GUEST EDITORIAL

PERSONAL PERSPECTIVES ON VOCATIONAL REHABILITATION IN SINGAPORE AND SWEDEN

Bodil J. Landstad*, Inger Olsson**, Patrick Millet***, Stig Vinberg****

ABSTRACT

This paper describes and analyses personal reflections on vocational rehabilitation in Singapore and Sweden from the perspectives of employees who have been on sick leave. Further, the study investigates what similarities and differences can be discerned from the accounts provided by the participants in the different countries. Interviews were conducted with five Singaporeans and five Swedes undergoing rehabilitation due to musculoskeletal problems. The most significant result is that more differences than similarities were identified; e.g. the Singaporeans had fewer days of sickness absence, they were diagnosed more swiftly, treatment and the rehabilitation process began earlier and there were no queues for treatment. The conclusion is that the Singaporean system seems to be more effective with respect to returning people to work. However, the Swedish system creates more security for all groups of people.

INTRODUCTION

Sweden, like many other Western countries such as North America, Australia and Europe, faces a problem: the large number of people who do not work due to sickness or injury. Musculoskeletal pain is the most common cause of health-related reductions in work ability in Sweden and in most other Western countries, and it often leads to sickness absence (1, 2). It may seem paradoxical that Sweden, with its high average life expectancy and extensive social security services, has such large numbers of people who are either sick-listed or have been granted a disability pension.

The increase in the number of people on disability pension in Sweden is troublesome, especially the fact that those receiving a disability pension are getting younger and younger (3). During

the period of 2000-2004, the number of days when people either received sickness benefits or were on disability pension was equivalent to approximately 14 per cent of all those in the Swedish workforce (3, 4). Although the figures have improved during recent years, the number of people on sick leave or disability pension is still high in Sweden (5, 6).

Some explanations for the high incidence of sickness absence in Sweden are: pressures related to greater levels of change in working life, reorganisation of workplaces within the public sector domain, the ageing population and shortcomings in the administration of the sickness insurance system (3, 7). Several public investigations conclude that inefficiency in coordinating rehabilitation activities is causing problems in the process of vocational rehabilitation (VR). In response to these facts, the Swedish government recently proposed a package of measures concerning VR and support for individuals with ill health; a rehabilitation chain with specified time limits, a rehabilitation guarantee and a developed occupational health services (5, 6, 8).

This situation is different in Singapore, where the working population appears to experience a very limited number of sick days (9). Research by Chan et al. (10) supports this. They found that in private companies an average of 3.2 days of medical leave was taken per person.

Studies have been carried out to compare Sweden with other European countries with respect to health, sick leave and rehabilitation (11, 12, 13). Remarkably, Sweden scores high on self-perceived health among citizens, despite the sick leave figures noted earlier. Other studies compare the health and welfare systems in economical terms in Singapore and Sweden (14, 15). However, there were no studies that compare individuals' experiences of the rehabilitation processes in the two countries. The differences in the level of sick leave between the two countries, makes it interesting to study possible factors that influence these differences.

In the present study the authors have chosen to focus on VR that is provided in the respective countries. VR is a process that is normally used for re-integrating those on sick leave in working life, and it is therefore assumed here, that the outcomes of the study can provide valuable knowledge about the differences.

Structures and functions in Singapore and Sweden

Elsewhere, the authors have described the differences in the organisational systems of health care, social security and rehabilitation between the Singaporean fund and Sweden's welfare system (16). In that study, part of a structure-functionalistic model (17) was used to identify and examine the differences that exist between these systems. The model proposes that all countries have systems that incorporate the social, political and economic structures of the society, and that, along with culture, these interact to formulate and execute the society's goals, including functions like health care, social security and vocational rehabilitation (17). Table 1 is a summary of the study. It can be seen that the countries' fundamental values are different.

