

Summary

An obligatory, general and uniform sickness insurance system like that in Sweden has both advantages and disadvantages. One advantage is that everyone, regardless of risk and need, is given income protection in case of incapacity to work due to illness. One disadvantage is that the system is vulnerable in terms of the incentives for actors involved in the sick-leave process. Historically, and by international standards, sick leave in Sweden has been characterised by high levels and extreme fluctuations. Following a clear decline between 2003 and 2010, sick leave is now once again on the increase. The Government anticipates that expenditure on sickness benefits will total approximately SEK 50 billion in 2018, which represents an increase of 150 per cent since 2010.

One important question for decision-makers is whether the increases and decreases in sick-leave rate are justified based on fundamental needs, or whether they are explained by other factors. This report looks at what research has to say about terms such as *sickness*, *health* and *capacity to work*, and the design of the current sickness insurance system with respect to the incentives for the actors involved to keep sick-leave rate at low levels. The aim is to increase understanding, based on medical and economic research, of why sick-leave rate can vary over time and between different groups, and propose changes that would lead to more stable and equal sick-leave rate over time. One of the starting points was that sickness insurance in its current form is well worth preserving. However, if willingness to pay is to remain strong, the insurance must reliably target the right people, i.e. benefit those who cannot work.

Health and capacity to work

The first part of the report discusses the meaning of *health* and *capacity to work*. A person's perception of his or her own health is determined by factors such as preferences, access to care, information and financial restrictions. Research has shown that given a certain level of more objective health indicators, highly educated people, high-income earners and women on average perceive their state of health as worse than people with low levels of education, low-income earners and men. Likewise, a person's *capacity to work* is difficult to establish and can be expected to be strongly linked to his or her own perceived state of health. This particularly applies to short periods of sick leave for which no medical certificate is required. One conclusion that can be drawn is thus that differences in sick-leave rate between groups should not be interpreted as real differences in their actual state of health. Nor should changes in sick-leave rate in society over time automatically be interpreted as meaning that there have been actual health changes.

This report clearly shows that differences in sick-leave rate over time and between groups cannot be explained solely by changes and differences in state of health and capacity to work. It is noted that the correlation between sick leave and other health indicators is weaker in times of high sick-leave rate than in times of low sick-leave rate. Correspondingly, the correlation between sick leave and other health indicators over time has been weaker in the northern parts of the country, where sick-leave rate has typically been higher than in the southern parts of the country. The report also notes that the sick-leave rate is higher among women than among men, regardless of sector. This remains the case even when a number of factors associated with work duties and position in the workplace are taken into consideration. Therefore, our analysis does not support the claim that has sometimes been made that the higher level of sick-leave rate among women is due to generally worse psychosocial working environments. One key insight gained from these analyses is thus that sick leave is partly determined by preferences, and that this must be taken into account when forming incentives for the actors involved to act in accordance with the aim of the insurance.

Actors in the sick leave process

The second part of the report describes the incentives for the main actors in the sick leave process and what we know of their actions from empirical research. The main actors are defined as being i) the insured party, ii) the doctor and iii) the caseworker at the Swedish Social Insurance Agency (Försäkringskassan). The insured party is either the individual or the employer, depending on the perspective taken.

A review of the empirical literature in the area of sickness insurance and related social insurance systems such as disability pensions, work injury insurance and the unemployment benefit system shows that there is clear support for the theory that individuals react to financial incentives: when the benefit level increases so does use of the insurance, and vice versa. Correspondingly, employers react to increased cost responsibility by increasing efforts to prevent sick leave among employees.

Extensive research also shows that time limits and screening and control have a dampening effect on use of the insurance. This applies both via the control or time limit itself as well as the incentives not to be controlled or reach a time limit.

Research into norms and social interactions shows that reception of benefits may be infectious. Empirical studies using data from the Swedish social insurance system have shown that if for some reason reception of benefits increases in an individual's surroundings, their own reception of benefits also increases. Research regarding the importance of the actions of doctors and case officers is still relatively new. Nonetheless, one recent study of the Swedish sickness insurance system shows that caseworkers and their attitude to the regulatory framework and to rehabilitation and cooperation initiatives may have a significant impact on sick leave.

Five proposals for better sickness insurance

There is nothing to suggest that the extreme fluctuations characteristic of sick-leave rate in Sweden over time are linked to health changes or to the working environment. Rather, research strongly suggests that the causes can be attributed to shortcomings in the incentives for the main actors to act in accordance with the

aim of the insurance. These shortcomings make sick leave sensitive to changes in regulations and their application, and to individuals' willingness to apply for sickness benefits. Even small changes in these respects can have major effects, via changing norms in society concerning sick leave.

The focus of our five proposals to improve the design of the sickness insurance system is to create better and more correct incentives for actors in the sick leave process. This is primarily to achieve a low and, over time, stable level of sick-leave rate and to better utilise individuals' capacity to work. The proposals target all of the main actors in the sick leave process and vary in terms of how far they differ from the current sickness insurance system.

