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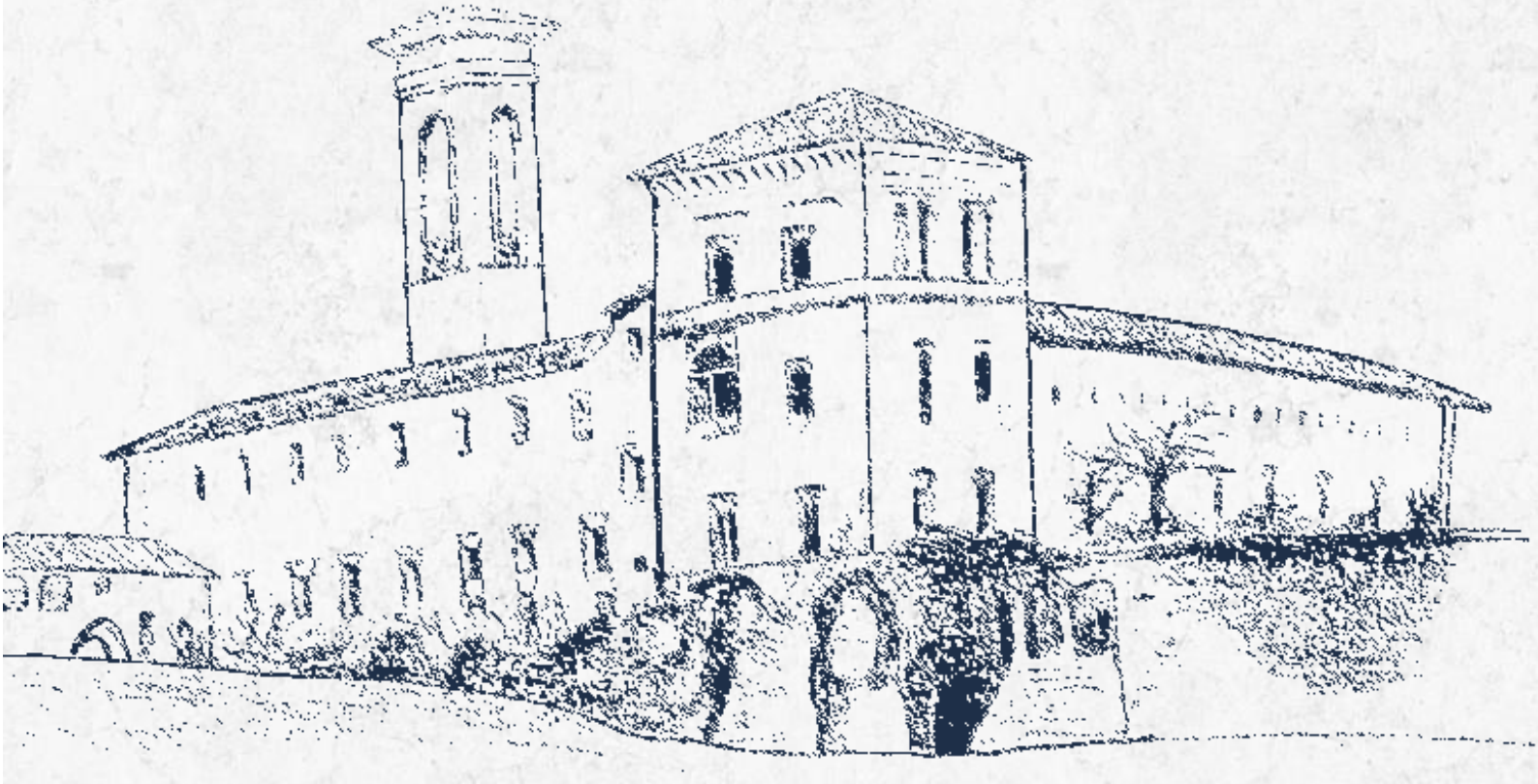

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Rethinking Sickness Absence Schemes to Promote Return to Work: Lessons from Comparative Experience

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Abstract. This article critically assesses how rigid legal frameworks for sickness absence, such as those in Spain and Italy, limit the sustainable reintegration of workers with chronic illnesses. These systems are grounded in a binary understanding of work capacity that generally prevents any form of work during medical leave and assumes a full recovery upon return. Drawing on a comparative analysis of the more flexible sickness absence models implemented in the United Kingdom, the Netherlands, and Sweden, the article identifies shared features that enable the combination of reduced work capacity with partial reintegration under adapted conditions. The article concludes by analyzing the Spanish Government's attempt to modernize the system with a recent proposal to introduce part-time sickness absence, followed by a critical analysis of the main objections it has raised in the public debate.

Keywords: *Sickness Absence, Temporary Incapacity, Return to work, Work Reintegration, Chronic Illness and Employment, Ageing Workforce*.

1. Introduction

In recent years, sickness absence and the associated cost of temporary incapacity benefits have become a growing concern across Europe. From 2006 to 2020, the estimated average number of days lost to sickness

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absence per employee rose from 9.2 to 10.8—an increase of 17.4 percent.[1] The COVID-19 crisis in 2020 accelerated this trend, and in some countries absence rates have continued to reach new highs annually. In Spain, for instance, the prevalence of sickness absence due to common (non-occupational) illnesses more than doubled over the last decade, rising from 19 per 1,000 employees on leave in 2012 to 47 in 2023.[2] Consequently, public spending on sickness benefits has increased significantly. Across the European Union, these expenditures grew by approximately 20 percent between 2014 and 2021. According to the most recent harmonized data from Eurostat, it accounted for 1.2 percent of the EU's total GDP in 2021.[3]

Several Europe-wide factors help explain these increases, with two standing out in particular. First, falling unemployment levels—observed EU-wide following the post-crisis recovery—reduce the opportunity cost of taking leave, making it more feasible for workers to claim sickness benefits. This is because when workers are less fearful of losing their job or being unable to find another they are more likely to take medical leave.[4] Second, demographic aging is contributing to longer and more frequent sickness absence; for example, workers over 50 now represent over a third of the workforce in Spain and across much of Europe. Workers this age are also twice as likely as those under 35 to suffer from chronic conditions and they take longer to recover.[5] Compared to workers under 25, sickness absences are 26 percent longer for those aged 25–35, 49 percent longer for those aged 36–50, and 83 percent longer for those over 51.[6]

Not only do these figures explain the growing concern of public authorities with the current state of sickness absence benefits, but they also explain their concern for the future. European governments increasingly acknowledge sickness absence as a critical challenge for

[1] A. Antczak, K. Miszczyńska, *Measuring and Assessing Sick Absence from Work: a European Cross-sectional Study*, Comparative Economic Research, 2023, vol. 26, n. 4, 37-60.

[2] Statistics from the Ministry of Social Security on sickness absence: https://www.seg-social.es/wps/portal/wss/internet/EstadisticasPresupuestosEstudios/Estadisticas/est45/est46 (accessed July 30, 2025).

