Chapter 3
Why do individualised industrial relations mean the underutilisation of policy tools? Workers who fall ill in Estonia

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1. Introduction

Estonia is a small, post-socialist country with a population of 1.3 million. People have a longer working life than in most other European countries: the duration of working life in Estonia in 2019 was 39 years compared to an EU-28 average of 36.4.[1] Moreover, the number of employed people aged 15-74 has been increasing over time, from 568 000 in 2010 to 671 000 in 2019 (an increase of 18 per cent),[2] despite the population staying relatively stable.[3] While the share of those aged 65-74 in the total population has remained roughly the same, at 10 per cent,[4] the share of 'elderly workers' between these ages has increased from 15 per cent to 27 per cent. The unemployment rate in Estonia has also been relatively low, at 5 per cent or below between 2015 and 2019.

Longer working life comes from the increased employment of elderly people who also are likely to suffer from chronic conditions. In 2016, the self-rated health condition of the Estonian population was relatively poor in general, with health being assessed as good or very good by 53 per cent of the population compared to an average of 68 per cent across the EU-28 (OECD and European Commission 2018). In relation, the number of expected healthy years in 2018 in Estonia was notably lower than in the EU on average, meaning that a relatively high share of elderly employees had some kind of health problem. The chronic morbidity rate in Estonia significantly exceeds that of the EU average at around 50 per cent in Estonia in 2018 compared to lower than 40 per cent in the EU. All these imply that more people of working age are likely to face health problems during their career, making the return to work – or reintegration – a relevant issue in Estonia. Additionally the relatively low unemployment rate implies that companies have a strong interest in hiring or retaining people including those with reduced work capability arising from health conditions.

Despite the relatively poor condition of health, the number of days per year and per person compensated because of absence from work due to illness was, between 2000 and 2018, lower on average in Estonia than in the OECD, fluctuating between 7.3 and 11.3 days in the former but averaging 12 days in the latter.[5] Public spending on incapacity, which refers to spending due to sickness, disability and occupational injury,

1. Eurostat. Table LFSI_DWL_A. Duration of working life - annual data.
2. Statistics Estonia. Table TT0202. Employed persons by age group and economic activity (1989-2019).
3. Statistics Estonia. Table RV021. Population by sex and age group, 1 January.
4. Statistics Estonia. Table RV021. Population by sex and age group, 1 January.
5. OECD.Stat. Health Status: absence from work due to illness, https://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#.

was around 2 per cent (close to the OECD average) between 2010 and 2017.[6] People not taking more days off work, even if they need to, is likely to be a sign of workers' weak labour market position.

Estonia has a poorly developed framework for the return to work with very limited (or a lack of) coordination between stakeholders and a restricted amount of institutional support but with ad hoc initiatives implemented by various actors. In this chapter we demonstrate that the return to work in Estonia is best understood as an integrated policy field that comprises measures in several areas including medical, labour market, social welfare and rehabilitation services. In terms of policy provision, there is greater visibility of the healthcare dimension. Although a reasonably solid institutional support system has been developed in respect of measures to ease labour market integration and specifically the return to work, employers and employees do not seem to have enough information about this and thus no faith that such support would actually exist in practice. Based on our analysis this seems to translate into rather meagre workplace level provision when it comes to return to work arrangements and, at least in part, this owes to an unsupportive organisational culture and a lack of organisation-level trade union activity.

The discussion in this chapter is based on desktop research of relevant documents such as legislative acts, research reports, policy plans and reports, and the mass media. Empirical fieldwork was also conducted based on interviews and roundtable discussions held with relevant national stakeholders, group discussions with employers and trade unions and three online surveys distributed to social partners, workers and company managers in Estonia.[7]

The chapter is structured as follows: in the next section, we introduce the policy framework on the return to work before exploring more closely the involvement of the social partners in shaping return to work policy at national level, thereafter discussing the issue at company level. The last section provides concluding remarks.

2. Policy framework for the return to work in Estonia

In Estonia, public policy discussions and issues surrounding the return to work following chronic illness fall mainly into the area of regulating and supporting the employment and economic activity of people with a work capability lower than 100 per cent. Such a condition may be temporary or permanent and it may be induced by work-related circumstances although not necessarily so. In general there are three reasons for reduced work capability:

— disability, which a person has been living with since before the start of that person's working life, probably but not necessarily since birth;

6. OECD. Public spending on incapacity, https://data.oecd.org/socialexp/public-spending-on-incapacity.htm.
7. For a more in-depth overview, see the Estonia country report by Taru and Roosalu (2021).

— occupational illness which has led to a temporary or permanent condition of reduced work capability; and
— occupational injury which has led to a temporary or permanent condition of reduced work capability.

