# CHAPTER 1: SETTING THE SCENE

## 1.1. Key trends since 1990

In Sweden, the 1970s and 1980s were a period of relatively stable economic growth characterised by very high and increasing rates of employment, reaching 90% for the population aged 25-54, and very low rates of unemployment, fluctuating at 2-3% (OECD, 1996). However, even then inactivity due to worker incapacity was a major labour market issue. Sickness absence was very high with short-term absence fluctuating significantly (OECD, 2005). Disability benefit recipiency was also comparatively high and growing, from 5% of the working-age population in the mid 1970s to 7% in 1990, mostly as a consequence of the increased take-up by women, though this was partly a by-product of their rising participation in the labour force.

The economic downturn in the early 1990s, caused by a severe foreign exchange crisis which erupted in the autumn of 1990, marked a turning point in Sweden. Unemployment leapt to 8-10% and remained at that level until 1998 (OECD, 2003a). Taking into account the additional numbers on sickness and disability benefit, in the mid-1990s no less than 20% of the working-age population were receiving a social insurance benefit – compared with 10-13% during the 1970s and 1980s.[1] This constituted a longer-term structural shift that still persists today with one in five working-age adults relying on a social insurance benefit of some kind.

How can this be explained? While unemployment fell again to 5% in 2000/2001, most of this increase was offset by an increase in the incapacity rate.[2] In 1998, sick-leave of all durations and inflows into disability benefit started to increase very rapidly (see Figure 1.1). Sick-leave with duration of less than six months increased by 90% until early 2002, sick-leave of 6-12 months by 140% until mid-2002 and long-term sick-leave of more than one year almost tripled until 2003. The annual inflow into disability benefit followed this trend, albeit with a delay, and more than doubled until 2004. As a consequence, the total incapacity rate of the working-age population peaked at 14% in 2004/2005.

After reaching these peak levels, absence rates fell back to roughly 1998 levels in 2008 (only sick-leave of over one year is still more frequent than it was ten years ago). However, the overall dependence on social insurance benefits did not change very much, though this was partly because unemployment rose to around 7%. This development highlights a strong negative correlation between sickness absence and unemployment, at least at the national level, as has been found in several studies in Sweden (*e.g.* Arai and Skogman-Thoursie, 2001; and Larsson, 2002).[3]

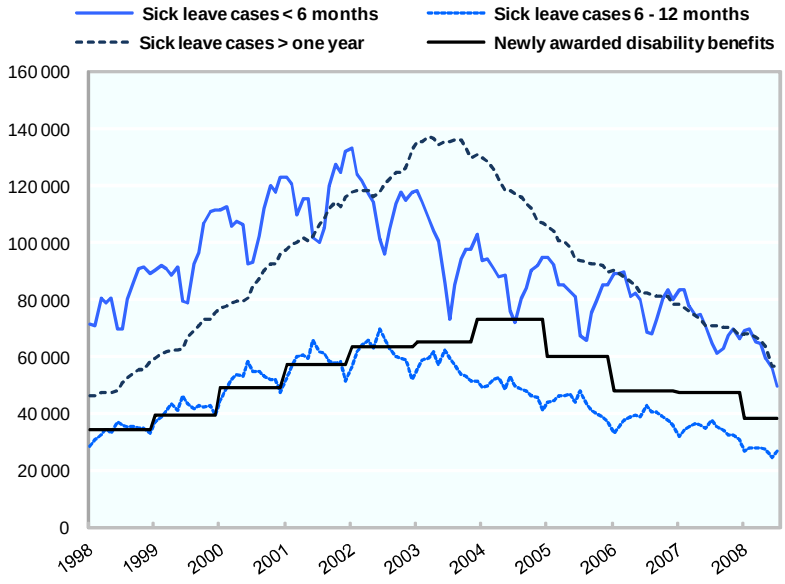
1. Total recipiency of social benefits, including social assistance payments provided by municipalities, was even higher, at around 23%.

2. The term "incapacity rate" is used in this report to denote the total number of people on either sickness or disability benefit in per cent of the working-age population.

3. The pro-cyclical pattern of the aggregate Swedish sickness absence rate is partly due to absence-prone workers being more likely to lose their job, as shown in Hesselius (2007).

Figure 1.1. **The four waves of incapacity benefit growth until 2004**

Cases of sick-leave and people awarded a disability benefit (monthly numbers)[a]

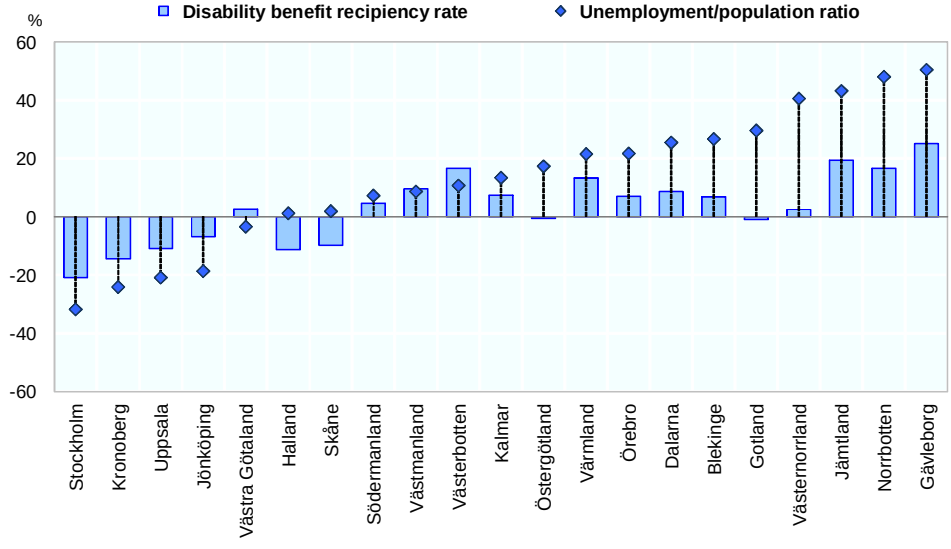



*a)* Sickness absence data are on a monthly basis, while the annual number of inflows into disability benefit is divided by 12 to derive a monthly estimate.

