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Sickness benefits and absenteeism-
A comparative study of Sweden and Great Britain

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Contents

Summary

Sweden has one of Europe's highest sickness absence rates and Great Britain one of the lowest. The Swedish sickness absence has fluctuated very much over the last decades, while the British rate is fairly stable. The thesis aims to cover the major aspects in society that can affect the sickness absence. The factors are divided into three groups; institutional, labour market related and structural. Through statistics and researches, the impact each factor has is discussed and examined. The emphasis is on the legal systems for obtaining benefits and the shape of employment protection in the countries. Possible effects of making alterations to the system are analysed, partly through glancing at the historical development of the absence rates. Some of the key factors to the differences are the higher number of females and elderly in employment in Sweden and the normative structures of the labour markets.

Preface

Suddenly I found myself in a small West Kensington flat with an old laptop and an interesting idea. Would I be able to make it? This thesis has been a challenge in many ways. After four years of studies in my hometown with the library of Lund University and the faculty of law a comfortable five minutes from my flat, it wasn't easy to my way in the huge city of London. It has not been simple, it has not been comfortable, but it has been a great experience. What finally made it all come together was my interest in the subject. Sickness benefits are always present in the current debate and a political hot question. This is law when it is close to the people as an everyday part of life. To incorporate comparative aspects to a subject with one foot in each country has been exceptionally rewarding. I got to see up close how British labour law in general and sickness insurance in particular works in reality and found that working in Britain, or at least London, is very different from working in Sweden. To be able to work with a sole subject of interest for an entire semester has developed my sense of law in societal context. Rather than working with a legal text, I have been able to explore how law cooperates with society and how the two shape one another.

Thanks to supervisor Ann Numhauser- Henning for letting me run loose and being there when I needed to. Thanks to Scott Barrie for being a great manager and letting this thesis be a priority. Thanks to Christian for convincing me to leave solid ground and last but not least thanks to London, my new home, may you keep treating me well.

Abbreviations

AFL	Lag (1962:381) om allmän försäkring
AML	Arbetsmiljölagen (1977:1160)
CEA	Contracts of Employment Act 1963
Chap.	Chapter
CLS	Community Legal Service
DAI	Disability Alliance Information and advice
DDA	Disability Discrimination Act 1996
DSS	Department of Social Security
DWP	Department for Work and Pensions
EAT	Employment Appeal Tribunal
LAS	Lagen om Anställningsskydd (1982:80)
LFS	Labour Force Survey
NI	National Insurance
NIB	National Insurance Board
OOT	Own Occupation Test
p.	Page
PCA	Personal Capability Test
Sec.	Section
SBU	Statens Beredning för Medicinsk utvärdering
SHI	Social Health Insurance
SIO	Social Insurance Office
SjLL	Lag (1991:1947) om Sjuklön
SSCBA	Social Security Contributions and Benefits Act 1992
SSP	Statutory Sick Pay
QD	Qualifying Days

1 Introduction

Which strange disease has made the Swedes the sickest people in Europe? Is there something in the meatballs? Do we catch it at IKEA? Or is it simply the bug of convenience that gives us the highest average ratings of sickness absenteeism in the European Union. The Brits are certainly a healthy people though. Despite the draughty houses, the fish and chips and the constant rain, they manage to be amongst the healthiest people in Europe.

The countries have very similar economic structure and developmental levels. The actual general public health does not differ very much. What do differ though are the sickness benefits systems and the legal employment protection. Would a stricter system cut the enormous expenses? Unfortunately, the answer is not that simple. There are countless of possible explanations to why Sweden has an average of 4,2 percent sickness absenteeism between the years 1983-2004 compared to Britain's 2,0.[1] There are structural differences, including rates of employment among elderly and women and there are differences in the use of employment contracts and in the employment protection. All of these factors are extremely hard to separate from each other. This is why, from the start, I realised that my master thesis will not provide any clear answers. The aim is to learn, compare, analyse and speculate. I hope the reader will find it as interesting as I have.

I focus on the benefit systems and employment protection, but other factors in society are allowed the necessary space. If the law makers shall be able to shape a well-functioning system, it is necessary to analyse why the current one doesn't work satisfactory. For this, a wide sociological perspective is essential, and I've tried to reflect that process in my thesis.

[1] RFV, *Sjukfrånvaron I Sverige I ett europeiskt perspektiv, 1983-2004,*

Following a short section on method and terminology, I commence my thesis by a brief description of the development of European health insurances in general. Hopefully, this will help the reader in understanding the normative thoughts behind the contemporary systems. The actual study is initiated in chapter five by a presentation of the absenteeism statistics that are the foundation for my conclusions and comparisons. I've tried to remain quite critical in my view of the statistics, and to consider all factors that I can imagine have affected the numbers. Chapter six is a description of the material legal rules in the Swedish and the British benefit systems. Regarding the Swedish system, I focus especially on the new system of co-financing, which the government hopes will reduce Sweden's sickness absence rates. The rules are compared and the most substantial differences are highlighted. In chapter seven, labour market- related factors such as employment protection are discussed. Chapter eight presents demographical factors and is followed by other explanation factors in chapter nine. Finally, I summarize the study and attempt to suggest areas where future changes could be successful.

"Work for those who can and security for those who cannot"[2]

British labour Government's key philosophy for welfare reform

[2] DSS, *A new contract for Welfare: Principles into practice*, p. 1.

2 Method

2.1 Sources

Before relocating to London, I tried to find some key books to use as foundation for my thesis. The literature overview published by The Swedish Council on Technology Assessment in Health Care, *Sjukskrivning- orsaker, konsekvenser och praxis*, was extremely useful as an introduction and a key to finding relevant studies. For a historical and more conceptual perspective on the sickness insurance, I found Saltman et al, *Social health insurance in Western Europe*, especially interesting. For the specific British perspective, Harris' *Social security law in context* was brilliant. When in London, I found myself without an internet connection for months. This made it complicated and expensive to reach information through the web, which probably made me use traditional, more reliable, sources more than I otherwise would have. However, for the presentation of the benefit system and statistics, it was essential to find updated information, which was only reachable through the internet. The statistics are mainly gathered from the homepage of the Swedish National Insurance Board, but it was very nicely presented up until 2003 in Bergendoff and Skogman Thoursie, *Utblick Europa: Är Sverige unikt?*, from 2004. Even towards the end I still found it difficult to interpret the different boards on the homepages with gathered statistics and resorted to the national statistics homepages instead. To lower the absenteeism rates is a very pressing goal for the Swedish government, considering the vast costs for insurances every year. This has resulted in several very helpful studies, often with comparative elements, made on behalf of the state

2.2 Terminology

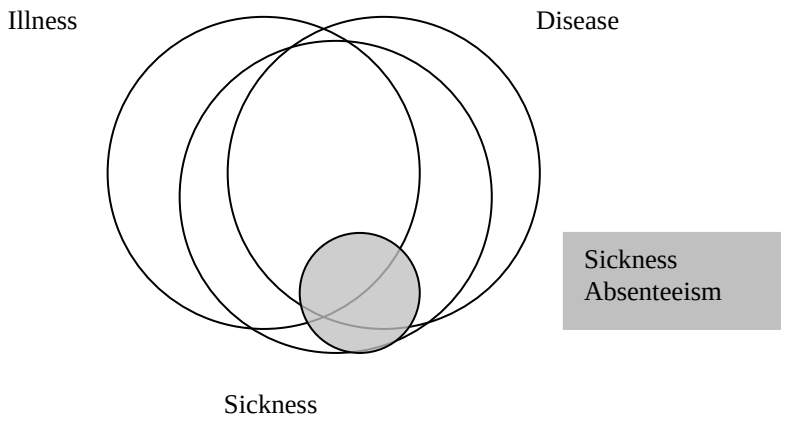
Since most of my sources are written in Swedish, some terms have been hard to translate. Again, also for this part, the internet has been a very useful tool. I've tried to consequently use the English translation, occasionally with the Swedish term in parenthesis.

What is a sickness? According to an old Swedish preparation work from 1944, it is explained as what according to normal use of language and common medical opinion is considered a sickness. It is added that with this terminology, a sickness is an abnormal state of body or mind that is not a part of the path of normal life.[3] The term sickness has later been widened in court practice. Today, extreme sadness and tiredness can be considered sicknesses.[4]

Some distinctions can be made regarding the concept of being unhealthy. *Illness* is the state of ill health that the individual experiences; the self- reported ill health. *Disease* is the medical part of the ill health. When an illness is diagnosed and medically recognized, it's a disease. *Sickness* is the social dimension of ill health. It represents the role that an ill person takes or is given in the interaction with the society surrounding him or her. This role is different in different cultures and over time and includes both certain rights as well as certain obligations. A person can be ill without having a disease.[5] It is also possible to have a disease without being ill, for example if you're not aware of the disease or you don't suffer from it. A person can also be given or take on a sick role without having neither a disease nor an illness, however this should be quite unusual. The figure below illustrates the relationship between the terms in relation to sickness absenteeism.[6]

[3] SOU 1944:15, *Utredning och förslag angående lag om allmän försäkring,* p. 162
[4] SOU 2000:72, *Sjukförsäkringen – basfakta och möjligheter,* p. 22.
[5] SBU, *Sjukskrivning- orsaker, konsekvenser och praxis,* p. 31.
[6] The illustration used is copied from SBU, *Sjukskrivning- orsaker, konsekvenser och praxis*, p. 31.

Figure 1. The relation between the terms of ill health and sickness absence.



Another difference that is worth to keep in mind, especially considering the British benefit system, is that between disability and incapacity. Disability is most often considered a loss or reduction of ability to function, whereas incapacity is the loss of capacity to work that springs from the disability.[7] A disability can according to this interpretation be everything from a cold to blindness or wheelchair dependency. The term disability has a different definition, which is more close to the common use of the word, in the British Disability Discrimination Act. According to this regulation, a disability is "a physical or mental impairment which has a substantial and long term adverse affect on the person's ability to carry out normal day activities".

2.3 Limitations

I limit the study and the discussion to employees, since rules for the self-employed are different in many aspects. A self employed can, for example, in Sweden chose a number of waiting days between 3 and 30 and is not covered by the British statutory sick pay.

It was necessary to leave the question of how much compensation might be added to the statutory by collective agreements and individual

[7] Harris, *Social security law in context*, p. 365.

contractual agreements as well as private insurances. However, this limitation makes a comparison problematic, which will be pointed out several times.

The statistics included spans from 1987 to 2004. It would create a bigger picture to include older statistics. This would have been possible, but I reckoned that since our way of life and the perception of the insurance changes over time, it would be more relevant to focus on the last 30 years.

Another limitation is the one regarding other cooperating systems. The former disability pension (now called long- term sickness benefit/ sickness compensation) in Sweden is very closely tied to sickness absence. Depending on how difficult it is to be pensioned, the absence rates vary. However it is complicated to compare countries if the aim is to get a complete picture of all the systems that might affect one another, and I felt that the line had to be drawn somewhere.

I've also refrained from widely discussing changes over time in the British system. Since the absenteeism in Britain is fairly stable, such a presentation would not help the conclusions significantly.