Table 1. Fundamental differences between the Singaporean and Swedish structures and functions

Structures	**Singapore**	**Sweden**
Social structure	Confucianism	Protestantism
Political system	One-party domination system Authoritarian regime Meritocratic values	Multi-party system Democratic regime Democratic values
Economic system	Market economy Strong governmental intervention Economic technocrats Ranked lower than Sweden in respect to 'fairness of financing'	Mixed economy/market economy Economic security Egalitarianism Social technocrats Ranked higher than Singapore in respect to 'fairness of financing'
Functions	**Singapore**	**Sweden**
Health care system	High private expenditure Dual health care system Promoting healthy life style	High public expenditure Medical-based health care system Promoting healthy life style intention

	Ranked lower than Sweden 'spends money on health care' Ranked higher than Sweden 'health list' Short waiting time for treatment	Ranked higher than Singapore 'spends money on health care' Ranked lower than Singapore 'health list' Longer waiting time for treatment
Social security system	Individual responsibility Save in individual funds for individual and family needs State financed capital fund Low sickness absence rates Short periods of sickness absence	Public responsibility Tax on income used for social insurance in public sector for all citizens' needs Supplementary private insurance Public welfare system High sickness absence rates Long periods of sickness absence
Rehabilitation system	Early rehabilitation Private and voluntary dominated rehabilitation No queues for rehabilitation No coordinated rehabilitation Employer can pay for rehabilitation	Early rehabilitation intention Public dominated and private rehabilitation Queues for rehabilitation Coordinated rehabilitation Employer is partly responsible for VR costs

Rehabilitation Systems in Singapore and Sweden

This paper uses the definition of VR put forward by the International Labour Organisation (ILO) (18, Part I, Article 1, § 2); "to enable a disabled person to secure, retain and advance in suitable employment and thereby to further such person's integration or reintegration into society". It should be noted that no standard definition of VR has been found in Singapore or Sweden. However, it seems that the general aim and principles in the ILO definition are well in line with aims and principles that are found in both countries.

Singapore

There is great emphasis on job training in Singapore; due to, among others things, labour market polices that depend on high levels of labour force participation and a healthy work force. There are, however, new developments over the last decade that show an awareness of the importance of VR. This has resulted in an increase in services provided by government, private agencies and voluntary welfare organisations, all offering various VR programmes to sick-listed persons (19).

The VR system in Singapore appears to be divided into three main areas: a) Employment Assistance for Job Seekers, b) Training Programmes for Individuals and c) Financial Assistance for the Needy. The programmes aim to provide vocational training and to develop new skills for workers during difficult periods that can arise over the course of their working lives. A financial subsidies programme is also available that companies can apply to, in order to put into place measures that enable persons with disabilities to remain or return to work (20).

It should be noted that from 2007, a new policy based on the idea of an 'inclusive society' was implemented by the Singapore Government that aims to increase the availability of VR services for persons with disabilities, thereby improving employment possibilities for them (21).

When it comes to distinct VR services that are available, the government provides rehabilitation services through many of the hospitals in Singapore; e.g. The Singapore General Hospital provides comprehensive health and ergonomic consultation to companies and individuals, and the View Road Hospital is generally seen as the centre for psychiatric rehabilitation in Singapore. The aim of providing occupational therapy is to help clients reduce the cost of injuries and disabilities and to help organisations maintain a high quality of working life for employees (22).

Other governmental interventions are made through Community Development Councils (CDC), where public organisations offer various VR services that cover many disabilities, and all Singaporeans are entitled to receive the services that are offered (23).

Another sector that provides VR are the various Voluntary Welfare Organisations (VWO) which offer VR programmes to persons in need of these services (23). VWO are becoming a regular part of the Singapore Health and Welfare System, particularly when it comes to

VR (24), with organisations like the Singapore Anglican Welfare Council, The Bizlink Centre or the Association for the Deaf (DIRC). VWO provide VR for the poor, elderly and persons with various disabilities. Their importance has been recognised by the Government, and therefore these services are now subsidised by the state (25, 26, 27).

It appears that there is no specific professional handling VR, such as a VR counsellor, but professionals working with VR are often university educated in various medical professions that are related to VR.

Sweden

The Swedish system of rehabilitation is built around cooperation between various actors. The Swedish National Insurance Board plays a central role, with responsibility for coordinating rehabilitation services and paying out benefits if a person is sick or taking part in a rehabilitation programme (28), but does not participate in the actual rehabilitation process. The health care system is responsible for medical treatment and medical rehabilitation. If social rehabilitation is required, the local social service office is responsible. During a sick leave or rehabilitation period, an individual is entitled to an allowance equalling 80 per cent of the income on which the sickness benefit is based. The social insurance office can also pay certain expenses such as travel costs during the work-oriented rehabilitation period. If a person requires occupational training or education, the employer or the National Labour Market Administration can take care of the costs (29, chap. 22 § 7).

