Sickness, Disability and Work: Breaking the Barriers

SWEDEN: Will the Recent Reforms Make it?

OECD

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Organisation for Economic Co-operation and Development
Directorate for Employment, Labour and Social Affairs

FOREWORD

Sickness and disability is a key economic policy concern for many OECD countries. Medical conditions, or problems labelled as such by societies and policy systems, are proving an increasing obstacle to raising labour force participation and keeping public expenditure under control. More and more people of working age rely on sickness and disability benefits as their main source of income, and the employment rates of those reporting disabling conditions are low. There is now an urgent need to address this "medicalisation" of labour market problems. In the current economic downturn, there is a risk that countries may be tempted to revert to using sickness and disability schemes to massage politically sensitive unemployment figures. The current context makes the reforms in Sweden especially important, but potentially more challenging to manage politically.

The OECD's Thematic Review on Sickness, Disability and Work examines national policies to control the inflow into sickness and disability benefit programmes, and to assist those beneficiaries who are able to work to reintegrate the labour market. It attempts to discover what leads a person with a health problem to withdraw from the labour market or remain outside of it, and to identify areas for further policy improvement. The main concern of the review is with people who could work but do not work. Many people with health problems can work and want to work, so any policy based on the assumption that they cannot work is fundamentally flawed. Helping people to work is potentially a "win-win" policy: it helps people avoid exclusion and have higher incomes while raising the prospect of more effective labour supply and higher economic output in the long term.

Sweden has not formally participated in the OECD's Thematic Review of eleven countries published in Volumes 1-3 of *Sickness, Disability and Work: Breaking the Barriers*. Instead it requested the OECD Secretariat to review the potential of its most recent and ongoing reforms, especially in regard to sickness absence and sickness benefit policy. This report is an assessment of the Swedish reforms, which aim to lower inactivity and increase participation, against the background of recent trends and policy responses in other OECD countries. It looks at what Sweden is currently doing and what more it could do to transform its sickness and disability schemes from passive benefits to active support systems that promote work. The report consists of three sections. Chapter 1 sets the scene by looking at key trends in the past 15 years and main policy responses until 2006. Chapter 2 discusses sickness and disability policy reforms introduced or further elaborated by the new government. Chapter 3 looks at what is needed in the short and long term to make the reforms work.

This report was prepared by Allen Gomes, Ana Llena-Nozal and Christopher Prinz (team leader), statistical work was provided by Dana Blumin and Maxime Ladaique, and administrative support by Claire Gibbons. Important inputs for the report were supplied by three Swedish government departments, the Ministry of Health and Social Affairs, the Ministry of Employment and the Ministry of Finance.

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EXECUTIVE SUMMARY

Sweden is currently undertaking a series of extensive reforms to address long-term structural problems with its sickness and disability policies. A new sick-leave process with a much stricter timeline for work-capacity assessment has been put in place to facilitate the return to work. The changes are far-reaching and in the right direction but given the breadth of reform and the size of the problem, implementation remains a big challenge. More could and needs to be done to ensure that the reforms live up to their promise. In particular, financial incentives remain weak for most players, particularly employers and the health system. Co-operation among the key institutional actors also needs to be strengthened in some areas.

Box 0.1. **Recommendations to improve the rehabilitation chain**

	Key policy challenges	Policy recommendations
1.	Assessment of work capacity and of work reintegration options happens far too late	• Sickness certificates exceeding seven days duration should be sent to the Social Insurance Agency immediately to make random checks of their validity via second medical opinions; • Where a worker takes more than a month's sick leave, automatically offer rehabilitation advice and support to their employer to facilitate their return; • Use the *FAROS* model of co-operation between the Social Insurance Agency and the Public Employment Service for all clients who have received a sickness benefit for 180 days.
2.	Medical authorities do not have sufficient incentives to pursue timely work resumption	• Introduce co-payment of sickness benefits with the county councils responsible for the health care system, as an incentive to keep down sick-leave duration and expedite return to work; • Provide a (medical) rehabilitation guarantee; • Report and sanction non-compliance of general practitioners to the new sick-listing guidelines.
3.	Employers have few obligations with respect to their sick employees	• Develop clear standards for assessing employers' efforts in work reintegration; • Increase the financial incentives for employers to act to ensure sick workers resume work; • Improve co-operation between employers and the Public Employment Service.

The severe foreign exchange crisis which erupted in autumn 1990 caused an economic downturn in the early 1990s that changed Sweden in ways that are still being felt. Unemployment jumped from below 2% in the late 1980s to 8-10% in the mid-1990s, and overall dependence of the working-age population on social benefits climbed from 12% to 20%. Initially, this growth in benefit use was driven by high unemployment. From 1995 onwards, however, there was a sudden structural shift onto long-term sickness and disability benefit: by 2004, 14% of the working-age population received either sickness or disability benefit, the highest level in the OECD.

This led to much discussion at all levels of Swedish society and eventually to calls for stricter application of existing legislation by the restructured Social Insurance Agency. This was, in turn, associated with a fall in moral hazard and sickness absence levels, prior to significant changes in the regulations.

In 2006, the new government which, during its electoral campaign, promised to reduce inactivity took office. Since the total incapacity rate (taking sickness and disability together) was still extremely high, it decided to change the system so that sick people were obliged to return to work faster or make efforts to find other more suitable work at an early stage. The driving force behind this important fundamental reform was evidence showing that the longer the period of inactivity, the less likely a person was of ever returning to the labour market.

Some of the recent changes represent a radical departure from previous policies. The idea of encouraging job mobility at an early stage is innovative and addresses one of the main causes behind the high and sometimes still increasing levels of sickness and disability in many OECD countries. Coupled with recent institutional adjustments, the Swedish reforms have the potential to reduce dependency on long-term sickness and disability benefits and increase the employment rate of people with disability.

That said, to ensure that these reforms live up to their promise further change is needed in a number of areas. In particular, it appears that responsibilities and financial incentives for key actors are not sufficient to ensure that the new *rehabilitation chain* will work as intended. Incentives to stay in work are weak for workers; they are offered very high replacement income on a long-term basis through collectively-agreed benefit top-ups. Supports and incentives for employers to retain workers appear weak as do incentives in the health care system run by county authorities and among general practitioners assessing work incapacity, to expedite return to work among those who take sick leave.

Finally, the political economy of reform remains an issue. These reforms represent a significant departure from previous policy and smooth implementation and encouraging results are going to be needed to win the hearts and minds of the Swedish population at large and the main stakeholders. This challenge is going to be exacerbated by the unfolding economic downturn and in particular, increasing unemployment over the next two years (OECD, 2008b).

CHAPTER 1: SETTING THE SCENE

1.1. Key trends since 1990

In Sweden, the 1970s and 1980s were a period of relatively stable economic growth characterised by very high and increasing rates of employment, reaching 90% for the population aged 25-54, and very low rates of unemployment, fluctuating at 2-3% (OECD, 1996). However, even then inactivity due to worker incapacity was a major labour market issue. Sickness absence was very high with short-term absence fluctuating significantly (OECD, 2005). Disability benefit recipiency was also comparatively high and growing, from 5% of the working-age population in the mid 1970s to 7% in 1990, mostly as a consequence of the increased take-up by women, though this was partly a by-product of their rising participation in the labour force.

The economic downturn in the early 1990s, caused by a severe foreign exchange crisis which erupted in the autumn of 1990, marked a turning point in Sweden. Unemployment leapt to 8-10% and remained at that level until 1998 (OECD, 2003a). Taking into account the additional numbers on sickness and disability benefit, in the mid-1990s no less than 20% of the working-age population were receiving a social insurance benefit – compared with 10-13% during the 1970s and 1980s.[1] This constituted a longer-term structural shift that still persists today with one in five working-age adults relying on a social insurance benefit of some kind.

How can this be explained? While unemployment fell again to 5% in 2000/2001, most of this increase was offset by an increase in the incapacity rate.[2] In 1998, sick-leave of all durations and inflows into disability benefit started to increase very rapidly (see Figure 1.1). Sick-leave with duration of less than six months increased by 90% until early 2002, sick-leave of 6-12 months by 140% until mid-2002 and long-term sick-leave of more than one year almost tripled until 2003. The annual inflow into disability benefit followed this trend, albeit with a delay, and more than doubled until 2004. As a consequence, the total incapacity rate of the working-age population peaked at 14% in 2004/2005.

After reaching these peak levels, absence rates fell back to roughly 1998 levels in 2008 (only sick-leave of over one year is still more frequent than it was ten years ago). However, the overall dependence on social insurance benefits did not change very much, though this was partly because unemployment rose to around 7%. This development highlights a strong negative correlation between sickness absence and unemployment, at least at the national level, as has been found in several studies in Sweden (*e.g.* Arai and Skogman-Thoursie, 2001; and Larsson, 2002).[3]

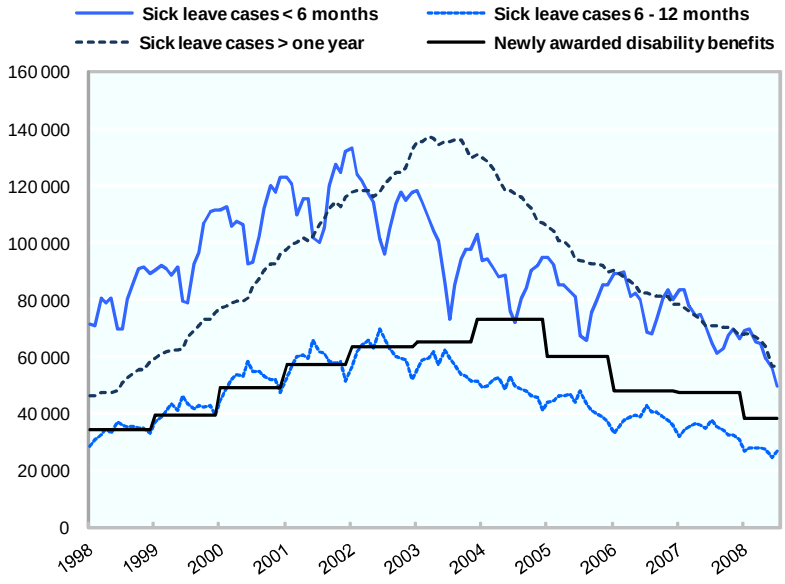
1. Total recipiency of social benefits, including social assistance payments provided by municipalities, was even higher, at around 23%.

2. The term "incapacity rate" is used in this report to denote the total number of people on either sickness or disability benefit in per cent of the working-age population.

3. The pro-cyclical pattern of the aggregate Swedish sickness absence rate is partly due to absence-prone workers being more likely to lose their job, as shown in Hesselius (2007).

Figure 1.1. **The four waves of incapacity benefit growth until 2004**

Cases of sick-leave and people awarded a disability benefit (monthly numbers)[a]

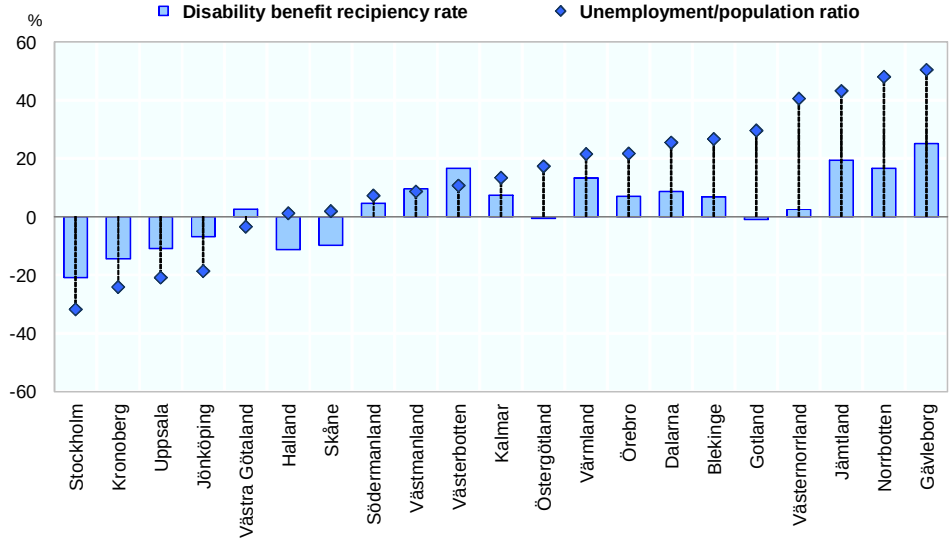


a) Sickness absence data are on a monthly basis, while the annual number of inflows into disability benefit is divided by 12 to derive a monthly estimate.

Source: Swedish Social Insurance Agency.

Figure 1.2. **A strong positive correlation between unemployment and disability across Swedish regions**

Differences in percent from the overall rate in the country in 2007[a]



a) Regions ranked by increasing order of the difference in their unemployment/population ratio from the overall country ratio

Source: Swedish Social Insurance Agency and Public Employment Service.

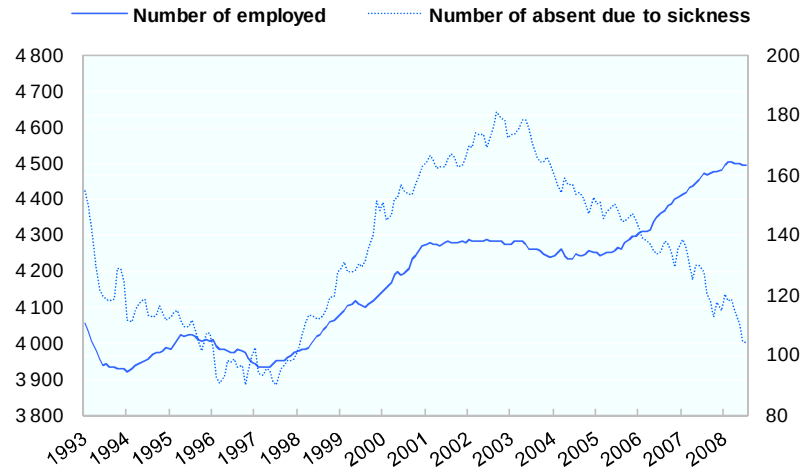
However, there is another mechanism at work. With sickness being the major gateway into permanent disability benefit in Sweden as it is in most OECD countries, high sickness absence rates have flowed on into increasing disability benefit recipiency (as shown in comparison with other countries in Figure 1.7) – and these rates have not fallen to the same degree and certainly not as quickly when unemployment rises, as it did in the 2002-2006 period. This is the second explanation for the persistently high overall dependence of the working-age population on social insurance payments – which is still close to 20% today.