*Source*: Swedish Social Insurance Agency.

Figure 1.2. **A strong positive correlation between unemployment and disability across Swedish regions**

Differences in percent from the overall rate in the country in 2007[a]




a) Regions ranked by increasing order of the difference in their unemployment/population ratio from the overall country ratio

*Source*: Swedish Social Insurance Agency and Public Employment Service.

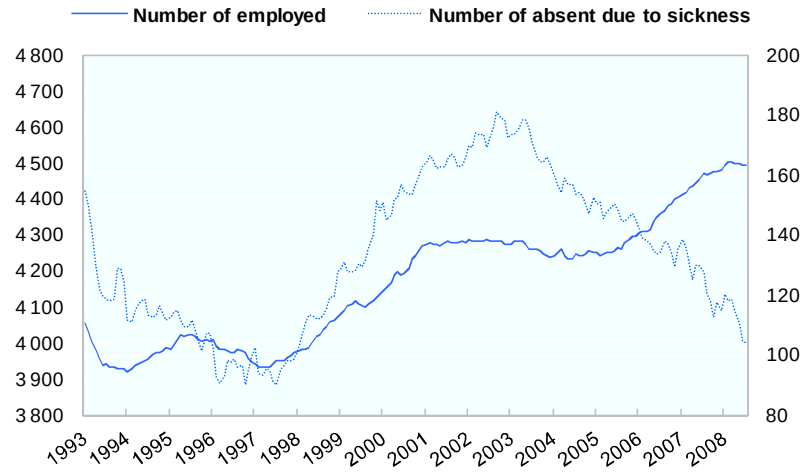
However, there is another mechanism at work. With sickness being the major gateway into permanent disability benefit in Sweden as it is in most OECD countries, high sickness absence rates have flowed on into increasing disability benefit recipiency (as shown in comparison with other countries in Figure 1.7) – and these rates have not fallen to the same degree and certainly not as quickly when unemployment rises, as it did in the 2002-2006 period. This is the second explanation for the persistently high overall dependence of the working-age population on social insurance payments – which is still close to 20% today.

Indeed, the relationship between disability and unemployment is quite a different matter, especially at the regional level. Counties with higher rates of unemployment also tend to have higher rates of disability benefit use (Figure 1.2), with a high statistical correlation of R=0.82. The causality of this relation, however, is not a given, although it appears that, first, both high levels of unemployment and high disability are indicators of a weak regional labour market and secondly, long-term unemployment is one of the risk factors in long-term disability (*e.g.* OECD, 2008a).[4]

The recent change in trends of benefit use shown in Figure 1.3 suggests that something different is now happening in Sweden. In the past three years, sick-leave numbers fell sharply despite a considerable increase in the number of employees. Until 2006, this change did not have an impact on overall dependence on social insurance benefits, because both unemployment and disability benefit recipiency increased. But in 2007, for the first time, employment increased at the same time as both unemployment and sickness absence fell.

Figure 1.3. **Sickness trend no longer follows the employment trend in recent years**

Seasonally adjusted 3-month moving average, persons aged 16-64, 1993-2008[a]




*a)* Employment on left-hand scale, sickness absence (people absent the whole week due to sickness) on right-hand scale.

*Source*: Statistics Sweden (LFS).

4. Johansson and Palme (2002) show that higher local unemployment is also associated with higher incidence of local sickness absence, together with a reduced likelihood of returning to work. Hence, the pro-cyclical negative relation between sickness and unemployment on a national level over time seems to go hand-in-hand with a positive association on a local level.

What is the reason behind this apparent shift in behaviour which seems to have started in 2004, *i.e.* prior to the new government taking office, and which has accelerated in the past two years? This question is explored briefly in the following section, covering the period until 2006, while policy changes after 2006 are the subject of Chapter 2.

## 1.2. Major reforms in the period 1990-2006

### *A. The 1990s*

Initially, the big economic downturn in the early 1990s opened a window of opportunity for reform (following a period without any major reforms during the 1980s). This window was used for various reforms of the sickness benefit scheme, especially:

- The introduction of a 14-day sick-pay period covered by the employer as of 1992;
- The (re-)introduction of a waiting day without any benefit payment as of 1993; and
- Three waves of reductions in the sickness benefit level, in 1991 (75% of earnings in the first three days and 90% until day 90 instead of 100%, and 90% instead of 95% thereafter), in 1992 (80% after day 90) and in 1993 (70% after the first year of absence).

The main purpose of these reforms in the early 1990s was to bring down public expenditures by cutting payments to make short-term savings. The result was a sharp reduction especially in short-term absences. Swedish workers were very sensitive to changes in the sickness replacement rate.[5]

The reforms undertaken to address the crisis, however, did not have lasting effects. First, because of the urgency reforms were pushed through very quickly, without the normal consultation process. They were not supported by the main stakeholders, especially the social partners. This lack of support had two effects. First, reforms were at least partly undermined by corresponding increases in collectively-agreed benefit top-ups (the replacement rates mentioned above include those top-ups)[6]. Secondly, pressure to at least partly reverse the changes increased sharply when economic conditions improved. Moreover, the changes in the early 1990s also had other undesired effects: the average length of a sickness spell increased because workers tried to avoid facing another period of either no pay (on the first day of absence) or low pay (on the second and third day).[7] Not surprisingly, therefore, in the second half of the 1990s compensation rates were partly increased again, offering 90% until the end of the first year and 80% thereafter. This led to a rapid rise in sickness absence rates thereafter.[8]

5. Various papers show a strong positive relationship between the sick-leave compensation rate and the absence level (*e.g.* Henrekson and Persson, 2004), though separating out the effect is difficult because changes in replacement rates coincided with other variations in the business cycle.

6. Collective agreements also introduced different compensation levels across workers: municipal workers and blue-collar workers have a higher compensation level from day 91 (90% instead of 80%).

