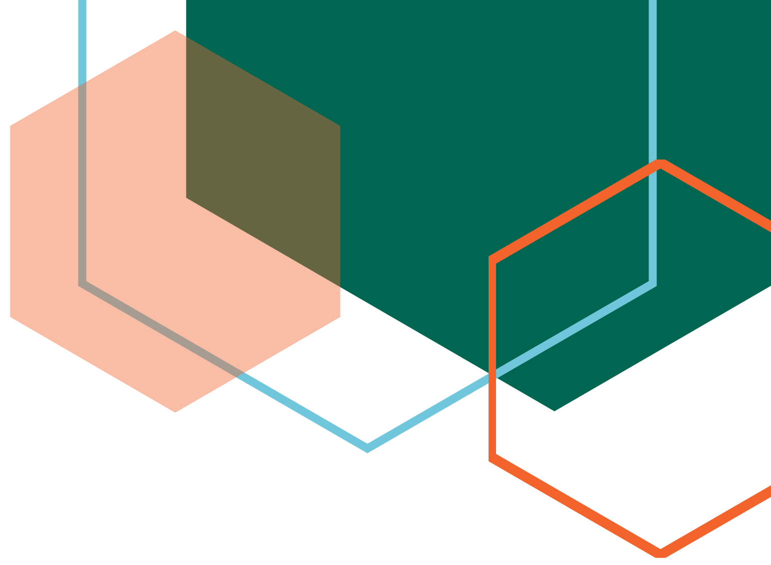

REWIR
WORKING PAPER
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Shaping return to work policy: the role of industrial relations at national and company level

Country report for Ireland

Negotiating Return to Work in the Age of Demographic Change through Industrial Relations (REWIR)
Project No. VS/2019/0075

Deliverable 3.1

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DCU BUSINESS SCHOOL

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List of abbreviations

CB – Collective Bargaining

CES – Comprehensive Employment Strategy

CIP – Critical Illness Protocol

CIPD – Chartered Institute of Personnel Development

CSO – Central Statistics office (Ireland)

CVD – Cardiovascular Disease

DACT – Disability Activation Project

DEASP – Department of Employment Affairs and Social Protection

DSP – Department of Social Protection

EDI – Employers' Disability Information Service

EU – European Union

FET – Further Education and Training

GDPR – General Data Protection Regulation

GP – General Practitioner

HIA – Health Insurance Authority

HR – Human Resource Department/Office/Function

HSA – Health and Safety Authority

HSE – Health Service Executive

IBEC – Irish Business and Employers Confederation

ICTU – Irish Congress of Trade Unions

IOSH – Institute of Occupational Safety and Health

IR – Industrial Relations

ISME – Irish Small and Medium Enterprises

ISSA – International Social Security Association

LEEF – Labour Employer Economic Forum

MNC – Multinational Corporation

NCC – National Competitiveness Council

NDA – National Disability Authority

NESC – National Economic and Social Council

NGO – Non-Governmental Organisation/ Charity/Voluntary Organisation

NPHET – National Public Health Emergency Team

PHI – Private Health Insurance

PRSI – Pay Related Social Insurance

RTW – Return to work after long-term illness

SIPTU – Services, Industrial, Professional and Technical Union

STP– Specialist Training Programme

SP – Social Partnership

TFEU – Treaty on the Functioning of the European Union

TRR – Temporary Rehabilitation Remuneration

TILDA – Irish Longitudinal Study on Ageing

UHI – Universal Health Insurance

VR – Vocational Rehabilitation

1 Introduction

This national report of the REWIR research project for Ireland provides information and an analysis of the role of industrial relations and healthcare provisions for workers returning to work after long-term illness. The project investigated the processes and practices available to employees returning to work after experiencing chronic/long-term debilitating illnesses, namely cardiovascular disease (CVD), cancers, mental health problems and chronic muscular/skeletal disorders. Chronic diseases are to be understood as diseases of long duration and generally slow progression (WHO, 2005). The REWIR project is a European Commission funded research project (Grant Agreement No. VS/2019/0075) which consists of six country partners; Ireland, Italy, Romania, Slovakia, Belgium and Estonia.

The team conducted a programme of research in Ireland into return to work (RTW) practices and policies for those experiencing long-term debilitating illnesses. Research was carried out among national level actors including NGOs, government agencies, business and employers' organisations and trade unions and key company-level actors across a range of sectors in Ireland. The principal aim of the Irish research was to gain an understanding of the range of practices and policies that exist in Ireland among companies and employers. The secondary aim of the project was, together with our European partners, to develop key recommendations for best practice approaches that could be offered to the Irish Government and its agencies, companies involved in providing services and support to workers, and the European Commission.

The Irish research team was led from Dublin City University and consisted of Dr Eugene Hickland, Dr Margaret Heffernan and Dr Aurora Trif, and included Dr Tish Gibbons.

The theoretical framework underpinning the REWIR project is actor-centred institutionalism (Scharpf, 1997). Actor-centred institutionalism is a useful instrument for understanding the role that stakeholders play in shaping policies, as it accounts for the institutional and policy contexts, as well as interactions between them. In this framework, the baseline is that social phenomena can be explained as the outcomes of interactions among actors, acknowledging that such interactions are structured and that outcomes are shaped by the characteristics of the institutional setting in which they occur (Scharpf, 1997). The approach taken by the project is that actor-centred institutionalism is a dynamic process, and that state welfare, health systems and workplaces can be considered institutions that are a co-generative arena where actors make choices and decisions that are not fixed or always exogenous (Jackson, 2010). Therefore, we acknowledge that ideas, activities, priorities, and relations and interactions between representatives of unions, employers, governments and others cannot be disentangled from the diversity in industrial relations practices and RTW policies across the EU. By taking an actor-oriented perspective, REWIR, therefore, puts key stakeholders and their actions, perceptions and experiences at the core of the project.

The report is organised in the following way:

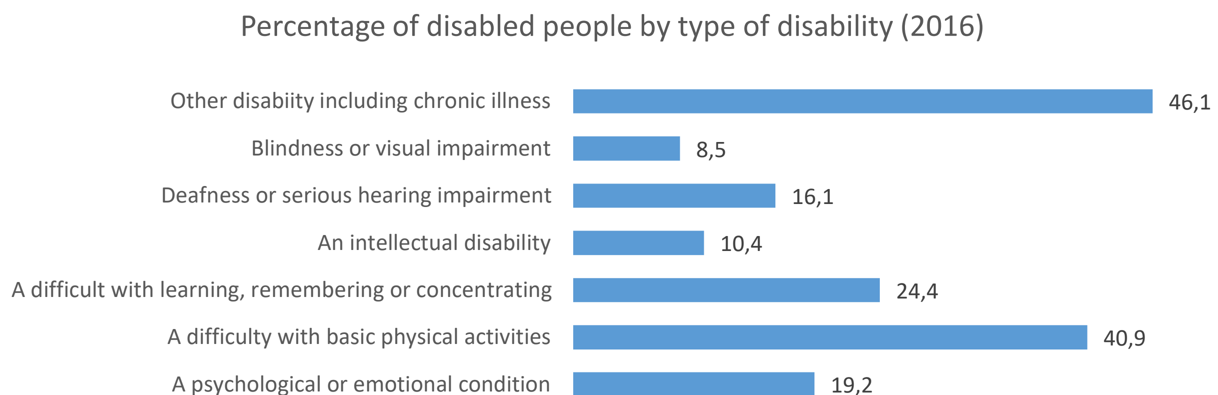
a) An overview of relevant facts about Ireland,
b) An explanation of the methodological approaches used in the completion of this report,
c) An outline of the policy frameworks on returning to work after a long-term illness in Ireland,
d) Involvement of social partners in shaping RTW policy at national level,
e) The RTW process at company level and the involvement of social partners,
f) Discussion of research findings and conclusions.

1.1. Some relevant facts about Ireland

The Irish state[1] was founded in 1921 and a written constitution was adopted in 1937 which has since been amended 39 times up to 2019, including joining the European Union (European Economic Community, EEC) in 1973. The Irish system of industrial relations (IR) emerged from developments within UK IR systems in the early twentieth century such as the trade union immunities legislation, and takes the general approach of voluntarism. Similar to the UK, Irish employment legislation is based on an assumption that an employer and employee agree a contractual relationship freely and voluntarily, on equal footing, and that this sets out the terms and conditions of employment. Traditionally, the regulation of the employment relationship has taken place almost exclusively at individual contractual level. Irish employment law is therefore almost an extension of the law of contract (Bacik, 2011).

There were 2,361,200 people at work in Ireland at the end of quarter 4, 2019, with an unemployment rate of 4.7% (CSO, 2020). The overall employment rate among persons aged between 15 and 64 years was 70.2% in quarter 4 of 2019 (CSO, 2020). Recent demographic changes and population ageing are having a profound impact on the Irish labour markets and across the EU - a major societal challenge that has been recognised by the EU Commission (EU Commission, 2014). This also impacts on labour market issues, particularly with regard to long-term illness and specifically absence from work due to a long-term illness. CSO (2019) reports that 13.7% of the Irish population have a disability, up 8% since the previous census in 2011. Figure 1 below breaks this number down by the nature of the disability. Chronic illness is at 46.1% with 19% reporting a psychological condition.

Figure 1: Percentage of disabled people by type of disability (2016)



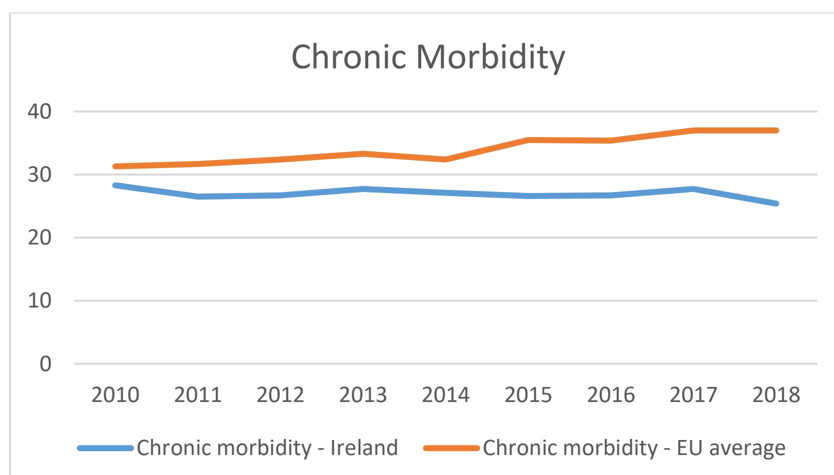
Key findings of the Irish Longitudinal Study on Ageing (TILDA) show that there is an expected substantial rise in the number of people living with a chronic disease in the coming years (Balanda, Barron and Fahy, 2010). This is due to Irelands growing population, ageing and lifestyle risk factors such as obesity becoming more common. See Figure 2 comparing chronic morbidity for Ireland versus the EU average. The nature of illnesses leading to work disability has changed over the years. The main work-related health problems reported in Ireland are musculoskeletal disorders, cancer and cardiovascular disease (CVD). CVD is the most common cause of death in Ireland, accounting for 36% of all deaths (Turner, Donoghue and Kenny, 2018). Approximately 10,000 people die each year from CVD including coronary heart disease, stroke and other circulatory diseases. The largest number of these deaths relate to coronary heart disease - mainly heart attack - at 5,000. Some 22% of premature

[1] The Irish state or references to Ireland *(Eire)* in this report refers to the country known as the Irish Republic and the legal jurisdiction therein and not the island of Ireland.

deaths (under the age of 65) are from CVD (HSE, 2020). Cancer is recognised as being the second most common cause of death registered in Ireland. The number of people in Ireland diagnosed as a new case with a form of cancer is approximately 22,321 per year, and at the end of 2015 there were approximately 148,443 cases of people living with cancer (National Cancer Registry, 2018). The number of people with muscular/skeletal disorders (MSD) who were off work due to a bone, joint or muscle problem in 2015 was 19,241 (CSO, 2016) and 15 per 1,000 workers reporting work-related illness in 2014 claimed to have an MSD (Russell et al., 2016). There is also widespread recognition of the growing incidence of chronic illnesses and mental health disorders, with depressive mental illnesses projected to be the leading cause of chronic disease in high-income countries by 2030 (WHO, 2008). According to an OECD *Health at a Glance* report (2018), Ireland has one of the highest rates of mental health illness in Europe, ranking joint third out of the 36 countries surveyed. These mental health problems cost the Irish economy over €8.2 billion annually. In 2016, the number of people in Ireland who claimed to have a psychological or emotional condition was 123,515, or 2.65% of the population; 36,595 were in the labour force, i.e. there was a 33% labour force participation rate for people in this group, and 35.6% were unemployed (CSO, 2019).

In 2015, the government launched its ten-year *Comprehensive Employment Strategy for People with Disabilities 2015-2024 (CES)* with a view to significantly increasing the proportion of people with disabilities in employment in Ireland. Prior to this strategy the NDA[2] (2005) reported that people with disabilities were two and a half times less likely to be in work than non-disabled people. The report also noted that 85% of working-age people with a disability or chronic illness acquired that disability while employed, thereby highlighting the importance of effectively managing retention in employment. As a result, a key strategic priority of the CES report focused on promoting job retention with an emphasis on strategies for intervention in the early stages of absence from work due to acquired disability. However, a European Commission Country Report for Ireland in 2019 revealed that Ireland still has a long way to go to achieving its target. It reported that Ireland still has one of the lowest employment rates for people with disabilities in the EU (26.2% compared to 48.1% in the EU in 2017). Ireland also has one of the highest gaps between people with and without disabilities (45.1 percentage points) in employment.

Figure 2: Chronic morbidity (people having longstanding illness or health problems)



[2] The National Disability Authority (NDA) is the independent statutory body that provides information and advice to the government on policy and practice relevant to the lives of people with disabilities.