Indeed, the relationship between disability and unemployment is quite a different matter, especially at the regional level. Counties with higher rates of unemployment also tend to have higher rates of disability benefit use (Figure 1.2), with a high statistical correlation of R=0.82. The causality of this relation, however, is not a given, although it appears that, first, both high levels of unemployment and high disability are indicators of a weak regional labour market and secondly, long-term unemployment is one of the risk factors in long-term disability (*e.g.* OECD, 2008a).[4]

The recent change in trends of benefit use shown in Figure 1.3 suggests that something different is now happening in Sweden. In the past three years, sick-leave numbers fell sharply despite a considerable increase in the number of employees. Until 2006, this change did not have an impact on overall dependence on social insurance benefits, because both unemployment and disability benefit recipiency increased. But in 2007, for the first time, employment increased at the same time as both unemployment and sickness absence fell.

Figure 1.3. **Sickness trend no longer follows the employment trend in recent years**

Seasonally adjusted 3-month moving average, persons aged 16-64, 1993-2008[a]



a) Employment on left-hand scale, sickness absence (people absent the whole week due to sickness) on right-hand scale.

Source: Statistics Sweden (LFS).

4. Johansson and Palme (2002) show that higher local unemployment is also associated with higher incidence of local sickness absence, together with a reduced likelihood of returning to work. Hence, the pro-cyclical negative relation between sickness and unemployment on a national level over time seems to go hand-in-hand with a positive association on a local level.

What is the reason behind this apparent shift in behaviour which seems to have started in 2004, *i.e.* prior to the new government taking office, and which has accelerated in the past two years? This question is explored briefly in the following section, covering the period until 2006, while policy changes after 2006 are the subject of Chapter 2.

1.2. Major reforms in the period 1990-2006

A. The 1990s

Initially, the big economic downturn in the early 1990s opened a window of opportunity for reform (following a period without any major reforms during the 1980s). This window was used for various reforms of the sickness benefit scheme, especially:

- The introduction of a 14-day sick-pay period covered by the employer as of 1992;
- The (re-)introduction of a waiting day without any benefit payment as of 1993; and
- Three waves of reductions in the sickness benefit level, in 1991 (75% of earnings in the first three days and 90% until day 90 instead of 100%, and 90% instead of 95% thereafter), in 1992 (80% after day 90) and in 1993 (70% after the first year of absence).

The main purpose of these reforms in the early 1990s was to bring down public expenditures by cutting payments to make short-term savings. The result was a sharp reduction especially in short-term absences. Swedish workers were very sensitive to changes in the sickness replacement rate.[5]

The reforms undertaken to address the crisis, however, did not have lasting effects. First, because of the urgency reforms were pushed through very quickly, without the normal consultation process. They were not supported by the main stakeholders, especially the social partners. This lack of support had two effects. First, reforms were at least partly undermined by corresponding increases in collectively-agreed benefit top-ups (the replacement rates mentioned above include those top-ups)[6]. Secondly, pressure to at least partly reverse the changes increased sharply when economic conditions improved. Moreover, the changes in the early 1990s also had other undesired effects: the average length of a sickness spell increased because workers tried to avoid facing another period of either no pay (on the first day of absence) or low pay (on the second and third day).[7] Not surprisingly, therefore, in the second half of the 1990s compensation rates were partly increased again, offering 90% until the end of the first year and 80% thereafter. This led to a rapid rise in sickness absence rates thereafter.[8]

5. Various papers show a strong positive relationship between the sick-leave compensation rate and the absence level (*e.g.* Henrekson and Persson, 2004), though separating out the effect is difficult because changes in replacement rates coincided with other variations in the business cycle.

6. Collective agreements also introduced different compensation levels across workers: municipal workers and blue-collar workers have a higher compensation level from day 91 (90% instead of 80%).

7. The initial idea with the 1991 reform was that it would increase the cost of beginning a work-absence period, thus leading to a decrease in incidence. But the reform also increased the cost of returning to work after day 90 so that workers on long work-absence spells increased their duration, as was found in Johansson and Palme (2004).

8. Hesselius and Persson (2007), for example, have shown that a 10 percentage point increase in the replacement rate for absences of duration of 91-360 days, in 1998, led to an increase in the number of

The early 1990s also marked the starting point for changes in the disability and vocational rehabilitation schemes. Vocational rehabilitation was reformed in 1992 with the aim of strengthening rights and responsibilities of workers and the employers, to encourage early intervention, to improve the coordination role of the Social Insurance Agency (SIA) and to open the provider market for private operators. Relevant changes in the disability benefit scheme included the introduction of the "elderly rules" in 1993 (when it was no longer possible for workers over age 60 to receive a disability benefit on the grounds of labour market reasons though medical criteria continued to be enforced less strictly) and the abolition of any special access conditions for workers over age 60 in 1997. The latter change is one of the reasons for the particularly sharp increase, starting in 1998, in long-term sickness absence – which is still much higher today than it was prior to 1998.[9]

There were additional factors explaining why reforms undertaken during the 1990s largely failed in the longer run. Due to the lack of support from the key stakeholders, policy implementation was very lax. Sickness monitoring, rehabilitation procedures and eligibility rules for disability benefits were, in theory, relatively strict by international standards, but poorly applied or not at all[10]. General practitioners were reluctant to deny sickness certificates to workers, despite a tougher set of rules introduced in 1995.[11] Employers failed to fulfil their obligation to undertake a rehabilitation investigation, which should form the basis for the preparation of a rehabilitation plan prepared by the SIA, without any consequences. Local social insurance offices faced strong incentives not to deny benefits, especially disability benefits, with elected local politicians being involved in administering the system.

B. Since the turn of the century

System reform came back on the agenda when it became clear that long-term sickness and disability was growing much faster than was fiscally tolerable. The far-reaching old-age pension reform enacted in 1999, following a long and comprehensive reform process, also added to the problem, as it left the disability benefit system (which was part of the pension system then) unreformed. Not only did this suddenly make the disability benefit appear more attractive than an actuarially reduced old-age pension, but in addition contributions to the new old-age pension system came for free on top of the disability benefit payment.

In mid-2000, a government committee proposed far-reaching reforms including to: *i)* extend the period of employer responsibility from 14 to 60 days; *ii)* introduce co-payments by the employer throughout the sickness spell; *iii)* limit the period of sick pay to one year; *iv)* merge sickness and disability insurance; and *v)* replace permanent disability benefit by a temporary activity benefit with special work incentives (for those aged 19-29) or a temporary sickness compensation (for those aged 30 and over).

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absences of such duration by, on average, 4.7 days and correspondingly an increase in the overall costs of the national sickness insurance by 3%.

9. Studying the impact of the 1997 reform, Karlström *et al.* (2008) found that, rather than leading to higher employment of the 60-64 age group, sickness and unemployment insurance absorbed many of those no longer entitled to disability insurance – the well-known communicating vessels effect.

10. According to a study by Ahlgren *et al.* (2008), the proportion of clients on sickness benefit who received vocational rehabilitation measures varied across SIA offices from 1.2% to 8.7%.

11. Söderberg and Alexandersson (2005) and Söderberg and Mussener (2008) found that doctors often fail to provide sufficient information concerning work capacity.

Resistance to reform by the social partners continued, but the poor outcomes allowed the government to introduce some changes. Sickness and disability insurance was merged in 2003, as proposed by the Committee, with slightly different rules for those younger and older than 30 years, but with no change in benefit levels. The proposal to introduce a time limit for sickness benefits was dropped but the employer period was increased to 21 days in 2004. This change was reversed again in 2005 when employers, in addition to being fully responsible for the cost of sickness absence for the first 14 days, had to co-finance 15% of the sickness compensation costs after the second week of absence and continuously throughout the sickness spell.

The most important change probably, however, was the restructuring of the SIA in 2005. Prior to this, the SIA was comprised of 21 semi-autonomous regional offices; decision processes differed largely, as did the outcomes in terms of benefit grants (as shown in Figure 1.2). Today, the SIA has a centralised administration thus bringing much greater consistency and purpose to the form and quality of frontline services. In addition, already in 2003, cooperation between the SIA and the Public Employment Service (PES) was improved, with a focus on long-term sickness benefit clients.

Sickness absence levels had already started to fall rapidly in 2003 (and in 2004 for absences of more than one year), and disability benefit inflows followed this trend in 2005. Analysts and policy makers generally agree that this fall was not brought about by a substantive change in regulations (essentially eligibility criteria, monitoring criteria and assessment procedures remained unchanged), but by a gradual improvement in the way existing regulations were being implemented.

This seems to have gone hand-in-hand with a change in social attitudes and norms, especially in regard to moral hazard in connection to the use of sick-leave on an ongoing basis. This is also reflected in a change in the process for granting sick-leave certificates by General Practitioner's (GP's), which is now done according to new guidelines. Though the first of these were formally introduced in 2007 (see Chapter 2) the process for developing them – which started several years earlier – had an impact on public attitudes. All this seems to reflect a gradual shift in policy consensus away from passively providing easily accessible replacement income to actively promoting participation in work. This provided a promising starting position for the new government, which took office in 2006 with the aim of reducing inactivity significantly.

Indeed, current reforms are very special and promising for one particular reason: this is the first time in the history of Swedish sickness benefit policy-making that structural change is being undertaken during a period of *falling* sickness absence. This suggests the reforms have considerable potential for breaking the pro-cyclical link between unemployment and sickness, even though the recent economic downturn might delay this success.

1.3. How Sweden compares with other OECD countries

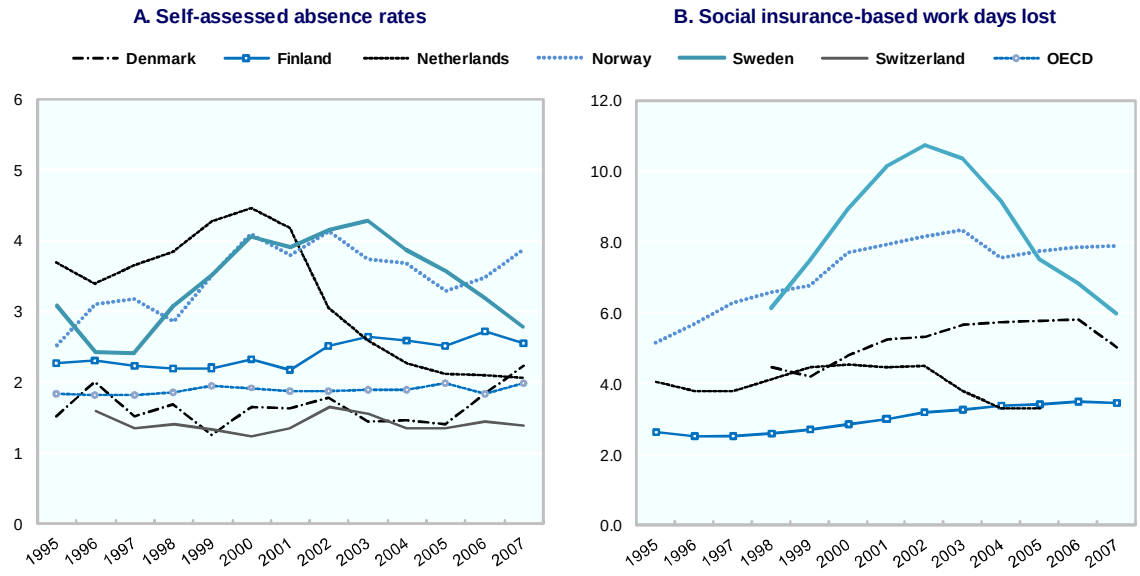
To better understand the need for reform of sickness and disability schemes in Sweden, it is helpful to compare outcomes with those in comparable OECD countries. In the following section, five countries which were reviewed by the OECD over the past three years are used as a benchmark: the other three Scandinavian countries (Denmark, Finland and Norway) and two other wealthy and small European economies (Netherlands and Switzerland). One has to keep in mind, however, that all of these countries are facing problems and seeking to reform their schemes. For example, in all countries spending on disability benefits is more than twice the OECD average.

A. *Sickness and disability benefit*

With almost 10% of workers absent from work at any time, the sickness absence rate in Sweden was huge only a few years ago, and much higher than elsewhere[12]. The fall in absence levels after 2002, however, was equally remarkable as the increase in the period 1998-2002[13]. Nevertheless, also today, at 6%, absence is still higher than in most other OECD countries, except Norway (Figure 1.4, Panel B). Measures based on self-reporting, *via* Labour Force Surveys, confirm this: 3.5% of Swedish (and Norwegian) workers report to have been absent due to sickness during the whole week before the interview. This is twice the average for European OECD countries (Figure 1.4, Panel A).

Figure 1.4. **Sickness absence was very high in 2003 and remains so by international standards**

Share of workers absent from work (A) and share of work days lost (B), 1995-2007[a,b,c]



a) Panel A gives the number of employed persons reporting not having worked at all during the week prior to being interviewed, due to illness, injury or temporary disability.

b) Data in Panel B were derived in the following way: the total number of annual absence days, unless available directly, is calculated by multiplying the number of spells by the average duration of each spell. This result is divided by the labour force resulting in the average number of days of sickness per person. These figures are further divided by the number of actual working days (the number of statutory minimum annual leave and paid public holidays are removed) in each country.

c) Annual absence days in Panel B are exclusive of both short-term absences covered by employer-paid sick pay and waiting days, *i.e.* absences of 1-9 days in Finland, 1-14 days in Denmark, 1-16 days in Norway and 1-15 days (and 1-22 days as of 2003) for Sweden. Data for the Netherlands, where the employer-period is two years, exclude absences of 1-7 days.

Source: EULFS for Panel A, data supplied by national authorities (Social Insurance Agency for Sweden) for Panel B.

