

Working Paper

**Demographic change and private sector disability management in Australia,
Canada, China and Switzerland:**

A comparative study

Thomas Geisen
Benedikt Hassler
Guy Ochsenbein
Nick Buys
Christine Randall
Henry Harder
Shannon Wagner
Liz Scott
Ignatius Yu Tak-Sun
Karen Yu Ling Lo-Hui
Tang Dan

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Contact

University of Applied Sciences and Arts Northwestern Switzerland
School of Social Work
Prof. Dr. Thomas Geisen
Riggenbachstrasse 16, 4600 Olten, Switzerland
T: +41 62 957 20 57, thomas.geisen@fhnw.ch

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1 Introduction

Prosperity and welfare in modern societies are highly dependent on educated and qualified workers. In recent years, demographic change and a growing shortage of qualified workers have presented new challenges for both developed and developing economies. Strategies to face these challenges include increased company activity to retain internal labour forces and, specifically, disability management. Disability management (DM) has been established world-wide as a valuable approach, not only to improving return-to-work (RTW) programs and thereby retaining employees, but also to enhancing working conditions and organizational development. Key stakeholders such as the International Labour Organization (ILO), the World Health Organization (WHO) and the International Forum for Disability Management (IFDM), view DM as crucial to supporting workers whose employment is threatened by illness or accident, and also to bringing injured employees back to work.

Yet despite widespread acceptance of DM principles, there is minimal comparative international research among private companies offering DM services. The lack of research in this area is unfortunate given that significant value may be gained by comparing countries with disparate systems, including assessment of the impact of political, social and legislative differences on service delivery. In order to ensure the ongoing development of international approaches to best practices in DM provision, we need to improve knowledge about the implementation and impact of DM in private companies according to country of service.

This study contributes to addressing the literature gap by undertaking a meaningful international comparison of DM services provided by private and public companies in Australia, Canada, China and Switzerland. These countries constitute a heterogeneous sample for analyzing the national context of DM service, including the impact of country-specific welfare and social insurance systems on DM processes. They also represent different stages in the implementation of private and public sector DM so stage of DM development is included as a variable of analysis in the study.

Our report begins with an overview of research in DM in general and in companies, then describes the parts of the welfare system relevant to DM for each of the four countries. The next section explains the research approach and methodology, and then the research findings are presented, on both country and international levels. The report concludes that there are several varieties of DM, but that there is limited coherence among them and that the next step in developing comprehensive disability management systems has yet to be taken.

2 Research on Disability Management

The World Report on Disability emphasizes the lack of research “on factors that influence labour market outcomes for persons with disabilities” (WHO & World Bank, 2011, p. 239). There is also little research on the value of DM across contexts, employees’ perceptions of DM programs, and employer support of workers, not only in work-related matters, but also in health and social matters through systematic, organizational strategies such as DM. To date, research into work-related disabilities has mainly focused on employment policies for disabled people (cf. Beyer, Jordán de Urríes, & Verdugo, 2010; Dempsey & Ford, 2009; Parmenter, 2011), disability prevention (cf. Loisel et al., 2005; Pomaki, Franche, Murray, Khushrushahi, & Lampinen, 2012), return-to-work programs (cf. Cheng, Loisel, & Feuerstein, 2011; Gensby, Labriola, Irvin, Amick, & Lund, 2014; Tjulin, MacEachen, & Ekberg, 2010), activities for specific health problems (cf. Schultz, Stowell, Feuerstein, & Gatchel, 2007; Waddell & Burton, 2005), and motives for and rates of return to work (cf. Bloch & Prins, 2001; Labriola, 2008; Young et al., 2005).

There is little research into the measures companies take when their employees are injured (Geisen, Kraus, Ochsenbein, Schmid, & Studer, 2013; Geisen, Lichtenauer, Roulin, & Schielke, 2008; Harder & Geisen, 2011; Niehaus, J., Marfels, Vater, & Werkstetter, 2008) and there is no cross-national or international comparative research on DM in the private sector.

3 DM in private and public companies

All OECD countries and developing economies currently face important demographic change (Martinez-Fernandez, Kubo, Noya, & Weyman, 2012). Fertility rates have declined and life expectancy has increased, creating aging populations around the globe, including in Australia, Canada, China and Switzerland (World Bank, 2013). As a result, both public and private employers are increasingly required to cope with a significantly diminishing and aging workforce (Federal Statistical Office, 2012; Geisen et al., 2013; Spoehr & Barnett, 2008; Ye, 2011) and there is a growing shortage of qualified workers (DEEWR, 2012; Gehrig, Gardiol, & Schaerrer, 2010; UNESCO, 2010). Together with labour participation rates, retirement age, and migration, these demographic trends determine the size of the workforce and the resulting requirements for employee-related services (Muenz, 2007). Moreover, protection of national and international workforce resources through the provision of demographically determined support will continue to be vital, since future economic growth will be highly dependent on labour force participation rates and labour productivity (ILO, 2010, p. 7). Given these changes, companies are more and more interested in long-term relationships with their employees in order to maintain internal labour forces. DM contributes to this aim of maintaining a healthy, productive and durable workforce by (a) supporting workplace-integration activities; (b) providing advice about health promotion, and illness and injury prevention; (c) creating workplace environments with capacities for accommodation and return-to-work options; (d) creating collaborative relationships between workplace stakeholders; (e) offering options for early intervention; (f) increasing access and ease of relationships with external professionals; (g) providing continuous care for employees in need and; (h) promoting workplace morale. Consequently, ongoing research into the most effective methods of increasing uptake and effectiveness of DM globally is an important factor in ensuring the viability of global labour markets.

Since the 1990s employer understanding of the importance of protecting employee health and well-being has been increasing. Employers now are more aware of the relationship between a healthy workforce and economic success as well as the need to respond positively to social, legal and political expectations regarding treatment of workers. The development of private sector DM is an important contributor to the movement towards maintaining a healthy and productive internal labour force, and protecting long-term employer-employee relationships. With durable workplace relationships as its main focus, DM is intended to support ill and injured employees on a case-by-case basis and to implement organizational changes for the prevention of workplace illness and injury (Buys & Randall, 2009; Geisen, 2010). Additionally, DM can be an important contributor to the creation of an organizational culture focused on ongoing learning and improvement (cf. Arnold & Bloh, 2003), and companies obtain an excellent return on investment when they implement DM programs (Buys & Randall, 2009; Curtis & Scott, 2004).

Few people successfully transition back into the labour market once they are on disability benefits, and the longer the benefits continue, the less likely return-to-work efforts are to be successful (OECD, 2010, p. 10). Therefore, employers see early intervention intended to prevent initial onset of disability and to keep loss of work time to a minimum as important. Similarly, an aging workforce and improved awareness of rights for individuals with disabilities has increased demand for disability services and for DM services within organizations. The exponential growth in disability costs drives companies to find meaningful

ways of maintaining healthy workforces. DM programs have been supported as a viable path to accomplishing workplace-specific disability prevention objectives and, in the big picture, help to maintain national social security systems, systems that are under pressure in all four identified countries (Jæger & Kvist, 2003; Ye, 2011).

Despite wide-spread acceptance of the human, political, social and economic benefits of disability management, recognition of its value has grown faster in some countries than others. The four research countries of this study represent different stages of DM development: Australia and Canada have been considered leaders in DM implementation and were among the first countries to implement DM as a workplace intervention (Harder & Geisen, 2011, p. 3). Many other efforts were made as a result of these pioneering steps, including the founding of the National Institute of Disability Management and Research in Canada in 1994 and the “Code of Practice” developed by the International Labour Organization (ILO) in 2002 (Geisen et al., 2008, p. 6). Knowledge of DM’s value spread and companies in Switzerland began to implement DM in 2000 (Geisen et al., 2008, p. 6). In China and elsewhere, large corporations have only recently begun to embrace the concept (Sun, Buys, & Wang, 2014; Yu, Chan, & Lo-Hui, 2011). In comparison with the countries where DM was initiated, China is bringing new perspectives related to its own context (Chan & Zhuo, 2011; Costa-Black, Cheng, Li, & Loisel, 2011).

4 The Welfare state and DM

Disability management practice in private companies is highly dependent on available national social services and related institutions. Gøsta Esping-Andersen created a typology for welfare states. He distinguished between liberal, conservative-corporatist and social democratic welfare state regimes (Esping-Anderson, 1990). According to this theorist, the degree of de-commodification and produced stratification are the main criteria for classifying different welfare states. Various sociologists and political scientists have criticized Esping-Andersen’s concept for a variety of theoretical, methodical and empirical reasons (cf. Bamba, 2007), but his proposed differentiation can be still fruitfully employed as descriptors of ideal-types in a Weberian sense. “Different sorts of welfare regimes pursue different policies, and they do so for different sorts of reasons” (Goodin, Headey, Muffels, & Dirven, 2003, p. 5).

Australia and Canada can be classified as typical liberal welfare states, with modest universal transfer payments, modest social insurance payments, and minimized de-commodification effects (Esping-Andersen, 1990, p. 26 f). For the years prior to the 1970s, this classification also holds for Switzerland (Armingeon, 2001, p. 145). However, institutional changes have brought Switzerland closer to the continental European welfare states (Armingeon, 2001, p. 146), one example being the 1977 change from a voluntary unemployment scheme to a compulsory, federal unemployment scheme (Ebbinghaus, 2000, p. 667). In contrast to Australia, Canada and Switzerland, Esping-Andersen’s “Western biased” typology cannot be applied in any meaningful manner to Chinese systems of social welfare. However, economic development and an aging population have put pressure on the Chinese government to reform and expand the social welfare system (Ye, 2011, p. 691 f). China’s current “work injury insurance [...] covers income compensation, medical expenses, and lifelong care guarantees for workers who become injured at work and temporarily or permanently lose their working capability” (Cheng et al., 2011, p. 45). At this stage, the compensation system is still relatively new, having been introduced in 2004, and the government remains the only insurer (Cheng et al., 2011, p. 51 f), which is different from other countries.

4.1 The Welfare State and DM in Australia

There are diverse insurance schemes in Australia that provide coverage for injury, depending on where and how the injury occurred. They include workers’ compensation, motor accident

and disability insurance schemes. Of these, workers' compensation legislation and regulations are the most influential in terms of DM. Australia now has over 15 separate workers' compensation and motor accident insurance schemes, administered under separate laws with different benefit systems. This fragmentation results in jurisdictional problems and disputation over responsibility for injuries. More broadly, social security is provided for Australian job seekers, indigenous Australians, families, retirees, students, and people with disability (including those no longer eligible for insurance payments) via Centrelink (Department of Human Services). In addition, Australia is currently implementing a new National Disability Insurance Scheme, funded by federal and state governments to replace previously fragmented social welfare for people with any disability (congenital or acquired).

Over the past 20 years, Australia's welfare system has been transformed by a series of neo-liberal governments. The neo-liberal approach is characterized by emphasis on reducing social expenditure, means-tested benefits, shifting responsibility for service provision from the government to the private and not-for-profit sectors, and the idea of "mutual obligation" (Fenna & Tapper, 2012; Mendes, 2009). Mutual obligation mandates that welfare recipients must actively seek work in return for welfare benefits, thus reinforcing the notion of the deserving and undeserving poor.

Workers' compensation systems, developed in countries such as the United States and Australia in the early 20th century, were arguably precursors to the modern welfare state, providing no-fault social insurance protection for workers in the event of work-related injury or illness (Fishback & Cantor, 2007). However, unlike many European countries, workers' compensations systems evolved separately from mainstream welfare programs, being legislated under their own statutes and primarily administered by dedicated, state-based authorities. The importance of these insurance schemes to the Australian welfare state is emphasized by injury statistics. For example, there were 117,815 reported serious workers' compensation claims in Australia in 2012-13, mainly in the transport and storage, agriculture, forestry and fishing, manufacturing and construction industries (Safe Work Australia, 2014). However, this number underestimates the true extent of work-related injury and disease. Many injured workers decide not to lodge a compensation claim and instead use sick leave provisions offered by employers. This phenomenon has led Safe Work Australia to calculate that the total cost of workplace injury and illness to the Australian economy for the 2012–13 financial year was \$61.8 billion, representing 4.1 per cent of Australian Gross Domestic Product (Safe Work Australia, 2015a).

Rehabilitation services became a feature of workers' compensation systems in the 1980s when mandatory rehabilitation for injured and ill workers was introduced as a means of addressing spiraling workers' compensation costs. Changes to workers' compensation laws meant that rehabilitation had to be provided to injured workers or motorists who experienced difficulty returning to work or resuming a normal life. Philosophically, these changes were grounded in the principle of mutual obligation, whereby injured workers in receipt of compensation payments were required to participate in return to work programs to minimize the loss of human and financial capital for employers in an increasingly competitive economic environment (Buys & Randall, 2009).

In recent years there has also been an increasing focus on employers taking responsibility for providing prevention and rehabilitation services in the workplace. This development represents the genesis of the disability management approach. In this context, Australian workers' compensation schemes required employers to play a much greater role in disability management. For example, in most workers' compensation schemes, employers must provide injured workers with suitable return-to-work duties, prepare return-to-work plans and keep employees' jobs open while they are off work. The length of time a job must be kept open

varies depending on the state. In some states, employers are also required to appoint a workplace-based RTW coordinator and put in place written rehabilitation policies and procedures. These policies must be made available to all employees (Safe Work Australia, 2015b). Such changes have made it easier for disability managers to get the cooperation and participation of employers and workers in RTW programs, and it is now common for large organizations to employ dedicated disability managers. Companies with integrated DM programs often do not distinguish between work related and non-work related injuries, recognizing that both result in absence and loss of productivity, although this approach is still uncommon in Australia. Too often in the past, only those employees who were injured at work (i.e. entitled to workers' compensation benefits) received rehabilitation assistance. Employees who incurred their disability or injury outside the workplace were left at home with minimal contact or assistance from the workplace. Employers have realized that this does not make economic sense, with employee turnover costing between one and two times a worker's salary in lost productivity (LifebyDesign, 2007), so many now provide the same RTW programs for employees with work-related and non-work related injuries (Fernberg, 1999).

The primary "welfare state issue" that will affect disability management in the next two decades is the significant increased prevalence of chronic illness among Australians, largely as a result of improvements in medical knowledge and diagnosis, and reduced mortality rates. At the same time Australia's population is aging. Exacerbating this situation is the strong relationship between aging, chronic health problems and disability. Australia now faces a shortage of skilled workers across all industries so over the next two decades employers will need to retain older workers and those with chronic conditions. Disability management services will be required to assist employers to accommodate aging and ill workers through flexible working hours and benefit plans, wellness programs, telecommuting from home, retraining, worksite accommodation and the like. Clearly, disability management will remain a key component in managing the economic and human costs of injury and illness, particularly if Australia is to remain competitive in an increasingly global business environment.

4.2 The Welfare State and DM in Canada

In Canada the term "social welfare" is not as commonly used as it is in Europe. The federal and the provincial and territorial governments share responsibility for the provision of what are commonly referred to as social services. The federal government is responsible for major sectors such as military, banking, transportation and infrastructure; the remaining governance is completed by the provinces or territories through provincial/territorial taxation or federal funding. The major welfare programs pertaining to DM are: Employment Insurance (EI) Sickness Benefits, Canadian Pension Plan (CPP) Disability Benefits and Workers Compensation. Employment Insurance provides sickness benefits to individuals who are unable to work due to sickness or injury and who meet specific eligibility criteria (Service Canada, 2014). EI sickness benefits are paid for a maximum of 15 weeks (Service Canada, 2014). The CPP Disability Benefits was introduced in 1966; to qualify for these benefits, an individual must have a severe prolonged disability, be under the age of 65 and have met CPP contribution requirements (Service Canada, 2015). Workers' compensation is designed to reduce financial hardships incurred by workers as a result of workplace injuries and occupational illnesses or diseases (Service Canada, 2013). EI and CPP are both federally administered, while workers' compensation legislation is the responsibility of provincial and territorial governments with the exception of federal employees. Private employers also provide services that are often funded by contributions from the employer and employees.

Disability management was introduced in Canada because of the human and financial costs of disability, in congruence with a changing legislative environment. At present, illness and

disability in Canada cost 2.4% of gross payroll (Stewart, 2013). In 2012 alone, disability cost the Canadian economy approximately 16.6 billion dollars (Stewart, 2013). DM has been active in Canada for approximately 20 years, yet there are no standardized DM programs. Employers generally have two main options for establishing a DM program: to employ a DM practitioner within the organization or to contract DM services to a private DM practitioner. The problems that presently exist between the welfare state and DM in Canada include lack of knowledge about the legislation, obstacles in communication between involved parties, and resistance or inability to implement DM programs.

The administration of workers' compensation legislation by provincial or territorial governments results in variations in legislation across the country. For example, at present, disability specific legislation only exists in Ontario (Accessibility and Ontarians with Disabilities Act, 2005), while British Columbia recently passed "Bill 14", extending workers' compensation coverage to include mental disorders and bullying in the workplace (WorkSafe BC, 2015). These differing legislations in provinces and territories pose difficulties for employers whose companies cross provincial and territorial boundaries. For example, nationwide companies with employees in several provinces must follow each province's regulations. In British Columbia, every workplace must meet the legal requirements of the Occupational Health and Safety (OHS) Regulations under the inspection jurisdiction of WorkSafe BC, while in Manitoba this is the responsibility of the Workers Compensation Board. In these situations, it may be beneficial for employers to use third party consultants for DM programs because they can more easily navigate the multiple legislations of regulatory bodies.

