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Sickness benefits in the EU: making sense of diversity

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Key points

- Income compensation during sickness **varies greatly** between Member States and over the past two decades has been the subject of important reforms, mostly aiming at enhancing the financial sustainability of these schemes.
- The overall reform trend has been towards **shortening** the duration of benefits and **reducing** replacement rates.
- This was especially the case during the **recession** and mostly in central and eastern European countries. Sickness benefits are among the social protection schemes which are more likely to be the subject of **austerity reforms** during economic downturns.
- New 'quick return to work' policies have only rarely been matched by **innovative strategies**, including follow-up benefits or suitable rehabilitation provisions. These policies should be approached with caution, and always be adapted to the work context and the type of illness.
- '**Presenteeism**' has become a significant social and economic challenge that should be acknowledged by domestic policymakers and social partners.
- In the context of the COVID-19 pandemic, public authorities should remove waiting periods and eligibility conditions for the self-employed and provide them with a replacement rate comparable to that of employees. Similar measures are needed for non-standard workers.

Introduction

One of the hallmarks of the European Union (EU) Member States' social protection systems, unlike that of other regions in the world, is the right to income protection in case of sickness. To differing extents, all EU countries provide three types of arrangements in case of sickness: a) sick leave; b) sick pay; and c) sickness benefits. Sick leave is the right to be absent from work during sickness and to 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; and sickness benefits are provided by the social protection system and are paid as a fixed rate of previous earnings or as a flat-rate amount¹. These features of income compensation during sickness vary greatly between

countries and have been the subject of reforms over the past two decades, mostly aimed at enhancing the financial sustainability of the sickness benefit schemes. One key issue is how the costs of both sick pay and sickness benefits are shared between the employer and the social security budget.

¹ The terminology and evidence provided in this policy brief draw on a comprehensive study, the data of which have been updated for the present publication (Spasova *et al.* 2016). The evidence in the country-specific cases has been provided mostly by Social Protection Committee delegates and European Social Policy Network (ESPN) experts. Updated legal information is drawn from the Mutual Information System on Social Protection (MISSOC) database, which can be consulted online.

Income protection in case of sickness has been widely recognised as a social right in key international agreements². The EU enshrined the right to social protection during sickness in its milestone Charter of Fundamental Rights (2000; Art. 34 and 35). At the same time, the European Commission proposed the right to 'adequately paid sick leave during periods of illness' for all workers in its March 2016 preliminary outline of the European Pillar of Social Rights. However, the clause was not included in the text of the Pillar that was solemnly proclaimed by the EU leaders and institutions in November 2017: in fact, the text does not even refer to sick leave. This should not come as a surprise, as the organisation and funding of sick leave and sickness benefit schemes fall within the competence of the Member States. Sick leave arrangements, and compensation in particular, is a sensitive topic on which the Member States have jealously defended their sovereign powers. This was clear to see during the debates on the proposed 'Directive on work-life balance for parents and carers' during 2017 and 2018.

The objective of this policy brief is to: a) review the current legal arrangements as well as the take-up of sick leave, sick pay and sickness benefits in the Member States; b) discuss the payment arrangements and the evolution of sick pay and sickness benefit expenditure, as well as current reform trends across the EU; and c) consider key challenges related to gender, age and socio-economic status.

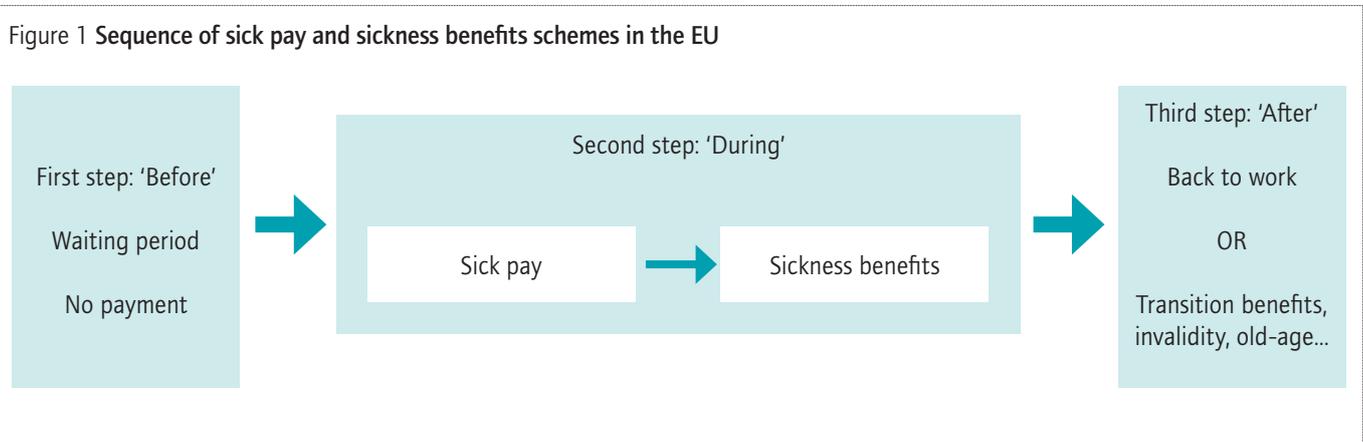
1. Social rights of workers in case of sickness: a snapshot

