SICKNESS BENEFIT ENTITLEMENT IN SWEDISH LAW

BY

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I. INTRODUCTION

1. *National Insurance*

Like many other countries Sweden has a special social insurance system. The Swedish system comprises a number of different forms of insurance belonging either to the National Insurance system or to the group of special insurances. National Insurance consists of health insurance, the basic pensions scheme and the supplementary pensions scheme. The rules governing these forms of insurance are collected together in an act, the National Insurance Act. The other forms of social insurance are partial pension insurance, industrial injuries insurance and unemployment insurance. The rules in respect of each type of insurance are contained in special statutes, though the rules are usually partly linked with the general rules of the Act.

The National Insurance Scheme covers a very broad group of people. Those who are insured are, on the one hand, all Swedish citizens and, on the other hand, all foreigners domiciled in Sweden. Consequently, as far as a Swedish citizen is concerned it does not matter in which country he is domiciled—he is insured anyway under the National Insurance Act. As against this, a foreigner must have a certain actual link with Sweden, a link that is demonstrated by his being domiciled in this country. The insurance is, moreover, compulsory. This means that anyone who meets the insurance requirements is *obliged* to belong to the insurance scheme. Naturally, only those who are insured qualify for National Insurance benefits. (In this case the fact that as a result of an international convention a foreigner may be guaranteed certain benefits is disregarded.) However, the fact that a person is insured constitutes only a *basic condition* for receiving compensation under the Act, and does not mean that the insured will automatically enjoy all the benefits provided for under the Act. Where different kinds of benefits are concerned different conditions apply regarding entitlement to compensation. In what follows it is precisely the conditions guaranteeing entitlement to sickness benefit that will be dealt with in detail and analysed.

The National Insurance Scheme is financed through employers' contributions and individual contributions. Employers' contributions are paid by the employer according to the remuneration paid to his employees in the course of a calendar year. Individual contributions on a certain percentage basis are

paid by self-employed persons whose incomes derive from a business or agriculture. A government subsidy also helps to finance health insurance and the basic pensions scheme.

In the country as a whole there are 26 regional Public Insurance Benefit Services (each with a large number of local offices) which handle the local administration of the public insurance system (hereinafter referred to as the Service). Appeals against the decision of the Service in connection with a social insurance benefit are made to the regional Insurance Court. There are, however, only three such courts, and experience has shown that this is too few, since these courts are unable at present to deal with all the cases brought before them within a reasonable time. This means that consideration of many important cases is delayed and may take several years. The highest court is the Supreme Insurance Court. The Insurance Courts and the Supreme Insurance Court have exclusive jurisdiction over disputes concerned with social insurance benefits. Such disputes therefore fall outside the jurisdiction of the ordinary courts of law. In hearings before the courts the case for the state is presented by a central government agency, the National Social Insurance Board. The Board also has other duties within the National Insurance Scheme in that it has the right to issue regulations under the National Insurance Act and supervise the work of the Service, tasks which may be difficult to reconcile with the task of representing the state before the insurance courts.

2. *Sickness benefit*

Health insurance takes three main forms: insurance for *medical service,* which is intended to cover the costs incurred as a result of illness or childbirth, insurance for *sickness benefit,* which is intended to compensate for loss of income on account of illness, and also *parental insurance,* which is intended to compensate for loss of income when parents refrain from gainful employment in order to take care of their own children. The following account will deal only with the rules relating to insurance for sickness benefit.

Insurance for sickness benefit is the oldest form of social insurance in Sweden, and its origins can be traced back to the sickness insurance movement that developed in Sweden during the second half of the 19th century. Originally, the health insurance offices were private benevolent societies and membership was voluntary. Gradually, however, it proved necessary for the state to intervene by supporting and regulating these health insurance schemes, and through the Health Insurance Act of 1910 the schemes received state subsidies at the same time as they came under a certain degree of state control. Membership in these schemes continued, however, to be voluntary, and it was not until the 1947 National Health Insurance Act was passed that health

insurance became compulsory. In 1962 the rules were incorporated in the National Insurance Act now in force.

Insurance for sickness benefit is intended to compensate for loss of income arising as a result of illness. The higher the insured person's income is the higher also is his sickness benefit, though the actual sum payable must be fixed in advance before the insured person falls ill. This means that the Service and the insured person know the amount of the sickness benefit to be paid out, and so the Service fixes in respect of each gainfully employed person who is insured for sickness benefit the income on which the benefit is based. This income is assessed as the money income or the benefits in kind, such as food, housing or car, which the insured person may be expected to enjoy during the year as a result of his or her own work. As soon as the income changes a new income will be worked out as a basis for sickness benefit, though the income forming a basis for sickness benefit cannot exceed a certain amount (at present 120 750 SEK) even if the insured person's actual earnings are in excess of this. Full sickness benefit per day amounts to 90 % of the assessed annual income forming a basis for sickness benefit divided by 365.

3. *Qualifying requirements for sickness benefit entitlement*

The requirements governing the entitlement to sickness benefit can be divided into two groups: one with formal conditions and one with physical conditions. The former group exists mainly to demarcate those insured persons who could qualify for sickness benefit. These formal conditions are concerned with facts that have no connection with a specific case of illness, while the physical requirements lay down the conditions under which an insured person who fulfils the formal requirements will be entitled to sickness benefit in some specific case of illness. These physical requirements may be said to describe in more detail what must be involved before a person is regarded as entitled to sickness benefit. The following study will take up first the formal requirements and then the physical ones.

II. FORMAL REQUIREMENTS

1. *The implications of the requirements*

Entitlement to sickness benefit presupposes formally, on the one hand, that the insured person is registered with the Service and, on the other hand, that his annual income on which sickness benefit is based is at least 6 000 SEK. To be registered with the Service the insured person must also have reached the age

of 16 and be domiciled in Sweden. This rule mainly affects Swedish citizens, since these are insured in accordance with the National Insurance Act even if they are living abroad. But as will be seen from the rule just mentioned, Swedish citizens domiciled abroad are not covered by insurance for sickness benefit. The requirement concerning a certain minimum annual income must be viewed against the background of the fact that insurance for sickness benefit is intended to compensate for loss of income of those who are gainfully employed. There must, though, be reasonable grounds for such compensation, and for this reason a very small income on which the insured person cannot support himself and which, furthermore, does not involve the usual obligatory income tax return cannot be regarded as entitling a person to sickness benefit.

There is, however, one category of insured persons, namely housewives/home-husbands, who are covered by insurance for sickness benefit even if their income is less than 6 000 SEK. Even though in such cases the sickness benefit is not intended to compensate for loss of income some compensation may be paid if the insured person is married and is living together with his/her spouse. The insured is also entitled to sickness benefit if he/she is living with a child under 16 years of age who is either his/hers or his/her spouse's or with a person with whom he/she has been married or has or has had children. The amount payable in sickness benefit for a housewife/home-husband is laid down in the Act and is at present 8 SEK per day.

