

Working conditions

How to respond to chronic health problems in the workplace?



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Authors: Oscar Vargas Llave, Julie Vanderleyden and Tina Weber

Research managers: Oscar Vargas Llave and Tina Weber

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European Foundation for the Improvement of Living and Working Conditions

Telephone: (+353 1) 204 31 00

Email: information@eurofound.europa.eu

Web: www.eurofound.europa.eu



Introduction

Individuals with a chronic disease have reduced employment and earnings prospects, partly because they are more likely to leave the labour market early or because they find it more difficult to re-enter employment after an absence. According to data from the Survey of Health, Ageing and Retirement in Europe (SHARE), while 74% of healthy individuals aged 50–59 are in employment, this declines to 70% among those with one chronic disease and falls as low as 52% for people with two chronic conditions.

Not being in work deprives people of the benefits employment can bring to well-being, quality of life, financial security and social inclusion. It also reduces the pool of labour for employers and leads to greater reliance on the benefit and pension system. While some people with chronic conditions are unable to continue working, many wish to and would be able to do so if the appropriate support and workplace accommodation of their needs were available.

The impact of chronic disease on workforce participation is a growing concern for policymakers. The rising share of older workers brings the issue of sustaining their employment and enhancing their ability to work into sharper focus. And, although chronic

conditions are more common among older workers, a growing share of younger workers is reporting long-standing illness. This, too, presents a policy concern, not least because of the significant scarring effect of labour market exclusion at an early stage in an individual's career.

This policy brief sheds a light on the extent to which workplace accommodation is helping to make work sustainable for workers with chronic disease – in the sense of helping them to manage their illness so that they can return to work or remain in work. It uses data gathered by Eurofound and Eurostat to set out:

- the prevalence of chronic disease in the EU workforce
- the extent to which workers with chronic disease have limitations in their daily activities, including the ability to work
- the extent to which workplaces have accommodated the needs of these workers
- whether such accommodations have made their work more sustainable

The policy brief also highlights where differences exist between Member States, as well as differences according to sociodemographic and work-related factors, such as gender, age, sector and occupation.



Policy context

There are two main, longstanding areas of EU policy that are particularly pertinent to the participation of individuals with chronic disease in the labour market, although neither is limited to this group. One is the strong emphasis on equal opportunities and equal treatment of people with disabilities in the labour market and wider society. The other relates to the strategic and policy initiatives targeting active ageing in the context of demographic change, to promote longer working lives up to retirement age. In addition, EU legislation and policy on occupational health and safety and on access to healthcare and social protection systems have an important role to play.

General policy principles

Fairness in the labour market and in welfare are among the cornerstones of the Sibiu Declaration on the future of Europe, made by the EU heads of state on 9 May 2019. In line with the principles laid down in the European Pillar of Social Rights, such fairness encompasses the inclusion of people with disabilities and enshrines their right to access services that enable them to participate in the labour market and in society, as well as the

right to a work environment adapted to their needs (Principle 17). Principle 3 on equal opportunities additionally provides for equal treatment and equal opportunities regarding employment for those with a disability. In terms of prevention, Principle 10 focuses on access to a healthy, safe and well-adapted work environment and emphasises that ‘workers have the right to a high level of protection of their health and safety at work’. Furthermore, linked to the concept of sustainable work, Principle 10 underlines the right to a working environment that enables individuals to prolong their participation in the labour market.

EU strategic and legislative frameworks

EU legislation in this area focuses on disability and does not currently specifically protect individuals on the basis of health status. Hence, workers with a chronic disease are not a particular policy target but are often included or referred to in policies aimed at the employment of people with disabilities. This holds true for both EU and national policy frameworks (Oortmijn et al, 2011).

The EU Occupational Safety and Health Framework Directive (89/391/EEC) requires employers to carry out risk assessments and to implement suitable prevention measures in order to eliminate risks at the source and to adapt work to workers. In addition to these general requirements that apply to all workers, employers are required to protect particularly sensitive groups against the dangers that specifically affect them and to organise workplaces to take account of the needs of disabled workers.

The EU Strategic Framework on Health and Safety 2014–2020 highlights the impact of the demographic challenges facing the EU and emphasises the important role played by the adaptation of workplaces and work organisation in successfully prolonging working lives. It also underlines the importance of addressing the challenges posed by chronic conditions, emphasising prevention and the reintegration of individuals who have such conditions.

Since 2011, the EU is party to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). The European Disability Strategy 2010–2020, designed to implement the UN convention in the EU, promotes active inclusion and the full participation of people with disabilities, including in employment. An evaluation of the strategy is currently underway (2019) to inform the development of a new strategic framework to support the full integration of people with disabilities in the labour market and society. An open public consultation, carried out within the framework of this evaluation, considered the lack of equal opportunities for these individuals in the labour market to be the key challenge to be addressed.

Article 26 of the EU Charter of Fundamental Rights also focuses on the integration of people with disabilities. It states that ‘the Union recognises and respects the right of people with disabilities to benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community’.

The Equality Framework Directive 2000 (Council Directive 2000/78/EC) prohibits discrimination on the grounds of disability, age, sexual orientation, and religion or belief in employment and occupation. It also obliges employers to provide reasonable accommodation for disabled individuals, with the exception of cases where this would entail a ‘disproportionate burden’.

There is a lack of clarity regarding the inclusion of the concept of (chronic) ‘sickness’ in the definition of disability, and European Court of Justice has adjudicated a number of court cases on the issue. While rulings in one case suggested that sickness cannot be regarded as a ground of discrimination in addition to those mentioned in the directive, in others the court suggested that the concept of disability may include illnesses in certain circumstances.