The Irish healthcare system is an outlier within Europe in that it has a complex dual-tiered system of both public-funded and private health insurance schemes. Therefore, the Irish system does not provide universal or equitable access to either primary or acute hospital care or universal healthcare in which patients are treated based on need rather than ability to pay (Connolly and Wren, 2018). When looking at chronic illness, the need to adopt a chronic care model as a template to measure and monitor progress in the reform of the Irish healthcare service has been recommended in numerous reports (for example see Darker, Whiston and O'Shea, 2015 and Department of Health policy framework Tackling Chronic Disease: Policy Framework for the Management of Chronic Disease, 2008). This care model is based on the understanding that improvement in care requires an approach that incorporates patient, provider and system-level interventions. Reform of the two-tier health system has been on the political agenda for a number of years. In 2011, the Programme for Government entitled *Towards Recovery, Programme for a National Government 2011-20*16 set out a commitment to end the "unfair, unequal and inefficient two-tier health system" by introducing universal healthcare financed by universal health insurance (UHI). This need for reform in the delivery of health services in the Irish healthcare system was also captured in the Department of Health (2012) strategy *Future Health – A Strategic Framework for the Reform of the Health Service 2012-2015.* An all parliamentary party report on the future of the Irish health system, called Sláintecare, was published in 2017 and set out a ten-year programme to transform health and social care services, but little progress has been made to date.[3]

The amount spent in Ireland on healthcare and services was 6.8% of GDP in 2019 (OECD, 2019). Private health insurance cover in the Irish health system at end of 2018 accounted for 2.22 million people or 45.5% of the population (PHI, 2019). Health spending per capita in Ireland is higher than in most other EU countries. In 2015, Ireland spent €3,939 per head on healthcare, compared to the EU average of €2,797. Around 70% of health spending is publicly-funded, which is well below the EU average. Out-of-pocket payments (15%) and voluntary health insurance (12%) are important parts of Irish health expenditure (EU, 2018). Private health insurance (PHI) has become part of employee benefits that companies offer. In a survey for the Health Insurance Authority in 2010, one in three employers reported that employees had access to private health insurance through their workplace. Of the employers who operated an employee PHI scheme, two in three (65%) paid some level of subsidy towards the cost, under four in 10 (38%) paid for all the costs, and 31% of employers reported that they did not pay any cost of employee PHI (Red C, 2010).

1.2 Research methodology

This report used a mixed method approach to data collection drawing on surveys, interviews, focus groups and discussion forums with relevant stakeholders. This data was supplemented with secondary research including reports and policy documents together with academic literature. These will now be outlined.

- *REWIR worker survey*: An online worker survey was hosted by WageIndicator.org to capture workers' experience of long-term absence from work due to a chronic illness and their process of return to work. Data collection began in December 2019. The total number of responses received was 80. The total number of usable responses[4] received was 29. See Table 1 in Appendix 1 for an overview of the sample.

[3] For an excellent analysis of Irish healthcare reform see Connolly and Wren (2018).

[4] The total number of relevant responses refers to those who responded 'Yes' to Question 6 – *Have you experienced a chronic disease in your working life?*

- *REWIR managers' survey:* The online managers' survey was hosted on surveymonkey.com and sought to explore Irish employers' opinions of long-term absence due to chronic illness and how they manage the RTW process. It also examined their attitudes to the role of employee representatives in this process and the national legal framework. Data collection began at the end of March 2020. A total of 19 responses were returned, six of which were discarded due to missing data, leaving a final sample of 13. See Table 2 in Appendix 1 for an overview of the sample.

- *REWIR social partner survey*: The web-based survey to social partners sought to capture insights from both employer associations and trade union bodies. Only one response was received for this survey from an Irish national trade union. See table 3 in Appendix 1 for an overview of responses.

Table 1: Overview of sample and respondent identification (Ireland)

Survey and target group	Total number of responses	Number of relevant responses
Workers' survey	80	29
Social partners' survey	1	1
Managers' survey	19	13

Note: The total number of responses refers to overall data intake for Ireland, 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?*

To complement the quantitative data above, qualitative data collection was also carried out. This involved (1) a roundtable discussion which took place in July 2019 with key stakeholders; (2) individual semi-structured interviews with key national stakeholders; and (3) two focus groups with employers and trade union representatives respectively. Please see Appendix 1 for a full overview of the sample descriptives for the REWIR workers' survey and REWIR management survey, together with an overview of respondents for the national stakeholder interviews, roundtable discussion and the two focus groups.

2 The policy framework on return to work in Ireland

This section analyses the policy framework on rehabilitation and return to work in Ireland. Ireland has no obvious policy framework on return to work and each scheme is administered in its own right and is often uncoordinated with other elements. All working people in Ireland have an entitlement to some social benefits (social welfare) from the state while out sick from work or if they are suffering from a chronic disease (CD), and the legislation for those payments is derived from the *Social Welfare Consolidation Act 2005 – Social Welfare Bill 2019.*

Currently, Irish workers have no statutory entitlement to an occupational sick pay scheme from their employer, except when it is provided for in a contract of employment, terms and conditions of employment or by way of a collective agreement. Some employers may decide to pay their employees during sick leave but if they do, the duration and level of pay is very much at the discretion of the employer. Across the EU, 22 countries already have a statutory right to sick pay, as does the UK. Ireland is one of only five EU members that does not recognise the statutory right to sick pay. It should be

noted however that the Covid-19 pandemic has prompted the Irish Government to launch a public consultation on the need to introduce one. The fact many employees, particularly those who are on low incomes, have no legal right to sick pay was recently highlighted by National Public Health Emergency Team (NPHET) and the acting Chief Medical Officer as "a problem in controlling outbreaks" of Covid-19.[5] Public sector and semi-state employments , all provide some form of employee sick pay scheme, which were mostly reduced in scope during the three years of the Troika Programme.[6] Most public sector sick/illness schemes consist of payment for: a maximum of 13 weeks (92 days) on full pay in a rolling one-year period, followed by a maximum of a further 13 weeks (91 days) on half pay in a rolling one-year period. In total, sick pay is subject to a maximum of 183 days paid sick leave in a rolling four-year period. One consequence of the contraction of public sector sick pay schemes in the wake of the Troika programme for Ireland has been the increase in public sector workers taking out private insurance policies to cover long-term illness and their income continuance while out sick from work.

In the private sector there are a wide range of sick pay schemes in operation; from where an employer continues to pay full pay for 12 working days in the retail sector to 12 weeks in the manufacturing sector. In all cases the practice is that employers will require eligible employees to claim state illness benefit payment and have it paid to the employer or the value of payment is deducted from wages. Alternatively, some employers will pay the difference between the amount of state illness benefit and the employee's normal rate of pay. A recent CIPD survey (2019) reported that 44% of private sector companies who participated in the survey did have some form of sick pay scheme. Therefore, many employees in Ireland do not have access to a company scheme and rely solely on the state for sick pay.

Social welfare benefits and schemes are administered by a government department – the Department of Social Protection (DSP)[7] (as existed in 2020). For those employees who cannot work due to illness, they are entitled to claim illness benefit from the state, provided they have enough PRSI (national insurance scheme) contributions. The applicable rate in 2020 was €190.55 per week and may be paid continuously for up to two consecutive years in one claim, except for certain illness such as tuberculosis, where the duration is unlimited. Otherwise, those employees who do not qualify for illness benefit are assessed for a Supplementary Welfare Payment, which is a discretionary scheme. In addition, there is a state welfare payment called the Occupational Injuries Benefit Scheme for those who do not get paid from a company sick pay scheme. This is available for people who have had an accident at or going to work. The scheme also covers people who have contracted a disease as a result of the type of work they do.

2.1 National policy frameworks

Whilst no policy framework explicitly focuses on the return to work of people with chronic illness, a number of recent initiatives examining disability do focus on the topic. As noted earlier, in 2015 the government launched its *Comprehensive Employment Strategy for People with Disabilities 2015-2024 (CES).* The strategy outlined six strategic priorities: (1) Build skills, capacity and independence; (2) Provide bridges and support into work; (3) Make work pay; (4) Promote job retention and re-entry to work; (5) Provide coordinated and seamless support; and (6) Engage employers. The only strategic

[5] As a result of the Covid-19 crisis, a *Sick Leave and Parental Leave (Covid-19) Bill 2020* was proposed by the opposition Labour Party in September 2020. See Labour (2020).

[6] On 28 November 2010, the European Commission, European Central Bank (ECB) and the International Monetary Fund (IMF), colloquially called the European Troika, agreed with the Irish Government on a three-year financial aid programme in order to cut government expenditure.

[7] In Ireland, government departments can be, and are, re-organised to cover different administrative functions according to priorities of the government at the time. The Department of Social Protection (DSP) was previously known as the Department of Employment Affairs and Social Protection (DEASP).

priority to focus on people already in employment was priority number 4 (Promote job retention and re-entry into work). Key actions detailed in the report to support this included the following:

- Develop guidelines to promote intervention in the early stages of absence from work
- Pilot new approaches to integrating work into the recovery model of mental health integration, including job coaches in mental health teams
- A continued programme to train trade union “disability champions” to support colleagues returning to work following onset of disability

To support this strategy, a number of initiatives/actions were introduced. Firstly, the government funded a new online service for employers, titled Employers’ Disability Information Service (EDI), which began as a three-year pilot in 2016.[8] This service was managed by a consortium of employer organisations (Chambers Ireland, IBEC and ISME) and was funded through the National Disability Authority (NDA). The purpose of the service was to provide employers with advice and information on employing and retaining staff with disabilities, and to provide a network for best practice. The NDA, in collaboration with the Institute of Occupational Safety and Health (IOSH), were tasked to work together to disseminate guidance for employers and employees on job retention and re-entry into work. At the same time, the Irish Congress of Trade Unions, under the Disability Activation Project (DACT)[9] were selected to develop training programmes for disability champions, trade union representatives and shop stewards to assist employers to support employees with a disability or chronic illness to return to work. A report was commissioned by the NDA examining good practice in organising national vocational rehabilitation services across a number of jurisdictions (published in 2017 by McAnaney and Wynne). The final strategic action focused on promoting and supporting strategies for intervention in the early stages of absence from work due to acquired disability. This involves coordination between the Health Service Executive[10] (HSE) and DSP. Whilst a number of these actions have proceeded, a key criticism is the fact that no single government department is leading on the delivery of the CES, and the view holds that there are limited resources behind the implementation of the strategy. The NDA review of progress on this strategy published in 2020[11] notes that there was slow progress on this strategic priority area in 2019, and advises on the importance of a focused effort in 2020, building on activity advanced under other strategic priority headings, which also have relevance in the context of return to work.

In conjunction with the policy above, there were a number of other significant developments in the Irish policy landscape focusing on chronic illness/disability. The *National Disability Inclusion Strategy 2017-2021*[12] was developed to set out a whole government approach to improving the lives of people with disabilities. Within this strategy, a number of key areas were identified including education, employment and joined up policies and public services. “Employment” highlights a key aim: People who become disabled are given the support they need to remain in or return to work if they so choose. Some of the actions set out in this strategy document have been achieved. Since it was developed, reforms have been made to the Partial Capacity Benefit Scheme. Other actions are still in progress, for

[8] See more information on EDI at http://www.employerdisabilityinfo.ie/.

[9] In 2012, the Minister for Social Protection Joan Burton announced funding of just over €7 million for a range of projects under the Disability Activation Project (DACT). The strategic aim of DACT was to increase the capacity and potential of people on Department of Social Protection disability/illness welfare payments to participate in the labour market. DACT funding ceased on 31 July 2015, much to the disappointment of key NGO groups such as Inclusion Ireland.

[10] The The HSE provides all of Ireland's public health services in hospitals and communities across the country.

[11] http://nda.ie/Publications/Employment/Employment-Publications/Comprehensive-Employment-Strategy-2019-NDA-Year-End-Review.docx.

[12] https://assets.gov.ie/18901/26182a87ecf84ddd8d60c215c0ce2520.pdf.

example developing proposals to address access to – or affordability of – the necessary aids, appliances or assistive technologies required for everyday living, for those people with disabilities whose entry, retention or return to work could be jeopardised due to unaffordability.

Overall, the policy framework in Ireland can be characterised as less well developed and more fragmented than other EU states. Provisions relating to long-term absence in Ireland have evolved but can still be seen as overly complex, partly because the long-term absence process occurs at the intersection of different sectoral responsibilities and government departments: employment, health and disability, equality and social inclusion (McAnaney and Wynne, 2017). Any initiatives introduced (e.g. the Employers' Disability Information Service (EDI) or Disability Activation Project (DACT)) are often short-term projects dependent on funding. Neither of these initiatives are still in operation in 2020.

Social protection agencies in Ireland do not focus on employment rehabilitation services for employed people with acquired disabilities/illnesses. When we examine support available through government agencies for people with chronic illnesses in returning to work, much of the emphasis is placed on those who are unemployed or economically inactive rather than those who are employed (see Appendix 2 for an overview of the main components of vocational rehabilitation in Ireland and gaps that exist). These supports, such as the EmployAbility Service and Community Employment, are supported by the Department for Social Protection. However, there is little evidence of state-funded and state-run occupational rehabilitation services supporting the return to work of employed people with chronic illness. In the past 10 years, a number of pilot programmes have taken place, driven by patient NGOs/advocacy groups under the Disability Activation Project (co-funded by the European Social Fund and DSP) to develop mechanisms to support workers returning to work after long-term absence due to a chronic illness. These include the *Working with Arthritis: Strategies and Solutions* programme developed by Arthritis Ireland, and *Work4You* by the Peter Bradley Foundation in conjunction with Acquired Brain Injury Ireland, which set up three vocational assessment teams to support people with Acquired Brain Injury to remain in or re-enter the workforce (McAnaney and Wynne, 2017). The view from NGOs in our study is that many of the strategic actions outlined in government policies are often left to them to implement without adequate government funding to support their implementation.

2.2 Sickness and invalidity benefit system in Ireland

In general, the welfare approach adopted applies passive measures to social protection, mainly income replacement through benefits payments. Table 2 below details the eligibility and characteristics of the main sick leave and illness schemes in Ireland. The main criteria for eligibility is a person having a genuine cause for absence based on a medical certificate. PRSI social contributions (regardless of their condition) is also a conditional criterion. There are complex eligibility interdependencies for secondary benefits and means testing for longer-term allowances.

Table 2: Eligibility conditions and benefit rates for sick leave and illness (Ireland)

Eligibility	**Illness benefit**: A scheme to support the employee if they cannot work in the short term due to illness. Must be under 66 and have PRSI contributions. **Invalidity pension:** Weekly payment to people who cannot work because of a long-term illness or disability and are covered by social insurance (PRSI).

