Chapter 4
In search of a coordinated national framework: opportunities and challenges for returning to work after chronic illness in Ireland

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1. Introduction

The prevalence of chronic diseases has been growing in Ireland over the past few decades. The main work-related health problems are musculoskeletal disorders, cancer and cardiovascular disease. Cardiovascular disease is the most common cause of death, accounting for 36 per cent of all deaths (Turner *et al*. 2018) followed by cancer. There is also a growing incidence of mental health disorders, with depressive mental illnesses projected to be the leading cause of chronic illness in high income countries by 2030 (WHO 2008). This rise in chronic illness, in the context of an ageing population, has a significant impact on labour supply in terms of workforce participation, turnover and early retirement.

There is no specific legal framework in Ireland for employees with chronic illness as the regulations concerning people with disabilities generally cover their rights as well as the obligations of employers. In 2015 the government launched its ten-year Comprehensive Employment Strategy for People with Disabilities 2015-2024 (CES) to increase the proportion of people with disabilities in employment. The National Disability Authority[1] (2005) reported that people with disabilities were two and a half times less likely to be in work than those without disabilities while 85 per cent of working-age people with a disability or chronic illness had acquired their condition while employed, thereby highlighting the importance of effectively managing retention in employment. A strategic priority of CES was the promotion of job retention, with strategies for intervention in the early stages of absence from work due to acquired disability. Ireland has a long way to go to achieving its target: in 2017 it had one of the lowest employment rates for people with disabilities in the EU (26 per cent) and one of the highest gaps in employment between people with and without disabilities in employment (45 percentage points) (European Commission 2019).

Healthcare systems are critical in addressing the management of individuals with chronic illness. 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 (OECD 2019). Even so, only around 70 per cent of health spending is publicly funded, which is well below the EU average. The Irish healthcare system has a complex dual-tiered system of both public-funded and private health insurance schemes; 46 per cent of the Irish population has some form of private health insurance.

1. This 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.

This dual system does not provide equitable access either to primary or acute hospital care or to a universal healthcare in which patients are treated based on need rather than ability to pay (Connolly and Wren 2019). The need to adopt a chronic care model has been recommended (Darker *et al.* 2015), which should seek to incorporate patient, provider and system-level interventions focusing on both the prevention and management of chronic illness through investment in primary care – a critical factor in ensuring successful re-integration into the workplace; but there has been little progress.

This chapter examines the barriers to, and facilitators of, employees returning to work after experiencing chronic or long-term debilitating illness within Ireland's voluntary industrial relations system. The discussion is drawn from primary and secondary data. The primary sources consist both of qualitative data (semi-structured interviews with key national stakeholders and two stakeholder discussion groups) and quantitative data (surveys of workers, managers and social partners).

The rest of the chapter is structured as follows: background information and national policy frameworks are presented in the next section before proceeding to discuss the role of the social partners in shaping such policy at national level. Finally it examines the role of actors at enterprise level who seek to facilitate the return to work of employees with chronic illness.

2. Policy framework on the return to work in Ireland

There is no overarching policy on rehabilitation and the return to work in Ireland. However, an exploration of policy frameworks indicates four distinct areas, administered separately and mostly uncoordinated, that are relevant in the context:

(i) occupational sick pay schemes;
(ii) the sickness and invalidity benefit system;
(iii) managing disability; and
(iv) provisions for rehabilitation and support for the return to work.

2.1 Occupational sick pay schemes

Ireland is one of only five EU countries in which there is no statutory entitlement to an occupational sick pay scheme, except when provided for in a contract of employment or negotiated by collective agreement. Otherwise the duration and level of sick pay is at the discretion of the employer. The Covid-19 pandemic has prompted the Irish government to launch a public consultation on the need to introduce occupational sick pay schemes. Many employees, particularly those who are on low incomes, have no legal right to sick pay, a fact highlighted by the National Public Health Emergency Team and the acting Chief Medical Officer as 'a problem in controlling outbreaks' of Covid-19 (Wall 2020).

Public sector and semi-state employments all provide some form of employee sick pay, although most of these were reduced in scope during the three years of the Troika Programme.[2] 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 education. It standardised, for the first time, paid sick leave arrangements across the generality of public services but effectively halved paid leave, the cost of which had been perceived as unsustainable, while also introducing a provision for extended leave in the case of critical illness or injury. Most public sector sickness schemes now 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 sickness leave in a rolling four-year period.

Two processes were key to this new scheme, namely Temporary Rehabilitation Remuneration and the Critical Illness Protocol. Temporary Rehabilitation Remuneration 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 Critical Illness Protocol defines eligibility criteria for the granting of extended sick leave for critical illnesses, while leaving the decision to award extended leave to the HR manager following consultation with the occupational health physician.