Policy monitoring and EU funding

As part of the European Semester monitoring processes, the European Commission’s country reports monitor, among other things, actions taken by Member States to enhance the participation of people with disabilities in the labour market. Under the European Structural and Investment Funds 2014–2020, resources are available to support the participation of disabled individuals in the labour market, including through labour market policy measures and infrastructure investments.

EU social partner actions

The European cross-sectoral social partners – BusinessEurope, CEEP, ETUC and UEAPME – have also contributed to developments in this area through the Autonomous Framework Agreement on Active Ageing and an Inter-generational Approach in 2017. This agreement addresses the issue of demographic change, how to enable workers to remain in work until retirement age, and the underlying goal of workplace accommodation of workers with chronic disease.

Key findings

- A quarter of the EU working population reports having a chronic disease. This share increased by 8 percentage points between 2010 and 2017. The upward trend is set to continue as the population ages, since workers over the age of 50 are more than twice as likely to have a chronic illness as workers under 35. However, among younger workers (aged 16–29) the share of those reporting chronic illness is also high and rising – from 11% in 2010 to 18% in 2017.
- Chronic conditions vary in their severity and the impact they have on the individual’s work and private life during different phases of the development of the condition. Among workers with a chronic disease, over half indicate that they are limited in their daily activities because of their condition.
- Having a chronic illness has implications for the sustainability of work, with affected individuals more likely to exit the labour market and become inactive. Over 40% of workers who say they are limited by their condition also say that they will not be able to work up to the age of 60.
- Workplace accommodation of the needs of workers with chronic disease can have an important impact on their job quality and the sustainability of work. This accommodation can be material (such as accessible workstations and voice-recognition software) or immaterial (such as working time adjustment and remote working). Working time flexibility is one of the most common forms of workplace accommodation.
- One-fifth of workers with a chronic disease report that their workplace or work activity has been adapted to accommodate their health problem. Among those whose daily activities are somewhat or severely limited, 30% have benefited from workplace accommodation. This leaves a high share of workers with a limiting health condition who are not being supported in this way.
- Over 40% of individuals with a limiting chronic disease who have had their workplace adapted believe that further accommodation will be required in the future, demonstrating that a one-off adaptation is often likely to be insufficient, and workers’ requirements need to be kept under review.
- Workers with low educational attainment and those in low-skilled occupations are more likely to have a chronic disease and experience limitations in their daily activities. At the same time, they are also less likely to benefit from workplace accommodation, which raises the issue of fairness in the workplace.
- Workers with a limiting illness whose needs have been accommodated at work have better job quality than those with a limiting illness whose needs have not been accommodated. Workplace adaptations are associated with improved career prospects for those with a limiting illness. Such workers also report lower levels of work intensity, lower stress levels and better work–life balance, all of which contribute to greater work sustainability and performance.
- Workplace size appears not to be a factor determining whether workplaces are likely to make adaptations. In addition, supportive workplace adaptations are more likely in workplaces where individuals feel they can voice their concerns and where they experience high levels of support from managers and colleagues.



Exploring the evidence

A chronic disease is an illness of long duration, not passed from person to person, that progresses slowly and requires ongoing treatment lasting for years or decades. For the purposes of gathering statistical information, the prevalence of chronic disease in the population is generally assessed through self-reporting – asking individuals whether they have ‘any illness or health problem which has lasted, or is expected to last, for more than 6 months’.

In this section, data from Eurofound’s 2015 European Working Conditions Survey (EWCS) are used to examine the experiences of workers with chronic disease, including whether they are limited in their ability to work, whether their workplace has accommodated their needs, and whether they report better job quality as a result. The analysis is supplemented by data from Eurostat surveys, which are used to provide details on the prevalence of chronic disease in the workforce and the broader EU population.

The analysis focuses on the working population aged 16–64 years, which includes employees and the self-employed.

How prevalent is chronic disease?

EU prevalence and trends

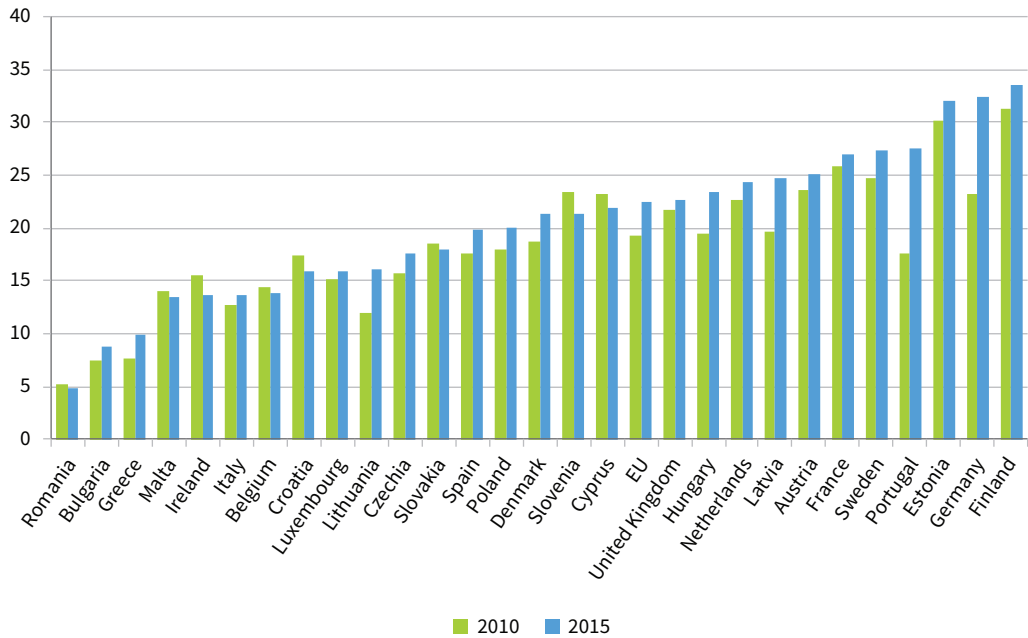
In 2017, nearly a third of the overall EU population and over a quarter of the working population reported that they live with a chronic disease. Prevalence has increased in the last seven years. Eurostat data show that between 2010 and 2017, the share of the EU population reporting having a longstanding illness or health problem increased by 6 percentage points (from 24% to 30%) in the 16–64 years age group. The increase in the working population was even greater at 8 percentage points (from 19% to 28%).

