First Exits from the Swedish Labor Market due to Disability

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Abstract

Nowadays, with an increasingly aging population, an increasing size of the population on disability benefits, and an implicitly lower level of economic output and foregone tax revenue, disability has become a major public policy issue in many countries. Estimating both single risk and competing risks models on a Swedish longitudinal database, this study analyzes the risk of exit due to disability at a certain age, conditional on having remained in the labor force until that age. The explanatory variables had not identical coefficients across destination types. For example, the estimated single risk model shows that a higher level of education decreased the hazard to exit the labor market with a disability pension, while the estimated competing risks model suggests that a higher level of education decreases increased the hazard of exiting with a partial disability pension, but it decreased the hazard to exit with a full disability pension.

Key words: disability pension; long-term sickness; single-risk and competing-risks models.

JEL Classification: I12, J14, J26, J28.

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1. Introduction

Working people are often exposed to physical, chemical, biological, and psychosocial factors that can cause short-term and/or long-term health problems, many of which could be prevented or controlled. Many of these people may end up with a disability. The complexity of the disability phenomenon is in part pictured by the evolution of its definition over time, which is presented in the Appendix.

Disability (and working capacity justifying a disability benefit) may also result from a number of diseases, injuries, or disorders that affect the visual, hearing, locomotor, or mental functions. Disability can affect working people of *all* ages, it diminishes life quality, and it increases the need for care and support from family and community members, as well as from health and social services. "Disability dependence" occurs when, for these reasons or others, employees do not return to work, although they may be capable of doing so. Instead, they become economically dependent on public or private financial support.

The economic approach to disability can take diverse forms, usually starting from the loss of working capacity, and related productivity loss, and then focusing on various aspects of exit, including economic relations with employers, social insurance officers, program administrators, and household members. The survey of Haveman and Wolfe (2000) discusses the main lines of economic research, addressing the issues of economic status and behavior of the working-age population with disabilities. Bound and Burkhauser (1999) review the behavioral and redistributive effects of transfer programs targeted on working people with disabilities, and they review the literature on the labor supply behavior of people with disabilities and how it is affected by disability program characteristics.[1]

In Sweden, although substantial public attention has focused on training and rehabilitation, labor market entry and placement of disabled workers, the problem of employees leaving the labor market early due to disability has received far less recognition.

[1] There have been few studies on disability exits from the labor market in Sweden (e.g., Berglind 1977; Hedström 1980; Wadensjö 1985, 1996; Hansson-Brusewitz 1992; Månsson et al. 1994, 1996; Wadensjö and Palmer 1996; Palme and Svensson 1997). Summarizing their findings, it seems that, there were three groups of independent variables that influenced the exit into disability: demographic variables; labor market variables and health variables.

Nowadays, however, with an increasingly aging population and a declining working-age population, disability has become a major public policy issue (not only in Sweden, but in many other countries as well). In addition to the aging issue, this attention is also explained by the increasing size of the population on disability benefits (10% of the working age population in December 2004), the increasing cost (64 billion kronor, the highest in the 2004 state budget),[2] and by an implicitly lower level of economic output and foregone tax revenue. The Government estimated the future cost for today's disability pensioners to 639 billion kronor (Riksrevisionen, 2005). Given that the percentage of younger people increased most, it is useful to learn more about *the age of the first exit* from the labor market due to disability and circumstances surrounding exit. Estimating both single risk and competing risks models using a longitudinal database for 1983-1991, this study analyzes the risk of exit due to disability at a certain age, conditional on having remained in the labor force until that age.

The study is organized as follows: the next section presents briefly the institutional and empirical framework, upon which our study is based, while sections 3 and 4, present the data, and the estimated results. The last section summarizes and draws conclusions.

2. The institutional and empirical framework

Prior to 1991, it was possible to be awarded a permanent or temporary disability pension on medical grounds, for those aged 16-64; or on medical and labor market grounds (i.e., due to long-term unemployment), for those aged 60-65.[3] Eligibility requirements for disability benefits have been tightened in successive reforms throughout the 1990s, and since 1997 medical reasons are the only valid criteria for granting a disability pension.

To be entitled to a disability pension, a physician must certify that the individual's capacity to work is reduced by at least 25%. If capacity to work is reduced for a long period but not necessarily permanently, the individual is entitled to a *temporary* disability pension

[2] In November 2005, 1 EURO ≈ 9,5 Kronor and 1 USD ≈ 8 kronor.