Return to work is supported by a mix of several sectoral policies: healthcare; employment relationships; active labour market policies; social welfare; and social care policies. The main legal acts that frame employment, illness, sickness leave and the return to work after treatment include the Employment Contracts Act,[8] the Health Insurance Act,[9] the Work Ability Allowance Act[10] and the Occupational Health and Safety Act.[11] In addition a range of other legislative acts regulate various aspects of employment contracts.[12] Meanwhile, there are two national-level policy documents that address chronic diseases and their prevention:

— the Disease Prevention Development Plan 2016-19 (from the Estonian Health Insurance Fund); and
— the National Health Development Plan 2020-30 (Ministry of Social Affairs, now in the process of development), listing chronic diseases as a separate category within the wider disease prevention plan.

The legislative act that regulates employment when an employee falls ill or is injured is the Employment Contracts Act. This allows an employer to terminate an employment contract extraordinarily where the employee has not been able to perform the duties of the job, due to his or her state of health, for more than four months (para. 88). However, before the termination of the employment contract, in particular on the basis of a health condition, the employer must offer other work to the employee. This includes organising, if necessary, in-service training, adapting the workplace or changing the employee's working conditions where such changes do not incur disproportionately high costs for the employer and where the offer of other work may, considering the circumstances, be reasonably expected.

The Health Insurance Act defines the categories of insured persons. All employed and self-employed people are covered by insurance. The Work Ability Allowance Act defines the access to employment of people with reduced work capability caused by long-term health damage and ensures an income for them under the conditions and to the extent provided by law. The Occupational Health and Safety Act frames the area of occupational health and defines the role of medical professionals such as occupational health doctors, occupational health nurses and other medical professionals which are relevant actors in the return to work context.

8. Employment Contracts Act, https://www.riigiteataja.ee/en/eli/ee/Riigikogu/act/529122020003/consolide. State Gazette 2009, 5, 35.
9. Health Insurance Act, https://www.riigiteataja.ee/en/eli/ee/504062020003/consolide/current, State Gazette 19.06.2002, 62, 377.
10. Work Ability Allowance Act, https://www.riigiteataja.ee/en/eli/530042020009/consolide State Gazette 13.12.2014, 1.
11. Occupational Health and Safety Act, https://www.riigiteataja.ee/en/eli/ee/527052014007/consolide/current. State Gazette, 1999, 60, 616.
12. Labour inspectorate homepage, https://www.ti.ee/et/tookeskkond-toosuhted/oigusaktid-viited.

In 2016, the work ability reform[13] was launched bringing together all labour market participation and employment-related services and transfers under one institution – *Eesti Töötukassa* (the Estonian Unemployment Insurance Fund; ET). Since mid-2016, work capability has also been assessed by the ET. The reform was rooted in the excessive financial burden on the public budget arising from state-paid pensions to disabled persons and to people with permanent partial or full loss of work capability, as well as in the finding that a considerable percentage of those with a medical condition did not benefit from state support. An audit carried out by the National Audit Office of Estonia in 2010 showed that the number of the disabled and reduced capacity pensions had been increasing since 2004, rising to over 200 000 by 2010 (Uder 2010) in a country of 568 000 economically active people.

Expenditure on disability had been increasing at a relatively high pace, from €56 million in 2000 to €279 million by 2010. This was a nearly five-fold increase and a disproportionally high one as two other large areas of social benefits had increased less: expenditure on old age pensions had increased 2.5 times and that on healthcare by a factor of three. Expenditure on disability had reached 12 per cent of all social benefit expenditure by 2013, a doubling of the 6.6 per cent which was the case in 2000.[14] This was alarming and commanded policy-makers' attention.

Veldre *et al.* (2012) established that the Estonian regulations and policies meant to support people with reduced work capability due to medical condition were comparatively inefficient and needed significant amendment. The main problem was that the focus until then had been on health loss instead of a person's capacity for work. Furthermore the assessment of work capacity needed to be prospective and to include recommendations of appropriate support measures that would help the person get back into the labour market. Essentially, this meant a transition from the previous system, in which a person with a loss of health was seen as a passive beneficiary of state aid, to one in which a person with reduced work capacity, as well as that person's employer, were seen as active agents supported by state services. Additionally the assessment of health condition, work capability, employment opportunities and support measures was regarded as in need of better coordination with each other in order to be effective; hence the aim of co-locating all these services in one institution instead of several as had been the situation until then. Preparation of the reform took several years but, in 2016, it was ready to be launched.