	Partial capacity benefit: A social welfare scheme that allows a person to return to work and continue to receive a payment from the Department of Social Protection (DSP). To qualify for partial capacity benefit you need to be currently getting either illness benefit (for a minimum of six months) or invalidity pension.
Duration	**Illness benefit:** Illness benefit must be claimed within six weeks of becoming ill. Illness benefit is paid for a maximum of: (1) two years (624 payment days) if you have paid at least 260 weeks of social insurance contributions since you first started work; or (2) one year (312 payment days) if you have paid between 104 and 259 weeks of social insurance contributions since you first started work. **Invalidity pension:** To qualify for invalidity pension you must have at least: (1) 260 weeks (five years) of paid PRSI contributions since entering social insurance; or (2) 48 weeks of paid or credited PRSI contributions in the last or second to last completed year before the start date of your permanent incapacity for work. You must have been incapable of work for at least 12 months and be likely to be incapable of work for at least another 12, or be permanently incapable of work. **Partial capacity benefit:** Payment lasts as long as the individual has an underlying entitlement to illness benefit or invalidity pension.
Source of payment	Department of Employment Affairs and Social Protection
Level of benefit	**Illness benefit:** Paid at four different rates. The department works out which rate you are paid based on your average weekly earnings in the relevant tax year. The department works out your average weekly earnings by dividing your total earnings (before tax and some other deductions) in the relevant tax year by the actual number of weeks you have worked. **Invalidity pension:** Maximum €208.50 per week **Partial capacity benefit**: €101.50 to €208.50 per week
Timing of RTW considerations	There are no specific regulations in place supporting those who are on sick leave and are considering returning to work after their leave ends.
Procedure to return to work	Informal reintegration usually via organisational absence management policies or company level insurance occupational therapy (OT) specialists.
Type of source for these provisions (e.g. law (dedicated or general), collective agreement, other)	**Illness benefit:** The main provisions are in: Part 2 - Chapter 8 (Sections 40 to 46) of the Social Welfare (Consolidation) Act, 2005 Number 26 of 2005, as amended and; Part 2 - Chapter 1 (Articles 20 to 28) of the Social Welfare (Consolidated Claims Payments and Control) Regulations, 2007 (S.I. no. 142 of 2007) as amended Regulations (EEC) No 883/04 and No 987/09 **Invalidity pensions** are covered by Articles 44-49 of EU Regulation No 883/04 on the coordination of social security systems.

2.3 Provisions for rehabilitation and return to work support

In terms of employment law, chronic disease/illness is encompassed within the definition of "disability". The main legal instruments in the area of rehabilitation and return to work in Ireland are: (1) Employment Equality legislation; and (2) Health and Safety legislation. The Employment Equality legislation includes disability, which obliges employers to make reasonable accommodation for people with disabilities. Therefore, for an employee returning to work after a long-term illness, an employer must take "appropriate measures" to meet the needs of that person in the workforce. The Safety, Health and Welfare at Work Act states that employers must create a safe and healthy workplace.

There are a number of government funding initiatives available to organisations to support an employee returning to work. These include:

1. **Employee Retention Grant Scheme:** The Employee Retention Grant Scheme aims to help private sector employers keep employees who acquire an illness, condition or impairment (occupational or otherwise) that affects their ability to carry out their job.

2. **Reasonable Accommodation Fund for the Employment of People with Disabilities:** The Department of Social Protection assists employers to support employees in having access to and remaining in employment by providing a number of grants and schemes. These include the Personal Reader Grant and the Job Interview Interpreter Grant. The ones relevant to this study include:
   - **Workplace Equipment/Adaptation Grant:** Grant assistance is available to employers of staff with disabilities who need an adapted or more accessible workplace, or the purchase of specialised equipment, in order to do their job. The grant can be applied for if the person with a disability is already employed or is about to be employed by you.
   - **Employee Retention Grant**: The purpose of the Employee Retention Grant Scheme is to assist employers to retain employees who acquire an illness, condition or impairment which impacts on their ability to carry out their job. The Employee Retention Grant Scheme is open to all companies in the private sector. This scheme assists in maintaining the employability of the employee when s/he acquires an illness, condition or impairment (occupational or otherwise) by providing funding to: (1) identify accommodation and/or training to enable the employee to remain in his/her current position; and (2) re-train the employee so that s/he can take up another position within the company.
   - **Wage Subsidy Scheme**: This is a financial assistance scheme paid to employers to encourage them to employ people with disabilities.
   - **Disability Awareness Support Scheme:** The Disability Awareness Support Scheme provides a maximum of €20,000 funding for private sector employers to arrange and pay for disability awareness training for staff who work with a colleague who has a disability.

In addition to workplace regulations, there are a range of uncoordinated trade union, employer and NGO voluntary activities, including: information and awareness-raising campaigns, employee wellbeing programmes, work–life balance programmes, employee assistance programmes and some family friendly policy initiatives.

3 Involvement of social partners in shaping return to work policy at national level

3.1 Actors and stakeholders in return to work policy

The existence in Ireland of a "national" functioning form of social dialogue involving government and social partners has been a contentious issue over the last decade. Irish national Social Partnership (SP) was a formal organisational process that began life in 1987 as a form of corporatist pay/income tax bargaining arrangement between employers and unions; it ran consecutively for over 20 years and produced seven national agreements.[13] These agreements were premised on voluntary dialogue between the state and multiple stakeholders (Dundon et al., 2006). During the 22-year SP era, many elements of the national agreements in their latter stages went beyond pure fiscal matters and encompassed a wide range of social policy areas. The final agreement, *Towards 2016*, was agreed in 2006 and included the engagement of civil society organisations (collectively comprising the Community and Voluntary Pillar of social dialogue) with a focus on engagement in social dialogue on work and social inclusion. Unfortunately, comprehensive RTW policies were not mentioned. Irish SP extinguished itself in 2009 (see McDonough and Dundon, 2010 for an overview). There is considerable debate and claims about which party actually ended the process. In the face of the Great Economic Crisis with an emergent "blame game", SP became widely synonymous in public commentary with the infamous "Celtic Tiger" over indulgences, and was deemed a strong contributor to the deep economic recession that Ireland endured in subsequent years. As a consequence, there has been no national-level process of social dialogue from 2009, except for the continued existence of two cross-industry advisory bodies: the National Economic and Social Council (NESC) and the National Competitiveness Council (NCC). Since 2009 there has been a continuation of normal democratic bilateral engagements with the Irish Business and Employers Confederation (IBEC), the Irish Congress of Trades Unions (ICTU) and NGOs lobbying the government on specific areas of concern at the annual budget or during law/policy making. In Ireland, ultimately, RTW procedures play out in the workplace and at individual level, rather than through collaborative policy development at the national level. These workplace-level interactions will be discussed further in section 4.

3.2 Views and level of involvement of industrial relations actors

At a national level, Ireland has no formal forum or process that involves key social partners or NGOs in discussions or formulation of policies on return to work for those recovering from long-term illness with the Irish Government or its agencies. To date there have been no moves to bring the government, social partners and NGOs into a process to develop a comprehensive all-encompassing RTW architecture provision for long-term illness. Instead what exists are sporadic issue-specific events that highlight a particular deficiency or failure, and a government department establishes a committee of inquiry and seeks public views on the matter, or a government minister will amend an existing programme or support. By and large it is the activities of NGOs in lobbying and publicising issues that have brought about change in the area of RTW policies, which in effect means that measures are developed in a piecemeal and uncoordinated fashion.

Recent developments in Ireland, however, suggest the possibility of increased activity on a renewed form of national social dialogue. In October 2016, the Irish Government re-established a form of national-level social dialogue entitled the Labour Employer Economic Forum (LEEF). LEEF was

[13] The seven national partnership agreements were: 1987: Programme for National Recovery (PNR); 1991: Programme for Economic and Social Progress (PESP); 1994: Programme for Competitiveness and Work (PCW); 1997: Partnership 2000; 1999: Programme for Prosperity and Fairness; 2001: Sustaining Progress; and 2006: Towards 2016. In 2010 a public sector only worker agreement was negotiated: the Public Service Agreement 2010-2014 (also known as the "Croke Park" agreement).

established to bring employers, trade unions and the government together to discuss views and policies on the labour market and matters of mutual concern, and would meet two to three times per year in formal plenary sessions. The move by the government to create LEEF was in response to calls from the main employer organisation IBEC and national trade union body ICTU for a national forum that would facilitate engagement on priority economic and social issues. LEEF has become a fluid entity in many respects. There are LEEF subgroup meeting on childcare, housing, pensions and employment. However, with important immediate national issues such as Brexit and Covid-19, representatives of LEEF's membership have met weekly and daily in many incidences as high-level stakeholder forums to agree on approaches and polices, e.g. the *"Return to Work Safety Protocol: Covid-19 Specific National Protocol for Employers and Workers*" (Gov, 2020).

Indeed, the reestablishment of formal social dialogue architecture directed by the Office of Taoiseach (Prime Minister) in Ireland has become an important policy commitment of the Irish Government. The policy programme, *"Our Shared Future"* (Gov, 2020a) for the new Irish three-party coalition Government of 2020 has committed to "Establish *a unit in the Department of Taoiseach to coordinate social dialogue. It will create new models of sectoral engagement; utilise public consultations, citizens' assemblies and strengthen current mechanisms such as the National Economic Dialogue and the Labour Employer Economic Forum (LEEF); [and] ensure in all our engagements that the role of the Oireachtas and Government in policy formation is fully respected*" (p. 136).

Irish national social partners from industry who were interviewed reported that they had representatives with an ongoing involvement in EU cross-industry and sectoral-level organisations, and were constantly involved in many and diverse formal consultations under Article 154 of the TFEU. In addition to social dialogue activities, their involvement covered a wide range of issues including health and safety and worker retention schemes, and stakeholder consultation and feedback on the EU Commission's Better Regulation Agenda. At a national level, IBEC and union officers felt that the ending of SP deprived them of access to national social dialogue on important issues. For many, social dialogue was viewed more broadly than just a wage bargaining device, and should encompass a range of societal issues such as return to work after chronic illness.

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

This decline in national-level social partnership means there has been an absence of national social partner involvement in shaping RTW policy. Neither employer groups nor unions indicated any dialogue on return to work at the national level. All the union officers interviewed related that they would welcome a national social dialogue on establishing a national framework for return to work after chronic illness. In the absence of a social dialogue forum, unions lobbied the government individually on issues during the framing of a new law or at Budget time. One union officer said, *"Our primary focus has been at workplace level in recent years but we need to focus on RTW issues and find ways to build a national common understanding with IBEC that is supported across government and voluntary organisations".* Another senior union officer said*, "in the ideal situation all union workplaces would have extensive CB agreements and provide for RTW policies and the like, but employers just will not engage with us on new agreements, not core pay stuff and the like, as they view them as adding cost to the company bottom line and not providing a benefit to the company but just a new cost item".*

There is, nonetheless, a fragmented and issue-specific amount of ongoing work on developing policy and guidance by NGOs, unions and national governmental bodies. As far back as 2002, the Workway initiative was developed by ICTU in conjunction with the employer body IBEC to raise awareness and promote the employment of people with disabilities and chronic illness in the private sector. This initiative was supported by the Department of Enterprise, Trade and Employment. It represented the

first such social partnership initiative in the area. That project ended in 2005 with key outcomes including IBEC/ICTU Disability and *Employment Guidelines and The Way Ahead – a Workway Policy* Document.

The National Disability Authority (NDA) and the Health and Safety Authority (HSA) have produced guidance documents for employers on retaining workers who have acquired a disability, with suggestions on best practices and relevant Irish law briefs. The HSA funds an annual report, The Health and Occupational Research (THOR) Republic of Ireland (ROI), which sets incidences of workplace-related illnesses to inform the work of the HSA inspectors and information programmes. For the purposes of this report both the NDA and HSA have focused on two areas of note: mental health and work-related musculoskeletal disease.

The important role of NGOs and patient groups emerged in many of the stakeholder interviews as a distinct part of the voluntary and community sector, and they are a critical pillar in social dialogue. All NGOs interviewed stated they did not have a strategy to engage with other social partners, particularly government, on RTW issues. The primary reason for this is resource constraints. Many of these groups work directly but on an ad hoc basis with employer groups, unions and health services to raise awareness of chronic illness and patient needs. NGOs such as the cancer charity the Marie Keating Foundation produced a guide (Keating, 2019) for employers and employees on returning to work after cancer, in partnership with Chambers Ireland. Arthritis Ireland, together with Fit for Work,[14] has developed a guide for employers that provides practical information and guidance to help them understand arthritis and musculoskeletal disorders, the effects on employees and support needed. Another example of NGO guidance is a *Pocket Guide to Returning to the Workplace* (SEE Change, 2020) on returning to work after/with mental health issues due to Covid-19, produced by SEE Change and Mental Health Ireland. The employer body IBEC has also partnered with SEE Change to produce a line manager's guide to mental health and wellbeing as part of their KeepWell programme.

3.4 Outcomes of social dialogue with regard to return to work

As reported above, there are no formal social partnership agreements in Ireland on the topic of return to work. However, there is evidence of social dialogue between social partners in developing RTW policies. Both union and employer interviews identified examples of their input in policy development at national level, particularly regarding the *Comprehensive Employment Strategy for People with Disabilities 2015-2024.* They acknowledged that they would often engage on topics together, e.g. in the area of mental health, and would work together on awareness-raising activities. ICTU and IBEC, for example, worked in collaboration to develop guidance called *Reasonable Accommodation Passport* (ICTU, 2019). The aim of the passport is to allow structured conversations about the impact of disability and chronic illness, and to ensure that the necessary employee and workplace supports are facilitated. The Fit for Work coalition, spearheaded by Arthritis Ireland and facilitated by ICTU, IBEC and Irish Small and Medium Enterprises (ISME), along with key health stakeholders, sought to better align the work and health agendas in Ireland. Its key focus was to drive important policy changes. Guideline documents for both employees and employers were developed from this coalition for key stakeholders.

Interviews highlighted that there is an appetite among all stakeholders to examine the topic of return to work, but there is a lack of consensus on what needs to be done. In the Fit for Work coalition, debate arose around replacing the sickness certificate supplied by medical doctors to employees to give to their employers with a fit to work note similar to that in the UK. There was no agreement on this. From the employers' perspective, there is the view that other stakeholders (e.g. unions and

[14] Fit for Work Ireland is a coalition of patients, physicians, health professionals, employer associations, trade unions and policy makers working to improve the early detection, prevention and management of musculoskeletal disorders (MSDs) in the workplace.

government) want the employer to accrue all of the costs associated with return to work, e.g. rehabilitation and sick pay.

