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Covid-19 trouble at work: A comparative qualitative analysis of disclosure, sickness absence and return-to-work in the UK, the USA, Australia and Japan

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ABSTRACT

This paper addresses working people's narrated experiences of managing covid-related sickness in relation to employment. Bringing together the sociology of chronic illness and disability, and of work and organisations, we contribute to understandings of Covid-19 experiences in the context of employment. We draw from interview studies of Covid-19 infection and recovery in four countries, the UK, the USA, Australia and Japan. This cross-country comparative qualitative approach enables us to suggest how macrostructural regulatory and policy environments, and micropolitical environments of social interaction and moral evaluation shape paths between disclosure to employers, sick leave-taking, recovery and return to work after Covid-19 infection. For many of our participants across the four countries – especially those lacking in job security – this path was not straightforward, entailing intertwined moral and material risks. We draw out wider real-world implications, with regards to precarious work and limited governmental safety nets, and sociological implications in terms of un-flattening our analyses of how people encounter and dispose of trouble at work.

1. Introduction

This paper addresses working people's narrated experiences of managing Covid-related sickness in relation to employment. This issue is of global concern, as paid sick leave policies covering the period of self-quarantine needed to restrict the spread of pandemic diseases, and the longer-term care needed for severe illness, are far from comprehensive across the countries of the world, or across different classes of workers (Heymann et al., 2020). We explore people's accounts of negotiating Covid-related sickness at work across four countries – the UK, the USA, Australia and Japan – enabling us to explore how macrostructural and micropolitical environments shaped people's paths between disclosure to employers, sick leave-taking, recovery and return to work following a Covid-19 infection. For many of our participants across the four countries – especially those lacking in job security – this path did not run straightforwardly, entailing moral and material risks which, we show, are intertwined.

Following from the classic concept of the "sick role" (Parsons, 1951), medical sociology has had long-standing discussions of the rationalization of health under capitalism, enabling understanding of how in capitalist regimes "health becomes a commodity like other commodities in the marketplace" (Turner, 1987, p. 172). In spite of these seemingly foundational insights, analyses of sickness in the context of employment have been few and far between. Ruth Pinder's (1995) study of chronic illness in workplaces is a notable exception. Her analysis of women's accounts of working alongside arthritis showed how the invisibilised and taken-for-granted functioning of the body in the workplace was troubled by their fluctuating symptoms. The women were charged with

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the task of "establishing trust or repairing trouble, which in turn highlights the differential ability of individuals to 'run with' ambiguity and disturbance, and of organisations smoothly to dispose of it" (1995, p.607). This work has been very generative, with Hall (2005) appreciating Pinder for illuminating how "employment is a bodily practice" (p.141) and how employees are "capable of and limited in, by their bodies, certain types of work" (p.148). However, certain sociologically flattening aspects to Pinder's analysis have also been criticised. Qureshi (2019) observes that Pinder "does not explore what might equip particular people to 'run with' ambiguity or of which particular organisations are able to dispose of it" (p.137-9). Similarly, Werth et al. (2018) note that "researchers who examine chronic illness in the workplace tend to focus on the disadvantaging effects … but not specifically on the role that power plays in their experiences" (p.172). This taps in to wider conversations in medical sociology about the need for analysis of chronic illness to be more politically engaged, taking the cues from disability studies' central insights regarding ableist oppression as the root of disadvantage (Thomas, 2012; see Scambler & Scambler, 2016). In this paper, drawing on Pinder, we take forward the focus on the trouble that illness creates in workplaces, and how this trouble is disposed of; which help to further our understandings of Covid-19 experiences in the context of employment. However, we also keep a close eye on the conditions for worker agency, in different contexts, in negotiating Covid-19 sickness in relation to employment.

In contrast with medical sociology, in the sociology of work and organisations there is extensive attention to micro-political interactions, wherein sickness absences are shown to be mediated by social interactions and moral evaluations. This has been elaborated upon in studies of disclosure of sickness or injury, and associated stigma (Francis et al., 2014); whether employees claim sickness leave or not (Grinyer & Singleton, 2000); and the bureaucratic "system problems" wherein compensation claims may become tortuously prolonged, giving workers a "toxic dose" beyond the initial injury (MacEachen et al., 2010). Studies also note the embodied harms of over-extension that may result from early returns to work (MacEachen et al., 2007), and the significance of social relations with co-workers and managers in shaping experiences of return (Tjulin et al., 2011; Werth, 2015). Collectively, this research provides insights to the *moral and material risks* entailed by ill health in the context of employment. However, it encompasses very disparate states of ill health and occupational injuries. In this paper, we angle relevant perspectives from this work towards Covid-19, which has several specificities as an illness. Covid-19 may be acquired through workplaces, particularly in-person and public-facing employment in sectors declared "essential" during the pandemic (Koh, 2020). As with other infectious diseases subject to epidemic controls – like SARS, H1N1 and Ebola (Kavanagh et al., 2012; Rothstein, 2015; Rothstein & Talbott, 2007) – people may be absent from employment not only when ill, but also when exposed and obliged to quarantine. For some, Covid-19 entails acute periods of ill health requiring temporary sickness absence, whilst others manifest chronic symptoms known as Long Covid, and need longer-term leave or become incapacitated (Murphy, McDowall, & McDowall, 2022).

