

Working Paper

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

A comparative study

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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, Ochsenein, 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 an aging population 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,

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

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 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 analyzed 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 counseling;
- 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, counseling, 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 1,201 participants, with the number of responses varying across items. The average age of our sample was 42.36 years (SD = 11.184), with 45.1% (N = 542) reporting as male and 53.5% reporting as female (N = 643). Educational achievement was well distributed with 32.8% (N = 453) reporting secondary level education and 62.6% (N = 752) having some form of post-secondary education. The majority of our respondents were married or in a marital-like relationship (70.9%); however, most of the sample was non-parenting (58.8%). The socioeconomic status of the sample was middle-class with an average US dollar corrected family income of \$87,728.92 (SD = \$47,775.92). Most respondents reported as managers (23.9%), professionals (18.2%), technicians/associate professionals (19.0%), and/or clerical support workers (15.2%). Only 78 respondents (6.5%) self-identified as individuals with a disability and 139 reported migrant working status (11.6%). The majority of the sample was working full-time (N = 963, 80.2%). The sample reported moderate to good physical health (M = 2.30, SD = .891; scale from 1 = very good to 5 = poor) as well as mental health (M = 2.12, SD = .913). Similarly, our sample missed little work due to disability, illness or health problems (M = 1.74, .992; scale from 1 = none to 6 = 6 months or more) and had both high job satisfaction (M = 1.93, SD = .779; scale from 1 = very satisfied to 5 = very dissatisfied) and high work-related morale (M = 1.98, SD = .838; scale from 1 = strongly agree to 5 = strongly disagree). Most respondents reported that their company took measures to prevent disability (M = 1.92, SD = .768; scale from 1 = strongly agree to 5 = strongly disagree), supported staying at work (M = 2.03, SD = .884), and supported return to work (M = 1.94, SD = .812); however, respondents were more likely to report stay at work (SAW) and return to work (RTW) initiatives for their co-workers (Self SAW: M = 2.14, SD = .909; Self RTW M = 2.11, SD = .928; Co SAW or RTW: M = 1.87, SD = .814). Similarly, respondents thought the quality of care provided to co-workers through these initiatives was higher than that received by the individual (Self SAW: M = 2.26, SD = 1.033; Self RTW M = 2.23, SD = 1.023; Co SAW or RTW: M = 2.00, SD = .920). Respondents felt that employers should continue to offer disability management programs (M = 1.56, SD = .667). However, despite wanting disability management programs to continue, respondents saw only moderate benefits in the programs for job satisfaction, physical health, mental health and morale (M = 2.18, SD = .811; M = 2.38, SD = .833; M 2.34, SD = .859; M = 2.34, SD = .838); in comparison, respondents saw benefits for co-workers as slightly more positive than their own individual benefits (M = 2.10, SD = .762; M = 2.21, SD = .785; M = 2.26, SD = .807; M = 2.29, SD = .796). Interestingly, respondents reported muted perceived benefit of disability management programs in terms of reduced sick times (Self M = 2.88, SD = .934; Co M = 2.72, SD = .871).

Regression Analyses

Using the full sample of all countries (N = 1,185), multiple linear (enter) 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 (from 1 = "strongly agree" to 5 = "strongly 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 addressed participants' perceptions of the disability management program that existed at 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. Each of the DM prevention (DP), stay at work (SAW) and return to work (RTW) programs predicted perceptions of DM's influence on individual and co-worker job satisfaction (all at $p \leq .05$). If employees felt that DM programs (prevention, stay-at-work, return-to-work) were available, then they also tended to report that these programs had a positive impact on job satisfaction (see Table 1).

DM program influence on physical health. Both the DP and SAW programs predicted perceptions of DM's influence on individual and co-worker physical health. In contrast, the 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 the RTW program and individual physical health.

DM program influence on mental health. Both the DP and SAW programs predicted perceptions of DM's influence on individual and co-worker mental health. In contrast, the RTW program predicted perceptions of DM's influence only on the mental health of the individual, not for 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 the RTW program and co-workers' mental health.

DM program influence on morale. Both the DP and SAW programs predicted perceptions of DM's influence on individual and co-worker morale. In contrast, the RTW program only predicted perceptions of DM's influence on physical health for the individual, not for 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 the RTW program and coworkers' morale.

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

Group Difference Analyses

Public versus private companies. Using one-way ANOVA, 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, differences were revealed for individual [Private (N = 572), M = 2.32; Public (N = 620), M = 2.44] and co-worker physical health [Private (N = 575), M = 2.15; Public (N = 615), M = 2.27], as well as co-worker morale [Private (N = 575), M = 2.23; Public (N = 613), M = 2.35]; no other group differences were evident (see Table 2). In each

case where differences were noted, private agencies resulted in more positive responses; respondents from private companies ranked DM's influence on their individual physical health and co-worker physical health and morale more positively than did those in public companies (see Table 2).

Union versus non-union. Using one-way ANOVA, comparisons were made between the international sample 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 all analyses, respondents from non-unionized work environments reported more positive responses. That is, workers in non-union environments reported more positive perceptions regarding DM's influence on job satisfaction, physical health, mental health, morale, and reduced sickness absence for both themselves and their co-workers (see Table 3).

Gender. Using one-way ANOVA, comparisons were made between self-reported men and women 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 men and women for any of the variables (see Table 4).

7.4.1 Australia

Regression Analyses

Using the Australian sample (N = 365), multivariate 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 (from 1 = "strongly agree" to 5 = "strongly 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 addressed participants' perceptions of the disability management program that existed at their workplace.

