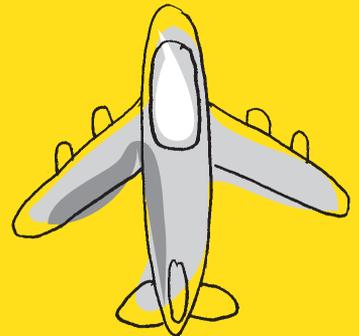
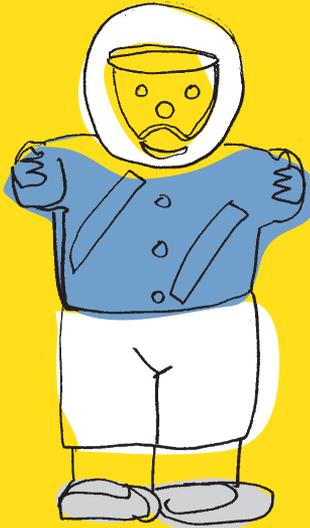
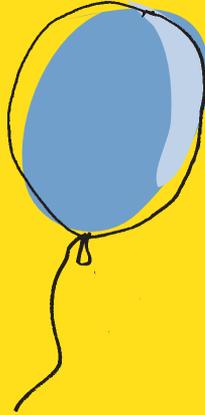
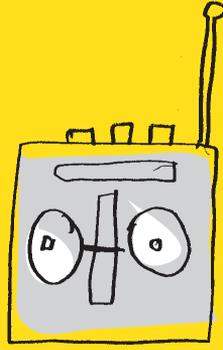
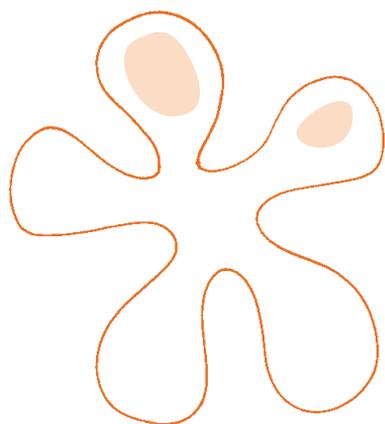


**Women, Men  
and Sickness Absence**



## Social Insurance in Sweden 2004

# **Social** Insurance in Sweden **2004**



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**S**ocial Insurance in Sweden 2004 is the latest in a series of annual publications from the National Social Insurance Board designed to provide an overall review and discussion of topics of current interest for social insurance.

The theme of this sixth volume is *Women, Men and Sickness Absence*.

Since the early 1980s, women have been sicklisted and granted disability pensions to a greater extent than men and the gap has grown over time. At present, women account for roughly two thirds of all sicklistings while men make up almost a third. Every tenth woman and every fourteenth man in the 16–64 age group receives a disability pension. The aim of this year's theme section is to shed light on these differences and discuss why they exist. We discuss the influence current norms and values regarding gender can have on the living and working conditions of women and men and, as a consequence, on their health, sickness absence and withdrawal from the labour force through disability pension.

By international standards, Sweden has made great progress in the area of gender equality. Over the past few decades, women in Sweden have increasingly fought for a position of greater equality in relation to men. In so doing, they have violated the existing norm system that lays down what is possible or impossible for a woman to do with her life. By contrast, men have not noticeably violated any corresponding norm system for men but have retained their superior status in relation to women, both at home and in the workplace. Thus, the living conditions of women and men are still significantly different. Different life situations and the lack of gender equality have in all probability contributed to the high rate of sicklisting and disability pensions among women. Nevertheless, it is hard to explain the extreme leap in the incidence of sickness absence between the years 1997 and 2002.

In this book, we demonstrate how several of the differences in sicklisting patterns for women and men can be explained in terms of the existing gender order. Women are forced to pay a high price for the lack of gender equality in family and working life – in the form of impaired health, sicklisting, disability pensions, lower benefits when sicklisted or on parental leave, and lower life-time earnings and pensions. We also show how the actions of both women and men help to preserve the gender order and inequality. We then go on to illustrate how employers and the social institutions set up to help individuals with failing health and work capacity reinforce the norm of women's relative subordination to men.

Many colleagues at the National Social Insurance Board have shared in the task of producing *Social Insurance in Sweden 2004*.

Britt-Marie Anderson has acted as editor. Each of the various sections has its own principal author. Sisko Bergendorff has been responsible for the theme section, Lena Ericson been responsible for *Social Insurance in Figures* and Jon Dutrieux for *The financial scope of the social insurance system*. The following people have been involved in the preparation of the theme section: Marcela Cohen Birman, Maria Eklund, Claudia Gardberg Morner, Ulrik Lidwall and Sten Olsson.

The manuscript has been critically scrutinized and commented on by Christina Ahlgren, M. D., Department of Public Health and Clinical Medicine, Occupational Medicine at Umeå University; Olof Bäckman, Ph. D. in Sociology, the Swedish Institute of Social Research at Stockholm University; Anne Hammarström, Professor, Department of Public Health and Clinical Medicine, Family Medicine at Umeå University; Pia Höök, Ph. D. in Economics, Feminist Organization Studies Fosfor, at the Stockholm School of Economics; and Malin Rönnblom, Ph. D. in Political Science at the Centre for Women's Studies, Umeå University. We thank them all for their contributions.

An especially warm thankyou goes to Heléne Thomsson, Ph. D. in Psychology at Transferens AB, who was an inspiration to our authors and contributed valuable ideas in the course of the work.

Stockholm, November 2004

Anna Hedborg  
Director General

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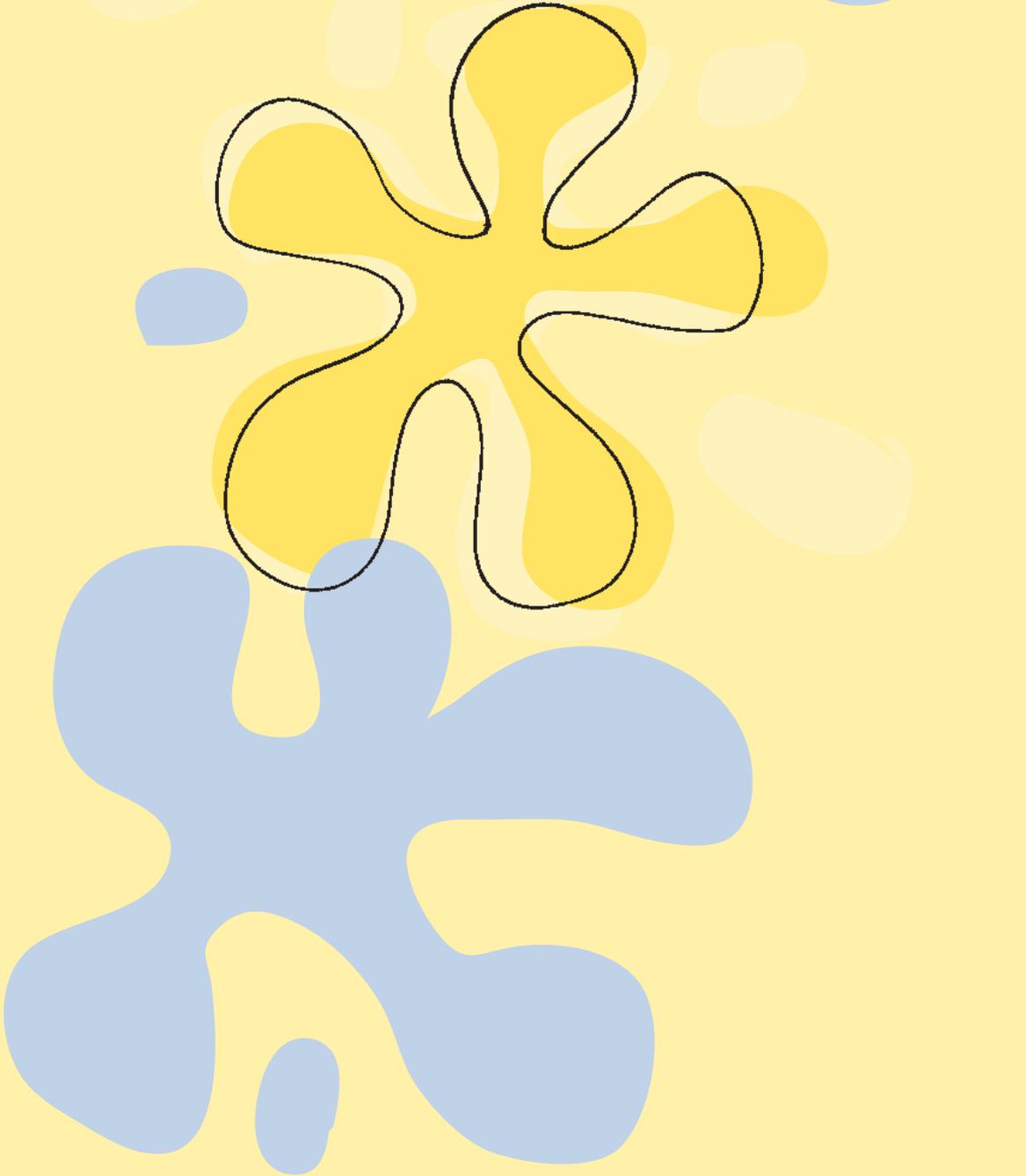
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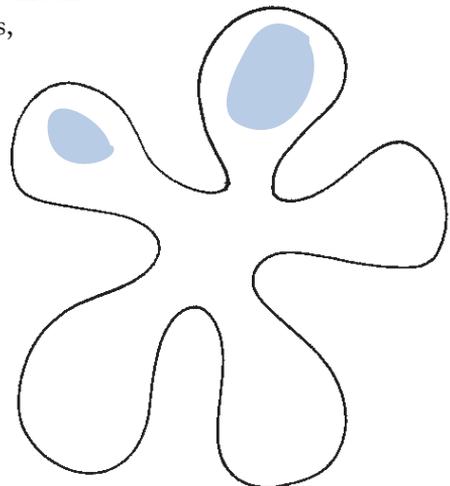
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## Social insurance in focus

The trend of increasing absence from work due to sickness and disability is a key item on the agenda of Sweden and many other countries. Since the 1960s, an ever increasing proportion of Sweden's working-age population has been sicklisted or granted a disability pension. This development is a serious social issue since many of those excluded from working life frequently experience a lower level of well-being and prosperity than people involved in the working community. Everyone should have the opportunity to attain a reasonable standard of well-being. That is why the "principle of work", one of a set of goals around which Swedish society is organized, emphasizes the right to work and full employment. It is a means of countering a social exclusion that is detrimental to society and individuals alike. Not least among the negative consequences of such exclusion is the long-term impact on the individual's personal finances, for example, in the form of a lower pension. It is also essential from the point of view of the national economy to reduce sickness absence and withdrawal from the labour force due to work incapacity.

Against this background, it is disturbing to note that there has been a particularly steep rise in sickness absence and the number of disability pension recipients among women over the past 25 years. While six per cent of women of working age in 1980 were either collecting a disability pension or sickness cash benefit for longer than one year, the proportion had risen to 13 per cent by 2003. During the same period, the corresponding proportion among men increased from six to nine per cent. Why was this? Has women's health deteriorated so much more than that of men over the past 25 years, or are other factors than health at work behind this phenomenon?

The aim of the theme section of Social Insurance in Sweden 2004 is to review and discuss the reasons for the differences in sickness absence and exits from the labour force due to work incapacity between women and men. A further aim is to extend the scope of the enquiry beyond the examination of customary risk factors. Thus, we will also consider how existing norms and values relating to gender affect



the living conditions, sickness absence and disability pension of women and men.

## Not just a question of biology

There is much evidence to suggest that women and men enjoy different health status and are affected by different ailments and injuries. Women seek medical care to a greater extent than men and are sicklisted much more often. Women also withdraw from the workforce prematurely due to deteriorating health more frequently than men. Men for their part suffer more accidents both at work and elsewhere and have a shorter life expectancy than women. These are just a few examples from a long list of indications of differences in the health of women and men.

The reasons for the differences in health and sickness of women and men are complex. The explanations discussed in scientific literature can be divided into at least two main hypothetical models: the biological/genetic model and the sociocultural model (see, for example, Hammarström et al. 1996, Kilbom & Messing 1999, Messing & Kilbom 1999, Socialstyrelsen 2004a).

The biological or genetic model focuses on those physical differences between women and men that can produce a different level of risk for illness. For example, hormonal changes during pregnancy weaken women's connective tissue and make their ligaments more flaccid. This can result in various degrees of pain and impaired mobility. Women also have thinner skin than men, making it easier for chemicals to penetrate and cause allergies and eczema. Men as a group have greater muscle fibre and muscular strength than women as a group. However, given the same level of static load, the average woman displays greater endurance than the average man because women's muscles generally have better blood circulation.

The sociocultural model seeks the cause of health differences in health-related behaviour and life circumstances – such as relationships in working life, family life and other social contexts. Since women and men to a large extent work in different occupations and experience different working conditions, this can affect their health differently. Even if women and men perform identical work tasks, they may do so in different ways due to differences in body size. The fact that workplaces are often adapted to normal-sized men may constitute a health risk for women and men of different physical stature. Family relationships and the amount of domestic work are further examples of circumstances that can create different risks of physical and mental suffering for women and men. In addition, the sociocultural model emphasizes the different ways in which

women and men perceive and evaluate health. Women and men tend not only to relate differently to similar symptoms and illnesses but also to adopt different measures in dealing with them.

However, neither model on its own can adequately explain the differences in health and sickness between women and men. Biological differences between the sexes interact with sociocultural factors to influence health. It is impossible to draw a precise line between where the one ends and the other starts. For example, conditions at work can influence blood pressure and immune defence. Hormone secretion can be affected by stress and sickness. At the same time, many health hazards and pressures in working life can be altered to reduce their impact on biological mechanisms. For example, the ability of women to continue working well into pregnancy is not determined by biological factors alone but also by working conditions. Greater adaptation of workplaces to individual needs can reduce the strains on people and the need for sick leave.

To gain a better understanding of what lies behind the differences in health of women and men, we can enlist the help of the scientific method known as gender theory (for example, Hirdman 1988, Connell 2003). Explanations within this theoretical field derive from analyses of the living conditions of women and men and the opportunities and limitations associated with them.

A gender-theoretical perspective means focusing less on the individual and more on structural relationships within groups, organizations and society. Research based on this model has revealed a complex interaction where power structures and cultural and social mechanisms in society mesh with psychological and biological factors. Gender-theoretical research demonstrates how a given situation can give rise to quite different outcomes for women and men. This approach regards the lives of women and men as, on the one hand, changeable, and on the other, socioculturally fixed. Moreover, health status, treatment by others and the odds of getting equal care and rehabilitation varies, though always within the framework defined by sociocultural structures.

Explaining the higher incidence of sickness absence and higher inflow to disability insurance among women is further complicated when we ask ourselves why collecting sickness cash benefits and disability pensions was far more common among men than women right up to the early 1980s and why it has become much more prevalent among women since then. We may then ask ourselves why the differences between women and men have increased dramatically since the later part of the 1990s. While sickness absence and the number of newly granted disability pensions follow a cyclical pattern, that is, they reflect the business cycle, the long-term trend moves steadily upwards. Is this trend a result

of societal changes during the past decades? Such questions have central significance for the theme section of Social Insurance in Sweden 2004.

In this introductory chapter, we briefly report on the temporary and permanent periods of sickness absence of women and men. Then we discuss what is understood by the concepts of health and sickness and by work capacity and incapacity. We go on to briefly describe those foundation stones of public welfare policy that are important for the living conditions of women and men.

In the chapter entitled *The living conditions of women and men – a gender perspective*, the gender order is described: how it arises, is maintained, changes and regulates relations and the division of labour between women and men.

In the chapter entitled *Working life, family life and sickness absence*, we analyze the causes of the differences in sicklisting and the number of newly granted disability pensions among women and men. We link the concept of gender to that of class in order to better describe the consequences the current gender structure can have for the living conditions, sickness absence and disability pension of various groups of women and men. However, it is impossible within the scope of this book to study sickness absence in relation to ethnic affiliation and relations between women and men of different cultural backgrounds. Further, we reveal some of the strategies employed by women and men in their attempt to combine gainful employment with family life in a satisfactory manner.

The chapter entitled *Support when health fails* focuses on the support that sicklisted women and men receive from doctors, employers, the Social Insurance Office and the Employment Office to help them regain their health and return to work.

In the concluding chapter, *The obstruction of gender equality*, we discuss the conclusions drawn from results in earlier chapters. In addition, we place the results in a wider equal opportunities perspective.

This theme section is based on a large number of studies, research papers and other literature. References are on page 175.

## Sickness absence and disability pension among women and men

Over the past few decades, the structure of society and particularly the participation of women in the labour market have undergone great changes. These changes have impacted on women's and men's living conditions, health, sicklisting and exits from the labour market due to work incapacity. To illustrate the extent of sickness absence and newly awarded

disability pensions in the Swedish population, this section presents a current picture as well as a picture of developments over the past decades.

### Sickness cash benefit, sick pay, sickness compensation, activity compensation, disability pension and temporary disability pension

Sickness cash benefit provides financial security in case of reduced work capacity due to ill health or injury. For the first part of a sickness period, an employee receives sick pay from the employer, followed by sickness cash benefit from the Social Insurance Office. Persons receiving sickness cash benefit are referred to as sicklisted.

#### *New benefits replace old ones:*

Sickness compensation and activity compensation provide financial security in case of long-term reduction in work capacity. Sickness compensation is payable to persons aged 30–64. Persons aged 19–29 can be paid activity compensation. Since 2003, these benefits have replaced disability pension and temporary disability pension.

Up to the end of 2002, disability pension provided financial security in case of permanently reduced work capacity, temporary disability pension in case of long-term reduced work capacity. These benefits were payable to persons aged 16–64.

In Social Insurance in Sweden 2004, we use the terms 'disability pension' and 'temporary disability pension' when referring to historical data. When working with current data, we use the terms 'sickness compensation' and 'activity compensation'.

### Absence from work due to sickness and disability today

In 2003, women accounted for 63 per cent and men for 37 per cent of days of sickness cash benefit paid out from sickness insurance. Periods of sickness absence were also longer for women than for men on average. The sickness absence rate, which is the number of days that sickness cash benefit is paid out per insured person and year, was almost twice as high for women as for men.

	Days of sickness cash benefit, %	Sickness absence rate	Sicklisting period of 60 days or longer, %	Newly granted sickness compensations/ activity compensations, %
Women	63	26	64	59
Men	37	15	36	41

Note: The sickness absence rate is the number of sickness cash benefit days in the 16–64 age group per registered insured person in this group.

SOURCE: RFV (THE NATIONAL SOCIAL INSURANCE BOARD) DATABASE STORE

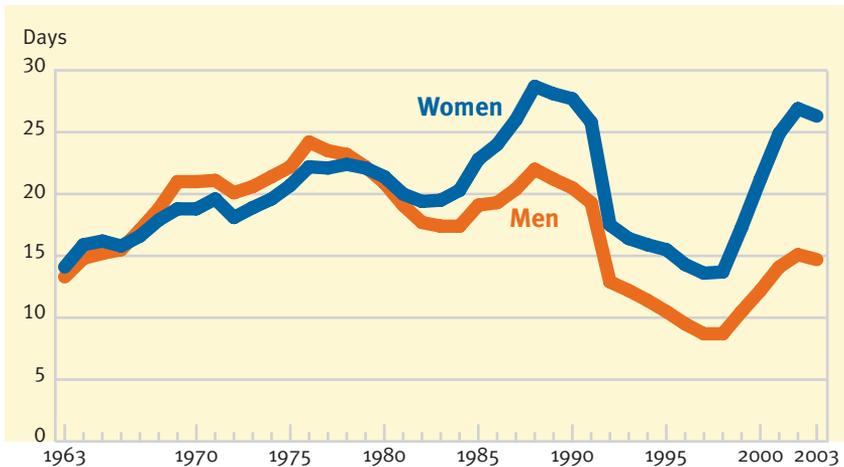
**Days of sickness cash benefit etc.** for persons aged 16–64, in 2003.

Men have a lower sickness absence rate than women in all age groups. Already in the age group 16–24, women’s absence rate is 80 per cent higher than men’s. Women are also granted sickness and activity compensation – previously named permanent and temporary disability pension – more frequently than men.

The vast majority of the people who are granted sickness cash benefit or sickness/activity compensation receive these benefits on a full-time basis. It is also possible to receive compensation for three-quarters, half or one-quarter of a day. Part-time benefits are more often paid to women than men. For example, quarter-day sicklisting is nearly twice as common among women as among men (RFV/Store).

### It wasn’t always like this

The sickness absence rate of both women and men has fluctuated dramatically over time. The absence rate is normally high during periods of economic growth and low during periods of recession. For a long time, women had a higher sickness absence rate than men. Since 1980, women’s absence rate has lain considerably higher and in 2002 it was as much as 77 per cent higher than men’s (Lidwall et al. 2004).



Note. The progress of the sickness absence rate was interrupted in 1992 by the introduction of the sick pay period. The definition of the sickness absence rate was changed in 1998.

SOURCE: RFV'S OFFICIAL STATISTICS

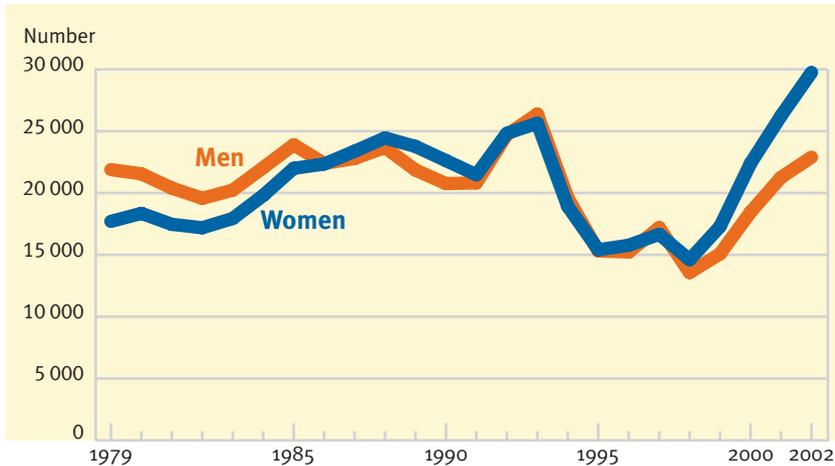
### Sickness absence rate development over time.

The difference between the sickness absence rate of women and men has increased in all age groups since 1990. The increase is greatest for the 20–39 age group and least for the 60–64 age group. While women aged

20–39 had a sickness absence rate 1.5 times as high as that of men in the same age bracket in 1990, the absence rate for women in this age group was twice as high in 2003.

In 1996, the costs for paid-out sickness cash benefit were spread fairly equally between women and men (51 and 49 per cent respectively). Since then, these costs have increased by 150 per cent expressed in year 2002 prices. The increase was 116 per cent for men and 183 per cent for women (RFV 2004a).

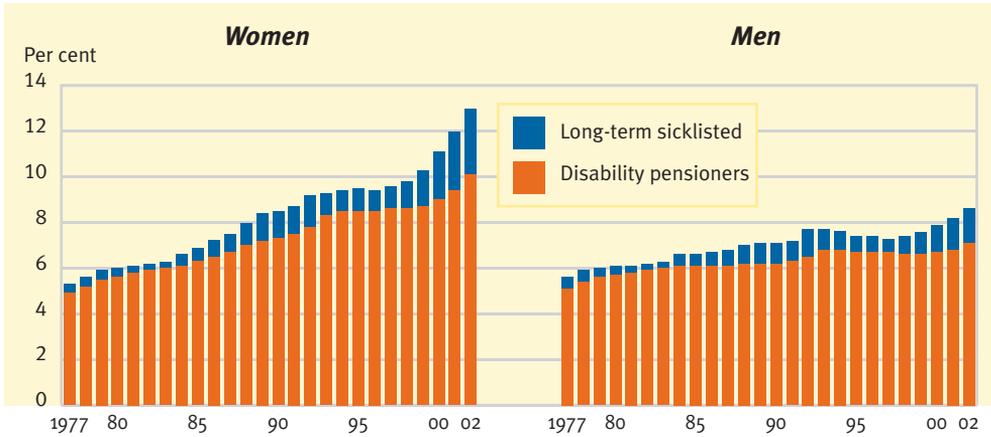
The incidence of long-term or permanently reduced work capacity, entitling to permanent or temporary disability pension, reveals on the whole somewhat smaller differences between women and men than is the case for sickness absence. Men were granted disability pension more often than women up to and including 1985. After that, the roles were reversed. The difference has increased dramatically since the second half of the 1990s.



SOURCE: RFV'S OFFICIAL STATISTICS

#### Number of newly granted permanent and temporary disability pensions.

The increase in newly granted permanent and temporary disability pensions during the second half of the 1990s is especially pronounced among women aged 30–39 (RFV 2004b).



SOURCE: BERGENDORFF ET AL. 2005

**The proportion of the population who receives permanent or temporary disability pensions or are long-term sicklisted for one year or longer.**

Every tenth woman and every fourteenth man in the 16–64 age group had disability pension or received temporary disability pension in 2002. If we add those who have collected sickness cash benefits for at least one year, still more have been dependent on social insurance for their livelihood.

The lives of men and women have thus not suddenly taken the forms we see today. The numbers in today's statistics of sickness absence and granted sickness compensations may be considered to be a consequence of a long and continuous process in which women and men tend to have relatively different living conditions.

### **Illnesses that cause absence from work due to sickness and disability**

For the most part, the same illnesses lie behind sicklisting for periods longer than 14 days and behind newly granted disability pensions. Diseases of musculoskeletal system and connective tissue are the most usual cause for both women and men, followed by mental and behavioural disorders. Back pain, lumbago and similar complaints, rheumatism and myalgia (muscular pain) are examples of frequently recurring diagnoses among musculoskeletal diseases.

Among mental disorders, stress reactions, anxiety and depression figure most prominently as reasons for sickness absence. Diseases of the circulatory system as well as injuries and poisoning are more common causes among men than among women. Women are sicklisted more often than men for mental disorders and symptoms, such as feeling ill and suffering from fatigue.

Diagnosis (disease category)	Sickness absence %		Permanent/temp. disability pensions %	
	Women*	Men	Women	Men
Musculoskeletal diseases	34	35	43	33
Mental disorders	20	16	27	29
Circulatory system diseases	3	6	4	11
Symptoms etc.	5	3	–	–
Injury, poisoning etc.	7	13	5	6
Other diseases	31	27	21	21
Total	100	100	100	100

\* Excluding pregnancy, childbirth and the puerperium

SOURCE: RFV (2003A) RFV (2004c)

### **Sicklisting longer than 14 days and newly granted permanent and temporary disability pensions in 16–64 age group during the years 1999–2002.**

Women are granted disability pensions to a much greater extent than men on grounds of musculoskeletal diseases. Mental disorders have increased dramatically as a reason for both temporary and permanent absence from work due to sickness and disability since the early 1990s. The increase is roughly the same for women and men. Men receive disability pensions more often than women on grounds of alcohol and drug abuse, which falls under the heading of mental disorders (RFV 2003a, Bergendorff et al. 2005).

The condition referred to as burnout has received much attention as a rapidly increasing cause of sickness absence. According to RFV's studies, however, burnout does not account for more than 1–2 per cent of all sickness spells lasting longer than two weeks. Women are more often sicklisted for burnout than men.

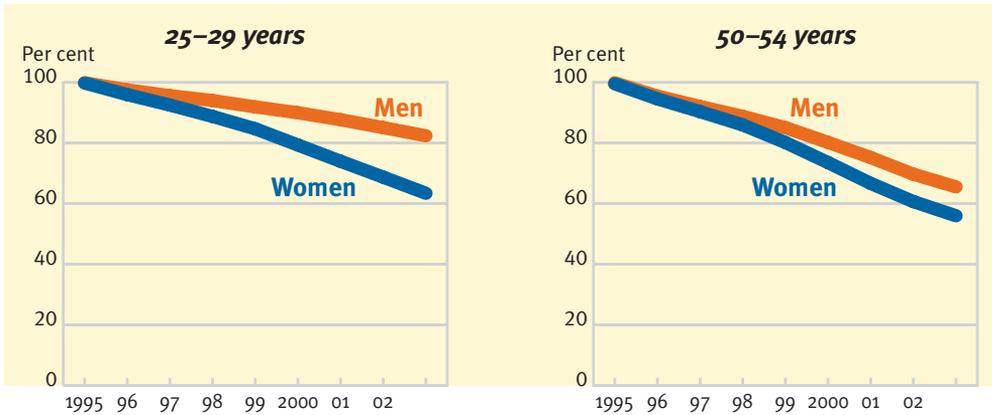
According to calculations carried out by the National Social Insurance Board (RFV), complications linked to pregnancy, for example, threatening miscarriage and pain caused by hormonal changes in the pubic bone joint, account for six per cent of all absence periods for women. Pregnant women are sicklisted also for other reasons, such as backache. If we include all sickness spells longer than 14 days that end as soon as the woman receives parental cash benefit, these account for an estimated ten per cent annually of all absence periods for women during the period 1999–2002. Among women in the 16–44 age group, a quarter of the spells longer than 14 days are estimated to be pregnancy-related.

### **Sickness absence in a long-term perspective**

The vast majority of women and men are able to carry on gainful employment over a long period of years without interruption for long-term

sickness absence. A follow-up of individual persons' sicklisting reveals that as many as 77 per cent of the men and 62 per cent of the women who received no sickness cash benefit during the period 1993–1994 were not either sicklisted for any long-term period during the following eight years.

In this follow-up, approximately eight out of ten men and six out of ten women in the 25–29 age group were never sicklisted for any long-term period during 1995–2002. In the 50–54 age group, almost seven out of ten men and almost six out of ten women had suffered no such break in their working lives.



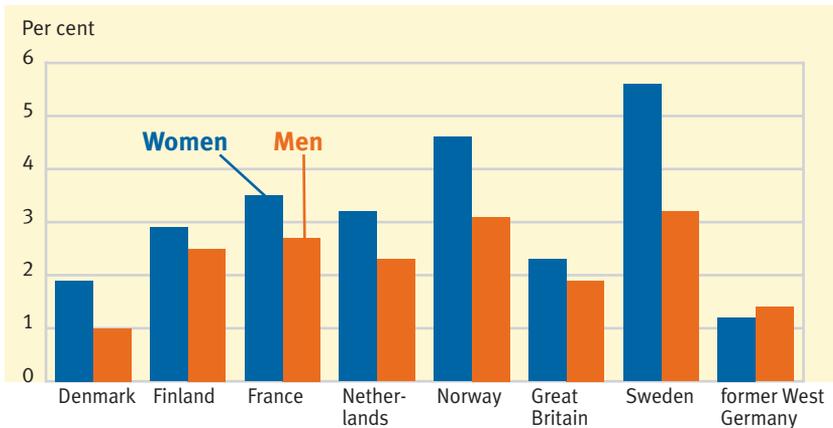
SOURCE: RFV (2004A)

**Proportion of women and men who have avoided sickness absence longer than four weeks.**

The period when women and men are gainfully employed without interruption for long-term sickness absence shows a gender difference mostly in younger years. Sick leave linked to pregnancy explains 75 per cent of the difference between young women’s and men’s absence in the years 1995–2002 (RFV 2004a).

**Women have higher sickness absence in many countries**

Sweden is not alone in having higher sickness absence rates for women than for men. The same situation exists in many other European countries. However, the difference between women and men is greater in Sweden than in other countries. Only in former West Germany do employed men have a somewhat higher sickness absence than employed women.



SOURCE: LABOUR FORCE SURVEYS, EUROSTAT

**Proportion of employees aged 20–64 sicklisted full-time** for at least one week in different European countries in 2003.

Since the early 1980s, sickness absence has increased faster among women than among men also in Finland, Denmark, Norway, the Netherlands and Great Britain. However, the increase has been greatest in Sweden, especially during the later part of the 1990s and the beginning of the 2000s.

## Health, sickness and work incapacity

Health and sickness are concepts that have meant different things to different cultures at different times. As society changes, so too can people's assessments of what is healthy or sick, good or bad, desirable or undesirable.

### A historical perspective

Medical historian Karin Johannisson (1994) has described how biological and medical science looked upon women's health and sickness a hundred years ago. It might seem strange going so far back in time while talking about the health of women and men today. But we can learn something from history. Johannisson has shown that there are similarities between the social changes of a century ago and those of today, between the industrial and post-industrial society, and in the ways these changes affect people's health.

At the end of the 19th century society was characterized by the rise of industrialism, a subsequent rapid change in the structure of society, urbanization, the growth of the women's rights movement and declining

birth rate. Medical science was then used as an effective weapon in the fight against women's rights. Men held back women's intellectual aspirations by asserting scientifically that women's reproductive capability was threatened by mental activity. Biological and medical science created new theories about the frail health of middle-class and upper-class women. Medical science contributed to the medicalization of such women by various diagnoses such as neurasthenia and thus strengthened resistance to the demands of the women's movement (Johannisson 1994, Ohlander 1996).

The links between health and sickness on the one hand and culture and society on the other are complex. The concept of sickness was in those days, and still is today, largely a social construction. When women began to demand greater freedom, there arose a tendency to define their subordination in relation to men in biological terms. Human equality was split down the middle in order to separate women from men. The female body was medicalized, and qualities and behaviour that did not conform to specified norms tended to be explained as sickness. The norm was represented by men, and women regarded as a deviation from it (Johannisson 1994). Men are still regarded as the norm, particularly within medical research. Women's hormonal cycle has been viewed as an obstacle to such research. Therefore, the results of research based on examination of men have long been used as the starting point for the medical treatment for women.

The similarities between the turn of the century in 1900 and that of 2000 are striking in many respects. The industrial period has become the so-called post-industrial period, characterized by increased production of services and information technology. Social changes are also fast today, and there is a forceful culture of competition, performance and pace. At both turns of the century, women and men experienced stress in a new social situation. At both times, new diagnoses arose legitimizing symptoms of frustration and distaste. For example, the neurasthenia of the 19th century had a successor in the 1980s. Overexertion and fatigue was given new legitimacy as the "yuppie sickness", which especially brought down younger men in mid-career. Since then it has changed its name to chronic fatigue syndrome (Johannisson 2001). In addition, there was burnout, which first appeared as a diagnosis in the Swedish classification of diseases in 1997.

### **Different ways of measuring health and sickness**

For a long time after the 19th century, health was regarded as the absence of sickness. Another view is that health and sickness represent opposite poles in a continuum. Individuals find themselves somewhere between

health and sickness at a given point in time. When sickness increases, health decreases.

In 1946, the World Health Organization (WHO) defined health in another way, as "a state of complete physical, mental and social well-being and not merely the absence of sickness or infirmity". Thus, WHO emphasized that health can only be judged on the basis of a holistic view of mankind. However, this concept of health has subsequently been criticized, among other things because the requirement of complete well-being is an almost utopian goal. Health defined in this way should rather be seen as a vision or goal to strive towards. Consequently, the concept of health was later redefined as a process of enabling people to improve their health and a resource for everyday life, not the objective of living (WHO 1986).

The difficulty of finding an adequate yardstick for measuring sickness and health has led to their being assessed in several different ways. Measurements can be based on medical assessments of functional ability, the individual's own perception of health and the assessment of health by society. Taken together, these measurement methods produce a relatively accurate picture of public health and the health of particular individuals.

### Three measurements of health

- Medical assessment, e.g. based on a doctor's examination
- Individual's own assessment, e.g. perceived illness
- Assessment by society, e.g. when sickness insurance compensates loss of income from work during sickness absence

Often the three measurements coincide. In such cases, physical changes and the experience of them are followed by social acceptance. But this is not always the case. We can experience pain without the doctor being able to find any cause of it. Or, for instance, we can have a lumbar disc hernia without feeling any pain. We can even – at least temporarily – have cancer or high blood pressure without being aware of it or feeling ill. In the following section, we discuss health from the perspective of society with the focus on social insurance.

### Average length of life

Public health has improved in many respects in Sweden in terms of both lifespan and functional ability. The population is ageing thanks to medical progress and improved habits of living. Mean life expectancy is among the highest in the world. At birth, Swedish women are expected

to live on average 82 years while men are expected to live just over 77 years (SCB 2004a). Since the 1960s, average life expectancy has increased by 5.2 years for women and by 5.4 years for men. The increase was greater for women than for men in the 1960s and 1970s, but since the 1980s average life expectancy has increased more for men, primarily because men's susceptibility to cardiovascular diseases has diminished.

However, increased longevity and the fact that the amount of time women and men spend in a state of serious ill health has diminished does not automatically mean people are healthier now than they were some decades ago. Since the 1970s, years of full health have also diminished.

### The health index

A Swedish health index is based on mortality figures and statistics concerning general health status, reduced motor functions and the incidence of long-term sickness with reduced work capacity from the Living Conditions Survey (ULF)

The index has four levels: years of full health, years of slight ill health, years of reasonably serious ill health and years of serious ill health.

SOURCE: SOCIALSTYRELSEN (NATIONAL BOARD OF HEALTH AND WELFARE) 1997

Since the later part of the 1970s, the expected number of years of full health at the ages of 16–64 has decreased from approximately 29 years to 26 years for both women and men. We cannot preclude the possibility that at least part of the decrease in years of full health may result from an increase in the reporting of illnesses requiring regular medication, for example, allergies (Socialstyrelsen, 1997).

### Mortality, violence and injuries

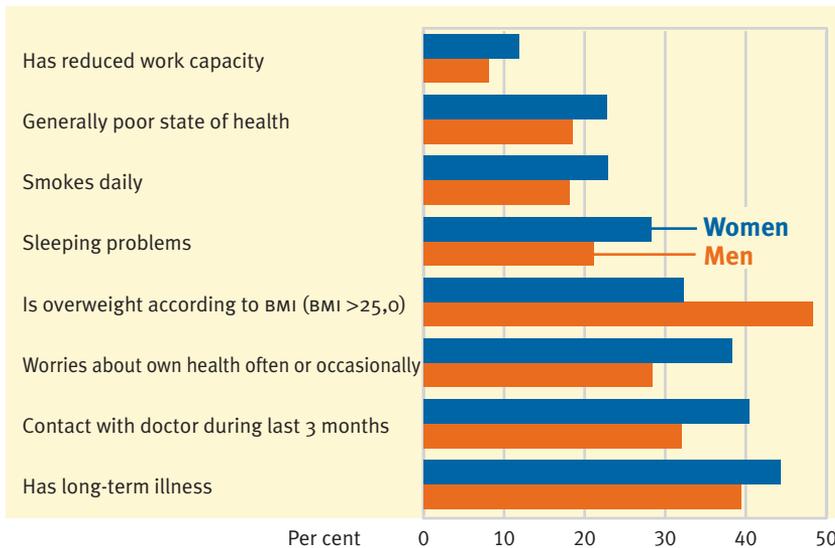
Mortality is higher among men than women at all ages in Sweden. Men's overmortality is largely due to higher mortality from cardiovascular diseases but also to mortality from lung cancer and other respiratory diseases, as well as injuries and suicide. Significantly, it is more common for men to die from the effects of alcoholism. Furthermore, men suffer injuries of various kinds to a greater extent than women. Work injuries are twice as common among men. Even violence and traffic accidents are more common among men than among women (Socialstyrelsen, 1997, 2003).

More women than men are treated in hospital for failed suicide attempts. Women also experience violence and the threat of violence to a greater extent than men. Certain professional groups are more exposed to violence – frequently from customers, clients or patients – than others. For example, this is true of home helps, psychiatric nursing staff, restau-

rant employees and female cashiers. Such experiences have a very negative impact on the well-being and health of women.

### Perceived health

When it comes to self-reported health, women report health problems to a greater extent than men. More women worry about their own health, experience anxiety, panic, fatigue and insomnia. In addition, women smoke more than men while men more frequently report overweight. Significantly more women than men also report long-term sickness, pain and reduced work capacity.



SOURCE: SCB (STATISTICS SWEDEN), LIVING CONDITIONS SURVEY (ULF) 2000/2001

### Self-reported health status.

The proportion of overweight persons is increasing in all population groups but above all among women in working-class jobs. The change over time has been the same for both sexes. Both women and men have increased their consumption of alcohol. The increase has been greatest among men (Folkhälsoinstitutet, 2003a).

The difference between women's and men's perceptions of health is not a phenomenon that first appears in adulthood and working life. Similar differences can be observed between girls and boys from the age of 13 onwards. Perceived health, physical and mental problems and general well-being deteriorate with increasing age for both sexes. More girls than boys aged 13–15 years report they are depressed, experience stress and suffer from headaches, stomachache and sleeping problems. Moreover,

these differences have increased over the last few years (Folkhälsoinstitutet, 2003b). One study showed that five per cent of teenagers exhibited symptoms of real depression and that girls were affected three times as often as boys (Olsson & von Knorring, 1999). A follow-up of schoolchildren during the period 1989–2002 further reveals that those who have suffered most from headaches, backache or anxiety during their school-days take the problems with them into adult life. And the pains grow worse in adulthood (Brattberg, 2004).

Much of the data on differences in health between women and men is based on the responses to questionnaire surveys. When assessing their own health, people may wish to appear "normal", at least to themselves, in spite of impaired health. The assessment is thus made by individuals whose experience is influenced by current norms and attitudes relating to female and male behaviour. Women and men are influenced in their answers by an attempt to be "typical" women or "typical" men. At the same time, people's perception of their own health status is a deciding factor for their behaviour and participation in society life.

### Assessment of health by society

Society's assessment of health is expressed, for example, in the regulatory framework of our social insurance schemes. Social insurance provides us with financial security when sickness or injury has reduced our work capacity temporarily or permanently.

