



Eurofound

Employment opportunities for people with chronic diseases



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This report examines employment opportunities for people with chronic diseases such as cardiovascular disease, cancer, chronic respiratory disease, diabetes, multiple sclerosis, arthritis and mental health problems in the EU28 Member States and Norway. People with a chronic disease may have a reduced working capacity and experience difficulty staying at or returning to work. The report looks at the prevalence of people suffering from chronic diseases, their employment situation, uneven distribution among occupations and sectors, and working conditions. It looks at policies and measures adopted by governments, social partners and enterprises to improve employment prospects and working conditions of people with chronic diseases. The study was compiled on the basis of individual national reports drawn up by Eurofound's national correspondents in response to a questionnaire.

Antonio Corral, Jessica Durán and Iñigo Isusi, IKEI Research and Consulting

Introduction and objectives

According to the definition used by the World Health Organization ([WHO](#)), chronic diseases, also known as [noncommunicable diseases](#) (NCDs) ‘are not passed from person to person. They are of long duration and generally slow progression’. A chronic illness means health problems requiring ongoing treatment for a period of years or decades. This definition implies that these diseases are recurrent, long-lasting and persistent (ongoing), and cannot be cured.

NCDs are the world’s biggest killers. According to a [WHO factsheet \(1.17 MB PDF\)](#), more than 36 million people die annually from NCDs (63% of global deaths), including more than 14 million people who die too young between the ages of 30 and 70 years.

The four main types of chronic diseases are:

- cardiovascular diseases such as heart attacks and stroke;
- cancers;
- chronic respiratory diseases;
- diabetes.

Common well-known chronic diseases include diabetes, heart failure, asthma, chronic obstructive pulmonary disease (COPD), cancer, epilepsy, multiple sclerosis, rheumatoid arthritis, Crohn’s disease, prolonged infectious diseases such as hepatitis and HIV/AIDS, and mental health problems such as depression and alcohol/drug abuse. This list is far from exhaustive and could also include some additional diseases such as chronic fatigue syndrome, muscular dystrophies and systemic lupus erythematosus (SLE). Each illness has its own particular characteristics and symptoms, and can affect people differently.

According to Eurofound’s [Third European Quality of Life Survey 2001–2012](#) (third EQLS), about 28% of Europeans report having a chronic (longstanding) physical or mental health problem, illness or disability, and the proportion is higher for women (30%) than for men (26%). The third EQLS found large differences by country: chronic illnesses and disabilities were most frequently reported in countries such as Finland (45%), Estonia (40%), Denmark (38%), Latvia (37%) and the UK (36%) in contrast with other Member States with a much lower prevalence rate such as Italy and Malta (both 15%), Greece and Slovakia (both 18%) and Slovenia (20%). Interestingly, the third EQLS also showed that, overall, the health status of Europeans seems to have deteriorated somewhat during the economic and financial crisis in terms of the prevalence of chronic diseases.

In general, chronic diseases are linked to ageing, lifestyle and genetic predisposition. They may or may not be caused (or made worse) by work. Although they are more commonly found in those aged over 65 years, they are relatively frequent among people of working age. The most recent [Eurostat statistics](#) show that 20.1% of employed persons in the EU28 reported longstanding illness or health problems in 2012, which is lower than the 26.4% among unemployed people and 58.2% among retired people. In addition, 13.3% of the employed population suggested that they had experienced limitations in their daily activities and work for six months or more due to health problems. Once again, the differences between countries were very large.

In addition to this significant incidence of chronic diseases, a [study on sickness, disability and work](#) published in 2010 by the Organisation for Economic Co-operation and Development ([OECD](#)) found that chronically ill employees experience major

difficulties in either staying at work or returning to work after a long period of absence, mainly due to insufficient support and consideration from companies and public authorities. These people often move into disability or early retirement and are thus excluded from the labour market. The OECD study also found that too few people with reduced work capacity manage to remain in employment. This highlights the importance of this comparative analytical report.

Chronic diseases suffered by the working population have important consequences at both macro and micro level. At macro level, the productive capacity of a nation's workforce is reduced if people with long-term or chronic health conditions are not kept as active participants in the workforce. Together with healthcare costs, this implies serious impacts on the country's economy. For example, respiratory diseases (such as COPD, asthma, lung cancer, pneumonia and tuberculosis) are estimated to cost the European economy more than €380 billion annually, including healthcare costs and lost working days (Loddenkemper et al, 2013). Costs related to mental health problems are estimated at between 3% and 4% of gross domestic product (GDP).

As explained in the next section, the concept of chronic disease from a work perspective is close to the notion of disability in the sense that the disease frequently induces a disability that hinders the employment integration of those affected. Legislation and policies are therefore commonly aimed at helping people with disabilities, including those suffering from chronic health conditions.

At micro level, chronic diseases can have numerous consequences, not only for the individuals affected by their disease and their families (grief, depression, adjustments) but also for the enterprises they work for and their colleagues (loss of productivity, added workloads).

Given the substantial impact of chronic diseases on the labour market and working life, increasing attention is being paid to policy strategies and interventions aimed at preventing employees with a chronic illness from moving into disability or early retirement.

This report seeks to:

- review the main definitions and types of chronic diseases used in the EU Member States and Norway, as well as identify available sources of information and studies at national level that contribute to characterising the situation of people with chronic diseases in relation to employment and/or working conditions;
- assess the importance and extent of the phenomenon of people with chronic diseases across the EU and Norway and recent developments over time, particularly regarding the employment situation of these people;
- provide quantitative and qualitative information on the working conditions of people with chronic diseases;
- describe the main policy initiatives and measures of public authorities and social partners to improve the employment situation and working conditions of people with chronic diseases, as well as examples of initiatives taken by individual enterprises to support workers affected to stay in work or return to work.

National perspective on chronic diseases and employment

Definitions of chronic disease

The commonest situation in European countries is that there is no specific definition of chronic diseases, either in a general or in an employment context. Indeed, the term ‘chronic diseases’ is rarely used in employment rhetoric and related legislation. In general, Member States refer to the general WHO definition given in the previous section or to the definition used in the [European Health Interview Survey \(EHIS\)](#) conducted between 2006 and 2009 of ‘longstanding illnesses or health problems which have lasted, or are expected to last, for six months or more’.

Similar definitions are applied in the context of national general health policies and statistics, for example:

- ‘diseases of long duration’ in the [Austrian Health Survey 2006–2007 \(in German, 227 KB PDF\)](#);
- ‘a long-term illness, progressive, often linked to a disability and to the threat of serious complications’ in the French [2007–2011 plan for the improvement of the quality of life of people with chronic diseases \(in French, 322 KB PDF\)](#);
- ‘a disease that lasts, or is expected to last, for a long time, usually for more than six months. It usually requires medical intervention for its healing or control’, in the Portuguese [National Health Survey 2005–2006 \(in Portuguese, 3.4 MB PDF\)](#);
- diseases that are ‘recurrent or have a long-term prognosis’ according to the [definition \(in Danish\)](#) used by the Danish Health and Medicines Authority ([Sundhedsstyrelsen](#)).

From an employment perspective, it is necessary to refer to the definition used in Eurostat’s [2011 EU Labour Force Survey ad hoc module on employment of disabled people \(390 KB PDF\)](#). This uses the term ‘longstanding health condition’, where: longstanding means that the health condition or disease has lasted or is likely to last for at least 6 months. The main characteristics of a longstanding condition or disease are that it is permanent and may be expected to require a long period of supervision, observation or care. Therefore, any acute (temporary) health problem, such as a sprained ankle, broken leg, appendicitis or a respiratory tract infection is not of interest. (Eurostat, 2011)

The chronic diseases considered in the Labour Force Survey (LFS) are listed in Table 1.

| Code | Description |
|-------------|------------------------------------------------------------------------|
| 01 | Problems with arms or hands (which includes arthritis or rheumatism) |
| 02 | Problems with legs or feet (which includes arthritis or rheumatism) |
| 03 | Problems with back or neck (which includes arthritis or rheumatism) |
| 04 | Cancer |
| 05 | Skin conditions, including allergic reactions and severe disfigurement |

| | |
|-----------|---------------------------------------------------------------------------------------------------------------|
| 06 | Heart, blood pressure or circulation problems |
| 07 | Chest or breathing problems, including asthma and bronchitis |
| 08 | Stomach, liver, kidney or digestive problems |
| 09 | Diabetes |
| 10 | Epilepsy (include fits) |
| 11 | Severe headache such as migraine |
| 12 | Learning difficulties (reading, spelling or math disability) |
| 13 | Chronic anxiety |
| 14 | Depression |
| 15 | Other mental, nervous or emotional problems |
| 16 | Other progressive illnesses (which include multiple sclerosis, HIV, Alzheimer's disease, Parkinson's disease) |
| 17 | Other longstanding health problems |

Source: Eurostat (2011), 'EU Labour Force Survey ad hoc module on employment of disabled people', p.4

In view of the national contributions prepared for this study (and also from the title of Eurostat's ad hoc module), however, the concept of 'chronic disease' in an employment context is very much related to the notion of 'disability'. The [UN Convention on the Rights of Persons with Disabilities](#) considers disabled people as those 'who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society (including on an equal basis with others)'. Note that the disability is not the medical or functional disorder as such, but the participation problem (for instance, in society or at work) that results from the deficient health condition. In this sense, the occupational disability depends on the occupation and is not fully determined by the chronic medical conditions but is the result of the interaction between these and the specific requirements and working conditions of a particular job. This means that the disability can be reduced or eliminated by workplace adaptation, which does not apply to chronic diseases or physical or psychological impairment as such.

All national social security systems include the concept of 'labour disability' or 'physically or mentally impaired persons', that is, people having a physical, sensory or mental impairment which results in a longstanding reduced ability to satisfy the personal needs of daily life, including the capacity to work. Thus, in most countries the legal definition of disability includes long-term diseases and health conditions or difficulties (physical or mental) in performing basic (work) activities.

In an employment context and depending on the duration of the impairment, the disability can be permanent or temporary, and can also imply a total or partial (in diverse degrees) inability to work (under 'standard' working conditions). As a result and under certain conditions, those affected by the disability to work are entitled to a sickness allowance or other social security benefits.

For instance in Cyprus, the [guidance on the Social Insurance Scheme \(107 KB PDF\)](#) defines as ‘incapable of work’ any insured person who, due to a specific illness or physical or mental disability, is not employable in the occupation they usually performed. In general in Estonia under the [guidelines on the regulation of the Minister of Social Affairs for determining incapacity for work \(in Estonian\)](#), the extent of the incapacity usually depends on a medical diagnosis. This can include both chronic illnesses (for example, chronic renal failure) and permanent loss of a body function or structure (for example, deafness).

In Poland, the [Act of 27 April 1997 on vocational and social rehabilitation and employment of persons with disabilities \(in Polish\)](#) refers to people who are aged 16 years-old or more and have a certificate of disability or inability to work as a consequence of a large number of possible long-term diseases and health conditions or difficulties in performing basic activities.

Chronic diseases may or may not have an occupational origin, in the sense that they can or cannot be the result of the particular characteristics or working conditions of certain jobs. In this sense, occupational diseases are those which are typical for particular categories of workers and the single or main reason for these diseases are physical, chemical, biological, psychological or other factors linked to a particular employment or profession. The registration and treatment of people with occupational diseases is generally regulated by law, as for example in Latvia where this [determination \(in Latvian\)](#) is performed by the [Ministry of Welfare](#).

Specific definitions and references to chronic diseases that take into account the employment perspective can be found in some EU countries. Thus, there is no standard definition in the case of Germany, but in 2004 the Federal Joint Committee ([G-BA](#)) published [guidelines on defining chronic disease \(in German, 98 KB PDF\)](#). According to these guidelines, an illness is defined as chronic if it requires treatment at least once every quarter over a minimum period of one year. For the illness to be defined as chronic, several additional criteria may apply, including that ‘the illness results in a disability of at least 60% or the persons’ employability is diminished by at least 60%’.

The [Finnish National Work and Health Surveys 1997–2012](#) carried out by the Finnish Institute of Occupational Health ([FIOH](#)) ask about ‘a long-term, at least 3 months, illness or injury diagnosed by a doctor’ and whether this interferes with the current work. In Hungary, the [2011 survey on people with disabilities in the labour market \(in Hungarian, 297 KB PDF\)](#) carried out by the Hungarian Central Statistical Office ([KSH](#)) considers people with disabilities and chronic diseases to be those who declared themselves ‘to suffer from chronic health problems, illness and feel themselves incapacitated to get a job, or to properly carry out their tasks at work’.

Also, in Portugal, [Order 861/99 of 18 September 1999 \(in Portuguese, 22.7 KB PDF\)](#) defines chronic disease as:

a long-term disease, with multidimensional aspects, with gradual symptoms and potentially disabling evolution, implying gravity by the limitations on the possibilities of medical treatment and acceptance by the patient whose clinical situation must be considered in the context of family life, school and work, this last one being particularly affected.

The concept of chronic diseases in an employment context is also considered in laws against discrimination. Examples are the Irish [Employment Equality Acts 1998–2011](#), the British [Equality Act 2010](#) (even though the term is not general used in the UK) or the more specific Dutch [Act on Equal Treatment on the Grounds of Disability or](#)

[Chronic Illness \(109 KB PDF\)](#) (AWGB), where provisions are established to protect employees against discrimination in the workplace, explicitly including people affected by disabilities and longstanding health conditions. In addition, employers are required to make the necessary work adaptations to enable effective participation in work of people who are disabled and chronically ill.

Statistics on chronic diseases and employment

The most cited source of statistical information on chronic diseases and employment is the [2011 Labour Force Survey ad hoc module on employment of disabled people \(390 KB PDF\)](#) carried out in European countries under guidance from Eurostat. The survey included the following questions in relation to employment and working conditions.

- Are you limited in the number of hours you can work per week due to your health condition?
- Are you limited in the kind of work and activities due to your health condition (for example, problems with carrying heavy loads, working outdoors, sitting for a long time)?
- Are you limited in getting to and from work due to your health condition?
- Does your workplace have special equipment (for example, voice computer) or workplace adaptations (for example, access ramp) due to your health condition?
- Do you have special working arrangements (for example, sitting while at work, specific working hours, telework, flexible hours or less strenuous work) due to your health condition?
- Do you receive personal assistance due to your health condition in order to be able to work? If yes, who do you receive personal assistance from (colleagues, supervisors, partner, family members, relatives, friends, neighbours, social services and NGOs, other)?

But despite the availability of national results for most countries, aggregated data at European level have not been published. A similar LFS ad hoc module on the [employment of disabled persons](#) was also implemented in 2002.

The EHIS provides information at European and national level on health status such as self-perceived health, chronic conditions, limitation in daily activities (including work), disease-specific morbidity, and physical and sensory functional limitations.

In addition, there are several national health surveys ([Finland \(in Finnish\)](#), [Netherlands](#), [Portugal](#), [Spain](#)) which, with diverse frequency, contain data on the prevalence of chronic diseases (though they are not always called or categorised as such) and which usually include questions on the employment situation of the population. However, little information is provided on the actual impact of the health condition on the employability of those affected or their working conditions. The same applies to the statistics and analysis conducted in several countries on information gathered through national population censuses (for example, [Ireland](#), [Malta](#), [Poland \(in Polish\)](#)).

All countries keep registers and databases on workers affected by disease (occupational or not) and with temporary or permanent incapacity to work for the purpose of managing and monitoring the payment of social insurance benefits (sickness benefit, disability pensions) and the provision of associated social services. However, these registers do not usually differentiate chronic diseases from other temporary illnesses. Nor do they provide information about the working conditions of the people affected.

Finally, several national registers and statistical sources do provide some information specifically linking chronic diseases (and disabilities) and employment. Table 2 contains a series of relevant examples extracted from the national contributions received for this study.

