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Shaping return to work policy: the role of industrial relations at national and company level

Country report for Italy

Negotiating Return to Work in the Age of Demographic Change through Industrial Relations (REWIR)
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Deliverable 3.1

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[1] This Chapter is dedicated to Dr. Lorenzo Maria Pelusi, who passed away prematurely in August 2020.

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1. Introduction

The share of the working-age population in Italy[2] was 64% in 2018, lower than the OECD rate of 65.1% and the EU-28 rate of 64.6%. With reference to 2019, the employment rate in Italy was 59% for the age group 15–64.[3] Looking at people over 64 still in employment, in 2016 the employment rate for the group 65–69 years old in Italy was 9.1% while that recorded in the OECD area was 20.9% (OECD, 2017). Two years afterwards, in 2018, the employment rate for the same age group increased to 12.3% in Italy and 22.3% in the OECD area (OECD, 2019a). However, the duration of working life is also getting longer, with the mandatory social security schemes sometimes activated later than age 64.[4] This upward trend should constitute an issue of pressing concern to Italian policymakers, as workers over age 50 are found to be more than twice as likely to have a chronic illness as workers under 35 (Vargas Lllave et al., 2019).

In Italy, during 2015-18, about 5.8 million people between the age of 18 and 64[5] claimed to be suffering from one or more chronic diseases. Considering the entire Italian population, in 2019 40.8% of residents said they suffered from at least one of the main chronic diseases identified, growing by approximately 1 percentage point compared with 2017 (Istat, 2019). Looking at Eurostat data, in 2015, more than 14% of Italian employees aged 16 or over reported a long-term illness – a proportion that is slightly higher than was detected in 2010 (13.3%) and greater than the average share measured in the same year in the EU (13%) (Vargas Lllave et al., 2019). Plus, chronic-degenerative pathologies are more frequent in the elder age groups: 54.1% of Italian people already suffer from chronic disease in the 55–59 age group and among people over age 75 the share reaches 86.9% (Istat, 2019, p. 126). Additionally, a disadvantage has emerged for women. From the analysis of data relating to the share of the population suffering from at least one chronic disease, women are the most frequently affected, especially over the age of 55. Overall, the most common chronic diseases in Italy are hypertension (18.1%), osteoarthritis/arthritis (16.4%), allergic diseases (11.6%), osteoporosis (8.1%), chronic bronchitis and bronchial asthma (6.0%), and diabetes (5.6%) (Istat, 2019, p. 126).

Chronicity projections indicate that by 2030 the number of patients with chronic diseases will rise above 26.5 million, while multiple chronic ones will be about 14.6 million. The most common chronic pathology will likely be hypertension, with almost 12.5 million people affected by 2030. While both osteoarthritis and arthritis will affect more than 11.3 million Italians, an increase in the total number of patients with these diseases is expected to occur, with about 1.5 million more

[2] The working-age population is defined as people aged 15–64. This indicator measures the share of working-age people among the total population. Source: https://data.oecd.org/pop/working-age-population.htm.

[3] Source: Istat, http://dati.istat.it/Index.aspx?DataSetCode=DCCV_TAXOCCU1.

[4] "In 2018, the 'normal' retirement age of 67 was around three years higher than the average retirement age. However, Italy has recently made a step back from the previous reforms, introducing the 'Quota 100' measure which until 2021 allows access to pension rights at the age of 62 with 38 contributory years. The revision of the legal retirement age was expected in 2019 to adapt to the changes occurring in the life expectancy index but no revision has been implemented. The calculation of adjustments based on life expectancies, the requirement of career years for early retirement and the legal age of retirement for some trades has been frozen until 2026" (OECD, 2019b). Source: https://www.oecd.org/italy/PAG2019-ITA_it.pdf.

[5] Istituto superiore di sanità, "Patologie Croniche riferite nella popolazione residente in ITALIA. PASSI 2015-2018 (18-69enni) e PASSI d'Argento 2016-2018 (ultra 65enni)", Source: https://www.epicentro.iss.it/coronavirus/pdf/passi/sars-cov-2-flussi-dati-confronto-passi-pda-patologie-croniche.pdf.

patients in 2030 compared with 2018. By 2030, the total number of Italians suffering from osteoporosis, however, is likely to be about 5.7 million people, which is over 800,000 more Italians than in 2018. Furthermore, the number of Italians who suffer from diabetes in 2030 will be around 3.9 million, while patients with heart deficiencies will be around 2.8 million (Università Cattolica Sacro Cuore, Istituto di sanità pubblica – Osservatorio Nazionale sulla salute nelle regioni italiane, 2019, p. 516).

Despite this future, Italy exhibits quite good health-status indicators (OECD, 2019c): a "life expectancy" [6] of 83 years (compared with an OECD average of 80.7); an "avoidable mortality"[7] of 143 (compared with an OECD average of 208); a "self-rated health"[8] of 5.8% (compared with an OECD average of 8.7%); and a "chronic disease morbidity"[9] of 4.8% (compared with an OECD average of 6.4%). Moreover, 100% of the Italian population has access to healthcare, with 73.9% of the total expenditure covered by prepayment plans. On the quality of treatments, recent data has shed light on the Italian "safe prescribing"[10] rate, which is slightly worse than the OECD average. By contrast, Italy has a very good "effective primary care"[11] outcome (IT 64; OECD 225) and data in line with the OECD average rates with regard to "effective secondary care"[12] (IT 5.4; OECD 6.9) and "effective cancer care"[13] (IT 86%; OECD 84.5%). The Italian health spending share, as a proportion of GDP, is in line with the OECD average, amounting to 8.8% and the proportion of 'practising' physicians and nurses per 1,000 inhabitants corresponds respectively to 4% and 5.8% (compared with OECD averages of 3.5% and 8.8%). Italy therefore has a high number of doctors and a low number of nurses; despite a growing trend in these percentages, there are still concerns for workforce shortages in this field, especially as the age of doctors is increasing. In addition, it is worth underlining that health spending in 2019 in Italy, comprising both government spending and voluntary health insurance and private funds, is US$3,649 per capita, which is slightly lower than the OECD average (US$4,224 per capita) and considerably lower than the amounts registered in other high-income EU countries such as France (US$5,376 per capita), Sweden (US$5,782 per capita) and Germany (US$6,646 per capita).[14] Finally, Italy has the fifth lowest number of long-term beds and in 2017 Italy spent less than 0.6% of GDP on long-term care (OECD, 2019c).

Therefore, although the Italian healthcare system shows high levels of service, the ageing of the Italian population and the steady increase in chronic diseases, particularly affecting people aged

[6] Years of life at birth.

[7] Deaths per 100,000 people (age-standardised).

[8] Population in poor health (% of population aged 15+).

[9] The OECD definition of "chronic disease morbidity" includes chronic diseases such as cancer, heart attacks and strokes, chronic respiratory problems and diabetes; see https://www.oecd-ilibrary.org/sites/5101558b-en/index.html?itemId=/content/component/5101558. For this specific indicator, OECD estimates for "chronic disease morbidity" consider only data about diabetes prevalence (% of adults, age-standardised).

[10] For this indicator, the OECD takes into account any antibiotics prescribed (defined as a daily dose per 1,000 people).

[11] For this indicator, the OECD takes into account avoidable asthma/COPD (chronic obstructive pulmonary disease) admissions (per 100,000 people, age–sex standardised).

[12] For this indicator, the OECD takes into account 30-day mortality following AMI (mortality following acute myocardial infarction) (per 100,000 people, age–sex standardised)

[13] For this indicator, the OECD takes into account five-year net survival from breast cancer (%, age-standardised).

[14] OECD (2020), Health spending (indicator), doi: 10.1787/8643de7e-en (accessed on 7 July 2020).

55 and over, are expected to lead to a greater demand for healthcare services, posing considerable pressures on the sustainability of the public system. Also, the growth in life expectancy and the incidence of chronic illnesses are likely to transform service delivery models towards the provision of long-term care outside hospitals and lead to an increasing demand for primary and preventive care (ADAPT, UBI Banca, 2019). Italy can count on a strong primary care system (proven by the low rate of hospital admissions for chronic diseases) to address the needs of an ageing population. Since 2007, the national programme "Gaining health: making healthy choices easier" (Guadagnare salute: rendere facili le scelte salutari) has been implemented by the Italian government in collaboration with the regions and autonomous provinces to tackle key risk factors like poor nutrition, physical inactivity, smoking and alcohol consumption. In 2016, following adoption of the Piano Nazionale della Cronicità, a national initiative to improve the coordination of chronic care,[15] many Italian regions tested the implementation of different health service models, combining health and social care in multispecialty community-based centres to better respond to the needs of patients with comorbidities. However, in most cases, these experiments have not been subject to any formal evaluation yet (OECD, European Observatory on Health Systems and Policies, 2019).

For the purposes of this report, in addition to the pressures posed on welfare and healthcare systems, it is essential to highlight that the increase in chronic diseases is likely to affect the following: work organisation and labour productivity (Tiraboschi, 2015; Pollak, 2014), occupational safety,[16] and labour markets and social security systems[17] (especially considering that many workers with chronic diseases currently prefer to leave their jobs instead of asking for adequate adjustments). It is thus not surprising to detect, in many countries, a steady increase in the share of people requesting sick leave, taking early retirement and living on long-term disability allowances (Tiraboschi, 2015, p. 5). Looking at the Italian situation, this trend may be partly due to the clear and unambiguous access requirements applicable to instruments such as sick leave, early retirement and disability allowances; conversely, the Italian body of mandatory rules on measures to be taken in (re)designing work and workplaces to facilitate return to work (RTW) is

[15] The whole document is available here: http://www.salute.gov.it/imgs/C_17_pubblicazioni_2584_allegato.pdf. It is oriented towards a better organisation of services and full responsibility by all the players involved in care. However, it contains just a few references to work and employment. First, as regards disease prevention, the plan mentions the importance of programmes for the promotion of healthy lifestyles (e.g. the programme "Gaining health: making healthy choices easier" of 2007), which need to involve all relevant sectors (schools, working environments, local communities, etc.) and stakeholders. Second, with reference to the continuity of care, the plan sheds light on the relevance of training care technicians and teachers as well as raising work colleagues' awareness of how to prevent, identify and deal with possible emergency situations. Plus, services related to patients' integration into the labour market are highlighted as important. Finally, the plan refers to the impact of rheumatoid arthritis and Crohn's disease on people's working life and notably, the social costs linked to absenteeism or attendance at work of people incapable of performing their tasks.

[16] Workers with chronic disease are indeed more likely to incur injuries and serious accidents at work (Kubo et al., 2014); cf. also the comparative report written by Corral et al. (2014), https://www.eurofound.europa.eu/publications/report/2014/employment-opportunities-for-people-with-chronic-diseases.

[17] This happens because the share of people who pay social contributions and actively participate in the labour market is gradually decreasing compared with 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 2060 (European Commission, 2012, pp. 60-61 and pp. 159-161).

considered more confusing by stakeholders and practitioners.[18] But it is largely acknowledged that in the long run, the participation of people with chronic diseases in the labour market will become essential to tackle the decline in labour supply (given the decrease in natality rates) and the shortage of a skilled workforce as well as to face the pressures on public health and pension systems induced by a drastic ageing of the workforce[19] (Tiraboschi, 2015; OECD, 2009, p. 22). Moreover, workplace accommodation of the needs of workers with chronic diseases can have a positive impact on the quality of the work produced and the sustainability of work through lower levels of work intensity and stress, as well as better work–life balance. The lower stress levels of the workers potentially also result in improved performance (Vargas Lllave et al., 2019).

The goal of this report is to investigate the role of industrial relations in Italy in supporting workers affected by a chronic disease in returning to work, especially after a long sick leave. The assumption underpinning this report is indeed the great contribution that social partners, viewed as relevant players in labour markets, can make to meeting the concrete needs of people with chronic diseases and setting up adequate activation policies for their RTW. This can be particularly true considering that the ability to react to a serious disease and RTW also depends on the resilience and vulnerability of the individuals involved (Tiraboschi, 2015, cit. p. 40), and is influenced by the support they receive by industrial relations players and institutions.

Since Italy belongs to the European southern cluster of industrial relations (Caprile et al., 2017), it boasts quite positive and steady values in collective bargaining coverage (80% in 2016)[20] and trade union density (34.4% in 2018).[21] Italy is also characterised by an irregular involvement of social partners in public policy formation, a scant development of employee representation in workplaces (Caprile et al., 2017), a little regulation and a high degree of voluntarism in industrial relations (Leonardi, 2017; Leonardi et al., 2017). The latter conditions have progressively made larger organisations subject to pressures and opposition from their constituents, which tend to compromise the development of cooperative industrial relations and pave the way to the growth of independent autonomous unions (Colombo and Regalia, 2016) and the multiplication of national collective labour agreements (CNEL, 2019). In the light of these factors and given a legislative framework for RTW that does not particularly support the role of industrial relations,[22] we would expect social partners to be scarcely involved in public policymaking in this field. Social partners would also be more engaged in public policy implementation, collective bargaining, and lobbying activities. We would also expect that good collectively-agreed experiences of RTW at the company level are largely dependent on the commitment of individual employers and workers' representatives, and will be mainly found in large enterprises in industrial sectors, where decentralised collective bargaining mainly takes place. Finally, we can expect a lack of coordination among the practices initiated by social partners as well as difficulty in engaging all

[18] These observations emerged in interviews and focus groups organised within the framework of this project.

[19] Likewise, European stakeholders from the health, social and employment sectors pointed out that "addressing chronic illness and work issues has the potential to lead to stronger economic growth, higher employment rates and labour supply, and reduce public spending on state/disability benefits, while resulting in fewer demands on healthcare systems and increased productivity". Source: European Commission (2017), cit. p. 5, https://ec.europa.eu/health/sites/health/files/policies/docs/2017_chronic_framingdoc_en.pdf.

[20] OECD Stat, https://stats.oecd.org/Index.aspx?DataSetCode=CBC.

[21] OECD Stat, https://data.oecd.org/.

[22] For more information, see the following section.

the relevant players (employers, trade union organisations, patient organisations, NGOs, etc.) in joint projects.

In order to verify whether these expectations are met in reality and to more broadly pursue the objective of this report, information and data from different perspectives (workers, employers, social partners) are collected via various tools: desk research (comprising the collection and analysis of relevant collective agreements); three online surveys respectively for workers, managers and social partners; semi-structured interviews with 6 national stakeholders (i.e. 1 policymaker, 1 researcher at a foundation dealing with neurological, chronic and rare diseases, 3 employees from three different private employment agencies, 1 legal consultant at a patients' association); two group discussions respectively with 3 managers and 6 workers' representatives at the company level; and one roundtable with 8 stakeholders (i.e. 4 trade unionists, 1 labour consultant, 1 legal consultant at a patients' organisation, 1 researcher at a trade union institute, 1 representative of a foundation promoted by a managers' association). More detailed information on the online surveys can be found in the following tables. The analysis of collected data and information follows the framework outlined by Mehtap Akgüç (CEPS), Marta Kahancová (CELSI) and Adela Popa (Lucian Blaga University of Sibiu) in July 2019.[23]

Table 1. Overview of sample and respondent identification – Italy

Survey and target group	Total number of responses	Number of relevant responses
Workers' survey	30	30
Social partners' survey	8	4
Managers' survey	47	39

Source: REWIR surveys - Italy

Note: The total number of responses refers to the overall data intake for Italy within the period of data collection. The number of relevant responses refers to the number of completed surveys for the social partners and the company survey. For the workers' survey, the number of relevant cases refers to responses where the respondent selected "Yes" in Question 6 – *Have you experienced a chronic disease in your working life?*.

Table 2. Overview of sample and respondent identification – REWIR workers survey for Italy

Workers' survey – overview of respondents' features	Responses (in percent if not stated otherwise)
Gender (Q1)	
Male	20
Female	80
Mean age in years (Q3)	51y
Mean length of working life in years (Q4)	28y
Level of education (Q2)	

[23] M. Akgüç, M. Kahancová and A. Popa (2019), "Working paper presenting a literature review on return to work policies and the role that industrial relations play in facilitating return to work at the EU, national and sub-national levels", REWIR Deliverable 1.1.