#### Financial security in case of reduced work capacity

Sickness insurance provides compensation in the form of sickness cash benefit for lost income from work in case of temporarily reduced work capacity, or in the form of sickness compensation or activity compensation (formerly disability pension or temporary disability pension) if the reduction in work capacity is judged to be long-term or permanent. Work injury insurance guarantees compensation when an occupational disease or injury results in a permanent reduction in the ability to undertake gainful employment. Rehabilitation cash benefit compensates lost income in connection with vocational rehabilitation.

Work capacity, not health or sickness in themselves, is the central concept in these insurances. It is thus not sufficient merely to be sick or injured to qualify for compensation in the form of sick pay from the employer or sickness cash benefit, sickness compensation and activity compensation from social insurance. A significant reduction in work capacity is also required. However, the cause of such a reduction must be sickness or injury.

## A changing concept of sickness

Assessments of reduced work capacity are based on a concept whose content is socially constructed and which, moreover, can change over time. The law regulating the right to compensation for loss of income due to reduced work capacity provides no definition of the concept of sickness. However, preparatory studies for the law from the 1940s contain pronouncements that are still considered decisive for the assessment of the right to compensation. In the prestudies, sickness is assumed to be the condition which in normal language usage and in the accepted view of medical science is regarded as sickness. However, malfunctions and physiological changes due to natural ageing, pregnancy or childbirth are not regarded as forms of morbidity since they belong to the natural life process (SOU 1944:15).

To define sickness in terms of normal language usage and the accepted view of medical science is one way of fixing the concept of sickness. It has the advantage of allowing the use of sickness insurance to be adjusted to medical science without having to change the rules. However, the lack of a precise definition makes it difficult to decide what may or may not be classed as sickness. To satisfy the needs of the public and reflect its language usage and its conception of social justice, changes in legislation and the administration of the law become necessary. As a result, the scope of sickness insurance compensation has been extended since the 1940s, partly due to the courts having created or changed legal practise, partly due to parliamentary amendments to the law.

Examples of conditions the sickness concept has come to embrace over time are multiple-child pregnancy, threatening miscarriage, bereavement and exhaustion as well as treatment for involuntary childlessness (infertility). What was previously considered part of the normal life process has thus become a morbid condition entitling the person to the same compensation as any other illness. It is worth noting that most of the conditions that have with time become compensation-qualifying relate to childbearing in some way, that is, a condition that only women can experience. Medical science has also classified new conditions as illnesses. Fibromyalgia (incompletely defined chronic pain syndrome) was first classified as an illness in 1987, followed by burn-out in 1997. The new illnesses occur more commonly as reasons for sick leave among women than men.

Sickness always has a medical dimension but it also reflects cultural values. Cultural codes constantly redefine what we may refer to as sickness. This is part of a social process involving many actors: doctors, patients, the Social Insurance Office – as administrator of sickness insurance – and the media (Johannisson, 2001). The concept of sickness has

been broadened by a gradual shift in the way doctors, patients and the Social Insurance Office have come to look upon sickness. On the eve of legislative changes in 1995, the Government thus expressed fears that sickness insurance risked becoming a general insurance for loss of income and argued against compensation being paid out for social and general living problems. The right to compensation was clarified in the legislation: it applies when a sickness, or comparable medical condition, reduces work capacity to such an extent that it affects the ability to earn a living through a normal job available in the labour market.

Also in the case of disability pensions, medical criteria have increasingly taken precedence over labour market or social considerations in the assessment of sickness and work capacity (Regeringens proposition, 1994/95:147, 1996/97:28). It is clarified that only lost income from paid work entitles to compensation.

### **Work capacity and work incapacity**

Our work capacity may be regarded as the result of a dynamic interaction between our personal resources and work. Physical, mental and social health is an important but inadequate prerequisite for work capacity. Both the physical and mental demands work places on us – such as our education and competence – affect our work capacity. Our motivation, job satisfaction and attitudes are also important. Moreover, our ability to use the resources effectively depends on the support of work colleagues and on the work environment. Excellent personal resources will not translate to excellent work capacity if the work lacks content or working conditions are bad. The opposite is also true – an interesting job and good working conditions will not make up for a lack of personal resources.

The fact that work capacity is affected by health status and job demands means that some people can work, given a certain state of health, while others cannot. It is also possible that we are incapable of working in one occupation but capable of working in another. Furthermore, the range of suitable alternative work tasks for people with impaired functional ability varies according to type of work and workplace. Access to special aids and equipment to facilitate work also varies. At the same time, there are workplaces where you are not always allowed to work even if you feel free of symptoms and capable of work. For example, a ban on working applies if you carry an infection and work in the food industry. Due to the risk of contagion, work cannot be permitted.

Since sickness does not necessarily affect work capacity, many people are able to work in spite of sickness. This is true of illnesses that can be treated successfully with medication, for example, type 1 diabetes, which often affects young people. The same applies to illnesses treated with a

suitable diet and exercise, such as slightly raised blood pressure, which is not uncommon in later middle-age. Moreover, many people suffering from different types of mildly acute or chronic diseases can continue to cope without any noticeable reduction in work capacity. In a medical sense they are ill, since they have an illness diagnosed by a doctor, but this does not necessarily mean they have to give up working.

Working during a spell of illness such as a bad cold occurs in most workplaces. The everyday term for this is 'sickness presence'. Working despite being ill is often a question of individual choice. The choice may be made out of consideration for oneself or for a customer, or because one does not wish to put one's work colleagues in a stressful situation.

### Who assesses work capacity?

During the first seven days, individuals themselves decide whether the reduction in their work capacity is such that sick leave, rest and recuperation will be a suitable treatment and enable them to return to work. After that, a doctor's certificate is required to verify work incapacity and its seriousness. At first, the employer compensates lost income with sick pay. If the doctor recommends continued sicklisting, the Social Insurance Office decides whether the individual can receive sickness cash benefit from sickness insurance.

In short, we can state that work capacity is in many cases virtually impossible to measure objectively. It is always a question of assessment, and the assessment is based on more or less exhaustive information about the particular individual's health and working conditions. This leaves scope for subjective interpretations of work capacity by patients, doctors and social insurance staff. Work capacity is thus a socially and culturally determined concept that is influenced by structural conditions in society. What expectations are placed on the ability of women and men to undertake gainful employment and support themselves in our society? Do expectations vary and are some perhaps higher than others? We must seek answers to these questions if we are to understand the differences in health, sickness absence and the number of granted disability pensions between women and men.

## A questionable trend

To sum up, we have a trend where men were sicklisted or granted disability pensions more often than women up to the early 1980s, after which sicklisting and disability pensions have been much more prevalent among women. While public health changes only gradually, temporary and per-

manent absence from work due to sickness and disability of both women and men vary dramatically from one period to another. Over the past 20 years, more women than men have ended up permanently excluded from the labour force due to work incapacity, and many also find themselves temporarily, and for prolonged periods, outside working life. Furthermore, gender differences in sickness absence and newly granted disability pensions have increased dramatically since the later part of the 1990s.

For a long time, it has been possible to attribute some of these differences to the fact that women and men work in different occupations and different sectors of society and have different working conditions, family relationships and lifestyles. For example, it was possible to understand the relatively small differences in the risk of long-term sickness absence during the period 1986–1991, because most women worked in the public sector and most men in the private sector. In 2002, however, when women ran double the risk of long-term sickness absence compared with men, it was impossible to fully explain the difference in terms of traditional work-related factors or other circumstances such as lifestyle and family relationships. It may serve as an illustration of our need to know more about the differences in sickness absence between women and men from a gender perspective. The mechanisms leading to sickness absence for women seem to be too subtle to be registered by the crude measuring tools used in normal statistical analyses. Meanwhile, vital facts about these mechanisms may still be missing. The reasons for the difference in temporary absence and withdrawals from the labour force through disability insurance between women and men are complex. Moreover, the changes undergone by our society over the past decades seem to have produced different living conditions and health for women and men.

Sweden enjoys a high standard of welfare and has progressed further than many other countries in establishing equality between women and men. Despite this, the gap between women's and men's opportunities to find gainful employment without risk to health is widening. Things seem to be moving in the wrong direction. Has the welfare state created a trap for women in the illusion that its solutions have removed the obstacles to real gender equality? The picture presented in this introductory chapter raises many questions about the living conditions of women and men in modern post-industrial society. These questions will be discussed in the following chapters.

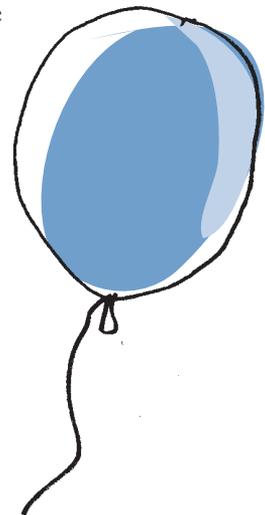
# The living conditions of women and men – a gender perspective

How well we feel depends a lot on our position in the labour market and conditions at our particular workplace, but our total life situation is also a factor. Therefore, we must also take into account the private sphere – that is, family life, leisure and social relationships – together with the wider context of cultural, political and economic conditions. In this chapter, we discuss the segregated positions of women and men in life's various arenas, how they arise and are reproduced, and their possible impact on our lives.

The line of argument in this theme section starts from the basic premise that the gender affiliation and gender identity of individuals affect their living conditions. Gender can be understood both as something that is prebuilt into social structures and as something that is created, reproduced and changed in relationships between people.

Gender as a structural principle operates at several different levels at once. Societal gender structures find expression in norms about how women and men "are" or "ought to be", as manifested, for example, in current politics, public discourse and expectations as well as in the media and advertising. But gender structures are also visible in the organization of the labour market and workplaces and in the way we behave in private relationships within families and with friends. Gender has a powerful impact on the development of a person's identity.

International gender theory describes the gender structures surrounding us at different levels in terms of a gender order or a gender power system. In the Swedish debate, Yvonne Hirdman (1988) has introduced the concept of the gender system to describe what is meant.



### The gender system

The gender system is sustained by two main basic premises: segregation and hierarchy. Segregation means that a distinction is made between women and men, between feminine and masculine and, not least, between the different activities women and men devote themselves to. Hierarchy means that the man represents the norm and that the masculine is ranked above the feminine. According to this view, women as a group is thus generally subordinate to men as a group, even though this is not necessarily so in every given situation or each particular case.

SOURCE: HIRDMAN 1988

However, the gender system is not static since society, norms and values change over time. Structures arise out of social relations and are therefore the result of actions by individuals and groups. Gender is thus viewed not as something that is fixed once and for all, but as something that is constantly "constructed", by ourselves and others in constant interaction, within the framework of the structures that surround us (for example, Connell 1999, 2003, Elvin-Nowak & Thomsson 2003).

## Arenas of everyday life

In research on welfare and living conditions, one speaks of the existence in society of different spheres or arenas in which we all act – both in daily life and in a lifetime perspective. The most important arenas are normally taken to be the labour market, the family and the welfare state (for example, Esping-Andersen 2000). In this theme section of Social Insurance in Sweden 2004, our focus is on the situation of people in working life, but these people are also parents, children, siblings, friends, neighbours and citizens. Among other things. How they succeed in combining these roles has a decisive influence on their health

Women and men, regarded as groups, do not occupy the same positions in society's various arenas. The balance between work and family life and our relation to the welfare system – primarily represented by sickness insurance and medical care – are recurrent themes in the book. Therefore, we shall describe the differences between women and men that appear in the various life spheres only briefly, by way of introduction to the results and analysis of later chapters.

### A gender-segregated labour market

The gender affiliation of individuals functions as a segregating principle in the labour market. Women and men work to a large extent in separate

occupations and with separate work tasks. They are found in separate branches of industry and are concentrated to separate sectors of working life, so-called horizontal segregation. Of the women active in the Swedish labour market, approximately half work in the public sector and half in the private sector. However, women make up the vast majority of public sector employees, while men mainly work in the private sector (SCB 2002). Vertical segregation, in its turn, means that women and men hold separate posts and positions within the same area. Typically, it is more difficult for women in general to advance and reach higher posts, a phenomenon now popularly referred to as the glass ceiling. "Female occupations" tend to be less well-paid than "male occupations" (that is, occupations where we find most women and most men respectively). But even within the same occupational area, men are paid on the whole somewhat better than women (Jonung 1997, Nyberg 1997, Soidre 2002).

There are also differences between women and men when it comes to terms of employment and job security. Women are more commonly found in part-time and temporary jobs, which weakens their position in the labour market (for example, Soidre 2002). This allows a greater degree of flexibility in relation to the family, and many women typically work part-time while the children are small. However, weaker ties with working life can also mean a weaker opening position in negotiating situations. For example, a substitute worker is likely to have lowest priority when timetable preferences are discussed. The position of men in the labour market is relatively strong. At the same time, it has proved difficult for many men to gain acceptance from employers, managers and colleagues for adjustments of work to family life – men are expected to be available for full-time paid work during all their working years (Hwang 2000).

In the labour market as a whole as in individual workplaces, gender structures are thus found, sometimes more and sometimes less apparent. Norms and values applying to gender influence terms of employment, work environment, work tasks, salaries and working hours. The separate positions of women and men in the labour market, the organization of work, and the significance of these for health and sickness absence, are discussed in detail in the chapter entitled *Working life, family life and sickness absence*.

### **The family – from contract to negotiation**

Family life has undergone great changes in the last few decades. In Sweden, the number of marriages has declined in favour of cohabiting couples and single households. The number of divorces has increased steadily, and therefore also the number of households with single parents

and the number of restructured families. In this section, the discussion primarily concerns heterosexual pair relationships and parenthood, that is, families that consist of a woman and a man living together with one or more children.

Within this family type, relationships have changed over time. For some decades now, having two breadwinners in the family is normal for married and cohabiting couples in Sweden. The earlier clear division between the woman who was mainly responsible for home and children – that is, the caring function – and the man who provided for his family has given way to a model where both increasingly share the same areas of responsibility. Nevertheless, men in general still earn more. Women's smaller share of family earnings primarily reflects the fact that they still have greater responsibility for unpaid housework. A gender-based division of labour within the family is thus, despite progress towards greater equality, still noticeable (Nyman 2002, Björnberg & Kollind 2003, Roman 2004).

In family research discussions about the ways in which people's family life patterns have changed over the past few decades in the West, a recurrent theme is the increased element of individualism (Beck 1992, Giddens 1995, Beck & Beck-Gernsheim 1995). If marriage between women and men was earlier characterized as a "contract" expected to last a whole lifetime with clear obligations for both partners, modern family arrangements are characterized by the notion of two independent individuals, each with their own life projects, entering voluntarily into a relationship.



This also implies that the partners can more easily opt for separation if they feel the relationship and its common goals are impossible to combine with personal life goals. The division of money, time, tasks and responsibilities in most families of today can no longer be taken for granted but is rather a subject for ongoing negotiations. Compromises must be made between the wishes of the individual and the needs of other family members. Individual needs and family needs must, in their turn, be put in relation to conditions in the surrounding world, such as paid work, social service and the housing market (Bäck-Wiklund & Bergsten 1997, Björnberg & Kollind 2003).

### Individualization

The trend towards increased individuality for both children and adults is not only the result of the structure of the Swedish welfare state, even though its role as a "modernizing agent" should not be underestimated. So-called modernity research has shown that individuality and individual autonomy is also a strong general trend in all Western cultures. Traditions are challenged, longstanding customs and values are questioned and forms of parenthood are open to interpretation and negotiation. Taken together, these circumstances amount to a qualitative and penetrating change in people's everyday lives as far as relationships and self-image are concerned. Increasing individualization is said to be one of the most striking features of late modern society.

SOURCE: BÄCK-WIKLUND & LUNDSTRÖM 2001

Ongoing negotiations and practical compromises in daily life mean that both women and men spend a lot of time, commitment and energy piecing together the "jigsaw" of everyday life. However, women still assume a relatively large share of the responsibility for ensuring the balance between work and family life functions. They interrupt their careers when the children are born and then, in order to cope with everyday family business, often work part-time while the children are small. Usually it is also the women who make adjustments in their lives in order to help aged parents or other close relatives in need of care. Responsibility for the family's social connections with friends and relations as well as the task of keeping track of school outings, doctor's appointments or parents' meetings, are further areas of responsibility that often fall to the woman's lot.

Studies have shown that the consequence of these conditions is that women have less time to themselves than men have. Many women are both able to cope with, and happy, balancing work and family life, but nevertheless find they lack time over for themselves, either for relaxation or leisure activities. Men, too, experience being short of time, but

in general they devote themselves to more leisure activities than women and report having more time to themselves. Being able to take a breather in life and occasionally focus only on oneself and one's own needs is very important for well-being and health (for example, Björnberg & Kollind 2003, RFV 2003d).

### **Welfare, equality and social citizenship**

The Swedish welfare model is general in nature, meaning that the entire population is covered by the various insurance schemes and that the state assumes a relatively large part of the responsibility for the welfare of the individual. The model is also characterized by its focus on individual autonomy, reflected in such reforms as the separate taxation of married couples which became law in 1971. These structural preconditions interact with the individualizing process in the private sphere and have great significance for the life choices of women and men (Bäck-Wiklund & Bergsten 1997).

The overriding goal of Swedish gender equality policy is well in line with the general goals of the welfare programme and aims at ensuring women and men the same opportunities, rights and responsibilities in all significant areas of life

#### **Gender equality policy objectives**

- Equal division of power and influence
- The same opportunities to achieve economic independence
- Equal terms and conditions with respect to owning their own business, work, employment conditions and career development opportunities
- Equal access to education and the development of personal ambitions, interests and talents
- Shared responsibility for work in the home and with children
- Freedom from sexual (gender-related) violence

SOURCE: WWW.REGERINGEN.SE

It is taken for granted today that women and men shall have equal opportunities to study, develop their talents and professional skills and reach positions of power. The knowledge, experience and values of both sexes must be utilized and allowed to influence developments in all spheres of society. The Government has decided that a gender equality perspective must permeate all parts of government policy.

Indeed, much has happened in the field of equality during the past few decades and the current laws governing, for example, working life or

social insurance schemes are formulated in gender neutral terms, that is, they are intended to have the same consequences for women and men. However, the regulations have to be applied in the real world, where there are striking differences between expectations and norm systems – and actual circumstances – of women and men. This means that the application of the rules is not gender neutral, thus influencing the outcome. Something happens in the gap that exists between policy and application (for example, Gardberg Morner 2003).

Since social benefits are largely based on previous earned income, an individual's income from paid work is of the greatest importance. Feministic welfare research has problematized the fact that the seemingly neutral citizenship concept has a gender dimension: "the citizen" is usually a male worker. This ideal type of citizen has no caring responsibilities but can work full-time for the whole working part of the life cycle without interruptions for childbearing, care of sick children, ageing parents or relatives. Women, due to their responsibilities for private caring, generally have a worse position in the labour market in the form of lower salaries, more part-time work and more temporary jobs. Thus, the cover offered by social insurance schemes is in practice different for women and men, even when the schemes are gender neutral in their design. Part-time work or temporary interruption of work during the years of building a family result in lower levels of compensation in benefits such as sickness cash benefit and pensions (for example, Orloff 1993, O'Connor 1996, Korpi 2000, Lister 2003).

There are other ways in which women's relation to the welfare state differs somewhat from men's. In their capacity as public employees, many women have the state, county councils or municipalities as employer. Women as a group are also more dependent on economic transfers from the welfare systems than men as a group. This means that women are affected comparatively severely by changes to these systems, both as employee and consumer in the welfare state, which was the case, for example, during the cutbacks of the 1990s (Sainsbury 2000). Research has also shown that women and men are partly treated differently in their contacts with the welfare system authorities, for example, the Social Insurance Office or medical care, which is the subject of the chapter entitled *Support when health fails*.

All things considered, we may note that in some ways women and men hold different positions in the various social arenas. The system works in such a way that one's position in one arena, for example, the labour market, has significance for one's position in the other arenas and thus for one's circumstances in life. The freedom of action or power that may be associated with different positions dramatically affects the op-

tions open to women and men in various situations, and partly explains the tendency people often have to reproduce existing structures. It takes a major effort for an individual to go against the norms and expectations of where one "ought" to be positioned in the various arenas of life. This is discussed further in the closing part of the chapter, but first it can be interesting to ask oneself how women and men came to end up occupying different positions in the first place. Why did it turn out this way?

## Constructing gender

What is it that makes women and men end up occupying different positions? And why do we continue making those choices which reproduce the differences between the sexes? Constructing gender is a life-long process. In this section we chiefly discuss the various processes within which gender is constructed during childhood and youth.

"One is not born a woman, but becomes one", wrote the French philosopher Simone de Beauvoir as early as 1949. One is not born a man either, one might add. What de Beauvoir was hinting at with her famous phrase was the construction of the so-called social sex, that is, all those norms, values and expectations that spring from apparently biological differences between women and men, and the effects they have on our life (de Beauvoir 1949/2002). According to this view, the biological division of the sexes is given, while social gender is created, sustained and changed through people's individual and collective actions. The gender power structures that exist in society are not a "natural" consequence of biology but socially constructed and therefore linked to such things as time and culture (see, for example, Connell 1999, 2003, Hirdman 2001, Elvin-Nowak & Thomsson 2003 for an orientation in the discussion of sex and gender).

In respect to health, it is important to emphasize that the biological differences existing between women and men naturally have an impact on the development of health and sickness. Women and men can be affected by different sickness patterns whose causes partly stem from biology and partly have social explanations, discussed in the chapter *Social insurance in focus*. When discussing sickness insurance, sickness absence and care, it is important to examine the consequences that different illnesses have for women and men respectively. It is not altogether unusual for physical differences to be used as a justification for treatments and expectations which have repercussions on equality and living conditions. The never-ending construction of gender thus influences all areas of life. And it begins early.

## Caring women and independent men

From the moment we are born, we are treated according to the sex we are seen to belong to. The biologically defined sex is the starting point, after which our environment (parents, teachers, colleagues, the media) encourages and reinforces the behavioural patterns that are expected of girls and boys respectively according to current norms and values about how girls and boys ought to be. These norms and values vary according to time and place, but nonetheless mean that girls and boys are treated differently.

Theories of parenthood and socialization point out how mothers and fathers, through their behaviour towards each other and the children, reproduce gender identities. Much simplified, the reasoning is that girls learn a caring and relationship-oriented attitude through their gender similarity to and thereby expected identification with the mother, while boys instead learn at an early age a more independent attitude towards their surroundings, in accordance with the surrounding gender power system and current norms and expectations. It is difficult to stand outside this system of gender specific norms and expectations, meaning that every choice made by women and men can be limiting (for example, Ve 1999, compare Elvin-Nowak & Thomsson 2003).

### Norms and actions create gender

Discourses on "gender", "motherhood" and "fatherhood" have great significance for the processes that reproduce gender division. Therefore, the significance of cultural factors should not be underestimated, especially not in the short perspective. Gender identity is recreated through our actions. Thus we construe ourselves as "men" and "women" while carrying out particular tasks. When women wash the family clothes and men mend the family car, it is not only clean clothes and a functioning car that are produced. Through their actions, women and men produce gender.

SOURCE: ROMAN 2004

What we are now speaking about is a social and cultural construction process where socialization is one important part of the creation of identity. The construction of gender does not, however, only take place within the family. Friends, school and leisure also play an important role in the creation of young people's identity. Studies have shown how girls and boys already in daycare are treated differently and schooled in a certain pattern of behaviour, a process that then continues at school where they meet different expectations and receive a different share of attention in the classroom. The social and cultural construction of gender functions through a system of rewards and punishments. "Correct" behaviour in

girls (for example, quiet) and boys (for example, active) is rewarded by the appreciation and approval of the group. "Wrong" behaviour (rowdy girl or sensitive boy) is punished either discreetly by the attitude of the group or outrightly through reprimands (Elvin-Nowak & Thomsson 2003).

What is judged to be right or wrong can vary within different groups, as it varies within different age groups and cultural contexts. Nor are people passive recipients of norms and values, but actively participate in the construction of their own gender identity, which may even include opposition to the expectations of the group. Whether or not we accept or oppose existing gender norms, however, we must nevertheless always relate to them in some way.

Rewards and punishments also govern our adult lives and influence how we behave, for example, in working life. A woman manager who behaves in a "masculine" way is seldom popular among her colleagues. A man who allows the needs of his children to seriously affect his working life can expect problems. Within the framework of this many-sided and ongoing process is constructed what is often referred to as "the gender identity". That is to say, women experience themselves as being (and want to be) "feminine" and men experience themselves as being (and want to be) "masculine". Exactly how femininity/masculinity is to be expressed can vary – but it is still a fundamental part of each individual (Elvin-Nowak & Thomsson 2003).

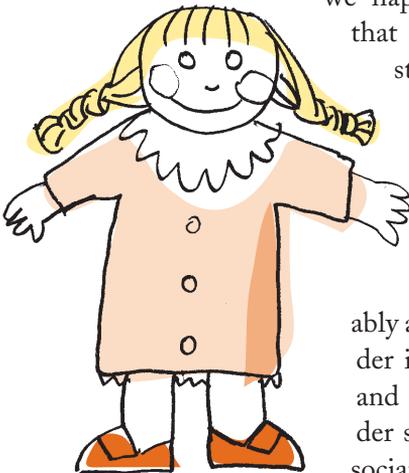
### Beautiful girls and brave boys

Gender is created and recreated incessantly in our spontaneous relationships with the people around us. But gender creation is also affected by

the public norms and values existing in the time and place we happen to find ourselves. Earlier we mentioned that Swedish welfare policy was actively aimed at strengthening individual autonomy and equality.

That is significant. Through this policy, images are conveyed of how the relationship between women and men "ought" to be, or how we "ought" to bring up our children.

In a country like Sweden, films, magazines, commercials, TV series and music videos probably also have a great influence on the creation of gender identity. The pictures of girls and boys, women and men that are projected are often powerful gender stereotypes. Being a "real" woman or man is associated with specific attributes and behaviour (Björk



1996, Bäck-Wiklund & Bergsten 1997, Hirdman 2004). The words and concepts we choose to use when speaking about girls and boys, women and men, are also significant. An important dimension of gender creation during early adolescence seized on by the media is the search for a sexual identity. An identity which is particularly dependent on confirmation from persons around one.

Femininity is created partly through girls learning to assume a certain look and behaviour. In a Western context, makeup, shaved legs, jewellery and tight-fitting clothes are examples of attributes that a young woman can employ to create her femininity and sexuality. An adult woman who has become a mother assumes instead a more neutral appearance: now the focus is on care of the children and family, which means sexuality is toned down (see, for example, commercials for washing powders or detergents). However, there is a double message. Young women of today also learn that nothing is impossible and that they are free to make whatever life choices they wish on the same terms as men. Many of the media images that young boys have to relate to are instead about being brave and doing fantastic things. According to current norms, men should be physically strong and take sexual initiatives. At the same time, young men of today have to relate to an image of masculinity that implies they can be caring and assume responsibility in the family. In addition to this, boys and men are now expected to spend a lot of time, energy and money on their appearance (for example, Faludi 1992, 2000, Björk 1996, Hirdman 2004)

Throughout our lives we are caught in the crossfire of signals and images of how women and men ought to be. The gender norms that are conveyed are seldom unambiguous and straightforward, but rather complex and contradictory. The result of the never-ending process of gender creation is that learned behaviours gradually start to appear natural and obvious. Within the framework of these preconditions, we then make the choices that shape our lives.

### **Free choice of education and occupation?**

A relatively early choice that is of great importance for later opportunities in life, not least one's position in the labour market, is the choice of education. Analyses of educational choices in Sweden have revealed a large measure of gender segregation. Even though gender differences in levels of education are on the whole slight, gender inequality is noticeable in the choice of educational programmes: "Upper secondary school is extremely gender segregated, especially in the vocational courses. A relatively large number of programmes are virtually single-gendered. Boys choose traditional technical programmes and industrial/handicraft

programmes, while girls choose health and medical care subjects and the humanities” (Jonsson 1997).

Gender patterns are reproduced in this way because we make choices that appear to ourselves and those around us as natural or ”particularly suited to us”. The girl or boy choosing a programme of study does so within the framework of powerful norm systems, where the choice is influenced by what close family members and comrades think and what the media and the rest of society signal. Today, there is a firmly-rooted notion that certain course programmes, certain occupational areas and certain workplaces go together with a certain gender identity. One usually talks about the gender branding of course programmes and professions based on a logic that says femininity is one thing and masculinity its opposite (for example, Karlsson 1997). This has given rise to the belief that courses with a masculine profile that have attracted many boys over the years are particularly suitable for men, while courses with a feminine profile that have attracted many girls are especially suitable for women.

The choice of education takes place during that same period of life when sexuality matures and expresses itself in ways that ensure the attention of those one wishes to attract. Sexual identity and gender identity are closely interwoven. So behind the choice of education, we find young people for whom sexual identity and gender identity compete with the sometimes ambiguous logic of those around them. On the one hand young people are encouraged to choose gender-typically and prove their femininity/masculinity, on the other hand they may also be encouraged to defy the norms and dare to choose differently, like girls today who are encouraged to choose a technical education.

Seen from the perspective of the individual, gender-typical choices of education and occupation are made on rational grounds. Everyone chooses what suits them best as individuals. The alternative to choosing gender-typically is to actively decide to go against the norm system because that is what one expressly wants to do. Those who make a choice that goes against expectations will be asked again and again why they made that particular choice. Those who choose gender-typically do not have to answer that question. However, this happens within the framework of a gender order, or a gender power system, which will often admire the girl who makes an unconventional choice (for example, technical education) but will less often admire the boy who makes an unconventional choice (for example, care education) and will often question his masculine value. The masculine is superior to the feminine (Elvin-Nowak & Thomsson 2003).

Theories that aim to explain the segregation in the labour market can be linked to these forms of reasoning (see Jonung 1997 for an overview).

One type of theory focuses on the supply side and deals with preferential differences, – that is, individuals – on the basis of acquired (gender specific) preferences, tastes, talents and capacity – themselves choose the profession they believe will give the best yield for a given investment.

On the demand side, that is, the employers, various forms of discrimination have been noted. A person who has chosen a gender-atypical education is especially likely to meet with a questioning attitude. Discrimination can be a matter of the employer's own notions about the specific applicant. For example, what does the employer think of the person from the gender perspective, and what does the employer think work colleagues and customers will think? One particular type of discrimination is called statistical discrimination, which is when the employer "lumps everybody together". This means that information and ideas about, for example, women or immigrants as a group, influence the treatment and assessment of individual applicants. An example of this is when women are expected to take the main responsibility in cases of parental leave or when children are sick, which can be seen as negative from the employer's perspective. Since the employer lacks complete information about the individual applicant, stereotypes like these can influence decisions.



On the whole, we can say that various complex factors at the individual, organizational and structural level work together to dictate the individual's educational and professional career. It is also reasonable to assume that the mechanisms reinforce each other. For example, the various reasons that cause women to choose an education and profession that seems suitable for women are precisely the reasons that make employers in other fields hesitate to employ them (Jonung 1997).

### Gender and organization

The processes we have described in this section have great significance for the interpersonal relations that make up the organizations we are a part of. While individual choices and actions – founded in gender construction processes – influence organizations and structures, the choices and actions we have seen above are conditioned by these same organizations and structures. Thus, there is a constant interaction between the different levels. That gender plays a powerful role in interpersonal relations means that organizations, for example, workplaces, function according to certain gender specific principles. These are not always clear-cut, so processes such as salary setting, allocation of work tasks or promotion at workplaces may appear to be "natural". At the structural level, however, a clear pattern emerges where women and men on the whole occupy different positions. Even if organizations are seemingly gender neutral, this does not tally with many women's experience of discrimination. In studies of organizations it is therefore necessary to introduce a power aspect in order to investigate the decision-making process (how, by whom, what) and the effects this has on various individuals and groups. Women and men face different conditions in organizations, which will be discussed further in later chapters (Wahl et al. 2001).

## Not only women and men

In this chapter the focus is on the significance of gender identity and its expression in Swedish society of today. Of course, gender is only one of the affiliations that impact living conditions and health. Class, ethnicity and age vary from person to person and mean different things in different contexts. Persons who are born with, or acquire, some form of functional disability live under a specific set of conditions. In the last few years, the significance of sexual affiliation has also received more attention than formerly. Important discussions have been held concerning the "hetero-normativity" that exists in society, which means that homosexual women and men risk being stigmatized as deviants. All these examples of people's affiliation and identity work together with gender and can in

certain situations "dominate" and push the significance of gender into the background. At a job interview, for example, the fact that a person was not born in Sweden can be more important than whether the person is a woman or man. A person's age is more important than gender when applying for a driving licence. Which aspect of our persona we ourselves and others emphasize in our meeting with the outside world depends on the context.

The fact that different aspects of our persona work together can reinforce prerequisites and living conditions in both positive and negative directions. For example, being a well-educated Swedish man provides more opportunities in the labour market than being a poorly educated immigrant. The phenomenon whereby different qualities and affiliations reinforce each other is known within current feminist research as "intersectionality". Here the focus is on how subordinated positions reinforce one another – for example, being a woman and coloured – and how different forms of dominance interact (Lykke 2003, de los Reyes et al. 2002). Thus, there are very great variations in being a woman or a man, which we should bear in mind when discussing gender differences.

In the next chapter, we focus primarily on the significance of working life for people's health. In this connection, it is particularly relevant to discuss differences in education and professional status, that is, class. The socially lopsided recruitment to tertiary education in Sweden is apparent. Still today, class affiliation determines who pursues post-secondary school studies at college or university. At the same time, education plays an increasingly important role as the labour market changes, which means people's living conditions are radically affected by the level of their education. It has also been shown that the income gap between different groups increased in Sweden during the 1990s, which shows the importance of people's labour market status for their life circumstances (sou 2001:79, Schedin 2003). To gender segregation in the labour market, we may add vertical social segregation.

Gender affiliation and gender identity thus work together with the class dimension to determine people's path through life. Gender is also constructed and expressed to some extent differently in different social groups, which means that the significance gender has for our life choices and life situation varies (Skeggs 1997, Ve 1999). The division of labour in the family has also been seen to vary somewhat according to class. People with blue-collar jobs tend to have a somewhat more "traditional" gender-based division of labour in the home than white-collar workers (Kellerhals 1988, compare Neramo & Evertson 2004).

The fact that our individual choices are structurally conditioned thus means different things for different people. The opportunities and ob-

stacles we meet have to do with the positions we occupy in the labour market, in the family, etc. which in turn partly has to do with whether we are women or men. In the labour market, in the family and in relation to welfare schemes, women as a group have a weaker position than men as a group. Examples of this mentioned in this chapter are women's greater share of part-time and temporary employment, greater responsibility for private care, and smaller benefits from a social insurance scheme based on the loss-of-income principle. Financial independence is a prerequisite for individual autonomy and for being able to govern one's own life. In this respect, men as a group have more autonomy than women.

In this chapter, we have focused on the differences in women's and men's capabilities and living conditions. The aim has been to shed light on the gender power structures that exist in society and that influence all our lives in large degree, even though they are often invisible and we remain unaware of them. The fact that more and more people experience deteriorating health due to pressures at work and in the family, and the dramatic increase in the sickness rate, set the theme for Social Insurance in Sweden 2004. Part of the explanation

of current gender differences in sickness may be sought in the mechanisms discussed in this chapter. In the next chapter, we discuss why work incapacity affects women to a greater extent than men.



# Working life, family life and sickness absence

Research into sickness absence is relatively extensive and has links to several broad fields of research and scientific disciplines. However, no comprehensive and general theoretical model for explaining sickness absence exists. Instead we have to make use of several models which are linked to different causal factors. In a frequently cited research summary of sickness absence, or rather absence from work, Steers and Rhodes (1984) define various categories of causal factors which they consider to be relevant for sickness absence. Individual characteristics such as age, gender and education as well as personal circumstances such as health and family situation are examples of such factors. Working situation and work environment, attitudes to work and job satisfaction, as well as personal motivation to work, are also important factors with which to explain sickness absence. In addition, the pressure to attend the workplace dictated by economic conditions, group norms and company atmosphere is of importance.

According to Steers and Rhodes, there is in general clear and unambiguous evidence to support the claim that work environment factors and personal factors such as age are significant for sicklisting. Even if two decades have passed since the research summary of Steers and Rhodes, their general conclusions are still relevant. Today's sickness insurance statistics reveal that a larger proportion of those sicklisted are women. Gender is viewed in the Steers and Rhodes model as a personal factor and is not further problematized.

To try to understand the overrepresentation of women among the sicklisted, we apply a gender theoretical perspective in the theme section of Social Insurance in Sweden 2004. We start from the premise that gender is not merely something we are born with but to a large extent a social construction that is created in interpersonal relations within an accepted social and cultural framework. We describe the situation of women and men in different areas and discuss whether possible differences can help explain the disparities in sickness absence between women and men.

In this chapter we report the consequences of conditions in working life and in family life that might be possible causes of the differences in the sickness absence of women and men. For example, physical and psychosocial factors at the workplace and physical and psychological

stresses outside working life have significance for how well women and men feel today, but they can also have long-term effects on our health.

Besides the traditional causal factors, we also try to grasp the significance of various structural factors that are important in a longer life cycle perspective. An example of a structural factor is the resistance to change of the norms and values which give rise to and sustain the current gender order. Norms and values concerning what choices are considered suitable for girls and boys, women and men, are handed down from generation to generation. Thus, we are all active carriers of our structures. Even if we do not think about it, or wish to do so, we cling to conservative patterns that give us security and a feeling of normality. This means, for example, that the structurally conditioned differences in sickness absence between women and men are able to persist over time.

Even if the long-term consequences of a gender structured society are difficult to study, they explain many of the differences in sickness absence that can be observed today between women and men. We shall therefore discuss the more long-term structural consequences of the gender order, gender segregation in the labour market, the way organisational culture reinforces this gender segregation, and the division of labour in family life.

Today, much knowledge is available about the work and living conditions of women and men from different social classes. Therefore, we make a connection between gender and class in order to describe the consequences that the current gender order can have for living conditions and health among various groups of women and men.

## Unequal terms in working life

Various aspects of working life are of central importance in explaining both sickness absence in general and the differences between women and men. Most sicklisted individuals have a job and society's ambition is indeed to help the sicklisted person return to working life.

### Inside or outside working life

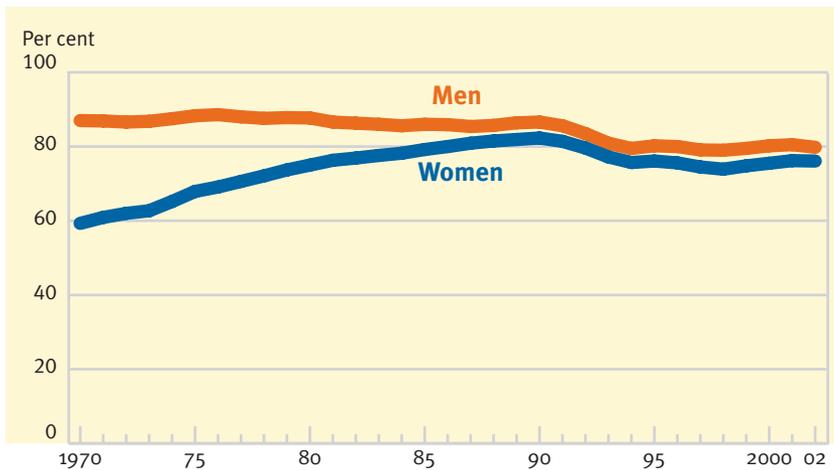
Over the last few decades, a structural transformation has taken place in the Swedish labour market with the result that some professions and business areas have expanded while others have diminished. This transformation has had negative consequences in particular for many men who have found it difficult to gain a foothold in the new businesses. Current social welfare policy has contributed to an increase in gainful employment among women. For women this has had positive effects in

the form of greater financial independence, which has meant a giant step towards gender equality.

### The labour force and the labour force rate

The labour force consists of persons who are either employed, or unemployed and available for work. The labour force rate is the proportion (%) of persons participating in the labour force in the population aged 16–64 years.

Women's participation in the labour force increased successively in all age groups during the 1970s and 1980s, while the participation of men was relatively constant. Both women and men reduced their labour force participation during the recession of the 1990s and despite an economic upswing at the end of the decade, labour force participation for both women and men remained relatively constant. Labour force participation of men is higher than that of women in all age groups, with the exception of the very youngest (16–19 years).

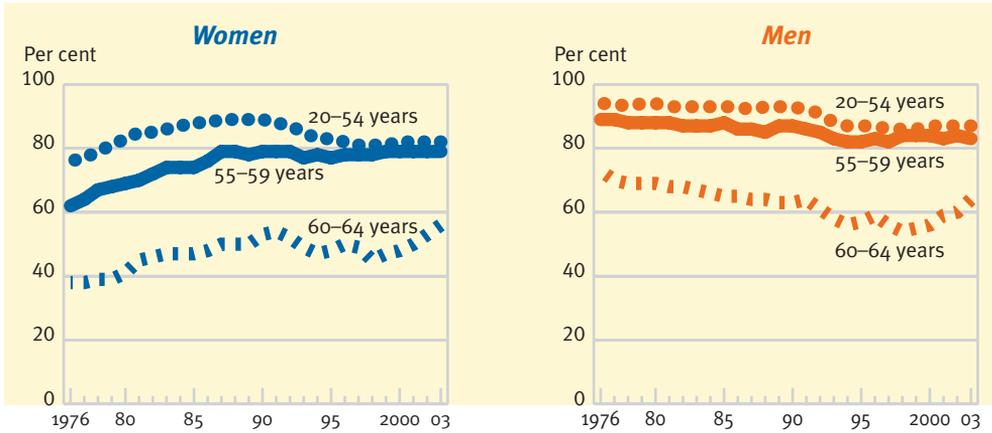


SOURCE: SCB (STATISTICS SWEDEN), AKU (LABOUR FORCE SURVEY)

#### Labour force rate.

It is primarily among older women that labour force participation has increased since the 1970s. Labour force participation among women in the 60–64 and 55–59 age groups is today approximately 20 percentage units higher than in the mid-1970s. The labour force participation of older men has on the other hand diminished, partly as a result of the lowering of the general retirement age in 1976, as well as the possibility of granting disability pension for older members of the workforce for labour market reasons up to 1991. The increased participation of older

women in working life is one of many explanations of women’s increasing sickness absence, since older persons are on sick leave to a greater extent than young ones.



