Chapter 7
Return to work practice in Slovakia: matching best practice with the scope of social partner activity

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1. Introduction

The labour market integration of disabled people has received increasing policy attention not only at EU level but also in particular EU member states, including Slovakia. In the context of labour shortages prior to the Covid-19 crisis, measures pertaining to a longer working life and quick (re)integration into work have become increasingly important. There are, of course, several contextual issues surrounding these policy debates.

Slovakia's 'Country Health Profile 2019' (OECD 2019) summarises that life expectancy in Slovakia has increased but that, at 77.3 years, it still remains among the lowest in the EU, where average life expectancy stood at 80.9 years in 2019. We should remember that, although life expectancy has increased, about 40 per cent of people aged 65 still report having at least one chronic disease. In general, access to healthcare in Slovakia has attained a decent level at which only 2.4 per cent of the population reported unmet medical needs in 2017 – the remaining percentage is likely to be related to ethnic divides and regional inequalities and not directly to chronic illness. Meanwhile the OECD's data on public spending due to incapacity show that Slovakia spent 1.86 per cent of its GDP in 2015 on disability cash benefits (payments made in respect of complete or partial inability to participate gainfully in the labour market due to disability). This is close to the OECD average, but significantly less than those countries which are spending more than 3 per cent of their GDP on this type of benefit (e.g. the Netherlands, Finland, Sweden and Norway).

After Slovakia's political and constitutional crisis in 1998, the employment rate rose from a nadir of 56.3 per cent in 2000 and saw continual growth in the years after 2014 to reach the EU average of 68.4 per cent in 2019.[1] At the same time, the employment rate of people with health conditions stood at just 16.6 per cent in 2015 (Ondrušová *et al.* 2017). Among the reported reasons for absence from work since 2006, the percentages of people citing chronic illness and disability as the main cause have oscillated between 7 per cent and 45 per cent.[2] Most of the policy attention has targeted people with formally-attained disability status, but there is a pool of people of working age who have faced chronic illness and long-term absence from work who do not have this status. In the context of pre Covid-19 labour shortages in the Slovak

1. Eurostat: Employment and activity by sex and age - annual data; online data code: LFSI_EMP_A; https://ec.europa.eu/eurostat/databrowser/view/LFSI_EMP_A__custom_697052/default/table?lang=en

2. Eurostat, Absence from work by main reason, sex and age group - quarterly data[lfsi_abs_q]; https://data.europa.eu/data/datasets/hvwzmlvgj18dxi5l5baaw?locale=en

labour market, the return to work of this group of people has become more important than ever before.

Research into the labour market integration of disabled people in Slovakia is, overall, rather scarce but the return to work after, or with, chronic illness of people who do not have formal disability status has been even less studied. The return to work is a complex process requiring the interaction of various stakeholders at various levels of policy-making and implementation, including workers and employers but also rehabilitation centres, health professionals, workers' representatives, the higher-level social partners as well as policy-makers. Policy areas which have an effect on the return to work encompass sickness, disability and employment. Despite the relevance in a labour market perspective of the return to work of people experiencing chronic illness, little is therefore known about how this process has evolved in Slovakia and how the distinct actors can play a facilitating role therein.

With this aim in mind, the chapter aims to identify (a) the role that is played by the industrial relations actors in shaping return to work policies and facilitating the returns process at workplace level; and (b) the opportunities and challenges which exist for strengthening social dialogue and industrial relations in Slovakia through greater involvement of the social partners in return to work policy and implementation. The analysis of these questions is set in the context both of Slovakia's healthcare system and its structures of industrial relations.

From an industrial relations perspective, Slovakia is an interesting case because it has a stable structure of bargaining partners and a detailed legislative system supporting their roles in collective bargaining, yet there is little vertical coordination between bargaining at the sectoral and the company levels (Kahancová *et al.* 2019). In the past 30 years of its post-socialist history, Slovakia's industrial relations has evolved into an embedded neoliberal system (Bohle and Greskovits 2012), with a key feature being a trade-off between trade union access to policy-making in the early 1990s and social peace (Bohle and Greskovits 2012). In turn, trade unions have formally gained access to tripartism although their membership has gradually declined. In response, unions are increasingly seeking new opportunities to strengthen their voice both at national and at workplace levels. It is thus interesting to explore the extent to which the return to work, a topic with outreach to both these levels and which closely concerns working conditions, yields opportunities for union involvement and bargaining.

Several original sources of data have been used for the analysis, including roundtable discussions and face-to-face interviews with relevant national stakeholders from government agencies, campaigning and patient support organisations, trade unions and employer associations. Moreover, online surveys have also been launched to collect responses from workers and managers; however, response rates were significantly influenced by the Covid-19 pandemic and the related economic and employment protection measures.

The remainder of this chapter is structured as follows. Section 2 introduces the policy framework for return to work policies in Slovakia while section 3 analyses the

involvement of the social partners in shaping these policies and their implementation at national level. Section 4 focuses on the company level and analyses the views of managers and workers while Section 5 summarises the main findings, responds to the research questions and formulates several policy recommendations related to the policy agenda.

