Chapter 5
Over-expectation and underprovision: overcoming the voluntarist and irregular approach of Italian social partners to the return to work

Ilaria Armaroli, Maria Sole Ferrieri Caputi and Lorenzo Maria Pelusi[1]

1. Introduction

In line with the majority of European countries, Italy is experiencing a slow, though quite steady, increase in the percentage of people affected by chronic illness.[2] In 2019, 40.9 per cent of Italian residents (compared to 38.6 per cent in 2010) said they had been suffering from at least one chronic disease. Chronic-degenerative pathologies are more frequent in older age groups: 54.1 per cent of Italian people aged 55-59 already experience chronic illness and, among the over-75s, the share reaches 85.4 per cent.[3] Projections indicate that, by 2030, the number of patients with a chronic disease will rise above 26.5 million while those with more than one will number 14.6 million (Università Cattolica Sacro Cuore, Istituto Sanità Pubblica 2020).

As regards the interplay between chronic illness and work, the share of the Italian working population affected by at least one chronic disease increased from 30.1 per cent in 2009 to 34 per cent in 2019. That same year, 78.3 per cent of Italians experiencing at least one chronic disease left the labour market, a total significantly higher than for people in good health (38.7 per cent). These data seem to confirm for Italy a trend which has been registered in many countries, i.e. an increase in the proportion of people requesting sick leave, taking early retirement and living on long-term disability allowances (EuroHealthNet 2017; Tiraboschi 2015).

In this scenario, the long-term effects of the Covid-19 pandemic must also be carefully monitored. In a survey conducted by *Fondazione Policlinico Universitario Agostino Gemelli IRCCS* on 143 patients in Rome who had recovered from Covid-19, 87.4 per cent of those interviewed (on average 60.3 days after the onset of the first symptoms) had at least one persisting symptom, particularly fatigue (53.1 per cent) and shortness of breath (43.4 per cent) (Carfi *et al.* 2020). It is reasonable therefore to expect that the delayed return to usual health for Covid-19 patients may lead to a protracted absence from everyday life, including work.

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2. Eurostat, People having a long-standing illness or health problem, by sex, age and labour status [hlth_silc_04], http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_silc_04&lang=en [Accessed on 30.12.2020].

3. Istat, Aspetti della vita quotidiana: Stato di salute – età dettaglio, http://dati.istat.it/Index.aspx?QueryId=15448# [Accessed on 30.12.2020].

These trends need to be adequately addressed since the participation of people affected by chronic illness in the labour market is considered important for a number of reasons. In the first place this is expected to reduce the impact on patients and help them successfully manage their condition in everyday life, thus fostering functional capacity, psychological well-being and even recovery (EuroHealthNet 2017). It is therefore no wonder that, according to different surveys on cancer (La Stampa 2011; Istituto Piepoli 2008), most Italian patients themselves consider work as a fundamental means of facing up to illness. The return to work of people with chronic illness is also essential in tackling the decline in labour supply (given the decrease in birth rates) and shortages of skilled labour, as well as combating the pressures on public health and pension systems induced by the dramatic ageing of the workforce (Tiraboschi 2015; OECD 2009). Moreover, workplace accommodation of the needs of workers with chronic illness can have a positive impact on the quality of work produced and its sustainability through lower levels of work intensity and stress, as well as better work-life balance (Vargas Llave *et al.* 2019).

The social partners are, as key players in labour markets, required to play a highly important role in activating flexible solutions and favouring return to work processes (Tiraboschi 2015). However, their contribution in this field, also with specific reference to the Italian case, is largely neglected in the literature.

Italy, which belongs to the 'southern' cluster of industrial relations in Europe (Caprile *et al.* 2017), boasts quite positive and steady values in collective bargaining coverage (80 per cent in 2016)[4] and in trade union density (34.4 per cent in 2018).[5] Even so, Italy is also characterised by an irregular involvement of the social partners in public policy formation, a scant development of employee representation in the workplace (Caprile *et al.* 2017), a generalised abstention of the law 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 pressure and opposition; this tends to compromise the development of cooperative industrial relations and has paved the way for the growth of independent autonomous unions (Colombo and Regalia 2016) and the multiplication of national collective labour agreements (NCLAs) (CNEL 2019). These are the features which make up the institutional framework for industrial relations in Italy and which potentially have an impact on their role in return to work processes.

This chapter relies on information and data gathered via various tools, including documentary research, surveys with workers, managers and social partners, semi-structured interviews with national stakeholders and group discussions with employers and workers' representatives at company level as well as a roundtable with stakeholders.

4. OECD.Stat, Collective bargaining coverage, https://stats.oecd.org/Index.aspx?DataSetCode=CBC [Accessed on 03.06.2020].
5. OECD.Stat, Trade union density, https://stats.oecd.org/Index.aspx?DataSetCode=TUD [Accessed on 3.06. 2020].

2. Legal policy framework on the return to work

The Italian legislation supporting people with chronic illness in returning to work is neither homogeneous nor specifically targeted. This is mainly due to the Italian system lacking a clear definition of chronic disease in legal terms and there is a trend, both in literature and case law, to equate illness with 'disability' (Fernandez Martinez 2017). Even though workers with chronic illness are generally not given specific rights, there are some provisions on the return to work and some protections which derive from being recognised as disabled. However, even this has taken different forms in the Italian legal system according to the objectives pursued from time to time by the legislator. As a result, there is an overlap in this field between various notions which have different meanings (e.g. 'handicapped[6] people', 'unfitness', 'disability', etc.) and their related pieces of legislation. Furthermore, the traditional influence of biomedical evaluations (focused on a person's condition and need for healthcare) has given rise to a number of legal provisions almost exclusively devoted to ensuring assistance and protection (e.g. through paid leave and benefits) to 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 has entered the legal system, paving the way for jurisprudential guidelines supporting the principles of social justice and non-discrimination at work (with an important role to be played by the employer in terms of the (re-)integration of disabled people) regardless of the specific causes of the disability.

