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The Employability, Employment
and Protection of People
with Chronic Diseases**

Michele Tiraboschi

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The New Frontiers of Welfare Systems: The Employability, Employment and Protection of People with Chronic Diseases¹

Michele Tiraboschi*

1. Framing the Issue

A growing share of the economically active population² reports to suffer from a temporary inability or a reduced ability to work because of the onset and the course of a chronic disease.

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¹ This paper is an earlier version of the one accepted for publication in the *E-Journal of International and Comparative Labour Studies*, Volume 4, No. 2 May – January 2015 (forthcoming).

² Also known as the “labour force”, that includes both employed and unemployed people.

Leaving aside overly technical definitions used in medicine and other research domains³, this paper employs the expression “chronic diseases” to refer to irreversible pathological alterations that require special treatment, long-term monitoring, observation, and care. These include cardiovascular and respiratory diseases, musculoskeletal disorders, HIV / AIDS, multiple sclerosis, several types of cancer, diabetes, obesity, epilepsy, depression and other mental disorders.

As far as the cases examined in this paper are concerned⁴, the impact that chronic diseases have on sick people in terms of income, job opportunities, career prospects and social inclusion varies considerably, as do the effects on their family members who are tasked with providing care and assistance (i.e. caregivers).

Some measures that might help cope with these specific issues are provided by the national systems of social security (e.g. early retirement programmes ensuring access to pension schemes or sickness allowances) and by laws and collective bargaining (e.g. the total or partial suspension of employment and the provision of wage compensation on a temporary basis) (see par. 2).

However, little attention has been paid to the economic impact that chronic diseases have on healthcare and welfare systems⁵. Particularly, in the medium and the long run. The major deficiencies of these systems as regards their financial sustainability are exacerbated by the rise in life expectancy⁶, the resulting upward adjustment of the retirement age and stricter criteria to access pension benefits⁷.

³ For a technical definition of “chronic disease”, see S. Varva (a cura di). *Malattie croniche e lavoro: una rassegna ragionata della letteratura di riferimento*. ADAPT University Press, 2014.

⁴ For an overall evaluation of the impact that chronic diseases have on post-industrial societies that considers economic indicators and socio-economic aspects, see P. BRAVEMAN, L. GOTTLIEB, *The Social Determinants of Health: It's Time to Consider the Causes of the Causes*, Public Health Reports, 2014, Supplement 2, pp. 20-31 and the bibliography therein. See also, UNITED NATIONS DEVELOPMENT PROGRAMME, *Addressing the Social Determinants of Non communicable Diseases*, Discussion Paper, October 2013.

⁵ This point is made cogently by R. BUSSE, M. BLUMEL, D. SCHELLER-KREINSEN, A. ZENTNER. *Tackling Chronic Disease in Europe: Strategies, Interventions and challenges*. European Observatory on Health Systems and Policies, World Health Organization 2010, who argue that “there is considerable evidence on the epidemiology of a chronic disease, but little on its economic implications” (p. 19). See also UNITED NATIONS, *World Population Ageing 2013*, Department of Economic and Social Affairs, ST/ESA/SER.A/348, 2013, p. 75.

⁶ Cf. D.E. BLOOM, E.T. CAFIERO, E. JANÉ-LLOPIS, S. ABRAHAMS-GESSEL, L.R. BLOOM, S. FATHIMA, A.B. FEIGL, T. GAZIANO, M. MOWAFI, A. PANDYA, K. PREITNER, L. ROSENBERG, B. SELIGMAN, A.Z. STEIN, C. WEINSTEIN. *The Global Economic Burden of*

1.1. Chronic Diseases: The Sustainability of Healthcare and Welfare Systems

As is widely known, people's longevity increases the demand for healthcare services and long-term social benefits, bringing about higher public expenditure⁸. Nevertheless, budget constraints and the ensuing tightening of the subjective and objective criteria to access pension and welfare benefits, compel people to postpone retirement and often to cope with physical, psychological, psychosomatic and psychosocial diseases while still at work (e.g. stress, anxiety, panic, depression, cognitive impairment, fatigue, and muscle weakness). In turn, this hampers the performance of day-to-day working tasks and translates into higher rates of absenteeism⁹.

At present, no data or reliable projections are available relating to the overall incidence of chronic diseases on the economically active population¹⁰ and employment trends¹¹. One explanation for this is that

Noncommunicable Diseases. Geneva, World Economic Forum, 2011. A 10-year increase has been reported in Europe in the last 50 years in relation to life expectancy. EUROPEAN COMMISSION, *Demography Report: Older, more numerous and diverse Europeans*, Commission Staff Working Document, Luxembourg, Publications Office of the European Union, 2011, p. 33.

⁷ Cf. OECD, *Pensions at a Glance 2013: Retirement-Income Systems in OECD and G20 Countries*, Paris, 2013 and EUROPEAN COMMISSION, *Pension adequacy in the European Union*, Brussels, 2012. In literature: M. SZCZEPANSKI, J.A. TURNER (eds.), *Social Security and Pension Reform: International Perspectives*, Upjohn Institute, Kalamazoo, 2014; A. GRECH, *Assessing the Sustainability of Pension Reforms in Europe*, in *Journal of International and Comparative Social Policy*, 2013, pp. 143-162.

⁸ Cf. F. BREYER, F. COSTA-FONT, S. FELDER. *Ageing, Health, and Health Care*. in *Oxford Review of Economic Policy*, 2010, pp. 674-690 and M. Suhrcke, D.K. Fahey, M. McKee, *Economic Aspects of Chronic Disease and Chronic Disease Management*, in E. Nolte, M. McKee (eds.), *Caring for People with Chronic Conditions: A Health System Perspective*, Maidenhead, Open University Press, 2008, pp. 43-63.

⁹ Cf. the comparative analysis from EUROFOUND on *Employment Opportunities for People with Chronic Diseases*, European Observatory of Working Life – EurWORK (<http://www.eurofound.europa.eu>). With reference to Italy, cf. ISTAT *Limitazioni nello svolgimento dell'attività lavorativa delle persone con problemi di salute*, op. cit.

¹⁰ Cf. For each chronic disease, OECD, *Health at a Glance: Europe 2012*, OECD Publishing, 2012, pp. 34-48. Cf. also WORLD HEALTH ORGANIZATION, *Non communicable Diseases Country Profiles 2011*, WHO Library Cataloguing-in-Publication Data, 2011 (p. 98 provides data on Italy).

¹¹ In reference to Italy, see ISTAT, *Limitazioni nello svolgimento dell'attività lavorativa delle persone con problemi di salute*, Report maggio 2013. A staggering 6.5 million people in the 15-to-64 year-old age group (that is 16.5% of the working population) reported to suffer from one or more chronic diseases that have different impacts on their working life.

workers tend to hide their real medical conditions from their employers because of the consequences that disclosing such information might have on their remuneration and career prospects.

However, the European Network for Workplace Healthcare Promotion estimated that almost 25% of the working age population in Europe experience disorders caused by at least one chronic disease¹² and that the share of the chronically ill in employment is equal to 19% of the labour force¹³. On the contrary, the rate of labour market participation in Europe of people over 55 years old—i.e. the share of the economically active population most at risk of losing the ability to work¹⁴—is projected to rise by 8.3% and by 14.8% in 2020 and 2060, respectively¹⁵.

In the Eurozone, the estimated impact of chronic diseases on workers over 55 years old is even more significant; a 10% and a 16.7% increase have been said to occur by 2020 and by 2060¹⁶.

Undoubtedly, the labour market participation of people with chronic diseases will become necessary in the long run to cope with the reduction in labour supply, a shortage of skilled workforce, and the pressure on the pension system caused by the considerable ageing of the labour force¹⁷. This is especially true in countries such as Italy, Japan and Spain, where the share of those aged over 65 is expected to peak in 2050, constituting one third of the entire population¹⁸.

¹² Cf. European Network for Workplace Health Promotion, *PH Work Promoting Healthy Work for People with Chronic Illness: 9th Initiative (2011 - 2013)*, 2013. Data are more detailed when it comes to the United States, where 40.3% of those in the 20-to-44 year-old age group suffer from at least one chronic disease, while 16.8% of those in the same age cohort have been diagnosed with two or more long-term conditions. In the 45-to-64 year-old age group, the share of population affected by at least one chronic disease rises to 68%, and those with two or more irreversible conditions are 42.8% of the total population. Cf. G. Anderson, *Responding to the Growing Cost and Prevalence of People With Multiple Chronic Conditions*, 2010, p. 8.

¹³ As estimated by the *Recommendations from ENWHP's ninth initiative Promoting Healthy Work for Employees with Chronic Illness – Public Health and Work*, p. 7.

¹⁴ Cf. K. KNOCHE, R. SOCHERT, K. HOUSTON. *Promoting Healthy Work for Workers with Chronic Illness: A Guide to Good Practice*. European Network for Workplace Health Promotion, 2012, p. 7.

¹⁵ Cf. EUROPEAN COMMISSION. *The 2012 Ageing Report: Economic and Budgetary Projections for the 27 EU Member States (2010- 2060)*. European Economy 2 | 2012, p. 63.

¹⁶ *Ibidem*.

¹⁷ OECD. *Sickness, Disability and Work: Breaking the Barriers – A Synthesis of Findings Across Oecd Countries*. Paris, 2010, p. 22.

¹⁸ OECD. *Sickness, Disability and Work: Breaking the Barriers etc.* cit., p. 24.

Moreover, investing in healthcare and welfare for the economically active population will increasingly become an “economic imperative”¹⁹ to ensure the sustainability of social security systems.

It should be also noted that, a decline of industrial work, employment opportunities and professional qualifications are on the rise in some crucial sectors, such as caregiving, which nevertheless faces some major issues. This is due to cyclical mismatches between labour supply and demand concerning medical staff²⁰, and a shortage of professionals with the necessary skills to understand²¹ and manage the problems experienced by people with chronic diseases (e.g. the desire to return to work, re-employment).

Significantly, the estimated cost to treat chronic diseases in Europe is 700 billion euro that is between 70% and 80% of total healthcare expenditure²². A steady increase has also been reported in the share of people requesting sick leave, taking early retirement and living on long-term disability allowances, who account for 10% of the labour force in some countries²³.

An international study conducted by the Harvard School of Public Health (HSPH) for the World Economic Forum²⁴ estimates that, between 2011 and 2030, there will be a \$47-trillion cumulative loss of output due to chronic diseases and mental illnesses connected to healthcare and social

¹⁹ Cf. HEALTHY WORKING LIVES. *Managing a Healthy Ageing Workforce: A National Business Imperative*. NHS Health Scotland, 2012.

²⁰ Cf., T. ONO, G. LAFORTUNE, M. SCHOENSTEIN. *Health Workforce Planning in OECD Countries: A Review of 26 Projection Models from 18 Countries*. OECD Health Working Paper, n. 62/2013 and M. SCHOENSTEIN. *Health Labour Market Trends in OECD Countries*. OECD Health Division, Global Health Workforce Alliance Forum Recife, 11 November 2013. For a summary in Italian, cf. A. SANTOPAOLO, F. SILVAGGI, G. VIALE. *La programmazione dei fabbisogni di medici e infermieri nei Paesi OCSE: verso un modello multi-professionale per rispondere alle sfide dell'invecchiamento e delle malattie croniche*. In *Bollettino ADAPT*, n. 31/2014.

²¹ In this perspective, Regulation No. 2013/1291/EU of 11 December 1991 provides some useful insights into the *Horizon 2020* framework programme of research and innovation. Cf. annex 1, part III (“Challenges for society”), where explicit reference is made to the emergency caused by chronic diseases and their economic and social costs.

²² EUROPEAN COMMISSION, *The 2014 EU Summit on Chronic Diseases – Conference Conclusions*, Brussels, 3 - 4 April 2014, p. 1.

²³ Cf. OECD. *Sickness, Disability And Work Keeping On Track In The Economic Downturn*. OECD Background Paper, Paris, 2009, p. 10.

²⁴ Cf. The study by D.E. BLOOM, E.T. CAFIERO, E. JANÉ-LLOPIS, S. ABRAHAMS-GESSEL, L.R. BLOOM, S. FATHIMA, A.B. FEIGL, T. GAZIANO, M. MOWAFI, A. PANDYA, K. PRETTNER, L. ROSENBERG, B. SELIGMAN, A.Z. STEIN, C. WEINSTEIN. *The Global Economic Burden of Non communicable Diseases*. Cit., p. 29.

security, reduced productivity and absenteeism, prolonged disability and the consequent reduction of income for the families involved. More precisely, 1.2% of GDP of the OECD area involves disability and related initiatives (2% if sick pay entitlements are factored in), that is some 2.5 times the cost of unemployment benefits²⁵. Measured as a percentage of total public social expenditure; the average cost of disability in the OECD area amounts to 10%, with peaks of 25% in some countries.