[3] Eurostat, *European System of Integrated Social Protection Statistics (ESSPROS)*, Publications Office of the European Union, Luxembourg, 2023.

[4] M. K. Shoss, L. M. Penney, *The economy and absenteeism: A macro-level study, Journal of Applied Psychology*, 2012, vol. 97, n. 4, 881–889.

[5] Eurofound, *How to Respond to Chronic Health Problems in the Workplace?*, Eurofound, Luxembourg, 2019, p. 4.

[6] AEVAL, *Evaluación de las medidas de racionalización y mejora de la gestión de la Incapacidad Temporal*, AEVAL, Madrid, 2009, p. 125.

productivity, public spending, and the long-term sustainability of social protection systems. As the population continues to age in the coming decades, pressure on healthcare and social security systems is expected to intensify. Given these changes, labor market policies that support employees on sick leave return to work are attracting interest in countries that have maintained a more traditional approach to sickness benefits. This shift is largely driven by the potential of such policies to contain rising costs by promoting adapted working conditions for convalescent employees, thus enabling a partial return to work before a full physical or mental recovery.

Countries such as Spain or Italy continue to uphold a traditional model of sickness absence maintained by a current legal framework that remains grounded in an understanding of illness as a passive condition. This model rests on a binary conception of work capacity where a worker is either deemed entirely unfit for work – and thus exempt from any laborious activities – or considered fully recovered and expected to resume their duties under the same conditions as before. Accordingly, this paper refers to such systems as "rigid" sickness absence models. Beyond the obligation to provide reasonable accommodation for persons with disabilities, no intermediate solutions are available for workers who have only partially recovered. Instead, those on medical leave are prevented from engaging in any form of work activity. As a result, legal framework prolongs periods of inactivity which generates substantial costs for the social security system, employers, and workers themselves.

This contrasts with the approach taken in the United Kingdom, the Netherlands, and Sweden, which have adopted more "flexible" sickness absence models that allow workers to return to work under safe conditions before full recovery. In these systems, return-to-work measures are designed to adapt job duties and working conditions to a worker's health status and residual functional capacity; thus, the focus shifts from what the worker cannot do to what they are still able to do. Accordingly, when a worker has partially regained their physical or psychological capacity, the priority is on identifying ways in which that capacity can be used rather than prolonging their inactivity. Employers and employees play active roles in identifying appropriate adjustments and negotiating work arrangements tailored to circumstances. This paradigm shift benefits both the public health and the financial sustainability of the system by reducing absenteeism and lowering the risk of long-term incapacity.

This paper outlines the main legal features of what is referred to as the "rigid" sickness absence model, highlighting the negative impact it has on the return-to-work prospects of workers on medical leave. These defining

features are then compared and contrasted to "flexible" sickness absence models, focusing on their effects on absence rates and the respective legal features' strengths and limitations. Within this conceptual framework, this paper analyzes two recent developments that may signal an incipient shift from a rigid to a flexible sickness absence model in Spain: (i) the return-to-work measures introduced through collective bargaining, and (ii) the proposal by the Ministry of Social Security in October 2024 to make sickness absence more flexible. The analysis of the public reception of the Ministry's proposal—and the reservations it triggered in political and social debate—sheds light on the fears and preconceptions that may be hindering the advancement of return-to-work policies in countries with similar rigid legal frameworks.

2. How Rigid Sick Leave Systems Undermine Return to Work

A temporary incapacity for work that results in sickness absence should be understood as an imbalance between a worker's health and the demands and requirements of their job. When these two variables do not align, a worker is deemed "unfit for work" and their employment contract is suspended. To address this situation, policy makers have traditionally relied on the provision of public or private healthcare services to restore the worker's health and return it to its previous state as much as possible. In addition, countries such as Spain or Italy devote considerable effort to verify the health status of workers on leave to prevent fraudulent claims.[7]

That said, this approach has only a limited capacity to contain sickness absence because it addresses only one side of the equation. In other words, while all their efforts are focused on restoring or monitoring a worker's health, the work-related variable remains unaltered. In contrast, innovative return-to-work programs act as a parallel or complement to the recovery itself. This dual intervention makes it possible to identify a new point of balance between a worker's health status and job demands more rapidly, which can shorten periods of sickness absence.

In rigid systems, the work-related variable remains fixed throughout the period of temporary incapacity because the legal framework conceptualises this process as a closed cycle: a worker's "usual job" serves

[7] In Spain, employees can be required to undergo control-focused medical examinations carried out by the Medical Inspectors of the Social Security and the employers' insurance associations. Similarly, Article 5 of the Italian Workers' Statute states that employers can require that medical inspectors from the Social Security Authority examine employees that are absent from work for health-related causes.

as the legal benchmark both for granting medical leave and for authorizing return to work. Although Spanish or Italian legislation does not explicitly define the concept of "usual job" , it is generally interpreted as the position held by an employee prior to the onset of incapacity, including its essential tasks and working conditions.

Therefore, a worker can only return if they are assessed as capable of performing their "usual job" under the same conditions. No consideration is given to whether a worker could carry out ancillary tasks, assume alternative duties within the organization, or remain active in employment under adjusted conditions—such as reduced hours, modified schedules, or a change in work location. In other words, medical assessments of work capacity for employees on sick leave do not take into account the possibility of adaptations or reassignments as an alternative to sickness absence.

With the focus placed so rigidly on the "usual job," a medical examination conducted by general practitioners determines a worker's capacity or incapacity for work.[8] In practice, this decision is framed in absolute terms—a binary choice between two clearly distinct conditions with no room for nuance or gradual assessment: one is either fit or unfit for work. Abiding by this logic, a worker is placed on sick leave if an illness interferes with their ability to carry out their usual duties because their capacity is assessed only in relation to the very specific demands of their work. Consequently, a hospitalized and unconscious worker is treated in the same manner as one who, despite experiencing reasonable difficulties commuting, retains full intellectual capacity and can perform creative tasks.

This strict distinction between capacity and incapacity for work rests on the assumption that sick leave benefits and work are incompatible. In other words, a worker is not permitted to carry out any tasks for their employer until they recover and their leave is finished. The rationale behind this rule is to prevent fraud in cases where individuals receive benefits due to their inability to work. Nevertheless, both the Spanish[9] and Italian[10] Supreme Courts have acknowledged the possibility for a worker on sick leave to engage in other professional or self-employed activities

[8] G. Vitiello, *L'incapacità temporanea al lavoro e la certificazione di malattia*, Pratica Medica & Aspetti Legali, 2011, n. 2, 5-12.

[9] Judgment of the Spanish Supreme Court (Tribunal Supremo) of 13 April 2004, appeal number 1508/2003.