SOURCE: SCB (STATISTICS SWEDEN), AKU (LABOUR FORCE SURVEY)

**Labour force rate.**

One study has shown that an ageing workforce and changed labour force participation influence the long-term sickness absence of women considerably more than that of men (Lidwall et al. 2004). The significance of the ageing workforce has thus been different for women and men.

**Long-term sickness absence**

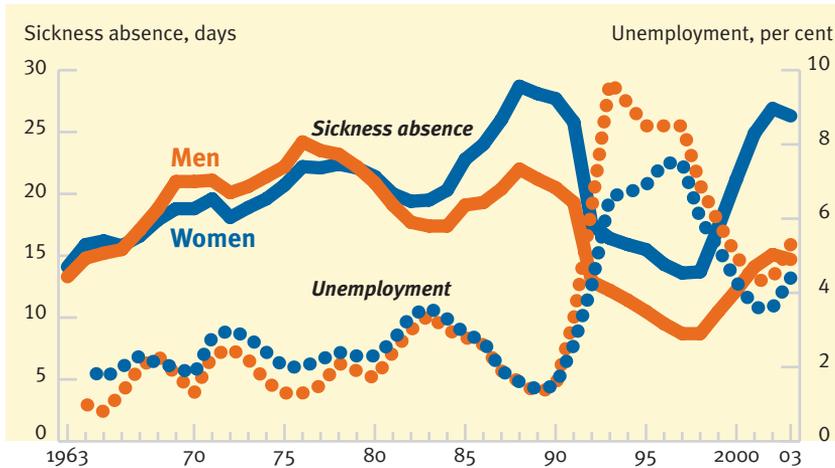
In the surveys of the National Social Insurance Board (RFV), the definition of long-term sickness absence has usually been sicklisting lasting 60 days or longer. The extremely long sickness absences of recent years and the increased overflow into sickness and activity compensation (previously known as permanent and temporary disability pension) has led to a situation where absence lasting more than a year has begun to be termed long-term sickness absence. In this book we adhere to the earlier definition.

By international standards, labour force participation among older age groups, especially women, is high in Sweden. Almost half of Swedish women in the 60–64 age group were still active in working life in 2000, compared with women in Finland and Denmark where just under a third, and the Netherlands and Germany where every tenth, woman in this age group was in the workforce. Among men at corresponding ages, just over half participated in the labour force in Sweden and approximately a third in Finland, Germany and the Netherlands (Ds 2002:49). Sweden is also

distinguished by the large proportion of women with small children who are gainfully employed.

### Unemployment and sickness absence for women and men

Movements in and out of the labour force and variations in unemployment have an impact on sickness absence. Studies have shown that sickness absence drops in times of recession when unemployment is high and rises in times of economic growth when unemployment is low (Lidwall et al. 2004, Henreksson & Persson 2004).



SOURCE: RFV AND SCB (STATISTICS SWEDEN), AKU (LABOUR FORCE SURVEY)

#### Sickness absence rate and unemployment.

Two main explanations of the connection between unemployment and sickness absence have been put forward. According to one, the propensity to report sick decreases when there is a higher risk of unemployment (a disciplining effect). The other explanation is that high unemployment results in persons with a high sickness absence being ejected from the labour market, thus reducing (short-term) sickness absence (a selection effect). Through this structural effect, increased unemployment can force labour to exit the market, increasing long-term sickness absence and in the long run also increasing the number of newly granted disability pensions.

Different patterns for women and men have been observed in the development of unemployment. During the period 1975–1986, unemployment was somewhat higher among women than men. Since 1988, the situation has been the reverse, and men are unemployed to a greater extent than women. In 2003, unemployment among men aged 16–64 was five per cent and among women four per cent. The severe recession dur-

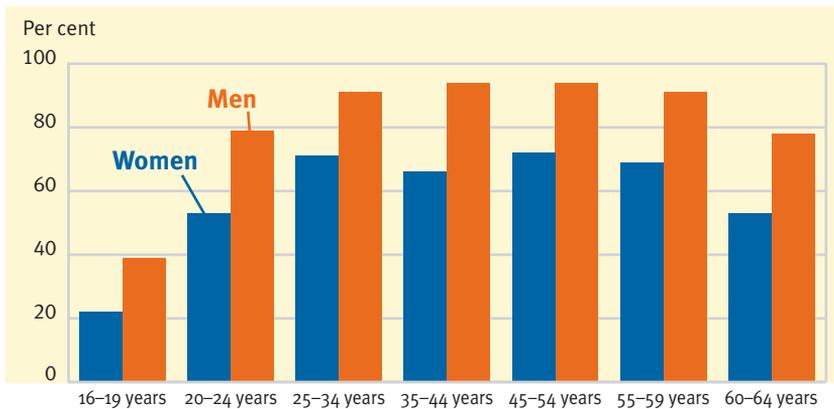
ing the first half of the 1990s drastically reduced job opportunities, particularly in man-dominated sectors such as the manufacturing industry. From the mid-1990s onwards, unemployment increased instead primarily among women. This was due to cutbacks in the municipal sector and other public sector operations.

A study of the development of the sickness absence rate for the period 1964–2002 reveals that unemployment and labour force participation influenced the absence rate of women more than that of men (Lidwall et al. 2004). One interpretation of this is that the level of women's sickness absence in the long term is governed by changes in the business cycle to a far greater extent than men's, which may affect their sickness absence behaviour. For example, women's sickness absence decreases more than men's during a recession, that is to say, unemployment tends to affect women and men differently. Long-term sickness absence increases among men when their unemployment increases, while the opposite applies to women. This suggests that long-term sickness absence functions to some extent as a labour market policy pressure valve for men. Women, on the other hand, to a greater extent withdraw from the labour force or refrain from entering it and thus disappear from sickness absence statistics. This phenomenon became apparent during the recession of the 1990s. At that time, it was especially young working class men, that is, men with low education, who were unemployed and therefore included in the labour force. Simultaneously, a large number of young persons, women in particular, chose to continue higher education studies as a result of the lack of job opportunities. These women were thus not included in the labour force (Regné 2000, SCB 2002, SCB 2004b).



## Different forms of employment for women and men

Men in all age groups work full-time to a much larger extent than women. In 2003, 94 per cent of employed men in the 35–44 age group worked full-time, while the corresponding proportion for women was 66 per cent. Moreover, many more men than women have permanent jobs (88 and 83 per cent respectively in 2003 according to Statistics Sweden). Many women work in various types of temporary employment, which weakens their position in the labour market where permanent full-time employment is the norm.



SOURCE: SCB (STATISTICS SWEDEN), AKU (LABOUR FORCE SURVEY) 2003

### Proportion of full-time employed persons.

In conclusion, different patterns emerge in women's and men's labour force participation, hours worked and forms of employment. Despite their high labour force participation, women have weaker ties to the labour market, with more temporary employment and a greater share of part-time work. This is also a pattern that Sweden shares with many other comparable countries. The pattern can be interpreted to mean that men are regarded as the main family breadwinners by society, organisations and individuals. Women are still expected to a far greater extent than men to combine gainful employment with responsibility for family and household work.

### Women and men in working life

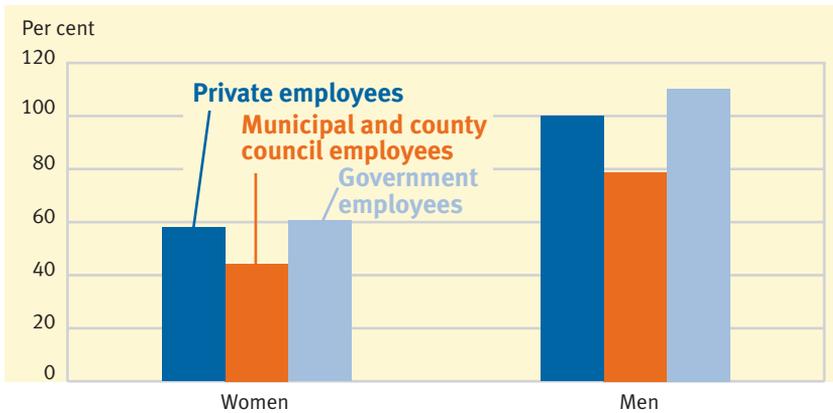
In spite of Sweden's high ambitions in the area of gender equality, the Swedish labour market is not one of equal opportunities. Admittedly, women and men have the same level of participation in the labour market, which is unique from an international perspective, but the Swedish labour market is strongly gender segregated (SOU 2004:43). Firstly, wom-

en and men work in widely separated parts of the Swedish labour market as regards occupations, business areas and social sectors – so-called horizontal segregation. Secondly, men are more often found in leading positions than women – so-called vertical segregation. In addition, men often have higher salaries than women, even if they occupy equivalent positions within the same profession. An underlying cause of both horizontal and vertical segregation is the gender-based segregation and hierarchization of work tasks in working life and in family life, as discussed in previous chapters.

### **Women and men work in different social sectors**

The majority (just over 60 per cent) of the women who were gainfully employed or entered the labour market during the 1960s and 1970s were employed in the rapidly expanding public sector. Most of them worked in municipal and county council operations, especially with nursing, schools and care services. Women's unpaid work with care and nursing in the home was thus transformed to a large extent into equivalent paid work outside the home. However, the concentration of women in the public sector has fallen from 60 to 50 per cent since the 1970s. The decrease mainly took place during the 1990s and was primarily due to cutbacks in public sector spending and to a lesser extent to privatization within the medical and care sector. However, this means that most women still work in the traditional woman-dominated occupations, though some of them now work under a different management. On the other hand, men have traditionally worked primarily in the private sector and do so even more today. At present, 82 per cent of men work in the private sector compared with 75 per cent in the 1970s (SCB 2003a).

The sector in which an individual works has significance for sickness absence. First of all, it is important to note that during the years 1995–2002, a larger proportion of men (77 per cent) than women (62 per cent) were never sicklisted longer than 28 days. Among those who were "healthy" during 1993 and 1994, private and public male employees had very good odds of avoiding sicklisting longer than 28 days during the years 1995 to 2002. On the other hand, the odds of staying "healthy" were significantly lower for women irrespective of employment sector and for men working in the municipal and county council sector. Municipal and county council employees had generally low odds of remaining "healthy" during the period 1995–2002. The differences between women and men are also striking. For example, the odds for privately-employed women remaining "healthy" are approximately 40 percentage units lower than for privately employed men (RFV 2004a).



Note: A value above 100 % means greater odds and values below 100 % smaller odds than for the comparison group. Privately employed men are the comparison group.

SOURCE: RFV 2004A

**Odds ratio for remaining "healthy"**, that is, avoiding sickness absence over 28 days, during the period 1995–2002 for persons aged 20–54 who were not sick-listed longer than 14 days during the years 1993–1994.

Other studies have confirmed that women and men with municipal employment stand a greater risk of being long-term sicklisted, in particular with mental disorders and burnout as the reason for absence (RFV 2002a, RFV 2003b). On the other hand, long-term sickness cases end after a shorter spell of time among municipal employees compared with long-term sickness cases within other sectors. This can be interpreted to mean that it is easier to return to municipal work, but may also indicate that less severe problems lie behind sickness absence (Palmer 2004).

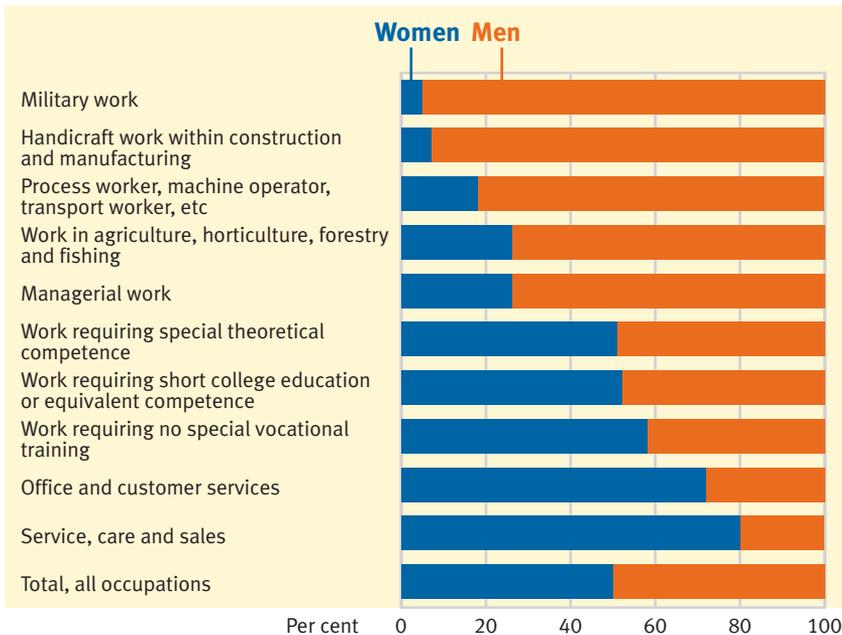
Women employees in local governments work mainly within medical and care services, while men are more evenly spread over the various fields of municipal activity. The largest professional group among male municipal employees are teachers. However, the increased risk of long-term sickness absence cannot be attributed to the profession as such, but the cause must be sought elsewhere, such as in the terms and working conditions that municipalities offer their employees. Staff reductions and reorganizations during the 1990s have led to a deterioration in working conditions in many municipalities. Interestingly enough, there seem to be no decisive differences in how women's and men's work capacity is affected by cutbacks and reorganizations within primary local government operations. Since women dominate among municipal employees, changes in municipal activities resulting in greater workload for staff influence and cause sickness absence for considerably more women than men.

### Construction workers and nurses

The division of labour that can often be observed between women and men varies among different societies and groups and changes over time. The traditional gender-based work plan setting out who does what kind of work can no longer be taken for granted. What were once given female and male professions and female and male chores in the home have changed and will probably continue to change in the future. Earlier, for example, it was virtually only men who were psychologists, doctors and priests, whereas today there are almost as many women in these professions. However, it should be noted that even if men today to a greater extent than previously work, for example, as nurses and assistant nurses, any equalization is due primarily to women working today in man-dominated professions. It should also be pointed out that no rapid changes are taking place and that the job patterns of women and men change but slowly.

The horizontal gender segregation in the labour market that can be attributed to the fact that women and men work in different professions, is seen most clearly in the manufacturing and building industries where male domination is extreme. Meanwhile, women dominate in welfare services production such as nursing, schools and care as well as in office and customer service work, that is to say, in lower-level white-collar jobs. The most even gender distribution is found among mid- and high-level white-collar workers.

In two extremely gender segregated professional areas, namely office and customer service work which is strongly woman-dominated and manual trades within the building and manufacturing industries which are strongly men-dominated, the difference in long-term sickness absence between women and men is greatest. Those women and men who deviate in their choice of profession from what is considered "normal" according to the gender order, often have to pay a high social price for doing so. They are sometimes questioned by those around and have to explain why they made the choice they did instead of choosing something else, that is to say, what was expected of them and regarded as "normal". Nowadays women are increasingly entering labour market job areas that were previously the preserve of men (SOU 2004:43). This is happening more because women are adjusting to male working life norms than because men are taking greater responsibility for family and home. Some research indicates that males who depart from the norm are perceived more positively in the workplace than their female counterparts (Wahl et al. 2001). This could be a contributory factor in women's higher sickness absence.



SOURCE: SCB (STATISTICS SWEDEN) YRKESREGISTRET (THE SWEDISH OCCUPATIONAL REGISTER) 2001.

### Gender distribution per occupational category (SSYK96) for wage-earning employees.

In the Swedish labour market, women work within a narrower spectrum of occupations than men and primarily in the public sector.

This can negatively affect the possibility of changing jobs, occupations or employers should this prove necessary, for example, due to ill health (le Grand et al. 2001). Another cause of women being trapped in certain occupations and sectors is that the competence training they receive is often customized to the occupational area they already work in, for example, nursing, school and other welfare services. The competence development that men receive is, on the other hand, more general in nature, making it easier for men to change occupation areas and jobs (Evertsson 2004).

Occupational affiliation is also an expression of what class a person belongs to. The fact that women as a group have higher sickness absence than men as a group, as well as that persons in blue-collar occupations are absent to a greater extent than people in white-collar occupations, is an example of how gender and class can reinforce one another. Women in blue-collar occupations also have the highest sickness absence. Explanations of why class has such importance for differences in sickness absence are complex. Working conditions and terms of employment are often worse in blue-collar occupations than in white-collar occupations.

The lower average income of the working class also affects conditions outside work, such as accommodation and leisure opportunities. Negative lifestyle factors such as smoking are more common in blue-collar occupations, especially among women. These are further examples of factors that can contribute to a higher frequency of sickness absence in blue-collar occupations.

Low-level white-collar employees and blue-collar workers dominate among individuals with sickness absence lasting 60 days or more. In 2003, 26 per cent of long-term sicklisted men were mid- or higher white-collar employees and 74 per cent low-level white-collar employees or blue-collar workers. Among long-term sicklisted women, the corresponding proportion was 37 per cent and 63 per cent respectively (RFV 2004d).

### **Different positions – different opportunities**

In both blue-collar and white-collar occupations, there are more men than women in leading positions. This means that men more often plan, organize and run organizations. Men's superior position in the hierarchy ensures that they are the main decision-makers in the organization, while women to a greater extent find themselves the object of men's decisions, which can lead to a state of powerlessness. The superior status of men results in their activities being valued higher than those of women in the labour market. Women's subordinate status means they less frequently hold positions of power in the occupations they work in and therefore more often become the object rather than the agent of change in an organization. Of just under 200,000 women and men who had leading positions in 2001, 26 per cent were women, which amounts to 1.4 per cent of gainfully employed women. Among gainfully employed men, 3.8 per cent had a job with management responsibility (scb (Statistics Sweden) Yrkesregistret (The Swedish Occupational Register) 2001).

Women in executive positions are thus a minority in an arena designed with men as the norm. In order to succeed, these women can be forced to orientate themselves towards men in order to neutralize the gender power system's negative effects on them personally, that is, they act heterosocially. By contrast, men in leading positions can identify and orientate themselves towards other men, that is to say, where the power is. A homosocial behaviour is thus possible for men. When men in positions of power face competition from women, their homosocial behaviour may, directly or indirectly, cause them to assume a hostile attitude and exclude women (Wahl et al. 2001).

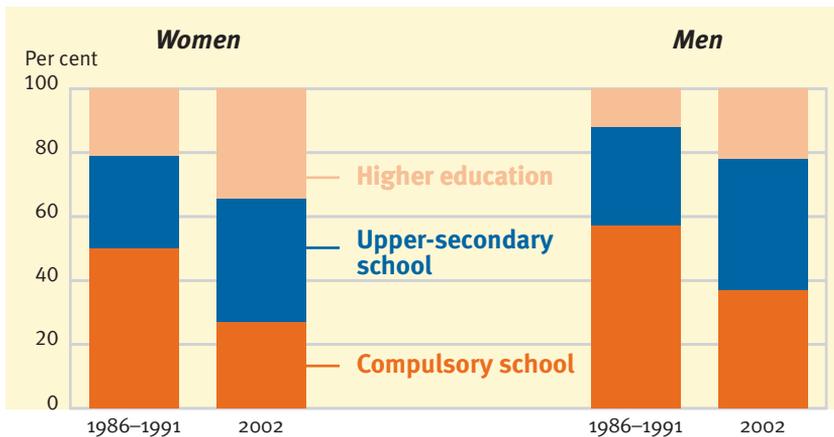
Women's heterosocial behaviour acts as a barrier to the formation of a female collective, leaving them more divided as a group. Relations to women at the lowest levels of the organization deteriorate. This may

result in their becoming isolated. To handle the stressful situation of being a minority group in a man-dominated sphere, women adopt various strategies. Often, they do this subconsciously. One strategy is flight, which may be expressed in sickness absence, among other things. Since men represent the norm, and therefore do not find themselves in the same situation as women, they need not, consciously or otherwise, adopt similar strategies.

Apart from women in leading positions having to experience the stress of defying norms and being pioneers, responsibility for the family or life outside the organization is at the same time more keenly felt by them than by men (Wahl et al. 2001). Swedish research has shown that the amount of stress hormone sank at the end of the working day for male managers, while it increased for female managers. Women managers thus experienced greater overall stress since they felt pressurized and subject to unreasonable demands both at work and in the home (Frankenhaeuser 1996).

### Well-educated women – increasingly absent from work due to sickness

People's level of education determines to a large extent their professional and class affiliation. Women and men with only basic education are also greatly overrepresented among the long-term sicklisted, compared with the proportion of poorly educated people in the population (RFV 2003b). This pattern has remained stable over the past two decades, irrespective of gender. Poorly educated people also run a greater risk of permanent exit from working life than well-educated people through disability pension (RFV 2004b).



SOURCE: RFV, LS SURVEY AND RFV-LS SURVEY

**Educational level of persons absent due to sickness for 60 days or more.**

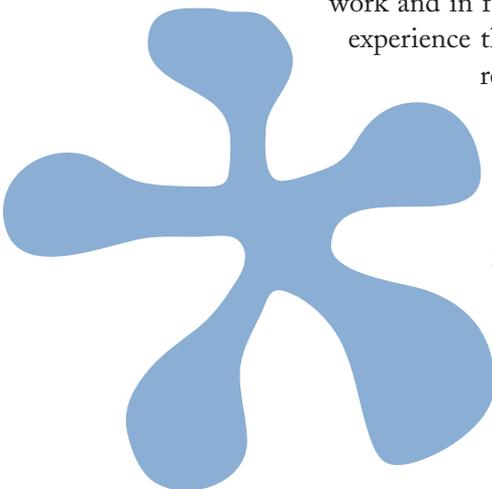
As the level of education in the population has risen and more people have received at least upper secondary education, there has been a relatively strong increase in long-term sickness absence among individuals with higher education, especially among women. A higher level of education is thus no guarantee against sickness absence for women to the same extent that it is for men.

That highly educated women are sicklisted more than highly educated men could possibly depend on the fact that higher education for women, in general, does not automatically lead to high-status jobs and large control over one's own work situation. Many highly educated women also work in the public sector, for example, doctors, nurses and teachers, who had problems in the 1990s with unfavourable working conditions and terms of employment. Many women are found in middle management in the public sector. In an age of reorganizations and downsizing, their work tasks are likely to include executing decisions that violate their own notions of quality in work. At the same time, some of the managerial qualities promoted as being necessary for rationalization work are firmness in action and "toughness". Such qualities reinforce a man's masculinity but cast doubt on a woman's femininity.

Highly educated women with career ambitions have to confront male career norms and, as mentioned earlier, to adopt various adjustment strategies with respect to a career. The male norm for leadership and professional careers involves, for example, a denial of other commitments in life that are not related to the job. As a result of the existing gender order, women can seldom allow themselves such an approach, since they are expected to take on full responsibility for family and children. Therefore, highly educated women in leading positions often have to bear the double burden of deviating from the female norm both at work and in family life. It is less common for women to experience the family in itself as a problem for her career.

Men, on the other hand, often express concern that a family is an obstacle to a woman's career opportunities. Therefore, highly educated women often feel they are discriminated against and hindered in their career, which in itself can be a stress factor.

It is important to note that mental disorders have increased more than other diagnoses as a cause of sickness absence since the end of the 1990s. Mostly, they concern depression, stress reaction and



anxiety syndrome. Often it is a question of highly educated women and men, that is to say, typically middle and high-level white-collar workers, who suffer from mental disorders. Still, sickness absence relating to musculoskeletal problems represents a greater cause of concern in terms of numbers sicklisted. These problems most commonly affect women and men with only upper-secondary education, that is to say, low-level white-collar workers and blue-collar workers (RFV 2002a).

### **Working conditions and sickness absence**

The fact that women and men to a large extent work within separate sectors and occupations means in practice that they have different working conditions and that they are exposed to different risk factors. Deficiencies in the physical or psychosocial work environment can create work-related health problems. To what extent the problems lead to sickness absence depends not only on the individual's problem but also on the extent to which it is possible to adjust the work to the problem. For example, pregnant women can work, at least some of the time, if their work situation is adapted to their capacity. In a Swedish study, it was found that a combination of physical and psychosocial workload is significant for the emergence of lower back pain among women but not among men (Vingård et al. 2000).

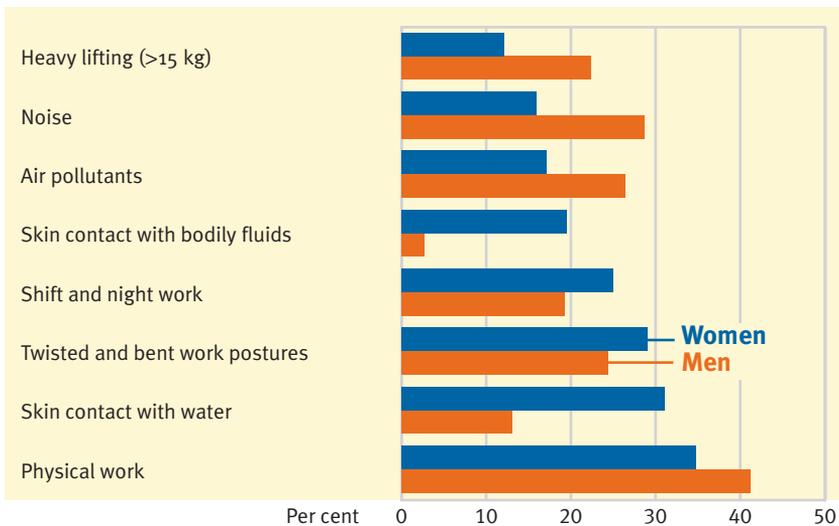
### **The physical work environment**

As regards the physical work environment, men have jobs involving heavy loads and physical exertion to a greater extent than women. Men are more frequently exposed to air pollutants, oil products, poor lighting, cold, vibrations and noise. In addition, men are more prone to various types of work accident than women. Women are exposed to water, bodily fluids and detergents to a greater extent than men. They also more frequently have twisted and bent work postures and they work more evenings and night shifts. Ailments resulting from work accidents have remained at a relatively stable level over the years, just over three per cent for men and approximately two per cent for women (Arbetsmiljöverket and SCB 2003).

It might appear that there are greater risks in men's work environment and men do indeed suffer more fatal accidents. In the assessment of risks, there is also a gender aspect. For example, an accident where a man fastens in a machine can have severe consequences and the workplace will be classed as hazardous, whereas a woman's back pain after lifting an old person is not equally "visible" but may be attributed in part to her bad lifting technique. Typical work environments of women are also detrimental to health but preventive measures may be difficult to imple-

ment. For example, it can be difficult to arrange for hearing protection at a day-care centre even though it could be necessary sometimes. Similarly, it can be difficult to use lifting aids for carrying and lifting small children, old people and others who need nursing and care but cannot themselves lend a hand.

Women report to a greater extent than men back, neck and shoulder problems, possibly because their work more frequently involves extreme work postures, repetitive work operations and heavy manual handling. The proportion of those with back, neck and shoulder problems has increased among both women and men since the end of the 1990s (Arbetsmiljöverket and SCB 2003).



SOURCE: ARBETSMILJÖVERKET OCH SCB (SWEDISH WORK ENVIRONMENT AUTHORITY AND STATISTICS SWEDEN), ARBETSMILJÖUNDERSÖKNINGEN (THE WORK ENVIRONMENT SURVEY) 2001.

#### Various types of physical work environment strain.

The physical work environment is still a serious risk factor in sickness absence (Socialstyrelsen 1997, RFV 2003b), even if there are some signs that the physical work environment problems have diminished over time. However, certain types of physical workload have increased for some employees during the 1990s (Socialstyrelsen 2001). Expanded work tasks within medical care are a case in point. Nurses have been obliged to take over part of the work previously carried out by hospital attendants and assistant nurses. Thus, nursing work now involves more heavy lifting and forward-bending postures (Härenstam et al. 2000). Visual display terminal (VDT) use has also increased in working life. Problems demonstrably associated with VDT work are primarily sight and musculoskeletal

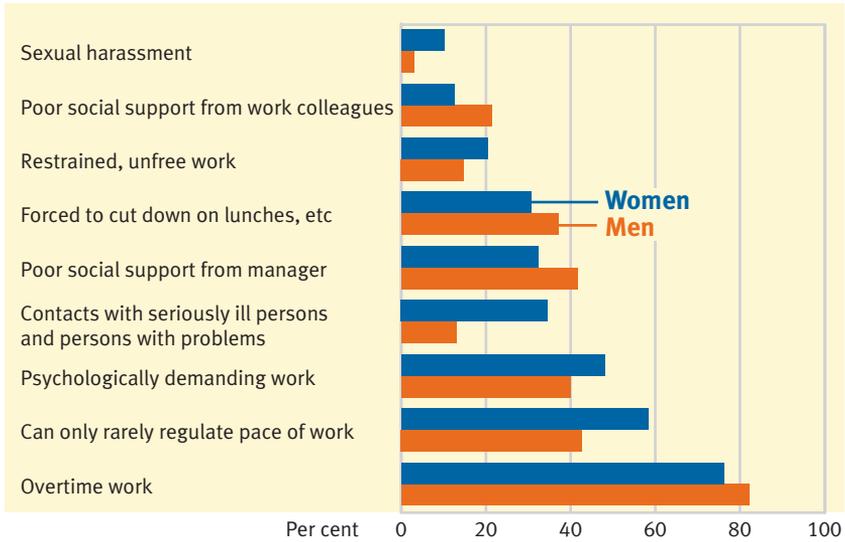
disorders (Wigaeus Tornqvist et al. 2000). According to the Swedish Work Environment Authority and the Statistics Sweden survey in 2003 on work related health problems, disorders deriving from VDT work are more prevalent among women than men.

Differences in women's and men's reported work-related disorders can be understood with the help of what Hirdman (1988) calls gender segregation and hierarchy. Horizontal segregation can be seen as a segregation where certain work tasks, professions and occupational areas are considered suitable for women while others are considered more suitable for men. Systematic gender differences in, for example, work environment and working conditions lead in turn to systematic gender differences in work-related disorders and sickness absence.

### **The psychosocial work environment**

The fact that women more often than men work with the care of people exposes them to greater psychosocial strain at work. Women experience to a greater extent than men being tied to their work in time and space and many experience their jobs as being psychologically stressful. Women also report much more often than men disorders deriving from stress and other psychological strain at work. These are the two most common causes of work-related ill health among women and the next most common cause among men. Among women, the proportion with stress-related disorders has increased by seven percentage units to just under 14 per cent since 1997, and among men by five percentage units to just over eight per cent.

More women than men feel they get strong social support from work colleagues and bosses. At the same time, women more often than men experience violence or the threat of violence as well as sexual harassment from managers and work colleagues. Here the gender affiliation of managers and work colleagues plays an important role. Women at male-dominated workplaces are particularly exposed as are women with male managers. Men work more overtime and must cut down on lunchtime more often than women. Men more often feel that work is not wholly meaningful. On the other hand, men have freer working hours and more opportunities to learn new things at work.



SOURCE: ARBETSMILJÖVERKET OCH SCB (SWEDISH WORK ENVIRONMENT AUTHORITY AND STATISTICS SWEDEN), ARBETSMILJÖUNDERSÖKNINGEN (THE WORK ENVIRONMENT SURVEY) 2001,

**Various types of psychosocial work environment strain.**

Reports of poor psychosocial work environments increased generally during the 1990s and are especially conspicuous for municipal and county council employees and for women in general. Within the welfare services sector (municipalities and county councils), major organizational changes and cutbacks took place during the 1990s. There are strong reasons for assuming that the negative development and people’s feelings about their work environment and health spring from the comprehensive organizational changes within the welfare services sector (Bäckman 2001).

### Measures of psychosocial work environment

The most established model for psychosocial work environment is the so-called demand-control-model. According to this model, the twin concepts demand and control constitute central dimensions of the psychosocial occupational environment.

High psychological demands mean that the individual must work fast and hard, that the work requires too great an effort, that the time for completing the tasks is insufficient and that the demands are contradictory.

Low control means that the individual has little chance of influencing how and what is to be done, that the individual feels a lack of stimulus and that the work tasks are repetitive.

Different combinations of demand-control produce different types of job situations. High demands and high control constitute an **active** job, high demands and low control constitute a **high-strain** job, low demands and high control constitute a **low-strain** job and finally the combination of low demands and low control constitute a **passive** job situation.

The demand-control-model has also been developed further to include social support from work colleagues and managers. Social support is regarded as a factor that counteracts the formation of harmful stress and reduces the risk of adverse health effects and sickness absence.

SOURCE: KARASEK 1979, KARASEK & THEORELL 1990

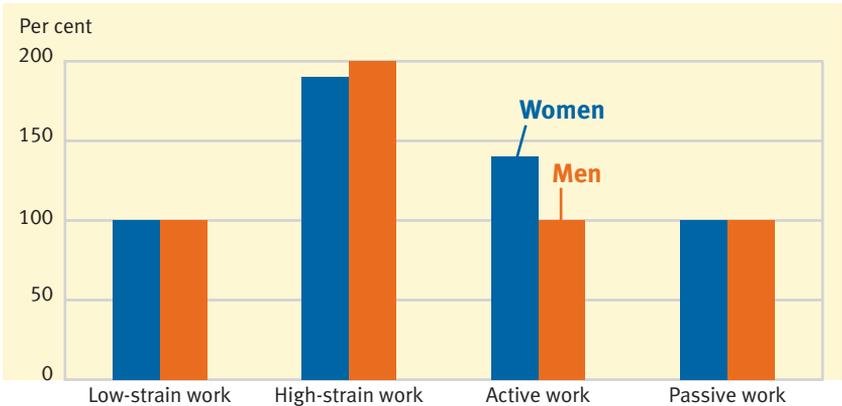
Extensive research has been able to confirm that the greatest risk of negative stress and sickness absence for women and men is to be found in so-called high-strain jobs, that is to say, jobs with high psychological demands where individuals themselves lack the opportunity to control the pace of work or how it is conducted (Karasek & Theorell 1990, Kivimäki et al. 1997, RFV 2003b). Moreover, it appears that sicklisted women with high-strain jobs have a greater propensity to long for disability pension than women with low-strain jobs, something that can lead to a permanent exit from working life (RFV 2004b). To work in a high-strain job is thus expected to increase the risk for sickness absence among both women and men. In studies, however, results pertaining to the effect of high-strain work on sickness absence have been somewhat contradictory. On the other hand, the connection between high-strain job and cardiovascular diseases is well supported in scientific literature. The occurrence of illnesses like lower back pain, neck and shoulder pains, psychological problems and gastrointestinal disorders, have also been explained with the aid of the demand-control model (Theorell 2003a, 2003b).

More recently, active jobs have been shown to constitute a risk factor in long-term sickness absence for women and for sicklisted women's desire for disability pension (RFV 2003b, RFV 2004b). The figure below shows that women in active jobs have a 40 per cent higher risk of long-term sickness absence compared with women in low-strain jobs. Earlier

studies have indicated that women’s active jobs consist to a large extent of so-called welfare service jobs within the public sector, that is to say, jobs within nursing, schools and care services. In that case, the special character of these jobs would seem able to explain the higher risk of long-term sickness absence better than the demand-control model. However, further analysis has revealed that especially women’s active jobs in the private sector heighten the risk of long-term sickness absence. This supports the claim that it is not women’s active jobs in the public sector that are the problem but that active jobs for women – perhaps especially in private companies – are problematical and increase the risk of long-term sickness absence.

**Risk of long-term sickness absence**

The risk of long-term sickness absence (sickness absence  $\geq 60$  days) in different types of work has been calculated by controlling for age, employer (sector), education, employer attitudes, the individual’s financial problems, exposure to bullying, and smoking habits. A risk that exceeds 100 per cent in the following figure is a heightened risk in relation to a low-strain job situation.



SOURCE: RFV 2003B

**Risk of long-term sickness absence in different types of job situations.** Low-strain work is the comparison group.

There is also a markedly higher risk among individuals with high-strain jobs. By contrast, no heightened risks appear among individuals with passive jobs or among men with active jobs. In a Finnish study of municipal employees, it was also found that so-called active jobs led to high sickness absence if the sense of coherence was weak. The pattern among women in active jobs in Finland was considerably more complex than

the pattern for men in active jobs and was also affected to a high degree by the existence of role conflicts between paid work and domestic work (Vahtera et al. 1996). The number of active and high-strain jobs increased dramatically during the 1990s while low-strain jobs diminished by a corresponding amount (RFV 2004b). This applied to both women and men. At the end of the 1980s, women had passive jobs to a higher degree, 14 per cent, compared with 9 per cent for men. Today, the differences consist of a greater proportion of women (11 per cent) than men (8 per cent) having a high-strain job.

There are also other models that can be used to explain the connection between the psychosocial work environment and ill health and sickness absence. According to the so-called effort–reward model, a lack of balance between effort and reward in work can lead to psychological stress and health problems (Siegrist 1996). Job rewards can consist of salary, status, development opportunities and a heightened self-esteem. This model could prove relevant, for instance, in explaining the increased sickness absence within the welfare services area during recent years. Within activities such as nursing, schools and care services, part of a job reward can be to give exposed or needy fellow creatures help. If this basis of professional identity and self-esteem is wrenched away from professional groups like teachers, children’s nurses, nurses, hospital assistants and home helps, to mention just a few, it can have highly negative consequences for job satisfaction and the ability to cope with job strain. During the 1990s, this is what happened to a large extent within those public services that employ a very large proportion of women (Bäckman 2001).

We can also problematize the gender order that leads to women’s rewards so often consisting of – in the best cases, perhaps we should add – diverse forms of verbal appreciation, while men’s rewards to a much greater extent consist of goods, services and money. It is naturally problematical from an equality perspective that women’s earnings and financial resources are less than men’s since it restricts opportunities to realize dreams and ideas. It also creates financial dependence in relation to men in pair relationships – as well as in relation to society within the framework of the welfare state.

### **Bullying and conflicts – a psychosocial work environment problem**

Bullying is a traumatic life event and a serious social stress factor in the workplace. Approximately 9 out of 100 gainfully employed Swedes were subject to bullying from work colleagues annually during the period 1989–1999 according to the Work Environment Surveys.

## Bullying

Bullying is negative or threatening behaviour that occurs regularly, repeatedly and over time. Often, it is a matter of manipulating the victim's reputation, work performance and communication with colleagues. A power imbalance exists between the bully and the victim where the victim is the weaker party. Bullying is not limited to workplace employees but can also come from people outside the work organization such as patients, clients and students.

SOURCE: VARTIA 2003

There are no differences between women and men in the reporting of bullying. Bullying is somewhat more common in the public sector than in the private sector. This is especially true of men in municipal employment. Women in supervisory positions are considerably more subject to these actions than women in non-supervisory positions. Sickness absence is higher among those who are subject to bullying than among those who are not subject to bullying. This applies to both women and men during the year when bullying is reported but also for a two-year prospect. If it were possible to eliminate bullying, lengthier sickness absence, at least 60 days over a 2-year period, might be reduced by approximately three per cent (Oxenstierna et al. 2004a).

Approximately four men and women out of ten report annually that they have been involved in conflicts at the workplace over a 12-month period during the years 1989–1999. Both women and men in supervisory positions experience conflicts to a greater extent than those who do not have supervisory positions. The risk of becoming involved in a conflict is greatest in all categories of employees who have small influence over their work situation. This is normally true of the poorly educated. There is a distinct risk for both women and men of becoming long-term sick-listed during the next two years if they are in conflict with management, compared with those who are not involved in such conflict. As regards conflicts with work colleagues, only women have a higher risk compared with those who are not involved (Oxenstierna et al. 2004b).

### Strategies for mastering strain at work

In the debate about sickness absence, it is sometimes claimed that employees resort to mass sick reporting as a means of putting pressure on the employer in a conflict situation. A conscious group strategy to attempt to influence employers and working conditions through collective sicklisting is not in keeping with the intentions of the law on compensation for lost income in case of reduced work capacity. Such group actions

and expressions of discontent are admittedly rare but nevertheless unacceptable adjustment strategies in working life.

We also have personal strategies for mastering the stresses and strains of working life. Such difficulties may be caused by working conditions or by individual circumstances such as health in relation to the demands placed on the individual by the job. These strategies are used for different stress situations as part of an interaction between individual and organization. It need not be a matter of extreme situations involving conflicts and bullying. In this section, we discuss the significance of these strategies for health and sickness absence from a gender perspective.

### Personal strategies

Openly protesting against bad working conditions or people you have come into conflict with at the workplace is an example of an active approach to working life difficulties. It is called open coping. Its opposite is covert coping, which means not doing anything about a certain problem or "getting out of the way", either through fear or because one cannot do anything about the situation (Theorell et al. 2004).

#### Coping

Coping means managing. Sometimes the term is used in a positive sense, that is, when it refers to successfully overcoming obstacles or problems. Sometimes it refers to how individuals behave in such situations irrespective of whether they are successful.

Coping is not just a personal quality. Social and psychosocial circumstances can influence our ability to cope and do so throughout our lives.

SOURCE: THEORELL ET AL. 2004

Men tend to employ open coping while women more often apply covert coping. Covert coping is most common among the youngest and the oldest employees. Men aged 45–54 employ open coping most of all (Theorell et al. 2000). The fact that many young employees are afraid to speak their minds is not surprising since they lack the experience of working life that older people have. Older people may, in turn, prefer to "get out of the way" rather than protest, for fear of not being able to find alternative employment if the workplace situation should become untenable after an open protest (Theorell et al. 2004).

Women and men with little power to influence when and how work is performed – usually persons with a low level of education – often resort to covert coping to deal with problems (Theorell et al. 2000). Young and old women with poor educational backgrounds would thus seem to have a high propensity to use covert coping.

