PREVENTING ABSENTEEISM AT THE WORKPLACE

RESEARCH SUMMARY

EUROPEAN FOUNDATION
for the Improvement of Living and Working Conditions

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Introduction

This publication is the summary report from the project 'Ill-health and workplace absenteeism: initiatives for prevention' of the European Foundation for the Improvement of Living and Working Conditions in Dublin. The aim of the project is to document and assess organizational, health, rehabilitation and other initiatives designed to improve workers' health and attendance at work.

In the first phase of the project a background paper has been produced in which existing data on sickness absence were analysed for patterns in different Member States, sectors and demographic groups. National information was provided by a network of experts. The results showed major differences in the regulations and in the way these are applied, between as well as within countries. Although the methodological deficits and difficulties are evident, the report highlights the causes and costs of absenteeism for different groups of workers and for different categories of enterprise.

In the second phase of the project eight national reports have been produced. These involve descriptions of the situation in Austria, Belgium, Germany, Italy, the Netherlands, Norway, Portugal and the United Kingdom. The reports focus on the strategies to address the causes of absenteeism. They include a review of absenteeism and measures to reduce rates in each of the Member States. In

these national reports the process of establishing such initiatives at the workplace, the participation of different groups in the work force and the costs and benefits have been analysed in the case studies.

In the final European synthesis report information from the earlier phases of the project has been updated and lessons from the initiatives to reduce the incidence of ill-health and related workplace absenteeism have been presented, illustrated by examples from the national case studies. Additional information has been assimilated, especially with respect to information for the new Member States of the EU, so that analyses from national correspondents in all Member States of the EU are described in this report. This synthesis report also contains information about experience in Norway, which is one of the most innovative countries in Europe in the field of absenteeism reduction.

1 The costs of absenteeism related to ill health

The scale of the issue

There are a range of expensive direct and indirect costs from absenteeism and disability. For example:

- in the UK 177 million working days were lost in 1994 as a result of sickness absence; this has been assessed at over £11 billion (13.2 billion ECU) in lost productivity and a cost of £525 (630 ECU) per employee.
- German employers paid in 1993 up to DM 60 billion (30,5 billion ECU) for the social security insurance of their workers to cover the payments during absence of work .
- Belgium, with an absenteeism rate of about 7%, paid 93 billion BFR (2,4 billion ECU) on sickness benefits in 1995 and 21 billion BFR (0,6 billion ECU) for benefits on work accidents and occupational diseases, which is altogether about 1.000 ECU per employee.
- The two thousand largest enterprises in Portugal lost 7.731 million working days as a result of illness and 1.665 million working days as a result of accidents in 1993. This is 5.5% of all working days at these companies.
- In the Netherlands the absenteeism rate was 8,3% in 1993, and the number of disabled persons increased up to 921.000 (14,2 % of the work force). The costs of the benefits for these conditions were about 35 billion NLG (16.6 billion ECU; 4.1

billion ECU for benefits on sickness absenteeism and 12.5 billion ECU for disability benefits).

The figures above are - with exception of the UK figures - based upon data regarding the benefits paid through the social security schemes. Figures about the other costs of ill health of workers are more difficult to obtain. Some information is available about the costs of work-related diseases and accidents, which are those directly related to the work environment. For example in Denmark, it has been estimated that the working environment accounts for 15% of the total sickness behaviour among 15-66 years olds and 20% if only sickness absence is considered: the socio-economic costs (including e.g. sickness absence costs, health care costs and early retirement costs) of these work-related diseases and accidents in 1992 were estimated between 3 to 3.7 billion ECU (on a working population of 3 million persons). The total costs to the British economy of work accidents and work-related ill health in 1990 has been calculated between 2% and 3% of total Gross Domestic Product, or a typical year's economic growth. These costs include the property damage incurred by industry, loss of potential output from the reduction in the available labour force, the costs of medical treatment, and administration costs incurred by firms, insurance companies, and the Department of Social Security.

Although the methods used to calculate the costs of absenteeism and ill health vary, it is evident that a lot of money could be saved by even a small reduction in absenteeism caused by ill health. In the next paragraph it will be argued that all parties - governments, employers, employees, insurance companies and society as a whole - have an interest in reducing workplace absenteeism and ill health. Ethical considerations are important, as they play a role in the selection of specific measures to reduce absenteeism and in the implementation process itself.

Which stake do the different parties have ?

Although the burden is not equally divided among the different parties - governments, employers, employees, insurance companies and society as a whole - they all bear a part of the

burden (costs) related to absenteeism and ill health. The individual worker (and his/her dependents) often has a reduced income as result of absenteeism related to ill health, especially when the absence is extended. He or she could have additional expenditure, for example payment for health care services or equipment and suffer a loss of welfare in the form of pain, grief and suffering. In addition frequent or long-term absenteeism can cause loss of jobs or disturbed relations with colleagues and superiors.

Employers are affected by the unpredictable nature of workplace absenteeism, which makes it necessary to adjust schedules or to take steps to replace the absent worker. In addition workplace absenteeism increases the company's costs (sick pay, payments above regulations, lost productivity, inferior quality, etc.) and hence has a negative effect on the company's competitive position.

Insurance companies often insure both the absenteeism risk and the health of the workers and their families. Usually they have to pay the benefits in case of absenteeism and the health care costs of the ill health of the employees.