[10] Italian Supreme Court (Corte di Cassazione), Labour Section, Judgment No. 13063 of 26 April 2022.

during the period of incapacity, provided that such activities do not interfere with the recovery process.[11] This reveals that the courts admit workers deemed unfit to perform their usual duties may still retain residual physical or mental capacities that would allow them to engage in alternative forms of activity. Thus, a paradox presents itself: while both systems implicitly recognize that work capacity is a relative rather than absolute condition, they lack structural mechanisms to channel such residual capacity back into the original employment relationship.

A worker may only return to work once they are deemed to be capable of working. In Italy, this occurs when the period indicated by the physician in a sickness certificate expires. In Spain, a worker returns only after a medical certificate declaring them fit for work is issued. Until that point, the legal framework does not provide for any professional interaction between the worker and their employer. A worker is thus treated as a passive subject; remaining disconnected from the workplace and required only to follow the prescribed medical treatment. Likewise, the employer plays no active role other than waiting for the worker's recovery. The employee-employer relationship is limited to control functions that verify the legitimacy of the absence, without any mandate to explore proactive alternatives to prevent or reduce it. In short, both parties to the employment relationship are deprived of the possibility to seek solutions that might reduce the duration or intensity of the worker's absence.

The most serious disadvantage of this inflexible model is that it postpones any return to work until an employee is considered capable of fully resuming their previous position under the same contractual conditions. In other words, workers who might be able to carry out work-related tasks with reasonable workplace accommodations are kept out of the labor market for longer than necessary. This delay is particularly problematic considering empirical evidence indicating that the longer a worker remains absent, the lower their chances of successful reintegration and the greater the decline in their overall quality of life.[12] For example, recent research conducted in the United Kingdom finds individuals who have been out of work for less than one year are nearly five times more

[11] See G. Di Corrado, *La malattia del lavoratore*, in W. Chiaromonte, M. L. Vallauri (eds.), *Trasformazioni, valori e regole del lavoro. Scritti per Riccardo Del Punta*, Firenze University Press, Florence, 2024, 415-432, offering a critical reassessment of this interpretation in the case of the Italian system.

[12] NIDMAR: *Disability management in the workplace: A guide to establishing a joint workplace programme*, Port Alberni, 1995, p. 3.

likely to return to employment than those who have been out of work longer.[13]

A further structural limitation of these inflexible models lies in their tendency to treat the return to work following a serious and prolonged illness as a seamless transition, disregarding the residual effects of one's condition. In many cases, even if a worker is deemed capable of working, they may experience lasting physical or psychological impairments after having been on sickness absence for some time. These impairments are overlooked by a binary model that equates return to work with a full medical recovery. In Spain, this structural blind spot contributes to high relapse rates among workers who had initially shown sufficient ability to re-join the labor force.[14] For example, individuals recovering from cancer are often forced to take renewed medical leave shortly after returning to work—not due to a recurrence of the disease, but because the workplace fails to offer transitional support.[15] In the absence of a phased reintegration procedure or an adjustment period, these workers may find themselves absent again or eventually granted permanent incapacity benefits.[16]

It must be acknowledged, however, that certain legal obligations do exist to accommodate workers with debilitating health conditions. First, European directives impose duties to adapt the work of employees who are particularly sensitive to occupational risks.[17] Second, they also stablish the obligation to implement reasonable adjustments that facilitate the integration of workers with disabilities.[18] These requirements are binding

[13] Department for Work and Pensions, Department for Business and Trade, *Keep Britain Working Review: Discovery. Independent Review of the Role of Employers in Tackling Health-Based Economic Inactivity and Promoting Healthy and Inclusive Workplaces*, https://www.gov.uk/government/publications/keep-britain-working-review-discovery (accessed July 17, 2025).

[14] SÁNCHEZ GALÁN, L., BAIDES GONZALVO, P. y REGAL RAMOS, R.: *Recaídas en incapacidad temporal: impacto de su regulación y control*, Medicina y Seguridad del Trabajo, 2019, núm. 256.

[15] J. M. Vicente Pardo y A. López Guillén García: Aptitud sobrevenida tras la incapacidad laboral prolongada por cáncer, Medicina y Seguridad del Trabajo, 2019, núm. 225.

[16] See, for example, in relation to the Italian system, M. Sammicheli, M. Scaglione, *An explanatory case report about critical differences of 'inability to work' in Italian welfare and social security systems*, Journal of Health and Social Sciences, 2019, vol. 4, n. 1, 117-122.

[17] Article 15, Council Directive of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work (89/391/EEC).

[18] Article 5, Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation.

across all European countries and apply to workers returning to work after a period of sickness absence too. The enforcement of these obligations is undoubtedly essential and highly beneficial in supporting a healthy and sustainable return to work.[19] What must be emphasized, however, is that countries operating under rigid sickness absence models do not integrate such accommodations into the legal framework governing sick leave and sickness allowances. In general, work adjustments are not conceived as supportive to a worker's recovery, but rather as a response to an already consolidated impairment of health.

3. Integrating Return to Work into the Legal Framework of Temporary Incapacity: The Case of Flexible Sick Leave Systems

Since the early 2000s, several European countries have undertaken far-reaching reforms to overcome the "rigidity" problems of the legal schemes governing sick leave and sickness benefits. These reforms were primarily driven by the need to contain rising public expenditure on sickness benefits. In all these cases, the focus of protection has shifted away from the worker's incapacity to perform certain tasks and towards their remaining employability.[20] Thus, when a worker is considered as having partially recovered their physical or psychological capacity, priority is given to identifying ways in which this capacity can be used rather than prolonging the period of inactivity. The various pathways of utilizing and retaining residual ability are commonly referred to as "activation measures" or "return-to-work programmes."[21]

Return-to-work plans are technical recommendations aimed at adjusting working conditions to match the capabilities of employees whose work capacity has been affected by illness or injury.[22] They allow workers on sick leave to return to work safely while still receiving medical treatment. These plans can encompass a wide range of functional or organizational adjustments, including change in workplace location, teleworking arrangements, transportation support to the workplace, functional

[19] S. M. Candura, M. Frascaroli, F. Scafa, *Il reinserimento lavorativo dopo malattia o infortunio: il ruolo del medico del lavoro*, INAIL, Roma, 2014.

[20] S. Devetzi, S. Stendahl, *Introduction*, in *Too Sick to Work? Social Security Reforms in Europe for Persons with Reduced Earnings Capacity*, Wolters Kluwer, Alphen aan den Rijn, 2011, p. 4.

[21] Eurofound, *Preventing Absenteeism at the Workplace. Research Summary*, Eurofound, Luxembourg, 1997, p. 20.