2. Policy frameworks on the return to work in Slovakia

Slovakia is among those countries with a limited framework for the return to work in which rehabilitation support essentially exists only for people with formal disability status and where government bodies are the main actors in terms of policy formulation.

There are two basic categories in the Slovak system as regards the workplace integration of people experiencing health-related disadvantages: recipients of invalidity benefit; and severely disabled people. A person receiving invalidity benefit must not be recognised as severely disabled and vice versa.

Invalidity benefit is backed by disability insurance and its acquisition is overseen by *Sociálna poisťovňa* (Social Insurance Agency; SP) based on a medical assessment. The purpose of the benefit, which is called an invalidity pension in Slovakia, is to provide the insured person with an income in the case of a decline in the ability to perform work activity because of the insured person's long-term unfavourable health condition. The following categories of worker are eligible for invalidity pension:

(i) disabled people;
(ii) those who have acquired the requisite number of years of pension insurance (which is determined by age); and
(iii) those who, on the day of their invalidity, did not meet the conditions for entitlement to a retirement pension or who have not been granted an early retirement pension.

The origin and duration of the disability are assessed in line with the benefit procedure by a social insurance physician. The calculation of the amount of the disability pension is complex and depends on the period of pension insurance which the insured person had acquired on the day of becoming entitled to invalidity pension. Subsequently, the 'accrued period' is the period from the origin of the right to an invalidity pension to the day of reaching retirement age.

While the receipt of invalidity benefit encapsulates the view that the person receiving it has reduced work capacity, severe disability is seen as the reduced ability to lead an active life which does not necessarily imply a reduced capacity for work. Thus, unlike a person in receipt of invalidity benefit, someone who is severely disabled does not receive wage compensation from SP but a benefit to compensate for the social impact of the health disadvantage.

In the absence of specific return to work policies in Slovakia, people with chronic illnesses are supported only by the sickness benefit system. Sickness benefit must be

provided to an insured person who has been recognised as temporarily incapacitated from work as a result of sickness or an accident or who is obliged to respect a quarantine measure (hereinafter 'temporary work incapacity'). The following categories are eligible for sickness benefit:

(i) employees;
(ii) self-employed people with compulsory sickness insurance;
(iii) people with voluntary sickness insurance; and
(iv) people who have become temporarily incapacitated after the termination of sickness insurance within the protected period.

Sickness benefit is paid by the employer for the first ten days and then by the public budget (via social insurance) until the end of temporary work incapacity. From the first to the third day, the benefit is 25 per cent of the daily assessment basis; from the fourth to the tenth day it is 55 per cent of it (this may differ as a result of collective bargaining and it can go up to 80 per cent). After ten days the level is calculated as 55 per cent of the daily assessment basis. The maximum duration of temporary work incapacity is set at 52 weeks. The expiry of this period does not lead to the termination of temporary work incapacity status where this can be justified by the individual's state of health continuing to be unfavourable. It does mean, however, that the insured individual is no longer entitled to sickness benefit.

We have said already that there are no coherent and detailed return to work policies in Slovakia and neither, consequently, is there much of a focus on people returning to work after long-term sickness or who are seeking reintegration into the labour market. It is not only this, however. It is also the case that Slovakia does not have any definition of these categories of people and we do not even know their number. Furthermore there are no studies that concentrate on this group. However, it is worth mentioning one measure in particular as well as some more general legal provisions of the Labour Code which may be supportive of a return to work process.

This measure is vocational rehabilitation (Act on Social Insurance § 95). This is a benefit that can be provided by accident insurance and is intended to support the worker's efforts in returning to work and with social reintegration. There is no legal right to rehabilitation, but it may be provided after an assessment of the medical fitness of an injured worker who, because of an accident at work or an occupational disease, has experienced a decline in work capacity. This is carried out by a medical assessor from social insurance and is made in particular view of the possibility of getting the injured worker back to work. The maximum duration of vocational rehabilitation is six months. In justified cases – in which it can be assumed that the injured worker will acquire the ability to work at his or her previous level of activity – benefit can be extended by another six months. The problem is, however, that this tool is little used and that some people appear to be ashamed to seek it; while counselling on the issue is also insufficient.

There are three legal stipulations in the Labour Code that are relevant in a return to work context. The first is the job guarantee provided under Labour Code § 157 – when a

worker returns after temporary work incapacity, the employer is obliged to assign him or her back to the original work they were undertaking and to their original workplace. Where such reassignment is not possible, the employer is obliged to assign the worker to different work which corresponds to the contract of employment.

The second stipulation, under Labour Code § 64, is a prohibition on notice which guarantees that the worker cannot be fired during the period of temporary work incapacity (sickness leave). There is also a general provision in § 2 of the Anti-discrimination Act which states that '[a]dherence to the principle of equal treatment shall lay in the prohibition of discrimination on the grounds of sex, religion or belief, race, nationality or ethnic origin, disability…' and that (in § 7):

> 'In order to apply the principle of equal treatment employers shall take appropriate measures to enable a person with a disability to have access to employment, to work of a certain type, to promotion or access to vocational training; except if the adoption of such measures would impose a disproportionate burden on the employer.'