As the key institution in the landscape of labour and health, ET implements significant aspects of labour market policy in Estonia. It offers a range of measures to employees who need support at the workplace because of their health condition as well as to employers on health-related issues. As a public institution, the ET board consists of six members: according to the law, two members are named by the national government, two by the national employer organisation and one each by the two national-level trade

13. For more on the work ability reforms see the homepage of the Estonian Unemployment Insurance Fund, https://www.tootukassa.ee/eng/content/work-ability-reforms; and that of the Ministry of Social Affairs, https://www.sm.ee/en/new-working-ability-support-system.

14. Statistics Estonia, table SKK02: Expenditure on Social Benefits by Indicator, Function and Year.

union confederations. The tripartite nature of this body means that the issues that ET regulates (including those related to the return to work) are the object of national-level social dialogue.

At establishment level, health and workplace-related issues are addressed by *töökeskkonna volinik* (working environment commissioners). By law, every organisation with more than 150 employees (and in others if the labour inspectorate so requires) should establish a working environment committee with the responsibility of ensuring occupational health and safety. Such a council needs to consist of representatives of management as well as those of employees. The working environment commissioners elected by employees have a responsibility for all occupational health and safety issues. Such mandatory committees are meant to foster social dialogue and are legally comprehended on the basis of an understanding that trade unions are not present in every organisation.

Occupational health and safety is thus one of the rare themes on which the state has made social dialogue compulsory. This does not mean that it works very well across all organisations and frequently it is the illusion of industrial relations which has been created under this framework rather than actual social dialogue (see also Ost (2000) on the emergence of illusionary corporatism in central and eastern Europe). The election of mandatory representatives creates an image of worker representation but, where there are no trade unions, the infrastructure for those representatives to engage meaningfully with workers to establish common grounds for what to negotiate with the employer is lacking. Thus every elected representative approaches the role foreseen by the law as they please – and, in the case that they are too busy with other tasks, the return to work may be not among their priorities; while, if their role is less valued by workers than by the management, this further decreases their chances of being efficient either bargaining or in consultation (see Kallaste *et al.* 2007).

While company-level dialogue is not always efficient, the legal regulations set down quite decent conditions for employees to apply for workplace adaptations. Yet there are still no specific measures on the return to work for workers with chronic illness. Additionally, with the exception of tuberculosis, there are no specific provisions for different kinds of diseases. In general, when an employed person falls ill and needs to be away from work, a doctor will issue a certificate for sickness leave to validate it. Based on this certificate, the employer and *Eesti Haigekassa* (the Estonian Health Insurance Fund; EH) pay benefits for temporary incapacity for work, commencing on the ninth day of illness. Sickness benefit is paid at a rate of 70 per cent of daily income and is subject to income tax. Although sickness benefit is paid for 182 consecutive days (240 days in the case of tuberculosis), employment protection lasts for only four months. It is possible that better terms may be agreed upon at company level, but most sectors do not have any provisions of this kind in sector-level collective agreements.

Thus we can conclude that there is no legal obligation to hire or retain workers with chronic illnesses. ET, with its national-level tripartite social dialogue and its offer of both benefits and services to employers and employees in general, does support hiring people with reduced work capacity which may encompass those with chronic illnesses.

At organisational level, the law foresees a position to be responsible for addressing health- and workplace-related issues – the working environment commissioner. However, low trade union density and the priorities of employee representatives around fundamental issues of membership growth and improved legitimacy (Kall 2020) mean that return to work issues occupy a rather lower level of priority.

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

In terms of its industrial relations structure, Estonia belongs to the neoliberal industrial relations system common to central and eastern European countries (EU OSHA 2016; Akgüç *et al.* 2019). Industrial relations are mostly developed at national level and much less so at the sectoral or company level (Kall 2020) while only a small fraction of workers are trade union members: Estonia has the lowest union density rates in Europe, declining from 94 per cent in 1992 to 4 per cent in 2017 (Visser 2019). Collective bargaining coverage, at about 20 per cent, is significantly lower than the OECD average and far lower than in those countries which have the highest coverage.

Negotiations on the minimum wage, the main issue in social dialogue in Estonia, are held by *Eesti Ametiühingute Keskliit* (the Estonian Trade Union Confederation; EAKL) and *Eesti Tööandjate Keskliit* (the Estonian Employers' Confederation, ETK). EAKL has 17 sectoral trade unions as its members; while, as of 1 November 2020, ETK has 23 sectoral employer organisations and 127 individual companies as members, from all economic sectors.[15] ETK is actively involved in public policy processes including those which fall within the remit of ET and EH.

Our research highlights that the return to work in Estonia is best understood as an integrated policy field comprising measures in a range of areas including medical, labour market, social welfare and rehabilitation services. Being such a fairly complex field, public policies related to the return to work are, however, perceived differently by the various stakeholders.

