Chapter 5

Activating Employers and Medical Professionals

Employers are key players in preventing health problems at work and facilitating a swift return to work for people absent from work due to sickness. This chapter sets out examples of good practice across the OECD to provide an effective combination of responsibilities and supports for employers, including stronger financial incentives to retain workers. It also seeks answers to the question how to provide a balanced policy package so to promote employment of people with health problems or disability through both job retention and new recruitment. Finally it also addresses the key role general practitioners are playing in the early phase of a sickness absence and ways to strengthen the employment orientation of doctors' sick-listing practices.

To raise labour demand for workers with health problems or disability is a major challenge for policy makers. Good incentives to work for those workers and good incentives for public authorities to provide the necessary employment support and enhance these workers' employability will not be enough. Employers are key players too. Employers, together with medical professionals and workers' representatives, are critically positioned to influence the trajectory of workers with health problems before labour market detachment has occurred. However, significant obligations for employers towards people with a chronic illness or disability, together with concerns about the implications in terms of the company's productivity and costs, can act as deterrents to employment.

A key challenge facing policy makers is to implement measures that promote job retention among people with reduced work capacity, but not to the extent that they simultaneously discourages the hiring of new workers with reduced work capacity, a chronic health problem or a disability. A flexible labour market is needed that accommodates the needs of these persons, together with strong responsibilities for employers to offer safe and healthy workplaces and to prevent sickness and work incapacity leading to entry into disability benefits. To this end, medical professionals who assess sickness and work incapacity act as gatekeepers for the benefit system and also need clearer responsibilities and directions.

5.1. Strengthen incentives for employers to keep workers with health problems

For workers with health problems who still hold a job, irrespective of whether they are on sick leave or not, preventative measures at work will help to retain employment and avoid transfers onto disability benefits. Employers, supported by workers' representatives, are uniquely well placed to help prevent such illness leading to deterioration of health and work readiness, and ultimately labour market detachment, because they are among the first to see the early signs and, knowing the worker's abilities and strengths, better able to respond adequately.

Obligations and financial incentives for employers are needed because they are very sensitive to the costs of employment. Employers will often think it would be in their interest to allow a worker with a history of sickness absence to quit work and take up publicly-funded income support, so the worker can be replaced by a worker in better health. Many employers perceive the costs of new recruitment and training to be lower than the costs of retention, adjustment and accommodation needed to maintain productivity with existing workers with health problems. In response, a number of OECD countries have set out to adjust the balance of carrots and sticks such that it is in an employer's financial interest to retain sick workers.

Health-enhancing work environments

The range of involvement of employers in the sickness and rehabilitation phase, their responsibilities towards their workers and the support given to them to fulfil these differ

widely across countries (Table 5.1). In short, the following picture emerges. First, in most countries today employers have an obligation to accommodate work or the workplace up to the point of accommodation reaching unreasonable or disproportionate expenses, though with rather different degrees of enforcement of this requirement. Secondly, most employers across the OECD are obliged, by law or through collective or individual agreements, to cover sick-pay costs for a sick worker for a certain period; this period, however, and the share of the wage to be paid, differ drastically across countries. Thirdly, in only a few countries do employers have any particular obligation in relation to a sick worker's rehabilitation, though in those few countries this obligation is considerable. Finally, there are big differences across countries in dismissal regulations, which are much tighter for workers who are sick than for other workers in some countries (making dismissal of a sick worker very difficult), but lower – though sometimes requiring the consent of the authority – in other cases (explicitly allowing dismissal because of sickness).

Strengthened employer obligations

A few countries stand out as having legislated obligations for employers that are more specific than elsewhere and go beyond the more general work or workplace accommodation obligation, which is difficult to enforce in practice. Although no evaluation exists of such specific regulations, they should make it more likely for workers with health problems or disability to be able to benefit from legislation and to improve their workplace skills and qualifications. Such regulations also take into consideration the wider benefits for both employers and society in terms of human capital improvements:

- Employers in Germany have to offer preferential selection for within-company training to workers with health problems and support them in attending training elsewhere. Moreover, these workers have not only a right to work assistance and an adapted workplace but they are also entitled to part-time employment.
- Larger employers in Luxembourg (25+ workers) are obliged to find an appropriate job for their sick workers, be it the same job at reduced hours or a different job.
- Employers in Spain must keep a post open for a worker with health problems for up to two years in case of a rehabilitation process that is projected to be successful. Moreover, former employees on disability benefit, once having recovered, have absolute priority for filling a suitable vacancy or must be offered a similar job (possibly with a reduced wage) when returning from a partial disability benefit.

The key challenge for all these employer obligations is their enforcement. Successful enforcement will also require the timely involvement of workers' representatives and trade unions. This is particularly so in countries where the social partners have traditionally been central players in social and labour market policy, *e.g.* the Nordic countries or Austria. Social partners can play an active role in supporting job retention and reintegration of workers with chronic health problems or disability through initiatives facilitating labour market mobility and flexibility. In Sweden, for example, recent bargaining includes efforts to introduce employer-paid rehabilitation in exchange for loosening employment protection. More generally, more flexibility in wage setting in collective agreements can also be useful to allow payment of a reduced hourly wage in cases where a workers' productivity fluctuates or is reduced due to a disability. Such reduced wages can be agreed for instance in Australia.

Table 5.1. **Obligations for the employer are generally weak in regard to vocational rehabilitation**

Employer obligations in three areas: work accommodation, vocational rehabilitation and sick pay