Communication between involved parties is another major challenge for the welfare state and DM in Canada. In both DM and welfare programs there are several parties involved, including employees, employers, healthcare providers, insurance companies, government and depending on the workplace, unions or regulating bodies. Without proper communication between these parties, it can be difficult to know who is responsible for what and where payments are coming from. For example, if an employee is approved for CPP payments, these may be adjusted if they are receiving income from other sources such as a private insurer or a provincial/territorial social assistance program.

Finally, another key problem is resistance or inability to implement DM programs. In particular, non-occupational injuries or illness are an area of proven difficulty. With the establishment of welfare programs that compensate employees with disabilities, there is the potential for many employers to forego DM programs. DM programs are not standardized, so it is the responsibility of each organization to take this up themselves. Organizations may not see any value in such a program and not want to invest money in creating one. In addition, even if they want to do so, small organizations may not be able to afford the initial costs of developing a program.

Canada is still in the process of learning how to make the best use of DM in workplaces and key challenges include lack of knowledge on legislation, challenges in communication between involved parties and resistance or difficulty with program implementation. Over the past two decades, DM has become much more common with attitudes and knowledge changing for the positive. The exponential costs of both illness and disability in Canada require continued learning and improvement on this matter.

4.3 The Welfare State and DM in China

There are some laws and regulations relating to the development of DM in China. The Social Insurance Law was enacted on July 1, 2001. There were five insurance programs included in the social insurance system: work injury insurance, pension insurance, medical insurance,

unemployment insurance, and maternity insurance. All of these insurance schemes were managed by the Ministry of Human Resources and Social Security in China. The Work Injury Insurance Regulations, enacted in 2004, was one of the key social insurance programs in China, compensating workers suffering from work accidents or occupational diseases. The work injury insurance regulations also describe the use of this insurance fund by the government as being to support work injury prevention activities and rehabilitation programs, including RTW programs for injured workers (Yu, Tang, Chan, Ip & Lo-Hui, 2011).

The Production Safety Law of 2002 aimed at strengthening the administration and enforcement of production safety so as to reduce and control work accidents and injuries. This law was administered by the Bureau of Work Safety.

The Occupational Disease Prevention and Control Law of 2002, is aimed at preventing and controlling occupational diseases, in order to protect workers' health. This law is managed by the occupational health department of the Ministry of Health.

In relation to return-to-work and employment of people with disability, the formation of the China Disabled Persons' Federation at 1988 was supported by the government in order to promote the welfare of people with disabilities, including support for and provision of vocational rehabilitation. The law on the Protection of Disabled Persons was enacted in 1990, to protect people with disabilities from discrimination. The employment quota scheme policy adopted in the year 2003 requires all public and private employers to reserve no less than 1.5% of jobs for people with disabilities.

China has become the "World's Factory" since the economic reforms that began in 1978. The resulting rapid economic growth has generated a drastic increase in work-related injury (Yu, Tang, Chan, Ip & Lo-Hui, 2011). According to statistics released by Ministry of Human Resources and Social Security, more than one million workers suffered work injuries in China in 2014 (Ministry of Human Resources and Social Security of PRC, May 2015). The total estimated direct economic loss from work injuries and occupational diseases is over a hundred billion renminbi. In order to address the increasing problem of work injury, the Chinese government enacted a new Work Injury Insurance Regulation in 2004 and has subsequently introduced different rehabilitation practices and guidelines under this regulation (Chan, 2008; Yu, Tang, Chan, Ip & Lo-Hui, 2011).

Recognizing the importance of prevention in reducing work injuries and injury-related costs, the Chinese government has increasingly emphasized the promotion of work injury prevention since 2009. Twelve cities, including Guangzhou, were selected and encouraged to run pilot projects and to summarize local models for future reference. (Ministry of Human Resources and Social Security of PRC, Sept 2009). Hence, a participatory occupational health and safety improvement program was initiated by the Hong Kong Workers' Health Centre (HKWHC) and the Guangdong Provincial Work Injury Rehabilitation Centre (GPWIRC) was set up in 2010 to explore the feasibility of using a local participatory model to prevent work injury. From 2010 to 2015, the program was provided to more than 100 enterprises in Guangdong province and the results were encouraging. It gradually received the attention and support of the Ministry of Human Resources and Social Security. The program was accepted into the labour insurance system in 2014, to which the government assigned a fund for the support of continuing delivery of the program. This pilot experience was reported at the experience-sharing forum of Work Injury Prevention in September 2015 by the head of the Guangzhou Municipal Human Resources and Social Security Bureau. In his speech, he described the program as one of the most successful practices in work injury prevention, which should be further promoted (Zhang, 2015).

The concept of work injury prevention was not valued much in China ten years ago but is gradually gaining the attention of the government and local enterprises. The good experiences identified in different pilot projects have become valuable references for other Chinese cities to enhance the development of work injury prevention.

With reference to overseas experiences in disability management, the Chinese government has also clearly stated that return to work is one of the missions of the work injury rehabilitation system. Recently, four work injury rehabilitation centres were selected in China as Regional Demonstration Platform Selections in Work Injury. These regional centres are located in Guangzhou, Beijing, Shanghai and Chongqing. Occupational rehabilitation is identified as one of the components of the regionally-based work injury rehabilitation centres. Rehabilitation agents regulate the accreditation: such a centre is required to have professionally trained people in occupational rehabilitation and in rehabilitation counseling support. The RTW rate is one of the mandatory service indicators: it should be over 75% successful and there should be a three-month job sustainability in RTW support for injured workers who are ranked at level 5 or lower in the disability assessment scale (Ministry of Human Resources and Social Security of PRC, July 2015). The work disability assessment scale in China ranges from Grade 1 to Grade 10. Grades one to four are the most serious work accidents, which result in permanent work disability; grades five and six indicate that injured workers have lost most of the ability to work. Grades seven to ten indicate that injured workers are suffering minor work injuries with partial disability.

Although the Chinese government has already identified work injury prevention and return to work as the key missions of the work injury insurance system, as yet there are no concrete measures to encourage companies to establish a DM system. Instead, the government continues its disability employment quota system requiring all public and private enterprises to reserve no less than 1.5% of employment opportunities for persons with disabilities. Enterprises that fail to meet this quota are required to pay a fine to the Disabled Persons Employment Security Fund. This Fund is used to support vocational training and job placement services for people with disabilities (ILO, August 2008).

4.4 The Welfare State and DM in Switzerland

The key areas of the Swiss social security system relevant to disability management are Invalidity Insurance, Health Insurance, Accident Insurance and Unemployment Insurance. There are also the Income Compensation Allowance (in case of obligatory military service and maternity) and family allowances.

In addition to the insurance-based social security schemes (except the allowances), which are based on and linked to gainful employment, there is a welfare benefit scheme that guarantees a minimum income to secure basic needs.

The development of workplace and social security based measurements started in Switzerland as early as 1877, when the Federal Factory Act (*Fabrikgesetzgebung*) (Studer, 1998, p. 162) became the first legislation to protect workers at the workplace. Since then occupational health and safety have gained a strong hold in legislation. For a long time, the focus was on accidents and thus to bodily injury, but mental health matters are also covered by this legislation. In 1912 the SUVA (Swiss National Accident Insurance Fund) was founded, as compulsory accident insurance for a large fraction of the workforce, mandated to supervise occupational safety in companies (SUVA, 2015). Since 1984 there has been an obligation on all employers to provide accident insurance for their employees. Private insurers are allowed to provide insurance coverage for employees. Today the SUVA insures nearly two million working people (out of a total workforce of almost five million) and all unemployed people. Private insurers cover the other employees. For disability management, the accident insurance

schemes are important for providing external disability management support for injured employees, basically in the return-to-work process and in workplace adjustment measures. In 2003, the SUVA was also the first social insurer in Switzerland to introduce a disability management system to support injured workers to return to work, called New Case Management.

In 1960, the accident insurance system was supplemented by the Disability Insurance (DI), regulated by federal law (*Invalidenversicherungsgesetz IVG*); since 1991 each canton has had its own Disability Insurance Office (DIO). There are three criteria for receiving support from the DIO: “impairment to health (regardless of whether it is congenital, illness-related or accident-related) leading to earning incapacity (medical criterion), a permanent or longer-term earning incapacity (economic criterion), and a causal link between them” (Federal Social Insurance Office, 2015). In its current form, DI has two main pillars. The first is obligatory for all people older than 17 and has two main functions: first, the DI tries to restore or to improve the working/earning capacity of people and attempts to reintegrate them into the labour market or help them to keep their job. This measure was introduced in 2008 with the fifth revision of the IVG and is called “early recording and early intervention”. Second, if the first step is not successful or only partially successful, then the invalidity insurance will pay a disability pension and helplessness allowance to the beneficiaries. “The beneficiary receives a full disability benefit if the degree of disability is at least 70%; three-quarter disability benefit if the disability degree is at least 60%; half disability benefit if the disability degree is at least 50%; and quarter disability benefit if the disability degree is at least 40%” (OECD, 2014a, p. 33). The Disability Insurance is a key player in support and practice of disability management in Swiss companies. Especially through the instruments and benefits for employees and employers to take measures for workplace preservation, the Disability Insurance can offer information and counseling for employees and employers who face severe health problems, as well as financial support for workplace adjustment.

Another important feature that promotes disability management in Switzerland is the Daily Allowance Insurance. Employers’ obligation to pay for sick-leave is comparable low. Depending on an employee's tenure, the employer may be obliged to continue paying the employee’s full wage [100%]” (OECD, 2014a, p. 45).¹ Companies cannot legally dismiss employees during period they are obliged to continue wage payments. Some collective labour agreements offer better conditions for their employees. Many employers cover the financial risk involved by a Daily Allowance Insurance, some employers, mainly in the public sector, do offer better conditions for their employees also without having an insurance. Only about 22 per cent of employees in Switzerland are covered by such improved conditions (OECD, 2014b, p. 45). Eighty per cent of the wage is covered by the insurance, for a duration of 720-730 days. During this period, dismissal of the employee is not allowed. At the beginning of the 2000s, the Daily Allowance Insurer started to introduce external DM for the employees on sick-leave, to promote an early return to work. The gain for employers and the employees is that they get access to DM services. In this way, companies without internal DM have access to professional support dealing with case-related work and health problems. However, insurer-based DM solutions are often questioned about their interest in case management: is it mainly to support employees and employers, or is it merely a way to reduce costs?

In recent years the pension funds have also become significant players in DM in Switzerland. In cases of reduced earning capacity due to health problems, the pension from this “first pillar” (disability pension) is complemented with money from a second pillar, which is an employer-based pension system (occupational pension fund) (Duell, Tergeist, Bazant, & Cimper, 2009). The employer-based pension system is only compulsory for employees

¹ There are three different scales that define the duration and each canton follows one of these three scales.

earning more than 21,150 Swiss francs (in 2015) per year. For self-employed people there is an optional insurance plan (OECD, 2014a, p. 34). “The level of both first and second pillar pensions is mainly determined by the degree of disability and the insured income while the number of years worked plays a minor role” (Duell et al., 2009). Depending on the cause of the reduced earning capacity, the disability insurance, the pension fund or the accident insurance (in case of an accident) compensate for the lack of income. In case of an accident, the pension fund contributes only if the combined support from the accident insurance and the disability pension do not reach 90 per cent of the insured wage. As well, in their provision of income security for disabled employees, the pension funds are increasingly relevant to DM. The funds can offer occupational measure if there is a chance to restore work capacity and avoid a loss of pension funds contributions.

While there are measures and incentives for DM in the social security system, there is no obligation for companies to adopt and use them. Furthermore, there is no strong obligation for companies to offer DM services for their employees. In this regard, article 6 of the Swiss labour law emphasizes the obligation of the employer to protect the health of employees at the workplace. However, Switzerland has experienced rising numbers of people who receive a pension from the invalidity insurance during the last 20 years, which has created financial problems. This trend has led to the introduction of several new labour market policies (cf. Duell et al., 2009). Under these new laws the invalidity insurance program increasingly tries to (re)integrate people with reduced work capacity into the labour market and supports companies to retain and reintegrate their employees. The new motto is: “rehabilitation before pension”. Although there is no law on DM, the social insurance system is increasingly interested in better prevention and return to work in companies, and the invalidity insurance scheme has tried to improve its cooperation with the companies. The new policies have helped to stabilize then reduce the number of people receiving and invalidity pension in the last ten years (BSV, 2015, p. 22). However, the number of new cases caused by mental health problems is still rising (especially among young people) and is seen as one of the main problems. In addition to the increased support from the invalidity insurance, the SUVA, private accident insurers, pension funds and sick leave insurances all support companies in their efforts to retain employees with reduced work capacities and to improve RTW rates for employees after illness or accident. For large and medium sized companies, health protection and health prevention becomes more and more important, especially in the face of new challenges generated by demographic change and a shortage of skilled workers. Increasingly, companies of that size are implementing additional health measures, e.g. corporate health management as a special type of DM.

4.5 Conclusion

The description of the welfare state conditions relevant to disability management shows that there are significant differences among the different countries. Whereas the situation in China can be characterized as a recent and dynamic development of welfare state schemes promoting selected DM features, driven by rapid economic growth during the last decades, the welfare systems of the other countries are characterized by coherence and complexity. In China, the implementation of occupational health and safety schemes including return to work measures began in the 2000s. Pilot regions have been identified to propel the implementation process of DM regulations, mainly focusing on work injuries through a general workers’ accident insurance. Besides that, China introduced a quota system according to which workers with disabilities must make up 1.5 per cent of their employees. One reason for that is to encourage companies to keep and to reintegrate employees with disabilities. The situation in China stands in contrast to that in Australia and Canada, where there are well-established company-based workers’ compensation systems, which were introduced to improve the protection and security of employees while making the companies responsible for the

financial support of employees suffering from work-related illness and accidents, including mental health problems. Regulations have been in place in those countries since the early 1980s; however the implementation of company-based support structures and DM schemes has only really taken off in the 2000s. This development is partly a result of the need to develop more cost-effective strategies in companies, which focus more on time lost due to absenteeism and more effective RTW measures. Cost-driven approaches seem to be quite effective in bringing DM into companies. But even if such systems are implemented in companies, that does not necessarily mean that they are effective, or that further development contributes to efficiency and efficacy. Whereas China can be seen as an example of a highly regulated approach, and both Australia and Canada as cost-driven DM approaches on the basis of welfare state regulation, companies' DM in Switzerland are not driven by a single motivation but by a plurality of internal and external incentives, based on the general legal and cultural view that employers are responsible for the well-being of their employees. Therefore in Switzerland there can be found a plurality of DM approaches in companies that rely on internal, cost-driven measures, as well as on external resources generating activities, e.g. with the Disability Insurance or the Daily Allowance Insurance. In conclusion, it is clear that "the underlying values and the understanding of welfare differ significantly" and, as a result, DM systems require flexibility and context-appropriate implementation that take into account national expectations, culture and social welfare systems (Sander, Schmitt, & Kuhnle, 2010, p. 17).

5 Research Approach and Methodology

5.1 International and interdisciplinary comparative research

The study was conducted by an international and interdisciplinary research team that includes researchers from Australia, Canada, China and Switzerland. The range of disciplines includes psychology, social work, economic sciences, medicine, sociology, health care and rehabilitation science. The international perspective and the interdisciplinarity of the research team contributed a lot to the research findings. However, during the research process several challenges came up, including (a) the need to develop a coherent terminology for DM, which is not yet established either inside the different countries or on the international level; (b) the need for a research practice that applies the same methods and methodology in each national context; (c) different ethical standards in each country regarding conducting research; and (d) being confronted with intercultural differences and 'critical incidents'. Further problems arose regarding methods and methodology for qualitative and quantitative research. Here not only the discourses and practices in the participating countries are different but also the research practices. Our international comparative approach to the research required in-depth communication about research methods, methodology and practice. A general challenge was that each country team faced its own difficulties in realizing the research project, which led to unequal progress in the project, including differences in the progress of recruiting companies and subsequently for completing data collection and analysis, and different standards for ethics approval. However, despite these difficulties a heterogeneous sample of companies was developed in each country, which was essential for the international comparison.

5.2 Ethical Standards in International Research

International and interdisciplinary research confronts the problem that there are different ethical standards on national and disciplinary levels. The standards applied for the research in such a situation must be the highest national and university standards of the countries and disciplines participating in the project. In this study, the research project had to gain ethics approval from the University of Northern British Columbia.

The University of Northern British Columbia conforms to Canadian federal requirements for the conduct of ethical research. Further information can be found in the Tri Council Policy Statement: Ethical Conduct for Research Involving Humans (2014). Compliance with these ethical standards is a requirement for all research that any researcher from UNBC participates in. This compliance ensures that all participants and their information are handled appropriately. All teams in the research partnership were in full compliance.

5.3 Aim and research questions

There is limited research into what measures and actions are taken by companies when their employees are injured and there is, to our knowledge, no cross-national or international comparative research on DM in the private sector. Therefore, an international analysis of DM programs in private companies, including the impact of national social systems on DM, and the effectiveness of different DM concepts and programs, is a significant contribution to knowledge about disability management. Further, this type of international study helps to reveal the factors that encourage private companies to implement DM and to highlight the specific benefits for workers in the countries analyzed (cf. Westmorland & Buys, 2004). This knowledge can then be shared in order to improve DM uptake in institutions and countries, furthering the development of workplace integration programs and helping companies to face the challenges created by demographic change.

This study focuses on countries with well-established DM systems as well others. The international comparative study is of DM in Australia, Canada, China and Switzerland. The aim is to answer the following research questions:

- What factors influence a private company's choice to implement a DM program?
- What are the perceived benefits/drawbacks of a DM program?
- What are the strengths/weaknesses of the current DM systems?
- What value do employees see DM having in terms of their job satisfaction, physical and mental health, employee morale, workplace attendance, etc.?

