DRAFT – NOT TO BE CITED

Mediating Sickness and Health?
- Activation Measures for Long-Term Ill in Sweden -

Anett Schenk (PhD)
Lund University
Department of Sociology
Box 114
SE-22100 Lund
Sweden
Anett.Schenk@soc.lu.se

Paper presented at the conference "'Activation' policies on the fringes of society: a challenge for European welfare states" organized by the Institute for Employment Research (IAB) and the Section Political Sociology of the German Sociological Association (DGS)

Abstract:
Exclusion from the labour market is not exclusively caused by unemployment. Long-term sick leaves, caused by e.g. chronic diseases or physically and mentally trying working environments, are as such an exclusion from the labour market just as they increase the individuals risk to become unemployed. In Sweden labour-market exclusion due to long-term sick leave has been increasing since the 1970s and today is politically acknowledged as a problem. As a consequence activation strategies and measures for long-term ill have been enacted. This paper is concerned with mediation meetings (avstämningsmöte) as one particular activation measure enacted in 2003.

This paper discusses the Swedish mediation meetings for long-term ill as part in a transformation process of the welfare state. A process, in which universal rights to welfare benefits are replaced by highly selective measures to "activate" the patient. The mediation meetings are discussed as measures that embrace conceptions of a "right" type of patient, supporting the development of a "conditional citizenship" that stresses moral values rather than citizens' rights to welfare benefits. At the same time it is argued that the participation in mediation meetings does not have any impact on the individual's chances to return to work. Instead, individual background variables and the assignment to rehabilitation-categories are by far better predictors regarding the odds to return back to work after sick-leave. In other words, the figures for sick leave may decrease not because of but despite such activation measures.

Introduction

It is a well-acknowledged matter in social sciences that the traditional welfare state has changed since the 1990s – a transformation that has been captured in terms of the "enabling-state" or "from welfare to workfare". This development finds its expression in social policies emphasising the citizens' social duties rather than their social rights. In this context "activating" labour market policies have been of major interest for debate. However, exclusion from the labour market is not exclusively caused by unemployment. Long-term sick leaves, caused by e.g. chronic diseases or physically and mentally trying working environments, are as such an exclusion from the labour market just as they increase the individuals risk to become unemployed.

In Sweden labour-market exclusion due to long-term sick leave has been increasing since the 1970s and today is politically acknowledged as a problem. As a consequence activation strategies and measures for long-term ill have been enacted. This paper is concerned with mediation meetings *(avstämningsmöte)* as one particular activation measure enacted in 2003. In these meetings a patient's working ability and options for rehabilitation are discussed by the patient, her social insurance officer, her employer, physician and other relevant parts. In the following attention is directed towards how a person's working ability is negotiated at these meetings and whether such meetings actually increase the probability to return to work and be included into the labour market again. The discussion is based on qualitative and quantitative data material conducted in a research project analysing mediation meetings held during 2006 in the southern region of Sweden.[1] Before turning towards the empirical material the paper will provide a short overview on the development of sick leaves in Sweden and the intentions with the introduction of the mediation meetings.

Mediation meetings as activation measures for long-term ill

Long-term ill and the number of people in sick leave have become a hotly debated issue in Sweden, since the number of citizens in sick leave has been increasing since the 1970s. In a historical perspective one might depict the development of sick leave in Sweden as a curve with heights en lows. In 1976 three per cent of the inhabitants between the age of 16 and 64 were in sick leave longer than 30 days. At the beginning of the 1980s the responding figures had decreased to two per cent, but reached a new top at the end of the 1980s and the beginning of the 1990s when 3,5 per cent of the people between 16 and 64 were in sick leave. Until 1996 sick leave decreased again to 2,5 percent, but reached a new top with five percent in 2001 (SOU 2002).