Sociological research on work and organisations has also attended to the ways in which sickness absence is shaped by macrostructural regulatory and policy environments. It highlights tendencies whereby worker compensation systems "across jurisdictions have worked towards a system of early return to work which reduces workers' time on income replacement benefits and places them back in the workplace before they are fully recovered" (MacEachen & Kosny, 2016, p. 225). In bringing together participants' accounts from four countries, our study adds insights by illuminating country-level specificities shaping sickness absence in relation to Covid-19 infection. The four countries differ in their Covid-19 responses. In the UK and the USA, fast-paced transmission in 2020–21 precipitated intense control measures targeting citizens' behaviour, locking down the economy and social life, with drastic impacts on employment. In the UK, the government responded with loan guarantees, grants and tax relief to prevent bankruptcies; a job retention scheme to avoid redundancies; and direct income support to the self-employed (Jasanoff et al., 2021, p. 97). In the USA, the government provided stimulus packages to raise economic demand and provide relief to the unemployed, providing $2 trillion to households and companies to retain their workers on payroll (Jasanoff et al., 2021, p. 102). By contrast, Australia responded quickly to the pandemic via border controls and stringent national lockdowns in early 2020, followed by state/territory-level lockdowns, with "even the smallest single-digit community outbreak … lead[ing] states to adopt strong measures" (Jasanoff et al., 2021, p. 35). The federal government injected substantial funds to alleviate economic stress, including funds to encourage businesses to keep employees on payroll and a temporary boost to unemployment benefits (Jasanoff et al., 2021). Japan's response did not include strict lockdowns, instead relying on individual and organisational responses. Policies were devised in a gradual and ad-hoc manner, considering epidemiological, economic, political and social concerns. The government approved extra budgets including stimulus packages to incentivize demand, and one-off stipends for residents, small businesses and freelancers (Jasanoff et al., 2021, p.69-71).

In relation to sickness absence regulations and policies, the four countries differ in their mix of statutory, corporate and private forms of income protection for workers during sickness absence; in eligibility across different tiers of workers; and in additional provisions introduced during the pandemic. Australia has the most expansive national safety net of the four countries, followed by Japan, the UK and last of all the USA (Rho et al., 2020, p. 5). The USA is a global anomaly among high-income countries in lacking any national paid sick leave policy up to the onset of Covid-19 pandemic, with even unpaid leave via the Family and Medical Leave Act often inaccessible (Heymann et al., 2021). This led to Congress passing sick leave provision at the federal level for the first time in March 2020, with the Families First Coronavirus Response Act providing up to two weeks of paid sick leave and family leave for Covid-19-related reasons for employees in firms with fewer than 500 employees; however, this temporary measure expired in 2021 (Jeliffe et al., 2021).

The differences across these four country contexts therefore give us an opportunity to explore the role of macrostructural factors in shaping individual negotiations of Covid-related sickness absence. Simultaneously, we attend to differences within the countries, examining how the occupational sectors in which participants work, and their job security influence sickness absence processes – aspects of participants' labour market positioning which relate to underlying gender, race/ethnicity, age and disability inequalities (Cunningham-Burley et al., 2006; Kosny et al., 2012; Mackenzie, 2014; Qureshi et al., 2014). This capacity for illuminating between-as well as well as within-country specificities is a strength of our cross-country comparative qualitative analysis, the methods of which we now go on to detail.

2. Data and methods

This paper draws from four country-level studies separately undertaken using DIPEx methodology (Ziebland et al., 2021), a qualitative approach to systematically elicit and analyse maximally heterogeneous perspectives on aspects of health experience, in this case experiences of Covid-19 infection. Whereas cross-country comparative research is dominated by quantitative studies and policy analysis, qualitative approaches can add greatly to our understandings of health and illness, with evidence from cross-country studies "show[ing] that things could be otherwise, challenging our assumptions about the rationality and inevitability of our own taken-for-granted systems and behaviours" (Chapple & Ziebland, 2018, p. 797). From the network of countries in the DIPEx International collaboration in which interviews on Covid-19 infection were undertaken – which are analysed in a comparative approach in this Special Issue – we focused on the UK, the USA, Australia and Japan because these countries had rich data on employment

experiences.

The interviews were conducted between 2020 and 21 across the four countries. In accordance with the DIPEx methodology, all four countries shared an approach to interviewing that began with an open-ended question inviting a participant to share their own personal narrative of Covid-19 infection, followed by semi-structured probing questions developed initially by the Australian team. These questions addressed the ways in which Covid-19 had affected participants' health and wider aspects of their lives. Employment was one of the areas we probed about, but it is important to note that the interviews were very wide-ranging and aimed to cover as many aspects of experience as the participants were willing to explore.