Not surprisingly, major concerns arise from the projections of healthcare and social security expenditure for the next decades²⁶. These concerns are of an economic nature and refer to the steady increase in chronic diseases, which develop at a higher pace than does the ageing of the population²⁷. Some of them, such as obesity, respiratory distress, depression and other mental disorders occur at a young age²⁸, making it even more difficult to identify and define them, and to devise adequate policy responses.

In the European countries – notably those that adopt the “Bismarck model”: Belgium, Estonia, France, Germany, Lithuania, Luxembourg, The Netherlands, Poland, The Czech Republic, Romania, Slovakia, Slovenia, Hungary²⁹ – where the costs of healthcare expenditure (not pensions) are covered by workers and businesses³⁰, an increase has been reported in the *old-age dependency ratio*. In other words, the share of those who pay social contributions and actively participate in the labour market is gradually

²⁵ Cf. OECD. *Sickness, Disability And Work Keeping etc.*. Cit., p. 13. where it is highlighted that in such countries as The Netherlands and Norway, expenditure for disability and sickness benefits accounts for 5% of GDP.

²⁶ Again, EUROPEAN COMMISSION. *The 2012 Ageing Report: Economic and Budgetary Projections for the 27 EU Member States (2010- 2060)*, cit.

²⁷ Cf. audizione del rappresentante di Farmindustria presso la Camera dei Deputati nella seduta n. 5 di lunedì 29 luglio 2013, p. 19 (available at www.camera.it).

²⁸ Cf., among others, J.C. SURIS, P.A. MICHAUD, R. Viner. *The adolescent with a chronic condition. Part I: developmental issues*. In *Archives Disease in Childhood*, 2004, p. 938–942.

²⁹ Cf. the report for the Committee of the Regions drafted by Progress Consulting and Living Prospects. *The management of health systems in the EU Member States - The role of local and regional authorities*. European Union, 2012, p. 98-102. In Italy, the law requiring the national health service to be funded through social contributions paid by employers and employees was repealed by Article 36 of Legislative Decree No. 446 of 15 December 1997. Now the national health service is financed by the government and the regions through the payment of certain levies on productive activities and personal incomes (IRAP and IRPEF). Cf. *Opzioni di Welfare e integrazione delle politiche*. Rapporto CEIS Sanità VIII Edizione, giugno 2012, p. 96.

³⁰ A comparative analysis of public expenditure on social protection in Europe (concerning the costs for retirement, disability, unemployment, family, housing, diseases and medical care) is provided by COORDINAMENTO NAZIONALE DELLE ASSOCIAZIONI DEI MALATI CRONICI. *XI° Rapporto nazionale sulle politiche della cronicità*. Roma, 176-180.

decreasing compared to those who qualify for and access social benefits. The European Commission has estimated that the *old-age dependency ratio* will double in the next few decades, rising from 26% in 2010 to 52% in 2060³¹, with a considerable increase in long-term healthcare and welfare expenditure linked to the ageing of the population³².

The same holds true for those countries where alternative mechanisms are in place to fund the welfare system, especially those such as in Italy with low rates of regular employment. Here, demographic changes and an ageing population place a strain on public expenditure (social security and healthcare) mainly because the limited implementation of the *pay-as-you-go* system, which is based on shared financing³³.

1.2. The Impact of Chronic Diseases on Labour Market Dynamics, Productivity and Work Organisation

Besides the concerns related to the initiatives to fund welfare systems, preoccupation arises also as regards another neglected issue³⁴, namely the impact of chronic diseases on labour market dynamics and, at the micro level, on the organization of work to manage the presence or the return to work of sick workers. This is because the latter are inevitably less productive and more prone to injuries³⁵ or serious accidents at work³⁶, as many studies have pointed out.

³¹ EUROPEAN COMMISSION, *The 2012 Ageing Report: Economic and Budgetary Projections etc.*, cit., pp. 60-61 and pp. 159-161.

³² EUROPEAN COMMISSION. *The 2012 Ageing Report: Economic and Budgetary Projections etc.* An overview is provided at pp. 34-36 and pp. 40-41. Cf. also D.E. BLOOM, E.T. CAFIERO, E. JANÉ-LLOPIS, S. ABRAHAMS-GESSEL, L.R. BLOOM, S. FATHIMA, A.B. FEIGL, T. GAZIANO, M. MOWAFI, A. PANDYA, K. PREITNER, L. ROSENBERG, B. SELIGMAN, A.Z. STEIN, C. WEINSTEIN, *The Global Economic Burden of Noncommunicable Diseases*, cit.

³³ On this point, see N. SALERNO. *Le risorse per il welfare del futuro. Insufficienza del pay-as-you-go e disegno multipilastro*. In *Diritto delle Relazioni Industriali*, n. 1/2015.

³⁴ Of significance is the recommendation of the European Council to assess the impact of this phenomenon and of the national reforms of the health systems on the labour market, productivity and competitiveness, more generally. Cf. COUNCIL OF EUROPEAN UNION, *Council conclusions on the "Reflection process on modern, responsive and sustainable health systems*, Employment, Social Policy, Health and Consumer Affairs, Council meeting Brussels, 10 December 2013, p. 4.

³⁵ According to a recent US study, an overall increase has been reported in the number of occupational injuries among employees with chronic diseases, which were distributed as follows: asthma (+14%), diabetes (+17%), heart diseases (+25%) and depressions

Comparing today's expenditure and population with the projections for 2060, it is labour input that acts as the main lever for growth in Europe. This is so in a context characterized by the overall aging and contraction of the economically active population, also in consideration of the share of people regarded fit for work³⁷. Coping with chronic diseases is not only a matter of social inclusion and protection. It also has an impact on the dynamics of labour productivity, with repercussions on the competitiveness of businesses and national economic systems and workers' career paths.

Significantly, chronic diseases are frequently linked to occupational risk factors resulting from working tasks³⁸, and from illnesses developed at work³⁹ or because of work⁴⁰. These present the case of an "hidden epidemic", as the International Labour Organization⁴¹ has put it, the impact of which is far greater than that of many acknowledged work

(+25%). Cf. K. M. POLLAK, *Chronic Diseases and Individual Risk for Workplace Injury*, in *Occupational and Environmental Medicine*, 2014, pp. 155-166.

³⁶ In this sense, cf. J. KUBO, B.A. GOLDSTEIN, L.F. CANTLEY, B. TESSIER-SHERMAN, D. GALUSHA, M.D. SLADE, I.M. CHU, M.R., CULLEN. *Contribution of health status and prevalent chronic diseases to individual risk for workplace injury in the manufacturing environment*. In *Occupational and Environmental Medicine*, 2014, pp. 159-166. Cf. also the comparative report written for EUROFOUND. *Employment Opportunities for People with Chronic Diseases*. Cit, especially the section *Higher exposure to risks and hazards*.

³⁷ EUROPEAN COMMISSION. *The 2012 Ageing Report: Economic and Budgetary Projections etc.* Cit. An overview of the report is available on p 34.

³⁸ In 2007 the World Health Organization has estimated that there were more than 300,000 fatalities because of various work-related diseases (not including the deaths from injury) the majority of which were chronic diseases. Cf. WORLD HEALTH ORGANIZATION. *Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016*. Copenhagen, 2012, p. 21.

³⁹ An example is the effects that passive smoking has on the development of tumours and cardiovascular diseases. Cf. among others, I. KAWACHI, G.A. COLDITZ. *Workplace Exposure to Passive Smoking and Risk of Cardiovascular Disease: Summary of Epidemiologic Studies*, in *Environmental Health Perspectives*. 1999, pp. 847-851.

⁴⁰ An example of this is the impact of certain psychological and social factors, like work-related stress, job instability, shift work and working long hours. Cf. among others N.H. ELLER, B. NETTERSTRØM, F. GYNTELBERG, T.S. KRISTENSEN, F. NIELSEN, A. STEPTOE, T. THEORELL. *Work-Related Psychosocial Factors and the Development of Ischemic Heart Disease A Systematic Review*. In *Cardiology in Review*, 2009, pp. 83-97 and M. KIVIMAKI, J.E. FERRIE, E. BRUNNER, J. HEAD, M.J. SHIPLEY, J. VAHTERA, M.G. MARMOT. *Justice at Work and Reduced Risk of Coronary Heart Disease Among Employees*. In *Archives of Internal Medicine*, 2005, pp. 2245-2251.

⁴¹ ILO. *The Prevention of Occupational Diseases*. Geneva, 2013, p. 4.

accidents, and gives rise to legal disputes, direct and indirect liability and additional costs for employers⁴².

As to labour supply and productivity, chronic diseases affect welfare systems, business dynamics and overall employment levels, and result in fewer active people and more barriers to labour market entry⁴³. As early as in 2007, the International Labour Organization reported that, in Europe, only 66% of the unemployed / jobless people between 16 and 64 years old had an opportunity to find a job; this percentage decreases to 47% for the chronically ill, and to 25% for those affected by a serious disability⁴⁴.

The “great crisis” that began in 2007 with the collapse of the financial markets inevitably worsened the odds to find employment for people with a chronic disease, particularly for those suffering from mental disorders⁴⁵. This despite the fact that they are more willing than before to search for a job, because of the reduction in public spending and the tightening of the criteria regarding retirement age or to qualify for permanent disability allowances.

The estimations from the Organization for Economic Cooperation and Development –which are in line with the data contained in the Report of the European Commission on Disability⁴⁶ and the very detailed information provided by the comparative analysis on chronic diseases by EUROFOUND⁴⁷ – report that the employment rate of those with

⁴² An attempt to estimate the cost of occupational diseases is provided by ILO *cit.*, pp. 8-9.

⁴³ Cf. R. BUSSE, M. BLUMEL, D. SCHELLER-KREINSEN, A. ZENTNER. *Tackling chronic disease in Europe: Strategies, Interventions and challenges*. Cit., pp. 20-24, more specifically the overview, the classification of chronic diseases, and the conclusions referred to in the relevant literature.

⁴⁴ Cf. ILO. *Equality at Work: Tackling the Challenges. Global Report Under the Follow-Up to the ILO Declaration on Fundamental Principles and Rights at Work*. Geneva, 2007, pp. 44-45. Cf. also S. GRAMMENOS. *Illness, Disability and Social Inclusion*. European Foundation for the Improvement of Living and Working Conditions, Dublin, 2003, pp. 43-47.

⁴⁵ Cf. S. EVANS-LACKO, M. KNAPP, P. MCCRONE, G. THORNICROFT, R. MOJTABAI. *The Mental Health Consequences of the Recession: Economic Hardship and Employment of People with Mental Health Problems in 27 European Countries*. In *PLoS ONE*, 2013, pp. 1-7

⁴⁶ EUROPEAN COMMISSION. *European Disability Strategy 2010-2020: A Renewed Commitment to a Barrier-Free Europe*. COM (2010) 636 def., p. 7.

⁴⁷ Cf. the comparative study of EUROFOUND on *Employment opportunities for people with chronic disease*, cit. (esp. the section *Employment situation of people with chronic diseases*, the national reports available at www.eurofound.europa.eu, and the documentation that can be accessed at the ADAPT Observatory on Work and Chronic Diseases available free of charge at the online platform <http://moodle.adaptland.it> (heading *Osservatori*).

chronic diseases is just over half of the economically active population, while the unemployment rate is twice as much⁴⁸.

This group of people faces objective difficulties at the time of entering and re-entering the labour market which are often associated with psychological strain and uncertainty, that lead them to abandoning plans of returning to work. They are also the victim of prejudices and stereotypes related to certain chronic diseases, and have to cope with forms of work organisation that penalise them as based on extremely rigid criteria, among others workplace presence, fitness for work and productivity. As far as the most vulnerable groups of the population⁴⁹ are concerned, some discriminatory practices arise that at times turn into systematic harassment (e.g. bullying) and unavoidably raise questions of social justice, inclusion and equity⁵⁰.

Furthermore, the relevant literature has pointed out that a vicious circle is often created, in that unemployment and unstable working conditions are the direct or indirect cause of chronic diseases and worsened health conditions, especially in relation to mental disorders⁵¹. A US study shows how the involuntary loss of employment among those aged over 50 doubles the risk of a heart attack; Japanese research analyses the impact of unemployment on people's lifestyles, emphasising the increase in the use of substances such as tobacco and alcohol, which are among the main causes of chronic diseases; other studies point out the impact of unemployment on mental disorders (anxiety, stress, depression, etc.)⁵². On

⁴⁸ OECD. *Sickness, Disability and Work etc.* Cit., p. 23 and p. 31, 32, 37.

⁴⁹ Cf. EUROPEAN COMMISSION. *European Disability Strategy 2010-2020: A Renewed Commitment to a Barrier-Free Europe*. Cit., where special reference is made to the vulnerability of women, young people, migrants and those with a mental disease.