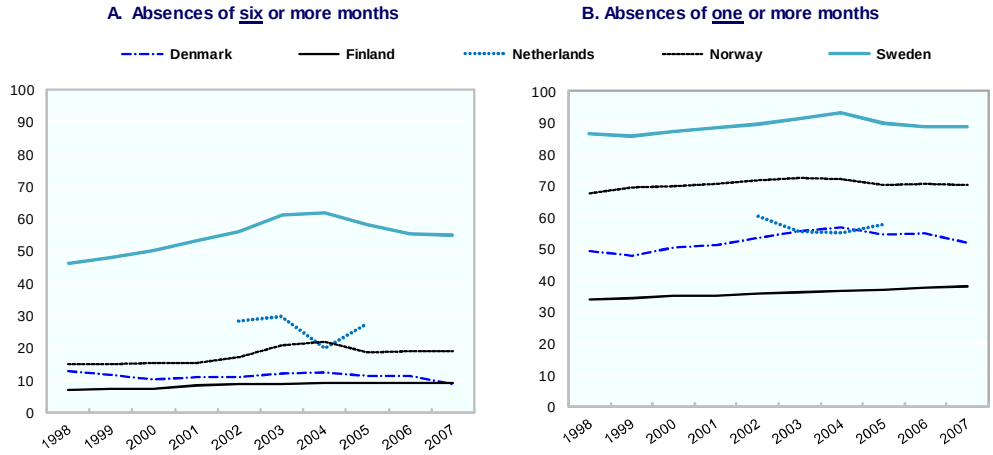
12. Only in the Netherlands, in the early 1980s, was absence rate at a comparable level. This was one of the driving forces behind the radical changes to its sickness benefit scheme, and later on also to its disability and vocational rehabilitation schemes (OECD, 2008).

13. Part of the decline in the absence rate in Sweden from 2003 to 2004 (as measured by administrative statistics, *i.e.* Panel B) is due to the lengthening of the employer-paid period, which is not covered in the data, from two weeks to three weeks (reduced again to only two weeks as from January 2005 when the co-payment was introduced). On the other hand, although even now one in ten new sick leaves extends beyond one year, the percentage of sickness benefits terminated between day 30 and day 90 has increased every year since 2005.

The main explanation for the high overall sickness absence level in Sweden is the extremely high share of long-term sickness absence – with Sweden being the only country in this sample with no time limit on sickness benefit until recently[14]. For instance, absences of more than six months comprise no more than 10% of all absences in most countries, but around 20-25% in the Netherlands (which has a two-year time limit) and in Norway, and exceed 50% in Sweden (Figure 1.5). Short-term absence is, therefore, even lower in Sweden than it is in many other countries.

Figure 1.5. **Sweden is still the leader in long-term sickness absence**

Long-term sickness absence spells as a share of all absence spells (percentage), 1998-2007[a]



a) Annual absence days are exclusive of both short-term absences covered by employer-paid sick pay and waiting days as in Figure 1.4.

Source: Administrative data supplied by national authorities (Social Insurance Agency for Sweden).

Sickness absence levels are critical for the development of the inflow into disability benefits, given that in most countries the majority of new disability benefit claimants would come into the system following a period on sickness benefits. In Sweden, this is now true for around three-quarters of all new claims (while it was more than 85% until 2005). Comparable figures in other countries are over 95% in Norway, where many people are going through an intermediate phase of medical and/or vocational rehabilitation, 85% in the Netherlands, 60% in Finland (where another 26% enter *via* a period of unemployment) and 50% in Denmark (where another third enters *via* social assistance).[15]

Trends in the annual rate of inflow into disability benefit in Sweden reflect the large fluctuation over time in sickness absence levels, as do the rates in Norway. The level of inflows oscillates around 1% of the labour force per year, in both Norway and Sweden; this is slightly higher than in Finland and much higher than in Denmark and Switzerland and, since recently, also in the Netherlands (Figure 1.6). The latter country is an example of how large the impact of far-reaching benefit reform can be: by significantly increasing the financial responsibility of employers and the financial incentives to work for workers (OECD, 2008), inflow rates in the Netherlands dropped from over 1% annually up until 2002 to only about 0.4% in the most recent year.[16]

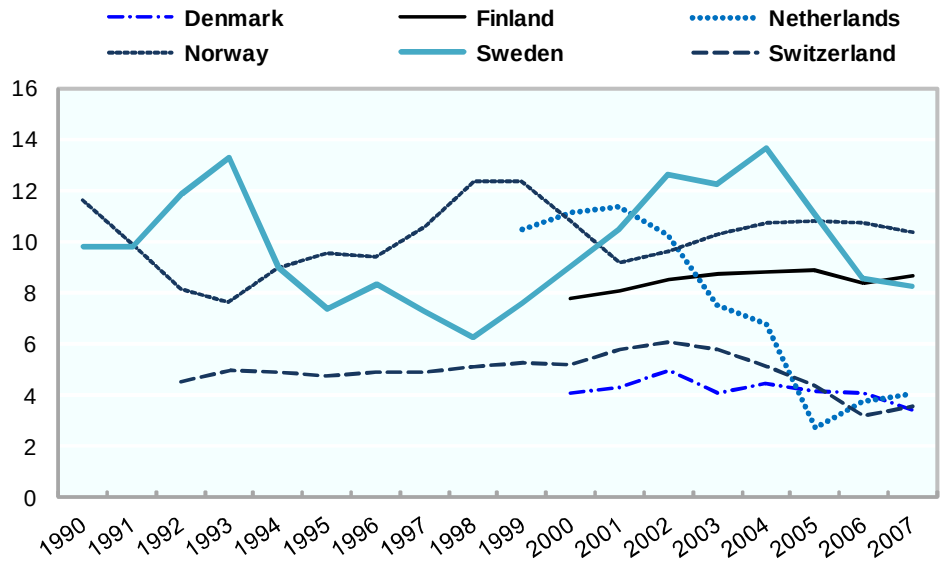
14 . The only other OECD country with no time limit for sickness benefits was Ireland, which is going to introduce a two-year limit for its Illness Benefit in 2009.

15. More details on pathways into disability benefits can be found in OECD (2006, 2007 and 2008).

16. After a number of transitional changes, the longer-term structural inflow rate into disability benefit in the Netherlands is projected to stabilise at around 0.5% – half the level prior to reform.

Figure 1.6. **Large fluctuations in disability benefit inflow in Sweden**

Disability benefit inflows per 1000 of the working-age population, 1990-2007



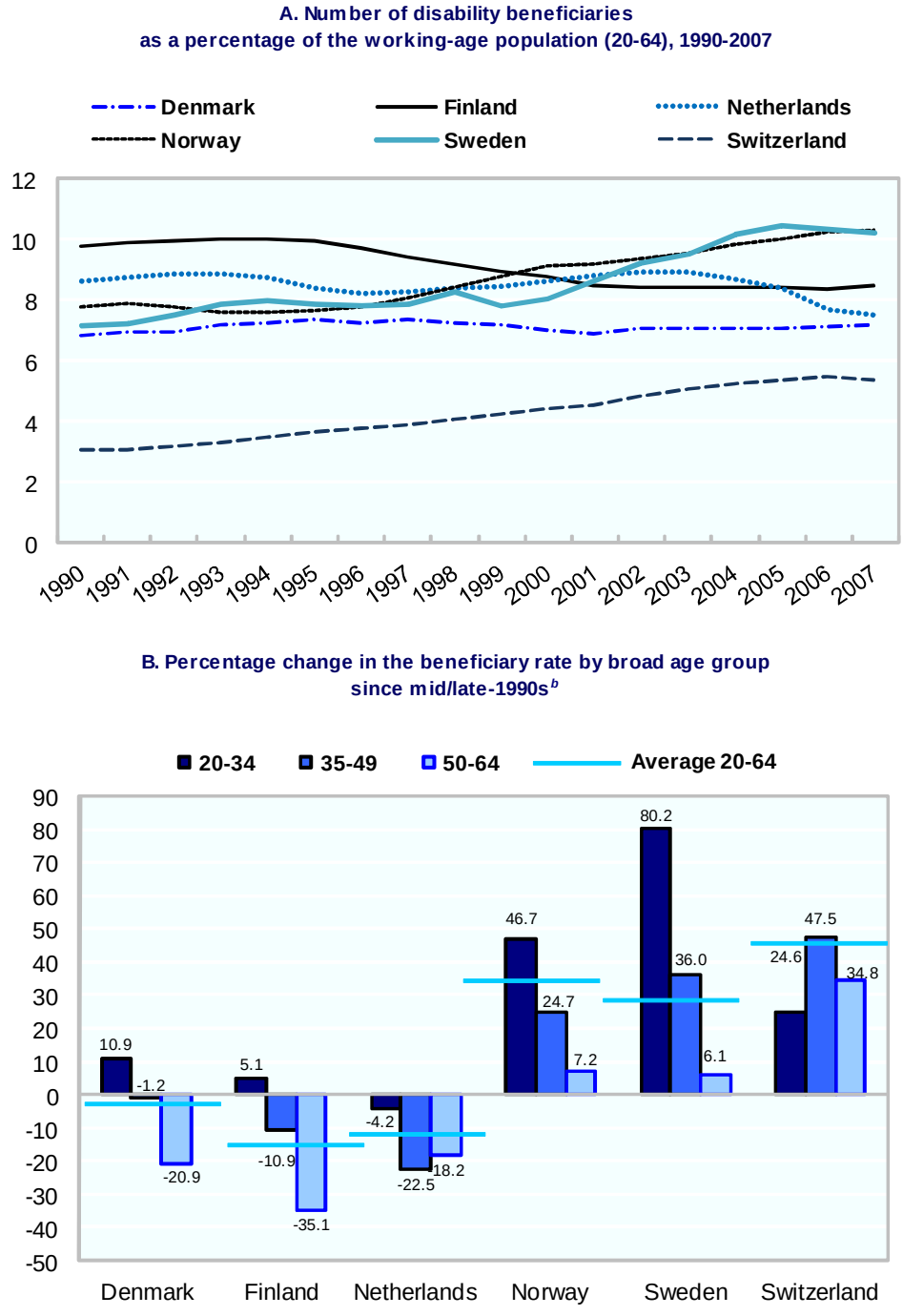
Source: Administrative data supplied by national authorities (Social Insurance Agency for Sweden).

Not surprisingly, the high inflow rates in Sweden and Norway have led to a continuous increase in the total disability benefit recipiency rate, which is now slightly above 10% in both countries (Figure 1.7, Panel A). The increase was much less pronounced in Finland, because the average new claimant is older and the average duration of being on disability benefit shorter. The example of Switzerland shows that at a lower initial level of benefit receipt, lower inflow rates would also produce rising disability benefit recipiency levels. The example of the Netherlands shows that falling inflow rates will also eventually translate into falling recipiency levels. However, this finding is partly explained by the reassessment of entitlements over the past three years of Dutch disability benefit recipients under age 45, which has indeed led to either a reduction or a loss of benefit in one of three cases. This is in sharp contrast to reforms in most other OECD countries, including Sweden, which tend to grandfather the entitlements of current recipients.

Panel B of Figure 1.7 shows that the increase in disability benefit recipiency rates in Sweden since the mid-1990s was by far the largest for young workers: 80% for those aged 20-34 years. This is a more general phenomenon also, though to a lesser extent, found in Norway, Denmark, Finland and the Netherlands, where trends for the youngest age group go against the general trend Switzerland seems to be an exception). The same trend is found in other countries (OECD, 2007). The result of this general phenomenon is that the average recipient is getting younger and the average duration of benefit receipt longer – increasing the total numbers on disability benefit and the fiscal costs of the programme accordingly.

Figure 1.7. **Sweden has recorded the largest increase in disability benefit recipiency since 2000**

Disability benefit recipiency rates and change in the beneficiary rates by broad age group (percentage)[a]



a) Beneficiaries: disability pension (Denmark, Norway, Sweden, Switzerland); earnings-related and/or national disability pension (Finland); Wajong, WAO and WIA disability benefit (Netherlands).

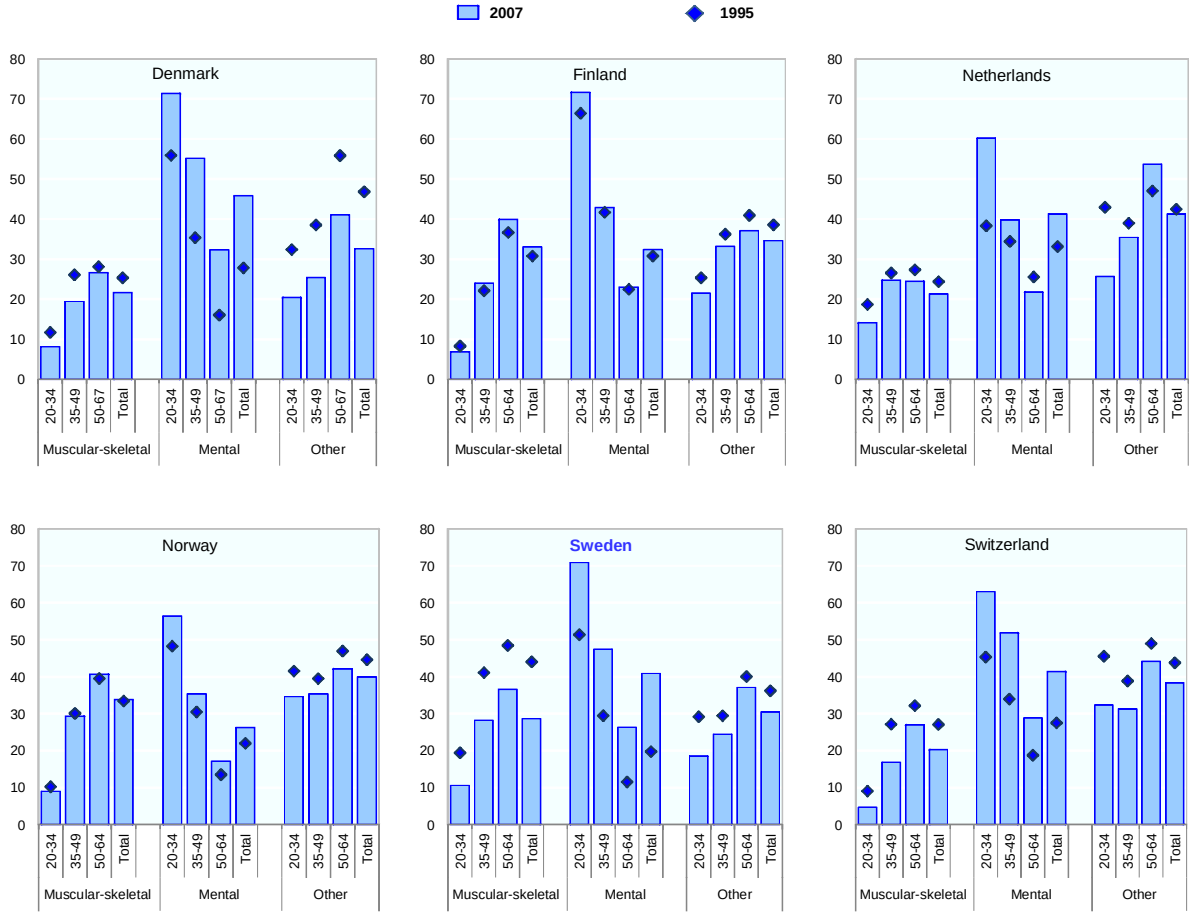
b) In Panel B, the period covered is 1995-05 in Denmark, 1999-2007 in the Netherlands and 1995-2007 in all other countries.

