

Chapter 3

Best practice for reducing sickness and disability absences

Sweden's single biggest economic problem is the high number of people absent from work due to sickness or disability. This chapter describes the problem and looks at what other countries have done to reduce absenteeism. It emphasises a mutual obligations approach to sickness insurance. This means placing greater responsibilities on the sick person, the employer and the social insurance office to get that person back to work as soon as possible.

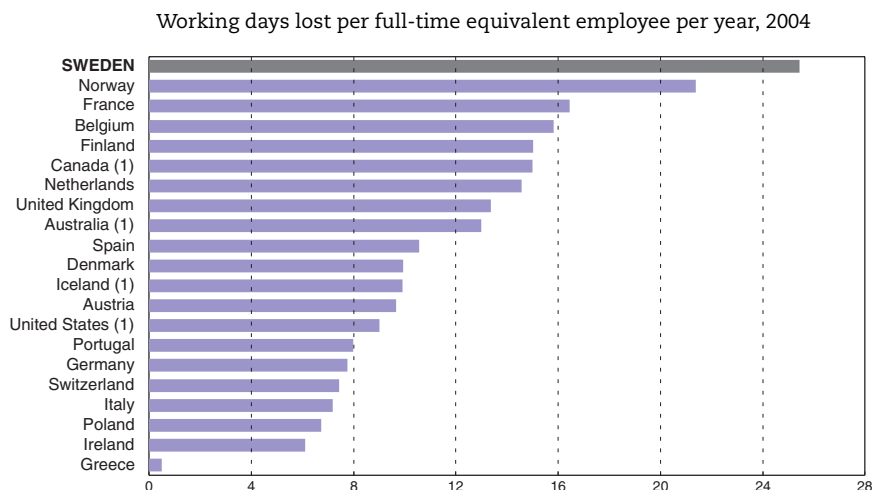
On an average day, around 14% of the working-age population is either on sick leave or on a disability benefit. This amounts to a significant drain on labour supply, incomes and economic activity. Recognising this, the government has set a target to halve the number of sick-listed people between 2002 and 2008. Achieving this goal would not only make Swedes wealthier now, it would go a long way towards ensuring that the welfare system can be sustained in the long term. The causes of such a high rate of absenteeism are not hard to find. Compared with other OECD countries, sickness insurance in Sweden is both generous and easy to get. Maintaining both of these features will not be possible. This chapter reviews the types of reforms that have worked in other countries and draws lessons about the steps that could be taken. The most important step would be to change the culture of sickness and disability insurance from one of providing passive income replacement towards the “mutual obligations” approach that Sweden already uses for unemployed people. In practice, this means placing greater responsibilities on the sick person, the employer and the social insurance office to get that person back to work as soon as possible. The government has taken some steps in this direction, but it needs to go further. If administration and gatekeeping can be brought closer to international best practice, then the problem of absenteeism might be solved without having to cut benefit levels.

Who are the sick and disabled?

The problem of sickness and disability absences can be split into two components: people who have a job but are not at work because of illness (sickness absentees); and people who are out of the labour force for medical reasons (the inactive). Sweden compares badly on both dimensions. *First*, the average number of working days lost per year due to sickness is the highest in the OECD (Figure 3.1).¹ This reflects both a high absence rate (i.e. the share of people who take time off in a given period) and a *long average length* of each spell (partly because sickness benefits can last several years). *Second*, the share of the potential workforce that has dropped out of the labour market for reasons of illness or disability appears to be large by international standards, especially for older people (see Figure 3.2, although note that it can be hard to distinguish between early retirement and inactivity caused by illness).

There are several “natural” reasons why Sweden’s sickness rate might be higher than in other countries. The most obvious is that the workforce is relatively old, and absence rates rise with age. But this cannot be the sole explanation because sickness absences are high across all age groups (Table 3.1). A second factor is that the female participation rate is high, and in most countries women are more likely than men to be off work sick. On the other hand, Swedes are healthier than most and have a long life expectancy (see Chapter 5), which should mean they are less likely to fall sick. Based on econometric evidence, it seems that the total effect of the various demographic and labour market characteristics is roughly zero, with the different factors cancelling each other out (Table 3.2).

Figure 3.1. **The number of working days lost due to sickness is the highest in the OECD**

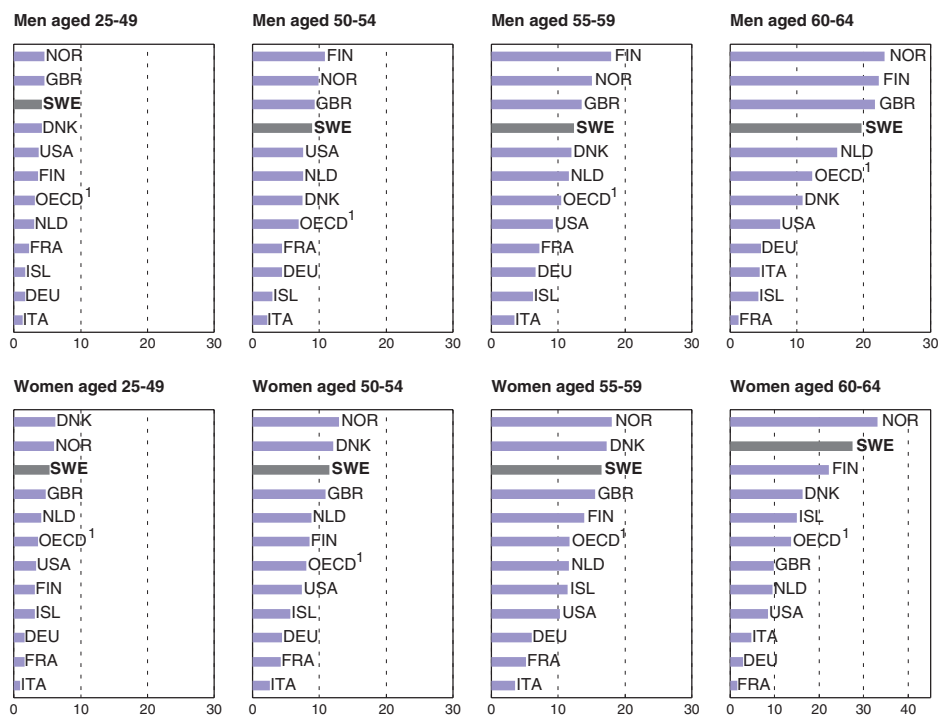


1. 2002.

Source: OECD estimates based on the European Labour Force Survey spring results.

Figure 3.2. **Inactivity because of illness or disability**

Percentage of the population in each age group, 2003



1. Average of 23 OECD countries for which data are available. Data for USA are 2001.

Source: European Labour Force Survey.

Table 3.1. **Sickness absence rate**

Percentage of people absent from work for the whole week in which the survey was taken, 1983-2001

	Age					Total
	Twenties	Thirties	Forties	Fifties	60-64	
Sweden	2.5	3.1	3.9	4.4	9.1	4.2
Netherlands	3.2	3.9	4.5	5.9	4.9	4.1
Norway	2.4	2.7	3.1	4.3	7.2	3.2
France	1.8	2.1	2.5	3.9	4.0	2.4
Finland	1.3	1.8	2.5	4.4	5.3	2.3
United Kingdom	1.8	2.1	2.5	3.9	4.0	2.0
Denmark	1.5	1.6	1.7	2.3	2.7	1.7
Germany	0.9	1.1	1.4	2.7	3.2	1.4
Weighted average	1.5	1.8	2.2	3.3	4.1	2.1

1. Data are the averages for 1983-2001, except Sweden (1987-2001) and Norway (1989-2001).

Source: Bergendorff, Sisko (2003), "Sickness absence in Europe – A Comparative Study", Swedish National Social Insurance Board.

Looking more closely at Sweden itself, there are significant differences in sickness absence rates across various groups (Figure 3.3):

- *by gender*: Sickness rates for women are, on average, twice as high as for men. The discrepancy has widened over time. Not surprisingly, rates are higher for women with young children.
- *by age*: Absence rates rise steadily with age. A man in his late-50s has an absence rate about as high as a women in her early-30s.
- *by education level*: The rate for people with only primary education is especially high at younger ages. Overall, it is around three times as high as for those with tertiary education.
- *by sector*: Employees in the public sector are about a third more likely to be off work than their counterparts in the private sector. A similar pattern is found in other countries that have high sickness absence rates, but it contrasts with France, Germany and Denmark where absence rates are almost the same in the government and business sectors.

