

Rehabilitation and return to work: Analysis report on EU and Member States policies, strategies and programmes¹

Executive summary

This study² investigates the systems for rehabilitation/return to work in place in the 28 European Union (EU) Member States, along with the four European Free Trade Association (EFTA) countries. It analyses what factors play a role in the development and implementation of a rehabilitation/return-to-work system. Finally, it identifies a number of elements of rehabilitation/return-to-work systems in European countries that could be considered as success factors.

Systems for rehabilitating sick and injured workers are increasingly viewed as important elements of national policy approaches towards the ageing workforce. Between 2002 and 2013, life expectancy in the EU-28 increased by 2.9 years, from 77.7 to 80.6 years (Eurostat, 2015a). In parallel, the proportion of 55- to 64-year-olds in the total working-age population rose strongly between 2000 and 2015 (from 16% to 20%) and is expected to reach 21% in 2020 (Fotakis and Peschner, 2015). Ageing is accompanied by a higher risk of developing (chronic) health disorders, such as depression, chronic bronchitis, cardiovascular disease and musculoskeletal disorders. In 2013, 33.4% of the older employed population (55–64 years) in the EU-28 suffered from a long-standing illness or health problem compared with 14.6% of the younger employed population (16–44 years) (Eurostat, 2015b). This ageing of the European workforce, combined with the stagnation of healthy life years and the prevalence of long-standing illness in older age groups, is compelling workplaces and national social security systems to improve the management of sickness absence and adapt work to chronic conditions and mild disabilities. Long-term sickness absence often leads to unemployment and is a major predictor for all types of exit from the labour market, including disability pension (OECD, 2010) and early retirement (Aranki and Macchiarelli, 2013), which are all major financial burdens for Member States, the workplace and society.

¹ Source: EU-OSHA – European Agency for Safety and Health at Work.

² This report forms part of the activities carried out to support a three-year pilot project initiated by the European Parliament and managed by EU-OSHA on the occupational health and safety (OSH) of older workers and the rehabilitation of sick and injured workers in Europe. The project aims to assess the prerequisites for OSH strategies and systems within different European Union Member States to take account of an ageing workforce and ensure better prevention for all throughout the working life.

Actions aimed at prevention – that is, at avoiding sickness – both at the workplace (occupational safety and health (OSH) interventions) and outside the workplace (public health interventions) are clearly important. But if sickness occurs, measures focusing on *rehabilitation* and *return to work* are also important in avoiding or minimising sickness absence leading to disability.

Rehabilitation – understood as the process of recovering ‘optimal physical, sensory, intellectual, psychological and social functional levels’ (WHO, 2016) – consists of three different aspects. *Medical rehabilitation* aims to restore the functional or mental ability and quality of life of people with physical or mental impairments or disabilities; *vocational (or occupational) rehabilitation* aims to enable persons with physical or mental impairments or disabilities to overcome barriers to accessing, maintaining or returning to employment or other useful occupation; and *social rehabilitation* aims to facilitate the participation of people with disabilities in social life. While exploring the linkages between the three types of rehabilitation, this study focuses in particular on the second category.

Return to work is a concept encompassing all procedures and initiatives intended to facilitate the workplace reintegration of persons who experience a reduction in work capacity or capability, whether this is due to invalidity, illness or ageing (ISSA, 2013). The return-to-work concept fits well in the current political context of maintaining the sustainability of social security systems and reducing the economic impact of sickness absence and mismanaged return to work leading to unemployment, disability pensions or early retirement.

This report analyses the systems in place for rehabilitation and return to work in the 28 EU Member States and the four EFTA countries. It also incorporates the evidence gathered through case studies describing return-to-work programmes in nine Member States and the results of expert workshops held in 10 Member States. The country studies were drafted by national experts in the field of health and safety at work between September 2013 and June 2014 and, therefore, this report does not include new policies or initiatives that countries might have introduced afterwards.

Rehabilitation and return-to-work policies and systems in European countries

The analysis of the national systems in place in 32 European countries (the EU Member States and EFTA countries) highlighted a great diversity of contexts, policies and stakeholders involved. On the basis of the investigation and analysis, the countries have been grouped according to their rehabilitation/return-to-work systems. The criteria for the categories included the obligations of employers regarding rehabilitation and return-to work, access to vocational rehabilitation, the country’s approach to disability, the timing of intervention and the focus on prevention, the coordination of stakeholders and/or multidisciplinary teams in the rehabilitation process and the level of external support provided to employers.