The studies were not designed primarily to explore employment, but all four country teams aimed to capture maximally heterogeneous experiences, in terms of severity of Covid-19 infection and in terms of participants' social positioning, meaning that each country sampled across working and retirement age and employment status. The UK study from the outset had an explicit focus on inequities, given that unequal impact of the pandemic had been made visible through nationally collected data early during the pandemic (Public Health England, 2020). Recruitment materials and pre-interview conversations noted special interest in learning about diverse experiences across occupation, race/ethnicity, geographic location within the UK, gender and age. The USA and Japan teams aimed for maximum variation, whilst the Australia team adopted a convenience-based approach due to the small numbers of infected people in the country. For the analysis in this paper, we included the interviews with non-working participants, since they often offered illuminating employment-related narratives in relation to their family/household members. In addition, some non-working participants had transitioned into retirement, volunteering or unemployment during the pandemic, and offered relevant accounts of how Covid-19 had played into those experiences.

Participants were recruited through multiple channels: across personal and professional networks and relationships, using word-of-mouth and social media; through our research networks, by rekindling contacts made through our earlier research projects; through connections and snowball chains across participant networks; through study posters, leaflets and newspaper advertisements; and through purposive mapping and contacting individuals and organisations identified via internet searches, for example trades union representatives.

Across the four countries, our recruitment channels led to an over-representation of health system workers – a fifth to a third of our participants in each of the countries. This is a heterogeneous category including healthcare workers directly involved in patient care as well as desk-based health service administrators and public health professionals. This high representation of health system workers has implications for the analysis that follows, as those directly involved in patient care were often subjected to strong infection control regulations and expectations in their workplaces. This was not always the case however, particularly during the earliest phase of the pandemic, when there were significant shortages in personal protective equipment. In the analysis that follows, we make explicit where we perceive specificities to health system workers due to their sector of work. Given that health system workers, however, encompass wide variations in in-person vs. remote working capacity, and variations in job security – which we highlight as factors shaping sickness absence experience – this over-representation does not invalidate our analysis.

Table 1 summarizes the participant demographics in each of the four countries. As this Table illustrates, the sample sizes are uneven, with the UK study the largest and the Australia study the smallest. This disparity in sample size is one of the many challenges of cross-country comparative qualitative analysis (see Chapple & Ziebland, 2018). Despite the differences in sample size, the following analysis reflects the range of experiences reflected within as well as across the four countries. The analysis was not, therefore, driven by any one country. Each country team completed their own autonomous within-country analyses in the original language of the interview using a coding structure developed partly from themes from the topic guide, and partly from themes that we developed during early data analysis. To build the cross-comparative analysis reflected in this paper, we held a series of online engagement sessions, which led us to design a data matrix to which all country teams contributed. This data matrix enabled us to identify similarities and differences from within our respective within-country analyses. At further online sessions, we reflected together on the broader macro-structural contexts underpinning the similarities and differences reflected in our data. The analysis is not then a collage across the four countries, but rather, pulls out the themes that are comparable and resonate, with depth and richness; as well as explores the nuances suggested by differences within and between the countries. Our intent is to conceptualise the employment troubles raised by Covid-19 infection, shaped by the specificities of the context to the employment, which are unpacked below under three main themes.

Table 1
Summary of participant demographics.

Country	Age	Gender	Self-identified race/ethnicity	Employment status
UK (N = 70)	20-29: 4 30 – 39: 19 40 – 49: 18 50-59: 19 60-69: 8 70-79: 2	Female: 45 Male: 24 Non-binary: 1	South Asian: 22 Black: 13 Orthodox Jewish: 4 East Asian: 4 White: 17	Retired, unemployed, homemaker, student, unknown: 20 Employed: 50
USA (N = 25)	20-29: 1 30-39: 2 40-49: 6 50-59: 8 60-69: 5 70-79: 3	Female: 21 Male: 4	Asian: 1 Arab-American: 1 Black: 21 Hispanic/Latinx: 4 Mixed race: 1 White: 17	Retired, unemployed, unknown: 5 Employed: 20
Japan (N = 14)	20-29: 1 30-39: 2 40-49: 2 50-59: 6 60-69: 2 70-79: 1	Female: 7 Male: 7	Japanese: 14	Student, unemployed: 1 Employed: 13
Australia (N = 8)	20-29: 0 30-39: 2 40-49: 3 50-59: 0 60-69: 1 70-79: 2	Female: 5 Male: 3	Australian peoples: 2 British: 3 European: 3	Retired, volunteering: 4 Employed: 4

3. Findings

Our findings focus on three main themes or areas of participant experience which resonated across the four countries: disclosure to the employer, sickness absence, and return to work. Fig. 1 illustrates the relationship between these three areas of experience, toggling them as key points along a journey, the path of which is not straight but meandering, as each participant navigates their own specific journey, with difficult choices alongside.

3.1. Disclosure of Covid-19 infection at work

Across all four countries, the strong public attention focused on the pandemic meant that overwhelmingly, participants described openness in informing the people they worked with and for when they thought they might have Covid-19. Priya in the UK, a security desk operator, said her co-workers were the first people she contacted when she suspected she had Covid-19: "I told my work, all knew … the whole of my office knew". Linda, a nurse from the USA, described calling in to work as an inevitable part of her diagnosis journey: "something didn't feel right. So, I called my boss, and I went in for testing". This openness was linked to pervasive moral expectations that they should not risk infecting others. These expectations appeared particularly pronounced for health system workers like Linda and Sally, a nurse in Australia: "I thought that, to be on the safe side, I should go and get tested. So, I was due to work. I called in sick and explained what my plan was, and headed off". Whilst workplace disclosure was a way of being "on the safe side", it was not straightforward for all our participants, however, bringing out several troubles at play: the trouble of withdrawing one's labour; the trouble of others' labour being withdrawn due to exposure; ambiguity about where the responsibility for Covid-19 infection lay; and violation of privacy. These troubles were shaped by nuances in terms of the setting and the choices available.