[22] International Social Security Association, *ISSA Guidelines: Return to Work and Reintegration*, ISSA, Geneva, 2013, p. 2.

mobility, modified working hours, or training initiatives aimed at enabling a worker to carry out their original duties.[23] This enables them to carry out their original tasks in an adapted form or allows them to take up alternative work involving less physically and psychologically demanding tasks. From a public policy perspective, enabling the use of such return-to-work arrangements requires institutional recognition that work capacity can be managed flexibly during recovery, rather than assessed exclusively in all-or-nothing terms.[24]

The concept of return-to-work measures belongs primarily to the field of occupational medicine and does not have an exact counterpart in legal terminology. This is particularly true in countries that operate under rigid sickness absence models. Nevertheless, this concept bears certain similarities to the concept of reasonable accommodation for persons with disabilities—both in terms of the wide variety of measures it may encompass[25] and the fact that it often applies to individuals with long-term or chronic illnesses.[26] In fact, some return-to-work measures may qualify as reasonable accommodations when implemented for workers with disabilities. For instance, the Court of Justice of the European Union confirmed in the HK Danmark[27] case that the part-time return to work granted to two Danish employees on sick leave due to musculoskeletal disorders constituted a valid form of reasonable accommodation. That said, return-to-work plans offer a practical advantage over reasonable accommodation measures, as they typically apply to a broader group of workers and are not necessarily limited to those with a legally recognized disability.[28]

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[23] European Agency for Safety and Health at Work, *Rehabilitation and Return to Work: Analysis Report on EU and Member States Policies, Strategies and Programmes*, European Agency for Safety and Health at Work, Luxembourg, 2016, p. 25.

[24] European Agency for Safety and Health at Work, *Rehabilitation and Return to Work*, cit. p. 8.

[25] Recital 20 of Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation provides a useful illustration of what reasonable accommodation measures may entail. It states: "*Appropriate measures should be provided, i.e. 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*."

[26] C. Carchio, *Rischi e tutele nel reinserimento lavorativo delle persone con malattie croniche e trapiantate: prime riflessioni alla luce del d.lgs. n. 62/2024*, Labour & Law Issues, 2024, vol. 10, n. 1, 1-18.

[27] CJEU, 11 April 2013 (Joined Cases C-335/11 and C-337/11, Ring and Skouboe Werge)

[28] European Agency for Safety and Health at Work, *Rehabilitation and Return to Work*, cit.

According to data from ESENER-2,[29] the countries where employers most frequently report having procedures in place to support employees returning to work after sickness absence are the United Kingdom, Sweden, and the Netherlands. Based on the assumption that they exhibit legal frameworks more conducive to return-to-work initiatives, these countries were selected for this comparative analysis.

A central feature of the UK approach is the *Fit Note*, introduced in 2010 to replace the previous *Sick Note*. Issued by general practitioners, the Fit Note enables not only a declaration of incapacity (*not fit for work*), but also an intermediate option (*may be fit for work*) that establishes the presence of residual work capacity. When this option is selected, the physician may include specific recommendations—e.g., phased return, adjusted duties, altered hours, or telework—to facilitate early reintegration. These recommendations are not binding, but they open a dialogue between an employer and an employee about possible adaptations. Notably, no formal medical discharge is generally required; workers may return as soon as adjustments are in place or recovery is sufficient, provided the note has not expired. This system grants a high degree of discretion to the parties concerned in negotiating the terms of the worker's return to work, as both the payment and administration of Statutory Sick Pay (SSP) have been fully transferred to employers. If no agreement is reached or accommodations cannot be made, the worker is treated as fully unfit and continues to receive SSP. Refusal to undertake suitable alternative work may, in certain circumstances, justify dismissal in some cases.

Research suggests that the introduction of Fit Notes had a modest positive effect in reducing long-term sickness absence and overall absenteeism.[30] Still, the system is currently under review following the identification of several issues undermining its effectiveness. First, the role of the general practitioner as the primary technical authority in supporting employees' return to work entails certain limitations.[31] These stem, on the one hand, from a lack of training in occupational health and, on the other, from the considerable burden of clinical duties that general practitioners are required to manage. As a result, 93 percent of Fit Notes issued by general practitioners deem a worker to be "not fit for work." Moreover,

[29] European Agency for Safety and Health at Work, *Second European Survey of Enterprises on New and Emerging Risks: Overview Report*, European Agency for Safety and Health at Work, Luxembourg, 2016, p. 27.

[30] S. Dorrington, E. Roberts, A. Mykletun et al., *Systematic review of fit note use for workers in the UK*, Occupational and Environmental Medicine, 2018, n. 75, p. 538.

[31] Department for Work and Pensions, *op. cit.*

when workplace adjustments are recommended, the guidance provided is often too vague to meet employers' practical expectations. There is also a degree of uncertainty regarding the expected conduct of employers along with medical recommendations. Employers often lack clear protocols on how to initiate conversations or engage in negotiations concerning a potential phased or flexible return to work.

In the Netherlands, a turning point came with the adoption of the Gatekeeper Act in 2002.[32] Under this legislation, employers and employees must agree on a return-to-work plan within the first eight weeks of absence. Every six weeks, both parties are mutually obligated to meet, cooperate, and review progress. Measures may include adapting the original job, retraining for a new position, therapeutic part-time work, or other forms of temporary adjustment.[33] It is also permissible for the employee to engage in therapeutic activities that may provide some support to the employer, or to do part-time work. In the latter case, an employee receives a corresponding portion of their wage for the hours actually worked, along with a supplementary allowance for the non-worked hours, which is paid either by their employer or their insurance provider.[34] All steps of the return to work process must be documented and are subject to review by social security authorities. Should these authorities determine that an employer has not taken adequate steps to support their employee's reintegration, they may be sanctioned and required to continue wage payments for a third of incapacity. Workers, for their part, may lose their benefits if they do not cooperate.

International comparative studies generally identify the Dutch model as a success story—not only for its effectiveness in reducing sickness absence rates, but also for its impact in lowering the number of claims for disability or permanent incapacity benefits.[35] Several features of the Dutch system make it effective: (i) it imposes legally binding obligations on both

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[32] M. A. Yerkes, *Transforming the Dutch Welfare State: Social Risks and Corporatist Reform*, Bristol University Press, Bristol, 2011, p. 56.

[33] F. Pennings, *The New Dutch Disability Benefits Act: The Link Between Income Provision and Participation in Work*, in S. Devetzi, S. Stendahl (eds.), *Too Sick to Work? Social Security Reforms in Europe for Persons with Reduced Earnings Capacity*, Wolters Kluwer, Alphen aan den Rijn, 2011.

[34] L. Kools, P. Koning, *Graded return-to-work as a stepping stone to full work assumption*, Journal of Health Economics, 2019, vol. 65, p. 191.