2.1 Sickness and invalidity benefit system

Paid sickness leave for workers is met by the employer during the first three days of absence and thereafter by *Istituto Nazionale Previdenza Sociale* (National Institute for Social Security; INPS) up to the 180th day. It is proportional to the normal wage but progressively decreases. This compensation is provided to workers experiencing illness and who cannot perform their job tasks.[7]

Important rules concern the calculation of the length of the so-called protected period, made up of the overall number of days of absence from work during which employees cannot be dismissed. These rules are either established by law (for white collar workers) or set in NCLAs at sectoral level (for blue collar workers). Many NCLAs extend the duration of the protected period in the case of certain illnesses.

When chronic illness leads to disability or an inability to work, as ascertained by public healthcare and the social security authorities, people are provided with an incapacity benefit (where there is an absolute and permanent impossibility of performing any work activity) or a civil invalidity benefit. In addition to the latter, a further mobility allowance is provided to those who cannot move about independently.

6. We are using the word as it appears in the Italian law.
7. INPS does not pay sickness compensation for certain categories of worker, including white collar workers in industrial sectors and managers in the industrial and craft sectors; in these cases it is the employer that pays the compensation.

In addition, occupational insurance for work-related accidents and occupational diseases, potentially applying also to workers with chronic illness, is financed through contributions paid mandatorily by employers to *Istituto Nazionale per l'Assicurazione contro gli Infortuni sul Lavoro* (National Institute for Insurance against Accidents at Work; INAIL) in respect of all employees and *lavoratori parasubordinati* (project-based contract workers). INAIL's assistance measures include: 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 functional impairments; and an allowance for people with mesothelioma contracted after exposure to asbestos, regardless of whether this was at work or elsewhere.

INAIL has also been entrusted by Law No. 190/2014 with the task of supporting the return process for workers with occupational illnesses. In 2016 INAIL therefore adopted a regulation on the return to work of people with work-related disabilities through which it launches public calls to finance work integration projects for disabled or unfit workers following an accident at work or an occupational illness. In addition to notifying INAIL of their availability to participate in these processes, employers can directly present projects of their own and apply for funding. However, trade unionists have pointed to procedural issues which inhibit access to these funds and a lack of knowledge in companies about the availability of finance for return to work projects, leading to the resources being little used.

INAIL also finances and conducts research on health and safety at work in collaboration with the social partners and, according to Budget Law 2019, it may fund projects presented by the social partners for informing and training workers and employers as regards the return to work of people affected by work-related disability.

2.2 Provisions for rehabilitation and return to work support

In addition to INAIL's role in respect of work-related illnesses, the return to work is favoured by a number of legislative provisions. The most important of these, specifically targeted at people with 'severe chronic and degenerative pathologies', is the right to switch the employment relationship from full-time to part-time (Legislative Decree No. 81/2015).

Other relevant opportunities derive from the potential for collective bargaining to complement and adapt certain legislative provisions in response to specific situations. For instance, 'smart working', regulated by Legislative Decree No. 81/2017, allows people to perform their job from home or other locations after signing an individual agreement.[8] Moreover, Legislative Decree No. 151/2015 introduces the possibility for

8. During the Covid-19 pandemic, the Italian government introduced a new right to work from home for disabled or immunosuppressed workers, as well as for those with a disabled or immunosuppressed person in their family. This right is meant to be temporary, up to the end of the health emergency, and is also dependent on whether this way of working is compatible with the characteristics of the activity being carried out. In addition, workers suffering from serious and proven diseases and who have reduced working capacity must be offered the possibility of working from home as a priority comparative to other workers.

workers to give some of their accrued but unused time-off to colleagues who need to take care of disabled or ill children. The above statutory provisions are frequently complemented by collective bargaining which sometimes expands their scope to people with chronic illness.

Those workers who are disabled (under the definition of Council Directive 2000/78/EC) also have the right 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).

Further opportunities may apply to people with chronic illness as far as their condition fits the legal notions of 'disability' (here interpreted in a narrow sense and essentially based on biomedical evaluation), 'unfitness' and 'handicap', that have to be ascertained by the healthcare and social care authorities. These include the right for workers with disabilities amounting to more than 50 per cent of capacity to 30 days leave per year for treatment (Legislative Decree No. 119/2011); the obligation on the employer to assign a worker who has been assessed as unfit to perform a specific task by the occupational physician to an equivalent, or lower-level, task without loss of remuneration (Legislative Decree No. 81/2008); the right for a worker with health problems to refuse night shifts (Legislative Decree No. 66/2003); the right for 'handicapped' workers to paid leave of two hours per day or three days per month and, supplementarily, the right to choose (or be transferred to) a workplace closer to their home (Law No. 104/1992).

Financial incentives apply to employers in the public and private sectors who hire disabled people on open-ended contracts (Law No. 68/1999), while the same law also establishes a legal obligation for employers to hire and retain disabled workers in a number proportionate to the dimensions of their enterprise (from one in companies with 15-35 workers to 7 per cent of the workforce in companies with more than 50 workers). The employer can comply with these provisions by hiring temporary agency workers as long as their contract duration is at least 12 months (Legislative Decree No. 151/2015) or, on the basis of the rules established in specific regional agreements signed by public job centres, trade unions and employer associations (Article 14 of Legislative Decree No. 276/2003), by contracting out certain activities to social cooperatives pursuing the integration of disadvantaged people.

One policy slowly spreading in larger companies is the creation within HR departments of a 'disability manager' specifically devoted to inclusion and the management of disabilities at work. The role of a person 'responsible for the inclusion at work' of disabled people is envisaged by Legislative Decree No. 151/2015[9] and the related costs may be partially reimbursed through funds established in each Italian region for the

9. 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 designated within 180 days of the adoption of Legislative Decree No. 151/2015, but these remain missing. In public administrations with more than 200 employees, the introduction of a professional figure for the inclusion at work of disabled people has been made compulsory (Legislative Decree No. 165/2001, as modified by Legislative Decree No. 75/2017).

employment of disabled people.[10] In addition, these funds may partially reimburse the expenses incurred by companies making reasonable workplace adjustments for workers whose level of incapacity exceeds 50 per cent.