Table 3.2. **The absence rate is not explained by demographic and labour market factors**

Sickness absence rate (share of people absent due to sickness for at least one hour during the reference week of the survey, average 1995-2003, per cent).

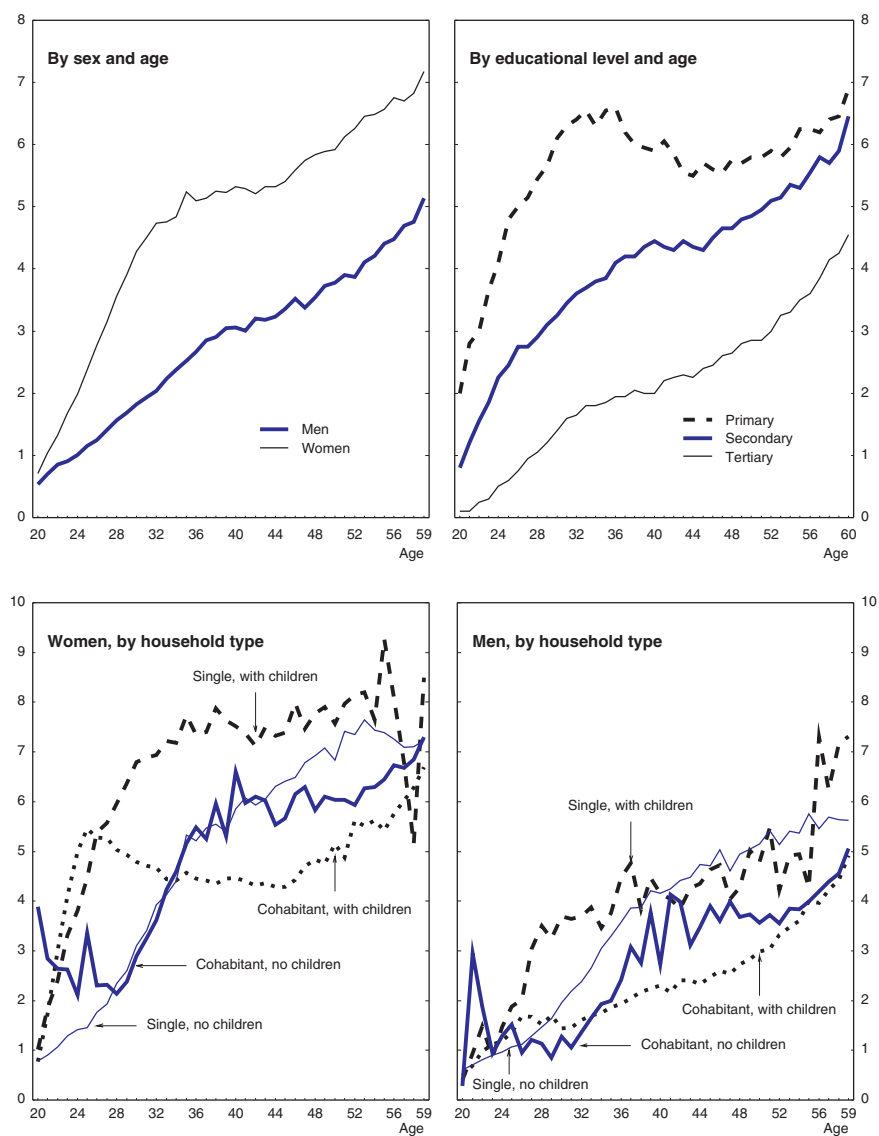
	Per cent
Swedish sickness absence rate	5.20
EU (unweighted) average sickness absence rate	2.75
Difference between Sweden and EU	2.45
The impact from having...	
... a higher labour force participation rate	0.56
... a lower share of part-time employment	0.32
... lower average hours of work	-0.09
... longer life expectancy	-0.73
Total difference explained by demographic and labour market factors	0.06

Note: In the model on which these calculations are based, there is no statistically significant impact coming from the age structure of the population once the other labour market variables have been included. The authors conclude that the age effect is captured within those variables.

Source: OECD calculations based on the econometric results from Bonato and Lusinyan's (2004) panel data study of work absences in Europe (IMF Working Paper 04/193).

Figure 3.3. **Sickness rates**

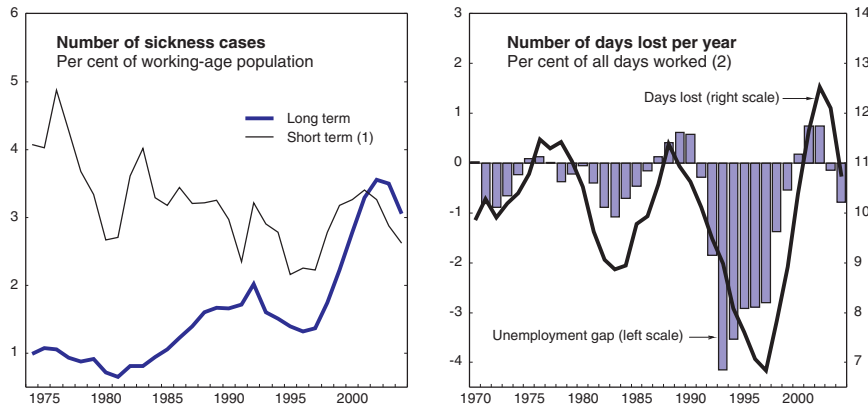
Per cent



Source: Statistics Sweden.

Similar patterns are seen for people who are on disability benefits. The main difference is that on average they are older, with half aged over 55.

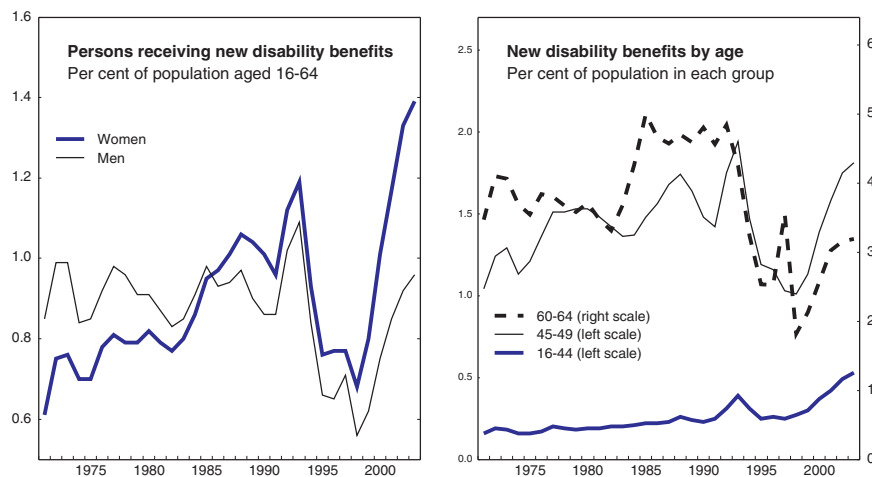
Looking at developments over time, the number of short-term sickness cases has shown a slight downtrend over the past few decades, but it is highly cyclical, rising when the labour market is tight² and falling significantly when unemployment is high (Figure 3.4). Sickness spells have been getting longer, however. The number of long-term spells has increased significantly, surging by more than 150% since 1998. The ageing of the population can explain only a small fraction of this increase; instead, it reflects the cyclical pick-up, more generous benefit levels and substitution between disability and long-term sickness benefits (access to disability benefits was tightened in the late 1990s). The result is that the total number of days

Figure 3.4. **Sickness cases and days lost**

1. The series has been adjusted (upwards) after 1992 so that it includes the waiting day and the number of days paid by employers (so it is comparable with the pre-1992 figures). The adjustment is based on Henrekson (2004) and NIER (2004).
2. These data are from a different administrative source than the data for Table 3.3, so they are not exactly comparable.

Source: National Institute of Economic Research, Statistics Sweden; OECD.

off work remains close to an all-time high (Figure 3.4, right-hand panel). The good news is that the number of sick days has fallen significantly over the past two years, although much of this reduction is because people have shifted onto disability benefits instead. Hence, the total number of working days lost due to ill health (sickness and disability combined) fell by only 1.5% from 2003 to 2004 (NIER, 2005). Looking back a little further, the inflow to disability pensions has leapt since the late 1990s, especially among women (Figure 3.5). It has also been getting younger (Figure 3.5, right-hand panel), and is now at or around its highest level for all age groups except those 60 to 64 years-old. As in most countries, the fastest rate of increase has been among people with stress and depression.