A unique aspect of Covid-19 is that close contacts of a positive case were also required to self-isolate. Penny in the UK, a midwife in her 50s, was conscious of the disruption that her positive Covid test would cause to her co-workers, in requiring them to isolate at home:

> Of course I had to tell my workplace, so they were all, you know, really a bit twitched [um]. There was, one of them waiting to go on holidays, [um], so everyone was all on tenterhooks, you can imagine it was terrible.

As suggested by this excerpt, part of the trouble brought by Covid-19 was a sense of feeling personally responsible for others having to quarantine. Simran in the UK, a childminder in her 40s, used very explicit language of guilt when talking about disclosure to the parents of the child she was looking after at her home in the days running up to her positive test:

> You do feel, I don't know, I don't know about other people … [pause] do you need to feel guilty about it? Because I don't know … [um] Sometimes it was like 'oh God it's because of me she has to isolate', kind of a thing.

For other participants, the notion of personal responsibility for their Covid-19 infection had been suggested to them by others in their workplaces, in ways that felt problematic. John in Australia, a research assistant, described how his primary concern was with the health of others in his workplace, whereas his employer's immediate response – to express a concern tracking down the source of the infection – felt to be punitive and to violate his privacy:

> So I got a phone call and I was told that I was positive. So I remember it quite vividly, it was a Saturday early afternoon and my immediate reaction was to ring everyone that I'd been in contact with and to let them all know. That was my immediate reaction, was concern for everyone else. There was one little [negative thing] – so, I had rung my boss, and at that point in time, I was more just concerned about letting everyone know, but he then asked me, where did I get it from.

The interview with Seiji in Japan, a part-time driver in the public sector, who had no permanent contract, reveals underlying conditions regarding the smooth disposal of the various forms of trouble entailed by notifying the workplace of a Covid-19 infection. Whereas the participants quoted above felt sufficiently secure to inform their employers, Seiji refrained from reporting his positive test result because he feared the "trouble" for his co-workers that would result – as he put it in precise words – might lead to his dismissal.

> While I was waiting for the test result, I thought that if the result came back positive I would cause a lot of trouble to the company. So, preparing for the worst case, I asked the company for a long leave until January 9th and got the approval. // The following Monday, I received the positive result from the local health centre. I still had some fever and felt disappointed of the fact that I was Covid positive. Since I had already told the company that I would take a long leave till early in the New Year … and I was confident that there were no close contacts in the workplace, and with dismissal due to "corona harassment" crossing my mind, I just couldn't tell the company about the infection. I now feel bad about not telling the company.

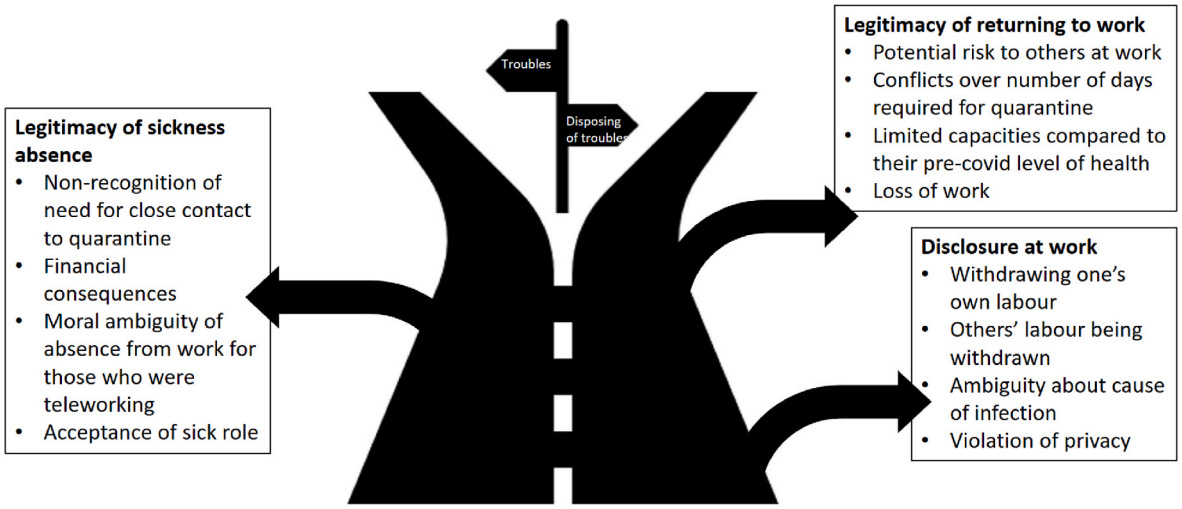

Fig. 1. Covid-related troubles at work, and disposing of them.

