# The Hidden Cost of an Unhealthy Europe

## Sickness Absence, Productivity and the Economic Case for Prevention

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# Foreword

# More healthy years – for people and for Europe

Europe faces a paradoxical health problem. We are living longer than ever before, yet far too many of these additional years are marked by illness, reduced work capacity and long periods of sickness absence. The question, therefore, is not only how we can help people live longer, but how we can help them live more years in good health.

When the cost of ill health is discussed, the conversation almost always focuses on healthcare budgets. Yet the greatest cost often arises elsewhere: in workplaces, businesses and the wider economy when people are forced to be absent from work for long periods. Sickness absence is therefore not only a health issue but also a matter of productivity, quality of life and Europe's long-term competitiveness. This report shows that sickness absence costs EU Member States hundreds of billions of euros every year, and that a significant share of these costs is linked to preventable ill health.

In EPHI's previous report, *From Cure to Care*, we argued for a shift in how we think about healthcare. Instead of devoting resources almost exclusively to treating people once they have already become ill, there are major opportunities to identify risks earlier, prevent ill health and thereby give more people more years in good health.



**This report shows that sickness absence costs EU Member States hundreds of billions of euros every year, and that a significant share of these costs is linked to preventable ill health.**

With this report, we take the next step and broaden the perspective from Sweden to Europe. European countries differ not only in the extent of sickness absence, but also in how healthcare and social insurance systems are organised. Sweden, for example, has a predominantly tax-funded healthcare system, while the Netherlands bases its healthcare system on mandatory health insurance and competing private insurers.

Economist Adrian Mehic shows how much sickness absence costs the EU—resources that, in many cases, could be used more effectively if more illnesses were prevented or treated at an earlier stage.

Our point is not that people should work when they are ill. On the contrary, this report is about how we can reduce preventable sickness absence and create systems that help people maintain their health and recover more quickly. If more Europeans can live healthier lives and retain their ability to work for longer, both individuals and society stand to benefit.

At EPHI, we hope this report will contribute to a broader European discussion on preventive health. If more people can live healthier lives and enjoy more years in good health while remaining in the labour market, individuals, the European economy and welfare systems will all benefit.



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*Stockholm, 2026*

# The Hidden Costs of Sickness Absence

When the cost of ill health is discussed in public debate, the focus almost always falls on healthcare expenditure. This is understandable, since hospitals, primary care centres, medicines and elderly care put pressure on national, regional and local government budgets. But healthcare expenditure represents only a small part of the broader economic cost of ill health. When people are unable to work because of illness, economic output also declines, while employers and colleagues have to manage the consequences of their absence.

Sickness absence therefore generates costs at several levels. Employers may have to pay sick pay, hire replacements or ask other employees to work overtime. This, in turn, means colleagues have to take over tasks, projects are delayed and customers have to wait. For the public sector, there are additional costs for sickness benefits, rehabilitation and healthcare. Longer periods of sickness absence can also lead people to leave the labour market altogether, reducing tax revenues and increasing expenditure on social insurance.

The benefits of improved health are therefore not limited to lower healthcare costs or an improved quality of life. They also include enabling more people to work, take care of themselves and remain active members of society for longer. An intervention that prevents or shortens a period of sickness absence can therefore create value far beyond what is visible in the healthcare budget.

## How many working days are lost?

Comparing sickness absence across countries is difficult. Countries differ in who pays compensation, how absence is recorded, how long a person may be off sick without a medical certificate, and which groups are included in the statistics. In some countries, the data are based on administrative registers, while in others they are based on surveys. Shorter periods of sickness absence may also be missing from registers; conversely, self-reported absence may be underestimated when people forget individual sick days.