Figure 3.5. **The inflow to disability pensions has surged**

Source: Swedish National Insurance Agency and OECD.

It is worth noting that these trends are not related to measures of health status. When compared with other countries, the high rate of benefit receipt is hard to square with the fact that Swedes are relatively healthy (see Chapter 5). Nor has the increase in work absences been caused by any decline in population health: if anything, health indicators have continued to improve over the past 20 years. Moreover, the share of older people reporting that they are in good health has increased fairly steadily over time (OECD, 2003a).

Overview of the system

Sickness insurance (SI) is a compulsory publicly administered programme aimed at providing compensation for lost income during temporary sickness spells. Compensation can be full (100%) or partial ($\frac{3}{4}$, $\frac{1}{2}$ or $\frac{1}{4}$), depending on the extent of loss of earnings capacity. The focus is now more clearly on a person's capacity to work in general, not necessarily whether they can go back to their old job. The benefit level has changed frequently over the past 20 years, with fairly sizeable cuts through the recession of the 1990s but some reversal since then (Table 3.3). It is now 80% of previous earnings (up to a ceiling of 115% of the average wage, although collective agreements often cover earnings above the ceiling). It is common for collective agreements to top-up the replacement rate to as much as 100% over the first three months. SI is funded primarily through a payroll tax levied on employers (around 12% of wages). A sickness benefit can be granted for an unlimited time, but recent policy changes have been aimed at trying to reduce the number of benefits granted for longer than one year.

Table 3.3. **Replacement rate history**

Sick leave compensation as a percentage of own income (and the share paid by employers)¹

	Dec. 1987 to Feb. 1991	Mar. to Dec. 1991	Jan. 1992 to Mar. 1993	Apr. to June 1993	July 1993 to Dec. 1995
First day	90	65	75 (75)	0 (0)*	0 (0)*
Days 2-3	90	65	75 (75)	75 (75)	75 (75)
Days 4-14	90	80	80 (80)	80 (80)	80 (80)
Third week	90	80	80	80	80
Fourth week	90	80	80	80	80
Until 90 days	90	80	80	80	80
Until 1 year	90	90	90	80	80
Over 1 year	90	90	90	80	70

	1996	1997	Jan. to Mar. 1998	Apr. 1998 to June 2003	July 2003 to Dec. 2004	Jan. 2005
First day	0 (0)*	0 (0)*	0 (0)*	0 (0)*	0 (0)*	0 (0)*
Days 2-3	75 (75)	75 (75)	80 (80)	80 (80)	77.6 (77.6)	80 (80)
Days 4-14	75 (75)	75 (75)	80 (80)	80 (80)	77.6 (77.6)	80 (80)
Third week	75	75 (75)	80 (80)	80 (0)	77.6 (77.6)	80 (12)
Fourth week	75	75 (75)	80 (80)	80 (0)	77.6	80 (12)
Until 90 days	75	75	80	80	77.6	80 (12)
Until 1 year	75	75	80	80	77.6	80 (12)
Over 1 year	75	75	80	80	77.6	80 (12)

* The waiting day can be partly avoided after 1993 by reporting sick part way through the day.

- The figures in brackets show the share that employers are required by law to pay. It does not include any top-ups (for most of this period, there has been an average 10% employer top-up, although this does vary across industry and has varied over time). Throughout the period shown in the table, coverage of the public system has been capped (but fewer than 10% of wage earners have consistently been above this cap, and collective agreements usually cover income above the cap). The **figures in bold** highlight changes relative to the previous scheme. From 2005, employers pay 15% of sick pay for full-time sick, but not if the sick person works part-time or is in employer-funded rehabilitation.

Source: National Social Insurance Board; OECD (2003), *Ageing and Employment Policies: Sweden*, Paris.

A *disability benefit* is available to those aged 30 and over whose work capacity has been reduced permanently. Since 2003, the disability pension has been renamed “sickness compensation” and has been integrated with the sickness insurance system (previously it was part of the pension system). However, this chapter will continue to refer to it as a disability benefit because it is less confusing for non-Swedish readers. It is available also for partial disability, and a temporary disability benefit can be given when work capacity is expected to be reduced for 1-3 years. The replacement rate, around 64%, is lower than for the sickness benefit. Younger people (aged 19-29) receive “activity compensation”, which is essentially the same as the disability pension except that it is granted only for a limited time (up to three years) and social insurance offices must try to find measures that will help improve their health or physical or mental capacity for work.

In effect, *work injuries* are bundled together with the sickness and disability system. On paper they are different schemes, but they are administered by the same agency and, like other social security benefits, are financed from employers’ contributions. The difference is that somebody injured at work receives full (i.e. 100%) compensation in the form of an annuity that tops up their sickness or disability benefit (so long as they have suffered a lasting reduction in work capacity).

The system is administered by the Swedish Social Insurance Agency. This new body was created in January this year by merging the 21 regional social insurance offices. The merger was made in an attempt to improve implementation and to reduce regional variations in practice. Local branches are now government offices, so now they can be controlled more directly by the national authorities. Administrative procedures have been tightened up to some extent, especially after a package of reforms that took effect in July 2003 (see Box 4.2 of 2004’s *Survey* for details), but they are still looser than in most other countries (see Box 3.1 and the rest of this chapter).

Box 3.1. Normal procedures over a sickness spell

The first day of a sickness spell is a “waiting day”, and in principle the sick person receives no pay or sickness benefits that day. Employers pay sick pay from the second to the fourteenth day (and 15% of sickness benefits thereafter; see below). After one week, a medical certificate must be produced. These are usually provided by the individual’s own GP. After two weeks the social insurance office becomes involved. It decides about entitlement to further sickness benefits and the degree of reduced working capacity, based on the original medical assessment. A sickness benefit can be paid for an unlimited period, so long as the person is unable to work because of sickness and has not been transferred to a rehabilitation benefit or a disability pension. The employer must produce a rehabilitation plan after 1-2 months (this can be done in conjunction with the insurance office). Around this time there should be a meeting between the person on sick leave, the employer and the insurance office; the government wants these meetings to take place more often. The person may then undergo rehabilitation (medical, social or vocational). If it seems likely that the reduced work capacity will last longer than a year, he or she will be granted a temporary or permanent disability benefit. In principle there should be a re-evaluation after one year of sick leave allowance, but in the past these have often not been performed on time and in any case the doctors at the social insurance office do not perform an independent medical assessment. For those awarded a disability benefit, there should be a re-assessment at least every three years. Implementation is patchy, however, although the government is trying to improve the process for long-term absentees.

What works in other countries?

The rest of this chapter reviews policy experiences in other countries and looks at how Sweden's approach compares with international best practice. The key features of the different benefit systems are compared in Table 3.4. It should be noted that in the discussion that follows, there is often no clear distinction drawn between short-term and long-term sickness, disability and work injury schemes because different countries use different labels and the issues are so intertwined.

Table 3.4. **Summary of main characteristics of sickness benefit systems**

	Number of waiting days	Benefit level (% of previous earnings) ¹			Maximum duration (years)	Employer period (weeks)	Index of compensation generosity ² (OECD = 100)
		After around 1 week	After around 1 month	After six months			
Countries with high absence rates³							
Sweden	1	80	80	80	Unlimited	2 ⁴	130
Norway	0	100	100	100	1	2	130
Netherlands	0	70	70	70	2	104	111
Belgium	1	100	60	60	1	4	99
Middle countries							
Finland ⁵	0	70	70	70	1	0	..
France	3	50	50	51	3	0	95
Canada	..	55	55	0	0.3	..	50
Austria	3	50	50	60	1	12	95
United Kingdom	3	flat (24)	flat (26)	0	1	28	80
Australia	..	flat (22)	flat (22)	flat (22)	122
Denmark	0	50	50	50	1	0	103
Iceland	14 ⁶	flat (23)	flat (23)	flat (23)	1	0	..
Switzerland	3	80	80	80	2	3	126
Spain	3	51	64	64	1.5	2	115
Portugal	3	65	65	65	3	0	118
United States	7	100	60	60	1	..	80
Countries with low absence rates							
Germany	0	90	90	70	1.5	6	115
Poland	..	80	100	0	0.5	..	115
Italy	3	50	67	0	0.5	12	84
Ireland	3	flat (53)	flat (53)	flat (53)	Unlimited	0	..
Greece	3	flat ⁷ (29)	flat (54)	flat (54)	1	0	..

