Chronically ill employees in the context of organizational culture

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Abstract:

In this article, the differences in implementation of policies in relation to chronically ill employees are discussed in the context of organizational culture. It appears that an appropriate organizational culture is required to be able to take measures to retain chronically ill employees. Various stakeholders view organizational culture as a magic bullet to help introduce company policy to retain chronically ill workers. Within functionalist approach to organizational culture, the three perspectives (integration, fragmentation and differentiation) can be distinguished. According to these perspectives, we classify organizations in accordance to the decision-making and hierarchical structures. We shall explore how the three organizational culture perspectives can be used for understanding what may constitute 'best practice' or 'best strategy' in order to address the question of what the organizations can do to facilitate sustained employability for chronically ill workers. The main objective was to determine what type of organizational culture is more effective for policies and practices in case of optimal functioning of chronically ill employees.

Preliminary research results are based on a number of case studies conducted with the managers and HRM of government and commercial organizations between March 2007 and October 2008. These case studies were based on open interviews and focus group sessions (for human resource departments) which were consequently analyzed using thematic analysis. For group sessions, we used concept mapping to collect information from two groups of HRM professionals and managers. Concept mapping is a structured methodology for eliciting, organizing and aggregating the ideas of groups of diverse stakeholders on a certain focus question. It uses qualitatively collected data from group members and results in quantitatively derived graphic maps (concept maps) displaying the interrelationships among ideas expressed by the group and its sub-groups. [i] [ii]

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We used literature study using systematic hand-search strategy involving medical, statistical, management and social science databases (Web of Science, MedLine, Pub Med, Psych Info, etc.). For the purpose of this study we only included physical and NOT psychological or mental disorders.
Key words: organizational culture, policy, employees, chronic diseases, integration approach, fragmentation approach, differentiation approach.

Introduction.

In the past decades the EU and national member states have adopted several policies to facilitate employability of people with chronic diseases. One underlying reason for introducing these policies is that labor participation is shown to has been shown to have a positive effect on health, social and financial position of people with chronic illness. Another reason for introducing these policies is that European governments hope to retain as many people as possible employable to counteract the negative effects of the graying population and reduce costs to society.

In the framework of a larger study of chronically ill employees and labor policy we have conducted a literature review in order to explore what measures organizations may have to take to facilitate sustained employability for chronically ill workers. A recurrent theme in many of the descriptive or research based publications we were able to locate is that organizational culture is a key factor in facilitating or inhibiting company measures regarding chronically ill employees. Organizational culture is a very broad concept however. The aim of this paper to explore and clarify the potential role that organizational culture may play in the design and implementation of policies aimed at the retention of chronically ill workers.

Chronic illness and work disability

Some of the common characteristics of chronic diseases include their duration (last longer than one year); physical or mental limitations; and requirement of ongoing medical care. Chronic diseases vary greatly: while many can occur at any age, most occur at older age. Symptoms vary in severity from mild to very serious and do not always follow an expected pattern (flare ups followed by remission periods versus constant symptoms). Diseases also vary in symptom visibility and progression. Long standing health problems or disabilities are referred to as LSHPD. Both acquired and inherited illnesses are considered as chronic, yet not all chronic conditions lead to disability to perform paid work.

Not all people with LSHPD experience problems at work. According to the WHO this depends on a number of different factors. While the main pathway to disability is understood to be the pathology leading to impairment leading to

functional limitations leading to disability, this pathway can also be effected by extra-individual factors (medical care and rehabilitation, medications, external support, and built, physical and social environment), risk factors (predisposing characteristics: demographic, social, behavioral, etc.), and intra-individual factors (lifestyle and behavior changes, psychosocial attributes and coping, and activity accommodations) (Nagi, 1974; Verbrugge and Jette, 1994:4). For the purpose of our study, we discuss both the life-long disabilities and periodically recurring illnesses.

The definition of work disability is far from fixed and is both culturally and contextually variable. Following the recommendations of the WHO in current European work force questionnaires Work disability is defined as a person's perception that chronic condition or handicap hampers or impedes them to find or to maintaining paid work (Bruins Slot, 2006:2).

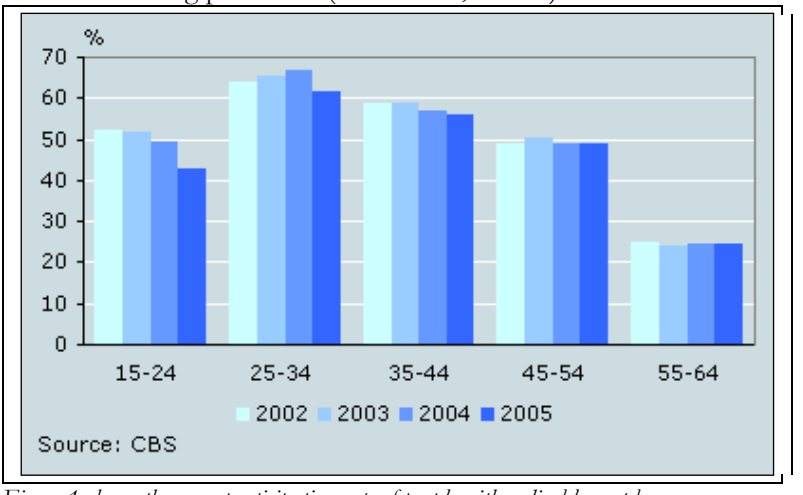

Figure 1 shows the gross participation rate of people with a disablement by age

Organisational Culture.