Low-qualified (up to lower secondary)	10%
Middle-qualified (up to post-secondary vocational)	50%
High-qualified (up to university education)	37%
Other	3%
Type of organisation where the respondent worked prior to diagnosis/treatment (Q14a 14b + Q32a 32b)	
Domestic	85%
Foreign owned	15%
Don't know	4%
Private sector	70%
Public sector	76%
Trade union membership (Q9 + Q27)	
Yes	50%
No	50%
Trade union presence at the workplace (Q11 + Q29)	
Yes	80%
No	20%
Type of job (Q16 + Q34)	
Intellectual	23%
In an office	47%
Manual	17%
Indoor	50%
Outdoor	3%
Intensive physical activity	13%
Intensive emotional stress	33%
Company size (Q13 + Q31)	
Below 20	17%
20–50	17%
50–500	37%
500–1,000	13%
Above 1,000	17%
Currently on sick leave (Q17)	
Yes	-
No	-
Three most frequently reported diseases (Q7 + Q25)	
1.	Cancer (50%)
2.	Other (27%)
3.	Arthritis (20%)

Source: REWIR workers survey - Italy

Table 3. Social partners survey – feedback overview for Italy, collected within the REWIR project

Overview of respondents' features	Responses

Type of organisation (Q2)	
Employers' associations	5
Trade unions	3
Other	-
Level of social dialogue engagement (Q4)	
National	2
Sub-national (territorial)	1
Sectoral	5
All three	-
Other	-
Three most commonly reported sectors represented (Q5)	
1.	Manufacturing (2)
2.	Hotels and restaurants (2)
3.	More answers (1)

Source: REWIR social partners survey - Italy

Table 4. Company survey – feedback overview for Italy, collected within the REWIR project

Overview of respondents' features	Responses
Ownership type (Q4)	
Domestic	27 (43%)
Foreign	20 (57%)
Company size (Q2)	
0–9	4 (9%)
10–49	6 (13%)
50–249	12 (26%)
Above 250	25 (53%)
Predominant types of workers (Q7)	
1.	Administrative workers/office clerical (14) (30%)
2.	Medium and high-skilled manual workers (12) (26%)
3.	Highly skilled specialists (9) (20%)
Three most commonly reported economic sectors represented (Q6)	
1.	Manufacturing (18) (39%)
2.	Other (9) (20%)
3.	Professional, scientific and technical activities (3) (7%)
Presence of trade union or other form or workers' representation (Q22)	
Yes	28 (82%)

No	6 (18%)

Source: REWIR company survey - Italy

2. The policy framework on return to work in the particular country

The Italian legislation supporting people with a chronic disease to return to work is neither homogeneous (several pieces of legislation apply) nor specifically targeted at people suffering from chronic diseases. This is mainly due to the fact that the Italian system lacks a clear definition of "chronic diseases" in legal terms and there is a trend, both in literature and case law, to equate them with "disabilities" (Fernandez Martinez, 2017, p. 76). Therefore, even though workers with a chronic disease are generally not provided with specific rights, there are some provisions on RTW and some other forms of protection deriving from the condition of disability. However, the concept of 'disability' has taken different forms in the Italian legal system according to the objectives pursued from time to time by the legislature. As a result, various notions and pieces of legislation overlap in this field (for instance, Law No. 104/1992 deals with the social inclusion of "handicapped people" whose condition must be ascertained by healthcare authorities; Legislative Decree No. 81/2008 refers to people "unfit for" specific job tasks, whose condition is verified by an occupational physician; and Law No. 68/1999 contains the unitary concept of "disabled people" though strictly clarifying the types of impairment, which must be ascertained by healthcare or social care authorities). Plus, given the traditional influence of biomedical evaluations (focused on a person's condition and need for healthcare) on these notions, they have given rise to a number of legal provisions almost exclusively devoted to ensuring assistance and protection (e.g. through paid leave, compensation and pensions) to the people falling within these specific categories (Bono, 2020). It is only with Legislative Decree No. 216/2003, the Italian transposition of Council Directive 2000/78/EC, that a broader, more dynamic and inclusive notion of "disability" (intended as a social fact, deriving from the interaction of both a person's conditions and the environment, as suggested by the UN Convention on the Rights of Persons with Disabilities of 13 December 2006) has entered our legal system, paving the way to jurisprudential guidelines supporting the principles of social justice and non-discrimination at work (with an important role to be played by the employer for the (re-)integration of disabled people at work) regardless of the specific causes of disability, which can thus also include chronic diseases.[24]

As we will better see in the following sections, in addition to legal provisions, in Italy further rights and protections are guaranteed to people with chronic diseases by collective bargaining.

Going back to the Italian legislative framework, regulations potentially favouring RTW processes for people with chronic diseases mainly concern:

- smart working (Legislative Decree No. 81/2017), allowing people to perform their job from home or other locations after signing an individual agreement. This norm can potentially give workers with a chronic disease a better work–life balance, especially if this is established in collective agreements;[25]

[24] See also note no. 25.

[25] Furthermore, with the recent Covid-19 pandemic, the Italian government has introduced a new right to work from home for disabled or immunosuppressed workers, as well as for workers with a disabled or immunosuppressed person in their family. This right is meant to be temporary, as it will last until the end of the state of health emergency, and also depends on whether this way of working is compatible with the characteristics of the activity to be carried out. In

- the possibility for workers to give some of their vacation time or leave time to colleagues who take care of disabled or ill children (Legislative Decree No. 151/2015). Further details and requirements to access the provision are established in collective agreements, which can extend this opportunity also to people affected by a chronic disease;
- the right to change the employment relationship from full-time to part-time in cases of "severe chronic and degenerative pathologies" (Legislative Decree No. 81/2015);
- the right for workers with disabilities of over 50% (as ascertained by healthcare or social care authorities) to a 30-day leave for treatment per year (Legislative Decree No. 119/2011);
- the obligation for the employer to assign a worker, who is unfit to perform a specific task according to an occupational physician, to an equivalent or a lower-level task while entitling the worker to the same remuneration as before (Legislative Decree No. 81/2008);
- the right for disabled workers (in the extended and inclusive meaning of Council Directive 2000/78/EC)[26] to reasonable accommodation in the workplace in order to ensure they have working conditions equal to those of other employees (Legislative Decree No. 216/2003);
- the right for a worker with certified health problems (as certified by either the company occupational physician or public healthcare facilities) not to perform tasks during night shifts (according to Legislative Decree No. 66/2003); and
- the right for handicapped workers (whose handicap is ascertained by healthcare authorities) to 2-hour per day or 3-day per month paid leave (Law No. 104/1992); complementarily to such leave, handicapped workers have the right to choose (or be transferred to) a workplace closer to their home, among those available; the same right is guaranteed also to caregivers.

With regard to sick leave in cases of chronic disease, the desk research did not obtain evidence of any specific legal provisions. General rules therefore apply: sickness compensation (paid by the employer during the first 3 days, and paid by INPS, the National Institute for Social Security, from the 4th day of absence from work) is proportional to the normal wage and progressively decreases. This compensation is provided to workers who are suffering from diseases and cannot perform

addition, a right of priority has been introduced for workers suffering from serious and proven pathologies and with reduced working capacity: they must be offered the possibility to work from home as a priority compared with other workers.

[26] Unlike the notion of disability included in Law No. 68/1999, Council Directive 2000/78/EC (which in Italy has been transposed by Legislative Decree No. 216/2003), does not require the disability to be certified by national institutions such as the social care services or health services. Moreover, the notion of disability contained in Directive 2000/78/EC is interpreted by the Court of Justice of the European Union in a broad manner in line with the interpretation provided by the UN Convention on the Rights of Persons with Disabilities of 13 December 2006, which was ratified by the European Union in 2010. Pursuant to the arguments of the Court, the notion of disability can cover several individual conditions as long as they compromise workers' full participation in their professional life; in this sense, this notion even includes obesity in given circumstances. Indeed, the concept of 'disability' within the meaning of Directive 2000/78/EC covers obesity if this state hinders the full and effective participation of the worker concerned in professional life on an equal basis with other workers on account of reduced mobility or the onset, in that person, of medical conditions preventing that person from carrying out work or causing discomfort when carrying out professional activity (see the judgment of 18 January 2018, *Ruiz Conejero*, C‑270/16, EU:C:2018:17, paragraph 30; judgment of 18 December 2014, FOA, C‑354/13, EU:C:2014:2463, paragraph 60).

their tasks. Still, INPS does not pay sickness compensation for certain categories of workers, including white-collar workers in industrial sectors and managers in the industrial and craft sectors. In these cases, the employer pays the compensation. Further rules concerning the calculation of the length of the protected period (during which sick workers cannot be dismissed) can be found in sectoral collective labour agreements. Many NCLAs extend the duration of the protected period in the case of certain pathologies, as discussed in the following paragraphs. In line with this approach by social partners, also recent judgments by national courts have established that before dismissing workers with a disability for being absent from work for a number of days exceeding the protected period, employers must prove that they have excluded from the calculation of the protected period those days of absence strictly related to the disability (Bono, 2020).

Moreover, when a chronic disease causes disability or inability to work, as ascertained by public authorities, sick people are provided with an incapacity pension (in the case of absolute and permanent impossibility of performing any work activity) or a civil invalidity pension. In addition to a civil invalidity pension, a further allowance is provided to those workers who are civil invalids who cannot move by themselves and need to be accompanied by someone else. There is mandatory occupational insurance for work-related accidents and occupational diseases paid by employers to INAIL, the National Institute for Insurance against Accidents at Work. INAIL also provides workers with incapacity pensions and allowances, where their condition is due to occupational disease. Most importantly, the institute has been entrusted by Law No. 190/2014 with the task of supporting RTW policies for workers with occupational diseases.

Finally, in Italy, there are incentives applying to employers in the public and private sectors hiring people with disabilities on open-ended contracts (Article 13, Law No. 68/1999, updated by Legislative Decree No. 151/2015 and other subsequent laws). These incentives, whose duration is 36 months, have two different amounts depending on the severity of the worker's disability: the first one is 70% of gross monthly salary if the worker has a reduced ability to work of over 79% or has a mental handicap causing a reduction in the work ability of over 45% (in the latter case the duration of the incentive is 60 months); the second amount is 35% of gross monthly salary if the worker has a reduced ability to work of between 67% and 79%. In addition to that, Law No. 68/1999 establishes a legal obligation for employers in hiring and retaining workers with a disability. Notably, employers must hire and retain: 1 worker with a disability in companies with 15–35 workers; 2 workers with disabilities in companies with 36–50 workers; and in companies with more than 50 workers, workers with disabilities must account for 7% of the overall workforce. Pursuant to Legislative Decree No. 151/2015, the employer can comply with these provisions also thanks to temporary agency workers, as long as their contract's duration is at least 12 months.

Besides the above-mentioned legislative instruments, there are some regional/local actions regarding return to work for employees suffering from disabilities, although no specific attention is paid to people with chronic diseases. Among the initiatives, we can list

- the SIL 22 job integration service,[27] which is an initiative from the province of Verona aimed at promoting the employment of people with disabilities by offering information

[27] For further information about the SIL (Servizi di Integrazione Lavorativa) service, see http://bancadati.italialavoro.it/bdds/download?fileName=C_21_Strumento_3609_documenti_itemName_0_documento.pdf&uid=db767bd5-4134-4fa8-938a-f581631d20ae.

provision, vocational training, career planning, case management and advocacy services, preparation for jobs, job matching and placement, and post-placement support; and

- the EMERGO plan,[28] which is a programme for people with disabilities promoted by municipal authorities in Milan and aimed at facilitating their labour market participation and retention of work through services supporting their training or other labour market (re-)integration activities.

One more policy slowly spreading in the larger companies is the establishment within Human Resources departments of a professional figure specifically devoted to the inclusion and management of disabilities at work, called a 'disability manager': this figure was firstly mentioned at the institutional level in the 2009 "White Book on accessibility and urban mobility" of the Municipality of Parma and the Ministry of Labour and Social Policies and then promoted in the 2013 "Biannual action programme for the promotion of rights and the inclusion of people with disability", as well as again in the programme's second version in 2017. The role of a person "responsible for the inclusion at work" of people with disabilities has been moreover envisaged in Legislative Decree No. 151/2015[29] and the costs related to her introduction may be partially reimbursed through the Funds for the employment of people with disabilities, established in each Italian region[30]. In addition, the regional fund for the employment of disabled people can provide partial reimbursement for the expenses incurred by companies when adopting reasonable adjustments (including the introduction of new technologies and the elimination of architectural barriers) for workers whose invalidity status exceeds 50%[31].

Finally, collective bargaining can establish joint labour–management committees or observatories at the workplace level also devoted to the inclusion of people with disabilities at work: their promotion was stressed in the 2013 "Biannual action programme for the promotion of rights and the inclusion of people with disability", adopted by the Italian government, as well as in the programme's second version in 2017[32].

Further information concerning these company-level policies and empirical cases is provided in the next sections.

[28] For further information about the plan EMERGO (Esperienza Metodologia e Risorse Generano Opportunità), see https://www.cittametropolitana.mi.it/export/sites/default/lavoro/pdf/emergo/Programmazione-emergo/Masterplan-Emergo-2019.pdf.

[29] The introduction of a professional figure for the inclusion at work of people with disabilities has been made compulsory in public administration with more than 200 employees (Legislative Decree No. 165/2001, as modified by Legislative Decree No. 75/2017). As regards, private workplaces, precise guidelines for the job placement of disabled people, based on a set of important principles including the promotion of an *ad hoc* professional figure, should have been designed within 180 days from the adoption of Legislative Decree No. 151/2015. However, they are still missing.

[30] For further information about the "disability manager", see p. 20 hereinafter.

[31] The obligation for Italian regions to establish a Fund for the employment of people with disabilities was firstly introduced via Law No. 68/1999 and then slightly renovated with Legislative Decree No. 151/2015. The Fund is financed by the penalties paid by companies not complying with the rules on the mandatory hiring of disabled people, the contributions of companies not subject to these rules, private donations, etc.

[32] For further information concering joint labour–management committees or observatories specific competences, see p. 22 hereinafter.

Table 5. Policy framework on return to work in Italy

Type of benefit	Level of benefits	Eligible workers	Piece of legislation
Right to part-time work	Right to change the employment relationship from full-time to part-time)	Workers with "severe chronic and degenerative pathologies"	Legislative Decree No. 81/2015
Leave for treatment	Right to a 30-day leave for treatment per year, in addition to the protected period (made up of the overall number of days of absence from work during which employees cannot be dismissed)	Workers with disability of over 50%	Legislative Decree No. 119/2011; additional leave can be established by collective bargaining; plus, many National Collective Labour Agreements extend the duration of the protected period in cases of certain pathologies
Right to an adequate job position	Obligation for the employer to assign the worker to an equivalent or a lower-level task with entitlement to the same remuneration as before	Each worker who is unfit to perform a specific task according to the occupational physician	Legislative Decree No. 81/2008
Reasonable accommodation	Right for disabled workers to a reasonable accommodation in the workplace in order to ensure they have working conditions equal to those of other employees	Disabled workers (with a broad meaning, as required by the Court of Justice of the European Union)	Legislative Decree No. 216/2003
Right not to perform night work		Workers with conditions which make them unfit for night work; such conditions must be certified either by the company occupational physician or public healthcare facilities.	
Paid leave	Right for handicapped workers to 2-hour per day or 3-day per month paid leave; as an alternative to such leave, handicapped workers have the right to choose (or be transferred to) a workplace closer to their home, among those available	Disabled workers whose handicap has been recognised as severe	Law No. 104/1992; additional leave can be established by collective bargaining
Sickness absence allowance	From the 4th to the 20th day, 50% of the average daily wage; from the 21st to the 180th day, 66.66% of the average daily wage	Workers who are suffering from diseases of any kind and are unable to perform their tasks	Law

Source: Authors' elaboration upon REWIR findings for Italy

3. Involvement of social partners in shaping return to work policy at the national level

3.1 Actors and stakeholders in RTW policy

Among the main actors involved in return to work policies in Italy, we can list the following:

- patients' associations, which contribute to RTW by
    - offering information, training and consultancy for ill workers and employers concerning the legal measures in place that favour people's (re-)integration into the labour market. An example in this regard is represented by the PROJOB initiative launched by AIMAC (Italian Association of Cancer Patients, Relatives and Friends) in 2012. It is applicable to every working context, where AIMAC professionals offer training for HR leaders, line managers and colleagues, consultancy for employers on the existent legal and contractual solutions for a better work–life balance, psychological support for workers affected by a chronic disease and workers assisting ill relatives, etc.[33] A legal support helpline for workers affected by oncological diseases is also provided by LILT (Italian League against Tumours);[34]
    - lobbying the national legislature so that it introduces regulatory adjustments in favour of RTW for people affected by chronic diseases. For instance, AIMAC played a relevant role in pushing the legislature to extend the right to change the employment relationship from full-time to part-time also to people affected by 'severe chronic and degenerative pathologies'; and
    - connecting patients either directly with companies or with public or private employment agencies so that they can be (re-)integrated into the labour market. An important example in this field is represented by the territorial partnership agreement signed in 2018 by AISM (Italian Multiple Sclerosis Society), the employers' association Unindustria of Rome, the ASPHI Foundation (promoting the inclusion of people with disabilities at school and at work through digital technologies), the pharmaceutical company Merck Serono and the local trade union organisations FILCTEM-CGIL, FEMCA-CISL and UILTEC-UIL of Rome, with the aim of facilitating the recruitment of workers affected by multiple sclerosis at the Rome site of Merck Serono.[35]

[33] For further information, see AIMAC (Associazione Italiana Malati di Cancro) https://www.aimac.it/aimac-per-te/pro-job-risorse-impresa-lavoratori.

[34] For further information, see LILT (Lega Italiana Lotta Tumori) https://www.lilt.it/oldportal/page4bff.html?id=1229&area=995.

[35] It is worth specifying that territorial partnership agreements of this kind are envisaged in Article 1 of Legislative Decree No. 151/2015. More precise guidelines for the job placement of disabled people, based on a set of important principles including the enhancement of territorial partnerships, should have been produced within 180 days from the adoption of Legislative Decree No. 151/2015. However, they are still missing.