When it comes to VR, this service is provided by both public and private institutions, with the unemployed sick-leavers mainly receiving services from public institutions. The public institutions are usually the employment offices that are situated throughout the country, which provide services free of charge and are generally seen as part of the extensive Swedish welfare system.

Employed sick-leavers may also receive services from private companies, which are paid for either by the employer, by private insurance policies or by the National Social Insurance Board. It is even possible that all three of these contribute to VR costs for some of the employed.

There are, however, no standard models or methods that are consistently used in Sweden; it appears that much of the work done by the employment offices or private rehabilitation units is based on local experience, and is influenced by various models or methods used in the medical, social and vocational fields (30).

An interesting fact is that it is just over a decade ago, that it became possible to gain a university degree in Sweden in any academic discipline specifically related to VR, making it difficult to argue the existence of the profession as such (31). The norm is that VR workers in Sweden are schooled in academic disciplines that are closely related to some aspect of the VR process, such as physical therapy, medicine, psychology and social work. Thus one can argue that the Swedish VR system, when compared to that of other Western countries such as the USA, is still maturing (31).

AIM

The aim of the study is to describe and analyse personal reflections on vocational rehabilitation in Singapore and Sweden, as provided by employees who have been on sick leave. Further, the study investigates the similarities and differences that can be discerned from the accounts provided by the participants in the different countries.

METHOD

A qualitative method approach built on reflective interviews was utilised (32) and the interviews thereby resembled conversations wherein both informants and interviewers discussed the topics raised and improved their knowledge of these. During the conversations different thoughts, ideas and conceptions in connection with the different structures and functions in Singapore and Sweden, emerged.

Participants

Five Singaporeans and five Swedes undergoing rehabilitation due to back and/or neck pain problems were interviewed. There were seven women and three men (from Singapore - 1 man and 4 women; from Sweden - 2 men and 3 women). The age of the participants ranged from 28 to 45 years in Singapore and from 35 to 49 years in Sweden. The selection criteria

were based on sex, age, employment, profession, diagnosis, and undergoing rehabilitation. The informants were selected by the staff at a rehabilitation clinic in Singapore and by the occupational health services unit of a multinational company in the south of Sweden. At the time of the interview, two interviewees, one in each country, were on sick leave as they were undergoing rehabilitation. The other Singaporeans were working full-time and the other Swedes were working part-time at the same time as they were undergoing rehabilitation.

Data collection

A common procedure that was followed for the interviews conducted in 2004, was that an introduction and information about the research project and the purpose of the study was provided to the participants. The participants were further informed that the questions concentrated on the time before the onset of the disease or injury, the present day, and thoughts about the future. The interviewees were encouraged to talk freely about their own life situation with a focus on the rehabilitation process.

Based on an interview guide that had been produced and tested in earlier Swedish studies (33, 34), a guide was developed for this study that included themes such as education, work, sickness and rehabilitation processes, family, network and leisure. The interview guide supported the authors' efforts to cover the different themes.

The interviewees consented to the use of a tape-recorder, and to giving feedback on possible questions after the analysis of the interviews. The length of the interviews varied from 45 minutes to one hour and 45 minutes. Two researchers carried out the interview with the participants from Singapore, while the second author carried out the Swedish interviews alone.

The conversations included process questions about the space of time before injury/disease, about the onset of the injury/disease, the present situation and about the future, to get a clear picture of how the participants perceived and interpreted their life situation. After each conversation the second author automatically reflected on what was said, either alone or together with others in the research group. During the process, the research group frequently discussed the results in relation to the different structures and functions in Singapore and Sweden. The authors also discussed the conversations with other researchers (32).

After the transcription analysis, some new questions arose. These questions were posed to the interviewees in a letter that was sent by either post or email. The texts were re-read and important notations from the interviews were added where applicable.

Data analysis

The narratives gathered recounted personal and social experiences from the world the interviewees lived in. The transcriptions were organised and structured by creating a timeline for each participant and then plotting the themes along this timeline as they emerged. In this way, each participant's event process in the form of work, sickness, diagnosis and rehabilitation was placed in chronological order to get an overall picture of their experiences. Finally, the results were organised by country and presented according to several thematic groups, and similarities contra differences were discussed.

