



# **Sick pay and sickness benefit schemes in the European Union**

## **Background report for the Social Protection Committee's In-Depth Review on sickness benefits**

**Brussels, 17 October 2016**

**EUROPEAN COMMISSION**

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*Contact:* Giulia PAGLIANI

*E-mail:* [giulia.PAGLIANI@ec.europa.eu](mailto:giulia.PAGLIANI@ec.europa.eu)

*European Commission  
B-1049 Brussels*

**European Social Policy Network (ESPN)**

**Sick pay and sickness benefit  
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**Background report for the Social  
Protection Committee's**

**In-Depth Review on sickness benefits**

**Brussels, 17 October 2016**

Slavina Spasova, Denis Bouget and Bart Vanhercke

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## SUMMARY, KEY FINDINGS AND CHALLENGES AHEAD

This Social Protection Committee (SPC) background report on sick leave and sick pay/sickness benefit schemes in the European Union sheds light on the huge variations in the way Member States address absence from work in case of temporary professional incapacity due to sickness.

It is important to clearly define and distinguish three key notions. *Sick leave* concerns the right to be absent from work during sickness and return to one's job when recovered. *Sick pay* is the continued, time limited, payment of (part of) the worker's salary by the employer during a period of sickness. A *sickness benefit* is provided by the social protection system and is paid as a fixed rate of previous earnings, or a flat-rate amount.

All European Union (EU) Member States provide sick leave and sickness benefits. In most of them, salaried and waged employees may also — by law, collective agreement or at the discretion of the employer — be entitled to sick pay, either for an initial shorter period of absence or for the entire duration of sick leave.

Sick pay and benefits schemes *vary widely* regarding their eligibility conditions, duration and replacement rates. Eligibility may indeed depend on whether people are dependently employed, self-employed or unemployed. They also often vary according to people's employment status (e.g. civil servants, white collar employees or blue collar workers). In some countries, civil servants and white collar employees may be entitled to longer periods of sick pay than blue collar workers and often to full pay during sick leave. By contrast, blue collar workers typically have to rely on less favourable sick pay conditions. Replacement rates of compulsory sick pay vary from 25% (SK) to 100% (e.g. BE, FI). The sickness benefit replacement rates range between 50% and 100% of the gross (or in some cases the net) salary. In the case of some flat-rate sickness benefits the replacement level of an average wage can be estimated at around 20% (MT, UK).

The report puts forward **six of key findings** and highlights **the main challenges** related to sick pay and sickness benefits.

The first finding is that **sickness benefit schemes have been subject to reforms in almost all Member States** over the past two decades. There have been enduring reforms, including reshuffling in the social security architecture in order to gear long-term benefits towards short-term schemes (e.g. DK, SE, UK) and tightening of the eligibility criteria for sickness and disability benefits in almost all Member States. In addition, many countries, particularly in Central and Eastern Europe, implemented short-term reforms at the onset of the financial and economic crisis in 2008. The main leverages used to reduce the cost of paid sick leave were the establishment of waiting periods, reduced income replacement rates and in some cases introducing sick pay: the latter measure was perceived as an opportunity to exercise closer control of the use of sick leave by the employer.

The second crucial finding is that while a **'quick return to work' policy** should be a key preoccupation of sickness benefit policies, **only a few Member States** have tried to **address** longer term absence on sickness benefits **through comprehensive rehabilitation and job reinsertion programmes** and new forms of benefits, i.e. 'follow-up benefits' (e.g. AT, DK, FI, SE). The main purpose of these 'follow-up' benefits' (e.g. retraining, rehabilitation benefits) is to avoid permanent exit from the labour market.

Moreover, evidence from these countries shows that ideally sickness benefit policies should be underpinned not only by proper rehabilitation/retraining measures but also by a comprehensive prevention agenda. Prevention seems to come onto the agenda of only a few countries which already have a comprehensive system of rehabilitation and job reinsertion programmes. Further discussions and reflexion are needed in order to put prevention (especially related to mental disorders) as a high priority on EU and Member States agendas.

The third main finding of this report is that there are **great differences in the need for and take-up of sickness benefits with regard to gender, age, occupation and socio-economic status**. Women take sick leave more often than men. The situation is the same with older workers, but evidence shows that this is the case for long-term rather than for short-term absence. Likewise, the more physically demanding occupation and the lower the socio-economic status, the more sickness absence is observed.

The fourth key finding is related to employment status, namely with regard to the self-employed and to short-term employment contracts. **Sickness protection for the self-employed varies widely between countries** in terms of insurance (compulsory/voluntary), entitlement to benefits and replacement rates of their income. There is only scarce information on the legal provisions for this category of workers and almost no evidence on coverage and take-up. With regard to short-term employment contracts, evidence shows that in many countries these workers are less protected due to stricter contributory period conditions.

The fifth pivotal finding is that the **sustainability of sickness benefit schemes is closely linked to the payment arrangements between the employer and the social security system**. In some countries, employer's sick pay has been perceived as a way to monitor the use of paid sick leave and reducing expenditure on sickness benefits by the social protection system. In some countries, employers pay the largest share of short-term sick leave, as sick pay legally lasts several weeks.

A last crucial finding of this report is that **sickness benefit schemes are closely interwoven with other social protections schemes**, namely disability pensions and early retirement pensions. In this respect, it is difficult to undertake an assessment of sickness benefit schemes without taking into account the complex interrelations between these categories of benefits. The transitions between benefits — e.g. from long-term sickness to permanent disability; or the transitions between unemployment and sickness benefit — have not been subject to sufficient academic scrutiny, with the exception of the Nordic countries.

This SPC report also identifies **an increasingly important challenge** faced by social protection which can at first sight be seen as the opposite of absence from work due to illness, namely presenteeism, i.e. the phenomenon of going to work while being in poor health. Much more difficult to quantify in terms of costs than the absence from work, **presenteeism seems to have become a key issue for policymakers to tackle** for several reasons. First, research shows that presenteeism, apart from the obvious danger of contamination of other workers, can lead to longer absence from work later on. Being present in poor health leads to loss of productivity and can result in poor general health and chronic diseases. These findings are particularly relevant in relation to mental disorders (burn-out, depression etc.), the incidence of which has significantly increased during the past decade and can also impact on general physical health. These issues can therefore have further knock-on effects on disability and unemployment schemes. Presenteeism, and the example in some countries of the use of holiday days for sick leave, would seem to call into question the notion of 'decent work' in European societies.

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A major problem for comparative assessment of Member State policies in this area relates **to shortage of relevant, reliable and fully comparable data**. Although there are data on the main indicators related to sickness absence and benefits (share in GDP, absence days etc.) more data are needed on the overall picture of how sickness benefits are financed, as well as on the assessment of transitions between benefits.

Moreover, and particularly in the context of the European Commission's 'Pillar of social rights' initiative, reflection and research are needed about the effects of reforms on the

adequacy (and the measurement of this notion through indicators) of social protection against absence from work due to illness. In this context, monitoring, peer review and exchanges of good (innovative) practices as well as policy challenges between Member States could boost the performance of national systems.



## INTRODUCTION

On 17 October 2016, the EU's Social Protection Committee (SPC) held its first-ever In-Depth Thematic Review (IDR) on the topic of Social protection aspects of sick pay and sickness benefits. The Review focused on challenges to enable the access to health care as well as to social protection schemes while avoiding early exit from the labour market (e.g. towards early retirement or disability pensions) of working-age people affected by long term sickness. This IDR placed on the agenda of the SPC the role of social protection in absence from work due to sickness, and notably in the rehabilitation and reinsertion of working-age people affected by longer-term sickness. Belgium, Germany and Finland acted as presenting countries, Ireland and Malta as reviewing countries. The present report summarises the main discussions during the IDR (see the questions raised during the debate in Annex 1) and hints at future work streams that could potentially be discussed within the SPC, possibly in interaction with the Employment Committee (EMCO).

The purpose of this SPC background report is to support the Commission's and Member States' analysis through an exploratory description and assessment of sick pay/benefit schemes in the European Union (EU) Member States.

The purpose of social protection in the case of sickness is to ensure access to health care and adequate financial protection. Sick leave, sick pay by employers and sickness benefit schemes are key social protection instruments to *'replace loss of income during periods of ill health. Sickness benefits and sick leave are crucial to addressing deteriorating health, health-related poverty and loss of productivity'* (ILO 2015). The main functions of sick leave are to allow the worker to access health care on time, convalesce more promptly, avoid the disease becoming chronic and to prevent contagion to other workers. Sickness benefit and sick pay replace part or all of the income lost during sickness (Scheil-Adlung and Sandner 2010).

At international level, sick leave with adequate sickness benefit is enshrined in the International Labour Organisation's (ILO) Social Security ('Minimum Standards') Convention (No. 102); the ILO 'Medical Care and Sickness Benefits' Convention (No. 130) which emphasises standards of benefits; the ILO 'Decent Work Agenda'; the 'Social Protection Floor Initiative' led by the ILO and the World Health Organisation (WHO); the Universal Declaration of Human Rights (Articles 22 and 25); and finally the International Covenant on Economic, Social and Cultural Rights (ICESCR, Article 9).

At European level, the right to health care and social protection during sickness is enshrined in various texts:

- (a) Article 35 of the EU Charter of Fundamental Rights (2000) stipulates that: *'Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities.'*
- (b) Article 34 of the Charter of Fundamental Rights (Ibid) reads as follows: *'The Union recognises and respects the entitlement to social security... in the case of sickness.'*
- (c) Article 151 Treaty on the Functioning of the European Union (TFEU 2007) states that the Union and the Member States shall have objectives including proper social protection. Furthermore, Article 153 TFEU sets out that the European Union shall support and complement the activities of the Member States in the social security and social protection of workers and the modernisation of social protection systems. Article 168 TFEU sets out that a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.

It should be noted that sick leave and sickness benefit schemes are within the competence of the Member States. At European level, legislation regulates the coordination of social security schemes and determines equal treatment of national and non-national EU insured persons (Verschueren 2011). The Member States of the EU have established various sick leave, sick pay and sickness benefit schemes. Most of them have both sick pay and sickness benefit schemes. *Sick pay* is the continued, time limited, payment of (part of) the worker's salary by the employer during a period of sickness. *Sickness benefit*, in turn, is provided by the social protection system and is paid as a fixed rate of previous earnings or a flat-rate amount. The entitlement to sick leave – i.e. the right to be absent from work due to sickness – and to sick pay and sickness benefit compensating income loss is grounded in a national mix of labour law, collective agreements and social protection legislation.

As the main purpose of sick leave and sick pay/sickness benefit is to allow people to recover and return to their work place, some Member States also emphasise rehabilitation and labour market reinsertion programmes as part of their policy approaches to absence from work due to sickness. Such programmes can be seen as key features to prevent the permanent exit from the labour market through early retirement or disability pensions of people affected by long term illness. The assessment of the adequacy of social protection during sickness should therefore also include an evaluation of the appropriateness of available prevention and rehabilitation/retraining measures.

At European level, the importance of rehabilitation and reintegration measures as an integral part of social protection in case of sickness have recently been covered in the first preliminary outline of a 'European pillar of social rights'. In order to ensure adequate and sustainable social protection, the outline indeed states that '*all workers, regardless of contract type, shall be ensured adequately paid sick leave during periods of sickness*' and at the same time '*the effective reintegration and rehabilitation for a quick return to work shall be encouraged*' (European Commission 2016a).

The purpose of the present Background Report is to provide an overview of sick leave and sick pay/sickness benefit schemes in the 28 Member States. Where data are readily available, it also offers a tentative comparative assessment of the coverage and the financial arrangements and trends of national schemes. The report also gives examples of recent and ongoing reforms, with a view to facilitating mutual learning between the Member States. The aim is to illustrate the main trends in national policies through a limited number of examples. In this respect, countries with similar developments are listed in brackets<sup>1</sup>.