A representative of the Estonian Chamber of Commerce and Industry perceives the return to work as belonging to the domain of workforce diversity, acknowledging that a considerable part of employees either have a medical condition or other reasons why they can work only under restricted conditions and who may need support to be able to work; and that helping people with reduced work ability find a job suits them and benefits the employer. A trade union representative thinks of return to work as an additional area of social security for workers which could potentially contribute to their (material) well-being. However, such thought processes are couched in financial terms – how much it would cost employers and the state to institute another form of insurance and what it would mean in terms of new taxes or tax rates – while the representative notes that employees as well as employers are more interested in discussing the level of (minimum) wages rather than occupational health, disease or injury problems.

15. https://www.employers.ee/meist-2/liikmed/

Representatives of the Ministry of Social Affairs, as well as ET, tend to think of return to work as a field within the wider area of policy measures targeting occupational health as part of the overall framework of employment and social heterogeneity. They also view potential advances in the return to work from a longitudinal perspective – measures that evolve together with other policy measures on social security and well-being – while also observing the importance of the context set down by the 2016 work ability reform.

Return to work policy has not been a distinct topic in social dialogue (except as part of the joint operation of ET). This is most likely to be the result of a lack of communication on the issue between stakeholders. Hence it is hard to describe the involvement of the actors in discussions which are focused solely on return to work policies; the involvement of stakeholders is based on other topics of social dialogue (where representatives agree that they are sufficiently involved). The main reason behind such a level of involvement has been that stakeholder participation in policy processes is one of the core principles of public administration in Estonia. In particular, one of the aspects of the Estonian system is the significant role of the state as a mediator – or rather the initiator – of policies in the return to work. Social dialogue on labour relations and employment in general is organised and carried out by the Ministry of Social Affairs which assures that trade unions, employer organisations, medical doctor organisations, organisations for people with reduced work capability and representatives of the national organisations responsible for relevant support services, such as ET, EH and the Social Insurance Board, are involved.

However, social dialogue in Estonia has tended to revolve around other themes and issues than the return to work. The main topic is wages and, in most sectors, this means the minimum wage. Occupational health matters are advanced mainly at the initiative of the Ministry of Social Affairs using participatory policy processes but outside the format of regular social dialogue between trade unions and employers. Awareness of the national-level return to work policies and measures in Estonia is, nevertheless, considerable and they are considered for the most part as quite elaborate although stakeholders had expected trade unions to be more active in return to work policy, an expectation that was not imposed similarly on employer organisations.

The involvement of stakeholders in EU-level social dialogue structures can be considered as sufficient: all of our interview partners had participated in EU-level social dialogue structures. Despite this involvement, the awareness of specific EU-level return to work policies is very low. At the same time, stakeholders had expected somewhat more initiatives from the EU when it came to the development of return to work policies at national level.

Return to work policies within Estonia are thus developed with a varying degree of involvement of the different social dialogue partners. The social partners see the role of the state (and the EU) as important, if not central, to policy development on the return to work, considering such policies to be of low priority for them. Their reasons for not being involved more intensely in policy processes are quite organisation specific. When it comes to applying return to work policies, organisations have been involved in

implementation only occasionally and are not planning on increasing their involvement. Hence those organisations that are involved in social dialogue are inclined towards involvement in policy development issues rather than in practical implementation.

There is an evident lack of cooperation between stakeholders, with the existence of several obstacles being reported during the research. Likewise, the implementation of return to work policies does not always go smoothly. This is an indication of the presence of bigger challenges to cooperation, not merely that of communication, with problems of occupational health, health insurance and return to work not being put on the table in regular social dialogue. There is no fierce opposition to stakeholder cooperation but, instead, a clear need to explain better its relevance to policy-making and even more so to policy implementation.

Our research indicates the need for a more active approach in return to work policy-making among both trade unions and employer organisations even though the latter do seem to have been relatively more involved. The same holds for involvement in implementing return to work policies. Such a configuration looks natural in the context of a national institutional set-up in which employers have managed to establish several umbrella organisations covering virtually all employers and enterprises while only a tiny number of employees are trade union members. While lobbying as a policy tool has been utilised, other options such as providing assistance to individual workers, engaging in collective bargaining or raising workers' awareness of their return to work rights through information campaigns have, however, also been deployed.

The lack of activism seems rather to be a problem of a lack of initiative in this particular policy area from both sides. Consequently the potential for future action on return to work measures in Estonia remains bleak. Trade unions have longstanding general interest in making progress on the issue but there is no profound interest in doing so as a result of other issues occupying a more active priority. Even so, trade unions could potentially pick up the issue of occupational injury insurance, covering those health problems which result from work accidents. Meanwhile employers are not interested in bringing return to work to the negotiation table as it would lead to an increase in their costs. Employers see that they have already taken the initiative of addressing the situation of people with reduced work capability. They see that return to work policies could be part of a workforce diversity approach and they acknowledge that not all workers are equal and that some require specific support. For employers, the return to work theme is thus primarily a workforce diversity issue rather than a health issue. Within that framework, health conditions are just one factor requiring attention.

