Effects of Best Practices to reduce Sickness Absenteeism in Health Care and Welfare Institutions

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Health care and welfare institutions may improve the health of their patients and clients, but the health of their own workers seems to diminish. Average workplace absenteeism (including pregnancy) in the Dutch health care and welfare sector is higher than the national average. We conducted a study among 1,600 employees in health care and welfare institutions, to find out what these institutions do about absenteeism and to see if whatever they do has the desired effect. The institutions we selected are known to deal with the problem more systematically than others. We found that sickness absenteeism policies were indeed actively carried out, but most employees are not familiar with them. Still, they report that they call in sick less often and go back to work sooner than they did two years ago.

Introduction

Health care and welfare institutions may improve the health and well-being of their patients and clients, but the health of their workers seems to diminish. Average workplace absenteeism (including pregnancy) in the Dutch health care and welfare sector is namely higher than the national average: 7.8% for health care and welfare institutions: 5.4% for all companies in 1999 (excluding maternity leave; CBS, 1999). We understand by 'workplace absenteeism' the *incapacity for work as a result of illness or disability for a period up to 52 weeks (*after this period of 52 weeks an incapacitated person is entitled to disability benefit (WAO)). The workplace absenteeism in nursing homes is generally higher than in hospitals. In 1999 workplace absenteeism (excluding maternity leave) in nursing homes was 8,4% against 7,2% in the hospitals.

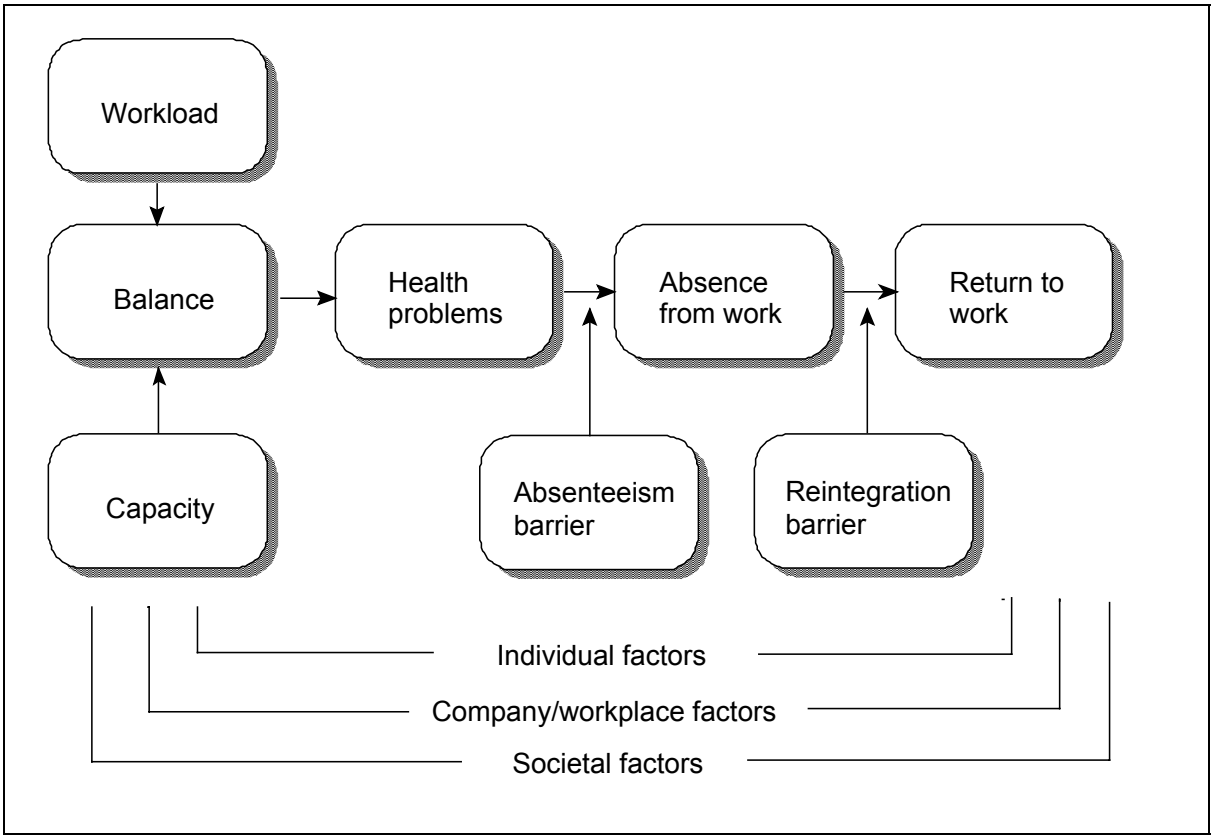
Main risk factors in the physical environment are: handling heavy objects, contact with biological agents, climatic and safety conditions. Main hazards in the organizational environment are working hours, work organization, job content and wages. Risk factors in the social work environment consist of work with colleagues, relations with management, relations with clients and the public, and information, consultation and participation (Verschuren et al. 1995). Employees in the care and welfare sectors clearly work under various aggravating conditions. According to Allaart et al. (2000) those who work in the care sector are more often confronted with such conditions than those in the welfare sector. For many employees in the care sector the work is physically demanding, especially in the care for the elderly and