⁵⁰ Cf. EUROPEAN COMMISSION. *The 2014 EU Summit on Chronic Diseases – Conference Conclusions*. Brussels, 3 - 4 April 2014, cit., p. 4. On this point, see also the comparative study from EUROFOUND on *Employment opportunities for people with chronic disease*, cit. (especially the section *Discrimination and prejudice at work*) and the national reports on the issue.

⁵¹ In addition to the pioneering study of M. JAHODA, P.F. LAZARSFELD, H. ZEISEL, D. PACELLI. *I disoccupati di Marienthal*, in *Studi di Sociologia*. 1987, pp. 229-231, see also the references in A. NICHOLS, J. MITCHELL, S. LINDNER. *Consequences of Long-Term Unemployment*. The Urban Institute, Washington, 2013, pp. 9-10. CFR. ATRES' D. Stuckler, S. Basu, M. Suhrcke, M. Coutts, M. McKee. *Effects of the 2008 recession on health: A first look at European data*. in *The Lancet*. 2011, pp. 124–125, and, comparatively, EUROPEAN FOUNDATION FOR THE IMPROVEMENT OF LIVING AND WORKING CONDITIONS, *Access to Healthcare in Times of Crisis*, Dublin, 2014.

⁵² Cf. the literature provided in S. VARVA (a cura di). *Lavoro e malattie croniche: una rassegna ragionata della letteratura di riferimento*. Cit.

the contrary, many studies report that the direct incidence of unemployment on health and mental conditions is irrelevant in those countries, e.g. Germany⁵³, where a sound system of social security is in place, with unemployment benefits and adequate re-employment services. Over the last decades, labour law and welfare systems have experienced significant changes due to new modes of production and work organization induced by technological innovations and globalization⁵⁴. As seen in the foregoing pages, equally important have been demographic changes, the ageing workforce⁵⁵ and the consequent impact of chronic diseases on work organization and on labour productivity. Labour law should give careful consideration to these issues, through an approach that favours personal wellbeing based on a more efficient and inclusive labour market, and promotes the modernization of the regulatory framework and the underlying industrial relations system.

1.3. Research Objectives

This study sets out to highlight the relevance that the impact of chronic diseases on the employment relationship and on the social security system might have on labour law and welfare systems, as well as on their future development. This research strand has been investigated only to a limited extent⁵⁶. Yet it might contribute to favouring the shift from a merely

⁵³ H. SCHMITZ. *Why are the unemployed in worse health? The causal effect of unemployment on health*, in *Labour Economics*, 2011, pp. 71-78. An opposite view on the same data is provided in L. ROMEU GORDO. *Effects of short- and long-term unemployment on health satisfaction: evidence from German data*. In *Applied Economics*, 2006, pp. 2335–2350.

⁵⁴ Cf., among others, the MCKINSEY REPORT. *The Future of Work in Advanced Economies*. McKinsey & Company, 2012.

⁵⁵ Cf. A. CHIVA, J. MANTHORPE. *Older Workers in Europe*. Open University Press, 2009 and the comparative study carried out by EUROFOUND (*Sustainable Work and the Ageing Workforce*, Luxembourg, 2012) and OECD (*Ageing and Employment Policies – Country Studies & Policy Review* available at www.oecd.org). In relation to the effectiveness of Italian social security, cf. N. C. SALERNO. *Finanziare il Welfare*, in *Quaderni Europei sul Nuovo Welfare*. 2014, n. 21, especially § 2, 3 e 4 on demography, employment and productivity.

⁵⁶ Among the early studies on this subject, cf. S. GRAMMENOS. *Illness, Disability and Social Inclusion*. Cit., especially p. 1, where it was argued that “chronic illness, and especially mental illness, remains very much a hidden issue. Discussion about disability tends to get stuck on the issue of rights, where there is a lackluster consensus, but fails to move into the area of active policy implementation. As a result, the disadvantages for people with disabilities or illness do not really change: they tend to be marginalised, even stigmatised,

passive and emergency income support measures – which at times results in labour market exclusion through so-called “medicalization” (see par. 2) –to more innovative approaches based on preventive measures at the workplace (see par. 4) and initiatives promoting the employability and the return to work of workers with chronic diseases (see par 3).

Carrying out innovative research on the relationship between work and chronic diseases is necessary for the future sustainability of welfare systems, and to effectively prompt the renewal of national industrial relations systems. Owing to technological and demographic changes, IR systems are now called to handle the transformations, either in formal and notional terms, of concepts such as “workplace presence”, “work performance”, “fulfilment of contractual obligations” (see below, par. 5) and to strike a new balance between productivity and equity, inclusion and social justice.

2. Chronic Diseases: The Shortcomings of the Current Responses Provided by Labour Law and Social Security Systems

As pointed out above, the employment prospects of people with chronic diseases are limited and have worsened over the past decades following economic stagnation and the crisis of international financial markets. Undoubtedly, reduced or limited workability affects the competitiveness of people with chronic diseases when searching for employment. In a similar vein, those who do have a job are less likely to keep it at the end of their sick leave.

Comparative analysis shows that protection schemes vary considerably across countries, since they depend to a great extent on the specific regulations on dismissal and other aspects, for instance one's inability to work, poor performances, and absence from work⁵⁷.

It is true, however, that the rigid classifications of chronic diseases according to categories laid down in national welfare and social security regulations, accentuate so-called medicalization⁵⁸ and contribute to creating structural barriers to employment⁵⁹.

and feel isolated from many parts of social and public policy as well as the labour market”.

⁵⁷ Cf. the comparative analysis by S. FERNÁNDEZ MARTÍNEZ. *Enfermedad crónica y despido del trabajador: una perspectiva comparada*. In *Relaciones Laborales y Derecho del Empleo*, n. 1/2015.

⁵⁸ The notion of “medicalisation” was employed for the first time in the 2002 issue of the *British Medical Journal* to refer to a widespread attitude in western societies that

In Europe as elsewhere⁶⁰, the traditional approach of social security systems draws on medically-driven criteria to determine the allocation of disability allowances that often produce early exit from the labour market of those concerned, even when unnecessary.

This brings about adverse effects on patients' morale and physical recovery. It is frequently the case that the chronically ill look for a job not so much for economic reasons, but because entering the labour market is associated with a return to a normal life⁶¹.

The boundaries between work ability and disability are blurred, considering that peoples' reaction to the same disease is different either in physical or emotional terms. Further, the course of a chronic disease is unpredictable because many subjective and objective factors come into play, among others the support provided by family, society, and healthcare facilities, personal income, treatment and recovery programmes.

By contrast, current social protection systems still adopt static and standardised models (*one-size-fits-all* solutions) that do not make it possible to conduct evaluations targeted on each person that consider one's ability to work, occupation and tasks, type of contract and working time, work environment and relationship with colleagues and supervisors. Nor do they take into account elements such as the characteristics of the firm and the welfare schemes implemented, any physical adjustments related to the

emphasizes the need for diagnosis, treatment rather than the promotion of people's well-being and health. Cf. R. MOYNIHAN, R. SMITH. *Too Much Medicine?*. In British Medical Journal, 2002, pp. 859-860 and S. BROWNLEE. *Why too much Medicine is Making us Sicker and Poorer*. Bloomsbury Publishing, 2010.

⁵⁹ This point is made cogently by A. VICK, E. LIGHTMAN. *Barriers to Employment Among Women with Complex Episodic Disabilities*. In *Journal of Disability Policy Studies*, 2010, pp. 76-77. Cf. also L.C. KOCH, P.D. RUMRILL, L. CONYERS, S. WOHLFORD. *A Narrative Literature Review Regarding Job Retention Strategies for People with Chronic Illnesses*. In *Work*, 2013, p. 126.

⁶⁰ Cf. The Canadian case described in A. VICK, E. LIGHTMAN. *Barriers to Employment Among Women with Complex Episodic Disabilities*. Cit., p. 77-78.

⁶¹ A vast amount of literature points out the therapeutic impact that employment has on sick people. Cf. among others EUROPEAN NETWORK FOR WORKPLACE HEALTH PROMOTION, *Promoting Healthy Work for Workers with Chronic Illness etc.*, cit. and J.F. STEINER, T.A. CAVENDER, D.S. MAIN, C.J. BRADLEY, *Assessing the Impact of Cancer on Work Outcomes What Are the Research Needs?*. In *Cancer*, 2004, esp. p. 1710, where it is argued that "work is important to the individual, to his or her family and social network, to the employer, and to society at large". In reference to the role of employment as a lever for social inclusion, see also S. ZAMAGNI. *People Care: dalle malattie critiche alle prassi relazionali aziendali*. In Atti del convegno della Fondazione Giancarlo Quarta, Milano, 26 ottobre 2011.

disease, the invasive nature of the treatment and its effectiveness, the evolution of the disease, and so on⁶².

As authoritatively highlighted by the Organization for Economic Cooperation and Development⁶³, many people with limited ability to work are considered by current welfare systems unfit for work, even when this is not completely the case. The entitlement to a disability allowance does not require beneficiaries to actively search for a job. In addition, in many countries, it is the law itself that prohibits the recipient of a disability allowance to work. Otherwise, they might lose their disability benefits, which are only slightly above subsistence levels⁶⁴.

Ensuring adequate protection to those with a permanent or temporary inability to work does not come down to merely providing protection in the labour market and the employment relationship. This is an issue to be dealt with from a medical and social perspective, as the question being posed is whether or not patients have to integrate their disability benefits resulting from their inability to work⁶⁵.

Compounding the picture are national policies relieving employers from certain formal obligations. While still required to bear the labour costs of their employees, they are released from providing practical solutions to the issues faced by workers with chronic diseases (e.g. absence from work). On their part, workers find it more advantageous to draw disability benefits on a permanent basis – and concurrently take up undeclared work – rather than benefitting from temporary unemployment benefits and having their remuneration reduced because of lower productivity or higher rates of absenteeism.

⁶² Cf. T. TASKILA, J. GULLIFORD, S. BEVAN. *Returning to Work Cancer survivors and the Health and Work Assessment and Advisory Service*. Work Foundation, London, 2013, esp. 3, where it is highlighted that “successful work retention for people with a diagnosis of cancer depends not only on the severity of one’s condition but also on the individual’s capacity to cope with crises or with fluctuations in health or functional capacity. The coping process nevertheless depends on several social aspects of work, such as the work environment and the amount of support one gets in the workplace. This process is also affected by the extent to which healthcare services prioritise work as a clinical outcome and a welfare system that supports job retention”. In the same perspective, cf. J.F. STEINER, T.A. CAVENDER, D.S. MAIN, C.J. BRADLEY. *Assessing the Impact of Cancer on Work Outcomes What Are the Research Needs?* In *Cancer*, 2004, pp. 1703-1711.

⁶³ Cf. OECD. *Sickness, Disability And Work Keeping On Track In The Economic Downturn*. Cit., qui p. 17-18.

⁶⁴ Again OECD. *Sickness, Disability And Work etc.* Cit., p. 18.

⁶⁵ *Ibidem*. For a useful overview of Italian legislation on disability, cf. M. CINELLI. *Diritto della previdenza sociale*. Giappichelli 2013, cap. XI.

Conceived in an economic, social and demographic scenario that was similar to the current one, the social security systems in place in Western European countries⁶⁶ now appear inadequate to attend to the issues resulting from chronic diseases discussed thus far⁶⁷ that can be regarded as new if we consider their scope, seriousness and economic impact. This and other factors indirectly contribute to shrinking the employment and re-employment opportunities for people suffering from a chronic disease. Barriers and disincentives to work are also provided by current labour laws and collective agreements. Particularly in Europe and North America, the traditional principles of non-discrimination and equal treatment⁶⁸ undoubtedly ensure a broad and modern set of formal rights and protection⁶⁹. Yet the practical implications of these safeguards are

⁶⁶ As to traditional welfare systems, cf. F. GIROTTI. *Welfare State. Storia, modelli e critica*. Carocci, Roma, 1998.

⁶⁷ Cf. also S. ZAMAGNI. *People Care: dale malattie critiche alle prassi relazionali aziendali*. Cit., “the welfare state in place in Europe as elsewhere following World War II is based on the idea that if someone is not fit for adequately carrying out certain tasks cannot think of staying on at work.

⁶⁸ Cf. S. FERNÁNDEZ MARTÍNEZ already referred to *Enfermedad crónica y despido del trabajador: una perspectiva comparada*, cit., spec. § 2. In relation to European anti-discrimination legislation, cf. FREDMAN. *Discrimination Law*. Clarendon Law Series, 2011; E. ELLIS, P. WATSON. *EU Anti-Discrimination Law*. Oxford University Press, 2012; B. DOYLE, C. CASSERLEY, S. CHEETHAM, V. GAY, O. HYAMS, *Equality and Discrimination*, Jordan Publishing Limited, 2010; D. SCHIEK, V. CHEGE (eds). *European Union Non-Discrimination law. Comparative Perspectives on Multidimensional Equality Law*. Routledge-Cavendish, 2009. An overview of North American anti-discrimination EU legislation, cf. P. BURSTEIN. *Discrimination, Jobs and Politics. The Struggle for Equal Employment Opportunity in the United States since New Deal*. The University of Chicago Press, 1998; R. C. POST, R.B. SIEGEL. *Equal protection by Law: Federal Antidiscrimination Legislation after Morrison and Kimel*. In *The Yale Law Journal*, 2000, pp. 441-526. As for the Italian case, cf. A. LASSANDARI. *Le discriminazioni nel lavoro. Nozioni, interessi, tutele*. Wolters Kluwer Italia, 2010.