Competences in terms of labour policy are also attributed to Italy's regions and autonomous provinces in the light of which, on top of these national provisions, there are some regional or more local activities which are relevant to the return to work. Examples include the SIL 22 job integration service in Verona, aimed at promoting the employment of disabled people by offering information, vocational training, career planning, job matching and placement, and other services; and the EMERGO plan, a programme promoted by the municipal authorities in Milan for disabled people aimed at facilitating their labour market participation through services supporting training or other return to work activities.

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

3.1 Industrial relations actors and return to work policy

Return to work policies for people with chronic illness may involve a great number of actors including public authorities, employer associations, trade unions, campaigning and patient support organisations, public job centres and private employment agencies, research organisations and companies.

By and large, the industrial relations actors are perceived as very important in the return to work by most of the stakeholders involved, especially considering the fragmented legislative framework and workers' needs for assistance and representation during their return process. Here, trade union representatives act as more or less a link between the worker with chronic illness and the other relevant stakeholders in accompanying the worker throughout the process. Moreover, both trade unions and employer associations provide support to workers and companies in the return to work and also collaborate with each other (mainly through collective bargaining at national, regional or company level) to establish solutions that facilitate return to work processes.

The social partners are becoming increasingly aware of the importance of returning to work for people experiencing chronic illness. However, there is a long way to go, since 75 per cent of trade union and employer representatives responding to our survey declare they have no knowledge of any national policy in this field. Neither are return to work issues perceived as a priority by many: while they acknowledge that they have only limited involvement in policy-making and implementation, representatives

10. The obligation for Italian regions to establish a fund for the employment of disabled people was firstly introduced via Law No. 68/1999 and then slightly modified by Legislative Decree No. 151/2015. Each fund is financed out of the fines paid by companies not complying with the rules on the mandatory hiring of disabled people, contributions from companies not subject to the rules, private donations, etc.

exhibit a rather ambivalent attitude concerning their possible greater engagement, some wanting to focus mainly on other issues of interest representation although 50 per cent do strive for a more active stance. Overall, the impression is that employer associations are largely indifferent towards these issues whereas, in some cases, trade union officials display a rather greater interest.

At workplace level, employers tend to regard workers with chronic illness as no longer efficient or productive which could lead some to violate or circumvent certain of their obligations. In turn, this could contribute to endorsing the perception, which is widespread among HR and line managers, that the legislative framework in this field is more of a limitation than an opportunity. Furthermore, some important legislative provisions, including those referring to reasonable adaptation, seem to be unknown by many employers and HR managers. The inclination of small companies to implement organisational solutions for return to work processes is further jeopardised by a lack of economic resource compared to larger companies. Furthermore, in some SMEs, workers' relocation to other tasks is more difficult given the scarcity of available alternative activities. At the same time, local trade unionists and workers' representatives are regarded by some HR managers as lacking specific knowledge on different chronic pathologies that affect workers in various ways depending on age, contractual relationship and the personal characteristics of the worker. Therefore, worker representatives are regarded as applying rather generalised solutions and simply focus on helping people receive the benefits which are appropriate for their level of incapacity. Overall a reactive, rather than a proactive and preventive, approach to the issue seems to prevail within both companies and trade unions.

Training and awareness-raising initiatives are advocated as a means of overcoming these problems and boosting the involvement of the industrial relations actors, while better dialogue and cooperation between all the stakeholders involved are well-regarded in terms of further spreading, improving and coordinating return to work practices. However, it is worth specifying that these sorts of belief are shared mainly among those who are actively engaged in return to work processes, whereas most of the representatives of the social partners who had no direct experience to report in this field were generally apathetic towards the potential for multi-stakeholder cooperation to facilitate the return to work.

3.2 Interactions between industrial relations actors and other stakeholders in return to work policy

Examples of how multi-stakeholder cooperation can overcome prejudices and the information gaps constraining the return to work are provided in the positive impact that public job centres and private employment agencies may have on employers dealing with the return to work of workers experiencing chronic illness. Companies are often unprepared for the requirements of Law No. 68/1999 which obliges the hiring of a certain percentage of disabled workers according to the size of the enterprise and often look to employment agencies for help and assistance. Employment agencies do not only recruit workers for the employer but (especially when equipped with personnel

specialised in the workplace inclusion of disadvantaged people) they can support the employer in the implementation of organisational solutions, working time flexibilities and the necessary task adjustments to ensure a worker's successful (re-)integration. One professional from a private employment agency told us:

> 'Our work 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 example is provided by Mestieri Lombardia Bergamo, an employment agency specialised in the job placement of disadvantaged people. This is a non-profit entity which, by participating in the local consortium Sol.Co Città Aperta, has become a benchmark for other cooperatives in the consortium in dealing with a disabled person or a worker with chronic illness: if a return to the workplace is not possible, Mestieri Lombardia Bergamo helps identify entities both within and outside the consortium that may be available to offer opportunities to the worker.

In contrast, the collaboration between industrial relations actors and campaigning and patient support organisations is still underdeveloped. It is not by chance that two in three representatives from private employment agencies underline the need for patient support organisations to be further engaged in return to work policies as many are essentially concentrated on aspects related to treatment. In this sense *Associazione Italiana Sclerosi Multipla* (Italian Multiple Sclerosis Association; AISM) represents a positive exception as it has cooperated both with Merck Serono (a pharmaceutical company) and Prioritalia (a trade union foundation) in the organisation of different training courses. It has also reached a local partnership agreement with the employer association Unindustria of Rome, the ASPHI Foundation (which promotes the inclusion of disabled people through digital technologies), Merck Serono and local trade union organisations FILCTEM-CGIL, FEMCA-CISL and UILTEC-UIL with the aim of facilitating the recruitment of workers affected by multiple sclerosis at Merck Serono's Rome site. Another positive example is represented by the PROJOB initiative launched by *Associazione Italiana Malati di Cancro* (Italian Association of Cancer Patients, Relatives and Friends; AIMAC) in 2012. AIMAC professionals offer training for HR managers, line managers and colleagues, consultancy for employers on legal and contractual solutions for a better work-life balance and psychological support for workers with chronic illness and those caring for ill relatives.