In order to operationalize the concept of 'organizational culture' we may need to outline what is meant by culture in general and organizational culture in particular. The notion of 'culture' in general may include 'knowledge, belief, art, morals, laws, customs, and any other capabilities acquired by man as member of society' (Tylor, 1871). Culture can also be seen as a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way you perceive, think, and feel in relation to those problems (Schein, 1992). Organizational culture may contain all of the elements of culture at large but is usually defined somewhat

narrower. Similar to culture in general, organizational culture may be seen in both material and ideational terms. We may note that material approach to organizational culture include formal practices, especially pay rates, and physical arrangements (including the dirt and noise or quiet luxury of a work environment) and other material aspects of organizational life. In contrast, ideational approach to culture (like symbolic analyses) focuses on *interpretations* of some kinds of cultural manifestations and content themes and represents the cognitive and emotional aspects of culture (Martin, 2002:137).

Criticizing functionalist approach.

To address the question of 'what the organizations can do to facilitate sustained employability for chronically ill workers' we need to examine a number of approaches to the study of organizational culture.

Within earlier organizational and management studies, the study of organisational culture was used as an important tool in predicting firm productivity and performance or helping firms to survive (Martin, 2002:160). The contemporary student of organizational culture 'often takes the organization not as a natural solution to deep and universal forces but rather as a rational instrument designed by top management to shape the behavior of the employees in purposive ways (Ouchi and Wilkins, 1985:462). The study of 'on successful firms' by Deal and Kennedy (1982) as well as Hoftstede's work on multinational firms (1980) attempted to come up with general recommendations for 'good culture' and 'best practices'. These studies have been undermined by consequent longitudinal empirical studies, which demonstrated that the initially successful companies with 'good' organizational culture could become less successful within a short period of time. Many postmodern theorists retorted that fluidity of norms, values and attitudes, as well as culture change were more characteristic of organizations that stability of cultural norms and structures.

As forces of globalization and innovation have raised the levels of cultural and technological diversity within and between firms, their ability to adapt to changing environments and the ability of individuals and groups to make good sense of the situations that they participate in has become increasingly important. Such sensemaking… requires an appreciation of the highly tacit and distributed nature of organizational knowledge as well as the complex, social practices through which such knowledge develops (Moss, 2001).

Alvesson (2002), in his critical volume Understanding Organizational Culture, argues for a less instrumental approach but for a broader definition of culture. Alvesson criticizes mainstream organizational culture thinking: 'The values and ideas to which organizational culture research pays attention are primarily connected with the means and operations employed to achieve pre-defined and unquestioned goals. A second problem is subordinating organizational culture

thinking to narrowly defined instrumental concerns also reduces the potential of culture to aid managerial action' (Alvesson, 2002:42). Alvesson warns about the danger of trivialization and 'managerialization' of culture, leading a student of organizational culture to 'premature practicality' (Alvesson, 2002:46). Further criticism of mainstream organizational culture studies within organizational and business studies is the accent on etic **(**outsider) perspectives, when the researcher attempts to generate objective and in some cases generalizable (rather than context-specific) knowledge, such as Hofstede's earlier work on multinational companies (Martin, 2002).

Management is presently viewed as a dynamic, participatory and interactive process of sensemaking (Weick, 1995) as managers try to find meaning in the actions that their organisations have performed and develop detailed understandings of their organizations' capabilities in order to facilitate strategic learning (Mintzberg and Waters, 1985). In the case of chronically ill employees, organizational procedures may involve reporting and disclosure procedures in order to open dialogue between managers and employees and potentially lead to solutions. When the problematic of the chronically ill workers is recognized as generic, or when the chronically ill are seen as a group for the purpose of the recognition of their special needs may be incorporated into the organizational sensemaking.

Three perspectives on organizational culture.

While we should be careful not to use 'culture' for the sake of developing a managerial tool only because it may be appealing because of its simplicity, we should avoid another extreme assuming that any use of organizational culture concept will be potentially too shallow to be useful. In examining position of different groups (such as the chronically ill employees) within organizations, we need to ask ourselves what type of organizational culture may lead to optimal results. The authors are aware of the fact that they themselves may repeat the fallacy of using culture as a managerial tool. Yet, using 'culture' in a specific perspective, as the case study analysis provided below demonstrates, can lead to meaningful observations, if not solutions, in the case of chronically ill employees. Social scientists' reluctance to engage with socially significant issues may leave 'organizational actors' outside of the socially and politically charged context in which they find themselves. While it is not the author's intention to advocate the position of the chronically ill employees, it is their intention that some form of engaged cultural approach may lead to greater understanding of social processes underlying culture change in organizations.