Table 2: Examples of national statistics specifically linking chronic diseases (and disabilities) and employment

| | Statistical source | Description |
|----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | Data Warehouse on labour market and social protection (in Dutch) | This forms a permanent link of the databases of different Belgian social security institutions, making it possible to examine the socioeconomic profile of people with chronic diseases. The HANDILAB research project (in Dutch) is based on these data and focused on this specific group. |
| BE | Flemish Public Employment Service (VDAB) – people with disability in the labour market | VDAB produces monthly statistics on the number of ‘labour disabled’ unemployed people, including information on gender, age, domicile, education level and unemployment duration. A 2010 report (in Dutch, 2.3 MB PDF) examined the situation of disabled people in the labour market. |
| | SCV-survey Sociaal-culturele verschuivingen in Vlaanderen (in Dutch) by the Research Department of the Flemish Government (SVR) | Since 2002, this annual survey has included two questions on the labour market situation of those with a chronic disease or disability. The survey covers a representative sample of the Flemish population (1,500 people). Results of the survey are pooled over the last three years to assure a sufficiently large sample size. |
| | Employability Monitor (in Dutch) of the Social and Economic Council of Flanders (SERV) | This three-yearly written survey is designed to measure workability in the Flemish labour market. It covers a representative sample of 20,000 employees. Since 2007, it has included a question on the existence/influence of chronic diseases. |
| DK | Work environment and health 2012 (AH2012, in Danish) | AH2012 covers about 16,000 people (aged 18–64 years), including employees and self-employed. It has questions on pain, sleep, self-rated health, work ability, anxiety, work-related disorders and depression. Respondents are asked if they have been diagnosed with a series of chronic diseases. |
| ES | Survey on disability, personal autonomy and dependency situations 2008 | This National Institute of Statistics (INE) survey includes people affected by chronic diseases, which are defined as long-term diseases that are diagnosed as such by healthcare professionals. The survey provides some limited data on the labour situation of those with disabilities. |
| FI | Finnish National Work and Health surveys 1997–2012 | These FIOH surveys represent currently occupationally active employees aged 25–64 years |

Table 2: Examples of national statistics specifically linking chronic diseases (and disabilities) and employment

| | Statistical source | Description |
|----|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | (in Finnish) | (sample size in 2012 was 1,827). The questions about chronic diseases refer to a long-term (at least three months) illness or injury diagnosed by a doctor and whether this interferes with current work. The questions in relation to employment concern occupation, industry, permanent/fixed-term contract, working time and flexibility. Questions about working conditions cover physical, ergonomic, chemical and psychosocial factors and safety at work, reconciliation of working and non-working life, skills development, and gender and age equality. |
| FR | Enquête santé et itinéraire professionnel 2006–2010 | This survey on health and professional careers, conducted jointly by the ministerial statistical office for health and solidarities (Drees) and the ministerial statistical office for labour and employment (Dares), collects details of the work, employment and health of people interviewed twice four years apart. Nearly 14,000 interviews were conducted in 2006 (including among the active population, employed, unemployed or inactive people and retired workers). The 2010 wave was able to re-interview 11,000 people. |
| HR | Croatian Health Service Yearbook (in Croatian) | The Croatian National Institute of Public Health (HZJZ) maintains the Croatian National Cancer Register, the Croatian National Psychoses Register and the Croatian Disabilities Register. The survey asks people if they are in work, if they are unemployed, and what their impairments are. |
| HU | Labour market, employment environment and health, 2009 (in Hungarian, 2.3 MB PDF) | This general survey by KSH is representative of the Hungarian population aged between 18 and 54 years. It provides information on: health status (including chronic diseases); labour market position and health; working conditions and health status; employees within the economic sectors and their health status; damage to health and complaints correlating with the work carried out; health-damaging working conditions within each sector; connections/relations between working conditions and health status; and health status within different occupations. |
| | Labour market, working conditions and health, 2011 (in Hungarian, 297 KB PDF) | This general survey by KSH is representative of the Hungarian population aged between 15 to 64 years with chronic diseases and disabilities. It provides information on: socioeconomic characteristics; labour market position; obstacles to active participation in |

Table 2: Examples of national statistics specifically linking chronic diseases (and disabilities) and employment

| | Statistical source | Description |
|----|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| IE | National Disability Survey 2006 (NDS) | <p>the labour market; and the situation and working conditions of those employed.</p> <p>The NDS asks detailed questions about the nature of difficulty the respondent has due to their disability, such as seeing, hearing, speech, mobility and dexterity, remembering and concentrating, intellectual powers and learning, emotional, psychological and mental health, pain and breathing. The NDS is conducted both in the home and at the workplace, and is based on Census data and a randomised sample (17,000 respondents across all ages).</p> |
| IT | Isfol quality of work survey (QWS) | <p>The survey includes only those chronic diseases as outcomes of both work-related diseases or work accidents. In the former case, diseases are classified as ‘without consequence’, ‘chronic but not invalidating’ and ‘invalidating’, the latter as ‘mild’, ‘serious but solvable’ and ‘invalidating’.</p> |
| NL | Netherlands National Working Conditions Survey (NWCS) (in Dutch) | <p>This annual cross-sectional survey carried out for the Central Statistical Office (CBS) by the Netherlands Organisation for Applied Scientific Research (TNO) involves a questionnaire sent to around 25,000 employees seeking information on long-term illnesses, disorders or disabilities, cause of these (work or not) and their influence on job performance.</p> |
| PL | State Fund for Rehabilitation of Disabled Persons (in Polish) (PFRON) | <p>PFRON provides data on the number of employees with disabilities and the employers who employ them.</p> |
| SE | Conditions in the labour market (in Swedish, 2.2 MB PDF) | <p>Statistics Sweden (SCB) conducted a survey every second year between 1996 and 2008, and recently in 2012, which examined the labour market situation for people with disabilities, including people with chronic diseases.</p> |
| SI | Risk factors for non-contagious diseases of adults in Slovenia in 2008 (in Slovenian, 1.1 MB PDF) | <p>Carried out by the Slovene Chronic Diseases Prevention Centre (CINDI) at the National Institute of Public Health (NIJZ), this survey used a sample of 7,352 questionnaires from adults aged 25–74 years to explore and evaluate the spread of behavioural risk factors connected with the condition of their health, mainly with non-contagious chronic diseases. The survey also included one question on the type of</p> |

Table 2: Examples of national statistics specifically linking chronic diseases (and disabilities) and employment

Statistical source **Description**

work.

Source: National contributions

Prevalence and effects of chronic diseases

Extent and evolution in EU28 and Norway

There is limited comparative information on the extent of people in Europe with chronic diseases. [Eurostat statistics](#) provide a general picture of the self-perception that Europeans have of their own health. In 2012, 31.5% of EU28 citizens (about 159.4 million people) said that they suffered from a longstanding illness or health problem, although only 9.9% of Europeans (50.1 million people) self-perceived their health situation as ‘bad’ or ‘very bad’ (Table 3). Meanwhile, 8.9% of EU28 citizens (45 million people) perceived longstanding severe limitations in their usual activities due to health problems.

| Table 3: Self-perception of their health of Europeans aged 16 and over (% of total population), 2012 | | | |
|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| | Have a longstanding illness or health problem | Self-perceived bad or very bad health situation | Self-perceived longstanding severe limitations in usual activities due to health problem |
| EU28 | 31.5 | 9.9 | 8.9 |
| AT | 33.1 | 9.0 | 9.6 |
| BE | 24.4 | 8.9 | 7.5 |
| BG | 18.6 | 11.9 | 3.9 |
| CY | 32.6 | 6.7 | 7.9 |
| CZ | 30.0 | 12.8 | 6.2 |
| DE | 37.0 | 8.5 | 10.9 |
| DK | 28.9 | 7.7 | 6.8 |
| EE | 43.7 | 16.3 | 9.8 |
| EL | 23.8 | 9.3 | 10.1 |
| ES | 26.2 | 8.1 | 5.1 |
| FI | 46.7 | 6.7 | 7.1 |
| FR | 36.6 | 8.5 | 8.8 |
| HR | 29.4 | 25.8 | 5.3 |
| HU | 36.0 | 16.1 | 7.9 |

| | Have a longstanding illness or health problem | Self-perceived bad or very bad health situation | Self-perceived longstanding severe limitations in usual activities due to health problem |
|-----------|------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| IE | 26.5 | 2.8 | 4.9 |
| IT | 24.5 | 12.4 | 9.5 |
| LT | 29.6 | 20.6 | 8.2 |
| LU | 20.2 | 7.4 | 5.8 |
| LV | 35.2 | 14.9 | 6.9 |
| MT | 28.9 | 3.4 | 2.8 |
| NT | 34.6 | 5.8 | 5.8 |
| PL | 34.5 | 14.7 | 7.5 |
| PT | 37.1 | 18.2 | 9.3 |
| RO | 19.8 | 9.6 | 8.0 |
| SE | 34.0 | 4.3 | 6.1 |
| SI | 35.3 | 12.4 | 11.5 |
| SK | 29.8 | 12.6 | 10.0 |
| UK | 32.9 | 8.2 | 10.6 |
| NO | 30.8 | 6.3 | 4.3 |

Note: Information for Ireland and Portugal refers to 2011.

Source: Eurostat

The Eurostat data show important differences between countries in relation to health self-perception. The countries with the highest percentages of people who claim these longstanding problems are Finland and Estonia (46.7% and 43.7% of the population, respectively), followed by France, Germany and Portugal (around 37% of the population in all three). In contrast, countries such as Belgium, Greece, Italy and Luxembourg, and especially Bulgaria and Romania, less than 25% of the population complain about these longstanding health problems. Moreover, information from Hungary highlights the existence of important regional differences in the health situation of individuals. According to a [2010 report from KSH \(in Hungarian, 278 KB PDF\)](#), people living in the central, most prosperous regions of the country are healthier and show lower levels of chronic diseases compared with more disadvantaged regions, that is, the South-Transdanubian region.

The available data for 2012 show important differences in how Europeans perceive their own health situation based on gender and age. Focusing on those who with a longstanding illness or health problem (a proxy indicator for chronic diseases), 33.3% of the female EU28 population claimed they had longstanding problems compared with

29.5% of men. As expected, this self-perception of longstanding problems increased with the age of respondents; 10.3% and 13.4% of people aged 16–24 and 25–34 years, respectively, suggested these problems compared with 42.5% and 60.0% among people aged 55–64 years and 65+ years, respectively.

Overall, the Eurostat data show that about a third (31.5%) of the EU28 population aged 16 and over suffered from a longstanding illness or health problem in 2010. This percentage goes down to 23.4% (one in four) when the EU28 population aged 16–64 years is taken into account.

The Eurostat data also show that this self-perception of longstanding problems is inversely related to the level of educational attainment of individuals. For example, 23.9% of the EU28 population with a university educational level, that is, International Standard Classification of Education ([ISCED](#)) levels 5–6, claimed in 2012 to have these health problems compared with 28.3% and 39.7% among ISCED levels 3–4 (upper secondary and post-secondary non-tertiary education) and 0–2 (lower secondary education and below), respectively.

These gender, age and educational patterns are confirmed by national evidence from a large group of countries such as:

- Belgium – the [surveys, lifestyle and chronic diseases programme](#) of the Scientific Institute of Public Health ([WIV-ISP](#));
- Bulgaria – [statistics on the employment of disabled people from the LFS ad hoc module, 2011](#) provided by the National Statistical Institute ([HCH](#));
- Czech Republic – [information on the level of long-term health-related problems \(in Czech, 186 KB PDF\)](#) published in 2012 by the Czech Statistical Office ([ČSU](#));
- Denmark – [statistics from the National Health Profile 2010 \(in Danish\)](#);
- Germany – [facts and figures from a 2010 study \(in German, 18.2 MB PDF\)](#) by the Robert Koch Institute ([RKI](#)) on health in Germany;
- Greece – the results of a health services evaluation survey carried out by the National School of Public Health ([ESDY](#)) in 2011;
- Ireland – data from the [2011 Census](#) compiled by the Central Statistical Office ([CSO](#));
- Poland – a [report \(in Polish, 1.1 MB PDF\)](#) from the Central Statistical Office ([GUS](#)) on people with disabilities in the labour market in 2011;
- Portugal – results from the [National Health Survey 2005–2006 \(in Portuguese, 3.4 MB PDF\)](#) carried out by Statistics Portugal ([INE](#));
- Spain – the report [Analysis of the labour market, working conditions and occupational risks from an age perspective \(in Spanish, 3.7 MB PDF\)](#) published by the National Institute of Safety and Hygiene at the Workplace ([INSHT](#));
- Slovakia – [data \(in Slovakian, 397 KB PDF\)](#) from the EU Survey on Income and Living Conditions (EU-SILC) 2012 compiled by the Slovak Statistical Office ([ŠÚ SR](#)).

In addition, [research \(in Slovenian, 211 KB PDF\)](#) on the prevalence of chronic diseases among the adult Slovene population is highest in pensioners and in those with a lower level of educational attainment, and significantly higher in the population with lower socioeconomic status.

According to a [2010 report on tackling chronic disease in Europe \(750 KB PDF\)](#) from the [European Observatory on Health Systems and Policies](#), the main chronic diseases among the European population are:

- cardiovascular diseases – such as atherosclerosis and stroke (23% of all causes);
- neuropsychiatric conditions – such as depression/schizophrenia, dementia, Parkinson’s disease, Huntington’s disease, multiple sclerosis (20% of all causes);
- cancer (11% of all causes).

Some way behind these three categories come digestive diseases (5% of all causes) and respiratory diseases (asthma/COPD) (5% of all causes), musculoskeletal diseases (4% of all causes) and diabetes (2% of all causes). This preponderance of cardiovascular problems and mental problems, although with some national variations, is confirmed by information coming from national sources (Table 4).

Table 4: Main chronic diseases in selected EU Member States and Norway

| | Main chronic diseases | Source |
|-----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| AT | Musculoskeletal problems (back and leg problems), followed by cardiovascular disorders, migraine/strong headaches, allergic reactions and respiratory problems | 2011 data from Statistics Austria (in German) |
| BG | Heart problems, blood pressure or blood circulation; musculoskeletal disorders; cancer; digestive problems; mental diseases | HCI statistics 2011 |
| CY | Heart, blood pressure, circulatory and brain problems; lower and upper limb problems; mental, neurological or psychological problems | Cypriot Statistical Service report 2006 (in Greek, 1.6 MB PDF) |
| CZ | Diseases related to heart and circulation system; musculoskeletal disorders (problems with back or neck, upper or lower limb problems); cancer | ČSÚ report 2012 (in Czech, 186 KB PDF) |
| EL | Heart, blood pressure or circulation problems; musculoskeletal disorders (back/neck, legs/feet problems); mental problems; cancer; digestive problems | National Health Interview Survey 2009 (407 KB PDF) |
| ES | Heart, blood pressure or circulation problems; musculoskeletal disorders; breathing problems (including asthma and bronchitis); diabetes; cancer; digestive problems; depression | INE data on health problems and their bearing on employment, 2011 |
| FI | Mental diseases; cardiovascular and neurological diseases and neoplasms; musculoskeletal diseases | 2011 report from Finnish National Institute for Health and Welfare (in Finnish) |
| LV | Cardiovascular diseases; chronic respiratory diseases; cancer; diabetes; psychological disorders | Statistical yearbook of health care in Latvia 2010 (137 KB PDF) |
| NO | Cardiovascular disease, cancer, mental health problems, diabetes, lung disease and | Health state of Norway 2010 |

Table 4: Main chronic diseases in selected EU Member States and Norway

| | Main chronic diseases | Source |
|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| | musculoskeletal diseases | (in Norwegian, 10.4 MB PDF) |
| PT | High blood pressure, rheumatic disease and chronic pain were the most prevalent chronic diseases followed by depression, diabetes and cancer. | National Health Survey 2005–2006 (in Portuguese, 3.4 MB PDF) |

Source: National contributions

The sources mentioned previously also suggest that the presence of these diseases varies according to age and gender. According to [2011 data from Statistics Austria \(in German\)](#), depression, cardiovascular disease and cancer are usually more prevalent among older people, whereas asthma is more prevalent among younger people. Musculoskeletal problems, depression and chronic anxiety, and cancer are more prevalent among women, whereas diabetes and cardiovascular diseases are more present among men.