5.4 Research design and methods

The research employed a mixed-methods multi-level approach, including both case-study methodology and survey-based data collection (cf. Creswell, 2009; Flick, 2009; Patton, 2002). In each of the four participant countries (Australia, Canada, China, Switzerland), a research sub-team took primary responsibility for collecting the data. For each of these case studies, the researchers collected data at the level of the employee, the DM-practitioners, and the employer, through problem-focused, guided interviews (Witzel, 1985).

5.5 Sampling and data collection

In each country, private and public companies were identified that had established a DM program for a period of at least two years. The aim was to have eight participating companies in each country. The completed data selection includes eight Swiss, eight Chinese, ten Australian, and six Canadian companies (in total 32 companies). In each company, four qualitative interviews were conducted with the human resources and disability management officers, and two with employees in need (n=128 interviews). The completed data collection includes 32 companies to compare at the international level (N=32 for international comparison). It was planned to structure the sampling process in order to allow cross-national comparison (cf. Patton, 2002). The primary matching criteria was the size of the companies and their business activities. Further sampling criteria should be revealed and applied during the research process according to the theoretical sampling strategy (Patton, 2002). However, it became clear that in each country, except for Australia, there were difficulties recruiting companies. Many companies were approached but decided not to participate. Reasons indicated for non-participation included ongoing restructuring processes, their own survey

activities, and other less company-specific reasons such as the current economic situation. Therefore the planned theoretical sampling strategy could not be applied during the research process and it was only possible to have a convenience sample with those companies that agreed to participate in this study. The recruiting process showed that public companies are also important in the application of DM programs in each country. For that reason a limited number of public companies were included in the research sample. Most of the sample 32 companies were private.

In the research team as well as in the discussion with the companies, concerns arose regarding the explicit naming of companies in reports and publications. In China, companies were uncomfortable with the name of their organization being used for reports and publications; however, ultimately it was possible to publish the companies' names in this report. But in Canada, the University of Northern British Columbia Research Ethics Board stipulated that company names not be made public. Hence, company names in the following table have been replaced with code names (Company A, Company B, etc.),

	Switzerland	Australia	China	Canada
1.	Company A (Pharmaceutical industry) around 13,000 employees in Switzerland	Company A (Recruitment) Australian branch only. 31,000 staff in 60 countries.	Company A (Pharmaceutical industry) over 1,700 staff	Company A (post secondary education institutions) 100-499 employees*
2.	Company B (Public Sector) around 27,000 employees	Company B (Health service provider) Australia wide company. 20,000 staff	Company B (Manufacturing in tire and rubber) over 1,700 staff	Company B (post secondary education institutions) 500-999 employees
3.	Company C (Mail Services) around 9,000 employees	Company C (Health service provider) International. 69 hospitals & 18,000 staff in Australia	Company C (Manufacturing in lighting products) over 500 staff	Company C (engineering consulting firm) 500-999 employees
4.	Company D (Mail Services) around 19,000 employees	Company D (Rehabilitation provider) 250 staff across Australia	Company D (Rehabilitation hospital) around 100 staff	Company D (industrial construction company) 100-499 employees
5.	Company E (Insurer) around 3,300 employees in Switzerland	Company E (Facility management services) Australian branch only. 10,000 staff in Australia & NZ.	Company E (Rehabilitation hospital) around 500 staff	Company E (health services provider) 100-499 employees
6.	Company F (Transport) around 27,000 employees	Company F (Facility management & security services) 36,000 staff across Australia	Company F (Manufacturing in golf set) around 500 staff	Company F (financial institution) over 5,000 employees
7.	Company G (Transport) around 8,000 employees	Company G (Insurer) 30 offices in Australia. 17,000 staff in 38 countries.	Company G (Hospital) around 300 staff	
8.	Company H (Insurer) around 3,000 employees	Company H (Telecommunications) Australia wide company with 32,000 staff, but some staff in 15 countries.	Company H (Manufacturing in paper) around 300 staff	
9.		Company I (Public Sector) Local regional council with 1,700 staff		
10.		Company J (Transport) International Airline. Serves 29 Australian cities with 9,400 staff		
Number of companies approached, but participation could not be arranged.				
	28 companies	4 companies	25 companies	74 companies

*UNBC ethics regulations stipulate that we not give exact staff numbers.

To supplement the qualitative analyses, survey-based quantitative data were collected from employees within each organization. The goal was to receive at least 30 completed questionnaires from each company. Specifically, the interest was in evaluating employee satisfaction with available DM programs, including perceived impacts on job satisfaction, health, employee morale, attendance, etc. Given that international DM research is scant and there are no available questionnaires that met our needs, our international research team created a questionnaire suitable for collection of this data. Translated versions (German, French, simplified and traditional Chinese) of the same questionnaire were used in each country to collect the survey data. Wherever possible, the questionnaire was available as an on-line survey and employees of each of the identified companies in each country were invited to participate. The information from the surveys was mainly used to provide descriptive, quantitative information about the employee perspectives on DM.

During recruitment, given that potentially appropriate organizations do not always use the DM specific terminology (and may instead use case management, health promotion, health management, etc. terminology), DM as implemented in a private company was operationalized if the following criteria were fulfilled (Geisen et al., 2008, p. 1):

- 1) analysis of data on sick leave and absenteeism of employees;
- 2) counselling and support of ill and injured employees;
- 3) co-ordination of activities and claims for reintegration; and
- 4) measures and activities of prevention in workplace health promotion.

5.6 Data Analysis

5.6.1 Qualitative Data Collection and Analysis

As DM is neither common nor standardized in either conception or execution, a qualitative research methodology was seen as the most suitable for gaining broad understanding of DM activities in the companies. Since little research has been done on DM in companies so far, the study provides a model for the further identification and systematization of different private sector DM strategies. In a first step, semi-structured interviews were conducted with employees, DM practitioners, and HR (Witzel, 1985). This allowed us to reconstruct the respective DM process and perceptions as well as the benefits/costs and strengths/weakness for the participant company's DM Program. During this process of data collection in the companies, different material and documents related to DM were collected. First, these data (e.g. DM-concept, DM-guidelines, DM-process-descriptions) were used to deepen our knowledge of DM gained through the interviews. Not all companies allowed access to their DM documents and procedures, so a systematic comparison on the initial level of data collection was not possible. Hence, the documents were merely treated as additional information to the other available data but not taken as a separate source of data.

The research took a multi-layered approach, investigating three different levels in the company in order to gather data about the implementation, development and benefits of DM for the employee (n=2, employees supported by DM), DM practitioner (n=1), and HR (n=1). Interviews (N=4, per case/company), conducted at all three levels, were recorded and transcribed verbatim. Data analysis was made on the basis of an initial coding based on grounded theory methodology to break up the data (Glaser & Strauss, 2005). After initial coding, categories and sub-categories were deductively developed from the research questions. This second step in analysis was based on content analysis (Kuckartz, 2014; Mayring, 2010). Content analysis is focused on those categories and sub-categories relevant to answer the research questions. The relevant categories were identified and the related statements summed up.

International comparison of the qualitative data started after the initial coding by each national research team. First, the research teams shared their initial coding lists and discussed commonalities and differences in coding. This step was used to gain a better understanding of wording and terminology used so far and to see if codes could be used in the different social contexts in the same way. In a research meeting of the complete research team the coding lists of each country were presented and discussed. Though the coding lists represented a different status of development and completion of the research process, an extensive exchange of the used codes took place and a better understanding of each coding process was possible. To improve and intensify this process, selected interviews were coded and discussed via Skype by a group of researchers from each national team. Based on these steps, researchers gained a comprehensive knowledge of the coding process in each team. Finally, the codes relevant for answering the research questions were selected and put into a table, which includes the relevant codes of each research team, a summing up of the meaning of each code based on the quotations for each code, including a quotation as an example. Based on that table the research questions were answered, and differences and commonalities between the DM practices of the companies of each country were identified. The way in which international comparison of the data was done made sure that from the beginning, a joint understanding of meaning and social specificities could be developed. At the same time, a comprehensive coding system could be developed and reworked for each country, according to its own data and national and company characteristics. As recently as the last step of content analyses, international comparison was made.

The process by which our international comparison was completed can be described as one in which the different steps of the research were used by the international team to improve mutual understanding of what DM means in each distinct context. This practice was developed in order to avoid misunderstandings and inadequacies in analysis. It helped to ensure that the particularities of the selected companies and the countries were retained and not diminished at a very early stage that is, in the process of coding itself, through use of a joint coding list. Especially due to time strains and geographical distances, such a process was only applicable if the research team could work together on the whole data set. But because in general this is not possible in international comparative research, a decision must be taken about at the stage at which the international comparison is going to be made. We adopted a three-step approach: (1) discussion and exchange of knowledge about social conditions and DM in companies; (2) more intensive discussion during the process of analyzing the data collected, proceeding through each country and company; and (3) using the categories and subcategories developed for the data set in each country to make an international comparison by focusing on the research questions.

5.6.2 Quantitative Data Analysis

Quantitative data was collected in order to evaluate employees' perceptions of DM in terms of its impact on such variables as job satisfaction, physical and mental health, employee morale and absenteeism. To our knowledge, no appropriate survey currently exists, so we created our own questionnaire. This was done at a joint meeting. Wherever and whenever possible, the questionnaire was provided as a voluntary on-line questionnaire to employees of all participant companies in all countries. Some companies did not have email addresses or internet access for all employees. In those cases, paper-and-pencil questionnaires were used. The quantitative data were initially analysed using descriptive statistics to provide a picture of employees' general perceptions of the value of DM to a variety of outcomes. In a secondary analysis we evaluated possible criteria that might lead to more positive and/or negative perceptions of DM. Our specific research questions for this analysis were:

- What is the influence of DM on job satisfaction, physical health, mental health, morale and sick time?

- Are there any differences between public and private companies?
- Are there any differences between union and non-union workers?
- Are there any gender differences?
- What differences do we observe between the countries on these questions?

6 Conducting DM in companies: principles and challenges on country level

6.1 DM in companies in Australia

Data collection in Australia started with 14 companies verbally agreeing to participate in the study; of those, ten companies were able to participate at the time of data collection and were taken for the final sample as agreed by the international research team. The companies include an airline, a regional local council, two health-care providers, a private rehabilitation provider, a recruitment services provider, an insurer, and two infrastructure service providers. These organizations are scattered over several Australian states and some of them are national companies. The challenges for the research team include the geographical distance between companies and in some cases, the geographical spread of workers within each organization. Fortunately, since the 1980s Australia has introduced significant legislative measures to promote rehabilitation. This has encouraged large companies in particular to develop in-house or third-party disability management programs.

Disability Management is one function of a larger human resources system in most Australian private companies. Typically, the human resources department of a large organization has several business arms with various reporting lines. For instance, the Work Health and Safety (WHS) section deals primarily with disability and injury prevention at a systems level, whilst disability management deals primarily with the return to work and claims management of injured workers once a disability or injury claim has been lodged and accepted. The segmentation of DM and prevention is apparent in many companies, whereby data gathering and disability management are undertaken by different sections. For example, it was common for respondents to report that the DM service area was not aware of absenteeism rates, as this information was gathered by a separate team and often not acted upon. Nevertheless, it is apparent that Australian companies share common guiding principles, as legislative requirements include recognizing the importance of disability and injury prevention, development of a safety culture, early intervention, reduction in time off work, and timely and sustainable return to work for injured workers. More recently Australian organizations have come to understand the benefits of a happy workforce and its direct correlation to increased productivity and reduced time off work. This type of approach has seen the rise of psychosocial health strategies based on positive psychology frameworks and wellness programs aimed at increasing resilience in workers, and the implementation of healthy lifestyle initiatives. These have proven successful in preventing and managing both physical and psychological injuries in the workplace, as well as increasing rates of retention, and maintaining a skilled and experienced workforce.

Implementation

Most Australian companies have established DM systems to control risk and mitigate high claim costs, low productivity and time off work. Several companies described their interest in implementation of DM programs as a business imperative in a global economic environment. A focus on prevention has been widely accepted as a means of curbing rising insurance premiums related to an escalation in both work related and non-work related injuries. For example, respondents discussed wellness programs such as equipping their workplaces with centres containing gymnasiums and child care facilities. The “when” and “how” of the implementation of DM programs in Australian companies are largely dependent on staff skills and resources. Injured workers spoke of the differentiation of DM implementation when

offered by an allied health professional rather than an administrative HR officer. The consensus was that professional staff are better equipped to understand matters of stigma and functional restrictions, and offer more timely and empathic service.

DM in practice

The model of service undertaken by Australian companies almost always resembles a linear progression from referral to assessment, planning, intervention, monitoring and evaluation. Several factors influence this process, including state legislation and regulations. On a micro level, the factors include doctors' and professionals' recommendations, external DM provider involvement, employer attitude and company culture in relation to DM and return to work, internal staff skills and resources, and timeliness of service provision.

DM prevention services in Australian companies interviewed include:

- Healthy lifestyle courses and workshops based on topics such as exercise and fitness, mental health fitness and nutrition;
- Expert advice and therapy such as massage and counselling;
- Flexible work arrangements; and
- Provision of reasonable adjustments in the work place such as aids and equipment and job re-design.

The legislative measures implemented to manage risk in the workplace are largely driven by the federal *Workplace Health and Safety Act 2012*.

DM management services in Australian companies include:

- Suitable duties plan development;
- Allied health assessment and advice;
- Job redeployment;
- Aids and equipment;
- Job re-design;
- Reduction or change in work hours or days at work;
- Supervision and support in the workplace;
- Time off work to attend appointments;
- Allocation of case manager to coordinate return to work; and
- Support from management.

The legislative measures implemented to manage injured and disabled people in the workplace are largely driven by state workers' compensation laws.

Evaluation

Human resources management in each company collects lost time injury rates and rates of general absenteeism. Some companies also conduct employee satisfaction surveys and find a correlation between staff satisfaction and successful implementation of their DM programs. However, data captured from evaluation is often not used to inform DM initiatives. In some companies this may be linked to the low take-up rates for staff surveys in which leadership and communication issues are prevalent.

We often see a correlation between, um, well, the hospitals that do well on the staff satisfaction and engagement survey usually are also doing very well with their health and safety indicators as well.

I suppose we don't use that data very well to inform the national program and that is probably an area that we could improve.

Characteristics of DM in Australia

Workers' compensation laws are very dominant in Australia and few have focused on the value of engaging staff to work on reducing overall workplace injuries. The companies in Australia that take a holistic approach to DM in the workplace demonstrate some key characteristics of strong leadership and the evaluation of staff engagement that leads to caring for workers.

Try and care for those staff and say, "Look, you're going to go home tired or a bit dirty, or whatever it may be. If you put in a hard day's work good on you, but we don't want you going home injured". So, that's, that's the primary motive.

It's not just wellness but it's, you know, culture creation and, you know, um, good leadership and strong management.

Workers' compensation by nature is a reactive scheme and for many years it has focused employers' attention on the outcome of injury. Leaders of change in Australia, in their attempt to reduce risk, have now realized that the best way to reduce the rate of workplace injuries is to avoid them in the first place by ensuring the workers are engaged in workplace safety and cared for.

6.2 DM in companies in Canada

Data collection in Canada was completed with six companies. They include a financial institution, two post-secondary education institutions, an engineering consulting firm, an industrial construction company and a health services provider. Some of these organizations are spread nationwide while others are limited to a single province or territory.

This sample of companies displayed considerable variation in the approach to disability management. There appear to be no specific qualifications required for conducting disability management and between companies there is variation in the roles, responsibilities and job titles of disability management practitioners. Two main options are presented to Canadian companies that want to establish a DM program: to employ a DM practitioner within the organization or to contract DM services to a private DM practitioner. Some companies have a single dedicated employee or a team of employees to manage disability, while others have employees who manage the company DM program while also fulfilling other responsibilities – such as payroll duties. In addition to the variation in disability management practitioners, there is also variation in what comprises a DM program within organizations.

Implementation

The sample of companies in Canada revealed several factors that influence a company's decision to implement a DM program. The most common reason given was concern for employees' health and wellbeing. For example, one company stated, "We want to keep our employees. Our employees are valuable, we want to work with them." Companies indicated that DM programs result in cost savings, increased productivity, employee retention, and better monitoring of absences.

We pay a lot of money to train the people to stay, to be with the company, right, a lot of long-term employees, a lot of money that goes into making sure that they're trained to do their jobs and it's in our best interest to keep them around.

DM programs are also seen as a beneficial recruiting tool. Canadian companies reported that external factors such as insurance companies, regulatory bodies, unions and government are all influential in the decision to implement a DM program.

DM in practice

In the Canadian companies there appear to be three components in DM programs: benefits, health promotion and injury prevention. Most companies have some form of benefits package that includes short-term disability and/or long-term disability benefits. Other benefits that many companies provide are Employee and Family Assistance Programs (EAP or EFAP), critical illness insurance, flexible work arrangements, counselling, vocational retraining and modified work programs. These benefits packages can be delivered either internally (within-company) or externally (through a private external service). Health promotion consists of the proactive measures that companies implement and promote in order to improve the health and wellbeing of their employees. Several Canadian companies reported that the workplace promotes not-for-profit health initiatives and sponsors employees' entry into such health-promoting events, including events such as Relay for Life with the Canadian Cancer Society, Run for the Cure with the Canadian Breast Cancer Foundation, and Heart and Stroke month with the Heart and Stroke Foundation. Health promotion also occurs through newsletters and pamphlets, seminars, wellness weeks, monthly health topics, health screening and reduced-cost gym memberships. Injury prevention consists of injury management programs, bulletins of accidents and near misses, mandatory education programs, health and safety committees and additional safety measures.