The figures for sick leave in Sweden reached their peak in 2003 when inhabitants between the age of 16 and 64 had been sick in average 41,8 days per year. Not only the numbers of days in sick leave were rising, the time periods of sick leave have been increasing as well. Additionally, the share of long-term ill that returns to work has been decreasing. Despite slightly decreasing figures, today still Sweden is among the European countries with the highest share of employees in sick leave with a remarkably high share of long-term ill (Nyman et al. 2002). In consequence the costs for the system of social administration have grown remarkably (see table 1) just as an increasing number of people is no longer integrated in the labour market (Hetzler et al. 2005; Alexandersson / Östlin 2001).

[1] The research project „Balancing Understandings – An Effective Technique for the Social Insurance Agency Rehabilitating Long-Term Ill?" was carried out by Prof. Antoinette Hetzler (project leader) and Anett Schenk at the Department of Sociology, Lund University, Sweden.

Table 1: Expenditure on grants for sick leave and pensions for early retirement, between 1995 and 2004, in billions SEK

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Grants for sick leave	10.8	17.1	15.9	20.8	27.9	36.5	42.9	48.5	48.5	44.1
Early retirements	14.5	13.5	13.5	13.6	37.9	47.7	50.2	29.9	58.5	64.2

Source: Svärdman 2006: 36

The Swedish government has acknowledged this development as a problem for both the social insurance system and the labour market. Discussions whether or not cut downs of social benefits would be necessary to prevent unwanted consequences of the high amount of sick leave can be traced back to the late 1980s (Ståhlberg 2004: 55). During the 1990s reforms of the system of Social Insurance lead among others to lower levels of sick benefits (Hetzler et al. 2005: 253). At the same time the Swedish government introduced a new guiding concept for the Swedish system of Social Insurance emphasising people's working ability *(arbetslinjen)*. Conditions of decreased health that did not have a clear medical cause were from now on assumed to be a matter of labour market- and social policy, instead of granting a person sick benefits.

It is not the physician's statement that a person is ill, which entitles to sick benefits. Such benefits are only granted if the National Social Insurance Agency *(Försäkringskassan - FK)* evaluates the person's ability to work to be limited or non-existing. When deciding whether to grant sick benefits or not, the National Social Insurance Agency (FK) is no longer focusing on the diagnosis, but on the citizen's "ability to work" that may exists despite any diagnosis. In cases of doubt the National Social Insurance Agency can ask for an expertise given by physicians working for the Agency. This expertise, however, is only based on documents regarding the patient's condition and diagnoses that already exist and not on an examination of the patient itself.

According to the Swedish government the working-ability-guideline *(arbetslinjen)* did not have the intended impact on neither the work of the FK nor the attitudes of patients and physicians. This in turn implied that the "health insurance risks to become a general insurance against loss of income" (Governmental Proposition 2002/03: 18). In 2002 and 2003 the Swedish government enacted new policies to fight long-term sick-leaves: The goal is to halve the number of days in sick-leave between the years 2003 and 2008. In 2002 the numbers had been up to 100 million days, the goal for 2008 was set at 48.5 million days. As a measure to realise this goal and to emphasize the working-ability-guideline, a change in the law introduced mediation meetings (*avstämningsmöte*) as a new working method for the National Social Insurance Agency July 1st 2003.

The expressed purpose of the mediation meeting is to elaborate the patient's working ability and options for rehabilitation. Generally every relevant part – which includes the patient, the social insurance officer, the patient's physician, employer, representative of the trade union – may initiate such a meeting, but it is the social insurance officer who is responsible for moderating and documenting the meeting. Mostly it is also the social insurance officer who initiated the meeting. A patient has the right to decline her participation in a mediation meeting when called to one, but will automatically loose her grants for sick leave.

13,500 mediation meetings were held during the first half of the year 2004 (RFV 2004). Estimating that these figure are not sufficient enough to reach the goal to halve the numbers of sick leave until 2008, January 2005 the Swedish government put the legal frame for mediation meetings in a more rigorous form, implying that a mediation meeting needs to be initiated not later than 90 days after the patient has been reported sick. Additionally the government aspired 90,000 mediation meetings to be held in 2006 (Government Decision

2005). From being an optional working method for the National Social Insurance Agency, mediation meetings became a demand for all cases of sick leave longer than 90 days – initiated with the intention to promote the working-ability-guideline.