According to a [2011 survey on people with disabilities in the labour market \(in Hungarian, 297 KB PDF\)](#) from KSH and an [analysis of LFS data \(3.2 MB PDF\)](#) for the UK Health and Safety Executive ([HSE](#)) published in 2013, about half those affected by chronic diseases suffer from at least two different kinds of diseases and around a quarter of those with a longstanding problem have three or more problems. According to [INE 2011 data on health problems and their bearing on employment](#), in the case of Spain three out of four people aged between 45 and 64 years suffered more than one chronic illness.

The available evidence also shows that there is an increasing percentage of people with longstanding health difficulties. In this sense, Eurostat data show that the percentage of people claiming to have a longstanding illness or health problem increased from 30.7% of the total EU27 population in 2005 to 31.5% in 2012. This trend, confirmed by a large set of national studies, is explained by several factors including a growing life expectancy, the ageing of the European population and the presence of unhealthy lifestyles (especially among the people with lower income and levels of educational attainment). These national studies include:

- Belgium – [Health Interview Survey 2013](#) and previous years;
- Czech Republic – [European survey on health in the Czech Republic EHIS 2008 \(in Czech\)](#);
- Denmark – [2007 public health report \(in Danish, 1.2 MB PDF\)](#) by the [Danish National Institute of Public Health](#);
- Norway – [public health report in Norway in 2010 \(in Norwegian, 10.4 MB PDF\)](#) by the Norwegian Institute of Public Health ([FHI](#));
- Portugal – [Portuguese national health plan 2012–2016 \(in Portuguese, 1.3 MB PDF\)](#).

Some literature suggests that the economic crisis that began in 2008 is having an effect on the health conditions of the European population. A [2011 report \(in Danish, 209 KB PDF\)](#) by the National Research Centre for the Working Environment ([NFA](#)) concludes that those workers affected by a high degree of job insecurity are at increased risk of

experiencing poor self-rated health and developing depression. This effect was found to be stronger among those employees who had previously experienced unemployment or who were aged over 50 years and who feared they would not be able to find a new job.

Another result of the economic crisis, which is discussed in a [report on healthcare policy in Latvia \(in Latvian, 995 KB PDF\)](#), is a deterioration in the provision of healthcare services (lack of screening programmes, long waiting lists) which in turn leads to added difficulties for those affected by chronic diseases. Recent [Greek research published by ESDY in 2013 \(in Greek, 844 KB PDF\)](#), which examined the effects of the crisis on patients suffering from several chronic diseases, found that:

- up to 64% of those suffering from chronic diseases faced difficulties in accessing a doctor and medical services due to financial/income-related limitations;
- 60% experienced longer waiting lists.

It was therefore concluded that the provision of primary healthcare was worse than three years before.

Employment situation of people with chronic diseases

Negative employment situation

The participation of those with chronic diseases in the European labour market can be labelled as problematic as they have a high risk of unemployment and inactivity, and fewer opportunities to have a job. According to [Eurostat data for 2012](#), 20.1% of those in the EU28 who were employed claimed to have a longstanding illness or health problem; this percentage increased to 26.4% for those who were unemployed, 58.2% who were retired and 31.5% among those in other inactive situations.

This negative situation is found in all Member States and Norway, though the presence of people with longstanding illness or health problems who are employed appears to be much higher in some countries (Estonia, Finland, France, Germany and Sweden) compared with others (Bulgaria, Greece and Romania) (see Table 5). Once again, Eurostat data suggest a higher presence of longstanding illness or health problem among employed women (21.5%) than among their male counterparts (19.0%), as well as a clear influence of the age variable (10.2% and 12.0% among people aged 16–24 and 25–34 years, respectively, compared with 24.2% and 33.3% among people aged 45–54 and 55–64 years, also respectively).

| | Employment status | | | |
|-------------|--------------------------|-------------------|----------------|---------------------------------|
| | Employed | Unemployed | Retired | Other inactive situation |
| EU28 | 20.1 | 26.4 | 58.2 | 31.5 |
| AT | 23.1 | 46.2 | 55.1 | 27.7 |
| BE | 14.2 | 26.2 | 40.0 | 31.0 |
| BG | 7.3 | 7.9 | 43.5 | 16.5 |

| | Employment status | | | |
|-----------|--------------------------|-------------------|----------------|---------------------------------|
| | Employed | Unemployed | Retired | Other inactive situation |
| CY | 22.7 | 21.5 | 79.0 | 25.0 |
| CZ | 15.7 | 31.9 | 54.1 | 30.5 |
| DE | 25.7 | 52.6 | 63.7 | 29.2 |
| DK | 19.8 | 36.7 | 40.8 | 38.8 |
| EE | 31.0 | 32.4 | 81.8 | 38.4 |
| EL | 8.8 | 12.0 | 54.2 | 24.3 |
| ES | 14.3 | 18.9 | 53.5 | 35.7 |
| FI | 34.1 | 50.4 | 74.1 | 44.2 |
| FR | 26.2 | 32.2 | 60.0 | 30.5 |
| HR | 10.6 | 15.1 | 61.6 | 21.5 |
| HU | 19.6 | 26.9 | 69.5 | 34.6 |
| IE | 14.6 | 21.4 | 52.5 | 37.2 |
| IT | 13.7 | 14.0 | 49.3 | 26.2 |
| LT | 11.9 | 20.8 | 66.8 | 29.8 |
| LU | 13.7 | 30.1 | 34.9 | 23.8 |
| LV | 20.5 | 29.1 | 72.4 | 27.6 |
| MT | 13.9 | 19.0 | 62.4 | 35.9 |
| NL | 24.0 | 61.5 | 52.0 | 39.7 |
| PL | 19.7 | 23.3 | 66.6 | 40.5 |
| PT | 21.9 | 30.5 | 66.1 | 42.0 |
| RO | 5.1 | 7.9 | 54.8 | 12.0 |
| SE | 28.2 | 36.2 | 49.5 | 31.1 |
| SI | 22.1 | 40.8 | 62.7 | 22.0 |
| SK | 17.4 | 23.1 | 63.7 | 25.0 |
| UK | 22.4 | 29.1 | 60.0 | 39.1 |
| NO | 23.8 | 45.9 | 39.7 | 46.5 |

Source: Eurostat

This negative employment situation of the ‘chronic group’ is confirmed by much national evidence. According to a [report \(in Dutch\)](#) from the Flemish Agency for Disabled Persons ([VAPH](#)), only 7.3% of the employed population in Belgium has a chronic disease compared with 15% of the unemployed and 31% among the total group of non-active people; two-thirds of non-working people indicated that their chronic disease or disability troubled them too much to have a paid job. Meanwhile, in Denmark [statistics from the National Health Profile 2010 \(in Danish\)](#) show that chronic diseases were more prevalent among respondents who had taken early retirement (36.8%) and old age pensioners (47.1%) than those who were unemployed (37.6%) or employed (25.1%). [Employment statistics for 2012 \(in Portuguese\)](#) from INE show that 73.2% of retired people in Portugal were affected by chronic diseases compared with 40.6% and 37.1% among unemployed and employed people, respectively. Similar differences can also be appreciated in:

- Croatia – [2013 study \(in Croatian, 1.3 MB PDF\)](#) for the Croatian Employment Service ([HZZ](#));
- France – [research by Saliba and co-workers published in 2007](#);
- Italy – [2011 statistics \(in Italian, 685 KB PDF\)](#) published by the National Institute of Statistics ([Istat](#));
- Romania – a [2011 report \(in Romanian, 227 KB PDF\)](#) issued by the National Institute of Statistics ([INS](#)).

This negative employment situation among individuals affected by chronic/long-term diseases is also reflected when the employment rate indicator is taken into consideration. [Austrian statistics \(in German\)](#) show that the employment rate of people with health impairments in 2011 was significantly below that of non-impaired individuals (67.2% versus 75.8%, respectively). In Belgium, an [SVR study \(in Dutch\)](#) found that the unemployment rate for people with chronic diseases in 2012 was 31.4% compared with 58.6% for healthy people, whereas the corresponding [figures for 2011](#) from Statistics Estonia ([Statistikaamet](#)) were 42.4% and 71.7%, respectively. In the Czech Republic, [data from the Labour Force Sample Survey 2012](#) released by ČSÚ showed that the employment rate of those with health-related disadvantages (17.1%) was more than three times lower than in the case of those without health-related problems (57.2%). According to Poland’s [Yearbook of Labour Statistics 2012](#) published by GUS and Slovakia’s [Labour Force Sample Survey for the second quarter of 2013 \(in Slovakian, 4.7 MB PDF\)](#) published by ŠÚ SR, these differences are three to five times higher among the total working population in Poland and Slovakia.

In contrast, unemployment and especially inactivity situations are much more acute among people affected by longstanding, chronic health problems. Focusing on those who want to work but are not able to find a job (unemployed), data from national sources such as [Statistics Estonia for 2011](#) and a [2012 report \(in Slovakian, 1.6 MB PDF\)](#) from the Institute for Labour and Family Research ([SŠPR](#)) show that unemployment rates for ‘chronic’ workers are typically double those of the average population.

The largest proportion of people with chronic diseases is typically outside the labour market in inactivity situations such as early retirement or in receipt of a disability pension. Thus, according to a [2010 report \(in Dutch, 2.3 MB PDF\)](#) from Belgium by VDAB, [statistics on the employment of disabled people from the LFS ad hoc module 2011](#) provided by [HCU](#) in Bulgaria, [data from the National Health Survey 2011–2012](#)

in Spain or the [results of the life opportunities survey](#) issued by the [Office for Disability Issues](#) in the UK, more than half of chronically ill persons of working age are not active in the labour market. Also in the UK, according to a [2013 factsheet from the Papworth Trust](#), disabled young people are more likely not to be in any form of education, employment or training (NEET) than their non-disabled peers (22% compared with 15%). This limited access to the labour market has a direct impact on the well-being of people with health problems. According to a [2012 report from OECD](#), around a quarter of this group lives below the poverty level.

Uneven employment paths for workers with chronic illness

The comparatively worse labour market situation of those affected by chronic and longstanding health problems discussed in the previous section is explained by a relatively quick transition from employment to unemployment/inactivity situations. Thus, a recent [Danish return-to-work project by NFA \(in Danish, 5.3 MB PDF\)](#) found that only half of those employees who went on the sick list due to a serious or long-term disease was still in employment after nine months. Similar higher flows to unemployment/non activity were also reported in a [2010 report \(in Dutch, 2.3 MB PDF\)](#) from Belgium by VDAB.

In the Netherlands, workers with a chronic disease face more difficulties in remaining in employment compared with the average population, as measured in terms of lower percentages remaining in employment one year later according to data from the [ad hoc module to measure chronic disease in the 2012 wave of the Netherlands Working Conditions Survey \(NWCS\)](#). [Findings from the Life Opportunities Survey in 2009–2010](#) by the Office for National Statistics (ONS) revealed that 80% of all those who became disabled were in employment at the time they acquired the disability, 60% were employed the following year and only 36% the year after that; the percentage of long-term unemployed was also higher for this group.

In contrast, the transition from inactivity/unemployment to employment seems to be particularly complicated for those affected by long-term and chronic diseases. For instance, [Austrian statistics \(in German\)](#) from 2011 show that those affected by chronic diseases more frequently suffer long-term unemployment than those with no health impairment; 43% of all health-impaired unemployed were long-term unemployed, whereas the rate was around 15% among those unemployed with no problematic health condition. Meanwhile, [data from the ad hoc module of the NWCS 2012 wave](#) found that only 8% of those unemployed with a chronic disease in the Netherlands were in employment one year later compared with 17% among those workers without a chronic disease. This was despite the fact that, as confirmed by [Maltese research based on 2011 Census data](#) for the National Commission for the Disabled (KNPD), the majority of them are ready to commence work should the opportunity arise.

According to the [Life Opportunities Survey in 2009–2010](#) carried out by ONS, the average annual rate of disabled people in the UK making the transition from economic inactivity to employment was 4%, while the equivalent figure for non-disabled people was six times higher. It is therefore not surprising that 43% of the British disabled population considered that the main barrier they faced was a lack of job opportunities.

Main reasons for uneven employment paths

These uneven employment transition paths can be explained by several specific difficulties experienced both by enterprises recruiting people with chronic diseases and by such workers when trying to obtain a job.

From an enterprise perspective, the available literature identifies a number of reasons suggested by enterprises that explain their reluctance to hire people with longstanding health difficulties and chronic diseases. Thus a [2006 report \(1.0 MB PDF\)](#) published by the Department for Work and Pensions (DWP) in the UK and Slovak research (Pavlíková and Kondášová, 2002) show that employers often believe that people with longstanding problems are less productive and impose additional costs on the enterprise. However, Irish research conducted in the healthcare, retail and hospitality sectors found little difference in overall job performance between employees with a disability and those without (Hernandez and McDonald, 2010). Meanwhile, [SCB statistics \(in Swedish, 2.2 MB PDF\)](#) show that Swedish employers are particularly concerned about the financial responsibilities that long-term sick leave causes their company, either in terms of paid wages during the absence (Swedish employers pay the wage for the first two weeks of sick leave) or legal obligations to facilitate the return to work including workplace adaptation requirements and limitations on firing people with these problems. Similar results are found in a [report on healthcare policy \(in Latvian, 995 KB PDF\)](#) from Latvia and a [report on the attitudes of employers to people with disabilities and visual impairment \(in Slovakian, 789 KB PDF\)](#) from Slovakia. [Research on people affected by multiple sclerosis \(in Hungarian, 105 KB PDF\)](#) shows that Hungarian employers have a poor understanding of the disease and the possibilities of those affected by it to continue working, and so they often prefer to terminate their contracts. In contrast, the [data from the ad hoc module of the NWCS 2012 wave](#) found that up to 14% of Dutch enterprises questioned had consciously hired ‘fragile workers’ (including workers with chronic health problems), with 3.8% of enterprises stating that this is an explicit part of their strategy. A [2012 report \(in Danish\)](#) from the Danish National Centre for Social Research (SFI) showed that employees are usually in favour of such active strategies from their companies; 68% of respondents had a positive attitude towards their company initiating special working arrangements for employees on long-term sickness absence and 66% had a positive attitude towards their employer hiring people with longstanding health problems.

From a worker’s perspective, the limitations they experience in their daily capacities have a negative influence on their full access to normal, full-time jobs outside the home. [Czech data from the LFS 2012](#) and [French research on living and working with a chronic disease \(in French\)](#) show that workers with long-term health-related problems were not only twice as likely to interrupt their working activity due to a health-related problem but also more likely to have longer periods of incapacity than people with no health problems. In Greece, a [2011 LFS survey ad hoc module on the employment of disabled people](#) carried by the Hellenic Statistical Authority (EL.STAT) reported that 40.9% of those with longstanding health problems stated that they could only work for a limited number of hours, 41.4% stated there were limitations in the type of work they could do and 20.1% stated there were limitations concerning their journey to and from work. The Estonian LFS ad hoc module in 2011 found that 29% of people with chronic diseases considered their employment possibilities were limited due to the lack of a suitable job, 10% due to transportation issues and 8% due to lack of autonomy or flexibility in work arrangements.