Despite the great diversity of legal arrangements for income replacement during sickness, the dominant model in most countries is built around three main sequences: 'before', 'during' and 'after' the receipt of the benefit (Figure 1).

The waiting period can be called a 'before' sequence, i.e. the 'period of time between the occurrence of the social security risk and the onset of the benefits' (MISSOC 2020) during which no compensation is paid. In general, waiting periods vary from one to seven days and last on average three days.

The payment of sick pay and sickness benefits constitutes the 'during' sequence. All Member States provide sickness benefits. In as many as 23 of them, there is also state-mandated sick pay provided by employers before the period of sickness benefit. By contrast, there are no state-mandated provisions in five countries, where sick pay is at the discretion of the employer or stems from collective agreements (see Table 1).

When the statutory period of receipt of sickness benefit terminates, the 'after' sequence begins: if workers provided evidence that they are unable to go back to work, the sickness benefit will be followed by a permanent incapacity benefit, early retirement and disability pensions, or social assistance – without a transitional gap.



Source: author's own elaboration.

Table 1 Waiting periods, sick pay and sickness benefits in the EU, 2019

Waiting period		Sick pay (state-mandated)		Sickness benefits
Yes	No	Yes	No	
AT, CY, CZ, EE, EL, ES, FI, FR, IE, IT, MT, PT, LV, SE, NL, UK	BE, BG, DE, DK, HR, HU, LT, LU, PL, RO, SI, SK	AT, BE, BG, CZ, DE, EE, ES, FI, FR*, HR, HU, IT, LU*, LT, LV, MT*, NL, PL, RO, SE, SI, SK, UK*	DK, CY, EL, IE PT	All EU Member States

Source: MISSOC (2020).

Note: *Specific arrangements between the employers' pay and the social protection system. This table focuses only on salaried workers' arrangements (i.e. self-employment is not included).

2 Including the International Labour Organisation (ILO) Social Security ('Minimum Standards') Convention (No. 102), the 'Social Protection Floor Initiative' led by the ILO and the World Health Organisation (WHO), and the United Nation's Universal Declaration of Human Rights (Articles 22 and 25).

As Table 1 shows, salaried workers have statutory access to sickness benefits in all EU Member States³. This is not always the case for the self-employed and the unemployed. Indeed, sickness protection for the self-employed varies widely between countries in terms of insurance (compulsory/voluntary), waiting periods, entitlement to benefits and income replacement rates. As a result, the self-employed, but also people working on non-standard employment contracts, are less protected in many countries. Box 1 provides some illustrations of recent measures taken by Member States that move in this direction.

Box 1 Examples of sickness benefits measures in the context of COVID-19, including for non-standard workers and the self-employed

Cyprus

In the context of the pandemic, sickness benefit will be paid to the self-employed under the same conditions as for employees.

Denmark

Employers or employees affected by COVID-19 will receive reimbursement of wages and sickness benefits as of the first day of sick leave, rather than after the usual 30 days.

Finland

A sickness benefit for those affected by COVID-19 (or told by a doctor to go into self-isolation) will be paid to both employees and the self-employed, accounting for the full loss of income and with no waiting period.

Ireland

For those affected by COVID-19 or told by a doctor to go into self-isolation, there will be no waiting periods, less strict eligibility conditions, and an increase in the benefit amount; this will be applied to both employees and the self-employed.

Source: author's own elaboration.

2. Payment arrangements and their duration

Sick pay

The 23 Member States which provide sick pay (see Table 1) can be divided into two groups, based on the duration of the compensation. In the first group⁴, containing the majority of the countries, sick pay lasts a maximum of two weeks. The second group⁵ provides much longer periods of sick pay, ranging from one month (for example, in Lithuania) to 721 days in the Netherlands (Figure 2).