Being "active" the right way

Activation policies emphasise the duties of the individual, as opposed to claiming the individual's rights against the welfare state. The key argument seems to be that of "mutual obligation" recipients of welfare benefits need to proof their will and ability to participate in society – they need to be taught "to be 'active' rather than 'passive' citizens" (Humpage 2007: 215).

In disability research there is a discourse on two concepts to grasp disability: an individual model and a social model. The individual model of disability "locates the 'problem' of disability within the individual and (…) sees the causes of this problem as stemming from the functional limitations or psychological losses which are assumed to arise from disability." (Oliver 1990: 3) The social model directs its attention towards society "(i)t is not individual limitations, of whatever kind, which are the cause of the problem but society's failure to provide appropriate services and adequately ensure the needs of disabled people are fully taken into account in its social organisation." (ibid.) In short one can say that the individual model asks "How can we fix the person?", while the social model asks "How can we fix society?"

Research in disability research indicates that "mutual obligation is likely to reinforce a medical model" framing welfare recipients "as 'conditional' citizens and ignore the obligations of the state and society regarding access and inclusiveness for people" (Humpage 2007: 215). Analysing the communication at 22 mediation meetings held during the year 2006 in Southern Sweden *(Skåne)* there is reason to make the same claim for these activation measures for long-term ill. As mentioned above, mediation meetings as activation measures were introduced with the intention to establish "working ability" not "diagnosis" as key concept in the practice of the FK, but also in the consciousness of physicians and patients. The purpose is to evaluate the patients working ability. Often these meetings are initiated by the FK and based on an expertise from a FK-physician claiming that the patient has a sufficient working ability. In such cases the patient's working ability is already claimed even before the meeting starts. In consequence the question on whether the patient has working ability is transformed into a question on how the patient can enhance and use her working ability in order to re-enter the labour market.

A mediation meeting comprises out of a number of professionals or experts within different fields – e.g. the social insurance officer, a physician, an employer – and a patient, who basically has expertise in two areas, those being her previous work and her own body and physical condition. Considering the purpose of mediation meeting, which is to make the patient realise her working ability, the focus is already set on the patient, not on society and its duties against the patient. It appears to be easier to change a patients mind regarding working ability, than to change society and make the labour market ensure the needs of people with decreased health. Mediation meetings comprise always an element of teaching the patient to think and live the right way, which may include moral values and touch very private spheres of the patient's life.

Jacob is 50 years and had been in sick leave about one and a half year after a stroke. At the mediation meting he meets his social insurance officer, two physicians, one rehabilitation-expert, one representative of the teachers trade union (to which he belongs) and his principle. Jacob is about to tell how he returned back to his work for the first time. He is still in sick

leave and the purpose is to find a strategy to re-connect with his work place. Susan is Jacob's principle, Marie his social insurance officer and Lara one of the physicians.

Susan: How is it going at home?
Jacob: Much better, better now. I am picking up things now instead of letting them laying where they are. This holds actually true for the entire family, so I think this time has been a good sabbatical so to say. (laughter) I think this is important, the less muddle I have around, the better…I don't get so absent-minded then
Marie: Well, this is almost a normal thing, even for children
Jacob: Yes, it is
Marie: They probably think it is good to be like their father now (laughter)
Lara: No, but it is probably good because then there are not so many impressions for you either, it is easier because you can focus better on what you are supposed to focus upon.

The meeting that is supposed to be about Jacob's working ability is just as much a meeting about routines and habits at home. Jacob's increased ability to organise things is not only discussed in relation to him, instead it is emphasised that this will have a positive impact on his children. By guessing that his children now want to be like their father, Marie stresses Jacob's role as a father – a slightly insinuation that he was not such a good one earlier. It is then Lara who tries to bring the conversation's focus back to Jacob and his situation, which succeeds only for the moment. Family routines appear as recurrent issues, e.g. later during the meeting, when the discussion is about Jacob's diet and weight-loss, even the time for family-dinner is asked for.