	Regarding work	Regarding rehabilitation	Regarding sick pay
Australia	Obliged to accommodate work or workplace, unless this would impose unjustifiable hardship (rigid interpretation of the term "unjustifiable").	Responsible for assisting in the occupational rehabilitation and return to work of their workers, as well as keeping the job available for a reasonable time.	The National Employment Standards provides for ten days of paid leave for each year of service for employees engaged on a full-time and part-time basis.
Austria	Obliged to provide reasonable accommodation, unless this would pose a disproportionate burden on the employer (when taking public aid funds into account).	No employer obligations.	Continued full wage payment for 6-12 weeks (depending on length of employment); thereafter half the wage for a period of four weeks (which is topped up by sickness benefit).
Belgium	Only for some high-risk sectors of the economy: reassign or adapt job after absence of four weeks due to illness or accident.	No employer obligations.	Continued wage payment for one month: 100% of earnings for white-collar workers; for manual workers 100% in 1st week, 60% thereafter.
Canada	Duty to accommodate workplace conditions (eliminate discrimination resulting from a rule, practice or barrier) except for cases of undue hardship (with fines in case of non-compliance).	For work-related injuries and illnesses, where reasonably practicable, duty to return an employee to work, possibly in a different position with different conditions.	No period of continued wage payment.
Czech Republic	Accommodate work conditions in response to the worker's abilities and health competence or offer a different job in case of long-term disability as proven by a medical certificate.	No employer obligations.	60% of average salary from the 4th-14th day, based on hourly salary and working hours.
Denmark	Emphasis on encouraging social responsibility of employers (social index, social accounting); duty for the employer to make appropriate adaptations which are not unreasonable. Dismissal during illness possible if established that the employee will not get well.	No employer obligations.	Collective agreements provide for continued wage payment in case of sickness for certain groups of employees (employer entitled to receive the worker's sickness cash benefit).
Finland	Reasonable accommodation related to work conditions, work organisation, working hours, work methods, facilities, training and arrangement of work, and work guidance.	No employer obligations but disability benefit premiums are experience-rated and employers have occupational safety and health obligations.	Continued wage payment for first nine days of sickness (50% if employed less than one month). By collective agreements most employers pay full salary during the first 1-2 months.
France	Duty to take measures to give access to, or to keep, a position corresponding to qualifications and to give access to professional training (unless costs are "disproportionate").	No employer obligations.	Full or part of the difference between the salary and the sickness cash benefits, in accordance with either national inter-professional agreement or the collective agreement conditions.
Germany	Provide employment according to skills and abilities, preferential selection for training within company, support to attend training elsewhere, examine vacancies for potential for disabled persons, right to work assistance, right to part-time employment, right to adapted workplace.	No employer obligations.	Continued wage payment for first six weeks; without re-insurance possibility.
Greece	Reasonable adjustments to have access to employment, work and participate in vocational training, without causing disproportionate expenses for the employer.	No employer obligations.	No statutory continuation of payment. Leave of absence may be increased by six working days for workers with an assessed disability of at least 50%.
Hungary	Ensure the provision of appropriate working environment to perform the job.	No employer obligations.	80 % of the "absentee pay" for up to 15 days. Can but is rarely supplemented by collective bargaining agreements (up to 100%).
Iceland	A new obligation to provide reasonable accommodation is in preparation.	No employer obligations.	Continued wage payment for at least one month after 12 months of consecutive employment. Collective agreements often more generous.
Ireland	Obligation of reasonable accommodation, including adjustment to provide access to the workplace, modifying the job content, working time and work organisation; dismissal possible during absence and because of the illness.	No employer obligations.	No statutory sick pay but many organisations operate sick-pay schemes: public sector, full wage for six months and a half wage for another six; private sector, full wage for 4-26 weeks.
Italy	Assign equivalent tasks or lower-graded tasks but under old conditions, make necessary adaptations to work organisation.	No employer obligations.	Statutory continuation of payment of wage for a maximum of 180 days per year (and in some specific cases 180 days again in the next year).
Japan	Take measures following a doctor's advice to change the nature of work, working hours or adapt the workplace of an employee.	No employer obligations.	Wage payment for three days.

Table 5.1. **Obligations for the employer are generally weak in regard to vocational rehabilitation** *(cont.)*

Employer obligations in three areas: work accommodation, vocational rehabilitation and sick pay

	Regarding work	Regarding rehabilitation	Regarding sick pay
Korea	With technical guidance, offer employment in line with abilities (but no sanctions).	No employer obligations.	No sick-pay scheme. Collective agreements can include regulations on sickness-related payments (*e.g.* for government officials).
Luxembourg	Companies with 25+ employees obliged to find an appropriate job for their worker, same job at reduced working hours or a different job (internal redeployment). If not possible or at excessive cost, external redeployment is sought.	No employer obligations.	Employees in the private sector continue to receive pay by the employer for 13 weeks (system for public sector is more generous).
Mexico	No employer obligations.	No employer obligations.	No period of continued wage payment.
Netherlands	Rehabilitation obligation can include work accommodation and working hours reduction, as well as training.	Duty to prepare a reintegration approach within eight weeks, submit a plan on rehabilitation measures after 42 weeks and a report after first year of sick leave; sanction: continued wage payment for up to a further year.	Continued wage payment – at least 70% of the salary, in practice up to 100% – for two years (except for work disabled persons for first five years of employment), but employers can take out private insurance; obligation to contract with sickness absenteeism management service.
New Zealand	Obligation to provide reasonable accommodation (employees and new applicants); employers are allowed to discriminate in case of risk of harm to that person or to others.	No employer obligations.	Five days' of paid sick leave after six months of continuous employment; plus five days for each subsequent 12-month period. Agreements can provide for more generous sick leave provisions.
Norway	Ensure suitable work (but dismissal possible after 6-12 months), arrange work conditions in general so as to enable employment of people with disabilities.	No employer obligations.	Continued wage payment during the first 16 days. Where the employer continues to pay the salary beyond this period, the sickness cash benefit is paid to the employer.
Poland	Ensure workplace accommodation and access; for work injuries: arrange for suitable workplace if employee declares readiness to return to work.	Disabled employees have a right to special breaks for rehabilitation exercises.	80% of gross earnings during past 12 months, paid for first 33 calendar days of illness.
Portugal	Only for work injured: adapt workplace, offer compatible job and part-time work.	Again, only for work injured: offer vocational training and leave to train for other employment.	No obligation; moreover, topping up sickness benefits is not permitted.
Slovak Republic	Provide training or study to acquire the requisite qualification to facilitate employment. Improve the equipment of the workplace to enable the worker to achieve, if possible, the same work or set up a sheltered workplace.	Some obligations to provide qualifications upgrading.	For first three calendar days, 25% of the daily earnings in the previous year; from 4th to 10th calendar day of incapacity for work, 55%.
Spain	Former employees on disability benefit who recover have absolute priority for filling a suitable vacancy; or (after partial benefit) must be offered similar job, with up to 25% reduced wage.	During promising rehabilitation process, employer must keep post open for two years.	Sickness benefit payment from 4th to 15th day of illness, at 60% of wages.
Sweden	Provide reasonable suitable accommodation if the employee or job applicant is sufficiently qualified (*e.g.* purchase tools and change working environment, work organisation, work tasks and working hours); provide, if possible, a different job in the company.	If sick employee is not eligible to disability benefit, employer needs to find suitable work or is responsible for taking rehabilitative measures that can be conducted in the company.	Continued wage payment during the first 14 days (except for first day) at 80% of wages.
Switzerland	Anti-discrimination regulations do not include hiring and firing practice; dismissal protection during period of continued wage payment.	No employer obligations.	Continued wage payment at 100 % for three weeks. Generally, employers pay full salary for three to six months, then 80% for up to two years.
Turkey	Work-injured workers are given priority; civil servants have the right to ask for a suitable job.	No employer obligations.	Continued wage payment for civil servants borne by state as employer.
United Kingdom	Must make reasonable adjustments, *e.g.* adjust premises, reallocate duties, alter working hours, modify equipment; advice and financial support available in certain circumstances.	No employer obligations except for allowing rehabilitation absences if this would be a reasonable adjustment.	Sickness benefit payment during entire 28-week period (reimbursement possible where costs exceed 13% of social security contributions); employers can re-insure with a private insurer.
United States	Provide reasonable accommodation, *e.g.* adjust equipment, make facilities accessible, modify work schedules, unless this would result in an undue financial hardship (sanctions include, *e.g.* back and front pay, attorney fees, accommodation, re-instatement, job offers).	No employer obligations.	Voluntary employer-paid benefits like leave accrual plans (paid sick leave up to 12 days per year or balance of 6-12 weeks, paid time off up to 20 days per year or balance of 4-6 weeks) or short-term disability benefits (which cover first 13-52 weeks).