The development of the scheme was carried out in consultation with the Public Services Committee of the Irish Congress of Trade Unions (ICTU). However, one consequence of the contraction of public sector sick pay schemes in the wake of the Troika Programme has been the increase in public sector employees taking out private insurance policies to cover long-term illness and income continuity while sick.

In the private sector there is a wide range of sick pay schemes in operation ranging from full pay for 12 working days in the retail sector up to a maximum of 12 weeks identified in the manufacturing sector. A survey by the Chartered Institute of Personnel Development (CIPD 2019) reported that 44 per cent of private sector companies who participated in the survey did have some form of sick pay scheme, confirming thereby that the majority do not offer a company scheme leaving their employees solely reliant on the state for sick pay.

2.2 Sickness and invalidity benefit system

Under the Social Welfare Consolidation Act 2005, all working people in Ireland have an entitlement to some social benefits (social welfare) from the state while absent from work or if they are experiencing chronic illness. The various schemes are administered by the Department of Social Protection,[3] with eligibility being dependent on having

2. On 28 November 2010, the European Commission, European Central Bank and the International Monetary Fund, colloquially called the European Troika, agreed with the Irish government a three-year financial aid programme in order to cut government expenditure.

3. In Ireland, government departments can be, and are, re-organised to cover different administrative functions according to the 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.

paid sufficient national insurance contributions. The applicable rate in 2020 was €190.55 per week which may be paid continuously for up to two consecutive years in one claim, except for certain diseases such as tuberculosis where the duration is unlimited. Employees who do not qualify for this 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 an illness or a disease as a result of the type of work they do.

2.3 Managing disability

Irish policy frameworks do not necessarily address chronic illnesses specifically but instead incorporate it into the 'disability' category. The CES 2015 strategy outlined six priorities:

(i) build skills, capacity and independence;
(ii) provide bridges and support into work;
(iii) make work pay;
(iv) promote job retention and re-entry into work;
(v) provide coordinated and seamless support; and
(vi) engage employers.

The only strategic priority to focus on people already in employment was the promotion of job retention and re-entry into work, with the key actions detailed in the report in support of this priority extended to 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 for mental health integration, including job coaches in mental health teams;
— a continuing programme to train trade union 'disability champions' to support colleagues returning to work following the onset of disability.

To support this strategy, a number of initiatives have been introduced. Firstly the government funded a new online service for employers, entitled Employers Disability Information Service, which began as a three-year pilot in 2016.[4] This service was managed by a consortium of employer organisations including Chambers Ireland, the Irish Business and Employers Confederation (IBEC) and Irish Small and Medium Enterprises, and was funded through the National Disability Authority. 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 to encourage best practice. The National Disability Authority, in collaboration with the Institute of Occupational

4. See more information at http://www.employerdisabilityinfo.ie/

Safety and Health, was tasked to disseminate guidance for employers and employees on job retention and re-entry into work.

Secondly ICTU, under the Disability Activation Project,[5] was selected to develop training programmes for 'disability champions': trade union representatives and shop stewards intended to assist employers support employees with a chronic illness in the return to work.

Thirdly a report was commissioned by the National Disability Authority examining good practice in organising national vocational rehabilitation services across a number of jurisdictions (McAnaney and Wynne 2017).

The final strategic action focused on promoting and supporting strategies for intervention in the early stages of absence from work due to acquired disability, based on coordination between the Health Service Executive[6] (HSE) and the Department of Social Protection.

Whilst a number of these actions have proceeded, a key criticism is that no single government department is leading on the delivery of the CES. Furthermore, the resources which have been made available for the implementation of the strategy are perceived to be insufficient.

Other significant developments in the Irish policy landscape focusing on chronic illness and disability include The National Disability Inclusion Strategy 2017-2021 that sets out a whole-government approach to improving the lives of people with disabilities (Department of Justice and Equality 2017). This identified a number of key areas including education, employment and the need for joined-up policies and public services. A key area was employment and for people who acquire a disability to be given the support needed to remain in or return to work. 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 in progress to address access to, or the affordability of, the necessary aids, appliances or assistive technologies required for everyday living for those people with disabilities whose entry to, retention in or return to work could be jeopardised due to unaffordability.

2.4 Provisions for rehabilitation and return to work support

In Irish employment law, chronic illness is encompassed within the definition of disability. The main legal instruments in the area of rehabilitation and return to work are the Employment Equality Acts and the health and safety legislation. The

5. In 2012 the Minister for Social Protection announced funding of just over €7 million for a range of projects under the Disability Activation Project. Their aim was to increase the capacity and potential of people receiving Department of Social Protection disability or illness welfare payments to participate in the labour market. Funding for these projects ceased in 2015, much to the disappointment of key NGO groups such as Inclusion Ireland.
6. The HSE provides all of Ireland's public health services in hospitals and communities across the country.

Employment Equality Acts include disability and obliges employers to make reasonable accommodation for people with disabilities. For an employee returning to work after long-term illness, an employer must take ‘appropriate measures’ to meet the needs of that person. Meanwhile the Safety, Health and Welfare at Work Act obliges employers to create a safe and healthy workplace.

