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More absence, but less impact on business performance. What can we learn from Swedish approaches to managing workplace mental health?

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ABSTRACT

Using employer-level survey data, this report compares how firms in England, Ireland and Sweden are responding to the challenges of workplace mental health. The three countries adopt very different approaches to the funding and provision of healthcare services and sickness benefits, with expenditure on mental health issues much higher in Sweden than in England and Ireland. Descriptive analysis of the survey data reveals significant differences between employers in the three countries, with Swedish firms reporting higher levels of mental health-related absence and much more long-term absence. Given that overall levels of mental health issues in the three countries are similar, this suggests underreporting of mental health issues by English and Irish employers, potentially driven by cultural factors and stigma associated with mental health issues. Swedish firms also report fewer firm-level impacts of mental health absence, as well as more widespread uptake of strategic and wellbeing initiatives for mental health. In the broader context of the availability of long-term government-funded sickness pay, this suggests that the more holistic approach to managing workplace mental health issues prevalent in Sweden may lead to lower levels of detrimental performance impacts. Policy implications are discussed.

EXECUTIVE SUMMARY

This study uses new survey data to compare the experiences and attitudes of English, Swedish and Irish employers as they manage workplace mental health issues, and identifies striking differences between the countries:

1. **More Swedish firms report mental health-related absence than their English and Irish counterparts.** Despite very similar prevailing levels of mental health issues more widely in the three countries, Swedish employers are more likely to report mental health-related sickness absence, and much more likely to report long-term mental health-related absence. It is possible that this disparity reflects cultural differences, with employees in Sweden more willing to disclose a mental health issues to their employer, which in turn may imply under-reporting of mental health issues by English and Irish employers. If this is the case, it suggests that addressing stigma assocated with mental health issues should be a priority for policymakers and employers, to encourage employees who are experiencing these issues to come forward and receive the help that they may need, and to reduce the risk of long-term implications. The availability of extended government-funded sick pay and the unilateral adoption of the diagnosis of Stress-induced Exhaustion Disorder (SED) by the Swedish government, which generally requires an extended period of

sickness absence, are also underlying factors that may help to explain the disparity in mental health sickness absence levels in Sweden England and Ireland.

2. **Fewer Swedish firms report that mental health-related absence impacts their business**. Despite reporting more mental health related absence, Swedish firms are less likely to say that such absence impacts their business operations. This suggests that giving employees the time away from work that they need to deal with mental health problems, rather than attempting to minimise absence due to mental health issues, may be a more effective way of managing these challenges. It is likely that the financial support provided by higher levels of government-funded sick pay, which are not currently available in England or Ireland, plays an important role in allowing this.

3. **While Swedish firms are more likely to report presenteeism, they report different patterns of presenteeism**. Swedish employees are much less likely to report working beyond contracted hours, and more likely to report working when unwell. This probably reflects working hours legislation which enshrines a 40-hour working week in law. In Sweden, presenteeism is also much less likely to be attributed to the need to meet deadlines or to mitigate staff shortages than in England and Ireland. Swedish firms are more likely than their English and Irish counterparts to say that they are addressing presenteeism. All employers should be encouraged to adopt practices to discourage regularly working beyond contracted hours and working when unwell. Initiatives focused on supporting firms in ensuring that their employees feel able to take sick leave when necessary and that they do not feel pressured into routinely working additional hours, would be relevant.

4. **While firms in each country see workplace mental health as their responsibility, Swedish firms are much more likely to adopt initiatives to address mental health issues than English and Irish firms**. The adoption of mental health initiatives in Sweden is also more consistent across sectors, which indicates that managing mental health is an embedded practice that is widely accepted as the norm by Swedish employers of all kinds. The gap between intention and action evident in Ireland and the UK in terms of supporting employee mental health and wellbeing is not evident in Sweden. This seems to reflect an underlying difference in attitudes towards mental health in the workplace, and it seems likely that the expectation that employers should routinely offer mental health support for employees drives higher adoption of mental health-related initiatives.