By combining a dense description of Member States' policies and assessment, the SPC report seeks to answer the following **three research questions**:

1. *How do national policies address absence from work due to sickness?*
2. *What are the main financing mechanisms and trends for sick pay/benefits and rehabilitation/reinsertion measures (including the issue of cost-sharing between the employers and the state and the sustainability of the schemes)?*
3. *How do national policies prevent people from (a) losing their right to return to work due to long-term sickness and (b) as a consequence the risk shifting towards early labour market exit (e.g. on early retirement or disability pension)?*

The present Report was drafted in the context of the European Social Policy Network (ESPN)<sup>2</sup> by Slavina Spasova, Denis Bouget and Bart Vanhercke of the ESPN's Network Core Team<sup>3</sup>.

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<sup>1</sup> For the countries' official abbreviations used in this report, see Annex 5.

<sup>2</sup> The authors warmly thank Gerhard Bäcker, Jonathan Bradshaw, Claude Martin, Robert Jahoda, Olli Kangas, Valentina Rupel and Eric Marlier for their prompt and valuable feedback on earlier drafts of this report, which

## 1. GENERAL DESCRIPTION OF SICK PAY AND SICKNESS BENEFIT SCHEMES IN THE EU MEMBER STATES

This section provides an overall description of the sick pay and sickness benefit schemes in the EU Member States (Section 1.1) and addresses transitions to other types of social protection benefits (1.2).

### 1.1 Description of Member States' sick pay and sickness cash benefit schemes<sup>4</sup>

All EU Member States provide rights to sick leave and to benefits compensating income loss during absence from work due to sickness. The period of sick leave and the duration of the entitlement to sickness benefits are fully aligned in many countries (BG, DE, CZ, EE, ES, FR, HR, LU, LT, LV, MT, PT, PL, SE, SK)<sup>5</sup>, with some exceptions (e.g. BG, CZ, LV; see below).

In some other countries, the duration of sick leave may be longer than the period of entitlement to sick pay/benefits, and workers may take unpaid leave (e.g. BG, EL, CZ, IE, IT, LV, UK). The provision of unpaid leave is most often not regulated by social protection legislation but rather by labour law. It may depend on the employer's discretion or even on the decision of a medical doctor. For instance, in Italy, once the sickness benefit expires, unpaid sick leave is provided under the scope of the National Collective Labour Agreement regulating each category of workers. This system is aimed at avoiding dismissal, but rules may differ greatly according to the workers' category. In Greece, unpaid leave depends on the insurance period and the opinion of the attending doctor. In this respect, the period of entitlement to sickness benefit and the duration of sick leave may not coincide and the duration of sick leave can exceed the period of payment of sickness benefit<sup>6</sup>. Accidents at work are the only case in which the duration of the leave granted by the doctor coincides with the sick leave paid for by the insurance fund<sup>7</sup>. Likewise, in Lithuania, unpaid sick leave is not enshrined in legislation, but employees may be granted such a leave, based on the opinion of a medical doctor. In the UK, employers are legally obliged to pay "Statutory Sick Pay" to employees for a maximum of 28 weeks during any period of sickness. However, an employer can choose – there is no

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was presented at the Social Protection Committee's In-Depth Thematic Review (IDR) on the topic on 17.10.2016. The present version has been updated by the authors to take into account the discussions of this IDR, as well as detailed written feedback by several national delegates and extensive comments and suggestions from the European Commission throughout the writing process, which are gratefully acknowledged. The usual disclaimer applies.

<sup>3</sup> The three authors are from the European Social Observatory (OSE, Brussels). The European Social Policy Network (ESPN) was established in 2014 to provide the European Commission with independent information, analysis and expertise on social policies in 35 European countries. It is managed by LISER (Luxembourg Institute of Socio-Economic Research), APPLICA and the OSE. More information on the ESPN: <http://ec.europa.eu/social/main.jsp?catId=1135&langId=en>.

<sup>4</sup> This section is based on the MISSOC comparative tables database (1 January 2016), Available at <http://www.missoc.org/INFORMATIONBASE/COMPARATIVETABLES/MISSOCDATABASE/comparativeTableSearch.jsp>

<sup>5</sup> The information on the alignment between the duration of sick leave and the period of entitlement to sickness benefit has been kindly provided by national correspondents from the Mutual Information System on Social Protection (MISSOC) (October-November 2016). Information from MISSOC and SPC members who responded to the question on the alignment of duration between sick leave and sickness benefit is available for 20 Member States: AT, BG, CZ, DE, EE, EL, ES, FR, HR, IE, IT, MT, PL, PT, LU, LT, LV, SE, SK and the UK.

<sup>6</sup> For example, if an employee who has been insured during the past 2 years for at least 120 days falls ill, he/she is entitled to paid sick leave (sickness benefit) from the insurance fund (IKA-ETAM) for 182 days (6 months). However, the attending doctor may grant a leave of absence from work due to illness for 250 days (approximately 8 months).

<sup>7</sup> Accidents at work are paid by the health insurance fund for as long as the illness lasts, without any minimum requirements, as long as the employee was covered on the day of the accident.

legal obligation – to provide additional or more generous sick pay and sick leave periods, including unpaid leave. Similarly, in Malta employment regulation does not provide for unpaid sick leave, and the employer may grant employees a period of unpaid leave out of goodwill. Employees may be granted exceptional unpaid sick leave in Bulgaria, the Czech Republic and Latvia. In Bulgaria, this can be the case when the employee has not reached 6 months of sickness insurance. S/he has a right to sick leave for the period of incapacity for work, but is not entitled to sickness benefit. The right to unpaid leave also exists in cases of quarantine or caring for a sick family member, when the sickness benefit is paid for only a limited period of time within one calendar year.

Entitlement to sick leave and sick pay/sickness benefit schemes vary considerably from country to country, and within a single country they may vary with regard to duration, eligibility conditions and benefit levels between different types of workers and depending on the type of sickness in question. Rights to sick leave and sick pay/benefit schemes can be enshrined both in social protection legislation and labour law. Moreover, in some countries, conditions of payment and duration are primarily negotiated through collective agreements (e.g. DK, FI, NL).

### 1.1.1 Eligibility criteria for sickness benefits

Eligibility for sickness benefits depends on two main criteria: a) the employment status of the person (salaried workers, self-employed, unemployed persons etc.), and b) the period of social security contributions and employment. In some cases, there are also criteria related to the type of sickness.

With regard to the *employment status*, workers are entitled to sick leave and social protection in the form of sick pay and/or sickness benefits in all EU Member States. Some categories of workers such as civil servants and salaried employees may (through collective agreements) be entitled to full pay during sickness. Workers may have the right to a short period of sick pay, followed by a longer period of sickness benefit; or may only be entitled to the latter. Moreover, conditions vary widely for self-employed and unemployed.

The self-employed are required to be insured only in 16 Member States (BE, DK, CY, EE, FI, FR, HR, HU, LU, LV, MT, PT, RO, SI, SK and SE). Their situation regarding the entitlement to sickness benefits is rather complex. First, in the above-mentioned 16 Member States where the self-employed are subject to compulsory insurance, there are often different contributory periods for the self-employed. Second, in some countries the self-employed subscribe to voluntary insurance schemes which may be statutory or private (e.g. BG, CZ, EE, ES, PL, LT). For instance, in Germany, the self-employed can choose between statutory and private health insurance. In both cases, they pay higher social contribution rates than salaried workers.

As for unemployed persons, half of the countries do not set special conditions (AT, CY, CZ<sup>8</sup>, DK, EE, EL, FR, HR, MT, RO, NL, UK). In some other Member States, there are strict conditions governing entitlement to sickness benefit for unemployed persons, namely in terms of *duration* (e.g. BE, BG, FI), the type of the contract before becoming unemployed (e.g. IT), the *timing* of the disease with regard to the duration of the employment contract (e.g. PL) and the *proof* of active job search (e.g. SE). Unemployed are not entitled to sickness benefits in Hungary, Italy (only in the case of fixed-term contracts), Lithuania, Luxembourg, Portugal, Slovakia and Slovenia. In Latvia, as of 2017, unemployed people will no longer be entitled to sickness benefit (unless sickness benefit was granted before dismissal).

In some countries, beneficiaries can also include working pensioners (e.g. LU, LV), apprentices (e.g. HR, IE, IT), students (e.g. FI) and the other members of the family

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<sup>8</sup> In the Czech Republic, there is a 'protection period' for the first seven days of unemployment.

(e.g. FI, in case of tuberculosis in IT). Finally, some excluding conditions can apply to persons who have the required employment status but who damaged their own health and whose sickness is supposedly a result of alcoholism or drug addiction, or in the case of criminal offense (e.g. LT, LV, SK).

A second set of eligibility conditions relate *to the period of social security contributions*. Around one third of the Member States, including Austria (except for rehabilitation benefit), Italy (except for farmers and show-business employees) and Luxembourg (except in case of cessation of the labour contract), do not require a specific duration of the contribution period for eligibility to receive sickness benefits. The same is true for CZ, FI, HU, SE, SI, SK, NL and LV (as of 2018).

In the other Member States, the required period of contribution is typically between two and three months, but with wide variations: from 14 days in Estonia to 9 months in Hungary, and even more than a year in Greece (depending on the duration of the sickness benefit). This period can be spread over a certain time span. For instance, in Croatia the minimum period is 9 months of consecutive contributions, or 12 months with interruptions during the two years preceding the sickness. Likewise, in Lithuania, the contribution period should be at least three months during the 12 months or at least six months during the 24 months preceding the sickness.

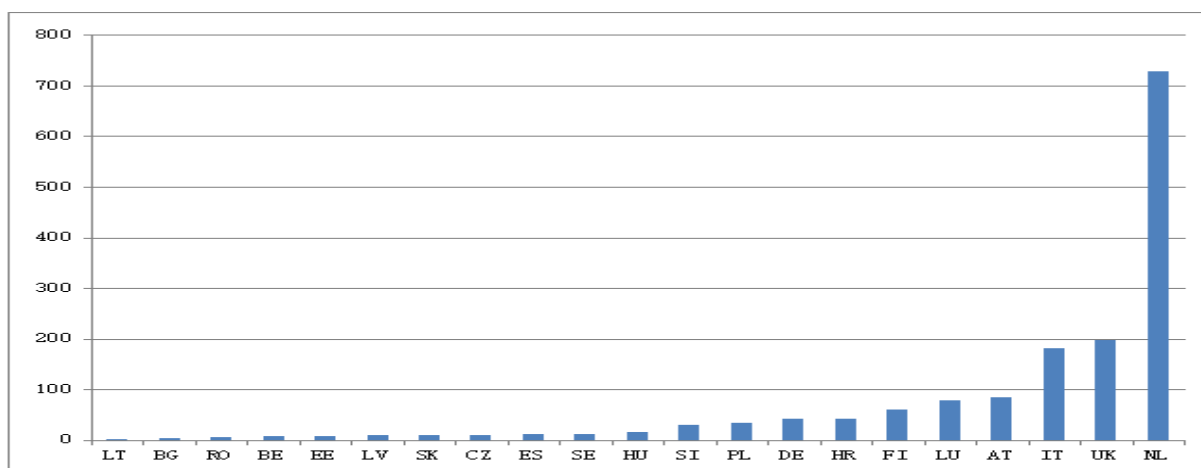
### 1.1.2 Payment arrangements and duration of sick pay and sickness benefits

Almost all Member States provide a *double payment arrangement* for sick leave. On one hand, there is a period of sick pay by the employer. On the other hand, after this period, benefits are paid by the social protection system.