The most important points here are the requirements relating to domicile in this country and to a certain minimum income.

2. *Domicile in Sweden*

Each Service keeps a register of insured persons. The register must be brought up to date as soon as the Service is informed that someone is to be registered or removed from the register. The most usual reason for an entry in the register is change of residence. An entry made because a person has moved to or from Sweden will determine whether the person is entitled to be insured for sickness benefit.

The term "domiciled" is not specifically defined in the National Insurance Act, but as far as possible it is to be interpreted in accordance with the rules relating to national population registration. This has meant that it has been possible to apply a simple principle—and one that is suitable for subordinate authorities—that anyone who is registered in a parish registration book in Sweden is also to be regarded as being domiciled in this country.

There are, however, certain exceptions from this principle. For example, a Swedish seaman who because of his sea service is registered in the Swedish

Seamen's Register and has not given notice of his intention to emigrate is regarded as being domiciled in Sweden.

Furthermore, it is not always the entry in the parish register that reflects the true place of residence of an insured person, and for this reason the Service considers that it has the right, after having carefully investigated the actual circumstances, to decide whether a person can be regarded as being domiciled in Sweden or not. Thus, the Service has the right to remove an insured person from its own register, irrespective of the parish registration, if the investigation should reveal that the person concerned intends to reside abroad permanently. In practice an attempt has been made to give the term "permanently" a certain homogeneous meaning. It has been considered that a period of one year could in this respect be taken as an indicator of what is to be understood as permanent or not.

The parish registration requirement and the one-year rule constitute a simple formula and ought not to cause the authorities who apply the laws any real problems. However, the precise meaning of the rules, in particular the one-year rule, could give rise to a rigid application of the law that might be to the disadvantage of the individual.

In case of people coming to Sweden importance is attached to the purpose, apart from the permanence, of their stay. The purpose has to be gainful employment or something comparable, for example study. A mere holiday stay—even if it lasts for more than one year—cannot be considered to constitute residence. A Swedish couple, both missionaries, who returned to Sweden after almost three years' service abroad, were regarded as domiciled here when their stay had lasted 18 months, with the first six months only being set aside for rest and recreation (FD 1962: 33). Two American researchers both had an acceptable purpose for their stay in Sweden: they intended to conduct medical research at a Swedish institute. One of them intended to stay here for about two years. He and his wife, who accompanied him, were regarded as resident in Sweden. The other, on the other hand, intended to stay in Sweden only about 10 months, and so for the whole of this time he and his wife were regarded as being resident in the USA (FD 1970: 5).

When people leave Sweden it seems that only those who are Swedish citizens can be considered as entitled to a one-year respite, though it is possible that the one-year rule also covers foreigners employed by Swedish firms who are transferred to work abroad. Other foreigners, however, fall outside the area covered by this rule, and if a foreigner intends to stay abroad indefinitely his residence in Sweden is regarded as at an end when he leaves the country. A Swedish man and his English wife were treated differently when, after living in Sweden for three years, they moved to England, where the husband was to study for two years, while his wife was to work, also for two years. The

husband was allowed to remain as a registered insured person for one year from the day they left for England, though his wife, by departing for England, was regarded as having ceased to be domiciled in Sweden (FD 1975:27).

An untypical case concerned a Turkish couple that left Sweden for Turkey when the wife fell ill with a special disease of the lungs, which it was felt could be best diagnosed and treated only by Turkish doctors. Prior to their departure the Service granted the wife a sickness benefit for a certain period, while the husband was removed from the Service register of insured persons as from the day following their departure. To begin with, the wife was allowed to remain on the insured persons' register as long as a sickness benefit was being paid to her, but after that the question arose of whether she, too, should be removed from the register. The Supreme Insurance Court decided by the smallest possible majority (3 against 2), however, that she should continue to be regarded as domiciled in Sweden. The majority maintained *that* the woman had been obliged to leave Sweden for treatment for a serious illness, *that* her illness had prevented her from returning to Sweden and *that* it was her intention to return to Sweden when she had recovered (FD 1976:5). The outcome of the case must be ascribed in the first place to the fact that the woman was unable freely to choose her place of residence, which could otherwise be assumed to have been in Sweden.

The fact that a Finnish or a Norwegian citizen works in Sweden but has his family back in his own country, but not very far from his place of work in Sweden, has led to certain problems as to how the law is to be applied. If the husband regularly visits his family at weekends and during other leisure periods the problem arises whether he is to be regarded as domiciled in Sweden or not. Thus, in two cases Finnish citizens living in accommodation provided at their place of work, who visited their families in Finland whenever they were free from work, were regarded as not being domiciled in Sweden, even though they both stated that their sojourn in Sweden was to be regarded as permanent (FD 1972:7, 1973:29). The actual situation can be particularly difficult to ascertain if the husband and his family have been resident in Sweden for some time and the family later move back to their country of origin while the husband stays on and continues working in Sweden. A mine-worker and his wife, both Norwegian, had been domiciled in Sweden for four years and had been registered with the Service. When the family moved back to Norway it was decided that the husband, who still worked at the mine in Sweden but spent the weekends and other leisure periods with his family at their house in Norway, was no longer resident in Sweden (FD 1967:31). In a later case, where the actual circumstances were similar, it was, however, decided that the husband was still domiciled in Sweden. A Finnish family had lived in Sweden for seven years, after which the wife and children moved back

to Finland and took with them all their household possessions. The husband, who had a permanent position with a Swedish enterprise, stayed on in Sweden and used to visit his family in Finland every weekend, unless weather conditions made it impossible (FD 1975: 36). In this case it seems that notice was taken of something that in previous cases does not seem to have been regarded as of any importance. What seems to have been decisive in this case was, in fact, that the husband in question paid income tax in Sweden and was also taxed as an unmarried person.

3. *Minimum income*

To be entitled to sickness benefit a registered insured person must have an annual income on which sickness benefit is based of at least 6 000 SEK. When registering an insured person and at the same time determining his income on which sickness benefit is based the Service must decide whether the person is eligible for insurance for sickness benefit. Any subsequent change of income that affects the right to sickness benefit entails reconsideration of the decision. The insured person is obliged within a certain period to report such a change in his income, and the Service, on its side, must obtain information of his income, either by asking the insured person himself or in some other suitable way.

