

Policy Department  
Economic and Scientific Policy

**Cancer and in general  
long-term illnesses at workplaces**

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## Executive Summary

Poor health represents a major factor of exclusion from the labour market due to the influence it exerts on early retirement. A key issue for policy makers is how to maintain the worker with residual potentialities in active life and at the same time cope with the difficulties the worker and employer come up with continued presence in the workplace.

The aim of this study is to gain an understanding of the barriers but also of the facilitators enhancing reintegration outcomes for chronically sick and absent workers. Without such an understanding, it is difficult to design and develop appropriate and transferable interventions and approaches. Cancer is addressed as a specific long-term illness throughout the study, in order to delimit, and, at the same time, concretise issues and proposals. The study also intends to highlight the characteristics of national legislations concerning support for workers with long-term illnesses to regain, where possible, social inclusion and integration in the labour market. The different schemes and approaches applied across the Member States are analysed to point out the level and duration of social protection of sick workers as well as how different countries support the workers' wages and previous standard of living during and after sick leave. The study also intends to analyse 'return to job' problems, policies and forms of reintegration of workers.

Considering how wide-ranging the implications of the "work and illness" issue are, and the fact that they can be analysed from several points of view and different perspectives, *Chapter I* focuses, on the one hand, on defining the perspectives and issues the study will consider, and on the other hand, on the relevant definitions that help to determine the limits of the study. *Chapter II* describes the activity rate and to what extent people with disability or long-term/chronic illness are involved in the labour market. Data on public spending on social protection across Europe are analysed, in particular as far as sickness benefits and disability pensions are concerned. Legislation on sick leave and sick benefits is the focus of *Chapter III*, which analyses different schemes throughout the European Union. *Chapter IV* presents examples from case studies: Finland, the UK and the Netherlands have been chosen as models of reintegration of workers in the labour market. Romania and Italy (together with the UK) are considered as of specific interest having special provisions for workers affected by cancer, and Italy in particular for the attention to the care perspective.

*Chapter V* presents the patients' point of view on the matter. European level organisations representing the voice of specific groups have been contacted in order to acquire data, information, and views on the possibilities to combine work and treatment and their suggestions on how to deal with job reintegration after a long period of absence from work.

Finally, *Chapter VI* summarises issues, problems, debate and best practices across Europe, analysed from the worker's perspective, from the perspective of the caregivers and from the perspective of the overall community, considering the positive and negative aspects, the barriers, and the specific support required.

### **Definition of long-term illness and relation with the definition of disability**

Despite the efforts of the World Health Organisation, there is no universal international legal definition of disability, nor is there any common definition in the EU countries. Recent studies on definitions of disability in various EU countries have shown variations from country to country but also within the countries. In general, within a Member State, each service may have its own definition of chronic illness and disability.

The same is true when qualifying illness. Proof of such difficulty is that the distinction between illness and disability is sometimes controversial. The European Court of Justice has recently addressed the issue in the *Chacón Navas case*, with an outcome that many experts of the field consider largely unsatisfactory. The Court took the view that the Community legislators, by using the concept of 'disability' in the anti-discrimination directive 2000/78/EC, deliberately chose a term that differs from 'illness'. The two concepts cannot therefore simply be treated as if they were the same. As a result of this decision, the protection from employment discrimination provided to disabled and ill people will continue to vary widely among the Member States.

The problem of consistency between medical, social and legal definitions is of the utmost importance, since the provision of financial benefits, services and other measures related to chronic illness and disability require the definition of the conditions under which a person may claim a right to them.

### **Illness and active life**

Eurostat data show that on average 18.4% of the European population aged 15 and over are hampered in their daily activities because of chronic conditions with considerable differences between countries. Data from the European Union Labour Force Survey indicate that in 2002, nearly 44.6 million people aged between 16 and 64 years had long-standing health problems or disabilities, but unfortunately, there is no distinction between disability and long-term illnesses. Data from SILC 2005 on people with long-standing illness or health problems reveal that the best employment integration is in Sweden and Finland with a success rate of around 30%, followed by Estonia, UK, Latvia and Germany (around 26% to 24%). The lowest rates of employed people are to be found in Mediterranean countries such as Greece, Malta, Italy and Spain (9-13% approx.).

Factors associated with job reintegration after long-term illness have also been analysed. Given the improvement in early diagnosis and cancer treatment, leading to higher survival rates, there is a rising incidence of workers with cancer diagnosis subsequently returning to paid work. This represents a fundamental result for individuals, employers and society as a whole.

The situation in Europe appears fragmented with significant differences in terms of expenditure on specific policies aimed at supporting disabled and sick workers. It also appears fragmented from the private and market perspective, in terms of accessibility and opportunities available for those who could have the opportunity to regain an active life if supported by technologies (teleworking), flexibility and specific measures of reintegration. After a long illness, many workers could return to work if supported by adequate technologies. In particular, in the case of workers that have found their autonomy reduced due to illness, or that require frequent periods of rest during the day, tele-work could represent a serious opportunity to reduce the period of sick leave. It can be observed that this opportunity is limited to white collars whose work can be assisted with the new technologies.

The figures present a broad gap existing between countries where tele-work is a possible support in returning to work for a large population of sick workers and countries where such accessibility is particularly limited.

### **Legislation on sick leave and sickness benefits**

The instrument of social security traditionally used to address the classical risks arising in industrial society (e.g. illness) shows weaknesses under certain circumstances: on the one hand, the ongoing changes affecting the structure of modern society put much pressure on welfare systems, bringing about problems in terms of economic sustainability.

Thus, attempts have been made, particularly at the EU level, to follow new and different paths with implementation of activation strategies aimed at enabling workers affected by chronic illness to reconcile their own condition with work activity. It is often said a quality job is the best safeguard against poverty and social exclusion. Increasingly, Member States are adopting "active inclusion" as the preferred route to promoting social and labour market integration. A balanced active inclusion approach requires to be accompanied by opportunities to build human capital, including the acquisition of IT skills, and addresses any existing educational disadvantage; it must also be accompanied by adequate counselling and guidance offered to the individual. Although the approach promoting early job reintegration seems dominant and enjoying widespread success, some criticism has been raised recently. In particular, the emphasis placed on the idea of "inclusion through work" seems to alter the relation between the various aspects of policy coordination so that the social aspects are substantially subordinated to economic-employment considerations: *"It is possible to argue that the social agenda is currently governed to maintain the economy and not for solely social purposes. In this context, employment and social policies are not only subordinated to the overall goal of competitiveness, but are intended to actively support this goal"*<sup>1</sup>.

For each of the 27 countries a short report on the protection system for illness at the workplace has been drawn up with an analysis of the current legislation: all 27 European countries have a compulsory social/sickness insurance scheme, which is universal only in the case of Finland. In all the other 26 countries, the beneficiaries are either all economically active people (employees and self-employed) or only employees. In general, the Nordic systems – in keeping with their more "universalist" vocation – show more awareness of the need to provide specific solutions, in the case of sickness, for unemployed people (who are particularly exposed to the risk of social exclusion). On the contrary the vast majority of Continental/ Mediterranean countries ensure no specific protection for the unemployed (e.g.: Italy, France, Spain, Greece, the Czech Republic), whereas higher protection is ensured in Germany and Belgium. In most European countries, the amount of benefit is related to the earning/income of the workers, except for Belgium, Ireland, Malta and the UK, where a lump sum or a flat rate benefit is paid; in Greece and Spain, it is related to contribution levels. The amount of the benefit is very different in terms of i) the percentage of earnings considered, ii) the components of the earning taken in consideration for the calculation, iii) the presence and level of a ceiling. The duration of sickness benefit differs considerably across Europe: a range of solutions can be identified from a minimum of 6 months (in Estonia, Greece, Italy, Cyprus, Malta, Poland and Romania) to a maximum of unlimited duration as in Bulgaria, Ireland and Sweden.

Alternative ways to address the issue of job reintegration of the chronically ill have been considered by adopting a more comprehensive approach including differentiated strategies and measures. Alternative measures and policies to sick pay allowance can be divided into three groups or categories: a) measures aimed at adapting the workplace and work activity to workers' reduced capacity; b) measures aimed at fostering life-long learning; c) measures aimed at removing individuals from the workplace whose reduced work capacity does not allow them to perform the assigned tasks (or any other task).

### **Main findings and issues**

The possibility to return to work has a direct impact on individuals and their families, while there are also clear implications for the overall community represented by employers and the economy, the health sector and the welfare system.

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<sup>1</sup> Kröger S., *Let's talk about it. Theorizing the OMC (inclusion) in light of its real life application*, Paper prepared for the doctoral meeting 2004 of the Jean Monnet chair of the Institut d'Études Politiques in Paris

### *From the perspective of the workers*

- Return to work for workers affected by long-term illness represents an important achievement for them, as it is a considerable step towards complete recovery and return to active life. However, various studies have demonstrated that return to work also involves several drawbacks such as stress, and deterioration in career prospects and job satisfaction.
- Job regaining is an essential step towards the return to 'life' but in many cases a prompt return can be associated with economic reasons: some survivors may work in spite of cancer related disabilities, to retain employer-sponsored health insurance, to replace income lost during treatment, or to cover expenses and protect against financial uncertainties associated with survivorship.
- According to the literature education levels and occupations modify the effect of cancer on employment. Individuals of lower educational attainment have a higher probability to have an earlier and 'harder' job reintegration compared to those with higher educational attainment. There may be more opportunities for individuals of higher educational attainment to access prolonged medical leave or to return to work part-time.
- The literature identifies some specific determinants of work resumption linked to different sectors and the type of jobs in which such labour integration appears possible. Long-standing illnesses seem to have stronger adverse social and economic effects on manual workers as, for example, manual jobs are less flexible, heavier, and teleworking is not possible. Consequently, manual workers have a higher incidence of disability: it is obviously easier for white collar-jobs to return to work, whereas jobs presupposing heavy physical activities can be very difficult for cancer patients to go back to. This also applies if the job involves piecework.
- Many studies concerning the rate of return to work and the factors associated with return to work in cancer survivors have been carried out. The rate of return to work ranges from 30% to 93%, with a wide variation in the factors affecting it. Factors that can adversely affect return to work include: a non-supportive work environment; manual labour employment; work posing physical demands; the site of a cancer, age and type of treatment all appear to have an impact on people's work decisions
- Employment discrimination is also an ongoing concern, since many legislations prohibit discrimination against disabled people but not against chronically sick people at both the European and national level
- Other normative barriers derive from the fact that existing legal rules are quite frequently borrowed by disability discipline, but chronic illness presents different characteristics. Invalidity is a permanent condition while cancer and other chronic illnesses are 'fluctuating' pathologies presenting moments of perfect ability and moments of absolute inability to work.

### *From the perspective of the caregiver*

The post surgical path of a person affected by cancer may include chemo and radio therapies, treatment and examinations repeated for several years, and this burden is very often on the shoulders of the family. The same effects may derive from other serious long-term illnesses. An inadequate or expensive care system leads in many cases to the family shouldering the full burden of care. Most of these carers are women (mothers, wives or daughters) and in some cases, they have to work part-time or give up their work.



This creates financial problems, and puts them at a disadvantage and at risk of poverty and marginalisation<sup>2</sup>.

Partners and other relatives can find it very hard to have both to work and to take care of the sick person – in terms of time and of mental strain. It might help both the patient and his or her spouse if they had a number of days at their disposal to take the patient to consult the doctor or receive treatment - without suffering loss of income. This would require changes in both the legislation and the minds of employers.

Moreover, a well-informed patient can have various opportunities to find help in bearing this burden. There are many examples of leaflets, guides and information campaigns organised by NGOs to inform patients of all the opportunities offered by social security, the public services or the NGOs directly, to help the families face the difficulties.

#### *From the perspective of the overall community*

The return to active life of a worker who has gone through severe, long-term illness represents an important step towards recovery for the individual but also a significant achievement for the community as a whole. For society, the economic burden of a sick worker includes not only the cost of health care and rehabilitation but also the lost productivity of those who quit work and the cost linked to the possible pauperisation of the worker and his/her family for the years to come. Recourse to a large extent to early retirement or to invalidity pension for those who may have residual working capacities represents a significant loss of human resources for European society in its entirety, and results in a form of exclusion as it expels from the labour market sick people who would be able to return to their jobs if only they were given the chance (and time) to cope with their own illness.

On the one hand, early retirement – linked or not linked to the granting of an invalidity pension – is a costly measure, which sometimes may not be compatible with the need for a more sustainable welfare system.

#### **Elements for the decision making process**

The overall challenge is to address actively the structural barriers to social inclusion in order to reduce them. In this specific case the key issue is promoting all possible help to meet the needs of workers with partial work ability, encouraging them to stay at work instead of going on from sick leave to a disability pension (if not strictly necessary). The EU inclusion strategy holds that employment is the key route to integration and social inclusion, with unemployment representing the major factor of exclusion.

#### *Policy suggestions from the perspective of the worker affected by a long-term illness*

a) To strengthen a supportive environment through information and advice to the worker, the colleagues and the management: a supportive environment is of great help to sick workers. They may feel accepted by the management and the colleagues even when, from time to time, they not feel able to carry out certain tasks, which could cause them distress or when they present specific needs linked to the management of their illness. Sick workers may require to be absent from work to receive treatment; they may require more help to perform their job during their cancer journey, or specific support to facilitate their return to work after treatment.

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<sup>2</sup> See Grammenos S., *Illness, Disability and Social Inclusion*, European Foundation for the Improvement of Living and Working Conditions, 2003



It is essential that all parties get appropriate and sufficient information, working for a change in attitudes in managements, colleagues and cancer patients - to make cancer or other long-term illnesses less of a taboo and to help sick workers to regain work with much more serenity. One way towards this goal is information on the specific needs of sick workers, on specific policy provisions and on external support that can be activated.

To support an effective reintegration of the worker, all workplaces should have a specific internal policy of illness management at the workplace, which includes specific policy provisions.

b) To support the introduction of disability management initiatives for workers affected by illnesses inducing disability: developments in information technology, and in particular teleworking, can offer tremendous opportunities in terms of support to job regaining for people affected by illnesses or disability. New technologies play an increasing role both at home and at work. If tele-work is a possible support for regaining jobs for people with illnesses or disability, the wide gap between countries in terms of wide e-accessibility represents an urgent priority, which should be tackled as soon as possible with policies promoting social inclusion through employment. As government services and public information are becoming increasingly available online, ensuring all citizens have access to public websites is as important as ensuring access to public buildings. On 12<sup>th</sup> May 2000, the EU Commission formally adopted a Communication on a 'Barrier Free Europe for People with Disabilities' (European Commission, 2000). This focuses on how policies can give disabled people the right to mobility in areas such as the information society, the opening of the internal market for technical aids and the protection of disabled consumers' rights. Several EU programmes have addressed this issue: eAccessibility is now part of [eInclusion](#) in the [third pillar of i2010](#).

c) To improve the skill of sick workers: considering that the higher the professional skill of the worker the easier he/she can have opportunities of a soft and adequate return to job after a long illness, a possible route towards job reintegration is to foster enhancement of the worker's professional skills before they return to the workplace. It is also obvious that the more skilled the worker is (and so adaptable to the changing situation) the less she/he is likely to be exposed to the risk of exclusion due to long-term illness. A possible strategy for job retention is to foster vocational training and life-long learning which enable workers to perform a broader range of tasks, reconciling the loss of work capacity with the employer's organisational requirements. The issue of "learning" is closely linked to that of the modification of worker's tasks as an alternative solution to dismissal.

*Policy suggestions from the perspective of the caregiver*

a) To pay more attention, from the normative point of view, to the burden of the family and the caregivers: partners and other relatives can find it very hard to hold down a job and take care of the sick person. It is both a question of time and mental strain. It might help both the patient and his or her spouse if they had a number of days at their disposal to take the patient to consult the doctor or receive treatment - without suffering loss of income. This would require changes in both the legislation and the minds of employers. In Europe, legislation generally fails to consider the impact of cases of cancer on the family: it may indeed happen to be considered only when the sick person is a child or is dying. We consider it a priority to introduce norms aimed at supporting those who have responsibility for caring for someone affected by cancer or other long-term illnesses.

*Policy suggestions from the perspective of the overall community*

a) To introduce criteria to clarify the distinction between disability and illness: guidance on how to distinguish between a chronic long-term illness and a disability appears essential. The 2008 EU Resolution on cancer<sup>3</sup> mentions this as a key point: it states, at point 34, that Member States and the Commission are asked to work towards the development of guidelines for a common definition of disability that may include people with chronic illnesses or cancer, and in the meantime for Member States that have not yet done so to act as quickly as possible to include those people within their national definitions of disability. There are many examples of national laws that define a disability as a condition which has lasted, or which is expected to last, for a minimum of 12 months (or some other period), e.g. the UK Disability Discrimination Act. These definitions can cover recently diagnosed conditions where it is known that the condition will be long-lasting, and, in principle and sometimes in practice, many long-lasting sicknesses do fall under the national antidiscrimination legislation (for example the UK Disability Discrimination Act). In this case, and in contrast to the judgment of the ECJ, certain chronic illnesses should be defined as disabilities for the purposes of the Directive.

It is worth noting in this respect that the latest Joint Report on Social Protection and Social Inclusion (2007) reflects the increasing attention paid by Member States to measures promoting active labour market inclusion for disabled people, but nothing is said about chronic and long-term illness. Chronic illness seems to be more relevant from the general point of view of health protection (in terms of tackling health problems, reducing costs and promoting healthier lifestyles) than from those of job retention and the back-to-work perspective.

Member States should bring in measures to reduce sickness burdens, also by increasing labour productivity and prolonging working life. In this respect, Member States and the EU should pay attention to specific policies of job reintegration able to consider the common features and specificities of long-term illness in the workplace, considering the peculiarities a chronic or long-term illness has with respect to disability.

b) to fight discrimination: workers affected by long-term illnesses, and cancer in particular, mention discrimination in the workplace as one of the main problems they face while regaining active life. The Framework Equal Treatment Directive 2000/78/EC, prohibits discrimination in employment, vocational training and membership in employment related organisations because of, among other factors, disability, but unfortunately it is not clear if this includes discrimination on the grounds of illness. This is a fundamental point: it is essential to clarify whether the prohibition of discrimination on the grounds of disability includes discrimination on the grounds of illness. Or, if illness is not considered a form of disability for the purposes of the Directive, it should be clarified whether the Directive prohibits discrimination on the grounds of illness separately, and in this case it is essential to understand if illness could be added to the list of protected cases explicitly mentioned in the Directive. Another suggestion is to promote a pan-European campaign to fight against discrimination of cancer patients (and other sufferers from long-term illnesses) in the work place addressed in particular to employers, explaining that people with a reduced work capacity remain essential resources in society and maintain a useful role to play in the workplace.

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<sup>3</sup> P6\_TA-PROV(2008)0121 *Combating cancer in the enlarged European Union*

c) To involve NGOs: NGOs representing sick people normally have a thorough knowledge of their specific needs, as well as policy provisions and best practices existing at the national and international level. The analysis that was carried out involving NGOs offers a clear picture of this. The specific role of these NGOs is to support sick people in daily and working life and, with their umbrella organisations, they are able to disseminate national good practices throughout Europe. At the EU level, it could be advisable practice to form a board of cancer patients and carers for preliminary discussions before new legislation concerning the conditions for European cancer patients is discussed and decided upon. At the national level, the institutions should work with NGOs to understand the specific needs of people with cancer and to introduce specific norms adequate to the specific needs of sick workers.

Employers should incorporate the NGOs best practice guidance into their illness and disability policies to ensure that the workers get the right support when returning to work after cancer diagnosis.

d) To enhance prevention rather than tackle exclusion: addressing the issue of chronic illness using the conceptual tools provided by EU health policies –, for instance, policies designed around the idea of prevention can also be useful. Some authors stress the crucial importance of early intervention. Indeed, once an individual has lost his/her work capacity (and in some cases his/her job) it is more difficult to carry out a back-to-work strategy aiming at job retention or reintegration. Specific attention in this respect should go into the specific regulations on sickness leave at the national level.

e) To promote a general integrated approach towards job reintegration: only an integrated approach, which takes into account social determinants of disability as well as the social factors affecting job retention of people with chronic health conditions, will enhance the effectiveness of a policy designed to promote reintegration of workers with chronic illness. Obviously, an integrated approach to the needs of workers calls for an integrated approach in terms of policies. Greater policy integration to get sick workers back to work could enhance the rate and the quality of job resumption in keeping with the overall EU strategy of inclusion through employment.



## The list of abbreviations

AOI	Assegno Ordinario di Invalidità
BEPG	Broad Economic Policy Guidelines
COUNCIL	Council of the European Union
DDA	Disability Discrimination Act
DH	<i>Department of Health</i>
DWP	Department for work and pensions
DSS	Department of Social Security (UK)
ENWHP	European Network for Workplace Health Promotion
ECHP	European Community Household Panel
EES	European Employment Strategy
EPL	Employment Protection Legislation
ESA	Employment and Support Allowance
FETD	Framework Equal Treatment Directive
GDP	gross domestic product
GNP	gross national product
IB	Incapacity Benefit
ICIDH	International Classification of Impairments, Disabilities and Handicaps
ICF	International Classification of Functioning, Health and Disability
IIDB	Industrial Injuries Disablement Benefit
ILO	International Labour Organisation
IRO	Individual Reintegration Plans
KELA	Social Insurance Institution (Finland)
LAFOS	Labour Force Service Centres (Finland)
LFS	European Union Labour Force Survey
LSHPD	long-standing health problems or disabilities
NAPs	National action plans
NGO	non-governmental organisation
NHS	National Health Service (Britain)
OECD	Organisation for Economic Cooperation and Development
OHS	Occupational health and safety
OMC	Open Method of Coordination
OSH	Occupational Safety and Health
OSHA	European Agency for Safety and Health at Work
PCA	Personal Capability Assessment
PI	Pensione di inabilità
PIW	Period of Incapacity for Work
PRB	Personal Reintegration Budget
RTWC	Return to Work Credit
SGP	Stability and Growth Pact
SME	Small and Medium Enterprise
SSP	Statutory Sick Pay
UWV	Social Security Agency
VLZ	Continued Payment of Wages During Illness Act
WAO	<i>Disability Insurance Act</i>
WGA	Resumption of Work (Partially Disabled Persons) Regulation
WHO	World Health Organisation
WIA	Work and Income Act
WVP	Eligibility for Permanent Incapacity Benefit
ZW	Ziektewet – Sickness Benefits Act



## ***Introduction***

Long-term illnesses affecting workers can be considered from many different perspectives. Two are of particular interest for the present study: the individual path towards social reintegration and the impact of a sick worker on the broader community.

Poor health is an important factor influencing early retirement and worker absenteeism. The probability of leaving the workforce at an early age is much higher for people with disabilities and long-term illnesses. Moreover, people who continue to work despite health problems are likely to be less productive than healthy people<sup>4</sup>: a key issue for the policy makers is how to maintain the worker with residual potentialities in active working life and at the same time to cope with the difficulties the worker and the employer come up against to keep jobs going.

On the one hand, in fact, EU policies often refer to employment as a key route to integration and social inclusion, but health problems represent a major factor of exclusion from the labour market with illness playing a major role in the current high rates of early retirement. This issue poses particular problems both to social security systems and to the individual worker in terms of human and financial costs, including loss of self-esteem and self-efficacy, loss of work-related skills and a range of psychological repercussions.

On the other hand, although the link between health and economic growth has been demonstrated, it is not always taken into account adequately in current legislation. The first Lisbon Agenda report did not even mention health; in 2005, the Healthy Life Years indicator was included as a Lisbon Structural Indicator, recognising that the population's life expectancy in good health was an important factor in understanding and supporting economic growth.

This study aims to understand the barriers and facilitators to favour reintegration for chronically sick and absent workers. Without such an understanding, it is difficult to design and develop appropriate and transferable interventions and approaches. In this respect, the study highlights the characteristics of National and European legislations concerning support for workers with long-term illnesses, helping them, where possible, towards social inclusion and reintegration in the labour market.

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<sup>4</sup> European Commission, *The contribution of health to the economy in the EU*, 2005



## **Part one) Overview of main issues, figures and policies**

## **Chapter I – Cancer and long-term illnesses and work: aims and limits of the study, perspectives and definitions**

This chapter outlines the main issues that will be addressed in the study and the key elements that will be further discussed in the following chapters. They will be treated in quantitative/qualitative terms referring to surveys, existing studies and literature, statistical data and figures.

The main aim of the study is to analyse welfare provisions targeted to workers with a long-term illness in terms of social protection and job reintegration policies. The different schemes and approaches applied across the Member States are analysed to point out the level and duration of social protection of a sick worker as well as how different countries support the worker's wage and his previous standard of living during and after sick leave.

The study also analyses 'return to work' problems, policies and forms of reintegration of workers, which involve various issues and policies:

- As the main focus of the study is on the reintegration of the worker after long absence due to bad health, specific analysis is made of active labour market policies targeted to people who have recovered from long-term illnesses
- The socio-economic and health determinants in job regaining are considered as key factors able to account for some of the differences in return to work rates
- The sectors and types of jobs in which labour integration appears possible are disentangled
- Legal and administrative aspects, as possible barriers to job regaining are taken into account where possible
- The care burden left on caregivers inside the family due to inadequate or expensive care systems is described as an area that requires more attention from policy-makers.

Considering how wide-ranging the implications of the "work and illness" issue are, and the fact that they can be analysed from several points of view and from various different perspectives, *Chapter I* focuses, on the one hand, on defining the perspectives and issues the study will consider and, on the other hand, the relevant definitions that help to determine the limits of the study and the specific terms and vocabulary.

### **1.1 The different perspectives from which the issue can be considered: from sectoral perspectives (labour law, welfare and social protection, occupational medicine) to an integrated social perspective (occupation and social inclusion strategies)**

The issue of chronic illness and work can be considered by taking into account the following perspectives:

1. the labour law perspective;
2. the welfare and social protection perspective;
3. the occupational medicine perspective.

#### **1. Labour law perspective**

The labour law perspective concerns the regulation of terms of employment as well as the legal means by which the illness risk is transferred to the employer, although to a limited extent. In more detail, such means normally consist of:

- suspension (but not termination) of employment and contractual obligations during the period of illness;
- guaranteed retention of job for a period of time set by law;
- maintenance of the obligation to pay wages (in some cases).

## 2. Welfare and social protection perspective

This perspective is concerned with the social protection system, seen as safeguarding workers from the social repercussions linked to illness. Analysis will focus on the functioning of social security instruments to cope with such social risks as income loss and need for “care”.

## 3. Occupational medicine perspective

With the occupational medicine perspective the problem is approached in the following terms:

a) Determination of employees’ fitness for work: an occupational physician’s evaluation of a worker’s suitability for the job in question is generally compulsory. When considering the opportunity of job reintegration of a worker with chronic illness, it is important to consider the work tasks and environment and to make a risk assessment.

b) Occupational medicine is also involved in the evaluation and quantification/ measuring of exposure to health risks.

This perspective, which includes accidents at work and professional diseases, may take us too far from the topic of the study. But as occupational diseases are a concern of the European Parliament, this chapter considers the perspective in terms of the main issues concerning the social protection of occupational diseases.

Each of these three perspectives has shown limits which call for reassessment of the traditional approach on both a theoretical and a practical basis.

- As regards labour law, a tendency to shift from passive to active instruments has been observed. See, for example, the so-called “reasonable accommodations” (see further for more detail).
- As for the welfare perspective, static forms of protection (income-related) tend to leave room for dynamic ones (e.g. back-to-work strategies).
- From a more general perspective of policy implementation, a certain inclination towards integrated forms of intervention can be observed: see, in particular, the integration between employment and social inclusion policy.

This study recognises the importance of an integrated approach, which makes it possible to combine all the relevant perspectives into a more comprehensive view.

At the same time, it suggests considering the risk of seeing the integrated strategies as a reduction of one perspective to another from a critical viewpoint (for instance, favouring work as a major form of inclusion).

## **1.2 Definitions: defining concepts is a crucial issue**

Defining concepts is a crucial issue, particularly when dealing with problems (like illness in the workplace) susceptible of being addressed in many ways and from different (and overlapping) perspectives, viewed in terms of medicine, law and sociology.

Legal, medical and social definitions of disability and illness have been a much-debated issue in Europe and around the world. Despite the efforts of the World Health Organisation, there is no universal international legal definition of disability, nor is there any common definition in the EU countries. Recent studies on definitions of disability in various EU countries have shown that disability definitions vary from country to country but also within each country. While there are similarities between the definitions of disabilities in some areas of social policy, legal disability definitions in each country differ with respect to income maintenance, employment measures or social assistance with daily life activities<sup>5</sup>.

“In general, within a Member State, each service has its own definition of chronic illness and disability. The different definitions that may be distinguished are related to:

- disability pensions: national social security systems often make reduction in work capacity a necessary criterion;
- disability allowances: social action often includes both medical and social criteria;
- benefits related to independent living: the definition is broader and takes into account limitations in the activities of daily living”<sup>6</sup>.

The problem of consistency between medical, social and legal definitions is of the utmost importance, since the provision of financial benefits, services and other measures related to chronic illness and disability requires definitions of the conditions under which a person may claim a right to them<sup>7</sup>.

When illness is involved, it is quite common to start from a medical perspective in order to describe just what illness is and to what extent it is able to affect the individual’s work capacity. However, if only this single perspective is taken into consideration the difficulty of giving clear and precise definitions is evident: for instance, when qualifying illness, what is the difference between terms like “chronic”, “acute” and “long-standing”? To what extent are different forms of illness able to affect an individual’s work capacity? This is a difficult question to answer. Proof of the difficulty is that the very difference between illness and disability is sometimes controversial (see the *Chacón Navas* case).

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<sup>5</sup> See, Degener T., *Definition of Disability*, E.U. Network of Experts on Disability Discrimination, Bruxelles, 2004.

<sup>6</sup> Ibid.

<sup>7</sup> See Grammenos S, *Illness, disability, and social inclusion*, European Foundation for the Improvement of Living and Working Conditions, 2003

**Box 1: Concepts concerning health and illness and their implications in work capacity from the perspective of occupational medicine**

Quality of life is the product of the interplay between the social, health, economic and environmental conditions that affect human and social development. It is a broad-ranging concept, incorporating a person's physical health, psychological state, level of independence, social relationships, personal beliefs and relationship to salient features in the environment. The quality of life is largely determined by the ability to access needed resources and maintain autonomy and independence.

Health is one of the main factors of quality of life. It is defined as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Health has many dimensions (anatomical, physiological and mental), is largely culturally defined, and may be pursued with activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting or maintaining health, whether or not such behaviour is objectively effective towards that end.

The health status of an individual, group or population may be measured by obtaining proxies, such as people's subjective assessments of their health; by means of one or more indicators of mortality and morbidity in the population, such as longevity; or by using the incidence or prevalence of major diseases.

It is important to distinguish disease from illness. Disease means failure of the adaptive mechanisms of an organism to counteract adequately stresses to which the organism is subjected, resulting in a disturbance in the function or structure of some part of the organism. This definition emphasizes that disease is multifactorial and may be prevented or treated by changing a combination of the factors. Disease is a very elusive and difficult concept to define, being largely socially defined and recognized in different terms.

We use the term illness when we deal with a person's own perceptions, experience and evaluation of a disease or condition, or how he or she feels. For example, an individual may feel pain, discomfort, weakness, depression or anxiety in different ways, and therefore may require different action from the health or social system.

Another important concept able to condition need/action is the difference between acute and chronic events. In the former case the event is characterized by a single or repeated episode of relatively rapid onset and short duration from which the patient usually returns to his/her normal or previous state or level of activity. The chronic condition, on the contrary, is permanent; leaves residual disability; is caused by non-reversible pathological alternation; requires special training of the patient for rehabilitation; or may be expected to require a long period of supervision, observation or care.

Cancer may be classified within this latter condition and may be defined as a disease in which abnormal cells divide without control and can invade other tissues. Cancer is not just one disease but many diseases: there are more than 100 different types of cancer. Cancer has a reputation for being a deadly disease. While this certainly applies to certain particular types, the truths behind the historical connotations of cancer are increasingly being overturned by advances in medical care. Patients are living longer with either quiescent persistent disease or even complete, durable remissions. Cancer is a disability when it or its side effects substantially limit(s) one or more of a person's major life activities. Even when the cancer itself does not substantially limit any major life activity (such as when it is diagnosed and treated early), it can lead to the occurrence of other impairments that may constitute disabilities. For example, depression may develop as a result of cancer, the treatment for it, or both. In the U.S., when the condition lasts long enough (i.e. for more than several months) and substantially limits a major life activity, such as interacting with others, sleeping, or eating, it is considered a disability for ADA (Americans with Disabilities Act) and qualifies for disability benefits.

In conclusion, let us see a possible distinction between impairment, disability and handicap:

Impairment may be defined as any loss or abnormality of psychological, physiological or anatomical structure or function. It is concerned with abnormalities of body structure and appearance, organ or system resulting from any cause. In principle, impairments represent disturbances at the organ level.

Disability on the other hand is the restriction or lack (resulting from an impairment) of ability to perform an activity in the manner, or within the range, considered to be normal for a human being. The term disability reflects the consequences of impairment in terms of functional performance and activity by the individual.

Handicap is the disadvantage for a given individual, resulting from an impairment or a disability that limits or prevents the fulfilment of a role that is normal (depending on age, sex and social and cultural practice) for that individual. The term handicap thus reflects interaction with, and adaptation to, the individual's surroundings.

It is of the utmost importance for there to be a certain degree of consistency between medical and administrative definitions, since the “provision of pensions, allowances and services related to chronic illness and disability require the definition of the conditions under which a person may claim a right to a benefit”<sup>8</sup>.

However, it is to be borne in mind that between the two perspectives (legal and medical), albeit converging, there is no perfect congruency. This is because the legislator, in order to decide what benefit is to be granted and to whom, not only has to consider illness from a medical perspective but also has to assess the social impact caused by the illness. In many European countries, experts and NGOs acting in the disability field often have demanded that disability should not be defined as a medical condition, nor an impairment. Only a non-medical definition, it was argued, could endorse the social model of disability<sup>9</sup>. As we will see below, illness has come in for similar debate.

### **1.3 The lack of clarity on the relationship between long-term illness and disability**

The study undertaken by the *European Foundation for the Improvement of Living and Working Conditions* on the strategies aiming at keeping people with chronic illness and disabilities in employment<sup>10</sup> highlighted that a clear distinction emerged, at both the national and European level, between:

- measures to combat the exclusion of people with disabilities who were unemployed or economically inactive, and
- those needed to respond to workers who developed a chronic illness that affected their work.

Nevertheless, while the distinction between disability and chronic illness is implicit in the structure of many national social protection systems, the concerns and challenges facing people as a result of disability and chronic illness *are similar in many ways*.

People experiencing a chronic illness, regardless of the cause, may have reduced work capacity and, without timely and appropriate reintegration, may be less likely to return to work. Still, they may not be considered ‘disabled’ under either social protection regulations or discrimination legislation.

The Framework Directive on Equal Treatment and Employment (2000) (FETD)<sup>11</sup> focuses on ‘people with disabilities’ as though they were a clearly delineated and stable group. In reality, *‘disability is a dynamic process that increases with age and affects many people with chronic illness. These are in effect a hidden group within disability policy in that they are, in administrative terms, ‘not yet disabled’<sup>12</sup>*.

The European Court of Justice recently addressed the issue in the *Chacón Navas case*<sup>13</sup>, with an outcome that many experts of the field consider largely unsatisfactory.

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<sup>8</sup> See Grammenos S, *Illness, disability, and social inclusion*, European Foundation for the Improvement of Living and Working Conditions, 2003

<sup>9</sup> For a recent detailed discussion of the social model of disability see: Barnes C., Mercer G. (eds.), *Implementing the Social Model of Disability”: Theory and Research*, Leeds, The Disability Press, 2004

<sup>10</sup> See *Employment and Disability: Back to Work Strategies*, European Foundation for the Improvement of Living and Working Conditions, 2004

<sup>11</sup> The Framework Equal Treatment Directive (FETD), 2000/78/EC, prohibits discrimination in employment, vocational training and membership in employment related organisations on the grounds of, among other things, disability.

<sup>12</sup> See R. Wynne, *Employment and Disability: Back to Work Strategies*, European Foundation for the Improvement of Living and Working Conditions, cit. above, n. 2.

<sup>13</sup> ECJ, *Chacón Navas v. Eurest Colectividades SA*, Case C-13/05 [2006] ECR I-6467

### **Box 2: The facts of the case**

In October 2003, Chacón Navas had been certified unfit for work on medical grounds and began receiving temporary incapacity benefits. She was given notice of dismissal, without any reasons, after six months. Spanish law distinguishes between ‘unlawful dismissal’ and ‘void dismissal’. Dismissal because of disability is ‘void’ and the worker is entitled to ‘immediate reinstatement’ and back pay. In the case of ‘unlawful dismissal’, the worker is only entitled to compensation, which had been offered to Chacón Navas, for the loss of employment. Chacón Navas responded by challenging her dismissal as void because it was discriminatory as she had been leave of absence and ‘temporarily unfit to work for eight months’. At a hearing, the national court ordered a medical report which stated she was ‘unfit to work and that it was not envisaged that she would return to work in the short term’. Spanish courts had previously held that dismissal because of illness was unlawful but not discriminatory. The essence of the national court’s referral was to inquire into the relationship between illness and disability and more particularly whether illness was subsumed into the concept of disability for the purposes of the FETD.

*The questions that the Spanish court asked the ECJ were:*

- a. The Framework Employment Directive prohibits discrimination on the grounds of disability – does this include discrimination on the grounds of illness? (i.e. should illness be regarded as a form of disability in some instances?)
- b. If illness is not a form of disability for the purposes of the Directive, does the Directive prohibit discrimination on the grounds of illness separately? (i.e. could illness be added to the list of protected grounds explicitly mentioned in the Directive?)

In his Opinion Advocate General Geelhoed argued that restraint is required in interpreting the term disability as it is used in the directive because of the history and wording of the Treaty of Amsterdam and the ‘potentially far-reaching economic and financial consequences’ of a provision dealing with an area of shared EU/national competency.

The Court took the view that the Community legislators, by using the concept of ‘disability’ in the directive, deliberately chose a term, which differs from ‘illness’. The two concepts cannot therefore simply be treated as if they were the same.

The Court found that the importance, which the Community legislature attaches to measures for adapting the workplace to the disability demonstrates that it envisaged situations in which participation in professional life is hindered over a long period of time. In order for a limitation to fall within the concept of ‘disability’, it must therefore be likely to last for a long time.

Having decided that illness must be different from, and not included in, disability, the Court consequently set out its interpretation of the term disability: ‘it must be understood as referring to a limitation which results in particular from physical, mental or psychological impairments and which hinders the participation of the person concerned in professional life’ and which will ‘probab[ly] ... last for a long time’.

There is nothing in the directive, the Court said, to suggest that workers are protected by the prohibition of discrimination on grounds of disability as soon as they develop any type of illness.

Thus, a person who has been dismissed by his employer solely because of illness does not fall within the general framework laid down by the directive for combating discrimination on grounds of disability.



The Court clearly rejected the notion that illness could come within the definition of disability with the unfortunate consequence that “semantics alone might determine whether a person is protected from adverse treatment”<sup>14</sup>.

Given that one of the objectives of the directive was to establish a common minimum standard of protection from discrimination throughout the EU, the European Court’s decision sets that minimum standard at a low level and anchors the protection provided by the directive in the medical model.

Some Member States have chosen definitions of disability, either explicitly or by default, which are much more inclusive and protect many more people from discrimination. See for instance the Dutch legislation, which covers discrimination on the grounds of a “real or supposed disability or chronic illness”<sup>15</sup>.

Other Member States have chosen definitions based firmly on the medical model that reflects the Court’s understanding of disability as set out in this decision. See for example the German legislation, which covers only those people classified, under medical criteria, as “severely disabled” (“*schwerbehinderter*”).

As a result of this decision, the protection from employment discrimination provided to disabled people will continue to vary widely among Member States.

For the purpose of this study, it is even more remarkable that the Court provided no guidance on how to distinguish between a chronic long term sickness and a disability included within the scope of the directive, even though this divide marks the line between protection and no protection from discrimination and from duty and no duty of reasonable accommodation to be complied by the employer<sup>16</sup>.

While one can agree that the scope of the directive should not be extended as to include “any type of sickness”, the narrow definition adopted made it impossible for the Court to examine the differences between sickness and disability and to establish how or when the one can change into the other<sup>17</sup>.

It is likely that the Court’s definition also fails to cover discrimination because of past disability, commonly experienced by those who have chronic illness, or perception of disability, commonly experienced by people with asymptomatic impairments that employers fear may turn into chronic illness and impose costs in the future<sup>18</sup>.

It is worth noting that in deciding the case, the Court failed to follow the advice of its Advocate General who had said that:

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<sup>14</sup> See D. Hosking, *A High Bar for EU Disability Rights. Case C-13/05, Chacón Navas v Eurest Colectividades SA*, in *ILJ*, 2007, p. 233. The author mentions as an alternative approach to the problem of defining disability for equality and non-discrimination law, which would have brought more people within the protective umbrella of the directive, the leading decisions of the Supreme Court of Canada (*Quebec Commissions des droits de la personne et des droits de la jeunesse v Boisbriand City*). This approach recognises that the attitudes of society and its members often contribute to the idea or perception of a ‘handicap’. In fact, a person may have no limitations in everyday activities other than those created by prejudice and stereotypes. The court limited its expansive interpretation of disability only by noting that ‘normal ailments,’ such as the common cold, would not be included since these do not normally attract a negative bias limiting or creating a barrier to full participation in society.

<sup>15</sup> L. Waddington, ‘*Implementing the Disability Provisions of the Framework Employment Directive: Room for Exercising National Discretion*’ in A. Lawson and C. Gooding (eds), *Disability Rights in Europe: From Theory to Practice*, Oxford: Hart Publishing, 2005, p. 120.

<sup>16</sup> The EU Directive provides that ‘in order to guarantee compliance with the principle of equal treatment in relation to people with disabilities, reasonable accommodation shall be provided ... unless such measures would impose a disproportionate burden on the employer’. On the concept of “reasonable accommodation” see further cap. 4.

<sup>17</sup> See M. Barbera, *Le discriminazioni basate sulla disabilità*, in M. Barbera (ed.), *Il nuovo diritto antidiscriminatorio. Il quadro comunitario e nazionale*, Giuffrè, Milano, 2007.

<sup>18</sup> Cf. D. Hosking, *A High Bar for EU Disability Rights. Case C-13/05, Chacón Navas v Eurest Colectividades SA*, *cit.*

- an illness which may cause a disability in the future was not the same as a disability, and was not covered by the Directive;
- however, an exception would exist where the illness caused long-term or permanent limitations which had to be regarded as disabilities;
- individuals with such illnesses/limitations would be regarded as disabled and come under the Directive.

In contrast to these remarks, the Court states: “There is nothing in Directive 2000/78/EC to suggest that workers are protected by the prohibition of discrimination on grounds of disability as soon as they develop *any type of sickness*”.

The judgement makes no distinction between:

- illnesses which are known as being long lasting (e.g. depression, diabetes, cancer) which could potentially be covered by the Directive if they were defined as disabilities,
- conditions which may develop into long lasting illnesses (and in this case be covered by the Directive)
- and conditions which are not long lasting (which will never be covered)<sup>19</sup>.

It is worth noting in this respect that there are many examples of national laws that define a disability as a condition which has lasted, or which is expected to last for, a minimum of 12 months (or some other period), e.g. UK Disability Discrimination Act. These definitions can cover recently diagnosed conditions where it is known that the condition will be long lasting and, in principle and sometimes in practice, many long lasting illnesses do fall under the anti-discrimination legislation (for example again the UK Disability Discrimination Act).

In this case, and in contrast to the judgment of the ECJ, certain chronic illnesses should be defined as disabilities for the purposes of the Directive.

#### **1.4 Is the difference between disability and illness quantitative or qualitative?**

The Courts decision makes a sharp, ontological distinction between disability and illness. According to another point of view, in essence the difference between disability and illness is quantitative rather than qualitative<sup>20</sup>. Illnesses that are of only a limited duration do not meet the requirements which are necessary in order to be classified as a disabilities, since a disability is a condition which is permanent, or, at the very least, long-term. *The question is whether an illness, which is also permanent or long-term, can be regarded as a disability.*

Illnesses such as heart disease, cancer, diabetes, kidney failure, asthma, eczema and mental illnesses such as depression or schizophrenia, would all seem to meet the criteria necessary to be classified as a disability, as well as being “a physical, mental or psychological impairment”.

In this respect, the study carried out by Grammenos for the European Foundation for the Improvement of Living and Working Conditions<sup>21</sup> suggests some important distinctions.

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<sup>19</sup> Cfr. European Disability Forum, *EDF analysis of the first decision of the European Court of justice on the disability provisions of the Framework Employment Directive. Case C-13/05 Chacon Navas v Euresit Colectividades SA, 11 July 2006*, EDF 06-14 – December 2006.

<sup>20</sup> Ibid.

<sup>21</sup> Cf. Grammenos S, *Illness, disability, and social inclusion*, European Foundation for the Improvement of Living and Working Conditions, 2003.

The term ‘chronic’ may be interpreted in different ways (a few months, one year, etc.): estimation is very sensitive to this measure. Inclusion of short-term limitations may increase the disability rate sharply. The wording is also important.

The general term of at least one functional disability/impairment gives a much higher rate compared with the restrictive and non-neutral term ‘handicap’. Recognised, registered disability is the most restrictive definition and consequently the corresponding rate is the lowest<sup>22</sup>.

‘Limiting longstanding illness’ is another concept used in many surveys: for example, the survey of living conditions in the Nordic countries, health interview surveys and the census in Belgium. In fact, the term ‘longstanding’ is broader than ‘chronic’ state.

Obviously, duration is also important in defining the notion of long-term absence rate.

Another important distinction lies in evaluation of what is ‘severe’ and ‘moderate’, in terms of the degree of disability. If we examine statistics on people with disabilities according to different definitions, we find very different figures. Thus, if we take into consideration people with a relatively slight problem, the rate will increase, but the rate decreases as the definition comes closer to severe limitations.

The United Kingdom is the only country with a well-developed tradition of questions on work-limiting disabilities. People whose health problems or disabilities are expected to last more than a year are asked the following question: “Does this health problem affect the kind of work that you might do? ... or the amount of paid work that you might do?”. If respondents fulfil either of these criteria, they are defined as having a work-limiting disability.

Finally, the study remarks on the provision of pensions, allowances and services related to chronic illness and disability requires the definition of the conditions under which a person may claim the right to a benefit.

In general, within a member state, each institution uses its own definition of chronic illness and disability. The different definitions that may be distinguished are related to:

- disability pensions: national social security systems often make a reduction in work capacity a necessary criterion;
- disability allowances: social action often includes both medical and social criteria;
- benefits related to independent living: the definition is broader and takes into account limitations in the activities of daily living.

Restrictive definition could well decrease the number of people who receive these benefits.

### **1.5 The medical and the social model of disability and illness**

Both the legal experts and NGOs commenting on the *Chacón Navas case* noted that the definition of disability formulated by the Court is based on the medical or individual model of disability<sup>23</sup>.

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<sup>22</sup> Ibidem.

<sup>23</sup> See above nn. from 6 to 10. See also L. Waddington, ‘Case C-13/05, *Chacón Navas v. Euresit Colectividades SA*’, in *CMLR*, 2007, pp. 487-499.

According to this definition, the cause of the disadvantage (or the “limitation”) is the “impairment”; and it is the “impairment” which hinders participation in professional life. Locating disability in the individual leads to policy responses targeted on the individual, including medical care, rehabilitation, and often segregated facilities dedicated to caring for those who are unable to adapt to the social environment in which they live.

This model can be contrasted with a social model of disability<sup>24</sup>, which, in its current form characterised as the ‘biopsychosocial model’ by the World Health Organisation<sup>25</sup>, conceives disability as a complex relationship between individual biomedical impairment, individual reactions to that impairment and associated functional limitations, and a social environment which is not responsive to the needs of that person.

Locating disability in the social environment leads to policy responses aiming at changing the environment to eliminate the structural barriers to equal participation, including anti-discrimination legislation, universal design building codes, integration and mainstreaming, and creating conditions of individual empowerment.

Both the European Commission and the European Council recognised the need to base policy on the social model of disability as early as 1996. In July of that year, the Commission adopted a *Communication on Equality of Opportunity for People with Disabilities*. The Communication notes that the way in which society is organised serves to exclude disabled citizens, and speaks of the evolution towards ‘an equal opportunities model in the field of disability policy’ within the Member States of the EU.

By the same token, extensive debate is taking place on the importance of social health determinants. Recent studies find a significant connection between income and health; education, lifestyle and health; employment status, job insecurity and health; working and living conditions and health.

Only an integrated approach, which takes into account these social determinants, as well as the social factors which affect job retention and reintegration of people with chronic health conditions, will enhance the effectiveness of a policy designed to promote reintegration of a worker with chronic illness.

Considering the confused, blurred panorama, it is of great importance that the Resolution of the European Parliament “*Combating cancer in the enlarged European Union*” P6\_TA-PROV(2008)0121 includes a call on the Member States and the Commission to work towards the development of guidelines for a common definition of disability that may include people with chronic illnesses or cancer. In the meantime, it calls on any Member States that have not done so to act quickly, possibly to include those people within their national definitions of disability

## **1.6 Main issues concerning occupational diseases**

An occupational disease is any chronic ailment that occurs as a result of work or occupational activity. Occupational hazards that are of a traumatic nature are not considered to be occupational diseases. Workers' compensation provides insurance to cover medical care and compensation for employees who are injured in the course of employment.

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<sup>24</sup> This model has been described along with others by M. Oliver and C. Barnes (eds.), *Disabled People and Social Policy: From Exclusion to Inclusion*, Longman, London, 1998; and by J.E. Bickenbach, *Physical Disability and Social Policy*, University of Toronto Press, Toronto, 1993.

<sup>25</sup> Cf. WHO, *Towards a Common Language for Functioning, Disability and Health: (ICF) The International Classification of Functioning, Disability and Health*, WHO, Geneva 2002.

While plans differ between jurisdictions, provisions are paid in place of wages (functioning in this case as a form of disability insurance), compensation for economic loss (past and future), reimbursement or payment of medical and like expenses (functioning in this case as a form of health insurance), and benefits payable to the dependents of workers dead during employment (functioning in this case as a form of life insurance).

Occupational safety and health is a cross-disciplinary area concerned with protecting the safety, health and wellbeing of employed people. As a secondary effect, it may also protect co-workers, family members, employers, customers, suppliers, nearby communities, and other members of the public who are impacted by the workplace environment.

Since 1950, the International Labour Organization (ILO) and the World Health Organization (WHO) have shared a common definition of occupational health. It was adopted by the Joint ILO/WHO Committee on Occupational Health at its first session in 1950 and revised at its twelfth session in 1995. The definition reads: "Occupational health should aim at: the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; the placing and maintenance of the worker in an occupational environment adapted to his physiological and psychological capabilities; and, to summarize, the adaptation of work to man and of each man to his job."

The reasons for establishing good occupational safety and health standards are frequently identified as:

- Moral - An employee should not have to risk injury at work, nor should others associated with the work environment.
- Economic - many governments realize that poor occupational safety and health performance results in cost to the State (e.g. through social security payments to the incapacitated, costs for medical treatment, and the loss of the "employability" of the worker). Employing organisations also sustain costs in the event of an incident at work (such as legal fees, fines, compensatory damages, investigation time, lost production, lost goodwill from the workforce, from customers and from the wider community).
- Legal - Occupational safety and health requirements may be reinforced in civil law and/or criminal law; it is accepted that without the extra "encouragement" of potential regulatory action or litigation, many organisations would not act upon their implied moral obligations.

Different States take different approaches to legislation, regulation, and enforcement.

