Barriers to Rehabilitation Outcome

By Antoinette Hetzler

Abstract: Work directed rehabilitation is seen in this article as a type of workfare introduced within social insurance. The purpose of introducing workfare into social insurance in Sweden 1992 was to decrease sick leaves through early and active rehabilitation. The article examines why work directed rehabilitation as workfare was not successful. The barriers to rehabilitation outcome discussed in this article are based on the empirical results of three different studies of work directed rehabilitation. Primary obstacles to work directed rehabilitation were found to be changing definitions of work capacity within the regular labor market, inability to influence change in the organization of work, unwillingness of grass-root bureaucrats to accept workfare in public health insurance, and changing attitudes of the Swedish population towards the concept of work capacity.

Why doesn't rehabilitation work? As soon as we ask why rehabilitation is not successful we have to understand what we mean by successful rehabilitation and for whom rehabilitation is to succeed. It is not enough to focus on an etymological explanation of rehabilitation to answer any of these questions. Instead we must look at the concept of rehabilitation in the setting in which it is being used and invoked.

The discussion on rehabilitation in this article aims to analyze barriers that hinder the success of work directed rehabilitation within Sweden. The starting point for our analysis is the introduction of the Swedish concept of "workfare" within social insurance. Rehabilitation directed towards return to work was the tool that was to transform social insurance from a passive organization paying out sick leave and early pensions for individuals with diminished work capacities. By effective use of rehabilitation as a social tool, the social insurance authority would become an active agency ensuring early and coordinated rehabilitation for those individuals who upon completing medical treatment were still unable to return to work.

Workfare as an ideology was formally imported into social insurance in Sweden with passage of a rehabilitation reform 1991/92. The reform was constructed around three basic principles: a better work environment, a more effective rehabilitation and an employer period of economic responsibility for compensating sick leave. The goal of the reform was...
to decrease sick leaves through early and active rehabilitation.

The empirical basis for my analysis of barriers to rehabilitation outcome is gathered from three different studies of work-directed rehabilitation carried out since workfare was introduced into social insurance.\(^3\) The first study is of 8000 long-term sick leaves terminated between 1991 and 1993 in Southern Sweden, the Work, Sickness, and Rehabilitation Study I, WSRS I (Hetzler & Eriksson 1993, Hetzler 1994, Hetzler 1996a, Hetzler 1996b, Hetzler 1997). The second study is an evaluation of 40 Swedish companies who participated in a program designed to institutionalize work directed rehabilitation within the work place, the Work Directed Rehabilitation Study, WDR, (Hetzler, Eriksson & Wesser 1995). The third study is a parallel to the study of long term sick leaves from the beginning of the 1990s and is based on information gathered about 4000 individuals who ended a long term sick leave in 2001/02, Work, Sickness, and Rehabilitation Study II, WSRS II, (Hetzler 2003).

Although the WDR study suggested the possibility of integrating a work directed rehabilitation perspective within the work environment, the other two studies, WSRS I and II, showed that rehabilitation did not increase the outcome for long term sick individuals to return to work. Barriers to rehabilitation outcome defined as return to work are discussed from three different perspectives: the work place and the organization of work, the social insurance agency and the organization of rehabilitation and the individual employee with a work-limitation impairment. By looking at both the organization of production and the behavior of authorities in relationship to rehabilitation and the goal to use rehabilitation to increase the number of individuals within the active working force, the perspective of and the situation for the individual employee becomes more focused. At the same time the barriers to rehabilitation can be discussed within a wider perspective of macro-phenomena concerning changes in labor markets as well as organizational considerations within the public sector and individual attitudes.

After a brief background to the introduction of workfare into social insurance, outcomes of the three empirical studies will be presented. The discussion takes up the problems and consequences of introducing workfare through rehabilitation into the social insurance system. The conclusion presents the difficulties of uniting competing ideologies of work and sickness within the welfare state and the advisability of relying on rehabilitation as a primary instrument of transformation.
Workfare and the Scandinavian Model

Workfare, as a goal, was introduced into social insurance in Sweden in 1992 through the introduction of the concept of work-directed rehabilitation as a means to reach a goal of full employment. Work-directed rehabilitation is defined as those measures that ease the return to gainful employment for those individuals who are on a prolonged sick leave or who are currently receiving a disability pension. The purpose for introducing work-directed rehabilitation within social insurance is to extend and uphold workfare as it is used in Swedish labor policy. Simply, this means, as many individuals as possible are to support themselves through their own work. But workfare also means that the public sector should prioritize active measures to return individuals to work even if these measures are more costly than economic remuneration paid out to the sick and the unemployed according to law (SOU 2000:78, p 51).

When the rehabilitation reform was introduced, the government designed rehabilitation so that the workplace and the employer would, if not bear, at least share the brunt of responsibility. The employer was responsible for both starting a rehabilitation investigation of the sick employee and for taking those measures necessary within their own work environment so that the employee could continue his/her employment.

The individual would be entitled to a higher compensation form than the cash allowance provided for traditional sick leave if he/she participated in work-directed rehabilitation. This higher compensation was seen as a method to enhance workfare as a principle of welfare policy. Even the social insurance authorities were subject to change. Instead of a role as transmitters of economic remuneration to sick citizens they would – under the principles of workfare – become both initiative takers and the agency responsible for coordinating rehabilitation. And they were expected to be efficient in their role as coordinators.

Thus, the introduction of workfare into social insurance was on paper designed to change 1) economic policy through new laws to enforce employers’ responsibility, 2) the functioning of public authorities through the expansion of workfare from labor policy to the social insurance system, and 3) the individual through incentives to encourage a choice of work as opposed to sickness.