5. **Swedish firms focus on different kinds of initiatives to address workplace mental health issues than English and Irish firms**. They are much more likely to adopt strategic or policy initiatives and investments in employee well-being than their English and Irish counterparts. For example, more Swedish firms have a budget for mental health activities, and more offer individual benefits such as counselling support and resilience training. This suggests more engagement with mental health issues at a senior level and an approach that prioritises the prevention of these issues. English and Irish firms are more focused on skills training activities which are potentially more reactive than preventative. Bearing in mind that Swedish firms report fewer impacts of mental health issues, our data suggests that the approach adopted in Swedish firms may be more effective in managing the impacts of workplace mental health issues, and that encouraging more movement to this approach in English and Irish firms may pay dividends for employees and employers.

6. **Remote working is more embedded in Sweden, and Swedish employers are more likely to use formal approaches to encourage a good work-life balance for those working remotely.** Swedish firms have the highest levels of remote working and are more likely than English and Irish firms to have had some level of remote working pre-pandemic. They are more likely to use manager role modelling and formal interactions to encourage a good work-life balance for remote workers, while English and Irish firms report more use of informal interactions to do so. Encouraging English and Irish employers to engage in more formal ways of reminding employees to prioritise their home life, rather than relying on informal conversations, may drive better outcomes.

Table 1 summarises the key policy implications that we draw from the evidence presented in this report.

Table 1: Summary of key evidence and policy implications

	Evidence	Interpretation	Implications
1	Swedish employers more actively support workplace mental health by adopting initiatives to address it. In the UK and Ireland there is an intention-action gap in employers' support for workplace mental health and well-being.	Employee expectations, workplace culture and representation, have helped to establish stronger norms relating to workplace mental health provision in Sweden.	Replicating Swedish employers' support for workplace mental health is likely to require systemic change beyond the individual workplace. Steps could be taken to strengthen the legislative/regulatory framework, e.g. requiring public sector contractors to adhere to the Mental Health Core Standards[1].
2	Strategic and policy measures to support workplace mental health and wellbeing are more common in Sweden. UK and Irish employers focus more strongly on training and monitoring.	Supporting workplace mental health is seen as a C-suite, strategic issue in Sweden. In UK and Irish firms, it is more often seen as a functional issue relating to personnel or HR management.	Encourage business leaders to see workplace wellbeing as a strategic issue. Seek to embed an understanding of workplace mental health and wellbeing in management training and leadership programmes
3	Swedish employers report higher levels of mental health issues (and long-term absence) but lower business impacts	Swedish employers' management of mental health issues, supported by the healthcare system, reduces the productivity cost of mental health issues	Use this evidence (and further analysis) to help build the business case for investment in supporting workplace mental health and wellbeing.
4	Swedish employers report higher levels of presenteeism and are more active in taking steps to address presenteeism related issues	Presenteeism in Sweden is primarily a well-being issue and is managed as such. In the UK and Ireland, presenteeism is more often a work organisation issue due to short-staffing or work deadlines.	This relates to broader issues around the quality of management in UK firms relative to international competitors. Sharing examples of effective work organisation and management may help counter presenteeism issues.
5	Remote working is more common in Sweden reflecting pre-pandemic patterns. Work-life balance is more formally managed by Swedish firms.	Swedish firms have a longer history of remote working. This has contributed to more formal management processes and less concern about work attachment and social interaction.	Increasingly important as hybrid working becomes more common. Sharing examples of best practice management may help to counter isolation issues.

[1] https://www.mentalhealthintheworkplace.co.uk/what-are-the-mental-health-core-standards/.

CONTENTS

INTRODUCTION

The worldwide increase in mental health issues in recent years has been well documented (World Health Organisation, 2023). As well as having significant implications for the individuals experiencing them, mental health issues are associated with firm-level impacts including reduced workplace productivity (Hennekam et al, 2021). Since early 2020, the Enterprise Research Centre (ERC) has been researching workplace mental health in England and we now have four waves of data tracking English employers' experiences of these issues. As part of a three-year Economic and Social Research Council (ESRC) funded project, we have recently extended the focus of this research beyond England, to include employers in Ireland and Sweden. Using the same survey instrument in all three countries we have collected comparative employer-level data on, among other things, attitudes towards and experience of mental health issues in the workplace, and the adoption of initiatives to address these issues.