In the European Union, Member States have enforcing authorities to ensure that the basic legal requirements relating to Occupational Safety and Health (OSH) are met. In many EU countries, there is strong cooperation between employer and worker organisations (e.g. Unions) to ensure good OSH performance as it is recognized this has benefits for both the worker (through maintenance of health) and the enterprise (through improved productivity and quality). The European Agency for Safety and Health at Work (OSHA) was set up in 1996 in Bilbao, Spain. Its mission is to make Europe's workplaces safer, healthier and more productive. This is done by bringing together and sharing knowledge and information, to promote a culture of risk prevention.

Member States of the European Union have all transposed into their national legislation a series of directives that establish minimum standards on occupational safety and health. These directives follow a similar structure requiring the employer to assess the workplace risks and put in place preventive measures based on a hierarchy of control. This hierarchy starts with elimination of the hazard and ends with personal protective equipment.

From the work and health perspective, EU policy documents tend to emphasise occupational health and safety measures within the workplace (see, for example, the work of Directorate General for Health and Consumer Affairs (DG Sanco) and the European Agency for Occupational Health and Safety). The Public Health Strategy of DG Sanco (European Commission, DG Sanco, 2003) makes little mention of the workplace as a setting for public health initiatives and no mention of chronic illness or disability. In EU policy documents and statistics are no explicit references to the group of workers who are the primary focus of this report, that is to say workers affected by illnesses not related to work injuries. They are at the intersection of social inclusion, employment, health, disability, active ageing and social protection policies, but not adequately covered by any one strand.

The Commission estimates in its communication on Health and Safety at work 2007-2012 that each year 300,000 workers suffer permanent disability to differing degrees due to occupational injuries. The EP suggested in its report on the Community strategy 2007–2012 on health and safety at work (A6-0518/2007) that the Commission considers the option of transforming the EU recommendation concerning occupational diseases (2003/670) into a minimum directive.

## Chapter II - The size of the problem in Europe: some figures

### 2.1 The size of the problem: the incidence of bad health conditions and in particular cancer among European habitants of working age

Data from the Eurobarometer<sup>26</sup> reveal that 29% of the population (EU 25) is suffering from a long-standing illness or health problem (see the following table), ranging from 11% in the younger age group to 26% in the 40-54 age group.

<b>Chronic Illness : Analysis by demographics and self-assessed general health</b>		
<i>Do you have any long-standing illness or health problem?</i>		
[‘Don’t know’ responses not shown. At EU level these amount to 1%]		
	<b>Yes</b>	<b>No</b>
<b>EU25</b>	29%	70%
<b>Sex</b>		
Male	26%	73%
Female	31%	68%
<b>Age</b>		
15-24	11%	88%
25-39	15%	85%
40-54	26%	73%
55 +	50%	49%
<b>Education (End of)</b>		
15	44%	55%
16-19	26%	73%
20+	24%	75%
Still Studying	11%	88%
<b>Health in general</b>		
Good	14%	85%
Bad	94%	5%
Neither good nor bad	60%	39%

Source: Eurobarometer 2007

*“With more than 10 million new cases every year, cancer has become one of the most devastating diseases worldwide. The causes and types of cancer vary in different geographical regions but in most countries, there is hardly a family without a cancer victim. The disease burden is immense, not only for affected individuals but also for their relatives and friends. At the community level, cancer poses considerable challenges for the health care systems in poor and rich countries alike.”<sup>27</sup>*

The impact of cancer is not the same throughout Europe: the following table shows the difference in the incidence of cancer affecting the population of working age in the 27 European countries. The highest incidence is in Hungary and generally in Eastern European countries, while the lowest is in Ireland and Greece and in general in Nordic and Southern European countries.

<sup>26</sup> Special Eurobarometer 272: Health in the European Union, 2007

<sup>27</sup> International Agency for Research on Cancer (IARC) *The World Cancer Report*, [www.iarc.fr](http://www.iarc.fr)



### Incidence of cancer in Europe - age (15-64)

	Crude average annual incidence rate for all cancers <sup>28</sup>		The world age-standardised incidence rate for all cancers	
	Male	Female	Male	Female
EU27 (2001)	125.2	86.8	107	71.5
Austria (2005)	106.7	82	87.5	64.9
Belgium (1997)	126.2	89.6	110.1	75.7
Bulgaria (2004)	149.7	94.7	122.1	73.8
Czech Republic (2004)	165.2	103.9	132.6	79.7
Denmark (2001)	112.8	122.1	88.5	94.1
Estonia (2005)	144.5	91.5	130.9	73.3
Finland (2004)	85.4	73.3	64.7	54
France (2003)	139.1	76.5	118.3	64.1
Germany (2004)	114.6	86.7	88.3	65.9
Greece (2004)	101.1	62.4	87.9	<b>51.2</b>
Hungary (2003)	<b>238.3</b>	<b>141.6</b>	<b>201.5</b>	<b>109.6</b>
Ireland (2005)	<b>74.2</b>	78.2	71.8	74.4
Italy (2002)	113.8	80.6	90.4	62.5
Latvia (2004)	154.9	101.5	139.3	80.7
Lithuania (2004)	149	99	141.8	82
Luxembourg (2004)	119.6	<b>61.3</b>	105.3	52.2
Malta (2004)	81	76	68.3	59.5
Netherlands (2004)	107.2	101.1	86.3	80.6
Poland (2004)	146.2	99.3	140.2	85.5
Portugal (2003)	116.8	70.9	102.6	59.1
Romania (2004)	149.5	93.7	140.5	82.1
Slovak Republic (2002)	150.6	88.6	150.4	79.7
Slovenia (2004)	133.9	88.3	113.1	71.3
Spain (2004)	114.4	61.4	105.5	53.8
Sweden (2002)	77	85	<b>58.9</b>	64.2
United Kingdom (2004)	94.1	90	77.2	72.6

Source: WHOSIS, WHO Statistical Information System. <http://www.iarc.fr/>

## 2.2 Illness and active life

This chapter focuses on the activity rate and to what extent people with a disability or long-term/chronic illness are involved in the labour market. In fact, working activity is closely related to general health status: activity status and daily-life activity can be limited by health problems, and in particular chronic illnesses can limit access to work and productivity in general, as indicated by the statistical data.

Data from the European Union Labour Force Survey (LFS)<sup>29</sup> indicate that in 2002 nearly 44.6 million people, aged between 16 and 64 years had long-standing health problems or disabilities (LSHPD); unfortunately, there is no distinction between disability and long-term illnesses.<sup>30</sup>

<sup>28</sup> expressed per 100 000 person-years

<sup>29</sup> Data provided by LFS (database of Eurostat) include the number of employed disabled people in almost all the 27 EU Member States. The LFS consists of the following variables: existence, type, cause and duration of longstanding health problem or disability, work limitations (regarding the kind of work or the amount of work, and mobility problems), and assistance needed or provided to work. Data are available by sex, age and countries

<sup>30</sup> Eurostat (2003): Employment of disabled people in Europe in 2002. Statistics in focus. No. 26/2003.

Eurostat data show that on average 18.4% of the European population aged 15 and over is hampered in daily activities because of chronic conditions. Obviously, the percentage is dependent on the age of the worker (see the table in the statistical annex to chapter II):

- in the youngest section (15- to 24-year-olds) with a European average of 8% of workers hampered in daily activities, we find a minimum of 0.8% in Poland, and between 2 and 3% in Malta, Greece and Italy, and a maximum of 19.5% in Finland
- in the following range (25- to 34-year-olds) with a European average of 9.3%: here, again, on the one hand Poland with 1.6% and Malta, Greece and Italy below 5%, and on the other hand Finland with 22.9%
- in the third range (35- to 44-year-olds) with an average of 12.4% once more we find Poland and Malta below 4% (followed by Greece and Italy) and Finland coming last with 27.6%
- the same situation is seen in the last two ranges: from the age of 45 to 54 the average is 17.6% with a minimum in Poland and Malta of 5.9% and a maximum in Finland of 31.2%. Between 55 to 64 years the average is 23.3% with a minimum in Malta (10.1%) and a maximum in Finland (39.1%) and Estonia (41.5%)

The considerable differences in the previous figures appear interesting but no studies have been found able to account for such big differences between Member States.

The data are probably not completely reliable but in any case, the appreciable differences between certain countries are significant. The Eurobarometer Data for 2006 show that 92% of people with a bad state of general health are restricted in their daily routine and 68% of people with long-term illness reported having experienced difficulties. Moreover, in this case too we find considerable differences across Europe: in the Eastern European Countries, the numbers of respondents indicating problems in daily-life activity exceed the European average. Such, for example, is the case in Estonia and Latvia (+9%), as well as Hungary (+10%). The lowest incidence is in Ireland, with an overall distribution similar to that already shown on the incidence of cancer.

### *2.2.1 Employment rates of people with a disability or long-term illness*

Data from 2005 (SILC) on people with a long-standing illness or health problem reveal that the best employment integration is in Sweden and Finland with around 30%, followed by Estonia, UK, Latvia and Germany (around 26 to 24%). The lowest rates of employed people can be found in Mediterranean countries such as Greece, Malta, Italy and Spain (from 9-13% approx.).

**People having a long-standing illness or health problem, aged 14-65 by sex (%), in employment 2005 (decreasing ranking)**

	<b>Total</b>	<b>Males</b>	<b>Females</b>
Sweden	32.3	29.7	35.3
Finland	30.5	29.7	31.5
Estonia	26.4	24.5	28.2
United Kingdom	26.2	26.2	26.2
Latvia	25.2	23.3	27.0
Germany	24.7	23.8	25.9
France	23.9	23.7	24.1
Hungary	23.9	23.4	24.4
Netherlands	21.8	21.3	22.4
Portugal	20.4	18.6	22.6
<b>European Union</b>	<b>20.2</b>	<b>19.3</b>	<b>21.4</b>
Slovenia	19.7	19.4	20.1
Denmark	19.2	17.9	20.7
Iceland	18.9	18.4	19.4
Czech Republic	18.6	17.9	19.4
Cyprus	17.8	18.5	16.7
Lithuania	17.8	16.5	19.1
Slovakia	17.7	15.9	19.6
Poland	17.5	16.3	18.9
Luxembourg	15.7	15.4	16.2
Belgium	14.5	15.0	13.8
Austria	13.3	12.0	15.0
Ireland	13.1	12.0	14.5
Spain	13.0	12.7	13.5
Italy	12.0	11.2	13.2
Malta	10.7	10.8	10.4
Greece	8.8	8.5	9.2

*Source: Eurostat, SILC Survey*

The Nordic and Baltic countries, together with the UK, France and Hungary offer greater employment support and opportunities to people with either a disability and/or long-term illness, differing significantly from the Eastern and Southern European countries.

There have been many studies on return to work and active life of long-term cancer survivors, all showing a high rate of return to work for long-term survivors and the importance that this has for the full recovery of the patients. In fact, given the improvement in early diagnosis and cancer treatment, leading to higher survival rates, there is a rising incidence of workers with cancer diagnosis returning to paid work after cancer. This represents a fundamental result for individuals, and indeed employers and society as a whole: for young and middle-aged survivors, returning to work is vital for financial and social well-being, as well as self-esteem.

*“The employment consequences of surviving cancer have potential importance both for society and for cancer survivors. With roughly half of adult cancer survivors' age < 65 years, many are at an age at which the effects of cancer and its treatment could alter their employment opportunities and choices. Cancer survivors who quit or cut back on work may suffer financially if their lost earnings are not replaced by other sources of income or if they lose access to employment-related health insurance.*

*Survivors who leave work may lose in psychological and social terms as well, considering the social connections afforded by work and its ties to self concept, self esteem, and life roles and satisfaction*<sup>31</sup>”.

A number of studies present converging figures on employment rates of cancer survivors:

- In a study by Bradley and Bednarek (2002)<sup>32</sup> the authors examine employment patterns of 253 long-term cancer survivors. Of those working at the time of initial diagnosis, 67% were employed five to seven years later. Of those who had to reduce their work schedules because they were undergoing treatment, 80% returned to their former schedules and almost all the patients reported that their employers were willing to accommodate their needs during treatment. Individuals who stopped working did so because they retired (54%), were in poor health or disabled (24%), or cited other reasons (22%).
- In a study by Bouknight, Bradley and Luo (2006)<sup>33</sup> on 416 employed women with newly diagnosed breast cancer, after 12/18 months more than 80% of patients returned to work after treatment (during the study period), and workplace accommodations played an important role in their return: 87% reported that their employer was accommodating to their cancer illness and treatment.
- Edbril and Rieker (1989)<sup>34</sup> examined the impact of cancer on work among adult male survivors of testicular cancer in a sample of 74 patients with cancer of the testis (median age, 30.0 years) who had completed treatment 2 to 10 years before the study. The results indicated that the cancer experience generally does not disrupt ability to work, job mobility, or career plans. The findings also suggested that work serves an important psychological function after treatment and that for a subgroup of survivors, it may provide a means for managing depression and anxiety.
- A study by Short et al. (2005)<sup>35</sup> reports employment- and work-related disability in a cohort of 1,433 cancer survivors one to five years after diagnosis, working at the time of their diagnosis. 41% and 39% of the males and females respectively stopped working during cancer treatment. Three-quarters of those individuals who had stopped working during treatment returned to work within the following year. The projected rate of return to work after 4 years was 84%. Of the survivors who quit work following their diagnosis and treatment, more than one-half did so within the first year; 13% of all the survivors who working at the time of diagnosis are expected to quit for cancer-related reasons in the first four years of survivorship. One survivor out of 5, 21% of females and 16% of males who were working at the time of diagnosis, reported cancer-related limitations in their ability to work. 53% of survivors had completed their initial treatment and were disease-free. 48% of those with any cancer-related disability were working during follow-up.

The following paragraphs present an analysis of the main factors associated with job reintegration of workers affected by long-term illnesses and their return to active life.

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<sup>31</sup> Short PF, et al. *Employment pathways in a large cohort of adult cancer survivors*. in: “Cancer” 2005

<sup>32</sup> Bradley C.J., Bednarek H.L. *Employment patterns of long-term cancer survivors* in: “Psychooncology”, 2002

<sup>33</sup> Bouknight, R., Bradley C., and Luo Z.: [Correlates of Return to Work for Breast Cancer Survivors](#). In: *Journal of Clinical Oncology*, 2006

<sup>34</sup> Susan D. Edbril EdM, Patricia P. Rieker: *The Impact of Testicular Cancer on the Work Lives of Survivors*. In: “*Journal of Psychosocial Oncology*”, 1989

<sup>35</sup> Short PF, et al. *Employment pathways in a large cohort of adult cancer survivors*. in: “Cancer” 2005

### 2.2.2 Factors associated with job reintegration

Illness at the workplace has become an important issue over recent years, and social inclusion of people with a disability or illness is crucial, being, as it is, a major factor of social inclusion in general. A significant number of people at work have short-term and long-term health problems: in recent years, greater efforts have been made by a number of countries to support people with health problems to remain in employment. Social and economic effects have to be taken into consideration, depending on the type and seriousness of illness: a relatively minor illness produces brief absence from work, while long-lasting and serious sicknesses have to be treated in a completely different way.

There have been many studies on the rate of return to work and the factors associated with return to work in cancer survivors: the rate of return to work varies greatly (ranging from 30% to 93%, according to the literature), depending on many factors, and in particular the following four:

- sectors and types of job
- duration of sick leave
- the site and type of cancer
- the work and social environment.

#### a) sectors and types of job

Several studies on this issue present contradictory positions: on the one hand it is agreed that manual labour employment and work posing physical demands show the lowest rates return to work, but on the other hand: “Survivors in more physically demanding jobs had higher disability rates, but were no more likely to quit work”<sup>36</sup>. There are some important reasons for this:

- several studies show that, financially, cancer hits working households hard: some survivors may work in spite of cancer related disabilities, perhaps to retain employer-sponsored health insurance, to replace income lost during treatment, or to cover expenses and protect against financial uncertainties associated with survivorship<sup>37</sup>.
- one study, for example, demonstrated that people on lower incomes were more likely to take longer sick leave, but those on the lowest incomes were slightly more likely to take no sick leave at all, which might be accounted for by strong financial pressures to return to paid work as soon as possible.<sup>38</sup>

Limiting long-standing illnesses seem in any case to have stronger adverse social and economic effects on manual workers: manual jobs are much more physically demanding compared with white collar work, cannot be performed via teleworking, in many cases are much less flexible due to shiftwork, etc. This might lead more manual workers into unemployment/early retirement compared to non-manual workers.

- Swedish and Finnish data show that the risk of adverse social consequences for people with limiting longstanding illness is greater among manual workers than among non-manual workers.<sup>39</sup>

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<sup>36</sup> Short PF, et al. *Employment pathways in a large cohort of adult cancer survivors*. in: Cancer 2005

<sup>37</sup> Ibid.

<sup>38</sup> McMillian Cancer Support, *Working Through Cancer. The road to recovery: getting back to work*, November 2007

<sup>39</sup> European Foundation for the Improvement of Living and Working Conditions, *Illness, disability, and social inclusion, 2003*

- A Finnish study highlights that survivors working in agricultural, forestry, fishing, transport, communication, manufacturing, or service industries were 18% to 20% less likely to be employed<sup>40</sup>. No other studies have been found on the issue offering indications as to whether this is a local specificity or a feature common to these sectors.
- A study by Bradley and Bednarek (2002)<sup>41</sup> indicates that many employed survivors who returned to work put in over 40 hours per week, although about 10% reported that they had at least one limitation that was imposed by their illness or treatment, particularly in relation to performing manual labour.

The level of education seems to be another important predictor: the study by Taskila-Brandt<sup>42</sup> indicated that individuals of lower educational attainment have a higher probability to work during illness compared to those with higher educational attainment. There may be more opportunities for individuals of higher educational attainment to access prolonged medical leave or to return to work part-time, or there may be financial reasons in terms of different levels of income and access to private health insurance.

#### b) duration of sick leave

Statistically significant differences in return to work rates were also found associated with the length of sick leave taken, with more than 90% of those with sick leave duration of less than 12 months returning to work, compared with 62% with sick leave duration of 12 months or more. Most of those who returned to work (59%) managed to do so within 6 months of diagnosis. However, 17% of those who were working before diagnosis were absent from work for more than 1 year<sup>43</sup>.

- The length of sick leave differed according to *treatment modality*, with 83% of those who received surgery alone returning to work in less than 6 months after diagnosis, compared with 47% of those who received surgery plus one or more treatments of radiotherapy, chemotherapy or hormone therapy, and 40% of those who did not receive surgery, one quarter of whom were absent for more than 1 year.
- *Economic deprivation* has been found to be associated with length of sick leave: those in the highest quintile of the income range were more likely to take less than 6 months sick leave (54.3%) compared with those in the lowest quintile (34.9%). Only one participant in the highest quintile took sick leave for 1 year and over compared with 25.6% in the lowest quintile. However, those in the lowest quintiles were slightly more likely to take no sick leave (30.4%) compared to those in the highest quintiles (18.7%). Again the possible interpretation is that on the one hand workers in the highest quintile work in less physically demanding jobs, and on the other hand workers of the lowest quintile in the UK (where the study was conducted) receive too modest a level of income benefit for sick leave, showing financial needs driving to immediate return to paid employment.

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<sup>40</sup> Taskila-Brandt T, et al. (2004): *The impact of education and occupation on the employment status of cancer survivors*. IN: "Eur J Cancer" 2004

<sup>41</sup> Bradley C.J., Bednarek H.L. *Employment patterns of long-term cancer survivors* in: "Psychooncology", 2002

<sup>42</sup> Taskila-Brandt T, et al. (2004): *The impact of education and occupation on the employment status of cancer survivors* in: "Eur J Cancer" 2004

<sup>43</sup> Amir Z., et alii, return to paid work after cancer: a British experience, J Cancer Surviv, I June, 2007

c) the site and type of cancer

Job regaining for cancer survivors depends mainly on the site of cancer: “Survivors of blood cancers were significantly more likely to quit work for cancer-related reasons than survivors of all cancers except for central nervous system, head and neck, respiratory, and Stage IV lymph cancers<sup>44</sup>”.

Another aspect to be taken into consideration is the stage of the illness: studies show that disability rates and drop-out rates (for both genders) were higher for survivors still having initial treatment for active cancer.

d) the work and social environment

NGOs supporting patients note that two out of three of those who returned to work experienced difficulties, including tiredness, loss of concentration and lack of confidence in their job. Almost one in five reported their working life had deteriorated because of their cancer: co-workers’ positive attitudes and a supportive work environment are determinants for a positive return to work after prolonged absence due to illness (see chapter V).

Flexibility regarding working hours or amount of work has also been reported as being positively associated with return to work.

Various studies point up the importance of providing information to workers and managers:

- from the worker’s perspective it has been shown that lack of advice from health care providers regarding return to work is related to a loss of confidence when back at work and consequently a harder path towards reintegration;
- management may find it difficult to help the worker reintegrate when he returns to work. A supportive management available to discuss some key aspects concerning the return, considering the opportunity to introduce periods of part time or a reduced work load, may help both parties. Cancer patients, for example, need a long time to rest after trying treatment and often suffer from long-term side effects: workers should be supported in this respect, and concrete information about specific aspects of recovery and modalities of reintegration can itself be of great help for a successful return.

In chapter V, the role of patients’ associations in this specific area will be considered, as it represents an essential factor for reintegration.

### **2.3 The spread of new technologies**

After long illness many workers could return to work if supported with adequate technologies. In particular, in the case of workers that have found their autonomy reduced due to illness, or that require frequent periods of rest during the day, teleworking could offer a real opportunity to reduce the period of sick leave. It can be observed that this opportunity is limited to white collars whose work can be assisted with the new technologies.

Access to society is a fundamental right, and a critical aspect for people with long-term illness or a disability. Access barriers are not only the physical barriers such as steps in a building: the concept of ‘accessibility’ is much broader. It relates to physical environment, information, services, economic activity, culture, language, etc. Enabling people with illness or disability to take fully part in society calls for the removal of all kinds of barriers that exist in public infrastructures, communications, information, work, etc.

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<sup>44</sup> Short PF, et al. (2005): *Employment pathways in a large cohort of adult cancer survivors*. in Cancer 2005

“The approach to disability endorsed by the Council (Council, 1997) is that barriers are an important impediment to participation in society, and that accessibility and mobility issues ought to be seen in the light of equal opportunities and the right to participate”<sup>45</sup>.

The spread of new technologies is a key factor in assuring wider access for disabled and sick workers to active life and in particular returning to work. Analysis of the differences throughout Europe takes into consideration this form of accessibility as a determinant in maintaining contact and subsequently returning to work in cases of disability consequent upon long-term illness. (The tables are set out in the Annex to chapter II)

- The share of individuals regularly using the Internet in Europe ranges from more than 75% in EU Nordic countries (The Netherlands, Denmark, Finland and Sweden) to less than 35% in some Eastern and Southern European countries (Italy, Bulgaria, Greece, Romania). The indicator refers to the share of individuals aged 16 to 74 accessing the Internet, on average at least once a week, within the last three months before the survey. Use includes all locations and methods of access.
- Considering the percentage of individuals aged 16 to 74 who have used the Internet in the last 3 months for interaction with public authorities (i.e. having used the Internet for one or more of the following activities: obtaining information from public authorities' web sites, downloading official forms, returning completed forms) once again, the Northern countries differ considerably from the Southern and Eastern Countries: in Denmark, the Netherlands, Sweden, Luxembourg and Finland more than 50% of the active population have used the Internet for interaction with public authorities, while the figure is less than 15% of the population in Poland, Greece, Bulgaria, Romania.
- Similar results are found for the indicator, which measures enterprises with people employed who regularly work part of their time (half a day per week or more) away from the enterprise's regular work site (at home) while having access to the enterprise's computer systems<sup>46</sup>. It is worth noting that in Lithuania, Latvia, Italy, Romania, Bulgaria and Poland less than 30% of the workers use teleworking in large enterprise, and this figure drops considerably for medium and small enterprises.

The previous figures show a wide gap between those countries where tele-work can offer possible support for job regaining for a large population of sick workers and the countries where this accessibility is not widely guaranteed.

## 2.4 Spending on health and sickness

Average spending on social protection<sup>47</sup> in the European Union in 2005 represented 27.2% of GDP. In general, the relative levels of social protection expenditures are highest in the richest countries as measured by GDP per capita. Social protection expenditures range from 12.4% to 16% in the Baltic States and Romania to around or above 30% in Sweden, France, Denmark and Belgium) (see Annex to Chapter II).

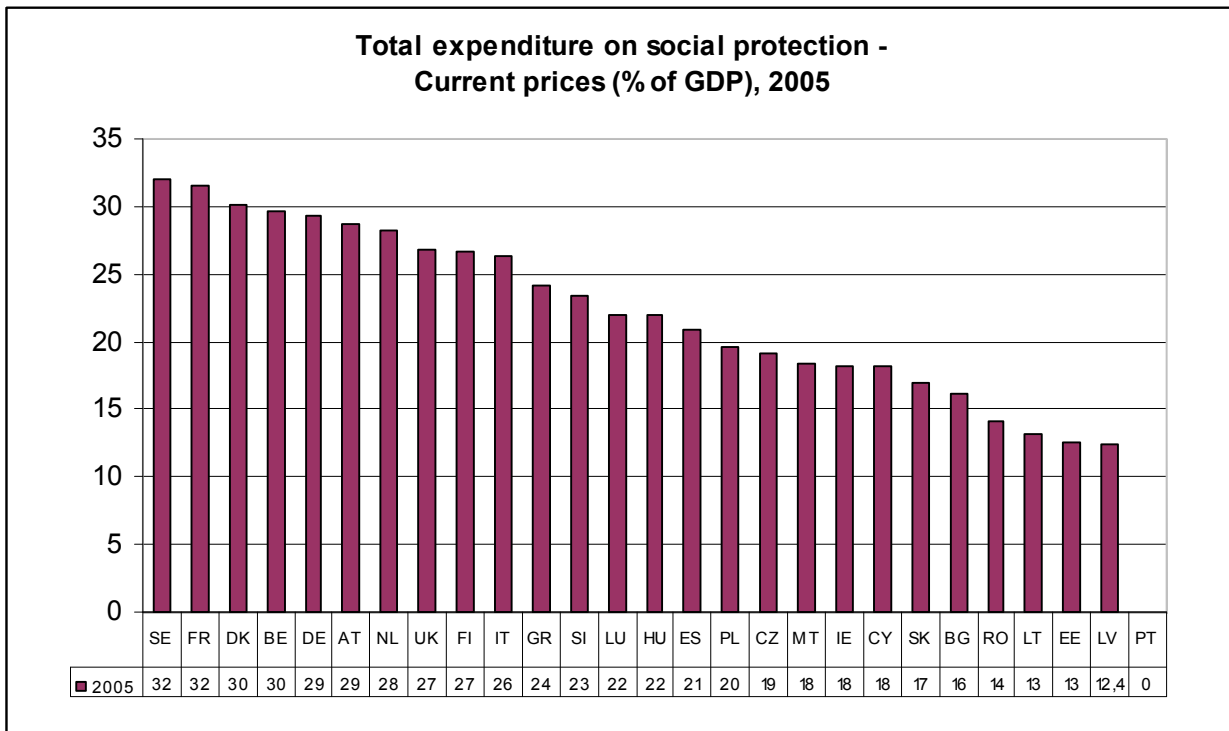
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<sup>45</sup> European Foundation for the Improvement of Living and Working Conditions, *Illness, disability, and social inclusion, 2003*

<sup>46</sup> It covers all enterprises with 10 or more full-time employees with their main activity in NACE sections: D, F, G, H (groups 55.1 - 55.2), I, K, O (groups 92.1 - 92.2 only)

<sup>47</sup> Expenditure on social protection includes: social benefits, which consist of transfers, in cash or in kind, to households and individuals to relieve them of the burden of a defined set of risks or needs; administration costs, which represent the costs of the management and administration of the scheme; other expenditure, which consists of miscellaneous expenditure by social protection schemes (payment of property income and others)

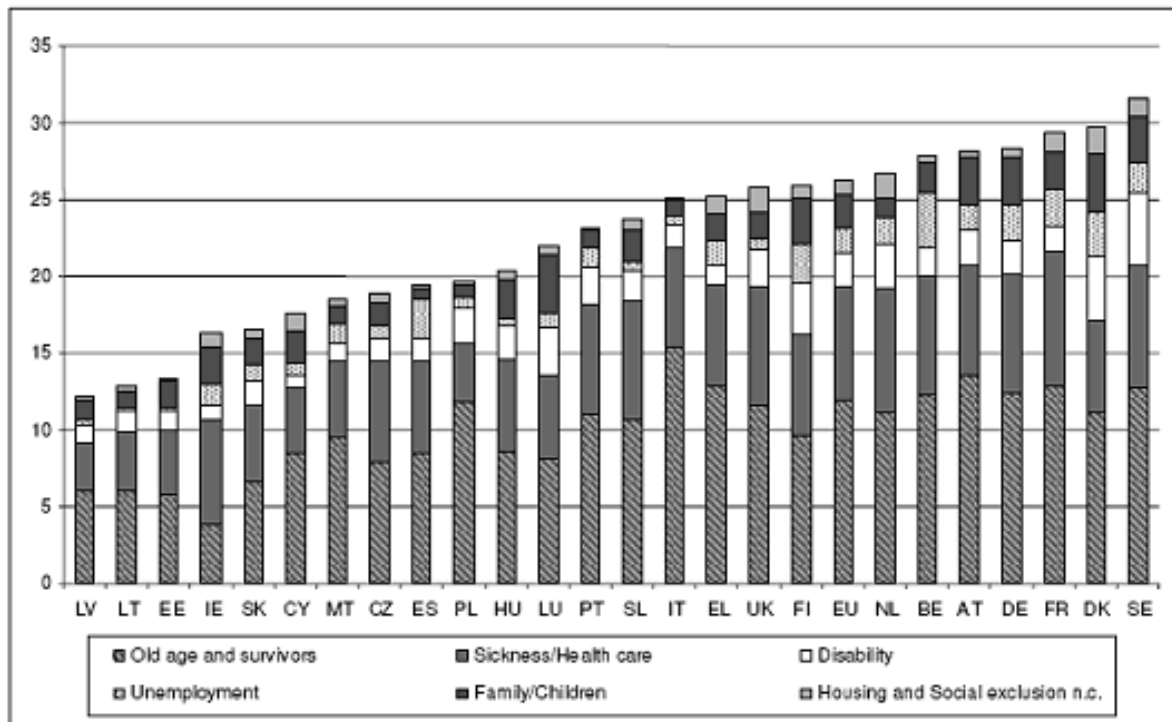




Source Eurostat

In all EU countries, pensions and health care represent the bulk (three quarters) of social protection expenditure, reaching on average 46% and 28% respectively of social protection expenditure. The rest is spent, to varying degrees, on disability, family-related benefits, unemployment, housing and other social exclusion benefits.

**Social protection benefits, by function, in % of GDP – 2004**  
**Joint report on Social Inclusion 2007**



Source: Eurostat - ESSPROS

In the context of our study, particular importance is attached to sickness benefits and disability.

Sickness leave and disability pensions in western European countries have increased appreciably in recent years.

*“With an increase in real terms of 3.4% per annum between 2000 and 2005 for the EU-25 as a whole, spending on the “sickness/health care” function rose at a faster rate than expenditure on the other functions over the same period. The acceleration observed since 2000 marks a general trend for the European Union, with the exception of the decreases in Slovakia (-2.1%) and Germany (-0.3%) and the low indices in Austria and Sweden. Between 2000 and 2005 the largest increases were in Latvia (13.5%), Ireland (10.7) and Hungary (9.2%)”*

The following two tables show the main differences across Europe.

<b>Social benefits for SICKNESS - (% of total benefits)</b>	
	<b>2005</b>
Ireland	40.9
Romania	36.2
Czech Republic	35.3
Slovenia	32.3
Estonia	31.9
Spain	31.6
The Netherlands	30.9
UK	30.9
Portugal (2004)	30.4
Lithuania	30.3
Hungary	29.9
France	29.8
Slovakia	29.5
Bulgaria	29
EU 27	28.6
Greece	27.8
Germany	27.3
Belgium	27.1
Italy	26.7
Malta	26.3
Latvia	26
Finland	25.9
Luxembourg	25.7
Austria	25.5
Cyprus	25.3
Sweden	24.3
Denmark	20.7
Poland	19.9

*Source. Eurostat*

<b>Social benefits for SICKNESS per head of population (PPS)</b>	
	<b>2005</b>
Luxembourg	3257.4
The Netherlands	2391.1
France	2257.5
Ireland	2227.2
UK	2175.7
Belgium	2128.7
Austria	2041.2
Sweden	1996.4
Germany	1989.7
Finland	1713.2
Denmark	1711.8
EU 27	1674.8
Italy	1605.1
Spain	1472.1
Slovenia	1434.9
Greece	1389.1
Portugal (2004)	1134.2
Czech Republic	1123.5
Cyprus	946.4
Hungary	927.2
Malta	807.6
Slovakia	645.2
Estonia	554.2
Lithuania	467.6
Poland	433.6
Romania	386.4
Bulgaria	353.2
Latvia	345.9

*Source. Eurostat*

The proportions of expenditure on sick leave compared with expenditure on disability pensions and early retirement pensions are of specific interest to our study. Except for the case of Cyprus, countries with the highest level of expenditure in particular on disability pensions but also partially on early retirement pensions belong to the Nordic and Continental model of Welfare. On the contrary, the countries with the lowest expenditure belong to the Eastern and Southern European model.

It is worth noting in the last column of the following table that the proportion of sums between per head paid sick leave benefit compared to per head disability pension differs notably across Europe, ranging from less than 20% in Romania and Portugal to more than 50% in Slovenia, Germany and Cyprus. These figures anticipate the differences in paid sick leave benefits, dealt with in Chapter III.

**Expenditure on chosen benefits in PPS per inhabitant, 2005**

	<b>Paid sick leave benefit</b>	<b>Disability pension</b>	<b>Early retirement pension</b>	<b>% represented by paid sick leave benefit on disability pension</b>
<i>The Netherlands</i>	509	703	204	42.0
<i>Luxembourg</i>	504	957	870	34.5
<i>Sweden</i>	485	700	198	40.9
<i>Cyprus</i>	345	71	1	82.9
<i>Germany</i>	341	251	185	57.6
<i>Finland</i>	302	523	147	36.6
<i>Austria</i>	301	410	262	42.3
<i>Denmark</i>	265	503	529	34.5
<i>Spain</i>	256	259	124	49.7
<i>Belgium</i>	206	379	0	35.2
<i>EU 27</i>	<b>197</b>	<b>255</b>	<b>98</b>	43.6
<i>Slovenia</i>	194	177	496	52.3
<i>France</i>	184	218	2	45.8
<i>Czech Rep</i>	162	185	40	46.7
<i>Ireland</i>	129	235	211	35.4
<i>UK</i>	120	284	0	29.7
<i>Italy</i>	118	181	0	39.5
<i>Greece</i>	115	159	542	42.0
<i>Hungary</i>	95	198	130	32.4
<i>Malta</i>	78	153	0	33.8
<i>Poland</i>	73	187	238	28.1
<i>Estonia</i>	70	90	144	43.8
<i>Portugal (2004)</i>	70	357	42	16.4
<i>Lithuania</i>	56	109	22	33.9
<i>Slovakia</i>	42	117	9	26.4
<i>Bulgaria</i>	34	61	87	35.8
<i>Latvia</i>	34	88	19	27.9
<i>Romania</i>	9	39	2	18.8

*Source - Eurostat - Esspross*

This is purely descriptive since it does not appear to have any particular correlation with the level of expenditure of a country or with the welfare model adopted by each country. The real difference is between countries that spend a large amount on social policies and countries that do not, and more specifically between countries that spend on active policies and countries that do not.

In conclusion, the situation in Europe appears fragmented with significant differences in terms of expenditure on specific policies aimed at supporting disabled and sick workers. It also appears fragmented from the private and market perspective, in terms of accessibility and opportunities available for those who could have the opportunity to regain an active life if supported with technologies, flexibility and specific measures of reintegration: this is the focus of the second part of the study.

## Chapter III - The protection system for sickness at the workplace

Legislation on sick leave and benefits for sickness is the focus of this chapter, which analyses different schemes throughout the European Union. What is of specific interest are the ways in which the different schemes are designed and function in relation to other measures.

The aim is to highlight the different measures and the different approaches adopted throughout Europe. Particular attention has been given, where possible, to the unemployed, self-employed and workers with atypical contracts.

### 3.1. The EU social protection models for fighting chronic illness at workplace

As shown in the previous sections of this research, chronic illness represents one of the main factors of exclusion from work<sup>48</sup>. Hence, it is hardly surprising that all 20<sup>th</sup> century welfare state systems have addressed such problems. However, in doing so each Member State has followed its own path, and a great variety of solutions are to be seen, no single EU social protection model existing. In fact, what is commonly defined as the EU social protection system is the result of various national systems, which sometimes differ greatly from one another.

It is therefore difficult to make an overall assessment and it is worth distinguishing between solutions referable to different general welfare state models, focusing on the main common features and prospective lines of convergence. Of course drawing a distinction between welfare state models always implies a certain degree of arbitrariness.

As is well known, the most common distinction is based on the dichotomy between the “Bismarckian” (or “occupational”) system and the “Beveridgian” (or “universalist”) system<sup>49</sup>. The former is essentially based on an actuarial system and financing techniques aimed at maintaining the workers’ income; the extent of entitlements to social benefits and their level depend on past and/or present participation in the labour market (in terms of seniority, duration of work and income). The latter is partially financed by tax revenue and intended to ensure an adequate, regular income; in principle, citizenship alone confers the right to “universal” and “unconditional” social assistance regardless of the previous participation of workers in the labour market. From the viewpoint of access to social protection, in a Beveridgian system, the distinction between employed and self-employed individuals seems to be less significant than in a Bismarckian system<sup>50</sup>.

However, it should be noted that the above-mentioned dichotomy, if accepted as a dogma, may be misleading, as the distinction has become less marked over the years, due to a process of “hybridisation”, which has been affecting EU welfare systems.

A more precise classification has been drawn up by Esping-Andersen, who identifies three types (or in his words “worlds”) of welfare state<sup>51</sup>:

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<sup>48</sup> See Grammenos S., *Illness, Disability and Social Inclusion*, European Foundation for the Improvement of Living and Working Conditions, 2003; Wynne R., McAnaney D., *Employment and Disability: Back to Work Strategies*, European Foundation for the Improvement of Living and Working Conditions, 2004.

<sup>49</sup> For a history of the idea of welfare state see Ritter G.A., *Der Sozialstaat. Entstehung und Entwicklung im internationalen Vergleich*, München, 1991.

<sup>50</sup> With regard to the dichotomy between Bismarckian and Beveridgian systems see also Vielle P., Walthery P., *Flexibility and Social Protection*, European Foundation for the Improvement of Living and Working Conditions, 2003, 19-20.

<sup>51</sup> See Esping-Andersen G., *The Three Worlds of Welfare Capitalism*, Cambridge: Polity Press, 1990. Such classification has also been adopted by Hemerijck: see Hemerijck A., *Come cambia il modello sociale europeo*, SM, n. 65, 2002, 191-235.

1. “Corporatist/conservatist welfare state” (“Continental model”): this welfare system is characterised by occupational schemes whereby the level of protection depends substantially on contribution, given the close link between social benefits and labour activity. A less important role is played by benefits financed through taxation. In general, within such systems individuals participating in the labour market as employees enjoy a higher level of protection than is granted to self-employed and atypical workers (and, *a fortiori*, to the unemployed), which may generate inequalities between labour market “insiders” and “outsiders”. Germany, Austria, France and Belgium are notable examples of this welfare approach;
2. “Social democratic welfare state” (“Scandinavian or Nordic model”): this model is “characterised, in principle, by the egalitarian aim to emancipate individuals from the market” and “a high level of services and benefits, accessible to the entire population and based on principles of social citizenship”<sup>52</sup>. This system is basically financed by tax revenue, while the workers’ contribution is generally low. Sweden, Denmark and The Netherlands are typical representatives of this model in Europe;
3. “Liberal welfare state” (“Anglo-Saxon model”): in this model, emphasis is put on the responsibility of the individual for the security of his/her own livelihood. Consistently with such a premise, the level of social benefits is normally lower than in the other models and state intervention is traditionally subject to “means testing”. With regard to the provision of benefits, a significant role is played by the private sector: since “the level of benefit is a function of the contributory capacity of the individual”<sup>53</sup>. The United Kingdom and Ireland are significant examples of this welfare system;
4. Some scholars (e.g. Maurizio Ferrera) consider a fourth welfare model, the “Mediterranean” one, characterised by the significant role played – within the welfare system – by family structures and informal types of solidarity as a form of protection of last resort<sup>54</sup>: according to those authors, welfare systems like those of Italy, Spain, Portugal and Greece present such features. However, as the Mediterranean model shares significant features with the Continental one, the former can be considered as a variant of the latter. For instance, with regard to invalidity (which may be the result of chronic illness), the Italian system shares the basic principles with the French one: indeed both systems are based on a compulsory social insurance scheme financed by contributions with earning- or income-related pensions<sup>55</sup>. In this report, the situations in the above-mentioned Mediterranean countries will be dealt with in connection to the Continental model and, whenever classification is needed, it will make use of the tripartition put forward by Esping-Andersen.

It is worth noting that the instrument of social insurance, traditionally used to address the classical risks arising in industrial society (e.g. illness), shows weaknesses under certain circumstances. On the one hand, the ongoing changes affecting the structure of modern society bring a great deal of pressure to bear on welfare systems, giving rise to problems in terms of economic sustainability (one of the problems to be solved by modern welfare systems is to select what situations deserve protection, given limited availability of resources)<sup>56</sup>.

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<sup>52</sup> Vielle P., Walthery P., *Flexibility and Social Protection*

<sup>53</sup> Ibid.

<sup>54</sup> See Ferrera M., *Modelli di solidarietà*, Bologna: il Mulino, 1993.

<sup>55</sup> See Missoc 2007.

<sup>56</sup> European Commission, *The Future Evolution of Social Protection from a Long-Term Point of View: Safe and Sustainable Pensions*, COM(2000) 622 Final

On the other hand, according to neo-institutionalist theories, sometimes a mismatch between old and new risks occurs, which may cause lack of coverage<sup>57</sup>. This is true not only with regard to pensions, which play a major role within modern social security systems, but also with regard to social assistance and health care<sup>58</sup>. A recent study published by the European Parliament<sup>59</sup> highlights that strengthening the design of health care financing can help to secure health system sustainability.

Thus, particularly at the EU level, attempts have been made to follow new and different paths, with the implementation of activation strategies aimed at enabling workers affected by chronic illness to reconcile their condition with work activities.

Therefore, over recent years the EU has been developing a very different approach. As well as the classical social insurance tools, traditionally developed at the national level, at the EU level a new approach has been gaining ground within the general framework provided by the Lisbon Strategy<sup>60</sup>. This approach, based upon the idea of inclusion through work, has become increasingly popular.

Seeking to trace back the emergence of this new dominant ideology in the EU, it is useful to refer to the British Commission on Social Justice<sup>61</sup>, the EU White Paper on competitiveness and Growth (1993), the EU White Paper on Social Policy (1994), the programme of the Labour Party (1997), and the Green Paper *A New Contract for Welfare* (1998), drawn up by the newly formed Blair administration, where the British government presented its analysis of connections between poverty, exclusion and the benefits system and which has since been the theoretical basis for proposed reforms. The main idea of the document is to “rebuild the welfare state around work”, estimating that “paid work is the surest route out of poverty”.

It is often said a quality job is the best safeguard against poverty and social exclusion; the incidence of poverty among the working population is, of course, far lower than among the jobless population. A job provides the opportunity, ideally, for the individual to develop his or her potential and integrate into society. To be precise, employment is a *sustainable* way out of poverty and social exclusion provided that the employment is lasting, pays enough to lift workers out of poverty and has all those features, normally referred to as “quality in work”, that promote the individual's future employment prospects, safeguard health and safety, and enhance human and social capital. Increasingly, Member States are adopting “active inclusion” as the preferred route to promoting social and labour market integration. An element of this is the clearly discernible trend towards making access to benefits conditional on job searching. A balanced active inclusion approach requires this to be accompanied by opportunities to build human capital, including the acquisition of IT skills, and addresses any existing educational disadvantage; it must also be accompanied by adequate counselling and guidance for the individual.

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<sup>57</sup> See Ferrera M., *Le trappole del welfare*, Bologna: il Mulino, 1998,

<sup>58</sup> See, for instance, the recent report *Healthcare Financing in the Context of Social Security*, in <http://www.europarl.europa.eu/activities/committees/studies/searchPerform.do>

<sup>59</sup> European Parliament, DG Internal Policies Of The Union, *Health Care Financing in the Context of Social Security*, 2008

<sup>60</sup> See *Presidency Conclusions*, Lisbon European Council, 23 and 24 March 2000

With regard to regulatory techniques adopted within the Lisbon Strategy it is worth mentioning the so-called “Open method of co-ordination”. See Barbera M. (a cura di), *Nuove forme di decisione e di regolazione: il Metodo aperto di coordinamento delle politiche sociali*, Giuffrè, 2006; Dehousse R., *The Open Method of Coordination: A New Policy Paradigm?*, Paper presented at the Conference *The Politics of European Integration: Academic Acquis and Future Challenges*, Bordeaux, 26-28 September 2002; Eberlein B., Kerwer D., *New Governance in the European Union: A Theoretical Perspective*, JCMS, Vol. 42, No. 1, 2004

<sup>61</sup> See Commission on Social Justice, *Social Justice. Strategies for National Renewal. The Report of the Commission on Social Justice*, London: Vintage, 1994.

Crucially, income support should be guaranteed at an adequate level, otherwise, with conditionality, there is the risk of driving the most disadvantaged even further to the margins.

This inclusion strategy is implemented by promoting *Active Labour Market Policies* to tackle lack of employability – in particular through investment in education and training and job counselling. Most of these policies are delivered by the Public Employment Services, in partnerships with other social and economic actors. In order to promote the integration of people furthest from the labour market, education and training policies often address the need of specific groups over and above the category of low-skilled individuals. These groups include older workers and young entrants into the labour market, migrants, women, the long-term unemployed, disabled people and those living in disadvantaged areas, including persons affected by economic restructuring. Targeted human capital policies have been put into place in most Member States. Another important aspect is the certification of job-related competencies and the assessment of skills and qualifications for groups such as migrants to improve skill-matching and the employability of the individuals concerned<sup>62</sup>.

Although this approach seems dominant, enjoying widespread success, some criticism has recently been raised. In particular, emphasis placed on the idea of “inclusion through work” seems to alter the relation between the various aspects of policy coordination so that the social aspects are substantially subordinated to economic-employment considerations<sup>63</sup>. Kröger observed: “The fact that social exclusion within this new context is dramatically reduced to fighting unemployment and increasing growth finds its practical correlation in the fiscal and economic governance in the EU, namely the Broad Economic Policy Guidelines (BEPG) and the Stability and Growth Pact (SGP), which are institutionally and normatively favoured areas of policy-making and policies exemplified by the requirement that all other OMCs be consistent with the BEPGs. Insofar as emphasis is placed on fighting unemployment in order to reduce social exclusion, the room that OMC/inclusion occupies is constrained by the European Employment Strategy (EES). It is therefore possible to argue that the social agenda is currently governed in order to maintain the economy but not for social purposes as an end in itself. In this context, employment and social policies are not only subordinated to the overall goal of competitiveness, but are intended to actively support this goal”<sup>64</sup>. Within the context of the relaunch of the Lisbon Strategy promoted by the Commission chaired by Barroso in 2005, sound macroeconomic conditions and policies are meant to be a precondition for developing effective social policies. Although in theory equal importance is given to increasing both productivity and employment (and employment playing a pivotal role within social policies), in fact the former is considered a priority if compared to the latter. This is clearly pointed out by the EC Commission when it states “*Lisbon’s overburdened list of policy objectives has obscured the importance of these actions which can drive productivity growth. From now on, structural reforms, through such policies, should be pivotal in the renewed Lisbon Strategy*”<sup>65</sup>.

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<sup>62</sup> See Council and Commission, *Joint Report on Social Protection and Social Inclusion 2007*, p. 59-60.

<sup>63</sup> The subordination of social policies to economic-employment policies is clearly put forward by the Second Kok Report: see *Facing the Challenge. The Lisbon Strategy for Growth and Employment*, Report from the High Level Group chaired by Wim Kok, Luxembourg: Office for Official Publications of the European Communities, 2004.

<sup>64</sup> Kröger S., *Let’s talk about it. Theorizing the OMC (inclusion) in light of its real life application*, Paper prepared for the doctoral meeting 2004 of the Jean Monnet chair of the Institut d’Études Politiques in Paris, section “Public Policies in Europe”, 11 June 2004. See also: Armstrong K.A., *Tackling Social Exclusion Through OMC: Reshaping the Boundaries of EU Governance*, in Börzel T., Cichowski R. (eds.), *State of the Union: Law, Politics and Society* (Vol. 6), Oxford: Oxford University Press, 2003; Chalmers D., Martin L., *The Open Method of Coordination and the European Welfare State*, London School of Economics and Political Science, Discussion Paper nr. 11, 2003; Radaelli C., *The Open Method of Coordination: A new governance architecture for the European Union?* Rapport nr. 1, Swedish Institute for European Policy Studies, 2003.

<sup>65</sup> See Commission, *Working Together for Growth and Jobs. A New Start for the Lisbon Strategy*, COM (2005) 24, Brussels, 2.2.2005, p.13.



### 3.1.1 Sickness benefits

Sickness benefit is the main instrument adopted by all Member States in order to prevent workers from being exposed to the risk of poverty and exclusion due to the reduced work capacity caused by illness.

For each of the 27 countries a short report on the protection system for sickness at the workplace has been drawn up, containing analysis of the legislation (see Annex to Chapter III). However, on first glance it is clear that there are notable differences between the solutions adopted by Member States, even within one single welfare model (from this standpoint the above-mentioned tripartition between different welfare “worlds” – as may be the case when using general models – is not always useful).

With more specific reference to sick pay benefits, in most of the European countries these are financed by contributions, but there are 10 countries where the provision is financed totally or partially by taxes:

#### Financing

<i>Contribution</i>		<i>Tax-financed protection scheme</i>
Austria	Malta <sup>66</sup>	Denmark
Belgium	The Netherlands	Estonia <sup>67</sup>
Bulgaria	Poland <sup>68</sup>	Finland <sup>69</sup>
Czech Republic	Portugal	France
Cyprus	Romania	Greece <sup>70</sup>
Finland <sup>71</sup>	UK <sup>72</sup>	Hungary
France <sup>61</sup>	Slovak Republic <sup>59</sup>	Lithuania <sup>73</sup>
Germany	Slovenia	Luxembourg <sup>59</sup>
Greece <sup>74</sup>	Spain	Malta <sup>59</sup>
Hungary <sup>61</sup>	Sweden	Poland
Ireland		UK <sup>75</sup>
Italy		
Latvia		
Lithuania		
Luxembourg <sup>59</sup>		

All 27 European countries have a compulsory social/sickness insurance scheme, which is only described as universal in the case of Finland. In all the other 26 countries, beneficiaries are either all economically active people (employee and self-employed) or only employees:

<sup>66</sup> and state subsidies

<sup>67</sup> Social tax

<sup>68</sup> and partially taxes

<sup>69</sup> State finances cash benefits of minimum amounts and rehabilitation grants

<sup>70</sup> Persons insured before 1.1.1993 Contributions by employees and employers

<sup>71</sup> State finances cash benefits of minimum amounts and rehabilitation grants

<sup>72</sup> Statutory Sick Pay paid contribution, taxes and the employer

<sup>73</sup> For specific targets of population such as police, state security, defence, etc

<sup>74</sup> Persons insured since 1.1.1993: Three-party financing (employee, employer, state)

<sup>75</sup> Statutory Sick Pay paid contribution, taxes and the employer

<b>Beneficiaries of compulsory sickness benefits</b>		
<b>economically active persons (employee and self employed)</b>	<b>Only employees</b>	<b>All residents</b>
Belgium	Austria	Finland <sup>76</sup>
Bulgaria	Czech Republic <sup>77</sup>	
Cyprus	Greece <sup>78</sup>	
Denmark	Ireland	
Estonia	Italy	
France	Lithuania <sup>71</sup>	
Germany <sup>71</sup>	Poland <sup>79</sup>	
Hungary	Portugal <sup>71</sup>	
Latvia <sup>71</sup>	Spain <sup>71</sup>	
Luxembourg		
Malta		
The Netherlands <sup>80</sup>		
Romania		
Slovenia		
Slovak Republic <sup>81</sup>		
Sweden		
UK		

In general, the Nordic systems – in keeping with their more “universalist” vocation – also show more awareness of the necessity of providing specific solutions, in the case of illness, for unemployed people (who are particularly exposed to the risk of social exclusion).