Source: Administrative data supplied by national authorities (Social Insurance Agency for Sweden).

There is another phenomenon throughout the OECD, which is closely related to this shift in the age structure of new and current claimants. Increasingly, disability benefits are being claimed on the basis of mental health problems. These conditions now account for some 70% of the inflow into disability benefits among younger adults in most countries, and for around 40% across all age groups. Sweden is no exception to this trend, although the change since the mid-1990s seems even faster than in most other countries; for instance, for the total population the share of the inflow caused by mental ill-health doubled from 20% to 40% within only 12 years.

Figure 1.8. **Mental health conditions are now the key concern in all OECD countries**

Distribution of total inflow to disability benefits by health reason and age, around 1995 and 2007 (percentage, total in each age group equals 100)[a]



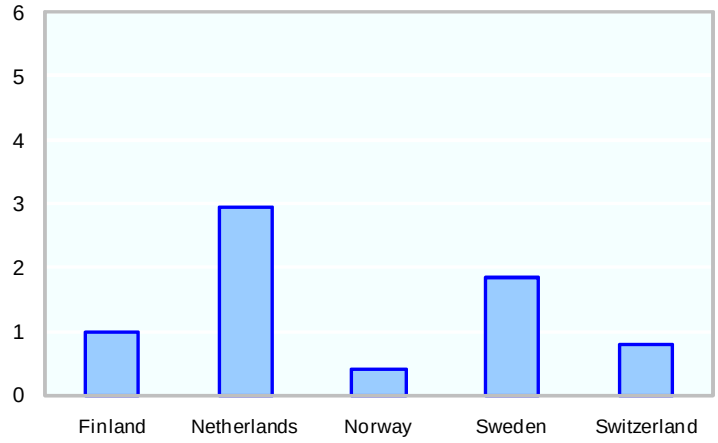
a) First year is 1999 for the Netherlands and 2000 for Denmark and Finland; second year is 2005 for Norway.
Source: Administrative data supplied by national authorities (Social Insurance Agency for Sweden).

There is much uncertainty about the reasons behind this phenomenon. Epidemiological and medical studies generally agree that the prevalence of mental ill-health as such has not increased significantly among the general population. Explanatory factors, therefore, include the reduced stigma on mental health problems and, associated with this, the higher frequency of doctors identifying mental ill-health as the main illness (rather than a co-morbidity), and the shift in the industry structure of the labour market which has resulted in increasing average psychological demands of work.

One of the reasons for the consistently high, and sometimes still increasing, numbers of people on disability benefit is the permanent character of these payments. Throughout the OECD, very few people ever exit disability benefits, especially to return to work. In most countries, including until recently Sweden, the rate of annual outflow is around or even below 1% of the recipiency population (Figure 1.9). Only very few countries have higher outflow rates, including the Netherlands which has done a full review of entitlements of all recipients under age 45 over the past few years, which has seen outflow rates rise to as much as 5% in peak years (and 3% in the last year). In Sweden, rates of outflow have long fluctuated around 1% but they have almost doubled recently – to reach 1.9% in 2007 and probably around 2.3% in 2008 (provisional OECD estimate). This outcome is a promising response to the recent policy changes.[17]

Figure 1.9. **Outflow rates from disability benefits are low but have increased in Sweden recently**

Annual outflow from disability benefits as a share of all disability benefit recipients (percentage), 2007[a]



a) All outflows, excluding deaths and transfers to old-age pension. Data for Finland refer to 2006.
Source: Administrative data supplied by national authorities (Social Insurance Agency for Sweden).

B. Social and economic integration of people with disability

Sickness and disability schemes provide key outcome indicators for policy makers. A different but equally important aspect for disability policy is the social and economic integration of people with disability. Measuring the latter is not straightforward because, unlike unemployment for example, disability and impaired health is not a clearly identifiable dichotomous category but a complex concept influenced as much by personal characteristics as by social and environmental factors and barriers. The following indicators are based on self-assessed disability, as measured by the European Survey of Income and Living Conditions (EU-SILC).[18] On the basis of this indicator, almost 20% of all Swedes aged 20-64 classify themselves as having a disability (the share is even higher in Finland but slightly lower than this in the other four countries).

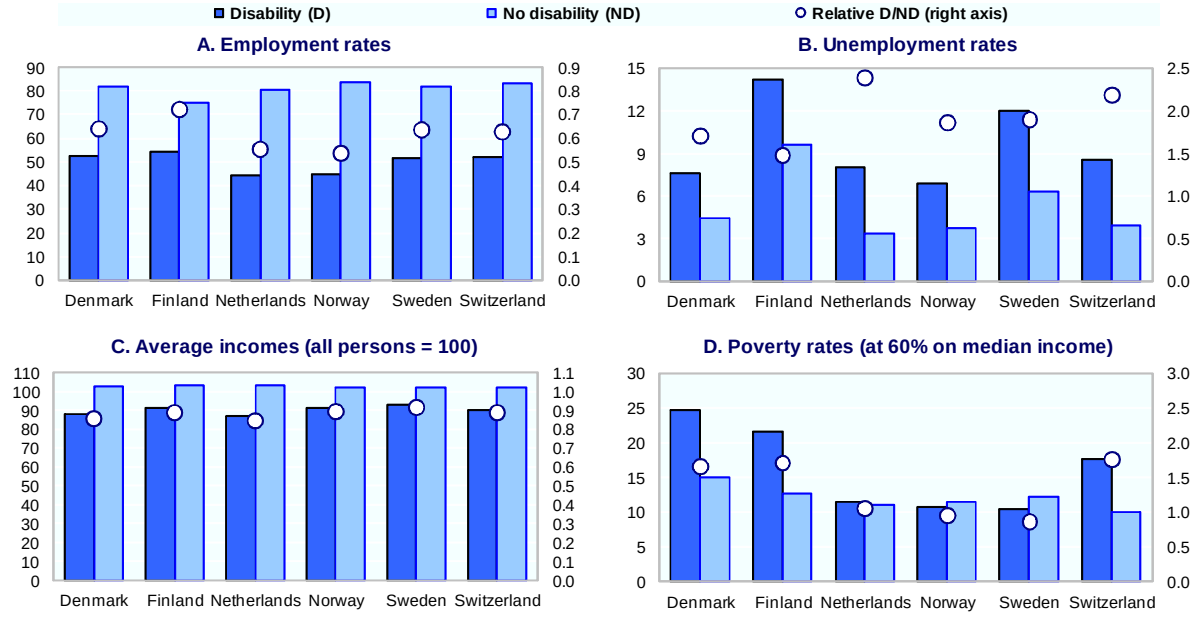
17 . More detailed outflow data for Sweden suggest that around one-third of those who leave disability benefit move into work, one in four into unemployment and one in six each onto either another benefit or into full-time education.

18 . A person is classified as having a disability if a) having a chronic health problem, illness or disability *and* b) being moderately or severely hampered in activities of daily living by this health condition.

Figure 1.10 shows that Sweden is doing comparatively well on some indicators of social integration of people with self-assessed disability. Employment rates of people with disability are only slightly above 50% but they are not higher in other better-performing OECD countries.[19] Relative to their peers without disability, employment rates in Sweden stand at around 62% – roughly the same value that is found in Denmark and Switzerland, with only Finland having a relative rate of over 70%.

Figure 1.10. **Employment is low and unemployment high, but incomes are also high and poverty is low**

Employment rates, unemployment rates, individual incomes and poverty rates: people with versus people without disability, age group 20-64, absolute (left-hand scale) and relative (right-hand scale), latest available year[a,b]



a) Definition of disability on a self-assessment basis. Denmark, Finland, Norway and Sweden: existence of a chronic health problem or disability and long-term limitations in daily life activities; the Netherlands: suffering from a long-lasting complaint, illness or disability which impedes carrying out or obtaining a paid job ("work disabled"); Switzerland: persons with reduced capacity due to a long-lasting health problem of more than a year.

b) Poverty rates: percentages of persons with disability in households with less than 60% of the median adjusted disposable income.

Source: Denmark and Norway: LFS 2005; Netherlands: LFS 2005/2006; Finland and Sweden: EU-SILC 2005; Switzerland: LFS 2005 for employment and unemployment, Health Survey 2002 for income and poverty.

Sweden is not doing as well in terms of unemployment rates, with over 12% of all people with disability being unemployed. On this account, among the countries compared, only Finland is performing worse. In most countries, including Sweden, unemployment is around twice as high for people with disability as for those without disability.

As in most OECD countries, individual incomes of people with disability are only 10 percentage points lower than for the population as a whole. Big differences across countries, however, are found in terms of poverty risks: in some countries, including Sweden but also Norway and the Netherlands, poverty rates do not vary with disability status while in the other countries poverty rates of households with a person with disability are 60-80% higher than for other households.

19. Employment rates of people with disability are significantly lower than this in some other OECD countries, including, for example, Ireland and Spain (around 35%) and Poland (less than 20%).

In conclusion, the following facts emerge in comparing Swedish sickness and disability policy outcomes with those in other OECD countries:

- Sickness absence rates are still high although they have fallen considerably in the past few years. However, long-term sickness absence in particular remains much higher than elsewhere in the OECD.

- Inflows into disability benefit, despite large variation over time and a falling trend in recent years, are among the highest in the OECD, in turn contributing to the very high disability benefit recipiency rate of over 10% of the working-age population.

- The increase in disability benefit recipiency was particularly large for adults aged 20-34; this is a general trend in many OECD countries but it is more evident in Sweden.

- Outflows from disability benefit used to be as low as in most other OECD countries until around 2004, but have risen steadily and significantly to around 2% annually since then.

- The share of mental health conditions among disability benefit recipients has increased rapidly in the past decade and has now reached 40%. Again, this is a universal trend across the OECD, with Sweden being among the "front-runners". Of particular concern is the significant increase in young people with mental health problems.

- As in most OECD countries, employment rates of people with disability are only around 60% of those of their peers without disability, while unemployment rates are almost double.

- Poverty rates do not vary with disability as is the case in a number of other OECD countries. In most countries, households with a person with disability usually experience a higher risk of being in poverty.

The following chapter summarises what the new Swedish government has done in the past two years to address these key challenges so as to improve outcomes.

CHAPTER 2: RECENT AND ONGOING REFORMS

The current *Alliance for Sweden* government was elected in 2006 with a mandate to restore the work-first principle and address labour market exclusion arising from long-term benefit receipt. This vision is at the heart of its proposed theme of *Social Europe starts with a job* for Sweden's upcoming presidency of the European Union in the second half of 2009. When the government came into office in 2006, almost 30% of the working-age population was unemployed, underemployed or receiving other social benefits, and its initial reforms focused on unemployment. Some 200,000 people have joined the labour market since then. More recent changes have been concerned with advancing employment possibilities for those affected by sickness and disability.

The government's reforms were predicated on an election mandate to address labour market shortages, as well as the cost of high numbers of unemployment, sickness and disability beneficiaries. The challenge for the government has been the cultural shift away from Sweden's strong historical attachment to the notion of a social welfare safety net and high moral hazard toward using benefits by many of those who can actually work.

Box 2.1. **What has changed since 2006?**

Situation in 2006	Situation in late 2008
Unlimited sickness benefit duration	Sickness benefit for a maximum of one year, but only if after 180 days there is no work capacity to perform any job. Prolonged sickness benefit can be granted for a maximum of 550 days
The employer finances the first 14 days of sickness absence and 15% afterwards, and is required to prepare rehabilitation investigation	The employer finances only the first 14 days, and may be asked to provide the SIA with information it needs for rehabilitation planning. The SIA can demand that a sick worker request from their employer a certificate showing what has been done to accommodate the employee
Disability benefit can be either temporary or permanent	Disability benefit is only granted for permanent reductions in work capacity
Disability beneficiaries are entitled to their benefit if they attempt work for up to two years; they will be reassessed if at work for longer	Disability beneficiaries are guaranteed not to be reassessed if they attempt paid work and are allowed to earn a substantial amount of income and still keep their benefit
No tax advantage for employing a person with disability	"Special new-start jobs" subsidise employers with an amount equal to twice the employers' contributions when hiring long-term unemployed and individuals previously on sickness, rehabilitation or disability benefits

2.1. Benefit reforms

Following reforms to tackle unemployment, the government more recently introduced policy and system changes to address the high numbers of sickness and disability benefit recipients. The aim is twofold: *i)* to *avoid* long-term sickness and disability benefit claims; *ii)* to *encourage* those furthest from the labour market on a permanent disability benefit back into work.

A. Sick-leave benefits: workers' rights and responsibilities

One of the more striking features of Sweden's revised sickness benefits policy and its corresponding *rehabilitation-chain* model is that recipients are being seen for the first time as actively responsible for adapting to their changed circumstances and staying in whatever work they are able to perform. In the past, these individuals were considered as incapacitated and essentially passive recipients of assistance from the SIA and their employer. Sweden's historically high rates of sickness absence and the high sensitivity of such absence to compensation levels (Chapter 1) indicate the presence of high moral hazard, with inappropriate sick-leave use, including by persons experiencing burn-out or wanting a career change.[20] In this regard, the change in policy approach makes a clear distinction between the problems of "being in the wrong job" and of experiencing a genuine reduction in employability/work capacity following sickness.

The new rules put the onus on the sick workers to take the lead in commencing dialogue at an early stage with their employers to find ways of maintaining their existing employment. The purpose of this is to minimise deterioration in their work-readiness that would otherwise result from prolonged benefit receipt and which in extreme cases leads to permanent incapacity and exclusion from the labour market.