Evaluation of DM

Canadian companies identified several tools used to evaluate the results of DM programs. Like the programs themselves, there is no uniform way in which companies evaluate the success of their programs. Assessment methods include employee surveys, audits, inspections, attendance statistics, injury rates, risk assessments and length of time spent on disability benefits. Some industry-specific tools include Recordable Incident Frequency (RIF), Total Recordable Incident Frequency (TRIF), near misses and first aid treatment logs and medical records. Finally, companies also evaluate the costs of these programs and whether regulatory body costs, long-term disability costs, sick time costs, and relief costs have been reduced.

Canadian companies also indicated that they are weak in the evaluation of DM programs, as they are often missing timely and accurate data collection. In interviews, the success of DM programs was indicated in the utilization of services. For example, one participant recognized that "people are not getting treatment because everything is covered." Another participant stated, "there was never any question we were going to receive the support we needed." While these do not speak of quantifiable evaluation of DM programs, they do indicate the success or lack of it of DM programs at an employee level.

Characteristics of DM in Canada

The Canadian companies revealed that DM programs have no consistent structure or implementation within organizations. Among the Canadian companies there is a high degree of variation in the role and qualifications of DM practitioners, the DM program components and the tools used to evaluate programs. The Canadian data provide insight into the strengths of current programs as well as the organizational and employee challenges that occur as a result of highly varied programs. The lack of a structured program is responsible for many of the organizational problems that companies face. One respondent stressed that "although that person [DM manager] is in charge of disability, they don't necessarily have a lot of background in disability training and certainly not in accommodation."

6.3 DM in companies in China

A wide variety of companies in Hong Kong and in mainland China were approached. Though the companies expressed great interest in participating in this international study, they had

difficulties obtaining final agreement to participate. There were major concerns regarding the privacy and confidentiality of the study, and how much information would be disclosed to the public. The problem was solved by a general anonymizing of the international data and companies. The research process in China has thus far showed that much more time was needed than anticipated to gain agreement for the company's participation. All the research instruments were translated and retranslated into Mandarin and Cantonese.

Since DM is not common in China, companies were hesitant about disclosing the data to any third party, including research institutes. At the same time, it was almost the first time that the terms and measures of DM were translated into Chinese. The common terms used for the system were "occupational safety program" or "return to work caring program". Therefore, many company representatives approached showed no interest in joining the research as they believed that their programs might not completely match the definition of the DM program as translated from the international research questionnaire. At the same time, the program contents of these interviewed companies were quite fragmented and not as well coordinated as the DM programs in other developed countries.

Implementation

Regarding the difficulties in setting up and operating the DM system, companies find it difficult to provide OHS prevention activities and training for night shift workers. Without external professional support, companies also have difficulties managing the human factor in occupational health and safety (OHS). It is also difficult to control the quality of services and equipment provided by external contractors and suppliers, which can create occupational health hazards in the workplace. It was found that the work injury compensation system leaves a gap in the reimbursement of medical costs for injured workers before the confirmation of work injury cases, and that some of the medical items may not be reimbursed by the existing work injury insurance. This means that companies must bear the medical costs involved in early medical treatment for injured staff.

There was a concern about the increase in management costs of operating DM programs. Sometimes, there is a delay in introducing OHS improvements, or providing good quality personal protective equipment (PPE). Some front-line staff draw back from work injury preventive measures out of concern about personal discomfort or negatively affecting productivity, which may in return lower their salaries. None of the interviewed companies conducts systematic analyses of the benefits of DM programs, which results in stress for the management about supporting DM programs.

DM in practice

Among the eight companies interviewed, DM program duration ranged from two years to more than ten years. The program measures included: improvement of workplace environment, regular body checks and follow up, general safety training, safety inspections and meetings for suggestions about improvements, purchase of work injury insurance scheme, provision of PPE, mental health and work stress relief support, staff wellness activities, work accident investigation and reporting, standardized attendance systems, emergency in-house medical centres, medical coverage and rehabilitation programs for injured workers, support of return to work through work adjustments, support from supervisors and colleagues after return to work.

There were two notable features of the program components: one was the support of company-based trade unions for delivering care visits to workers in hospital or at home after sustaining work injuries. The company-based trade unions take up some of the human resources roles in delivering staff wellness programs such as staff outings and exercise

programs. The other was that some companies offer jobs to the careers of injured workers in case the injured person cannot return to work in the same company. These are part of the caring measures of the programs.

In terms of RTW strategies, some companies find it difficult to providing work adjustment for their skilled workers. Some injured workers do not embrace the concept of return to work, and some refuse to accept work adjustment proposals or to join the return to work program.

Evaluation

There were no systematic cost-benefit analyses of whole DM programs by the interviewed companies in China. But regarding their achievements, companies found that the programs help to improve company's reputation for being concerned with workers' well-being. They enhance the workers' sense of belonging and reduce the staff turnover rate, which in turn reduces management costs for recruiting and hiring. They also help to maintain workers' health, improve their morale and productivity, and to foster a safety culture. In general, the programs help to reduce sick days and to improve job satisfaction. They also help to lower work injury compensation costs by reducing the number of work accidents.

There was a general remark by the interviewees that the concept of disability management is ambiguous in China and management does not find it easy to implement programs without clear understanding of their contents and without any clear reference model in China. At the same time, there is no systematic professional training for DM personnel. It is difficult to hire well-trained DM professionals and thus the costs of replacing the DM professionals in the companies are increased because new staff must be trained.

In general, companies also have concerns about the sustainability of DM programs and the increased premium prices that may be incurred with insurance companies. Other perceived drawbacks listed by Chinese companies include conflicts with government assistance such as employment insurance, resistance to change, abuse of the programs, difficulties in implementation, lack of control and bureaucracy.

Characteristics of DM in China

Disability management in China is closely linked to occupational health and safety policies. The provision of services can be internal and also external, by service providers. Companies do already implement a wide range of DM activities, but a systematic linkage of the different activities as demanded by comprehensive DM is not yet in place in these companies.

Regarding future challenges, there were some concerns about the OHS system and improvement of workplace environment, including the costs involved in replacing old production facilities because of safety issues. Some of the interviewees said that they would like to focus not just on the front-line workers in production lines but also to pay more attention to the health concerns of administrative and office workers. There was also concern about the OHS awareness of the workers and the urge to provide them with more OHS training. It is difficult for companies to integrate the OHS management system into the management of daily operations. It is important, for example, to run drills for different contingencies including fires at night and chemical explosions. Some of the companies highlighted the importance of implementing more controls to reduce noise and dust in the workplace. Looking forward, companies would like to provide more wellness program for women's health, especially for female staff during periods of pregnancy and breast feeding. For work injury prevention, companies want to establish on-site controls to reduce accidents. In relation to return-to-work schemes, companies believe that it is important to improve the

work adjustment program. They would like to focus not just on work accidents and injuries, but also on work-related chronic diseases.

Companies have found that it is not easy to obtain workers' feedback on the programs, so it is also important to enhance communication among different departments on OHS and DM issues. Finally, all the interviewed companies expressed a need to set up comprehensive evaluation systems to assess the effectiveness of their DM programs. It is also considered important to translate DM from an ambiguous concept developed by overseas companies into some concrete measures with local experiences for reference in China.

6.4 DM in companies in Switzerland

The sample of eight companies in Switzerland showed a substantial degree of variation of companies in disability management approaches. This ranges from rather basic to highly complex approaches. Often the companies do not follow an integrated approach but rather employ a pillar strategy in which health management, including work and safety, prevention and case management are separated from each other and have little interconnection within a given firm. Viewed from a comprehensive approach of disability management, it is most striking that case management and prevention in the majority of companies appear to be only very loosely connected. Another important insight is that the qualification levels of the disability management practitioners are highly diverse; there seems to be no specific set of qualifications regarded as necessary to conducting disability management.

DM implementation

Various motives and reasons were identified as relevant to the Swiss companies' decisions to introduce DM programs. The main reasons were growing absentee rates, health problems linked to an aging workforce, and increasing costs for both personnel recruitment and insurance premiums. At the same time HR and DM professionals reported several motives that underlie the implementation of DM. Firstly, having a DM program influences the image of the company and it makes it a more appealing employer both in recruitment processes and because it improves employee loyalty. Employee loyalty is seen as vital to ensuring stable internal labour markets and to securing occupational know how. Secondly, DM is valuable for productivity. Since healthy employees are more productive, DM increases employee performance.

I am convinced that healthy and motivated employees are able to perform better. If we can make a contribution to that, it will pay off.

Furthermore, several companies pointed out that social responsibility and responsibility for the well-being of the workforce are important management principles to them. In order to be able to expect performance from the employees the company must make sure that there is a healthy environment and tailored support for employees with reduced work capacities.

There are various motives behind it. One is the company's value system. [Company G] depicts itself as a socially-responsible employer and is willing to carry responsibility.

Additionally, the introduction of DM is seen as a professionalization and an improvement in health competences in the company. It offers the possibility of combining the activities of different business units and increasing the imbrications of different health-related activities already established in the companies.

The companies introduced DM programs in most cases either in cooperation with universities or in collaboration and exchange with other companies. Pilot projects were often used to test

specific forms of DM in the starting phase of implementation. The introduction of DM was in all cases a stepwise process.

We developed a concept, firstly to deal with absences [...] Afterwards, at a certain point the absences were under control and then we wanted no new absences to occur and we continued with prevention.

DM was in all companies built on existing structures. On the one hand there were existing occupational safety structures with a long history. On the other hand, return to work used to be managed by people from HR or supervisors. The companies had to build on and integrate the existing structures into the more elaborate and comprehensive DM programs. The new structures allowed the companies to improve the health competences and the support for people after accident or sickness absence, and to recruit specifically skilled personnel for this support process. Today, the companies report that the DM casework is well established. However, most companies still struggle to deduce insights from DM casework and to use this knowledge to improve prevention and health promotion activities. Key challenges met during the introduction of DM were especially the recent financial crisis and other economic developments that hindered further development of DM mostly because of lack of financial or human resources.

DM in practice

DM casework (Case Management), occupational safety, prevention, and health promotion are the core components of the Disability Management programs in Switzerland. In most of the companies, occupational safety has a long tradition and has existed for a long time. Case Management programs have been established in the last ten years to improve return to work results. Health promotion and prevention were fostered during the establishment of DM programs.

The competence centre is a core unity; it was associated with health promotion, prevention and case management, and resources were pooled. Today, it provides services, support, a type of business lead (*Fachführung*) and normative guidelines for the whole company.

Some form of absence management is at the core of RTW programs in all companies. However, the companies have different mechanisms for starting a RTW (DM case work) process. In some of the companies, supervisors or HR are responsible; in others the absence management system directly informs the DM professionals after a specified number of days absent or after certain absence patterns. The DM professionals are responsible for RTW and they coordinate between private and public insurances, doctors, HR, supervisors, and the employees. In some cases, the employees can choose between an internal and an external case manager. Measurements in the RTW process include round table meetings with key stakeholders, working time adjustments, workplace adjustments, stepwise RTW, and assistance in finding a new job within the company or, more rarely, outside the company. Some companies additionally offer sheltered or integration workplaces for people with reduced work capacities. However, the number of reintegrated people with disabilities from outside the companies remains low. The employees mainly appreciate having someone who cares and who helps them to deal with the different tasks related to their absence from work and return to work.

Well, no. I was glad about that. I knew that she supports me and knows my case 100%. That was great. I really appreciated it.

However, they often mentioned that supervisors and the busy work environment do not help the return to work or to keep well and healthy at work.

Health promotion activities vary considerably. Most of the companies have fitness centres or other sports programs that the employees can make use of at a cheap rate or free of charge. However, especially for decentralized, fragmented companies, these services are often restricted to the main sites. Moreover, companies invest in workplace facilities (e.g. standing desks), awareness campaigns regarding mental health and stress, and workplace ergonomics in general. Most of the interviewed employees knew about the health promotion activities but did not use any of them. Several employees referred to social events as important health and well-being activities that they highly appreciate.

Evaluation

More than half of the companies acquired the Friendly Workspace label from Health Promotion Switzerland, which assesses key elements of the companies' health management systems. The friendly workspace label represents an important tool in the evaluation of their own DM program and it fosters the companies' image.

We are evaluated so to speak by the friendly work space certification. This happens every few years.

Yes there are several. It's for sure an image factor. It's also an external evaluation which I think is very good. It indicates where there is potential for development and where to look. Well I think it is important to do it. And I think it makes it more attractive to work for [Company H]. For people from outside.

Currently, in most of the companies there is no systematic and elaborated form of internal evaluation of existing DM programs.

Characteristics of DM in Switzerland

There are three key challenges with respect to DM in Swiss companies. Firstly, DM professionals and HR often feel a lack of support and commitment from supervisors and or the management.

With more support from above it might work faster, faster implementation. The employees would more likely take notice of us.

Secondly, company size seems to be a problem in various ways because it impedes the reaching of employees at all or early enough, makes diffusion of knowledge slow and companies report that there is not enough knowledge about the implementation of DM and DM practice in large Swiss companies so far. Thirdly, the amount of sick leave for people with mental health problems and support for a return to work of these people still presents major difficulties. In general, all the companies have implemented advanced forms of return to work programs; however, they still struggle in the prevention and early recognition of certain health issues.

Well I think the areas where we are good and I am satisfied with is on the one hand the reactive part, the case management, thus what we do with sick people [...] The whole topic of occupational safety works well. We have started in the preventive field, there are good initial approaches. However, we need to improve in early recognition of specific health issues and to foster the training of supervisors, and in a second step maybe of employees, to deal with such issues.

Viewed from the comprehensive approach of disability management, it is most striking that DM case-work and prevention in the majority of companies appears to be only very loosely interconnected.

6.5 Conclusion

The implementation and practice of DM in the different countries shows that the companies all face similar challenges. They must solve the problem of obtaining the professional know-how they need to implement and conduct DM programs. In our participating countries they can use external DM-services or develop a company-based DM program. Only in China is there a strong focus on company-based DM. There, external support is given by experts and expert-organizations but the companies do not delegate to a DM service agency. However, the overall perception of DM in companies is that it is very much needed. This attitude is supported directly by legal demands and indirectly by welfare state measurements that are supportive of implementing DM. The main reason for companies to introduce DM is cost effectiveness and productivity. Both are seen in a wider sense, meaning that companies are highly responsive to their own company culture as well as to the social context in which they are situated. For those companies that already have a long tradition of fulfilling legal requirements for occupational safety and employee health, the incentives to develop a DM program are already deeply-rooted in company culture, whereas firms without that background are struggling to introduce DM programs because of a lack of experience in that field. The latter can be seen in China, where a company culture of social responsibility must first be developed. However, in contrast to the other countries, companies in China are responsive to a kind of social responsibility that is not limited to the employees as workers but is also directed to the employee's family context, whereas in the other countries a strict division between the needs of employees in their workplace, and employees' private and family issues prevails. This shows that company culture is an important factor for DM, including from an international perspective. In the following chapter we look in more detail at the findings from our international comparison.

7 Conducting DM in companies: a four-country comparison

The following section brings together international findings on companies with DM and presents their commonalities and differences in implementation, effectiveness and employer/employee perspectives of DM in their companies.

7.1 Implementation of DM programs in companies

The common internal motivators for organizations in all four countries to implement DM include valuing or caring for workers and staff productivity, as well as reducing costs associated with poor health, injury absence and staff turnover. Swiss, Canadian and Chinese employers also referred to social responsibility, company image and recruitment motivators, which Australian employers did not. Chinese and Australian companies are also motivated to engage employees in an organizational safety culture with support from management, which is partly driven by legislative compliance requirements.

External factors pushing companies in all four countries to implement DM include national politics and insurance. Swiss, Canadian and Chinese companies also look to international factors, such as WHO recommendations and international best practice standards. The Australian companies on the other hand are overtly Australia-centric in their implementation of DM, even in those organizations that are part of bigger international organizations. Both Canadian and Australian companies are strongly driven by legislative responsibility. In addition, Canadian organizations are highly motivated by accountability to unions, regulatory bodies, the public, as well as human rights and environmental legislation.

Primary illness and injury prevention measures in all four countries include health and wellness programs and employee assistance programs, as well as injury and illness prevention strategies and equipment. Swiss, Canadian and Chinese companies also promote physical fitness with access to training facilities and a range of health initiatives, as well as health promotion activities. In addition, Swiss and Canadian companies offer flexible and transitional work arrangements for older workers, for example.

Secondary prevention measures in all four countries include absence management strategies, risk assessments and accident investigations, as well as insurance to cover work-related injury, illness and disability. In addition, companies in Switzerland, Canada and Australia provide money and resources to accommodate injured or ill workers and pay for medical expenses, even before their condition has been declared compensable. Occupational health and safety measures in all four countries include equipment and strategies to manage known risks, and occupational health and safety committees. In China there was also mention of CCTV systems to monitor workplaces.

Tertiary prevention of long-term disability in all four countries includes return to work support and retraining if required. Organizations in Switzerland and Australia mentioned the use of case management strategies. Australian and Chinese companies also emphasized support for medical interventions, including referral to external treatment providers. Both Canadian and Chinese companies provide some support to family members. In the case of China, this extends to offering job to family members of seriously injured workers in order to offset losses to family income.

Evaluations conducted by companies in all four countries include time measures, such as absenteeism and work time lost due to injury, as well as cost measures and return to work outcomes. All countries, except Canada, also mentioned employee feedback or staff satisfaction surveys. Both Switzerland and Australia observed problems with how evaluations are used in companies, including a lack of feedback loops to inform DM initiatives, and unsystematic approaches to evaluation.

All four countries acknowledged that politics and legislation are key drivers of DM implementation in companies. Similarly, various types of insurance play an important role in the implementation of DM in all four places. Legislated insurance requirements are a particularly strong driver of DM in Australia.