Research organisations focused on chronic illness seem to experience even lesser chances of interaction with the industrial relations players. Indeed, these occasions are largely limited to the collection of information required by research projects in which researchers conduct interviews with managers and trade unionists or workers' representatives; or, occasionally, to the workplace training programmes that some such organisations, for example *Fondazione IRCCS Istituto Neurologico Carlo Besta*, have developed on disability management.

Regional and local public authorities and INAIL also interact with industrial relations stakeholders. Aside from the involvement of the social partners in *Consiglio di Indirizzo e Vigilanza* (INAIL's Orientation and Oversight Committee; CIV),[11] an important example is represented by the Memorandum of Understanding signed in January 2020 by the Lazio regional directorate of INAIL on behalf of local trade unions, employer organisations and several associations for disabled people. The Memorandum concerns the use of INAIL funds for carrying out, with the support of the public employment centre, return to work projects for disabled people involving the breaking down of architectural barriers, the adaptation of workstations and the organisation of training. Another case is provided by the project *Insieme per il Lavoro*, resulting from a collaboration between the Municipality of Bologna and the Archdiocese of Bologna, aimed at facilitating the job placement of people experiencing social and economic vulnerability. The project was launched in 2017 and has developed thanks to interaction with local trade unions and employer associations as well as with a network of enterprises available to integrate such workers.

Even so, these important experiences seem quite rare in the Italian landscape and are often focused on broad categories of disabled or disadvantaged workers which may encompass, though do not specifically refer to, people with chronic illness.

According to a director of the Ministry of Labour and Social Policies, trade unions and employer associations are in steady and permanent dialogue with the legislator concerning labour and industrial relations issues and, with specific regard to return to work policy, have been consulted prior to the introduction of some legislative provisions. However, the social partners offered us a quite different picture with most trade union and employer representatives declaring that they were not involved in policy-making on this issue.

3.3 Outcomes of social dialogue and collective bargaining with regard to return to work policy at national and local levels

At national level, it does seem that social dialogue processes have resulted in the introduction of legislative provisions seeking to facilitate the return to work; while some important bipartite or multipartite social dialogue activities have been conducted at regional or local level. On top of the aforementioned 2020 Memorandum signed in Lazio, agreements were signed in July 2015 by the Municipality of Alessandria and local trade union confederations; and in November 2011 by the Municipality of Pomezia, the social consortium Coin and local trade unions. Both are aimed at the placement into work of disabled people, thus extending potentially to people with chronic illness. A local collective agreement was signed among social cooperatives in the area of Bologna in April 2018 delivering information and consultation with workers' representatives concerning people 'with functional limitations' and the health and safety measures being put in place in individual cooperatives; furthermore, it also focused on possible

11. This body is charged with defining the programmes, guidelines and strategic multi-year objectives of INAIL as well as monitoring the proper management of the Institute's economic resources.

relocation opportunities to be implemented in conjunction with social consortia and local cooperatives specifically devoted to the workplace inclusion of disadvantaged people. This process is coordinated and supported by a regional bilateral committee.

As regards national-level collective bargaining, most of the NCLAs signed by the most representative trade unions (i.e. those affiliated to the major confederations *Confederazione Generale Italiana del Lavoro*, *Confederazione Italiana Sindacati Lavoratori* and *Unione Italiana del Lavoro*) provide measures that ensure work continuity for people affected by serious illnesses requiring periodic treatment. Many NCLAs (such as those for the food industry, the electrical sector, professional services firms, environmental services and social cooperatives), ensure that periods of hospitalisation and absence related to the need for life-saving therapies and long-term treatment are not considered in the calculation of when the protected period ends for workers affected by certified chronic illnesses (including cancers, HIV, multiple sclerosis and muscular dystrophy). 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, as far as 32-36 months, for workers affected by chronic illness. Moreover, once the protected period is over, NCLAs can provide ill workers with the possibility of benefiting from unpaid leave of absence that can last for four, six or twelve months depending on the sector.

Other agreements, such as the NCLA for the metalworking sector as well as that for retail, specify that absences related to chronic illness are not a reason for wage reductions; while the NCLA for the food industry grants workers affected by serious pathologies or medical necessities the opportunity to obtain a severance payment in advance.

Clauses in other collective agreements concern working time such as the right to change the employment relationship from full-time to part-time (confirming the rights laid down in the law); paid time-off (also in compliance with Law No. 104/1992); other forms of working time flexibility (e.g. the banking sector agreement provides workers affected by cancers and degenerative diseases with greater flexibility on entry to and exit from work); and the exclusion of chronically ill workers from certain work shifts (e.g. on Sundays). The NCLA for the banking sector considers telework a suitable tool to facilitate the return to work of disabled people.

Some NCLAs also establish funds supplementing the essential health provisions offered by the public system and thus improving access to treatment for workers. These funds are financed out of the contributions paid by employers (and, in some cases, also by workers) operating in the sectors concerned. These funds can offer the reimbursement of expenses related to surgical operations, specialist examinations, diagnostic tests (in the metalworking and food sectors), treatment and rehabilitative therapies for cancers (in the banking sector) as well as medical consultancy and assistance (in the apparel industry).

The sorts of measures set down in NCLAs are generally aimed at guaranteeing job protection, economic support, work-care-life balance and enhanced access to healthcare for workers affected by disabilities or chronic illness. Less attention,

however, is paid to the procedural and infrastructural elements (such as ad hoc training activities for managers and workers' representatives, targeted information and consultation processes and guidelines for company-level bargaining on return to work processes) whose use may potentially sustain the actual application of national-level provisions that are indeed not always known and implemented at company level. Relevant provisions in this sense can, however, be detected in the NCLAs in the chemical and pharmaceutical and the banking sectors. Moreover, unlike local social dialogue, NCLAs do not generally cast attention to active labour policies and tend to concentrate on securing jobs and making them more sustainable for disabled or sick workers rather than empowering workers themselves in the labour market. Only the NCLA for agency workers (probably because of its cross-sectoral nature) seems to acknowledge and sustain possible occupational transitions for disabled workers by supporting vocational training and job placement paths for these workers.

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

3.4.1 Workers' experiences with the return to work process

Considering the type of illness, our worker survey reveals that cancers are the ones most often diagnosed while other frequent diseases with an impact on work include: musculoskeletal disorders; chronic respiratory, cardiovascular and mental illnesses; arthritis; and diabetes.