The borders between a holistic or salutogenetic view of a patient's situation and a morally loaded education in how to be a good person appear somewhat blurry. Considering the purpose of mediation meetings this is not very surprising. The purpose is to evaluate a persons working ability – not necessarily the persons working ability in relation to her earlier work. Within this broad frame, nearly all capability of physical movement and mental alert can be interpreted as part of working ability. Under such circumstances it becomes then the individuals task to realise her potential, which basically put nearly every aspect of a persons life under scope.

Some patients, however, are what at first sight looks as quite "active" patients. They appear highly motivated, driven and highly independent when initiating their return to work. Lisa is 58 years and had been in sick leave with a stress-related condition of fatigue about a year, when she decided to return to her old work place and to test how it feels to work again. The FK was informed about that and Lisa had the support of her superior at her work place. However, after a few days she recognised that she was not ready to return. The purpose of this meeting is to find a way for a second try. At the meeting are Lisa, Rebecca, her social insurance officer, Lisas principle, a physician and a rehabilition expert. Lisa starts to tell about her own initiative and her attempt to work again that unfortunately failed

Lisa: So I started and took contact with Robert and tried to get an appointment and I called the NSIA and the person who replaced me and coordinated…and then, it was my plan, and I thought that I would start again as soon as possible, the next day, and…
Physician: …and no one else told you (laughter)
Lisa: No, I am fully aware of that, that I am where I am today very much because… (overlapping talk) …well I follow my intuition and I don't know any better
Physician: Right
Lisa: …and I should have listened more to Rebecca (short laughter) …and I thought I start as soon as possible to test my work place again, clean up, I had so many piles of paper and mailboxes full…So I work with the person who replaced me and from June 1st I would

work 25 per cent and later 50 per cent and I coordinated our vacation and arranged everything and I thought I would be fully back in autumn

Rebecca: You talk about your work? Back to your old work?

Lisa: Yes

Rebecca: That was the idea, your idea?

Lisa: Yes and my ambition and I felt motivated and then…

Rebecca: But you came back to your work place, which you had left when you felt worst (everybody in the room says "mm" or "yes") well left a…I don't want to say mess but…

Lisa: Yes

Rebecca: …but lots of papers and files…

Lisa: Yes!

Rebecca: and ideas that have not…

Lisa: Yes, there was something left. Yes, and I ….

Rebecca: aaaah, I am getting sweaty (laughter)

During the entire meeting Lisa claims her willingness to work, emphasising that she misses the social contact with her colleagues and how important a purposeful work is to her. Lisa is fully aware of her failure. Yet, when Lisa starts to tell what happened, the physician interrupts her by asking whether the decision to go back to work really was Lisa's. The obvious answer and the laughter, already insinuate that Lisa's attempt to return to work was at least unwise. Later Rebecca – Lisa's social officer – interrupts Lisa several times, pointing out to her that she attempted to return to a place where she felt "worse" and left a "mess". Lisa's attempt to test working again is devaluated by both the physician and Rebecca. This appears somewhat difficult to understand if the result of this mediation meeting is considered: Lisa will start at her old work place in June with a working time of 25 per cent. During July she will take vacation and it is aspired that she will slowly increase her workload to 50 per cent. This result matches quite well with the plan that Lisa had in the first place, so why devaluating a patient's attempt to return to work on her own accord?

The reason for the devaluation of Lisa's attempt for returning to work is hardly her plan as such (since it matches well with the result of the mediation meeting), it is rather that Lisa did not follow the rules. She did not "listen" to Rebecca and was "active" in her own terms. By doing so she was – certainly unintentionally – undermining the authority and expertise of the social insurance officers and medical professionals such as physicians. The mediation meeting restored this authority and "taught" a patient to be active the right way.

Mediation back to work?

The very idea that activation measures such as mediation meeting may teach people that there is a right way of being active and that this teaching process puts even the individual and her private sphere under scope is somewhat repulsive. However, one may argue that such teaching process may have their justification due to their success. Maybe there really is a right way of being active and maybe it is in mediation meetings one can learn this? If this is the case, patients participating at mediation meetings should have higher changes to return to work as compared to patients who did not have the opportunity to participate in such a meeting.