What does need bringing forward is the central role of the state administration in the process of supporting the employment of people with chronic illness. Returning to work is one strand of action on a wider agenda of interventions aimed at supporting people with reduced work capacity. Here, it is the Ministry of Social Affairs, ET and the Social Insurance Board which are the central players in this respect. Trade unions do seem interested in being more involved but the employer organisations are quite happy with how things are.

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

4.1 Workers' experiences with the return to work process

A majority of workers with chronic illness are concerned about their return to work. This does not differ systematically based on the type of illness reported. Two major types of fear can be distinguished: one associated with not being able to meet productivity standards after illness; the other associated with being left without adequate, or indeed any, support. The most common chronic disease reported by respondents is cardiovascular disease followed by other chronic diseases such as cancer, mental disorders and musculoskeletal diseases.

Among those who are only recently diagnosed, a sizable share of workers do not intend to take time off from work because of their illness. One of the reasons for this is where employers' reactions to employees' sickness leave had not been supportive. Nevertheless the majority of employees with a recent diagnosis of a chronic illness did have an arrangement with their current employer to return to the same position after treatment and, indeed, many of those with more longstanding conditions had actually been able to return to the same job.

In general, the team leader/line manager is considered to be the most important person in supporting a worker's return to work and is also the primary point of contact when support measures come under discussion. Company management, trade unions and the relevant labour inspectorate are far less usual in this respect. Indeed, people returning to work had mostly been in contact with their colleagues and/or with their line manager. In all, this suggests a very scattered picture with no certainty and more reliance on informal relationships (with one's colleagues, for example) than a standard procedure followed with the involvement of human resource professionals, therapists or trade union representatives.

While workers mostly return to work on their own initiative, the role of medical doctors in the making of this decision is important as is that of their family. This pattern gives the impression of a lack of active interest on the part of the workplace. Workers' experiences reveal that adjustments to tasks and duties, probably in terms of reduced workload and part-time work as well as modifications in the working environment, are the most common changes after illness while those which occur least are the postponement of deadlines as well as adjustments in daily working time. However, once a decision is taken, colleagues also have an important role in facilitating return to work after illness together with friends, family and the general practitioner. The role of management as well as trade unions in supporting the return to work is reported to be small and there are deficiencies in advice and support from the employer as well as from the trade union.

Regarding the role of trade unions in the return to work, this is in in stark contrast with workers' vision of the potential. Trade unions are expected to be ready to address the health-related issues of workers and to support the return to work by negotiating

binding agreements with the employer, e.g. in terms of reducing working hours, stress and workload for people after long periods of sickness leave. Evidently expectations do not match the reality and very few workers have experienced help from their trade unions.

In general, the overall experience of returning to work is moderately satisfactory. Despite a level of dissatisfaction with the process, most people feel welcome when returning to work after chronic illness.

4.2 Perspectives of managers on the return to work process

Managers are in agreement that an employee with a serious illness is likely to cause significant problems for company operations. They underline that such an individual would be replaced, perhaps not immediately but certainly were the problems to persist, and that that this would be done before serious financial consequences had emerged for the organisation.

Meanwhile managers consider information/advice on adapting the workplace and working spaces in general, as well as specialist direct advice, e.g. from doctors and therapists, to be useful when dealing with workers' sickness leave. Information on the financial strategies to deal with absences related to sickness leave, legal advice and external counselling/cooperation with dedicated professional associations and/or patient organisations are options mentioned less frequently. When it comes to making arrangements to support the return to work, three ideas are highlighted by managers:

— the worker should be entitled to the adjustment of their working duties (working time and workload) but at the organisation's discretion;
— workers should be entitled to a phased return to work on full pay;
— the worker should be legally entitled to adjustments to working duties (working time and workload).

The adjustment of working time and workload is perceived to be effective by the largest number of managers. These actions were also among the most frequent offers to employees returning to work. There certainly are many managers who do accept working part-time and the possibility of unexpected interruptions, but it turns out that not all managers accept such arrangements in practice. However, relatively few line managers and team leaders hold the opinion that the employment of a person with reduced work capability would bring about additional challenges associated with the reorganisation of workflow. The main challenges that were mentioned, however, are:

— taking time off;
— a lack of recognition of the difficulties that lower-level managers face in connection with workers' absence;
— that a worker returning to work with reduced duties increases the workload of other colleagues;
— staying in touch with the worker during that person's absence.