Two main trends emerged from the analysis. First, in some countries, the focus is on the implementation of antidiscrimination and equality in employment policies, mainly targeting people with disability. In these countries, the system focuses more on the promotion of access of people with disability to the labour market than the actual reintegration process following a long-term sickness absence that has led to disability. Second, other countries address rehabilitation with the more general perspective of ensuring the sustainability of social security systems. In these countries, the system targets all workers and focuses more on early sickness absence management and the prevention of exclusion from the labour market. From these overall trends, four groups of countries were identified³:

- The first group of countries consists of Austria, Denmark, Finland, Germany, the Netherlands, Norway and Sweden. Among the main characteristics of these countries are the inclusiveness of their rehabilitation system (all workers are entitled to rehabilitation), their focus on prevention and early intervention, the broad responsibility of the employer in the return-to-work process, the effective coordination of multidisciplinary teams and the case-management approach. The rehabilitation of workers is generally supported by an integrated policy framework for the promotion of sustainable working lives or the prevention of exclusion from the labour market.
- The second group of countries consists of Belgium, France, Iceland, Italy, Luxembourg, Switzerland and the UK. These countries have well-developed frameworks for rehabilitation and return to work, but coordination across the different steps of the return-to-work process, from medical and vocational rehabilitation to reintegration at the workplace, remains limited. As a result, return-to-work considerations are generally dealt with only at the end of the sickness absence, with limited room for early intervention. Two countries, however, stand out. Recent policy developments in France and the UK indicate a shift towards more comprehensive and integrated approaches to rehabilitation and return to work.
- The third group consists of Bulgaria, Estonia, Ireland, Spain, Lithuania, Hungary, Portugal and Romania. In general, these countries do not have coordinated approaches and only limited institutional support for the return to work of workers after sickness absence. However, some ad hoc initiatives on the part of governmental agencies and non-governmental organisations were identified. Vocational rehabilitation services and support for the return-to-work process are generally available to people with disabilities. In most cases, rehabilitation can also be accessed by workers

³ The information provided on Liechtenstein was too limited to allow its inclusion in any of the groups.

returning to work after an occupational accident or disease or while suffering from a long-term/chronic affection or partial incapacity to work.

- The fourth group consists of the Czech Republic, Greece, Croatia, Cyprus, Latvia, Malta, Poland, Slovenia and Slovakia. Countries in this group have a limited framework in place for rehabilitation and return to work. Rehabilitation support for workers exists essentially only for people with disability, and aims at promoting their access to the labour market. Likewise, support to employers only targets the hiring or reintegration of people with disabilities.

Determinants of rehabilitation/return-to-work systems

A comparative analysis of national systems highlighted a number of factors that play a role in the development of a rehabilitation/return-to-work system. A common driver for all European countries is that the costs of sickness absence and disability benefit schemes contribute to a substantial part of expenditure on social welfare and therefore are a target of public spending reforms. In many countries, the entry point for the question of return to work at policy level is the lack of sustainability of social security systems and the need to reform the management of sickness absence and disability.

The evolution of the narrative on rehabilitation/return to work and the recommendations of supranational organisations, such as the Organisation for Economic Co-operation and Development (OECD) or the International Social Security Association (ISSA), have highlighted the need for holistic approaches to return to work, individualised interventions with the active participation of the persons concerned, and improved coordination and cooperation of the different actors. Awareness of these elements accompanied a progressive shift in Member States from a focus on providing rehabilitation services to integrate people with disability into the labour market to a focus on return-to-work strategies intervening early to avoid people leaving the labour market because of a reduced capability to work.

While the influence of EU policy frameworks for employment, OSH and public health on the development of national systems has been rather limited – as one of the main areas of intervention for the development of return-to-work systems is social security – the EU has had an important impact on the development of national policies on antidiscrimination in employment and adaptation of workplaces to the needs of people with disabilities.

At the national level, two main factors influence the effectiveness of the rehabilitation/return-to-work systems: (1) the scope of the systems and (2) the presence of coordination mechanisms. In countries that approach the question of rehabilitation and return to work by focusing on the needs of people with

disabilities for (vocational) rehabilitation, the scope of the system is relatively narrow and focuses on people with officially recognised reduced working capacity or on people who suffer from certified occupational accidents or diseases. In countries that focus on sickness absence management and approach the topic through the angle of return to work, of which rehabilitation is only one component, all workers going on medium- or long-term sickness absence are entitled to rehabilitation and are supported in their return to work.