The OECD has therefore developed a more comparable indicator based on the EU Labour Force Survey. It covers full-time employees and measures the number of working weeks lost each year due to illness. It includes both full weeks of absence and hours lost when an employee is able to work only part of the week. To adjust

for the underreporting of sickness absence in labour force surveys, the OECD also doubles the observed values. Based on OECD data, sickness absence in the EU averages around 2.9 working weeks per full-time employee per year, with each country's figures weighted according to its share of EU employment. At five working days per week, this corresponds to just under 15 working-day equivalents. Compared with a working year of around 250 working days, this represents approximately six per cent of working time. Although six per cent may appear relatively small for an individual company, the sums become very large when the entire EU labour market is taken into account.

## Large differences between countries

There are substantial differences in sickness absence between countries. Table 1 below shows the average number of weeks of sickness absence per full-time employee in a selection of EU countries and Norway. The table is based on OECD statistics for 2025. Sickness absence amounts to just under six weeks per full-time employee in Norway, around five weeks in Finland and Spain, and just over four weeks in France. Sweden and Germany are slightly above three weeks. In some eastern and southern European countries, reported absence is considerably lower. In Italy and Greece, for example, sickness absence averages less than one week per full-time employee.

Differences between countries should not necessarily be interpreted as an indicator of population health. Low recorded sickness absence may indeed indicate good health, but it may equally reflect low compensation, weak employment protection or sick people going to work despite being unfit for work. Conversely, relatively high absence may partly reflect a sickness insurance system that makes it possible to stay at home, more comprehensive recording by employers of short-term sickness absence, or the fact that more people with reduced work capacity are actually in employment.

International comparisons are also affected by the composition of the labour market. Sickness absence, for example, tends to be higher in physically demanding occupations and in jobs where employees cannot work from home. Countries with large healthcare, social care, industrial or transport sectors may therefore have a different absence profile from countries in which more people work in office-based and knowledge-intensive occupations.

**Table 1: Number of working weeks of sickness absence per year per full-time employee in a selection of EU countries and Norway, 2025.**
Approximate day equivalents rounded to the nearest whole number.

| Country | Weeks per full-time employee | Approximate working day equivalents |
|---|---|---|
| **Norway** | 5.7 | 29 |
| **Spain** | 5.0 | 25 |
| **Finland** | 4.8 | 24 |
| **France** | 4.1 | 21 |
| **Germany** | 3.5 | 18 |
| **Austria** | 3.3 | 17 |
| **Sweden** | 3.2 | 16 |
| **EU average** | 2.9 | 15 |
| **Netherlands** | 2.7 | 14 |
| **Denmark** | 2.1 | 11 |
| **Poland** | 1.8 | 9 |
| **Slovakia** | 1.2 | 6 |
| **Italy** | 0.6 | 3 |
| **Greece** | 0.2 | 1 |

Despite these caveats, the differences between countries are so large that they can hardly be explained solely by statistical or structural differences. They also indicate that sickness absence is, to some extent, influenced by factors that can be changed. The working environment, access to healthcare, rehabilitation, preventive health-care and the design of social insurance systems can affect both how often people take sick leave and how quickly they return to work.

Norway is an example of how the design of social insurance can affect sickness absence. The country has the highest level of sickness absence in the comparison above, while the Norwegian sickness insurance system has no equivalent to Sweden's qualifying-day deduction, which in practice functions as a form of deductible in the sickness insurance system. In Norway, employees are generally entitled to sickness benefits from the first day of illness, and the employer normally pays the benefit for the first 16 calendar days. This does not allow us to conclude that the absence of a qualifying-day deduction causes Norway's high sickness absence, but it nevertheless illustrates a fundamental trade-off in sickness insurance: generous insurance provides stronger financial protection in the event of illness,

while at the same time reducing the individual's financial cost of being absent from work. The issue of the qualifying-day deduction once again became salient ahead of the 2026 election, when the Social Democrats, the Left Party and the Green Party campaigned on abolishing it.[1]