The third stipulation refers to job assignment (§ 55). This obliges the employer to reassign the worker to another job if, because of a medical condition, he or she has lost the long-term ability to continue carrying out the previous work, if he or she is not allowed to do so due to an occupational disease or if he or she has reached the maximum permissible exposure at the workplace determined by a decision of the competent public health authority. The medical report must show that the worker has lost the ability to continue to perform the work done to date; such an opinion could be issued by a physician, specialist doctor or a medical facility. Where such a medical report has been issued, the worker must submit this to the employer and request a transfer to another job.

We should also note that some collective agreements do exist that partially stipulate provisions on the return to work. Some establish an employer's obligation to the worker in the form of financial compensation if he or she develops an occupational disease or work-related injury or receives a one-off financial sum during long-term incapacity for work due to health problems. Workers with an occupational disease are sometimes, based on a provision in the collective agreement, protected against the termination of employment in the event of organisational change.[3] Furthermore some large companies, such as Volkswagen Slovakia, have developed internal policies that seek to take preventive action so that people do not end up being absent due to sickness.

The increased labour market protections available for people with health conditions is presented as a blanket statement in several strategic documents that set out the reasons and tools to support the work integration of vulnerable people. Several laws, allowances and measures help such people integrate into the labour market and, in respect of this, there exists a number of stipulations including increased labour law

3. In this context, it is notable that the employer has a general legal obligation to ensure health and safety at work and that this has a preventive aspect concerning the emergence of various occupational diseases and injuries.

protection, active labour market policies, mandatory quotas for the employment of people with disabilities and vocational guidance services. There are, in addition, sheltered workshops and, since 2018, social enterprises for work integration as well as several NGOs dealing with this issue. However, where someone returns to work following a chronic illness that did not lead to the acquisition of formal disability status, sickness leave is the basic tool and there are almost no other options (measures, procedures or interventions) available in the Slovak legislation to help these people get back to work.

Therefore we conclude that, generally, the legislative framework on the return to work is limited in Slovakia. Currently the actual returns process is largely discretionary, resulting from the interaction between the relevant actors and company-level policies, and lacking a strict anchoring in dedicated legislation.

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

As summarised earlier, the existence of return to work policies, measures and policy implementation is tied up with people having formal disability status or decreased work capacity. This connection is firmly embedded in the perceptions of the social partners and other stakeholders, e.g. campaigning and patient support organisations supporting disabled people. Policies on the return to work therefore rarely relate to people with or after chronic illness in the absence of formal disability status or eligibility for invalidity benefit.

This perception of the return to work concept needs to be kept strongly in mind and provides the backdrop to our analysis which exploits three sources of data: a survey of the social partners[4] and interviews and roundtable discussions with stakeholders.

3.1 Key actors in return to work policy

Government bodies are the main actors in terms of the formulation of policies on the return to work. *Ministerstvo práce, sociálnych vecí* a *rodiny* (the Ministry of Labour, Social Affairs and Family) designs the legislative framework and determines the conditions applying to work assistance for disabled people and other supportive measures. The creation of return to work policies and the monitoring of their implementation is the job of a specialist department in the ministry. An important role is also attributed to Ústredie *práce, sociálnych vecí* a *rodiny* (Central Office of Labour, Social Affairs and Family; *ÚPS*VaR), the central labour market authority in Slovakia. This is an umbrella labour market organisation with a broad regional structure of 46 local labour offices which manage a database of jobseekers, including jobseekers with reduced work capacity.

4. The sample used for the analysis is rather small; therefore the findings need to be taken as indicative rather than representative of the opinions of the social partners in Slovakia. More details can be found here: https://www.celsi.sk/en/projects/detail/64/

Return to work is not a key issue that ranks high on the trade union agenda. This is more the result of a lack of resource and a shortage of expertise than any absence of a willingness to be more active. On the employer side, associations act based on the demands of their members which are not interested in greater activity on the issue of the return to work.

Other relevant actors are the health insurance agencies which possess the most detailed evidence of people experiencing chronic illness and disability. *Agentúry podporovaného zamestnávania* (the Supported Employment Agencies) and occupational health physicians are additional actors with the potential to influence return to work policies. Campaigning and patient support organisations perceive their contribution as indirect in the sense that they provide personal support services (targeting courage and self-confidence) so that such workers can be better integrated into the work process.

3.2 Views and level of involvement of industrial relations actors

The social partners perceive EU-level return to work policies as relevant and call for greater action, citing that EU-level social dialogue should adopt binding recommendations for the member states in this area. Despite this, more than half are not aware of any EU-level policies that support the return to work for workers after treatment for chronic illness.

In contrast to the low awareness of EU-level policies, the social partners are conscious of national policies and measures in this area. They believe that Slovakia has, in general, an elaborate policy framework and that it properly implements and enforces return to work practices. As established earlier, however, these are predominantly associated with disability and are not ones comprehending the return of workers after treatment for chronic illness. Indeed, our interviewees among the social partners confirm that a standardised policy on the return to work following chronic illness is absent at national level.

Consequently the involvement of the social partners in shaping return to work policies after chronic illness is limited. Research shows that they are currently working on, or actively involved in, neither policy creation nor its implementation.