DM program influence on job satisfaction. Both SAW and RTW programs predicted perceptions of DM's influence on individual and co-worker job satisfaction. In contrast, the DP program did not predict perceptions of DM's influence on job satisfaction for either the individual or for co-workers. That is, Australian employees reported SAW and RTW programs as linked to DM's influence on their own, as well as their co-workers' job satisfaction; alternately, DP was not significantly linked to DM's influence on either individual or co-worker job satisfaction (see Table 5).

DM program influence on physical health. DP predicted perceptions of DM program influence on co-worker physical health. In contrast, SAW and RTW programs predicted perceptions of DM's influence on physical health for both the individual and their co-workers. That is, Australian employees reported SAW and RTW programs as linked to disability management's influence on their own, as well as their co-workers', job satisfaction, but saw DP efforts as beneficial only for their co-workers.

DM program influence on mental health. Each of the DP, SAW and RTW programs predicted DM's influence on mental health for both the individual and co-workers. That is, Australian employees reported all forms of disability management intervention as beneficial for DM's influence on both individual and co-worker mental health.

DM program influence on morale. DP and SAW programs were predictive of perceptions regarding DM's influence on individual and co-worker workplace morale. In contrast the RTW program was only predictive of DM's influence on individual workplace morale. In other words, for Australian employees, all forms of DM intervention were important for DM's influence on workplace morale, but RTW interventions were reported as not significantly important for co-worker workplace morale.

DM program influence on sick time. Interestingly, for Australian employees, there were no significant relationships between the DP and RTW programs for DM's perceived influence on individual or co-worker sick time. However, SAW programs significantly predicted DM's influence on both individual and co-worker reduced sickness absence.

Group Difference Analyses

Public versus private companies. Using one-way ANOVA, comparisons were made between the Australian respondents in public and 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, differences were revealed for individual responses on job satisfaction (Public $N = 51$, $M = 2.37$; Private $N = 314$, $M = 2.11$). Respondents from private companies ranked DM's influence on individual job satisfaction as greater than did respondents from public companies (see Table 6).

Union versus non-union. Using one-way ANOVA, comparisons were made between the Australian sample's respondents from union and 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 one-way ANOVA, comparisons were made between self-reported men and women 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 ($N = 218$), multivariate 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 (from 1 = "strongly agree" to 5 = "strongly disagree"). It is important to note that in every case, a disability management program had existed in participant companies for a period of at least two years. Therefore, the questions addressed participants' perceptions of the disability management program that existed at their workplace.

DM program influence on job satisfaction. The RTW program predicted perceptions of DM program influence on individual and co-worker job satisfaction. In contrast, the DP program only predicted perceptions of DM's influence on job satisfaction for the individual, not for co-workers, and the SAW program did not predict either individual or perceived co-worker job satisfaction. That is, Canadian employees reported DP and RTW programs as linked to DM's

influence on their own job satisfaction; alternately, for their co-workers, only the RTW program was reported to be of benefit (see Table 9).

DM program influence on physical health. The DP program predicted perceptions of DM's influence on individual and co-worker physical health. In contrast, the RTW program only predicted perceptions of DM's influence on physical health for co-workers, not for the individual, and the SAW program did not predict perceptions of either individual or co-worker physical health. That is, Canadian employees reported DP as linked to DM's influence on their own, as well as their co-workers', physical health, but saw RTW interventions as beneficial only for their co-workers.

DM program influence on mental health. The DP program predicted perceptions of DM's influence on individual and co-worker mental health. In contrast, the SAW program only predicted perceptions of DM's influence on mental health for co-workers, not for the individual; alternately, the RTW program only predicted perception of DM's influence on mental health for the individual. That is, Canadian employees reported DP efforts as having a positive impact of DM's influence on mental health for both themselves and their co-workers, but felt that the RTW program was significantly positive only for them as individuals, and the SAW program was significantly positive only for their co-workers.

DM program influence on morale. Only the DP program predicted DM's influence on workplace morale for both the individual and co-workers. Neither SAW nor RTW was predictive of DM's influence on individual morale; however, the SAW program 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 among any of the DP, SAW, or RTW programs for DM's perceived influence on individual or co-worker sick time.

Group Difference Analyses

Public versus private companies. Using one-way ANOVA, comparisons were made between the Canadian respondents from public and 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 co-worker responses to job satisfaction, physical health, mental health, and morale. In each case where differences were noted, respondents from private companies ranked DM's influence on their individual and co-workers 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 one-way ANOVA, comparisons were made between the Canadian sample's respondents from union and 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 all analyses, Canadian respondents from non-unionized work environments reported more positive responses. That is, workers in non-unionized environments reported more positive perceptions regarding DM's influence on job satisfaction, physical health, mental health, morale, and reduced sickness absence for both themselves and their co-workers (see Table 11).

Gender. Using one-way ANOVA, comparisons were made between self-reported men and women 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). There was only one significant difference between the responses of men and women for any of the variables; specifically, Canadian male respondents (N = 77, M = 2.52) reported significantly lower perceptions of DM's influence on their physical health, as compared to Canadian female respondents (N = 134, M = 2.27) (see Table 12).

7.4.3 China

Regression Analyses

Using the Chinese sample (N = 218), multivariate 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 (from 1 = "strongly agree" to 5 = "strongly disagree"). It is important to note that in every case, a disability management program had existed in participant companies for a period of at least two years. Therefore, the questions addressed participants' perceptions of the disability management program that existed at their workplace.

DM program influence on job satisfaction. The DP program predicted DM's perceived influence on job satisfaction for both the individual and for co-workers. In contrast, neither the SAW nor the RTW programs had a significant effect of DM's perceived influence on job satisfaction for either the individual or co-workers. That is, Chinese employees reported general DP as important for influencing job satisfaction for both themselves and their co-workers, but did not report significant benefit of specific SAW or RTW interventions (see Table 13).