In most countries, sick pay is calculated as a percentage (i.e. a compensation rate) of the (daily or monthly) gross wage, and varies from 25% in Slovakia to 100% of the monthly gross wage in Belgium and Finland. This compensation rate depends on various

3 Qualifying periods vary widely among countries. There are no qualifying periods in AT, CZ, EE, FI, HU, IT, LU, NL, SE, SK and SI (for detailed information see MISSOC 2020).

4 LT, SE, BG, EE, RO, SK, LV, ES, CZ, HU.

5 SI, FI, DK, BE, PL, DE, HR, LU, AT, MT, UK, FR, NL.

factors, such as the duration of the employment contract, the worker's status (civil servant, white collar, blue collar, etc.), the existence of collective agreements and the type of injury (for example, an occupational accident). Collective agreements may be of great importance as they can provide considerably better conditions than those enshrined in the law.

Sickness benefits

The maximum legal duration of cash sickness benefits for work absence again varies widely between countries: from 22 weeks within nine months in Denmark, to three years in Portugal. Only very rarely is there no maximum legal period (see Figure 3).

Comparing the duration of sick pay and sickness benefit (Figures 2 and 3), there is no correlation, either positive or negative, between the two: countries in which employers have to provide sick pay for only a short time do not automatically provide sickness benefits for a longer period. And vice versa: long periods of sick pay do not imply a shorter sickness benefit duration.

In the majority of EU countries, the replacement rate for sickness benefits varies between 70% and 100% (Figure 4), but it may also depend on the past period of social contributions, the worker's status (white versus blue collar), the arrangements in collective agreements, and the type of sickness (MISSOC 2020). It is noteworthy that in seven Member States the replacement rate is 50% or lower; in the UK and Malta it is as low as 20%.

3. National expenditure and reforms

Sick leave spending⁶ represented nearly 12% of total health and sickness social expenditure and 1% of GDP in the EU28. However, there are significant differences between countries. Greece and Romania have the lowest expenditure in terms of GDP in the EU28, at 0.2%. At the opposite end of the spectrum, Germany (1.9%) and the Netherlands (1.7%) spend the highest percentage of GDP on sickness benefits (Figure 5).