[35] J. van Sonsbeek, R. Gradus, *Estimating the effects of recent disability reforms in the Netherlands*, Oxford Economic Papers, 2013, vol. 65, p. 849. The authors attribute a 25 percent reduction in the rate of access to permanent disability benefits to the impact of recent sickness absence and disability policy reforms.

employers and employees; (ii) it establishes an incentive structure that ensures compliance with the legal duty to design and implement a reintegration plan; and (iii) it ensures the effective coordination of the various actors involved in the return-to-work process.[36] In addition, the system benefits from strong engagement by social partners who include return-to-work measures in collective bargaining agreements.[37]

In Sweden, reforms have redefined temporary incapacity as a condition of "reduced work capacity due to illness" since the 1990s. Medical certificates must specify the degree of incapacity—100 percent, 75 percent, 50 percent, or 25 percent—determining the portion of working time during which an employee is required to perform work duties. This assessment is dynamic and adjusts as recovery progresses. Since 2008, a structured "Rehabilitation Chain" establishes specific medical review deadlines and gradually expands the frame of reference for assessing work capacity. During the first 90 days, the evaluation focuses on whether a worker can perform their usual tasks or any suitable temporary duties offered by the employer. After 90 days, a change of position within the company may be required. From day 180 on, the assessment shifts to a worker's capacity to perform any job available in the general labor market. Studies indicate that these measures contributed to a decline in sickness absence rates.[38]

An important feature of this model is that, while working reduced hours, workers still receive a public benefit that compensates for the partial loss of income corresponding to the portion of the workday they miss. This distinguishes Sweden and the rest of the Nordic countries from others such as Italy, where part-time work is also available as a way to employ workers with reduced work capacity. According to Legislative Decree nº 81/2015, workers diagnosed with oncological or chronic-degenerative conditions are entitled to request a transition to part-time employment in the Italian system. However, the corresponding wage reduction is not compensated by any public benefit, which results in a significant loss of income. This shortcoming has been identified as one of the main reasons

[36] O. Mittag et al., *Intervention policies and social security in case of reduced working capacity in the Netherlands, Finland and Germany: a comparative analysis*, International Journal of Public Health, 2018, vol. 63, p. 1086. See also E. Vossen, N. van Gestel, *The activation logic in national sickness absence policies: Comparing the Netherlands, Denmark and Ireland*, European Journal of Industrial Relations, 2015, vol. 21, n. 2, 165–180.

[37] Yerkes, *op. cit.*, p. 56.

[38] Nordic Social Statistical Committee, *Sickness Absence in the Nordic Countries*, Nordic Council of Ministers, Copenhagen, 2015, p. 45.

for the limited uptake of the measure.[39] Moreover, unlike the Swedish system, the Italian measure is not a generalizable solution. Instead, it suffers from a significant drawback of being designed with a limited scope of application, based on restrictive and ambiguous eligibility criteria.[40]

4. Integrating Return to Work into the Legal Framework of Temporary Incapacity: The Case of Flexible Sick Leave Systems

Until recently, legislative efforts in Spain that address the growing number of workers with chronic illnesses have focused primarily on safeguarding the employment contract.[41] This is true for Italy as well, where anti-discrimination law concerning disability has increasingly been used to enable ill workers to retain their jobs for longer periods.[42] However, this gradual strengthening of employment protection for sick workers does not reduce the rigidity of medical absences, nor does it address the adverse effects such rigidity continues to produce. Instead, it remains a largely defensive strategy[43]— one that does not guarantee a worker's prospects to sustain their employment given the constraints of their health condition, despite the formal safeguards afforded to the employment contract.

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[39] S. Fernández Martínez, *La permanencia de los trabajadores con enfermedades crónicas en el mercado de trabajo: Una perspectiva jurídica*, Adapt University Press, Modena, 2018, p. 185.

[40] F. Alifano, G. Impellizzieri, *La tutela del lavoratore con malattia cronica tra (nuove) figure professionali e soluzioni organizzative*, Paper presented at the 5th World Congress CIELO Laboral 2025, *Towards a Reconfiguration of Social Law in Light of the Transformation of Work?*, Bordeaux, June 4–6, 2025

[41] For example, in 2020, the possibility of dismissing workers who accumulated repeated and intermittent absences due to health reasons was abolished. Shortly thereafter, in 2022, all forms of discrimination on health-related grounds were prohibited, including dismissals directly linked to the worker's illness. More recently, the legal provision allowing employers to automatically terminate the employment contract when the Social Security medical services determined that the worker was suffering from a permanent condition preventing them from performing their usual occupation has also been repealed.

[42] C. Carchio, F. Cucchisi, *La tutela del lavoratore malato cronico e trapiantato: sfide e prospettive alla luce del modello bio-psicosociale di disabilità*, Paper presented at the 5th World Congress CIELO Laboral 2025, Towards a Reconfiguration of Social Law in Light of the Transformation of Work?, Bordeaux, June 4–6, 2025.

[43] G. Impellizzieri, Luci e ombre del contributo della giurisprudenza all'evoluzione del rapporto tra malattia (cronica) e lavoro, Università degli Studi di Urbino "Carlo Bo", Urbino, 2025.

Due to the legal rigidity both in Italy[44] and Spain[45], concrete measures of collective bargaining have been introduced to facilitate the return to work of absent employees and reduce the need for full sickness absence among sick workers. These measures remain partial and fragmented, however, and are insufficient in addressing the challenges posed by an aging workforce and the increasing prevalence of chronic conditions.

For this reason, particular attention should be paid to the proposal presented by the Spanish Government in October 2024, which is currently under negotiation between social partners. The Spanish Government announced the introduction of flexible sick leave publicly, outside of the established channels of dissemination and without prior consultation with trade unions or employer organizations. This procedural deviation triggered immediate criticism, particularly from certain left-wing political parties and trade union representatives, who viewed the measure as a potential threat to workers' rights. Nevertheless, negotiations between social partners are currently ongoing and being conducted with a degree of discretion, despite the rocky start.[46]

4.1. Return-to-Work Provisions in Spanish Collective Agreements

A first group of collective agreements recognize a general right to temporary job reassignment for employees with "reduced work capacity." For instance, the III Collective Agreement for Sales Network Staff of Aguas Danone (2020), and the Provincial Agreement for the Packaging and Processing of Natural Spices, Condiments, and Herbal Products in the Province of Burgos (2023) establish an obligation for employers to temporarily modify the employee's position without any reduction in salary. The Collective Agreement for the General State Administration (2019) goes further by requiring an employee to first receive professional training tailored to their new position if necessary. Another noteworthy feature is the possibility of modifying one's place of work to allow access

[44] Alifano and Impellizzieri, *La tutela del lavoratore con malattia cronica*, cit.

[45] J. J. Fernández Domínguez, *Incapacidad temporal y vigilancia de la salud. Programas de incorporación al trabajo (un análisis desde la negociación colectiva)*, Documentación Laboral, 2025, n. 134, 33-61.

[46] At the time of writing, the reform remains at a preliminary stage of development and has not yet been formalised in any official legislative text or policy document. As such, the analysis presented here should be understood as a provisional and exploratory assessment, based on the limited information currently available and subject to future developments in both the legislative process and social dialogue.

to rehabilitation services, particularly when the relevant medical facility is located at a considerable distance from the worker's residence.

A second, more extensive group of recent collective agreements introduces return-to-work measures specifically designed for employees recovering from cancer. These agreements reflect growing societal awareness of the challenges these individuals face in resuming employment. In some instances, these measures may be extended to workers recovering from other serious health conditions. In the latter cases, however, approval is typically subject to an assessment by the company's occupational health service and contingent upon an employer's organizational capacity. These clauses are found primarily in agreements created by large companies or in collective bargaining processes within the public sector.

