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Long-Term Sickness Absence in Finland

Trends by Sex, Age and Diagnostic Group
from 2010–2023

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Long-Term Sickness Absence in Finland

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Abstract

Monitoring sickness absence trends across different population and diagnostic groups is essential for identifying emerging patterns in health and work disability. This report aimed to examine trends in long-term sickness absence in Finland by sex, age, and the most common diagnostic groups for the period 2010–2023.

Data were collected from national registers covering all non-retired residents aged 16–67 in Finland from 2010 to 2023 (annual N > 3.1 million persons). Long-term sickness absence (LTSA) was defined using information on the receipt of sickness allowance, a benefit provided after a 10-day waiting period. Annual LTSA prevalence and LTSA days were calculated by sex, 10-year age groups, and most important diagnostic groups.

Throughout 2010–2023, LTSA was more common among women than among men and among older age groups than younger age groups. The relative importance of different diagnostic groups causing LTSA changed significantly during the study period. The importance of musculoskeletal diseases declined, while LTSA due to mental disorders rose sharply during the latter half of the study period, particularly among women aged 16–44. By the end of the study period, mental disorders had become the leading cause of LTSA in most sex and age groups, except men over 45 and women over 55, where musculoskeletal diseases remained the primary cause. Other diagnostic groups contributed less significantly to LTSA.

The findings underscore the need for targeted measures to support mental health and work ability, especially among young adults, and to sustain the positive trend in reducing musculoskeletal diseases and other somatic diseases causing work disability.

Keywords (YSO): sickness absences, daily sickness allowances, incapacity for work, mental disorders, musculoskeletal diseases, Finland

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1 Introduction

Monitoring sickness absence trends across different population and diagnostic groups is essential for identifying emerging patterns in health and work disability. Sickness absence is quite common among Finnish wage earners: according to the 2023 Quality of Work Life Survey conducted by Statistics Finland, nearly three out of four Finnish wage earners reported having been absent due to sickness at least once in the previous 12 months (Sutela et al., 2024). Sickness absences were more prevalent among women (78%) than among men (69%). Longer absences are less common: in the past 12 months, 16% of female wage earners and 12% of male wage earners reported having at least one sickness absence spell lasting 10 days or more (Sutela et al., 2024). However, long-term trend data on sickness absence prevalence are not available from the Quality of Work Life Surveys, as comparable data have not been consistently collected across different years. Furthermore, Finland lacks national official statistics or registers on the total number or duration of sickness absences, since absence data from employers and healthcare providers are not collected into any national database.

In contrast, the prevalence and burden of longer sickness absences can be monitored through the receipt of sickness allowance. Sickness allowance is a benefit paid by the Social Insurance Institution of Finland (Kela) under the Health Insurance Act (L 1224/2004). It compensates for income loss due to temporary incapacity for work caused by sickness or impairment lasting longer than 10 consecutive working days. Working days are counted from Monday to Saturday, excluding public holidays. During the period covered by the analyses in this report, sickness allowance was payable to non-retired individuals aged 16–67 for a maximum total period of 1 year within a 2-year span¹. In addition to employed persons and entrepreneurs, sickness allowance can also be granted to other working-age groups, such as unemployed persons and students, if they are unable to perform their usual duties – such as job searching or studying – due to sickness or injury. A physician’s certificate with a valid diagnosis is required to obtain the benefit. The amount of sickness allowance is calculated based on the individual’s previous income. For those with little or no earnings, a standard minimum allowance is provided.

The first 10 working days of absence, defined as the first day of sickness plus the following 9 working days, constitute the waiting period for sickness allowance. For employees, this waiting period is covered by a mandatory employer period, during which they are usually compensated with full salary according to the Employment Contracts Act (L 55/2001). Self-employed persons and entrepreneurs, on the other hand, may apply for a separate benefit – sickness allowance for self-employed

¹ From the beginning of year 2025, the lowest age limit of new sickness absence spells is 18 years.

persons and entrepreneurs insured under the Self-Employed Persons' Pensions Act (L 1272/2006) – to cover their loss of income during the waiting period for the standard sickness allowance.

Depending on the collective agreement applicable to a specific field of work, employers may pay full or partial salary to employees for periods longer than the mandatory waiting period for sickness allowance (for examples of different agreements, see Toivonen, 2012). If the salary paid during sickness absence (also called sick pay) exceeds the amount of sickness allowance, Kela reimburses the allowance to the employer. In all cases, information on entitlement to sickness allowance is recorded in registers linked to the absent individuals, regardless of whether the allowance is paid to the employer or directly to the individual. This system enables the monitoring of sickness absences at the individual level through the receipt of sickness allowance.

This report utilises data on compensated sickness allowance spells to measure long-term sickness absence (LTSA) in Finland. The most noteworthy development reported in recent studies examining LTSA trends in Finland is that LTSA due to mental disorders has increased significantly during and after the latter half of the 2010s (Blomgren & Perhoniemi, 2022, 2025; Perhoniemi & Blomgren, 2025). At the same time, the importance of somatic diagnoses, particularly musculoskeletal diseases, has declined (Blomgren & Perhoniemi, 2022, 2025). Consequently, mental disorders are now the leading cause of LTSA in Finland. A similar pattern has been observed, for example, in Sweden (Försäkringskassan, 2024, 2025).

Both in Finland and Sweden, mental disorders dominate compensated LTSA spells especially among young people (Försäkringskassan, 2024; Kela, 2025). However, systematic, detailed, and up-to-date studies on age-, sex-, and diagnosis-specific trends are lacking. Recent Finnish studies on overall and diagnosis-specific trends of LTSA (Blomgren & Perhoniemi, 2022, 2025; Perhoniemi & Blomgren, 2025) have not reported age-specific results for all-cause LTSA or for the main diagnostic categories causing LTSA. Some earlier analyses published in Finnish have included age-group-specific examinations, but they have used rather broad age categories and covered only a limited number of diagnostic groups (Blomgren, 2016, 9.2.2023). Furthermore, most studies have focused on LTSA prevalence, with less attention given to the total burden of LTSA measured in sickness absence days.

Utilising register records on paid sickness allowance spells, this report aims to provide information on trends in LTSA prevalence and LTSA days in Finland by sex, age, and most common diagnostic groups for the period 2010–2023. Due to the waiting period for sickness allowance, the analyses cover sickness absences lasting more than 10 working days.

2 Data and Methods

The study utilised individual-level register data covering all Finnish residents aged 16–67, linked with records on sickness allowance from 2010 to 2023. The dataset includes demographic information and sickness allowance data from Kela as well as socioeconomic data from Statistics Finland. All registers were linked using personal identity codes assigned to Finnish residents, after which these identifiers were removed from the data set. The researchers accessed only pseudonymised data to ensure privacy.

No ethics approval was required, as the study used only secondary register data. Established conventions of good scientific practice and data protection were followed in analysing the data and presenting the results.

2.1 Study Population

The study population was defined annually as Finnish residents aged 16–67 who were not retired, based on year-end data from 2009 to 2022 (corresponding to analysis years 2010–2023 in tables and figures for clarity). Retired individuals were excluded using information on socioeconomic status, based on the classification of Statistics Finland (Statistics Finland, 1989), as retirees are generally not eligible for sickness allowance and thus not part of the population at risk for LTSA. The annual number of individuals in the final study population ranged between 3.1 and 3.2 million. The study population was categorised into five approximately 10-year age groups (see Table 1 for distributions by sex in 2010 and 2023). This non-retired population, stratified by sex and age group, was used as the population at risk in the LTSA analyses.

Table 1. Age Distributions of Women and Men in the Study Population in 2010 and 2023.