For employers, incentives also depend on how the costs of sickness absence are distributed. The Netherlands provides a clear contrast to many other European systems. A Dutch employer is normally required to pay at least 70 per cent of an ill employee's salary for up to two years and is also responsible for rehabilitation and return to work. This contrasts with Sweden, where the employer only has to pay 80 per cent, less the qualifying-day deduction, for 14 days, after which the remainder of the cost largely falls on the sickness insurance system. When such a large share of the cost of long-term sickness absence remains with the employer, investing in preventive measures becomes more financially attractive. According to OECD data, sickness absence is also lower in the Netherlands than in Sweden, despite the Dutch system placing significantly greater financial responsibility on employers for long-term sickness absence. The difference illustrates how greater cost responsibility can also create stronger incentives to prevent ill health and facilitate a swift return to work.

## What drives sickness absence?

A large share of sickness absence is linked to diagnoses for which preventive measures, early treatment and rehabilitation can potentially reduce both the risk and duration of sickness absence. In Sweden, mental ill-health accounted for 46 per cent of ongoing sickness cases in May 2026. This was followed by musculoskeletal disorders, such as muscle and joint conditions, at 18 per cent; cancer at 7 per cent; and two categories, injuries and poisoning, and diseases of the nervous system, at 6 per cent each.[2] Mental health conditions and musculoskeletal disorders also dominate in Norway.[3] The two largest diagnostic groups are particularly relevant from a preventive perspective. To reduce the risk of musculoskeletal disorders, employers can, for example, invest in measures that improve workplace ergonomics. Similarly, early interventions for stress and mental ill-health can reduce the risk of problems developing into long-term sickness absence. Even when the illness itself cannot be prevented, early treatment and rehabilitation can help shorten sickness absence and facilitate a return to work.

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[1] Omni (2026). "Dadgostars plan kring karensavdraget: Köra över C". [Dadgostar's Plan for the Qualifying-Day Deduction: Overriding the Centre Party]. Published 16 January 2026.

[2] Swedish Social Insurance Agency (Försäkringskassan). Figures refer to May 2026.

[3] Norwegian Labour and Welfare Administration (NAV). Figures refer to 2025.

## Sickness absence corresponds to labour costs of around €540 billion

To estimate the cost of sickness absence across the EU, absence can be compared with total compensation of employees. Eurostat's *'compensation of employees'* measure includes wages and other remuneration as well as employers' social contributions. In 2025, this total amounted to approximately €9,039 billion in the EU Member States (Eurostat 2026). Under the central assumption that 6 per cent of potential working time is lost through sickness absence, the direct labour cost is approximately €540 billion per year.

It is important to emphasise, however, that EU GDP (gross domestic product) would not automatically increase by €540 billion if all sickness absence disappeared. Compensation paid to an employee who is off sick is not in itself the same as an economic loss. Some work is made up later or carried out by colleagues, and some organisations can maintain production despite the absence. At the same time, this often creates other costs in the form of increased workloads, overtime or postponed tasks.

The €540 billion should therefore be regarded as an estimate of the value of the working time and labour costs associated with sickness absence, rather than an exact calculation of lost GDP. But the figure indicates the order of magnitude: it corresponds to approximately 2.9 per cent of the EU's nominal GDP in 2025, which was around €18,800 billion (European Commission 2026). The result also depends on the average level of sickness absence used. With 2.5 weeks of absence, the direct cost would be around €450 billion. With 3.5 weeks, it would be closer to €630 billion. A reasonable range is therefore approximately €450–630 billion, with €540 billion as the central scenario.

## The true cost is higher

The direct labour cost also fails to capture the full loss of production. The calculation above covers only sickness-related absence among people who are still classified as full-time employees. It therefore does not take into account the full economic cost of long-term ill health. If, for example, mental ill-health or musculoskeletal injuries lead a person to permanently reduce their working hours or leave the labour market altogether, this results in a loss of production that is no longer recorded as sickness absence. Added to this are public expenditure on long-term benefits and lost tax revenues. The total labour-market cost of ill health is therefore greater than the sickness-absence calculation suggests.