Our data material comprises out of 3089 cases of sick leave in Southern Sweden *(Skåne)*, all with duration of at least 60 days, who have ended their sick leave during the fourth quarter of the year 2005. 15.1 per cent of the cases – that is 466 cases – had participated at a mediation meeting.

It is not surprising to find differences between the group that participated in a mediation meeting and the group that did not (see table 2). The share of women was seven per cent higher among the cases with a mediation meeting and the average age is two years lower. In both groups the largest occupational categories are patients with an employment at municipalities and within the private sector. However, the share of the former is higher within the group that participated in a mediation meeting, while the share of employees within the private sector is higher within the group that did not participate in a mediation meeting. The length of sick leave was considerably higher among the patients that had been called to a mediation meeting. Diagnoses of mental illness and regarding musculosceletal diagnoses are the two major categories of diagnoses, but the share of diagnoses of mental illnesses is remarkably higher within the group of patients that participated in a mediation meeting.

Table 2: Overview of differences between the group that participated in a mediation meting and the group that did not (selection of variables)

	Group without a mediation meeting (2623 cases)	**Group with a mediation meeting (466 cases)**
Percentage of women	60 %	67 %
Age (mean)	49 years	47 years
Length of sick leave (mean)	544 days	826 days
Diagnoses		
Diagnoses of mental illness	27,9 %	41,2 %
Musculoskeletal diagnoses	33,9 %	38,2 %

Some of these differences may increase or limit a patient's chances to return to work. One may e.g. assume that the longer the time of sick leave the lower the odds that a person will return to her previous work. On the other side supply of and access to rehabilitation measures may vary depending upon whether a person is working in the public sector, e.g. for municipalities, or in the private sector – and may compensate for longer sick leaves.

At the same time variables such as age or diagnosis increase or limit already a person's chances to participate in a mediation meeting. A binary logistic regression (see table 3) analysis showed that patients belonging to the age groups between 26-35 and 46-55 have the highest odds to be invited to a mediation meeting. Patients with a diagnosis of mental illness will participate in a mediation meeting with a higher probability as musculosceletal diagnosis. Gender has – despite the slightly overrepresentation of women – no impact on the odds to be invited to a mediation meeting. Interesting in this context are the odds regarding the length of sick leave – the longer the period of sick leave the higher the odds that the patient has participated in a mediation meeting. For patients who had been in sick leave longer than 730 days the odds to participate in a mediation meeting are almost 14 times higher as compared to patients with a sick leave shorter than 180 days.

This is interesting insofar as it indicates that the National Social Insurance Agency applied the mediation meeting as a method in the rehabilitation-work for long-term ill. The political intention, however, was rather that mediation meetings should work as a measure to prevent such long sick leaves – the guideline that a mediation meeting should have been initiated not later than 90 days after a patient had been reported sick, is a clear indication for that. One reason for this contradiction between political intention and practical application may be unclear communication patterns – in short: the political side and the steering board of the National Social Insurance Agency were unable to convincingly and successfully communicate the purpose and intention with the mediation meetings.

Another explanation might be of a more practical nature. Before a mediation meeting can be held there are some stages the case needs to go through. First, and this is compulsory, the

case will be assigned to a rehabilitation-category, responding to different stages of evaluation or rehabilitation. In total there are six such categories. Second, a physicians expertise should be available for the mediation meeting. Finally, a so-called SASSAM-evaluation should be carried out. SASSAM is a working method in which the patient – with the help of a medical professional or personal supervisor – already reflects about her working ability. First reports carried out by the National Social Insurance Agency emphasised the problem to carry out all necessary steps within 90 days. Despite the fact that not all registered sick leaves will last 90 days or longer.