Source: Information provided by national authorities.

Occupational health services

In many countries, prevention policy is still predominantly focused on preventing work injuries and occupational accidents and diseases. Occupational health and safety regulations are well developed throughout most of the OECD, and they have contributed to a decline in work accidents in most countries. However, several countries have gone a step further and put in place regulations to help prevent unnecessary labour market detachment arising from poor working conditions. Occupational health services (OHS) are often used as a tool for achieving this:

- Regulations in Finland ensure that employers have access to information, advice and support. Employers are legally obliged to purchase private or community-run preventive OHS to monitor workplace practices on a regular basis, through active programmes assessing and minimising workplace risks, early detection of reduced work capacity and other strategies to prevent disability. Public subsidies are available to support employers in these tasks.
- Also in the Netherlands, until recently employers were obliged to contract an OHS company. This strict obligation was introduced in 1996 when employers became responsible for sick-pay for a whole year. The formal obligation was alleviated recently because the system is now well embedded. The role of the OHS is broader than in Finland and includes advice on prevention, but also management of sickness absenteeism and prescriptions for rehabilitative health treatment.
- Sweden is putting considerable new resources recently into re-establishing its OHS system, with generous financial support to companies contracting services approved by the National Social Insurance Agency. Although contracting is voluntary, OHS covers nearly half of the workforce. The function of OHS is to facilitate early and co-ordinated medical and vocational rehabilitation and work accommodation actions, including – where needed – background assessments of the employee's work capacity, according to the Social Insurance Agency's recommendations.

Other countries are strengthening their systems in similar ways, without necessarily using OHS. Denmark, through its Working Environment Act, has put in place similar requirements on employers to monitor and address issues in the work environment, including risk assessment and the effects of the work environment on sickness absence. The Working Environment Authority visits employers unannounced and require them to address hazards. If violations are not attended to within six months, fines can be imposed. In addition, assessments are published, including all violations, on the authority's website as a further incentive to employers to address this issue. The effects of all these developments have not been evaluated rigorously. However, it appears that such changes are a useful complement to more far-reaching changes to employer incentives.

Dealing with arduous work

A particular issue is how best to tackle deteriorating health of people working in arduous jobs or occupations for many years or decades. Early retirement schemes were introduced during the 1980s in most OECD countries with an eye on jobs which cannot realistically be maintained all through the working life until the legal retirement age of around 65 years. With the phasing-out or abolition of early-retirement schemes in many OECD countries in the course of comprehensive pension reform and the (planned) increase in several cases of the legal retirement age (often to around 67 years), the issue of how to

address arduous work is back on the policy agenda again in several countries. Some countries, including *e.g.* Austria and Poland, have introduced special retirement schemes for arduous work, allowing earlier retirement with no or lesser benefit cuts for certain workers. These schemes are narrowly defined (*e.g.* in terms of far-above-average calorie usage for large parts of the career) to avoid misuse; as a result, take-up is very low.

In most countries, arduous work is treated within the existing systems and will often lead to premature retirement through a disability benefit. Countries have done very little to prevent or address this issue directly. A notable exception is the planned Dutch regulation on arduous work. In essence, arduous work should not last more than 30 years. After this period, the employer is requested to move the employee into a different, not arduous job. If the employers fail to find new employment for their workers in question, they will have to start paying into a fund for each individual employee. The worker can draw upon this fund, thus in essence allowing retirement some two years before the regular age (which is now 65 and will be raised to 66 in 2020 and 67 in 2025). In this way, earlier labour market exit – of up to two years – would be fully funded by employer premiums. This is an innovative approach making employers more responsible, although the resulting buffer fund for two years may not be large enough to address the problem fully. Moreover, problems could also arise for workers moving to arduous jobs with *other* employers.

Sickness monitoring and management responsibilities to shorten sickness absence

The majority of people ending up on a long-term disability benefit initially go through a period of employment and sick-pay of varying length. Pathways into disability benefit show considerable variation across the OECD, but in all countries between one-half and three-quarters of all new disability benefit claimants were previously employed or drew a sickness benefit (Table 5.2).[1] These shares refer to the status *immediately* before the claim; many of those claiming a disability benefit from unemployment or social assistance will also have had interim periods of sickness absence beforehand. This is the major reason for why tackling sickness absence early on can be a very effective strategy for minimising the likelihood of eventual long-term labour market detachment. Employers are critically positioned to monitor absences, which in and of itself can reduce inappropriately long sick leave (*e.g.* Puhani and Sonderhof, 2009), and to support an employee in recovering or learning to manage their condition such that they remain in work.

Procedures for assessing and monitoring sickness absence

Several countries, in an attempt to curb high absence rates, have put in place a process of early intervention and absence monitoring involving employers in various ways. Norway and the Netherlands provide two good examples:

- In Norway (where sickness benefit can be received for up to one year), within the first eight weeks of absence the employer together with the employee has to draw up a follow-up plan describing the return to work and including relevant documentation. Employers are obliged to submit this plan to the national insurance office on request. Measures to prevent long-term absence and test the worker's functional ability must be carried out at the workplace.
- In the Netherlands (where sickness benefit can be received for up to two years), employers need to inform the company doctor during the first week of absence. By week eight, the employer and the employee must prepare a reintegration plan with concrete steps to be taken to achieve reintegration and arrangements for evaluating progress.

