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

Country report for Romania

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

CEE - Central and Eastern European

HR – Human Resources

NFPP - National Fund of Public Pensions

NHIH - National Health Insurance House

REWIR – title of the project “Negotiating Return to Work in the Age of Demographic Change through Industrial Relations”

RTW – Return to work

1 Introduction

Population ageing constitutes a demographic development that presents the potential to impact labour markets across the European Union member states as well as to challenge the sustainability of both welfare states and healthcare systems. The research project "Negotiating Return to Work in the Age of Demographic Change through Industrial Relations" (REWIR) sets out to examine the role of industrial relations (that is, the complex system of interrelations between employers and employees, trade unions, employer organisations, and state authorities) in facilitating the return to work (RTW) of people affected by chronic diseases. By chronic disease we refer to diseases of long duration and slow progression that are not subjected to contagious transmission, and which can be categorised into six major groups: cardiovascular diseases, cancers, diabetes, chronic respiratory disease, musculoskeletal diseases, and mental afflictions.

In this context of demographic transformation, the REWIR project aims at understanding how different industrial relations systems across European countries shape RTW policies and influence their implementation. More specifically, the REWIR project is underpinned by a series of six major research questions: (1) How do relevant EU-level social partners promote a healthier Europe as well as active and healthy ageing? (2) What is the role played by trade unions and employers' associations in particular national contexts regarding the implementation of RTW policies? (3) What are the opportunities for the stakeholders involved in the RTW process (trade unions, employers' associations, governments, etc.) to devise, through debate and negotiation, better ways of facilitating the return to work of people affected by chronic diseases? (4) How could interactions between employers and employee representatives improve the situation of people affected by chronic diseases through information, consultation and co-determination? (5) How do workers undergoing RTW after experiencing chronic illness perceive the role of social partners in helping to prevent the risk of marginalisation, discrimination, and poverty? (6) Finally, in the context of the European Commission's Europe 2020 agenda, how does the role of industrial relations help (re)define the concepts of 'intergenerational fairness', 'longer labour market involvement', 'job performance', 'presence at work', and 'fitness to work'?

The REWIR project comprises a comparative analysis of the interplay between industrial relations systems and return-to-work policies in multiple European countries, grouped into four clusters based on their policies for RTW: (1) countries with a comprehensive approach (Austria, Denmark, Finland, Germany, the Netherlands, Norway, and Sweden); (2) countries characterised by a step-wise approach (Belgium, France, Iceland, Italy, Luxembourg, Switzerland and the UK); (3) countries with ad-hoc approaches (Bulgaria, Estonia, Hungary, Ireland, Lithuania, Portugal, Romania and Spain); and (4) countries with limited approaches to RTW (Czechia, Greece, Croatia, Cyprus, Latvia, Malta, Poland, Slovenia and Slovakia). In this deliverable, we report the situation and findings regarding Romania, a country categorised as having an ad-hoc approach to policies on RTW and rehabilitation after chronic conditions.

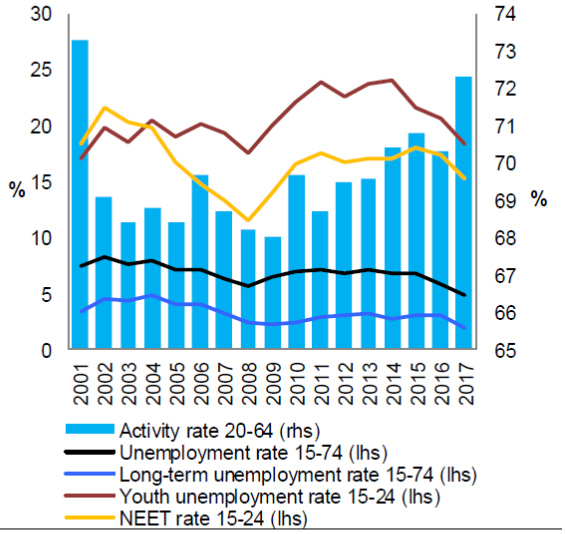
1.1 Labour market indicators

Romania experienced one of the harshest transitions to democracy after the regime change of 1989. The country's post-socialist transformation implied a massive restructuring of the productive sector underpinned by large-scale deindustrialisation and the privatisation of previously state-owned enterprises. Although labour market conditions have continued to improve in the last few years, Romania still faces ongoing challenges. According to Eurostat longitudinal data, the percentage of people aged

between 20 and 64 employed in the workforce has followed a U shape over the last two decades, with a turning point in the wake of the financial crisis of 2007-08. After it reached the lowest employment rate in 2011 (63.8% of the population aged between 20 and 64), during the following years the percentage increased slowly but steadily until the employment rate reached 70.9% in 2019. Despite this upward trend, Romania is still slightly below the mean employment rate calculated for the 27 European Union countries, which in 2019 stood at 73.1%. Several indicators depict the Romanian labour market situation (European Commission, 2019):

- The activity rate was 72.3% in 2017, an increase from the pre-crisis level (the activity rate is the percentage of the working-age population among the country's total population).
- The employment rate increased, reaching 65.5% in 2017 (the employment rate is the percentage of the employed population among the working-age population).
- The unemployment rate was at its lowest level in December 2018 (3.8%).
- The long-term unemployment rate (being unemployed for more than 12 months) also decreased and was low compared with other European countries – 1.6% in 2019 (Eurostat/Trading Economics, 2019). Yet, a good share of this category remained unemployed (73.2%) or became inactive (13.2%).
- The participation rates are low for several categories, including people with disabilities.
- There are very few active labour market policies in place; they are not sensitive to individual needs or to improving the skills of workers who intend to resume work.

Figure 1. Labour market overview



(1) Activity rate and employment rate (% of population), total, ages 20-64; Unemployment rate and long-term unemployment rate (% of labour force), total, ages 15-74; Youth unemployment rate (% of labour force), total, ages 15-24; NEET: Not in education, employment, or training (% of population), total, ages 15-24
Source: European Commission

Source: "Country Report Romania 2019" (European Commission, 2019).

1.2 Health expenditure and incidence of chronic illnesses

The healthcare system in Romania is based on social health insurance paid by the employed population from salaries (since 2017). The state pays contributions for several social categories (the unemployed, pensioners with low retirement incomes, people receiving social benefits) and the coverage for other categories is sustained from the contributions of employed people (children and students under 26 years old, pregnant women, and people with disabilities and chronic illnesses). Despite the neoliberal policies implemented in the healthcare system during the last decade, the system remains centralised, as the state continues to play a major role in collecting and distributing the money. The Euro Health Consumer Index ranks Romania in second-last place (34th) among countries in Europe, acknowledging long-lasting deficiencies in managing the public healthcare sector and the high cost of in-patient care over out-patient care. Romania also has problems with healthcare outcomes (infant deaths, cancer survival, deaths before age 65), the range and reach of services provided and prevention (Björnberg and Phang, 2019). The healthcare system is chronically underfinanced.

In Romania, there are no reliable public health data regarding the registered incidence of chronic illnesses that can be easily accessed. Scattered data can be found in various resources but with many limitations regarding the access, quality of data and the source which provided it. The main cause of morbidity and mortality in Romania is the category of cardiovascular diseases (ischemic heart disease and cerebrovascular incidents). The mortality rate from ischemic heart disease is three times higher than the EU average (OECD/European Observatory on Health Systems and Policies, 2019). Cancer is the second cause of morbidity and mortality, with pulmonary cancer being the most frequent cause of death in this category. Around 46% of people beyond age 65 suffer from at least one chronic disease. Women are more affected that men.

The available information on chronic illnesses is based on reports made by family physicians, who are legally required to gather and register data concerning the chronic diseases affecting patients who are assigned to their surgeries. However, studies have found that only around 80% of the total number of family physicians report health data on chronic illnesses, which means the statistics detailed below are considerably underreported.

Table 1. Registered chronic illnesses reported by family physicians in 2017

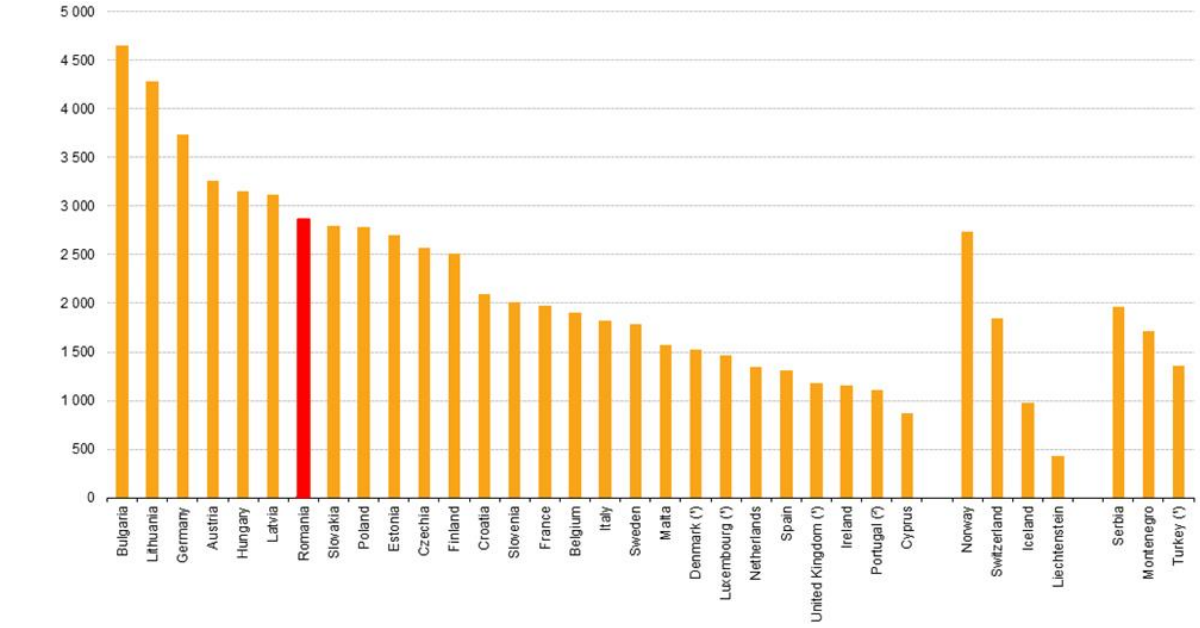
Chronic disease	Prevalence of people with chronic illness per 100,000 inhabitants	Absolute no. of registered chronic illnesses
Hypertension condition (high blood pressure)	12,725.0	2,507,653
Ischemic heart disease (coronary artery disease)	5,966.8	1,175,858
Diabetes mellitus	4,012.3	790,676
Chronic obstructive pulmonary disease	2,082.7	410,429
Cerebrovascular diseases	1,717.1	338,372
Peptic ulcer disease	1,526.0	300,727
Kidney stone disease	864.9	64,859
Mental disorders	2,278.6	-

Source: Ministerul Sănătății (2017).

Regarding musculoskeletal diseases (MSDs), it is estimated that over 600,000 Romanians (more than 3% of the country's population) suffer from one form or another of rheumatic disorder. Although these rheumatic and musculoskeletal disorders are generally old age diseases, statistics show that the active population is also significantly affected. Therefore, besides the pressure exerted on the healthcare system, MSDs have an important socioeconomic impact upon the labour market as well as on the welfare state. In this regard, a report has documented that more than half of absenteeism in the workplace and around 60% of permanent incapacity to work are caused by MSDs in Romania (Dorobantu, 2018).

Another relevant, although indirect, indicator of the prevalence of chronic diseases in Romania is given by hospital discharge rates. Figure 2 below details the hospital discharge rates for in-patients with diseases of the circulatory system, which are among the most prevalent chronic illnesses in Romania. As shown in Figure 2, Romania ranks among the EU countries characterised by high rates of hospital discharge (2,870 per 100,000 inhabitants), which indicates that there are more Romanians, in comparison with the EU average, who suffer from and receive treatment for circulatory diseases.

Figure 2. Hospital discharge rates for in-patients with diseases of the circulatory system (2017)



Source: Eurostat (online data code: hlth_co_disch2).

Romania also has the second-highest standardised death rate from diseases of the circulatory system in the EU (898.9 per 100,000 inhabitants.). In comparison with countries least affected by circulatory diseases (e.g., France, Spain, Norway), Romania has a standardised death rate which is four times higher, for both the active population and people over 65 years of age. Compared with the EU average, the standardised death rate from diseases affecting the circulatory system in Romania is around 2.5 times higher (see Table 2).