#### ▪ Sick pay

In most of Member States, income loss compensation entails that employers for a period continue to pay a salary (in full or in part) in case of absence due to sickness. Graph 1 illustrates the duration of sick pay enshrined in national law.

**Graph 1. Duration of sick pay in EU28**



**Source:** MISSOC (2016).

Cyprus, Denmark, Greece, Ireland and Portugal are not included in this graph, as sick pay is not state-mandated in these countries, where the entitlement to sick pay stems either from collective agreements or is at the discretion of the employer; duration can hence vary accordingly. For instance, in Denmark and Cyprus, payment by the employer depends on collective agreements. In Ireland, the payment is at the discretion of the employer in accordance with the employee's contract.

The French and the Maltese situations are also particular. In France, the employer pays employees the entire (or a part of the) difference between the salary and the amount of

the sickness cash benefits from the general health insurance scheme, in accordance with the national inter-professional agreement on monthly payments of wages or the collective agreement conditions, if the latter is more favorable. In Malta, the Government pays flat-rate sickness benefits. The first 24 days are fully paid; the following 24 days are on half pay (the difference between the flat rate and the employee's wage is funded by the employer). After this period, Maltese receive only a flat rate benefit (Maltese presentation at the SPC (2016)).

Member States can be divided into two groups with regard to the duration of sick pay. In the first group, sick pay lasts a maximum of two weeks. For instance, in Lithuania employers pay only the first two working days of the sick leave. Likewise, in Bulgaria, there are three paid days and in Romania five. In the Czech Republic, Estonia, Hungary, Finland, Latvia, Slovakia, Spain and Sweden sick pay (by the employer) lasts between 8 and 15 days.

The second group of countries provides much longer periods of sick pay. This can be more than a month in Austria (6 to 12 weeks), Croatia (42 weeks), Italy (max 180 days), Luxembourg (77 days), Poland (33 days) and the Netherlands (104 days maximum). In the UK, the Statutory Sick Pay is paid by the employer in case of sickness for at least 4 consecutive days up to a maximum of 28 weeks.

Whether payment by the employer continues, often depends on the length of the employment contract and the arrangements in the collective agreements. In some countries, sick pay can last considerably longer depending on collective agreements (e.g. FI, SE). For instance, in Finland, legislation compels the employer to pay nine days of full salary but through collective agreements blue collar workers usually receive sick pay up until one month, and white collar and civil servants for even more than three months.

In most of the countries the amount of the sick pay is calculated as a percentage (i.e. a compensation rate) of the gross wage (daily or monthly) and varies from 25% (SK<sup>9</sup>) to 100% (e.g. BE, FI). This compensation rate depends on various factors such as the duration of the employment contract, the worker's status (civil servant; white collar; blue collar) in connection with collective agreements and the type of injury (occupational accident, etc.). For instance, in Finland, the employer pays a full salary for the first 9 days, provided that the employment contract has lasted at least one month. If the sick pay lasted less than a month, only half of the salary is paid. In Belgium, employers pay the full wage during one month for white collar employees. However, for blue collar workers the sick pay at the level of the full wage only lasts for seven days and then gradually decreases. Only in Malta and the UK is the sick pay from the employer a flat rate payment. In the UK, the level of the Statutory Sick Pay is £88.45 in 2016 (€120) per week and has been frozen until 2019.

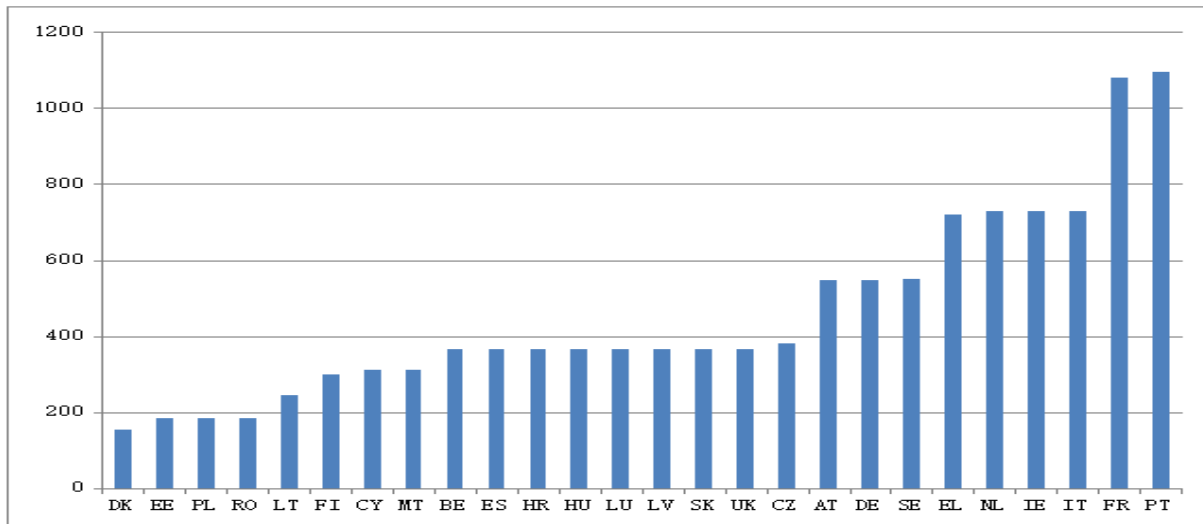
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<sup>9</sup> In Slovakia, the first three days of sick leave are paid by the employer at 25% of the assessment base, then from the 4th to the 10th calendar day the sick pay is 55% of the assessment base.

### ▪ **Sickness benefits**

All 28 Member States provide benefits paid by the social protection system. An overview of the maximum legal duration of sickness benefits is presented in Graph 2.

**Graph 2. Maximum legal duration of sickness benefits in the EU28**



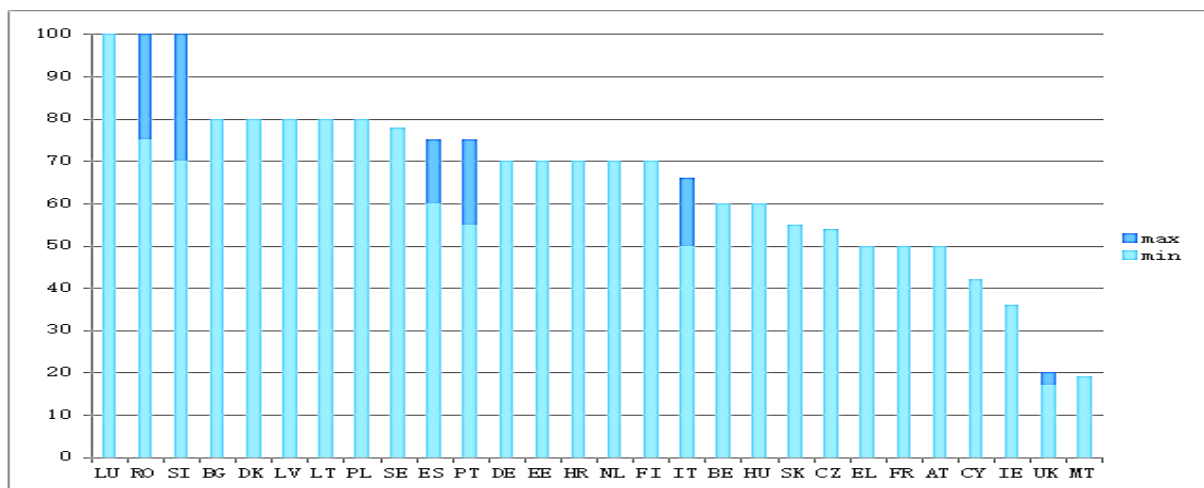
**Source:** MISSOC (2016)

The maximum legal duration of cash sickness benefits for work absence varies widely between countries: from 22 weeks within 9 months in Denmark, to 3 years in Portugal. Slovenia and Bulgaria are the only countries where sickness benefit can be provided for an unlimited duration. In Slovenia, medical doctors specially appointed for the task and the medical commission of the Health Insurance Institute are responsible for establishing the duration of sickness benefit. Similarly, in Bulgaria, the benefit is paid until the recovery of capacity for work or the establishing of invalidity.

The sickness benefit duration can depend on the period of social contributions paid (e.g. EL, IE), the type of sickness (e.g. unlimited duration for tuberculosis in IE, PT) and on the frequency of the same sickness (e.g. DE). For instance, in Croatia, after 12 months on sickness benefit the beneficiary must submit a claim for an invalidity pension, the entitlement to which is certified within the 60 following days. If invalidity has not been certified, then the worker continues to receive the sickness benefit until recovery. However, if after 18 months the worker is still absent on the same diagnosis without interruption, the amount of the benefit is halved.

Some countries also provide *supplements for dependents*, i.e. dependent family members such as children and unemployed spouses (e.g. EL, FR, IE, IT, MT and PT). In most Member States, the sickness benefit paid by the social protection system is calculated as a percentage of the gross (or in some cases the net) daily or monthly salary and varies between 50% and 100% thereof. Many countries apply an earnings ceiling to insurance coverage (e.g. AT, BE, DK, BG, CZ, HR, HU, FI, FR, LT, LV, NL). Only a few countries do not apply any earnings ceilings to insurance coverage (e.g. EE, PL). A general overview of sickness benefit replacement rates<sup>10</sup> is presented in Graph 3.

<sup>10</sup> The replacement rates do not take into account the supplementary compensation from private insurance companies or mutual insurances.

**Graph 3. Sickness benefit replacement levels, EU28, 2015**

**Source:** MISSOC 2015.

The sickness benefit replacement rate varies most often according to the period of social contributions, the worker's status (white versus blue/collar), the arrangements in collective agreements, and the type of sickness (e.g. ES, PL, PT, IT, RO, SI and UK). For instance, in Poland, the average rate of sickness benefits is 80%, but in some circumstances, it can be 100%. In Romania, the sickness benefit is calculated at 75% of the gross earnings during the last 6 months but it can be 100% in case of specific sicknesses (AIDS, all types of cancer, tuberculosis) and surgical emergency. Only Ireland, Malta and the United Kingdom apply a flat rate amount. In Malta and Ireland, the amount depends on the civil status of the beneficiary (single/married). The replacement levels of the flat-rate benefits in Ireland, Malta and the UK are estimated at around 36%, 19% and 20% respectively (see Graph 1).

As for the *self-employed*, information on the replacement of income is very scarce. In many countries, there are also differences between the period of entitlement to sickness benefits for employed and for self-employed persons (e.g. BE, BG, HR, PT). For instance, in Portugal sickness benefit is only granted to the self-employed for a maximum period of 365 days, compared with 1095 days for salaried persons.

In Denmark, the sickness cash benefit for the self-employed is calculated on the basis of their earnings and the same maximum of earnings applies as for salaried workers. In cases where the self-employed persons have subscribed to a voluntary insurance scheme, they are entitled to at least 2/3 of the maximum amount. In Slovakia, the self-employed receive 25% of the assessment base during the first 3 days of incapacity for work and then 55%.

### 1.1.3 Waiting periods

The waiting period for receiving sickness benefits is the '*period of time between the occurrence of the social security risk and the onset of the benefits*' (MISSOC database definition). Slightly less than half of the Member States generally do not apply waiting periods: BE, DE, DK, FI, HU, HR, LI (except for authors/writers), PL, RO, SK and SL. Still, in some of these countries the self-employed are subject to waiting periods (e.g. HR, DK, FI).

In the other EU Member States, general waiting periods vary from 1 to 7 days and last on average 3 days. Again, self-employed people are subject to different conditions with longer waiting periods (e.g. CY, HR, PT). In Portugal, the waiting period which applies to the self-employed is 30 days, while it is 3 days for salaried workers. In Sweden, self-employed can choose the number of waiting days depending on the level of contributions they are willing to pay.



