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Adela POPA*, Felicia MORÂNDĂU**

Abstract

This paper aims to analyse the lived experiences of Romanian health professionals regarding the legislation that regulates work participation of people with chronic diseases which are subject to long-term sick leave, disability certification and/or invalidity pension, due to their condition. The topic is important, especially because legislation seems to be rather a barrier than a protective factor, provides unclear or insufficient guidelines, and is not accessible enough. The methodology has a phenomenological orientation and is mixed, combining desk research on Romanian legislation related to work after chronic diseases with semi-structured interviews done with 33 participants, belonging to six categories of health professionals. The results of the desk research were included in a report that highlights the main legal provisions on work with chronic conditions. The analysis of the interview data was conducted using Nvivo software, based on an inductive approach. The results emphasized three themes: the current state of the legislation and the system, the impact of the current legislation and directions for change. Conclusions are relevant for Romanian decision-makers in this area. Thus, the most significant problem of the Romanian legislation related to work, from the health professionals' perspective, points to unclear roles, responsibilities, and guidelines, with a relevant impact on patients and employers. Also, health professionals discuss the lack of coordination among them and with other stakeholders involved in the process (employers, employment agencies, non-profit organisations) and suggest some

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changes that could contribute to a better work (re)integration for individuals with chronic diseases.

Keywords: work participation, return to work, chronic conditions, legislation, mixed methods.

Résumé

Cet article vise à analyser les expériences vécues des professionnels de santé roumains concernant la législation qui régule la participation au travail des personnes atteintes de maladies chroniques soumises à un congé de maladie de longue durée, à une certification d'invalidité et/ou à une pension d'invalidité, en raison de leur condition. Le sujet est important, surtout parce que la législation semble plutôt être un obstacle qu'un facteur de protection, fournit des directives peu claires ou insuffisantes, et n'est pas suffisamment accessible. La méthodologie a une orientation phénoménologique et est mixte, combinant une recherche documentaire sur la législation roumaine relative au travail après des maladies chroniques avec des entretiens semi-structurés réalisés avec 33 participants, appartenant à six catégories de professionnels de la santé. Les résultats de la recherche documentaire ont été inclus dans un rapport qui met en évidence les principales dispositions légales concernant le travail avec des maladies chroniques. L'analyse des données d'entretien a été réalisée à l'aide du logiciel Nvivo, selon une approche inductive. Les résultats ont mis en évidence trois thèmes : l'état actuel de la législation et du système, l'impact de la législation actuelle et les orientations pour le changement. Les conclusions sont pertinentes pour les décideurs roumains dans ce domaine. Ainsi, le problème le plus significatif de la législation roumaine liée au travail, du point de vue des professionnels de la santé, réside dans des rôles, des responsabilités et des directives flous, ayant un impact pertinent sur les patients et les employeurs. De plus, les professionnels de la santé discutent du manque de coordination entre eux et avec d'autres parties prenantes impliquées dans le processus (employeurs, agences de placement, organisations à but non lucratif) et suggèrent quelques changements qui pourraient contribuer à une meilleure (ré) intégration professionnelle des personnes atteintes de maladies chroniques.

Mots-clés: participation au travail, retour au travail, maladies chroniques, législation, méthodes mixtes.

Introduction

Chronic conditions often affect work ability, and as a result, some people living with these conditions may have no option but to take long-term sick leave or pursue an invalidity pension (and sometimes apply for disability certification). The population of interest in this study is the working-age population suffering from chronic conditions that had a long absence from work (long-term medical leave or invalidity pension) which significantly disrupted their job and career activities (from now on, we will refer to these persons with chronic diseases by using the "PwCD" abbreviation). These people require additional support from employers and/or other stakeholders such as health professionals, workforce counsellors etc., for resuming their relation to work and can receive more or less support from the legislative framework in place.

Although marked by difficulties, work participation is important and beneficial for these people. Work participation following a chronic disease diagnosis is an umbrella term encompassing a variety of situations such as returning to work after long-term sick leave or invalidity pension of third degree, continuing work during treatment but with limited work capacity, changing the job as a result of the diagnosis, or looking for the first job in case of people with a long-term limitation that never worked. The literature is rich in providing the benefits of work participation for PwCD. It allows for a quicker recovery (Kox *et al.*, 2019), provides psychological comfort by helping individuals to resume their normal life (Amir *et al.*, 2008; Tiedtke *et al.*, 2010), strengthens personal and professional identity (Isaksson *et al.*, 2015; Midtgaard *et al.*, 2009), and addresses financial concerns (Amir *et al.*, 2009; Moffatt & Noble, 2015).

