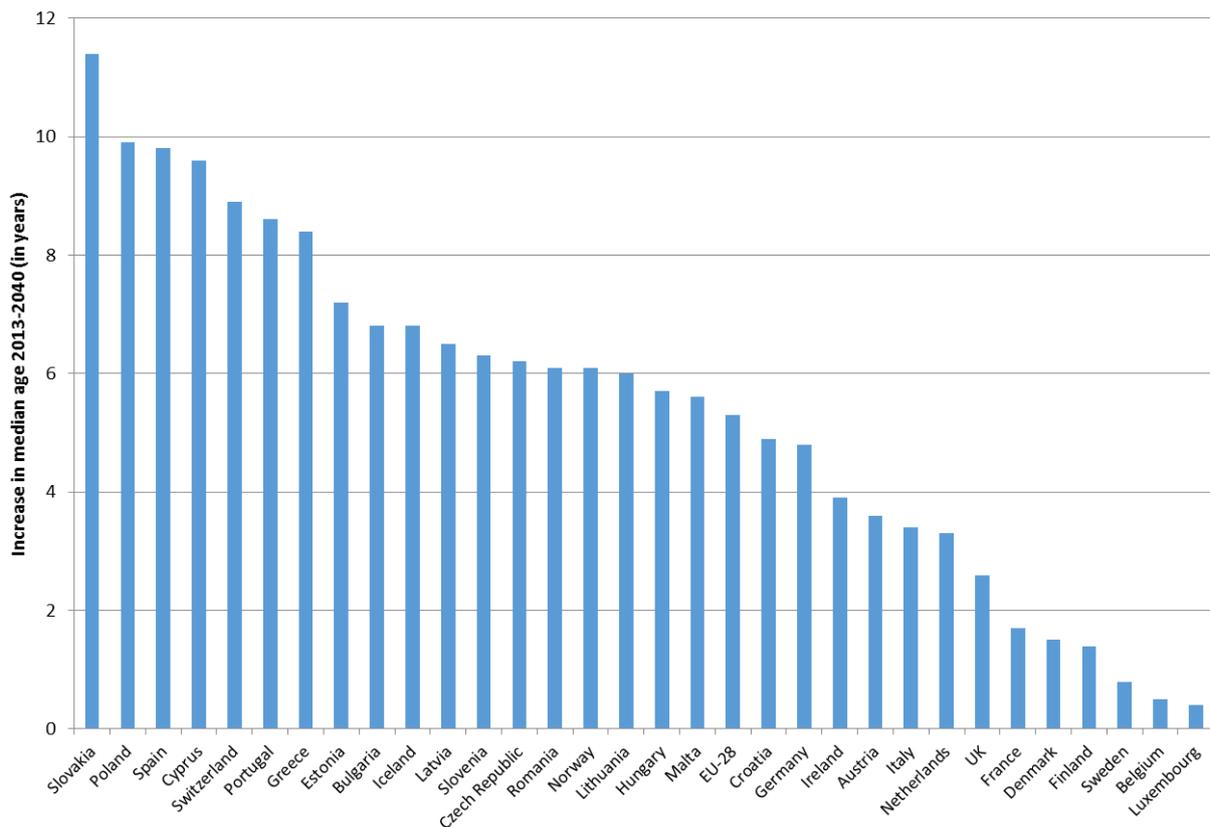
Population ageing in Europe

The European population (referring here to the population in the EU and EFTA countries) has been ageing significantly during the past decades owing to rising life expectancy and declining birth rates. Life expectancy has increased since 1960 in all EU Member States and EFTA countries, especially for women. Between 2002 and 2013, life expectancy in the EU-28 has increased by 2.9 years, from 77.7 to 80.6 years (Eurostat, 2015a). This trend is projected to continue and intensify. According to Eurostat estimates, life expectancy at the age of 65 in the EU-28 is expected to increase further until 2040 by around three years for both men and women (Eurostat, 2014d).

Consequently, by 2040, median ages will increase in the EU Member States and EFTA countries and the gap between countries with the highest and lowest median age will increase (Figure 3)⁹ (Eurostat 2014b, 2015e).

⁹ In 2013, two-thirds of the Member States had median ages ranging from 39 to 43 years (a range of four years) while, in 2040, two-thirds of the Member States will have a median age ranging from 43 to 50 years (a range of seven years).

Figure 3: Increase of the median age between 2013 and 2040, EU-28 and EFTA countries



Source: Eurostat, 'Population: Structure indicators [demo_pjanind]', 21 October 2015, for 2013 data; and Eurostat, 'Main scenario — Projected demographic balances and indicators [proj_13ndbims]', 8 December 2014, for 2040 data.

Looking more specifically at the ratio of the working-age population (those aged 15–64 years) to the people aged 65 and above (who are not employed) — called the old-age dependency ratio (OADR) — a significant increase can also be observed between 2013 and 2040 (Eurostat 2014b, 2015e).

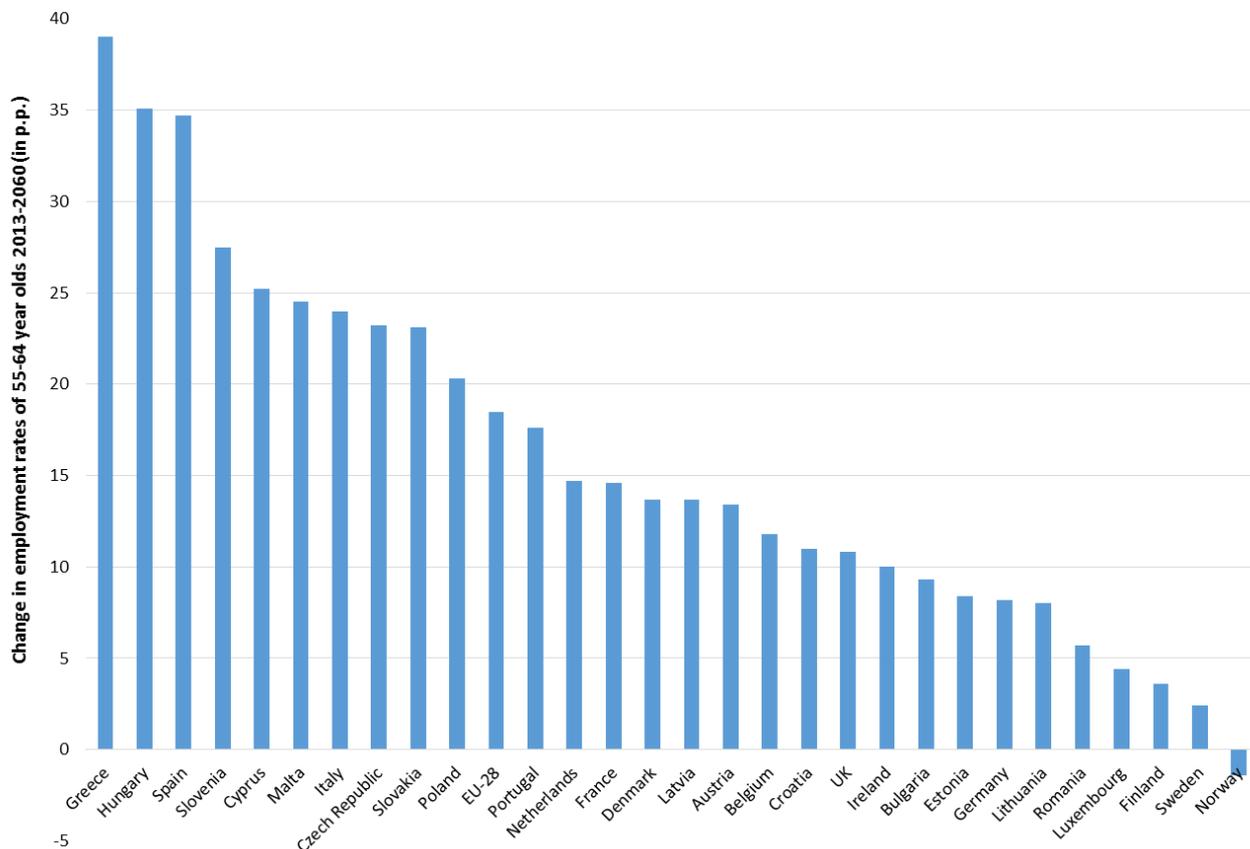
In **Estonia, Greece, Spain, Latvia, Lithuania, Poland, Portugal, Slovenia** and **Slovakia**, both the median age and the OADR are expected to increase more than the EU-28 average until 2040. This means that not only will the populations in these countries age faster than average, but also that the proportion of over 65-year-olds is expected to increase significantly.

Ageing of the workforce

The ageing of the overall population in Europe is resulting in parallel ageing of the workforce. In the 28 EU Member States, the proportion of the 55- to 64-year-olds in the total working-age population (15–64 years) increased greatly between 2000 and 2015 (from 16 % to 20 %) and will continue to increase to 21 % in 2020 (Fotakis and Peschner, 2015).

To tackle these demographic changes, countries are implementing policies encouraging the employment of workers over 55, providing incentives to workers to stay longer in employment, and reducing access to early retirement. As a result, the employment rate of older workers, currently low in some EU Member States, will increase in all countries (Figure 4). According to projections by the European Commission, across the EU-28, the employment rate of older persons will increase from 50.2 % in 2013 to 67.1 % in 2060. The strongest increase will be in **Greece, Hungary, Spain, Slovenia, Cyprus, Malta, Italy, the Czech Republic** and **Slovakia** (EC, 2014).

Figure 4: Changes in employment rates among 55- to 64-year-olds in European countries between 2013 and 2060



Source: Commission Services, EPC, in: 'The 2015 Ageing Report. Underlying Assumptions and Projection Methodologies', European Economy 8/2014, p. 66, for 2060 data (Data for Switzerland and Iceland missing); Eurostat, Employment rates by sex, age and nationality (%) [lfsa_ergan], 9 January 2015 for 2013 data.

Current pension reforms are tending to increase the retirement age to 65–67 in many EU Member States. However, in the EU in 2013, men aged 50 could, on average, expect to live only an additional 17.5 years without severe or moderate health problems and, for women, this figure was 17.8 years. 'Healthy life years' expectancy is not improving as fast as the European population is ageing. In fact, on average, 'healthy life years' expectancy has remained stable for men in the EU between 2010 and 2013, and has slightly decreased for women (Eurostat, 2015a). The number of older workers with health conditions is therefore likely to increase with increasing retirement age, jeopardising older workers' participation in the labour market.

4.1.2 Prevalence of chronic diseases and work-related health problems

Age is not an indication of capability and does not determine a worker's ability to do a job. However, age is an important factor in the occurrence of chronic health problems. Various chronic diseases such as cardiovascular diseases, cancers, chronic obstructive pulmonary disease, diabetes and depression are highly prevalent within an ageing workforce, and becoming more so (Varekamp and van Dijk, 2010). The number of older employees (over 55) reporting a long-standing illness is greater than in other age groups (Eurostat, 2015b). Similarly, cancer incidence increases with age for all types of cancer. Around 42 % of cancers are diagnosed in individuals between the ages of 50 and 70 (IARC, 2016).

In addition, ageing often goes hand in hand with an increased risk of developing disorders that can lead to functional limitations and disability at work. In particular, because of decreased functional capacity, older workers are more prone than younger ones to work-related MSDs, especially lower back pain (Okunribido et al., 2011). However, age is not an independent risk factor for MSDs. Adverse working conditions (repetitive work, time constraints, painful positions, heavy loads, etc.) have a great

impact on the incidence of MSDs.

Because the workforce in Europe is ageing, the risk of developing health problems while being at work is also increasing.

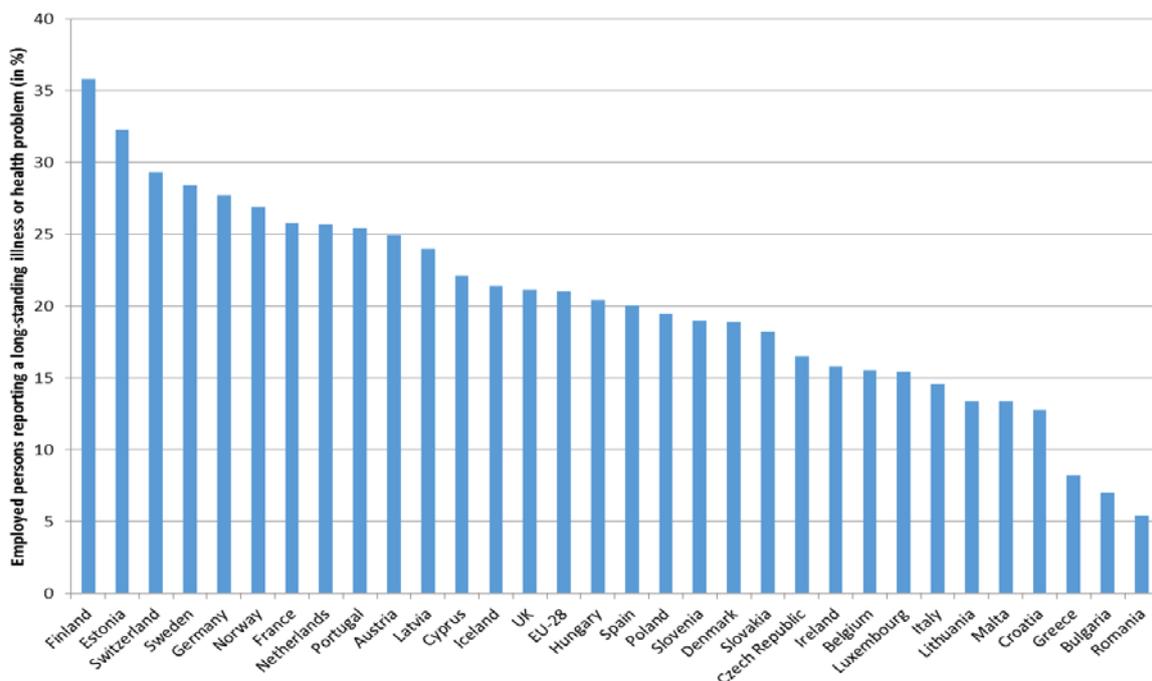
Long-standing illnesses and chronic diseases

Eurostat defines a long-standing health problem as ‘a health condition or disease which has lasted or is likely to last for at least 6 months. The main characteristics of a long-standing condition or disease are that it is permanent and may be expected to require a long period of supervision, observation or care’ (Eurostat, 2011a). According to the EU Statistics on Income and Living Conditions (EU SILC), in 2013, 32.5 % of the total EU-28 population reported having a long-standing illness or health problem (Eurostat, 2015b). Although figures stay relatively stable over the years, there is a slight increase of reported long-standing illnesses in the EU-28 population from 31.4 % in 2010 to 32.5 % in 2013.

Data show large differences between countries in terms of health perception. The highest reported incidences can be found in **Finland** (47.5 %), **Estonia** (44 %), **Portugal** (40 %), **Latvia** (40 %) and **Germany** (38 %), while in **Romania** and **Bulgaria** less than 20 % of the population reports long-standing health problems (Eurostat, 2015b). Whether or not people report health problems is influenced by their behaviour and awareness towards illness, as well as their social and cultural background. This can partly explain these differences.

In 2013, as shown in Figure 5, a significant proportion of employed people in the EU-28 (21 %) reported having a long-standing illness or health problem, although it was lower than the proportion of unemployed persons (27.8 %) and much lower than the proportion of retired people (58.6 %). This figure is higher than that of 19.6 % reported in 2010. The highest reported incidences were found in **Finland, Estonia, Switzerland, Sweden, Germany, Norway, France** and the **Netherlands**, all significantly above the EU average. The lowest reported incidences were found in **Romania, Bulgaria, Greece, Croatia** and **Malta** (Eurostat, 2015b).

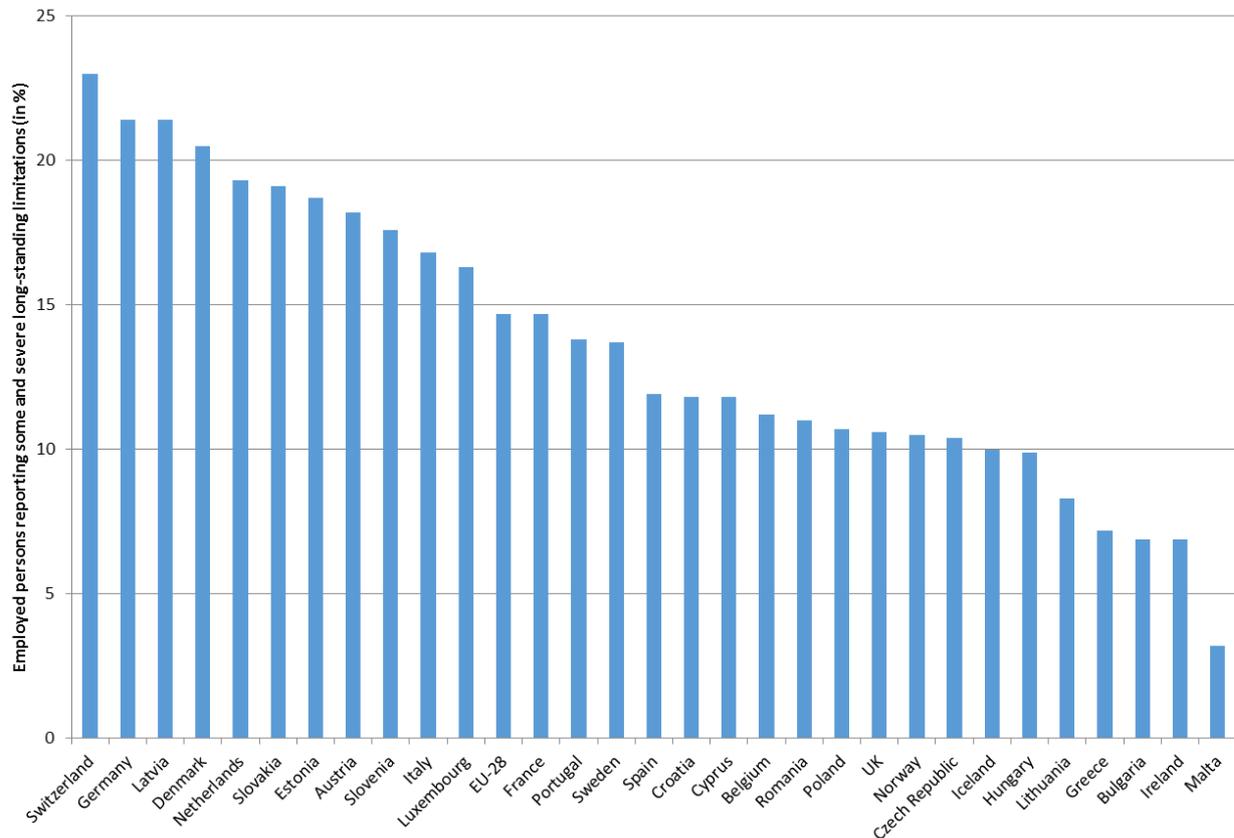
Figure 5: Employed persons reporting a long-standing illness or health problem in 2013, EU-28 and EFTA countries



Source: Eurostat, EU SILC, ‘People having a long-standing illness or health problem, by sex, age and labour status (%) [hlth_silc_04]’, 23 March 2015.

In addition, as illustrated in Figure 6, 14.7 % of employed people in the EU reported some severe long-standing limitations in their usual activities because of a health problem (Eurostat, 2015f).

Figure 6: Employed persons reporting some long-standing limitation and severe long-standing limitations in usual activities due to health problems in 2013, EU-28 and EFTA countries



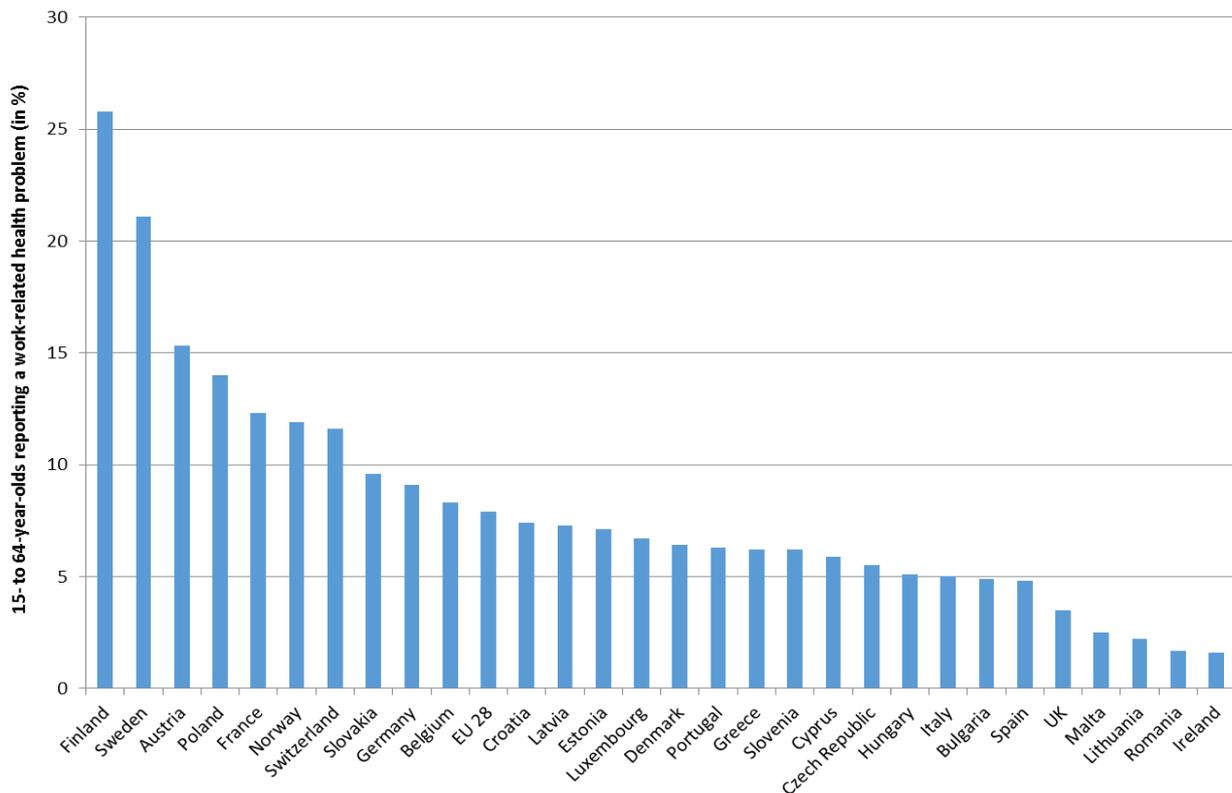
Source: Eurostat, EU SILC, 'Self-perceived long-standing limitations in usual activities due to health problem by sex, age and labour status [hlth_silc_06]', 8 May 2015. Data for Finland are missing for 2013. In 2012, however, Finland had the highest rate of self-perceived long-standing limitations in the EU (24.3 %).