This low commitment to being more involved in policy direction is supported by a relatively high level of satisfaction with the current extent of their involvement. Employer associations are more satisfied with this than are trade unions which acknowledge that they should be more active in this area. However, the involvement of the social partners here is mostly conditioned by external factors, i.e. the national government's priorities or agenda in national social dialogue. Moreover, the reasons for non-involvement relate to the internal organisational structures of the social partner organisations: the social partners do not consider involvement in return to work policy-making as a key priority on their agendas and, therefore, are not actively taking initiatives to increase their participation in policy development.

Considering policy implementation, most social partners have an awareness of specific measures that facilitate the application of return to work policies and are actively involved at this stage, more at company level and using an informal, case-by-case approach. This is conditioned by the presence of a committed representative of trade unions or employer associations within the company who is actively engaged in policy implementation on the issue.

Trade unions are mostly involved in collective bargaining and providing individual assistance to workers (e.g. by assisting them with the bureaucratic procedures of applying for benefits or helping them voice their problems to the employer). The type of collective bargaining related to the return to work that trade unions have been involved in has occurred solely at national level.

The employer association is in a position to submit various proposals concerning return to work policies, and to get these on the agenda, since it is a member of the national tripartite council. However, it is basically against any regulation, including on the return to work, and does not see any demand coming from its members. On the other hand, it does welcome any measure which supports the flexibilisation of work which might also be relevant to people returning to work after a long illness or with a disability. It sees employers' views on return to work policies not only as an economic matter but also as a matter of social responsibility:

> 'We as employers want to act like those who are not only interested in profit but want to be perceived by the public as those who are also interested in people who are not at their best in terms of the ability to work.'

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

Most social partners evaluate the degree of cooperation between stakeholders (trade unions, employer associations, government, labour market institutions, medical organisations, rehabilitation centres and NGOs) as potentially important in facilitating a sustainable and feasible return to work policy framework, but they do see obstacles in it. However, the majority repeatedly confirm that there is a lack of cooperation in terms of return to work policy-making and implementation. The social partners generally agree that more intensive interaction between stakeholders is essential and also that trade unions and employer associations should both be more active in return to work policy implementation at national level. At the moment, cooperation works only partially and between some actors, but an overall umbrella mechanism at national level is also missing. For example, attempts to initiate systemic cooperation to promote the enforcement of the UN Convention on the Rights of Persons with Disabilities, which would bring together all relevant actors, failed due to insufficient political support.

Some campaigning and patient support organisations express strong dissatisfaction with the amount of cooperation with employment offices as well as with their unwillingness to assist the return to work in individual cases. Meanwhile government

bodies claim that they do cooperate with trade unions at sectoral or company level where a trade union organisation has been established.

The most relevant platform for cooperation is the Committee for Disabled People which joins representatives of government and public regional administrations with campaigning and patient support organisations. This Committee is the place to discuss urgent problems and to initiate or prevent a change in the legislation that might damage the interests of disabled people. The Committee also consults on particular cases of alleged discrimination against disabled people and drafts recommendations for improvement although it only rarely proposes policy documents, focusing more on various initiatives. Trade unions and employer associations are either not present on the Committee or are present but not active.

Other platforms for cooperation are the employment committees which operate in the state employment offices which are spread widely throughout the regions. Trade unions and employer representatives are involved in these committees and they do discuss the employment of someone with reduced work capacity or with formal disability status. The committees seek to place such a person either in a particular company or in sheltered workshops or workplaces.[5]

This lack of cooperation between all the relevant actors results in the absence of any acknowledgement of the problems as well as a lack of development of the skills associated with how to treat a person returning to work following chronic illness. The need here for a change of approach by the social partners was expressed to us by one representative of a patient support organisation:

> 'I would be interested in the trade unions' response to the extent to which they have mapped the problems of people who find themselves in a chronic disease situation and what they do for them. The people themselves who are to return to work solve many issues, but they will certainly not come to the trade union with a solution. So, instead, proactive detection is needed.'

3.4 Outcomes of social dialogue with regard to return to work policy

Stakeholders consider that incorporating return to work measures into collective agreements might be difficult. Nevertheless social dialogue resulting in specific agreements could be a useful tool for making return to work policy more visible and in terms of raising awareness. There are doubts that it would solve particular cases, but it could be used as a 'reminder' to boost sensitivity towards the people concerned.

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5. A sheltered workshop is a workplace where there is more than one job established for a disabled person and where at least 50 per cent of workers are disabled. A sheltered workplace is a workplace where a job for a person with a disability has been established but which is not a sheltered workshop. A workplace where a disabled citizen carries out a self-employed activity is also considered a sheltered workplace. A sheltered workplace can also be set up in the household of a disabled person.

State administration representatives consider that policy guidelines on the return to work are necessary and report that the social partners are, for the most part, involved in commenting on the legislation which has already been drafted. ÚPSVaR could not, however, comment on the state of social dialogue in the return to work area: it is a subordinate agency and acts strictly in terms of the implementation of current legislative measures. It does not possess competencies in social dialogue and cooperates with employers only as far as supporting them in the employment of disabled people.