[3] Since January 2003, the terms disability pension and temporary disability pension were replaced by activity compensation for people between the ages of 19-29 and sickness compensation for those aged between 30-64.

(granted for up to 3 years at a time). This is determined with the help of a medical evaluation.

Disability pensions were payable in full, three quarters, two thirds, half or one quarter of the full rate basic pension and supplementary pension. Full disability pensions as basic pensions used to correspond to the full old age pension. Since 1st July 1995 however, the level for the basic pension has been reduced to 90% of the base amount for single pensioners and 72.5% for married pensioners. Since 1st January 1996, disability pensioners also receive the lower amount if their spouse is not drawing a pension. The reduced levels have partly been reimbursed for by a raised pension supplement.

The social insurance system is built in such way that it gives employees whose working capacity is (or may be considered to be) reduced due to sickness or injury a choice between various early-exit pathways from the labor market. When choosing a temporary or permanent early exit from the labor market, employees are assumed to maximize their lifetime utility. The choice alternative for an employee after a long-term sickness can be return-to-work, partial disability or full disability, and full or partial early retirement with the old-age system from age 60. The exit from the labor market due to disability is not completely an individual decision, as it is conditional on a medical evaluation, as well as a work capacity evaluation of a social insurance officer. Additionally, we assume that financial and psychological dependence may negatively affect employees who become disabled. Thus, the decision to exit with a disability pension may be difficult to accept. Employees who suffer from a chronic sickness, for example, may find themselves in a gray area, where they would qualify for a disability pension, but could continue to work. It is assumed, then, that the individual decision is made on the basis of actual utility given the financial resources. Given the financial resources provided by the disability pension, the decision may be *for disability* if the employee values more leisure and/or “psychic gains” that do not relate to the job or work environment, or *for work* if the employee enjoys work and/or can cope with the work environment, and/or derives utility from the social network related at work, and related factors, such as the structure of a fixed schedule.

We assume people make rational choices under uncertainty in a given risky environment and these choices both determine the hazard of exit, and the change in it over

time. According to Lancaster (1990), if we could observe the hazard function of a number of people living in the same risky environment and using the same decision making policy, or operating in environments and using policies which differ in known ways, we could confirm or refute the theory of their behavior and determine parameters that could be interpreted according to economic theory. Our aim is to estimate the hazard of exit, which is the risk that a person will exit at a certain age due to disability, assuming that (s)he has remained in the labor force until that age. The framework outlined above and the data allow for various types of early withdrawal from the labor force. Therefore, the exit decision will be estimated within a duration framework using both single risk and competing risks models.[4]

3. The data

The data, which come from the Long-term Sickness (LS) database owned by the Swedish National Social Insurance Board, include longitudinal information for about 4500 people during 1983-1991, on personal characteristics, earnings, history of sickness absenteeism from 1983, and rehabilitation history from 1986, and all exits from the labor market.[5] There are two *random* samples of Swedish insured population on working age. The first sample (IP) is representative for Swedish population, aged 20 to 64 during 1986-1991. The second (LSIP) is essentially the same as the first, *except* that everyone had *at least* one sickness spell of at least 60 days during the period 1986-1989. The IP sample includes about 1800 persons, while the LSIP sample one includes about 2700 persons. Both samples are analyzed here, allowing us to draw conclusions about slightly different populations: the IP sample is representative for the Swedish population on working age, while the LSIP sample is representative for the Swedish *working* population with a relatively bad health status.

Table A1 in the Appendix shows descriptive statistics for the analyzed samples by disability pension status, reported at *exit date*, which is either the actual date of first exit, or the end of the observation period (December 31, 1991) for those who had not exited.

[4] See Andrén (2001) for a detailed description of these models.
[5] See Andrén (2001) for a detailed description of the LS-database.