According to [employment statistics for 2012 \(in Portuguese\)](#) from INE, workers with chronic diseases suggested that the main barriers to staying in the labour market were related to the type of work they could perform (38.3% of workers), followed by the number of working hours per week (32.1%) and difficulties related to mobility (16.2%). For Spain, [INE statistics for 2011](#) gave similar percentages of 33.4%, 23.2% and 12.9%, respectively. It is not therefore strange that [research \(1.2 MB PDF\)](#) by the [Equality Authority](#) and the Economic and Social Research Institute ([ESRI](#)) reported that 66% of men and 42% of women with a disability in Ireland found their disability ‘considerably/severely’ restricted their participation in the labour force; in Hungary, this percentage goes up to 62.4% in a [2011 survey on people with disabilities in the labour market \(in Hungarian, 297 KB PDF\)](#).

Given these barriers, workers affected by longstanding health problems and chronic diseases require individualised solutions, ranging from individualised work paces to individualised work assignments. For instance, according to [Portuguese statistics for 2012 \(in Portuguese\)](#) and [Spanish statistics for 2011](#), around 8% of workers with chronic diseases argue that they need special equipment and/or new workplaces to carry out their work. This percentage goes up to 10.9% in Poland according to [Polish statistics from GUS for 2011 \(in Polish, 1.1 MB PDF\)](#).

Impact of extent and type of disease

A number of elements influence the transitions of people with chronic diseases between employment, unemployment and inactivity situations including:

- the extent and type of the chronic disease;
- the age of the individual affected by a longstanding chronic disease.

Having a longstanding illness or health problem does not necessarily limit the activities individuals can do. According to [Eurostat statistics for 2012](#), 8.9% of EU28 individuals self-perceive longstanding ‘severe’ limitations in usual activities due to a health problem (compared with 31.5% who have a longstanding illness or health problem), though this percentage is directly related to the labour status of the respondents (2.6% among employed, 7.4% among unemployed, 19.1% among retired and 13.8% among other inactive people).

[Recent Belgian research \(in Dutch\)](#) from the Social and Economic Council of Flanders ([SERV](#)) which compared the workability for persons with and without chronic diseases found that 41.9% of those employees without a chronic disease reported at least one workability problem. This percentage went up to 58.7% for those employees with a moderate chronic disease and to 78% for those with a serious chronic disease. In the Czech Republic, [data from the LFS 2012](#) show that people with the highest level of disability worked only in 4.1% of cases, whereas those with lower levels of disability or health-related disadvantages worked in 44.9% of cases. In Italy, a [2008 report \(in Italian, 2.1 MB PDF\)](#) by the National Association of Rheumatic Patients ([ANMAR](#)) found that 22.7% of those employed affected by arthritis had to change their work habits or stop working; this proportion increased with the number of years they had suffered from this disease (from 17.9% among those coping with it for less than two years to 30.1% among those dealing with it for more than 10 years).

Regarding the effects of the type of disease on permanence in employment, evidence from several countries shows that employment rates are particularly poor for those with

learning disabilities and especially mental health problems (less than 20%), whereas the highest employment rates (above 50%) are for those with diabetes, skin conditions or chest/breathing problems (including allergies). This evidence comes from:

- Belgium – a [report \(in Dutch\)](#) published by VAPH in 2012 and updated in 2014;
- Ireland – [research \(1.2 MB PDF\)](#) by the Equality Authority and ESRI;
- Malta – a [2011 report \(943 KB PDF\)](#) by the [Richmond Foundation](#) on the assessment of the impact of mental health on employment;
- UK – the DWP’s [life opportunities survey](#).

According to [official statistics from Luxembourg \(in French\)](#), employment rates in 2012 were relatively high for people suffering from migraine attacks (74%), digestive or kidney problems (72%) and for people having back or neck problems (69%), whereas they were significantly lower for people suffering from cancer (41%) or depression (48%). [Evidence from Austrian statistics \(in German\)](#) shows that the proportion of employed persons in 2011 was especially low among those with a mental health impairment (around 30%) compared with those with other health impairments such as skin or back problems (68%). Similarly, a [report from 2013 \(in Danish\)](#) from the Appeals Board (Ankestyrelsen) confirms that mental disorders (most often stress, depression and anxiety) are particularly associated with becoming permanently disabled from work. A [2007 report \(in Slovakian, 553 KB PDF\)](#) from Slovakia and a [2012 report \(in Swedish, 1.3 MB PDF\)](#) from Sweden suggest that enterprises usually anticipate more problems with those affected by mental and behavioural disorders than with those who have physical disabilities. [Data from the Irish 2011 Census](#) suggest that adults at work with hearing or breathing problems usually work more often on a full-time basis than people with mental or vision difficulties.

It could be argued that the results detailed above are strongly influenced by age considerations. Available Eurostat data (Table 6) show that:

- the percentage of inactive individuals who report having a longstanding health problem increases with the age of respondents;
- this percentage is always higher than those among people who are unemployed and (especially) employed in the same age group.

This suggests that the ‘age–health status’ is one of the most important factors in deciding whether to continue working or to retire from the active labour market.

Table 6: People with a longstanding illness or health problem, by age and labour status, 2012 (%)

| | Age 16–24 | Age 25–34 | Age 35–44 | Age 45–54 | Age 55–64 |
|-------------------------------|-----------|-----------|-----------|-----------|-----------|
| Employed persons | 10.2 | 12.0 | 16.0 | 24.2 | 33.3 |
| Unemployed persons | 10.5 | 14.8 | 23.3 | 37.4 | 47.0 |
| Retired persons | n/a | 92.6 | 70.5 | 57.0 | 47.1 |
| Other inactive persons | 10.4 | 18.7 | 34.2 | 50.3 | 60.2 |

Source: Eurostat, 2013

Similar results are found in the following studies:

- Austria – [statistics for 2011 \(in German\)](#);
- Belgium – a [report on absenteeism in Belgium in 2013 \(in Dutch\)](#) compiled by [SDWorx](#);
- Czech Republic – [statistics published in 2011 by the Ministry of Labour and Social Affairs \(in Czech, 4.4 MB PDF\)](#);
- Slovakia – [a 2011 report from the Slovak Disability Council \(in Slovak, 661 KB PDF\)](#).

In the case of Austria, while the employment rates of those with a health impairment and those with none were about the same among 15–24 year-olds, the difference was 2.8 percentage points among 25–34 year-olds, 6.2 percentage points among 35–44 year-olds and 9.7 percentage points among 45–54 year-olds.

Influence of the economic crisis

Some national reports suggest that the economic crisis which began in 2008 is also having a significant impact on the employment situation of those affected by longstanding health problems and chronic diseases. This is reflected in deteriorating employment opportunities and an increase in unemployment and inactivity levels.

[Evidence \(in Dutch\)](#) from the Flemish Public Employment Service ([VDAB](#)) and figures from GUS in Poland show an increase in the number of unemployed people with a chronic disease or disability between 2008 and 2011, that is, precisely the period more affected by the crisis. Similarly, in Sweden, the crisis doubled the number of unemployed people with limited working abilities due to health issues in 2013 compared with 2008 according to a [2013 article \(in Swedish\)](#) in the magazine *Svensk Handikaptidskrift*. In contrast, a [2012 report \(in Slovakian, 1.6 MB PDF\)](#) from [SŠPR](#) shows that active public involvement (via European and national resources) in the support to those with limited working abilities has resulted in the maintenance of the employment situation of this group.

Uneven distribution of workers among job categories and sectors

Greater presence among less skilled groups and manual occupations

A large amount of available evidence shows that those workers in less skilled, manual occupations have a higher presence of chronic diseases than highly skilled, high-level groups.

[Austrian research from 2011 \(in German\)](#) shows that unskilled labour and employees engaged in manual work are more frequently affected by chronic health issues and health impairments than white-collar workers, especially compared with academic and comparable occupations, managers and office workers. A [report \(in Dutch\)](#) published by VAPH in 2012 and updated in 2014 shows that the percentage of blue-collar workers in Belgium with longstanding health problems (10.5%) was almost twice that for white-collar workers (5.5%). Meanwhile, elementary occupations (such as production workers) had the highest percentage of employees with a chronic disease (15%), up to three times more than highly skilled employees and nearly five times more than managers. Similarly, [2006 statistics \(in Greek, 1.6 MB PDF\)](#) from the [Cypriot Statistical Service \(CyStat\)](#) show that continuous health problems were more prevalent among blue-collar workers and farmers, especially compared with other groups such as teaching staff or scientific/specialised staff. [Croatian research \(in Croatian, 3.9 MB](#)

[PDF](#)) by HZZ on the education and employment of people with disabilities stresses that the low educational attainments of many people with chronic diseases has a negative influence on the possibilities of them finding a job.

In the Czech Republic, [data from the LFS 2012](#) show that the highest proportion of workers with chronic diseases was identified in manual and physically demanding professions, particularly among elementary workers, International Standard Classification of Occupations (ISCO) category 9, of which a quarter suffered from chronic diseases. According to [data for 2013](#) from Statistics Estonia and [Maltese research for KNPD based on 2011 Census data](#), working people with chronic diseases were two times more likely to work in elementary occupations than people without chronic diseases, whereas a contrary relationship could be identified among managers (ISCO category 1).

According to the FIOH survey [Work and health in Finland 2012 \(in Finnish\)](#), a chronic disease diagnosed by a doctor and that interfered with work was most common among farmers and skilled agricultural, forestry and fishery workers (17%) in Finland, whereas the corresponding percentages were 10% among upper white-collar workers, 13% among lower white-collar workers and 15% among blue-collar workers. The [2011 LFS survey ad hoc module on the employment of disabled people](#) carried by EL.STAT found that, whereas 12.9% of Greek farmers, cattle breeders, foresters and fishermen and 9.8% of blue-collar workers had longstanding health problems caused or worsened by their work, only 3.3% of office employees and 3.2% of scientific, artistic and similar professionals believed this applied to them. In Ireland, [research by the CSO based on 2011 Census data \(3.8 MB\)](#) found that the occupations with the highest presence of people affected by chronic diseases included agricultural workers, personal care and service occupations, transport and mobile machine drivers and operators and, finally, elementary trades and related occupations. In the Italian region of Piedmont, some professions and occupations such as wood carpenters, miners, ceramics workers, construction workers and road pavers particularly reported having at least two chronic diseases, according to [research published in 2005 \(in Italian, 112 KB PDF\)](#). In the UK, [analysis of LFS data \(3.2 MB PDF\)](#) for the HSE published in 2013 shows that people with work-limiting, health-related conditions were more likely to work in lower level and manual occupations, usually linked to low-paid and low-skilled working conditions. Similar occupational patterns can be identified in:

- France – [research by Saliba and co-workers published in 2007](#);
- Luxembourg – [official statistics from Luxembourg \(in French\)](#) for 2012;
- Norway – [Health conditions in Norway 2010 \(in Norwegian, 10.4 MB PDF\)](#);
- Poland – [Yearbook of Labour Statistics 2012](#) published by GUS;
- Portugal – [Employment statistics for 2012 \(in Portuguese\)](#).

A [report on absenteeism in Belgium in 2013 \(in Dutch\)](#) suggests that one explanation for the higher rate of chronic diseases among less skilled/blue-collar workers is the limited job variation, higher physical workload and higher risk of accidents at work that characterise these types of occupations and jobs.

The key role that occupations play in the incidence of chronic diseases is why some sectors have a higher presence of workers affected by long-term chronic diseases. According to evidence from a number of countries (Austria, Belgium, Bulgaria and Slovakia), these sectors are typically agricultural/forestry/fishing and industrial

activities, as well as tertiary subsectors such as social work services, transport and household employment. Such evidence includes:

- Belgium – [report on absenteeism in Belgium in 2013 \(in Dutch\)](#) compiled by SDWorx3;
- Bulgaria – [data from the LFS ad hoc module in 2011 on employment of people with disabilities \(in Bulgarian\)](#) from HCI;
- Slovakia – [LFS results for the fourth quarter of 2011 \(5.2 MB PDF\)](#) published by ŠÚ SR and including the ad hoc module on the employment of people with disabilities.

For example, [2011 data from Statistics Austria \(in German\)](#) suggest that 57.5% of all employed persons in the agricultural sector are affected by chronic diseases, with musculoskeletal problems ranked first.

[Research by the CSO based on 2011 Census data \(3.8 MB\)](#) shows that, in Ireland, the sectors with a higher presence of people affected by chronic diseases are in the order:

- healthcare and social work;
- agriculture, forestry and fishing;
- industry;
- education;
- transportation.

Greater presence in some occupations and economic sectors

Existing evidence shows that the most common longstanding health problems among the employed population are musculoskeletal disorders, followed by mental disorders and circulatory problems.

For instance, a [2013 report \(in Danish\)](#) from the Appeals Board found that mental disorders (48%) and musculoskeletal problems (19%) accounted for the largest proportion of sickness absence and disability pensioning in the last quarter of 2010, whereas other diseases related to eczema, migraine or respiratory problems affected a smaller percentage of people.

[Employment statistics for 2012 \(in Portuguese\)](#) showed that 35.8% of those employed who suffered from health problems identified musculoskeletal diseases as the main health problem, followed by heart, high blood pressure and blood circulation problems (11.8% of respondents).

[Data from the National Health Survey 2011–2012](#) in Spain show that the most recurrent chronic illnesses among workers were lumbar backache (affecting 14.6% of all workers, 2.5 million workers in total), high cholesterol (12.6%, 2.2 million workers in total) and cervical backache (12.2%, 2.1 million workers in total).

A similar importance of musculoskeletal problems as the most prevalent chronic diseases interfering with work was found in Finland according to [Work and health in Finland 2012 \(in Finnish\)](#) and in the Netherlands according to [data from the ad hoc module of the 2012 wave of the NWCS](#).

The empirical evidence also shows a positive relationship between some chronic diseases and some occupations and economic sectors. Thus, as far as musculoskeletal chronic problems are concerned, evidence from several countries shows that these

problems seem to be more frequent among agricultural/forestry/fishery, industrial, construction, and social and healthcare industry workers, that is, in general sectors with a high physical load. Such evidence comes from:

- Austria – [2011 data from Statistics Austria \(in German\)](#);
- Denmark – [2007 public health report \(in Danish, 1.2 MB PDF\)](#);
- Hungary – [a peer review by Imre and co-workers \(in Hungarian, 624 KB PDF\) in 2011 of cases of increased exposure to occupational diseases](#);
- Poland – [Yearbook of Labour Statistics 2012](#) published by GUS.

According to an [analysis of LFS data \(3.2 MB PDF\)](#) for the HSE in the UK, manual handling, awkward or tiring positions and keyboard work are usually at the root of these problems.

As far as heart, blood pressure or circulatory problems are concerned, [information on the level of long-term health-related problems \(in Czech, 186 KB PDF\)](#) published in 2012 by ČSÚ, [data from the ad hoc module of the 2012 wave of the NWCS](#) in the Netherlands and a [report \(in Polish, 1.1 MB PDF\)](#) from GUS on people with disabilities in the labour market in 2011 show that managers are the category of the working population that suffers most from these diseases, followed by technicians, associate professionals and clerical support workers.

A [2011 report \(943 KB PDF\)](#) by the Richmond Foundation and research by Rugulies et al (2010) shows that depression, anxiety and other mental diseases are more frequent among unskilled blue-collar workers, health and community work employees, construction, education and public administration workers. Tight deadlines, together with long working hours, unreasonable quotas, insufficient staff numbers, high levels of responsibility or bullying are explanatory factors for this type of disease, according to [analysis of LFS data \(3.2 MB PDF\)](#) for the HSE in the UK and a [2011 report on occupational health and safety in Malta \(7.7 MB PDF\)](#) for the Maltese Occupational Health & Safety Authority (OHSa).

A [2007 report on asthma and COPD in the adult population in western Norway \(in Norwegian, 729 KB PDF\)](#), shows workers in the smelting, metalwork, wood processing, mining and tunnelling sectors are particularly affected by these problems, as well as people working in hairdressing, painting and cleaning.