### Coping strategies have significance for sickness absence

Covert coping influences sickness absence. Long-term sickness absence may even be the only possible way to protect oneself or "get out of the way" in difficult working life circumstances.

Covert coping increases the risk of sicklisting for women in the short term. Covert coping also increases the risk of extensive sickness absence for men but only in the long-term. The few middle-aged men who use covert coping run a greater risk of eventually developing high blood pressure and being sicklisted to a larger extent than other men of the same age. That men in general have a lower incidence of long-term sickness absence than women may also be an expression of the fact that men have a lower incidence of evasive behaviour and therefore force themselves to go on longer than women. In the long term, this behaviour can lead to ill health and extensive sickness absence. If evasive behaviour in the form of covert coping could be completely eliminated, almost nine per cent of longer sickness absence spells among men and an equivalent proportion of women's sickness absence spells could be avoided in the short term (Theorell et al. 2004).

In summary, men more frequently employ an open coping strategy and speak their minds to a greater extent than women. On the other hand, women more frequently use an evasive coping strategy in the form of sickness absence. If we interpret this in terms of gender theory, it would seem that women's generally more subordinate position with little opportunity to influence their working conditions, together with women's generally greater propensity to use covert coping, might lie behind many women's sick leave.

### Gender and working life

As regards work environment, we may by way of summary note that in the Swedish labour market men are to a greater extent exposed to various physical work environment risks, while women to a greater extent experience psychosocial work environment problems in their jobs.

Gender theory research also shows that individuals and groups of individuals who violate current gender structure respecting separation and hierarchy are subjected to special strain, which may have consequences for health and result in long-term sickness absence. Research on gender minorities within occupational groups supports this reasoning. From a gender theory perspective, the fact that women to a greater extent than men are affected by the gender order is to be explained by women's relative subordination.

Apart from competing for the same positions, women's entry into the labour market can also mean that habitual patterns for creating masculine

career identity are challenged as many women prove that it is possible to successfully combine work and family.

## Different conditions of family life

To increase our knowledge of what contributes to women's and men's health, sickness and work (in)capacity, it is not enough simply to study working life conditions. It is equally important to examine the conditions of everyday life. The private sphere includes work done to ensure the functioning of home, family and social relations. The starting point, as sketched in the chapter entitled *The living conditions of women and men – a gender perspective*, is the fact that a large part of our actions and behaviour in everyday life is influenced by what we ourselves and those around us consider to be feminine and masculine. It affects our view of which tasks women and men perform and ought to perform, both at work and in the home. Swedish and international studies focusing on the combination of work and family life show that the total life situation is important when examining the relationship between work and ill health (Barnett & Marshall 1991, Lundberg et al. 1994, Thomsson 1996). In trying to understand the relationship between the living conditions and health of women and men, it is thus necessary to take their total life situation into consideration.

Age, years	20–34	35–44	45–54	55–64
<b>Women</b>				
Single with children aged 0–16	1.6	3.1	1.4	0.1
Single without children	10.4	2.3	3.9	5.8
Married/cohabiting with children aged 0–16	11.4	15.9	5.8	0.4
Married/cohabiting without children	8.5	2.4	11.4	15.6
<b>Men</b>				
Single with children aged 0–16	0.4	1.4	0.8	0.1
Single without children	15.9	5.1	4.7	4.3
Married/cohabiting with children aged 0–16	7.7	14.9	8.5	1.5
Married/cohabiting without children	8.1	2.6	8.5	15.5

SOURCE: SCB (STATISTICS SWEDEN), AKU (LABOUR FORCE SURVEY), 2003

**Population** by sex, age and type of family.

The presence of children is often considered primarily to affect the ability of women to combine work with family life. Population statistics show that most women and men with children are found in the 35–44 age group. Young women live with children to a greater extent than young men do. After the age of 45, more men than women live in households

with children. Meanwhile, it is important to note that many women and men live alone or cohabit without children.

### **Division of work in the home**

Since the 1970s, the proportion of gainfully employed women and the proportion of families with two gainfully employed adults have doubled. However, despite the fact that women today are gainfully employed to almost the same extent as men, women still have greater responsibility for relational, caring and household work.

There is no definite biological or economic explanation of why some work tasks are regarded as feminine and other as masculine. Gender branding, that is to say, the division of labour between women and men, can nevertheless be said to result from complex processes constantly at work which involve both single individuals and overall structural systems (Persson & Wadensjö 1997). The society we live in is permeated by norms, traditions, history and culture which in concert affect the gender branding process. This process is seen in the way qualities are linked to gender and the (gender) qualities are linked to work tasks. As a result of this, certain tasks come to be regarded as feminine and others as masculine. For example, women are expected to be more empathetic, caring and relations-oriented than men. It is women who are expected to understand and care about others and empathize with others' situations. This is conceived to be a feminine quality, which in turn means that women are expected to take care of children and old parents, while men are expected to devote themselves to other tasks in the home that do not require the same relations-orientation, such as maintenance and repair work. The fact that work tasks are gender branded thus depends on both conscious and subconscious learning of women's and men's attitudes and self-identity (Westberg 2001).

### **Women's responsibility for relational, caring and household work**

In 2000/01, Statistics Sweden (SCB) conducted for the second time a survey of people's use of time, aimed at describing the similarities and differences in the everyday life of women and men. It presents a rough picture of how much time women and men devote to various activities, in and outside the home. In the use-of-time study, it is stated that women and men during an average day have on the whole the same number of hours of productive work, but that they are different in kind. Women work more hours than men in the home (unpaid), while men are gainfully employed (paid) more hours. For gainfully employed men as a group, time spent in gainful employment decreased on average by 21 minutes a day during the 1990s, while there was no significant change for gainfully

employed women. As a group, women were gainfully employed the same amount of hours in 2000/01 as in 1990/91 on average.

	<b>Women</b>		<b>Men</b>	
	<b>In 2000/01 (hrs:min)</b>	<b>Change from 1990/91 (min)</b>	<b>In 2000/01 (hrs:min)</b>	<b>Change from 1990/91 (min)</b>
Gainful employment	7:40	13	8:21	<b>-21</b>
Domestic work	4:11	<b>-41</b>	3:00	-5
Leisure time	4:58	<b>16</b>	5:21	<b>15</b>

Note: Significant changes are marked in bold.

SOURCE: SCB (STATISTICS SWEDEN) (2003B)

**Average time per day for different activities.** Women and men aged 20–64 years.

The greatest change that took place in the 1990s was otherwise that women in all age groups reduced the time they spent on domestic work. In 2000/01, women devoted just over 4 hours a day to domestic work, which is 41 minutes less per day on average compared with 1990/91. Meanwhile, the time men devoted to housework amounted to 3 hours, which does not equate to any significant change between the two periods of time under study. One consequence of this is that the total time spent by women on paid and unpaid work is on average half an hour longer per day than that of men.

However, the differences in women's and men's overall working hours might be underestimated. Hours spent doing paid work as opposed to unpaid work are not easily totalled, since they are calculated differently and are not gender neutral. Paid work is counted as gross hours, that is to say, travelling time, pauses and other activities during the working day are included in gross working hours. Meanwhile, the time women and men devote to household work is net working hours. This means that if a household chore is interrupted by a coffee break or a telephone call, this time is not included in home working hours. Using this method of calculation, women's overall working hours in particular are underestimated, since women carry out the major part of domestic and caring tasks. Moreover, women work to a relatively large extent near the home, while men more frequently commute to work. This means that long travelling times are included in the gross working hours of men to a greater extent than is the case for women.

Women and men who are single and do not have children devote a more or less equal amount of time to unpaid work in the home. There is a much greater difference between cohabiting women and men without children, where the division of household labour is definitely more unbalanced. Cohabiting women without children devote on average more

time to domestic work than women who are single without children. Childless cohabiting men for their part devote on average less time to domestic work than childless single men (SCB 2003b). This is also true of young couples who are regarded as being gender equal both by themselves and by those around them (Holmberg 1993).

A hypothesis often put forward in this context is that it is when cohabiting couples have children that women devote increasingly more time to unpaid work in the home while men devote increasingly more time to paid employment. Meanwhile, gender theory researchers doubt that children are the prime reason for cohabiting women and men choosing a traditional way of life, that is to say, where the woman assumes responsibility for care of the home and the man assumes the role of breadwinner. They suspect other social processes cause the relationship to be structured around male domination and female subordination. It seems likely that a power asymmetry exists between woman and man even before the arrival of the child, but the child makes visible and reinforces the latent asymmetry (Holmberg 1993).

### **Different areas of responsibility**

Women and men often have a division of labour and a division of responsibility in both domestic work and professional work. In families where women and men live together with children it is often the woman who performs the everyday chores that cannot be put off and that are in addition easier to combine with looking after a child. Such tasks are not usually performed at scheduled times but as the need arises. This applies, for example, to preparing food, washing up, laundering, tidying, planning family activities, maintaining social contacts and taking care of old and sick parents or other relatives. For many men, domestic work means washing and repairing the car, cutting the grass and repainting the facade. Men thus perform maintenance and repair work, which to be sure takes a long time but is not so repetitive. And if the work is not done, no third party is affected, such as a child or an aged parent, which is the case if women put off or skip "their" assignments. Therefore, men can to a greater extent than women choose when to perform their tasks and how to perform them (Elvin-Nowak & Thomsson, 2003).

Women's and men's different areas of responsibility in the home can be a contributory reason why women are affected by certain complaints that men are spared. Even though a gainfully employed woman and a gainfully employed man perform the same tasks at a workplace, the amount and/or type of domestic work, in combination with the gainful employment, can result in women being affected by ill health to a greater extent than men. Women also report to a greater extent than men that

they suffer from fatigue, which might be explained by the many areas of responsibility women have in the home (Kilbom et al. 1999).

That women as a group assume greater responsibility for domestic work than men as a group also becomes evident when one studies which activities women and men perform when they come home after a day at work. Approximately 70 per cent of women perform some kind of domestic work directly they get home, while the corresponding proportion of men is just under 50 per cent. Many hours after the end of paid work, a higher proportion of women than men still perform some kind of unpaid work in the home.

According to one gender theoretical approach, the division of labour between women and men in the home is connected to the expectations that all the time surround them. Both women and men receive confirmation from their surroundings when they perform the tasks expected of them, tasks which are typically "feminine" and "masculine" respectively. In this way, the subordination of women and the domination of men are preserved. Both women and men thus participate in cementing the patriarchal structure of society. Because people have internalized these gender-bound patterns of behaviour, they appear to be natural and are thus difficult, if not impossible, to change. These structures can also look different depending on the situation and context of the individual.

### **Free time – more or less free**

In addition to gainful employment and domestic work, women and men also have free time, that is to say, time when they can do whatever they want. For example, they can devote themselves to sport, recreation or cultural activities. During the 1990s, both women's and men's free time increased somewhat and now amounts to approximately five hours a day (see the table on page 73). Men's free time is somewhat longer than women's. The time use survey from Statistics Sweden also reveals that men more often round off their working day with activities of their own choice, while women continue to work in the home or look after children once the working day is over. For example, irrespective of how much time has passed since the end of the working day, a greater proportion of men than women watch TV.

Men's work is more concentrated to weekdays and daytime (paid work), while women's work is more evenly distributed over the full week and throughout the day (unpaid work). Women's many everyday tasks contribute to splitting up their free time, the time they have to themselves, into brief periods snatched whenever possible. Their free time is interrupted or brought to an end to a greater extent than men's by spells of domestic work and care of children. For many women, there is seldom

any free time left after they have finished their paid work and work in the family (SCB 2003b).

That women as a group partly have less free time, partly have a more fragmented free time, means that women have less time than men for recovery, rest and recreation. An important question to ask is whether the short and stressful free time can have a negative effect on their health? Have not women the same need of time to themselves and recovery as men? The answer is presumably yes. There is no evidence to suggest that women to a lesser extent than men sometimes need just to sit down without doing anything useful, just relaxing. Many women feel constantly tired, low-spirited and inadequate (Thomsson 1998). But in an attempt to fulfil the expectations of those around and be seen as a "good" woman, many continue to live in the situation they find so full of demands and



exhausting, which in the long run can result in deteriorated health and sickness absence. By prioritizing others before themselves, they are rewarded by those around them with appreciative and praising words, which help preserve the gender hierarchy.

Research has shown that a lack of rest and recovery has a negative effect on the health of women as of men. Due to women's smaller amount of free time, it could constitute a greater problem for this group. It could also be a partial explanation of why women have higher sickness absence than men.

In a study of women and men with children from the Swedish National Social Insurance Board, women state that they wish they had more free time and time to themselves in order to achieve a better balance in daily life. Men for their part state that more time with the children and the family would help them achieve a better balance in daily life (RFV 2003d). Furthermore, other interviews with women have shown that many find it difficult to prioritize themselves and their own life. The fragmented free time is probably influenced by the demands of current norms and expectations of how women should live, function and behave. All their lives, women have been trained to disregard – and are also expected to disregard – their own needs and instead to provide care for others such as children and aged parents (Thomsson 1998).

### **Women's double responsibilities – blessing or burden**

For a long time, women have been expected to cope with both earning a living and looking after a family. But what is the effect of having these double responsibilities? Is it clearly negative to have a full-time job and

main responsibility for home and family? Can having double fields of responsibility contribute to higher sickness absence among women? The literature on these questions is growing, both in Sweden and internationally.

There are two hypotheses about the double work burden. One of them is usually referred to as the *expansion hypothesis* and is based on the idea that someone with a wide range of roles and life tasks feels better than someone with a limited number of roles (Lennon & Rosenfield 1992). For example, someone who is both a dentist and a mother can compensate stress in one area of her life with positive happenings in another. Experience of multiple spheres of life is assumed to give increased well-being due to, for example, better finances, more social support and greater self-confidence. This, in turn, is assumed to increase the ability of women and men to manage different types of situation. The psychological benefits of having multiple roles have been shown to be greatest when family responsibility, measured in terms of responsibility for small and/or several children, is not too large.

The other hypothesis is usually called the *overload hypothesis* and here the focus is on people's limitations. It is thought that the combined requirements of family and work can create more demands than are possible to cope with. Multiple roles and commitments contribute to increased load and greater risk of role conflicts, which in turn can create negative stress and ill health. According to this hypothesis, the primary role, whether it be earning a living or looking after home and family, is so demanding that each extra life task increases the risk of negative health effects (Cosser 1974). This has been shown to be most problematical for women with full-time jobs and children (see, for example, Lundberg et al. 1994).

### **Double effects of double work**

The results of empirical studies of the effects of double work on health are mixed. Some show that working women with children at home are sicklisted to a lesser extent than childless women, while other studies indicate that women with children are more frequently sicklisted. In addition, there are some studies where no relationship at all has been found between women's health and double responsibilities (see, for example, Mastekaasa 2000).

Härenstam et al. (2000) believe that a combination of both hypotheses is probably called for in order to understand the connection between work and health. They contend that multiple life tasks affect health positively provided that the overall workload is not excessive.

A Swedish study also indicates that both expansion and overload hypotheses are relevant when examining the relationship between work and life situations on the one hand and health on the other (Nordenmark 2002). The results of the study show that women to a greater extent than men suffer from stress and wish to reduce their working hours and that the reason for this is connected to family responsibility. It is primarily cohabiting women with children who wish to reduce their working hours. This is probably because it is financially possible for this group to cut down on working hours, while it is usually financially impossible for single women with children. Nor is the latter group expected to "take care of" either husband or housework to the same extent as cohabiting women with children. For men, part-time work is not an equally possible scenario. While it is totally accepted, almost to the point of being expected, that women work part-time for some part of their lives, it is far from being an accepted model for men. Men are expected to work full-time and often overtime. The relatively high salary that men earn can also make it less advantageous to work part-time, while women, who earn relatively less, do not lose as much by reducing their working hours.

The results of the study can also be interpreted from a class perspective. People – but especially women – who have highly qualified jobs and are strongly committed to their work, wish more often than others to reduce the number of hours they work, which supports the overload hypothesis. At the same time, these persons are observed to have equal or lower stress levels compared to others. This supports the expansion hypothesis, that is to say, despite the fact that women and men with double responsibilities wish to reduce their working hours, it does not mean they experience negative stress more often than others. One explanation can be that the advantages of having multiple roles outweigh the stress-producing effects that double commitments can have on their health.

In a recent study from the Swedish National Social Insurance Board (RFV), the odds of avoiding longer periods of sicklisting (longer than four weeks) were calculated for the years 1995–2002. One interesting finding was that women's and men's odds more than doubled if they had got children during the period examined. The results also show that women and men who had got children had almost equal odds of avoiding a long period of sickness absence. The odds were somewhat lower for men who did not have children, but those with the lowest odds of all of avoiding sicklisting were childless women (RFV 2004a). A possible explanation as to why childless women have less chance of staying healthy is that they are exposed to stresses in the work environment for longer periods than women who have children.

The situation where a person is active in both working life and the family and both partners share the household chores has come to be called the *balance model* (Härenstam, Aronsson & Hammarström 1996). Härenstam & Bejerot (2001) find that a combination of family life and paid employment not only has a positive effect on the health of both women and men but also on equality in society.

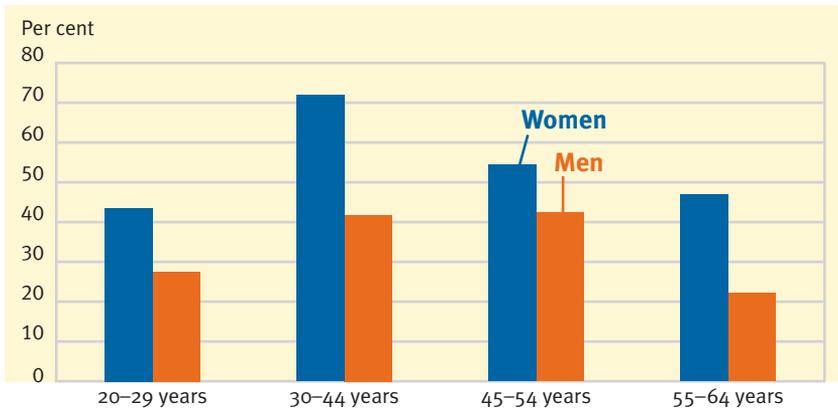
The possibility of achieving a balance between work and private life, without the overall load becoming too great, varies according to the various phases of life. Since people continue studying up to ever higher ages, entry into the labour market is put off until the future. There is thus a risk that the first years of gainful employment coincide with building a family and parenthood. The particular type of balance between the various spheres achieved during this period may also impact the years to come for both women and men. An overload during a few intensive years can cause wear and ill health that only reveals themselves later in life. Another result of postponing entry to the labour market is that childbirth is also postponed until women are older, which can put an added strain on women's health.

A further aspect is that many women and men with children simultaneously have older parents who need care and help with certain tasks. When financial, physical and emotional obligations towards one's own children coincide in time with having aged parents who need support, this becomes a double burden for the so-called middle generation ("the sandwich generation") (Gardberg Morner 2003). Since it is women who are expected to be – and often they also are – the ones who take care of the family, this constitutes a heavy load for women in the middle generation, not least for those women who also earn a living.

### **Conflict between working life and family life**

It is a well-known fact that circumstances in private life affect people's ability to handle and cope with pressure and stress at work. It is also true that conditions at work permeate the remaining hours of the day. On the borderline between paid work and private life there lurk many potential conflicts (Salomon & Grimsmo 1994). If these conflicts grow too large, they may contribute to stress-related ailments and ultimately also to sickness absence.

A major questionnaire survey conducted by the Swedish National Social Insurance Board in the spring of 2002 dealing with sicklisted persons' own perception of their work and life situation also confirms the impact of overall workload on the health of both women and men.



SOURCE: RFV (NATIONAL SOCIAL INSURANCE BOARD), HALS SURVEY 2002

### **Sicklisted persons who feel that the conflict between professional work and domestic work has contributed to their sicklisting.**

Personal experience of conflict is more common among women than men in all age groups, but the pattern is the same. Among both women and men, it is primarily those in the 30-44 age group who also have children who report that the conflict between work and private life has contributed to their sickness absence. Among women, it is mainly those with children aged 7-15 years who experience a conflict between paid employment and unpaid domestic work and feel this conflict has also contributed to their sickness absence, while among men it is chiefly those with children aged 0-6 years.

One possible explanation why women with older children experience the conflict between work and family life as having contributed to their sickness absence might be that their opportunities for part-time work are reduced when the child grows older. Parents lose the statutory right to part-time work when the child turns 8 (in the private sector) or 12 (in the public sector). When the mothers, who are the ones who mostly take the chance to work part-time, later begin to work full-time again, they might perceive a demand both from themselves and from their surroundings to continue being responsible for the same amount of care and domestic work as in the years with a young child and part-time work. If they fail to do this, they are punished by their surroundings and themselves by being regarded as "bad" mothers. When the demands grow too large, they experience a conflict between the two spheres of life, which in turn can lead to deteriorated health and sickness absence.

When children move away from home, parents can experience a reduction in the demands of everyday life. However, new everyday demands can arise, in the form of care of aged parents or care of an aged

spouse. As the number of old people in Sweden grows, the general need for care in society increases. Higher demands are thus placed on relatives. Given the current gender order in the structure of society, the task falls most often to women: wives, daughters and daughters-in-law. As a result, the conflict between private life and working life, which women experience to a greater extent than men, remains also at more higher ages.

A study by Grönlund (2004) reveals that women in pair relationships where she works part-time and he works full-time experience less conflict between work and family than women in pair relationships where both partners work full-time. Part-time work is a way for women to solve the conflict between work and family. However, according to the same study, it is not conflict-reducing for men that she works part-time and he works full-time. The study also shows that women experience less stress in the traditional family model where the man assumes the role of breadwinner and she does most of the domestic work. The division of household labour appears to have no effect on the conflict between work and family. This could be because the heavier burden of work is outweighed by the positive aspects of spending a lot of time with the children. Another explanation can be that it is psychologically rewarding to do the things one is expected to do. A woman who takes on the responsibility for home and family receives positive confirmation and encouraging words from the people around, which makes her feel like a good woman, a good mother, a good wife, etc. In the short term, this makes a woman feel good and appreciated, while in the long term she may feel bad (Thomsson 1998).

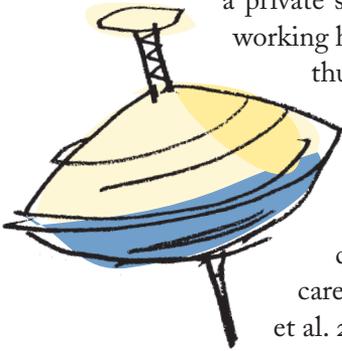
Both women and men in pair relationships where both have university education experience a greater conflict between work and family compared with pairs where neither has an academic background. Women experience a greater conflict if the woman, but not her partner, has university education (Grönlund 2004). That may be because a high position in working life is seldom sufficient for a woman to be able to negotiate a deal on reduced domestic work.

On the other hand, it is not conflict-creating for men to be better educated than the woman. Due to the norms and values that dominate society, there is greater understanding for a man than a woman who negotiates a deal to do less housework. A situation where the man has higher status fits more easily into the habitual thought patterns that exist. Paradoxically, it is the traditional family, that is to say, where the woman takes care of most of the domestic work and caring tasks, irrespective of whether she does paid work or not, and the man has the role of breadwinner, that is the cause of most stress for men (Grönlund 2004).

### Adjustment strategies

Regarded as groups, women and men adjust in different ways to an excessive overall workload. Women use more strategies than men to cope with the combination of paid work and domestic work. Which adjustment strategy women choose depends among other things on their level of education and position in the labour market as well as the phase of life they are in (Lindgren 1992, Roman 1994). Adjustment strategies are not devised in isolation but within the permitted framework of structures and norms.

When the demands of working life increase for women who have children, making it difficult to combine work with parenthood and a private sphere, women often choose to temporarily reduce their working hours in favour of having more time with the children and thus they also often get more time for domestic chores. They also change their work location, switch jobs in order to find a better way of combining work with family life, postpone their professional career until the children are grown-up, refrain from, postpone or limit the number of children and use their social network to get help with the care of their children (Roman 1994, Tyrköö 1999, Härenstam et al. 2000).



Women as a group thus seem, fully in line with the gender order, to give childcare and domestic work top priority while paid work becomes a secondary concern and has to wait. For example, a woman may refrain from applying for a higher position such as that of manager – yet another way of solving the conflict that arises so often between a professional career and domestic work.

Men as a group often do the opposite. When work demands increase, they tend to withdraw from the private sphere, handing over responsibility for domestic work to the woman. Then, if there is any time over, they spend time on domestic work and care of children (Härenstam et al. 2000). Statistics from the Labour Force Survey 2002 (SCB 2003a) even show that men with small children at home on average worked one extra hour a week compared with all employed men. An explanation of why it is possible for men more often than women to devote themselves to gainful employment is that men often have a wife or partner who take prime responsibility for the child/children. It may also be so that the man is forced to work so much in order to compensate for the woman's loss of income.

Women who are strongly committed to their jobs, for example, those with management positions, mostly live with men who also have demanding jobs and who do not take prime responsibility for the children.

The greater focus of men on professional work and on supporting the family are probably yet another expression of the gender order that permeates society. There are expectations among family and friends as well as among work colleagues and managers that the man should be the family breadwinner. According to current norms and values, men who have acquired a family are often attractive in the labour market. So it is not legitimate for men to refrain from applying for higher positions just because the domestic situation is claiming more attention.

By doing what is expected of them, that is to say, in the first place prioritizing paid work, men end up with a superior status in relation to women. And it is through this superior status that they receive confirmation of their male role, that their gender identity is confirmed. In a corresponding manner, women who prioritize care activities and domestic work are confirmed in their female role (Haavind 1985).

A consequence of the adjustment strategies which women as a group use, and which operate within given structures and norms, is that the position of women in the labour market is affected negatively. By their actions, women lose both income and career opportunities. Their actions do not only have a temporary effect but have long-term consequences such as a lower lifetime income and old-age pension. Women's good intentions of creating a good situation for children and family are thus not always the best solution in the long run.

Women and men who make gender-based choices between family and work both risk becoming unhappy. The man because he neglects his family. The woman because she neglects her professional career and chance of personal development through gainful employment. On the other hand, women and men who do not make gender-based choices are destined to experience the double stress of being deviants both at work and in the family context. Neither the woman nor the man will be able to live up to the traditional norm of what is feminine or masculine respectively.

Why do women to an increasingly large extent "choose" to adjust to the total life situation, while men "choose" the role of breadwinner? If we accept the view that there is a constantly ongoing process where gender is constructed, which was discussed in the chapter entitled *The living conditions of women and men – a gender perspective*, these "choices" can be explained: it costs too much to be unconventional. Quite simply, it is hard work having to motivate one's choices to others who do not understand. It is considerably easier to follow the norms that exist by choosing what is typically "feminine" if you are a woman and what is typically "masculine" if you are a man.

It is important to remember that the "choices" made by women and men take place in a situation that includes both their own and others' expectations of how they should choose. By behaving and acting in a way that others expect, both women and men receive their reward in the form of psychological confirmation, which by extension means they themselves maintain and constantly recreate the existing gender hierarchy.

## The significance of different living conditions

Many of the differences in the sickness absence of women and men can be explained by observable conditions in working life in the widest sense. For example, it concerns differences in physical and psychosocial work environment, psychological demands in the workplace, opportunities to influence and rewards, as well as possibilities to combine work and family life. On the other hand, there seems to be nothing to support the claim that the differences in sickness absence are due to women and men responding differently to the same pressures at work. Certainly, there may be differences in the way women and men appear to handle, for example, conflicts at work. But such differences can also be understood as differences in position and influence as well as due to current norms of how women and men are expected to behave.

As regards the significance of family life, there is relatively little support for the hypothesis about double workloads. Nevertheless, as a whole there are good grounds for claiming that there are mechanisms in the interface between family life and working life which cause women and men to be affected in different ways. Role conflicts may be one such mechanism, that is to say, there are different expectations as to how women and men should prioritize between family life and working life or between unpaid and paid work. Such role conflicts can influence the health of professional working women negatively. Men are often given greater opportunity to meet increased work demands through working even longer hours, while such a solution is a difficult option for women due to their greater responsibility for household and care of family and children. Women also stand to lose less in purely financial terms. It does not matter if they devote themselves to the family or not, their salary is often low anyway



# Support when health fails

In connection with sickness and work incapacity, women and men come in contact in different degrees with such public welfare systems as health and medical services and social insurance. In this chapter, we briefly discuss how women and men may be influenced by social insurance regulations and changes made to them. We also report on other welfare schemes that women and men are affected by in connection with sickness absence and the granting of disability pension. Finally, we discuss how norms and values surrounding gender can influence the various actors in the welfare system and employers, which in turn can influence the outcome for individuals with reduced work capacity.

## Women and men in social insurance

Social insurance reflects the norm of equality between women and men. However, its regulations must be applied in a real world where there are different norms for how women and men are expected to act and behave and where their actual conditions differ. As a result, the implementation of the insurance can produce different outcomes for women and men. Furthermore, social insurance is designed on the principle of compensation for lost income up to a ceiling. Since women generally have lower salaries than men, the insurance also offers different financial incentives to women and men to work and to return to work after being on sick leave.

### Parental insurance and working life

The current design of parental insurance can produce negative effects for women since it contributes to a traditional division of labour in the home. As long as women claim the greater part of parental leave, men who have children need not assume the same burden of responsibility for domestic work and care of children during the first few years as women who have children. Extensive use of parental insurance disadvantages women in working life, for example, in the form of poorer promotional prospects and salary development. This in turn has a negative influence on earnings-related benefits such as sickness cash benefit and parental cash benefit. The way women and men divide up parental leave thus also produces a long-term negative effect on women's finances in the form of a lower pension (SOU 2004:70).

There are also examples of parental leave having the opposite effect on salary development. In a study of Swedish conditions from the first half of the 1990s, Albrecht et al. (1998) find that salary development for men is affected negatively when they claim parental leave. However, the authors find no indication that parental leave has a negative effect on the salary development of women. This is a manifest example of how outcomes are affected by norms and values regarding women and men. Women are expected to claim a larger portion of parental leave. Therefore, their salary development is not negatively affected by the simple act of claiming parental leave. Women's salaries have already been set with regard to the expected, that is, they will be away from work more often than men, partly due to childbirth, partly because their sickness absence is greater than men's. On the other hand, men who claim a large share of parental leave are punished for their unconventional behaviour and can expect a poorer salary development than they would have had if they had not taken parental leave. However, the general effect may be said to be equal for both women and men: absence from work due to a high sense of responsibility for children is punished by poorer salary development in the Swedish labour market.

### **Gender neutral sickness insurance**

Despite the fact that sickness insurance is designed to be gender neutral, the regulations and implementation of sickness insurance produce different outcomes for women and men. A greater excess, for example, in the form of a lower compensation level in sickness insurance, affects low earners most. Women, who generally have lower incomes than men and more often have small financial margins, are thus affected to a greater extent by a high excess. In addition, qualifying days affect women to a greater extent than men because women are more often sicklisted than men. All other things being equal, women suffer a greater relative loss than men when different forms of excess are introduced into the insurance system. Another aspect that affects women and men differently is an increase in the responsibility of the employer for the cost of sickness absence, for example, by an extended sick pay period. Such responsibility may make the employer more restrictive in the employment of individuals who are judged to have above-average sickness absence. As a result, many employers may regard women as high-risk labour to a greater extent than men.

Sickness insurance compensates loss of income in case of sicklisting up to a ceiling. This means that people with higher incomes, the majority of whom are men, have a lower proportion of their income compensated by sickness insurance. However, they often receive additional compen-

sation from collectively agreed supplementary insurance schemes. The combined compensation normally amounts to 90 per cent of lost income. Studies have shown that individuals with lower incomes, primarily low-earning single parents, the majority of whom are women, may have little financial incentive to return to work (SOU 2004:2).

Norms and values are basic to how sickness insurance is used while at the same time sickness insurance itself sends out signals as to how it is to be used. The criteria that must be met before an individual receives a benefit – sickness and work incapacity – are often difficult to measure with any degree of certainty. Assessments can be hard to make. Meanwhile, sicklisted persons' and others' experience of sickness insurance sometimes creates the wrong impression of what the insurance may be used for. A dramatic increase in sickness absence, such as has happened since 1997, can produce a shift in the norm for using sickness insurance not only among women and men working today but also among those who are about to enter the labour market.

## Welfare system actors

Women and men struck by sickness or injury may need help to regain their health and return to working life. Depending on the cause of the sickness absence, how protracted the condition is and what measures are required, help is available from the health and medical services, the employer, the Social Insurance Office, the Employment Service and the municipal social services. However, the individual is always the main actor. The interaction between the individual and the above actors can influence both parties' picture of and expectations on how women and men act and behave. These expectations are not always overtly expressed but influence us nevertheless in any given situation.

### Health and medical services – an actor of importance

A sickness spell most often begins with somebody feeling unwell and reporting sick. From the eighth day of sickness a doctor's certificate must be sent to the employer confirming a reduction in work capacity. Thus, the contact with the health and medical services is of great significance for women's and men's sicklisting.

### Responsibilities of health and medical care

The health and medical services are responsible for providing medical care, treatment and rehabilitation. The health service goal for rehabilitation is to help the individual achieve the best possible functional ability and physical and mental well-being.

SOURCE: THE HEALTH AND MEDICAL SERVICES ACT (1982:763)

### Doctor power and patient power

The relationship between doctor and patient is traditionally characterized by a patriarchal structure where the doctor, in her/his role as expert, is superior to the patient (Johannisson 1994). Since both doctor and patients, women and men, participate in and are influenced by existing norms surrounding gender, a complex interaction can arise between a doctor and patient of different sex (Eriksson 2003). However, the doctor's professional skills can counteract the risk that norms and values about "feminine" and "masculine" behaviour might influence their assessments. Hopefully, doctors are made aware during their medical training of the gender order within which both they and their patients operate.

Of Swedish doctors, 60 per cent are men and 40 per cent women. The majority of patients are women (Socialstyrelsen 2002). Despite a preference by women and men to be treated by doctors of the same sex, it is thus common for women to be treated by doctors of the opposite sex (Ottosson 1999, Fjällman et al. 2003). Female patients are doubly subordinated in their meeting with a male doctor, firstly on account of their gender in relation to the man, secondly on account of their subordinate status as patient in relation to the doctor and the doctor's power over the patient. On the other hand, in male patients' meetings with female doctors, two ranking systems collide, on the one hand the authority of the doctor, on the other hand the superior status of the male, which also has consequences albeit different in kind from when the positions are reversed.

Patients' behaviour, doctors' attitudes to patients and communication between doctor and patients has been the subject of several studies. Foreign research has shown that there are differences in communication between doctors and patients depending on whether the two parties are of the same or opposite sex. Both female doctors and female patients have a more collaborative approach. Moreover, female doctors often give more consultation time and confirmation than male doctors (van den Brink-Muinen et al. 2002, Roter et al. 2002).

## Different assessments

Compared to women, men receive more detailed diagnoses (Socialstyrelsen 2004a). Women more frequently than men have symptoms that do not fit any particular diagnosis, for example, fatigue, non-specific chronic pain and mild mental complaints. Such symptoms can be difficult to associate with well-defined syndromes. The criteria that must be met for an individual to receive compensation from sickness insurance – sickness and work incapacity – is therefore often difficult to measure with any degree of certainty. The doctor seldom knows what demands the patient's job places on work capacity but has to rely on the patient's description. Assessments can be particularly difficult to make in cases of mental disorders. These illnesses have increased most as a cause of sickness absence since 1997, to a greater extent among women than among men.

According to Swedish and international research, it is more difficult for women than men to get their illnesses confirmed by doctors (Reid et al. 1991, Bäckström 1997, Ahlgren & Hammarström 2000). Men's detailed diagnoses may depend among other things on the fact that medical research is mainly carried out on men. Thus, men's symptoms are in many cases better known in the medical profession. Analyzed from an overall structural standpoint, it can be understood as an effect of the gender order. The relative subordination of women leads to men's illnesses being perceived not only as "male illnesses" but also as the norm for all illnesses.



For example, the "male" norm is seen in the way new, expensive medical technologies and medicines are first spread to middle-aged men, in the fact that women more often suffer from undesirable effects of medicine, and the somewhat more limited access women have to cataract operations (Socialstyrelsen 2004a).

Men often wait longer than women before getting in touch with a doctor. Meanwhile, men die more often of diseases that could have been prevented or treated (Socialstyrelsen 2004a). Men's late contacting of medical services can presumably be explained in part by the dominant male ideal that says men should not show weakness and should manage on their own (Kjellberg 1999, Connell 2003). This too can be seen as an expression of the gender order, in which women are considered to be weaker and in greater need of protection by, for example, doctors.

When doctors are asked to assess commonly occurring, constructed but authentic typical cases of patients with the same background and health, female doctors certify reduced work capacity more often than male doctors (Englund 2000). Meanwhile, doctors consider that patients have great influence over the decision to issue a medical certificate for sick leave or not (Edlund et al. 1998). In one study, district doctors in the county of Dalarna issued certificates of reduced work capacity in 92 per cent of cases although they would not have recommended sicklisting if the patients themselves had not wished to be sicklisted (Englund 2001).

### **Employers and working conditions**

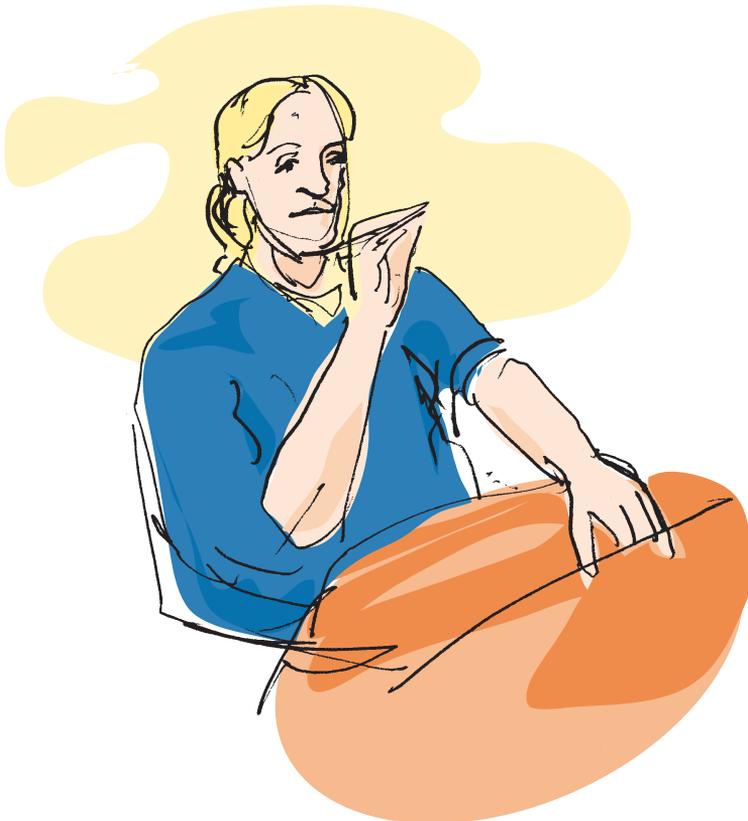
Approximately half of those sicklisted longer than 14 days consider work has wholly or partly caused their sickness absence (RFV 2002b). An employer often has plenty of opportunity to notice the first signs of a deterioration in the work capacity of an employee. Therefore, the employer is in a key position and has the opportunity to act early to prevent sicklisting and shorten absences from work for health reasons.

### **Work environment measures for men**

In times of increasing sickness absence and work injuries, working conditions always come in for close scrutiny. For example, this happened at the end of the 1980s, when considerable work environment problems could be pointed out, not least through the work of the Working Environment Commission. A new work environment law came into force at the beginning of the 1990s as a direct response to the bad conditions. Under the law, employers must adapt working conditions to people's different physical and mental aptitudes (Working Environment Act 2003:1099, 2 chap 1 §).

In order to improve the working environment, a special working life fund was created from employer contributions. The following work environment programmes, worth a total of SEK 31 billion, were conducted primarily within "male" work areas. Private employers, who employ eight of ten men but only five of ten women, were granted three quarters of the funds collected. Employers in the public sector, for example, in health and medical services, where an overwhelming majority of employees are women, thus received only a quarter of the funds (von Otter 1997).

The fact that public employers applied for so relatively few grants from the Working Life Fund demonstrates their lack of insight into the significance of working conditions for the work capacity and productivity of their employees. Moreover, after the funds ran out in mid-1990s, severe cuts and reorganizations were made in the public sector. Work environment risks in the reorganizations that were carried out were ignored in nursing, schools and care services. Furthermore, the consequences of these changes for staff are by and large unresearched according to the Welfare Balance Sheet for the 1990s (SOU 2001:79). However, there are many indications that poor working conditions and increased demands



on staff due to downsizing may have contributed to the fact that women's sicklisting has increased more than men's since 1997 (Bäckman 2001).

### **Employer responsibility for rehabilitation**

The employer is responsible under the National Insurance Act to identify and investigate sicklisted employees' need of rehabilitation. According to the Working Environment Act, employers shall establish a rehabilitation organisation for vocational rehabilitation and adaptation of workplaces. This means, among other things, that when necessary the employer will offer employees special work aids or provide other work tasks more suited to the state of health of the employee. In many cases, work adjustment is a necessary precondition for a return to work after a period of reduced work capacity.

#### **Employer responsibility for rehabilitation**

The employer's responsibility includes monitoring the individual employee's need of rehabilitation. The employer shall, in cooperation with the employee, investigate and assess the employee's need of rehabilitation, ensuring that the necessary rehabilitation measures are implemented. The employer must always investigate the need for rehabilitation when an employee is ill for longer than four weeks running, has many short sickness absences or if the employee requests it. The work capacity of the individual shall be utilized as much as possible.