The rule on an annual minimum income may become relevant, on the one hand, when an insured person starts work or takes on additional work so that the income limit is reached or, on the other hand, when an insured person ceases to work or reduces the extent of his work so that his income falls below the minimum limit. In time, partly as a result of the way the Supreme Insurance Court applies it, the rule has been modified somewhat since it has been the desire of the authorities to avoid allowing temporary income changes, and also certain reasons for a change in income, to affect the application of the rule. In its ordinances the National Social Insurance Board has laid down in more precise terms the area of application of the rule. When calculating the income on which sickness benefit is based, the only income to be taken into account is the income an insured person may be assumed to earn in the course of six consecutive months' work or from work that is performed on a yearly basis. In addition, the income on which sickness benefit is based must not be reduced if the insured person ceases to be gainfully employed or reduces his hours of work for a period shorter than six consecutive months. An insured person who was given leave of absence from his employment in order to build his own house, and whose leave of absence could be estimated to continue for 7 ½ months, was regarded as not being eligible for insurance for sickness benefit (FÖD Dnr 147/80: 7).

A number of various reasons for a fall in income have not been regarded as justifying a change in the income on which sickness benefit is based, and one of these is leave of absence in connection with pregnancy or in order to take care of a child. If a woman ceases to be gainfully employed or reduces her hours of work not more than six months before the expected birth of her child, the income on which her sickness benefit is based must not be reduced during her pregnancy. In addition, the income on which a parent's sickness benefit is based must not be reduced during the period the parent is wholly or partly on leave of absence from work in order to take care of a child under the age of eighteen months.

Furthermore, if an insured person is in receipt of sickness benefit, or is doing his military service, the income on which his benefit is based must not be reduced during this period. Similarly, a course of study may also constitute a reason for a fall in income without thereby affecting the income fixed for the purpose of determining the scale of sickness benefit. In the Act certain types of education (adult education, research work and professional training) are specifically mentioned, and those engaged in these must not have any reduction made in their income on which sickness benefit is based. Furthermore, income is not to be reduced for the person who is free from his job for a course of study within his own professional field, or is otherwise studying within his own professional field for a period not exceeding one year. Usually, disputes concerning the application of the rule are connected with the question of whether the studies do or do not fall within the insured person's professional field. A director of a social services department who was studying law at the university was not considered to be pursuing a course of study within his own professional field (FD Dnr 2097/77). A holder of a post as a secretary with a local municipality, who was studying at high school in order to have a chance of promotion to a more highly-qualified and above all more independent position, was also not considered to be pursuing a course of study within her own professional field (FD Dnr 276/78). As against this, an insured person, who was working as a secretary with a pharmaceuticals company, was considered to be pursuing a course of study within her own professional field when she took a high school study course where one of the aims was to provide the student with a knowledge of physics, chemistry and biology (FÖD Dnr 299/80:4).

In certain circumstances an unemployed person can also continue to be eligible for insurance for sickness benefit, but in that case he is required to be registered as seeking employment at the labour exchange and must also be prepared to accept work offered to an extent that corresponds to the income fixed as a basis for sickness benefit. When the rule is being applied it can sometimes result in a dispute as to whether the insured person can be

considered to be at the disposal of the labour market. It may, for example, be questioned whether he really is looking for work or has refused to accept the work offered to him.[1]

A decision by the Service that the income on which sickness benefit is based no longer reaches 6000 SEK need not mean that the insured person is excluded from insurance for sickness benefit. The fact is that he/she may instead meet the requirements laid down in respect of an insured housewife/home-husband and thus be entitled to a full benefit of 8 SEK per day. Because of this, married and unmarried insured persons are often treated differently, in that the unmarried person is excluded from the insurance while the married one is allowed to remain as an insured housewife/home-husband.

III. PHYSICAL REQUIREMENTS

1. *The implications of the requirements*

The rule that defines the physical requirements for entitlement to sickness benefit is short and concise. It reads: "Sickness benefit is payable in the event of an illness that leads to capacity for work being reduced by at least one half." Thus, in the first place the insured person must be ill. This illness, moreover, must reduce the capacity to work by at least one half. The rule, which at first sight might seem a simple one, has, however, proved quite difficult to apply in practice. In what follows a number of problems are listed which can arise when the rule is being applied.

Linked to the physical rule there is a rule relating to the size of the sickness benefit. This rule implies that a full benefit is payable only if the insured person is completely unable to work, otherwise the benefit will be at the rate of 50 per cent.

2. *The term "illness"*

The Act does not contain any definition of the term "illness". In older preparatory legal work there are certain statements concerning the meaning of the term, and these are still regarded as providing guidance.[2] From these it follows that when assessing whether a person is ill the authorities should keep

[1] See A. Christensen, "Disqualification from Unemployment Benefits", 24 *Sc.St.L.*, pp. 153 ff. (1980).

[2] *Socialvårdskommitténs betänkande. 7. Utredning och förslag angående lag om allmän sjukförsäkring, SOU* 1944: 15, pp. 162 f.

to what is normally regarded as illness according to linguistic usage and to current medical opinion. With this as a starting point illness can be described as any abnormal bodily or mental condition that does not coincide with that usually associated with normal health. However, these points of view are not intended to limit the authorities in applying the Act—quite the reverse since in the *travaux préparatoires* referred to it is stated that when applying the Act account should also be taken of what is reasonable. Thus the authorities in their application of the Act have in fact a good deal of freedom to decide the meaning of the term "illness". The rulings of the Supreme Insurance Court, which contain statements concerning the extent of the term, usually mean that large groups of people are either entitled to or excluded from sickness benefits. For this reason the rulings usually tend to attract a good deal of attention and are reported in detail in the daily press.

The view has been that the disabilities and physiological changes that are connected with the ageing process in people or with pregnancy and childbirth are part of the normal business of living and are not, therefore, to be regarded as illnesses. A woman who, according to her doctor's certificate, was on the sick-list as completely unable to work on account of fatigue in connection with her pregnancy, was refused sickness benefit since in her case her medical condition was quite normal (FÖD Dnr 381/78). Similarly, a woman whose pregnancy had been free of complications and whose delivery was normal was considered to be ineligible for sickness benefit, since weakness after childbirth was a normal condition that could not be regarded as an illness (FD Dnr 259/77). On the other hand, in a recent case the Supreme Insurance Court has ruled that the condition of an insured person after a Caesarean section is to be regarded as an abnormal physical condition of a kind that cannot be said to be connected with the normal business of living and should therefore be counted as an illness. The nature of the operation and the woman's subsequent condition were regarded as comparable to the conditions obtaining during an ordinary abdominal operation (FÖD 81:21).