4. Estimation results and discussion

In this study, we focus only on exits due to disability. *Waiting time* until the first exit from the labor market due to disability was measured in years of age, because both the age when people started to work, and their working history were not in the data. Nevertheless, even if these data were available, we will still prefer the years of age because: 1) the employees' productivity may fall bellow what (s)he is paid, creating an incentive for the employer to "push" them on the direction of exit, and perhaps to lose interest in helping them; 2) the employees working capacity may decline due to a number of factors (i.e., the work environment/tasks are no longer as suitable; the employees' physical capacity may deteriorate due to a long absence of sufficient physical activity; health can become poorer; skills may become outdated, and the willingness or capacity to accommodate to change lower; they may desire more leisure, etc.). Therefore, exit alternatives may look more attractive at different ages, regardless of when people started to work. On the other hand, a long working career itself may be a factor of increasing importance with increasing age. At any given age, the hazard of exiting for those who did not exit earlier was estimated both nonparametrically and semiparametrically.

4.1. Nonparametric results

Nonparametric analysis let the dataset speak for itself and makes no assumption about the functional form of the survival function and thus no assumptions about hazard or cumulative hazard functions. Additionally, the effects of the covariates are not modeled, the comparison of the survival experience is done at a qualitative level across the values of covariates.

Figure 1 shows the smoothed hazard functions for the two samples by disability pension rate. The hazard of early exit was higher for the LSIP sample than for the IP sample. In the IP sample, the hazard of exit with a full pension increased dramatically at about age 50, and shortly thereafter for partial pensions, while in the LSIP sample, there were no such clear "break-points". Instead, there was a steady increase starting much earlier. The difference seems clearly explained by the different health status of the samples, previous long-term sickness seems often to be a "precursor" to earlier exit. Therefore, an

obvious policy recommendation is that, in addition to the (widely) used policies providing income support for disable people, policies designed to enable workers on sick leave to return to work should be used.

Figure 1 here

4.2. Semiparametric results

Table 1 shows the estimates of a Cox model for all types of exit, and separately for each type for the IP sample, and Table 2 shows these estimates for the LSIP sample. These are discussed separately. The likelihood-ratio chi-square statistic for the null hypothesis that the explanatory variables have identical coefficients across destination types is significant at well beyond the .01 level for both IP and LSIP samples, and therefore we reject the hypothesis. These results suggested that the analysis must be done by exit type.

Table 1 here

Table 2 here

A. The working-age sample

For *the IP sample*, considering all exits together, except gender, marital status and educational level dummies, all other variables are statistically significant by conventional criteria. Naturalized Swedes were 3 times as likely as Swedish born people to leave the labor force earlier due to disability at any given age, while foreigners were about 5.13 times as likely at any age. Citizenship may be a proxy for culture and attitudes toward work, as well as, human and perhaps health capital when starting working, but also for occupation, work environment and working conditions. Many of those who are not Swedish born immigrated to Sweden before 1973, during a period characterized mainly by an economically motivated migration. Given the health and human capital at that time (which not necessarily were the same as for Swedish born people), if they had jobs that required mainly (heavy) physical effort, the results here would not be unexpected.

Previous history of sickness mattered: for each one hundred days of previous sickness, there was about a 25% increase in the risk of exit, but for each additional spell of

sickness there was a decrease of 7.9% in the risk of disability exit.

Regional unemployment was also a significant push factor for exit: each one percent increase in the regional unemployment rate was associated with about a 30% increase in the risk of exit due to disability.

When a distinction was made among different kinds of exit (i.e., full or part-time) in the IP sample, it was found that compared to people with lower education, higher education decreased the hazard of exit with a *full* disability pension, but increased hazard of exit with partial disability benefit. The first result can be attributed to investment in health, but also by different work environments and working conditions for persons with low and high education. The second result may indicate that it is easier for persons with higher education to remain in the workforce (at least partially).

Foreign-born people were about 9.5 times as likely as Swedish born to exit with a full disability pension, while naturalized Swedes were about 5.5 times as likely. Being in a rehabilitation program (both vocational and medical) increased the probability of exit with a part-time benefit, but being in a vocational rehabilitation had no significant impact on exit with full disability. This may mean that participation in a rehabilitation program could be considered somewhat successful, in that some people can combine part-time work with partial benefit.

B. Working population with a relatively bad health status

For *the LSIP sample*, when no distinction was made among different kinds of exits (i.e., considering all exits together), except dummies for gender and medium level of education, all other variables were statistically significant at the 10% level. The hazard of exit for married people was about 80% of the hazard of singles. The hazard of exit for higher educated people was about 66% of the hazard of lower educated people, and even lower (about 48%) for exits with full benefit.