7. The initial idea with the 1991 reform was that it would increase the cost of beginning a work-absence period, thus leading to a decrease in incidence. But the reform also increased the cost of returning to work after day 90 so that workers on long work-absence spells increased their duration, as was found in Johansson and Palme (2004).

8. Hesselius and Persson (2007), for example, have shown that a 10 percentage point increase in the replacement rate for absences of duration of 91-360 days, in 1998, led to an increase in the number of

The early 1990s also marked the starting point for changes in the disability and vocational rehabilitation schemes. Vocational rehabilitation was reformed in 1992 with the aim of strengthening rights and responsibilities of workers and the employers, to encourage early intervention, to improve the coordination role of the Social Insurance Agency (SIA) and to open the provider market for private operators. Relevant changes in the disability benefit scheme included the introduction of the "elderly rules" in 1993 (when it was no longer possible for workers over age 60 to receive a disability benefit on the grounds of labour market reasons though medical criteria continued to be enforced less strictly) and the abolition of any special access conditions for workers over age 60 in 1997. The latter change is one of the reasons for the particularly sharp increase, starting in 1998, in long-term sickness absence – which is still much higher today than it was prior to 1998.[9]

There were additional factors explaining why reforms undertaken during the 1990s largely failed in the longer run. Due to the lack of support from the key stakeholders, policy implementation was very lax. Sickness monitoring, rehabilitation procedures and eligibility rules for disability benefits were, in theory, relatively strict by international standards, but poorly applied or not at all[10]. General practitioners were reluctant to deny sickness certificates to workers, despite a tougher set of rules introduced in 1995.[11] Employers failed to fulfil their obligation to undertake a rehabilitation investigation, which should form the basis for the preparation of a rehabilitation plan prepared by the SIA, without any consequences. Local social insurance offices faced strong incentives not to deny benefits, especially disability benefits, with elected local politicians being involved in administering the system.

### *B. Since the turn of the century*

System reform came back on the agenda when it became clear that long-term sickness and disability was growing much faster than was fiscally tolerable. The far-reaching old-age pension reform enacted in 1999, following a long and comprehensive reform process, also added to the problem, as it left the disability benefit system (which was part of the pension system then) unreformed. Not only did this suddenly make the disability benefit appear more attractive than an actuarially reduced old-age pension, but in addition contributions to the new old-age pension system came for free on top of the disability benefit payment.

In mid-2000, a government committee proposed far-reaching reforms including to: *i)* extend the period of employer responsibility from 14 to 60 days; *ii)* introduce co-payments by the employer throughout the sickness spell; *iii)* limit the period of sick pay to one year; *iv)* merge sickness and disability insurance; and *v)* replace permanent disability benefit by a temporary activity benefit with special work incentives (for those aged 19-29) or a temporary sickness compensation (for those aged 30 and over).

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absences of such duration by, on average, 4.7 days and correspondingly an increase in the overall costs of the national sickness insurance by 3%.

9. Studying the impact of the 1997 reform, Karlström *et al.* (2008) found that, rather than leading to higher employment of the 60-64 age group, sickness and unemployment insurance absorbed many of those no longer entitled to disability insurance – the well-known communicating vessels effect.

10. According to a study by Ahlgren *et al.* (2008), the proportion of clients on sickness benefit who received vocational rehabilitation measures varied across SIA offices from 1.2% to 8.7%.

11. Söderberg and Alexandersson (2005) and Söderberg and Mussener (2008) found that doctors often fail to provide sufficient information concerning work capacity.

Resistance to reform by the social partners continued, but the poor outcomes allowed the government to introduce some changes. Sickness and disability insurance was merged in 2003, as proposed by the Committee, with slightly different rules for those younger and older than 30 years, but with no change in benefit levels. The proposal to introduce a time limit for sickness benefits was dropped but the employer period was increased to 21 days in 2004. This change was reversed again in 2005 when employers, in addition to being fully responsible for the cost of sickness absence for the first 14 days, had to co-finance 15% of the sickness compensation costs after the second week of absence and continuously throughout the sickness spell.

The most important change probably, however, was the restructuring of the SIA in 2005. Prior to this, the SIA was comprised of 21 semi-autonomous regional offices; decision processes differed largely, as did the outcomes in terms of benefit grants (as shown in Figure 1.2). Today, the SIA has a centralised administration thus bringing much greater consistency and purpose to the form and quality of frontline services. In addition, already in 2003, cooperation between the SIA and the Public Employment Service (PES) was improved, with a focus on long-term sickness benefit clients.

Sickness absence levels had already started to fall rapidly in 2003 (and in 2004 for absences of more than one year), and disability benefit inflows followed this trend in 2005. Analysts and policy makers generally agree that this fall was not brought about by a substantive change in regulations (essentially eligibility criteria, monitoring criteria and assessment procedures remained unchanged), but by a gradual improvement in the way existing regulations were being implemented.

This seems to have gone hand-in-hand with a change in social attitudes and norms, especially in regard to moral hazard in connection to the use of sick-leave on an ongoing basis. This is also reflected in a change in the process for granting sick-leave certificates by General Practitioner's (GP's), which is now done according to new guidelines. Though the first of these were formally introduced in 2007 (see Chapter 2) the process for developing them – which started several years earlier – had an impact on public attitudes. All this seems to reflect a gradual shift in policy consensus away from passively providing easily accessible replacement income to actively promoting participation in work. This provided a promising starting position for the new government, which took office in 2006 with the aim of reducing inactivity significantly.

Indeed, current reforms are very special and promising for one particular reason: this is the first time in the history of Swedish sickness benefit policy-making that structural change is being undertaken during a period of *falling* sickness absence. This suggests the reforms have considerable potential for breaking the pro-cyclical link between unemployment and sickness, even though the recent economic downturn might delay this success.