- Benefit rules are complex. These columns show approximate replacement rates of the public insurance scheme for "typical" full-time workers. Replacement rates in some countries, including Sweden, are often topped up to 100% by employers for a certain period. For flat rate benefits, the figures are for a single-earner family with two children earning the average wage. See the Sources for exact details of the various schemes.
- This is a summary index of benefit generosity based on ten dimensions, including coverage, ease of access, benefit level and duration and the strictness of medical assessment. See Annex 2 of OECD (2003), *Transforming Disability into Ability*, for more details.
- Countries are ranked in descending order of average sickness absence rate in 2002.
- From 2005, employers pay a 15% co-payment for the full duration of a (full-time) sickness spell.
- The figures for Finland take account of the employer top up, in which the employer pays 100% for 3 days and effectively eliminates the waiting days. This is done through central agreements that cover all wage earners.
- The waiting period starts after a physician has certified the illness.
- Strictly speaking, the benefit level is not a flat rate but is capped at a low level and therefore most people will be receiving the maximum – namely, 29% of the economy-wide average production worker wage for the first 15 days and 54% thereafter.

Source: EU MISSOC database (http://europa.eu.int/comm/employment_social/missoc/missoc2004_en.pdf); OECD (2003), *Transforming Disability into Ability*, Paris.

Better administration and gatekeeping

Receiving a benefit should entail certain obligations for the sick person

Developing a culture of mutual obligations means that benefit receipt should depend on participation in employment, vocational rehabilitation and other integration measures. Active investment should be the counterpart to benefit receipt to ensure that the sickness benefit is not just a soft alternative to the unemployment insurance system. The earlier this starts the better. The OECD's review of policies for sick and disabled people concluded that "the most effective measure against long-term benefit dependency appears to be a strong focus on early intervention. As soon as a person becomes [sick or] disabled... a process of tailored intervention should be initiated" (OECD, 2003b, p. 162). The most appropriate measures and timing will obviously depend on individual circumstances. Taking this approach implies that recipients who do not co-operate in reintegration efforts should face some sort of sanction; in Norway, for example, sickness benefit payments can be withheld if a claimant rejects rehabilitation measures. While Sweden is a leader among OECD countries when it comes to *offering* early rehabilitation, it is less good at ensuring that people actually take it up.³ Increasing the focus on active measures should also apply to older people, especially as they are more likely to be long-term benefit recipients. However, no OECD country performs well in this respect. Benefit administration for people over the age of 45 is usually very passive and tends to focus on income support rather than trying to get the beneficiary back into the workforce.

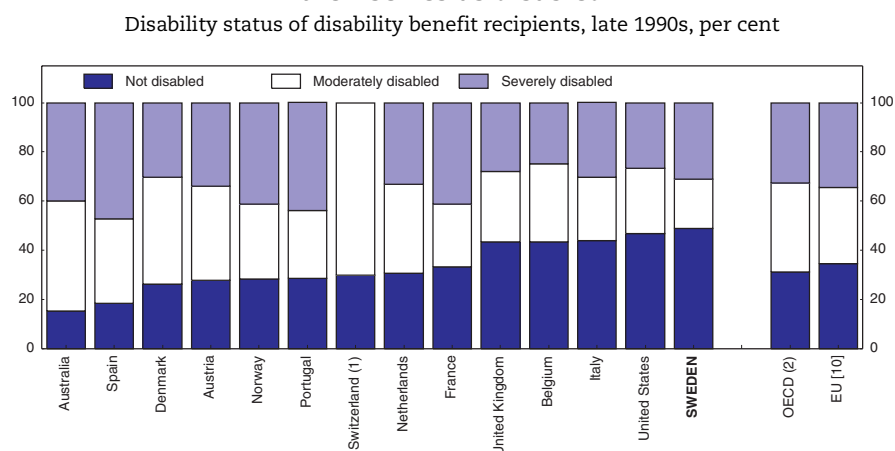
Improving the initial assessment process

A major challenge is to find the right balance between minimising both the exclusion error (refusing the benefit for people who need it) and the inclusion error (granting benefits to those who do not need them). Some sort of gatekeeping is required. However, getting a sickness benefit appears to be much easier in Sweden than in most countries. Half of all Swedes who are receiving some form of sickness or disability payment do not actually regard themselves as disabled (Figure 3.6). Moreover, sickness absence rates are more procyclical than in most countries, another sign that access is relatively easy and in some cases is in a certain sense voluntary (Table 3.5).

The first step in the assessment process is the requirement to provide a medical certificate. In Sweden, this occurs after the seventh day. In Finland and Iceland, by contrast, a certificate is needed from the first day, and in Germany it is required after the third day. More important, however, is how the medical assessments are actually done. In most countries, assessment – at least for long-term benefit recipients – is done by specialised insurance doctors rather than by the applicant's own doctor. That is not really the case in Sweden. Social insurance physicians base their opinion on the assessment of the applicant's own GP (OECD, 2003) and do not re-examine the patient. Individuals themselves therefore have a great deal of influence over sick-listing decisions. One study found that in nearly 90% of the cases in Sweden, the physician offered sick listing only after the patient had specifically requested it, while another study found that patients were seldom denied a medical certificate if they asked for one.⁴ GPs in most countries are not in a good position to make unbiased decisions because they have every incentive to please a patient who may have been with them for many years.

Sweden has tried to improve the assessment process since 2003, but with limited success so far. An important step has been to abolish the "Ghent model", effective from the

Figure 3.6. **Half of Swedish sickness and disability recipients do not classify themselves as disabled**



1. "Severe" and "moderate".
2. Switzerland excluded from the average.

Source: OECD (2003), *Transforming Disability into Ability*, Paris.

start of 2005, in which the system was administered by autonomous legal entities, and instead local offices have become government agencies staffed by civil servants. Bringing them under the government's wing should, in time, lead to more control and better – and more uniform – implementation of policy. Indeed, local offices have got tougher over the past two years, but they have much further to go. The sickness benefit refusal rate remains very low, at around 1%.⁵ Even this small improvement has been difficult. Earlier this year, for example, the civil court in Uppsala found that the local insurance office had been wrong to refuse sick pay to a person who declared himself incapable of working after his boss had "exposed him to insults, bullying and harassment." It appears that cultural attitudes have not moved fully towards assessing a person's ability to work in general, rather than in his or her previous job.

While it is necessary to tighten up decisions on initial sick listing, it is far more important to make sure that short spells do not become long ones. In Sweden, extending a medical certificate is easy and in some cases is done over the telephone (although technically this is against the rules). In contrast to most countries, GPs retain a major role for long-term sickness and disability benefits as well. However, they are often not the best

Table 3.5. **Sickness absences are strongly pro-cyclical in Sweden**

Correlation between sickness absence rates and the unemployment gap

Belgium	-0.82*	Ireland	0.04
Sweden	-0.51*	Finland	0.06
Netherlands	-0.47*	Denmark	0.08
Greece	-0.36	Norway	0.17
Iceland	-0.24	Luxembourg	0.28
Germany	-0.23	Austria	0.28
Switzerland	-0.09	Spain	0.30
United Kingdom	-0.03	Italy	0.30
France	0.03	Portugal	0.43

* Significant at the 5% level.

Source: Bonato, Leo and Lusine Lusinyan (2004), "Work Absence in Europe", IMF Working Paper 04/193.

judge of whether someone can re-enter the workforce. The majority of long-term problems reflect back, knee or mental disorders which are difficult to diagnose and usually require specialists to gauge the degree of work that a person is capable of doing. That is why most countries have strengthened the role of independent medical assessors for longer-term problems. There is a trend towards increased use of interdisciplinary teams of experts – including vocational specialists – that make the final benefit decision. Rejection rates can be high, ranging from 17 to 25% in Norway and Denmark to around 50% in Austria and Portugal. The only other countries where GPs play as important a role as they do in Sweden are Norway and the United States. Both cases are revealing. Norway has the second-worst sickness absence problem in the OECD, and absenteeism in the United States is higher than might be expected, considering that benefit levels there are on the low side. Australia and Switzerland have circumvented the gatekeeping problem by making increasing use of the possibility to ask for an additional, independent medical assessment. This is now done in about two-thirds of all cases, demonstrating how important a second opinion can be. While there are no regulations that prohibit independent second opinions in Sweden, they are almost never undertaken.