Sickness absence is also associated with indirect costs. When an employee is absent, the work often has to be performed by someone else. Colleagues may have to deprioritise their regular tasks, managers have to spend time on staffing and administration, and companies may need to hire temporary staff. The effects can be particularly large if the absent employee works in a team, is difficult to replace or performs time-critical tasks.

Nicholson et al. (2006) estimate these so-called multiplier effects for 35 occupations and find a median multiplier of 1.28, meaning that the loss of production is 28 per cent higher on average than the absent worker's wage. A later Dutch study finds an average multiplier of 1.25 (Brouwer et al. 2023), while other empirical estimates show larger effects. Krol et al. (2023) show that the results vary considerably between occupations. In some occupations, absence appears to cause only small additional production losses beyond the absent employee's own output, while indirect costs can be substantial in other occupations. Examples of occupations with low indirect costs include fast-food cooks and automotive mechanics (Nicholson et al. 2006), while engineering occupations show high indirect costs (Pauly et al. 2008). As a simplified sensitivity analysis, we therefore assume that indirect productivity effects increase the cost by 25–50 per cent.

Applied to the EU's direct labour cost, this yields additional indirect productivity costs of around €135–270 billion per year, bringing the total cost to €675–810 billion per year. This broad estimate is equivalent to roughly 4 per cent of EU GDP.

This does not mean that the entire amount could be recovered through policy reform. Not all sickness absence can or should be prevented. People need to stay at home when they are ill, both to recover and to avoid infecting others. A policy focused solely on reducing the number of sick days risks increasing presenteeism, worsening health and creating longer periods of sickness absence later. The relevant question is therefore not how to eliminate all sickness absence, but how to reduce preventable absence and how people who become ill can receive the right treatment, rehabilitation and support more quickly in order to return to work.

## Small improvements have large effects

Because the total cost is so large, dramatic changes are not required to generate significant economic gains. If sickness absence in the EU could be reduced by ten per cent, from 15 to around 13.5 working-day equivalents per employee, the direct labour cost would fall by almost €55 billion per year. If the estimated multiplier effects are also included, such a reduction would correspond to around €69–81 billion per year in lower production losses and labour costs.

This does not mean that every preventive intervention is cost-effective. Screening, health checks, digital monitoring and various types of workplace programmes also require resources and may produce weak results if targeted at the wrong groups. Preventive measures must therefore be evaluated in the same way as other health-care interventions. Measures should be assessed according to how much ill health and absence they actually prevent and whether their costs compare favourably with alternative uses of resources.

But the calculation shows why an overly narrow budget perspective can be misleading. A region that finances early treatment may bear the full cost, while much of the benefit accrues to the employer, the state and the individual through fewer sick days and higher earned income. If different parts of society pay for the intervention and reap the benefits, the incentives to invest in preventive health are weakened.

## From managing absence to preventing it

Sickness absence is first and foremost a result of people being ill. But it is also a signal of how well healthcare, the labour market and social insurance systems work together. A more health-oriented system would intervene earlier. This could include faster access to primary care, physiotherapy and psychological treatment, as well as better working environments, early rehabilitation and clearer coordination between healthcare providers, employers and social insurance. Digital tools – for example, self-monitoring, in which patients measure health indicators that are automatically transmitted to healthcare professionals – can also facilitate the early detection of diseases and risk factors.

The shift in perspective also benefits employers. Better health can reduce absence and thereby lower both production losses and labour costs. For the public sector, this means that the costs of preventive health measures must be weighed against the fact that reduced sickness absence generates higher tax revenues, lower expenditure on sickness benefits and less pressure on healthcare services. As the population ages, limiting the public costs associated with ill health will become increasingly important.

Increased longevity is a major achievement. The full benefit, however, is realised only when more of those years can also be lived in good health and with the ability to work. The shift from healthcare to health care is therefore not only about reducing pressure on hospitals. It is also about harnessing the human and economic potential that is currently lost through preventable ill health.

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