Table 5.2. **Pathways into disability benefit are manifold but sickness is a major precursor everywhere**

Origin of new disability benefit claimants as a percentage of all new claims, most recent available year

Australia[a]	2008	Denmark	2006	Finland[b]	2004	Luxembourg[c]	2005
Employed	44	Employed	7	Employed	4	Employed or sickness benefits	67
Sickness benefit	1	Sickness benefit	39	Sickness allowance	60	Unemployed/Redeployed	23
Unemployment benefit	36	Flex job	3	Unemployed	26	Social assistance	2
Other	18	Waiting benefit	9	Study grant	1	Other inactives	7
		Rehabilitation	3	Rehabilitation allowance	8		
		Social assistance	34	Parenthood allowance	1		
		Other	4				
Total	*100*	Total	*100*	Total	*100*	Total	*100*
Netherlands	2006	Norway	2004	Sweden	2007	United Kingdom[d]	2002
Employer paid sick leave	62	Unemployment	2			Employed	40
UWV sickness benefit	38	Sickness benefit	42	Sickness benefit	76	Statutory sick pay	17
Of which:		Medical rehab benefit	34	Other	24	Unemployed	26
Temping agency workers	4	Vocational rehab benefit	22			Income support	12
Temporary contracts	17					Other inactives	5
Unemployed	15						
Other	3						
Total	*100*	Total	*100*	Total	*100*	Total	*100*

a) Based on people entering onto Disability support pension between mid-2007 and mid-2008.
b) Based on KELA social insurance benefits only.
c) Based on people entering into either temporary or permanent disability benefit or the tide-over allowance in 2005.
d) Data refer to 2001/02. Previous benefit status is defined as statutory sick-pay receipt *immediately* before staring an incapacity benefit claim, and refers to the *90-day period* before starting a claim in case of previous unemployment or income support status.

Source: National submissions.

Steps need to be re-evaluated at six-week intervals. After the first year of illness, an evaluation report has to be drawn up to summarise the efforts during the first year and set out the steps planned for the second year. A final reintegration report has to be prepared by week 87-91, upon filing a disability benefit claim.

These strengthened sickness monitoring obligations had a major impact on sickness absence rates in the Netherlands (*e.g.* de Jong *et al.*, 2006) but not in Norway. Significant drops in absence rates will only occur if changes are implemented rigorously and in combination with much stronger financial incentives for employers to follow these regulations, and sanctions for those who do not. For example, sanctions are legally possible in both Norway and the Netherlands but while sanctioning employers is not done in Norway, 13% of all Dutch employers face the major sanction of having to continue sickness benefit payment for a third year because of failure in making sufficient efforts to retain a sick worker. In addition, especially for countries hesitant to strengthen employer incentives, absence monitoring cannot be left in the hands of employers alone but will also have to involve the responsible public authorities in various ways, not only to monitor and support employers' actions. This issue is addressed in Chapter 6. The critical role in this context of general practitioners is the topic of Section 5.3.

Financial liability for sick pay

Research for Sweden, which has changed sickness benefit payment rates repeatedly over the past two decades, has shown that workers react very sensitively to changes in

payment rates (*e.g.* Henrekson and Persson, 2004, Hesselius and Persson, 2007). Evidence on the impact of stronger employer incentives is scarce because few countries have ever changed these significantly. Those which have, like the Netherlands and the United Kingdom, have seen considerable falls in sickness absence rates (Chapter 2):

- The Netherlands went furthest in this regard. Starting with a fully public sickness benefit system until the mid-1980s, step by step a larger share of the financial liability for sickness benefits was transferred to employers – initially for a few weeks, later for a full year and now employers pay the costs of sickness benefits for as long as two years during which workers usually cannot be dismissed (unless they fail to comply with their co-operation obligation and refuse to accept another position or role in the company). Employers can reinsure their risk with a private insurer, as most of the small but only a few of the large companies do.
- In a similar way in the United Kingdom, employers are now responsible for statutory sick-pay for a period of six months, again with reinsurance possibility. However, not only is the period shorter than in the Netherlands but also benefit payment rates are lower and other obligations in terms of monitoring and managing sickness absence largely non-existent.

The extent of employer co-payment differs drastically across OECD countries (Table 5.1). Some countries have long had a period of continued wage-payment by the employer of several months, without a reinsurance possibility, including Austria (6-12 weeks), Germany (six weeks), Italy (up to 180 days), Luxembourg (13 weeks for white-collar workers) and Switzerland (up to six months, varying with tenure). None of these countries have particularly high absence rates, while those countries with the highest absence rates (like the Nordic countries) tend to have a very short employer-provided wage-payment period. There is no "ideal" period, but increasing employer co-payments can be an effective strategy in tackling high absence rates.

Absence trends in the Netherlands and the United Kingdom suggest that strengthened employer co-payments will initially lead to a significant fall in short-term absences. To reduce long-term absences, considerable financial incentives will be needed: In the Netherlands, for example, increasing the employer-paid period from one year to two years was apparently more effective in lowering long-term absence than increasing this period to one year (OECD, 2008). However, it is difficult to disentangle the various independent effects of the incentives shift on the one hand and the much stronger monitoring obligations on the other.

Financial liability for disability benefit costs

While employer-provided sick pay of varying duration is common across the OECD with a trend in some cases towards extending this period, only a few countries go a step further and mandate an employer contribution to longer-term disability benefit costs via experience-rating of premiums, whereby employers pay more if their workers make above-average claims. In the Netherlands, experience-rating of public disability insurance was first introduced in 1998; since 2003, employers have to pay for most of the costs of the first five years of disability benefit receipt by their former workers. With the latest benefit reform the system was changed yet again, so that now employers are *de facto* paying for as much as ten years for those with a partial earnings incapacity but no longer for those with full and permanent incapacity. A similar system in Finland, affecting large firms only,

implies that companies may have to pay up to 80% of the total disability benefit bill of their workers in case of job loss as a result of disability. Switzerland and Canada are seeing similar trends but in this case they are being driven by the private insurance sector which is very important in both countries (OECD, 2006 and OECD, 2010).[2]

What was the impact of these changes? In the Netherlands, this particular feature of reform was one of the key factors explaining the recent and very sharp fall in the rates of inflow into disability benefits (Koning, 2005). For Finland, it was shown that experience-rating reduces the flow from sickness benefit to disability benefit, while not affecting the flow into sick leave (Korkeamäki and Kyyrä, 2009). The recent development of experience-rating in the private insurance market in Canada and Switzerland has never been evaluated but this change is likely to have contributed to the very large and somewhat unexpected drop in the inflow into disability benefits in Switzerland (partly via falling levels of sickness absence) and the small drop from an already rather low level of annual disability benefit claims in Canada.