Table 2. Causes of death – diseases of the circulatory system (2016)

Country	Number of deaths (number)	Standardised death rates (per 100,000 inhabitants)		
		Total	Persons aged < 65 years	Persons aged ≥ 65 years
Bulgaria	70,509	1,094.9	166.3	4,928.3
Romania	148,619	898.9	114.4	4,137.7
Latvia	15,876	848.5	139.2	3,776.5
Lithuania	23,056	845.7	122.7	3,830.4
Hungary	62,727	737.5	103.9	3,353.2
Estonia	8,019	643.0	83.0	2,954.7
Croatia	23,221	630.7	64.7	2,967.3
Slovakia	23,038	620.2	80.8	2,846.9
Czechia	47,700	569.9	57.9	2,683.7
Poland	168,280	552.7	76.1	2,520.1
Slovenia	7,952	431.7	32.4	2,080.0
Austria	33,370	397.4	30.7	1,911.2
Germany	339,887	381.1	37.8	1,798.6
Finland	19,687	360.2	40.6	1,679.4
EU-28	1,832,835	358.3	43.9	1,656.4
Liechtenstein	97	353.4	24.3	1,711.6
Greece	43,917	351.5	50.6	1,593.7
Malta	1,209	332.7	33.6	1,567.8
Cyprus	1,802	331.6	36.1	1,551.4
Sweden	31,674	318.6	27.8	1,518.9
Iceland	737	315.1	18.5	1,539.6
Ireland	9,218	309.0	31.5	1,454.6
Luxembourg	1,263	298.2	24.2	1,429.1
Portugal	32,685	296.7	32.9	1,385.9
Italy	220,749	296.2	25.1	1,415.3
Belgium	30,175	268.8	29.1	1,258.6
Netherlands	38,954	264.4	24.6	1,254.1
Switzerland	20,908	263.0	20.6	1,263.9
United Kingdom	153,888	253.3	37.4	1,144.6
Denmark	12,569	248.3	28.4	1,155.9
Norway	11,027	247.5	21.6	1,180.1
Spain	118,824	237.3	27.1	1,105.2
France	143,967	197.2	24.1	912.1

Source: Eurostat (online data codes: hlth_cd_aro and hlth_cd_asdr2).

In terms of health expenditure, although spending has increased steadily over recent years, Romania still ranks lowest among European Union member states. Whereas average health expenditure as a percentage of gross domestic product (GDP) in the European Union is 9.8%, in 2017 Romania allocated only 5% of the country's GDP to the healthcare system (and 4.0% in 2016). The gap between Romania and the average indicator at the level of the EU increases when comparing health expenses per capita, adjusted by purchasing power parity (PPP). In this regard, Romania spends €1,029 per capita PPP, significantly less than the €2,884 in the European Union in 2017 (OECD/European Observatory on Health Systems and Policies, 2019). In terms of the proportion from total government expenditure, public

spending on health in Romania constituted 11.9%, less than on general public services (13.0%), economic affairs (13.3%), and slightly more than on education (10.8%).

Table 3. General government total expenditure by function in the EU and Romania (2016) (as a % of GDP)

Domain	EU average	Romania
Health	7.1	4.0
Social protection	19.1	11.6
Sickness and disability	2.7	1.1
Old age	10.2	8.4
Survivors	1.3	0.1
Family and children	1.7	1.4
Unemployment	1.3	0.1
Others	1.7	0.5

Source: Eurostat, "General government expenditure in the EU in 2016".

The largest share of Romania's government expenditure went on social protection (34.2%), compared with the EU average of 41.2%. In terms of the share of the country's GDP, government expenditure on social protection represented 11.6% in 2016, which is almost half the EU average of 19%. As detailed in Table 3, public expenditure on sickness and disability in Romania is almost three times lower than the EU average (1.1% of GDP in Romania compared with 2.7% of GDP in EU member states).

1.3 Social dialogue in Romania

The type of industrial relations system in Romania is Central and Eastern European (CEE) neoliberal and decentralised (Bechter, Brandl, and Meardi, 2012; Bohle and Greskovits, 2012). Traditionally, Romania had a strong trade union movement and a coordinated system of collective bargaining until the reform of social dialogue legislation in 2011. This legislation changed how trade unions were established and how they functioned. The result was a decrease in collective bargaining from 100% (in 2010) to around 35% currently (Stoiciu, 2016). Other sources support this figure of 36% of collective bargaining coverage (European Trade Union Institute, 2020). According to the same data source, the proportion of employee participation in trade unions in Romania is 33%, but the numbers vary depending on the source of data. At present, social dialogue in Romania is weak and largely ineffective, as responsibility for bargaining is placed at the company level and the actors in the companies have not fully assumed their role. Of all the issues addressed by trade unions, mostly their influence on health issues is low and RTW problems are usually solved in ad-hoc decisions and ways.

1.4 Research design and methodology

This country report focuses on Romania and is based on a methodological framework which draws on a mixed-method data-collection process ranging from surveys to face-to-face individual interviews, group interviews and workshops with relevant stakeholders, and documentary analysis.

Three web-based surveys were conducted, each addressing a particular target group covering the entire spectrum of industrial relations: managers and employers, workers, and social partners (Table 4). Details regarding the three web-based surveys are provided in Tables 5-7 below.

Table 4. Overview of the sample and respondent identification – Romania

Overview of the sample and respondent identification – Romania

Survey and target group	Total number of responses	Number of relevant responses
Workers' survey	127	40
Social partners' survey	7	6
Managers' survey	44	35

Source: own elaboration

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

The workers' survey (Table 5) gathered the experiences of Romanian employees who have undergone a period of absence from work due to chronic illness. The survey included items in the Romanian language and was posted online on the website salarulmeu.ro, which is part of WageIndicator.org (https://salarulmeu.ro/drepturile-tale/munca-si-boli/reveniti-la-munca-dupa-concediu-medical).

The occupational structure of workers is displayed in five categories which had the highest number of answers: legal, social and cultural professionals and associated professionals (four); health professionals (four); business and administration associate professionals (four); production and specialised services managers (four); and other (seven). Another category, customer services clerks, had three answers. The following occupations had two answers each: teaching professionals and stationary plant and machine operators. Other categories had one answer.

Table 5. Overview of the sample and respondents' identification – REWIR workers' survey for Romania

Workers' survey – structure of responses	Responses (in percent if not stated otherwise)
Gender (Q1)	
Male	9
Female	31
Mean age in years (Q3)	49.8y
Mean length of working life in years (Q4)	27.8y
Level of education (Q2)	
Low-qualified (up to lower secondary)	1
Middle-qualified (up to post-secondary vocational)	5
High-qualified (up to university education)	32
Other	2
Type of organisation where the respondent worked prior to diagnosis/treatment (Q14a, 14b + Q32a, 32b)	
Domestic	27
Foreign owned	9
Don't know	5

Private sector	15
Public sector	24
Do not know	1
Trade union membership (Q9 + Q27)	
Yes	14
No	26
Trade union presence at the workplace (Q11 + Q29)	
Yes	21
No	19
Type of job (Q16 + Q34)	
Intellectual	31
Manual	2
Indoor	17
Outdoor	3
Intensive physical activity	9
Intensive emotional stress	18
Company size (Q13 + Q31)	
Below 20	1
20 - 50	10
50 - 500	11
500 - 1000	9
Above 1000	9
Currently on sick leave (Q17)	
Yes	2
No	2
Three most frequently reported diseases (Q7 + Q25)	
1.	Cancer (23)
2.	Cardiovascular disease (7)
3.	Musculoskeletal (4)

Source: own elaboration

Note: sample size = 40 (no. of respondents from Romania).

Table 6. Structure of the social partners, survey data for Romania collected within the REWIR project.

Structure of responses	Responses
Type of organisation (Q2)	
Employers' associations	3
Trade unions	4
Other	0
Level of social dialogue engagement (Q4)	
National	4
Sub-national (territorial)	1
Sectoral	2
Two of the most commonly reported sectors represented (Q5)	
1.	Manufacturing (2)
2.	Not reported (5)

Source: own elaboration

Note: sample size = 7 (no. of total respondents from Romania); only 6 responses were relevant.

The web survey addressed to social partners set out to gather insights and experiences from both employers' associations and trade unions. The Romanian research team was responsible for collecting data for four countries: Romania, Bulgaria, Croatia, and Slovenia (see in Table 6 details on the Romanian survey). The survey included questions in English and was conducted through SurveyMonkey (https://www.surveymonkey.com/r/K67LMG7). The team identified a list of relevant contacts of trade unions and employers' associations in the four countries, which was used to distribute the survey by mail. The list was reviewed and updated repeatedly during the last months to receive more responses. The main limitation in obtaining the required number of responses was the language of the survey (English).

Table 7. Structure of the companies, survey data for Romania collected within the REWIR project.

Structure of responses	Responses
Ownership type (Q4)	
Domestic	35
Foreign	9
Company size (Q2)	
1-9	7
10-49	10
50-249	18
Above 250	9
Predominant type of workers (Q7)	
1.	Administrative workers/office clerical (14)
2.	Highly skilled specialists (13)
3.	Low skilled manual workers (6)
Three most commonly reported economic sectors represented (Q6)	
1.	Public administration (11)
2.	Healthcare, caring services (6)
3.	Manufacturing (4)
Presence of Trade Union or other form or workers' representation (Q22)	
Yes	22
No	8
Not answered	14

Source: own elaboration

Note: sample size = 44 (no. of total respondents from Romania); there were 35 relevant responses.

The managers' survey (Table 7) aimed at collecting data regarding how Romanian employers manage the process of dealing with an employee affected by chronic illness and the latter's returning to work. The survey included questions in Romanian and was carried out through SurveyMonkey (https://www.surveymonkey.com/r/YT2PNP3?lang=ro). The team already had a database of contacts from a previous project, which was expanded with employers from other cities and other sectors.

Besides collecting quantitative data through survey methodology, the research team also used desk research to analyse the policies for RTW in Romania and conducted qualitative research in three ways: (1) a roundtable organised in July 2019; (2) two focus groups, arranged in January 2020, one with employers and the other with trade union representatives; and (3) individual semi-structured interviews with relevant national stakeholders. Combined with the quantitative data collected through web surveys, these qualitative approaches consisting of individual and group interviews and workshop discussions allowed us to gather a wide range of information regarding the multiple facets of managing return to work after suffering chronic illnesses. We will detail these methods below.

The desk research was used to perform a detailed analysis of the national policies for sick leave absence caused by chronic illnesses and the policies for return to work (provisions, actors involved, strengths and weaknesses of the current policy framework). The results are presented in section 2 of the present report.

The roundtable was conducted on 7 June 2019 with 19 participants (15 stakeholders and 4 staff-members from the Lucian Blaga University of Sibiu – LBUS). After a brief presentation of the project (aims, research questions, methods, stakeholders), a guidelines-based discussion was organised on the project's theme. The participants at the Romanian roundtable event represented the following public institutions, trade unions, and private companies:

- Ministry of Labour, Agency for Social Benefits, Social Work, Service for Social Inclusion
- Ministry of Labour; Territorial Inspectorate for Work
- Association for Cancer Support (the participant was also a cancer survivor)
- Association for Oncological Patients in Romania
- Association of employers (local representative)
- SANITAS Federation (health)
- ULBS trade union representative
- company trade union, automotive industry (two representatives)
- employer, automotive industry
- employer, electronic components
- employer, automatic systems (industry) (two representatives, the local manager and the HR director)
- employer, construction (HR director).

Two focus groups were conducted in January 2020: (1) the first one on 14 January 2020, with 13 participants (11 employers and 2 LBUS staff); the participants came from companies located in Sibiu and the surrounding region, 9 private and 2 public. Their domains of activity are in the automotive, construction, energy, electrical devices, cultural and public facilities sectors, and are of various sizes; (2) the second focus group was organised on 15 January 2020, with 8 participants (7 company-level trade

union representatives). The participants represented trade unions from various organisations located in the regions of Sibiu and Mureș, 3 private and 4 public, which are different in terms of size. Their domains of activity are in public services and facilities, social matters, the environment, education, the automotive, industry, energy and electronics sectors. The discussions in both focus groups were guided by questions that were agreed in the consortium, exploring the participants' experiences with cases of employees affected by chronic illnesses and how the process of returning to work currently is and could be facilitated by organisational management.

Seven individual interviews were conducted over January-February 2020 with key representatives from national institutions relevant for the project, as follows:

- an occupational physician and expert within the service of the Work Risk Factors Evaluation, working at the District Health Authority Sibiu (a local body of the Ministry of Health);
- an HR recruiter at a private employment agency;
- a career counsellor at a public employment agency;
- a physician with medical expertise in rehabilitation for work capacity, who is also a member of the College of Physicians, working at the County Pension House (a public institution for invalidity pensions and local body of the Ministry of Labour and Social Protection);
- two social workers, one being an inspector at a public institution for social benefits for disabled people (a local body of the Ministry of Labour and Social Protection) and the second being a counsellor working at the service for the assessment of people with disabilities (public institution); and
- a policymaker at the Ministry of Labour and Social Protection in Romania.

2 The policy framework on return to work in Romania

This section summarises the policy framework for sickness, invalidity and return to work in Romania. The data were collected mainly using desk research, but also from individual interviews. Of the four groups of countries described by Belin et al. (2016), Romania belongs to the third group, having an *ad-hoc approach*, which is not planned and supervised, but decided on a case-by-case basis. The target groups are workers with disabilities and occupational conditions or injuries, and for some provisions also workers with chronic illnesses. There are few actors involved and no statutory programmes for RTW (for further details see D1.1_REWIR Analytical framework).