More than two in three workers are concerned about their return to work, most often on the grounds that the employer might not be willing to adjust working conditions to their post-illness situation. Workers also fear being left without support from the employer if their subsequent productivity, concentration and work performance do not fully meet the employer's expectations. Other reasons for concern are the risk of being required to return to work at full productivity right after treatment and without any adjustment period, as well as the possible need to work long hours shortly after long-term absence. Discrimination by colleagues and unequal financial treatment, in the sense that workers may not get bonuses due to their lowered productivity, constitute additional grounds of concern.

With reference to workers' actual return experiences, in a majority of cases the initiative to return had been made by the workers themselves although almost one in four identifies that the triggering role here was played by the specialists treating them. Indeed, the first actor with whom workers discuss their return to work is their medical specialist (38 per cent), followed by the general practitioner (29 per cent), the family (21 per cent) and trade unions to a lesser extent. It is thus no wonder that a crucial role in facilitating the return to work is played by both the medical specialists and the family. The role attributed to rehabilitation institutes, nurses and physiotherapists (considered as crucial by 20 per cent of workers), as well as general practitioners and colleagues (their role is important in combination with other actors for one in four workers), is also relevant although less important is the contribution of NGOs or similar organisations

and trade unions or other employee representatives (60 per cent of workers deem them to be unimportant).

With specific reference to the help provided by trade unions, almost half of workers declare that they are not satisfied, although one in four are very pleased, receiving the expected advice and support. More than eight in ten workers have not had the wish to join trade unions as a means of better facilitating their return to work after treatment, even though at least one trade union operates in most of the workplaces where respondents are employed. Moreover, although the vast majority of workers think that 'the trade union should always be ready to address the health-related issues of workers' and that 'support for the return to work should be an important element on the negotiations agenda between trade unions and the employer', only a small minority declare that there have been actual negotiations between their employer and workers' representatives about adjustments to their work tasks and responsibilities after the return to work. Only one in four workers knows of other cases where a trade union proved to be helpful in facilitating the return to work.

Neither are workers satisfied with the support received from their employer: more than one in four are not satisfied at all and just 16 per cent report that they were very happy.

Turning to the specific characteristics of the return to work process, respondents are equally divided between those who, after chronic illness, had returned to the same job position and those who had not done so. The majority (57 per cent) receive either no support or only limited help with regard to tasks or duties while, as for adjustments in the work environment and in the type of employment, almost one-half are not provided with any support. Similar results concern the opportunity to postpone deadlines although less negative findings emerge with reference to adjustments in daily working time (offered, to an extensive or reasonable degree, to 34 per cent of workers), flexible working time solutions to facilitate medical examinations or treatments (extensive or reasonable support for 43 per cent of workers) and the reassignment of some original tasks and responsibilities (extensive or reasonable support for 39 per cent of workers). However, at least two out of five workers receive either no support or limited assistance in all these areas.

3.4.2 Perspectives of HR, line managers and other relevant company actors on return to work processes

The importance of regular contact with workers during absence is largely acknowledged by HR and line managers. Indeed, despite them working mainly in large enterprises with more than 250 employees, they are generally informed of the employee's specific chronic illness directly and there were relatively few cases of where they had instead been informed by the employee's own occupational physicians or the company's medical specialist. Regular contact with workers during 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. On these occasions, workers are generally notified of work-related issues and, albeit in fewer instances, also engaged in decision-making and planning processes on work-related topics.

During sickness leave, three in four managers say they are forced to implement important organisational measures generally implying a rearrangement of workflow and a redistribution of job tasks among other workers as well as, to a rather lesser extent, the replacement of the sick worker. One in ten undergo financial difficulties. It is thus no wonder that most (70 per cent) declare that they encourage processes for the return to work during treatment. While dealing with workers on sick leave, HR and line managers find it useful to receive consultancy advice from an external expert or campaigning and patient support organisation, as well as information or advice on the specific chronic illness and proper adjustments which may be implemented in the workplace. We pointed earlier to the important support given by private employment agencies to companies, although managers frequently identify that this is missing, along with legal advice on sickness leave and external counselling.

Managers report that return to work processes are generally initiated by workers (56 per cent) or managers or employers (38 per cent) and anticipated either by a thorough discussion or informal conversation between workers and managers, allowing for a shared planning of specific return to work paths. A small majority of companies provide workers with a phased return to work, even though this is largely not written in any specific document or adaptable to individual situations. Return to work processes tend therefore to take the form of 'one size fits all' solutions, indivisibly addressed to all workers, and managed mostly by HR managers even though the role of line managers and team supervisors is conceived as equally important. Meanwhile, less responsibility is attributed to dedicated health and safety committees. The prevailing approach to the return to work seems to be essentially reactive when facing a specific situation, although there is a need for collaboration between HR managers and other business departments as regards the adoption of a preventive and proactive attitude which could result in the reconfiguration of workstations in such a way that they are suitable both for healthy workers as well as disabled or sick ones.

In the large majority of cases, companies do cooperate with external stakeholders when handling return to work situations. Indeed, such collaboration, as well as the relationships between the managers and those employees affected by chronic illness, are considered as pivotal in these processes and many respondents declare that both aspects should be further improved.

As regards the content of return to work processes, adjustments to working duties are perceived as relevant and, according to most, should be binding in law (74 per cent) rather than simply subject to managerial discretion (53 per cent). One in four managers think that individuals returning to work after chronic illness will not be able to perform the same duties as before, while there is also evidence that HR and line managers also believe that such workers are less committed to work. In this respect, the vast majority think that ill workers are likely to be absent from work more often than their colleagues (76 per cent). This, in turn, may be perceived as increasing the workload of colleagues. Subsequently, adjustments to working time, work tasks or workload are deemed necessary by the vast majority of respondents. In about half of cases, training for employees returning to work after chronic illness is offered, although it is far less common also to find training initiatives targeted at other workers on how to deal

with colleagues returning to work (around 28 per cent). There is a level of support for converting training from being 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 new health conditions and personal skills developed by the worker as a result of their illness.