Work-related health problems

The 2013 Labour Force Survey (LFS) estimated that 7.9 % of all workers of the EU-27 aged between 15 and 64 suffered from one or several work-related health problems during the past 12 months (compared with 8.1 %¹⁰ in 2007). This varies greatly across countries: **Finland, Sweden, Austria, Poland** and **France** are the countries where most workers have reported work-related health problems in 2013, while **Ireland, Romania, Lithuania, Malta** and the **UK** are the countries where the fewest workers have reported work-related health problems (Figure 7) (Eurostat, 2015g).

¹⁰ Figure for 26 countries: EU-27, not including France because of unreliable data from this country.

Figure 7: Persons aged 15–64 years reporting a work-related health problem in 2013, EU-28 and EFTA countries



Source: Eurostat, LFS ad hoc modules 2013, 'Persons reporting a work-related health problem by sex, age and educational attainment [hsw_pb1]', 18 November 2015. Data for 2013 are not available for the Netherlands and Iceland.

In most of the countries, the proportion of workers of all age groups reporting work-related problems decreased from 2007 to 2013, particularly in **Denmark** and **Poland**. However, it has increased since 2007 in 10 countries (Eurostat, 2015g). Work-related health problems are more prevalent in older age groups. On average, the proportion of older workers (>55) reporting a work-related health problem is higher than the proportion of younger workers (35- to 54-year-olds), with an average at EU level of 11.3 % in 2013 (Eurostat, 2015g).

In all EU and EFTA countries in 2013, the most prevalent work-related health problems among the population aged 15 to 64 were MSDs — ranging from 40.4 % in **Luxembourg** to 71.5 % in **Norway** — except in the **UK** where the prevalence of psychosocial disorders is slightly higher than that of MSDs¹¹ (Eurostat, 2015h). The second most widespread work-related health problem is psychosocial disorders (stress, depression and anxiety). Over 20 % of workers aged 15–64 reported suffering from psychosocial disorders in **Belgium, Denmark, Ireland, France, Luxembourg, Portugal, Sweden, Switzerland** and the **UK**. The highest proportions of workers reporting psychosocial disorders were in **Ireland** (31.4 %) and the **UK** (41.8 %) (Eurostat, 2015h). European statistics on disability benefits show that, apart from MSDs, mental health problems make a substantial contribution to disability, in particular among young people. One-third of disability benefits are related to a mental condition, rising to as high as 40–45 % in some countries (EC, 2011).

Because of limitations in the data for 2013, Table 1 uses data from the 2007 LFS to show, at EU level, the most serious work-related health problem during the previous 12 months, self-reported by employees of all ages. Overall, the results are similar to those of 2013, with MSDs being by far the most common most serious health problems reported by people, and psychosocial disorders the second most common.

¹¹ Data on MSDs are missing for the Netherlands and Iceland; many values of for other health related-problems (cardiovascular diseases, pulmonary disorders and psychosocial disorders) are of low reliability, which is why the results have to be interpreted with caution.

Table 1: Self-reported most serious work-related health problem during the past 12 months, % of all employees who reported a work-related health problem during the past 12 months; by gender and by most prevalent types of diseases, EU-27

		Cardiovascular disorders	Musculoskeletal disorders	Stress, depression, anxiety	Pulmonary disorders	Headache, eyestrain
35–44 years	EU-26*	2.9	60.9	16.4	4.6	4.4
	Women	2.6	57.3	18.5	4.6	5.8
	Men	3.1	64.1	14.4	4.6	3.2
45–54 years	EU-26*	6.2	61.3	13.5	4.7	4.8
	Women	4.7	61.5	15.0	4.2	5.4
	Men	7.6	61.2	11.9	5.3	4.3
55–64 years	EU-26*	11.3	59.9	9.2	5.8	2.8
	Women	9.0	64.4	9.5	4.2	3.2
	Men	13.4	56.0	9.0	7.2	2.4

Source: EU LFS ad hoc module 2007 on accidents at work and work-related health problems, 'Persons reporting their most serious work-related health problem in the past 12 months, by type of problem -% [hsw_pb5]'.
 *The EU-27 average is calculated without France, as, because of different wording used in the question, its results are not comparable to other countries.

The high prevalence of MSDs as the most serious work-related health problem across all age groups shows that prevention at all ages is highly important, especially for this type of work-related health problem.

4.1.3 Relationship between poor health, sickness absences and labour participation

Poor health can have a major impact on withdrawal from the labour force because of early retirement, disability or unemployment. The OECD shows that long-term sickness absence is an important precursor of the occurrence of disability (OECD, 2010), and the European Central Bank (ECB) found that persons who have a bad health status are twice as likely to retire early compared with persons who are in good health (Aranki and Macchiarelli, 2013).

In addition, national surveys have shown a link between the length of the sickness absence and the age of the worker. Younger workers are more likely to take short periods of sickness absence but may take them more frequently. In addition, on average, the total time spent on sickness absence per year increases with age. For example, in **Germany** in 2010, workers in the construction sector aged 15–25 spent, on average, 17 days on sickness absence, while workers aged 55–65 in the same economic sector were absent for about 35 days owing to ill-health. This compares with 8 and 19 days, respectively, for administrative workers (BKK Bundesverband, 2011). In the UK (excluding Northern Ireland), between 2010 and 2013, 46 % of long-term absentee employees were aged 50 or over, while workers aged 50 or over represented 27 % of the total employee population (DWP, 2014).

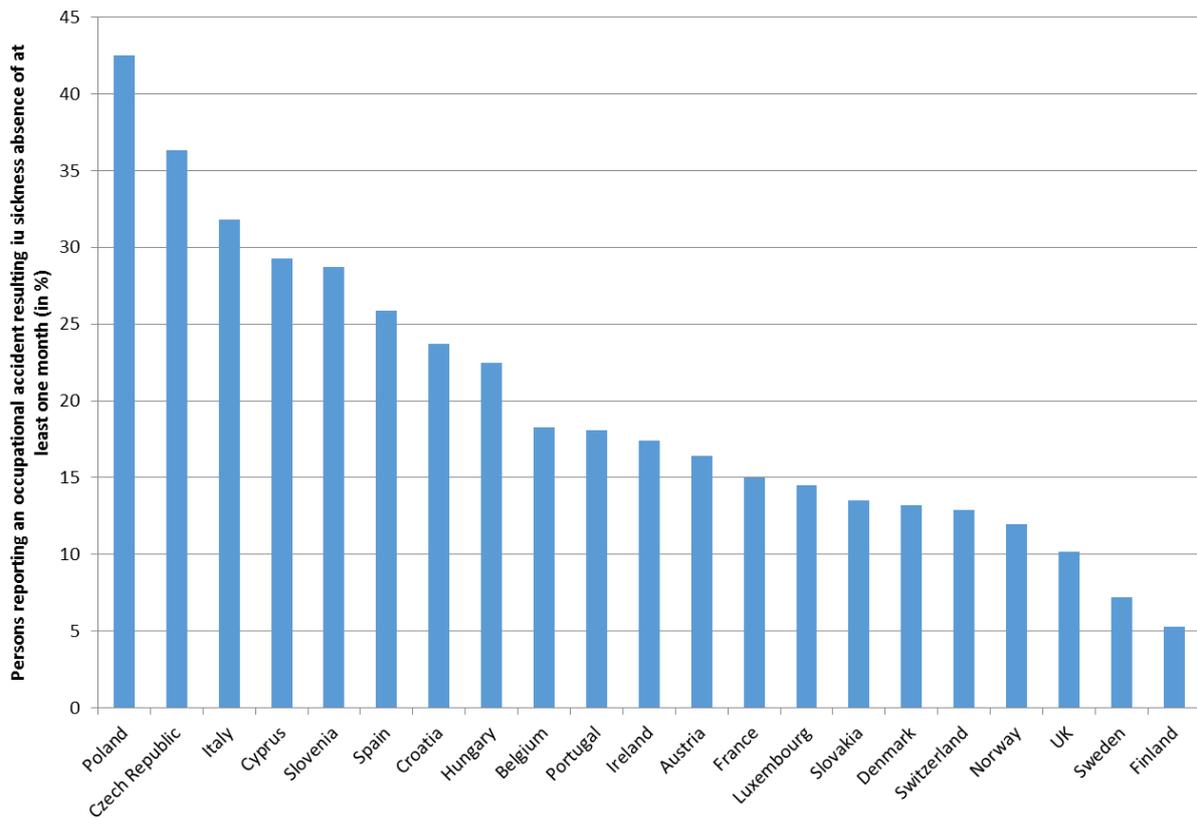
Thus, the ageing of the European workforce means that the prevalence of long-term sickness absence is likely to increase over the coming decades.

Sickness absence

The prevalence of sickness absence across European countries is a good indicator of the impact of ill-health on work. Unfortunately, data do not exist at EU level for sickness absence due to common health problems. Only data for sickness absence due to work-related health problems is available.

According to the LFS, most of the reported work-related accidents and health problems result in the worker being absent from work, with a significant proportion of these for more than one month (Figure 8). In 2013, on average, 72 % of European workers who suffered from an occupational accident during the previous 12 months reported that it resulted in a sickness absence. Twenty per cent of these workers reported that the sickness absence lasted more than one month (Eurostat, 2015i).

Figure 8: Persons who had one occupational accident or more over the previous 12 months reporting that it resulted in sickness absence of at least one month, in 2013, EU-28 and EFTA countries

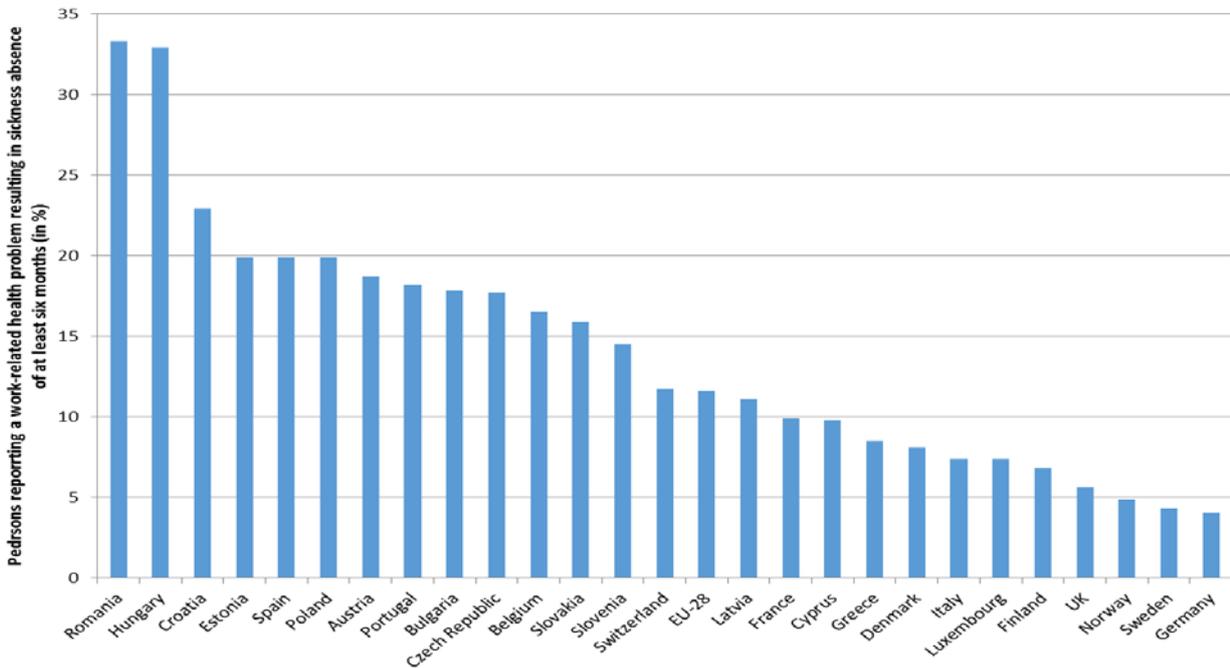


Source: Eurostat, EU LFS, 'Persons reporting an accident at work resulting in sickness absence by period off work [hsw_ac3]', 17 November 2015. Data for Bulgaria, Estonia, Germany, Greece, Iceland, Latvia, Lithuania, Malta, the Netherlands and Romania are missing.

In addition, in the EU-28, 55 % of workers who suffered from a work-related health problem (i.e. excluding occupational accidents) reported that it resulted in a sickness absence (Eurostat, 2015j).

For 20.6 % (EU-28) of these workers, the sickness absence lasted at least one month, for 14.1 % (EU-28) it lasted at least three months and for 11.6 % (EU-28) it lasted at least six months (Figure 9). Sickness absences of at least six months are reported particularly often in **Romania, Hungary** and **Croatia**, while the lowest figures are found in **Germany, Sweden** and **Norway** (Eurostat, 2015j).

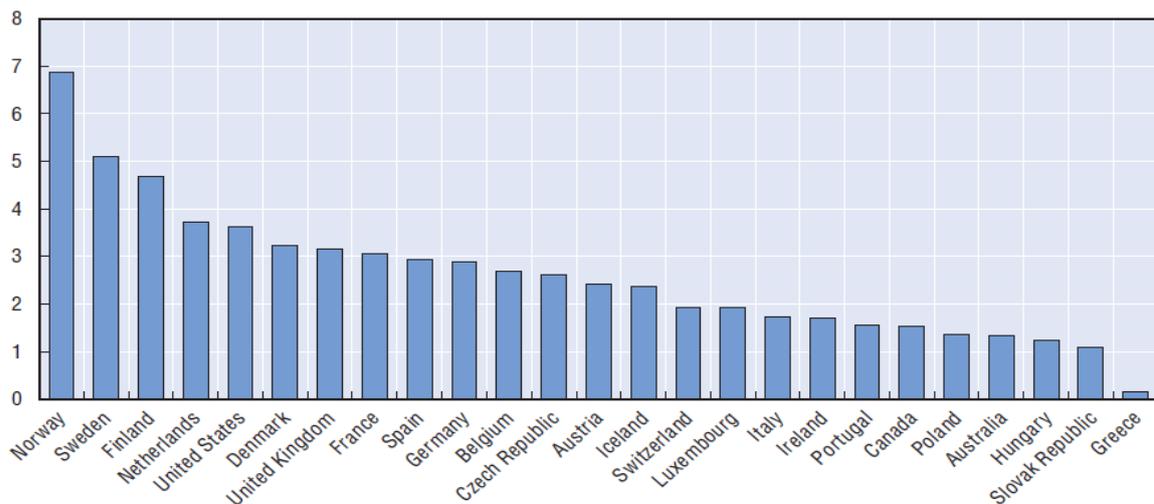
Figure 9: Persons who had one work-related health problem or more over the previous 12 months reporting that it resulted in sickness absence of at least six months, in 2013, EU-28 and EFTA countries



Source: Eurostat, EU LFS, 'Persons reporting a work-related health problem resulting in sickness absence by period off work [hsw_pb3]', 18 November 2015. Data for Iceland, Ireland, Lithuania, Malta and the Netherlands are missing.

Long-term sickness absence is a precursor of disability (Figure 10). According to the OECD (OECD, 2010), between 50 % and 90 % of workers receiving disability benefits enter the schemes after a sickness absence, not because of congenial disability. In addition, the OECD indicates that, in certain countries, in particular the Nordic countries, there is a link between the high sickness absence rates and the high disability beneficiary rates.

Figure 10: Incidence of sickness absence of full-time employees in selected OECD countries in 2008



Source: OECD, *Sickness, Disability and Work, Breaking the barriers*, 2010, p. 63. a) 2004 for Australia and 2007 for Iceland. The incidence of work absence due to sickness is defined as the proportion of full-time employees absent from work due to sickness and temporary disability (either one or all days of the working week). Data are annual averages of quarterly estimates. Estimates for Australia and Canada are for full-week absences only. The OECD report identifies the EU LFS and national labour force surveys for Australia, Canada and the United States of America as its main sources.

Health and labour force participation

Ill-health can be a risk factor for labour market participation and can be a reason for unemployment. Data from the EU SILC survey show that, in all EU Member States, employed people report long-standing health problems less often (21 % in 2013) than those who are unemployed (27.8 %) (Eurostat, 2015b). National studies have confirmed that workers with long-standing health problems face difficulties in remaining in employment. The **Danish** return to work project found that only half of the employees who went on long-term sick leave because of a long-standing illness or chronic disease were still in employment after nine months (Eurofound, 2014). Among economically inactive people, poor health has also been identified as a reason for not looking for work. According to the LFS, in 2013, 14.9 % of all economically inactive people (aged 15–64) reported that the main reason for not seeking employment was their own health or disability. Large differences in this statistic can be observed across European countries, from 43.1 % in **Iceland** to 3.4 % in the **Czech Republic** (Eurostat, 2016).

Ill-health is also a major predictor for all types of exit from the labour market and, in particular, early retirement. The proportion of retired people between 55 and 64 years old reporting a long-standing illness in comparison with employed people between 55 and 64 years of age (47.7 % against 33.4 %, respectively) suggests that older workers with health problems leave the labour market earlier than older workers who do not have health problems (Eurostat, 2015b). This is commonly referred to as the 'healthy worker effect'. A study from the ECB found that persons who are in bad health are 2.4 times more likely to retire early compare with those who are in good health (Aranki and Macchiarelli, 2013). According to the LFS, perceived health status is the principal factor influencing workers' decision to leave work after having become eligible for a pension (Table 2) (Eurostat, 2014e).

Table 2: Main reason for stopping work among people who receive a pension in the EU-27 (%), 2012

Main reason for stopping work	
Had reached eligibility for a pension	37.0
Own health or disability	20.8
Had reached the maximum retirement age	9.8
Lost job and/or could not find a job	7.4
Favourable financial arrangements to leave	7.2
Other reasons	5.3
Other job-related reasons ¹²	4.0
Family or care-related reasons	3.9
No answer	4.4

Source: Eurostat, LFS ad-hoc module 2012, 'Main reason for economically inactive persons who receive a pension to quit working (%) [lfsso_12reasnot]', 17 February 2014.

Workers with long-standing health problems often experience difficulties in returning to work. An OECD study found that return to work after entering a disability benefit scheme is extremely low. On average, in the OECD countries where data are available, only around 1–2 % of beneficiaries leave a disability benefit scheme annually for reasons other than death or retirement. This includes return to employment but it also includes loss of eligibility (OECD, 2010).

Conclusions

Despite improvements in the provision of health care and in workplace health prevention and promotion over the past decades, the ageing of the workforce (through demographic change and increasing employment rates of older workers) means that European workers and employers are going to be increasingly confronted with ill-health at work over the coming decades. Although European-wide

¹² Other job-related reasons include inconvenient working hours, tasks, health and safety at the workplace, job stress, job too demanding, skills not adequate or not valued, employers' attitude, among others.

data on people who stay at work with health problems are lacking, the data on long-standing illnesses and work-related health problems suggest that poor health status is more common in older workers than in younger workers.

The following remarks on the health status of the European workforce in relation to demographic change and the ageing of the workforce are relevant for rehabilitation/return-to-work schemes:

- the incidence of long-standing illnesses, and in particular MSDs, cancers and cardiovascular diseases, is likely to increase in the European workforce as it ages;
- older workers need longer periods than younger workers to recover from their health problems, leading to longer absences from work;
- health plays an important role in the decision of people to retire early;
- long-term sickness absence is a precursor of disability.

The future demographic trends in age will increase the pressure on Member States and companies to address long-term sickness absence and improve prevention at the workplace and return-to-work processes in order to avoid early retirements and exclusions from the labour market for health reasons.

When data on long-term sickness absence are put in the perspective of the grouping of Member States made in Chapter 3, an interesting trend can be observed. Without stating that there is a direct cause–effect link, in many of the countries that have well-developed systems for rehabilitation/return to work (e.g. **Finland, Norway and Sweden**), the proportion of workers reporting sickness absence of more than six months is relatively low compared with the EU average. While a number of other factors also come into play — such as the distribution of the working population across different sectors, access and quality of health care and rehabilitation services, and the possibility of entering disability benefit schemes early — the presence in these countries of mechanisms to support the reintegration of workers on sickness absence might also contribute, in part, to these results.

4.2 Supranational influences and wider economic determinants

At the international level, a shift has occurred over the past 50 years regarding how rehabilitation and return to work are addressed. As far back as 1955, international organisations recognised the need to promote and maintain the employability of people with disability. More recently, international organisations have been paying attention to the question of improved sickness and disability management to avoid exclusion from the labour market of people with serious health problems. At the European level, EU developments in health and safety at work and antidiscrimination have also strongly influenced national policies related to work adaptations for people with reduced capacity, but have had less influence on national policies for rehabilitation and return-to-work strategies.

This section also considers the impacts of the current economic crisis, which has increased the pressure on countries to ensure the sustainability of their social security systems. Sickness absence and disability expenditures are among the most costly social welfare policies and have therefore tended to be first in line for reforms.

4.2.1 The international context

The reintegration of workers with disabilities in the labour market has been a preoccupation of international organisations working on employment, health and antidiscrimination for several decades. The United Nations, the ILO and the WHO have all addressed the question of the **rehabilitation** of people with disability with the objective of preventing societal exclusion.