However, two out of three private employment agencies interviewed underline the need for patients' associations to be further engaged in RTW policies, as many of them are found to be essentially concentrated on aspects related to treatment;

- government and particularly the Ministry of Labour and Social Policies, which contribute to RTW mainly by drawing up regulations that enable people with chronic diseases in need of treatment to keep on working and by issuing explanatory circulars;
- public authorities, and notably
    - ASLs (local health authorities), located throughout Italy, which carry out the physical exam to assess the invalidity status of the person;
    - INPS, which, following the physical exam performed by ASLs, confirms the invalidity status and pays the related pensions. INPS is also responsible for the payment of sickness compensation to the worker, from the 4th day of absence from work up to 180 days. But INPS does not pay sickness compensation for certain categories of workers, including white-collar workers in industrial sectors and managers in the industrial and craft sectors. In these cases, the employer pays the compensation;
    - INAIL, which manages insurance for accidents at work and work-related diseases. The contribution to INAIL is mandatorily paid by employers for all their employees and project-based collaborators (*lavoratori parasubordinati*). Among the assistance measures provided by INAIL and potentially directed at workers with chronic diseases (as long as they have contracted the disease at work), there is a daily allowance for temporary absolute inability, targeted at people injured at work or affected by an occupational illness if they are unable to work for a period of time; compensation for the impairment of the psychophysical integrity; and an allowance for people with mesothelioma contracted after being exposed to asbestos, regardless of whether the exposure was at work or somewhere else. Importantly, INAIL has been entrusted by Law No. 190/2014 with the task of supporting RTW policies for workers with occupational diseases. Subsequently, in 2016 INAIL adopted the regulation on the return to work and occupational integration of people with disabilities due to work and it currently launches public calls to finance projects on integration at work for disabled or unfit workers following an accident at work or an occupational disease. In addition to notifying INPS of their availability to participate in these processes, employers can directly present projects on reintegration at work and apply for these funds. However, a few trade unionists have pointed out some procedural problems jeopardising access to these funds and consequently, the fact that many companies give up on applying. Moreover, INAIL has set up a call centre service (available in several languages) directed at disabled workers in search of advice and information regarding health, education and labour issues. Finally, INAIL finances and conducts research on health and safety at work, also in collaboration with social partners, and according to the Budget Law 2019, it can fund projects presented by social partners for informing and training both workers and employers as regards the reintegration at work of people affected by a work-related disability;

- councillors for equal opportunities, operating at national, regional and territorial levels, who, though mainly focused on gender discrimination, deal with the promotion and dissemination of best practices and support active labour market policies to ensure equal opportunities. As revealed by one trade union official in the banking sector, a councillor for equal opportunities has been helpful in convincing a company to adopt organisational solutions for a disadvantaged worker. Moreover, in 2010, an agreement was signed by FAVO (Italian Federation of Oncological Associations of Volunteering) and the national councillor for equal opportunities for the launch of information and training activities targeted at workers and focused on the prevention of oncological diseases. Still, with the exception of these cases, their role in RTW processes does not seem particularly developed;

- public job centres and private employment agencies that contribute to RTW mainly by assisting companies in the job placement of disabled people (with specific percentages of invalidity certified by public authorities), which are to be mandatorily hired and retained (in different quotas according to organisational size) in companies with more than 14 employees under Law No. 68/1999.[36] According to Article 14 of Legislative Decree No. 276/2003, the employer can comply with these provisions also by contracting out certain activities to social cooperatives committed to the integration of disadvantaged people,[37] prior to the signature of specific territorial agreements by public job centres, trade union organisations and employers' associations.[38] Moreover, following Legislative Decree No. 151/2015, the employer can fulfil the obligation also thanks to temporary agency workers, as long as their contract's duration is at least 12 months. Traditionally, public job centres and private employment agencies provide mentoring and assistance for workers in their job search and facilitate the match with companies. They can be contacted by both companies willing to comply with the mandatory recruitment of disabled people, and workers in delicate conditions willing to enter or re-enter the labour market. Moreover, many public job centres and private employment agencies have established specific departments/divisions or foundations dedicated to the job placement of disabled and disadvantaged people. Thanks to these internal structures, private employment agencies can today deliver comprehensive projects encompassing both tutoring and support for disabled workers, and consultancy and training for managers and colleagues. The main solutions that private employment agencies help companies adopt are organisational, entailing the selection of the right tasks and the establishment of hourly flexibility granted to disabled workers. These policies have been implemented by Randstad, through its departments Randstad HOpportunities and Randstad HR Solutions, in a company facing the return to work of a disabled employee after a serious work-related accident. But similar projects are currently undertaken by the Adecco Foundation for Equal Opportunities;[39]

[36] Provided that they have a certified percentage of invalidity, people affected by chronic diseases can be subject to mandatory recruitment and retainment according to Law No. 68/1999.

[37] According to the Italian legislation, they are called "*cooperative sociali di tipo B*".

[38] However, the use of this option is still largely overlooked by both Italian companies and social cooperatives. For further information, see Istituto per la Ricerca Sociale (IRS) (2019).

[39] For further information, see Fondazione Adecco, https://fondazioneadecco.org.

- research organisations focused on chronic diseases, which contribute to RTW mainly by conducting research activities on chronic diseases also with regard to their impact on work and employment. An example in this sense is represented by the EU-funded joint action CHRODIS PLUS, involving the Italian IRCCS Foundation Carlo Besta Neurological Institute together with some international partners, particularly the development of a training tool for managers, helping them to measure and increase the inclusiveness and workability of people with chronic diseases in public and private enterprises, as well as a toolkit for improving health and wellbeing in workplaces for all workers regardless of their specific workability. These instruments are being tested in different work settings across various European countries, including Italy (Silvaggi et al., 2020). Research organisations can also conduct initiatives in collaboration with labour market mediation bodies such as employment agencies. This is the case of the action research carried out between 2013 and 2015 by the GIMEMA Foundation and the Adecco Foundation for Equal Opportunities to better understand the professional and employment situation of people affected by blood diseases. Finally, research organisations can deliver training modules targeted at HR leaders, who are responsible for dealing with disabilities at work. An example in this field is represented by the 30-hour training course organised by the Italian IRCCS Foundation Carlo Besta Neurological Institute with the Catholic University of Milan and the banking group Intesa San Paolo, specifically addressing workers' representatives and HR leaders.

- employers and HR leaders, which contribute to RTW by

    - putting in place the main legislative provisions supporting the (re-)integration of people affected by chronic diseases at work, such as the right for a worker with oncological or chronic and degenerative pathologies to change the employment relationship from full-time to part-time (according to Legislative Decree No. 81/2015); the right for a worker with a certified percentage of invalidity of over 50% to a 30-day leave for treatment per year (according to Legislative Decree No. 119/2011); the employer's obligation to adapt workplaces to the needs of workers with disabilities and to assign workers who become unable to perform previous tasks to equivalent or lower-level tasks, while paying them the same remuneration as before (according to Legislative Decree No. 81/2008); the employer's duty to provide disabled workers with reasonable accommodation in the workplace (according to Legislative Decree No. 216/2003); the right for a worker with certified health problems not to perform tasks during night shifts (according to Legislative Decree No. 66/2003); the employer's obligation to hire a certain percentage of disabled workers (according to Law No. 68/1999); the right for handicapped workers to get 2-hour per day or 3-day per month paid leave or, as an alternative to the above measures, to choose (or be transferred to) a workplace closer to home, among those available;

    - discussing and/or reaching agreements with workers' representatives or local trade union officials, especially in unionised work settings, to implement health and safety, reskilling, working time and organisational solutions for the (re-)integration of people with chronic diseases at work; and

- delivering training courses for employees, also thanks to the financing of interprofessional funds,[40] which can be devoted to raising the workforce's awareness of disabilities and chronic diseases at work. For instance, at the pharmaceutical company Merck Serono, an experiential laboratory was organised with the support of a patients' association and the deployment of digital technologies, with the aim of enabling workers and managers to actually experience the impact of a certain disease on their physical capacities. Intesa San Paolo in the banking sector organised a course on disability management for its employees.

Importantly, especially at large, well-structured and particularly sensitive companies, the HR department has a professional figure specifically devoted to the inclusion and management of disabilities at work. As mentioned before, especially in large, well-structured and particularly sensitive companies, the HR department has been integrated with a professional figure, called "Disability Manager", specifically devoted to the inclusion and management of disabilities at work. According to an HR official at a manufacturing company, the collaboration between HR leaders and other business departments, such as an industrial division, is particularly important for the adoption of a preventive and proactive approach to the topic which, for instance, could imply the reconfiguration of work stations in such a way that they are suited to both disabled and non-disabled workers;

- head of the prevention and protection service (RSPP, *Responsabile del Servizio Prevenzione e Protezione*) at the company or workplace level, who is a figure envisaged by Legislative Decree No. 81/2008. The worker in charge is generally appointed by the employer to coordinate the overall prevention and protection services at the company or workplace level. The head can contribute to RTW by helping the employer identify and assess all risk factors, by designing the measures to ensure health and safety at work and by proposing information and training programmes for workers. In performing this role, the head of the prevention and protection service collaborates with the employer, the occupational physician and workers' representatives for health and safety (RLS, *Rappresentante dei Lavoratori per la Sicurezza*). Most importantly, the head contributes to drafting the risk-assessment document (DVR, *Documento di Valutazione dei Rischi*), which should encompass also those risks affecting certain groups of workers (disabled workers, workers with chronic diseases, etc.). With regard to these delicate situations, the document should be drafted by also consulting individual workers, patients' organisations, health professionals, engineers and ergonomics experts, etc. In small companies work settings, the role of the RSPP can be directly played by the employer, after attending a special training course;

- the occupational physician who contributes to RTW by collaborating with the employer in workplaces through both risk assessment (i.e. the physician contributes to drafting the DVR) and the protection of health and safety. Notably, the physician monitors workers' health status, diagnoses the type of unfitness for certain tasks and helps the employer understand if it is possible to give the worker other tasks. Medical check-ups performed by

[40] These funds are bilateral funds established via collective agreements in different economic sectors and managed by employers' associations and trade unions, devoted to the promotion and the financial support of lifelong learning in companies. They are financed by a contribution paid by the employers.

the occupational physician on the worker are paid for by the employer. Yet, the role of occupational physicians in supporting the (re-)integration of people with diseases at work is sometimes questioned by trade unions and workers' representatives – as one workers' representative affirmed, the occupational physician usually takes the company's side;

- workers' representatives at the workplace level, which can take two different forms in Italy – an RSA (*Rappresentanza Sindacale Aziendale*) and an RSU (*Rappresentanza Sindacale Unitaria*). The former is regulated by the 1970 Workers' Statute and can be set up in each workplace by those trade union organisations that have signed (or participated in the negotiation on)[41] a collective agreement applied in the workplace. Each RSA is conceived as a representative in the workplace of each trade union organisation and is entitled to specific rights and prerogatives. Conversely, an RSU, which is conceived as a unitary labour-representation structure in the workplace encompassing all trade union organisations, applies to those workplaces covered by NCLAs signed by the employers' associations adhering to Confindustria (the main employers' confederation representing companies in industrial sectors) and the trade union federations affiliated with CGIL, CISL and UIL. Indeed, Confindustria and the three trade union confederations introduced the RSU with a 1993 cross-sectoral agreement; their role and composition have been confirmed, though with some changes, in the subsequent cross-sectoral collective agreements signed up to today. As a result, an RSU can be established in workplaces with more than 15 employees and its members are elected by workers among lists presented by the trade unions that have signed or adhered to the above-mentioned cross-sectoral agreements. Both RSAs and RSUs can contribute to RTW by discussing and sometimes reaching agreements with management concerning health and safety and organisational solutions (allocation to different tasks and training opportunities, working time adjustment and new forms of flexibility, remote working, etc.) for the adaptation of work settings to people with chronic diseases. What is more, they monitor and ensure the implementation of legislative and NCLA provisions at companies. Indeed, according to one representative from a private employment agency, companies with a labour representation body are largely more sensitive to these issues than non-unionised ones;

- workers' representatives for health and safety (RLS), which operate in each workplace (1 RLS for a workplace with up to 200 employees, 3 for workplaces with 201 to 1,000 employees and 6 for larger workplaces) and their role is regulated by Legislative Decree No. 81/2008. Further prerogatives can be attributed by collective agreements. They contribute to RTW as the employer must consult them before undertaking risk-assessment procedures together with the RSPP and the occupational physician. They also take part in the periodic meetings on health and safety protection that the employer has to organise at least annually. At companies or workplaces where an RLS has not been elected, these functions are performed by a territorial RLS. A site-level RLS operates in temporary work settings where more than one company performs tasks (e.g. construction sites);

- joint labour–management committees or observatories at the workplace level, which can be established via collective bargaining with specific competences in the analysis and management of welfare, work–life balance, corporate social responsibility and the

[41] This clarification was given by the Constitutional Court with judgement No. 231/2013.

inclusion of people with disabilities at work. Their promotion was stressed in the 2013 "Biannual action programme for the promotion of rights and the inclusion of people with disability" as well as in its second version in 2017. An example in this regard is represented by the observatory on disabilities established in 2017, by a collective agreement, in the pharmaceutical company Merck Serono and composed of a disability manager, an RSPP, an occupational physician and trade union representatives. Similar observatories have been established in other companies, especially in the pharmaceutical and banking sectors;

- trade unions and employers' associations, which contribute to RTW mainly by
    - reaching national or territorial collective labour agreements that provide general rules and guidelines favouring the (re-)integration of people with chronic diseases at work in specific sectors or territories (e.g. extending the duration of the protected period for ill workers in need of treatment; the introduction of new leave and forms of working time flexibility). At the local level, they can also assist workers' representatives and employers in reaching company-level collective agreements that establish organisational and health and safety solutions for RTW. At companies where there are no workers' representatives, local trade union officials can also monitor and ensure the implementation of legislative and NCLA provisions. Finally, national sectoral social partners are also responsible for the establishment, via collective bargaining, of integrative health funds financed by employers (and in some cases, also by workers) and aimed at supplementing essential health provisions offered by the public system. However, certain funds end up replacing the role of the public health system in providing essential services (ADAPT, UBI Banca, 2019, pp. 65-122);
    - carrying out awareness-raising, training and research activities to deepen their knowledge on the issue and sensitise companies and workers' representatives. Three examples in this regard could be mentioned:
        - the 2017 booklet "Unfitness for the task and workers' disability: New rights and contributions to the reasonable accommodation in the employment relationship", published by the trade union confederation CISL;
        - the training project "Disability & Work" promoted by Prioritalia Foundation (established by Manageritalia, a trade union federation representing managers in the tertiary sector) and AISM, aimed at training disability managers;
        - the 2012 brochure "Quello che è importante sapere per le lavoratrici e i lavoratori affetti da patologie oncologiche invalidanti" (What is important to know for workers affected by invalidating oncological diseases) produced by the office of the national councillor for equal opportunities, the trade union confederations CGIL, CISL, UIL, UGL and Confsal, AIMAC and FAVO.

      Moreover, according to Legislative Decree No. 81/2008, at the local level, joint labour–management bodies (managed by both trade unions and employers' associations) can be established to support companies in the identification of

technical and organisational solutions to ensure health and safety and, with the financial contribution of interprofessional funds, to deliver or promote training activities in this field. An example in this regard is represented, for the craft sector in the Emilia-Romagna region, by EBER (Ente Bilaterale Emilia-Romagna), which performs activities and provides services to companies also in the context of health and safety thanks to the regional joint labour–management entity OPRA (Organismo Paritetico Regionale);

- lobbying policy- and lawmakers. In this regard, it is worth mentioning that social partners are represented in the Orientation and Oversight Committee (CIV, Consiglio di Indirizzo e Vigilanza) at INAIL, which is charged with defining the programmes, guidelines, and strategic pluriannual objectives of INAIL as well as monitoring the proper management of the institute's financial resources; and
- delivering assistance and consultancy services, also thanks to their territorial structures and their forensic physicians, to companies and workers in this field. Notably, the trade union patronage service INCA-CGIL (which helps workers gain access to their rights in a number of domains such as healthcare, social security and occupational diseases) is conducting interviews all over Italy to shed light on occupational diseases and to support workers in reporting their condition without fear of being dismissed. Plus, according to some trade unionists who participated in our discussion group, trade unions tend to act as a link between the worker with a chronic disease and the other relevant stakeholders (the HR department, occupational physician, trade union patronage, public authorities, etc.). Due to the fragmentation of actors and competences dealing with these issues, trade unions accompany the person throughout all the necessary steps that must be taken.

3.2 Views and level of involvement of industrial relations actors in RTW policy

Overall, industrial relations actors are perceived as very important in RTW by the many stakeholders involved in these processes, especially considering the fragmented legislative framework in this field and the workers' need to be assisted and accompanied. Notably, both trade unions and employers' associations provide support to workers and companies in RTW and collaborate with each other to establish (mainly through collective bargaining at the national and decentralised level) solutions that facilitate RTW processes.