Decisions to grant long-term disability benefits should be made in a regional or central office, and by experts rather than politicians

An additional problem is that local insurance offices can find it hard to make an unbiased assessment, especially in small communities where the applicant is likely to know the case officer. Some countries try to solve this problem by having decisions on permanent disability *prepared* locally but *made* more centrally by a social insurance doctor who is not part of that community. This is done in Finland, Spain, Norway and the United States, for example. In Sweden, the formal decision to grant long-term benefits is made by a local social insurance board comprising local politicians. The panel does not include the insurance officer or a physician, although its decision is based on the investigation made by the social insurance office. Sweden is the only OECD country with this type of system. Some other countries also use independent panels to make the final decision (e.g. Italy, Switzerland and Portugal), but in every case it includes doctors or experts in vocational rehabilitation.

Regular monitoring and re-testing is necessary

Once a benefit is granted, assessment should be repeated at regular intervals to determine whether a person's condition or work capacity has changed. Put another way, sickness benefits normally should be granted for a fixed duration only. There clearly needs to be flexibility here, as re-testing is unnecessary if a disability really is permanent. In some countries, and especially in Scandinavia, benefits are more or less permanent because re-testing is rare, even if it is theoretically possible at any time. As noted in Table 3.1, a re-evaluation should take place after one year of sick leave allowance, although in the past these have often not been performed on time. Disability benefits should be re-evaluated at least every three years, but again implementation of this policy has been patchy. Moreover, none of these re-evaluations includes an independent medical re-assessment. Reconsidering a person's eligibility is done more regularly and systematically in some other countries. Reviews take place every two to three years in Austria, Germany and Italy, for example, and within five years in Australia and the Netherlands. In most countries, however, there is a big difference between the policy "on paper" and how strictly it is

implemented in practice. Nevertheless, the Dutch experience shows that follow-up assessments can be helpful. In the mid-1990s they reviewed all recipients below age 45 (including those who had previously been granted a permanent benefit), leading to reclassifications or loss of benefit in a third of all cases (OECD, 2003b). The government is clearly trying to improve the re-assessment process, and international experience shows that it would be helpful to step up efforts in this area.

Occasional random checkups on SI recipients can be an effective way to find out whether a person's health has improved and to combat fraud. This may sound tough, but it is common in other European countries (*e.g.* Austria, Belgium, France and Italy), and in some countries checks are possible at the request of the employer. Checkups were part of the Swedish approach until the 1980s, but since then there has been virtually no monitoring of benefit recipients. Each country has to make its own decision as to how hard a line to take, but having no checking at all is surely too soft – and is strikingly at odds with the strict mutual obligations approach that Swedes are comfortable with for the unemployed.

The use of partial sick leave must be carefully monitored

The government is putting increased emphasis on partial or part-time benefits. In theory, decisions to grant partial benefits should depend on how much work the sick person is capable of doing. In practice, it is based on how much work he or she actually does (virtually everyone receiving a partial benefit works part time). It is hard to know whether partial benefits are a good idea or not. There is a risk that they invite a higher inflow, especially among older workers who may want to scale back their hours of work for lifestyle reasons. A partial benefit then becomes an income top-up while they go through a gradual early retirement. If there were no option to grant a partial benefit, then some of these people would stay at work full time, but others would completely withdraw from the workforce and receive a full benefit instead. There is no clear evidence of which of these two effects would dominate. However, the international experience is that countries which place more emphasis on partial benefits tend to have particularly high benefit recipiency rates (although causation could run in the other direction: countries with high inflow rates may try to deal with them by encouraging partial benefits). This partly explains why Denmark has moved in the opposite direction to Sweden, replacing partial benefits with wage subsidies (“flexjobs”). Sweden therefore needs to carefully monitor how partial benefits are being used, especially considering that the inflow to partial benefits has surged since 1999, but with little apparent reduction in the inflow rate to full benefits.

Flexible rules can help overcome benefit traps

It is important that benefit rules are flexible so that people can “try out” going back to work without having to worry about going through the whole administrative process again if their attempt fails and they need to go back on a benefit. Sweden is a leader in this respect. A disability benefit can be put on hold for up to two years, and it continues to be paid for the first three months back at work. The problem is that few people make use of this option. In the first two years after the scheme was introduced (in 2000), less than 0.5% of recipients tried to go back to work. This lack of interest might suggest that income replacement rates are high enough that most people on disability benefits have little interest in returning permanently to the workforce. Of course, it might also be the case that they are in fact too sick to work.

The Dutch experience with tighter administration

Faced with similar problems to Sweden, the Netherlands has radically restructured its sickness and disability systems. Better gatekeeping and administration have been key parts of the reforms, along with experience rating of firms. Both employers and employees face greater obligations earlier in the sickness spell, especially concerning rehabilitation. When someone subsequently applies to move off sickness insurance and onto a disability benefit, the social insurance office can refuse the request if it thinks that rehabilitation efforts have not been sufficiently serious. Social insurance doctors also have less discretion in granting access to partial disability benefits, with gatekeeping having become more rules based. The sickness insurance scheme has been privatised, with employers now responsible for the first two years of sick pay, and there will be some privatisation of the partial disability scheme from next year (giving employers a choice between public, private or no insurance). These measures have all contributed to a significant reduction in sick leave, driving it below Swedish levels for the first time for many years (OECD, 2004). Firms are able to re-insure the risks they face under the sickness insurance scheme, but it is interesting that this does not seem to have diluted the incentives they face: after controlling for factors such as firm size, the rate of absenteeism has been virtually the same whether a firm re-insured or not (de Jong and Lindeboom, 2004). This suggests that adverse selection – where only the “bad” firms choose to re-insure – has not been a significant problem in the private insurance market.⁶

Increasing incentives on employers

For how long should employers be responsible?

In recent years, most countries have increased obligations on employers to encourage them to invest in prevention and retention measures. Employers in Sweden have had to pay the first two or three weeks of sickness insurance since 1992 (except for a brief period in 1997 when they covered the first month). Practices vary widely, but this is on the low end of the scale (Table 3.4) which may be why it does not seem to have had much impact so far.⁷ Employers in the Germanic countries, for example, pay the first one to three months, while obligations can be as long as six months (in the United Kingdom) or two years (in the Netherlands).

Employers' responsibility for sick pay underwent a significant change this year. On top of paying for the first two weeks (a reduction from the three weeks for which they were previously responsible), employers must now pay 15% of the cost of sickness benefits for the remainder of the sickness spell. In return, the payroll tax was lowered so that labour costs for employers as a group should be roughly unchanged. The charge will not apply if the sick person is in rehabilitation or working part-time, and their liability ends if the employee is granted a permanent disability benefit. The aim is to give firms a greater incentive to avoid workplace injuries and to get people into rehabilitation earlier. However, it is unclear whether this is the most sensible way of going about it. The key issue is the optimal time profile of their financial obligations, including the question of whether responsibility should go to zero at some point. It is hard to say whether it would be more effective for firms to cover the full benefit for a longer but limited period (say, three months) or to pay 15% indefinitely. The first option might be a better way to meet the government's main objective, namely to have the sick person's problems dealt with sooner in the spell, because they could reduce their costs significantly by encouraging the employee to enter a vocational rehabilitation programme early on. Under the alternative

setup, there is less urgency because the firms' net savings may be quite low (it avoids the 15% co-payment but must pay for the rehabilitation programme).⁸ The second question – whether the firms' responsibility should go to zero – depends to a large extent on how many of the long-term sick go back to work. If long-term sickness is mainly a stepping stone to a permanent disability benefit or to early retirement, then employer obligations merely raise average labour costs rather than improve incentives at the margin. For these reasons, it might have been better if the government had extended beyond 21 days the period for which employers have full responsibility, but to have kept a definite cut-off period after which the public SI system would take over. A government commission in 2000 recommended changes along those lines (extending the employer's period to 60 days and lowering the payroll tax), but the proposal was rejected by the social partners.

Involving employers in vocational rehabilitation

Active involvement by employers can be an effective way to deliver successful re-integration. Different approaches exist, ranging from moral suasion and work-based occupational health programmes to compulsory employment quotas. Swedish employers are obliged to prepare a rehabilitation plan, and in this respect Sweden is an example of good practice that is not found in many other countries. However, many employers ignore their obligations. To make the requirement more effective requires empowering employers to prepare sensible plans (*e.g.* giving them better assistance), monitoring the plans and their impact and introducing sanctions for non-compliance. At the same time, the social insurance office will need greater powers to act when a person refuses rehabilitation. Moreover, simply putting more emphasis on monitoring and managing employees can be surprisingly effective. In Svenska Statoil, for example, every employee on long-term sick leave and those who had had more than five absences in a year were called in for a discussion with a manager and the Human Resources division. By doing so, it halved its absenteeism rate between 2001 and 2004 (PersonnelToday, 2004).