3 The Development of Health insurance in Europe

In 1883, Germany created the first codification of social health insurance (SHI). Up to that time, all health insurances were voluntary and non-legalised. This does not in any respect mean that they were not well founded. The SHI and the solidarity thought it's based on has evolved ever since the Middle Ages. The first insurances developed in small groups of craftsmen in the middle ages and the occupation was for very long the central core of the social insurance model in German speaking countries and Sweden.[8]

Bismarck's legislation of 1883 emerged from a concern that the Marxist-influenced labour unions would get to powerful. Many west-European countries (Austria, Denmark, Belgium, Switzerland, and United Kingdom) swiftly followed. The process continued after the wars and by 1945, most European countries had some sort of legal health insurance. The coverage was expanded to include all workers, being compulsory, between 1945 and 1996. Both Sweden and the UK had more than 90 percent coverage by 1960.[9] The Southern European countries developed the insurance later than northern Europe due to the late industrial revolution, but the coverage level rose quickly.

The next step in the process towards today's insurance was the creation of a fully tax- based system.[10] In most countries this ignited reservations. It was feared that the bureaucracy would damage the social solidarity model than had been developing for centuries.[11] Today, the normative trend towards emphasizing the individual rather than the collective citizenship might challenge the SHI and it's concept of solidarity.

[8] Saltman et al, *Social health insurance in Western Europe*, 2004, pp. 21-22.
[9] Saltman et al, *Social health insurance in Western Europe*, 2004, p. 25, figure 2.1.
[10] This was done in Sweden 1970 and in The UK 1946. Saltman et al, *Social health insurance in Western Europe*, 2004, p. 26, Table 2.1.
[11] Saltman et al, *Social health insurance in Western Europe*, 2004, p. 26.

When people turn to private insurance, many of the key features of the social insurance, such as universalism, will be lost.

4 General principles in health insurance

The sickness insurance is a social insurance, meaning that it is an individual insurance that is obligatory and is provided by the state, rather than an insurance company.

The SHI systems might be remarkably different between countries, but it has some very basic characteristics that are common to all. The contributions are fixed or based on a person's wages and never connected to the contributor's health state. Most countries have a 100 per cent coverage of the population, and when the coverage is less it's the high-income earners that are, voluntarily or mandatory, to seek commercial health insurance instead. National economical literature provides two arguments as to why the sickness insurance should be obligatory. The first is to avoid the problem of "free riders". Most people might join a voluntary insurance, but there would always be the persons that, for different reasons, would not. If such an individual fell ill, it would be extremely hard for society to deny that person healthcare and benefits. The second argument is that of asymmetrical information. The individual generally has better knowledge of his or her health state than the insurance company. A voluntary insurance would result in high- risk individuals joining and low- risk individual staying outside the system. This, in it's turn, would lead to higher premiums and even fewer low- risk individuals joining.[12] The members of the insurance system would be a negative selection, an excess of people with high health risks, which would eventually cause the system to break down.

Why are the sickness insurances run by the state? First of all, the social insurances aim not just to compensate an income loss, but are also a form of income distribution. If the insurances were private, individual aspects that might be considered discriminatory, would probably weigh in.

[12] SBU, *Sjukskrivning- orsaker, konsekvenser och praxis,* p. 29.

If privately run, there would also be a problem of information- sharing. The competing companies would not be able to know if individuals had already claimed benefits from other companies.

When evaluating how generous a sickness benefit system is, it is easy to start with the level of compensation. Normally, the compensation varies over time, and during the waiting days, the compensation level is zero. A typical system profile is that no compensation is paid out during the waiting days up until day a. Thereafter, a compensation of x percent is obtained between day a-c, provided a medical certificate is presented on day b. After day c, the replacement level is somewhat lowered to y per cent until day d, when the person no longer can obtain any benefits. [13] As we will see, the British system does not fit very well in to this standard pattern.

Henreksen et al (1989) borrow two terms, fault no. 1 and fault no. 2, from statistical theory, and apply them to the risks with sickness insurance systems. Fault no. 1 means that a hypothesis is disregarded, even though it is true. If a hypothesis that is false is accepted, fault no. 2 is made. A method with less risk of fault no. 1 automatically results in a higher risk of fault no. 2, and the other way around. There are two extreme types of insured people, healthy people that exploit the system, and the people that are genuinely sick. The insurance can be restrictive, which would hit hard against both types. “Cheaters” would be forced to go to work, but so would the genuinely sick persons and fault no. 1 would thereby be committed. If, instead, the system is generous, the genuinely sick would get the compensation they deserve, but it would be easier and more lucrative to exploit the system. As Henreksen et al. put it “Fault no. 1 is to starve the sick and fault no. 2 is to feed the cheaters”. The authors also draw a parallel to a trial, when the judge is forced to choose between the two types of faults. Fault no. 1 is to judge an innocent, while fault no. 2 is to free a guilty. Fault no. 1 is in every civilized legal system in this case much more serious than

[13] Henrekson et al, *Bruk och missbruk av sjukförsäkringen*, pp. 23-24.

fault no. 2, which results in demands for high levels of proof. It is not as easy to determine which fault is more serious in the case of sickness insurances, and therefore systems are very differently shaped. [14]

4.1 Social insurance models

There are three different types of models for the ideal welfare state. The Social-democratic model is exemplified by the Scandinavian countries. Benefits are universal and compensations rather high, while the contribution from the insured are low. The second regime is the Liberal model, where only modest income loss is compensated. This model can be said to exist in the Anglo-Saxon countries. In this model a high level of means- testing is applied. The last model in this theory is the corporatist model in Continental- Europe. This model means a limited coverage with high replacement levels.[15] The theory of the welfare state models, originally presented by Gösta Esping- Andersen in 1990[16] were tested by Kangas in 1991 through cluster analysis. Kangas found some, but not very strong support for the theory.[17]

Initially it is essential to point out that Sweden and UK actually built their systems on two different socio-political models. The British system is based on a Basic protection model (flat- rate model), which means that all citizens have a protection with relatively low, not income related compensation. Another model is the cooperative model, used in Germany and France. The cooperative model is completely based on income- related programs that apply to different categories of professions. In Sweden and the rest of Scandinavia a combination of these two models, the standard protection model, is used.

[14] The entire way of reason is strongly inspired by Henrekson et al, *Bruk och missbruk av sjukförsäkringen*, pp. 71-78.
[15] Kangas, *The politics of social rights*, p. 93.
[16] Models presented in Esping- Andersen, *the Three worlds of Welfare Capitalism.*
[17] Kangas, *The politics of social rights*, pp. 93-102.

5 Sickness absenteeism

5.1 Problems with comparations between countries

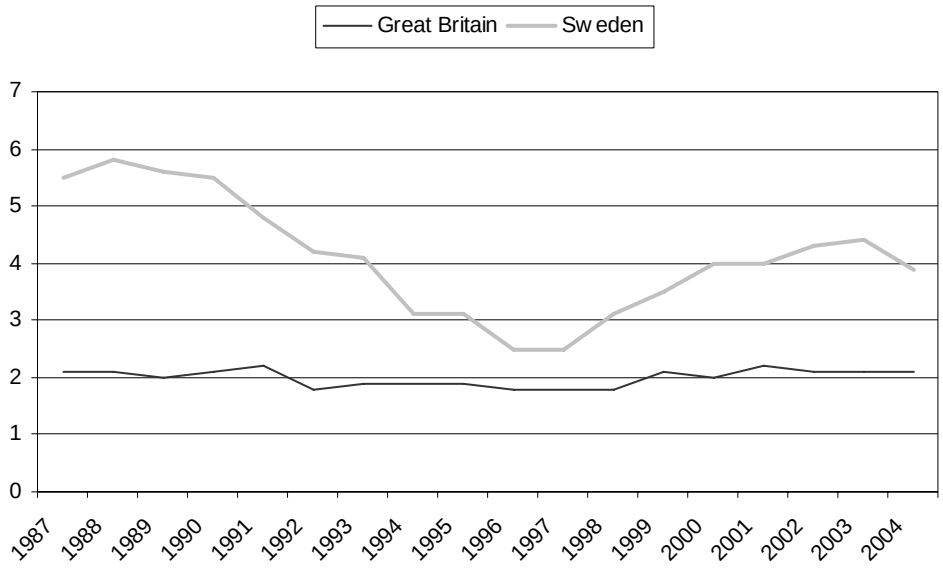
There are always some built-in problems with comparing different countries. First of all, to find data that is in reality comparable might be difficult. The data is often gathered in different ways and the definition of central terms can differ. Second, the systems are different between countries. The conditions for compensation vary and the burden of compensation is placed in different ways. Third, the economical structure in the countries can affect the analysis. A country with mainly agricultural or industrial workers has a higher frequency of work related illnesses and accidents than a country that's highly developed in terms of technology et cetera. Fourth, and last, other significant systems complicate the interpretation of the data. As an example, if the benefits are taxable in one country but not in another, the actual level of compensation might be hard to present. [18] The problem of data- gathering and terminology is insignificant in this comparison, since the statistics in that study is based on the countries own labour force surveys, where sickness absence is defined in the same way. The fact that the systems differ regarding conditions, cost burden and duration among other things, and that this influence the figures, is in fact what this thesis aims to investigate and therefore a desirable source of error. The economical structure is very similar in Sweden and Britain and this problem can be disregarded. When it comes to influences from other systems, such as the tax system, it is extremely hard to cover in this type of study, but the problem is good to bear in mind.

[18] Ds 2002:49, *Den svenska sjukan – sjukfrånvaron I åtta länder,* pp. 12-13.

5.2 A first glace at the statistics

The statistics in this chapter is based on Sweden's and Great Britain's labour force surveys (LFS) for which the gathering of data has been as identical as possible. Labour force surveys are conducted through interviews with a representative selection of the population and compiled by EUROSTAT since 1983. Included is every employed person between the ages 16-64. Self employed and unemployed are excluded. People on disability benefits (earlier sick pension) are included if they are partially employed. The results are based on the formal reason for absence, that is, how the absence is financed. If the sickness absence is financed through other means than benefits, for example through flexible hours, it is not included in the data. Only full time absence that lasts an entire week is included and there is no information as to the duration of the absence. Absence that last shorter than five days is not included. This poses a problem when analyzing the figures since one of the focal points in the system's differences is the waiting days. Since Sweden only have one waiting day while UK has three, the absence shorter than five days is very relevant. A person that's sick for tree days get two days compensation in Sweden but none in Britain. Despite this, the differences are striking and are likely to be even greater if the short- time absenteeism was included.

Graph 1, Sickness absenteeism (%) among employed between 1987 and 2004.



Between the years 1987 and 2004, the sickness absence has fluctuated a lot more in Sweden than in the UK. The lowest value for Sweden is 2.5 per cent in 1996 and the lowest value for the UK is 1.7 in 1997 and 1998. Sweden's highest value is 5.7 in 1988 while the highest value in the UK is 2.3 in 1991. The Swedish average between the years is 4.1 compared to UK, which has an average of 2.0 per cent. The difference between the highest and the lowest value is in Sweden 3.2, while the corresponding value in the UK is just 0.6.