According to many stakeholders interviewed, social partners are becoming more and more aware of the importance of RTW for people affected by chronic diseases. Nevertheless, there is still a long way to go, since 75% of the trade union and employers' representatives responding to our survey expressed that they did not know of any national policy in this field. RTW issues were not perceived as a priority by many of the social partners' representatives surveyed: while they acknowledged their limited involvement in policymaking and implementation in this domain, they exhibited an ambivalent attitude concerning their possible greater engagement. On the one hand, they still wanted to focus mainly on other issues of interest representation; on the other hand, 50% of respondents wanted to strive for a more active stance in policymaking and implementation. Overall, the impression arising from the surveys and discussion groups is that employers' associations are largely indifferent towards these issues, whereas in some cases, trade union officials display a greater interest.

Moreover, at the company level, employers largely exhibit prejudices about workers with chronic diseases, who are considered no longer efficient and productive. This is reflected in some employers' attempts to violate or circumvent certain norms and in the widespread perception among HR leaders and managers that the legislative framework in this field is more of a limitation than an opportunity. Additionally, some very important legislative provisions, such as those enshrined in Legislative Decree No. 216/2003 on reasonable accommodation, seem to be unknown to many employers. To complicate the picture, small companies' inclination to implement organisational solutions for RTW processes is further jeopardised by the lack of financial resources compared with those available to larger companies.[42] Among SMEs, workers' reassignment to other tasks is also more difficult given the little variety of available activities. In addition, according to a trade union official participating in a discussion group, even when central management at large enterprises formally exhibits its openness to the inclusion of people with disabilities or chronic diseases, this mentality is not always reproduced among branch-level managers dealing with practical cases.

Meanwhile, trade unionists are largely regarded as lacking specific knowledge of the different chronic pathologies that can affect workers and the various impacts they can have according to the age, contractual relationship and personal characteristics of the worker. Therefore, they tend to apply very general solutions and to simply focus on helping people receive the pensions related to their invalidity status. Overall, a protective, rather than proactive and preventive, approach to the issue seems to prevail within both companies and trade unions. In the words of an HR leader who participated in our discussion group, trade unions "largely activate themselves only in response to specific cases".

To overcome these problems and boost the involvement of industrial relations actors in this domain, training and awareness-raising initiatives are largely advocated by the stakeholders interviewed. Dialogue and cooperation between all the stakeholders involved in this field are sought for a further spread, improvement and coordination of RTW practices. However, it is worth specifying that this belief is shared mainly among those people who were engaged in RTW processes and who were either interviewed or were participants in our discussion groups, whereas most social partners' representatives who replied to our questionnaire but did not report any direct experience in this field were generally apathetic towards multi-stakeholder cooperation for RTW.

3.3 The nature of interactions between industrial relations actors and other stakeholders in RTW policy

Examples of how multi-stakeholder cooperation can overcome some of the cultural and information gaps constraining RTW are provided by the positive impact that private employment agencies frequently have on employers that deal with the (re-)integration of workers affected by

[42] However, it should be mentioned that the regional fund for the employment of disabled people, first introduced by Law No. 68/1999 and slightly amended with Legislative Decree No. 151/2015, can provide partial reimbursement for the expenses incurred by companies when making reasonable adjustments (including the introduction of new technologies and the elimination of architectural barriers) for workers whose invalidity status (certified by INPS) exceeds 50%.

chronic diseases.[43] In these cases, indeed, companies are often unprepared and in need of orientation and guidance. Employment agencies (especially if they are equipped with personnel specialised in the inclusion of disadvantaged people at work) do not just recruit a worker for the employer but can also support the employer in the implementation of organisational solutions, working time flexibility and the necessary task adjustments to integrate the worker. One representative's work at an employment agency "consists of discussing with the company and trying to erase preconceptions, by proving that certain limits can be overcome thanks, for instance, to the allocation of the worker to a different position. It happens very often that diseases described as unbearable by companies can actually be handled." Another relevant example that concerns an employment agency is provided by Mestieri Lombardia Bergamo, which specialises in the job placement of disadvantaged people. By being a non-profit entity and participating in the local consortium Sol.Co Città Aperta, it has become a landmark for the other cooperatives of the consortium when they deal with a person with a disability and/or a chronic disease. If internal reintegration is not possible, Mestieri Lombardia Bergamo helps identify those entities both within and outside the consortium that are able to include the worker.[44]

By contrast, the collaboration between industrial relations actors and patients' associations is still underdeveloped and limited to specific cases. In this sense, AISM represents a positive exception as it has cooperated with both the pharmaceutical company Merck Serono and the trade union foundation Prioritalia for the organisation of different training courses. It has also signed a territorial partnership agreement with the employers' association Unindustria of Rome, the ASPHI Foundation, the pharmaceutical company Merck Serono and the local trade union organisations FILCTEM-CGIL, FEMCA-CISL and UILTEC-UIL of Rome, with the aim of facilitating the recruitment of workers affected by multiple sclerosis to the Rome site of Merck Serono. These AISM initiatives are coherent with priority 6.2 of the association's agenda for 2020, which entails support for the RTW of people with multiple sclerosis and subsequently, the AISM engagement with social partners for collective agreements that better favour "work–care–life balance" solutions for these workers.[45]

Research organisations focused on chronic diseases seem to experience even less chance of interaction with industrial relations players. As revealed by one representative from the Italian IRCCS Foundation Carlo Besta Neurological Institute, these occasions are largely limited to the collection of information required by the research projects carried out by the institute, within which researchers may conduct interviews with managers and trade unionists or workers' representatives. In addition to that, it is worth mentioning the educational role that the Carlo Besta Institute played, along with the Catholic University of Milan and the banking group Intesa San Paolo, in a 30-hour training course on disability management addressed at workers' representatives and HR leaders.

Other stakeholders that sometimes interact with industrial relations players in the field of RTW policies are regional and territorial public authorities and INAIL. Aside from the involvement of social partners in the Orientation and Oversight Committee of INAIL, an important example in

[43] As previously mentioned, under Law No. 68/1999, the employer is obliged to hire a certain percentage of disabled workers according to the size of the enterprise. Plus, sometimes employers can deal with agency workers who have contracted a chronic disease. In these cases, companies can resort to employment agencies for help and assistance.

[44] For further information, see the website of Sol.Co Città Aperta: http://www.solcocittaaperta.it.

[45] For further information, see the AISM's Agenda on Multiple Sclerosis 2020: https://www.aism.it/sites/default/files/Agenda_della_sclerosi_multipla_2020.pdf.

this sense is represented by the Memorandum of Understanding signed on 8 January 2020 by the Lazio region, the regional directorate of INAIL, on behalf of the local trade unions and employers' confederations and some associations of disabled people. The memorandum concerns the use of INAIL funds for carrying out, with the support of the public employment centre, projects of (re-)integration at work of people with disabilities, which may imply the breaking down of architectural barriers, the adaptation of work stations and the organisation of training activities. The memorandum was signed at the premises of the pharmaceutical company Merck Serono, which adhered to its content. Another case is provided by the project Insieme per il Lavoro, resulting from the collaboration between the municipality of Bologna and the Archdiocese of Bologna and aimed at facilitating the job placement of dependent people. The project was launched in 2017 with the signature of a dedicated protocol and has developed thanks to the interaction with local trade unions and employers' associations (which are part of the steering committee) as well as with a network of enterprises willing to integrate these workers. Professionals from Insieme per il Lavoro support both workers and companies during the entire employment relationship and particularly in its initial phases, by also financing training activities and internships.[46] Yet, these important experiences seem to be quite rare in the Italian landscape and often focused on disabled or disadvantaged workers rather than on people with specific chronic diseases. Some HR leaders who participated in our discussion group complained about their poor and limited relationships with public entities like ASLs, INPS and INAIL. Notably, as one HR leader put it, "[i]f I call INAIL or ASL, I do not get any answers".

Finally, from the interview with a director of the Ministry of Labour and Social Policies, it emerged that trade unions and employers' associations have a steady and permanent dialogue with the legislature concerning labour and industrial relations issues; with specific regard to RTW, they were consulted before the introduction of some legislative provisions. Nevertheless, as previously mentioned, the questionnaire submitted to Italian social partners revealed a quite different picture, with most of the trade union and employers' representatives reporting that they were not involved in policymaking in this field (100% of employers' representatives reported they were not involved at all; 50% of trade union representatives responded that they "have marginal involvement in RTW policymaking").

3.4 Outcomes of social dialogue with regard to RTW policy (covering national and if relevant sectoral/regional social dialogue)

At the national level, social dialogue processes that have occurred between industrial relations actors and lawmakers have resulted in the introduction of some legislative provisions aimed at facilitating RTW. At the same time, as we have seen in the previous section, some important bipartite or multipartite social dialogue activities have been conducted at the regional or territorial level. In addition to the Memorandum of Understanding signed on 8 January 2020 in the Lazio region, we can mention the agreement signed in July 2015 by the Municipality of Alessandria and the local trade union confederations regarding the continuation of an active labour policy project for the inclusion of people with disabilities at work and the agreement signed in November 2011 by the Municipality of Pomezia, the social consortium Coin and the local trade union organisations to sustain a project for the job placement of 13 disabled people in the territory. Therefore, the main outcomes of social dialogue at the regional and local levels are projects inherent to active labour

[46] Further information is available on the website of Insieme per il lavoro: http://www.insiemeperillavoro.it.

market policies with specific regard to disabled or disadvantaged people. In accordance with this approach, the territorial collective agreement for social cooperatives in the area of Bologna signed on 6 April 2018 provides for an information and consultation procedure with workers' representatives concerning not only the number of people "with functional limitations" and the health and safety measures put in place in single cooperatives, but also possible reassignment opportunities (following ad hoc training and reskilling paths) to be implemented in synergy with social consortia (which cooperatives participate in) and those local cooperatives that are specifically devoted to the inclusion at work of disadvantaged people. This process can be coordinated and supported by the territorial bilateral committee, composed of both trade unions and employers' representatives. An example of these fruitful relationships in the social cooperation sector is given by the Bergamo consortium Sol.Co Città Aperta where, according to one HR leader of a cooperative that takes part in the consortium, the non-profit employment agency Mestieri Lombardia Bergamo (which specialises in the job placement of disadvantaged people) operates by helping social cooperatives of the consortium find a new occupation for those disabled workers who cannot be internally reassigned to other tasks.[47]

By contrast, with regard to national-level collective bargaining, the main provisions concern the protection of workers with disabilities or serious and chronic pathologies in the employment relationship. The majority of the national-level collective agreements signed by the most representative trade union organisations in Italy (which are those affiliated with CGIL, CISL and UIL) provide for measures that ensure the job retention of people affected by serious pathologies requiring periodic treatments. For instance, in the NCLAs for the food industry, electrical sector, professional firms, environmental services and social cooperatives, the periods of hospitalisation and absences related to life-saving therapies and long-term treatments are not considered in calculating the end of the so-called protected period (made up of the overall number of days of absence from work during which employees cannot be dismissed) in the case of workers affected by certified serious pathologies (oncological diseases, HIV, multiple sclerosis, muscular dystrophy, Cooley's anaemia, etc.). Similarly, some NCLAs (such as those for the banking sector, chemical and pharmaceutical sectors, glass industry, apparel industry, and stone materials) increase the length of the protected period, even up to 32/36 months, for workers affected by serious and chronic diseases. Moreover, once the protected period is over, NCLAs can provide ill workers with the possibility of benefitting from a non-paid leave of absence that can last for 4, 6, 12 months or even 24 months, as is the case in the banking sector.

Further provisions established at the national level regard the financial support for ill workers, including the NCLA for the metalworking sector, as well as that for the retail sector, which specify that absences related to serious and chronic diseases are not a determining factor for any wage cuts (which are instead established for a certain number of absences not ascribable to pathologies). On the other hand, the NCLA for the food industry grants workers affected by serious pathologies or medical necessities the opportunity to get their severance payment in advance.

Other clauses concern working time and particularly the right to change the employment relationship from full-time to part-time (as enshrined by Legislative Decree No. 81/2015), paid time off (also in compliance with Law No. 104/1992), forms of working time flexibility (e.g. the NCLA for the banking sector provides workers affected by oncological and degenerative diseases with greater flexibility on entry and exit from work in terms of working hours) and the exclusion

[47] For further information, see the website of Sol.Co Città Aperta: http://www.solcocittaaperta.it.

of ill workers from certain work shifts (e.g. on Sundays). Plus, the NCLA for the banking sector considers telework to be a suitable tool to facilitate the integration of disabled people at work.

Among the many NCLAs covering economic sectors in Italy, those signed for the banking sector and the chemical and pharmaceutical ones appear to be the most sensitive to the problems faced by workers with disabilities and/or diseases. Indeed, in the chemical and pharmaceutical sectors, the NCLA offers guidelines for company-level collective bargaining, by suggesting the implementation of ad hoc training activities and job placement projects with regard to disabled people, the elimination of architectural barriers and the setting-up of dedicated, joint labour–management committees. The same NCLA envisages a role for the national observatory (composed of both trade union and employers' representatives) in the promotion of local-level projects for the removal of architectural barriers and the job placement of disabled and disadvantaged workers, by also considering existing financial opportunities and the national and regional legislation in this field. The NCLA for the banking sector promotes 'disability-friendly' working organisations, where the professional figure of the disability manager should be introduced and training courses should be tailored to the specific needs of disabled workers. The same NCLA for the banking sector extends the scope of the information procedure, held in annual meetings with workers' representatives at the company level also to the number of work stations that can be attributed to disabled people and the introduction of digital and technical tools useful to removing the communication obstacles for disabled workers. It also sets forth the establishment of a national labour–management observatory with the task of developing initiatives for disabled workers. These NCLA provisions can be particularly appreciated for their clear objective to foster social dialogue and industrial relations on these topics also at the local and company levels, by strengthening information and consultation procedures with workers' representatives, suggesting organisational solutions and guidelines, and providing coordination and support for these processes from the national level to the decentralised one – thus overcoming the widespread lack of sensitivity and engagement among employers and workers' representatives, which has been reported by some interviewees.

Moreover, it is worth highlighting the role played by integrative health funds, established by collective bargaining in different economic sectors, in supplementing essential health provisions offered by the public system, thus improving access to treatment for workers. These funds are financed by contributions paid by employers (and in some cases, also by workers) operating in the concerned sectors and offer health services to workers (mainly employees with open-ended contracts but also workers with fixed-term contracts after a certain seniority). In some cases, health services are guaranteed also to relatives of the workers covered by the NCLA that has introduced the integrative health fund. With specific reference to workers affected by chronic diseases, these funds can offer the following helpful measures: reimbursement of the expenses related to surgical operations or an allowance for each day of hospitalisation; reimbursement of expenses related to specialist examinations, diagnostic tests and analyses, and (as in the case of the FASA fund for workers in the food sector and the SAN.ARTI fund covering craftworkers) treatments and rehabilitative therapies for oncological diseases; reimbursement of expenses related to prosthetic replacements; monthly or annual allowances or reimbursement of nursing care in case of temporary or long-term lack of self-sufficiency, as in the case of the CASDAC fund in the banking sector; medical consultancy and assistance along with the monitoring of clinical values, especially for chronic pathologies, as in the case of the SANIMODA fund addressed at workers in the apparel industry; financial coverage of periodic medical check-ups and generic screenings specifically

targeted at women, men and the elderly, aimed at the prevention of different oncological diseases, such as skin and thyroid cancers and chronic pathologies due to functional overload, as in the case of MÈTASALUTE fund for metalworkers.

Finally, the NCLA of private employment agencies regulates a key, active labour-market solution, which consists of training courses organised by individual employment agencies, financed by the sectoral interprofessional fund FORMATEMP and addressed at potential candidates for temporary job experiences at companies. The financial coverage of these courses is guaranteed by FORMATEMP provided that at least 35% of participants are employed every year; importantly, disabled people are excluded from the calculation of this proportion so as not to compromise their possibility of training. This active labour policy appears to be quite unique among Italian national collective labour agreements, and is justified by the specific target of the NCLA: agency workers who are subject to discontinuous and flexible occupational paths.

3.5 Views on the future potential for action on RTW and the contribution of industrial relations actors

The role of industrial relations in RTW processes is not particularly promoted by Italian legislation. The fragmented rules concerning RTW processes occasionally refer to the contribution of social partners and collective bargaining. As in other action domains, the Italian industrial relations system is indeed characterised by the absence of law and a high degree of voluntarism. This has given rise to phenomena such as union pluralism, multiplication of collective agreements, and a lack of collective-bargaining governability (Leonardi, 2017). The involvement of social partners in policymaking is moreover defined as irregular and highly politicised (Visser, 2009). This institutional setting inevitably affects the degree and type of engagement of Italian industrial relations' actors in defining and managing RTW policies at all levels.

Notably, the involvement of social partners in this domain comes to depend essentially upon their sensitivity and awareness of the problem. These characteristics are facilitated by the relationships between social partners and other stakeholders, such as patients' associations, public and private employment agencies, research organisations and public authorities. However, these interactions, which are moreover important in this specific field given the multidimensionality of the issue (affecting the worker primarily as a person and a member of a family and a social community), are neither systemic nor particularly favoured by any coordination effort at the national level; rather, they seem limited to certain contexts and situations, deriving from the availability and interest of certain individuals.