Naturalized Swedes were about 1.7 times as likely to exit due to disability as Swedish born people, while the foreign born were 2.5 times as likely as the Swedish born. These proportions were even higher for full benefits, and lower for part-time benefits.

Being in a rehabilitation program (both vocational and medical) increased the

probability of exit: Those who participated in a vocational rehabilitation program were about 1.3 times as likely to exit with full benefit as those who had not, and about 3.07 times as likely to exit with a part-time benefit. Those who participated in a medical rehabilitation program were about 1.9 times as likely to exit with full benefit as those who had not, and about 1.7 times as likely to exit with a part-time benefit. It seems that vocational rehabilitation had a higher impact on the decision of part-time pensions, while medical rehabilitation had a higher impact on exits with full pension. This may be associated with likelihood for persons with more severe medical problems to require medical rehabilitation, whereas vocational rehabilitation provides a means to remain active at least part-time.

Previous history of sickness had significant effects on the hazard of exit: for each one hundred days of previous sickness there was about an 11.9% increase in the risk of exit, and even higher (about 14%) for full pensions, but lower (about 7.4%) for part-time benefits. On the other hand, each additional spell of previous sickness was associated with about a 8.2% decrease in the risk of exit. As we have seen in the descriptive statistics of the samples, persons with a previous history of long-term sickness often have a history of many spells. One possible explanation of this is that previous sickness spells give people the opportunity to recuperate, thus delaying or avoiding exit due to disability. This is a result that supports the belief that preventing and controlling the deterioration of the health capital of people would decrease the number of exits from the labor market due to disability. Unemployment was again a significant push factor: Each one percent increase in the regional unemployment rate was associated with about 6.1% increase in the risk of exit, and even higher (14.1%) for full pension; and it was associated with about 10.5% decrease in the risk of exit with part-time benefit, which can be related to the fear of getting unemployed.

5. Summary and conclusions

The risk of exit due to disability at a certain age, conditional on having remained in the labor force until that age was analyzed using a Cox model for all types of exit, and separately for each type of exit. The explanatory variables had not identical coefficients across destination types. For example, the estimated single risk model shows that a higher

level of education decreased the hazard to exit the labor market with a disability pension, while the estimated competing risks model suggests that a higher level of education decreases increased the hazard of exiting with a partial disability pension, but it decreased the hazard to exit with a full disability pension.

The results show that participation in a vocational rehabilitation program increased the risk of exit with a partial disability, which could imply that rehabilitation was in a way efficient (in the sense that people are kept in the labor market). For persons with more severe medical problems, this may be associated with likelihood to require medical rehabilitation, whereas vocational rehabilitation may provide a mean to remain active at least part-time. Reducing the incidence and severity of disability in a population involves changes in the social and physical environment at work, changing attitudes towards what is required of especially older workers and what individuals should require of themselves in society, as well as changing individual performance (by improving physical capacity, learning new skills, being flexible enough to change tasks/jobs, etc.). Therefore, the health and educational systems should be developed in such a way to make it easier for individuals to achieve human and health capital that would allow them to reach a higher level of welfare. The development of strategies to reduce "disability dependence" thus requires detailed understanding of the underlying systems for rehabilitation and financial support, including the structure of the support and service system, the routes by which one enters it, and those by which one can exit, as well as the characteristics of the worker who becomes disabled. More effort should be made to design flexible programs that can be adapted to individual needs. Making the alternative of returning to work more attractive would reduce the economic burdens on society, and it would improve the quality of life and self-esteem of many employees who otherwise might have become disabled as well.

The decision to exit the labor market is an extreme alternative, and is not always the best alternative for the individual. On the other hand, even supposing that it is accepted that working some hours has a positive impact on individuals with health problems, it is difficult to match individuals with available jobs on the market. In such conditions, the process of integrating these people in the labor market becomes very complex, and it requires resources allocated on both sides: training and/or vocational rehabilitation of those

individuals, and the improvement of the working conditions and rethinking the job tasks in general. One possible proposal for policy would be that more resources should be allocated for preventing long-term sickness in general, but especially focus on the work environment for groups at higher risk. Even with these improvements, disability will always be a very complex phenomenon that requires dynamic and flexible policies aimed to a better well being of the individuals themselves, and the welfare of society in general.