Sweden and Ireland were selected for study because they presented the opportunity to explore workplace mental health issues in two quite different socio-political environments compared to England, with varying approaches to healthcare provision and distinctive national cultures. As anticipated, our analysis identifies significant employer-level differences between the three countries in terms of attitudes towards mental health issues, approaches towards the management of these issues, and outcomes. This report presents these differences and discusses their implications for policy and practice. We focus on two main research questions:

- How do employers in Sweden, England and Ireland experience workplace mental health issues?
- What are the similarities and differences in employer approaches towards these issues, and what are the implications for the management of mental health in the workplace?

The report proceeds as follows. In the next section, we provide an overview of healthcare systems and workplace culture in the three countries. Section 3 provides a brief overview of the sample under study. Section 4 then presents comparative findings related to mental health sickness absence, presenteeism, the adoption of mental health initiatives in firms and hybrid working in the three countries. Finally, we draw conclusions and present implications for policy and practice.

1. CONTEXT - HEALTH SYSTEMS, MENTAL HEALTH PREVALENCE AND CULTURE

1.1 Healthcare systems in Sweden, England and Ireland

How do the healthcare systems of the three countries under study compare, and what implications might this have for firm-level approaches to workplace mental health? This section offers a brief outline of healthcare provision in Sweden, England and Ireland, including funding, access and the extent to which it is centralised.

Sweden, which has a population of around 10.6 million (Worldometer, 2024), has a strong social welfare system and a universal health insurance scheme, giving all citizens equal access to health care regardless of income, status, or illness. The Swedish healthcare system operates at three levels – national regional and local – but is highly decentralised (Laugesen et al, 2021). While central government is responsible for policy and regulations, twenty-one county regions are responsible for the financing and provision of healthcare and 290 municipalities are responsible for disabled and elderly care. The system is financed mainly through taxes (85 per cent) with the rest being funded through patient payments for specific items including prescriptions and services such as adult dental and eye care (Heshmati et al, 2022). Private healthcare provision in Sweden has been rising in recent years and critics argue that this has placed an additional burden on the public system, as well as eroding public trust in the system, because private or insurance-funded patients receive priority treatment, often in publicly funded facilities (Lapidus, 2022).

Like Sweden, access to healthcare in England (population 67.7 million) (Worldometer, 2024) is based on clinical need and not the ability to pay. National Health Service (NHS) care is free at the point of use and there is a significant degree of decentralisation. While central government sets budgets and objectives, responsibility for the provision of NHS services lies with devolved healthcare systems in each of the four home nations. NHS England has operational responsibility for services in England and oversees 42 Integrated Care Systems which have responsibility for bringing together local health and care organisations in their specified regions, and which have the flexibility to make their own decisions about how partners work together in their area. Public funding for UK NHS expenditure is around 79.5%, above the EU average but below that of Sweden. The majority of this comes from general taxation and National Insurance contributions. Patient payment for specific items such as prescriptions, dental treatment and eye care makes up around 17% of healthcare spending (Anderson et al, 2022). In 2015, around 10.5% of the

UK population had private healthcare insurance, around 87% of which was provided by employers, and in the same year, private healthcare insurance accounted for 3.3% of total health expenditure (Thorlby and Arora, 2020).

Connolly et al (2022) acknowledge that 'in a universal primary care system all individuals would have eligibility for primary care services which would be provided free at the point of use' and that, on this definition, Ireland's provision of healthcare is 'something of an anomaly in Europe' (p.282). The Irish two-tier healthcare system incorporates two categories of means-tested entitlement to health care. Category 1 Medical Card holders account for 32 per cent of the population and can access free primary healthcare services but must pay a proportion of prescription charges. Category 2 non-Medical Card holders are entitled to subsidised hospital care and prescriptions but must pay the full cost of GP and other primary care services. 57 per cent of the population of 5.1 million falls into this group. GP Visit Card holders (11 per cent of the population, including those under 6 years of age and those over 70) can access free GP services but otherwise have the same entitlement as Category 2 individuals. Evidence suggests that unmet healthcare needs in Ireland, where individuals do not seek medical help for an issue, may be driven by affordability issues (Connolly and Wren, 2017).