The employer is responsible for implementing vocational rehabilitation measures possible within or in connection with his/her company's activities. The approach should be one of enabling the employee to continue working for the employer.

SOURCE: WWW.FK.SE, RFV 2004E

Insufficient work adjustment can be a factor in explaining why women are absent due to sickness and reduced work capacity for longer periods than men. In a recently completed study, 17 per cent of the long-term sicklisted men, sicklisted for at least two months, and 10 per cent of the long-term sicklisted women say that the employer has helped them change both work tasks and workplace (RFV 2004f). In another study, sicklisted men with low back pain report to a greater extent than women that the employer has suitable work tasks that can be carried out in spite of possible residual discomfort (39 and 26 per cent respectively). If the absence has continued for more than three months, the possibility of work adjustment is a success factor for the return to work of both women and men. It is especially efficacious for men (Bergendorff et al. 2001).

These results indicate that employers and work organizations view men as a more important labour force than women. From a gender the-

ory perspective, the efforts on behalf of men could be interpreted as an expression of men's traditional role as breadwinner. Perhaps men are also regarded as more indispensable than women for their employer or for trade and industry as a whole.

### **The employment exchange and mobility**

Changing employers was more common among men than women in the 1980s. In the 1990s, the pattern was reversed. One explanation is that the number and proportion of temporary and part-time jobs increased in certain women-dominated sectors. It may also reflect a broader range of employers in the labour market for women. In addition, unemployment has been higher among men than among women since the 1990s, which has contributed to diminished mobility among men (Arbetsmarknadsstyrelsen 2003).

If sicklisted persons cannot return to their original jobs and the employer cannot offer suitable alternative work tasks, the Public Employment Service can assist in finding other work. Furthermore, the service can offer, for example, training for another profession or various kinds of support to enable sicklisted persons to support themselves via paid work.

#### **The responsibility of the Public Employment Service**

The public employment service is responsible for making available labour market policy programmes to persons who are unemployed or risk unemployment. The employment service is responsible for job procurement, job counselling, vocational rehabilitation and training.

The Social Insurance Office shall enlist the help of the Employment Service to find out what rehabilitation measures are available for out-of-work sicklisted people.

SOURCE: WWW.AMS.SE, RFV 2004E

Women and men who are both sicklisted and unemployed comprise a group that has long been difficult to rehabilitate. Special collaboration has been established between the Social Insurance Office and the Public Employment Service to help them return to work. The first results from this work reveal that men have to a large extent received some form of employment support, in most cases a wage subsidy, which means they have employment. Women have to a greater extent received regular educational courses. The Employment Services have had difficulty finding suitable work for sicklisted women who previously worked in woman-dominated occupational areas such as the care sector and who for health reasons have been unable to continue working in the same field (RFV

2004g). The gender segregated labour market, which we discussed in some detail in the previous chapter, and a gender typical way of thinking constitute a greater obstacle to finding work for sicklisted unemployed women than for sicklisted unemployed men.

### **Different assessments of the Social Insurance Office**

According to sickness insurance regulations under which the Social Insurance Office operates, sicklisted persons may be rehabilitated. The aim of rehabilitation is for them to regain their work capacity and the possibility of supporting themselves through gainful employment.

The Social Insurance Office is responsible partly for ensuring that rehabilitation needs are investigated, partly for coordinating the various measures necessary to help individuals regain their work capacity after illness. Investigation, planning and implementation of rehabilitation should always be done in close cooperation with the individuals concerned.

#### **Responsibility of the Social Insurance Office**

The Social Insurance Office has overall responsibility for establishing the rehabilitation needs of the individual and ensuring that measures necessary for an effective rehabilitation are implemented. When necessary, the Social Insurance Office must ensure necessary investigations are conducted. If the individual is entitled to rehabilitation compensation, the Social Insurance Office must draw up a rehabilitation plan. The individual is entitled to this compensation while participating in vocational rehabilitation intended to shorten the sickness period or restore full work capacity.

The Social Insurance Office must also coordinate and monitor the measures necessary for the rehabilitation operation as stipulated by law. In its work with rehabilitation, the Social Insurance Office will collaborate, if the individual consents, with employer and employee organization, health and medical care, social services, labour market bodies and any other authorities that may be concerned.

SOURCE: RFV 2004E

It is rare for men to work as rehabilitation case officers at the Social Insurance Office. The sicklisted nearly always meet a woman case officer. In this section, we discuss how the way in which case officers view women's and men's living conditions and capabilities influences their assessments and helps to explain the differences between women's and men's sickness absence and exit from the labour force through disability pension.

The legislation governing the handling of sicklisting and rehabilitation by the Social Insurance Office provides no separate rules for women and men. However, when the law is applied, the outcomes for women

and men are often different (RFV 1998). For example, the assessments made in connection with rehabilitation offer scope for interpretation and action by case officers within the framework of the gender order. In a study conducted by the National Social Insurance Board (RFV 1999), a large number of case officers at the Social Insurance Office were asked to assess the rehabilitation possibilities for authentic typical cases where the persons had identical backgrounds and aptitudes but were of different sex. Of course, assessing of typical cases does not wholly correspond to real life but it gives an indication of possible differences in case officers' assessments of rehabilitation potential for women and men.

In cases of persons with back and neck pain, case officers regarded the family situation as an obstacle to rehabilitation for one fourth of the women and for a few per cent of the men. Furthermore, they recommended medical rehabilitation and work training to a greater extent for women and further education or relocation to other work tasks for men. The case officers also judged that the men would either return to work full-time or be granted a disability pension after the rehabilitation programme, while they judged that the women to a large extent would return to work on a part-time basis. Women with a low level of education received by far the worst prognosis (Walestrand and Overgaard 1998, RFV 1999).

Several studies have pointed out differences in vocational rehabilitation between women and men in the real world, too. Men to a greater extent become objects of vocational investigation and receive further education, while women more often receive work training (RFV 1997, RFV 2001, Ahlgren & Hammarström 2000). Thus, there is a clear difference both in the Social Insurance Office case officers' assessments of women's and men's rehabilitation potential and in the kind of measures they regard as adequate for women and men respectively.

### **The man as norm**

The difference between women's and men's rehabilitation is so consistent that it becomes reasonable to isolate and study the structures in society and in the application of social insurance which contribute to these differences. Sennvall (2002, 2003) mentions two examples of such structural factors, on the one hand, the procurement of rehabilitation services by the Social Insurance Office, on the other, the gender segregated labour market.

Rehabilitation case officers have in each rehabilitation case to choose between predetermined and procured rehabilitation services. Sennvall (2002, 2003) notes that even if rehabilitation occurs as often for women as for men, the rehabilitation that women receive costs much less. Moreover, women receive measures later in the course of the illness and for

shorter periods. At the same time as the difficulty in finding alternative work for women is recognized as a problem in the rehabilitation of women (for example, Bäckström 1997), further education and retraining is not often used to equip them better for other types of work. The system seems to function in such a way that vocational rehabilitation favours a larger group of men than women (RFV 1997).

So there is a good deal of evidence that men are regarded as family breadwinners also within vocational rehabilitation. This may be interpreted to mean that women are not on the whole as indispensable in the labour market as men are. Work seems to be regarded as something so central to a man's life that the energy spent on finding rehabilitation measures for men is greater than that spent on finding measures for women. This often leads to the choice of measures such as vocational courses for man-dominated occupations, for example, welding courses, courses for drivers, real estate technician courses and IT courses (Sennvall 2002, 2003). The choice of measures is more limited for women. This not only means that horizontal segregation is maintained, but that not all women receive adequate rehabilitation.

As mentioned in the chapter entitled *Working life, family life and sickness absence*, opportunities for women to change jobs are negatively affected by the fact that their competence development is often adapted to the special requirements of their employer, for example, in nursing, schools and care services, and is seldom of use outside this sector (Evertsson 2004). This is also to a high degree a labour market problem. There are very few alternative employers within the occupational areas traditionally found in the public sector. This contributes to maintaining the horizontal segregation. Studies have also shown that women to a greater extent than men like to live close to their workplace, which further reduces opportunities for changing jobs (Arbetsmarknadsstyrelsen 2003). This wish exists within the framework of what women – especially women with children – find reasonable, possible and appropriate for them to wish.

Men's own suggestions for rehabilitation have greater significance for the chances of receiving a measure, despite the fact that women make suggestions to the same extent as men (Bäckström 1997, Sennvall 2002, 2003). The difference may be due to men's suggestions being taken more seriously, against the background of their special mode of communication and their relative superiority. In the existing gender order, there is a built-in communication structure in which men are expected to express their views and needs objectively and directly. Their proposals are approved because they behave "normally", that is to say, in the way men do. On the other hand, women often cover up their message in the way

women are expected to do, which does not follow the norm of male – and therefore “normal” – behaviour (Wahl et al. 2001).

Both women and men often experience a sense of powerlessness because it takes such a time before rehabilitation gets going. However, a man is seen as making just demands which can and should be met while a woman in the same situation is felt to be obstinate and troublesome (Ahlgren & Hammarström 2000). Because women feel they are not allowed to be – or feel bad when they are – too obstinate, they also risk losing the chance to influence their own lives (Bäckström 1997).

Similar examples of the consequences of the gender order for the application of the rules can also be taken from other areas. Both social services (Kullberg 1994) and care of drug addicts (Socialstyrelsen 2004c) appear to treat women and men differently despite rather similar problem descriptions. Within drug addition treatment, men receive activity-oriented measures, women receive therapy. Here we find a parallel with the Social Insurance Office’s proposal of further education or change of job for men and medical rehabilitation for women.

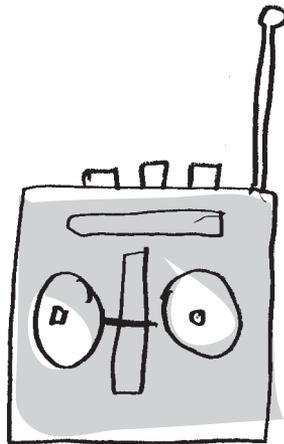
## Lack of overall responsibility at early stage

There are many actors besides the individual involved in sicklisting in Sweden, but none of these has any overall responsibility for the individual’s health and work capacity at an early stage of the sickness spell. The doctor’s assessment of work capacity comes first, no later than the eighth day of sickness absence. The Social Insurance Office is informed of the absence after some weeks. The employer is responsible for handing in a rehabilitation report to the Social Insurance Office within two months. The Social Insurance Office has thus little opportunity to intervene at an early stage and discuss rehabilitation possibilities and to integrate the various measures that need to be taken to help the individual regain his/her work capacity.

Unlike Sweden, both Germany and Finland have very low sickness absence, especially among women. This is probably the result of continuous follow-up of sickness spells from the start and of close cooperation between the Social Insurance Office, the employer and health and medical service or occupational health service. This means that sickness absence stemming from problems at the workplace, for example, bad physical working conditions or conflicts and deficiencies in work organization, are identified early and underlying problems can be dealt with rapidly (RFV 2003e). Due to the way the Swedish system works, such information often only surfaces much later, by which time the “sick role” has established itself in the individual and the employer has had time to create

other, possibly more permanent, solutions and replaced the absentee with a substitute.

All the actors are influenced by the norms surrounding gender and may therefore reinforce the female subordination and male domination that the individuals carry within them. Both doctors and Social Insurance Office case officers are of the opinion that women's situation is more complex than men's and that women are therefore more difficult to rehabilitate. Women's expected, and often factual, prioritization of children and family or care of older relatives can prove stumbling blocks to rehabilitation (Bäckström 1997, Ahlgren & Hammarström 2000). High competence and a professional approach that includes knowledge of the gender order are necessary in order to minimize the risk of different assessments of the needs, potential and limitations of women and men.



## The obstruction of gender equality

The aim of the theme section of Social Insurance in Sweden 2004 is to report on the differences in sickness absence and disability pensions of women and men and to discuss possible reasons for these disparities. The discussion focuses on the significance of existing norms and values surrounding gender and how these can influence women's and men's living and working conditions, opportunities and personal options, and therefore also health, sickness absence and exit from the labour market through disability pension.

To analyze and try to understand the full range of differences in sickness absence of women and men is a task that is as difficult as it is important. We have to realize that our knowledge generally is full of gaps when it comes to explaining the causal relations that lie behind sickness absence, and this applies particularly to the dramatic increase in long-term sickness absence at the end of the 1990s. So it may seem to be a virtually insuperable task to understand and describe why women's sickness absence is more extensive than men's. However, with the help of established gender theory research, our understanding of the mechanisms at work in this problem area may be considerably enhanced, and more distinct interpretations may be made. This in turn makes it possible to problematize even further the future development of both women's and men's sickness absence as well as gender equality in general.

### Different patterns in sickness absence and disability pension

Since the early 1980s, women have had higher sickness absence and been granted disability pensions to a greater extent than men, and the differences have grown over time. At present, women account for approximately two thirds of the sickness absence. Moreover, every tenth woman and every fourteenth man aged 16–64 have withdrawn from the labour force through a disability pension.

- On the whole, the same illnesses cause sickness absence (longer than 14 days) and entitle to disability pension among women and men. Musculoskeletal diseases are the most common cause, followed by mental disorders.
- Musculoskeletal diseases are equally common causes of sickness absence among women and men while mental disorders are more common among women than men.

- Women's exit from the labour market through disability pension is caused to a greater extent than men's by musculoskeletal diseases while men's disability pension is more often due to mental disorders.
- Men's occupational diseases are approved as work injuries to a greater extent than women's occupational diseases.
- Otherwise, the following applies to both women and men: sickness absence and withdrawal from the labour market through disability pension are more common among older than younger people, among individuals with low education and low income – who are usually in blue-collar and lower-level white-collar jobs – and among employees in the public sector.

The dramatic growth of sickness absence since the end of the 1990s concerns both women and men. The increase has occurred for all types of illnesses, within all age groups, in all regions and in all occupational categories, industries and sectors. However, the increase has been particularly dramatic for women, and especially among women in the public sector working in fields such as nursing, schools and care.

- Sickness absence and newly granted disability pensions have increased dramatically among young people, especially among women.
- Sickness absence has become increasingly common among highly educated women, while there has been no striking increase among highly educated men.
- Sickness absence and disability pension due to mental disorders have increased for both women and men. The increase is more noticeable among women.

So what do these differences in temporary and permanent absence due to sickness and disability between women and men depend on?

There are many explanations. Biological factors can explain a small part of the differences, but different social and cultural conditions have greater significance. On the one hand, these conditions influence the actual situations where ill health arises, on the other hand, they influence how large the need for sick leave is for a given reduction of work capacity. Therefore, it is important to bear in mind the differences in women's and men's working conditions and other living conditions when one tries to explain women's greater share of compensated sickness absence and inflow to disability pension.

Despite the fact that much of the research into the causes of sickness absence has taken into account many different aspects, we still know relatively little about why there are such large differences between women and men. Knowledge is also limited concerning the accumulated effects of various types of pressures in working life and family life. Therefore, it seems necessary to add one more dimension to the discussion, a gender theoretical perspective, when possible explanations are discussed.

### Gender affiliation matters

The line of reasoning in the theme section starts from the premise that an individual's gender affiliation and gender identity has significance for his or her living conditions and the expectations he or she meets, but also for one's view of oneself and the choices each one makes in their life. This in turn is assumed to have a connection with health and sickness absence. The reasoning is also based on a view of gender as something socially constructed, rather than biologically predetermined. This implies that the way women live and act, just as the way men live and act, is regarded as something that is always changeable and possible to influence.

A gender theoretical perspective means in this context that the explanation of the outcome in sickness absence is not only to be sought in the individual but also in the structural conditions that determine how every individual shapes their life. Structures, such as the organization and functioning of the labour market, arise out of social relations and are therefore the result of how individuals and groups act. By our choices and actions we thus influence the structures that surround us. At the same time, the structures influence how individuals and groups can act – there is a constant interaction between the various levels.

Through the treatment and expectations of the world around, individuals continue to acquire throughout their lives norms and values regarding what it means to be a woman or a man. This means that the choices an individual woman or man makes concerning, for example, education, interests, work or responsibility in professional life and family life are influenced by current gender norms. Irrespective of whether the individual woman or man chooses to live according to the norm or otherwise, nobody is uninfluenced by the norms that generally apply in the culture, time and social group where he or she lives.

Based on the well-established norms about how women and men are supposed to be, a system has been created in society that is called the gender order. What effects the gender order has on the actions of a single individual, or on the possibilities and difficulties the person in question encounters, vary from person to person. They are also the result of other factors than gender, such as class, ethnicity, physical and mental functional aptitudes and generational affiliation. Gender is never the only factor influencing a person's identity or possibilities, but is usually a very important factor.

Against the background of this way of reasoning, the difference between women and men in their use of sickness insurance can be understood as one more consequence of the gender order and the norms that govern expectations and behaviour. Individual women and men, the actors involved in the processes leading up to sickness absence or disability

pension, for example, employers, doctors or the Social Insurance Office's case officers, live and operate in a society that takes certain things for granted.

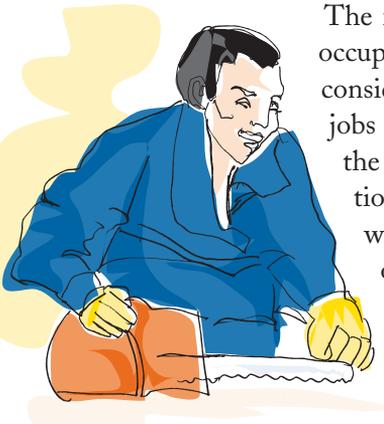
At the highest level, the gender order implies a separation between "masculine" and "feminine", which has been described theoretically by the concepts of segregation and hierarchy. Segregation means that a distinction is made between women and men, between feminine and masculine and not least between the tasks women and men mainly devote themselves to. Hierarchy means that the man is the norm and that the masculine is superior to the feminine. For the sake of clarity, further arguments will be linked to this simplified division.

The various arenas of society that in this theme section have been pointed out as essential for the understanding of women's and men's sickness absence are working life, family life and the relation to the public welfare system. Women and men, regarded as groups, do not have the same positions in these arenas. This has importance for what opportunities and obstacles they meet in their everyday life, within the framework of the complex norm-governed social systems. It also has significance for how both the individuals themselves and the world around them view their needs and abilities.

### The gender order in working life

Segregation and hierarchy have their counterparts in the labour market. The horizontal gender segregation means that women and men most often work within widely separated professions, industries and sectors. For example, eight out of ten men work in the private sector, but only five of ten women. The vertical gender segregation (the hierarchy) means that women less frequently hold top positions. Whatever the causes of the gender segregated labour market, it results in separate working and living conditions for women and men.

The fact that women and men often work in separate occupations means that their working conditions differ considerably. Within certain extremely man-dominated jobs such as that of construction worker or firefighter, the risk of work injuries and highly dangerous situations is a concrete reality. Within certain extremely woman-dominated jobs such as preschool teacher or assistant nurse, the physical work environment risks rarely include danger to life and limb. Instead, working closely with highly dependent people involves high psychological demands. Psychologically demanding work can in itself



and in combination with physically demanding work lead to work-related disorders and sickness absence. Since many women work under such conditions, it is clear that women are affected to a greater extent than men.

That certain occupations and work tasks are regarded as particularly suitable for women or men respectively can contribute to locking-in of people in occupations and thus limit the choice of potential employers. Such inflexibility can be an obstacle to further gainful employment if the work should result in incipient illness and work incapacity. The fact that many occupations, industries and work tasks are divided according to gender causes the separation of women and men to be reinforced and maintained by the norms and values thus engendered about masculinity and femininity.

Hierarchy is expressed in working life through vertical gender segregation. For example, men hold leading positions to a greater extent than women. In 2004, the board of directors of Swedish companies registered on the stock exchange comprised 85 per cent men and 15 per cent women, while only four of 300 managing directors were women. Men also have higher salaries than women, even when performing the same kind of work. Since women less frequently have supervisory positions, they are more often the objects of reorganization and changes in work methods and work content, while men are more likely to initiate such changes. People who are involved in cutbacks, reorganizations and other major changes at the workplace run a greater risk of developing stress-related symptoms that lead to sickness absence. Such changes particularly hit women in the public sector during the 1990s.

Many women with higher education experience that they are being obstructed in their career due to their sex. This can give rise to different forms of stress and adjustment strategies where sickness absence can appear as a way out. Both organizations and single individuals have expectations on the opportunities and limitations that women and men respectively have when it comes to taking on various job assignments. Structural obstacles placed in the way of women pursuing a career and reaching top positions can be interpreted as personal weaknesses by both individuals and organization. It makes it possible for the individual not to feel a victim of circumstances, while the structure within an organization can remain unchanged.

Bad working conditions, such as physically and psychologically demanding work, serious conflicts with work colleagues or supervisors as well as bullying and offensive discrimination on grounds of gender, can put a great strain on the well-being and health of both women and men. In general, the less opportunity individuals have to influence their work

and the conditions at the workplace, the stronger the propensity to withdraw from the difficulties. Women in general have less opportunity to influence their work situation compared with men. Research based on Swedish conditions has also shown that reactions to severe strain in working life are connected to sickness absence.

### **The gender order in family life**

It is not only in working life that a gender order prevails. Segregation and hierarchy are also found in private life. Men in pair relationships usually have higher salaries than women, giving them greater financial power and influence (hierarchy). As a result of internalized norms and values, men as a group devote more time to gainful employment than women as a group (segregation). On the other hand, women devote a greater amount of their working time to unpaid work in the home, which is also valued less than paid work. Women and men find confirmation in taking responsibility for the tasks they are expected to take responsibility for. By acting and behaving according to expectations, both women and men contribute to maintaining the gender order.

It is important to point out that it is not only the amount of time that women and men spend on various activities that is of significance for their prospects and well-being. The content of household work plays a role in the well-being or psychological strain experienced by women and men respectively. Caring for children and relatives as well as daily household chores cannot always be postponed without someone suffering. Such activities cannot always be planned or cancelled in the way that is possible in the case of, for example, certain maintenance and repair jobs. Women's unpaid work has thus a larger element of necessity in it than men's unpaid work. Moreover, the services often performed by the man in the home can to a larger extent be bought on the open market. The current gender order and the current gender equality ideal mean that women are expected, by themselves and by others, to be able to balance working life and family life. For men, there is more of a choice.

The difficulty of combining full-time paid work with prime responsibility for home and family makes many women adapt their working life to their family life rather than the other way around. To do this, for example, women often take long parental leave, reduce their working hours when the children are small and choose to take less qualified jobs or to work near the home. Within the family, such strategies can be seen as reducing the friction between work and family life and between the woman and the man in the pair relationship.

Women's adjustment strategies, which are often about getting everyday life to function for themselves and their loved ones, operate within

given structures and norms. However, these strategies not only result in the women concerned creating possibilities for themselves, but also enable men to devote a great deal of time to paid work. As a result of their own and others' expectations, men can feel obliged to live up to the role of breadwinner. Neither woman nor man thus deviates from the existing norms and values about how women and men should prioritize between paid and unpaid work. This in turn means that the traditional division of labour between women and men is conserved.

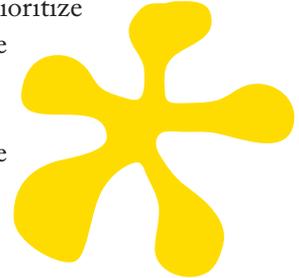
However, the adjustment strategies used by women have their drawbacks. They ultimately have a negative effect on their position in the labour market. They have less pay for their work and worse career and development opportunities. In the long term, their lifetime income will be lower, which in turn gives a lower old age pension. Nevertheless, it is important to point out that the choices made by women – and men – always take place within a given framework that includes both others' and their own expectations of what choices they are supposed to make.

It is generally supposed that the double workload is an explanation of women's higher sickness absence rates. There is some support for this assumption from empirical studies, but many studies also indicate that the presence of children in a family reduces the risk of prolonged sickness absence for women. There is evidence that children in a family also reduce the risk of sickness absence for men.

In general, our knowledge about the significance of various family life conditions, and their impact on women's and men's health is patchy at best. This is true of, on the one hand, women's and men's possibilities to combine work and family life throughout the whole life cycle, and, on the other hand, the existence of conflicts, abuse and violence in private life, which in turn can seriously affect individual well-being and thus the need of sick leave. Furthermore, it is a delicate task to investigate the long-term accumulated effects of these conditions.

### **Norm-driven use of sickness insurance**

Sickness insurance is designed to be gender neutral. However, its regulations have to be applied in a real world where there are different norms for how women and men are expected to act and where their actual conditions differ. Therefore, the outcome of the insurance in practice amounts to different things for women and men. For example, the existence of a qualifying day affects women's compensation from sickness insurance more than men's since women are more often absent due to sickness. Meanwhile, it is not yet clear whether the qualifying day serves



its intended purpose of reducing sickness absence to any noticeable extent. What is known, however, is that so-called sickness presence occurs at workplaces. This means that individuals, to avoid being without compensation due to the qualifying day, go to work even though their general state of health is impaired by a cold or other minor health problems. However, no research has been done on the long-term effects of sickness presence on health and work capacity.

Norms and values largely determine how sickness insurance is used, while at the same time sickness insurance itself sends out signals about how it should be used. There is always a medical dimension to the sickness that leads to work incapacity, but this also reflects cultural values. What is to be considered as sickness justifying sickness absence is redefined again and again through a social process involving several participants – doctors, patients, employers, the Social Insurance Office and the media.

### **Norms affect all the actors of society**

All actors whose task it is to support and help the sicklisted are influenced by the current norms relating to gender. They allow, consciously or otherwise, general notions of gender typical relationships to affect their judgements. This means that by their actions they may reinforce an individual's own conception of how women and men can and should act and what possibilities and limitations they have in any given situation.

An example of the impact these norms and values have is the fact that employers seem to prefer men to women when making workplace adaptations once work incapacity has been confirmed. Another example is the differences that appear in the difficult assessments of women's and men's rehabilitation potential that the case officers of the Social Insurance Office have to make. They often reflect the view of the man as norm and family breadwinner. Thus, the choice of rehabilitation services provided by the Social Insurance Office, especially opportunities for education, is greater for men than for women. Corresponding examples can be taken from activities within medical care, the Employment Service and other social institutions. At the same time, however, there is a risk that various actors in their ambition to act in a gender neutral manner ignore important conditions that can differ between women and men. What is needed is a gender-conscious and professional approach to reduce the risk for similar situations leading to different assessments depending on gender.

No one in the administration of the Swedish sickness insurance system and among the other involved actors has at an early stage an overall picture of the individual's health and work capacity. The responsibility is divided. The doctors are usually not informed about the limitations

and possibilities associated with the patient's workplace. The employer is not allowed to contact the doctor concerned but may, on the other hand, contact the Social Insurance Office. The Social Insurance Office is able to contact both doctor and employer. Sickness insurance regulations being what they are and the application of the insurance what it is, it often takes a long time before these contacts are made. Moreover, the Social Insurance Office has not been prepared or had the resources to meet the dramatic increase in sickness absence of recent years. Bearing in mind that roughly half of the sicklisted consider the workplace to be wholly or partly the cause of sickness absence, it is plain that the earlier an interaction between the actors – individual, employer, doctor and Social Insurance Office – takes place, the better for all concerned.

Conditions in Sweden can be compared to those in Germany and Finland, where a highly developed information system provides the basis for continual follow-up of the individual's sickness spell from its beginning and of sickness absence at specific workplaces. The low rate



of sickness absence in these countries probably partly depends on close cooperation between their Social Insurance Office, employers and health and medical services or occupational health services. This means that absences that stem from workplace problems, for example, bad physical working conditions, conflicts or poor work organization, are identified at an early stage and underlying problems can be rapidly dealt with. The level of sickness absence is also much lower in these countries than in Sweden, not least in the case of women. That is also true of sickness absences among women in the public sector.

The economic crisis in Sweden in the 1990s with cutbacks and re-organizations in its wake, especially in woman-dominated workplaces in the public sector, can in the light of the existing gender order at least partly explain why women's sickness absence has shot up so dramatically. In individual cases, it is often both reasonable and necessary to be on sick leave for a shorter or longer period. However, in society as a whole, sickness absence has lately become more and more socially accepted as a cure for all kinds of symptoms and problems in life. Sickness absence is not always the most adequate solution for the individual. There is a risk in letting sickness absence be the answer to an unmanageable complex of problems. If bad working conditions, a lack of gender equality in the family or a combination of both contribute to sickness absence, it is important that the individual strives to make a change. In cooperation with employers and welfare system actors, alternative possibilities ought to be checked out.

The significance of structures for the differences in sickness absence between women and men has previously been highlighted, but it is important to note that both women and men have choices and can influence their life situation. The individual is always a key actor during the sickness absence period. Through recurrent or long-term sickness spells, both women and men risk moving ever further away from the labour market and finally ending up in social exclusion. If sickness absence continues to be particularly prevalent among women, it may also contribute to the strengthening of the gender order.

## The future

There are a number of possible future scenarios for women's and men's conditions in working life and family life as well as for the development of sickness absence and the number of newly granted disability pensions.

Welfare and gender equality policies have increased women's participation in working life and made them more financially independent. At the same time, these policies have partly cemented the gender order by

having made family policy – for example, childcare, parental insurance and child allowance – very much into a women's issue. Family policy has however increased women's opportunities for gainful employment and made them more financially independent in relation to men. On the other hand, men have rather been released from part of the responsibility that previously rested on them as family breadwinner, for example, through the introduction of maintenance support. Men have not had to adjust to any noticeable extent to increased gender equality. They have been able to continue placing top priority on working life at the expense of family life.

The options available to both women and men to select a life and lifestyle make it possible to combine work and family life in a way that leaves everyone feeling well. However, so far the choices open to women and men have been limited by the gender order and its associated norms of what is "normal". In a more equitable future, women and men will hopefully share more equally responsibility for children, on the understanding that both would be expected to interrupt their paid employment in equal measure. Such a development would be made easier if we had a more flexible labour market that gave women and men a better chance of combining work with private life. The risk of employers discriminating women in the labour market would be less if it was considered normal for both women and men to work part-time or interrupt their gainful employment during certain phases of life. Then the opportunities for women and men to compete on equal terms would also increase.

A possible but problematical way to reduce long-term sickness absence can be to give the employer greater financial responsibility for the costs of sickness absence. It could lead to a more rigorous selection of applicants to new jobs, that is to say, one selects the applicants who are expected to have good health and low sickness absence. This is likely to have negative consequences for more women than men. Greater employer responsibility for costs also means an increased element of privatization in sickness insurance, which can undermine the aim of social insurance to provide the same insurance for everyone, regardless of the risk of becoming ill and incapable of work.

Men are affected to a greater extent than women by illnesses and pains that can be diagnosed using available medical knowledge since these are medically well-known phenomena. Women's symptoms are to a greater extent unresearched and unexplained. However, developments in medical science mean that new forms of illness can be discovered, diagnosed and treated. Better biomedical knowledge about the causes of symptoms can result in more women receiving an established diagnosis. This may mean that more and more conditions are accepted as a cause of

work incapacity, which in turn means that costs for, among other things, sickness insurance increase. If the connection between a psychologically demanding work environment and its biomedical effects can be established more clearly, it can also mean increased pressure on work injury insurance, especially from women.

To be able to reduce sickness absence and the number of disability pensions, especially among women, it is necessary to prevent health problems – not least those that arise in connection with gainful employment – to a greater extent than is the case today. This must be done at various levels in order to have any effect. It is important to follow sickness absence at the workplace with the aim of identifying and improving bad workplaces. An early intervention in the sickness spell by the health and medical services and the Social Insurance Office is also crucial. But that is not sufficient. In order to prevent women's sickness absence in the long-term, there must be more gender equality. This requires unrelenting efforts on the part of individual women and men as well as of organizations, such as workplaces, to create equal opportunities for women and men. However, those with power, who are most often men, will not relinquish it voluntarily. Therefore, it is important that women do not accept their subordinate position but themselves take an active responsibility for driving the development towards increased gender equality. This is necessary even if there is sometimes a price to pay for challenging the norms of how women and men ought to act.

Over the last few decades, new generations of women and men in Sweden have grown up in generally favourable circumstances. Therefore, they may be said to claim more of what life has to offer and probably to react faster and more strongly to less favourable conditions in everyday life, for example, at work, than the generations who were young in the 1960s and 1970s. The fact that young women and men are sicklisted to a greater extent than previously could be interpreted as a sign that young people feel their working conditions per se are unreasonable or impossible to combine with a functioning private and family life. If the gaps in gender equality are allowed to remain and the psychological demands of working life continue to increase, it is probable that such sickness absence becomes even more common in the future.

The children and young people who grew up in the 1960s and 1970s saw by observing their mothers that it was quite possible to combine family life and gainful employment. The generations that grew up in the 1960s and 1970s have higher demands and ambitions for their professional life, while at the same time the demands of working life have increased significantly, for example, the demand for higher education. Their children in turn often have to witness their parents largely ab-

sorbed in their work. The children of today also have to witness how their mothers especially experience a strong conflict between their professional careers and responsibility for home and children and how the conflict can be so trying that it sometimes leads to sickness absence. Just how children and young people interpret such signals from adults is naturally hard to know. Children and young people can possibly get the idea that sick leave is a good way to solve these kinds of conflict, which would be a matter of serious concern for sickness insurance. Another hypothesis is that both girls and boys, but especially girls, might get the impression that it is not worth mothers having a proper job. Such an attitude would have a devastating effect on future gender equality in society.

## The dilemma of gender equality

From an international perspective, Sweden has made great progress in the field of gender equality. Over the last few decades, women in Sweden have increasingly fought for a status equal to that of men. In their struggle, women have defied the existing norm system relating to their life, possibilities and limitations. By contrast, men have not to any great extent defied the corresponding norm system for men, but have retained a position of authority in relation to women, both at home and at work. Therefore, the life conditions for women and men still differ significantly. The difference in life conditions and the lack of gender equality seem to have had negative consequences in the form of a high level of sickness absence and disability pensions for women. One might thus be tempted to think that a return to a more traditional division of labour between women and men would be preferable. However, such a retreat is neither desirable nor possible. Instead, the work of promoting gender equality both in working life and in family life should be intensified.

### Obstacles to gender equality

What obstacles lie in the way of increased gender equality? The negotiating position of the woman is often weak in a pair relationship due to her having a significantly lower salary than the man. Being in such a subordinate position, it is difficult for her to demand the man take greater responsibility for the children and housework, for example, by taking extended parental leave or working part-time to give her a chance to concentrate on her job. This would mean the family losing significant income. Most women – and men – who find themselves in this situation, consider it to be a rational solution that the man works at least full-time while the woman assumes major responsibility for children and house-

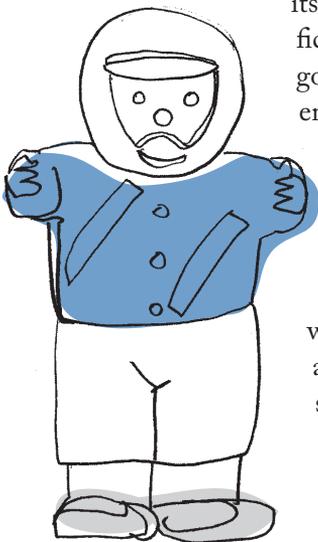
work. Family economic considerations are said – by both women and men – to weigh heavily.

Higher salary is a prerequisite for women gaining greater power over their own lives, becoming financially independent from their partners and achieving a better negotiating position or position of power in the family. However, there are structural obstacles in the way. Many women have been forced to watch their male colleagues succeed better in individual salary negotiations with the employer. Large women collectives, such as municipal employees, have taken strong union action to fight for higher salaries, but have failed to achieve any significant result.

Men's work is worth more than women's work according to the norm system that both women and men live their lives by. For example, an industrial worker earns considerably more than his wife who works with health care. Newly qualified academics see the same phenomenon in those areas where women and men have the same level of education and the same work tasks. For example, female masters of engineering receive a much lower starting salary (SEK 2,000 less per month) than their male counterparts. One explanation may be that employers view younger women as high-risk labour. They calculate that women will be absent from work to a greater extent than men, partly in connection with having a baby, partly because statistically women's sickness absence is greater than men's. So why should employers pay as much salary to women as to men?

The norms also mean that the improvements to work environment that have been made are mainly in male-dominated environments and areas of activity because they are driven by the demand for profits. Work environment improvements together with efficiency-raising and productivity-raising measures often go hand in hand in profit-driven ventures. In the work environment of many women, such as within medical and health care, incentives for improvements are often lacking, which contributes to higher sickness absence among women.

That couples divide up areas of responsibility in the traditional manner does not promote equality between women and men. The way in which individual women and men in pair relationships choose to solve the division of labour between them is often characterized by short-term thinking. In the long term, the woman loses out by this, not only because the division of responsibility in the family easily sets in a permanent mould when the children are small, but also because her lifetime



income and pension will be smaller. By sacrificing her own professional development and earnings prospects, the woman also risks ending up in a difficult financial situation in the event of divorce, her partner's death or his long-term unemployment or sickness absence. But the family lives in the here and now and tries to get everyday life to function in the way that is best for everyone. The short-term prospect easily gains the upper hand.

Meanwhile, many women lack financial incentives to invest in gainful employment. Their income is only marginally reduced when they take parental leave or are on sick leave while the cost for men is higher in absolute terms. Moreover, society's norms can make it easier for women than men to be absent from an unsatisfying job which in any case offers little financial reward or chance of development. Since women are expected to be absent from work more often than men, many employers do not try very hard to get women to return to the workplace. Thus, current norms and attitudes obstruct gender equality and, in addition, contribute to higher sickness absence among women than men.

Highly educated women both wish to and can be seen as the pioneers of real equality, at least in the labour market, through their attempt to compete in the labour market on the same terms as men. One reason why women seldom reach equally high positions in organizations as men may be the lack of gender equality in family life that makes it impossible for them to compete for higher positions on equal terms with men. Another reason is the fact that preconceived notions about female and male qualities cause women to be systematically discriminated against in working life so that they are never given the same opportunities as men.

### **Lack of gender equality has its price**

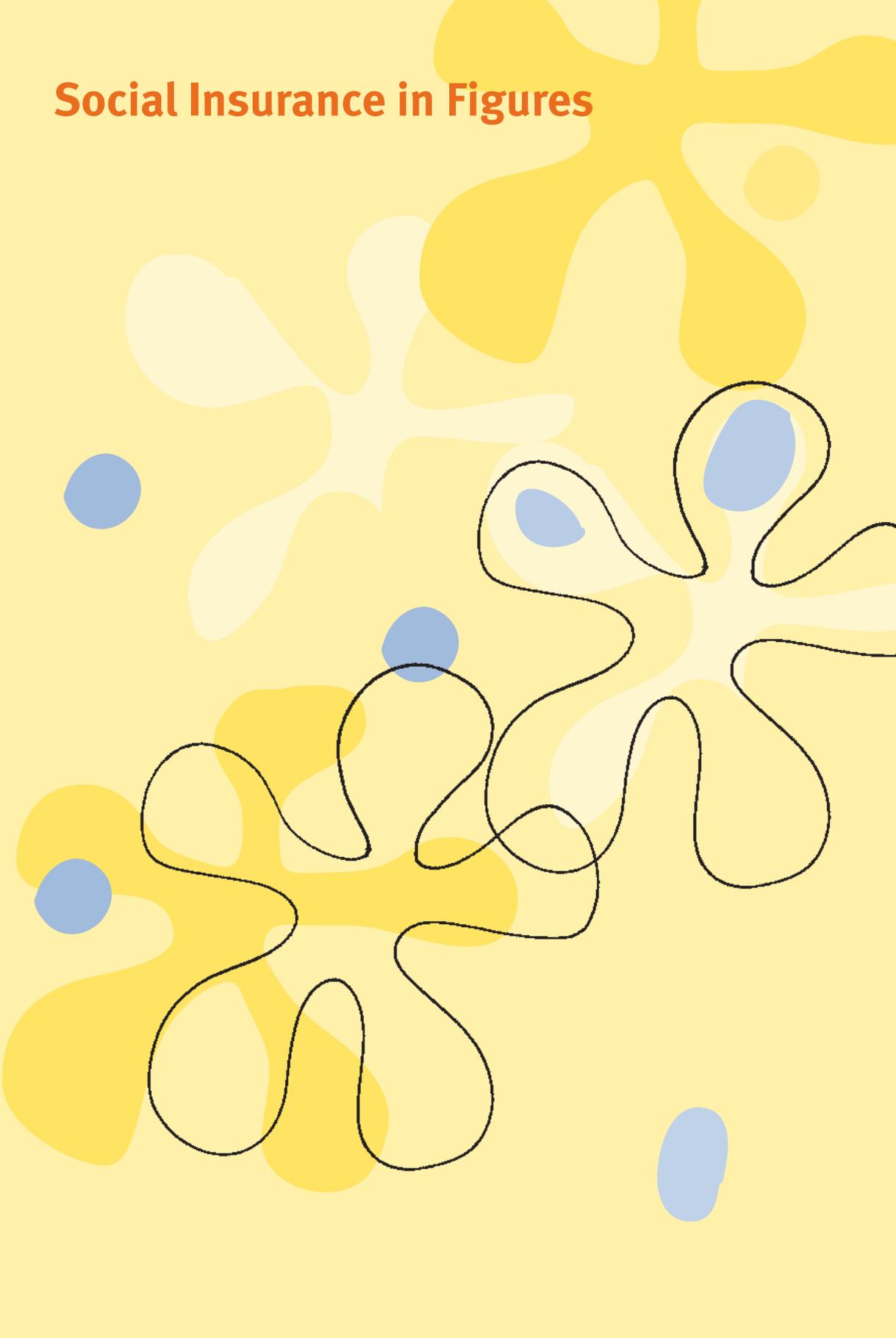
In this theme section, we have shown that many of the differences in women's and men's sickness absence patterns can be understood in terms of the existing gender order. Women have to pay a high price for the lack of gender equality in the family and in working life. The price consists of impaired health, sickness absence and exit from the labour market through disability pension, lower compensation rates for sickness cash benefit, parental cash benefit and other social insurances as well as lower lifetime income and pension. We have also shown that both women and men by their actions contribute to the continued lack of gender equality. Furthermore, we have revealed how employers and other social institutions, whose task is to help the individual when health and work capacity fail, reinforce the norm of women's relative subordination in relation to men.