5.2. Supporting measures to ensure employers can fulfil their responsibilities

Financial incentives are the most effective means to ensure enforcement of employer responsibilities because failure to fulfil obligations automatically leads to a sanction in the form of *e.g.* higher benefit co-payment. Without adequate financial incentives it is difficult to enforce strengthened employer responsibilities. Moreover, incentives or sanctions are often not strong enough, as is for example the case for mandatory employment quota schemes in most countries which impose a penalty (OECD, 2003) which many employers just see as a minor additional non-wage cost.

Stronger responsibilities and financial incentives for employers also need to be matched by better supports to help them fulfil their obligations. This includes making employers aware of the extent to which their management practices affect the health of workers and their ability to remain attached to the labour market despite an illness (*e.g.* Tepper, 2007; Fjell *et al.*, 2007). Awareness-raising is also important with regard to false beliefs on the costs of workplace accommodation: Evidence suggests that accommodation costs are close to zero in around one-third of all cases, and substantial in only a few cases.

Employers vary in their expertise and experience in managing sick workers and it is impractical to expect them to fulfil their responsibilities to a high standard without quality supports, and backup. Better supports need to be provided by public employment agencies in particular. Employers also typically shy away from cumbersome administrative procedures and contacts, so the challenge for operational policy makers is to provide support in a form that fits with the needs of employers.

Job retention versus *new hiring: the inherent challenge*

Adequate support for employers is particularly important with the aim of providing a level playing field for job retention and job hires so as to help both insiders and outsiders – the inherent challenge for all labour market policies and institutions. Policy can influence the retention-hiring challenge, as research comparing the situation in the Netherlands, with its strong focus on job retention, and Denmark, with its flexicurity model with easy dismissal has shown. According to Veerman (2001), a much larger proportion of sick workers return to work with their employers in the Netherlands (72%) than in Denmark (40%). On the contrary, the dismissal of a sick employee does not seem to have any negative

impact on the likelihood of return to work in Denmark but has a strong negative impact in the Netherlands (Høgelund, 2004).

As noted in Chapter 3, there are a range of employment measures that countries can use to support either job retention or hiring of new workers. However, evidence on the effectiveness of some of these measures is generally poor and sometimes inconclusive. Moreover, the limited available evidence suggests that most measures including employment quotas, anti-discrimination legislation and regulations which create strong financial incentives to keep people with health problems in work will often serve to protect the jobs of *existing* workers. At the same time, these measures can inadvertently reduce hiring opportunities for jobseekers with health problems or disability because employers form a view that the various imposed responsibilities (including accommodations costs but also costs arising from increased chances of a lawsuit) are collectively so onerous and contracts with those workers legally so difficult to terminate, that it is safer not to take on any workers with (potential) health issues.

For example, a number of empirical studies on the impact of anti-discrimination regulations in the United States have suggested that new legislation had resulted in lower employment rates for people with disability (*e.g.* DeLeire, 2000; Acemoglu and Angrist, 2001), even though the gradual fall in employment rates of people with disability since the mid-1990s cannot be *causally* linked to the introduction of such legislation (*e.g.* Begle and Stock, 2003).

Mandatory employment quotas, which are generally better enforced than anti-discrimination legislation though not better evaluated, seem to suffer from the same problem. Evaluation of the impact of the quota scheme in Austria, one of the countries with relatively high quota enforcement and fulfilment (OECD, 2003), suggests that the quota helps some workers developing a disability to stay in work, but at the expense of keeping jobseekers with disability further away from the labour market, with the net employment effect being *negative* on balance (Humer *et al.*, 2007). The problem may be one of incentives and enforcement insofar as there is no practical way of preventing an employer from filling their quota with existing staff who have low productivity because of existing health issues, rather than taking on new workers with reduced work capacity who are perceived to be less productive.

There is no obvious solution to this problem but governments need to be aware of the risks and fallacies, try to provide a balanced set of supports to stimulate labour demand through both job retention and new hiring, and to adjust the balance in line with measured outcomes. For instance, improvements of a quota system, even if far-reaching and including *e.g.* an increase in the levy to be paid for non-fulfilment, may not be enough to stimulate employment prospects for workers with health problems unless overall labour demand is buoyant.[3]

Provide adequate support for employers to match responsibirlities

Financial supports for employers

Subsidies are the most commonly employed policy measure in OECD countries for promoting employment opportunities for people with disability. Subsidies are typically available in two different forms: *i) accommodation subsidies* supporting the costs associated with making accommodations to a workplace; and *ii) wage subsidies* contributing to the costs of employing a worker with a chronic health problem or disability. The former will

often be used to retain workers and the latter for stimulating new job hires. However, there is considerable overlap and a scheme providing a generous and permanent wage subsidy – like the Danish flex-job scheme – can easily encourage employers and employees alike to transform a full-time job into a subsidised part-time position.

Workplace accommodation subsidies have gained in importance in the course of the spreading of anti-discrimination legislation across OECD countries. A recent EU study concluded that workplace accommodation tends to be too limited in focus – *i.e.* too much centred on the reimbursement of direct costs – and that effective workplace accommodation should combine technical solutions to accommodate a particular health problem with training measures (before and after recruitment), on-the-job assistance and awareness-raising measures targeting managers and co-workers (Heckl, 2009).

As far as wage subsidies are concerned, systems that are well targeted to the needs of the employer and the employee and flexible over time and in relation to the person's work capacity (which might be changing over time) so to allow the employer to test a worker and the PES to lower or cut-off the subsidy quickly when the worker's productivity has increased seem to be most efficient. Several countries have interesting systems in place, although evaluations of these are often lacking:

- The Swedish employment agency offers a flexible wage subsidy mainly for new recruitments. The subsidy can cover up to 80% of the wage cost for a period of up to four years. The level of the subsidy is determined by the degree of work capacity, as assessed by the agency, and adjusted regularly in line with changes in the person's capacity level.
- The PES in Luxembourg operates a wage subsidy that is temporary, though usually lasting for three years; to extend the subsidy an employer must re-apply and prove that the productivity of the person continues to be reduced.
- The Finnish PES uses a flat-rate wage subsidy paid at a level below the minimum wage which is granted for up to 24 months at a time (social enterprises can receive a more generous subsidy).