See for example:

- the Danish system, whereby the unemployed and people participating in labour market provisions are entitled to the same amount they would have received had they not fallen ill;
- the Swedish system, whereby unemployed people are entitled to sickness cash benefit (*sjukpenning*) with the same amount they received before the last employment ended, as long as they are actively looking for a job, but the maximum is SEK 486 (€ 54) a day<sup>82</sup>.

On the contrary, with regard to illness, the vast majority of Continental/ Mediterranean countries guarantee no specific protection for the unemployed (e.g.: Italy, France, Spain, Greece and the Czech Republic, whereas greater protection is provided in Germany and Belgium).

<sup>76</sup> aged 16-67

<sup>77</sup> Voluntary insurance for self-employed

<sup>78</sup> and assimilated to employee

<sup>79</sup> Voluntary insurance for self-employed

<sup>80</sup> The Sickness Benefit Act continues to exist as a "safety net" for employees who do not or no longer have an employer

<sup>81</sup> Possibility of voluntary insurance for all other people over the age of 16

<sup>82</sup> See Missoc 2007.

Let us look at the special unemployment conditions in different European countries:

<i>Special conditions for the unemployed</i>			
<b>no special conditions or no entitlement for the unemployed</b>	<b>payment of sickness benefit</b>	<b>entitled to the same amount they would have received if not fallen ill</b>	<b>continuation of unemployment benefits</b>
Czech Republic	Belgium <sup>83</sup>	Denmark	Germany <sup>84</sup>
Estonia	Bulgaria <sup>85</sup>	Sweden	Luxembourg
Greece	Lithuania		Slovenia
Spain	Malta		
France	Poland <sup>86</sup>		
Ireland	Finland <sup>87</sup>		
Italy	Romania		
Cyprus			
Latvia			
Hungary			
The Netherlands			
Austria			
Portugal			
Slovak Republic			
UK			

A major differentiation with regard to sickness – even within welfare “worlds” which are supposed to be characterised by a certain degree of internal homogeneousness and uniformity – can be observed on analysing other features of the national protection legislations such as the “qualifying period” for entitlement to sick pay benefits, the “amount and the criterion for its determination” and their “duration”. From this point of view, the legal framework appears to be somewhat fragmented:

- a) “*Qualifying periods*”: a number of countries do not require any work or qualifying period (Austria, Czech Republic, Estonia, Finland, Hungary, Germany, Italy, Latvia, Liechtenstein, Luxembourg, Slovenia, Sweden, and the Netherlands); others call for various requirements to be met in order to have access to sick pay benefits. As can be seen, the regulation of the qualifying periods is regardless of any classification between general models;

The requirement of a qualifying period, mentioned above, raises a more general issue: indeed legal and administrative barriers in terms of eligibility may exclude a number of workers from entitlement to sickness benefits.

The conditions imposed by Member States (in terms of degree, duration and nature of illness/disability) to be met by workers in order to receive sickness benefits tend to generate exclusion.

<sup>83</sup> Cannot be less than the unemployment benefit

<sup>84</sup> For jobseekers; for unemployed initially (up to 6 weeks) continued wage payment paid by the Labour Agency, then sickness benefits paid by the sickness insurance fund to the amount of the previous wage replacement benefit

<sup>85</sup> Unemployment benefit is suspended while receiving sickness benefit

<sup>86</sup> The payment of benefit continues if the incapacity to work started during the period of employment.

<sup>87</sup> If an unemployed person has received unemployment benefits for at least 4 months, the sickness benefit will amount to at least 86% of the unemployment benefit.

- b) “*Amount and the criterion for its determination*”: In most European countries the amount of benefit is related to the earning/income of the workers, except for Belgium, Ireland, Malta and the UK, where a lump sum or a flat rate benefit is paid, and Greece and Spain, where it is related to contribution levels.

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***Criterion for determination of the amount***

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<b>earnings or income related benefits</b>	<b>lump-sum or flat rate benefits</b>	<b>Contribution-related benefits</b>
Austria	Belgium <sup>88</sup>	Greece
Belgium <sup>89</sup>	Ireland <sup>90</sup>	Spain <sup>91</sup>
Bulgaria	Malta <sup>92</sup>	
Cyprus <sup>93</sup>	UK <sup>94</sup>	
Czech Republic		
Denmark		
Estonia		
France		
Finland <sup>96</sup>		
Germany		
Greece		
Hungary		

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In some countries the employer pays the benefit as a continuation of paying wages. This is particularly the case in Austria, Belgium<sup>97</sup>, Germany, Italy, Malta, the Netherlands, Poland, Slovenia, the Slovak Republic and Sweden.

The amount of the benefit varies greatly in terms of the percentage of earnings considered, the components of the earnings taken into consideration for the calculation, or the presence and level of a ceiling.

**Amount of sickness benefit**

<b>Austria</b>	50% of gross wage or salary, 60% from 43rd day of sickness. Ceiling: € 3,840 per month
<b>Belgium</b>	60% of earnings Ceiling taken into account for the compensation: € 110
<b>Bulgaria</b>	80% of the average daily gross earnings or the average daily contributory income on which contributions have been paid
<b>Cyprus</b>	Basic Benefit 60% of the lower part of weekly average insurable earnings over the benefit year, increased by 1/3 for the first dependant and by 1/6 for other dependants (maximum of three dependants). Supplementary Benefit: 50% of the upper part of weekly average insurable earnings over the benefit year with a ceiling.

<sup>88</sup> for self-employed

<sup>89</sup> For employees

<sup>90</sup> Flat Rate Sickness Benefit and supplements for employees

<sup>91</sup> For temporary incapacity

<sup>92</sup> Flat Rate Sickness Benefit and supplements for dependants

<sup>93</sup> Other benefits depending on contributions and the duration of affiliation

<sup>94</sup> Flat Rate Sickness Benefit

<sup>95</sup> Benefits depending on the registered earnings and on the duration of incapacity

<sup>96</sup> In some cases with a minimum/flat rate benefit

<sup>97</sup> For employee during a limited period

<b>Czech Republic</b>	25% of the Daily Assessment Base for the first 3 days and thereafter 69% of the Daily Assessment Base (calculated using gross monthly earnings which are taken into account as follows: up to € 19 first 14 days 90%, then 100%, € 19 to 27: 60%; earnings over € 27 are not taken into account)
<b>Denmark</b>	Sickness cash benefit calculated upon the basis of the hourly wage of the worker with a maximum of € 459 per week or € 12 per hour (37 hours per week), and upon the number of working hours.
<b>Estonia</b>	80% of the average gross daily wage. No ceiling.
<b>Finland</b>	Daily amounts dependent on annual earnings: earnings under € 1,128: € 15.20 per weekday. earnings € 1,128 - € 29,392: 70% of 1/300 earnings; earnings € 29,393 - € 45,221: € 66.27 plus 40% of 1/300 of earnings exceeding € 29,392; above € 45,221: € 88.66 plus 25% of 1/300 of earnings exceeding € 45,221. The part-time sickness allowance amounts to 50% of the preceding sickness allowance.
<b>France</b>	General scheme for employees: 50% of daily earnings, in a limit of 1/720th of the annual ceiling, maximum € 44.70. 66.66% of daily earnings with a limit of 1/540th of the annual ceiling from 31st day for beneficiaries with 3 children, maximum € 59.60.
<b>Germany</b>	Sickness benefit: 70% of the normal salary (wages and income from work normally received) but not exceeding 90% of the net salary.
<b>Greece</b>	For the first 15 days: the total ceiling plus supplements for dependants (max. 4) is € 15.22 per day. After 15 days: the total ceiling for benefits plus supplements for dependants (max. 4) is € 27.87 per day.
<b>Hungary</b>	Sickness benefit paid as a percentage of average daily gross earnings. The amount of the benefit depends upon length of previous insurance period. At least 2 years: 70% of the daily average, less than 2 years (or during inpatient treatment): 60% of the daily average. No ceilings.
<b>Ireland</b>	Sickness Benefit: € 185.80 per week. Family supplements: Adult dependant: € 123.30 per week. Each child dependant: € 22.00 per week.
<b>Italy</b>	Without hospitalisation: 75%. From 21st day 100% (earnings taken as basis: real earnings). With hospitalisation: allowance is reduced to 2/5 for the insured without dependants.
<b>Latvia</b>	80% of the average gross wages upon which contributions have been paid during six months.
<b>Lithuania</b>	After the first two days: 85% of average monthly Compensatory Wage <sup>98</sup> . The benefit must not be lower than 1/4 of the average insured income of the current year
<b>Luxembourg</b>	The full salary which the insured person would have earned if she/he had continued to work.
<b>Malta</b>	Benefit is paid in accordance with the number of days worked in a normal week up to a maximum of six days. The rates are: single parent or married person whose spouse is not employed on a full-time basis: € 16 per day. Single person: € 11 per day.
<b>The Netherlands</b>	70% of the daily wage. Maximum daily wage considered: € 174.64.

<sup>98</sup> Compensatory Wage: the average wage paid during a quarter before the last quarter of sickness from which contributions to sickness and maternity insurance have been collected. The compensatory wage cannot exceed 5 times the national average insured income (although contributions are paid on the full wage).

<b>Poland</b>	80% of reference wage <sup>99</sup> per month 70% of reference wage per month in event of hospitalisation 100% of reference wage per month in specific cases (sickness during pregnancy, accidents travelling between home and work, etc.)
<b>Portugal</b>	Daily benefit: percentage of the average daily wage: 65% when the incapacity period is lower than or equal to 90 days; 70% when the incapacity period is between 91 and 365 days; 75% when the incapacity period goes beyond 365 days. Minimum amount: 30% of the indexing reference of social support or the average earning if it is lower than this percentage.
<b>Romania</b>	75% of the average insured gross earnings over the last 6 months. The amount is increased to 100% of the average insured earnings if the sickness benefit is due to: tuberculosis, AIDS, any type of cancer, infectious and contagious diseases, and medical and surgical emergencies.
<b>Spain</b>	From 4th to 20th day 60% of the calculation basis <sup>100</sup> ; from the 21st day, 75% of the calculation basis.
<b>Slovak Republic</b>	55% of the assessment base (daily earnings calculated on the basis of the previous year, monthly ceiling 1.5 times the national average monthly wage) from the 11th day of work incapacity.
<b>Slovenia</b>	Percentage of the recipient's average monthly gross wage in the previous calendar year (the basis). The benefit amounts to: 90% for sickness; 100% for occupational diseases and other specific reasons; 80% for an injury unrelated to work or nursing of an immediate family member. Benefit may be between the amount of the Statutory Reference Amount <sup>101</sup> (€ 237.73 net per month) and the gross wage the beneficiary would receive if he/she were working.
<b>Sweden</b>	80% of the income qualifying for sickness cash benefit. The sickness cash benefit is paid up to a ceiling of 7.5 times the price base amount (€ 32,616).
<b>United Kingdom</b>	As for the rate of payment, current statutory sick pay is £75.40 per week. No SSP is payable to employees whose average weekly earnings come to less than £90.00. Short-term incapacity benefit: paid at two rates: lower rate of € 91 per week for the first 28 weeks; higher rate of € 107 thereafter. Additions: spouse aged 60 or over or adult caring for dependent child € 56. Child dependency increases with higher rate benefit: € 14 for first child, € 17 for each other child

- c) “*Duration*”: The duration of sickness benefit varies considerably across Europe: a certain variety of solutions may be identified ranging from a minimum of 6 months (in Estonia, Greece<sup>102</sup>, Italy, Cyprus, Malta, Poland and Romania) to a maximum of unlimited duration such as in Bulgaria, Ireland and Sweden. The most common is to grant up to 1 year of sick pay leave. In the case of long-term illness, the sickness benefit in most countries is substituted by other measures, and in particular with concession of an invalidity pension. The situation in the UK is interesting as there is a shift from a generic form of assistance to a specific form of assistance for long-term ill workers, the short-term incapacity benefit being replaced by long-term incapacity benefit: that seems

<sup>99</sup> Reference wage: calculated on the basis of gross earnings during the 12 months preceding the cessation of work for which contributions were paid.

<sup>100</sup> Calculation basis: quotient of contribution basis of the month prior to the date of leave divided by the number of days corresponding to this contribution.

<sup>101</sup> The Statutory Reference Amount is defined as an "individual amount that provides a worker with material and social security" and is determined annually

<sup>102</sup> It depends on the duration of contribution

to have reduced the number of claimants of invalidity pensions (for details see further the UK case study).

### Duration of Sickness benefits

<b>Austria</b>	Generally the legally stipulated minimum time period is 1 year. According to the insurance funds' statute, however, the sickness benefit can be extended to 1.5 years.
<b>Belgium</b>	Maximum of 1 year (period of "primary incapacity for work").
<b>Bulgaria</b>	Paid from the second day of sickness until recovery of work capacity or recognition of invalidity.
<b>Cyprus</b>	Basic and Supplementary Benefit: 6 months (156 working days). If the beneficiary is still unable to work after the 156 days but is not expected to remain permanently so, then the Sickness Benefit may be extended to 312 days.
<b>Czech Republic</b>	1 year (maximum of 84 days per year for invalidity pensioners who are still employed).
<b>Denmark</b>	1 year in 18 months; the first two weeks of a period of sickness not included. Benefits can be paid for a longer period under certain conditions, as for example when beginning a probable rehabilitation process, when the municipality starts analysis of an application for a disability pension or in the case of employment injury; similarly when a sick person's work capacity seems recoverable. If necessary, benefits can be paid for a longer period up to 6 months so that the sick person's work capacity can be tested.
<b>Estonia</b>	Up to 6 months (182 calendar days) per case of sickness.
<b>Finland</b>	For the same sickness, limited to 1 year over a 2-year period.
<b>France</b>	1 year per period of 3 consecutive years, but until the end of 3 years for long-term sickness.
<b>Germany</b>	Sickness benefit for the same sickness, limited to 1.5 years over a 3-year period.
<b>Greece</b>	Duration of benefits depending on the length of the period of contributions: 6 months, 1 year or 2 years
<b>Hungary</b>	Maximum 1 year (If the insurance period is less than 1 year than the maximum duration equal to the period of insurance).
<b>Ireland</b>	Unlimited if the claimant has paid 260 weekly contributions. Limited to 1 year if between 52 and 260 weekly contributions paid.
<b>Italy</b>	Maximum of 6 months per year.
<b>Latvia</b>	1 year from first day of incapacity if incapacity has been continuous, or 1.5 years (78 weeks) over a 3-year period if incapacity has proved repetitive with interruptions.
<b>Lithuania</b>	The sickness certificate may be extended for an established period of time (up to four months). If the person has not recovered after that period it is obligatory to apply to the Disability and Employment Capacity Assessment Office, which deals with the determination of disability.
<b>Luxembourg</b>	Maximum: 1 year, payment ends if an invalidity pension is granted.
<b>Malta</b>	Maximum duration: up to an aggregate of 6 months (156 working days), but could be extended in certain cases when the claimant undergoes any major surgical operation or intervention or suffers a severe injury or is afflicted by some serious disease which requires long treatment before the person can resume duties for any number of days not exceeding 1 year (312 working days) in a two-year period.
<b>The Netherlands</b>	Maximum 2 years.
<b>Poland</b>	Maximum 6 months.

<b>Portugal</b>	Maximum 3 years (then, possibly, invalidity).
<b>Romania</b>	The duration of sickness benefit is 6 months, counted from the first day of the contingency. The duration of the sickness benefit is longer in cases of special diseases, including any type of cancer, according to the phase of the disease (1 year, with a right to extension up to 1.5 years)
<b>Slovenia</b>	1 year. Longer duration of benefit possible with the approval of the commission.
<b>Slovak Rep</b>	Maximum 1 year
<b>Spain</b>	1 year. Possibility of extension for 6 months when foreseeable that the beneficiary will recover work capacity.
<b>Sweden</b>	There is no formal limitation but the sickness cash benefit may be converted into Activity compensation (for people aged 19 to 29 years) or Sickness compensation (for people aged 30 to 64 years) if the sickness continues for an extended period of time.
<b>United Kingdom</b>	Short-term incapacity benefit: 1 year maximum in a period of incapacity for work; lower rate payable for first 28 weeks, followed by higher rate from week 29. Then replaced by long-term incapacity benefit.

With regard to the “duration” of benefits a point that cannot be disregarded is that, however generous a protection system may be, none seem to be inclined to ensure sick pay benefits indefinitely (unless illness turns into a permanent form of disability, which implies the application of different rules). This can be a problem in the case of chronic illness, particularly when it reduces the individual’s work capacity but is not serious enough for him/her to have the right to disability benefits.

Reduced work capacity may affect the employment relationship insofar as it makes the fulfilment of contractual obligations more difficult. In legal systems that consider the supervening incapacity to perform the assigned tasks justification for dismissal, this may lead to termination of the employment contract, with all the obvious problems for the sick worker. Moreover, this is due to labour market imbalances, since it has been demonstrated that the unemployment rate of people with a moderate illness or disability is about twice the level of those with no disability, while the rate of people with a severe illness or disability is about three times the level of the non-disabled (although significant variations between the various EU countries can be observed). As we have seen, the employment rate of people with disabilities is high in countries where overall employment is high. This indicates that general conditions carry more weight than specific conditions linked to illness or disability. This does not mean that the latter are not statistically significant. Considerable variations between countries are observable.

- The employment rate for people with a moderate disability is below the European average in six Member States (Belgium, Greece, Spain, Ireland, Italy and Luxembourg). The employment rate for those with a severe disability is below the European average in eight Member States (Belgium, Denmark, Spain, Greece, Ireland, Italy, Finland and the United Kingdom).
- The employment ratio of the moderately disabled to the non-disabled is 68% at EU level, but only 47% in Ireland, revealing a substantial disadvantage for people with disabilities. At the other extreme, it is 82% in Finland, where the situation is rather better.
- The employment ratio of the severely disabled to the non-disabled is 35% at EU level. This ratio is only 22% in Denmark, where the severely disabled are most disadvantaged, but at the other extreme it is 58% in France.



In general, there is a greater variation between countries in the employment ratio of moderate to non-disabled, compared with severe to non-disabled<sup>103</sup>.

That is why, as well as sick pay benefits, it is of the utmost importance to deploy alternative solutions and instruments in order to prevent workers' exclusion.

### *3.1.2 Solutions alternative to sick pay benefits*

As mentioned above, granting sick pay benefits may prove unsatisfactory in many respects. Therefore, it is necessary to consider alternative ways to address the issue of chronic sickness at work by adopting a more comprehensive approach, including differentiated strategies and measures.

This problem has been addressed in different ways across Europe. Alternative measures and policies to sick pay allowance can be divided – for the sake of simple exposition – into three groups or categories:

- measures aimed at adapting the workplace and the work activity to workers' reduced capacity;
- measures aimed at fostering life-long learning (with specific regard to the Lisbon Strategy);
- measures aimed at removing individuals from the workplace, whose reduced work capacity does not allow them to perform the assigned tasks (or any other task).

These three groups of measures and policies will be dealt with below.

#### *a) Adapting the workplace and work activity to workers' reduced capacity*

The aim of adapting the workplace plays a crucial role under disability provisions, at both the European and national level, but it is substantially disregarded by legislators when dealing with chronic and long-term illness. This omission appears particularly serious considering that the path from long-term absence, due to chronic illness, to long-term unemployment, economic inactivity and social exclusion is well documented.

Chronic illness can lead to social exclusion, through restricted work opportunities. Moving from illness to exclusion has repercussions at many levels. The social costs are reflected in effects on solidarity, social cohesion, equality and engagement.

While great importance is attributed to measures designed to facilitate job maintenance for disabled people, less attention is paid to strategies for preventing exclusion for people affected by chronic illness.

The Framework Directive 2000/78/EC – and national legislations deriving from it – assigns the employer the duty to adopt “reasonable accommodations” for disabled people but not for people affected by long-term illness (see Chapter II).

The concept of “reasonable accommodation” needs some clarification. Under Article 5 of the Framework Directive 2000/78/EC reasonable accommodations are to be provided. This means that employers are to take appropriate measures, where needed in a particular case, to enable a person with a disability to have access to, participate in, or advance in employment, or to undergo training”. As examples of reasonable accommodations see Recital 20, where are suggested “effective and practical measures to adapt the workplace to the disability, for

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<sup>103</sup> Grammenos S, *Illness, disability, and social inclusion*, European Foundation for the Improvement of Living and Working Conditions, 2003

example adapting premises and equipment, patterns of working time, the distributions of tasks or the provision of training or integration resources”.

Such exemplification is not exhaustive. Organisational measures (e.g. adapting working time) as well as measures seeing the worker as a “person” (e.g. training) are to be taken into consideration in order to comply fully with the directive. These measures are to be adopted unless they result in a “disproportionate burden in the employer”<sup>104</sup>. However, Article 5 specifies, “this burden shall not be disproportioned when it is sufficiently remedied by measures existing within the framework of the disability policy of the Member State concerned”.

However, reductive interpretation yielding to the temptation to subordinate reasonableness only to a cost-based evaluation is to be avoided, as the cost of a given measure is only one of the indicative factors to be taken into account in order to assess what is reasonable and what is not. As Advocate General Geelhoed puts it, “what is reasonable is also determined by the cost of appropriate resources, the proportionality of those costs if they are not reimbursed by the authorities, the reduction of or compensation for the disability thus made possible and the accessibility of the disabled person concerned to other occupations or forms of business where disability will be no obstacle or far less of an obstacle”<sup>105</sup>.

Far from basing his decision on a sharp dichotomy between adequacy of the measure taken and the burden on the employer, the judge should have drawn a balance between the employer's and the disabled person's interests.

All countries provide social inclusion, vocational training and rehabilitation programmes specifically targeting people with disabilities who are economically inactive, but they fail to make sufficient efforts to provide for long-term absent workers with similar measures.

The lack of protection for sick people (as compared with the disabled) has been severely criticised<sup>106</sup>. Actually, useful lessons could be learned from measures and policies aimed at promoting labour market participation for people with disabilities. Many of the incentives and support for people with disabilities could be very helpful to someone wishing to get back to work after a long-term illness. For instance, the above-mentioned “reasonable accommodations” could represent a step towards job retention and reintegration. Reasonable accommodations would be particularly suited in addressing situations as troublesome as chronic illness. Indeed, in many cases chronic illness cannot be tackled by general norms, but calls for specific measures to be taken, geared to the needs of the individual (which is why reasonable accommodations are often seen as being referable to an “individual justice model”, although the dichotomy between “individual justice model” and “group justice model” has given rise to a certain amount of controversy).

A deeper awareness of the negative implications of long-term illness at the workplace is needed, because in EU official documents and surveys there is a lack of analysis and targeting (a possible explanation is that social protection, rehabilitation and return to work systems were not originally designed to deal with chronic illness, nor to work in an integrated manner)<sup>107</sup>.

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<sup>104</sup> See Recital 21 Framework Directive 2000/78/EC: “to determine whether the measures in question give rise to a disproportioned burden, account should be taken in particular of the financial and other costs entailed, the scale and financial resources of the organisation or undertaking and the possibility of obtaining public funding or any other assistance”.

<sup>105</sup> See Advocate General Geelhoed's opinion in *Chacón Navas*, § 83.

<sup>106</sup> See Wynne R., McAnaney D., *Employment and Disability: Back to Work Strategies*, European Foundation for the Living and Working Conditions, 2004

<sup>107</sup> *Ibid.*

The latest Joint Report on Social Protection and Social Inclusion (2007) reflects the increasing attention paid by Member States to measures promoting active labour market inclusion for disabled people, but nothing is said about chronic and long-term illness'. *Chronic illness* seems to be more relevant from the general viewpoint of health protection (in terms of tackling health problems, reducing costs and promoting healthier lifestyles) than from considerations of job retention and back-to-work perspective. This also emerges from the recent integrated guidelines, stating, "Member States should also enact measures for health protection, for prevention and for the promotion of healthy lifestyles with the goal of reducing sickness burdens, increasing labour productivity and prolonging working life"<sup>108</sup>.

It can also be useful to address the issue of chronic illness using the conceptual tools provided by EU health policies, such as those designed around the idea of prevention. Some authors stress the crucial importance of early intervention. Indeed, once an individual has lost his/her work capacity (and in some cases his/her job) it is more difficult to implement a back-to-work strategy aiming at job retention or reintegration.

The argument for early intervention incorporates a number of action principles:

- it is not inevitable for a health condition, regardless of its impact on function or activity, to lead to exit from employment;
- it is better to prevent individuals from losing their jobs than investing in the endeavour to get them back to work once unemployed or inactive;
- early intervention is the most effective way to achieve job retention and reintegration;
- early intervention can only be effective if responsibility for action is located in the workplace;
- coordinated delivery of appropriate services and supports is essential for effective return to work<sup>109</sup>.

As well as reasonable accommodations, a solution worth taking into account is modification of the worker's tasks.

Member States usually adopt a number of measures aimed at reintegrating people affected by sickness or disability, some legally binding. Here are some examples<sup>110</sup>:

- in *Spain*, which stipulates reintegration in the same post or, when this is not possible, in an inferior category with the same remuneration; a worker has priority for vacancies in the same company (in return, employers receive social security subsidies);
- in *Italy*, where employers have to assign equivalent tasks to disabled people, or, if this is not possible, lower graded tasks but under previous conditions (see Law n. 68/1999). Moreover, making an exception to the general prohibition to assign lower tasks, the judges consider assignation to lower tasks as a lawful alternative to dismissal whenever a worker, although not yet declared disabled, has been affected by a reduction of work capacity due to illness or injury;

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<sup>108</sup> See Commission, *Integrated Guidelines for Growth and Jobs (2008-2010)*, including a Commission Recommendation on the Broad guidelines for the economic policies of the Member States and the Community (under Article 99 of the EC Treaty) and a Proposal for a Council Decision on guidelines for the employment policies of the Member States (under Article 128 of the EC Treaty). p. 28.

<sup>109</sup> See Wynne R., McAnaney D., *Employment and Disability: Back to Work Strategies*, European Foundation for the Living and Working Conditions, 2004

<sup>110</sup> See Grammenos S, *Illness, disability, and social inclusion*, European Foundation for the Improvement of Living and Working Conditions, 2003.

- in the *Netherlands*, where a recent law obliges companies to make greater efforts to retain employees who have suffered an illness or disability;
- in *Sweden*, where the employer has to make reasonable adjustments to the work (place) or, if possible, provide a different job in the same company. For instance, Sweden adopts a “step-by-step model” which can be described as follows: “the assessment of working ability should be carried out in steps. When an insured client is unable to return to his or her ordinary work (step 1), the primary measure is to seek alternative tasks with the client's employer (step 2-4). In the absence of suitable alternative work, or if such a measure would require overly lengthy rehabilitation, the client's work capacity should then be assessed against the general labour market (step 5 and 6). A client who, despite disease, can manage a different normal job (step 5) is not entitled to any social insurance allowance. Other types of work than those normally existing on the job market should be considered only if they are actually available to the client (Government Bill 1996/97: 28). If an insured client is no longer capable of managing his or her work full-time, nor alternative work with the employer nor any other job normally available on the labour market, but is still assessed as having residual work capacity, he or she may be entitled to a partial allowance (Social Insurance Act). If examination of a case of sick leave shows that impairment of the client's work capacity is permanent or will last for more than one year, the Social Insurance Act states that the sickness allowance should be replaced by a permanent or temporary disability pension”<sup>111</sup>.

#### *b) Life-long learning*

For job retention strategies to be implemented, it is crucial to foster vocational training and life-long learning to enable workers to perform a broader range of tasks, reconciling the loss of work capacity with the employer’s organisational requirements.

Clearly, the point about “learning” is closely linked to modification of worker’s tasks as an alternative solution to dismissal.

Vocational training and life-long learning are key concepts within the European Employment Strategy and the Lisbon Strategy (in 2000, the Presidency Conclusions set the Union a new strategic goal for the next decade: “to become the most competitive and dynamic knowledge-based economy in the world capable of sustainable economic growth with more and better jobs and greater social cohesion”)<sup>112</sup>. Member States, in compliance with the EU guidelines, are called upon to adopt all the relevant measures.

As it is stated in the latest Joint Report on Employment<sup>113</sup>, more investment in human capital is needed in order to improve access to employment for all age groups, to raise productivity levels and quality at work, and to build a workforce that can adapt to change. There is clear evidence that many workers fail to enter or to remain in the labour market because of a lack of skills, or more generally due to skill mismatches. The importance of the need to improve education and skills is fully reflected in the Employment Guidelines adopted by the Council in 2005.

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<sup>111</sup> Ahlgren A., *Vocational rehabilitation, work resumption and disability pension. A register-study of cases granted vocational rehabilitation by social insurance offices in a Swedish county*, Karolinska Institute, Stockholm, 2006.

<sup>112</sup> See *Presidency Conclusions*, Lisbon European Council, 23 and 24 March 2000, paragraph 5. See also Rodrigues M.J. (ed.), *The New Knowledge Economy in Europe*, Edward Elgar, 2002.

<sup>113</sup> See Council and Commission, *Employment in Europe 2006*

Two of the guidelines specifically cover this area: Guideline 23, which calls for expanding and improving investment in human capital through specified measures including lifelong learning strategies, and Guideline 24, which calls on Member States to adapt education and training systems in response to new competence requirements.

Considering that the higher the professional skill of workers the easier they deal with the return to job after a long illness, a possible route towards job reintegration is to promote a rise in the professionalism of workers before their return to the workplace. Indeed it is obvious that the more skilled workers are (and adaptable to the changing situation) the less they are likely to be exposed to the risk of exclusion due to long-term illness<sup>ii</sup>.

National Reform Programmes provide some example of measures adopted with the purpose of improving workers' skills to achieve the goal of job retention. For example, Spain recently endorsed a package of measures implementing Guideline 24, concerning the reform of the ongoing training system for the employed and unemployed to favour life-long learning. In particular, a subsystem of professional training for employment has been created that does not distinguish between occupational professional training and ongoing professional training, and the reform has been carried through of the model of continuous training for the employed and unemployed to favour life-long learning<sup>114</sup>.

Another interesting example is represented by the Italian law n. 53/2000 that allow workers, with more than 5 years of seniority, to benefit from a leave for continuous training (see Article 5) in order to keep their skill high and become more adaptable to labour market changes. The maximum duration of such a leave is 11 months throughout the working life.

### *c) Early retirement*

A fairly common way of addressing the problem of chronic illness consists in giving workers the opportunity to withdraw from labour market through early retirement schemes.

This raises some questions.

On the one hand, early retirement – normally linked to the granting of an invalidity pension – is a costly measure, which may not be compatible with the need for a more sustainable welfare system. As has been observed, “early retirement places a substantial drain on social protection systems”. The growth in the numbers withdrawing from the labour force before the official retirement age has been a marked feature of the labour market. In many countries, those retiring early are sometimes supported by disability benefits, which are used as a substitute for unemployment benefits. However, the response to this is mainly focused on administrative and procedural changes to payment systems and active labour market measures for those already out of the workforce. The key strategy proposed is to adjust payment levels to reduce exit from work rather than trying to encourage people to return to their jobs<sup>115</sup>.

On the other hand, early retirement may result in a form of exclusion insofar as it expels those who would be able to return to their jobs if only they were given the chance (and time) to cope with their own illness.

See for example the 2007 Progress Report on the Dutch National Reform Programme (2005-2008): “the introduction of the Work and Income (Capacity for Work) Act (WIA) on 29 December 2005 was an important step towards a more activating social security system. It is regarded as the final step in a policy process spanning several years.

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<sup>114</sup> (see Royal Decree 395/2007, of 23 March, regulating the subsystem of Vocational Training for Employment in *Spain National Reform Programme. Second Progress Report 2007*).

<sup>115</sup> See Wynne R., Mcananey D., *Employment and Disability: Back to Work Strategies*, European Foundation for the Improvement of Living and Working Conditions, 2004

This process included the introduction of the Eligibility for Permanent Incapacity Benefit (Restrictions) Act (WVP), the Continued Payment of Wages During Illness Act (VLZ) and the reassessment operation. [...] With the introduction of the VLZ in 2005, the employer's obligation to continue paying salaries was extended from one to two years.

As a result of this change, the number of new claimants in the incapacity benefit system was very low in 2005. All these measures have helped reduce the number of new incapacity benefit claimants. The reassessment of benefit recipients began in 2004 and will continue until the end of 2008<sup>116</sup>.

Solutions like the one adopted by the Dutch legislator are of utmost interest insofar as they seeks to compose two conflicting ways of addressing the issues of chronic illness and disability. It has been noted that "at a macro level, inappropriate and/or ineffective policies can be a substantial barrier to improved job retention and reintegration. One example is the inherent contradiction between attempts to reduce unemployment among people with disabilities while, at the same time, subsidising the withdrawal from work of people who suffer illness or injury"<sup>117</sup>.

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<sup>i</sup> See Council and Commission, Joint Report on Social Protection and Social Inclusion 2007, p. 67 "Promoting the inclusion of disabled people is more extensively covered than in previous National Action Plans, with all Member States highlighting measures targeted at disabled people; AT, EL and PT have made it one of their priority objectives. Most Member States identify the need to mainstream disability issues into all relevant policies, but there are considerable variations in the degree to which they explain how this will be done in practice (HU, SE and IE present advanced mechanisms). The UK is introducing a new Disability Equality Duty requiring all public bodies to promote equality of opportunity for disabled people and to publish and implement Disability Equality Schemes. For disabled people to live as independent a life as possible and to be socially included in their local communities, it is vital – and also cost-effective – to build up local services, which, to a large extent, can replace institutional care. A number of Member States (BG, CY, CZ, EL, LV, LT, MT, PL, RO, SI, SK) focus on measures to develop community-based services, i.e. to cater for ongoing deinstitutionalisation. DK, DE and UK are promoting independent living by introducing individual choice of service providers; DE has introduced personal budgets. FI, CZ, DK, IE, FR and AT are all taking measures to promote accessible housing. As further explained in the section on health care, e-Health can play an important role in making independent living possible. Several reports refer to the elimination of barriers to education and training at all levels for disabled people and people with special educational needs (both through the elimination of physical barriers and through the provision of specific support). Many countries envisage specific support. The choice varies between special schools and special needs education in mainstream schools. BG's National Programme for Employment and Vocational Training for persons with permanent disabilities is a programme to increase the employability of people with disabilities, to make employers aware of the possibilities of employing disabled people, and to raise public awareness and combat stereotypes. Motivational and vocational training is provided for disabled people, suitable sustainable employment is sought and financial support to employers who employ disabled people is provided. The outcomes are monitored via monthly Employment Agency statistics. To encourage good practice among employers, a symbol for a positive attitude towards people with disabilities has been introduced, which can be awarded to selected employers following certain evaluation criteria. Most attention is given to measures promoting active labour market inclusion. AT, BE, DK, IE and LV are setting clear targets for increasing the employment rate among disabled people. In the UK, the New Deal for disabled has helped almost 75,000 people into jobs, and the Pathways to Work programme will be extended to the whole country by 2008. DK has a funded action plan up to 2009 to bring more disabled people into work. In IE, public bodies are required to be proactive in employing disabled people. AT, CY, DE, IE, IT, PL and SE all have different forms of subsidy schemes, while FR and HU focus on measures to make workplaces and training accessible.

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<sup>116</sup> See, 2007 Progress Report on the Dutch National Reform Programme for 2005-2008. In the context of the Lisbon Strategy.

<sup>117</sup> Wynne R., Mcananey D., *Employment and Disability: Back to Work Strategies*, European Foundation for the Improvement of Living and Working Conditions, 2004

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EE and HU are introducing new employment rehabilitation/welfare systems in 2007. In CZ, the legal obligation to provide individual plans for vocational rehabilitation remains to be implemented. LV is launching a National Programme to improve infrastructure, social care facilities and social rehabilitation institutions with EU co-financing. BE and DK are promoting diversity in the labour market (BE: an annual award to the best enterprise, DK: a network for raising awareness among municipalities and jobcentres). In all Member States there is still a long way to go, however

<sup>ii</sup> As it has been observed by the Joint Report on Employment, “skill levels have an important relation to employment rates, with the rate generally being higher the greater the educational attainment level. In 2005 the average employment rate among the high skilled in the EU was 82.5% and for the medium skilled 68.7%, whereas for the low skilled it was only 46.4%. The greatest within country differences in employment rates for the low- and high-skilled are found among the east European new Member States, with differences above 50 percentage points for most and as high as 70 percentage points in Slovakia. In these countries, the importance of skill levels to the employment status of individuals is the most pronounced. The variation in employment rates across Member States is significantly higher for the low skilled. Employment rates for the high skilled range from 76.9% in France to around 87.5% in Lithuania, Portugal and the UK, a difference of only around 10 percentage points, while for the low skilled it ranges from an extremely low 13% in Slovakia to as high as around 66% in Portugal. The countries where employment rates for the low skilled are very low (below 30%) are all among the new Member States from Eastern Europe, reflecting the relatively low level of labour market participation by the low skilled in these countries, although it is also the case that the shares of the low skilled in the working age population in these countries are well below the EU average. Focussing on unemployment rates, the average unemployment rate for the low skilled in the EU is more than twice that for the high skilled. Differences in unemployment rates between these two groups are particularly pronounced in the Czech Republic and Slovakia, as well as in Poland. In the former two countries, the unemployment rate for the low skilled is more than ten times that for the high skilled. This contrasts markedly with the situation in Cyprus, Denmark, Greece, Italy, Luxembourg, The Netherlands, Portugal and Spain where the unemployment rates for low and high skilled differ by less than 5 percentage points”

## **Part two) Towards inclusion**



## Chapter IV - Inclusion measures: examples from case studies

The design of the sick leave systems and general characteristics of the job reintegration policies implemented in selected countries will be presented in this chapter in more detail, based on reviews of the literature, reports on research, data collected, and interviews with significant actors.

The case studies were selected considering the presence of one or more of the following points:

- a) inclusion measures and 'return to job' policies intended to support return to work instead of early retirement;
- b) the model of reintegration of workers involving several policies such as employment, care, health, education and mobility;
- c) spread of new technologies as a determinant of the possibility to maintain contact and then to return to work;
- d) the risk of inactivity trap to highlight whether means-tested benefits/allowances act as disincentives to work, and possible solutions adopted;
- e) specific provisions concerning cancer;
- f) specific attention to the care perspective in terms of the support offered to carers.

Considering the study focuses on the models of reintegration of workers in the labour market, we have selected as case studies **Finland, the UK and the Netherlands. Romania and Italy** (together with the UK) are considered as of specific interest, having special provisions for workers affected by cancer, and Italy in particular for the attention to the care perspective.

## Case study - Finland

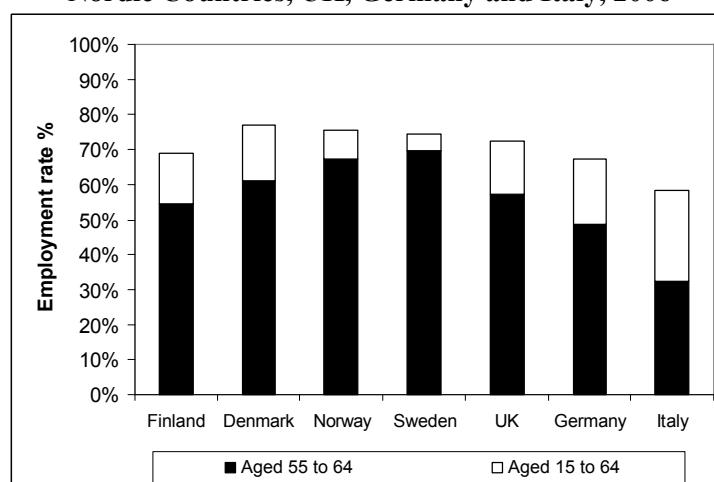
### *The sick leave scheme in the context of the Finnish welfare system*

The Finnish welfare system exhibits many features that are usually attributed to those of Nordic (Scandinavian) countries. Like the Swedish, Danish and Norwegian welfare systems, the Finnish welfare system is founded on universalistic principles, i.e. all citizens are entitled to basic social security measures and have equal access to the social service system. This means that social benefits and social services are directed to and used by all citizens regardless of their connections with the labour market, rather than by individuals belonging to specific occupational groups. In academic scholarship on welfare states, universalism is considered the 'hallmark' of the welfare systems belonging to this typology.

Like the other Nordic welfare states, the Finnish one is publicly funded through general taxation and individual contributions. Due to the generosity of social entitlements, both expenditure costs and fiscal requirements are extremely high by international standards.

The welfare states belonging to the Nordic typology also combine the extensive social insurance system with active labour market policies that promote full employment and high labour market participation. However, in this respect, the Finnish welfare system seems to constitute an exception within the typology. In fact, when we look at employment rates among individuals aged 55-64, Finland shows a value below those recorded in other Nordic countries. In 2006 the employment rate of individuals belonging to this age group was 54.5% in Finland compared to 60.9% in Denmark, 67.4% in Norway and 69.8% in Sweden. The Finnish value was even lower than that of the United Kingdom (57.3%) and only slightly higher than that of Germany (48.5%).

**Employment rate by age,  
Nordic Countries, UK, Germany and Italy, 2006**



The Finnish situation is different from other Nordic countries because of more generous early retirement schemes that, especially in the aftermath of the economic recession occurring in the early 1990s, induced elderly workers to retire instead of re-entering the labour market or benefiting from labour market measures, whereas, in other Nordic countries the role of early exit policies is of lesser importance (like in Denmark) or similar schemes have recently been abolished (as in Sweden). For this reason, it has been argued that Finland is closer to the Continental than the Nordic Model.

In fact, compared to the other Nordic countries, it has been easier to accept permanent withdrawal from the labour market in Finland, for reasons related to the structural changes of the country's economy<sup>118</sup>.

Another difference between Finland and the other Nordic countries is due to the functioning of the sickness insurance scheme. Currently, the Finnish scheme resembles those of the other Nordic countries only in the earning-related component of the scheme. In fact, provisions for non-insured unemployed persons are more generous than in other Nordic countries and they include a universalistic flat-rate scheme that has historically been "the most generous in the entire OECD hemisphere in terms of minimum security"<sup>119</sup>.

The Finnish social security provisions for sick and disabled individuals will be scrutinized in detail below. These provisions also support individuals coping with severe illness on a long-term basis, such as those suffering from cancer. This is particularly true in the case of early retirement schemes. In fact, previous studies have found that in Finland the employment rate of cancer survivors tends to be slightly lower than in the rest of the population. This is mainly due to early retirement on grounds of disability, even though this risk tends to vary depending on the cancer type and site<sup>120</sup>.

### ***The design of the measure***

#### *The sickness scheme*

Finnish sickness insurance is a universalistic scheme targeted to all residents aged 16-67. As mentioned above, the insurance scheme is based not only on an earnings-related component but also on a flat-rate component, which covers uninsured individuals. The sickness benefit can also be provided on a part-time basis to workers who have been absent from work due to sickness for at least 60 days but are still partly incapacitated and unable to work full-time. Each kind of provision can be received for a period no longer than 300 working days within 2 years<sup>121</sup>.

Provisions for *employed individuals* include what is termed a sick-pay period of 9 days during which the employers pay full-wages to the beneficiaries. Still, no benefit is paid during the first day of work incapacity (i.e. it is a 'waiting' day). After the sick-pay period, the earnings-related allowance can be provided, constituting compensation for income lost due to temporary incapacity for work on account of sickness. The compensation level is set at 70% of earned income for individuals belonging to the low- and middle-income brackets (up to € 28,404 a year). Compensation levels decrease for higher incomes and tend to be more generous for single parents and couples with or without children than for single individuals without children. However, as shown in the figure, in the last few years compensation levels for single and single-parent individuals have been reduced more than those for individuals living with a partner.

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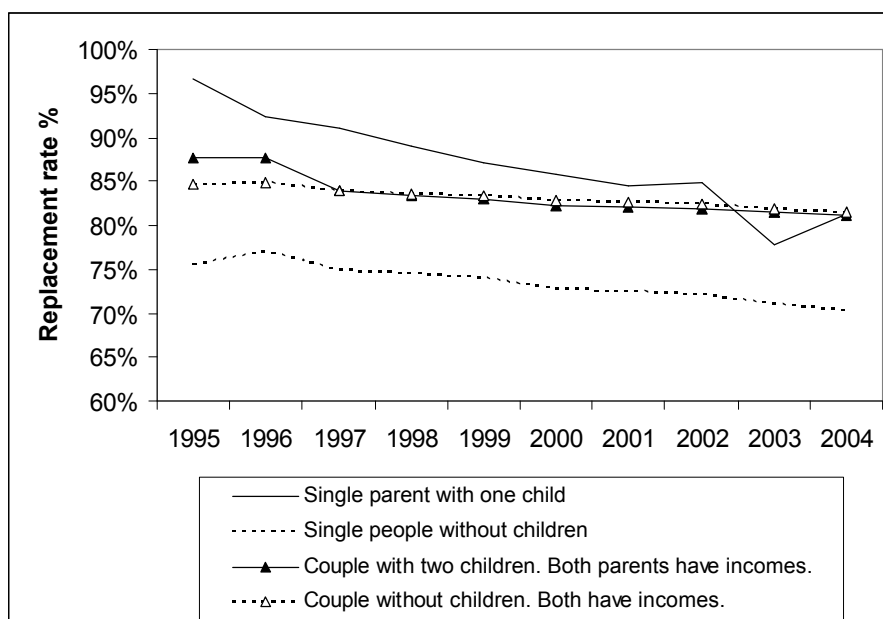
<sup>118</sup> Hytti, H. (2004). 'Early Exit from the Labour Market through the Unemployment Pathway in Finland'. *European Societies* 6(3):265-297.

<sup>119</sup> Kangas, O. (2004) 'Institutional Development of Sickness Cash-benefit Programmes in 18 OECD Countries'. *Social Policy & Administration* 38(2):190-203.

<sup>120</sup> Taskila-Åbrandt, T., Pukkala, E., Martikainen, R., Karjalainen, A. and P. Hietanen. 'Employment Status of Finnish Cancer Patients in 1997'. *Psycho-Oncology*, 14(3):221-226.

<sup>121</sup> MISSOC (2006).

**Percentage of disposable income per month while receiving sickness benefit, typical cases, individuals with average industrial worker's income, 1995-2004<sup>122</sup>.**



Employers must integrate the predefined compensation level in accordance with collective bargaining. The employers' compensation is equivalent to the full wage for the first 1-3 months and to about 65-70% of income during the subsequent period, depending on the labour contract<sup>123</sup>. Once the 300-day limit is reached, recipients can gain further entitlements to sickness allowance only if they have been capable of work for at least one year<sup>124</sup>.

*Insured unemployed individuals* who are already in receipt of unemployment benefits are entitled to a sickness benefit equivalent to at least 86% of the amount of the unemployment benefit (i.e. the amount of the sickness benefit depends upon the amount of the unemployment benefit). Uninsured unemployed individuals (i.e. applicants who do not receive unemployment benefit and have no earnings or earnings lower than the predefined minimum necessary to be entitled to sickness allowance) are entitled to a flat-rate daily basic allowance that is currently equivalent to about € 11 per working day<sup>125</sup>.

However, for both insured and uninsured unemployed people, work incapacity must be of duration of at least 55 waiting days without interruption before the benefit can be awarded.

366,912 persons received sickness benefit in 2006, of which 12,345 suffered from cancer<sup>126</sup>.

*Disability pensions and other provisions for disabled individuals*

In Finland, two different disability pension schemes are available to 16-64-year-olds who cannot be reintegrated in the labour market for disability reasons: the disability pension (*Työkyvyttömyyseläke*) is provided for an indefinite period while the cash rehabilitation subsidy (*Kuntoutustuki*) is provided only for short periods.

<sup>122</sup> <http://www.nom-nos.dk/nososco.htm>

<sup>123</sup> MISSOC (2006).

<sup>124</sup> [www.kela.fi](http://www.kela.fi)

<sup>125</sup> [www.kela.fi](http://www.kela.fi)

<sup>126</sup> KELA (2007), p. 169.

Both the benefits are paid to individuals who have already received sickness allowance for the maximum period of payment (one year, i.e. 300 working days; see below for a detail description of the functioning of the sickness scheme)<sup>127</sup>.

The **disability allowance** (*Vammaistuki*) can be awarded indefinitely or for a specified period only and has the objective of compensating working-age individuals with disabilities and helping them to cope with their ordinary activities and/or with their work or studies.

The **disability pension** is provided to workers who have lost their ability to work due to sickness and whose incapacity to work is estimated to last for at least one year. In order to be eligible for the disability pension, the working capacity should not exceed 2/5. *The disability pension is provided from the end of the maximum period of payment of sickness benefit until the beneficiary is eligible for the old-age pension* (63 years for those eligible for the earnings-related pension and 65 for those who, instead, are only eligible for the flat-rate pension). The amount of the disability pension is between € 445.12 and € 524.85 depending on the individual's marital status and the municipality of residence. This amount is reduced by 50% when the beneficiary already receives other benefits exceeding the sum of € 577<sup>128</sup>.

The **cash rehabilitation subsidy** is a disability scheme provided for short periods to individuals with temporary work incapability on account of illness or injury and whose work capacity is assessed to be restorable by means of rehabilitation measures. Still, in order to be eligible for cash rehabilitation benefit, no more than 3/5 of individual working capacity must be left. Like the disability pension, the cash rehabilitation benefit is provided as of the end of the maximum period of entitlement to sickness benefit, but only on a temporary basis<sup>129</sup>.

In 2006, 153,554 individuals were in receipt of a disability scheme (139,229 for an unspecified period and 14,325 on a short-term basis), of which 6,145 suffered from cancer. Pensioners for disability totalled 24.26% of all pensioners<sup>130</sup>.

Furthermore, disability allowance can be paid to working-age individuals whose health is weakened due to illness or injury. Only individuals that are working or studying can receive the allowance. Therefore, unlike the disability pension, the disability allowance is only meant to cover extra-expenses arising from handicap or illness. It is paid in respect of:

- general handicap resulting from illness or injury;
- reduction of functional capacity due to illness or injury making an individual unable to be independent in his or her daily living;
- additional costs related to ordinary everyday activities arising from illness or injury (such as special costs related to ordinary everyday activities, special transport or housing requirements, special equipments, specialist help, special arrangements for performing housekeeping tasks, etc.)<sup>131</sup>.

The amount of this benefit depends on the degree of disability and can be € 79.83, € 186.28 or € 361.21 per month.

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<sup>127</sup> The following description of Finnish disability scheme relies upon MISSOC (2006). *Social protection in the Member States of the European Union, of the European Economic Area and in Switzerland. Comparative Tables. Part 6: Slovakia, Finland, Sweden, United Kingdom. Situation on 1 January 2006*. Köln: MISSOC-Secretariat.

<sup>128</sup> MISSOC (2006).

<sup>129</sup> MISSOC (2006).

<sup>130</sup> KELA (2007), *Kelan tilastollinen vuosikirja 2006*. KELA: Helsinki, p. 45 and p. 98.

<sup>131</sup> www.kela.fi

Eligibility for disability allowance is not means-tested and the benefit is not taxable<sup>132</sup>. If eligibility is affected by change in the recipient's condition, a new test needs to be made, and the allowance may be either discontinued or recalculated<sup>133</sup>.

In 2006, 25,342 individuals received disability allowance, of which 303 suffered from cancer<sup>134</sup>.

#### *Early retirement pension schemes*

As mentioned above, in Finland older individuals who are not able to reintegrate into the labour market because of illness or disability can be made eligible for different early retirement schemes.