## 1.3. How Sweden compares with other OECD countries

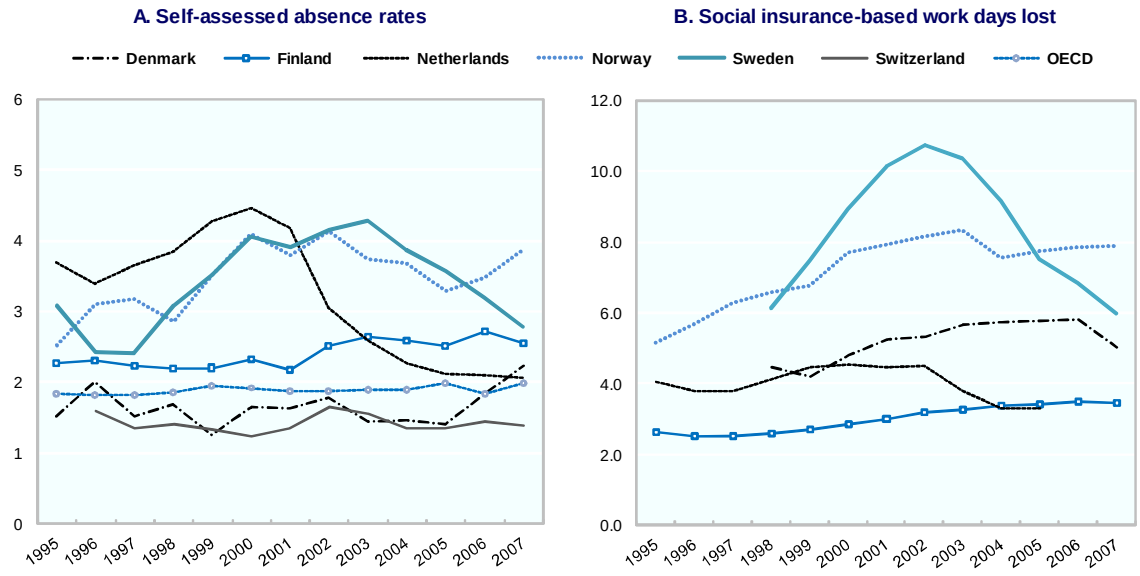
To better understand the need for reform of sickness and disability schemes in Sweden, it is helpful to compare outcomes with those in comparable OECD countries. In the following section, five countries which were reviewed by the OECD over the past three years are used as a benchmark: the other three Scandinavian countries (Denmark, Finland and Norway) and two other wealthy and small European economies (Netherlands and Switzerland). One has to keep in mind, however, that all of these countries are facing problems and seeking to reform their schemes. For example, in all countries spending on disability benefits is more than twice the OECD average.

## A. *Sickness and disability benefit*

With almost 10% of workers absent from work at any time, the sickness absence rate in Sweden was huge only a few years ago, and much higher than elsewhere[12]. The fall in absence levels after 2002, however, was equally remarkable as the increase in the period 1998-2002[13]. Nevertheless, also today, at 6%, absence is still higher than in most other OECD countries, except Norway (Figure 1.4, Panel B). Measures based on self-reporting, *via* Labour Force Surveys, confirm this: 3.5% of Swedish (and Norwegian) workers report to have been absent due to sickness during the whole week before the interview. This is twice the average for European OECD countries (Figure 1.4, Panel A).

Figure 1.4. **Sickness absence was very high in 2003 and remains so by international standards**

Share of workers absent from work (A) and share of work days lost (B), 1995-2007[a,b,c]




*a)* Panel A gives the number of employed persons reporting not having worked at all during the week prior to being interviewed, due to illness, injury or temporary disability.

*b)* Data in Panel B were derived in the following way: the total number of annual absence days, unless available directly, is calculated by multiplying the number of spells by the average duration of each spell. This result is divided by the labour force resulting in the average number of days of sickness per person. These figures are further divided by the number of actual working days (the number of statutory minimum annual leave and paid public holidays are removed) in each country.

*c)* Annual absence days in Panel B are exclusive of both short-term absences covered by employer-paid sick pay and waiting days, *i.e.* absences of 1-9 days in Finland, 1-14 days in Denmark, 1-16 days in Norway and 1-15 days (and 1-22 days as of 2003) for Sweden. Data for the Netherlands, where the employer-period is two years, exclude absences of 1-7 days.

*Source*: EULFS for Panel A, data supplied by national authorities (Social Insurance Agency for Sweden) for Panel B.

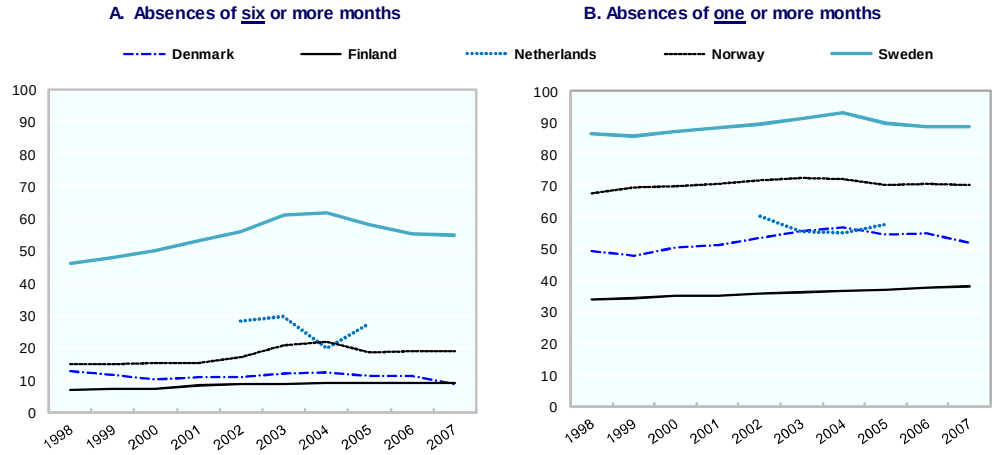
12. Only in the Netherlands, in the early 1980s, was absence rate at a comparable level. This was one of the driving forces behind the radical changes to its sickness benefit scheme, and later on also to its disability and vocational rehabilitation schemes (OECD, 2008).

13. Part of the decline in the absence rate in Sweden from 2003 to 2004 (as measured by administrative statistics, *i.e.* Panel B) is due to the lengthening of the employer-paid period, which is not covered in the data, from two weeks to three weeks (reduced again to only two weeks as from January 2005 when the co-payment was introduced). On the other hand, although even now one in ten new sick leaves extends beyond one year, the percentage of sickness benefits terminated between day 30 and day 90 has increased every year since 2005.