After seeing the huge differences, it is highly relevant to highlight some important changes in the Swedish benefit system during the investigated period. Between 1987 and February 1991, the compensation level was 90 per cent of the income plus 10 per cent from collective agreements during the entire sickness period. In March 1991, the compensation was radically lowered to 65 + 10 per cent the first tree days and 80+ 10 between day 4 and 90. From the graph above, it is easy to see that the sickness rates sank radically (0.8 per cent) from 1990 to 1991. The sick pay was introduced in January 1992 and period of 14 days was low in an international comparison. In April 1993, further contractions were made. The waiting day was introduced and the compensation level after day 90 was lowered to 80 percent. In January 1996, the compensation levels were generally lowered to

75 per cent. The sickness rates kept decreasing. The period of sick pay from the employer was prolonged to 28 days in January 1997, just to be lowered to 14 days again in April 1998. Up until 1998, when the levels were raised by 5 per cent, the compensation levels were pretty much stable. July 2003 brought a lowered level of compensation, 77.6 percent and added 7 sick pay days. In January 2005, the system of co- financing was introduced.[19] In relation to this, the compensation levels again became 80 percent and the period of sick pay 14 days. The rapid increase of absence between 1998 and 2003 was in 2004 turned to a decrease that is expected to last for some more years.[20]

Other relevant changes are that in October 1995, new stricter rules for decision making and evaluations were introduced. In January 1997, the medical requirements were elevated and in January 2002, the extended evaluation of the right to benefit ceased to be. In July 2003, it was decided that the sickness compensation for unemployed shall never be higher than the highest possible unemployment compensation.

Table 1. Changes in compensation levels 1987-2003. Compensation in percent of income.[21]

Day in Sick spell	87-Feb. 91	March-dec 91	Jan 92- March 93	Apr- June 93	July 93- Dec 95	Jan.-dec. 96	Jan.-dec. 97	Jan.-march 98	April 98	July 03	Jan 05
1	90+ 10	65+ 10	75	0	0	0	0	0	0	0	0
2-3	90+ 10	65+ 10	75	75	75	75	75	80	80	80	80
4-14	90+ 10	80+ 10	90	90	90	75	75	80	80	80	80
15-28	90+ 10	80+ 10	80+ 10	80+ 10	80+ 10	75+ 10	75	80	80+ 10	80/77.6+ 10*	80+ 10
29-90	90+ 10	80+ 10	80+ 10	80+ 10	80+ 10	75+ 10	75+ 10	80+10	80+10	77.6+10	80+ 10
91-365	90+ 10	90+ 10	90	80	80	75	75	80+10	80+10	77.6+10	80+ 10
366-	90+ 10	90+ 10	90	80	70	75	75	80+10	80+10	77.6+10	80+ 10

*80+ 10 day 15-21, 76.6+ 10 day 22-28.

[19] All of the statistics and information on this page is collected from RFV redovisar, *Sjukfrånvaron i Sverige i et europeiskt perspektiv, 1983-2004* and Ds 2002:49.
[20] RFV redovisar, *Sjukfrånvaron i Sverige i et europeiskt perspektiv 1983-2004*, p. 2.
[21] Lindwall et al, *utvecklingen av sjukfrånvaron I Sverige*, p. 177.

5.3 Explanatory factors to the differences

To explain the differences in sickness absenteeism between countries, literature and studies provides three main groups of explanation factors. The first group is institutional explanations based on the "access" factor. If the systems are liberal and easy to access combined with high compensation levels, it functions as a work disincentive and stimulates absenteeism. These explanations will be presented and discussed in chapter 6. When studies aren't based on individual factor, but for example institutional, it is in general possible to find correlations but it's very hard to detirmine the direction of causality.

Another group of explanation factors, which will be presented in chapter 7, is connected to the labour market. The studies focusing on this are divided into two contending lines. According to one view, fear of dismissal for either personal or labour market related reasons, makes the individual work more, regardless of the actual health state. The other view implicates that when unemployment is high, and termination of employment is easy, numerous individuals suffer from negative health consequences, and absenteeism is higher. This view suggests that, since it is harder to find work in a tough environment, an unhealthy individual is more likely to stay on sickness benefits. This is also a better financial option than being on unemployment benefits.[22]

The last group of explanation factors are structural, that is, connected to demographical and structural factors such as the age of the population, the gender of the work force and differences in participation rates. These kinds of explanations can be construed as "needs" and will be discussed in chapter 8.

[22] Kangas, *The politics of social rights,* pp. 109-111.

6 Access explination factors

6.1 The Swedish benefit system

6.1.1 Basic principles

The basic principles of the right to Sickness benefit are regulated in the 3rd chapter 7 § in the National Insurance Act (Lag (1962:381) om allmän försäkring, AFL). The benefit is granted when the insured person's capacity to work is diminished with at least one quarter. Depending on how much the capacity is diminished, the benefit can be paid in full, in tree quarters, in half or in one quarter. The incapacity is judged solely on medical criterion and the decision should not be affected by conditions of the labour market, economical or social conditions. This limitation reflects that problems that aren't a consequence of the sickness shouldn't be solved with the funds that are provided for sickness benefits, since that would give a misrepresentative image of the state's costs.[23]

If the insured isn't able to return to his or her normal position, other positions with the employer should primarily be considered. If there are no other possible positions, or if another position would require to extensive rehabilitation efforts from the employer, the insured's ability to work should be tested in respect of the labour market in general. The Insured lacks the right to benefits if there is a common occupation on the labour market that he or she is able to conduct. The right to sickness benefits is re-evaluated continuously.

6.1.2 Replacement Levels

If the Insured is covered by the rules in the Law on sick pay from the employer (Lag (1991:1047) om sjuklön, SjLL), the employer pays for the first 14 days of absenteeism. Sick pay was introduced in 1992 to extend the

[23] Prop. 1996/97:28, *Kriterier för rätt till ersättning I form av sjukpenning och förtidspension*, pp. 9-10.

employer's responsibilities for the employee's health. The period of sick pay has fluctuated between 14 and 28 days and the compensation level is the same as the sickness cash benefit; 80 per cent of the income. In connection with the introduction of co-financing, the period of sick pay was shortened to 14 days from 21 to compensate the employer somewhat for the new expenses.

The Swedish system includes one waiting day, which means that the first day of illness is unpaid. Thereafter, the insured is entitled to 80 per cent of his or her income base for sickness cash benefit as stated in 3rd chapter 2 c and 4 §§ AFL. The income base for sickness benefit is calculated on the expected earnings during the year to come. This often results in a higher calculated income than the actual real income.[24] There is an upper limit, an "income roof", for the compensation. If the insured earns more than 7.5 base amount[25], he or she will not be compensated for the excess, according to AFL 8th Chap. 5 §. In 1999 12.5 per cent of the Swedish men and 7.2 per cent of the women had incomes that exceeded the roof of 7.5 base amounts. There are two ways to calculate the sickness benefit, either as a calendar day calculated benefit or as an hourly-/day calculated befit. The calendar day method means that 80 per cent of the SGI is divided by 365. This type of benefit is paid from the fifteenth day in a sick period. The hourly and day based benefit is 80 per cent of the SGI divided by the normal amount of working hours or working days per annum. If a person is not covered by sick pay during the initial 14 days, for example if he or she is unemployed or self-employed, they can get paid according to the calendar day method if. The method is also used if the insured otherwise would have obtained parental benefits, pregnancy benefits or rehabilitation benefit. For all other cases, the person who does not get sick pay is compensated according to the hour- or day calculation method.

Most workers in Sweden are covered by collective agreements that give them additional protection against income loss. These kinds of

[24] Christensen, *Social Security Law*, p. 142.
[25] The base amount for 2005 is 39 400 sek.

compensations are considered as sick pay. Besides collective agreements, many employers and unions offer group- or sometimes individual sickness insurances. Compensation from the individual private insurances will not reduce the sickness benefit.

6.1.3 Long- term Sickness Compensation

After a longer period of illness, the sickness cash benefit is usually transferred into a long- term benefit at a lower compensation level called sickness compensation. There is no set time for when this conversion is to take place. The average time with sickness cash benefit before converted into sickness compensation was in 2002 two years and one month. The sickness compensation is financed through employer's fees. If the worker has a minimum of one year's normal income, he or she is entitled to an income- related compensation. The compensation level is 64 percent of the salary up to a earnings roof of 7.5 base amounts per year. The compensation is often higher due to additional agreements. If the person in question lacks the one year's pension funding income, or has a very low income- related compensation, he or she will obtain a guarantee level compensation instead. The guarantee level is 2.4 base amounts (AFL 9th chap. 8 §) and is a benefit based on residence rather than work.

6.1.4 Waiting days

Today, the Swedish system includes one waiting day. The number of waiting days has changed over time. From 1955, Sweden had three waiting days, which were shortened to one in 1967. In 1987, the waiting day was removed altogether, but was brought back in 1993. The waiting days can be considered as a kind of excess. Because there is always a moral hazard involved in insurances, the waiting days are working as a buffer to avoid exploitation of the system. The idea of waiting days can be compared to the excess in private insurances. The excess is there as an incitement for the individual to avoid damage. If full compensation was reachable, a person would generally be less careful. Regarding sickness insurances, a person can

to some extent affect his or her health state by choosing their way of living, but the waiting days are not likely to have any effect on these choices.

Waiting days are a form of discrimination between different illnesses. The short- term illnesses are not compensated in the same way as the longer sick sprees. In a way, this can be considered fair since the short- term illnesses are harder to predict and therefore pose a bigger threat to productivity. But generally, it is the long- term sicknesses that create a real financial problem for society.

Waiting days have been known to elevate the long term absenteeism. This phenomenon can be explained in different ways. Perhaps a person who has been ill during the waiting day/-s, feel that the income loss suffered justifies another sick day or two. Another explanation might be that people rather stay at home until they are completely healthy to avoid another sick spree and thereby another waiting day/-s.

6.1.5 Qualifing conditions and duration

There is no qualification period before a person is covered by the insurance, unlike the British system. The employee is normally covered by the right to sick pay from the first day of employment. If the time of employment is planned in consent to be less than one month, the employee must have been employed for fourteen days, before he or she is covered (SjLL 3 §).

Sickness cash benefits are based on work and it is not necessary for the person to live in the country according to the Social Insurance Act (socialförsäkringslagen (1999:700)) 3rd Chap. 1 §. A person registered with the Social Insurance Office (SIO) has the right to receive sickness cash benefit if he or she has an income on which to base sickness benefit (sjukpenningsgrundande inkomst, SGI) of at least 24 per cent of the base amount, according to AFL 3rd chap. 1 §. The illness must be reported to the SIO from the first day of absence. The guarantee level (2.4 base amounts) of sickness compensation and activity compensation is based on residence, which means that it is required that the claimant lives in Sweden. To obtain the income- related level (64 percent of the income), the claimant has to work in Sweden.

There is no upper limit to how long one can receive sickness cash benefit. The SIO shall, according to AFL 16th chapter 1 §, investigate whether there are possibilities to convert the sickness cash benefit into sickness compensation or activity compensation. A rehabilitation benefit, which is paid with the same amount as the sickness cash benefit, is rewarded after a sickness period if a person takes part in vocational training.

6.1.6 Administration

When the insured falls ill, he or she should present a written assurance to the Social Insurance Office (SIO) containing information about the disease, a description of the insured's work tasks and his or hers personal judgement of the ability to work (AFL 3rd chap. 8 §). This information is passed on under a truth pledge, and to give wrongful information is punishable under the Criminal Act (BrB) 15th chapter 10 §.