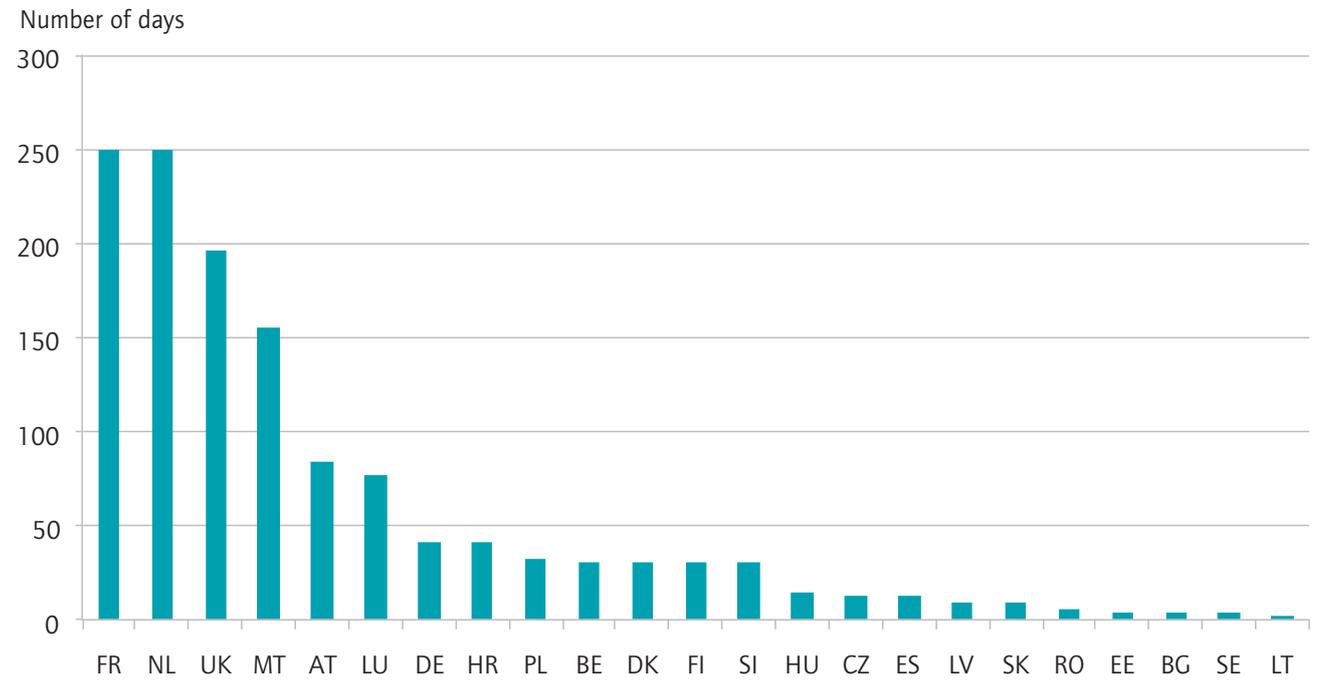
Impacts of the crises and reforms

The main reform trend over the past decade was towards reducing expenditure on sickness benefits – and in particular during the 2008 crisis period. The key mechanisms used to reduce the cost of paid sick leave were the establishment of waiting periods, reductions in income replacement rates and, in some cases, the introduction of sick pay: the latter measure was perceived as an opportunity to exercise closer control over the use of sick leave by the employer.

Even though the long-term trend in EU28 paid sick leave expenditure in GDP is relatively stable, many countries have had to cope with significant changes in expenditure. We can distinguish between two groups of countries regarding the evolution of paid sick leave expenditure in relation to GDP. The first group, made up mostly of

6 Sick leave spending refers to mandated sick pay by employers and sickness benefits from the social security system.

Figure 2 Maximum legal duration of sick pay in the EU28, 2019



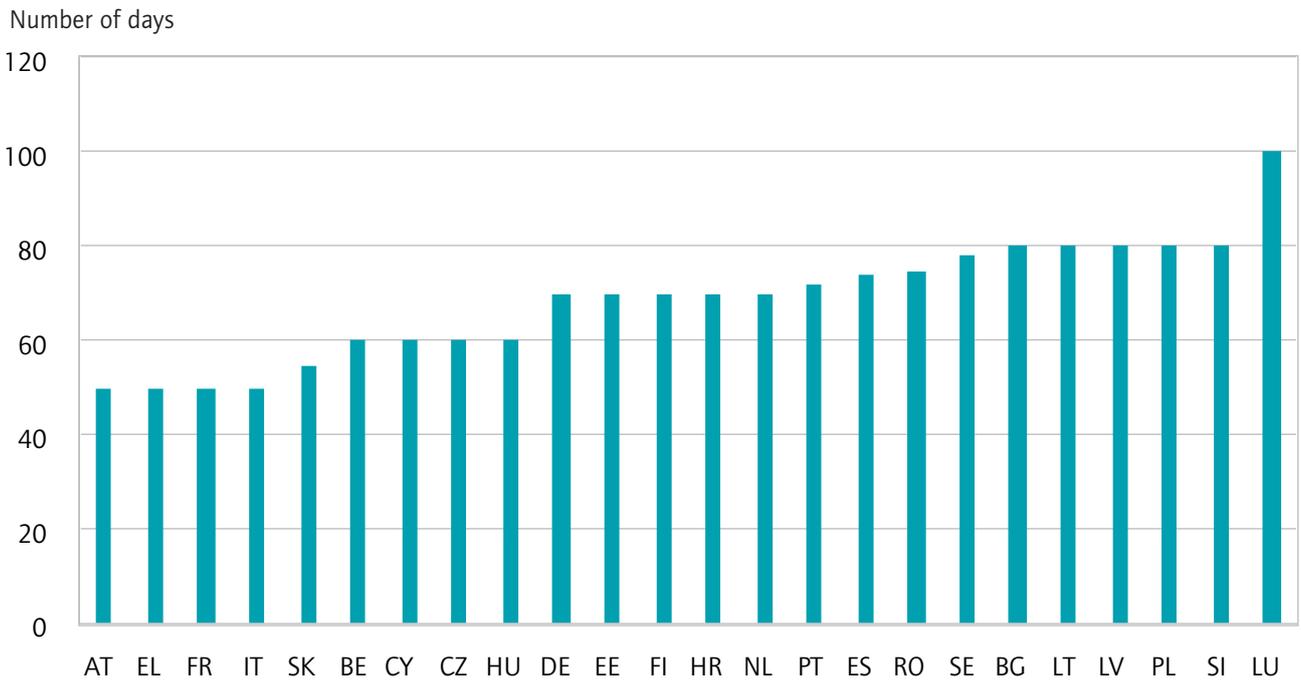
Source: MISSOC (2020).