Rehabilitation of people with reduced work capacity

The ILO has considered the need to provide vocational rehabilitation to disabled persons since 1955, but it was not until 1983 that it adopted Convention No 159 on Vocational Rehabilitation and

Employment (Disabled Persons). The Convention defines a disabled person as ‘an individual whose prospects of securing, retaining and advancing in suitable employment are substantially reduced as a result of a duly recognised physical or mental impairment’. The Convention recommends a number of measures to promote employment opportunities for disabled persons, in particular the provision of financial incentives to employers to make reasonable adaptations to workplaces and work organisation and support for vocational training and vocational guidance. At the date of writing this report, 82 countries have ratified this Convention, including 21 EU Member States. Belgium, Bulgaria, Estonia, Latvia, Austria, Romania and the UK have not ratified the Convention.

The main international framework for the rehabilitation of people with disability is the United Nations Convention on the Rights of Persons with Disabilities (UN Convention), adopted in 2006. It aims to ‘promote, protect and ensure the full and equal enjoyment of all human rights by persons with disabilities’. The definition of persons with disabilities in the Convention is broad. It states that ‘persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others’ (UN, 2006). The UN Convention also makes the link between the occurrence of some form of physical or mental impairment and age, mentioning that ‘many, if not most people, will acquire a disability at some time in their life due to physical injury, disease or aging’. The Convention, to which the EU has been party since 2007, covers a number of key areas including discrimination, employment and habilitation and rehabilitation services. Articles 26 (Habilitation and rehabilitation) and 27 (Work and employment) are particularly relevant. While Article 26 provides general guiding principles with regard to rehabilitation (e.g. that it should be started as early as possible and should be based on evaluation made by a multidisciplinary team), Article 27 covers a number of measures to be taken by State Parties to promote the ‘realisation of the right to work’ of people with disabilities. Some of these measures are relevant for rehabilitation/return-to-work systems, such as the protection of their right to safe and healthy working conditions; the prohibition of discrimination on the basis of disability in, inter alia, career advancement and safe and healthy working conditions; access to career advancement opportunities on the open labour market and assistance in obtaining, maintaining and returning to employment; and ensuring that reasonable accommodation is provided to persons with disabilities in the workplace.

In parallel, the WHO has also developed a strong body of recommendations and policies related to the rehabilitation of people with disability (WHO, 2016). The focus of the policies promoted by the WHO is more health oriented than employment related. The WHO has also published guidelines for community-based rehabilitation, which aims to enhance the quality of life for people with disabilities and empowers them to access and benefit from education, employment, health and social services. Under the theme ‘livelihood’, the guidelines look at five aspects: skills development, self employment, wage employment, financial services and social protection. While a number of recommendations related to skills development and lifelong learning are relevant for the development of rehabilitation/return-to-work systems in European countries, the guidelines focus mostly on people with disabilities in low-income countries.

The WHO also developed the International Classification of Functioning, Disability and Health (ICF), a hybrid and universal model of disability that encapsulates the wide range of conditions from very minor to severe. It was adopted by all 191 WHO member states in 2001 (WHO, 2001) as the international standard to describe and measure health and disability. In addition to supporting a more uniform classification of health and disability, the ICF also reflects a shift in thinking about disability and its interaction with the broader socio-economic environment. This evolution, influenced by a large body of scientific literature from Europe and North America, is reflected in the recommendations on rehabilitation from a number of international organisations over the past 10 years or so. In particular, the concepts of **return to work** and of considering work as an outcome of rehabilitation have become important considerations when thinking about the reintegration of people with disabilities in the labour market. This in turn paves the way for a more comprehensive approach focused not solely on people who have a formal recognition of disability, but encompassing all those who have to leave their work (on a one-off or regular basis) because of their health.

Return-to-work strategies and the management of sickness absence

The OECD has also been paying attention to the need to promote the participation of people with disabilities in social and economic life and their engagement in gainful employment. In 2003, the OECD published 'Transforming disability into ability' (OECD, 2003), which analysed the policies put in place in 20 countries to engage people with disability in gainful employment and ensure their income security. As a follow-up, in 2010, it published the report 'Sickness, disability and work: breaking the barriers' (OECD, 2010), with conclusions on the development of effective rehabilitation and return-to-work strategies for people with disabilities and chronic health issues.

While sickness and disability policies are evolving in most OECD countries, they do so at varying degrees and at varying speeds. Many countries are combining greater employment support for people with disabilities or chronic health problems with stricter conditions for accessing sickness and disability benefits. Another evolution is the increasing focus on the person's remaining work capability when determining benefit eligibility, rather than an assessment of the degree of disability. The OECD finds, however, that in most countries these reforms have not gone far enough and a change of mindset may still be needed to ensure that employment is seen as a way to tackle disability. The systems in place in many OECD countries are still more passive (relying on benefits) than active (promoting employment).

The OECD emphasises the major role played by employers to protect their workers' health and to react early to potential problems. It recommends both an extension of employers' responsibilities with regard to the management of sickness absence and a strengthening of the incentive and support system to help them fulfil these obligations. It also highlights the key role of GPs in the decision-making process for the return to work of those on sickness absence. Considering the number of actors involved in the return-to-work process, the OECD recommends better coordination and cooperation mechanisms and the implementation of 'one-stop-shop' approaches to facilitate coordination and ensure more transparency and accountability in the process. As described in Section 3.2, the rehabilitation/return-to-work systems in Europe that are considered the most comprehensive generally reflect these recommendations.

In its 2011 report 'Sick on the job? myths and realities about mental health and work', the OECD also discusses the need for better strategies to ensure the return to work of workers on sickness absence because of mental health issues. It recognises that many people with such issues are excluded from the labour market because of unsuitable or late assessments of their working capabilities and support needs. It calls for earlier interventions for workers with mental health issues on sickness absence, based on closer cooperation between the mental healthcare system and employers (OECD, 2012).

As social security institutions play a very important role in the return-to-work process in most countries, the ISSA has also been working on the issue of return to work. In 2013, it issued its *Guidelines on Return to Work and Reintegration* (ISSA, 2013). The guidelines address, first, the national legal, institutional and policy frameworks and, second, the intervention level, that is, workplaces, healthcare institutions, workers, vocational service providers, etc. ISSA's guidelines mirror those provided by other institutions on return-to-work strategies, such as the OECD, the ENWHP, the Fit for Work Europe Coalition and Eurofound.

The ENWHP, the Fit for Work Europe Coalition and Eurofound have worked recently on the integration at the workplace of people with chronic diseases (Bevan, 2013; ENWHP, 2013; Eurofound, 2014). The ENWHP and the Fit for Work Europe Coalition have pushed for several years for better public policies to address discrimination against persons with chronic diseases, with a specific focus on MSDs by the Fit for Work Europe Coalition. Both Eurofound and the ENWHP recommend the reorientation of current public policies on the rehabilitation and reintegration of people with chronic diseases, rather than the provision of financial compensation and benefits. At the workplace level, Eurofound recommends the implementation of flexible forms of work to adapt to the circumstances of the affected person, as well as the identification of risk factors for chronic diseases during risk assessment procedures, in particular in certain sectors or for certain occupations. Finally, awareness raising and exchange of good practices, at EU, national and workplace levels, are also highlighted as effective instruments in the development of effective reintegration systems for people with long-standing illnesses.

The key themes that emerge throughout these recommendations include the need for a holistic approach to return to work, an individualised approach with the active participation of the person concerned, coordination and cooperation of the different actors, and the monitoring and evaluation of measures. But most of all, what these organisations all recommend is to intervene as early as possible in order to avoid the risk that workers leave the labour market because of a lack of support.

4.2.2 The European context

At the EU level, the issue of getting people back to work following a medium- or long-term sickness absence has not been addressed in a single policy framework but rather in a fragmented manner across different policy areas. As illustrated in Chapter 3, this fragmentation across policy areas is mirrored in many Member States' systems, which do not have a holistic approach to the issue of rehabilitation and return to work.

Rehabilitation and return to work have been addressed at the EU level within three main policy areas: disability/antidiscrimination, public health and OSH. EU employment policies have focused mostly on the reintegration into the labour market of unemployed workers (economic rehabilitation). Even though some coordination is taking place across the three above-mentioned areas, the effectiveness of EU policies in rehabilitation/return to work is compromised by the fact that social security legislation and policies, which are major drivers of rehabilitation/return-to-work systems, are an exclusive competence of the Member States.

Mirroring what happened at the international level, the EU started looking at the issue of rehabilitation/return to work from the perspective of the rehabilitation of people with disabilities. It has focused either on the general population, through public health and antidiscrimination policies, or on workers with disabilities and the obligation in OSH and antidiscrimination legislation for employers to provide reasonable accommodation of the workplace.

Disability and antidiscrimination

In 2000, the EU took a big step forwards in the fight against discrimination with the adoption of Directive 2000/78/EC¹³ establishing a general framework for equal treatment in employment and occupation (the Employment Equality Directive). The Directive covers disability and places a requirement on employers to make *reasonable adjustments to accommodate disabled people* (Council Directive 2000/78/EC). This is relevant to the rehabilitation of workers who have developed acute or chronic health problems and suffer from a recognised degree of disability. To date, this EU requirement to accommodate work for workers with disabilities is the only basis in a number of EU Member States for adapting the workplace based on a worker's health condition (see Section 3.5). While it is undoubtedly a very powerful instrument when it comes to antidiscrimination at the workplace, because it addresses people with disability (i.e. formally recognised as having a disability) and has been promoted as an antidiscrimination measure, it is not in itself sufficient to cover the needs of those returning to work after a long sickness absence.

The European Union has also signed and ratified the 2007 UN Convention on the Rights of Persons with Disabilities (UN, 2006), which includes the promotion of occupational rehabilitation, job retention and return-to-work programmes for disabled people. This means that all EU legislation, policies and programmes must comply with the Convention's provisions on disability rights (within the limits of EU competences).

The European Disability Strategy 2010–2020, in its priority on 'health', makes the links across antidiscrimination and disability policy, OSH policy and public health policy. The Strategy notes that the Commission will pay specific attention to promoting action in the field of health and safety at work to reduce risks of disabilities developing during working life, to improve the reintegration of workers with disabilities and to develop early intervention services.

¹³ Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation (OJ L 303, 2.12.2000, p. 16–22).

Public health

In EU public health policies, the promotion of health at the workplace and the need to reduce employment losses due to ill-health have led to recommendations of closer cooperation between employment, social protection and public health policies (EC, SEC (2007) 1376¹⁴). The Commission also announced the launch of a Communication on the health of the workforce to strengthen mechanisms for information exchange and cooperation on this issue between Member States, the Commission and the business community. However, no further action seems to have been taken on the issue.

Little else is mentioned in the various Public Health Programmes (EC, SEC (2007) 1376) or in other relevant health-related policy documents (EC, 2013a) with regard to rehabilitation and return to work, other than the inclusion of unemployment and disability as factors associated with poorer health and, thus, areas where targeted interventions are required.

Occupational safety and health

From a health and safety at work perspective, the 2002–2006 Community Strategy on health and safety at work (EC, COM (2002) 0118 final¹⁵) has already emphasised the importance of raising awareness of employers, in particular in small companies, about the need to reintegrate people with disabilities into employment. It is only in the subsequent 2007–2012 Community Strategy on health and safety at work (EC, COM (2007) 62 final¹⁶) that an explicit reference was made to the problem of the reintegration of workers with disabilities or victims of occupational accidents or diseases into the labour market. Member States were encouraged to implement specific measures ‘to improve the rehabilitation and reintegration of workers excluded from the workplace for a long period of time because of an accident at work, an occupational illness or a disability’ (EC, COM (2007) 62 final).

However, the evaluation report of the 2007–2012 Strategy (EC, 2013b), published in March 2013, revealed that more than half of Member States had not established mechanisms to improve the rehabilitation and reintegration of workers excluded from the workplace. It showed that there remains a strong need for further EU action in this field and that particular attention should be paid to the better rehabilitation of those with existing or degenerative disorders, including MSDs. In addition, objectives should be set that target the rehabilitation of those with mental health problems. Based on these findings, the new Strategic Framework on Health and Safety at Work for 2014–2020, adopted on 6 June 2014 (EC, COM (2014) 332 final¹⁷), reiterates the need for reintegration and rehabilitation measures, especially in the context of population ageing, in order to avoid permanent exclusions of workers from the labour market.

Unfortunately, these actions are not coordinated with the EU’s employment policies, which have only addressed the issue by encouraging Member States to create national policies to increase the employability of workers with disabilities and facilitate their reintegration into the labour market. Beyond ad hoc references in policy documents, the EU has not yet seriously considered the implications of sickness absence on employment and social security systems.

¹⁴ Commission Staff Working Document, document accompanying the White Paper *Together for Health: A Strategic Approach for the EU 2008–2013*, SEC (2007) 1376, Brussels, 23 October 2007.

¹⁵ Communication from the Commission, *Adapting to change in work and society: a new Community strategy on health and safety at work 2002–2006*, COM (2002) 0118 final, Brussels, 11 March 2002.

¹⁶ Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, *Improving quality and productivity at work: Community strategy 2007–2012 on health and safety at work*, COM (2007) 62 final, Brussels, 21 February 2007.

¹⁷ Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, *An EU Strategic Framework on Health and Safety at Work 2014–2020*, COM (2014) 332 final, Brussels, 6 June 2014.

4.2.3 Economic factors

Since the mid-2000s, the economic crisis has greatly affected economies and societies globally. The mainstream response from most European countries was to introduce drastic cuts in public spending combined with a strict target towards fiscal consolidation. The crisis brought about a number of changes across European countries. Overall, priority was given to adopting measures that would rapidly improve public finances and help to achieve specific macroeconomic targets. Under these circumstances, policy areas relevant to rehabilitation and return to work, in particular employment, health care and social security, were also subject to numerous changes.

Social security reforms were also introduced to constrain costs, including for the three main social security schemes relevant to rehabilitation and return to work: old-age pensions, sickness benefits and disability benefits (see below). In some European countries, social security reforms have been accompanied by the implementation of a support system to enhance the employability of people with reduced capacities, for example through vocational rehabilitation, and to prevent people on long-term sickness absence from permanently leaving the labour market by encouraging their return to work.

Conversely, a number of countries present a combination of factors that have a major influence on the situation of workers with health problems:

- they have reformed their disability benefit schemes, tightening allocation criteria and/or reducing amounts allocated;
- they have reformed their early retirement benefit schemes, again by tightening allocation criteria or in some cases removing the possibility altogether;
- they make limited investments in vocational rehabilitation measures for people with disability; and
- they have not, to date, put in place a system to support the reintegration or return to work of workers on medium- or long-term sickness absence.

In these countries, people with medium- or long-term (or chronic) health problems stay at work, become registered unemployed or become inactive with no financial support. Only a minority receives disability benefits or, for those close to retirement age, go on early retirement. The lack, in these countries, of support structures for rehabilitation and return to work at the national and workplace levels can have two main consequences for workers with a medium-/long-term health problem. Either they are at risk of exclusion from the labour market if they cannot find a job that is adapted to their capacities or they keep working in jobs that are not adapted to their capacities and run the risk of further impairing their health, up to the point where they develop a recognised degree of disability that, in some cases, gives them rights to financial and rehabilitation support.

Two areas of social security systems are particularly interesting for rehabilitation and return to work: old-age pensions and sickness and disability benefits.

With regard to **old-age pension schemes**, the predominant changes were to increase the official retirement age and tighten award criteria for regular and early pensions. This potentially affected people who, in countries such as **Germany** or **Italy**, were previously eligible for early retirement benefits because of reduced capacity to work, and, following the reforms, were subject to tighter award criteria. It also affected those people who chose to leave work early and applied for early retirement benefits because of their health condition.

As regards **expenditures on sickness absence and disability**, long-term sickness absence and early retirement from the labour market because of health reasons are both major burdens for the individual, the workplace and society. There are no specific indicators for the cost of sickness absence at EU level, however. According to the European system of integrated social protection statistics (ESSPROS)¹⁸, expenditures for sickness and health care¹⁹ in 2012 reached 28.5 % of the total social protection expenditure. This is much higher than expenditures for unemployment benefits, which

¹⁸ ESSPROS distinguishes eight functions of social protection: sickness benefits/health care, disability benefits, old-age pension, survivors benefits, family/children benefits, unemployment benefits, housing and social exclusion benefits.

¹⁹ ESSPROS defines sickness benefits/health care as 'income maintenance and support in cash in connection with physical or mental illness, excluding disability. Health care intended to maintain, restore or improve the health of the people protected irrespective of the origin of the disorder'.

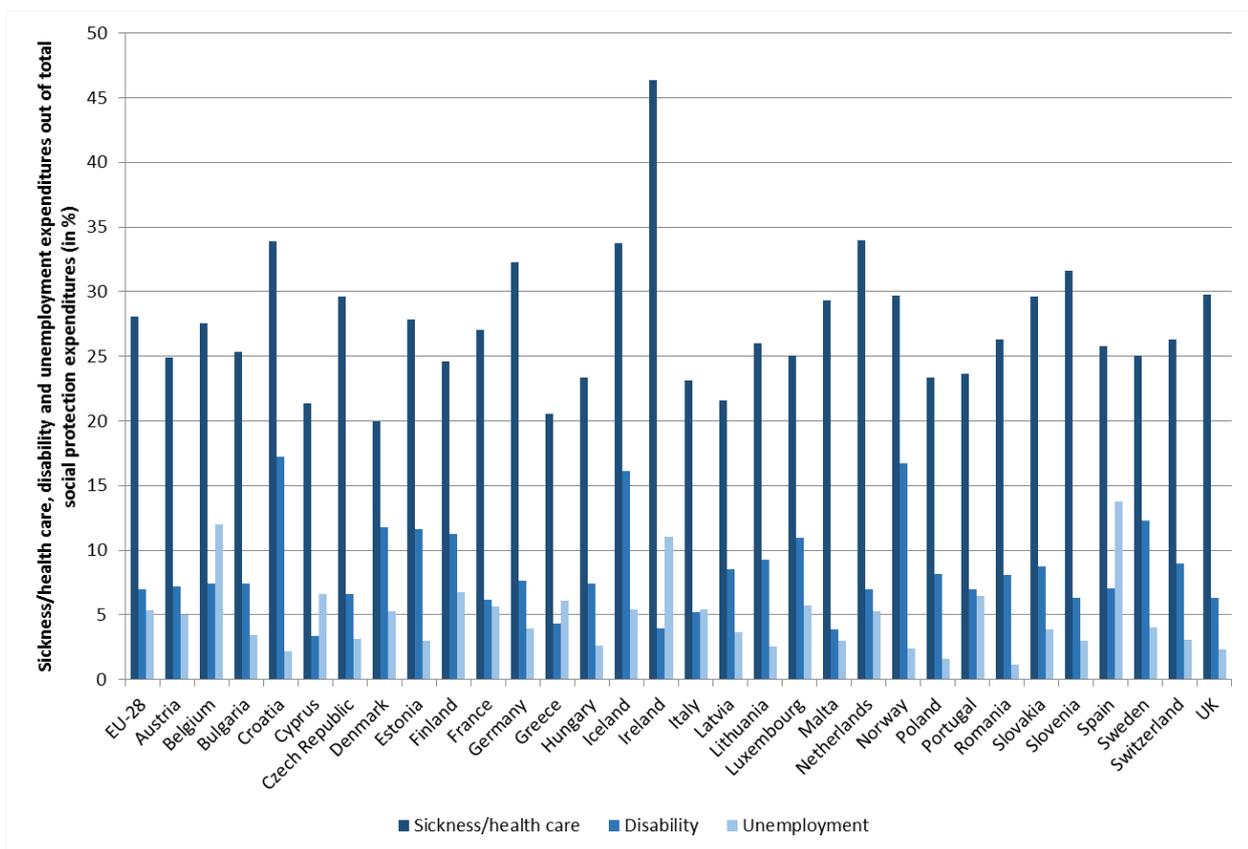
accounted for 5 % of all social protection benefits in the EU-28 in 2012.

In the United Kingdom, estimates show that sickness absence costs employers approximately GBP 9 billion (approximately EUR 12.2 billion) a year on sick pay and other indirect costs and the overall economy GBP 15 billion (approximately EUR 20.4 billion) a year, mostly in lost output (Black and Frost, 2011).

As mentioned in Section 4.1, sickness absence is often a precursor of disability. The economic argument for improved rehabilitation/return-to-work systems therefore also requires consideration of expenditures on disability benefits. Expenditures on disability pensions are defined as periodic payments intended to maintain or support the income of a person who is below the legal/standard retirement age and suffers from a disability, which impairs his or her ability to work or earn beyond a minimum level laid down by legislation (Eurostat, 2011b).

In 2012, expenditures on disability constituted an important part of social welfare spending — they were higher, for instance, than expenditures on unemployment (Figure 11) (Eurostat, 2015k). Disability pensions amounted to 0.9 % of the GDP across the EU-28 (Eurostat, 2015l). Although at EU level this proportion remained the same in 2012 as in 2008, several countries decreased their expenditures on disability pensions and early retirement due to reduced capacity to work in the realm of pension reforms (Figure 11).