Analysis and interpretation was started during the data collection phase, and required specialist knowledge of the different systems in the two countries. From the data, similarities and differences between the countries were detected. To understand the informants' social reality, the results were interpreted in a larger context, a background relief (35). The results were analysed by means of the health care, social security and rehabilitation systems in Singapore and Sweden as well as the social, cultural, political and economic structures of the two societies (16).

For the purpose of illuminating and simplifying matters such as similarities and differences between the countries, the authors compiled the results and sent them to the interviewees, who were given a further opportunity to revise the retelling of their own experiences. The results were then corrected based on the responses of some of the participants.

Ethical considerations

It was made clear that participation was voluntary and that the participant's contributions would be kept confidential and unidentifiable in the report. Each of them gave their written consent to participate in the interview by signing a consent form. They were also promised an opportunity to correct their own data before the written presentation of the study.

RESULTS

Seven dominant themes emerged: 'Education, work and work situation', 'Family and leisure time activity', 'The onset of disease/injury, medical examination and diagnosis', 'Queuing and treatment', 'Sickness absence', 'The rehabilitation process' and 'Economy'.

Education, work and work situation

Generally, the Singaporeans had a higher level of education than the Swedes. The Singaporeans studied hard and worked full-time simultaneously, either in the country, or abroad to be more able to compete in the labour market. The Swedes did not express the same purposefulness with their studies. All the interviewees had full-time employment. The Swedes had had longer periods of employment with the same employer than the Singaporeans. Some of them were project leaders; only the man was a manager. One Singaporean and three Swedes had vocational training in the company. In each group there were persons who had worked abroad, both men and women. In one Singaporean narrative, it was clear that a married couple longed to move and work abroad. They reflected on the social policies of their own country and one Swedish woman expressed it like this:

'It is really exciting to work in other countries – in particular. In some of the positions I held I was the only Swede. You adjust well to their way of living and how they work, because it's not the same as it is in Sweden... Germany is well – I think they have a better system than what we have. I got that impression in any case, they have a very developed social security system.'

Nothing in the Singaporeans' experiences indicated that there were any preventive measures at the workplaces. In contrast, this is central in the Swedish company, which is noticeable in the recurrent health check-ups, physical aids, information about stress and promotion of physical activities during hours of work, among other things. Once a year, the Swedish company arranged a rehabilitation journey to Spain for a small group of employees with special needs.

Family and leisure time activity

A big difference between the Swedes and the Singaporeans is the family constellations. In Singapore, married couples with children live in their own flats, and single persons live with their parents. In Sweden, some of the parents have separate places to live with joint custody of the children, and single men as well as single women live in their own flats or houses. The interviewees stated that Singaporeans mostly live with their mothers, who are responsible for the housework. In one family the wife and the husband shared the homework, which is more pronounced and common in Western countries. One Singaporean family had a maid who helped in the home. Another difference is the extent of contact interviewees had with their parents and family. The Singaporeans described how they were expected to have a great deal of ongoing personal contact with their parents. But contact between generations could also move in the other direction, as exemplified by a grandmother who looked after her grandchild during her daughter's working hours. The Swedes said that they hardly ever had any contact with their parents. The interviewees in the two countries had different leisure time activities. For some Singaporeans the church appeared to be important, something that no one in the Swedish group emphasised. Some Swedes had pets as company and a hobby as well as their own garden. One woman talked about her garden as follows:

'I am really happy to have the garden. Now that I am doing so poorly, I can always go out and sit in the garden. In the spring the weather was really nice, so to just sit there in the garden... I like it very much in any case. Not that I had the energy to do very much, but I did do some weeding at least.'

As Singapore is located in a small geographic area, going abroad was usual in the informants' leisure time. The Swedes said that they were mostly at home or at their holiday cottages or went touring in their own country. They went abroad more seldom after their injury or illness.

The onset of disease/injury, medical examination and diagnosis

The Singaporeans incurred their injuries initially in 2002, and none of them had had earlier problems with their motor systems. From the interviews it was evident that the physical diagnosis in Singapore was confirmed shortly after the onset of the disease/injury, and the interviewees could describe the diagnosis in a detailed way.

'According to the doctor L5-S1 is the problem. I went for this procedure, this computed tomography, and it's confirmed that L5-S1 is the root of the problem'.