Workplace absenteeism also has a negative effect on the national economy as a result of a loss of potential output from the reduction in available labour force and an increase in costs of medical treatment and of social security. Therefore national governments have an interest in keeping absenteeism low and limiting the costs of social security and the cost of health care. Governments cannot sustain the high costs of disability and early retirement. For society it is important that people can work healthily up to retirement age and can contribute to the gross national product.

2 The European study on absenteeism and ill health

■ Aims of the study

The aims of this study on workplace absenteeism and ill health are:

- to document and assess organizational, health, rehabilitation and other initiatives designed to improve workers' health and attendance at work
- to document the processes and mechanisms of workplace initiatives to reduce absenteeism, by identifying the methods used and the role played by the different groups;
- to elaborate the barriers and supporting factors for successful initiatives;
- to establish the relative costs and benefits of workplace activities directed at the reduction of absenteeism related to ill health.

■ Definition of absenteeism

In this study absenteeism is defined as: *temporary, extended or permanent incapacity for work as a result of sickness or infirmity*. Temporary work incapacity refers to the first period of absenteeism; in most countries limited to the first 52 weeks of disability. Extended or permanent disability relates to arrangements after the first period of absenteeism, in most countries the first 52 weeks of incapacity of work. Additionally temporary absenteeism has been

divided into short- (1-7 days), medium- (8 to 42 days) and long-term (more than 42 days) absenteeism.

Workplace absenteeism and ill-health

Although there is some cynicism and scepticism about the issue, it is absolutely clear that ill health is the main reason for workers to be absent from work. However, ill health does not necessarily means absence from work. Although employees with health problems are in general more frequently and for longer periods absent from work than 'healthy' employees, there are employees with health problems who are not more absent at all. In addition not all activities aimed at reducing workplace absenteeism have an effect on the health of employees. Workplace absenteeism can for example also be reduced by making changes in the provisions of the social security system. A company can also try to reduce workplace absenteeism by tightening up procedures relating to control of absenteeism and by intensifying checks on absent employees. However, in this study the emphasis is on initiatives in which workplace absenteeism has been decreased by addressing the health problems of employees and by tackling the underlying causes of health problems in the workplace.

3 The perspectives of national governments and social partners

There is a growing interest in workplace absenteeism among the Member States of the European Union. Although the 1980s were generally characterized by a widespread passivity on this issue among the major players in most European countries, this situation has changed at the end of the 1980s and in the 1990s. The process started in the Northern part of Europe, but gradually interest in absenteeism is also growing in the Southern part of the EU. Among the prompting factors are the increasing number of unemployed workers, growing national and international competition, and a shift of manufacturing production to Eastern Europe and Asia. These aspects points in the same direction: the costs of labour has to be reduced to keep (industrial) employment in Europe. The costs of the social security have a great effect on the labour costs and on the ultimate price of products. Countries with a relatively high expenditure in the field of social security threaten to price themselves out of the international market.

The budgetary problems of governments also play a role; these arose during the 1970s and the beginning of the 1980s, but public finances are now under increasing pressure in part due to the approaching introduction of EMU. In this situation many governments are changing legislation in the field of absenteeism and disability, and shifting responsibility to individual employers and employees. The preconditions for benefits are being tightened

up and the benefits themselves reduced. Employers increasingly have to pay the costs of absenteeism and disability in their company themselves. However they are evidently not keen to absorb too much financial responsibility. The unions are worried about the development of selection processes which exclude workers in poor health. Furthermore they emphasize the work environment as a main cause of (long-term) absenteeism and disability.

In some European countries there are joint (national) programmes of employers and employees - and generally also national governments - to combat workplace absenteeism and reduce ill health in companies. For example, in Finland the government, the employer organisations and the unions started to discuss the possibilities of a programme to extend the working capacity of older workers in 1989. These discussions led to the implementation of the comprehensive 'maintenance of workability programme'. In Denmark the government started a campaign in 1994 under the name 'social engagement of companies'. The aim of this campaign is to promote and support workplace initiatives activities directed at improving the situation of long-term absentees and avoiding exclusion from the workforce due to reduced work capacities. In Norway the government and the social partners agreed on a national programme to reduce absenteeism in 1991. In Portugal the government and the organisations of employers and employees signed a historical agreement on health and safety at work in 1991. This agreement included activities directed at the prevention of occupational diseases and the rehabilitation and reintegration of disabled workers.

4 Regulations and statistics on workplace absenteeism

Regulations on temporary work incapacity

Table 1 gives a summary of the main characteristics of the social security systems with regard to temporary work incapacity in the Member States of the European Union (and Norway). This refers to the first period of absenteeism, in most countries limited to the first 52 weeks of absence.

If the regulations are examined in more detail the following may be observed:

- In thirteen countries a certificate from a medical practitioner is required in cases of temporary sick-leave.
- In eleven countries the employee who is on temporary sick-leave can expect to have to wait one or more days, that is to say, no benefit applies to the first day(s) of absence. However collective agreements or employment contracts may involve full or topping up payment of salary by the employer (see page 8).
- In eleven countries there is officially a loss of income in the case of temporary sick-leave, in the sense that salaries are not paid or that the benefit percentage paid is less than 100% of the last wage earned.
- Eleven countries operate with a maximum period of temporary unfitness for work of approximately one year.