Health professionals (HPs) represent one category of stakeholders involved in the process of returning to work after a long absence which can considerably influence if and in what way PwCD resume work. While in practice HPs play a significant role in supporting workers' (re)integrate into work, the support offered is largely shaped by legislation. The legislation relevant for chronic diseases and work is an essential factor in the process (de Rijk *et al.*, 2022), and can be either a barrier or a facilitator for work resumption. These three elements – the worker with a chronic condition, the health professional (doctor, psychologist or social worker) and the legislation – form a dynamic relationship, within the larger system of work rehabilitation which can take many forms (Belin *et al.*, 2016). The views of HPs on the existing legislation are essential. Beyond medical interventions, legislation is the main tool they use, or must follow, when helping PwCD to reintegrate into work. Thus, we will try to examine the views of the Romanian HPs on the legislation relevant to the work participation of PwCD, as this is a topic of great importance for understanding how the process can be improved.

No systematic data is publicly available in Romania on the number of PwCD on various pathways in relation to work (employed or self-employed, on sick leave, on invalidity pension etc.). According to Eurostat, 7.5% of the Romanian working-age population (16-64 years) had a long-standing illness or health problem in 2024 (Eurostat, 2024). Of this population, only 3.6% people were employed in 2024 and this is the lowest percentage in the EU-27 countries, highlighting the consistent difficulties PwCD have in returning back to work. For comparison, the average of employed persons with a long-standing illness or health problem in EU-27 in 2024 was 25.3%. A total of 390,564 people were receiving an invalidity pension in Romania in the first quarter of 2025 and 47.5% of them were on a third-degree invalidity pension, which allows for part-time work National Institute of Statistics , 2025). No data is available on the actual number of people with a third-degree pension that actually work. The average rate of returning to work after a long absence due to a chronic disease varies significantly. For example, the average rate in case of cancer is 62% (Amir *et al.*, 2018; Mehnert, 2011), while for stroke is between 11% and 85% (Popa *et al.*, 2023).

The current legislation in Europe deals well with offering general employment protection (Kiasuwa Mbengi *et al.*, 2016), safeguarding against discrimination (Shim *et al.*, 2019), and offering work modifications and advantages to assure a good adaptation of the worker who resumed work, such as phased return to work (Cenik *et al.*, 2019) or the employer's obligation to provide occupational health services (Horppu *et al.*, 2016). At the same time, some provisions are not sufficiently reflected in legislation or are not included in all national policy frameworks. To name just two, work accommodations need clearer guidance in many national settings (Popa, & Popa, 2020; Rondinone *et al.*, 2023), and employers should have clearer responsibilities in the process (Amir *et al.*, 2018; Popa *et al.*, 2020; Ståhl *et al.*, 2011).

The legislation in many national settings seems to be rather a barrier than a protective factor. A consistent bulk of literature exists on how national legal frameworks fail to support PwCD who want to resume work, as well as the other actors involved in the process, such as HPs, who are the focus of this paper. The main complaints on the current policies, as resulted from studies on various types of HP, refer to not providing clear roles and responsibilities for those involved in the process (Kiasuwa Mbengi *et al.*, 2016; Lamort-Bouché *et al.*, 2019) or allowing for role dispersion, i.e. the spread of responsibilities across multiple professionals without clear delineation of who is responsible for what (Zegers *et al.*, 2022). In some cases, the unclear role pertains to specific categories of HP, such as general practitioners in Netherlands (Sarfo *et al.*, 2022), occupational physicians in Italy (Persechino *et al.*, 2019) or treating physicians in Belgium (Tiedtke *et al.*, 2012). In Romania, the role of occupational physicians remains primarily formal and evaluative, thus this role is informally assumed by treating physicians or family doctors (Popa *et al.*, 2020, 2021b). One last issue is that employers and other actors relevant to work participation are often absent from the policy frameworks (Popa *et al.*, 2020, 2024; Ståhl *et al.*, 2011). For this reason, individuals who begin a long-term medical leave tend to maintain only a superficial connection with their employer. Employers generally lack internal procedures for the management of return-to-work processes or workplace adaptation. Consequently, when they help a patient to return to work, this is usually done through an informal process, grounded in personal values rather than legal norms (Popa *et al.*, 2020, 2021b).

Another problem points to having unclear or insufficient guidelines in policy, i.e. not specifying clearly what diverse actors should do. A successful work reintegration process is grounded in two essential steps: the assessment of the patient's remaining work capacity and a clear return-to-work procedure. The current legislation in many countries contains unclear provisions for both these steps (Dewa *et al.*, 2015; Rondinone *et al.*, 2023). Regarding the return-to-work procedures, the situation is even more difficult considering that very few countries provide clear guidelines in their legislation. Thus, limited return-to-work provisions are common for countries in Europe *(*Désiron *et al.*, 2022; Kamp *et al.*, 2024; Popa, & Popa, 2020). Often, studies look at provisions for specific diseases such as the need for clearer guidance for patients with advanced cancer (Zegers *et al.*, 2022) or the need for better guidelines regarding work adaptations (Kiasuwa Mbengi *et al.*, 2016).