There are a number of government funding initiatives available to organisations to support an employee’s return to work. One is the Employee Retention Grant Scheme that 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. Another is the Reasonable Accommodation Fund for the employment of people with disabilities which includes workplace equipment and adaptation. Other initiatives include financial assistance schemes to encourage employers to employ people with disabilities including the Disability Awareness Support Scheme and the Wage Subsidy Scheme.

In addition to workplace regulation, there is a range of uncoordinated voluntary activities being undertaken by trade unions, employers and non-governmental organisations (NGOs), including information and awareness-raising campaigns; employee well-being programmes; work-life balance programmes; employee assistance schemes; and some family friendly policy initiatives.

Overall, the policy framework in Ireland can be characterised as fragmented compared to other EU states. Provisions relating to long-term absence have evolved but can still be seen as overly complex, partly because long-term absence procedures occur at the intersection of different sectoral responsibilities and government departments: employment; health and disability; and equality and social inclusion (McAnaney and Wynne 2017). Any initiatives introduced (e.g. the Employers Disability Information Service or the Disability Activation Project) are often short-term projects: indeed, neither were still in operation as of 2020.

Social protection agencies in Ireland focus on the unemployed or economically inactive rather than those who are absent from work due to a chronic illness. There is little evidence of state-funded and state-run occupational rehabilitation services which support the return to work of employed people with chronic illness. A number of pilot programmes have taken place, however, driven by campaigning and patient support organisations under the now-defunct Disability Activation Project (co-funded by the European Social Fund and the Department of Social Protection) to support workers’ return to work after long-term absence due to 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 of NGOs is that many of the strategic actions outlined in government policies are often left to them to implement without adequate government funding.

3. Social partner involvement at national level

3.1 Demise of social partnership and consequences for the return to work

Social partnership was a formal process of dialogue that began life in 1987 as a form of corporatist pay/income tax bargaining arrangement. It ran consecutively for over 20 years and produced seven national agreements. Premised on voluntary dialogue between the state and multiple stakeholders, many elements of the national agreements went, in the latter stages, beyond pure fiscal matters to encompass a wide range of social policy areas. However, social partnership extinguished itself during, and as a direct consequence of, the global financial crisis (for an overview, see McDonough and Dundon 2010). As a consequence there has been no national-level process of social dialogue since 2009 except for the continued existence of two cross-industry advisory bodies: the National Economic and Social Council; and the National Competitiveness Council. Some bilateral engagements have, however, taken place in that IBEC, ICTU and NGOs lobby the government on specific areas of concern at the time of the annual budget or as part of the law- and policy-making process. Return to work procedures have continued to play out in the workplace and at individual level, as explored later, rather than through collaborative policy development at national level.

In October 2016, the Irish government re-established a limited form of national-level social dialogue entitled the Labour Employer Economic Forum which brought together employers, trade unions and the government to discuss views and policies over matters of mutual concern. With the emergence of important national issues such as Brexit and Covid-19, they have met weekly and even daily in many instances as high-level stakeholder forums to agree on approaches and policies, e.g. the Return to Work Safety Protocol: Covid-19 Specific National Protocol for Employers and Workers (Government of Ireland 2020).

Nonetheless, IBEC and ICTU officers felt that the ending of social partnership 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 but as one which should encompass a range of societal issues such as the return to work following chronic illness. Instead what now exists are sporadic issue-specific events highlighting a particular deficiency or failure in response to which a government department will establish a committee of inquiry and seek public views on the matter, or a government minister will amend an existing programme or measure of support. By and large it is the activities of NGOs in lobbying and publicising issues that have brought about change in the area of the return to work which, in effect, means that measures are developed in a piecemeal and uncoordinated fashion.

3.2 Subsequent stakeholder activity

Union officers would welcome social dialogue on establishing a national return to work framework and, in its absence, have frequently lobbied the government individually

on the issues which it raises. One union officer expressed to us a common theme articulated by many:

> 'In an ideal situation all union workplaces would have extensive collective bargaining agreements and provide for RTW policies and the like, but employers just will not engage with us on new agreements.'

NGOs and patient groups could be a critical pillar in social dialogue on the return to work, although NGOs report that they do not have a strategy to engage with other social partners, particularly the government, on such issues. The primary reason for this is resource constraints. Many groups work directly, albeit 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 (2019), have produced a guide for employers and employees on returning to work after cancer, in partnership with Chambers Ireland. Arthritis Ireland, together with Fit for Work,[7] 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 the support they need. Another example is the Pocket Guide to Returning to the Workplace (SEE Change 2020) on returning to work after or with mental health issues due to Covid-19, produced by SEE Change and Mental Health Ireland. IBEC has also partnered with SEE Change to produce a guide for line managers on mental health and well-being as part of their KeepWell programme.