2.1. The sickness and invalidity system in Romania

The Romanian social security system is based on social insurance (for the invalidity pension) and health social insurance (for sick leave). Different institutions formulate the criteria and supervise the sick leave and invalidity requirements: the Ministry of Health for the sick leave provisions (*temporary work incapacity* in Romanian law) and the Ministry of Labour and Social Protection for invalidity pensions, disability benefits (since 2019) and other related benefits. The provisions for sickness absence and invalidity are established by law, thus the system is rather centralised. This means that the trade unions and employers' associations have a less significant contribution to how these systems function and how they are shaped. There are different measures established for work accidents and occupational diseases and diseases not related to work.

Table 8. Policy framework for sick leave and invalidity in Romania

Sick leave provisions	
Eligibility	For the provisions related to sick leave, or temporary work incapacity (TWI) All workers, provided they comply with three conditions: they are insured by the public social insurance system; they have a contribution period of at least 6 months, completed in the last 12 months prior to the occurrence of the risk (exception – workers suffering from work accidents, occupational diseases, and tuberculosis); and they provide a medical certificate. Unemployed people are eligible to enter TWI and receive the allowance only if they suffer from work accidents or occupational diseases that occurred during their participation in vocational rehabilitation courses and because of them. Pensioners who generate income for which they pay social insurance contributions are also eligible for TWI as other workers.
Duration	Generally, the duration of TWI is a maximum of 183 days (6 months) in a year. After 90 days, the TWI can be extended to 183 days only following the approval of the social security expert physician.

	For several special diseases, the duration is more than 180 days, as follows: 1 year, in the last 2 years, for tuberculosis and some cardiovascular diseases; 1 year, which can be extended to 1.5 years, in the last 2 years, for types of tuberculosis other than pulmonary, AIDS and cancer; 1.5 years, in the last two years, for pulmonary tuberculosis treated surgically and osteoarticular tuberculosis; and 6 months, in the last 2 years, for other forms of extra-pulmonary tuberculosis.
Source of payment	The temporary work allowance is generally paid by the employer from the first day of sick leave until the 7th, or 12th, or 17th day of sick leave (depending on the number of employees: <20, 21-100, >100) and then from the public budget of social insurance until the end of the TWI (the National Fund for Social Health Insurance). In cases of work accidents and occupational diseases, the allowance is paid by the employer from the first day of sick leave for workers with an individual labour contract. For unemployed people, the allowance is paid from the public budget of social insurance.
Level of benefits	Generally, the level of benefit is 75% of the average monthly income earned in the last 6 months prior to the month when the disease occurred. It is 100% of the average monthly income earned in the last 6 months prior to the month when the disease occurred through a work accident or occupational disease, or is tuberculosis, AIDS, cancer.
Timing of RTW considerations	At the end of the sick leave period; the only early intervention is the obligation for the workers with sick leaves longer than 90 days to follow a medical rehabilitation programme. The RTW is usually done informally, it is not planned and is rarely phased (part-time work then full-time work). When resuming work, the occupational physician must give an assessment but is not really involved in the RTW process.

Invalidity pension	
Eligibility	Workers who lost all or at least half of their work capacity due to: work accidents or occupational diseases neoplasms, HIV/AIDS, schizophrenia; or accidents and diseases not related to work, only if the worker has completed the required contribution period, which is in relation to the worker's age. There are three degrees of invalidity and the assessment of work capacity is done by expert physicians of social insurance who are part of the National Pension House, belonging to the Ministry of Labour and Social Protection. The workers are periodically reassessed (at intervals between 1 and 3 years, depending on the disease, until they are retirement age) with some exceptions.
Duration	The invalidity benefit can be offered until the person goes into retirement, but every 1-3 years the person is reassessed by the expert physician of social insurance. Several situations may halt the benefit payment.
Source of payment	The invalidity pensions are paid from the National Fund of Public Pensions. The contributors to this fund are salaried workers, employers and the self-employed.

Level of benefits	The invalidity benefit amount can vary and is calculated based on the gross salary and the contribution period. The minimum benefit is 700 RON (€145). There are professions which belong to special categories; such workers can obtain a greater benefit.
Timing of RTW considerations	During the invalidity period, the pensioners must follow a medical rehabilitation programme recommended by the expert physician of social insurance. The benefit will no longer be paid if the pensioner is not complying with this regulation. After the invalidity pension, RTW means that the worker must find another job. Here too, the occupational physician must give an assessment but is not really involved in the RTW process.
Type of source for these provisions (e.g., law (dedicated or general), collective agreement, other)	Dedicated laws: Law 19/2000 (public pension system) Law 263/2010 (the unitary system of public pensions).

Source: own elaboration

2.2. Policies on return to work in Romania

Romanian legislation provides several stipulations which are indirectly related to RTW, as presented in Table 9. These provisions are general, indicating broad principles rather than specific actions designed to facilitate RTW. No specific measure, procedure or intervention for RTW facilitation is provided by law after the sick leave ends. The RTW is not planned, but employers are able to allow the worker to resume work on a part-time schedule first (depending on the type of job). RTW roles are allocated to the treating physician, the employer, the occupational physician and the local public employment agency, and not to other actors. The employer has a marginal role in RTW. No active labour market policies are in place.

Table 9. Policy framework for return to work in Romania

Policy framework for return to work	
Procedure for return to work	**During sick leave (**Emergency Ordinance 158/2005) No specific procedure for RTW is specified, involving the employer or occupational physician. Yet, there are several stipulations regarding the *recovery of work capacity* that must be followed during the sick leave period and which facilitate RTW: To achieve the recovery of work capacity, the worker can benefit from a medical and spa treatment for recuperation. Workers with sick leave longer than 90 days can benefit from treatment at a medical rehabilitation spa, of 15-21 days, following an individual plan provided by the treating physician and approved by the social security expert physician. The individual medical rehabilitation plan is phased and mandatory and is done in specialised medical facilities which have a contract with the social security houses (there is one in every county). *At the end of every phase of the rehabilitation plan, the social security expert physician reassesses work capacity and recommends either continuing the medical rehabilitation, returning to work or starting the invalidity pension*.

The spa treatment and medical rehabilitation is paid for by the National Health Insurance House.

The payment of allowances is conditioned on the worker's compliance in following the recuperation plan.

Resuming work (Labour Code; Law 355/2007)

Workers must obtain a medical certificate (fit note) from the occupational physician (OP) if they return to work after sick leave of more than three months, or whenever the OP considers necessary. It is the same if they change jobs (Law 355/2007).

Workers cannot be fired during the TWI (sick leave) period.

If the worker lacks work capacity (validated by the social security expert physician*), the employer has to offer another work position compatible with the skills and/or the work capacity of the worker*. The worker must respond in three days if accepting the new position offered by the employer. If the employer does not have vacant positions to offer, the employer must refer the worker to the local employment agency, which will offer guidance for obtaining a new job according to the worker's skills and capacity. The employer is allowed to fire the worker only if that person does not respond in three days to the job position proposal or only after the referral to the local employment agency.

If fired as presented above, the worker may receive compensation according to the individual work contract or to the collective labour contract.

The fit note (which can have four results – able to work, conditionally able to work, temporarily unable and permanently unable to work) is issued by the occupational physician for three purposes:

to confirm the skills of the worker for the former or the new job;

to establish measures for work adaptation when necessary; and

to re-orient the worker towards another job which helps the worker to maintain health and work capacity.

Provisions for people with disabilities (Law 448/2006)

There are several provisions solely for people with disabilities who want to obtain a job or to return to work (these people must have a disability certificate, issued by the Commission for Assessing Adults with Disabilities, which is part of the Ministry of Labour and Social Protection):

Every person with a disability who wants to (re-)integrate into work can benefit from free assessment and professional guidance; that person also has the right to actively participate in this process of evaluation and guidance, to receive proper information and to choose the work activity.

The public authorities have the obligation to establish and maintain sheltered units and sheltered jobs.

The public authorities have the obligation to initiate measures to incentivise the employers to hire and maintain in work people with disabilities.

	The public authorities must offer social services and counselling for the people with disabilities, their families, employers to facilitate the work (re-)integration and assisted employment. Sheltered units are called Work Integration Social Enterprises, functioning as either profitable companies or not-for-profit associations and usually specialise in production and commerce. At least 30% of the workforce in sheltered units must be employees with disabilities. Their functioning is incentivised through tax exemptions if complying with certain conditions imposed by law. Sheltered jobs are adjusted for the needs of persons with disabilities within the sheltered units. Employers with at least 50 employees have the obligation to hire workers with disabilities – 4% of the total number of employees. For employers who cannot hire employees with disabilities, the law offers two alternatives: (i) to pay monthly to the state budget a sum representing 50% of the minimum gross salary (which was €275.39 in 2017), multiplied by the number of jobs unoccupied by persons with disabilities; and (ii) to buy services or products made by people with disabilities in sheltered units, the value of such services/products purchased being the equivalent of the sum owed to the state. Employers who hire workers with disabilities can benefit from the deduction of expenses for workplace adaptation and also of the expenses for vocational rehabilitation and guidance. Workers with disabilities have the right to benefit from *reasonable accommodation of the workplace* (modifications done by the employer to the work schedule, or the offer of special equipment or technologies), counselling and work mediation, the possibility to work less than 8 hours daily (following the commission's advice), and exemption from payroll tax. Employers have the obligation to adapt the workplace according to the needs of *groups sensitive to risks* (including people with disabilities) – Law 319/2006. **Other general provisions** The interdiction of discrimination based on chronic non-communicable diseases at the workplace (Government Ordinance 137/2000) Occupational physicians assess the work ability of workers with chronic illnesses – the concept of *special medical surveillance (*Government Decision 355/2007)
Type of source for these provisions (e.g. law (dedicated or general), collective agreement, other)	Dedicated laws: Emergency Ordinance 158/2005 (temporary work incapacity and social security) Labour Code (53/2003) Government Decision 355/2007 (employee health monitoring) Law 448/2006 (protection and promotion of the rights of people with disabilities) Law 319/2006 (security and health at the workplace) Government ordinance 137/2000 (prevention and sanction of discrimination)
Any other aspect relevant for the country	No measure, procedure, or intervention for RTW facilitation is provided by law after the sick leave ends.

	The worker must follow an individual plan to regain work capacity, but this is only for medical problems (medical rehabilitation). The employer has only a marginal role in return to work (see above). Other actors such as NGOs or support professionals (psychologists, social workers) do not have a formal role in RTW.

Source: own elaboration

3 Involvement of social partners in shaping return-to-work policies at the national level

This section presents findings from the social partners' survey, the roundtable discussion, the two focus groups with employers and trade unions, and from the interviews with national stakeholders.

3.1 Actors and stakeholders in return-to-work policies

In this section we describe the actors shaping and implementing the RTW policies in Romania as well as the role they play in this process. A major characteristic of the Romanian policymaking system is its centralised nature, which means that the process of proposing and planning policies is rather centralised as opposed to following a bottom-up approach. The state plays the main role in the process and the involvement of social partners and other stakeholders is relatively low, as we will detail below. Traditionally, and even more so since 2011, the practice of social dialogue in Romania has been weak. As outlined in the previous section, trade unions and employers' associations are not encouraged to assume an active role in the process of policymaking, which is almost entirely attributed to the government.

The three key national actors managing the funds for sickness, disability and invalidity are (1) the National Health Insurance House (NHIH), which is the public institution coordinating the sickness benefits; (2) the National Fund of Public Pensions (NFPP), monitoring the invalidity pensions; and (3) the Ministry of Labour, which is involved in coordinating activities related to the disability benefits. The professional categories formally stipulated in law which are directly or indirectly involved in managing sickness, disability and invalidity are specialised physicians, occupational physicians, expert physicians of social insurance, and social workers.

At the national level, the tripartite social dialogue is coordinated through institutional structures. The main body is the Tripartite National Council for Social Dialogue, established at the government level and composed of members of trade union and employers' confederations and members of the government (Ministerul Muncii și Protecției Sociale, 2020). The technical secretariat role is done by the Social Dialogue Commission, functioning within the Ministry of Labour. Also, at the national level there are consultations between the government and the Economic and Social Council, which is a civic dialogue body composed of civil society representatives.

Besides these actors involved at the state level, employees and trade unions as their representatives should have a significant role in shaping RTW policy. There are five trade union confederations with representation at the national level, which in the past have been involved in fighting common causes: the National Trade Union Confederation 'Cartel Alfa', National Trade Union Bloc, National Confederation 'Frăția', National Confederation 'Meridian', and Confederation of Democratic Trade Unions in Romania. The trade union representation is significantly larger in industry (75–85%) compared with public administration (30%) (European Trade Union Institute, 2020). Regarding collective bargaining, since 2011 collective agreements can be negotiated only at the industry/sector level, at the company level and for groups of companies, and not at the national level. The negotiations are regulated by the Social Dialogue Code. Only trade unions that represent at least 7% of the employees in a sector of activity can negotiate at the national level (10% for employers' associations). In each company only one trade union can be representative of the employees' interests. In companies with more than 20

employees and no trade union, employee representatives can be elected (European Trade Union Institute, 2020). All companies with more than 10 employees should elect health and safety representatives, but their responsibilities are rather general in maintaining health and safety conditions at work. Still, around 57% of the organisations in Romania declare that they are using RTW procedures or measures (compared with 67% in the EU-28). The information on health and safety in Romanian organisations comes to a great extent from labour inspectorates (in 82% of the organisations) and much less from trade unions (for 11% of organisations) or employers' organisations (27%) (Irastorza, Milczarek, and Cockburn, 2016).