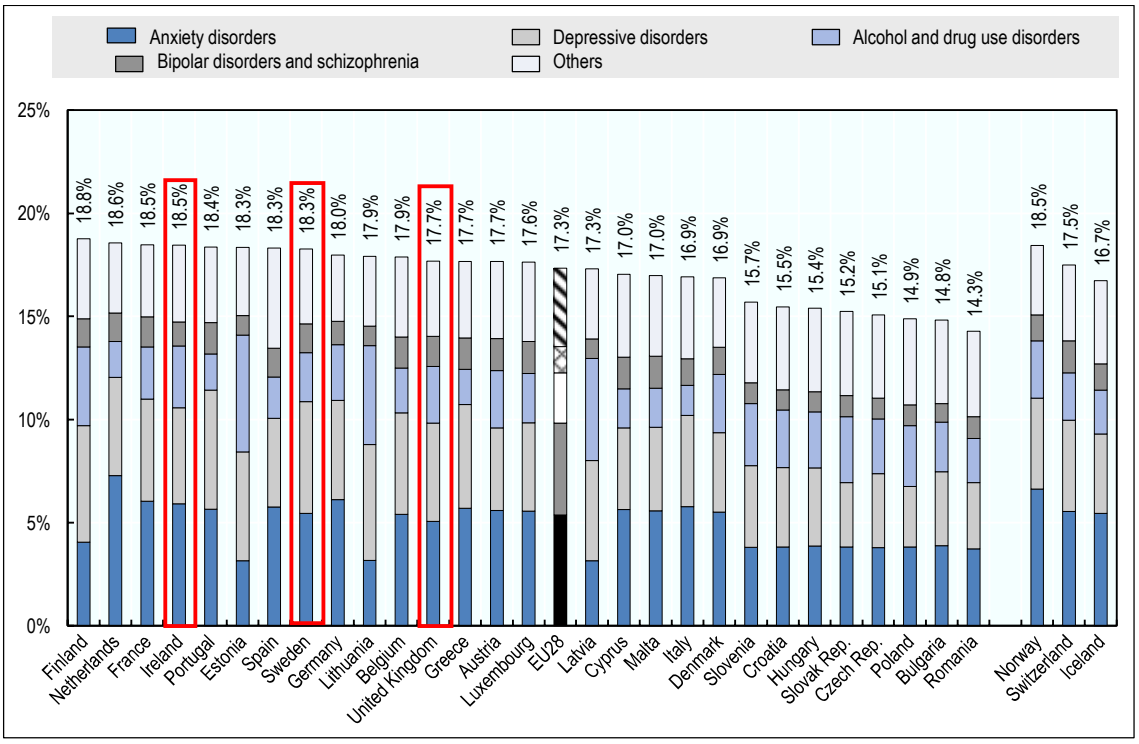
Overall, there are key differences in the structure and funding of, and access to, healthcare services in Sweden England and Ireland. While Sweden and England have adopted universal largely publicly-funded approaches, by contrast, Ireland's system offers a mix of free, subsidised and privately-funded services. These distinctions are likely to shape the way that employers experience workplace health and well-being in general since they will inevitably impact on, among other things, the cost burden of sickness to employers as well as levels of absenteeism. National approaches to mental health care, which are considered in more detail in the next section, will also potentially influence how employers approach the management of mental health issues in the workplace.

1.2 Prevalence and costs of mental health issues in Sweden England and Ireland

Data from the Organisation for Economic Co-operation & Development (OECD) and the European Union (EU) shows that overall in Europe more than one in six people has a mental health problem. However, while the prevalence of mental health issues varies

considerably by country, as shown in Figure 1.1, Sweden, the UK[2] and Ireland all report similar levels of a range of mental health problems.