Typically, the SIO comes in contact with the insured after 15 days of illness, when the period of sick pay is over. A medical statement is required from the seventh day after the illness is first reported (AFL 2nd Chap. 8 § sec. 2). The insured's ability to work is to be judged by the SIO according to a step-by-step model. In the first step, it is decided weather the sick person could perform his or her normal work after some treatment and absence.

The second step is to examine if the insured can continue with the normal tasks after a period of rehabilitation or modification of the tasks. Sickness benefits can be paid during the period the measures are taken, up to a normal maximum of three months.

Step three is used if it is clear that the insured isn't able to return to the normal work tasks and means deciding weather it is possible for the insured to perform other tasks with the employer without extra efforts from the employer. The ability to work is at this stage judged in respect to the possible position. The sickness benefit can be paid during necessary treatment and absence, but not while waiting for the other position to be available. If it isn't possible to provide another position without efforts from the employer, step four is to decide if another position can be filled after

some education or rehabilitation. The time limit for benefits during the rehabilitation is around one year.

When the possibilities with the current employer are emptied, the ability to work should be tested against the labour market in step five and six. If the insured is able to perform another common job, he or she is to be judged as able, even if that job isn't available to him or her at that moment in time. In step five it's decided whether the other job could be performed without extra efforts and step six is after some education or rehabilitation. In the seventh and last step, the SIO should consider if the incapacity will last for at least a year or is permanent. If so, the benefit should be changed into sickness compensation or activity compensation.[26]

The national insurance department should always go through step one to four before getting further in the model. This reflects the responsibility of the employer towards the employee and is in line with the rules in the Employment Protection Act (Lagen (1982:80) om anställningsskydd, LAS,). The employer is not obligated to offer a different temporary position if he is not able to.[27] If the employee is offered a position during the illness and turns it down, he or she is not entitled to sickness benefit. The employer is always obliged to consider the individual employee's personal circumstances and adapt the work environment according to it as stated in the Work Environment Act (Arbetsmiljöllagen (1977:1160), AML). When it comes to the rehabilitation responsibility, it is somewhat unclear how far the obligation stretches and depends on the circumstances in each case.[28]

6.1.7 The New System of Co- financing

Starting from January 2005, the Swedish government introduced a new set of rules for the financing of the sickness insurance. The main change is that the employer is to pay 15 percent of the cost for sicknesses that last longer than the period of sick pay, which is 14 days. This only applies to full- time absenteeism and not whilst rehabilitation compensation is paid. Before the

[26] These benefits have replaced the former disability pension.
[27] Prop. 1994/95:147, *Rätten till förtidspension och sjukpenning samt folkpension för gifta,* p. 47.
[28] Prop. 1990/91:141, *Om rehabilitering och rehabiliteringsersättning,* p. 52.

introduction of co-financing, the period of sick-pay was 21 days and the shortening was, together with lowered employer's fees, a compensation for the new costs. Employees that fall under a special high- risk protection, that is have a sickness that that during a twelve month period include a risk of one ore more longer sick sprees or are donators of biological material, are not covered by the co- financing system.[29] There is also a possibility for employers to protect themselves from some of the cost by joining sick-pay insurance. This replaced the previous legal high- cost protection that was problematic from a community point of view according to the EC-commission and therefore approved only on a temporary basis. [30]

If the sickness has no connection with the workplace, this kind of regulation is not likely to have a great effect. Possibly, the employer might take preventive measures such as to contribute financially or give employees time off to exercise, but the regulations are mainly intended to get the employer to prevent or shorten workplace related sickness.

The cost of sickness insurance can be carried either by the employee, the employer or the government. However, the party that formally pays for the insurance however, is not always the side that in reality carry the cost. In the end, it's likely that the employee bears the burden through taxes or lowered salary. Thee distribution choice is, according to Henrekson et al[31], more a question of technique to influence ways of thinking. It affects the behaviour of the labour- market parties and is indirectly of importance to productivity and salary development. The recent privatisation is a step away from the traditional base for a social insurance. When the cost is divided between all workers, they, and not the employer, carry the risk for sicknesses, which is the principal argument against co- financing.

[29] Law on Sick Pay from the employer (SjLL) 13-16 §§.
[30] Ds 2004:16 *Drivkrafter för minskad sjukfrånvaro,* p. 84. The provision was reported to the commision under art. 88.3 of the treaty. The article obliges the member states to report certain kinds of govornemental financial support.
[31] Henrekson et al, *Bruk och missbruk av sjukförsäkringen,* p. 89.

Palmer (2005) lists four possible measures that might be taken by the employer to lower the cost of the co- financing.[32] Two of them are positive consequences of the regulation and two of them are unwanted.

First, the employer could focus more on the absent employees and try to get them back to work as soon as possible. It's enough for the employer to get the absent back on a part- time basis to avoid the cost of co-financing. This creates a risk of prolonged part- time absenteeism, since the employer might not prioritise that group.

Second, the employer might increase preventive measures to avoid healthy staff from becoming ill. Third, a negative consequence might be that the employer makes an effort to get rid of employees that are considered a problem health wise, for example overweight or mentally fragile persons. This is a short- time effect that would result in further marginalization of already weak groups.

Last, but not least, the employer might become more careful and selective when expanding the workforce, which is quite dangerous for a society of high unemployment and rigid employment protection structure. With the new regulation, it becomes increasingly important to the employer to identify persons that poses a risk health wise when recruiting. This may hit hard against women and older people, since they statistically are sicker than others. It is also worth mentioning that the Netherlands have used the system of co- financing for some time now, and the proved effect is that employers tend to refuse persons with health risks and the sickness rates have not decreased at all.[33]

The actual result is at this stage impossible to see, but the privatization means that some people with an established work position are likely get a better deal than the persons that are trying to access the labour market.

[32] Palmer, *Sjukskrivning och förtidspension de närmaste åren,* pp. 31-34.
[33] Palmer, *Sjukskrivning och förtidspension de närmaste åren,* p. 34.

6.2 The British Sickness Benefit System

6.2.1 Basic Principles

In a case of illness or disability, which is not caused by an accident at work, there are in Britain two different forms of benefits. One is paid by the employer and is called Statutory Sick Pay (SSP). The SSP was introduced in 1983, but the duration was then only eight weeks.[34] Since 1986, the SSP can be paid for a maximum of 28 weeks. Normally there's three waiting days before any benefit can be claimed. Accordingly, the illness must have lasted for at least four days in a row including weekends and bank holidays. However, if the sickness lasts at least 4 days in a row and is followed by another sick period of at least four days with less than eight weeks between them, the second period will not contain any waiting days. This is called linking periods.

There is a lower earnings limit for claiming SSP. On average, the claimant must have earned at least £ 82 a week. The average is calculated over the last eight weeks before the illness.

The SSP is paid daily for the days the claimant would normally work, the Qualifying Days (QD). The standard rate is £ 68.20[35] per week, regardless of how much one earns. The employer can demand a medical certificate after seven days of illness.

The Other benefit form is the incapacity benefit, which replaced the former sickness and invalidity benefits in 1995. The main provisions are found in the Social Security Contributions and Benefits Act 1992 (SSCBA). The benefit is paid by the government and commences when the SSP ends, or after three days illness if there is no entitlement to SSP at all. Normally, to claim incapacity benefit, one should have paid national insurance contributions and been sick for at least four days in a row. However, there are special rules for young people. If the claimant is between the age 16 to

[34] Harris, *Social security law in context*, p. 368.
[35] Statutory Sick Pay (Rate of Payment) Regulations 1990 sec. 2 (1) (a).

20 (or 25 if he or she has been in education or training for at least three months before the age of 20) and has suffered at least 28 weeks of incapacity which started before the age of 20 (alterably 25), benefit can still be claimed.

6.2.2 Replacement levels

The SSP is fixed to a flat- rate, £ 68.20 a week, with no additions due to age or dependants. There are three levels of income loss compensation by incapacity benefit. The lowest rate is £57.65 a week and is called the short-term incapacity benefit. This rate is paid if one does not get SSP and have been sick at least four days in a row, alterably gets benefit based on the special rules for young people. The rate can be somewhat higher if the claimant has dependants, either adults or children (SSCBA sec. 86 A(1)). If the illness has lasted between 28 and 52 weeks, the appropriate rate is the short- term benefit at a higher rate, which is £ 68.20 a week.[36] If covered by the young people's rules, one must have been getting the short term lower rate for at least 28 weeks. The highest level, £ 76.45 a week, is the long-term incapacity benefit. This is the British equivalent to the Swedish sickness compensation. It is paid to people who have been sick for more than 52 weeks and young people who have been getting incapacity benefits for 52 weeks. This rate can be raised, not only due to dependants, but also according to age. If the illness can be classified as terminal, the long- term rate will be paid as soon as after 28 weeks. There is regarding pensions, since 1999, an upper earnings limit for the incapacity benefit. If the claimant receives £ 85 or more a week as occupational or personal pension, 50 per cent of the excess income is deducted from the incapacity benefit.

6.2.3 Waiting days

The British system contains three waiting days (SSCBA sec. 31(4)), as opposed to Sweden's one. Again, a remainder of the fact that the waiting days often are abolished through collective agreements or contracts is in

[36] If the claimant is over state pension age, the short-term lower rate is 73.35 and the higher rate 76.45.

place. The reinstatement of the Swedish waiting day in 1993 had a substantial effect on the sick- rates, and it is plausible that the number of people staying home two to three days is much greater in Sweden than in Britain. As stated before, the statistics unfortunately does not cover this. In a short term perspective the absenteeism should be higher the lower the number of waiting days. The direct economic incitement on day two probably makes a semi- sick Swede stay at home, whist the Brit goes to work and decreases absenteeism. If the hypothesis is that an equally ill person in Sweden stays at home three days (whereof two are compensated) and the same person in Britain stays home only one day, the Swede ought to be more rested and healthier. The possibility that the Swede falls ill again, perhaps for a longer period, should logically be smaller than for the Brit, and therefore a small number of waiting days should lower the absenteeism in a long term perspective.

6.2.4 Qualifing conditions and duration

To get statutory sick pay, the claimant's contribution record is irrelevant and there is no means- testing. Employees with short- term contracts or low earnings are excluded from the SSP. If these individuals have an adequate contribution record, they will instead receive the lower rate of the short-term incapacity benefit. To qualify for incapacity benefit, one must have paid contributions to the national insurance during at least one (two?) of the most recent tax years. Prior to 1999, any one tax year would do, but the government wanted to make the entitlement to incapacity benefit based on recent work and contributions. The NI contributions are automatically deducted from the wages.

When comparing the Swedish and British system it is often said that the Swedish lacks an upper time limit, while the British has an upper time limit of 52 weeks. This is true, if you don't regard the British long- term incapacity benefit, which is obtained after 52 weeks, as a compensation for sickness. There is no upper time limit as to receiving this, as long as the person is incapable of work according to the "all-work" test. As stated

above, under sec. 6.1.3., the Swedish sickness benefit is converted into sickness compensation after an average of 2 years. The difference is that this does not happen automatically, and in some cases, might not happen at all. The sickness compensation is lower than the sickness benefit, whilst the long- term incapacity benefit is higher than the short- term. The qualifying conditions are the same; the person in question shall not be able to conduct any type of work on the labour market. Mainly, the sickness compensation and the long- term incapacity benefit both lack upper time limits and are comparable.