Age group	Women 2010,		Women 2023,		Men 2010,		Men 2023,	
	N	%	N	%	N	%	N	%
16–24	287,011	19	263,804	17	299,004	19	278,607	17
25–34	325,807	21	339,455	22	342,434	22	361,490	22
35–44	318,030	21	338,945	22	327,127	21	361,556	22
45–54	351,919	23	310,258	20	349,204	22	320,428	20
55–67	264,167	17	319,259	20	254,949	16	306,331	19
All age groups	1,546,934	100	1,571,721	100	1,572,718	100	1,628,412	100

2.2 Measures of Sickness Absence

Information on sickness allowance spells compensated by Kela was retrieved for the years 2010–2023 and linked to the study populations defined at the end of the preceding year. All sickness allowance spells were classified into diagnostic groups based on the International Classifications of Diseases, 10th revision (ICD-10) (World Health Organization, 2015). In addition to all-cause sickness absence, the diagnostic groups most commonly associated with LTSA were analysed separately (see Table 2, p. 9).

Information on the start and end dates of work disability spells, as well as the associated diagnoses, was used in the calculations. Following the method previously described by Blomgren and Perhoniemi (2025), two outcome measures of LTSA were defined: (1) the annual prevalence (%) of LTSA in the population at risk, also referred to as the frequency of sickness absence (Hensing, 2009); and (2) the annual number of LTSA days per person in the population at risk, also previously called the sickness absence rate (Blomgren & Perhoniemi, 2022). For the first measure, all sickness allowance spells or their 10-day waiting periods that occurred at least partly during each observation year were included, even if the spell began before or ended after that year. For the second measure, the total number of LTSA days (measured in calendar days and including the waiting periods for sickness allowance) occurring within each observation year was summed for each individual. In the diagnosis-specific analyses, both LTSA prevalence and LTSA days were calculated separately for each diagnostic group listed in Table 2.

Table 2 presents the total number of individuals with LTSA and the total number of absence days by diagnostic group in the study population for the years 2010 and 2023. Table 2 displays the diagnostic groups in a descending order by the number of absent individuals in 2023. Overall, both the number of absent individuals and the total number of absence days declined between years 2010 and 2023. In 2023, approximately 316,000 individuals in the study population experienced LTSA, resulting in over 21 million absence days (measured in calendar days). During the observation period, the relative importance of diagnostic groups also shifted. Most notably, mental and behavioural disorders surpassed musculoskeletal diseases as the leading cause of LTSA, both in terms of the number of absent individuals and the total number of absence days.

Table 2. Number of Individuals With Long-Term Sickness Absence and Total Annual Long-Term Sickness Absence Days by the Most Common Diagnostic Groups in the Study Population in 2010 and 2023.

Diagnostic group	Absent individuals^a, 2010	Absence days^b, 2010	Absent individuals^a, 2023	Absence days^b, 2023
F00–F99 Mental and behavioural disorders	63,705	5,071,705	105,371	7,519,004
M00–M99 Diseases of the musculoskeletal system and connective tissue	117,738	7,449,855	80,703	5,320,405
S00–T98 Injury, poisoning and certain other consequences of external causes	54,595	3,075,532	44,760	2,334,529
G00–G99 Diseases of the nervous system	15,145	989,309	17,386	1,134,690
J00–J99 Diseases of the respiratory system	19,472	567,225	16,427	436,371
C00–D48 Neoplasms	16,143	1,398,150	14,699	1,234,527
K00–K93 Diseases of the digestive system	16,823	598,343	13,552	464,041
I00–I99 Diseases of the circulatory system	16,894	1,163,256	11,357	864,032
O00–O99 Pregnancy, childbirth and the puerperium	11,497	442,273	8,087	294,730
Other diagnostic groups	34,637	1,387,889	41,685	1,686,859
All diagnostic groups	334,127	22,143,537	315,574	21,289,188

a Number of individuals having any long-term sickness absence during the year.

b Number of absence days related to long-term sickness absences, measured in calendar days.

3 Results

3.1 Long-Term Sickness Absence Prevalence and Absence Days by Sex and Age Group

Figures 1 (p. 11) and 2 (p. 12) show trends in annual LTSA prevalence (%) and annual LTSA days per person among the population at risk, stratified by sex and age group, for the years 2010–2023. The corresponding numerical values for prevalence and absence days per person are provided in Appendix Tables 1 and 2 for the years 2010, 2016 and 2023.

In 2023, 12.2% of women and 7.6% of men aged 16–67 experienced LTSA (Figure 1; Appendix Table 1). During the first half of the study period, the prevalence of LTSA among women decreased overall, but later increased again, returning to the 2010 level. Among men, the prevalence showed a generally decreasing trend throughout the period. In all age groups, the prevalence of LTSA was consistently higher among women than among men. Across the entire study period, LTSA prevalence was higher in older age groups than younger age groups both among women and among men.

During the study period, LTSA prevalence rates among women showed some convergence across age groups. The youngest age group of women exhibited an upward trend throughout the study years, with a marked increase beginning after 2016. Women aged 25–34 also showed a notable rise in LTSA prevalence after 2016, resulting in higher prevalence in 2023 compared to 2010. In contrast, the older age groups of women generally showed a decline in LTSA prevalence between 2010 and 2023, with relatively stable trends during the latter half of the period.

Among men, the age groups 35–44 and 45–54 exhibited a clear decreasing trend in LTSA prevalence, while changes in other age groups were relatively minor. The youngest age group showed a slight increase in LTSA prevalence between 2010 and 2023 also among men, although this rise was considerably smaller than that observed among women.

In 2023, women aged 16–67 had an average of 7.8 LTSA days per year per person in the population at risk, compared to the 5.6 days among men (Figure 2; Appendix Table 2). The trends in annual LTSA days largely mirrored those of LTSA prevalence. However, differences between sexes were smaller for LTSA days per person than for LTSA prevalence, primarily because absence spells tend to be longer on average among men than women (Blomgren & Jäppinen, 2021; Kela, 2025).

As a result, when averaging the total number of LTSA days across the entire population at risk – including individuals with no LTSA spells – the gap between women and men narrows compared to LTSA prevalence. Data on the duration of sickness absence spells among persons having LTSA are not included in this report.

The relative difference between women and men in both LTSA prevalence and LTSA days was smaller in older age groups than in younger ones.

Figure 1. Annual Prevalence (%) of Long-Term Sickness Absence by Age Group Among Finnish Non-Retired Women and Men Aged 16–67 in 2010–2023.