Martin (2002) distinguishes three theoretical views of cultures in organizations: integration, differentiation, fragmentation perspectives. The

integration perspective focuses on those manifestations of a culture that have mutually consistent interpretations. An integration portrait of a culture sees consensus (although not necessarily unanimity) throughout organization. The differentiation perspective focuses on cultural manifestations that have inconsistent interpretations, such as when top executives announce a policy and then behave in a policy-inconsistent manner. From differentiation perspective, consensus exists within an organization – but only at lower levels of analysis, labeled "subcultures". The fragmentation perspective conceptualizes the relationship among cultural manifestations as neither clearly consistent nor clearly inconsistent. Instead, interpretations of cultural manifestations are ambiguously related to each other, placing ambiguity, rather than clarity, at the core of culture (Martin, 2002:94). Martin describes these approaches in metaphors:

From the differentiation perspective, consensus exists within an organization – but only at the lower levels of analysis, labeled 'subcultures'. Subcultures may exist in harmony, independently, or in conflict with each other… To express the differentiation perspective in a metaphor, subcultures are like islands of clarity in the sea of ambiguity…

In the fragmentation view, consensus is transient and issue specific. To express the fragmentation perspective in a metaphor, imagine that individuals in a culture are assigned a light bulb. When an issue becomes salient (perhaps because a new policy has been introduced or an environment of the collectivity has changed), some light bulbs will turn on, signaling who is actively involved (both approving and disapproving) in this issue. At the same time, other light bulbs will remain off, signaling that these individuals are indifferent to or unaware of this particular issue. Another issue would turn on a different set of light bulbs. From a distance, patterns of light would appear and disappear in a constant flux, with no pattern repeated twice' (Martin, 2002:94).

The three perspectives oppose each other on the three dimensions of comparison: the relationship between cultural manifestations, the orientation to consensus in culture, and treatment of ambiguity. At the same time, because these perspectives take different positions on these three dimensions, they compliment each other by offering a wider range of insights (Martin, 2002:120). All three perspectives are particularly useful for the study of policy and consequent change within organizations. Martin argues that it is through combination of the three perspectives that the better understanding of organizational culture can be achieved.

To sum up the results of previous studies of employees and employers' perspectives, optimal functioning of the (chronically ill) employees is often attributed to organizational culture. Adjustments can be made at the level of the cultural forms (such as adjusting physical arrangements), formal practices (such as agreed number of working hours) and informal practices (such as adjusting

expectations and developing greater flexibility and understanding). By formal and informal practices in this case we particularly mean those employed between either colleagues of the employee, line managers and the employee, or combination of these (Martin, 2002). Within human resource management studies, competing values model of Quinn (1988) is used and focuses on four different orientations of organizational culture: supportive, innovative, regulating and goal-centered. In this context, a psychological contract between employer and employee plays a large role.

Seeing the relationship between employer and employee as purely a formal contractual relationship, misses the point of this relationship. The psychological contract between employer and employee means the reciprocal expectation concerning the way in which the work relations are formed in practice, and is at least as important as the formal employment contract. This also applies in the case of sickness. If a sick employee is held responsible by formal contractual arrangement concerning reintegration activities, the trust between employer and employee can be damaged. Even if these measures accelerate the resumption of work, the danger exists that it does harm to the psychological contract and to reciprocal trust (de Beer, 2007:30 Translated HK).

Addressing the literature on chronically ill employees, we discovered that there is a general consensus within the employee-centered studies that it is through the change in organization culture that the optimal results can be achieved. While the policy seems to be formed from the integration perspective, the actual practices testify to the success of fragmentation perspective. Fragmentation in this case may be used synonymously with flexibility, both in relations between employer and employee and in flexibility towards interpretation and implementation of generally formulated policies.

Beatty and Joffe (2006) refer to a 'culture of flexibility' which should enable the chronically ill to remain on their jobs: "When accommodations can be made, many times they are simple and inexpensive. By taking a proactive stance toward possible job redesign, organizations demonstrate their support. Creating a culture of flexibility and openness fosters an environment in which people feel safe discussing their physical limitations, their work preferences, and the resources they need to get their work done" (Beatty and Joffe, 2006:195). Mijden (2006) discusses a number of aspects of organizational culture that could facilitate chronically employees functioning in the organizations. Greater openness and flexibility of the employer towards the employee should facilitate both communication and joint responsibility towards the chronically ill worker. People-orientation and flexibility of working processes are seen as essential to successful functioning of the chronically ill employees (Mijden, 2006:2).