Individuals who were born before 1950 are eligible for a scheme called **unemployment pension** (*Työttömyyseläke*). The system works as follows: individuals born before that year turning 57 years old and in receipt of unemployment benefits can be eligible for an extension of their entitlements until they turn 60. After that, they become eligible for an unemployment pension, which amounts to the same as the disability pension. Hence, the unemployment pension functions as a special type of disability pension that is granted on less stringent medical criteria than the regular disability pension<sup>135</sup>.

In 2006, 20,451 individuals received the unemployment pension<sup>136</sup>.

Individuals who were born in 1943 or before can be made eligible for an **individual early retirement pension** (*Yksilöllinen varhaiseläke*) when their capacity for work has been permanently reduced and they cannot reasonably be expected to re-enter the labour market. In order to qualify for the early retirement pension, the claimant must be between 62 and 64 years of age and his or her work incapacity has to make him or her unable to continue working (e.g. due to illness, injury, ageing, etc.). This benefit will be abolished as of 2009<sup>137</sup>.

In 2006, 5,850 individuals were in receipt of the early retirement pension of which 129 suffered from cancer<sup>138</sup>.

<b>Synthesis of the main figures on provisions for workers affected by long term illness or disability 2006</b>				
	<b>beneficiaries</b>	<b>% resident population</b>	<b>due to cancer</b>	<b>% resident population</b>
Recipients of the sickness benefit	366,912	69.8	12,345	2.3
Pensioners for disability	153,554	29.2	6,145	1.2
Disability allowance	25,342	4.8	303	0.1
Unemployment pension	20,451	3.9		
Early retirement pension	585	0.1	129	0.0

Here is an overview of the labour market measures for persons with employment problems caused by illness or disability.

<sup>132</sup> MISSOC (2006).

<sup>133</sup> www.kela.fi

<sup>134</sup> KELA (2007), p. 126.

<sup>135</sup> MISSOC (2006).

<sup>136</sup> KELA (2007).

<sup>137</sup> MISSOC (2006).

<sup>138</sup> KELA (2007).

### ***Job retention and back-to-work strategies***

Finnish labour market policy is based on a two-tier system arrangement:

- ‘first-level’ active labour market measures are targeted at unemployed individuals, usually covered by insurance-based unemployment schemes and with full capacity to work. They are arranged by employment offices;
- while ‘second level’ active labour market measures are targeted at individuals with particular employment problems and in particular those in receipt of means-tested and last-resort benefits. They are arranged by the employment offices together with the municipalities.

‘First level’ active labour market measures in Finland consist of both subsidised job placements and training programmes, and did so even when the former were historically more important (but their importance has recently decreased). In March 2008 35,813 individuals were taking part in subsidised job placement programmes (1,071 in the state public sector, 8,660 in the municipal public sector and 26,082 in the private sector), 45 334 in training programmes and 6,280 in job alternation programmes<sup>139</sup>.

The ‘second level’ of active labour market policies was initially institutionalised by the *2001 Act on Rehabilitative Work Experience*, which stipulated a new legal framework for long-term programmes or persons with severe employment problems (for example, due to long-term illness).

A new tailor-made activation programme, the so-called Rehabilitative Work Activity, was introduced by the Act on Rehabilitative Work Experience, administration of which is based on cooperation between employment offices and municipal social welfare authorities. Rehabilitative Work Activities are labour market measures oriented towards unemployed individuals who have been unemployed long-term, in receipt of means-tested and last-resort benefits and/or who need special and multi-professional treatments. Rehabilitative Work Activities aim to improve the beneficiary’s employment chances and are based on an *integrated approach to activation*. In fact, representatives of the employment and social welfare offices collaborate with the unemployed individual in defining a tailor-made activation plan: “The activation plan is supposed to create a tailored pathway to employment consisting of labour policy measures, social and health services and rehabilitative work experience according to individual needs”<sup>140</sup>.

By participating in Rehabilitative Work Activities individuals are entitled to a bonus payment of about € 8 per day, made by the municipality (later refunded by the central government through earmarked grants) or by the Social Insurance Institution (KELA), depending on the circumstances<sup>141</sup>. In 2006, 38,900 activation plans of this kind were drawn up (of which, 7,400 were for individuals under 25 years of age, for whom participation in the programme is compulsory).

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<sup>139</sup> Employment bulletin of the Finnish Ministry of Employment and the Economy, March 2008. 22<sup>nd</sup> April 2008.

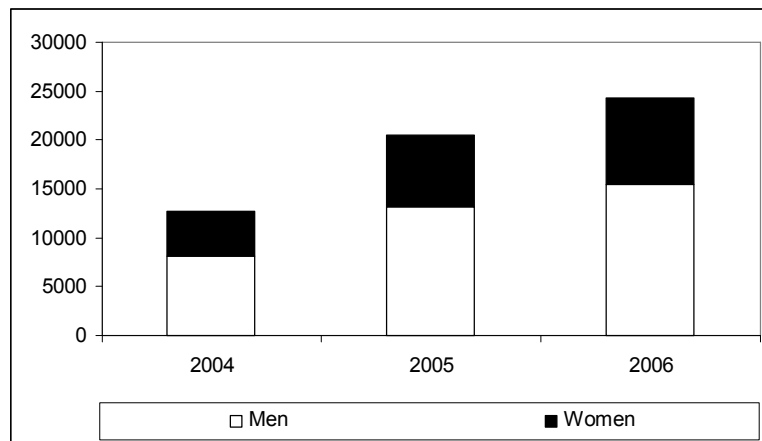
<sup>140</sup> Kauppi, H. (2005) *General Framework for Long-Term Social Impact Evaluation of an Employment Strategy*. Ministry of Labour of Finland: Helsinki.

<sup>141</sup> In Finland there are two last-resort means-tested benefits: the labour support which is administered by the Social Insurance Institution (KELA) and the living allowance which is administered by the municipalities. The long-term unemployed in receipt of labour market support receive the bonus payment related to participation at the Rehabilitative Work Experience from KELA, while individuals in receipt of the living allowance receive this benefit from municipalities.

The period 2004-2006 saw extensive employment office reform and new services were created, jointly administered by the state-controlled employment offices and municipal social welfare offices known as *Labour Force Service Centres* (LAFOS, or *Työvoiman palvelukeskus*).

The Finnish government took the decision to implement this reform since traditional labour market measures arranged by the employment services were not considered able to help customers in need of multi-professional treatments. In fact, LAFOS integrate not only the competences of public employment and social welfare service into the same 'joint' service but also cooperate with the local offices of the Social Insurance Institution (KELA) and with the healthcare services administered by the municipalities. In 2006, there were 39 Labour Force Service Centres in Finland and they had 20,614 job-seeking customers (15,482 men and 8,822 women)<sup>142</sup>.

**Clients in the labour force service centres, by gender, 2004-2006<sup>143</sup>**



As stated in the recent Nationwide Customers Criteria (defined by the national steering committee supervising this project), the aim of LAFOS is also to promote employability skills for the long-term unemployed with low labour market capacities and employment prerequisites as well as individuals re-entering the labour market after long periods of absence due to illness. However, “customers sent to the Labour Force Service Centres must have *adequate social and health-related preconditions* in order to take advantage of the services offered by the Labour Force Service Centre”<sup>144</sup>. This means that the multi-professional treatments provided by LAFOS are expected to follow more intensive rehabilitative treatments, such as cancer treatments. Furthermore, a long-term unemployment condition and a period of receipt of last-resort benefits are also required to access the service.

Another labour policy measure whose purpose is to create jobs in particular for the disabled and long-term unemployed with employment problems is the *social enterprise*<sup>145</sup>. Social enterprises were introduced by law in 2004 and are for-profit firms that are expected to compete on an equal footing with other enterprises and pay all their employees the wages specified in the collective labour agreements.

<sup>142</sup> Ministry of Labour of Finland (2007) *Employment Report 2006*. Ministry of Labour: Helsinki.

<sup>143</sup> Ministry of Labour of Finland.

<sup>144</sup> Ministry of Labour. 2007. *Nationwide Customer Criteria For Labour Force Service Centres*. 31.05.2007. Helsinki: Ministry of Labour: Helsinki.

<sup>145</sup> The following description draws from SYFO (2006). *Manifesto for Social Enterprises in Finland*. SYFO, Forum for Social Entrepreneurship: Helsinki.



On the other hand, social enterprises differ from other enterprises because at least 30% of their employees must be accounted for by the long-term unemployed, ageing jobseekers, or persons with impaired capacity for work (such as individuals with disabilities due to illness). Social enterprises can receive different types of subsidies from the central government, as compensation for the reduced work contributions of disabled or long-term unemployed individuals. Two different subsidies cover up to 50% of labour costs.

The *employment subsidy* varies from € 430-770 per month, depending on the work capacity of the subsidised employee. This benefit can be paid for two years when the social enterprise hires a long-term unemployed person and for three years when the social enterprise hires an unemployed disabled person.

The *combined subsidy* is instead granted to those who are already in receipt of labour market support (a means-tested and last-resort benefit provided by a social insurance institution). This benefit is equivalent to € 930 (including labour market support) during the first year of employment and equivalent to € 500 (including labour market support) during the second year of employment.

### ***Assessment of the Finnish system***

So far, Finnish social security provisions for chronically and long-term sick individuals have been mainly based on income compensation schemes. Individuals who suffer from loss of work capacity are in fact entitled to sickness benefits but they can also leave the labour market through early retirement schemes.

In recent years, the labour market policy system has been reformed in such a way as to provide multi-professional services for individuals with severe employment problems, such as impediments arising from long-term illness. New jointly administered employment services and labour market measures are now more focused on *rehabilitation before work* of individuals whose work capacities are reduced due to disease or injury. However, the condition of long-term unemployment is necessary to access these labour market programmes. On the other hand, the processes that lead to work disability due to long-term illness often start and progress within an employment relation rather than in an unemployment condition.

A recent study has explained the relatively higher exit rate from the labour market of cancer patients against the background of the lack of supportive services, especially from their workplaces: “By developing such supportive services, the possibilities to help people to continue working would improve. Furthermore, cancer survivors should be offered opportunities to return to work more flexibly from retirement or unemployment. The decision either to work or quit working should be one that can be made at an individual level, regardless of a person’s history of illness”<sup>146</sup>.

A strategy specifically designed to support labour market integration for chronically or long-term sick individuals is absent in Finland, although they can be entitled to a wide range of different social security measures compensating for their loss of income and, in some circumstances, allowing them to leave the labour market on a permanent basis.

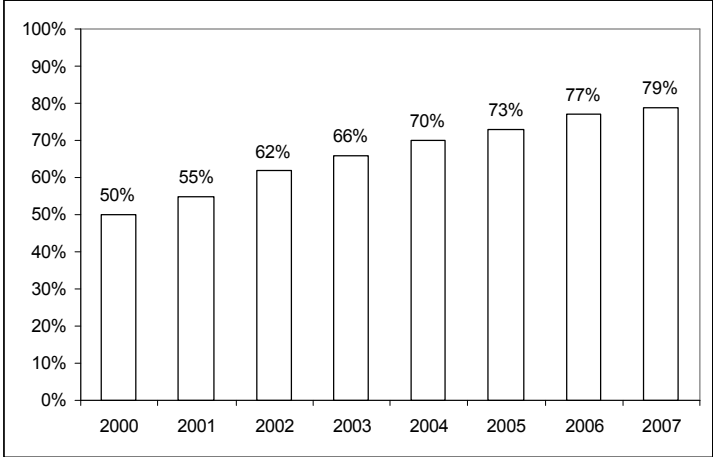
In the near future, the further development of new technologies may allow for the implementation of supportive services for individuals who cannot be easily reintegrated into their workplace after prolonged absence due to sickness or hospitalisation.

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<sup>146</sup> Taskila T. 2007. *Cancer Survivors at Work – Work-related Problems and Factors Associated with their Employment, Work ability and Social support from the Work Community*. People and Work Research Reports 80, Department of Public Health, Faculty of Medicine, University of Helsinki, Finland. Finnish Institute of Occupational Health: Helsinki.

The share of Internet users has impressively increased in recent years in Finland. As shown in the figure below, Internet users increased from 50% of the population in 2000 to 79% in 2007. Furthermore, differences between the shares of Internet between densely populated and sparsely populated areas also narrowed early on in the decade<sup>147</sup>.

**Internet users, percentage of 15 to 74-year-olds, 2000-2007<sup>148</sup>**



Thus, the widespread use of new technologies in Finland may open up new employment possibilities for chronically and long-term sick individuals or, at least, create the conditions for implementation of new supportive services aimed at increasing and enhancing their work capacities (e.g. making teleworking at home easier).

<sup>147</sup> Survey on ICT usage in households and by individuals 2007. Statistics Finland.

<sup>148</sup> Ibid.

## **Case Study – United Kingdom**

### ***The sick leave scheme in the context of the UK welfare system***

The United Kingdom has a comprehensive, regulated, state administered social security system that covers the entire population. The *Department of Social Security* (DSS) is responsible for the Development, maintenance and delivery social security programme and of the Government's policy for Child Support. The DSS is responsible for retirement and disability pensions, unemployment and sickness insurance, general assistance for lone mothers, the sick and disabled, the unemployed benefit scheme and other support for people on low incomes. The costs of the contributory benefits are covered by National Insurance Contributions paid by employees, employers and the self-employed. The insured persons pay a single (or global) contribution covering all the contributory benefits. The contributions are paid into the *National Insurance Fund*, which operates on a 'pay-a-you-go' basis.

So far, the UK protection system for sickness and disability has been based on two pillars: the Statutory Sick Pay (SSP) and the Incapacity Benefit (IB).

The main legal sources are Social Security Contributions and Benefits Act 1992, Social Security (Incapacity for work) Act 1994 and Social Security Act 1998.

### ***The design of the measures***

#### ***The Statutory Sick Pay (SSP)***

The sickness benefit scheme is paid to people who are unable to work because of sickness through *Statutory Sick Pay* (SSP) paid by the employer.

Section 151 of the Social Security Contributions and Benefits Act 1992 requires employers to make payments to sick employees for up to 28 weeks in each period of incapacity for work. The right to receive statutory sick pay is subject to the employee conforming with certain conditions relating to:

- *the formation of a period of incapacity for work*: The first qualification is that the employee's absence must form a PIW (Period of Incapacity for Work): that is, the period must total 4 complete days. However, they do not have to be working days. Employees with more than one contract of employment with the same employer are treated as if they were employed by two separate employers — and therefore may have more than one entitlement to statutory sick pay (SSP) in respect of one absence — if, but only if, the earnings from each employment are treated separately for National Insurance purposes. Periods of incapacity for work are linked to form one PIW if they are separated by no more than 56 days (including Saturdays and Sundays).
- *a period of entitlement*: Once it is established that a PIW exists, the next stage is to see whether it forms part of a period of entitlement. This begins on the first complete day of incapacity and ends when: (a) the employee is fit to return to work; or (b) the employee reaches maximum SSP entitlement in the PIW (whether linked or not) of 28 weeks' payment.
- *qualifying days*: SSP is only paid in respect of qualifying days: qualifying days are to be agreed between the employer and employees. They should generally reflect the days on which the employee is normally required to be at work, subject to the requirement that there must be at least one qualifying day in each week — that is, in each period of seven days beginning with a Sunday.

As for the rate of payment, current statutory sick pay is £75.40 per week. No SSP is payable to employees whose average weekly earnings come to less than £90.00. These rates will normally be increased on 6 April each year. The daily rate of SSP is calculated by dividing the weekly rate by the number of qualifying days in the relevant week.

An employee reaches the maximum entitlement to SSP in one spell of incapacity (if the rate of SSP payable does not change) when he or she has been paid 28 times the rate (£2111.20).

#### *Incapacity benefit*

UK Incapacity Benefit can be paid to people unable to work because sick or disabled and too young to get a UK State Pension – under 60 for women and under 65 for men. The rules for UK Incapacity Benefit and the amount workers get depend on whether their incapacity is short- or long-term. Benefit is usually paid at three basic rates:

- short-term (lower rate) for the first 28 weeks;
- short-term (higher rate) from the 29th to 52nd week; and
- long-term rate from the 53rd week.

Incapacity Benefit is available to people under State Pension age who are not working because sick or disabled. In particular, workers who are not entitled to the Statutory Sick Pay, for instance because they are employees still on absence for sickness after 28 weeks (and so are no longer entitled to SSP) or self-employed or unemployed, may claim Incapacity Benefit.

#### *Benefits designed for people affected by cancer*

It has been observed that “every year approximately 90,000 people of working age in England are diagnosed with cancer. Given improvement in cancer treatment, leading to higher survival rates with the increased incidence of cancer diagnoses returning to paid work after cancer, the return to active life is increasingly important for individuals, employers and the society”<sup>149</sup>.

Back-to-work objectives are pursued through the so-called *Pathways to Work Strategies* (see next paragraph), while protection consisting of income support is generally ensured by the benefits described in the previous one.

Moreover, people affected by certain forms of cancer are covered by the *Pneumoconiosis Etc. (Workers’ Compensation) Act 1979*. The 1979 Act provides one-off lump sum compensation for sufferers (or their dependants if they have died) of certain dust-related diseases. An essential condition is that sufferers be unable to claim damages from the employers who caused the disease because the latter ceased trading.

People entitled to apply for it are those suffering from the following dust related diseases caused by their employment or certain dependants if the sufferer has died: Diffuse Mesothelioma; Pneumoconiosis (which includes Silicosis, Asbestosis and Kaolinosis); Diffuse Pleural Thickening; Primary Carcinoma of the Lung (only if accompanied by asbestosis or diffuse pleural thickening); and Byssinosis.

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<sup>149</sup> Amir Z., Moran T., Walsh L., Iddenden R., Luker K., *Return to paid work after cancer: A British experience*, J Cancer Surviv, 2007, p. 129 ff.

As for the conditions of entitlements, sufferers should normally be in receipt of Industrial Injuries Disablement Benefit (IIDB) in respect of one of the above diseases; dependants can claim IIDB posthumously but there are time limits for making posthumous claims; the employer who caused or contributed towards the disease should normally have ceased trading. The sufferer or dependants are not to have brought court action or received compensation from an employer in respect of the disease<sup>150</sup>.

### ***Job retention and back-to-work strategies***

*The new Employment and Support Allowance (Welfare Reform Act 2007).*

A reform proposal was presented in 2006 to help people on incapacity benefits return to work. In 2006, there were over 2.7 million people on incapacity benefits: around 80 to 90 per cent of those who came onto benefits expected to work again, yet few of them did (it has been proved that the longer people remain on benefits, the less chance they have of leaving it). The benefits system reinforced this by offering more money the longer people were on benefits and by requiring them to prove their ongoing incapacity, rather than actively encouraging and supporting them to take steps towards getting back to work<sup>151</sup>.

This is why the British Government has decided to place more emphasis on the objective of increasing labour market participation rather than just supporting sick people through incapacity benefits<sup>152</sup>.

So much clearly emerges from the UK's National Reform Programme 2005-2008, where it is stated that the Government focuses "on action to help those at risk of social exclusion to get a job and remain in work. Our achievements in reducing unemployment mean that we are now well placed to provide more help for groups of people who have been excluded from the labour market, and proposals for reform were published in January 2006. Key targets included reducing the number of people claiming incapacity benefits by a million in a decade".

The pivotal idea, which characterises the UK welfare reform, is to reduce the amount of money used to finance incapacity benefits to provide more money in return for work-related activity.

The Welfare Reform Act 2007 was designed to this challenge, comprising a broad range of measures applied to various areas. In terms of sickness and disability policy, the key proposal is the introduction of a new *Employment and Support Allowance* (ESA) for claimants assessed as having "limited capability for work" because of a health condition or disability<sup>153</sup>. ESA will replace both incapacity benefit and means-tested income Support on the grounds of disability from 2008 on<sup>154</sup>.

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<sup>150</sup> See [http://www.jobcentreplus.gov.uk/jcp/Customers/WorkingAgeBenefits/Dev\\_007983.xml.html](http://www.jobcentreplus.gov.uk/jcp/Customers/WorkingAgeBenefits/Dev_007983.xml.html)

<sup>151</sup> DWP Green Paper, *A New Deal for Welfare: Empowering People to Work*, 2006.

<sup>152</sup> In 2006, the DWP (Department for work and pensions) observed: "The increase in the number on incapacity benefits that occurred between the 1970s and the mid-1990s is largely explained by a decline in the proportion of people leaving benefits within the first 18 months and consequently increasing numbers who remain on the benefits long-term. Currently just over half of the caseload has been on benefits for more than five years. This is not because people with transitory health conditions do not recover quickly and return to work – in fact, the majority do. Almost 60 per cent of people who started to receive incapacity benefits in 2004 left within a year. However, for the remaining 40 per cent who do not return to work quickly, the prognosis is bleak – only 22 per cent of claimants already claiming for a year will leave within the next year and 29 per cent of them will still be receiving benefits after another eight years. This is the result of a system that, rather than helping people with health conditions back into work, simply allowed them to remain on benefits with little or no intervention".

<sup>153</sup> Under Article 1 of the Welfare Reform Act, "a person has limited capability for work if: (a) his capability for work is limited by his physical or mental condition, and (b) the limitation is such that it is not reasonable to require him to work".

<sup>154</sup> Comments can be read in OECD, *Sickness, Disability and Work: Breaking the Barriers – Australia, Luxembourg, Spain and the United Kingdom*, 2007. The Employment and Support Allowance is regulated by Section 1 of the Welfare Reform Act 2007. Under Article 1, basic conditions for being entitled to ESA are: having limited capability for work, being at least

ESA has a contributory strand accessible via a National Insurance Contribution test and an income-related strand accessible via an income test. Most claimants will be required to go through an assessment phase, which will normally last for 13 weeks from the start of the claim. Recipients of the income-related strand may also qualify for certain premiums and housing costs.

Once the assessment phase is complete and subject to satisfying the criterion of “limited capability for work”<sup>155</sup>, claimants will move on to the main phase of the benefit. Their entitlement will then consist of:

1. the basic rate – a flat rate of benefit, regardless of age and,
2. on top of this, a work-related activity or support component.

The majority of claimants will be entitled to the work-related activity component and will be required to engage in “conditionality”, entailing work-focused health-related assessments and work-focused interviews. Failure to engage can lead to a reduction in benefit.

Claimants who demonstrate “limited capability for work-related activity” will be entitled to the support component instead of the work-related activity component, in addition to the basic rate. This applies to claimants with the most severe health conditions and will not be subject to any conditionality requirements<sup>156</sup>.

#### *The “Pathways to work” Process*

Worthy of mention in addition to the *Employment and Support Allowance* the *Pathways to Work* process, which aims to provide a single gateway to financial, employment and health support for people claiming incapacity benefits. It is a joint initiative between the *Department for Work and Pensions* (DWP) and the *Department of Health* (DH).

The majority of those claiming Incapacity Benefit do not have severe conditions, and the longer an individual is away from work, the less likely is he/she to return. Similarly, the longer people are away from work, the more their physical and mental health declines.

*Pathways to Work* offers a dual approach to assistance, providing a coordinated approach to addressing the barriers that people face when affected by sickness or disability, rather than simply compensating them for the disadvantage they face.

The main features of this process can be described as follows<sup>157</sup>:

- a *Personal Capability Assessment* that focuses on what the customers can do rather than what they cannot do. The assessment is also used to determine whether they are entitled to the benefit. Because of the nature of their illness, some people will be exempt from this assessment and any further mandatory involvement;
- a *mandatory work-focused interview* eight weeks after making a claim for incapacity benefit (except in cases where this is deferred or waived due to the nature of the illness);

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16 years old; not having reached pensionable age; being in Great Britain; not being entitled to income support; not being entitled to jobseeker’s allowance (and is not a member of a couple who are entitled to a joint-claim jobseeker’s allowance).

<sup>155</sup> Personal Capability Assessment (PCA) is the process applied to assess individuals’ eligibility for incapacity benefits. As part of welfare reform proposals the assessment has been reviewed, to transform it into a more positive assessment of mental and physical capability and of the support an individual needs to help them work. The new process, called the Work Capability Assessments, will be applied to people who claim Employment and Support Allowance when it is introduced in Autumn 2008. See DWP – Health and Benefits Division, *Transformation of the Personal Capability Assessment*, September 2006; see also <http://www.dwp.gov.uk/welfare-reform/pca.asp>

<sup>156</sup> See *Employment and Support Allowance Regulations 2008* – Explanatory Note, in [www.dwp.gov.uk](http://www.dwp.gov.uk)

<sup>157</sup> For further information on the *Pathways to Work* process see the Department for Work and Pensions (DWP) website: [http://www.dwp.gov.uk/welfare-reform/pathways\\_process.asp](http://www.dwp.gov.uk/welfare-reform/pathways_process.asp). See also *UK National Report on Strategies for Social Protection and Social Inclusion 2006-2008*.

- a *screening tool* at the initial work-focused interview will establish who will have more work-focused interviews and who will be exempt from further mandatory participation;
- access to a range of *programmes to support the customer in preparing to work*, including the *Condition Management Programme* which aims to help customers to manage their health condition or disability so that they can get back to work;
- a *Return to Work Credit* (RTWC), where customers who enter employment can qualify for a weekly payment of £40 a week for 12 months if their salary is below £15,000 a year.

### *Reasonable accommodation*

Removing the barriers to the participation of disabled people in society is also central to the UK Government's approach. From this perspective significant results have been achieved: in particular, progress has been made through the launch of the Office for Disability Issues alongside a range of cross-Government initiatives, and implementation of the Disability Discrimination Act (DDA) 1995 and 2005. A campaign, targeted at SMEs, business intermediaries and trade bodies ran until December 2006, and has raised awareness of the DDA among employers surveyed to 92 per cent. The Government is currently planning a campaign to challenge employers' assumptions about the employability and willingness to work of people who are disabled or have a long-term health condition<sup>158</sup>.

Employees who, due to their illness, are declared to be disabled under the Disability Discrimination Act 1995 (DDA) benefit from special protection. The DDA requires the employer to make reasonable adjustments to disabled employees' working arrangements or conditions to make sure they are not treated less favourably than other employees<sup>159</sup>.

### *An assessment of the UK system*

According to the UK's National Reform Programme, "there are currently 2.67 million people in receipt of incapacity benefits (IB). Pathways to Work pilots have had a positive effect in decreasing this number. A total of 32,000 people have been helped into work since the pilots began in October 2003, and the number of IB claimants is now falling. The most recent results from the evaluation of Pathways showed that new claimants in Pathways areas were 7.4 percentage points more likely to be in employment after 18 months. Their impact on benefit receipt over the first year of a claim has also been considerable. By December 2006, Jobcentre Plus was delivering Pathways support to 40 per cent of new and repeat IB customers, while Pathways delivered by private and voluntary sector providers will be rolled out in the remaining 60 per cent of the UK by 2008"<sup>160</sup>.

No impact assessment has been completed for these regulations as they have no impact on the private or voluntary sectors. An assessment of the impact of these regulations on the public sector only has been made<sup>161</sup>.

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<sup>158</sup> See *Lisbon Strategy for Jobs and Growth* – UK National Reform Programme, September 2007, p. 22.

<sup>159</sup> Examples of reasonable adjustments to working arrangements include: changing individual's working hours; providing help with transport to and from work; arranging home working, providing a safe environment that can be maintained; allowing an employee to be absent from work for rehabilitation treatment. Examples of adjustments to a job are: providing new or modifying existing equipment and tools; modifying work furniture; providing additional training; modifying instructions or reference manuals; modifying work patterns and management systems; arranging telephone conferences to reduce travel; providing a mentor; providing supervision; reallocating work within the employee's team; providing alternative work. See HSE, *Working together to prevent sickness absence becoming job loss*, in <http://www.hse.gov.uk/pubns/web02.pdf>; see also <http://www.hse.gov.uk/sicknessabsence/index.htm>

<sup>160</sup> See *Lisbon Strategy for Jobs and Growth* – UK National Reform Programme, September 2007, p. 21.

<sup>161</sup> See DWP, *Impact Assessment of the Employment and Support Allowance Regulations 2008* (public sector impact only), available at <http://www.dwp.gov.uk/welfarereform/employment.asp>

### Summary of caseload impacts of applying the WCA to ESA claimants

Financial Year	Cumulative ESA caseload reduction (average)	In-year expenditure savings (average)
2008/09	neg	-£0m
2009/10	-30,000	-£50m
2010/11	-50,000	-£85m
2011/12	-65,000	-£115m
2012/13	-75,000	-£135m
2013/14	-85,000	-£155m
2014/15	-90,000	-£170m
2015/16	-95,000	-£190m
2016/17	-105,000	-£200m
2017/18	-110,000	-£215m

Early evaluation of *Pathways to Work* has shown that there has been an 8-10 per cent increase in the rate of people coming off incapacity benefits after four months of their claim compared to non-pilot areas, and five times as many people in pilot areas are joining the New Deal for Disabled People programme<sup>162</sup>.

In particular, the employment rate of disabled people increased from 38.1 per cent in 1998 to 46.6 per cent in 2005. The New Deal for Disabled People has now helped almost 75,000 people into jobs<sup>163</sup>.

The Government has committed itself to expanding this programme as a result of these successes. In particular, “the Government will invite new voluntary sector and private sector providers to manage Pathways to Work in new areas, testing innovative approaches and focusing on improving job entry and retention. The Pathways to Work programme will be extended to cover every part of Britain by 2008”<sup>164</sup>.

As observed above, people who return to work are entitled to a *Return to Work Credit* (RTWC). Assessing the impact of ESA on the incentives/disincentives to return to work is not easy at this stage of the reform.

Initial assessment was recently made by the OECD. It observed: “the effects of a possible introduction of the ESA on financial incentives to work are clear-cut: average effective tax rates are slightly lower – around 1-3 percentage points for singles, and around 5-8- percentage points for one-earner couples, across the whole earnings range considered, i.e. taking up work becomes slightly more attractive. Interestingly, the higher assumed ESA rate does not entail higher effective tax rates [...]. Nonetheless, effective tax rates in the United Kingdom for the ESA recipients would remain at a comparatively high level. Former average earners would still lose more than 70% of their gains when entering work, except if they earn more than before or if they earn between 40 and 50% of average wages in order to benefit from tax credits. Even in those cases, more than half of additional gross earnings are taxed away”<sup>165</sup>.

In conclusion: the present case clearly shows that the UK system pays particular attention to sickness at the workplace, proving to be in the forefront in many respects:

<sup>162</sup> See DWP and DH, *Health, work and well-being – Caring for our future. A strategy for the health and well-being of working age people*.

<sup>163</sup> See *UK National Report on Strategies for Social Protection and Social Inclusion 2006-2008*, p. 28.

<sup>164</sup> See *UK National Report on Strategies for Social Protection and Social Inclusion 2006-2008*, p. 28. For an assessment of the *Pathways to Work* Programme, see Bewley H., Dorsett R., Getinet H., *The Impact of Pathways to Work*, DWP, 2007.

<sup>165</sup> OECD, *Sickness, Disability and Work: Breaking the Barriers*



- a) although traditional forms of protection such as sick pay and incapacity benefits provide workers with a good coverage, the focus of intervention seems to be shifting towards a more proactive approach: see, for instance, the idea (implied in the Welfare Reform 2007) of incentive back-to-work solutions instead of just paying incapacity benefits;
- b) the UK system seems to achieve a good combination of both public and private forms of intervention in addressing the issue of sickness at the workplace (as to private forms of intervention, see the above mentioned involvement of private actors in the *Pathways to Work* process);
- c) from a job retention perspective, the British experience is remarkable: the UK has been developing good practices with regard to reasonable adjustments for disabled people which have increased significantly the employment rate of disadvantaged persons;
- d) the dynamic UK labour market – characterised by a proactive approach – is one of the main reasons why the country has achieved very good results in terms of employment rate and activation. UK employment rates, compared to EU targets, are a clear indication of remarkable performance: according to Eurostat the UK (overall) employment rate in the second quarter of 2007 was 74.4% (while the Lisbon target is 70%).

### ***The sick leave scheme in the context of the Italian welfare system***

Under the overall responsibility of the Ministry of Labour and Social Welfare, Italy's general social security system includes social insurance schemes covering the loss of income from work due to sickness or maternity, as well as obligatory basic pensions (invalidity, survivor's and old age insurance) and unemployment and family benefits. This general scheme covers wage earners and some assimilated groups of self-employed persons (smallholders, sharecroppers and tenant farmers, craftsmen and trades people). A separate insurance scheme covers accidents at work and occupational diseases.

The Italian protection system for illness at the workplace basically consists of a compulsory social insurance scheme for employees with earnings-related benefits. This system, closely linked to employment status, is financed by means of social contributions, being modelled on the principle of cooperation between the categories of beneficiaries involved.

Alongside this type of classic continental social insurance scheme, the Italian system also provides instruments – designed to protect not only workers but all citizens – of a universalistic and free nature.

### ***The design of the measure***

#### *Sick pay benefits and sick leave: General regulation of illness at the workplace*

Under Article 2110 Civil Code, which sets the general principles applicable to illness at the workplace, employees are entitled to sick pay benefit, on condition that they deliver a medical certificate to the employer, who can decide to have verification carried out<sup>166</sup>. The medical certificate serves to prove the employee's incapacity for work. In fact the Italian labour law definition of sickness only refers to conditions implying the incapacity for work.

The law requires that during a certain period (called “periodo di comporta”), the duration of which is usually set by collective agreements, the employer cannot terminate the employment relationship by dismissing the sick employee. Therefore until the end of the “periodo di comporta” job retention is ensured by law.

As for the amount and duration of sick pay benefit, a distinction has to be drawn between two categories: “operai” (workmen or “blue-collars”) and “impiegati” (clerks or “white-collars”):

- white-collar employees are entitled to the same wage they got before falling ill, although it is progressively reduced as time goes by (up to 50%)<sup>167</sup>; The legal duration of such benefit is 180 days.
- blue-collar employees are entitled to a social security allowance, paid by INPS (Istituto Nazionale di Previdenza Sociale), which amounts to 60% of their salary. For this benefit to be delivered, a 3-day waiting time is set<sup>168</sup>. The legal duration of the benefit is 180 days.

However, it should be stressed that legal provisions represent basic protection. In fact collective bargaining has significantly improved the level of social protection in cases of illness.

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<sup>166</sup> Forms of control are specifically regulated by Article 5 of “Statuto dei lavoratori” and Article 2 of Law 33/1980.

<sup>167</sup> See Law 1825/1924.

<sup>168</sup> By Law 562/1926

For instance, the 3-day waiting time – during which no allowance is given under the law – is normally covered by collective agreements, obliging the employer to pay a certain amount of money.

#### *Specific provisions for workers affected by cancer*

Before Law 276/2003 came into force, very few provisions – from a labour law perspective – addressed the problem of workers affected by cancer, worthy of mention among which is framework Law 104/1992, with specific regard to:

- 30 days paid leave for medical treatment related to a certificated invalidity (above the 50% threshold);
- employee's right to perform the labour activity at a workplace which is as close as possible to his/her domicile;
- employee's right not to be transferred from a workplace to another against his/her will.

Moreover, in addition to the above-mentioned benefits, Law 53/2000 introduced a special (albeit not paid) leave, with duration up to 2 years. In order to be entitled to this leave, employees working both in the private and public sector must have serious (and certificated) reasons, e.g. suffering from cancer. During this leave period employees receive no wages and are not allowed to perform any work activity. However, they have the right to keep their job until the end of the period of leave.

#### ***Job retention and back-to-work strategies***

##### *Job retaining measures: Arrangements concerning tasks assignation*

As observed above, under Article 2110 the employer cannot dismiss the sick employee until the end of the so-called “periodo di comporto”. The duration of this period is determined by collective agreements. However, once that period has passed, the employment contract can be terminated since dismissal would then be based on a legitimate justification. Consequently it is of the utmost importance for collective agreements – when determining the duration of the “comporto” period – to take into account that cancer is often a long-lasting illness.

Collective agreements may extend the duration of “comporto” when long-lasting illnesses (especially cancer) are concerned, which seems reasonable given that recovery from cancer usually implies long medical treatment, incompatible with rapid return to work.

However, the surveys show that very few collective agreements provide such extension of the “comporto” for those workers who are affected by cancer and those few agreements mainly cover the public sector, not the private one<sup>169</sup>. From this standpoint, there is ample room for improvements: for instance, in case of long-term illnesses such as cancer, a certain duration of the “comporto” period could be provided for by the law for both public and private sector so as to ensure a common ground of protection to all workers regardless of the fact that they are employed in public or private sector .

Assignation to different (often lower) tasks may represent a solution to prevent people with chronic illness from being dismissed after the *comporto* period has passed.

As a general rule, under Article 2103 of the Civil Code employee's tasks can be modified only with assignation to equivalent or higher ones (the intention being a form of protection of the employee's professional competence).

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<sup>169</sup> See, for instance: CCNL Enti Locali of 14<sup>th</sup> September 2000; CCNL Scuola of 26<sup>th</sup> May 1999; CCNL Cassa Depositi e Prestiti of 2<sup>nd</sup> July 2002; CCNL Ministeri of 16<sup>th</sup> February 1999<sup>169</sup>.

However, making an exception to the general prohibition to assign lower tasks (under Article 2103), the judges consider assignation to lower tasks a lawful alternative to dismissal whenever an employee, although not yet declared disabled, has been affected by a reduction of work capacity due to sickness or injury.

Law explicitly provides for flexible forms of task assignation when disabled people are involved (see Law 68/1999). When a disabled employee's health condition deteriorates – to the extent that the employee is no longer compatible with the previously performed tasks – Article 10 provides for suspension of the employment relationship as long as incompatibility persists. During this period disabled employees may go in for vocational training enabling them to return to work (subject to organisational adjustments, for instance, assignation to different tasks). Only in the case of persisting incompatibility, the worker can be dismissed.

### *Telework*

Telework represents an interesting solution to make work organisation more flexible and give workers the opportunity to keep working and maintain their jobs in cases of chronic sickness.

However, the full potential of telework has yet to be developed in Italy (although progress has been made, especially in the public sector<sup>170</sup>). According to data from 2002, only 2.2% of workers do their work at home, while in a number of EU Member States this percentage is decidedly higher<sup>171</sup>.

<b>Place of Work of Italian workers</b>			
	<b>Men</b>	<b>Women</b>	<b>Total</b>
<b>At home</b>	2.10%	2.40%	2.20%
<b>Not in a fixed place</b>	22.50%	5.10%	16.00%
<b>In the workplace</b>	75.30%	92.50%	81.80%
<b>Total</b>	62.60%	37.40%	100.00%

Source: Giaccone M., *Place of Work and Working Conditions – Italy*, <http://www.eurofound.europa.eu/ewco/studies/tn0701029s/it0701029q.htm>, 2007

Italy has no systematic legislation regulating telework. The European Framework Agreement on Telework concluded in 2002 by the EU social parties was implemented in Italy through a national framework agreement, the *Accordo interconfederale* signed on 9<sup>th</sup> June 2004. Subsequently the implementation of telework has relied on collective bargaining, which may result in an uneven spread of this form of work.

### *Specific employees' rights in case of cancer*

#### a) Part-time work

Specific flexible instruments are designed to help employees affected by cancer retain their jobs. In particular, when cancer implies a reduction in work capacity the law<sup>172</sup> recognizes the right to modify the employment relationship shifting from full-time to part-time<sup>173</sup>.

<sup>170</sup> With regard to telework in the public sector, see: <http://telelavoro.formez.it/>

<sup>171</sup> See *Place of Work and Working Conditions*, European Foundation for the Improvement of Living and Working Conditions, 2007.

<sup>172</sup> Article 12-bis Law 61/2000 (introduced by Law 276/2003)

<sup>173</sup> See Rubino R., Spanò I., *I diritti del lavoratore affetto da patologie oncologiche: un'informazione ancora lacunosa e imprecisa*, Bollettino Adapt, Newsletter no. 3, 14.3.2008, p. 2 ff..

Collective agreements have implemented this provision further, seeking to streamline the shift from full-time to part-time<sup>174</sup>.

The recent Law 247/2007 has strengthened the level of protection, recognising the right to a “fast track” shift from full-time to part-time, also for employees whose consorts, children or parents are affected by cancer<sup>175</sup>.

It is to be noted that, as emerges from the interview with Iannelli<sup>176</sup>, in some cases these measures have been introduced thanks to lobbying activity performed by cancer associations rather than full awareness of cancer-related issues on the part of the legislator.

#### b) Transfer to another office

In cases of serious disability civil servants have priority over the non-disabled in choosing the nearest available office.

Disabled employees, whether civil servants or not, have the right to apply for transfer to a nearer office (if available) and in any case cannot be transferred without their consent. Relatives in charge of care activities for workers suffering from cancer have the same right, albeit subject to their own employer’s organizational needs.

#### *c) Special leaves*

Seriously disabled employees (and people sick with cancer often are) are entitled to paid leave to follow medical treatments and their relatives in charge of the assistance can benefit from absence from work to take them to hospital. Under article 33 Law 104/1992:

- disabled employees benefit from paid leave consisting of 2 hours per day or 3 days per month;
- their relatives benefit from 3 days per month unless the disabled person they look after is hospitalized on a full-time basis.

#### *Invalidity and incapacity benefits: protection against common risks*

Specific legal instruments are provided for those suffering from long-standing illnesses, causing permanent incapacity to produce work-related income, although distinction must be made as to whether the incapacity is caused by common risks or occupational risks.

When common risks are involved, Law 222/1984 distinguishes between “invalidity” and “incapacity”, and different benefits are granted depending on whether an employee is considered “invalid” or “unable”. Invalids are entitled to the “Assegno Ordinario di Invalidità” (AOI) while unable individuals are entitled to the “Pensione di inabilità” (PI).

Both of them are temporary benefits, provided as long as the conditions generating the reduction in work capacity persist.

There are 2.1 million AOI and PI recipients (women 56.7% and men 43.3%). Among them 43.3% only get the AOI/PI allowance, while 56.4% can cumulate the AOI/PI allowance with other types of pensions. It should be stressed that the quantities of both AOI/PI recipients (- 6.3% from 2004 to 2005) and AOI/PI allowances (- 3.8% from 2004 to 2005) have decreased over recent years<sup>177</sup>.

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<sup>174</sup> See, for instance: CCNL Lavoratori delle imprese radiofoniche e televisive of 27<sup>th</sup> April 2005; CCNL Settore della distribuzione cooperativa of 2<sup>nd</sup> July 2004

<sup>175</sup> See Alessi C., *La flessibilità dopo la legge di attuazione del Protocollo sul welfare: prime osservazioni*, in WP C.S.D.L.E. “Massimo D’Antona”, no. 68/2008.

<sup>176</sup> Representative of F.A.V.O. (Federazione italiana associazioni di volontariato in oncologia) - ECPC

<sup>177</sup> See ISTAT and INPS, *I beneficiari delle prestazioni pensionistiche – Anno 2005*, 11 gennaio 2007.

### *Invalidity allowance (“Assegno Ordinario di Invalidità”)*

A worker whose earning capacity, in occupations suited to his/her ability, is permanently reduced to at least one third as a result of sickness or infirmity (physical or mental) is considered an “invalid” for the purpose of the invalidity allowance (AOI).

The invalidity allowance is paid on a monthly basis and reversion to survivors is not provided for.

The minimum amount of pension (*pensione minima*), € 5,669.82, is paid if the annual taxable earnings of the person concerned are less than double the minimum social pension (*assegno sociale*) on the 1st January each year (2007: € 10,123.36), or than 3 times the social pension (2007: € 15,185.04) if the person is married. For persons insured since 1.1.1996, there is no statutory minimum pension<sup>178</sup>.

### *Incapacity pension (“Pensione ordinaria di inabilità”)*

The incapacity pension (*pensione di inabilità*) is payable to the insured person or beneficiary of the invalidity allowance, who is absolutely and permanently incapable of any occupational activity as a result of sickness or infirmity (physical or mental).

Entitlement to the incapacity pension is subject to foregoing wages and any other pay.

For persons insured since 1.1.1996 the conventional contribution constitutes 33% of the income for each contribution year. Contribution amounts are adjusted yearly, according to the average increase in GDP over the last five years. The pension is calculated by multiplying contribution amounts by an actuarial coefficient, which varies according to age (min. age is 57 years, max. age is 65 years). The minimum coefficient applies for those under 57<sup>179</sup>.

Unlike AOI, the incapacity pension is reversionary to survivors.

### *Means-tested measures*

These measures<sup>180</sup> are designed to help all citizens (not only workers) in need of and lacking in means of support. In particular:

- e) “assegno di invalidità civile”: this benefit is given to people with invalidity of at least 74%; it amounts to € 242.84 per month (on condition that the annual income is less than € 4171.44); in this case, registration is required in the special unemployment lists for disabled people;
- f) “indennità di accompagnamento”<sup>181</sup>: this benefit is given to those who, due to their sickness, are no longer self-sufficient when performing normal activities such as feeding, getting dressed, personal hygiene and so on. It amounts to € 457.66 per month. The Supreme Court of Cassation<sup>182</sup> stated that also terminally sick patients are entitled to the “indennità di accompagnamento”, which seems to show significant support for people and families affected by cancer;
- g) “indennità di frequenza”<sup>183</sup>: under-age people attending any type of school (including nursery-school), therapeutic centre, rehabilitation centre or centre for vocational training are entitled to this allowance, but it is an alternative to the “indennità di accompagnamento”.

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<sup>178</sup> See MISSOC 2007.

<sup>179</sup> See MISSOC 2007.

<sup>180</sup> based on the legal provision of Article 38, par. 1, of the Italian Constitution

<sup>181</sup> Law 18/1980, Law 508/1988 and D.Lgs 509/1988

<sup>182</sup> See decisions 7179/2003, 10212/2004, 1268/2005

<sup>183</sup> Law 289/1990

## *An assessment of the Italian system*

### *Pension reform and early retirement schemes*

As pointed out by scholars “the pension systems of the enlarged Europe are gradually adapting their individual features to the requirements imposed by an ageing population in a situation in which their financial sustainability is coming under ever increasing pressure. One of the main means by which this objective can be attained is rising the retirement age. In this respect almost all the recent pension reforms reflect the will to increase incentives to postpone retirement and encourage working lives to be continued to an older age”<sup>184</sup>. Another common feature is that rigidity prevails over flexibility in relation to the time and manner of retirement. Italy does not seem to be an exception to this trend, as is clearly borne out by the reforms implemented over the last 15 years.

However, in most EU countries<sup>185</sup> early retirement schemes have been adopted which reward shortened careers or offer easy conditions in the cases of disability and unemployment. In Italy, for example, under Article 80 Law 388/2000, people whose invalidity (at least 74%) has been certificated are entitled to a benefit consisting of 2 months of notional contribution for every year they have worked in the condition of an invalid, regardless of the cause of invalidity. This notional contribution cannot exceed 5 years.

In conclusion, the Italian social protection system seems to be adequate with regard to job retention objectives, given that a good deal of instruments can be used in order to support people with illness or disability (sick pay benefits, paid leaves, tasks assignation and so on). Besides, more attention has recently been paid to chronic illnesses such as cancer<sup>186</sup>. What seems to be lacking, with specific regard to cancer, is an organic body of regulations as provided for tuberculosis.

Some problems may still arise after workers have lost their jobs due, for example, to dismissal for exceeding the “comporto” period (although collective agreements often manage to extend the duration of this period). As has recently been observed, “in Italy the Employment Protection Legislation (EPL) for permanent workers still remains quite strong; this provides protection for [people] when employed. When unemployed, however, not much help is provided to get people back to work”<sup>187</sup>.

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<sup>184</sup> See Fornero E., Monticone C., *Flexible Retirement in Europe*, European Papers on the New Welfare, No. 8, September 2007, p. 145.

<sup>185</sup> Except for those countries such as Denmark, the Netherlands, Ireland and the United Kingdom where the pension benefit is flat rate, i.e. it is not proportionate to salaries or contributions, but rather to the length of the contribution period or residence in the country.

<sup>186</sup> See the provisions introduced by Law 276/2003 and 247/2007

<sup>187</sup> Sestito P., *Why and How to Prolong Working Life: A Labour Market Perspective*, in European Papers on the New Welfare, <http://eng.newwelfare.org/?p=184&page=3>

### ***The sick leave scheme in the context of the Dutch welfare system***

Social security in the Netherlands can be subdivided into social welfare benefits (*sociale voorzieningen*) and social insurance benefits (*sociale verzekeringen*). In addition, there are other arrangements not classed as social security by tradition but providing financial assistance, such as housing subsidies or statutory funding of higher secondary and university education<sup>188</sup>.

Social welfare benefits are financed from central government funds. They are intended as basic provision and are means-tested. The major form of social welfare provision comprises the social assistance benefits provided under the *National Assistance Act*.

Social insurance is primarily funded from the contributions paid by employees, and the system is compulsory: all employees are automatically insured and also pay a contribution. There is a further distinction between:

- *Employee Insurance Scheme (werknemersverzekeringen)*: as its name implies, Employee Insurance is confined to employees; benefits are related to the last wage earned, and are received in the event of loss of pay because of sickness (after the first year of absence), permanent incapacity for work and unemployment (see Unemployment Benefits Act and Disablement Benefits Act).
- *National Insurance Scheme (volksverzekeringen)*: National Insurance applies to all residents of the Netherlands; benefits are not related to pay and comprise the state old-age pension, survivors' pensions, child benefit, pensions received under the *General Disablement Pensions Act* and benefit under the General Act on Exceptional Medical Expenses.

### ***The design of the measure***

#### *Employee Insurance Scheme*

Within the employees schemes all employees (including civil servants since 1998) are compulsorily insured. The benefits provided for within such schemes include:

- sickness benefits;
- disability benefits;
- unemployment insurance.

#### *Sickness Benefits*

Sickness benefits are regulated by the Sickness Benefits Act (*Ziektewet – ZW*).

The Dutch Civil Code stipulates that employers must continue to pay at least 70% of the sick employees' wages for the first two years of their sick leave (see Article 7:629 Dutch Civil Code)<sup>189</sup>. In the first year of sickness, this amount should not be less than the applicable minimum income. The employer continues paying the salary until the employee has been on sick leave for 104 weeks, but never longer than the duration of the contract.

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<sup>188</sup> See <http://www.eurofound.europa.eu/emire/Netherlands/Socialsecurity-NL.htm>. See also ESIP, *The Structure of Social Insurance in Europe*, 2005. A complete survey of the Dutch labour law and social security system is made by Jacobs T.J.M., *The Netherlands*, ELL – Suppl. 276 (January 2004), Kluwer Law International.

<sup>189</sup> It is worth mentioning that collective agreements often extend the coverage up to 100% of the salary.



People who no longer have an employer can claim sickness benefit under the Sickness Benefits Act (thus the Sickness Benefits Act continues to exist as a safety net)<sup>190</sup>.

However, this particular feature of the Dutch social protection system has drawn the attention of the EU Committee of Social Rights. Since the ZW seems to be only a safety net –income protection for sick employees being based on the employer's statutory obligation to continue to pay wages – the Committee is doubtful about the consistency of the Dutch system with international social security standards, especially article 12 of the European Social Charter<sup>191</sup>. In particular, the Committee has considered the situation not to be in conformity with the Charter because the report presented by the Dutch government to uphold the privatization of sickness benefits “does not show that the right to sickness and invalidity benefits is effectively secured as a social security right under the new system”<sup>192</sup>.

The sickness benefit is 70% of the daily wage (maximum daily wage is € 177,03) of the insured and is payable for a duration of 104 weeks' sickness<sup>193</sup>, after which there assessment is made as to whether the sick employee is entitled to a wage supplement or a benefit due to full occupational disability (see the information about the WIA). Under certain conditions, sickness benefits can be topped up with a supplement payable under the Supplementary Benefits Act. Each month, 8% of the sickness benefit is reserved for holiday allowance, which is paid out in May<sup>194</sup>.

Insurance is compulsory for employees. However, workers who are not insured (e.g. the self-employed) can opt for insurance under the Sickness Benefit Act at the Social Security Agency (UWV).