That which is unusual in this venture is that workfare is usually invoked for able-bodied unemployed individuals without easy access to the labor market. Public health insurance, providing economic compensation during sickness, is premised on individuals being non-able to partake in the labor market. That is, as Kildal (2001) points out, the first condition of workfare is that it is directed towards able-bodied recipients.
Barriers to Rehabilitation Outcome

The official government rhetoric for imposing workfare in public health insurance was to decrease both absence due to illness and the exclusion of individuals from the labor market. In this way the state would also control increasing cost for public health insurance. To understand why workfare invaded social insurance, blurring the relationship between non-able and able-bodied recipients, it is necessary to look at what had happened in Sweden during the 1980s.

During the last part of the 1980s, Sweden found itself in a highly unusual overheated period of a business cycle. Unemployment was at an all time low and it was difficult to find sufficient manpower to satisfy demand. But at the same time, cost for public health insurance was increasing. This primarily was because of the increase in long term sicknesses defined as sick 90 days or more. 85% of the long term sick had a permanent job and thereby were seen as having a strong connection with a work place. It is not so difficult to understand why the government found it reasonable to attack the work place. By issuing a rehabilitation reform, the Swedish government clearly pointed out that the working force was not a “use-and-dispose” commodity where a public health insurance program would be available to pick up and support individuals treated by employers as discarded commodities. In fact, the 1991/92 legislation was a final step in a process of government investigations and reports throughout the second half of the 1980s. This process originally started as an effort to improve the working environment as work injury cases became more plentiful throughout the 1980s and invoked a governmental response which included the symbolism of naming and shaming the 400000 worse jobs.

But the last step in this investigative and legislative period coincided with a rapid and catastrophic economic turn of events for Sweden that swept the country into its deepest depression since the 1930s. Unemployment suddenly increased from 1.8% to over 10%. The workforce shrank as jobs disappeared. A real estate bubble followed by a financial bank crisis weakened the monetary basis of Sweden and prior practices of devaluing the currency as a reaction to inflation were no longer a feasible alternative. Within the period of a few years, Sweden adapted to a variety of changes. An important change began when Sweden started application procedures for membership in the European Union. This meant accepting a half-decade of public austerity to meet the European Union’s monetary convergence demands. Stabilization of the currency premised on low inflation became more important for social democratic government policy than full employment. Yet full employment, workfare, would lower cost for the State and contribute to better public finance.
During this period, the first years of the 1990s, the number of long term sick leaves diminished as the number of unemployed increased. A number of researchers explained this phenomenon as natural and drew parallels with other not so drastic changes in previous business cycles. However, after reaching an all-time low in 1997, the number of long term sicknesses started to increase rapidly and within a period of only two years were suddenly 80% higher. This rapid increase has continued as of this day. (See Diagram 1. Number of Women and Men (%) with Long term Sickness in Sweden in Relation to the total population. 1976-2001 Long-term sickness in Sweden 1976 – 2001).

Diagram 1.


It is thereby not surprising that the late 1990’s and the beginning of the year 2000 saw a reoccurring interest by the government for establishing workfare in social insurance. The interest also focused on why rehabilitation to work had failed. But what was introduced less than 15 years ago, has today taken on other dimensions. Workfare is an ideology that is at odds with an ideology of social rights for compensation for income loss when an individual experiences a work limitation because of sickness. Quite simply, Marshall’s articulation of a welfare state (1950) advances the idea of an evolutionary concept of citizenship grounded in the expansion of rights the state accords citizens. Social rights follow after the development of civil and political rights and guarantee each individual a protection of equal status. That is, Scandinavian welfare states have defined more risks in everyday life as responsibilities of the state. Social risks experienced by the individual, such as sickness or work injury are defined by the state as situations invoking a legitimate need for income protection. (Esping-Andersen 1999). Thus public health insurance compensations are established within the welfare state as a social right and not as a social benefit that society may demand to have repaid.

In an overheated market where an employer treats employees as “use and dispose” commodities, responsibility for rehabilitation can be a method to induce employer attitude change. But in a situation where employers’ demands on work ability are increasing and where the number of work places has successively decreased, workfare as an ideology and rehabilitation as an instrument of change become more obtuse.

The greatest discrepancy in using workfare in general public health insurance and workfare in social assistance and unemployment is the legal relationship of the individual to an employer. The following chart compares the three major systems for income support for the Swedish population between 16 and 64 years of age.

As seen in the chart below, the commitment to workfare varies within the different branches of income support. Commitment is highest within unemployment insurance and is part of the traditional development of unemployment funds (Axelsson et al. 1987). Social assistance within social welfare has a moderate adherence to workfare. Theoretically, the judgment of whether work is appropriate is governed within social assistance according to the law of unemployment insurance. Social assistance in Sweden was preceded by social help and prior to social help, economic help to the needy was provided by “the poor laws”.

Antoinette Hetzler

Chart One: Three public systems for income support in Sweden

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<th>Social Welfare</th>
<th>Unemployment Insurance</th>
<th>Public Sickness Insurance</th>
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<td>Monetary Allowance</td>
<td>Low</td>
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<td>Low to Moderate Income related</td>
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<td>Labor Market</td>
<td>Unemployed or Under employed</td>
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<td>Long-term Sick leave: 85% employed 1997.</td>
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<td>Agency Workfare</td>
<td>Municipality</td>
<td>Unemployment Benefit Fund</td>
<td>Regional Social Insurance Office</td>
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<td>Commitment To Workfare</td>
<td>Moderate</td>
<td>High^6</td>
<td>Low</td>
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<td>Targeted Group</td>
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The poor laws had helped certain groups of individuals in Sweden who were unable to support themselves through work on the open labor market. These included elderly indigent people, invalids, the chronically ill, families with many children, the unemployed etc. The development of universal public health insurance took care of many of these groups. In 1948, the introduction of the pension system took away 20% of individuals who relied on the poor laws for their survival. Another 20% disappeared in 1955 when the laws of public health insurance were enacted. By the end of the 1960s the number of individuals dependent on income support from Social help decreased only to increase again during the 1970s reaching a high point in 1974 and decreasing but stabilizing in the 1980s at a higher level than the 50s and 60s (Bagger-Sjöback 1979). In the first half of the 1990s, social assistance again increased in Sweden reaching a top in the middle of the 1990s. It has since decreased as sick leaves and disability pensions started to increase. The construction of the Swedish welfare state is premised on the creation of social rights within the public sector (Hetzler 1994). These rights are not conditional but apply in situations of work limitations. Sickness documented by a physical or mental condition that limits one or more life activities including the capacity to work is considered a work disability.