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

One aspect of the recent impact of Covid-19 in Ireland, along with Brexit as existent economic and political threats, has been clear evidence of national social dialogue and social partner involvement in the development and implementation of national (governmental) economic, social and health policies. It could be argued that both Covid-19 and Brexit can be regarded as national emergency situations, where everyone pulls together. There is a historical legacy in Ireland of social corporatism at many levels or an institutional memory of national partnership (Regan, 2017) as witnessed in SP from 1987 to 2009 and the more recent re-emergence of national social dialogue in LEEF. Sheehan (2018) argues that the SP construct from 1987 has strong continuities in contemporary Ireland in the manner in which employers and unions continue to engage in industrial relations practices. Interview data showed return to work was a priority for all industrial relations actors. An employer association interview claimed they were "*pushing an open door*" on the topic. Based on the survey and qualitative data for this report, there emerges an understanding among the social partners that comprehensive RTW policies and architecture are absent in the Irish health and social protection systems, and that these should be developed as part of LEEF discussions in the future. Employer groups agreed there was an appetite currently for more social dialogue, though not social partnership agreements. The potential, therefore, exists for the possibility of an all government comprehensive approach through social dialogue to RTW policies in Ireland in 2021 and beyond, but the point is to make it happen in a more strategic and coordinated manner.

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

To add more depth to RTW policy in Ireland at national level, we also examine RTW processes at the company level. In this section we draw on data from (1) the REWIR workers' survey; (2) the REWIR managers' survey; and (3) the focus groups. In addition, data from the national interviews and roundtable discussions are included. Appendix 1 provides further descriptive samples for each of the two surveys and a summary of participants in the focus groups, national stakeholder interviews and roundtable discussions.

Evidence from this study show that RTW processes at company level occur generally as part of a company's Absence and Attendance Management Policies. These policies typically set out the administrative arrangements for paid sick leave and attendance at work, and outline the support available to all employees on an extended absence from work due to illness. In some organisations, line managers are responsible for implementing absence management policies and sick leave policies. In other organisations, line managers and HR departments work together to support employees who are on extended leave, and to support employees to return to work. All managers interviewed for this study acknowledged the increasing importance and occurrence of long-term sick employees and their return to the workplace. Some indicated that their organisations had occupational health insurance, where the insurance company became the case manager during an illness related absence from work and worked with HR throughout the process.

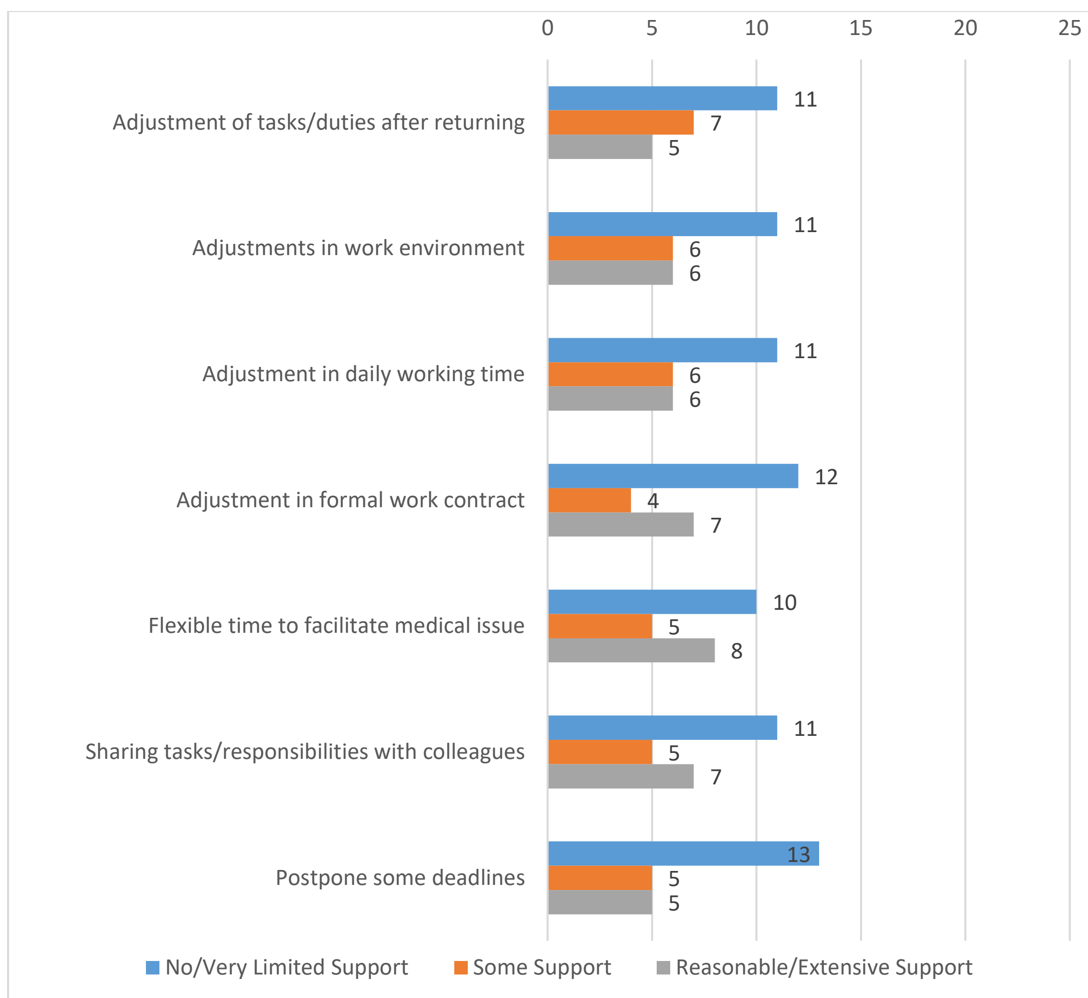
4.1 Workers' experiences with the return to work process at company level

The major chronic illnesses reported in the workers' survey were cancer (27%), other (23%) and cardiovascular, musculoskeletal and mental illness (all 15% respectively). The majority of respondents

reported they had already returned to work after a chronic disease. Only three respondents indicated they had been diagnosed recently and their treatment has just started or was about to start shortly. Of the workers who had already returned to work, a large majority of respondents (87%) reported feeling concerned about returning to work. Interviews with patient groups highlighted major concerns around unknown expectations of an employer, fear of acceptance back into the workforce and that their employer would not understand their particular circumstances. Worker survey data showed a major concern around the need to return to work at full productivity with no adjustment period (45%). This was closely followed by a fear that there would be nobody available to support them if they experienced work problems due to recent treatment and sick leave. No adjustments to work conditions and work hours (both 30%) were also reported as key concerns. 65% of workers stated that they returned to the same job. Figure 3 highlights the lack of adjustments made for workers when returning to work. A third of respondents reported receiving adjustments to daily working time (31%) and formal work contracts (34%). Adjustments in tasks and postponement of deadlines were reported as receiving limited or no support.

Interview and focus group data highlighted the importance of providing reasonable accommodations to individuals returning to work, and a number of examples were outlined including (1) redesigning a job description; (2) redeployment or reassignment of duties; (3) flexible working; (4) job sharing; and (5) modified workstation/adaptation to buildings. The introduction of the reasonable accommodation passport (developed by ICTU and IBEC) was highlighted as important guidance for providing a structure around what could be a difficult conversation. This guidance assists in the method and organisation of conversations between workers and employers to ensure that adjustments are put in place to help them fulfil their role in a way that works both with them and for them.

Figure 3: Adjustments received by workers when returning to work after a long-term illness



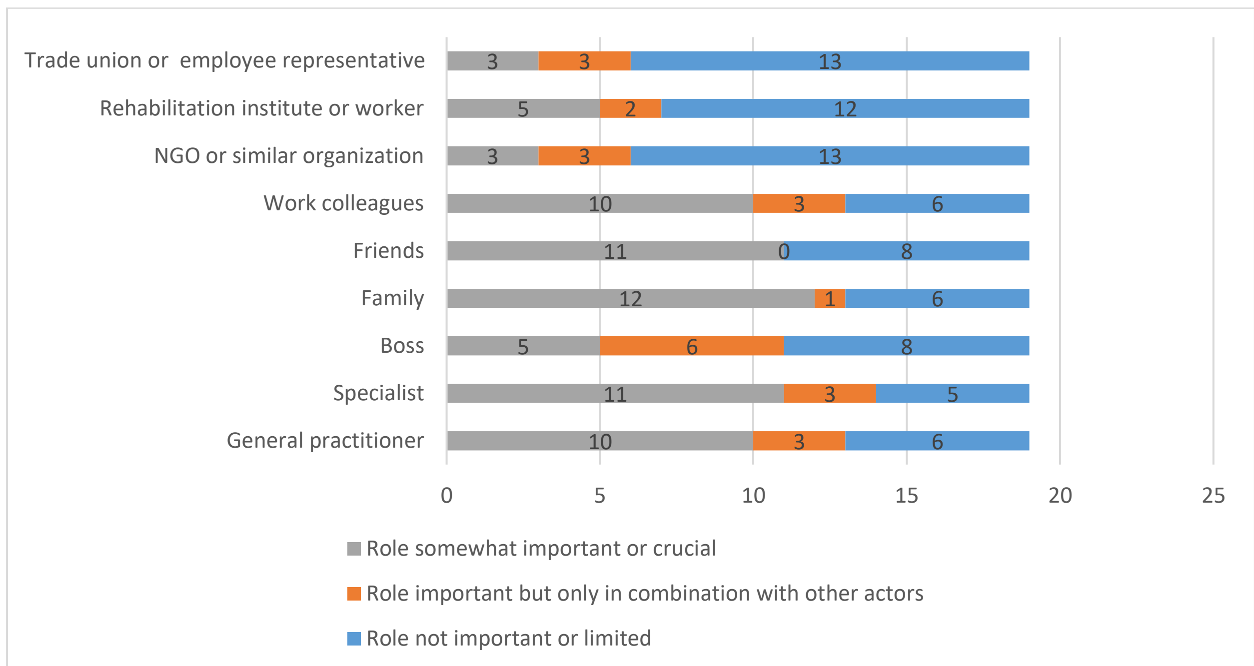
Source: REWIR worker survey. Own calculations. Number of respondents = 23

For those who had returned to work, 70% reported that they were in touch with a general manager or HR department during their absence. 48% were in touch with work colleagues, followed closely by a direct manager (39%). Over 80% of respondents indicated that they had returned to work on their own initiative, with 22% reporting that it was initiated by their medical professionals. When we examine experiences with returning to work, over half of the workers' survey respondents reported not being satisfied or being only partially satisfied with the support they received. 60% reported dissatisfaction with the help and support received from their trade union. The majority of respondents returned to their own job (65%).

In examining the RTW process, the REWIR workers' survey identified a number of actors as important. Medical actors (e.g. general practitioner (GP) or specialist) were rated as most important (see Figure 4). This was closely followed by family, friends and work colleagues. The importance of social interaction with co-workers is an important theme in the RTW process in considering how the workgroup will reintegrate the returning worker (Tjulin, Maceachen, Stiwne and Ekberg, 2011). Survey results indicate that NGOs and trade unions play a limited role in return to work at company level. This finding is supported by the focus group data. All managers interviewed who worked in an organisation that recognised trade unions reported no involvement of a union in the RTW process. The communication on returning to work was usually between the HR department (and/or line manager) and the employee. No information was shared with the union representatives on an employee's health problems or return to work. A union would only become involved if an employee approached them directly, or if a situation escalated and disciplinary proceedings were being introduced due to

absence or performance issues. The worker's manager was rated as less important relative to work colleagues. The manager was, however, identified as important in combination with other actors. Stakeholder and manager interviews highlighted this issue. In the majority of cases, the HR department managed the cases on a day-to-day basis and the relevant line manager dealt with the granular detail. Many managers, however, did not wish to deal with the sick leave process and left it to HR to manage this through regular employee check-ins, etc. They then worked in tandem with healthcare professionals to facilitate the RTW process. This concurs with the survey results, where 70% of respondents reported liaising with their HR department during their treatment and absence. This was followed by work colleagues (48%) and their line manager (40%). Healthcare professionals, such as occupational therapists, were seen by many stakeholders as being a critical linchpin in successful return to work due to their proactivity in setting out a roadmap for their return by checking on readiness, thinking about practicalities, liaising with the employer on adjustments and motivating individuals to go back to work.

Figure 4: Worker evaluations of the role of different actors in facilitating return to work after long-term illness



Source: REWIR worker survey. Own calculations. Number of respondents = 19

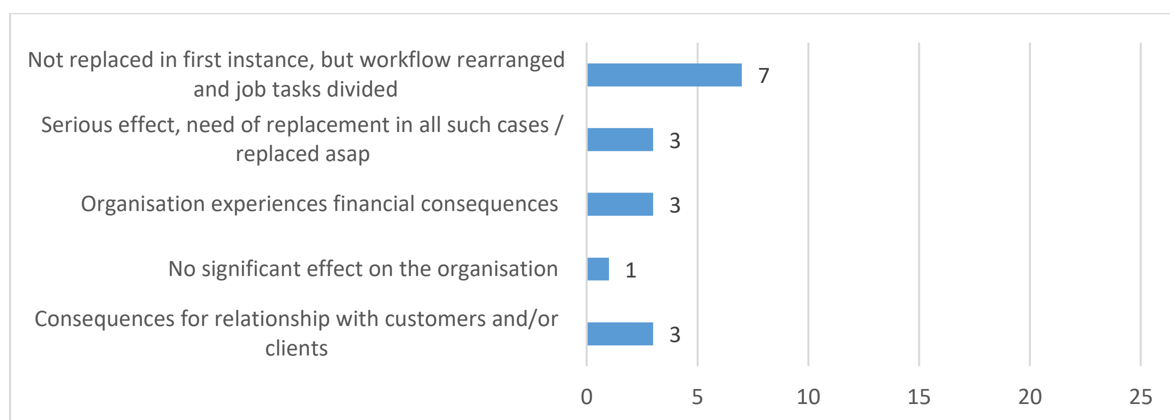
Of the three respondents currently on leave due to chronic illness, two reported that they expected to be absent from work for six months or less. Another indicated they did not know how long they expected to be absent. Two reported they had received a supportive response from their employer, with one saying they continued to be supported while on leave. The final respondent reported an indifferent response. Two respondents expected to return to their current role after treatment. The other respondent did not know at this point if that would be possible. All three respondents reported little support from trade unions either due to there being no union (one respondent), not communicating it to their trade union rep (one respondent) or the trade union having an indifferent attitude to workplace absence (one respondent). Those respondents who were currently absent due to chronic illness reported that their line manager (one response), general practitioner (one response) and rehab institute (one response) were the most important actors to support their return to work.