Figure 11: Expenditures on sickness benefits/health care, disability benefits and unemployment benefits as a percentage of total social protection expenditure in EU and EEA Member States in 2012

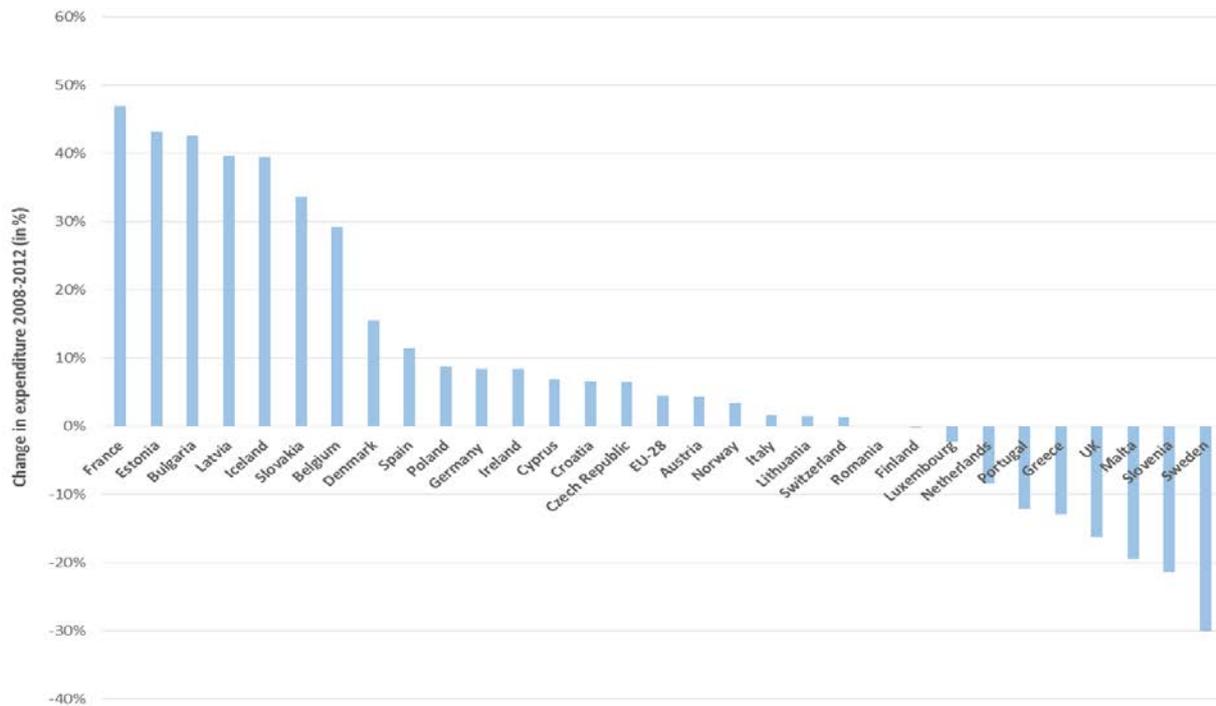


Source: Eurostat, 'Health care expenditure, Expenditure: main results [spr_exp_sum]', 17 December 2015. Although data for 2013 are available, it was decided that 2012 data would be presented, as a number of values for 2013 are missing and many are flagged as provisional.

Reforming disability benefit allocation consists mainly in restraining the allocation criteria. In practice, people who could previously be covered by invalidity pension schemes are now compelled to remain at work or to transfer to another benefit scheme such as unemployment or social welfare, especially if, at the same time, access to early retirement schemes is also restricted.

Between 2003 and 2008, **Germany, Italy, Luxembourg, the Netherlands, Austria and Poland** decreased their expenditures on disability pensions/early retirement benefits related to reduced capacity to work²⁰. Between 2008 and 2012, an additional eight countries saw a decrease in these expenditures (Figure 12). Reasons for these decreases could include better prevention, improved working conditions or improved general health among the population, but could also be explained in terms of restricted access to this type of pension or reduced pension amounts, which, especially in times of economic crisis, make it necessary for people to stay at work longer (Eurostat, 2015).

Figure 12: Change in expenditures in disability benefits and early retirement benefits due to reduced capacity to work between 2008 and 2012



Source: Eurostat Social Protection Statistics, 'Pensions [spr_exp_pens]', 12 November 2014; Milieu own calculations (the graph was prepared by adding expenses on two types of pension benefits: disability pension and early retirement benefit due to reduced capacity to work). Change is expressed in percentage based on numbers expressed in purchasing power standard (PPS)/inhabitant. For presentation purposes, Hungary, which saw a decrease of -94 %, was not included in the graph.

In 2012, **Bulgaria, the Czech Republic, Estonia, Greece, Cyprus, Latvia, Lithuania, Hungary, Malta, Poland, Romania, Slovenia and Slovakia** had very low disability pension expenditures per capita (even though some had seen an increase since 2008), suggesting restrictive criteria for the allocation of disability pensions. In addition, most of these countries have also reformed their early retirement system over the past decade. In 2012, the proportion of people on old-age pensions who received early retirement benefits is lower than the EU average in most of these countries (apart from **Poland and Hungary**)²¹.

²⁰ Denmark reduced its disability pension expenditures to 0.00 in 2008; however, the early retirement benefit scheme seems to have replaced the disability pension, since the former's expenditure in 2008 was at the same scale as that of the previous disability pension. Thus, it is not considered a decrease.

²¹ Note that the figures presented in this section are based on the sum of disability pensions and early retirement benefits related to reduced capacity to work, since early retirement benefits related to reduced capacity to work play a significant role in some countries. However, for many countries, data on early retirement benefits are missing and it was assumed that in these countries this scheme does not exist/does not play a significant role. However, limitations because of non-reporting may exist.

Expenditure on rehabilitation

Expenditures on rehabilitation for disabled people, as defined in the ESSPROS manual as ‘provision of specific goods and services (other than medical care) and vocational training to further the occupational and social rehabilitation of disabled people’ (excluding medical rehabilitation), vary greatly across Member States. On average, in the EU-28, Member States spent EUR 37 per inhabitant (in purchasing power standards) in 2012 on rehabilitation. Higher spenders were the **Netherlands, Norway, Finland, France and Germany**, which spent between EUR 70 and EUR 120 per inhabitant. In addition to those countries where no expenditures for rehabilitation were reported (**Croatia, Iceland and Luxembourg**), the lowest expenditures were in **Slovakia, Romania, and Bulgaria** (Eurostat, 2015m).

4.3 National determinants: influence of traditions and the legal, policy and institutional frameworks

The national systems in Europe for rehabilitation and return to work are very diverse. On the one hand, the majority of countries deal with sickness absence and the rehabilitation of workers with disabilities in a fragmented and ad hoc manner. On the other hand, a number of countries have adopted more comprehensive frameworks for rehabilitation and return to work, valuing early and interdisciplinary interventions and individualised approaches. A number of factors come into play that determine the characteristics of a country’s approach to rehabilitation/return to work. This issue transcends specific policy areas. It is not confined to health and safety at work or antidiscrimination but requires broader employment, public health and social security considerations to be taken into account.

In its 2013 *Guidelines on Return to Work and Reintegration*, the ISSA observes that the development and implementation of return-to-work systems rely on public policy and the legislative framework. This section first looks at legal and policy determinants, taking into account the broader question of the traditions for OSH in European countries. Second, it examines the institutional determinants, including the question of the coordination of stakeholders.

4.3.1 OSH and social security traditions

The diversity of historical backgrounds and political systems across European countries explains the variety of legal traditions and social security systems.

In each country, legislative and regulatory power is shared in a different way between Government and Parliament. Moreover, law-making and regulatory processes can lead to different types of acts and documents, ranging from strictly binding (e.g. laws, decrees, ministerial decisions) to non-binding, soft-law norms (e.g. policy documents, strategies, action plans, roadmaps). On the basis of these varied political cultures and legal traditions, each country uses a different proportion of law, regulation, administrative action or policy guidance to pursue specific goals and is more or less ‘regulatory driven’ or ‘policy driven’. In some countries, collective agreements also have a strong regulatory function, for example in **Belgium, Denmark, France and Finland**.

In some cases, detailed and prescriptive standards and requirements are set by legislation, while other countries adopt a more ‘self-regulatory market’ approach and favour policy instruments. The way countries regulate health and safety at work and employers’ obligations within that with regard to OSH prevention and management illustrates these differences. It is also apparent in the way countries regulate the management of sickness absence, which is central to rehabilitation/return-to-work systems. Some countries (e.g. **France, Croatia and Luxembourg**) have detailed procedures in their legislation regarding what employers should do when an employee is on long-term sick leave. In other countries, the legislation provides a general framework and the detailed rules are left to the discretion of collective agreements at branch or company level (e.g. in **Denmark**) or of employers (e.g. in **Germany**).

Rehabilitation/return-to-work systems are also strongly influenced by the level of cooperation between the different stakeholders involved in the process. Countries in Europe have different ways of drafting policy and legislation, which can be more or less collaborative and involve social partners to varying

degrees. The maturity of social dialogue in a country therefore has a strong influence on how return to work is dealt with. This is true at both national and workplace levels. At national level, traditions of collaborative policy development can more easily lead to the implementation of integrated systems for return to work, based on the close collaboration of entities that do not necessarily stem from the same national authority/ministry. However, ultimately, successful return-to-work outcomes play out at workplace and individual levels. The implementation of collective agreements regulating the reintegration of workers following a sickness absence can be as effective as a national integrated framework for return to work. The presence of collective agreements at workplace level means that the actors involved in the return-to-work process — employer, workers, HR, OSH services, worker and trade union representatives — are already used to collaborating on issues related to well-being at work and are likely to work well with external services and expertise.

At the workplace level, the presence of OHSs also influences reintegration procedures. Despite an increasing development of OHSs in EU Member States since the adoption of Framework Directive 89/391/EC²², how these services have developed and how influential they are in policy development and on workers' well-being depends very much on the country's tradition, history and socio-economic context. As observed by the Finnish Institute of Occupational Health (FIOH), in the **Nordic countries** and the **Netherlands**, OHSs have a strong influential presence. In continental northern countries, insurance systems for occupational accidents and diseases also reinforce the influence of collaborative mechanisms, such as a works council or OHS, on the development of OSH prevention policies. On the other hand, in **Ireland** and the **United Kingdom**, the presence of OHSs in companies is concentrated in large companies.

European countries can have a centralised or a decentralised/regionalised approach to OSH. This means that the adoption and implementation of OSH-related decisions and instruments can either be entirely controlled by a centralised institution or be decentralised to regional or local authorities. While both systems have their comparative advantages, effective rehabilitation/return-to-work systems require a certain degree of proximity with actors at local level. Comprehensive systems might rely on the intervention of a national centralised institution, but they can be effective only if the policy developed at national level is relayed at the local level. A myriad of local relays can play an important role in the implementation of rehabilitation/return-to-work systems, from labour inspectors and external OSH services to local employment agencies and agencies providing sickness and disability benefits. In certain countries with a high degree of regionalisation (e.g. **Germany, Spain**), regional branches of insurance or pension organisations may be more proactive than the national branch in establishing innovative programmes.

The organisation of social security and, more generally, welfare systems in European countries also have a strong influence on how rehabilitation/return-to-work systems function. Return-to-work systems have been implemented in countries with different approaches to social security and welfare. While this report does not aim to analyse in detail the different models for social welfare across Europe, the main categories of social welfare, as defined by the FIOH, should be briefly mentioned (Hämäläinen, 2008):

- The first category is the Nordic welfare model, including, according to FIOH, **Denmark, Finland** and **Sweden**, to which **Iceland** and **Norway** can be added. It is characterised by a Beveridge welfare system, that is, universality of social welfare protection, uniformity of benefits based on needs rather than income and unity of the state-centred management of welfare, based on taxation, high trade union density and strong national institutions.
- The second category is the continental welfare model (**Austria, Belgium, France, Germany, Liechtenstein, Luxembourg, the Netherlands** and **Switzerland**). It is characterised by a Bismarck welfare system, that is, welfare benefits financed by workers' and employers' contributions based on income rather risks, with variable trade union influence and variable degree of state influence.
- The Anglo-Saxon model (**Ireland** and the **United Kingdom**) is also characterised by a Beveridge system but with a liberal (i.e. not state-centred) approach to welfare; a targeted,

²² Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work (OJ L 183, 29.6.1989, p. 1–8).

rather than redistributive, system of social services provision; and less decision-making power of trade unions on OSH-related issues.

- The Southern/Mediterranean welfare states (**Greece, Spain, Italy and Portugal**) have a mixed system because of reforms of the healthcare system and the decentralisation of administration to regions and local communities and have a relatively low trade union density (except in Italy). Both **Cyprus** and **Malta** could be added to this group, as they also present a number of mixed characteristics, but the strong influence of the liberal Anglo-Saxon model should be taken into account for these two countries (Natali, 2008).
- Finally, countries from **Central and Eastern Europe** have been largely influenced by both their experience with communist governance and their transition towards democratic and economic liberalisation. Although there are significant differences in their healthcare models, these countries are mainly characterised by a Bismarck model of social welfare, although some countries remain strongly state-centred and dependent on general taxation rather than contributions (EC, 2002). Trade union density is low, sectoral social dialogue is generally weak and there is a lack of a consolidated system of industrial relations (Aiginger and Leoni, 2009).

National traditions in OSH and social security are important determinants in the construction of rehabilitation/return-to-work systems. Different traditions and models are not necessarily a determinant of how developed or advanced a return-to-work system is but rather a determinant of how it is organised, who the main actors are and what responsibilities they have, for example differences in the degree of responsibility for compensation of sickness absence between the state and the employer.

4.3.2 Legal frameworks

The legal frameworks that regulate how rehabilitation and return to work function in the EU and EEA countries are diverse. However, they present a number of similarities in terms of the designation of responsibilities for rehabilitation/return to work. There are very few countries that present a unique legal framework to deal with the question of rehabilitation/return to work. In most of them, the issue is addressed through several pieces of legislation related to disability and antidiscrimination, OSH, employment and social security. Where they exist, return-to-work systems are governed by a set of laws (or a unique law) that regulates the various components of the return-to-work process, from compensation for sickness absence to the provision of rehabilitative services and reinstatement at work.

At least what is present in all countries is the obligation for employers to provide 'reasonable accommodation' for workers with a disability, stemming from the EU *antidiscrimination legal framework* (Article 5 of Directive 2000/78/EC). In **Norway**, similar provisions are included in the Inclusive Workplace Agreement. In **Iceland**, employers have an obligation in their OSH legislation to adapt the workplace to the abilities of their workers but there does not seem to be specific employment antidiscrimination provisions comparable to those in the EU. **Switzerland** does not have specific provisions obliging employers to provide reasonable accommodation to workers with disabilities, although there are mechanisms to support them if they wish to do so.

On the other hand, national legislation systematically includes provisions related to *social security/insurance*, that is, compensation for sickness absence, allocation of disability benefits or pensions, and the accompanying assessment of work capacity to determine the need of the worker for health or disability-related benefits. Such legislation determines how a country deals with sickness absence management, where the main responsibility lies for compensation for sickness absence and what the conditions are for the allocation of disability benefits (for more detail, see Section 4.3.5).

In addition, in a number of countries, provisions in the *OSH legislation* complement these two basic aspects. The OSH legislation contains provisions related to the role of the employer and/or the OHSs (when they exist) in the reintegration process. With regard to the role of the employer, the OSH legislation can require them to adapt workstations and workplaces to the needs and abilities of their workers, without them being recognised as having a disability. In **Hungary**, for instance, the decree

on ‘fitness-for-job, professional and personal hygienic medical examinations’ requires employers to align workers’ working conditions with their abilities.

With regard to the OHSs, the requirements in the OSH legislation can cover the following: carrying out medical examinations when the worker comes back to work and, often, a follow-up to determine potential loss of work ability; making recommendations to employers on possible adaptations to workstations/workplaces to take into account the loss of work ability (depending on the country, these recommendations can be prescriptive or optional for the employer); and requesting a reinstatement or even a pre-reinstatement visit after a certain duration of sickness absence to assess possibilities for returning to work with the worker, for example on a part-time basis. In **Romania**, for instance, the law on Monitoring of Workers’ Health requires the occupational physician to carry out a medical examination after a minimum of 90 days of sickness absence to assess the worker’s ability and decide upon possible rehabilitation measures, such as adaptation of their workstation or adaptation of working time. Such provisions build on the concept of ‘reasonable adaptation’ in antidiscrimination legislation, that is, the principle of adapting the work to the person rather than adapting the person to the work, which is central to the return-to-work processes.

In a few countries, their OSH legislation also describes the reinstatement procedure for people coming back to work after a certain period of sickness absence, from four weeks to three months. In countries where the presence of OHSs in companies is very formalised (e.g. **Belgium, France, Finland**), the procedure set out in the law clearly describes the role of the OHS and of the employer.

In a number of countries, additional *labour market and employment provisions* exist to give an incentive to workers and/or employers for returning to work. This can include flexible working arrangements for people on sickness absence who wish to come back to work but do not feel ready for working full-time (part-time work, flexible working hours to accommodate treatment, resting breaks, etc.). In **France** and **Luxembourg**, for instance, the measure ‘part-time employment period for medical purposes’, inscribed in the law, allows workers to work part-time temporarily, while receiving their full salary, to facilitate their return to work after a long sickness absence. In certain countries (**Austria, Denmark, Finland, Germany, the Netherlands, Norway, Sweden** and **Switzerland**), the legal framework also establishes obligations for employees to undertake a rehabilitation programme to access disability benefits (‘rehabilitation before compensation’ schemes, see Section 4.3.5). Financial incentives for employers can also be found in some legislation. In **Denmark**, §56 of the Act on Benefits in the Event of Illness or Childbirth stipulates that employers hiring a worker with an increased risk of absence from work because of a long-term or chronic health problem can be reimbursed for the first 21 days of sickness absence every time the worker is off work because of their condition.

Finally, the law may also set *coordination mechanisms* for returning to work. In such cases, the law — which may fall under employment, OSH, social security or any other relevant area — describes in detail the role and responsibilities of the actors in charge of leading and coordinating the return-to-work process. This may be the employer, as in the 2002 Gatekeeper Improvement Act in the **Netherlands**, or it may be the leading institution(s) for rehabilitation and return to work, as in the **Danish** Act on Benefits in the Event of Illness or Childbirth, which describes the coordinating role of the local authorities (municipalities) in the rehabilitation/return-to-work process. In some cases, the law may even support the implementation of a system fully dedicated to rehabilitation/return to work, as is the case with the 2011 Work and Health Law in **Austria**, which has set up the ‘fit2work’ programme.

The absence of a strong legal framework for return to work is not necessarily a determinant of how advanced a country’s return-to-work system is. In **Norway**, employers are encouraged to take steps to reduce sickness absence and support their workers’ return to work after sickness absence through the Inclusive Workplace Agreement, concluded by the government and social partners in 2001. In the **United Kingdom**, the implementation of the Fit for Work services has not required the same type of legal provisions as the fit2work service in **Austria**. As mentioned in the previous section, the level of influence of the legal framework on the implementation of an effective return-to-work framework depends on the regulatory traditions of the countries. In those countries that are regulatory driven, the absence of laws for the coordination of rehabilitation and return to work is a sign of a lack of maturity of the system. On the other hand, in policy-driven countries, other factors, such as the maturity of the policy framework and the coordination of the actors involved in the process, will play an important role in the development of effective return-to-work systems.

4.3.3 Policy frameworks

The main references to rehabilitation in the national policy frameworks are in documents related to disability and antidiscrimination policy. Most European countries have a policy framework on disability and antidiscrimination that refers to vocational rehabilitation as a tool to integrate people with disability into professional life. As is the case with the legal framework, many countries integrate the question of rehabilitation within policy discussions on disability.

From the perspective of health and safety at work, many EU Member States make reference to the question of the rehabilitation and reintegration of workers in their national OSH strategies. In a number of countries (**Bulgaria**, the **Czech Republic**, **Croatia**, **Latvia**, **Malta** and **Slovenia**), this is likely to have been influenced by the reference to rehabilitation and reintegration in the European Strategy for Health and Safety at Work 2007–2012 (see Section 4.2.2).

Health is another policy area where rehabilitation is regularly mentioned. In most cases, this is restricted to medical rehabilitation, such as the **Estonian** care and rehabilitation plan 2013–2020, but in some cases it covers a more global approach to rehabilitation, also considering vocational and social rehabilitation and coordination across different areas, such as in the **Portuguese** National Health Plan 2012–2016. In a few countries, rehabilitation is also addressed in health policies focusing on specific diseases or health problems. In **France**, for instance, since 2009, the various Cancer Plans have strongly focused on the professional reintegration of cancer patients after treatment. In the new Cancer Plan 2014–2019, recommendations for return to work are addressed to all people at risk of professional exclusion because of a health problem and not solely cancer patients. In **Spain** and **Portugal**, specific strategies target rheumatic diseases and MSDs, in which the question of professional reintegration is raised.

In a few Member States, social security institutions, which are major players in rehabilitation/return-to-work systems, have developed specific policies to improve their system for rehabilitation. In **Austria**, for instance, the Association of Austrian Social Security Institutions has adopted the Rehabilitation Plan 2012, in collaboration with Health Austria GmbH, to plan healthcare needs with regard to rehabilitation. In **Finland**, KELA has published a 'Development Programme for Rehabilitation 2015', which aims to improve the effectiveness of KELA's activities with regard to rehabilitation. However, these policies are focused on the activities of these institutions and do not have a global perspective on the whole return-to-work process.

Finally, the question of the return to work of workers with a health problem can also be integrated into a broader policy framework, tackling the question of the sustainability of work and the need, from a cross-policy perspective, to retain people longer at work in good and healthy conditions. This is the case in **Denmark**, **Germany**, **Austria** and **Sweden**, where governments have given attention since the mid-2000s to the need to maintain employability and ensure the sustainability of the social security systems and have tackled the issue by reinforcing cooperation across policy areas. This has supported the creation of integrated systems or programmes for rehabilitation and return to work: fit2work in **Austria**, the large Return to Work programme in **Denmark**, the coordination associations in **Sweden** and RehaFutur in **Germany**.

Both the **United Kingdom** and **France** are on similar paths towards the development of comprehensive policy frameworks; the **United Kingdom** has the Health, Work and Well-being Strategy and **France** has the Health at Work Plan, which integrates the relevant policy areas for return to work, that is, OSH, public health, employment and social security. **Denmark**, **France** and **Sweden** use similar language relating to the prevention of exclusion from the labour market. Using this terminology broadens the discourse on return to work to considerations related to social exclusion, discrimination against vulnerable groups, and social equality and equity, instead of discussing it only through the perspective of the viability of the social security systems.

