

**Labor Market Activation Policies
For the Long-Term III -
A Sick Idea?**

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Introduction

Unemployment compensation, social assistance and compensation for a decreased work capacity because of illness are the major social rights programs in Sweden responsible for replacement of income lost. Active Labor Market Policy (ALMP) is a relevant strategy for use in cases of income lost because of unemployment and underemployment.¹ ALMPs are expected to correct labor market imperfections (Pierre 1999). Activation programs are a strategy being used for individuals on social assistance (welfare). If a person is on a long-term social assistance benefit in Sweden, it is because he/she is in some way excluded as not qualified for an ALMP program. Activation programs for people on social assistance (welfare) can be thought of as Social Activation Policy (AP) with a goal of funneling a person into an ALMP program.

Although there is much work on the affect of ALMP in Sweden (Forslund & Krueger 1997, Sianesi, 2002) and research on AP (Konle-Seidl 2007) has become more prevalent, a third policy approach directed towards the re-commodifying of individuals has escaped attention. In the advanced welfare states, this policy affects many more individuals than those unemployed or on social assistance. The new area of activation policy is a reconstruction of rehabilitation programs for the long-term ill to better align them as programs designed to return the sick individual to the labor market². I term this third area of activation policy as a *re-activation policy* (R-AP). Although some attempts to start these programs began during the 1990s, it has not been until recently that we can observe that they have been extended to ever increasing categories of individuals, they are used to legitimate curtailment of social rights, and they are a clear failure in returning the individual to work. Moreover, they have led to a burgeoning cottage industry of businesses who offer their services both in identifying the degree of work capacity remaining in the long-term ill and in preparing them to re-enter the labor market or to qualify for an ALMP program.

This paper focuses on the use of re-activation policy programs in Sweden. It is organized into three different parts. The first section of the paper attempts to frame re-activation

¹ Research on ALMP varies. A study by Forslund and Krueger 1997 showed that Sweden spent 3 percent of GNP on government ALMP as opposed to 2 percent in German and less than 0,5 percent in the United States. The programs in Sweden include extensive job training, public sector relief work, recruitment subsidies, youth programs, and mobility bonuses. Forslund & Krueger provide new evidence that public relief workers displace other workers, especially in the construction sector. Although they caution interpretation of the results of their research, they do point out that the review of the previous literature suggests that job training programs have small effects on wages and re-employment in Sweden. Sianesi (2002) found in a study of 110 000 individuals in a ALMP program once in a program were more likely to be back within another program than those that were unemployed longer by not waiting to enter a program or never entering a program. She means that ALMP program, even though it locks individuals into the program, shows that they are more likely to be employed than those not in a program. But also that they return to another program more often than those not in a ALMP program. In fact Sianesi means that the positive effect on employment does in fact arise because the programmes considerably reduce the chances of being unemployed outside the official unemployment system.

² These programs are not regular vocational and/or occupational rehabilitation which have existed since the 1950s and have developed as a field of medicine. Such rehabilitation is termed medical rehabilitation and is discussed below.

policy programs by looking at them together with ALMP and AP programs. The second section of the paper presents an evaluation of re-activation policy programs in use in Sweden. The evaluation examines two hypotheses: 1) *people selected into a R-AP program are more likely be back at work than those that did not participate into the program at the end of their sickness*; and 2) *the agency processing individuals for rights to long-term sickness benefits select individuals that are in most need of help in returning to work*. The evaluation will show that neither of these hypotheses can be accepted. The third section of the paper introduces different possible reasons why activation policy has been used in cases of the long-term ill and why they continue to be used given the failure of re-activation policy programs. The paper concludes with a brief discussion of the possible effect on governance and individual when the state enters into arenas of the private sphere.

1.Re-activation policy, Active Labor Market Policy and Activation Policy – “able bodied” or “dis-able bodied”

The original ALMP program ideology designed to improve the work capacity of the unemployed has been taken over and modified for groups of individuals with loss of income due to reasons other than structurally induced unemployment. Whereas the original ALMP program was designed to *maintain* a work capacity over a period of unemployment, the AP program is designed to *create* a work capacity for individuals on long-term social assistance. The R-AP program is designed to *discover* a work capacity in the case of the long-term ill individual.

Not only is there a difference between Maintaining, Creating and Discovering work capacity, there are differences in the underlying processes that originally affected work capacity.

Table One: Active Labor Market Policy, Activation Policy, Re-Activation Policy

	Work Capacity	Status	Causes	Social Right
ALMP	Maintain	Unemployed	Structural	Unemployment
AP	Create	Welfare	Case-related	Social Assistance
R-AP	Discover	Long-term Ill	Medical	Social Insurance

If we look at Table One, we see that the original situation for using Active Labor Market Policy was a structural response to a structural problem affecting able-bodied workers not able to find employment. When we look at Activation Policy or Re-Activation Policy we see that they are not directed towards able-bodied workers. Instead, it is just because of dis-abledness, social and/or physical, that individuals are not part of an Active Labor Market Policy.