Table 1: Summary of the main characteristics of the social security systems relating to temporary work incapacity in the Member States of the European Union and in Norway

country	medical certificate needed	number of waiting days	continuation of full payment	benefits level	maximum duration
Austria	yes	None	4-12 weeks	60%	78 weeks
Belgium	yes	1 day	7/30 days	60%	52 weeks
Denmark	no	None	no	up to 100%	52 weeks
Finland	yes	9 days	no	70%	300 days
France	yes	3 days	no	50-66_%	12 months
Germany	yes	None	6 weeks	80%	78 weeks
Greece	yes	3 days	no	50-70%	360 days
Ireland	no	3 days	no	fixed	375 days
Italy	yes	3 days	no	50-66_%	26 weeks
Luxembourg	yes	None	365 days	100%	52 weeks
Netherlands	no	2 days	no	70%	52 weeks
Norway	yes	None	365 days	100%	52 weeks
Portugal	yes	3 days	no	65%	365 days
Spain	yes	3 days	no	60/75%	12 months
Sweden	yes	1 day	no	75%	no max.
United Kingdom	yes	3 days	no	fixed	28 weeks

■ Regulations on extended or permanent work incapacity

Table 2 gives a summary of the main characteristics of the social security systems with regard to extended or permanent work incapacity in the Member States of the European Union (and Norway). This relates to arrangements after the first period of absenteeism (in most countries 52 weeks).

If the regulations are examined in more detail the following may be observed:

- In eight countries the regulations on extended or permanent disability are linked, time-wise, to the regulations governing temporary sick-leave. In these countries there is a waiting period for the former which is equivalent to the maximum period applicable to the latter (mostly approximately 1 year).
- The definitions and conditions of payment are rather diverse. They are often based on the minimum loss of earning capacity or a minimum percentage unfitness for work. This varies between 1% (no minimum) and 74%. This loss must be assessed before any benefit is paid.

Table 2: Summary of the main characteristics of the social security systems relating to extended or permanent work incapacity in the Member States of the European Union and in Norway

country	waiting period	minimum loss of earning capacity	benefits level	maximum age
Austria	None	20%	up to 67%	None
Belgium	1 year	66_%	up to 65%	60/65 years
Denmark	None	50%	pension	67 years
Finland	300 days	40%	pension	65 years
France	None	66_%	up to 90%	60 years
Germany	None	50%	pension	None
Greece	None	33%	pension	60/65 years
Ireland	1 year	None	fixed	None
Italy	None	74%	pension	60/65 years
Luxembourg	1 year	None	pension	65 years
Netherlands	1 year	15%	up to 70%	65 years
Norway	1 year	50%	pension	67 years
Portugal	1 year	66_%	pension	62/65 years
Spain	1 year	33%	pension	None
Sweden	None	25%	pension	65 years
United Kingdom	52 weeks	None	fixed	60/65 years

- In ten countries an invalidity pension is paid in case of permanent disability.
- In general, the maximum age for benefit for permanent disability is tied to the age for receipt of the old age pension. In four countries the disability benefit also continues after this age, but includes the old age pension.

Great differences exist in the regulations governing absences due to illness and disability in the various Member States of the EU and Norway. At the same time there is a big discrepancy between the formal regulations and the way they are handled in practise. In most countries practice is much more favourable than the official regulations. In many countries groups of employees receive a top-up from their employers for a shorter or longer period in case of absenteeism.

It is very difficult to establish comparable figures for absenteeism and disability in the Member States of the European Union. National statistics for temporary sick leave exist in eleven countries. In addition, these statistics are often neither complete

nor very reliable. Although the data on permanent disability are better, it is still very difficult to establish the total number of disabled persons because in a number of countries disabled employees may be included in different sets of statistics at the same time.

Available data show great differences in levels of absenteeism (3.5% for Denmark and 8% for Portugal) and disability (between 3% for Ireland and 13,3% for the Netherlands). These figures are related to the proportion of the work force absent from work due to to temporary or permanent work incapacity on a given day. It is very difficult to explain these differences. One might conclude that workers in the country with a high level of absenteeism are less healthy than workers in another country with low levels of absenteeism. This may be true, but workplace absenteeism is a complex and multi-causal phenomenon, which is influenced by many factors.

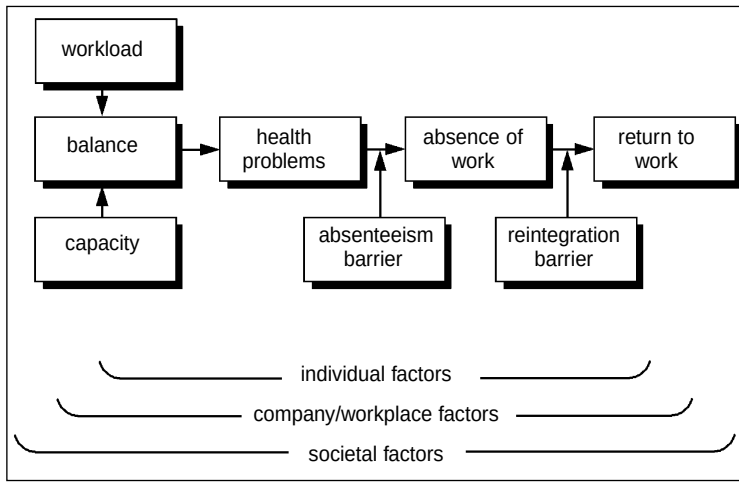
5 Strategies to reduce workplace absenteeism