Previously, sickness benefit was granted in the event of a spontaneous abortion but not when the woman herself had requested an abortion and the subsequent operation was not caused by illness. The trend here, however, is in the direction of accepting that abortions of all kinds are operations connected with illness. This practice will have a noticeable effect on the economy of the country, something the Supreme Insurance Court is of course well aware of and which may explain the cautious attitude previously displayed by the Court. During 1980, nearly 35 000 women had abortions in Sweden. Most of these were certified sick for one week, though some 3 000 required a longer period than this. If we allow for a sickness benefit of 150 SEK a day on the average, the total cost to the country would be about 35 million SEK if all the

women concerned applied for sickness benefit. As regards sterilization, which previously was not counted as an operation causing illness, it now seems that this, too, is regarded as giving rise to a condition entitling people to sickness benefit.

As a result of the criterion of reasonableness it is considered that compensation ought to be paid in connection with treatment that is caused by congenital physical defects and where the treatment given can improve the working capacity of the person concerned. For example, an operation for harelip or a squint ought to entitle a person to sickness benefit, though it is felt that no benefit ought to be paid if the measures taken are in the main a result of a desire to improve the appearance. A man who, because of an operation for the removal of large tattoos carried out by an amateur, was obliged to stay away from work altogether for a certain period of time, was however held to be entitled to sickness benefit, since the operation would cure his mental distress caused by the tattoos and would not in the first place improve his appearance (FD Dnr 708/77). An insured person who had lost his upper-jaw set of dentures and regarded himself as unable to work until a new set was provided, was however not regarded as entitled to sickness benefit (FD Dnr 1109/78).

An explicit rule in the Act lays down how in a specific case the term illness ought to be extended. Here it is stipulated that a condition of reduced working capacity resulting from an illness for which a sickness benefit has been paid, and still remaining after the illness has passed, is none the less to be regarded as illness. This rule is intended to establish that even after an illness any residual incapacity for work due to deformities and mutilations ought to be ranked as an illness. The rule contains the important limitation that the incapacity for work must always be traceable to an illness. In the application of the law the requirement that there must be a link with an illness has had considerable influence. It has for one thing affected the assessment of cases where the insured persons were unable to work because their spectacles were broken or their contact lenses have cracked. As a rule nearsightedness or impaired vision is not regarded as a disease in itself. One woman who applied for sickness benefit for the period during which she was unable to work because she had broken her spectacles, had her application rejected since, according to current medical opinion, the vision defect she suffered from was regarded as inherent and not as an illness (FD 1975: 44). As against this, however, it was held that entitlement to sickness benefit did exist when the greatly reduced sight of the insured person had been caused by an operation designed to cure a cataract with which the person had been born (FD 1977: 15). The person who is greatly dependent on his spectacles can quite easily be affected by certain symptoms of illness, such as headaches or nausea, during the period he is without spectacles, and so the insured person who states that he is unable to

work owing to headaches or nausea will usually receive a sickness benefit. One woman who mentioned in passing that eye strain quickly caused headaches, nausea, impaired judgment of distance, etc., but merely stated the cause of illness as "cleaning and checking of contact lenses" did not, however, receive any sickness benefit (FÖD Dnr 1007/79:4). An insured person who had been sicklisted by a doctor because he had broken his spectacles, had only 20 per cent normal vision and was thus completely dependent on his spectacles while at work. The representative of the state (the National Social Insurance Board) accepted that he had a right to sickness benefit and was of the opinion that in the application of the National Insurance Act a reduction of vision as serious as that from which the insured person was suffering ought to be regarded as an illness. However, the Supreme Insurance Court ruled against this and expressed the opinion that this could not be a question of an illness since the cause of the reduction of vision was extreme nearsightedness and astigmatism (FÖD Dnr 45/80:3).

Furthermore, the entitlement to sickness benefit presupposes that a visit to a doctor and hospitalization have been caused by the insured person's illness. An insured person who had been examined to determine whether he could be a kidney donor was regarded as not entitled to a sickness benefit (FD 1967:1), while another insured person who had suffered from spinal trouble from childhood was paid a sickness benefit for the period of time she had visited an institution for medical treatment and for trying out a shoulder halter (FD 1969:21).

As may be seen from the above, the decisions of the Supreme Insurance Court make it possible to establish to some extent what kind of condition can be embraced by the term illness. In these cases the actual condition of the insured person is quite clear and the main question is whether this can be designated "illness". There is also another kind of case that is concerned with the question of whether the insured person can be considered ill. These are cases of the kind where the Service has reason to doubt the accuracy of the details supplied by the insured person concerning his illness. In other words, the point at issue is whether the insured person is really suffering from the illness he claims to have. In such cases the Service or the court usually arrange for a doctor to examine the insured person, and the doctor's report usually forms the basis of the decision of the Service or the court. If the doctor has made a wrong diagnosis a retroactive sickness benefit can be paid later. A woman who had been wholly or partly on the sick-list for two years with an illness diagnosed as virus + bronchial+psychic insufficiency was considered by her doctor to be free of her earlier trouble and to be capable of full-time work. Both the Service and the court were of the opinion that a sickness benefit should no longer be paid, but before the Supreme Insurance Court had time to

decide on the case the woman died of a brain tumour that must have been there for many years and have been the cause of the illness described by the woman. The Supreme Insurance Court ruled that the woman had been entitled to a sickness benefit even after the Service had decided to discontinue her benefit (FÖD Dnr 1059/79: 3).

To be able to establish that the insured person is entitled to a sickness benefit the Service must learn the nature of the illness. A benefit is not paid out when the insured person has at any time refused to name his illness, and the reason for the decision is that it has not been made clear that the capacity to work has been reduced on account of illness. Not even when the insured person was a doctor—who pointed out that according to the law she was not obliged to name the illness and that the diagnosis was her own private business—was the existence of an illness felt to have been reliably confirmed (FÖD Dnr 915/80: 5).

The wording of the law makes it clear that there must be a specific illness that causes a reduction in the capacity to work. In certain cases the insured person is suffering from an illness, though at the same time it may be uncertain whether the illness itself is the reason why the insured person is unable to work to the normal extent. A man who suffered from severely reduced vision, but who had up to that time managed to do his work because after many years he had come to know every nook and cranny of his place of work, applied for a sickness benefit for the period he had not been able to attend his place of work because of rebuilding work. Three of the Supreme Insurance Court judges ruled that the reason why the insured person was unable to carry out his work was the rebuilding of his place of work and that a benefit could not therefore be paid, while two judges declared that while the rebuilding work was in progress the man was unable to do his work because of his defective vision and was therefore entitled to a benefit (FD Dnr 417/76). A married couple whose four-year-old daughter lay seriously ill in hospital took it in turn to sit with the child and during this period were on the sick-list with the diagnosis "nervous trouble". In this case the reason for the reduced capacity to work was regarded not as the stated illness but as the parents' desire to take care of their child (FÖD Dnr 868, 869/80: 9).