Both IBEC and the ICTU pinpoint examples of the input they have had in policy development at national level, particularly regarding the Comprehensive Employment Strategy. Each acknowledge that they would often engage on topics jointly, for example in the area of mental health, working together on awareness-raising activities such as the 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 the ICTU, IBEC and Irish Small and Medium Enterprises, along with key health stakeholders, is seeking better alignment of the work and health agendas in Ireland. Guideline documents for both employees and employers have been developed by this coalition for key stakeholders.

3.3 The potential for future action

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 has arisen around replacing the sickness certificate supplied by medical doctors to employees to give to their employers a 'fit to work' note similar to that in the UK, but

7. 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.

no agreement has been reached. Employers fear that other stakeholders (e.g. unions and government) want employers to meet the costs associated with the return to work, e.g. of rehabilitation and providing sick pay.

Brexit and especially Covid-19 has prompted some dialogue regarding national (governmental) economic, social and health policies. Evidence has emerged that return to work has become a priority for industrial relations actors, with one employer association claiming it was 'pushing an open door' on the topic. It is also clear that there is an understanding among the social partners that comprehensive return to work policies and architecture are absent in the Irish health and social protection systems but could be developed as part of the activities of the Labour Employer Economic Forum. Therefore the potential does exist for a comprehensive approach through social dialogue for more strategic and coordinated return to work policies in Ireland.

4. At the level of the enterprise

Evidence cited in this chapter[8] shows that return to work processes at company level occur generally as part of a company's absence and attendance management policies. In some organisations, line managers are responsible for implementing absence and sickness leave policies; in others, line managers and human resources (HR) departments work together to support employees who are on extended leave and to support them in returning to work. Managers do acknowledge the increasing occurrence, as well as the importance, of employees on long-term sickness leave. Some indicate that their organisations hold occupational health insurance, in which the insurance company becomes the case manager during illness-related absence from work, working with HR throughout the process.

Some additional detail regarding the worker experience, management perspectives and the level of interaction between each of these are explored below.

4.1 The worker experience

The major chronic illnesses reported by workers in our survey are cancer (27 per cent), cardiovascular, musculoskeletal and mental illnesses (15 per cent each) and other (23 per cent). The majority report they had already returned to work after chronic illness, with only a small share indicating they had been diagnosed recently and that their treatment had either just started or was about to start shortly.

Among workers who had already returned to work, a large majority report feeling concerned about their return. Campaigning and patient support organisations highlight major concerns: the unknown expectations of an employer; a fear of acceptance back

8. For further details on this study, please refer to the REWIR Ireland report here: https://www.celsi.sk/media/datasource/National_Report_Ireland_merged.pdf

into the workforce; and that the employer would not understand their particular circumstances. Workers' major concern is focused on the need to return to work at full productivity with no adjustment period (45 per cent), closely followed by a fear that there would be nobody available to support them if they experienced work problems due to recent treatment and sickness leave. The absence of adjustments to work conditions and working hours are also reported as key concerns (each by 30 per cent).

Two-thirds of workers return to the same job while one-third receive adjustments to daily working time and formal work contracts. Adjustments to tasks and the postponement of deadlines are, however, reported as receiving limited or no attention.

We can clearly highlight the importance of providing reasonable accommodation for individuals returning to work such as redesigning a job description; redeployment or the reassignment of duties; flexible working; job sharing; and modified workstations or adaptation of buildings. The Reasonable Accommodation Passport (developed by ICTU and IBEC) evidently provides important guidance in terms of structuring 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 which help them fulfil their role in a way that works both with them and for them.

More than two-thirds of workers who had returned to work report that they had been in touch with a general manager or HR department during their absence. Slightly less than half were in touch with work colleagues, followed closely by a line manager (more than one-third). Over 80 per cent indicate that they had returned on their own initiative, with one in five reporting that this had been initiated by medical professionals. When we examine experiences with the return to work, over half of workers report not being satisfied, or being only partially satisfied, with the support they had received while nearly two-thirds report dissatisfaction with the help and support received from their trade union.

Workers pinpoint medical actors (e.g. a general practitioner or specialist) as the most important contributor in return to work processes, closely followed by family, friends and work colleagues. The importance of social interaction with colleagues is an important theme in the return to work process in the sense of considering how the group will reintegrate a returning worker (Tjulin *et al.* 2011), yet trade unions have little formal involvement in the process. Communication is usually between the HR department (or line manager) and the employee, with no information being shared with 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. Even a worker's manager is rated as less important than work colleagues in the return to work, although the manager is identified as important in successful reintegration, in combination with other actors.