Introducing industry or employer risk rating

Most countries have some form of risk rating across industries, at least for work injuries, although some have different SI rates as well. Sweden is one of the few that still levies the same premium in all sectors despite there being relatively large variations in absence rates across industries (Table 3.6). This reduces the incentive to try to curb work-

Table 3.6. Sickness absence rates vary markedly between sectors

Average number of sick days per worker aged 30-64 in establishments with at least 30 employees in 1991

Electricity and gas	13
Construction	15
Trade	18
Mining	18
Government administration	20
Manufacturing	22
Banking and Finance	27
Health and childcare	28
Transport	30
Total	25

Source: Arai, Mahmood and Peter Skogman Thoursie (2004), "Sickness Absence: Worker and Establishment Effects", *Swedish Economic Policy Review* 11, 9-28.

place injuries and implicitly subsidises employment in high-risk sectors. Industry risk rating could usefully be introduced in Sweden, although in the first instance it could be limited to injuries and illnesses that are clearly work-related.

Basing insurance premiums on the individual firm's history is less common, although it is used in around half a dozen OECD countries. Individual experience rating creates strong incentives for firms to try to reduce work-place injuries and get their employees back to work. Dutch companies face different premiums depending on how successful they are at reducing absenteeism, and premiums there have become more differentiated over time (OECD, 2004). In New Zealand's work injury scheme, companies with a good safety record, and who can show that they have taken significant steps to minimise the risks to their workers or who were actively involved in rehabilitating employees, are able to negotiate substantial reductions in their premiums. In response, many firms have tried actively to improve their working environments.

Sweden could consider a similar approach. The 15% co-payment does create some differentiation across firms as those with poor sickness records will pay more, but this is equivalent to a deductible or excess in insurance terms, rather than an experience-rated premium. As a first step, Sweden could consider setting different SI contribution rates for public and private employers. Sickness absence is a third more prevalent in the public sector. It appears that only some of this can be explained by the fact that the public sector is more likely to employ older female workers⁹ (although it is fair to say that the evidence on how much variation exists across industries, after taking account of individual characteristics such as sex and age, remains inconclusive; further research would help policymakers assess whether industry-related premiums would be helpful or not).

The main potential drawback of experience-rated premiums is that they give employers an incentive to avoid hiring people who might be sick listed in the future (adverse selection). But this incentive has already been created through the introduction of the 15% co-payment, and in any case it can be mitigated or avoided. One way is to exclude the highest risk groups, such as former disability recipients and people with a history of repeated sickness spells (as in the Netherlands). Indeed, Sweden already does this, as employers can avoid paying sick pay if a worker has been given an exemption in advance through a special high-risk protection. An additional option is to ban detailed investigation of a job applicant's medical history, as has been done in the Netherlands and to some extent in the United Kingdom.

Having a separate workplace injury scheme

The appropriate financial obligations on employers differ between work injury and general sickness/disability programmes. That is why the two risks are separated in most countries. They require a different funding structure (costs of work injuries should be fully borne by the employer) and justify a different minimum level of disability (even minor reductions in work capacity from a work injury should be fully compensated). Sweden's approach of largely combining the two systems is unusual and means that, at the margin, employers probably pay too little for work injuries and too much for sickness spells that are out of their control. The fact that employers did not take out private re-insurance to cover the costs they faced under the previous rules reinforces this conclusion. It would be better to separate the systems, basing the work injury programme on the ILO's internationally agreed list of occupational diseases. Although the work injury scheme should be run under different rules and have different financing, there are advantages to keeping some co-ordination with

sickness insurance because a sick person will need the same type of support and rehabilitation no matter whether the injury was caused at work or not.

Shouldering employers with extra costs may backfire unless other parts of the system are reformed as well

An important proviso applies to any measure that imposes costs on employers. For the policy to be effective, the company has to be able to do something to reduce sickness absence. If not, financial responsibility just drives up labour costs and may have a negative impact on employment. Incentives will be sharpest where the employer faces an increased marginal benefit from reducing absenteeism and has some levers with which to do something. This means that an increased responsibility for employers needs to go hand in hand with other reforms that tighten benefit administration and reduce the incentives for employees to misuse the system. The approach of imposing rehabilitation responsibilities and a 15% co-payment on firms is likely to be more effective if the government also takes bigger steps towards the sorts of gatekeeping and administration improvements discussed in this chapter.

Moreover, reforms would be more effective if employment protection rules were eased at the same time. International evidence shows that strict employment protection leads to more absences.¹⁰ Swedish evidence points in the same direction: workers on temporary contracts are only half as likely as permanent employees to be off sick (Meyer and Wallete, 2005). In addition, sick listing is to some extent used as a way of getting around seniority rules that make it harder to lay off older workers. Placing more responsibility on employers for sickness absences will increase the effective cost of these employment protection rules and may make firms less willing to hire in the first place. It was for similar reasons that Austria and Germany recently relaxed their special dismissal protection rules for disabled workers, realising that they were causing more harm than good for older workers.

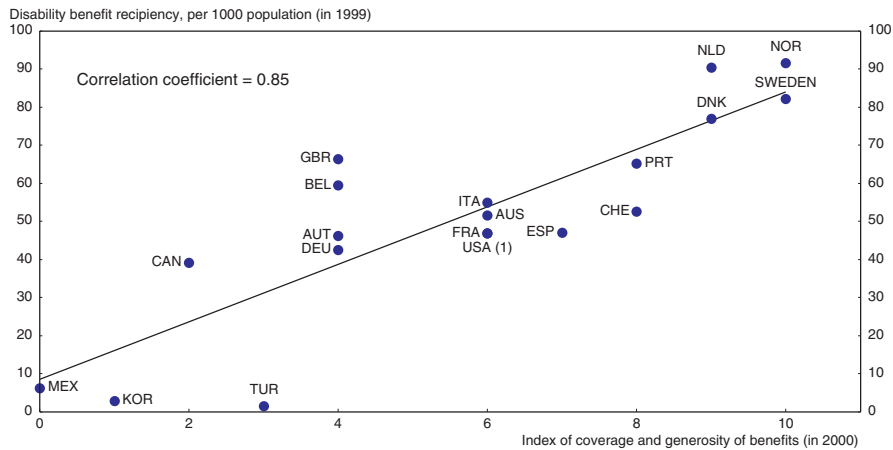
Restructuring benefit systems to minimise the disincentives to work

Beware of making the sickness and disability system too generous

There is no doubt that high benefit levels reduce the incentive to work. Comparing across countries, OECD (2003b) found that benefit levels and coverage are the two most powerful predictors of sickness and disability rates (Figure 3.7). In a more rigorous econometric study of work absences in European countries, Bonato and Lusinyan (2004) show that the level of benefits has a large impact on the absence rate and that the elasticity is particularly big in Sweden. Their estimates suggest that cutting the benefit replacement rate by 10 percentage points would reduce absences in Sweden by around 11%. The link between benefit levels and the absence rate in Sweden is clear even from a casual glance at Swedish data. In the late 1980s and early 1990s, benefit replacement rates were around 100%. Benefit levels were reduced through the first half of the 1990s, and a one-day waiting period was introduced in 1993. The number of sick cases was substantially reduced, especially after 1993. In 1998, benefit replacement rates increased again, particularly for longer absences where the rate went from 75% to 90%. Around the same time, the incidence of long-term sickness began to increase dramatically. This is not to say that the compensation level has been the only factor behind these developments. Nevertheless, various studies that control for other factors also confirm that changes in benefit generosity have had strong effects on sick leave behaviour in the past. Henrekson and Persson (2004), for example, concluded that “when the insurance system is made more generous, the aggregate number of sick days increases, and when the system is made more austere, the number falls”.¹¹

Figure 3.7. **Coverage and generosity determine benefit reciprocity levels**

Benefit coverage and benefit generosity vs benefit reciprocity outcome



1. The scatter plot is the same value for the United States and France.

Source: OECD (2003), *Transforming Disability into Ability*, Paris.