The territorial level can thus be a laboratory of interesting experiences that need to be better detected and explored, as they are not led or encouraged all over the country by any national directive or decisive multi-stakeholder policy action. In the local settings mapped in this report, multi-stakeholder cooperation takes the form of concrete job (re-)integration processes addressed at people in very vulnerable and disadvantaged conditions, including those affected by chronic diseases, where different actors put their own skills and resources to service. Further research should be conducted to gather more local experiences and understand their determinants, enabling factors, and concrete results so as to investigate whether in Italy, where a comprehensive national approach does not seem likely at the moment and probably would not deliver homogeneous results

either,[48] a multiplier effect of bottom-up territorial initiatives can occur and somehow be sustained. Nonetheless, that issue is not the focus of this report.

In addition to territories, sectors can represent a further dimension affecting the specific contribution of social partners to RTW policies. At this level, trade unions and employers' associations mainly interact with each other by negotiating and signing collective labour agreements aimed at guaranteeing job protection, financial support, work–care–life balance and enhanced access to healthcare for workers affected by serious diseases. The main focus is therefore on the provision of a set of rules for workers in need of treatment while being in a contractual employment relationship. Less attention is cast on those procedural and infrastructural elements, like joint labour–management bodies devoted to the issue, ad hoc training activities for managers and workers' representatives, targeted information and consultation processes, potentially sustaining the actual application of national-level provisions, which indeed are not always known and implemented at the company level. Relevant exceptions have nevertheless been detected in the NCLAs of the chemical-pharmaceutical and banking sectors. Also, unlike territorial social dialogue, sectoral collective agreements tend to concentrate on measures and solutions available for workers as long as they are employed in specific work settings, whereas only the NCLA for agency workers (probably because of its cross-sectoral nature) acknowledges the possibility of occupational transitions for disabled workers and deals with these situations.

With specific regard to the main targets of the above-mentioned sectoral-level provisions, it has been observed that they can be either disabled workers, workers affected by serious and chronic pathologies, workers hit by oncological and degenerative diseases, or workers in need of life-saving therapies (Osservatorio AISM, 2017). While the concept of disability in the Italian legal and contractual system is generally associated with the recognition of a specific status by a public authority, serious and chronic pathologies are sometimes exemplified with references to specific diseases, which may need to be confirmed and certified. As a result, different sectoral collective agreements not only provide for different forms of protection but also address different worker categories that are not easily identifiable. To overcome this complexity and facilitate a simpler, more immediate and generalised application of available rights and provisions, a normalisation of concepts in NCLAs, with no need of particular interpretations or third-party certifications, and an extension of contractual safeguards to broader groups of workers (in line with the approach suggested by the UN Convention on the Rights of People with Disabilities of 13 December 2006 and recently acknowledged by the European Union) have been encouraged (Osservatorio AISM, 2017).

Finally, it should not be overlooked that union pluralism and the multiplication of NCLAs[49] create a further differentiation among the forms of protection made available to workers affected by chronic diseases and increase the risk that many sick workers do not benefit from the rights and provisions previously mentioned and established in the NCLAs signed by the main trade union organisations in Italy (CGIL, CISL and UIL). To counter this phenomenon, social partners have undertaken important steps over the last years towards the measurement of trade union representativeness and the subsequent identification of those NCLAs signed by most

[48] This characteristic has a long history in Italy (cf. Locke, 1995).

[49] Today, the number of NCLAs in Italy exceeds 900. Most of the NCLAs are signed by worker organisations, not adhering to CGIL, CISL or UIL, which are the most representative trade unions in Italy. These NCLAs also provide lower financial and normative standards to workers (CNEL, 2019).

representative trade unions, which Italian legislation refers to in a number of provisions, concerning e.g. the identification of the contractual wage level to be used for the calculation of social security contributions and the possibilities of deviation from legal standards.[50] However, these measurement processes are still ongoing, and solutions are not easy to find, especially if the intention is to balance the protection of worker rights and the elimination of social dumping via collective bargaining with the maintenance of freedom of association and union pluralism, as fundamental features of the Italian system of industrial relations. In this regard, more concrete actions of social partners at the local level aimed at finding both economically and socially sustainable solutions to territorial problems, thus reducing companies' temptations to apply alternative and low-cost NCLAs, are highly recommended (Tomassetti, 2019).

4. The return to work process at the company level and the involvement of social partners

4.1 Workers' experiences with the return to work process at the company level

Considering the workers' types of diseases, the online survey revealed that cancer/oncological diseases (50%) are the most diagnosed chronic illness, followed by "others" (27%), arthritis (20%), chronic respiratory diseases (7%), cardiovascular diseases (7%), mental disorders (3%) and diabetes (3%). None of the respondents had been diagnosed with musculoskeletal diseases, and 3% of workers did not specify their disease. Among the most serious diseases that workers had experienced with a considerable impact on their career and work, cancer/oncological diseases were selected by 43% of respondents, followed by "other diseases" (26%), which, though not specified in detail, include cardiovascular diseases (9%), arthritis (9%), and musculoskeletal disease, chronic respiratory diseases, and diabetes (each one picked by 4% of workers). None of the respondents chose mental disorders.

For the purpose of this report, 68% of workers participating in our survey were concerned about returning to work, while 32% of them reported that they were not worried. The main reasons for these concerns were related to the fact that the employer might not be willing to adjust working conditions to post-illness conditions (41%). Workers could also be afraid of being left without any support from the employer if their productivity, concentration, and work performance did not fully meet the employer's expectations (29%). Other reasons for concern were represented by the risk of being required to return to work at full productivity right after treatment and without any adjustment period (24%), as well as the possible need to work long hours shortly after a long-term

[50] An intersectoral agreement on representativeness was reached on 28 June 2011 by Confindustria, CGIL, CISL and UIL, which set criteria for industry-level and company-level bargaining. These criteria were confirmed in the cross-industry collective agreement signed on 10 January 2014, followed by an agreement signed with INPS in 2017 that, however, expired on 16 March 2018. Moreover, on 28 February 2018, Confindustria, CGIL, CISL and UIL signed another agreement, stressing again the relevance of making effective the criteria for the measurement of trade union and employer association representativeness, also in a view of contrasting pay and social dumping via collective agreements signed by non-representative worker and employers' organisations. Therefore, more recently, in 2019, Confindustria, CGIL, CISL and UIL signed an agreement with INPS and INL (National Labour Inspectorate), which attributes to INPS a prominent role in the measurement of trade union representativeness. This assessment should be used by both INPS and INL to identify those NCLAs signed by most representative trade unions, which Italian laws sometimes refer to for the recognition of contributory and normative incentives. A very similar agreement was later signed with Confapi, representing small and medium-sized enterprises. Further intersectoral collective agreements have been signed over the past few years by CGIL, CISL and UIL with other employer confederations (such as those covering the services sector, cooperatives and craft companies) for the measurement of trade union representativeness.

absence (24%). Furthermore, workers were afraid of not being provided with any support in the event that they experienced problems with productivity, concentration and work performance (24%), discrimination by their colleagues (12%), or financial discrimination that prevented them from getting financial bonuses due to their lowered productivity (12%). Among respondents, 6% selected other possible reasons, though without clarifying their nature.

As regards the relationships between the sick worker and the company during the period of leave due to treatment, it is worth underlining that 68% of workers reported that during their treatment they were in touch with their colleagues, 32% with the direct manager (team leader, line manager and similar), 12% with the general manager or the HR department and only 8% with trade unions or employee representatives. Finally, it is notable that 16% of them were in contact with no one but the employer during their sickness leave.

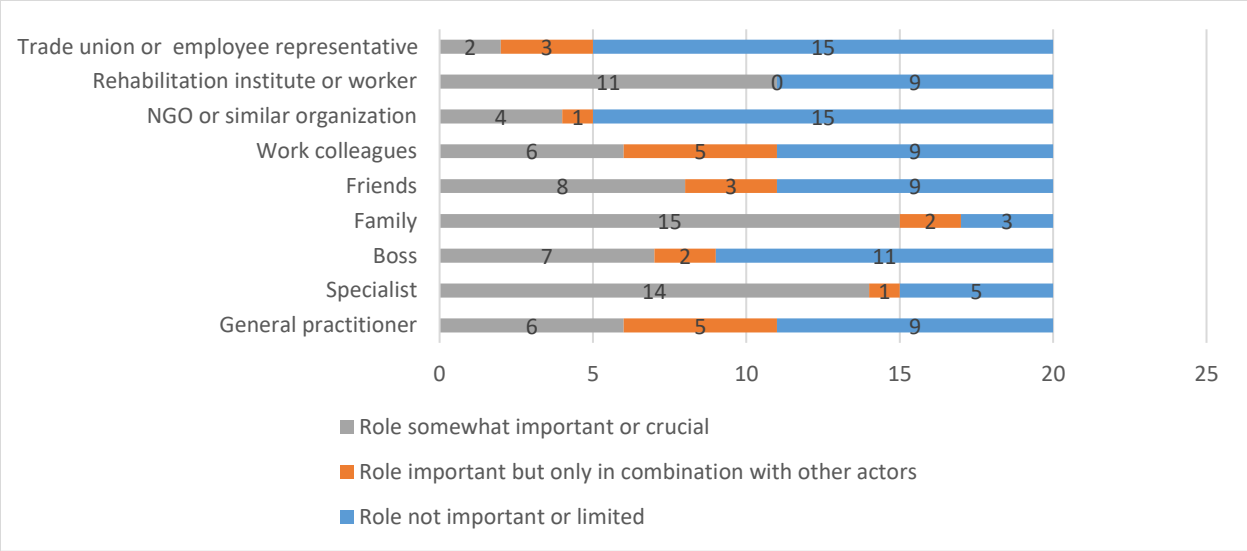
According to the workers surveyed, the most important people or institutions that should help them return to work after the treatment of a chronic disease are the team leader or the line manager (36%), the HR department (29%), a patients' organisation (18%), a psychologist or an occupational therapist at work (11%), a psychologist or an occupational therapist outside the company (11%), a rehabilitation institute (7%), a labour market authority (7%), the employer (7%), and a trade union (7%). The remaining respondents either generally suggested "other people/organisations" without any specification or indicated that they did not have a clear opinion (4%), or that they "don't need support and [did] not contact any of the above persons or organisations" (7%).

With reference to the workers' concrete experience with return to work following a long period of absence, for 64% of cases the initiative to return to work was taken by workers themselves, for 24% of cases it was prompted by specialists treating their disease (oncologists, psychiatrists, cardiologists, etc.), for 12% of cases by general practitioners, for 4% by the boss, for 4% by the family and for 4% by someone else. None answered that the initiative to return to work was prompted by friends, colleagues, an NGO or similar organisation dealing with that type of illness (e.g. Italian League against Tumours), a rehabilitation institute, rehabilitation nurse or physiotherapist, a trade union representative or other employee representative (e.g. a shop steward, employee delegate, works council representative). The first actor with whom workers discussed returning to work after their illness was the specialist treating the disease (oncologist, psychiatrist, cardiologist, etc.) (38%), followed by the general practitioner (29%), family (21%), other (8%) and trade unions (4%). None of the respondents indicated friends, colleagues, an NGO or similar organisation dealing with their specific type of illness (e.g. Italian League against Tumours) or a rehabilitation institute, rehabilitation nurse, or physiotherapist.

It is thus no wonder that according to many respondents, the most important roles in facilitating their return to work after a sickness leave were played by the specialists treating the disease (for 50% of workers this actor was crucial in enabling the experience of returning to work) and family (45% of workers rated family as crucial) (Figure 1). Also quite relevant were the roles played by rehabilitation institutes, rehabilitation nurses, and physiotherapists (considered pivotal by 20% of workers), general practitioners and colleagues (in these two cases in particular their role was considered important in combination with other actors, 25%). Less relevant was the role played by NGOs or similar organisations dealing with specific types of illness (while 65% of workers evaluated them as not important, 10% said they had a very limited role and another 10% of workers viewed these actors as vital) and the role of trade union representatives or other employees'

representatives (60% of workers deemed them to be unimportant, 15% saw their role as very limited and for only 15% of respondents were they important but only in combination with other actors).

Figure 1. Workers' evaluation of the role of different actors in facilitating return to work after sickness leave (Q48)



Source: REWIR workers survey, own calculations; number of respondents: 20.

With regard to the support received by workers from employers in returning to work, the majority of workers (28%) were not satisfied at all and 20% were partly satisfied as they deemed the support offered to be limited. By contrast, 24% of them claimed to be satisfied as they had received the expected advice and support, but only 16% of workers reported being very satisfied and that the support received had exceeded their expectations. A middle position was taken by 12% of workers, moderately satisfied because the support offered was not remarkable, yet they had not expected more.

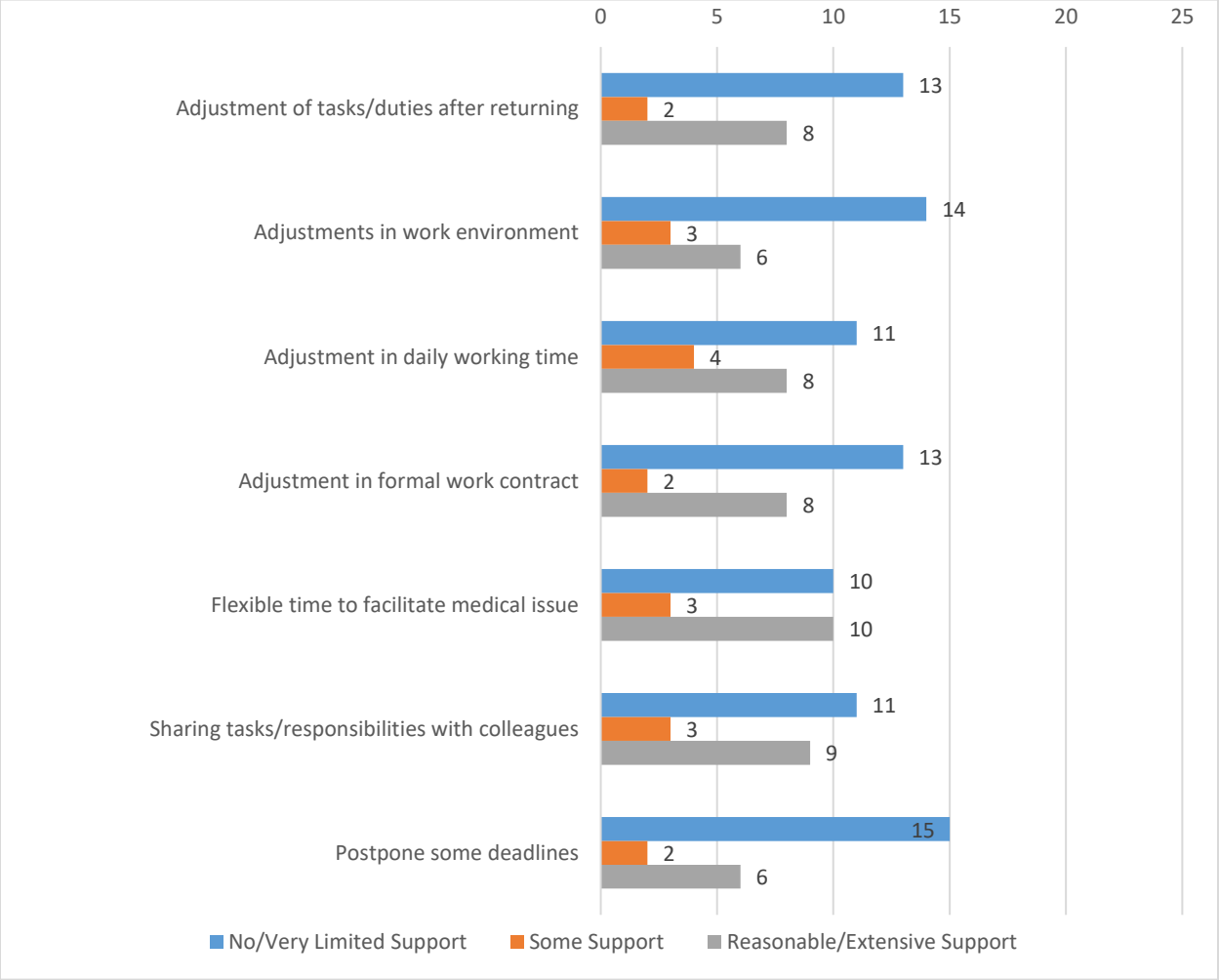
With specific reference to the workers' opinion about the help and support received from their trade union in returning to work, almost half of the respondents reported that they were not satisfied at all (48%) whereas another 24% of them were partly satisfied with the limited support offered. On the other hand, 24% of the interviewed workers were satisfied and thought that they had received the expected advice and support even though nobody was truly satisfied. Finally, 4% of the workers stated that they were moderately satisfied because the support offered was not extensive, but they had not expected more. Almost all of the workers who were not trade union members (83%) did not wish to join a trade union after being diagnosed with a chronic disease in order to support or facilitate their return to work after treatment. Such data are also relevant if we consider that there is a trade union active in almost all the workplaces where respondents work (80%). These figures seem to underline the weakness of trade unions in supporting RTW in the perception of workers. Indeed, although the vast majority of workers thought that "the trade union should always be ready to address health-related issues of workers" (50% strongly agreed; 25% agreed) and that "support for RTW should be an important element in the agenda of negotiations between the trade unions and the employer" (45% strongly agreed; 30% agreed), in only 6% of cases did workers indicate that there had been actual negotiations between their employer and trade

union/employee representatives about adjustments to work tasks and responsibilities after returning to work. Besides that, most of the respondents had an indifferent opinion (30%) about the capacity of trade unions to facilitate RTW in Italy. Finally, only 25% of respondents had knowledge of other cases where the action of a trade union proved to be helpful in facilitating the return to work of workers after the treatment of a chronic disease. This figure may show a lack of sharing of the successful experiences.