A last significant category of legislation problems relates to accessibility and financial constraints. Accessibility is complex and refers to various issues such as lack of understanding of provisions (Désiron *et al.*, 2022; Edlund, & Dahlgren, 2002; Sarfo *et al.*, 2022), administrative bottlenecks or organisational problems. Administrative challenges such as too complex administrative procedures (Stochkendahl *et al.*, 2018) or specific legal rules that limit aspects of stakeholders' collaboration, for example the exchange of information (Anema *et al.*, 2002), complicate even further the accessibility of the law. The lack of structured collaboration between actors or services is found in many countries with various legal backgrounds (Holwerda *et al.*, 2015; Popa *et al.*, 2023). The financial problems are also significantly discussed in literature. A major topic relating to the social security systems' sustainability is the poor balance between compensation and activation (Popa *et al.*, 2023; Tiedtke *et al.,* 2012).

The above presented problems of the legislation have a significant impact on all categories of actors. Although undisputable, the impact of the legislation on PwCD is beyond the scope of this paper and was analysed in another paper. The impact on HP can take many forms such as less confidence in providing work-related advice (Sarfo *et al.*, 2022), less trust in their role (Putrik *et al.*, 2019), variation in the adherence to the guidelines (van Muijen *et al.*, 2015) or poor collaboration with other stakeholders (Désiron *et al.*, 2022). Access and financial problems also have an impact on the return-to-work process (Wynne-Jones *et al.*, 2014) and support (Magalhaes *et al.*, 2017), on accessing services (Sarfo *et al.*, 2022) and of course on the policy implementation (Cenik *et al.*, 2019; Shim *et al.*, 2019). Generally, these problems are combined, thus creating a systemic negative effect on work participation (Kosny *et al.*, 2018).

Similar with the legislative frameworks in Europe, the Romanian legislative context presents more or less the same features, as comparable social, economic and political conditions shape law elaboration and implementation. In Romania, work participation for people with long-term health conditions unfolds in a challenged labour market characterised by high economic vulnerability at the lower end of the wage distribution. Romania's statutory minimum wage is among the lowest in the EU, while the in-work at-risk-of-poverty rate was the highest in the EU in 2022 (European Commission, 2024). The employment rate was 63% in 2023 (substantially below the OECD average) and informal employment remains very high compared to OECD countries, resulting in uneven access to stable and protected work (OECD, 2025b). At the same time, broader system capacity constraints are present. The World Bank's Human Capital Index for Romania was 0.58 in 2020, indicating enduring challenges in education and health over the life course (Avitabile, 2020). Access to healthcare still is a structural constraint, as high unmet needs driven mainly by low population coverage and cost-sharing for certain services are present (OECD, 2025a). In addition, political instability and uncertainty over fiscal policy continue to affect reforms in Romania, undermining policy continuity in all domains, including work participation (European Commission, 2024).

We presented above mainly the literature in Europe on this topic, as only very few papers analyse the Romanian legislative context related to chronic conditions and work. Yet a previous study on the Romanian legislation (Popa, & Popa, 2020) highlighted fragmented responsibilities and limited procedural coordination across sickness absence, disability certification, and work participation pathways. This is the main reason indicating why health professionals' accounts are central for identifying how the legislative framework is enacted, where it breaks down, and what types of norms and coordination mechanisms are most feasible in the Romanian context. We therefore used policy-implementation lens: when legal rules are incomplete, ambiguous, or poorly coordinated, frontline actors effectively "make" the policy through everyday decisions and documentation practices.

Considering this background, this paper aims to explore the views of various categories of HP on the current legislation for work participation in case of PwCD who had a long absence from work, based on their lived experience of using this legislation in providing support for such patients, in a country with an underfinanced and overwhelmed healthcare system (Vlădescu *et al.*, 2016) and with a limited framework for work reintegration in case of workers with diseases or disability (Popa *et al.*, 2024). The main contribution of this paper is that it adds to the existing literature regarding how various stakeholders view work participation following long-term absence from work due to chronic disease, by putting Romania on the map of countries where this complex issue was studied. This study presents the lived experience of HP regarding the use of legislation in practice and the meaning they attach to their role in relation to the legislation, to the level of support the current legislation allows for the patients and to the changes that are necessary for improving it.