7.2 Effectiveness of DM programs in companies

Effectiveness is a key issue in disability management. Examining the implementation of DM in the researched companies, we find both internal and external factors of influence. This is relevant if we ask about the effectiveness of DM programs: What aims do companies have and how are they reached? The focus here can be directed to the employer's side as well as the employees' side. Both are salient in understanding the effectiveness of DM programs.

Looking at the benefits of DM from an employer's perspective, we find that the companies in the four countries see employee retention, employee recruitment, increased productivity and fast return to work as important. Here we do not find many national differences, but there are differences among the companies. Firms with more comprehensive DM in each country tend to focus mostly on productivity, seeing the other benefits as important ways to reach the key aim. For other companies, that adopt more limited approaches, employee retention and an effective return to work process are the main aims. In this regard DM developments in companies reflect the progress companies have already made. Here again it is not the national context that is relevant but how long a DM strategy has been in place in a company. In general, the benefits of DM as seen by companies as residing in a more stable, engaged and motivated workforce.

The cost-efficiency of DM programs can be shown to be highly relevant for all the companies but cost-effectiveness is very dependent on the social welfare context within which companies are situated. For companies in Canada and Australia, it can be shown that implementing DM is highly cost-effective right from the beginning. However, in Switzerland and China, companies regard the cost-effectiveness of DM programs as difficult to analyze and at best can be reached in the middle to long term. The main reason is that there are fewer company-based insurance schemes and more general, state-regulated social insurance plans whose premiums are not influenced by a company's action. Therefore, in these two countries, public discourses tend to focus more on the moral and social responsibility of employers than in Canada and Australia. Nevertheless, the cost savings of an efficient DM program are crucial to maintaining and extending DM programs in companies and because of that, a safe and healthy workplace, employee appreciation, income replacement and availability of extensive resources are seen as crucial by the companies. However, for some companies, the costs are also perceived as a potential danger for the future development of DM programs. This is mainly the case in private companies, while in public companies costs are seen as less of a danger for DM programs, but political decision-makers are regarded as influential.

The strengths of DM in companies include the immediate benefit of increased safety and DM awareness in the workplace. This is especially valid for companies in Canada and Australia. For Swiss and Chinese companies this effect is only seen as a result of DM activities in the long run. Australian companies emphasized the role DM plays in establishing a strong safety culture, influenced from the bottom up, where workers are able to decide on the best way to manage risk and to prevent illness and disability; as well as that, companies with DM offer greater opportunities for employees. This is less the case for the companies in the other participating countries. Whereas companies with DM programs in Australia report improved opportunities to raise "hot topics" such as mental illness, this does not seem to be the case for Chinese companies; Swiss and Canadian companies mention this issue as one of the major problems to be tackled. For them, DM offers the potential for such discussion but this is seldom taken up by employees. For all the companies in all countries, disability management is seen as contributing to the enhancement of the company's reputation for DM innovation, especially where DM is monitored and evaluated.

In the companies in Canada, Australia and Switzerland, the strengths of DM programs were coded into four sub-categories: Services, Interactions, Operation and Return to Work. These categories are less relevant for Chinese companies, where workplace safety is the main focus and companies report less on the activities associated with comprehensive DM programs. All Canadian companies identified service strengths, including access to benefits, extensive resources, availability of experts in the field, fast response and high levels of care. This is also the case for Australian companies, but less for Swiss companies because some of those activities depend less on companies' DM than on social welfare institutions. Chinese companies are less engaged in such practices. Furthermore, many of the strengths identified in Canadian, Swiss and Australian interviews were specific to the interactions that occur between parties involved in DM programs. These include being accommodating, flexible, working with the individual, avoiding discrimination, supportive and empathetic staff, and having an open-door policy. Strengths identified in RTW programs include providing employees with funding for further education while on modified duties, ability to work part-time while on long-term disability, and modified duties. Operations are another area in which companies in Canada, Australia and Switzerland see benefits in their DM programs. These include the use of technology to make information available, catching the people who need programs, providing training, implementing safety protocol and the ease of access to the program. In conclusion, organizations recognize that DM programs have been successful in these areas.

In the thematic analysis of Canadian interviews, weaknesses were categorized into organizational challenges and employee challenges. In both of these categories, the weaknesses identified were primarily related to claim and case management. Organizational challenges were further divided into three areas of weakness: Communication, recordkeeping and workplace/return to work. Australian companies reported similar weaknesses, whereas the weaknesses of Swiss and Chinese companies are different. Companies in Switzerland see weaknesses in a lack of employee engagement and responsibility in DM programs. For Swiss companies, case management itself is only seen as a problem if different external actors are involved in a case and it is not the company's DM that leads. Communication, recordkeeping and workplace/return to work are not reported as weaknesses but as strengths of DM in Swiss companies.

With a few exceptions, employees who have been involved in a DM program identify problems for the employees. These weaknesses include denied claims, low compensation, pressure to RTW and lack of graduated RTW opportunities. It was identified that there are often administrative responsibilities for employees and the onus or burden is on them to come up with their own solutions. As for the programs themselves, weaknesses include the lack of formal wellness programs and of focus on mental health and well-being. Other weak points for employees include insensitivity towards participants in the program and having to relive traumatic experiences by discussing the situation. Whereas the situation in China is similar to the Canadian situation, the situation in Australia and Switzerland is different. The weaknesses mentioned in the Canadian interviews are rarely reported in Australia or in Switzerland.

All the participating countries are struggling to manage the stigma associated with disability and injury in the workplace. Particularly in Australian companies, this affects organizational safety cultures, e.g. the rate of reporting near misses and incidences, and asking for help. This is less important in Switzerland mainly because such incidents are usually included not in DM programs but in occupational health and safety. Australian companies report overly-complicated safety reporting systems, which discourages workers from engaging with safety matters as the system is perceived a "tick box exercise"; this is not reported at all in the companies of the other participating countries. For Australian companies, several more challenges are reported, including the complexities of managing mental health injuries in the workplace and the competing priorities often experienced by profit-driven businesses; developing resilience in the workplace; using feedback gathered from various arms of the business to inform and improve the DM processes; legislative impacts on service delivery in relation to maintaining quality of DM service delivery. Such problems are also reported in Canada and in Switzerland, but less in China. Again, the lack of that kind of challenge in Chinese companies is due to the fact that there is no comprehensive DM implemented.

In conclusion it can be shown that strengths and weaknesses of DM in companies are generally associated less with national differences and more with the development of DM programs in the different companies. The more complex DM systems become, the more challenges there are to conducting case management, getting different actors involved, and having an effective communication among the different internal and external actors. However, it seems that differences in this regard are either company-related, which means that DM programs are often paralleled by additional programs like occupational health and safety programs, or are health prevention programs that also incorporate DM tasks. Others are related to different processes and programs linked to welfare state questions, such as short- and long-term disability programs in Canada and Australia.

7.3 Employee perspectives on DM

There appears to be an appreciation of the benefits brought by disability management programs across the countries. These included benefits mentioned by employees in all four

countries: feeling valued and supported, receiving financial assistance, and improved psychological wellness. Canadian and Chinese employees particularly mentioned improved safety at work and comprehensive medical services. Swiss and Australian employees seemed to take some of these benefits for granted.

Employees in all four countries believe that DM programs are valuable for health as they provide many resources that can be used to improve employee health. However, this depends on the take-up rates for health initiatives, as mentioned by Australian and Swiss employees. Employees reported that there would be more value to these programs if they emphasized stress management and mental health, especially in Canada, and if the information about what support is available were better communicated. Lack of timely communication is a particular problem for Australian employees, who reported feeling blamed, stigmatized and neglected when DM responses are poor. Both Swiss and Australian employees indicated a lack of trust in company-driven case management processes.

We also learned that DM programs can have a positive, negative or neutral influence on morale. In China, employee morale seems to be mostly positively influenced by DM and in Switzerland it is either positive or taken for granted. In Australia and Canada, morale is both positively and negatively influenced, depending on how DM strategies are implemented for individuals. Morale tends to improve when employees know they have benefits, as they feel more involved and valued by the company. In contrast, anything that is not included in DM programs may negatively influence morale. Examples of negative influence on morale included unaddressed fears about return to work (Switzerland), increased stress on co-workers due to absence (Canada and Switzerland), and negative management communication style (Australia). Additionally, some employees in Canada expressed disappointment in their job when returning from disability as no one had taken responsibility for their tasks and they were left with a heavy workload.

Furthermore, some employees said that their experience with DM programs had changed their outlook on the company. In China, Australia and Switzerland, employees reported feeling more closely connected to their employer and wanting to stay with the company as a result of the support provided in a DM process.

7.4 Employee perceptions of DM's value

Descriptive Analyses

The complete international sample included 1,304 participants, with the number of responses varying across items. The average age of our sample was 41.83 years ($SD = 11.299$), with 43.1% ($N = 562$) reporting as male and 55.2% reporting as female ($N = 720$). Educational achievement was well distributed with 33.0% ($N = 430$) reporting secondary level education and 60.2% ($N = 785$) having some form of post-secondary education. The majority of our respondents were married or in a marital-like relationship (68.9%); however, most of the sample was non-parenting (60.1%). The socioeconomic status of the sample was middle-class with an average US dollar corrected family income of \$89,023.28 ($SD = \$48,917.77$). Most respondents reported as managers (22.5%), professionals (17.8%), technicians/associate professionals (18.6%), and/or clerical support workers (17.9%). Only 79 respondents (6.1%) self-identified as an individual with a disability and 139 reported migrant working status (10.7%). The majority of the sample was working full-time ($N = 1033$, 79.2%). The sample reported moderate to good physical health ($M = 2.30$, $SD = .892$; scale from 1 = very good to 5 = poor) as well as mental health ($M = 2.13$, $SD = .917$). Similarly, our sample missed little work due to disability, illness or health problems ($M = 1.75$, $SD = .987$; scale from 1 = none to 6 = 6 months or more) and had both high job satisfaction ($M = 1.94$, $SD = .776$; scale from 1 = very satisfied to 5 = very dissatisfied) and work-related morale ($M = 1.96$, $SD = .824$;

scale from 1 = strongly agree to 5 = strongly disagree). Most respondents reported that their company took measures to prevent disability (M = 1.92, SD = .775; scale from 1 = strongly agree to 5 = strongly disagree), support staying at work (M = 2.04, SD = .872), and support return to work (M = 1.95, SD = .807); however, respondents were more likely to report stay at work (SAW) and return to work (RTW) initiatives for their co-workers (Self SAW: M = 2.63, SD = 1.549; Self RTW M = 2.64, SD = 1.595; Co SAW or RTW: M = 2.03, SD = 1.126). Similarly, respondents thought the quality of care provided to co-worker through these initiatives was higher than that received by the individual (Self SAW: M = 2.24, SD = 1.043; Self RTW M = 2.22, SD = 1.033; Co SAW or RTW: M = 2.03, SD = .979). Respondents felt that employers should continue to offer disability management programs (M = 1.63, SD = .829). However, despite wanting disability management programs to continue, respondents saw only moderate benefit in the programs for job satisfaction, physical health, mental health and morale (M = 2.20, SD = .804; M = 2.39, SD = .824; M = 2.37, SD = .855; M = 2.36, SD = .834); in comparison, respondents saw benefits for co-workers as slightly more positive than individual benefits (M = 2.13, SD = .763; M = 2.23, SD = .774; M = 2.28, SD = .802; M = 2.31, SD = .789). Interestingly, respondents reported muted perceived benefit of disability management programs in terms of reduced sick times (Self M = 2.90, SD = .933; Co M = 2.71, SD = .865).

Regression Analyses

Using the full sample of all countries (N = 1,304), cumulative odds ordinal logistic regression was employed to predict disability management's (DM) influence on job satisfaction, physical health, mental health, workplace morale and reduced sickness absence, from respondents' perceptions of whether their company provided disability prevention, stay at work, and return to work initiatives within their organization. Responses to the survey questions were ordered as being in one of three categories: agree, neutral, or disagree. It is important to note that in every case, a disability management program existed in participant companies for a period of at least two years. Therefore, the following questions reflected participants' perceptions of the disability management program that existed within their workplace:

1. My company takes measures to prevent disability (DP) in the workplace.
2. My company has a program designed to help workers with disability, injury or health problems stay at work (SAW).
3. My company has a program designed to help workers with disability, injury or health problems return to work (RTW).

DM program influence on job satisfaction. Agreement that the participants' companies had a DM prevention program (DP), stay at work (SAW) program and return to work (RTW) program predicted perceptions of DM's influence on coworker job satisfaction (all at $p \leq .05$). However, only agreement with DP and RTW predicted perceptions of DM's influence on the job satisfaction of the individual. If employees agreed that DM programs (prevention, stay-at-work, return-to-work) were available, they were also more likely to agree that these programs had a positive impact on job satisfaction (see Table 1).

DM program influence on physical health. Agreement that the participants' companies had each of DP and SAW programs predicted perceptions of DM's influence on individual and coworker physical health. In contrast, RTW program only predicted perceptions of DM's influence on physical health for others, not for the individual responding. That is, employees felt that the availability of DP and SAW programs were valuable to DM's influence on physical health for both the individual and co-worker; however, there was no significant relationship reported between RTW program and individual physical health.

DM program influence on mental health. Agreement that the participants' companies had each of DP and SAW programs predicted perceptions of DM's influence on individual and co-worker mental health. Furthermore, neutral responses to the same questions also predicted the same effect. However, RTW program did not predict perceptions of DM's influence on mental health for either the individual or co-workers. That is, employees felt that the availability of DP and SAW programs were valuable to DM's influence on mental health for both the individual and co-workers; however, there was no significant relationship reported between RTW program and mental health.

DM program influence on morale. Agreement that the participants' companies had each of DP and SAW programs predicted perceptions of DM's influence on individual and co-worker morale. However, RTW program did not predicted perceptions of DM's influence on morale for either the individual or co-workers. That is, employees felt that the availability of DP and SAW programs were valuable to DM's influence on morale for both the individual and co-workers; however, there was no significant relationship reported between RTW program and morale.

DM program influence on sick time. Agreement that the participants' companies had each of DP and SAW programs predicted perceptions of DM's influence on individual and co-worker sick-time. In contrast, RTW program did not predict perceptions of DM's influence on sick time for either the individual or co-workers. That is, employees felt that the availability of DP and SAW program were valuable to DM's influence on sick time for both the individual and co-workers; however, there was no significant relationship reported between RTW program and sick time.

Group Difference Analyses

Public versus private companies. Using Kruskal-Wallis H tests, comparisons were made between the international sample's respondents from public versus private companies on DM's influence for job satisfaction, physical health, mental health, morale and reduced sickness absence (for both the respondent and the respondent's perception for co-workers). Using $p \leq .05$ as the criteria, there were no significant differences revealed for any variable (see Table 2).

Union versus non-union. Using Kruskal-Wallis H tests, comparisons were made between the international sample's respondents from union versus non-union work environments on DM's influence for job satisfaction, physical health, mental health, morale and time missed (for both the respondent and the respondent's perception for co-workers). For coworker workplace morale only, respondents from non-unionized work environments reported more positive responses (Unionized N = 430, mean rank = 647.38; Non-unionized N = 805, mean rank = 601.24; see Table 3).

Gender. Using Kruskal-Wallis H tests, comparisons were made between self-reported males and females in the international sample on DM's influence for job satisfaction, physical health, mental health, morale and time missed (for both the respondent and the respondent's perception for co-workers). There were no significant differences between the responses of males and females for any of the variables (see Table 4).

7.4.1 Australia

Regression Analyses

Using the Australian sample (N = 365), cumulative odds ordinal logistic regression was employed to predict disability management's influence on job satisfaction, physical health,

mental health, morale and time missed, from respondents' perceptions of whether their company provided disability prevention, stay at work, and return to work initiatives within their organization. Responses to the survey questions were ordered as being in one of three categories: agree, neutral, or disagree. It is important to note that in every case, a disability management program existed in participant companies for a period of at least two years. Therefore, the questions reflected participants' perceptions of the disability management program that existed within their workplace.

DM program influence on job satisfaction. Agreement that the participants' companies had a RTW program predicted perceptions of DM's influence on job satisfaction for co-workers, but not for the individual. Furthermore, DP and SAW programs did not predict perceptions of DM's influence on job satisfaction for either the individual or for co-workers. That is, Australian employees reported RTW program as linked to DM's influence on their co-workers' job satisfaction but not their own; and DP and SAW was not significantly linked to DM's influence on either individual or coworker job satisfaction (see Table 5).

DM program influence on physical health. Agreement that the participants' companies had a RTW program predicted perceptions of DM's influence on physical health for co-workers, but not for the individual. Furthermore, DP and SAW programs did not predict perceptions of DM's influence on physical health for either the individual or for co-workers. That is, Australian employees reported RTW program as linked to DM's influence on their co-workers' physical health but not their own; and DP and SAW was not significantly linked to DM's influence on either individual or coworker physical health.

DM program influence on mental health. Agreement that the participants' companies had a SAW program predicted perceptions of DM's influence on mental health for the individual, but not for co-workers. Furthermore, DP and RTW programs did not predict perceptions of DM's influence on mental health for either the individual or for co-workers. That is, Australian employees reported SAW program as linked to DM's influence on their mental health but not their co-workers'; and DP and RTW was not significantly linked to DM's influence on either individual or coworker mental health.

DM program influence on morale. Agreement that the participants' companies had a SAW program predicted perceptions of DM's influence on individual morale, but not for co-workers. Furthermore, DP and RTW programs did not predict perceptions of DM's influence on morale for either the individual or for co-workers. That is, Australian employees reported SAW program as linked to DM's influence on their morale but not their co-workers'; and DP and RTW was not significantly linked to DM's influence on either individual or coworker morale.