Figure 1.1: Prevalence of mental health problems in European countries



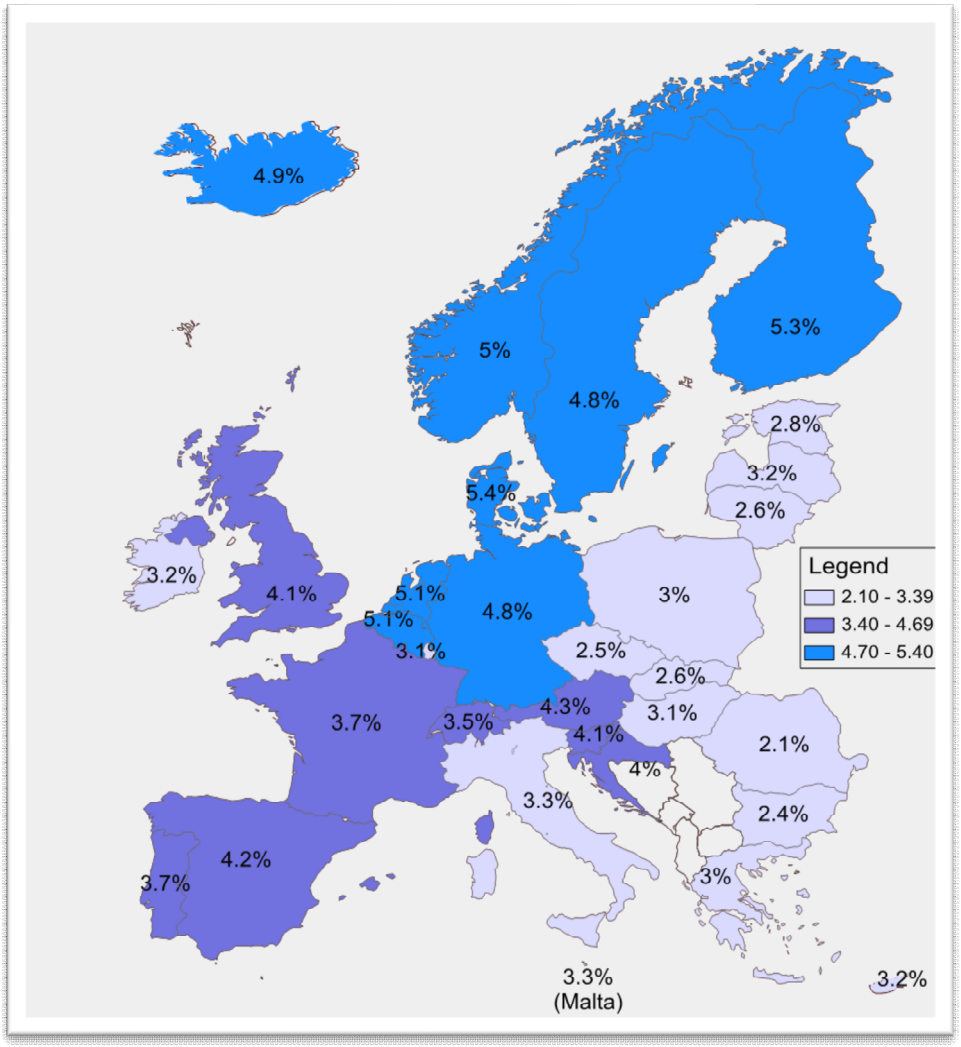
Source: OECD/European Union (2018)

Despite this, the costs of mental health issues in the three countries as a proportion of Gross Domestic Product (GDP) varies considerably. OECD/EU data puts Sweden among the highest group of countries in terms of mental health costs, and Ireland among the lowest, with the UK somewhere in between, as shown in Figure 1.2. The OECD (2018) notes that these variations may reflect differences in the social security benefits provided to people with mental health problems, including paid sick leave benefits, disability benefits and unemployment benefits, as well as different levels of spending on mental health care services. It also distinguishes between direct costs such as healthcare and social security expenditure, and indirect costs mainly related to labour market impacts such as reduced employment and productivity, and acknowledges that capturing the full extent of the latter is difficult.