⁶⁹ Cf. the comparative study carried out for EUROFOUND. *Employment opportunities for people with chronic disease*. Cit. (esp. The section *Main policy measures and initiatives at national level*) and the national reports available at EUROFOUND’s website (www.eurofound.europa.eu). The international literatures has given empirical evidence of some major developments at a company level when dealing with chronic diseases. This translates into forms of support given to workers, who only in a few cases have been discriminated. Cf. the study on a group of female workers affected by breast tumour conducted by R.R. BOUKNIGHT, C.J. BRADLEY, L. ZHEHUI. *Correlates of Return to Work for Breast Cancer Survivors*. In *Journal of Clinical Oncology*, 2008, pp. 345-353 esp. p. 148 and p. 150, where it is stated that “more than 80% of patients returned to work during the study period, and 87% reported that their employer was accommodating to their cancer illness and treatment” and that “few women (7%) reported problems with discrimination because of cancer, suggesting that this was not a widespread problem for breast cancer patients in our sample.”

frequently overlooked, as are the preventive measures at work (see par. 4), the subjective and objective conditions of the chronically ill and the features of the companies they work for (see par. 5).

Consequently, the limited effectiveness of formal labour laws⁷⁰ comes as no surprise. In many countries, and along the lines of what happens with welfare systems, chronic diseases are considered through a passive and standardised approach, without ensuring economic incentives to employers, *ad-hoc* protection and promotion, and above all active policies favouring job retention and the return to work, along with medical and psychological support⁷¹. If anything, the numerous formal requirements in place to protect workers with a chronic health condition sometimes act as a disincentive to employers. To the point that they employ subtle practices that border on discrimination in order not to hire sick workers. They fear that, by concluding an employment relationship with them, they will have to deal with complex procedures concerning their termination for economic reasons, should sick workers fail to integrate with their colleagues at work or because of their inability to work⁷².

⁷⁰ The low effectiveness of the formal safeguards provided by labour law is highlighted, among others by F. DE LORENZO. *Presentazione Progetto ProJob: lavorare durante e dopo il cancro.* (proceedings) ADAPT – FAVO dell'11 settembre 2014, Roma, available at the ADAPT Observatory on *Work & Chronic Disease*.

⁷¹ Cf. the work by A. DE BOER, T. TASKILA, S.J. TAMMINGA, M. FRINGS-DRESEN, M. FEUERSTEIN, J.H. VERBEEK. *Interventions to enhance return-to-work for cancer patients.* In *Cochrane Database of Systematic Reviews*, 2011, esp. pp. 3-4. A classification is provided of those interventions to help workers with cancer to return to work, which can be also applied to anyone with a chronic disease. Such measures are: (1) *Psychological* (“any type of psychological intervention such as counselling, education, training in coping skills, cognitive-behavioural interventions, and problem solving therapy, undertaken by any qualified professional (e.g. psychologist, social worker or oncology nurse”); (2) *Vocational* (“any type of intervention focused on employment. Vocational interventions might be person-directed or work-directed. Person- directed vocational interventions are aimed at the patient and incorporate programmes which aim to encourage return-to- work, vocational rehabilitation, or occupational rehabilitation. Work-directed vocational interventions are aimed at the workplace and include workplace adjustments such as modified work hours, modified work tasks, or modified workplace and improved communication with or between managers, colleagues and health professionals”); (3) *Physical* (“any type of physical training such as walking, physical exercises such as arm lifting or training of bodily functions such as vocal training”); (4) *Medical or pharmacological* (“any type of medical intervention e.g. surgical or medication such as hormone treatment”); (5) *Multidisciplinary* (“a combination of psychological, vocational, physical and / or medical interventions”).

⁷² This aspect is highlighted by the OECD report. *Sickness, Disability And Work Keeping On Track In The Economic Downturn.* Cit., p. 25. An overview of national legislations that prohibit dismissing workers for economic reasons arising from their inability to perform

In considering the return to work of those who lost their job because of an illness, the poor results recorded by certain measures should be seen as equally predictable. These include the low effectiveness⁷³ of reserved employment (e.g. designating some occupations to sick workers), certain tax exemptions and the possibility to temporarily suspend⁷⁴ the employment relationship laid down by many legal systems, that usually applies only to firms with a given number of employees⁷⁵.

The few studies on this topic have highlighted that the implementation of the quota system for workers with chronic diseases has produced some results in terms of job retention for those who are already employed, while penalising job-seekers, thus negatively impacting their employment trends⁷⁶.

Even without considering those elusive practices put in place by some employers, hiring and keeping workers with a chronic disease should not be done to fulfil a legal obligation and avoid sanctions. It requires a positive attitude and the active participation of both employers and workers that should be based on mutual adaptation in order to reconcile their respective needs (so-called sustainable work, see par. 5).

To ensure treatment and care and avoid the dismissal of the chronically ill, suspension from work also plays a part, although applying for limited periods of time. Further, despite some innovations introduced by collective bargaining (see par. 5), work suspension is not adequate to manage long-term and serious diseases as chronic ones, which also require flexible working hours and working tasks for both workers and their

their task cf. *International Dismissal Survey*. Laga, Belgium. October 2012. With special reference to Germany, cf. R. SANTAGATA. *I licenziamenti in Germania: i presupposti di legittimità*, in *Diritto delle Relazioni Industriali*. 2013, qui spec. pp. 889-892. On the case of the UK, cf. *Dismissals for Long Term Sickness Absence*. In Library of House of Commons, January 2010.

⁷³ As far as Italy is concerned, cf. il MINISTRO DEL LAVORO. *VI Relazione al Parlamento sullo stato di attuazione della legge 12 marzo 19998, n. 68 "Norme per il diritto al lavoro dei disabili"* (anni 2010 – 2011). Roma, pp. 56-75.

⁷⁴ Pursuant to Italian legislation (Article 14 of Act No. 68/99), employers in the private sectors and certain public entities that cannot hire the number of disabled workers required by the law can be partly relieved of such obligation upon payment of a contribution to the Regional Fund for the Employment of Disabled People.

⁷⁵ For a comparative analysis cf. the study carried out for EUROFOUND on *Employment opportunities for people with chronic disease*, and the national reports widely referred to in this paper.

⁷⁶ Still OECD. *Sickness, Disability And Work Keeping On Track In The Economic Downturn*. Cit., p. 25.

families⁷⁷. This is the only way to reconcile the worker's willingness to actively participate in the working life and the employer's need to be efficient and productive.

Another aspect to consider is that the foregoing suspension and the reduction of the working activity for workers with a chronic health condition come along with lower remuneration – just when they might incur higher expenses (medicines, nursing, assistance and so forth)⁷⁸ – and place them at a disadvantage in terms of career prospects and professional growth.

Equally significant is that employers –mainly in Southern Europe, e.g. Italy⁷⁹ –express increasing disapproval with granting paid leave and suspension from work to both sick workers and their families. They lament that workers are overprotected and that they repeatedly take time off from work even when not needed. This practice, coupled with inadequate monitoring from those in charge (social security and health authorities) ends up penalizing those who really require long time off from work due to their illness⁸⁰.

Consequently, the forms of protection ensured by law and collective agreements based on quota systems, the suspension of the employment relationship and job retention strategies for the time needed for treatment, are designed for salaried and open-ended employment (that in Southern Europe mainly concerns male workers hired by large companies)⁸¹.

⁷⁷ Still EUROFOUND. *Employment opportunities for people with chronic disease*. Cit., along with the national reports.

⁷⁸ Osservatorio sulla condizione assistenziale dei malati oncologici. 6° Rapporto sulla condizione assistenziale dei malati oncologici. Sanità, Il Sole 24 Ore, 2014, p. 28, and *Meeting the needs of people with Chronic Conditions*, National Advisory Committee on Health and Disability, Wellington, New Zealand, 2007, pp. 8-9. Cf also the data in F. DE LORENZO. *Presentazione Progetto ProJob: lavorare durante e dopo il cancro*. Atti del convegno ADAPT – FAVO dell'11 settembre 2014, Roma, available at the ADAPT Observatory on Work & Chronic Disease.

⁷⁹ This risk was pointed out in Italy some ten years ago. *L'assenteismo costa l'1% del PIL*. In Il Sole 24 Ore del 5 dicembre 2007. Some similar concerns are regularly raised in the reports from Centro Studi of Confindustria on the labour market and the Italian economy (available at www.confindustria.it).

⁸⁰ This explains the clamour following the renewal of some collective agreements (e.g. the commerce sector) where the social partners agreed to reduce workers' safeguards in the event of repeated short-term absence from work, in order to focus on the protection of long-term and more serious diseases. Cfr. E. CARMINATI. *Lotta agli assenteisti e maggiori tutele per i malati gravi*. In Bollettino Speciale ADAPT, 7 aprile 2011, n. 17.

⁸¹ This argument is supported by an examination of female unemployment rates, which are still low in Southern Europe, and the gender of the workforce in atypical and precarious employment. Not to mention that workers are still tasked with caring for

Nevertheless, the recent evolution and fragmentation of the labour market reported an intensive use of intermittent, temporary and atypical work, that does not allow those with a chronic disease to fully benefit from the foregoing safeguards⁸² for long periods.

Artisans, small business owners, the self-employed and those who are economically dependent on a single principal/client are faced with even more insecurity. This is because they fall outside the notion of “legal subordination” and the ensuing safeguards provided by labour law, which are still relevant although salaried employment is no longer the most widespread form of work⁸³.

Consequently, the invitation of the European Commission to “take due account of the problems of fairness”⁸⁴ requires a review of existing national social security systems. The foregoing considerations make it clear that workers with chronic diseases who want to stay on at work or re-enter the labour market need more than quota systems and the formal protection ensured to healthy workers by traditional labour law.

Likewise important is envisaging innovative and individually-targeted welfare policies, and measures promoting new definitions for “productivity” and “workplace presence” helping reconcile patients’ and employers’ needs. There is an increasing awareness of the need for wide-ranging and innovative changes when considering the relationship between work and chronic diseases⁸⁵.

family members and sick people. Cf. S. GABRIELE, P. TANDA, F. TEDIOSI. *The Impact of Long-Term Care on Caregivers' Participation in the Labour Market*. ENEPRI Research Report No. 98, November 2011, esp. p. 6; and EUROPEAN COMMISSION, *Long-term Care for the Elderly*, Luxembourg, Publications Office of the European Union, 2012.

⁸² Cf., among others, M. GIOVANNONE, M. TIRABOSCHI (a cura di). *Organizzazione del lavoro e nuove forme di impiego. Partecipazione dei lavoratori e buone pratiche in relazione alla salute e sicurezza sul lavoro – Una Literature Review*. 2007 in Osservatorio ADAPT Nuovi lavori, nuovi rischi, pp. 9-13. In relation to our analysis, see A. C. BENSADON, P. BARBEZIEUX, F.O. CHAMPS. *Interactions entre santé et travail, Inspection Générale des Affaires Sociales*. Paris, 2013, p. 5.

⁸³ Cf. among the many contributions in G. DAVIDOV, B. LANGILLE (eds.). *Boundaries and Frontiers of Labour Law*. Hart Publishing, 2006 and, more recently, H. ARTHURS. *Labour Law as the Law of Economic Subordination and Resistance: A Counterfactual?*. Comparative Research in Law & Political Economy. Research Paper, n. 10/2012.

⁸⁴ Cf. EUROPEAN COMMISSION. *The 2014 EU Summit on Chronic Diseases – Conference Conclusions*. Cit., p. 4. With reference to chronic diseases, see Resolution of the European Parliament of 10 April 2008, *Combating cancer in the enlarged European Union*.

⁸⁵ A call to change the paradigm from the medical point of view that has implications on work was made as early as ten years ago by the World Health Organisation in *Innovative Care for Chronic Conditions*, 2002, p. 4.

This is because public institutions adopt a narrow-minded approach to regulate the issue, for instance by considering rights, obligations, sanctions, and the provision of care and assistance as separate elements. Yet a comprehensive strategy is needed that considers sick workers' human dimension while laying down inclusion policy⁸⁶.