in people's homes. Further, psychologically demanding work (in mental health care) and work under time pressure (in hospitals and in the care for the elderly) occur relatively often. Employees in the welfare sector are mainly confronted with *psychologically* demanding work. Only those who work in child day care do a lot of *physically* demanding work..
All these different risk factors call for different approaches to reduce workplace absenteeism. The Dutch Ministry of Health, labour organisations, trade unions and employers organizations for health care institutions agreed to work out a shared approach to reduce absenteeism as a way to have more workers available in the health care and welfare institutions. To expand their insight they initiated a study to examine the effectiveness of strategies to reduce workplace absenteeism. The aim of this study commissioned by the Institute for Labourstudies (Organisatie voor Strategisch Arbeidsmarktonderzoek: OSA) is to investigate the types of interventions used by the health care and welfare institutions in the Netherlands and to examine the effectiveness of these interventions in actually reducing workplace absenteeism (Van Vuuren et al, 2001, Smit & Van Vuuren, 2001).

Types of interventions to reduce workplace absenteeism

Workplace absenteeism is a phenomenon influenced by many factors. If we look at the whole process of becoming ill, being absent from work, recovering and going back to work, it becomes evident, on consulting the load-capacity model (Van Dijk et al.) and the decision model (De Groot, 1958), that illness arises as a result of a discrepancy between work load (stress factors) and capacity (the absorption capacity). Depending on the absenteeism threshold (in which the opportunity and the need for absenteeism play a part) illness results in absenteeism depending on the course of the illness and the work resumption threshold. By the resumption threshold we mean the totality of the factors which affect the course of the illness and the resumption of work (for example the actions of the doctor acting for the insurance company, loyalty to the company, the availability of specially adapted work, waiting times in curative care, etc.). This whole process is in turn influenced by individual factors, company and workplace factors, and social factors. In Figure 1 the model (derived from Veerman, 1990) is represented schematically.

Figure 1: The model used in this study of the process of becoming ill, being absent from work, recovery and resuming work.



Many forms of intervention are used to reduce absenteeism. I describe three types of intervention which affect different elements in this model. These types of intervention have to do with the process of becoming ill, being absent from work, recovering and resuming work (Gründemann & Van Vuuren, 1997, Van Vuuren et al, 1999).

The first kind of interventions are *procedural measures*, which are aimed mainly at raising the absenteeism threshold, that is, make is less likely that people stop going to work. By a procedural approach to absenteeism we understand measures which aim at instituting better procedures regarding the reporting of absenteeism, the monitoring of absenteeism and counselling in absenteeism. A part of this could be the introduction of the registration of absenteeism, setting up a socio-medical team (discussion between the company management, company doctor and personnel officer on cases of absenteeism and absenteeism policy), the introduction of first-day monitoring, the creation of a budget through the use of which measures can be taken, training managers in the conduct of absenteeism interviews, and the institution of contractual incentives such as forfeiting a day's holiday in the event of illness and giving a bonus in the event of no absenteeism. The measures are therefore aimed at reducing both the

need for absenteeism in employees and/or the opportunity for absenteeism, and at creating preconditions for effective prevention and cure of disorders.