The main explanation for the high overall sickness absence level in Sweden is the extremely high share of long-term sickness absence – with Sweden being the only country in this sample with no time limit on sickness benefit until recently[14]. For instance, absences of more than six months comprise no more than 10% of all absences in most countries, but around 20-25% in the Netherlands (which has a two-year time limit) and in Norway, and exceed 50% in Sweden (Figure 1.5). Short-term absence is, therefore, even lower in Sweden than it is in many other countries.

Figure 1.5. **Sweden is still the leader in long-term sickness absence**

Long-term sickness absence spells as a share of all absence spells (percentage), 1998-2007[a]




*a)* Annual absence days are exclusive of both short-term absences covered by employer-paid sick pay and waiting days as in Figure 1.4.

*Source*: Administrative data supplied by national authorities (Social Insurance Agency for Sweden).

Sickness absence levels are critical for the development of the inflow into disability benefits, given that in most countries the majority of new disability benefit claimants would come into the system following a period on sickness benefits. In Sweden, this is now true for around three-quarters of all new claims (while it was more than 85% until 2005). Comparable figures in other countries are over 95% in Norway, where many people are going through an intermediate phase of medical and/or vocational rehabilitation, 85% in the Netherlands, 60% in Finland (where another 26% enter *via* a period of unemployment) and 50% in Denmark (where another third enters *via* social assistance).[15]

Trends in the annual rate of inflow into disability benefit in Sweden reflect the large fluctuation over time in sickness absence levels, as do the rates in Norway. The level of inflows oscillates around 1% of the labour force per year, in both Norway and Sweden; this is slightly higher than in Finland and much higher than in Denmark and Switzerland and, since recently, also in the Netherlands (Figure 1.6). The latter country is an example of how large the impact of far-reaching benefit reform can be: by significantly increasing the financial responsibility of employers and the financial incentives to work for workers (OECD, 2008), inflow rates in the Netherlands dropped from over 1% annually up until 2002 to only about 0.4% in the most recent year.[16]

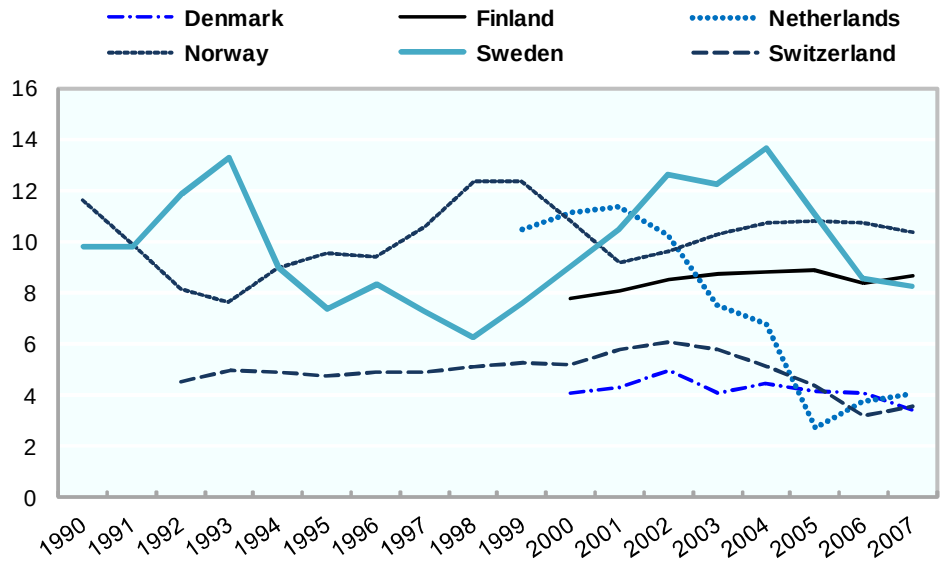
14 . The only other OECD country with no time limit for sickness benefits was Ireland, which is going to introduce a two-year limit for its Illness Benefit in 2009.

15. More details on pathways into disability benefits can be found in OECD (2006, 2007 and 2008).

16. After a number of transitional changes, the longer-term structural inflow rate into disability benefit in the Netherlands is projected to stabilise at around 0.5% – half the level prior to reform.