Several years after the reform of social dialogue legislation in 2011 (Law 62/2011), social dialogue in Romania appears to be weak and ineffective, as reflected in the accounts of participants in the roundtable discussion and focus groups. Thus, they draw a grim and problematic picture of the current influencing power of trade unions in Romania. According to them, the provisions of Law 62/2011 are very restrictive for the trade unions while favouring employers. As a result, the number of collective agreements negotiated at the company level have dropped significantly and the social dialogue has been reduced to a few points based only minimally on requirements from the work code. Trade unions tend to deal mostly with financial issues and work conditions, but the health and safety issues remain under-regulated. Therefore, RTW – which is a particular topic in the health and safety field – is usually not explicitly addressed by social dialogue means.

Several employers' confederations are visible and active at the national level: the National Council of Small and Medium Enterprises in Romania, Employers' Confederation Concordia, the General Union of Industries in Romania, the National Romanian Employers, and the Union of Employers in Romania. Besides trade union confederations, these are significant social partners.

Another key institutional actor is the public employment agency with its territorial agencies (41, with 1 in each county), which is directly involved in the labour market and deals with the main problems in this field. Yet, this agency deals mostly with unemployed people in good health and has only a formal and marginal role regarding workers returning to work after sickness or disability.

Civil society is also characterised by little involvement in shaping RTW policies, although in recent years the influencing power of NGOs has increased in some fields. A large number of NGOs acting as patient organisations fight for the rights of patients with chronic illnesses, yet RTW constitutes a rather marginal issue for many of them. In this regard, there are 135 associations and 33 foundations active in the field of cancer, but only 9 associations and 1 foundation are engaged in explicit actions facilitating work reintegration (Popa, Vlase and Morândău, 2016). Some initiatives could be undertaken by researchers active in this field, as a result of the projects they carry out, but communication with the upper political layer is usually limited, as there are no formal bottom-up ways to propose policies or changes in policy (public consultations are rarely organised, ineffective and usually not transparent).

Based on the discussions with all the stakeholders in our study, the main conclusion is that they are not directly involved in shaping the RTW policy after chronic illness, at the national level. Their formal activities are related in many ways to the labour market, but they are not specifically addressing the RTW process. They declared that there are no specific provisions in the law for RTW facilitation. Some of the stakeholders in our study are involved in managing the health risk factors at the workplace.

The participants in the focus group with employers agreed that the following categories of actors should be those most involved in shaping RTW policy: the state (as the most important actor – overall

agreement), employers (especially the HR departments) and employees. The state provides the general legal framework within which the employer can offer tailored measures to facilitate RTW. The participants in the study appreciated that the specialist physician should be involved more. In their view, trade unions are marginally involved, and their involvement is usually restricted to financial issues.

The trade union representatives participating in the second focus group also agreed that the state, through the policies issued, is the most important actor, followed by the trade unions, the employers and the College of Physicians. Still, all the participants in the study see themselves as passive actors regarding their influence in shaping policies, as they acknowledge that they merely act in the context of law. In their view, the lack of initiative in shaping policy is explained by the lack of mechanisms strengthening cooperation between political actors and stakeholders at the lower level.

3.2 Views and level of involvement of industrial relations actors in return-to-work policies

Seven Romanian organisations participated in the survey of social partners: three employers' associations and four trade unions, but only six responses were relevant. All of them are involved in the tripartite national social dialogue. The low number of responses represents a limitation which we tried to overcome by supplementing the data from this survey with data from other sources: the roundtable discussion, focus groups and interviews with social partners.

Social partners' perceptions of EU-level return-to-work policies

The data from the survey we conducted show that there is collaboration between national and European social partners. Just over half of the Romanian social partners affirmed that their organisation participates in EU-level social dialogue structures. Also, four respondents stated that they have knowledge of EU-level policies that support RTW for workers after treatment for chronic diseases.

Most trade union representatives agreed that the RTW agenda should be part of an EU strategy and that the EU-level agenda addressing RTW policies should be more active on this issue. Regarding the form of EU-level involvement, the social partners agreed that both non-binding recommendations and binding policies should be set out for member states, to the same extent (see Table 10 in section 4.2).

Regarding the role of EU-level social dialogue committees in shaping EU-wide RTW policies, five of the six respondents considered that EU-level social dialogue should embrace RTW policies more actively on the agenda and adopt binding recommendations for the member states. Four participants disagreed with the idea that the EU-level agenda addresses RTW policies appropriately and no changes are needed. Five of the participants in the study agreed that RTW is an issue that should be on the agenda of EU-level social dialogue. In the social partners' perception, the EU-level RTW policies should be a framework for national policies. Cooperation at the EU level is considered necessary and relevant.

Social partners' perceptions of national return-to-work policies

Regarding national RTW policies, the main problem in Romania, in the opinion of social partners, is not the absence of an elaborate policy framework but the lack of good implementation and enforcement. Thus, most respondents declared that they knew about the existence of national policies and measures

that support RTW after chronic diseases in Romania. Also, half of the respondents considered that Romania has an elaborate policy framework but lacks good implementation and enforcement. Only one participant considered that Romania has a poor policy framework and lacks good implementation and enforcement.

Directive 2000/78/EC establishing a general framework for equal treatment in employment and occupation is not a well-known measure. One respondent did not know about it, two others considered that the directive had not been implemented, while there were four nonresponses.

Almost all the participants in the study agreed that trade unions should be more active in addressing the RTW policymaking process. They also expect more from employers' associations, considering these should be more active. Only one respondent thought trade unions are active enough, and that RTW should not be a priority for employers' associations at the national level. On the knowledge side, two-thirds of respondents knew about specific measures that facilitate the implementation of RTW policies in Romania and two declared that they did not know any such measures.

Regarding the actual involvement of social partners in the process of policymaking, five of the six respondents are involved and occasionally consult on the RTW policymaking process. A majority of them strive for more active involvement in RTW policymaking. When social partners are involved in policymaking actions, the initiative seems to be balanced, as half of them asserted they had the initiative and the other half acknowledged that the initiative was driven by external factors (at the national or EU level). Two important barriers to involvement in shaping RTW policy were identified by the participants in the survey: the government disregarding their initiatives and not being recognised as a relevant partner for RTW policymaking.

In terms of the actual involvement of social partners in the process of policy implementation, one-third of them have occasional involvement, while the rest have limited to ad-hoc, marginal involvement. The cause for this reduced involvement in RTW policy implementation is the lack of a national strategy or legislative framework to facilitate their engagement. Half of them monitor how the RTW policy is implemented at the company level and one-third monitor it at the national level. But there is interest in extending the organisations' involvement in RTW policy implementation, as almost all of the study participants said that they strive for more active involvement.

As pointed out in part by our previous research (Popa & Popa, 2019), the participants in the focus groups identified several positive aspects of the current Romanian legislation on sick leave, invalidity and RTW, such as the work code, which is a good policy (integrative and complete); the generous period of sick leave for some diseases, which is fully payed; the impossibility to fire a worker during sick leave (the position is kept open until the worker comes back); and the stipulations on occupational diseases (some of them being chronic illnesses). On the negative side, the participants mentioned the following: the gradual RTW and also flexitime are not regulated enough; the non-existent counselling services; the rehabilitation services are totally insufficient and have a low degree of accessibility; the fact that sick leave is granted only for 1 month (the worker must go to a specialist physician every month to obtain another 30 days of sick leave and then take the sick leave certificate to the employer), thus making it impossible for the employer to make replacement plans in long term; and there are no facilities to help employers to accommodate an employee's return after chronic illness, as the system is based only on sanctions.

In conclusion, in terms of RTW policymaking, the responses collected indicate poor involvement by all stakeholders. They do not have the proper means to participate and they rather withdraw from this process, as the state is deemed to have the most responsibility. On the other hand, the social partners agreed that there are some RTW stipulations in policy, but these are not specific enough. They mentioned the need for a legal framework with clear procedures for employers and other stakeholders that can support RTW after chronic diseases. The EU-level strategy should be reflected in this framework. Social partners are aware that they should be more active in making and implementing RTW policy, but they consider their influencing power to be insufficient.

Social partners' perceptions of the role of national industrial relations in returning to work

Data collected in this study emphasise the need for collaboration between the state, employers and trade unions. Social partners acknowledged that both the trade unions and the employers' associations should be more active in RTW policy implementation at the national level.

The survey highlights that social partners are involved mostly in activities related to collective bargaining, and then in equal shares but less in raising workers' awareness of their rights, lobbying public institutions and assistance to individual workers. The two actors which are involved in collective bargaining do not engage in negotiations at the national, sectoral or regional levels, but only at the company level.

The data gathered through conducting the focus groups show that trade unions are considered to be important actors in RTW policy, from the perspective of all stakeholders. Among the suggestions offered by participants was that their role could include negotiations on health funds and bonuses for workers with chronic illness. However, data from the company survey show that only around 38% of the managers consult with trade unions and/or employee representatives on RTW issues. The number of nonresponses to this question (50%) highlights the low level of social dialogue. Also, collective agreements at the company level address RTW only in 16% of the companies, while one-third of the managers agreed that RTW should be managed in company-level collective agreements. Only 16% of the companies have a collective agreement and only one-third of the workers are affiliated with a trade union. Therefore, industrial relations are judged as important for RTW, yet the framework within which the actors could function effectively is missing.

The same idea of the importance of the role of social partners in shaping and implementing policy was expressed in the interviews. It is essential, in the participants' view, that all categories of social partners, from all levels, participate in social dialogue. Yet, it was stated that the involvement of trade unions and employers' associations in social dialogue at the national level was always in order to improve the policy proposals of the Ministry of Labour. This indicates that the main and the most active role is attributed to the ministry.

3.3 The nature of interactions between industrial relations actors and other stakeholders in return-to-work policies

Along with the actors involved in the system of industrial relations, other stakeholders play a relevant role in RTW policymaking and implementation. Half of the social partners agreed that the cooperation

between them and other stakeholders (the government, labour market institutions, medical organisations, rehabilitation centres, NGOs, psychologists, therapists and other professionals) to facilitate RTW policy creation is vital. One-third of the respondents considered this cooperation to be potentially important, although there are obstacles. The same can be said about the cooperation on RTW policy implementation in Romania, with the latter being seen as more important than cooperation on RTW policies.

In the interviews, the representatives of private employment agencies and the public employment agency emphasised their willingness to cooperate with industrial relations actors, yet they indicated that in their experience informal relationships and personal recommendations matter much more in the interactions with industrial relations actors.

3.4 Outcomes of social dialogue regarding return-to-work policies (national and if relevant sectoral/regional social dialogue)

The interviews with various categories of stakeholders indicated little collaboration with industrial relations actors (mostly trade unions), as there were a lot of nonresponses to the respective questions. Only the representative of the Ministry of Labour and Social Protection revealed an example of cooperation having as a result some "proposals [on] public policy (normative acts) which were adequate and sensitive to their needs and grievances".

Although most of the social partners who responded to the survey desire more active involvement in RTW policymaking and implementation, the outcomes are poor. The individual (personalised) approach at the company level is considered to be more useful and it is a common practice to use collective bargaining. An example was offered by one company, in which the trade union negotiated the terms that when a worker loses work capacity and no other job can be offered within the company, the worker will receive a lump sum payment of two years' salary and be made redundant to receive 24 salaries and to fire the worker. More often the trade unions are financially involved (by helping the employee with money for treatment) and in some cases they offer support and encourage the employees to return to work but only as an informal action. In some companies, the collective agreement specifies in detail how the worker will be helped in case of long-term illness, with general sections on health, but not specifically for RTW.

3.5 Views on the potential for action on return to work and the contribution of industrial relations actors

Very few examples of best practice concerning RTW policies were offered and these were rather abstract: "cooperation between the social partners in the creation of legislation at the national level" and "when the employee returns to work, the union deals with his/her appointment [to] the initial position".

Several measures were proposed to improve collaboration in social dialogue, with most of them related to the legislation and targeting the national level: to elaborate better legislation; to enable fiscal facilities in legislation for employers in order to support an appropriate environment for employees with chronic illnesses (trade unions and the government should have the responsibility); and to include RTW on the collective bargaining agenda. Another measure proposed is to build a real culture at the company

level that enables measures related to RTW, based on the argument that organisations with a good performance record are those that take care of their human resources.