Trade union representatives challenge the feasibility of a general procedure for social dialogue at national level and warn against unnecessary bureaucracy and impracticalities. Even if a return to work process was anchored in a collective agreement at national level, it would be challenging to implement and oversee. Here, they regard an individual approach at company level to be more useful. Employee representatives at company level similarly prefer an individual, informal approach in specific cases without any anchoring in social dialogue practice at national level. This is in line with findings that the return to work agenda is currently outside the scope of trade union activities which are focused on sectoral and company-level collective bargaining, monitoring processes and in providing assistance to individual workers.

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

For some trade union representatives, collective agreements at sectoral or company level are seen as potential and practical tools for extending obligations to employers. NGOs and charities, despite not having experience with collective bargaining, also see an opportunity for social dialogue to include supportive measures for disabled people (or who have chronic illness) at company level. At the same time, there is room to seek improvement in the involvement of labour inspectorates in return to work cases following an accident at work; stakeholders identify that the inspectorates should not just act as an enforcement body but should also provide preventive advice and counselling for disabled people.

Stakeholders also highlight a need for greater flexibility in employment services and better information on vocational training for disabled people and those experiencing chronic illness before entering the labour market. Trade unions need similarly to be better informed about the particular contribution they can make as well as more available for people seeking to return to work.

There is also room for improvements in the legislation. The law on sickness insurance allows only 52 weeks of paid sickness leave and, after one year of this, people have to be granted disability status. Furthermore it is acknowledged that there is space for campaigning and patient support organisations to campaign for people in general to accept illness and to avoid shaming and stigmatising disabled people or those with illnesses.

To sum up, the involvement of the social partners in shaping and implementing return to work policies is limited. One contributory factor here is that the policy framework does not comprehend people returning to work following chronic illness. The absence of a proper policy framework does, however, provide space for an informal and individualised approach by the social partners in terms of their capabilities of providing support in this area. All the actors expect improvements in cooperation and are open to their more systematic involvement in this area, in particular as part of workforce diversity management in the case of employers and as part of collective bargaining in the case of trade unions.

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

This section focuses on experiences with return to work at company level, i.e. the experiences of workers and managers based on the data and information gathered from our primary research activity.

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

Regarding individual experiences of returning to work, it is important to note that the number of responses to the survey was quite low and to consider the following statements with a degree of caution.

The most prevalent type of disease in our sample of workers was cancer, followed by cardiovascular disease and musculoskeletal diseases while the rest identified other types of illness or a combination of several. The prevalence of particular illnesses in our sample corresponds to data from the general population according to which the most frequent causes of the hospitalisation of patients in 2018 were circulatory system diseases, digestive system diseases and cancer (NCZI 2018).

Most respondents state that they were not concerned about their return to work. Those who were concerned expressed that were most commonly afraid of the need to jump in at full productivity right after treatment without an adjustment period. Other concerns related to the fear of a lack of support at the workplace and financial discrimination, as well as having no support from the employer and the pressure to work long hours right after recent treatment.

Almost all workers with a prevailing diagnosis intend to return to their current job after treatment and nearly half plan to continue working during treatment, if possible. Most also have an arrangement with their current employer to return to the same work position after treatment and, among those respondents who had already been through the return to work process, more than two-thirds did indeed return to the same position.

A direct team leader or line manager is considered to be the most important person in terms of supporting an individual worker's return, followed by the HR department. Some respondents also mention campaigning and patient support organisations as important in helping to facilitate the return to work. The direct team leader or line manager was likewise listed as the go-to contact in easing the return process in terms of making adjustments to working time, exposure to stress, physical well-being at work and similar aspects, although a smaller number of workers would turn to the company's HR department for help.

During treatment, the people at the workplace with whom respondents are most often in touch are their colleagues and, to a lesser extent, their direct manager. A small share identify that they were not in contact with anyone from their workplace during their sickness leave. Most of the time, respondents return to work on their own initiative, but some had also returned after medical approval, either based on advice from their general practitioner or a specialist treating their illness. Medical staff (specialists as well as the general practitioner) were also among the first to discuss an individual's return to work.

Nearly half of the workers who responded to the question say that had not felt particularly welcome after they had returned to work. Moreover, more than half do not feel that the company was well prepared in terms of making the necessary accommodations as a result of their health condition. In addition, nearly two-thirds say they had not received extensive mentoring and guidance from either their company or employer or the trade union/employee representatives upon their return while the return to work does not seem to have been a process that was particularly well-coordinated between the company and their doctors.

Of all the categories of potential work adjustments, the majority receive no, or only very limited, support in respect of the health conditions they experience due to chronic illness. Where reasonable or extensive support was received, this was mostly in connection with being flexible about time, the sharing of tasks with colleagues and the postponement of some deadlines.

Workers' families and the specialists treating illness play a crucial role in the returns process while the role of the employer in this respect is not considered very important and support from work colleagues or friends is also seen as limited. The vast majority identify that NGOs, organisations for rehabilitation and trade union/employee representatives do not play an important role in their process of returning to work.