Very few managers believe that a person returning to work after illness and treatment will be less valuable than other workers. In general, managers are quite supportive and prepared to adapt the working conditions of people returning to work with a chronic condition. However, most managers are unaware of organisational practice in terms of supporting the return to work.

Moreover return to work issues are not addressed in company-level collective agreements. In this vein, managements do not have regular contact with the trade union regarding the return to work and further difficulties are caused by the lack of organised representation on the health and safety committee responsible for dealing with return to work issues.

4.3 Interactions between employer and employee in facilitating the return to work

Employees generally do feel welcome at work when they return after illness. However, there are no other major positive experiences: employees do not perceive their companies to be well-prepared to accommodate the necessary adjustments; the returning employee does not receive extensive mentoring and guidance from the trade union or the employer; and the return to work is often not well organised.

Employees do recognise that their employers are not fully unprepared: the two most common offers to people returning to work are the possibility of a phased return process and the establishment of a formal procedure for managing the situation. Here, companies may offer adjustments to work tasks and working time, along with informal procedures, a thorough discussion and individualised plan, workplace adaptations and training for the returning worker.

A somewhat different picture emerges from the managerial point of view. Here, half of managers say that contact with the worker on sickness leave is regular although a similar number say it is irregular and, in one case, there was a confession of no contact. One could thus conclude that there are some companies where there is some regularity in interactions between the management and employees on sickness leave while in others such contacts are irregular. In any case, such contact as does exist tends to be rather informal. Regarding the content of communications, for the most part this is reported as being designed to keep the worker informed of work-related issues.

4.4 Experiences in facilitating the return to work

Over the entire 2015-19 period, the unemployment rate in Estonia was 5 per cent or below. This means that companies have had a strong interest in retaining people and this also holds for people with reduced work capacity: in a tight labour market situation, companies have an interest in providing employees with support so that they can work.

However, there is not a lot of information available on good practice in the return to work. Making use of national-level policy measures should be listed among these, since there is not much beyond that offered by individual employers – and, often, even existing policy measures are not considered despite the availability by law of a range of in-cash, in-kind and on-demand measures. Awareness of these measures, and then consequently of how to take advantage of them in practice, is low. The claim has been made that employers, especially managers, have little awareness of the possibilities available in supporting the return to work and that they may also suffer from a lack of research time.

Given the paucity of evidence of good practice, we have extracted some examples. We define a good experience as a situation in which an employee has experienced a supportive employer environment when returning to work after chronic illness or with a chronic disease and encountered no problems in this regard. An example of good practice is where an employer (i.e. manager) is able to discuss existing cooperation with a trade union in the return to work context and expresses a preference to access more support. We describe below the experiences of workers who have returned to work as well as those who had as yet no practical experience of this but who had nevertheless been diagnosed with a chronic illness.

Considering workers who had been diagnosed only recently and who thus did not yet have return to work experience, we examined the responses they received from the employer and from the trade union representative when they announced their treatment and the need for a period of sickness leave. The following pattern appears:

— The best return to work experience: upon announcing the need for treatment and sickness leave, there was a generally supportive response from the employer and from the trade union, even though no help or support might have been offered during the period of sickness leave. Where the employee was not a trade union member, he or she reported that they had thought about joining the union since their diagnosis in order to get proper support when returning to work.
— Trade-union supported return to work: there was a generally supportive response from the trade union (even though no help or support might have been offered during the period of leave) but an indifferent response from the employer with the company, in the worker's view, only caring for its business and not for the well-being of employees.
— Unsupported return to work: in this case, the employee either did not plan to take extended leave and/or did not feel confident enough even to announce the need for long-term absence to the employer as they feared losing their job. One worker volunteered in response to an open-ended question: 'Anything like that always makes the employer panic'. In such cases, either there was no trade union representative at the workplace to whom the employee could turn or, alternatively, the employee did not tell the representative of the need for long-term absence.

In the most supportive return to work model, people would contact the human resources department of the company for support while, in the trade union-supported model, the contact point might, instead, be a psychologist or occupational therapist from outside

the company who would assume the role of most important person to support their return to work. This highlights that support may well rely on professional suggestions from people outside an organisation.

Among workers who do have a personal return to work experience, in terms of evaluating the level of satisfaction with the help and support received from the employer and from the trade union, approximately half are satisfied while the other half feel that the support that they had received was insufficient. The key aspect that most distinguishes the best return to work experiences – where the employee is satisfied with both the employer and with the trade union – seems to be being made to feel welcome upon returning. Among other determinants of good return experiences is the employee actually having relatively low expectations: since employer support for adjustments upon the return to work appears mostly to be rather weak, this might contribute to the avoidance of disappointment. Another more important factor for defining a good return experience is that the employee did not feel worried about their return. This can be related to the kind of illness experienced but also to their position in the organisation being more secure.