Figure 3 Maximum legal duration of sickness benefits in the EU28, 2019



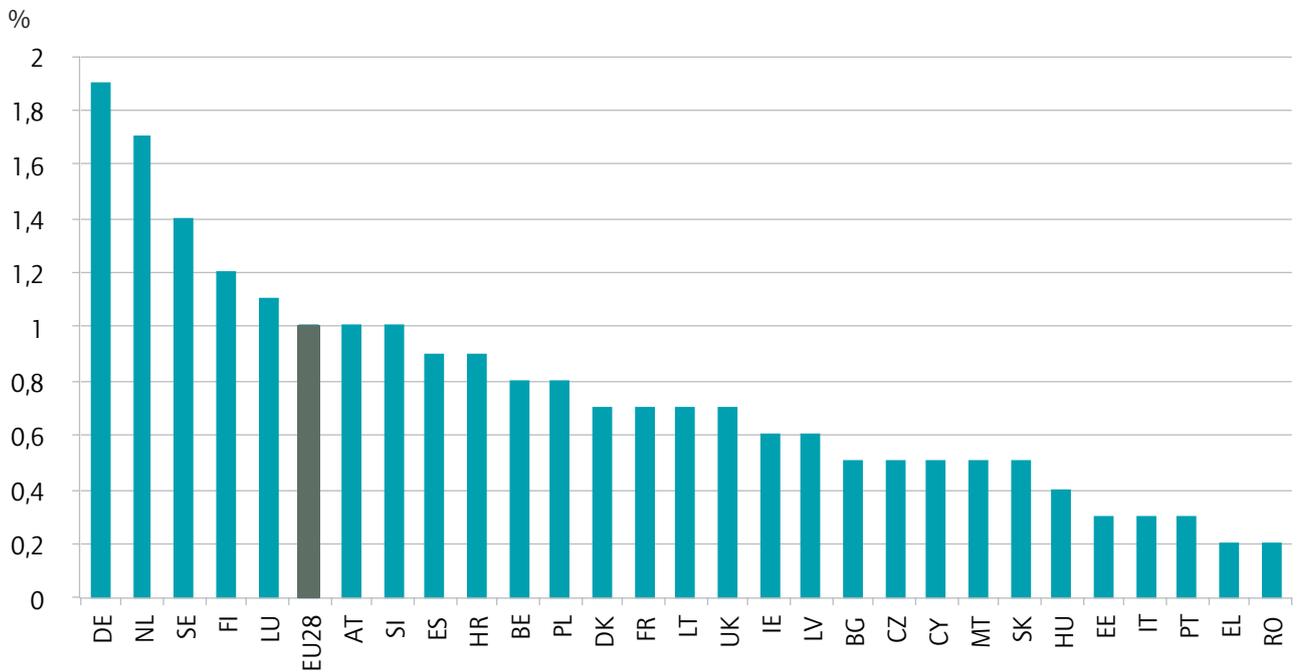
Source: MISSOC (2020).

Figure 4 Sickness benefit replacement levels, EU28, 2019



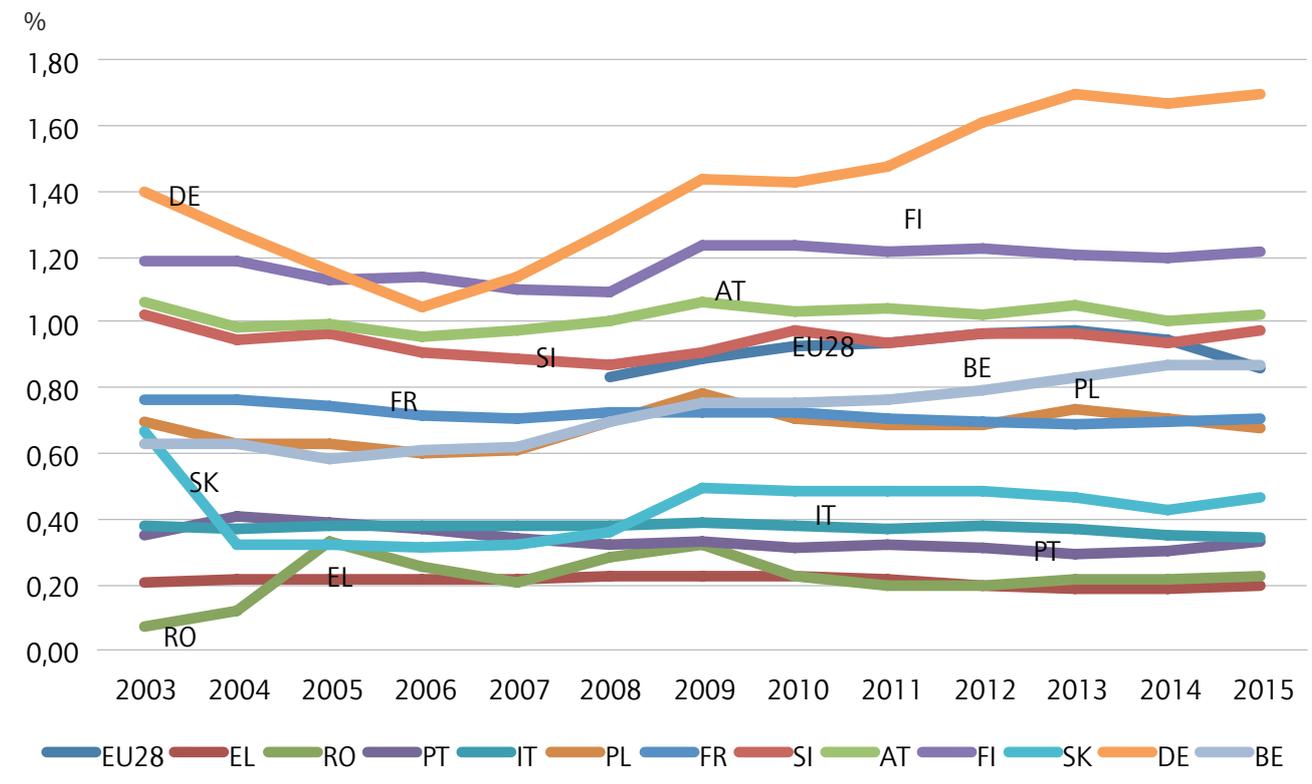
Source: MISSOC (2020). Please note that in some countries the replacement rate may vary according to the period of receipt of benefits, family situation etc. In Malta, Ireland and the United Kingdom sickness benefits are provided at a flat rate. Denmark calculates it on the basis of a specific method and does not apply a replacement rate.