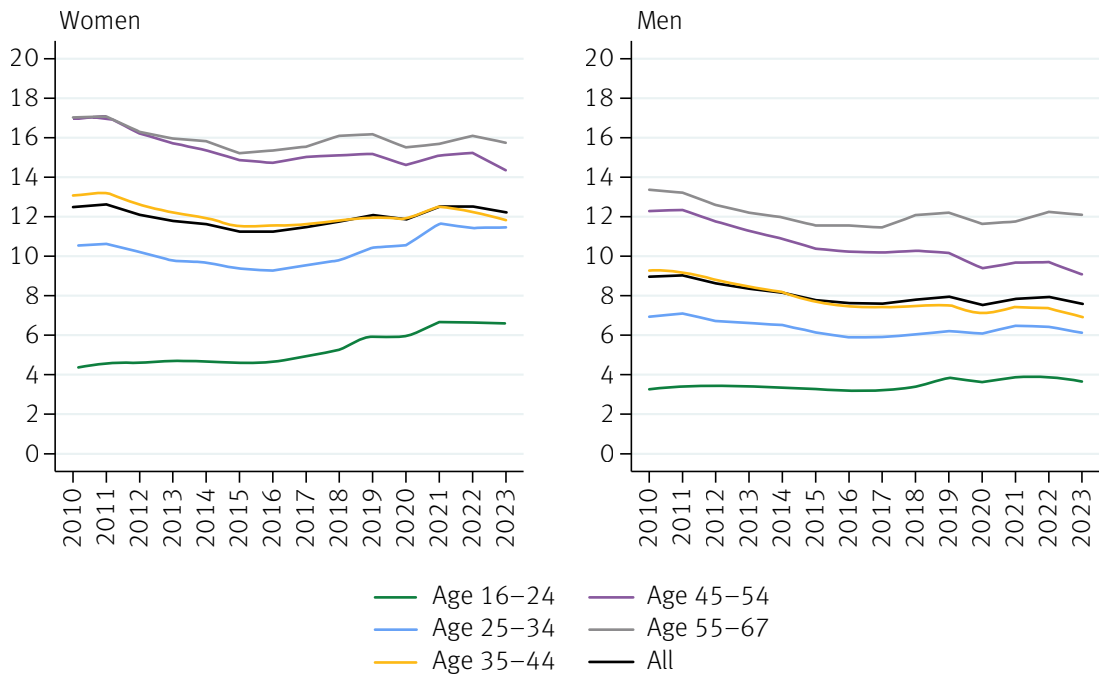
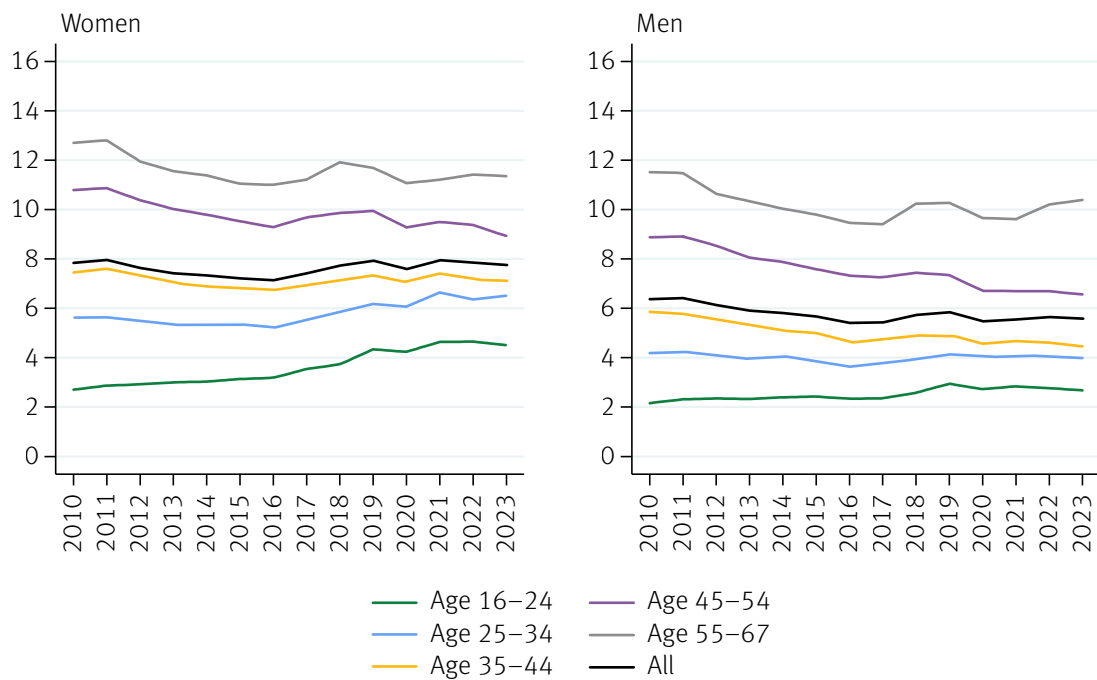


Figure 2. Annual Number of Long-Term Sickness Absence Days per Person in the Population at Risk by Age Group Among Finnish Non-Retired Women and Men Aged 16–67 in 2010–2023.



3.2 Long-Term Sickness Absence Prevalence and Absence Days by Sex and Diagnostic Group

Figures 3 and 4 (p. 14) show trends in annual LTSA prevalence (%) and annual LTSA days per person among the population at risk, stratified by sex and diagnostic group, for the years 2010–2023. The corresponding numerical values for prevalence and absence days per person are provided in Appendix Tables 3 and 4 for the years 2010, 2016, and 2023. See Table 2 (p. 9) for more detailed definitions of the diagnostic groups.

The relative importance of different diagnostic groups causing long-term sickness absence changed significantly over the study period. In 2010, musculoskeletal diseases were the leading cause of LTSA for both women and men, with an annual prevalence of 4.4% among women and 3.1% among men (Figure 3 (p. 14, Appendix Table 3)). Between 2010 and 2023, LTSA due to musculoskeletal diseases steadily declined by roughly one third among both sexes. In contrast, LTSA based on mental disorders increased markedly between 2016 and 2023, especially among women. The prevalence of LTSA due to mental disorders rose by 74% among women and by 40% among men between 2010 and 2023. Consequently, mental disorders, with an LTSA prevalence of 4.7% in 2023, became the leading

cause of LTSA among women, surpassing musculoskeletal diseases. Among men, mental disorders, with an LTSA prevalence of 2.0% in 2023, nearly reached the level of musculoskeletal diseases. The gender gap in LTSA prevalence was greatest for mental disorders compared to all other diagnostic groups.

Injury and poisoning formed the third largest diagnostic group causing LTSA in 2023 for both women and men. LTSA due to injuries declined between 2010 and 2023, particularly among men. All other main diagnostic groups classified under ICD-10 were less prominent in terms of LTSA, showing an annual prevalence of approximately 0.3%–0.7%. The residual category of other diagnostic groups showed a temporary increase around the COVID-19 pandemic years, peaking in 2022, as COVID-19 diagnoses were classified under the main group U, which is reserved for codes used for special purposes (World Health Organization, 2015). Respiratory diseases showed a temporary rise in 2020, likely because COVID-19 cases were initially diagnosed to group J (respiratory diseases) of ICD-10 before the specific U07–U10 diagnostic codes were established for this use. Conversely, year 2021 saw a decrease in LTSA due to respiratory diseases, probably reflecting the refinement of COVID-19 diagnostic classification and the impact of pandemic containment measures, which also helped reduce the incidence of standard respiratory diseases.

Annual LTSA days exhibited trends similar to those observed in LTSA prevalence across diagnostic groups (Figure 4, p. 14). When measured by the number of LTSA days per person, mental disorders surpassed musculoskeletal diseases among women earlier than when measured by LTSA prevalence. Among men, mental disorders caused more LTSA than musculoskeletal diseases in terms of LTSA days per person in the population at risk during the later years of the study period. These differences are largely attributable to mental disorders, typically resulting in longer absence spells compared to musculoskeletal diseases.

Here, too, the relative differences between women and men were somewhat smaller when measured by LTSA days than by LTSA prevalence. This is because individual absence spells were, on average, longer among men than among women (more detailed data not shown in this report).

Figure 3. Annual Prevalence (%) of Long-Term Sickness Absence by Diagnostic Group Among Finnish Non-Retired Women and Men Aged 16–67 in 2010–2023.

