EXECUTIVE SUMMARY

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

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

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

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

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

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

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

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

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