Figure 5 Percentage of paid sick leave expenditure in GDP in the EU, 2016



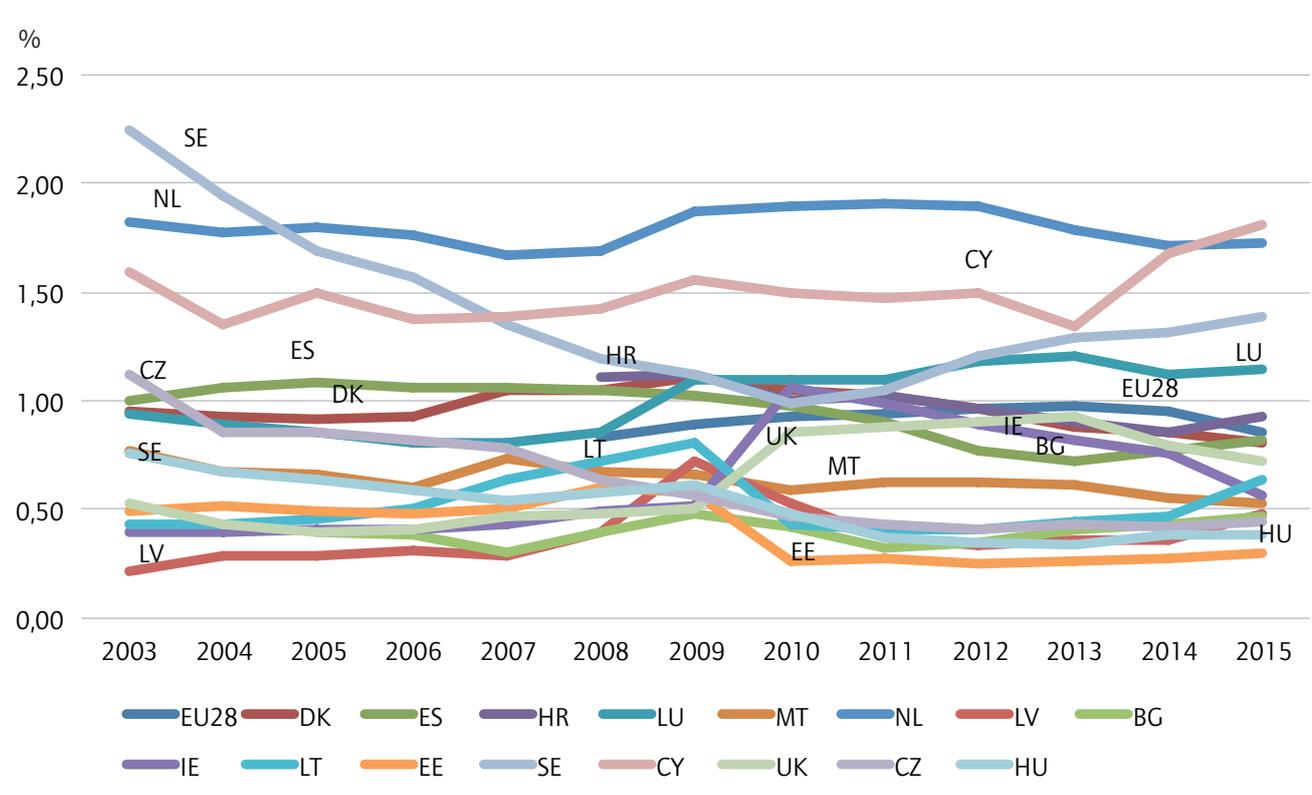
Source: Eurostat, ESSPROS (2019).