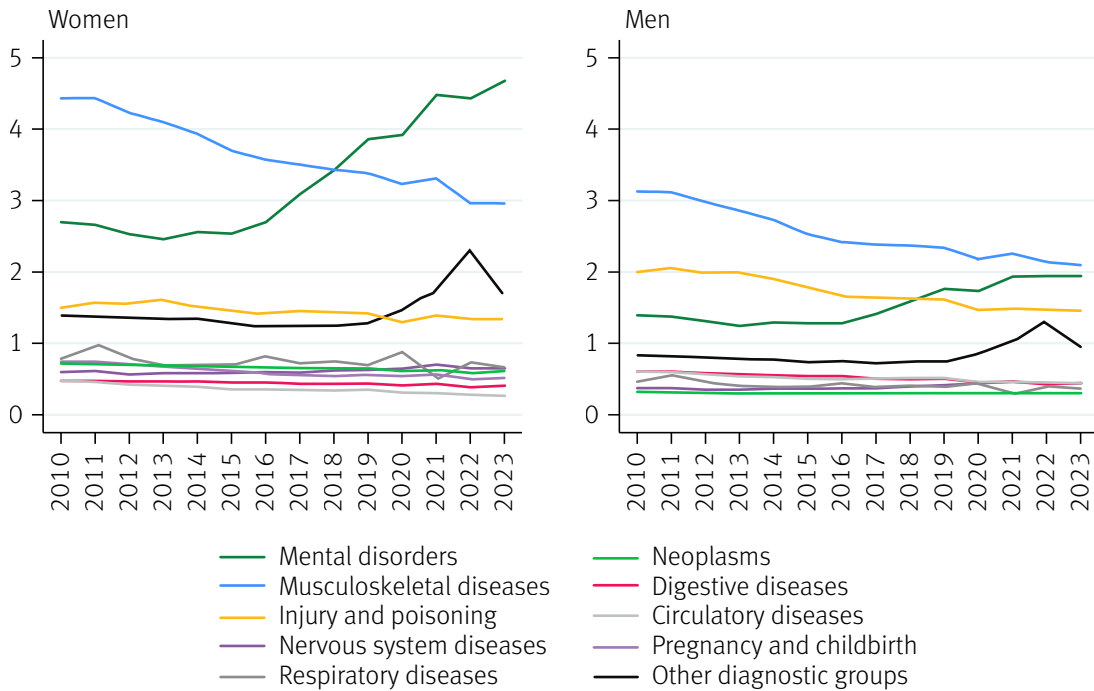
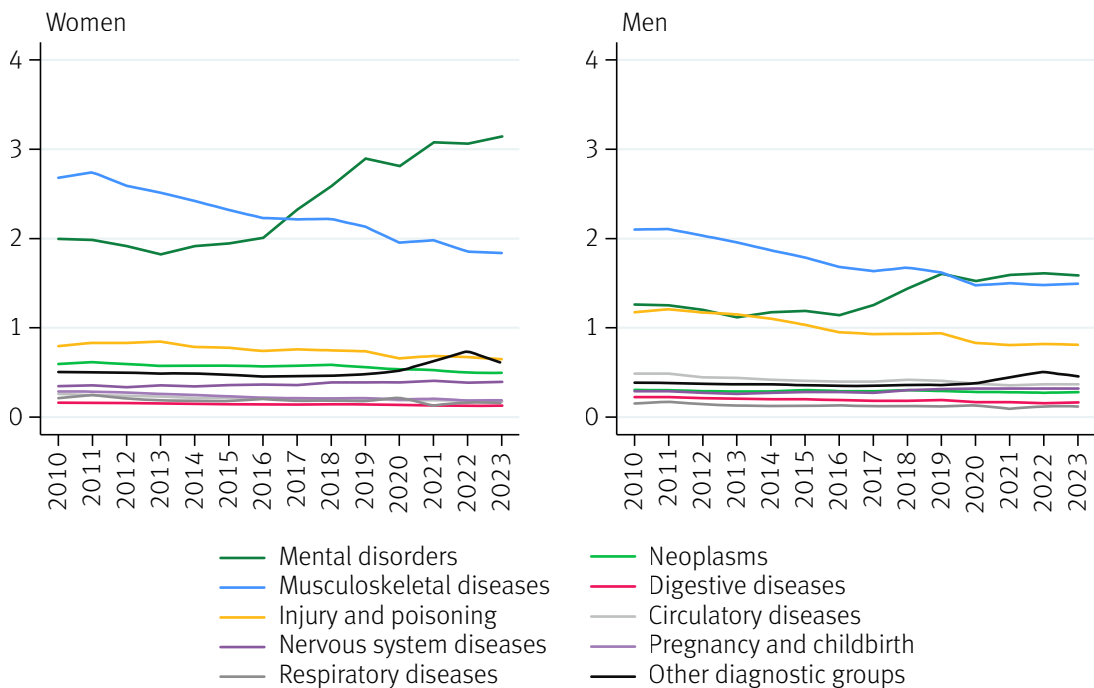


Figure 4. Annual Number of Long-Term Sickness Absence Days per Person in the Population at Risk by Diagnostic Group Among Finnish Non-Retired Women and Men Aged 16–67 in 2010–2023.



3.3 Long-Term Sickness Absence Prevalence and Absence Days by Sex, Age, and Diagnostic Group

Figures 5 and 6 (pp. 17–18) present trends in annual LTSA prevalence (%) by diagnostic group for women and men across different age groups, with the three youngest groups shown in Figure 5 and the two oldest groups in Figure 6. Figures 7 and 8 (pp. 19–20) display the corresponding trends in annual LTSA days. The corresponding numerical values for LTSA prevalence and LTSA days per person for the years 2010, 2016, and 2023 are provided in Appendix Tables 5–8.

The most significant diagnostic groups causing LTSA varied between women and men, by age groups, and depending on the year. Diagnosis-specific trends also differed between women and men as well as across age groups.

Mental disorders were clearly the leading diagnostic group for LTSA in age groups 16–24, 25–34, and 35–44, particularly during the latter half of the study period (Figure 5). Among women aged 16–24, mental disorders were the most common cause of LTSA throughout the entire period from 2010 to 2023. In contrast, among men in the same age group, injury and poisoning was the most prevalent diagnostic group until the mid-2010's, after which mental disorders became the leading diagnostic group. In 2023, 4.1% of women aged 16–24, 5.8% of women aged 25–34, and 5.4% of women aged 35–44 had LTSA due to mental disorders. In the final years of the study period, mental disorders also surpassed musculoskeletal diseases as the leading cause of LTSA among women aged 45–54 (Figure 6).

Overall, the prevalence of LTSA due to mental disorders was consistently higher among women than among men across all age groups, and it increased across all sex and age groups between 2010 and 2023. The rise was most pronounced in the two youngest age groups, where prevalence more than doubled among women and nearly doubled among men over the study period. Among men, however, the increase largely levelled off in all age groups during the final years of the study period.

Although musculoskeletal diseases showed a steady decline across all age groups, they remained the leading cause of LTSA among women and men aged 55–67 as well as among men aged 45–54 throughout the study period. Musculoskeletal diseases were also among the most important diagnostic groups in the younger age groups, although clearly less prevalent than in older age groups.

Some clear sex- and age-specific patterns also emerged. For example, among women aged 25–34, pregnancy- and childbirth-related conditions were the third most common diagnostic group causing LTSA. On the other hand, older men relatively often had LTSA due to circulatory diseases, a diagnostic group that was of lesser importance in other sex and age groups.

In terms of LTSA days (Figures 7 and 8), the trends and differences between sex and age groups were largely similar to those observed for LTSA prevalence. However, since LTSA spells due to mental disorders are, on average, longer than those caused by most somatic diseases, the curves for mental disorders appear relatively higher in LTSA days than in LTSA prevalence. By the end of the study period, mental disorders accounted for an annual average of 3–4 LTSA days per each person in the population at risk among women in age groups under 55 years and about 2 days among women aged 55–67. Among men, the number of LTSA days per person ranged between 1 and 2 across all age groups. In contrast, musculoskeletal diseases caused approximately 4 absence days per person annually among both women and men aged 55–67. Among men, the number of LTSA days due to musculoskeletal diseases was relatively similar to that among women.

Figure 5. Annual Prevalence (%) of Long Sickness Absence by Diagnostic Group in 2010–2023, Finnish Non-Retired Women and Men in Age Groups 16–24, 25–34, and 35–44.