Differences across Member States

The EU average disguises differences between countries not only in relation to the overall prevalence of chronic disease but also with regard to trends.¹ As shown in Figure 1, Romania has the lowest share of the working population reporting a chronic disease (5% in 2015), while Finland has the highest share

¹ Since Eurostat data from 2017 is not available for all Member States, information from 2015 (and 2010) is used in the analysis that follows.

Figure 1: Trend in chronic disease (%) in the working population, Member States, 2010–2015



Source: Eurostat, *hlth_silc_04*, extracted 14 June 2019

(34%). Other countries with high shares are Austria, Estonia, France, Germany, Portugal and Sweden (above 25% in each), while in Bulgaria and Greece the shares are below 10%.

While there has been an overall increase in the prevalence of chronic disease in the working population, a number of countries saw a decline between 2010 and 2015: Belgium, Croatia, Cyprus, Ireland, Malta, Romania, Slovakia and Slovenia. The rise in individuals reporting a chronic disease has been greatest in Portugal (10 percentage points), Germany (9 percentage points), Portugal and Latvia (5 percentage points in each).

Differences between countries in the rates of chronic disease persist even when factors such as demographic profile, sectoral composition of the economy and so on are taken into consideration. These differences, as well as differences in trends, are difficult to explain without further research. Likely factors behind such variations include the nature and methodology of data collection, cultural differences, social and physical environment

(inside and outside of work), differences in national definitions and in assessment of disability, and the quality of diagnostic and healthcare services.

Reasons behind the rising trend

The rising share of individuals reporting chronic disease can be attributed to a range of factors, including:

- work and lifestyle factors that are causing an increase in some conditions, including musculoskeletal disorders, mental health conditions and cardiovascular disease
- improved survival rates for some diseases, such as various cancers and HIV/AIDS (European Observatory on Health Systems and Policies, 2010)
- population ageing, which has changed the overall balance of age cohorts towards older age groups, where chronic disease is more prevalent
- cultural change making it more socially acceptable to be open about having a chronic condition

Disparities between working and total population

Considering that having a long-standing illness is likely to have an impact on a person's ability to work, it is not surprising that more people in the general population report having a chronic disease than in the working population. However, between 2010 and 2015, the gap between the two populations has declined in the EU overall (from 5% to 4%).

The proportionally larger increase in the share of the working population with chronic disease compared to the general population could be attributed to a number of factors (in addition to those mentioned above):

- sectoral shifts in the economy towards less physically demanding tasks (meaning people can do this work more easily even with a chronic disease) alongside an increase in exposure to psychosocial risks, which can affect mental health and well-being
- improving economic and labour market trends post-crisis in many EU countries, which have served to improve the labour market position of groups that previously were more disadvantaged, including those with chronic disease
- the policy emphasis on activation and foreclosing avenues to early retirement, as well as more limited access to disability and unemployment benefit in some countries, and broader socioeconomic factors, which could mean that individuals with chronic diseases might see no viable (financial) alternative but to continue working despite their condition
- improved treatments that make it more feasible to continue working with a chronic disease

Groups most affected

Are certain groups of individuals particularly affected by chronic conditions, thus potentially making it possible to target policy action? EWCS data show that individual and work-related characteristics have a role to play (summarised in Figure 2).

Figure 2: Characteristics associated with higher and lower likelihood of reporting a chronic disease



Age

Workers over the age of 50 are more than twice as likely to have a chronic illness as workers below age 35. And those aged 35–49 are one and half times more likely to report a chronic condition. However, Eurostat data show that among workers aged 16–29, the percentage reporting chronic illness is also high and rising – increasing from 11% in 2010 to 18% in 2017.

Gender

Figures also show a slight predominance in women reporting chronic disease (24% of women and 21% of men, respectively). This small difference between women and men is also found across age groups. However, after different factors likely to impact developing a chronic disease are taken into account, women are only slightly more likely than men to be affected by chronic illness.

Education and occupation

Individuals with lower educational attainment and those in lower-skilled occupations are more likely to be affected by chronic disease. This likely reflects the link between chronic illness and material deprivation, which can be both a cause and an effect of low educational and occupational attainment (Bartley et al, 2004).

Employment status

In terms of employment status, employees with an indefinite contract have the lowest odds of having a chronic disease, whereas workers who are self-employed without employees have the highest odds. This confirms the findings of other studies that indicate that workers with atypical contracts are more likely to report living with a chronic disease (Kim et al, 2008; Virtanen et al, 2003).

Work duration

Chronic disease is more common among part-time workers: individuals working less than 20 hours per week are most likely to report having a chronic disease, with those working 35–40 hours least likely to do so. As will be discussed in more detail below, the

higher prevalence among part-timers could be linked to adjustments made to accommodate people's needs in living with a chronic disease, whether these are formal working time adaptations or decisions made by individuals who judge that they cannot work full-time.

Most common conditions

According to Eurostat, the most prevalent chronic diseases are musculoskeletal disorders, followed by cardiovascular diseases, cancers, chronic respiratory diseases and mental health conditions. It is important to note that chronic diseases may or may not be caused (or be made worse) by work. Prevention therefore also has a significant role to play in reducing the development and impact of chronic disease in the workplace.

What is the impact on work?