6.2.5 Administration

For a long time, the concept of incapacity was very vaguely defined in English law. The administrators were forced to turn to whether it was reasonable to expect that a person with the same age, education and health as the claimant was working. This was changed when the sickness and disability benefits were substituted by the incapacity benefit in 1995. There are now two tests for incapacity. The Own Occupation Test (OOC) is the first one and the applying individual must pass this in order to get compensation during the initial 28 weeks of the sick spell. The OOC assesses the claimant's ability to carry his or her own usual work (SSCBA sec.171 B (1-3)) and is based on medical certificates and sometimes examinations by a doctor associated by the Department for Work and Pensions (DWP).

When 28 weeks has gone by, the person will have to pass a Personal Capability Assessment (PCA) according to SSCBA sec. 171 C (1-3). This test was before the 1999 reform called the "all- work test", a term which is still widely used, and assesses the ability to conduct any type of work. [37] The PCA measures the capacity to perform certain pre- specified physical and mental functions and is also used for other types of benefits that are based on incapacity to work. Even if a person does not get enough points on the PCA, he or she can still be considered incapable of work if special circumstances apply (SSCBA sec.171 D (1)). The PCA was introduced to

[37] DAI, *Claiming Disability benefits,* p. 20.

make the evaluation more objective, but experts consider the PCA to be less claimant- friendly than the formerly used test of reasonableness.[38]

6.3 A Comparation of the systems.

Table 2. Compensation rules for sickness benefits

	UK	Sweden
Duration	52 weeks.	No upper time limit
Compensation level	£ 57.65-76.45 per week. Taxable.	80 % of the income. Taxable.
Waiting days	3 days	1 day for employed
Medical Certificate	From day 7	From day 7
Sick pay	28 weeks (for salary that exceeds £ 72 per week)	14 days+ co-financing
Part-time absence	No	Yes
Benefits Taxable	All but short- term IB	Yes

It is important to remember that this comparison is only between the legal insurance systems, and that to what extent private insurances are used is not weighed in. Neither is it considered that additional insurances consist as benefits provided by many employers.

The most common illnesses such as small colds, headaches and mild food poisoning do not last longer than a couple of days. This is also the kind of illness cases when it might be possible to work anyway. Staying home sick is a day- to- day decision and if a person feel almost healthy after a day at home, the likelihood that he or she attend work the following day is far much greater if they know that they won't get paid if you don't. This should mean that the shorter sick spells are very much dependant on the number of waiting days. However, these shorter spells are not included in the statistics presented below in chapter 6.1. This means that the differences in sickness

[38] Harris, *Social security law in context*, p. 366.

rates due to the differences in number of waiting days are not included, and therefore the actual differences in sickness rates ought to be even greater.

The insurance is a national responsibility and is administrated by a national insurance board in both countries. The alternative would be council administration, which is practised is Denmark, or administration by the labour market parties, as in Germany and France. In The Netherlands, the main part of the system is privatized.[39] In both Sweden and Britain, there is a part of private funding in the system, through the sick pay paid by the employer. The period of Sick pay is 28 weeks in Britain, compared to 14 days in Sweden. However, since the introduction of the system of co-financing, the Swedish employer has an extended reasonability without time limit to pay part of the benefits.

The Swedish system is based on income, whilst the British has a fixed, rather low, compensation rate. £ 57.65 - 76.45 should be compared with the minimum wage, which is around £ 200 per week before tax reduction. While a Swedish person gets 80 per cent of the average blue collar salary, a British person only gets 17 per cent.[40] Again, I want to point out that most British workers get further compensation through collective agreements and contract with employers. It's almost impossible to survive on the legal British sickness benefit, while with the Swedish, the daily financial loss from being sick is not as harsh.

Sweden is the only European country that does not have an upper time limit for sickness benefits. How much does this affect the sickness rates? When it comes to long term illness the sickness absence is often converted to sickness compensation and therefore not shown in the statistics. The British limit of 52 weeks actually only refers to the short- term incapacity benefit.

[39] Ds 2003:63, *Den Svenska sjukan II- regelverk och försäkringsmedicinska bedömningar i åtta länder*, p. 45.
[40] Ds 2003:63, *Den Svenska sjukan II- regelverk och försäkringsmedicinska bedömningar i åtta länder*, p. 51.

When 52 weeks has passed, the long term incapacity benefit that lacks upper limit, takes over (provided the PCA test is passed). The difference in upper limit is, from what I can see, in reality not as significant.

There are many psychological factors that complicate the return to work after a long period of absence. What has changed at the workplace? Do the colleagues still respect me? Will I be able to handle my tasks? Have I forgotten too much? Am I still needed? These are some of the questions that the long term sick struggles with. To conquer that resistance, it is essential that the transition is made as easy and lucrative as possible.

6.4 Studies of the correlation between economic incentives and absenteeism

Naturally, most of the studies in the field of correlation between economic incentives and absenteeism are conducted in the field of economy rather than law. However, from a legal point of view, it's essential to know in what way and to which extent the laws affect people's behaviour. In this, we can be grateful for the economists' work that allows us to draw conclusions and analyse rather than working with the actual data. I've chosen three quite extensive studies that all show a connection between economic incitements and absence from work.

The oldest study is from 1979 and is conducted by N. A. Doherty.[41] The study aims to "examine whether the variations in sickness absence can be explained by economic variables"[42] Doherty studied insurance data from the year 1954 up to 1969. Results showed that "the relative generosity of National Insurance benefits had some effect on the level of certified incapacity for work".[43] Doherty also concludes that job security influences decisions about sickness absence to the same degree that the economical incentives.

[41] Doherthy, *National Insurance and Absence from work.*
[42] Doherthy, *National Insurance and Absence from work,* p. 50.
[43] Doherthy, *National Insurance and Absence from work.* p. 63.

The second study I've chosen to lean on is published in 1996 and conducted by Johansson and Palme by using Swedish micro data.[44] The study is limited to blue- collar workers and includes nearly 2000 persons. The central conclusion is that the group of men show a negative effect on work absence corresponding to the cost of being absent, but the group of females do not.

Henrekson and Persson of Stockholm University carried out the last study I'd like to mention in 2003. [45] The authors used time- series data for Sweden spanning between 1955 and 1999 and concluded that the changes in compensation levels over the years have directly influenced the sickness absence rates. They also prove that this effect is stronger among women than men, which contradicts Palme's results.

To investigate abuse of the sickness benefit, in 1984, Bjurulf, Törnevik and Eeg- Olofsson, looked at the sickness reports over the different days of the week, and how long the sick spell turned out to last depending on which day one fell ill.[46] The study showed that the sickness most often started on a Monday and very rarely on a Saturday and that the Friday very often was the last day with compensation. Despite this, the writers conclusion was that no proof of a wide abuse of the insurance and that the effect shown was a natural consequence of the laws and regulations. Henrekson et al. deepened the study in 1992[47] with the same results and meant that the week- day effect was a clear indication of abuse of the insurance. They also found that a large amount of people tend to go back to work on day six, since a medical certificate is required from day seven.

[44] Johansson, Palme, *Do economic incentives affect work absence?*
[45] Henrekson, Persson, *The effects on Sick Leave of Changes in the Sickness Insurance System.*
[46] Bjurulf et al., *Sjukskrivningsbilden i Östergötland.*
[47] Henrekson et al., *Bruk och missbruk av sjukförsäkringen,* p. 31-44.

7 Labor market related Explanatory factors

7.1 Employment protection

In both Sweden and Britain, there are two types of reasons for dismissal. The first is when the employment is terminated due to organisational reasons. This means that it is external factors, such as productivity or economics that forces the employer to terminate contracts. As we will see, a person's sickness history can rightfully be weighed in when the employer makes the decision of which staff members to dismiss. More rarely used is the second type of dismissal, which is dismissal due to personal reasons. In this case, a person's absence may be considered as a factor only when the absence is without a legitimate reason.

7.1.1 Termination of employment due to organisational resons

7.1.1.1 Sweden

To terminate an employment in Sweden the employer must have a valid reason according to 7 § in the Employment Protection Act (LAS). If the decision is based on lack of work, there must be an actual organisational need and the employer is obliged to try to find another place within the organisation for the employee before terminating the employment. If it's possible for the employer to relocate the employee within his organisation, the dismissal is not based on a due cause. According to 22 § LAS, the most recently hired employee should be the one to leave first, a principle of "last in- first out". This prevents the employer from picking the persons he or she wishes to keep and let the rest leave due to organisational reasons. This rule obviously provides a superficial protection for the persons who have been with the company for a long time to adopt a somewhat more relaxed attitude

to work, while the new employees are forced to make themselves irreplaceable. If the company has less than ten employees, the employer is allowed to pick two key people to be exempt from the priority order.

So far the equation is quite easy, but the concept of "sufficient qualifications" somewhat complicates the process. The law provides that, after the dismissals have been made, the people that are left must be qualified for the tasks that are left. The employee must live up to the minimum requirements posed on a new employee.[48] In an interesting case from the Swedish labour court, (AD 1984 no. 144), an employer stated that some people where unqualified for certain tasks due to bad health. The court found that it was not proved by the employer that the lack of health made the employees unqualified. But ill health can in certain cases make a person unqualified. In AD 1977 no. 64, the labour court decided that a sales manager had become unqualified for his work due to a heart condition. The concept of "sufficient qualifications" is a way to "sneak" in personal aspects in the dismissal decision, where, clearly, health aspects and thereby possibly indirectly sickness absence can be considered as a due reason for making a certain person redundant.

7.1.1.2 Great Britain

When a British employer is about to make some staff redundant, he or she must be as fair as possible in how many people they dismiss and how these people are chosen. The selection criteria must be objective and can include factors such as disciplinary records, attendance, job efficiency, timekeeping and the period of employment with the employer. The employer is also obliged to offer employees alternative positions if it is possible. If 20 employees or more are made redundant within a 90- day period, the employer must consult trade unions that represent the workforce or chosen representatives within the workforce. The period of consultation should be at least 30 days, if the employer wants to make 20- 99 persons redundant and 90 days if 100 or more are to be dismissed. [49]

[48] Iseskog, *Uppsägning vid arbetsbrist,* p. 51.

[49] CLS, *Employment- your rights at work,* pp. 9-10.

7.1.2 Termination of employment due to personal reasons

7.1.2.1 Sweden

If an employer wishes to terminate a contract due to personal reasons, it must not be based solely on circumstances that was known to the employer two months before the dismissal, according to 7 § LAS. This rule is rather flexible since it does not apply if there are substantial reasons for the delay. The concept of valid reason could in this aspect be divided into three parts; *misconduct, consciousness* and *damage.*[50] Every violation against the employment contract is considered misconduct. The employer carries the burden of proof and has to present actual events or an actual situation that constitutes misconduct. The employee must be able to understand that he or she has done something wrongful. The employer should have made it clear, if it is not obvious, that the behavior is intolerable. The misconduct must be of relevance to the employer, that is, it must be damaging to the employer in some way. Not only does this mean direct financial damage, but can also include constant tardiness et cetera. As well as with redundancy, the employer must relocate the employee within the organisation if it is possible, but in this case, it is only required if it can be rightfully asked by the employer.