However, we need to stay alert to the fact that supportive, open and flexible organizational culture does not yet guarantee that chronically ill employees are

optimally functioning at work. The social context of work place support is equally important (Johnson and Hall, 1988; McDonough and Amick, 2001).

Organizational culture and policy.

Like in several other European countries in the Netherlands, until the end of the 20st century the state was responsible for the provision of work disability benefits of workers who were ill (Bloch and Prins, 2001). In response to concerns about the disproportionably high percentage of employees who were receiving disability benefits, new legislation was passed in The Netherlands in 2004 Poortwachter (the Gatekeeper law), which shifted the responsibility for paying disability and sickness benefits from the state to the employer. Before 2004, employers were responsible for the management of sickness absence in order to prevent any claims for disability benefits. What is more, an employer had a duty to offer a suitable alternative job for the disabled employee, and adapt the work place and to finance rehabilitation programmes and pay the salaries to a maximum more than a year of those on permanent contracts.

The situation of relative freedom in interpretation of policy by organizations in general and employers in particular is relatively new in The Netherlands and its effects on chronically ill employees still need to be examined. Currently, there is very little known about how these changes are being experienced by the employers and HRM within different organizations. However, when national level policies are formulated for special branches and organizations (such as 'CAO' – collective labour agreement for civil servants) the guidelines towards the treatment of the chronically ill employees remain broad and general.

Within literature on human resource management, control model, which implies central coordination of decision-making and implementation, may be compared to that of integrational perspective. Control model of personnel management can be described in terms of fixed hierarchies, whereas organizational culture reflects bureaucratic and instrumental orientation of both employers and employees where protocol is strictly obeyed (Kluytmans, 2005: 253). Dutch health management policy prior to 2007 implied such an integrational perspective.

The new Dutch policy may be characterized in terms of 'involvement' model, which implies more flexible and negotiable relations between employers and employees, and possibility of looser interpretation of policy. Kluytmans (2005) characterizes organizational culture within the involvement model as task- and clan-oriented (p. 254). This clan-orientation in this case refers to group adaptation of social contract, reflecting common value pattern, collective risk-avoidance behavior and selective reward system. Kluytmans acknowledges a recent change in contractual relationships which have become more differentiated at the levels of social bonding between the employer and employee, person-organization-fit

becomes more fluid, 'functioning paradigm' (expected tasks belonging to a particular job description) less fixed. These models of organizational culture can thus be compared to the fragmentation and differentiation perspectives model.

As discussed in the introduction, Poortwachter law makes employers responsible for the management of sick leave. In response to this policy shift, employers are establishing new company based programs to promote job retention for ill employees. Until recently these programs focused primarily on encouraging the return to work of employees who are on sick leave. But prompted by EU policies and concerns about shortages on the labor market companies are also becoming increasingly interested in the development of proactive programs, which focus on the prevention of sick leave and work disability among employees with chronic illness.

Policy within integration, differentiation and fragmentation perspectives.

We may distinguish between a few branches of HRM that are (sometimes) involved in the decision-making process. These include staffing and recruitment (hiring decisions and processes); employee separations (retirement, hiring freeze, terminated employees); performance appraisal; training and career development; compensation; employee rights, protection; interaction employee management; and diversity management.

We may place the functioning of the branches of HRM within differentiation, fragmentation and integration perspectives. We may place organizations in a few categories according to relationships and hierarchies between departments and stakeholders' groups (in Martin's terms, 'subcultures'). These organizations may be roughly classified in terms of those in which either line managers, top managers, HRM or other stakeholders

1.formulate policy

2.interpret policy

3.implement policy

4.receive, control and disseminate policy-relevant information

5.implement eventually adjusted policy

Reflecting upon the best practice examples of Poortwachter, we notice that there is a large amount of flexibility possible within different organizations as far as interpretation of policy is concerned. Based on the examples of best practices, we may conclude that policies are interpreted and implemented in accordance to specific organizational structure and culture rather than following general guidelines. This reflects the general trend within European and Dutch policies in allowing organizations greater flexibility in employee –employer relations.

Martin (2002) warns that while many practitioners had invested time and money in cultural change interventions, their prescriptions for better policies were

hardly useful. At the level of organizations, within one industry or even across industries, significant differences in interpretation and implementation of the general policies are noticed. From our previous studies it emerged that national-level as well as industry or branch level policies are not experienced as 'set in stone' and done 'by the book' – rather, they are negotiated, contested, interpreted and implemented to suit particular organizational or institutional needs. We hypothesized that these differences can be largely explained by organizational culture underlining differential relations between groups of stakeholders within an organization: top managers, line managers, HRM and corporate doctors.

While integrational perspective on organizational culture stresses the importance of consensus within groups or departments ('subcultures') within an organization, we would expect that policy will be interpreted and implemented in accordance to general guidelines. It seems that while organizations strive towards integration, the actual experience shows that various departments often function independently of each other or ad hoc when it comes to individual cases. Noticing that there is a large difference in how organizations interpret and implement policies, we may conclude that fragmentation and differentiation forces between the groups of stakeholders are at play.