DM program influence on sick time. Agreement that the participants' companies had a RTW program predicted perceptions of DM's influence on sick time taken by co-workers, but not by the individual. Furthermore, DP and SAW programs did not predict perceptions of DM's influence sick time taken by either the individual or for co-workers. That is, Australian employees reported RTW program as linked to DM's influence on their co-workers' sick time but not their own; and DP and SAW was not significantly linked to DM's influence on either individual or coworker sick time.

Group Difference Analyses

Public versus private companies. Using Kruskal-Wallis H tests, comparisons were made between the Australian sample's respondents from public versus private companies on disability management's influence for job satisfaction, physical health, mental health, morale and time missed (for both the respondent and the respondent's perception for co-workers).

Using $p \leq .05$ as the criteria, there were no significant differences revealed for any variable (see Table 6).

Union versus non-union. Using Kruskal-Wallis H tests, comparisons were made between the Australian sample's respondents from union versus non-union work environments on disability management's influence for job satisfaction, physical health, mental health, morale, and reduced sickness absence (for both the respondent and the respondent's perception for co-workers). No significant differences were revealed on any variable (see Table 7).

Gender. Using Kruskal-Wallis H tests, comparisons were made between self-reported males and females in the Australian sample on disability management's influence for job satisfaction, physical health, mental health, morale and time missed (for both the respondent and the respondent's perception for co-workers). No significant differences were revealed on any variable (see Table 8).

7.4.2 Canada

Regression Analyses

Using the Canadian sample ($N = 222$), cumulative odds ordinal logistic regression was employed to predict disability management's influence on job satisfaction, physical health, mental health, morale and time missed, from respondents' perceptions of whether their company provided disability prevention, stay at work, and return to work initiatives within their organization. Responses to the survey questions were ordered as being in one of three categories: agree, neutral, or disagree. It is important to note that in every case, a disability management program existed in participant companies for a period of at least two years. Therefore, the questions reflected participants' perceptions of the disability management program that existed within their workplace.

DM program influence on job satisfaction. Agreement that their company had a RTW program predicted perceptions of DM program influence on individual and co-worker job satisfaction. Furthermore, neutral response to the same question, and affirmative response to the question of if their company had a SAW program also predicted perceptions of DM's influence on job satisfaction for co-workers, but not for the individual. That is, Canadian employees reported RTW program as linked to DM's influence on their own job satisfaction; alternately, for their co-workers, both RTW and SAW was reported to be of benefit (see Table 9).

DM program influence on physical health. Agreement that their company had a SAW program predicted perceptions of DM program influence on individual and co-worker physical health. Furthermore, neutral response to the same question, and affirmative response to the question of if their company had a RTW program also predicted perceptions of DM's influence on physical health for co-workers, but not for the individual. That is, Canadian employees reported SAW program as linked to DM's influence on their own physical health; alternately, for their co-workers, both SAW and RTW was reported to be of benefit.

DM program influence on mental health. Agreement that their company had a DP and RTW program predicted perceptions of DM's influence on individual mental health, but not for co-workers. In contrast, both affirmative and neutral responses to the question of if their company had a SAW program predicted perceptions of DM's influence on mental health for co-workers, but not for the individual. That is, Canadian employees reported DP and RTW efforts as having a positive impact of DM's influence on mental health for themselves but not for their co-workers, and felt SAW was only significantly positive for their co-workers.

DM program influence on morale. Only SAW predicted DM's influence on workplace morale for both the individual and co-workers. Neither DM nor RTW was predictive of DM's influence on individual morale; however, SAW was significantly predictive of DM's perceived influence on workplace morale for co-workers.

DM program influence on sick time. Interestingly, for Canadian employees, there were no significant relationships between any of DP, SAW, or RTW for DM's perceived influence on individual or coworker sick time.

Group Difference Analyses

Public versus private companies. Using Kruskal-Wallis H tests, comparisons were made between the Canadian sample's respondents from public versus private companies on DM's influence for job satisfaction, physical health, mental health, morale and reduced sickness absences (for both the respondent and the respondent's perception for co-workers). Using $p \leq .05$ as the criteria, differences were revealed for both individual and coworker responses to physical health, mental health, and morale; and coworker responses to job satisfaction. In each case where differences were noted, private agencies resulted in more positive responses; respondents from private companies ranked DM's influence on job satisfaction, physical health, mental health, and workplace morale as greater than did respondents from public companies (see Table 10).

Union versus non-union. Using Kruskal-Wallis H tests, comparisons were made between the Canadian sample's respondents from union versus non-union work environments on DM's influence for job satisfaction, physical health, mental health, morale, and reduced sickness absence (for both the respondent and the respondent's perception for co-workers). Differences were revealed for both individual and coworker responses to job satisfaction, physical health, mental health, and morale, with Canadian respondents from non-unionized work environments reporting more positive results. That is, workers in non-unionized environments reported more positive perceptions regarding DM's influence on job satisfaction, physical health, mental health, and morale for both themselves and their co-workers (see Table 11).

Gender. Using Kruskal-Wallis H tests, comparisons were made between self-reported males and females in the Canadian sample on DM's influence for job satisfaction, physical health, mental health, morale, and reduced sickness absence (for both the respondent and the respondent's perception for co-workers). No gender effects were revealed for any variable (see Table 12).

7.4.3 China

Regression Analyses

Using the Chinese sample (N = 235), cumulative odds ordinal logistic regression was employed to predict disability management's influence on job satisfaction, physical health, mental health, morale and time missed, from respondents' perceptions of whether their company provided disability prevention, stay at work, and return to work initiatives within their organization. Responses to the survey questions were ordered as being in one of three categories: agree, neutral, or disagree. It is important to note that in every case, a disability management program existed in participant companies for a period of at least two years. Therefore, the questions reflected participants' perceptions of the disability management program that existed within their workplace.

DM program influence on job satisfaction. Interestingly, for Chinese employees, there were no significant relationships between any of DP, SAW, or RTW for DM's perceived influence on individual or coworker job satisfaction (see Table 13).

DM program influence on physical health. Interestingly, for Chinese employees, there were no significant relationships between any of DP, SAW, or RTW for DM's perceived influence on individual or coworker physical health.

DM program influence on mental health. Agreement that their company had a DP program predicted DM's perceived influence on mental health for co-workers, but not the individual. In contrast, neither SAW nor RTW had a significant effect of DM's perceived influence on mental health for either the individual or for co-workers. That is, Chinese employees reported general DP efforts as important for influencing mental health for co-workers, but not themselves; and did not report significant benefit of specific SAW or RTW interventions.

DM program influence on morale. Agreement that their company had a DP and SAW program predicted DM's perceived positive influence on workplace morale for co-workers, but not the individual. Interestingly, neutral response to the question of if their company had a RTW program also predicted a negative influence on workplace morale for co-workers, but not an affirmative response to the same question did not predict any influence. That is, Chinese employees reported DP and SAW as important for positively influencing workplace morale for co-workers, and a lack of strong RTW negatively influencing workplace morale for coworkers.

DM program influence on sick time. Agreement and neutral response that their company had a DP program predicted DM's perceived influence on reduced sickness absence for both the individual and for co-workers. In contrast, neither SAW nor RTW had a significant effect of DM's perceived influence on reduced sickness absence for either the individual or for co-workers. That is, Chinese employees reported general DP as important for DM's influence on reduced sickness absence for both themselves and their co-workers, but did not report significant benefit of specific SAW or RTW interventions.

Group Difference Analyses

Public versus private companies. Using Kruskal-Wallis H tests, comparisons were made between the Chinese sample's respondents from public versus private companies on DM's influence for job satisfaction, physical health, mental health, morale and time missed (for both the respondent and the respondent's perception for co-workers). Using $p \leq .05$ as the criteria, differences were revealed for individual job satisfaction, coworker mental health, and sick time taken by both the individual and co-workers. In each case where differences were noted, public agencies resulted in more positive responses; respondents from public companies ranked DM's influence on their individual job satisfaction, coworker mental health, as well as both individual and coworker reduced sickness absence more positive than did those from private companies (see Table 14).

Union versus non-union. Using Kruskal-Wallis H tests, comparisons were made between the Chinese sample's respondents from union versus non-union work environments on DM's influence for job satisfaction, physical health, mental health, morale, and reduced sickness absence (for both the respondent and the respondent's perception for co-workers). For individual job satisfaction only, Chinese respondents from unionized work environments reported more positive responses (Unionized N = 103, mean rank = 97.76; Non-unionized N = 104, mean rank = 110.18; see Table 15).

Gender. Using Kruskal-Wallis H tests, comparisons were made between self-reported males and females in the Chinese sample on DM's influence for job satisfaction, physical health, mental health, morale and reduced sickness absence (for both the respondent and the respondent's perception for co-workers). No differences were revealed for any variable (see Table 16).

7.4.4 Switzerland

Regression Analyses

Using the Swiss sample (N = 482), cumulative odds ordinal logistic regression was employed to predict disability management's influence on job satisfaction, physical health, mental health, morale and time missed, from respondents' perceptions of whether their company provided disability prevention, stay at work, and return to work initiatives within their organization. Responses to the survey questions were ordered as being in one of three categories: agree, neutral, or disagree. It is important to note that in every case, a disability management program existed in participant companies for a period of at least two years. Therefore, the questions reflected participants' perceptions of the disability management program that existed within their workplace.

DM program influence on job satisfaction. Agreement that their company had a RTW program predicted DM's influence on job satisfaction for the individual, but not for co-workers. In contrast, neither SAW nor RTW had a significant effect of DM's perceived influence on job satisfaction. That is, Swiss respondents felt the RTW was important for DM's influence on individual job satisfaction, but that DP and RTW had no significant influence for either themselves or their co-workers (see Table 17).

DM program influence on physical health. Interestingly, for Swiss employees, there were no significant relationships between any of DP, SAW, or RTW for DM's perceived influence on individual or coworker physical health.

DM program influence on mental health. Agreement that their company had a SAW program predicted perceptions of DM's influence on individual, but not coworker, mental health. In contrast, DP and RTW did not predict DM's perceived influence on mental health for either the individual or co-workers. That is, Swiss employees reported SAW as having a positive impact of DM's influence on mental health for themselves, but not co-workers; and felt DP and RTW had no significant influence for either themselves or their co-workers.

DM program influence on morale. Interestingly, for Swiss employees, there were no significant relationships between any of DP, SAW, or RTW for DM's perceived influence on individual or coworker morale.

DM program influence on sick time. Agreement that their company had a SAW program predicted perceptions of DM's influence on the sick time taken by co-workers, but not by themselves. In contrast, DP and RTW did not predict DM's perceived influence on sick time taken by either the individual or co-workers. That is, Swiss employees reported SAW as having a positive impact of DM's influence on sick time taken by co-workers, but not themselves; and felt DP and RTW had no significant influence for either themselves or their co-workers.

Group Difference Analyses

Public versus private companies. Using Kruskal-Wallis H tests, comparisons were made between the Swiss sample's respondents from public versus private companies on DM's influence for job satisfaction, physical health, mental health, morale, and reduced sickness

absence (for both the respondent and the respondent's perception for co-workers). Using $p \leq .05$ as the criteria, differences were revealed for individual and coworker job satisfaction, and individual mental health. In each case where differences were noted, public agencies resulted in more positive responses; respondents from public companies ranked DM's influence on their individual and job satisfaction, and individual mental health more positive than did those from private companies (see Table 18).

Union versus non-union. Using Kruskal-Wallis H tests, comparisons were made between the Swiss sample's respondents from union versus non-union work environments on DM's influence for job satisfaction, physical health, mental health, morale, and reduced sickness absence (for both the respondent and the respondent's perception for co-workers). No differences were revealed for any variable (see Table 19).

Gender. Using Kruskal-Wallis H tests, comparisons were made between self-reported males and females in the Swiss sample on DM's influence for job satisfaction, physical health, mental health, morale, and reduced sickness absence (for both the respondent and the respondent's perception for co-workers). For individual job satisfaction only, male respondents reported more positive responses than female respondents (Male N = 251, mean rank = 220.90; Female N = 213, mean rank = 246.17; see Table 20).

7.4.5 Summary

Taken as a whole, our data suggest that when considered either as a comprehensive international sample, or as individual countries, respondents reported the influence of disability management programs as positively predicting job satisfaction, physical health, mental health, workplace morale and reduced sickness absence. However, the specific component of disability management program (disability prevention, stay-at-work, or return-to-work) predicted positive outcomes differently, depending on the country of analysis. For example, in Canada, no component of disability management predicted reduced sickness absence; whereas, in Switzerland, reduced sickness absence was predicted by stay-at-work programs specifically; in China it was predicted by disability prevention programs; and in Australia, it was predicted by return-to-work programs. Other country-specific outcomes across all variables are described in detail above.

In addition, our results suggest that, for Canada, the influence of disability management on the measured factors is generally considered more positive in private, non-unionized companies. In comparison, there were no significant differences between public and private, and unionized and non-unionized companies in Australia. China's results were in contrast to the Canadian results and suggested more positive outcomes from disability management in cases of public, unionized workplaces. Similarly, the Swiss participants reported some positive results from disability management in public companies, but not in unionized workplaces.

Gender analyses suggested little influence with only one significant difference. Specifically, Swiss males reported greater influence of disability management programming on job satisfaction, as compared to Swiss females.

8 Concluding Remarks

To our knowledge, the present project constitutes the first international comparative study to provide both qualitative case-study and quantitative survey-based data from four countries at varying stages of disability management implementation, and with substantially different political and social systems. The cooperation of our international research team in this project will result in increased international collaboration for DM services, attainment of meaningful knowledge of DM practices according to country, increased dissemination of DM knowledge

globally, and potential social and political influence on the treatment of injured and ill workers around the world.

All of this makes an international analysis of disability management programs in private companies, including the impact on them of particular national social systems, and the effectiveness of different DM concepts and programs, is a highly significant contribution to the literature in this field. Moreover, this type of international study contributes to understanding of the factors that encourage private companies to implement DM and highlights the specific benefits for workers in the countries analyzed. This knowledge should be shared broadly, in a bid to increase the adoption of disability management programs where they currently do not exist, in institutions and countries, to further the development of workplace integration programs and to help companies to face the challenges posed by demographic change.

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Appendix

Table 1

Ordinal Regression of Company DM Program Variables in Prediction of Employee Workplace Perceptions – Overall Sample

Dependent Variable	R^2 of model	Predictors	Response	Odds Ratio (95% CI)	p
Job Satisfaction of Self	.142	DP Program	Agree	1.93 (1.09, 3.41)	.024
			Neutral	0.86 (0.46, 1.63)	.649
		SAW Program	Agree	1.43 (0.75, 2.75)	.280
			Neutral	0.76 (0.40, 1.46)	.407
		RTW Program	Agree	4.36 (2.01, 9.45)	<.001
			Neutral	1.91 (0.89, 4.11)	.098
Job Satisfaction of Fellow Employees	.162	DP Program	Agree	2.56 (1.43, 4.57)	.001
			Neutral	1.20 (0.63, 2.29)	.583
		SAW Program	Agree	1.97 (1.02, 3.80)	.043
			Neutral	0.91 (0.48, 1.76)	.786
		RTW Program	Agree	4.25 (1.95, 9.25)	<.001
			Neutral	2.06 (0.95, 4.46)	.067
Physical Health of Self	.105	DP Program	Agree	1.87 (1.06, 3.27)	.030
			Neutral	0.94 (0.50, 1.77)	.855
		SAW Program	Agree	2.98 (1.57, 5.66)	.001
			Neutral	1.86 (0.98, 3.55)	.058
		RTW Program	Agree	1.77 (0.82, 3.79)	.143
			Neutral	0.99 (0.46, 2.12)	.977
Physical Health of Fellow Employees	.138	DP Program	Agree	2.14 (1.21, 3.78)	.009
			Neutral	1.01 (0.53, 1.90)	.979
		SAW Program	Agree	2.55 (1.35, 4.84)	.004
			Neutral	2.05 (1.08, 3.89)	.029
		RTW Program	Agree	3.33 (1.56, 7.12)	.002
			Neutral	1.29 (0.61, 2.75)	.505
Mental Health of Self	.118	DP Program	Agree	2.32 (1.31, 4.10)	.004
			Neutral	1.17 (0.62, 2.21)	.631
		SAW Program	Agree	3.52 (1.86, 6.66)	<.001
			Neutral	2.47 (1.30, 4.70)	.006
		RTW Program	Agree	1.72 (0.81, 3.65)	.156
			Neutral	0.94 (0.44, 1.99)	.862
Mental Health of Fellow Employees	.126	DP Program	Agree	2.17 (1.23, 3.84)	.007
			Neutral	1.14 (0.60, 2.16)	.681
		SAW Program	Agree	3.83 (2.02, 7.26)	<.001
			Neutral	2.11 (1.11, 4.01)	.023
		RTW Program	Agree	1.80 (0.85, 3.84)	.127
			Neutral	1.08 (0.50, 2.30)	.848

(Continued)

Table 1 (Continued)

Workplace Morale of Self	.116	DP Program	Agree	2.36 (1.35, 4.10)	.002
			Neutral	1.21 (0.65, 2.24)	.549
		SAW Program	Agree	2.55 (1.35, 4.82)	.004
			Neutral	1.35 (0.71, 2.56)	.363
		RTW Program	Agree	2.11 (0.99, 4.49)	.052
			Neutral	1.24 (0.58, 2.65)	.574
Workplace Morale of Fellow Employees	.129	DP Program	Agree	2.43 (1.37, 4.31)	.002
			Neutral	1.32 (0.70, 2.51)	.390
		SAW Program	Agree	3.26 (1.72, 6.16)	<.001
			Neutral	1.63 (0.86, 3.09)	.133
		RTW Program	Agree	2.09 (0.98, 4.48)	.058
			Neutral	1.21 (0.56, 2.58)	.628
Sick Time Taken by Self	.066	DP Program	Agree	2.35 (1.34, 4.14)	.003
			Neutral	1.56 (0.83, 2.93)	.165
		SAW Program	Agree	2.22 (1.19, 4.16)	.013
			Neutral	1.48 (0.79, 2.78)	.224
		RTW Program	Agree	1.41 (0.67, 2.98)	.370
			Neutral	0.92 (0.44, 1.95)	.830
Sick Time Taken by Fellow Employees	.110	DP Program	Agree	2.85 (1.61, 5.04)	<.001
			Neutral	1.39 (0.74, 2.62)	.310
		SAW Program	Agree	2.89 (1.53, 5.44)	.001
			Neutral	1.87 (0.99, 3.53)	.052
		RTW Program	Agree	1.35 (0.63, 2.88)	.437
			Neutral	0.75 (0.35, 1.60)	.456

Note: For all predictors, a response of "Disagree" was the reference response, and therefor not included in the table.