3. *Reduced capacity to work*

The existence of an illness does not automatically entitle a person to a sickness benefit. The illness must be of such a kind as reduces the capacity for work by at least one half. (If a person's capacity for work is reduced to zero a full benefit is paid, otherwise the benefit will be 50 per cent.) The question of

which standard is used when assessing a person's incapacity for work is important in practice. The incapacity may be related either to the person's possibility of performing his normal duties or to his possibility, on the whole, of doing a reasonable job of work. The result of the assessment is often different in these two cases. The Act contains a rule which reads as follows: "When assessing whether total incapacity for work exists, if the illness is expected to last only a short time, special attention must be paid to whether, because of his illness, the insured person is not in a position to carry out his normal or equivalent duties."

The meaning of the rule is that when assessing incapacity for work where a temporary illness is concerned the authorities must take account of the present work being done by the sick person. It would not be reasonable to expect a person to change his job simply because he is off work ill for a short period. The consequence, however, is that persons with the same illness could be assessed differently as regards their incapacity for work according to the kind of work they do. When implementing the Act the first requirement is to decide whether an illness is short or long and then, if it is assessed as long, whether it reduces not just the insured person's capacity to carry out his ordinary work but also his capacity to carry out other suitable duties. A lorry driver who had been on the sick-list for eighteen months as a result of injuries received in an air crash was regarded as not being capable of working as a driver but was considered to be capable of carrying out other suitable work in the form of administrative duties in the haulage business, and consequently his sickness benefit was withdrawn (FD Dnr 1538/75). An insured person whose work had hitherto consisted of grinding and polishing panes of glass and who was unable to work in an atmosphere containing a lot of dust, received a sickness benefit for eight months, but as it was then felt that his general capacity for work was no longer reduced by at least one half he was declared no longer eligible for a sickness benefit (FÖD Dnr 887/79: 5). Another insured person, whose employment as a factory worker had resulted in the nape of her neck being affected, had been on the sick-list for three months because of this. She was actually retrained as a laboratory assistant, but prior to her illness she had worked for about nine months in her old job. She was considered to be entitled to a sickness benefit because the illness could not be regarded as long-lasting and because the reduction in her capacity for work ought to be assessed taking into account her chances of carrying out factory work and not work in a laboratory (FÖD Dnr 889/80: 5).

In practice the question of a reduction of the capacity for work often resolves itself into a matter of assessing the evidence. In principle, the responsibility for the investigation rests with a public authority and in the first place with the Service. Consequently, the Service must make the necessary enquiries by

calling for various documents, questioning the insured person, his employer, doctor or other person, and also by visiting the insured person. However, in one respect the Service can require the insured person to produce the evidence, namely by insisting that the reduction of the capacity for work is supported by means of a doctor's certificate. In the normal case such a certificate is only required as from the seventh day after illness is reported. Even if the insured person has not produced the doctor's certificate as required, a sickness benefit may still be paid, but then it will be up to the person himself to make it clear that he really has been ill and that he did what he could reasonably be expected to do in order to obtain a certificate. When an insured person cannot produce a doctor's certificate, the amount of evidence he must submit to the Service can often be very considerable. It is also a difficult job for the authority itself to arrive at an opinion about such a large amount of information.

One insured person claimed that he had submitted a medical certificate, but all the Service had was a receipt for medical treatment, which the Service assumed he had sent in by mistake thinking it was the certificate. The district medical officer visited by the insured person was now serving in another area and had no notes concerning the sicklisting of the insured person and had no recollection at all of his having visited him. At the district medical centre there were no entries in the medical journal or other details relating to the insured person. A physiotherapist who was visited three times by the insured person during the period of illness was also unable to supply any information about this person's capacity for work. The person in question had visited his employer during the time he was ill and had informed him that he was on the sick-list because of back trouble, that he was receiving treatment for it from a physiotherapist and that the treatment had not yet been completed. From the information relating to these events which contained statements from several different persons the authorities then had to try to piece together the whole story. The Court noted, on the one hand, that the insured person had not tried to avoid submitting a doctor's certificate but had been under the impression that he had submitted one to the Service and, on the other hand, that enquiries in other respects could be considered to have reliably confirmed that the illness had led to a loss of capacity for work. It was felt that a sickness benefit should be paid (FD 1962: 9).

One important piece of evidence is usually what the insured person has done in order to obtain a doctor's certificate and what prevented him from getting one. An insured person who had felt he was unable to contact the doctor on a public holiday and waited until the next day before fixing an appointment with the doctor, and also informing the Service of what had happened, was held to have been completely unable to work on account of illness also on the public holiday in question (FD 1970: 20 I). Another insured person who had been ill

with chicken pox and who invoked the risk of infection as a reason for not visiting a doctor and obtaining a medical certificate within the time stipulated, was regarded as having an acceptable reason for his failure to provide a certificate (FD 1970:24). An insured person who had tried to make an appointment with a certain doctor but had been informed that the doctor was away, and was asked to phone again three days later, was regarded as being entitled to sickness benefit for the three days he had not been able to make contact with the doctor (FD Dnr 2222/75). As against this, however, a bare majority (3 against 2) of the Court were of the opinion that an insured person who only tried to obtain an appointment with a doctor at a local medical centre and had not contacted the local hospital and informed the Service of the difficulty of getting an appointment with a doctor, had not done all that could reasonably be expected of him in order to obtain a medical certificate to the effect that he was unable to work (FD Dnr 386/76).

In the great majority of cases insured persons do, of course, provide the medical certificate required by the Service. As mentioned above, this certificate must confirm the reduction in the capacity for work, though it is in the first place the Service which decides whether the certificate is valid. The fact that the insured person is able to produce a certificate need not mean that the Service is convinced that his capacity for work is reduced. From what is known about the normal effects of the illness in question and on the basis of the personal medical examination the doctor will, when issuing the certificate, make use of certain formulations. His conclusions are often arrived at on the basis of assumptions and arbitrary values, and it is possible that another doctor might come to a completely different result. On its side the Service has access to a medical expert and the statement this expert submits can sometimes lead the Service to feel that it need not attach too much importance to a certificate that has been submitted. Similarly, the courts can call on medical experts to submit statements even when there already is a doctor's certificate. This has created a certain amount of irritation in the medical profession in that the Service and the courts play medical statements off against each other in this way. In this connection the authorities use two different formulations. They can claim that it has not been confirmed that the capacity for work has been reduced by at least one half, or they can rule that the capacity for work has not in fact been reduced to this extent. In the first case the authorities do not exclude the possibility that the capacity for work may have been reduced, but the certificate and any additional information that exists do not prove this to be the case. In the second case the authorities have enough information to enable them to come to a sound conclusion, even though this conclusion may conflict with that of the doctor who signed the certificate. Consequently, one could say that the differences of opinion really are greatest in the second case.