Limitations on ability to work

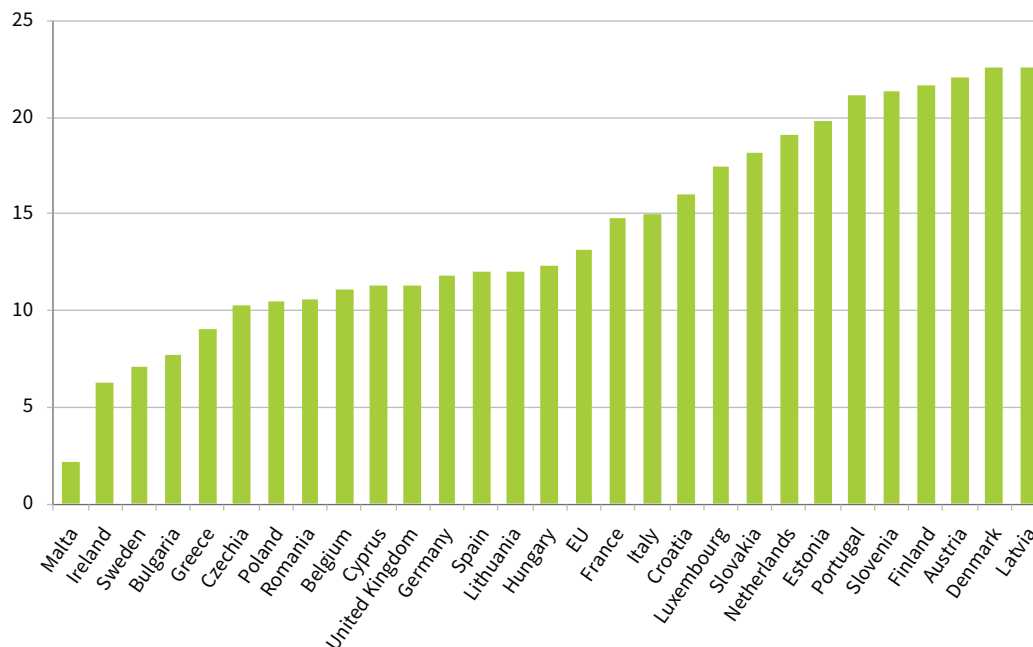
Each health condition varies not only in its severity and responsiveness to treatment, but also in its impact on an individual's ability to work. With respect to policies and practices to retain workers with chronic disease or to enable their return to the labour market after an absence, the needs of those whose daily activities (including work) are limited because of their condition are of particular importance.

The extent to which limitations arise with regard to employment is likely to be influenced by a range of factors including the nature and severity of the illness (including the phase during its development), the quality of healthcare provision and treatments available, and legislative and policy framework surrounding the requirements and support for workplace accommodation.

Eurostat reports that in 2015, 13% of the working population in the EU said they had a limiting longstanding illness. This was a slight increase on the 2010 figure.

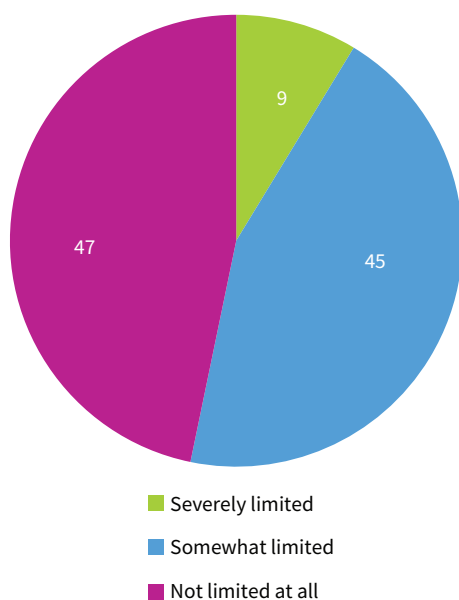
As Figure 3 illustrates, there are large differences between countries. Further research is needed to explain these differences

Figure 3: Share of working population (%) reporting a longstanding limiting illness, Member States, 2015



Source: Eurostat, *hlth_silc_04*, extracted 14 June 2019

Figure 4: Share of workers (%) with chronic disease, by severity of limitation of daily activities, EU, 2015



Source: EWCS, 2015

and trends between countries, particularly since few data are currently available on the scale and nature of workplace adaptations available in different countries and the legislative and policy measures impacting this.

The EWCS provides a breakdown of the severity of limitations on activity experienced by workers with chronic disease (Figure 4): 9% say that they are severely limited by their condition, 45% say they are somewhat limited and 47% consider themselves not to be limited at all. This means that just over half of workers with a chronic disease are limited in their daily activities due to their condition.

Factors linked to work limitations

Is it possible to determine any factors or characteristics that make it more likely that having a chronic disease limits a person's ability to work?

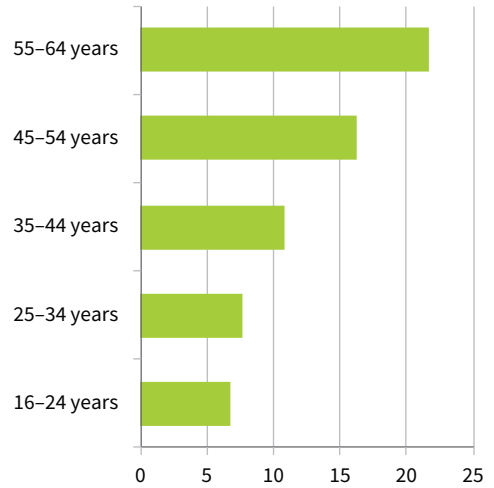
Generally speaking, it is possible to say that younger workers are less likely to report a limiting illness than older age groups, as

demonstrated by Eurostat data in Figure 5. Additionally, a slightly higher share of women have a limiting illness (14%) than men (12%).