3. From Subsidies, Quota Systems and Passive Protection Measures, to Activation, Work-life Balance and Retention Policies

In view of the considerations made above, the 2006 UN Convention on the Rights of the disabled⁸⁷ is a starting point to modernize social protection systems and labour law in relation to the emerging issues of chronic diseases and the ageing of population. The Convention is the result of a complex and cultural process to approach the issue of diversity in society⁸⁸. This document points out that the condition of disability, as defined in the broadest possible sense⁸⁹, is not based on the idea of "limitations" as an intrinsic quality or condition of individuals. It is more akin to an "interaction" between impaired or disadvantaged people and physical, "behavioural" and "environmental" barriers, which prevent their actual participation in society and their inclusion in the labour market in a condition of equality with others⁹⁰.

⁸⁶ In the same sense, Cf. S. GRAMMENOS. *Illness, Disability and Social Inclusion*. Cit., esp. p. 1: "the public sector tends to tackle the issue from one perspective (public health) or another (social affairs) and usually not in a comprehensive way (physical illness but not mental illness; social assistance but not inclusion; benefits but not activation). There is a lack of critical assessment about how the policies work and what could be the best allocation of resources".

⁸⁷ UN Convention for the Rights of Persons with Disabilities of 13 December 2006, which was subsequently approved and enforced by the European Union through Decision No. 2010/48. The convention was ratified in Italy by means of Act No. 18 of 3 March 2009.

⁸⁸ T. J. MELISH. *Perspectives on the un convention on the rights of persons with disabilities: The UN Disability Convention: Historic Process, Strong Prospects, and Why The U.S. Should Ratify*. In *Human Rights Brief*, 2007.

⁸⁹ Here reference is made to disability strictly speaking, being this an evolving concept, as pointed out in let. e) of the Preamble of the Convention.

⁹⁰ Cf., in various passages, the Preamble of the Convention, especially let. e). See also the *International Classification of Impairment Disabilities and Handicaps* (ICIDH) by the World Health Organisation that has been appended to the *International Classification of Diseases* (ICD) and the March 2002 *International Classification of Functioning, Disability and Health* (ICF). Here, disability is defined as an interactive and evolving process resulting from the complex interaction of health conditions and environmental and personal factors. See

This point has been also made by European institutions in relation to people with disabilities⁹¹. The main argument is that the issues faced by workers with chronic diseases and their employment cannot be dealt with only from a medical point of view. This approach often causes their exit from the labour market and the safeguards ensured by labour law and collective bargaining still consider them as “different”.

Further, the implementation of initiatives promoting their social inclusion cannot be dependent upon the good will or the indulgence of employers and human resources managers⁹², although many of them are moving in the right direction by devising effective codes of conducts⁹³ and policies as part of corporate social responsibility (see par. 4).

Removing those barriers (either physical or not) that prevent or limit sick workers' access to the labour market⁹⁴, is the first step to facilitate their inclusion. Further initiatives should take due account of human diversity and contribute to better matching labour demand and supply. This matching cannot be predetermined by law (for instance through designing

also S. GRAMMENOS. *Illness, Disability and Social Inclusion*. Cit., pp. 29-34 and J. PITCHER, G. SIORA, A. GREEN. *Local Labour Market Information on Disability*. In *Local Economy*, 1996, pp. 120-130.

⁹¹ Cf. the European Directive No. 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation for disabled persons that moves away from the mere provision of support that has long marked European and national legislation. Consideration of the evolution of the notion of disability, the employment and the return to work of people with disabilities is given in the Communication of the European Commission concerning the *European Disability Strategy 2010-2020: A Renewed Commitment to a Barrier-Free Europe*. Brussels, COM (2010) 636 final and in the clarification made by the ECJ through *HK Danmark* 11 April 2013, C-335/11 e C-337/11, and the *European Commission vs The Italian Republic* of 4 July 2013, C-312/11 and Z., 18 March 2014, C-363/12.

⁹² And workers. In Italy, there has been a case that received extensive media coverage. A bus driver returned to work after his paid leave. He was still sick so his 250 colleagues made available their leave to help him keep his job. Cf. *L'autista di bus tornata alla vita con le ferie regalate dai colleghi*. In *Il Tirreno*, 7 maggio 2014.

⁹³ See the comparative studies carried out by EUROFOUND, and par 3.2 “Examples of enterprises and/or collective agreements implementing initiatives or establishing clauses to support people with chronic diseases” of the national reports contained in A. CORRAL, J. DURÁN e I. ISUSI. *Employment opportunities for people with chronic diseases*. European Observatory of Working Life, November 2014.

⁹⁴ In relation to the issue of disability strictly speaking, cf. the Communication from the European Commission *European Disability Strategy 2010-2020: A Renewed Commitment to a Barrier-Free Europe*. Cit., p. 4. See also S. GRAMMENOS, *Illness, Disability and Social Inclusion*, cit., pp. 36-42.

a number of jobs for sick workers), nor can it be promoted through economic incentives or sanctions.

Rather, it is essential to define a conceptual and operational framework modelled on individuals⁹⁵ that considers each work environment. This will allow for a shift away from abstract models and standardised work performance assessment methodologies in use in Fordism, when a different legal framework, and different organisational and production needs were in place (see par. 5).

Traditional recovery strategies – concerning the medical, professional, and psychological sphere⁹⁶ – should be supplemented by policies favouring the return to work and re-employment of workers with chronic diseases. To do so, a different approach is needed that involves our attitude rather than the legal or the institutional framework: emphasis should be given to people's abilities and not to their disabilities⁹⁷.

This means to prioritise “what people with health problems can still do at work and, consequently, develop appropriate support and programs that strengthen them in this regard”⁹⁸.

This has been done in Australia, Denmark, Finland, The Netherlands, Sweden, United Kingdom, New Zealand⁹⁹ where policies favouring sick workers' job retention and return to work have been successfully implemented.

A different approach can pave the way to an action plan to bring to fruition the reform of welfare and industrial relations systems that were

⁹⁵ In the same vein, see cf. S.J. TAMMINGA, J.H. VERBEEK, A.G. DE BOER, R.M. VAN DER BIJ, M.H. FRINGS-DRESEN. *A work-directed intervention to enhance the return to work of employees with cancer: a case study*. In PubMed, 2013, pp. 477-485.

⁹⁶ Cf. the classification of re-employment strategies and the considerations applicable to all chronic diseases put forward in A. DE BOER, T. TASKILA, S.J. TAMMINGA, M. FRINGS-DRESEN, M. FEUERSTEIN, J.H. VERBEEK. *Interventions to enhance return-to-work for cancer patients*. Cit. *supra* footnote 70.

⁹⁷ In this perspective, see the study from OECD. *Sickness, Disability And Work Keeping On Track In The Economic Downturn*. Cit., p. 19 that describes the shift from “disability to ability”. Cf. also OECD. *Transforming Disability into Ability Policies to Promote Work and Income Security for Disabled People*. Paris, 2003.

⁹⁸ Again, see OECD. *Sickness, Disability And Work Keeping On Track etc.* Cit.

⁹⁹ See the national reports carried out between 2006 and 2008 by OECD on *Sickness, Disability and Work: Breaking the Barriers* and available on the OECD website. See also some more recent reports on innovative re-employment policies for disabled workers and the chronically ill conducted by EUROFOUND (*Employment Guidance Services for People with Disabilities*) available at <http://www.eurofound.europa.eu/> as well as the study *Employment opportunities for people with chronic disease*, cit. especially the National reports from Denmark, Finland, The Netherlands, Sweden and the United Kingdom.

initially intended in Europe as emergency solutions. They were passive measures put in place to provide a response to the economic crisis, yet they resulted in a mere reorganisation of social and healthcare expenditure, which was put into question by less available resources. By contrast, welfare reform and healthcare spending reviews should be carried forward taking into account demographic changes and future labour dynamics. This will provide decision-makers and supranational institutions with financial responses and anthropological answers in a time marked by economic and social turmoil that results in worry and uncertainty¹⁰⁰. The issues faced by people with chronic diseases and their return to work may be dealt with through a comprehensive strategy. This approach seems essential in the current demographic scenario to devise welfare schemes that focus on individuals.

3.1. Rethinking Welfare-to-work Policies, Incentives and Public Subsidies

In Europe, some major interventions are needed in relation to *welfare-to-work* policies¹⁰¹ and economic incentives, which so far have failed to consider the vocational rehabilitation of people with chronic diseases notwithstanding the recommendations from EU institutions¹⁰². Thus they are entitled to a number of benefits, but empirical evidence has shown that these forms of aid contribute to their exclusion from the labour market¹⁰³.

This aspect is exemplified by a number of countries (Denmark, Luxembourg and The Netherlands)¹⁰⁴ where priority has been given to the review of public subsidies over procedures to assess workers' working

¹⁰⁰ Cfr. COMITATO PER IL PROGETTO CULTURALE DELLA CONFERENZA EPISCOPALE ITALIANA. *Per il lavoro. Rapporto-Proposta sulla situazione italiana*. Editori Laterza, Bari, 2013.

¹⁰¹ As already done in some countries. Cf. OECD. *New Ways of Addressing Partial Work Capacity*. Progress Report, April 2007, pp. 4-7.

¹⁰² Cf., among others, EUROPEAN COMMISSION. *The 2014 EU Summit on Chronic Diseases*. Cit., esp. p. 3 “the use of structural, research and other EU funds for this purpose should be improved”.

¹⁰³ According the OECD, the majority of persons with a partial work capacity who take up disability benefits never return to the labour market. Data from various countries suggests that after being on disability benefits for a year, statistically more recipients are dying than returning to employment. Cf. OECD. *Sickness, Disability And Work Keeping On Track etc.* Cit., p. 19.

¹⁰⁴ Cf. OECD. *New Ways of Addressing Partial Work Capacity*. Cit., p. 4.

capabilities¹⁰⁵, so that people with reduced work abilities are to some extent regarded as fit for work and do not access disability allowance. In empirical terms, the direct correlation is yet to be demonstrated between the way welfare and social security systems are conceived and the strategies favouring or preventing labour market inclusion for these workers. But it is a fact that in countries where no permanent or temporary disability benefits are provided to people with a reduced work ability, lower inactivity rates for people with chronic diseases are reported¹⁰⁶.

This move is likely to produce an increase in the unemployment rates for this category of workers (Luxembourg's case)¹⁰⁷, yet it fulfils the purpose of addressing the employability and re-employment of workers with chronic diseases considering a labour-based approach rather than taking a medical perspective (see par. 2). A reallocation of public subsidies should follow. They should not be used to fund passive policies that lead to inactivity but to promote economic incentives favouring workers' retraining and return to work.

A case in point is Danish *flex-jobs*¹⁰⁸, that is subsidised employment schemes for those with a reduced workability of at least 50%¹⁰⁹. Disability benefits in Denmark are only granted to those with a permanent reduced work ability that does not allow them to perform work, irrespective of whether or not they attend activation or vocational rehabilitation programmes. Instead, special forms of unemployment benefits are provided to those who can engage in part-time work through adequate medical, therapeutic, and psychological support and training. Employers who resort to flex-jobs are paid economic incentives, while workers receive a standard wage.

¹⁰⁵ This point has been made by the OECD. *New Ways of Addressing Partial Work Capacity*. Cit., p. 4. With reference to the Estonian case, cf. also M. MASSO. *Estonia: Employment opportunities for people with chronic diseases*. European Observatory of Working Life, November 2014.

¹⁰⁶ Again, OECD, *New Ways of Addressing Partial Work Capacity*, cit., qui p. 7.

¹⁰⁷ Ibidem.

¹⁰⁸ In comparative terms, the system in place in the Netherlands is particularly significant (see OECD. *New Ways of Addressing Partial Work Capacity*. Cit., p. 5-8). This system consists of two main components. The long-life provision of a disability benefit for those who are no longer able to work and another form of benefit for those with a partial and temporary disability. Those falling within this second group are employed in low-paying occupations and entitled to a bonus. They are also engaged in job-searching and labour market participation initiatives.

¹⁰⁹ Again OECD. *New Ways of Addressing Partial Work Capacity*. Cit., qui p. 5.

The Danish case is of relevance if compared to other countries, e.g. Italy, where working time adjustments or even the right of sick workers to work part-time provided by law¹¹⁰ or collective bargaining¹¹¹ in the event of certain chronic diseases did not produce tangible results¹¹². This is due to the weak correlation of working time measures with social security and assistance benefits, and with incentive schemes promoting re-employment. They inevitably involve adaptation of the work environment on the part of the employer¹¹³ that is not offset by the reduction of the sick worker's salary because of fewer hours worked.

Likewise important are those retraining strategies envisaged by public and private employment services to help sick workers re-enter the labour market¹¹⁴. The case of Norway¹¹⁵ stands out as noteworthy¹¹⁶. Here, the public employment service works together with the national institute of social security to simplify and coordinate the services provided, and to ensure close interaction between active and passive employment policies, for example when granting work incentives and disabilities benefits. Further, the principle of conditionality¹¹⁷ has been strengthened in many

¹¹⁰ Cf. the national reports contained in EUROFOUND. *Employment opportunities for people with chronic disease*. Cit.