Even if both an Activation Policy and a Re-Activation Policy is seen as or is legislatively passed as a type of Active Labor Market Policy, this is a misnomer. Activation policy as well as re-activation policy has a formal goal to move people off of welfare or social insurance to a position of economical self-support through work. However, these individuals are not able-bodied and thus we find in outcomes of both activation policy

and re-activation policy programs for the long-term ill, people that simply are unable to work. Those people that are no longer in need of social assistance or no longer medically incapacitated, usually find work without the help of AP or R-AP programs (Hetzler et al 2005).

Both AP and R-AP programs have come about because of mistrust and mistrust lies in the fact that governments believe that people on long-term welfare assistance or those on long-term sick leave, both programs defined as social rights, are in fact able-bodied and can find employment on the open market if they tried.³ Thus activation programs and re-activation programs have as their real goal to find the legitimate dis-abled and separate them from those posing as dis-abled. Programs geared towards social activation usually try to create habits or behavior patterns in an individual that will allow them to seek work. These might be waking up a certain time and appearing at a location every day. Or it might be learning the Swedish language.

In cases of re-activation policy programs, the long-term ill individual has already acquired skills of “work behavior” but instead has, because of illness, a reduced work capacity. Programs aim at finding a portion of the individual’s total work capacity that can still be used. If because of illness or other impairment of physical or mental performance, work capacity is reduced, the question becomes if there exists within the individual a portion of “healthy” capacity which can be discovered as existing along side the “ill” reduced portion.

A structural effect of this process is that individuals are caught in processes that prolong their situation as welfare recipients or as long-term ill. There is also a spill over to legitimate ALMP programs. As AP and R-AP programs become more plentiful, original ALMP programs designed to maintain work capacity are being questioned as necessary. The able-bodied individual is being seen as competent enough to maintain his own work capacity without help of an Active Labor Market Policy program.

2. Evaluation of Re-activation policy programs in Sweden

Sweden introduced the use of re-activation policies designed to return the long-term ill to work in the beginning of the 1990s⁴. In order to discuss the policy use of re-activation

³ A number of attempts designed to change the differences in reimbursement for differing benefits were used by the government to move people from the sick rolls. Social insurance because of illness was seen as economically more advantageous for the individual than receiving unemployment benefits. These changes were not in fact sufficient to stop increases on the sick rolls. See Melen (2008).

⁴ At the time the policy of using Activation Policy programs in social insurance for long-term ill was introduced, the National Board of Social Insurance declared the south of Sweden a test area for developing procedures for a “Fight for Health.” The “Fight for Health” included methods of agency bureaucrats to shorten sick leaves and also a variety of special designed programs to return the sick individual to work. An evaluation of this initial period (Hetzler A & Erikson K, 1997) was extremely valuable as a reference period ten year later when R-AP programs were in full force. The same area as that examined and evaluated in 1990-1993 was revisited in the study of 2001-02.

programs, it is necessary to first understand if they truly do return the long-term ill to work. The material I present is an evaluation of the effect of R-AP programs and is based on a recently completed research project of 4007 long-term ended sick cases in 2001-2002 and a detailed follow-up of 400 of the cases two years later. The 4007 long-term ended sick cases were randomly selected in the southern province of Sweden so that every fourth long-term sick case that ended during a 15 months period was selected for the study. 691 individuals or 17,3 per cent of the total population participated in a R-AP program.

The main concerns of the evaluation were the results of re-activation programs for the *individual* as well as the process by which people are selected into programs.

Do individuals return to work quicker than those that do not participate in re-activation programs? How do individuals participating in labor re-activation programs while on sick leave end their sick leave?

The paper also examines the *processes* involved in activation programs. What kinds of activation programs are in use for the long-term ill? Are people from marginalized and weak groups (e.g., unemployed, immigrants, unskilled, lower socio-economic groups) differentially selected to participate in activation programs)?

The political implications of re-activation policy programs affect the concept of “sickness” as well as the social right for compensation for reduced work capacity that in Sweden has been centralized through state social insurance. A person who is long-term ill and is on sick leave benefits by definition has a reduced working capacity because of illness. Such a person can be in need of rehabilitation after an illness in order to increase the quality of his life. He/she can also be in need of vocational rehabilitation in order to be able to return to work. One would not normally think of rehabilitation as a re-activation program. Yet beginning in the 1990s when Sweden faced the biggest recession in modern times and when sick rolls began to rise as those on unemployment and social assistance began to fall, the principle of self-support through own work capacity began its march into sick-leave and the character of vocational rehabilitation changed to a simulation of ALMP.

2.1 Re-activation policy and the individual. Within the Swedish Social Insurance Agency in Sweden, the agency charged with processing cases of individuals on sick leave, there are two categories of rehabilitation: Working life rehabilitation and Medical rehabilitation. Medical rehabilitation defines a number of programs which might be considered in other countries as a part of vocational rehabilitation. Medical rehabilitation includes physical therapy, work therapy, special treatment for those with sight and hearing impairments and normal medical care. There are also a number of secondary services offered the individual that are also included in the agency’s concept of medical rehabilitation. They include supporting functions, counseling and functional testing.