The majority of interview data showed that RTW policies were developed at workplace level. One union officer related that even within a multinational corporation (MNC) with companywide polices, there was deviation from these by individual line and HR managers at plant level. He provided an example of one pharma MNC that had local agreements on sick pay and sick leave that were different in two Irish plants of the MNC. He stated that*, "The only means in many instances to get some flexibility for a member with a serious illness is to get the line or HR manager to see the need for compassion for an employee. It is not an ideal situation that relies on hard cases and compassion and not an agreed process for all".* The important point made in the latter observation is that line and HR managers mostly have the ability to grant additional flexibility to employees with a serious illness on their return to work. It does, however, underscore the broad situation in Irish workplaces that without a national scheme or framework on return to work, many employees have to rely on the decency and pastoral care of individual managers.

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

We now turn our attention to company perspectives of return to work. Looking at the consequences of employee absence on the company, 58% of managers surveyed indicated that they would not replace an absent employee but would rearrange workflow and job tasks. Some respondents reported that an absence had a serious effect on the business (25%), with financial consequences (25%) and consequences for the client and/or customer relationship (25%). Conversations with employer associations highlighted the business impact of having an employee absent from work for a prolonged period. This was particularly pertinent for small and medium-sized enterprises (SMEs), who were much more likely to be impacted by an employee absence due to limited resources and competitive pressures.

Figure 5: Perceived effect of an employee absence in the organisation



Source: REWIR manager survey. Own calculations. Number of respondents = 12

Managers reported information/advice on adjusting workplace and work spaces (25%) and external counselling e.g. from doctors/therapists as the most valuable resources needed to support workers returning to work after chronic illness. When asked what resources they felt were lacking in their organisation, information on adjusting workplaces, information on financial strategies in dealing with sick leave absence and external counselling from both doctors/therapists and patient organisations were all highlighted (18.18% respectively). Insufficient knowledge about work and specific illnesses was mentioned as a barrier to return to work by patient groups and occupational therapist interviews. This then led to lack of clarity about who takes responsibility and which healthcare professional should start the discussion on return to work. This lack of clarity is further exacerbated by the lack of a national vocational rehabilitation (VR) service or framework that was available to all workers on sick leave due to chronic illness. Research consistently shows that timely access to related support services are critical to the successful return to work for people diagnosed with a chronic illness, or a framework that is available to all.

The attitudes of managers towards workers with chronic illness has been highlighted in previous research as impacting RTW success (see Amir, Neary and Liker, 2008 for example). Table 3 below shows that a majority (72.73%) disagreed with the view that workers with chronic illness were less committed to their work. Over two thirds (63.64%) believed that employees should be entitled to an adjustment to their working duties due to a chronic illness, at the employers' discretion. Only 27.27% were in favour of a legal entitlement to an adjustment to working duties. However, they also reported

that having a worker with a chronic illness did lead to an increase in their colleagues' workloads as a result. They also stressed the importance of staying in touch with the worker while they are on sick leave (83.34%). Interestingly, half of respondents believe that senior managers in their organisation do not recognise the difficulties that lower-level managers have to face when managing a worker's absence and attendance.

Table 3: Attitudes of employers towards workers with chronic illness

	Strongly disagree/disagree	Neither agree /disagree	Strongly agree/agree	Don't know
Are unable to perform their duties as before	36.36	27.27%	27.27%	9.09%
Less committed to work	72.73%	9.09%	9.09%	9.09%
Leads to increases in colleagues' workloads	18.18%	9.09%	63.64%	9.09%
Likely to be absent from work more often than other workers	18.18%	18.18%	54.54%	9.09%
Should be entitled to adjustment to working duties at employers' discretion	27.27%	0.00%	63.64%	9.09%
Should be legally entitled to adjustment to working duties	36.36%	27.27%	27.27%	9.09%
Should have a phased return to work on full pay	25.00%	25.00%	33.33%	16.67%
I would recommend more time off than the current legislation stipulates	16.67%	41.67%	33.33%	8.33%
Senior managers do not recognise the difficulties that lower-level managers face with workers' absence and attendance	25.00%	16.67%	50%	8.33%
It is important to stay in touch with the worker during his/her absence	0%	8.33%	83.34%	8.33%
Returning to work during treatments helps normality and is encouraged in our organisation	8.33%	41.67%	33.33%	16.67%

Source: REWIR manager survey. Own calculations. Number of respondents = 12

Respondents reported that the HR department (75%) was the main department that managed the return to work of employees after absence due to chronic illness. This was supported by company-level focus groups. All participants in the group discussion indicated that the HR department formally dealt with absence management and long-term sick leave together with the RTW process. Both the manager survey (72%) and focus groups highlighted that the line manager should also be responsible for handling the RTW process. This does not always happen, however. Fearful attitudes, line manager burden and poor relationships were identified as significant barriers as to why a manager may not become involved in return to work. Fearful attitudes encompassed both fear about discussing the illness and how the employee might respond, and the fear of being misinterpreted. This latter fear aspect is particularly pertinent when communicating with an employee while they are absent from work. Respondents spoke of a fear that a check-in phone call might be interpreted as pressure to return to work. Line manager burden includes the additional demands placed on the line managers in managing the tensions between providing support for employees who are ill while fulfilling statutory and company procedural requirements, which are often further reinforced as a result of lack of training and limited HR support.

4.3 Interactions between employer and employee in facilitating return to work

The overarching theme to emerge from the company-level discussions is that return to work after chronic illness is a complex process with no one-size-fits-all formula. It can be impeded by a number

of factors including organisational, personal and medical factors, and timely access to related support services. Discussions with workers, patient groups, occupational therapists and managers all highlighted that a one-size-fits-all approach to return to work does not work in practice.

From the manager survey, 64% indicated they had a common standard procedure for managing return to work for all employees. All management participants in the focus group reported that they had absence management policies which managed illness, long-term illness and employees returning to work after long-term illness, and all agreed having this policy was important as it gave clarity to everyone on how the process would work. Some had a specific sick leave absence management policy and procedures that clearly set out what happens when an employee is absent through illness. Where this policy existed, it typically set out: (1) detail on the sick pay scheme and the income continuance plan if one existed; (2) notification and certification requirements; and (3) requirement to attend a doctor nominated by the employer for medical assessment. This also set out guidelines for when they return to work. 73% of survey respondents (REWIR manager survey) reported there was a possibility for a phased return to work in the organisation, and that in managing the RTW there was close cooperation with other external organisations, e.g. occupational health services (72.73%). When asked what improvements were needed, over half of managers (54.55%) reported that: (1) better interpersonal relations between managers and employees dealing with return to work was needed; and (2) better cooperation with external stakeholders in facilitating return to work (e.g. doctors, occupational therapists) was needed.

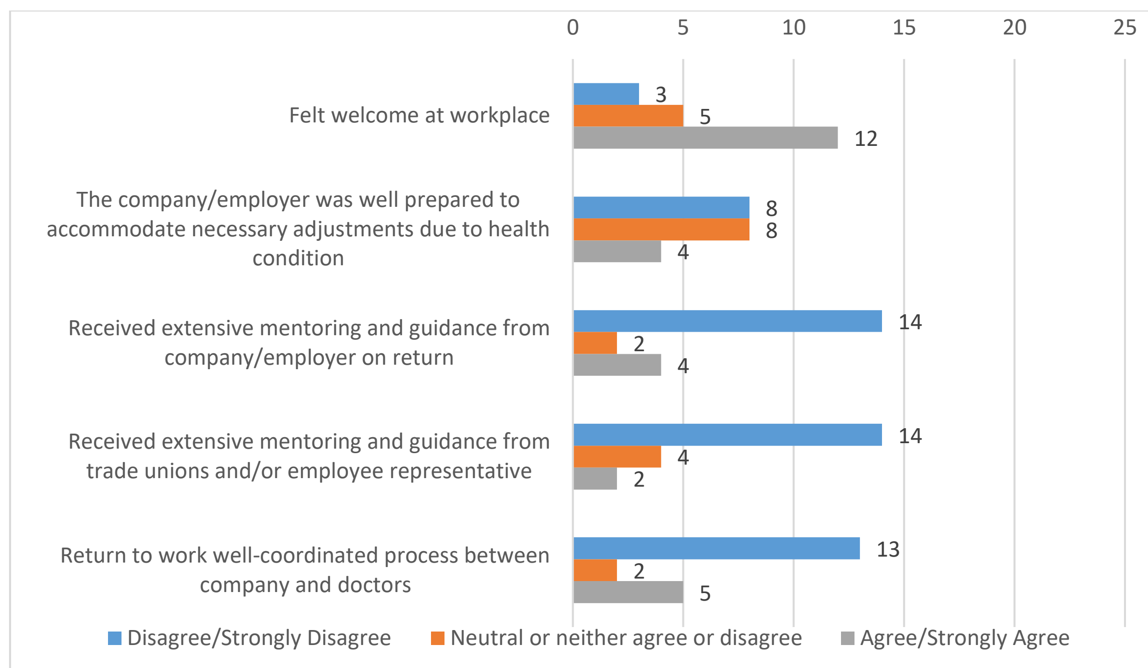
External stakeholders especially were identified as critical in the return to work at company level. In Ireland there is no standard universal model of occupational rehabilitation. Most occupational rehabilitation is available in Ireland through a number of large public and private sector organisations, or through private insurance providers of income protection plans and personal health insurance. Services are provided by a mix of in-company professionals and private sector providers. All of the focus group members indicated that their organisation had an income protection policy. This means that once an employee is unable to work due to an identifiable illness, this policy will pay the employee until they return to work or until they reach retirement. These insurers such as Irish Life take on the case after a number of weeks. Within this they assess the claim and work on rehabilitation and return to work programmes. The RTW process then moves outside the organisation with the insurance company managing the employee case. Views on this model were mixed. One union officer related that companies did not want to manage employees who were out long-term sick and were happy for insurance companies to take on that role. He said, "*Many firms see HR today as an add-on and not a core function, and outsource to their healthcare insurance provider the management of RTW. It is in their financial interest to get people back to work ASAP or off the company books".* Evidence of this outsourcing of the RTW task was given where an employee was off work with a mental illness problem for many months. Besides the medical professionals, the only contact he had with his organisation was through the private insurance "nurse" visit to his home every two months to agree to continue paying his sick pay. The provision of health staff in the form of occupational nurses in companies is largely only in the big manufacturing firms. They are no longer employed directly by those firms and in many case employed on part-time contracts. One occupational health physician said that, *"I do not know of a single workplace in the Irish private sector that has a full-time occupational physician on site, unlike it was in the past when we had such things as the "company doctor" who is now likely to be on a paid retainer to big firms to see employees from time to time".* One case company in this study did have a full-time occupational nurse in employment, and the company showed strong evidence of good practice by:

- supporting employees while they are absent from the workplace due to illness,
- working with employees to plan their return to work,
- assisting employees to integrate into the workplace when they return to work,

- regularly reviewing reasonable accommodations as the employee's needs, their environment or their work duties change.

Workers' experience of returning to work was mixed. 60% of respondents reported being welcome at the workplace. 40%, however, reported that their company was not prepared to accommodate them with work adjustments in their return to work. One interview respondent provided the example of a female returning to work after cancer who worked on an assembly line and received no accommodations via a phased return, reduced hours or redeployment to less physical work. Due to the precariousness of her work and having no sick pay entitlements, that female felt she had no option but to return to work under those working conditions.

Figure 6: Workers' experience with the return to work process



Source: REWIR worker survey. Own calculations. Number of respondents = 20

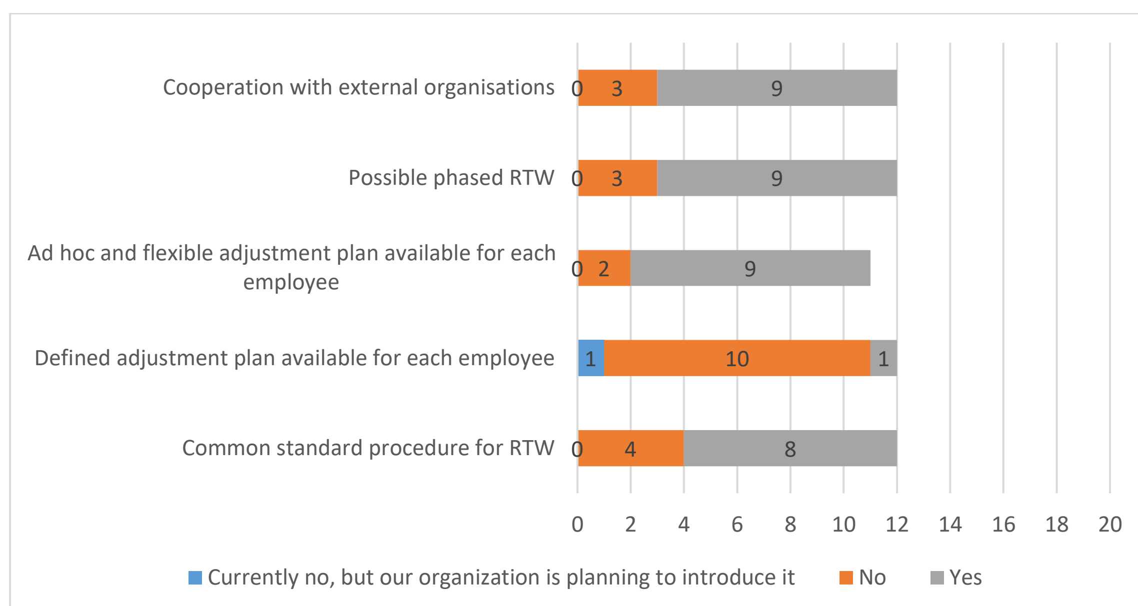
From the manager survey, data indicated that 100% of respondents had heard about an employee being diagnosed with a chronic illness directly from the employee either formally or informally. Managers reported that interactions with workers on sick leave happened both formally (62%) and informally (38%) and happened regularly (61.54%). Over half of respondents (58%) indicated that they kept the worker informed about work-related issues. However, only 20% reported involving the worker in work-related issues. The reason for this may relate back to the previous discussion of fearful attitudes where a phone call could be misinterpreted as pressurising the employee to connect with work. In terms of who initiates the return to work, 54% of returns were initiated by the employee themselves. However, just under half of employers (45.5%) stated they initiated the return.