Several respondents shared their individual experiences and suggestions for changes to the system. One respondent with cancer suggested increasing the limits on paid visits to the doctor ('sick days'), due to their increased frequency relating to the nature of their illness. Another pointed out that each experience with the return to work is different, influenced by company, supervisor and many other factors. Indeed, several identify the significance of a sector-specific approach: in their experience, sectors such as IT, which regularly has a shortage of workers, appears to have the ability to involve workers with health conditions (after or during sickness leave) more easily than others

due to the nature of IT work. While computer-based work allows for greater flexibility, workers can, for instance, perform smaller tasks or work from home.

Nevertheless, some experiences of workers were rather negative:

> 'After returning to work, one seems to be sitting on an express train. Everyone expects that I will manage the whole amount of work. Nobody talks about surviving the diagnosis and the limitations resulting from it. My work pace is monitored and occasionally corrected by my husband or I try to refuse the work that exceeds normal working hours. I have problems with being on time. I refuse to work unpaid overtime and take my work home for the night.'
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> 'After returning to work, I was under pressure from my superiors and colleagues to quit my job and be replaced with a healthy worker.'

It is clear that unions have only limited opportunities to support workers. Of those respondents who discussed their sickness leave with trade union representatives, only one in five confirm a supportive response in terms of the help and support offered to them while an equal proportion report no help or support being offered during sickness leave. Our sample was split into equal groups of unionised and non-unionised workers, but the majority have trade union or employee representatives present in their workplace. Of those respondents who were not union members, most had not thought about joining the trade union in order to support or facilitate the process of their return to work. This confirms that workers do not consider trade unions and employee representatives to be important actors in the return to work.

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

Investigating how employee absence due to a long-term medical condition affects the organisation, the vast majority of managers state that the employee is not replaced in the first instance but that the workflow is rearranged and job tasks divided between other employees. Notably, a small share of managers pinpoint that there is no significant effect on the organisation.

Managers consider that legal advice regarding sickness absence plays a supportive role in helping them deal with workers absent on sickness leave. The same is true of external counselling, e.g. from doctors and therapists as well as cooperation with dedicated professional associations and/or campaigning and patient support organisations, such as the League against Cancer. On the other hand, managers also reveal that all the resources that might be potentially supportive in dealing with workers on sickness absence are all equally missing: legal advice regarding sick leave; information on financial strategies in dealing with sickness related absence and external counselling.

Managers mostly agree that a worker should be entitled to an adjustment of their working duties at the organisation's discretion and that it is crucial to stay in touch with the

worker during the period of absence. At the same time, managers mainly disagree that a worker is less committed to work after being diagnosed with a chronic illness. They would not, however, recommend more time-off than the current legislation stipulates.

A majority of managers state that there is trade union or employee representation in the organisation. Even so, company-level collective agreements do not address the return to work. Instead, practices that would best apply to the organisation are: interaction between management and unions regarding return to work policy and practice, as long as this is ad hoc and not regular; and the inclusion of a worker representative on the committee addressed to occupational health and safety. The barriers that managers see in terms of cooperating with trade unions and other employee representatives in facilitating the return to work is that the management of, and responsibility for, the return to work process may become unclear. At the same time, the most prevalent outcomes that they find beneficial as regards engaging with unions/employee representatives on the return to work are training sessions for managers and team leaders directly exposed to interaction with workers with chronic conditions; and training sessions for the union and/or employee representatives who are likewise involved.

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

4.3.1 Workers' perspectives

Workers feel that their employers were generally supportive after they had announced the need to take sickness leave but, at the same time, did not feel that their employers offered any help or support during their absence. In practice, neither did they benefit from any mentoring or coordination of experience between the company and their doctors.

The level of satisfaction with the help and support received from employers and trade unions at company level shows variance. Most are satisfied with both employers and unions, but more than one-third express strong dissatisfaction with the support and help (or lack thereof) from trade unions. Furthermore over two-thirds state that there were no negotiations between their employer and trade union/employee representatives about adjustments to their work tasks and responsibilities after the return to work.

4.3.2 Managers' perspectives

A majority of managers describe the type of interactions with workers during sickness leave as irregular and mostly informal. The responses here suggest that workers on sickness leave receive no updates on work-related issues during their period of leave: managers admit that, during a worker's sickness absence, they neither keep the worker informed about work-related issues nor involve him or her in work-related matters (such as asking for that person's opinion, advice or involvement in planning or in decisions). According to managers, the return to work is indeed, in line with the responses of workers presented above, initiated mostly by workers themselves.

Regarding return to work procedures that might be available at company level, a few admit that either there are no specific procedures or that they do not know about them. If any return to work procedure is available, then there is the possibility of a phased return to the organisation and/or that the organisation might cooperate in this respect with other external parties, e.g. the occupational health service.

Corresponding to previous findings, the type of support most frequently offered to an employee returning to work is the availability of informal procedures. Another relatively common support is that, before the worker's return, there is a thorough discussion to plan the return process. However, it seems that managers also expect the worker to be back to regular productivity upon returning to work without the need for adjustments.