The effects of those individuals receiving medical rehabilitation are not discussed in this paper.⁵ However, by defining medical rehabilitation as a special category common to vocational rehabilitation, the programs that are designed solely to put a person back to work, more clearly identify these programs as re-activation policy (R-AP) programs.

Working life rehabilitation measures are programs that we mean are R-AP and are intended to discover a work capacity in the long-term ill individual. These programs include educational courses, work training, work testing, work adaptation, employment at state work centers and active sick leave.

Our hypotheses is that people selected into a R-AP program would more likely be back at work than those that did not participate into the program.

17.3 per cent (691) of the total population in the research population received some sort of working life rehabilitation. A study performed of the long-term ill in the beginning of the 1990s in the same area of Sweden found that of 8000 terminated long-term illness only 8,3 percent had undergone a working life rehabilitation program. The use of these programs within a ten year period has increased by over 100 per cent.⁶

The most common program for those that were selected for R-AP was simply work training. Actually, this means that the sick individual was required to return to work for a number of hours every week as a condition for keeping her sick pay. This is not a formal requirement of law for maintaining a sickness benefit. Practically, if an individual on sick pay refuses to try and return to work, the social insurance office could argue that it no longer had enough proof to determine a reduction in work capacity and could withdraw the benefit.

Work training program was organized so that the individual on sick leave was thought to gradually increase her working time and when it finally stabilized at a level of 100 per cent or at a lower level, the employer would start paying wages and the social insurance authorities would stop paying a sickness benefit.⁷ 55 per cent of those with working life rehabilitation were enrolled in such a program (380 individuals). Work training programs were generally returning to the same work place but not necessary the same position as was held prior to sick leave. For example, a grade school teacher on sick leave for stress and anxiety might return to the school and work in the library.

⁵ I am not interested in this paper on the outcomes of medical rehabilitation because many of the services defined as medical rehabilitation are also a part of normal medical care. Thus, there is not clear delineation between medical care and vocational training.

⁶ A complete comparison with the study done in 1990-1993 can be found in Hetzler et al 2005.

⁷ These programs are of a decided advantage for the employer. Whatever work the long-term ill person is performing is being done without cost for the employer. One can say that the employer has an interest in keeping his employee on long-term sickness payments and in a work training program. This means that the individual is not recognized as stabilized at a certain level of work (25, 50 or 100%). Usually, the program is prolonged as one tests the ability to increase the number of hours of work. If the individual can not complete a certain number of hours, the program might continue to give the individual a new "chance."

The next most common program was work testing. This was given to 14 percent or 97 individuals in the study. Work testing was usually out-sourced to an agency that attempted to find an activity that the individual with a reduced work capacity caused by illness could perform. In these cases, the long-term ill individual was not able to return to his original place of employment for one or the other reasons.⁸ But also, work testing was used if the individual was unemployed at the time of his illness or during his illness became unemployed. These program last for a series of weeks and can involved things as varied as painting furniture, welding, computer training, cooking food, writing resumes, group discussions or working in parks. At the termination of the program, the individual on sick-leave is evaluated by a team running the particular program. The evaluation is an assessment of the individuals working capacity based on his/her performance in the program. In a person can go back to work his/her disability will be assessed in relation to their normal job. If not, the disability will be assessed in relation to other work that the employer can offer. If the employer has no other work to offer the capacity for work is assessed in relation to the needs of the labor market as a whole.

The third program most often used was to complement the long-term ill person's education with a new educational program. This was used in 11 percent of the cases or about or 82 individuals.⁹

What we do see is that for those individuals that were involved in R-AP programs the average length of the sick period was 326 days longer than those not selected for an R-AP program.¹⁰ The average length of sick leave for those outside the program was 246 days. (See Table 2 below.)

But what was even more interesting is the fact that the R-AP measure was introduced early in the sickness process. Those that were selected for an R-PA program were assigned to the program within four or five months of their sick period. This suggests that the program itself contributed to a longer than necessary sick leave.

For those that underwent a working life rehabilitation process, the days of sick leave varied between those that returned to work and those that were granted a pension. For those that eventually received an early pension, their sick leave was an average of 939 days or over two and a half years. Those that were granted an early pension but did not participate in a R-PA, were only on sick leave an average of 650 days before receiving a pension. While those that returned to work, returned in a little over a year (397 days of sick leave), slightly longer than those who did not participate in a R-AP program and returned to work. This is important, because in the study 51 percent of those in the R-AP program ended their sickness with an early pension while only 34 per cent of them in a program returned to work. For those individuals that were on a long term sick leave and

⁸ This usually occurred for individuals with a psychiatric diagnosis. Often the individual had a work place dispute in connection that then resulted in a sick leave. In these cases, the individual usually did not want to return to the work place.

⁹ The other programs used were a program where individuals were put back to work in an work environment adjusted to their physical needs (45 individuals). 37 individuals were in a program of sick leave as a preventive method. 35 individuals were in individually tailored programs.