The dilemma of gender equality is difficult to solve. To achieve real equality between women and men and change the power asymmetry in pair relationships, it is necessary – but not sufficient – for women to have gainful employment and for men to spend more time caring for children and relatives and doing domestic work. Meanwhile, other changes are necessary. A prerequisite for achieving such changes is that women and men recognize, and also modify, the subtle patterns that shape the relationships in which they live. In this connection, increased awareness of how the gender order affects everyone's actions in various situations is essential.

### **Changes needed at several levels**

To achieve equality between women and men, it is thus necessary to change the structural relationships that exist in organizations and in society as a whole. The male domination in these arenas as well as in family life must be challenged. If the underlying problems that cause sickness absence are allowed to go unseen, the gender order will be reinforced and its negative consequences remain. Individual women and men must therefore assume greater responsibility and act to influence and change impeding structures both at work and in the family. It is a demanding social task that cannot be borne solely by one half of the population, that is to say, women. Men's strengths are required, not least because they have more power than women in many areas and thus more opportunity to make changes. Men should realize that they pay considerable amounts of tax to finance women's health-related absence from working life. That ultimately means less welfare for all, both women and men.

# Social Insurance in Figures



# Social Insurance in Figures

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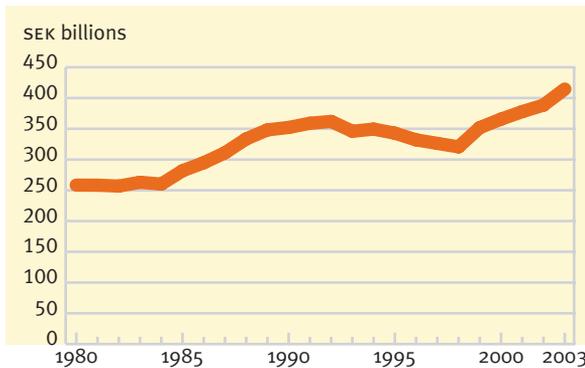
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# The Financial Scope of Social Insurance

## Social insurance expenditure

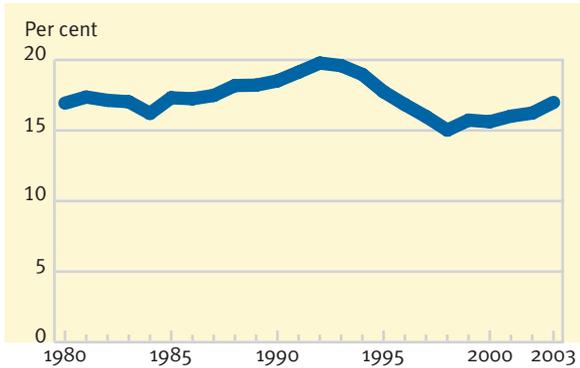
In 2003, social insurance expenditure totalled SEK 414 billion, representing one-sixth of the gross national product (GNP) and just over half of the expenditure below the expenditure ceiling set by the Swedish Parliament. For every SEK 100 spent on private consumption, SEK 25 comes from social insurance. Since 1980, expenditure has risen by SEK 156 billion or by 60 per cent expressed in 2003 prices. However, in relation to GNP the level of expenditure remains the same as in 1980.



**Social insurance expenditure in 2003 prices.** The long-term trend for social insurance expenditure is upward, mainly due to the constantly increasing old-age pension payments.

There was a dramatic increase in expenditure during the second half of the 1980s. Then, from 1993 to 1998, total expenditure in fixed prices declined, primarily due to cost-cutting regulatory changes. These included reduced levels of compensation and the introduction of a sick-pay period and a qualifying day in sickness insurance. Greatly increased expenditure from 1999 onwards was mainly due to a sharp rise in the cost of sickness insurance and ATP (supplementary pension). In 1999, a number of major changes were made to the social insurance system, including the introduction of national old-age pension contributions. Many of the insurance schemes, such as sickness cash benefit and

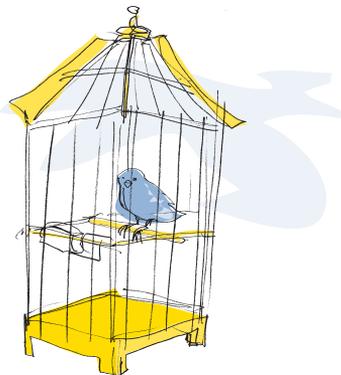
parental cash benefit, rank as pension-qualifying income. In addition, care of young children qualifies for pension rights. The state pays old-age pension contributions corresponding to pension rights, amounting to almost SEK 20 billion for social insurance in 2003.



**Social insurance expenditure in relation to GNP.** In relation to GNP, expenditure is more cyclical in its development, lacking long-term ups and downs.

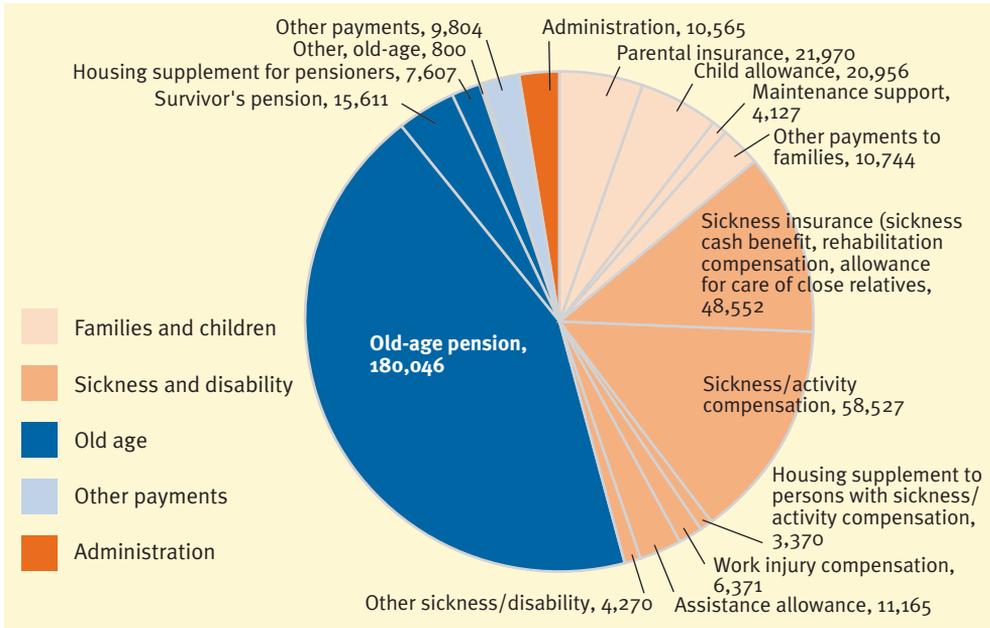
Social insurance payments play a significant role in the national economy. In 2003, they equaled 17 per cent of GNP, which is roughly the same level as that found during the greater part of the 1980s. After rising in a virtually unbroken curve, total social insurance payments reached a peak in 1992, equaling almost 20 per cent of GNP. During the rest of the 1990s, social insurance expenditure shrank even faster in relation to GNP than its value expressed in fixed prices.

Viewing social insurance expenditure in relation to GNP in a longer perspective, we see that after the expansive trend of the 1960s and 1970s it has been more cyclical in character since the start of the 1980s.



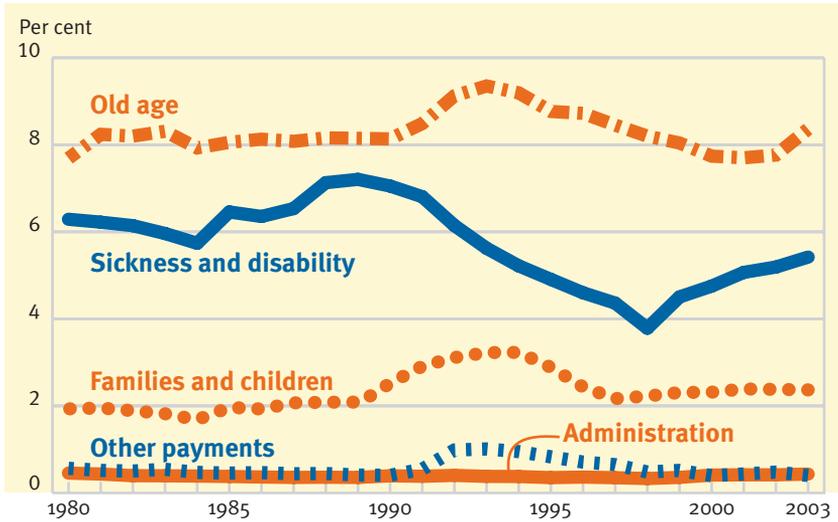
Type of insurance/benefit	2001	2002	2003
<b>Financial security for families and children</b>			
Parental insurance	18,372	20,042	21,970
Child allowance	21,108	21,018	20,956
Housing allowance for families with children and for young people	3,994	3,717	3,595
Care allowance for disabled children	2,053	2,110	2,232
Maintenance support	4,380	4,298	4,127
Child pension, etc	951	977	1,045
Pension right for childcare years	3,276	3,669	3,831
Adoption allowance	33	39	41
<b>Subtotal</b>	<b>54,167</b>	<b>55,870</b>	<b>57,797</b>
<b>Financial security in case of sickness and disability</b>			
Sickness insurance	42,810	48,395	48,552
Medical care benefits, etc	2,198	1,969	2,829
Disability pension, sickness/activity compensation	50,167	49,917	58,527
Housing supplement for disability pensioners	2,912	3,148	3,370
Disability allowance	1,060	1,177	1,200
Work injury compensation	7,246	7,273	6,371
Car allowance	226	212	215
Assistance allowance	8,238	9,767	11,165
Other benefits	18	22	27
<b>Subtotal</b>	<b>114,875</b>	<b>121,880</b>	<b>132,255</b>
<b>Financial security in old age, etc</b>			
Old-age pension	153,680	161,229	180,046
Survivor's pension	13,056	13,444	15,611
Housing supplement for pensioners	7,495	7,366	7,607
Maintenance support for the elderly	.	.	634
Part-time pension pension	260	182	104
Other pensions	72	65	61
<b>Subtotal</b>	<b>174,563</b>	<b>182,286</b>	<b>204,064</b>
<b>Other payments</b>			
Activity support	9,759	11,093	9,684
Daily cash benefit to conscripts, etc	7	5	5
Family allowance to conscripts	73	72	78
Other	48	40	37
<b>Subtotal</b>	<b>9,887</b>	<b>11,210</b>	<b>9,804</b>
<b>Administration</b>			
	9,424	9,761	10,565
<b>Total</b>	<b>362,916</b>	<b>381,007</b>	<b>414,485</b>

**Social insurance expenditure from 2001 to 2003 in SEK million**, including national old-age pension contributions.



**Breakdown of expenditure for 2003 in SEK million.** Half of social insurance expenditure (49 per cent or SEK 204 billion) went to old-age pensioners and survivors. Just under one-third (32 per cent or SEK 132 billion) went to the sick and disabled. Support for families with

children amounted to 14 per cent (SEK 58 billion). In addition there were various other benefits, primarily within the labour market area (SEK 10 billion). The remainder comprised administrative costs (SEK 10 billion).



**Payments from the main types of social insurance as a proportion of GNP.**

Expenditure in the area of financial security in old age stands for a relatively stable share of GNP and for approximately half of all social insurance expenditure. Expenditure in the area of financial security in case of sickness and disability has shown considerably more variation. After a rapid increase in expenditure for both sick leave and work injury in the second half of the 1980s, expenditure fell dramatically from 7.2 per cent of GNP in 1989 to 3.8 per cent in 1998. The drop was the combined result of fewer sick leaves, the introduction of a sick-pay period, the reduction of compensation levels and the transfer of responsibility for medicine costs to the county councils. Since 1998, expenditure as a share of GNP has risen due to increasing sickness absence. The development of expenditure in the area of financial security for families with children primarily reflects the large cohorts of children at the end of the 1980s and start of the 1990s.



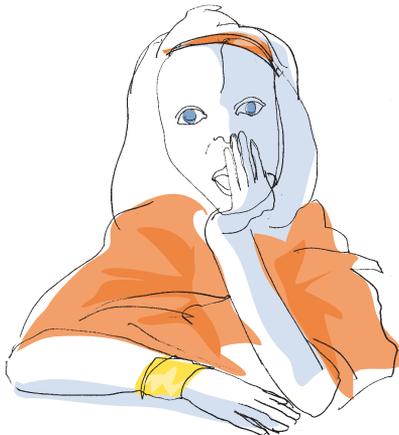
## How social insurance is financed

Social insurance benefits are financed primarily through social insurance contributions from employers and self-employed people, general pension contributions, national old-age pension contributions, tax revenue and interest earned on funds.

Certain insurance benefits are financed entirely out of tax revenue. These include child allowance, housing allowance and some other allowances for families with children, certain benefits for disabled people and housing supplement for pensioners and people receiving sickness or activity compensation. Expenditure for maintenance support not covered by payments from parents liable for maintenance is paid out of taxes. Assistance allowance is partly financed by the municipalities.

Five types of insurance are financed wholly or in part through general social insurance contributions. These are parental insurance, sickness insurance, work injury insurance, old-age pension and survivor's pension. The proportion to be covered by contributions varies according to insurance category and has changed over time.

The link between incoming contributions and financing of the benefits they are intended for is relatively tenuous. With the exception of old-age pension, contributions are not transferred to a specific fund but go instead to the national budget, from which social insurance benefits are paid out. Since contributions are intended by statute to finance particular benefits, in this section we report contributions and benefits side by side as in a more autonomous financial system.



Type of insurance	Income, SEK million				Expenditure, SEK million			Surplus/ deficit
	Charges	Statu- tory govt. funding	Other	Total	Pay- ments	Admini- stration	Total	
Parental insurance	22,143	168	–	22,311	21,551	896	22,447	–136
Child allowance	–	21,057	–	21,057	20,956	101	21,057	–
Housing allowance to families with children, etc	–	3,960	–	3,960	3,595	365	3,960	–
Care allowance for disabled children	–	2,380	–	2,380	2,232	148	2,380	–
Maintenance support	–	2,551	1,979	4,530	4,127	403	4,530	–
Pension right for childcare years	–	3,831	–	3,831	3,831	..	3,831	–
Sickness insurance <sup>1</sup>	108,278	2,958	–	111,236	107,512	3,724	111,236	9,695 <sup>4</sup>
Health care benefits	–	3,058	–	3,058	2,829	230	3,058	–
Disability allowance	–	1,287	–	1,287	1,200	87	1,287	–
Activity support	9,684	183	–	9,867	9,684	183	9,867	–
Work injuries	7,665	196	–	7,861	6,371	394	6,765	1,096
Car allowance	–	252	–	252	215	37	252	–
Assistance allowance	–	8,808	2,477	11,285	11,165	120	11,285	–
Old-age pension								
Via national pension fund (AP Fund)	165,107	–	82,058	247,165	155,410	2,359	157,769	89,396
Via national budget <sup>2</sup>	12,515	12,241	–	24,756	24,643	130	24,774	–
Premium pension scheme	20,267	–	–	20,267	11	285	296	..
Survivor's pensions	17,115	1,081	–	18,196	16,656	74	16,730	1,498
Housing suppl. (BTP)	–	11,381	–	11,381	10,977	403	11,381	–
Maintenance support for the elderly	–	642	–	642	634	8	642	–
Part-time pension	–	106	–	106	104	2	106	0
Other benefits	41	163	61	266	216	35	251	–
Non-apportioned administration <sup>3</sup>	–	580	–	580	–	580	580	–
<b>Total in 2003</b>	<b>362,815</b>	<b>76,884</b>	<b>86,575</b>	<b>526,274</b>	<b>403,919</b>	<b>10,565</b>	<b>414,485</b>	<b>..</b>

<sup>1</sup> Including sickness and activity compensation, pregnancy cash benefit and allowance for care of close relatives.

<sup>2</sup> Including social insurance offices' administrative costs.

<sup>3</sup> Mainly social insurance offices' costs due to changes in the pension debt.

<sup>4</sup> Difference between sickness insurance contributions paid and expenditure they are intended by law to finance.

**Social insurance income and expenditure in 2003.** Social insurance is primarily financed through social insurance contributions, general pension contributions, national old-age pension contributions, tax revenue and interest earned on funds.

According to the statutory financing regulations, costs should be covered in part by social insurance contributions and general pension contributions. However, the actual proportion for any one year is only approximate. The law does not specify for each insurance scheme the extent to which it is to be financed by contributions.

In 2003, income from social insurance contributions, national old-age pension contributions, general pension contributions and exchange rate differences, interest, etc, totalled SEK 445 billion. State funds added SEK 77 billion. In total, this meant that income exceeded expenditure by just over SEK 110 billion. In 2002, income was less than expenditure by approximately SEK 35 billion.

The part which according to statutory regulations should be financed by tax revenue was just under 19 per cent of expenditure in 2003. Payments from municipalities, parents liable for maintenance, etc, made up one per cent.

Positive developments on the stock exchange in 2003 meant that exchange rate differences and interest, etc, from the First National Pension Fund (AP-fonden) gave a plus of SEK 82 billion.

Of the insurances financed by contributions, sickness and work injury insurance together with survivor's pensions produced a combined surplus of SEK 12 billion in 2003. After a number of years when sickness insurance contributions failed to cover expenditure, sickness insurance produced a surplus of almost SEK 10 billion in 2003. Work injury insurance has produced a surplus over a number of years, gradually wiping out previous deficits. In 2003, the surplus was SEK 1 billion. The part of old-age pension financed via the AP Fund gave a surplus of SEK 89 billion.

Since income in the premium pension scheme – just over SEK 20 billion – is made up of reserve funds, it is impossible to say exactly what share of total expenditure for old-age pensions was covered by contributions.



Premium rates in per cent	1999	2000	2001	2002	2003	2004
Old-age pension <sup>1</sup>	6.4	10.21	10.21	10.21	10.21	10.21
Survivor's pension <sup>1</sup>	1.7	1.7	1.7	1.7	1.7	1.7
Sickness insurance						
– Employer's contribution	7.5	8.5	8.8	8.8	11.08	11.08
– Self-employed	8.23	9.23	9.53	9.53	11.81	11.81
Parental insurance <sup>1</sup>	2.2	2.2	2.2	2.2	2.2	2.2
Work injury <sup>1</sup>	1.38	1.38	1.38	1.38	0.68	0.68
Labour market contribution						
– Employer's contribution	5.84	5.84	5.84	5.84	3.7	3.7
– Self-employed	3.3	3.3	3.3	3.3	1.16	1.16
General salary contribution <sup>1</sup>	8.04	3.09	2.69	2.69	3.25	3.13
Total employer's contrib.	33.06	32.92	32.82	32.82	32.82	32.70
Total general contribution	31.25	31.11	31.01	31.01	31.01	30.89

<sup>1</sup> Same premium rate for employers and self-employed.

### Statutory contributions to social insurance as a percentage of chargeable income.

Social insurance contributions are based on the salaries of employees and self-employed persons. They are paid by the employer and the self-employed person respectively.

The general pension contribution is paid by employed persons. It is based on earned income and other income such as sickness cash benefit, parental cash benefit, unemployment insurance, etc, up to a total of 8.07 times the income base amount during one year.

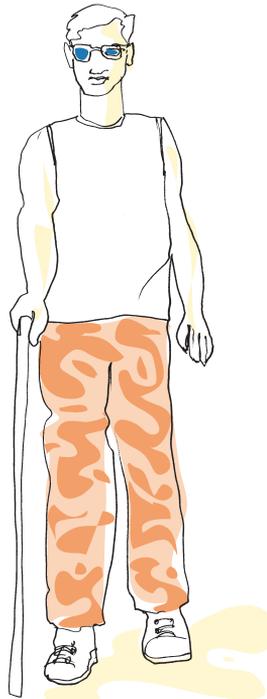
Between 1999 and 2001, contributions were changed frequently. In 1999, contributions for basic pension and part-time pension were dropped and contributions for parental insurance and survivor's pension were introduced. Contributions for sickness insurance and old-age pension were adjusted. Cuts and rises in contribution rates have been simultaneously compensated by corresponding rises and cuts in the general salary contribution so that the overall premium rate has been kept relatively constant.

The share of social insurance financed by social insurance contributions has varied considerably.

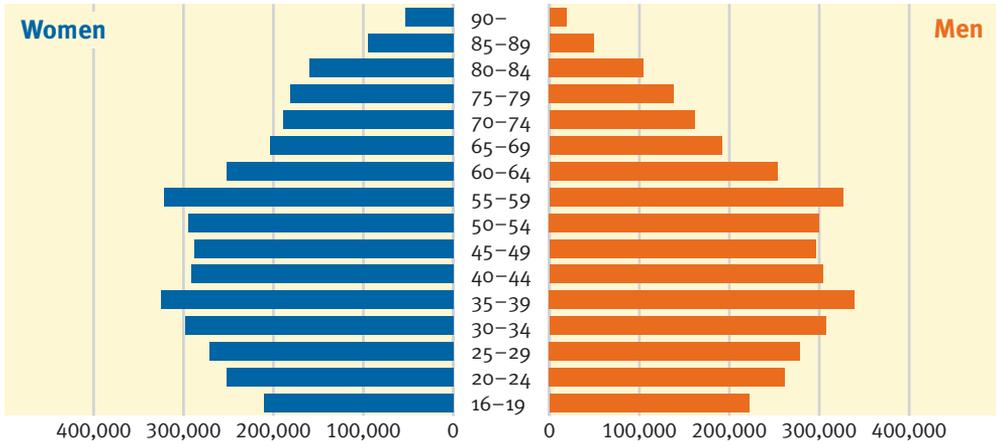
Year	Social insurance	General contributions paid <sup>1</sup>	Paid contributions as contribution a proportion of total social insurance expenditure, in per cent <sup>1</sup>
1985	103,936		67
1990	193,512		75
1995	166,672	28,385	65
1996	168,883	37,959	71
1997	165,956	47,261	74
1998	154,996	52,025	72
1999	152,564 <sup>2</sup>	59,610	67 <sup>2</sup>
2000	209,151 <sup>2</sup>	63,734	82 <sup>2</sup>
2001	235,039 <sup>2</sup>	65,156	85 <sup>2</sup>
2002	242,165 <sup>2</sup>	67,895	84 <sup>2</sup>
2003	263,086 <sup>2</sup>	69,957	82 <sup>2</sup>

<sup>1</sup> Excluding payments within the labour market sector and compensation to conscripts.  
<sup>2</sup> Excluding the premium pension scheme, including national old-age pension contributions.

**Contributions received in SEK million.** Note that the figures are not wholly comparable over time. This is partly due to the many regulatory changes made, mostly at the end of the 1990s, partly to the fact that periodization of contributions was implemented differently from year to year.



## Registered insured persons



### Registered insured persons in 2003.

Swedish citizens and foreign nationals resident in Sweden are insured under the National Insurance Act (AFL).

All insured persons aged 16 and over and resident in Sweden are regis-

tered at the Social Insurance Office. Persons leaving Sweden are considered as domiciled here provided their stay abroad does not exceed one year.

### Regulations 2003

Age	Women	Men	Women and men
16-19	210,292	222,126	432,418
20-29	523,226	540,229	1,063,455
30-39	623,493	645,961	1,269,454
40-49	579,635	599,412	1,179,047
50-59	615,865	626,347	1,242,212
60-69	456,017	445,205	901,222
70-79	370,972	299,523	670,495
80-89	254,188	153,483	407,671
90-	53,030	18,819	71,849
<b>Total</b>	<b>3,686,718</b>	<b>3,551,105</b>	<b>7,237,823</b>

### Registered insured persons in 2003.

Sickness cash benefit insurance covers all registered insured persons whose estimated annual earned income is least 24 per cent of the base amount. In 2003, this was the equiva-

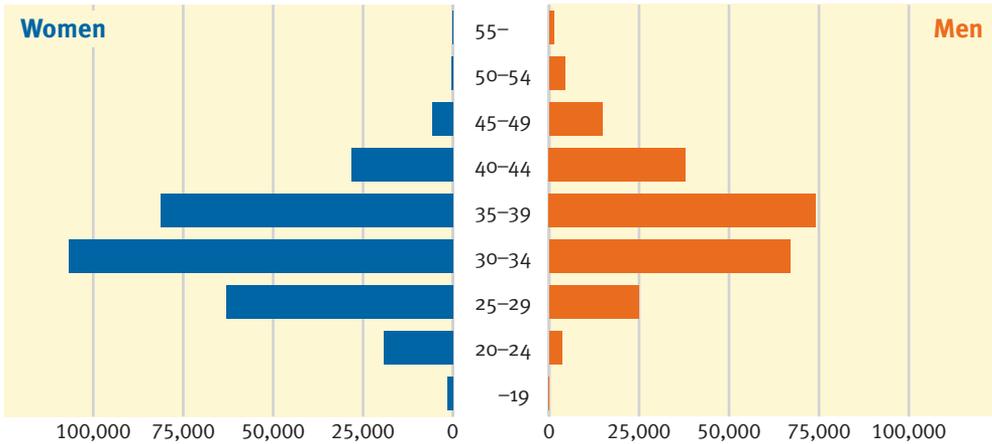
lent of SEK 9,300. Income entitling to sickness cash benefit is at most 7.5 times the base amount per annum (SEK 289,500 in 2003).

### Regulations 2003

# Financial security for families and children

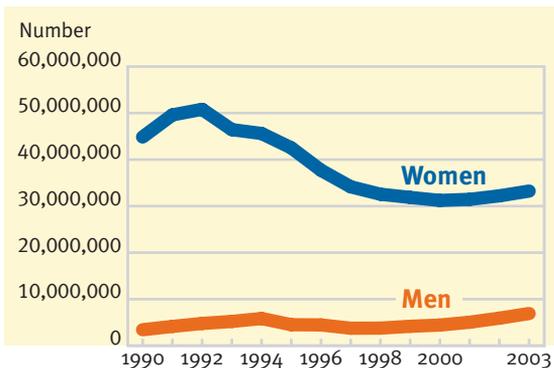
## Parental cash benefit for the birth of a child

Parental insurance is designed to help both parents combine parenthood and working life.



**Persons with parental cash benefit in 2003.** Women have consistently used parental insurance to a greater extent than men. 535,000 persons received parental cash benefit in 2003. Women made up 57 per cent, and men 43 per

cent. 38 per cent of women and 58 per cent of men were aged over 35. In age groups over 40, more men than women received parental cash benefit, due to older men having children with younger women.



**Number of days with parental cash benefit.** Of the 40 million days with parental cash benefit claimed in 2003, women accounted for 83 per cent. The figure clearly shows the impact of the baby boom in the years around 1990. The number of days claimed peaked in 1992 and subsequently declined over succeeding years as the birth rate fell. However, a slight rise has been noticeable in recent years. The number of days claimed for men has increased more rapidly than for women. Thus, men have increased their share of days claimed from 10 per cent in 1997 to 17 per cent in 2003.

**Regu-  
lations  
2003**

Parental cash benefit for the birth or adoption of a child is available for a total of 480 days per child. For the first 390 days, the benefit is related to the parents' loss of income, though the minimum amount payable is SEK 120 per day. For the remaining 90 days, everyone receives the minimum amount of SEK 60 a day.

If the parents have joint custody of the child, each of them is entitled to half the total number of parental cash benefit days. However, one of the parents may transfer the right to parental

cash benefit to the other parent, with the exception of the 60 days known as the "father/mother months".

The benefit is payable for different portions of a day – whole, three-quarters, half, quarter or eighth. Parental cash benefit can normally be claimed up to the child's eighth birthday or the completion of the first year of school. The level of compensation is 80 per cent of the income entitling to sickness cash benefit. In 2003, the maximum parental cash benefit was SEK 635 per day.



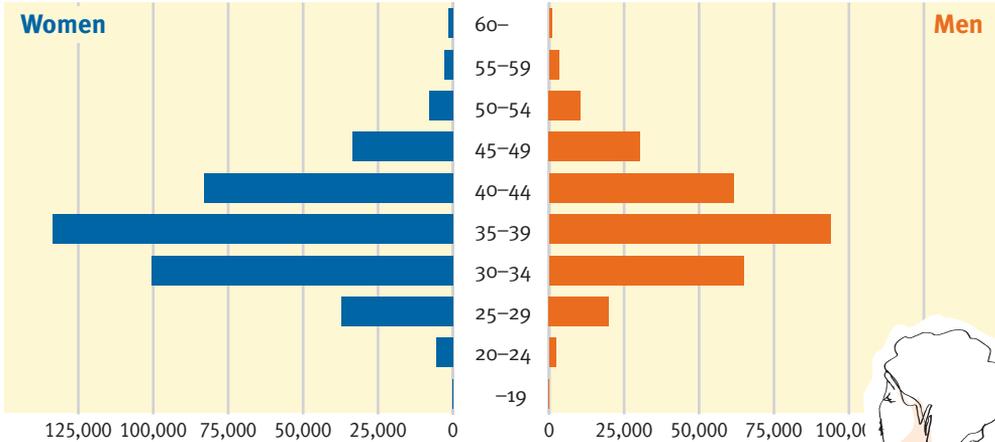
Age	Number of recipients		Average number of days		Average amount, over the year, SEK	
	Women	Men	Women	Men	Women	Men
-19	1,672	56	172	60	25,558	10,227
20-24	19,151	3,515	158	42	42,769	16,687
25-29	63,055	24,869	134	36	48,740	16,232
30-34	106,897	67,041	112	32	45,691	15,316
35-39	81,121	74,145	90	29	35,977	13,381
40-44	28,185	37,936	70	27	25,438	12,095
45-49	5,696	14,851	45	26	13,889	11,108
50-54	471	4,484	40	28	11,673	11,287
55-	19	1,390	72	29	19,924	14,875
<b>Total</b>	<b>306,267</b>	<b>228,623</b>	<b>109</b>	<b>30</b>	<b>40,944</b>	<b>13,896</b>

**Parental cash benefit for the birth of a child in 2003.** Out of a total of SEK 15.7 billion paid out in parental cash benefit

for the birth of a child in 2003, 80 per cent went to women and 20 per cent to men.

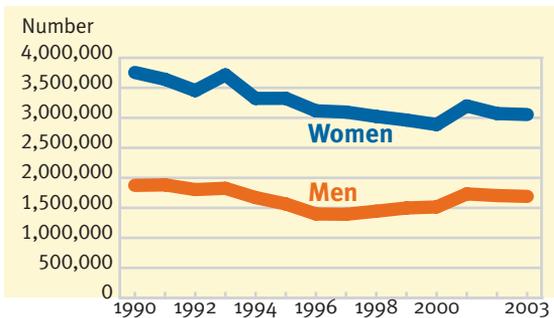
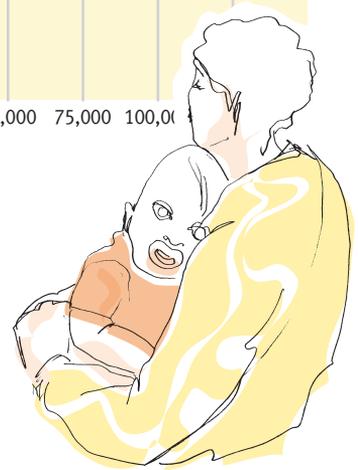
## Temporary parental cash benefit

Temporary parental cash benefit enables parents to stay home from work when their child is sick.



### Persons with temporary parental cash benefit for the care of a child in 2003.

In 2003, 693,000 persons received temporary parental cash benefit. The majority were women, accounting for 59 per cent. Men made up 41 per cent, which is less than the proportion of men who claimed parental cash benefit for the birth of a child. Distribution according to age and sex for both types of benefit is similar.



### Days with temporary parental cash benefit for the care of a child.

Out of a total of 4.7 million days paid in 2003, women received 64 per cent. Payments made to men declined for several years in succession but in recent years have risen slightly. Despite an increase in the number of children during the 1990s, the number of days for which payment was made for the care of sick children decreased for the major part of this period. The rate of compensation was twice reduced during the reported period but was raised in 1998.

Regulations  
2003

A parent is entitled to temporary parental cash benefit for the care of a sick child. This applies to children under 12 and in certain cases up to the age of 16. It applies if a parent has to give up paid employment because the child is sick or infected, or the child's normal custodian is sick or infected, or a visit must be paid to the community preventive health service, etc. Normally, compensation is paid for 60 days per child and year. A further 60 days may be claimed if the child is sick or a visit must be paid to the community preventive health service. The right to temporary parental cash benefit may in certain circumstances be transferred to another person who stays at home from work to care for the child in place of the parent.

Parents of children covered by the Swedish Act on Support and Service for Certain Functionally Disabled Persons (LSS) may receive compensation for the care of a sick child aged between 16 and 21 (sometimes older).

In addition, the parent of a child who is under 16 and covered by LSS is also entitled to ten so-called contact days per child and year. These days may be used for parental training courses, settling the child in or visiting the child during pre-school or after-school recreational activities.

The benefit is payable for different portions of a day – whole, three-quarters, half, quarter or eighth. The level of compensation is 80 per cent of the income entitling to sickness cash benefit.

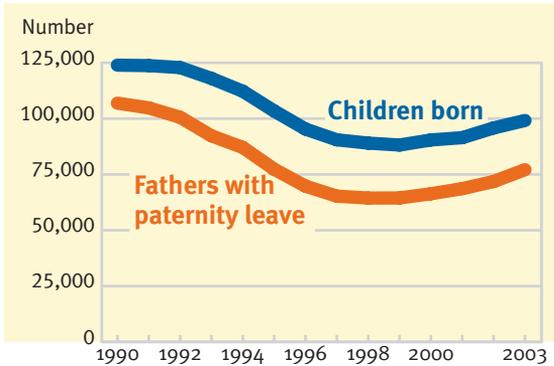
Age	Number of recipients		Average number of days		Average amount, over the year, SEK	
	Women	Men	Women	Men	Women	Men
-19	39	13	10	5	3,734	3,447
20-24	5,567	2,195	9	8	4,783	5,202
25-29	37,127	19,935	9	7	5,311	5,414
30-34	100,626	64,792	9	7	5,302	5,030
35-39	133,392	93,710	8	6	4,922	4,561
40-44	82,955	61,617	7	5	4,318	4,125
45-49	33,425	30,363	6	5	3,807	3,740
50-54	7,926	10,475	5	5	3,350	3,529
55-59	2,925	3,251	3	5	2,156	3,433
60-	1,510	806	3	4	1,816	3,025
<b>Total</b>	<b>405,492</b>	<b>287,157</b>	<b>8</b>	<b>6</b>	<b>4,772</b>	<b>4,496</b>

**Temporary parental cash benefit for the care of a child in 2003.** In 2003, out of a total of approximately SEK 3.2 billion paid out in temporary parental

cash benefit for the care of a child, 60 per cent went to women and 40 per cent to men.

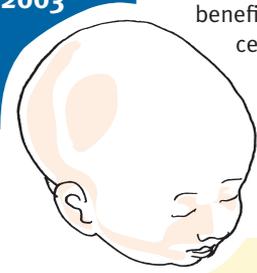
## Father days

Father days enable the father to be present at the birth of his child, manage the home and take care of children when a child is born.



**Father days.** The number of children born and the number of fathers claiming father days reached a peak in 1990, when approximately 86 per cent of fathers claimed father days. During the greater part of the 1990s, the number of father days declined as fewer children were born and the proportion of new fathers taking advantage of their 10 allowed days dropped to 72 per cent. In 2001, the trend was reversed once more. In 2003, almost 78 per cent of fathers claimed father days.

### Regulations 2003



In connection with the birth or adoption of a child, the father has the right to temporary parental cash benefit for 10 days per child. In certain circumstances, these days may be claimed by someone other than the

father. They must be claimed within 60 days after the arrival of the child in the home or after the adoptive parent has assumed custody of the child. The compensation level is 80 per cent of the income entitling to sickness cash benefit.

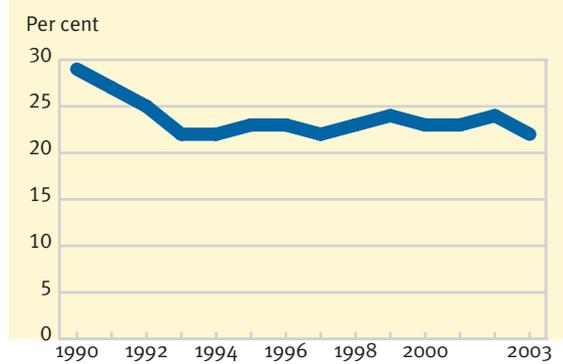
Age	Number of recipients		Average number of days		Average amount, over the year, SEK	
	Women	Men	Women	Men	Women	Men
-19	-	38	-	8.7	-	4,479
20-24	8	2,771	7.5	9.6	3,163	6,480
25-29	23	14,968	7.8	9.7	5,427	7,265
30-34	56	28,885	5.9	9.7	4,180	7,672
35-39	80	20,167	6.3	9.7	4,774	7,701
40-44	89	7,011	7.9	9.6	5,792	7,452
45-49	79	2,030	7.5	9.6	5,501	7,253
50-54	76	563	7.2	9.6	5,076	7,188
55-59	54	171	7.1	9.5	5,095	7,032
60-	15	42	8.0	8.4	5,096	6,307
<b>Total</b>	<b>480</b>	<b>76,646</b>	<b>7.1</b>	<b>9.7</b>	<b>5,112</b>	<b>7,519</b>

**Father days in 2003.** During 2003, approximately SEK 580 million was paid out in father days. Just over 2 million of this amount was paid to women.

## Pregnancy cash benefit

Pregnancy cash benefit enables pregnant women who are unable to continue working to take time off to rest.

**Number of women with pregnancy cash benefit.** During the later stages of pregnancy, most women receive social insurance compensation in the form of pregnancy cash benefit, sickness cash benefit or parental cash benefit. The proportion of women receiving pregnancy cash benefit increased throughout most of the 1980s, peaking at almost 30 per cent in 1990. After a noticeable decline in the early 1990s, the proportion has remained fairly constant at around 23–24 per cent.



A pregnant woman may only receive pregnancy cash benefit if her employer is unable to offer her alternative employment more suitable to her condition during the final stages of pregnancy. She may in that case receive pregnancy cash benefit for a maximum of 50 days during the last two months of pregnancy. If the Working Environment Act stipulates a

ban on a certain kind of work during pregnancy, a woman is entitled to pregnancy cash benefit for each day the ban is in force.

The compensation level is 80 per cent of the income entitling to sickness cash benefit. In 2003, the maximum pregnancy cash benefit was SEK 635 per day.

### Regulations 2003

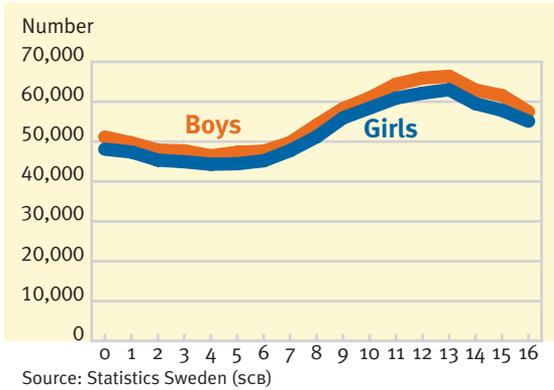
Age	Number of recipients	Average number of days	Average amount over the year, SEK
<19	41	38	11,470
20–24	2,809	39	15,400
25–29	8,110	39	17,020
30–34	7,516	38	17,850
35–39	3,127	38	17,726
40–44	576	37	17,210
45–49	20	39	19,390
<b>Total</b>	<b>22,199</b>	<b>38</b>	<b>17,192</b>



**Pregnancy cash benefit in 2003.** In 2003, SEK 381 million was paid out in pregnancy cash benefit to just over 22,000 women.

## Child allowance

Child allowance is designed to even out financial inequalities between families with and without children and over the life cycle.



**Number of children in 2003.** At the end of 2003, there were 892,000 girls and 939,000 boys in the 0–16 age group. The chart clearly illustrates the effect of the so-called baby boom. The very large number of children born around 1990 had reached the age of twelve or thirteen by 2003. Since the peak year of 1990, the number of births has gradually diminished, but a slight upturn is currently discernible. The number of children born in 2003 (zero years in the figure) was 20 per cent lower than the number born in 1990.

### Regulations 2003

Child allowance includes basic child allowance, extended child allowance and large-family supplement.

All parents have the right to basic child allowance for children domiciled in Sweden, up to the quarter when the child reaches the age of 16. Subsequently the parent may receive so-called extended child allowance for as long as the child attends compulsory school or the equivalent.

A parent who receives basic child allowance, extended child allowance or study grants for three or more children also receives a large-family supplement. Child allowance is tax-exempt.

Child allowance is SEK 950 per child and month. Large-family supplement is SEK 254 per month for the third child, SEK 760 for the fourth child and SEK 950 for the fifth and every additional child.