EWCS data was analysed to discover whether country of residence and socioeconomic factors have an impact on whether a chronic disease is limiting or not. Country of residence was found to be associated with limiting illness, as were education and occupation. As was the case in relation to chronic disease, lower-skilled and less well-educated workers are more likely to report having a limiting illness (Figure 6). These findings are confirmed by other studies (Burstrom et al, 2003; Rahkonen et al, 2006).

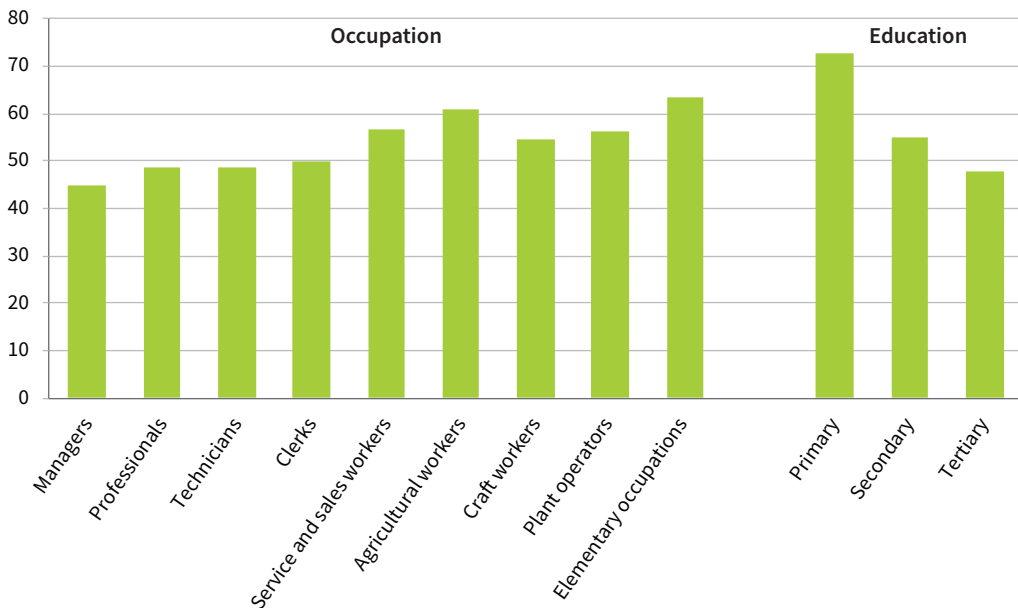
In contrast to workers reporting chronic disease, there are no statistically significant differences between workers with limiting illness in terms of their employment status or workplace size. The analysis also found that individuals with a limiting illness are more likely to work less than full-time hours. As discussed below, this could be a sign that workplace adaptations have been made.

Figure 5: Share of workers (%) reporting a limiting illness, by age group, EU, 2015



Source: Eurostat hlth_silc_06; extracted 17 June 2019

Figure 6: Share of workers (%) with a limiting chronic disease, by occupation and education, EU, 2015



Source: Eurostat, hlth_silc_04, extracted 14 June 2019

Reasonable accommodation: What does that mean?

Having a chronic disease can make work unsustainable for a worker unless suitable measures are taken to accommodate their needs or inclusion policies are implemented to support their continued employment.

The Equality Framework Directive 2000 (Council Directive 2000/78/EC) provides for ‘reasonable accommodation’ in employment for people with disabilities. Article 5 states 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. 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.

The protection provided by the directive is therefore not specifically based on health status but rather depends on the national definition of disability. It provides the possibility for an employer to argue that an accommodation would place a disproportionate burden on them, an exemption that micro and small businesses are arguably more likely to resort to, as they generally have fewer resources. The requirement also depends on the national context and legislative provisions and support measures available.

Prevalence of workplace accommodation

EWCS data show that around one-fifth of workers with a chronic disease indicate that their work or workplace has been adapted to accommodate their health needs. Among those who are limited in their daily activities by illness, 30% indicate that a workplace adaptation has been made. This means that over two-thirds of workers with a limiting health condition are not being supported by

any accommodation in the workplace. The figure is 10% for those who do not experience limitations. When considering these data, it must be borne in mind that potential requirements for adaptation differ significantly depending on the nature of the disease and associated limitations.

There are differences regarding the extent to which adaptation is made available in different countries, but further research would be needed to explain the reasons for these.

Factors associated with accommodation

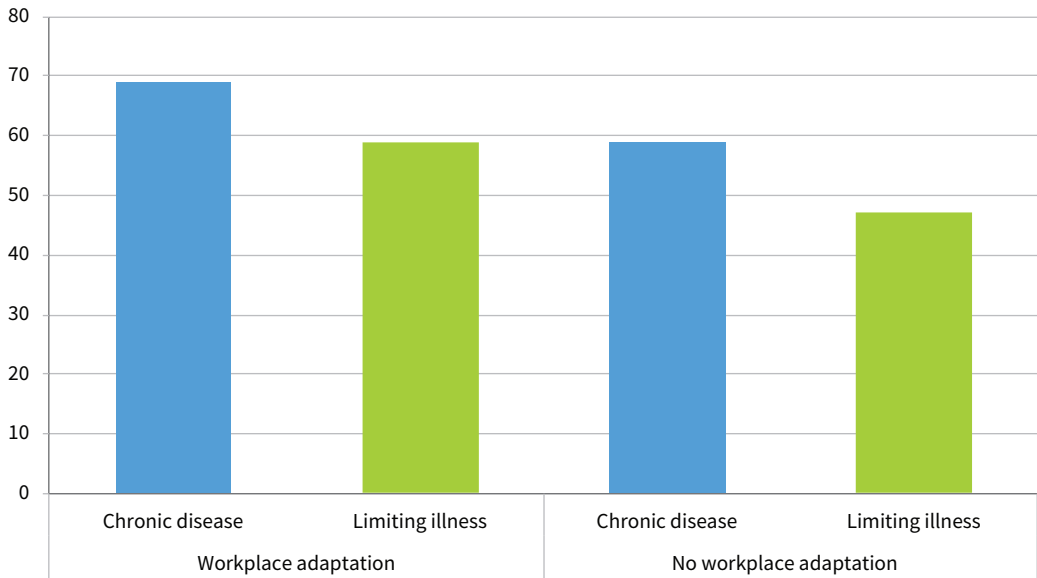
Are there any factors linked to the workplace or employment or indeed individual characteristics that impact a worker’s likelihood of benefiting from workplace accommodation?