Figure 1.6. **Large fluctuations in disability benefit inflow in Sweden**

Disability benefit inflows per 1000 of the working-age population, 1990-2007



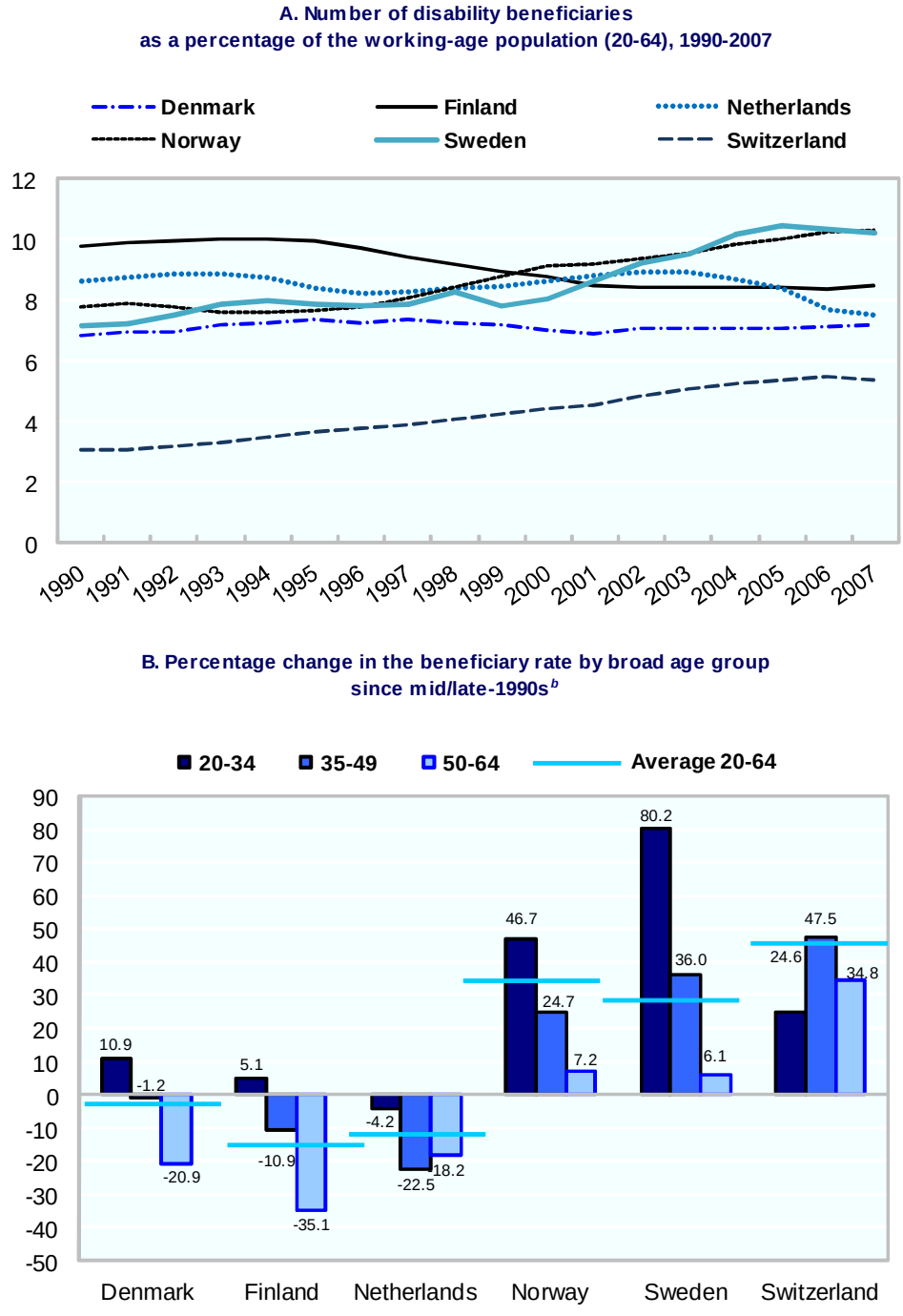

*Source*: Administrative data supplied by national authorities (Social Insurance Agency for Sweden).

Not surprisingly, the high inflow rates in Sweden and Norway have led to a continuous increase in the total disability benefit recipiency rate, which is now slightly above 10% in both countries (Figure 1.7, Panel A). The increase was much less pronounced in Finland, because the average new claimant is older and the average duration of being on disability benefit shorter. The example of Switzerland shows that at a lower initial level of benefit receipt, lower inflow rates would also produce rising disability benefit recipiency levels. The example of the Netherlands shows that falling inflow rates will also eventually translate into falling recipiency levels. However, this finding is partly explained by the reassessment of entitlements over the past three years of Dutch disability benefit recipients under age 45, which has indeed led to either a reduction or a loss of benefit in one of three cases. This is in sharp contrast to reforms in most other OECD countries, including Sweden, which tend to grandfather the entitlements of current recipients.

Panel B of Figure 1.7 shows that the increase in disability benefit recipiency rates in Sweden since the mid-1990s was by far the largest for young workers: 80% for those aged 20-34 years. This is a more general phenomenon also, though to a lesser extent, found in Norway, Denmark, Finland and the Netherlands, where trends for the youngest age group go against the general trend Switzerland seems to be an exception). The same trend is found in other countries (OECD, 2007). The result of this general phenomenon is that the average recipient is getting younger and the average duration of benefit receipt longer – increasing the total numbers on disability benefit and the fiscal costs of the programme accordingly.

Figure 1.7. **Sweden has recorded the largest increase in disability benefit recipiency since 2000**

Disability benefit recipiency rates and change in the beneficiary rates by broad age group (percentage)[a]




*a)* Beneficiaries: disability pension (Denmark, Norway, Sweden, Switzerland); earnings-related and/or national disability pension (Finland); Wajong, WAO and WIA disability benefit (Netherlands).

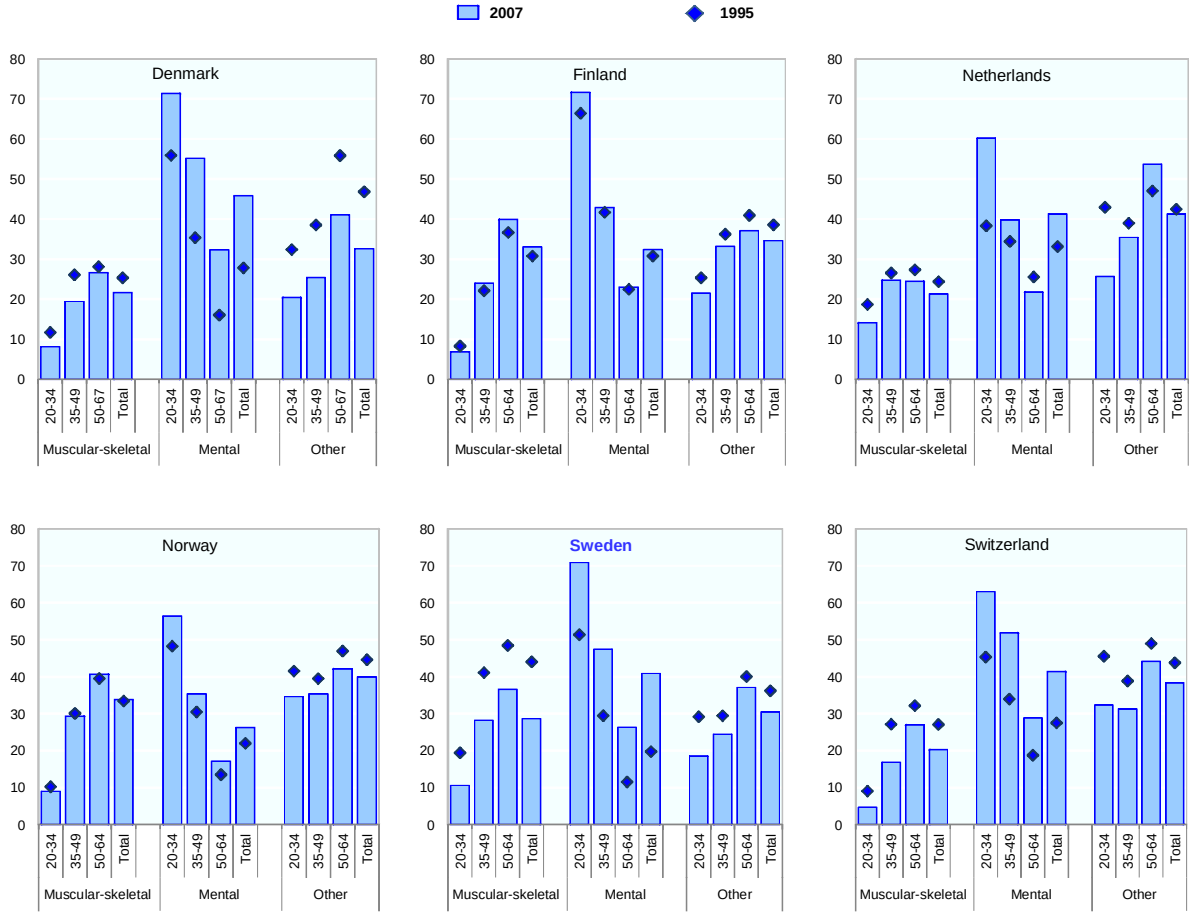
*b)* In Panel B, the period covered is 1995-05 in Denmark, 1999-2007 in the Netherlands and 1995-2007 in all other countries.