#### *Disability benefits*

In the Dutch legal system a person is considered completely or partially incapable of working when, as a result of sickness or infirmity, he/she cannot earn the same as healthy workers with similar training and equivalent skills normally earn at the location where he/she works or worked most recently, or in the vicinity. No distinction is made as to the cause of incapacity (invalidity or employment injury).

With regard to disablement benefits, a distinction must be drawn between workers falling ill/disabled before 1<sup>st</sup> January 2004 and those who falling ill/disabled subsequently, since two different regulations are applicable: the *Disability Insurance Act* (WAO) and the *Work and Income according to Labour Capacity Act* (WIA).

#### *Disability Insurance Act (WAO).*

The Disablement Insurance Act (*Wet op de arbeidsongeschiktheidsverzekering, WAO*) entitled disabled employees under the age of 65 to a benefit if still at least 15% unfit for accepted employment after 104 weeks of disability. The WAO-scheme will continue for persons who currently receive benefit under the WAO conditions.

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<sup>190</sup> However this particular feature of the Dutch social protection system has caught the attention of the EU Committee of Social Rights. Since ZW seems to be only a safety net –the income protection for sick employees being based on the employer's statutory obligation to continue to pay wages – the Committee is doubtful about the consistency of the Dutch system with international social security standards, especially Article 12 of the European Social Charter. For further details see EU Committee of Social Rights, *European Social Charter – Conclusions XVIII-1. Articles 1, 5, 6, 12, 13, 16 and 19 of the Charter*, 2006.

<sup>191</sup> For further details see EU Committee of Social Rights, *European Social Charter – Conclusions XVIII-1. Articles 1, 5, 6, 12, 13, 16 and 19 of the Charter*, 2006.

<sup>192</sup> *Ibidem*.

<sup>193</sup> From 2004 onwards the 52-week continued wage payment was prolonged to 104 weeks. Combined with the Improved Gatekeeper's Act, the employer who does not fulfil his obligations may face continued wage payment of up to 3 years.

<sup>194</sup> See MISSOC 2007. See also SZW – Ministry of Social Affairs and Employment, *A Short Survey of Social Security in the Netherlands, Summary as at 1 January 2008*.

The WAO benefit consists of two phases<sup>195</sup>:

1. Loss of income/pay benefit based on the daily wage (a maximum of € 177,03). Each month, 8% is reserved for holiday allowance, which is paid out in May. The duration of the loss of income/pay benefit depends on the recipient's age as of the date on which the WAO benefit becomes payable.

2. The subsequent benefit is based on the subsequent daily wage. In principle, subsequent benefit can be drawn until the age of 65. The subsequent daily wage is calculated as follows: for each year above the age of 15 on the date on which the WAO benefit becomes payable, 2% of the difference between the previous wage (a maximum of € 177,03 per day) and the minimum wage, including 8% holiday allowance (€ 66,55 per day), is added to this minimum wage<sup>196</sup>.

The amount of the loss of income/pay benefit and the subsequent benefit depends, apart from the (subsequent) daily wage, on the degree of occupational disability.

The WAO was succeeded on 1 January 2006 by the Work and Income according to Labour Capacity Act (WIA).

*Work and Income according to Labour Capacity Act (WIA).*

The Work and Income According to Labour Capacity Act (*Wet Werk en Inkomen naar Arbeidsvermogen, WIA*) provides for employees entitled to occupational disability benefit upon full and permanent occupational disability. Those still able to work partially will receive a supplement to their wage.

For employees who became sick on or after 1 January 2004, a qualifying period of 104 weeks applies. They are then entitled to benefit under the WIA, provided they are at least 35% occupationally disabled.

Workers who are fully and permanently occupationally disabled will receive an occupational disability benefit on condition that they are at least 80% occupationally disabled with no prospect or only a small chance of recovery. If that is the case they become eligible for benefit on the basis of the Income Provision Scheme for People Fully Occupationally Disabled (IVA) of 75% of the daily wage (maximum daily wage € 177.03).

*Resumption of Work (Partially Disabled Persons) Regulation (WGA)*

For the partly disabled, the emphasis is not on income protection but on the possibilities of rehabilitation; the Resumption of Work (Partially Disabled Persons) Regulation (*Regeling Werkhervatting Gedeeltelijk Arbeidsgehandicapten, WGA*) encourages both the employee and the employer to endeavour to rehabilitate the employee.

Under this scheme, beneficiaries receive a wage subsidy if they are working, and otherwise a benefit. While the wage subsidy covers 70 per cent of the difference between the old wage (up to a ceiling) and the new wage, the benefit amounts to 70 per cent of the old wage during a first stage (duration of which is age-dependent, as for unemployment benefit) and to 70 per cent of the minimum wage times the loss in earnings capacity thereafter ("second stage"). This implies a 70 per cent withdrawal rate in the first stage but a powerful work incentive in the second stage.

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<sup>195</sup> See SZW – Ministry of Social Affairs and Employment, *A Short Survey of Social Security in The Netherlands, Summary as at 1 January 2008*.

<sup>196</sup> For example, if a person is aged 45 on the date on which his WAO benefit becomes payable, thus 30 years over the age of 15, this is then (30 x 2% =) 60% of that difference. This amount, added to the minimum wage, is the subsequent daily wage and forms the basis for the subsequent benefit.

For incomes between the minimum wage and the threshold for the benefit calculation, the second stage wage subsidy tends to be more generous than today's DB (excluding private top ups) the younger the beneficiary, the higher the pre-disability wage and the more severe the reduction in earning capacity"<sup>197</sup>.

Employers have to cover the risk of partial disability under the WGA. They can choose between private insurance companies and the public insurer (UWV) or may even carry the risk themselves. In the public system, premiums will be differentiated at the firm level to discourage employers with a low-risk profile from systematically opting out of the public system, making it expensive for the remaining firms. The government will investigate whether there is a need for mitigating differences in premiums during private insurers' necessary capital build-up. Whether a claimant is covered by private or public insurance, benefit conditions are fixed and the UWV will remain in charge of assessing the degree of disability in any case. These decisions represent the outcome of intensive debate as to whether or not to fully privatise the insurance of the first five years of partial disability, as initially proposed by the government<sup>198</sup>.

*Disablement Assistance Act for Handicapped Young Persons (Wajong).*

The Disablement Assistance Act for Handicapped Young Persons (*Wet arbeidsongeschiktheidsvoorziening jonggehandicapten, Wajong*) makes provision for a minimum benefit for young handicapped people.

A person is eligible for Wajong benefit if he is living in the Netherlands, is below the age of 65, and

- is at least 25% occupationally disabled on the date on which he reaches the age of 17, or
- becomes at least 25% occupationally disabled after this date (but before his 30th birthday) and has been a student for at least six months in the year prior to the occupational disability<sup>199</sup>.

As for the amount of the benefit provided for by *Wajong*, it depends on the degree of disability and the benefit basis. The basic rate for this benefit is the minimum (youth) wage.

Should a young handicapped person be in need of so much help that regular care is necessary, the benefit can be increased to a maximum of 100% of the base rate. This does not apply if the person in question has been admitted to an institution and the costs involved are met by an insurer. In addition to *Wajong* benefit, any person on *Wajong* benefit below the age of 23 will be entitled to an additional allowance. This allowance is meant to offset the negative income effects of the *Healthcare Insurance Act and the Care Allowance Act*<sup>200</sup>.

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<sup>197</sup> See OECD, *OECD Economic Survey of the Netherlands 2004: Reform of the Sickness and Disability Benefit Schemes*, 2004. See also Högelund J., Veerman T.J., *Reintegration: Public or Private Responsibility – The Dutch and Danish Reintegration Policy Towards Work Incapacitated Persons*, ISSA, 2000.

<sup>198</sup> See OECD, *OECD Economic Survey of the Netherlands 2004: Reform of the Sickness and Disability Benefit Schemes*, 2004. See also Högelund J., Veerman T.J., *Reintegration: Public or Private Responsibility – The Dutch and Danish Reintegration Policy Towards Work Incapacitated Persons*, ISSA, 2000.

<sup>199</sup> See A Short Survey of Social Security in the Netherlands, Summary as at 1 January 2008

<sup>200</sup> See SZW – Ministry of Social Affairs and Employment, *A Short Survey of Social Security in the Netherlands, Summary as at 1 January 2008*.

## ***Job retention and back-to-work strategies***

### *Reintegration trajectories and reintegration facilities.*

For people who are disabled there are roughly two types of reintegration instruments: a) reintegration trajectories and b) reintegration facilities<sup>201</sup>.

a) Reintegration trajectories are intended to help people receiving disability benefits back to work. This may include for example (re)training and schooling. The reintegration market to help disabled people was privatised in 2002. This means that private companies tender for contracts with the UWV<sup>202</sup> to reintegrate clients. UWV can buy a regular trajectory for a person on disability benefit. This can include schooling, training, interviewing, etc. It can also include a trial placement. The beneficiary can work for a maximum of three months without being paid (he/she can keep his/her benefits). A condition for this is that the employer intends to hire the employee after the trial placement. A new option was introduced in 2004 allowing disabled people to design their own 'Individual Reintegration Plans' (IRO). This IRO followed an experiment with a so-called 'Personal Reintegration Budget' (PRB), which is still available in three regions. This will not be discussed in detail given the low numbers of users (805 people chose this kind of plan) and lack of information on the placement rates. With the IRO people can plan their own reintegration paths and decide which means (such as work placement, application training or education) to make use of. They also have the opportunity to choose their own reintegration company.

b) Reintegration facilities are instruments needed by (partly) disabled people who are either working or involved in a reintegration process for return to work. This may include transportation to work, facilities for blind people, job coaches, wage dispensation, etc. There are also specific rehabilitation and schooling institutions for disabled people. Facilities are provided for also for the employer. The financial consequences of hiring or employing workers with a structural functional limitation are offset by various measures: for example, if an employee gets a sickness benefit from an UWV employer he/she can deduct the benefit from the wage to be paid during sickness.

Interestingly, the Dutch legislator has provided for a cooperative system between employer and employee. During the first 104 weeks of disability, the employer is responsible for reintegration activities if he/she has the obligation to continue wage payment. For those still covered by the Sickness Benefits Act, the responsibility lies with the UWV, the administering institute. Beneficiaries receiving a long-term disability benefit for the partly disabled are legally obliged to cooperate in reintegration activities. The UWV is responsible for the administration of reintegration.

To increase pressure on employers, on 1<sup>st</sup> April 2002 a new came into force: the *Improved Gatekeeper's Act*. This Act requires that employer and employee give proof to the UWV that sufficient rehabilitation efforts have been undertaken in the 52 weeks preceding the claim for long-term benefit. If the UWV is of the opinion that not enough activities have been performed, the claim for long-term disability benefit will be denied, and the period of continued wage payment will be prolonged for a period of up to one year. Employer and employee have to report progress in the rehabilitation process to the UWV. After 6 weeks, the Health and Safety Organisation has to perform problem analysis. Subsequently, the employer and employee have to devise an action plan to get the employee back to work, with the same employer or elsewhere.

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<sup>201</sup> See Cornell University, *Sickness and Disability Schemes in the Netherlands Country memo as a background paper for the OECD Disability Review*, GLADNET Collection, 2007.

<sup>202</sup> UWV is the Dutch Institute for Employee Benefit Schemes.

At first sight, the Improved Gatekeeper's Act seems to be working: employers and employees invest seriously in reintegration activities, and very often this leads to resumption of the former job, the adapted job, or placement in other work, with the same employer or another employer<sup>203</sup>.

#### *Local authorities and reintegration to work*

As pointed out by the Dutch National Strategy Report on Social Protection 2006-2008, “with the economic recovery the opportunities on the labour market are increasing, even for people who have not had paid work for a lengthy period. The government has taken a number of policy initiatives to bolster this development. For example, the government plans to introduce “return-to-work jobs” from 2007. The local authorities will be given the possibility to offer return-to-work jobs to social assistance recipients with little chance of finding work, who will be allowed to retain their benefit for two years as they find their way back into the labour market. The return-to-work jobs are intended for social assistance recipients who have the greatest difficulty in finding work due to personal circumstances. The return-to-work job will give them two years to develop and move on to a learning-working programme, a work placement scheme or take some other step towards regular work. The local authorities will decide who qualifies for a particular return-to-work job. The intention is that the jobs will be temporary and above all useful for the individual’s personal development. The job may be with a municipal body or another employer. The return-to-work jobs are an addition to the existing range of instruments. The local authorities can ultimately decide for themselves how they want to help their clients climb the first rung on the reintegration ladder”<sup>204</sup>.

#### *Reasonable accommodations*

Significant measures have also been adopted with regard to the “reasonable accommodations” required by the Framework Directive 2000/78/EC. One of the most important is the *Act on Equal Treatment of Disabled and Chronically Ill People* of 1<sup>st</sup> December 2003, which contains regulations banning (direct and indirect) distinctions on grounds of disability or chronic illness. It gives disabled and chronically ill people in particular the right to the adjustments necessary to enable them to participate fully in society. From a labour law perspective, it means that the employer has a duty to provide disabled workers with reasonable accommodations: adjustment is required if it is adequate and necessary to enable a disabled person to participate in work (unless the obligation placed upon the employer results in a disproportionate burden).

#### *Initial assessment of the recent reforms*

At this stage it is quite difficult to assess the impact of the reform on the social security system (the WIA will be evaluated in 2010). In any case, one of the first effects consists in the decrease in disability benefit claimants. In 2005, the number of people in the Netherlands claiming the three most important types of social security benefits declined. According to the latest figures published by Statistics Netherlands, the total number of labour disablement benefits dropped by over 60 thousand; income support benefits dropped by 11 thousand and unemployment benefits by 18 thousand. The number of labour disablement allowances was reduced by more than 60 thousand in 2005. The reduction was evenly spread across both genders. In December 2005, the number of benefits dropped below 900 thousand, when 899 thousand benefits were registered. In 2004 and 2003, the number of benefit recipients was reduced by 21 thousand and 11 thousand respectively. The overall decrease in labour disablement benefits is mainly the result of a decrease in the number of new claimants.

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<sup>203</sup> See Bocking A., *Changes in legislation on disability in the Netherlands*, ISSA European Regional Meeting, 2007.

<sup>204</sup> See *National Strategy Report on Social Protection 2006-2008* in the context of the Lisbon Strategy, p. 19.

On average, the number of new claimants dropped by over 80 percent from nearly 7,500 a month in 2002 to over 1,300 a month in 2005. The outflow of claimants remained stable over the period 2002-2005. The decrease in the number of new claimants is largely due to the *Wet Verbetering Poortwachter* (an act promoting rapid reintegration of sick employees) and an amendment to the *Wet Uitbreiding Loondoorbetaling bij Ziekte*. The amendment came into force on 1<sup>st</sup> January 2004 and extends the period employers are obliged to pay full wages, in case of illness, to two years. This caused the number of benefits to decrease further in the course of 2005. Moreover the above-mentioned Improved Gatekeeper's Act has been playing a significant role<sup>205</sup>.

Whatever the reason may be, a drastic decrease in numbers of disability beneficiaries has been clearly observed. See, for example, the case of long-term disability benefits.

**Influx into long-term disability: until 2006 WAO (Disability Insurance for Employees), from 2006 WIA (Work and Income according to Labor Capacity)**

	2001	2002	2003	2004	2005	2006
WAO	103.900	92.300	66.300	59.200	19.900	11,000
WIA	0	0	0	0	0	21000
Total	103.900	92.300	66.300	59.200	19.900	32,000
Disability Risk (%)	1,55	1,34	0,95	0,85	0,29	0.46

Source:BOCKTING A., *Changes in legislation on disability in the Netherlands*, ISSA European Regional Meeting, 2007.

A summarised version of the effects of the changes in legislation since 2002:

<b>Granted benefits 2000-2002</b>	<b>100.000</b>
Of which:	
- first claims	95.000
- re-opened benefits	5.000
<b>First claims 2000-2002</b>	<b>95.000</b>
<i>Minus effect Improved Gatekeeper's Act</i>	<i>-42.000</i>
<b>First claims after Improved Gatekeeper's Act</b>	<b>53,000</b>
<i>Minus effect Prolonged Wage payment by employer</i>	<i>-13,000</i>
<i>Minus effect reassessment WAO-beneficiaries</i>	<i>-5,000</i>
<i>Minus effect WIA</i>	<i>-7,000</i>
<b>Structural level first claims</b>	<b>28,000</b>
<i>Introduction effects WIA</i>	<i>-7,000</i>
<b>Influx 2006</b>	<b>21,000</b>

Source:BOCKTING A., *Changes in legislation on disability in the Netherlands*, ISSA European Regional Meeting, 2007

<sup>205</sup> See CBS Statistics Netherlands, *Labour disablement benefits down by 60 thousand*, Press Release, 6<sup>th</sup> March 2006.

***The sick leave scheme in the context of the Romanian welfare system***

The social model provided by the Government of Romania is grounded on a balance between competition, partnership and solidarity. This means that the social protection measures, including the social assistance for certain categories or groups of persons must be combined with actions for job creation, but also with social solidarity actions. At the same time, certain public funds (the public pension fund, the public health insurance fund, the public fund for unemployment insurance) are managed by administration boards, which include representatives from the government, employers associations and trade unions<sup>206</sup>.

In Romania, chronic diseases (cardiovascular and cerebro-vascular diseases, cancer, pulmonary tuberculosis) represent a major public health problem. Cardiovascular and cerebro-vascular diseases are the main causes of mortality, responsible for approximately 63% of deaths (according to the official statistics from 2004). The average rate of mortality caused by these chronic diseases is three times higher than the European average. Cancer is the second cause of mortality in Romania, causing 15% of the total deaths.

Romania is one of the few countries in Central and South-Eastern Europe with a significant number of people affected by HIV/AIDS. According to the National Report of the HIV/AIDS Monitoring and Evaluation Department in Romania, by the end of 2006, a cumulative total of 16,877 cases of the HIV virus had been recorded. Of these, 10,264 people were registered with AIDS. Furthermore, Romania is a country with a high incidence of tuberculosis due to its socio-economic problems.

***The design of the measure***

*Romanian legislation concerning sick leave*

According to Romanian legislation, it is compulsory for all Romanian citizens with residence in Romania to be insured; this also applies to foreigners or stateless citizens who have taken up residence in Romania. In order to become eligible for medical care, any person must be insured (through *GEO no. 76/2007 regarding special fiscal registration procedure and the payment of social contributions*, the legal framework required to socially insure Romanian citizens temporarily working abroad was set up so that they can benefit from all employment rights). In Romania, all employees and employers have to pay contributions to the social health insurance scheme: 6.5% of the employee's gross monthly income; 7% of the total gross monthly wages earned by employees and paid by employers. For the unemployed, the contribution basis represents the monthly unemployment benefits covered by the unemployment insurance budget.

Insured persons are divided into two categories:

- those insured by effect of the law: employees in public and private sectors, politicians elected in central and local governments, magistrates, the unemployed, persons working in co-operative systems, owners of land and forest and various others;

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<sup>206</sup> The European Commission – Employment and Social Affairs DG, Study on the Social Protection Systems in the 13 Applicant Countries - Romania Country Study; January 2003

- the self-employed who contribute to the system themselves and also the persons insured by effect of the law who also want to reach the maximum level of contributions (three times the national average gross salary). The law covers all working categories and there is equality between men and women.

The insured persons can benefit, on the grounds of a medical certificate, from sick leave and benefits for temporary work incapacity. Insured sick persons have the right to sick leave and benefits. Benefits can only be received if contributions have been paid to the system for at least 6 months over the last 12 months or for at least 12 months in the last two years, before occurrence of the sickness.

Sick leave and benefits can be provided for a maximum 183 days in a year, calculated from the first day of sickness; the approval of the social insurance expert physician is necessary for the last 91 days. Sick leave and benefits are provided for a longer period in the case of particular diseases:

- 12 months, in the last 2 years, for pulmonary tuberculosis and certain cardiovascular diseases;
- 1 year, with the possibility of extension to 18 months (with the approval of the social insurance expert physician), for meningeal, peritoneal and urogenital tuberculosis, including the suprarenal glands as well as AIDS and any type of cancer, according to the phase of the disease;
- 18 months, in the last 2 years, for operated and osteo-articular tuberculosis; 6 months, with the possibility of extension up to 1 year, in the last 2 years, for other forms of extra-pulmonary tuberculosis (with the approval of the insurance medical adviser).

Allowances for temporary work incapacity for medical reasons are paid by the employers and by the social health insurance budget. Depending on the number of employees as of the date when the temporary incapacity for work occurs, the employers pay:

- from the first to the seventh day of temporary incapacity of work (if they have up to 20 employees);
- from the first to the twelfth day if they have between 21 to 100 employees;
- from the first to the seventeenth day if they have over 100 employees.

Allowances are paid from the social health insurance budget as follows: from the day following the interval covered by the employer up to the end of the period of temporary work incapacity of the insured individual (or up to his/her retirement); from the first day of temporary work incapacity, for the unemployed or other categories of persons (associates or shareholders, members of family businesses, freelancers, administrators or directors under administration or directors' contracts).

The level of benefits for temporary work incapacity is 75% of the calculation basis, which represents the arithmetical mean for the last 6-months income, and for which the contribution was paid. For special cases, including the above-mentioned diseases, as well as medico-surgical emergencies and certain infectious diseases, the level of the benefits is 100% of the calculation basis. Allowances for temporary incapacity for work caused by occupational illnesses or by workplace accidents are paid from the first day of temporary incapacity up to the end of this condition or up to retirement.



Some preventive and curative medical services for sick people with certain chronic diseases (tuberculosis, AIDS, cardiovascular diseases, cancer and diabetes), certain drugs and sanitary materials are granted from the state budget and from the budget of the social health insurance fund, through the national health programmes. Persons lacking insurance but suffering from the above-mentioned diseases can also benefit from these services.

### *Work incapacity pensions*

The public pension system is funded by social security contributions paid by employers and employees. The employee's contribution is for a minimum period of 15 years and a maximum period of 30 years for men and 25 years for women. The employer's contributions are set at differing rates depending on the severity of the work, as follows: 19.75% (normal conditions) amounting to some 4.3 million workers; 24.75% (difficult conditions) amounting 190 thousand workers; 29.75% (special conditions – such as working in the mining industry) 24 thousand workers.

The overall rate for social contributions is quite substantial, standing at 47.8% (among the highest in Central and Eastern Europe). The government is committed to applying a gradual reduction of about 2% annually during 2006-2008. The first reduction occurred in January 2006, when the rate of social contributions paid by employers was cut to 30.25% from 32.5% and social contributions to be paid by employees remained unchanged at 17%.

Persons eligible for *work incapacity pensions* are insured individuals who have totally or partially lost their work capacity subsequent to accidents at work, occupational illnesses and tuberculosis, common diseases and activity related accidents.

Depending on the job tasks performed and the degree of disability acquired, the following levels are considered:

- First degree: total loss of work capacity, the disabled person requiring permanent care or supervision by another person;
- Second degree: total loss of work capacity, while the disabled person can manage for him/herself without the help of another person;
- Third degree: loss of at least half of the work capacity, but the disabled person manages to perform an occupation. The persons who suffer from a chronic disease are included in the third degree of invalidity.

A doctor specialised in medical assessment decides whether a person is to be classed as first, second or third degree, based on the required documents. The medical expert can also decide when a person is eligible to start work again, in which case the work incapacity pension is annulled. Invalidity pensioners are subjected to a medical check-up at 6-12 month intervals until they reach the standard pension age.

It is worth noting that the public pension system has registered an increase in the numbers of people receiving invalidity pensions – now at around 18% of all those who receive the age limit pension - although the income represented by the work incapacity pensions is lower than the income represented by the salary.

### ***Job retention and back-to-work strategies***

The Labour Code and the National Collective Agreement (i.e. the employment contract that specifies the obligations and the rights of the employer and the employee) have no specific conditions concerning job reintegration. These documents only stipulate that: when a post is left temporarily vacant, the employer can hire someone else until the employee that holds the position returns from sick leave.

Nevertheless, the fact remains that trade unions can negotiate the labour contract with employers in large companies. This may include the negotiation of wages, work rules, complaint procedures, rules governing hiring, firing and promotion of workers, benefits, workplace safety and return-to-job policies. In a number of collective agreements with national and private companies, certain conditions concerning job reintegration are stipulated: a) employees can keep their jobs until they return from sick leave. b) employees who have partially lost their work capacity due to work accidents or illnesses, or if their previous work environment has become harmful to their health (due to working conditions or the specific pollution of the environment), on the doctor's recommendation, have the right to proper work places, maintaining the basic wages (earnings, remuneration and pay-check) and the permanent increments corresponding to the previous work place for a 1-3-month term. In cases of work accidents or illnesses, the time frame is 3 months. Employees aged 55 years (men) and 50 years (women), with work experience of 25 years (men) and 20 years (women), who are unable to continue their activity in those working conditions due to objective reasons (age and health), can be relocated to other work places, but on condition that the previous basic wage is maintained.

### ***An assessment of the Romanian system***

*The main problems in current legislation highlighted by organisations representing patients with cancer*

- Length of sick leave

The maximum 18 month sick leave may not be sufficient: it depends on the duration of oncology treatment. Sometimes this treatment takes longer (if the patient is recommended both chemo and radiotherapy, or even has to have pre-surgical treatment), and only 6 months or less are left for recovery. The duration of the sickness leave should depend on the type and stage of cancer.

- Job reintegration

There are no rehabilitation procedures to regain a job adequate to this condition. The main problem is that cancer survivors are not legally recognised as a particular disadvantaged group with special needs in this matter, and there are no special programmes focused on their job reintegration. Until 2007 they were assimilated to disabled persons, but now they are denied recognition of their disability, due to the fact that **sickness is not legally assimilated to disability**.

### *Policy recommendations*

Cancer survivors should be regarded by legislation as a particular disadvantaged group, and discrimination based on health problems should be banned with severe legislative measures. Cancer survivors, recognised as a distinct disadvantaged group, should be directed to specific programmes, specially designed for their reintegration in the labour market. Specific legislation should be adopted to encourage social and professional rehabilitation procedures to regain a suitable job and to encourage employers to hire them.

Women suffering from breast cancer are subject to double discrimination, since most of them are no longer young and already disadvantaged by age. Special legislation should be adopted to provide these women with services to support their reintegration: vocational and psychological counselling, health centres for physical recovery; to allow them to work only 6 hours/day and to encourage employers who hire people with cancer.

There is another important point that requires specific attention on the part of the legislator. In Romania, people with an illness pension cannot receive a wage. If they are also considered disabled persons, they receive special aid, which will be halved if they get a job. This seems to be a clear disincentive to job reintegration and action should be taken to change this, as it evidently limits the active life of sick workers.

From the care perspective: during the first period of treatment, when the patient needs constant care (immediately after surgery, or during chemo and radiotherapy), one family member should be entitled to paid sickness leave to take care of this person. The families should also receive psychological counselling. In cases of severe stages of cancers, the patients should be entitled to have a permanent caregiver within the social protection system, or one family member should receive an indemnity for this period.

The above-mentioned provisions are not mandatory for every firm or company, and as a result many people who suffer from chronic diseases find it very difficult to return to their former workplaces after recovery. Legislation or collective agreements, at least, should consider specific inclusion measures and “return to job” policies. The employers should be encouraged, through incentive measures, to hire people who suffer or have suffered from a chronic disease. In the absence of incentives or laws encouraging employers to hire people suffering from chronic disease, the former tend to avoid doing so, considering it only a burden.

## Chapter V - From the patients' point of view

European level organisations representing the voice of specific groups have been contacted in order to acquire data, information, and views on the possibilities to combine work and treatment and their suggestions on how to deal with job reintegration after a long period of absence from the patients' point of view. Attention concentrated on a specific chronic illness, having the highest incidence throughout Europe: cancer.

*"Individuals must play a role in taking care of their own health, and therefore citizens' and patients' participation and empowerment need to be regarded as core values in all health related work at EC level. ... Citizens' empowerment can also be supported by civil society and NGOs, including patients' groups and disease support and advocacy networks. This principle also applies to the global dimension, and relates to the need to ensure "grassroots" ownership of development policies in respect to the Paris Declaration on Aid Effectiveness, which states that citizens and governments should play an active role in policy making."*<sup>207</sup>

Cancer advocacy groups and NGOs are well established in most developed countries and have powerful influence in high-income countries in raising awareness of the burden of cancer and directing public and private efforts and resources into cancer control.

There are many umbrella organisations at a European level, grouping many of the national NGOs. We contacted the following organisations:

### **International Union Against Cancer (UICC)** <http://www.uicc.org>

The International Union Against Cancer is a leading international umbrella organisation for cancer advocacy. The International Union Against Cancer, also known as the UICC, is the most prominent and inclusive international body dedicated to cancer control. The UICC has 270 member organisations in 80 countries. Many of these organisations are typical nongovernmental, volunteer-based cancer societies, but many are also government-funded (often national) cancer institutes and research institutions. This mix is beneficial for the UICC, but government-funded institutes are not usually considered to be true advocacy bodies because they are not government independent.

### **Europa Donna (member of the The European Cancer Patient Coalition)**

<http://www.cancereurope.org/europadonna>

Europa Donna (ED) is the dominant breast cancer advocacy group in Europe, consisting of national organisations from 39 countries. The original core and impetus came from Western Europe, but the membership currently includes about a dozen mostly middle-income countries from Eastern and Central Europe and the former Soviet republics.

Each ED member country has its own National Forum and interacts with its own national government, as well as through the Europe-wide network to influence the broader political structures in Europe. National Fora include patients, female health professionals, breast cancer-related organisations and institutions, and women supporting the fight against breast cancer. Education, information, and lobbying are the three major activities. Lobbying takes place nationally in Member States and throughout Europe.

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<sup>207</sup> [http://ec.europa.eu/health/ph\\_overview/Documents/strategy\\_working\\_document\\_en.pdf](http://ec.europa.eu/health/ph_overview/Documents/strategy_working_document_en.pdf)

### **The European Cancer Patient Coalition**

[www.ecpc-online.org](http://www.ecpc-online.org) member of [www.cancerworld.org](http://www.cancerworld.org)

This is an umbrella organisation for all cancer patient groups from across Europe. The ECPC was launched in 2003 to represent the views of cancer patients in the European healthcare debate and to provide a forum for EUROPEAN CANCER PATIENTS to exchange information and share best practice experiences. To date the ECPC has over 200 national members across the EU.

### **European Patients' Forum** [www.eu-patient.eu](http://www.eu-patient.eu)

The EPF is the umbrella group of pan-European patient groups active in the field of European public health and health advocacy. The EPF came into being in January 2003 as a direct response to calls by the European Commission and other EU institutions to have one pan-European patient body to address and consult on issues of interest to patients in the European healthcare debate.

### **ECL Association of European Cancer Leagues** <http://ecl.uicc.org>

The association of European Cancer Leagues (ECL) is an alliance of national and regional Cancer Leagues. The ECL is located in Brussels; it is a non-profit association, created in 1980, and consisting of 29 members, located throughout extended Europe: they combine efforts to fight cancer, provide support to cancer patients and their relatives, and improve the quality of treatments.

In 2004-2005, the ECL Working Group on Patients' Rights and Duties agreed to focus its work on the questions relating to cancer patients and their working environment. The working group has looked at issues such as the right to keep a job, returning to work, finding a new job, and all the social and financial support schemes linked to these questions. The "European Framework for Protecting Cancer Patients at Work" was adopted by ECL members in November 2005.

The text was the subject of a presentation to some 20 Members of the European Parliament (MEPs) in January 2006. The ECL will actively work closely with MEPs towards the best possible protection of cancer patients at work.

Some of the organisations contacted have involved their country members, inviting them to answer a questionnaire (See Annex V6).

Only four of the five organisations answered, and for each organisation, we received one or more questionnaires filled in or materials prepared by the organisation presenting their point of view on the problem of working with a cancer.

The main elements emerging from the interviews and questionnaires are as follows:

### **5.1 Feelings and needs of cancer patients highlighted in the interviews, questionnaires and studies**

This chapter is based largely on the following material provided by the organisations:

1. The results of a UICC study conducted by one of the members, the UK MACMILLAN Cancer Support, on problems and possible solutions in getting back to work after cancer: MacMillan Cancer Support, *Working Through Cancer- The road to recovery: getting back to work*, November 2007
2. An interviewee with the representative of Italian FAVO, an organisation belonging to both ECPC and ECL

3. Two questionnaires concerning Denmark, one from ECL and one from Europadonna
4. A questionnaire concerning Spain belonging to UICC
5. Questionnaires from Europadonna concerning Romania, Sweden, Ireland; Greece, Poland and Estonia

*A) The need to get back to work as soon as possible*

- Experience has shown that the most important problems for workers with cancer are daily problems: therapies today are not as strong as they used to be and the becoming chronic, leaves the patient all the problems involved in dealing with an illness that lasts 10/20 years. Thus, attention shifts from health problems to work problems, considering both the economic aspects and the need to return to normal life. It has been demonstrated by international studies that cancer patients' wages fall by 25% in the first year after diagnosis.
- People with cancer have a strong attachment to the labour market. As well as the financial necessity of earning, many desperately want to 'get back to normal' and returning to work is central to this. People do not need to be coerced or cajoled to go back to work; they simply need the right support at the right time. Getting back to work soon after treatment is seen as part of re-establishing a normal lifestyle, and this is a strong incentive for sick workers. However, this eagerness to return to work can create problems in going back too soon.
- Many factors are involved when people make decisions about work after cancer diagnosis. Economic need is a major factor. 'Getting back to normal' is also a powerful motivator, cited in several US and UK studies, and shows the important part work plays in people's lives. This suggests that providing effective support is more valuable than coercing people back to work. 'I wanted to get back to work as soon as possible... work was the normal life I had before and that's why I focused on it.'
- Financial pressures are a strong factor in driving people back to work, especially important given the extra costs of treatment over a long period. This is more strongly felt by people who had less entitlement to sick pay from their employers, and who were off work for more than twelve months.

*B) The difficulties involved in the return to work*

- Many people are unable to stay in work after cancer or other long-term illnesses: a significant minority of people with cancer have permanent effects after treatment, including disability or functional limitations like fatigue and loss of concentration.
- Working life deteriorates: two in three of those who returned to work experienced difficulties including tiredness, loss of concentration and lack of confidence in their job, and almost one in five of this group reported their working life had deteriorated as a result of their cancer. 'I didn't feel quite ready physically and I still felt a bit wobbly mentally and emotionally, but I was coming to the end of my full pay and I just couldn't afford to go onto half pay'. Working life also becomes harder because, on one hand, cancer patients need a long time to rest after tough treatments, and, on the other hand, they are often affected by long-term side effects, which need to be checked at regular intervals after treatment, thereby entailing frequent absences for check-ups.
- Changing the work-life balance: Having survived cancer and returned to work the work-life balance changes, attaching much less importance to work compared to family life.

- In some work places, the management and the colleagues find it difficult to handle the situation, when the sick employee returns to work. It is essential that the management and the sick employee discuss and agree upon some key aspect concerning the return – they might for instance agree on a period of part time or reduced workload. It is just as vital to agree upon how the colleagues should be informed.

*C) The lack of knowledge from several points of view*

- The evidence base on cancer survivorship and work is still relatively weak. Still too little is known about the barriers people face when returning to work or what interventions are most effective.
- There is a lack of suitable medical advice. The perception of NGOs is that sick workers receive little or no medical advice to help understand the impact cancer and its treatment will have on their working lives, and to help them to return to work at the right time. In most countries, sick workers do not receive any medical advice when returning.
- There is a lack of knowledge in the management of many workplaces. The management should be told about the specific aspects and typical late effects that characterise cancer patients: temporary or permanent experiences of fatigue, reduced ability to concentrate or remember, pain or other conditions that require specific considerations.

*D) Suggestions*

- Employers have a key role to play. A good relationship with the employer/line manager makes a successful return to work more likely. Phased return to work is perceived by workers as a real help. Moreover, a good relationship with the employer is one of the major determinants in successful return to work. Support received by colleagues during sick leave is also highly valued.
- Easing back into work: Where occupational advisers are involved, people are normally able to make a gradual return to work with a lighter workload and/or a shorter working week. This approach has valuable benefits and can influence people's longer-term employment prospects and well-being.

## **5.2 What else is needed for patients with cancer?**

*A) To increase information and advice to the worker, colleagues and employees*

- It is essential that the parties at the labour market get appropriate and sufficient information, working for a change in attitudes in managements, colleagues and cancer patients - to make cancer less of a taboo. Employers should be taught how to react in a responsible and helpful way when one of their employees get cancer – for example asking the sick employees about their needs and abilities – and start developing good tools appropriate for company management. Some examples can be seen throughout Europe: a number of these are presented in the Annexes to Chapter V.
- Too many people return to work after cancer treatment without any medical or rehabilitation advice on how to deal with their problems at the workplace. To make this transition smoother, people need information about returning to work and need to refer to occupational health and rehabilitation services at key points in the care pathway.
- (In those countries where this has not yet happened) institutions should work with NGOs to understand the specific needs of people with cancer and introduce specific norms suiting the specific needs of sick workers.

Employers should incorporate NGO best practice guidance into their sickness and disability policies to ensure that the workers get the right support when returning to work after cancer diagnosis.

- There is an urgent need for more research in order to have a greater understanding of the issue and inform policy solutions. Macmillan, for example, urges the National Cancer Research Institute (UK) to make work and cancer a strategic research priority.

*B) To fight discrimination at the workplace*

- through information to explain that people with a reduced work capacity have a useful role to play in the workplaces and in society.

*C) To disseminate best practices applied in various parts of Europe able to conciliate work, recovery and treatment*

- Many good practices exist throughout Europe and the NGOs are trying to disseminate them among their members. Wider dissemination through EP initiatives would afford better results.

*D) To pay more attention, from the normative point of view, to the burden of the family and care givers*

- Partners and other relatives can find it very hard to have to work and take care of the sick person: it is a question of both time and mental strain. It might help both the patient and his or her spouse if they had a number of days at their disposal to take the patient to consult the doctor or receive treatment - without suffering loss of income.
- This would require changes in both the legislation and the minds of employers. In Europe, in most cases, legislation does not consider the impact of cancer on the family, in some cases considered only when the sick person is a child or is dying.
- The less well-off need to have their transportation costs covered when following their sick relatives to treatment sessions. They might need practical help with household tasks as well, especially if there are small children in the family.

*E) The involvement of NGOs*

- The EC should always invite a board of cancer patients and carers to preliminary discussions before new legislation concerning the conditions for European cancer patients is discussed and decided upon.

### **5.3 The role of NGOs**

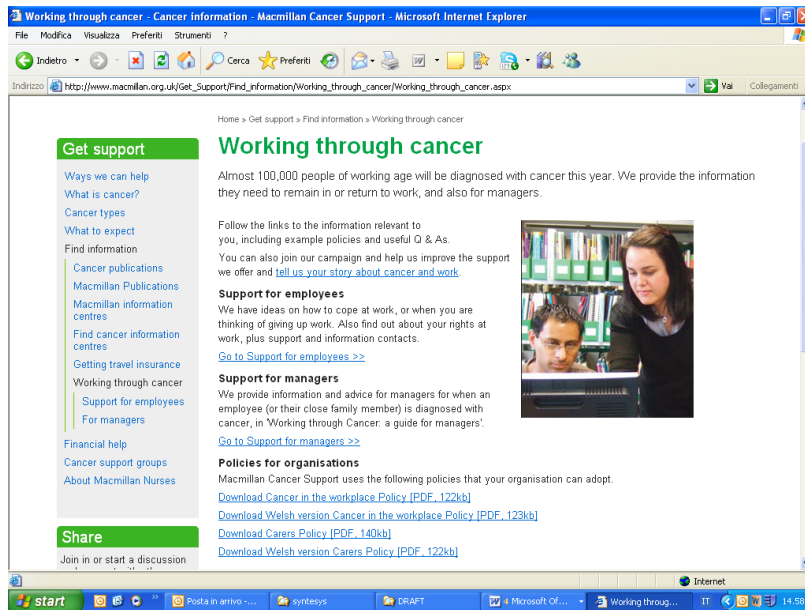
#### **UICC Organisations - MACMILLAN Cancer Support - UK**

Macmillan's national Working Through Cancer campaign is tackling the issue of working with a cancer. "We have already campaigned successfully to extend protection, under the Disability Discrimination Act 1995, to people with cancer from the point of diagnosis. The next phase of our MMRU research programme will explore the views and experiences of line managers and occupational health practitioners. Ultimately, we aim to develop and test an effective model for supporting people with cancer to return to work. An expert panel is being set up to provide strategic advice and support to the campaign. We are developing a range of tools, guides and information products to help rehabilitation, occupational health and Human Resources professionals to support people in returning to work."

Macmillan organisation has prepared several guides to support job regaining by the sick worker, including, notably, the following two:



- Working through cancer: a guide for employees (Annex V1)
- Working through cancer: managers guide (Annex V2)

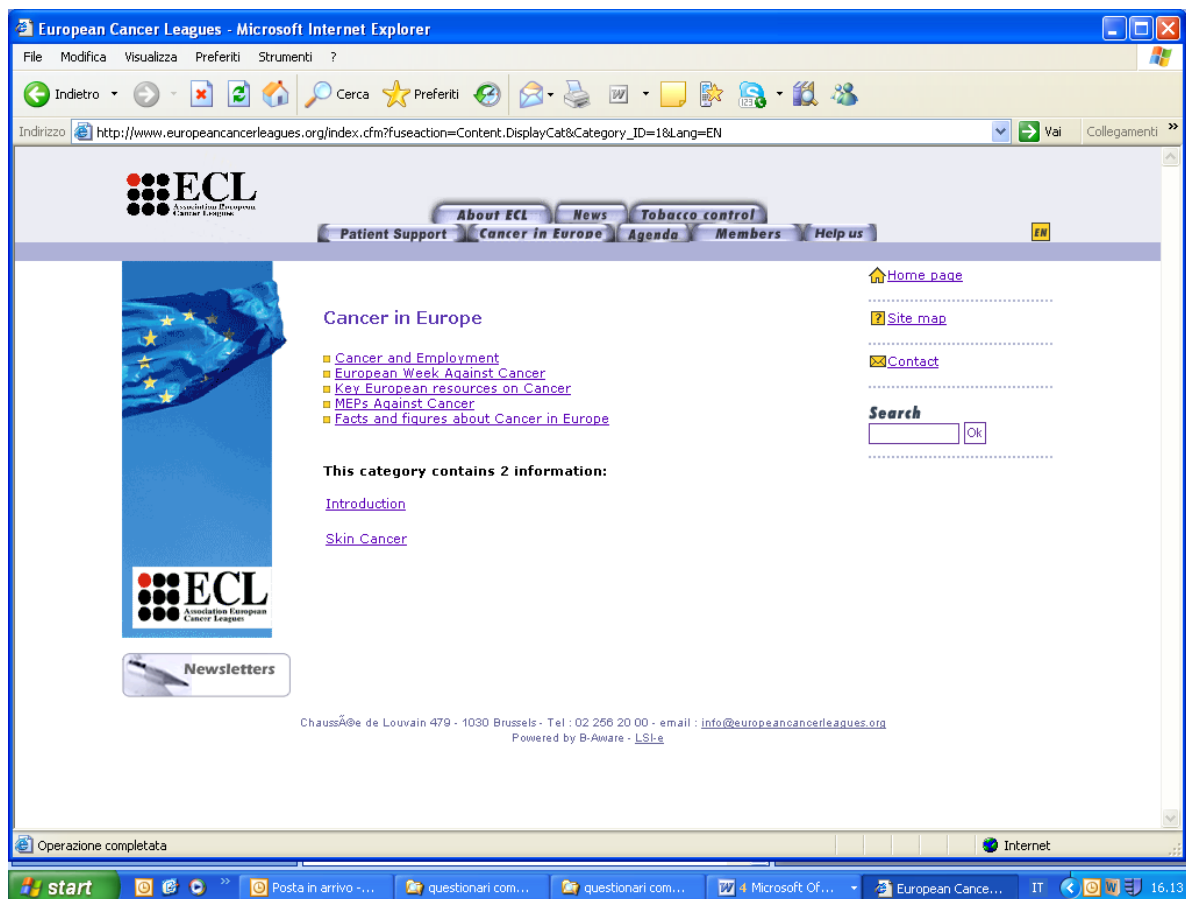


## ECL and UICC organisations

During its General Assembly of June 2002 in Oslo, the ECL adopted a joint declaration on patients' rights with the aim to offer a common strategy on patient support to all their European members. The document, based on common human values, covers the following themes: the right to medical care and treatment, right to information, right to self-determination, right to confidentiality and privacy, and the right to social support and patients' responsibilities.

In addition to the joint declaration, a list of recommendations for the main actors (legislators, policy makers and non-profit associations) was also approved. Ideas for further collaboration with other partners were also listed. In this way, ECL hopes to provide the best conditions for a dynamic and global approach in order to protect cancer patients.

See Annex V3: ECL Oslo declaration



National members have adopted the Oslo declaration and have promoted their specific instruments, disseminating them throughout Europe:

### **Aimac - Favo – Italy**

With the awareness that information both to the workers and to the employer is the most important and useful instrument of integration and support, these two Italian organisations have formulated ECL guidelines on the rights of patients, I DIRITTI DEL MALATO DI CANCRO, a guide containing a consistent section concerning the right to work of workers with a cancer. This guide has been widely disseminated and implemented throughout Europe. See the guide in Annex V4: “I diritti del malato di cancro”.

These two organisations in Italy are working to:

1. fight discrimination at the working place
2. disseminate information on existing laws and opportunities that may help workers to go back to work while continuing therapies
3. implement two important law specific workers with cancer: one concerns the possibility to reduce the working time when needed, going back to full time when the worker is able to; the other allows for a marked reduction in bureaucratic formalities to obtain allowances for a person with working inabilities. This law is particularly important as it allows people to take care of their sick relatives.



## The Danish Cancer Society

The Danish cancer Society is working to make sure that the parties at the labour market get appropriate and sufficient information. They are working for a change in attitudes in managements, colleagues and cancer patients - making cancer less of a taboo.

For this purpose, they have published and distributed a handbook for company managements with useful advice and guidelines written for company managements: “When an employee develops cancer” – see Annex V5.

The Danish Cancer Society has contributed to the ECL publication “European Framework for Protecting Cancer Patients at Work” in 2005.


The Danish Cancer Society - Kræftens Bekæmpelse - Microsoft Internet Explorer

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Indirizzo <http://www.cancer.dk/Cancer/The+Danish+Cancer+Society.htm>

Forside - Patienter og pårørende - Forskning - Sundt Liv - Støt os - Om foreningen - Børn og unge - Kampagner



www.cancer.dk > Cancer.dk > The Danish Cancer Society

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Støt kræft sagen

**The Danish Cancer Society**

**About our Homepage**  
As there are many cancer related web-sites available in English, we have chosen to concentrate on providing cancer related information in Danish. However, we do provide a more detailed description of the work of some of our research departments:

- ▶ Institute of Cancer Epidemiology
- ▶ Institute of Cancer Biology
- ▶ Centre for Genotoxic Stress Research

There is also a short introduction to our research funding guidelines in english here:

- ▶ Funding

**Aims and Main Fields of Activity**  
Our aims are:

- to prevent the development of cancer
- to improve patients' chances of successful recovery
- to limit the physical, psychological and social side-effects of cancer


**The main activities are within**

- research

Udskriv - Tip en ven

**De seneste nyheder**

- ▶ Børneteater om kræft i familien
- ▶ Parfume flaskoner - Magi & Skønhed
- ▶ Læger skal snakke om ryggestop ved diagnosesamtalen
- ▶ Kræft i sammenhæng med social ulighed skal udforskes
- ▶ 30,5 millioner kroner til Kræftens Bekæmpelse
- ▶ Se video fra landsindsamlingen

 Nyheder om kræft som RSS-feed

▶ Tilmeld dig nyhedsbrevet her

Tilmeld dig nyhedsbrevet

**E-mail:**

**Navn:**

**Evt. Arbejdsplads:**

Operazione completata

Internet

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## Chapter VI - Issues, problems, debate and best practices across Europe and conclusions

### 6.1. Long-term illnesses at the workplace: main findings and issues.

*“Getting back to work is a huge milestone for many people recovering from cancer. It represents a return to normality, financial security and a key point in reclaiming a daily routine. But it can be a difficult journey and one that people can feel they’re doing on their own... Returning to work after a cancer diagnosis is an emerging issue... Ten-year survival rates for all cancers combined have doubled over the last 30 years. Around 46% of those diagnosed are now surviving for ten years or more, and that number is still rising”*.<sup>208</sup>

The main findings of the study are summarised here to highlight the principal issues associated with the return to active life of workers affected by long-term illnesses, and in particular by cancer. They are given from perspective of the workers, the caregivers and the community as a whole. The main issues at stake and the best practices identified to tackle those issues represent the support analysis with the aim of providing elements for the decision making process.

The ability to return to work has a direct impact on individuals and their families, and there are clear implications for the overall community represented by employers and the economy, the health sector and the welfare system. All these aspects will be considered in the following paragraphs .

#### 6.1.1. From the perspective of the workers

*Socio-economic determinants of early job reintegration after a long-term illness.*

Job regaining is an essential step towards the return to ‘life’ but in many cases prompt return can be associated with economic reasons.

- International studies demonstrate that for cancer patients the wage in the first year after diagnosis falls by 25%: in a US study, it is demonstrated that, financially, cancer hits working households hard. 71% experience a loss in household income, amounting on average to 50%<sup>209</sup>.
- Some survivors may work in spite of cancer related disabilities, possibly to retain employer-sponsored health insurance, to replace income lost during treatment, or to cover expenses and protect against financial uncertainties associated with survivorship<sup>210</sup>.
- People on lower incomes are more likely to take longer sick leave. However, those on the lowest incomes are slightly more likely to take no sick leave at all, which might be explained by strong financial pressures to get back to paid work as soon as possible.<sup>211</sup>
- Financial pressures are a strong factor in driving people back to work, which is especially important given the extra costs of treatment over a long period. This is more strongly felt by people who have less entitlement to sick pay from their employers, and who are off work for more than twelve months.

*Other social determinants of job reintegration.*

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<sup>208</sup> McMillian Cancer Support, Working Through Cancer- The road to recovery: getting back to work, Nov 2007

<sup>209</sup> Ibid.

<sup>210</sup> Short PF, et al. (2005): Employment pathways in a large cohort of adult cancer survivors. IN: *Cancer* 2005;103(6)

<sup>211</sup> McMillian Cancer Support, Working Through Cancer- The road to recovery: getting back to work, November 2007

- Education levels and occupations modify the effect of cancer on employment<sup>212</sup>. Individuals of lower educational attainment have a higher probability of being employed than those with higher educational attainment. There may be more opportunities for individuals of higher educational attainment to access prolonged medical leave or to return to work part-time.
- The literature identifies some specific determinants of work resumption associated with different sectors and the type of jobs in which it appears possible. Survivors working in agricultural, forestry, fishing, transport, communication, manufacturing, or service industries were 18% to 20% less likely to be employed. Long standing illnesses seem to have stronger adverse social and economic effects on manual workers as, for example, manual jobs are less flexible, are heavier, and teleworking is not possible. Consequently, manual workers have a higher incidence of disability. White-collar jobs are obviously easy to return to, whereas jobs presupposing heavy physical activities can be very difficult for cancer patients to go back to work. The same applies if the job involves piece-work.

*The impact of early return to the workplace on the health and wellbeing of workers in general*

Return to work for persons affected by long-term illness represents an important achievement, as it is a significant step towards complete recovery and return to active life. However, various studies have demonstrated that return to work also involves several drawbacks such as stress, and deterioration in career prospects and job satisfaction<sup>213</sup>. For this reason both positive and negative aspects have been considered, as well as other possible barriers to reintegration.

a) positive aspects

For people affected by chronic illness, remaining active and present in the labour market represents a fundamental aspect of quality of life and recovery. In fact, empirical studies report that unemployment affects life satisfaction and generates symptoms of psychological distress.