One major issue for wage-subsidy schemes is to avoid deadweight, substitution and displacement effects.[4] If it is very easy for an employer to claim such subsidy for a worker with disability, this is likely, *ceteris paribus*, to raise deadweight. To avoid deadweight, the Finnish system is very strict in terms of conditions to be fulfilled by the employer who would, for instance, not be entitled to a subsidy if the vacancy could be filled without such subsidy. Indeed, the well-targeted Finnish scheme was shown to have stimulated employment in subsidised firms without distorted competition or crowding out of employment in non-subsidised firms (Kangasharju, 2005). This contrasts with findings for the very generous Danish flex-job subsidy which has produced only modest employment effects, with an estimated 52% deadweight loss (Datta Gupta and Larsen, 2007).

Notwithstanding the risk of deadweight loss, a key issue in increasing the effectiveness of wage subsidies is to increase their use. Take-up of such programmes tends to be low (see Chapter 6), be it because of a relative short payment period and/or a low and inflexible payment level, or because of a narrow target group and/or a burdensome procedure to justify eligibility, or a combination of both.

Accessible information and guidance when it is needed

Two key issues in relation to the limited use of tools designed to stimulate labour demand are a lack of awareness among employers of the availability of these schemes and

the onerous procedure in many cases for applying for support. Employers in many countries have indicated their willingness to try to employ a person with reduced work capacity and productivity with financial support compensating this disadvantage if only this would be easier to apply for and not require much time investment. In response to this, several countries have put in place easily accessible information systems for employers:

- In Norway, mirroring the one-stop-shop idea for people with disability, employers have a personal contact officer in the nearby local workplace centre who will provide timely advice on all sickness and disability-related matters including sickness management and job retention as well as information in regard to challenges and available services for new job hires.
- The JobAccess initiative in Australia includes a comprehensive internet website (*www.jobaccess.gov.au*), a free telephone advice service (handled by trained advisers), an online workplace adjustment tool giving a range of practical ideas and solutions for workplace modifications and adjustments, and an online claims process for the payment of workplace modifications and other services.
- Spain's National Centre for Personal Autonomy and Technical Aids operates a comprehensive website on assistive technology and accessibility (*www.ceapat.org*). Services offered include assessment and advice for workplace adaptations, adaptation of technical tools, training activities and information and advice on universal accessibility.
- In the Netherlands, following new legislation in 2010, 30 new service institutions were established for employers to reduce cumbersome administrative procedures.

A key factor in stimulating labour demand and the use of corresponding support schemes is the *business case* for employing people with health problems or disability. Especially for smaller companies, it is often difficult to make a business case based on hard evidence, even though anecdotal evidence suggests that workers with disability tend to be sick less often, extremely reliable and loyal to their employer and thus have a high retention rate. A key challenge therefore is to convince employers to hire *one* worker with disability: Once employers have their first positive experience, they are far more likely to hire another worker with disability.

A special issue in this regard is the need for the Public Employment Service to lead by example. The PES will have to be a model employer so to be able to make a convincing business case and place people with health problems into work successfully. Along these lines, the PES in Germany has made great efforts in recent years; today, 9% of its workforce has a disability.

Facilitating employer networks

What has been found to be of particular importance in motivating employers to hire a worker with disability is information based on experiences from *other* employers. To collect and share experience is one of the main aims of the United Kingdom's Employers' Forum on Disability, a charity organisation funded by voluntary contributions from its members (mainly large private companies). The Forum advises employers through regular exchange and conferences, produces relevant publications, such as a guidebook on sickness management, and benchmarks its members against other members.

Information and good-practice sharing organised by employer-funded networks is important. Governments cannot do everything and encouragement is needed for

initiatives that arise from the private sector. In this regard, employer-run circles or networks have developed in a number of OECD countries, either at the behest of government initiatives or by groups of employers in certain branches or regions directly. These employer collectives may play an important role in helping employers redeploy workers who are no longer suited to a particular job because of illness or injury to other firms, without the involvement of public authorities. Such networks have grown in those countries which have recently shifted considerable responsibilities onto employers:

- In the Netherlands, in response to the extension of employer-provided sick-pay to two years, during which dismissal is almost impossible, employer networks have mushroomed. These networks are organised on a regional level.
- Also in Sweden, in response to the recent requirement for employers to seek alternative jobs in their company for a worker who has been sick for over three months, employer circles have arisen to help place in other jobs or companies workers no longer suited to their own job. There are two lessons from these examples. First, the strengthened employer responsibilities created a stronger mutual interest and willingness to hire workers from other companies in exchange for the possibility of redeploying their own workers who develop problems that may leave the employer with a large wage bill. Secondly, there is great potential in organising such networks on a regional level so to stimulate transfers *across* sectors where it is less likely for a worker to experience the same workplace factors that may have contributed to their sickness absence.

Mitigating employer risks associated with hiring disabled persons

With strengthened employer responsibilities like those in Sweden or the Netherlands, there is also a strong case for measures directly addressing the retention-hiring challenge. Obligations for employers to offer sick workers another job in the company, or even help them find another job elsewhere, and financial incentives like experience-rating of disability insurance premiums, as discussed above, include the risk that employers will actively seek to avoid hiring persons who they perceive to be at higher risk of sickness or disability. Measures are needed to mitigate these risks in order to avoid that better employment outcomes resulting from the new tools stimulating job retention are countered by falling recruitment of workers with disability.

The Netherlands – where policy development over the past 15 years was driven by the aim to straighten incentives for employers and workers – has gone furthest in addressing this goal. The Dutch *no-risk policy and premium discount* effectively absolves employers of a significant part or all of the risks that arise when taking on a person at higher risk of sickness. The no-risk policy, introduced in 2003 and extended in 2005, removes the usual obligation of employers in the Netherlands of paying sickness benefits for up to two years of illness for employees with a disability.[5] Instead, the employee insurance covers these costs. Disability premium discounts are also available when employers hire these types of workers. In addition, hiring a person aged at least 50 years or keeping an employee older than 54.5 (that is, older persons at high risk of entering disability schemes as a form of early retirement) earns employers an additional financial advantage: They do not pay the basic disability premium for these workers. To date, no evaluation of these measures is available.