¹⁰ See Table 3 appendix. The table is explained more fully in the following section of the paper.

were not in a R-AP program, 23,8 per cent of them ended their sick leave with an early pension while 56,3 per cent of them returned to work. This result points to the fact that R-AP programs were not successful.¹¹ This is further confirmed by looking at the length of sick leave for those on the program. It might be considered reasonable that a person on an R-AP program would return to work somewhat later than the person not on a program. With the help of the material presented in **Table 2: Days on Sick Leave with/without participation in R-AP program or Rehabilitation**, we can calculate that an individual returning to work was on average on sick leave 151 days more (397 days instead of 246 days) as opposed to the individual that returned to work without R-AP.

Table 2: Days on Sick Leave with/without participation in R-AP program or Rehabilitation

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	246,213	6,027		40,853	,000
	R- AP	325,813	13,937	,320	23,378	,000
	Med Reh	347,345	12,850	,371	27,030	,000

^a Dependent Variable: Days on sick leave

However, we also know from a multiple regression analysis using the length of sick leave as the dependent variable that 29, 8 percent of sick leave days were directly related to the intervention of R-AP and/or medical rehabilitation. (See Table 3)

Table 3: Multivariable regression analysis of the length of sick leave

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	,546 ^a	,298	,298	322,512

^a Predictors: (Constant), Med Reh, R- AP

In the case of the individual ending his sickness by returning to work and having participated in an R-AP program 119 days of his sick leave could be explained by participation in the program. Thus the person who would probably return to work with or without the program encountered about 119 of days on unnecessary sick leave.¹²

¹¹ A look at how cases with R-AP programs ended their sick leave ten years earlier (1990-93), we see that 63,3 percent returned to work while only 11,9 percent ended their sick leave after R-AP program with an early pension.

¹² Another method used in the study also confirmed that the programs were not successful in returning the selected individuals to work. This study used profiles of different types of long-term sick leave cases and looked at the likelihood of individuals with this profile would return to work by participating in a R-AP program or without an R-AP program participation. For a middle aged person (31-45), lower income with

2.2 Selection for a re-activation policy program. A widely used argument in defense of activation and re-activation policy programs when faced with failing results is that these programs select the most hopeless cases for participation. The argument is that these individuals would most likely never return to work and that any return to work is more than would be possible without the program. To disprove this argument, one would have to design a study where individuals categorized as hopeless cases were randomly assigned to a program or not. Such a study has not been done. (See the comment in footnote 12 as a possible rebuttal of this argument from statistical comparisons of comparable cases.) It should be mentioned that the social insurance agency had developed a method to categorize cases. The method involved categorizing a long-term sick leave case into one of three categories: Wait and watch cases; RA-P or medical rehabilitation cases; and early pension cases. A fairly general categorization into one of the three categories is done early in the case (before 60 days of sick leave) and between 60 and 90 days an investigation re-examines the case and decides if the case is in need of medical rehabilitation or in need of a RA-P program to return to work. For those cases so identified, the case becomes subject to special processing by a case coordinator.¹³

From what we showed about those that returned to work at the end of their sick leave and those that were early pensioned at the end of their sick leave, we can conclude that the method of categorization had over estimated those in need of a RA-P program and underestimated the number of individuals that should be categorized as early pension cases. That is, if the selection process was correct, we would expect that those in RA-P programs would return to work as often as those without benefit of the program but their return would take a somewhat longer time. The same return to work statistics that showed the programs were not successful also show that the method for selecting cases in need of R-AP failed. If the outcome for the cases selected for R-AP showed that selection clearly did not point-out who would return to work with help, was there any other pattern that showed itself in case characteristics of those selected?

A hypothesis is that the agency processing individuals for rights to long-term sickness benefits select individuals that are in most need of help in returning to work.

A possibility to test if in fact those in most need of help are being assigned to R-AP programs would be to compare the characteristics of those assigned with those not assigned to programs. By also looking at the characteristics of those that returned to work after a long- term illness and those that ended their long-term illness with an early pension, we can demonstrate if those that were selected for R-AP program had the same characteristics as those most likely to be early pensioned.

an unspecified back ache, the likelihood for a man on a R-AP program to end his sick leave with a return to work was 39% and for a women 36%. Without participating in a R-AP program the likelihood increased to 63% for men and 60% for women (Hetzler et al 2005).

¹³ The separation of cases and the creation of a difference between an “investigator” and a “co-ordinator” when the need for a RA-P program is decided is a measure of professionalizing the case workers. We are not able in this paper to present an analysis of the entire method. However, it was built-up in the area where are study was done and had been in effect for few years before our study. But there have been critical comments about the method. An evaluation of the method (named the SASSAM method) concluded that it is doubtful if the method makes it easier to evaluate and prioritize cases. (Siggelkow 2003).

We used a 4-step stepwise, forwards logistic regression to test the odds of individuals selected to R-AP programs. The variables that originally were in the model of selection variables included biological characteristics variables (age, sex, national origin), work-related and socio-economic variables (employment status, occupation and income) and medical variables (category type of illness, institutional affiliation of referring doctor). The model discarded those variables that were not statistically significant in determining who was selected for an R-AP program. These variables were employment status, occupation, sex and national origin.