These results are, however, sometimes at odds with the degree of satisfaction in these fields perceived by workers. Workers' experiences with the return to work process are complex and, in the majority of cases, they do not see their companies as being prepared to put in place the necessary adjustments required by their health condition. They also perceive there to be a lack of coordination between companies and doctors during the process. Moreover, workers underline the weak support received from companies and trade unions during the process with specific reference to mentoring and guidance practices. Given this context, it is no surprise that less than one-half of workers declare that they felt welcome when they returned to the workplace.

Finally, we should not lose sight of the finding that a considerable share of managers expect workers to return to their previous productivity level with no need for adjustment (around one in three) or that about the same proportion had no clear opinion on this point. Confusion around this issue potentially hints at the current definitions and assessments of labour productivity being inadequate when it comes to workers affected by chronic illness: these methodologies are rather abstract and standardised. More particularly, there is no consideration of individuals' health and mental conditions at work and the various organisational and adjustment measures which should not be neglected when assessing the work performance (and its sustainability) of people with chronic illnesses in a given context (Tiraboschi 2015).

3.4.3 Experience of (and good practice in) facilitating the return to work at company level and the role of industrial relations

Return to work policies for workers following chronic illness do not constitute a prominent topic for company-level collective bargaining in Italy.[12] Indeed, although managers find it important to include a worker representative on the committee addressing occupational health and safety, and that cooperation with workers' representatives is widely considered to be helpful in increasing workers' motivation and improving the quality of relationships between workers and managers, regular interaction with workers' representatives does not always appear to be an attractive option for HR and line managers. Interaction takes a long time and is less flexible than unilateral decision-making; it also entails the risk of additional requests being made by the workers' side. The result is that, when these issues are tackled in collective agreements at company or workplace level, this mainly stems from where managers are sensitive to workers' problems and from a willingness to share commitment with

12. The scope of the analysis is represented by the ADAPT database of company-level collective agreements which has gathered together approximately 3 000 collective agreements. The findings from the database accord with the views of workers in our survey in which 82 per cent of the latter say there are no negotiations between their employer and trade union/employee representatives about adjustments in work tasks and responsibilities after returning to work.

workers' representatives. Another relevant prerequisite for negotiations over these topics is constituted by an awareness among worker representatives of the issues at stake and an inclination to deal actively with them.

By and large, not all the steps in a return to work 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 and that are not included in collective agreements. Moreover, individual processes of return can be managed by the social partners totally outside the regulatory framework of collective agreements. For example, the relocation of a worker to different activities within a social cooperative has not been written down in any agreement even though it has been handled by both employer and trade union representatives. Consequently HR and line managers tend to see that the most beneficial results of the involvement of workers' representatives in this field are not only binding collective agreements but also training sessions organised for managers and workers' representatives, information leaflets distributed to workers and inputs made from the labour side on how to improve company return to work policies internally.

Employers occasionally do consult workers' representatives, but they still prefer to activate and implement return to work processes unilaterally, albeit sometimes in collaboration with external experts and organisations. Important examples in this sense are from the banking group Unicredit, which has organised awareness-raising initiatives on disability (e.g. online courses, days dedicated to disability management, focus groups, etc.) as well as training and professional mobility paths for deaf and blind people (Stefanovichj 2017). In recent years, return to work initiatives have also been promoted by the energy group Eni and AIMAC, with the participation of INPS, the Sodalitas Foundation and *l'Ordine Provinciale dei Consulenti del Lavoro* (Provincial Association of Labour Consultants) in Milan. Their project is entitled *Una rete solidale per attuare le norme a tutela dei lavoratori malati di cancro sui luoghi di lavoro* (Solidarity network to implement the norms protecting cancer patients in workplaces) and is aimed at identifying regulatory solutions for Eni workers who have had various cancers. The project also focuses on raising workers' and managers' awareness of these problems so as to promote better job integration policies. The digital platform 'Know and Believe', built in partnership with AIMAC and addressed to enterprises and health funds for the organisation of awareness-raising campaigns, collaborative events, online training courses and other initiatives to boost the prevention of cancer, is also worth mentioning in this respect.

In addition to these activities carried out by companies mainly outside the sphere of industrial relations, company-level collective bargaining can offer a normative framework for HR managers and workers' representatives when dealing with return to work processes as it makes available organisational solutions and tools that can be used in specific cases.

Among the different company-level collective agreements that do address this issue, the most significant clauses regard the increase in the length of the protected period or a job retention guarantee being offered until the complete recovery of a worker

affected by cancer. Further norms that have been established in this way concern work-life balance and, notably, the provision of unpaid sickness leave and additional paid time-off to undergo medical examinations and treatment (sometimes reserved explicitly to workers with chronic illnesses); and the possibility for certain categories of worker (including disabled workers and ones experiencing chronic illness) to benefit from the unused time-off accrued to individual workers but voluntarily transferred to a 'Solidarity Working Time Account' (introduced by Legislative Decree No. 151/2015[13]). Other company-level solutions which have been collectively agreed as regards workers with chronic illness include an exemption from working on weekends or on certain shifts, priority access to remote work and the possibility to be transferred to sites closer to home or allocated to different tasks where they are unfit for their previous activities (also in compliance with Legislative Decree No. 81/2008).

Specific attention is also paid to wage protection during periods of absence, particularly in the form of the return to work at up to the full amount of the normal wage and the guarantee of full performance-related pay (excepting the various days of absence from work).

Other provisions, found somewhat less frequently in company-level collective agreements, concern dedicated training courses for workers after long periods of absence and campaigns for the promotion of healthy lifestyles, often in collaboration with external experts and organisations. Welfare measures potentially targeted at workers with chronic illness may also be encompassed by the direct provision or reimbursement of expenses for medical examinations, tests and check-ups as well as of contributions to health funds and for insurance policies against the risk of not being able to support oneself or of developing serious illnesses (Tiraboschi 2019). By and large, however, these solutions are primarily devoted to increasing access to healthcare for workers from the perspective both of the prevention of serious diseases and their proper treatment rather than the direct facilitation of return to work policies.