#### **1.1.4 Job protection during sick leave**

In almost all European countries protection from dismissal is guaranteed during sick leave, subject to certain conditions. One exception is Denmark, where no statutory protection from dismissal exists but where there are specific clauses in most collective agreements (Deloitte 2013).

Usually workers can be dismissed when sickness lasts for a longer period of time. For instance, in Poland a worker can be dismissed when s/he is absent for more than three months (for a contract of less than six months) or for a period longer than the period for which the worker has been receiving sick pay and sickness benefit (typically 182 days). Likewise, in Latvia, the maximum duration of the sickness benefit is in general 26 weeks, and then employers can dismiss workers due to long-term sickness. In Germany, dismissal of a worker is also possible for long-term sickness, but under strict conditions: both a negative prognosis and a serious detriment to business interests, for frequent short-term sicknesses, for loss of efficiency due to sickness, for alcoholism, or custody (Deloitte 2013).

#### **1.1.5 Social security contributions from sick pay and sickness benefit**

In most of the countries, beneficiaries of sick pay and sickness benefits do not pay social security contributions (BE, BG, CY, EE, EL, HU, IE, IT, LV, LT, MT, PT, SE, SK). In the rest of the countries, claimants continue to pay social security contributions while on sick pay or sickness benefits. The requirements can vary widely according to the type of social risk (health care, old-age etc.) to be covered.

### **1.2 Transition from sickness benefits to other types of social protection benefits**

After the duration of the sickness benefits expires, and the health status of the person has not improved sufficiently to get back to work, the beneficiary can shift to another type of benefit: e.g. early retirement and disability pensions or social assistance.

A sickness benefit is paid for a '*short-term or temporary work disability (work incapacity)*' (Prins 2013). When the right to sickness benefit expires, and a working life age person is still unable to work, all Member States provide disability benefits/pensions to tackle '*permanent work disability (permanent work incapacity), be it partially or fully, be it combined with (part time) employment or with dependency on benefits*' (Prins 2013). The distinction between short-term and long-term incapacity is not watertight and the methods of disability measurement and transition from sickness benefits to disability benefits vary widely between countries. The combination of part-time employment and sickness/disability benefit can add a supplementary difficulty to analysing these transitions (see Section 2.1). People affected by a long-term sickness in pre-retirement age also have the possibility to claim an early retirement pension. However, the conditions for early retirement through the pension system have been systematically tightened in all Member States (European Commission 2015) even for workers in arduous and hazardous jobs who are more subject to occupational sickness and injuries than ordinary workers (Natali *et al.* 2016).

In most of the countries, there are no transitional gaps between sickness benefits and permanent incapacity benefits. If the person is proven to be unable to go back to work, s/he falls under other incapacity schemes: provisional disability benefit and permanent invalidity benefit/pension. In cases where a person is unable to go to work, but is not eligible for a permanent incapacity benefit, s/he can benefit from social assistance.

During the past decade, some countries have tried to address the issue of transition by creating new categories of benefits. In many cases, these represent a kind of 'follow-up' benefit after sickness benefits and aim at getting people back to work. These schemes focus on rehabilitation and flexible work for those with some degree of incapacity for

work. Examples are retraining, rehabilitation and labour market insertion benefits. Their purpose is typically to avoid transition of recipients to permanent benefits such as early retirement, disability pensions and social assistance.

These new policies can be illustrated through four concrete examples: the Austrian rehabilitation and retraining benefits; the Danish Flexjobs programme; the Finnish partial sickness benefit; and the Swedish schemes for rehabilitation and retraining (see Box 1). The assessment of some of these schemes and their results are discussed in Section 2.

**Box 1. A third way between sickness and disability: labour market reinsertion and rehabilitation benefits in selected countries**

**Austria**

Since the 1<sup>st</sup> of January 2014, temporary invalidity pensions have been replaced by a 'rehabilitation benefit' and a 'retraining benefit' (the first stage of implementation concerns only people below the age of 50). The main goals of the reform are to reduce the number of people who fall into permanent invalidity retirement, to increase the effective retirement age, and to foster active labour market participation.

The rehabilitation benefit is paid at the same level as sickness benefit and is provided by the health insurance following an assessment of the health status by the newly established evaluation competence centres. Recipients must participate in the health rehabilitation programmes, and then undergo a re-evaluation of their health status after a maximum of one year. This benefit is granted in cases where re-training is estimated inappropriate or unreasonable and the person needs to improve their overall health status.

The re-training benefit is paid at the same level as the unemployment benefit (55% of earlier earned income, i.e. the 'basic amount', plus family supplements. The person also receives a supplement of 22% of the basic amount. This benefit is basically intended to enable the re-training of a person who cannot carry on with her/his former profession due to their health status. The measure is handled by the Public Employment Service (Input from Marcel Fink, ESPN national coordinator for Austria).

**Denmark**

Since 2012 the National Return-to-Work Programme aims at promoting the return to work during and after sick leave. The programme includes the establishment of multidisciplinary teams of professionals, the introduction of standardised work ability assessment and sickness absence management procedures, as well as a comprehensive return-to-work training course for all multidisciplinary team members (EU-OSHA 2015). Moreover, in December 2013 a Sickness Benefit Agreement was signed, which reinforces continuous follow-up, early intervention, and job clarification programmes during sickness absence. Along with these developments Denmark also implemented the 'Disability Pension and Flex Job Reform' of 2013 which introduced intensive reinsertion programmes (resource process programmes) and re-oriented the flex jobs to persons with the weakest work ability. The disability status of the claimants, irrespective of their age, is frequently re-assessed. The worker receives a wage which is linked to his degree of incapacity to work combined with a social protection benefit. For example, if the person works 20 hours per week and has a work capacity of 50%, the wage amounts to 10 hours of work per week. There is also a ceiling whereby the benefit and the wage combined must not exceed the person's previous income (Kvist 2016).

**Finland**

In Finland, a 'partial sickness benefit' was introduced in 2007. The new benefit made it possible for the first time to combine part-time sick leave with part time work (Kausto *et al.* 2014). After the expiry of the sickness benefit payment, a person can claim disability pension between the ages of 18 and 62: until the beneficiary reaches the statutory pensionable retirement age. If there is a chance that his/her work capacity might be restored, the person may be granted a temporary cash rehabilitation benefit either on a full or a partial basis (Kangas and Kalliomaa-Puha 2016).

**Sweden**

The pension reform in 1994/1998 (fully implemented in 2003) separated disability pensions (abolished in 2003) from old age pensions and made all disability benefits part of the universal sickness insurance. A number of rehabilitation and retraining compensations and benefits are payable in connection to the sickness benefits. For example, a rehabilitation allowance, as well

as special allowances, may be granted instead of sickness benefits.

In 2008, the so-called 'Rehabilitation chain' has been introduced to the sickness insurance system. It consists in the establishment of a fixed time schedule for work ability assessments during the period of payment of sickness benefits (Hartman 2011). Although several steps of assessment have been set up, the Swedish social protection offers many possibilities of extended sickness benefits schemes.

Continued work is promoted by parallel efforts by public rehabilitation programmes (combined with sickness cash benefits), retraining through active labour market programmes, and through the general educational system (Input from Johan Fritzell *et al.*, ESPN national experts for Sweden).

A rather different case of reform in sickness benefits schemes is the United Kingdom. The country reformed its sickness and disability benefits schemes in the 1990, but unlike the examples of innovative schemes and programmes presented in Box 1, the newly-established reforms are based on activation and control rather than on rehabilitation. Employees who are sick may claim Statutory Sick Pay (SSP) from their employers. This benefit took over from the national insurance contributory sickness benefit paid by employers for short-term sickness. People who are disabled and unable to work may claim an Employment and Support Allowance (ESA). ESA replaced the 'incapacity benefit' and its non-contributory equivalent, the 'severe disablement allowance'. Employment and Support Allowance (ESA) is paid by the UK government to those with 'limited capability for work' who qualify for the SSP, after seven waiting days (Bradshaw 2016). These benefits have been combined with an increased requirement on retraining at work and reinsertion programmes as well as with a stricter control of the beneficiaries. For instance, a medical doctor's certificate (after the first seven days of sickness), called a 'fit note', can establish adaptations of working hours or work to aid their return. The doctor may refer the person to the Fit for Work service (government financed but independent) after 4 weeks in order to reinsert SSP beneficiaries. The ESA beneficiaries are subject to work focused interviews and other work related activities<sup>11</sup> (Ibid).

### 1.3 Conclusion

All Member States provide sick leave and sickness benefits. In most of them, workers are also entitled to sick pay (except for CY, DK, EL, IE and PT). Sick pay and sickness benefits schemes vary widely regarding their eligibility conditions, duration and replacement rates. In many countries, sick pay lasts between one day and two weeks (BG, CZ, EE, ES, HU, FI, LT, LV, RO, SE) but can also reach more than 30 weeks in a few countries (e.g. HR, NL). The entitlement to sickness benefits can vary widely from 22 weeks within 9 months in Denmark to 3 years in Portugal. Only Bulgaria and Slovenia do not have a determined sickness benefits' period.

The replacement rates of sick pay equally vary widely: from 25% (SK) to 100% (e.g. BE, FI). The sickness benefit replacement rates represent between 50% and 100% of the gross (or in some cases the net) salary. In the case of some flat-rate sickness benefits the replacement level can be estimated at around 20% (MT, UK). Slightly less than half of the Member States do not apply waiting periods: this is the case in BE, BG, DE, DK, FI, HU, HR, LI (except for authors/writers), PL, RO, SK and SL. In the remaining countries, these waiting periods last 3 days on average. In many of the EU Member States self-

<sup>11</sup> In October 2016, the UK government announced that these targeted measures will be dropped for people with long term and deteriorating conditions (Input from Bradshaw (2016), ESPN national expert).

employed are subject to different eligibility conditions and payment periods for sickness benefits when compared to contractual workers.

With regard to the right to return to work after sick leave, all European countries protection from dismissal is guaranteed during sick leave under certain conditions (except for Denmark).

After the duration of the sickness benefits expires, and the health status of the person has not improved sufficiently to return to work, the beneficiary can shift to another type of benefit: e.g. unemployment benefits, early retirement and disability pensions or social assistance. During the past decade, many countries have tried to address the issue of transition by creating new categories of benefits aimed at getting people back to work. So-called 'follow-up' benefits after sickness benefits indeed focus on rehabilitation, retraining, flexible work (e.g. AT, DK, FI, SE) and labour market insertion benefits for those with some degree of work incapacity. Their purpose is typically to avoid transition of recipients to permanent benefits such as early retirement and disability pensions.

## 2. ASSESSMENT OF THE SICK PAY AND SICKNESS BENEFIT SCHEMES IN THE EU 28

Over the past decade, most of the Member States have tried to reduce public finance expenditure on sickness benefits, in particular since the economic and social crisis in 2008. To this purpose, public authorities used different leverages such as reductions in benefit rates, tightening of eligibility conditions, shortening the duration of the benefits or reforming the payment arrangements (both sick pay from employers and the benefit paid by the social protection system).

The purpose of Section 2 is to provide some elements for assessment of the impact of recent reforms and to analyse the long-term trend in some variables where data are readily available. This exploratory section describes and analyses the consequences and the new trends following these reforms. It assesses features of the schemes such as coverage and take up (2.1), levels of income replacement of sickness benefits (2.2), and the evolution of expenditure on sickness benefits (2.3).

### 2.1 Coverage and take-up

Detailed comparative evidence on coverage and take up of sick pay and sickness benefits is scarce. In general, the take-up of long-term sickness benefits has decreased over the past decade in many Member States mainly due to the reforms of the eligibility conditions and the duration of the benefits aiming at reinserting people into employment. Moreover, particularly during the economic and social crises, some Member States have reduced the replacement rates of sickness benefits, which has also impacted the take up (e.g. CZ, LV, LT).