Underlying framework for the absenteeism and reintegration process

In this study the process of becoming ill, being absent from work, recovering and resuming work, is viewed in terms of a lack of balance between the person and the environment. This means that health problems may arise as a result of a discrepancy between the workload (demands and requirements) and the capacity of the worker (abilities and skills). Depending on the attendance motivation and the pressure to attend - which refer to the opportunity and the need for absenteeism - health problems result in absenteeism (incapacity for work). These last factors are reflected in the so called 'absenteeism barrier'. Return to work depends on the course of the illness and the 'reintegration barrier'. By the reintegration barrier is meant the totality of the factors which affect the course of the illness and the return to work. This whole process is in turn influenced by individual factors, company and workplace factors, and societal factors. For instance at the individual level, biological and psychological factors such as the physical constitution and mental resilience of an employee influence his or her capacity. Genuine illness not derived from the workplace is one of these factors which diminish the capacity of an employee and leads to a misfit between the workload and the capacity of an individual. This framework deals therefore with absenteeism related to ill health caused by the work as well as with

absenteeism related to ill health not linked to work. In Figure 1 this framework is represented schematically.

Figure 1: The process of becoming ill, being absent from work, recovering and return to work.



Four types of interventions can be distinguished, which address different elements in this framework.

1. The first kinds of intervention are procedural measures, which are aimed at raising the absenteeism barrier; these are measures for the monitoring and control of absenteeism.
2. Preventive work-oriented measures aim to reduce the discrepancy between workload and capacity by reducing the workload. This is done by removing the work-related causes of the problems in the area of safety, health and well-being.
3. Preventive person-oriented measures are those in which employees are supported to work (and live) in a safe and healthy way. These person-oriented measures aim to improve the balance between workload and capacity by increasing the capacity of individuals.
4. The last types of intervention aimed at reducing workplace absenteeism are reintegration measures. These reintegration measures aim to lower the reintegration barrier and to accelerate the return to work of sick employees.

The daily practice of absenteeism reduction at the workplace

With reference to these four types of intervention, general practice in reducing absenteeism related to ill health can be described for the Member States of the EU and Norway. However, the information available offers only an impression of the situation, as no systematic research has been done on the strategies applied to tackle absenteeism related with ill health in most countries.

In almost all countries great emphasis is placed on procedural measures to reduce workplace absenteeism.These measures are also found in the proposed and implemented changes in legislation on sickness benefits and absenteeism policy in the majority of the EU countries.These measures are also found in the proposed and implemented changes in legislation on sickness benefits and absenteeism policy in the majority of the EU countries.

Despite the introduction of the European Framework Directive on Health and Safety in almost all Member States, prevention activities at the workplace are still taking place only on a modest scale in most European countries. There appear to be some regional differences, such that, in Southern European countries preventive measures are aimed more at the improvement of work environments for safety and health, while, in Northern European countries, more emphasis is put upon promoting the health and well-being of employees. In addition, preventive measures are often limited to person-oriented activities and not directed at the work-related causes of ill health.

Reintegration activities are not very common (yet) as an intervention strategy, but experience in the Nordic countries shows that much could be achieved through reintegration measures as a means of reducing absenteeism.

6 Models of good practice

Examples of good practice have been analysed and described in eight countries (see Table 3). The workplaces were selected because they are dealing with the absenteeism problem in a more systematic way than other companies in their country. Therefore the case study companies are not representative examples of workplace initiatives to combat absenteeism. Key elements of 'good practice' included a systematic approach; interventions based on needs assessment; a focus on active worker participation; and regular evaluation.

Table 3: Description of the cases country by country (part 1)

Austria

The three Austrian cases are: a large administration department of the Bank of Austria (1,700 employees with a majority of women); the printing and packaging materials factory Alfred Wall (570 employees); and the sewage and waste treatment company Entsorgungsbetriebe Simmering EBS (300 employees). All three cases are in the private sector. The examples are not specifically absenteeism projects. The initiative in the Bank of Austria is part of the health policy of the company and relates to a broad workplace health promotion programme in this company. The other two initiatives are part of a more general workplace activity directed at the reduction of ill health. EBS for example introduced the obligation to produce a medical certificate already after one day of absence, while according to the national regulations a certificate has to be presented after three days. But also EBS and the Alfred Wall company combined procedural measures with work- and person-oriented preventive measures.

Belgium

The Belgian companies which took part in the research project are two subsidiaries of multinationals, namely Du Pont de Nemours Belgium NV in the chemical industry field and the motor car manufacturing company Volkswagen Brussels NV. In addition the cleaning service of the Belgian Ministry of Employment and Labour was included

in this evaluation. The size of these organizations (organizational units) varies markedly, employing approximately 5,800, 950 and 66 staff respectively. The initiatives describe new forms of absenteeism strategies. In the two subsidiaries the measures were initiated by the multinational mother company. In the chemical company Du Pont de Nemours the activities focused upon workplace health promotion. In the Volkswagen works the accent was on the reintegration of absentees offering special adapted work. Alternative work was initially presented in case of absence due to an occupational accident, later also in case of absence due to illness. Attendances bonuses were also introduced. While it is true that in this company absenteeism has fallen markedly, social conflicts also arose. In the Ministry cleaning service, employees have participated in the inventory of the work problems and in finding solutions. The solutions chosen, however, are not very radical and are limited by administrative obstacles.