¹¹¹ Cf. the comparative study carried out for EUROFOUND on *Employment opportunities for people with chronic disease*, cit., especially the section *Examples of enterprises and collective agreements implementing support initiatives*.

¹¹² In Italy, only 8.6% of workers with an oncological condition asked to transform their employment relationship from full-time to part-time or other flexible working arrangements. By contrary, 20% of workers with cancer reported having left their job. Cf. Osservatorio sulla condizione assistenziale dei malati oncologici, *6° Rapporto sulla condizione assistenziale dei malati oncologici*. Sanità, Il Sole 24 Ore, 2014, p. 25.

¹¹³ Cf. again the case of the Netherlands (footnote 107) where the employer is under the obligation to adapt the workplace to the sick worker's health conditions for which some economic incentives are made available. See the national report on The Netherlands by W. HOOFTMAN NDI. HOUTMAN, contained in EUROFOUND, *Employment opportunities for people with chronic disease*. Cit. par. 3.1.

¹¹⁴ An overview of some good practices is provided in the summary documents edited by S. AUTIERI, F. SILVAGGI. *Buone prassi in materia di reinserimento delle persone con disabilità: schede di sintesi*. In Bollettino ADAPT, n. 34/ 2014. Cf. also EUROFOUND. *Employment opportunities for people with chronic disease*. Cit.

¹¹⁵ The same happens in the UK. Cf. the national reports of Norway and the United Kingdom included in the comparative analysis conducted for EUROFOUND on *Employment opportunities for people with chronic disease*, cit.

¹¹⁶ Cf. F. SILVAGGI. *Il ritorno al lavoro dopo il cancro: una prospettiva europea*. In Bollettino ADAPT, n. 27/2014.

¹¹⁷ Cf. the national reports included in EUROFOUND. *Employment opportunities for people with chronic disease*. Cit.

countries. In other words, receiving or maintaining social security benefits is made dependent upon participation in training and retraining schemes¹¹⁸, while promoting a more adequate link between public and private placement services through cooperation and subsidiarity¹¹⁹.

3.2. Reviewing the Strategies for Work-life balance and Equal Opportunities: Promoting *Work-health-life Balance*

At a European level, additional efforts should be channelled into reviewing the strategies concerning workers' work-life balance and equal opportunities, not only in terms of gender but to promote *work-health-life-balance*. This will help boost business productivity and efficiency¹²⁰ in the short and the long run, while dealing with certain employment-related issues like quality, sustainability¹²¹, diversity, and the impact of technology on one's working and personal life. A major overhaul of stagnating OHS legislation is therefore needed, since it was conceived for an industry-based economic and a social paradigm that are now outdated.

Following the transposition of Directive No. 89/391/EEC of 12 June 1989¹²² into national legislation, the employer is under the obligation to ensure the safety and the "health of workers in every aspect related to the work"¹²³, "adapting the work to the individual, especially as regards the

¹¹⁸ Cf. B. GAZIER. *Vers un nouveau modèle social*. Champs Essay, Parigi, 2009; F.J., GLASTRA B.J. HAKE, P.E. SCHEDLER. *Lifelong Learning as Transitional Learning*. In *Adult Education Quarterly*, 2004, n. 54; A.M. Saks, R.R. Haccoun. *Managing performance through training and development*. Toronto, Nelson Education, 2010.

¹¹⁹ On the definition of the conditionality principle in relation to the Italian case, cf. L. CORAZZA. *Il principio di condizionalità (al tempo della crisi)*. In *Giornale di Diritto del Lavoro e di Relazioni Industriali*, 2013, pp. 489-505.

¹²⁰ On the importance of the strategies to concurrently ensure social protection and production efficiency, cf. E. RAMSTAD. *Promoting Performance and the Quality of Working Life Simultaneously*. In *Internal Journal of Productivity and Performance Management*, 2009, pp. 423-436.

¹²¹ On the concept of sustainable work, see EUROFOUND. *Sustainable Work and the Ageing Workforce*. Luxembourg, 2012, especially p. 7-8.

¹²² Cf. Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work.

¹²³ Article 5 of the Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work.

design of workplaces, the choice of work equipment and the choice of working and production methods”¹²⁴.

Also, Council Directive No. 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation¹²⁵ calls for the need to promote a labour market favourable to social inclusion, asking Member States to formulate a coherent set of policies aimed at combating discrimination against groups such as persons with disability¹²⁶.

Prompting the adoption, whereas possible¹²⁷, of policies to promote equality, the Directive also provides that employers envisage “appropriate

¹²⁴ Art 6 let d) of the Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work. As regards the transposition of this principle into national legislation, see EUROPEAN COMMISSION, Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of Regions on the practical implementation of the provisions of the Health and Safety at Work Directives 89/391 (Framework), 89/654 (Workplaces), 89/655 (Work Equipment), 89/656 (Personal Protective Equipment), 90/269 (Manual Handling of Loads) and 90/270 (Display Screen Equipment), COM(2004)62. As far as Italy is concerned, Article 42 Legislative Decree No. 81 of 9 April 2008 health and safety at work titled “measures in the event of unfitness to perform a specific mention” sets forth that “the employer [...] puts in place the measures indicated by the relevant health authorities. If workers’ fitness is required to perform certain tasks and they are unable to perform them, workers should be assigned to an equivalent or a lower-level task while being entitled to the same remuneration as before”. Pursuant to this provision, the employer is required to make an attempt at replacing the worker who is unfit for the task assigned, irrespective of the seriousness of his/her inability. On the right of the worker to be assigned to a different task, also through a reasonable change of work organization, see S. GIUBBONI. *Sopravvenuta inidoneità alla mansione e licenziamento. Note per una interpretazione “adeguatrice”*. In *Rivista Italiana di Diritto del Lavoro*, 2012, pp. 304-308.

¹²⁵ Cf. Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work.

¹²⁶ Par. 8) of Council Directive 89/391/EEC of 12 June 1989 provides that “the Employment Guidelines for 2000 agreed by the European Council at Helsinki on 10 and 11 December 1999 stress the need to foster a labour market favourable to social integration by formulating a coherent set of policies aimed at combating discrimination against groups such as persons with disability. They also emphasise the need to pay particular attention to supporting older workers, in order to increase their participation in the labour force”.

¹²⁷ Article 5 of Directive No. 2000/78/EC sets forth that “In order to guarantee compliance with the principle of equal treatment in relation to persons with disabilities, reasonable accommodation shall be provided. This means that employers shall take appropriate measures, where needed in a particular case, to enable a person with a disability to have access to, participate in, or advance in employment, or to undergo training, unless such measures would impose a disproportionate burden on the employer.

measures, i.e. effective and practical measures to adapt the workplace to the disability, for example adapting premises and equipment, patterns of working time, the distribution of tasks or the provision of training or integration resource”¹²⁸.

As is well known, a part of the literature¹²⁹ has seriously called into question the employers’ interest to devise measure to adapt the workplace to the need of workers with a chronic diseases. This also includes employers unwillingness to assign other tasks or to employ individuals with a chronic disease. Instead, they welcome public training schemes for chronically ill employees while they are still in employment.

One might also note that the obligations referred to above, which are contained in both legislation and employment contracts, are not as effective as they should be because they are not supplemented by adequate measures of work-life balance based on employability and the mutual adaptability of the parties concerned. If these initiatives were put in place, the employer would have a more pro-active attitude, not just to comply with formal obligations, but because these actions might benefit the company in terms of productivity, efficiency, cost-saving (either direct and indirect costs) and employee loyalty (par. 5).

Ensuring sustainable work to both the employer and the sick employee¹³⁰ will make it possible to give practical form to certain “recommendations”¹³¹ which are taken for granted but poorly implement. According to these recommendations, the programmes involving mutual adaptation should be in force while workers with chronic diseases are still in employment, to prevent one’s inability to work rather than dealing with

This burden shall not be disproportionate when it is sufficiently remedied by measures existing within the framework of the disability policy of the Member State concerned”.

¹²⁸ Par. 20) of Directive No. 2000/78/CE.

¹²⁹ Cf. S.H. ALLAIRE, J. NIU, M. P. LA VALLEY. *Employment and Satisfaction Outcomes from a Job Retention Intervention Delivered to Persons with Chronic Diseases*, in *Rehabilitation Counseling Bulletin*. 2005, p. 108, where it is argued that: “it’s not clear that employers would be interested in intervention that helps employees identify and request accommodation”. In relation to the employer’s unwillingness to take on workers with disabilities and to the costs to adapt the workplace, cf. also DEPARTMENT FOR WORK AND PENSIONS. *Economic and Social Costs and Benefits to Employers of Retaining, Recruiting and Employing Disabled People and/or People with Health Conditions or an Injury: A Review of the Evidence*. 2006, p. 88.

¹³⁰ Cfr. EUROFOUND. *Sustainable Work and the Ageing Workforce*. Cit.

¹³¹ Cf. the first of the nine *Recommendations from ENWHP’s ninth initiative Promoting Healthy Work for Employees with Chronic Illness – Public Health and Work*, p. 10, which is frequently overlooked.

it afterwards, when they have lost their skills and are forced out of the labour market (so called job mastery)¹³².

4. Promoting the Prevention of Chronic Diseases at the Workplace

Prevention has now become a stated objective of the European Commission in the medium and long term. Decision-makers at the EU level¹³³ have stressed the need to act on risk factors (smoke, alcohol, eating habits, lifestyles) paying particular attention to the most vulnerable groups.

In this perspective, workplaces, schools and universities play a major role to devise preventive measures that should be more effective than those in place thus far¹³⁴.

This is even more so as the major issues concerning the relationship between employment and chronic diseases are due to social and economic determinants (income levels and education), so the ability to react to a serious disease and return to employment also depends on the resilience and vulnerability of those involved¹³⁵. In turn, the manner in which legal

¹³² In this perspective, see S.H. ALLAIRE, J. NIU, M. P. LA VALLEY. *Employment and Satisfaction Outcomes etc.* Cit.

¹³³ Cf. EUROPEAN COMMISSION. *The 2014 EU Summit on Chronic Diseases*. Cit., p. 2 e p. 4.

¹³⁴ *Ibidem*. Cf. A.C. BENSAOND, P. BARBEZIEUX, F.O. CHAMPS. *Interactions entre santé et travail, Inspection Générale des Affaires Sociales*. Paris, 2013, p. 6.

¹³⁵ Resilience and vulnerability are key concepts in the academic debate concerning prevention and mitigation strategies. They are also being given priority at the micro-level (i.e. at the individual, community and company level), following demographic, economic, environmental and work-related changes and the increasingly special character of workers and workplaces. Consequently, the one-size-fits-all rule is no longer applicable. The word “resilience” was first used in physics and ecology, thanks to the work of C.S. HOLLING. *Resilience and Stability of Ecological Systems*. In *Annual Review of Ecology and Systematics*, 1973, 1-23. Later on, the term was also employed to refer to people, families, communities and organizations. In considering disruption or hardship, resilience is defined as a positive adaptability trajectory (cf. F.H. NORRIS, S.P. STEVENS, B. PFEFFERBAUM, K.F. WYCHE, R.L. PFEFFERBAUM. *Community resilience as a metaphor, theory, set of capacities, and strategy for disaster readiness*. In *American Journal of Community Psychology*, 2008, pp. 127-135) and constitutes «the capacity for successful adaptation, positive functioning or competence [...] despite high-risk status, chronic distress, or following prolonged or severe trauma», cf. B. EGELAND, E. CARLSON, L.A. SROUFE. *Resilience as process*. In *Development and Psychopathology*, 1993, pp. 517-534. As for vulnerability, the 2010 glossary of the United Nations International Strategy for Disaster Reduction (UNI-SDR) states that it is “the characteristics and circumstances of a community, system or asset that make it susceptible to the damaging effects of a hazard”.

obligations are fulfilled changes in each workplace and rests on the response – either negative or positive – provided by each company.

On a close reading, “wellness at work” is not a new concept among employers. They have voluntarily decided¹³⁶ to take further action, moving from merely complying with protection measures against chronic diseases imposed by legislation and collective agreements to setting forth initiatives of Corporate Social Responsibility¹³⁷, i.e. to raise awareness¹³⁸ about lifestyles and habits that are detrimental to their employees’ health¹³⁹.

These important measures are often funded by public and private entities or by the employer himself by means of economic and financial incentives¹⁴⁰. Such initiatives consider two main aspects: preventing chronic diseases by acting on risk factors (primary prevention); diagnosing and treating them at their early stage, that is before complications arise

This concept is closely connected to that of resilience, as pointed out by C. FOLKE. *Social-Ecological Resilience and Behavioural Response*. Beijer International Institute of Ecological Economics, Royal Swedish Academy of Sciences, 2002, p. 3 and T. CANNON. *Vulnerability analysis and the explanation of “natural” disasters*. In A. VARLEY (editor), *Disasters, Development, Environment*, Wiley, 1994, p. 19. The authors argue that vulnerability is a complex element resulting from the combination of primary (status, gender, ethnics,) and secondary factors (e.g. age).