A number of studies have established a link between occupations and the presence of certain chronic diseases. A [2008 report \(in German, 1.2 MB PDF\)](#) for the Federal Institute for Occupational Safety and Health (BauA) on the health situation of truck and bus drivers found a number of health problems in this group, namely diseases affecting the circulatory system (heart attack, ischemic heart diseases, high blood pressure and strokes) and diseases affecting the musculoskeletal system (back pains, herniated disks). In Lithuania, a study found that 32% of hairdressers suffered adverse skin effects from the exposure to products used to perform work tasks, with 31.3% reporting acute effects and 18.8% chronic effects (Vilnius University Hospital and Faculty of Medicine of the Vilnius University, 2011).

A [2008 report \(in Spanish, 4.1 MB PDF\)](#) for INSHT found that workers in the Spanish agriculture sector were particularly exposed to musculoskeletal problems (lumbar or cervical backache, among others) as a consequence of their work. A [2010 report \(in Spanish, 2.5 MB PDF\)](#) by the Foundation for the Prevention of Occupational Risks (MCA-UGT) on blue-collar workers in the stone sector showed that these workers were particularly affected by the risk of lung or respiratory diseases (such as chronic silicosis)

and chronic dermatitis after long contact with some stones, as well as with the risk of developing chronic musculoskeletal problems derived from weight manipulation. [Research published in 2007 \(in Spanish, 267 KB PDF\)](#) found that wood sector workers were prone to developing cancer and other chronic diseases affecting the skin or the lungs and the respiratory system.

However, [German research published in 2012 \(in German, 376 KB PDF\)](#) argues that, even if the evidence seems to point to a link between a higher prevalence of chronic diseases in some sectors and occupations and the corresponding working conditions, it is hard to distinguish between occupational factors and lifestyle factors leading to longstanding health problems given that many of these illnesses are caused by harmful individual habits such as smoking, an unhealthy diet or being overweight.

Working conditions of people affected by chronic diseases

Adaption of specific work stations

Workers affected by long-term health difficulties and chronic diseases experience serious time and mobility limitations in their working capacities. These affect the type of work they can do. The question is to what degree do enterprises facilitate the adaption of working contents and environment to the specific needs of these people?

Looking at [2011 data from Statistics Austria \(in German\)](#), typical measures applied by enterprises include providing a job with primarily sedentary activities, reduced hours, and the option of some kind of flexible working time or telework. In Belgium, a [report \(in Dutch\)](#) published by VAPH in 2012 and updated in 2014 states the most preferred measures used by enterprises to support people with longstanding health problems include adaption of working tasks, adaption of the quantity of work and adaption of work equipment. Meanwhile, a [report on the attitudes of employers to people with disabilities and visual impairment \(in Slovakian, 789 KB PDF\)](#) from Slovakia and [SCB statistics \(in Swedish, 2.22 MB PDF\)](#) from Sweden show that the majority of employers tend to offer those employees who experience a worsening in their health status a new job position and related necessary training rather than an adjustment of the original workplace and career position. In the UK, a [2013 report \(1.1 MB PDF\)](#) from the [Work Foundation](#) on the life and employment opportunities of young people with chronic conditions found that the most typical forms of support include adaptation of working hours and patterns. The same conclusion was reached in Italy in a [report with data from 2011](#) issued by the National Institute of Statistics ([Istat](#)).

However, the available information also shows that not everybody who needs to be supported is actually supported. This is despite the fact that national legislation often gives the right to a reasonable adaptation of the workplace and contents. Thus, in the case of Belgium, the support provided by enterprises to people with longstanding health problems and chronic diseases is lower than the levels requested by workers themselves, according to a [report \(in Dutch\)](#) published by VAPH in 2012 and updated in 2014; for instance, 53% and 38% of the Belgian workers with chronic diseases had asked for an adaptation of tasks and quantity of work, respectively, although only 34% and 25% of them effectively obtained this type of support. In the Czech Republic, [data from the LFS 2012](#) show that 27.6% of workers affected by longstanding diseases have a special need to adjust their working activity, but only 11.4% of them actually obtain these adjustments (such as flexible working hours and less physically demanding tasks). The data also show that only a very low proportion of working persons with chronic diseases

use special equipment or workplace arrangement, clearly below the percentage of people who identify a need for these special tools (11.4% compared to 27.6%, respectively).

In Cyprus, [2006 statistics \(in Greek, 1.6 MB PDF\)](#) from CyStat show that the percentage of working people affected by longstanding health problems who are provided with some form of assistance in performing their work is very low (only 4.1%), though the survey does not specify the type of assistance. A study on [health conditions in Norway 2010 \(in Norwegian, 10.4 MB PDF\)](#) found that one out of two employees who report limitations with regard to what tasks they can perform had seen adaptation in their employment situation in terms of involvement in other working tasks, changed working hours and physical arrangements or a combination of these measures. However, one in five of those who had not had their employment situation adapted had argued there was a need for such an adjustment.

In Romania, a [2011 report \(in Romanian, 227 KB PDF\)](#) issued by INS showed that only 30% of those employed affected by longstanding health problems received special health assistance from their employer to perform their professional duties; the majority of them (72.3%) received personal assistance, 47.7% benefited from special conditions at the workplace and 9.5% had special equipment and/or special adjustment to the workstation. Similarly in the UK, a [2013 report \(1.1 MB PDF\)](#) from the Work Foundation shows that slightly less than half (49%) of employees with longstanding health impairments reported no workplace adjustments had been discussed or offered by their employer, despite a legal obligation to do so.

In contrast, other countries show more positive involvement of employers in relation to adaptation efforts. A [2012 report \(in Danish\)](#) from [SFI](#) shows that 42% of Danish companies employed at least one person with a longstanding health problem in 2012. In separate [research by NFA \(in Danish\)](#), only 17% of Danish companies reported that they did not initiate individual arrangements with employees on long-term sickness absence to facilitate their return to work.

However, some research suggests that it is not only enterprises that are reluctant to adapt employment situations for workers affected by chronic diseases. Thus, some Irish authors stress that employees with a chronic illness may leave an organisation without asking for the additional flexibility that could have helped them stay in their jobs, especially in the case of people with higher-level positions who are especially reluctant to ‘drop back’ to their earlier career stages (Beatty and Joffe, 2006).

According to [research by NFA \(in Danish\)](#) and a [lecture](#) by Niamh Fawl to the Irish Congress of Trade Unions National Disability Authority (NDA) Forum in April 2012, larger enterprises are more active in either having formal employee retention policies for people who acquire a longstanding health problem or in introducing adaptations to accommodate people with longstanding health difficulties. [German research \(in German, 13 MB PDF\)](#) commissioned by the Federal Ministry of Labour and Social Affairs (BMAS) and published in 2008 found that only 28% of small companies introduced company integration practices (BEM) for workers with recurrent illnesses lasting for more than six weeks within a year compared with 38% and 68% among medium-sized and large enterprises, respectively. Larger enterprises also had greater success in their integration efforts than small and medium-sized enterprises (SMEs). A [report \(in German\)](#) from the Health and Work Initiative (IGA) describes how several factors facilitate the implementation of BEM practices such as:

- a corporate health or active ageing policy;

- the presence of a work doctor within the company;
- a corporate culture characterised by trust and cooperative management styles.

[Research](#) by the Chartered Institute for Personnel and Development ([CIPD](#)) in the UK suggests that employers who are active in providing work adjustments for people affected by chronic diseases report a positive impact on employee motivation and employee engagement after making such changes.

Higher exposure to risks and hazards

A number of studies suggest that workers affected by chronic diseases have a higher exposure to risks and hazards at work.

According to the [European survey on health in the Czech Republic EHIS 2008 \(in Czech\)](#), workers with long-term health-related problems are twice as likely to be subject to hazards like noise and vibrations, chemical substances, dust, products of combustion, smoke, gas, as well as working in an unnatural position than those without such problems (17.4% and 12%, respectively); this also increases their exposure to injuries.

The [Finnish National Work and Health Survey 2012 \(in Finnish\)](#) found that workers with chronic diseases perceive higher exposure to harmful noise, dust and chemicals in their working environment and find their physical work space more strenuous than their 'healthy' counterparts. The [ad hoc module of the 2012 wave of the NWCS](#) also identified a similar higher exposure to physical risk factors in Dutch workers with chronic diseases. Dutch workers with a chronic disease more often feel the need to take (additional) health and safety measures in respect of exposure to risk factors (25% compared with 13% among workers without a chronic disease). In contrast, evidence from Slovakia shows that employees with longstanding health problems are exposed to only small- or middle- scaled working risks (Kordošová, 2012).

Data from the Czech Republic show that workers with long-term diseases are more subject to exposure to time pressures and/or excessive overloads than workers with no diseases. This situation seems to be particularly relevant among female workers; up to 21.5% of those with long-term diseases claimed to be heavily exposed to excessive work overloads and stress levels compared with only 11.2% among women with no disease, according to the results of the [European survey on health in the Czech Republic EHIS 2008 \(in Czech\)](#).

According to the survey on [work and health in Finland 2012 \(in Finnish\)](#), workers with chronic diseases felt their work was more mentally strenuous than workers with no diseases.

Discrimination and prejudice at work

Information from a number of countries shows that workers with chronic diseases are particularly affected by discrimination and prejudice at work, usually as a consequence of their poor health situation.

In the Czech Republic, the results of the [European survey on health in the Czech Republic EHIS 2008 \(in Czech\)](#) show that up to 9% of those with a long-term disease and in work claimed to have experienced discrimination in the workplace compared with 4.9% among those without any disease.

A [2012 report \(in Spanish, 3.4 MB PDF\)](#) from the Spanish Group of Patients with Cancer ([GEPAC](#)) found that three out of 10 people surveyed with cancer had felt discriminated at work as a consequence of their disease.

A [2011 report \(943 KB PDF\)](#) by the Richmond Foundation suggested that Maltese workers affected by mental health problems are particularly affected by discrimination and lack of support at work.

In Hungary, a [study among employed people with multiple sclerosis \(in Hungarian, 105 KB PDF\)](#) indicated that their main problem at work is a lack of understanding among colleagues and supervisors, resulting in incorrect judgement of their condition and ability to carry out their work. [Statistics on the employment of disabled people from the LFS ad hoc module 2011](#) highlight similar problems in Bulgaria. In the UK, the [Life Opportunities Survey in 2009–2010](#) found that 20% of this type of workers reported negative attitudes by their employers as a major difficulty at work. In France, [research on living and working with a chronic disease \(in French\)](#) showed that employers have a negative perception of workers with chronic diseases due to their absences from work and their associated low productivity levels. According to [Work and health in Finland 2012 \(in Finnish\)](#), Finnish workers with chronic diseases said they received less support and help from managers and colleagues; they also considered less frequently that their manager dealt with employees fairly and equally.

These problems of discrimination often result in violence and harassment problems. According to the [European survey on health in the Czech Republic EHIS 2008 \(in Czech\)](#), this problem was particularly important among those aged 25–34 years and among women, who also seemed to be particularly affected by sexual harassment problems at work. In Ireland, in a [study on disability in the labour market \(1.2 MB PDF\)](#) by the Equality Authority and ESRI, up to 29% of working people with longstanding health problems claimed to be particularly affected by bullying/harassment problems, a percentage that increased between 2004 and 2010. As found by [a 2011 report from the Slovak Disability Council \(in Slovak, 661 KB PDF\)](#) and the [Life Opportunities Survey in 2009–2010](#) in the UK, it is therefore not surprising that workers with longstanding health problems manifest very poor self-confidence levels.

In contrast, [research \(in Polish, 5.2 MB PDF\)](#) from Poland found that working people affected by longstanding health problems particularly valued the relationships they developed with co-workers and superiors, and much more so than other elements such as career opportunities and professional development.

Flexibility at work and work–life reconciliation

The limited evidence on the extent to which workers with chronic diseases have flexible working arrangements in order to cope with their diseases suggests that, in general, workers with chronic diseases have little capacity to influence the workload, the length of their working days and the possibility of working from home. This evidence comes from the FIOH survey, [Work and health in Finland 2012 \(in Finnish\)](#) and work by TNO to [measure chronic diseases as part of the ad hoc module of the 2012 wave of the NWCS](#). The same sources also show that workers affected by chronic diseases have more problems balancing work and life elements and are therefore poorly satisfied with their ability to reconcile working and non-working life.

High rate of temporary and part-time employment

Workers with chronic diseases and longstanding health problems are usually overrepresented in fixed-term, temporary contracts, usually on a part-time basis.

[Statistics published in 2011 by the Ministry of Labour and Social Affairs \(in Czech, 4.4 MB PDF\)](#) reveal that those with health-related disadvantages in the Czech Republic are more often, on average, employed on a fixed-term contract than those who do not have these disadvantages (18% compared with 7%); this finding applied mostly to full-time jobs. However, almost three-quarters of those with health-related problems who had a part-time job worked on the basis of a permanent contract compared with 64% among those with no health problems. A [2013 study \(in Croatian, 1.3 MB PDF\)](#) for HZZ also found a similar higher presence of fixed-term contracts compared with permanent contracts.

Available information on the full-time/part-time nature of work provides ample evidence of the overwhelming presence of part-time contracts among workers with chronic diseases. The main reason is likely to be the limitations that people with longstanding health problems and chronic diseases experience. [Czech statistics published in 2011 \(in Czech, 4.4 MB PDF\)](#) indicate that Czechs with disabilities or health-related disadvantages worked part time considerably more often than other respondents (42.1% and 5.1%, respectively). [Data from the Irish 2011 Census](#) show a higher presence of part-time jobs, in the sense that 55% of Irish men and 78% of Irish women with longstanding health problems worked less than 40 hours a week, a proportion definitively higher than among the remaining population. [Official statistics from Luxembourg \(in French\)](#) for 2012 show that 29% of workers affected by a chronic disease were working part time compared with only 15% of those in good health. In Sweden, [SCB statistics \(in Swedish, 2.22 MB PDF\)](#) indicated a higher presence of those with a chronic disease working part time, especially among women. According to a [GUS report \(in Polish, 1.1 MB PDF\)](#) on people with disabilities in the Polish labour market in 2011, 24% of those employed with longstanding health problems indicated that these are the main reason limiting their number of working hours.

This high presence of part-time work may explain, among other elements, why Dutch workers with a chronic disease more often claimed a lack of money in their households than workers with no diseases (25.1% versus 19.2%, respectively) in the [ad hoc module to measure chronic disease in the 2012 wave of the NWCS](#). Similarly, Lithuanian research points to low wages as one of the main problems among workers with chronic diseases (Zalimiene et al, 2007; Okunevičiūtė Neverauskienė et al, 2009; Okunevičiūtė Neverauskiene, 2012).

However, the [work and health survey in Finland 2012 \(in Finnish\)](#) found shorter working hours among workers with chronic disease, as well as a lower presence of having a regular nine-to-five job. Similarly, [figures from Statistics Estonia](#) show that workers with chronic diseases are more likely to work during the evening (about 27% work at least half their working days between 18.00 and midnight compared with 20% among workers with no chronic diseases. This situation could be explained either by a lack of other alternatives or by the need to reconcile work and life, including the need to receive care from health and social services during the day.

Limited access to corporate training opportunities

There is some evidence to suggest that the access of workers with chronic diseases to training opportunities within enterprises is less than that of their ‘healthy’ counterparts. According to evidence from the [ad hoc module to measure chronic disease of the 2012 wave of the NWCS](#), 20% of Dutch workers with a chronic disease were urged by their supervisor to develop their knowledge and skills, a percentage lower than among those

with no chronic health problems. This training was usually aimed at being able to deal with future changes in their current employment.

[Research \(in Polish, 5.2 MB PDF\)](#) found that 31% of workers in Poland affected by longstanding problems had no opportunity to develop their occupational skills, and 25% of respondents had no opportunity to take part in occupational training or workshops. It is therefore not strange that nearly half (45%) of working people affected by longstanding health problems in Poland claimed they had no chance of promotion at work.