Methodology

Study design

This paper is part of larger research which explored the views of various stakeholders (health professionals, employers, human resources recruiters, counsellors from work force agencies, representatives of non-profit organisations) on how work (re)integration of PwCD who took long absences from their work can be facilitated. This research first begun in 2016 and back then included in-depth interviews with patients suffering with cancer and other comorbidities, as well as interviews with HPs, employers and recruiters. In a second stage, in 2022, we have done a survey on patients with various chronic conditions and interviews with HPs, employers and NGO representatives. For understanding the context, we have analysed the legal Romanian framework relevant for this topic. More specifically, using desk research, we have analysed 19 pieces of Romanian legislation (laws, government decisions, emergency ordinances, and ministerial orders) regarding work following chronic diseases in Romania, identified through a comprehensive search. The results of this desk analysis were already synthetised in a report (Popa *et al.*, 2021a) and were used as a background for analysing the interviews. While the data on patients, employers and NGO representatives was analysed and is subject of other published or forthcoming papers, in this paper we focus exclusively on data collected from interviews with HPs in the two stages of the research.

The general objective of the study is to analyse the lived experience of HP navigating the legislative framework for the employment of PwCD. Starting from this aim, we established three research questions to explore deeper the perspectives of various HP that frequently interact with PwCD. Our research questions are:

1. What is the perception of healthcare specialists on their role in work reintegration of PwCD, in relation to the current Romanian legislation on this topic?
2. What is the HPs perspective on whether the current legislation constraints or enables the work participation of PwCD after a long sick leave, as well as the efforts done by employers in this respect?
3. What changes are necessary, from HPs perspective, to create a legal context which is more supportive for PwCD in their effort to resume work?

This paper thus uses a mixed design, involving (1) desk research on Romanian policies relevant for chronic diseases and work for understanding the legal background and (2) semi-structured interviews with six categories of health professionals, i.e. specialist physicians, oncologists, social security physicians[1], occupational physicians, family physicians and other (psychologists and social workers).

The interviews were collected in two stages: first, in 2016, interviews were collected on the topic of cancer and work participation, while in 2022, interviews were collected on the topic of chronic diseases and work participation. The reason for this two-staged data collection was that we started studying cancer in relation to work as part of a research grant[2] and all the results pointed to the necessity of studying not only cancer in relation to work but also other chronic diseases. Thus, we obtained funding from another grant[3] in which we interview other HPs on the topic of chronic diseases in general. A team of six psychologists and sociologists worked for identifying potential participants, contacting them and doing the interviews. In total, 33 interviews were collected in both stages.

The methodological orientation of the interview analysis is phenomenological, with a focus on the lived experience of the respondents in relation to the support offered for PwCD considering return to work (Smith *et al.*, 2022). Thus, when constructing the interview guide, we paid attention to capture how legal regulations intersect with and influence the HP professional practice. Questions were carefully crafted to grasp the essence of their experience regarding the specialist-patient-law interaction and the meanings HPs attach to this experience.

Participant selection and setting for the interviews

The participants were selected purposively, as we included health professionals in the six categories mentioned, from public and private medical services in Romania, in a balanced way regarding the number of participants per each category. HPs were usually approached by email or by phone and in every category, we contacted more participants (usually 8-10), yet part of them refused to be part of the study, usually due to the lack of time. All the interviews in 2016 stage were collected in the HPs' medical practices, while those of 2022 were mainly collected online, through the Google Meet or Zoom platforms, due to the effects of the COVID-19 pandemic.

Interview data collection

The interview guide was developed by the research team with a phenomenological orientation (Manen, 2016) and consisted of seven main questions with flexible prompts. To enable comparison across the two data-collection stages, we used two highly similar versions of the guide, maintaining a common core of experience-focused questions across interviews. In line with van Manen's emphasis on *everyday lived experience* and the value of *experiential material* (often elicited through concrete anecdotes) as a starting point for phenomenological inquiry, interviews were anchored in specific recent cases rather than abstract opinions about policy. Participants were invited to detail concrete encounters with work-related legislation, while prompts were used to reconstruct events, decisions, interactions, and meanings (e.g., when and how legal requirements became relevant in specific cases, how work ability was understood in that situation, how coordination with the patient and other actors unfolded). While the core questions were kept consistent to support cross-professional comparison, prompts were adapted in real time to each professional category's role and typical interface with work-related pathways. The interview guide was pilot tested with one physician, then adjustments were made for the final version. All interviews were conducted by experienced qualitative researchers. All participants signed informed consent forms and had the choice to withdraw from the interview at any time. The interviews were audio recorded and transcribed verbatim. Brief field notes were taken during collection. The interviews lasted in average 1,5 hours. We used theoretical saturation, i.e. when no significant new information was retrieved from them, we stopped the collection for that category.

Data analysis

For the report on policies, the identified policies were screened in order to extract all relevant information on chronic disease and work. A careful synthesis of the main legal provisions was done and included in the report.

The interviews were repeatedly read, and emergent themes were developed through inductive coding done by the authors of this paper, using Nvivo 14. These themes captured the essence of the experience of the respondents in relation to the work participation of their patients. A pattern was identified among these themes and structured as presented in the following section.

Results

A total of 33 HPs participated in interviews and their characteristics are shown in Table 1. Three major themes were identified, each with sub-themes: A. The current state of the legislation and the system; B. The impact of the current legislation, and C. Directions for change. We will present them briefly below.