DM program influence on physical health. Both DP and RTW programs predicted perceptions of DM's influence on co-worker physical health only. SAW did not predict DM's influence on either individual or perceived co-worker job satisfaction. That is, Chinese employees reported DP and RTW programs as linked to DM's influence on their co-workers' physical health, but reported no significant benefit for any intervention with respect to DM's influence on their own physical health.

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

DM program influence on morale. The DP program predicted DM's perceived influence on workplace morale for both the individual and for co-workers. In contrast, neither SAW nor RTW programs had a significant effect of DM's perceived influence on workplace morale for either the individual or for co-workers. That is, Chinese employees reported general DP as important for influencing workplace morale for both themselves and their co-workers, but did not report significant benefit from specific SAW or RTW interventions.

DM program influence on sick time. The 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 programs 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 one-way ANOVA, comparisons were made between the Chinese sample's respondents from public and 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 both all variables except for co-worker job satisfaction, individual physical health and co-worker physical 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 job satisfaction as well as both individual and co-worker mental health, workplace morale and reduced sickness absence, more positively than those in private companies (see Table 14).

Union versus non-union. Using one-way ANOVA, comparisons were made between the Chinese sample's respondents from union and 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 15).

Gender. Using one-way ANOVA, comparisons were made between self-reported men and women 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 ($N = 368$), multivariate 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 (from 1 = "strongly agree" to 5 = "strongly disagree"). It is important to note that in every case, a disability management program had existed in participant companies for a period of at least two years. Therefore, the questions addressed participants' perceptions of the disability management program that existed at their workplace.

DM program influence on job satisfaction. The DP and RTW programs predicted DM's influence on job satisfaction for co-workers, but not the individual. In contrast, SAW programs predicted DM's influence on job satisfaction for the individual, but not co-workers. That is, Swiss respondents felt that SAW interventions are important for DM's influence on individual job satisfaction, but that DMP and RTW programs are more important for their co-workers (see Table 17).

DM program influence on physical health. The DP program predicted DM's influence on physical health of co-workers, whereas the SAW program predicted DM's influence on

physical health of the individual. For Swiss employees, RTW interventions did not predict perceptions of DM's influence on either individual or co-worker physical health.

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

DM program influence on morale. The DP and SAW programs predicted perceptions of DM's influence on workplace morale for the individual; in contrast, RTW measures were not predictive for the individual. None of DP, SAW, or RTW programs was significantly predictive of DM's influence on workplace morale of co-workers. That is, Swiss employees thought DP and SAW important for DM's influence on their own workplace morale, but saw less influence of the RTW program. There was no perceived influence of any DM intervention on workplace morale of co-workers.

DM program influence on sick time. Interestingly, for Swiss employees, both DP and SAW programs predicted DM's perceived influence on individual and co-worker reduced sickness absence; in contrast, RTW was not predictive for either the individual or co-workers.

Group Difference Analyses

Public versus private companies. Using one-way ANOVA, comparisons were made between the Swiss sample's respondents from public and private companies on DM's influence on 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 18).

Union versus non-union. Using one-way ANOVA, comparisons were made between the Swiss sample's respondents from union and non-union work environments on DM's influence on job satisfaction, physical health, mental health, morale, and reduced sickness absence (for both the respondent and the respondent's perception for co-workers). For co-worker job satisfaction only, Swiss respondents from non-unionized work environments reported more positive responses (Unionized $N = 165$, $M = 2.24$; Non-unionized $N = 208$, $M = 2.04$; see Table 19).

Gender. Using one-way ANOVA, comparisons were made between self-reported men and women in the Swiss sample on DM's influence on 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 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 components of disability management (disability prevention, stay-at-work, and return-to-work programs) 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. Other country-specific outcomes are described in detail above.

In addition, our results suggest that for Canada, the influence of disability management on the measured factors is generally regarded more positively in private, non-unionized companies. In comparison, there were no significant differences between public and private companies in Switzerland (more positive for non-union), and no significant differences between unionized and non-unionized employees in Australia (more positive for private). China's results contrast to the pattern of the other countries and suggest more positive outcomes from disability management in cases of public, unionized workplaces.

Gender analyses suggest little influence, with only one significant difference. Specifically, Canadian men reported a greater influence of disability management programming on physical health than Canadian women.

Table 1: Employee perceptions of DM's value

		DM program influence on...									
		Individual job satisfaction	Co-worker job satisfaction	Individual physical health	Co-worker physical health	Individual mental health	Co-worker mental health	Individual morale	Co-worker morale	Individual sick-time	Co-worker sick time
Australia	SAW										
	RTW										
	DP										
Canada	SAW										
	RTW										
	DP										
China	SAW										
	RTW										
	DP										
Switzerland	SAW										
	RTW										
	DP										
Positive and significant relationship											