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

Employer organisations' preferred way of organising the return to work, based on the perceived need for improvement at organisational level, can be divided into two groups. One group seems to prefer better cooperation with external stakeholders (medical doctors, therapists, patient organisations and so on) in facilitating returns, perhaps accompanied with (even) better legislative and institutional support. This group suggests that they have already done everything they can at company level and thus need external insight, or perhaps a push, to go a step further. The second group seems to be interested in looking for internally-oriented solutions on the return to work, some of them more informal ones (better interpersonal relations between managers and employees, leading to a better handling of workers returning from long-term sickness leave) and some more formalised ones (better organisation-wide policies and activities).

The main benefits of cooperation between management and trade unions, seen from the point of view of managers, are training sessions for managers directly exposed to interaction with workers with chronic illness, input from trade unions in company internal policies, informal agreement on the role of employee representatives in supporting the management of return to work processes and specific return to work provisions in collective agreements.

Managers overall perceive the legislation to be too general to be useful to an organisation. The legislation may set out a general framework but it does not specify the arrangements that need to be undertaken by an organisation. It thus appears that managers do not regard the legislation in Estonia to be particularly helpful in arranging return to work adjustments or in regard to the development of their company policies. Some managers

would welcome more specific provisions to guide their organisation in its approach to the return to work. However this is not a general perception as a small subset of managers do think that the legislation provides quite sound guidelines for company-level actions. We are also aware that some managers would prefer the legislation to be more flexible and leave more space for company-level managerial decisions on return to work issues while another group think it sufficient that the return to work is contextualised as part of a broader set of policies on the labour market integration of people with chronic illnesses.

Thus there are some companies that perceive the legislation to be sufficient, as they would like to arrange return to work matters at their company themselves; while there are others that would prefer to receive more specific indications about what they should do to arrange return to work after chronic illness.

From a workers' perspective, trade unions should be occupying a significant role in the process. A large share believe that support for the return to work needs to be an important element on the agenda of negotiations between trade unions and employers; while a similar share think that the unions need always to be ready to address the health-related issues of workers. The preferred form of support from unions is the negotiation of binding agreements with the employer, e.g. in terms of reducing working hours, stress and workload for people after long periods of sickness leave. Only a small subset of workers think that their unions could not do more or hold the opinion that their unions were simply not powerful enough. Unfortunately none were able to identify any good examples of how a trade union had been helpful in the return to work process.

Hence from the employee side the prevailing view is that trade unions should be doing more than they have been doing. Ultimately, however, the perception of workers about the role of the union in facilitating the return to work is dependent on whether the actual return experience was one that had been supported by the employer or the trade union.

Workers with an employer-supported return to work experience in which trade unions were absent and who had initially been more concerned about their return agree that unions should be prepared to address health-related issues. This implies a need to empower trade unions as a precondition for them being able to adopt a greater role in the return to work process. However, those who were initially not concerned about their return – implying that they were more confident about making their own arrangements with their employer – suggested that trade unions could already start to work on facilitating returns in Estonia without first needing to accrue more power.

In the case of people with a union-supported return to work experience, this might have led the individual to disagree that trade unions in Estonia were insufficiently powerful to facilitate the return to work. They are able to assert that unions could facilitate returns, preferably by negotiating binding agreements with the employer but also by offering individual consultation. These workers also somewhat agree that trade unions should always be ready to address the health-related issues of workers and that support for the return to work should be an important element on the negotiations agenda.

5. Conclusions

This chapter provides evidence of how the return to work after chronic illness is supported in Estonia. Estonia is characterised by an open labour market – it is relatively easy to lose a job as well as to gain a new one – which frames the situation in which illness forces one to stop working. Against such a background, the employment contract is often, although not always, terminated by the employer. Small companies, which constitute the absolute majority of enterprises in Estonia, cannot redistribute work tasks among other workers and thus need to hire a new person so that these may be continued. There is no obligation to re-employ a worker after medical treatment. After treatment, individuals returning to the labour market may find their personal work capacity is reduced as serious illness and/or a chronic condition is one of the reasons why a person loses work capability. It is primarily this situation that is being addressed by public policies which seek to support the finding and retention of a job for a person with reduced work capability. Covid-19 offers a window of opportunity to emphasise return to work issues but this is yet to emerge on the policy agenda amidst all the others; thus far, the existing return policy measures have neither been discussed nor reformed and nor have any new initiatives yet been put forward for discussion.