A. The current state of the legislation and the system

The interviews contain elaborated discussions on the legislative status-quo, with four sub-themes being more prominent.

Fragmentation and incoherence

Romanian legislation is perceived as incomplete and “with many loopholes” which make it too permissive. HPs observe that many laws are not applied due to the lack of methodological implementation norms, such as the Law 292 of 2011 (Law of social assistance), which could have unified the systems for evaluating people with disabilities and invalidity pensions, but was not applied due to the lack of norms from the Ministry of Labour (which we noticed also in the policy analysis). The system for helping PwCD is described as “cumbersome” and “disastrous”, with bureaucratic hurdles and a “doubling of systems” that costs money.

> *A peculiarity of our system is the distinction made between the concept of disability and the concept of invalidity pension. There are people who qualify for both... At one point, a social assistance law was proposed that would unify the assessment system for both medical expertise and disability, so there would no longer be two separate commissions. Yet, this law is not in place. So right now, we have two overloaded systems, which duplicate bureaucracy and each have their own army of employees and each make assessments of the health status and work ability. It would be better if they functioned as a single system and if the law unified the medical criteria regarding disability and chronic illnesses. I don't see social justice in the current system. (SSP-5)*

These aspects were also identified through our desk analysis on the current legislation, i.e. the fragmentation of the legislation, the fact that some provisions are incomplete (they lack operational regulations) or too general.

Table 1. Participants’ characteristics (n=33)

Characteristics	Number
Gender	
Male	14
Female	19
Medical speciality (abbreviation):	
Social security physicians (SSP)	7
Treating/specialist physicians (TP)	5
Oncology physicians (OP)	6
Occupational physicians (OccP)	6
Family physicians (FP)	4
Other (psychologist, social worker) OthP	5

Domain	
Public	22
Private	10
Non-profit	1
City	
Sibiu	17
Cluj-Napoca	5
Năsăud	2
București	2
Alba Iulia	1
Craiova	1
Slobozia	1
Timișoara	1
Piatra-Neamț	1
Mehedinți	1
Mediaș	1

Fragmentation and incoherence are characteristics that pertain not only to the legislative content but also affect the coordination and collaboration mechanisms among stakeholders. There is a significant lack of effective collaboration between key institutions such as commissions for people with disabilities, local social work services, the County Employment Agencies, Pension Houses, and the National Institute for Medical Expertise. Databases of these institutions are not integrated, thus making it difficult to monitor patients after receiving invalidity pension or returning to work. There is an agreement between HPs that employers are one important category missing from the legislation, although in practice they influence the process significantly. Communication between medical specialists is described as extremely limited, occurring only indirectly through the patient carrying documents from one doctor to another.

> *I believe there is no communication at all. The only connection is through the patient, who goes from one doctor to another. No one takes the trouble to contact the family doctor and inform them… Face-to-face communication is almost non-existent, but through medical documents we are, in a way, kept informed about the patient's current situation. The patients bring the medical documents to the family doctor only if they want. (FP-2)*

The lack of explicit legal prescriptions for employers was underlined, also, in our policy analysis. In fact, only one explicit prescription target employers in the current policy, namely their obligation to contact the local workforce agency, in case the employer does not have any adequate vacancies, in order that the employee who is unable to work to receive job offers, before terminating their employment.

Lack of specific obligations and other inadequacies

A subject debated a lot in the interviews is the lack of the legal obligation for the treating and oncology doctors to discuss with their patients the possibility of returning to work. Most physicians do this voluntarily, as they believe this is important, and they are often asked by the patient to provide advice. Yet, the consensus among the HP interviewed is that such a provision should exist in law. Also, regarding obligations, labour law does not require the employers to offer an easier position to the workers returning after a long period of medical leave, while in the case of persons with disabilities, employers often prefer to pay fines rather than employ them.

> *Do you have the obligation to do this? [a.n., to discuss about work with the patient] - No, I don't. Each doctor does it voluntarily and according to their own conscience.*
>
> *Do you think there should be such an obligation, perhaps by law? - There are many things that should be established by law. I don't know… maybe this should be one of them as well, but I believe that any doctor with a conscience who does their job properly would not fail to discuss such matters with the patient. (OP-2)*

Another major issue is that the legislative framework governing occupational medicine is considered "totally inappropriate" due to the direct contractual relationship between the employer and the occupational health physician, which creates a financial dependence and may affect the physician's impartiality. Besides these serious problems, HPs gave examples of contradictions in the law, such as those concerning night shift work for people with chronic conditions or pregnant women.