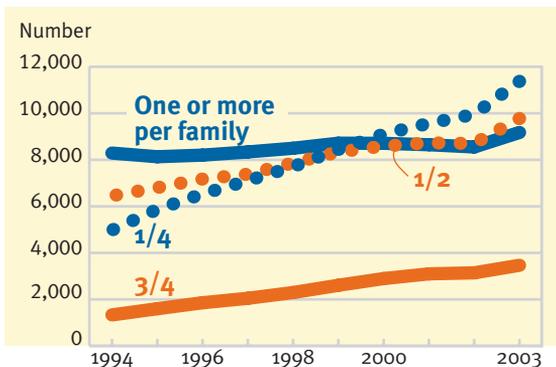
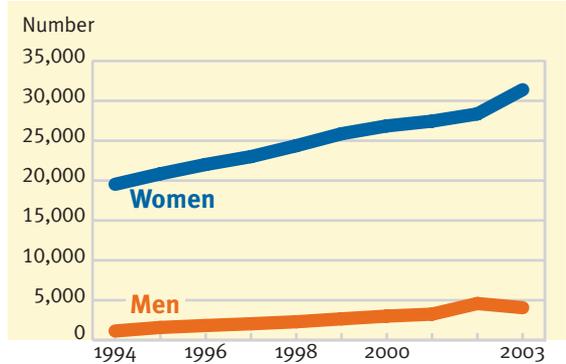
	Monthly sum, SEK			Yearly sum, SEK
	Child allowance	Large-family supplement	Total	
1 barn	950	–	950	11,400
2 barn	1,900	–	1,900	22,800
3 barn	2,850	254	3,104	37,248
4 barn	3,800	1,014	4,814	57,768
5 barn	4,750	1,964	6,714	80,568
For every additional child	950	950	1 900	22 800

**Child allowance amounts in 2003.** Approximately SEK 21 billion was paid in child allowance in 2003.

## Care allowance

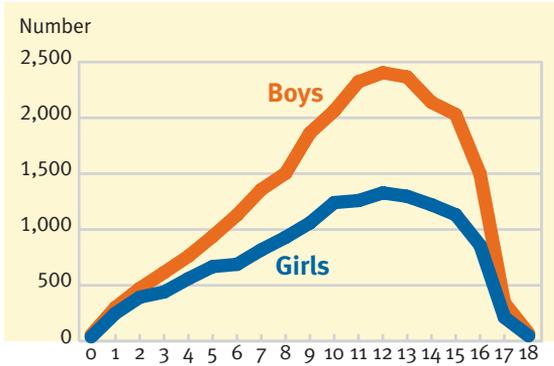
Care allowance helps parents give a sick or functionally disabled child the care, attention and support necessary for it to develop optimally.

**Recipients of care allowance.** The number of parents with care allowance has increased by more than 70 per cent since the mid-1990s. Primarily children with psychological diagnoses account for the increase. Behavioural disorders such as DAMP and ADHD have increasingly motivated claims. From 2003, care allowance may be granted for children up to 19 years old, which has led to a natural increase. The proportion of fathers among recipients is small but has nevertheless risen from just over 5 per cent to almost 12 per cent.



**Care allowance according to level.** In 1988, one-fourth compensation was introduced and in 1992 three-quarters compensation was added. More people could now be granted care allowance

than previously, and the lowest level has become the most common. Psychological diagnoses have increased and there has been a shift from younger to older children.



**Children with care allowances in December 2003.** Among children receiving care allowance in December 2003, girls accounted for approximately 37 per cent and boys 63 per cent. Boys dominated in all age groups. The proportion of girls was highest in the lower age groups, accounting for 40–45 per cent up to the age of five.

**Regulations 2003**

Parents may receive care allowance for their child if the child is in need of special supervision or care for a period of at least six months, at most up to and including the month of June in the year the child reaches 19. The need for special supervision or care must be due to illness, learning difficulties or other functional disabilities. The parent may also receive care allowance if the child's sickness or functional disability results in increased expenses (additional costs).

If the parent takes care of several sick or functionally disabled children in the specified age group, the right to care allowance is based on their total need of supervision and care as well as on the extent of the increased expenses.

Care allowance is payable at 100, 75, 50 or 25 per cent of the full benefit rate. Full care allowance is 2.5 times the base amount per annum, which in 2003 amounted to SEK 8,042 per month. Care allowance is taxable and qualifies for pension. However, care allowance for increased expenses is exempt from tax.

Under certain circumstances, compensation for additional costs may be paid on top of the normal amount for full benefit. A care allowance may be granted even if there is only a need of compensation for additional expenses. In such cases, care allowance is 36 or 62.5 per cent of the base amount per annum depending on the size of the additional expenses.

Age	All children		Children in families with care allowance for one child	
	Girls	Boys	Girls	Boys
0–2	682	831	594	714
3–5	1,668	2,315	1,296	1,836
6–8	2,436	3,992	1,830	3,102
9–11	3,559	6,252	2,652	4,871
12–15	4,979	8,939	3,892	7,174
16–19	1,119	1,910	899	1,556
<b>Total</b>	<b>14,476</b>	<b>24,246</b>	<b>11,196</b>	<b>19,260</b>

**Children with care allowance in December 2003.** Just over one fifth of the children were in families receiving care allowance for more than one child.

Approximately 8 per cent of both girls and boys with care allowance were aged 16–19, the age group created by the new rules in 2003.

**Care allowance in December 2003.**

A total of just over sek 2 billion in care allowance was paid out during 2003, of which 90 per cent went to women and 10 per cent to men.



Age	Number of recipients (parents)		Average amount per month, SEK	
	Women	Men	Women	Men
-24	178	4	5,249	5,529
25-29	1,344	65	4,716	4,956
30-34	5,322	382	4,689	4,120
35-39	9,864	965	4,549	3,986
40-44	8,192	1,152	4,589	3,801
45-49	4,576	850	4,573	3,822
60-65	1,567	406	4,605	4,073
55-	352	238	4,608	4,288
<b>Total</b>	<b>31,395</b>	<b>4,062</b>	<b>4,601</b>	<b>3,955</b>

## Child pension and surviving children's allowance

A child is entitled to a child pension and surviving children's allowance if one or both of its parents are deceased.

Children under 18 are entitled to receive a child pension. A child who is studying and is entitled to extended child allowance or a study grant (for basic or high school studies in principle) may continue to receive the pension up to the end of June in the year the child turns 20.

The size of child pension depends

primarily on the parent's income and the number of children in the family. As a supplement to or replacement of child pension, the child can in certain circumstances receive surviving children's allowance. This amounts to 40 per cent of the price base amount for each deceased parent, equivalent to SEK 1,287 per month during 2003.

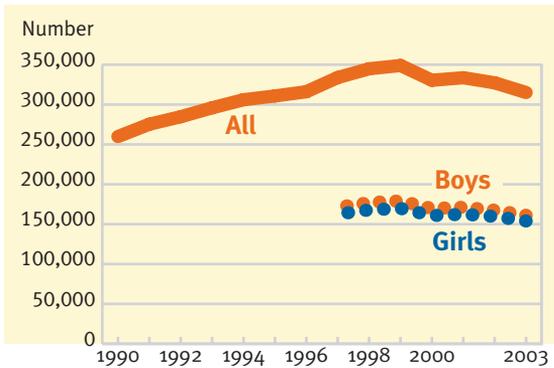
**Regu-  
lations  
2003**

Age	Number of recipients		Average amount per month, SEK	
	Girls	Boys	Girls	Boys
0-4	374	415	2,394	2,376
5-9	2,033	2,065	2,457	2,433
10-14	5,528	5,863	2,578	2,562
15-19	7,403	8,027	2,711	2,721
<b>Total</b>	<b>15,338</b>	<b>16,370</b>	<b>2,622</b>	<b>2,619</b>

**Child pensions in December 2003.** Out of a total of SEK 1 billion paid in child pension and surviving children's allowance in 2003, around 48 per cent went to girls and 52 per cent to boys.

## Maintenance support

Through maintenance support society guarantees that children of separated parents receive a certain amount of maintenance even when parents responsible for paying maintenance default on their obligations.



### Children with maintenance support or maintenance advance.

In December 2003, maintenance support was paid from the social insurance scheme to approximately 315,000 children and young people aged 0–20. This was just under 14 per cent of all children in this age group. The increase in the number of children receiving maintenance support/maintenance advance during the 1990s was due both to an overall increase in the number of children and to a larger proportion of them receiving these benefits. Moreover, extended maintenance support was introduced in 1997. Since 2000, both the numbers and the proportion have diminished.

### Regulations 2003

Parents have a maintenance obligation towards their children until the child turns 18, or longer if the child continues in school. When a child lives permanently with only one of the parents, the other parent must contribute towards the child's upkeep by paying maintenance support. The level of maintenance is determined by agreement or by a court of law, based on the child's needs and the parents' combined financial means.

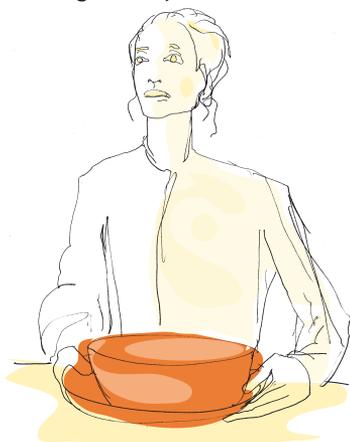
A child is entitled to maintenance support from the Social Insurance Office if

- the parent liable for maintenance support fails to pay or pays less than SEK 1,173 a month
- paternity has not been established
- the child has been adopted by only one parent.

Maximum maintenance support is SEK 1,173 per month and child. Extended maintenance support can be paid for a child pursuing studies which qualify for extended child allowance or a study grant, but no longer than June in the year the child turns 20.

Maintenance support may be granted in the form of full maintenance support or supplementary support. When full maintenance support is paid, the parent liable for maintenance must repay, either in full or in part, the costs borne by society for the maintenance support paid to the other parent. The repayment liability is set at a percentage of the income he/she had in his/her latest tax return.

**Children with maintenance support in December 2003.** In each reported age group, it is almost equally common for girls to receive maintenance support as boys. Numbers are highest for those aged 12–17.



**Maintenance support in December 2003.** In 2003, SEK 4.1 billion was paid in maintenance support, of which 85 per cent went to women and 15 per cent to men.

Age	Number of recipients		Proportion of each age group, per cent	
	Girls	Boys	Girls	Boys
0–2	6,199	6,492	4.4	4.4
3–5	13,120	13,833	9.8	9.8
6–8	20,060	20,864	13.9	13.8
9–11	30,475	31,857	17.4	17.4
12–14	38,529	39,855	20.9	20.4
15–17	35,909	37,384	21.6	21.3
18–20	9,724	10,824	6.4	6.7
<b>Total</b>	<b>154,016</b>	<b>161,109</b>	<b>14.0</b>	<b>13.9</b>

Age	Number of recipients		Average amount, in December, SEK	
	Women	Men	Women	Men
–24*	14,685	10,142	1,126	1,123
25–29	14,032	777	1,575	1,415
30–34	29,758	2,494	1,806	1,558
35–39	47,229	6,264	1,926	1,644
40–44	38,405	6,910	1,801	1,649
45–49	21,758	4,960	1,581	1,582
50–54	8,373	2,447	1,403	1,468
55–59	1,974	977	1,269	1,446
60–	199	428	1,230	1,438
<b>Total</b>	<b>176,413</b>	<b>35,399</b>	<b>1,708</b>	<b>1,456</b>

\* Including recipients of extended maintenance support.

Age	Number of parents liable to pay		Number with debts		Average debt* in December, SEK	
	Women	Men	Women	Men	Women	Men
–24	788	2,634	29	513	4,741	8,070
25–29	2,652	8,067	445	3,368	9,603	15,270
30–34	6,560	18,606	1,723	8,890	14,529	25,741
35–39	11,620	37,388	3,832	18,283	17,615	33,985
40–44	10,231	41,397	4,206	21,634	18,283	36,766
45–49	5,437	34,092	2,786	18,755	17,253	34,220
50–54	2,077	21,067	1,241	12,451	15,589	29,435
55–59	499	10,599	318	6,346	13,653	26,841
60–	61	4,906	47	2,972	11,068	23,641
<b>Total</b>	<b>39,925</b>	<b>178,756</b>	<b>14,627</b>	<b>93,212</b>	<b>16,826</b>	<b>31,649</b>

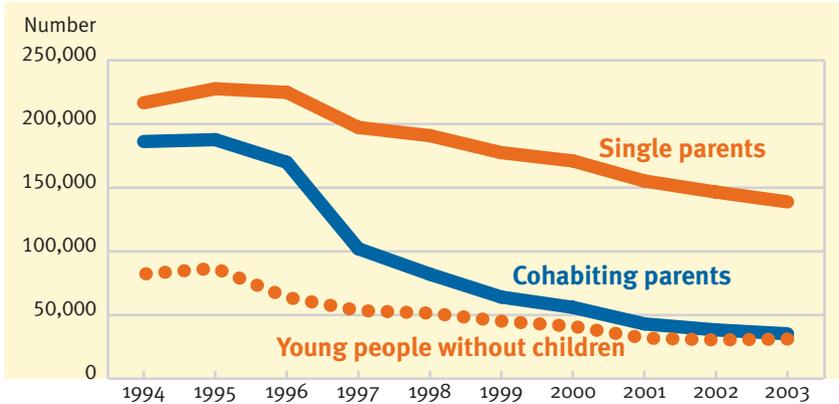
\* The average debt is calculated on the basis of those parents liable for maintenance who have debts.

**Parents liable for maintenance in December 2003.** Of the 219,000 parents liable for maintenance in December 2003, 18 per cent were women and 82 per cent men. 37 per cent of the women were in debt to the Social Insurance

Office as opposed to 52 per cent of the men. Out of the total debt of SEK 3.2 billion at the end of 2003, women accounted for 8 per cent and men 92 per cent.

## Housing allowance

Housing allowance is designed to enable financially weak households to live in good-quality and sufficiently spacious accommodation.



### Households with housing allowance.

The number of households receiving housing allowance has decreased over the past few years as a result of chang-

es in the regulations. The decrease has been most evident among households consisting of two parents and children.

### Regulations 2003

Families with children and young households without children (aged 28 and younger) may receive a housing allowance.

The amount of allowance depends on the composition of the household, cost of accommodation, size of dwelling and size of income.

Those applying for a housing allowance are required to estimate their income for the calendar year or years for which they are applying. On the basis of this information, a preliminary housing allowance is calculated. After notice of final taxation for the year of the allowance, final housing allowance is determined. The decision on final housing allowance for 2003 will be announced in 2005. Households receiving too large a preliminary allowance must repay the difference.

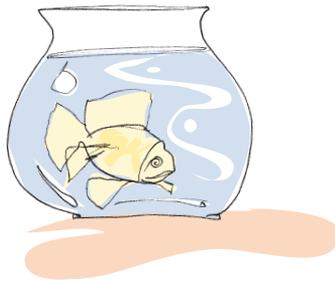
If the difference exceeds SEK 2,500, an additional fee is charged. On the other hand, if a household has received too little preliminary allowance, the difference is made up with interest.

For married or cohabiting couples with children, the housing allowance is means-tested individually. The benefit is reduced if their individual annual income exceeds SEK 58,500.

For a single parent, the housing allowance is reduced if annual income exceeds SEK 117,000.

For young households without children, the allowance is reduced if the annual income of single persons exceeds SEK 41,000 or if the combined income of couples exceeds SEK 58,000.

	Max. housing allowance per month, sek	Max. living area, sq metres	Income limit above which the allowance is reduced, SEK per year		Regulations 2003
			Single persons	Married/cohabiting couples	
<i>Families with children</i>					
Number of children					
1	2,500	80	117,000	58,500/applicant	
2	3,175	100	117,000	58,500/applicant	
3	3,900	120	117,000	58,500/applicant	
4	3,900	140	117,000	58,500/applicant	
5 or more	3,900	160	117,000	58,500/applicant	
<i>Households without children</i>					
18–28 years	1,100	60	41,000	58,000	



Age	Number of households by type			Average amount per month and household, SEK		
	Single persons		Couples	Single persons		Couples
	Women	Men		Women	Men	
–24	14,677	9,935	1,968	932	690	1,184
25–29	14,257	7,047	3,982	1,426	780	1,417
30–34	17,193	1,683	4,850	1,819	1,161	1,689
35–39	27,181	3,459	6,638	1,803	1,224	1,811
40–44	28,056	4,846	7,000	1,698	1,242	1,866
45–49	18,534	4,155	5,359	1,533	1,211	1,931
50–54	8,354	2,713	3,459	1,475	1,246	1,910
55–59	2,654	1,440	1,761	1,457	1,256	1,878
60–	487	875	1,239	1,597	1,280	1,804
<b>Total</b>	<b>131,393</b>	<b>36,153</b>	<b>36,256</b>	<b>1,578</b>	<b>993</b>	<b>1,758</b>

### Housing allowance in December 2003.

Housing allowance is mainly paid to single parents, most often women. In December 2003, a total of around 204,000 households received a preliminary housing allowance.

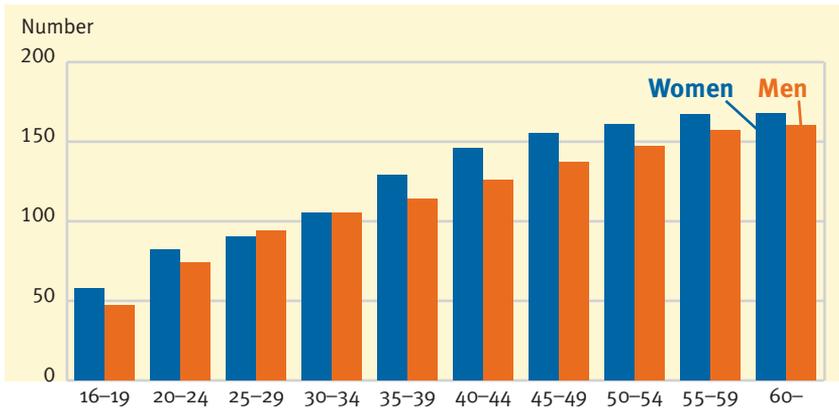
In 2003, a total of SEK 3.6 billion was paid in housing allowances to about

272,000 households. About SEK 2.5 billion went to the approximately 64 per cent of households where a woman was the sole breadwinner. Households where a man was the sole breadwinner amounted to approximately 18 per cent and received SEK 0.4 billion.

# Financial security in case of sickness and disability

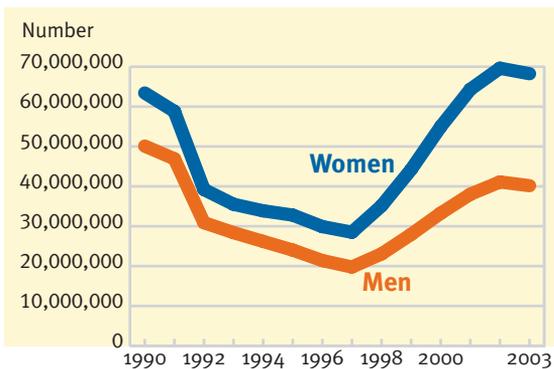
## Sickness cash benefit

Sickness cash benefit provides financial security during periods of reduced working capacity due to sickness.



**Sickness cash benefit days per recipient in 2003.** The number of sickness cash benefit days increases with advancing age for both women and men. This might be interpreted to mean that medical risks increase with age. It may

also mean that the pressures of working life increase or that persons who have been professionally active over a long period have also been subjected to greater overall strain.



**Paid sickness cash benefit days.** Since 1997, the number of sick days paid by social insurance has increased dramati-

cally, following a period of steady decline in the early 1990s. The causes of the increase in sick leave over the last few years are many and complex. Some of the explanations that have been offered include public sector cutbacks in the mid-1990s, a deteriorating psychosocial working environment, changes in the age structure of the population, and ever more stressful private life. Women account for an increasing proportion of sick leave absences. For women, the number of paid sick days was approximately 68 million in 2003, signifying an increase of approximately 40 million days since 1997.

## Regulations 2003

In the event of loss of income due to medical reasons, a person may receive 100, 75, 50 or 25 per cent of sickness cash benefit, depending on the degree to which working capacity is impaired.

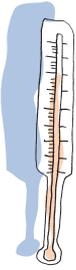
It is also possible to receive sickness cash benefit for medical treatment or medical rehabilitation aimed at preventing sickness or reducing the sickness period.

During the first 21 days of a sickness period, an employee receives sick pay from the employer, except for the first day which is a qualifying day. If reduced working capacity due to sickness persists after the end of the sick pay period, an employee may receive sickness cash benefit from the Social Insurance Office. Self-employed persons may have a qualifying

period of 3 or 30 days.

There is no official limit to how long a person may receive sickness cash benefit but the Social Insurance Office is obliged to have investigated one year after the sick-reporting day at the latest whether the person can receive sickness compensation instead, or activity compensation in the case of those under 30.

Full sickness cash benefit is 80 per cent of the income entitling to sickness cash benefit multiplied by 0.97 for all days in the sickness period except the qualifying day. The maximum sickness cash benefit for one day was SEK 615 in 2003. Special rules apply to unemployed persons, and for these the maximum daily compensation was SEK 521.

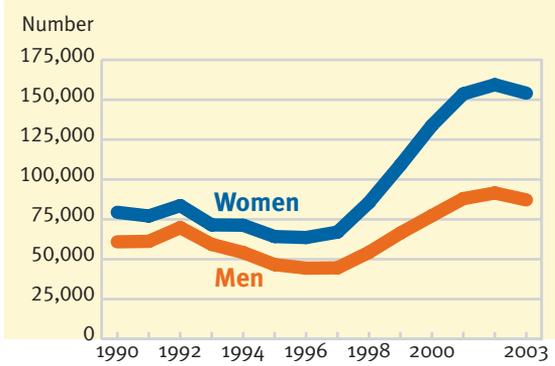


Age	Number of recipients		Average number of days		Average amount over the year, SEK	
	Women	Men	Women	Men	Women	Men
16-19	817	723	58	47	14,985	14,605
20-24	20,379	12,933	82	74	27,267	29,634
25-29	42,449	19,538	90	94	32,556	40,268
30-34	61,166	26,914	105	105	38,807	45,663
35-39	67,451	36,383	129	114	46,722	49,406
40-44	58,296	37,012	146	126	50,992	53,327
45-49	58,398	37,941	155	137	53,640	57,094
50-54	62,236	41,513	161	147	54,775	60,617
55-59	69,414	50,089	167	157	55,732	65,132
60-	50,512	41,379	168	160	55,049	66,685
<b>Total</b>	<b>491,118</b>	<b>304,425</b>	<b>139</b>	<b>132</b>	<b>48,132</b>	<b>55,466</b>

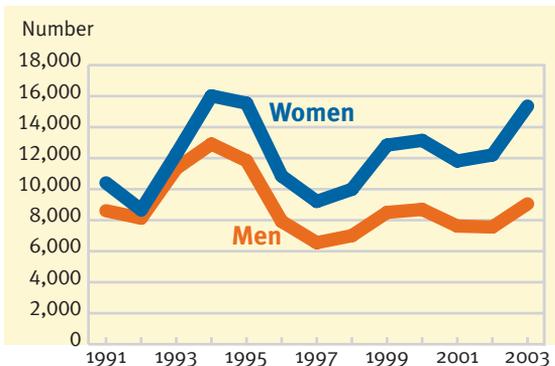
**Sickness cash benefit in 2003.** Out of a total of approximately SEK 41 billion paid out in sickness cash benefit in 2003, 58 per cent went to women and 42 per cent to men.

## Vocational rehabilitation

Various rehabilitation programmes exist to help the long-term sick to return to work.



**Long-term sickness.** Long-term sickness refers here to cases of sickness lasting at least 60 days. The number of persons on long-term sick leave decreased somewhat in the early 1990s, mainly due to the fact that many long-term sick were granted permanent or temporary disability pensions. Between 1996 and 2003, the number of persons sick for longer than 60 days has risen from 108,000 to 241,000. This represents an increase of 123 per cent. The greatest increase has been among women. The proportion of women among the long-term sick rose from 59 to 64 per cent during the period 1996–2003.



**Purchase of rehabilitation services.** In 1994, the number of purchases of rehabilitation services reached a peak. The number of purchases for women has consistently remained at a significantly higher level than for men, which is explained by the fact that the majority of cases of long-term sickness are found among women. The purchase of rehabilitation services is dependent on how resources are allocated and thus the development of the number of purchases does not follow the curve for the number of cases of long-term sickness.

## Regulations 2003

Trial work experience, work training, assessment by the Labour Market Institute (AMI) and further education courses are examples of programmes offered by vocational rehabilitation.

In connection with vocational rehabilitation, an individual may receive rehabilitation cash benefit to compensate lost income and a special allowance to cover certain so-called additional costs arising from rehabilitation activities (e.g. travel-

ling expenses). In addition, the Social Insurance Office may offer allowances for work aids and provide compensation for travel to and from work instead of sickness cash benefit.

Rehabilitation cash benefit is payable at 100, 75, 50 or 25 per cent of the full rate. Full rehabilitation cash benefit is 80 per cent of the income entitling to sickness cash benefit. In 2003, the maximum rehabilitation cash benefit per day was SEK 635.

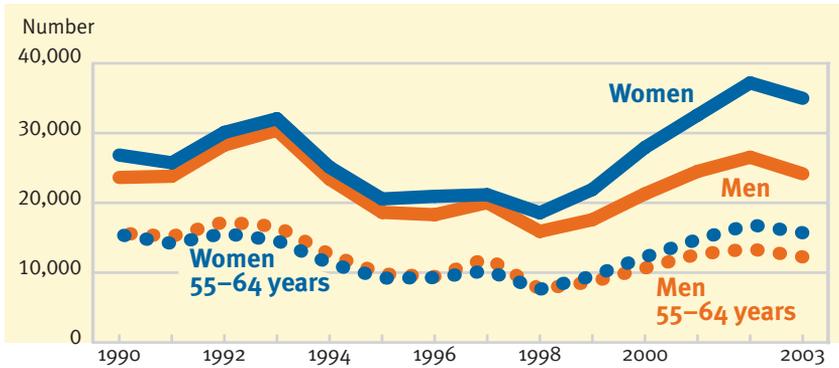


Age	Number of recipients		Average number of days		Average amount over the year, SEK	
	Women	Men	Women	Men	Women	Men
16-19	7	9	60	40	18,048	13,165
20-24	726	446	92	107	33,595	45,679
25-29	1,918	1,203	98	101	38,749	47,568
30-34	3,845	1,853	99	102	40,597	49,112
35-39	5,922	2,717	99	103	40,820	49,525
40-44	5,829	2,767	100	101	41,058	48,338
45-49	5,788	2,577	96	99	39,650	47,785
50-54	5,536	2,544	91	94	37,744	45,837
55-59	4,591	2,159	82	89	34,396	43,691
60-	1,594	715	76	76	31,565	37,929
<b>Total</b>	<b>35,756</b>	<b>16,990</b>	<b>94</b>	<b>98</b>	<b>38,670</b>	<b>46,982</b>

**Rehabilitation cash benefit in 2003.** Out of a total of SEK 2.2 billion for rehabilitation cash benefit in 2003, 63 per cent went to women and 37 per cent to men.

## Sickness compensation and activity compensation

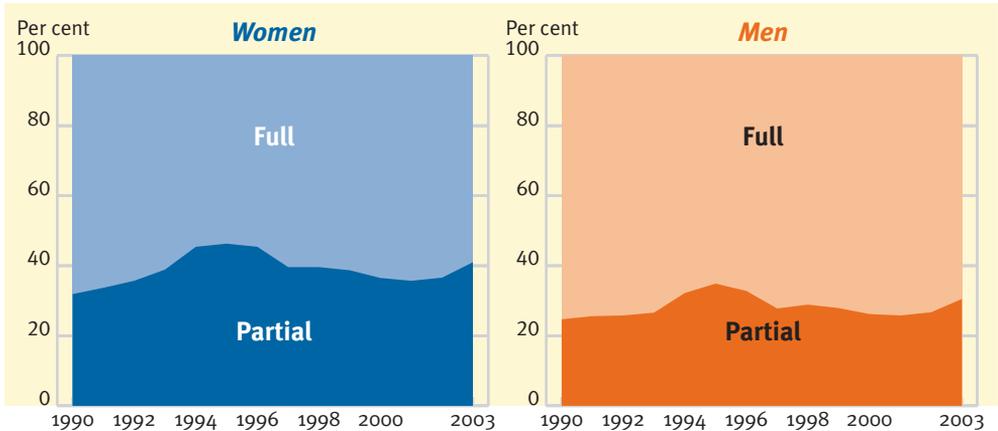
Sickness compensation and activity compensation provide financial security in cases of long-term reduction in work capacity. The benefits replace permanent and temporary disability pension.



### Newly granted sickness and activity compensation (permanent and temporary disability pensions prior to 2003).

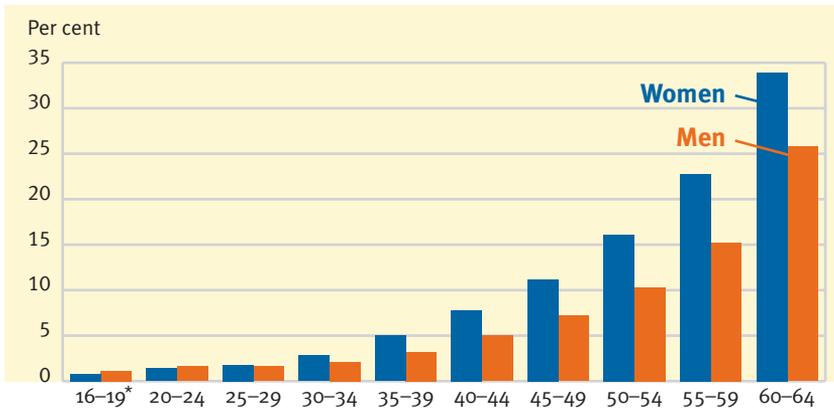
In the early 1990s, the granting of new disability pensions rose to record heights. The main reason was the greatly increased involvement of the social insurance offices in the field of rehabilitation. A large number of persons on long-term sick leave were granted permanent disability pensions because they were deemed unable to return to work even after rehabilitation. After reaching a peak in 1993, the granting of new disability pensions decreased, and in 1998 sank to the lowest level since the early 1970s. The decline was due to fewer cases of long-term sick leave in combination with tightened

regulations and their more restrictive application. In recent years, cases of long-term sickness have increased dramatically, causing the number of new disability pensions once again to soar. The decline in 2003 does not reflect the real trend, which continues upwards. Rather, it reflects the delay in handling following the launch of the new system of compensation. The age distribution has undergone a strong shift from older to younger people. The average age of those with newly granted compensation has fallen from just under 55 at the end of the 1980s to just over 50 today. As of 2003, no further compensation is granted to those under 19 years of age, causing the average age to move slightly in the other direction.



**Newly-granted sickness and activity compensation according to scope (permanent and temporary disability pensions prior to 2003).** Partial compensation is more common among women than men. The proportion of partial benefits rose steadily during the second half of the 1980s and the

first half of the 1990s. In 1995, a peak was reached, when 46 per cent of the women and 35 per cent of the men were granted partial compensation. Because cases of partial sickness cash benefit have increased, the tendency is for sickness compensation and activity compensation to follow suit.



\* The 16-19 age group comprises persons who had disability or temporary disability pension in December 2002, the compensation for which has been recalculated to sickness compensation, and persons aged 19 who have been granted activity compensation.

**Proportion of the population with sickness and activity compensation in 2003.** In December 2003, there were more than 507,000 persons with sickness or activity compensation – 296,000 women and 211,000 men. This means that almost 9 per cent of the population of working age have for

health reasons wholly or partially left working life with sickness or activity compensation, and the proportion rises with increasing age. In all age groups over 25, more women than men have compensation. In the age groups 60-64, the proportion receiving sickness compensation is as high as 30 per cent.

## Regulations 2003

Sickness or activity compensation may be granted to those aged 19–64 who for medical reasons have a working capacity reduced by at least 25 per cent for a period of at least one year. There are four levels of compensation: 100, 75, 50 or 25 per cent of the full rate.

Activity compensation is granted to persons aged 19–29. It is always granted for a limited time only. Activity compensation may be combined with participation in various activities aimed at drawing on the individual's potential for development and work during the years of youth. Young people who have not yet completed their basic or secondary education due to

functional disability are entitled to activity compensation for the duration of their studies.

Sickness compensation is granted to persons aged 30–64. The compensation is limited in time for cases of long-term but non-permanent reduction in working capacity.

Sickness or activity compensation may be paid in the form of income-based compensation and guarantee compensation. Income-based compensation is tied to earned income. Guarantee compensation is granted to persons with low earnings. It is at most 2.4 of the price base amount, which was equivalent to SEK 7,720 per month in 2003.

Most recipients of sickness compensation are people who have been forced by ill health to leave the labour market after a long working life. This group receives compensation proportional to previously earned income.

The overwhelming majority of those receiving compensation at very young ages have severe congenital disabilities

or disabilities contracted early on in life. The majority have had no opportunity via gainful employment to build up their own insurance protection in the pension system and therefore receive basic level compensation. 71 per cent of those with activity compensation received only guarantee compensation in 2003.



Age	Number of recipients		Average amount per month, SEK		Percentage of population, per cent	
	Women	Men	Women	Men	Women	Men
16–19	1,485	2,115	7,758	7,758	0.7	0.9
20–24	2,339	2,924	7,536	7,667	0.9	1.1
25–29	3,439	3,504	7,281	7,580	1.3	1.2
30–34	8,452	6,416	7,235	7,809	2.8	2.1
35–39	16,305	10,760	7,366	8,209	5.0	3.2
40–44	22,903	15,184	7,367	8,368	7.8	5.0
45–49	32,276	21,418	7,483	8,587	11.2	7.2
50–54	47,408	30,986	7,632	8,865	16.1	10.3
55–59	73,239	49,751	7,870	9,390	22.8	15.2
60–64	85,437	65,474	8,123	9,996	33.9	25.8
<b>Total</b>	<b>293,283</b>	<b>208,532</b>	<b>7,767</b>	<b>9,165</b>	<b>10.4</b>	<b>7.2</b>

**Sickness compensation in December 2003.** Pensions for people receiving permanent or temporary disability

pensions prior to 2003 were recalculated as sickness compensation regardless of age.

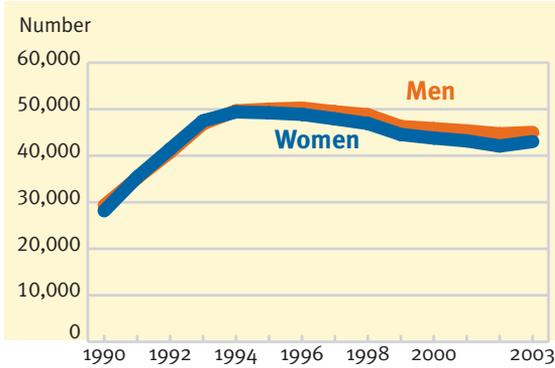
Age	Number of recipients		Average amount per month, SEK		Percentage of population, per cent	
	Women	Men	Women	Men	Women	Men
19	219	332	6,646	6,701	0.44	0.62
20–24	1,199	1,196	6,659	6,797	0.47	0.45
25–29	1,422	1,106	6,945	7,506	0.52	0.39
<b>Total</b>	<b>2,840</b>	<b>2,834</b>	<b>6,801</b>	<b>7,083</b>	<b>0.38</b>	<b>0.37</b>

**Activity compensation in December 2003.** Out of a total of approximately SEK 50 billion in sickness compensation and activity compensation in 2003, 54 per cent went to women and 46 per cent to men.

SEK 40.7 billion was paid out as income-based compensation. Women made up 59 per cent of those with income-based compensation and received 54 per cent of the total paid out, while men made up 41 per cent of those with income-based compensation and received 46 per cent of the total.

## Work injury compensation

Work injury compensation provides financial security when a person’s working capacity is reduced due to a work injury.



**Number of individual life annuities according to the work injury insurance in December.** At the end of the 1980s and beginning of the 1990s, the number of work injury claims assessed by the regional social insurance offices increased sharply. At the same time, the number of cases where actual work injury was established also increased. The decline after 1993 was due to the introduction of much stricter criteria for approval of a work injury.

### Regulations 2003

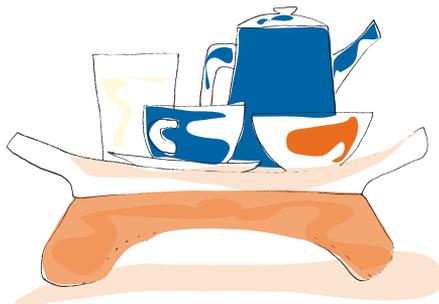
All persons engaged in gainful employment in Sweden are insured against work injuries. The term work injury refers to accidents or illnesses resulting from harmful influences at work. Compensation may be paid for loss of income, cost of dental care, cost of medical care abroad, sickness cash benefit in certain cases, and costs for special aids. There is also compensation for survivors and for help with funerals. The largest compensation paid out from work injury insurance is an annuity. This is only payable if an approved work injury has led to a lasting reduction in a person’s earning ability. While still suffering from the immediate effects of an injury, employees receive regular sick pay or sickness cash benefit. People with injuries that appeared on

1 January 2003 or later receive compensation for qualifying days when granted an annuity.

If a person’s earning capacity is permanently reduced due to work injury, he or she has the right to a so-called work injury annuity. The annuity is designed to compensate the recipient for all lasting loss of income. In order to calculate the size of the annuity, the income the person would probably have earned if the accident had not occurred is compared with the income the person is likely to receive after the accident. The annuity provides compensation for the entire difference, but may not exceed 7.5 times the price base amount per year, which was equivalent to roughly SEK 24,100 per month in 2003.

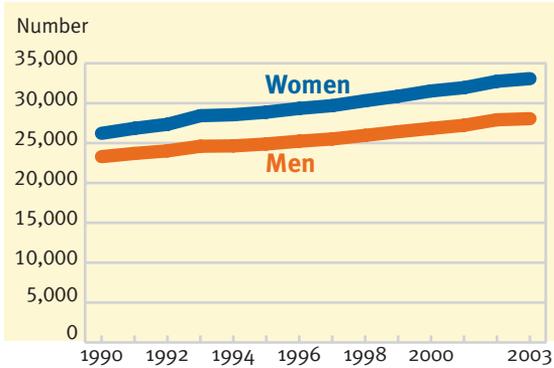
**Work injury annuities in December 2003.** Out of a total of SEK 4.9 billion in work injury annuities in 2003, women received 41 per cent and men 59 per cent.

Age	Number of recipients		Average amount per month, SEK	
	Women	Men	Women	Men
20-24	11	20	9,159	11,488
25-29	73	160	7,186	9,369
30-34	324	564	6,773	7,473
35-39	1,082	1,740	5,371	6,088
40-44	1,719	2,712	4,667	5,735
45-49	2,919	3,990	4,218	5,388
50-54	5,236	5,890	4,055	5,284
55-59	9,183	9,545	3,973	5,381
60-64	12,008	12,427	4,023	5,548
65-	10,485	7,966	1,001	923
<b>Total</b>	<b>43,040</b>	<b>45,014</b>	<b>3,381</b>	<b>4,718</b>

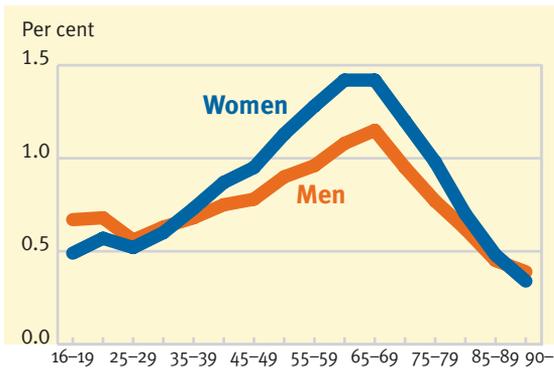


## Disability allowance

Disability allowance provides financial security for people with functional disabilities who need the help of another person and/or have additional costs due to their disability.



**Persons with disability allowances.** The numbers have increased steadily since the beginning of the 1990s and in 2003 there were 23 per cent more people receiving disability allowance.



**Proportion of persons in the population with disability allowances in 2003.** Generally, disability allowances are more common among women than men. The proportion is greatest in the 60–69 age range.

### Regulations 2003

Persons who suffer from reduced functional ability over a significant period of time and thus need time-consuming help from another person in order to cope with life at home or at work are entitled to disability allowance. It is also possible for them to receive a disability allowance if they have significant additional costs due to their functional disability. Persons who have become functionally disabled between the ages of 19–65 may

receive a disability allowance.

There are three compensation levels: 36, 53 and 69 per cent of the base amount per year, depending on the assistance required and the size of the additional costs. In 2003, these three levels corresponded to SEK 1,158, SEK 1,705 and SEK 2,220 per month. The blind and the deaf always receive allowances if their disability arose before the age of 65.

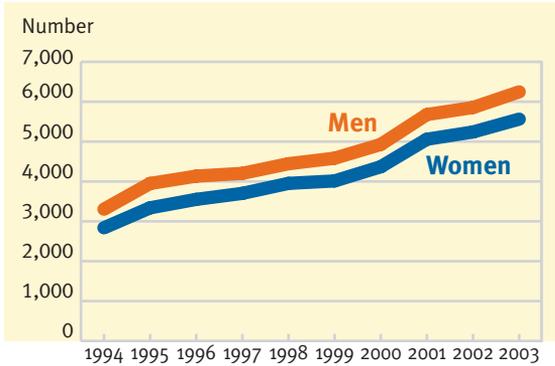
**Disability allowance in December 2003.** Out of a total of just under SEK 1.2 billion in disability allowance in 2003, 54 per cent went to women and 46 per cent to men.

Age	Number of recipients		Average amount per month, SEK	
	Women	Men	Women	Men
16-19	1,024	1,494	1,515	1,512
20-29	2,884	3,394	1,470	1,501
30-39	4,163	4,261	1,507	1,540
40-49	5,304	4,577	1,520	1,548
50-59	7,434	5,864	1,507	1,559
60-69	6,479	4,947	1,466	1,492
70-79	4,048	2,587	1,421	1,417
80-89	1,563	861	1,332	1,319
90-	179	72	1,254	1,233
<b>Total</b>	<b>33,078</b>	<b>28,057</b>	<b>1,478</b>	<b>1,512</b>



## Assistance allowance

Being able to employ personal assistants gives functionally disabled people a chance of living normal lives.