Finally, it is worth mentioning the experiences of those companies (largely concentrated in the chemicals and pharmaceutical and the banking sectors) that have established, via collective agreement, the professional figure of a 'disability manager' and/or joint labour-management observatories or committees on disability, entrusted with the task of activating awareness-raising campaigns targeted at all workers and the design of welfare, training and organisational solutions for the effective return to work of disabled people. Following the setting-up of these roles and bodies, and despite the term 'disability' being potentially misleading as it seems to exclude many chronic illnesses, some companies have reached collective agreements regarding the launch, in partnership with campaigning and patient support organisations, of specific projects for the workplace inclusion of people affected by chronic illnesses at work (e.g. the local partnership agreement signed by Merck Serono referred to in section 3.2). Another example is the 2018 agreement signed by banking group Intesa San Paolo

13. Legislative Decree No. 151/2015 formally includes the possibility of workers transferring, on solidarity grounds, unused time-off solely to workers who need to assist their sick children. However, collective bargaining has expanded the scope of this measure.

which envisages a project for the inclusion of autistic workers, in collaboration with a specialist association, as well as an alternative training path for mentally disabled students. Funding for the initiatives at Intesa San Paolo comes from the sectoral bilateral employment fund and the solidarity company account financed by the employer and by workers voluntarily giving up a small percentage of their salaries for this purpose.

4. Conclusions

The Italian legislation on chronic illness and labour rights generally does not attribute functions and competences to industrial relations specialists, and the social partners themselves argue that policy-making processes in respect of the return to work provide rather poorly for their involvement. The legal framework on the return to work after chronic illness in Italy is also significantly fragmented and this compromises local players' thorough knowledge of it and their ability to implement it properly. Furthermore both employers and social partners frequently lack this legal expertise while being usually somewhat disinterested in these topics, preferring 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, being mainly focused on generalised responses to disability or chronic illness. Most NCLAs, indeed, tend to provide workers who have chronic illnesses with employment and wage security, a fair work-life balance and, thanks to supplementary health funds, with better or additional healthcare services. Although the measures agreed in this field mainly relate to these social areas, some differences can be detected across different sectoral NCLAs as regards the scope and generosity of these solutions and their main targets (e.g. either disabled workers, workers with chronic illness, workers affected by cancers and degenerative diseases, workers in need of life-saving therapies, etc.). In particular it has been reported that there is a lack, across different NCLAs, of clear and homogeneous definitions of the worker categories which are intended to be the beneficiaries of return to work measures and other forms of protection (Osservatorio AISM 2017). This has led to great confusion in their application and, consequently, to the risk of unequal treatment across companies and economic sectors.

It is in the light of these considerations that we can agree with and further advance AISM's suggestion that the social partners overcome the disparities in protection standards caused by the varying beneficiaries identified in different NCLAs and extend the rights and prerogatives to more comprehensive and less compartmentalised worker categories (Osservatorio AISM 2017). The potential wide and generalising effect of this approach must not, however, overlook the specific characteristics of each condition and the particular needs of every single person with chronic illness, in respect of whom each return to work plan needs to tailor its measures carefully.

With reference to decentralised industrial relations, it is worth pointing out that local and company-level bargaining on the return to work after chronic illness is largely underdeveloped and reliant on the mutual willingness of individual trade unions, employer representatives and managers. As a consequence, when it does take place,

company-level bargaining is essentially limited to large and well-structured companies (generally equipped with the necessary financial and technical resources to address return to work processes), that are mainly concentrated in specific sectors such as the chemical and pharmaceutical, energy and banking sectors.

As observed from the sectoral level, collective company-level solutions are usually aimed at providing workers with protection within their existing employment relationship and do not support, nor cover, any possible employment transitions. In contrast, active labour market policies and return to work programmes are found to be more frequently designed and implemented at regional level, where the social partners often engage with other relevant stakeholders in joint initiatives and projects. At company level, employers and workers' representatives may sometimes be found to cooperate with each other in return to work processes even outside the framework of formal collective agreements. As a result, the processes of return for workers experiencing chronic illness in Italy still seem to be largely managed on an informal and individual basis. In companies, these processes are mostly addressed unilaterally by company managers – at best, with the support of a few external experts – whilst the involvement of workers' representatives is quite rare. This situation is likely to jeopardise worker voice in return to work processes, thus explaining the already-polarised views of workers on the amount of support received from their employers. The situation also explains surveyed workers' largely negative perceptions on workplace adaptations after long-term absence and the role of labour representatives in these dynamics.

In partial contribution to the prevailing informality of the management of these issues, as well as the lack of a homogeneous, widespread commitment among the social partners to return to work processes, is the absence of any form of coordination and promotion starting from national industrial relations levels. Exceptions can be found in the NCLAs for the chemical and pharmaceutical and the banking sectors, where trade unions and employer associations have emphasised certain procedural aspects (e.g. ad hoc training activities for managers and worker representatives and targeted information and consultation rights), enabling local negotiating parties to put in place informed and site-specific solutions. Moreover, these NCLAs have sought to enhance the role of a national bilateral observatory in promoting and coordinating active labour market projects at local level, as well as encouraging companies to adopt disability management plans. It is thus not by chance that the most relevant collective return to work solutions have been implemented in companies operating in these sectors. However, both these agreements suffer from the lack of a clear provision of a monitoring system aimed at checking the implementation in practice of the suggested measures.

In the light of these findings, it is desirable that the social partners at national level take action to foster the role of local actors on this topic and improve their competencies at doing so. Successful results can be achieved especially when social partners collaborate with research institutes, campaigning and patient support organisations, public institutions and other relevant stakeholders in this field. However, these interactions, which are all the more important in this area given the multidimensionality of the issue (affecting the worker primarily as a person and a member of a family and a social community), seem limited to certain contexts and situations stemming from the availability and interest of

particular individuals. Major efforts should thus be oriented towards deepening social partner knowledge of the existing legal framework, strengthening multi-stakeholder cooperation and coordination across different levels and promoting a preventive and proactive approach to the return to work. This ought to have been done prior to the emergence of a critical health situation, and not in response to one, by redesigning work environments to make them more inclusive and sustainable for all and by rethinking notions of productivity, work performance, task fulfilment and suitability for work, inter alia, concerning their more appropriate adaptation to the needs of workers experiencing chronic illness (Tiraboschi 2015). This is even more urgent considering that workers undergoing a return to work are largely worried about not being able to keep up their usual levels of productivity and performance, and that a considerable portion of managers expect workers to be back at their previous pace with no adjustments.