Seiji eventually lost his job after he filed a claim for salary compensation for his Covid-related absence, because of which the company learned about his infection. The company cast him as irresponsible for not reporting his infection. However, as the extract above suggests, since Seiji was confident that he had not infected his colleagues, he felt it was more important to avoid causing trouble to his colleagues and to the company, by requiring that his co-workers should quarantine and be absent. This account suggests how the capacity to inform one's employer about Covid infection may be impeded by a lack of job security, his concerns about dismissal piqued by being a "contingent worker" (Facey & Eakin, 2010). The ways in which different tiers of workers are able to dispose of Covid-19 related trouble are developed in the following section on sickness absence, which further illuminates the significance of cross-country differences in paid sick leave policies and procedures.

3.2. Legitimacy of sickness absence

Across all four countries, the strong public attention focussed on the pandemic did not mean that the need for Covid-related absences was always recognised. Several Covid-related troubles were at play for our participants: controversies over the need for close contacts to quarantine; the financial consequences of absence, in the context of uneven paid sick leave policies and procedures; the moral ambiguity of absence from work for those who were teleworking; and the acceptance of the sick role by participants. Following from the previous section on disclosure, we found some participants describing controversies at their places of work whereby employers disputed, or were annoyed about the need for close contacts to quarantine. Kasumi in Japan, a college faculty member, described a punitive response from her superior, who demanded she apologize for the inconvenience she caused to others who had to take time off to quarantine. Using the exact word "trouble", Kasumi reflected that:

> I don't think it's right to demand apologies from someone who took time off in your workplace for causing trouble to others … // [Someone in the workplace] might get into a traffic accident, or might take time off due to illness, or might have to attend their family who has fallen ill. People with various circumstances and backgrounds work in the workplace. Society is made up of such people.

Similarly, Sally in Australia, the nurse practitioner introduced above, described how her husband clashed with his employer over the need to quarantine. Although he had been the close contact of a positive case, his employer did not support his request to stay away from work. This was in March 2020, a time when Covid-19 absence policies in Australia were not well established, and cases were few in number but shocking. Sally described her husband's employer placing numerous burdens of evidence upon him in order to justify his absence from work, evidence that he could not produce as he did not want to leave the home to get a legal affidavit signed. Adding to this "toxic dose" of "system problems" (MacEachen et al., 2010), further confrontations ensued when he declined to disclose whom he had been in close contact with, out of the privacy concerns which we noted above were widespread; leading to his eventual involvement of his union, to negotiate with his manager on his behalf.

> My husband's employer was difficult. They, um, wanted him to provide a stat[utory] dec[laration] about his, um, inability to come to work, and obviously, he couldn't provide a stat dec, because he couldn't leave the house to go and get a stat dec signed. Um, and they wanted to know who his exposure had been to, so, um, he obviously didn't want to disclose who it was that he was a close contact with, um, so that made it very difficult. Um, and in the end, he had to get the union – his union involved, and to go above his manager to a higher level, to try to say, you know, you're asking completely inappropriate things.

In relation to participants' own Covid-related sickness too, the claiming of financial compensation was concerning for many participants. Accounts of accessing paid sick leave diverged between the four countries. In Australia, accessing paid sick leave was straightforward for the participants, because paid sick progressively accumulated from the first day of work and was paid at 100% of normal income (Rho et al., 2020). Research assistant John did not experience accessing paid sick leave to be problematic, in the context of the long service he had given to the organisation: "because I'd been there so long, I had accrued a lot of sick leave and I had had 250 days sick leave". By contrast, in the other countries many participants were concerned about pay cuts due to sickness absence. In Japan, sick leave encompasses two thirds of the regular salary (Rho et al., 2020). For nurse Ikue, it was preferable to use up her annual leave rather than use the sick pay that was extended to Covid patients and close contacts: "we can receive only 60% of our salary. So, the company asked us to choose between using that system or using my annual paid leave which I can get 100% of my salary". In the UK and USA narratives about difficulties in accessing paid sick leave were especially abundant, these being the countries in our study where paid sick leave provisions are most limited (Rho et al., 2020). In the UK, participants eligible for sick pay accessed one of two forms: Occupational Sick Pay paid by the employer, for a set number of days and often paid at a relatively high percentage of average wages, or Statutory Sick Pay, which is paid at one of the lowest average wage replacement rates in OECD countries (Patel et al., 2022). The scant level of Statutory Sick Pay led Manuela and her co-workers at a disability charity to confront their employer when that was all they received beyond the first 14 days. To dispose of this trouble, they approached their trades union to protest the employer's decision, and were successful in accessing full pay for the full period:

> They were going to pay us Statutory Sick Pay or a minimum of, and I had to stay off after that, I had to stay off another you know nearly 14 days but it wasn't. In total I was locked in my flat for 21 days … // And after that period my employer, obviously, didn't want to pay us like the full pay. They wanted to pay us the Statutory Sick Pay. Statutory Sick Pay is awful. It's like £70 or £80 a week. That doesn't even cover our rent … // … [So] we grouped together and we went to our union together.