Figure 6a Evolution of sick pay and cash sickness benefits spending as a share of GDP 2003–2015



Source: Eurostat, ESSPROS (2019).

Figure 6b Evolution of sick pay and cash sickness benefits spending as a share of GDP 2003–2015



Source: Eurostat, ESSPROS (2019).

continental and southern European countries, is characterised by stability or even a slight growth in expenditure during the period 2003–2015 (Figure 6a).

The second group, by contrast, is characterised by a decline in expenditure (Figure 6b). In some of these countries (mostly in central and eastern Europe and Ireland) there has been a considerable drop in expenditure, especially during the crisis period, just after the implementation of important reforms.

Most of the countries in group two, which witnessed a considerable drop in sickness benefits expenditure during the crisis, implemented temporary measures such as cuts in replacement rates and in the duration of benefits (for example, the Czech Republic, Hungary, Latvia and Lithuania). In Lithuania, between 2010 and 2015, the replacement rate of sickness benefits was reduced by half: from 80% to 40% of the average monthly salary. Another example of drastic reforms is Hungary, which has been reforming sickness and disability benefits since 2003. As a result, between 2005 and 2013 the average daily number of sick pay beneficiaries decreased by half. Meanwhile, the number of sick leave days was reduced almost by half, as was the expenditure as a share of GDP (0.61% to 0.34%). In Ireland, in 2005, employees with long-term illnesses could receive sickness benefit indefinitely, but by 2016, the indefinite duration entitlement had been abolished and a maximum duration of two years imposed (Spasova *et al.* 2016).

Financing of sickness benefit schemes has long been on the political agenda of many Member States: notably the legal provisions related to cost-sharing between employers and the social security system. In some countries, employers account for the biggest part of expenditure. This may be because the number of beneficiaries taking short-term sick leave (on *sick pay*) is higher than those on long-term leave (on *sickness benefits*). In addition, in many cases employers pay a compensation rate of more than 80%, or even a full salary (see Section 1).

For instance, in Germany, the greater share of sickness expenditure (around 75%) is paid by the employers; likewise in Slovenia and Luxembourg. However, in other countries such as Belgium and Croatia, the share of sick pay in terms of total spending on sickness expenditure is much lower.

Some countries have used employers as gatekeepers to the social security system, i.e. introducing a sick pay. The experience in Bulgaria, where three-day sick pay was introduced in 2010, shows that this type of reform may have a limited effect on constraining expenditure growth. Although expenditure decreased between 2010 and 2012, from 0.43% to 0.39%, it began to increase again from 2013 and reached record levels in 2015 (Spasova *et al.* 2016).

Finally, and especially in the context of the 2008 recession, 'quick return to work' policies have been high on the agenda of several Member States. Only a few of them, however, 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' (for example, in Austria, Denmark, Finland and Sweden; for more information, see Spasova *et al.* 2016). By way of illustration, in Finland a 'partial sickness benefit'

was introduced in 2007; this is a voluntary arrangement, making it possible to combine part-time sick leave with part-time work. In Austria, temporary invalidity pensions were replaced by a 'rehabilitation benefit' and a 'retraining benefit' in 2014. These kinds of benefits and partial sick leave are expected to maintain the connection to the labour market and involve both employee and employer in finding an arrangement which suits both sides. Some research in Nordic countries has indeed shown positive effects of these practices (Kausto *et al.* 2008, Thorsen *et al.* 2015).

However, there is no one-size-fits-all solution. Research shows that total sickness absence was about 20% lower for people with musculoskeletal pain on part-time sick leave than for people with musculoskeletal pain on full-time sick leave. By contrast, partial sick leave has had only a weak effect on full recovery in the early stages of work disability due to mental disorders, and a stronger effect when it was granted after 60 days of full sick leave. In most of these schemes the social partners have an important role to play in designing the rehabilitation programme and the work arrangements (Thorsen *et al.* 2015). These practices should thus be addressed with caution: there are several factors involved, such as the type of illness, the access to well-suited rehabilitation and training practices, and the role of the social partners. The latter should play an important role in the design of the arrangements and as an intermediary between the employee and the employer.