Table 2

Results of Kruskal-Wallis Tests Comparing Employee Workplace Perceptions by Private vs Public Companies (Agree, Neutral, or Disagree) – Overall Sample

Measure	Private		Public		χ^2	<i>p</i>
	N	Mean Rank	N	Mean Rank		
Job Satisfaction of Self	673	654.88	620	638.45	0.914	.339
Job Satisfaction of Fellow Employees	674	657.47	617	633.47	2.178	.140
Physical Health of Self	674	639.06	620	656.68	0.926	.336
Physical Health of Fellow Employees	677	642.03	615	651.42	0.304	.581
Mental Health of Self	650	621.63	591	620.31	0.005	.941
Mental Health of Fellow Employees	646	621.29	592	617.54	0.048	.827
Workplace Morale of Self	673	639.68	613	647.70	0.198	.656
Workplace Morale of Fellow Employees	673	635.90	613	651.85	0.813	.367
Sick Time Taken by Self	676	646.74	613	643.08	0.037	.847
Sick Time Taken by Fellow Employees	676	652.51	611	634.59	0.894	.344

Table 3

Results of Kruskal-Wallis Tests Comparing Employee Workplace Perceptions by Unionized vs Non-Unionized Employees (Agree, Neutral, or Disagree) – Overall Sample

Measure	Unionized		Non-Unionized		χ^2	<i>p</i>
	N	Mean Rank	N	Mean Rank		
Job Satisfaction of Self	431	626.65	811	618.76	0.199	.656
Job Satisfaction of Fellow Employees	430	632.25	810	614.26	1.156	.282
Physical Health of Self	431	631.06	812	617.19	0.541	.462
Physical Health of Fellow Employees	428	628.23	813	617.19	0.397	.529
Mental Health of Self	416	605.88	774	589.92	0.762	.383
Mental Health of Fellow Employees	417	609.75	770	585.47	1.918	.166
Workplace Morale of Self	428	639.98	808	607.12	3.138	.076
Workplace Morale of Fellow Employees	430	649.38	805	601.24	7.008	.008
Sick Time Taken by Self	431	632.95	808	613.09	1.042	.307
Sick Time Taken by Fellow Employees	429	636.88	807	608.73	2.089	.148

Table 4

Results of Kruskal-Wallis Tests Comparing Employee Workplace Perceptions by Gender (Agree, Neutral, or Disagree) – Overall Sample

Measure	Male		Female		χ^2	<i>p</i>
	N	Mean Rank	N	Mean Rank		
Job Satisfaction of Self	557	618.60	715	650.45	3.466	.063
Job Satisfaction of Fellow Employees	559	622.94	710	644.50	1.788	.181
Physical Health of Self	559	644.99	714	630.75	0.609	.435
Physical Health of Fellow Employees	560	641.88	711	631.37	0.387	.534
Mental Health of Self	526	608.88	695	612.60	0.044	.834
Mental Health of Fellow Employees	526	600.94	692	616.01	0.782	.376
Workplace Morale of Self	556	623.64	710	641.22	0.963	.327
Workplace Morale of Fellow Employees	556	619.89	709	643.28	1.763	.184
Sick Time Taken by Self	558	630.02	709	637.13	0.142	.706
Sick Time Taken by Fellow Employees	557	613.78	708	648.12	3.306	.069

Table 5

Ordinal Regression of Company DM Program Variables in Prediction of Employee Workplace Perceptions – Australia Only

Dependent Variable	R^2 of model	Predictors	Response	Odds Ratio (95% CI)	p
Job Satisfaction of Self	.160	DP Program	Agree	1.34 (0.32, 5.70)	.690
			Neutral	0.53 (0.11, 2.70)	.448
		SAW Program	Agree	10.00 (0.77, 130.26)	.079
			Neutral	4.62 (0.35, 60.21)	.243
		RTW Program	Agree	12.13 (0.93, 159.04)	.057
			Neutral	4.15 (0.30, 56.87)	.286
Job Satisfaction of Fellow Employees	.209	DP Program	Agree	3.50 (0.82, 14.86)	.090
			Neutral	1.55 (0.31, 7.84)	.597
		SAW Program	Agree	2.89 (0.28, 30.33)	.375
			Neutral	1.11 (0.11, 11.77)	.928
		RTW Program	Agree	32.35 (2.48, 422.08)	.008
			Neutral	8.68 (0.65, 115.71)	.102
Physical Health of Self	.106	DP Program	Agree	2.71 (0.67, 10.96)	.163
			Neutral	1.21 (0.25, 5.77)	.814
		SAW Program	Agree	6.56 (0.70, 61.54)	.099
			Neutral	5.46 (0.58, 51.34)	.137
		RTW Program	Agree	2.15 (0.24, 19.08)	.492
			Neutral	0.61 (0.06, 5.75)	.667
Physical Health of Fellow Employees	.160	DP Program	Agree	1.48 (0.35, 6.25)	.591
			Neutral	0.57 (0.11, 2.86)	.496
		SAW Program	Agree	3.09 (0.33, 29.12)	.324
			Neutral	2.25 (0.24, 21.35)	.480
		RTW Program	Agree	25.88 (2.62, 256.01)	.005
			Neutral	6.68 (0.65, 68.35)	.110
Mental Health of Self	.135	DP Program	Agree	2.71 (0.66, 11.04)	.165
			Neutral	1.35 (0.28, 6.51)	.711
		SAW Program	Agree	13.10 (1.36, 125.79)	.026
			Neutral	8.25 (0.85, 79.96)	.069
		RTW Program	Agree	3.92 (0.42, 36.37)	.229
			Neutral	1.35 (0.14, 13.24)	.797
Mental Health of Fellow Employees	.145	DP Program	Agree	2.66 (0.67, 10.55)	.165
			Neutral	1.16 (0.25, 5.44)	.852
		SAW Program	Agree	5.15 (0.57, 46.49)	.145
			Neutral	2.18 (0.24, 19.81)	.487
		RTW Program	Agree	5.26 (0.59, 47.03)	.137
			Neutral	2.13 (0.23, 20.06)	.507

(Continued)

Table 5 (Continued)

Workplace Morale of Self	.149	DP Program	Agree	4.02 (0.96, 16.80)	.057
			Neutral	1.91 (0.39, 9.39)	.428
		SAW Program	Agree	10.07 (1.05, 96.89)	.046
			Neutral	7.27 (0.75, 70.22)	.087
		RTW Program	Agree	3.25 (0.35, 29.95)	.298
			Neutral	0.77 (0.08, 7.49)	.821
Workplace Morale of Fellow Employees	.135	DP Program	Agree	4.08 (0.97, 17.16)	.055
			Neutral	1.67 (0.34, 8.26)	.532
		SAW Program	Agree	4.16 (0.42, 41.30)	.223
			Neutral	2.06 (0.21, 20.62)	.540
		RTW Program	Agree	4.62 (0.47, 45.39)	.189
			Neutral	1.83 (0.18, 19.10)	.612
Sick Time Taken by Self	.062	DP Program	Agree	1.50 (0.38, 6.00)	.563
			Neutral	0.96 (0.20, 4.56)	.962
		SAW Program	Agree	4.21 (0.47, 37.97)	.201
			Neutral	2.56 (0.28, 23.34)	.404
		RTW Program	Agree	4.16 (0.47, 37.11)	.201
			Neutral	2.59 (0.27, 24.41)	.406
Sick Time Taken by Fellow Employees	.091	DP Program	Agree	1.36 (0.35, 5.21)	.657
			Neutral	0.45 (0.10, 2.06)	.305
		SAW Program	Agree	0.78 (0.09, 7.01)	.821
			Neutral	0.41 (0.04, 3.81)	.436
		RTW Program	Agree	13.10 (1.30, 131.61)	.029
			Neutral	7.62 (0.72, 80.41)	.091

Note: For all predictors, a response of "Disagree" was the reference response, and therefor not included in the table.

Table 6

Results of Kruskal-Wallis Tests Comparing Employee Workplace Perceptions by Private vs Public Companies (Agree, Neutral, or Disagree) – Australia Only

Measure	Private		Public		χ^2	<i>p</i>
	N	Mean Rank	N	Mean Rank		
Job Satisfaction of Self	314	179.79	51	202.76	2.977	.084
Job Satisfaction of Fellow Employees	314	184.49	51	173.85	0.729	.393
Physical Health of Self	314	182.29	51	187.35	0.131	.718
Physical Health of Fellow Employees	314	183.73	51	178.53	0.159	.690
Mental Health of Self	314	182.35	51	187.00	0.110	.740
Mental Health of Fellow Employees	314	185.63	51	166.82	1.949	.163
Workplace Morale of Self	314	182.08	51	188.65	0.225	.635
Workplace Morale of Fellow Employees	314	183.19	51	181.81	0.011	.918
Sick Time Taken by Self	314	182.69	51	184.93	0.024	.876
Sick Time Taken by Fellow Employees	314	182.05	51	188.85	0.216	.642

Table 7

Results of Kruskal-Wallis Tests Comparing Employee Workplace Perceptions by Unionized vs Non-Unionized Employees (Agree, Neutral, or Disagree) – Australia Only

Measure	Unionized		Non-Unionized		χ^2	<i>p</i>
	N	Mean Rank	N	Mean Rank		
Job Satisfaction of Self	54	185.05	306	179.70	0.173	.677
Job Satisfaction of Fellow Employees	54	186.32	306	179.47	0.325	.569
Physical Health of Self	54	178.76	306	180.81	0.023	.880
Physical Health of Fellow Employees	54	182.47	306	180.15	0.034	.854
Mental Health of Self	54	175.02	306	181.47	0.228	.633
Mental Health of Fellow Employees	54	181.40	306	180.34	0.007	.935
Workplace Morale of Self	54	178.19	306	180.91	0.042	.838
Workplace Morale of Fellow Employees	54	187.75	306	179.22	0.432	.511
Sick Time Taken by Self	54	185.86	306	179.55	0.205	.650
Sick Time Taken by Fellow Employees	54	196.10	306	177.75	1.694	.193

Table 8

Results of Kruskal-Wallis Tests Comparing Employee Workplace Perceptions by Gender (Agree, Neutral, or Disagree) – Australia Only

Measure	Male		Female		χ^2	<i>p</i>
	N	Mean Rank	N	Mean Rank		
Job Satisfaction of Self	123	180.00	238	181.52	0.025	.875
Job Satisfaction of Fellow Employees	123	185.99	238	178.42	0.707	.400
Physical Health of Self	123	184.84	238	179.02	0.328	.567
Physical Health of Fellow Employees	123	181.33	238	180.83	0.003	.958
Mental Health of Self	123	187.71	238	177.53	1.003	.317
Mental Health of Fellow Employees	123	184.61	238	179.13	0.315	.575
Workplace Morale of Self	123	185.67	238	178.59	0.498	.480
Workplace Morale of Fellow Employees	123	182.57	238	180.19	0.060	.806
Sick Time Taken by Self	123	181.52	238	180.73	0.006	.940
Sick Time Taken by Fellow Employees	123	180.92	238	181.04	<0.001	.991

Table 9

Ordinal Regression of Company DM Program Variables in Prediction of Employee Workplace Perceptions – Canada Only

Dependent Variable	R^2 of model	Predictors	Response	Odds Ratio (95% CI)	p
Job Satisfaction of Self	.222	DP Program	Agree	2.15 (0.64, 7.23)	.214
			Neutral	1.21 (0.33, 4.36)	.773
		SAW Program	Agree	1.51 (0.41, 5.56)	.534
			Neutral	1.00 (0.28, 3.60)	.997
		RTW Program	Agree	7.36 (1.81, 30.03)	.005
			Neutral	2.37 (0.59, 9.42)	.222
Job Satisfaction of Fellow Employees	.271	DP Program	Agree	1.18 (0.32, 4.34)	.803
			Neutral	0.78 (0.20, 3.11)	.729
		SAW Program	Agree	4.70 (1.20, 18.47)	.027
			Neutral	1.61 (0.43, 6.07)	.485
		RTW Program	Agree	13.33 (2.88, 61.62)	.001
			Neutral	9.04 (1.97, 41.45)	.005
Physical Health of Self	.214	DP Program	Agree	2.71 (0.75, 9.79)	.129
			Neutral	1.57 (0.40, 6.08)	.518
		SAW Program	Agree	4.07 (1.00, 16.54)	.050
			Neutral	1.57 (0.40, 6.16)	.517
		RTW Program	Agree	3.97 (0.92, 17.17)	.065
			Neutral	3.58 (0.83, 15.43)	.087
Physical Health of Fellow Employees	.315	DP Program	Agree	1.92 (0.54, 6.85)	.315
			Neutral	1.16 (0.30, 4.47)	.826
		SAW Program	Agree	7.61 (1.83, 31.60)	.005
			Neutral	6.44 (1.58, 26.26)	.009
		RTW Program	Agree	7.40 (1.67, 32.79)	.008
			Neutral	2.42 (0.56, 10.40)	.234
Mental Health of Self	.267	DP Program	Agree	5.59 (1.45, 21.47)	.012
			Neutral	2.82 (0.69, 11.53)	.150
		SAW Program	Agree	3.20 (0.82, 12.44)	.093
			Neutral	2.39 (0.63, 9.03)	.198
		RTW Program	Agree	5.65 (1.27, 25.19)	.023
			Neutral	3.07 (0.70, 13.56)	.138
Mental Health of Fellow Employees	.247	DP Program	Agree	1.88 (0.55, 6.48)	.315
			Neutral	1.21 (0.32, 4.48)	.780
		SAW Program	Agree	9.70 (2.45, 38.47)	.001
			Neutral	5.86 (1.53, 22.50)	.010
		RTW Program	Agree	3.32 (0.80, 13.75)	.097
			Neutral	2.32 (0.56, 9.57)	.244

(Continued)

Table 9 (Continued)

Workplace Morale of Self	.205	DP Program	Agree	2.68 (0.80, 8.99)	.111
			Neutral	1.43 (0.40, 5.16)	.586
		SAW Program	Agree	5.44 (1.47, 20.10)	.011
			Neutral	2.41 (0.67, 8.63)	.175
		RTW Program	Agree	1.56 (0.39, 6.22)	.530
			Neutral	1.18 (0.30, 4.75)	.812
Workplace Morale of Fellow Employees	.263	DP Program	Agree	2.09 (0.61, 7.14)	.239
			Neutral	1.30 (0.35, 4.82)	.692
		SAW Program	Agree	9.93 (2.57, 38.39)	.001
			Neutral	5.39 (1.44, 20.18)	.012
		RTW Program	Agree	2.63 (0.64, 10.81)	.180
			Neutral	1.55 (0.38, 6.39)	.544
Sick Time Taken by Self	.054	DP Program	Agree	1.60 (0.46, 5.59)	.462
			Neutral	0.93 (0.25, 3.52)	.916
		SAW Program	Agree	3.25 (0.84, 12.56)	.087
			Neutral	3.54 (0.93, 13.48)	.064
		RTW Program	Agree	0.44 (0.10, 1.82)	.254
			Neutral	0.37 (0.09, 1.57)	.178
Sick Time Taken by Fellow Employees	.095	DP Program	Agree	2.73 (0.76, 9.76)	.123
			Neutral	1.72 (0.44, 6.65)	.433
		SAW Program	Agree	3.73 (0.95, 14.60)	.058
			Neutral	3.30 (0.87, 12.61)	.080
		RTW Program	Agree	0.77 (0.18, 3.34)	.728
			Neutral	0.68 (0.16, 2.96)	.610

Note: For all predictors, a response of "Disagree" was the reference response, and therefore not included in the table.