For instance, Hungary has been reforming sickness and disability benefits since 2003. As a result, between 2005-2013 the average daily number of sick pay beneficiaries decreased by half, from 102 to 54 thousand people. Likewise, the number of sick leave days decreased almost by half from 37 million to 20 million. As the eligibility conditions became stricter, the number of very short periods of sick pay leave increased while the number of claims over 30 days decreased. Moreover, replacement rates of sick pay have also been reduced. Hungarian experts also point to the practice of using the right to paid holidays as a substitute for sick leave, or being present at work in bad health because of the fear of losing one's job. In terms of gender differences in take-up, women stay at home on sick leave 40-56% more than men, mainly because of sick children (9 out of 10 cases) while men took sick leave because of work accidents twice as often as women (Input from Fruzsina Albert and Róbert Gál, ESPN national experts for Hungary).

In Sweden, long-standing reforms have been going on since the 1990s. There was a sharp decrease in the number of beneficiaries between 2002 and 2010. After 2010 the number of sickness benefit days has increased progressively, attaining 10.3 days in September 2015 (13.5 for women and 7.2 for men). As the number of sickness benefit days has increased by almost 70 per cent since 2010, spending on sickness benefits has increased by 12 billion (SEK) (1, 254 billion Euros) in the period 2010-2014. During 2015 there was a strong inflow of new cases of sickness, especially for psychiatric diagnoses. The length of sick leave also continued to increase (Input from Johan Fritzell *et al.* (2016), ESPN national experts for Sweden). However, it should be noted that the number of beneficiaries of sickness compensation in the age groups 55-59 and 60-64 has dropped considerably during the 2000s in Sweden. This was mainly due to the tightening of the early retirement possibilities (pensions/disability benefits)<sup>12</sup> (Försäkringskassan 2014). In

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<sup>12</sup> The most common diagnosis in these age groups are (a) musculoskeletal conditions and (b) psychological diagnoses (of which 55 % concern anxiety and 40% mood disorder), with increasing numbers especially among women. The number of older-workers receiving sick pay had increased slightly since 2010, but now remains stable and is at a historically low level.

Denmark, also due to various changes introduced in 2012 (see point 1.2) the number of sickness benefit claimants dropped by 27%: from 71,136 in 2011 to 51,660 in 2015 (Input from Jon Kvist, ESPN national coordinator for Denmark).

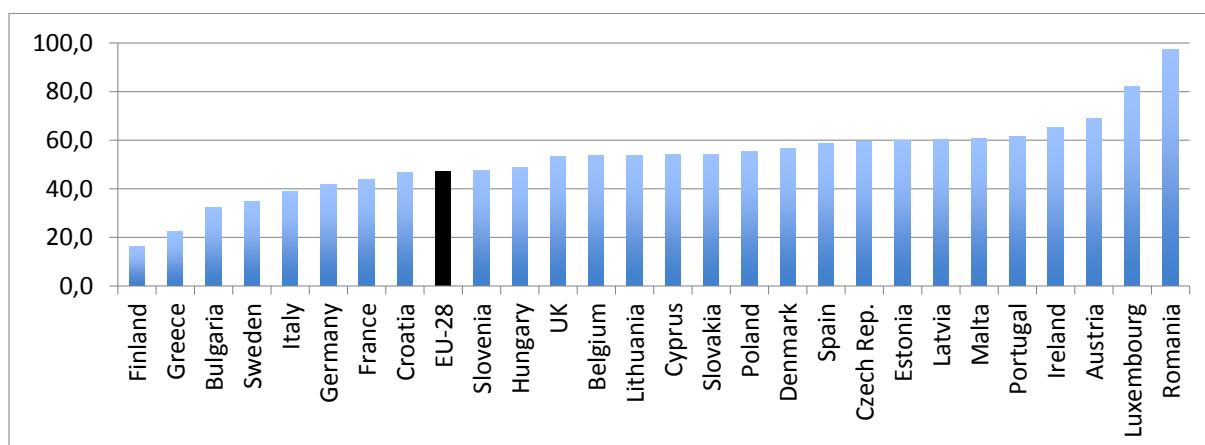
Another reason for the non-take up of sickness benefits in Europe can be related to the economic situation. Research from Sweden, Norway and the Netherlands shows that the number of paid sick leave days is related to economic cycles and diminishes during periods of high unemployment. The main reason for this is that workers are more likely to be dismissed in times of economic recession and might want to be present at work even when unwell. In addition, in many countries periods of unemployment allow for a transition to disability schemes and therefore reduce the number of paid sick leave days (Scheil-Adlung and Sandner 2010). The correlation is still obvious in Sweden, and to a lesser extent in Finland and Denmark (Thorsen *et al.* 2015).

In other countries, there is the opposite concern: the increase in the number of persons on sickness benefits and permanent disability. For instance, in Belgium in 2014, in order to tackle this issue, the national health insurance established a Health Care Knowledge Centre (KCE) to monitor and analyse these trends. The number of beneficiaries receiving short term sickness benefit from the national health insurance after the period of sick pay from the employer only slightly decreased from 417 thousand in 2011 to 409.5 thousand workers in 2012. The share of women is higher than that for men and the percentage is higher for blue collar workers than for white collar workers (Input from Wouter Schepers *et al.*, ESPN national experts for Belgium). The number of beneficiaries of sickness benefit for more than a year increased by 40% – from 264,668 to 370,408 – between 2009 and 2014. The cases of sick leave due to musculoskeletal disorders (MSD) have increased almost by half between 2010 and 2016 and cases relating to mental health disorders almost by 30% over the same period (Perl 2016).

In Finland, these categories of disease represent the most common reasons for partial sick leave (musculoskeletal disorders: 42,6%; mental and behavioral disorders: 29%). The number of beneficiaries of this partial sickness benefit has steadily increased in both categories over the past 5 years (Kela 2016).

Comparative data on coverage and take up are equally scarce. The European Labour Force Survey ad-hoc modules on 'Accidents at work and other work-related health problems' (EU-LFS 2008 and 2013) provide valuable information, although they only cover the aspect of a work-related health problems.

**Graph 4. Percentage of working age people (15-64 years old) reporting a work-related health problem resulting in sick leave in 2013**



**Source:** EU-LFS ad hoc module on 'Accidents at work and other work-related health problems' 2013 (no data available on The Netherlands).

Graph 4 focuses on self-reported sick leave due to work-related health problems. Around half (40-60%) of working age people report a work-related health problem in a large

majority of Member States (17 out of 27). The percentage is lower than 40% in only five countries (Finland, Greece, Bulgaria, Sweden and Italy), and in five countries it is largely higher than 60%: Portugal, Ireland, Austria, Luxembourg and Romania.

It should be noted that there has been a considerable increase in some countries in reporting a work-related health problem resulting in sick leave between 2007 and 2013 (AT, FR, HU, IE, LU, PL, PT, RO). For instance, there has been a considerable increase between 2007 and 2013 in Austria (from 55.4% to 68.9%), Luxembourg (63.4% 81.9%) and Romania (56.1% to 97.4 %). In some other countries, there has been a significant decrease (e.g. DE, CZ, FI, LI).

## 2.2 Levels of income replacement from sickness benefits

As described in Section 1.1, income replacement rates for sickness benefits vary between 50% and 100 %. In some countries that provide flat-rate benefits the replacement level can be estimated at around 20% (MT, UK). During the economic and social crises, some Member States reduced the replacement rates for sickness benefits (e.g. CZ, LV, LT).

For instance, in 2009 the sickness benefit replacement rate in the Czech Republic was 60% of the Daily Assessment Base from the 15th to 30th day of sick leave, then 66% for the next 30 days and finally 72% as of the 61st day of sick leave. In a context of fiscal consolidation, a single rate of 60% was established for 2010 which still applies in 2016. In addition, in 2008, a waiting period of 3 days was implemented. These changes have affected the income replacement ratio, which considerably decreased between 1996 and 2013 (Input from Tomáš Sirovátka *et al.*, ESPN national experts for the Czech Republic; see Annex 2).

Likewise, in Lithuania, between 2010 and 2015 the replacement rate of the sickness benefit was reduced by half: from 80% to 40% of the average monthly salary. Even though the previous rate was restored in 2015, some experts point to the fact that the self-employed still do not benefit from adequate benefits (Input from Romas Lazutka *et al.*, ESPN national experts for Lithuania). Reductions in replacement rate levels also occurred in Latvia between 2010 and 2014. Likewise, the long-standing reforms in Hungary not only reduced the take-up of sickness benefits but also their adequacy (Input from Fruzsina Albert and Róbert Gál, ESPN national experts for Hungary).

In Finland, sickness benefit is payable to all employees and all the self-employed, and to other categories such as students etc. In principle, the benefit is income-related without ceilings. However, the replacement rates, to some extent, are dependent on income brackets. These rules result in lower compensation rates in median-to-high-income groups. As an example, the replacement rate for the average income-earner has decreased from 87% in 1990 to 70% in the mid-2015. In the higher income categories, the decrease has been significant, from over 80% in the 1980s to about 35%-40% in 2010 (Input from Laura Kalliomaa-Puha and Olli Kangas, ESPN national experts for Finland).

In the UK, SSP and the ESA came to replace previous sickness and disability benefits, with the aim of reducing the number of beneficiaries. As discussed in Section 1.2, the income replacement level of the SSP benefits is around 20%. These benefits have been assessed as inadequate by UK social and rights workers, who point out that '*many people are faced with financial hardships and debt which can be debilitating when trying to live on a level of benefits which are clearly inadequate*' (UK Welfare Rights Worker cited in Etherington and Inogold 2012).



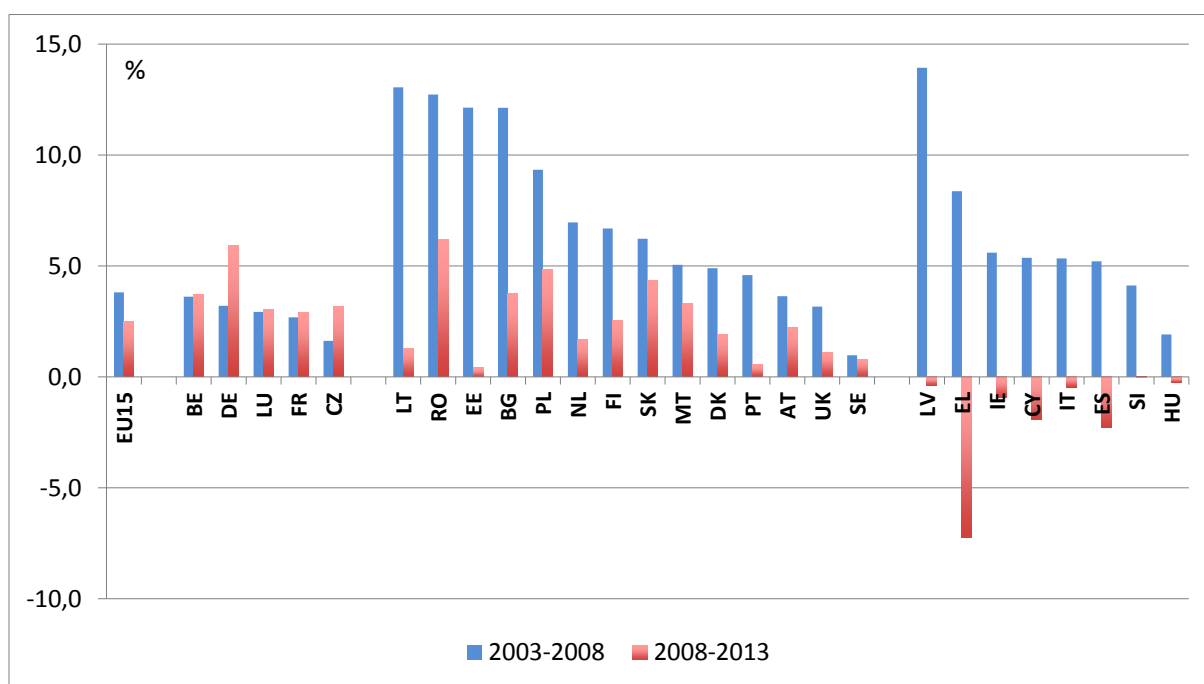
## 2.3 Long-term evolution of spending and cost-sharing between employers and social protection

This section mainly addresses the long-term trends in two variables from ESPROSS data: the annual evolution rate of sickness benefits (purchasing power standard, pps) per inhabitant (2.3.1), and the share of sickness benefits in GDP (2.3.2). The section also focuses briefly on cost-sharing of financing between employers (sick pay) and national social protection systems (cash sickness benefits) (2.3.3).