This is a noticeable difference from the Swedes' experiences. Their diagnoses were not described in the same detailed way. Some of them had a whiplash injury, and the others said that even after several years since the onset, they were still without a diagnosis. Besides the neck and back problems, the Swedes also had other problems like numbness in the face, legs and hands, tension headache and anxiety. The ability to concentrate was a problem for some of the Singaporeans. The Swedes sustained their injuries between 1996 and 2003. The men had had many years of previous medical histories after a work injury and a car accident, respectively. Similarly, all of them experienced pain after trouble from the motor system in their necks or backs, or both. They also mentioned trouble with fatigue and sleepiness.

One woman in each country viewed their injuries in a longer historical perspective. They perceived a connection between long-term work with computers, back trouble and the obvious pain.

Queuing and treatment

Queuing for medical examination and treatment was usual for the Swedes. This was not a problem that the Singaporeans had experienced. The diagnosis in Singapore was made almost at once. In Sweden it takes longer, which in the informants' opinion, is due to the authorities' organisation and work situation or to the injury being hard to identify, localise and establish. In both countries a similar pattern in the use of medicinal treatment was observed; interviewees commented that they were more restrictive about their consumption of medicine. All of the interviewees were taking part in well-developed back-to-work rehabilitation programmes aimed at restoring full function. In addition, the Singaporeans received traditional Chinese treatment, such as massage and acupuncture. Some Swedes also received complementary treatment. Some persons in Sweden were waiting for a back operation and had been waiting for more than a year.

Sickness absence

All of the Singaporeans had had a period of sickness absence directly after the injury, mostly for two to four weeks. One of them had returned gradually to work over some time until she

was back on full-time duty. Some of them had worked full-time after the absence. At the time of the interview, one person had been on full-time sick leave for more than a month. A Singaporean woman said:

'I have no idea how long I can be on sick-leave, because right now the company is very kind to me because it happened during working time. Had it been an outside accident maybe they would have to ask me to go, but because I was injured in the cause of work they have been like OK'.

The main difference observed is that the Singaporeans had lower propensity for sickness absence than the Swedes, who had had several long-term periods of sickness absence that had lasted between some weeks and more than four years. On the occasion of the interview all of them were on sick leave, either half- or full-time. Some disapproval of the doctors was expressed by the interviewees in both countries. A Swedish woman expressed her feelings thus:

'I regret that I didn't make sure I took a longer sick leave to begin with. I was in such a hurry to get back. There are many discussions about certifying sickness absence for people – that one should not certify sickness absence. I understand that the doctors – they are relieved when someone says they don't want to be on sick leave. That was my experience. I wanted to work of course – I enjoyed my work. I felt that the doctors were really on my side. They didn't tell me to rest – I didn't know how this worked. I trusted the doctor. That is, I never really got the impression that she truly understood how difficult it was – how much pain I was in. I don't know. Pain in general, you can't see it. If you see something, it's that you look tired and pale. You don't want to hear that. Otherwise, it doesn't show... A broken leg, then you would have had a cast and bandages for a few weeks/months...'

The rehabilitation process

The rehabilitation process follows after treatment, and in this study includes medical rehabilitation and ends with VR. It is under the rehabilitation process that the goals and ambitions of the individual are pursued. Nearly all the Singaporeans underwent traditional Chinese treatments alongside Western medical rehabilitation when they began treatment at

the hospital and were afterwards referred to the rehabilitation clinic, where they followed an established medical programme. Nearly all the Swedes had been investigated and assessed at a rehabilitation or pain clinic, at which one person was to begin a more comprehensive one-year rehabilitation programme. At the occupational health services in Sweden, some had received complementary treatments such as massage and relaxation. A major difference between the countries was that the rehabilitation process started earlier for the Singaporeans than for the Swedes. It is not unusual that there are waiting periods of up to nine months, to get access to a 5-week rehabilitation programme in Sweden.

Nearly all of the Singaporeans said that they had been lucky, because their immediate managers understood their situation. The employers had paid for the rehabilitation and medicine for those who had a work injury with the aim of getting them back to work as soon as possible. A Singaporean describes the process as follows:

'After two weeks in hospital after I was discharged, I have to go back to the hospital regularly for check ups. The day after the doctor recommended a private rehabilitation clinic, because it's supposed to be good for people with strain problems. He told me to go to the rehabilitation clinic to see if I really need surgery. The doctor says the worst scenario is a fusion surgery on the back. But this would be the last resort because it is still quite early for me to go through this surgery'.