Finland has also recently introduced regulations mitigating somewhat the hiring disincentive arising from the experience-rating of employer premiums to its disability

benefit scheme. With lesser employer obligations, it seems less urgent at this very moment for several other countries to introduce balancing measures like these.

5.3. Stronger employment focus by medical professionals

Like employers, medical professionals who assess sickness and disability claims are key actors in determining the take-up of sickness and disability benefits. The decisions they make about a person's fitness for work determine how long that person can remain detached from their workplace and claim benefits. This is crucial because allowing a person to stay out of work for an extended period of time is a known route to disability benefit schemes and permanent detachment from the labour market.

The formal justification for allowing such extended periods of work absence is that the medical practitioner has found robust evidence to conclude that being away from work is necessary for recuperation, and that to do otherwise would be to jeopardise the individual's health. However, given the prohibitive cost of comprehensive medical testing and the absence of objective tests for a range of health problems, practitioners must often base their decisions on the self-reported symptoms of the patient. Work by the National Board of Health and Welfare in Sweden suggests that practitioners may unwittingly authorise more sick leave than is necessary, in cases actually diminishing health outcomes.[6]

In view of the large and increasing body of literature concluding that work is generally good for health, especially mental health (Waddel and Burton, 2006, OECD, 2008a), more efforts will need to be made to keep sickness absence periods no longer than necessary. General practitioners (GPs) are typically the first contact for a person whose health is deteriorating. The doctor's reaction and advice will be crucial in terms of guiding the sick worker back to work quickly, or allowing the worker to become sick on a persistent basis.

Recognising that inappropriately long sick leave incurs costs for employers and the public purse and risks labour market detachment, countries are exploring ways of improving sick-listing practices. In regard to medical assessments for disability benefit entitlement, a general trend across the OECD is to raise the medical powers of the benefit-granting institution, thereby reducing the relevance of the practitioner's assessment. The introduction of regional medical services of the disability insurance in Switzerland, a country which used to rely heavily on GPs' assessment in determining disability benefit eligibility, is an example in case: Medical assessments have become easier and more homogenous across the country, and the new medical gate-keeping role assigned to the disability insurance system is also a factor in the recent large drop in disability benefit inflow rates.

There is no such shift towards an increased medical role on the part of the social insurance authority in certifying sick leave. Across the OECD, such certificates continue to be provided by GPs and form the basis for paying a sickness benefit. However, a number of promising reforms have been implemented addressing sick-listing practices of medical professionals, including one or a combination of the following three elements: *i*) provision of medical guidelines for doctors; *ii*) clearer administrative procedures; and *iii*) systematic control of sickness certificates.

Providing medical guidelines

In the first place, it is important to provide sufficient information to medical professionals about the "ideal duration" of absence from work for the most frequent health problems; ideal in terms of ensuring a fast recovery as well as enabling a return to work as quickly and fully as possible, recognising the negative longer-term effect of enduring periods of inactivity for the worker. Several countries have started to realise the need for better medical guidelines for GPs, in particular in view of the large share of mental and muscular-skeletal health problems reported:

- In Sweden, medical guidelines introduced in 2007 prescribe appropriate periods of sickness absence that are likely to produce a good outcome for the 90 most frequent medical conditions, which together account for three-quarters of all sick leaves taken. Recommendations also include information on treatment, prognosis and expected recovery time. The recommended period of absence was developed on the basis of empirical data on the typical absence period, and in consultation with medical experts. The development process itself has helped to generate awareness among GPs and the public alike of the forthcoming change in sick-listing practice.
- Similarly, in Ireland and the Netherlands, medical guidelines and protocols are currently being developed to encourage earlier return from sick leave. Guidelines in the Netherlands aim at improved co-operation between GPs and occupational health doctors by making the former more aware of the importance of the concept of work capacity and the advantages of resuming work. Protocols provide scientific evidence about the relation between a particular illness, treatment and work capacity to promote more uniform medical assessment.

Rigorous evaluation of the impact of the guidelines is unavailable but it is likely they are a contributing factor to the sharp decline in sickness absence rates in both the Netherlands and Sweden. It will be important to ensure that medical professionals fully understand and make use of these guidelines. Therefore, it is essential to develop them on the basis of medical but also occupational evidence, ideally produced and agreed upon by the medical sector itself. It is also important to spread the general principles of the guidelines including the need for GPs to use sickness certificates as yet another tool for care and treatment so to speed up recovery, not as a bridge into inactivity (OECD, 2009).[7]

Clear procedures for medical professionals

A second way to harmonise sick-listing practices and avoid unnecessarily long sick leave is by setting clearer and pre-defined administrative procedures which doctors ought to follow. Again, several countries have taken steps into this direction:

- In Norway, GPs are obliged to guide sick workers in a manner that strengthens their work motivation and base sickness certificates on the question of whether or not there are sufficient medical grounds for an absence from work. After six weeks of absence, an extended medical certificate must be completed and sent to the insurance authority. GPs who fail to follow the regulations could lose their entitlement to issue medical certificates.
- In Luxembourg, since 2005, after an extended period of sickness absence (six weeks in the past sixteen weeks) a special form has to be completed by the attending GP and forwarded to the Administration of Medical Control. Information on the form allows the public administration to judge the justification of the extended sick leave. If the form is not returned within four weeks (following a reminder after two weeks), benefit

payments will be stopped. As this form and also the reminder are sent to the sick person rather than the doctor, the patient and the doctor jointly carry responsible for explaining extended periods of sick leave.

Administratively prescribed procedures often go far beyond merely requesting GPs to provide regular updates of the sickness certificate. Frequent certificate updates can be a useful first step but only if this information is used in a productive way. For instance, in Ireland sickness certificates have to be renewed on a weekly basis but there is no limit to the number of renewals and no particular intervention in case of frequent renewal. Along these lines, the potential of stricter administrative procedures for doctors will only be harvested if compliance is monitored and non-compliance sanctioned.