In many European countries, policies focus mostly on the promotion of the right to work of people with disability (i.e. antidiscrimination in employment policies), their needs for medical and vocational rehabilitation (i.e. employment and public health policies) and support for workplace reintegration (i.e. OSH and antidiscrimination policies). Only a few countries present a coherent, holistic and cross-policy framework to maintain employability and promote the early return to work of all workers with health problems, including Denmark, Germany, the Netherlands and Finland.

4.3.4 The scope of the systems

The differences in the legal and policy frameworks reveal a difference in perspectives across European countries as to what rehabilitation/return to work should aim to do or who these systems should target.

A third of the European countries studied for this project target only people with a disability for vocational rehabilitation. This is in line with the evolution at the international and EU levels (see Section 4.2). The entry point into the issue of rehabilitation and return to work has been, for all countries, the question of the reintegration of people with disability into the labour market. In many European countries, this is still the only driver for a rehabilitation system, which focuses primarily on medical rehabilitation, but also sometimes on social and vocational rehabilitation. Return-to-work or reinstatement procedures at the workplace do not exist or, if they do, focus on the obligation of the employer to provide reasonable accommodation and are therefore employer driven. In only a few cases, for instance **Switzerland**, the restriction of the target group to people with disability is also accompanied by concrete return-to-work support measures.

Who is targeted by the systems described in the paragraph above depends largely on the national definition of disability, which can differ from one country to another. For instance, both **Germany** and **Latvia** have included in their legal frameworks the notion of 'predictable disability' or of persons 'threatened with disability'. Predictable disability is defined in **Latvia** as 'a limited functioning caused by a disease or a trauma which, in the case of the required medical treatment and rehabilitation services not being provided, may be a reason for determining disability'. The Social Insurance Institute of **Finland**, KELA, also targets people 'at risk of incapacity'.

Extending the definition of disability to those people who may become disabled or incapacitated if they are not provided the right services in time broadens the scope of the system and is a driver for early intervention. In addition, a few countries have, in practice, extended their definitions of disability to include people with chronic or long-term illnesses. This is the case in **Portugal**, where the OSH legal framework requires employers to adapt the working conditions of workers with chronic illnesses. It is also the case in **Estonia**, where the Social Insurance Board provides services to workers with long-term sickness or permanent health conditions.

The attitude of society towards disability is also an important factor in how effective rehabilitation/return-to-work systems are. In **France**, for instance, the definition of disability is based on the difficulties of accessing the labour market rather than compliance with physical and/or mental health requirements (percentage of invalidity). This definition potentially allows the inclusion of people affected by long-term or chronic illnesses such as cancer or other health problems not commonly recognised as disabilities. In order to have access to a number of specialised services helping the return-to-work process, such as vocational rehabilitation, an official recognition as disabled is necessary. However, studies have shown that workers in **France** — in contrast to **German** workers for instance — are reluctant to receive the status of 'disabled' for fear of facing obstacles in the development of their career or their integration into collective work (Maresca et al., 2008, p. 33). Because of this, it is not uncommon in France for employers, in particular large companies, to encourage their workers to get formal recognition of their work incapacity in order to benefit from the tools available in France to support the rehabilitation/return to work of people with disability²³.

As shown in Chapter 3, the target group of rehabilitation/return-to-work systems in a number of countries extends to workers who have suffered an occupational accident or disease. The responsibility for compensation for occupational accidents/diseases, either of the employer or of the state, explains why such countries aim to put in place procedures and programmes to support the quick reintegration of these workers at the workplace. In countries that have fully inclusive systems, namely those that cover all workers, there are also usually specific programmes and activities for victims of occupational accidents and diseases. In certain countries, such as **France**, it is clear that the return-to-work programmes and support for workers with occupational health problems are the first stepping stone towards a more inclusive system. In other countries, such as **Slovakia**, there is no sign of such evolution.

²³ Another factor to take into account is that having more workers with a formal recognition of disability helps companies reach their employment quota of 6 % of people with disability.

Finally, in a handful of countries, rehabilitation or return-to-work systems target all workers without a need to be recognised as disabled or to have suffered a work-related injury or disease (**Austria, Belgium, Denmark, Finland, Germany, Iceland, Luxembourg, the Netherlands, Norway, Sweden and the United Kingdom**). Therefore, only approximately one-third of European countries have return-to-work systems in place that formally cover everyone, including people who suffer from long-term or chronic health problems.

The scope of the systems is an important determinant of the implementation of comprehensive return-to-work services. The analysis above shows that, in the majority of European countries, rehabilitation is still mainly seen as an instrument to support people with disabilities, while return to work is considered through the lens of the obligation of the employer to accommodate the needs of people with reduced capacities. The link with sickness absence management is missing.

4.3.5 Sickness and disability benefit systems

The OECD, in the foreword of its 2010 report on ‘Sickness, disability and work — breaking the barriers’, stated that ‘too many people of working age who were able to work relied on sickness and disability benefits as their main source of income’ (OECD, 2010). This trend is not a reflection of a lack of motivation or desire of people with health problems to work but rather an illustration of the incapability of national social security and employment systems to provide suitable conditions for them to do so.

The economic crisis has also led a number of countries to adopt reforms in the area of sickness absence and disability compensation, with the objective of keeping people active on the labour market and reducing benefit allocations. In some cases, this has been done only through changes in the allocation criteria. In other cases, this has led to the development of rehabilitation/return-to-work systems.

Sickness absence compensation

While an evaluation of the costs to employers of sickness absence would require a much more in-depth analysis than provided for in the scope of this project, a comparison of the different procedures for the compensation of sickness absence and allocation of disability benefits in European countries in 2013–2014 allows interesting conclusions to be drawn on the links between sickness absence and rehabilitation/return-to-work systems. In particular, the question of who is responsible for providing compensation to sick workers plays an important role in who holds (or takes) the responsibility for rehabilitation and return to work. There are three different trends across the countries studied:

- The first trend concerns countries where the employer pays for income compensation during sickness absence for a duration of at least 30 calendar days before the state takes over income compensation. This duration, defined in the law, varies from a minimum of 30 days (or four weeks) in **Belgium**²⁴, **Denmark, Iceland and Slovenia** (33 days for **Poland**²⁵) to two years in the **Netherlands** (three in some circumstances), with interim durations of six weeks (**Germany and Croatia**), 6 to 12 weeks (**Austria**), 13 weeks (**Luxembourg**) and 28 weeks (**United Kingdom**). In the majority of these countries, the level of compensation paid by the employer amounts to the full salary of the worker. The exceptions are the **United Kingdom**, where the Statutory Sick Pay amounts to approximately EUR 107 a week, although most companies would have higher sick pay arrangements for their employees, and the **Netherlands**, where compensation for sickness absence — that can last up to two years — amounts to a minimum of 70 % of the sick person’s salary. In all these countries — notwithstanding the human costs — the financial cost of a worker on medium- or long-term sickness absence can be quite high for the employer.
- The second general trend includes countries where the employer is responsible for income compensation during sickness absence for less than 30 days before the state takes over

²⁴ Following recent reforms in Belgium, it is foreseen that this will increase to two months. Under the current system, a distinction is made between white-collar workers and blue-collar workers, with compensation by the employer paid to the latter for only two weeks before the sickness insurance funds take over.

²⁵ In Poland, if the worker is over 50, the employer pays for sickness absence for only 14 days (instead of 33).

income compensation. In this configuration, the employer's direct cost for the compensation of sickness absence is relatively limited in time. The state institution responsible for compensating workers on sickness absence takes over relatively rapidly. The time during which employers pay for the salary (or part of the salary) of their sick worker varies from three days in **Bulgaria** and **Switzerland** to seven days in **Lithuania**, eight in **Estonia**, nine in **Finland**, 10 in **Latvia** and **Slovakia**, 15 in **Hungary** and **Spain**, 16 in **Norway** and 21 days in the **Czech Republic**. The level of compensation paid by the employer in these countries ranges from 60 % (**Czech Republic, Spain**) through 80 % (**Latvia, Lithuania**) to 100 % (**Finland, Norway**) of the person's income.

- The final group includes countries where the employer is not, or never solely, responsible for compensating for the worker's loss of income. This is the case in **Ireland, Greece, France, Italy, Cyprus, Malta, Portugal** and **Romania**. In all of these countries (except **Cyprus** and **Romania**, for which the information is not conclusive), the employer can complement the compensation provided by the national social security institution, which is usually lower than in other countries (around 50 % of the person's salary). This complement can be decided during contract negotiations or it can be part of a more general collective agreement at company or branch level.

The duration for which employers have to pay for sickness absence benefits can influence the type of system in place. In **Finland** and **Sweden**, for instance, the state social security body plays an important role in rehabilitation and return to work, which reflects the fact that it is fully responsible for compensating people on sickness absence from day 10 and 15, respectively. In contrast, in the **Netherlands**, the whole return-to-work process falls under the responsibility of the employers who have the legal obligation, and the financial incentive, to support the quick reintegration of their employees. The level of compensation that employers should pay also plays an important role. Employers who have to pay the full salary for several weeks or months of someone on sickness absence are likely to have a stronger and more immediate incentive to put in place effective return-to-work procedures than employers who pay directly for only a few days — even if the latter's indirect costs, in particular contributions to the social security system, are negatively impacted.

Disability-related benefits

OECD data show that the likelihood of someone on disability benefit coming back to the labour market is rather low (OECD, 2010). In its 2013 *Guidelines on Return to Work and Reintegration*, the ISSA supports this argument by observing that workers who lose attachment to their pre-disability employer and enter the benefit system are 'much less likely to re-enter the labour market in the long term' (ISSA, 2013). In 2010, the OECD looked at recent trends in reforms of disability policy and concluded that, one way or another, all OECD countries had put measures in place to increase the labour participation of people on disability benefits and avoid their permanent exclusion from the labour market. This includes, among others, restricting access to disability pensions, making the carrying out of rehabilitation a condition of the allocation of disability benefits and allowing people on disability pension to work.

Restricting access to disability pensions

Restricting access to disability pensions is usually done by modifying allocation criteria:

- One of the most common criteria for receiving a disability or invalidity pension is to suffer from a certain degree or percentage of loss of work capacity. This is assessed mostly on the basis of medical criteria but, in certain countries, additional factors are taken into account to do this assessment, such as the person's social and professional situation. The assessment of loss of working capacity then becomes an assessment of remaining capabilities. **Germany** seems to be the only European country to attribute disability benefits based on the number of hours that a person can work every day, that is, under normal labour conditions, three hours for full disability and six hours for partial disability. In the German system, even with full disability benefits, a person is considered able to work up to three hours a day.

- Timing can also be a criterion in the allocation of disability benefits. In **Belgium, Ireland, Spain, the Netherlands, Slovakia, Sweden** and the **United Kingdom**, a person cannot be allocated disability benefits before the end of sickness absence compensation.

The OECD notes that, over the past 20 years — and increasingly recently — many European countries have modified their minimum levels of disability required to receive benefits or have introduced regular re-assessment of the entitlements, showing a trend towards stricter regimes for disability benefits. Without a support system for rehabilitation, some of the recent changes made to the disability benefit allocation procedures could exclude workers with serious or chronic health problems from the income-support system (disability or unemployment benefits) and lead them to claim other, less supportive, forms of social welfare benefits.

Rehabilitation before compensation

Another measure to increase the labour participation of people on disability benefits is to make rehabilitation a condition for the allocation of disability benefits. This principle — known as ‘rehabilitation before compensation’ — makes rehabilitation an integral part of statutory compensation. Socio-vocational rehabilitation is both a right and an obligation, that is, no earning compensation is awarded until rehabilitation possibilities have first been assessed. To date, this principle is applied in **Austria, Denmark, Finland, Germany, the Netherlands, Norway, Sweden** and **Switzerland** and is supported by a solid system for vocational rehabilitation. Some countries have taken a step further by bringing the allocation of disability benefits to an end altogether and instead providing financial support for rehabilitation and employment promotion measures. This is the case in **Austria**, which, since 2012, provides financial support for rehabilitation to all workers below the age of 50 with a reduced work capability. Disability benefits are given only to workers older than 50 who have not returned to work even after following rehabilitation programmes. In **Norway**, since 2010, the Work Assessment Allowance merges previous rehabilitation and disability benefits and is meant to cover costs related to medical treatment and any measures related to return-to-work. Finally, in **Sweden**, no disability benefits are provided. Workers with a permanently reduced capacity to work, and for whom all possibilities for returning to work have been exhausted, receive sickness compensation, which is re-evaluated every three years.

Combining work income and disability benefits

A number of countries in Europe have introduced recent changes to their disability systems and now allow people who receive disability benefits to earn an income at the same time. This includes **Belgium, Denmark, Germany, Ireland, France, Cyprus, Lithuania, Portugal, Slovenia, Finland** and the **United Kingdom**. There is usually a limit on how much income per week a person can earn or how many hours a week a person can work while receiving disability benefits. As mentioned before, these measures help to shift the perception of disability benefits from ineluctably permanent towards temporary income-support measures for the worker in rehabilitation.

Reducing disability benefits: the case for early intervention

In 2010, the OECD investigated the links between sickness absence and the allocation of disability benefits and concluded that the majority of disability benefit claimants (between 50 % and 90 %) enter the disability benefit system after a long period of sickness absence (OECD, 2010). These observations support the argument that effective return-to-work policies should be based on an early intervention principle and that interventions should take place during sickness absence. Rehabilitation policies and programmes that involve intervening after the person has been recognised as disabled come in rather late in the process, at a point when the person has already been out of work for a long time and the path to rehabilitation and return to work is likely to be longer and more difficult. Rehabilitation programmes to promote the employment of people with disability are critical, but an effective reduction in disability benefit claims can happen only if these programmes are combined with a system to better manage sickness absence and return to work.

4.3.6 Institutional framework and stakeholders

The institutional framework in which rehabilitation/return-to-work systems are implemented plays a very important role in the type of services that will be provided in a country and how coordinated and effective the system is. Which institution leads or is involved in the process depends on the country's history and tradition with regard to questions of social security, employment, health and OSH.

Often, different institutions will be responsible for different aspects of the rehabilitation/return-to-work process, for example national healthcare systems are responsible for medical rehabilitation while social security institutions and employment agencies take care of vocational rehabilitation. In most countries, one institution is likely to take the lead in the process, or at least have a greater interest in the issue of rehabilitation/return to work. Several institutions can be equally involved in the process and, particularly in such cases, whether the system is effective or not depends on the existence of coordination mechanisms (see Section 4.3.7). In addition, the employer and non-institutional actors, such as insurance companies, social partners, non-governmental organisations, etc., can also play a critical role in the rehabilitation/return-to-work process.

Institutional actors

In the majority of countries, relevant activities for rehabilitation/return to work are put in place by social security institutions. The institutions that take the lead or are most proactive in the question of rehabilitation/return to work can be from different branches of social security, such as health, pensions or occupational accidents and diseases. Other institutional actors, such as employment agencies, local authorities or disability-related institutions, can have a strong, even leading, role.

Social security institutions

The reason for these institutions becoming involved in the rehabilitation process is straightforward. They are responsible for all or part of the costs of workers on sickness absence, from medical costs to compensation for loss of earnings and the provision of disability benefits. Therefore, they have a financial stake in the reintegration of sick or injured workers to reduce costs related to sickness and disability compensation.

Three aspects, in particular, determine how social security institutions are involved in the rehabilitation/return-to-work process:

- The first aspect is the types of services these institutions provide. In certain countries, the organisation is only responsible for making an assessment of work capability in order to decide on the allocation of health- and disability-related benefits. In some cases, this is also accompanied by recommendations for the worker and/or the employer and OSH services on workplace adaptations. At the worker's request, other organisations, such as disability-related organisations or employment agencies, may be involved in the follow-up process. In certain cases, such as in **Finland** or **Sweden**, social security institutions go further by providing, or paying for, vocational rehabilitation services — such as vocational training or work trials — and/or providing individualised advice on return to work to the worker and/or the employer, for example on needs for ergonomic adaptations, changes in the working schedule, etc.
- The second aspect is the population targeted by the services offered. As shown in Section 4.3.4, in most countries, the programmes in place for rehabilitation target only people with a recognised degree of disability and/or people suffering from occupational diseases or accidents. This happens because different institutions are responsible for different aspects of social insurance: one institution may be responsible for healthcare insurance, one for insurance against occupational accidents/diseases, one for earning-related pensions, another for disability-related pensions, etc. This division of responsibility means that each institution does not have the same interest, and role to play, in the rehabilitation/return-to-work process. A common situation in Europe is that those institutions responsible for compensation for occupational accidents and diseases take the lead in the development of rehabilitation/return-

to-work procedures, as the compensation costs (per worker) are usually higher than for the compensation of non-occupational health problems.

- The third aspect is the degree of cooperation between employers and other stakeholders. In most countries, there is no formal coordination mechanism with the employer and little (technical) support is provided to them for the reintegration of their sick/injured worker. Employers benefit only from a form of financial support but, in some cases, the worker has to be recognised as disabled. In only a few countries, such as in the **Netherlands, Finland and Sweden**, has the leading institution for rehabilitation and return to work put in place a formal coordination mechanism to involve employers in the return-to-work process. In addition to coordinating with employers, these institutions can also coordinate with other external stakeholders such as vocational service providers or employment agencies.

Healthcare systems

In all countries, medical rehabilitation of the sick or injured worker takes place within the general healthcare system. In some countries with insurance-based systems, exceptions exist for workers suffering from occupational accidents or diseases who can follow medical treatment and rehabilitation in the facilities of insurance institutions.

In general, the GP is the first port of call of the sick or injured worker. The GP is usually the person responsible for issuing the certification of temporary incapacity to work that is required to enter sickness absence and receive sickness absence benefits. In most cases, the GP is also responsible for ending the sick leave. Workers receive medical treatment and medical rehabilitation from therapists, hospitals, clinics, etc., depending on their needs as identified by the GP or the treating physician. GPs, and more generally healthcare professionals, therefore have a critical role in the return-to-work process. The timing of their interventions is usually critical in the quick reintegration of the worker. The Fit for Work Europe Coalition reports that timely interventions from physiotherapists and clinical psychologists can have a significant impact on the return to work of workers suffering from MSDs (Bevan, 2013).

In some countries, health insurance institutions or sickness insurance funds can also play a role in the return-to-work process. In most cases they will have a strong impact on the medical rehabilitation phase (in particular in **Ireland** and the **United Kingdom**), but in other cases they can play an important role in coordination with the employer and in the reintegration of the worker at the workplace. In **Belgium** and **France**, the medical advisor of the sickness insurance organisation (private in Belgium, public in France) has a critical role in monitoring sickness absences and, if necessary, coordinating with the worker and the employer (in France) for the reinstatement of the worker into the workplace.

General social security institutions

In many countries studied, the main institution involved in vocational rehabilitation and return to work is the social security agency (**Bulgaria, Cyprus, Estonia, Finland, Greece, Latvia, Lithuania, Luxembourg, Norway, Poland, Portugal, Slovakia, Spain** and **Sweden**). The degree of involvement of this institution in the whole return-to-work process varies from being the main coordinating body, as in **Norway** and **Sweden**, to being solely responsible for the allocation of health and disability benefits, as is the case in **Greece**. In between, social security bodies can have very diverse roles and responsibilities in the process, depending on the tradition of the country, the degree of autonomy the institution has and how proactive it is (or can be) on these issues.

Occupational insurance organisations

In many European countries, employers are required to take up insurance to protect their workers against the risk of occupational accidents. In most European countries, occupational insurance is managed by public organisations, while in a few countries (**Belgium, Denmark, Spain**, the

Netherlands, Finland and the **United Kingdom**), it is run by private insurance companies²⁶.

Occupational insurance organisations, public or private, can play an important role in the development of effective return-to-work processes. Like other social security institutions, insurance organisations have an economic interest in the quick reintegration of workers at the workplace. In most countries, they are responsible for compensating the loss of earnings of the worker who has suffered from an occupational accident or disease and is on sickness absence. They also typically cover the costs of medical treatment and medical rehabilitation. In some countries, such as **Belgium, Germany, Spain, Austria, Portugal** and **Finland**, the insurance system covers all of the healthcare costs of the sick or injured worker, whereas, in other countries, it supplements the health insurance system, covering additional expenses not provided under the public healthcare system (Pecillo, 2013). Occupational insurance systems can also be responsible for covering other costs such as the provision of technical aid to support the reintegration at the workplace of workers with reduced capabilities and, in some countries, such as **Germany** or **Finland**, they are responsible for paying the disability pension of workers with permanent disability.

Because of the costs incurred by occupational accidents and diseases, insurance organisations often implement prevention activities at the workplace to avoid their occurrence. In addition, in a number of countries, for example **Austria, Finland, Germany, Italy, Romania, Spain** and **Switzerland**, the occupational insurance system also takes charge of vocational rehabilitation and return to work in order to ensure that the worker reintegrates the workplace or labour market quickly. **Finland** has shown particular leadership in this area, which can be partly explained by the fact that the occupational insurance system is privately run. Since 1964, private accident insurance companies have created the Insurance Rehabilitation Association of Finland (VKK), which assists insurance companies in planning and implementing rehabilitation and return-to-work services of their clients.

In **Austria, Germany, Finland** and **Switzerland**, the lead shown by occupational insurance organisations to set up effective return-to-work processes for victims of occupational accidents and diseases has been a driver in the implementation of a comprehensive system for all workers.

Pension organisations

In a few countries, for example **Germany, Austria, Slovenia** and **Finland**, the pension institution or pension insurance scheme also plays an important role in the rehabilitation/return-to-work process. In **Slovenia**, the intervention of the Pension and Disability Insurance Institute is limited to people with a disability and workers who have suffered from an occupational accident or disease. In **Germany, Austria** and **Finland**, the pension insurance schemes — public in Germany and Austria and private in Finland — are responsible for providing sickness absence and disability benefits to people who are suffering from non-occupational illness or injury, which covers a large proportion of the population on sickness absence. They have therefore put return-to-work programmes in place to encourage the early reintegration of people on sickness absence and to avoid their transfer to the disability benefit system. Such programmes can be implemented either at national/federal level or by regional branches of the pension scheme. For instance, in 2011, the **German** statutory pension insurance scheme in Westphalia implemented the project RehaFuturReal®, which aimed to rehabilitate and reintegrate workers on sickness absence. This was based on the nationwide initiative RehaFutur launched in 2009 by the Federal Ministry of Labour and Social Affairs.