Public health insurance’s official and primary purpose in the Swedish society is to provide income security with
sickness and old age. Compensation is premised on the level of earned income. As Bagger-Sjöbäck (1979) points out when the Law of Public Insurance was enacted in 1963 the requisites for a disability pension were categorically based on a permanent reduction in work capacity on medical grounds. By 1960, exclusion of people from the labor market was so extensive that something had to be done. Bagger-Sjöbäck means that parliament changed the conditions for disability pensions to allow for granting pensions for labor market causes in 1972 and expanded this for other none medical-related causes in 1977 as an adaptation of the disability pension institute to on-going exclusion processes within the labor market. This use of public health insurance is inconsistent with a workfare ideology. The introduction of workfare into public health insurance must be seen against the background of how disability pensions were used throughout the 1970s and 1980s to accommodate the reality of labor market practices designed to marginalize certain workers deemed for one reason or the other to be inadequate. It should also be pointed out that disability pensions granted for labor markets reasons were never highly used in Sweden and eventually were discontinued in 1989 (Hetzler 1994). This does not mean that disability pensions were not used for labor market reasons. Rather this means that a redundant individual would apply for a disability pension by invoking a medical diagnosis instead of redundancy. But this previous policy, extending the use of disability pensions to cover a variety of social and/or labor market problems, permeated the administration of public health insurance and can be seen as a possible explanation of why it was difficult to gain support for workfare in public health insurance.  

Models of increased disability pensions and sick-leaves

Theoretical models which attempt to explain increases in early pensions or long-term sickness are not only important for the light they throw on illness in contemporary society but also for their importance in explaining changes in the welfare state. Probably the most important concept developed relating the welfare state and the relationship between work and sickness was the concept of decommodification. The concept was developed around the idea that the State played a role in taking individuals out of the labor market. The individual was not solely a commodity to be used by employers. Instead the welfare state compensated an individual for his limited working capacity through the development of social rights. Esping-Andersen (1990) points out that all the Scandinavian welfare states have made a distinct effort to minimize the individual’s dependency on the labor market and to de-commodify their welfare through universal generous compensation benefits.
Other models have tried to explain the increase in the use of public health insurance by looking either at causes within the work environment or within the individual. Models, which concentrate on the work environment, are usually premised on the relationship between the levels of work demand put upon the employee in relation to the level of control the individual has over his work situation. When demand is high and control is low, the individual is expected to experience stress and sickness. Methods for decreasing sick leaves and disability pensions are simply to improve the working environment. Models that blame changes in the individual for the increase use of health insurance point out that compensation for not being at work is quite close to compensation from work earnings. Individuals prefer a slightly lower compensation from health insurance than going to work. The solution to reducing work absence in this model in simply to reduce remuneration. These models also discuss changes in attitudes towards both work and sickness.

Government investigations that are not influenced by theoretical models but practical questions have also been interested in why sick leaves have increased in Sweden. The usual panorama of reasons explored are poorer health, deteriorating work environment, demographic changes in the working force, increased employment, changing economic incentives for the individual and the employer, restrictive use of laws governing early pensions, and administrative failures. These practical questions can be seen as following the three types of causal models developed in the Scandinavian countries for explaining increased demand on the contemporary welfare state. Berglind (1994) has summarized these models. The first model is defined by Berglind as the choice model. The model emphasizes that individuals choose to take an early disability pension instead of working. They do this because it is more profitable for them economically but damages the welfare state. The second model, according to Berglind, can be called the exclusion model. According to this model it has become more difficult, especially for the elderly, to obtain and maintain employment in an increasingly competitive labor market. Exclusion risk within the labor market is reflected in the increase of disability pensions. The third model is a model termed by Berglind as the system model. Within this model possibilities and obstacles for increasing the use of the social insurance system are determined by the way the system is administered. Individuals with a sickness or disability are moved from one category to another depending on different government programs, administrative workloads, discriminatory selection methods and costs (Hetzler 1992).

Assessment of barriers to rehabilitation outcome has an interest in the theories of why work limitations have increased.
Long-term sickness is a reflection in itself that rehabilitation is not successful. Berglind’s three models can be used in a discussion of the organization of rehabilitation as well as rehabilitation of the individual. The system model explains not only the increase in work limitations but also the failure of rehabilitation. Both the choice and the exclusion model defined by Berglind are reflected in my analysis concerning rehabilitation and the individual. But Berglind’s three models exclude the context of the changing labor market, the organization of production, and the importance it has on a state’s adaptation to the disabled individual. (Stone 1985, Esping-Andersen 1990).

Organization of Production

Changes in the organization of production influence the possibility to rehabilitate individuals within their work environment. Many of the models geared to understanding the individual at work are based on how the employee is treated at his/her workplace. These models center on how much the organization of production allows the individual to decide over his/her work and concentrate on such concepts as flexibility at work and participation in decision-making.