Germany

The German examples derive from one non-profit-making organization and two profit-making companies, namely the local public transport company for Nürnberg (approximately 2,300 employees), a subsidiary of the chemical company Beiersdorf AG in Hamburg (approximately 5,500 employees) and the small porcelain company Sinterit GmbH with 125 staff. In all three projects the introduction of measures was preceded by thorough analysis. At Beiersdorf and Sinterit use was made of health circles (analysis and solutions to health problems through participation of the employees concerned). In both companies the health circles led to the identification and implementation of new measures. It is only in the small earthenware company that explicit attention was given to the procedural approach to absenteeism by setting up monitoring procedures and training managers in absenteeism interviews. In the transport company mainly reintegrative measures are taken. There is an active reintegration policy being pursued there and the measures taken are only preventive in the sense of preventing further harm through, for example, reduction in working hours for older employees. Other preventive measures were not taken. Nor is much attention paid to safety measures in these three companies, because safety is not longer regarded as a problem in Germany.

Italy

The three Italian cases are all local plants of industrial companies, namely the glass factory Bormioli Rocco Casa (approximately 300 staff), the meat processing company Inalca (approximately 600 staff) and the tile works Ragno SpA (approximately 700 employees). The examples described are not specific absenteeism projects. Attention in the projects is focused mainly on reducing occupational diseases and industrial accidents. The emphasis lies on training employees in the use of personal protective equipment (automation of lifting operations, safer equipment and machines, etc.). The measures are not based on an examination of needs among employees, but on analysis of accidents (and absenteeism). Only in the meat processing industry Inalca were the employees involved in risk analyses. Apart from that there is little direct participation of employees in the selected projects. Generally it is a matter of a top-down approach. Contact between the companies and the trade union is regular and based on broad participation; industrial relations are progressive and allow the various problems involved in protecting workers' health and safety to be managed by means of collaboration and the exchange of information and knowledge among the interested parties.

Netherlands

In the Netherlands initiatives are described in the Waterland Hospital (approximately 800 employees), the construction company Nelissen van Egteren Bouw BV (approximately 150 staff) and the metal working company Thomassen en Drijver

Verblifa (approximately 375 production workers). A common approach to workplace absenteeism emerges from these three Dutch case descriptions. This approach combines a procedural approach to absenteeism with preventive measures focused on both work and person and with reintegrative measures to promote the return of the long-term sick. The three projects are based on active participation by employees, a cost-benefit analysis, a systematic approach (first diagnosis, then intervention), a comparison with control companies, and are all externally financed. It is also striking that the works council - not the trade union - represents staff in the Dutch projects. It emerges from all three projects that the involvement of middle management is a problem. Nevertheless the three projects are successful. Absenteeism related with ill health in the three companies has fallen demonstrably and the cost-benefit analysis of these attempts to reduce absenteeism shows a positive balance.

Norway

The participants from Norway in the evaluation study are the municipality of Trondheim (7,700 employees) and the food plant As Rora Fabrikker (74 employees). In these two organizations the majority of the employees are women. Both Norwegian projects are good examples of how absenteeism can be reduced in an organization. However, one of the projects appears not yet to have led to the desired result. Both use a systematic approach, are (reasonably) balanced in their design, have a participatory approach and in addition a high involvement of management, trade unions, medical service and middle management and are centrally directed by the national project set up by the central employers' associations and trade unions. One striking feature is the large amount of attention paid to preventive work-oriented measures to improve the well-being of employees. A procedural approach to absenteeism exists, but few measures are aimed at improving safety. In both projects the effects of the approach to absenteeism can only be indicated in general terms and there is a lack of detailed cost-benefit calculations.

Portugal

The three Portuguese studies are: a copper mine (1,000 employees); a local authority (approximately 1,300 staff); and a subsidiary of a multinational in the field of electronics (approximately 350 employees). The activities undertaken focus largely on improving safety (reducing industrial accidents and occupational diseases) and health (periodical checks, medical care). Among safety measures more use is made of person-oriented measures (personal protective equipment) than work-oriented measures. The copper mine and the local authority provide basic health facilities as a part of the measures. The local authority and the electronics company pay considerable attention to reintegration. In addition all three companies use procedural measures. The copper mine applies financial incentives in the form of attendance bonuses, for example. Participation occurs to only a limited extent in the Portuguese case studies; it is mainly a top-down approach.

UK

The approach described in the three UK projects seems to be typical of the approach in progressive British companies. The three very large profit making companies, the utilities company East Midlands Electricity (4,200 employees), the Post Office (200,000 employees) and the car components company Unipart (1,800 employees), all take preventive measures focused on work in order to improve the safety and health of employees. In addition they undertake preventive measures in order to increase the well-being of employees, mainly through measures related to the individual. In the projects almost no measures were described which attempted to reduce stress by means of a work-oriented approach. The companies appear to value promoting the health of their employees more than reducing the cost of absenteeism from the point of view of efficiency; they undertook no extensive cost-benefit analyses.

The case study material has been analysed in a qualitative way. The preconditions for success have been derived from the workplace experiences and their evaluation. These analyses give a quite clear picture of the aspects which are of importance to successfully reducing absenteeism related to ill health.

Systematic approach

It is important that workplace initiatives directed at the reduction of absenteeism related to ill health go beyond a piecemeal response to health problems as they arise, so that they address problems before they become serious through a systematic and comprehensive approach to improve the health of the work force. An approach based on the 'policy cycle of problem solving' seems to work well in practice. This includes different steps such as: preparation of the project; investigation of the health problems; organising solutions before interventions are carried out; and an evaluation of the impact.

Co-ordinating project team

The success of a workplace project on absenteeism and ill health depends on a number of factors, of which the main one is the building of a committed project team which has a clear brief to manage and implement the project. This project team can be established by adapting the existing workplace structures or by setting up a new team.