A sick person has an enhanced employment protection. If the misconduct is due to illness, the rules are somewhat different than above stated. The special protection is applicable to all illnesses, regardless of if they are connected to the workplace or not. In reality, the most common case is alcoholism, which is considered an illness in many cases. Just being sick is of course not a valid reason for dismissal. But if the sickness leads to misconduct, such as low performance and illegitimate absence, it can constitute an indirect dismissal reason. A rule has been formed in case law which means that if the sick person misconducts to such a degree that he or she is no longer capable of conducting any work of significance, there is a valid reason for dismissal. Persons suffering from illnesses that are not

[50] Iseskog, *Uppsägning av personliga skäl*, p. 85.

addictions are not very likely to misconduct. Their absence will mainly be legitimate and reported. The enhanced protection is connected with the employer's rehabilitation responsibility. This responsibility consists of making an evaluation to understand the sick person's needs and thereafter adopt the workplace and the work tasks accordingly. If the employer has completed all the rehabilitation responsibilities satisfactory, and the problem still exists, the enhanced protection has basically been used. At this point, the employer can apply the "valid reason" concept that has been explained above.[51]

7.1.2.2 Great Britain

An employee has the right not to be dismissed *unfairly*, according to the Employment Rights Act (1996) section 94(1). To be covered by the provision, the employee must have been employed during two years. Even if this is not the case, a claim can be brought if the dismissal is due to union activities, health and safety questions, pregnancy or practice of statutory rights (s.108 (3)). The employer must show that the reasons for dismissal were fair. Fair reasons, according to s. 98 (2) can be

(a) related to the capability or qualifications of the employee for performing work of the kind which he was employed by the employer to do, or

(b) related to the conduct of the employee, or

(c) was that the employee was redundant, or

(d) *Was that the employee could not continue to work in the position which he held without contravention of a duty or restriction imposed by or under an enactment*.

If neither of these apply, the dismissal might still be unfair, if it is due to some other substantial reason (s.98 (1)(b)). Such a reason can be unacceptable periods of absence because of illness. In *Wharfedale Loudspeakers Ltd. V. Poynton 1993*, the complainant was dismissed after long periods of absence due to genuine illness after three warnings. The EAT held the dismissal as fair due to "some other substantial reason".

[51] Iseskog, *Att vara anställd*, p. 110.

If any of the reasons in s. 98(2) are at hand, the dismissal is prima facie fair, and goes through the test of reasonableness in s.98 (4). Without going further into the test of fairness, it can be noted that a dismissal due to capability related to ill health can be considered fair if the employee is permanently unfit for work, and the employer has conducted a thorough investigation.[52]

7.1.3 Notice periods

Maybe it can be considered far- fetched to claim that notice periods can be relevant to a person's sickness absenteeism behavior. They are however quite different in length between the countries, and interesting in the larger concept of employment protection. A person employed for 10 years is entitled to 6 months notice in Sweden, compared to 10 weeks in Britain. In both Sweden and Great Britain, the notice period is often regulated in collective or other agreements. The Swedish statutory notice period varies between one and six months, depending on the length of employment.

Table 3. Swedish notice periods.

Employed	Notice	Employed	Notice
0-2 years	1 month	6-8 years	4 months
2-4 years	2 months	8-10 years	5 months
4-6 years	3 months	10-	6 months

In Great Britain, According to section 86 of Contract of Employment Act (1963), the statutory minimum notice period when the employer terminates the contract is one week between the second month and the second year of employment. After two years, the number of weeks of notice augments with one per year up to 12 years employment. If the employment relationship has lasted longer than twelve years, the minimum notice period is 12 weeks. If the employee terminates the contract the notice period is one week if the contract has lasted more than one month (CEA s. 1(2)). The notice periods applies to part- time workers in both countries. If the contract is silent regarding notice period, there is an implied term under the British common

[52] Harrison, *Employment law*, p. 315.

law that the notice shall be reasonable, which in many cases mean exceeding the statutory minimum.[53] The employee can of course waive his or her right to notice or accept financial compensation instead in both Sweden and Britain.

7.1.4 Conclutions regarding employment protection

It is quite interesting to see that, in Sweden, a person's illness is allowed to be considered as a factor when it comes to redundancy, due to the concept of sufficient qualifications, but not as a personal reason in general. In Great Britain, a person's sickness record is allowed as a factor when it comes to both redundancy dismissals and dismissals for personal reasons. Discrimination laws works as a hinder when the individual in question has an illness that qualifies, but hardly regarding weak health in general. In my opinion, the flexible British labour market reasonably plays a big role in keeping the absence rates down. This has also been proved in a number of studies, for example the earlier mentioned study by Doherty.[54] Even if the Brits formally are quite protected, it is a matter of the traditional view that market economy is more important than the individual's protection. Regarding job security, Great Britain and Sweden can be considered as two opposite poles in the normative spectra, where Britain stands for market-economy and flexibility while Sweden represents the protection of the individual.

7.2 Discrimination laws

Both Sweden and Great Britain have laws that provide a protection against discrimination due to disability. The classical example of disability is being depending on a wheelchair, but in fact, a disability might also be illnesses such as permanent back pain or age dementia. The laws are both in line with EC legislation in the area of discrimination and cover direct and indirect discrimination in the areas of recruitment, promotion, employment conditions, benefits and dismissal. The Swedish law, Prohibition of

[53] Harrison, *Employment law*, p. 260.
[54] Doherty, *National insurance and absence from work.*

Discrimination in Working Life of People with Disability Act (Lag (1999:132) om förbud mot diskriminering i arbetslivet på grund av funktionshinder), is from 1999 and the British, the Disability Discrimination Act, is from 1995.

Both regulations also stipulate that the employer has a responsibility to carry out adaptations in the work environment to meet the needs of the employed. The definitions of disability are simular, but have distinctive differences. In the Swedish law, a disability is a *durable* physical or psychological *limitation* of a person's *ability to function*. The disability can spring from an accident or a decease that occurred from birth, thereafter or is predicted to occur.[55] To be covered by the British legislation, one has to have an impairment that has *substantial* and *long term* effect on the ability to *carry out normal activities*.[56] The Swedish definition doesn't refer to normal activities, but instead to the ability to function. The scope is rather limited when it comes to "normal" deceases, but several long term illnesses can actually pose a disability.

7.3 Unemployment and business activity

The latest year's decrease in absence coincides with an increase of unemployment, which follows the historical pattern. A decline in business activity can affect the absenteeism in several ways. The research on this matter is not unified. Support has been found that high unemployment lowers the short- term absence but increases the long- term.[57] Other studies show that the absence gets higher when unemployment does.[58] In theory if unemployment is high, the absenteeism should be lower. However, the advantage will depend on the impact the job has on a person outside work, socially and economically.[59] That people are less absent in a weak economy is, in theory, due to a pro-cyclic effect and it springs from two factors. First,

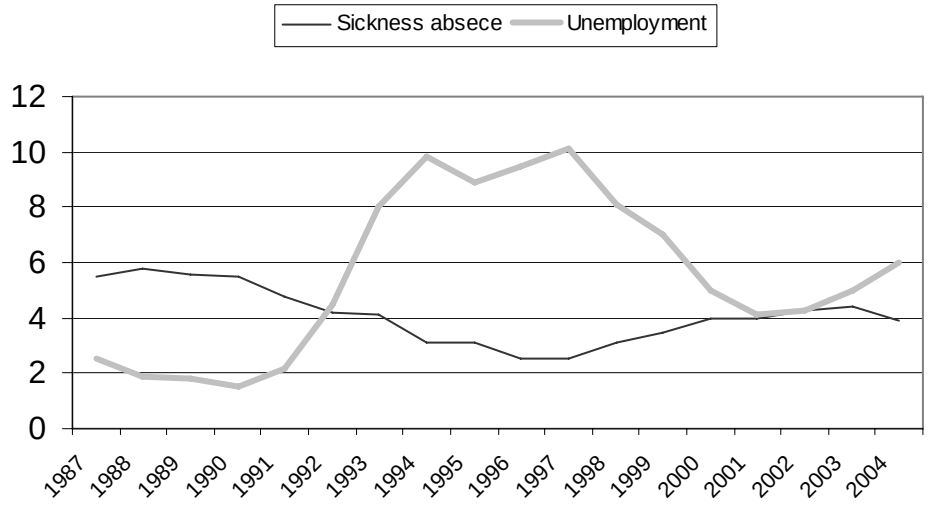
[55] Lag (1999:132) om förbud mot diskriminering I arbetslivet på grund av funktionshinder, 2 §.
[56] Disability Discrimination Act (1995) section 1 (1).
[57] Lindwall, Skogman Thoursie, *Sjukfrånvaro och förtidspension.*
[58] Kangas, *The politics of social rights*, p. 119.
[59] Bellaby P, *Sick f*rom work, p. 185.

unemployment has a disciplinary effect. The higher the risk is to loose employment, the more you try to keep it. Second, high unemployment has a selective effect. When the employers are able to select amongst a set of workers, they tend to keep or employ the ones that are less sick. Another argument is that work in itself can be dangerous, and unemployment actually improves health. The unemployed may also be less likely to report sick, since unemployment benefits are paid out anyway.

There are also many theoretical arguments why absenteeism should rise with rising unemployment. First of all, unemployment itself is considered a health danger. For the unemployed, illness can be an effect of the stress, isolation and discomforts that being without occupation creates. For the ones that are occupied, high unemployment brings anxiety of loosing the job. Another argument is that the employer is less reluctant to absenteeism in low conjuncture, and that the employee is more likely to call in sick when it will not affect colleagues and the employer as much as if unemployment was low. Also, when business activity is high, the work intensity is often higher, which might be stimulating to many people, and thereby make the individual healthier.

In Sweden, there's a clear correlation between unemployment and sickness absenteeism. When unemployment is high, the sickness absenteeism is low and vice versa. This correlation is quite unique and does not exist in Great Britain or most other European countries. It is very hard to explain why there's a clear connection in Sweden but not elsewhere, but the conclusion has to be that at this point in time, it's not possible to use unemployment as a valid explanation factor for sickness absenteeism since the pattern is different between the countries. The graph below illustrates the relationship between unemployment and sickness absenteeism in Sweden over the last decades. It shows that high unemployment rates often correlates to lower sicknes absence rates and the other way around.

Graph 2. Sickness absence (%) among employed and unemployment (%) among work force in Sweden 1987-2004. [60]



I wish to briefly compare the unemployment benefits in Sweden and Britain, since they can affect the sickness rates. When the conditions between two systems are different, it affects how many individuals that use each system.

Table 4. Conditions for Unemployment benefit in Sweden and Great Britain.

Country	Work Qualification	Duration	Compensation level
Sweden	6 months within one year.	300 days. For persons over 57; 450 days. Could be extended to 600 days.	Basic protection: 270 SEK per day Income- related: 80 percent up to 680 SEK per day the first 100 days.
Great Britain	None. National Insurance fees must have been paid.	Fee- related part: 6 months. Need-related part (based on total incomes in family): no limit.	£ 31.95- 53.05 per week depending on age.