Table 4: Odd Ratios for Selection to an R-AP program shows the results of the odd ratios for a four stepwise regressions. The only variables that were significant in determining who participated in an R-AP program were age, affiliation of the referring doctor, diagnosis and yearly income. These four variables together only accounted for 2,9% of variation in who was selected, Cox & Snell R squared, or 4,8% of variation according to the Nagelkerke R squared measurement. Age, the most determining of the four variables, showed that those individuals between the ages of 36-45 were more likely than any other age category to participate in an R-PA program. Those least likely to be selected were those 25 years of age or younger and those older than 56. Those between 46 and 55 years old were almost as likely to be selected for participation as their colleagues between 36 and 45 years of age.

When the doctor who attested the validity of the illness was a company doctor employed at a care center provided by the company (as opposed to affiliation at a hospital, a local community care center, or a private doctor), the person was almost twice as likely to be selected for a R-PA program than if the doctor was affiliated with any other institution. Any individuals with illnesses other than those associated with musculo-skeletal or psychiatric illnesses were less likely to be selected into a program. Those with a yearly income of between 100,000 and 150,000 Swedish crowns (approximately 10700 – 16000 Euro per year) were more likely to be in such a program than others.¹⁴

¹⁴ Table 4 shows that the income groups 100 000 – 150 000 is only significant at the 10 per cent level.

Table 4: Odd Ratios for Selection to an R-AP program

	Step 1	Step 2	Step 3	Step 4
Age				
36-45	1***	1***	1***	1***
>25	,360***	,377***	,411***	,393***
26-35	,778*	,788*	,824	,815
46-55	,913	,905	,931	,941
56>	,473***	,460***	,476***	,476***
Affiliation of Doctor attesting Illness				
Work Place Care		1,931***	1,837***	1,908***
Diagnosis				
Mental			1,426***	1,423***
Musculous-Skeleton			1,606***	1,546***
Other			1***	1***
Yearly Income				
< 100.000				1***
100.000-150.000				1,428*
150.001-200.000				1,022
200.001-250.000				,944
250.001-300.0000				,831
> 300.000				,717
Model Summary				
-2 log likelihood	3174,699	3153,888	3131,869	3117,070
Cox & Snell Rsq	,013	,019	,025	,029
Nagelkerke Rsq	,022	,031	,042	,048

When we look at which individuals returned to work, **Table 5: Odd ratios for those Returning to Work after a Long-term Illness**, we see that return to work is most related to how long time the individual was on sick leave. Those on sick leave for three to six months have only a 60 per cent chance of returning to work compared to those on six leave only two to three months. The chances fall to only 6 per cent for those on sick leave between one and two years and only to 1 percent for those on sick leave two years or more. On the other hand, those that have been on sick leave form two or more years have a 480 times higher odds of being early pensioned than those on sick leave 2 – 3 months (**Table 6: Odd Ratios for individuals Early Pensioned after a Long-term Illness.**)

Table 5: Odds ratio of returning to work after a long term illness
 Stepwise (6 step) – Forward:LR. (cut value ,500)

	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
Number of sick days						
<3 months (ref)	1***	1***	1***	1***	1***	1***
3-6 months	,647***	,672***	,649***	,641***	,639***	,641***
6-12 months	,270***	,294***	,307***	,310***	,306***	,309***
12-24 months	,067***	,066***	,068***	,069***	,067***	,069***
>24 months	,020***	,020***	,017***	,018***	,018***	,018***
Employment status						
Employed (ref)	1***	1***	1***	1***	1***	1***
Unemployed	,216***	,209***	,229***	,221***	,215***	
Other	,173***	,142***	,167***	,164***	,160***	
Age						
36-45 (ref)		1***	1***	1***	1***	
<25		,423***	,447***	,449***	,443***	
26-35		,675***	,668***	,672***	,670***	
46-55		,778**	,780*	,796*	,800*	
>55		,351***	,357***	,371***	,374***	
Yearly income						
50000-100000 (ref)			1***	1***	1***	
100001-150000			1,318	1,303	1,302	
150001-200000			1,777***	1,758***	1,770***	
200001-250000			2,393***	2,358***	2,382***	
250001-300000			2,115***	2,043***	2,068***	
>300000			3,003***	2,855***	2,906***	
Diagnosis						
Mental				1,364***	1,394***	
Musculous-Skeleton				,956	,969	
Other (ref.)				1***	1***	
Affiliation of Doctor attesting Illness						
Work Place Care					,709**	
Model Summary						
-2 log likelihood	3568,29	3359,44	3276,935	3236,500	3227,38	3222,641
Cox & Snell Rsq	,300	,341	,356	,364	,365	,366
Nagelkerke Rsq	,401	,455	,476	,486	,488	,489

Table 6: Odds ratio of being pensioned after a long-term illness
Stepwise (6 step) – Forward:LR. (cut value ,500)