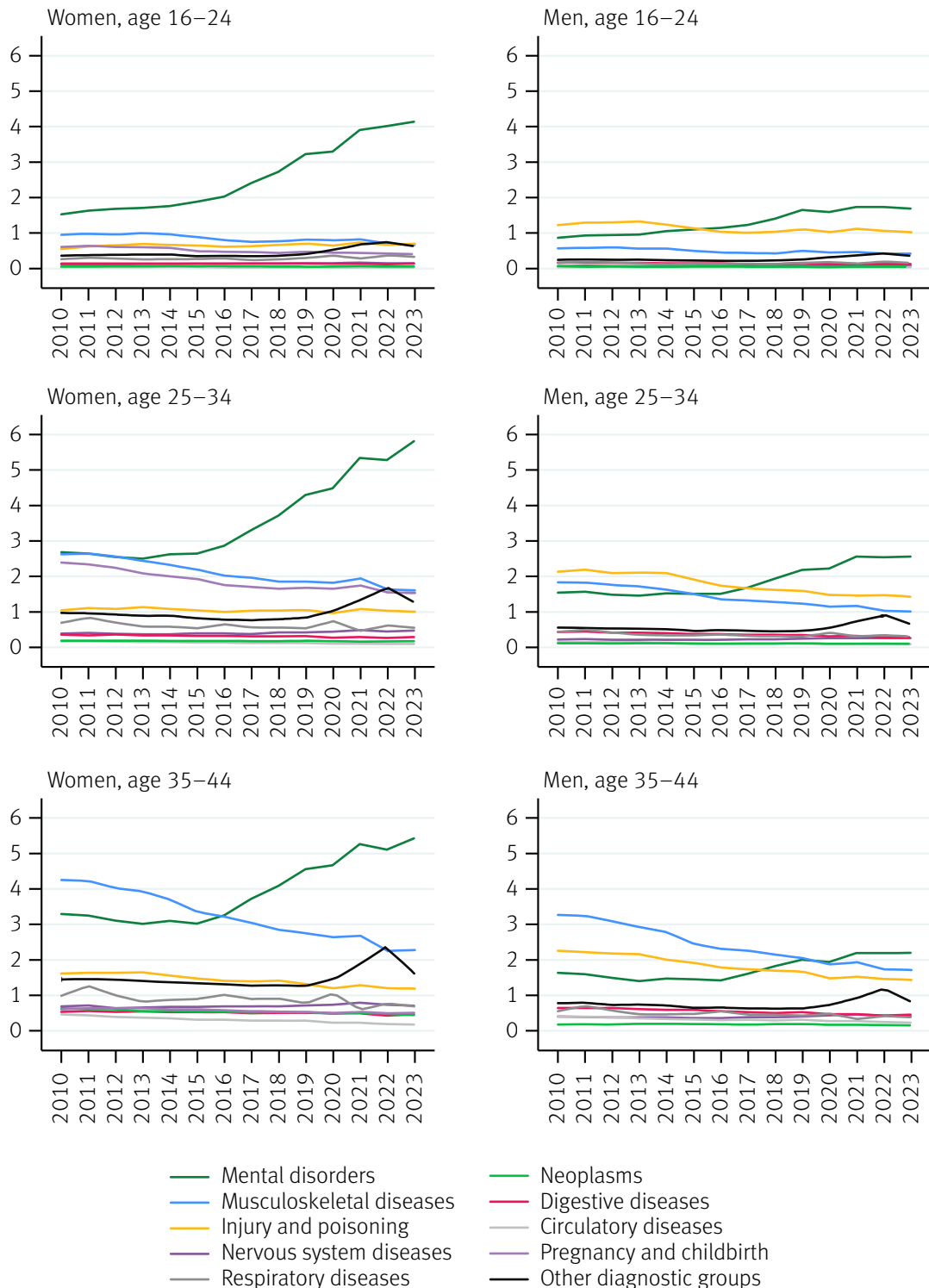


Figure 6. Annual Prevalence (%) of Long Sickness Absence by Diagnostic Group in 2010–2023, Finnish Non-Retired Women and Men in Age Groups 45–54 and 55–67.

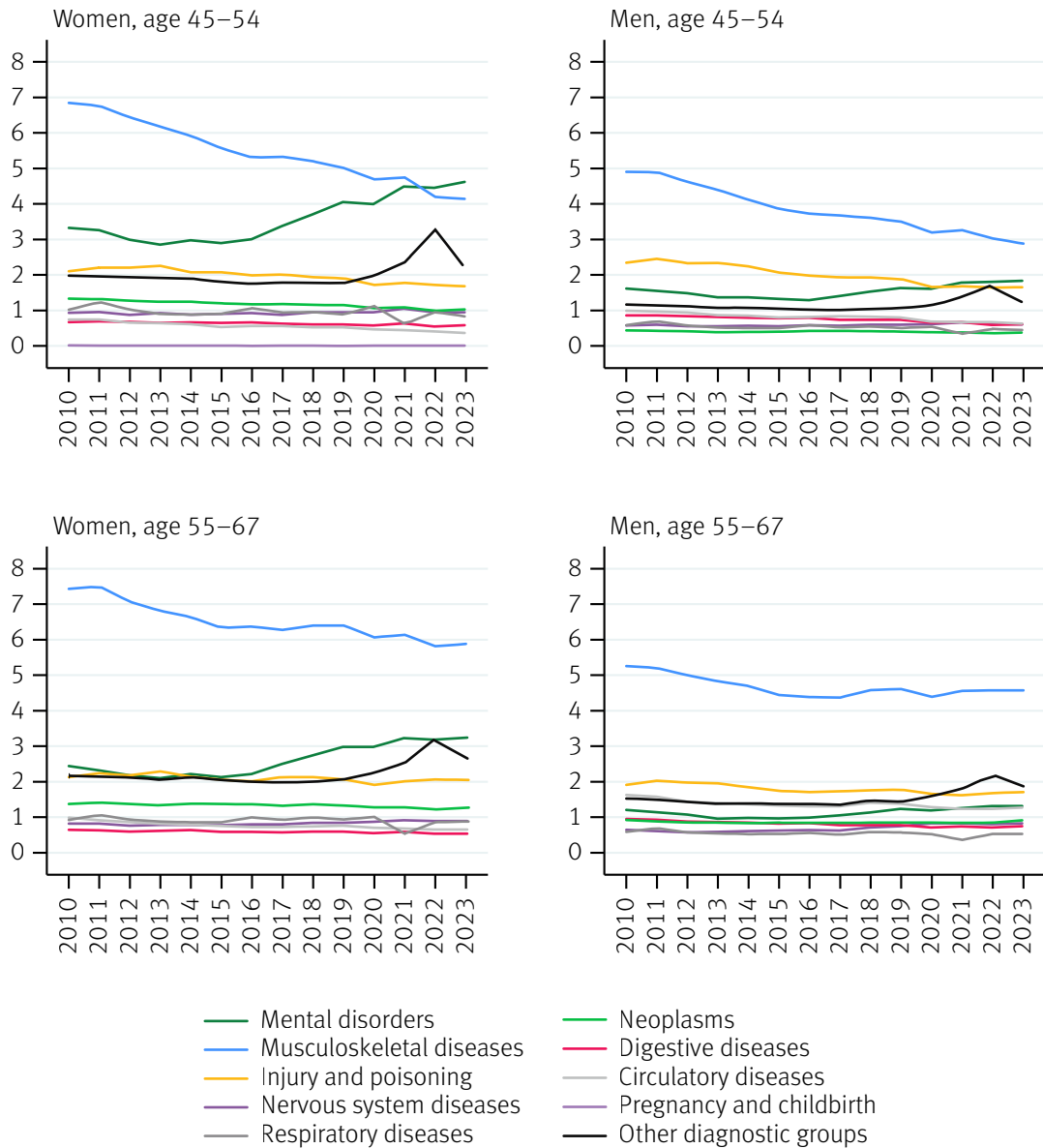


Figure 7. Annual Number of Long-Term Sickness Absence Days per Person in the Population at Risk by Diagnostic Group in 2010–2023, Finnish Non-retired Women and Men in Age Groups 16–24, 25–34, and 35–44.