### 2.3.1 Evolution of sickness benefits expenditure

Graph 5 shows the differentiated effects of the crisis and the reforms on the evolution of the amount of sickness benefit per inhabitant in EU Member States. The average annual growth of sickness benefit<sup>13</sup> per inhabitant in EU15<sup>14</sup> was 3.8% during the period 2003-2008 and it significantly diminished to 2.5% after 2008. The trends of this indicator are strikingly different between the Member States. Nevertheless, all of them shared the same positive evolution of the indicator during the period 2004-2008.

**Graph 5. Average annual evolution rate of sickness benefits (pps) per inhabitant in two periods: 2003-2008 and 2008-2013**



**Source:** ESSPROS, 2016.

After 2008, the landscape is different and we can distinguish three groups of countries. As expected, due to the crisis-driven structural reforms and budgetary restrictions, the sickness benefit per inhabitant decreased during the period 2008-2013 in Latvia (-0.4%), Greece (-7.2% per year), Ireland (-0.9%), Cyprus (-1.9%), Italy (-0.5%), Spain (-2.3%), Slovenia (-0.02%) and Hungary (-0.24%).

A second (larger) group of countries (AT, BG, DK, EE, FI, LT, MT, NL, PL, PT, RO, SE, SK, UK) is characterised by a significant lower, but positive average annual growth rate of

<sup>13</sup> The amount of the sickness benefit is calculated in purchasing power standards (pps).

<sup>14</sup> EU28 data not available for an analysis for the period 2003-2013.

the sickness benefit per inhabitant. In some countries, the decline of growth is huge (e.g. EE and LT).

A third (small) group of countries comprises Belgium, Germany, Luxembourg, France and the Czech Republic. It is characterised by a rather small growth rate over 2003-2008 and considerably higher growth rates after 2008. In other words, sickness benefits do not seem to be affected by the economic crisis in these countries. In this respect, one point must be noted: four of these countries are characterised as Bismarckian or 'corporatist' regimes (BE, DE, FR, LU) in which the social protection has been, at least historically, built and managed by social partners and social insurances schemes.

### **2.3.2 Long-term trend in spending for sick leave in relation to GDP**

Besides the evolution of the amount of sickness benefit per inhabitant, another variable (ESSPROS, 2016) also provides some information on the long-term sustainability of the scheme in European countries: the spending for sick leave in relation to GDP (see Annex 3). These data comprise expenditure from both sick pay and sickness benefits due to sickness and injury<sup>15</sup>. In most countries under scrutiny the resources used for paid sick leave represent on average 0.97% (EU 28) and around 5.9% (together with disability) of the total social protection expenditure (40.4% EU28).

In 2012, the percentage of sick leave spending was 0.97% of GDP in the EU28 and, since 2008 (0.88%), the long-term trend is slightly increasing. We note again a very significant difference between countries. Romania has the lowest expenditure in the EU 28, accounting for 0.2% of GDP in 2013, followed closely by Portugal at 0.3%. At the opposite end of the spectrum, Germany (1.67%) and the Netherlands (1.95%) spend the highest percentage of GDP on sickness benefits.

Again, as for the rate of sickness benefit per inhabitant (i.e. the average annual evolution rate), the biggest decrease is observed in Estonia, Latvia and Lithuania between 2009 and 2013. The sharp decline in the percentage in the Baltic countries is due to the diminishing replacement rate of sick leave expenditure, which was cut almost by half between 2010-2014/2015, but is also largely influenced by the large GDP cycle due to the crisis. The Czech Republic's percentage has steadily decreased over the past decade, from 1.25% in 2003 to 0.57% in 2013. Likewise, there has been a considerable decline in Spain, from 1.07% in 2007 to 0.72% in 2012. A long-term significant decline can be observed in Sweden between 2003 and 2013 (from 2.24% to 1.29%). However, the percentage has again slightly increased in Sweden since 2010, when the level was 0.99%.

In other Member States the percentage of expenditure in terms of GDP has been quite stable over the past 10 years. There have been only small variations and in 2013 these countries have the following figures: Austria (1.06%), Denmark (0.9%), Croatia (0.96%), France (0.83%), Finland (1.2%), Belgium (0.84%), Slovenia (1%). Germany is an exceptional case where the percentage increased from 1.05 % in 2003 to almost 1.7% in 2013. Ireland is also an atypical case: expenditure increased from 0.67% in 2003 to 1.07% in 2010 and then slightly decreased to 0.82% in 2013.

### **2.3.3 Sickness benefit spending and cost-sharing**

The issue of cost-sharing of sickness absence is a high-profile one, and many governments have used or plan to use this leverage in order to tackle the problems of

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<sup>15</sup> More precisely, the data take into account (a) cash benefits which replace in whole or in part loss of earnings during temporary inability to work due to sickness or injury, (b) sick pay provided by employers in the form of continued payment of wages and salaries during sickness are taken into account (Eurostat, 2008; ESSPROS Manual, Luxembourg, Eurostat: 45). Separate data on sick leave and sickness benefits are provided in section 2.3.3.

sustainability of public finances. However, these reforms have contradictory consequences and lead to substitution effects in an increasingly complex system of distinct social protection benefits.

For instance, in Germany, the biggest share of sickness expenditure (around 75%) is paid by the employers, accounting for 1.5% of GDP. The expenditure for sickness benefit paid by the social security corresponds to about 0.37% of GDP<sup>16</sup>. Likewise, in Slovenia and Luxembourg, employers pay the highest share for sick leave. In 2013, Luxembourg paid 1.2% of GDP (€561 million) for sickness absence. Most of this amount (72%) was paid by the employer as sick pay (€405 Million). The National Health Fund has paid 22% (€121 million) on sickness benefits. Finally, a replacement revenue of 6% (€34 Million) was paid as a result of temporary sickness due to an occupational injury. However, it should be stressed that 80% of the employer's expenditure is refunded by a mutual insurance employers' fund (Input from Hugo Swinnen *et al.*, ESPN national experts for Luxembourg).

In Slovenia, employers also pay the biggest share for sickness absence (67%) in 2013 and the social protection system transfer accounts for 33%. However, the distribution of the total number of days paid by the employer and by the social security system is equal (50/50) and rather constant. It appears that the average duration of paid leave tends to be shorter for employers (7.8 days) than for the social security system (15.8 days). This means that the number of beneficiaries of sick pay is higher than those receiving sickness benefits from the social security system. Moreover, the average amount per day is also higher for the employers, due to the legislative requirements. A significant increase in spending (10.4%) between 2014 and 2015 is due to the growing number of cases (7.7%), but also to some transitions between benefits. According to the ESPN national experts, this is the consequence of a decrease in unemployment and a rise in the statutory pensionable age (Input from Nada Stropnik *et al.*, ESPN national experts for Slovenia).

In Croatia, cost-sharing figures are more balanced. Sick leave payments totaled for 2.76% of GDP in 2014 compared with 2.85% in 2013. In 2014, 1.25% of these were covered by employers, i.e. related to sickness of 42 days or less, and 1.51% were covered by the social protection system (sickness of over 42 days). The average length of sick leave in 2014 was 17.25 days, compared to 18.13 days in 2013 (Input from Paul Stubbs *et al.*, ESPN national experts for Croatia).

In other countries, the share of sick pay in the total spending is much lower. In Belgium, in 2013, the guaranteed wage payment by employers during the first weeks of sickness amounts to €759 Million of total spending while the National Institute for Health and Disability Insurance (INAMI/RIZIV) paid twice as much: around € 1,639 Million (both employees and self-employed). In April 2016, the Belgian Health Minister announced that she intended to increase the share of sick pay by employers and partly reduce the sickness benefit paid by the health system after the first period of guaranteed wage, for a certain period. The proposal is underpinned by the contention that employers will be stricter gate-keepers than the social security system (Input from Wouter Schepers *et al.*, ESPN national experts for Belgium).

However, the experience in Bulgaria shows that this type of reform may have a limited effect on constraining growing expenditure. Expenditure on sickness benefits has been relatively stable over the past ten years but there has been a fluctuation between 2010 and 2013. Expenditure decreased between 2010 and 2012 from 0.43% to 0.39% and then again increased to 0.43% in 2013. Recent data show that since 2013, these values have been constantly increasing and have reached record levels in 2015. These developments are surprising because Bulgarian policy makers have undertaken reforms

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<sup>16</sup> In order to tackle these imbalances in cost-sharing, Germany's Council of experts in the health sector suggested a discussion on a new model of part-time work on medical grounds.

since the beginning of the crisis in 2008. In 2009 there were discussions on the misuse of sickness benefit, so a 3-day sick pay was introduced in 2010. The underlying idea was that employers would become more aware of the use being made of sick leave and would exercise better supervision than the social security system. These measures have not worked as expected and the figures for sickness benefit expenditure are higher than in the previous 4 years. It appears that the measure provided some results in the first 2 years after its introduction, i.e. in 2010 and 2011. Although the reasons for this increase are complex (including GDP fluctuations due to the crisis), experts highlight that sick leave possibly served as a buffer, making up for other deficits in the social assistance system and the labour market (Input from Boyan Zahariev *et. al.*, ESPN national experts for Bulgaria).

## 2.4 Conclusion

Four main findings stand out from this assessment section. Firstly, based on partial information, it seems safe to say that some countries, which implemented long-term reforms of sickness benefit schemes, have seen a considerable drop in the coverage and take up of sickness benefits. Moreover, take up can be linked to economic cycles and diminishes during periods of high unemployment: workers sometimes fear dismissal and prefer being present at work. The second finding is that in some countries the income replacement level has diminished due to long-term reforms or *ad hoc arrangements* during the crisis. Thirdly, there are two distinctive trends concerning expenditure on sickness benefits. There has been a significant slowdown or even decrease in spending in many countries (e.g. DK, ES, HU, IE and LT). In a second group of countries, the trend has been towards a rather steady growth in expenditure (BE, DE, FR, LU). Fourthly, cost-sharing of expenditure between the employers and social security system is a rather complex issue and depends on the legal arrangements on sick pay. It appears that in some cases employers share the biggest part of expenditure. This may be due to the fact that the number of beneficiaries taking short sick leave (on sick pay) is higher than those on long-term leave (on sickness benefits). Moreover, in many cases employers pay a full salary or more than 80% of compensation rate.

### 3. KEY ISSUES AND RISKS FOR SICK PAY/BENEFIT SCHEMES

#### 3.1 The flipside of absenteeism: the challenge of presenteeism

Tightening conditionality and decreasing the rates of sickness benefits have resulted in a fall in the number of beneficiaries in the EU28. However, this situation also brought about an increase in presenteeism, i.e. the phenomenon of going to work while being in poor health. Over the past decade there has been increased interest in the challenge of productivity loss at work, as a result of presenteeism.