*Source*: Administrative data supplied by national authorities (Social Insurance Agency for Sweden).

There is another phenomenon throughout the OECD, which is closely related to this shift in the age structure of new and current claimants. Increasingly, disability benefits are being claimed on the basis of mental health problems. These conditions now account for some 70% of the inflow into disability benefits among younger adults in most countries, and for around 40% across all age groups. Sweden is no exception to this trend, although the change since the mid-1990s seems even faster than in most other countries; for instance, for the total population the share of the inflow caused by mental ill-health doubled from 20% to 40% within only 12 years.

Figure 1.8. **Mental health conditions are now the key concern in all OECD countries**

Distribution of total inflow to disability benefits by health reason and age, around 1995 and 2007 (percentage, total in each age group equals 100)[a]



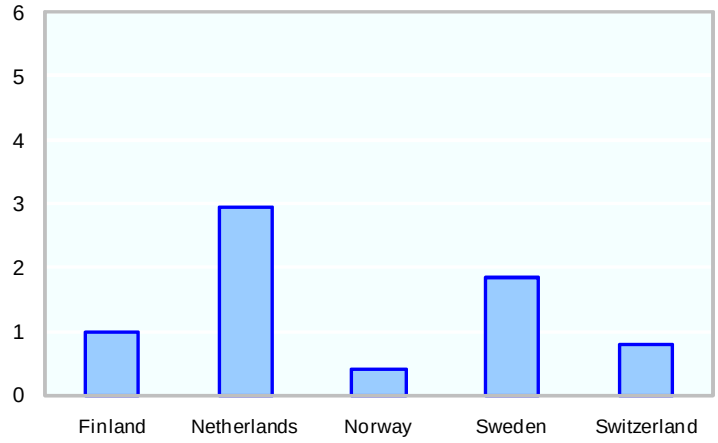

*a)* First year is 1999 for the Netherlands and 2000 for Denmark and Finland; second year is 2005 for Norway.
*Source*: Administrative data supplied by national authorities (Social Insurance Agency for Sweden).

There is much uncertainty about the reasons behind this phenomenon. Epidemiological and medical studies generally agree that the prevalence of mental ill-health as such has not increased significantly among the general population. Explanatory factors, therefore, include the reduced stigma on mental health problems and, associated with this, the higher frequency of doctors identifying mental ill-health as the main illness (rather than a co-morbidity), and the shift in the industry structure of the labour market which has resulted in increasing average psychological demands of work.

One of the reasons for the consistently high, and sometimes still increasing, numbers of people on disability benefit is the permanent character of these payments. Throughout the OECD, very few people ever exit disability benefits, especially to return to work. In most countries, including until recently Sweden, the rate of annual outflow is around or even below 1% of the recipiency population (Figure 1.9). Only very few countries have higher outflow rates, including the Netherlands which has done a full review of entitlements of all recipients under age 45 over the past few years, which has seen outflow rates rise to as much as 5% in peak years (and 3% in the last year). In Sweden, rates of outflow have long fluctuated around 1% but they have almost doubled recently – to reach 1.9% in 2007 and probably around 2.3% in 2008 (provisional OECD estimate). This outcome is a promising response to the recent policy changes.[17]

Figure 1.9. **Outflow rates from disability benefits are low but have increased in Sweden recently**

Annual outflow from disability benefits as a share of all disability benefit recipients (percentage), 2007[a]




*a)* All outflows, excluding deaths and transfers to old-age pension. Data for Finland refer to 2006.
*Source*: Administrative data supplied by national authorities (Social Insurance Agency for Sweden).

## *B. Social and economic integration of people with disability*

Sickness and disability schemes provide key outcome indicators for policy makers. A different but equally important aspect for disability policy is the social and economic integration of people with disability. Measuring the latter is not straightforward because, unlike unemployment for example, disability and impaired health is not a clearly identifiable dichotomous category but a complex concept influenced as much by personal characteristics as by social and environmental factors and barriers. The following indicators are based on self-assessed disability, as measured by the European Survey of Income and Living Conditions (EU-SILC).[18] On the basis of this indicator, almost 20% of all Swedes aged 20-64 classify themselves as having a disability (the share is even higher in Finland but slightly lower than this in the other four countries).

