CHAPTER 2: RECENT AND ONGOING REFORMS

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

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

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

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

2.1. Benefit reforms

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

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

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

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

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

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

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

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

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

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

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

B. Sick-leave benefits: employers rights and responsibilities

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

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

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

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

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

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

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

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

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

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

D. Encouraging persons with disability back into the labour market

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

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

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

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

E. Employment programmes for persons with disability

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

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

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

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

2.2. Institutional reforms

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

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

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

A. Constraining medically determined sick-leave

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

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

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

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

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

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

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

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

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

B. Building rehabilitation capacity using a public-private approach

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

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

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

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

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

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

Partnering with counties to strengthen OHS and medical rehabilitation capacity

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

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

C. Restructuring the SIA

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

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

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

Co-ordinating agency services to focus on client outcomes

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

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

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

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

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

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

2.3. Comparing the reform intensity

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

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

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

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

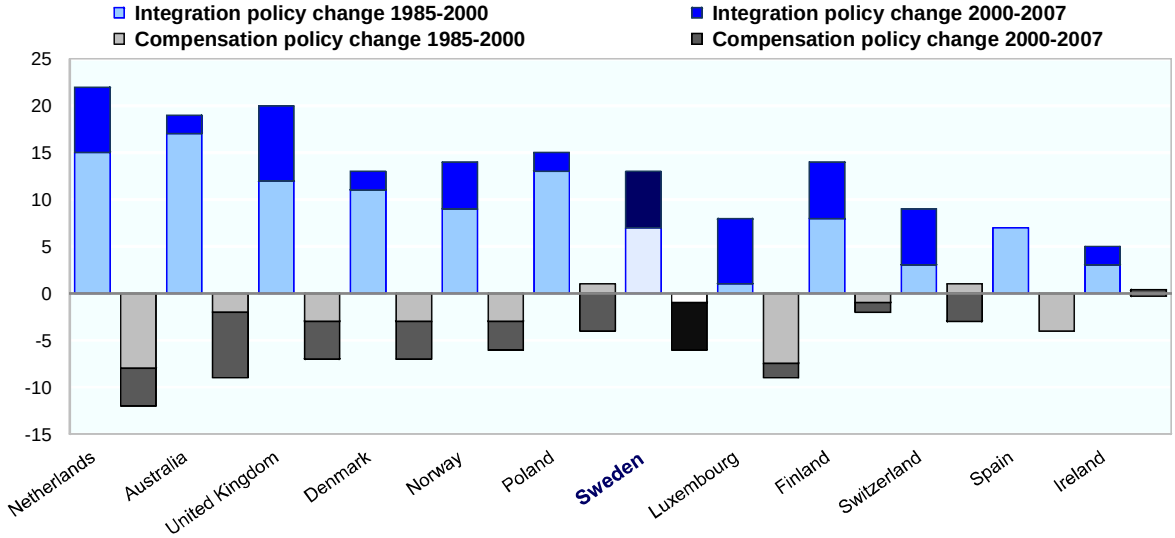
27 . To obtain a reasonable overview of what is happening in policy both over time and across countries, in OECD (2003) a policy index was developed which consists of two dimensions, the generosity and accessibility of benefits (the "compensation policy" dimension) and the generosity and accessibility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

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

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

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

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



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

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

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