Older workers (aged 50 and over) are more likely to see their health needs accommodated than younger workers (33% compared with 27%, respectively). This difference is most likely linked to the level of limitations experienced, as well as the individual’s seniority within the workplace, since workers of greater seniority are more likely to report that a workplace accommodation has been made for them. There is little difference, however, between men and women in this respect.

It was noted earlier that individuals with primary education and those in elementary occupations are more likely to have a chronic disease and experience limitations in their daily activities. At the same time, they are less likely to have their needs accommodated, which raises issues of fairness in the workplace.

As regards employment status, data indicates that workers with a limiting illness on fixed-term contracts are least likely to have had their workplace adapted (23%). The highest percentage is found among the self-employed without employees (35%). This may indicate that some individuals become self-employed to be able to adjust their activities to the requirements of their illness, which they may not find possible in dependent employment.

Figure 7: Share of workers (%) who feel supported by their manager, by health status and presence or absence of workplace adaptation, EU, 2015



Source: EWCS, 2015

Workplace size does not appear to impact the likelihood of accommodation being made available to those with limiting illnesses, nor does the presence of a health and safety committee, trade union or works council. Among other things, this could be linked to the fact that individuals can be reluctant to disclose that they have a chronic disease, for fear of discrimination.

Communicating the diagnosis of such an illness and requesting necessary adjustments is generally considered to be a private matter between line manager and the individual employee. This is interesting in the context of another finding that shows that workers with a chronic disease who have benefited from workplace adaptation are more likely to say that they receive support from their managers (Figure 7). The same is true when comparing those with a limiting illness who have obtained an accommodation and those who have not. Furthermore, it chimes with the finding that individuals with a chronic disease who say that they are able to express their views in the workplace are more likely to have benefited from workplace accommodation.

Types of workplace accommodation

A workplace accommodation can be material (such as accessible workstations, height-adjustable desks and technological solutions including voice-recognition software) or immaterial (such as working time adjustment and remote working). Because each condition has a different impact on the individual's ability to work, any requirements for adaptation are individual and dependent on different phases in the symptomology of the disease.

The EWCS does not gather data on the types of adaptation made, but it does ask workers about their working hours and working time flexibility, which are among the most common forms of workplace accommodation. Table 1 shows that individuals with a limiting illness who have a workplace accommodation are more likely to work reduced hours and to indicate that they have scope to adapt their working hours than those who have not.

Table 1: Working time arrangements (%) among workers living with limiting illnesses with and without workplace accommodation, EU, 2015

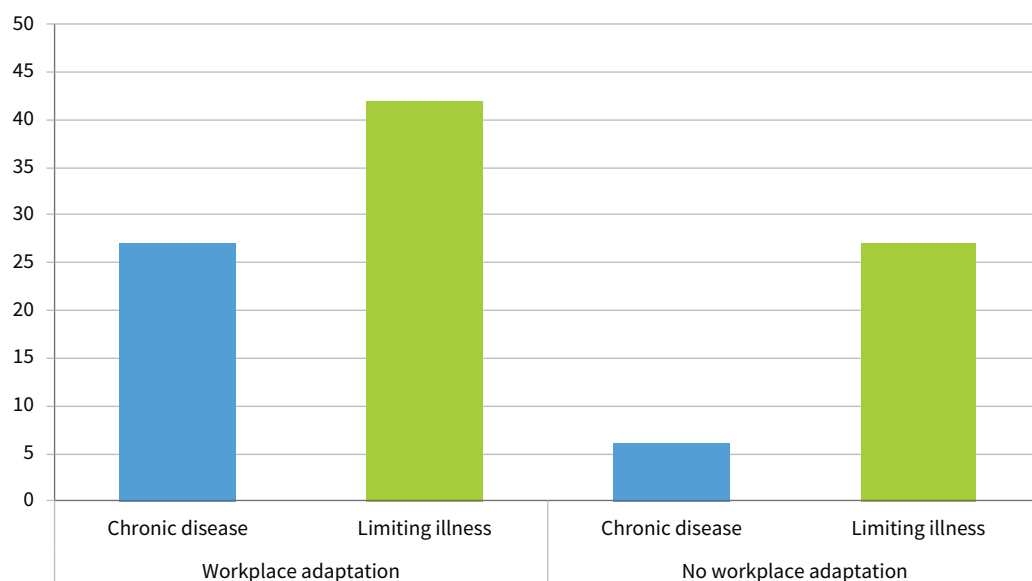
Working time arrangements	Limiting illness with accommodation	Limiting illness with no accommodation
Work fewer than 34 hours	39	35
Have scope to adapt working hours	25	19

Source: EWCS, 2015

From the available data, it is not possible to assess the extent to which part-time working is a specifically agreed form of adaptation or the result of decisions by workers with limiting conditions who are unable to work full-time hours. Further research would also be required to determine the extent to which working hours and working arrangements are flexible based on the particular stage within the development of a chronic disease, which variously impacts the health condition and therefore one's ability to work.

Among individuals with a limiting illness and for whom an adaptation has been made, 42% think that further adaptations will be needed in the future to accommodate their condition. The percentage is lower (27%) among those with a limiting illness but without current workplace accommodation (Figure 8). This could be a reflection of the severity of their condition and the limitations of those who already benefit from accommodation.