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

Dependent Variable	R2 of model	Predictors	B	SE (B)	P
Job Satisfaction of Self	.159	Constant	1.280	.064	< .001
		Company DM Program	.157	.033	< .001
		Company SAW Program	.097	.041	.017
		Company RTW Program	.207	.044	< .001
Job Satisfaction of Fellow Employees	.166	Constant	1.241	.060	< .001
		Company DM Program	.178	.031	< .001
		Company SAW Program	.105	.038	.006
		Company RTW Program	.162	.041	< .001
Physical Health of Self	.112	Constant	1.620	.068	< .001
		Company DM Program	.135	.035	< .001
		Company SAW Program	.183	.043	< .001
		Company RTW Program	.068	.046	.144
Physical Health of Fellow Employees	.153	Constant	1.359	.063	< .001
		Company DM Program	.160	.032	< .001
		Company SAW Program	.143	.039	< .001
		Company RTW Program	.132	.043	.002
Mental Health of Self	.139	Constant	1.467	.070	< .001
		Company DM Program	.156	.036	< .001
		Company SAW Program	.190	.045	< .001
		Company RTW Program	.099	.048	.039
Mental Health of Fellow Employees	.157	Constant	1.391	.065	< .001
		Company DM Program	.179	.034	< .001
		Company SAW Program	.205	.042	< .001
		Company RTW Program	.057	.044	.196
Workplace Morale of Self	.157	Constant	1.426	.066	< .001
		Company DM Program	.168	.034	< .001
		Company SAW Program	.183	.042	< .001
		Company RTW Program	.112	.045	.013
Workplace Morale of Fellow Employees	.156	Constant	1.433	.064	< .001
		Company DM Program	.169	.033	< .001
		Company SAW Program	.212	.040	< .001
		Company RTW Program	.056	.043	.192
Sick Time Taken by Self	.084	Constant	2.177	.077	< .001
		Company DM Program	.132	.040	.001
		Company SAW Program	.260	.049	< .001
		Company RTW Program	-.042	.053	.428
Sick Time Taken by Fellow Employees	.126	Constant	1.858	.071	< .001
		Company DM Program	.186	.036	< .001
		Company SAW Program	.189	.045	< .001
		Company RTW Program	.061	.048	.205

Table 2

Means, Standard Deviations (SD), and Results of One-Way ANOVAs Comparing Employee Workplace Perceptions by Private vs Public Companies – Overall Sample

Measure	<u>Private</u>		<u>Public</u>		<u>ANOVA</u>	
	Mean	SD	Mean	SD	<i>F</i>	<i>p</i>
Job Satisfaction of Self	2.14	.793	2.20	.827	1.743	.187
Job Satisfaction of Fellow Employees	2.08	.757	2.13	.767	1.617	.204
Physical Health of Self	2.32	.787	2.44	.870	5.923	.015
Physical Health of Fellow Employees	2.15	.778	2.27	.787	7.051	.008
Mental Health of Self	2.29	.834	2.38	.881	3.447	.064
Mental Health of Fellow Employees	2.22	.814	2.30	.800	2.867	.091
Workplace Morale of Self	2.29	.801	2.38	.869	3.195	.074
Workplace Morale of Fellow Employees	2.23	.775	2.35	.810	7.118	.008
Sick Time Taken by Self	2.83	.921	2.92	.944	2.587	.108
Sick Time Taken by Fellow Employees	2.73	.897	2.70	.847	.219	.640

Table 3

Means, Standard Deviations (SD), and Results of One-Way ANOVAs Comparing Employee Workplace Perceptions by Unionized vs Non-Unionized Employees – Overall Sample

Measure	<u>Unionized</u>		<u>Non-Unionized</u>		<u>ANOVA</u>	
	Mean	SD	Mean	SD	<i>F</i>	<i>p</i>
Job Satisfaction of Self	2.27	.853	2.12	.793	8.213	.004
Job Satisfaction of Fellow Employees	2.21	.826	2.05	.723	12.501	<.001
Physical Health of Self	2.47	.879	2.33	.808	7.889	.005
Physical Health of Fellow Employees	2.32	.812	2.14	.765	13.662	<.001
Mental Health of Self	2.44	.904	2.29	.832	8.111	.004
Mental Health of Fellow Employees	2.38	.836	2.20	.788	13.402	<.001
Workplace Morale of Self	2.45	.899	2.27	.802	12.083	.001
Workplace Morale of Fellow Employees	2.43	.844	2.22	.763	18.385	<.001
Sick Time Taken by Self	2.97	.970	2.83	.909	6.188	.013
Sick Time Taken by Fellow Employees	2.79	.893	2.66	.852	5.518	.019

Table 4

Means, Standard Deviations (SD), and Results of One-Way ANOVAs Comparing Employee Workplace Perceptions by Gender – Overall Sample

Measure	<u>Males</u>		<u>Females</u>		<u>ANOVA</u>	
	Mean	SD	Mean	SD	<i>F</i>	<i>p</i>
Job Satisfaction of Self	2.15	.787	2.18	.828	.510	.475
Job Satisfaction of Fellow Employees	2.11	.728	2.09	.788	.128	.721
Physical Health of Self	2.42	.849	2.33	.817	3.455	.063
Physical Health of Fellow Employees	2.25	.768	2.16	.795	3.241	.072
Mental Health of Self	2.35	.832	2.31	.878	.632	.427
Mental Health of Fellow Employees	2.27	.747	2.24	.854	.290	.590
Workplace Morale of Self	2.34	.802	2.31	.861	.301	.583
Workplace Morale of Fellow Employees	2.29	.750	2.28	.830	.030	.863
Sick Time Taken by Self	2.91	.930	2.84	.936	1.654	.199
Sick Time Taken by Fellow Employees	2.69	.865	2.73	.876	.504	.478

Table 5
Standard Regression of Company DM Program Variables in Prediction of Employee Workplace Perceptions – Australia Only