We now turn our attention to procedures used in return to work in Irish companies. Figure 7 below shows the most common measures reported were: (1) a phased return; (2) cooperation with external organisations; and (3) an ad hoc flexible adjustment plan for each employee. These are closely followed by common standard procedures for return to work. Focus groups interviews reinforced the flexibility and ad hoc nature of the RTW procedures. No company had a defined adjustment plan. The discussion of return to work was always on a case-by-case basis with the employee and sometimes via the occupational therapist. All acknowledged that simple adjustments within the workplace can be

effective in facilitating return to work. The importance of cooperation with external stakeholders emerged in all stakeholder interviews as an important aspect. From the survey, communication and cooperation between healthcare workers / occupational therapists and the employer were seen as critical in facilitating successful return to work.

This lack of clear workplace procedures can lead to perceptions of unfairness and lack of transparency. As mentioned previously in Section 4.1 there is evidence of a lack of consistency in the implementation of sick leave and RTW policies even within the same organisation. This can lead to perceptions of unfairness by the employee. van den Bos and Lind (2002) argue that workers pay greater attention to fairness during times of uncertainty such as when on sick leave or returning to work after a chronic illness. It follows that interventions that yield reductions in perceived injustice for the returning worker should be associated with more positive outcomes. A national framework on RTW is one such intervention which may set clear procedural rules in managing the RTW process.

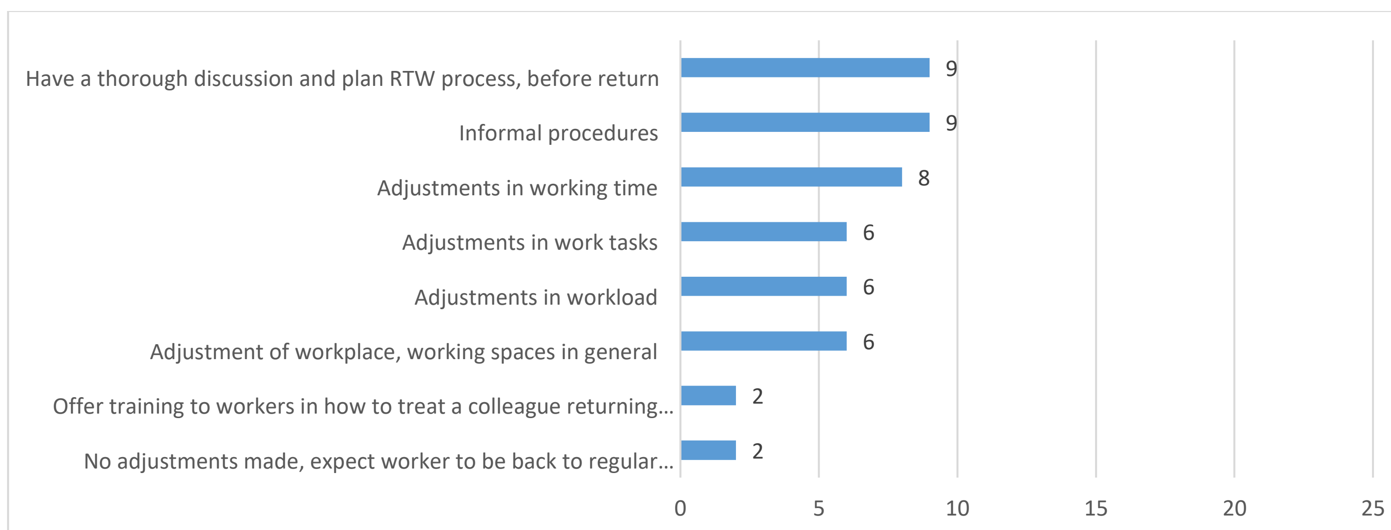
Figure 7: Availability of return to work procedures in the company



Source: REWIR manager survey. Own calculations. Number of respondents = 12

Both research and best practice identify the importance of communication in the return to work (e.g. see ISSA, 2013). 75% of company respondents stated that they ensured a thorough discussion with the worker and put in place a plan for the RTW process before their return. Discussions with occupational therapists and consultants working in the RTW area all reinforced the importance of agreeing an individual plan before the employee returns, which should include any adjustments to workload or work patterns that might be needed. Over half indicated they offered some form of adjustments in working time, work tasks, work load and work spaces. Very few reported offering training to co-workers in how to treat a colleague who is returning to work after long-term illness. One example of training was given by a cancer patient organisation, who were approached by a manager with a training request to address him and his team about how they could support a key employee who was returning to work after cancer treatment. They wanted to support that worker back into the workplace and turned to the NGO for guidance.

Figure 8: Support offered by the company to the employee returning to work



Source: REWIR manager survey. Own calculations. Number of respondents = 13

The introduction of the General Data Protection Regulation (GDPR) in May 2018 was mentioned in a number of discussions with managers and HR as a new, complicating issue in facilitating employees' return to work. For an employer, the processing of a medical report is necessary to ensure they deal with sick pay or can assess fitness to return to work, identify reasonable accommodations for the returning employee and ensure they adhere to employment law. GDPR legislation, however, places constraints on the processing of data, which means that employers can only insist on the following information from a doctor or occupational health physicians: (1) that the employee is unfit to work; (2) how long they will be unfit for; and (3) when they are medically fit to return. In the opinion of some managers interviewed, this negatively impacted their ability to work with the employee to support their successful transition back to work, as they did not have full details of the illness and could not plan for reasonable adjustments to their workload or the workplace. Occupational specialists interviewed also expressed concern on this matter. In their opinion, communication and cooperation between healthcare professionals and employers were seen as facilitators for planning a successful return to work. However, knowledge of the chronic illness was a requirement to set out a plan. Patient organisations highlighted how individuals were different and many did not want to be labelled or stigmatised due to their illness. For some, there was uncertainty regarding the disclosure of their illness to employers. As a result, there was a challenge in balancing the needs of the worker and those of the employer by ensuring confidentiality for the worker and then facilitating adaptations and allowing others to understand workplace difficulties that may occur (Brannigan et al., 2017).

The nature of an illness was highlighted as a real concern by both employers and employees. There is a view that illnesses had both visible and invisible elements. For example, a stroke patient returning to work may have visible changes such as mobility issues. However, cognitive changes were more invisible such as difficulties with memory, data processing and language, which in turn caused fatigue and anxiety. Mental health illness was mentioned in many interviews as the most complex illness, as there was a fear on the part of the employer about how to manage it and also a fear on behalf of the employee with regard to being stigmatised or that they would be considered less worthy workers.

Interviews showed that there were significant differences in managing long-term sick leave between the public sector and the private sector. The Public Service Sick Leave Scheme was introduced in March 2014 in the majority of sectors in the Public Service and in September 2014 in the Education Sector. This new scheme standardised paid sick leave arrangements across the generality of the Public Service for the first time and effectively halved paid leave access for the majority of public servants, while also

introducing a provision for extended leave in the case of critical illness or injury. It aimed to lower the perceived unsustainable cost of sick leave for the Public Service by reducing the period of time for which paid sick leave is available, while maintaining a good level of protection for public servants absent from work due to illness or injury. Two processes were key to this new scheme – Temporary Rehabilitation Remuneration (TRR) and Critical Illness Protocol (CIP). TRR is a non-pensionable discretionary payment that can be paid to public servants who have exhausted access to sick leave at full and half pay and who are likely to be able to resume work. The CIP defines eligibility criteria for the granting of extended sick leave for critical illnesses (six months at full pay and six months at half pay, subject to an overall limit of one year in a four-year rolling period). The decision to award extended leave is made by the HR manager following consultation with the occupational health physician. The development of this scheme was done in consultation with the Public Services Committee of Irish Congress of Trade Unions (ICTU).

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

Across this research, there was some evidence of organisations (both public and private sector) providing employees with appropriate RTW plans and accommodations. All interviewees indicated that having a good understanding of the chronic illness and its side effects was critical. For return to work to be effective it must be seen as a process, not just an event. This allows for clarity in the management of expectations on how quickly an employee could "return to normal" upon their return. It also allowed for discussion over any adjustments needed to accommodate them upon their return. The needs of workers with chronic illnesses varied according to the type of illness. Cancer sufferers might have different needs and require different accommodations to those suffering from stroke or mental illness. A second point of good practice was around communicating with the employee at various point in the process. One patient group stressed it was "*really important to signpost for people…. Know where to go and ask questions. What resources are available"*. Communication should begin at the point of diagnosis and start of sick leave. At this point procedures on who and how often the organisation will be in touch should be agreed and clearly outlined. They also stated that communication should continue while they are on sick leave and just before they return in order to work with the employee in planning how and when they will return. Finally, they stated that conversations should take place after their return in order to review their return process and the effectiveness of any adjustments made for them in the workplace. A comment by a respondent in the manager survey highlights the importance of the relationships within the organisation: "*These processes depend largely on how workers get along with the team, and the manager's human practices and thinking".* The importance of a work plan was seen as critical. Best practice examples showed that there should be a meeting six weeks in advance to work out a phased return. Responsibilities should be discussed in terms of targets to be met, hours that need to be worked, etc. with a clear discussion of capabilities and accommodations, and a full disclosure about medical appointments needed during work hours.

Interviews with SME employer groups showed that SMEs are often less prepared to cope with an employee being off work on long-term illness and have difficulties also with the reintegration process. Due to resource constraints they are often hugely impacted by a worker going on sick leave, even though they want to adhere to best practice. If they have employee continuance insurance this drives up premiums in the following year. As one interviewee noted when discussing an owner of an SME, "*He asked what was best practice and what were other firms doing and as the conversation progressed he became concerned about potential insurance liability of 'sick' people on his premises and how much it would cost". S*MEs generally do not have extensive HR expertise, especially in managing an employee who is absent due to ill health. There are also challenges when an SME employee returns to work, as they are often less likely to be able to agree to a phased return or redeployment to other work tasks.

Operational factors were also found to limit the extent to which employers could make reasonable adjustments through adjusting working hours and/or job content. For example, one of the organisations taking part in the focus groups was operating in manufacturing refractory products in a high risk setting due to high temperatures and a lot of electromagnetic activity. Examples were given of accommodations being made including moving toilet facilities to the ground floor for one employee, or moving an employee to lighter duties, office work or projects. In this context, the issue of GDPR emerged as a critical issue given the high risk site employees worked in. Given the high electromagnetic activity on the site, the organisation wanted to do a risk assessment for an individual if an issue such as stroke or heart disease emerged. This site had a full-time onsite nurse who worked closely with the employee before, during and after their return to work. However, with GDPR many employee sickness certificates have stated “sick” or “fit to return to work” with no detail on the nature of an illness. This practice has implications as not only is it putting the employees’ health at risk (if they return to work and the employer does not know of a specific impairment) but also that of their co-workers should a medical event happen on site. Medical practitioners view the information provided on an employee sickness certificate as a matter of patient confidentiality. In this instance, the role of their onsite nurse (who was the key liaison with the employee on sick leave) and an occupational therapist was identified as the most critical factor. The onsite nurse maintained regular contact with the employee and a high trust relationship was evident, thus allowing the organisation to get sufficient information on the illness to plan the successful reintegration of that staff member.

Interviews with unions and managers revealed a number of examples of public bodies providing reasonable accommodations to employees with chronic illnesses. The HSE published a recent update to their Rehabilitation of Employees Back to Work After Illness or Injury Policy & Procedure in order to bring it “*in line with international evidence-based best practice in the area of workplace rehabilitation”.* In some public sector organisations, disability liaison officers are responsible for supervising the provision of reasonable accommodations. However, in other organisations occupational health therapists are involved in this process.

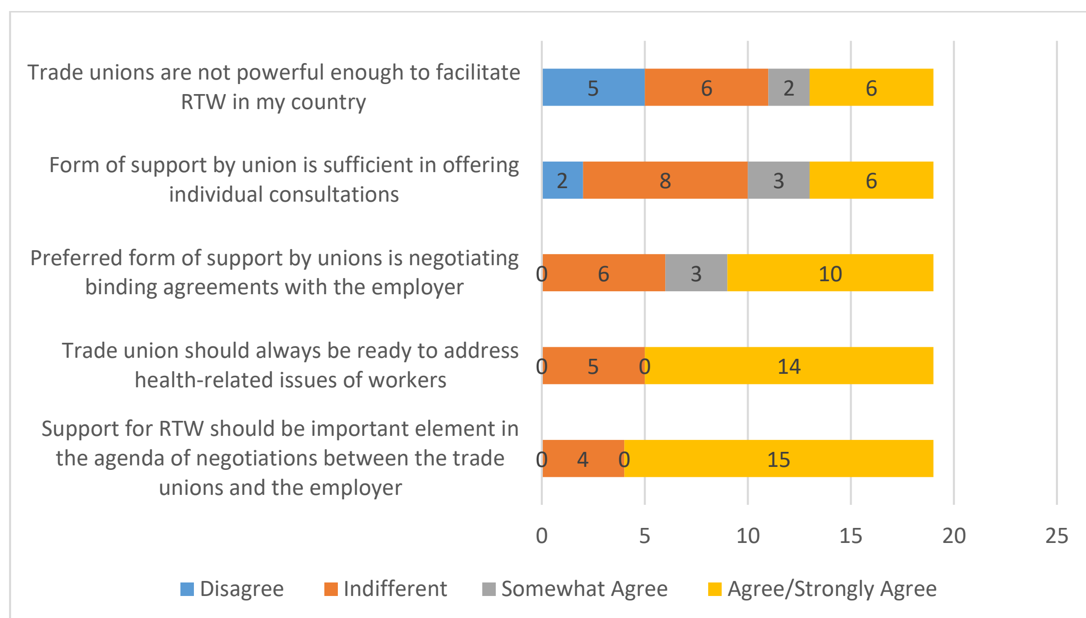
4.5 Views on future potential for social dialogue to support the creation and implementation of return to work policies at company level

All participants in this study believed creating cooperation between all the different stakeholders involved was critical to facilitate the implementation of RTW programmes. However, at company level there was a lack of consensus around the role of trade unions and return to work. Both the worker and manager surveys examined the role of trade unions in return to work. Respondents to the worker survey showed limited engagement by trade unions. Over 60% of respondents to the worker survey indicated they were not a union member, even though 57% indicated there was a union in their organisation. 89% stated they had not thought about joining a trade union since their diagnosis to support their return to work. Figure 9 outlines workers’ opinions on the role of unions in return to work. 78% agreed that support for return to work should be an important element in negotiations between trade unions and employers, followed closely by trade unions being ready to address health-related issues of workers.

