Introduction
Over a period of several years now vocational rehabilitation and how it can be reformed and improved has been a subject up for debate in many different countries. OECD has also shown interest in strengthening vocational rehabilitation and have shown examples on how it can be improved. There are several reasons why vocational rehabilitation has been put in focus. One reason can be demographical. In order to sustain their welfare systems many countries are obliged to have enough people working to ensure the necessary tax revenues (Wikström, 2008). Another reason is the exceptionally high cost for sickness allowance and disability pensions. In Sweden public funding for sick absence and disability pension is now on level with the cost for the entire national defence programme, judicial system, child allowance and half the parental insurance system. A third reason is the increasing amount of unemployed people. Health problems among unemployed people are common and have been shown in many studies (Stankunas et al. 2006, Reine et al. 2003, Okoro et al. 2003).

Vocational rehabilitation can contribute to lessen the burden on society in terms of reduced sick leave and early retirement and fewer state benefit disbursements. It can increase productivity and contribute to continued payments of taxes. One consequence of the lack of effective vocational rehabilitation for an individual with sickness absence is a weakened financial position. It can also lead to isolation and exclusion from the labour market, as well as quite often leading to other disorders. Too many sick cases result in a disability pension.

Many definitions have been proposed for vocational rehabilitation. The one that seems to be the most complete is the one that defines vocational rehabilitation as “Medical, psychological, social and occupational activities aiming to re-establish among sick or injured people with previous work history their working capacity and prerequisites for returning to the labour market, i.e. to a job or availability for a job” (Selander 1999). This definition however omits those who have never worked. Many young people today find it extremely difficult to enter the labour market and those with disabilities find it even harder. In my opinion the words “with previous work history” should be erased from the definition. My suggestion is that the definition of vocational rehabilitation
should be “Medical, psychological, social and occupational activities aiming to re-establish among sick or injured people their working capacity and prerequisites for returning or entering the labour market, i.e. to a job or availability for a job”. Vocational rehabilitation is a representative of a wide range of vocational and educational services that are offered to people who are working, as well as those out of work or who have never worked. Disabled people participate less in the labour market than non-disabled people.

Vocational rehabilitation in Sweden will be facing great challenges in connection with the new reforms, which have recently been introduced in the Swedish Sickness Insurance System. Sweden has a population of 9 million people. The labour market constitutes 4.6 million Swedes and of those 3.6 million are in work any ordinary day. Currently 117,000 people are on sickness absence. 518,000 people receive a disability pension. This means that around 14% of the working population doesn't work. If we include those who are unemployed, the figure is 19%. Sweden has had compulsory social sickness insurance since 1955. All Swedes aged 16–65 are covered by this insurance. Sickness benefit is an income related benefit, which is related to your annual income. Compensation is 80% of your monthly income. Sickness insurance requires one qualifying day without compensation. Disability pension compensates for 65% of your annual income and is topped by 10% from the union and your employer together. Employers compensate the first two weeks on sickness benefit after which the Social Insurance Agency takes over.

From a European perspective, Sweden, along with Norway, has one of the highest rates of sickness absence in Western Europe and it has trebled laterally. Finland and France are next in line. An international comparison has shown that the amount of disability pensioners in the population has developed in dramatically different ways within countries but also between countries. The amount of disability pensioners is high in Sweden, Norway and Poland. Finland also rates among the top five. Sick-listing inflow has been considerably high for many years and it would appear that the model used in Sweden to assess the right to compensation from the social insurance hasn't worked out as intended. It was too easy to advance from sick-listing to a disability pension. The sick-listing- and rehabilitation process is slow and indistinct. People were sick listed and became passive while waiting for rehabilitation activities to be initiated. Too many people left the labour market permanently for a disability pension. Studies have shown that early rehabilitation increases the possibilities for successful rehabilitation and decreases the risk for disability pension (Kuoppala and Lamminpää 2008, Marnetoft et al. 2001).

The Government now hopes that the sickness insurance inflow will be stopped by these new reforms and improved process regarding sick listing and the investments being made in early activities including vocational rehabilitation and financial coordination between the Social Insurance Agency, employer, job office and health care system. First, a Rehabilitation chain with fixed limits for testing work capacity has been introduced. Second, a Rehabilitation
Guarantee has been implemented: and third, a new occupational health care service is under construction. Sweden has also taken an initiative to create a medical support system for physicians to use in the sick-listing process regarding normal sick-listing periods for different diagnoses. The National Board of Health and Welfare has been assigned the responsibility to work on this support system for decision making along with about 40 specialists from 20 fields of medical specialties.

In July 2008, a Rehabilitation Chain with fixed limits for testing work capacity was introduced. During the first 90 days of sick listing efforts are made to enable a return to previous or different work with the same employer. If you can’t return to work, you have to look for a new work. After 180 days you must have special reasons in order to be allowed to keep your sickness benefit. For example ongoing care/treatment or vocational rehabilitation, which will lead to a return to work. After one year you must reapply for sickness benefit. This is only for people with severe diseases. When sick listing exceeds one year, the Social Insurance Agency is obliged to take a decision regarding either disability pension or a return to work or unemployment for the individual. Disability pension can only be granted for permanently reduced working capacity and when vocational rehabilitation is not expected to increase the working capacity. The new approach in vocational rehabilitation focuses on increased personal responsibility for initiating possibilities for an adjustment in the individual’s ordinary work or for finding new work.