Other models that attempt to link the individual to his/her work place and the changing organization of production are introduced through using the concept of Sense of Coherence (Antonovsky 1991). By depicting the individual as oriented towards making his/her life coherent for himself/herself three characteristics become important. For the individual, action or events within her environment have to be comprehensible; they must be experienced as manageable and also as meaningful. These models of behavior of the individual have lead to a variety of hypothesis concerning the relationship of the work environment to health. The models of increased stress and change in the work environment and an individual’s sense of coherence have been connected with each other. An example is in a government investigation of work directed rehabilitation (SOU 2000:78) where the characteristic of action being seen as “meaningful” is elaborated by the statement that something has more meaning when the individual participates in decision-making and can influence events. The government study also points out that a long line of research has shown that individuals with a high sense of cohesion have better health, both physically and psychologically. These studies are not referenced, nor is it referenced that the Swedish population has, in general, a high sense of cohesion in everyday life. A criticism of using Sense of Coherence measurements as an indicator of problematic work situations is the inability to specify a causal relationship. Is ill health a result of a low sense of cohesion or does ill
health influence a sense of cohesion negatively. (Lundberg & Nyström 1995)

Aronsson and Sjögren (1994) are well-known researchers who have built on the model of decision-making and demands at work and integrated the model with concepts of feelings of belonging and feelings of purpose. Their work has been influential in further discussions of what is meant by good work and can be used to show what should be done in work-directed rehabilitation. There are five variables that distinguish the good work situation from a bad work situation: the level of demand placed upon the worker; the possibility for control over one’s own work situation, the possibility to develop at work; the degree of belonging; and the sense of purposefulness. All of these models, while useful, are developed from the perspective of the worker. If we look at what happened to the organization of production in Sweden during the 1990s, we see different concerns emerging from the employer. These concerns are important for the outcome of work-directed rehabilitation.

According to Drucker (1993) the organization of the work place and the reorganization of work are the core of an ongoing management revolution. The revolution in production, which, according to Drucker, replaced the industrial revolution, was completed by 1990 when the need for labor was only about a fifth of what was needed when Frederick W. Taylor presented his scientific management philosophy (1920s) for the organization of the production and transportation of goods and services. In Sweden, the management revolution was well underway by the mid-90s when we completed our WDR study (Hetzler & Eriksson 1995) The main goals for processes of change were 1) to change production relationship to meet demands from customers for fast delivery of specially manufactured products with high quality, and 2) to meet demands from employees for a higher working life quality. Increased learning at the level of production operators was a key concept. In the 40 organizations studied in WDR, four processes of change were found as central focus points in both the private and the public sector of working life. These were decentralization, work rotation, slimming the permanent work force and creation of a flatter organization that would eliminate middle management.

The re-organization strategies that evolved from the management revolution had consequences for how rehabilitation became anchored and cared for within a company. Barriers to rehabilitation outcomes related to the organization of production can be seen in two different but connected and dependent fields functioning within the work place.
Barriers to Rehabilitation Outcome

Figure 1

The left figure is a field showing the Field of Labor Markets Visions and Manifest Functions, and represents the driving forces in the "good company". These driving forces function as goals and values for the "good company". The field on the right is called the Field of Everyday Life, and represents processes in the daily organization of work and its managements. It can be seen as the backside of the Field of Visions. Both fields and the characteristics embedded in them are the results of a basic process of change in technical knowledge, organization and competition. These processes of change are what Drucker characterizes as the revolution of management.

WDR research showed that there is a complicated relationship between the two fields. A barrier to the outcome of
rehabilitation is the fact that a successful rehabilitation strategy which begins in the left field as a vision and a commitment is often weaken by processes in the field of everyday life. An interview with management about their rehabilitation program at Stora Skog exemplified this situation.

The world has changed a lot since we started this program in 1985. Attitudes in society have changed. But we still have the same problem. We will succeed eventually. According to my experience, projects that entail lots of changes take about five years to get into place. Attitudes must change and the changes should be able to withstand a business cycle with both recession and growth. We work with a total conception about the work environment, sick leave and rehabilitation. But it is difficult with rehabilitation. It is hard to transfer someone with a musculo-skeletal disorder to an easier job. (Is there opposition to preventive measures?) During bad times it is hard. For management all ways of changing work organization are seen as a threat. At the operative level, change means you have to readjust your point of view. Organizational changes bring about new situations for people, and they get worried. Redundancy is hard to handle.

At another company, an interview with a 26-year-old male employee who had quit his job shows how everyday reality worked in his rehabilitation situation.

I was called to the company after I had been on sick leave for quite a while. They said they thought I should quit. So I quit. I wanted to quit anyway but they talked to me in a way that I understood that if I didn’t quit they would have to fire me. I went through a rehabilitation program. The health insurance agency arranged a shit of a job for me, sweeping floors and making coffee.

Then I came back to my regular job but I got a pain in my back immediately. Actually, I would really like to study. I was hoping that rehabilitation would help me to go back to school.

(Do you think that the company did everything they could so that you could remain at your job?) There is a damn double morality. ABC Company was really nice to me at the start of my illness but then they just flipped-out. Their idea is if you are sick you should quit. They have a pretty bad opinion of those of us that are back on the job. They taunt you when you come back to work after a sickness. (What do you think they should have done?) They should give the guys a little support! I worked here for six years and they never gave me any support. (Do you know anyone else who quit in
Connection with an illness?) I know two guys who can’t work just now. One guy’s shoulder collapsed and another guy had stomach problems because of the gases that are used on the production line. (Do you believe that other people will want to work here in the future?) Right now, people want to work despite the cost, but they won’t be happy here. This is a bad place to work at, some people are treated special and others, those that are on sick leave are treated like shit. They should change to a more humanistic management. I would never go back, not even if I was broke.

This ex-employee was critical of his former employer. But the union representative at his work place confirmed the picture given. What was described by the employee and confirmed by the union was defined in the WDR study as a typical exit-model company. In this model, the realities of the everyday life field find a share ness of understanding between the public health insurance agency and the company.

The union representative shows how the exit-model works in his explanation about the possibilities for a worker to come back to work after a long-term sickness.

It’s worse now than it was three or four years ago. Now the public health insurance agency writes people off and they say they can’t do anything else. They mean they can’t rehabilitate the person and they just write him off as healthy.