Table 3: Odds for participation in a mediation meeting

	Wald	Sig	Exp (B)
Age			
36-45 (ref.)	36,641	,000	1
<25	2,349	,125	1,973
26-35	18,827	,000	2,246
46-55	28,782	,000	2,215
>55	20,089	,000	1,894
Length of sick leave			
60-180 days (ref.)	145,317	,000	1
181-365 days	21,546	,000	3,699
366-730 days	64,338	,000	8,654
>730 days	99,255	,000	13,911
Diagnosis			
Diagnoses of mental illness (ref.)	10,627	,005	1
Musculosceletal diagnoses	3,869	,049	0,778
Other	10,261	,001	0,616

Cox & Snell: ,125; Nagelkerke: ,218

The social insurance officers at the FK find themselves in a somewhat tricky situation: On the one side they are aware of the fact that a mediation meeting within 90 days is hardly to realise. On the other side there is a strong demand, from both the political side and the steering board of the FK, to initiate a large number of mediation meetings. Choosing between applying mediation meetings according to the textbook and filling the quotas of mediation meetings that should be held, the social insurance officers seem to prefer the latter – maybe also as an attempt to find ways for rehabilitation for patients that have been in sick leave for years.

Table 4: How did people end their sick leave?

	Group without a mediation meeting (2623 cases)	Group with a mediation meeting (466 cases)
Back to work	45.9 %	43.6 %
Unemployed	7.1 %	9.2 %
Withdrawn sick benefits	4.2 %	5.6 %
Early retirement (full-time)	17.2 %	16.1 %
Early retirement (part-time)	12.3 %	16.5 %
Other social benefits	4.4 %	3.0 %
Others	8.9 %	6.0 %

To recognise that there is indication that social insurance officers did not apply mediation meetings according to the political intensions does, however, say not very much about whether these meetings increase the patients' changes to return to work or not. A first look at

how the patients in both groups ended their sick leave does not show distinct different patterns for both groups (see table 4). The share of patients who were unemployed after sick leave, who had their sick benefits withdrawn and who received early retirement pension part-time was somewhat higher within the group that had participated in mediation meetings. However, the differences between the percentages are of a minor scale and percentages do not say anything about probabilities or odds.

In order to get a more modulated impression on what factors support a patients returning back to work we used a binary logistic regression analysis. First we tested for the patients' odds to return to work. Later, we tested for the patients' odds to end their sick leave with an early retirement. Returning back to work is assumed to be the "best-case scenario" for the patient. Even though returning to work does not necessarily mean returning to the previous work place, but it implies in any case to leave a position of exclusion by re-entering the labour market. Ending sick leave with early retirement is assumed as being the "worst-case scenario". Early retirement implies not only a financial loss for the individual but can also be seen being one step further away from the (socially) integrating aspects of the labour market.

Table 5: Odds for returning to work

	Wald	**Sig**	**Exp (B)**
Women	5,700	,017	0,806
Age			
36-45 (ref.)	163,362	,000	1
<25	43,395	,000	6,416
26-35	91,987	,000	3,533
46-55	107,056	,000	3,210
>55	58,586	,000	2,226
Length of sick leave			
60-180 days (ref.)	490,595	,000	1
181-365 days	54,821	,000	0,404
366-730 days	213,998	,000	0,159
>730 days	440,208	,000	0,061
Diagnosis			
Diagnoses of mental illness (ref.)	32,558	,000	1
Musculosceletal diagnoses	16,792	,000	0,638
Other	30,921	,000	0,523

We included the variables for gender, age, duration of sick leave, diagnosis, participation in SASSAM and participation in a mediation meting. In both calculations the computer-programme (SPSS) excluded the variables for participation in SASSAM and in a mediation meeting. For all other variables we could find remarkable differences regarding the odds to end sick leave either returning back to work (see table 5) or entering early retirement (see table 6).

The odds to end sick leave by returning back to work are somewhat smaller for women as they are for men. The youngest age-cohorts have also the highest odds to return to work. The probability to return to work is almost six times higher for those younger than 25 as compared to those at the age between 36 and 45. It is interesting to notice that the age-group between 36 and 45 (our reference-group) has the lowest odds to return to work. Even the age-groups between 46 and 55 years and those older than 55 have higher odds to return to work. Not surprising, we find that patients with the shortest duration of sick leave also have the highest odds to return to work. This holds also true for patients with a diagnosis of mental illness.