Further, in the UK there are numerous categories of workers excluded by Statutory Sick Pay, including self-employed people and those on casual or flexible contracts whose income falls below an eligibility threshold (Patel et al., 2022). Patience's husband was working on a zero-hours contract, and went to work whilst feeling unwell with classic Covid symptoms:

> My husband works with this contract, what do they call it, zero hours, so if if you don't work, you don't get paid, period. // He was more taking risk I suppose and we saw what happened. // I think he was in denial so he did, until today he would say "I didn't feel that". Well, I know, I was [observing him], he didn't, didn't eat.

In the USA, only a few of the participants had paid sick leave to cover their illness absence. Linda, the nurse, said she felt "lucky" in being paid for the first two weeks of her sickness. However, when she was out of work longer-term, she too got behind in her bills. Health system administrator Miguel had access to up to 10 business days of paid leave under Covid-19, but similarly, described a significant financial impact: "my Covid pay was capped, [um] which I did not know … So, it made almost like a 50% reduction to my paycheck".

Related to the material aspects of claiming leave, the moral aspects of claiming leave were also concerning for many participants. In the context of her more than 14 days of sickness absence due to Covid-19, midwife Penny in the UK described her moral quandaries over

remaining on sick leave, feeling personally confronted as someone who rarely called in sick:

> It's that guilt of having to phone into work and say "I'm still not very well." It's awful, because I don't, don't *ever* take sick time. [Um], and I, you know, was saying "I'm really sorry, I'm really sorry", and that's how you feel.

By contrast with Penny's in-person healthcare work, for others, teleworking seemed to create liminal spaces of simultaneous fitness and sickness, where it became possible for participants to keep working, as they were not exposing co-workers to infection. This liminality – of being not fit, but not sick – was described extensively in the USA, where many participants described soldiering on with work through the infection. Health system administrator Miguel wondered whether worked throughout his acute illness had put him at risk for Long Covid:

> There was a point eventually where I had exerted myself so badly that [um] it got so bad that I basically couldn't do anything. [Um] And that's when I wanted to kick myself. And I don't know why I did that to myself. It was [um]–I guess I kept thinking that I was strong, and that I could keep going, and I could– I was resilient, and I was tough, and "I can work, and go to school. And I can fight Covid, right?" [laughing] Being naive, of course, and [um] certainly that wasn't the case, right?

Some teleworkers felt fortunate in their ability to keep working through Covid infection rather than risk losing employment, cognizant that not all have this option. Isabel in the USA, who worked within the public health system, said she felt "very privileged in having a job that allows me to still work while I'm recovering …//It really made me just feel very humble. [Um] That so many in our community just did not have that opportunity". Similarly, Kim in the USA said she felt "really lucky that I was able to work from home during that time. Otherwise, I must have lost that job". Widespread layoffs had massively increased Kim's workload, however, leading to her sense of being *less* fortunate – in other regards – than the rest of her team, who had been furloughed. She pointed out that even if the limited period of the furlough led to financial difficulties for her colleagues, furlough had freed them from the pressures of work, whereas she was left shouldering a huge workload whilst sick:

> Right after the lockdown began, a lot of companies furloughed a bunch of people, and most of the people in my team got furloughed. Again, I was [laughs] left alone to take care of a lot of work. [Um] So, even though I was sick, I was trying to kind of hypnotize myself and like try to think of myself like, "I'm okay, I can do this", you know, kind of thing … I was trying to push myself. But again, I don't know. It could, because I've done that, I still have my job, which I love [laughs] … This might sound really annoying to the people who were furloughed and who were in financial difficulties, but I was like thinking, "oh, I should have been furloughed".

As suggested by the extracts in this section, "contingent workers" (Facey & Eakin, 2010) across the countries were impeded in negotiating sickness absences. Desk-based office workers were privileged in negotiating continued pay, but disadvantaged in often submitting themselves to the harms of presenteeism. There appeared to be further differences across the countries due to the specific provisions for paid sick leave. The following section addressing participants' narratives of return to work following Covid-19 takes forward the cross-cutting influence of job security on the smooth disposal of Covid-related trouble at work.

3.3. Returning to work

Across the four countries, participants expressed significant concerns regarding the matter of returning to work. The Covid-related troubles they faced included navigating whether they could still be a risk to others at work; conflicts over the fixed number of days in mandatory self-isolation periods, when symptoms exceeded them; their limited capacities compared to their pre-Covid levels of health; and possible loss of work. Kumi in Japan, a musician, commented on the social pressure she sensed against returning to work on the grounds that she might still be infectious: "I felt the pressure that I was not allowed to come back unless the PCR test came back negative". Disability support worker Manuela in the UK described conflict with her employer, over their insistence that she return to work 14 days into her sickness. Whether or not she still had the virus in her body, Manuela felt unwell at 14 days:

> There was this controversy of "ah no, like, you can come back to work because this is a false-positive" [laughs]. Ah, but "okay, it could be a false positive but I am not strong, you know I am not strong to go back to work. Why are you forcing me?". And I had a lot of arguments with my bosses.