1. A maximum time limit is necessary

A maximum time limit is a key component in achieving a level of sick-leave rate that is stable in the long term. It sends a signal that sick leave cannot continue indefinitely, thus creating incentives for all actors involved to find another solution before the upper time limit is reached. The research is also clear that time limits, and controls in a wider sense, have a dampening effect on sick leave. The Swedish government has announced that the current maximum time limit of 2.5 years of sick leave will be abolished on 1 February 2016. We argue that instead, quite the reverse should be considered; reducing the maximum time limit. This would probably create better prospects for any follow-up measures to be effective.

2. Avoid early measures

While time limits and controls of entitlement to benefits are clearly supported by research, the support for early measures is weak. On the contrary, the assessments that have been undertaken show that early action instead leads to longer sick leave and worse prospects of returning to work. For a strategy involving early measures to be effective, the right individual must receive the right measures. At present, there is only weak support for the notion that various kinds of rehabilitation and cooperation initiatives help the individual back to work. There is also much to indicate that caseworkers' work in assessing who needs measures and who does not is complicated. Rather than

unconditionally stepping up efforts to implement early measures, current findings instead support restraint when it comes to early action in cases of sick leave.

3. Place conditions on doctors' right to issue medical certificates

The role of doctors in the sickness insurance system is complex. This is partly because many illnesses lack distinct diagnostic criteria, and partly because declaring incapacity to work requires knowledge of the specific work duties concerned. There is a need to stimulate research into how capacity to work is affected by different diagnoses – particularly psychiatric diagnoses – to provide better support to doctors in their work. Correspondingly, doctors need to increase their knowledge of the requirements in different type of work.

Research has shown that attempts to provide county councils with incentives to grant less sick leave are swathed in difficult considerations. We propose instead that the Swedish Social Insurance Agency should be able to set quality requirements for care providers who issue medical certificates. These could for example consist in doctors being required to have certain knowledge of the sickness insurance system and how to assess capacity to work. Furthermore, the Swedish Social Insurance Agency could be tasked with scrutinising patterns in the granting of sick leave among care providers on an ongoing basis. This would allow non-objective differences and deviations from the bases for insurance-medical decisions to be rapidly discovered and investigated. In cases of repeat criticism or of outright fraud, it should be possible to withdraw care providers' right to issue medical certificates. As with public performance reports in the health and medical care system, the statistics at care provider level could also be published. This would probably have a disciplinary effect on the issuing of medical certificates.

4. Increase employers' cost responsibility for sick leave

Employers have an information advantage over the insurance provider with respect to the measures they can take to avoid sick leave among their employees. Swedish employers' cost responsibility for sick leave is relatively limited by international comparison. They pay sick pay for the first 14 days of sick leave,

with the exception of one initial qualifying day. Because employers are insured against direct costs for long-term sick leave, there is little incentive to act to keep sick leave down via preventive measures and measures to enable those on sick leave to return to work, for example. We believe that there are strong arguments in favour of strengthening employers' financial incentives to act to keep sick-leave rate down. Moreover, controls to ensure that employers and employees are doing their utmost to avoid sick leave need to be increased.

In one model outlined, the employer has to pay sick pay throughout the entire period that an employee is on sick leave. The cost responsibility rises the longer the sick leave continues. Additionally, the employer must be able to present a plan for the measures to be taken to facilitate a return to work in cases of sickness. The plan must be scrutinised and approved by the Swedish Social Insurance Agency. Both employers and employees should be offered financial incentives to meet their commitments under the plan. To avoid the risk of increased cost responsibility for employers further complicating the labour market situation of groups that are already vulnerable, exceptions to the cost responsibility should be made for selected groups.

5. Reduce political influence on sickness insurance and sick leave

The incentives for restrictiveness in insurance provided by central government are less than in the case of privately administered insurance. This is because central government, at least in the short term, has soft budgetary restrictions. The political price of preventive and long-term action is often deemed too high relative to short-term passivity. There is therefore much to indicate that separating political governance and governance of sickness insurance would benefit the aim of low and stable of sick-leave rate in the long term.

We advocate clearer management by objectives of sickness insurance. In one possible model, the Swedish parliament would determine the level of benefits and what constitutes a reasonable sick-leave rate (including take-up rate of disability insurance) in much the same way as the Swedish parliament currently sets

targets for the inflation. The Swedish Social Insurance Agency would then be tasked with administering the target set.

How the Swedish Social Insurance Agency has handled its role as supervisory authority in the sickness insurance system has probably had a significant impact on sick-leave rate trends, particularly in recent years. Provided that the incentives for doctors and employers to keep sick-leave rate down are strengthened, and the Swedish Social Insurance Agency is given greater opportunities to exercise control over those actors, we argue that it should be possible to achieve low and stable levels of sick-leave rate via this route. With the creation of the Swedish Social Insurance Inspectorate, ongoing assessment and scrutiny of the Swedish Social Insurance Agency's work will be possible. This aspect is crucial to accountability if the Swedish Social Insurance Agency fails to achieve the target set by the parliament while maintaining legal certainty.