You have a right to rehabilitation after a certain time, but you have to show that you are getting better. So when they think that there is nothing more to do they almost force a guy on sick leave to quit because they aren’t successful in finding a replacement job for him. That’s how they take care of the long-term sick guys today. And everyone is happy. The company can show the Work Life Fund that sick leaves have gone down and they meet the Funds’ demands. So the Work Life Fund has not had the effect on employees it should have had.

The barriers to rehabilitation outcome that are premised within changes in the organization of production define a need to counteract the elimination of individual workers from the labor force and to enhance a model whereby competence is continually developed and the work environment minimizes causes of sickness and injury. The actual barriers are the redefinition of work capacity, which exclude a portion of the working force. The redefinition of work capacity is supported or opposed by the public health insurance agency by patterns established with employers. Three possible patterns are possible,
1. A traditional pattern is a pattern where the employer used the public health insurance agency as an agency for paying out sick-leave insurance and for deciding cases of disability pensions.

2. A discontinuation pattern describes the situation where an employer is not interested in cooperating with the public health insurance agency. In this case, the employer does not negotiate or discuss rehabilitation possibilities and discourages any constructive attempts at solving the situation for the employee. Eventually, the public health insurance agency is shutout of communication with the employer.

3. A development pattern in which channels of communication are established between the employer and the public health insurance agency and patterns of co-operation are established which satisfy both sides.

Pattern one and two indicate barriers to rehabilitation outcome while, pattern three functions as a device to reduce exclusion because of illness or injury.

**Organization of Rehabilitation**

There has been continual discussion of who and how work-directed rehabilitation should be organized in Sweden. Sweden has attempted to cope with this on two-fronts by distinguishing responsibility for rehabilitation of employees between employers and the public sector and by determining within the public sector how co-ordination and financing of rehabilitation should be carried out. Rehabilitation co-operation among public sector agencies has been regulated since 1998. Many individuals circulate between different rehabilitation actors and the need for co-ordination of resources has long been recognized. Financing of co-operative rehabilitation and budgetary restraints as well as territorial thinking are all barriers to rehabilitation.

These barriers are shown as working through what Berglind (op.cit) calls the system model explanation of marginalization processes. The administration of public health insurance defines and redefines individuals into categories of disabled, long-term sick, or healthy dependent on the use of administrative categories and political directives. (Stone 1985, Hetzler 2003, Beatty et al. 2000)

The local insurance boards have responsibility for coordinating different governmental agencies and the measures they use for rehabilitating the same individual. In the 2003 budget presented to parliament, the government has suggested that at most 5% of funds budgeted for the costs of sick leave can be used for co-ordination. At the same time, the government admits that money budgeted to local insurance boards for rehabilitation has not been used. The focus on monetary budgets
and financing rehabilitation takes the spot light off what kind of rehabilitation is offered and whether rehabilitation, when offered, is successful. It also deflects a debate about using money designed for income support for administrative programs.

The monetary concerns of budgeting rehabilitation reveal as well the deficiency with the idea of workfare within public health insurance. 2003 results showed that 20% of money budgeted for rehabilitation including quality medical analysis of which measures are necessary for individual rehabilitation (2002) was not used by the public health insurance agencies. According to the National Social Insurance Board, inability to use designated funding is acknowledged as a substantial administrative failure. Recent reactions to fail using rehabilitation funds in Sweden have led to a suggestion by the Minister of Labor that more responsibility for rehabilitation is taken by the unemployment boards.

Even though the responsible agency does not discredit the idea of workfare within public health insurance, the reason why money is not used remains unanswered. The National Social Insurance Board speculates that there is too much administrative time taken up with assessing need and this increases the risk that the need for rehabilitation is not being met. Usual reasons given by the National Insurance Board why rehabilitation funds are not used by local public health insurance agencies are: 1) the local public health agencies have had too much to do and consequently many of the employees are themselves ill long term: and 2) the administrative methods used by the local public health insurance agencies are deficient.

I would like to introduce a third reason. Rehabilitation to work of individuals who no longer have a working capacity due to sickness is doomed to fail. The progressive changes in work ability demanded by new production systems have eliminated a number of work positions. Work capacity is not a static state of being. If individuals are defined as having a work capacity that is not recognized on the current labor market, the individual will be unemployed. The public health insurance agency recognizes that the labor market is in constant change and rather than rehabilitate a person to unemployment, that is, a non-existent job, they do not spend rehabilitation money. (Hög 1991) The alternative is to create another labor market financed by the state. This is a labor market created by the state and financed by the state and creates non-effective work positions for individuals lacking a competitive work capacity. This market has not been created in Sweden although it has been a matter of discussion. Public health insurance agencies are not willing to use public funds to rehabilitate individuals to a non-existent labor market.
Researchers in fact recognized this in the early 1990's. Workers within the public health insurance saw disability pensions as a reasonable alternative to unemployment (Ahrne 1989). This also means that workfare was not accepted as a guiding value within the bureaucratic administration of public health insurance. In order for it to be a guiding principle, the medical authority of the corps of physicians in Sweden would have to be displaced and their authority replaced by a non-medical authority concerning work ability.

The original study, Work, Sickness, and Rehabilitation Study I (WSRS I), undertaken at the point of introduction of workfare into public health insurance threw some light on the work patterns of the social insurance agencies. The study of 8000 documented cases included information of the situation of the person on sick leave at the time of onset of illness, measures taken by the public health insurance including rehabilitation services, employer, profession and diagnosis as well as sick history and the reason for termination of the sick leave.

1. One of the most interesting findings of the study was the fact that the work method used by the public health insurance agencies did not develop. That is, there was no critical evaluation of the results of work directed rehabilitation and whether they were successful or not.