Figure 8: Share of workers (%) who perceive a need for future workplace adaptation, by health status and presence or absence of workplace adaptation, EU, 2015



Source: EWCS, 2015

The work done by EU-OSHA indicates that simple changes to accommodate individuals, such as ergonomic improvements, can be beneficial not just for individuals with certain chronic conditions (including musculoskeletal disorders) but all workers. Hence universal or inclusive design of workplaces could reduce the need for individual accommodations (EU-OSHA, 2013 and 2017).

Does accommodation make a difference?

Job quality

Of particular relevance to policymakers is knowing whether workplace adaptations are having a positive impact on people’s ability to work and therefore helping to retain valuable human capital. Here we look at the job quality of workers with and without a chronic disease, a limiting illness, and a workplace adaptation, taking account of the seven dimensions of job quality as defined by Eurofound. Figure 9 summarises these dimensions.

Figure 9: Overview of job quality indices



Source: Eurofound (2017)

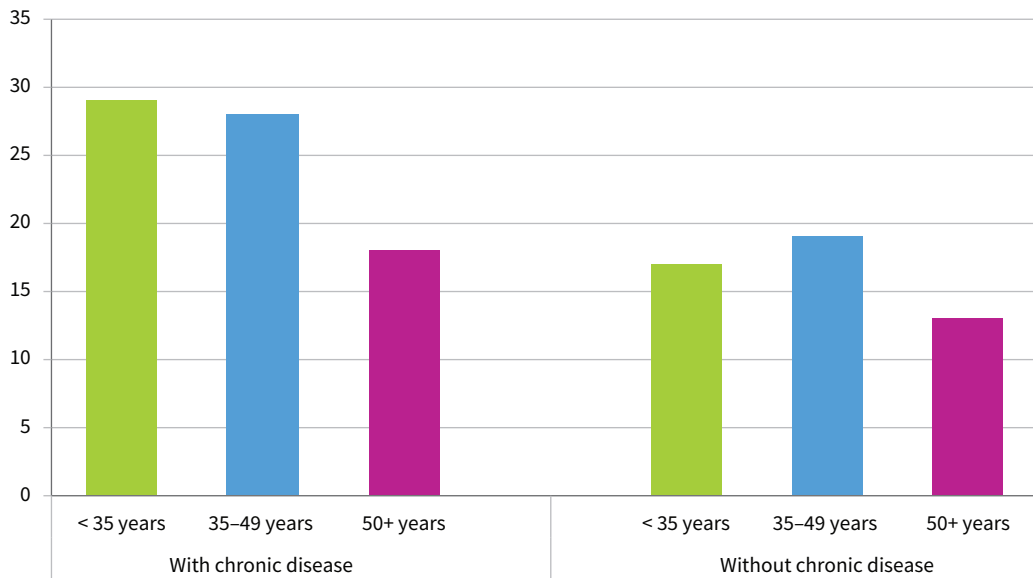
The main findings on job quality are as follows.

- In relation to physical environment, social environment, work intensity, working time quality and prospects, workers with a chronic disease, both non-limiting and limiting, report less positive outcomes than workers who have no health condition.
- Compared to workers without a health condition, those with a limiting illness and no workplace adaptation have the worst job quality in terms of the physical and social environments, working time quality and prospects. In addition, they experience greater work intensity.
- Workers with a limiting illness who have a workplace adaptation are also worse off compared to healthy workers, but they indicate better outcomes than their counterparts with no adaptation.
- Similarly, workers with a limiting illness and no workplace adaptation are more likely to report workplace stress than those who have had their workplace adapted. They also indicate higher levels of presenteeism and are more likely to be absent from work.

Work–life balance

Work–life balance is an important factor in making work sustainable: if workers are able to balance the demands of home life with a job, they are more likely to stay in work. Across all age groups, workers with a chronic disease experience poorer work–life balance than those without such a condition (Figure 10). Within the group of workers with a chronic disease, poor work–life balance is even more common among those for whom it is limiting and who have caring responsibilities. Further analysis shows that for workers with a limiting illness, adaptation seems to play a role in improving their work–life balance.

Figure 10: Share of workers (%) who report poor work–life balance, by presence or absence of chronic disease and age, 2015



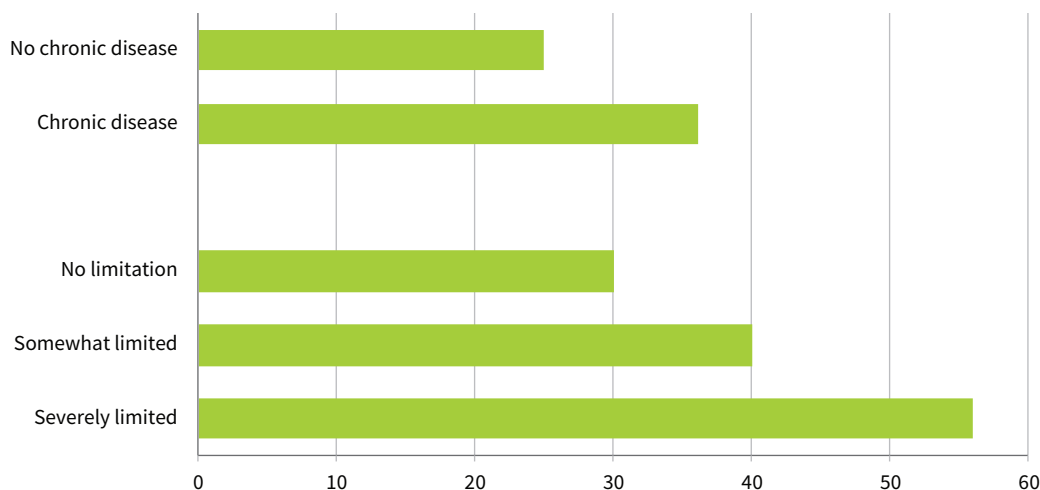
Source: EWCS, 2015

Sustainability

As job quality is closely linked with work sustainability, and the above findings demonstrate that individuals with chronic

disease and limiting illness experience poorer job quality outcomes, it is not surprising to find that these workers are less likely to believe that they will be able to work up to the age of 60. Of

Figure 11: Share of workers (%) who indicate that they will not be able to work up to the age of 60, by health status, 2015



Source: EWCS, 2015

those individuals who are severely limited by a chronic condition, 56% say that they will not be able to work up to 60, compared with 25% of those without a chronic disease (Figure 11).