The qualitative data collected reveals that current approaches to RTW are based on informal actions and the employer's willingness and good intentions. The participants mentioned the need for a clear strategy and procedures, from the upper legislative level to the company level, to help employers and employees in the RTW process. Two notable suggestions were made: first, to include in the law the possibility to cumulate sick leave with a gradual return to work of 2–4 hours (at present, if the worker wants to return to work for 4 hours, the sick leave is suspended); this would be similar to the actual legislation for going back after maternity leave. This measure should be available as an option, for those who want it. The second suggestion was to introduce an reintegration *incentive* (a financial incentive for those who go back to work earlier), similar to that for maternity leave.

The employers' associations should have a more active role in RTW, especially in the case of organisations with no trade unions. In such cases, the trade unions should be replaced by other structures, as it is important for employees who face health problems to be informed and better represented. The participants suggested training for employers and employees that helps raise awareness about health, disease prevention and work-related issues. Small companies should be given special attention, as managers believed they are less interested in health and safety at work and they are reluctant to change. Also, for small companies the burden of legal obligations and taxes is higher and more overwhelming than for medium and large companies.

In the workers' view, the most important persons/departments that could offer help with work reintegration after chronic disease are the HR department, the team leader/line manager and the boss of the company. Another important recommendation which was voiced in the focus group with employers was to establish an agency where workers could access all the needed services for RTW in one place – rehabilitation, counselling for RTW, legal advice, and medical advice. Such a service could function as a 'safety net' for people who fall out of all the systems (medical, employment, social security). This suggestion was expressed also in an interview with a private recruitment agency. The interviewee considered that a great move forward would be to have an integrated service at the national level for the RTW process, and/or a system with a platform, telephone helpline and virtual community that could help employees to address questions regarding RTW and receive specialised help.

A discussion worth mentioning about the future potential for action on RTW and the contribution of industrial relations actors occurred in an interview with a representative of a private recruitment agency, when speaking about that person's former collaboration with trade unions and employers' associations (not on RTW issues). The representative's experience showed that trade union representatives were less involved and less open to collaboration and dialogue, and their expectations developed exclusively around possible benefits and ready-to-go solutions, and not active participation. Instead of this, trade unions should be opinion leaders, and not only benefit-demanding groups. Another surprising insight was that the collaboration with employee representatives was better than the collaboration with trade unions. The employee representatives engaged more actively in negotiations with the employers, were less conflictual and more flexible than the trade union representatives.

From the perspective of the participants in the individual interviews, trade unions and employers must play an active role in the improving rehabilitation and return to work. Moreover, the collaboration

between the occupational physician and the HR specialist is considered essential for a successful RTW. The occupational physician was also considered an important actor by the participants at the roundtable, alongside the patients' organisations, health providers, and employment services. In one of the interviews, an expert physician of social insurance showed that, based on his experience, the majority of workers with a long period of sick leave (over a year) following a severe chronic illness preferred to start retirement instead of go back to work, even if they still had work capacity. In his opinion, this preference can be explained through the lack of counselling and vocational support available to these workers and the lack of support from the employer, and also through the inflexibility of the provisions for part-time work. He suggested that RTW for workers with a low level of employability (workers with only half of their work capacity left, i.e. the *third degree of invalidity)* could be facilitated by collaboration between three actors: the public employment agency, occupational physicians and social security expert physicians. Another meaningful suggestion for a change in the law was to financially stimulate employers to hire workers with conditional work ability. More specifically, the proposal was to replicate the incentives that by law are currently received by employers who hire unemployed people in the field of RTW after chronic conditions. A deficiency pointed out was the fact the expert physician of social insurance has no collaboration with social workers, which would be essential for an accurate assessment of work capacity. Currently, work capacity is evaluated based on medical documents and the patient's declarations and is not based on a social investigation done by the social worker in the patient's environment. This can negatively influence the work capacity assessment. This was another suggestion regarding how the policy should be improved.

The stakeholders agreed that more involvement from the public employment agency is necessary. However, the representative of this institution stated that one career counsellor usually works with 3,000 unemployed persons. This serious shortage of career counsellors explains why their involvement in RTW issues is low. Presently, this institution has no programmes for workers with a chronic illness looking for job reorientation.

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

This section examines the perspectives on RTW at the company level, by analysing quantitative and qualitative data from various resources, such as the workers' survey, the managers' survey, the roundtable discussion, the focus groups with employers and trade unions, and interviews with relevant national stakeholders.

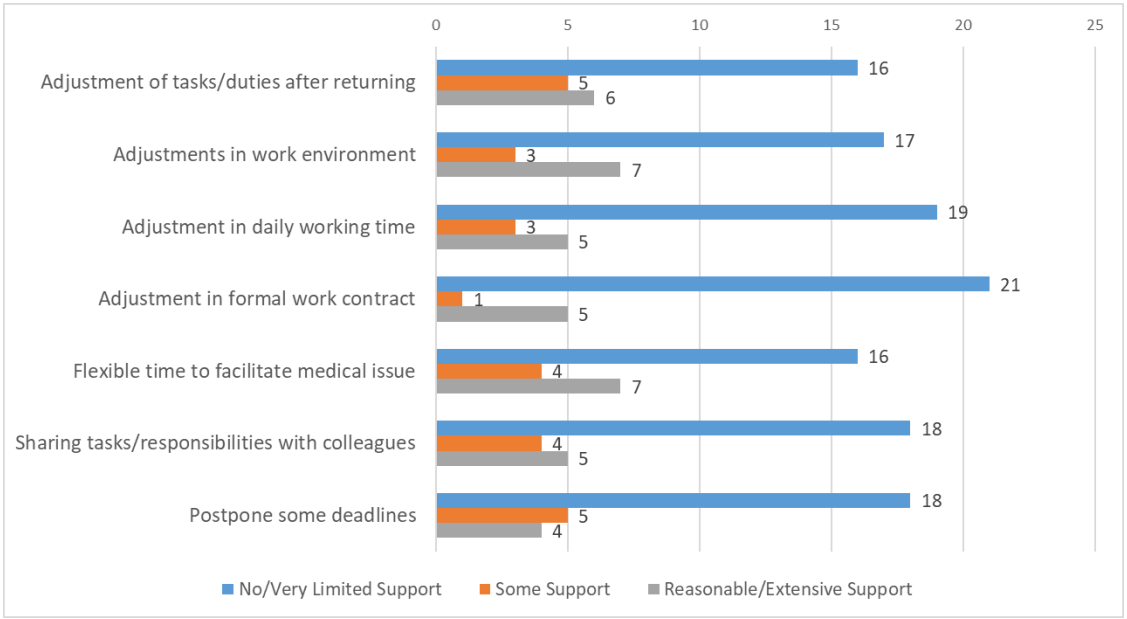
4.1 Workers' experiences with return to work at the company level

Following the data obtained from the worker and company surveys as well as the stakeholder focus group and interviews, we collected information describing the current situation concerning the RTW process at the company level and the involvement of social partners.

The most prevalent diseases among Romanian workers (as reported in the Romanian workers' survey, N=36) were oncological disease (61.1%), cardiovascular disease (11.1%), musculoskeletal disease (8.3%) and diabetes (5.5%). The most serious disease was considered by the workers to be cancer (61.7%), cardiovascular diseases (11.7%) and musculoskeletal disease (5.8%).

Most of the respondents in the sample (N=32) were concerned with their RTW (62.8%), while 37.1% responded that they were not concerned. The biggest concern was that nobody at work would offer support (50%), followed by the fear of being left without any support from the employer (44.4%). Other responses showed that 38.8% of the respondents in the sample were concerned because of financial discrimination; 38.8% were worried they needed to jump in at full productivity right after treatment with no adjustment period; and 33.3% expected their employer was not willing to adjust the working conditions to their work ability.

Figure 3. Adjustments received by workers when returning to work after a long-term illness (Q47)



Source: REWIR workers' survey, own calculations; number of respondents: 27.

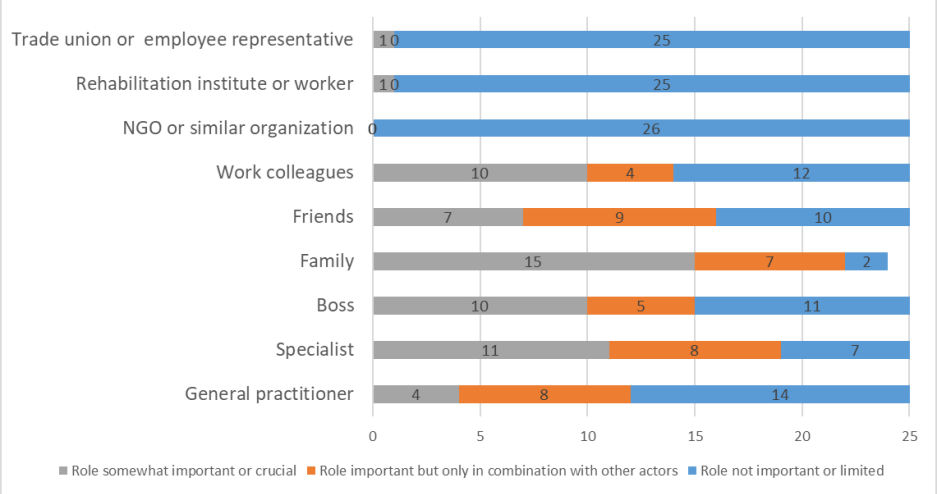
For the respondents in our sample having a past RTW experience (N=36), the most important actors to offer support for RTW is the HR department in the company (28.5%), the team leader/line manager (25.7%), and the boss of the company (22.8%). Less frequent responses were the psychologist/occupational therapist outside the company (17.1%), a rehabilitation institute (8.5%) and the trade union (5.7%).

Regarding the actual RTW, almost half of the workers expressed they were not at all or just partly satisfied with the help and support they received from the employer (48.5%) and 34.2% said they were satisfied and very satisfied. Even more dissatisfaction was expressed regarding the help and support offered by trade unions (51.4% were not at all or partly satisfied), while 19.9% were satisfied and very satisfied.

In terms of adjustments at the workplace, high percentages of respondents revealed they had received no support in adjustments to their work contract (62.9%), in postponing some deadlines (55.5%), in their daily working time (40.7%), or in sharing their tasks/responsibilities with colleagues (44.4%). In general, very limited or some form of support was offered for all types of adjustments (Figure 3). On the positive side, they received reasonable and extensive support mostly for having flexible time at work for medical appointments (25.9%), in their work environment (25.9%) and in their task/duties (22.2%).

Studies have shown that keeping in contact with a manager and colleagues is important for a successful RTW (McKay, Knott and Delfabbro, 2013; Isaksson et al., 2015). In our sample, 82.8% of the workers were in touch with their colleagues during their treatment, 40% with their direct manager and 20% with the general manager or HR department (N=35). Only two respondents kept in touch with the trade union. The initiative to return to work seems not to be work-driven, since most of the workers say it was their personal initiative (70.5%), followed by the specialist's initiative treating their disease (35.29%), their families' (14.7%) or the boss's initiative (11.7%) (N=34). The decision to RTW was first discussed with the specialist physician (40.6%) and the family (37.5%).

Figure 4. Workers' evaluation of the role of different actors in facilitating return to work after sickness leave (Q48)



Source: REWIR workers' survey, own calculations; number of respondents: 26.

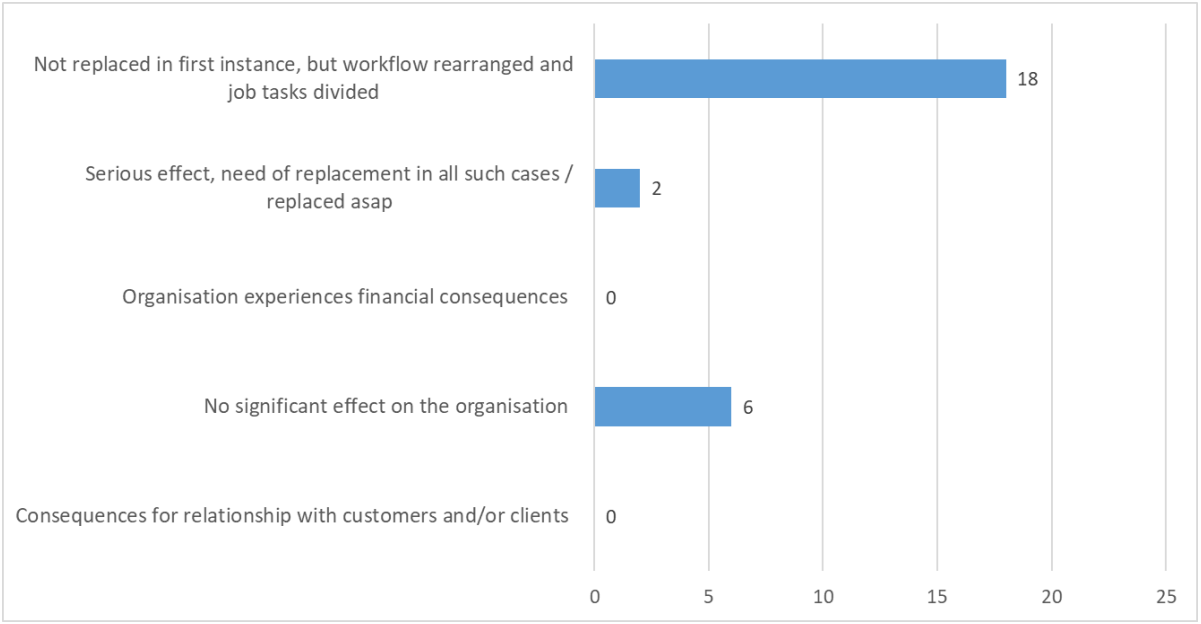
In the workers' view, RTW seems to be a subject that mostly workers, their families and doctors deal with, as the role of family is seen as most crucial in enabling RTW (41.3%), then the role of the specialist physician (24.1%) and the role of colleagues from work (17.2%). On the opposite side, the workers considered that NGOs do not have an important role in enabling their RTW (96.5%) and neither do a rehabilitation institute/nurse (89.6%) or a trade union representative (89.6%) (Figure 4).