[2] OECD data does not disaggregate England from the UK

Table 1.1 offers further detail on the reported costs of mental health issues in Sweden, the UK and Ireland, and shows that while the labour market effects are measured as broadly similar, there are stark differences in expenditure, with Irish spending on mental health systems and social benefits much lower than Swedish and UK expenditure. It is also striking that in Sweden, expenditure on social benefits related to mental health is 1.68% of GDP, compared to 0.87% and 0.72% in the UK and Ireland respectively.

Figure 1.2: Estimated direct and indirect costs related to mental health problems across EU countries



Source: OECD/European Union (2018)

Table 1.1: Estimates of total costs (direct and indirect) of mental health problems, in million EUR and as a share of GDP, 2015

	Total costs		Direct costs				Indirect costs	
			On health systems		On social benefits		On the labour market	
	in million EUR	% of GDP	in million EUR	% of GDP	in million EUR	% of GDP	in million EUR	% of GDP
EU28	**607 074**	**4.10%**	**194 139**	**1.31%**	**169 939**	**1.15%**	**242 995**	**1.64%**
Ireland	8 299	3.17%	2 232	0.85%	1 891	0.72%	4 176	1.59%
Sweden	21 677	4.83%	5 696	1.27%	7 558	1.68%	8 423	1.88%
United Kingdom	106 024	4.07%	36 353	1.40%	22 704	0.87%	46 967	1.80%

Source: OECD/European Union (2018)

These differences reflect different national approaches to the funding of sickness absence. In Sweden, employers pay for the first two weeks of sickness absence, after which the Swedish Social Security Agency takes over, providing around 80% of employees' salary for up to 364 days. Employees may also be eligible for extended sick pay beyond the first year (Försäkringskassan, 2024). This compares to employer-paid Statutory Sick Pay in England at a fixed rate of £109.40 per week for 28 weeks (UK Government, 2024) and in Ireland of 70% of an employee's rate of pay up to a maximum of 110 Euros a day for five days (Irish Government, 2024). So, although the three countries experience similar levels of mental ill-health, fundamentally different approaches, particularly in the provision of sickness benefits, mean that the national cost implications and the costs borne by employers differ significantly.

1.3 Broader cultural factors

While a detailed review of national culture is beyond the scope of this report, prior literature points to a strong connection between health behaviour and national cultural values (Braithwaite et al, 2020). For example, the superior healthcare performance of Nordic countries including Sweden has been attributed to political, economic and social factors and in particular to higher self-expression values which combine to result in a greater likelihood for investment in wellbeing and quality of life (Mackenbach and Mackee, 2013). Perhaps relatedly, national societal values have also been found to shape the uptake of flexible working (Peretz et al, 2017). It is worthwhile, therefore, to provide further context for the study by briefly noting some of the differences in the national cultures of the three countries that have been identified in prior research.

Swedish workplace culture has been characterised as open, with a focus on consensus in decision-making (Hayden & Edwards, 2001). And Swedish societal norms, institutional factors and individual rights are said to combine to give Swedish employees a strong sense of entitlement to flexibility and work-life balance (Hobson et al, 2011). Swedish working hours legislation supports this, with a maximum 40 hour working week enshrined in law, along with a maximum of 200 hour per year of overtime and five weeks of paid holiday (Skans, 2004). Swedish values are often described as universal and hedonistic and include honesty, freedom, equality, and happiness (Kalmus & Vihalemm, 2006). Although Sweden has often been characterised as having a high suicide rate, which is attributed to stress, isolation and addiction issues, OECD data indicates that this is not the case, and that rates are around the median level (Nordics Info, 2022). In 2003 in Sweden, the new diagnosis of stress-induced exhaustion disorder (SED) was unilaterally adopted by the Swedish healthcare system. SED has subsequently become the most common diagnosis supporting long term sick leave in Sweden (Lindsäter et al, 2023) and proponents argue that the introduction of the diagnosis has helped to challenge taboos related to mental health problems and contributed to broader acceptance of these issues (BBC, 2019). Nevertheless, there is still considerable stigma attached to mental illness in Sweden, with more than half of sufferers reporting unfair treatment or avoidance behaviour from others which they attributed to their condition (Hellström et al, 2023). Swedish workers are much more likely to than UK or Irish workers to be unionised, with 65.2% belonging to a labour union, compared to 25.4% of employees in Ireland and 23.4% in the UK (Statista, 2024).