In spite of these stories, nearly all of the Singaporeans were worried about losing their jobs, if they were to be absent due to their sicknesses. Another cause of worry for the women was their age, because they felt they were old once they crossed thirty. The employers prefer younger employees. For some of the Singaporeans this caused frustration and one described the feeling as follows:

'There are good days and there are bad days, it's really that terrible and a few days I get frustrated and I just keep quiet and I just lie on the bed and I try to do some stretching'.

This situation was very different from that of the Swedes, who said that their job was secure, because the employers are responsible for their rehabilitation irrespective of whether the injury is work-related or not. They are also responsible for having rehabilitation meetings at the workplace, where the employees are given opportunities to discuss their work situation

with the employer, a representative of the trade union and, if necessary, a representative of the social insurance office. The occupational health service was described as a spider in a net for the interviewees when it came to following up their situation.

One of the men had taken part in the company's recurrent yearly rehabilitation journey to Spain, and the other man was at work for some hours every day despite being sick-listed. The aim was to have a normal daily routine and an occasion to meet workmates instead of being at home where the only activities were watching TV and videos and surfing the Internet. The goal is to get the employee back to work and a better life as soon as possible. All the interviewees in the study said that they now have a different life with restrictions due to pain and aches.

Economy

The economic prerequisites for sickness absence are different in Singapore and Sweden. The interviewees in Singapore stated that their employer paid their sickness leave benefits in the first two weeks of absence and this was covered by insurance. They also paid for the medicine and rehabilitation. Some said that they used their own private insurance, the Central Provident Fund (CPF) for hospital treatment and rehabilitation.

Nearly all the Singaporeans commented that daily life is expensive. Many described, among other things, a monthly payment to their parents, which is common in Singapore. At the same time, they lived with economic uncertainty since an employer could give notice and they could lose their job. Only recently has it been possible to sell one's flat, and some noted that this could provide one financial solution if one's situation became dire.

The Swedes talked about the social benefits from the social insurance office or the insurance associated with the work injury. The benefits are financially less than the regular salary, which results in a situation with less money, but the interviewees said that because of their injuries they could not be as active as earlier, during their leisure time. The great difference is that the Swedes had an unlimited period of benefits.

The study brought out similarities and differences in the VR processes that were experienced by the interviewees in their respective countries (Table 2).

Table 2. Similarities and dissimilarities between interviewees in Singapore and Sweden

	Interviewees in **Singapore**	Interviewees in **Sweden**
Working	Full time, presence of fatigue and sleepiness	Full time, presence of fatigue and sleepiness
Disease/injury	Musculoskeletal disorders	Musculoskeletal disorders
Medical examination	Examined at hospital	Examined at a rehabilitation or pain clinic
Medical treatment and rehabilitation	Nearly all referred from hospital to a rehabilitation clinic Treatment and rehabilitation started early	The occupational public health services at the company supported the employee Treatment and rehabilitation started late
Vocational rehabilitation	Treatment and rehabilitation started early The immediate manager supported the situation Employer was responsible for employees' rehabilitation only if the injury is work-related	Treatment and rehabilitation started late The occupational health services at the company supported the employee Employer was responsible for employees' rehabilitation irrespective of whether the injury was work-related or not Employer was responsible for rehabilitation meetings at the workplace

	Women employees worried about losing their jobs because of their 'high' age	Employees secure in their employment
Return to work	All returned to work (full-time)	All returned to work (either full-time or part-time)

DISCUSSION

Common factors emerged in the interviews in Singapore and Sweden. Directly after the onset of the disease/injury, the interviewees had had a period of sickness absence from work. The goal was to return to work as soon as possible and all the interviewees were undergoing physiotherapy and medical treatment. It is also interesting to note the Singaporeans' acceptance of Western rehabilitation methods with a focus on the physical programmes, in the same way as the Swedes accept Chinese treatments. Treatments from other parts of the world are complementary to the traditional treatments in both countries.

Some informants in both countries expressed disapproval of the doctors' understanding of their situation. All the interviewees in the study stated that they now had a different life with restrictions because of their pain and aches.