	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
Number of sick days						
<3 months (ref)	1***	1***	1***	1***	1***	1***
3-6 months	3,827***	4,022***	4,385***	4,149***	4,052***	4,034***
6-12 months	32,511*** 27,689***	29,263***	30,754***	28,418***	27,172***	
12-24 months	170,899*** 151,801***	155,467***	166,013***	160,403***	152,156***	
>24 months	431,374*** 538,265***	520,794***	567,290***	558,311***	541,212***	
Age						
36-45 (ref)		1***	1***	1***	1***	
<25		,342**	,332**	,327**	,355*	
26-35		,609**	,591***	,597**	,609**	
46-55		2,197***	2,343***	,2,426***	2,476***	
>55		5,884***	6,450***	6,730***	6,752***	
Yearly income						
50000-100000 (ref)			1***	1***	1***	1***
100001-150000			,578**	,601**	,599**	,606**
150001-200000			,429***	,455***	,445***	,457***
200001-250000			,234***	,262***	,259	,271***
250001-300000			,255***	,289***	,280***	,309***
>300000			,173***	,201***	,196***	,226***
Employment status						
Employed (ref)				1***	1***	1***
Unemployed				2,146***	2,346***	2,391***
Other				,613	,672	,741
Affiliation of Doctor attesting Illness						
Work Place Care					2,085***	2,020***
Diagnosis						
Mental						1,040
Musculous-Skeleton						1,558***
Other (ref.)						1***
Model Summary						
-2 log likelihood	2467,142	2215,524	2138,983	2103,478	2086,839	2072,938
Cox & Snell Rsq	,378	,421	,434	,439	,442	,444
Nagelkerke Rsq	,545	,607	,625	,634	,638	,641

We have already mentioned above that those that have been assigned to participate in a R-AP program have a longer sick leave than those not assigned. A look at Table 3 shows

the results of a multiple regression analysis of how being assigned to an R-AP program and/or a medical rehabilitation program influences the length of sick leave. Participation in a program accounts for 29,8 per cent of the variation in number of sick days among the individuals in the sample.

I conclude that the second hypothesis of the study does not show that individuals were systematically being selected for R-AP programs. We can say that because the individual variables we looked at for selection of individuals for R-AP programs only account for a very little per cent of the explanation of how people were being selected for the programs. Instead choosing individuals for R-AP programs seems to follow no rhyme or reason. But we can see that the programs themselves increase time on sick leave and this in itself is the primary explanatory factor of who goes back to work.

The variable that was most determining of the four variables significant in selecting a person for an R-AP program was age. Persons between 36 and 45 years of age had the best chance of being chosen for a R-AP program and also were the category of those more likely to go back to work with or without being a part of the program. The elderly workers, those over 55 had the least chance of returning to work after a long-term illness. This group also had seven times the odds of being early pensioned than those in the 36 – 45 age group. If selection was made to help those most in need, or to give those about to fall out of the labor market permanently, older people would be more likely to be selected than those in the 36 to 45 age group.

A comparison of Table 4 and Table 6 also shows that those with the greatest odds of ending a sick leave with an early pension share the characteristic of having lower incomes and of coming from company doctors who attested the illness resulting in a long-term sick leave.

3. Why Use Re-activation Policy Program

The presentation of the programs involved and the process surrounding R-AP strongly suggests that the introduction of activation policy into social insurance for the long – term ill has failed. The study also suggests that the programs, even if not fulfilling their goal of helping the long-term ill back to work in shorter time, are not, instead, being used for those in most need. Instead, it clearly shows that programs themselves by prolonging a sick leave lower the chances for an individual to return to the labor market. The majority of individuals in the R-AP programs end their sick leave with an early pension and not by returning to work. The participation in an R-AP program means that it takes a little more time to reach an early pension.

Rather than meeting the goal of returning the long-term ill to work, the R-AP programs can be seen as *legitimizing a decision-making practice* within the social insurance agency. The model of decision-making prior 1990 for the social insurance agency case worker was to simply wait and watch during a long-term illness. With the help of a physician attesting to permanent reduction in work capacity, the case could also be

resolved by granting an early pension.. By introducing a third category for decision-making, selecting individuals for special programs directed towards returning them to work, a dilemma was cast into the decision-making process of categorizing the sick individual. R-AP programs became a program to legitimate the status of a long-term ill individual as a “worthy” early pensioned case. Going through work training or work testing and failing, was hard evidence that the individual had a “reduced work capacity”. Thus decision-making became easier for the social insurance case worker. The abundant rise in percent totals of those in R-AP programs that eventually were pensioned from 1990-1993 to 2001-2002 show that these programs were chosen by social insurance case worker from the perspective of their own work situation. The case manager is anxious to end a case. Moving an individual to an early pension when self support through own work was being introduced into social insurance, was no longer an easy measure for a civil servant. R-AP programs can be seen as a round-about way to a legitimate early pension and one which would not reflect back on the person managing the case.

If we take another look at how these programs are directed, we do see two interesting dimensions. One dimension is that individuals with higher incomes are usually not put into these programs.

Although Table four does not present the results of occupational status in terms of participation in R-AP programs, occupation is highly correlated both with a socio-economic index and with income. Occupational status is not available for the entire population and thus was not able to be used in our regression analysis because it reduced the number of valid cases. However, the study does show that those individuals in a management position had half as many participants (10 percent) in R-AP programs than those without a special occupational education (27 percent) (Hetzler et al 2005).