In the majority of instances, the HR department manages cases on a day-to-day basis while the relevant line manager deals with the granular detail. Many managers, however, do not wish to deal with the sickness leave process, leaving it to HR to manage

through regular 'check-ins' with employees, etc. and then through working in tandem with healthcare professionals to facilitate the return to work. Indeed, 70 per cent of workers report liaising with their HR department during their treatment and absence, followed by work colleagues (48 per cent) and the line manager (40 per cent). Healthcare professionals, such as occupational therapists, are seen by many stakeholders as being the linchpin of a successful return to work due to their proactivity in setting out a roadmap for returning, checking on individuals' readiness, thinking about the practicalities, liaising with the employer on adjustments and motivating individuals to go back to work.

Return to work policies tend to be developed at the level of the individual enterprise. The more successful approach often lay in being able to persuade a local 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.'

Evidently line and HR managers do, for the most part, have the ability to grant flexibility to employees with a serious illness but it does underscore the broad situation in Irish workplaces that, without a national scheme or framework on the return to work, many employees have to rely on the decency and pastoral care of individual managers.

4.2 Managerial perspectives

More than half of managers indicate that they would not replace an absent employee due to illness but would rearrange workflow and job tasks. Some report absence having a serious impact on the business (25 per cent), leading to financial consequences (25 per cent) or having other effects on clients and/or customer relationships (25 per cent). Employer associations highlight that the business impact of an employee absent from work for a prolonged period is particularly pertinent in respect of small and medium-sized enterprises due to limited resources and competitive pressures.

Managers perceive information and advice on adjusting workplaces and workspaces, financial strategies in dealing with sickness absence and external counselling, e.g. from doctors and therapists, to be the most valuable resources in supporting workers returning to work after chronic illness. A key barrier noted among campaigning and patient support organisations and occupational therapists is, however, insufficient knowledge of workplaces and specific illnesses, leading to a lack of clarity about who takes responsibility and which healthcare professional should start the discussion on the return to work. The absence of a national vocational rehabilitation service or framework available to all workers on sickness leave due to chronic illness is a major problem. Research consistently shows that timely access to related support services, or a framework available to all, is critical in a successful return process for people diagnosed with chronic illness. Lund *et al.* (2008) established that the longer the duration of absence due to illness, the greater the future risk of receiving a disability pension and of permanent exclusion from the labour market.

The attitudes of managers towards workers with chronic illness have been highlighted in previous research as having a significant impact on a successful return to work (Amir *et al.* 2008). Most of the managers we spoke to disagree that workers with chronic illnesses were less committed to their work. More than half believed that employees, at the employers' discretion, should be entitled to an adjustment to their working duties due to chronic illness, although only a small share are in favour of a legal entitlement to this. However, they also report that having a worker with a chronic illness did lead to an increase in the workloads of their colleagues. Most managers also stress the importance of staying in touch with a worker on sick leave while, interestingly, half believe that senior managers in their organisation do not recognise the difficulties faced by lower-level managers in managing a worker's absence and attendance.

Managers believe that it should be the HR department that formally deals with absence management and long-term sickness leave, together with the return procedure, leaving the line manager to be mainly responsible for handling the actual return process. This does not always happen, however. Fearful attitudes, the burden on line managers and poor relationships are significant barriers explaining why a manager may not become involved in the return to work process. Fearful attitudes encompass both a fear of discussing the illness and of how the employee might respond as well as a fear of being misinterpreted, with the latter being particularly pertinent during communications with an employee absent from work; for example, a 'check-in' phone call might be interpreted as putting pressure on an individual to return to work. The burden on line managers includes the additional demands placed on them in managing the tensions between providing support for employees who are ill while fulfilling statutory and company procedural requirements; furthermore, this is often reinforced by a lack of training and limited HR support.

4.3 Employer-employee engagement and outcomes

The return to work following chronic illness is a complex process with no 'one size fits all' formula. It can be impeded by a number of factors: organisational; personal; medical; and the timely access to related support services.

A large majority of managers believe that a common standard procedure is needed to manage the return to work for all employees. Here, an absence management policy is vital as it gives clarity to everyone about the process. Some organisations do indeed have a specific sickness absence management policy and procedures which clearly set out what happens when an employee is absent through illness. Where such a policy exists, it typically sets out:

(i) detail of the sick pay scheme and the income continuity plan (if one exists);
(ii) notification and certification requirements; and
(iii) the requirement to attend a doctor nominated by the employer for medical assessment, and guidelines for the return to work.

Return to work policy is perceived as an important part of the employee's rehabilitation process (Higgins *et al.* 2012). However, the way in which sickness absence is managed could be seen as punitive. Taylor *et al.* (2010: 274) argue that a shift in sickness absence management must be seen against the background of decades of neoliberalism 'which has unambiguously strengthened managerial prerogative'.

Most managers highlight the potential in their organisations for a phased return with the close cooperation of other external organisations e.g. occupational health services. In terms of the improvements which could be made to this process, more than one-half of managers cite better interpersonal relations between the managers and employees dealing with the return to work and better cooperation with the external stakeholders (e.g. doctors and occupational therapists) involved in facilitating returns.