Irrespective of the reason, if there is a lack of agreement between the doctor who issued the certificate and the Service, the person who suffers will in the end be the insured person, since if the Service should refuse to accept the certificate as valid he will lose his entitlement to a benefit. At the same time, a patient who trusts his doctor will usually follow his instructions concerning rest and absence from work, and obviously the authorities must take this into account in cases involving sickness benefit. Only if the insured person himself has reason to doubt the accuracy of the doctor's assessment concerning his reduced capacity for work should the entitlement to sickness benefit be disallowed (FD 1967: 13, 25). In this connection the assumption is that the insured person has had reason to doubt the accuracy of the doctor's assessment from the moment he received the first communication on the matter from the Service.

A sickness benefit may be paid even if the insured person falls ill while on a visit abroad and remains abroad during the period of the illness. As regards foreign immigrants in Sweden who pay visits to their native countries, it is usual for them to visit doctors there who will certify them sick. The Service and the courts are, however, very reluctant to accept these foreign certificates. Many such certificates make no reference to the reduction in the capacity to work and are so deficient in other respects that they cannot provide a basis for a decision about the payment of sickness benefit. But even where the certificates are quite detailed it is usual for the Service and the courts to require the submission of further evidence. In one respect, however, a foreign certificate can lead to the payment of a benefit, namely if it can be shown that the insured person has visited a Swedish doctor on previous occasions for the same complaint and as a result was sicklisted and paid a benefit (FD Dnr 1599/75, 812/76, 105/77, 30/77). Furthermore, if immediately after his return to Sweden the insured person has been examined by a doctor who certifies that he is suffering from the illness specified in the foreign medical certificate, so that one continuous period of illness may be assumed to have existed, then a similar situation arises (FD Dnr 942/74, 2149/75, 1781/76). The restrictive attitude adopted by the authorities must to some extent be viewed against the background of the fact that the Service has no opportunity of paying a visit to the person who is ill if the person concerned is abroad.

Another type of medical certificate concerning which the Service and the courts are very strict is a certificate relating to the physical condition of the insured person during a period of time that precedes the day on which the certificate was issued. The contents of such a certificate would therefore have a retroactive effect and the authorities accept such certificates only on certain conditions. The most usual case is that it was not to begin with possible to diagnose the illness and that a definite diagnosis could only be made after

further examination or when the symptoms became more obvious. Against the background of his observations of the patient during the period of illness and his subsequent discoveries concerning the illness, the doctor will then be considered to be in possession of enough information on which to base a retroactive certificate. During his first examination of a patient a doctor was unable to find any definite objective signs of spinal trouble. However, on the basis of what transpired following a subsequent X-ray examination, he was of the opinion that the patient could quite well be suffering from the spinal trouble in question. He saw the patient later and then he issued a medical certificate back-dated to apply from the day of the first visit. The Supreme Insurance Court seems to have accepted the certificate of illness (FD 1962: 30). An insured person who was first treated for prostatis but who eighteen months later was found to be suffering from a disease of the lymph gland was paid a sickness benefit back-dated to cover the whole of the period he had been away from work. The reason was that it was regarded as highly likely that the symptoms he had displayed during the year before the diagnosis was finally established had been due to the disease of the lymph gland, in fact the spread of the illness suggested this (FD Dnr 824/74). However, the Supreme Insurance Court refused to accept the medical certificate when the doctor felt he was justified in sicklisting the insured person retroactively by taking account, on the one hand, of the details supplied by the patient himself and, on the other hand, of his own knowledge of the patient from earlier medical examinations (FD 1973: 1).

Work or other activities may indicate that the insured person's capacity for work is not reduced to the extent that is required to entitle him to sickness benefit. In that case the fact that the medical certificate sicklists someone as completely unable to work will have no effect whatsoever. It is conceivable that the doctor makes a wrong diagnosis, but it might also happen that by not following the doctor's instructions the patient prevents or delays his recovery. Some awkward implementation problems can arise if the patient who has, up to that time, worked during his period of illness, decides to stop work and thereafter follows the doctor's instructions. It is usual for the patient to travel to some other locality for recreation or rest. However, the majority of the members of the Supreme Insurance Court seem to be of the opinion that no entitlement to a sickness benefit ought to be granted since the insured person has already indicated that he is able to work in spite of his illness (FD Dnr 2782/77, 2818/77).

By paying the insured person a visit the Service inspector can establish that this person is not staying away from work, and if he refuses to receive a visit from the inspector the insured person's sickness benefit will be withdrawn or reduced. It is through the insured person's reporting his illness that the Service

learns about it and can undertake the necessary verification. There is therefore a rule to the effect that no sickness benefit will normally be paid for any period prior to the date on which illness is reported to the Service. The Service must also know where the sick person is staying. An insured person who during his period of illness moves to another locality without informing the Service, or goes abroad without the permission of the Service, will run the risk of having his benefit withdrawn or reduced. There is also a penal aspect to be considered. Any person who obtains a sickness benefit even though he is working more than the Act permits can be convicted of fraud, and in that case he will of course be required to repay the money received.

However, even if an insured person is listed as completely unable to work he may perform a certain amount of work without thereby running the risk of losing his entitlement to a benefit. The point is that it is felt that a person who is on the sick-list should not be compelled to remain completely idle. Often it is useful if he has something to occupy himself with, though it is not easy to say exactly how much work a person on the sick-list may perform without losing his benefit. A housewife/home-husband who is not otherwise gainfully employed cannot continue to run the home in the usual way if he is to receive a full sickness benefit (FD Dnr 743/77). He ought, however, to be able to carry out occasional tasks, for example preparing simple meals (FD Dnr 2019/77), but must not undertake any major household chores such as making the beds, washing clothes or cleaning (FD Dnr 487/75). However, if the person concerned is gainfully employed on a full-time basis the situation is different. If he refrains from doing his ordinary work he will still be entitled to a full sickness benefit, even if he continues to carry out his usual household duties. His right to sickness benefit will only be affected if he undertakes more household chores than usual during his period of illness (FD 1972:22). A school pupil, who through previous work earns an income large enough to form the basis for a sickness benefit, is regarded as fully capable of working if he attends his usual school lessons (FD Dnr 196/76, 1742/76, 671/78). The fact that the previous work is quite separate from his schoolwork and that the insured person is at present unable to carry it out is regarded as irrelevant. If the insured takes part in sports activities or undertakes other leisure activities, although on the sick-list, he can, according to the circumstances, run the risk of losing his right to a full benefit. A sicklisted person who took part in competition football in Division 6 in spite of back trouble was regarded as being entitled to only a 50 % benefit (FD Dnr 494/77). One insured person who was on the sick-list for trouble with his right knee and who played ice hockey at a relatively highly-skilled level during the period he was ill, lost the whole of his sickness benefit (FD Dnr 1035/77). A handball player whose back trouble did not prevent him from taking part in his sport, but who stayed away from his work as a salesman