The more generous the system, the greater the risk of moral hazard. There are many Swedish studies which demonstrate that moral hazard and misuse of SI are significant problems (for example, absence rates for men are higher on their birthday or when major sporting events are on – see Skogman Thoursie, 2002 and 2005). That is one reason why countries with more generous sickness and disability schemes need to be more vigilant about ensuring that benefits are given only to those people who genuinely need them. Finland and Germany, for example, both have relatively generous benefit levels but have better gatekeeping and earlier intervention than Sweden. Their absence rates are noticeably lower as a consequence.

Extending the waiting period beyond one day

In order to reduce moral hazard, optimal insurance policies usually include an “excess” or “deductible” that the insured party has to pay. In the case of sickness insurance, this corresponds to the waiting period before benefits are paid. In Sweden, the waiting period is one day. This is short by European standards; three days is the norm (Table 3.4), and it can be as long as 9 or 14 days (in Finland and Iceland respectively). Sweden’s experience shows that the waiting day has a sizeable impact on the absence rate. When the waiting day was abolished between 1987 and 1991, so most people could report sick with no loss of earnings, the number of one-day and two-day absences surged.¹² In 1992 the waiting day was restored; this move, along with a cut in the replacement rate, led to a sharp fall in short-term leave.

Making sure sickness and disability benefits are co-ordinated with other parts of the social security system

Sickness and disability benefits are often used as a more attractive route to early retirement. Sweden has taken some care to design a flexible pension system in which the payout rate is actuarially reduced the earlier it is taken. While nice in theory, the problem is that few people are influenced by the incentive because it is easy to leave the workforce on a sickness or disability pension instead. A relatively small fraction of people take their

public pension before the age of 65. It is more common for older workers to take unemployment or sickness insurance for a year or two and then either retire on a pension (if they are 65) or move on to a disability benefit: a third of 65 year-olds have previously been awarded a disability benefit. For most workers, there is a large financial incentive to take the sickness insurance pathway to early retirement. For typical 55 year-olds on an average income, for example, the net present value of their future income stream if they retire via the labour market insurance path is more than twice as big as that resulting from taking the public and occupational pension route (Palme and Svensson, 2003).¹³ One reason is that benefits are not actuarially reduced before age 65, whereas the pension is. But perhaps more importantly, sickness and disability benefits count as pensionable income. A person is therefore better off retiring on a benefit and continuing to build up a bigger pension, which they then take at age 65.

Some countries have started to deal with similar problems in their own disability and retirement systems. For example, benefits are actuarially reduced for older recipients in Austria and Germany to try to keep the different income support systems co-ordinated. And in Portugal, Poland and Spain, earned income counts more than benefit income towards the defined-contribution pension.¹⁴ Based on experience abroad, it is probably unrealistic to expect labour supply to increase significantly – even if the disability route to early retirement were closed off to some extent – as most older people want to retire and will choose the best pathway available. The difference, however, is that if they choose to retire early under the pension scheme, then they rather than the taxpayer will pay for it.

Finally, it is worth noting that many people are better off claiming sickness insurance rather than unemployment insurance because SI has a higher ceiling (115% of the average wage, compared with around 90% for UI). It would be better to align the systems, as recommended by the Lindbeck Commission more than a decade ago.¹⁵

Box 3.2. Summary of recommendations

The scale of the problem in Sweden means that comprehensive reforms in many areas are needed. Few of the recommendations on their own would make much of a dent in the problem of absenteeism. Together, however, they might. The key is to develop a culture of “mutual obligations” in which the sick person, the employer and the social insurance office each have clear responsibilities.

Responsibilities for the social insurance office

Improve the assessment process: Require a medical certificate earlier. Re-assess eligibility more frequently, and re-introduce occasional random checks. Social insurance doctors should undertake an independent medical assessment, possibly after a few weeks but certainly before granting permanent disability benefits. The decision to grant a disability benefit should be made by a panel comprising social insurance and rehabilitation experts, not by local politicians.

Carefully monitor how partial benefits are being used to ensure they are not just an income top-up for people who want to scale back their working hours. Make it easier for people on partial benefits to change employer.

Box 3.2. Summary of recommendations (cont.)

Responsibilities for the employer

Increase financial responsibilities on employers, but only if other parts of the system are tightened up as well. Monitor their response to the 15% co-payment. If it does not have the intended effect, replace it with a higher up-front cost but with a limited duration (*e.g.* full responsibility for the first 2-3 months only). Involve employers in vocational rehabilitation, and ensure this starts earlier. Introduce employer or industry risk-weighting. As a first step, the premium could be differentiated between the public and private sectors.

Separate out the workplace injury scheme, and have it fully funded by employers. Consider allowing this scheme to be run by the private sector. In negotiating labour market agreements, ensure that these agreements do not overrule policy objectives (*e.g.* through top-ups to benefit levels).

Reforms would be more effective and have fewer side effects if employment protection rules were eased as well.

Responsibilities for the sick person

Increase the focus on active measures – in most cases, receipt of a benefit should depend on participation in employment, vocational rehabilitation and other integration measures.

Extend the waiting period beyond one day. Sickness and disability benefits should not count towards pensionable income (at least beyond a certain age) so as to reduce the incentives for using these benefits as a pathway to early retirement. Align the SI and UI ceilings.

If all other reforms fail to deliver a significant reduction in absenteeism, then as a last resort the generous benefit levels may have to be cut.

Notes

1. The estimates in Table 3.3 are from the Spring European Labour Force Survey. Absences in Sweden continued to fall for the rest of 2004, so the figure for the whole year is likely to be lower than shown here.
2. There are two common explanations of why such absences may be pro-cyclical. First, high unemployment acts as a worker disciplining device, reducing the likelihood that they will take sick leave for minor health problems. Second, a tight labour market may pull in marginal workers who are more likely to have higher rates of absenteeism. There is no clear evidence whether health itself may vary over the business cycle, for example due to work pressure during boom times.
3. In 2003, less than one in five long-term (more than 60 days) sickness benefit recipients were in a rehabilitation programme. Of those who were, their programmes lasted an average of 100 days.
4. See Englund and Svärdsudd (2000) and Granvik (1998).
5. From March to September 2003, 2 741 applications for a new benefit or for extension of an existing benefit were refused. At an annual rate, this corresponds to around 2% of the stock of sickness benefit recipients and thus is 1% of the inflow given that the average duration is around ½ year. See Dagens Nyheter (2005).
6. The private insurance market has evolved over time, with the variation in premium rates across firms having become much larger in the last couple of years. When sickness pay was first privatised in 1996, around half of all companies took out private insurance. The insurance companies competed fiercely for customers in the first years, so premiums were well below their break-even level. It was hard to see what impact privatisation had in the early years because its effects were masked by a cyclical upswing, as absenteeism tends to rise when the labour market is

tight (see Table 3.5). Insurers began adjusting premiums in 2000 and 2001 after making heavy losses, with premium rates becoming noticeably differentiated across firms.

7. See Statens Folkhälsoinstitut (2003) and Hytti (2003).
8. It could be argued that rehabilitation should not start too early because of the high deadweight costs of paying for a programme that many people would not need because they would go back to work soon enough anyway. That may be true, but it calls into question the basic objective of trying to encourage early intervention; it is not relevant to the question of whether a high up-front cost would be better than a flat 15% when it comes to achieving the goal.
9. Some of the difference can be explained by differences in gender and age: the public sector employs more women and older people, for example, both of which will tend to raise sickness rates (Olsson, 2003). This will be offset to some extent by different average education levels. Arai and Skogman Thoursie (2004) find that substantial variation across establishments and across sectors remains even after individual characteristics have been taken into account.
10. In one Italian study, for example, absenteeism more than doubles as soon as a worker is protected from firing (Ichino and Riphahn, 2003). For other evidence, see the studies referred to in Ichino and Riphahn (2004).
11. In another study, Johansson and Palme (2004) found that the benefit reform in 1991 had the largest impact on short-term absences, but the poor design of the reform made it less likely that people would return to work if they had been on the benefit for more than 90 days. The reason is that the benefit rate was lowered only for the first three months of each sickness spell, so people who went back to work risked having to rejoin the sickness benefit later at a lower rate.
12. See Andrén (2004) and Henrekson and Persson (2004). The latter study estimated that the abolition of the waiting day in 1987 boosted the average number of sick days by 10%. The effect was of moderate size but statistically insignificant for men, but was highly significant for women.
13. In Palme and Svensson (2003), the net present value for that 55 year-old is almost exactly twice as large in the labour market insurance path relative to the pension path. Their modelling, however, is based on the old pension system. The new notional defined-contribution system makes the sickness and disability option even more attractive.
14. In Portugal, only earned income counts towards a disability benefit. In Poland, benefit income accrues at half the rate of earned income. In Italy, a full disability benefit accrues towards a pension, but a partial disability benefit earns no pension rights.
15. The systems were partially aligned in July 2003; from that date, people moving from UI to SI would face the lower UI ceilings on their benefits.