The results of WSRS I showed the following:

2. Cases were not correctly identified in relation to need of rehabilitation
3. The majority of cases were identified as cases under surveillance and no rehabilitation measures were taken
4. Cases identified as rehabilitation or pension cases were re-identified during the sick-leave
5. Fewer than 16% of cases received a rehabilitation measure
6. Rehabilitation was not successful. Successful is defined in the study as return to work.
7. Rehabilitation was used to legitimate a case that was to end as a disability pension.
8. Women received other rehabilitation than men. Women received rehabilitation as work in the “actual environment”. Men received a bought measure or service.
9. The Public health insurance agency’s own evaluation of results was geared to measurement of measures per case instead of result of measures.

When we look at the current study of Work, Sickness and Rehabilitation, WSRSII, cases recently closed (2001/2002), we see similar patterns emerging, which indicates that workfare has not influenced rehabilitation.

In WSRSI, 68.8% of long-term sick leaves that started for an individual with an employment (76.8% of the population) ended with a return to work. Yet when we look at the figures from
WSRSII, we see that only 60.6% of those with employment at the beginning of their illness (71.8% of the total population) ended their sick leave by returning to work. This indicates that in those cases where there should have been the highest chances of returning the individual to work, administrators of public health insurance are less successful than they were ten years earlier. In fact, ten years earlier the Swedish economy was in the midst of the worse recession in 70 years and unemployment rates were the highest since the 1930s.

By looking at some results from WSRSII, the 2001-2002 population, we can see what 10 years of workfare within public health insurance has accomplished. Who receives medical rehabilitation today? We can see that 78.6% of individuals on long-term sick leave receive no additional medical rehabilitation during their sick leave. Those that eventually returned to work had no additional medical rehabilitation in 90.4% of cases. When additional medical rehabilitation was given those that returned to work it was inevitably physiotherapy (4.1%). But those individuals that ended sick leave through a disability pension (28.4% of the total population) received additional medical rehabilitation in 48% of cases or in almost one of every other case. Even here additional medical rehabilitation was traditional physiotherapy (20.1%). In general we can say that those that do receive additional medical rehabilitation receive physiotherapy (9.2%). Another 4.1% of individuals on sick leave is directed towards an assessment of their functional work capacity or to ordinary medical treatment.

Besides medical rehabilitation a person on sick leave can also be provided with work-directed rehabilitation. When we look at the specific work-directed rehabilitation measures that the 2002 population received, we see that 82.7% did not receive any work-directed rehabilitation measure. The majority that received a work-directed rehabilitation measure received work training. 2% were allotted an educational training and 2.4% was subjected to a work trial to assess there work ability.

Once again, we see that the few work-directed rehabilitation measures allotted the long-term sick were handed out to those that eventually would be granted a disability pension. 31% of individuals who ended their sick period with a disability pension had received a work-directed rehabilitation measure. Yet those that returned to work had the advantage of a work-directed rehabilitation measure in only 11% of the cases. The type of work-directed rehabilitation when allotted was traditional training at their regular work place or else a trial work period at another job.

Whereas the 1992 population showed that more rehabilitation was given men, the 2002 population showed that women in general received more rehabilitation
than men. This was not true for women and men who returned to work. It was seldom that these individuals were accorded work directed rehabilitation. Instead just as in 1990, those men and women that eventually were awarded a disability pension were given more rehabilitation. This was true more for women than men. 33.3% of women awarded a disability pension had work directed rehabilitation but only 26.7% of men who were eventually declared permanently disabled. The type of rehabilitation measure given men and women had also become more equal after 10 years. The usual work directed rehabilitation was to return the individual to his work and let him train himself at his own job. This was accorded both women and men equally. Slightly more women were given educational retraining (2.5% as opposed to 1.4%).

What is amazing is that the pattern of treating cases and dispersing rehabilitation discovered in 1992 is almost identical to the pattern in 2002.

1. Although there has been a slight increase in the number of individuals afforded either medical or work directed rehabilitation, it is still less than 20% of cases that receive rehabilitation.
2. Rehabilitation does not lead to a return to work.
3. Rehabilitation often is used in cases that end as disability pensions.
4. Women and men receive about the same amount of rehabilitation with a slight tendency to direct rehabilitation towards women who will eventually be awarded disability pensions.

The public health insurance agency has attempted to improve their methods of identifying cases in need of work directed rehabilitation. However, the number of cases in the 2002 population that pass through the needles eye for a coordinated use of rehabilitation are small and account for only 6.6% of the total number of cases.

If we look at the outcome of the 6.6% cases designated as cases qualifying for coordinated rehabilitation we see that they did not fare much better than the total population of cases. In 54.4% of the cases the individual returned to work, in 15.7% of cases he/she was judged healthy but ended his/her sick leave with unemployment and in 21.5% of the cases the individual was awarded a disability pension. He/she was transferred into other programs in the remaining 8.4% of cases.

Generally, as has been shown by comparing results from two studies WSRS I and WSRSII; there has been a decline in returning sick individuals to the normal labor market since workfare was introduced into social insurance.

The barriers to rehabilitation outcome emanating from the public health insurance agency can be traced to
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1. Ideological inconsistency of workfare and the social right to remuneration for diminished work capacity

2. Bureaucratic traditions which synchronizes the working of the public health insurance agency with changes within the labor market

3. The non-existence of a labor market for rehabilitated workers

4. Difficulty in identification of cases where rehabilitation increases possibility of return to work

5. Insufficient rehabilitation devices

The individual with a long-term sickness finds himself/herself within these processes of inclusion and exclusion.

Rehabilitation and the Individual

The constant increase in the number of individuals absent from work because of illness in Sweden has not only put pressure on the health insurance program but also on the individual who takes a sick absence. Short-term sick leaves have often been a matter of contention within the Scandinavian welfare state and the debate usually focused on changing morals in relationship to work obligations and the need for a qualifying period before benefits for sick leave would be paid. As economists emphasized incentive systems to influence individual behavior and other behavioral scientists discussed changes in work environment, the old patterns of explanation of environment or individual have resurfaced as workfare as an ideology has not dented the increase in long-term sicknesses.