Beyond the acute sickness, the significant and prolonged impact of Covid made for difficulties in resuming work, when chronic symptoms undermined participants' capacities to fulfil their job roles. Danielle in the USA kept delaying her return to work at a local bar: "I couldn't hardly [laughing], hardly walk up and down the stairs at my apartment, let alone going back to the bar". In Australia, Mike's brain fog symptoms made the computer-based parts of his job role very challenging. He described having to learn to pace himself:

> You need to be able to find the level where you can perform ongoingly, and pace yourself out, and you need to – no matter how well you feel, you need to remind yourself, "okay, I feel really good today, but I need to maintain that", because as soon as you go, "I feel really good, oh, I'm going to do something up at this energy level" – and then, oh, surprise surprise, tomorrow, you're going to need to take a day off.

The participants' accounts diverged in describing their employment trajectories with chronic symptoms or Long Covid. Some participants' employers enabled adaptations around their reduced capacities. In Japan, Sadao, an office worker, was given permission to telework until his health improved: "I went back to work, but I worked at home during October. The company proposed teleworking for the rest of October, so it was November when I returned to the office". The supportiveness of managers and co-workers was important in participants' accounts of return to work (see Tjulin et al., 2011; Werth, 2015). In the UK, accountant Neerja's employers were supportive even though her symptoms had gone on for months:

> I am still taking it easy you know, one day if I feel tired I am telling my manager, "not feeling great today", you know, "can I just take a half day off" and he says "yeah that's absolutely fine". So they are very, very supportive [um] and because, the year end is really busy as well, but they are very supportive and if I want to take a break I just tell them "no, today is not my day. Just wanna take a break not because of my anxiety or anything but because I am generally feeling tired".

By contrast, social worker Morag felt that her manager was dismissive of her symptoms:

> You want to be a really good team player and [um] do and you do the work that you were able to do, [but] while I was in recovery, I could I could not do it. I couldn't do it and see I had I had a bit of brain fog as well. So I remember mentioning to one of my managers that I couldn't do the report that she was asked me, because I couldn't remember … and her response was, "oh well, doing the report will help with your brain fog." And I just found, I just found that it was just a really unsympathetic world.

The capacity to smoothly request and receive accommodations appeared to be a privilege especially afforded to workers with job security. By contrast, some "contingent workers" (Facey & Eakin, 2010) we spoke to described feeling compelled to return to work when they

were not well enough, for fear of losing their job. In the USA, Laura described not feeling able to be open with her manager: "I'm a little bit hesitant to get into too much detail". She worked at a college book store, but her work was significantly seasonal, with no guarantee of return. She felt in a way fortunate that she had gotten Covid-19 during her unemployed season. Nonetheless, her Long Covid symptoms limited her capacities when she returned to work, making her reticent about returning in the heaviest month in terms of the workload - whilst also unable to turn down the offer of work due to the stipulations of unemployment benefits in the USA. She described feeling ambivalences and pressures on all sides:

> The way my job is set up is I'm not guaranteed to be called back. So, I'm always a little nervous about giving them too much reason to say that I can't handle the job … // If you're offered work, and you don't accept it, it can interfere with unemployment. I'm, you know, coming up, they asked me if I wanted to come back early in December instead of just January and do part of the job that is a lot more physical. And honestly, I don't think I could handle it, partially the pain, partially the exhaustion. And I'm, you know, nervous about how I'm answering those questions.
>
> Q: Yeah. So you want to decline, but you don't want to have to say why.
>
> Well, I would love to not decline, actually! I'd love to be able to make some money.

Brynn, also in the USA, had a similarly punishing experience in her car sales job. She described how she had returned to work out of a fear that otherwise, she would lose her job, compounding her worries about finances triggered by her husband's retirement. She went back to work after two months, but described how uncompromising her manager was, and how the work was undertaken at an immense cost to her physical and mental health.

> [When I returned to work] I started at four hours, and they said I had to work eight hours, and I actually kind of battered my doctor in going back [laughing] because I was afraid I was going to lose my job. And husband was going to retire [that] summer, and he did, but not the way we thought it would happen, so kind of worried about finance and all of that … But they kept threatening me, and I was having, I didn't realize it at the time, but I was having panic attacks … The Covid was just, the emotional and the physical and the mental part of it [um], but I, finally I did walk out, basically just because I thought I was losing my mind and I was ashamed of myself.

As the extract above suggests, Brynn ended up "walking out" of the job. She did this amid a conflictual situation at work, and after having a significant physical and mental toll exacted from her because of the lack of appropriate support at work, such that this did not feel like an especially empowered situation. Across the four countries many participants disposed of the trouble of their reduced capacities by leaving work. In the USA, Miguel resigned from his health system administration job, seeing this as a simple prioritisation of health over work: "I got so sick that I don't think anything really mattered anymore. I think it was more 'I just need to get better. I want to get better, and I need to get better', right?". Other participants echoed Miguel's casting of the decision not to return to work as an unambiguous prioritisation of their health. However, when health insecurities were compounded by a lack of job security, we also saw accounts of people being *forced* to leave work. John in Australia narrated conflict at work precipitating his dismissal. A research assistant in a fixed-term role, he believed he had contracted Covid at the hospital where he worked, and had raised this concern with his manager, but his concerns were disregarded. Following this confrontation, his contract – which had been renewed annually for many years – was not renewed. He spoke angrily about the business not valuing his service and inhumane treatment:

> It was a heartless, horrible thing to go through. It just made me feel like after giving 20 years of service to that employer, that to be treated like that was just so mortifying. It really annoys me that they put business ahead of health. // They were calling me every 10 minutes, leaving a message one time and then repeating, trying to call me, trying to talk to me without leaving evidence of what they were going to say. I didn't need that at that time, I just needed to be left alone and then once I was better to deal with everything, but they just frustrated me even more. For them it was always about, "oh no, it's going to look bad for the business name", they didn't care about me.