Only four respondents were on sick leave at the time of filling out the questionnaire. Two of them expected to be absent from work between 6 and 12 months, one expected to be absent for more than 12 months, and another one declared no intention to be absent from work. Also, one person received a supportive response from the trade union. Respondents received a supportive or indifferent response from the employer regarding their need for sick leave. All workers (N=4) intended to return to their current job after treatment and one of them continued working during treatment. For three of them, returning to the same position was guaranteed. Most of them appreciated that their manager was the most important person to support RTW.

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

Regarding the consequences a worker's absence will have on the company, 66.6% of the respondents to the company survey in Romania (who are managers and HR directors) would choose not to replace the worker but to rearrange the workflow and to divide tasks between other employees and 22.2% thought there would be no significant effect on the organisation (Figure 5).

Figure 5. Perceived effect of an employee's absence on the organisation (Q12)



Source: REWIR company survey, own calculations; number of respondents: 27.

In terms of the resources needed for company representatives to support workers on sick leave, managers valued external counselling from doctors and therapists (23.5%), receiving information/advice on the types of chronic diseases (23.5%), external counselling/cooperation with dedicated professional associations and/or patient organisations (20.6%), and information on adjusting the workplace and working spaces in general (17.7%). On the other hand, the managers noted that there is a lack of information on financial strategies in dealing with sick-leave related absence (26.5%) and also a lack of external counselling from doctors and therapists (23.5%).

The survey reveals interesting results regarding the company representatives' attitudes towards workers with chronic illnesses (Table 10). The company representatives disagreed with the idea that individuals returning to work after chronic disease are unable to perform their duties as before (37.5%) and that workers will be less committed to work after being diagnosed with a chronic disease (41.9%). A large percentage of respondents are either neutral (41%) or agreed that a worker returning to work with reduced duties increases the workload of colleagues (37.5%). More than half of them agreed with the idea that a worker with a chronic disease is likely to be absent from work more often than other workers (54.2%), yet in their view, the worker should be entitled to adjustments of working duties (working time and workload), both at the organisation's discretion (62.5%) and legally (68%). Company representatives agreed and strongly agreed that workers should have a phased return to work on full pay (52.2%). They shared the view that senior managers do not recognise the difficulties that lower-level managers face with workers' absence and attendance (39.1%). They thought it was important to stay in touch with the worker during that person's absence (68%) and that returning to work during treatment helps normality and is encouraged in their organisation (54.2%).

Table 10. Attitudes of company representatives towards workers with chronic diseases (Q17) (in percent)

	Strongly disagree and disagree	Neither agree nor disagree	Agree and strongly agree
Individuals returning to work after a chronic disease are unable to perform their duties as before	37.5	29.2	33.3
The worker will be less committed to work after being diagnosed with a chronic disease	41.7	29.2	16.7
The worker returning to work with reduced duties increases the workload of colleagues	20.8	41.7	37.5
The worker with a chronic disease is likely to be absent from work more often than other workers	16.7	16.7	54.2
At the organisation's discretion, the worker should be entitled to adjustment to working duties (working time and workload)	12.5	25.0	62.5
The worker should be legally entitled to adjustment to working duties (working time and workload)	20.0	12.0	68.0
Workers should have a phased return to work on full pay	17.4	21.7	52.2
I would recommend more time off than the current legislation stipulates	33.3	29.2	29.2
Senior managers do not recognise the difficulties that lower-level managers face with workers' absence and attendance	39.1	17.4	30.4

It is important to stay in touch with the worker during the absence	12.0	16.0	68.0
Returning to work during treatments helps normality and is encouraged in our organisation	25.0	8.3	54.2

Source: The company survey, own calculations; number of respondents: 26.

In Romanian companies, the RTW process is managed by the HR department (64.2), the line manager/team leader (25%) and general management (7.1%). The respondents viewed this situation as adequate, but 32.1% of them favoured the idea that, besides HR department and line/team managers, a dedicated health and safety committee should manage this process.

Among our sample of companies, there is no defined adjustment plan available for each employee returning after a long illness (60.7%), no common standard procedure for managing RTW (50.0%) and no ad hoc and flexible adjustment plan is used (50.0%). The respondents were equally divided between 'yes' and 'no' regarding the possibility of a phased RTW in their organisation (32.14%). On the positive side, the companies cooperate with other external organisations (for example, the occupational health service) when managing RTW situations (60.7%). One key participant in an interview (a health professional at a public health institution) with extensive experience regarding RTW after occupational diseases and work accidents and who is also consulted by or invited onto health and safety committees in organisations, stated that some employers refuse to make the necessary adjustments because they want to avoid creating a precedent which other employees might require also.

When asked what would improve the RTW process in their organisation, the answers referred to interpersonal relations between managers and workers returning from long-term sick leave (36.6%), the organisation's policies (30%), the legislative and institutional support (26.6%) and cooperation with external stakeholders (13.3%).

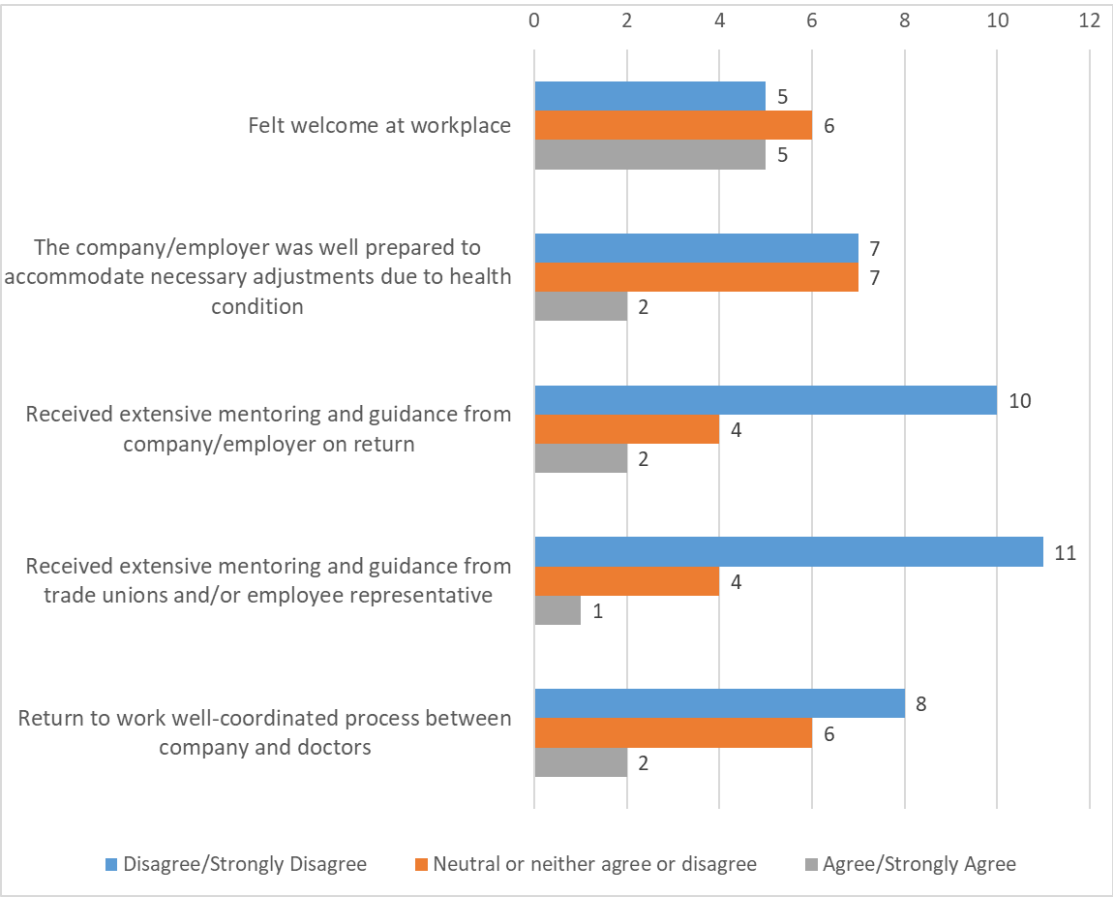
Most company-level representatives who responded to the survey stated that there is a trade union or another form of employee representation at their organisation (73.3%), but RTW is not addressed in the company's collective agreements (22.7%), although some of them think it should be (31.8%). In 18.8% of the companies, RTW is addressed in collective agreements, and the same percentage of companies do not have a collective agreement (18.2%). In more than two-thirds of the companies over half of employees are unionised (68.2%). Yet, there is no consultation with the trade unions or employee representatives on RTW issues (57.1%).

Only 19% of the respondents in companies agreed there is regular interaction between managers and trade unions on RTW issues, while 42.8% thought this interaction is ad hoc and not regular. Still, in 57.1% of the companies a trade union representative is part of the committee addressing occupational health and safety, which deals also with RTW issues. They agreed that this is important; therefore, 61.9% plan to include a workers' representative on the committee addressing occupational health and safety. In their view, this kind of cooperation can bring significant benefits for the company. Thus, large percentages of managers agreed that their cooperation with the workers' representatives on RTW issues can increase cooperation within the team (52.3%), the workers' motivation (42.8%) and labour productivity (38%), and can decrease turnover (38%). When this cooperation is not taking place, the most frequent barriers are the long time it takes for this cooperation to be achieved and the fact that trade union representatives also come with other requests for RTW stipulations. Yet, 28.5% of them do not expect any challenges.

4.3 Interactions between employers and employees in facilitating return to work

The answers pertaining to the RTW experience of workers and their interaction with the employer are either neutral or draw a rather negative picture (Figure 6). Thus, 37.5% of the workers neither agreed nor disagreed with the statement that they felt welcomed at their workplace, while the same percentage (31.2%) were either in agreement with this statement or disagreement. Regarding how well prepared the company/employer was to accommodate the necessary adjustments for the worker, again, the same percentage of respondents (43.7%) were either disagreeing or were neutral. The majority of them (62.5%) did not receive extensive mentoring and guidance from their company/employer and even more respondents (68.7%) did not receive mentoring and guidance from the trade union. Half of the respondents considered their RTW not to be a well-coordinated process between the company and their doctors. Three-quarters of the workers declared that they returned to the same job position. Other issues around the employer–employee interactions for RTW facilitation were discussed in section.

Figure 6. Workers' experience with the return-to-work process (Q44)



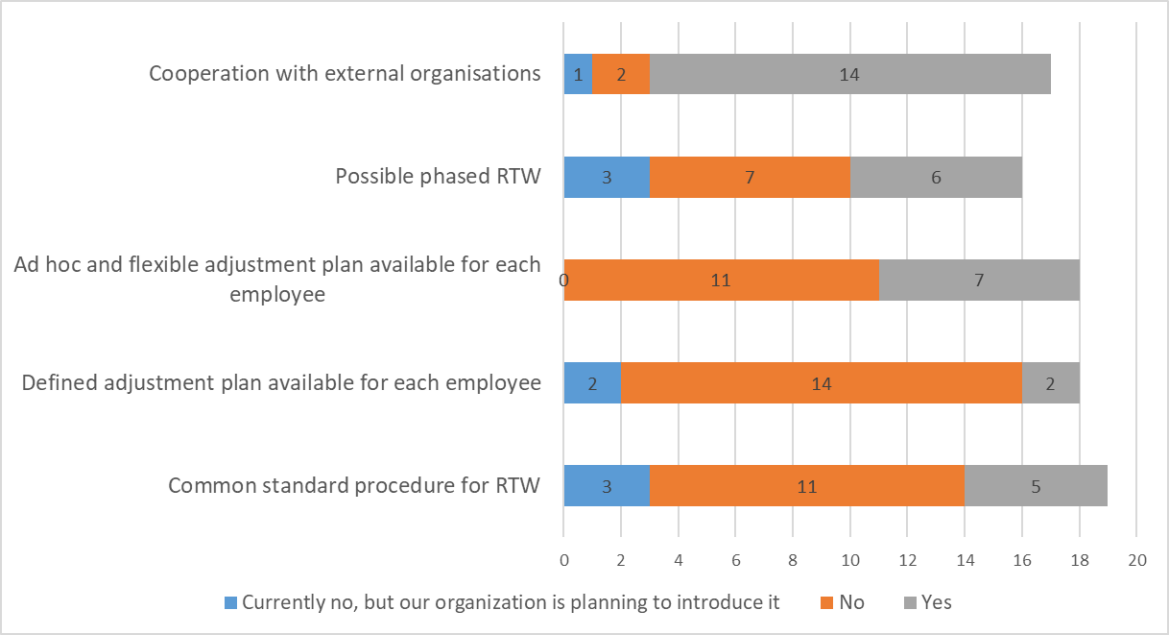
Source: REWIR workers' survey, own calculations; number of respondents: 16.