Dependent Variable	R^2 of model	Predictors	<i>B</i>	SE (<i>B</i>)	<i>P</i>
Job Satisfaction of Self	.233	Constant	1.131	.109	<.001
		Company DM Program	.106	.058	.067
		Company SAW Program	.238	.073	.001
		Company RTW Program	.271	.077	<.001
Job Satisfaction of Fellow Employees	.252	Constant	1.052	.102	<.001
		Company DM Program	.093	.054	.090
		Company SAW Program	.239	.068	.001
		Company RTW Program	.275	.072	<.001
Physical Health of Self	.138	Constant	1.511	.119	<.001
		Company DM Program	.109	.063	.085
		Company SAW Program	.174	.079	.029
		Company RTW Program	.213	.084	.011
Physical Health of Fellow Employees	.216	Constant	1.143	.110	<.001
		Company DM Program	.137	.058	.020
		Company SAW Program	.230	.074	.002
		Company RTW Program	.234	.077	.003
Mental Health of Self	.204	Constant	1.253	.122	<.001
		Company DM Program	.148	.065	.023
		Company SAW Program	.230	.082	.005
		Company RTW Program	.268	.086	.002
Mental Health of Fellow Employees	.247	Constant	1.083	.112	<.001
		Company DM Program	.215	.060	<.001
		Company SAW Program	.271	.075	<.001
		Company RTW Program	.191	.079	.016
Workplace Morale of Self	.205	Constant	1.283	.114	<.001
		Company DM Program	.132	.061	.030
		Company SAW Program	.221	.077	.004
		Company RTW Program	.251	.081	.002
Workplace Morale of Fellow Employees	.224	Constant	1.187	.108	<.001
		Company DM Program	.182	.057	.002
		Company SAW Program	.297	.072	<.001
		Company RTW Program	.124	.076	.102
Sick Time Taken by Self	.105	Constant	2.016	.138	<.001
		Company DM Program	.016	.074	.826
		Company SAW Program	.336	.092	<.001
		Company RTW Program	.090	.097	.357
Sick Time Taken by Fellow Employees	.137	Constant	1.719	.138	<.001
		Company DM Program	.110	.074	.136
		Company SAW Program	.324	.093	.001
		Company RTW Program	.125	.097	.201

Table 6

Means, Standard Deviations (SD), and Results of One-Way ANOVAs Comparing Employee Workplace Perceptions by Private vs Public Companies – Australia Only

Measure	<u>Private</u>		<u>Public</u>		<u>ANOVA</u>	
	Mean	SD	Mean	SD	<i>F</i>	<i>p</i>
Job Satisfaction of Self	2.11	.803	2.37	.720	4.650	.032
Job Satisfaction of Fellow Employees	2.06	.777	2.06	.645	.000	.990
Physical Health of Self	2.32	.832	2.41	.753	.528	.468
Physical Health of Fellow Employees	2.14	.815	2.16	.674	.019	.889
Mental Health of Self	2.31	.893	2.41	.779	.565	.453
Mental Health of Fellow Employees	2.22	.858	2.18	.623	.138	.711
Workplace Morale of Self	2.27	.842	2.39	.695	.954	.329
Workplace Morale of Fellow Employees	2.19	.807	2.27	.635	.533	.466
Sick Time Taken by Self	2.75	.959	2.82	.793	.306	.580
Sick Time Taken by Fellow Employees	2.64	.963	2.75	.913	.529	.468

Table 7

Means, Standard Deviations (SD), and Results of One-Way ANOVAs Comparing Employee Workplace Perceptions by Unionized vs Non-Unionized Employees – Australia Only

Measure	<u>Unionized</u>		<u>Non-Unionized</u>		<u>ANOVA</u>	
	Mean	SD	Mean	SD	<i>F</i>	<i>p</i>
Job Satisfaction of Self	2.17	.818	2.15	.798	.027	.868
Job Satisfaction of Fellow Employees	2.07	.797	2.05	.758	.037	.847
Physical Health of Self	2.31	.820	2.34	.828	.054	.817
Physical Health of Fellow Employees	2.20	.810	2.13	.799	.381	.537
Mental Health of Self	2.26	.828	2.34	.888	.385	.535
Mental Health of Fellow Employees	2.24	.823	2.21	.832	.053	.817
Workplace Morale of Self	2.26	.782	2.29	.836	.067	.796
Workplace Morale of Fellow Employees	2.24	.751	2.20	.795	.126	.722
Sick Time Taken by Self	2.76	.889	2.75	.944	.006	.937
Sick Time Taken by Fellow Employees	2.76	1.063	2.63	.933	.877	.350

Table 8

Means, Standard Deviations (SD), and Results of One-Way ANOVAs Comparing Employee Workplace Perceptions by Gender – Australia Only

Measure	<u>Males</u>		<u>Females</u>		<u>ANOVA</u>	
	Mean	SD	Mean	SD	<i>F</i>	<i>p</i>
Job Satisfaction of Self	2.16	.729	2.13	.831	.101	.751
Job Satisfaction of Fellow Employees	2.10	.718	2.03	.779	.737	.391
Physical Health of Self	2.38	.805	2.29	.825	.937	.334
Physical Health of Fellow Employees	2.17	.776	2.11	.806	.420	.517
Mental Health of Self	2.41	.848	2.26	.882	2.152	.143
Mental Health of Fellow Employees	2.27	.790	2.18	.848	.995	.319
Workplace Morale of Self	2.36	.759	2.23	.843	1.957	.163
Workplace Morale of Fellow Employees	2.24	.725	2.16	.808	.688	.407
Sick Time Taken by Self	2.80	.920	2.73	.949	.559	.455
Sick Time Taken by Fellow Employees	2.68	.961	2.62	.950	.333	.565

Table 9
Standard Regression of Company DM Program Variables in Prediction of Employee Workplace Perceptions – Canada Only