Ultimately, as collective agreements mainly provide protections for workers within their existing employment relationship, greater attention should be paid by the social partners to the 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 the external support which, today, is largely being sourced from relatives, physicians, colleagues and professionals from campaigning and patient support organisations. It is in this area that, given the many personal changes and events (e.g. disease, maternity, caregiving, etc.) which potentially have an impact on individuals' careers, the maturity, innovativeness and readiness of industrial relations actors and institutions will be measured.

References

Bono R. (2020) La giurisprudenza nazionale a tutela del lavoratore disabile tra divieti di discriminazioni e obbligo di soluzioni ragionevoli, in Del Punta R., Gottardi D., Nunin R. and Tiraboschi M. (eds.) Salute e benessere dei lavoratori: profili giuslavoristici e di relazioni industriali, Bergamo, ADAPT University Press, 67-81.

Caprile M., Riobóo I. Welz C. and Rodríguez R. (2017) Mapping varieties of industrial relations: Eurofound's analytical framework applied, Luxembourg, Publications Office of the European Union. https://www.eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef1755en.pdf

Carfì A., Bernabei R. and Landi F. (2020) Persistent symptoms in patients after acute COVID-19, JAMA, 324 (6), 603-605.

Colombo S. and Regalia I. (2016) Changing joint regulation and labour market policy in Italy during the crisis: On the edge of a paradigm shift?, European Journal of Industrial Relations, 22 (3), 295-309.

CNEL (2019) 10° Report periodico dei Contratti Collettivi Nazionali di Lavoro vigenti depositati nell'Archivio CNEL. http://www.bollettinoadapt.it/wp-content/uploads/2020/02/Decimo_report_CCNL_vigenti_dicembre_2019.pdf

EuroHealthNet (2017) Joint statement on 'improving the employment of people with chronic diseases in Europe, Framing paper. https://bit.ly/3xu323X

Fernández Martínez S. (2017) L'evoluzione del concetto giuridico di disabilità: verso un'inclusione delle malattie croniche?, Diritto delle Relazioni Industriali, 27 (1), 74-97.

ISTAT (2019) Sanità e salute, in Annuario statistico italiano 2019, Roma, Istituto nazionale di statistica, 121-160. https://www.istat.it/it/files//2019/12/C04.pdf

Istituto Piepoli (2008) Quel brutto male: il vissuto sociale del cancro RAPPORTO 286-2007, Milano, Istituto Piepoli. https://dg4fet0kj3gdo.cloudfront.net/download/allegati/Quel_brutto_male.pdf

La Stampa (2011) Gli ammalati di cancro vogliono continuare a lavorare, La Stampa, 17 May 2011. https://www.lastampa.it/salute/2011/05/17/news/gli-ammalati-di-cancro-vogliono-continuare-a-lavorare-1.36961494

Leonardi S. (2017) Trade unions and collective bargaining in Italy during the crisis, in Lehndorff S., Dribbush H., Schulten T. (eds.) Rough waters: European trade unions in a time of crises, Brussels, ETUI, 83-107.

Leonardi S., Ambra M. C. and Ciarini A. (2017) Italian collective bargaining at a turning point, Working Paper "Massimo d'Antona' INT 139, Catania, Centre for the Study of European Labour Law 'Massimo D'Antona, University of Catania. https://bit.ly/3k7Onrk

OECD (2009) Sickness, disability and work keeping on track in the economic downturn, Paris, OECD Publishing. http://www.oecd.org/employment/emp/42699911.pdf

Osservatorio AISM (2017) Sclerosi multipla, gravi patologie, disabilità: analisi della contrattazione collettiva nazionale, Genova, Associazione Italiana Sclerosi Multipla. https://allegati.aism.it/manager/UploadFile/2/20171215_723.pdf

Stefanovichj S. (ed.) (2017) Disability management, welfare e permessi solidali: analisi di casi aziendali e contrattuali che affrontano la sfida della disabilità e gravi patologie, Roma, Edizioni Lavoro.

Tiraboschi M. (2019) Welfare for people. Secondo rapporto su ill welfare occupazionale e aziendale in Italia, Bergamo, Adapt University Press.

Tiraboschi M. (2015) The new frontiers of welfare systems: the employability, employment and protection of people with chronic diseases, E-Journal of International and Comparative Labour Studies, 4 (2). http://ejcls.adapt.it/index.php/ejcls_adapt/article/view/283/384

Università Cattolica Sacro Cuore, Istituto Sanità Pubblica (2020) Rapporto Osservasalute 2019. Stato di salute e qualità dell'assistenza nelle regioni italiane. https://www.osservatoriosullasalute.it/osservasalute/rapporto-osservasalute-2019

Vargas Llave O., Weber T. and Vanderleyden J., (2019) How to respond to chronic health problems in the workplace, Luxembourg, Publications Office of the European Union. https://www.eurofound.europa.eu/publications/policy-brief/2019/how-to-respond-to-chronic-health-problems-in-the-workplace

All links were checked on 07.06.2021.

Database and datasets

Eurostat, People having a long-standing illness or health problem, by sex, age and labour status [hlth_silc_04]. http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_silc_04&lang=en [Accessed 30.12.2020].

Istat, Aspetti della vita quotidiana: Stato di salute – età dettaglio. http://dati.istat.it/Index.aspx?QueryId=15448# [Accessed 30.12.2020].

Istat, Aspetti della vita quotidiana: Stato di salute – posizione nella professione. http://dati.istat.it/Index.aspx?QueryId=15448# [Accessed 30.12.2020].

OECD.Stat, Collective bargaining coverage. https://stats.oecd.org/Index.aspx?DataSetCode=CBC [Accessed 03.06.2020].

OECD.Stat, Trade union density. https://stats.oecd.org/Index.aspx?DataSetCode=TUD [Accessed 03.06.2020].