Where they exist, coordination mechanisms for rehabilitation and return to work may be inscribed in the law or defined in a policy framework, instituted at national level or left to the appreciation of workplace actors, developed around a leading institution or formed as a network of several players, institutional or not. Coordination mechanisms intervene at different stages of the return-to-work process, starting at the very beginning of the process, when medical treatment is taking place, between medical doctors and the workplace (employer or occupational health services). Coordination between rehabilitation service providers and the workplace (and occupational health services when they exist) is also key to defining an individual rehabilitation plan and supporting the employer in deciding on workplace adaptations. Finally, coordination between the employer and human resources (HR) departments and, when they exist, occupational health services is also needed when the worker is reintegrated into the workplace.

The role of the employer is critical in the return-to-work process and varies a lot from one country to another in Europe. In general, the level of involvement of the employer in the process depends on the national legal framework and the nature of the responsibilities given to the employer with regard to sickness absence management. In some countries, employers have to pay for sickness absence compensation for a relatively long time (up to two years in the Netherlands), giving them a strong and immediate incentive to put in place effective return-to-work procedures. In other countries, this obligation is shorter in time but is accompanied by other responsibilities, from making workplace adaptations (in most European countries) to preparing an individual work plan (for instance, in Germany).

Factors for a successful rehabilitation/return-to-work system

The legal, institutional and policy frameworks of successful return-to-work systems have a number of common elements that contribute to their effectiveness at national and workplace levels:

- *Coherent legal frameworks*: A legal framework that covers all aspects of the process is necessary for a successful return-to-work system, either by regulating all the steps of the return-to-work process under a single legal act or by defining in the law clear coordination mechanisms across these different steps.

- *Integrated policy frameworks*: Integrating the return-to-work system in a comprehensive policy framework, which covers all relevant policy areas, helps define coherent objectives and set goals for its implementation and provides a foundation for the designation of clear coordination mechanisms.
- *Effective coordination mechanisms*: Coordination across relevant policy areas is a critical success factor in the development of effective return-to-work systems. This includes coordination of policy formulation across employment, public health, OSH and social security areas. It also means coordinating stakeholders, as many can be involved in return-to-work systems.
- *Scope of the system*: Approaching the question of rehabilitation/return to work through the perspective of the right to equality of people with disability is too limited to effectively address the issue of return to work. An inclusive system targeting all workers with a health problem is needed.
- *Early intervention*: Intervention at an early stage of the sickness absence increases the chance of the worker to get back to work quickly. The longer workers stay off work, the lower their chances to reintegrate easily into the labour market.
- *Tailored intervention*: Successful return-to-work interventions are tailored to the worker's needs and abilities. They involve the creation of individual plans with adapted measures for rehabilitation/return to work and the active participation of the worker. This also calls for the use of an interdisciplinary approach in order to cover the whole return-to-work process. Thus, medical and non-medical professions need to work together.
- *Case management*: Case managers help the worker through the different steps of the rehabilitation process and facilitate their interactions with various stakeholders, including the employer. A case-management approach is based on the principles of cooperation and coordination of all relevant parties to the benefit of the individual worker.
- *Incentives*: Incentive-based systems can increase the participation of employers and workers in the system without using binding instruments. Incentives for employers include increasing the employer's responsibility for compensation of sickness absence (negative) and the provision of financial support to deal with a person's return to work (positive). For workers, it includes aligning the allocation of disability benefits with the execution of rehabilitation programmes, or encouraging part-time return to work while still receiving sickness benefits.
- *Support activities*: Support activities from institutional and non-institutional actors can help employers to develop individual action plans and put reintegration measures in place for people returning to work following sickness absence. Support can be financial (e.g. for adaptations of the work

environment to the needs of people with reduced work capability) or technical (provision of guidance documents for the reintegration of a person with a specific health problem, support from consultants to make ergonomics assessments and adjustments). Support can be provided by national and regional governmental organisations as well as by other intermediary organisations that have an easier access and dialogue with workplaces and workers, including work insurance and pension organisations, OSH advisory services, local employment agencies, healthcare facilities, business and trade union organisations.