¹³⁶ An overview of the measures taken at a company level is provided in *The Willis Health and Productivity Survey*. New York, 2014. Cf. also S. MATTKE, H. LIU, J.P. CALOYERAS, C.Y. HUANG, K.R. VAN BUSUM, D. KHODYAKOV, V. SHIER. *Workplace Wellness Programs Study, Final Report*. RAND Health, 2013 who report that more than 50% of US companies with more than 50 employees (that is $\frac{3}{4}$ of the US workforce) provides wellness programmes.

¹³⁷ Cf. the Green Paper of the European Commission. *Promoting a European Framework for Corporate Social Responsibility*. Brussels, 18.7.2001 COM (2001) 366 final, esp. § 2.1.2.

¹³⁸ Cf. E. MASSAGLI (a cura di). *Il welfare aziendale territoriale per la micro, piccola e media impresa italiana*. ADAPT Labour Studies e-Book series, 2014, n. 31.

¹³⁹ Among the first authors who highlighted the new approach of company policies (from initiatives to prevent occupational injuries and diseases to those preserving one’s health), see R.E. GLASGOW, J.R. TERBORG. *Occupational Health Promotion Programs to Reduce Cardiovascular Risk*. In *Journal of Consulting and Clinical Psychology*, 1988, pp. 365-373.

¹⁴⁰ This topic has been recently investigated by Z. BAJOREK, V. SHREEVE, S. BEVAN, T. TASKILA. *The Way Forward: Policy Options for Improving Workforce Health in the UK*. The Work Foundation, London, 2014, esp. pp. 27-32. In relation to the incentive schemes devised by the employer, cf. K.M. MADISON, K.G. VOLPP, S.D. HALPERN. *The law, policy, and ethics of employers’ use of financial incentives to improve health*. In *Journal of Law Medicine, Ethics*, 2011, pp. 450-468. The authors consider the expediency and the legitimacy of these incentive schemes in terms of coercion and discrimination against certain groups of workers on grounds of their habits.

that prejudice workers' health and their opportunity to stay on at work (secondary prevention)¹⁴¹.

In reality, the company-based initiatives intended to prevent chronic diseases (e.g. weight management, the provision of healthy food at workplace canteens, smoking bans, health education, regular check-ups, in-company physical exercise, discounts on the enrolment fees for the gym), and social security schemes supplementing or providing medical coverage are seen as initiatives of Corporate Social Responsibilities or widespread examples of good practices¹⁴².

As widely pointed out by an increasing number of scholars at the international level¹⁴³, and particularly if a long term perspective is taken¹⁴⁴, these wellness-at-work initiatives benefit the employer, either directly or indirectly. Some major advantages from the company include: the reduction of the costs arising from their employees' disability, increased productivity and loyalty, talent retention, reduced absenteeism, fewer workers on leave, and a lower impact of presenteeism¹⁴⁵, that is working when one's health conditions do not allow to perform duties.

Including the promotion of employee health and well-being in the company policies gives employers the opportunity to review their

¹⁴¹ A wide number of case studies is provided in S. MATTKE, H. LIU, J.P. CALOYERAS, C.Y. HUANG, K.R. VAN BUSUM, D. KHODYAKOV, V. SHIER. *Workplace Wellness Programs Study, Final Report*. Cit. The issue of workplace wellbeing is considered by OECD. *How's Life? 2013 - Measuring Well-Being*. OECD Publishing, 2013, esp. pp. 147-171.

¹⁴² On the desire to emulation as a lever to adopt workplace wellness strategies, cf. S. ZAMAGNI. *People Care: dale malattie critiche alle prassi relazionali aziendali*. Cit.

¹⁴³ See the review by L.S. CHAPMAN. *Meta-Evaluation of Worksite Health Promotion Economic Return Studies: 2012 Update*. Marzo - aprile 2012, ADAPT Observatory on Work & Chronic Diseases, that collects the results of over 100 studies published on peer-reviewed journals. See also, L.L. BERRY, A.M. MIRABIT, W.B. BAUN, *What's the Hard Return on Employee Wellness Programs?*. In *Harvard Business Review*, 2010, pp. 105-112; K. BAICKER, D. CUTLER, Z. SONG, *Workplace Wellness Programs Can Generate Savings*. In *Health Affairs*, 2010, pp. 304-311; C. HOCHART, M. LANG. *Impact of a Comprehensive Worksite Wellness Program on Health Risk, Utilization, and Health Care Costs*. In *Population Health Management*, 2011, pp. 111-116; H. VAUGHAN-JONES, L. BARHAM. *Healthy work: Evidence into action*. The Oxford Health Alliance, The Work Foundation - RAND Europe, London, 2010, PRICE WATER HOUSE COOPERS. *Building the case for wellness* 4th February 2008. Report for the UK Department for Work and Pensions, 2008.

¹⁴⁴ Cf. S. MATTKE, H. LIU, J.P. CALOYERAS, C.Y. HUANG, K.R. VAN BUSUM, D. KHODYAKOV, V. SHIER. *Workplace Wellness Programs Study, Final Report*. Cit., espe. p. 3 where they make reference to "selected employers with strong commitments to wellness".

¹⁴⁵ As for presenteeism, cf. K. KNOCHE, R. SOCHERT. K. HOUSTON. *Promoting Healthy Work for Workers with Chronic Illness: A Guide to Good Practice*. Cit. p. 9.

organizational and productive models considering the transformation of work in the economy and society spurred by wide-ranging changes in demography and technology¹⁴⁶.

The positive effects that wellness policies produce at the company level have been widely acknowledged. For this reason, a question is being asked as to why many employers fail to devise initiatives that in practical terms help to prevent and raise awareness about occupational health¹⁴⁷. This aspect can be partly explained by the impact of the economic and financial crisis on company budgets¹⁴⁸, and by the fact that small-sized businesses are the norm in Italy, thus these initiatives are poorly implemented¹⁴⁹. Adding to this are the many legal, fiscal, organization and cultural obstacles that hamper the dissemination of wellness-at-work practices¹⁵⁰.

5. A New Industrial Relations Perspective: Productivity and Sustainable Work and the Importance to Rethink the Notions of “Presence at Work”, “Job Performance” and “Full Compliance with Contractual Terms”

Thus far, the present investigation has enabled us to cast light on three main lines of action, the implementation of which has however been limited and fragmented: 1) to modernize the national systems of social

¹⁴⁶ In this sense, a study has been carried out on the impact that wellness programmes have on the effectiveness of organisations. Cf. the WORLD ECONOMIC FORUM. *The Wellness Imperative Creating More Effective Organizations*. Geneva, 2010, p. 16.

¹⁴⁷ This is the question posed by Z. BAJOREK, V. SHREEVE, S. BEVAN, T. TASKILA. *The Way Forward: Policy Options ecc.* Cit., p. 9.

¹⁴⁸ In this perspective, see Z. BAJOREK, V. SHREEVE, S. BEVAN, T. TASKILA. *The Way Forward: Policy Options ecc.* Cit., p. 10.

¹⁴⁹ In relation to the Italian industrial relations system, one might note that an innovative set of benefits has been put in place for employees that also includes the provision of healthcare services (so-called bilateralism). These benefits are now widespread in many industries characterized by micro and small-sized businesses. See

M. TIRABOSCHI. *Bilateralism and Bilateral Bodies: The New Frontier of Industrial Relations in Italy*. In *E-Journal of International and Comparative Labour Studies*, 2013, pp. 113-128, and the study conducted by Italia Lavoro in 2012/2013 concerning the duties and the functions of bilateral bodies, among other the provision of complementary healthcare (cf. ITALIA LAVORO. *Gli enti bilaterali in Italia – Primo rapporto nazionale*. 2013, pp. 127-146).

¹⁵⁰ Cf. S. MATTKE, H. LIU, J.P. CALOYERAS, C.Y. HUANG, K.R. VAN BUSUM, D. KHODYAKOV, V. SHIER. *Workplace Wellness Programs Study*, RAND, Santa Monica, 2013 and R.Z. GOETZEL et al.. *Do Workplace Health Promotion (Wellness) Programs Work?* In *Journal of Occupational and Environmental Medicine*, 2014, pp. 927-934.

protection that should be more individual-oriented 2) to step up activation policies, as well as those concerning work-life balance and retention 3) to provide preventive measures at the workplace.

Nevertheless, a detailed analysis of the national and international literature shows that the management of the delicate relationship between employment and chronic diseases fails to consider the role that the industrial relations system might play¹⁵¹.

It must be pointed out that there have been some pioneering studies that have pointed out how collective bargaining in different industries has supplied further protection to workers affected by “serious diseases”¹⁵², by acting along with traditional legal provisions.

This usually takes place through: 1) longer statutory leave of absence and sick leave 2) forms of income support while the employment relationship is suspended¹⁵³ 3) regular breaks to allow treatment and help recover from mental and physical strain 4) policies of work-life balance based on the rescheduling of working time, telework and temporary and voluntary part-time arrangements¹⁵⁴ 5) working arrangements allowing caregivers the opportunity to strike a balance between work and family commitments¹⁵⁵

¹⁵¹ Cf. la *literature review* curata da S. VARVA. *Malattie croniche e lavoro: una rassegna ragionata della letteratura di riferimento*. Cit.

¹⁵² For the Italian case cf., S. BRUZZONE. *Disabilità e lavoro - Una disamina delle disposizioni contrattuali per la conciliazione dei tempi di lavoro e cura: il caso della Sclerosi Multipla*. Associazione Italiana Sclerosi Multipla, 2012 e già ID., *Il lavoro come precondizione di inclusione sociale nell'ambito dei diritti umani*. In AA.VV.. *Lavoro e disabilità: la sclerosi multipla e le patologie croniche progressive nel mercato del lavoro*. In Osservatorio Olympus, 2002 (<http://olympus.uniurb.it>). For a detailed analysis of the terms laid down by collective bargaining at national and company level, cf. ADAPT. *Rapporto sulla contrattazione collettiva in Italia (2012-2014)*. ADAPT University Press, 2015, especially the section *Malattie croniche e lavoro nella contrattazione collettiva*.

¹⁵³ Cf. the company-level collective agreement concluded by Luxottica on 17 October 2011, which is among the first initiatives in this field. Pursuant to this agreement, employers with serious diseases are entitled to an allowance equivalent to up to 100% of their remuneration if they are absent from work for more than 180 days.

¹⁵⁴ A comparative analysis, that is limited to oncological diseases, is provided in the study by M. TIRABOSCHI (a cura di). *Promoting new measures for the protection of women workers with oncological conditions by means of social dialogue and company-level collective bargaining* carried out in 2008 for the European Commission, funding line *Industrial Relations and Social Dialogue*, available at the ADAPT Observatory on *Work and Chronic Diseases*.

¹⁵⁵ In Italy, a first intervention to afford protection to caregivers for workers with oncological conditions is Legislative Decree No. 276 of 10 September 2003 (also known as the Biagi Law). This provision allows caregivers to work part-time and request leave to better reconcile work and family commitments. See M. Tiraboschi. *Lavoro e tumori: Quali*

6) initiatives enabling workers to be assigned to new tasks¹⁵⁶ or to be transferred¹⁵⁷.

These measures, although laudable, are still sketchy and present some shortcomings. They are not based on a full understanding of the aspects they intend to regulate, and no links exist with public and private welfare systems¹⁵⁸. The case of Italy is an egregious example. Here, a high number of collective agreements¹⁵⁹ allowed workers with oncological conditions¹⁶⁰ to enter part-time work, in full compliance with the law. Although widespread, this practice was not implemented consistently and resulted in forms of discrimination against those workers who were affected by chronic diseases other than oncological ones. This is because the latter are not given the same opportunities to change their working schemes as the

tutele?. In *Bollettino Speciale ADAPT*, n. 16/2014. On the US case, cf. K. MATOS, E. GALINSKY. *2014 National Study of Employers*. Families and Work Institute, 2014.

¹⁵⁶ The collective agreement concluded in the energy sector sets forth that in order to facilitate the re-employment of sick workers, new tasks will be assigned to them – also through part-time and flexible working arrangements – taking into consideration the indications provided by the public health authorities or the certified centers that assist these workers during treatment and rehabilitation, in line with the employers' organizational and productive needs. Although implicitly, the provision suggests that the recommendations provided by the foregoing public entities might refer to either part-time or flexible working schemes or the tasks to be performed. Cf. *Rapporto sulla contrattazione collettiva in Italia (2012-2014)*, ADAPT University Press, cit.