Regarding patients' odds to end their sick leave by entering early retirement, we find the rather opposite picture. It is more likely that a female patient will end her sick leave by

entering early retirement as it is for a male patient. The age-group between 36 and 45, which was the group with the lowest odds to return to work, is also the age-group with the highest odds to enter early retirement. While the youngest age-group, those younger than 25, have the lowest odds to end their sick leaves in early retirement. The longer the duration of sick leave the higher the odds to enter early retirement – the group with the longest sick leaves, that is sick leaves longer than 730 days, have a hundred times higher odds to end their sick leaves with early retirement as compared to the group with the shortest sick leaves. Patients' diagnoses of mental illness have the lowest odds to enter early retirement. It is not surprising, that the category "others" shows the highest odds for early retirement, since this category contains among others cancer diagnoses or accidents, which can lead to long sick leaves and part-time early retirement with later reappraisal.

Table 6: Odds for ending the sick leave with early retirement (full-time and part-time)

	Wald	Sig	Exp (B)
Women	11,596	,001	1,391
Age			
36-45 (ref.)	235,009	,000	1
<25	35,087	,000	0,270
26-35	153,870	,000	0,104
46-55	104,748	,000	0,294
>55	49,959	,000	0,478
Length of sick leave			
60-180 days (ref.)	439,145	,000	1
181-365 days	51,308	,000	11,133
366-730 days	125,023	,000	39,319
>730 days	199,174	,000	100,428
Diagnosis			
Diagnoses of mental illness (ref.)	23,300	,000	1
Musculosceletal diagnoses	16,374	,000	1,607
Other	19,653	,000	1,769

What our calculations show is that statistically the participation in either SASSAM-evaluations or mediation meetings are necessary factors when predicting the odds for returning to work or ending sick leave by entering early retirement. Very basic variables – related to the person as such and her health status – were already sufficient to predict probabilities regarding what happens to a patient after ending sick leave. As already mentioned, the statistical programme excluded both SASSAM and the mediation meeting from the calculation. This in turn is not very surprising. As mentioned above, before patients are invited to any of the FK's activation measures (e.g. mediation meetings), patients are assigned to different rehabilitation-categories – and these categories pre-structure already the odds to participate in a SASSAM-evaluation and in a mediation meeting.

We focus upon four out of six rehabilitation-categories, those being: Further investigation (being the reference variable), Testing for early retirement, Matter for prognostication and Planning / Realisation. In table 7 we can see that the category "Planning / Realisation" has the highest odds for both participation in SASSAM and a mediation meeting. This category has somewhat better odds regarding patients' chances to return to work, but the odds for entering early retirement are only minimal smaller as compared to the reference variable. The category "Matter for prognostication" shows the highest odds for returning back to work and by far the lowest odds for entering early retirement, but obviously this category shows such positive results even though – or thanks to the fact – that the patients in this category have the lowest odds for both participation in a SASSAM-evaluation and a mediation meeting. The category

"Testing for early retirement" shows – barely surprising – by far the highest odds for entering early retirement and the lowest odds for returning to work. However, the odds for activation measures such as SASSAM and mediation meetings are only slightly higher as compared to our reference variable.

Table 7: Odds for different status-categories to participate in a SASSAM-evaluation, a mediation meeting, return to work and start early retirement.