While at the European level of policy we may speak of integration perspective, in which disability, equality, public health and employment policies 'work together', national policies place an emphasis on flexibility and openness of implementation of policy. We may hardly speak of integration realizing that organizations rarely have consistent policy in regards to the chronically ill employees. Organizations vary in accordance with particular arrangements in the way information about the chronically ill is disseminated, processed and how the decisions are made. Some companies may indeed be seen from both the 'islands' or 'subcommunities' fragmentation or differentiation perspectives, where corporate doctor and external physiotherapist work together, or where HRM and employers are separately involved, or where employee only has an opportunity of disclosure with the company doctor.

Organizational differences: case studies.

New policy towards greater employees' responsibility and flexibility of organizational rules gains its confirmation. The shift towards greater personal responsibility implies tendency towards integration, when both employers and employees reach a kind of consensus through the process of open negotiation. Adversely an alternative view could be that precisely because the consensus needs to be reached, the underlying conflicts (differentiation) and differences in interest (fragmentation) come to the fore. While the Dutch protective policy before 2007 allowed employers little freedom in treating the chronically ill employees and integration of policy with decisions was reached through centralized control,

relations between the employer and employee presently became less centralized and more fragmented.

Haagse Hogeschool (HHS).

HHS, a University of Applied Science (professional education college or polytechnic) has some 1.600 staff (roughly half of which work full-time) and about 17.000 students. The central policy is formulated through the government CAO (general regulations for civil service workers). As most organizations in The Netherlands, HHS formulates the equal opportunities policy. This policy implies that all employees and job applicants are treated fairly and equally, regardless of their gender, sexual orientation, marital status, race, ethnic or national origin, religion, age or disability. During interviews with HR representatives (n =8) and line managers at HHS (n=4), it emerged that it is normally the HR representative who get notified about a health condition by chronically ill workers. This happens in cases when the employee tries to avoid disclosure with the line manager, yet illness is perceived by the employee as interfering with his work tasks.

HRM does not normally disseminate this information to the line managers. Information is sometimes conveyed to the top management, if redeemed important and with the employee's consent. Sometimes HRM receives information from the corporate doctor and then either contacts the employee or in some cases both employee and the line manager. Depending on a number of factors, such as the employees' wishes, severity of reported disorder, degree of interference with and the ability to perform the work task, cooperation of the line manager, etc. plans of action are formulated.

Eventual decisions in regard to these cases (possibility of making structural or functional adjustments, termination of employment, etc.) are made and implemented by either the line managers in consultation with the employee and HRM, or by the line manager in consultation with the top manager, or simply between the HRM and the employee (in case no major adjustments are needed). One of the HRM representatives summarized this process as being 'somewhat arbitrary' and 'depending on individual case'. Subjectivity of such a decision making process is confirmed by one of the line managers, a middle-aged male head of one of the academic departments:

Sometimes we 'follow the book' [the CAO]. But the book does not spell out what needs to be done in each individual case. We know we cannot discriminate and we need to support chronically ill workers. But […] how it really happens at the grass root level is a different question. Sometimes it all depends on employee's disclosure. Sometimes it's the boss who needs to make the first step… noticing that someone [employee] isn't performing well… [Interview April 2008, translated from Dutch by author H.K[1].].

[1] All quotes in this article are from interviews conducted between April and June 2008,

The same respondent reflected on the question of what he considers to exemplify 'best practice' or 'good strategy':

There might be as many opinions about it as there are people in the room [8]. I don't personally think there is one winning formula or an ideal prescription for what needs to be done. Maybe sensitivity to each individual case is the most important guiding principle… I would however suppose, leaning upon my previous experiences, that a centralized system in which it's the [top] management that makes all the decisions [regarding chronically ill employees] isn't that effective. After all, these [chronically ill] employees are not all the same. You can not require a person to talk about their condition, let alone treat it in accordance to what a [corporate?] doctor or the boss says. If you threaten [the employee] with firing them if they miss a lot of [work] days – that's not an effective strategy to promote disclosure and deal with the condition… There needs to be a dialogue to discuss what the possibilities are, what special needs need to be met or what expectations are… Maybe a good starting point is HRM… Yes, employee talking to HRM representative first.

A female member of HR department disagrees:

It's easy to say: let the worker come to us. What if they don't? And how are we supposed to deal with it? HRM are not specialized [medical] professionals. If we are not asked to convey the information further [to the employer], we are left with the question of what to do about it… It's one thing getting a complaint about health and it's another question of whether HRM should be a bridge between the worker and the management. This could also lead to having to choose sides [employee or employer]… It's not a neutral issue… Ideally, I think, there should be strict policy rules according to which worker should feel protected enough to talk to his boss directly. It should be the boss' responsibility, we deal with different things…

It appears that interpretation and implementation of policy related to formal sickness prevention and absenteeism is largely left to the stakeholders within the organization itself. The process of information acquisition and dissemination within this organization is rather sporadic and decentralized.