Increasing the chances of workers with long-standing illness remaining at work means both improving the quality of life of survivors from long-term illnesses and reducing socio-economic inequalities as a consequence of illness. This does not necessarily mean remaining in their original jobs, which could harm their health yet further.<sup>214</sup>

A Finnish study<sup>215</sup> showed that most employees considered themselves as being able or partially able to work despite their health problem. If the patient was convinced of the benefits of work-related interventions, the disability risk was significantly reduced.

b) negative aspects

People surviving cancer may find their jobs affected adversely over the long-term in a variety of ways that include physical limitations, fatigue, emotional problems, difficulties with concentration and memory, awkward or negative interactions with co-workers, and changing personal priorities<sup>216</sup>.

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<sup>212</sup> Taskila-Brandt T, et al. (2004): *The impact of education and occupation on the employment status of cancer survivors*. IN: 'Eur J Cancer' 2004

<sup>213</sup> Amir Z. et al., *Return to paid work after cancer: a British experience*, J Cancer Surviv, 1 June, 2007

<sup>214</sup> European Foundation for the Improvement of Living and Working Conditions, *Illness, disability, and social inclusion, 2003*

<sup>215</sup> Maritmo (Kari-Pekka) *Factors associated with self-assessed work ability*.

<sup>216</sup> Short PF, et al. (2005): *Employment pathways in a large cohort of adult cancer survivors*. IN: *Cancer* 2005;103(6)

Symptoms and health problems caused or aggravated by work are common. “New research by Macmillan Cancer Support reveals that people who have had cancer treatment experience a range of problems when returning to work and that many are not getting the medical and rehabilitation advice and support they need”.<sup>217</sup>

c) barriers to reintegration

Many studies concerning the rate of return to work and the factors associated with return to work in cancer survivors have been carried out. The rate of return to work ranges from 30% to 93%, with a wide variation in the factors affecting it. Factors that can adversely affect return to work include:

- a non-supportive work environment, manual labour employment
- work posing physical demands
- The site of a cancer, age and type of treatment all appear to impact on people’s work decisions:
  - a) having head and neck cancer is a negative factor in this respect.
  - b) age is significant insofar as older workers are better equipped to deal with the emotional impact of cancer diagnosis, but may need additional support to keep working until retirement. Younger workers need more psychological support.
  - c) The type of treatment was a key influence in return to work rates. Of those who only received surgery, 90% returned to work. Those who received radiotherapy and/or chemotherapy or hormone therapy tended to take longer to return. Only 71% of those who received treatment other than surgery returned.
- Employment discrimination is also an ongoing concern, since much legislation prohibits discrimination against disabled people but not against chronically sick people at both the European and national level (see Chapter 1).
- Other normative barriers derive from the fact that the existing regulations are quite frequently borrowed by disability discipline, but chronic illness presents different characteristics. Invalidity is a permanent condition while cancer and other chronic illnesses are ‘swinging’ pathologies presenting moments of perfect ability and moments of absolute inability to work.

d) possible support for job reintegration

- Flexibility regarding work hours or amount of work is positively associated with return to work,
- Co-workers’ positive attitudes,
- Supportive care directed towards symptom management, rehabilitation, and accommodation of disabilities, particularly in those survivors at highest risk,
- Offer of individual practical and emotional support to staff who are affected directly or indirectly by cancer,
- Occupational advisers allowing people to make a gradual return to work with a lighter workload and/or a shorter working week.

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<sup>217</sup> McMillian Cancer Support, Working Through Cancer- The road to recovery: getting back to work, November 2007

## 6.2 Main findings and issues from the perspective of the caregiver

The post surgical path of a person affected by cancer may include chemo- and radio-therapies, treatments and exams repeated for several years, and this burden is very often on the shoulders of the family. The same effects may derive from other serious long-term illnesses. An inadequate or expensive care system leads in many cases to the family shouldering the full burden of care. Most of the carers are women (mothers, wives or daughters) and in some cases, they have to work part-time or give up their work. This creates financial problems, and puts them at a disadvantage and at risk of poverty and marginalisation<sup>218</sup>.

### Possible support for caregivers

Partners and other relatives can find it very hard to have to both work and take care of the sick person – in terms of time and mental strain. It might help both the patient and his or her spouse if they had an number of days at their disposal to take the patient to consult the doctor or receive treatment - without suffering loss of income. This would require changes in both the legislation and the minds of employers.

Moreover, opportunities are open to a well-informed patient to find help to bear this burden. There are several examples of leaflets, guides and information campaigns organised by NGOs aiming at informing the patients of all the opportunities given by the insurance, the public services or the NGOs directly, intended to help the families in facing the difficulties. In some countries, the caregiver has the possibility to take advantage of ‘supporting leave’: see the following examples:

- in *Italy* for example the caregiver can ask for a ‘congedo straordinario’, for a maximum of two years.
- In *Lithuania* for those nursing a family member there is paid leave for a maximum duration of 7 days for those taking care of adults and of 14 days for those taking care of children under the age of 14 years. For those caring for hospitalised children leave is authorised for the course of treatment but no longer than 120 days. For children under 18 who are sick with an oncohaematological disease, or who have undergone a complicated operation or have experienced trauma or burning the leave for the caregiver is for the full course of treatment but no longer than 120 days.
- In *Slovenia* workers receive sickness benefit (80% of the Statutory Reference Amount) for the nursing of an immediate family member

## 6.3 Main issues from the perspective of the community as a whole

The return to active life of a worker who has gone through a severe and long-term illness represents an important step towards recovery for the individual but also an important attainment for the community as a whole. For society, the economic burden of a sick worker includes not only the cost of health care and rehabilitation but also the lost productivity of those who quit work and the cost linked to the possible pauperisation of the worker and his family for the years to come. Large-scale recourse to early retirement or invalidity pensions for those who may have residual working capacities represents a significant loss of human resources for the entire European society and results in a form of exclusion as it expels sick people from the labour market, who would be able to return to their jobs if only they were given the chance (and time) to cope with their own sickness.

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<sup>218</sup> See Grammenos S., *Illness, Disability and Social Inclusion*, European Foundation for the Improvement of Living and Working Conditions, 2003



On the one hand, early retirement – linked or not linked to the granting of an invalidity pension – is a costly measure, which may not be compatible with the need for a more sustainable welfare system. As has been observed by the European Foundation for the Improvement of Living and Working Conditions<sup>219</sup>, “early retirement places a substantial drain on social protection systems. The growth in the numbers of withdrawing from the labour force before the official retirement age has been a marked feature of the labour market. In many countries, those retiring early are sometimes supported by disability benefits, which are used as a substitute for unemployment benefits. However, the response to this is mainly focused on administrative and procedural changes to payment systems and active labour market measures for those already out of the workforce. The key strategy proposed is to adjust payment levels to reduce exit from work rather than trying to encourage people to return to their jobs”.

Two very interesting examples concerning this come from the *UK* and *Finland* case studies: in particular, in the *UK* a reform proposal was presented in 2006 to help people on incapacity benefits return to work. In 2006, there were over 2.7 million people on incapacity benefits. Around 80 to 90 per cent of those who came onto benefits expected to work again, yet few of them did (it has been proved that the longer a person remains on benefits, the less chance they have of leaving). The benefits system reinforced this by offering more money the longer people were on benefits and by requiring them to prove their ongoing incapacity, rather than actively encouraging and supporting them to take steps towards a return to work<sup>220</sup>. That is why the British Government has decided to put more emphasis on the objective of increasing labour market participation rather than just supporting sick people through incapacity benefits. This clearly emerges from the UK's National Reform Programme 2005-2008, where it is stated that the Government focuses on action to help those at risk of social exclusion to get a job and remain in work. The pivotal idea that characterises the UK welfare reform is to reduce the amount of money used to finance incapacity benefits to provide more money in return for work-related activity.

In *Finland*, relatively generous early retirement schemes induced old and sick workers to retire instead of re-entering the labour market or to participate at labour market measures. In some of the other Nordic countries, the role of early exit policies is of lesser importance (as in Denmark) or analogous schemes have recently been abolished (as in Sweden). A new tailor-made activation programme, the so-called *Rehabilitative Work Activity*, was introduced to enable cooperation between employment offices and the municipal social welfare authorities. Rehabilitative Work Activities aim to improve the possibility for the beneficiary to be employed and are based on an *integrated approach to activation*. In fact, representatives of the employment and social welfare offices collaborate with the unemployed individual in defining a tailor-made activation plan. By participating in Rehabilitative Work Activities, individuals are entitled to a bonus payment. Since traditional labour market measures arranged by the employment services were not seen to be able to help customers in need of multi-professional treatments, the so-called *Labour Force Service Centres* (LAFOS) were created. The aim of LAFOS is to promote employability skills of workers absent for a long period due to sickness.

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<sup>219</sup> See Wynne R., Mcananey D., *Employment and Disability: Back to Work Strategies*, European Foundation for the Improvement of Living and Working Conditions, 2004

<sup>220</sup> DWP Green Paper, *A New Deal for Welfare: Empowering People to Work*, 2006.

## 6.4 Reintegration in the labour market: issues at stake and good practices identified

As observed in the first part of this report, the issue of reintegration of chronically ill people into the workplace can be addressed through the multiple perspectives of labour law, social security and occupational medicine. While our study does not consider the latter, in the following paragraphs we summarise its main results and provide an analysis of the best practices emerging from the national cases in light of the other two perspectives.

### 6.4.1 Labour law perspective

The case studies presented in the previous section confirm a tendency to shift from passive to active instruments. However, in many countries norms concerning the reintegration of chronically sick people in the labour market are still the same as those regulating the integration of the disabled, while, in some respects, these two categories face very different problems. For example, while one of the main problems for the disabled is mobility, for the chronically sick it is the possibility of frequent absence to follow treatment. This calls for a clear distinction between disability and illness as well as better tailored measures.

#### Reasonable accommodations

With regard to adaptations to the workplace, the most innovative approach is surely that consisting of the adoption of reasonable accommodations. These can be defined as effective and practical measures to adapt the workplace to the disability, for example adapting premises and equipment, patterns of working time, the distribution of tasks or the provision of training or integration resources. This development is the result of the Equal Treatment Directive 2000/78/EC, which introduced the duty to make effective reasonable adjustments for disabled people.

Although greater importance is normally attached to reasonable accommodations designed to facilitate job maintenance for the disabled than to those addressing the needs of chronically sick people, such solutions are also becoming common in some countries as means for tackling chronic illness.

A fairly common way of adopting reasonable accommodations is modification of worker's tasks. Member States usually adopt a number of measures aimed at reintegrating people who become affected by illness or disability. Here are some examples<sup>221</sup>:

- *Sweden*: the employer has to make reasonable adjustments to the work (place) or, if possible, provide a different job in the same company. For instance, Sweden adopted a "step-by-step model": a) assessment of working ability: when an insured client is unable to return to his or her ordinary work, b) the primary measure is to seek alternative tasks with the same employer c) in the absence of suitable alternative work, or if such a measure would require over-lengthy rehabilitation, the employee's work capacity should then be assessed against the general labour market d) an employee who, despite disease, can manage a different normal job is not entitled to any social insurance allowance e) if an insured employee is no longer capable of managing his or her work full-time, alternative work with the employer or another job normally existing on the labour market, but is still assessed as having residual work capacity, he or she may be entitled to a partial allowance. If examination of a case of sick leave shows that impairment of the employee's work capacity is permanent or will last for more than one year, the Social Insurance Act states that

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<sup>221</sup> See Grammenos S, *Illness, disability, and social inclusion*, European Foundation for the Improvement of Living and Working Conditions, 2003

sickness allowance should be replaced by permanent or temporary disability pension”<sup>222</sup>

- *Spain*: reintegration in the same post or, when this is not possible, into an inferior category with the same remuneration is provided for; a worker has priority for vacancies in the same company (in return, employers receive social security subsidies);
- *Italy*: employers have to assign equivalent tasks to disabled people, or, if this is not possible, lower-graded tasks but under the previous conditions. When disabled employees’ health conditions get worse – and therefore they are no longer compatible with the previously performed tasks – Article 10 provides for suspension of the employment relationship as long as the incompatibility exists. During this period disabled employees may do vocational training, which enables them to return to work (subject to organisational adjustments, if possible and reasonable: for instance, assignation to different tasks). Only in the case of persisting incompatibility, the worker can be dismissed. Moreover, making an exception to the general prohibition to assign lower tasks, the judges consider assignation to lower tasks as being a lawful alternative to dismissal whenever a worker, although not yet declared disabled, has been affected by a reduction of work capacity due to illness or injury;
- *The Netherlands*: a recent law obliges companies to make greater efforts to retain employees who have suffered an illness or disability. Employer and employee are encouraged to develop an action plan to get the employee back to work, in the same job or elsewhere. To judge by the initial empirical evidence, the *Improved Gatekeeper's Act* seems to be working: employers and employees invest seriously in reintegration activities.
- *The United Kingdom*: employees who, due to their illness or sickness, are declared to be disabled under the Disability Discrimination Act 1995 (DDA) can benefit from the duty of reasonable adjustments of working arrangements or conditions placed upon the employer by law

According to the examples provided for by Recital 20 of Directive 2000/78/EC reasonable accommodations may also consist of flexible working time patterns when adopted on an individual basis (consistently with the individual nature of the reasonable accommodations). However, as shown in the following section, flexible working time patterns or collective agreements on a general basis can be provided for by law.

#### Working time patterns

Flexible working time patterns can be useful for both sick workers (who need to follow treatment) and workers whose relatives are sick and need care. The law and collective agreements in most cases provide two types of flexible solutions:

- A common solution consists in calculating the average working time over a certain period (fixed by collective agreements and in any case no longer than 52 weeks: the so-called reference period). Applying this scheme, chronically sick workers might work less when medical treatments are needed and more when they are not, without giving up a full-time work activity.

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<sup>222</sup> Ahlgren A., *Vocational rehabilitation, work resumption and disability pension. A register-study of cases granted vocational rehabilitation by social insurance offices in a Swedish county*, Karolinska Institute, Stockholm, 2006.

This solution can be useful for carers but not necessarily for the sick worker, implying that she/he had to work longer in periods without treatment in order to be absent for the treatment – for cancer patients almost impossible. The whole sick leave system could indeed be questioned.

- More possibilities are offered with alternative use of such a traditional instrument as part-time work. In this respect, *Italy* is an interesting case, since specific measures have been adopted not only for workers with cancer but also for their relatives. In particular, when cancer implies a reduction in work capacity, legal provisions recognise the right to modify the employment relationship shifting from full-time to part-time. Collective agreements have further implemented this provision seeking to streamline the shift from full-time to part-time. The recent Law 247/2007 has strengthened the level of protection, recognising the right to a “fast track” to shift from full-time work to part-time work, also for employees whose consort, children or parents are affected by cancer.

#### Paid leave

Another useful instrument is represented by paid leave, generally provided for to help seriously disabled workers to follow proper medical treatments but not specifically tailored for people sick with cancer. Nevertheless, all the workers assessed as disabled under national legislations may benefit from paid leave. An interesting example is the paid leave dealt with in the case of *Italy*.

#### Improving the skills of sick workers.

One of the main findings of the present study is that skill levels bear an important relation to the possibility of job retention or return to work, with the rate generally being higher in proportion to the educational attainment level. One good example of measures which can improve workers’ skills so as to achieve the goal of job retention is offered by *Spain*. Royal Decree 395/2007 has created a system of professional training for employment that does not distinguish between occupational professional training and ongoing professional training. It might be predicted that chronically sick workers will also benefit from the model of continuous training for the employed and unemployed to favour life-long learning.

#### Active labour market policies

Active labour market policies reduce the risk of social exclusion of chronically sick workers and foster job retention and reintegration. Early intervention is the most effective way to achieve job retention and reintegration; coordinated delivery of appropriate services and supports is essential for effective return to work

In this respect, two notable cases are worth mentioning.

*Finland* has recently activated a new action programme, called *Rehabilitative Work Activity* based on an *integrated approach to activation*. Representatives of the employment and social welfare offices collaborate with the unemployed individual in defining a tailor-made activation plan. The activation plan is supposed to create a tailored pathway to employment consisting of labour policy measures, social and health services and rehabilitative work experience according to individual needs. With the development of such supportive services, the possibilities to help people to continue working would improve. Furthermore, cancer survivors should be offered opportunities to return to work with more flexibility than the choice between retirement or unemployment. The decision either to work or quit working should be made at an individual level, regardless of a person’s history of illness”.

In the *UK* the *Pathways to Work process* aims to provide a single gateway to financial, employment and health support for people claiming incapacity benefits.

*Pathways to Work* offers a dual approach to assistance, providing a co-ordinated approach to addressing the barriers that people face when affected by illness or disability, rather than simply compensating them for the disadvantage they face. Early evaluation of *Pathways to Work* has shown that there has been an 8-10 per cent increase in the rate of people coming off incapacity benefits after four months of their claim compared to non-pilot areas, and five times as many people in pilot areas join the New Deal for Disabled People programme.

#### 6.4.2 Welfare perspective

Although traditional forms of protection such as sick pay and incapacity benefits still provide workers with ample coverage, the focus of intervention seems to be shifting towards a more proactive approach.

An example is provided by the UK Welfare Reform 2007, which provides for incentives to back-to-work solutions instead of simply paying incapacity benefits and seems to achieve a good combination of both public and private forms of intervention in addressing the issue of sickness at the workplace.

The reform includes a broad range of measures in various areas. In terms of sickness and policy, the key proposal is the introduction of a new *Employment and Support Allowance* (ESA) for claimants assessed as having “limited capability for work” because of a health condition or disability.

Impact assessment has not been completed for these regulations, as they have no impact on the private or voluntary sectors. However, an assessment of the impact of these regulations on the public sector has been made and shows a prospective decrease of expenditure on sick benefits and incapacity benefits.

In the *Netherlands* the target of the introduction of a more activating social security system was pursued with the introduction of the Work and Income (Capacity for Work) Act (WIA) on 29<sup>th</sup> December 2005. This is regarded as the final step in a policy process spanning several years. The process included the introduction of the Eligibility for Permanent Incapacity Benefit (Restrictions) Act (WVP), the Continued Payment of Wages During Illness Act (VLZ) and the reassessment operation. [...] With the introduction of the VLZ in 2005, the employer’s obligation to continue paying salary was extended from one to two years. As a result of this change, the number of new claimants in the WAO incapacity benefit system was very low in 2005. All these measures have helped reduce the number of new incapacity benefit claimants.

The reform has been seen as a redistribution of responsibilities from the State to the employers and thus as a form of privatisation of social security responsibilities. The shifting of responsibility for the income provision of sick employees to employers was based on the premise that employers did not take sufficient initiatives to reduce sickness and keep sick employees in the workplace. As mentioned already, the Dutch reform has been criticised seriously by the European Committee of Social Rights (the body supervising the European Social Charter) insofar as the system undermines the collective nature of the funding of the social security system. The Committee also considered “the situation not to be in conformity with the Charter because the report does not show that the right to sickness and invalidity benefits is effectively secured as a social security right under the new system”. The ILO Committee of experts reached similar conclusions. The Dutch government dismissed the charge. Nevertheless, additional legislative measures were undertaken to mitigate the possible negative effect of the abandonment of social partners of the social security schemes and the risk of discrimination of workers with a history of illness problems. The monitoring of developments by international bodies is still ongoing.

The Dutch experience shows that radical reforms in the field of social security can be undertaken but they must be subject to strict scrutiny and progressive adjustments.

## 6.5 Elements for the decision making process

*“The society pushes people with illness and disability into a situation of social exclusion that lies beyond their control. These critiques led to a revision of policies in favour of people with disabilities and the acceptance by policy-makers of the importance of environmental and attitudinal factors”<sup>223</sup>.*

The last section in the study presents possible recommendations on policies that could be implemented to maintain those people in active status, in terms of integration in the work process through the management of the illness at the workplace.

The overall challenge is to address the structural barriers to social inclusion actively in order to reduce them. In this specific case, the key issue is promoting all possible help to meet the needs of workers with partial work ability, encouraging them to stay at work instead of passing from sick leave to a disability pension (if not strictly necessary): the EU inclusion strategy holds that employment is the key route to integration and social inclusion, with unemployment representing the major factor of exclusion.

For effective illness/disability management at the workplace there are various interventions that can be implemented. In this respect, Europe appears fragmented with significant differences in terms of:

- expenditure on policies aiming at supporting disabled and sick workers,
- protection of sick workers needing long absence for complete recovery
- policies aiming at job regaining in terms of flexibility and specific reintegration measures
- from the private and market perspective, in terms of accessibility and opportunities available for those who could have the opportunity to regain an active life if supported by technologies.

Let us summarise some possible options in this direction following the same structure presented above; that is to say, from the perspective of the worker affected by a long-term illness, from the perspective of the caregiver and from the perspective of the community as a whole.

### 6.5.1 Policy suggestions from the perspective of the worker affected by a long term illness

#### a) To strengthen a supportive environment through information and advice to the worker, colleagues and management

A supportive environment is of great help to sick workers: they may feel accepted by the management and the colleagues even when, from time to time, they not feel able to carry out certain tasks which could cause them distress or when they present specific needs linked to the management of their illness. Sick workers may require to be absent from work to receive treatment; they may require more help to perform their job during their cancer journey, or specific support to facilitate their return to work after treatment.

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<sup>223</sup> European Foundation for the Improvement of Living and Working Conditions, *Illness, disability, and social inclusion*, 2003

It is essential for all parties to receive the appropriate and sufficient information, working for a change in attitudes in managements, colleagues and cancer patients - to make cancer or other long-term illnesses less of a taboo and help sick workers to regain work with much more serenity.

One way towards this achievement is information on the specific needs of sick workers, on specific policy provisions, on external support that is possible to activate.

To support effective reintegration of the worker, all workplaces should have a specific internal policy of sickness management at the workplace, which includes specific policies provisions, but can go beyond them. Examples of internal policies were presented in chapter V, as in this respect the role of NGOs appears to be fundamental. Some issues that could be considered are:

- All managers should have the responsibility to familiarise themselves with the policy and to work within its parameters. They should also have the responsibility to ensure that all staff are aware of the policy and understand their own and the organisation's responsibilities in respect of it;
- The sick employees should be asked about their needs and abilities, and a start should be made on developing good tools appropriate for company management;
- Managers should ensure that decisions on recruitment, promotion and access to training and other opportunities are made on the basis of merit and that a cancer/illness diagnosis (whether current or prior) does not result in unfair or discriminatory treatment;
- To support the introduction of work adjustments, such as changes to working hours, and adjustments to the workstation or office equipment;
- To ensure paid time off for treatment;
- To support a phased return if necessary.
- Last but not least: the literature shows that the return to work after cancer treatment without any medical or rehabilitation advice induces major problems in terms of work acceptance and dealing with health and psychological problems at the workplace. To make this transition smoother, it would be advisable to introduce relevant support helping workers to be better informed about returning to work through specific advice provided by occupational health and rehabilitation services.

b) To support the introduction of disability management initiatives addressed to workers affected by illnesses inducing disability

Developments in information technology, and in particular teleworking, can offer tremendous opportunities in terms of support to job regaining for people affected by illnesses or disability. New technologies play an increasing role both at home and at work.

If teleworking is a possible support to job regaining for people with illnesses or disability, the wide gap between countries in terms of ample e-accessibility represents an urgent priority, which should be tackled as soon as possible with policies promoting social inclusion through employment. As government services and important public information are becoming increasingly available online, ensuring that all citizens have access to public websites is as important as ensuring access to public buildings. On 12<sup>th</sup> May 2000, the EU Commission formally adopted a Communication on a 'Barrier Free Europe for People with Disabilities' (European Commission, 2000).

This focuses on how policies can give disabled people the right to mobility in areas such as the information society, the opening of the internal market for technical aids and the protection of disabled consumers' rights. Several EU programmes have addressed this issue: eAccessibility is now part of [eInclusion](#) in the [third pillar of i2010](#).

c) To improve the skill of ill workers

Considering that the higher the professional skill of the worker the easier he/she can deal with the return to job after a long illness, a possible route towards job reintegration is to promote a rise in the professionalism of the worker before her/his return to the workplace. It is obvious that the more the worker is skilled (and so adaptable to the changing situation) the less she/he is likely to be exposed to the risk of exclusion due to long-term illness. *“The skill content of the EU-25 working age population continues to rise, contributing to a more employable and adaptable workforce and in turn to increased employment and participation rates. Since employment rates are generally higher the greater the educational attainment level, this change in the skill structure of the working age population can be seen as a positive development for employment as a whole”*<sup>224</sup>.

A possible strategy for job retention is to foster vocational training and life-long learning enabling workers to perform a broader range of tasks, reconciling the loss of work capacity with the employer's organisational requirements. The issue of “learning” is closely linked to that of the modification of worker's tasks as an alternative solution to dismissal.

*6.5.2 Policy suggestions from the perspective of the caregiver*

a) To pay more attention, from the normative point of view, to the burden of the family and the care givers

Partners and other relatives can find it very hard to have to work and to take care of the sick person. It is both a question of time and mental strain. It might help both the patient and his or her spouse if they had a number of days at their disposal to take the patient to consult the doctor or receive treatment - without suffering loss of income. This would require changes in both the legislation and the minds of employers. In Europe, in most cases, the legislation does not consider the impact of cancer on the family: in some cases, this is considered only when the sick person is a child or is dying.

We consider it a priority to introduce norms aiming at supporting those who have responsibility for caring for persons affected by cancer or other long-term illnesses.

*6.5.3 Policy suggestions from the perspective of the community as a whole*

a) To introduce criteria to clarify the distinction between definition disability and illness

In Europe the distinction between sickness and disability is not clean-cut: some Member States have chosen definitions of disability, either explicitly or by default, which are much more inclusive and also protect people from discrimination based on sickness<sup>225</sup>. Other Member States have chosen definitions based firmly on the medical model, which reflect the Court's understanding of disability as set out in the decision mentioned in the study. As a result, the protection from employment discrimination provided to disabled people will continue to vary widely among the Member States.

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<sup>224</sup> See Council and Commission, *Employment in Europe 2006*, p. 53 ff.

<sup>225</sup> L. Waddington, ‘Implementing the Disability Provisions of the Framework Employment Directive: Room for Exercising National Discretion’ in A. Lawson and C. Gooding (eds), *Disability Rights in Europe: From Theory to Practice* (Oxford: Hart, 2005) 107 – 34).



The Court of Justice provided no guidance on how to distinguish between a chronic long-term sickness and a disability included within the scope of the directive, even though this divide marks the line between protection and no protection from discrimination and between duty and no duty of reasonable accommodation to be respected by the employer.

The 2008 EU Resolution on cancer<sup>226</sup> mentions this as a key point: it states, in point 34, that

- Member States and the Commission are asked to work towards the development of guidelines for a common definition of disability that may include people with chronic illnesses or cancer
- and in the meantime that Member States have not done so should act as quickly as possible to include those people within their national definitions of disability.

It is worth noting in this respect that the latest Joint Report on Social Protection and Social Inclusion (2007) reflects the increasing attention paid by Member States to measures promoting active labour market inclusion for disabled people, but nothing is said about chronic and long-term illness. Chronic illness seems to be more relevant from the general point of view of health protection (in terms of tackling health problems, reducing costs and promoting healthier lifestyles) than from those of job retention and the back-to-work perspective.

Member States should enact measures to reduce sickness burdens, also by increasing labour productivity and prolonging working life. In this respect, Member States and EU should pay attention to specific job reintegration policies taking into account the common features and specificities of long-term illness in the workplace, considering the peculiarities a chronic or long-term illness has in respect to disability.

#### b) To fight discrimination

Workers affected by long-term illnesses, and cancer in particular, mention discrimination in the workplace as one of the main problems they face while regaining active life. The Framework Equal Treatment Directive (FETD), 2000/78/EC, prohibits discrimination in employment, vocational training and membership in employment related organisations because of, among other grounds, disability, but unfortunately, it is not clear if this includes discrimination on the grounds of sickness. To begin with:

- it is essential to clarify whether the prohibition of discrimination on the grounds of disability includes discrimination on the grounds of sickness;
- or, if sickness is not considered a form of disability for the purposes of the Directive, it should be clarified whether the Directive prohibits discrimination on the grounds of sickness separately, and in this case it is essential to understand if sickness could be added to the list of protected grounds explicitly mentioned in the Directive.

Another suggestion is to promote a pan-European campaign to fight against discrimination of cancer patients (and other long-term illnesses) in the work place addressed in particular to employers, explaining that people with a reduced work capacity remain essential resources in society and maintain a useful role to play in the workplaces.

#### c) To involve NGOs

NGOs representing sick people normally have a thorough knowledge of their specific needs, of policy provisions, of best practices existing at a national and international level. The analysis that was carried out involving NGOs offers a clear picture of this.

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<sup>226</sup> P6\_TA-PROV(2008)0121 *Combating cancer in the enlarged European Union*

The specific role of these NGOs is to support sick people in daily and working life and, with their umbrella organisations, they are able to disseminate national good practices throughout Europe.

At the EU level it could be an advisable practice for the EC to invite a board of cancer patients and carers to preliminary discussions before new legislation concerning the conditions for European cancer patients is discussed and decided upon.

At the national level, institutions should work with NGOs to understand the specific needs of people with cancer and introduce specific norms adequate to the specific needs of sick workers.

Employers should incorporate NGOs best practice guidance into their sickness and disability policies to ensure that the workers get the right support when returning to work after cancer diagnosis.

#### d) To enhance prevention rather than tackle exclusion

Addressing the issue of chronic illness using the conceptual tools provided by EU health policies, for instance those designed around the idea of prevention, can also be useful. Some authors stress the crucial importance of early intervention. Indeed, once an individual has lost his/her work capacity (and in some cases his/her job) it is more difficult to implement a back-to-work strategy aiming at job retention or reintegration.

The argument for early intervention incorporates a number of principles:

- it is not inevitable for a health condition, regardless of its impact on function or activity, to result in exit from employment;
- it is better to prevent individuals from losing their job than invest in attempting to get them back to work after they become unemployed or inactive;
- early intervention is the most effective way to achieve job retention and reintegration;
- early intervention can only be effective if responsibility for action is located in the workplace;
- coordinated delivery of appropriate services and supports is essential for effective return to work<sup>227</sup>.

Specific attention in this respect should be incorporated in the regulations applying to sickness leave at the national level.

#### e) To promote a general integrated approach towards job reintegration

Only an integrated approach, which takes into account social determinants of disability as well as the social factors affecting job retention of people with chronic health conditions, will enhance the effectiveness of a policy designed to promote reintegration of workers with a chronic illness.

An integrated approach in considering the needs of workers calls for an integrated approach in terms of policies. Stronger integration of job-regaining policy for of sick workers could enhance the rate and the quality of job resumption in coherence with the overall EU strategy of inclusion through employment.

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<sup>227</sup> See Wynne R., Mcananey D., *Employment and Disability: Back to Work Strategies*, European Foundation for the Improvement of Living and Working Conditions, 2004

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## Annex to chapter II

### Statistical Annex

<i>Activity restriction in the past 6 months, of employed people by age (%) - Hampered in daily activities because of chronic conditions Total population, 2005</i>					
	<b>15 to 24</b>	<b>25 to 34</b>	<b>35 to 44</b>	<b>45 to 54</b>	<b>55 to 64</b>
	<b>years</b>	<b>years</b>	<b>years</b>	<b>years</b>	<b>years</b>
Austria	8.1	8.8	14.1	23.1	31.1
Belgium	8.8	10	11.5	15.1	19.1
Czech Republic	7.2	10.6	12	18.6	22.5
Cyprus	7.2	7.4	12.8	19.8	31.5
Denmark	12	6.4	8.3	10.2	12
Estonia	12.6	15.4	17	31.2	41.5
Finland	19.5	22.9	27.6	29.9	39.1
Germany	10.4	15.1	21.3	28.1	36.9
Greece	2.5	4.3	6.3	9	14.7
France	5.4	7.6	9.8	15	19.3
Hungary	7.7	9.5	14.5	24.1	32.4
Ireland	4.8	6.4	8.2	9.4	13.4
Italy	2.9	4.5	6.8	10.4	14.4
Latvia	14.9	15.2	16.6	25.4	33.2
Lithuania	8	11.1	14.4	19.5	27.6
Luxembourg	7.1	10	14.6	20.2	20.9
Malta	2.2	2.6	4	5.9	10.1
Netherlands	9.9	8.6	10.3	14.5	17.6
Poland	0.8	1.6	2.9	5.9	11.5
Portugal	4.8	5.7	12.8	20.4	36.4
Slovenia	13.7	11.2	16.5	21.7	20.5
Slovakia	8	9.2	13.3	20.4	23.3
Spain	7.6	10.6	11	14.2	20.6
Sweden	9.4	9.1	13.2	14.5	18.6
United Kingdom	5.7	7.7	10.3	13.6	16.1

**Eurostat**



Share of individuals regularly using the Internet: % of individuals who accessed the Internet, on average, at least once a week, 2007			
Netherlands	81	Slovakia	51
Denmark	76	Hungary	49
Finland	75	Slovenia	49
Sweden	75	Lithuania	45
Luxembourg	72	Spain	44
UK	65	Czech Rep	42
Germany	64	Poland	39
Belgium	63	Cyprus	35
Austria	61	Portugal (2004)	35
Estonia	59	Italy	34
France	57	Bulgaria	28
Latvia	52	Greece	28
<b>Eu 27</b>	<b>51</b>	Romania	22
Ireland	51	Malta	--

Source. Eurostat

E-government usage by individuals - total: Percentage of individuals aged 16 to 74 using the Internet for interaction with public authorities, 2007			
Denmark	58	Hungary	25
Netherlands	55	Slovakia	24
Sweden	53	Belgium	23
Luxembourg	52	Cyprus	20
Finland	50	Portugal	19
Germany	43	Latvia	18
France	41	Lithuania	18
UK	38	Italy	17
Ireland	32	Czech Rep	16
<b>Eu27</b>	<b>30</b>	Poland	15
Estonia	30	Greece	12
Slovenia	30	Bulgaria	6
Austria	27	Romania	5
Spain	26	Malta	--

Source. Eurostat

**Share of enterprises that have remote employed people who connect to the enterprise's IT systems from home, 2006; % (order by large enterprises)**

	<b>Large enterprises (250 employed persons or more)</b>	<b>Medium enterprises (50-249 employed persons)</b>	<b>Small enterprises (10-49 employed persons)</b>
Denmark	95	81	46
Netherlands	85	56	29
Sweden	84	59	34
UK	79	49	26
Finland	77	56	24
Belgium	71	50	21
Luxembourg	66	25	16
Germany	65	39	15
Slovenia	65	32	23
Austria	64	37	16
Cyprus	62	28	10
Ireland	59	38	20
<b>EU27</b>	<b>55</b>	<b>30</b>	<b>13</b>
Estonia	53	34	18
Greece	52	25	14
Portugal	49	21	7
Czech Republic	48	31	15
Spain	40	17	5
Hungary	36	16	8
Slovakia	34	17	12
Lithuania	30	13	11
Latvia	27	12	5
Italy	23	7	2
Romania	20	9	6
Bulgaria	17	10	9
Poland	15	8	3

## Expenditure in social protection across Europe

### Total expenditure on social protection - current prices (% of GDP)

	2005
Sweden	32.0
France	31.5
Denmark	30.1
Belgium	29.7
Germany	29.4
Austria	28.8
Netherlands	28.2
Eu 27	<b>27.2</b>
Uk	26.8
Finland	26.7
Italy	26.4
Portugal	24.7
(2004)	
Greece	24.2
Slovenia	23.4
Luxembourg	21.9
Hungary	21.9
Spain	20.8
Poland	19.6
Czech Rep	19.1
Malta	18.3
Ireland	18.2
Cyprus	18.2
Slovakia	16.9
Bulgaria	16.1
Romania	14.2
Lithuania	13.2
Estonia	12.5
Latvia	12.4

Source. Eurostat

### Social benefits per head of population by function (PPS)

	2005
Luxembourg	12694.2
Denmark	8260.0
Sweden	8222.2
Austria	7998.2
Belgium	7868.5
Netherlands	7740.1
France	7563.2
Germany	7275.3
Uk	7042.6
Finland	6618.8
Italy	6008.7
Eu 27	<b>5858.1</b>
Ireland	5443.7
Greece	4999.1
Spain	4663.5
Slovenia	4441.9
Cyprus	3743.6
Portugal (2004)	3731.2
Czech Rep	3181.4
Hungary	3101.5
Malta	3066.9
Slovakia	2190.1
Poland	2181.8
Estonia	1735.0
Lithuania	1544.8
Latvia	1329.9
Bulgaria	1216.8
Romania	1068.4

Source. Eurostat

## **Annex to chapter III: The Member States fiches of EU 27**

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France .....	19
Germany .....	23
Greece.....	25
Hungary .....	28
Ireland.....	31
Italy.....	33
Latvia .....	35
Lithuania .....	37
Luxembourg.....	41
Malta.....	42
The Netherlands .....	44
Poland .....	47
Portugal.....	50
Romania .....	52
Slovenia .....	54
Slovak Republic .....	56
Spain.....	58
Sweden.....	60
United Kingdom.....	63

The following country fiches have been drawn through the analysis in particular of:

- the European Social Insurance Platform (*The Structure of Social Insurance in Europe*)
- Missoc tables<sup>1</sup>
- Comparative studies, literature, and the contribution of other important sources, such as the National Strategic Reports, have been integrated to complete the analysis realised.
- Employment guidance services for people with disabilities: this database of employment guidance services contains case studies from 16 EU Member States. These have been selected on the basis that they adopt new or enhanced approaches providing employment services for the target group of people with disabilities or chronic illnesses. The database consists of employment guidance services that are relatively new, that seek to integrate a range of services, that seek to mainstream the target groups into general employment services and those that seek to provide integrated pathways to work. These cases are of potential interest to a range of people. These include professionals operating in employment guidance services, be they in the mainstream or specialist sectors, rehabilitation professionals, policy makers, employers and others.

Only in some case examples of an integrated approach towards job regaining have been found.

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<sup>1</sup> All the descriptions are widely quoted from following sources: a) The European Social Insurance Platform, *The Structure of Social Insurance in Europe* <http://www.esip.org/index.php?id=1>; b) Missoc database;

## Austria

Austrian social security is regulated by 'the social law' and includes health insurance, accident at work insurance, pension insurance and unemployment insurance. The financing of social security is characterised by a 'pay as you go-system'.

The Austrian sickness insurance branch is set up and managed by nine regional sickness funds (*Gebietskrankenkassen*) and eight company sickness funds (*Betriebskrankenkassen*). Further there are sickness funds for railwaymen and miners, public sector employees, farmers and trade and industry self-employed persons (all together 21 funds). These funds cover insurance for medical and social care and are responsible for collecting the contributions, including those due for the other insurance schemes (pension, accident, unemployment). The Austrian General Accident Insurance Institute (*Allgemeine Unfallversicherungsanstalt, AUVA*), a self-administrating public law body, is the main competent institution covering workers, employees, miners and self-employed persons against the risks at work. The AUVA is in charge of managing the scheme, which includes accidents at work and occupational diseases. Like in the other social security branches there are, in addition to the AUVA, special funds for certain professional groups (for example farmers). All together there are 4 accident insurance institutions.

The schemes are based on the principle of compulsory insurance. The means required to provide social security come mainly from contributions payable by the insured and, in the case of employees, by their employers as well. As far as these sources of income do not fully cover the benefits payable, the State assumes liability for the deficit in the form of a guarantee and provides a contribution from its general tax revenues.

In Austria, the competent institutions within the pension and accident-at-work insurances are particularly responsible for paying long-term care allowance (cash-benefits). But they also offer rehabilitation to the persons insured with them to prevent imminent reduction in fitness for work.

### Basic principles

The sickness benefit scheme is a compulsory social insurance scheme for employees with earnings-related benefits organised in terms of continuation of payment of wages and salaries by the employer.

### Beneficiaries

All employees in paid employment.

Unemployed persons receiving benefits from unemployment insurance (*Arbeitslosenversicherung*).

Participants of vocational rehabilitation.

### Duration of benefits

Sickness benefit (*Krankengeld*): Generally the legally stipulated minimum time period is 52 weeks. According to the insurance funds' statute, however, the sickness benefit can be extended to 78 weeks.

### Amount of the benefits

Sickness benefit (*Krankengeld*): 50% of gross wage or salary, 60% from 43rd day of illness.

Ceiling: € 3,840 per month. For persons with earnings below the marginal earnings threshold for compulsory insurance who are voluntary insured, the sickness benefit is € 122.54.

Qualifying period

Neither work period nor qualifying period required.

Special conditions for unemployed

No special conditions.

## **Belgium**

The Belgian social protection system is divided into one scheme for employees, one for self-employed persons and one for civil servants. The employees' scheme (employees and workers) is the most important; it receives the social contributions from employees and employers (via the employer), the state allowances and other funds and redistribute the corresponding amount to the different, functionally decentralised institutions (except the accidents at work branch).

Belgian social health insurance covers the whole population in the case of sickness, maternity and invalidity. It is run by the National Institute for Sickness and Invalidity Insurance (*Institut national d'assurance maladie-invalidité, INAMI*)<sup>2</sup>

### **Basic principles**

The protection system for sickness at workplace is based on a compulsory social insurance scheme mainly financed by contributions, covering the active population (employees and self-employed). For the employees in case of illness the continuation of payment of wages is provided by the employer during a limited period (guaranteed salary); then, income related benefits are paid by the mutual insurance fund. For the self-employed lump-sum benefits are provided.

### **Beneficiaries**

All workers bound by a contract of service and categories assimilated thereto. Specific rules concern the self-employed.

There is no possibility of voluntary insurance.

### **Duration of benefits**

Maximum of one year (period of "primary incapacity for work").

The compensation insurance starts when the guaranteed salary period paid by the employer is over. This means after two weeks of disability for workers and one month for employees.

### **Amount of the benefits**

General rule concerning the compensation insurance: 60% of earnings. Exception: since the 31st day of disability for co-habitant recipients: 55% of earnings. Ceiling taken into account for the compensation: € 110 per day for incapacities occurred since 1.1.2007, € 109 per day for incapacities occurred from 1.1.2005 to 31.12.2006 or € 107 per day for incapacities occurred before 1.1.2005. (to be checked)

### **Qualifying period**

Period of work and membership required: 6 months, in which 120 days of work or assimilated periods (unemployment, legal holidays, etc.).

Proof of payment of minimum amount of contributions.

To have ceased all activities because of reduction of earning capacity of at least 66%

### **Special conditions for unemployed**

The incapacity benefit during the first six months cannot be less than the unemployment benefit.

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<sup>2</sup> European Social Insurance Platform, The Structure of Social Insurance in Europe



Examples of an integrated approach towards job regaining

Flemish Public Employment Service, Belgium	
<p><b>Country:</b> Belgium  <b>Target Groups:</b> people with disabilities or illnesses  <b>Initiative type:</b> general careers guidance, work placements, training, job search support, job application support, financial support and advice</p>	<p>The Flemish Public Employment Service (Vlaamse Dienst voor Beroepsopleiding en Arbeid-sbemiddeling, VDAB) has a department that deals specifically with people with disabilities: VDAB-Diensten voor Personen Met Handicap. This unit directs people with disabilities to a variety of services which aim to help people in this group to find a job. Such jobs are either secured in the 'normal' work environment or in sheltered workplaces.</p>

Flemish Emancipation Affairs Service, Belgium	
<p><b>Country:</b> Belgium  <b>Target Groups:</b> people with disabilities or illnesses  <b>Initiative type:</b> work placements, job application support</p>	<p>The Emancipation Affairs Service of the Ministry of the Flemish Community – an Equality and Non-discrimination Agency – has started an initiative to employ people with a disability. The basic premise is that those with a disability should be able to obtain a role that has been adjusted to their needs. The Flemish Community administration has developed a project entitled 'Wervend Werven' for 2007–2009, which aims to promote the employment of people with a disability within the administration. By 2010, it hopes that disabled persons will constitute 4.5% of its staff.</p>

Vooruitzenden project, Belgium	
<p><b>Country:</b> Belgium  <b>Target Groups:</b> the short-term unemployed, people with disabilities or illnesses  <b>Initiative type:</b> general careers guidance, work placements, job search support, job application support</p>	<p>A temporary work agency initiative aims to ensure that people who have acquired disabilities during a previous job can be reintegrated in the labour market, through an interim position. The project is known as Training Funds for Temporary Workers (Vormingsfonds voor de uitzendkrachten/Fonds de formation pour les interimaire, Vooruitzenden). In addition, the initiative tries to enhance local cooperation between personal assistants of people with disabilities and the agencies' offices. The agency, Adecco, has utilised local subsidies in two successful pilot projects in Flanders and Wallonia</p>

Flemish Federation of Sheltered Workplaces, Belgium	
<p><b>Country:</b> Belgium</p>	<p>'Beschutte werkplaatsen' or work shelters offer a</p>

<p><b>Target Groups:</b> the long-term unemployed, the short-term unemployed, people with disabilities or illnesses</p> <p><b>Initiative type:</b> work placements, job application support, confidence building</p>	<p>sheltered working environment, as well as specific training, to prepare people with a disability for their reintegration into 'normal' working environments. The service is managed by the Flemish Federation of Sheltered Workplaces (Vlaamse Federatie van Beschutte Werkplaatsen). To support participants in their transition to the regular labour market, they also receive the help of Job Pathway Support (Arbeidstrajectbegeleidingsdienst, ATB).</p>
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### Success Network, Belgium

<p><b>Country:</b> Belgium</p> <p><b>Target Groups:</b> people with disabilities or illnesses</p> <p><b>Initiative type:</b> general careers guidance, work placements, training, job search support, job application support, confidence building, environmental adaptations, awareness raising</p>	<p>The Walloon Success Network (Réseau Wallon des réussites) is an initiative launched by the Minister of Social Affairs and Health in the Walloon region of Belgium, Thierry Detienne. It aims to match jobseekers who have disabilities with prospective employers who are willing to employ people with disabilities. This is done through a website which offers several facilities such as job offers, job vacancies, employment information and a discussion forum to exchange experiences.</p>
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### Agency for the integration of people with disabilities, Belgium

<p><b>Country:</b> Belgium</p> <p><b>Target Groups:</b> people with disabilities or illnesses</p> <p><b>Initiative type:</b> general careers guidance, work placements, training, job search support, job application support, financial support and advice, confidence building, environmental adaptations, awareness raising</p>	<p>The Walloon agency for the integration of people with disabilities (Agence Wallonne pour l'intégration des personnes handicapées, AWIPH) promotes and enhances opportunities for people with disabilities to find paid employment, in both the regular labour market and in sheltered work environments. The initiative advises and supports people with disabilities who are seeking employment, and emphasises the importance of integration to employers. It also offers information on financial assistance which is available to both employees with disabilities and to employers to assist in occupational integration.</p>
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## **Bulgaria**

The National Social Security Institute (NSSI) is a public organization which is compulsory for all employers and for self-employed not earning less than the national minimum income. The insurance is fee based, paid by the employer and employee. The NSSI administers the mandatory insurance programmes for disability, old age and survivors' benefits, sickness and maternity, work injuries and occupational diseases as well as control and information services for citizens.

The NSSI, on the basis of the Code for the Obligatory Public Insurance, guarantees the citizens' right to pensions and benefits. The Institute manages the funds of the state social security, as for example the National Health Insurance Fund (NHIF), and is responsible for the development, operation and management of the compulsory health insurance scheme.<sup>3</sup>

### **Basic principles**

The Bulgarian protection system for sickness at workplace is based on Social insurance contributory scheme providing earnings-related benefits for economically active persons.

### **Beneficiaries**

Compulsory insurance is provided for: Employees working for more than five working days or 40 hours per calendar month, civil servants, employees, executives, paid and active members of co-operatives in many sectors. Other specific categories may join voluntarily such as registered free lance professionals and craftsmen, sole entrepreneurs owners or partners in commercial companies, registered farmers, working pensioners.

### **Duration of benefits**

Paid from the second day of illness until the recovery of capacity for work or the establishing of invalidity.

### **Amount of the benefits**

The daily cash benefit is 80% of the average daily gross earnings or the average daily contributory income on which contributions have been paid for the period of six calendar months preceding the occurrence of the incapacity for work but no more than the average daily net remuneration for the period on the basis of which the benefit is calculated (for earnings ceilings see Table I "Financing").

### **Qualifying period**

Minimum period of insurance: 6 months.

No qualifying period required for insured persons under the age of 18 years.

### **Special conditions for unemployed**

Payment of the cash unemployment benefit shall be suspended for the period during which the person receives a temporary disability benefit.

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<sup>3</sup> Gesellschaft für Versicherungswissenschaft – und Gestaltung (2003), Study on the Social Protection Systems in the 13 Applicant Countries - Bulgaria Country Study. DG Employment and Social Affairs. Brussels

## Cyprus

The current social insurance scheme, operative since October 1980, incorporates the previous flat-rate scheme, in a modified form, and supplementary earnings-related benefits.

Thus, the scheme is divided into two parts: the basic part, corresponding to the repealed flatrate scheme, and the earnings related part.

The scheme compulsorily covers every person gainfully occupied in Cyprus, employed and self-employed alike. Benefits which are granted under the Social Insurance Scheme include marriage grant, maternity grant, funeral grant, maternity allowance, sickness benefit, employment benefit, invalidity pension, old age pension, widows pension, orphan's benefit, missing person's allowance, employment injury benefit, temporary incapacity disablement benefit and death benefit.

Between the benefits granted under the Social Insurance Scheme provided that the beneficiaries fulfil the contribution conditions, there are the *Sickness benefit* and *invalidity pension*, that is payable to persons who have been incapable for work for at least 156 days and are expected to remain permanently incapable for work i.e. unable to earn from work which they are reasonably expected to perform, more than 1/3 of the sum earned usually by a healthy person of the same occupation and education in the same area, or more than 1/2 of the aforesaid sum in the case of persons between the ages from 60 to 63. In addition a *disablement benefit* may take the form of either a grant (lump sum) or a pension, depending on the degree of disablement.<sup>4</sup>

### Basic principles

The sickness benefit scheme is a compulsory social insurance scheme financed by contributions covering the active population (employees and self-employed) providing earnings-related pensions and other benefits depending on contributions and the duration of affiliation.

### Beneficiaries

Employees, self-employed persons; voluntary insurance possible for persons working abroad in the service of Cypriot employers.

### Duration of benefits

Sickness benefit is payable up to 312 days (one year) in each period of interruption of employment: Basic (Βασικό Επίδομα) and Supplementary Benefit (Συμπληρωματικό Επίδομα) are payable for 156 days. If the beneficiary is still incapable to work after the 156 days but is not expected to remain permanently incapable to work, then the Sickness Benefit (Επίδομα Ασθενείας) may be extended to 312 days.

### Amount of the benefits

*Basic Benefit (Βασικό Επίδομα)*: 60% of the lower part of weekly average insurable earnings over the benefit year, increased by 1/3 for the first dependant and by 1/6 for other dependants (maximum of three dependants). A spouse (male or female) is a

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<sup>4</sup> European Social Insurance Platform, The Structure of Social Insurance in Europe  
<http://www.esip.org/index.php?id=1>

dependant if he/she is neither working nor receiving any benefit from the Social Insurance Fund (Ταμείο Κοινωνικών Ασφαλίσεων).

In the case where the spouse is not a dependant of the beneficiary, the increase for the dependant children is equal to the 1/6 of the basic benefit for each child (maximum number of dependant children: two).

*Supplementary Benefit (Συμπληρωματικό Επίδομα):* 50% of the upper part of weekly average insurable earnings over the benefit year. Maximum weekly amount of supplementary benefit cannot exceed weekly Basic Insurable Earnings (Βασικές Ασφαλιστέες Αποδοχές).

#### Qualifying period

The insured person has been insured for at least 26 weeks up to the date of incapacity. Lower part paid insurable earnings up to the date of incapacity equal to at least 26 times the weekly Basic Insurable Earnings<sup>5</sup> (Βασικές Ασφαλιστέες Αποδοχές): € 142 per week; and paid and credited insurable earnings in the benefit year are at least equal to 20 times the weekly amount of Basic Insurable Earnings.

#### Special conditions for unemployed

**No special conditions.**

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<sup>5</sup> Lower part of insurable earnings: insurable earnings up to Basic Insurable Earnings.