The most common form of work adjustment for employees with cancer is a reduction of working hours and a proportional reduction in salary based on medical evaluation. For example, the III Collective Agreement of the Naturgy Group (2023) and the VIII Collective Agreement of Repsol, S.A. (2023) both allow cancer patients to request part-time work arrangements.

In the public sector, several collective agreements provide for the gradual reintegration of cancer survivors into full working hours without any reduction in salary. For example, employees of the regional administration of the Generalitat of Catalonia are entitled to a phased return plan, under which the working day is reduced by 50 percent during the first month, 25 percent during the second, and 10 percent during the third, with a minimum of two hours of daily work. In many cases, flexible schedules and favorable access to telework, relative to other employees in the organization, accompany these reductions.

These temporary work adaptations are recognized as a cancer patients' subjective right and medical proof of illness is usually sufficient to access them. Nevertheless, certain agreements, such as the Collective Agreement for the regional public administration of the Community of Madrid (2025), require additional evaluation of whether any adaptations will contribute to the worker's full functional recovery, if they will help employees avoid situations of hardship, or remove difficulties in job performance. The involvement of occupational risk prevention services is required in some cases, either through a prior report or through continuous supervision and monitoring of the measure's implementation.

One notable shortcoming of most collective agreements is that they do not expressly involve workers' legal representatives in the return-to-work

process, which runs counter to technical recommendations of the Spanish National Institute for Occupational Safety and Health.[47] Explicit provisions should be introduced to ensure their participation, both to support employees and to safeguard against the inappropriate implementation of these measures. The involvement of legal representatives would also promote a more comprehensive preventive culture—one that extends beyond the narrow confines of traditional occupational risk prevention to encompass a broader vision of workplace health and safety.

4.1. Legislative Reform Proposal for a Partial Sickness Absence Scheme

According to information publicly available at the time of writing[48], the proposed flexibilization of sickness absence or temporary incapacity in Spain is framed as a measure that would (i) allow for benefits to be received by a worker in cases where they hold multiple jobs, and (ii) enable workers on long-term sick leave to gradually return to work when their health permits.[49]

The first part recognizes that a worker who performs services for multiple employers or combines salaried and self-employed work may be declared temporarily incapacitated for one of these jobs while being allowed to continue the other. This aspect of the reforms is relatively uncontroversial and has received support from employers and trade unions. Its implementation would also be straightforward, as it reflects a line of interpretation already accepted by Spanish courts.

The second part, regarding a gradual return to work, has proved more contentious. Although the government has not provided a detailed clarification on the adaptations proposed that support this reintegration, public debate has interpreted the proposal as the introduction of a "part-time temporary incapacity" model. This mechanism would allow workers who cannot yet perform their full working hours due to illness or injury—but who are recovering from their most limiting symptoms—to resume work on a reduced basis. Under this measure, employees would gradually

[47] Technical Guidance Note No. 1116 Maintenance and Return to Work: Procedure, p. 2.
[48] July 2025.
[49] eldiario.es, *La Seguridad Social da un giro respecto a las bajas flexibles: reincorporación gradual con alta médica*, eldiario.es, 14 October 2024, https://www.eldiario.es/economia/seguridad-social-da-giro-respecto-bajas-flexibles-reincorporacion-gradual-alta-medica_1_11731922.html (accessed December 29, 2024).

reintegrate by assuming a reduced workload in respect to their ability. Spain's approach resembles the Swedish model in this sense, where partial work activity does not result in a significant loss of income since public benefits compensate for the hours missed by an employee on leave. Unlike the Nordic model, however, the government clarified that its initial approach is a return-to-work plan would be voluntary for the worker.

According to official statements, this proposed flexibilization would apply only to long-term cases of temporary incapacity due to chronic illnesses. This aligns with established rationale for return-to-work plans in comparative law and practice, which typically reserves flexibility for prolonged conditions due to medical, technical, and economic considerations. Return to work is generally conceptualized as a process whereby a disease or accident places the worker in a stage of professional inactivity, where at least partial recovery is required before any attempt to resume work can be made. The re-approach to work after partial recovery typically begins by readjusting the demands of a job to a worker's capacity.[50] These return-to-work plans are thus designed for illnesses marked by acute episodes, with symptoms progressively alleviated due to medical treatment.[51]

When presenting the proposal, the Minister referred explicitly to the case of cancer survivors as an example because it enjoys a broad social consensus regarding the need for improved legal and labor treatment.[52] In fact, 55 percent of workers in Spain who return to work after cancer already report having done so gradually, while half of those who did not would have preferred a phased return despite a lack of legal regulation.[53] However, in the absence of publicly supported return-to-work schemes, the burden is currently borne either by employers—who voluntarily

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[50] A. E. Young, R. T. Roessler, R. Wasiak et al., A Developmental Conceptualization of Return to Work, Journal of Occupational Rehabilitation, 2005, n. 15, 557-568.

[51] In contrast, in cases involving short-term but incapacitating illnesses, such as gastroenteritis or the common flu, there is generally no intermediate phase between medical leave and recovery during which the worker might require or benefit from any form of job accommodation.

[52] El Mundo, *Escrivá quiere que los trabajadores de baja se reincorporen a su empleo aunque no estén del todo curados*, El Mundo, 3 October 2024, https://www.elmundo.es/economia/2024/10/03/66fe659ce85eceee628b458b.html (accessed December 29, 2024).

[53] Federació Catalana d'Entitats contra el Càncer (FECEC), *1er Barómetro Cáncer y Trabajo en España*, FECEC, Barcelona, 2023, https://juntscontraelcancer.cat/wp-content/uploads/2024/10/DEFINITIU_1er_Barometro-de-Cancer-y-Trabajo-en-Espana-2024_CAT.pdf (accessed February 23, 2024).

implement or negotiate collective agreements—or by workers themselves, who already face significant economic costs beyond the workplace. Undertaking the proposed reform would entail standardizing and generalizing the right to reduced working hours for all patients in the same situation and ensuring a more equitable distribution of its costs among the various parties involved.

Confusion has clouded the public reception of the proposal because of ambiguity around the timing of adapted work reintegration for those with chronic illnesses. Specifically, the possibility that return-to-work measures might shorten the duration of a worker's absence has been interpreted in certain trade union and political circles as a restriction of workers' rights, that is, depriving them of the necessary rest time for a proper recovery.[54] Some warn that the proposal would effectively compel sick workers to return to work prematurely;[55] other criticisms focus on the potential impact on workers' health, questioning whether the proposed change might compromise their physical or mental well-being by allowing them to return to work before full recovery.[56] In response, the government clarified that any reintegration measures would apply only after a medical certificate of fitness for work is issued by a public health service, confirming that a worker has sufficiently recovered.