Albert Heijn.

Another case is that of Albert Heijn (AH), a Dutch supermarket chain store. At this location AH has 619 employees, of whom about half full-timers. This AH has the team leaders for the different areas, who are responsible for groups of 20-30 employees, such as the controllers and the secretaries. The interview was recorded with Martijn D., the line manager, and Frank T., the physiotherapist from a training institute for health, recreation and work.

Physiotherapists are hired in at AH to rate and treat employees if they have

translated from Dutch by the author.

reported physical problems. This is done in close cooperation with the company's medical officer. Frank has consultation hours three times a week and the team leaders can make an appointment for an employee, either preventively or in the case the employee already has physical discomfort. According to Frank, the corporate doctor's office is normally the place where the chronically ill go to for advice: 'They can also go to the team leader, and then they can make an appointment with me or the company's medical officer'. Martijn compliments this by saying:

"If there is a problem with things such as back or shoulder they can easily make an appointment with Frank, thus it is easy to plan. For other things, such as problems with lungs, they can go to the doctor within the company. Many companies do not have that possibility for employees, as they do not have a doctor and physiotherapist within the company"...

Reflecting on the Dutch policies regarding chronically ill, Martijn says: 'Well, years ago we had medical tests for people that applied for a job. Nowadays this is not the case anymore, but of course it makes a big difference. It is now only for certain jobs, where it is really necessary'.

For individual organizations, reflects Frank, different rules may apply, particularly including the possibilities for subsidies: "In the Netherlands the government subsidizes companies that employ those people. Thus they make it appealing to firms to employ chronically ill or disabled people. Those subsidies can be money, but also other things…." Martijn adds: 'it can be a bit scary for the employee to employ a chronically ill person, especially when you don't know how it is with subsidies and such, as there is always a bit more risk involved when employing someone with an illness'.

Croda.

Croda is part of international Uniquema company, which specializes in innovation in the area of raw material use. The company has approximately 4000 employees, working in 36 countries. Activities can be broadly classified into consumer care which consists of global businesses in personal care, health care, home care and crop care; and industrial specialties. At the Dutch location in Gouda, Croda employs an undisclosed number of managing and manual worker staff. Croda formulates the so-called whistle blowing policy which allows employees to raise concerns with management about the conduct of others which they consider to be in some way damaging to the organization or others within it. Croda also formulates the equal opportunities policy and has some special internal policies concerning the chronically ill workers.

We interviewed Nel Van G., policy advisor and an occupational health nurse who works in Croda's HRM department. According to Nel, Croda has a pleasant working environment for chronically ill workers. She stated that chronically illness is not of an importance for Croda, the employees are never discriminated by race,

religion, gender, age or health. Nel also stated that although the company has a low proportion of chronically ill workers (3.1%), the management and HR Department try to build respectful and beneficial relationships between the managers and the workers. In general, it provides flexible working schedules and better working environment in order for them to keep up with their working performance. For instance, people with diabetes to have a day-night rhythm otherwise they can get sick, so Croda offers them a special working schedule with no night shift. Croda also makes effort to improve working conditions for chronically ill workers, for example change their work place, and provide special equipment such as chairs.

Through contacting Nel, sick employees they can get necessary help from the company doctor. Chronically ill people can enjoy certain tax reduction through pensions or tax benefits, if they stop working. If there are a lot of chronically ill people, Nel states that it is also possible to get tax reductions and some financial discount from the company. At the age of 55 and older, people that can not keep up with their function because of a chronic sickness can get transferred to a lower job position in the company but still get paid the same amount of salary as before. The procedure for disclosure and adjustment may vary but generally Nel feels that Croda is open to anybody requesting special equipment or adjustment due to their condition:

He or she does not have to say that he or she is sick and what kind of sickness he or she has. There is no difference for our company whether a worker is sick or not because if he is, then he gets special work environment in order to help him feel better at work. He can get special furniture or work different times than normal schedule…

Yet some functions within Croda require worker testing having to do with their specialization- Nel particularly refers to manual factory workers.

Some of them might have chronic illnesses but can be a very productive candidate for a certain work placement. In this case there are no negative effects. They can start or continue working and if their health condition becomes worse, the company can always help him with it. For example, if someone has diabetes and their condition becomes worse, they can work fewer hours than before to improve their health…

If a worker is sick, the company makes sure that there is enough innovation at his work place so that he can still perform his work. We make sure the worker is satisfied and his condition does not get worse. Some of the things that can be changed are: working hours, space on their work place, arranging special furniture… [Eventually the worker may be] transferred to a lower job position but still get paid the same amount of salary as before.

Nel feels that communication between the ill worker and the manager in Croda is well arranged. Nel feels that clarity and simplicity (of approach) is

necessary and that it helps that she is both the contact person and the company doctor.