External stakeholders are indeed critical in the return to work process at company level. In this respect, an income protection policy is vital under which an employee unable to work due to an identifiable illness is paid until they return to work or reach retirement. These insurers, such as Irish Life, take on the case after a number of weeks, assess the claim and work on rehabilitation and return to work programmes. The return to work process is thus moved outside the organisation, with the insurance company managing the case.

In the view of managers themselves, interactions between managers and workers on sick leave happen quite regularly (both formally and informally). More than half of managers indicate that they keep the worker informed about work-related issues although only one in five report involving the worker in actual decisions. This may be due to a fear that contact could be misinterpreted as pressurising the employee to re-connect with work.

Having no clear workplace procedures can lead to perceptions of unfairness and a lack of transparency, compounded by a lack of consistency in the implementation of sickness leave and return policies even within an organisation. 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 after, or with, 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 the return to work is one such intervention which may set clear procedural rules for managing the return process.

Communication in the return to work – ensuring a thorough discussion with the worker and putting in place a prior plan for their return – is clearly important. Discussions with occupational therapists and consultants working in this area reinforce the importance of agreeing an individual plan before the employee returns. The plan should include any adjustments to workload or work patterns that might be needed. Over half of companies do offer some form of adjustments in working time, work tasks, workload and workspaces. Few, however, offer training to co-workers in how to treat a colleague returning to work after long-term illness. One rare example is provided by a cancer patient organisation which had been approached by a manager requesting training on how to support a key employee returning after cancer treatment.

The introduction of the General Data Protection Regulation (GDPR) in 2018 is a new, complicating issue in facilitating the 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, identify reasonable accommodations for the returning employee and ensure they adhere to employment law. GDPR, 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 physician: that the employee is unfit to work; how long they will be unfit for; and when they are medically fit to return. Some managers think that this has a negative impact on their ability to work with the employee to support a successful transition back into work as they do not have full details of the illness and cannot plan for reasonable adjustments to workload or the workplace. Occupational specialists also express concern about this; communication and cooperation between healthcare professionals and employers are clear facilitators in the planning of a successful return, but knowledge of the chronic illness is a requirement to implement such a plan. Campaigning and patient support organisations highlight, however, how individuals are different and that many do not want to be labelled or stigmatised due to their illness. For some employees, this results in uncertainty regarding the disclosure of their illness to their employers. A consequent challenge lies in balancing the needs of the worker and those of the employer by ensuring confidentiality for the worker and then looking to facilitate adaptations and allow others to understand the workplace difficulties that may occur.

A number of managers and employer representatives raise the issue of sickness certification, required in Ireland to confirm that an individual is ill. A study by King *et al.* (2016) found that Irish general practitioners report significant difficulties in relation to sickness certification. Over half the respondents in their study indicated a preference for introducing a 'fit to work' note as the current system had an excessive focus on disability. In their view, a key strength of the 'fit note' is thus its shift away from disability towards empowering sick patients to go back to work.

The nature of an employee's illness is a concern both for employers as well as for employees, illnesses having both visible and invisible elements. For example, a stroke patient returning to work may have visible changes such as mobility issues. However, cognitive changes such as difficulties with memory, data processing and language, in turn causing fatigue and anxiety, are less visible. Many interviewees report mental health illness to be the most complex illness, entailing a fear on the part of the employer of how to manage it and on the part of the employee with regard to being stigmatised or considered less valuable as a worker.

4.4 Identification of good practice

The coordination of the return to work requires an understanding both of the worker with an illness and of the work environment as well as the presence of an individual work plan. There is some evidence of organisations (both public and private sector) which provide employees with appropriate plans and accommodation. Here, however, having a good understanding of the chronic illness in question and its side effects is

critical. If the return to work is to be effective, it must be seen as a process not just an event. Such a perspective allows for clarity in the management of expectations on how quickly an employee could 'return to normal' and also facilitates the discussion about any necessary adjustments. The needs of workers with chronic illnesses vary according to the type of illness: cancer survivors might well have different needs and require different adaptations than those experiencing a stroke or mental illness.

A second point of good practice emerges in connection with communicating with the employee at various points in the process. One campaigning and patient support organisation stresses that:

> 'It is really important to signpost for people… [so that they] Know where to go and ask questions. What resources are available.'

Clearly outlined and agreed communications should begin at the point of diagnosis and/or the start of sickness leave and continue both in its duration and prior to the return to work in terms of planning how and when the employee will return. Employees suggest that conversations should also take place after their return in order to review their return process and the effectiveness of any adjustments made for them in the workplace. One manager commented to us on the importance of relationships within the organisation, too:

> 'These processes depend largely on how workers get along with the team, and the manager's human practices and thinking.'

Beatty and Joffe (2006) highlighted that an understanding and supportive supervisor is the most significant factor contributing to a successful return to work experience.