Deficient access and funding, but high bureaucracy

A major problem of the current legislative framework is the lack of proper rehabilitation services which are perceived as "quasi-non-existent" or "very difficult to access and expensive" (OccP-4). Usually, they are not reimbursed by the Health Insurance House on an outpatient basis. There is no state budget allocation for medical rehabilitation and although a legal framework exists in this respect, the waiting lists are long, often exceeding the duration of the medical leave. The situation is even worse for the psychological and vocational rehabilitation. The lack of funds and qualified personnel prevents the development of these services.

Another access problem, also linked to financial limitations, regards the screening programs, which are approved and funded by the ministry, yet they do not attract enough of the population due to the lack of a legal leverage to enforce participation. Low medical education of patients and financial scarcity complicate even further this situation.

HPs complain about excessive paperwork; too short medical consultations often interrupted by other patients; constant time pressure; unnecessary patients' revisions (such as for those with permanent work-hindering diagnoses); malfunctioning informatic systems; understaffed counties with only two social security physicians consulting too many patients daily; and a lack of integration between medical specialties due to non-integrated databases.

> *The system is… They created a software program for medical expertise that is of so low quality. Obviously, it is good to have an IT system, but it doesn't work well at all, and there is no possibility for support or upgrades. Because of this, and also for other reasons, it is sometimes easier just to give the patient a new appointment date [a.n., to call the patient for another assessment of their case, within the legal deadline]. (SSP-5)*

The duration of medical leave (up to 1.5 years for cancer or 1 year for other chronic conditions) is generally considered sufficient by the participants, but there are no levers to encourage return after this period. Some patients choose to retire due to the difficulty of finding adapted jobs or the lack of other financial alternatives. Thus, the current legislation rather encourages workers not to return to activity. Yet, the invalidity pension does not allow the wellbeing of the patients, as it is rather a "mockery pension" (OthP-1) that does not even cover the food needs of patients.

> *The current legislation encourages patients to think: "if I can retire, why shouldn't I?" (OthP-5)*

B. The impact of the current legislation

Impact on patients

Excessive bureaucracy and lack of clear information make patients feel lost in an informational chaos. Only few of them can deal with the informational obstacles on top of managing their disease. By failing to provide proper support, the current law creates financial insecurity and a lack of motivation to return to work, as perceived by the HP, and by this contributes to social isolation and stigmatization, perpetuating the perception that the disease means social withdrawal than recovery.

The rather symbolic difference between the third-degree pension and the second-degree pension discourages work reintegration, as the financial incentive to work part-time is weak if the pensions are almost equal. This, combined with a cultural mindset of giving up work ("if I can retire, why shouldn't I?", OthP-5), contributes to a significant loss of the workforce.

> *The current system lacks a holistic support for patients, and by this, I mean an integrated support that offers a wide range of services. We have insufficient and inaccessible rehabilitation services, the psychological support and social work is often absent in medical units where it would be most needed, there is a lack of home-based treatments, no support for families, and a lack of other essential services provided for these people in the community. (OccP-6)*

Impact on employers

The impact on employers seems to be significant according to the HPs' accounts. First, the lack of clear guidelines on job adaptation (accommodations), which also resulted from our desk analysis on policies, creates important difficulties for the worker. Second, some employers lack education and awareness on this problem and as a result they prefer not to hire people with chronic illnesses due to fear of decreased productivity, absenteeism, or potential work accidents. Because the law does not offer financial incentives, employers choose to pay penalties instead of hiring.

C. Directions for change

The subject of what changes are necessary to create a more supportive context for work (re)integration of PwCD was widely discussed by the participants. Many policy changes were suggested, some of them major, and sometimes involving various institutions.

Fundamental legislative reforms

Some of the changes suggested concern major reforms that should be done in several systems, such as: the clarification of disability and invalidity concepts and the unification of legislation on invalidity pensions and disability certificates, thus eliminating the current ambiguities and contradictions; the transfer of occupational medicine to the public health system to ensure the independence of doctors from employers and allow better control of service quality and compliance with legislation. In addition, this would enable data collection and real preventive interventions; modifications to the Labour Code to oblige or incentivise employers to care for employees with chronic illnesses and provide them with adapted working conditions (reduced hours, easier tasks, avoiding night shifts) in order to retain them at work; to have integrated support and rehabilitation services, reimbursed by the state, accessible to all patients.

Role of institutions and collaboration

HP consider that the ministries (of Labour, Health and Education) must collaborate and take responsibility for issuing integrated public policies. The County Employment Agencies (AJOFM-uri) "should be more proactive" (SSP-

4) in vocational guidance and reintegration, offering training courses adapted to the needs of PwCD and facilitating contact with employers. Social work services must be strengthened and equipped with qualified personnel and sufficient time to provide case management and real support for families.