Etos/AHOLD.

Ahold is an international group of quality supermarkets based in the United States and Europe. We have interviewed the Human Resource manager of one of the Etos locations Gerard K. (location and details undisclosed). Gerard reflects that there are large issues associated with illnesses of the employees particularly because of the physical nature of work (mostly standing and walking).

Gerard thinks that the chronically ill work mostly in the headquarters in administrative jobs and that "percentage of the chronically ill people in the shops is zero because they can't work there". While there are more chronically ill working at the shops, Gerard reflects, the only really suitable working place is in the headquarters. ARBO Dienst (Occupational Helath Service) may evaluate the working possibilities and adjustments for an individual worker.

At the location in Rotterdam Gerard spoke once to a chronically ill lady with reuma who was persistent in trying to work at the shop despite her disability:

She can't give money back to the customer… She can't put a shampoo on the shelf. It is impossible for her. So I told her we are going to a reintegration office to look for her to get a job somewhere else, outside of the Etos… But we always help people if they are ill, and it is not working at the Etos, to find work elsewhere. And we pay for it. A lot of it. It's a government policy. When someone is ill for two years we pay them salary. And after they [have to deal with] UWV. After the first year we look, okay, can this person come back in the labor market. Well this lady with reuma is not coming back. We also got that checked by an agency. And the coming year the reintegration office is going to look how they can educate her to a job somewhere else.

Nonetheless, Gerard states, Etos does not try to discriminate against workers or potential applicants. Still, hiring procedure necessitates some disclosure in older applicants.

According to Gerard, Etos does not have a consistent policy, while Ahold does. There is some sporadic documentation, as in recording the numbers of chronically ill employees and the nature of their illness. The data is sometimes entered into the company's data base but managers or HR representatives at other Etos locations, but Gerard does not know what happens to it afterwards and weather the data is consistent with the actual numbers of the chronically ill. When asked whether he is satisfied with the existing policy at Etos, Gerard replied: "At the headquarters, I think yes. In the distribution centers and the shops, forget it".

Nettorama.

Nettorama is a supermarket based in Nieuwegein (Utrecht). Nettorama focuses more on offering the lowest price guarantee on it is products and less on the customer service. Nettorama in Nieuwegein has 74 employees, two- third of

which works part-time, most of them are students and housewives. According to the interviewed manager, two of the employees are chronically ill at the moment. The manager interviewed, T., has almost 25 years of experience in the supermarket business, 8 of them working as a manager at the Nettoramma.

There are set procedures to follow in case of sudden illness, but not necessarily in case of chronic complaints. When an employee gets sick he or she has to call early in the morning to inform the manager about his condition. The manager reports this employee's sickness to the head office trough the intranet.

But when the employee is not back to work within 8 weeks the head office of Nettorama sends Commit Arbo to the employee in order to get a health checkup. Commit Arbo helps employer and employee find a way to remain the employee's job… Special cases such as pregnancy and hospitalized workers can get a leave maximum for 16 weeks. Disabled or elderly people can not work in a supermarket because of the heavy work load. The Nettorama has no time and money to set up special equipment for the needs of those people.

During the application procedure managers screen the applicants through oral questioning and a question in the application form. T. also checks formal employers and asks for references. A supermarket does not have many employees that are not easy to replace. Everyday new floor workers and cashiers apply for a job. Part-time employees that apply get a temporary working contract which is automatically renewed every six months three times. After the third time the employee does not get a new contract anymore.

So for the Nettorama is does not matter that the employee is sick and just replaced him or her by another person. That is the reason why Nettorama does not have a special policy towards chronically ill employees. When a worker for instance has been sick 4 times in 1 month the manager sends a letter to the head office in order to review the matter and take action toward this worker. First the head office sends a warning letter to this workers' house. If the worker still calls in sick too often other actions will be taken. Off course this is not the case if you are a full-time and you have a permanent contract.

Mr. T. considers the supermarket too small to have a policy towards the chronically ill nor to have any trainings or courses for managers or employees. To illustrate his own experience with the chronically ill T. gave an example of a young men with back pain. He has been working the whole year off and on. So the Nettorama contacted Commit Arbo and scheduled a meeting between a Commit Arbo representative, the Nettorama Manager and the worker.

They have agreed that the worker has to do exercise physical therapy or go to a bewegingscentrum (a center for sport and physical activities). This worker used to work 40 hour a week. Now in order to retain his job again he works for 2-4 hours a day. Once he tried to work for 6 hours in a day but that was too much for him…This disclosure is based on trust. Back pain is not something you can not

check very easily. There is no other way then to help him to the point that he can work fulltime. We sometimes have a meeting with him to evaluate his condition and ask for proof that he applied for one of the agreements.

Reflecting upon these studies, we may conclude that some differences in interpretation and implementation of policy exist. For example, unlike in the case of Haagse Hogeschool, the line manager and the physiotherapist of Albert Heijn reported that they receive information about the chronically ill employees regularly, and that there is an established procedure for treating different illness cases.