Some of the managers in unionised companies indicated that there were no provisions in their collective agreements. A recent report by the European Agency for Safety and Health at Work (2016) claims that the implementation of collective agreements regulating the reintegration of workers following a sickness absence can be as effective as a national integrated framework for return to work. Some evidence of this can be found in the union interviews. All union officers related that employment with longstanding collective bargaining (CB) agreements in manufacturing and financial services still provided the best CB agreements covering illness and RTW elements. One example given was Baxter Healthcare. In 2018, an agreement was made to expand sick pay entitlement from full pay for up to

four weeks and 75% pay for the next eight weeks, minus social welfare payments, per incident year, to eight weeks at full pay and six weeks at 75% pay. One officer from the Services, Industrial, Professional and Technical Union (SIPTU) stressed that Baxter in pharma manufacturing could afford to pay extra sick pay and was willing to do so, but many Irish and smaller firms did not have the ability to pay. A Mandate officer related that outside of the big supermarket chains, "*many retail workers did not have any form of sick pay scheme and had to rely on State benefits*". In instances where there was a CB agreement but not specifically one relating to sick pay or return to work, union respondents reported that return to work became an "individual" issue. In such circumstances, union officers represented an employee with an HR manager and sought a personal agreement for the union member to have paid time off for treatment or return to work on lighter duties. As one SIPTU officer stated, "*When the CB agreement, if it exists at all, does not cover how to deal with employees with serious illness, we have to make individual without prejudice agreements with companies for individual union members that cannot be applied in other instances*". In this instance, the presence of collective agreements at workplace level means that the actors involved in the return to work process — employer, workers, HR and trade union representatives — reach a consensus as they are familiar with collaborating on issues related to wellbeing at work (European Agency for Safety and Health at Work, 2016).

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

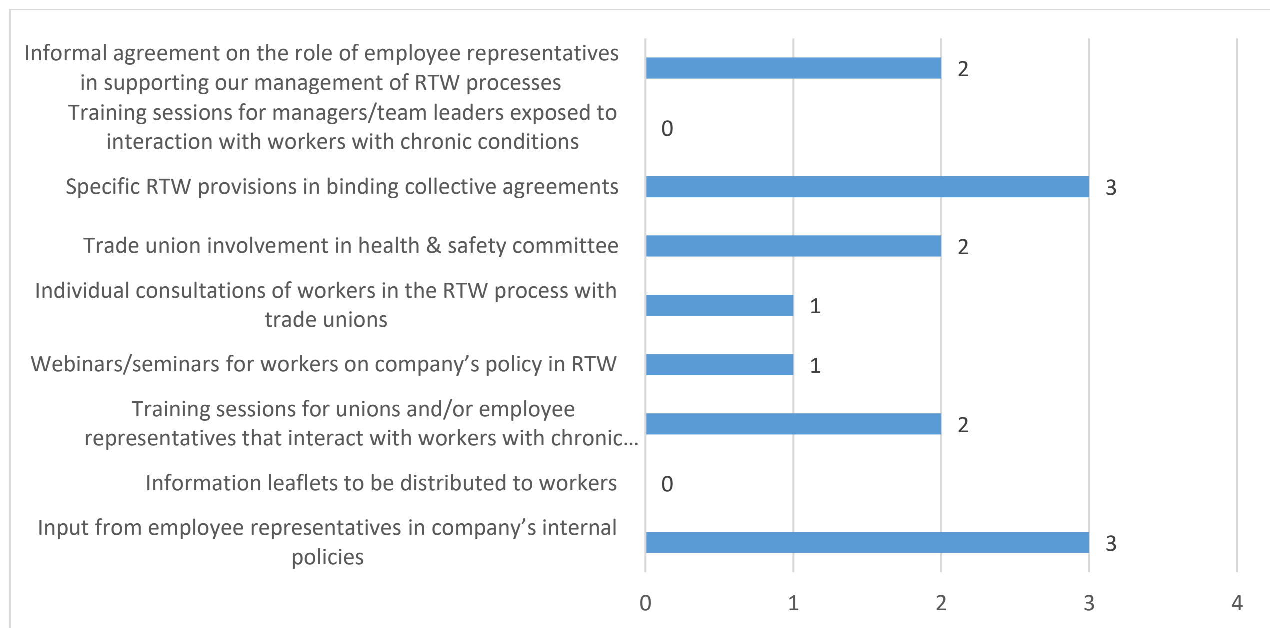


Source: REWIR worker survey. Own calculations. Number of respondents = 20

Looking at the company-level data, in examining attitudes to the role of trade unions in return to work, 54% of organisations indicated they had a trade union or some form of employee representation (see figure 10 below). Of those who were unionised, return to work was an issue that was addressed in company-level agreements in 42% of respondents. 57% indicated they did not consult with trade unions on RTW issues. 60% disagreed with the statement that they had regular interactions with trade unions regarding return to work. One third of respondents reported a union committee member being part of a committee addressing occupational health and safety (which was also responsible for dealing with RTW issues). Over half of respondents reported that cooperating with unions / employee representatives led to additional requests being attached to RTW stipulation. Beneficial outcomes

identified included binding collective agreements (43%) and input from employees into company internal policies (43%). Two of the managers in the focus group were from a unionised organisation. One was in manufacturing and the second was a global logistics company. Both agreed that shop stewards tended not to get involved in RTW issues unless they felt that agreed entitlements were not being given or a case was being mishandled or perceived to be processed unfairly.

Figure 10: Perceived beneficial outcomes from interactions with unions / employer representatives on return to work

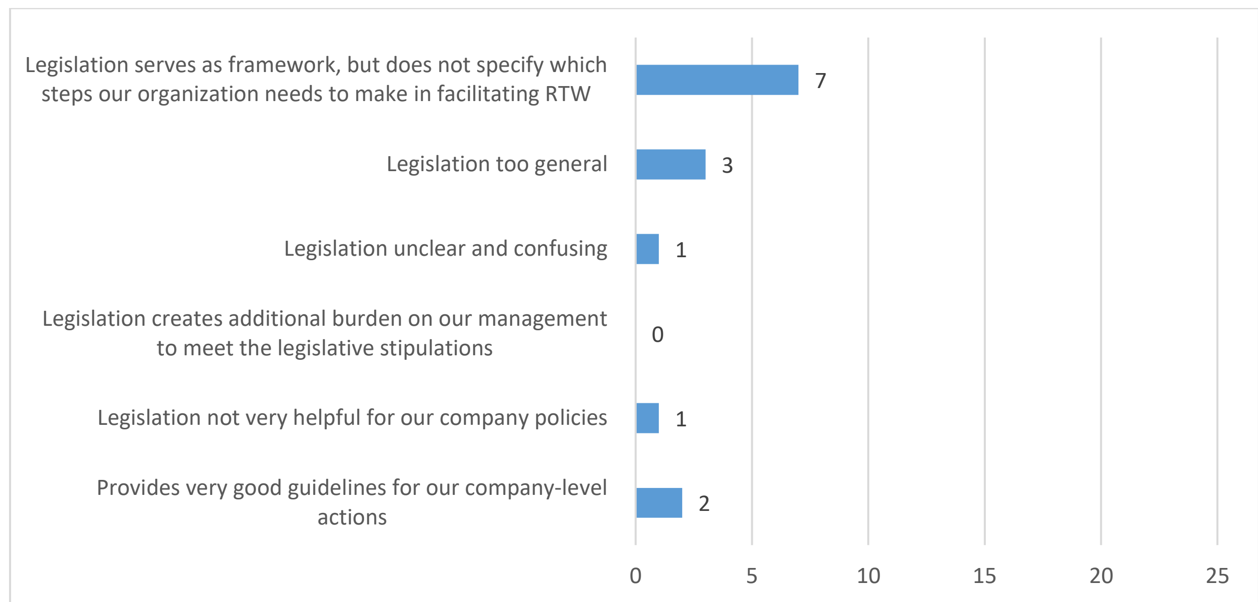


Source: REWIR manager survey. Own calculations. Number of respondents = 12

In both the manager focus groups and REWIR manager survey there appeared to be a consensus that the current Irish legislation was sufficient. For example, a quote from the manager survey stated, "*We have a very successful RTW practice which is very employee centric. Current legislation is also very adequate in preserving workers' rights in this area and in fact places a big burden on organisations which may not have the same resources as ours to manage such a difficult situation".* However, the lack of specificity in the steps in return to work was highlighted as an issue. For example, a comment in the REWIR manager survey states, "*It would be helpful to look at this from an employer perspective and develop an innovative set of provisions that can allow employers to more easily manage long-term illness cover for their organisation and bring some more certainty in supports and plans for their business while still retaining adequate supports to employees. A big ask, I know".*

Interviews with employer associations also stated that legislation was adequate and helped provide clarity. They stated that recent case law supported the view that "*reasonable accommodation"* was broadly defined and gave strong protections to employees. It went beyond accommodations in terms of equipment for example, but also focused on hours of work or the work itself. In their words, it "*puts it up to employers to confirm medically that it is not a discriminatory dismissal… prevents employers from moving too quickly in ending employment".* In their opinion, it is not new legislation that is needed but increased employer awareness of reasonable accommodation and understanding about what it means.

Figure 11: Perceived support offered by legislation to organisations in managing return to work after chronic illness



Source: REWIR manager survey. Own calculations. Number of respondents = 12

5 Discussion and conclusions

This section summarises the main findings from this study and proposes a number of key recommendations. From the research, it appears that the majority of stakeholders concur in seeing return to work as a critical issue. Early intervention, timely and proactive use of organisational procedures, communication between key stakeholders and multidisciplinary coordination across government departments/agencies and at workplace level emerged as being the most important factors in managing return to work after chronic illness. The main findings are outlined below.

5.1 Return to work framework at national level

At a national level in Ireland there is no systematic support framework guiding the reintegration of employees with chronic illness back into the workplace. This is due to Ireland traditionally taking a voluntarist and decentralised approach to regulating employment terms and conditions. Our findings suggest no coordinated approach and limited institutional support for the return to work of workers in sickness absence. Instead there are a number of important, relevant ad hoc initiatives from government and other state bodies, trade unions, employer associations and patient groups/NGOs. Unlike in other countries, the welfare approach adopted in Ireland applies passive measures to social protection, mainly through income replacement through benefit payments. Employees have no statutory right to an occupational sick pay scheme. The decision whether to provide sick pay is at the discretion of employers under current legislation. As a result, the current system operates on an ad hoc basis and, consequently, some people are well provided for while others are not. Those worst affected tend to be on lower incomes and in certain essential sectors such as childcare and meat processing. The question of who is responsible for providing compensation to sick workers plays an important role in who holds (or takes) the responsibility for rehabilitation and return to work. In Ireland that is not fully clear.

The evidence gathered for this report suggests that chronic illness is an important issue at national level. Numerous reports have been commissioned examining chronic illness across a number of government departments. It does seem that supporting people with chronic illness in Ireland is focused on the preventative and medical care aspects rather than on RTW mechanisms. Where chronic illness is captured in a work context, it typically tends to come under the umbrella of disability. The *Comprehensive Employment Strategy for People with Disabilities 2015-2024* (CES) is one strategy document outlining the importance of retaining workers with disabilities/chronic illness. However, the recent NDA report on CES progress laments lack of progress on this particular strategic priority. There is still no evidence of a comprehensive coordinated framework of employment and job retention at a national level. Where coordination does take place, it focuses on getting unemployed disabled people into employment via initiatives such as EmployAbility, managed by the Department of Social Protection. The recent work of McAnaney and Wynne (2017) highlights this as a significant gap in government policy, whereby people are required to be unemployed/inactive before they can avail of vocational rehabilitation support. See Table A.2 in Appendix. Research has highlighted the importance of timely intervention in supporting workers back to work successfully. Lund (2008) found that the longer the duration of absence due to illness, the greater the future risk of receiving disability pension and permanent exclusion from the labour market.

Non-traditional industrial relations actors, especially individual patient groups and NGOs, play an important role in the development of RTW policies and guidelines. They have their own distinct focus on a singular chronic illness and therefore have different needs and priorities. The strength of patient groups and NGOs is their knowledge of the needs of workers with specific health problems. However, they face barriers due to lack of access to resources, most through voluntary donations or in some cases funded by the Department of Health. This has been critical in their individual ability to provide services and advocate on behalf of their own patient cohort. The concept of workplace wellbeing and good mental health appears to be the one issue that has the gained the most traction with social partners in recent times. IBEC have developed actions to persuade companies to embrace corporate wellbeing polices and introduced *The Keepwell Mark* accreditation scheme for employers, which has been supported by the government.

5.2 Role of social partners in return to work

Overall, Irish social partners reported strong awareness of the importance of return to work, but due to the decline in national-level social partnership there is very little evidence of social partner involvement in shaping RTW policy at the national level. In the public sector there was evidence of negotiation with unions on the Public Service Sick Leave Scheme, which was introduced in March 2014 in the majority of sectors in the Public Service and Education Sector. Integrating people with chronic illness back into work requires active cooperation between the government and other public authorities and the social partners. Whilst we found evidence of social dialogue, it was ad hoc and fragmented and often short term due to lack of funding. Findings from this study show that it is at the company level that RTW procedures are developed. However, at the company level, there was limited evidence of trade union involvement in RTW policy implementation.

At the company level, attention to the different phases in the RTW process (i.e. while the employee is off work, when the employee returns back to work, and once back at work during the phase of sustainability of work ability) emerged as a critical factor in return to work. In terms of successful return to work, the following practices were critical: (1) clear RTW policy; (2) initial contact with the worker; (3) evaluation of the worker and job tasks; (4) development of an RTW plan with accommodations; (5) work resumption; and (6) follow-up of the RTW process. At company level, return to work was predominantly managed within an organisation's absence management policy, owing to a lack of a national framework. RTW policy is perceived, in the literature reviewed, as being an important part of the employee's rehabilitative process (Higgins, O'Halloran and Porter, 2012).