Upper part of insurable earnings: insurable earnings over Basic Insurable Earnings.

Benefit year: Starts the first Monday of July and ends the last Sunday prior to the first Monday from which the next benefit year starts.

## **Czech Republic**

The Czech Republic's social security system is based on the principle of mutual and intergenerational solidarity. This principle is largely applied to redistribution under the state social support and social care benefits system from which the state guarantees payment of benefits from the state budget only to a certain group of people. The Czech Republic's social security system secures citizens against the following risks: sickness, accident, disability, old-age, death, childbirth and unemployment. The Czech legislation distinguishes between two separate mandatory insurance systems: the health insurance system and the social security system, which includes pension insurance, sickness insurance and unemployment insurance. The Czech Social Security Administration (ČSSZ) is responsible for sickness and pension insurance for almost all people in the Czech Republic. The ČSSZ comprises a medical assessment service responsible for the evaluation of the state of health and ability to work of the insured persons for the purposes of social security, state social support, social care, etc.

As of 31 December 2004, 4.091.242 employees and 267.524 self-employed persons were registered for the sickness insurance. Employees are required to register for the sickness and pension insurance by law. Self-employed persons may register for the sickness insurance voluntarily.

The social security system is funded on a continuous basis. This means that the expenses for benefits in a given period are covered by income from the contributions collected in the same period. The funding is governed by Act No. 589/1992 Coll., on Social Security Contributions and the State Employment Policy Contributions, as amended. Pursuant to the Act, social security contributions (for sickness and pension insurance) and contributions to the state employment policy are collected and represent income to the state budget.

Contributions are paid by employees, employers and self-employed persons and the amount is defined by a percentage rate of the assessment basis determined for the reference period.

### **Basic principles**

Sickness benefits in cash fall into the scope of activity of the Czech Social Security Administration. It is a compulsory social insurance scheme for employees with earnings-related benefits. Self-employed can access a voluntary insurance.

Its purpose is to replace income (wage, salary) in case of sickness. The sickness and maternity insurance covers four types of benefits: the sickness benefit, family member care benefit, pregnancy and maternity compensation benefit and the maternity benefit. The sickness insurance of self-employed persons covers two types of benefits: sickness and maternity benefits<sup>6</sup>.

The Czech system does not include accident insurance as a separate branch. The benefits awarded in respect of accidents at work and occupational diseases equal to the

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<sup>6</sup> SSZ The District Social Security Administrations execute sickness insurance for self employed persons and employees of small enterprises (up to 25 employees), manage the execution of the sickness insurance in organisations where sickness insurance benefits are paid, carry out assessments of the state of health of citizens for the purposes of social security, monitor the assessment of temporary disability to work and collect social security contributions

benefits granted in respect of diseases due to general causes and are paid from the same system (benefits in kind from the health insurance, benefits in cash from the sickness insurance and pensions from the pension insurance). There are some partial differences in the amounts of benefits in cash awarded and in the conditions of entitlement to these benefits.”<sup>7</sup>

#### Beneficiaries

Compulsory for all employees.

Voluntary insurance for the self-employed.

#### Duration of benefits

1 year (maximum of 84 days per year for old-age or invalidity pensioners who are still employed).

The sickness insurance benefits are granted for calendar days. Sickness benefits are granted for a maximum period of one year from the beginning of incapacity for work, however, no longer than the incapacity for work lasts and only until full or partial disability has been acknowledged.

#### Amount of the benefits

25% of the Daily Assessment Base (Denní vyměřovací základ) for the first 3 days and thereafter 69% of the Daily Assessment Base.

Daily Assessment Base is calculated using gross monthly earnings which are taken into account as follows: up to € 19: first 14 days 90%, then 100%, € 19 to € 27: 60% earnings over € 27 are not taken into account.

#### Qualifying period

Employees: Neither work period nor qualifying period is required.

Self-employed: Participation in self-employed persons' sickness insurance for the minimum period of 3 months prior to the temporary incapacity to work occurred.

#### Special conditions for unemployed

No special conditions.

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<sup>7</sup> European Social Insurance Platform, The Structure of Social Insurance in Europe  
<http://www.esip.org/index.php?id=1>

## **Denmark**

Danish social policy is basically structured according to the Nordic welfare state model with a large public sector offering various services in the social field, in many cases free of charge. Social security as a whole encompasses a public basic coverage for all Danish citizens as regards invalidity, old age, health care, sickness and maternity benefits as well as wide ranging benefits for families with children, a supplementary pension scheme for employed persons, industrial injury insurance as well as unemployment insurance. A major part of social security is financed wholly out of general taxation, with the State, the local authorities and the counties bearing the largest share of the total social security expenditure. However, contributions from employers, wage-earners and self-employed are paid into three 'Labour Market Funds' in order to finance unemployment benefits, early retirement benefits, sickness and maternity benefits, and employment measures. Since 1999, one single Labour Market Fund (*Arbejdsmarkedsfonden*) has replaced the above three funds. The respective labour market contribution are transferred to the tax authorities. There is no link between the contributions paid and the right to benefits.

The system include social pensions with the traditional old age pension, special old age and partial retirement pensions as well as different forms of invalidity pension including anticipatory pension (on health related and on social criteria). These pensions are integrated into a coherent but complex set of rules. Social pensions are financed through taxation and are not based on any form of insurance. They consist of a basic amount and a means-tested pension supplement which is subject to taxation<sup>8</sup>.

### **Basic principles**

Sickness benefits belong to the tax-financed protection scheme for the active population (employees and self-employed) with earnings-related benefits.

Cash benefits in the case of sickness and maternity are paid by the local authorities (within the guidelines of the Ministry of Social Affairs).

### **Beneficiaries**

All employees and self-employed (including helping spouse), or persons who have just completed a vocational training course for a period of at least 18 months and persons doing a paid work placement as part of a vocational training course, or unemployed entitled to benefits from unemployment insurance or similar benefits (anti-unemployment measures). Persons in a "flexible job" with a private or public employer.

### **Duration of benefits**

52 weeks in 18 months; for pensioners or people who have reached the age of 65 (67 in special cases) not more than 13 weeks in a 12-month period

The first two weeks of a period of sickness are not included.

Benefits can be paid for a longer period under certain conditions, for example when beginning a probable re-education process, when the municipality starts the analysis of an application for disability pension or in the case of employment injury. Similarly when an ill person work capacity seems recoverable. If necessary, benefits can be paid for a longer period up to 26 weeks, in order to test the ill person work capacity.

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<sup>8</sup> European Social Insurance Platform, The Structure of Social Insurance in Europe



The local authorities carry out control. Every 8 weeks they assess the possible steps to take. At the first control and at the last one after 6 months of illness during a period of 12 months, the local authorities will draw up a future assistance plan to be proposed to the ill person. If the work capacity is not recovered, the local authorities must start the procedure leading to an invalidity pension.

#### Amount of the benefits

Salaried workers: Sickness cash benefit (sygedagpenge) calculated upon the basis of the hourly wage of the worker (contributions to Labour Market Fund, Arbejdsmarkedsfonden, deducted), with a maximum of € 459 per week or € 12 per hour (37 hours per week), and upon the number of hours of work.

Period to be covered by the employer: 2 weeks.

Self-employed: Sickness cash benefit calculated on the basis of the earnings from the occupational activity of the self-employed person, with the same maximum as mentioned above. The self-employed persons who have taken out a voluntary insurance are entitled to at least 2/3 of the maximum amount.

#### Qualifying period

Salaried workers: the employer pays the benefits for a minimum working period of 74 hours during the 8 weeks immediately preceding the sickness.

The municipality pays the benefits for a period of work of at least 120 hours in 13 weeks immediately preceding illness and for specific categories (unemployed, workers in flexible jobs, or during a training activity etc).

Self-employed: Professional activity on a certain scale for a duration of at least 6 months within the last 12 month period, of which one month immediately precedes the illness.

Voluntary insurance for self-employed and helping spouse: 6 months period (except work injury and persons who have recently set themselves up as self-employed persons and become member of the insurance within three months after the termination of their salaried activity).

#### Special conditions for unemployed

The unemployed and persons participating in labour market measures are entitled to the same amount they would have received had they not fallen ill, with the maximum amount indicated above.

## **Estonia**

The social security system consists of the following programs: the pension system, the health insurance system, the family benefit system, and the unemployment benefit system.

The social assistance, the family benefit system and the social benefits to the disabled are non-contributory schemes financed by the Government. For access to social security benefits, residence and fulfilment of a qualification period (in employment or equalised activity) is necessary. It is granted on an individual basis. The pension scheme consists of four sub-schemes: national pensions, old-age pensions, invalidity pensions and survivors' pensions. The unemployment benefit system is funded by the unemployment insurance contributions.

The social insurance programmes are financed and administered by the social fund, the health insurance fund and the employment fund.

The pension and health system are contributory social security schemes funded by social taxes. The employers pay the social taxes (33% of pay, composed by 20% for pensions and 13% for health insurance) to the social funds and health insurance fund, while no social taxes are imposed on the employees. Health insurance is also granted to pensioners, children, registered unemployed, military, persons on parental leave.

The health scheme consists of three schemes: services of medical treatment, sickness/maternity cash benefits and compensations for pharmaceuticals. Occupational accidents and diseases are integrated into the health and pension insurance schemes. The health care is partially controlled by the Government, by the county administrations and municipalities. The organisation of social assistance, home assistance, care/nursing services and institutions, and care for children, the elderly and the disabled is of the responsibility of the municipalities.<sup>9</sup>

### **Basic principles**

The sickness benefit scheme is a compulsory social insurance scheme for the active population (employees and self-employed) with earnings-related benefits.

### **Beneficiaries**

All employees and self-employed, on whose behalf Social Tax (sotsiaalmaks) has been paid.

### **Duration of benefits**

Up to 182 calendar days per case of illness. In case of tuberculosis up to 240 calendar days per case of illness.

### **Amount of the benefits**

80% of the reference wage in cases of illness.

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<sup>9</sup> Bernotas D., Guogis A., Evaluation of Social Security in Lithuania, Latvia and Estonia: Achievements and Drawbacks. <http://palissy.humana.univ-nantes.fr/msh/costa15/pdf/nantes/guogis.pdf>; Leppik L. (2001), Social security system in Estonia. [http://www.socialsecurity.fgov.be/bib/frames/engels/btsz\\_01\\_2001\\_leppik.htm](http://www.socialsecurity.fgov.be/bib/frames/engels/btsz_01_2001_leppik.htm)

100% of the reference wage in cases of work injury, occupational disease or other health impairment connected to work caused by the fault of the employer and incapacity for work caused in the course of defence of the State, interests of society or in the course of preventing a crime.

Reference wage: average gross daily wage over the previous calendar year calculated on the basis of income liable to Social Tax (sotsiaalmaks). No ceiling.

Qualifying period

Waiting period of 14 days is required as of the commencement of employment or service.

Special conditions for unemployed

No special conditions.

Examples of an integrated approach towards job regaining

Career guidance course, Estonia	
<p><b>Country:</b> Estonia  <b>Target Groups:</b> the long-term unemployed, unemployed with additional job seeking needs, people with disabilities or illnesses, men, women, job seekers over 50 years of age, job seekers under 30 years of age  <b>Initiative type:</b> general careers guidance, job search support, job application support, confidence building, awareness raising</p>	<p>The objective of the career guidance course is to support participating students in finding trainee placements and to prepare them for the open labour market. The main outcome of the initiative carried out at the Astangu Vocational Rehabilitation Centre is that participating students are ready to enter the labour market.</p>

Supported employment services, Estonia	
<p><b>Country:</b> Estonia  <b>Target Groups:</b> people with disabilities or illnesses  <b>Initiative type:</b> general careers guidance, work placements, training, job search support, environmental adaptations, awareness raising</p>	<p>The objective of this initiative, which is among the services provided by the Astangu Vocational Rehabilitation Centre (Astangu Kutserehabilitatsiooni Keskus), is to find suitable employment for clients with disabilities in cooperation with employment specialists. It is intended that clients who have learned new skills during their vocational training will enter the open labour market, work in a regular environment and be capable of maintaining a job.</p>

## **Finland**

The Finnish social security system is based on the Nordic welfare state model and predominantly consists of: a comprehensive basic benefit scheme to secure people's livelihood - with *Kansaneläkelaitos (KELA)* being the competent institution for these financial benefits; earnings related benefits to ensure a reasonable level of consumption in various risk situations and municipal social services, rehabilitation, health care and medical care (benefits in kind) which are funded mainly by tax revenues and which are equally accessible to the entire population.

The system of national sickness insurance administered by the Social Insurance Institution (KELA) supplements the public health care system. National sickness insurance is funded through contributions by employers and insured employees. The Government is responsible for ensuring the adequacy of the health insurance funds. National and earnings-related pension schemes include a wide range of benefits including old-age pensions and early old-age pensions, disability pensions, cash rehabilitation benefits (temporary disability pension), individual early retirement pensions (for persons born 1943 or earlier), unemployment pensions (for persons born before 1950) and survivors' pensions.

### **Basic principles**

The sickness benefit scheme is a universal compulsory sickness insurance scheme for all residents with earnings-related benefits and in some cases a minimum/flat rate benefit.

Part-time sickness allowance for an employee or for a self-employed person who has been on a sick leave for an uninterrupted period of at least 60 days.

### **Beneficiaries**

All residents aged 16-67.

In addition, non-resident employed or self-employed persons working in Finland for at least 4 months are immediately covered.

### **Duration of benefits**

For the same illness, limited to 300 days (excluding Sundays) over a 2-year period.

### **Amount of the benefits**

Daily amounts dependent on annual earnings:

- earnings under € 1,128: payable only if sick leave lasts more than 55 days with limitations: € 15.20 per week day.
- earnings € 1,128 - € 29,392: 70% of 1/300 earnings;
- earnings € 29,393 - € 45,221: € 66.27 plus 40% of 1/300 of earnings exceeding € 29,392;
- above € 45,221: € 88.66 plus 25% of 1/300 of earnings exceeding € 45,221.

The amount of part-time sickness allowance is 50% of the amount of preceding sickness allowance.

### **Qualifying period**

Neither work period nor qualifying period required.

### **Special conditions for unemployed**

If an unemployed person received unemployment benefits for at least 4 months, the sickness benefit will amount to at least 86% of the unemployment benefit.

Examples of an integrated approach towards job regaining

Employment service centres, Finland	
<p><b>Country:</b> Finland  <b>Target Groups:</b> the long-term unemployed, unemployed with additional job seeking needs, people with disabilities or illnesses, men, women, job seekers over 50 years of age, job seekers under 30 years of age  <b>Initiative type:</b> general careers guidance, work placements, training, job search support, job application support, financial support and advice, confidence building, environmental adaptations</p>	<p>The services of the Employment Service Centres (ESCs) are based on multi-professional individual counselling. The centres are joint service points for local authorities, including employment offices, municipal social and health services and social insurance services, as well as other service providers. ESCs offer a variety of rehabilitation and activating services for their clients.</p>

Social enterprises, Finland	
<p><b>Country:</b> Finland  <b>Target Groups:</b> the long-term unemployed, people with disabilities or illnesses  <b>Initiative type:</b> work placements, training, financial support and advice, confidence building</p>	<p>Social enterprises (Sosiaalinen yritys) are a new form of enterprise which aim to provide work opportunities for people with disabilities or those who are long-term unemployed. The public employment service aims to support jobseekers' employment in the open labour market, as well as improving their labour market potential. The legislation on social enterprises thus gives a more solid status to enterprises of this kind which are already established, in addition to supporting the establishment of new businesses.</p>

## France

France has one of the most comprehensive social security systems in Europe. The '*régime général*' is the main single scheme covering the majority of insured people, in principle all wage-earners, regarding sickness, maternity, old age, invalidity, death, survivors, accident at work and occupational diseases as well as family benefits.

Besides the '*régime général*' there are several other schemes divided by profession: the autonomous schemes (*régimes autonomes*) for independent occupations other than agriculture (manual workers, traders, liberal professions, ...) as well as the special schemes (*régimes spéciaux*) that partly or wholly manage the social security of occupational groups in public services (civil servants, agents in the SNCF, EDF-GDF,...). There is also the '*régime agricole*' covering employees and self-employed people in the agricultural sector. Except for the latter, all schemes fall under the authority of the Ministry of Solidarity, Health and Family.

In August 2004, the National Union of Health Insurance Funds (UNCAM – Union Nationale des Caisses d'Assurance Maladie) was created in order to have a more comprehensive framework in the health field. The CNAMTS (Caisse nationale d'assurance maladie des travailleurs salariés) is the main component of the UNCAM. It covers about 85% of the population.<sup>10</sup>

### Basic principles

The sickness benefit scheme is a compulsory social insurance scheme with earnings or income-related benefits.

### Beneficiaries

All working population except for certain self-employed.

### Duration of benefits

General scheme for employees (Régime général d'assurance maladie des travailleurs salariés, RGAMTS): 12 months (360 days) per period of 3 consecutive years, but until the end of 36th month for long-term sickness.

### Amount of the benefits

General scheme for employees (Régime général d'assurance maladie des travailleurs salariés, RGAMTS):

- 50% of daily earnings, in a limit of 1/720th of the annual ceiling, maximum € 44.70.
- 66.66% of daily earnings with a limit of 1/540th of the annual ceiling from 31st day for beneficiaries with 3 children, maximum € 59.60.

### Qualifying period

General scheme for employees (Régime général d'assurance maladie des travailleurs salariés, RGAMTS): Payment of a minimum of contributions on the basis of N. times the minimum wage (salaire minimum interprofessionnel de croissance, SMIC) of € 8.44 per hour on 01.07.2007 or minimum duration of activity:

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<sup>10</sup> European Social Insurance Platform, The Structure of Social Insurance in Europe

- For the first 6 months: 1,015 SMIC in the 6 preceding months or 200 hours worked in the previous 3 months.
- After 6 months and having been registered for a minimum of 12 months since having stopped working: 2,030 SMIC in the 12 previous months, including the 1,015 SMIC of the first 6 months or 800 hours worked in the 12 previous months, 200 of which in the first 3 months.

#### Special conditions for unemployed

General scheme for employees (Régime général d'assurance maladie des travailleurs salariés, RGAMTS): No special conditions.

#### Examples of an integrated approach towards job regaining

ESAT initiative, France	
<p><b>Country:</b> France  <b>Target Groups:</b> people with disabilities or illnesses, men, women  <b>Initiative type:</b> work placements, confidence building, environmental adaptations</p>	<p>The main objective of the ESAT initiative (Les établissements ou services d'aide par le travail) is to facilitate integration into the mainstream labour market for people with disabilities. The initiative covers all people with disabilities and is unique in France. In 2005, some 32 people with disabilities used the service.</p>

Delta Insertion, France	
<p><b>Country:</b> France  <b>Target Groups:</b> people with disabilities or illnesses, men, women  <b>Initiative type:</b> work placements, training, job search support, job application support, environmental adaptations</p>	<p>The 'Delta Insertion' project aims to help those with disabilities to build a career in mainstream employment after they have taken part in the standard employment service for disabled persons, known as ESAT (Les établissements ou services d'aide par le travail). At the end of the employment placement, Delta Insertion supports and maintains the people with disabilities in their job.</p>

Isatis, France	
<p><b>Country:</b> France  <b>Target Groups:</b> people with disabilities or illnesses, men, women  <b>Initiative type:</b> work placements, training, job search support, job application support, confidence building</p>	<p>The Isatis project aims to provide individual support for people with disabilities, by identifying and improving their technical and social skills, and helping them to accept and live with their physical and/or mental limitations. Isatis organises workshops and offers customised training, company-based vocational courses, accommodation for a few participants, as well as personalised support and regular assessments.</p>

Functional re-education and rehabilitation centre, France	
<p><b>Country:</b> France</p>	<p>The CMRRF (Centre Mutualiste de Rééducation et</p>

<p><b>Target Groups:</b> people with disabilities or illnesses, men, women</p> <p><b>Initiative type:</b> training, job search support, job application support, confidence building, environmental adaptations, awareness raising</p>	<p>de Réhabilitation fonctionnelles) is a functional re-education and rehabilitation centre in Kerpape in Brittany. The centre provides support to 500 people who require re-education and rehabilitation care within the framework of full-time hospital care, day care or outpatient services. Its aim is to help people with disabilities to integrate or reintegrate into the labour market and to support them in realising their projects in terms of education, training or remaining in employment when possible.</p>
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#### Messidor, France

<p><b>Country:</b> France</p> <p><b>Target Groups:</b> people with disabilities or illnesses, men, women</p> <p><b>Initiative type:</b> work placements, training, job search support, confidence building</p>	<p>The Messidor initiative targets people who have had a mental illness and aims to support their return to employment. Under this initiative, people are placed in small work teams of about five to six people in factories that are suitably adapted to their needs. An employee in charge of the manufacturing unit and a job integration advisor work closely with these workers and regularly evaluate their progress.</p>
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#### Passmo, France

<p><b>Country:</b> France</p> <p><b>Target Groups:</b> people with disabilities or illnesses, men, women</p> <p><b>Initiative type:</b> work placements, job search support, environmental adaptations</p>	<p>The Passmo project aims to enable disabled workers who are working in sheltered employment services for people with disabilities – ESAT (Les établissements ou services d’aide par le travail) – to gain employment in a company. In implementing this initiative, funding has been given to the companies involved in the project over the past three years, in order to compensate for lower productivity and the time required by disabled workers to adapt to their new employment circumstances.</p>
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#### Sickness insurance fund of Île-de-France, France

<p><b>Country:</b> France</p> <p><b>Target Groups:</b> the long-term unemployed, the short-term unemployed, people with disabilities or illnesses, men, women, job seekers over 50 years of age, job seekers under 30 years of age</p> <p><b>Initiative type:</b> training, job search support, confidence building, environmental adaptations, awareness raising</p>	<p>The Sickness insurance fund of the Île-de-France region aims to allow people with disabilities to access or return to reliable and sustainable employment. The initiative seeks in particular to give people with disabilities the chance to use new information and communication technologies, gain experience in a professional environment and avail of employment services.</p>
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#### Salva Vita work experience programme, Hungary

<p><b>Country:</b> Hungary</p>	<p>The Salva Vita Foundation launched its first pilot</p>
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<p><b>Target Groups:</b> people with disabilities or illnesses, men, women</p> <p><b>Initiative type:</b> work placements, training, confidence building</p>	<p>work experience programme in Budapest in 1996, involving a school module to promote integrated employment for young people with intellectual disabilities. This new educational approach aims to prepare senior students for leaving school and taking up employment. The last 10 years have proved the effectiveness of the programme in supporting independent living for people with intellectual disabilities. The initiative fosters socialisation skills, preparing students for employment through skills development and also for adult life and independent living.</p>
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## Germany

The core area of Germany's social security system is based upon the principle of social insurance (*Sozialversicherung*), including the following three schemes: health insurance, accident at work insurance, pension insurance. The organisation of Germany's social security is traditionally based on the principles of solidarity, decentralisation and self-government (*Selbstverwaltung*). At federal level social security falls under the responsibility of the Ministry of Health and Social Security (*Bundesministerium für Gesundheit und Soziale Sicherung*), except for unemployment insurance where the Ministry of Economics and Labour (*Bundesministerium für Wirtschaft und Arbeit*) is competent. As a general rule, the prerequisite for obtaining insurance benefits is membership of a social insurance institution. People in gainful employment (dependent labour relationship) are compulsorily insured if the place of activity lies within the German territory. Except for the unemployment scheme, all insurance schemes offer voluntary insurance to certain groups. There are several exceptions to the insurance obligation (civil servants) as well as special rules for self-employed people. Social insurance benefits are predominantly financed from contributions (about two thirds) with the wage or income level from employment being the basis.

State subsidies play an important role in the fields of pension insurance and unemployment insurance. Apart from that, the State finances other social security benefits, such as family benefits, out of general taxation. The pension insurance benefits are financed through contributions from the insured persons, the employers and tax-based state supplements. It is constructed as a pay-as-you-go system.<sup>11</sup>

### Basic principles

Sickness benefits belong to the compulsory social insurance scheme financed by contributions for employees and categories of persons assimilated thereto up to a certain income limit with earnings-related benefits paid in form of continuation of payment of wages and salaries paid by the employer.

The sickness funds are responsible for collecting all contributions in the social insurance field in form of an overall insurance contribution (*Gesamtsozialversicherungsbeitrag*).

### Beneficiaries

Employees and assimilated.

### Duration of benefits

Sickness benefit (*Krankengeld*) for the same illness is limited to 78 weeks over a 3-year period.

### Amount of the benefits

Sickness benefit (*Krankengeld*): 70% of the normal salary but not exceeding 90% of the net salary. The normal salary (*Regelentgelt*) considers wages and income from work, normally received (during last 3 months), insofar as subject to contribution. After one year there is an adjustment as for pensions.

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<sup>11</sup> European Social Insurance Platform, The Structure of Social Insurance in Europe

Qualifying period

Neither work period nor qualifying period required.

Special conditions for unemployed

Initially (up to 6 weeks) unemployment benefits are paid as continued wage payment by the Labour Agency, then sickness benefits are paid by the sickness insurance fund to the amount of the previous wage replacement benefit paid by the Employment Agency.

Concerning the beneficiaries the unemployment benefit II (Arbeitslosengeld II) there is the continuation of payment by the competent authority. If necessary there is the assessment of earning capacity in the event of a longer period of incapacity for work or in the event of disability.

Examples of an integrated approach towards job regaining

Füngeling Router job creation project, Germany	
<p><b>Country:</b> Germany</p> <p><b>Target Groups:</b> the long-term unemployed, the short-term unemployed, unemployed with additional job seeking needs, people with disabilities or illnesses, men, women, job seekers over 50 years of age, job seekers under 30 years of age</p> <p><b>Initiative type:</b> general careers guidance, work placements, training, job search support, job application support, confidence building, awareness raising</p>	<p>Füngeling Router has developed job creation measures and successful job-worker matching initiatives for young people with disabilities, aimed at integrating such people into employment. Other key areas of activity include: in-company prevention of disabilities affecting the work ability of employees, integration management for employees with job relevant health restrictions, enabling disabled workers to keep their jobs through the provision of equal access to further training, as well as overall career advancement and support.</p>

## Greece

Greece has a state-run social welfare system; the administration does not provide for universal coverage. The social security system varies from one sector of the economy to another, mainly on account of the transition from an agriculture-based economy to a post-industrial service economy. Social security in Greece comes under the Ministry of Employment and Social Protection which supervises the different social insurance systems (*systema koinonikis asphalisseos*). They are administered by several independent institutions under public and private law. Social insurance as provided by the main institutions comprises benefits related to old age, survivors, invalidity, sickness insurance, maternity, work accidents and occupational diseases. The largest social insurance system is managed by the Institute for Social Insurance (*Idryma Kinonokon Asphaliseon*, IKA) which covers the majority of the employees. As far as the other schemes are concerned administrative responsibility depends on the professional category or occupational branch (i.e. coverage of special branches such as public sector funds of banks, the telecommunications organisation etc.). Amongst the most important institutions charged with the insurance of special groups are the Organisation for Free Professions Insurance (O.A.E.E.) and the Organisation for Agricultural Insurance (OGA). These funds cover the risks of sickness and maternity, invalidity, old age and death. The O.A.E.E. is the largest of the institutions responsible for self-employed people, while the OGA is the insurance scheme for farmers and people over 65 not receiving a pension from another fund.

To qualify for benefits under the IKA scheme people have to be gainfully employed, except for health care where pensioners and insured unemployed people and their dependants are covered as well. The social insurance systems are financed in various ways through contributions paid by employees/insured persons and employers, indirect taxes (social financing resources) and from state subsidies (out of general taxation or profits of capital owned by the social insurance institutions). The financing is, as a general rule, based on the 'pay-as-you-go' system.

The financing and the contribution level depends on the date of entry to the insurance scheme: if insurance was taken out before 1 January 1993 contributions are shared between the employer and the employees.

The reform of 1992 introduced a tripartite financing system for the IKA scheme: for people entering the labour market after 1 January 1993, the State participates in the financing with a proportional contribution of 3/9 in addition to the contributions from employees (2/9) and employers (4/9). The contribution level has been increased as well. In 1999, about 2 million people were insured under the IKA scheme. The number of beneficiaries totalled some 5.98 million. Invalidity pensions are payable when the required insurance period (number of work days) is completed. If invalidity is caused by an industrial accident or occupational disease, one working day suffices for entitlement to benefits. If invalidity is caused by a non-industrial accident certain contribution conditions apply. The amount of pension is related to the degree of invalidity: at least 80% incapacity gives entitlement to a full pension, 67% incapacity gives entitlement to

75% of the full pension and 50% incapacity gives entitlement to 50% of the full pension.<sup>12</sup>

Basic principles

The sickness benefit scheme is a compulsory social insurance scheme for employees with earnings-related benefits.

Beneficiaries

All employees and assimilated.

Duration of benefits

Duration of benefits depending on the length of the period of contributions: 182, 360 or 720 days.

Amount of the benefits

For the first 15 days: The total ceiling for sickness benefit (ΕΠΙΔΟΜΑ ΑΣΘΕΝΕΙΑΣ) plus supplement for dependants (max. 4) is € 15.22 per day (daily wage assumed for 3rd insurance category).

After 15 days: The total ceiling for benefits plus supplements for dependants (max. 4) is € 27.87 per day (daily wage assumed for 8th insurance category).

Qualifying period

100 days of work subject to contributions during the previous year or the 12 first months of the 15 preceding the illness (duration of benefit: 182 days).

300 days subject to contributions during the 2 years, or 27 months of the 30, preceding the illness (duration of benefit: 360 days).

1,500 days of insurance during the last 5 years preceding the incapacity for work due to the same illness (duration of benefit: 720 days).

Special conditions for unemployed

No special conditions.

Examples of an integrated approach towards job regaining

Netjob Hellas, Greece	
<p><b>Country:</b> Greece  <b>Target Groups:</b> the long-term unemployed, unemployed with additional job seeking needs, people with disabilities or illnesses, men, women  <b>Initiative type:</b> training, job search support, job application support, financial support and advice, confidence building, awareness raising</p>	<p>Netjob Hellas is a European-funded project aimed at integrating highly trained people with disabilities into jobs in the information technology (IT) sector. It applies a methodology developed in Denmark (NetJob) to the Greek context. The strategy also involves a close assessment of the needs of employers. Participants in the initiative are trained for specific vacancies within particular companies.</p>

Proteus Developmental Consortium, Greece	
<p><b>Country:</b> Greece</p>	<p>The Proteas Developmental Consortium is an</p>

<sup>12</sup> European Social Insurance Platform, The Structure of Social Insurance in Europe

<p><b>Target Groups:</b> people with disabilities or illnesses, men, women</p> <p><b>Initiative type:</b> work placements, training, job search support, job application support, financial support and advice, confidence building, awareness raising</p>	<p>initiative which aims to combat discrimination against people with physical disabilities, by integrating them into targeted workplaces. The project is co-financed by the Greek Ministry of Labour and the European Social Fund, as part of the EU EQUAL initiative. Proteas is an alliance of 16 organisations that have combined their extensive professional experience, knowledge and expertise in order to promote issues of equality in the labour market.</p>
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## Hungary

The social security in Hungary has five main branches. Pensions and health services (including statutory work accident system) are classified as social insurance. The other three branches are unemployment insurance, universal family support system and social assistance system. The risks covered by the system are sickness, maternity, old age, invalidity, occupational diseases (accident-related disability), employment injuries, survivorship, child raising and unemployment.

Various medical benefits, temporary disability benefit, work injury allowance are covered by the health insurance system. Benefits for permanent disability are covered by the pension insurance system.

35 diseases are recognized and listed in the annex of Decree No 217/1997 (XII.1.) of the Government. The list also includes occupations that are assumed to lead to occupational disease as well as setting down time limits of exposure after which there is an assumption that any disease is an occupational disease (e.g. loss of hearing caused by noise; field of work working at any workplace where the noise emission exceed a specified level for at least 5 years). This system applies to all enterprises. There is no minimum qualifying period.<sup>13</sup>

### Basic principles

The sickness benefit scheme is a compulsory social insurance scheme for the active population (employees and self-employed) with earnings-related benefits.

The Absence Fee (Távolléti díj) is paid by the employer.

### Beneficiaries

Gainfully employed and assimilated persons are insured compulsorily against all risks: employees (including the public sector), the self-employed (including member of cooperatives), several assimilated groups, and beneficiaries of income subsidy, unemployment benefit or unemployment benefit paid prior to retirement.

### Duration of benefits

Maximum 1 year (If the insurance period is less than 1 year, than the maximum duration equal to the period of insurance).

### Amount of the benefits

Sickness benefit (Táppénz) is paid as a percentage of average daily gross earnings (over the previous calendar year).

The amount of the benefit depends upon length of previous insurance period:

- At least 2 years: 70% of the daily average
- less than 2 years (or during inpatient treatment): 60% of the daily average.

There are no ceilings.

### Qualifying period

Neither work period nor qualifying period required.

### Special conditions for unemployed

No entitlement for unemployed persons.

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<sup>13</sup> European Social Insurance Platform, The Structure of Social Insurance in Europe

## Examples of an integrated approach towards job regaining

Social and employment counselling service, Hungary	
<p><b>Country:</b> Hungary  <b>Target Groups:</b> people with disabilities or illnesses  <b>Initiative type:</b> job search support, confidence building</p>	<p>This initiative is a complex, person-centred service, established by the Motivacio Foundation, which includes social and employment counselling such as jobseeking, career, psychological and legal advice. It also encompasses labour activation, follow up, employer advice and other complementary services according to the special needs of people with disabilities.</p>

VAS county employment services, Hungary	
<p><b>Country:</b> Hungary  <b>Target Groups:</b> the long-term unemployed, the short-term unemployed, people with disabilities or illnesses  <b>Initiative type:</b> work placements, training, job search support, job application support, general careers guidance, financial support and advice</p>	<p>The VAS county employment services based in western Hungary aim to support the employability of people with disabilities by providing comprehensive employment guidance counselling. They also offer employers an innovative range of services, seeking to improve their willingness and capacity to employ people with disabilities.</p>

Active Workshop Programme, Hungary	
<p><b>Country:</b> Hungary  <b>Target Groups:</b> people with disabilities or illnesses  <b>Initiative type:</b> general careers guidance, training, job search support, confidence building, environmental adaptations</p>	<p>The main objective of the Active Workshop Programme, which is run under the auspices of the EU-led EQUAL programme, is to tackle labour market discrimination against people with intellectual disabilities and autism. The programme has developed an innovative model which supports the systematic development of employment opportunities for people in this group.</p>

4M programme, Hungary	
<p><b>Country:</b> Hungary  <b>Target Groups:</b> people with disabilities or illnesses  <b>Initiative type:</b> job search support, job application support, confidence building</p>	<p>The 4M initiative (Megoldás Munkáltatóknak és Megváltozott munkaképességű Munkavállalóknak) is a Hungarian labour market service, modelled on an initiative in the United Kingdom, to assist people with a reduced working capacity to find employment. It aims to develop an accepting environment for these workers through awareness-raising measures and also targets employers in the open labour market.</p>

Salva Vita supported employment programme, Hungary	
<p><b>Country:</b> Hungary  <b>Target Groups:</b> the long-term unemployed, people</p>	<p>The aims of the Salva Vita Foundation's supported employment programme are to foster the social and</p>



<p>with disabilities or illnesses, men, women, job seekers under 30 years of age</p> <p><b>Initiative type:</b> job search support, confidence building, awareness raising</p>	<p>labour market integration of people with disabilities into employment, to change the attitudes of employers towards hiring disabled workers, and to foster independent lifestyles among such workers. It is innovative in that it treats job applicants as partners, provides services to employers, and aims to ensure individual-orientated, multi-dimensional and survey-based services during the entire job-seeking process.</p>
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## Ireland

The Department of Social, Community and Family Affairs (DSFCA) is responsible for the administration of Social Insurance, Social Assistance and other schemes such as child benefit, under the authority of the Minister for Social, Community and Family Affairs. The Social Insurance benefits are contributory benefits and include old age, retirement and survivor's pensions, sickness and invalidity pensions, benefits in respect of occupational accidents and diseases, maternity and adoptive benefits as well as unemployment benefit.

Social Assistance benefits are means-tested and provide a broad range of income maintenance payments to persons who do not qualify for the Social Insurance scheme.

The social insurance scheme is financed by contributions from employees, employers and self-employed people and by exchequer contribution based upon the pay-as-you-go system. The insurance scheme for accident at work and occupational diseases is financed out of employer's contributions.

The Welfare Office in Dublin is responsible for the Injury Benefit, which is paid during the first 26 weeks after the accident. After a period of 26 weeks, the Disablement Benefit is paid. Apart from these major benefits, there are in addition an unemployables supplement and a constant attendance allowance. People, who are not entitled to an insurance benefit, may receive the meanstested disability allowance.<sup>14</sup>

### Basic principles

As a general rule, every person who is employed within the Republic of Ireland is compulsorily insured. In April 1988, insurance became compulsory for self-employed as well. There is also the possibility to take out voluntary insurance. Most of these compulsorily insured employed people are covered against all risks (contribution Class A). The Pay Related Social Insurance contributions (PRSI) are collected by the taxation service, i.e. the Revenue Commissioners. Benefits in kind for sickness and maternity are financed by the State and from health levy. Benefits for industrial injuries and occupational diseases are based on contributions.

The sickness benefit scheme is a compulsory social insurance scheme for employees with flat-rate Illness Benefit and supplements for dependants.

### Beneficiaries

With some exceptions, all employees and apprentices aged 16 years and over.

### Duration of benefits

Unlimited (to age 66) if the claimant has paid 260 weekly contributions.

Limited to 52 weeks if between 52 and 260 weekly contributions paid.

### Amount of the benefits

Illness Benefit: € 185.80 per week.

Family supplements: Adult dependant: € 123.30 per week.

Each child dependant: € 22.00 per week.

### Qualifying period

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<sup>14</sup> European Social Insurance Platform, The Structure of Social Insurance in Europe

52 weekly contributions paid since first starting employment and 39 weekly contributions paid or credited during the relevant contribution year preceding the benefit year, of which a minimum of 13 must be paid contributions.

The latter requirement may be satisfied by contributions paid in some other contribution years, or 26 weekly contributions paid in each of the two relevant contribution years preceding the benefit year.

Special conditions for unemployed

No special conditions.

Examples of an integrated approach towards job regaining

Disability awareness training, Ireland	
<p><b>Country:</b> Ireland  <b>Target Groups:</b> people with disabilities or illnesses  <b>Initiative type:</b> general careers guidance, job search support, awareness raising</p>	<p>In this initiative, Employment Services Officers (ESOs) working at FÁS, Ireland’s national training and employment agency, were invited to take part in a three-day disability awareness programme. The training programme addressed all aspects of career guidance for people with disabilities, including assessment of abilities, exploration of vocational possibilities, job matching, work placement and supported work options.</p>

Mainstreaming employment services, Ireland	
<p><b>Country:</b> Ireland  <b>Target Groups:</b> the long-term unemployed, the short-term unemployed, unemployed with additional job seeking needs, people with disabilities or illnesses, men, women, job seekers over 50 years of age, job seekers under 30 years of age  <b>Initiative type:</b> general careers guidance, providing access to voluntary work, training, job search support, job application support, financial support and advice, confidence building, environmental adaptations, awareness raising</p>	<p>The ‘Mainstreaming employment services for people with disabilities’ initiative is carried out by Ireland’s national training and employment agency FÁS (Foras Áiseanna Saothair). The project came about as a result of a review in the late 1990s of all legislation, policy and services relating to people with disabilities in Ireland. In line with the principles of non-discrimination and integration, a new policy of mainstreaming employment services was introduced, which in practice involves directing people to use the mainstream services provided by FÁS.</p>

## Italy

Under the overall responsibility of the Ministry of Labour and Social Welfare, the general system of Italy's social security includes social insurance schemes covering the loss of income from work as regards sickness, maternity (and tuberculosis), obligatory basic pensions (invalidity, survivor's and old age insurance) as well as unemployment and family benefits. This general scheme covers wage earners and some assimilated groups of self-employed persons (smallholders, sharecroppers and tenant farmers, craftsmen and trades people).

A separate insurance scheme covers accidents at work and occupational diseases.

The National Social Security Institute (Istituto nazionale della previdenza sociale, INPS) is the body responsible for administering these schemes, except for the employment injuries' and the national health scheme. INPS, together with its services on regional, provincial, town and district level, has also the task of collecting the social security contributions.

Contributions have a parafiscal nature, mainly following the pay-as-you-go-system.

Except for the new pension scheme, contributions are, as a general rule, levied on wages without an upper limit (a minimal wage however exists). Employees have to pay contributions for sickness and maternity, invalidity, old age and survivorship, and a special solidarity contribution. The employer pays, in addition, contributions with respect to unemployment and family allowances. Only the employer's contribution rate differs according to the branch involved, i.e. industry or trade.

When necessary, contribution transfers between the social insurance branches may occur.

Italy has a pension insurance scheme covering almost all employed and self-employed workers. Special schemes cover particular categories of persons. Invalidity pensions paid by INPS do not result from an accident-at-work. The benefit provided can either be a pension (absolute and permanent inability to pursue any kind of professional activity) or an allowance (permanently reduced earning capacity). The amount depends on the duration of the insurance period.<sup>15</sup>

### Basic principles

The sickness benefit scheme is a compulsory social insurance scheme for employees with earnings-related benefits in form of continuation of payment of salary by the employer.

### Beneficiaries

No cash benefits but statutory continuation of salary for employees.  
Tuberculosis presents a special treatment.

### Duration of benefits

Maximum of 6 months (180 days) per year.

### Amount of the benefits

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<sup>15</sup> European Social Insurance Platform, The Structure of Social Insurance in Europe

Without hospitalisation: 50%. From 21st day 66.66% (earnings taken as basis: real earnings). With hospitalisation: Allowance is reduced to 2/5 for insured without dependants.

Qualifying period

Neither work period nor qualifying period required.

Special conditions for unemployed

No special conditions.

Examples of an integrated approach towards job regaining

Medialabor service, Italy	
<p><b>Country:</b> Italy  <b>Target Groups:</b> people with disabilities or illnesses  <b>Initiative type:</b> general careers guidance, work placements, job search support, job application support, financial support and advice</p>	<p>The aim of the Medialabor service is to increase the occupational, personal and social autonomy of people with disabilities, who either attend courses in the vocational training centre 'Don Calabria' or live in the community. Private companies, as well as people with disabilities, can avail of the services of Medialabor . Medialabor offers companies consultancy services in the field of disability management in the workplace.</p>

'SIL 22' job integration service, Italy	
<p><b>Country:</b> Italy  <b>Target Groups:</b> unemployed with additional job seeking needs, people with disabilities or illnesses  <b>Initiative type:</b> general careers guidance, job search support, job application support</p>	<p>This regional initiative from the province of Verona aims to promote the employment of people with disabilities through encouraging cooperation between service suppliers from both health and social (employment) services. It offers a range of specific measures to clients, which are delivered using a case management perspective. It also seeks to network service suppliers with employers and individuals.</p>

## Latvia

The State Social Insurance Agency (VSAA) is a state institution under supervision of the Ministry of Welfare, performing the public administration function in the area of social insurance and social services. It is responsible for all benefits in cash.

Financing: State social insurance benefits are financed by the state: special social insurance budget for disability, maternity and sickness benefits.

The insurance compensations for occupational diseases and injuries at work include benefits in cash. The following benefits in cash are available to the insured person:

- sickness benefits in case of temporary incapacity for work (short-term benefit);
- compensation for the loss of capacity for work (long-term benefit);
- lump sum benefit (can be substituted by insurance compensation for the loss of capacity for work in case of permanent loss of capacity for work within range of 10 to 24 percent);
- reimbursement of treatment, nursing, medical rehabilitation expenses, compensation for the prosthetic appliances, reimbursement of expenses for rehabilitation equipment, reimbursement of the travel expenses to health care institutions.

Latvian pension system is based on the principles of the state compulsory social insurance system thereby according to the law insured persons has entitlement to receive pensions. Concerning the *disability pension*: prior to reaching the pension age insured person, if they have been recognized as disabled shall be entitled to a disability pension, excluded shall be persons whose disability has been caused by an accident at work or an occupational disease. Insurance (work) record: No less than 3 years in total. The disabled persons who have reached the pension age shall be granted the old age pension instead of a disability pension. The amount of pension calculated depends on the period of insurance, social insurance contributions made during last 5 years before the prescription of invalidity.<sup>16</sup>

### Basic principle

The sickness benefit scheme is a compulsory social insurance scheme providing earning related benefits.

Sickness benefit shall be granted if an employee is absent from work and loses earnings.

### Beneficiaries

Compulsory insurance for all employees, self-employed and assimilated.

Spouses of self-employed persons may join the insurance voluntarily.

Coverage: only insured persons have the right to receive maternity, sickness and funeral benefits

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<sup>16</sup> European Social Insurance Platform, The Structure of Social Insurance in Europe

Duration of benefits

Sickness benefit shall be paid from 15th day of inability to work but for a period no longer than 52 weeks from the first day of inability to work or for no longer than 78 weeks within a 3- year period if incapacity has been repetitive with interruptions. The employer is responsible for paying sickness money for the first 14 calendar days starting from the second day of the temporary inability to work. Sickness benefit shall be granted in the amount equivalent to 80 percent of insured person's average insurance contributions wage that is calculated from the wage of six months period before illness.

Amount of the benefits

80% of the average gross wages upon which contributions have been paid during six months. This six-month period applies from two months before the month in which the incapacity occurred.

Qualifying period

Neither work period nor qualifying period required.

Special conditions for unemployed

No special conditions.

## Lithuania

Lithuanian social policy is basically structured according to the Continental welfare state model but also have elements of Nordic welfare state model. Employed persons or civil servants shall be insured by all branches of the obligatory social insurance in case they are paid a wage for their work. When the country citizens are insured obligatorily by all branches of the social insurance, then the social insurance contribution equal to 3 percent shall be deducted from their monthly wage. The remaining part of the social insurance contribution equal to 31 percent shall be paid by the employer.

Contributions shall be calculated and deducted from each wage paid for work to each insured person.

*Persons* insured under compulsory or voluntary social insurance fall under Lithuanian social coverage system for sickness and maternity benefits.

*In case of accidents at work and Occupational Diseases* the insured persons despite their social insurance period shall receive *the sickness benefit* subject to the accident at work or occupational disease. The size of the sickness benefit is 100 per cent of the compensatory wage since the first day of incapacity for work up to its re-establishing or up to the time the person will be acknowledged as the disabled.

To be eligible for an Invalidity pension: Invalidity involves either a permanent or prolonged incapacity for work. Depending on age, the insured must have a minimal social insurance work record. *Invalidity pensions*: The persons under 23 years old shall have the right to get the invalidity pension considering that they satisfy conditions for minimal and necessary state social insurance period for invalidity pension. Minimal social insurance period for other persons is as follows: 1 year if age is up to 26, 2 years if turned 26, 3 years if turned 29, 4 years if turned 32 and 5 years if turned 35 and more. Necessary state social insurance period for invalidity pension shall be nominated as follows: 1 year age is up to 24, insurance period grows 4 months every year if turned 24, insurance period grows 1 year if turned 38, but can't overtop necessary insurance period that is stated for old-age pension. Invalidity pension varies according to the assessed degree of invalidity.<sup>17</sup>

### Basic principle

The sickness benefit scheme is a compulsory social insurance scheme for employees and assimilated financed by contributions and providing earnings-related benefits. Special schemes for officers of the police, state security, defence and related services financed by the state.

Voluntary membership for the self-employed (financed by contributions).

### Beneficiaries

Compulsory for all employees and assimilated.

Self-employed persons may join the scheme voluntarily.

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<sup>17</sup> European Social Insurance Platform, The Structure of Social Insurance in Europe



### Duration of benefits

The sickness certificate may be extended for an established period of time: up to four months or 122 days. If the person has not recovered after that period it is obligatory to apply to the Disability and Employment Capacity Assessment Office (Neigalumo ir darbingumo nustatymo tarnyba) which is concerned with the determination of disability. Sickness benefits for employed disabled persons who receive State social insurance Lost Working Capacity Pension (Neteko darbingumo pensija) are paid for no more than 90 days per year. This restriction is not applied for employment injuries or occupational diseases.

In cases where a person voluntarily undergoes in-patient treatment for alcoholism or drug addiction he/she is entitled to receive sickness allowance for no longer than 14 days. Maximum duration of benefits for those nursing a family member: adults: 7 days, children under the age of 14 years: 14 days, children under the age of 7 years in in-patient clinic: for the course of treatment but no longer than 120 days, children under 18 who are ill with an oncohaematological disease, have undergone a complicated operation or have experienced trauma or burning: for the full course of treatment but no longer than 120 days.

### Amount of the benefits

85 % of the insured's average monthly compensatory wage (Kompensuojamasis uždarbis) is paid after a 2-day waiting period. (The employer pays at least 80% of the insured's average wage for the first 2 days.) The monthly benefit must not be less than 25 % of the average wage in Lithuania. The compensatory wage must not exceed 3.5 times the average wage in Lithuania (as defined by the Department of Statistics).

The Compensatory Wage is the average wage paid during a quarter before the last quarter of sickness from which contributions to sickness and maternity insurance have been collected. The compensatory wage cannot exceed 5 times the national average insured income (although contributions are paid on the full wage). The benefit must not be lower than  $\frac{1}{4}$  of the average insured income of the current year (einamųjų metų draudžiamosios pajamos).

### Qualifying period

Sickness benefits are allowed at least 3 months of insurance period during the past 12 months or at least 6 months during the past 24 months. If an incomplete sickness insurance record is as a consequence of parental leave to care for a child aged 1 to 3, a social insurance record is calculated from 12 months prior to the leave commencing.

### Special conditions for unemployed

Sickness benefit is granted to unemployed persons getting ill during receipt of unemployment benefits. The unemployment benefit has to be repaid for this period (up to a maximum of 30 days).