Clear tasks and responsibilities

An essential feature of any workplace activity is an explicit agreement at the beginning of the project concerning its scope, the resources that are needed and the tasks and responsibilities of the project team and other stakeholders. These agreements may be formal or informal, depending on the culture of the company.

Support of senior and line management

Active involvement of higher management is a key for the success of workplace initiatives; not only at the beginning of the project but also at the later stages. This increases the identity of the project within the organization, facilitates decision-making and is of

decisive importance for the implementation of measures and the cooperation of middle management and workers.

Active worker participation

Employee participation should be an explicit goal in designing a prevention project, because it is a condition for programme effectiveness. Workers are the primary experts on their work and work environment. It is efficient and effective to make use of their creative and problem solving capacity. Besides health benefits - as the objective of the prevention project - can only be achieved through employee participation. Health improvement cannot be inflicted on employees from above.

Good information and communication

There are two groups who must be informed of the progress of the absenteeism initiative. Firstly there are the participants themselves who should be informed about the developing programme. Secondly there is a need to communicate progress to management structures within the organisation. Good communications are an essential requirement for integrating health improvement measures into organisational policy and practice.

Active involvement of personnel management, occupational health service and external guidance

The participation of the personnel department and the OHS can help middle management to reduce ill-health absenteeism, but should not absolve initiate middle managers from responsibility for the handling of absenteeism. The involvement of outside parties may increase the credibility of the project and enhance the sense of objectivity. It often makes it easier to initiate a project and promotes closer collaboration between the different parties within an organization. During the project outside experts must, however, endeavour to build upon the existing know-how and helps the organization itself to identify and resolve problems.

Involvement of works councils, health & safety committees and trade unions

It appears that participation of the works council or H&S committee members contributes to good results, while the

participation of trade unions appears less important for positive effects. It may be that works council members and H&S committee members are more involved with matters of content, while the trade unions are more involved as formal representatives.

Balanced package of measures

A balanced package of measures also appears to be related to the successful reduction of workplace absenteeism. A balanced approach involves procedural measures to raise the absenteeism barrier and to make it less simple to report oneself sick, but also preventive measures focused on both the person and the work, through which health problems can be prevented. Finally reintegrative measures are important to lower the reintegration barrier and to facilitates the return to work of the sick employee.

The treatment of absenteeism related to ill-health as a normal company phenomenon

Finally absenteeism and ill health are common features confronting every workplace. They can have a great impact on the productivity and the competitive position of companies. It is important that companies realise this, and integrate measures to reduce absenteeism and ill health into their organisational policy and practice.

7 Conclusions and recommendations

■ Conclusions

1. There is a major disparity between the human and economic scale of the issue and the priority given to it in practice by the key players

There is a paradox at the heart of these analyses of workplace absenteeism in Europe; vast amounts of money are involved in paying for absenteeism due to ill health, but major players have been relatively inactive for a long period. In each of the Member States the social security schemes pay out billions of ECUs yearly as benefits for absenteeism and disability. Attention to this problem within national governments is growing at this moment, but this phenomenon is rather recent. Likewise employer organisations and unions have not been very engaged by the issue until recent years.

2. Governments are shifting the burden

The situation has changed since governments have become more concerned about public spending and the reduction of the public sector national debt. Other significant factors are the creation of the open European market, increasing international competition, the growing numbers of unemployed persons and the globalisation of the production process, where (international) companies relocate jobs to (cheaper) developing countries. In this situation

efforts are being made to reduce the costs of labour to remain competitive and to keep industrial employment in Europe.

Governments are shifting the financial responsibility for absenteeism and disability to employers and employees. This policy has a double-sided effect: it relieves pressure on the public sector budget and it is an incentive to employers and employees to reduce absenteeism.

3. Regulations on absenteeism and disability vary markedly between European countries

Great differences have been found in the regulations governing absences due to illness and disability in the various Member States. In one country a person unfit for work will be paid normally for a period, while temporary unfitness for work in another country may mean a halving of the person's income. However countries which have a favourable system of benefits for temporary absences do not necessarily have favourable regulations on extended or permanent disability. At the same time there is a big difference between the formal regulations and real experience; practice in most countries is much more favourable than the official regulations.

4. Statistical information is lacking

In spite of the financial significance of the issue of absenteeism and ill health there is relatively little national information on levels of absenteeism and the factors which influence this. National data on absenteeism are only available to a limited extent. Furthermore these statistics often only relate to a part of the working population; for example most statistics only include employees working in large companies. It is difficult to obtain absenteeism data on employees working in SMEs and such data are often not complete; this is critically important when most European employees are working in companies with less than 10 employees.

5. Interpretation of national differences in levels of absenteeism is difficult

The available data on levels of absenteeism and disability show great differences between countries. It is however very difficult to

explain the causes of these differences. One might conclude that the workers in the country with a high level of absenteeism are less healthy - or have lower life expectancy levels - than the workers in another country with low levels of absenteeism, but this is not necessarily so. Levels of absenteeism and disability do not relate clearly to characteristics of the national regulations. There is a fundamental problem that the available national data are not presented in a comparable or complete way.

6. Companies focus on absence control procedures to reduce absenteeism and ill health

In most European countries employers try to reduce absenteeism by tightening up procedures and checks on absent workers (regulatory and disciplinary measures). In spite of the implementation of the EU Framework Directive on Health and Safety at Work, preventive activities are still not very common within companies in the European Union. Most preventive activities are limited to person-oriented measures in the field of occupational accidents and diseases - such as training and information, use of protective equipment and stress management - and are not directed at work-related causes of ill health and accidents. It also appears that reintegrative measures too, directed at the redeployment of long-term absentees, are not much used at this moment by European employers.