The other dimension that merits special attention is that those individuals selected for participation for R-AP programs are more likely to have doctors affiliated with the work place attesting to a reduced work capacity because of illness or other impairment in physical or mental performance than doctors affiliated with hospitals, community care or private doctors. Cases ending in an early pension are also more often generated by, or funneled through a company doctor.

One possible conclusion is that R-AP programs inadvertently are producing, running and financing a second labor market. The labor market is targeted towards unskilled workers in lower income categories with a reduced working capacity. R-AP programs looked at as a second labor market can be seen as producing flexibility in the labor market as well as providing economic subsidies for the employer.

The corporate doctor is well aware of the demands governing performance within the work place. By attesting to a long term illness and a reduced work capacity he is helping both the worker and the employer. He is helping the employer by opening-up a position for either a new employee or for down-scaling the work force without taking the costs involved with layoffs or a low producing worker. The worker usually seeks out a doctor to be cured or to reduce pain or impairment. He might, however, find out from his

physician that his pain is chronic. The suggestion to participate in an R-AP program is a way of instilling hope of coming back to a regular job after periods of “trying” to work. It is also a way to legitimate a permanent early pension and exit from the work force.

However, a follow-up study of 400 individuals from the study two years later showed that those individuals that were early pensioned had a higher score on a sense of coherence scale than those individuals still involved in the labor market. These individuals had compensated the permanent loss of work and ill health with other aspects of daily life which involved friends and family (Hetzler 2007, Hetzler 2008). Moreover, attitudes towards work had changed from being valued high because of possibilities to develop oneself to being valued because of friendships and contact with others (ibid). The early pensioned individual often pointed out that his/her economy was now certain and that it was possible to adjust to it. One could conclude from the follow-up study, that marginalization from the community did not occur when an individual was early pensioned from active participation in working life. This was prevalent for both men and women in the follow-up study. Also as early pensions became more common, they became more accepted in the community. Coping strategies developed for a life outside of the labor market at a younger age than normal retirement age with a reduced work capacity.

I have suggested two possible reasons why re-activation policy programs are at work in social insurance systems. One reason is that the programs have helped the front line bureaucrat preparing and managing the case of a long-term ill individual reach a decision for an early pension. The other reason I suggest is that re-activation policy programs are part of a larger transformation of the labor market. These programs are creating a secondary labor market of those individuals who would normally be on sick leave or early pensioned.

To understand the reasonableness of these two possible uses of re-activation policy programs it is necessary to return to the beginning of the 1990s when the concept of “work-way” (arbetslinje) was introduced into social insurance. There is a close relationship between work and illness in an advanced welfare state and that relationship is dependent on full employment (Mishra 1990, Ahrne 1989). Labor law in Sweden has developed with the ambition to protect the worker so that her work capacity would not be exploited. In Sweden, the employment contract has been the object of extensive regulation. Illness is also extensively regulated. The county in Sweden has a duty to provide medical aid and care to all citizens. Social insurance sickness benefits compensates the individual for loss of income because of occasional reduced work capacity in connection with illness or with a permanent reduced capacity through an early pension. Work and sickness are tied to each other through the concept of work capacity.

The “work-way” in social insurance meant that the insured with an affirmed illness would be returned to a full work capacity through rehabilitation. This rehabilitation, as mentioned, was not normal occupational rehabilitation but would be specially designed for return to work. R-AP programs were to be a tool that would make it easier for the long-term ill to return to work. A medical diagnosis was necessary to be on sick leave but

in itself it was no longer sufficient to insure for an individual who had been ill for a longer period of time to continue on to an early pension.

The message to the Swedish population was clear. They were to understand their bodies as machines. Parts of the body could be replaced, work capacity could be re-created. No one needed to be old or worn-out. In one way, this was naturally a positive message. This perspective however goes against the more traditional medical view that capacities decreased naturally with old age.

The message of the “work-way” in social insurance can also be seen as the declared official policy of how sickness and social insurance is to be understood in Sweden. In Sweden as in other countries, illness has been coupled to a reduced capacity. With the new “work-way” perspective, it is assumed that the person on sick leave should be experienced as healthy. If a person on sick leave does not regain his full work capacity in a reasonable time (now thirty days but with pressure to start action after fourteen days), the individual on sickness benefits becomes suspicious first from the local social insurance agency and eventually from, it was thought, work mates and friends.

In 2003, the Swedish government reformed the early pension system and codified the official policy by introducing new rules and terminology for what previous was termed “early pension” and is now called “sick- and activity compensation”. In the official social insurance view, the perspective was that every person was assumed to be fully capable to work until they reached the age of pension. The report states “The changed terminology had a clear intention – the old early pension was experienced as a compensation that could be paid-out until one was old enough to receive an old-age retirement pension. An important change, therefore, was that sick- and activity compensation became a part of sick leave insurance as opposed to an early pension that was a part of the pension system.”(Socialforsakrings rapport 2008:2)

“Work-way” made its way into social insurance in Sweden just when Sweden went into a period of dramatically increased numbers of the long-term sick (defined as sick at least 60 days). This period started in 1997 and continued until 2004 when there was some change in the statistics. In the five years proceeding the study reported above (1997-2002) the increase in sick cases in Sweden was 117 percent, from 155,697 paid sick days in 1997 to 338 124 days in 2002. The increase was in all types of cases, from a few days to those over a year. We know that the increase was higher for women and for the elderly, we also know that the increase was higher within the public sector. We know the diagnose group for stress and other mental diagnoses increased. The increases were so great that in 2001 the total absence from work because of health related causes was equivalent to 400 000 year workers. 14 percent of workers were away from work because of sick leaves or early pensions and this increased to 16 percent in 2002.