Other institutional actors

Local authorities

In a few countries (mostly Nordic countries), local authorities play a prominent role in the rehabilitation/return-to-work process. The most striking example is **Denmark**, where the municipalities hold the main coordinating role in the return-to-work process and are responsible for providing health,

²⁶ In Belgium, Denmark and Spain, occupational disease insurance is managed by a public entity.

social and employment services, including compensation for sickness absence. In **Sweden**, the Social Security Agency is supported in the return-to-work process by municipalities, which are responsible for social rehabilitation and the provision of social services. In **Norway**, municipalities are the extended arm of the national healthcare services and are therefore responsible for medical rehabilitation. The Norwegian Labour and Welfare Administration, which has overall responsibility for the return-to-work process, must therefore coordinate with them.

Involving municipalities or local authorities in the return-to-work process is a way for the national coordinating body to reach the local level and possibly more easily reach employers. In most advanced countries, the main coordinating body (when there is one) usually has a number of regional/local branches in any case. The Fit for Work services in the **United Kingdom** and the fit2work programme in **Austria** consist of nationwide networks of local units dedicated to return to work. At the local level, decentralising the process is a key component of any successful return-to-work system.

Employment agencies

Employment agencies are also important actors and are the lead organisations in the development of rehabilitation/return-to-work systems in some countries (**Czech Republic, Estonia** (after the upcoming reform) and **Malta**). Several reasons explain the involvement of employment agencies. Firstly, they have a clear incentive in reducing the number of people with health problems who receive unemployment benefits. This includes people who have a reduced working capacity that prevents them from going back to their previous occupation following an illness or an accident, but who have not had a formal recognition of disability and do not receive disability benefits. In their review of sickness absence, Black and Frost show that, in the **United Kingdom**, the proportion of people who are unemployed is almost the same as the proportion who are still in employment after more than one year of sickness absence (Black and Frost, 2011).

In addition, employment agencies are likely to be in contact with providers of vocational training, as these provide services for unemployed people in need of professional reconversion for reasons other than health. Employment agencies in some countries have also developed programmes to support the reintegration of workers into their previous workplace. This is the case, for instance, in **Portugal**, where the Institute of Employment and Professional Training supports workers with the development of a reintegration plan and provides vocational rehabilitation services if needed. However, depending on the degree of coordination between institutions and the efficiency of the system, the interventions of the employment agencies may arrive quite late in the process for the worker: either far past medical rehabilitation or even after the end of the sickness absence.

Disability-related institutions

Finally, in a number of countries (**Bulgaria, Croatia, Hungary, Iceland, Lithuania**), specific institutions for the rehabilitation of persons with disabilities are in charge of assessing the degree of disability, allocating disability benefits and coordinating the provision of rehabilitation services.

The workplace

By definition, a return-to-work system should involve workplace actors, in particular the employer. In certain countries, the process is solely employer driven. This can be because there is no institutional framework in place to support the process and therefore the existence of a return-to-work system for the worker on sickness absence depends on the minimum legal obligations and the employer's willingness to put in place adequate measures. Or it can be because the legal and policy framework for rehabilitation and return to work gives the lead to the employer, assigning to him/her clear responsibilities and incentives, as is the case in the **Netherlands**.

The employer's role in the reintegration process depends first and foremost on the obligations inscribed in the law. In certain countries, clear rules are defined regarding the role of employers and workplace actors, for example requiring employers or OHSs to draw up reintegration plans, to set up individualised measures to adapt the workplace and the working conditions to the working capacity of

the returning worker, and to monitor the worker's health to ensure the sustainability of the return to work. In countries where no such obligation exists in the law, employers that are keen to put sickness and disability management policies and programmes in place in their company would need either support to do so from external organisations or to define their own rules based on experience, in consultation with their workers and other relevant actors involved in the process, such as OHSs, HR, workers' representatives, trade unions, etc. In countries with more limited legal and/or institutional settings for rehabilitation/return to work, sickness and disability management policies are more likely to be implemented in large or multinational companies than in small and micro companies, especially in those with parent companies in countries with stronger legal and/or institutional return-to-work systems.

What can make a difference in the involvement of the employer in the return-to-work process is the support received to implement return-to-work procedures in the workplace. This support can be internal or external and it can be technical or financial.

Technical support can come from (internal or external) OHSs. In a number of countries, the reinstatement procedures inscribed in the law give a formal role to the OHSs. They serve as a safeguard for the returning worker, who should be offered an occupation adapted to their capacities. They also serve as a support mechanism for employers who are not necessarily qualified to assess their workers' remaining capacities and propose adequate workplace adaptations. In countries where the reinstatement procedure relies heavily on OHSs, it may be more difficult for small and micro companies, which do not have internal services and depend on external services for support. Technical support can also come from the institutions described in the previous and following sections and can take different forms, from technical guidance documents (e.g. on how to reintegrate a worker with a specific health problem) to the provision of counselling sessions (e.g. to help workplaces make an ergonomics assessment prior to the return to work of the person with a disability, draw up a return-to-work plan or provide workplace adaptations).

In many countries, financial support is more easily available for employers than technical support. Financial support can consist in financial incentives for employers to put in place return-to-work mechanisms, for example decreased contributions to social security schemes, tax relief or support to pay for the salary of a worker with reduced capacity. It can also help the employer to purchase necessary equipment (e.g. adapted equipment for a specific disability) or necessary services (e.g. counselling sessions). Funding can also be made available for employees to undertake vocational rehabilitation). Vocational rehabilitation can be partly funded by social insurance (for instance in Germany, Austria and Sweden), health insurance (France), the state (France, Norway) or another entity responsible for rehabilitation, such as the municipalities in Denmark.

How effective technical and financial support is depends on how aware employers are about its existence and the modalities to make use of it. In many countries, the support is earmarked for workers with a recognised degree of disability.

4.3.6.1 Non-institutional actors

Non-institutional actors can be a significant force in the development and implementation of rehabilitation/return-to-work systems, in particular in countries where they are traditionally major actors in the fields of OSH, employment and social security policy development.

Social partners

Across Europe, social partners are, on average, not very active in the field of rehabilitation/return to work. In only a few countries have social partners taken initiatives to support employers and workers with return to work. From the trade union perspective, these initiatives focus on promoting the worker's access to vocational training and rehabilitation systems. In **Denmark** and **Sweden**, the Confederations of Trade Unions (LO in both countries) have included the issue of rehabilitation and return to work in their guidelines for the development and implementation of collective agreements on well-being at work. From the employer and business side, the support provided by social partners focuses on technical guidance and advice to support the employer in navigating sickness and disability

management systems in their country. In the **United Kingdom**, the Confederation of British Industries has produced a guidance document entitled 'Getting better — workplace health as a business issue', which identifies early intervention and rehabilitation as the second and third stages, respectively, of a proactive approach to sickness and disability management. Initiatives can also be undertaken at the sectoral level. In **Belgium**, the National Committee for Hygiene and Safety in the Construction Sector published a report in 2012 on 'adapted work for workers with physical work inability'.

Even if only a limited number of national businesses' and workers' organisations have carried out separate activities related to rehabilitation/return to work, their role is critical at the workplace and intervention levels. Workers are not always aware of the support that is available to them upon their return to work, such as the possibility to meet with the OHSs and determine if workplace adaptations may be needed. This can be overcome if a clear policy on sickness absence and disability management is established with clear procedures in place that are well communicated to the workers. In a number of countries, company agreements are adopted to define the policy and rules for the management of sickness absence and of disability. Involving workers' and trade union representatives during the development of the company's policy on return to work helps to create ownership from the workers towards the process and ensures that they are aware of the mechanisms in place to support them.

Private actors

Private rehabilitation service providers comprise medical rehabilitation providers (such as physiotherapists, psycho-motor therapists, psychological therapists, wellness centres, etc.) and vocational rehabilitation providers, such as training centres. They can be contacted by the insurance or case manager in the context of an individual rehabilitation plan or directly by the employer to support and advise on workplace adaptation and individual rehabilitation measures. In the first case, services are usually funded or co-funded by the insurance provider (sickness, accident or invalidity insurance, depending on the Member State and/or the individual situation of the employee). In **Finland**, the Insurance Rehabilitation Association of Finland (VKK) does not have dedicated rehabilitation or training facilities, but uses the services of various public and private rehabilitation service providers (including private vocational training institutes) and private rehabilitation facilities. In the second case, the employer generally pays for the services with, in certain cases, the support of public grants. In the **Netherlands**, advice and coaching on how to set up and develop a re-integration action plan for an employee on sick leave is provided by private enterprises, specialised in coaching and assisting in re-integration, the 're-integration bureaux', or general multidisciplinary occupational health and safety service providers. Private service providers can also propose case-management rehabilitation services to employers or insurers²⁷.

Other non-institutional actors

Other types of non-institutional actors have a strong interest in rehabilitation and return to work and have contributed to raising the level of awareness about the need to pay attention to these issues. In many countries, disability-related non-governmental organisations and charities have been working on the topic of the vocational rehabilitation of people with disability for a long time. In a few countries, research institutions working on OSH and prevention have also largely been contributing to, and are even leading, the discussion, such as the Fit for Work Europe Coalition in the **United Kingdom**, Prevent in **Belgium** or the FIOH in **Finland**.

Research organisations specialised in the prevention of one disease (or one type of disease) can also be particularly active in developing return-to-work strategies adapted to those suffering from this disease. Different types of illnesses will require different types of reintegration measures. A worker suffering from cancer will need a very different approach to work reintegration from that of a worker suffering from a musculoskeletal or cardiovascular problem or from a mental health problem. Not only

²⁷ See the case study 'Northumbrian water limited "Wellbeing Programme" ' from the UK, produced in the framework of the project Safer and Healthier Work at Any Age.

should the measures at work be different, but the way the return to work is approached should also be different, including from a psychological perspective.

Cancer prevention organisations, such as the League against Cancer in **France**, the MacMillan Cancer Support charity in the **United Kingdom** and the Flemish League Against Cancer in **Belgium**, have worked particularly actively on the issue of the return to work of cancer patients. Cancer requires a lot of flexibility on the part of the employer. Measures, such as gradual return to work, part-time work or phased-in retirement, as promoted in a number of countries, are considered to be efficient ways of ensuring the sustainable return of workers who have suffered from cancer. Back-to-work strategies for people suffering from MSDs have also been investigated by a number of organisations, such as the Work Foundation in the **United Kingdom** and the coalition of partners leading the ZORRO project in **Belgium** focusing on healthcare personnel suffering from severe back pain.

Mental health problems have also received some attention, although not to the same degree as physical problems. The lack of support for the return to work of people suffering from mental health problems is common across Europe. The REINTEGRA network in **Austria** aims to provide rehabilitation and return-to-work support to workers with psychological problems. In the **UK**, the Sheffield Occupational Health Advisory Service (SOHAS) has been working since 2009 with the local service for Improving Access to Psychological Services (IAPT) to support the return to work of people with mental health issues.

In **Ireland** and the **UK**, for instance, which are traditionally more employer driven than regulatory driven, non-institutional actors play an important role in the development and implementation of national policy. In the **UK**, a number of charities, such as the British Heart Foundation or Arthritis Care, have developed guidance and advice mechanisms to support the reintegration of workers with specific health problems.

The presence of a strong institutional framework is an important driver for the implementation of a national rehabilitation/return-to-work system. How this framework is built and which institution takes the lead depends on the country's traditions and functioning in terms of OSH, social welfare and employment. In countries with more limited institutional involvement, non-institutional actors can also be significant drivers for the development of a national policy on rehabilitation/return to work. While one institutional framework cannot be said to be better than another, the presence of coordination mechanisms is a major factor in the implementation of effective rehabilitation/return-to-work systems.

4.3.7 Coordination

One of the main defining criteria for the grouping applied in Chapter 3 is the degree of coordination across the various stakeholders involved in the return-to-work process. Return to work is a complex process that covers a number of steps to be taken from the moment the person goes to his/her GP with a health issue to the point when they are reintegrated into their workplace. Depending on the complexity of the case (type of health problem, duration of sickness absence), the worker will need to go through a number of services for their medical, professional, social and personal recovery. This is why the presence of coordination mechanisms is essential to guide the worker and their employer through this complex journey.

Coordination mechanisms

Coordination mechanisms can take various forms. They can be either part of traditional governance structures, led by one of the institutions described in the previous section, or a stand-alone service set up specifically for rehabilitation/return to work. In most countries with rehabilitation/return-to-work systems in place, coordination mechanisms are set up by the leading institution, such as the main social security body (e.g. the Social Insurance Agency in **Sweden**, KELA in **Finland** or the NAV in **Norway**), local authorities (e.g. municipalities in **Denmark**) or insurance and pension organisations (e.g. the statutory accident insurance scheme in **Germany**). Each of these institutions will have a specific department or unit to deal with rehabilitation/return to work.

Only two countries have set up stand-alone services specifically for rehabilitation and return to work: Austria and the UK. In **Austria**, the fit2work programme was set up in 2012 as a network of regional and local units providing counselling to workers who have left work because of a health problem and

want to reintegrate quickly and to employers who want to intervene to maintain the employability of an individual worker or of their whole workforce. In the **UK**, the Fit for Work advice service started operating in December 2014 in a number of pilot locations. With this new service, GPs or employers can refer workers on sickness absence to a team of occupational specialists who will help them to prepare a return to work plan identifying the obstacles and needs for quick reintegration at the workplace.

Whether integrated or stand-alone, these coordination mechanisms have a number of characteristics in common:

- they act as one-stop-shops, where workers and employers can receive all the information they need through a single point of contact;
- they offer multidisciplinary services in order to cover the different needs of the individual — either as part of their in-house competences or by coordinating with external providers;
- they use a ‘case-management’ approach, that is, a return-to-work professional is in charge of helping the worker to navigate the different services needed for successful return to work and ensuring that the services proposed correspond to the worker’s needs;
- they provide individualised advice, fully tailored to the worker’s needs and capacities.

In the **Netherlands**, which has a fully employer-driven return-to-work system, coordination with the relevant actors involved in the reintegration support mechanism takes place at workplace level. In this case, company agreements can define a company’s policy with regard to sickness and disability management and the roles and responsibilities of each actor involved. This is also true in other countries with strong traditions of social dialogue at workplace level, such as **Denmark** and **Germany**, where employers also have a strong responsibility for the return-to-work process.

When is coordination needed?

There are several moments in the return-to-work process when coordination between the different parties involved is particularly important.

The first is at the very beginning of the process, when medical treatment is taking place. The Fit for Work Europe Coalition has carried out research since 2009 on how European countries (and a number of other countries such as Israel and Canada) deal with the (re)integration into the labour market of people suffering from MSDs. Some of the findings from this research relate to the link between medical treatment and integration in the labour market. The coalition’s studies note that, in most European countries, there is a lack of consideration for work outcomes during medical treatment and GPs may even be reluctant to consider return to work before a person’s health has been fully restored (e.g. McGee et al., 2010; Zheltoukhova et al., 2012).

In the **UK**, a similar observation is made by Black and Frost looking at the ‘fit note’ certification system. Black and Frost add that, even if GPs take into account a person’s individual work task when deciding upon return to work, it is unlikely that the GP would think about possibilities for adapting the working environment to accommodate a person’s impairments, as this is not the role of the medical doctor but rather of the occupational physician (Black and Frost, 2011). At the same time, GPs in most countries are those who decide when a person is ‘fit’ or able to return to work.

For reasons of medical confidentiality, in many countries it is not acceptable that the employer and the medical doctor share information about the worker’s health status. This is where the coordinating bodies can come into play and make the link between the medical side of the rehabilitation process and the actual return to work. In individual ‘case-management’ approaches, the coordinator in charge of one individual’s file has access to that person’s health records as part of the background information needed to prepare a rehabilitation plan and may coordinate with other health professionals to assess a person’s state of health. In the **Netherlands**, where there is no single coordinating body, this coordination role between the medical side and the work environment can be fulfilled by two actors: the health insurance funds and the OHSs or occupational physician. In **Belgium**, the medical adviser of the health insurance fund can also play this coordinating role (in theory). Practice shows that improvements are needed in both countries on the coordination between the three types of doctors

(medical, insurance and occupational).

The second step in the return-to-work process in which coordination is needed is the start of vocational rehabilitation. Not all workers need vocational rehabilitation but those who do can easily get lost in the large variety of services and providers that exist. In addition, workers may not know exactly what kind of vocational rehabilitation service they need, based on their health condition and their professional situation. Once again, a 'case manager' can help the worker to decide what service they need and where to receive these services. Without a case-management approach or a body supporting the worker at this stage, it may be difficult for the individual worker to know which service will be most useful.

Finally, coordination is also needed when the worker is reintegrated into the workplace. Return to work cannot be successful without a clear involvement of workplace actors. This includes not only the employer but also, when they exist, OHSs and HR departments. These services can play a very important role in return to work, as they provide the expertise needed to adapt the worker's environment. The adaptations needed for sustainable reintegration following sickness absence usually cover both OSH (e.g. adaptations of equipment) and HR (e.g. adaptation of working time), hence the need for involvement of both services. This is what can make the reintegration process difficult for small and micro companies, where such services are usually not present and these functions are fulfilled by the employer. A support service for return to work providing guidance and technical advice to companies can help overcome these barriers, in particular for small and micro companies.

Returning to work after a medium- to long-term sickness absence is a complex process requiring a number of steps, some of which should be taking place in parallel, and not consecutively, to ensure early return to work and avoid long or permanent exclusion from the labour market. Thus, whatever the basis for coordination, the presence of coordination mechanisms for rehabilitation and return to work is one of the most significant determinant in the implementation of return-to-work systems.

4.4 Conclusions

Chapter 4 focused on the determinants of a rehabilitation/return-to-work system and attempted to capture some of the factors that influence the features and components of a rehabilitation/return-to-work system.

The overall economic context

When looking at all determinants together, at international, EU and national levels, one factor stands out as a common driver for all European countries for the implementation of rehabilitation/return-to-work systems: the collective realisation, inflated by the economic crisis, that the costs of sickness absence and disability benefit schemes contribute to a substantial part of expenditure on social welfare and that therefore public spending reforms are required. Taking into account the present and future demographic changes in the age of the European population, guaranteeing the sustainability of social security systems is a concern common to all European countries.

The supranational influences

The discussion at national level of rehabilitation and return to work originates from the commitment of developed countries since the Second World War and the development of welfare states to develop equality policies for people with disabilities and to increase their opportunities to access the labour market. This trend is reflected in the way the issue of rehabilitation and return to work has been dealt with at international level. There has been a progressive shift from a focus on providing rehabilitation services to integrate people with disability into the labour market to a focus on return-to-work strategies intervening early to avoid people leaving the labour market because of a reduced capability to work. The influence of EU policy frameworks for employment, OSH and public health on the development of national systems has been rather limited. This is explained by the fact that one of the main areas of intervention for the development of return-to-work systems is social security, which is a competence of the Member States, where the EU does not intervene.

National determinants

At the national level, with the exception of the economic argument for reduced spending on social welfare benefit schemes, determinants related to national traditions, policy or legislation do not have a strong influence in triggering action. A country more policy driven than regulatory driven can develop an effective return-to-work system, for instance based on an incentive-driven sickness compensation system or on an institutional framework with well-defined roles and responsibilities and coordination across stakeholders.

The various determinants at national level shape the system rather than influence its existence or its effectiveness. In that sense, sickness compensation systems that put more responsibility on employers are typically accompanied by a legal obligation for employers to put in place support mechanisms for the reintegration of their sick employees. In addition, a return-to-work system led by a long-standing social security institution will have to develop strategies to coordinate the action of the relevant service providers and may need changes in these institutions' structures. Alternatively, the country might decide to create a stand-alone institution for the purpose of coordinating the return-to-work process, with adequate coordination mechanisms already built in.

Two factors, however, carry more weight than others. The first is the scope of the systems. As mentioned above, most countries have approached the question of rehabilitation and return to work by focusing on the needs of people with disabilities for (vocational) rehabilitation. Today, however, a number of countries are focusing on sickness absence management and approaching the topic through the angle of return to work, of which rehabilitation is only one component. The scope of the return-to-work systems in these countries is therefore much broader. It covers all workers going on medium- or long-term sickness absence and is not restricted to people with officially recognised reduced working capacity or to people who suffer from certified occupational accidents or diseases. The second important factor is the presence of coordination mechanisms. These mechanisms can be

inscribed in the law or defined in a policy framework, instituted at national level or left to the appreciation of workplace actors, developing around one main leading institution or forming a network of several players, institutional or not. Whatever their form, coordination mechanisms are a key determinant in the implementation of effective return-to-work systems, in particular to guarantee efficient support to employers and effective cooperation between health services (GPs/OHSs).

5 Factors for a successful rehabilitation/return-to-work system

This chapter investigates a number of factors that contribute to the successful implementation of rehabilitation/return-to-work systems and programmes. This compilation of success factors is based on the analysis of the countries' systems for rehabilitation/return to work and their determinants, the analysis of the in-depth descriptions of programmes implemented in nine Member States (case studies) and the research review of effective return-to-work interventions at workplace or individual levels. It also incorporates recommendations from international organisations such as the WHO, OECD, ISSA and ENWHP.

The chapter first presents success factors at the policy level. It then considers success factors at the intervention level (both outside and inside the workplace).

5.1 Policy level

The ISSA observes that return-to-work systems need a policy and legal basis to function properly (ISSA, 2013). The study shows that the legal, policy and institutional frameworks of successful return-to-work systems have a number of common elements, even when implemented in countries with very different profiles and traditions, including:

- a legal framework covering all aspects of the process;
- an integrated policy framework, covering all relevant policy areas;
- effective coordination mechanisms;
- an inclusive system targeting all workers with a health problem;
- incentives for both employers and workers;
- a number of support activities from institutional and non-institutional actors.