Although absence from work is easier to quantify and is often perceived as an important driver of financial costs, presenteeism can also be a significant challenge for employers and social protection systems alike. Some research estimated that presenteeism can cost a lot more than sickness absence and short-term disability (Goetzel *et al.* 2004 cited in Koopmanschap *et al.* 2013). For instance, recent studies also indicate that for 18 different diseases, presenteeism contributed between 14 and 73% (average 48%) of the total direct and indirect costs of enterprises. (Schultz *et al.* 2009 cited in Koopmanschap *et al.* 2013).

Absenteeism and presenteeism can be interrelated when a worker is not fully recovered but regained her/his normal working activity. This results in a high risk of deteriorated health and sickness absence. The reasons for presenteeism can be multiple, including downward economic cycles (high unemployment leading to fear to lose one's job), uncompensated waiting periods, strict demands of medical certificate, production-related factors, non-recognized psychological risks. Studies have shown that the non-recognition of psychological risks sickness such as burn-out and mood disorders caused by stress can lead to deterioration of the physical health status.

It should be stressed that challenges of sickness and disability vary according to the disease: they are quite different, for example, between musculoskeletal diseases and mental disorders. In the latter category, the outflow from disability benefits due to recovery has been lower than for musculoskeletal diseases (EHS Today 2016). In this respect, some countries recently initiated various programmes to tackle prevention of stress-related mental disorders and the issue of labour market reintegration of people who left the labour market because of this type of concerns. In Germany, for instance, there is an ongoing work programme, "Protection and strengthening of health in the case of work-related mental load" (2013-2018), run jointly by federal ministries, the Länder, accident insurance providers and social partners. Its main objectives are the identification of risks, prevention, information, development of special programmes and training of professionals (German presentation at the SPC 2016). Similarly, in Belgium, a comprehensive programme, "Multidisciplinary reintegration plan", including prevention, rehabilitation and labour market reinsertion, is announced for 2017 (Perl 2016).

The issue of recovery from sickness is complex and involves both sufficient offer of paid sick leave and rehabilitation/insertion schemes. Part-time sickness benefit schemes combined with employment and/or rehabilitation (available in the Nordic countries) have been analysed as good practices. Partial sick leave has been found to increase the likelihood of return to regular working hours and to be associated with higher employment rates. Again, the reason for the disease matters a great deal. Thus, a Swedish study reported a weak effect of partial sick leave on full recovery in the early stages of work disability due to mental disorders, and a stronger effect when partial sick leave was granted after 60 days of full sick leave (Thorsen *et al.* 2015). Although part-time sick leave can be considered as a good practice, recent studies and experiences show that prevention and comprehensive health programmes are extremely important to tackle the issue of presenteeism (EHS Today 2016).

### 3.2 Sick leave: the gender issue

Research shows that women make use of sick leave more often than men. For instance, in Denmark women on average have 11.23 sickness absence days and men 6.61. Likewise, in Sweden women take twice as many sickness absence days: on average 8.45 days, against 4.27 for men. The difference between men and women is higher for long-term sickness absence than for short-term sickness absence (Thorsen *et al.* 2015). In Germany, there are similarly important differences between men and women in all economic sectors. The most salient differences were observed in postal services, where female workers on average reported 17.3 sick leave days, as compared to 15.6 for male workers; in health services a similar picture arises: 14.6 for women and 12.2 days for men (Scheil-Adlung and Sandner 2010). Data from the UK also show considerable differences between men and women. Sick leave rates have fallen for both genders since 1993, but men consistently have a lower sick leave rate than women. In 2013 the lost working hours were around 1.6% for men (down from 2.7% in 1993). During the same period the reduction for women was from 3.8% to 2.6% (Office for National statistics of the UK 2014).

The reasons for women's higher sick leave take up are multiple and include precarious work and work contracts often linked to low income as well as part-time work, involving gaps in social health protection coverage (Scheil-Adlung and Sandner 2010). Moreover, it appears that women tend to report poorer health in self-evaluation questionnaires and are more inclined to seek medical help for less severe sicknesses. Women are also more often diagnosed with sicknesses related to mental health. Another explanation is related to the burden of home work and the care for children (Thorsen *et al.* 2015). Finally, women take sick leave related to pregnancy and birth. However, as pointed out by several ESPN national experts, the analysis of women's sick leave must include national employment rates by gender and age. For instance, Nordic countries have high employment rates for women aged 60-64 while this is not the case in France and the UK, which can explain lower sick leave take up in the latter countries (Scheil-Adlung and Sandner 2010).

Although women take more and longer sick leaves, research highlights that they are less likely to enter into disability schemes than men. However, they are more likely to transit to disability benefits once they have received a sickness benefit (OECD 2010). One of the explanations could be precisely the higher take up of long-term sickness benefits, but also the more frequent psychological (mood) disorder diagnosis. The structure of the labour market and female employment rates should also be taken into account when interpreting these data.

### 3.3 Sickness absence of older workers

Research shows that sickness absence rates increase considerably with age. One important nuance is however in order: older workers more often take long-term sick leave, while young workers have more short-term leave absence. This is for instance the case in Denmark, where both categories have a similar overall rate of sickness absence: on average 9.07 days for workers aged 50-59 and 9.5 days for 20-29. For long-term absence, older workers take almost twice as much leave when compared to their younger colleagues: 28 days versus 14 days. Likewise, in Finland, older workers take more long-term sickness absence (91 compared to 365 days). However, older employees have less medium-length sickness absence (15 to 90 days) than younger employees. The situation is very similar in Sweden, where older workers account for more both medium-term (15 to 90 days) and long-term (91 to 365 days) sickness absence (Thorsen *et al.* 2015). In the UK, sickness benefit take-up increases with age but diminishes when workers reach the standard pensionable age. In 2013, there were around 1.2% hours of absence due to sickness for those aged 16 to 24; and 1.5% for those aged 25 to 34. These figures increase with age: 2.0% and 2.8% sickness absence for the age categories 35 to 49 and 50 to 64, respectively (Office for National statistics of the UK 2014).

Finally, it should be noted that older workers report more work-related problems than their younger colleagues. In 2013, the percentage of work-related health problems resulting in sick leave in the EU28 was 42.7% for the age group 15-34, 47% for the cohort 34-55 and 49.8% for the age group 55-64. There is a significant increase in these figures though: in 2007 the corresponding figures were 33.8 %, 37.6% and 30.5%, respectively. The most striking increase concerns the age group 55-64: sickness absence rates rose from 30.5% to 49.8% (EU-LFS ad hoc module on Work related problems 2007 and 2013). More in-depth research is needed in order to analyze these data. There are however several plausible explanations. First, health status deteriorates with age and older people need longer periods to recover. Secondly the considerable increase between 2007 and 2013 can be the result of deteriorating work conditions due to the crisis. As mentioned before, in some countries psychological diagnoses are continually increasing among older workers (see point 2.1). This also underlines the relevance of the programmes of prevention, rehabilitation and job reinsertion for older workers.

Research on labour exit of Swedish older workers has shown that sickness benefits and disability pensions are elements beyond individuals' control that can determine an early exit from the workforce. Different studies (Nilsson *et al.* 2016; Försäkringskassan 2014) find an inverse correlation between involuntary exit pathways (e.g. sickness absence) and voluntary pathways (early statutory or occupational pensions). Therefore, when eligibility conditions for sickness absence are tightened (e.g. after the 2008 insurance reform), an increase in early retirement pensions partially counterbalances the decrease in sickness absence. However, reforms tightening eligibility conditions for early retirement and disability pensions generally resulted in lower take-up of disability benefits/pensions (Nilsson *et al.* 2016). The coverage of early retirement and disability pension schemes varies widely between Member States, and the highest rates are to be found in countries such as Estonia, Luxembourg, Belgium and Lithuania (see Annex 4). Between 2009 and 2012, there was an overall decline in the number of beneficiaries. There was an increase most particularly for disability pensions in Belgium and Estonia. Empirical data also suggest a transition from sickness benefits to disability benefits in the Baltic countries (see Graph 2 and Annex 4).

### **3.4 Sickness absence related to occupational and socio-economic status**

Research clearly points to a correlation between occupational status, socio-economic status and sickness absence. The more physically demanding occupation and the lower the socio-economic status, the more sickness absence is granted (Thorsen *et al.* 2015). As mentioned above, some countries even apply different rules for sick pay according to the workers' status: civil servants and white-collar employees may be entitled to longer periods of sick pay than blue-workers, and often to full pay during sick leave. By contrast, blue-collar workers typically have to cope with less favourable benefit level conditions (e.g. BE, FI).

Results from the ad hoc EU-LSF survey on accidents at work and work-related health problems (2013) show that self-reported health problems due to work vary only slightly between the category of managers and professionals and the category of plant and machine operator assemblers: 7.3% and 8.2% respectively. By contrast, the survey also shows that there are differences in reported work-related health problems with regard to education level. For instance, 52.3 % of people with pre-primary or primary education report a work-related health problem resulting in sick leave, while only 40% of those with tertiary education report such problems. Data on more narrow categories of occupation show that in the UK in 2013, workers in caring and leisure lose 3.2% of working hours because of sickness, and those in 'elementary occupations' 2.5%. At the opposite end of the spectrum, managers and senior officials lost half that time because of sickness: 1.3% (Office for National statistics of the UK 2014).

These results can only be considered as a partial explanation, as the LFS's categories by occupation are very large. However, research comparing blue-collar and white-collar workers (as a proxy for high physical work demands) indeed highlights that blue-collar

occupations experience higher levels of work incapacity (Shaw *et al.* 2013). Physical occupations (e.g., construction, nursing) are often associated with longer incapacity periods, but, interestingly enough, the *mean differences* between blue-collar and white-collar workers are not very large. A possible explanation is that white-collar jobs can be mentally and psychologically strenuous (Ibid).

OECD research emphasises that low-skilled workers have a higher risk of becoming a disabled beneficiary. Moreover, low-skilled sickness benefit recipients are more likely to transit to disability schemes than are high-skilled beneficiaries. Interestingly enough, high-skilled employees have a higher risk of transiting from sickness absence to disability benefits than medium-skilled employees (OECD 2010). Some studies propose the correlation between social-economic status and health literacy as a possible explanation (smoking, physical exercise, alcohol intake and dietary habits) (Thorsen *et al.* 2015). Although the correlation between occupational status, socio-economic status and sickness absence is complex, comprehensive prevention programmes – including return to work coordination, ergonomics worksite visits, physiotherapy, behavioural therapy and rehabilitation – have proven to prevent long-term absences (Tompa 2013). Moreover, the identification and monitoring of potentially long-term health problems at an early stage is essential for avoiding the transit from sickness to disability schemes (OECD 2010).

### 3.5 Conclusions

This section identified four main risks for sickness absence and transition from sickness to disability schemes.

Firstly, over the past decade research has identified presenteeism as an important issue related to loss of productivity at work. Being present at work in a poor health can lead to longer absence from work later on. Presenteeism is particularly relevant for mental disorders (including burn-out and depression), the incidence of which has significantly increased during the past decade and can also impact on general physical health. These issues can therefore have further knock-on effects on the disability and unemployment schemes. There is a need for social protection systems to help people before they become ill, namely through comprehensive prevention programmes. This is of particular importance for (newly recognised) mental disorders.

The second and third challenges are related on one hand to gender differences and age differences in sick leave take-up. Both women and older workers have more sick absence days and both take more long-term leaves. In a period where the overall shrinking of the working age population commits Member States to optimize the labour supply from available resources the benefits from limiting working hours lost due sickness absence are increasing.

Fourthly, research shows that occupation and socio-economic status matters for sickness absence. The more physically demanding the occupation and the lower the socio-economic status of the workers, the more sickness absence is observed. Even though these findings should be cautiously considered, they call for holistic prevention programmes and adequate sickness protection for the different categories of workers.