> *Yes, for example, it would not be a bad idea for the medical unit to have a service with 2-4 psychologists and social workers, and maybe some other specialists to handle this aspect. It could be a service that is part of the oncology clinic. These professionals could focus solely on psychosocial support, as they would not have the limited time that doctors have. They could talk to the patient and explain everything the patient needs to know and understand. (OP-6)*

NGOs are considered "a powerful force" (OthP-4) and should be encouraged and supported to take on some of the support and reintegration tasks, especially in the absence of adequate public services. Yet doctors have very limited collaboration with the non-profit sector.

Education and awareness

Most HPs agree that much is to be done regarding raising the health education and awareness. The need for extensive medical education, starting from primary school, to combat fear, prejudice, and stigmatization related to chronic diseases, especially cancer was stressed as very important. Not only the general population should be educated, but also employers should be trained to value more the human resources and the potential of each individual. The creation of a package of information and suggested guidelines for human resources departments was recommended, in relation to the reintegration of cancer patients.

> *... but in Romania, there are still people who believe that if someone has cancer, it is contagious. I find this unacceptable. It is inexcusable not to speak to a colleague at the workplace because they have cancer, and this stems from a lack of education. There absolutely must be public health programs to educate people towards a better understanding of chronic diseases. (TP-4)*

Tools and resources

Several suggestions were made in this sub-theme. One major recommendation was to have a centralized portal/website to gather all relevant information (legislation, rights, support services) for patients, employers, and doctors involved in work reintegration after chronic diseases. Another one was to use toolkits for a correct assessment of the professional skills, thus allowing for work reorientation if needed. Third, the provision of qualified human resources for support (psychologists, social workers) was considered essential. Fourth, the development of condition-specific algorithms to guide the patient's journey from diagnosis to professional reintegration, for simplifying the access to services. Fifth, to have more vocational counsellors in the County Employment Agencies.

Discussion

The present article investigates the views of several categories of health professionals regarding the Romanian legislation for work reintegration of people with chronic diseases, analysed against a background obtained from desk research on Romanian policies. This investigation must be understood within Romania's broader socioeconomic and political landscape, characterized by chronic underfunding in public services, weak interinstitutional coordination, and legislative instability, which profoundly shape how work participation policies are implemented. The main contribution of this paper is that it offers insights into the Romanian policy framework for return to work, both an objective evaluation (through the policy report) and an experiential one (the interviews), which adds to the existing studies on the same topic conducted in other countries. Besides this, the paper brings important results which delineate a system with limitations and challenges.

The findings of this paper align with existing research, highlighting consensus on unclear roles, vague guidelines, administrative barriers, poor coordination between doctors and stakeholders, and disease-specific challenges that often hinder successful return to work. Many studies indicate that HPs in Romania face similar difficulties with the legislation on return to work, as reported by HPs in other countries or settings.

The combination of insufficiently defined roles and responsibilities and incomplete and unclear guidelines in law is considered the most severe and significant problem of the current legislation, not only in this study but also in other works (Désiron *et al.*, 2022; Kiasuwa Mbengi *et al.*, 2016; Magalhaes *et al.*, 2017; Tiedtke *et al.*, 2012; Zegers *et al.*, 2022). This allows for too much ambiguity, making some parts of the law impossible to use. Surprisingly, this deficiency is observed not only in countries with low resources and weaker health care and social security systems, but also in countries with better resources and a long tradition for return to work.

HP in Romania encounter similar challenges regarding coordination and collaboration with other stakeholders, as those in other countries, despite widespread acknowledgement of its importance (Hillborg *et al.*, 2013; Stergiou-Kita *et al.*, 2016). Poor communication between different categories of HPs (Anema *et al.*, 2002; Bains *et al.*, 2012; Saliba *et al.*, 2013) or specifically between two categories, such as occupational and treating physicians (Holwerda *et al.*, 2015) is recognised also by HP in our sample. Communication is perceived deficient also between HP and employers or other individual or institutional stakeholders, by our respondents, thus confirming findings from other studies (Bains *et al.*, 2012; Dorland *et al.*, 2016;

Tiedtke *et al.*, 2012). Against this background of uncoordinated communication, the patients serve as a link between professionals. For example, when a patient is referred to a specialist, the family doctor often receives no direct update unless the patient personally delivers the documents. This can lead to gaps in care, as the patient is already overwhelmed with the disease, or psychological, social and financial problems.

Administrative and systemic inconsistencies, as well as financial problems, are another major issue in the current legislation in many countries including Romania. The lack of coordination between social insurance and healthcare systems is observed also in other contexts (Ståhl *et al.*, 2011) and not only in Romania. The same is true for administrative burdens resulting from complex regulations (Kosny *et al.*, 2018; Schnitzler *et al.*, 2018) and for the high amount of paperwork (Maiwald *et al.*, 2015). Doctors in other national settings also report low resources, thus creating constraints on the work reintegration process (Kelaher, & Harrex, 2017; Maiwald *et al.*, 2015).