Policy-relevant findings

A number of policy-relevant findings have been identified with regard to the prerequisites of a national system to address the issue of rehabilitation/return to work.

Holistic systems

The majority of European countries do not sufficiently consider the needs of people on medium- and long-term sickness absence returning to work with a reduced work capacity – where the person is able to do the same job but less of it – or reduced work capability – where the person is unable to perform the same tasks. Broadening the scope of the systems to all workers has two main benefits:

- It supports *early intervention*, as the worker enters the system during the sickness absence, rather than once he/she has been recognised as disabled. How early a worker should enter the system is still under investigation.
- An early inclusion system for all workers after a defined duration of sickness absence allows for a *stepped-care approach*. Here, workers are provided with different types of services and support depending on the nature of their health problem, its severity and the duration of their sickness absence.

Integration within a broader policy framework

The return-to-work system should be inscribed in a broader holistic and integrated policy framework for sustainable working lives. This requires coordination across all relevant policy areas: employment, public health, OSH, social security, fundamental rights and vocational education. It also requires the establishment of common goals and a commitment to a shared agenda across policy areas (e.g. employment and health). Joined-up budgeting across the different policy areas can also reinforce coordinated activity and increase resource efficiency.

Cross-policy coordination is particularly important in the context of reforms of social security systems, in particular health and disability benefit schemes. These reforms should be coordinated with a support system for rehabilitation and return to work. With adequate support mechanisms, adapted working conditions

and an occupation suited to the person's condition, remaining at work need not affect health stability.

At EU level, mainstreaming the issue of rehabilitation/return to work in different policy areas could be considered. Further action could build on the Commission's commitment to launch a Communication on the health of the workforce to implement cooperation mechanisms between relevant actors in employment, social protection and public health fields. This study has shown repeatedly the importance of considering return to work as an outcome of medical treatment.

Coordinated systems

In many European countries, a lack of coordination between medical doctors, vocational rehabilitation providers and the workplace impedes or delays return to work. Returning to work after a medium- to long-term sickness absence is a complex process, requiring a number of steps to be followed and the combined action of different professions that are not necessarily used to working together. The workplace should be the central point of focus of return-to-work systems.

Knowledge exchange and transfer of practices from countries that have established such coordination structures would be beneficial. Considering the multi-disciplinary nature of this topic, the sharing of good practice is also necessary among all professional communities involved, including medical and paramedical professionals, occupational health specialists, employment and HR experts, social security experts and antidiscrimination experts, as well as the scientific and professional community, and policy-makers.

Financial and technical support

For workplaces, returning to work can be a complicated process, involving budget considerations, HR, OSH, etc. For small and micro companies, the process can become particularly complex, especially if they do not have an internal OSH or HR department or staff member. External technical and/or financial support can, therefore, help employers to develop individual action plans and establish reintegration measures for people returning to work following a sickness absence. Intermediary actors, such as work and pension insurance organisations or OSH external services, play an important role in the provision of this support or at least in relaying, at the workplace level, the type of support available at national level.

Raising awareness

Raising the awareness of those involved in the development and implementation of a rehabilitation/return-to-work system is a major challenge, as their

interests, needs and roles differ considerably. It is, however, a critical success factor. Company culture plays an important role in the return to work of someone after a medium- or long-term absence. Intermediary actors also have a critical role to play in raising awareness at workplace level on the opportunities and the challenges of return to work, in particular for small and micro companies.

Research gaps

Finally, while research efforts should continue to focus on the analysis of workplaces to identify and eliminate or mitigate factors contributing to occupational ill-health, additional research is also needed in the following areas:

- the practical implementation of existing national return-to-work systems to evaluate, among other things, their impact, feasibility and cost-effectiveness;
- evidence on the effectiveness and applicability of return-to-work models in small and micro companies;
- evidence on the impact of the organisational culture on health at work, including cooperation with colleagues and management, team cultures and political organisation of workers' interests;
- the specific needs of older workers, women, people on long-term sickness absence (i.e. more than one year) and people suffering from mental health disorders in the return-to-work process;
- the need for more harmonised statistical data, including better accounting for differences in definitions and interpretations across EU countries in relation to, inter alia, rates of sickness absence, rates of return to work after a sickness absence, transfers from sickness absence benefit schemes to other income-support schemes, and people working with a chronic or long-term health problem.