However, this management of sickness within what could be seen as a punitive policy has been critiqued in the literature. Taylor et al. (2010) for example argue that this shift in sickness absence management must be seen against the background of decades of neoliberalism "which has unambiguously strengthened managerial prerogative". The issue around sickness certification emerged in a number of discussions with managers and employer representatives. In Ireland, a sick cert is required to certify that the individual is ill. A study by King et al. (2016) found that Irish GPs reported significant difficulties in relation to sickness certification. Many felt that sickness certification impacted adversely on the therapeutic relationship. Over half of respondents in their study indicated a preference for introducing a fit to work note as they felt the current sick certification system had an excessive focus on disability. In their view, a key strength of the fit note was its shift away from disability towards empowering sick patients to return to work. However, a limitation of fit to work notes includes a lack of training and knowledge among GPs in occupational health matters, which may result in employees returning to work too early or without adequate accommodations.

5.3 Barriers and facilitators to return to work

A number of key barriers and facilitators relating to return to work emerged from the surveys and focus groups at company level. The Irish benefits system as a whole was seen as a complex system to navigate, especially when also dealing with a chronic illness. At different points in the process, workers must engage with multiple government departments and bodies, many of whom do not coordinate with each other. Having a clearly signposted policy around return to work was critical for work re-entry and adjustment back into work. Effective RTW procedures require a high level of workplace coordination and communication, as well as coordination with external services including medical services, rehabilitation providers, etc. Interactions with HR and the line manager in particular emerged as important in return to work. Beatty and Joffe (2006) report that having an understanding and supportive supervisor is the most significant factor contributing to successful work experience. Return to work coordination requires an understanding of both the worker with an illness and the work environment. When discussing reasonable accommodations, we found that organisations needed to effectively communicate their policies and procedures on absence management and reasonable accommodations so that all employees understand them and navigate the process effectively. Organisations also needed a process for regularly reviewing reasonable accommodations as the employee's needs, their environment or their work duties changed. These challenges of navigating benefits, communicating between stakeholders and negotiating accommodations before return to work were identified by Hoefsmit et al. (2013) as bottlenecks that can hamper return to work. Finally, the needs of workers and their individual illnesses are important. A key finding is that there is no one-size-fits-all formula for workers returning to work after a chronic illness. The needs of cancer patients are very different to those of stroke survivors. Brannigan et al. (2017) stress that education is necessary in the workplace to ensure that employers and co-workers are aware of the impairments, activity limitations and participation restrictions of the workers returning to work. Furthermore, there is a need for flexibility and creativity to adequately support and encourage return to work.

5.4 Recommendations

We outline below a number of key recommendations within this research.

- Introduce legislation to make **sick pay an employment right** for all workers in Ireland. This will bring Ireland in line with European norms and align it with the European pillar of social rights to ensure workers have adequate and sustainable social protection where "all workers, regardless of contract type, shall be ensured adequately paid sick leave during periods of sickness" (European Commission, 2016).
- To support the principal that "effective reintegration and rehabilitation for a quick return to work shall be encouraged" (European Commission, 2016) the Irish national system needs to be

underpinned by **proper, coordinated, easy to navigate rehabilitation measures**. There is a need for a national framework and establishment of RTW schemes with a particular focus on vocational rehabilitation to replace the current fragmented workplace-centred schemes. To do this the government needs to engage all actors in creating more responsive services.

- Establish **an inter-departmental government group to investigate RTW policies** similar to *The Interdepartmental Group on Fuller Working Lives*, chaired by the Department of Public Expenditure and Reform, which was established in January 2016. The aim of the group will be to get input from all relevant government departments, in order to examine the implications in both the public and private sectors; to arrange for engagement with key stakeholders as part of this examination; and to make recommendations to government on the creation of a set of policies aimed at supporting a national integrated framework/scheme on return to work after long-term illness beyond just a focus on those who are unemployed.
- A key outcome of this group should be that its members work together to develop an effective coordinated policy approach to returning to work with a chronic illness, and to draw up a **clear implementation plan** based on that approach that provides a continuum of closely aligned services, so that from the perspective of the individual it is a seamless system. This requires the development of interdepartmental protocols at national and local level.
- There is a need to integrate into any national framework/scheme the work and experiences of **NGOs/charities/support groups**, be they Section 38 or Section 39 organisations,[15] and occupational healthcare professionals and their organisations. This is currently done in an ad hoc manner. Their voice needs to be captured in a more meaningful way at a national level.
- A **national social dialogue between ICTU and IBEC** should commence on creating a national common approach to return to work after long-term illnesses that would best reflect the interests of employers and employees. The work of creating and sustaining RTW policies should be a priority at workplace level between unions and employers.
- The Chartered Institute of Personnel and Development (CIPD) as the national recognised body for HR professionals should be encouraged to develop best practice approaches on RTW polices for its members, in order to promote the importance of RTW policies and reasonable accommodation. This should include guidance on line manager trainer on RTW.
- The identification of best practice champions for return to work should be used as examples in any national communications strategy.

[15] The HSE has arrangements with other organisations to manage and deliver health and personal social services. Annually the HSE provides funding for the delivery of a range of services to agencies (known as Section 38 agencies) and organisations. Section 38 arrangements involve organisations that are funded to provide a defined level of service on behalf of the HSE, while under Section 39 the HSE grant aids a wide range of organisations to a greater or lesser extent.

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Appendix 1

Appendix 1 provides an overview of the main **sources of data** presented in this report. These are:

- REWIR workers' survey (Ireland)
- REWIR managers' survey (Ireland)
- REWIR social partners' survey (Ireland)
- Interviews with relevant national stakeholders
- Roundtable discussion with key stakeholders
- Group discussions with (a) employers and (b) trade unions

REWIR workers' survey (Ireland)

A web-based survey among individual workers was used to collect evidence on the perceptions of individual workers returning to work after long-term illness. Table 1 provides details on the demographic characteristics of the sample.

Table 1: Overview of sample and respondent identification – REWIR workers' survey for Ireland

Workers' survey – structure of responses	Responses
Gender (Q1)	
Male	13
Female	18
Mean age in years (Q3)	47
Mean length of working life in years (Q4)	26
Level of education (Q2)	
Low qualified (up to lower secondary)	0
Middle qualified (up to post-secondary vocational)	8
Highly qualified (up to university education)	21
Type of organisation where the respondent worked prior to diagnosis/treatment (Q14a 14b+Q32a 32b)	
Domestic	17
Foreign owned	8
Don't know	4
Private sector	1
Public sector	12
Trade union membership (Q9+Q27)	
Yes	12
No	17
Trade union presence at the workplace (Q11+Q29)	
Yes	17
No	12
Type of job (Q16+Q34)	
Intellectual	23
Manual	6
Indoor	11

Outdoor	1
Intensive physical activity	7
Intensive emotional stress	3
Company size (Q13+Q31)	
Below 20	3
20 – 50	1
50 – 500	11
500 – 1,000	5
Above 1,000	9
Currently on sick leave (Q17)	
Yes	3
No	0
Three most frequently reported diseases (Q7+Q25)	
1. Other	8
2. Cancer	7
3. More answers	4

The respondents to the survey were from a number of different occupations. The highest number of responses were within teaching professions (4), other (4), health (3), building/construction (3) and ICT professional (2). The remaining responses were spread across a broad number of occupational categories including sales, legal and administrative roles.

REWIR Social partners' survey (Ireland)

This online survey sought to uncover the approaches to and experiences of employers' associations and trade unions in shaping and implementing EU-level and country-specific policies aiming to facilitate return to work. Table 2 highlights the responses from Irish social partners.

Table 2: Social partners' survey data structure for Ireland collected within the REWIR project

Structure of responses	**Responses**
Type of organisation (Q2)	
Employers' associations	
Trade unions	1
Other	
Level of social dialogue engagement (Q4)	
National	1
Sub-national (territorial)	
Sectoral	
All three	
Other	
Three most commonly reported sectors represented (Q5)	
1.	
2.	
3.	

REWIR managers' survey (Ireland)

Table 3 below provides an overview of the structural characteristics of the workplaces that participated in the REWIR managers' survey (Ireland).

Table 3: Company survey data structure for Ireland collected within the REWIR project

Structure of responses	Responses
Ownership type (Q4)	
Domestic	11
Foreign	8
Company size (Q2)	
0-9	1
10-49	3
50-249	5
Above 250	10
Predominant type of workers (Q7)	
1. Administrative workers / office clerical	7
2. Highly skilled specialists	3
3. Medium and high-skilled manual workers	3
Three most commonly reported economic sectors represented (Q6)	
1. Education, research	3
2. Financial services	2
3. Professional, scientific and technical activities	2
Presence of trade union or other form of workers' representation (Q22)	
Yes	7
No	5

Roundtable discussion with key stakeholders

A roundtable discussion took place on 27 June which was facilitated by the project researchers (Ireland). Table 4 provides a summary of stakeholders involved.

Table 4: Summary of stakeholders involved in roundtable discussion

Stakeholder category	Number
Patient organisation representative	2
Trade union representative	2
Employer association representative	2

Interviews with relevant national stakeholders

Interviews were undertaken with key stakeholders such as government representatives, patients' organisations, NGOs and charities who participate in shaping RTW policies. Table 5 below provides a summary of the number of national stakeholder interviews conducted in early to mid-2020. It also details the stakeholder group they belong to.

Table 5: Summary of stakeholders involved in national interviews

Stakeholder category	Number
Patient organisation representative/NGO	10
Employer association representative	3
Trade unions	2
Civil servant involved in RTW policy	2
Occupational health physician/therapist	3
Vocational assessment service	1
Consultant – return to work	1
Academic/physician with expertise in RTW. Royal College of Surgeons	1

Stakeholder group discussions with (a) employers and (b) trade unions

Two focus groups were conducted as part of this study with (1) employers and (2) trade unions. The aim of these discussions was to identify topics relevant to employers and unions in maintaining employment through RTW policies, including best practice.

Table 6: Summary of stakeholders involved in focus groups (employer and trade union)

Employer focus groups	Number
Senior HR Business Partner (Logistics company)	1
Manager (ICT company)	1
HR Generalist (Manufacturing company)	1
Manager (Food production)	1
Employment assistance officer (Civil service)	1
Trade union focus groups	**Number**
National trade union representative	11

Appendix 2

The main components of vocational rehabilitation in Ireland are presented in Table A.2 below. McAnaney and Wynne's (2017) review identified a number of gaps in Irish occupational and vocational rehabilitation (VR) services compared to other countries.[16] These are:

- **People required to be unemployed/inactive before they can avail of vocational rehabilitation**
  The majority of employment-related services with regard to vocational rehabilitation related to those who are not currently employed.

- **No systematic access to functional capacity evaluation, psychological support or physical functional capacity building**
  Access to functional capacity evaluation, psychological support or physical/functional capacity building as part of a rehabilitation plan has been shown to be important. In Ireland, there are no provisions for access to these functions.

- **No systematic structured pathways to timely vocational rehabilitation**
  When it comes to vocational rehabilitation, the Irish social system is mostly passive. There is no systematically structured approach to ensure that people access VR in a timely manner. Nor are there formal links between the health system and the limited VR-type services available to employed workers.

- **No formal definition of or policy on vocational rehabilitation and no legal basis for current Irish VR activities**
  Unlike other jurisdictions, there is no basis for the current Irish system of VR. Another sign of the lack of a formal system is that no formal definition of VR exists in government policy or any department websites.

- **Divided departmental responsibilities between the Department of Social Protection and the Department of Education and Skills – no joined-up system**

- **No case management system to coordinate different support from different providers**
  Within the Irish VC system there is no formal support (case management) available in the wider system to coordinate interventions and support from different providers and social protection plan and a key worker within a specific service.

[16] They acknowledge that some of these services are available to certain employees (e.g. the HSE), or where private sector employers have an insurance scheme that offers this facility.

Table A.2. VR elements available in Ireland and 12 other jurisdictions

	Components	**NL**	**DE**	**PT**	**FR**	**ES**	**DK**	**LT**	**NO**	**SI**	**FI**	**QLD**	**NZ**	**IRL**	**Unemployed**	**Employed**
Assessment & Evaluation	Vocational assessment	●	●	●	●	●	●	●	●	●	●	●	●	EmployAbility	●	
	Functional capacity evaluation	●	●	●	●	●	●	●	●	●	●	●	●			
	Job/Person matching	●	●	●	●	●	●	●	●	●	●	●	●	EmployAbility/ Employer Based Training	●	
	Work sampling or on the job assessment	●	●	●	●		●		●	●	●	●	●	EmployAbility/ Employer Based Training/FET STP		
Advice & Guidance	Information & Advice about Vocational rehab	●	●	●	●	●	●	●	●	●	●	●	●	Citizen information/Intreo	●	●
	Guidance and counselling	●	●	●	●	●	●	●	●	●	●	●	●	Intreo/HSE Employment Guidance	●	
Vocational Education & Training	Specialised Vocational Education/ Training	●	●	●	●	●	●	●	●	●	●	●	●	ETB	●	
	Pre Vocational training	●	●	●	●		●	●	●	●	●	●	●	FET STP	●	
Health & Wellbeing Support	Psychological supports	●	●	●	●	●	●	●	●	●	●	●	●			
	Physical/ Functional capacity building	●	●	●	●		●	●	●	●	●	●	●			

On the Job Support	Job Coaching	●	●	●	●	●	●	●	●	●	●	●	●	EmployAbility	●	
	Supported Employment	●	●	●	●	●	●		●	●	●	●	●	EmployAbility	●	
	Job search and placement services	●	●	●	●	●	●	●	●	●	●	●	●	EmployAbility/ Employer Based Training/ FET STP	●	
Adaptations & Technologies	Workplace Adaptations	●	●	●	●	●	●		●	●	●	●	●	DSP	●	
	Assistive Technology	●	●		●	●	●		●	●	●	●	●	DSP	●	
	Reasonable Accommodation	●	●		●	●	●		●		●		●	DSP	●	●
Service Coordination	Case management	●	●	●			●	●		●	●	●	●			
Alternative Employment Options	Social Enterprise	●	●	●	●	●	●		●	●	●	●	●	DSP	●	
	Sheltered Employment	●	●	●	●	●	●		●	●	●	●	●	HSE/DSP	●	
Other supports	Access to adapted transport	●	●		●	●	●		●	●	●	●	●			●

NL = the Netherlands; DE = Germany; PT = Portugal; FR = France; ES = Spain; DK = Denmark; LT = Lithuania; NO = Norway; SI = Slovenia, FI = Finland, QLD = Queensland; NZ = New Zealand.

Source: McAnaney, D., and R. Wynne (2017), *International good practice in vocational rehabilitation: lessons for Ireland*, Dublin, Ireland: National Disability Authority (pg. 57).