The use of certificates that formally document what action has been taken to return a sick leave beneficiary to work, are a tangible example of this shift in expectations. From January 2008, the SIA has been able to demand that a sick leave beneficiary approach their employer for a certificate showing what options there are for adjusting the workplace so that the sick worker can continue to work. The intent of this is to make the employee more active in prompting their employer to find ways of accommodating them back into work. An employer who does not issue this certificate will receive a further request directly from the SIA and, failing this, can be fined for non-compliance.

From July 2008, a sick worker who advises an employer that they are unable to work receives wage payments from their employer for the first 14 days (with a one-day waiting period). Beyond this period, the employer notifies the SIA which commences processing of the worker along a *rehabilitation chain* and payment of sickness benefits.

During the first 90 days in which a person receives sickness benefits, they are expected to try to find a way to resume their existing job, possibly with some modification of duties but no change in salary or other non-salary benefits. Between the 90th and 180th day of sickness benefit receipt, if the worker cannot perform their old job, they are expected to pursue one of the following two options:

- To cooperate with their employer to try to find another job in that business, including jobs which may offer lesser total remuneration.

20 . Anecdotal evidence suggests that half of all absences are work or workplace related.

- To take leave of absence from their current employer for up to six months in order to try out another job with another employer. During this time the individual's original employment is protected. During such leave of absence workers can also choose to register as unemployed and receive unemployment benefit and vocational rehabilitation services from the PES[21].

After 180 days, the intent is to assess these clients against all jobs in the labour market if they have some remaining work capacity. If it is likely that they will return to work within 12 months from the first day of absence because they are already working part-time or following rehabilitation, for instance, this work-capacity assessment may be postponed. If the person is judged as having remaining work capacity, they are expected to resume work with their employer. If they cannot do so, they can seek a new job with the support of the PES and, if they have unemployment insurance, they can also receive unemployment benefits. Otherwise, they may be entitled to social assistance, depending on their family income and assets. In cases where the person is deemed to have no remaining work capacity, they are assessed for a disability benefit. While entitlement for sickness benefits usually ceases after a year,[22] responsibility of employers for sick workers remains so long as a workplace agreement exists.

B. Sick-leave benefits: employers rights and responsibilities

Employers in Sweden have primary responsibility for rehabilitating workers who take sick leave and for acting to provide a safe and healthy workplace. Larger business may have safety committees appointed by trade unions that monitor compliance and safety issues, and who can report violations to the Working Environment Authority (WEA) if necessary. The Swedish system relies on employer's performing their obligations relating to worker rehabilitation and accommodation under the Workplace Environment Act, and on trade unions and the WEA for enforcement.

An employer is obliged to help a staff member whose ability to perform their job becomes affected by sickness, to resume work in the same or another job in their business, or else to support them in securing more suitable work with another employer. As noted earlier, the SIA can ask a worker to obtain a certificate from their employer to show what options there are for adjusting the workplace to accommodate the worker. Only when an employer can show they have tried everything reasonable to accommodate the worker, negotiations to terminate the employment contract can commence with the involvement of their trade union. Employers who terminate an employment contract without fulfilling the aforementioned obligations can be sued by the staff member or their trade union for an unfair dismissal, with a penalty equivalent to as much as 32 month salary[23].

The new rules include a legal right for an employer to ask for a doctor's certificate from the first sick day because it is well-established that such increased monitoring reduces moral hazard or inappropriate sick-leave usage (Hesselius *et al.*, 2005). On the other hand, the new rules remove a number of employer obligations toward sick workers. Firstly, the 15% co-payment of sickness benefit costs introduced a few years ago has been abolished. Employers are also no longer obliged to undertake a formal "rehabilitation investigation" that used to feed into a "rehabilitation plan" prepared by the SIA for sick workers. Employers are now only required to respond to questions from the SIA as

21 . A sickness beneficiary is not ordinarily entitled to seek help from the PES without a referral from the SIA, whereas unemployed persons can.

22 . In exceptional circumstances where payment is continued for up to 550 days if this is likely to enable a worker to return to their original job.

23 . For repeated breaches an employer can be prosecuted by the WEA.

the latter start to prepare a plan. The main argument behind this change being that the compliance burden was too high for the many small businesses that constitute the vast majority of employers and most did not undertake these investigations anyway.

C. Sick-leave and disability benefits: the role of the SIA

As discussed above, the SIA has an important role in establishing medical confirmation of a worker's eligibility for sickness benefits and formulating a rehabilitation plan in concert with the person, their employer and the PES. With the new sickness system in place, this role is changing: it now involves working in collaboration with the PES to help sickness beneficiaries stay in or find new work. The aim is to ensure access to the support available at the PES to help the person maintain their existing employment or find other, more suitable employment. The regular collaboration should include a contact meeting after 90 days of sickness absence and a so-called hand-over meeting after 180 days, *i.e.* when the sickness benefit entitlement is likely to expire.

The new sickness benefit process also has a number of repercussions on the disability benefit process and the role of the SIA in this regard. With the introduction of the new *rehabilitation chain*, disability benefits can only be granted by the SIA after a person's work capacity has been assessed as being *permanently* reduced; granting a disability benefit on a temporary basis for temporary incapacity is no longer possible. This makes it even more critical to secure proper assessments at the different stages of the rehabilitation chain. The elimination of long-term sickness benefit entitlements cannot be cushioned or undermined by more lenient granting of temporary disability benefit entitlements. The effectiveness of this will entirely depend on the way the new regulations are applied. SIA decision makers might feel pressure to assess a temporarily disabling condition as permanent to avoid too many disability benefit refusals. This, however, would conflict with and nullify the objectives of the reforms.

D. Encouraging persons with disability back into the labour market

An innovative approach to enticing persons assessed as having a permanent disability back to the labour market will commence in January 2009. This initiative was launched because, there was a view that in the 1990s and early 2000's, people were transferred to disability benefits without a thorough work capacity assessment and that investigations found around half had some residual work capacity. All persons who have been designated eligible for permanent disability benefits will be encouraged through a financial incentive to attempt to return to the productive labour market in whatever capacity they can manage. This encouragement will take the form of allowing persons on a full disability entitlement to earn up to 42,800 SEK per year before their benefit starts to progressively reduce. Moreover, all such recipients will be allowed to cease work and resume their disability benefit at anytime and without reassessment. Allowing them to resume benefits at anytime and without hindrance helps overcome their fear about failing in the attempt and having to endure a long and drawn-out re-assessment process.

This policy may also support persons whose ability to cope with incapacity improve over time such that they develop some productive labour to contribute. Providing them with a financial incentive to work may induce them back to the labour market. This scheme is also likely to suit persons with an episodic health condition. An additional attraction of this policy is that any work and income taxes these persons contribute to the economy are a bonus obtained at minimal cost to the state.

To help facilitate employment for persons with disability, employers who hire individuals previously receiving a sickness or a disability benefit are eligible for a tax reduction equivalent to twice the employers' social security contribution. The longer such a newly-hired person had been

inactive, the longer the period of time that employers' social security contributions are reduced. Over a period of five years, this would constitute approximately half of the total non-wage cost. The employer is also not obliged to pay the first 14 days of sickness absence for employees previously receiving a disability benefit. In addition, an in-work tax credit was introduced to increase the supply of labour, generating further incentives for people with disability to take-up work[24].

E. Employment programmes for persons with disability

In response to disappointing results of evaluations of active labour market programmes, the new government reallocated funding from these programmes toward incentives to encourage persons with disability back to the workplace. Approximately 14 billion SEK has been allocated to facilitate employment of 90,000 persons with disability, either through wage subsidies or Samhall[25] jobs for people with very severe disability.

Wage subsidies are used by the PES as direct incentives to get employers to take on people with less severe disability. Such clients are referred by the PES to potential vacancies and if there is a possibility of employment, a temporary wage subsidy is negotiated with the employer. The subsidy can cover up to 80% of the wage or be used to subsidise the cost of a job coach.

A new three-step approach was launched in 2006 to manage clients into work for whom the current array of instruments was insufficient. The first step includes assessment and guidance, followed by "development employment" (step 2) and "security employment" (step 3). Development employment is a temporary stage which cannot last more than one year, while security employment can be a permanent stage. The new approach will be evaluated in 2009. Initial results show that the new guidance step is not being used as much as expected because PES caseworkers prefer the traditional guidance which allowed for a longer time for assessment (six months instead of three).

The government is also considering wage subsidies for promoting entrepreneurship among people with disability in the 2009 bill. The government is also interested in increasing funding for supported employment and personal assistants.

2.2. Institutional reforms

The new government continued and extended structural reforms to welfare institutions to support the abovementioned policy changes. Formal guidelines regarding appropriate periods of sick-leave absence for various sickness conditions have been developed to help minimise the amount of leave that GPs grant to sick people. The major public institutions responsible for administration of benefits and supporting beneficiaries to return to work have been restructured or reorganised to operate in a more centrally directed and coordinated fashion, and with a clear focus and purpose of helping beneficiaries return to work as quickly as possible. Finally, the government is funding the PES and county authorities to support the entry and growth of the necessary providers of vocational and medical rehabilitation services to support the policy changes (see below).

24 . Estimated labour supply effects of the reform are high; in the case of single mothers, for instance, working hours are predicted to increase by 3% and social assistance participation to decrease by 20%. The impact is predicted to be much higher for low-income households (Aaberge and Flood, 2008).

25 . Samhall was originally a government-owned company which became a limited company in 1992. It operates across the 24 counties in Sweden. According to legislation, 40% of the employees must have a severe disability and employment of individuals with multiple disabilities is actively encouraged. Samhall receives a state subsidy covering most of the wages paid to its employees.

A. Constraining medically determined sick-leave

A worker seeking a medical sick-leave certificate in Sweden will now more likely find that their GP limits the amount of time off work to the minimum period appropriate for their particular condition, thanks to an important supporting component of the reforms led by the National Board of Health and Welfare[26] (NBHW) in partnership with the SIA.

In the past, GPs awarded varying durations of sick leave for the same condition and due to patient demand characteristics, sometimes tended to err on the high side. While specific recommendations on the appropriate time for sick-leave for different diseases have been issued, GPs can award higher-than-recommended absence periods but are required to provide written justification for why the extra time off work is necessary. Though the SIA's purpose is to minimise inappropriate use of sick-leave benefits, the NBHW is promoting the change among GPs as a culture shift in the way they prescribe sick leave; that it should be used sparingly because it is "good medicine" to keep people in work where possible to minimise the health, social and economic problems arising from labour market detachment.

The broad rationale behind this innovation is that excessively long sick leave may be medically detrimental for some conditions. It also detaches a person from the labour market during which time their work confidence and readiness deteriorates. In the past this has led to many persons becoming excluded from the labour market for extended periods or even indefinitely – even if they recover from the original illness. By way of example, the guidelines for General Anxiety Disorder recommend that sick leave be minimised because an affected individual is more likely to excessively ruminate if socially isolated. Another good example is absence leave following coronary surgery. In this case four weeks leave is recommended as sufficient because resuming activity after this time assists healing and results in a better medical prognosis.

Box 2.2. **Innovative practice: NBHW Sick-leave Guidelines**

The guidelines developed by the NBHW prescribe appropriate periods of sickness absence for the 90 ICD-10 medical conditions that account for approximately three quarters of the sickness leave taken in Sweden. The NBHW guidelines are intended to make the medical decision-making process for granting sick leave more homogenous and transparent, and to minimise the awarding of inappropriately long sick leave.

The period recommended for each ICD-10 condition was determined through a series of consultations with groups of medical experts, and reflects their consensus view. The development process itself generated media and public interest that helped raise awareness among practitioners and the public alike of the forthcoming change in practice.

The guidelines include both general principles and specific recommendations. General principles include the NBHW's professional view of sick leave and the need for practitioners to use sick-leave certificates carefully as another tool for care and treatment. The specific recommendations include information on treatment, prognoses and recovery time for common medical conditions, as well as recommendations for the duration of sick-leave that is likely to produce a good outcome. The guidelines also contain information about what practitioners can do in atypical cases that may warrant additional sick leave or other expert input.

26 . The NBHW is responsible for the registration and oversight of medical and selected other health professionals in Sweden.

To prevent inappropriate circumvention of this new system of sick-leave guidelines by a worker who tries to obtain additional sick-leave certificates from one or more GPs (*i.e.* "doctor shopping"), the SIA can detect if corresponding certificates were from different providers and inform the last practitioner, and request reconsideration.

B. Building rehabilitation capacity using a public-private approach

To assist the large number of people with sickness or disability-related problems back into work, the government is seeking:

- To grow a market of private providers of vocational and placement services;
- To concentrate the resources and significant skills of the PES on helping clients who are further from the labour market to return to work;
- To grow the medical rehabilitation service capacity administered by county authorities.

Collectively, these actions seek to create a public-private mix of services to reduce the numbers of persons with work capacity being excluded from the labour market.

Reorienting the PES to help those furthest away from work to return

The broad overall task of the PES has always been to facilitate functioning of the labour market by matching jobseekers to employers who want to recruit staff. Up until 2006, the PES used traditional ALMPs to occupy many of those unemployed. However, partly in response to poor outcome evaluation results of ALMPs (*e.g.* Adda *et al.*, 2007), the new government shifted focus and spending into measures to stimulate labour demand and reduce unemployment or underemployment. As a result, a large number of ALMPs provided by the PES have been discontinued including bonus jobs, educational leave replacement positions, jobs for recent graduates and general and enhanced recruitment incentives. As well as directing the PES to cut back on ALMPs, the government has asked it to focus on clients furthest from the labour market, including those who are only able to work a few hours. Programmes were to a great extent, although not exclusively, offered to jobseekers who take part in the job guarantees; those participants have been unemployed for at least a year (or at least three months, if under age 25).

The government has recently started to introduce privately owned rehabilitation services as an alternative to public employment services. The PES has received extra funding to purchase vocational rehabilitation services from private providers for around 1,500 sickness beneficiaries in a pilot project that will run over two years. Along the lines of the Australian model, it is expected that private providers will be funded in three steps for the unemployed or underemployed clients they provide vocational rehabilitation services to and then place in work. They will receive an initial payment at the beginning of the programme when they accept a new client, a second payment after placement in work and a final payment after employment has been sustained for a significant period indicating good attachment to the labour market. A criticism of similar outsourcing in Australia has been the finding that private providers "cream profit" by accepting easy-to-place clients and "park" the less work ready. An interesting feature of the Swedish public-private approach is that the PES is not being downsized as was the case with its Australian counterpart.