Amid these criticisms, it should be emphasised that even if the proposed measures apply to workers who are not fully recovered, that would never entail an obligation to perform tasks beyond a worker's functional capacity. This would be legally prohibited under Article 25 of the Occupational Risk Prevention Act (LPRL), which expressly forbids assigning workers to positions for which they are manifestly unfit. The novelty of the proposal lies in introducing legal mechanisms to support gradual reintegration, thereby facilitating a smoother return to work. The purpose is not to increase the level of suffering the law can impose on the

[54] USO, *Baja laboral flexible: pérdida de derechos y más poder a las mutuas*, USO, 3 October 2024, https://www.uso.es/baja-laboral-flexible-perdida-de-derechos-y-mas-poder-a-las-mutuas/ (accessed January 3, 2025).

[55] El País, *Los socios del Gobierno arremeten contra las bajas flexibles y critican a la Seguridad Social por falta de detalles*, El País, 5 October 2024, https://elpais.com/economia/2024-10-05/los-socios-del-gobierno-arremeten-contra-las-bajas-flexibles-y-critican-a-la-seguridad-social-por-falta-de-detalles.html (accessed January 2, 2025).

[56] La Vanguardia, *El Gobierno estudia una baja médica flexible que permita combinar recuperación y empleo*, La Vanguardia, 3 October 2024, https://www.lavanguardia.com/economia/20241003/9992735/baja-medica-flexible-trabajar-combinar-empleo-trabajo-gobierno.html (accessed January 3, 2025).

worker; rather, it reduces a high level of demand that an employer may impose once the suspension of an employment contract is lifted.

Moreover, research in occupational medicine has shown that, contrary to traditional assumptions, many health conditions do not require complete rest for effective recovery.[57] In fact, some studies suggest that combining medical treatment with adapted work participation can lead to a faster and more sustainable recovery compared to recovery in traditional sickness absence models.[58] In addition, a loss of connection with the workplace generates a sense of isolation and devaluation in a worker, which may lead to psychosocial impairments that hinder their return to work.[59] Adapted work activity should therefore be regarded as part of the therapeutic intervention aimed at supporting a worker's full rehabilitation.[60] In other words, a properly managed and gradual return to work would improve—rather than jeopardize—the health of employees on sick leave.

In line with stated evidence, international recommendations emphasize that return-to-work plans or measures should preferably be implemented following an early intervention.[61] That is, they should be activated as soon as the worker's health condition allows. As previously discussed, a return to work becomes more difficult the longer a worker is absent due to the progressive deterioration of work-readiness over time. Therefore, even when such measures are intended for workers with long-term illnesses, a more advisable approach is (i) to begin planning return-to-work strategies as soon as it becomes clear that the absence will be prolonged, and (ii) to implement them as early as medically feasible.

Another line of criticism raised by Spanish trade unions and political actors is that, although the government presented it as a voluntary

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[57] J. Gervás, A. Ruiz Téllez, M. Pérez Fernández, *La incapacidad laboral en su contexto médico: Problemas clínicos y de gestión*, Fundación Alternativas, Madrid, 2006, p. 32.

[58] L. C. Bosman, J. W. R. Twisk, A. S. Geraedts, M. W. Heumans, *Effect of partial sick leave on sick leave duration in employees with musculoskeletal disorders*, Journal of Occupational Rehabilitation, 2020, vol. 30, p. 204.

[59] J. M. Vicente Pardo and A. López-Guillén García, Problemas y factores psicológicos en el retorno al trabajo tras incapacidad temporal prolongada por cáncer de mama, Medicina y Seguridad del Trabajo, vol. 63, n. 248, 2017, show that approximately 36 percent of breast cancer patients develop minor psychiatric disorders, not so much at the initial stage of diagnosis—as might be expected—but rather during the final phase of medical treatment. These conditions hinder return to work and are more likely to arise when the period of sick leave has exceeded one year or when the worker perceives limited support in the workplace, among other risk factors.

[60] European Agency for Safety and Health at Work, *Rehabilitation and Return to Work*, cit. 24.

[61] International Social Security Association, *op. cit.*, p. 2.

measure for workers, they would not be truly free to refuse participation in return-to-work schemes in practice. For example, employers may use the plans or measures as a tool to pressure workers on sick leave to return to work prematurely. Within the inherently unequal power dynamics of the employment relationship, a gradual return to work would not constitute a genuinely free choice for the worker according to this criticism. In other words, an employee could be compelled to return against their will under pressure from an employer seeking to reduce the financial costs associated with absenteeism.

These concerns are not unfounded, as some employers do engage in improper practices of pressuring workers who are on sick leave. Nevertheless, specific legal safeguards can be introduced to mitigate this risk, the most obvious being a requirement that any progressive return to work be prescribed by a physician within the public health system. Such a decision would be based on medical and objective criteria, independently assessed, and would rule out premature reintegration. Additional safeguards could include involving workers' representatives in the design and implementation of return-to-work plans, which would ensure transparency and balance in the process. A specific protection against retaliation could also be established for workers on sick leave by declaring null and void any employer action aimed at undermining or interfering with their protected status.

5. Concluding Remarks

This article highlights the serious challenges posed by application of rigid sickness absence models that obstruct the return to work for employees with chronic illnesses, such as those present in Spain and Italy. The structural rigidity of these legal frameworks prevents any form of work activity during medical leave because it rests on a binary conception of health—one that is ultimately simplistic, reductive, and counterproductive. On the one hand, it disregards the possibility that partially recovered workers may have regained some degree of work capacity and therefore offers no legal tools to support their reintegration. On the other hand, a rigid system generally requires workers who have been absent for extended periods to resume all their previous duties at once, without appropriate transitional or adaptive measures. As a result, workers remain on leave for longer than necessary, increasing the risk of long-term inactivity and escalating the economic burden on the social security system.

In contrast, international comparative analysis offers a more reasonable alternative: the flexibilization of sickness absence, as implemented in countries such as the United Kingdom, the Netherlands, and Sweden. These approaches provide better accommodation for partial work capacity and promote earlier reintegration under adapted conditions. While each national reform reflects specific historical and institutional contexts, a cross-country analysis reveals that all three models share a set of core structural features.[62] These stand in clear contrast to the defining traits of rigid sickness absence models, as described in Section Two. Table 1 illustrates this contrast by comparing the key characteristics of rigid systems with more flexible approaches that actively support a return to work.

Rigid Model of Sickness Absence	Favorable approach to Return-to-Work
Temporary incapacity is the standard response to workers' health impairments.	Work inactivity is considered a last resort and only happens when no alternative solutions are viable.
Work capacity is treated as a binary condition, with no room for intermediate solutions.	Work capacity is regarded as a continuum, allowing for intermediate solutions between full capacity and total incapacity.
Workers on sick leave are generally excluded from engaging in work.	Workers whose capacity has not been reduced to zero are encouraged to work to the extent possible, provided it does not hinder their recovery.
Workers return to the same job position under the same working conditions held as before.	Temporary adaptation of job duties or working conditions is encouraged if it enables an earlier return to work.
Both workers and employers are placed in a passive or merely expectant role until there is medical authorization to return to work.	Workers and employers are actively involved in implementing measures to support an earlier and sustainable return to work.