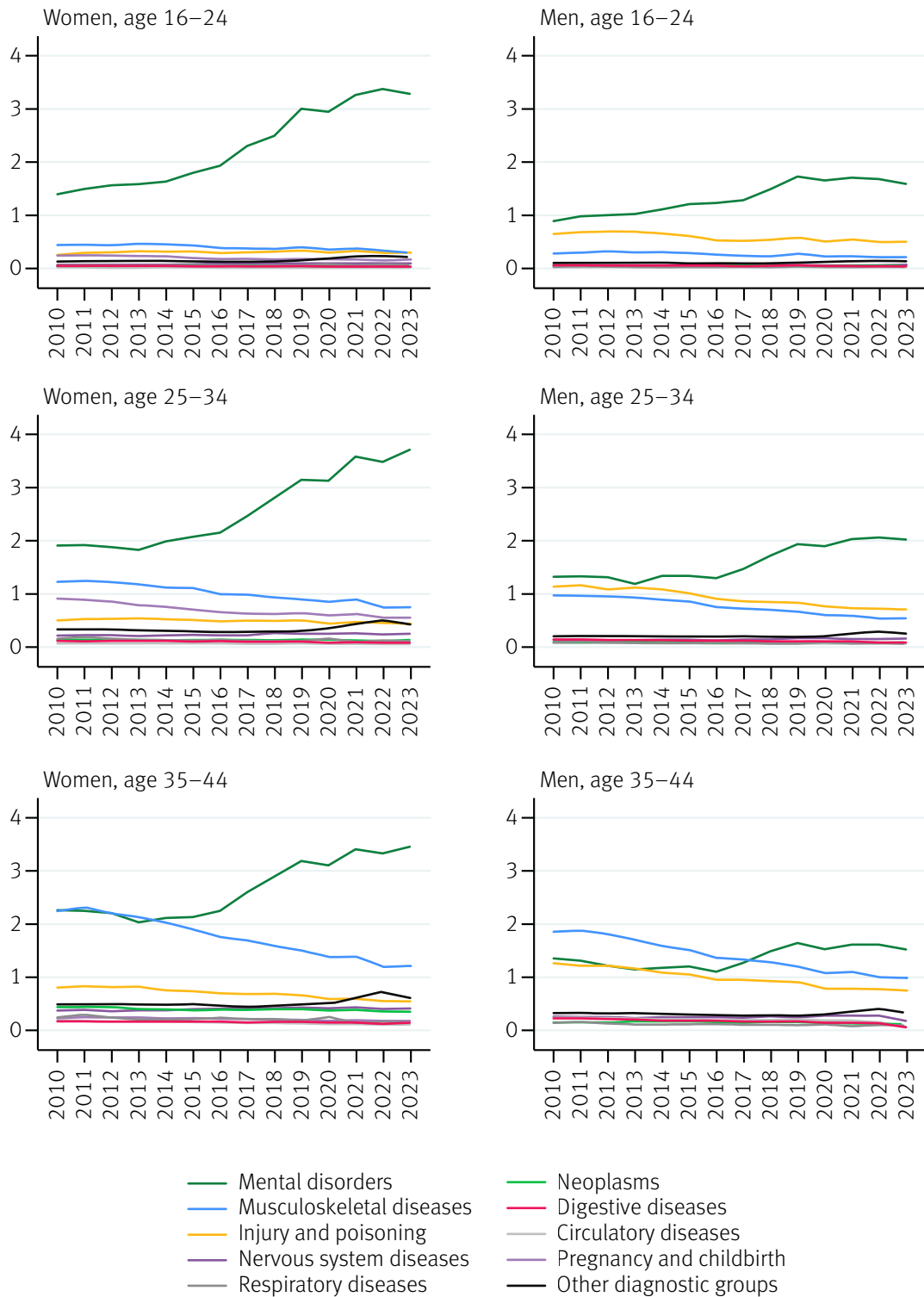
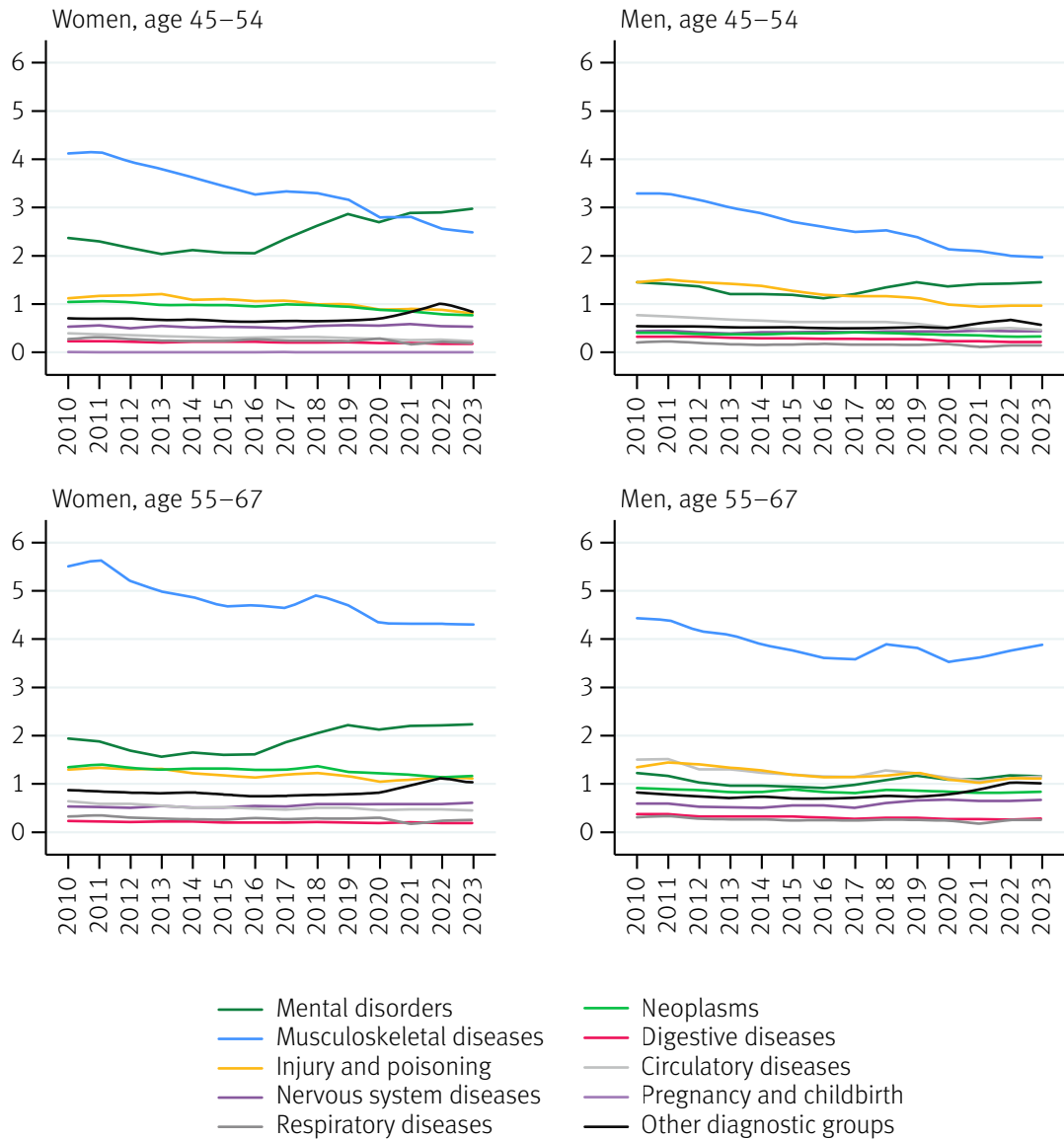


Figure 8. Annual Number of Long-Term Sickness Absence Days per Person in the Population at Risk by Diagnostic Group in 2010–2023, Finnish Non-Retired Women and Men in Age Groups 45–54 and 55–67.



4 Summary and Discussion

To monitor the development of sickness absence in Finland, this report presented trends in long-term sickness absence (LTSA) among the Finnish working-age population for the period 2010–2023 by sex, age, and diagnostic group. The calculations were based on the receipt of sickness allowance, a benefit paid by the Social Insurance Institution of Finland (Kela) to compensate for income loss due to incapacity for work or inability to perform normal duties. Two register-based measures of LTSA were used: (1) the annual prevalence (%) of LTSA, calculated as the proportion of persons with any LTSA spells during each observation year, and (2) the annual number of absence days due to LTSA spells, calculated per person in the population at risk. The latter measure reflects the total burden of LTSA days relative to the size of each population group, rather than the average length of absence spells among those with absences. Due to the 10-day waiting period for sickness allowance, shorter sickness absences were not included in these analyses. Shorter absences are not recorded in national registers, so the total burden of sickness absence across different population groups could not be measured.