The second kind of interventions are intended to prevent employees from becoming ill. These *preventive measures* can be work-oriented or employee-oriented.

- Preventive work-oriented measures aim to reduce the discrepancy between load and capacity by reducing the load. This is done by removing the cause of problems in the area of safety, health and well-being. This means that things are tackled at the source by for example acquiring safer equipment, climate control, rotation of tasks, etc.
- Preventive employee-oriented measures are measures in which employees are taught to work (and live) in a safe, healthy and well-being-promoting way. These employee-oriented measures aim to reduce the discrepancy between load and capacity by increasing the capacity of individuals. Here one can make a distinction between training courses related mostly to safety and others which are related more to health or welfare. Examples are training in the use of personal protection equipment, lifting courses, lifestyle activities (food, smoking, alcohol, exercise), training courses on work consultation and courses on stress management.

The third type of interventions aimed at reducing workplace absenteeism are *reintegration measures*. These curative measures are intended to lower the return threshold and to promote as fast a return to work as possible. This can be achieved through support by managers (maintaining contact, participating in the socio-medical team), medical care by the company medical service (medical surgery, physiotherapy, treatment by private specialists) and re-integration activities (drafting a return plan, offering specially adapted work).

Our study investigated the types of interventions used by Dutch health care and welfare institutions as perceived by key persons representing the employer and their employees and the effectiveness of these interventions to reduce workplace absenteeism

Method

Procedure

The study is based on data collected in 33 health care and welfare institutions. These were selected because they are known to deal more systematically with the problem of absenteeism than others.

The institutions were from different branches: hospitals (5), nursing homes and institutions for care of elderly (5), institutions for the care of disabled (4), home care (4), institutions for mental health care (5), child day care (5) and community and social work (5). In each institution we interviewed key persons (personnel officers and representatives of management and workers). The employees were asked to complete a questionnaire (a hundred per institution and 300 in one institution upon special request). In total, 3,500 questionnaires were distributed. 1608 employees responded, which means a response of 46%.

Sample

Table 1 compares the sample population with the total of employees working at health care and welfare institutions in the Netherlands.

Table 1 Comparison sample with working population in health care and welfare institutions

		Sample %	Population%
Sexe (N=1601)	Male	21%	23%
	Female	79%	77%
Age		Mean= 38 year, 10 months	Mean= 33 year, 6 months
Education (N=1592)	Lower and intermediate education (primary, secondary and vocational education)	58%	74%
	Higher education (university)	42%	26%
Type of institution(N=1586)	Hospitals	13%	40%
	Nursing homes and care institutions for the elderly	15%	22%
	Home care institutions	12%	13%
	Institutions for care for the disabled	14%	11%
	Institutions for mental health care	18%	7%
	Institutions for community and social work	12%	3%
	Institutions for child day care	16%	3%

Table 1 shows that only concerning the participation of women the sample is representative for the total population of workers in the health care and welfare sector. The age and education of the respondents is higher than generally the case is in the Dutch health care and welfare sector. Also workers in institutions for care for the disabled, mental health care, community and social work and child day care are over-represented and workers in hospitals are underrepresented. This is because we made use of a stratified sample: we chose to select of each sub-sector five

organisations to participate in our research. One organization for home care withdrew and in the case of one organization for care for the disabled the questionnaires were lost in the mail.

Measures

All data obtained are based on perceptions and hence subjective.

The key persons representing the employer (hereafter called ‘management’ or ‘employer’) and the respondents on behalf of the employees (‘employees’) were asked to give their view on the way their organizations carry out workplace absenteeism policies and how effective they considered these policies to be.

Workplace absenteeism policy

Three types of intervention to reduce workplace absenteeism were differentiated, e.g. procedural measures, preventive measures and reintegration measures. Both key persons representing the employer and employees were asked about these three kinds of measures.

Procedural measures as perceived by the employees were operationalized by asking the respondents whether they were familiar with a procedure to report oneself sick, whether someone contacted them if they call in sick and whether someone contacted them during illness, and whether they could go to the occupational health service if they have health problems related to work. The answers are 'no’ or ‘I do not know' (0) and 'yes'(1). The answers to these four questions were combined in one scale with scores between ‘no measures known’ (0) and ‘all four measures known’ (1). The reliability of this scale is low, Cronbach’s alpha is .47.