Everyone on the labour market suffering from slight or moderate depression, anxiety, stress related illnesses or non specific neck and back pain aged between 16–67 years is included in a Rehabilitation Guarantee. This means that they have the right to receive evidence-based Cognitive Behavioral Therapy (CBT) and multimodal treatments. The Guarantee focuses on frequently used diagnoses such as musculoskeletal problems and minor or moderate mental illness. Evidence-based multi-modal rehabilitation, which includes psychological and physical activities, is available for people with chronic joint pain. Learning about pain and support through empowerment is also included in multi-modal rehabilitation. The work is team based, representing different professions. CBT is available for slight or moderate mental illness. More diagnoses will be included when evidence based rehabilitation research shows positive effects regarding other illness. Those working with CBT must be qualified, and assessment and treatment can take place both individually or in groups.

A new occupational health service is also under construction, the aim of which is to make the rehabilitation process more effective. Services wishing to be included in this new occupational health services to establishing the sick listing and rehabilitation process must apply for a special certificate from the social insurance agency. Staff working at the occupational health service must be specialized in the relation between work and illness. Case managers will coach and support people to remain in the labour force. If the reform is implemented as planned it will become a powerful instrument in the
sick listing and vocational rehabilitation process - primarily for the individual, who will be able to commence an early vocational rehabilitation with focus on returning to work.

The reason for creating a medical sick listing support system was to investigate the substantial differences regarding the length of sick-listing periods that existed from an international perspective. The deviations in the length of sick-listing periods for similar diagnoses may quite well be due to unclear diagnoses or treatment or passive waiting periods. Attitudes to sick listing and different sick listing praxis could be another explanation, as could adaption to a sick role. The medical support system will guarantee the quality of the sick-listing process and ensure that the process follows the rules and regulations in force. It contains detailed recommendations concerning the normal length of sick listing for different diagnoses and can serve as a guideline for physicians when deciding about the normal physiological healing period. It was implemented in March 2008 for somatic diseases and for psychiatric diseases in August 2008.

The most important task for the Social Insurance Agency is to assess the working capacity and sick listing must be due to medical reasons only. The employment office manages the vocational rehabilitation through job coaches or case managers. The Social Insurance Agency has a total responsibility for vocational rehabilitation and for ensuring that other actors fulfill their given assignments. Job security during illness is not influenced by the new social insurance reforms. The main responsibility for employees’ rehabilitation still lies with the employer.

For the employer the rehabilitation reform can lead to a decrease in sickness absence and the subsequent cost for this, as well as providing opportunities for commencing the rehabilitation process at an early stage. The fixed time limits for testing the work capacity can also lead to a more effective prognosis for the length of sick listing. A more effective sick listing and rehabilitation process will reduce the cost for society and reduce the number of people exiting the labour market for a disability pension. It can also lead to an increased capacity in the health care sector with fewer people on sick listing.

The health care system and vocational rehabilitation both face substantial challenges in the new social insurance system. Will the physicians and the rehabilitation counselors use the medical support system in their work to decrease the sickness absence? Will the rehabilitation chain function as planned? Can the health care sector meet the demands from the Rehabilitation Guarantee? And how will the new reformed occupational service cope? Ongoing evaluations have not yet produced answers as to how the different actors involved in the social insurance sector are coping with the new situation they are currently facing. Some evaluations carried out are not encouraging. 42 % of the physicians have never or very
seldom used the medical support system. 20 % of the rehabilitation counselors have not reminded the physicians about the new complementary system. They lack the time for this, they declare. 47 % of the rehabilitation counselors are of the opinion that the medical support system is not prioritized among their managers. The rehabilitation chain seems to work. The sickness capacity rate has decreased from 43 days per year and insured person to 35 days. At the same time there has been a small or in fact no increase of social allowance. This is also true for newly granted disability pensions.

The Rehabilitation Guarantee faces immense challenges. There is a lack of people with adequate training in CBT. The majority of health centres are not skilled in meeting people in pain. There is a definite need for a new recruitment of people with those skills, but funds are lacking. The new occupational health services are also facing tremendous challenges. Which Universities will provide the new training program for people working in the sector? What type of training is suitable for case managers? How should they work with prevention and vocational rehabilitation? When will it be up and functioning?

Conclusions

The decisions behind the medical support system must be firmly established among the physicians and the rehabilitation counselors. Information regarding its importance must be spread. Research is needed to investigate the effects of the Rehabilitation Chain. The health care sector lacks the necessary resources to be able to live up to the rehabilitation Guarantee. More people need to be trained in CBT and Multi-modal rehabilitation. When will the new occupational service be of any use in the sick listing- and vocational rehabilitation process? This is an important question. The cost for sickness absence in Sweden is still much too high compared with other EU countries.

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References