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Table of contents

Executive summary	8
Assessment and recommendations	11
Chapter 1. Key challenges	21
Economic performance over the past decade	23
The ageing challenge: to preserve the core of the welfare system as the dependency ratio rises	28
Labour supply needs to rise if the welfare system is to be maintained	34
Achieving environmental objectives in the least-cost way	37
The equity-efficiency tradeoff	38
Conclusions	39
Notes	39
Bibliography	40
Annex 1.A1. Taking stock of structural reforms	41
Chapter 2. Strengthening public finances	45
Strengthening of public finances is needed to make the welfare state sustainable	46
Fiscal easing has pushed public finances off a sustainable course	49
What tools are available to improve public finances?	55
Notes	62
Bibliography	63
Chapter 3. Best practice for reducing sickness and disability absences	65
Who are the sick and disabled?	66
Overview of the system	71
What works in other countries?	73
Notes	84
Bibliography	85
Chapter 4. Raising hours worked	87
High employment rates combine with low average working hours in Sweden	88
There are still pockets where labour market participation can be raised	95
Implementation of unemployment policies should be tightened	101
Notes	106
Bibliography	107
Chapter 5. Improving quality and value for money in healthcare	109
Context and overview of the system	110
Strengths	114
Key challenges	116

Summary and recommendations for reform	133
Notes	135
Bibliography	136
Annex 5.A1. Indicators of health status	139
Annex 5.A1. Lifestyle factors that influence health	141



Boxes

1.1. Are international comparisons distorted by differences in the size of government?	26
1.2. Recent trends	29
2.1. Income taxes and working time	57
2.2. Summary of recommendations	62
3.1. Normal procedures over a sickness spell	72
3.2. Summary of recommendations	83
4.1. Summary of recommendations	105
5.1. Examples of National Quality Registers	116
5.2. The maximum waiting time guarantee	120
5.3. Privatising St. Göran's Hospital	126
5.4. Recommendations for reform	134

Tables

1.1. Output and productivity growth	25
1.2. Contribution to labour productivity growth in the manufacturing sector	27
1.3. The ICT manufacturing sectors in several European economies	28
1.4. Summary of medium-term projections	30
1.5. Scenarios for total hours worked	31
1.6. Increase in public service standards (enrichment)	33
2.1. The fiscal gap is sizeable	48
2.2. Discretionary fiscal policy has contributed to the deterioration of the fiscal balance	50
2.3. Margins under the ceilings have been steadily eroded and tax expenditures increased	52
2.4. General government finances are falling short of the surplus target	53
2.5. The marginal cost of public funds is likely to be significant	59
3.1. Sickness absence rate	68
3.2. The absence rate is not explained by demographic and labour market factors	68
3.3. Replacement rate history	71
3.4. Summary of main characteristics of sickness benefit systems	73
3.5. Sickness absences are strongly pro-cyclical in Sweden	75
3.6. Sickness absence rates vary markedly between sectors	79
4.1. Anatomy of a typical work year	89
4.2. Full-timers have reduced their working hours	90
4.3. The impact of policy changes on the private rate of return to university education	97
4.4. Main income source after labour force exit for people born between 1927 and 1932	101
4.5. The number of places in ALMPs has been reduced	103
5.1. Expenditure on long-term care	122
5.2. Financing county council medical care	129

5.3. Consumption and taxes in the long term	130
5.4. Supplementary appropriations to local government are common	132

Figures

1.1. The sources of differences in income	22
1.2. GDP and private consumption per capita	23
1.3. Labour productivity growth has picked up	27
1.4. The labour market has been slow to bounce back	29
1.5. The general government fiscal surplus needs to rise	32
1.6. Total labour supply is around average	35
1.7. Effective employment is much lower than actual employment	35
1.8. Employment rates by age	36
1.9. The income distribution is relatively equal	38
2.1. Population ageing will depress public finances	47
2.2. Higher state grants may hold back tax hikes by local governments this year and next	52
2.3. Reaching the 2% surplus target will require a substantial improvement of central government finances	54
2.4. High taxes reduce hours of work	57
3.1. The number of working days lost due to sickness is the highest in the OECD	67
3.2. Inactivity because of illness or disability	67
3.3. Sickness rates	69
3.4. Sickness cases and days lost	70
3.5. The inflow to disability pensions has surged	70
3.6. Half of Swedish sickness and disability recipients do not classify themselves as disabled	75
3.7. Coverage and generosity determine benefit reciprocity levels	82
4.1. The marginal tax wedge is high	91
4.2. Take-home pay relative to pre-tax earnings is low	92
4.3. Students start their tertiary education late	95
4.4. Study support is generous but comprises mostly loans	96
4.5. Immigrant employment gaps are big	98
4.6. Refugees constitute a relatively large part of immigration	99
4.7. Participation rates drop significantly for 60-64 year-olds	100
4.8. Expenditure on active labour market policy is high	102
4.9. Employment protection is relatively strict in Sweden	104
5.1. The population is relatively old	111
5.2. Total health expenditure is in line with national income	112
5.3. Health resource utilisation	113
5.4. Long-term spending pressures	114
5.5. Swedes do not see a doctor very often	117
5.6. Access to physicians is relatively inequitable	118
5.7. Spending on pharmaceuticals is around average	127
5.8. Health spending is significantly pro-cyclical	131
5.9. Indicators of health status	140
5.A2.1. Swedes are relatively slim	141
5.A2.2. Calorie intake is low	142
5.A2.3. Alcohol consumption is low	142
5.A2.4. Smoking rates are low	143
5.A2.5. Swedes exercise a lot	143

BASIC STATISTICS OF SWEDEN

THE LAND

Land area (1 000 sq. km)	411	Inhabitants in major cities, including suburbs (31 December 2003) thousands	
Lakes (1 000 sq. km)	39	Stockholm	1 694
Arable area (1 000 sq. km) (2003)	27	Göteborg	817
Woodland (1 000 sq. km) (1998-2002)	227	Malmö	536

THE PEOPLE

Population (31 December 2003), thousands	8 976	Net natural increase per 1 000 inhabitants (average 1999-2003)	-0.4
Number of inhabitants per sq. km	22	Net migration (average 1999-2003), thousands	24.5
Net natural increase (average 1999-2003) thousands	-1.0		

THE PRODUCTION

Gross domestic product in 2004 (Kr billion)	2 542.9	Gross fixed capital formation in 2004 Per cent of GDP	15.9
GDP per head, US\$	38 609	Per head, US\$	6 155
		Employment	
		Total civilian, thousands, 2004	4 214
		Per cent of total, 2003	
		Agriculture, forestry, fishing	2.1
		Industry	22.7
		Other	75.2

THE GOVERNMENT

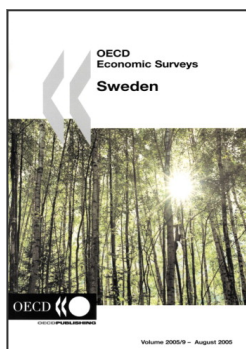
Per cent of GDP in 2004:		Composition of Parliament	Number of seats
Public consumption	27.8	Social democrats	144
General government current revenue	58.2	Moderates	55
Public gross fixed capital formation	2.8	Liberals	48
		Christian democrats	33
		Left	30
		Centre	22
		Greens	17
		Total	349
		Last general election: September 2002	
		Next general election: September 2006	

THE FOREIGN TRADE

Exports of goods and services, 2004 (per cent of GDP)	46.2	Imports of goods and services, 2004 (per cent of GDP)	38.2
Main merchandise exports (per cent of total), 2003		Main merchandise imports (per cent of total), 2003	
Forestry products	13.3	Forestry products	3.4
Mineral products	9.4	Mineral products	8.4
Chemical products	12.0	Chemical products	11.0
Energy products	3.2	Energy products	9.4
Engineering products	51.6	Engineering products	43.9
Other products	10.5	Other products	23.9

THE CURRENCY

Monetary unit: Krona		Currency units per US\$, average of daily figures:	
		Year 2004	7.35
		April 2005	7.08



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