Preventive measures: The same kind of questions are asked about the use of seven preventive activities (to improve physical working conditions, mental working conditions, work stress/work pressure, lifting courses etc.). The answers are 'no’ or ‘I do not know' (0) and 'yes'(1). The answers to these seven questions were combined in one scale with scores between ‘no measures known’ (0) and ‘all seven measures known’ (1). The reliability of this scale is sufficient, Cronbach’s alpha is .66.

Reintegration measures are also operationalized by asking the employees whether they were familiar with three different kind of activities to supervise sick employees and to promote swift return to work of sick employees. The answers are 'no’ or ‘I do not know' (0) and 'yes'(1). The

answers to these three questions are combined in one scale with scores between 'no measures known' (0) and 'all three measures known' (1). The reliability of this scale is low, Cronbach's alpha is .43.

On the organizational level we asked the keypersons the same kind of questions about these three interventions. The answers given by the majority of the key persons we took as the answer of the employer

Effects of workplace absenteeism policy

Seven measures were used about possible effects of workplace absenteeism policy. Three on organization level, and four on individual level.

On organization level we have information about the institutions' figures on absenteeism *percentage* (except absence due to pregnancy/population at risk), absenteeism *frequency* (total number of new spells/population at risk) and percentage of persons who received disability benefits in 1999.

The first measure on individual level concerns the self-reported absenteeism *frequency* (number of new spells) over the last twelve months. Possible answers are 'no new spells' (0), 'one or two spells' (1) and three or more spells (2).

The second individual measure asked five questions about the *assesment* of the respondents about workplace absenteeism policy like: Do you think that your organization pays special attention to prevention and reduction of absenteeism? Do you think that your organization is active enough in promoting swift returns to work? Possible answers are 'yes' (1) or 'no' (0). The answers to these five questions are combined in one scale with scores between 'negative'(0) and 'positive' (1). The reliability of this scale is low, Cronbach's alpha is .48.

The third individual measure consists of a combination of the answers on four questions about the degree *absenteeism is discussible* with colleagues and superiors. The scores of this scale range also between 'negative'(0) and 'positive' (1). The reliability of this scale is reasonable, Cronbach's alpha is .61.

The fourth individual measure indicates the degree the respondents have changed their *absenteeism behaviour* compared with two years ago. On the basis of five questions a score is computed between 'no changes'(0) and 'all changed (1). The reliability is good, Cronbach's alpha is .82 .

Results

Workplace absenteeism policy as perceived by employers and employees

In this section I describe the correlation between the workplace absenteeism policy as perceived by the employers and as perceived by the employees. In other words, Are there differences between how the employer and employees look upon the institution's absenteeism policy? Three types of interventions are distinguished: procedural, preventive and reintegration measures. The respective answers of employer and employees are correlated per institution.

Degree of agreement on preventive measures

For the preventive measures we compared the answers to six questions. These relate to physical demands, work pressure, work stress, risk of infection, safety/aggression and violence, rosters, working hours, and confidence person for sexual harassment, aggression and violence. Table 2 describes the degree to which management and employees agree regarding the preventive approach to these risks.

Tabel 2: Agreement regarding preventive measures (in percentages)

		Employer			Agreement
	Employees	**Yes**	**no**	**Total**	**per cent**
Physical demand	yes	61	5	66	63
	no	32	2	34	
	Total	93	7	100	
Work pressure/stress	yes	14	17	31	49
	no	34	35	69	
	Total	48	52	100	
Infection risk	yes	21	25	46	58
	no	17	37	54	
	Total	38	62	100	
Safety/aggression	yes	31	10	41	55
	no	35	24	59	
	Total	66	34	100	
Rosters/working hours	yes	17	26	43	56
	no	18	39	57	
	Total	35	65	100	
Confidence person	yes	48	9	57	67
	no	24	19	43	
	Total	78	22	100	

As Table 2 shows, measures to reduce physical demands are implemented most (according to the employers), followed by the appointment of a confidence person sexual harassment etc. Employees however do not always seem to be aware of these provisions. In two-thirds of the cases, for example, employers and employees agree about the presence or absence of a confidence person.. Nearly eight out of ten employees has an employer who says that such a

person is available. No more than six out of ten employees say that their institution has such a confidence person. And 9% of these say this without justification, since the key persons of their institution states that no confidence person is provided. The reverse situation is even more frequent: for 24% of the employees their management claims to have a confidence person, while the employees either says that such a person does not exist or say that they don't know.