In the context of the lack of a formalised policy on the return to work at national level beyond disability policies, companies deal with the return to work of their workers individually and behind closed doors. HR departments deal with an individual's return on a case-by-case basis and, most probably, there are no formalised processes or policies at company level. Nevertheless, several good practices and experiences are apparent from our research. For example, in a large automotive manufacturer, trade unions are part of a health and safety committee that treats every return case individually. In another smaller workplace, the informal nature of the interaction between manager and workers had smoothed the return process, as did the level of engagement during the period of sickness leave itself and the need to cope with the employer's various bureaucratic obstacles in order to adjust the workspace to fit the returning worker.

Asking managers about how to improve the return to work process in their organisation revealed that most see the need for better cooperation with external stakeholders, e.g. medical doctors, therapists and campaigning and patient support organisations. Another suggestion for improvement is the demand for better organisation-wide policies and activities. Finally, managers would welcome more specific provisions in the legislation on the return to work to guide the organisational approach, as well as the legislation itself becoming more flexible, leaving more space for company-level management decisions on return to work issues.

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

Nearly nine out of ten workers are unaware of cases in which a trade union had proved helpful in the facilitation of a return to work. Workers' lack of awareness of trade union work, together with their opinion 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 element of negotiations between trade unions and the employer, identifies that there is major potential for social dialogue to act as a tool to address return to work processes. Significant issues remain, however: for example, one-third of workers perceive trade unions to be insufficiently powerful to facilitate the return to work in Slovakia while

a quarter are unsure whether the preferred form of support should be to seek binding agreements with employers.

From the employer perspective, although based on a small number of responses, managers prefer to look to training sessions for team leaders who are directly exposed to interaction with workers experiencing chronic conditions. According to managers, the legislation is too general in terms of managing returns to work following chronic illness and thus does not offer sufficient support to companies. Furthermore the legislation has other shortcomings in that it is unclear and creates further burdens, and is thus not particularly helpful.

Overall, the following can be summarised about the return to work process at company level. Employees receive only limited support from their employer in the process of returning to work following chronic illness. The majority return to work on their own initiative and most receive support neither from the employer nor the trade unions at the workplace. Employers, on the other hand, deal with returns to work on an individual basis and without formal rules within the organisation. Managers expect employees to have the same productivity level as before and the availability of adjustments to working conditions is limited.

5. Discussion of research findings and conclusion

In terms of the legislative framework, the legislation in Slovakia is biased towards those people with chronic conditions who acquire formal disability status or who are entitled to invalidity benefit from the state. The vast majority of policies, as well as the policy implementation experience, focuses on this subgroup, leaving those undergoing return to work processes, but without formal disability status, subject to the individual discretion of employers and general sickness benefit policies.

The actors involved in policy-making and implementation relevant to the return to work (and including disability policies) include stakeholders at state level and the social partners as well as NGOs, charities and campaigning and patient support organisations. Among these, return to work policies are identified as among the ‘core business’ of specialised government and employment offices, patient support organisations, NGOs and charities.

For both trade unions and employer organisations, return to work policies are secondary or even marginal as regards their current agendas. Awareness of EU-level policies on the return to work remains low among the Slovak social partners although they do support more active EU-level policies promoting the return to work in member states. At the same time, some maintain that return to work policies should be addressed exclusively at national level due to the diversity in European policy frameworks and industrial relations systems.

In contrast, the social partners are well aware of national return to work policies (where these are related to formal disability status) but are not actively involved in

policy design as this is not a core priority for their organisations. It is also clear that the social partners lack a coherent national strategy towards the return to work of people following chronic illness. Despite lacking a dedicated framework for national return to work policies which extends beyond disability, most of the social partners think that Slovakia has an elaborate policy framework and properly implements and even enforces practices on the return to work. Regarding policy-making and implementation in this area, employer associations perceive their involvement as sufficient although there is a demand for more active involvement among the trade unions.

At national level, return to work policies are not a priority for trade unions due to low capacity and a priority focus on other, broader, interests of workers. Nevertheless trade unions are involved in commenting and consulting on the relevant legislation and provide legal consultation for their members, when needed. Besides this, trade unions are mostly engaged in providing individual assistance to individual workers at company level, something that is viewed as more beneficial than unions supporting an agenda on the return to work in national-level social dialogue. On the other hand, social dialogue could, where it results in specific agreements, be a valuable tool to make policy on the return to work more visible and to raise awareness among all stakeholders on the potential role that trade unions could play in the return to work process.

Employer associations at the highest level, as regular members of the national tripartite council, can submit various proposals for the amendment of return to work policy. Nevertheless, they do not perceive any demand from their membership base for such activity. Even though the return to work theme is perceived by employers both as an economic issue and as a matter of social responsibility, employers resist stricter regulation and call for greater work flexibilisation in general and for the return to work agenda to be addressed individually at workplace level.

Despite such obstacles, the social partners do see opportunities for their greater involvement in this policy area. Most evaluate the level of cooperation between trade unions, employer associations, government, labour market institutions, medical organisations, rehabilitation centres and NGOs as potentially important in terms of facilitating a sustainable and feasible policy framework on the return to work. Furthermore there is general interest in increasing the participation of the social partners both in policy design and implementation. Suggestions for improving the role of social dialogue include a better integration of the return to work agenda in collective bargaining, more systematic data collection and reform of the present system and of the quotas for employers to employ disabled workers.