Examples of 'best practices'.

Based on the studies of employers and HRM, it appears that the most important factors from the employers' perspectives were well-informed professionals who cooperate effectively; employees' coping capacities and commitment to work; financial regulations at the workplace; adequate social security provisions, medication, and therapy; a positive attitude on the part of employers and colleagues; and suitable working conditions (Varenkamp et al: 2005).

The Kroon op het Werk ('Crown on the Work') initiative provides awards to employers who succeed well in implementing this law. Kroon op het Werk award of Poortwachter for best disability management practices in 2006 was given to Waterland Ziekenhuis, while five other organizations were nominated for the award. These organizations are thoroughly described, including individual stories, cases and experiences described by employers, employees and HR managers within these organizations. The Chairman of the Council of the governing board of Waterland Ziekenhuis states:

Health care has too many rules, protocols, measures… and a sickness absence of 8%. If you want to lower that percentage you must change culture first. Do not level everything with rules, but return their own responsibility to the people. Instead of punishing sickness absence we started reward those staying at work. For example, my child is sick and I call: `I cannot come because my child is sick'. Then you as an executive can react formally and say: do you take a free day or do you want to report yourself as sick?' But you can say also: 'Take the time to work it out and I'll see you when all is well'. That sounds very different, it feels different and it works also different. Because if someone says something like that to me then I appear a couple of hours later at my work. And we have an houseful of women with young children, so it really matters in terms of reducing sick leave' (http://www.kroonophetwerk.nl/Waterland_Ziekenhuis_winnaar_2006%20_eigen_verantwoordelijkheid_teruggeven_327.html Translated HK).

The study of Haafkens et al. (2007) of Dutch employers' and HRM's perspectives using a small sample involved in concept mapping study, revealed a number of themes. Each professional group identified 6 themes. Common themes

were: a need for "clear company policy", "employees who take their own responsibility", "more knowledge among HRM/managers about chronic disease and it's prevalence in the company", "work adaptations". One theme was only mentioned by managers: "good cooperation between the manager and employee". Themes only mentioned by HRM professionals were: "a culture of trust, openness and communication within the organization" and "support within the organization". The importance of self-disclosure was reported by all interviewees.

Disclosure might be problematic due to the complex interplay of identities and the fear of stigmatization and discrimination (Munir et al, 2005). In the study of the views of employees and health professionals in The Netherlands, professional guidance in dealing with chronically ill employees was found to be conditional on self-disclosure, severity of illness symptoms, and socio-demographic factors having to do with age, gender and educational level (Detaille et al. 2006, and Zirkee et al 2008). Disclosure of illness by the chronically ill employee may have a number of implications on continuation of their employment. Aside from having supportive organizational culture, self-disclosure may be prompted by other structural or socio-demographic factors. Findings from the study of the chronically ill employees refer to positive influence of supporting employers and colleagues on disclosure of illness (Munir et al, 2005). In this study, self-management of the chronically ill as well as supportive organizational culture was taken into consideration. Munir et al. (2005) found that discrete self-management factors predicted different levels of disclosure: partial self-disclosure, when only line managers were informed about the presence of a chronic illness and full self-disclosure, when line managers were also informed how that chronic illness affected employees at work. The greater severity of symptoms of chronic illness by employees, the more self-disclosure was reported. Furthermore, employees were found more likely to report disclosure to line managers if they had already disclosed to colleagues, thus creating a kind of support chain within organization.

Conclusion

From having glanced the occupational health policy alone we might have concluded that in the organizations where reporting chronic illness becomes generic due to unified and strong policy (integration) best results will be achieved. Yet, the cases demonstrate that it is rather due to openness and flexibility of organizational arrangements that the optimal results in terms effecting individual employees are achieved.

The differences in implementation of policy towards the chronically ill employees were found at the level of hierarchy of relationships, information flow and decision-making process between the stakeholders, such as employers (line

managers), human resource managers, corporate doctors and employees. When our database is expanded and we have a wider set of case studies, we may be able to classify the organizations in accordance to different institutional or cultural arrangements and deduce which arrangements work better in enabling the chronically ill employee to continue optimally functioning at work.

The concept of organizational culture viewed from integration, differentiation and fragmentation perspectives is quite useful for addressing these differences. While current Dutch policy focuses on integration and differentiation perspectives, it appears that fragmentation is more effective for policies and practices in case of optimal functioning of chronically ill workers.

It appears that there is a gap between the formal structures promoting employment and actual experiences of the stakeholders within organizations. Flexible, supportive and open organizational culture emerged as one of the key factors for optimal functioning of the chronically ill employees.

More research on the stakeholder groups could supplement case studies and examples of best practices such as those of Poortwachter. Extended empirical study of employer and HRM's perspectives should promote better understanding of how the national-level policies are implemented in different contexts and why success of these policies differs across organizations.

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