7. Case study companies illustrate an alternative approach

The case study companies show that an alternative approach is feasible and fruitful. Although 'hard' impact data are often lacking the analyses give a rather clear picture of the aspects which are of importance to successfully reducing absenteeism. Success factors are:

- a systematic approach;
- a co-ordinating project team;
- clear tasks and responsibilities for the persons involved in the activities;
- active support from senior and line management;

- an active role for employees and the recognition of employees as experts;
- good information and communication with all staff;
- involvement of the personnel department, the company medical service or external guidance;
- involvement of the workers council, the safety, health and well-being committee or trade unions;
- a balanced package of measures and
- the treatment of workplace absenteeism as a normal company phenomenon.

Within the EU, regional differences have been identified with regard to the use of a project team and the participatory approach. In the Southern European case studies both aspects were less evident. The establishment of a specific project team to co-ordinate the absenteeism and health activities does not seem to be necessary for a successful result in the Southern countries. The case study companies in the Southern part of Europe also had more participation in the workplace activities by representatives, rather than direct forms of participation. However, and in conclusion, a workplace initiative can only be successful, when activities address specific health problems in the company and fit into the culture of the organisation and the country.

■ Recommendations

1. *Absenteeism and its causes should be placed much higher on the agenda of the European Union, national governments, employers organisations and unions. This attention should go beyond financial and economical aspects to include health aspects (healthy workers and healthy workplaces).*

The current report should be used to place absenteeism and ill health much higher on the agenda of the major key players. Awareness of the major economic and human significance of absenteeism caused by ill health has to be raised. At the same time the key players should become aware of the potential and practicality of reducing absenteeism.

2. *Standardised data on absenteeism and ill health need to be made available on the national and European levels. This will make it possible to make a proper comparison of absenteeism and ill health in the EU, to analyze the national trends in absenteeism, to assess the impact of legislative changes and to evaluate the effects of national action programmes.*

More detailed and valid data are required in relation to absenteeism in the fifteen countries of the European Union. This project has demonstrated the difficulty of collecting and using the existing statistical information on absenteeism and disability. The available data show great differences in levels of absenteeism and disability. They evoke questions about the influence of specific characteristics of the social security system as well as regarding the influence of the composition of the working population in terms of age, gender, education, industrial sector and company size. However these questions cannot yet be answered definitely.

3. *Governments, employers organisations and unions together should establish national action programmes to address absenteeism and ill health. The aim of these programmes should be to encourage companies and workers to start preventive activities at the workplace, to extend the active work participation of older workers and to reintegrate long-term absentees.*

The changing social-economic context calls for a dialogue between governments, employers organisations and unions at national level. The aim of this dialogue is to develop an action programme to encourage companies and workers to start preventive workplace initiatives, to extend the active work participation of older workers and to reintegrate long-term absentees. A special effort should be made to support SMEs. All parties have an interest and a responsibility in an integrated approach to absenteeism, the work environment, health and safety, ageing and economic expenditure. Such an integrated approach involves extension of preventive activities directed at the individual and the work environment.

4. *Employers and employees require information about the possibilities (methodologies, tools and practical experiences) to reduce absenteeism related to ill health by preventive activities and reintegration of long term absentees.*

This report illustrates that there is a wealth of experience in workplace initiatives directed at the reduction of absenteeism related to ill health. It is evident that companies can learn a lot from the experiences of other companies in and outside their own country. However there is a lack of well documented examples of successful absenteeism initiatives. An additional problem is that some of the best examples are only described in the national language and are not accessible for an international audience. As a results of this situation many companies are not aware of enabling factors and barriers they will meet when they start activities to reduce absenteeism related to ill health.

5. *Training modules on workplace activities to reduce absenteeism related to ill health need to be developed for practitioners and for (health) professionals at the workplace.*

Workplace initiatives to combat absenteeism can be started and implemented by a wide range of people within or outside the organisation. Key staff in the workplace could be a human resources manager, a line manager, a health and safety specialist, an occupational health nurse or the occupational physician and staff or trade union representatives. In SMEs individual employers or employees may have to 'carry the burden'. External consultants could be health and safety agencies, occupational health agencies, local health authorities or management consultants. However most groups require additional training and education to manage a successful absenteeism project, which not only influences the level of absenteeism in the company but also the health of the workers.

6. *SMEs have to be supported and encouraged to reduce ill health associated with absenteeism and to start workplace activities.*

SMEs are much more vulnerable for workplace absenteeism, and in particularly for long-term absenteeism, than larger companies.

Besides SMEs often lack internal know how to prevent workplace absenteeism related to ill health. Diffusion of health and safety activities into small and medium sized companies was and still is very problematic in all the Member States of the European Union. Typical problems faced by SMEs include lack of resources and lack of skills. SMEs have to be supported to initiate activities to reduce absenteeism related to ill health. This support includes dissemination on information on relevant models of good practice, provision of infra-structural measures on a local or regional level or for industrial sectors, and financial incentives. Solutions have to be developed in close co-operation with the social partners for SMEs.