As seen in the table above, the British unemployment benefit is lower in compensation and generally shorter in duration than the Swedish. No conclusions about the sickness rates can be drawn from this. In both countries, Sickness compensation is higher than unemployment compensation. If the compensation level was higher for unemployment than sickness, one could expect individuals to cling to unemployment rather than

[60] RFV redovisar, *Sjukfrånvaron i Sverige i ett europeiskt perspektiv 1983-2004,* p. 5.

sickness benefits. The same could be expected if the system was easier to access. However, there are no such differences that could explain the differences in sickness rates. Also, unemployment is lower in Great Britain than in Sweden, which means that if the sickness rates and the unemployment rates are added, even greater differences appear between the number of persons in the labour market and the people outside.

8 Demographical explanation factors, “Needs”.

In Ds 2002:49, a study by the expert group for studies of public economy (ESO) was presented. The study was based on the labour force surveys and a multivariable analytical factor was used to establish how one factor influences sickness rates after other factors have been taken into account. The analysis showed that a high rate of female and elderly workers will increase the sickness rates. It also showed that people on temporary contracts are less absent than those with permanent contracts. Since Sweden has more women and elderly in the workforce, this could be an explanation factor to some of the differences in sickness rates. However, the study decides through regression analysis, that the differences in absenteeism between countries would not be much smaller if the structural factors were exactly the same.

In Ds 2003:63, the ESO results are taken a step further to see exactly how much of the difference would be eliminated if the workforce structure in Sweden was the same as in Denmark, Finland, France, Great Britain and Germany together. It comes to show that 8.9 percent of the differences in 2000 are explained by the workforce structure.[61] This means that sickness absenteeism would be 0.4 percent lower if structural differences are taken into account. From this it is possible to conclude that the age and gender of the workers and the contract type play a rather modest role in the matter of absence ratings. Even so, I’d like to discuss the different structural factors and in what way they affect the ratings.

[61] DS 2003:63, *Den svenska sjukan II,* p. 31-32.

8.1 Age of the workers

The older a person gets, the more likely he or she is to be absent from work due to illness. Therefore, it is important to compare the age of each country's population and to what extent the different age groups are a part of the workforce. In 2000, 23 per cent of the Swedish and 21 per cent of the British population was between the ages 50-59 years. In both countries, around 8 percent was older than 60 but younger than 64 years old. How many of these elderly people are still working in each country? In 2000, 77 per cent of the men between 50 and 59 were working in the UK while 82 percent worked in Sweden. In the age group 60-64, around 50 percent of the men were active in both countries. When it comes to the women, the differences are clearer. Between 50 and 59, 64 percent were working in UK, compared to 80 per cent in Sweden. Among the women between 60 and 64, 25 per cent were working in the UK compared to 43 in Sweden. The big differences between British men and women in the oldest group are explained by the fact that the age for retirement for women is 60 and for men officially 65.

Table 5. Percent of older population who are part of the work force 2000.

Age	Swedish women	British women	Swedish men	British men
50-59	80	64	82	77
60-64	43	25	49	47

As we can see, the Swedish labour force is significantly older than the British. The table also shows that older women in Sweden engage in labour to a greater extent than the British.

8.2 Gender structures

Statistics show that in Sweden, women in the public sector are disproportionably absent due to sickness.[62] Actually, if only the male population is compared, the absence rates are only slightly higher in Sweden

[62] Palmer, *Sjukskrivning och förtidspension de närmaste åren*, p. 19.

than in Britain.[63] An explanation could be that a perception of woman as the keeper of the household and the man as the income source still exists in society. When studying how economic incitements affect the absence rates, it is the actual economic loss that is interesting and one explanation to why women are absent more is simply that their loss is smaller.[64] A popular explanation is that since the woman has to work both in the household and in the workplace, as opposed to the man that does not help out at home, a woman is more likely to be overwhelmed by the volume of work and this in its turn results in sickness absence.[65] The differences are most significant in the groups between 25 and 39 years, that is in the ages when people are most likely to have children. This is explained mainly by sickness absences during pregnancy.

Table 6. The number of sick days with compensation per insured person in Sweden during 2002.

Age group	Women	Men	Quota W/M
16-19	0.6	0.4	1.50
20-24	7.3	4.3	1.70
25-29	15.3	7.0	2.19
30-34	23.0	10.0	2.30
35-39	28.3	13.4	2.11
40-44	31.7	16.5	1.92
45-49	34.7	19.3	1.80
50-54	39.6	23.2	1.71
55-59	45.2	28.9	1.56
60-64	42.4	31.1	1.36
All	27.1	15.3	1.77

The fact that the gender differences are much greater in Sweden than in Britain is much due to the higher percentage of females in work in Sweden. The probability for participation from women with weak health augments with the number of women in work.[66]

In the labour force statistics, the people that are part- time absent are not shown, but considered as working. Sweden is the only country where it's possible to be absent only on part- time. Since the people that are part –

[63] Palmer, *Sjukskrivning och förtidspension de närmaste åren,* p. 26.
[64] Palmer, *Sjukskrivning och förtidspension de närmaste åren,* p. 27.
[65] Palmer, *Sjukskrivningen i Sverige- en inledande översikt,* p. 46.
[66] RFV redovisar, *Sjukfrånvaron i Sverige i ett europeiskt perspektiv 1983-2004,* p. 7.

time absent are considered as working in the statistics, it means that the absence rates in reality are higher than shown.

Women in Sweden are absent during longer periods than men and have been so since 1983. Palmer shows that, when part- time absence is considered as true absenteeism, it can explain some of the differences in absence duration. People that are part- time absent tend to be absent during longer periods than the people that are full- time absent, and since women are more part- time absent than men, that explains some of the extreme differences in long- term absenteeism between men and women.[67] Of course, in the labour force statistics, this can not be used as an explination since only full- time absenteeism is shown.

Another aspect is the different branch structures in the countries. Generally, absence among women is higher in healthcare than other sectors. The number of women employed in healthcare is much higher in Sweden than in Great Britain (33.6 percent compared to 21.5 percent). Men are more absent if they work in the industry sector than other sectors. [68]

8.3 Contract type

People who are employed on temporary contracts in Sweden are less likely to be absent due to illness than people with permanent contracts. This is a logical effect of temporary workers trying to get a permanent position. Another reason for lower absenteeism could be that temporary contracts are used more often when unemployment is high since the workers rather accept a temporary contract than nothing at all. As previously mentioned, when unemployment is high, the Swedish absenteeism tends to be lower. Studies show that a higher number of temporary contracts only lower absence in Sweden but not in Britain.[69] Even though a temporary contract will motivate a person to work harder, it may also be a source of anxiety and insecurity which might lead to a sickness caused by psychological stress. A more far-fetched reason for illness is that people on temporary contracts earn less and

[67] Palmer, *Sjukskrivning och förtidspension de närmaste åren,* p. 25.
[68] RFV redovisar, *Sjukfrånvaron i Sverige i ett europeiskt perspektiv 1983-2004,* p. 11.
[69] RFV redovisar, *Sjukfrånvaron i Sverige i et europeiskt perspektiv 1983-2004,* p. 11.

limited finances leads to a more unhealthy living. It seems that the factors even out each other in Britain, but not in Sweden. In Sweden, the absence among employees on temporary contracts was 56 percent lower than for employee's on permanent contracts.[70] Temporary contracts are getting more and more common in both Sweden and UK, but there is a huge difference in the usage of them, especially among young people.

Table 7. The percentage of workers employed under temporary contracts in 2000 divided into different age groups.[71]

	20-29 years	30-59 years	60-64 years
Sweden	28.5	9.4	7.9
UK	8.6	5.2	7.9

While discussing the effect of types of employment, it is important to not forget about the part- time workers. In Sweden this type of workers are more likely to be absent due to illness, but in the UK the situation is opposite.[72] The absence among part- time workers was 25 percent higher for women and 27 percent higher for men in Sweden during the years 2000-2004.[73] Since most of the part- time workers are women and women are more likely to be absent, one could expect that this group is more absent. But then again, if most part- time workers are hoping for a full- time employment, the effects could even out each other. In any case, this can not be used to explain the differences between Sweden and UK, since the effect of part-time contracts goes is opposite directions in the countries.

[70] RFV redovisar, *Sjukfrånvaron i Sverige i et europeiskt perspektiv 1983-2004,* p. 2.
[71] Bergendoff et al, *Svensk sjukfrånvaro i ett europeiskt perspektiv,* p. 123.
[72] Bergendoff et al, *Svensk sjukfrånvaro i ett europeiskt perspektiv*, p. 83.
[73] RFV redovisar, *Sjukfrånvaron i Sverige i et europeiskt perspektiv 1983-2004,* p. 9.

9 Other Explanatory factors

9.1 The public health and Work environment

When it comes to the five basic health indicators, smoking, alcohol consumption, obesity, average life length and remaining life length after 65, the Swedes are very healthy. Neither are there any significant differences in the health care systems that could explain the rate differences.[74]

The health that people in Sweden claim to experience is fairly stable between the years 1980- 2000. It is interesting to notice that the differences in experienced health between age groups have been diminished. Older men experience better health and younger women somewhat worse. [75]

In the beginning of the 90's, Sweden developed a very extensive legal protection against insufficient work environments. This, in combination with technical progression should mean that the physical work environment improved significantly. The European Foundation for the Improvement of Living and Working Condition made a survey in 2002[76], which indicated that the psychosocial work environment (high work pace, headache and sleeping disorders) is perceived somewhat worse in Sweden than in other countries. This might account for some of the differences, but is not enough to explain the extent of them. Factors such as leadership and organisation cultures could affect the rates, but I've found no measurements of this.

The work environment could be used to explain part of the absence rates. Increased physical and psychological stress is, of course, a big cause to why people do get sick or not, and in many types of work these stress factors have increased. A typical example is women working within the health services. In addition to this, many of the unqualified jobs are disappearing from the labour market, which could result in people getting sick simply

[74] Marklund et al, *Den höga sjukfrånvaron problem och lösningar,* p. 11.

[75] SOU 2002:62, *Kunskapsläge sjukförsäkringen,* p. 62.

[76] Paoli et al., *Third European survey on working conditions.*

because they are not able to handle the higher demands. Studies conducted by the Swedish National Institute for Working Life (arbetslivsinstitutet) show that sickness that's related to the workplace has increased substantially over the last 10 years.[77] During the 90's, the global market, technology development and cut downs in especially the public sector, has changed the workplaces functioning. Changes include demands for increased flexibility, slimmed organisations and a higher overall age among the labour force.

9.1.1 The Swedish work environment legalisation

The Swedish Work Environment Act (arbetsmiljölagen (1977:1160), AML) basically obliges the employer to provide a good work environment. The employer shall follow regulations and requirements from the Work Environment Board (Arbetsmiljöverket) as well as conduct a systematic control of the work environment. In addition, the employer must take all "technically known and economically possible measures" to prevent illness and accidents. A point very relevant to this study is the employer's responsibility for rehabilitation. In tree cases, the employer is required to conduct an investigation of the possibilities for rehabilitation. When an employee has been ill for more than four weeks, when an employee is ill for the sixth time during the recent twelve- month period and when the employee asks for an evaluation. The evaluation is to be sent to the Social Insurance Office, which, in cooperation with the employer and the employee, establishes a rehabilitation plan.