Partnering with counties to strengthen OHS and medical rehabilitation capacity

Until 1993, occupational health services (OHS) were funded and administered through a collective agreement between the unions and employers' confederations until the latter terminated the arrangement. The government of the time also subsequently abolished its subsidy for OHS. Since then it has been up to individual employers to fund the purchase of OHS services they deemed appropriate under open market conditions. Particularly among smaller businesses which constitute the bulk of private employers, this has meant that OHS is underfunded. To address this, around 1.6 billion SEK has been provisioned in the government's budget to develop the capacity of occupational health services. Discussions between federal and county authorities and OHS providers are presently underway to establish a new system under which the government would contribute this additional funding. The details on the respective responsibilities of the counties and the OHS providers are being negotiated.

Another important role of county authorities in Sweden is the administration of its health and medical services. The government is looking to enhance capacity for medical rehabilitation by increasing resources to county councils over the period 2008-2010. Around 1.8 billion SEK have been budgeted for counties to provide evidence based medical rehabilitation. The county councils can either provide the rehabilitation through the health services they directly administer or by purchasing services from private providers. It is envisaged that the purchasing of services will stimulate the growth of a private provider market so that over time, counties will have sufficient service capacity to draw upon to offer a medical rehabilitation guarantee.

C. Restructuring the SIA

The SIA administers social insurance benefits including sickness and disability, work-injury and the old-age pension. Prior to 2005, the SIA operated 21 regional offices making somewhat autonomous decisions about client assessment and benefit entitlement. This resulted in large variation across regions (see Chapter 1). Lack of uniformity in the application of regulations was believed to have been a factor in the rapid growth in the numbers of inactive people on sickness and disability benefits. The main goal of restructuring the SIA was to strengthen central control in order to improve consistency in the administration of social insurance at the front line and focus the agency on reducing numbers of clients on long-term benefits. In order to participate in joint initiatives with other organisations helping sickness beneficiaries such as the PES, the SIA needed its staff at all levels to support centrally agreed directives and to work in a consistent way.

Centralisation and reorganisation of its functions allowed the SIA to make a number of changes to operate more effectively, such as setting national targets for reducing the time for deciding whether a benefit will be awarded. The ability to steer resources and plan across county borders has enhanced the agency's ability to decrease processing times for occupational injury cases. In the case of sickness benefits, the SIA is setting up a new group able to make a quick assessment of benefit entitlement with the aim of processing 90% of the cases within 30 days. Other new work processes have been introduced to ensure more uniform service delivery.

As well as increasing uniformity of business processes, centralisation of control has allowed the SIA to respond to the governments' directive to have SIA frontline staff engaging with clients to expedite their return to work, instead of processing benefit forms and medical certificates. Applications for welfare assistance are being increasingly managed through the internet and processed at the national centre – except where more support from employers or local GPs is needed, in which case these are managed by a local branch and SIA officer.

Co-ordinating agency services to focus on client outcomes

A tangible outcome of the changes to the PES and the SIA is the joint agency cooperation in helping long-term sickness beneficiaries back into work. Previously cooperation was hampered by funding in silos, having different objectives in assessing work capacity and in the case of the SIA, the considerable variability in frontline practice across regions. While the two agencies continue to differ in focus when assessing work capacity, the institutional reforms in recent years together with an innovative funding approach (Box 2.3) seem to have facilitated a remarkably effective model of cooperation.

Each year the Director-Generals of the SIA and PES sign off on a joint agency plan to be implemented by staff at various lower levels. Working together, frontline service delivery staff members develop joint agency plans for each common client. There is a steering committee at the central level between PES and SIA to make decisions in those cases where staff in local offices cannot agree. However, use of this committee has been rare. Since 2003, around 50,000 clients have received rehabilitation through the PES under this scheme.

This so-called FAROS model developed by the PES and SIA for those clients who used to fall in between the responsibility of the two agencies, *i.e.* unemployed people on long-term sickness benefit, has been in use since 2005. The approach starts with a meeting between the two agencies to develop a plan for the person to return to work as soon as possible. Every individual case is discussed by a case manager from the SIA and the PES, and clients receive more intensive follow-up from the PES as the caseworker has only 35 clients instead of the usual allocation of 100 clients.

Box 2.3. **Innovative funding to overcome administrative silos**

The SIA has been allocated special funding that can only be spent in conjunction with the PES on sickness beneficiaries who require vocational rehabilitation to help them find work. Moreover, the agencies are required to jointly plan at all levels as well as report twice yearly on what they have been doing together and on how many clients they have jointly helped into work. It seems this approach has been effective in stimulating sustained interagency cooperation and focus on common clients. This represents a significant development in addressing the problem of funding in silos that has compromised the achievement of client-centred outcomes in many OECD countries.

Though it would be administratively simpler for the SIA to hand over clients to the PES and for the latter to be directly allocated the funding for vocational rehabilitation, doing so would remove the need for staff from each agency to regularly spend time together, including with the client, to plan an approach and agree on how resources will be used. This purely administrative mechanism has provided a space for SIA and PES staff to build positive and trusting working relationships that seem to lie at the heart of the observed cooperation.

2.3. Comparing the reform intensity

The current Swedish government's reforms built on those of earlier administrations to address the high numbers of sickness and disability benefit recipients, and the low employment rate of people with chronic health conditions or disability. How do these compare, overall, to changes in other OECD countries, both in the more recent past and in a longer-term perspective? This can be understood in

terms of the policy typology developed in OECD (2003) and updated in the course of the ongoing thematic review (OECD, 2006, 2007, 2008).[27]

According to this policy typology, compared with the OECD average, Sweden has a relatively more developed activation policy, as indicated by above-average reintegration scores. At the same time, however, Sweden also (and still today) has above-average compensation scores, reflecting a more generous and more easily accessible sickness and disability benefit system. As for a number of other OECD countries, including for instance Finland and Norway, the latter may well be an obstacle to better outcomes from the more developed reintegration policy.[28]

Figure 2.1 shows policy trends in Sweden as compared to those countries reviewed by the OECD in the past three years, both before and after 2000. Almost without exception, across the OECD integration policies have been strengthened (*i.e.* integration policy scores have increased) and benefit generosity cut (*i.e.* compensation policy scores have fallen). As regards Sweden, two conclusions can be drawn: First, change has been very significant on both dimensions, but this is also the case in many other countries. Some countries, the Netherlands, Australia and the United Kingdom in this sample, have seen even more comprehensive reforms.[29] Secondly, the reform intensity in Sweden has increased considerably in the past eight years, especially on the side of the benefit system which remained largely untouched by the reforms prior to the turn of the century. Potentially, this could lead to better outcomes in the form of higher labour market integration and lower benefit dependence of the population in question in the medium term.

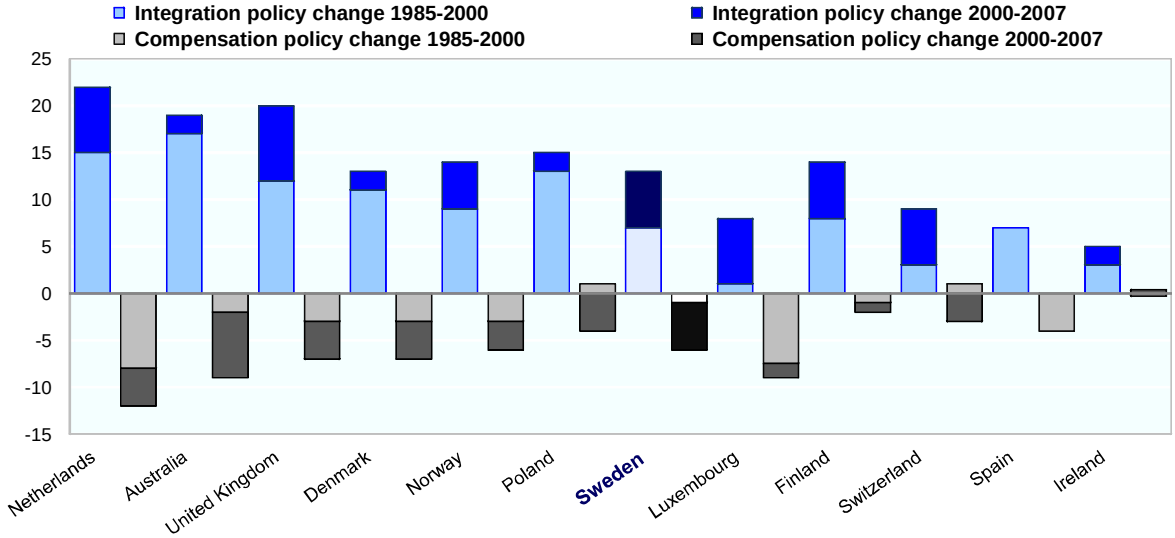
27 . To obtain a reasonable overview of what is happening in policy both over time and across countries, in OECD (2003) a policy index was developed which consists of two dimensions, the generosity and accessibility of benefits (the "compensation policy" dimension) and the generosity and accessibility of employment policies (the "integration policy" dimension). The index of compensation takes into account ten policy parameters: *i)* coverage of the benefit system; *ii)* the minimum disability level; *iii)* the disability level needed to get a full disability benefit; *iv)* the maximum benefit level at average earnings; *v)* the permanence of benefits; *vi)* the medical assessment; *vii)* the vocational assessment; *viii)* the sickness benefit level; *ix)* the sickness benefit duration; and *x)* the unemployment benefit level and duration in comparison with disability benefit. Also for the index of integration, ten policy parameters are taken into account: *i)* access to different programmes; *ii)* the consistency of the assessment structure; *iii)* employer responsibility; *iv)* supported employment programmes; *v)* subsidised employment programmes; *vi)* the sheltered employment sector; *vii)* vocational rehabilitation programmes; *viii)* the timing of rehabilitation; *ix)* benefit suspension regulations; and *x)* work incentives. Each country is ranked on a scale of zero to five on each of these twenty categories based on the Secretariat's judgement. No attempt is made to assess which of these categories is most important; all have equal weight. [Details of the points attached to each aspect of policy and the policy stance of 20 OECD countries in 1985 and 2000 can be found in OECD (2003, 2006, 2007 and 2008).]

28 . This conclusion holds for all years of analysis, *i.e.* 1985, 2000 and 2007/2008: while integration scores have been rising and compensation scores falling in the past twenty years, Sweden had scores significantly above the OECD average in all years. For instance, today's compensation score for Sweden is 31 points on the 50-point compensation scale, compared with an OECD average of 27 points. On the integration scale Sweden has 34 out of 50 points, compared with 29 for the OECD average.

29 . The four Scandinavian countries all fall in the same group of countries with "medium" reform intensity: integration scores have increased by around 12-14 points and compensation scores fallen by some 6-7 points (though less than this in Finland) between 1985 and 2007.

Figure 2.1. **Swedish reforms in an international perspective: Not top but very close to**

Changes in compensation and integration policy scores 1985-2000 and after 2000[a,b]



a) Countries are ranked by the decreasing sum of absolute changes in both dimensions taken together from 1985 to 2007/08.

b) The scale gives the change in policy on a 50-point indicator developed by OECD, see footnote 27.

Source: Secretariat estimates based on information from national authorities as well as OECD (2006, 2007 and 2008), *Sickness, Disability and Work: Breaking the Barriers* (Vol. 1-3), Paris.

CHAPTER 3: MAKING THE REFORMS WORK

The breadth of institutional and sickness and disability policy change in Sweden has been considerable and impressive. Success of the latest reforms, however, will hinge on the actual implementation of the new system and the effectiveness of its various incentives. Given the pace of reform, the fact that the new approach may appear to be a harsh and radical departure from the past for some, and that reform is being implemented during a period of rising unemployment and falling labour demand, its success is not assured. There exist a number of areas where further action to support the ongoing reforms seems warranted. In particular, it appears that responsibilities and financial incentives for key actors are not sufficient to ensure that the new *rehabilitation chain* will work as intended. Without some of the changes and adjustments recommended herein, there is a risk that the new system could yet again turn into a new form of benefit chain, with many people leaving work never to return.

3.1. Ensure widespread acceptance of and support for reform

In broad terms, the *political economy of reform* is about the socio-political processes that have to be considered alongside economic and social factors in making major policy and institutional change in a successful manner. The process of reform has been quite different in the past two years compared with earlier efforts which involved more extensive and time-consuming consultation with social partners and other stakeholders. While this has enabled the government to move faster, it also carries the risk of losing the support of key players – support that is needed to achieve the intended economic and social outcomes.

A. Involving all stakeholders

Changes to sickness policy in Sweden in the past two years have been very fast. Contrary to reforms of the unemployment system, which were already presented during the 2006 election campaign, the key pillars of sickness benefit reform were only developed after the new government took office. The speediness of reform, however, limited the level of consultation with key stakeholders. The social partners were only given a few weeks to respond. While the political cost of this remains to be seen, more engagement may needed to convince all stakeholders of the need for further change in the current direction, in particular the need to reconsider access to historically generous long-term sickness benefits.

The successful comprehensive reform of the Swedish old-age pension system during the 1990s, which culminated in the introduction of a benchmark-setting notional defined-contribution benefit system in 1999, offers a number of lessons which could also be useful for the ongoing change of the sickness and disability benefit scheme. Successful reform requires first a strong proposal for change, then winning support of key stakeholders and, finally, implementing change as negotiated. Much of this was achieved during the 1990s through the work of a broad parliamentary commission on pension reform.

Setting-up a similar high-level parliamentary commission to achieve a broad consensus on unemployment, sickness and disability benefit matters, is currently under discussion. The work of various ongoing commissions or committees can be seen as preparatory work for this purpose. This is,

in particular, true for the Work Capacity Commission, the mission of which is to assess the concept of work capacity in order to prepare a broadly accepted definition to be used to assess entitlements to various kinds of supports. The aim is to improve coherence between the law and what people and politicians expect from it, to clarify what can reasonably be expected from people, and to avoid the use of contradictory definitions by different authorities.

Recommendations:

- Establish a high-level parliamentary commission on working-age benefit reform as quickly as possible and involve all key stakeholders in its operation, including NGOs, social partners and the main public authorities.

B. Supporting change in industrial relations

The social partners have traditionally been central players in social and labour market policy in Sweden. It will be important to involve them in the policy process and convince them of the need for change as they have an array of tools and instruments that are important for the success of sickness activation policy. These tools can be used to support or complement reform, or to nullify it, wholly or partly. The topping-up of public benefits in collective agreements or through bilateral agreements between unions and insurance companies is an example of the latter: changes (typically reductions) in benefit levels with the aim to improve work incentives have often been annulled by corresponding increases in agreed benefit top-ups. This is not in the best interest of the system as a whole.