Currently, Lars Heikensten, Governor of the National Bank of Sweden (Riksbanksschef) stated in a newspaper interview (2003) that the Bank of Sweden has an obligation to point out developments, which threaten monetary stability. Possible threats, according to Heikensten besides a negative population development, include absence from work because of sickness. Although Heikensten refused to state solutions to problems of absence from work, he did mention workfare as a social control device that worked well within unemployment insurance. He also mentioned that public health insurance can be formed as a more traditional insurance where the individual takes more responsibility for financing the system.

Quite simply, the solution to curbing the use of the public health insurance is seen as either harder control mechanism or by shifting costs to the individual by some sort of privatization of insurance. Models for explaining the increase in disability presented by Berglind (see above) can also be seen as figuring into the relationship between the individual and rehabilitation. Some might argue that it is more profitable for a person to stay on long-term sickness and await a possible disability pension than to work for his/her rehabilitation and return to work. This choice model is not very
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convincing. Payment during rehabilitation is slightly higher than compensation on sick leave. Another model presented by Berglind, *the model of exclusion*, can explain the situation between the individual and rehabilitation. As attractive positions in the job market able to accommodate individuals in ill health disappear, competition for remaining positions hardens. People with a diminished work ability demonstrated by a long-term sick leave might feel as if there was no possibility for them to be rehabilitated to work. Instead they might end up as rehabilitated and unemployed. This is in fact the argument of Beatty et.al (2000). They mean that even if we do not know the exact mechanisms by which people are diverted onto sickness benefits and the precise balance between choice and compulsion is unclear, “once on sickness benefits, people are staying there longer rather than returning to employment. Longer stays on sickness benefits are consistent with the notion that there are fewer job opportunities for workers with an illness or a disability. They are also consistent with the high risk in moving from a relatively high benefit to insecure employment or to lower unemployment benefits.” (p 621)

Is the individual a barrier to his/her own rehabilitation outcomes? Many of the models of increased disability pensions do point to changing attitudes as a possible explanation (Marklund 1992, Berglind 1994) for the increase. A recent analysis of individuals’ attitudes towards rehabilitation and the attitudes of rehabilitation actors finds that usually administrative rehabilitation actors are more negative to rehabilitation possibilities than the individual. (Hetzler 2003) It should be pointed out that in the majority of cases, however, administrative actors and the sick individual are in agreement concerning rehabilitation.

The process of being sick and then being identified as permanently disabled takes time and goes through stages. The mere fact that the majority of long-term sick leaves are not judged as in need of any intervention means that these cases, left alone will normally end in a return to work. In 2002 1433 or 36.4% of the cases in *WSRSII* were categorized as wait-and-see cases. In fact 72.7% of these cases ended with a return to work, whereas only 54.4% of those cases categorized as in need of work-directed rehabilitation went back to work. And as pointed-out above only 52.4% of all long-term sick leave cases resulted in a return to work.

We do know some things about those that return to work. Those that are not subjected to rehabilitation intervention fair better than those identified as in need of work-directed rehabilitation. Those with employment are more likely to return to work than those without. Those with a muscle-skeleton diagnose have less of a chance to go back to
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work than those with psychiatric diagnose.

The National Health Insurance Board conducted a survey of the views of individuals on sick leave towards health and work (2002:16). The survey was conducted with people on long-term sick leave as well as a population not on sick leave. The study found that about 20% of those on sick leave would have wanted a disability pension. 58% on sick leave meant that if they themselves could decide about their work situation they would be able to work at least part time. And more than 50% of the people on sick leave gave work as partly or fully responsible for their sickness.

This attitude study together with the study of actual outcome of long-term sickness in WRSRI and WRSRII shows that the people within the labor market have adjusted their definitions of sickness to the changing definitions of work and the management revolution in everyday working life. What is seen as changing attitudes towards work, with an implication of a weakening of the work ethic, is simply the advancement of management’s new definitions of work ability. Many individuals feel that they do not have the physical or mental ability to produce the work capacity demanded and if the demanded work capacity is “normal” than they are “sick.”

Whereas the National health Insurance Board interprets the individual’s response to the theoretical question of how much work he/she could do if he decided over his/her work situation as indicating that measures taken for rehabilitation adaptation of the work place can be of great importance for a return to work, the barriers to rehabilitation outcome revealed by the WDS and discussed above, show that ability to decide over one’s own work situation, and changing the definition of expected work capacity per employee, is not conceivable within the evolving present management perspectives.

Conclusion

Why doesn’t rehabilitation work? What is holding up the return of workers to work? The answer is found in a series of subtle organizational changes involving a management revolution as well as changing relationships between the public and the private sector. This is coupled with a growing acceptance of the changing concept of expected work capacity inherent within the management model.

The empirical study of 40 Swedish companies, WDR, that attempted to institutionalize work directed rehabilitation within their work place revealed rehabilitation barriers within the organization of production. A comparison of actual long-term sick leaves from two different periods 1991-1993, WRSRI, and 2001-02, WRSRII, provided empirical evidence about the organi-
zation of rehabilitation and the relationship between rehabilitation and the individual. Together these three perspectives allow the possibility to sift through barriers to rehabilitation.

The biggest obstacles to work-directed rehabilitation can be summarized as:
1. Changing definitions of work capacity within the regular labor market.
2. Inability for work-directed rehabilitation functioning through the public health insurance agency to influence changes in the organization of work.
3. An attitude of acceptance by grass root level workers within the public health insurance agency that new definitions of expected work capacity have permanently disabled a portion of the working population.
4. Changing attitudes by the working population about the concept of work capacity.

Rehabilitation outcomes measured as a return to work have fared poorly in Sweden. The agencies grass-roots administrators met the introduction of workfare into public health insurance with distrust. Resources available for rehabilitation were not used. This could be because of not knowing what type of rehabilitation could be used or because administrators simply did not agree with the State policy of using workfare within public health insurance. At the same time the definition of expected working capacity and a managerial revolution within the public and private sector has combined to increase the number of individuals outside of the ordinary labor force. The right to public health insurance when an individual experiences a mental or physical work limitation is strongly engrained in the public identity of the Swedish population. The concept of rehabilitation, when perceived as workfare, can be experienced as an attack on this social right when the prospects of employment in the national labor market are viewed as very small. The combination of these factors creates the barriers to rehabilitation outcomes.