Regarding the other work risks there is still less agreement (50% to 63%) between management and employees. The greatest agreement is on measures taken concerning physical demands (63%). Least agreement is found on measures in the area of work load and stress (49%).
Actually, however, this should be relativized. It is quite conceivable that an employee is not aware of a measure, because that measure is specifically aimed at part of the employees, for example, those who work under conditions where climate problems may play a role. This sort of thing may hold for preventive measures, though not in other cases. Procedural measures and those for reintegration may be assumed to hold for all employees. Let us see what happens in those areas.

Agreement on procedural measures
Concerning procedural measures we asked a large number of questions, of both key persons (management) and (representatives) of the employees. To determine the degree of agreement we selected four of these questions. These are queries about the protocol for absenteeism, reporting of illness, contact with absentee employees and the presence of a facility for occupational health consultation if employees have health problems related to work..
Employees were asked whether they were familiar with all the rules attending absenteeism, and we compared this with the question put to their employer, whether there was a protocol (stipulating all these regulations). We further asked both employers and employees whether the institution contacts the sick employee and whether such contact is maintained. And we asked about the existence of occupational health consultations. The degree to which the answers of both parties agree are represented in Table 3.

Table 3.: Agreement concerning procedural measures (in percentages)

		Employer			agreement
	Employee	**yes**	**no**	**Total**	**per cent**
Absenteeism protocol	yes	91	0	91	91
	no	9	0	5	
	Total	100	0	100	
Initial contact	yes	90	0	90	90
	no	10	0	10	
	Total	100	0	100	
Contact maintained	yes	78	0	91	78
	no	22	0	9	

	Total	100	0	100	
Occupational health consultation	yes	54	3	57	57
	no	40	3	43	
	Total	95	5	100	

All employees say that an absenteeism protocol is formulated and that contact is made and maintained with sick employees. Nearly all employees seem to know about these procedural measures. This is not true of the preventive occupational health consultation facilities. All employers provide this facility, only half of the employees know that such is the case.

Agreement concerning reintegration measures

As to rules covering reintegration we asked employers and employees about intensified supervision on the part of the occupational health practioner, extra attention by the leadership and the use of work adaptation for the reintegration long-term incapacitated employees.

Table 4 indicates that the majority of the employers implement measures to promote the reintegration of long-term incapacitated employees. Nearly all employers have the leadership pay extra attention to long-term sick people and make use of work adaptations to facilitate the return to work.

Table 4.: Agreement on reintegration measures (in percentages)

		Employer			Agreement
	Employee	**yes**	**no**	**Total**	**per cent**
Medical supervision	yes	57	23	80	63
	no	14	6	20	
	Total	71	29	100	
Attention by leadership	yes	58	2	59	59
	no	39	1	40	
	Total	97	3	100	
Work adaptation	yes	74	8	82	76
	no	16	2	18	
	Total	90	10	100	

It appears that employees are aware of these measures to a limited degree only. The picture held by employers agrees with the policy management claims to pursue in less than two-thirds or three-quarters of the cases. A possible explanation here is that employers who have not themselves been ill for an extended period may not be very familiar with the measures. After all, they have no actual experience with them.

Degree of agreement

On first sight the above comparisons of preventive, procedural and reintegration measures seem to show a reasonable measure of agreement between what management reports and what employers perceive and know about the policies. But considering that pure guesswork will

yield a 50% chance of agreement, we should understand that the corrrelations actually found are often no greater than mere coincidence would yield. We find only a few aspects where the linkage is greater than mere chance should lead us to expect.[1]

If we look merely at the results for all employers and employees in total, the replies of the two groups seem reasonably similar. But if we tally how many employees actually offer the same answers as their employers the differences prove appreciable.. What I means is that frequently, employers say that a measure does exist, while a large number of their employees know nothing about it. The opposite also occurs, though to a lesser degree: employers say that a measure applies while many of the employers say that this has never been instituted. It turns out then, that the actual agreement between employees and employers regarding the degree to which a policy dealing with working conditions, absenteeism and reintegration is implemented in the organization is much less than the total percentages of the replies would have us believe.