	SASSAM		**Mediation meeting**		**Return to work**		**Early retirement**	
	Sig	Exp (B)	Sig	Exp (B)	Sig	Exp (B)	Sig	Exp (B)
Further investigation	,000	1		1		1		1
Testing for early retirement	,092	1,232	.140	1.202	.000	0.007	.000	111.475
Matter for prognostication	,000	0,103	.000	0.097	.000	2.213	.000	0.189
Planning / Realisation	,000	4,666	.000	4.667	.000	1.514	.906	0.975

Considering the odds for patients to return to work or to enter early retirement the statistical analysis leads to the conclusion that none of the activation measures – neither the mediation meeting nor the SASSAM-evaluation that is seen as a preparatory step towards the former – actually improves the patients chances to get re-integrated into the regular labour market. On the level of variables related to individual characteristics gender, age, duration of sick leave and diagnosis are already good predictors regarding how patients end their sick leave. On the level of variables related to work of the organisation – the FK that is – the rehabilitation-categories tell a great deal about the odds to return to work, they seem to work as a funnel leading cases of sick leave towards different outcomes.

Final remarks

This paper discussed mediation meetings *(avstämningsmöte)* that had been introduced as an activation measure for long-term ill in Sweden. The introduction of these meetings marked an important shift in the work of the National Social Insurance Agency and in social policy in general – instead of focusing on the diagnoses, the patient's working ability is now the guiding concept.

This new concept, however, is far from clear and stringent and puts the responsibility on developing and realising working ability very much on the individual. This finds also its expression in mediation meetings. When professionals such as social insurance officers and physicians meet the patient the focus is very much on the individual's responsibility to adapt to the expectations on how an "active person" is. The "mutual obligations"-strategy implies high demand on the individual on how to live and act, which supports the hypothesis that mutual obligation is likely to support a individual model assuming that the cause of the problem (exclusion from the labour market because of decreased health) is to find within the individual.

Despite the problematic aspects of teaching the patient that have been found in mediation meetings, it is also questionable whether these meetings even are suitable to bring people back to work. Statistically variables on individual characteristics and the rehabilitation-categories of the National Social Insurance Agency predict more precisely the odds to return to work.

Literature

Alexanderson, Kristina / Östlin, Piroska (2001) Work and Ill-health among Women and Men in Sweden, in: Marklund, Staffan (red.) *Worklife and Health in Sweden 2000.* Stockholm: Arbetslivsinstitutet, pp. 119-134.

Governmental Proposition (2002/03) *Förändringar inom sjukförsäkringen för ökad hälsa i arbetslivet.* Proposition 2002/03:89, Stockholm.

Hetzler, Antoinette / Melén, Daniel / Bjerstedt, Daniel (2005) *Sjuk-Sverige. Försäkringskassan, rehabilitering och utslagningen från arbetsmarknaden.* Stockholm: Symposion.

Humpage, Louise (2007) Models of Disability, Work and Welfare in Australia, in: *Social Policy & Administration,* 41 (3), pp. 215-231.

Nyman, Kjell / Palmer, Edward / Bergendorff, Sisko (2002) *Den svenska sjukan – sjukfrånvaron i åtta länder.* DS 2002:49, Stockholm: Departementsserien, Finansdepartementet, ESO.

Oliver, Mike (1990) The individual and the social models of disability. Paper given at Joint Workshop of the Living Options Group and the Research Unit of the Royal College of Physicians on People with Established Locomotor Disabilities in Hospitals. The Disability Archive UK. http://www.leeds.ac.uk/disability-studies/archiveuk/Oliver/in%20soc%20dis.pdf (accessed March 14th 2008)

Government Decision (2005) *Regleringsbrev för budgetåret 2006 avseende Försäkringskassan*. Regeringsbeslut 2005-12-200. Stockholm: Socialdepartementet.

RFV – Riksförsäkringsverket (2004) *Redovisning av återrapporteringskrav enbligt regeringsbrev 2004 avseende verksamhetsområdet Åtgärder mot ohälsa.* Dnr. 6135/2004, Stockholm: Riksförsäkringsverket.

SOU 2002: 62 *Kunskapsläge sjukförsäkringen. Delbetänkande av utredningen om analys av hälsa och arbete.* Stockholm: Fritzes.

Ståhlberg, Ann-Charlotte (2004) *Socialförsäkringarna i Sverige.* Stockholm: SNS Förlag.

Svärdman, Håkan (2006) *Behöver Socialförsäkringarna en extreme makeover?* Stockholm: Folksam / Premiss förlaget.