Another important part of the questionnaire submitted to workers concerned the actual development of the process of return to work, its characteristics and ways of implementation. In this regard, the respondents were equally divided between those who, after a long-term illness, returned to the same job position (47%) and those who did not (47%).

Looking at the work adjustments to work assignments (tasks/duties) received after returning to work (Figure 2), most workers did not receive the necessary adjustments with regard to tasks/duties (no support in this field, 35%; very limited support, 22%; some support, 9%; reasonable support, 26%; extensive support, 9%). As for adjustments to the work environment, a large number of workers did not receive any support in this area (no support, 43%; very limited support, 17%; some support, 13%; reasonable support, 17%; extensive support, 9%). Similar considerations applied to adjustments to the type of employment (no support, 43%; very limited support, 13%; some support, 19%; reasonable support, 17%; extensive support, 17%). Additional factors include ratings concerning the possibility to postpone some deadlines (no support, 47%; very limited support, 17%; some support, 9%; reasonable support, 13%; extensive support, 13%); the findings on the adjustments to daily working time, which were more positive (no support, 30%; very limited support, 17%; some support, 17%; reasonable support, 17%; extensive support, 17%); the measures adopted to introduce flexibility to working time in order to facilitate medical examinations or treatments (no support, 30%; very limited support, 13%; some support, 13%; reasonable support, 17%; extensive support, 26%); and those adjustments aimed at reassigning some of their tasks/responsibilities to their colleagues (no support, 35%; very limited support, 13%; some support, 13%; reasonable support, 26%; extensive support, 13%).

Figure 2. Adjustments received by workers when returning to work after a long-term illness (Q47)



Source: REWIR workers survey, own calculations; number of respondents: 23.

In addition to the findings that emerged from the online survey submitted to workers within the framework of this project, it is important to highlight that the impact of cancer on working conditions and job retention grows with the increase of pre-existing vulnerability, as cancer has greater negative effects on flexible and temporary workers, on women and on workers who are approaching retirement (FAVO, 2019, pp. 15, 20).

A recent Italian survey showed that the professional situation of patients in most cases (about 80%) remains unchanged before and after the diagnosis of oncological disease, although there is a decrease in their income. Only 50.2% of respondents reported that they had been able to maintain the same remuneration level prior to the disease: the average decrease in the overall income (not only deriving from work) was 39.5%, with drops of between 20% and 50% of income; in some cases the drop in income was even higher, for 11.3% of respondents (FAVO, 2019, p. 20). In Table 5, the decreases in incomes are divided according to the respondents' jobs. As shown, craftworkers, self-employed workers and freelancers cited the most significant reductions in their

incomes. Among the employed people, there was a significant difference between employees on open-ended contracts, those on fixed-term ones and people employed in flexible forms of work.

Table 6. Income decrease by professional category

Could you indicate how much your income has decreased since the start of the disease (as a percentage, by professional category)											
	Total	**Em-ployed**	**Self-em-ployed**	**Inactive**	**Em-ployed on open-ended con-tracts**	**Em-ployed for a fixed term**	**Workers with flexible forms of work**	**Self-em-ployed**	**Free-lancer**	**Craft-worker**	**Retailer**
No reduc-tion	50.	61.1	40.9	30.7	58.0	32.9	47.1	27.6	36.7	40.9	50.0
Up to 20%	18.5	21.7	18.9	10.0	19.8	22.9	5.9	13.8	13.9	13.6	17.9
21–50%	20.0	14.8	22.0	31.3	18.0	21.4	17.6	24.1	27.8	18.2	21.4
51–80%	5.5	1.3	10.2	12.0	1.7	14.3	17.6	17.2	12.7	4.5	0.0
Beyond 80%	5.8	1.1	7.9	16.0	2.4	8.6	11.8	17.2	8.9	22.7	10.7

Source: Own translation and adaptation of FAVO (2019), Graphic no. 6.

The professional situation of self-employed workers, craftworkers and people employed in flexible forms of work experienced very severe changes after the onset of the disease. Only 35% of flexible workers remained in the same professional category. Among the other flexible workers, those who lost their jobs and those who devoted their time to housework represented 35% (equally distributed), whereas 11% applied for retirement. Almost 50% of workers suffering from cancer as a group became inactive after diagnosis. Similar, albeit minor, changes affected those who were fixed-term workers at the time of the diagnosis, as 38.6% of them had become inactive at the time of the survey (2018). In particular, 20% of fixed-term workers were unemployed, and 10% of these unemployed workers had applied for retirement (FAVO, 2019, p. 20). Considering the interviewees as a whole, in 54.1% of cases the disease did not negatively affect career and education, while 76.5% of flexible workers and 62.9% of fixed-term workers reported that the disease had negatively impacted their professional activity. The switch to working part-time concerns, on average, 30.9% of workers diagnosed with cancer, but that share rises to 53.8% for people employed in flexible forms of work, 60.0% for traders, 50.0% for craftworkers and 48.8% for freelancers. In addition, it is interesting to note that having a disease led to other important work-related effects, such as worsened performances at work (36.8% of the interview sample).

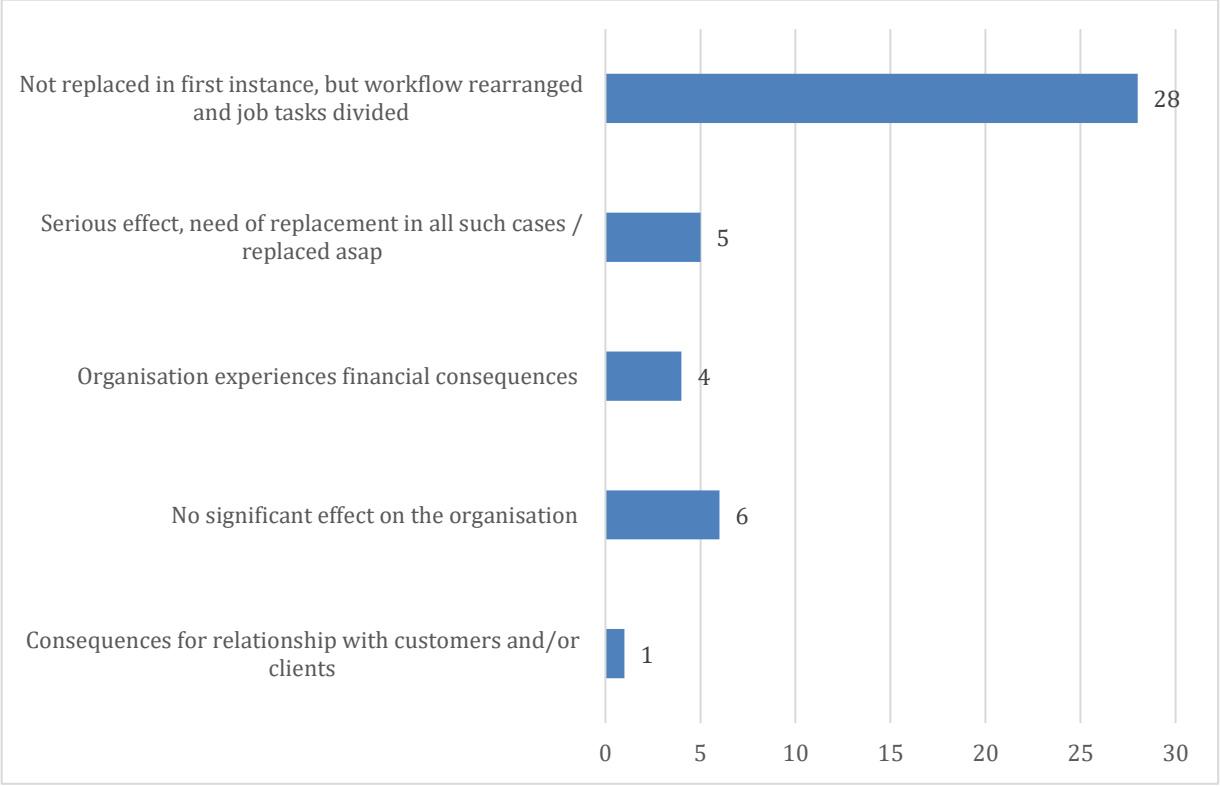
Finally, the survey points out that having a disease represents a greater factor of weakness in the labour market for those workers in a weaker contractual position as well as for women, who lost working days twice as much as men, and for workers aged between 55 and 64, 45.8% of whom lost from 6 months up to 1 year of work in 2019 (FAVO, 2019, p. 20).

4.2 Perspectives of HR, line managers and other relevant company actors on return to work processes at the company level and interactions between employers and employees

The importance of regular contacts with workers during their absence is largely acknowledged by the HR leaders and managers who answered our questionnaire. Indeed, despite the fact that they work mainly in large enterprises (53% of respondents work in companies with more than 250 employees), they are generally informed of the employee's specific chronic disease directly by the concerned employee, either via formal communication (36%) or during an informal conversation (28%). Fewer employers are instead informed by an employee's own occupational physicians (10%) or by organisation's medical specialist (15%). Regular contacts with the worker during the worker's absence are not always ensured through formal channels (such as standard HR requests for medical updates) but sometimes via informal phone calls and friendly conversations (41%). On these occasions, workers are generally informed of work-related issues (61%), while in fewer cases, they are truly engaged in decision-making and planning processes on work-related topics (41%). Therefore, during their absence, it seems that employees retain mainly a passive connection with work.

During these periods of absence, managers are forced to implement important organisational measures that generally imply a rearrangement of the workflow and a redistribution of job tasks among other workers (74%) (Figure 3), and to a lesser extent the replacement of the sick worker (13%), as well as financial difficulties (10%).

Figure 3. Perceived effect of an employee absence on the organisation (Q12)



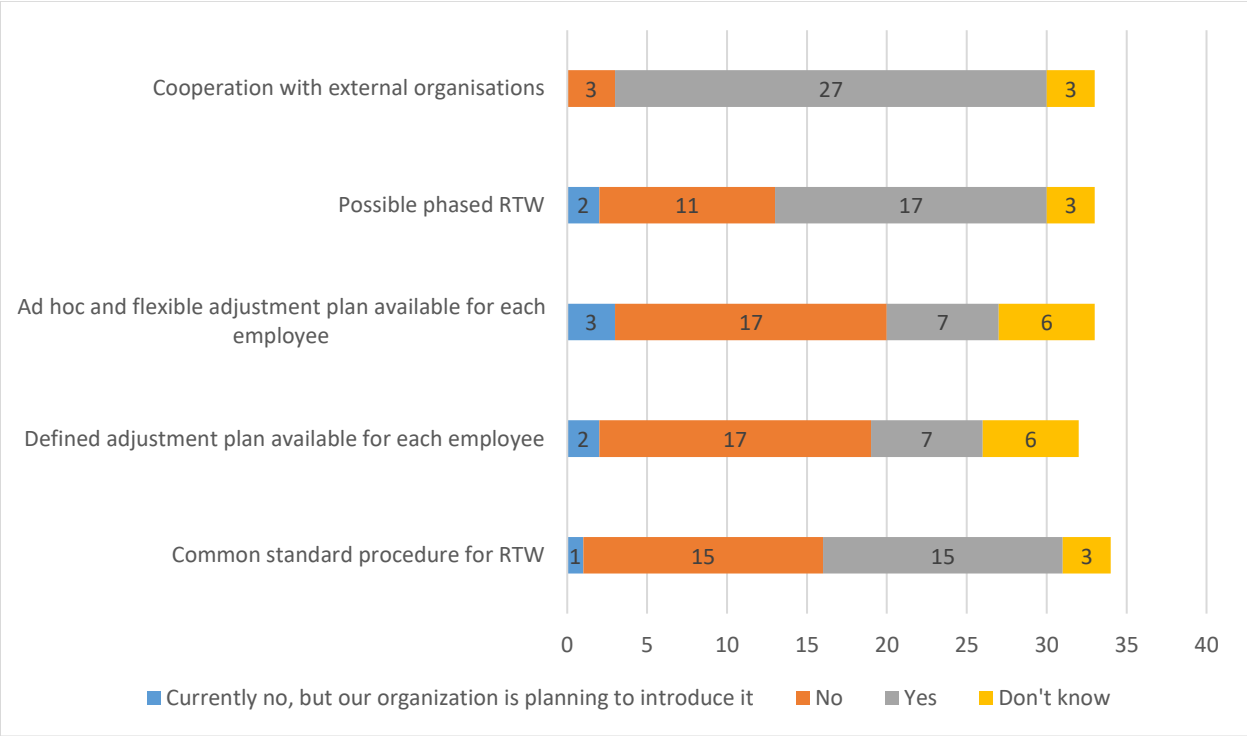
Source: REWIR managers' survey, own calculations; number of respondents: 38 (multiple response options).

It is thus no wonder that many of them expressed that they appreciated and encouraged RTW processes during treatments (70%). While dealing with workers on sick leave, HR leaders and managers found consultancy services from an external expert or patients' association useful, as

well as information or advice on the specific chronic disease and proper adjustments implemented at the workplace. We pointed out earlier the important contribution by private employment agencies. However, the latter kind of support is frequently perceived as missing by many companies, along with legal advice on sick leave and external counselling.

According to the survey submitted to managers, RTW processes are generally initiated by workers (56%) or managers/employers (38%) and anticipated by either a thorough discussion or informal conversation between workers and managers, which allow for shared planning of specific RTW paths. As shown in Figure 4, although the majority of companies provide workers with a phased RTW (52%), this process is largely not written in any specific document or made adaptable to individual situations. RTW processes tend thus to take the form of one-size-fits-all solutions, indistinctly addressed at all workers (44%).

Figure 4. Availability of return to work procedures at the company (Q20)



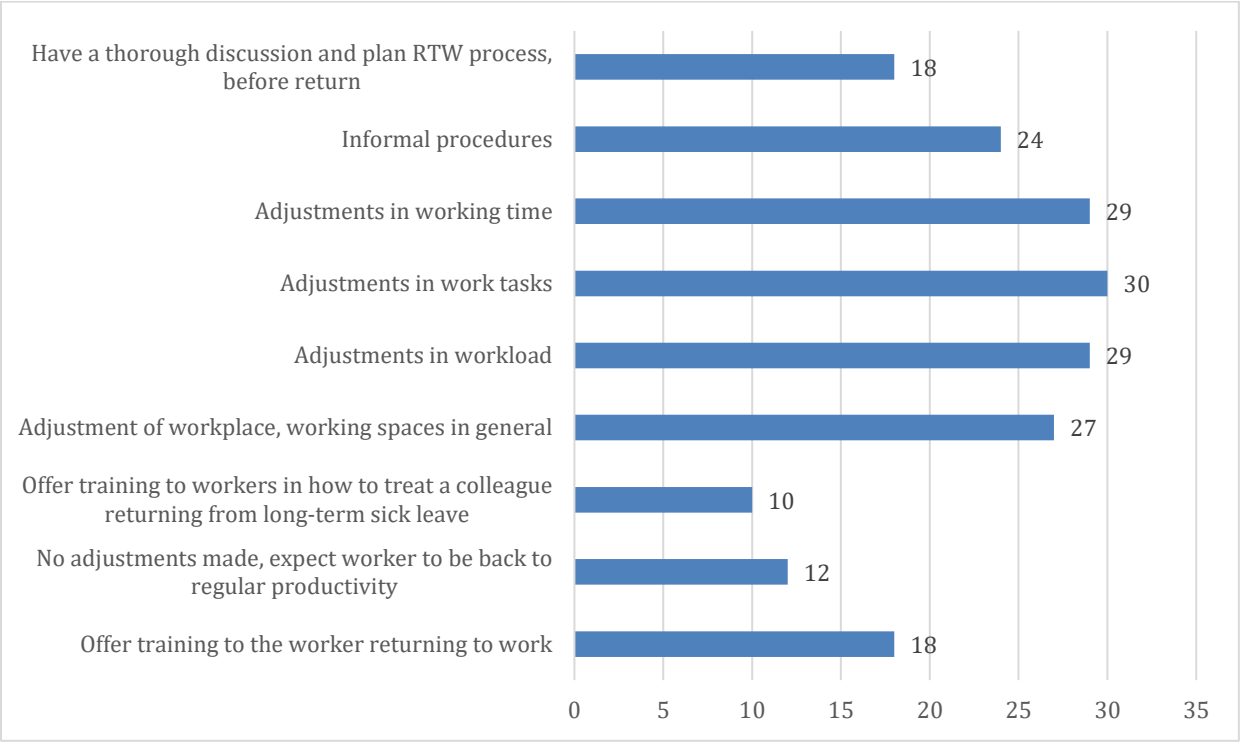
Source: REWIR managers' survey, own calculations; number of respondents: 32–34.

They are managed by HR leaders (68%) even though the role of line managers and team supervisors was conceived as equally important (56% with this perception, similar to that reported among workers); less responsibility was attributed to dedicated health and safety committees. As one HR leader explained during a discussion group, the prevailing approach to RTW processes seemed to be essentially reactive in facing a specific situation. By contrast, the collaboration between HR leaders and other business departments, such as an industrial division, should be encouraged for the adoption of a preventive and proactive attitude to the topic which, for instance, could imply the reconfiguration of work stations in such a way that they are suited to both disabled and non-disabled workers.