The conclusion that can be drawn from this is that in the health care and welfare institutions investigated, the employees are insufficiently knowledgeable about the measures employers claim to exist in the context of policy aimed at working conditions, absenteeism and reintegration. Basically, only a limited number of procedural measures are well known by employees.

Effects of prevention, procedure and reintegration measures

To discover the effects of policies regarding working conditions, absenteeism and reintegration we used the data of the questionnaires distributed among the employees in 33 health care and welfare institutions. In addition, we made use of data gathered on the level of the institution as such. This data is on the percentage of absenteeism, frequency of absenteeism and relative entry into disablement insurance. We oriented ourselves particularly on the perceived measures and effects on the level of the employees. This means that we did not seek to determine whether the 'official' policy as the key persons told us was carried out by the institution had effect; rather, we wanted to know whether the policy as perceived by the employees had effect. As demonstrated above, there is an appreciable difference between the measures taken according to the employers and what has actually been achieved in this areas according to the workers.. The latter is important for insight into the results of the absenteeism measures taken. At issue is not a paper policy, but actual implementation and a successful approach. Moreover, some effects of absenteeism and reintegration measures (next to the frequency and nature of the absenteeism on the level of the institution) are available only on the level of the employees, for example by asking them about their attitude towards the measures and possible changes in their behaviour over the past years.

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[1] The question whether the outcomes agree significantly or deviate importantly was calculated via

For the effect measurements on the level of both the institution and the employees we inspected to see whether these correspond with the measures to prevent or reduce sickness absenteeism as perceived by the employees. We applied univariate variance analyses[2] in which the averages of the effect measurements of the group of employees who perceived few policy measures are compared with those of the employees who perceived many of these measures. On account of the univariate analyses we cannot entirely exclude that other factors, too, can influence the correlations found. In view of the direction of the correlations found it seems plausible to accept that these correlations actually exist. Table 5 shows that employees who perceive many preventive measures differ from the employees who perceive few preventive measures in the following ways.

- they tend to be employed in an institution where absenteeism is reported less frequently;
- their assessment of the total policy on working conditions and absenteeism is more favourable;
- they consider absenteeism more discussible and approach their colleagues more on those terms;
- more of them have changed their absenteeism behaviour for the better (higher absenteeism threshold and lower return threshold);
- in recent months they have been absent because of illness less often.

Table 5 further shows that employees who perceive more procedural measures differ from employees who perceive fewer procedural measures:

- they tend to be employed in an institution where the absenteeism percentage is lower;
- their assessment of the total policy on working conditions and absenteeism is more favourable;
- they consider absenteeism more discussible and approach their colleagues more on those terms.

Finally Table 5 shows that employees who perceive more reintegration measures differ from employees who do so to a lesser extent, on the following points:

- they work in institutions with relatively fewer people turn to Disability Benefits
- their assessment of the total policy on working conditions and absenteeism is more favourable;
- they consider absenteeism more discussible and approach their colleagues more on those terms.

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the statistic techniques *kappa* and *mcnemar*.

[2] Univariate variance analyses were carried out because many absenteeism data was lacking on institution level, so that in multivariate analyses the N would become unnecessarily small.