Dependent Variable	R^2 of model	Predictors	B	SE (B)	p
Job Satisfaction of Self	.255	Constant	1.205	.159	<.001
		Company DM Program	.159	.077	.041
		Company SAW Program	.079	.104	.447
		Company RTW Program	.343	.107	.002
Job Satisfaction of Fellow Employees	.244	Constant	1.108	.148	<.001
		Company DM Program	.139	.072	.056
		Company SAW Program	.134	.096	.165
		Company RTW Program	.246	.100	.014
Physical Health of Self	.235	Constant	1.516	.153	<.001
		Company DM Program	.202	.074	.007
		Company SAW Program	.164	.100	.101
		Company RTW Program	.157	.102	.128
Physical Health of Fellow Employees	.294	Constant	1.160	.138	<.001
		Company DM Program	.166	.067	.014
		Company SAW Program	.145	.090	.109
		Company RTW Program	.237	.093	.011
Mental Health of Self	.281	Constant	1.328	.152	<.001
		Company DM Program	.284	.076	<.001
		Company SAW Program	.094	.100	.347
		Company RTW Program	.219	.104	.037
Mental Health of Fellow Employees	.248	Constant	1.294	.150	<.001
		Company DM Program	.192	.073	.009
		Company SAW Program	.218	.098	.027
		Company RTW Program	.113	.101	.266
Workplace Morale of Self	.224	Constant	1.467	.168	<.001
		Company DM Program	.215	.081	.009
		Company SAW Program	.175	.109	.109
		Company RTW Program	.166	.112	.142
Workplace Morale of Fellow Employees	.234	Constant	1.315	.160	<.001
		Company DM Program	.178	.078	.023
		Company SAW Program	.233	.104	.026
		Company RTW Program	.129	.108	.232
Sick Time Taken by Self	.023	Constant	2.960	.166	<.001
		Company DM Program	.077	.081	.345
		Company SAW Program	.153	.109	.163
		Company RTW Program	-.124	.112	.271
Sick Time Taken by Fellow Employees	.058	Constant	2.582	.145	<.001
		Company DM Program	.133	.070	.058
		Company SAW Program	.110	.093	.241
		Company RTW Program	-.037	.097	.702

Table 10

Means, Standard Deviations (SD), and Results of One-Way ANOVAs Comparing Employee Workplace Perceptions by Private vs Public Companies – Canada Only

Measure	<u>Private</u>		<u>Public</u>		<u>ANOVA</u>	
	Mean	SD	Mean	SD	<i>F</i>	<i>p</i>
Job Satisfaction of Self	2.25	.820	2.61	.920	8.639	.004
Job Satisfaction of Fellow Employees	2.05	.705	2.38	.887	8.293	.004
Physical Health of Self	2.40	.735	2.83	.871	13.994	<.001
Physical Health of Fellow Employees	2.14	.718	2.51	.813	11.357	.001
Mental Health of Self	2.34	.753	2.80	.913	15.026	<.001
Mental Health of Fellow Employees	2.21	.724	2.60	.872	11.416	.001
Workplace Morale of Self	2.45	.827	2.84	.967	9.049	.003
Workplace Morale of Fellow Employees	2.27	.766	2.66	.935	9.989	.002
Sick Time Taken by Self	3.13	.737	3.26	.878	1.254	.264
Sick Time Taken by Fellow Employees	2.99	.664	3.07	.757	.729	.394

Table 11

Means, Standard Deviations (SD), and Results of One-Way ANOVAs Comparing Employee Workplace Perceptions by Unionized vs Non-Unionized Employees – Canada Only

Measure	<u>Unionized</u>		<u>Non-Unionized</u>		<u>ANOVA</u>	
	Mean	SD	Mean	SD	<i>F</i>	<i>p</i>
Job Satisfaction of Self	2.72	.960	2.21	.786	17.845	<.001
Job Satisfaction of Fellow Employees	2.46	.937	2.07	.680	11.927	.001
Physical Health of Self	2.90	.898	2.44	.742	16.827	<.001
Physical Health of Fellow Employees	2.60	.841	2.16	.686	17.413	<.001
Mental Health of Self	2.92	.941	2.33	.736	25.618	<.001
Mental Health of Fellow Employees	2.72	.901	2.20	.685	21.871	<.001
Workplace Morale of Self	2.95	1.009	2.45	.802	15.730	<.001
Workplace Morale of Fellow Employees	2.78	.965	2.27	.753	18.784	<.001
Sick Time Taken by Self	3.26	.892	3.13	.731	1.416	.235
Sick Time Taken by Fellow Employees	3.09	.768	2.95	.626	1.923	.167

Table 12

Means, Standard Deviations (SD), and Results of One-Way ANOVAs Comparing Employee Workplace Perceptions by Gender – Canada Only

Measure	<u>Males</u>		<u>Females</u>		<u>ANOVA</u>	
	Mean	SD	Mean	SD	<i>F</i>	<i>p</i>
Job Satisfaction of Self	2.58	.908	2.40	.892	2.117	.147
Job Satisfaction of Fellow Employees	2.27	.801	2.23	.858	.101	.751
Physical Health of Self	2.81	.869	2.58	.830	3.575	.060
Physical Health of Fellow Employees	2.52	.788	2.27	.787	4.963	.027
Mental Health of Self	2.65	.870	2.60	.898	.180	.672
Mental Health of Fellow Employees	2.52	.805	2.40	.859	.941	.333
Workplace Morale of Self	2.69	.990	2.68	.910	.008	.930
Workplace Morale of Fellow Employees	2.49	.894	2.51	.898	.046	.830
Sick Time Taken by Self	3.24	.809	3.20	.845	.165	.685
Sick Time Taken by Fellow Employees	3.08	.802	3.02	.678	.289	.592

Table 13
Standard Regression of Company DM Program Variables in Prediction of Employee Workplace Perceptions – China Only