One question in the worker survey allowed the respondents to give open feedback on their experience of RTW. Their responses (15 in total) reveal mostly negative experiences. Specifically, 13 responses were negative and 2 were neutral. The negative responses can be placed on a continuum, from

extremely negative experiences to mildly negative. The extremely negative experiences are as follows: "I had a horrible experience [at] my former job, so I had to look for another job." "My employer, which is a public one, did not care about my disease, so after my returning I have worked as much as the other employees. Nowadays, with Covid-19, my employer abuses and discriminates after I had the audacity to say that he endangers my life and exposes me to this virus." "I did not receive [the] salary raise that all the other colleagues have received. They [i.e., the employer] said to me that I [had] lost this opportunity." "I did not have the opportunity to return to the same position. They totally refused this." Other workers invoked mildly negative experiences, such as returning to work but having to deal with extreme fatigue and exhaustion, returning to work without being physically fit because the sick leave period had ended, or returning to work without receiving any form of support. Two responses were neutral, saying that the timing of RTW is important and that the boss and colleagues have an important role for RTW.

Turning to the managers' perspective, 57.1% of the companies have regular contact with the workers during their sick leave/absence from work, 28.5% of the companies have irregular contact and 14.3% opt for no contact at all. Within our sample, 54.2% have formal interaction with workers (e.g., a set HR procedure, formally requesting regular medical reports on the continuity of work), while 42.9% have informal interaction (e.g., phone call, friendly conversation, indirect information via the workers' colleagues). During sick leave, most of the managers keep the workers informed about work-related issues (62.9%) and involve them in work-related issues (64.5%). There was wide agreement regarding who initiates the RTW process in the managers' view, which is the worker (78.7% of the cases) or the doctors/therapists (12.1%).

Figure 7. Availability of return-to-work procedures at the company (Q20)



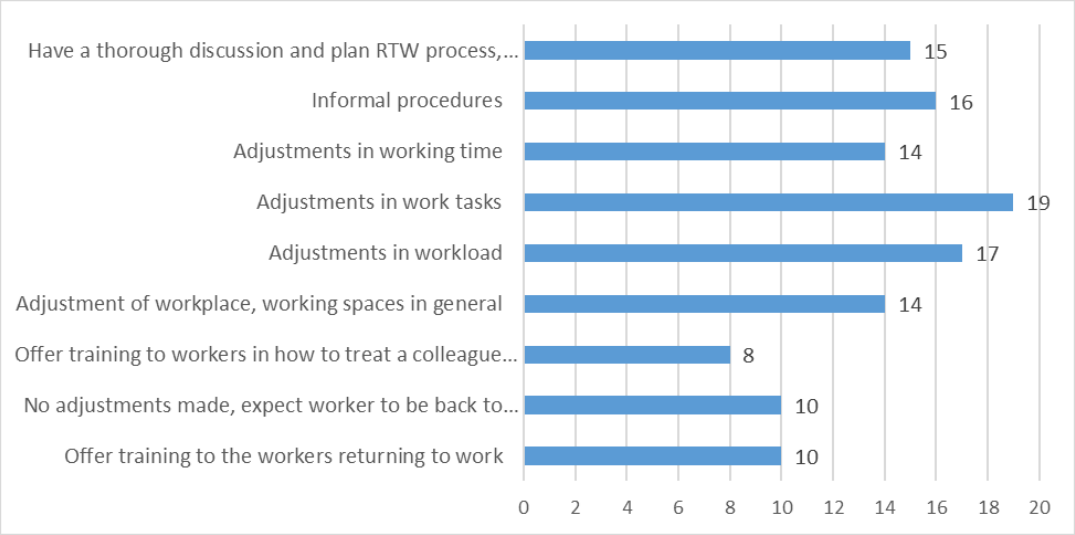
Source: REWIR company survey, own calculations; number of respondents: 24.

As presented in Figure 7, Romanian companies usually do not have common standard procedures for RTW. Neither do they utilise defined or ad-hoc adjustment plans for each employee in this situation,

although the need for such plans and procedures is recognised and some of the companies' plan to introduce them. Yet, the possibility of a phased RTW is available at some of them, although there are more that do not have this possibility. The most common practice at the Romanian companies is cooperation with external organisations for managing RTW situations. From previous research we know these external organisations/professionals fall into one of two categories: the public employment agencies and occupational physicians.

Considering the lack of company-level procedures for RTW, Romanian companies compensate by using other ways of facilitating job reintegration for workers with chronic illnesses (Figure 8). The practice of having a discussion before the worker's return seems to be generalised, as 56.2% of the managers in our sample discussed the RTW in such a meeting, which is informal in most of the cases. The company-level actors also stated that they offered adjustments mostly to the work tasks and workload, and less than half of them to the working time. Half of them also offered adjustments to the workplace. The managers were realistic about the worker's productivity after return and they know it takes time to achieve full productivity. Less than half (45%) said they offer training to the workers returning to work, and also to colleagues to prepare for the worker's return (32%). All these results support the findings from another study carried out on Romanian employers (Popa et al., 2020).

Figure 8. Support offered by the company to the employee returning to work (number who agree/strongly agree) (Q16)



Source: REWIR company survey, own calculations; number of respondents: 27.

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

Data from group discussions and interviews show what the managers indicated as good practices, which is maintaining contact with employees during sick leave, being in contact and aware of employees' real needs, encouraging RTW by letting the workers know they are valuable employees, and adjusting the working conditions for a successful RTW. Other good practices indicated are the impossibility to fire sick workers during sick leave, the obligation to keep their positions open until they come back, a generous

period of fully paid sick leave for some diseases (a year and a half for cancer, HIV/AIDS, tuberculosis) and good legislation on occupational diseases (some of which are chronic illnesses).

Surprisingly, managers in the focus groups appreciated that the most difficult cases to accommodate back to work were not the employees with cancer, but the ones with mental conditions. In their view, alcohol and drug addictions as well as depression are the most difficult challenges in the workplace. They thought that recovery after mental health is quite long and, in most cases, the sick leave is not long enough for recovery to take place. Another challenge is that employees with addictions usually do not recognise they have a problem. The participants revealed stories of RTW failure for workers with mental health disorders prone to violent behaviour. They agreed that managers in general have to make a shift from being too focused on what the worker cannot do to focusing on what the worker can do in the company. Other negative points in the legislation were mentioned, but these are presented in section 3.2.

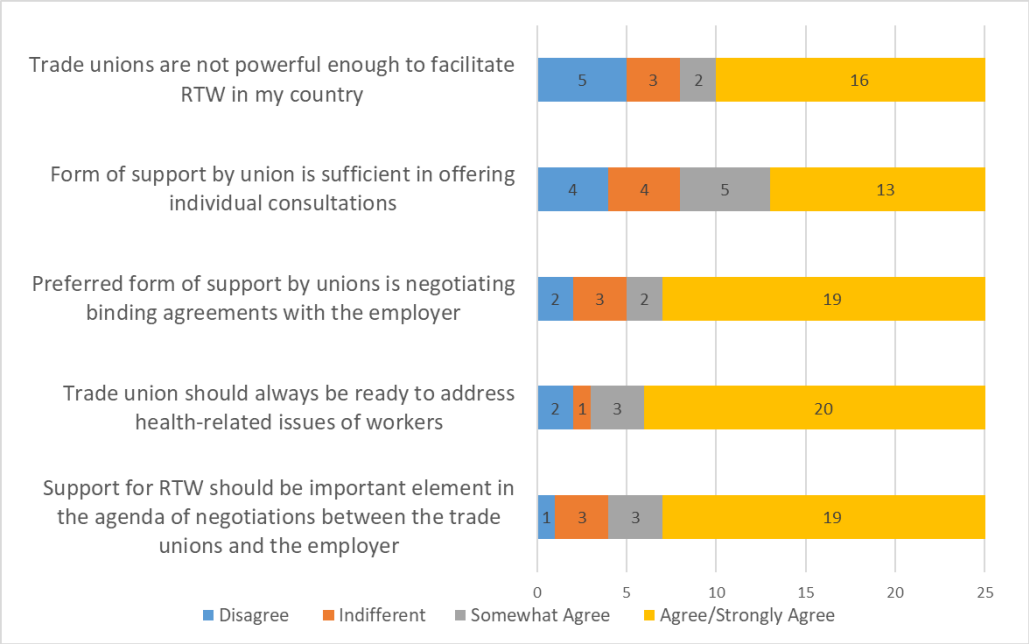
In terms of what should be improved regarding the current RTW legislation, 39% thought there is need for more specific provisions to guide organisations on RTW and for more flexible legislation in order to give more space for company-level management decisions. Yet, 17% of the respondents believed that no change in legislation is necessary.

An important deficiency of the Romanian legislation was intensely discussed in the focus groups with employers: the situation when an employer cannot provide an adjusted job position (or a new position) for a worker who received the 'conditionally able to work' assessment from an occupational physician. In this case, the employer is legally required to refer the worker to the local employment agency and only afterwards does the employer have the right to fire the worker. The problem identified by the participants is that there are workers who have lost their jobs, who are no longer patients (therefore, they cannot receive financial support anymore for invalidity), but who are too young to retire. Usually, the vocational rehabilitation programmes last from several months to a year or longer, and more often are not available, which prevents them from acquiring new skills for a new job. These workers have no solution for the burdensome situation in which they are in. Many employers in our focus group had such workers and regretfully could not find viable solutions for them. During the focus group, they debated over several measures for a more active labour market that could be introduced in policy. One solution proposed was that such cases could be managed by the public employment agency, yet the representative of this institution explained why this is not possible at present. Another solution was to establish an agency which could offer training for new skills and other forms of support for them. Other suggestions for improving the legislation are presented in section 3.5 of this report.

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

An important part of the workers' survey regards how they perceive the role of trade unions in RTW. A large percentage of respondents (78.6%) did not think about joining a trade union after their recent diagnosis, in order to support or facilitate their RTW after treatment. In half of the cases there is no trade union or any other form of employee representation at the workplace. For most of the respondents (83.3%), no negotiations took place between their employer and trade union/employee representatives about adjustments to their work tasks and responsibilities.

Figure 9. Workers' opinion on the role of unions and their dialogue with employers for facilitating return to work (Q49)

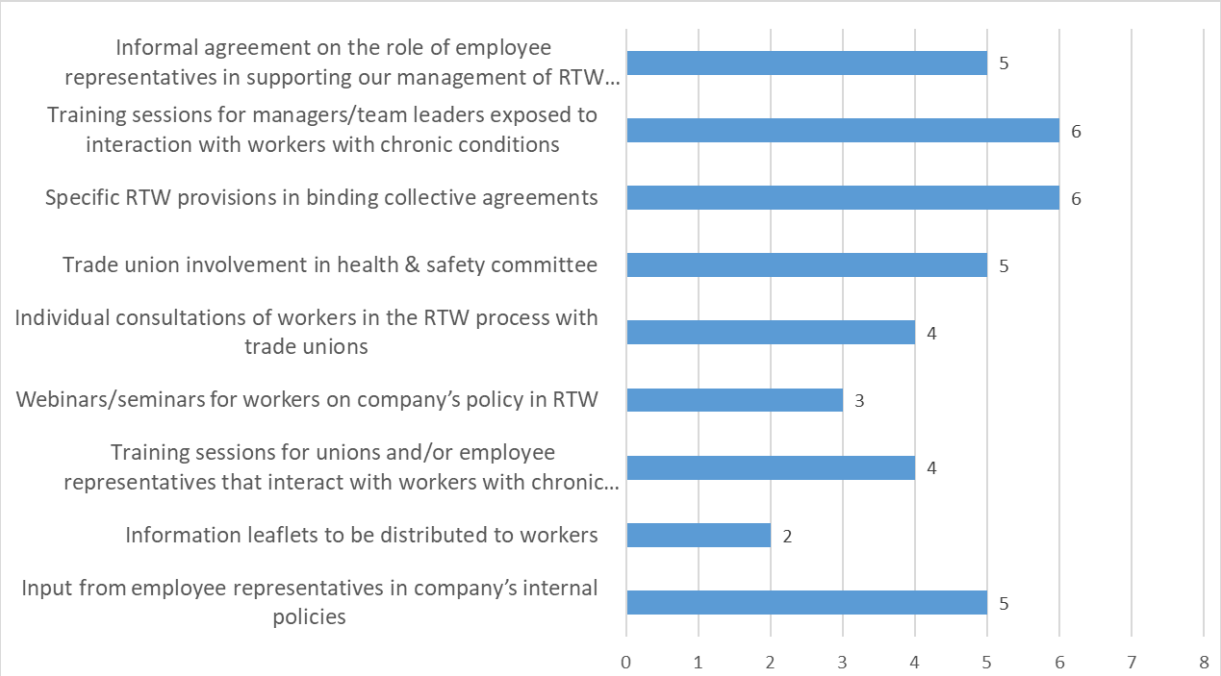


Source: REWIR workers' survey, own calculations; number of respondents: 26.