Throughout the study period, both the prevalence of LTSA and the number of LTSA days were higher among women than among men and among older age groups than among younger age groups. Differences in LTSA rates between the age groups are largely related to higher levels of somatic morbidity and work ability problems among older age groups compared to younger persons (Finnish Institute for Health and Welfare, 2023). Women having more sickness absence than men, on the other hand, is an internationally recognised phenomenon (Allebeck & Mastekaasa, 2004; Mastekaasa, 2014), related partly to differences between the sexes in the burden of ill health and in working conditions (Laaksonen et al., 2008). Women also use health services more than men do (Rinne et al., 2022) and are thus more likely to obtain physician’s certificates required for LTSA. In recent years, the rise in LTSA due to mental disorders especially among women has further increased the gap in LTSA between women and men.

The relative importance of different diagnostic groups causing LTSA changed considerably over time, echoing earlier findings on diagnosis-specific trends in Finland (Blomgren & Perhoniemi, 2025; Kela, 2024). While LTSA due to somatic diagnoses – primarily musculoskeletal diseases – generally declined, LTSA due to mental disorders increased markedly between 2016 and 2023, particularly among women. A similar pattern of rising LTSA due to mental disorders and declining LTSA due to musculoskeletal diseases has also been observed in other countries, for example Sweden (Försäkringskassan, 2025). Injury and poisoning formed the third most important diagnostic group in terms of LTSA. All other main diagnostic groups

classified under ICD-10 were less prominent in terms of LTSA, each showing an annual prevalence of clearly less than 1% among both women and men.

The trend of increasing LTSA due to mental disorders and decreasing LTSA due to musculoskeletal diseases can be partly attributed to the changing psychological and physical demands in working life. As occupational structures and job tasks have shifted, physical demands of work have steadily decreased, while psychological demands, driven by the growth of service and knowledge work, have increased. In addition, reduced stigmatisation of mental health issues, changing help-seeking behaviour for mental disorders, and a broader rise in mental vulnerability in contemporary society may also help explain the observed increase in LTSA due to mental disorders. (Blomgren & Perhoniemi, 2025; Hensing et al., 2006; Hensing & Wahlström, 2004; Perhoniemi & Blomgren, 2025; Väänänen, 2024.)

The increase in LTSA due to mental disorders was most pronounced among younger age groups (16–24, 25–34, and 35–44 years). By the end of the study period, mental disorders had become the leading cause of LTSA in most age and sex groups. Musculoskeletal diseases remained the most prevalent cause only among men aged 45–54 and both women and men aged 55–67. Several factors have been identified as contributing to the rise in mental health issues among young people, including increasing employment insecurity, growing intergenerational inequality, unregulated use of social media, and anxiety related to climate change (McGorry et al., 2024). As mental disorders have increasingly driven LTSA in younger age groups, while musculoskeletal diseases have declined in older age groups, an overall convergence in LTSA rates across age groups has been observed in recent years.

This study was based on register data covering the entire working-age population and their long-term sickness absences from 2010 to 2023, as measured by the receipt of sickness allowance. Registers covering the total population provide a reliable and comprehensive data source, with no self-report bias and very little missing information. The analyses utilised detailed data on sickness allowance spells, including the start and end dates of work disability as well as the associated diagnostic causes. The waiting periods for sickness allowance were included in the definition of LTSA used in this report. For this reason, and because the calculations of prevalence and absence days were based on the actual timing of sickness absence spells, the results are not directly comparable to the official sickness allowance statistics (Kela, 2024, 2025), which are based on sickness allowance payment dates rather than the true timing of the absences.

In conclusion, this report provided a comprehensive overview of LTSA trends in Finland from 2010 to 2023, highlighting notable shifts in the diagnostic causes

and demographic patterns of work disability. The analyses showed consistently higher LTSA rates among women and older age groups, with a significant rise in absences due to mental disorders after the mid-2010s, especially among younger individuals. While LTSA related to somatic conditions, particularly musculoskeletal diseases, has declined, the growing burden of sickness absences related to mental disorders reflects broader changes in work demands, societal attitudes, health-seeking behaviour, and the mental well-being of the population. The findings underscore the need for targeted measures to support mental health and work ability, especially among young adults, and to sustain the positive trend in reducing musculoskeletal diseases and other somatic diseases causing work disability.

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Appendices

Appendix Table 1. Annual Prevalence (%) of Long-Term Sickness Absence by Age Group Among Finnish Non-Retired Women and Men Aged 16–67 in 2010, 2016, and 2023.

Age group	Women, 2010	Women, 2016	Women, 2023	Men, 2010	Men, 2016	Men, 2023
16–24	4.3	4.6	6.6	3.3	3.2	3.7
25–34	10.5	9.3	11.5	6.9	5.9	6.1
35–44	13.1	11.6	12.0	9.3	7.5	7.0
45–54	17.0	14.7	14.3	12.3	10.2	9.1
55–67	17.0	15.4	15.7	13.4	11.6	12.1
All age groups	12.5	11.2	12.2	9.0	7.6	7.6

Appendix Table 2. Annual Number of Long-Term Sickness Absence Days per Person in the Population at Risk by Age Group Among Finnish Non-Retired Women and Men aged 16–67 in 2010, 2016, and 2023.

Age group	Women, 2010	Women, 2016	Women, 2023	Men, 2010	Men, 2016	Men, 2023
16–24	2.7	3.2	4.5	2.2	2.3	2.7
25–34	5.6	5.3	6.5	4.2	3.6	4.0
35–44	7.5	6.7	7.1	5.8	4.6	4.5
45–54	10.8	9.3	8.9	8.9	7.3	6.5
55–67	12.7	11.0	11.4	11.5	9.5	10.4
All age groups	7.8	7.1	7.8	6.4	5.4	5.6

Appendix Table 3. Annual Prevalence (%) of Long-Term Sickness Absence by Diagnostic Group Among Finnish Non-Retired Women and Men Aged 16–67 in 2010, 2016, and 2023.

Diagnostic group	Women, 2010	Women, 2016	Women, 2023	Men, 2010	Men, 2016	Men, 2023
Mental disorders	2.7	2.7	4.7	1.4	1.3	2.0
Musculoskeletal diseases	4.4	3.6	3.0	3.1	2.4	2.1
Injury and poisoning	1.5	1.4	1.3	2.0	1.7	1.5
Nervous system diseases	0.6	0.6	0.6	0.4	0.4	0.4
Respiratory diseases	0.8	0.8	0.7	0.5	0.4	0.4
Neoplasms	0.7	0.7	0.6	0.3	0.3	0.3
Digestive diseases	0.5	0.5	0.4	0.6	0.5	0.4
Circulatory diseases	0.5	0.4	0.3	0.6	0.5	0.4
Pregnancy and childbirth	0.7	0.6	0.5	0.0	0.0	0.0
Other diagnostic groups	1.4	1.3	1.7	0.8	0.7	1.0
All diagnostic groups	12.5	11.2	12.2	9.0	7.6	7.6

Appendix Table 4. Annual Number of Long-Term Sickness Absence Days per Person in the Population at Risk by Diagnostic Group Among Finnish Non-Retired Women and Men Aged 16–67 in 2010, 2016, and 2023.

Diagnostic group	Women, 2010	Women, 2016	Women, 2023	Men, 2010	Men, 2016	Men, 2023
Mental disorders	2.0	2.0	3.1	1.3	1.1	1.6
Musculoskeletal diseases	2.7	2.2	1.8	2.1	1.7	1.5
Injury and poisoning	0.8	0.7	0.6	1.2	0.9	0.8
Nervous system diseases	0.3	0.4	0.4	0.3	0.3	0.3
Respiratory diseases	0.2	0.2	0.2	0.2	0.1	0.1
Neoplasms	0.6	0.6	0.5	0.3	0.3	0.3
Digestive diseases	0.2	0.1	0.1	0.2	0.2	0.2
Circulatory diseases	0.3	0.2	0.2	0.5	0.4	0.4
Pregnancy and childbirth	0.3	0.2	0.2	0.0	0.0	0.0
Other diagnostic groups	0.5	0.5	0.6	0.4	0.4	0.5
All diagnostic groups	7.8	7.1	7.8	6.4	5.4	5.6

Appendix Table 5. Annual prevalence (%) of Long-Term Sickness Absence by Age Group and Diagnostic Group Among Finnish Non-Retired Women Aged 16–67 in 2010, 2016, and 2023.