Dependent Variable	R^2 of model	Predictors	B	SE (B)	p
Job Satisfaction of Self	.118	Constant	1.235	.154	<.001
		Company DM Program	.177	.070	.013
		Company SAW Program	.076	.093	.416
		Company RTW Program	.135	.096	.161
Job Satisfaction of Fellow Employees	.129	Constant	1.232	.151	<.001
		Company DM Program	.259	.069	<.001
		Company SAW Program	.038	.091	.672
		Company RTW Program	.073	.094	.437
Physical Health of Self	.095	Constant	1.332	.159	<.001
		Company DM Program	.133	.073	.068
		Company SAW Program	.057	.096	.556
		Company RTW Program	.165	.099	.098
Physical Health of Fellow Employees	.104	Constant	1.265	.153	<.001
		Company DM Program	.147	.070	.037
		Company SAW Program	.006	.092	.950
		Company RTW Program	.199	.095	.038
Mental Health of Self	.064	Constant	1.426	.165	<.001
		Company DM Program	.163	.075	.032
		Company SAW Program	.072	.100	.472
		Company RTW Program	.052	.103	.612
Mental Health of Fellow Employees	.093	Constant	1.302	.161	<.001
		Company DM Program	.174	.073	.019
		Company SAW Program	.096	.097	.326
		Company RTW Program	.080	.100	.428
Workplace Morale of Self	.108	Constant	1.340	.158	<.001
		Company DM Program	.212	.072	.004
		Company SAW Program	.125	.096	.193
		Company RTW Program	.025	.099	.801
Workplace Morale of Fellow Employees	.124	Constant	1.264	.161	<.001
		Company DM Program	.217	.073	.003
		Company SAW Program	.183	.097	.060
		Company RTW Program	-.002	.100	.982
Sick Time Taken by Self	.153	Constant	1.448	.186	<.001
		Company DM Program	.305	.085	<.001
		Company SAW Program	.133	.112	.237
		Company RTW Program	.089	.116	.444
Sick Time Taken by Fellow Employees	.172	Constant	1.378	.185	<.001
		Company DM Program	.288	.084	.001
		Company SAW Program	.147	.111	.186
		Company RTW Program	.135	.115	.242

Table 14

Means, Standard Deviations (SD), and Results of One-Way ANOVAs Comparing Employee Workplace Perceptions by Private vs Public Companies – China Only

Measure	<u>Private</u>		<u>Public</u>		<u>ANOVA</u>	
	Mean	SD	Mean	SD	<i>F</i>	<i>p</i>
Job Satisfaction of Self	2.19	.748	1.89	.619	11.231	.001
Job Satisfaction of Fellow Employees	2.08	.718	1.91	.648	3.646	.057
Physical Health of Self	2.16	.711	1.99	.704	3.227	.074
Physical Health of Fellow Employees	2.09	.698	1.92	.668	3.665	.057
Mental Health of Self	2.17	.728	1.88	.693	9.865	.002
Mental Health of Fellow Employees	2.19	.751	1.87	.647	12.711	<.001
Workplace Morale of Self	2.24	.682	1.94	.714	10.440	.001
Workplace Morale of Fellow Employees	2.22	.723	1.95	.720	8.067	.005
Sick Time Taken by Self	2.79	.903	2.30	.740	20.878	<.001
Sick Time Taken by Fellow Employees	2.83	.911	2.31	.731	23.198	<.001

Table 15

Means, Standard Deviations (SD), and Results of One-Way ANOVAs Comparing Employee Workplace Perceptions by Unionized vs Non-Unionized Employees – China Only

Measure	<u>Unionized</u>		<u>Non-Unionized</u>		<u>ANOVA</u>	
	Mean	SD	Mean	SD	<i>F</i>	<i>p</i>
Job Satisfaction of Self	2.02	.626	2.06	.810	.144	.704
Job Satisfaction of Fellow Employees	1.99	.602	2.02	.788	.088	.767
Physical Health of Self	2.05	.600	2.08	.809	.082	.775
Physical Health of Fellow Employees	1.99	.551	1.98	.788	.010	.920
Mental Health of Self	2.02	.700	2.01	.757	.009	.923
Mental Health of Fellow Employees	2.04	.656	2.02	.812	.036	.849
Workplace Morale of Self	2.11	.670	2.04	.762	.469	.494
Workplace Morale of Fellow Employees	2.13	.696	2.00	.776	1.518	.219
Sick Time Taken by Self	2.58	.913	2.50	.848	.454	.501
Sick Time Taken by Fellow Employees	2.59	.933	2.49	.824	.693	.406

Table 16

Means, Standard Deviations (SD), and Results of One-Way ANOVAs Comparing Employee Workplace Perceptions by Gender – China Only

Measure	<u>Males</u>		<u>Females</u>		<u>ANOVA</u>	
	Mean	SD	Mean	SD	<i>F</i>	<i>p</i>
Job Satisfaction of Self	2.03	.639	2.05	.747	.044	.834
Job Satisfaction of Fellow Employees	2.02	.632	1.98	.724	.226	.635
Physical Health of Self	2.09	.655	2.04	.742	.347	.556
Physical Health of Fellow Employees	2.04	.600	1.95	.736	.914	.340
Mental Health of Self	2.06	.701	1.98	.737	.581	.447
Mental Health of Fellow Employees	2.06	.615	2.00	.790	.361	.549
Workplace Morale of Self	2.14	.696	2.02	.710	1.612	.206
Workplace Morale of Fellow Employees	2.12	.726	2.06	.735	.377	.540
Sick Time Taken by Self	2.48	.707	2.59	.957	.894	.345
Sick Time Taken by Fellow Employees	2.52	.759	2.60	.939	.552	.458

Table 17
Standard Regression of Company DM Program Variables in Prediction of Employee Workplace Perceptions – Switzerland Only