In the majority of cases (82%), companies cooperate with external organisations when handling RTW situations (Figure 4). Indeed, collaboration with external stakeholders as well as relationships between managers and employees affected by chronic diseases were considered pivotal in these processes and many respondents indicated that both aspects (29% and 41% respectively) should be further improved. These findings are in line with the considerations on multi-stakeholder cooperation (as explained earlier in this report) that emerged during interviews and discussion groups with managers, trade unionists and workers' representatives.

As regards the specific content of RTW processes, adjustments to working duties were perceived as relevant, and according to many respondents, these adjustments should be binding by law (74%) rather than simply subject to managers' discretion (53%). Indeed, many respondents (26%) thought that individuals returning to work after a chronic disease would not be able to perform the same duties as before, while 46% of these respondents did not have a clear opinion on this topic. Some HR leaders and managers were also convinced that workers with a chronic disease are less committed to work (29%) and the vast majority of them thought that workers affected by a chronic illness are likely to be absent from work more often than their colleagues (76%). This in turn may be perceived as increasing the workload of their colleagues, and according to 44% of respondents, "the worker returning to work with reduced duties increases the workload of colleagues". Subsequently, adjustments to working time, work tasks or workload are necessary and hence reported by the majority of respondents (about 80%) (Figure 5).

Figure 5. Support offered by the company to the employee returning to work (number who agree/strongly agree) (Q16)

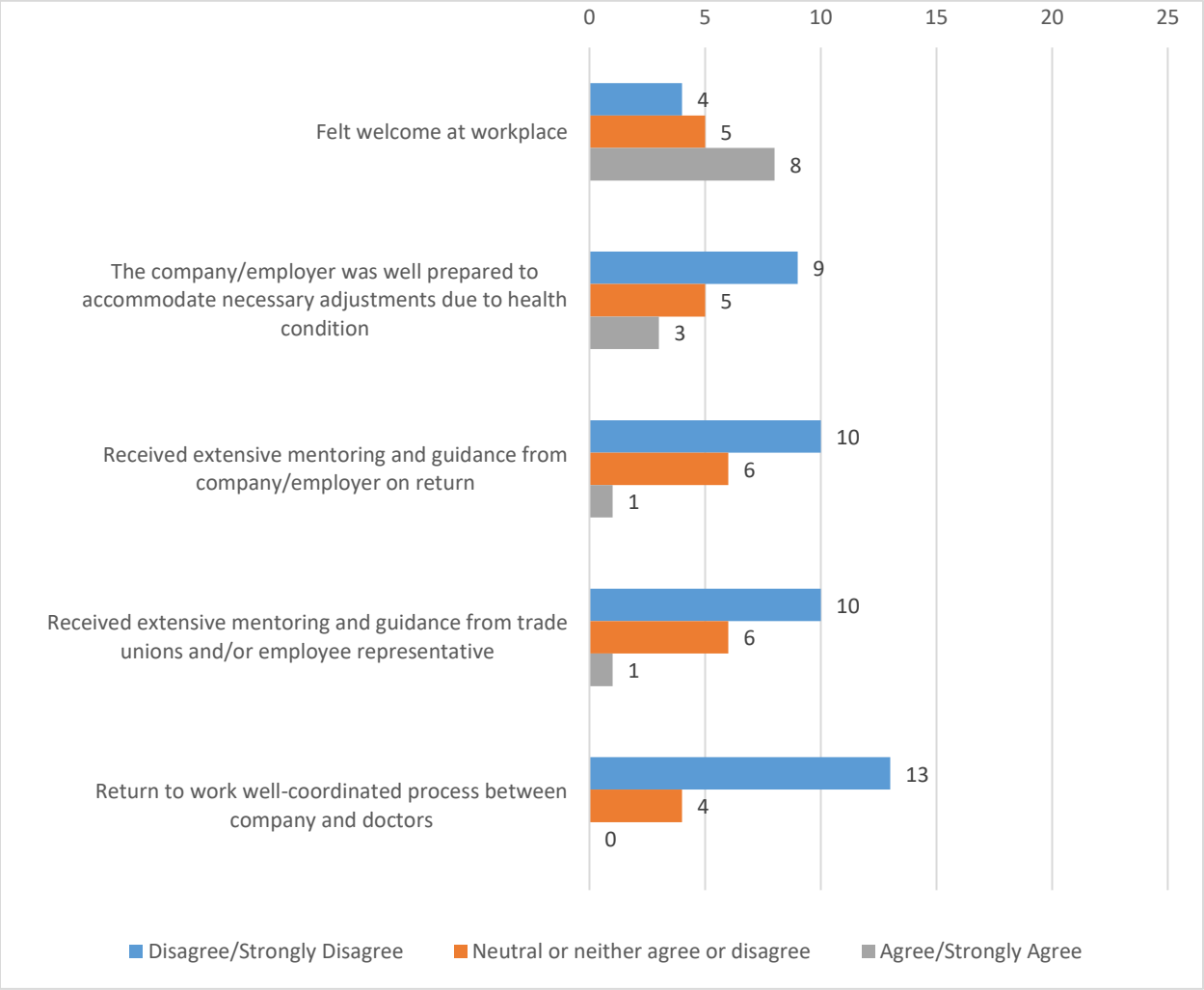


Source: REWIR managers' survey, own calculations; number of respondents: 37 (multiple response options).

In many cases, training for the employee returning to work after a chronic disease is offered as well (about 50%), while it is far less common to also find training initiatives targeted at other workers on how to deal with RTW processes (around 28%) (Figure 5).

These results are, however, sometimes at odds with the degree of satisfaction in these fields perceived by workers and reported in the previous sections. According to the survey of workers (Figure 6), their experience with return to work process was complicated and in the majority of cases companies were not prepared to put in place the necessary adjustments in line with the workers' health conditions and there was a lack of coordination of this process between companies and doctors. Moreover, respondents underlined the weak support received from companies and trade unions during the RTW process with specific reference to mentoring and guidance practices. It is not a surprise that fewer than half the respondents reported feeling welcomed when returning to the workplace.

Figure 6. Workers' experiences with the return to work process (Q44)



Source: REWIR workers' survey, own calculations; number of respondents: 17.

Experiences of RTW processes and practices at the company level are better described in the following section, which covers investments in new technologies, wage protection, and welfare measures for the prevention of specific diseases. The following section also describes better access to treatment. Interestingly, one HR leader participating in a discussion group suggested converting training from merely an adaptive measure for upskilling or reskilling a worker after a long period of absence into a more proactive process that gives value to the personal skills developed by the worker because of the disease. A similarity was detected between this approach and the emerging programmes for new mothers, such as MAAM (Maternity as a Master), aimed at using life experience to enrich work.

Still, we should not overlook the considerable share of managers expecting the worker to be back to usual productivity, with no need for adjustment (around 33%). Nor should we overlook the respondents who did not have a clear opinion on this point (31%). The confusion around this topic potentially hints at the inadequacy of current definitions and assessments of labour productivity when it comes to workers affected by chronic diseases. These methodologies and plans are indeed rather abstract and standardised with no consideration of individual health and mental conditions

at work and the various organisational or adjustment measures, which should not be neglected when assessing the work performance (and its sustainability) of people with chronic diseases in a given context (Tiraboschi, 2015).

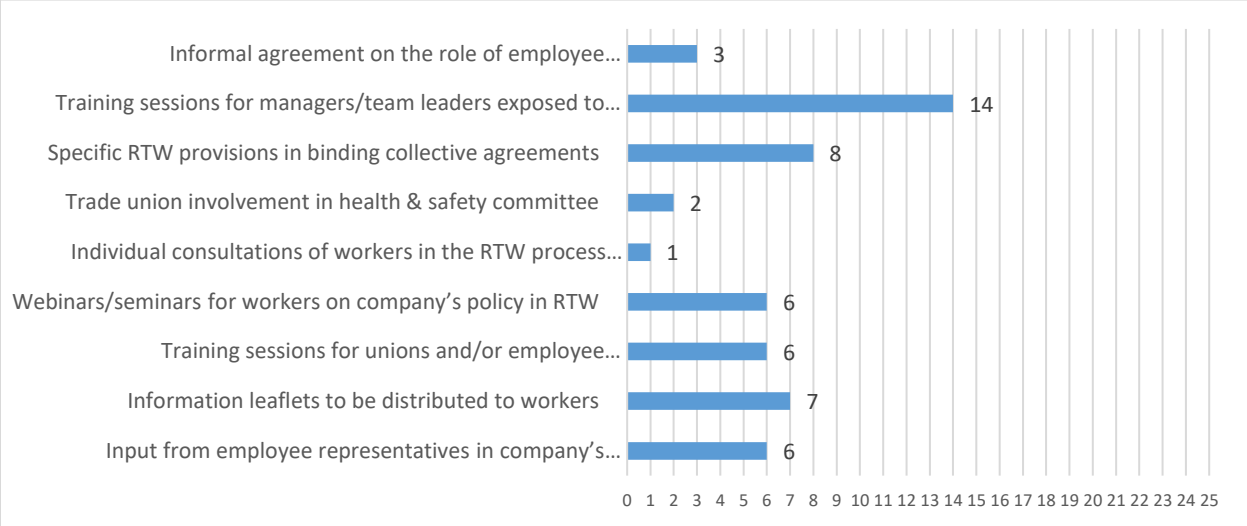
4.3 Experience with (and good practices in) facilitating return to work at the company level and the role of industrial relations

RTW policies for workers affected by chronic diseases do not constitute a prominent topic in company-level collective bargaining in Italy.[51] Indeed, although managers found it important to include a workers' representative as a part of a committee addressing occupational health and safety (62%) and cooperation with workers' representatives in this field was largely considered helpful for increasing workers' motivation (54%) and improving the quality of relationships between workers and managers (54%), regular interaction with workers' representatives was not always an attractive option for HR leaders and managers who responded to our questionnaire. Such interaction takes a long time and is less flexible than unilateral decision-making (33%); it also entails the risk of additional requests on the side of labour (37%). As a result, when these issues are tackled in collective agreements at the company or workplace level, this is mainly due to the management's sensitivity to the workers' problems (this sensitivity is increasing, according to one HR leader interviewed, with the progressive ageing of the workforce in companies) and its willingness to share its commitment in this field with workers' representatives. Another relevant prerequisite for negotiations over these topics, according to people taking part in our discussion groups, is constituted by worker representatives' awareness of these issues and their inclination to actively contribute to dealing with them.

However, as one HR leader observed, not all steps of a RTW process are formalised in a collective agreement: there are some reasonable adjustments that may imply significant investments by the company in new technical facilities and equipment, which are not included in collective agreements. Moreover, RTW processes can be managed by social partners even outside the regulatory framework of collective agreements. For example, the reassignment of a worker to different activities within a social cooperative has not been written in any agreement, even though it has been handled by both the employer and trade union representatives. As demonstrated from the questionnaire for managers and HR leaders (Figure 7), indeed, workers' representatives can be involved in either regular (23%) or ad hoc meetings (33%) concerning RTW practices, and the most beneficial results are not only binding collective agreements (29%) but also training sessions for both managers (52%) and workers' representatives (22%) on dealing with workers affected by chronic diseases, information leaflets distributed to workers (26%), and inputs on the labour side on how to improve a company's internal RTW policies (22%).

[51] The scope of the analysis is represented by the ADAPT database of company-level collective agreements. Today, the database gathers approximately 3,000 collective agreements. The findings from the database are in line with the results from the workers' survey, as 82% of respondents said that there are no negotiations between their employer and trade union/employee representatives about adjustments in work tasks and responsibilities after returning to work.

Figure 7. Perceived beneficial outcomes from interaction with unions/employee representatives on return to work (Q28)



Source: REWIR managers' survey, own calculations; number of respondents: 27 (multiple response options).

Though employers occasionally consult workers' representatives, employers still prefer to unilaterally activate and implement RTW activities, sometimes in collaboration with external experts and organisations.[52] Important examples in this sense are the actions performed by the banking group Unicredit, which raises awareness of initiatives on disability (online courses, days dedicated to disability management, focus groups, etc.). as well as training paths and professional mobility for deaf and blind people. The introduction of technological tools allows blind and deaf people to execute their tasks (Stefanovichj, 2017). Similarly, according to one HR leader, a company specialised in energy and automation succeeded in building a dedicated path, made up of sound devices and sensors, to allow a partially sighted worker to enter the workplace, in lieu of simply offering him the possibility of working from home. Indeed, remote working was not perceived as a satisfying option by the worker as it would have implied detachment from the social fabric of the company. In recent years, further RTW initiatives have been promoted by the energy groups Eni and AIMAC, with the participation of INPS, Sodalitas Foundation and the Provincial Council of the Association of Labour Consultants of Milan. The project, partly financed by the Ministry of Labour, is entitled "Una rete solidale per attuare le norme a tutela dei lavoratori malati di cancro sui luoghi di lavoro" (A solidarity network to implement the norms protecting cancer patients in workplaces) and it is aimed at identifying regulatory solutions in favour of Eni workers who may have had oncological diseases. The project also focuses on raising awareness among workers and managers of these problems so as to promote better policies of job integration. The project is part of the PROJOB initiative launched by AIMAC. Moreover, it is worth mentioning in this field the digital platform "Know and Believe", built in partnership with AIMAC and addressing enterprises and health funds for the organisation of awareness-raising campaigns, collaborative events, online training courses and other initiatives to boost the prevention of

[52] As seen before, RTW processes can be handled by employers with the support of professionals from employment agencies, whereas training courses to raise awareness of workers and managers of the topic can be organised by employers with the contribution of patients' associations. The appreciation of this kind of external support was also clear from the questionnaire submitted to HR leaders and managers.

oncological diseases, hence reducing their social costs. Among the main clients of this platform, we detect large groups in the banking and telecommunication sectors and consultancy firms.[53]

In addition to these actions carried out by companies mainly outside the industrial relations' field, it should be stressed that company-level collective bargaining can offer a normative framework for HR leaders and workers' representatives when coping with RTW processes, as it makes available organisational solutions and tools that can be used in specific cases. As discussed below, collective provisions in companies mainly concern job and wage protection during long sick leave and periods of absence, work–life balance when periodic treatments and medical examinations are needed, improved access to healthcare to both prevent and cure possible diseases, and, though in fewer cases, the establishment of dedicated bilateral committees and professional figures charged with the launch and coordination of comprehensive projects for the (re-)integration of people with disabilities.

In more detail, among the different company-level collective agreements that address this issue, the main clauses regard increases to the length of the protected period or the job retention guarantee until the complete recovery of a worker affected by an oncological disease. Further norms established by collective bargaining concern work–life balance and notably, the provision of non-paid sick leave and additional paid time off to undergo medical examinations and treatments (sometimes reserved explicitly for workers with serious and chronic diseases), and the possibility for certain categories of workers (including workers with disabilities and/or a chronic disease) to benefit from the time off entitled to individual workers (according to NCLAs) but not used by them and voluntarily transferred to the so-called solidarity working time account (legally introduced by Legislative Decree No. 151/2015[54]). Other organisational solutions collectively agreed for workers with chronic diseases may include the exemption from working on Sundays, Saturdays or on certain shifts, the priority of access to remote work and the possibility to be transferred to other company sites closer to home or to be assigned different tasks in case of unfitness for previous activities (also in compliance with Legislative Decree No. 81/2008).

Specific attention is paid, in company-level collective agreements, to wage protection during periods of absence, particularly in the form of an integration of up to 100% of the normal wage (by adding an employer's financial contribution to the sickness compensation paid by INPS from the fourth day of absence) and the guarantee of full performance-related pay albeit with the various days of absence from work (which, in cases other than serious diseases, would determine a proportional reduction in the bonus). With regard to variable pay plans, it is interesting to note that some agreements offer workers the opportunity to convert part of the performance-related bonus into paid additional time off; this solution could be particularly relevant for RTW processes.

Other provisions, though less frequent in company-level collective agreements, involve dedicated training courses for workers after long periods of absence and prevention campaigns for the promotion of healthy lifestyles (e.g. the introduction of healthier and greener menus in canteens),

[53] For further information, see the website: http://www.knowandbe.live/.