Table 1: Key features of rigid and flexible sickness absence models (Author's elaboration, 2025).

Empirical studies generally support the effectiveness of sick leave schemes and flexibilization reforms, showing that combining medical convalescence with adapted work tasks can promote health improvement,

[62] M. Crespi Ferriol, *Incapacidad temporal y programas de retorno al trabajo: una reforma necesaria*, Trabajo y Derecho: Nueva Revista de Actualidad y Relaciones Laborales, 2021, n. 73, 33-50

ease the transition from absence to employment, and help prevent relapses. Return-to-work measures contribute to reducing sickness absence rates and can prevent the premature exit of workers with health conditions from the labor market. While significant challenges have impeded the implementation of such reforms—and persistent shortcomings keep certain schemes under review—their practical operation offers valuable insights. Analysing both their strengths and limitations provides important lessons for countries that continue to rely on rigid sickness absence models but are considering a transition towards more flexible approaches.

Encouragingly, there are signs of an incipient shift. Certain collective agreements have already introduced proactive return-to-work measures through qualitative or quantitative job adaptations in Italy and Spain. However, in the Southern European industrial relations models, collective bargaining has a limited capacity to influence employment relations. As a result, these measures—although innovative—remain relatively scarce, have a limited personal scope, and are sometimes restricted in substance to specific conditions such as cancer.[63] In contrast to this relative insufficiency, comparative international analysis shows that the key enabling factor for the widespread and effective implementation of return-to-work programs is the existence of a coherent legal framework that supports the process.[64]

Given this, the recent initiative by the Spanish Government that proposed a structural legislative reform of sickness absence that supports individuals with long-term illnesses return to work should be highly valued. The proposal to introduce part-time temporary incapacity may offer a path towards legal modernization, aligning the Spanish system with the best international practices and with empirical evidence on sustainable work reintegration. Nonetheless, the strong public backlash against this proposal suggests that the reform will be far from easy or uncontested. This is due to persisting misconceptions regarding the incompatibility of illness and work, and the presumed harm of combining them. Moreover, legitimate concerns have been raised regarding the need to provide workers with sufficient legal safeguards to protect them from potential abuse during the implementation of return-to-work measures. These concerns reveal some barriers that may be preventing similar transitions in other countries with comparable systems, such as Italy.

[63] Alifano and Impellizzieri, *La tutela del lavoratore con malattia cronica*, cit.
[64] European Agency for Safety and Health at Work, *op. cit.*, p. 8.

In short, the transition towards a sickness absence model that supports return to work is both a complex issue from a legal standpoint and a politically and socially sensitive topic. Meaningful change will require not only regulatory innovation, but also a broader cultural transformation in the way incapacity and recovery are understood. Integrating into the collective imagination a more complex, but also more realistic, sustainable, and mutually reinforcing relationship between health and work would bring about this change.

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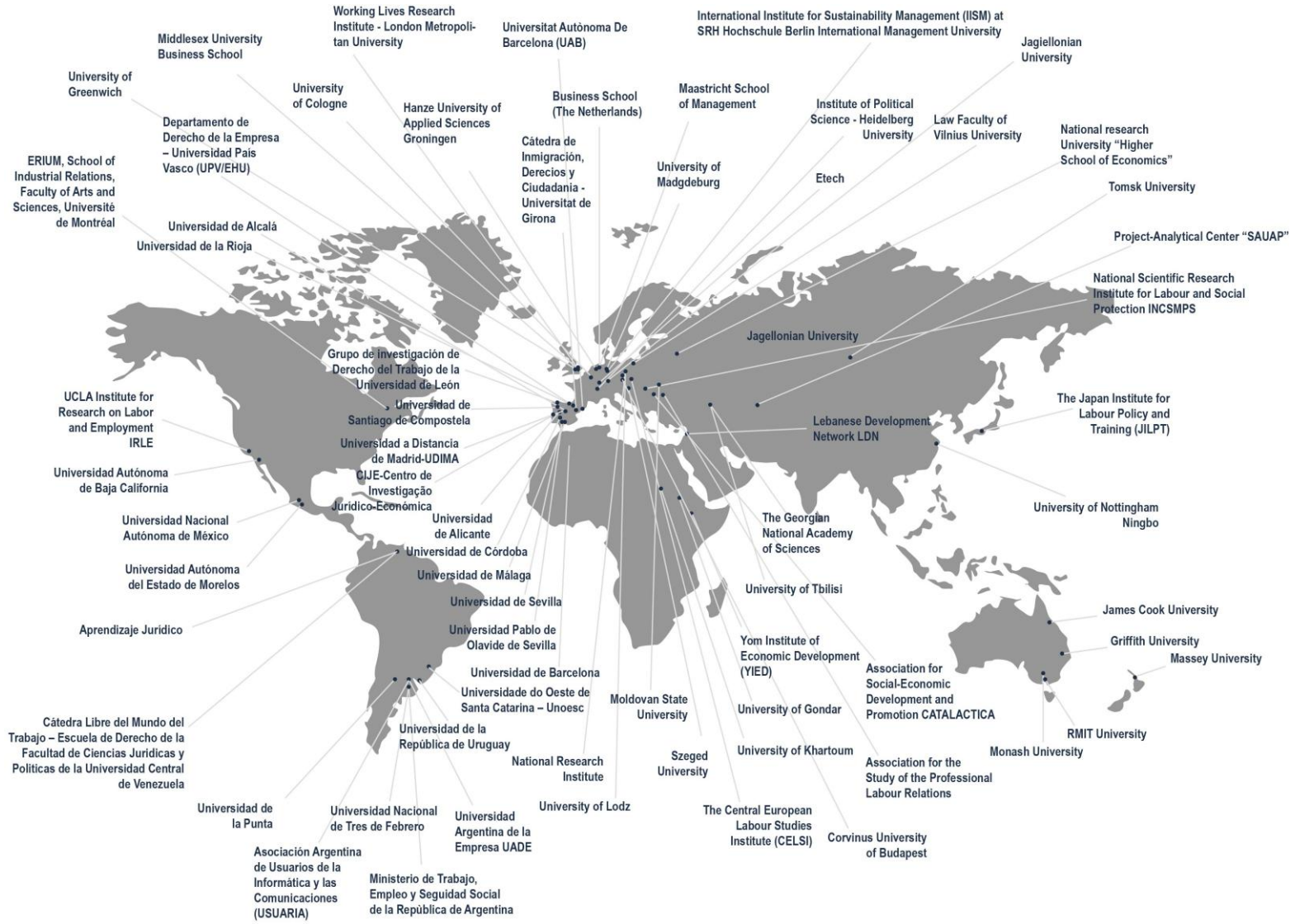

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