Legal framework

The legal basis for return-to-work systems may be found across different legal acts covering health, antidiscrimination, OSH, employment and social security. A legal framework that covers all aspects of the process in a coherent way is necessary for a successful return-to-work system, either by regulating all the steps of the return-to-work process under a single legal act or by defining in the law clear coordination mechanisms across these different steps. In **Germany**, for instance, the return-to-work process is codified in the Social Security Code Book IX on the 'integration and rehabilitation of disabled people', which was reformed in 2004 to introduce the notion of Workplace Integration Management to maintain the employability of people who become unfit for work. In **Austria**, the creation of the fit2work programme was based on the 2011 Work and Health Law, which states that a prevention and information tool should be developed for the fostering of work ability of the Austrian workforce and avoiding permanent illness, leading to disability and early retirement.

The majority of countries have defined rules related to rehabilitation/return to work more broadly than through the angle of discrimination against people with disability and the promotion of their right to work. The OSH legal framework may contain an obligation for employers to adapt working conditions to the abilities/capacities of the worker. Some countries even go further by mentioning that the working environment should aim to maintain or restore workers' abilities. It can also define rules for the reintegration of workers at the workplace after a certain duration of sickness absence. In addition to normal rules regarding compensation for sickness absence and allocation of disability benefits, the social security legal framework can also contain provisions to support effective return to work. In a number of countries, such as **Germany**, **Austria** and **Finland**, the provision of sickness absence benefits is conditional on the worker's participation in a rehabilitation programme.

In countries with comprehensive return-to-work systems (see Section 3.2), antidiscrimination legislation is no longer the pivotal legal act for the process, as in other countries. The main issue of

reintegration and return to work has shifted from consideration of the employability of people with disabilities to looking at these systems as aspects of a broader strategy to reduce long-term sickness absence and prevent what France calls *désinsertion professionnelle* (exclusion from the workplace because of a health problem).

Policy framework

Some countries with successful return-to-work systems have pursued a more policy-centred approach. Return-to-work systems are more likely to be effective if supported by a coherent and integrated policy framework. This framework should define the main objectives of the system and provide a foundation for the designation of clear coordination mechanisms. As observed by the ENWHP, the creation of a holistic strategy for return to work helps to raise its importance on the policy agenda (ENWHP, 2013).

A policy for return to work should be integrated, that is, it should cover all relevant areas of the process. A unified policy framework helps with the designation of roles and responsibilities. However, it should not prevent mainstreaming of the issue in different policy areas. In **France**, returning to work with cancer is part of public health policy, while preventing exclusion from work because of a health problem is included in the upcoming national OSH strategy.

In many countries, the entry point for the question of return to work at policy level is the lack of sustainability of social security systems and the need to reform the management of sickness absence and disability. Return-to-work interventions, which help people to remain at work, reduce welfare payments, avoid lost tax revenues and reduce social exclusion. Considering the issue of rehabilitation and return to work from an economic angle, rather than purely an antidiscrimination or OSH angle, helps to raise its profile at national level, especially in times of economic hardship. At the same time, the objective of developing effective return-to-work systems should be part of countries' broader strategies for sustainable working lives.

At the end of the 1990s, **Sweden**, confronted with a serious problem of high sickness and disability benefits expenditure, started to look at the issue from an economic and budgetary perspective. In **Denmark**, similar considerations on sickness absence towards the end of the 2000s have led the government to initiate the tripartite agreement on the reduction of sickness absence that, subsequently, led to the creation of the successful National Return to Work Programme. The **German** and **Austrian** governments have launched initiatives on rehabilitation and return to work (RehaFutur in Germany and Fit for the Future in Austria) by opening the discussion on the need to maintain the work ability and employability of people with reduced working capacity in order to reduce the number of people on invalidity pensions. Considering the predominance of economic matters in the current policy discourse, making the question of return to work an integral part of the global policy framework for economic sustainability also ensures that economic objectives do not counteract the benefits of return-to-work interventions.

Coordination

Coordination across relevant policy areas is a critical success factor in the development of effective return-to-work systems. This means coordinating policy formulation across employment, public health, OSH and social security areas. It also means coordinating stakeholders, as many can be involved in return-to-work systems. According to the ISSA, new collaborative structures have to be established between the different actors (i.e. employers, the medical profession and social security institutions).

The **Belgian** Institute for Sickness and Invalidity Insurance is developing consultation platforms to allow for discussions between all stakeholders. **Austria** has implemented the Fit for the Future and fit2work networks through the coordinated action of the Federal Ministry of Labour, Social Affairs and Consumer Protection (BMASK), the pension and insurance organisations (PVA, AUVA) and the health insurance funds. In **Sweden**, the Act on Financial Coordination of Rehabilitation Measures prescribes the creation of independent local coordination associations, in which are represented the Social Insurance Agency, the Public Employment Service, municipalities and the counties. The associations function on the basis of a joined-up budget to which all administrations contribute and are responsible for coordinating the overall rehabilitation process.

Coordination across areas can also be done for a specific disease. The Fit for Work Europe Coalition suggests that national care plans should be implemented for people with MSDs and should include measures to promote coordination and cooperation between health and social security institutions and employers. The **French** Cancer Plan 2014–2019, coming from the Ministry of Social Affairs and Health, also proposes that pilot regional coordination platforms be set up to coordinate the actions of those involved in the return to work of cancer patients.

Scope of the systems

While approaching the question of rehabilitation/return to work through the perspective of the right to equality of people with disability is certainly a starting point in the development of return-to-work systems, it is too limited to cover the full array of benefits an effective return-to-work system can bring to society. In many countries, people suffering from non-work-related accidents and diseases — that is, those not officially recognised as being caused by work — who do not have an official recognition of work incapacity are left out of vocational rehabilitation programmes and workplace reintegration interventions.

As noted by the ISSA, an effective return-to-work system should be all-inclusive and cover anyone suffering from a health problem, whether this has been caused directly by work or not. Divorcing entry into the rehabilitation/return-to-work system from certification systems for the allocation of benefits contributes to enlarging the target of return-to-work systems and therefore their overall effectiveness. Black and Frost demonstrate that reforming the current approach to sickness absence in the **UK** to adopt a more comprehensive and inclusive return-to-work system would not only increase social welfare and individuals' well-being, but also actually save up to GBP 400 million (approximately EUR 550 million) a year to employers and GBP 300 million (approximately EUR 410 million) a year to the state (Black and Frost, 2011). Successful return-to-work systems in Europe are those that cover all workers who are on medium- or long-term sickness absence, whatever the origin of their health problem. Very advanced systems based on early intervention can also cover workers with a health issue before they go on sickness absence.

Sickness absence and disability allocation systems

As discussed in Section 4.3.5, how countries function with regard to sickness absence compensation and allocation of disability benefits are critical aspects of return-to-work systems. While the analysis does not aim to identify one system as being more appropriate for rehabilitation/return to work than others, a number of observations can be made by looking at the sickness absence and disability compensation systems of countries with effective return-to-work systems:

- In a number of countries with a continental welfare model of health care in place (i.e. based on contributions from workers and employers), the employer is responsible for paying a full salary to the employee on sickness absence for a relatively long period of time, that is, from several weeks up to several months. This is the most direct way to incentivise employers to bring their workers back to work quickly. However, as Black and Frost mention, systems that put most of the responsibility for compensation of sickness absence on the employer risk employers avoiding hiring people with pre-existing health problems. Appropriate safeguards and support mechanisms need to be put in place to prevent this. In the **Netherlands**, where employers have to pay 70 % of the salary of an employee on sickness absence for up to two years, the Employee Insurance Agency (UWV) provides employers with a 'no-risk insurance' policy (*noriskpolis*) for employees on health or disability benefits for five years, which means that, if the person gets sick during that time, the Agency rather than the employer will pay for sickness benefits.
- Certain countries coordinate the allocation of disability benefits with the execution of rehabilitation programmes. Workers must undergo appropriate steps for rehabilitation and they can then receive disability benefits only if rehabilitation has failed and they have not reintegrated into the workplace or the labour market. In this case, the implementation of effective rehabilitation and return-to-work programmes is driven by the economic need of insurance and pension organisations to reduce the number of people on health and disability

benefits. In **Finland**, the Employees Pensions Act (395/2006) states that 'before a pension provider makes a decision on a disability pension, it shall ensure that the employee's possibilities of rehabilitation have been investigated'. In this context, socio-vocational rehabilitation is both a right and an obligation, that is, no compensation is awarded until rehabilitation possibilities have first been assessed.

- In a number of European countries, the possibility exists for workers to work part-time while still receiving disability benefits. This is advantageous for three main reasons. Firstly, as the OECD remarks, it does not necessarily pay to go back to work (because of in-work taxes and benefit withdrawals) (OECD, 2010), especially among the low-earning category of workers. Working part-time while still receiving disability benefits (even partial) raises the financial returns of work and can counteract financial incentives not to go back to work. Secondly, it contributes to dispelling the idea that receiving disability benefits is a permanent situation, difficult to exit (as illustrated by the very low annual rates of outflow from disability benefits in OECD countries) (OECD, 2010). Finally, it allows the worker to retain a relationship with the employer and the workplace (as per the ISSA recommendation) and therefore to keep feeling productive while on the path to recovery.

Support actions

For workplaces, return to work can be a complicated process, involving considerations related to budgets, OSH, HR, etc. For small and micro companies, the process can become particularly complex, especially if they do not have an internal OSH or HR department or staff. External support, such as OHSs, can help employers to develop individual action plans and put reintegration measures in place for people coming back to work following sickness absence.

The first type of support available to employers is financial, for example for adaptations to the work environment to accommodate the needs of people with reduced work capability. Financial incentives such as tax relief or support to pay for the salary of workers with reduced capabilities are also a successful driver to involve employers in the reintegration of workers with health problems.

The provision of technical support can also help employers. This can include the provision of guidance documents for the reintegration of a person with a specific health problem (e.g. guidance from the **Irish** Heart Foundation). It can also include the support from consultants to make an ergonomics assessment prior to the return to work of the person with reduced work ability or support for job modifications (e.g. as done by the Regional Agency for the Improvement of Working Conditions in the Aquitaine region (ARACT Aquitaine) for people with chronic diseases in **France**). Finally, it may comprise provision of a personal helper to support the person with disability at work (e.g. in **Denmark**).

Support can be provided by national and regional governmental organisations as well as by other intermediary organisations that have easier access to and dialogue with workplaces and workers, including work insurance and pension organisations, OSH advisory services, local employment agencies, healthcare facilities, business and trade union organisations, etc. In **France**, ARACT Aquitaine supports companies in adapting their working conditions in order to maintain workers in employment or to ensure the quick reintegration of workers suffering from chronic diseases.

5.2 Intervention level

Return-to-work interventions take place at two different levels: outside the workplace and inside the workplace. Successful return-to-work interventions depend on the execution of a number of steps that differ from one national system to the other depending on the country's social security and OSH system. However, a number of common elements contribute to the development of successful systems, including:

- an assessment of remaining work capacity;
- early, tailored and interdisciplinary interventions;
- coordination mechanisms;

- consideration of mental health issues;
- evaluation and follow-up;
- awareness of employers.

Focus on remaining working capacity

The first step of a return-to-work intervention is the assessment of working capacity to determine if the person has experienced a loss in their work capacity because of the sickness absence. Such an assessment can also be made in prevention, when the worker starts to develop signs of physical or mental fatigue. Rather than presenting the assessment as a tool to measure 'loss', many countries now refer to an assessment of 'remaining work capacity'.

The focus on remaining work capabilities/capacities — taking into account somebody's occupational and socio-economic situation, their skills and competences, and the broader labour market situation — is in line with the most recent theoretical models for return-to-work interventions (see Section 2.2) and gives a more positive outlook to the procedure. Workers may be more willing to undergo such an assessment if the objective is to determine what support they need to come back to work rather than whether they have a disability or not (which in some countries is strongly stigmatised).

The assessment of working capacity is strongly associated with the allocation of health or disability-related benefits. Black and Frost, in their independent review of sickness absence in the UK, recommend the creation of an Independent Assessment Service, which would provide an in-depth assessment of a person's physical and/or mental functions and provide advice on support for return to work. Such a service would be independent from the already existing Work Capability Assessment, which aims to determine entitlement to health-related benefits. Access to the service should be possible after only four weeks of sickness absence.

By separating the two assessments, the Black and Frost model allows the separation of the process of reintegration into the workplace of the sick or injured person from considerations of disability benefits allocation. In a number of countries, this is already the case, as the employer is legally obliged to develop a return-to-work plan after a certain number of weeks of sickness absence. For this, they must assess the abilities of the worker (often with the support of the OSH services) along with the possibilities for reintegration. Providing an independent service to make this assessment may ensure a higher quality in the assessment and subsequent advice but, at the same time, good collaboration with the employer is key to ensuring that the recommendations are followed through.

Addressing mental health

As indicated in Section 4.1.2, mental health problems are the second highest cause of work-related health problems and are therefore a major cause of sickness absence. In 2012, the OECD noted that about one in three, and in some countries as many as one in two, new disability benefit claims were attributed to mental ill-health (OECD, 2012). Return-to-work interventions should therefore aim to address mental health. However, the review of Member States' policies and programmes on rehabilitation and return to work shows that mental health is scarcely considered at the policy and intervention levels. According to the OECD, many people with mental health issues are excluded from the labour market because of unsuitable or late assessments of their working capacities and support needs (OECD, 2012).

All the factors that contribute to successful return-to-work strategies, such as early intervention, cooperation between the healthcare and occupational health systems, flexible work arrangements, etc., are of course relevant for mental health problems. But targeted interventions increase the effectiveness of return-to-work interventions for people with mental health issues and there is a need to improve vocational rehabilitation for workers with mental health problems²⁸.

²⁸ See the 'State-of-the-art review on rehabilitation/return-to-work' produced in the framework for the project Safer and Healthier Work at Any Age.

In the **UK**, the Sheffield Occupational Health Advisory Service (SOHAS) works with the Improving Access to Psychological Therapies services (IAPT) — a national-led initiative to provide faster access for people suffering from depression and anxiety disorders to therapies — to help people with mental health disorders return to work. The Employment Advice programme launched in 2009 provides specialist employment advice to patients with mental health conditions by ensuring that considerations related to employment, return to work, workplace adaptations and adjustments are taken into account when accessing psychological therapies.

Early intervention

The argument for early intervention features throughout this report. One of the main reasons for intervening early is economic: the OECD found that there is a link between long-term sickness absence and entry into disability benefit systems and, at the same time, a very limited outflow rate from disability benefit schemes (OECD, 2010). In addition, according to the ISSA, the longer a person stays off work because of a health problem, the lower their chance is of returning to work (ISSA, 2013). Therefore interventions at the sickness absence stage are more effective at reducing expenditures for invalidity pensions than taking action after the person has entered the disability benefit scheme.

The examination of the different national procedures for reintegration at the workplace following a sickness absence shows that countries are increasingly aiming for early contacts between the worker on sickness absence and the employer or the coordinating body for return to work. The new Fit for Work advice services to be implemented in the **UK** propose that assessment of working capacity be undertaken four weeks after the person has been placed on temporary work incapacity. In contrast, in **Finland**, the social security body KELA does not intervene before three months of sickness absence unless the worker requests support on the recommendation of their GP.

The responsibility put on employers to make early contact with the worker — as is the case in **Denmark, Germany, the Netherlands, Norway** and **Sweden** — encourages them to take a proactive approach to return to work. It also allows work-related considerations to be integrated in the medical treatment phase. On the other hand, in some countries, employers are not allowed by law to contact the worker on sickness absence to avoid putting pressure on the worker to return to work even in unsuitable conditions for his/her health condition.

Tailored interventions

Successful return-to-work interventions are tailored to the worker's needs and abilities. A tailored approach allows information about the worker's occupational and personal history to be taken into account for an individual plan with adapted measures for rehabilitation/return to work to be created. It involves the active participation of the worker in the process and helps build trust between the actors involved.

Tailored interventions can lead, at a more general level, to a stepped-care approach. The stepped-care approach differentiates the services provided to each worker in relation to the seriousness of their conditions and the duration of their sickness absence. The longer the duration of sickness absence, the more complex and structured the intervention should be. People with common health problems can be helped with a few basic principles of health care and workplace management, which often have low costs. People who experience difficulties in returning to work may need more structured medical, vocational and social rehabilitation, as well as reassignment from their previous occupation, which might require re-training and more complex discussions at the workplace, involving more actors (employer, line managers, HR, OHS, etc.).

In the **Netherlands**, the Centre for Chronic Illness and Work (CCZW) runs a programme entitled 'Certification of experts-by-experience: work and participation', which provides targeted and personalised reintegration and return-to-work services for people with a chronic disease. The trainers or coaches working for this programme are 'experts by experience' in the sense that they are themselves suffering from a chronic disease. This approach allows the provision of tailored and personalised support from the coaches to the workers. The **Danish** Return to Work programme and the **Austrian** fit2work programme also provide individual support to sick workers. In both cases, a

consultant (Austria) or a return-to-work coordinator (Denmark) sets up an individual follow-up plan tailored to the capacities and needs of the sick worker.

Interdisciplinary interventions

Combining the efforts of experts from different professional backgrounds is a major determinant of successful return-to-work interventions. At policy level, return-to-work systems extend across a number of areas, from public health to social security via OSH and employment. At the intervention level, a similar structure is found and workers navigating these systems can be faced with a large number of administrative structures to consult in order to make their way back to work.

Thus, the most successful systems are those with an interdisciplinary approach. Interventions are sometimes qualified as multidisciplinary because they bring together different medical and paramedical occupations (such as general medicine, specialist medicine, psychiatry, physiotherapy and other types of therapy). However, covering the whole return-to-work process means that non-medical professions also need to be involved, such as employment and labour market experts, ergonomists, psychologists, vocational rehabilitation experts, coaches and trainers and social and administrative officers. In the **Danish** Return to Work programme, the return-to-work coordinator — usually a social worker — works in close collaboration with the return-to-work team composed of a psychologist and a physiotherapist. In **France**, ARACT Aquitaine teamed up with patients' associations, labour inspectorates, ergonomics associations, and pension and occupational health insurance organisations to study the impacts of chronic diseases on work and propose methodologies to a number of workplaces to reduce them²⁹.

Using an interdisciplinary approach rather than a multidisciplinary approach implies that the different experts involved in the process do not just complement each other but actually interact with one another. An interdisciplinary intervention means that the different experts involved in the return-to-work process work together to determine the appropriate pathway for the worker's reintegration into the workplace or labour market.

Coordination of stakeholders

The return-to-work process has a complex and multifaceted quality in all aspects studied in this report (legal, policy, institutional). Because of this complexity, the argument made above for cooperation across areas at the policy level also cascades down to the intervention level. A number of stakeholders are involved in the process. To be practical for the worker and employer, this interdisciplinary system needs to be supported by solid and simple coordination mechanisms. All relevant stakeholders should communicate, cooperate and set common goals. The roles of all players should be clearly defined and responsibility should be taken when appropriate.

One of the challenges for successful coordination relates to the roles of the GP and the occupational physician. The role of the GP or primary care physician is key in the early stages of the return-to-work process, as described in Section 4.3.6. The occupational physician on the other hand is a very important actor in the final stages of the return-to-work process and is the one responsible for deciding upon adaptation measures and monitoring their implementation, as well as the worker's health to ensure that the return to work is sustainable.

As explained in Section 4.3.7, coordination with the physicians(s) can be difficult for the employer or the OHSs/occupational physician for reasons of medical confidentiality. In addition, research has shown that GPs can be reluctant to send a person back to work before they have fully recovered their functional capacities. A change of mindset is needed. Work should be considered as potentially contributing to someone's recovery rather than an obstacle or even a contributor to someone's ill-health. But, for this, the GP and any other primary care physicians need to consider work as an outcome of the medical treatment. A coordinating body for return to work can play an important role in making the link between the person's primary care physician and the workplace, in particular the

²⁹ For more information about this case, see the case study 'Assisting companies in taking better account of chronic diseases at the workplace — France' produced in the framework of the project Safer and Healthier Work at Any Age.

occupational physician, and in ensuring that the administrative sickness absence does not last longer than is actually needed.

Recently, a number of countries have merged services from different administrations into coordination platforms, or *one-stop-shops*, which allow workers and employers to enter the return-to-work system through a single point of contact. In some cases, these coordinating bodies are also those responsible for managing sickness absence benefits, giving them a financial incentive for effective return-to-work mechanisms. This is the case in **Denmark**, where sickness benefits come out of local authorities' budgets, which are also the main coordinating bodies for the return-to-work process. The OECD recalls that, in addition to providing simplified access to return-to-work support, one-stop-shops are also easier to monitor and evaluate in terms of performance (OECD, 2010).

In addition, to help with the coordination of different institutions and mechanisms, a number of countries have put in place (or are exploring the idea of) *case managers*. They can have different names (consultants in the **Austrian** fit2work programme, social insurance officers in **Denmark** or case managers in **Finland** and **France**) but often perform similar functions, namely to help the worker through the different steps of the rehabilitation process and facilitate their interactions with various organisations. A case-management approach is based on the principles of cooperation and coordination of all relevant parties to the benefit of the individual worker.

Case managers should be return-to-work professionals who can help the worker navigate the various services needed for rehabilitation and return to work. Several national systems in Europe have adopted similar approaches to case management. In **Denmark**, the social insurance officer is responsible for coordinating the return-to-work process for an individual worker. In **France**, the National Health Insurance Fund for Employees has put in place personalised assistance programmes for cases where return to work is considered difficult (workers that are victims of serious occupational accidents or at risk of losing their job because of health problems or reduced working capacity) aiming to identify up-front the worker's needs and develop a personal return-to-work plan.

Workplace intervention

A number of success factors can be identified that are related to the roles of workplace and non-workplace actors. Although the study has not focused specifically on workplace interventions, the research review and the case studies have, to some extent, investigated what factors can contribute to the successful implementation of a return-to-work intervention at the workplace level.