All stakeholders agree that cooperation between the various types of actor is, however, lacking and that there is room for improvement. Cooperation could be extended to involve other stakeholders too, such as labour inspectorates or employment promotion agencies, rehabilitation centres and others. At the same time, the level of cooperation that does prevail needs to be intensified and to become a platform for the specific discussion of topics related to the return to work.

Collective bargaining and collective agreements at sectoral or company level are seen as potential practical tools to stipulate obligations for employers in terms of return to work policies. There is also room for the legislative improvement of the present disability policy and its implementation procedure. This includes, for example, an amendment to the legislation on sheltered workplaces for disabled people. While the current allocation to sheltered workplaces does not facilitate an easy transition into regular jobs, a legislative amendment should aim to revisit the role of a sheltered labour market for people with health conditions, In particular, it should propose a mechanism for cooperation between employers and other stakeholders, including unions and NGOs, supporting labour market integration to facilitate an easier and more direct return to regular jobs instead of sheltered ones.

At company level, workers undergoing a return to work process are mostly fearful of a lacking transition period and that they would be expected to resume working at immediate full productivity. Lived experience indeed shows that this is the case on the part of most employers in the absence of a national-level policy on the return to work and since most employers do not normally have even a company-level policy stipulating the exact process that should be followed. In the few cases where concessions are granted, these refer to flexible time arrangements and task sharing with other colleagues. For the most part, no specific return to work procedures are available at company level and, even where they are, managers have little awareness of them. Neither are workers aware of the potential role for trade unions in facilitating their return. Nevertheless several examples of good practice may be identified at company level where employers have successfully managed to integrate workers with health conditions and/or disabilities.

Despite being in touch with colleagues, and occasionally with their line manager, during their treatment, most respondents feel only ambivalently welcome at their workplace after they return. Managers also acknowledge that interactions with workers during their period of sickness leave are irregular and informal. A majority of workers do not think that the company is sufficiently well prepared to accommodate the necessary adjustments required by their health condition. Where adjustments are made, this is mainly in connection with time flexibility, task sharing with colleagues and the postponement of some deadlines.

There is a variation in the level of satisfaction of workers with the help and support they receive from employers and trade unions at company level. Most are satisfied, but one-third express strong dissatisfaction with the support and help they received from trade unions. Overall, the role of trade union/employee representatives is not perceived as an important one in the process of their returning to work. This might, however, be influenced by the relevant respondents not consulting with employee representatives on their need for a long-term period of absence. Furthermore most workers are unaware of cases in which a trade union had proved helpful in terms of facilitating a return to work. Despite some workers regarding trade unions as insufficiently powerful in this respect, they still expected that trade unions would always be ready to address the health-related issues of workers. Workers support the notion that the return to work should be an element of negotiation between trade unions and employers. These opinions, too, highlight the potential for social dialogue as a tool to address return to work processes.

Research into the return to work in Slovakia shows that there is a missing link between EU-wide strategic concepts, their integration into national policies (which are currently restricted to people formally recognised as disabled) and their subsequent implementation in practice at company level. Companies lack policies on workforce diversity and there is an insufficient elaboration of the concepts of an ageing workforce, fitness for work and the overall concept of workforce diversity, extending to workers with health conditions. The connection between EU, national and company-level use of such concepts is currently limited. Better interconnection could be facilitated via the European Semester but also via a better articulation of social partners' interests as regards their own EU-level organisations and social dialogue committees.

Our policy recommendations refer to roles, strategies and particular actors at various levels where return to work policies and their implementation need attention, as well as in terms of a conceptual understanding of the return to work.

First, the study points to the need for more systematic data collection on people with chronic conditions and their working life trajectories. This is currently lacking and thus complicates policy-making and the implementation of return to work policies.

Second, return to work policy should, conceptually, clearly distinguish between people with and without formal disability status. The focus is currently the former and a dedicated policy mix for the latter group is almost non-existent.

Third, given the need for more effective policy implementation on the return to work, closer cooperation between stakeholders is desirable in terms of discussions among expert groups but also in connection with practical steps. The latter should encompass a more coordinated management of the return to work process at national level (e.g. integrating this agenda into a single umbrella organisation rather than decentralising it across various stakeholders that lack cooperation).

Fourth, the greater involvement of trade unions is called for at each of the national, sectoral and company levels. At national level, unions could build on their priority of workforce protection, which is shared by state stakeholders, while opportunities for including return to work provisions in collective bargaining at sectoral and company levels may be explored.

Fifth, at company level, and despite employers' longstanding preference for addressing the return to work on an individual basis, a more systematic approach would be welcome by workers actually undergoing a return to work. This would add to the transparency of employment policies as well as assisting their interaction with national-level policies. Trade union involvement in framing diversity policies at company level more broadly, but also in including stipulations on the return to work, also constitute areas for further exploration and analysis.

Finally, the study has identified a gap between relevant EU-level policies (not only in the narrow sense of the return to work but in the broader sense of an ageing population, fitness for work issues and the labour productivity debate), national-level policies and

the decentralised implementation level. The comparative experience of various EU member states is essential as a means of facilitating better articulation between these levels to address return to work policies within the EU from a multi-level governance perspective.

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