Similar training patterns were reported in the [work and health survey in Finland 2012 \(in Finnish\)](#) and in Slovakia in a [report on the attitudes of employers to people with disabilities and visual impairment \(in Slovakian, 789 KB PDF\)](#).

A [2013 study in Croatia \(in Croatian, 1.3 MB PDF\)](#) and [research in Poland \(in Polish, 5.2 MB PDF\)](#) suggest one possible explanation for these lower levels of training activities: the limited levels of qualifications and associated low positions that people with longstanding health problems and chronic diseases usually occupy, especially when these health problems have affected the person for a very long time. According to the Estonian LFS ad hoc module in 2011, up to 10% of Estonian workers affected by longstanding health problems claimed that their lack of qualifications and skills was the main barrier at work. The corresponding figure for the UK from the [Life Opportunities Survey in 2009–2010](#) was 28%.

Measures to improve the work situation of people with chronic diseases

European policy context

As stated in the European Commission's White Paper, [Together for health \(123 KB PDF\)](#), fulfilling the [Europe 2020 strategy](#) (which aims to turn the EU into a smart, sustainable and inclusive economy promoting growth for all) has one prerequisite, that is, a population in good health. One of the main objectives of the EU health strategy is 'fostering good health in an ageing Europe'. Ageing, as a result of low birth rates and increasing longevity, is one of the main European social challenges and is likely to increase demand for healthcare due to an increase in the prevalence of chronic diseases while also reducing the working population. There is thus a need for policies to foster active, healthy ageing to promote employability and employment and to enable people to stay active for longer.

The Commission staff working document [Investing in health \(2.4 MB PDF\)](#), published in 2013, affirms that investing in people's health as human capital helps improve the health of the population in general and reinforces employability. This makes active employment policies more effective, helping to secure adequate livelihoods and contributing to growth. Within this framework, the objective of contributing to employability and enabling people to remain active for longer is established.

The health status of individuals strongly influences their participation in the labour market. For example, an early exit from the labour market is often the result of health-related problems. Depression, musculoskeletal diseases and unhealthy lifestyle factors (for example, obesity and physical inactivity) are also associated with reduced on-the-job productivity and high absenteeism rates. More than a fifth of the people currently employed suffer from a chronic condition and have their daily and working activities restricted.

It is therefore possible to boost economic growth by improving the health status of the population and enabling people to remain active and in better health for longer. But as

highlighted by the staff working document, the potential benefits of health investments through increased population employability are not currently fully understood. One of the ways to enable people to remain active and in better health for longer is to help those with chronic conditions who do not require hospitalisation to function actively in society (including at work) and at home ‘by empowering them to take care of their health in close collaboration with healthcare providers’. It further highlights that ‘tackling the problem of chronic diseases and addressing the main risk factors that determine population health will help increase people’s employability and enable them to stay longer in the workforce’.

Occupational safety and health (OSH) policies have a crucial role to play in to this respect. The [EU Strategic Framework on health and safety at work 2014–2020 \(129 KB PDF\)](#) seeks to ensure that the EU continues to play a leading role in the promotion of high standards for working conditions. This framework identifies three major challenges; one of them refers to ‘tackling demographic change’ and calls on Member States to take account of the ageing of the EU’s workforce by appropriately adapting workplaces and work organisation including working time, workplace accessibility and workplace interventions targeted at older workers. In addition, ‘reintegration and rehabilitation measures allowing for early return to work after an accident or disease are required to avoid the permanent exclusion of workers from the labour market’. The strategy also proposes ‘supporting the recruitment and return to work of people with a chronic or rare disease, disability or mental health disorder through integrated pathways combining various forms of employability measures such as individualised support, counselling, guidance, access to general and vocational education and training, as well as access to services, notably health and social services’.

The first [EU summit on chronic diseases](#), held in Brussels on 3–4 April 2014, brought together key policymakers, stakeholders and interest groups to:

- explore ways to address chronic diseases effectively in the EU;
- develop recommendations along a number of questions such as the medical, social and economic benefits of sustainable investments in health, the identification of ways to reduce the burden of chronic diseases and some common reflections on how to strengthen the prevention and management of chronic diseases.

Main policy measures and initiatives at national level

General policies and regulations

It is not easy to identify specific programmes or measures addressed at people with chronic diseases, particularly employment initiatives. Although national policies are diverse, in most countries the focus of the initiatives developed by public authorities and social partners is people with disabilities. In many cases, policies addressed at those with disabilities are the only existing measures affecting the employment situation of people with chronic diseases (who may or may not be specifically mentioned in these policies). Although national regulations concerning labour incapacities and/or disabilities are widespread in Europe, many countries do not have an official definition of the term ‘chronic disease’ in their labour legislation.

In general terms, access to specific policies and working conditions by people with chronic diseases depends on their particular case and circumstances. Access is generally

determined by the legal recognition of their incapacity for work by official committees which assess people's health problems. In many countries, people with chronic diseases but with no recognised reduced working ability are employed under the same terms and rules as the rest of the labour force.

In addition to the concept of 'people with disabilities', some countries also consider specific conditions such as 'partial' or 'reduced' work capacity, which are subject to diverse regulations in national labour legislation. For example, in Czech Republic, public authorities are currently discussing whether 'persons with a disadvantage in the labour market in terms of health' should be granted the same employment conditions as people with other disabilities. In Ireland, the [Department of Social Protection](#) has recently introduced a 'partial capacity scheme' which provides benefit to workers who have an illness but can work in some capacity.

Broadly speaking, all countries have labour laws to protect employees at work and promote equal treatment, combating discrimination towards people with disabilities or health problems. For instance, in Belgium, social security regulations and labour legislation at federal level include specific laws on protecting employees at work, such as the [Law of 4 August 1996 on well-being at work \(in Dutch\)](#) and the [Law of 10 May 2007 on combating discrimination \(in Dutch\)](#). In Greece, the Law of 3304/2005 on the 'Application of the principle of equal treatment irrespective of racial or ethnic origin, religion or other belief, disability, age or sexual orientation' protects also the right of persons with disabilities to equal treatment in employment. In the UK, the [Equality Act 2010](#), covering people with disabilities and chronic diseases among other groups, replaced the Disability Discrimination Act 1995 (known as 'DDA'). In Romania, the National Strategy for the Social Inclusion of Disabled Persons 2014–2020 was in its public debate phase during the first months of 2014 (at the beginning of June 2014 it was still in the project stage). This proposes a number of steps to sustain the employment of disabled people.

Many countries apply a 'quota system' for the recruitment of people with disabilities, usually including people with long-term health problems. In Cyprus, Law 146(I)/2009 on the recruitment of people with disabilities in the wider public sector regulates the recruitment of people with disabilities who meet certain objective criteria, at a rate of 10% of the jobs. This law aims to promote employment opportunities for people with disabilities to counterbalance their reduced opportunities due to their disability.

According to national legislation in Slovakia, employers are obliged to employ persons with chronic diseases, following a quota system.

In contrast, there are circumstances where people with health problems might see their employment situation in danger. For instance, according to the Employment Contracts Act that came into force in Estonia in 2009, employers are obliged to ensure working conditions correspond to OSH requirements but can terminate an employment contract if an employee is unable to perform their duties for over four months due to their state of health. In Latvia, employers have the right to give a written notice of termination if an employee is unable to work due to temporary incapacity for more than six months, if the incapacity is uninterrupted, or for one year within three years, if the incapacity repeats with interruptions.

However, many national laws refer to the provision of special equipment and adapted working conditions, training and preparation programmes for people with disabilities, or for those who have some impairment or health condition that places a limitation on their employment. For instance, in the Netherlands, the Equal Treatment Act, approved in

2003, prohibits unequal treatment of people with a disability or chronic illness. The act states that:

- there should be no discrimination on grounds of disability or chronic illness in conditions of employment;
- employers need to make the necessary work adaptations to enable effective participation in work of the disabled and chronically ill.

Similarly, in Ireland, employees are protected from discrimination on the grounds of their disability through the Employment Equality Acts 1998–2011 which include equality in the following aspects of employment:

- advertising vacancies;
- equal pay;
- access to employment;
- vocational training and work experience;
- terms and conditions of employment;
- promotion or re-grading;
- classification of posts;
- dismissal;
- collective agreements.

The acts confer an obligation of ‘reasonable accommodation’ on the part of the employer to ensure that people with disabilities have access to employment, can participate or advance in employment, and undertake training.

Similarly, in Portugal, the [Labour Code \(in Portuguese, 1.1 MB PDF\)](#) includes a set of measures aiming to protect and support workers with a disability or a chronic disease. In particular, the code stipulates the same rights and duties as for any other worker in terms of the access to employment, training, career progression to working conditions. It also establishes that workers with a disability or a chronic disease may be exempted from a task if this affects their health or safety at work. Also, in Sweden, employers have a general responsibility for an employee with a chronic disease. This responsibility is legislated: the employer must, according to the Work Environment Act (*Arbetsmiljölagen*), ensure the organisation is appropriate for working adjustments and possible rehabilitation.

Support measures for workers and employers

Many countries rely on initiatives aimed at making access to the labour market easier for those with disabilities and/or chronic diseases based on the offer of financial compensation to employers to cover the costs, among other things, of training programmes and work adaptations.

In Ireland, state support for private sector employers to encourage the retention of people with chronic illnesses in jobs comes in the form of the ‘employee retention grant’ or the ‘workplace equipment and adaptation grant’. Similarly, in the Netherlands, employers can obtain financial compensation through a lower premium for sickness/disability insurance and can be compensated for expenditure on work adaptations. In Slovenia, via the programme [Employ.me/Encouraging employment of difficult-to-employ people \(in Slovakian, 808 KB PDF\)](#), the Employment Office covers

part of the training costs and employers can reclaim the costs of workplace adjustments. In Slovakia, there are special measures under the framework of the national project ‘Employment of persons with disabilities’, which includes supportive financial schemes such as contributions to establish sheltered workshops or to hire a work assistant.

Sweden has an employment form known as ‘wage-subsidised employment’ (*lönebidragsanställning*), which seeks to reduce the frictions in working life for people with a reduced ability to work and to increase the incentives for companies to hire people with these kinds of problems. If the employee needs job support (*arbetshjälpmedel*) in terms of assistance or special equipment to be able to perform normal working tasks, this is paid for by the employer; if necessary, it is also possible to apply for financial support provided by the Swedish Social Insurance Agency ([Försäkringskassan](#)). In Norway, the main policy measure developed to favour the employment situation and working conditions of people with chronic diseases and other health problems is the tripartite Agreement on a More Inclusive Working Life, known as the [IA Agreement \(in Swedish\)](#). This provides, among other things, facilitation grants to businesses to encourage employers to organise work so that a worker can remain in their job despite having a chronic disease.

In Belgium, the [Flemish Region \(in Dutch\)](#) and the [Walloon Region \(in French\)](#) have a number of subsidised or sheltered workshops for people with difficulties in the labour market. People with chronic diseases reentering work are allowed to switch to a part-time regime in combination with a sickness allowance. Employers can access extra premiums and compensation for possible extra costs (such as extra training) in employing people with chronic diseases through various schemes ([Vlaamse Ondersteuningspremie](#), [Tegemoetkoming in de kosten van een arbeidspostaanpassing](#), [Prime à l’intégration](#) and [Contract d’adaptation professionnelle](#)).

An evaluation of the ‘Vlaamse Ondersteuningspremie’ (VOP) in 2010 revealed that a majority of employees had not been told about it by their employer. This problem was solved by a reform of the system in 2010 which gave the right to apply to the employee. Once the employee has gained the right to the VOP, the employer can begin the procedure to receive the premium.

Some public programmes aimed at increasing employability and the return to work of people with disabilities include special working time regimes and extraordinary leave of absence, some of them explicitly regulated for supporting particular diseases and health treatments. For instance, in Poland, the [Act of 27 April 1997 on vocational and social rehabilitation and employment of persons with disabilities \(in Polish\)](#) defines the basic rights of employees with disabilities and of employers employing people with disabilities. It identifies some solutions which make it easier to implement more flexible arrangements at the workplace to cope with the diseases and to attend treatment appointments. In particular, the employees with disabilities have the right to an additional break in the daily working time, an additional holiday leave (10 days per year), and time off work for medical examinations and treatment, rehabilitation and purchase or repair of orthopaedic equipment. Furthermore, they have a shorter working time of seven hours daily and 35 hours weekly.

In Italy, regulations for disabled people, which also affect employees with chronic diseases, establish the right to work part time where oncological treatment is needed. Those reporting a certified incapacity above 50% are eligible to 30 days leave per year for medical care. In the case of disability, three working days of leave per month (or a two hours per day reduction in their daily working time) are paid only for serious disabilities.

Most national labour contracts exempt employees with chronic diseases from the 180-day limit of absence days over three years that allows employers to fire them. In the private sector in Greece, workers who fulfil the labour contract requirements have the option to access leave of absence for blood transfusion or haemodialysis (additional paid leave of up to 22 days per year) and leave of absence due to AIDS (additional paid leave of up to one month per year).

Public labour offices may also offer work rehabilitation programmes aimed at people with disabilities to promote their return to work and to help them find a job. For instance, the Labour Office of the Czech Republic ([ÚP ČR](#)) provides people with disabilities with ‘work rehabilitation’. This consists of continuous support in employing and retaining workers with disabilities and includes guidance on suitable professions, jobs and other economic activity, theoretical and practical preparation, and intermediation of employment. In Slovakia, there are supportive schemes for people with disabilities such as employment agencies and counselling and information centres.

In Croatia, HZZ in cooperation with the Institution for Vocational Rehabilitation and Employment for Persons with Disabilities ([URIHO](#)) has developed new models of professional rehabilitation (‘work centres’ and ‘virtual workshops’) in line with the measures and activities of the National Strategy for Equal Opportunities for Persons with Disabilities 2007–2015. In Malta, the Employment and Training Corporation ([ETC](#)) runs a number of employment schemes for physically and intellectually disabled individuals and those with mental illnesses. These include [Bridging the gap](#), which offers job-seekers a period of work experience. A currently closed scheme, [Community inclusive employment scheme](#), provided disabled people with the opportunity to be employed by local councils, among others.

The French National Agency for the Improvement of Working Conditions ([ANACT](#)) has been given the mission of encouraging both job retention and professional reintegration for workers with chronic diseases. Linked to this, ANACT is playing an important role in the implementation of the French 2014–2019 Cancer Plan. The 2009–2013 plan has already led to some measures to facilitate working situations. The 2014–2019 plan currently sets out measures to continue the efforts already achieved such as:

- improving available solutions and adapting them to the personal situation of people with chronic diseases;
- raising awareness among companies;
- moving towards better territorial coordination of different stakeholders involved in job access or maintenance.

To help employers manage employees with chronic diseases, ANACT published [guidelines on good practices \(in French, 8.8 MB PDF\)](#) in 2012. The Regional Association for the Improvement of Working Conditions in Aquitaine ([ARACT Aquitaine](#)), in collaboration with [ANACT](#), is in charge of developing the project, [Chronic illnesses and work \(in French\)](#), to promote the permanence in employment, under the best conditions, of people with representative pathologies (cancer, diabetes, HIV AIDS, multiple sclerosis and hepatitis). The project, which is part of the European project [PH Work: Promoting healthy work for people with chronic illness](#), has developed new resources and tools (information, training and intervention) for supporting employees affected by chronic diseases. ARACT Aquitaine has received a European ‘excellence award’ for its work in this field.

In Finland, the [Ministry of Social Affairs and Health](#) has begun a [programme](#) for people with partial work capacity. The concept is aimed at ensuring there is a seamless chain of services for people with partial work ability that helps them to continue working or to find employment; the ‘work ability coordinator’ has a key role in advising and supporting cooperation among all actors (that is, the worker, workplace, occupational health, social security and insurance, and employment services).