The importance of a work plan is particularly critical. Best practice examples show that there should be a meeting six weeks in advance to work out a phased return. This meeting should agree on a number of issues such as the targets to be met, hours to be worked, etc. and with a clear discussion of capabilities and adjustments, and full disclosure about medical appointments during work hours. It is, however, acknowledged that such best practice could constitute an onerous cost for small and medium-sized enterprises who generally do not have extensive HR expertise, especially in managing an employee absent due to chronic illness. Challenges are also acknowledged around the capacity of a small and medium-sized enterprise to accommodate a phased return or redeployment to other work tasks. Operational factors may additionally limit the extent to which employers can make reasonable work plan adjustments in working hours and/or job content. High risk settings are particularly problematic in situations, for example, of high temperatures, electromagnetic activity, toilet facilities on higher floors or an absence of the availability of lighter duties.

The public sector may well be better equipped to demonstrate best practice and there are a number of examples of public bodies providing reasonable accommodations to employees with chronic illness. The Health Service Executive (HSE) has published a recent update of its 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' (HSE 2020). In some public sector organisations, disability liaison officers or occupational therapists are responsible for supervising the provision of reasonable accommodations.

4.5 The future potential of social dialogue in the return to work

The creation of cooperation between stakeholders is certainly critical in facilitating the implementation of return to work programmes. However at company level there is a lack of consensus around the role of trade unions in the return to work. Workers point to limited engagement by trade unions, although over 60 per cent of respondents in the study were not union members. Even so, almost nine in ten stated they had not thought about joining a trade union in search of support for their return to work since their diagnosis. More than three-quarters nevertheless agree that support for the return to work should be an important element in negotiations between trade unions and employers, followed closely by trade unions being ready to address the health-related issues of workers.

Some managers told us that, despite their companies being unionised, there are no return to work provisions in collective agreements. A report by the European Agency for Safety and Health at Work (EU-OSHA 2016) claims that the implementation of collective agreements regulating the reintegration of workers following sickness absence can be as effective as a national integrated framework for the return to work. Some evidence of this can be found amidst the consensus that enterprises with longstanding collective bargaining agreements, in manufacturing and financial services, provided the best arrangements in dealing with chronic illness and the return to work. One example is Baxter Healthcare, a pharmaceuticals manufacturer, where an agreement was made in 2018 to expand sick pay entitlement to eight weeks at full pay and six weeks at 75 per cent pay. One officer from the Services, Industrial, Professional and Technical Union (SIPTU) stressed that Baxter could afford extra sick pay and was willing to do so but that many other, and smaller, firms in Ireland did not have the ability to pay. One trade union 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 a collective bargaining agreement does not have return to work provisions, return thus usually becomes an 'individualised' issue. In these circumstances, union officers represent an employee with an HR manager and seek a personal agreement for the union member to have paid time off for treatment or adaptations on their return. One SIPTU officer reported:

> 'When the collective bargaining 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 such instances, however, 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 — are more easily able to reach consensus since they are familiar with collaborating on issues related to well-being at work.

Turning to attitudes towards the role of trade unions in the return to work, more than half the managers we interviewed indicated the presence of a trade union or some form of employee representation. Among those who are unionised, however, return to work is not an issue addressed commonly in company-level agreements. A little less than one-half of managers do not consult with trade unions on these sorts of issues although one-third report that the committee addressing occupational health and safety (and which is also responsible for dealing with return to work issues) contains a union member. Over half report that cooperating with unions or employee representatives had previously led to additional requests being attached to return to work stipulations.

There appears to be consensus among managers that the current Irish legislation is sufficient; one manager declared to us:

> 'We have a very successful return to work practice which is very employee centric. Current legislation is also highly 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 over the stages of the return to work process is highlighted as an issue in a further comment that:

> '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.'

4.6 Return to work and Covid-19

The Covid-19 pandemic has had a significant impact on workers with chronic illness. Beyond the employment-related issues, it has had major implications for their access to healthcare, particularly primary care, in seeking to manage chronic illness. Many organisations providing essential follow-up care are Section 38 and 39 NGOs[9] and voluntary groups established with the support of charitable donations. Fundraising has collapsed during Covid-19 and many charities report their finances to be uncertain

9. The HSE has arrangements with other organisations to manage and deliver health and personal social services. The HSE provides annual funding for the delivery of a range of services to agencies (known as Section 38 agencies) and organisations. Section 38 arrangements involve organisations 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.

or in difficulty. A survey by The Wheel found that 82 per cent of charities are 'very concerned' about whether they will have sufficient funds to provide their services in 2021 (The Wheel 2021). This also shines a light on how reliant the state is on such organisations to provide critical services including cancer support, mental health services and stroke rehabilitation.