Diagnostic group	Age group 16–24			Age group 25–34			Age group 35–44			Age group 45–54			Age group 55–67		
	2010	2016	2023	2010	2016	2023	2010	2016	2023	2010	2016	2023	2010	2016	2023
Mental disorders	1.5	2.0	4.1	2.7	2.9	5.8	3.3	3.3	5.4	3.3	3.0	4.6	2.4	2.2	3.2
Musculoskeletal diseases	1.0	0.8	0.6	2.6	2.0	1.6	4.3	3.2	2.3	6.9	5.3	4.1	7.4	6.4	5.9
Injury and poisoning	0.6	0.6	0.7	1.0	1.0	1.0	1.6	1.4	1.2	2.1	2.0	1.7	2.1	2.0	2.1
Nervous system diseases	0.1	0.1	0.1	0.4	0.4	0.5	0.7	0.7	0.7	0.9	0.9	0.9	0.8	0.8	0.9
Respiratory diseases	0.3	0.3	0.3	0.7	0.6	0.6	1.0	1.0	0.7	1.0	1.1	0.8	0.9	1.0	0.9
Neoplasms	0.1	0.1	0.1	0.2	0.2	0.2	0.6	0.5	0.5	1.3	1.2	1.0	1.4	1.4	1.3
Digestive diseases	0.1	0.1	0.1	0.4	0.3	0.3	0.5	0.5	0.4	0.7	0.7	0.6	0.6	0.6	0.5
Circulatory diseases	0.0	0.0	0.0	0.2	0.1	0.1	0.5	0.3	0.2	0.7	0.6	0.4	1.0	0.7	0.6
Pregnancy and childbirth	0.6	0.5	0.4	2.4	1.8	1.5	0.6	0.6	0.5	0.0	0.0	0.0	0.0	0.0	0.0
Other diagnostic groups	0.4	0.4	0.6	1.0	0.8	1.2	1.4	1.3	1.6	2.0	1.8	2.2	2.2	2.0	2.6
All diagnostic groups	4.3	4.6	6.6	10.5	9.3	11.5	13.1	11.6	12.0	17.0	14.7	14.3	17.0	15.4	15.7

Appendix Table 6. Annual Prevalence (%) of Long-Term Sickness Absence by Age Group and Diagnostic Group Among Finnish Non-Retired Men Aged 16–67 in 2010, 2016, and 2023.

Diagnostic group	Age group 16–24			Age group 25–34			Age group 35–44			Age group 45–54			Age group 55–67		
	2010	2016	2023	2010	2016	2023	2010	2016	2023	2010	2016	2023	2010	2016	2023
Mental disorders	0.9	1.1	1.7	1.5	1.5	2.6	1.6	1.4	2.2	1.6	1.3	1.8	1.2	1.0	1.3
Musculoskeletal diseases	0.6	0.4	0.4	1.8	1.4	1.0	3.3	2.3	1.7	4.9	3.7	2.9	5.3	4.4	4.6
Injury and poisoning	1.2	1.0	1.0	2.1	1.7	1.4	2.3	1.8	1.4	2.3	2.0	1.7	1.9	1.7	1.7
Nervous system diseases	0.1	0.1	0.1	0.2	0.2	0.3	0.4	0.4	0.4	0.6	0.6	0.6	0.6	0.6	0.8
Respiratory diseases	0.2	0.1	0.2	0.4	0.4	0.3	0.6	0.5	0.4	0.6	0.6	0.4	0.6	0.6	0.5
Neoplasms	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.4	0.4	0.4	0.9	0.8	0.9
Digestive diseases	0.2	0.1	0.1	0.4	0.4	0.3	0.6	0.5	0.4	0.9	0.8	0.6	1.0	0.8	0.8
Circulatory diseases	0.0	0.0	0.0	0.1	0.1	0.1	0.4	0.3	0.2	1.0	0.8	0.6	1.6	1.3	1.3
Other diagnostic groups	0.2	0.2	0.3	0.6	0.5	0.6	0.8	0.7	0.8	1.2	1.0	1.2	1.5	1.4	1.9
All diagnostic groups	3.3	3.2	3.7	6.9	5.9	6.1	9.3	7.5	7.0	12.3	10.2	9.1	13.4	11.6	12.1

Appendix Table 7. Annual Number of Long-Term Sickness Absence Days per Person in the Population at Risk by Age Group and Diagnostic Group Among Finnish Non-Retired Women Aged 16–67 in 2010, 2016, and 2023.

Diagnostic group	Age group 16–24			Age group 25–34			Age group 35–44			Age group 45–54			Age group 55–67		
	2010	2016	2023	2010	2016	2023	2010	2016	2023	2010	2016	2023	2010	2016	2023
Mental disorders	1.4	1.9	3.3	1.9	2.1	3.7	2.3	2.3	3.5	2.4	2.1	3.0	1.9	1.6	2.2
Musculoskeletal diseases	0.4	0.4	0.3	1.2	1.0	0.8	2.2	1.8	1.2	4.1	3.3	2.5	5.5	4.7	4.3
Injury and poisoning	0.3	0.3	0.3	0.5	0.5	0.4	0.8	0.7	0.5	1.1	1.1	0.8	1.3	1.1	1.1
Nervous system diseases	0.1	0.1	0.1	0.2	0.2	0.3	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.6
Respiratory diseases	0.1	0.1	0.1	0.2	0.1	0.1	0.2	0.2	0.1	0.3	0.3	0.2	0.3	0.3	0.3
Neoplasms	0.0	0.1	0.0	0.1	0.1	0.1	0.4	0.4	0.3	1.0	0.9	0.8	1.3	1.3	1.2
Digestive diseases	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.2	0.1	0.2	0.2	0.2	0.2	0.2	0.2
Circulatory diseases	0.0	0.0	0.0	0.1	0.1	0.0	0.2	0.1	0.1	0.4	0.3	0.2	0.6	0.5	0.5
Pregnancy and childbirth	0.2	0.2	0.2	0.9	0.7	0.6	0.2	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.0
Other diagnostic groups	0.1	0.1	0.2	0.3	0.3	0.4	0.5	0.5	0.6	0.7	0.6	0.8	0.9	0.7	1.0
All diagnostic groups	2.7	3.2	4.5	5.6	5.3	6.5	7.5	6.7	7.1	10.8	9.3	8.9	12.7	11.0	11.4

Appendix Table 8. Annual Number of Long-Term Sickness Absence Days per Person in the Population at Risk by Age Group and Diagnostic Group Among Finnish Non-Retired Men Aged 16–67 in 2010, 2016, and 2023.

Diagnostic group	Age group 16–24			Age group 25–34			Age group 35–44			Age group 45–54			Age group 55–67		
	2010	2016	2023	2010	2016	2023	2010	2016	2023	2010	2016	2023	2010	2016	2023
Mental disorders	0.9	1.2	1.6	1.3	1.3	2.0	1.4	1.1	1.6	1.5	1.1	1.5	1.2	0.9	1.2
Musculoskeletal diseases	0.3	0.3	0.2	1.0	0.8	0.5	1.9	1.4	1.0	3.3	2.6	2.0	4.4	3.6	3.9
Injury and poisoning	0.7	0.5	0.5	1.1	0.9	0.7	1.3	1.0	0.8	1.5	1.2	1.0	1.3	1.1	1.1
Nervous system diseases	0.0	0.1	0.1	0.1	0.1	0.2	0.3	0.2	0.3	0.4	0.4	0.4	0.6	0.6	0.7
Respiratory diseases	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.1	0.3	0.3	0.3
Neoplasms	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.4	0.4	0.3	0.9	0.8	0.8
Digestive diseases	0.1	0.0	0.0	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.2	0.4	0.3	0.3
Circulatory diseases	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.2	0.2	0.8	0.6	0.5	1.5	1.2	1.2
Other diagnostic groups	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.5	0.5	0.5	0.8	0.7	1.0
All diagnostic groups	2.2	2.3	2.7	4.2	3.6	4.0	5.8	4.6	4.5	8.9	7.3	6.5	11.5	9.5	10.4

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