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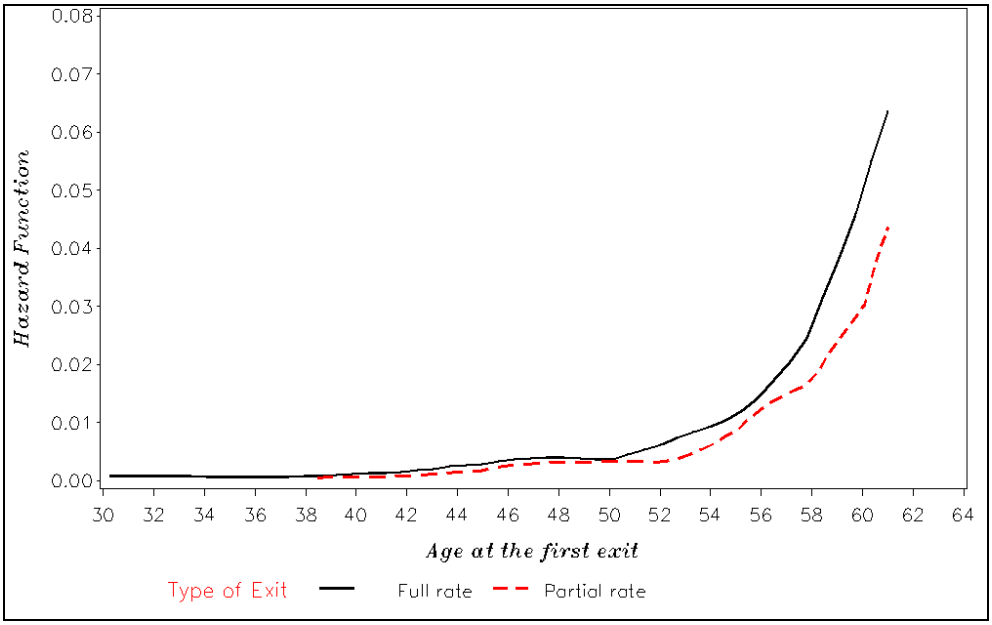
Appendix

A1 The definition of disability

The World Health Organization made an attempt in 1980 to find a way out from the dilemma of a right term for disability by issuing the International Classification of Impairments, Disabilities, and Handicaps (ICIDH). “Disability” was defined as “any restriction or inability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being”. ICIDH was criticized as model of consequence of disease in the following years, and a new version, ICIDH-2, is currently being drafted. It differs substantially from the original one, being *a classification of human health and disability*, systematically arranged according to somatic, psychological and social levels. ICIHD has moved away from its old focus on the impacts of diseases or other health conditions (the 1980’s “consequence of disease” classification) to a new focus on what constitutes health (today’s “components of health” classification). Both a “medical model” and a “social model” have been proposed for understanding and explaining disability and health (The term “model” here means an explanatory style or paradigm). The medical model views disability as “a personal problem, directly caused by disease, trauma or other health condition, which requires medical care provided in the form of individual treatment by professionals”. The social model, on the other hand, views the disability mainly as “a socially created problem, and principally as a matter of the full integration of individuals into society”.

Under the medical approach, the management of the disability is aimed at cure or the individual’s adjustment and behavior change, while under the social approach, it is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of people with disabilities in all areas of social life. Medical care is viewed as the main issue, and at the political level the principal response is that of modifying or reforming healthcare policy, while environmental changes is viewed as an attitudinal issue, which at political level becomes a question of human rights.

a)



b)