in a sports shop on account of this trouble, was not considered to have had his capacity for work reduced by at least one half (FD Dnr 2876/77). Similarly, it was held that participation in a car rally by a person who suffered from inflammation of the pancreas, was evidence that the capacity for work was not reduced by at least one half (FD Dnr 1385/78). Anyone who is on the sick-list on account of back trouble and who informs the Service that during the period of his illness he is going to stay on board his motor boat or undertake lengthy journeys by car or train, may be considered not to have had his capacity for work reduced by at least one half (FD Dnr 27/77, 41/76, 517/76, 2137/76, 49/78, 1129/78).

In practice, difficult implementation problems often arise when the person who is on the sick-list, with his capacity for work reduced by at least one half, remains in his previous occupation but has different working hours and/or different duties. From case law it is clear that if an insured person is to retain his entitlement to a 50 % benefit he must have reduced his hours of work by at least one half of a normal working day or a normal shift. In this context the fact that, after having been put on the sick-list, the insured person only works for 50 % of the hours formerly worked per day, week or month is of no consequence. One woman who could choose to work either during the mornings or the afternoons decided on the former since, in view of her illness (rheumatism), she felt more rested then. However, the morning shift was 35 minutes longer than the afternoon one and for this reason (she was working more than 50 % of her normal working day) the Service refused to pay her a sickness benefit. The Court, however, seems to have been of the opinion that the time difference was far too small to have affected the woman's right to a sickness benefit, and decided that a 50 % benefit should be paid (FD Dnr 1640/76). A woman who, prior to being put on the sick-list, worked partly as an assistant in a school dining room and partly as a school cleaner and whose working day was thus nearly ten hours long, gave up her cleaning work but came every day for five hours to work in the school dining room. The fact that she had shown that she could work for five hours a day resulted in a ruling that her working capacity was not reduced by at least one half (FD Dnr 230/77). Similarly, the person who, during the period of illness, had changed over to working only every other week, but on a full-time basis, or to night work for 10 whole nights per month, was held not to have had his capacity for work reduced by at least one half (FD Dnr 2541/76, 1124/77).

In the cases cited the factor that deprives the insured persons of an entitlement to sickness benefit is that these persons have demonstrated that they are able to work to such an extent that their capacity for work cannot be considered to have been reduced by at least one half. However, the fact that each has earned an income during the period of illness is of no immediate relevance. In

reality this does not square with the idea that the sickness benefit is designed to compensate for loss of income during illness. As things are now a person who is ill and for this reason stays away from work is able to receive both sickness benefit and pay, as long as the employer feels that a salary should be paid even though the person concerned is off work ill. It could be that an employer wishes to pay a full salary to a faithful old servant who has fallen ill, and in that case the latter will also be entitled to a sickness benefit if he is away from work. However, in certain cases the compensation an insured person has received during his period of illness may have some bearing on the assessment of his entitlement to sickness benefit. When the authorities are to assess the extent of work performed by the insured person during the period he is on the sick-list, it is usual for them to take the financial return from this work as a pointer. The method is not expressly laid down in the Act but has in the main been developed in case law. In most cases it is simple to apply, even though, as will be seen below, the result can at times be open to question.

An insured person who is on the sick-list on a 50 % working-capacity basis and because of this stops working at one job but continues working on something else, will as a rule have his entitlement to sickness benefit assessed according to what proportion of his total income he receives. An insured person who was off sick owing to a knee injury was able to carry out his work as manager of a macadam factory, but was prevented from looking after his own stud farm and poultry farm. According to information supplied by the person himself, when he was fit he devoted approximately the same number of hours a week to each of these two activities. However, the annual income from these activities differed considerably. He earned 46 500 SEK as manager of the factory and between 10 000 and 15 000 SEK from his own business. The Supreme Insurance Court ruled that his work as manager of the macadam factory was to be regarded as his chief occupation and as he had been able to carry out this work his capacity for work had not been reduced by at least one half (FD 1968: 30). An insured person who was on the sick-list on account of a hand injury continued working as superintendent of an art society, but was prevented by the injury from carrying out his own work as an artist. His duties as a superintendent occupied him for 21 hours a week and for this he received 60 000 SEK a year, while his artistic production brought in about 36 000 SEK. The Supreme Insurance Court observed that the major portion of the insured person's income on which the benefit is based had been attributed to his part-time work as a superintendent and the smaller portion to his earnings from his work as an artist. In the circumstances his capacity for work could not have been reduced by at least one half (FÖD Dnr 5/80: 7). In these cases the differences in incomes were decisive as regards the insured person's entitlement to a sickness benefit. However, the actual division of work as between the

various activities was not felt to be of real importance, and the Act can hardly be said to provide support for this course of action.

Furthermore, an increase in income for someone who is on the sick-list on a 50 % working-capacity basis can lead to loss of entitlement to a 50 % benefit. By reporting the income increase the sicklisted person can receive a higher benefit for the remaining period of illness. This means that the insured person stands to gain by reporting the change in income to the Service, but the information supplied can quite easily come to be used in a way that will be to his disadvantage. An insured person, who prior to being on the sick-list had a benefit-based income of 40 000 SEK a year, reported to the Service that he expected his annual income from *part-time* work as a consultant to increase to 60 000 SEK. He claimed that the increase was due to the increased turnover of his firm, but the authorities held that the income details supplied proved that he had increased by no small amount the work he was carrying out. His capacity for work was considered not to have been reduced by at least one half (FD Dnr 359/76). An insured person who, prior to being on the sick-list, had worked for five hours a day delivering newspapers for an annual income of 13 388 SEK, had reduced his hours of work to 3.5 a day, but owing to a pay increase his annual income was at the same time increased to 16 440 SEK. Taking into account the nature of his work and the income he received, the authorities decided that his capacity for work had not been reduced by at least one half (FD Dnr 2048/75). His daily hours of work (3.5) were in this case not exactly one half of his former working day, and in any case came to less than one half of a normal, full working day. What is worth noting, however, is that though his hours of work were less he received a higher income than before.