English workplace culture, by contrast, is more centralised and hierarchical and more individualistic, with much more focus on autonomy and self-sufficiency (Egan, 1997). It has been characterised as less focused on societal outcomes and equality than Swedish culture (Bliven, 2013). This is perhaps linked to the still-strong social class system in England (and the UK) which is underpinned by deep-seated economic, cultural and social capital differences (Le Roux et al, 2008). Government legislative attempts to encourage a better work-life balance have sometimes been impeded by incompatible organisational cultures and the persistence of the ‘ideal worker’ narrative, which prioritises full-time continuous work and traditional male and female family roles (Bond, 2004), although attitudinal shifts towards gender equality have continued in recent years (Park et al, 2014). Of the three countries under study in this report, the UK has the lowest level of precarious workers. Precarity here refers to involuntary part-time and temporary work, and job insecurity related to fear of job loss, and in the UK this is estimated to apply to 4.3% of the workforce, slightly lower than the 4.5% in Ireland, but substantially below the 12.6% in Sweden (Kretsos & Livanos, 2016).

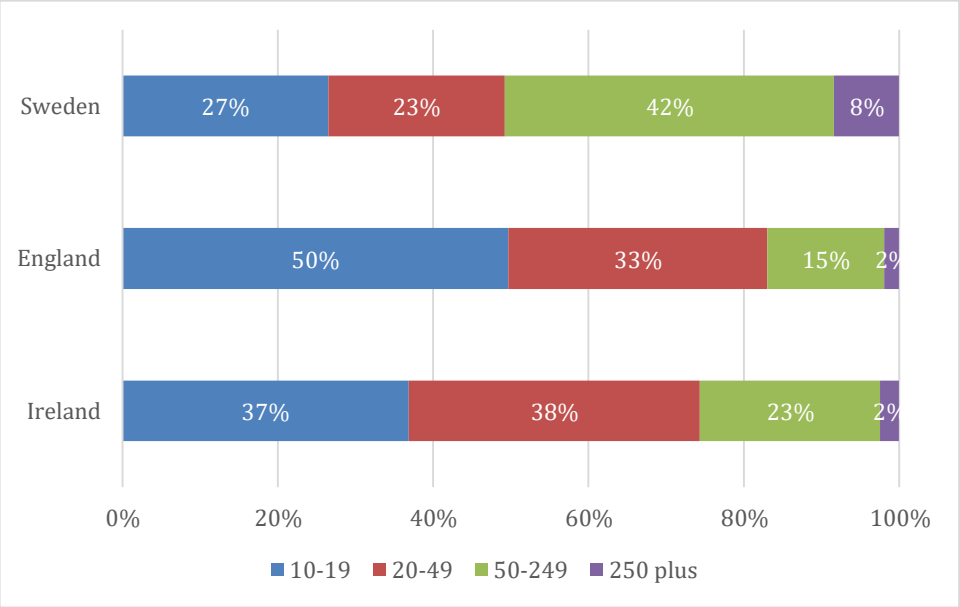
Perhaps because of language and geographical closeness, numerous prior studies have asserted cultural similarities between Ireland and England. The two countries have strikingly similar scores on Hofstede's (1983) Masculinity and Uncertainty Avoidance indices, indicating that both may attach similar importance to work goals including employment security, opportunities for advancement, and the opportunity to help others. The scores also predict similar work stress levels in the two countries. Other research finds a more nuanced picture, however, and that Irish employees place more importance on goals associated with helping others than English employees, and are more concerned with employment security than the English. Irish employees have also been found to perceive work as less stressful than their English counterparts (Boyd, 1994). Issues of work-life balance in Ireland have also been addressed in prior literature, and findings suggest that while inflexible work patterns can be problematic for employees seeking to find the right balance, Ireland lags behind other EU countries in the provision of flexible working arrangements (The Irish Times, 2023). These issues are complicated by the 'heavily gendered nature of care and other unpaid work carried out in Ireland' (Russell et al. 2019, pIX).