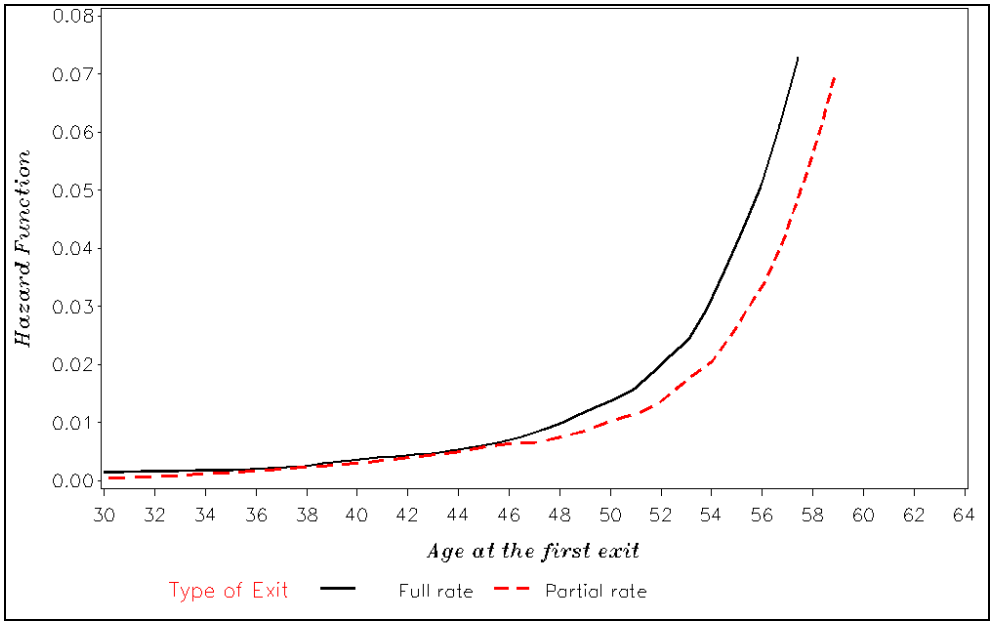


Figure 1 Smoothed hazard functions- Exits with full or partial disability pension, IP (a) and LSIP (b) samples

Table 1 Semiparametric estimates for single-risk and competing-risks models of first exit due to disability, IP sample

Variable	All exits			Full Pension			Partial Pension		
	β	Std Err	HR	β	Std Err	HR	β	Std Err	HR
Women (CG: men) [a]	0.04	0.21	1.04	-0.07	0.26	0.93	0.29	0.35	1.34
Married (CG: unmarried)	-0.06	0.22	0.94	-0.28	0.28	0.76	0.49	0.38	1.63
Education level (CG: low)									
Medium	-0.01	0.27	0.99	-0.59	0.40	0.56	**0.75**	0.41	2.13
High	-0.25	0.42	0.78	**-1.10**	0.62	0.33	**0.92**	0.57	2.52
Citizenship (CG Swedish born)									
Naturalized Swede	**1.12**	0.30	3.06	**1.71**	0.34	5.53	-0.55	1.02	0.58
Foreigner born	**1.63**	0.35	5.13	**2.25**	0.39	9.52	0.02	1.03	1.02
Rehabilitation type									
Vocational	**0.74**	0.30	2.09	-0.36	0.44	0.70	**2.06**	0.44	7.85
Medical	**1.13**	0.31	3.11	**0.93**	0.40	2.53	**1.69**	0.49	5.44
Sickness days before exit [b]	**0.23**	0.02	*25.60*	**0.29**	0.03	*33.00*	**0.14**	0.04	*15.00*
Sickness spells before exit	**-0.08**	0.02	*-7.90*	**-0.13**	0.03	*-12.50*	-0.03	0.03	*-3.40*
Earnings (1000 SEK)	**0.00**	0.00	*-0.30*	0.00	0.00	*0.00*	**-0.01**	0.00	*-0.90*
Regional unemployment	**0.27**	0.08	*30.50*	**0.36**	0.10	*42.60*	0.13	0.13	*14.20*
Testing H_0: BETA=0[*]									
Likelihood ratio	225.45			165.56			97.61		
Score	394.64			247.84			226.97		
Wald	251.07			154.31			115.23		
-2 Log-likelihood [c]	1289.9	1064.5		819.8	654.2		472.4	374.8	
Events| censored cases	116	1680		74	1722		42	1754	

Notes: The estimates in **bolds** are significant at the 10%-level. *Italics* for hazard ratio (HR) indicate that for the continuous variables it had been recomputed as *phr* = 100*(*HR*-1).

[*] For all models, the degrees of freedom (DF), is 12, and the chi-square statistic is significant beyond 0.001 level; [a] CG is the comparison group; [b] in hundred; [c] the first value for the case without covariates, and the second value for the case with covariates. All these notes apply to Table 2.