## **ANNEX 1: SPC In-Depth Review on sickness benefits: questions to the Member States - 17 October 2016**

### **1. Access to sick leave and sick pay/benefit schemes**

Sickness affects all people irrespective of type of employment contract, whether dependently or self-employed and irrespective of whether they are employed, unemployed or inactive. Still the access to and the quality of sick pay/benefits often differ for people in these categories.

*In your country to what extent do people, who are self-employed, working on a-typical contracts or unemployed have access to sickness benefit schemes? And to what extent do the access to and the quality of sick leave and sick pay/benefit differ between such categories as civil servants, white collar employees and blue collar workers?*

### **2. Coordination of sick leave and sick pay/benefit schemes**

Sick leave is the right to be absent from (and return to) work due to illness. Sick pay/benefit compensates (at least part of) the income lost during the absence due to illness. The two are supposed to combine to facilitate access to health care and recovery thus ensuring that people return to work as quickly as possible. Yet, in a number of countries, the duration of sick leave and the period of entitlement to sickness benefits are not well aligned. Moreover, sickness benefit schemes may not be particularly focused on enabling people to come back to their job. Notably, this can be the case when it comes to longer-term illness.

*In your country to what extent is the period of entitlement to sickness benefit aligned with the duration of sick leave? And to what extent are sickness benefit schemes and access to health care focused on enabling people to return to work before exceeding their right to sick leave?*

### **3. Avoiding that long-term sickness leads to premature LM exit on early retirement or disability**

Once the right to sickness benefits expires and the person is unable to return to work Member States usually provide some access to early retirements or disability pension possibly in combination with protected employment. But some Member States have programmes of re-habilitation and reinsertion that seek to intervene before the duration of sick leave and sickness benefits expire.

*In your country to what extent can people affected by long-term illness draw on supporting measures of re-enablement and re-insertion to help them get back to work and avoid a slide towards premature early exit?*

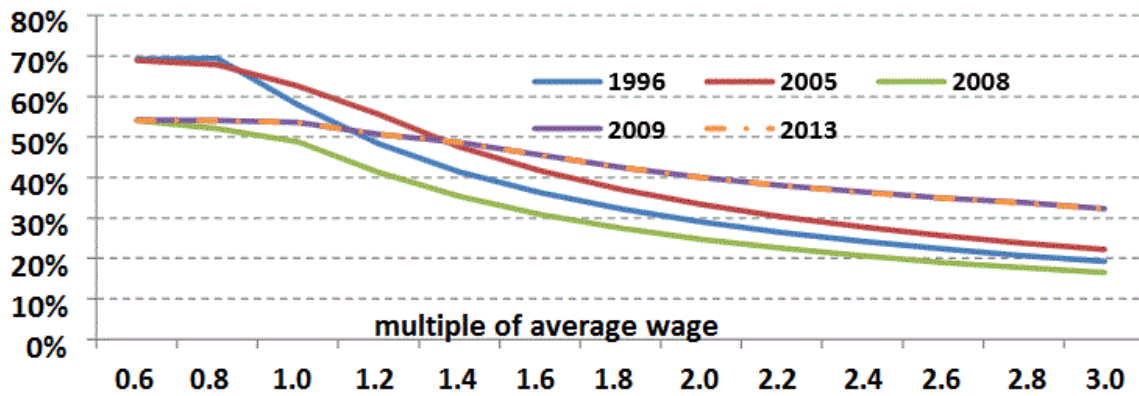
*Are there grey zones – such as overlaps, gaps or inconsistencies – linked to the transition between benefits, as a result of which people are left without coverage?*

### **4. Newly recognised mental disorders and sickness benefits**

Research shows that mental health problems (e.g. burn-out) related to work have become more frequent in the European Union. Around half of European workers consider stress to be common in their workplace, and research suggests that it contributes to around half of all lost working days.

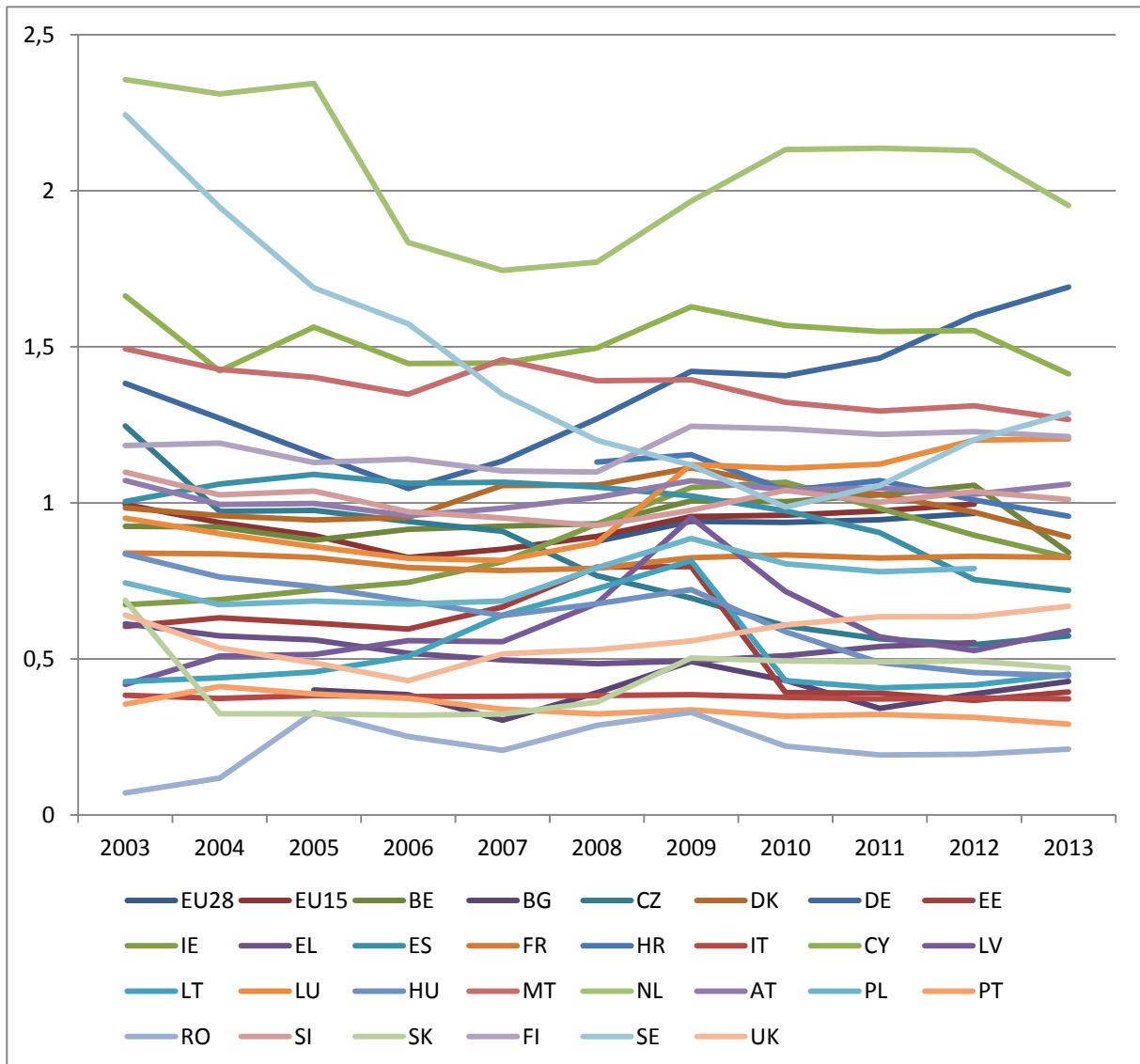
*Are such mental health problems recognised in your countries and how are they addressed in the sickness benefits policies?*

## ANNEX 2: Czech Republic: Change in the replacement ratio of sickness insurance between 1996 and 2013



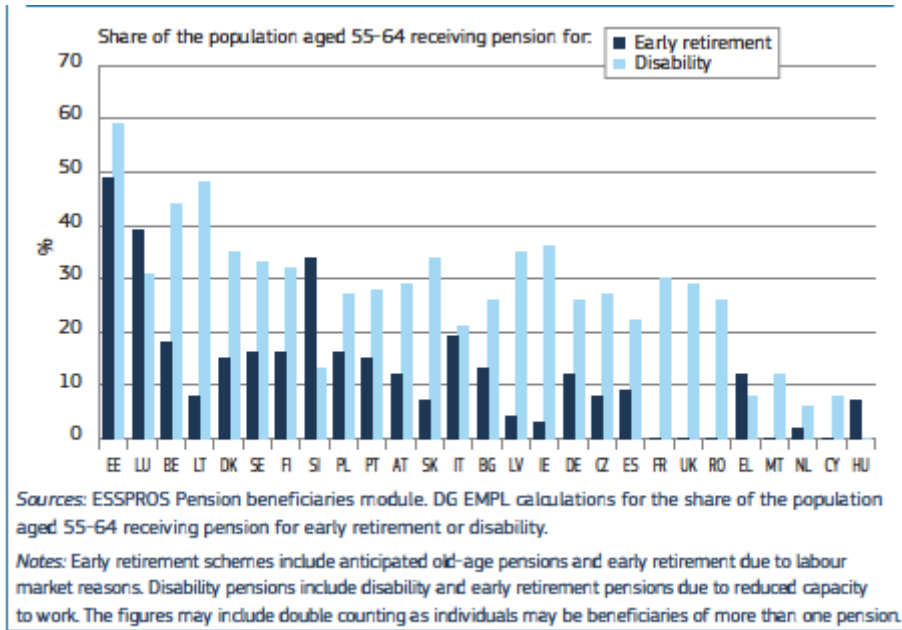
**Source:** Input from Tomáš Sirovátka *et al.*, ESPN national experts (data from the Czech ministry of social affairs, 2013).

**ANNEX 3: Evolution of the share of sick pay and cash sickness benefits spending to GDP 2003 - 2013 (in market prices €)**



Source: ESSPROS 2016.

### ANNEX 4: Share of beneficiaries per relevant population by type of pension (2012)



**Source:** European Commission (2016b).

**ANNEX 5: Countries' official abbreviations**

<b>EU countries prior to 2004, 2007 and 2013 Enlargements (EU-15)</b>		<b>EU countries that joined in 2004, 2007 or 2013</b>	
<b>BE</b>	Belgium	<b>2004 Enlargement</b>	
<b>DK</b>	Denmark	<b>CZ</b>	Czech Republic
<b>DE</b>	Germany	<b>EE</b>	Estonia
<b>IE</b>	Ireland	<b>CY</b>	Cyprus
<b>EL</b>	Greece	<b>LV</b>	Latvia
<b>ES</b>	Spain	<b>LT</b>	Lithuania
<b>FR</b>	France	<b>HU</b>	Hungary
<b>IT</b>	Italy	<b>MT</b>	Malta
<b>LU</b>	Luxembourg	<b>PL</b>	Poland
<b>NL</b>	The Netherlands	<b>SI</b>	Slovenia
<b>AT</b>	Austria	<b>SK</b>	Slovakia
<b>PT</b>	Portugal	<b>2007 Enlargement</b>	
<b>FI</b>	Finland	<b>BG</b>	Bulgaria
<b>SE</b>	Sweden	<b>RO</b>	Romania
<b>UK</b>	United Kingdom	<b>2013 Enlargement</b>	
		<b>HR</b>	Croatia

## ANNEX 6: Databases and References

### Databases

ESSPROSS, European System of Integrated Social Protection Statistics. Available [online](#).

Eurostat, Health care statistics. Available [online](#).

MISSOC, Mutual Information System on Social Protection. Available [online](#).

EU-LFS, European Labour Force Survey. Available [online](#).

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