¹⁵⁷ Still in relation to the Italian case, the collective agreement concluded in the construction sector is worth a mention. This collective agreement contains a provision pursuant to which workers who cannot be reassigned due to certified health or family reasons cannot be dismissed if the company can still employ him in the same productive unit. Therefore, workers' health conditions are taken into consideration to avoid their dismissal, since their health status is used as evidence of their inability to be reassigned. This provision bears relevance in that the only clause regulating workers' transfer is Article 33 of Act No. 104 of 5 February 1992, which however is concerned with disabled workers or their family members. Cf. *Rapporto sulla contrattazione collettiva in Italia (2012-2014)*, ADAPT University Press, cit.

¹⁵⁸ The author of this paper has dealt with this issue in *Oltre il conflitto: le nuove prospettive del welfare aziendale in Italia*, in *Contratti e contrattazione*, dicembre 2014, n. 12, pp. 4-5. In reference to the Italian case, see E. MASSAGLI. *Il welfare aziendale territoriale per la micro, piccola e media impresa italiana*. Cit.

¹⁵⁹ Cf. *Rapporto sulla contrattazione collettiva in Italia (2012-2014)*, ADAPT University Press, cit.

¹⁶⁰ Article 46 of Legislative Decree No. 276 of 10 September 2003. Cf. Ministerial Circular No. 40/2005. An analysis of this provision and the relevant collective agreements is provided in P. TIRABOSCHI, M. TIRABOSCHI. *Per un diritto del lavoro al servizio della persona: le tutele per i lavoratori affetti da patologie oncologiche e tumore al seno*. in *Diritto delle Relazioni Industriali*, 2006, n. 2, 524-530.

former, nor is this prejudicial treatment sufficiently and reasonably motivated by lawmakers or IR actors¹⁶¹.

One thing is acknowledging that labour lawyers, HR managers and trade union representatives superficially consider chronic diseases as an undistinguished group when it comes to affording safeguards. They all produce vulnerability and long-term absence from work requiring adaptation in relation to working hours and full compliance with contractual obligations. Another thing is extending and implementing protection and rights through collective bargaining and its actors, who obviously lack the necessary medical knowledge to draw a distinction between different chronic diseases and their impact on the employment relationship. This state of affairs is not the result of chance events¹⁶² but by the seriousness of the disease and its effect on workers and their residual capacity to fulfil contractual obligations.

Significantly, the few studies that have monitored the impact that diseases have on one's employment and return to work following treatment and recovery have been mostly carried out by teams of doctors on just one disease¹⁶³. In addition, the literature has only rarely dealt with the effects that the many types of different diseases have on employment. Besides the needs that are common to all sick workers (coping strategies, support of colleagues, adequate working conditions, health and social assistance, incentives, flexible working times and adequate workloads, absence management, presenteeism, etc.), some special aspects concern chronic diseases in relation to their duties according to the type of disease¹⁶⁴ and the response to treatment.

Similarly to the systems of social protection described in par. 2, collective bargaining has provided support to workers affected by chronic diseases

¹⁶¹ S. BRUZZONE. *Disabilità e lavoro ecc.*, cit., esp. pp. 11-16, pp. 19-20, p. 23, pp. 28-29. To many people, cancer differs from other chronic diseases and workers with an oncological condition might experience social stigmatization, especially at work, as though it were not possible to recover and return to work.

¹⁶² This is what happened in Italy where the idea to give workers with an oncological condition the right to part-time work was suggested informally to the then Deputy Minister of Work Maurizio Sacconi by Prof De Lorenzo who was the President of the National Association of People with Cancer, their Relatives and Friends at the time of drafting the Biagi Law.

¹⁶³ Cf. the literature review by S. VARVA. *Malattie croniche e lavoro: una rassegna ragionata della letteratura di riferimento*. Cit.

¹⁶⁴ Cf., in relation to workers with rheumatoid arthritis, diabetes mellitus or suffering from hearing loss, S.I. DETAILLE, J.A. HAAFKENS, F.J. VAN DIJK. *What employees with rheumatoid arthritis, diabetes mellitus and hearing loss need to cope at work*. in *Work Environment & Health*, 2003, pp. 134-142.

through a one-size-fits-all approach that is inappropriate to define and deal with each case. One explanation for this is that the safeguards currently in place do not lend themselves to evaluations targeted on individuals and on the consequences that the disease has on one's performances. Neither do they take account of the occupation, contractual terms and tasks etc. Consequently, entrusting the employer with the task to reasonably adapt these safeguards to the need of each sick worker¹⁶⁵ proves unsuccessful. The measures involving the industrial relations system concern salaried and standard employment (see par. 2) and usually take a defensive approach. In other words, with a view of helping sick workers to safeguard their jobs and source of income, the initiatives in place are aimed at moving away from merely assessing the fulfilment of duties and the arising inability to carry out tasks as elements to terminate the contract¹⁶⁶. This explains why the set of formal rights accorded to workers with chronic diseases in legislation and the employment contract are ineffective¹⁶⁷, particularly when they are not properly linked to additional initiatives (i.e. training, psychological support, recovery¹⁶⁸) and included in wellness-at-work policies at the company level (see par. 4).

Yet industrial relations might play a decisive role as regards activation policies and the return to work of workers with chronic diseases. This will only happen through collective bargaining and the bilateral bodies in place to manage workers' benefits at the company and the local level, which help raise awareness of the transformation of work stemming from organizational, demographic and technological changes that considerably affect such concepts as "presence at work", "job performance" and "full compliance with contractual obligations".

When devising innovative forms of protection, consideration should be given to the recent evolution of both contractual and working arrangements, and to explain the major changes in work and

¹⁶⁵ In this perspective, cf. the recommendations of the EUROPEAN NETWORK FOR WORKPLACE HEALTH PROMOTION. *Recommendations from ENWHP's ninth initiative Promoting Healthy Work for Employees with Chronic Illness – Public Health and Work*. Cit., p. 5.

¹⁶⁶ The issue is dealt with in a comparative perspective by S. FERNÁNDEZ MARTÍNEZ. *Enfermedad crónica y despido del trabajador: una perspectiva comparada*. Cit. In reference to the Italian case, cf. S. GIUBBON. *Sopravvenuta inidoneità alla mansione e licenziamento*. Cit.

¹⁶⁷ Cf. F. DE LORENZO. *Lavorare durante e dopo il cancro: una risorsa per l'impresa e per il lavoratore*. cit. *supra*, nota 77 in relation to the Italian case.

¹⁶⁸ See note 70.

production¹⁶⁹. These major developments, which are accelerated by the ageing of the population, profoundly affect the concept of “worker”, “capabilities”, and “fitness for work”. While employed in a loose sense in the past, these notions are now increasingly considered in relation to one’s task¹⁷⁰ and the different stages of one’s career.

The examination of chronic diseases provides an opportunity to experiment on new organizational and regulatory models that consider ongoing demographic and economic changes and favour a better evaluation of labour productivity¹⁷¹. This should take place taking into account each worker’s professional and career paths and the emerging idea of “sustainable work” so that one’s performances should be assessed considering health and mental conditions while at work¹⁷². This brings to

¹⁶⁹ On the way to do business and organise production, the evolution of atypical and autonomous work, the evolution of trades, skills and professions, the challenge of the modernization of the labour market, see *Le Grande Trasformazione del Lavoro*, blog ADAPT su Nòva, Il Sole 24 Ore (<http://adapt.nova100.ilsole24ore.com>).

¹⁷⁰ R. LINARES, V. MORTARA. *Abilità, idoneità, capacità, validità: problematiche dell'inserimento, riammissione e reinserimento al lavoro*. In F. PELONE (a cura di), Atti VII Convegno Nazionale di Medicina Legale Previdenziale, INAIL, 2009, p. 303.

¹⁷¹ As already pointed out in par. 1, productivity is being questioned by a demographic situation in which the index of economic dependency (EUROPEAN COMMISSION, DIRECTORATE-GENERAL OF ECONOMIC AND FINANCIAL AFFAIRS, *The 2012 Ageing Report: Economic and budgetary projections for the EU27 Members States (2010-2060)*, 2012, esp. pp. 71-75), coupled with a rise in the direct and indirect costs to treat chronic diseases (for the European case, see F. DE LORENZO. *Presentazione Progetto ProJob: lavorare durante e dopo il cancro*. Cit.; for the US case, see U.S. Workplace Alliance. *The Burden of Chronic Disease on Business and U.S. Competitiveness*. 2009) and the unemployment of people with chronic disease (the higher costs are those resulting from the “years out of work”) bring about a number of critical issues in relation to the sustainability of social and economic systems that call for a rethinking of sick workers’ retention and return to work. This point is made clear by R. BUSSE, M. BLÜMEL, D. SCHELLER-KREINSEN, A. ZENTNER. *Tackling chronic disease in Europe: Strategies, Interventions and challenges*, European Observatory on Health Systems and Policies. World Health Organization 2010, p. 20: “With regard to labour supply and labour productivity, chronic conditions and diseases mean fewer people in the workforce, with early retirement, barriers to employment, and stigma. There is reasonable evidence on the negative impact of chronic disease and risk factors on the labour market, showing that chronic disease affects labour supply in terms of workforce participation, hours worked, job turnover and early retirement as well as wages, earnings and position reached”.

¹⁷² In this sense, cf. the relevant work carried out by EUROFOUND. *Sustainable Work and the Ageing Workforce*. Luxembourg, 2012, which provides a detailed description of the main indicators concerning “sustainable work”. In literature, cf. P.P. DOCHERTY, J. FORSLIN, A.B. SHANI. *Creating Sustainable Work Systems – Emerging Perspectives and Practice*. Routledge, London, 2002.

the fore the major role that can be played by current industrial relations systems. Although facing a decline¹⁷³, industrial relations might be given fresh momentum as a tool to thoroughly review¹⁷⁴ the criteria to redistribute and to assess the value of work, balancing between employers' needs and workers' protection.

Through adequate collective bargaining, one option could be that of including "some guarantees" in the employment contract facilitating proper management in the event of a chronic disease, while ensuring certain levels of labour productivity¹⁷⁵. This would come along with fine-tuning job performance in line with the radical changes in society, production and work organization. The throughout and analytical assessment of each performance should be founded on objective and subjective parameters according to the sustainability of work in a given production context.

One conclusion that can be drawn from the present investigation that will certainly serve as a starting point from future research is that the complex relation between work and chronic diseases is far from marginal in labour law. Research into this relation will enable to go beyond those engrained practices that characterize the current job grading schemes laid down in collective bargaining in many countries¹⁷⁶, which were conceived to assess job performance in 1900s. What is needed now is a system modelled on individual needs and the contribution that each worker can provide to

¹⁷³ On the decline of industrial relations and its subfields, cf. the vast amount of literature in B. KAUFMAN, *Il principio essenziale e il teorema fondamentale delle relazioni industriali*, in M. MASSAGLI, R. CARAGNANO (a cura di). *Regole, conflitto, partecipazione*. Giuffrè, 2013, pp. 3-40, and the academic debate originated by A. HASSEL. *The Erosion of the German System of Industrial Relations*. In *British Journal of Industrial Relations*, 1999, pp.. 483–505.

¹⁷⁴ On the prospects for reviewing industrial relations, see again B. KAUFMAN. *Il principio essenziale e il teorema fondamentale delle relazioni industriali*. Cit. On the German case and wide-ranging theoretical implications, see W. STREECK. *Re-forming Capitalism. Institutional Change in the German Political Economy*. Oxford University Press, 2010.

¹⁷⁵ An egregious example of this is the collective agreement concluded on 26 February 2011 in the manufacturing sector referred to above. The employer's needs to increase productivity in relation to absenteeism lead to favour long-term absence from work over short-term one to benefit workers with serious chronic diseases. Cf. E. CARMINATI. *Lotta agli assenteisti e maggiori tutele per i malati gravi*. Cit.

¹⁷⁶ On the prospects to move away from the hard-and-fast rules used in employment grading cf. L. RUSTICO, N. TIRABOSCHI. *Standard professionali e standard formative*. In M. Tiraboschi (a cura di), *Il testo unico dell'apprendistato*, Giuffrè, Milano, 2911, pp. 423-450 that consider the Italian case. An overview of the issue is also provided in M. MAGNANI. *Organizzazione del lavoro e professionalità tra rapporti e mercato del lavoro*. In *Giornale di Diritto del Lavoro e di Relazioni Industriali*, 2004, p. 165 and ff.

production that moves away from a purely commercial evaluation that only considers the mere provision of work in exchange of remuneration¹⁷⁷.

¹⁷⁷ This certainly provides the opportunity to employers to cooperate with institutions and goes behind the provision of remuneration for the services performed. The traditional view is described in U. CARABELLI. *Organizzazione del lavoro e professionalità: una riflessione su contratto di lavoro e post-taylorismo*. In Giornale di Diritto del Lavoro e di Relazioni Industriali, 2004, p. 1 and ff.

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