[54] Legislative Decree No. 151/2015 formally acknowledged the possibility for workers to transfer unused time off, on solidarity grounds, exclusively to workers who need to assist their sick children. However, collective bargaining has expanded the scope of application of this tool. Plus, it should be noted that solutions of this kind were introduced by collective agreements even before the adoption of Legislative Decree No. 151/2015, as was the case for many transport companies. For further information, see Stefanovichj (2017).

also in collaboration with external experts and organisations.[55] Overall, as regards welfare measures, the Italian Budget Law from 2016, while confirming fiscal and contributory incentives for social provisions and services offered by companies to their employees, formally acknowledged a role for collective bargaining in this field. With specific reference to measures potentially targeted at workers affected by chronic diseases, the direct provision or reimbursement of medical examinations, analyses and check-ups as well as the contributions directed to health funds and insurance policies against the risk of non-self-sufficiency or serious pathologies, offered and paid by employers to their employees either unilaterally or in compliance with collective agreements, are not subject to the payment of labour income-related taxes. That is why welfare plans that include these kinds of services have increasingly been made available by companies, often with the support of dedicated welfare platforms (ADAPT and UBI Banca, 2019). As seen at the national level, also company-level collective bargaining can establish integrative health funds. Yet, given the large diffusion of sectoral funds and the employer's obligation, stated in different NCLAs, to pay related contributions and register employees in them, a decrease in the number of company-level funds has been reported (ADAPT and UBI Banca, 2019, pp. 65-122). An important exception concerns the energy company Eni, which not only financially supports the sectoral health fund, named FASIE, but also provides its employees with an additional fund, called FASEN, which offers integrative social and health measures such as medical screenings and examinations for the prevention of serious diseases. By and large, these welfare measures are primarily devoted to increasing access to healthcare for workers from the perspective of both prevention of serious diseases and their proper treatment, rather than to directly facilitating RTW policies.

Finally, it is worth mentioning the experiences of those companies (largely concentrated in the chemical, pharmaceutical and banking sectors) that have established, via collective bargaining, the professional figure of the disability manager and joint labour–management observatories or committees on disabilities, entrusted with the task of launching awareness-raising campaigns on the issue targeted at all workers and designing welfare, training and organisational solutions for an effective (re-)integration of people with disabilities. Following the setting-up of these roles and bodies, that, as mentioned above, were promoted in the 2013 and 2017 "Biannual action programme for the promotion of rights and the inclusion of people with disability", these companies have sometimes reached collective agreements regarding the launch, in partnership with patients' associations, of specific projects for the inclusion of people affected by chronic diseases at work.[56] As noted earlier, an example in this regard is represented by the territorial partnership agreement signed in 2018 by AISM, the employers' association Unindustria of Rome, the ASPHI Foundation, the pharmaceutical company Merck Serono and the local trade union organisations FILCTEM-CGIL, FEMCA-CISL and UILTEC-UIL of Rome. Another example is included in the 2018 agreement signed by the banking group Intesa San Paolo, which envisages both a project for the inclusion of workers affected by autism in collaboration with a specialised association and an alternate training path for students with intellectual disabilities. Interestingly, the agreement provides for the possibility for the latter initiative to be financed by the fund for

[55] For instance, the company-level collective agreement signed at Lamborghini on 16 July 2019 envisages an information campaign targeted at workers for the promotion of proper nutrition and lifestyles in collaboration with the AIRC Foundation, specialised in research on cancer.

[56] The reference to these partnership agreements at the territorial level was moreover included in Article 1 of Legislative Decree No. 151/2015.

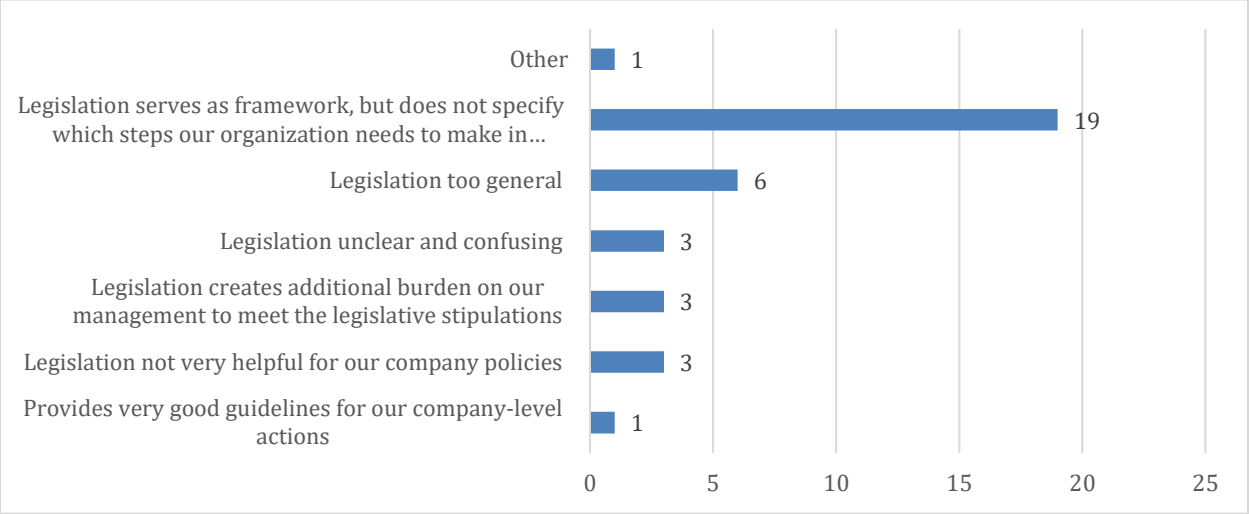
employment (Fondo per l'Occupazione, FOC), established by national-level social partners in the banking sector in 2012 and aimed at subsidising projects for outplacement and worker reskilling as well as initiatives for the inclusion of young people at work. Moreover, a small part of the workers' monthly wage (amounting to €1) can be voluntarily devoted to a solidarity company account (partly financed also by the employer) that is used to fund these initiatives for the inclusion of people with disabilities at work.

4.4 Views on the future potential for social dialogue to support the creation and implementation of return to work policies at the company level

Despite the fact that, according to managers participating in our discussion group, company-level solutions are theoretically more suited to face very individual- and context-specific RTW processes, the role of social dialogue and industrial relations in RTW processes at the company level in Italy is generally limited. This condition apparently derives from both scant interest by management in involving workers' representatives in these issues and limited attention paid by trade unions to this field of action. Subsequently, employers and managers tend to act unilaterally in this area or, at best, in collaboration with external organisations and consultants. But within the context of a very fragmented legislative framework and widespread preconceptions around the impact of chronic diseases on work, company-led RTW processes do not seem to be extensively developed (mainly limited to large and well-structured companies and concentrated in certain economic sectors) and when actually implemented, they frequently end up not satisfactorily producing adjustments and results for workers.

Many managers do acknowledge their difficulties in this field and partly blame the institutional framework. Indeed, many of the respondents to our questionnaire asked for clearer rules (39%) and greater legislative and institutional support for these processes, also considering that legislation serves as a framework, but "does not directly specify which steps our organisation needs to make in facilitating RTW" (65%). Notably, legislation is perceived as currently being too general (21%), unclear, confusing (10%) and not very helpful to management (10%), which sometimes considers it a burden (10%) and tries to circumvent or violate some provisions as emerged from the discussion group we held in Italy (Figure 8). According to the surveyed managers, there should be a clear and specific legal framework for actions in this field, perhaps accompanied by better institutional guidance and more chances for cooperation with external stakeholders (including patients' associations and physicians) so as to favour successful RTW processes at the company level.

Figure 8. Perceived support offered by legislation to organisations in managing return to work after chronic illness (Q29)



Source: REWIR managers' survey, own calculations; number of respondents: 29 (multiple response options).

The impression indeed is that legislative provisions and incentives on RTW are not lacking in Italy, but they are not set out in a unitary framework that is easily understandable and applicable by employers. The latter instead are not adequately informed of the existing rules (which not only represent limitations but also, sometimes, even opportunities) in this field and RTW issues are largely neglected at the company level mainly due to the lack of sufficient knowledge and preparation of managers. It is not by chance that the most successful experiences have been generated by management in partnership with external professionals and organisations (including research institutes, employment agencies and patients' associations). This finding confirms, as discussed earlier, the importance of employers receiving guidance and support while addressing these very delicate issues, and proves that RTW after a chronic disease is a multidimensional topic, which should be tackled from a variety of perspectives (i.e. the welfare and healthcare system, labour market and labour relations) and through the synergetic contribution of as many stakeholders as possible.

In line with these considerations, it is important to highlight that the space left by workers' representatives, who are not particularly engaged in RTW processes, may increasingly be filled by other stakeholders in this field, which nonetheless do not traditionally operate in work environments and probably lack the necessary skills and sensitivities to successfully act in these contexts. Indeed, workers who responded to our questionnaire and reported in our survey that they had not been effectively supported by trade unions during their diseases, often found guidance and advice among medical specialists, general practitioners and family members, with whom they maintained stable relationships during their periods of absence and interacted even at the beginning of the RTW process.

These findings paint quite a sad picture for workers' representatives in Italy: not always capable of assisting the worker with a chronic disease during an absence from work and the subsequent reintegration process, and therefore progressively losing their supporting role for workers to the advantage of other social players. This is even more alarming as RTW after a chronic disease is bound to be more and more central in future work settings in Italy and coordinated multi-

stakeholder actions in this field have already proved to be particularly effective. Fortunately, as emerged from the online survey, many workers have not given up on expecting a more concrete role for trade unions in this field. In detail, trade unions were largely expected to address health-related issues at work (75%) and focus on RTW policies in collective bargaining (75%) (Figure 9). Interestingly, though, for only 30% of respondents did collective bargaining represent the most preferred form of support they expected to receive from their representatives. Though not clearly expressed in the survey, it is reasonable to claim that workers would appreciate their representatives simply participating in regular or ad hoc meetings with managers, providing their inputs on these delicate issues, and offering them individual guidance during their periods of absence and subsequent reintegration phases.

Figure 9. Workers' opinion of the role of unions and their dialogue with employers for facilitating return to work (Q49)

Source: REWIR workers' survey, own calculations; number of respondents: 25.

5. Conclusions

From desk research and the collection of data and information as described in the previous sections, it emerges that the Italian legislation on chronic diseases and labour rights generally does not

support the role of industrial relations in this area and social partners argue that the policymaking processes still poorly provide for their involvement. The legal framework on RTW after a chronic disease in Italy is also greatly fragmented, which results in all the key players at the local level (line managers, the HR division, company consultants and trade unionists) needing to have a thorough knowledge of the legislation and the ability to properly deal with its application. However, both employers and social partners (i.e. trade unions and employers' representatives) often lack this legal expertise. Furthermore, they are usually not very interested in these topics and prefer to focus their action on more traditional issues.

It is thus no wonder that the role of collective bargaining in this area is rather limited and traditional, being mainly based on generalised responses to diseases. National collective labour agreements signed by the three main trade union organisations (CGIL, CISL and UIL), indeed, tend to provide workers with chronic diseases employment and wage security, a fair work–life balance and – thanks to supplementary health funds – better or additional healthcare services. Although measures agreed in this field mainly relate to these social areas, some differences can be detected across different sectoral-level NCLAs as regards the scope and generosity of these solutions and their main targets (workers who are either disabled, affected by serious and chronic pathologies or by oncological and degenerative diseases, or in need of life-saving therapies, etc.). More particularly, AISM, an association representing people affected by multiple sclerosis, has reported the lack of clear and homogeneous definitions across different NCLAs of the worker categories intended to be the beneficiaries of RTW measures and other forms of protection (Osservatorio AISM, 2017). This has proved to lead to great confusion in their application and, consequently, to the risk of discrimination across companies and economic sectors. Moreover, within an industrial relations system characterised by a low degree of legal institutionalisation and union pluralism (Leonardi, 2017; Leonardi et al., 2017), workers can be subject to so-called pirate labour contracts (concluded by colluding trade union associations) or to NCLAs other than those involving CGIL, CISL and UIL, which generally do not provide workers with chronic diseases the same protection standards as those listed above (ADAPT, 2020, pp. 263-307).

With reference to decentralised collective bargaining, it is worth pointing out that in Italy, territorial and company-level collective bargaining on RTW after a chronic disease is largely underdeveloped and depends on the willingness and availability of individual trade unions, employer representatives and managers. As a consequence, when taking place, company-level collective bargaining is essentially limited to large and well-structured companies (generally equipped with the necessary financial and technical resources to address these issues), which are moreover concentrated only in specific sectors (such as the chemical, pharmaceutical, energy and banking sectors).

As observed at the sectoral level, collectively agreed solutions at the company level are usually aimed at providing workers with protection within their existing employment relationship and do not support, nor do they cover, any possible employment transitions. By contrast, active labour market policies and job (re-)integration programmes are found to be more frequently designed and implemented at the territorial level, where social partners often engage with other relevant stakeholders in joint initiatives or projects, which are not always formalised in collective agreements and can be discovered through online desk research or direct interviews with the participants. Similarly, at the company level, employer and workers' representatives are sometimes found to cooperate with each other in RTW processes even outside the framework of formal collective agreements. As a result, RTW processes for workers suffering from chronic

diseases in Italy still seem to be largely managed on an informal basis, especially at the decentralised level. Within companies, these processes are moreover mostly addressed unilaterally by company managers – at best, with the support of a few external experts – while the involvement of workers' representatives is quite rare. This situation is likely to marginalise worker voices in RTW processes, thus reasonably explaining the already polarised workers' views on the support received from employers. The situation also explains the workers' largely negative perceptions of workplace accommodations after a long-term absence and the role of representatives in these dynamics, as emerged from the online survey.

Partly contributing to the prevailing informality in the management of these issues as well as the lack of a homogeneous, widespread commitment by social partners to RTW, is the absence of any form of coordination starting from the central/national industrial relations level. Relevant exceptions can be found in the NCLAs for the chemical-pharmaceutical and banking sectors, where trade unions and employers' associations have tried to enhance the role of a national bilateral observatory in promoting and coordinating active labour market projects at the local level, as well as in encouraging companies to adopt disability management plans. It is thus not by chance that, as seen before, the most relevant collectively-agreed RTW solutions have been implemented by companies operating in these sectors. However, both these agreements seem to lack a clear provision on a monitoring system aimed at checking the actual implementation of suggested measures.

In the light of these findings, it is desirable that social partners at the central/national level take action to foster the role and improve the ability of local players on this topic. As demonstrated in previous sections, successful results can be achieved – especially when social partners engage in collaborations with research institutes, patients' associations, public institutions and other relevant stakeholders in this field. The main efforts should thus be oriented towards deepening social partners' knowledge of the existing legal framework, strengthening multi-stakeholder cooperation and coordination across different levels, and promoting a preventive and proactive approach to RTW issues. This should be done (perhaps by taking advantage of the resources allocated by the Italian government for these purposes),[57] even prior and not only in response to the emergence of a critical situation, by redesigning work environments to make them more inclusive and sustainable for all and by rethinking the notions of productivity, work performance, fulfilment of the task and suitability for work, inter alia, for their greater adaptation to the needs of workers affected by chronic disease. This is even more urgent considering that workers facing RTW are largely worried about not being able to sustain their usual productivity and performance levels, and that a considerable portion of surveyed managers expect workers to be back at their previous productivity pace with no adjustments.

Interestingly, by tackling these central issues and preparing the ground for smoother job (re-)integration processes for people with chronic diseases, social partners could find out they are taking an important step towards not only prolonged professional careers in the face of negative pressures that the ageing of the workforce is already posing for public health and welfare systems (Iodice, 2020), but also greater sustainability of work and a more human-centred approach to economic growth and development. These results could be beneficial to our economy in general

[57] For instance, according to the Budget Law 2019, employers' associations, trade unions, bilateral bodies and non-profit organisations can present INAIL projects for informing and training employers and workers as regards the topic of reintegration at work of people affected by a work-related disability and apply for INAIL funds.

and to all workers, given the many personal changes and events (disease, maternity, caregiving, etc.) potentially impacting their careers and performance levels, which they can experience throughout their life. It is also in the light of these considerations that we can agree with and further advance AISM's suggestion for sectoral-level social partners to overcome the disparities in protection standards caused by the various beneficiaries identified in different NCLAs and extend rights and prerogatives to more comprehensive and less departmentalised worker categories (Osservatorio AISM, 2017). The potential wide and generalised effect of this approach must not, however, overlook the specific characteristics of each condition and the particular needs of each person with a chronic disease, for whom even encompassing and well-structured RTW plans need to have their specific measures carefully tailored. Finally, as collective agreements mainly provide protections for workers within their existing employment relationship (in terms of, e.g. job and wage security, work–care–life balance), greater attention should be paid by social partners to periods of transition (such as periods of absence from work due to treatment and periods of transition to a different job), within which workers may feel lost and in need of external support (which today they largely find in relatives, physicians, colleagues and professionals from patients' associations). Again, it is at this level that, given the widespread condition of vulnerability in post-industrial societies[58] and from the perspective of transitional labour markets,[59] the maturity, innovativeness and readiness of industrial relations players and institutions will be measured.

[58] According to Ranci (2002), the socioeconomic transformations of post-industrial societies (e.g. precarious and more discontinuous working careers, fragile social and family networks, unresponsive social institutions) have engendered a condition of frequent and prolonged vulnerability, which derives from the unstable inclusion of individuals in the main channels of social integration and resource distribution (i.e. work, family, welfare systems), thus jeopardising their autonomy and capacity for self-determination. This condition would call for a rethinking of current models of social protection, which should not merely be based on the recognition of rights but also on the strengthening of individuals' capabilities.

[59] By transitional labour markets we mean a new conception of the labour market as an open social system and of labour itself as a category that contains different possible statuses and conditions of workers. This is linked to the wide ongoing transformations of work and to the growing fragmentation and discontinuity of working careers, so the issue is how to provide workers with the tools that enable them to deal with these occupational transitions. In this context, the traditional job position, meant as a stable employment over time, loses its centrality while elements such as professionalism and employability increase in importance (Casano, 2018).

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