Looking at the role of trade unions in the RTW process (Figure 9), 75.8% agreed and strongly agreed that trade unions should always address health-related issues of workers, 72.4% appreciate that RTW should be on the trade unions' agenda and the same percentage stated that this issue should be addressed through binding agreements with the employer. Yet, 58.6% thought that trade unions are not powerful enough to facilitate RTW. Moreover, 79.31% of the respondents were not aware of other cases where a trade union proved helpful in facilitating RTW.

Moving to the company level and regarding what possible outcomes could result from collaborating with trade unions and be beneficial (Figure 10), our respondents to the company survey mentioned in decreasing order: the inclusion of specific RTW provisions in binding collective agreements (33.3%), training sessions for managers/team leaders directly exposed to interaction with workers with chronic conditions (33.3%), input from employee representatives on internal policies (27.7%), informal agreement on the role of employee representatives in supporting RTW management (27.7%), trade union involvement in the health and safety committee (27.7%), having training sessions for unions and employee representatives on RTW issues (22.2%) and being able to have individual consultations between workers and trade unions (22.2%).

Figure 10. Perceived beneficial outcomes from interaction with unions/employee representatives on return to work (Q28)



Source: REWIR company survey, own calculations; number of respondents: 18. Multiple answers possible.

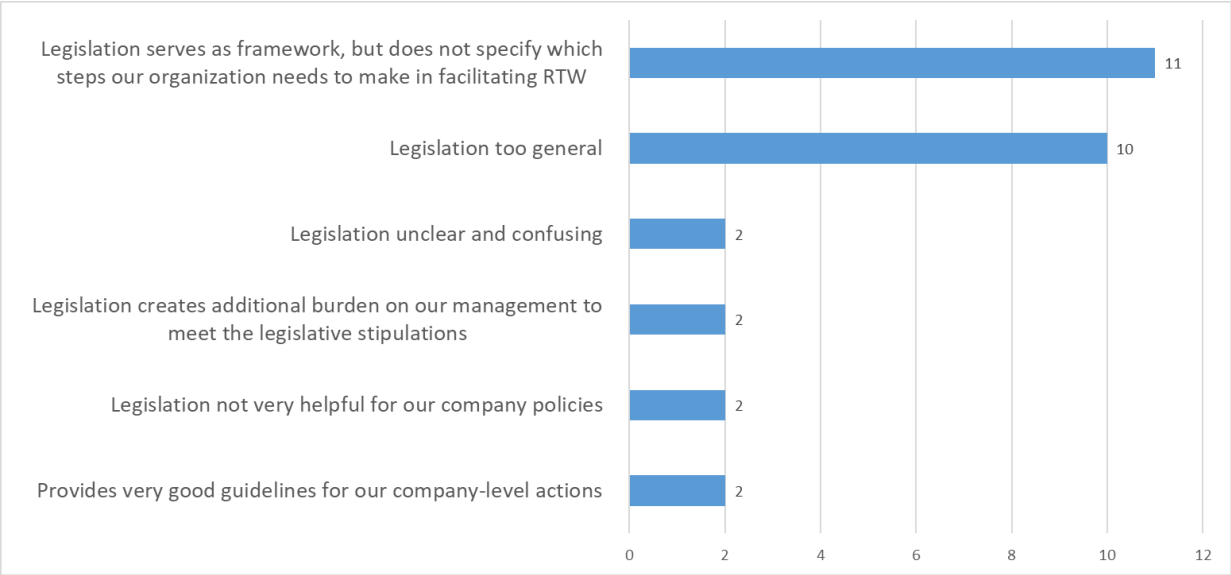
In terms of how the current legislation on RTW is perceived by stakeholders in organisations, the most prevalent opinion is that general legislation is available, which serves as a framework but lacks specific recommendations for organisations on RTW facilitation (47.8%) (Figure 11). This opinion, coupled with the perception that the legislation is too general (43.4%), indicate an important need of Romanian organisations – to have more specific policy recommendations for approaching workers with chronic illnesses. In the current form, the legislation is considered not very helpful (8.7%). Only 8.7% of the companies in our sample are satisfied with the current legislation, stating it is helpful.

Both qualitative and quantitative data gathered in Romania pinpoint the managers' need for the current legislation on RTW to be revised. Some participants in the focus group gave examples of initiatives related to other areas (not RTW) through which they tried to fill the gaps in legislation. They initiated measures which, in their view, should have been proposed by the state. Other participants suggested that this might be the solution to compensate for the old policy framework, which is inadequate to the present dynamic labour market, i.e. to initiate small changes in their companies and to disseminate them as examples of good practice that later may be generalised through state programmes, thus leading to improvements in the legislation. These initiatives taken by employers as actors within the social dialogue are essential and should be known and promoted.

The company survey reveals the same findings as the focus group. A significant percentage of respondents (39.1%) would welcome more specific provisions in law for guiding the RTW approach at the company level. Around one-quarter of the respondents wished for more flexible legislation that would leave more space for company-level decisions. A smaller share of the respondents (8.7%) would benefit

from legislation that leaves more space for company-level interaction with unions/employee representatives without binding outcomes on RTW issues. None of the respondents opted for legislation stipulating binding regulations for RTW. Around 25% of the companies considered that either no change is necessary in the current legislation (17.3%), or that it is enough that RTW is part of a broader set of policies on the integration of people with chronic diseases into the labour market (8.7%).

Figure 11. Perceived support offered by legislation to organisations in managing return to work after chronic illness (Q29)



Source: REWIR company survey, own calculations; number of respondents: 23. Multiple answers possible.

5 Conclusions

All the data collected for Romania converge towards the idea that returning to work is an issue insufficiently regulated by law, which does not generate enough involvement by stakeholders. Romania has a general policy framework for sick leave, invalidity and disability, which stipulates roles for employers, physicians, the public employment agency and public authorities, but mostly concerning benefits and in general terms. Among the social dialogue triad, the state has the most substantial role, while employers and trade unions have rather marginal roles. The perception of the stakeholders in our study was consistent with this situation, as they deemed the state as having the most important role. Despite this, the data provide good examples of initiatives for facilitating return to work in companies, proving that employers and trade unions can have an important role too. We draw conclusions for each category relevant to return to work.

The relevant legislation on return to work. The policy framework for sick leave, invalidity and disability provides only general guidelines, mostly in relation to the benefits, eligibility and period of entitlement. The policy does not contain specific measures or interventions for making return to work easier when the sick leave or the invalidity period is over, although some of the provisions concern and facilitate RTW to some extent (for example, the individual medical rehabilitation plan, see section 2.2). The social security system is based on social insurance and health insurance, and it is coordinated by two ministries (health and labour) and several lower-level agencies/services. Several pieces of law regulate these issues and the process of applying for these benefits is characterised by a considerable amount of bureaucracy. One positive aspect of the Romanian legislation is the generous time for sick leave (1 year or up to 1.5 years for some diseases, such as cancer), which is fully paid.

The invalidity benefit can be offered until the worker goes into retirement, but every 1–3 years the person is reassessed by an expert physician of social insurance. Several situations may halt the benefit payment, for example the worker's failure to follow the medical rehabilitation plan, which is mandatory during the invalidity period.

The RTW process after sick leave or invalidity has an informal nature (the only formal step required is an assessment provided by the occupational physician that the worker can resume work): it is not planned, it is rarely phased (a part-time period followed by full-time work) and entails very few formal obligations for the employer. RTW roles are allocated to the treating physician, the employer, the occupational physician, and the local public employment agency and not to other actors. Yet, the employer has a marginal role in RTW. No active labour market policies are in place. The law provides general stipulations for resuming work, such as the provisions for work capacity recovery, the regulations regarding the fit note and the provisions on sheltered units/jobs and assisted employment (for workers with disability), which are presented in section 2.2.

Involvement of social partners in return to work. The institutional actors at the state level play the most important role in RTW. Thus, the National Health Insurance House, the National Fund of Public Pensions and the Ministry of Labour are the key actors. Based on all the data collected for Romania, the stakeholders outside the state level (employers' associations and trade union representatives) are not currently involved in the RTW process to their full potential and see themselves as rather passive actors, especially in shaping policy. Moreover, employers and trade unions are rather content with the situation,

maintaining that the state should be the main actor, although employers agree they could do more for facilitating RTW.

Surprisingly, more than half of the social partners in our sample positively evaluated the Romanian policy framework as being elaborated enough but lacking good implementation and enforcement. They agreed that the EU-level strategy should be reflected in this framework and that there is a lot of work ahead on RTW policy implementation. Yet, trade unions and employers' associations felt that they did not have enough power or proper instruments to shape policy. Our findings also highlight the most preferred way of approaching RTW: more focused legislation on RTW, which should give enough space for companies to implement tailored measures and initiatives for the affected workers.

All the participants in our study agreed that trade unions and/or employee representatives should make an important contribution to RTW. The present situation, as revealed in the surveys and interviews, shows little involvement of trade unions in RTW and reduced collaboration with other industrial relations actors. A little more than one-third of the managers consult with trade unions and/or employee representatives on RTW issues. Also, collective agreements at the company level address RTW only in 16% of the companies. Instead, their role seems to be more about negotiating financial benefits for workers in difficult situations. Still, all the participants agreed that trade unions could become more active opinion-leaders that could raise awareness of RTW issues. Employee representatives are perceived as having even more potential than trade unions, as they are more flexible, more open to discussion and more ready to find new and creative ways to solve work issues such as RTW.

The perspectives of workers on return to work. The findings from the workers' survey show a rather negative situation regarding their RTW experiences. In their view, they should receive support primarily from the HR departments, team/line managers and general manager, and to a lesser extent from an occupational physician, a psychologist, or trade union. The results, however, show dissatisfaction with the support they received from the employer and even more with that from the trade unions. Most of them kept in contact with their colleagues at work but less so with their direct or general manager. The workers' families and their physicians were two key actors which offered support and influenced their RTW success. In terms of adjustments, they received reasonable and extensive support mostly for flexible time at work, regarding the work environment and in their tasks/duties. No mentoring or guidance was offered to most of them by the employer or the trade union. The open feedback they offered on their RTW experience was largely negative, disclosing a continuum of adverse experiences from indifference and lack of support to discrimination and abuse. In the workers' view, RTW should be on the trade unions' agenda, yet the current experience is that trade unions are insufficiently involved.

In conclusion, with the exception of the government and the subordinated institutions, the rest of the actors (trade unions, employers, NGOs) believe they have a passive role in RTW and that not more can be done to change this status quo. When they propose ideas for improvement, usually their suggestions pertain once again to the state and legislation and not to possible involvement on their part. Indeed, the best way to improve professional reintegration after chronic disease would be to have specific legislation on RTW with defined roles, steps and outcomes. But even in the absence of such legislation there are ways to move things forward in this area. First, the role of trade unions and employers' associations is essential, as they can be the 'voice' of workers with chronic illnesses and of their employers, which also deal with great difficulties regarding absence from work. These two categories of stakeholders have the power to channel to a higher level the difficulties and dissatisfactions of employers and workers.

Therefore, this first opportunity for change involves the continual efforts of trade unions and employers' associations to raise awareness of RTW issues, even when a change in policy is not probable in the near future. Second, an improvement for these workers could be accomplished by including RTW in the collective agreements at the company level, at least in theory. Yet, as the participants in the focus group with trade unions declared, only about a third of Romanian companies now have collective agreements and among these, only approximately 5% are negotiated in the company. The rest of them have a simulacrum of a collective agreement, which is usually very brief. This situation is a consequence of the social dialogue reform in 2011, which dramatically decreased collective bargaining in Romania. Third, the interactions between employers and trade unions/employee representatives could be intensified, as currently there is little consultation between them on issues related to RTW and trade unions are involved mostly in supporting the worker financially. At present, workers with chronic health conditions mostly trust the employers to offer support for RTW, but they expect more involvement from the trade unions. Fourth, opportunities for policy change in this area might also develop from initiatives carried out by researchers in the field who can indicate, based on their studies, the most effective ways to bring about improvement. In Romania, studies in this area have started to accumulate only recently. It is essential for these studies to continue in order to gain knowledge about RTW in specific policy and social contexts, in countries where such studies have not previously been done. More studies are needed from a comparative perspective at the EU level, not only for the countries with a well-developed framework for RTW, but also for countries with limited scientific knowledge in this area.

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