The employment of people with reduced capacity for work is supported by a range of policy measures. Institutionally the central role in developing and implementing policies with relevance for the return process has been played by the Ministry of Social Affairs (specifically the Work and Pensions Department) and its associated organisations. Since 2016, when the work ability reform was launched, implementation of all the benefits and services supporting people with reduced work capacity has come under the remit of the ET while oversight of the subsequent legally-binding regulations is provided by the labour inspectorate, an agency of the Ministry of Social Affairs dealing with the area of governance. The current policy mix addressing people returning to work after illness or with a chronic condition has been developed at the initiative of the same ministry. Its Work and Pensions Department has been behind the policy processes in which all stakeholders have had an opportunity to have a say on the topics and themes related to the return to work after serious illness and/or with a chronic condition.

Currently there is a wide range of support measures which are offered both to employees with reduced capacity for work and to the companies that employ them. The mix includes support in terms of time (boundaries on working time and shifts), in-kind assistance (various support services, consultations for employees and employers as well as job training programmes) and cash benefits (for both employees and companies that employ people with reduced capacity for work). A very important milestone in the evolution of the policy mix is the work ability reform which saw all support measures transferred to ET so that the assessment of a person's degree of work capability, the planning and offer of support measures, the review of the effectiveness of the measures offered and all other related activities are carried out by a single organisation.

Neither trade unions nor the employer organisations have taken much initiative in these policy processes. Trade unions have not focused on return to work or occupational health

because of a more significant interest in wages, expressly the level of the minimum wage. Given that return to work policy is rather scattered between different fields, as well as the rather low unionisation rate and the weak state of sectoral social dialogue, trade unions and employer organisations are mainly mobilised by the Ministry of Social Affairs since the social partners' own interest in engagement is relatively low: they do not feel notable dissatisfaction with the present situation; they have stronger interests elsewhere; and they feel that they have made their contribution already. While national employer and employee associations are represented on international discussion forums, the debates seem not to have managed to initiate spill-over effect to local levels via the usual policy trails. Analysis suggests that income will probably continue to be the central concern for trade unions. Unions might consider raising the issue of occupational injury insurance but the likelihood of even that taking place is not high. For their part, the employer associations have developed a different frame of reference for addressing people with reduced work capability – the workforce diversity approach. From this point of view, people with reduced capacity for work because of a health condition constitute one category of the diversified workforce. Returning to work after a serious illness and/or with a chronic condition is one of the processes that, among others, needs to be approached appropriately. Employers do feel that they are doing enough to employ and support people with reduced capacity.

Overall, the social partners in Estonia consider the current state of public policy affairs to be quite satisfactory and they do not perceive that there is a need for considerable changes. Neither trade unions nor employer associations have clearly-defined goals and agendas in the area of return to work and they do not express a wish to set them. Although the state has put in place rather generous regulations and support measures, there may well be problems with following these through in daily practice. Employees as well as employers lack information about their rights and duties and the available support measures. Relatively many employees in the situation of returning to work after an illness and/or with a chronic condition do not feel confident about turning to their employers to discuss support measures or to contact other institutions. Employees expect trade unions to be more active in occupational health and return to work matters. Yet trade unions in Estonia are generally weak and present only in a handful of sectors.

Employees did not express any significant amount of open discontent with the functioning of the return to work system in recent years. There might be two explanations for this. First, it might be that the majority is, to a large degree, content with the existing system and services. Indeed, the state has been allocating a good deal of resources to support people in going back to work with reduced capability. The system of labour market benefits and services has been growing and improving substantially in the last two decades while the work ability reform signals a general trend towards greater agency on the part of employees (as well as employers). Second, employees might fear losing their jobs. Although the Estonian labour market is flexible and open, the situation might be complicated for certain categories of people such as those with reduced capacity for work who might experience more hardship in finding a new job than the average worker.

The findings of the chapter suggest that the way things are now arranged is likely to persist without major change. This means that the central role of the public sector in policies relevant to the return to work will continue and that the social partners – trade unions, employers and other players – will continue with their limited role, participating in policy processes mostly initiated by the Ministry of Social Affairs without their own clear goals and agenda. It is worth noticing, however, that national-level discussions – which are crucial in representing workers in industrial relations – are particularly visible to the public as they attract media exposure. Moreover, when only national (and sometimes also sector-level) trade union organisations engage in negotiations, there is a higher likelihood that they have sufficient qualified human resources to secure both expertise and media coverage. Focusing social dialogue on the national level, instead of the sectoral or company level, might thus have even greater potential to change policies on the return to work after, or with, chronic illness. This might both compensate for the lack of company-level trade union activity around these issues and support such discussions being developed. With Covid-19 making the issues related to the return to work much more prominent in everyone's social reality as well as on the policy agenda, more attention could be expected in reconciling the interests of the social partners in this regard.

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