Dependent Variable	R^2 of model	Predictors	B	SE (B)	p
Job Satisfaction of Self	.097	Constant	1.402	.123	<.001
		Company DM Program	.152	.060	.012
		Company SAW Program	.017	.068	.805
		Company RTW Program	.194	.077	.013
Job Satisfaction of Fellow Employees	.119	Constant	1.373	.115	<.001
		Company DM Program	.229	.056	<.001
		Company SAW Program	.015	.064	.820
		Company RTW Program	.151	.072	.037
Physical Health of Self	.060	Constant	1.915	.134	<.001
		Company DM Program	.088	.064	.173
		Company SAW Program	.192	.073	.009
		Company RTW Program	-.025	.083	.763
Physical Health of Fellow Employees	.091	Constant	1.619	.123	<.001
		Company DM Program	.181	.060	.003
		Company SAW Program	.093	.068	.172
		Company RTW Program	.077	.077	.317
Mental Health of Self	.096	Constant	1.727	.139	<.001
		Company DM Program	.076	.068	.267
		Company SAW Program	.193	.077	.013
		Company RTW Program	.056	.086	.519
Mental Health of Fellow Employees	.090	Constant	1.710	.129	<.001
		Company DM Program	.133	.063	.036
		Company SAW Program	.158	.072	.029
		Company RTW Program	.022	.080	.779
Workplace Morale of Self	.118	Constant	1.577	.121	<.001
		Company DM Program	.127	.058	.031
		Company SAW Program	.135	.067	.045
		Company RTW Program	.115	.076	.130
Workplace Morale of Fellow Employees	.072	Constant	1.827	.118	<.001
		Company DM Program	.098	.058	.092
		Company SAW Program	.097	.064	.130
		Company RTW Program	.085	.073	.248
Sick Time Taken by Self	.088	Constant	2.246	.149	<.001
		Company DM Program	.201	.073	.006
		Company SAW Program	.223	.082	.007
		Company RTW Program	-.048	.093	.604
Sick Time Taken by Fellow Employees	.154	Constant	1.731	.126	<.001
		Company DM Program	.237	.062	<.001
		Company SAW Program	.144	.070	.040
		Company RTW Program	.095	.079	.230

Table 18

Means, Standard Deviations (SD), and Results of One-Way ANOVAs Comparing Employee Workplace Perceptions by Private vs Public Companies – Switzerland Only

Measure	<u>Private</u>		<u>Public</u>		<u>ANOVA</u>	
	Mean	SD	Mean	SD	<i>F</i>	<i>p</i>
Job Satisfaction of Self	2.05	.784	2.12	.799	.419	.518
Job Satisfaction of Fellow Employees	2.19	.794	2.12	.743	.436	.510
Physical Health of Self	2.48	.718	2.44	.865	.168	.682
Physical Health of Fellow Employees	2.28	.806	2.32	.789	.097	.756
Mental Health of Self	2.37	.786	2.40	.848	.037	.847
Mental Health of Fellow Employees	2.26	.828	2.36	.773	.496	.482
Workplace Morale of Self	2.28	.745	2.35	.811	.362	.548
Workplace Morale of Fellow Employees	2.39	.710	2.38	.744	.001	.973
Sick Time Taken by Self	2.93	.910	3.03	.958	.474	.492
Sick Time Taken by Fellow Employees	2.63	.707	2.69	.847	.259	.611

Table 19

Means, Standard Deviations (SD), and Results of One-Way ANOVAs Comparing Employee Workplace Perceptions by Unionized vs Non-Unionized Employees – Switzerland Only

Measure	<u>Unionized</u>		<u>Non-Unionized</u>		<u>ANOVA</u>	
	Mean	SD	Mean	SD	<i>F</i>	<i>p</i>
Job Satisfaction of Self	2.16	.814	2.07	.780	1.219	.270
Job Satisfaction of Fellow Employees	2.24	.842	2.04	.662	6.543	.011
Physical Health of Self	2.52	.901	2.38	.790	2.427	.120
Physical Health of Fellow Employees	2.40	.859	2.24	.729	3.663	.056
Mental Health of Self	2.47	.876	2.34	.799	1.994	.159
Mental Health of Fellow Employees	2.43	.811	2.28	.738	3.339	.069
Workplace Morale of Self	2.42	.858	2.27	.747	3.244	.073
Workplace Morale of Fellow Employees	2.45	.793	2.33	.687	2.385	.123
Sick Time Taken by Self	3.09	.993	2.95	.910	2.135	.145
Sick Time Taken by Fellow Employees	2.73	.839	2.64	.812	1.008	.316

Table 20

Means, Standard Deviations (SD), and Results of One-Way ANOVAs Comparing Employee Workplace Perceptions by Gender – Switzerland Only

Measure	<u>Males</u>		<u>Females</u>		<u>ANOVA</u>	
	Mean	SD	Mean	SD	<i>F</i>	<i>p</i>
Job Satisfaction of Self	2.06	.790	2.18	.794	2.161	.142
Job Satisfaction of Fellow Employees	2.10	.745	2.18	.766	.890	.346
Physical Health of Self	2.46	.887	2.41	.771	.281	.597
Physical Health of Fellow Employees	2.29	.798	2.34	.790	.377	.540
Mental Health of Self	2.37	.828	2.43	.867	.493	.483
Mental Health of Fellow Employees	2.29	.732	2.45	.849	3.374	.067
Workplace Morale of Self	2.31	.767	2.36	.848	.448	.504
Workplace Morale of Fellow Employees	2.33	.703	2.46	.791	2.663	.104
Sick Time Taken by Self	3.06	.987	2.92	.870	1.634	.202
Sick Time Taken by Fellow Employees	2.64	.843	2.73	.792	.865	.353