Systematic control of sickness certificates

Medical guidelines and clear procedures form the basis for more harmonised and less subjective sick-listing practice, but their impact hinges on the degree of compliance monitoring. Again, several countries have in place, or recently strengthened, monitoring and control systems:

- In Spain, in 2004, the national social security institute (INSS) established a special directorate responsible for absence controls. INSS employs over 500 doctors who monitor and reassess ongoing sickness cases. Selection for reassessment is based on a rich administrative database with complete sickness absence histories of the entire workforce, including information on the employee, the employer, the cause of absence and the full medical history. Information is automatically registered through mandatory reporting of every case by both the employer and the GP. The INSS controls people with absences which are longer than the average duration for a specific sickness, as specified by very detailed lists for almost all possible illnesses.

The Spanish case is probably not easily transferable to other countries because of privacy and confidentiality issues. The database includes *individual* information for every employee and information is automatically updated on a daily basis (OECD, 2007). However, better controls are possible in many different ways often requiring far less detailed and transparent information. For instance, monitoring can simply include regular controls of randomly selected sickness certificates by a higher authority, *i.e.* by controlling doctors employed or authorised by the benefit agency or the sickness insurance.

Several OECD countries, including Austria and France, have such control systems in place. In Austria, for instance, sickness certificates are regularly verified on a random basis, starting as early as after around one week of absence. Many of those absent from work who are called in for a control visit will have returned to work before attending the control visit – in itself indicating the effectiveness of this approach. Notably, in Austria such controls by social insurance doctors start so early despite an extended period during which sick pay is provided by the employer (6-12 weeks), recognising the long-run cost for the public purse of any long-term absence. This is only possible, of course, because of the strict duty of notification of absences by the employer from very early on.

Financial incentives for doctors

Ultimately, the effectiveness of these tools and interventions – guidelines, procedures, controls and combinations of those – in terms of actually changing sick-listing practices of medical professionals will depend on the sanctions subsequently imposed on them. This

could in the extreme include a (presumably initially temporary) suspension of sick-listing authorisation which, in turn, would have a negative impact on GPs' incomes. However, this is rarely ever done even if it is legally possible, as is the case in Norway.

Instead, encouragement is used in other ways. A promising development recently in the Nordic countries is the move towards partial return to work from sick leave. For many illnesses, the question is not one of full temporary incapacity for work. Rather, especially for many of the growing number of absences due to mental health problems, it would often be possible for the patient to return to work in a partial capacity, thereby significantly reducing the duration of inactivity. Recent research from Norway has shown that more frequent granting of partial absence by doctors leads to less frequent slips into disability benefit of their patients three years down the road (ongoing research at the University of Bergen). In one way or another, all Nordic countries today have regulations in place so to increase the use of partial sickness leave – which is legally not possible in most OECD countries. In Norway, for example, partial sickness always has to be considered before a full absence can be granted.

At the broader systems level, the authorities who administer the national (or sometimes regional) health care entities that licence, employ or in some other way reimburse the GPs who issue sickness certificates, should have an intrinsic financial interest in managing their system in ways that promote employment. This issue goes beyond the scope of this report but one avenue to this may be through transferring a component of the liability for public expenditure on sick leave from social protection budgets to the health sector. In doing so, health system authorities who manage medical practitioners would have an incentive to encourage them to keep the duration and corresponding cost of sick leave to the minimum necessary for good health and good employment outcomes.

5.4. Conclusion

Many countries have started to realise the important role employers are playing in preventing, monitoring and managing sickness absence so to prevent longer-term labour market exit of their workers. Employers are best placed to ensure health-enhancing work environments and react at an early stage. Similarly, general practitioners have a key role to play in minimising sickness absence to the necessary length and setting people's mindset early on to a swift return to work rather than a continued sick role. In different ways, countries are seeking to engage better both employers and general practitioners.

For employers, the key issues will be to fortify, extend, monitor and enforce responsibilities and corresponding financial incentives, especially in regard to sickness absence, while at the same time providing sufficient supports for them to fulfil their strengthened obligations. For general practitioners, a combination of medical guidelines, clear procedural structures and systematic control will be needed.

A key challenge in stimulating labour demand is how to promote job retention of workers with chronic health problems or disability without jeopardising recruitment chances for those without a job. This will require a flexible labour market and a well-balanced mix of responsibilities and supports, and occasionally specific measures addressing any imbalances, thereby also requiring the involvement of the social partners.

Notes

1. Australia is an exception because of the particular sickness benefit eligibility criteria. After ten days of continued wage payment by the employer, sick employees can be laid off, and without a valid employment contract they will not be entitled to a sickness benefit. Instead, they will be directed to the unemployment benefit scheme. Unemployment benefit recipients with temporary work incapacity are not transferred to sickness benefit. Moreover, casual workers who make up for around one-quarter of the workforce and one-third of all workers with disability are not covered by sickness benefit.
2. For Canada, this statement refers to voluntary long-term disability insurance which covers roughly half of the employed workforce and makes up around one-fifth of total disability benefit spending. For Switzerland, this refers to both the mandatory second-pillar occupational disability benefit plans and the equally mandatory sickness cash benefit insurance, which is integrated in private health insurance.
3. Employment quotas are also only mildly effective for another reason: quotas across the OECD cover people with a legally registered disability status. This administrative legal status is yet again different from the definition used by disability benefit systems and defines disability in a rather narrow way. Hence, even in countries with relatively high quota fulfilment rates of around 60% (*e.g.* Austria, France and Germany), the quota will not make a difference for the much larger group of people with milder chronic health problems.
4. Deadweight losses arise when hiring would also have occurred in the absence of the wage subsidy. Substitution and displacement effects occur when the jobs created by the wage subsidy replace jobs for other categories of workers (substitution) or displace jobs elsewhere in the economy as a result of a distortion in competition (displacement).
5. Workers counting towards the no-risk group include persons who are entitled to a disability benefit (implying an earnings-capacity reduction of 35% or more); people whose earnings capacity after two years of illness is reduced by 15-34% (*i.e.* not enough to be entitled to a disability benefit); and individuals entitled to sheltered employment. It is applicable to new as well as own employees. Entitlement holds for five years initially, with the possibility of extension.
6. For example, it was found that workers meeting the criteria for Generalised Anxiety Disorder have a better prognosis if they stay at work rather than at home because, in isolation, they are more likely to ruminate excessively and further deteriorate. Likewise, four weeks recuperative leave following coronary surgery tends to have a better prognosis because becoming active (within prescribed limits) after this time supports healing and adjustment.
7. Notwithstanding the new guidelines, GPs in Sweden can award absence periods that are longer than recommended; however, they are required to provide written justification for why the extra time off work is necessary in a particular case.

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