However, social partners can play an active role in supporting job retention and reintegration of workers with ill-health or disability. This could include through initiatives to facilitate labour market mobility and flexibility. Some initiatives to this end are ongoing; for instance, recent bargaining includes efforts to introduce employer-paid rehabilitation in exchange for looser employment protection. The government should make every effort to support the use of industrial relations in moving from passive sickness benefit payment to active job retention.

Recommendations:

- For social partners to consider introducing more flexibility in wage setting in collective agreements so to allow payment of reduced hourly wages in cases where a workers' productivity fluctuates or reduces due to a disability. Currently, the only possibility is to work part-time at full capacity, which is not possible for persons with some forms of disability.

- The new option of taking leave of absence from a current job during a sickness phase to try another job, or employer, while maintaining the work contract with the previous employer, should be more actively promoted in order to increase job mobility at an early stage.

- Employees should be reminded at an early stage of sickness absence to seek the support of their trade union during the rehabilitation process.

3.2. Strengthen responsibilities and incentives of key players

The recent suite of policy reforms address fundamental problems and appear promising. However, closer scrutiny reveals gaps that could compromise the effectiveness of these reforms.

Various actors have been assigned new roles in the new rehabilitation chain, but not enough has been done to ensure these roles will be fulfilled as intended.

A. Employer responsibilities and incentives

Financial incentives for Swedish employers to adapt work and workplaces to retain people with partially-reduced work capacity have always seemed comparatively weak, despite a strong legal framework, in the form of a comprehensive Working Environment Act. At two weeks, the period of employer-provided sick-pay is short by international comparison (and even this period is sometimes covered by private reinsurance contracts). Financial incentives for employers have been weakened further by the abolition of the only recently introduced 15% co-payment for sickness benefits, and their responsibility for assisting in the development of a rehabilitation plan was removed altogether. This is unfortunate in view of the positive results in some other countries, such as the Netherlands, which has shown that such policies can effectively facilitate good employment practices.

The recent reforms affecting entitlement to sickness benefits do not include robust standards and criteria for determining whether an employer has made bona fide attempts to adjust the workplace to retain a sick worker in their job or to place them in another job as required under the new rules. Though the financial penalty for failing to do so is high in principle (up to 32 months of salary), it would appear less so in practice if employees and employers come to see that it cannot be imposed because the propriety of employers in this regard cannot be reliably assessed. This presents an opportunity for less scrupulous employers to circumvent employment protection legislation, knowing that genuinely sick workers will find the emotional and financial strain of pursuing a legal case prohibitive, and without agreed operational criteria the WEA[30] and trade unions are likely to have difficulty making the legal case necessary to have sanctions imposed. With potentially thousands of workers each year in such a situation, a large administrative and financial burden could fall on trade unions to represent them in litigation. Moreover, there is a sizeable risk that if such impropriety on the part of even a small number of employers captures the attention of the media and public, the broader reform agenda could be jeopardised. Agreed operational criteria would also provide employers with clarity regarding what is reasonably required of them and when they can say they have addressed their obligations in good faith.

Recommendations:

- Consider re-introducing sickness benefit co-payments by employers. Alternatively, lengthen the period of employer-provided sick-pay to make sure that good absence management and monitoring[31] pays off. Reinsurance of these costs should only be possible with premiums that take the sickness cases created by the company into account ("experience-rating").

- Premiums to the workers' compensation scheme, which covers work injuries, work accidents and occupational diseases, should be both risk-rated (by sector) and experience-rated (by individual employer). The current uniform premiums imply an unfair cross-subsidy from careful to careless employers and from low-risk to high-risk sectors of the economy.

30. The WEA only seeks to impose sanctions on employers who can be shown to repeatedly fail in fulfilling their responsibilities under the Work Environment Act.

31. Sickness monitoring and absence management can significantly reduce inappropriate sick leave use.

- Employers (and also employees) should have the option of accessing the rehabilitation expertise and resources of public agencies[32] when undertaking workplace adjustments that help workers affected by sickness remain attached to their employer.

- The WEA, working with the SIA, employer and trade union representatives, should lead the development of agreed operational criteria for assessing whether an employer has made genuine bona fide attempts to fulfil their obligation to adjust the workplace to retain a sick worker or to place a sick worker in another job.

B. Facilitating labour demand

It is reasonable to surmise that the activation policies of the reformed system will facilitate a surge in the supply of labour, particularly former sickness beneficiaries from January 2009. However, policies to facilitate demand for them or other persons with partial work capacity are not strong. This imbalance in the supply and demand orientation of recent reform is of particular concern because of the recent economic downturn which will increase the general labour supply. Securing employment for people with reduced work capacity is going to become even more difficult as competition for jobs increases.

Insufficient policy attention is being paid to address the perceived and actual challenges faced by employers in taking on a worker with reduced or temporarily affected work capacity. Action in this regard is a necessary step toward ensuring there is adequate growth in appropriate employment opportunities for the increasing numbers of these persons seeking work. Many employers perceive there to be greater risk in taking on former or current sickness or disability beneficiaries as they are often seen to be potentially less productive than other workers. Given Sweden's strong employment protection, it is likely that some employers will fear being stuck with a worker who both costs more to manage and produces less.

While under the current policy, temporary wage subsidies are available to be used by the PES as an inducement to employers to accept such workers, much more education of employers is needed to broaden the pool willing to take on these persons, particularly as the global economic downturn will mean there are more competitors for every job. Education and in-work support are also needed to help fellow employees accept a new work-mate who is less productive or who has special needs.

It is critically important that the recent crisis in the global economy does not scare governments into (re)opening the gates into inactivity. Lessons from the past clearly show that doing so – be it through introducing early retirement pathways or more lenient entry into disability benefit schemes – is very costly in the medium and long run. These approaches result in large numbers of otherwise productive people becoming permanently lost to the economy; previous experience shows they do not return to the labour market when the economy improves. Moreover, reversing such policies is very difficult and costly in political terms. As such, efforts in the present to activate and/or retrain persons with health problems who lose their job in the current crisis are both necessary and important to ensure that they keep at least a partial foothold in the labour force. When the economy picks up again, it will be possible to return them to fuller employment. By comparison, those parked in disability schemes will, with few exceptions, be impossible to activate.

32. The PES, the SIA and the WEA all have expertise in areas of rehabilitation assessment, planning and management, though with largely different resources and staff capacity.

Recommendations:

- Provide education and incentives to facilitate the expansion or creation of "employer circles" that employers can use to help place workers who are no longer suited to their particular business. Drawing from the experiences of similar employer networks in the Netherlands, these circles should be organised on a regional rather than sectoral level to stimulate cross-sector mobility.

- Extend the exemption from employer-provided sick-pay to hiring of people who were sick for at least one year (currently this is only available for hiring of disability beneficiaries). As with the reduction in social-security premiums, the duration of this exemption could vary with the duration of sickness-related inactivity of the hired worker.

C. Compliance with sick-leave guidelines

GPs who authorise sickness certificates are important actors in the success of the innovative system of sick-leave guidelines, both in reducing inappropriate sick-leave usage and helping to lower moral hazard in this regard. More precisely, it is important that GPs create the right expectations (in terms of the expected duration of sickness absence) at a very early stage. However, early indications suggest that many GPs are not complying with the new guidelines and this is delaying the pace of reform. Non-compliance is a significant issue, particularly as there are no direct incentives to induce or compel GPs to support the new work-oriented approach.

While the NBHW appears to be operating on an assumption that the SIA will blacklist GPs who consistently fail to comply with the new guidelines, the SIA has not taken a firm stance seemingly out of concern that doing so could undermine the partnership approach it wants to build with the medical community – particularly as the SIA has no internal capacity to perform medical assessments. The lack of sanctions may slow the pace of implementation if the medical community develops a view that they are not obliged to cooperate with the new arrangements governing sick leave.

Recommendations:

- Sickness certificates exceeding seven days duration should be sent to the Social Insurance Agency immediately, by either the sick worker's GP or the employer, to undertake random checks of the compliance with the new medical guidelines.

- The SIA should cease to accept non-compliant sickness certificates. For clients in dire financial circumstances, a discretionary emergency benefit may be required to sustain them during such a delay period.

- The SIA should be obligated to report repeated non-compliance of GPs to the NBHW for investigation and sanction. The NBHW should make compliance with the sick-leave guidelines a condition for renewal of registration of GPs.

- Outcome data need to be collected to continuously improve and refine the guidelines. A more evidence-based set of guidelines would provide better health and employment outcomes and be used with greater fidelity by sceptical GPs.

D. Incentives for county authorities

County authorities are important players in Swedish sickness and disability policy, because they are in charge of the health care system. In this function, they employ the vast majority of GPs and are responsible for medical rehabilitation. Regional governments are very autonomous in Sweden, being elected by the public and collecting income tax directly for their own budget. Influencing them will not be easy but it is necessary. In addition to providing clearer responsibilities and incentives for GPs, it may be prudent to consider better incentives for county authorities as well.

Through their responsibilities, counties have a key role in the new rehabilitation chain. Delays to signing agreements with county authorities to provide pre-employment services to support the new system mean that urgently needed services are not adequately developed. In particular, this is true for the new OHS system, which was meant to be put in place in concert with the new process at the workplace. A key role of this service would be to monitor health and safety in the workplace and to help employers manage sickness absence. This delay could have significant consequences for the implementation of the reformed sickness benefit system.

Recommendations:

- Introduce the OHS system as swiftly as possible by signing agreements with counties and OHS providers, and consider mandatory OHS coverage for all workplaces. OHS services should have a strong focus on early sickness absence identification and intervention.

- Medical rehabilitation agreements with the counties should be signed quickly and the idea of a medical rehabilitation guarantee pursued. A similar national health care guarantee commits counties to offering treatment within 90 days of a treatment decision.

- Consider introducing sickness benefit co-payment by county councils to raise the incentive for county authorities to reduce sick leave in their region. Reduced sickness absence levels would then automatically translate into savings for the county. Financial incentives could also reward county-level compliance with the sick-leave guidelines.

- The recently developed Danish benchmarking tool Jobsindsats.dk, a continuously updated internet portal which allows local, regional and national authorities to compare practices on a local level on a wide range of indicators, could be taken as a good practice and adapted to the specific circumstances and needs of Swedish counties.

Healthy work environments

Much of the recent reforms rest on a premise that sickness is a temporary condition caused either by discrete in-work accidents or lifestyle factors outside of the workplace, and that ongoing participation in work does not ordinarily make people unwell, but instead produces good financial and other outcomes. There is an expectation that altering the incentives and supports to return to and stay in work will address the problem of large numbers on welfare.

However, empirical research in Sweden also indicates that some workplaces manage staff in ways that cause them to become unwell, and that recent changes in the formal employer-worker relationship, employment agreements, outsourcing and pressure to perform in the workplace since the

early 1990's are related to health conditions underpinning sick-leave use[33]. Incentives, education and support to make sure workplaces management practices are healthy would seem warranted, but this seems conspicuously absent from the policy agenda.

Recommendations:

- As part of the new OHS system being negotiated by the government and key stakeholders, emphasis should be placed on educating employers about the productivity benefits associated with healthy work environments. Incentives to offset the cost of promoting workplace practices that are conducive to good physical and mental health could be provided.

- OHS providers should undertake annual employee surveys of healthy workplace management and other practices, which would allow the government authority managing OHS to publish the performance of each business and in each county.

E. Making work pay

To encourage people to stay in work, the government has recently introduced an additional tax credit of SEK 1,000 per month (which roughly corresponds to EUR 100) for those who remain in paid work. The labour supply effect of this reform was shown to be significant, at least for certain groups of the population (e.g. single mothers) but the impact on people with health problems is unknown.

A general problem for the Swedish social protection system is that it is predicated on the basis of public benefit entitlement where most people receive generous collectively-agreed top-ups. Coverage of the latter is not universal but, due to the high degree of unionisation, the large majority of beneficiaries have very high replacement income. Previous efforts in Sweden to adjust wage replacement rates to increase the incentive to remain in work have generally been countered by corresponding adjustments to the benefits negotiated under collective agreements. Policy is needed to constrain these practices or to develop alternative strategies that ensure the financial incentive to be in work is meaningful, and that being sick is not seen as more advantageous than unemployment.

Though not ostensibly a part of the sickness benefit reforms, the government has cut subsidies to unemployment funds and raised the flat-rate contribution from workers by 40%. This change has had a sizeable impact, resulting in an almost doubling of the number of uninsured persons. One result of the latter is that through this change the number of people not entitled to unemployment benefit upon expiration of their sickness benefit entitlement after six months, or possibly one year, will be larger. If antipathy towards the government occurs because a large number of people end up without work as the global economy slows, while not being entitled to social security payments, the broader reforms could be jeopardised.

33 . Theorell (2004) reviews Swedish literature showing that since the 1990's workplaces have experienced increased work pressure, reduced decision latitude and diminishing social support and that these changes have resulted in increased risk of coronary heart disease, myocardial infarction, psychological stress, musculoskeletal and gastro-intestinal disorders. Similar associations were found by Westerberg (1997), Vingard *et al*. (2000), Westerlund *et al*. (2004) and Magnusson-Hanson (2008). Oxenstierna *et al.* (2004, 2005) show that reductions in social support influenced by management decisions are associated with long term sick-leave utilisation.

Recommendations:

- Explore alternate incentives to reward people for staying in work that cannot readily be negated by the compensation available through collectively-negotiated private sick-leave insurance.

- Make sure the impact of falling unemployment insurance coverage on the new sick leave system is fully understood. Despite the recent change, unemployment benefit continues to be massively tax-financed so that exclusion from the system seems unjustified.

3.3. Facilitate policy implementation by continuing institutional change

The recent suite of policy reforms is promising, particularly in light of the corresponding structural reforms to the SIA and the PES. However, ultimate success will depend considerably on how well the government continues to manage the implementation of the new approach in a number of key areas.