The provisions of the Act do not support the view that a possible future income and its size should affect a sick person's entitlement to a benefit. According to the Act it is the absence of the capacity for work that is to decide. However, the view that the possible future income of the person on the sick-list should be taken into account is so deeply rooted that it has been found necessary to introduce a special provision in the Act to cover the case where the person on the sick-list receives pay for looking after a foster-child. This provision states that the right to sickness benefit is assessed irrespective of the foster-parent's fee during the period the benefit is paid. The purpose of the rule is to ensure that any person who is being paid for looking after a foster-child does not run the risk of losing his sickness benefit in respect of other work he is unable to carry out because of illness. It would seem that the introduction of this rule amounts to an indirect recognition in the Act of the principle that income is of importance when determining a person's entitlement to a benefit, even though only one specific situation is referred to here. What is of interest is that if the person on the sick-list does not have an outside job to do, the

assessment of his right to a sickness benefit will be made without taking into account the pay received for looking after a foster-child. The amount of the benefit will then be dependent on whether or to what extent the person concerned has been involved in looking after the foster-child. If the person concerned has not been involved in such care he will receive a full benefit, otherwise the benefit will be 50 % or nothing at all (FD 1977: 22, Dnr 1009/77, 1425, 1426/77, 1237/77, 2221/77, 2528/77). Consequently, in these cases the method employed for assessing the capacity for work of the person on the sick-list is solely the one laid down in the Act.

The right to a full benefit of a person who earns money on the side during his period of illness will depend on the scale of the work and also on the amount earned. If both are insignificant a full benefit will be paid. An insured person who had reported to the Service that he was totally incapable of work owing to a damaged right hand had taken part in three local council meetings during the period he was ill, but these meetings were short and the total remuneration he received was 75 SEK. He was regarded as entitled to a full benefit even for the days he attended the meetings (FD 1966: 18). An insured person who had three positions (as a verger, a school caretaker and a baths superintendent) and who was put on the sick-list as totally incapable of work owing to back trouble, had arranged for his wife to stand in for him, in return for payment, as school caretaker and baths superintendent. He had helped her with certain tasks such as unlocking and locking up the school and wash-house, ordering oil and changing fuses, but he was also regarded as being entitled to a full benefit (FD 1970: 26).

However, should the amount of work or the income be considerable the benefit could be halved, and in certain situations this outcome can appear questionable. An insured man who operated his own security business alongside his employment as a traffic supervisor had, during his illness, carried out certain tasks for his own business, such as signing certain documents and making a few telephone calls. However, more than one third of the income on which his benefit was based derived from his own security business, and so he was regarded as entitled to a 50 % benefit (FÖD Dnr 956/80: 4). If this person had not earned so much from his security business it is very probable that he would have received a full benefit, since the work he carried out was very little indeed. A comparison may be made with the case noted above, where the man did one or two jobs for his wife who was standing in for him. Presumably the courts take into account the fact that an insured person who earns money on the side during a period of illness will be making an "unreasonable" profit if he also receives a full benefit. However, the Act does not require the authorities to adopt such a view. Even in the case where the amount of work is on a certain scale while the income is insignificant, the result can be less satisfactory. An

insured man who in addition to his full-time job as a greaser at a steelworks ran a horticultural business as a side-line had, according to the Service enquiries, continued to operate his side-line as usual during his period of illness. He was considered to be entitled only to a 50 % benefit (FÖD Dnr 703/79: 7). Through this the insured person suffered a considerable loss of earnings. His income from the horticultural business corresponded to 7 SEK of the full daily benefit, and if one considers that the purpose of the benefit is to compensate for loss of income, his benefit ought to have been reduced by 7 SEK only. However, the Act does not permit this because any benefit must be either full or only 50 %.

IV. CONCLUDING OBSERVATIONS

As mentioned above, the principal intention of the Swedish system of insurance for sickness benefit is to compensate an insured person for loss of income owing to illness. In consequence of this the amount of the sickness benefit is determined by reference to the income earned by the insured person (what is known as the income on which the benefit is based). Strangely enough, this intention has not emerged quite so clearly when it comes to assessing the conditions that entitle a person to a benefit. Certain of these conditions or requirements serve no more than a limiting purpose and will not therefore reflect the intention behind the insurance. Among these are the requirement concerning residence in Sweden and that relating to the illness the insured person is suffering from. However, the requirement that a certain minimum income should exist does express the idea that the loss of income must be of a certain size. The effect is reduced to some extent by the fact that a housewife/home-husband is entitled to a benefit without needing to suffer any loss of income. (The situation is different if during an illness the housewife/home-husband needs help with the household work and has to pay for this help.) What is most striking is that the substantive rule is not directly linked with the main purpose of insurance, nor has it been coordinated with the rule relating to the determination of the size of the benefit. Instead, the rule takes up the question of an illness that leads to the capacity for work being reduced by at least one half. Consequently, the insured person does not need to suffer any loss of income during his illness. Furthermore, there are only two levels of benefit, full and 50 %, and these are paid out according to the reduction of the capacity for work and are not therefore related to the size of the lost income. Of course, a person who is away from work because of illness will in the great majority of cases lose his income. However, the cases described above have shown that in certain cases it is difficult to apply the rule exactly by reference

to its wording, and this is particularly true of the case where the insured person does some work or continues with an occupation during the period of illness. In such cases the authorities have felt that they ought to attach as much importance to the financial return as to the scale of the work carried out. In other words, in order to achieve a satisfactory result they have had to specify a requirement that is not expressly evident from the wording of the Act. In addition to this, the implementation of the rule that a benefit will be either full or 50 % and that the right to a full benefit presumes a complete reduction of the capacity for work can lead to questionable results. Undertaking work that may not yield very much income can result in a 50 % benefit only, or even none at all. The fact that the benefit is not reduced in proportion to the size of the income during the period of illness can mean that the insured person suffers a loss of income that might appear to be unjustified.

In the implementation of the Act there is a tendency to interpret the terms and expressions used in the rules in a formal manner. This is connected with the conscious endeavour to find definite rules that leave little scope for arbitrary judgments. For example, the term domicile has been interpreted by reference to whether the insured person is registered in the parish register, and a period of at least one year is needed if permanent residence is to be accepted. The method makes it easy for subordinate authorities to apply the rules, but there is a risk that the implementation of the rules will be rigid and not suited to the circumstances in individual cases. As we saw, the term illness, as used in the Act, is intended to cover a wide field and has to be determined on the basis of what is reasonable. It is to be noted, however, that the Service is reluctant on its own to undertake a wider interpretation of the term illness, and has regarded the determination of the scope of this term as a matter for, in the first place, the Supreme Insurance Court. Usually, the findings of the Court lead to the formulation of a simple rule as to whether a certain condition is to be regarded as an illness, and the Service can then apply such a rule without difficulty.