More broadly this disruption in health services due to Covid-19 has paused work in many parts of Irish Health provision[10] and patients are either not getting diagnosis or treatment or are postponing or avoiding attending hospitals or family doctors. For example, the Irish Cancer Society estimate that 450 cancers and 1400 pre-cancers were not detected in Ireland up to July 2020 due to Covid-19. This suggests a 'Covid hangover' in terms of delayed diagnosis and treatments that may have significant short-term and long-term impacts on the health of Irish workers.

Covid-19 poses significant challenges in particular for people with chronic illness and concerning their ability to work. However, several initiatives and policies emerged in the early stages of the outbreak in 2020. In May 2020, the Department of Enterprise, Trade and Employment published a Return to Work protocol developed through social dialogue, which was a significant and positive development. This protocol allows everybody to work from home wherever possible; and it gives individuals with health conditions guidance to remain at home where practical, that accommodations will have to be introduced to keep them safe (2m distance at minimum) on their return to work and that they would be the last group of workers returning to the workplace. All employees are, prior to returning, required to complete a Covid-19 Pre-Return To Work form at least three days in advance of their physical return. Individuals are asked on the form if they have any concerns around their return to work. Anecdotally it is reported that this has raised concerns for both employers and workers. For workers, it raises the problem of disclosure: people who may have an underlying health problem are worried about Covid-19 and returning to work in that, up to now, they may have been managing without disclosing their condition to their employer. For the employer, this forced disclosure requires them to acknowledge and manage what has then been reported.

A major question raised by the Covid crisis concerns the assumptions which underpin policy-making in the area of work. Covid-19 has amplified the structural inequality that exists in the labour force. As mentioned in section 2, Ireland is an EU outlier in that it does not have a statutory sick pay scheme. This lack of statutory sick pay has emerged as a significant topic of public interest during Covid-19. Due to its absence, many workers who were sick went to work, as did those who should have quarantined due to being a close contact. The government has promised to introduce legislation by the end of 2021 and consultations are taking place with unions and employers.

10. For example, the national cervical screening programme was paused for over three months from March to July 2020.

5. Conclusion

There is no national framework in Ireland which guides the reintegration of employees with chronic illness back into the workplace. Largely this is due to Ireland traditionally taking a voluntarist and decentralised approach to the regulation of employment terms and conditions. Instead there are a number of important, albeit relevant, ad hoc initiatives from government and other state bodies, trade unions, employer associations and campaigning and patient support organisations. Unlike in other countries, the passive welfare approach to social protection, mainly through income replacement or financial benefit, has been adopted in Ireland. Employees not covered by a collective agreement or as part of an employment contract have no statutory right to an occupational sick pay scheme.

The evidence gathered for this chapter suggests that chronic illness is an important issue at national level. It does seem that supporting people with chronic illness in Ireland is focused on the preventative and medical care aspects rather than on the mechanisms supporting the return to work. Where chronic illness is captured in a work context, it typically tends to come under the umbrella of disability. Non-traditional industrial relations actors, like campaigning and patient support organisations, play an important role in the development of return to work 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 support groups is their knowledge of the needs of workers with specific health problems. However, they face barriers due to the lack of resources, most of which come from voluntary donations, although there are some cases of organisations being funded by the government. This has placed a critical limitation on their ability to provide services and advocate on behalf of their patient cohort.

Overall, Irish social partners report strong awareness of the importance of the return to work. However, there is no evidence of national social partner involvement in return to work policy except in the public sector where there is evidence of negotiation with unions on the Public Service Sick Leave Scheme. Whilst we did find evidence of social dialogue, it was ad hoc and fragmented and often short-term due to the lack of funding. Our findings show that the company level is where return to work procedures are developed but there is limited evidence of trade union involvement in the implementation of return to work policy.

A number of key barriers and facilitators relating to the return to work emerge from the research. The Irish benefits system as a whole is seen as a complex system to navigate, especially when simultaneously 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 the return to work is critical to the re-entry process and to workers' subsequent adaptation. Effective return 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 line managers in particular surface as critical in a successful return to work process.

When discussing reasonable accommodations, organisations need to communicate their policies and procedures on this effectively so that all employees understand them and are able to navigate the process. Organisations also need a process for regularly reviewing reasonable accommodations as the employee's needs, their environment or their work duties change. These challenges – of navigating benefits, communicating between stakeholders and negotiating accommodations before the return to work – were identified by Hoefsmit *et al.* (2013) as bottlenecks that can hamper the return to work.

This chapter has set out the Irish national framework and experience of various actors on the return to work. A major finding is that the majority of stakeholders accept that returning to work with, or after, chronic illness is an important issue. Early intervention, the timely and proactive use of organisational procedures, communication between key stakeholders and multidisciplinary coordination across government departments and agencies and at workplace level emerge as the most important factors in managing the return to work after chronic illness. Furthermore there is no 'one size fits all' formula for such workers: ultimately, it is the needs of workers, as influenced by their illnesses, that are the most important consideration.

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