However, more differences than similarities became obvious between the Singaporeans and the Swedes. This analysis points to factors of vital importance for an individual's recovery and return to work. There are major differences in this respect because the Singaporeans in the study got their diagnoses shortly after the onset of the disease/injury and did not have to wait like the Swedes for medical examinations or treatments. Some of the Swedes were still, up to eight years after the onset of their injury/illness, waiting for their diagnoses. The Swedes think the queues are due to how the authorities organise services and to how they work as well as to the fact that their injury/illness seems to be hard to identify, localize or establish.

Furthermore, the study found variances in the analysis of the rehabilitation processes. Treatment and rehabilitation in Singapore began shortly after the onset of injury, much earlier than in Sweden. The Singaporean women expressed concern over losing their jobs because of their age. They are old in their employers' view after 30 years of age. A big difference

was the employers' responsibility if the employees suffered a disease or injury. In Sweden, an employer is responsible for any illness or injury while in Singapore employers are only responsible for work-related diseases or injuries. In Sweden, all employees are protected by the Work Environment Act (AML) and regulations about systematic work with working environment (36) and VR (37) are enforced in workplaces. These statutory foundations have no counterpart in Singapore. Another difference was that the Swedish company had its own department of occupational health services, supporting work environment and rehabilitation processes.

The results clearly show that the Singaporeans in this study had a lower rate of sickness absence and that the Swedes had an opportunity to work fewer hours a week during the period of recovery. It is not unusual that the Swedes had recurrent periods of sickness absence. Some of the Singaporeans continued to work full-time after the onset of the disease/ injury and only one Singaporean woman was on full-time sick-leave.

Both the Singaporeans and the Swedes had trouble with fatigue and sleepiness at the time of the onset of the injury, all individuals received physiotherapy and medical treatment, a perceived relation between long-term computer use and musculoskeletal pain were found in both countries, and the life-styles of all the interviewees had changed because of aches and pain. Trouble with fatigue and sleepiness at the time of the injury is probably a sign of a working life characterised by increased job demands and work load (3, 8, 38).

As mentioned earlier, sickness absence in Sweden has been, and still is, high compared to many other Western European countries. Despite a large number of studies on the causes of sickness absence (3, 39), knowledge is still lacking in this area. It is notable that the Swedish Government has proposed a package of measures aimed at creating a more effective and swift rehabilitation processes. A possible future development is that the Swedish system for VR will become more similar to the system in Singapore. However, differences concerning the employers' responsibilities and support from Occupational Health Services will likely remain. In Sweden, initiatives are currently being taken to develop these services and stimulate more active and supportive rehabilitation processes both for organisations and employees in need of VR measures. These changes demand more VR-competence among the staff in the Occupational Health Services, due to the fact that they are more used to working with promotion and prevention measures.

It is notable that the rehabilitation processes seem to be more effective in Singapore without support from the Occupational Health Services. One conclusion is that there are other rehabilitation actors in Singapore (governmental services like employment assistance, training programmes and financial assistance; private agencies; voluntary organisations) that contribute to the VR-processes. Another conclusion is that there are factors other than support from consultants that can explain successful VR. The authors' opinion, which is in line with research in the area, is that factors like effective coordination among actors in the field of VR, incentives for individuals and employers, individuals' locus of control and ability and motivation to work are some of these (1, 30, 40, 41).

Thus, in analysing the data and making comparisons, it is done so in line with the suggestions put forward by Lindahl (42). Lindahl states that it is necessary to develop a well-reflected conception of all important factors and related theories, to describe, compare and understand them and how they function in practice, when carrying out international comparisons. Such comparisons can contribute to developing the VR-processes in both countries in order to more effectively get individuals with diseases or injuries back to work. Sweden can, for instance, learn a great deal from Singapore about the importance of early assessment of health conditions and early treatment and measures aimed at getting individuals back to work. Singapore, on the other hand, can learn from Sweden about the employers' responsibility if employees get a disease or injury and the importance of a welfare system that provides greater security to those who are in need of health care, social security or rehabilitation.

*Address for correspondance
Department of Health Sciences
Mid Sweden University
831 25 Östersund, Sweden
Phone: +47 74166121; Fax: +46 63165626
Email: bodil.landstad@miun.se

**Faculty of Health Science
Nord-Trøndelag University College
Levanger, Norway

***Department of Social Sciences
Mid Sweden University
Östersund, Sweden

****Swedish National Institute of Public Health
Östersund, Sweden

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