A. Improving institutional cooperation

Due to institutional reforms in recent years the SIA and the PES are better organised to deliver services in a consistent manner across the country, and in a joined-up way thanks to the innovative funding approach that underpins their cooperation. Staff members across agencies have good ongoing relations together with better knowledge about the functioning and advantages of the other agency, particularly in relation to helping sickness beneficiaries return to work. The new policy framework requires this good cooperation and continuous information exchange to continue, particularly as they require work-capacity assessments for very different purposes: the SIA assessment is largely medical and to determine benefit entitlement; the PES assessment is instead focused on vocational ability and potential. It is encouraging to see that while the two agencies continue to operate different capacity assessments they have built a functional and productive means of collaborating for some of their common clients.

While the PES has personnel with considerable expertise in rehabilitation, the SIA is responsible for engaging with the employer and sick worker during the early months of benefit receipt. The SIA does not involve the PES until the worker has been on a sickness benefit for six months – by which time their work-readiness has deteriorated considerably[34]. The process for managing sickness benefit by the SIA and of collaboration between the SIA and the PES prioritises the assessment of eligibility for benefits well in advance of that for rehabilitation. The focus should clearly be the other way round, if the goal is to prevent sickness benefit recipients from inadvertently establishing themselves on a track of inactivity.

The SIA lacks internal capacity to assess the work capacity of clients and has to rely on external medical practitioners. If it is not able to procure appropriate screening at the established intervals to determine whether the person has some capacity in order to bring the PES into the process, the time this external assessment takes will undermine the effectiveness of the new rehabilitation chain concept. While the PES has specialists available at each local office to help a worker or employer to

34. After three months of sickness, an individual can establish contact with the PES so that after six months if they are no longer entitled to sickness benefit the process has already started. However, there is no obligation to do so; it is up to the individual to ask for help.

assess work capacity or adjust a work situation to keep a person in work, they are not able to assist until called in by the worker or the SIA[35].

Recommendations:

- The SIA should consider seeking second medical opinions more frequently to check the validity of sickness certificates provided by GPs; many OECD countries, including France, are doing this on a random basis with quite some success.

- To improve the efficiency of the rehabilitation chain, a good triage system is needed at an early stage to ensure a swift and early transfer of clients, *e.g.* from the SIA to the PES and on to a rehabilitation specialist.

- Better incentives (including sanctions) are needed to make sure that the *contact meetings* taking place from day 90 of sickness benefit receipt are scheduled promptly. These meetings should also involve the employer, who is ultimately responsible for the sick worker.

- After the 180th day of sickness benefit receipt when entitlement ends, *hand-over meetings* should be organised whenever necessary which involve the worker, the SIA and the PES but also, possibly, the employer, the doctor and the trade union.

- More generally, the very successful FAROS model of SIA-PES co-operation for clients who are long-term sick should be gradually adopted for all clients who have received sickness benefit for at least 180 days (or even earlier in some cases, if resources permit).

B. Modernising service provision

Outsourcing of vocational rehabilitation and placement services is not a new practice and the Swedish approach seems to have avoided some of the problems observed with this type of approach in other countries. However, there remain significant threats to its success, which if left unattended could easily mean poor outcomes particularly for those furthest from the labour market.

An important lesson from Australia and elsewhere in the OECD is that the compliance burden associated with publicly-funded service contracts can cripple many smaller private sector providers, particularly rural-based and non-profit organisations. Over time, these withdraw from the market leaving a smaller number of large private-sector providers to dominate. Driven by commercial priorities, they tend to actively target easier-to-place clients in urban centres where there are more job opportunities as this requires the least-skilled front-line staff, comparably simple organisational management and is therefore most profitable. Clients who live in rural or remote areas or who are more difficult to place for other reasons are often avoided for these same reasons. Even where bounty incentives have been offered to attract private providers to work with more challenging clients, this has not comprehensively resolved the issue. Mainly because complex clients have heterogeneous service needs and helping them requires a provider to recruit and retain a broader range of highly-skilled personnel in multiple disciplines, as well as investing considerably more management time and cost in delivering services to rural and remote areas. Commercial success is in large part about

35. The WEA is a comparably smaller agency whose role is to monitor workplace occupational health and safety and compliance with corresponding legislation. It does not have the capacity or capability to give advice to and support employers in keeping workers affected by sickness in work in the early phase of benefit receipt, when the chances of successful rehabilitation are highest.

maximising profit and minimising cost and management complexity. It is harder to run a sustainable commercial enterprise placing complex clients.

Recommendations:

- The outcome-based compensation paid to private vocational rehabilitation and placement providers should be structured in a way that encourages them to accept and be rewarded for success in placing less work-ready clients with more complex needs.

- Private vocational rehabilitation and placement providers working with clients in rural and remote areas should receive additional compensation to ensure there is adequate service coverage outside of major metropolitan centres.

3.4. Conclusion

Sweden is currently undertaking extensive reforms that represent a radical departure from previous policies that are aimed at cutting its large pool of sickness and disability beneficiaries. Notwithstanding the pace of reform, the country has succeeded in introducing some important changes including transforming major public agencies and therefore has a good chance of success.

The challenges in front of Sweden appear fourfold: Firstly, as one would expect, around implementation of the new system; secondly, around continuing policy development as gaps – especially insufficient incentives for the main actors – become obvious; and thirdly, around winning the hearts and minds of a nation that has traditionally shown high moral hazard toward the take-up of sickness benefits by those who have some work capacity. The recent turn in the broader world economy is also expected to place additional pressure on the reforms.

Panicked by rising unemployment in the past, led some OECD nations to lose focus on the importance of keeping those affected by sickness or diminished work capacity attached to the labour market – or worse still, to allow them easy entry into disability schemes. The price of this short-term thinking has however been shown to be enormously costly: both in terms of their labour becoming permanently lost to the economy and the enormous permanent welfare burden that has had to be carried into the future without any sign or hope for respite.

Given its historically high numbers of sickness and disability beneficiaries, the important reforms which Sweden has been implementing to maximise the productive contribution of such persons needs to continue – and continue to be a point of focus in its overall labour policy, even though attention may eventually be needed to stimulate employment among the general working-age population in response to the recent economic crises. Success in this regard will play a significant part in determining whether Sweden is more strongly positioned with a lower welfare burden and capable labour supply once economic conditions improve.

BIBLIOGRAPHY

Aaberge, R. and L. Flood (2008), "Evaluation of an In-work Tax Credit Reform in Sweden: Effects on Labour Supply and Welfare Participation of Single Mothers", IZA Discussion Paper Series, No. 3736, Institute for the Study of Labour, Bonn.

Adda, J., M. Dias, C. Meghir and B. Sianesi (2007), "Labour Market Programmes and Labour Market Outcomes: A Study of the Swedish Active Labour Market Interventions", IFAU Working Paper No. 27, Institute for Labour Market Policy Evaluation, Uppsala.

Ahlgren, A., A. Bergroth, J. Ekholm and K.S. Ekholm (2008), "Selection of Clients for Vocational Rehabilitation at Six Local Social Insurance Offices: A Combined Register and Questionnaire Study on Rehabilitation Measures and Attitudes among Social Insurance Officers", *Journal of rehabilitation medicine*, Vol. 40, No. 3, pp. 178-184.

Arai, M. and P. Skogman-Thoursie (2001), "Incentives and Selection in Cyclical Absenteeism", FIEF Working Paper Series No.167, Trade Union Institute for Economic Research, Stockholm.

Henrekson, M. and M. Persson (2004) "The Effects on Sick Leave of Changes in the Sickness Insurance System", *Journal of Labour Economics*, Vol. 22, No.1, pp. 87-113.

Hesselius, P. (2007), "Does Sick Absence Increase the Risk of Unemployment", *Journal of SocioEconomics*, Vol. 36, No. 2, pp. 288-310.

Hesselius, P. and M. Persson (2007), "Incentive and Spill-over Effects of Supplementary Sickness Compensation", IFAU Working Paper No. 16, Institute for Labour Market Policy Evaluation, Uppsala.

Hesselius, O., P. Johansson and L. Larsson (2005), "Monitoring Sickness Insurance Claimants: Evidence from a Social Experiment", IFAU Working Paper No. 15, Institute for Labour Market Policy Evaluation, Uppsala.

Johansson, P. and M. Palme (2002). "Assessing the Effect of Public Policy on Worker Absenteeism", *Journal of Human Resources*, Vol. 37, No. 2, pp. 381-409.

Johansson, P. and M. Palme (2004), "Moral Hazard and Sickness Insurance: Empirical Evidence from a Sickness Insurance Reform in Sweden", IFAU Working Paper No. 10, Institute for Labour Market Policy Evaluation, Uppsala.

Karlström, A., M. Palme and I. Svensson (2008), "The Employment Effect of Stricter Rules for Eligibility for DI: Evidence from a Natural Experiment in Sweden", Stockholm University Working Papers in Economics No. 3, Stockholm.

Larsson, L. (2002), "Sick of Being Unemployed? Interactions between Unemployment and Sickness Insurance in Sweden", IFAU Working Paper No. 6, Institute for Labour Market Policy Evaluation, Uppsala.

Magnusson-Hanson, L., T. Theorell, G. Oxenstierna, M. Hyde and H. Westerlund (2008), "Demand, Control and Social Climate as Predictors of Emotional Exhaustion Symptoms in Working Swedish Men and Women", *Scandinavian Journal of Public Health*, Vol. 36, No. 7, pp. 737-743.

Ministry of Finance (2008), *Budget Bill 2009: Putting Sweden to Work – Safeguarding Welfare*, Budget Statement and Summary, Government Offices of Sweden, Stockholm.

OECD (1996), *OECD Economic Surveys: Sweden 1996/1997*, OECD, Paris.

OECD (2003), *Transforming Disability into Ability: Policies to Promote Work and Income Security for People with Disability*, OECD, Paris.

OECD (2003a), *Employment Outlook*, OECD, Paris.

OECD (2005), *OECD Economic Surveys: Sweden*, OECD, Paris.

OECD (2006), *Sickness, Disability and Work: Breaking the Barriers – Vol. 1: Norway, Poland and Switzerland*, OECD, Paris.

OECD (2007), *Sickness, Disability and Work: Breaking the Barriers – Vol. 2: Australia, Luxembourg, Spain and the United Kingdom*, OECD, Paris.

OECD (2008), *Sickness, Disability and Work: Breaking the Barriers – Vol. 3: Denmark, Finland, Ireland and the Netherlands*, OECD, Paris.

OECD (2008a), *Employment Outlook*, OECD, Paris.

OECD (2008b), *OECD Economic Surveys: Sweden*, OECD, Paris.

Oxenstierna, G., H. Westerlund, J. Ferrie, M. Hyde, J. Hagberg and T. Theorell (2005), "Structural Work Change and Health: Studies of Long Spells of Sick Leave and Hospitalization among Working Men and Women during a Period of Marked Changes in the Swedish Labour Market", in A. G. Antoniou & C. L. Cooper (Eds.), *Research Companion to Organizational Health Psychology*, Edward Elgar, Northampton, MA.

Söderberg, E. and K. Alexandersson (2005), "Sickness Certificates as a Basis for Decisions Regarding Entitlement to Sickness Insurance Benefits", *Scandinavian Journal of Public Health*, Vol. 33, pp. 314-320.

Söderberg, E. and U. Müssener (2008), "Entitlement to Sickness Benefits in Sweden: The Social Insurance Officers Experiences", *Environmental Health Insights*, Vol. 2, pp. 13-23.

Theorell, T (2004), "Democracy at Work and its Relationship to Health", in M. L. Perrewé and D.C. Ganster (Eds), *Research in Occupational Stress and Well Being. Emotional and Physiological Processes and Positive Intervention Strategies (Vol. 3)*, Elsevier, Amsterdam, pp. 323–357.

Vingård, E., L. Alfredsson, M. Hagberg, Å. Kilbom, T. Theorell, M. Waldenström, E. Wigaeus-Hjelm, C. Wiktorin and C. Hogstedt (2000), "To What Extent do Current and Past Physical and Psychosocial Occupational Factors Explain Care-seeking for Low Back Pain in a Working Population? Results from the Musculoskeletal Intervention Center Norrtälje Study" *Spine*, Vol. 25, No. 4, pp. 493–500.

Westerberg, L. and T. Theorell (1997), "Working Conditions and Family Situation in Relation to Functional Gastrointestinal Disorders: The Swedish Dyspepsia Project", *Scandinavian Journal of Primary Health Care*, Vol. 15, No. 2, pp.76-81.

Westerlund H, T. Theorell and L. Alfredsson (2004), "Organizational Instability and Cardiovascular Risk Factors in White-collar Employees: An Analysis of Correlates of Structural Instability of Workplace Organization on Risk Factors for Coronary Heart Disease in a Sample of 3,904 White Collar Employees in the Stockholm Region", *European Journal of Public Health*, Vol. 14, No. 1, pp. 37-42.

LIST OF ACRONYMS

EU-SILC	European Survey of Income and Living Conditions
GP	General Practitioners
NBHU	National Board of Health and Welfare
OHS	Occupational Health Services
PES	Public Employment Service
SIA	Social Insurance Agency
WEA	Working Environment Authority

Sickness, Disability and Work: Breaking the Barriers

SWEDEN: WILL THE RECENT REFORMS MAKE IT?

How is it possible for average health status to improve while many workers continue to leave the labour market permanently due to health problems, forced to rely on welfare to survive? At the same time, many working-age adults with reduced work capacity are denied the opportunity to work. This social and economic tragedy is common to virtually all OECD countries, including Sweden. It is a paradox that warrants explaining as well as innovative action.

This single-country report in the OECD series *Sickness, Disability and Work* explores some of the reasons behind this phenomena in Sweden and the potential of its innovative recent and ongoing reforms, for example with regard to sickness absence and benefit policy, to lower inactivity and increase participation. The report includes a range of recommendations to address evident and foreseeable gaps, with consideration to broader impacts from the global financial crises on the Swedish economy.

Since 2006 when Sweden had the highest level of dependence on sickness and disability benefits in the OECD (14% of the working age population), significant reforms have taken place to address structural issues dating back to the mid-1990s when a shift from unemployment benefits occurred. The hitherto time-unlimited sickness benefit was capped to six months and those no longer eligible becoming expected to seek to continue work in an amended or different job, including in one with a different employer if necessary. This reform is particularly significant because it aims to address one of the key problems affecting many other countries: people holding on to the wrong jobs for too long.

This report concludes that further change is needed to ensure that the reforms live up to their promise. Responsibilities and financial incentives for some of the key actors, particularly employers and the health care system, and co-operation among some institutional actors, all have to be strengthened.

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