Table 10

Results of Kruskal-Wallis Tests Comparing Employee Workplace Perceptions by Private vs Public Companies (Agree, Neutral, or Disagree) – Canada Only

Measure	<u>Private</u>		<u>Public</u>		χ^2	<i>p</i>
	N	Mean Rank	N	Mean Rank		
Job Satisfaction of Self	84	101.40	136	116.12	3.462	.063
Job Satisfaction of Fellow Employees	81	98.48	136	115.27	5.164	.023
Physical Health of Self	82	92.18	137	120.66	13.019	<.001
Physical Health of Fellow Employees	83	98.31	133	114.86	4.847	.028
Mental Health of Self	83	91.64	135	120.48	12.941	<.001
Mental Health of Fellow Employees	80	92.76	136	117.76	10.293	.001
Workplace Morale of Self	84	94.46	134	118.93	9.180	.002
Workplace Morale of Fellow Employees	84	92.88	137	122.11	13.458	<.001
Sick Time Taken by Self	85	103.36	136	115.78	2.601	.107
Sick Time Taken by Fellow Employees	85	104.64	136	114.97	1.889	.169

Table 11

Results of Kruskal-Wallis Tests Comparing Employee Workplace Perceptions by Unionized vs Non-Unionized Employees (Agree, Neutral, or Disagree) – Canada Only

Measure	<u>Unionized</u>		<u>Non-Unionized</u>		χ^2	<i>p</i>
	N	Mean Rank	N	Mean Rank		
Job Satisfaction of Self	104	120.06	108	93.44	12.490	<.001
Job Satisfaction of Fellow Employees	103	115.65	106	94.65	9.021	.003
Physical Health of Self	104	120.63	107	91.78	14.667	<.001
Physical Health of Fellow Employees	100	115.13	108	94.66	8.184	.004
Mental Health of Self	102	124.27	108	87.77	22.741	<.001
Mental Health of Fellow Employees	103	120.97	105	88.35	19.624	<.001
Workplace Morale of Self	102	120.81	108	91.04	14.844	<.001
Workplace Morale of Fellow Employees	104	124.47	109	90.33	20.155	<.001
Sick Time Taken by Self	104	112.14	110	103.11	1.519	.218
Sick Time Taken by Fellow Employees	103	113.03	110	101.35	2.682	.101

Table 12

Results of Kruskal-Wallis Tests Comparing Employee Workplace Perceptions by Gender (Agree, Neutral, or Disagree) – Canada Only

Measure	Male		Female		χ^2	<i>p</i>
	N	Mean Rank	N	Mean Rank		
Job Satisfaction of Self	77	113.53	138	104.91	1.186	.276
Job Satisfaction of Fellow Employees	78	104.59	134	107.61	0.172	.679
Physical Health of Self	78	116.24	136	102.49	3.075	.079
Physical Health of Fellow Employees	77	114.71	134	100.99	3.361	.067
Mental Health of Self	77	108.32	136	106.25	0.067	.795
Mental Health of Fellow Employees	77	107.82	134	104.96	0.138	.710
Workplace Morale of Self	77	105.35	136	107.93	0.102	.749
Workplace Morale of Fellow Employees	78	103.90	138	111.10	0.821	.365
Sick Time Taken by Self	78	107.04	138	109.33	0.088	.767
Sick Time Taken by Fellow Employees	78	106.51	138	109.62	0.171	.679

Table 13

Ordinal Regression of Company DM Program Variables in Prediction of Employee Workplace Perceptions – China Only

Dependent Variable	R^2 of model	Predictors	Response	Odds Ratio (95% CI)	p
Job Satisfaction of Self	.134	DP Program	Agree	1.40 (0.34, 5.79)	.640
			Neutral	0.34 (0.07, 1.63)	.178
		SAW Program	Agree	3.48 (0.65, 18.51)	.144
			Neutral	2.10 (0.40, 11.05)	.380
		RTW Program	Agree	2.17 (0.27, 17.64)	.468
			Neutral	1.46 (0.19, 11.02)	.712
Job Satisfaction of Fellow Employees	.148	DP Program	Agree	3.33 (0.89, 12.45)	.074
			Neutral	0.74 (0.17, 3.16)	.685
		SAW Program	Agree	3.29 (0.59, 18.29)	.174
			Neutral	2.89 (0.52, 16.12)	.227
		RTW Program	Agree	1.80 (0.21, 15.54)	.593
			Neutral	1.03 (0.13, 8.17)	.976
Physical Health of Self	.137	DP Program	Agree	2.67 (0.72, 9.86)	.141
			Neutral	0.99 (0.23, 4.26)	.991
		SAW Program	Agree	3.26 (0.62, 17.11)	.163
			Neutral	4.18 (0.77, 22.67)	.098
		RTW Program	Agree	1.58 (0.18, 13.71)	.677
			Neutral	0.48 (0.06, 3.84)	.489
Physical Health of Fellow Employees	.139	DP Program	Agree	3.16 (0.81, 12.31)	.098
			Neutral	1.15 (0.25, 5.23)	.857
		SAW Program	Agree	1.85 (0.31, 10.98)	.501
			Neutral	3.63 (0.60, 22.03)	.161
		RTW Program	Agree	3.22 (0.34, 30.51)	.308
			Neutral	0.81 (0.10, 6.81)	.846
Mental Health of Self	.084	DP Program	Agree	3.45 (0.92, 13.00)	.067
			Neutral	1.25 (0.29, 5.43)	.768
		SAW Program	Agree	2.54 (0.44, 14.78)	.298
			Neutral	3.06 (0.51, 18.50)	.224
		RTW Program	Agree	0.81 (0.08, 8.36)	.861
			Neutral	0.45 (0.05, 4.25)	.486
Mental Health of Fellow Employees	.112	DP Program	Agree	3.70 (1.00, 13.68)	.050
			Neutral	1.28 (0.30, 5.48)	.737
		SAW Program	Agree	4.27 (0.79, 23.05)	.091
			Neutral	4.52 (0.80, 25.62)	.088
		RTW Program	Agree	0.74 (0.08, 7.12)	.795
			Neutral	0.36 (0.04, 3.17)	.355

(Continued)

Table 13 (Continued)

Workplace Morale of Self	.095	DP Program	Agree	3.24 (0.92, 11.40)	.067
			Neutral	1.15 (0.28, 4.71)	.845
		SAW Program	Agree	3.51 (0.68, 18.26)	.135
			Neutral	2.26 (0.43, 11.75)	.334
		RTW Program	Agree	0.95 (0.12, 7.66)	.959
			Neutral	0.79 (0.10, 5.98)	.820
Workplace Morale of Fellow Employees	.164	DP Program	Agree	5.63 (1.59, 19.93)	.007
			Neutral	2.34 (0.56, 9.70)	.243
		SAW Program	Agree	6.90 (1.31, 36.37)	.023
			Neutral	3.38 (0.62, 18.34)	.158
		RTW Program	Agree	0.17 (0.02, 1.72)	.133
			Neutral	0.08 (0.01, 0.79)	.031
Sick Time Taken by Self	.147	DP Program	Agree	14.54 (3.98, 53.21)	<.001
			Neutral	9.18 (2.16, 39.06)	.003
		SAW Program	Agree	1.24 (0.26, 5.99)	.788
			Neutral	0.87 (0.18, 4.27)	.869
		RTW Program	Agree	0.71 (0.10, 5.20)	.735
			Neutral	0.35 (0.05, 2.50)	.299
Sick Time Taken by Fellow Employees	.142	DP Program	Agree	10.10 (2.85, 35.77)	<.001
			Neutral	6.47 (1.56, 26.78)	.010
		SAW Program	Agree	3.49 (0.71, 17.06)	.122
			Neutral	2.52 (0.51, 12.47)	.258
		RTW Program	Agree	0.38 (0.05, 2.89)	.352
			Neutral	0.18 (0.03, 1.33)	.094

Note: For all predictors, a response of "Disagree" was the reference response, and therefore not included in the table.

Table 14

Results of Kruskal-Wallis Tests Comparing Employee Workplace Perceptions by Private vs Public Companies (Agree, Neutral, or Disagree) – China Only

Measure	Private		Public		χ^2	<i>p</i>
	N	Mean Rank	N	Mean Rank		
Job Satisfaction of Self	115	127.38	120	109.01	8.887	.003
Job Satisfaction of Fellow Employees	114	123.24	120	112.05	3.596	.058
Physical Health of Self	114	119.54	120	115.57	0.407	.523
Physical Health of Fellow Employees	114	118.03	120	117.00	0.033	.857
Mental Health of Self	114	123.26	120	112.03	3.623	.057
Mental Health of Fellow Employees	114	125.42	120	109.98	6.844	.009
Workplace Morale of Self	114	122.53	120	112.73	2.409	.121
Workplace Morale of Fellow Employees	115	124.36	120	111.90	3.630	.057
Sick Time Taken by Self	115	132.68	120	103.93	12.947	<.001
Sick Time Taken by Fellow Employees	115	134.41	120	102.28	16.053	<.001

Table 15

Results of Kruskal-Wallis Tests Comparing Employee Workplace Perceptions by Unionized vs Non-Unionized Employees (Agree, Neutral, or Disagree) – China Only

Measure	Unionized		Non-Unionized		χ^2	<i>p</i>
	N	Mean Rank	N	Mean Rank		
Job Satisfaction of Self	103	97.76	104	110.18	4.474	.034
Job Satisfaction of Fellow Employees	103	98.54	104	109.41	3.694	.055
Physical Health of Self	103	99.34	104	108.62	2.493	.114
Physical Health of Fellow Employees	103	99.85	104	108.11	2.379	.123
Mental Health of Self	103	101.85	104	106.13	0.593	.441
Mental Health of Fellow Employees	103	101.12	104	106.86	1.049	.306
Workplace Morale of Self	103	102.66	104	105.33	0.199	.655
Workplace Morale of Fellow Employees	103	104.60	104	103.41	0.038	.845
Sick Time Taken by Self	103	101.91	104	106.07	0.306	.580
Sick Time Taken by Fellow Employees	103	102.68	104	105.31	0.122	.726

Table 16

Results of Kruskal-Wallis Tests Comparing Employee Workplace Perceptions by Gender (Agree, Neutral, or Disagree) – China Only

Measure	Male		Female		χ^2	<i>p</i>
	N	Mean Rank	N	Mean Rank		
Job Satisfaction of Self	106	114.19	126	118.44	0.483	.487
Job Satisfaction of Fellow Employees	106	113.06	125	118.49	0.861	.354
Physical Health of Self	106	116.81	126	116.24	0.008	.927
Physical Health of Fellow Employees	106	115.90	126	117.00	0.038	.846
Mental Health of Self	106	116.95	126	116.12	0.020	.887
Mental Health of Fellow Employees	106	114.46	126	118.21	0.410	.522
Workplace Morale of Self	106	116.53	126	116.48	<0.001	.993
Workplace Morale of Fellow Employees	106	116.59	126	116.42	0.001	.979
Sick Time Taken by Self	106	112.32	126	120.02	0.935	.333
Sick Time Taken by Fellow Employees	106	111.39	126	120.80	1.383	.240

Table 17

Ordinal Regression of Company DM Program Variables in Prediction of Employee Workplace Perceptions – Switzerland Only

Dependent Variable	R^2 of model	Predictors	Response	Odds Ratio (95% CI)	p
Job Satisfaction of Self	.134	DP Program	Agree	1.85 (0.67, 5.15)	.236
			Neutral	1.17 (0.37, 3.68)	.787
		SAW Program	Agree	0.73 (0.25, 2.13)	.564
			Neutral	0.44 (0.15, 1.28)	.133
		RTW Program	Agree	4.10 (1.14, 14.77)	.031
			Neutral	1.22 (0.34, 4.30)	.760
Job Satisfaction of Fellow Employees	.142	DP Program	Agree	2.10 (0.74, 5.94)	.161
			Neutral	1.03 (0.33, 3.26)	.958
		SAW Program	Agree	1.35 (0.49, 3.78)	.562
			Neutral	0.69 (0.25, 1.92)	.478
		RTW Program	Agree	2.52 (0.72, 8.78)	.147
			Neutral	0.97 (0.28, 3.36)	.962
Physical Health of Self	.074	DP Program	Agree	0.82 (0.30, 2.24)	.703
			Neutral	0.47 (0.15, 1.44)	.186
		SAW Program	Agree	2.34 (0.88, 6.24)	.090
			Neutral	1.36 (0.50, 3.69)	.545
		RTW Program	Agree	0.93 (0.27, 3.13)	.902
			Neutral	0.52 (0.15, 1.77)	.293
Physical Health of Fellow Employees	.106	DP Program	Agree	1.50 (0.54, 4.18)	.441
			Neutral	0.60 (0.19, 1.86)	.371
		SAW Program	Agree	1.48 (0.55, 3.98)	.433
			Neutral	1.08 (0.40, 2.91)	.886
		RTW Program	Agree	1.81 (0.54, 6.12)	.337
			Neutral	0.74 (0.22, 2.52)	.636
Mental Health of Self	.109	DP Program	Agree	0.98 (0.34, 2.83)	.966
			Neutral	0.53 (0.16, 1.72)	.289
		SAW Program	Agree	3.05 (1.12, 8.35)	.029
			Neutral	2.38 (0.85, 6.68)	.099
		RTW Program	Agree	0.96 (0.28, 3.28)	.944
			Neutral	0.37 (0.11, 1.31)	.123
Mental Health of Fellow Employees	.110	DP Program	Agree	1.04 (0.36, 3.02)	.942
			Neutral	0.56 (0.17, 1.85)	.344
		SAW Program	Agree	2.38 (0.87, 6.48)	.090
			Neutral	1.20 (0.43, 3.34)	.727
		RTW Program	Agree	1.44 (0.42, 4.92)	.563
			Neutral	0.73 (0.21, 2.55)	.622

(Continued)

Table 17 (Continued)

Workplace Morale of Self	.085	DP Program	Agree	1.01 (0.37, 2.75)	.987
			Neutral	0.70 (0.23, 2.14)	.528
		SAW Program	Agree	1.17 (0.42, 3.27)	.762
			Neutral	0.63 (0.22, 1.80)	.388
		RTW Program	Agree	2.76 (0.79, 9.65)	.111
			Neutral	1.32 (0.37, 4.66)	.670
Workplace Morale of Fellow Employees	.081	DP Program	Agree	0.77 (0.26, 2.26)	.630
			Neutral	0.48 (0.15, 1.60)	.235
		SAW Program	Agree	1.28 (0.48, 3.44)	.622
			Neutral	0.69 (0.25, 1.87)	.462
		RTW Program	Agree	3.12 (0.91, 10.69)	.070
			Neutral	1.74 (0.50, 5.98)	.381
Sick Time Taken by Self	.065	DP Program	Agree	1.43 (0.50, 4.07)	.504
			Neutral	1.04 (0.33, 3.31)	.948
		SAW Program	Agree	1.47 (0.56, 3.89)	.432
			Neutral	1.06 (0.40, 2.84)	.905
		RTW Program	Agree	2.29 (0.69, 7.60)	.177
			Neutral	1.14 (0.34, 3.81)	.832
Sick Time Taken by Fellow Employees	.158	DP Program	Agree	1.61 (0.56, 4.60)	.374
			Neutral	0.71 (0.22, 2.25)	.559
		SAW Program	Agree	3.56 (1.33, 9.51)	.011
			Neutral	2.13 (0.79, 5.75)	.134
		RTW Program	Agree	1.39 (0.41, 4.67)	.595
			Neutral	0.53 (0.16, 1.81)	.315

Note: For all predictors, a response of "Disagree" was the reference response, and therefore not included in the table.

Table 18

Results of Kruskal-Wallis Tests Comparing Employee Workplace Perceptions by Private vs Public Companies (Agree, Neutral, or Disagree) – Switzerland Only

Measure	<u>Private</u>		<u>Public</u>		χ^2	<i>p</i>
	N	Mean Rank	N	Mean Rank		
Job Satisfaction of Self	160	253.81	313	228.41	5.469	.019
Job Satisfaction of Fellow Employees	165	259.55	310	226.53	9.813	.002
Physical Health of Self	164	251.56	312	231.63	2.856	.091
Physical Health of Fellow Employees	166	246.43	311	235.03	1.034	.309
Mental Health of Self	139	232.87	285	202.56	7.234	.007
Mental Health of Fellow Employees	138	219.78	285	208.23	1.117	.290
Workplace Morale of Self	161	245.73	308	229.39	2.033	.154
Workplace Morale of Fellow Employees	160	243.81	305	227.33	2.095	.148
Sick Time Taken by Self	162	246.35	306	228.23	2.306	.129
Sick Time Taken by Fellow Employees	162	234.13	304	233.16	0.007	.935

Table 19

Results of Kruskal-Wallis Tests Comparing Employee Workplace Perceptions by Unionized vs Non-Unionized Employees (Agree, Neutral, or Disagree) – Switzerland Only

Measure	<u>Unionized</u>		<u>Non-Unionized</u>		χ^2	<i>p</i>
	N	Mean Rank	N	Mean Rank		
Job Satisfaction of Self	170	226.89	293	234.97	0.591	.442
Job Satisfaction of Fellow Employees	170	235.25	294	230.91	0.180	.671
Physical Health of Self	170	233.94	295	232.46	0.016	.898
Physical Health of Fellow Employees	171	236.08	295	232.00	0.140	.709
Mental Health of Self	157	203.13	256	209.37	0.338	.561
Mental Health of Fellow Employees	157	206.68	255	206.39	0.001	.978
Workplace Morale of Self	169	234.57	290	227.34	0.423	.515
Workplace Morale of Fellow Employees	169	230.31	286	226.64	0.110	.740
Sick Time Taken by Self	170	234.06	288	226.81	0.388	.533
Sick Time Taken by Fellow Employees	169	232.14	287	226.36	0.245	.621

Table 20

Results of Kruskal-Wallis Tests Comparing Employee Workplace Perceptions by Gender (Agree, Neutral, or Disagree) – Switzerland Only

Measure	Male		Female		χ^2	<i>p</i>
	N	Mean Rank	N	Mean Rank		
Job Satisfaction of Self	251	220.90	213	246.17	6.174	.013
Job Satisfaction of Fellow Employees	252	224.53	213	243.02	3.489	.062
Physical Health of Self	252	234.14	214	232.74	0.016	.900
Physical Health of Fellow Employees	254	232.77	213	235.47	0.065	.799
Mental Health of Self	220	202.36	195	214.37	1.317	.251
Mental Health of Fellow Employees	220	199.51	194	216.56	2.827	.093
Workplace Morale of Self	250	223.87	210	238.40	1.818	.178
Workplace Morale of Fellow Employees	249	219.93	206	238.81	3.092	.079
Sick Time Taken by Self	251	229.96	206	228.94	0.008	.928
Sick Time Taken by Fellow Employees	250	224.15	206	233.78	0.723	.395