Linked to this is a trend which characterises recent legislation in some countries, focused on the idea of participation and workability, in order to reduce sickness absence. In Denmark, the government launched the [return-to-work project \(in Danish, 5.3 MB PDF\)](#) in 2010 to promote return to work among sickness absence beneficiaries. The programme consisted of a coordinated, tailored and multidisciplinary effort, delivered by multidisciplinary teams located at municipal sickness benefit offices. Recently, in 2013 the Danish government launched a [new disability pension reform \(in Danish\)](#), under which municipalities must initiate a holistic and multidisciplinary effort (known as a *ressourceforløb*) to promote workability. The concept is based on the idea that people receiving a disability pension must work a limited amount of hours if possible, and in periods where they are capable of working enough to support themselves, they will not receive the pension. Meanwhile, in the Netherlands, the emphasis is on participation. Everyone who can work should work and the focus is no longer on what people cannot do but on what they can do. The latest regulation on this aspect is the proposed Participation Law (*Participatiewet*), with which the government wants to ensure that more people with a work incapacity get a job.

Due to the increase in the proportion of the population with a permanent incapacity, the share of inactive population with incapacity, shortcomings in staying-in-work/return-to-work policy measures, and the need to improve the sustainability of the social insurance system, the [Sotsiaalministeerium](#) in Estonia is currently preparing to reform the system. The first step is to move from evaluating incapacity to evaluating capacity for work. This will include professional recommendations to employees and assistance to employers. This stage of the reform is expected to come into force in 2015.

Information and awareness-raising campaigns

In addition to the measures aimed at facilitating the employment and retention of people with health problems, many countries have launched information and awareness campaigns, including the dissemination of good practices.

Among the initiatives in Ireland is the ‘Workway initiative’. This was started in 2004 by the social partners, the Irish Congress of Trade Unions ([Congress](#)) and the Irish Business and Employers’ Confederation ([IBEC](#)). This initiative has a long-term focus on changing attitudes by ‘raising awareness and developing guidelines and solutions to address the underlying issues and problems associated with the continued high level of unemployment among people with disabilities’.

In Spain, an initiative developed by INSHT has created a website known as the [portal for health promotion at work \(in Spanish\)](#), which offers useful information on the issue and presents good practices for the promotion of health and safety at work, including the management and support of workers with chronic diseases. The INSHT’s [2013 training catalogue \(in Spanish, 928 KB PDF\)](#) included a training course for businesses and workers called ‘Workplace chronic diseases: How to act at the company’. Likewise, in Portugal, the Directorate-General of Health ([DGS](#)) through a [National Programme for Occupational Health 2013–2017 \(in Portuguese, 2.7 MB PDF\)](#), introduced a set of 51 measures for the protection and promotion of workers’ health. The programme includes

an activity that seeks to establish referral models for differentiated care for chronic illnesses, mental health and other health issues through health services at work and occupational health provision.

Austria has a prevention and early intervention programme developed by the social partners and government called [fit2work \(in Austrian\)](#). This low threshold, free consultation service is for employees whose job is endangered due to health problems or for people who have difficulty finding employment due to a health condition. The programme acts as a ‘one-stop shop’ whose objective is to increase awareness of existing measures provided by various authorities and institutions. Over 17,000 people received basic information on the programme in 2013, the first year of nationwide coverage.

In Germany, an information system called [REHADAT \(in German\)](#) supports the vocational integration and occupational inclusion of disabled people. Commissioned by the Federal Ministry for Health ([BMG](#)), it was established by the Cologne Institute for Economic Research ([IW](#)) in 1988. REHADAT is supported by a steering committee made up of representatives of a multitude of organisations and institutions concerned with social security/care in Germany. These include the Federal Ministry for Labour and Social Security ([BMAS](#)), the Federal Employment Agency ([BA](#)), the Confederation of German Trade Unions ([DGB](#)) and the German Confederation of Employers’ Associations ([BDA](#)). The database includes case studies of successful vocational integration (with details of the technical, ergonomic and organisational layout of the workplaces), articles and research projects, and information on laws, workshops and seminars.

The project [Innovative measures in the field of occupational rehabilitation, guidance, training and employment for people with disabilities \(in Bulgarian, 8.9 MB PDF\)](#) began in Bulgaria in May 2012 and ended in April 2013. It included study visits in Belgium to learn about good practices and workshops to present these practices. The partners involved were the National Federation of Employers of Disabled People (Bulgaria), Association ‘Horizons’ (Bulgaria), municipalities, employment offices and the Knowledge Centre Social Europe ([KCSE](#)) in Belgium. The project presented a compendium of best practice in Bulgaria and Belgium aimed at improving the labour market situation and social inclusion of disabled people through rehabilitation, training and an adapted working environment.

There have also been numerous European initiatives. One of the most significant is the programme, [Public health and work: Promoting healthy work for employees with chronic illness](#), developed by the European Network for Workplace Health promotion ([ENWHP](#)). This aimed to bring together best practices to keep employees with chronic diseases at work, promote their health status and help them return to work; a [good practice guide](#) was published in 2012. Belgium, Cyprus, Finland, Greece, Hungary, Slovakia and Slovenia are among those countries participating. Under the programme’s framework, the Greek Centre for Occupational Health and Safety ([KYAE](#)) recently published a [guide of good practices \(in Greek\)](#) in collaboration with the [Institute of Social and Preventive Medicine](#) which seeks to promote healthy working conditions for people with chronic diseases. In Cyprus, the Department of Labour Inspection of the Ministry of Labour and Social Insurance launched an [information campaign \(in Greek\)](#) on the promotion of healthy jobs for people suffering from chronic diseases. In Slovenia, the Clinical Institute of Occupational, Traffic and Sports Medicine Ljubljana ([KIMDPŠ](#)) carried out the programme and in Hungary it was the National Health

Development Institute ([OEFI](#)). [Prevent](#), an organisation working for prevention and protection in the workplace was the Belgian partner; they created the website, [Move Europe – a European campaign for promotion of health at work \(in Dutch and French\)](#).

Examples of enterprises and collective agreements implementing support initiatives

Many of the initiatives identified in the previous section are aimed at workers with chronic diseases and workers with other types of disabilities, as both are generally subject to similar difficulties in terms of access to, or permanence in, employment.

A number of organisations across Europe actively favour the employment of people with chronic diseases and/or disabilities via training and guidance support services. For instance, in 2009, the social enterprise MTÜ Abikäsi in Estonia began labour mediation in cooperation with a number of companies to improve employment for people with special needs and health problems. In Belgium, in 2008, the online platform [Wheelit \(in Dutch\)](#) was established as a national online recruitment point for employers and employees with chronic diseases or disabilities. For example, people with chronic diseases can upload their curriculum vitae and information is provided on support measures for employers.

Several institutions offer support on entering the labour market for workers with mental health issues. For instance, in Spain, the Spanish Confederation of Groups of Relatives and Persons with Mental Illnesses ([Feafes](#)) recently created the programme ‘Employment and mental health’, which seeks to promote the employment of people with severe and chronic mental illnesses. In Malta, the Richmond Foundation runs programmes for those with mental health issues. These include a [staff organisation support programme](#), which is a preventative employee assistance programme (EAP), and the [supported employment programme](#), which trains, assists and supports people with mental health problems to find suitable and sustainable employment.

There are also special centres for the integration and retention of people with disabilities in the labour market. In Spain, Special Employment Centres are companies where 70% of the staff are workers with disabilities; those centres were created after the [1982 Law for the social integration of the disabled \(in Spanish, 542 KB PDF\)](#). In Poland, there are special forms of enterprises employing people with disabilities; for instance, if more than 50% of the workforce consists of people with disabilities, an employer can obtain the status of ‘supported employment enterprise’ (*Zakład Pracy Chronionej*). Such enterprises do not have to pay some taxes and fees, but are obliged to run a special fund from which the costs of the vocational, social and medical rehabilitation of employees with disabilities are paid.

Various collective agreements include advantageous conditions for people with health problems. In Portugal, the [collective agreement \(in Portuguese, 709 KB PDF\)](#) between the municipal public health company (HPEM) and the National Union of the Local Government Employees ([STAL](#)), establishes specific measures for employees with permanent or temporary disease or injury. These cover their employment in functions compatible with their clinical status, vocational training, measures for the adaptation of the workstation, part-time work and training leave. Also in Portugal, the collective agreement between the National Association of Slaughterhouses and Manufacturing Industries of Poultry Meat (ANCAVE) and the Farming, Food and Forestry Union ([SETAA](#)), established [specific measures \(in Portuguese, 709 KB PDF\)](#) for employees with reduced work capacity due to age, disease or accident, including adequate working conditions and wages, and adequate vocational training.

Under some collective agreements in the Netherlands, workers are not paid the first day of sickness absenteeism (so-called ‘waiting days’). The collective agreements for carpenters, the fashion industry and furniture makers, however, protect sickness absenteeism among workers with a chronic illness as these waiting days do not apply (or only partly apply) to workers with a chronic disease.

According to Estonian regulations, neither the employer nor the health insurance fund is obliged to pay sickness benefit for the first three calendar days of an employee’s temporary incapacity to work. However, it is quite common for employers to also pay the benefit for these days, which helps people with chronic diseases whose health problems tend to periodically worsen or return.

However, examples were found at national level of enterprises that have initiatives to support people with health problems or reduced work capacity.

In Bulgaria, [KCM Ltd](#) has applied an innovative [practice \(in Bulgarian\)](#) that aims to ensure employment and to improve the productivity of chronically ill and disabled people. This initiative consisted of the creation of a ‘specialised enterprise’ based on the outsourcing of some activities from the parent company. The specialised enterprise develops new types of activities and creates workplaces for people with chronic diseases or disabilities, adapted to their needs. In the case of health improvement, employees return to the parent company.

In Czech Republic, individual enterprises have introduced specific measures to encourage chronically ill workers to stay at work. Two examples are [Siemens Mohelnice](#), which has established a protected working place for those who would otherwise have to leave their job for health-related reasons, and [AGC Glass Europe](#) which transfers workers with chronic diseases or after an injury to another job position with compensation for their previous wage level.

In Finland, a public in-house enterprise of around 500 employees in the city of Oulu has developed [management procedures \(in Finnish, 2.5 MB PDF\)](#) to assist its employees to continue their working career despite their disabilities. Changes in work processes are made to accommodate the work ability of the employee considering the commissioned work and the composition of the work team. The new processes are designed in close cooperation with occupational health services and the city administration. The analysis shows that this activity reduced sick leave and disability pensions, and was economically cost-effective.

In France, [Delpeyrat](#) has implemented a number of initiatives to support people with chronic diseases. The objective was to improve working conditions for all workers (maintaining professional skills within the company) and to reduce absenteeism, moving from individual management of job retention for workers with chronic diseases towards collective management. Actions included identifying the number of reported cases of workers with chronic diseases, and the development of a monitoring and supportive approach by, for instance, implementing a dedicated person to refer to on each working site. This helps the management team to gain awareness of the consequences of chronic diseases on the situation of workers, and to arrange physical or organisational adaptations, thus avoiding dismissals for inability to work.

In Germany, DHL has developed a seven-week integration phase for a worker affected by cancer, during which the work volume and hours are gradually increased until previous levels are reached. In one instance, when an employee’s arm swelled due to her illness impairing her body strength and gripping power and making paperwork

impossible, she was reintegrated into working life at DHL over seven weeks as her working position was adapted. DHL cooperated with her pension provider, which paid for the new workplace design. In a second example from Germany, a soil removal and disposal company established a new workplace for a surveyor in the cartographic department who was affected by asthma and had limited mobility in his knee. His tasks were modified and he was provided with new adapted tools and clothing.

[COSMOTE](#), the largest company in the Greek mobile phone sector, developed a cooperation initiative between its health and safety team and an interdisciplinary medical team based on a programme for the reintegration and support of employees with chronic diseases and for the prevention of the chronicity of diseases. The programme included:

- evaluation of the employee's medical history by a medical team;
- identification of those physically and mentally diseased within the company;
- counselling and decision-making on a possible change of job or the creation of a new post;
- continuous evaluation of the employee's condition.

In Ireland, [Abbott Vascular](#) has introduced an early intervention programme which is triggered after five days of absence by an employee due to illness. The programme provides occupational health support onsite, as well as a comprehensive preventative programme that focuses on the health and well-being of employees. As a result of the programme, Abbott saved 213 workdays between January and June 2012 which would otherwise have been lost through sickness.

[FMC Technologies](#) in Norway has implemented measures to support people with chronic diseases. Examples of how FMC actively facilitates a good working environment include automatic door openers, remote control of the security barrier to make it easier for disabled people to enter/leave the workplace, a fitness centre for disabled and a facilitated climate for employees with multiple sclerosis. All managers undergo health and safety training and training on the monitoring of sick leave in order to reduce sickness absence, strengthen job attendance, create a better work environment, and prevent exclusion and withdrawal from working life due to chronic disease.

In Slovenia, the state-owned motorway management company DARS took part in the [ENWHP project](#). As part of the [campaign \(247 KB PDF\)](#), the company introduced different activities for maintaining employees' health, with a long-term aim to reduce the extent of chronic diseases and the extent of changed working capacities due to disability. The company increased opportunities for disabled employees to keep their jobs through additional training or retraining, and improved conditions for employees with chronic illnesses so that they could return to work after long-term sick leave. They also applied a workplace health promotion programme to maintain and enhance the health of all employees.

In the UK, [Lloyds Bank](#), part of the financial services group [Lloyds Banking Group plc](#), has put in place a programme that ensures that employees with disabilities have the same opportunities for career progression as their non-disabled colleagues.

Conclusions

Chronic diseases are health problems that require ongoing treatment for a period of years or decades. This implies that these diseases are recurrent, long-lasting and persistent, and cannot be cured. The four main types of these illnesses (also known as

non-communicable diseases) are cardiovascular, cancers, chronic respiratory disease and diabetes. Chronic diseases are generally linked to ageing, lifestyle and genetic predisposition.

Though they may or may not be caused (or made worse) by work, it is clear that chronic diseases can have a serious impact on the working capacities of the people affected. Chronically ill employees often experience great difficulties either staying in work or returning to work after a long period of absence. They often move into disability or early retirement, and are thus excluded from the labour market; in addition, too few people with reduced work capacity manage to remain in employment. In this sense, chronic diseases suffered by the working population have important consequences both at macro and micro level.

Even so, the most common situation in European countries is that there is no specific definition of chronic diseases, either in general or in an employment context. In fact, the term ‘chronic diseases’ is rarely used in employment rhetoric and related legislation. On a whole, Member States refer to two definitions:

- the general WHO definition of non-communicable diseases (‘not passed from person to person; they are of long duration and generally slow progression’);
- the definition used in the European Health Interview Survey (‘longstanding illnesses or health problems which have lasted, or are expected to last, for six months or more’).

From an employment perspective, it is necessary to refer to the definition used in Eurostat’s 2011 Labour Force Survey ad hoc module on the employment of disabled people, where the term used is a ‘longstanding health condition’ that it is permanent and may be expected to require a long period of supervision, observation or care.

The concept of ‘chronic disease’ in an employment context is very much related to the notion of ‘disability’. The UN Convention on the Rights of Persons with Disabilities considers disabled people as those ‘who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society’. In that sense, all national social security systems include the concept of ‘labour disability’ or of ‘physically or mentally impaired persons’ but very rarely the notion of ‘chronic diseases’ as such. As a result, national statistics dealing specifically with the employment situation or working conditions of the people affected by chronic diseases are relatively rare.