7. *Specific research activities are necessary to support national activities at the workplace. This includes e.g. analyses of the processes through which ill health and absenteeism can be influenced at company level, research into the transferability of the experiences of big companies into small companies, and studies on the real costs and benefits of workplace activities to reduce absenteeism related to ill health.*

Although much research has been done into the relationship between aspects of health and work on the one hand and absenteeism and disability on the other many practical questions still cannot be answered satisfactory. One pertinent question concerns the role of participatory approaches in South European practice. Likewise, the potential to build the experiences of big companies into a methodology for SMEs needs further research. Other relevant research questions coming from this study relate to the real costs and benefits (material and immaterial) of workplace activities to reduce absenteeism related to ill health and to the potential role of health insurance/sickness funds in the reduction of ill health and absenteeism at work. Answers on these questions should contribute to a better understanding of the processes by which ill health and absenteeism can be influenced at the workplace.

8. *Employers and workers can have a knowledge base to start preventive and reintegrative activities at the workplace. These activities should:*

   – *use a systematic and comprehensive approach*
   – *be based on the needs of the work force*
   – *aim at active employee participation*
   – *be applied across all workers in the company*

Although this is one of the last recommendations of this report, it is certainly not the least important. Sustainable improvement of health and an associated reduction in absenteeism can only be accomplished at the workplace itself.

Employers and employees can learn from this report how to set up preventive and reintegrative activities and to reduce absenteeism related to ill health. The experiences from the case studies present a broad picture of how to set up these activities and what barriers and enabling factors may be encountered. The success factors are effectively the main principles for these activities.

9. *Sooner or later activities to reduce absenteeism should be integrated into ongoing company activities. Occupational health staff and human resource management should work together to integrate absenteeism into management, and to integrate health promotion activities into organisational policy and practice.*

Absenteeism and ill health should primarily be management responsibilities. HRM and OHS could of course support management on this issue. Management should use their knowledge and experience when they start workplace activities to reduce absenteeism related to ill health. Line management should made responsible for the level of absenteeism related to ill health in their department. By incorporating measures of absenteeism and ill health into quality and other systems, these issues could be integrated into organisational policy and practice.

Finally the main recommendations from this study for specific bodies are presented in an overview (Table 4).

Table 4: Overview of the main recommendations for specific bodies

National governments should:

- start a dialogue with employers and unions to set up a national action programme to promote and to support workplace activities directed at absenteeism related to ill health, extension of active work participation for older workers and reintegration of long-term absentees
- support this programme with information, dissemination of examples of good practice, development of training programmes, research, monitoring of outcomes and provision of anti-discrimination legislation on health and age
- stimulate the collection of national data on absenteeism and disability so that these data can be compared with data from other European countries

Employer organisations should:

- encourage companies to start preventive activities at the workplace and stop the selection of workers on grounds of age and/or health
- organise demonstration projects in specific industrial sectors and disseminate the experience of these projects in handbooks and videos
- promote cooperation in prevention between larger companies and SMEs on a regional or sectorial level, and the exchange of practical experiences

Individual companies should:

- use the results of health needs assessments to set up preventive activities, to focus on the health of the workers and to develop an age-specific personnel policy
- ask their suppliers for proof of their good health and safety practice

Trade unions should:

- also play a role in the promotion of workplace health activities and the dissemination of information as a contribution to the national programme
- train their members for active participation in workplace activities and for participation in a project group or steering committee
- make agreements on investments in workplace safety and health in collective bargaining with employers

Workers councils and individual workers should:

- press their employers to pay more attention to health at work

The *occupational health services (OHS)* should:
- play an initiating or supporting role in the organization of preventive and reintegrative activities at the workplace
- support management to integrate health promotion activities into organisational policy and practice
- increase cooperation with general practitioners and other relevant health specialists to support the rehabilitation of long-term absentees

Insurance/sickness funds have a direct financial interest in the national programme on reduction of absenteeism related to ill health and in workplace health promotion. These funds should:
- support the national programme financially and reward employers who initiate workplace health activities
- play a role in exchange of information for and between SMEs
- fund research into the costs and benefits of interventions directed at the reduction of absenteeism related to ill health
- support the development of standardized registration systems for absenteeism

The *academic community* should:
- play a role in the development of new models and methodologies (especially for SMEs), in evaluation of existing prevention programmes, in the development of monitoring systems, and in research on aspects such as costs and benefits of specific interventions at the workplace.

The national initiatives should be supported on European level by the *European Union.* This contribution should include the following aspects:
- promotion of exchange of experiences between countries
- dissemination of information on models of good practice
- funding of methodology development (especially for SMEs) and supra-national research activities
- stimulation of the development of training modules to manage prevention and absenteeism projects
- promotion of comparable statistical data on absenteeism and disability

PUBLICATIONS FROM THE EUROPEAN FOUNDATION PROJECT ON ILL HEALTH AND WORKPLACE ABSENTEEISM:

Background paper:

Gründemann, R.W.M., Winter C.R. de & Smulders, P.G.W. (1994). Absenteeism in the European Union. European Foundation for the Improvement of Working and Living Conditions, Dublin (Working Paper No. WP/92/22/EN).

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PREVENTING ABSENTEEISM AT THE WORKPLACE

RESEARCH SUMMARY

As pressures increase on the budgets of social protection systems and on the competitiveness of companies, so more attention is being paid to measures to reduce workplace absenteeism and its cost. This booklet draws together the main results and conclusions from a study, in all EU countries and Norway, which looked at ill-health as the main cause of absence from the work. It charts patterns of workplace absenteeism and strategies to reduce absence, specifically identifying lessons for good practice. The recommendations on public policy, monitoring, training and action are addressed specifically to the many parties with potential to improve health and attendance at the workplace.

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