Table 5. Measures concerning working conditions and absenteeism, and results

Results	Preventive measures		Procedural measures		Reintegration measures	
	Low M (N)	High M (N)	Low M (N)	High M (N)	Low M (N)	High M (N)
Absenteeis percentage 1999 (excl.)	7,5 (817)	7,6 (717)	7,7 (861)	7,5* (667)	7,6 (758)	7,5 (761)
Reporting frequency 1999	1,74 (688)	1,65* (598)	1,70 (703)	1,70 (579)	1,69 (636)	1,70 (639)
Disability Benefit	0,015 (589)	0,014 (513)	0,015 (620)	0,014 (478)	0,016 (558)	0,014* (532)
Assessment	0,52 (808)	0,62 (750)***	0,52 (869)	0,63*** (689)	0,50 (766)	0,64*** (787)
Discussible	0,49 (671)	0,51* (652)	0,48 (728)	0,52*** (595)	0,48 (631)	0,51*** (689)
Absenteeism behaviour	0,30 (675)	0,36** (633)	0,33 (724)	0,34 (584)	0,35 (631)	0,32 (672)
Absenteeism frequency	1,88 (839)	1,80** (754)	1,83 (895)	1,86 (695)	1,84 (790)	1,85 (791)

* p < 0,05, ** p < 0,01, *** p < 0,001 One-way Anova was conducted

The more measures regarding working conditions and absenteeism employees perceive, the more positive their assessment of the policy in their institution, and the more they feel that the absenteeism of their colleagues is discussible and the more they feel that they themselves too should provide proper justification for their absence. As to the results on the institutional level the perceived measures correspond with a lower absenteeism percentage, or a lower reporting frequency, or a lower turn to Disability Benefits, but never two or three of these results on the institutional level simultaneously. Moreover, only the implemented preventive measures have an effect on the degree to which employees are inclined to continue working while ill (absenteeism behaviour) and the number of times they reported sick during the past year (absenteeism frequency).

Conclusions and discussion

The kinds of measures that the institutions can introduce to push back absenteeism are procedural measures, preventive work-oriented measures and/or person-oriented measures, and reintegration measures. It turns out that the active organizations studied make use of virtually every one of these measures. Employees in the health care and welfare institutions however are insufficiently aware of the measures which, employers say, are in force. It appears that in the health care and welfare institutions investigated, the employees are insufficiently knowledgeable about the measures employers claim to exist in the context of policy aimed at working conditions, absenteeism and reintegration. Basically, only a limited number of procedural measures are well known by employees.

The approach to absenteeism differs from one institution to the other. All institutions are certainly not equally active in the matter of policy regarding occupational health and safety

and absenteeism. On the whole, the genuinely active institutions tackle absenteeism in integral ways. They pay attention to prevention of absenteeism generally, and to procedures regarding absenteeism and to resumption of work.
The empirical inquiry indicates that as far as quality of the measures goes, these could be made to fit the context of the institutions better, particularly in relation to workload and psychological pressure. In addition, we noted that the institutions take few measures aimed at improvement of the labour relations and the consequences of reorganizations or mergers. Then too, only a few institutions are actively involved in approaching absenteeism in a more businesslike way.

The analyses performed indicate that preventive measures are the more effective interventions. It also appears that employees who note the presence of more *procedural measures* work in an institution with a lower absenteeism percentage; employees who note the presence of more *preventive measures* work in an institution where sickness reporting is less frequent; employees who note the presence of more *reintegration measures* work in an institution where a relatively lower percentage of people turn to Disability Benefits.
On the individual level we found that the more measures regarding working conditions and absenteeism employees perceive, the more they report that they call in sick less often and go back to work sooner than they did two years ago.

Also in an earlier study (Van Vuuren et al, 1999) we found that of all interventions, preventive measures appear to be the most effective in reducing absenteeism. The results of that study on absenteeism policy in the health sector was however presented with some restrictions. The information was merely gathered by asking the personnel officers. In this study we overcome these restrictions by gathering information from different sources (documentation, key persons as management, member of the work council, personel officers and last, but not least employees) . And again the present results fit the general picture which is known from earlier research in this area.

In view of the multiplicity of factors conducive to absenteeism and the different natures of these, policy in the sector health care and well-being ought to be exceptionally extensive and of high quality. The studies show that, next to the ‘standard measures’ such as improvement of the absenteeism protocol and absenteeism policy, training the leadership and smooth cooperation with the Occupational Health Services, the most important areas to tackle absenteeism are:

- investing in good employer practice;
- adequate internal communication;
- an open culture of responsibility;

- optimal working conditions and, finally;
- sufficient means and guarantees to implement the occupational health and safety, absenteeism and reintegration policies.

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