Second, this study contributes to the scientific literature in the field also by providing new evidence on some remaining points of contention among researchers such as doctors' competency to advice about work, on whether the legislation is a constraining or enabling factor for return to work, and the effectiveness of the individualized versus standardized approaches.

Participants in this study expressed mixed opinions about whether specialized physicians should include advice about work in their consultations. Most of them supported this idea and presented potential benefits, while some of them highlighted potential difficulties in doing this, for example the short time of the consultations. A comparable inconsistency persists in the literature, with certain studies indicating that treating physicians may lack expertise in providing work-related guidance (Tiedtke *et al.*, 2012), while others describe clinicians as knowledgeable advocates and authorities in this area (Dewa *et al.*, 2015). Although there are challenges, it is important for HP to bring up work-related topics as soon as possible to ease the patients' transition from diagnosis to work (*Petersen et al.*, 2017).

Themes were broadly shared across specialists, but their emphasis differed in ways consistent with their role in work participation pathways. Social security and occupational physicians most often discussed legal criteria, certification, and procedural requirements, given their proximity to formal work-capacity assessments and workplace-related documentation. Treating physicians focused on clinical trajectories and functional limitations. Family physicians highlighted longitudinal care and the coordination burden of paperwork across institutions, whereas other health professionals highlighted functional recovery and psychosocial barriers. The epistemic relevance of the data does not lie in treating HP accounts as exhaustive representations of patients' lived experience, but in using them as stakeholder evidence about how work-related legislation is interpreted, enacted, and operationalised in practice through everyday documentation, gatekeeping, and coordination practices; in this sense, variation in knowledge or engagement across professional groups is itself an informative finding, and not merely individual subjectivity. It signals role-specific exposure to legislation and to different segments of the patient's work journey, and procedural ambiguity and institutional gaps which could be problematic.

The present study examines the ongoing discussion about whether legislation serves as a constraining (Tiedtke *et al.*, 2012) or enabling factor (Zegers *et al.*, 2022) in work reintegration for persons with chronic diseases. Participants generally agree that, in its current state, Romanian legislation presents more challenges than support. The main reasons identified include the absence of methodological norms for certain laws, extensive bureaucracy, a lack of enforcement measures for non-compliance, and limited activation policies.

Regarding the tension between the individualised versus standardized approaches in work reintegration of PwCD, most respondents in our sample suggested that a more individualized approach, adapted to each case, would be more beneficial and necessary, yet the current legislation is often too rigid or deficient in allowing this. The same discussion is present in the literature, with Sjobbema et al. (2017) advocating for individualised approaches based on case-specific needs, while Björk Brämberg *et al.* (2018) argue for standardized methods of reintegration to ensure consistency. The individualised approach is important in the view of the respondents in this study because it would better respond to disease related characteristics and individual needs. Also, it will allow for customised psychological support and accommodations at the workplace. Instead, the current law imposes rigid criteria and regulations on all patients.

The strengths of this study include the use of mixed methods that allow the exploration of the health professionals' views against an analysis of the existing policies, the variety of health professionals interviewed, and the inclusion of the Romanian context in the literature on this topic. One limitation is the size of the sample (not having HP from other parts of the country).

Conclusions

The study examined two elements of the dynamic triade consisting of the worker with a chronic condition, the health professionals (doctor, psychologist or social worker) and the relevant legislation. The analysis presented in this article was informed by a comprehensive desk analysis of the Romanian policies for work reintegration of people with chronic conditions and by 33 interviews done with health professionals of different specialties. The data show that health professionals struggle with the current legislation due to unclear roles, responsibilities and guidelines. The inadequate coordination among health professionals and also with other stakeholders (employers, employment agencies, non-profit organisations) significantly limits the success of the return-to-work process and poses an additional burden on workers. While health professionals suggest that changing this situation can be done only through a major reform of the medical and social security system, and through investing in education, they also suggest other possible changes, easier to accommodate.

Notes

[1] In the Romanian legislation, these physicians are called *the social security expert physicians.*

[2] *Community participation for reducing the burden of cancer: stakeholders' involvement in facilitating the return to work of cancer patients.* Project website: https://sites.google.com/a/ulbsibiu.ro/adela-popa/pn-ii-ru-te-2014-4-0478. Project ID: PN-II-RU-TE-2014-4-0478. Funded by: The Romanian Ministry of Education, CNCS-UEFISCDI. Contract no.: 363/1.10.2015. Project director: Adela Popa.

[3] *The challenges of returning to work after chronic illness in Romania: barriers, facilitators and collaboration of stakeholders.* Project website: https://sites.google.com/a/ulbsibiu.ro/adela-popa/cercetare/chronic-conditions-and-work-project. Project ID: PN-III-P4-ID-PCE-2020-1384. Funded by: The Romanian Ministry of Education, CNCS-UEFISCDI. Contract no.: PCE 154/16/02/2021. Project director: Adela Popa.

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