According to the available data, up to 31.5% of EU28 citizens (approximately 159.4 million people) claim to suffer from a longstanding illness or health problem, although only 9.9% of Europeans (50.1 million people) self-perceive their health situation as ‘bad’ or ‘very bad’. Meanwhile, 8.9% of EU28 citizens (45 million people) perceive longstanding severe limitations in their usual activities due to health problems. Women, older people and people with lower levels of educational attainment have the poorest self-perception of their health situation, where important differences can be also appreciated between Member States. Overall, the Eurostat data show that about a quarter (that is, 23.4%) of the EU28 population aged over 16 years suffers from a longstanding illness or health problem before reaching the retirement age.

Cardiovascular and mental problems are the main chronic complaints, followed by cancer, digestive, respiratory and musculoskeletal diseases.

People with chronic diseases in the European labour market have a higher risk of unemployment and inactive situations and fewer opportunities for having a job. This group of people experience relatively ‘easy’ transition paths from employment to unemployment/inactivity situations but ‘complicated’ transition paths from inactivity/unemployment to employment. In this sense, 20.1% of EU28 individuals who were employed in 2012 stated they had a longstanding illness or health problem; this percentage increased to 26.4% for those unemployed, 58.2% among those who said they were retired and 31.5% for those in another inactive situation. Musculoskeletal disorders are the main typical longstanding health problems among the employed population, followed by mental disorders and circulatory problems.

There are several reasons for this unfavourable rate of access to employment among people affected by chronic diseases. The main difficulties suggested by enterprises when recruiting this type of person include:

- poor understanding of the disease;
- perceived poor productivity levels;
- eventual costs for the enterprise (that is, the need to pay wages during periods of absence, existing legal obligations to facilitate the return to work, limitations on firing and need to adapt workplaces).

Workers with a chronic disease themselves eventually experience some significant limitations in their capacities which influence the type of work they can perform. These include:

- longer periods of absence compared with workers who do not suffer from a chronic disease;
- higher probability of interruptions to working activity due to a health-related problem;
- time and mobility limitations;
- need to adopt flexible/personalised solutions.

The extent and type of the chronic disease also influences the employment transition paths for workers affected. People with learning disabilities, mental health problems and cancer are particularly hindered in their participation in the labour market compared with people affected by migraines, diabetes, skin conditions or chest /breathing problems (including allergies).

Available evidence from a large number of Member States also shows a concentration of people with work-limiting health-related conditions in lower level, manual and low-skilled occupations (these can include blue-collar workers, farmers, agricultural, forestry and fishery workers, construction workers, drivers and social care personnel). The key role played by occupation in the incidence of chronic diseases explains why some sectors show a higher presence of workers affected by long-term chronic diseases (for instance, agricultural/forestry/fishing, industrial activities, social work services, transport and household employment). There is also wide empirical evidence that shows a direct relationship between certain chronic diseases and some occupations and economic sectors, for example:

- diseases affecting circulatory and musculoskeletal systems among truck and bus drivers;

- skin-related diseases among hairdressers;
- lung/respiratory diseases, chronic dermatitis and musculoskeletal problems among stone sector blue-collar workers.

Finally, the economic crisis that began in 2008 is having an important negative impact on both the health conditions of the European population and the employment situation of people affected by longstanding health problems and chronic diseases. The latter is reflected in an increase in unemployment and inactivity levels compared with healthy people and a deterioration in employment opportunities.

Despite the limited information on the working conditions associated with employed people affected by chronic diseases, some elements are clear.

First, evidence from a large number of Member States shows that not all workers affected by chronic diseases who need support are actually supported, or at least not at the level required and despite the fact that national laws often give them the right to reasonable adaptation of their workplace. In contrast, some enterprises (especially large ones) have an active and positive approach towards introducing retention or workplace adaption policies for workers affected by chronic diseases. Such enterprises tend to be those with a health or active ageing policy, a work doctor within the company, or a corporate culture characterised by trust and cooperative management styles. Typical measures applied by enterprises include adaption of working tasks, the quantity of work and working equipment, including training opportunities.

Second, workers affected by chronic diseases also suggest that they face a higher exposure to risks and hazards at work. Thus they have more exposure to noise and vibrations, chemical substances, dust, products of combustion, smoke and gas, as well as having to adopt an unnatural position in their working environment. Workers with chronic diseases also suggest they are more exposed to time pressures, stress levels and/or excessive overloads.

Third, workers affected by chronic diseases claim to be more prone to discrimination practices and prejudices at work. A lack of support at work and a lack of understanding from colleagues and supervisors are important problems in this respect in several Member States. Unfortunately, these problems of discrimination often result in violence problems at work, including bullying and harassment. Greater absences from work and the lower productivity levels due to poor health are probably at the heart of these problems.

Workers with chronic diseases also have a more limited capacity to influence their amount of work, the length of their working days or the possibility of working from home. They also experience more problems related to balancing work and life elements. In addition, these workers are more often working on the basis of a fixed-term, temporary contract than a permanent contract. The available information provides ample evidence on the fewer full-time and regular nine-to-five jobs among workers with chronic health problems than their healthy counterparts. This can probably be explained by the limitations that this group of people experience and the need to reconcile work and life, including the need to participate in health and social services during the day.

Finally, workers affected by chronic diseases have limited access to training opportunities within enterprises compared with their healthy counterparts. Possible explanations for this include the low-paying positions that people with longstanding health problems usually occupy or the limited possibilities of promotion at work for this group of individuals.

In most countries, the focus of policies and measures applied in favour of people with chronic diseases is on disabilities in general and not specifically those affected by chronic diseases. Although national policies are varied, in many cases the measures addressed at people with disabilities are the only ones affecting the employment situation of people with chronic diseases. Meanwhile, people with chronic diseases but with no recognised reduced working ability (that is, legally recognised incapacity for work) are generally employed under the same terms and conditions as the rest of the labour force.

All countries have labour laws which promote equal treatment and prevent discrimination towards people with disabilities or health problems. Some countries apply a ‘quota system’ for the recruitment of persons with disabilities. Some national laws mention the provision of adapted working conditions or workplace adjustments for people with health problems; the labour legislation in a number of countries states that employers must make the required work adaptations to enable the equal participation of disabled workers. References to equality in terms of career progression, training and so on were also found. Linked to this, there are public initiatives based on the provision of financial compensation; several countries offer grants aimed at covering the costs of workplace adaptation, training and prevention programmes, as well as compensation for contributions to sickness insurance or financial incentives for companies to hire people with a reduced ability to work. In addition, there are a small number of public programmes aimed at increasing employability and the return to work of people with disabilities or chronic diseases, including special working time regimes and extraordinary leave arrangements. There are also examples of regulated flexible arrangements to cope with diseases and attend treatment.

Furthermore, public institutions (for example, employment offices and national agencies of working conditions) play a key role in supporting those with health problems to find employment, by offering guidance services, rehabilitation programmes and training courses. There are also examples of recruitment platforms which link employers with employees who have chronic diseases or disabilities. A significant example of a campaign to raise public awareness is the European programme, [Public Health and work: Promoting healthy work for employees with chronic illness](#), developed by ENWHP. This collected details of best practice to keep employees with chronic diseases at work, promote their health status and help them return to work. Several European countries took part in this project.

Finally, there are a number of cases of sectorial collective agreements which include clauses referring to the adaptation of working conditions or to leave and temporary incapacities. There are also examples of specific measures applied by particular companies. For instance, several enterprises have implemented specific training and prevention programmes or health promotion initiatives, or improved their practices concerning health and safety issues. Likewise, some enterprises have created specially adapted workplaces or have developed adjusted work processes to support workers affected by health problems.

According to the information available, chronic diseases have a significant impact on European workers and that in general their working conditions do not take into account their specific needs. As a whole, the issue of chronic diseases implies a series of peculiarities for companies, such as flexibility and workplace adaptation. However, most of them do not seem to be sensitive to or concerned about these needs.

Apart from a few exceptions, however, mitigation policies and measures are not widely developed. Moreover, chronic diseases are rarely specifically regulated, as policies

normally refer to labour incapacities and/or disabilities. In addition, existing legislation on the issue typically refers to the provision of financial compensation and benefits rather than to the actual labour integration of the people affected. It is therefore important that regulations allow flexible management of the employment situation of people with chronic disease so that they can:

- adapt their working time and workloads without diminishing their entitlement to benefits;
- keep on working in a way that takes their disabilities into account.

Specific policies that seek to keep people with chronic diseases at work (or support their reintegration after spells of illness) need to be implemented such as:

- awareness-raising campaigns addressed at both companies and workers;
- specific guidance and training for work colleagues and managers;
- assistance in workplace adaptation.

An ageing workforce in Europe with a higher prevalence of chronic diseases makes it imperative to give a strong impulse to these kinds of policies.

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Annex: Perception of longstanding limitations in usual activities due to health

Table A1: Percentage of population with self-perceived longstanding severe limitations in usual activities due to health problems, by labour status, 2012

| | Employed | Unemployed | Retired | Other inactive |
|------|-----------------|-------------------|----------------|-----------------------|
| EU28 | 2.6 | 7.4 | 19.1 | 13.8 |
| AT | 3.2 | 20.5 | 21.0 | 10.0 |
| BE | 1.4 | 7.9 | 13.9 | 14.7 |
| BG | 0.4 | 0.7 | 10.1 | 6.1 |
| CY | 3.2 | 4.4 | 26.1 | 6.8 |
| CZ | 1.6 | 4.9 | 12.0 | 11.6 |
| DE | 3.4 | 25.9 | 21.8 | 14.6 |
| DK | 2.6 | 14.4 | 8.1 | 14.9 |
| EE | 2.6 | 2.5 | 26.1 | 13.3 |
| EL | 3.0 | 4.9 | 22.4 | 12.2 |
| ES | 0.9 | 1.6 | 12.8 | 10.3 |
| FI | 2.3 | 7.7 | 14.4 | 10.9 |
| FR | 3.0 | 6.5 | 18.7 | 10.8 |
| HR | 0.8 | 1.5 | 11.5 | 6.6 |
| HU | 1.5 | 3.7 | 17.0 | 12.0 |
| IE | 1.0 | 2.3 | 10.6 | 9.7 |
| IT | 3.1 | 4.9 | 18.9 | 13.9 |
| LU | 2.8 | 8.3 | 11.5 | 8.5 |
| LT | 0.9 | 1.9 | 21.3 | 12.3 |
| LV | 1.3 | 3.2 | 19.7 | 7.1 |
| MT | 0.5 | 1.0 | 6.2 | 4.7 |
| NL | 1.4 | 17.5 | 10.3 | 11.5 |
| PL | 1.7 | 3.3 | 16.6 | 13.2 |
| PT | 1.9 | 4.5 | 23.2 | 13.7 |
| RO | 1.0 | 3.1 | 22.7 | 6.6 |
| SE | 2.9 | 11.4 | 10.4 | 10.5 |
| SI | 5.6 | 15.6 | 22.6 | 7.0 |
| SK | 2.7 | 6.1 | 25.3 | 12.6 |
| UK | 3.1 | 5.9 | 22.2 | 24.0 |
| NO | 1.5 | 9.5 | 7.2 | 11.1 |

Source: Eurostat

Table A2: Percentage of employed population with self-perceived longstanding severe limitations in usual activities due to health problem, by sex and age, 2012

| | Men | Women | 16–24 years-old | 25–34 years- old | 35–44 years- old | 45–54 years- old | 55–64 years- old | 65+ years- old |
|------|------------|------------|--------------------|------------------------|------------------------|------------------------|------------------------|----------------------|
| EU28 | 2.5 | 2.8 | 0.9 | 1.3 | 2.0 | 3.1 | 4.8 | 9.1 |
| AT | 3.1 | 3.3 | 1.3 | 1.6 | 3.5 | 3.5 | 6.2 | 8.2 |
| BE | 1.2 | 1.6 | 1.1 | 0.4 | 1.4 | 2.1 | 1.8 | n/a |
| BG | 0.4 | 0.4 | n/a | 0.4 | 0.4 | 0.3 | 0.6 | 2.4 |
| CY | 4.0 | 2.2 | 1.4 | 1.4 | 2.5 | 3.8 | 7.1 | 7.7 |
| CZ | 1.2 | 1.9 | 0.2 | 0.7 | 1.3 | 1.4 | 3.8 | 2.9 |
| DE | 3.4 | 3.5 | 0.7 | 1.5 | 2.7 | 3.5 | 7.2 | 3.1 |
| DK | 2.7 | 2.5 | 4.6 | 1.0 | 3.2 | 2.6 | 2.9 | 1.8 |
| EE | 2.3 | 3.0 | 4.7 | 0.9 | 1.2 | 3.1 | 5.4 | 5.4 |
| EL | 3.0 | 2.9 | n/a | 2.1 | 2.0 | 2.4 | 6.8 | 18.3 |
| ES | 0.8 | 0.9 | 0.6 | 0.4 | 0.6 | 1.0 | 2.0 | 3.0 |
| FI | 2.2 | 2.5 | 0.8 | 1.6 | 1.8 | 2.9 | 3.3 | 3.1 |
| FR | 3.0 | 3.0 | 0.4 | 1.6 | 2.2 | 4.2 | 5.8 | 2.5 |
| HR | 0.9 | 0.6 | 0.1 | 0.2 | 1.1 | 1.0 | 0.8 | n/a |
| HU | 1.2 | 1.8 | 0.5 | 0.6 | 1.5 | 1.7 | 2.9 | n/a |
| IE | 1.2 | 0.8 | 0.8 | 1.2 | 0.9 | 0.5 | 1.6 | 2.2 |
| IT | 3.0 | 3.1 | 1.2 | 1.8 | 2.4 | 3.9 | 4.3 | 7.6 |
| LT | 1.0 | 0.7 | 0.3 | n/a | 1.0 | 0.9 | 2.0 | 0.9 |
| LU | 3.0 | 2.5 | 2.2 | 2.3 | 3.0 | 2.7 | 4.0 | 2.4 |
| LV | 1.0 | 1.5 | 0.7 | 0.1 | 0.9 | 1.6 | 2.7 | 3.8 |
| MT | 0.4 | 0.6 | 0.3 | n/a | 0.5 | 0.9 | 1.0 | 4.6 |
| NL | 1.4 | 1.5 | n/a | 1.5 | 1.3 | 1.9 | 1.2 | 0.5 |
| PL | 1.8 | 1.5 | 0.6 | 0.7 | 1.3 | 2.3 | 3.7 | 3.2 |
| PT | 7.7 | 10.3 | 3.8 | 4.6 | 6.2 | 11.5 | 18.3 | 21.4 |
| RO | 0.7 | 1.4 | 0.3 | 0.4 | 0.4 | 1.0 | 2.8 | 16.6 |
| SE | 2.4 | 3.4 | 0.8 | 2.0 | 2.3 | 3.9 | 4.0 | 2.2 |
| SI | 5.3 | 5.9 | 1.0 | 3.4 | 4.3 | 7.8 | 9.8 | n/a |
| SK | 2.8 | 2.6 | 1.4 | 1.4 | 1.9 | 3.8 | 5.0 | 5.0 |
| UK | 2.6 | 3.7 | 1.2 | 1.4 | 2.4 | 2.8 | 4.3 | 13.4 |
| NO | 1.3 | 1.7 | 2.0 | 1.4 | 1.7 | 1.4 | 1.1 | 2.6 |

Note: n/a = not available

Source: Eurostat

Country codes

Code **Country**

AT Austria

BE Belgium

BG Bulgaria

CY Cyprus

CZ Czech
Republic

DE Germany

DK Denmark

EE Estonia

EL Greece

ES Spain

FI Finland

FR France

IE Ireland

IT Italy

LT Lithuania

LU Luxembourg

LV Latvia

HR Croatia

HU Hungary

MT Malta

NL Netherlands

NO Norway

PL Poland

PT Portugal

RO Romania

SE Sweden

SI Slovenia

SK Slovakia

UK United
Kingdom

EF/14/59/EN