As we have shown, the number of individuals with an early pension as a way of ending a sick leave has increased with the increase in the number of sick leaves but also had increased as a proportion of those ending a sick leave. Between 1999 and 2004 the number of individuals granted an early pension increased in Sweden from 39 000 per

year to 72 000 per year. Since then it has decreased and in 2006 was 50 000 per year. At this time a total of 560 000 received compensation for a sick- and activity benefit previously known as an early pension.

From an administrative perspective, we can see that the social insurance organization in Sweden is forced to find a way to get people off of the sick rolls. Tightening qualifying rules for benefits, changing definitions of work capacity, limiting the amount of time that can be spent on sick leaves, streamlining decision-making concerning rights to sick leave, educating doctors in “social insurance law”, setting up incitement for doctors and medical districts to lower rates of sick leave per population are all measures adopted and currently in place. All the measures together are a significant public reform of one of the basic institutions in Sweden.¹⁵ R-AP is one of these measures. It is widely touted but does not deliver a return to work.

Conclusion

It is in the above administrative perspective as well as the political perspective one has to understand the Re-activation Policy programs and why, despite their failure to return chronically sick, worn down individuals to work, the programs are kept in place and even expanded.

One could say that the introduction of “work way” into social insurance influenced not only the concept of sickness but the concept of work as well. By attacking the connection between illness and other mental or physical impairment and work, both sickness and work lost their importance in the everyday life of the individual. As regulation of work and sickness is a protection against exploiting the work capacity of the individual, a government policy threatening this relationship is in need of providing a justification to those caught up in policy programs which clearly fail. This justification is provided by the introduction of an enormous machinery to uncover those that cheat the system. As the government increases its mistrust of citizens through campaigns designed to show the rationality in harder controls to find those posing as “dis-abled,” the more the population becomes convinced that society is populated by posers. This is because the second justification used by the government to reign in skyrocketing sickness benefit and early pension costs, it is only a small part of the population that can be permanently 100 per cent dis-abled before the age of retirement. Instead everyone has some work capacity somewhere.¹⁶

At the same time, the campaign to fragment the healthy part of the body from the impaired part of the body, has many people turning to stress and or anxiety diagnoses that cover the entire body and the entire reduction of work capacity. As more and more people

¹⁵ The changes encountered would not have been so easily possible if the government did not nationalized social insurance from a semi-autonomous structure of social insurance in 24 provinces to a centralized state agency in 2005.

¹⁶ A series of commercials sponsored by the Swedish Social Insurance Agency to convince the population that their health, like the proverbial glass of water, was half full not half empty was quickly taken off the air.

are finding themselves in situations of illness and with a doctor's certificate in their hands, they are discovering that access to sickness benefits is restricted and that their time on sick leave and how it is to be spent depends on the Social Insurance Agency. In turn, many find themselves mistrusting the Swedish Social Insurance Agency and the current political parties in office. This is taking place although the prior government instituted and started the public reform of social insurance and the introduction of "work-way" into sickness benefits.

As pointed out in the paper, those individuals most affected by the changing policy are those with lower incomes and those with lower unskilled jobs. Their possibilities when assessed with a higher work capacity than they experience or can sell in the present job market are to file for unemployment or to accept the reduction in income of a loss in sickness benefits. Some households might be able to accommodate one of its members unwilling to continue working full time because of impairment. In such a case, the cost of the impairment previously accepted by the State will be taken by the household.

It should be pointed out that the rise in the sick rolls in Sweden starting in 1997 was in the period following Sweden's most serious recession since the before the depression of the 1930s. Between 1992 and 1994, 500 000 jobs were lost in Sweden and job growth since that time has only accommodated a return (given growth of the population) of about 300 000. Just as Forslund and Krueger (1997) showed that public relief workers displaced other workers, I suggest that one effect of R-AP programs is providing a secondary labor market. However, this cannot be considered a large market. The long-term ill in Sweden at any particular time is about 198 000 individuals of which approximately maximum 20 to 30 per cent are selected for R-AP programs.

In conclusion, I will state that re-activations policy programs exist within a complex field motivated by economic costs, administrative pressures and ideological changes in the relationship between work and sickness. Re-activation policies and their introduction into the area of re-commodifying an individuals work capacity are directed not towards the abled-bodied but towards, for the most part, employed individuals with a medically documented illness or impairment. They give us a special tool to understand changing social policy where the analysis of public policy reform cannot be hidden behind rhetoric of failed individual responsibility.

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