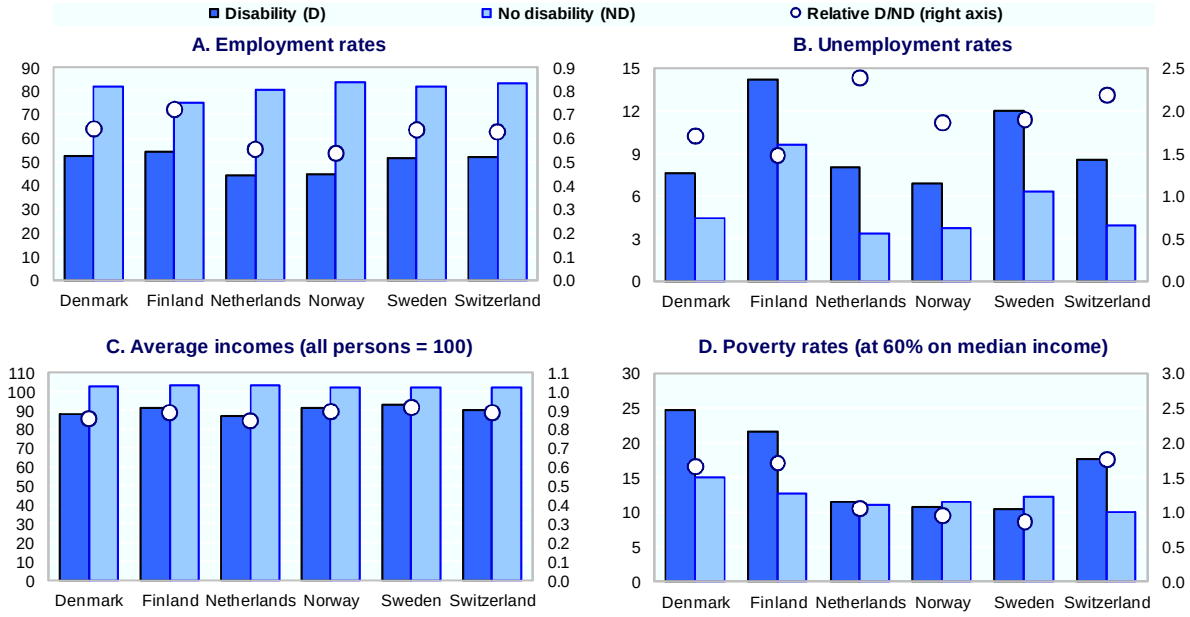
17 . More detailed outflow data for Sweden suggest that around one-third of those who leave disability benefit move into work, one in four into unemployment and one in six each onto either another benefit or into full-time education.

18 . A person is classified as having a disability if a) having a chronic health problem, illness or disability *and* b) being moderately or severely hampered in activities of daily living by this health condition.

Figure 1.10 shows that Sweden is doing comparatively well on some indicators of social integration of people with self-assessed disability. Employment rates of people with disability are only slightly above 50% but they are not higher in other better-performing OECD countries.[19] Relative to their peers without disability, employment rates in Sweden stand at around 62% – roughly the same value that is found in Denmark and Switzerland, with only Finland having a relative rate of over 70%.

Figure 1.10. **Employment is low and unemployment high, but incomes are also high and poverty is low**

Employment rates, unemployment rates, individual incomes and poverty rates: people with versus people without disability, age group 20-64, absolute (left-hand scale) and relative (right-hand scale), latest available year[a,b]




*a)* Definition of disability on a self-assessment basis. Denmark, Finland, Norway and Sweden: existence of a chronic health problem or disability and long-term limitations in daily life activities; the Netherlands: suffering from a long-lasting complaint, illness or disability which impedes carrying out or obtaining a paid job ("work disabled"); Switzerland: persons with reduced capacity due to a long-lasting health problem of more than a year.

*b)* Poverty rates: percentages of persons with disability in households with less than 60% of the median adjusted disposable income.

*Source*: Denmark and Norway: LFS 2005; Netherlands: LFS 2005/2006; Finland and Sweden: EU-SILC 2005; Switzerland: LFS 2005 for employment and unemployment, Health Survey 2002 for income and poverty.

Sweden is not doing as well in terms of unemployment rates, with over 12% of all people with disability being unemployed. On this account, among the countries compared, only Finland is performing worse. In most countries, including Sweden, unemployment is around twice as high for people with disability as for those without disability.

As in most OECD countries, individual incomes of people with disability are only 10 percentage points lower than for the population as a whole. Big differences across countries, however, are found in terms of poverty risks: in some countries, including Sweden but also Norway and the Netherlands, poverty rates do not vary with disability status while in the other countries poverty rates of households with a person with disability are 60-80% higher than for other households.

19. Employment rates of people with disability are significantly lower than this in some other OECD countries, including, for example, Ireland and Spain (around 35%) and Poland (less than 20%).

In conclusion, the following facts emerge in comparing Swedish sickness and disability policy outcomes with those in other OECD countries:

- Sickness absence rates are still high although they have fallen considerably in the past few years. However, long-term sickness absence in particular remains much higher than elsewhere in the OECD.

- Inflows into disability benefit, despite large variation over time and a falling trend in recent years, are among the highest in the OECD, in turn contributing to the very high disability benefit recipiency rate of over 10% of the working-age population.

- The increase in disability benefit recipiency was particularly large for adults aged 20-34; this is a general trend in many OECD countries but it is more evident in Sweden.

- Outflows from disability benefit used to be as low as in most other OECD countries until around 2004, but have risen steadily and significantly to around 2% annually since then.

- The share of mental health conditions among disability benefit recipients has increased rapidly in the past decade and has now reached 40%. Again, this is a universal trend across the OECD, with Sweden being among the "front-runners". Of particular concern is the significant increase in young people with mental health problems.

- As in most OECD countries, employment rates of people with disability are only around 60% of those of their peers without disability, while unemployment rates are almost double.

- Poverty rates do not vary with disability as is the case in a number of other OECD countries. In most countries, households with a person with disability usually experience a higher risk of being in poverty.

The following chapter summarises what the new Swedish government has done in the past two years to address these key challenges so as to improve outcomes.