He had recently made a complaint to the relevant government work authorities in Australia, but had clearly been shaken by the experience, questioning if he would ever work again:

> My future worries me a little bit, about whether I can get back to what I was before and whether I can do things that I was doing confidently before. Of course, having lost my job as well and now looking for another one, I question myself as to whether I can do what I was doing before, as efficiently as I was doing it before.

In light of these excerpts from the four countries, we now return to the issues raised in the introduction, to take stock of the moral and material aspects of Covid-related trouble at work.

4. Concluding discussion

As these excerpts indicate, participants' accounts of negotiating Covid-related trouble at work suggest many resonances with existing sociological work. Our analyses demonstrate the need to attend to the conditions for worker agency in negotiating their need for sickness absence, at the macrostructural and micro-political levels. We also perceive how the conditions of the Covid-19 pandemic have created specific material and moral demands on workers.

Telling others at work about one's Covid-19 symptoms or infection brought troubles of withdrawing one's own and, in the context of isolation of close contacts, also others' labour, raising ambiguities about where the responsibility for Covid-19 infection lay, and concerns about privacy. These troubles were shaped by nuances of context, in terms of the setting and the choices available. Across the four countries, the high level of public attention focussed on the pandemic meant that our participants were compelled to disclose Covid-19 to employers, co-workers and other close contacts through work. The moral obligation to protect others appeared especially pronounced for the health system workers. Where participants encountered difficulties in disclosing their Covid-19 infection at work, the accounts identify how a lack of job security created fears that causing trouble to co-workers and to the organisation could lead to one's dismissal. This finding resonates with Facey and Eakin (2010)'s analysis of "contingent workers" as impeded in managing ill health given how such work typically offers low reciprocity, uncertainty, discontinuity and marginalization.

"Contingent workers" inability to smoothly dispose of Covid-related troubles was also highlighted in relation to sickness absence, where the accounts revealed impediments to taking absence to cover the full period of self-quarantine, acute illness and chronic symptoms. This was particularly the case in the UK and the USA, where governmental social safety nets regarding paid sick leave are known to be especially restricted (Rho et al., 2020). This led to presenteeism and inappropriate non-use of leave-taking. The accounts highlight how the facility of remote working – precluded to in-person public-facing workers, such as many but not all of the health system workers we interviewed – led to distinct challenges in claiming sickness absence. The teleworkers described a liminality due to it being possible for them to keep working, since they were not exposing co-workers to infection, which exposed them to harms of presenteeism, even if they felt privileged in still retaining their jobs overall.

Across all four countries, the accounts show "contingent workers" having to go back to work before they felt well or ready, and it being harder for them to secure adaptations to their occupational role to make carrying out their jobs feasible in line with altered health capacities. Indeed Covid-19 illness precipitated many exits from employment – resignations and early retirements, redundancies and dismissals – which sometimes reflected people negotiating with their feet, by walking out, whilst others were forced to leave their jobs.

As we stated in relation to our methods, our cross-country comparative analysis is exploratory, and our suggestions regarding the ways in which the occupational sectors in which participants worked, and participants' job security influenced their employment experiences following Covid-19 infection would benefit from further research. Nonetheless, some important conceptual and real-world implications may be drawn out from our study.

Sociologically, whilst it could be said that illness inherently engenders trouble at work under rationalized capitalist regimes, our study suggests the need to un-flatten analyses of how *particular* individuals get to run with ambiguity and *particular* contexts enable people to dispose smoothly of trouble but not others. Relatedly, given that our analyses have highlighted how "contingent work" and restricted governmental safety nets shaped participants' accounts of Covid-related trouble at work, there are important policy implications from our study. Participants' accounts illustrate the significance of regulatory/policy environments regarding paid sick leave, substantiating demands for long-term increases in levels of Statutory Sick Pay in the UK, which has been found to be a major reason for low adherence to social isolation guidance (Patel et al., 2022; Patel & Jung, 2022), and for federal sick leave provision in the USA beyond the now-expired Families First Coronavirus Response Act (Jeliffe et al., 2021). Heymann and Sprague (2021) contend that "without a doubt, had sick pays been available at the national level in the US at the beginning of this pandemic, fewer people would have had to go to work sick and there would have been less spread" (p.2). This is true without a doubt, but not limited to the first two urgent years of the Covid-19 pandemic. Long-term provision across multiple tiers of workers will be crucial to mitigating the impacts that Covid-19 and Long Covid have had in exacerbating disability employment gaps (Abzhandadze et al., 2023; Gualano et al., 2022; Holland, 2021), as well as crucial to economic recovery and future pandemic preparedness (Rothstein & Fox, 2023).

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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