The first success factor is the integration into the overall company policy on well-being or health and safety at work of sickness and disability management programmes to support the return to work of people with reduced working capacity or who have been absent from work for a long time. Return to work is the last stage (tertiary prevention) of a comprehensive prevention and sickness absence management policy in a company. It formalises the procedures and roles of all involved parties, including the OHSs and HR departments, when they exist. It also shows workers that the company cares about their well-being upon their return to work and might encourage them to be proactive with their own return to work.

The second success factor is the employer's pro-active attitude, which can compensate (to a certain extent) for a lack of support mechanisms outside the workplace. Employers are best placed to react early to potential health issues. In **Austria**, employers can call on the fit2work services to intervene for the whole company, making a diagnosis of the situation with regard to prevention and sickness absence and recommending a number of measures to maintain workers at work and enhance employability. They can also contact fit2work for a single individual worker. In both cases, the employer is proactive and has understood the benefit of intervening at an early stage.

In a number of countries (**Denmark**, **Germany**, the **Netherlands**, **Norway** and **Sweden**), the employer is obliged, by law, to react at an early stage to a sickness absence. The employer's involvement in the return-to-work procedure is maximised in the **Dutch** system, where employers are obliged by law to set up a procedure for the reintegration of their workers on sickness absence and have to pay for workers' sickness absence benefits (70 % of the worker's salary) for a duration of two years (which can increase to three years if it is not demonstrated that the employer has made all possible efforts to reintegrate the worker in suitable conditions).

The third success factor is the level of awareness at the workplace on the needs of workers returning with a reduced capacity to work. Employers also have an important role to play when it comes to addressing workers' and managers' preconceptions and attitudes towards colleagues with reduced working capacity or colleagues coming back after a long sickness absence and needing adaptations of their working time. Programmes that intervene at the whole company level, rather than at the individual level (such as the fit2work programme), can help raise workers' and managers' awareness of sickness and disability management.

Evaluation/follow-up/monitoring

Performing an evaluation is a very important part of the return-to-work process, at both policy and intervention levels.

There are few nationwide evaluation results from return-to-work systems. In **Sweden**, the evaluation of the implementation of the 2003 Act on the Financial Coordination of Rehabilitation Measures showed that, for each person who returns to work after a return-to-work intervention, society earns back the funds invested in that person. Of the 8,600 participants who concluded their intervention in 2013, 31 % had a job or went back to school directly after the conclusion of the intervention. This compares with only 11 % before an intervention. Another positive result of the coordination of rehabilitation measures is that fewer of the participants are in need of public benefits (e.g. sickness benefits, unemployment benefits, etc.).

Other time-limited interventions have been evaluated. The evaluation of the **Danish** national Return to Work programme, which ran between April 2010 and April 2012, showed that the effects of the programme on sickness absence levels varied a lot among municipalities but that the effects at individual level (on the workers themselves) were positive. The case-management approach allowed workers to feel fully supported and to build a trusting relationship with their case manager. In **Germany**, the external evaluation of the project RehaFuturReal® of the statutory pension insurance scheme in Westphalia (Deutsche Rentenversicherung Westfalen) showed that a high proportion of the participants in the programme (74 %) could be reintegrated into the labour market, either with their previous employer (56 %) or with a new employer (18 %). In addition, the programme supports the argument for early intervention, as the first counselling session was carried out between 14 and 48 days from the day of the request for rehabilitation benefits to the pension scheme, compared with the delay of three to six months before the programme was implemented.

At the intervention level, evaluations can take place at the level of the workplace as a whole or at the level of the individual. They can be performed if a company has put in place a sickness and disability management programme with quantitative and qualitative indicators to measure the outcomes of the programme (such as number and duration of sickness absences, number of reinstatement visits organised, etc.). Evaluations carried out by external services might be more objective and precise than in-house evaluation, but can be costly. Carrying out in-house monitoring and evaluation is already an important step forwards.

At the individual level, the follow-up of the worker coming back to work is essential to ensure that any adaptations made to the worker's environment and working conditions are suitable to their condition in the longer term and that their return to work is sustainable. This monitoring can be done either by the case manager or by the occupational physician.

6 Policy-relevant findings

In Europe, an ageing general population and working population, coupled with an increasing retirement age, is resulting in longer working lives. Given the strong correlation between age and the emergence of health problems, the incidence of workers suffering from chronic illness is likely to increase over the coming 50 years. With long-term sickness absence from work a strong precursor of disability, the incidence of (non-congenital) disability is also likely to increase with an ageing population, unless specific action is taken in the areas of:

- prevention, to avoid the occurrence of sickness both at the workplace (OSH interventions) and outside the workplace (public health interventions); and
- rehabilitation and return to work, to break the link between sickness absence leading to disability.

This study on rehabilitation and return to work examines the systems in place in European countries (covering the 28 EU Member States and four EFTA countries). It analyses the factors that influence the development and implementation of rehabilitation and return-to-work systems and examines their most successful elements.

A number of policy-relevant findings have been identified with regard to the prerequisites of a national system to address the issue of rehabilitation/return to work.

Holistic systems

The majority of European countries do not sufficiently consider the needs of people on medium- and long-term sickness absence returning to work with a reduced work capacity — where the person is able to do the same job but less of it — or reduced work capability — where the person is unable to perform the same tasks. In many cases, only those with a recognised degree of disability or victims of occupational accidents or diseases have access to vocational rehabilitation and support to reintegrate into the labour market. Even in these cases, the support offered focuses mostly on vocational rehabilitation to enhance the employability of people with reduced working capacity and on support for workplace adaptations to provide ‘reasonable accommodation’ as prescribed by Directive 2000/78/EC.

Countries that have adopted a holistic approach to rehabilitation and return to work have enlarged their scope to include all workers on medium- or long-term sickness absence. Advanced systems also include a prevention component, which aims to retain workers with health problems in employment, using early intervention to prevent and minimise sickness absence. Broadening the scope of the systems to all workers has two main benefits:

- It supports *early intervention*, as the worker enters the system during their sickness absence, rather than waiting until a disability diagnosis has been made. While the critical entry point to the system (in terms of weeks following the start of the sickness absence) remains under investigation, all evidence points to the considerable positive effects of structures that systematically facilitate return to work.
- An early inclusion system for all workers after a defined duration of sickness absence allows for a *stepped-care approach*. Here, workers are provided with different types of services and support depending on the nature of their health problem, its severity and the duration of their sickness absence. Workers with ‘lighter’ health conditions — easily managed through medical rehabilitation and adaptations at the workplace — can be treated and return more quickly to a suitable work environment, while those with more complex or chronic health problems may require more complex interventions before returning to work under appropriate conditions.

The stepped-care approach is based on the principle that return-to-work interventions should be tailored to the worker’s needs and abilities. More practically, a tailored approach involves the preparation of an individual plan with adapted measures. At the workplace, the employer, HR staff and the occupational physician (when they exist) work together to put in place appropriate workplace

adaptations, ranging from simple ergonomic adaptations of workstations to adapted work schedules to accommodate treatment or rest periods.

Integration in a broader policy framework

Among the countries with specific return-to-work systems, no single legal, policy or institutional framework is immediately transferable to all, given their different OSH profiles and social security traditions.

One common element of these countries, however, is that the return-to-work system and supporting activities sit within a broader holistic and integrated policy framework for sustainable working lives. This coherence requires coordination across all the relevant policy areas, including employment, public health, OSH, social security, fundamental rights and vocational education. It also requires that common goals and a commitment to a shared agenda across policy areas (e.g. employment and health) be established. Joined-up budgeting across the different policy areas can also reinforce coordinated activity and increase resource efficiency.

Cross-policy coordination is particularly important in the context of reforms of health and disability benefit schemes. A common trend, inflated by the economic crisis, is the drive to decrease public spending, particularly sickness and disability benefits. In a number of countries, a decrease in such expenditure has been visible over the past decade. Whether this is due to policy reforms reducing the number of beneficiaries (e.g. by tightening the allocation criteria) or because the amounts available for health and disability benefits have decreased, it can have dramatic consequences for individuals in need of such benefits as income support. These individuals may transfer to another benefit scheme (e.g. unemployment, social welfare), remain in work or return to work too quickly, increasing the risk of developing chronic conditions and, eventually, disabilities. Without proper support, this can have serious health implications, especially for workers in arduous occupations, leading to a total loss of working capacity and permanent exclusion from the labour market.

Reforms of social security systems should be coordinated with a support system for rehabilitation and return to work. With adequate support mechanisms, adapted working conditions and an occupation suited to the person's condition, remaining at work need not affect health stability. On the contrary, studies show that it can help with the recovery process. The development and implementation of rehabilitation and return-to-work support mechanisms are, therefore, an essential component of national reforms of sickness and disability benefit schemes.

At EU level, the issue of rehabilitation/return to work should be mainstreamed in different policy areas. Following the Commission's commitment in the European Disability Strategy 2010–2020, further action is needed to promote action to reduce risks of disabilities developing during working life, to improve the reintegration of workers with disabilities and to develop early intervention services. Similarly, the promised Communication on the health of the workforce to implement cooperation mechanisms between relevant actors in employment, social protection and public health fields should be delivered. This study repeatedly demonstrates the importance of considering return to work as an outcome of medical treatment, and EU public health policies should reflect the need for better consideration of work-related issues by public health professionals.

Coordinated systems

A variety of roles and responsibilities exist in the reintegration process. The employer usually carries the legal obligation for such processes, but this may be shared with OHSs or the occupational doctor, where relevant. Reintegration processes exist in most European countries, with varying degrees of complexity.

A key element is how this reintegration process is integrated into the overall return-to-work system, and how workplaces interact with external stakeholders to achieve this. In many European countries, employers (or OHS/HR service) only become involved at the end of the process when the worker has been considered 'fit' to work again. This reflects the fact that much of the attention on the rehabilitation/return-to-work process is placed on the pre-return phase, with little consideration given to the post-return phase and the sustainability of the worker's reintegration.

Medical doctors and occupational physicians have a pivotal role in the process. In many countries, there is little or no coordination between medical doctors and the workplace, often as a result of medical confidentiality issues. In addition, in many countries, the lack of an appropriate cooperation structure significantly limits coordination between the primary physician and the medical experts of the organisation coordinating the return-to-work process, such as a social security agency.

Coordination mechanisms with clear roles and responsibilities contribute to the effective functioning of the system. Returning to work after a medium- to long-term sickness absence is complex, requiring combined action from different professions that are not necessarily accustomed to working together (GPs and employers for instance). Additional factors that contribute to effective coordination are outlined below:

- Coordination is most effective when there is *clear leadership* and direction from one institution/organisation, which can be a pre-existing institution (most common situation) or a new organisation created for the purposes of return to work.
- *Joined-up budgeting* across different organisations can improve the efficiency of resource use. A new organisation dedicated to rehabilitation/return to work could provide the opportunity to put in place a joint budget to cover expenses related to medical and vocational rehabilitation, return-to-work supports and, possibly, sickness and disability benefits.
- *Interdisciplinary teams*, including medical and paramedical experts (general medicine, specialist medicine, psychiatry, physiotherapy and other types of therapy) and non-medical professions (such as employment and labour market experts, ergonomists, psychologists, vocational rehabilitation experts, coaches and trainers, and social and administrative officers), should work together to determine the appropriate pathway for the worker's reintegration into the workplace or labour market.
- The creation of the role of *case manager* helps both the worker (primarily) and the employer to navigate through the different steps of the rehabilitation process and facilitates their interactions with other stakeholders.
- Involving the *employer* (and OHS/HR service) at an early stage in the return-to-work process improves the likelihood of successful reintegration. It ensures that measures taken for the reintegration are realistic and adapted to the conditions in the company, for example taking into consideration the other types of occupations or the financial constraints of the company.

Given the diversity of national contexts and social security systems across Europe, there is no one approach that can be transferred directly to all countries. However, more knowledge exchange and transfer of practices is needed from countries that have established such coordination structures and countries that have not. Considering the multidisciplinary nature of this topic, sharing of best practice is also necessary among all professional communities involved, including medical and paramedical professionals, occupational health specialists, employment and HR experts, social security experts and antidiscrimination experts, as well as the scientific and professional community and policy-makers. A formal structure to organise such discussion and knowledge exchange would strengthen the credibility and legitimacy of the process.

At EU level, this could be done through the establishment of a working group-type structure, bringing together experts from all the Member States and neighbouring countries with experts from diverse professional backgrounds, including public health, OSH, employment, social security, antidiscrimination and vocational education.

Financial and technical support

Rehabilitation programmes for workers with reduced capabilities often focus on the external support needed by the worker to recover their capacity, or to identify an occupation suitable for their capabilities. Little attention is paid to the potential for adaptation of the previous workplace beyond an employer's obligation to provide 'reasonable accommodation' to people with disabilities. The report concludes that the workplace should be the central point of focus of return-to-work systems, both to understand the individual health problem and, ideally, to return the worker to that same workplace.

For workplaces, return to work can be a complicated process involving budget considerations, HR, OSH, etc. For small and micro companies, the process can become particularly complex, especially if they do not have an internal OSH or HR department or staff. External technical and/or financial support can, therefore, help employers to develop individual action plans and establish reintegration measures for people returning to work following a sickness absence. Intermediary actors, such as work and pension insurance organisations or OSH external services, play an important role in the provision of this support or at least in relaying, at the workplace level, the type of support available at national level.

Technical support can take the form of guidance and advice from professionals in the fields of ergonomics, HR, OSH and disability, ideally coordinated by a case manager. Such support is critical for the effective implementation of return-to-work systems in small and micro companies. At the EU level, a guidance document could be developed on adapting the working environment to the needs and abilities of each individual worker, as per the requirement of the OSH Framework Directive, taking the health status of the worker into account. This should include practical guidelines for such adaptations, in the absence of internal HR/OSH expertise.

Financial support to employers can include funding for adaptations to the workplace to accommodate the needs of people with reduced capabilities, or tax and insurance premium reductions. Financial supports can also directly target workers, for example the possibility of continuing to work while still receiving their sickness absence or disability benefits. For people in low-paid jobs, in particular, this would allow them to view disability benefits as a temporary form of income support while they continue to undergo rehabilitation to either recover their work capacity or find appropriate work arrangements that allow them to return to full-time work.

Raising awareness at all levels

Raising the awareness of those involved in the development and implementation of a rehabilitation/return-to-work system is a major challenge, as their interests, needs and roles differ considerably. It is, however, a critical success factor.

Employers, workers and other workplace actors need to be more aware of the benefits and opportunities of a return-to-work policy in a company and, in general, of the complex relationship between health and work. Company culture plays an important role in the return to work of someone after a medium- or long-term absence. Studies show that companies with reintegration policies tend to already have an OSH or active ageing policy or a corporate culture based on trust and cooperative management styles (Eurofound, 2014). Employers must understand the benefits associated with retaining a worker with a reduced work capacity, such as keeping skills and experience in-house, and of making adaptations enabling a worker to return from long-term sick leave compared with hiring a new 'healthier' person to replace the worker.

Intermediaries such as work insurance organisations, OSH advisory services, labour inspectorates and business and trade union organisations have a critical role to play in raising awareness at workplace level on the opportunities and the challenges of return to work, in particular for small and micro companies, which may not have support from internal HR and OSH services.

Research gaps

Finally, while research efforts should continue to focus on the analysis of workplaces to identify and eliminate or mitigate factors contributing to occupational ill-health, additional research is also needed in the areas of:

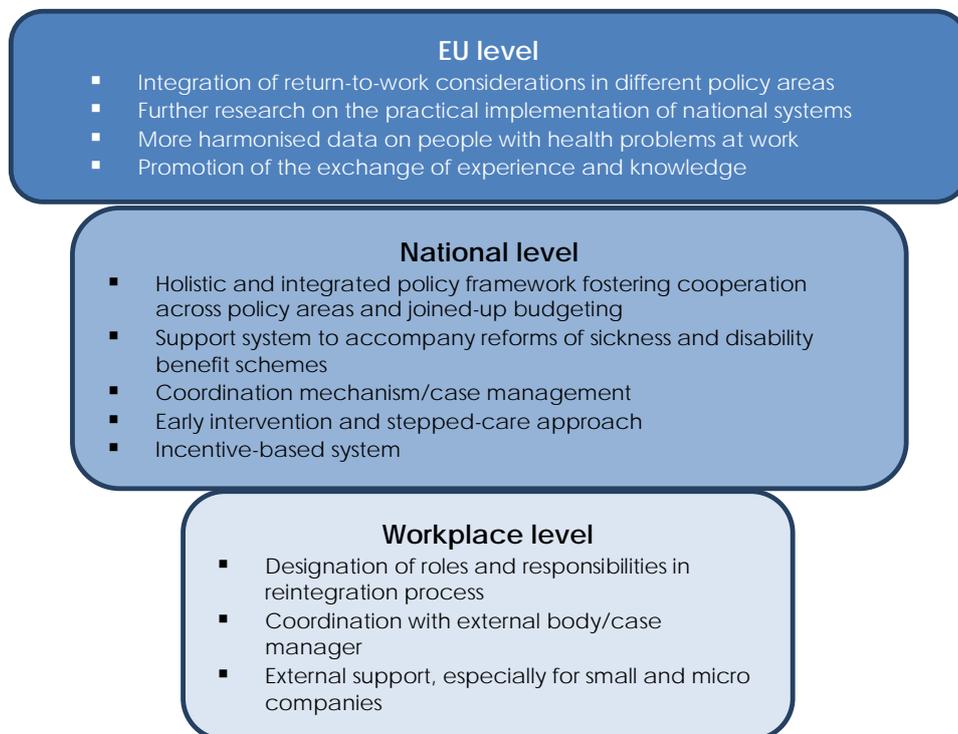
- evaluation of the impact, feasibility and cost-effectiveness of existing national return-to-work systems — research would be needed on the potential return on investments of rehabilitation measures in companies to incentivise employers' investments and support the development of return-to-work systems;
- the effectiveness and feasibility of return-to-work models in small and micro companies;
- the impact of the organisational culture on health at work, including cooperation with colleagues and management, team cultures and political organisations of workers' interests;

- the specific needs of older workers, women, people on long-term sickness absence (i.e. more than one year) and people suffering from mental health disorders in the return-to-work process;
- more harmonised statistical data, including better accounting for differences in definitions and interpretations across EU countries in relation to rates of sickness absence due to both occupational and non-occupational health problems; rates of return to work after short-, medium- and long-term sickness absences; transfers from sickness absence benefit schemes to disability benefit schemes or other income-support schemes; people working with a chronic or long-term health problem; and people benefiting from workplace adaptations to accommodate a health condition.

Governance levels

These findings can also be presented according to the three levels that influence the development and implementation of a country's rehabilitation/return-to-work system, as illustrated in Figure 13.

Figure 13: Levels of governance for the development and implementation of rehabilitation/return-to-work systems



Taking all three levels together, the factor that seems especially important for implementing successful and effective return-to-work systems is the degree of coordination.

At the national policy level, defining a coherent framework for return to work requires coordination across different policy areas, as return to work is governed by elements of OSH, public health, employment, antidiscrimination and social security policies. At the level of the system itself, the presence of coordination mechanisms to define the roles and responsibilities of all the different stakeholders involved in the process increases the likelihood of success, while, at workplace level, coordination mechanisms between the workplace and the coordination body provide a way of guaranteeing that the employer (and de facto the worker) receives adequate support throughout the process, which is particularly important for small and micro companies.

Finally, the EU can provide support to the development of national rehabilitation/return-to-work systems by ensuring that the issue is mainstreamed into the relevant policy areas, and by creating structures that promote the exchange of experience and transfer of knowledge among the Member States.

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Annex: Analysis indicators

The following criteria or qualitative indicators were used to categorise the 31 countries. Within one group, each country does not necessarily tick all the boxes as presented below.

Table 3: Qualitative indicators for the analysis of country profiles with regard to rehabilitation and return to work

Qualitative indicators	Group 1	Group 2	Group 3	Group 4
Target groups:				
• people with a recognised disability	x	x	x	x
• people with an occupational injury or disease	x	x	x	
• people with a chronic/long-term condition	x	x	x	
• all workers (for reintegration procedures)	x	x		
• all workers (for full RTW process)	x			
Policy orientation:				
• antidiscrimination	x	x	x	x
• accommodation of workplace for people with disability	x	x	x	x
• maintenance of employability	x	x	x	
• prevention of exclusion	x	x		
• management of sickness absence	x			
• early intervention	x			
• individualised approach/case management	x			
Coordination mechanisms:				
• no supporting institutional body				x
• institutional body for rehabilitation of persons with reduced work capacity		x	x	
• institutional body leading RTW process	x	x		
• multidisciplinary platform for RTW process	x			
• no coordination with workplace			x	x
• limited coordination with workplace		x		
• enhanced coordination with workplace	x			
• no formal procedures for reintegration at workplace			x	x
• formal reintegration procedures for employers	x	x	x	

Qualitative indicators	Group 1	Group 2	Group 3	Group 4
Programmes and initiatives:				
<ul style="list-style-type: none"> programmes promoting access of people with disabilities to labour market 	x	x	x	x
<ul style="list-style-type: none"> vocational rehabilitation programmes for people with reduced work capacity 	x	x	x	
<ul style="list-style-type: none"> programmes to promote RTW for people with specific diseases 	x	x		
Support and incentives:				
<ul style="list-style-type: none"> financial support for employers for reintegration of people with reduced capacity 	x	x	x	
<ul style="list-style-type: none"> financial support for employers for reintegration of workers after sickness absence 	x	x		
<ul style="list-style-type: none"> technical support for employers for reintegration following sickness absence 	x	x		
<ul style="list-style-type: none"> incentives for workers to come back to work early 	x	x		

The European Agency for Safety and Health at Work (EU-OSHA) contributes to making Europe a safer, healthier and more productive place to work. The Agency researches, develops, and distributes reliable, balanced, and impartial safety and health information and organises pan-European awareness raising campaigns. Set up by the European Union in 1994 and based in Bilbao, Spain, the Agency brings together representatives from the European Commission, Member State governments, employers' and workers' organisations, as well as leading experts in each of the EU-27 Member States and beyond.

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