Table 2 Semiparametric estimates for single-risk and competing-risks models of first exit due to disability, LSIP samples

Variable	All exits			Full Pension			Partial Pension		
	β	Std Err	HR	β	Std Err	HR	β	Std Err	HR
Women (CG: men) [a]	-0.01	0.08	0.99	0.05	0.10	1.05	-0.08	0.14	0.93
Married (CG: unmarried)	**-0.20**	0.08	0.82	**-0.23**	0.10	0.79	-0.16	0.14	0.85
Education level (CG: low)									
Medium	-0.08	0.11	0.92	**-0.27**	0.14	0.76	0.23	0.17	1.26
High	**-0.41**	0.18	0.66	**-0.74**	0.24	0.48	0.20	0.28	1.22
Citizenship (CG Swedish born)									
Naturalized Swede	**0.52**	0.14	1.68	**0.66**	0.17	1.94	0.18	0.26	1.19
Foreigner born	**0.90**	0.15	2.46	**1.02**	0.18	2.77	**0.55**	0.27	1.73
Rehabilitation type									
Vocational	**0.59**	0.10	1.80	**0.27**	0.13	1.31	**1.12**	0.17	3.07
Medical	**0.64**	0.10	1.90	**0.67**	0.13	1.95	**0.55**	0.18	1.73
Sickness days before exit [b]	**0.11**	0.01	*11.90*	**0.13**	0.01	*14.00*	**0.07**	0.02	*7.4*
Sickness spells before exit	**-0.09**	0.01	*-8.20*	**-0.10**	0.01	*-9.50*	**-0.06**	0.01	*-5.4*
Earnings (1000 SEK)	**0.00**	0.00	*-0.30*	0.00	0.00	*-0.10*	**-0.01**	0.00	*-0.8*
Regional unemployment	**0.06**	0.03	*6.10*	**0.13**	0.04	*14.10*	**-0.11**	0.06	*-10.5*
Testing H_0: BETA=0[*]									
Likelihood ratio	580.55			430.68			213.48		
Score	633.91			470.87			235.20		
Wald	598.76			438.53			221.36		
-2 Log-likelihood [c]	8941.7	8361.1		5934.3	5503.6		3031.5	2818.0	
Events| censored cases	700	1926		461	2165		239	2387	

Table A1 Descriptive statistics by individual at "exit" date, IP and LSIP samples

	No exit		Full disability		Partial disability	
Variable	IP	LSIP	IP	LSIP	IP	LSIP
Women	0.50	0.58	0.46	0.48	0.60	0.54
Marital status						
(1=married, 0=single)	0.52	0.54	0.51	0.60	0.62	0.58
Married women	0.27	0.34	0.27	0.30	0.31	0.31
Citizenship						
Swedish born	0.88	0.85	0.70	0.83	0.95	0.87
Naturalized Swedes	0.05	0.07	0.16	0.09	0.02	0.07
Foreign born	0.07	0.09	0.14	0.09	0.02	0.07
Educational level						
Low	0.47	0.56	0.85	0.83	0.66	0.74
Medium	0.36	0.34	0.11	0.13	0.24	0.20
High	0.17	0.10	0.04	0.04	0.10	0.06
Age groups						
18-35 years	0.33	0.33	0.07	0.07	0.05	0.07
36-45 years	0.29	0.29	0.09	0.11	0.10	0.18
46-55 years	0.24	0.24	0.31	0.33	0.31	0.30
56-65 years	0.14	0.14	0.53	0.49	0.55	0.45
Age	41.99	42.11	53.35	52.33	53.62	51.93
	(10.89)	(10.94)	(9.57)	(8.88)	(8.11)	(9.38)
Earnings, 1000 SEK	169.80	164.79	113.60	141.06	96.60	112.04
	(95.08)	(63.34)	(93.10)	(76.40)	(61.32)	(66.34)
Regional	2.37	2.34	2.68	2.50	2.58	2.22
unemployment rate (%)	(1.19)	(1.19)	(1.57)	(1.30)	(1.25)	(1.21)
Sickness spells before exit	9.18	14.15	3.36	4.33	5.17	5.09
	(9.79)	(11.28)	(4.73)	(4.94)	(6.70)	(6.84)
Sickness spells after exit			0.08	0.12	4.79	5.63
			(0.49)	(0.88)	(8.61)	(7.91)
Sickness days before exit	119.27	459.33	537.77	741.74	564.69	654.20
	(237.48)	(418.02)	(422.45)	(416.92)	(495.24)	(478.48)
Rehabilitation type						
Vocational	0.03	0.19	0.12	0.21	0.38	0.30
Medical	0.01	0.08	0.14	0.18	0.19	0.16
n	1680	1926	74	461	42	239