**Persons with assistance allowance.** Assistance allowance was introduced in 1994. Over the following ten years, the numbers of recipients increased steadily. Men recipients have always outnumbered women.

### Regulations 2003

Assistance allowance is available to persons who suffer from autism, learning difficulties, significant functional disabilities after brain damage or other major and lasting functional disabilities not due to normal ageing. However, persons living in sheltered group accommodation are not entitled to assistance allowance. If there are reasonable grounds, the allowance can be paid for a short period of time while the person is in hospital. The allowance from the Social

Insurance Office to the functionally disabled is to be used for the employment of personal assistants (carers) who can help them in their daily lives. Functionally disabled persons may themselves employ one or more assistants directly or use those available from the municipality or other organizations.

Assistance allowance is paid at a standard rate per hour. It was SEK 198 in 2003.



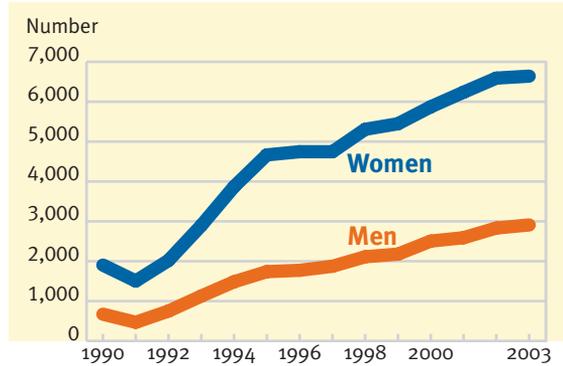
**Assistance allowance in December 2003.** Out of a total of SEK 11.2 billion in assistance allowance in 2003, approximately 46 per cent went to women and 54 per cent to men. The municipalities provided SEK 2.5 billion.

Age	Number of recipients		Average number of hours per month	
	Women	Men	Women	Men
0-14	668	858	332	350
15-19	393	511	365	396
20-24	359	503	456	482
25-29	377	464	493	488
30-34	319	428	454	497
35-39	375	453	447	461
40-44	352	423	432	462
45-49	416	414	430	472
50-54	501	511	425	437
55-59	702	620	401	418
60-64	627	623	394	395
65-	474	439	344	332
<b>Total</b>	<b>5,563</b>	<b>6,247</b>	<b>407</b>	<b>425</b>

## Allowance for care of close relatives

The allowance for care of close relatives enables a person to stay home from work to look after a seriously ill member of the family.

**Persons with an allowance for care of close relatives.** The allowance for care of close relatives was introduced in mid-1989. In 1991, the level of compensation was lowered, which may explain the decrease in the number of people receiving the allowance that year. The following year, the rules were changed so that even a person looking after a seriously ill relative in hospital or other institution (i.e. not only in the home) was entitled to receive the allowance. The steady increase since 1991 can partly be attributed to increased public awareness of the existence of such an allowance but the most important factor is the ageing population. Women



look after relatives to a far greater extent than men. Among those receiving care, however, the sexes are evenly represented.

Persons staying home from work to look after a seriously ill person in the home or in a care institution are entitled to receive an allowance for care of close relatives. Generally, the allowance is payable for a maximum of 60 days for each person cared for.

The allowance is payable at 100, 50 or 25 per cent of the full rate. The full compensation rate is 80 per cent of the income entitling to sickness cash benefit.

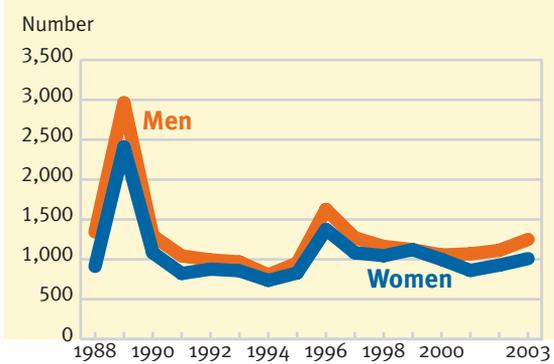
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Age	Number of recipients		Average number of days		Average amount over the year, SEK	
	Women	Men	Women	Men	Women	Men
-24	86	59	10	11	5,473	6,079
25-29	210	126	11	11	6,700	7,942
30-34	424	270	11	10	6,419	6,836
35-39	779	409	9	10	5,455	7,409
40-44	980	478	9	9	6,028	5,972
45-49	1,224	474	10	10	6,346	6,408
50-54	1,201	443	10	11	6,672	7,262
55-59	1,152	404	12	14	7,221	8,996
60-	585	246	14	17	7,936	10,630
<b>Total</b>	<b>6,641</b>	<b>2,909</b>	<b>11</b>	<b>11</b>	<b>6,550</b>	<b>7,423</b>

**Allowance for care of close relatives in 2003.** Out of a total of approximately SEK 65 million in allowance for care of close relatives in 2003, 67 per cent went to women and 33 per cent to men.

## Car allowance

Car allowance is to help people with permanent functional disabilities who have difficulty moving from place to place.



**Granted car allowances.** Car allowances were introduced in October 1988, and the majority were granted when the benefit was new. Since it is possible to get a new car allowance every seventh year, there was a new peak in 1996. Somewhat fewer women than men have received this benefit. Means-tested allowance for the purchase of a car have mainly gone to women. On the other hand, costs for adapting cars have been higher for men.

### Regulations 2003

Car allowance for the purchase of a car may be granted every seventh year. Car allowance may also be granted for adapting a vehicle and in certain cases for driving lessons. The basic prerequisite for receiving a car allowance is that the individual has a permanent functional disability that presents significant difficulties in getting around or in using public transport. The following groups are entitled to a car allowance providing they meet the basic prerequisites:

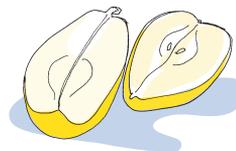
- A person under 65 who is reliant on

a motor vehicle for work purposes or for rehabilitation/training.

- A person under 65 who has been granted a car allowance according to the rules for the preceding group, but who has subsequently received sickness or activity compensation.
- Another person aged between 18 and 49 who will be the actual driver of the vehicle.
- A parent with children under 18.
- Parents whose children fulfil the basic requisites.

Age	Number of recipients		Average amount, SEK	
	Women	Men	Women	Men
0-15	178	216	66,608	71,585
16-19	36	57	78,482	102,471
20-24	24	44	130,327	176,103
25-29	42	48	144,972	123,633
30-34	56	60	121,306	220,435
35-39	84	109	141,937	126,356
40-44	84	141	115,833	113,305
45-49	110	127	126,506	109,145
50-54	80	106	141,131	114,069
55-59	80	85	123,085	128,490
60-	65	74	115,323	122,006
<b>Total</b>	<b>839</b>	<b>1,067</b>	<b>113,102</b>	<b>116,086</b>

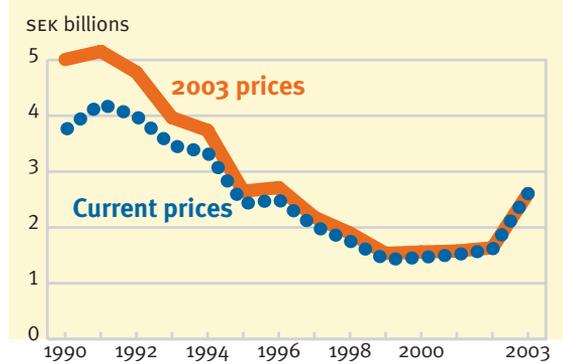
**Car allowances granted in 2003.** Out of a total of SEK 214 million in car allowances in 2003, 43 per cent went to women and 57 per cent to men.



## Dental care

The aim of dental care insurance is to make possible a high level of dental health irrespective of personal incomes.

**Amount paid for dental care.** Compensation regulations have been progressively changed, obliging patients to pay an ever larger share. Costs for dental care insurance thus decreased between 1992 and 1999, but regulatory changes during 2002 led to a steep rise in costs in 2003.



Dental care for children under 20 is free of charge.

All adults receive financial support for everyday health-promoting dental care, that is, basic dental care. This includes preventive treatment, fillings, root treatment and suchlike.

For crowns, braces, and suchlike, as well as for orthodontic treatment, there is high-cost protection for patients in acute need of treatment.

As of July 2002, special compensation rules apply to all insured persons aged 65 and over. Apart from an initial amount payable by the patient of SEK 7,700 and the cost of materials, the Social Insurance Office pays for the complete treatment.

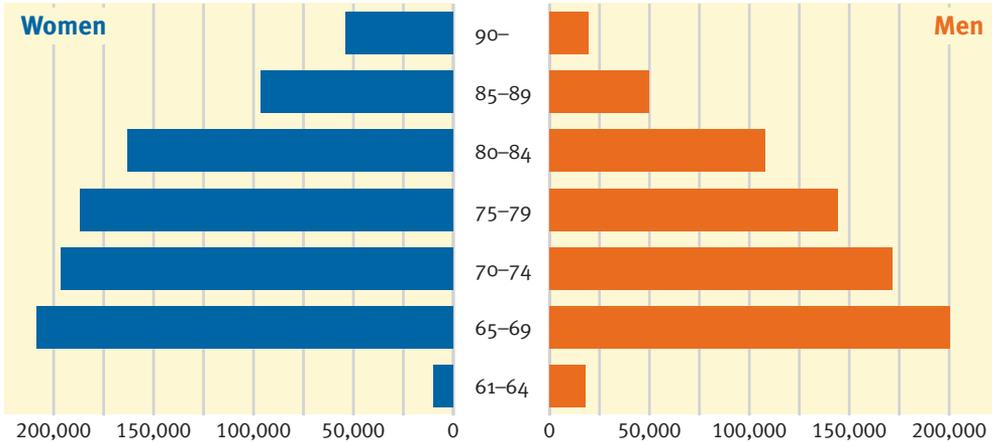
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## Financial security in old age, etc.

### Old-age pension

Old-age pension provides security in old age. It consists of income pension, premium pension and guarantee pension.



**Old-age pensioners in 2003.** Among old-age pensioners there are significantly more women than men, since

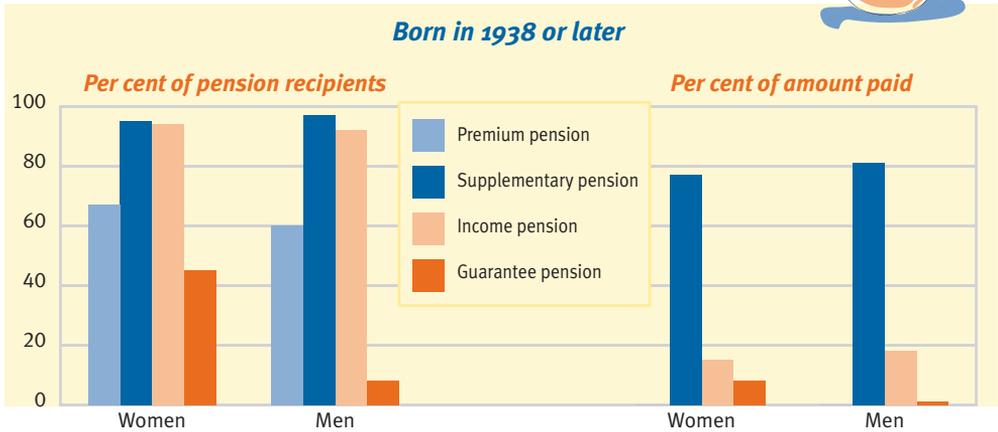
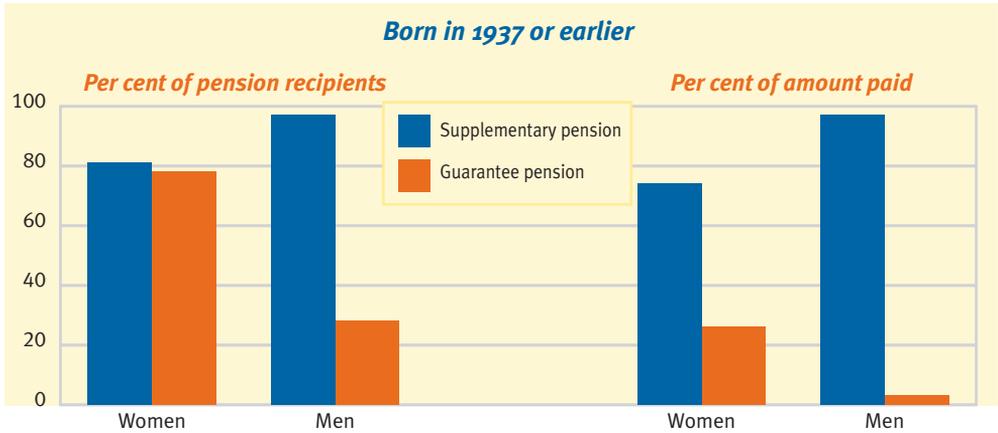
women as a group live longer than men. Only among pensioners in the age group 61-64 do men outnumber women.



'Guarantee pension' means that the recipient receives guarantee pension alone or in combination with one or more of the other types of pension. 'Other pension' indicates that the recipient does not receive guarantee pension but one or more of the other types of pension.

**Old-age pensioners with or without guarantee pension in 2003.** The increased participation of women in working life during the late twentieth century is clearly illustrated. The

proportion with guarantee pension increases progressively with increased age, from 59 per cent to virtually 100 per cent for women.



**The different types of pension in 2003.**

Persons aged 66 and over (that is, those born in 1937 or earlier) can only receive guarantee pension and supplementary pension. 78 per cent of the women and 28 per cent of the men received guarantee pension. Out of a total of 862,000 women, 161,000 received guarantee pension alone, while out of a total of 652,000 men as few as 20,000 received guarantee pension alone. This reflects the different earning patterns of men and women for these generations. In December 2003, only 112,000

pensioners were covered by the new income pension scheme, 84,000 of which were 65-year-olds. As well as guarantee pension and supplementary pension, these could receive income pension and premium pension. 67 per cent of the women and 60 per cent of the men had premium pension but the amounts involved so far have been insignificant. 45 per cent of the women and 8 per cent of the men received guarantee pension, while just under 3 per cent of women and 1 per cent of men received guarantee pension alone.

## Regulations 2003

Old-age pension must be applied for, though not before the age of 61. People may postpone claiming old-age pension as long as they like and the pension increases in value the longer a person waits. Old-age pension is payable as a whole, three-quarters, one-half or one-quarter benefit. As of January 2003, pensions are taxed in the same way as earned income.

The right to old-age pension is earned primarily through gainful employment from the age of 16 onwards. Earned income – together with certain so-called pensionable amounts – forms the basis of the individual pension. One accumulates pensionable amounts, for example, while receiving sickness or activity compensation or while one is the parent of small children. The pension right amounts to 18.5 per cent of the pension base.

The earned parts of the pension

are paid out in the form of income pension and premium pension. The pension right for the income pension is 16 per cent of the base while the remaining 2.5 per cent is placed in funds for the premium pension. If earned pension falls below a certain basic security level, it is supplemented with a guarantee pension.

The general old-age pension has recently been reformed and applies to all those born in 1938 or later. Persons born earlier receive their old-age pension in the form of supplementary pension and, possibly, guarantee pension. Supplementary pension largely equates to the earlier basic pension and general supplementary pension (ATP) which is based on pension points in the old scheme. Also persons born in the period 1938–1953 receive their earned pension to varying degrees in the form of supplementary pension.

Age	Number of recipients		Average amount per month, SEK	
	Women	Men	Women	Men
61–64	10,013	18,028	5,768	8,353
65–69	208,572	200,389	8,739	11,731
70–74	196,368	171,679	8,109	11,656
75–79	186,733	144,324	7,507	11,578
80–94	162,839	107,819	6,952	11,348
85–89	96,080	49,967	6,597	11,053
90–	53,683	19,200	6,211	9,369
<b>Total</b>	<b>914,288</b>	<b>711,406</b>	<b>7,628</b>	<b>11,427</b>

**Old-age pensions in December 2003.** SEK 180 billion was paid out in old-age pension in 2003, approximately 46 per cent to women and 54 per cent to men.

Supplementary pension accounted for SEK 154.1 billion of the total amount.

Women made up 52 per cent of old-age pensioners with supplementary pension, but only 40 per cent of the amount went to women. Men made up 48 per cent of pensioners and received 60 per cent of the amount.

## Maintenance support for the elderly

Maintenance support for the elderly allows persons with a low old-age pension or no pension at all the chance to support themselves.

Maintenance support for the elderly is payable to persons resident in Sweden who have reached the age of 65. The benefit is means-tested and its aim, like that of the special housing supplement to pensioners, is to guarantee the individual a reasonable standard of living. The standard of living level corresponds to a set financial minimum level and the costs

for a reasonable home. The reasonable cost of accommodation was at most SEK 5,700 per month for single persons and SEK 2,850 for couples in 2003. The reasonable standard of living level was approximately SEK 4,200 per month for single persons and approximately SEK 3,500 for couples. The benefit is granted for a maximum of twelve months at a time.

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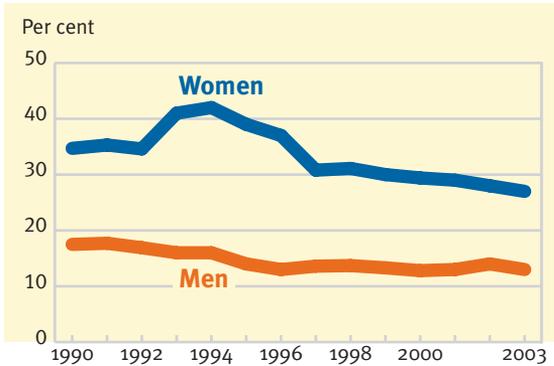
Age	Number of recipients		Average amount per month, SEK	
	Women	Men	Women	Men
65–69	2,500	1,907	3,871	2,533
70–74	1,990	1,507	5,680	3,576
75–79	1,452	883	5,817	3,788
80–84	863	522	3,995	2,930
85–89	404	157	3,339	2,889
90–	241	75	2,564	3,398
<b>Total</b>	<b>7,450</b>	<b>5,051</b>	<b>4,677</b>	<b>3,129</b>

**Maintenance support for the elderly in December 2003.** In 2003, SEK 634 million was paid out in maintenance

support for the elderly, of which approximately 69 per cent went to women and 31 per cent to men.

## Housing supplements for pensioners, etc.

The housing supplements enable pensioners and certain other low-income groups to live in good-quality accommodation without sacrificing their standard of living in other ways.



**Proportion of persons with housing supplement.** Women have lower pensions than men on average and have a lower financial standard also in other respects. The proportion of women with housing supplement is twice that of men.

### Regulations 2003

The housing supplement consists of – housing supplement for pensioners (BTP) – special housing supplement for pensioners (SBTP).

**BTP** may be granted to persons with full old-age pension, widows’ pension, special survivor’s pension, wives’ supplement, sickness compensation or EU pension equating to Swedish benefits. BTP is not granted for old age pension taken out before the age of 65 (early withdrawal).

The size of the housing supplement depends on the cost of the accommodation and the income and assets of the individual. In 2003, the maximum BTP was 91 per cent of accommodation costs up to SEK 4,500 per month, giving a maximum of SEK

4,095. BTP is a tax-free form of support which the individual must apply for.

**SBTP** is a form of support designed to guarantee individual pensioners a reasonable standard of living, corresponding in principle to a set minimum financial level and the cost of adequate accommodation. The highest acceptable cost of accommodation is SEK 5,700 per month. To qualify for SBTP, a person must already have been granted BTP. In addition, the person’s income after deductions for reasonable housing costs must be under a certain fixed minimum level. The supplement is paid in the form of a supplementary amount bringing the income level up to the minimum income level.

Age	Number of recipients		Average amount <sup>1</sup> per month, SEK	
	Women	Men	Women	Men
16-19	499	675	1,870	1,837
20-24	1,912	2,238	2,541	2,481
25-29	2,858	2,958	2,614	2,645
30-34	3,783	3,647	2,440	2,516
35-39	5,943	5,196	2,169	2,332
40-44	7,423	6,470	2,089	2,226
45-49	9,370	7,854	2,094	2,121
50-54	11,696	8,754	2,116	2,085
55-59	14,465	9,327	2,133	2,009
60-64	14,347	8,427	2,049	1,909
65-69	27,259	10,807	1,783	1,719
70-74	35,295	10,443	1,786	1,573
75-79	48,500	11,208	1,858	1,424
80-84	60,677	11,188	1,983	1,371
85-89	49,183	7,028	2,155	1,407
90-	35,740	5,877	2,401	1,696
<b>Total</b>	<b>328,950</b>	<b>112,097</b>	<b>2,035</b>	<b>1,840</b>

<sup>1</sup> The average amount includes BTP, SBTP.

**Housing supplement in December 2003.** In 2003, SEK 11 billion was paid out in housing supplement. Approximately 76 per cent of this was paid to women and 24 per cent to men.



Age	Number of recipients		Average amount per month, SEK	
	Women	Men	Women	Men
65-69	26,995	10,684	1,784	1,721
70-74	35,267	10,432	1,786	1,573
75-79	48,469	11,196	1,857	1,423
80-84	60,634	11,182	1,983	1,371
85-89	49,162	7,025	2,155	1,407
90-	35,718	5,875	2,401	1,696
<b>Total</b>	<b>256,245</b>	<b>56,394</b>	<b>2,002</b>	<b>1,523</b>

**Housing supplement for old-age pensioners in December 2003.**

Housing supplement for old-age pensioners was approximately SEK 7.6 billion in 2003, of which 86 per cent went to women and 14 per cent to men.

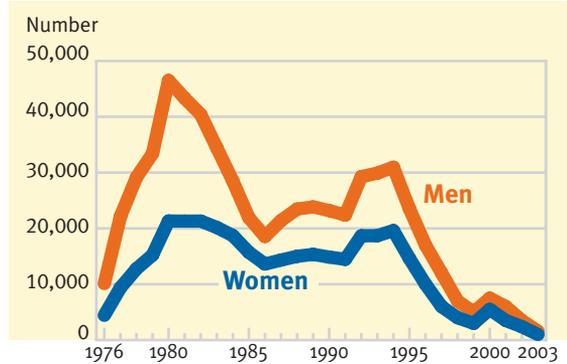
Age	Number of recipients		Average amount per month, SEK	
	Women	Men	Women	Men
16-19	499	674	1,870	1,837
20-24	1,912	2,234	2,541	2,481
25-29	2,851	2,954	2,615	2,645
30-34	3,770	3,641	2,440	2,517
35-39	5,905	5,188	2,170	2,332
40-44	7,360	6,454	2,088	2,226
45-49	9,250	7,840	2,093	2,121
50-54	11,532	8,736	2,113	2,085
55-59	14,111	9,314	2,127	2,009
60-64	13,577	8,408	2,035	1,909
<b>Total</b>	<b>70,767</b>	<b>55,443</b>	<b>2,148</b>	<b>2,161</b>

**Housing supplement for persons with sickness compensation or activity compensation in December 2003.** Housing supplement for persons with sickness or activity compensation was approximately SEK 3.3 billion. Of this, 56 per cent was paid to women and 44 per cent to men.

## Part-time pension

Gainfully employed persons wishing to reduce their working hours a few years before retirement could claim part-time pension up to the year 2000.

**The development of the part-time pension.** Part-time pension has existed since 1976 and is now being phased out. Since 2000 no new applications for this form of pension have been accepted.



**After 2000 it is no longer possible to apply for a part-time pension.** The part-time pension will thus have come to an end by 2005.

Gainfully employed persons in the age group 61–64 who wished to reduce their working hours could receive part-time pensions. The part-time pension is 55 per cent of the

difference between before and after the reduction in working hours. After reducing their working hours, persons with part-time pensions must work between 17 and 35 hours a week on average. It is possible to receive compensation for a reduction in working hours of up to 10 hours per week at most.

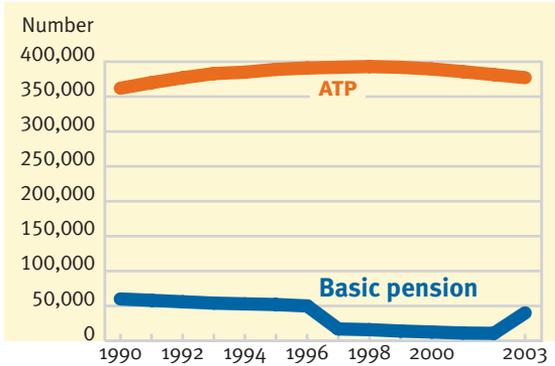
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Out of a total of SEK 85 billion in part-time pensions in 2003, approximately one third went to women and two thirds to men.

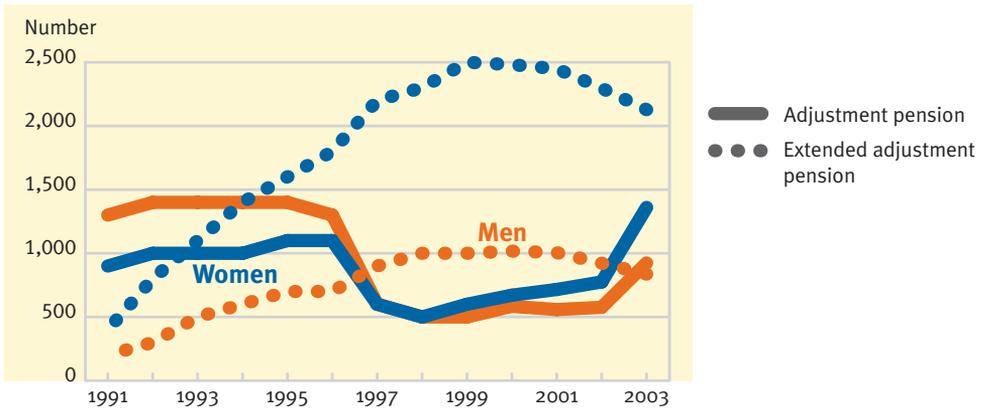


## Survivor's pension for adults

Survivor's pension provides financial security to persons whose close relatives have died.



**Women with widow's pensions.** The widow's pension was abolished in 1990 but due to transitional regulations the number of women receiving widows' pensions from the ATP scheme actually increased for a while. However, the number receiving basic pensions fell dramatically due to the introduction of means-testing in April 1997. Means-testing has been abolished in the new pension scheme and the number of widows with guarantee pensions is almost on a par with the number of basic pensioners in 1996 (that is, before means-testing was introduced).



**Adjustment pensions and extended adjustment pensions.** The period for which an adjustment pension is payable was reduced from one year to six months in 1997, which meant the number of persons receiving the benefit at any one time was halved. At the same time, there was an increase in the

number of persons receiving extended adjustment pensions. As of 2003, the period for which an adjustment pension is payable has once again been increased, as reflected in the statistics. More than twice as many women as men receive extended adjustment pensions.

The survivor's pension for adults includes

- adjustment pension
- extended adjustment pension
- special survivor's pension (no longer granted after 2002)
- widow's pension.

These benefits are paid as a form of income-based pension, determined by the previous income of the deceased. As a supplement to or instead of the income-based pension, it is possible under certain circumstances to receive guarantee pension. It is 2.13 times the price base amount, which was SEK 6,852 per month in 2003. As of January 2003, pensions are taxed in the same way as earned income.

The surviving spouse (or equivalent) may receive an **adjustment pension** if he/she is younger than 65 and

- was at the time of the death permanently cohabiting with children under 18, or
- had cohabited continuously with the deceased for a period of at least five years prior to the time of the death.

The adjustment pension is payable for ten months and its size is based on the deceased person's accumulated income pension or pension points for supplementary pension. The adjustment pension is payable concurrently with a person's own pension.

If the survivor has custody of children under 18 years of age, he/she receives an extended adjustment pension for 12 months or until the youngest child reaches the age of twelve. The right to **extended adjustment pension** ceases to apply if the survivor remarries.

The right to **widow's pension** and the size of widow's pension depends on the age of the woman, on whether the couple were married or in an equivalent relationship at the close of 1989 and on the husband's years with pension points (ATP points). The pension is coordinated with sickness compensation, activity compensation and old-age pension. Widow's pension is no longer payable if the widow remarries.

### Widow's pensions in December 2003.

The majority of women receiving a widow's pension are themselves old-age pensioners, but approximately 12 per cent are still of working age. In 2003, just under four out of ten female old-age pensioners also received widows' pension. Since 2003, a so-called basic pension supplement has been included in the average amount up to the age of 65, which accounts for the high amounts for these age groups.

Out of a total of SEK 15.2 billion in widow's pensions in 2003, 77 per cent went to widows who were 65 or older.

Age	Number of recipients Women	Average amount per month, SEK Women
–39	235	2,758
40–49	3,802	4,138
50–59	19,924	6,200
60–64	21,741	7,133
65–69	28,917	2,683
70–74	48,319	3,160
75–79	72,238	3,311
80–89	149,402	2,875
90–	35,897	1,841
<b>Total</b>	<b>380,475</b>	<b>3,312</b>

Age	Number of recipients		Average amount per month, SEK	
	Women	Men	Women	Men
-29	23	3	6,611	6,852
30-34	45	17	6,887	6,856
35-39	69	34	6,663	6,741
40-44	109	47	6,691	6,621
45-49	216	76	6,686	6,707
50-54	338	147	6,864	6,643
55-59	501	247	6,846	6,723
60-64	59	353	6,482	6,737
<b>Total</b>	<b>1,360</b>	<b>924</b>	<b>6,785</b>	<b>6,713</b>

**Adjustment pensions in December 2003.** As a result of transitional regulations, the majority of women over 60 receive widow's pensions instead of

adjustment pensions. Out of a total of SEK 185 million in adjustment pensions in 2003, 60 per cent went to women and 40 per cent to men.



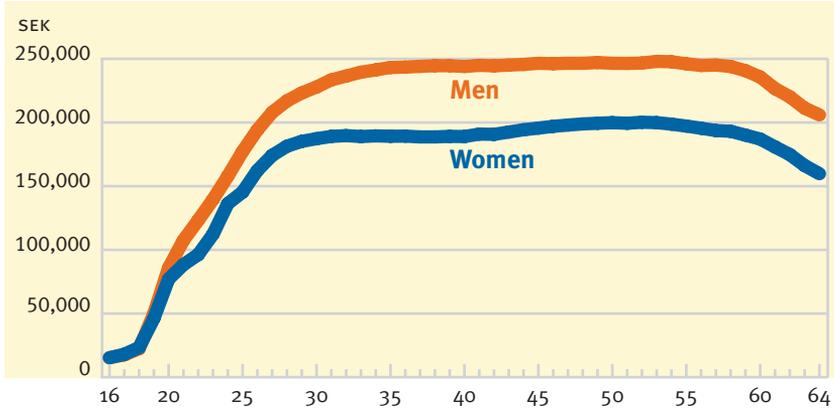
Age	Number of recipients		Average amount per month, SEK	
	Women	Men	Women	Men
-29	122	11	6,732	6,916
30-34	251	54	6,589	6,734
35-39	598	177	6,751	6,752
40-44	605	232	6,776	6,755
45-49	405	194	6,662	6,599
50-54	139	107	6,703	6,843
55-59	8	43	5,167	6,096
60-64	-	19	-	6,633
<b>Total</b>	<b>2,128</b>	<b>837</b>	<b>6,712</b>	<b>6,694</b>

**Extended adjustment pensions in December 2003.** Out of a total of SEK 251 million in extended adjustment

pensions in 2003, 72 per cent went to women and 28 per cent to men.

## Earned pension base

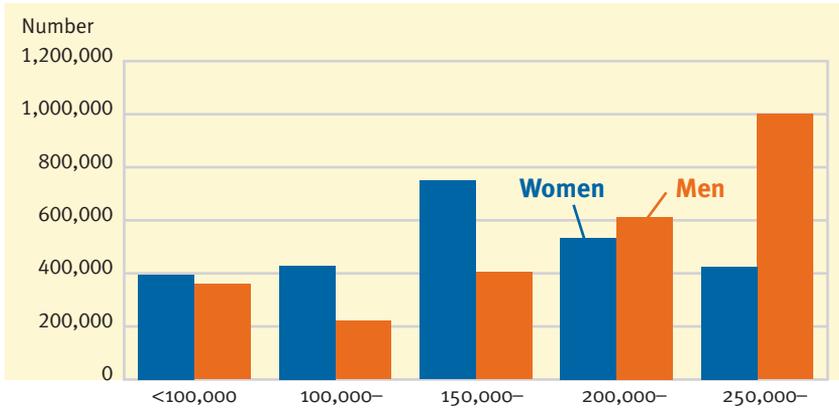
The earned pension base according to the reformed pension system rules is shown here for persons aged 16–64.



**The median pension base in 2002** may be seen as a picture of the expected average lifetime-income profile for each yearly cohort. The differences in income between men and women are considerable. The earned pension base for women is approximately 80 per cent of that for men. The disparity is largely explained by wage differences between the sexes and shorter working hours for women in paid employment. The fact that the pension base in all age groups stands at roughly the

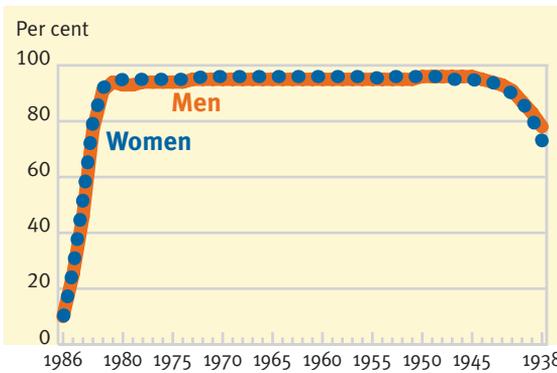
same level is because almost half the younger women receive pensionable amounts for childcare years. The pension base increases with age, reaching a peak in the 50–55 age group. In higher age groups, the pension base diminishes due to reduced working hours. A greater incidence of long-term sick leave and retirement with disability pension further lowers the median for the pension base at more advanced ages.





**Number of persons by earned pension base in 2002.** The income differences between men and women are clearly

seen. Women are over-represented in the lower income brackets as men are in the higher ones.



**Proportion of the population with a pension base in 2002.** Almost 95 per cent of the population in the ages 21–60 have earned a pension base. The high proportion is explained by the fact that the pension base is calculated on the basis not only of salary but also of

sickness or activity compensation, sickness cash benefit, parental cash benefit and unemployment benefit.

For the oldest groups, the proportion of individuals with a pension base is lower, primarily due to early retirement.

Regulations  
2003

The pension base is the sum of pensionable income and pensionable amounts up to 7.5 income base amounts. Pensionable income includes income from employment, income from self-employment and social insurance payments (sickness cash benefit, parental cash benefit, unemployment benefit, etc). Pensionable amounts are calculated for sickness compensation, activity compensation (disability pension), compulsory service, studies and

childcare years. Pension rights are then calculated as 18.5 per cent of the pension base. The pension right for income pension is 16 per cent and the pension right for premium pension is 2.5 per cent of the pension base for persons born in 1954 or later. For those born between 1938 and 1953, a lower percentage is allocated to income pension and premium pension depending on the number of twentieths in the reformed pension scheme.

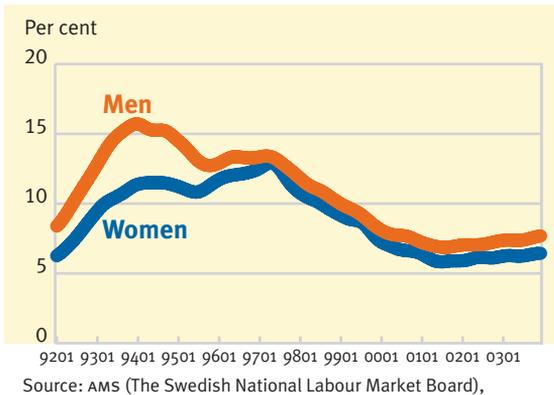
Age	Number of persons with pension base		Proportion of population, per cent		Pension base median, SEK	
	Women	Men	Women	Men	Women	Men
16-19	84,204	83,403	41.3	38.6	28,400	29,400
20-24	239,120	245,006	94.2	93.1	98,800	116,700
25-29	265,297	272,292	95.0	94.1	171,600	205,800
30-34	288,432	295,673	96.0	95.0	188,900	235,800
35-39	311,932	324,815	96.3	95.3	189,000	243,900
40-44	275,571	283,879	95.9	95.0	191,500	244,800
45-49	276,995	282,738	95.8	95.1	197,700	246,500
50-54	288,562	293,545	95.6	95.7	199,600	247,100
55-59	300,107	308,871	94.5	95.3	194,000	244,300
60-64	203,343	207,803	85.1	87.0	175,300	221,300
<b>Total</b>	<b>2,533,563</b>	<b>2,598,025</b>	<b>90.6</b>	<b>90.0</b>	<b>180,700</b>	<b>225,200</b>

**Earned pension base in 2002.** The proportion of women who had earned a pension base was just under 91 per cent and the proportion of men was 90

per cent. Half the women had a pension base higher than SEK 180,700 and half the men had a pension base higher than SEK 225,200.

## Unemployment insurance

Unemployment insurance is an active and integrated part of labour market policy in which the employment strategy is the main alternative and cash benefits are a last-resort measure for people between jobs.



**The proportion of officially unemployed persons and participants in labour market programmes.** The labour market weakened during 2003 and unemployment rose on average to 5 per cent of the workforce. The increase was greater for young people than for other groups. Apart from the recession and the reduced number of jobs available, the increase is explained by fewer training places in municipal adult education and fewer participants in labour market programmes.

On average, 223,000 persons were registered as unemployed at the close of each month, which was 5 per cent of the workforce. The corresponding figure for 2002 was 4.2 per cent. On average, 92,000 persons participated in labour market programmes each month, which was 25,000 fewer than in 2002. The increase in the number of unemployed is largely the result of longer periods of unemployment.

Unemployment among young people has increased to a greater extent than among other age groups. Young people are normally the first to be affected

by swings in the business cycle. The number of 18–24-year-olds who were either officially unemployed or participating in programmes was 56,000 on average at the close of each month in 2003, or 11.9 per cent of the workforce, which was almost 5,000 more young people in one year.

Unemployment has increased most for people with higher education. The last few years' downturn in the IT sector and the telecom industry and in associated service activities has brought increased unemployment to groups otherwise scarcely affected by swings in the economy.

Of the total increase of 37,000 persons officially unemployed between 2002 and 2003, those with high school education accounted for almost 17,000 and those with basic school education for just over 7,000 persons. The number of unemployed with college education rose by 13,000 persons or 28 per cent.

More people worked on an hourly basis in 2003. The number of persons in hourly-paid employment rose during 2003 to an average of 78,000 persons at the end of each month, an increase of 4,000 persons in one year. This is typical of a recession, when employers are reluctant to recruit.

74 000 persons were given notice of redundancy. It is the highest level in ten years and an increase of almost 7,000 in one year. The majority of those affected by notice of redundancy were in the manufacturing industry – 27,000 persons. Within the municipalities and county councils, 4,900 persons were given notice of redundancy.

**Unemployment benefits paid.** Unemployment benefit payments rose sharply at the beginning of the 1990s in step with rising unemployment and peaked in 1993 at approximately SEK 40 billion.

The regulations governing unemployment benefit have changed over time.



Source: AMS (The Swedish National Labour Market Board)

In order to qualify for unemployment benefit, applicants must be able-bodied and free to undertake employment, be prepared to accept the offer of a suitable job, be registered as a job seeker at the government jobcentre, participate in drawing up an individual action plan together with jobcentre staff and actively search for suitable work though.

Unemployment insurance consists of basic insurance and voluntary income-based insurance.

The basic payment is SEK 320 per day for those who have worked full-time. This is paid to those fulfilling the work or study criteria and who are not members of an unemployment benefit

fund or have not been a member long enough.

Compensation from voluntary income-based insurance may be paid to those who have been members of an unemployment benefit fund for at least one year and who meet the work criteria. The size of the daily cash allowance depends on the income the person received prior to unemployment. The daily cash benefit is 80 per cent of previous earnings subject to a maximum of SEK 680 per day. During the first 100 days of a payment period, an increased daily cash benefit may be payable at a maximum rate of SEK 730 a day.

## Regulations 2003

Age	Number of recipients		Average number of days		Average amount over the year, SEK	
	Women	Men	Women	Men	Women	Men
-24	37,197	37,612	64	76	26,977	35,810
25-29	48,380	42,220	70	88	36,226	49,816
30-34	49,856	37,443	75	92	42,510	56,149
35-39	45,670	34,822	79	96	45,463	59,500
40-44	32,414	27,960	80	99	45,844	61,453
45-49	24,434	23,089	82	102	47,087	63,401
50-54	20,597	20,699	87	106	49,797	66,501
55-59	20,389	20,976	94	112	54,172	71,075
60-	19,900	21,794	116	130	63,639	82,425
<b>Total</b>	<b>298,837</b>	<b>266,615</b>	<b>80</b>	<b>97</b>	<b>43,451</b>	<b>58,025</b>

Source: AMS (The Swedish Labour Market Board)

**Compensation from unemployment insurance in 2003.** Out of a total of SEK 28.5 billion in unemployment benefits

in 2003, SEK 13.8 billion (46 per cent) went to women and SEK 15.5 billion (54 per cent) to men.



## More statistics

Additional statistical details are available on the Swedish Social Insurance Agency's home page (address: [statistik.forsakringskassan.se](http://statistik.forsakringskassan.se)).

You may also address questions about statistics directly to the Swedish Social Insurance Agency by contacting the following people:

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# Social Insurance in Sweden 2004

The Swedish social insurance administration is a natural part of virtually every citizen's life. It is of considerable importance, not only in terms of people's security and welfare, but also in terms of the national economy, with a current total expenditure per annum of approximately SEK 430 billion.

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