The law also demands that the employer takes appropriate workplace adoption methods to make it possible for the employee to perform the work or return to it despite the illness.

9.1.2 The British work environment legislation

In Great Britain, legal intervention in the area of health and safety at work has a long history, but was up until 1974 very fragmented. The Health and

[77] Ds 2004:16, *Drivkrafter för minskad sjukfrånvaro,* p. 38.

Safety at Work Act (1974) is accompanied by regulations regarding consultation with employees, management of health and safety and use of work equipment. The Workplace (Health Safety and Welfare) Regulations (1992) cover many aspects such as temperature, ventilation, lightning, facilities and seating. Regulations provide a general duty for the employer to *as far as is reasonably practicable* ensure the health, safety and welfare of the employees.[78] The term *reasonably practicable* is vague and little guidance has been given by the courts as to the interpretation.[79] There is also a common law "duty of care" that consists of a responsibility to take reasonable care to provide a safe workplace.[80]

9.2 Changes in norms

An abstract but present explanation factor is the general public attitude. Some speak of a lowered work moral combined with a laisser- faire attitude among the medicals vouching for the ill, which in combination raises the sick rates. In a Swedish study presented in SOU 2002:62[81] , it's concluded that "something has happened in the cooperation between the individual, the workplace and the medical. Reporting sick has become an increasingly accepted way to handle pressure and strains that people encounter in their life".[82] The social acceptance has probably augmented with the increased number of sickness reports. At this point in time, this is all speculative and there are no studies that prove this change in norms.

9.3 The Gate keeper function

In all insurance system, it's essential to have some form of control function to ensure that the system isn't exploited or abused. One such function is the medical certificate. The British system requires such a proof from the 8th day of a sick spell and the Swedish from the 7th day. Before that, it's enough with the individuals own statement. Other European countries have stricter

[78] Health and Safety Regulations (1974) s. 2(2).
[79] Harrison, *Employment law*, p. 157.
[80] Gayner, *The employment relationship*, p. 51.
[81] Presened in SOU 2002:62, *Kunskapsläge sjukförsäkringen*, The AHA- study.
[82] Translated freely.

demands for certificates. In Finland, a medical certificate is required from the first day and in Germany from the third. In France, medicals that write too many certificates are punished by getting limited financial compensation.[83]

Generally, it is possible to conclude that the higher the level of compensation, the more necessary an effective administration of the insurance becomes. The gate- keeping function the medicals constitute becomes more essential.[84]

The medicals role in the insurance system has been widely discussed. Some diseases are extremely hard to establish and many of the "modern" diseases, such as fibromyalgia and being "burnt out", are not recognised by all medicals. In many cases, the medical certificate will just be a repetition of the symptoms that the insured claims to experience. The system of sickness insurance in general constitutes a reason for the medic to be suspicious. It is unfair that some people are sick and some are not. It is also very unfair that some diseases are easy to spot, while some are fairly obvious.

The former Swedish system allowed a socio- medical perspective, that is, consideration of a person's situation as to finances, education etc. This is no longer allowed, but the tradition might live on to affect the decisions. Great Britain doesn't have any insurance medicals that are employed by the state. Instead, they are all in private practice, which limits their gate-keeping function

In Ds 2003:63[85], a modest study of how the medical gate- keeping function is practiced in different countries is presented. Five fictive cases were presented to doctors and they were to judge whether the person would normally be reported sick or not. According to the study, the British medicals were actually the most generous of all, and would provide certificates for all of the individuals. The British medicals also stated that the likelihood for the individuals to get their illness approved by the system was 72 per cent, whereas the Swedish doctors only appreciated the chances

[83] Bergendoff S, Skogman Thousie, *Utblick Europa: Är Sverige unikt?* p. 18.
[84] Hogstedt et al, *Den höga sjukfrånvaron sanning och konsekvens,* p. 351.
[85] Ds 2003:63, *Den Svenska Sjukan II,* pp. 87-97.

to 58 per cent.[86] It is very hard to draw any conclusions from this small study, but at least the British medicals don't seem to be more restrictive than the Swedish.

In a fresh study by Larsson, Kruse, Palme and Persson, it is shown that Swedish medicals in 90 percent of the cases render a certificate to a person who asks for it, even though the medical consider the person to be healthy. [87]The authours also conclude that the Social Insurance Office rarely question the certificats. The results clearly indicate that that the medicals, as well as the SIO, are not functioning satisfactory as gate- keepers.

[86] Ds 2003:63, *Den Svenska sjukan*, pp. 94-94.
[87] SNS välfärdsråd, *Nio av tio friska som vill ha sjukintyg blir sjukskrivna.*

10 Conclusions

10.1 How extensive is the problem?

During the years 2000-2003, 14 percent of the Swedish population between the ages 20- 64 obtained either sickness cash benefit or sickness compensation. The total costs for this was in 2003 110 milliard Swedish crowns, which represents a 50 percent increase over four years. It is mainly the long- term absenteeism that poses a problem to the government. Historically, the shape of the replacement system has proved to have a substantial impact on the absence rates. The government has focused on motivating the employer to make efforts to prevent illness and aim to get sick people back as soon as possible. The main incitement for this is of course the new system of co- financing and the result from that remains to be evaluated. It is relevant to point out the recent decrease in the absence rates after 2004, but the problem is still substantial and the rates are, compared to most European countries, very high. The decrease is to a high degree due to more people transferring from sickness cash benefit to sickness compensation, which is negative, since that is a more permanent solution and the likelihood of the person retuning into the workforce is very small.

10.2 What can be done?

Would the absence rates be diminished if Sweden were to make changes in the institutional rules, that is, the actual legal benefit system? Let's first take a look at the waiting day. When it was introduced in Sweden in 1993, it had a substantial effect on the sickness absence. There is however no obvious connection between the number of waiting days and the long- term absence. The statistics presented does not include the absence during the first five days, which per se makes it impossible to get to these differences by adding more waiting days. Great Britain has a system with tree waiting days. As

mentioned before, the difference in waiting days ought to make the presented statistics misrepresentative, since the number of people staying at home on day two and three must be quite dissimilar. It would be very interesting to compare these figures, but unfortunately there is no reliable statistics that makes this possible.

What about the replacement levels? It is very hard to draw any conclusions regarding the replacement level, since they in both Sweden and the UK are more formal that real. The labour market parties establish collective agreements, and the market is full of private additional insurances. This provides the individual with choices and benefits that widely exceeds the legal limitations. However, some of the more unqualified professions with low- income earners still lack agreements profitable to the employee. A lowered compensation level would stimulate these people to go back to work. But then we must ask us, is the group of financially weak people with professions that often are a strain on health really the group we want to target? Well, this discussion can only end with an attempt to identify the "cheater", which is an impossible task. To lower the level of the sick pay would inevitably benefit companies with high sickness absence, which would not be considered desirable. Also, the augmenting sickness absenteeism in Sweden after 1999 cannot be explained by the compensation levels, since they had been consistent since 1998.

The income roof has been raised to ensure that the insurance covers more people fully. This is a way of avoiding that the credibility of the system is diminished. To raise or lower the income roof, would not likely affect the absenteeism much, but the higher the income roof, the less private insurances are needed.

Great Britain is known to nurture a very flexible labour market, whilst Sweden is a country that by tradition focuses on the security and welfare of the individual. When it comes to employment protection, it is clear to see that, in general, it is easier to dismiss an unwanted person in Britain than it is in Sweden. However, The Swedish labour market is moving towards more flexibility, and in reality it is very likely that the person is negotiated

out of employment with finances or other agreements. If this, "non- legal" aspect is disregarded, the question that remains is- does fear of dismissal affect the individual's sickness absence behaviour and if the answer is yes, in what way? Personally, I think that the job security, in combination with the traditional normative foundations that it rests on, affect absence behaviour among citizens very much. Even if it was possible to formulate an absolute answer to the questions above, it would be exceptional to make changes in the employment protection just to force down sickness absenteeism.

The Swedish absenteeism is decreasing, but the number of people getting disability benefits or activity compensation is increasing[88], which implies that the decrease is only cosmetic. It is aspects like this that can be hard to trace, but affect the figures considerably.

There is no miracle cure to the problem of sickness absenteeism. To appoint more responsibility to the employer, both financially and by protective laws, seem to create at least a temporary change. Statutory sick pay is paid during a maximum of 28 weeks in Britain, and the new Swedish rules on co-financing could therefore be said to make the systems more alike.

I cannot stop myself from presenting a very non- scientific perception. It seems to me that attitudes towards work are generally different in Great Britain than in Sweden. Maybe it mostly applies to Londoners, but for the Brit, work appears to be more central than to most Swedes. Brits work longer days, associate more with their colleagues after hours and make their job the priority. In Sweden, I find that work to most people is a secondary priority and the family and spare time is the first. This is of course a very wide and bold generalisation, based on my personal perception without any real support. I also think that in Sweden, when the public constantly learn about the high absence rates, it causes a kind of collective justification- if

[88] Försäkringskassans årsredovisning 2004, p. 29. 60 percent of the finished sickness benefit cases during a year are transferred to disability benefit or activity compensation.

everybody else exploit the system, why shouldn't I? In Britain, it is still shameful to be sick and it is not something people discuss in general.

A key factor could be the medicals acceptance and support of symptoms that the insured states to experience. Maybe it would be a good idea to, as in France, limit the number of medical certificates each doctor is allowed to write? Probably not, since that would target sick people as well as "cheaters" randomly. The decision would be more a result of chance, since different doctors would have different quotas left. But maybe that is what we have today? People with illnesses that are hard to recognise will search among medicals until they find one to accept their condition as incapacitating state. The only study I found on this matter implicates that the British medicals are more generous than the Swedish. This is of course connected to the fact that they are not employed by the government and therefore don't have the same gate- keeping function. Such a control is not as needed in Britain as in Sweden, since the compensation levels are very low.

Supplement A

Overview of sickness absence explanatory factors.[89]

factor	Correlation
Institutional factors (access)	
Rules/ organisation -conditions for qualification -replacement levels -duration -administration -other social insurances -taxes -burden placement	The Legal and other rules affect all parties. Other insurances and systems have effects on the use and shape of the sickness benefit system. The placement of the burden influences the way the different actors behave and their attitude towards the system.
Labour market related factors	
Work places -contract type -work environment -leadership	Work environment and leadership affects the employee's level of sickness and their absence. An insecure contract correlates to attitudes and stress levels.
Society -business activity -branch structure	Society affects the employees, the kinds of jobs that are provided, the work environment and the employer's attitudes.
Structural factors (needs)	
Employees -demographics -sickness -attitudes	The employee's actual health state and the population of a country results in different absence rates. Attitudes can be based on culture and history among other things.
Other factors	
Gate keeping -personnel politics in the workplace -medical practice -insurance medicals supervision -insurance organ's practice	The gatekeeper is influenced by for example society, attitudes and politics. It is the gatekeeper that ultimately approves the absence.

[89] The base of the scheme is from Ds 2003:63, *Den svenska sjukan II*, p. 37.

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