EWCS data also indicate that those with a limiting illness but without workplace accommodation are more likely to believe their work to be unsustainable.

Chronic disease and discrimination

Nearly 3% of individuals with a chronic disease feel that they have been discriminated against on the grounds of disability. This rises to 4.5% when looking specifically at those who have a limiting illness. This gives cause for concern, given the presence of EU legislation (fully implemented in all Member States) prohibiting discrimination on the grounds of disability in employment.



Policy pointers

- The rising numbers of individuals living and working with chronic disease and limiting illness increases the urgency to address the issue of how to make work sustainable for these individuals. This is all the more true when one considers the human and economic cost of early exit from work, low rates of return, and inactivity among this group. Without policy intervention, the high and rising incidence of chronic disease in the workplace is likely to impact on productivity, through sick leave as well as early exit and the associated requirements to recruit replacement staff.
- The prevalence of chronic disease is highest among older age groups, but the incidence of such conditions is also rising among younger workers. Since poor health is one of the main reasons for early labour market exit, a holistic life cycle policy approach is needed to support prevention of disease and to ensure effective retention and reintegration of individuals affected by chronic disease in the labour market. This should encompass health, occupational health and safety, social protection and employment policy, as well as labour and non-discrimination legislation and should tie into an overall strategy dealing with demographic change.
- EWCS data illustrate the positive impact that making accommodations for the needs of workers with chronic disease has on the quality and sustainability of their work. It can also contribute to preventing the development of further health problems such as those arising from stress.
- There are differences in access to workplace accommodation, depending on country, contract type, educational attainment and occupation. This raises issues of fairness that need to be addressed.
- In the context of an increase in atypical employment contracts, particular attention needs to be paid to ensuring fairness in access to workplace accommodation for individuals on different contractual arrangements.
- The finding that many workers with a limiting illness and a workplace accommodation are likely to require further adaptation in the future points to the need for approaches that keep the requirements of affected workers under regular review. One-off interventions are likely to be insufficient.

- Working time flexibility and other flexible working arrangements have been demonstrated to improve the quality of work and sustainability of work for workers with chronic disease. Awareness-raising around the issue of workplace accommodation should highlight that very simple changes relating to working time flexibility can often have a significant impact on the ability of those living with chronic disease to stay in employment.
- Despite the encompassing nature of the UNCRPD definition of disability, significant variation and uncertainty remains in relation to the protection of individuals with chronic disease in national legislation and policy – and as a result in company practice. In light of the judgments of the European Court of Justice, an assessment should be carried out to determine whether further clarification and guidance is needed with regard to the coverage of chronic disease in the context of EU non-discrimination legislation, particularly in relation to the right to reasonable accommodation. A review of the European Disability Strategy should seek to address this issue.
- The findings of the EWCS can contribute to raising awareness of the importance of workplace accommodation for the retention and recruitment of workers with chronic disease. Its findings should be supplemented with further research as well as information-sharing on good practices linked to workplace accommodation. This should, amongst other things, compare the economic benefits with the costs incurred for making such adjustments. A starting point has been provided by the EU-funded PATHWAYS and CHRODIS projects (see Nazarov et al, 2019 and Silvaggi et al, 2019).
- Better recognition is also needed of the impact of chronic disease, to address common misconceptions that can lead to discrimination. Examples of successful enterprises that have developed active retention or recruitment policies for workers with chronic disease need to be identified and shared and their positive results highlighted. The experience of workplace physicians and occupational health services could play a role in this regard. Activities could also be developed to increase employees' sensitivity and awareness of chronic disease and its very individual implications, to generate enhanced support and understanding among colleagues.
- Social partners should incorporate the issue of integration and retention of workers with chronic disease into social dialogue at all levels.
- More data and research are needed to better understand the significant differences in the share of self-reported chronic disease in the wider population and among workers and the trends, as well as the differences in the extent of workplace accommodation offered. This should also include an assessment of the impact flexible working arrangements and other adaptations have on the retention of workers with chronic disease.



Resources

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Eurofound web topic 'Disability and chronic disease',
<https://www.eurofound.europa.eu/topic/disability-and-chronic-disease>

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The number of workers living with chronic health conditions is rising in the EU. Such conditions affect people's ability to work to varying degrees. While some are unable to continue working, many wish to and would be able to do so if their workplace made adaptations to accommodate their needs. Maintaining labour force participation is a key issue for policymakers in the context of demographic ageing and a falling working-age population.

This policy brief examines chronic disease in EU workplaces: its prevalence, the impact on ability to work, the extent that workplaces are making adjustments for workers with chronic disease and the effect of that on job quality. It finds that most workers with a chronic disease that limits their ability to work do not benefit from workplace accommodation. It also finds that such adaptations can have a positive impact on the quality and sustainability of work.

The European Foundation for the Improvement of Living and Working Conditions (Eurofound) is a tripartite European Union Agency established in 1975. Its role is to provide knowledge in the area of social, employment and work-related policies according to Regulation (EU) 2019/127.