4. Old and new challenges for sickness compensation

Ageing, gender and socio-economic status are the most well-known and well-documented challenges with regard to sickness compensation. However, several nuances should be considered.

Age: moderate but increasing differences between cohorts

Research shows that sickness absence rates increase considerably with age. Older workers more often take long-term sick leave, while young workers take more short-term leave (Thorsen *et al.* 2015). In general, older workers report more work-related problems than their younger counterparts, but the difference is not striking. In 2013, the percentage of work-related health problems resulting in sick leave in the EU28 was 42.7% for the 15–34 age group, 47% for the 34–55 group and 49.8% for the 55–64 group (EU-LFS ad hoc module on work-related problems 2007 and 2013).

Gender: women's higher sick leave take-up

As far as gender differences are concerned, research shows that women take sick leave more often than men, and especially more long-term leave (Thorsen *et al.* 2015, Scheil-Adlung and Sandner 2010).

The reasons for women's higher sick leave take-up are multiple and include precarious work and work contracts often linked to low income (Scheil-Adlung and Sandner 2010). One of the main explanations is women's responsibility for housekeeping and care activities, and especially the care of children and older relatives;

this can result in sick leave related to care activities (Thorsen *et al.* 2015). Women also have more frequent psychological (mood) disorder diagnoses (OECD 2010).

Occupational and socio-economic status: no dominant factors

Research has demonstrated a correlation between occupational status, socio-economic status and sickness absence, although the differences are not significant. The more physically demanding the occupation, and the lower the socio-economic status, the higher the take-up of sick leave (Thorsen *et al.* 2015). Physical occupations (such as construction and nursing) are often associated with longer incapacity periods, but, interestingly enough, the differences between blue-collar and white-collar workers are not large.

For instance, 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 (ad-hoc EU-LSF survey, 2013). By contrast, low-skilled workers have a higher risk of transiting to long-term/permanent benefits than high-skilled beneficiaries (OECD 2010).

Presenteeism: the flipside of absenteeism

Absenteeism is a well-researched subject in relation to sickness benefits. From an economic point of view, absenteeism has been blamed for losses in productivity and profit. However, another, 'new' challenge is emerging, linked to some extent to absenteeism: *presenteeism*, i.e. the fact of going to work while in poor health. Some research has estimated that presenteeism can cost a lot more than sickness absence and short-term disability (Goetzel *et al.* 2004, Smith 2016). Recent studies also indicate that for 18 different diseases, presenteeism contributed between 14% and 73% (on average, 48%) of the total direct and indirect costs of enterprises (Schultz *et al.* 2009).

Absenteeism and presenteeism can be interrelated when workers return to their normal working activity while still ill or not fully recovered. A vicious circle is then created, which may lead to a high risk of health deterioration and thus to more sickness absence. The reasons behind presenteeism are multiple, including downward economic cycles: high unemployment leading to fear of losing one's job, waiting periods without compensation, strict requirements for a medical certificate and non-recognised psychological risks which can lead to a deterioration of physical health. In this respect, workfare 'return to work' practices should be designed in a way to avoid the risks of presenteeism.

It should be stressed that presenteeism is particularly a problem for those with mental disorders (including burn-out and depression), the incidence of which has significantly increased during the past decade, and which can also impact on general physical health (Kela 2016, Goetzel *et al.* 2004).

Conclusions

The majority of the Member States follow the same model for income protection in the case of sickness: state-mandated sick pay provided by the employer and sickness benefits financed by the social security system. Yet the practical arrangements vary considerably: eligibility conditions, the employment status of the person, waiting periods, duration, and replacement rates, as well as expenditure in relation to GDP. The self-employed, but also people working in non-standard employment contracts, are less protected in many countries.

Over the past two decades, and especially during the great recession, countries have reduced the access to sickness leave in order to improve the financial sustainability of their social protection systems.

An increasingly important challenge in relation to sick leave is presenteeism, which typically leads to absenteeism, particularly when related to psychological disorders. The issue of recovery from sickness is complex and involves both sufficient provision of paid sick leave and rehabilitation/insertion schemes. And while 'quick return to work' policies have been on the agenda of several Member States, only a very small number of countries have established innovative and comprehensive follow-up programmes and benefits. Presenteeism should be taken seriously, now more than ever in the corona crisis.

We believe that in the context of the COVID-19 pandemic, public authorities should remove waiting periods and eligibility conditions for the self-employed and provide them with a replacement rate comparable to that of employees. In a similar vein, public authorities should suspend the requirement of a qualifying period for non-standard workers.

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