### Examples of an integrated approach towards job regaining

Employment agency for people with hearing difficulties, Lithuania	
<p><b>Country:</b> Lithuania</p> <p><b>Target Groups:</b> the long-term unemployed, the short-term unemployed, unemployed with additional job seeking needs, people with disabilities or illnesses, men, women, job seekers over 50 years of age, job seekers under 30 years of age</p> <p><b>Initiative type:</b> general careers guidance, providing access to voluntary work, job search support, job application support, confidence building, awareness raising</p>	<p>This project aims to improve the employment prospects of people with hearing difficulties. An employment agency for people with hearing difficulties was created, using employment mediators. The main task of the mediators is to search for suitable job positions, and to present to employers an audiovisual database of people with hearing difficulties who are unemployed. Mediators also offer assistance after employment.</p>

Valakuniai Rehabilitation Centre, Lithuania	
<p><b>Country:</b> Lithuania</p> <p><b>Target Groups:</b> people with disabilities or illnesses, men, women, job seekers under 30 years of age</p> <p><b>Initiative type:</b> training, job search support, confidence building, awareness raising</p>	<p>The Valakuniai Rehabilitation Centre provides comprehensive vocational rehabilitation services for people with disabilities. These services include vocational skills and capacities assessment, vocational guidance, work rehabilitation, vocational training, a job search and employment service, medical rehabilitation, work therapy, independent living skills training and an assessment of driving skills.</p>

Employment of people with mental and intellectual disorders, Lithuania	
<p><b>Country:</b> Lithuania</p> <p><b>Target Groups:</b> unemployed with additional job seeking needs, people with disabilities or illnesses</p> <p><b>Initiative type:</b> job search support, job application support</p>	<p>The main aim of this project is to promote the integration of people with mental and intellectual disabilities, as well as their relatives, into the labour market. To this end, pilot testing of a new qualification of 'job coach' has been implemented. In Lithuania, this is the first time that specially trained staff will be available to help people with intellectual or mental disabilities to prepare for employment, get a job and stay in work.</p>

Vocational training and labour market integration of disabled persons, Lithuania	
<p><b>Country:</b> Lithuania</p> <p><b>Target Groups:</b> the long-term unemployed, the short-term unemployed, people with disabilities or illnesses</p> <p><b>Initiative type:</b> general careers guidance, training, job search support, confidence</p>	<p>A social partnership approach was used in implementing this project, aimed at creating employment opportunities for people with disabilities. Representatives of 20 social dialogue partners established an informal club called 'Equal opportunities' (Lygios galimybės). During the project, the target group gained social and</p>

	psychological skills and new vocational skills which are in demand in the labour market. The project encouraged the creation of social enterprise companies for people with disabilities.
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Business Encouragement Centres, Lithuania	
<p><b>Country:</b> Lithuania</p> <p><b>Target Groups:</b> unemployed with additional job seeking needs, people with disabilities or illnesses</p> <p><b>Initiative type:</b> general careers guidance, training, job search support, confidence building, awareness raising</p>	<p>Over a period of two and a half years, six business encouragement centres for disabled people have been established in the main cities of Lithuania. Specially trained consultants provide a range of services in these centres. The counselling service includes business planning, development of social enterprises, information on financial sources for business and advice on the physical adaptation of premises for people with disabilities. The centres also offer administration services and training courses, as well as job-searching techniques and mediation regarding employing people with disabilities.</p>

## **Luxembourg**

Social security in Luxembourg encompasses the following sectors: sickness and maternity insurance, old age, invalidity and survivors' pensions, accident-at-work insurance, unemployment benefits and family allowances. All people professionally active in Luxembourg are covered by the sickness and maternity insurance scheme. They are either compulsorily or voluntarily covered. The spouse and direct descendent are co-insured as well, provided that they are dependent upon the insured person and not covered because of professional activity. The sickness funds (*Caisses de Maladie*) administrate the sickness and maternity insurance scheme. They have a common representation on the national level which is the *Union des caisses de maladie (UCM)*. The UCM as well as the sickness funds are legal bodies under public law. Nine sickness funds administrate the insurance scheme, in principle according to the professional category of the insured person. The sickness fund for white collar workers in the private sector (*Caisse de maladie des employés privés*) is competent for white-collar workers and those self-employed people who are primarily engaged in an intellectual activity. For blue-collar workers and voluntary insured people the sickness fund for blue collar workers is competent (*Caisse de maladie des ouvriers*). The sickness fund of the self-employed (*Caisse de maladie des professions indépendantes*) is the competent body for artisans, traders and industrialists. The agricultural sickness fund (*Caisse de maladie agricole*) is competent for people working within the agricultural sector. Two sickness funds are responsible for the administration of people working in the public and municipal sector: The sickness fund of civil servants and the public sector employees (*Caisse de maladie des fonctionnaires et employés publics*) and the sickness fund of civil servants and employees at the municipalities (*Caisse de maladie des fonctionnaires et employés communaux*). The steel plant 'Arbed' has its own sickness fund for blue- and white-collar workers. Finally the Medical Mutual Society of the Luxembourg Railways (*Entraide médicale des chemins de fer luxembourgeois*) is competent for workers in the railway sector.<sup>18</sup>

### **Basic principles**

The sickness benefit scheme is a compulsory social insurance scheme financed by contributions for all active population (employees and self-employed) with earnings-related benefits.

### **Beneficiaries**

All active persons and pensioners in paid employment.

### **Duration of benefits**

Maximum: 52 weeks. Payment ends if an invalidity pension (pension d'invalidité) is granted.

### **Amount of the benefits**

The full salary which the insured person would have earned if he had continued to work.

### **Qualifying period**

Neither work period nor qualifying period required.

### **Special conditions for unemployed**

No entitlement for unemployed persons. They receive unemployment benefit (indemnité de chômage).

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<sup>18</sup> European Social Insurance Platform, The Structure of Social Insurance in Europe

## **Malta**

The Social Security system in Malta is provided by the state and is administered by the Department of Social Security which falls under the authority of the Ministry for the Family and Social Solidarity.

The system provides for two basic schemes that offer various benefits and assistances that are centrally administered.

One scheme is known as the Contributory Scheme, and the other as the Non Contributory Scheme.

In the Contributory Scheme, the basic requirement for entitlement is that specific contribution conditions are satisfied. Between the Contributory Scheme the following benefits are paid: a) Retirement, Survivor's, Invalidity, Disablement and Parent's Pensions; b) Unemployment, Sickness and Occupational Injury Benefits

Invalidity Pension Payable to persons deemed permanently incapable for suitable full-time or regular part-time employment. Various rates according to different conditions.<sup>19</sup>

### **Basic principles**

The sickness benefit scheme is a compulsory social insurance scheme for the active population (employees and self-occupied) with flat-rate benefits in form of continuation of payment of salary paid by the employer.

It exits a waiting period of 3 days, which are covered by the employer. Sickness benefits are paid by the State and the employer pays the difference between wage and benefit (if the latter is lower).

In no case may total number of such benefit days exceed the total number of contributions paid since person's first entry into scheme.

When sickness exceeds 60 benefit days, the person may either apply for an extension of sickness benefits or for an invalidity pension. In both cases, person is assessed by the Department's medical panel – an invalidity pension is awarded if the person is certified unfit for any kind of work for at least 3 years. Disablement Pension is payable if injury or disease caused or contracted whilst at work is considered to cause a loss of physical or mental faculty calculated between 20% & 89%. Rates are awarded according to degree of Disability. Where the degree of disablement is assessed at 90% and over, the person concerned is automatically awarded an Invalidity Pension at the full rate.

### **Beneficiaries**

All gainfully occupied persons (employees and self-occupied persons) who have not yet reached retirement age. Sickness benefits are paid to employed and self-employed persons.

### **Duration of benefits**

Maximum duration: up to an aggregate of 156 working days, but could be extended in certain cases when the claimant undergoes any major surgical operation or intervention or suffers a severe injury or is afflicted by some serious disease which requires a long

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<sup>19</sup> European Social Insurance Platform, The Structure of Social Insurance in Europe

treatment before such person can resume duties for any number of days not exceeding 312 days in a two year period.

Benefit is payable from the 4th day of incapacity for up to 156 benefit days per year or up to maximum 312 benefits days per year if person undergoes major surgery or suffers severe injury (not work related) or is afflicted by serious disease requiring long treatment before person may resume work; total number of benefit days during a 2-year period may not exceed 468.

#### Amount of the benefits

Benefit is paid in accordance with the number of days worked in a normal week up to a maximum of six days. The rates are:

- Single parent or a married person whose spouse is not employed on a full-time basis:(€ 16) per day.
- Single person: € 11 per day.

The benefit is paid every week.

#### Qualifying period

- To qualify for these benefits, an insured person needs to satisfy two contribution tests:
- he/she must have at least 50 weeks of paid contributions since entry into social security system;
- must have at least 20 weeks of paid or credited contributions during the last two contribution years prior to the benefit year in which the claim is submitted.

#### Special conditions for unemployed

Sickness Benefit paid to unemployed persons on a 6-day week basis in any period of sickness during unemployment.

## **The Netherlands**

The Netherlands have two kinds of insurance schemes, the employee insurance schemes (*Werknemersverzekeringen*) and the national insurance schemes (*Volksverzekeringen*).

As far as the insurances within the employees schemes are concerned, all employees (including civil servants since 1998) are compulsorily insured.

The employee benefits include the disablement benefits (WAO), sickness benefits (ZW) and the unemployment insurance (WW). The health insurance (ZFW) is also based on employment but administered differently.

The national insurance schemes only provide for a minimum social protection. Everyone who lives in the Netherlands is statutorily insured under the national insurance schemes, irrespective of whether they have Dutch nationality or whether they have income.

Nonresidents are insured if they are employed in the Netherlands and pay wage tax on this basis. However, their partners or spouses who live in their country of residence are not coinsured.

The contributions for the employee insurance schemes are collected by the Lisv as far as the WAO and the WW are concerned. The premiums collected should be sufficient to meet benefit claims and operating costs.

The funds thus raised are also used to finance rehabilitation and return to work projects and to subsidize certain specific projects. The Lisv is responsible for the fund management. Apart from this the Lisv also manages the so called 'safety net fund' according to the ZW. Since 1996, only sick people without an employer (e.g. temporary workers, pregnant women) still get a sickness (cash) benefit. The Dutch system does not have a specific accident-at-work scheme. People with a regular job who are unable to work continue to receive their salary from their employer for the maximum of one year according to the Civil Law (*Burgerlijk Wetboek*). Afterwards, if a person is still unable to work, they may be eligible for a disablement benefit according to the WAO. The UVIs decide whether the person is entitled to receive a benefit under this scheme. The WAO benefits are not work-related (all kind of accidents are covered). It is only of importance whether a person is employed or not. The WAO benefits are provided until the age of 65. From this age on, people have the right to receive benefits within the general old age pension scheme (AOW). Employers have an opting-out-possibility: They can provide for coverage of the invalidity-risk by private insurance. The UVIs are the responsible bodies for granting the WAO benefits. They are listed above.

### **Basic principle**

The sickness benefit scheme is the continuation of payment by employer for the first two years of sickness. The Sickness Benefit Act (*Ziektewet, ZW*) continues to exist as a "safety net" for employees who do not or no longer have an employer, and in a few special circumstances.

### **Beneficiaries**

All employees under the age of 65.

Duration of benefits

104 weeks

Amount of the benefits

Sickness Benefit Act (Ziektewet, ZW) as safety net (see "Basic principles"): 70% of the daily wage. Maximum daily wage considered: € 174.64.

Qualifying period

Neither work period nor qualifying period required.

Special conditions for unemployed

No special conditions.

Examples of an integrated approach towards job regaining

Early Intervention Service, Netherlands	
<p><b>Country:</b> Netherlands <b>Target Groups:</b> the long-term unemployed, the short-term unemployed, people with disabilities or illnesses, men, women, job seekers over 50 years of age, job seekers under 30 years of age <b>Initiative type:</b> training, confidence building</p>	<p>One of the main objectives of the Early Intervention Service (Vroege Interventie) is to offer people with disabilities an appropriate labour-specific intervention to prevent long periods of unemployment after ceasing work. The initiative includes an assessment tool to measure functional capacity and a 'quicksan' procedure to identify levels of vocational potential and the need for vocational rehabilitation.</p>

Horizon project, Netherlands	
<p><b>Country:</b> Netherlands <b>Target Groups:</b> the long-term unemployed, unemployed with additional job seeking needs, people with disabilities or illnesses, men, women, job seekers over 50 years of age, job seekers under 30 years of age <b>Initiative type:</b> training, confidence building</p>	<p>Two European transnational partners in France and the Netherlands developed, under the Horizon programme, a professional development initiative to assist people with disabilities to participate in vocational assessment, guidance, training and employment. The aim of this cooperation was to enhance the labour market integration process through sharing of experiences and transferring best practice for people with chronic lower back pain through multidisciplinary treatment.</p>

Bacalao Project, Netherlands	
<p><b>Country:</b> Netherlands <b>Target Groups:</b> the long-term unemployed, unemployed with additional job seeking needs, people with disabilities or illnesses, men, women, job seekers over 50 years of age, job seekers under 30 years of age <b>Initiative type:</b> training, job application support, confidence building</p>	<p>Three European transnational partners in Germany, the Netherlands and Spain have developed several professionally designed approaches to vocational assessment, guidance, training and placement in employment for people with disabilities. This initiative focused on people with neck or whiplash problems after car accidents and chronic fatigue and took the form of a multidisciplinary training programme</p>



Eminus project, Netherlands	
<p><b>Country:</b> Netherlands</p> <p><b>Target Groups:</b> people with disabilities or illnesses, men, women</p> <p><b>Initiative type:</b> general careers guidance, work placements, training, job search support, job application support, confidence building, environmental adaptations, awareness raising</p>	<p>As part of the EU-funded project Eminus, REA College Netherlands – which provides vocational training for people with a physical disability – has built virtual classrooms designed for training students at home for jobs that they can carry out from the home. With virtual classes of four students per teacher, interactive communication and live presentation of lessons, the initiative aims to get as close as possible to regular education. Fast internet connections and streaming video allow for non-verbal communication in visual and sign language.</p>

Arthritis project, Netherlands	
<p><b>Country:</b> Netherlands</p> <p><b>Target Groups:</b> the long-term unemployed, unemployed with additional job seeking needs, people with disabilities or illnesses, men, women</p> <p><b>Initiative type:</b> general careers guidance, training, job search support, job application support, confidence building</p>	<p>One of the main objectives of this project is to offer unemployed or economically inactive people an appropriate labour-specific intervention such as training, job coaching, worksite visits or counselling so that these individuals can return to the labour market. An assessment tool for the target group has been developed to assess functional capacity, which can assess levels of vocational assessment or vocational rehabilitation. The project's target group include the unemployed and/or economically inactive population, employees with chronic arthritis who are absent from work on a long-term basis, employees with physical and coping disabilities, as well as people with frequent medical symptoms.</p>

## **Poland**

The Polish social security system is composed both of insurance and non-insurance (provision) elements. The social insurance of employees and farmers include Sickness insurance (only in terms of cash benefits) and Work accident insurance. The Polish social insurance system covers practically all economically active persons, that is: employees and self-employed persons.

The Social Insurance Institution (ZUS) provides following benefits in various life situations and in particular concerning the reduction of capacity of work: : a) sickness and maternity (sickness allowance, maternity allowance, care allowance, compensatory allowance, rehabilitation benefit); b) incapacity for work (disability pension, training pension); c) accidents at work and occupational diseases (compensatory benefits in respect of health damage or death, that is: lump-sum compensation, health benefits; benefits in respect of effect of accidents at work on earning capacity, that is: sickness allowance, rehabilitation benefit, disability pension, training pension, survivors' pension)

ZUS pays some of non-insurance benefits as well social pension (it is a civil benefit, financed from the State budget, governed by the provision of the law of 27 June 2003 on the social pension. The social pension is payable to an adult person, who is completely incapable of work and whose impairment of body functions occurred before reaching the age of 18 years, or before reaching the age of 25 years, but in the course of education in school or higher school, or in the course of doctoral studies or post-graduate studies. ZUS evaluating doctor is a body competent for evaluating and certifying the complete incapacity for work).

The following kinds of insurance have been distinguished in the farmers' social insurance system: work accident, sickness and maternity insurance and pension insurance. Both kinds of insurance cover *ipso jure* any farmer (with the spouse and members of the household), whose farm include arable land of more than one reference hectare or a special section of agricultural production, provided that he or she has not been covered by other social insurance system and does not have the determined right to a pension.

From *work accident, sickness and maternity insurance* KRUS ensures the following benefits to farmers: lump-sum compensation in respect of permanent or protracted health damage or death in result of accident at work in agriculture or agricultural occupational disease, sickness allowance, allowance in respect of a child birth or taking the child to be brought up, maternity allowance. The amount of the benefits from this scheme is fixed by the minister of agriculture on the proposal of the Farmers' Council.

The Social Insurance Institution (ZUS) is also responsible for determining the right to and paying disability pensions and survivors' pensions. The same legal act that governs old-age pensions also governs benefits due to incapacity for work and death of breadwinner.

The *disability pension* is granted to a person insured who is incapable of work and has completed at least 5-year insurance period (contributory and non-contributory periods) during the last decade before applying for the pension or before occurrence of incapacity for work. The pension may have the permanent character if incapacity for

work is permanent, or periodic character, if it is granted for a period indicated in ZUS decision. Apart from the disability pension there is a training pension, which is payable to a person meeting the conditions for receiving disability pension, who has received a decision on the necessity of vocational retraining due to incapacity for work in earlier occupation.

### Basic principle

The basic legal act, which governs an obligation of insurance and rights to cash benefits due to sickness and maternity, is the law of 25 June 1999 on cash social insurance benefits in respect of sickness and maternity. The benefits ensured by ZUS are such as: sickness allowance, maternity allowance, care allowance, compensatory allowance, and rehabilitation benefit.

The sickness benefit scheme is a compulsory social insurance scheme for employees with earnings-related benefits paid in terms of continuation of payment of wages and salaries paid by the employer. Voluntary membership for self-employed. The benefits are payable by ZUS or by employers and are financed from the Social Insurance Fund.

### Beneficiaries

Compulsory insurance for all employees.

Voluntary membership for the self-employed.

### Duration of benefits

*Sickness allowance* is payable during the period of incapacity for work, however not longer than 6 months (in case of tuberculosis 270 days), with a possibility of its prolongation maximum by 3 months in the case if further medical treatment or rehabilitation promise recovery of earning capacity.

The rehabilitation benefit is a benefit for ending the medical treatment. It is granted to the person insured that after cessation of sickness allowance is still incapable of work and further treatment or rehabilitation promise the recovery of earning capacity. The benefit is granted not longer than for a period of 12 months.

### Amount of the benefits

100% of reference wage per month: for an illness occurring during pregnancy; for a travel accident between home and work; for an absence from work due to the donation of tissue or organs to another person.

70% of reference wage per month in event of hospitalisation.

80% of reference wage per month all other circumstances.

The Reference wage is calculated on the basis of gross earnings during the 12 months preceding the cessation of work for which contributions were paid.

### Qualifying period

Compulsory insurance: 30 calendar days.

Voluntary membership: 180 calendar days.

No qualifying period in case of: a graduate has paid contributions for at least 90 calendar days after obtaining the diploma, the insured person has paid compulsory contributions for 10 years, absence due to a travel accident between home and work, Members of Parliament and senators who join the insurance within 90 days after their tenure.

Special conditions for unemployed

The payment of benefit continues if the incapacity for work has started during the period of employment.

Examples of an integrated approach towards job regaining

Integralia Foundation, Poland	
<p><b>Country:</b> Poland  <b>Target Groups:</b> the long-term unemployed, the short-term unemployed, people with disabilities or illnesses, men, women, job seekers under 30 years of age  <b>Initiative type:</b> general careers guidance, work placements, training, job search support, confidence building, awareness raising</p>	<p>The Integralia Foundation provides special training for disabled people who are seeking employment. The training teaches individuals the necessary job activation and job search skills for finding a job, drafting a suitable curriculum vitae and job application letter, preparing for an interview and presenting themselves at the assessment centre. Participants also take part in training in communications and are informed about the legal aspects associated with the employment of disabled people.</p>

Service for computer specialists with disabilities, Poland	
<p><b>Country:</b> Poland  <b>Target Groups:</b> people with disabilities or illnesses  <b>Initiative type:</b> general careers guidance, work placements, training, job search support, job application support, confidence building</p>	<p>Biuro Karier Osób Niepełnosprawnych (ON) is a newly formed non-governmental organisation (NGO) that operates a specialist employment service for people with disabilities who have good computer skills. The organisation has created a register of such skilled workers and it seeks to obtain employment for its clients through the provision of employment counselling services.</p>

## Portugal

Social security in Portugal comes under the supervision of the Ministry of Labour and Social Solidarity. According to the new Social Security Framework Law<sup>13</sup>, the public social security system is divided into three subsystems, the insurance subsystem (which comprises the general social security scheme for the employees and for the self-employed - contributory), the solidarity subsystem (which covers the non-contributory scheme) and the family protection subsystem.

In principle, all salaried employees and self-employed people are compulsorily insured in the general scheme; there are, however, several special rules for certain self-employed people.

The insurance subsystem comprises benefits in respect of temporary loss of income due to sickness (including occupational diseases), maternity, paternity and adoption or unemployment, and in case of old age or invalidity, and death. Contributions are collected as an overall rate for the general social security system.

The flatrate contribution is levied upon wages (about 1/3 is born by the employees and about 2/3 by the employers). The contribution level and the division between employees and employers is fixed by the Parliament. These social security contributions almost entirely finance the benefits covered by the contributory scheme (sickness and maternity, invalidity, old age, survivorship, family benefits and unemployment) without state subsidies. The employer pays in addition a special wage contribution to cover occupational diseases. The employer's accidents at work contributions depend on the premiums set by the insurance companies. Sickness and maternity, paternity and adoption cash benefits are provided within the public social security system, which is financed by its own budget (its receipts are basically composed of social security contributions).

### Basic principle

The sickness benefit scheme is a compulsory social insurance scheme for employees (voluntary scheme for self-employed and persons working at home) with benefits depending on the registered earnings and on the duration of incapacity.

### Beneficiaries

All employees.

### Duration of benefits

Maximum 1,095 days (then, possibly, invalidity).

In case of tuberculosis: Unlimited.

### Amount of the benefits

Daily benefit: Fixed by applying a percentage varying according to the incapacity duration to the average daily wage for the 6 months preceding the 2 months in which the illness began:

- 65% when the incapacity period is lower or equal to 90 days;
- 70% when the incapacity period is between 91 and 365 days;
- 75% when the incapacity period goes beyond 365 days;
- in the event of tuberculosis: 80% or 100% if insured has up to 2 or more dependants.

Minimum amount: 30% of the indexing reference of social support (indexante dos apoios sociais) or the average earning if it is lower than this percentage.

Qualifying period

6 months affiliation with registered remuneration of which 12 days during the 4 months prior to the one preceding the day of incapacity.

Special conditions for unemployed

No special conditions.

Examples of an integrated approach towards job regaining

Gaia Vocational Rehabilitation Centre, Portugal	
<p><b>Country:</b> Portugal  <b>Target Groups:</b> unemployed with additional job seeking needs, people with disabilities or illnesses  <b>Initiative type:</b> general careers guidance, work placements, training, job search support, job application support, financial support and advice, confidence building, environmental adaptations, awareness raising</p>	<p>The aim of the Gaia Vocational Rehabilitation Centre (Centro de Reabilitação Profissional de Gaia, CRPG) is to provide quality services in the field of rehabilitation and reintegration for people whose professional lives are affected by illness or injury. CRPG was awarded the European Quality in Rehabilitation Mark (EQRM) as a result of the high standard of the centre's services in promoting the quality of life of people with disabilities and the development of a more open and inclusive society, guided by ethical principles of respect for the centre's clients and good management practices.</p>

Neuropsychological Rehabilitation Programme, Portugal	
<p><b>Country:</b> Portugal  <b>Target Groups:</b> unemployed with additional job seeking needs, people with disabilities or illnesses  <b>Initiative type:</b> general careers guidance, providing access to voluntary work, work placements, training, job search support, job application support, financial support and advice, confidence building, awareness raising</p>	<p>The Neuropsychological Rehabilitation Programme (NRP) is aimed at people who have traumatic brain injury. The programme addresses a gap in services between medical rehabilitation and vocational rehabilitation whereby the programme's participants now receive a range of psychological support services to enable them to take advantage of vocational rehabilitation.</p>

## **Romania**

The social model provided by the Government of Romania is grounded on the balance of competition, partnership and solidarity. This means that the social protection measures, including the social assistance for certain categories or groups of persons must be combined with actions for job creation, but also with actions of social solidarity. At the same time, certain public funds (the public pension fund, the public health insurance fund, the public fund for unemployment insurance) are managed by administration boards, which include representatives from the government, employers associations and trade unions<sup>20</sup>.

According to Romanian legislation, it is compulsory for all Romanian citizens with a residence in Romania to be insured, this also applies to foreigners or stateless citizens who have taken up residence in Romania. In order to become eligible for medical care, any person must be insured (through *GEO no. 76/2007 regarding special fiscal registration procedure and the payment of social contributions*, the legal framework required to socially insure Romanian citizens temporarily working abroad was set up so that they can benefit from all employment rights). In Romania all employees and employers have to pay contributions to the social health insurance scheme: 6.5% of the employee's gross monthly income; 7% of the total gross monthly wages earned by employees and paid by employers. For the unemployed, the contribution basis represents the monthly unemployment benefits covered by the unemployment insurance budget.

### Basic principle

The sickness benefit scheme is a compulsory social insurance scheme for the economically active population (employees and self-employed persons) providing an earnings-related benefit.

### Beneficiaries

All employees in paid employment; those who benefit of unemployment allowance; self employed persons; persons who have elective functions or are named in executive, legislative or judicial authority during the mandate period; members of a handicraft co-operative; associates, sleeping partners or shareholders; administrators or managers who signed an administration or a management contract; members of family associations.

### Duration of benefits

The duration of sickness benefit (Beneficiu de boala) is 180 days in any 1 year period, counted from the first day of the contingency.

As from the 90th day medical leave can only be extended to 180 days, with the approval of the social insurance expert physician.

The duration of the sickness benefit is longer in cases of special diseases as follows:

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<sup>20</sup> The European Commission – Employment and Social Affairs DG, Study on the Social Protection Systems in the 13 Applicant Countries - Romania Country Study; January 2003

- 1 year in the last 2 years for pulmonary tuberculosis and some cardiovascular diseases settled by the National Health Insurance House with the agreement of the Public Ministry of Health;
- a) 1 year, with a right to extension up to a year and a half for meningeal, peritoneal and urogenital tuberculosis, including of the suprarenal glands as well as AIDS and any type of cancer, according to the phase of the disease;
- b) a year and a half, in the last 2 years, for operated and osteo-articular tuberculosis;
- c) 6 months, with possibility of extension up to 1 year, in the last 2 years, for other forms of extra-pulmonary tuberculosis with the approval of the medical expert of the social insurance.

#### Amount of the benefits

The amount of social insurance benefits is 75% of the average insured gross earnings over the last 6 months.

The amount is increased to 100% of the average insured earnings over the last 6 months if the sickness benefit is caused by: tuberculosis, AIDS, any type of cancer, group A infectious and contagious diseases, and medical and surgical emergencies.

#### Qualifying period

Qualifying period of at least 1 month of contribution.

#### Special conditions for unemployed

Unemployed persons are entitled to the same sickness benefits as provided to employed persons and under the same conditions.



## Slovenia

Slovenia's social security system includes compulsory health, unemployment, pension, disability and invalidity social insurance, which are in charge of the government (Ministry of Labour, Family and Social Affairs and the Ministry of Health). It consists of a compulsory contribution, partly financed from the state budget.<sup>21</sup> All employed and self-employed people are required to contribute to Slovenian social insurance with an average rates of 15.5% of the earnings. The social assistance scheme and the system of family benefits (parental allowance, child benefit, large family allowance, special childcare allowance, partial payment for loss of income) are not financed by contributions but are financed by the governmental budget.

Entitlement to health insurance as well as to pension and invalidity insurance is on individual and family base.<sup>22</sup> It is financed by (public) funds, collected on the basis of contributions paid by employers and employees, and by several other categories of contribution obligors.

The Health Insurance Institute of Slovenia provides compulsory health insurance, for health care services and several financial benefits (sick benefits for diseases unrelated to work, employment injuries or occupations diseases, reimbursement of travel costs, and funeral costs, and insurance money paid in case of death).<sup>23</sup> It covers employees, self-employed persons, farmers, pensioners, recipients of social assistance, invalidity or victims of war or its consequences and unemployed persons. Also citizens residing in Slovenia not insured under any other heading are covered by the insurance system.

The pension and disability insurance is under the responsibility of the Institute for Pension and Disability Insurance. State pension is non-contributory, but largely financed by contributions. Entitlement to unemployment insurance is on an individual basis and is compulsory for all workers in an employment relation, while it is voluntary for the self-employed.

### Basic principle

The sickness benefit scheme is a compulsory social insurance scheme financed by contributions for the active population (employees and self-employed) with earnings-related benefits and is paid as continuation of payment of wages and salaries paid by the employer.

### Beneficiaries

All employees, self-employed persons and farmers (those who pay contributions).

### Duration of benefits

1 year. Longer duration of benefit possible with the approval of the commission.

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<sup>21</sup> [http://ec.europa.eu/employment\\_social/missoc/2007/02/2007\\_2\\_si\\_en.pdf](http://ec.europa.eu/employment_social/missoc/2007/02/2007_2_si_en.pdf)

<sup>22</sup> MISSOC- Info 2/ 2007: Financing social protection, [http://www.socialsecurity.fgov.be/bib/frames/engels/btsz\\_01\\_2001\\_vidmar.htm](http://www.socialsecurity.fgov.be/bib/frames/engels/btsz_01_2001_vidmar.htm)

<sup>23</sup> European Observatory for Health care Systems (202), Health care system in transition, Slovenia. Vol. 4 No. 3 2002. <http://www.euro.who.int/document/e76966.pdf>

### Amount of the benefits

Sickness Benefit (nadomestilo plače za čas bolezni) amounts are calculated as a percentage of the recipient's average monthly gross wage in the previous calendar year (the basis). The benefit amounts to:

- 100% for occupational diseases, industrial injuries, the donation of tissue, organs or blood, quarantine, war invalids and civilian invalids of war;
- 90% for illness;
- 80% for an injury unrelated to work or nursing of an immediate family member.

Benefit may be between the amount of the Statutory Reference Amount (zajamčena plača) and the gross wage the beneficiary would receive if he/she was working.

The Statutory Reference Amount is defined as an "individual amount that provides a worker with material and social security" and is determined annually. The SRA for August 2006 amounts € 237.73 per month (net).

### Qualifying period

No qualifying period required.

### Special conditions for unemployed

No entitlement for unemployed persons. They receive Unemployment Benefit (nadomestilo za primer brezposelnosti) (see table IX "Unemployment").

### Examples of an integrated approach towards job regaining

New Way training programme, Slovenia	
<p><b>Country:</b> Slovenia</p> <p><b>Target Groups:</b> the long-term unemployed, the short-term unemployed, unemployed with additional job seeking needs, people with disabilities or illnesses, men, women, job seekers over 50 years of age</p> <p><b>Initiative type:</b> work placements, training, job search support, job application support, confidence building, environmental adaptations, awareness raising</p>	<p>The New Way programme focuses on vocational training, psychosocial rehabilitation and support for securing and especially retaining employment for certain groups of unemployed persons, such as those with traumatic brain injury. The vocational rehabilitation period aims to enhance the long-term employment possibilities of clients, either in the open labour market, in the social economy, in supported or protected employment, or in terms of social inclusion. The programme uses an interdisciplinary and multidimensional approach.</p>

Training job mentors, Slovenia	
<p><b>Country:</b> Slovenia</p> <p><b>Target Groups:</b> people with disabilities or illnesses, men, women, job seekers under 30 years of age</p> <p><b>Initiative type:</b> general careers guidance, training, job application support, financial support and advice, confidence building, environmental adaptations, awareness raising</p>	<p>The project aimed to develop a training programme for job mentors in Slovenia and Austria who could assist target groups of people who have difficulty in accessing the labour market. The activities of the programme included the development of a common methodology and standards, a test project among a group of 15 job mentors, a common evaluation of the programme, as well as a cross-border exchange between job mentors.</p>

## **Slovak Republic**

The social insurance system comprises, apart from the sickness insurance, pension insurance and accident insurance, also the unemployment insurance with the current inclusion of legal form of providing benefits out of this system, and the insurance in case of employer's insolvency named the guarantee insurance.

The Social Insurance Agency is a statutory institution with a nationwide competency in the area of the sickness insurance, pension insurance, accidental insurance, unemployment insurance guarantee insurance. Sickness insurance Benefits provided by the SIA in this area are the cash benefits, the benefits in kind are provided by the Health Insurance Company.

The cash benefit types include: sickness benefit, attendance care benefit, equalization benefit, maternity benefit.

*Attendance care benefit:* is provided per days in the amount of 55% of the daily assessment basis from the first day of attendance on a sick child, a husband, a wife, a parent or on a sick parent of his/her spouse, whose health condition demands a treatment by another natural person;

The *invalidity pension* – the qualifying condition is a reduction of capacity to perform the gainful activity due to a long term unfavourable health condition (longer than 1 year) by more than 40%, and achieving the required insurance period as of the day of disability occurrence and non qualifying to the old age pension, or non awarding the early old age pension. The pension insurance period is not required on condition invalidity occurred due to a working injury or an occupational disease.

### **Basic principle**

The sickness benefit scheme is a compulsory social insurance scheme for employees and self-employed with earnings-related benefits. There is the possibility of voluntary insurance for all other persons over the age of 16.

Continuation of payment of wages and salaries paid by the employer.  
Special scheme for policemen, soldiers and custom officers.

### **Beneficiaries**

All employees, self-employed persons and voluntarily insured.

### **Duration of benefits**

The *sickness benefits* are provided from the social insurance system from the 11th day of employee's working incapacity, in case of self – employed person and voluntarily insured person from the 1st day of a temporary working incapacity until the end of the working incapacity, or until the recognition of disability, not longer than 52 weeks from the arise of the temporary working incapacity.

After 1 year of temporary incapacity and then the health condition must be reexamined.

### **Amount of the benefits**

The calculation method of a daily amount of sickness benefit has been simplified and unified for employees, self – employed persons and voluntarily insured persons. During the temporary working incapacity, the employee's income replacement during the first ten days is provided by an employer, and from the 11th day it is provided by the SIA.

*Sickness benefit:* is provided per days: in the first 3 days it equals to 25% of the daily assessment basis, from 4th until 10thday it equals to 55% of the daily assessment basis<sup>24</sup>, paid out by the employer. From the 11th day of temporary incapacity for work the cash sickness benefit is 55% of the daily assessment basis, and is paid out by the SIA

Self-employed and voluntarily insured: during the first 3 calendar days of incapacity for work 25% of the assessment base, then 55%.

Only 50% of the benefit is paid if the sickness has been a consequence of alcohol or drug abuse. In case of non-compliance with the treatment, the entitlement is suspended for 30 calendar days.

#### Qualifying period

Employees: No qualification period required.

Self-employed and voluntarily insured persons: 270 calendar days of membership in the sickness insurance system during the 2 years before the sickness occurred.

#### Special conditions for unemployed

No special conditions.

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<sup>24</sup> Daily earnings calculated on the basis of the previous year, monthly ceiling 1.5-times of the national average monthly wage.

## Spain

The main concept of Spain's current social security system was laid down in the '*Ley de Bases de la Seguridad Social 1963*' and developed further since then. The statutory contributory schemes include a general system for all dependent employees of the industry and services (*Régimen General*) as well as some special schemes (for self-employed persons, for the agricultural sector, for mariners, for miners, for domestic workers, for civil servants and for students) according to different sectors of activity or for special groups of insured persons. The level of benefits provided within these schemes may differ.

In principle, coverage includes sickness, maternity, temporary incapacity for work, invalidity, old age, death, survivorship, family benefits and unemployment. Contributory schemes are compulsory.

Non-contributory schemes (health care, old age and invalidity pensions, unemployment allowance, cash benefits for dependent children) have been introduced in order to provide basic provisions to those who do not benefit from the contributory schemes. They are financed by the state.

Today, about 98% of the Spanish population are part of the social security system, either in the contributory general scheme (*Régimen General*), in one of the special schemes (*Regimenes especiales*) or in the non-contributory system.

Social security contributions are calculated as a percentage of the contribution basis. They cover: health, temporary incapacity, pensions, maternity and family benefits. In the general scheme the contribution basis is approximately in line with the salary of the employed person.

The contribution liability is subject to a minimum and a maximum wage limit. The employer is responsible for paying the social contributions (the employees' 1/6 and the remaining 5/6 employers' share).<sup>25</sup>

### Basic principle

The sickness benefit scheme is a compulsory social insurance scheme for employees and assimilated groups with contribution-related benefits for temporary incapacity (*Incapacidad temporal*).

### Beneficiaries

All employees.

Special scheme for the self-employed

### Duration of benefits

12 months. Possibility of extension for 6 months when foreseeable that the beneficiary will become capable for work.

### Amount of the benefits

From 4th to 20th day of sick leave inclusive, 60% of the calculation basis.

From the 21st day, 75% of the calculation basis.

Calculation basis: Quotient of contribution basis of the month prior to the date of leave divided by the number of days corresponding to this contribution.

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<sup>25</sup> European Social Insurance Platform, The Structure of Social Insurance in Europe

Qualifying period

Contributions paid for 180 days during 5 years prior to the date of leave in case of common illness. No contribution period in case of accident.

Special conditions for unemployed

No special conditions.

## Sweden

One known characteristic of the Swedish social insurance system is its universal nature which means that all citizens legally residing in Sweden are obligatory insured by a uniform system irrespective of occupation, and in many cases regardless of whether the individual is gainfully employed or not. In most cases, a person has to be registered with one of the social insurance offices (when he/she reaches the age of 16) in order to be entitled to benefits. Sickness insurance, work injury insurance, the national basic pension scheme the supplementary as well as partial retirement pensions are mainly financed through general social security charges. In 1997, 73,5% of the total social insurance expenditure were covered by social security charges and general contributions from insured persons. Charges are not levied individually but through a collective system on a company's total wage cost (paid by the employer). They amount to a little less than 30% of the total sum of wages in the case of employed people (for self-employed people contributions amount to slightly above 25% of their income from work).

A European study in 2003 showed that Sweden had the highest proportion of sick listed people: 4,5% of the employed workforce. For 2004 social insurance costs related to sick-listing corresponded to € 14000, twice the growth of national GNP<sup>26</sup>

The main duty for the national insurance system with relation to the sickness insurance is the payment of sickness cash benefits. Parental insurance, close relative allowance and a number of care allowances are also part of this insurance scheme financially.

During periods of temporary illness, the sickness cash benefits are paid under the ordinary regulations on sick pay and sickness cash benefit. In the case of long lasting or permanent incapacity, pension payments are the basic benefits and annuity under the work injury insurance scheme is paid as a supplement.

### Basic principle

The sickness benefit scheme is a compulsory sickness insurance scheme for the active population (employees and self-employed) with earnings-related benefits. It is paid in terms of continuation of payment of wages and salaries by the employer.

### Beneficiaries

All employees and self-employed.

### Duration of benefits

There is no formal limitation but the sickness cash benefit (sjukpenning) may be converted into Activity compensation (aktivitetsersättning) (for persons aged 19 to 29 years) or Sickness compensation (sjukersättning) (for persons aged 30 to 64 years) if the illness continues for an extended period of time.

### Amount of the benefits

80% of the income qualifying for sickness cash benefit (sjukpenning). The sickness cash benefit is paid up to a ceiling of 7.5 times the price base amount (prisbasbelopp)=

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<sup>26</sup> Ahlgren A., Vocational Rehabilitation, Work Resumption and Disability Pension, Department of Public Health Sciences – Karoliska Institutet, Stockholm 2006

€ 32,616.

The social insurance office (försäkringskassa) pays sickness cash benefit as from the 15th day in a period of illness. However, certain categories of the insured, such as the unemployed, the self-employed and day-to-day employed, may be entitled to sickness cash benefit from the 2nd day in a period of illness.

Qualifying period

Neither work period nor qualifying period required.

Special conditions for unemployed

Unemployed persons are entitled to sickness cash benefit (sjukpenning) with the same amount they received before the last employment ended, as long as they are actively looking for a job, but the maximum amount is € 52 a day.

Examples of an integrated approach towards job regaining

Forum 50+ work marketplace for older workers, Sweden	
<p><b>Country:</b> Sweden  <b>Target Groups:</b> the long-term unemployed, people with disabilities or illnesses, men, women, job seekers over 50 years of age  <b>Initiative type:</b> general careers guidance, training, job search support, job application support, confidence building, environmental adaptations</p>	<p>This initiative to create a work marketplace for older workers aims to provide jobs for 50% of the programme's participants within nine months, which means an employment period of at least six months' duration. The initiative also aims to combat discrimination against older workers. An important element of the initiative is that the activities carried out must resemble real working life situations as much as possible. Professional educators are involved in the project and each participant is assigned an individual job coach.</p>

Rehabilitation for high-skilled workers, Sweden	
<p><b>Country:</b> Sweden  <b>Target Groups:</b> people with disabilities or illnesses, women  <b>Initiative type:</b> work placements, training</p>	<p>The aim of this project was to tackle the problem of shortage of nursing staff by facilitating the return to work of qualified nurses on sick leave. After a short period of vocational training, during which suitable tasks were tested, nurses with reduced working capacity were employed by the state-owned vocational rehabilitation services company Samhall, which was then able to supply this personnel to the municipalities and county councils.</p>

Green Staircase, Sweden	
<p><b>Country:</b> Sweden  <b>Target Groups:</b> the long-term unemployed, people with disabilities or illnesses, men, women, job seekers over 50 years of age, job seekers under 30 years of age  <b>Initiative type:</b> general careers guidance, training, job search support, financial support and advice, awareness raising</p>	<p>The Green Staircase initiative targets long-term unemployed people and those in receipt of sickness benefits who have been absent from working life for a long time. It aims to develop an action plan defining the career direction of participants in the programme, their ability to work full time or part time and steps to be taken</p>



	to enable them to return to work. The main innovation is basing activities in the forest which is viewed as a rehabilitating environment.
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Spektra project, Sweden	
<p><b>Country:</b> Sweden</p> <p><b>Target Groups:</b> the long-term unemployed, people with disabilities or illnesses, men, women, job seekers over 50 years of age, job seekers under 30 years of age</p> <p><b>Initiative type:</b> work placements, training, job search support, job application support, financial support and advice, confidence building, environmental adaptations, awareness raising</p>	<p>The Spektra project started in 2005 and to date some 24 persons, all with some kind of disability, have participated. The innovative nature of the project involves the use of both the Swedish Employment Service and private training and employment agencies, making the participants responsible for their own situation, and focusing on individual adaptations to the workplace.</p>

Vocational rehabilitation in cooperation, Sweden	
<p><b>Country:</b> Sweden</p> <p><b>Target Groups:</b> the long-term unemployed, people with disabilities or illnesses, men, women</p> <p><b>Initiative type:</b> training</p>	<p>This joint project by the Swedish Employment Service and the Social Insurance Office targets unemployed people on disability benefit, employed people on sick leave who need to change their job because of their illness, and people on job activation support or time-limited sickness benefit. In 2006, some 12,000 clients participated in this project throughout Sweden.</p>

## United Kingdom

The United Kingdom has a comprehensive, regulated, state administered cash benefit social security system which covers the entire population. The *Department of Social Security* (DSS) is responsible for the Development, maintenance and delivery social security programme and of the Government's policy for Child Support. The DSS is responsible for retirement and disability pensions, unemployment and sickness insurance, general assistance for lone mothers, the sick and disabled, the unemployed benefit scheme and other support for people with low income. The costs of the contributory benefits are covered by National Insurance Contributions paid by employees, employers and the self-employed. The insured persons pay a single (or global) contribution covering all the contributory benefits. The contributions are paid into the *National Insurance Fund* which operates on a 'pay-a-you-go' basis.

### Basic principle

The sickness benefit scheme is paid to people who are unable to work because of sickness through the *Statutory Sick Pay* (SSP) paid by the employer. It is a compulsory social insurance scheme for employees and self-employed persons, which has flat-rate benefits.

The entitlement condition is linked to the average weekly earning which must be at or above the point at which National Insurance Contributions become payable. After 28 weeks, Incapacity Benefits is payable by the state. State benefits for sickness/invalidity are administered by the *Benefit Agency*.

### Beneficiaries

Statutory Sick Pay (SSP): Employees only.

Short-term Incapacity Benefit (IB): Employed and self-employed persons (except married women who opted before April 1977 not to be insured) and unemployed.

### Duration of benefits

Short-term incapacity benefit: 52 weeks maximum in a period of incapacity for work; lower rate payable for first 28 weeks, followed by higher rate from week 29. Then it is replaced by long-term incapacity benefit.

### Amount of the benefits

Short-term incapacity benefit: Paid at two rates: lower rate of € 91 per week for first 28 weeks; higher rate of € 107 thereafter. If over pension age, up to € 120 per week.

Additions: Spouse aged 60 or over or adult caring for dependent child € 56 or if over pension age € 69.

Child dependency increase with higher rate benefit, or from first day if over pension age: € 14 for first child, € 17 for each other. Not available for claims from April 2003.

### Qualifying period

Statutory Sick Pay: Employees' earnings before sickness must have reached the Lower Earnings Limit (LEL) for National Insurance contribution purposes.

Short-term incapacity benefit: Must have paid sufficient contributions in any one of the

three tax years before the year of the claim, and have been paid or been credited with sufficient contributions in 2 relevant tax years; normally the 2 preceding the year of the claim.

Employees have to satisfy the contribution conditions where they claim short-term incapacity benefit on cessation of Statutory Sick Pay.

Special conditions for unemployed

No special conditions.

Examples of an integrated approach towards job regaining

Want 2 Work, UK	
<p><b>Country:</b> United Kingdom  <b>Target Groups:</b> people with disabilities or illnesses, men, women  <b>Initiative type:</b> work placements, training, job application support, confidence building</p>	<p>The ‘Want 2 Work’ initiative is one of a number of pilot projects aimed at assisting older people in receipt of incapacity benefit. Advisers offer advice to people in relation to the full range of employment benefits and provide support to enable beneficiaries to access these benefits. Delivery of this initiative takes place through outreach provisions in local community outlets in Wales.</p>

Work preparation for disabled people, UK	
<p><b>Country:</b> United Kingdom  <b>Target Groups:</b> unemployed with additional job seeking needs, people with disabilities or illnesses  <b>Initiative type:</b> general careers guidance, providing access to voluntary work, work placements, training, job search support, job application support, confidence building, awareness raising</p>	<p>The ‘Work Preparation’ programme is a Jobcentre Plus initiative in the UK that enables unemployed people with a disability and/or long-term health problem to explore employment opportunities through a programme of external work placement and a corresponding support network. One such programme in Scotland is run by Momentum, a vocational rehabilitation service for people with traumatic brain injury.</p>

**Annex to chapter IV: Applicable statutory basis and basic principles concerning sickness benefits in Europe**

<b>Sickness - Cash benefits<sup>1</sup></b>	
	<b>Applicable statutory basis</b>
<b>Belgium :</b>	<p>Employees: Health Care and Sickness Benefit Compulsory Insurance Act (Loi relative à l'assurance obligatoire soins de santé et indemnités/Wet betreffende de verplichte verzekering voor geneeskundige verzorging en uitkeringen), co-ordinated on 14 July 1994, Royal Decree of 3 July 1996 on the execution of this Act and Regulation of 16 April 1997 on the execution of Article 80-5 of this same Act.</p> <p>Hospital Act (Loi sur les hôpitaux/Wet op de ziekenhuizen), co-ordinated on 7 August 1987.</p> <p>Law of 27 June 1969 revising the Decree-law of 28 December 1944 on the social security of workers.</p> <p>Self-employed: Royal Decree of 20 July 1971 on the creation of a health care and maternity insurance for the self-employed and their helping spouses.</p>
<b>Bulgaria :</b>	<p>Social Insurance Code (Кодекс за социално осигуряване) 1999 title amended 2003.</p> <p>Law on Health (Закон за здравето) 2004.</p> <p>Ordinance on the medical expertise of the working capacity (Наредба за медицинската експертиза на работоспособността) 2005.</p>
<b>Czech Republic :</b>	Act No. 54/1956 on Employees' Sickness Insurance (Zákon o nemocenském pojištění zaměstnanců).
<b>Denmark :</b>	Con. Act No. 1047 of 28 October 2004 on Sickness Benefit Act (om lov nr. 852 om dagpenge ved sygdom og fødsel).
<b>Germany :</b>	<p>Social Code (Sozialgesetzbuch), Book IV of 23 December 1976.</p> <p>Social Code (Sozialgesetzbuch), Book V, introduced by the Health Reform Act (Gesundheits-Reformgesetz) of 20 December 1988 and recently further developed by the Act on Strengthening Competition in Statutory Health Insurance (Gesetz zur Stärkung des Wettbewerbs in der gesetzlichen Krankenversicherung (GKV - WSG)) of 26 March 2007.</p>
<b>Estonia :</b>	<p>Health Insurance Act (Ravikindlustuse seadus) 2002.</p> <p>Estonian Health Insurance Fund Act (Eesti Haigekassa seadus) 2000.</p>
<b>Greece :</b>	Legislative Decree 1846 of 14 June 1951 on social insurance as amended.
<b>Spain :</b>	<p>Social Security General Act (Ley General de la Seguridad Social) approved by Legislative Royal Decree No. 1/94 of 20 June 1994.</p> <p>Decree No. 3158/66 of 23 December 1966 and other provisions.</p> <p>Ministerial Order of 13 October 1967.</p> <p>Royal Decree No. 1300/95 of 21 July 1995.</p>

<sup>1</sup>

Source: Missoc

<b>France :</b>	General scheme for employees (Régime général d'assurance maladie des travailleurs salariés, RGAMTS):  Social Security Code (Code de la sécurité sociale), Articles L 323-1, and following.  Several other schemes, in particular for certain categories of self-employed and employees.
<b>Ireland :</b>	Social Welfare Consolidation Act 2005.
<b>Italy :</b>	Law No. 833 of 23 December 1978 instituting the National Health Service (Servizio Sanitario Nazionale, S.S.N.).
<b>Cyprus :</b>	Social Insurance Law (Νομοθεσία Κοινωνικών Ασφαλίσεων): No. 31/56 of 1957, No. 2/64 of 1964, No. 106/72 of 1972, No. 41/80 of 1980-2007.  The Social Insurance (Benefit) Regulations.  The Social Insurance (Contribution) Regulations.
<b>Latvia :</b>	Law on State Social Insurance (Likums "Par valsts sociālo apdrošināšanu") of 1 October 1997.  Law on Maternity and Sickness Insurance (Likums "Par maternitātes un slimības apdrošināšanu") of 6 November 1995.
<b>Lithuania :</b>	Law on Sickness and Maternity Social Insurance (Ligos ir motinystės socialinio draudimo įstatymas) of 21 December 2000 (No. IX-110).  Law on Support in Case of Death (Įstatymas dėl paramos mirties atveju) of 23 December 1993 (No. I-348).
<b>Luxembourg :</b>	Book I of Social Insurance Code (Code des assurances sociales) in the terms following the Law of 27 July 1992.
<b>Hungary :</b>	Act LXXXIII of 1997 on the benefits of Compulsory Health Insurance, (törvény a kötelező egészségbiztosítás ellátásairól).
<b>Malta :</b>	Social Security Act (Att dwar is-Sigurta' Soċjali) (Cap. 318).
<b>The Netherlands :</b>	Sickness Benefit Act (Ziektewet, ZW) of 5 June 1913.
<b>Austria :</b>	General Social Insurance Act (Allgemeines Sozialversicherungsgesetz, ASVG) of 9 September 1955.  Continued payment of wages and salaries: (White collar) Employees Act (Angestelltengesetz) 1921 and Continued Payment of Wages and Salaries Act (Entgeltfortzahlungsgesetz, EFZG) of 26 June 1974.
<b>Poland :</b>	Law on Social Insurance Cash Benefits in Cases of Sickness and Maternity (Ustawa o świadczeniach pieniężnych z ubezpieczenia społecznego w razie choroby i macierzyństwa) of 25 June 1999.
<b>Portugal :</b>	Statutory Decree 28/2004 of 4 February 2004, modified by the Statutory Decree 146/2005 of 26 August 2005.
<b>Romania :</b>	Emergency Ordinance of Government (Ordonanta de urgenta a Guvernului) No. 158/2005, published in OJ No. 1074/29 November 2005.
<b>Finland :</b>	Sickness Insurance Act (Sairausvakuutuslaki) of 21 December 2004.

<b>Slovenia :</b>	<p>Health Care and Health Insurance Act (Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju) (Official Gazette of the Republic of Slovenia, no. 100/2005).</p> <p>Rules on Compulsory Health Insurance (Pravila obveznega zdravstvenega zavarovanja) (Official Gazette, no. 30/2003).</p>
<b>Slovak Republic :</b>	<p>Law on Social Insurance (Zákon o sociálnom poistení) No. 461/2003.</p> <p>Law on Income Replacement in case of employees' temporary incapacity for work (Zákon o náhrade príjmu pri dočasnej pracovnej neschopnosti zamestnanca) No. 462/2003.</p> <p>Law on Funeral Grant (Zákon o príspevku na pohreb) No. 238/1998.</p> <p>Law on Compensation for Pain and on Compensation for Reduced Social Opportunities (Zákon o náhrade za bolesť a náhrade za sťaženie spoločenského uplatnenia) No. 437/2004.</p>
<b>Sweden :</b>	<p>National Insurance Act (Lag om allmän försäkring) of 1962.</p> <p>Sick Pay Act (Lag om sjuklön) of 1991.</p>
<b>United Kingdom :</b>	<p>Social Security Contributions and Benefits Act 1992.</p> <p>Social Security (Incapacity for work) Act 1994.</p> <p>Social Security Act 1998.</p>