Notes
1 The word rehabilitation comes from latin. Re means again and habilis means functional. Other entries in this journal treat the changes in the concept of rehabilitation. Rehabilitation is, of course, related to the definition one has of disability. The most frequently used model of disability is usually considered to be Said Nagi’s model where disability is seen as a dynamic process in which an individual’s pathology interacts with the socioeconomic environment. Nagi’s model is also not different from what is referred to as the environment relative concept of handicap. (See Burkhauser, Daly, Houtenville, and Nargis 2002 for a further discussion of disability relation to work-limitation data).
2 The Swedish term for workfare is "arbetslinje" which is translated as work approach. Kildal 2001 talks about active labour market policy in Scandinavian countries as a form of activation policy which she distinguishes from workfare. She defines workfare as having the following four characteristics: 1) oblige able-bodied recipients, 2) to work in return for their benefits 3) on terms inferior to comparative work in the labour market, and 4) are
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essentially linked to the lowest tier of public income maintenance systems. Kildal then means that politicians and researchers blur activation policies and workfare and although there are differences in relationship to the four criteria for workfare she shows, in her work, that activation policies are sliding, in all Scandinavian countries, into workfare. In this article, I treat “arbetslinje” or the work approach as a variation of workfare. Workfare as “arbetslinje” or work approach has been a component of the Swedish welfare state since 1918. At that time a State Commission on Unemployment presented a plan for the creation of work for the unemployed. (Axelsson, Löfgren and Nilsson 1987) The Scandinavian model of the welfare state is premised on full employment. Legal requirements for both social assistance and unemployment are conditional on the individual presenting himself/herself as available for work within the national labour market.

Each of these studies was done within an active research group, VSA (Welfare, Social Insurance and Working Life) at the Sociology Department, Lund University under my direction. Kjell E. Eriksson and Erik Wesser were involved in the first two studies. Daniel Melén and Emma Torstensson are currently working on the third study. The research was made possible through basic funding for Program Support from Samhällsvetenskaplig Forsknings Råd (Swedish Council for Social Research) as well as Arbetsmiljöfunden. (Swedish Work Environment Fund), Rådet för Arbetslivsforskning (Swedish Council for Work Life Research), and RFV (The National Social Insurance Board).

By instituting a higher sick leave compensation for those individuals engaged in rehabilitation, the Swedish workfare model is a variation from the pure workfare model introduced by Kildal (2001, p 3).

In 1997 85% of those on long-term sick leave were in employment. By 2001 the number of long-term sick with employment was estimated at 75%. Those individuals with a limited long-term disability allowance because of sickness are protected by laws of employment and do not lose their employment tenure. A permanent disability is a ground for termination of the employment relationship.

Workfare was a central and main component of unemployment policy since the introduction of cash compensation for unemployment in 1914. For a detailed description of labor policy in Sweden during the 1990s see Axelsson, Löfgren and Nilsson 1987, Den svenska arbetsmarknadspolitiken under 1900-talet Prisma: Stockholm

Stone (1985) in The Disabled State presents a convincing argument that the concept of disability is tied to the local labour market. She argues, as I do, that disability is an administrative category which takes into account the situation in the labour market as well as the availability of suitable jobs. What Stone describes as an expansion of disability from a medical to a vocational concept is particularly obvious in Sweden. This point was brought to my attention by an anonymous reviewer of this manuscript.

Since being introduced by Offe in 1984 and elaborated by Esping-Andersen 1990 the concept of decommodification has been subjected to a variety of criticism and elaboration. See for example O’Connor, Orloff and Shaver 1999.

Halvorsen and Johannessen (1998) mean that the medicalisation of unemployment can be seen at times within the company while the individual is still employed. They mean that a disability pension is seen by both the employer and the employee as more preferable and a more legitimate type of exclusion from the labor market than unemployment.

SOU 2000:78, p 96 “Ges vi dessutom möjlighet att vara delaktiga och påverka så motiveras vi som individer att aktivt bidra till lösningarna av den uppkomna situationen. Translation: If we are given the possibility to participate, and to influence situations, we are motivated as individuals to
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actively contribute to solutions of problematic situations.

11 This was true for all companies with or without special funds from the five year Working Life Fund. The Working Life Fund was created through an act of Parliament in 1989 (1989:484). Through a special work environment tax, all employers were required, under a period of 16 months, to pay 1.5% of their payroll costs into the Working Life Fund (Arbetslivsfonden). The funds were to be disbursed during the 1990s upon application from companies. The 11 billion clowns from the fund would be redistribute to the work environment for "a contribution to employers for costs partly for rehabilitation measures for employees with long-term diminished health, partly for measure to decrease employees’ sick leaves, partly for investing in a better work environment...” (Prop. 1989/90:62)

12:1999 (FKF) Det behövs en ny politik för rehabilitering (There is a Need for a New Policy for Rehabilitation) is a debate pamphlet written by actors within the public health insurance administration. They state that a large number of jobs have disappeared. They mean "... (there)...are other kinds of demands concerning theoretical knowledge and there are higher demands than earlier. This means that we have fewer work positions to rehabilitate people for and if they do appear they are usually accompanied by demands for long and intensive measures on our part.”

13 But within the unemployment insurance, labor policy allows for the use of the unemployed to strengthen the labor force in the public sector.

References

FKF 1:1999 Det behövs en ny politik för rehabilitering (There is a Need for a New Policy for Rehabilitation), Stockholm.
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Lag 1989:484 Om särskild Arbetsmiljöavgift (On a Special Work Environment Tax).


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