2. DATA COLLECTION AND CHARACTERISTICS OF FIRMS SURVEYED

Data were collected using a common questionnaire in all three countries, administered via Computer Assisted Telephone Interviewing (CATI), which has proven to be the best way to reach the appropriate personnel within a business. Within each organisation, the most senior person with responsibility for the health and wellbeing of employees was sought to be interviewed. Businesses with 10 or more employees were in scope for the survey. This definition of employee numbers excluded owners and partners, agency staff and contractors but included other directors and temporary and casual staff. Organisations were additionally screened to ensure: (a) they were not a local or central government financed body; (b) they had been trading for 3 or more years. A disproportionate stratified sampling approach was adopted to ensure that the sample achieved in each country was representative of the business population. Fieldwork took place between September and December 2022 in Ireland, between January and May 2023 in England, and between September and December 2023 in Sweden.

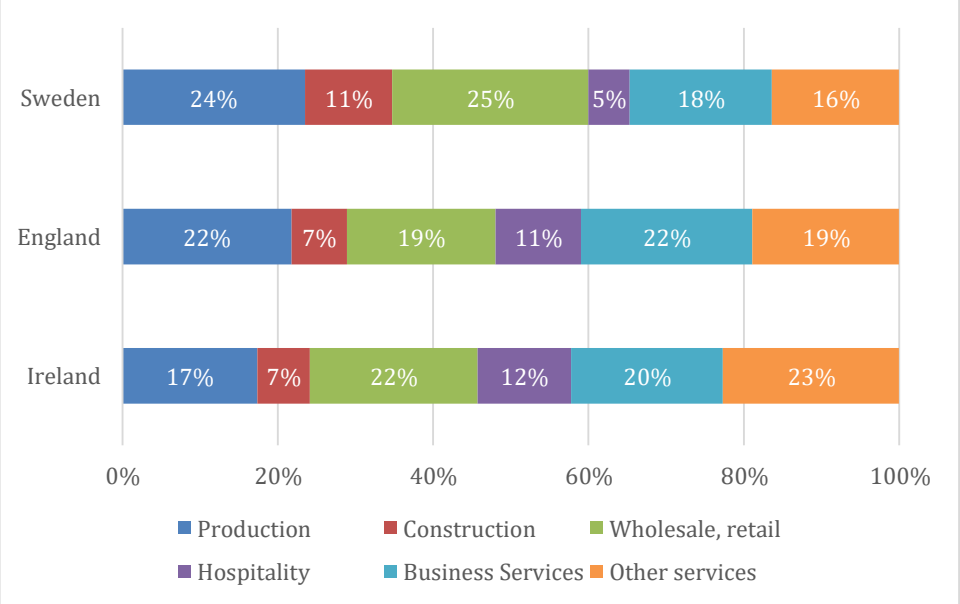
Figure 2.1 shows the breakdown of respondent firms by size in each country and demonstrates that respondents in England are typically smaller than firms in the other two countries. Sweden has the largest proportion of larger firms. There is some variation in sector breakdown as shown in Figure 2.2. Ireland has the smallest proportion of production firms and the largest proportion of other services firms. Irish firms are also older (Figure 2.3) than those in Sweden and England, but English firms are the most likely to report multi-site operations (Figure 2.4). Swedish firms are the least likely to be family-owned but the most likely to report that they employ staff with temporary contracts (Figure 2.5).

Figure 2.1 Size of firms by number of employees, by country



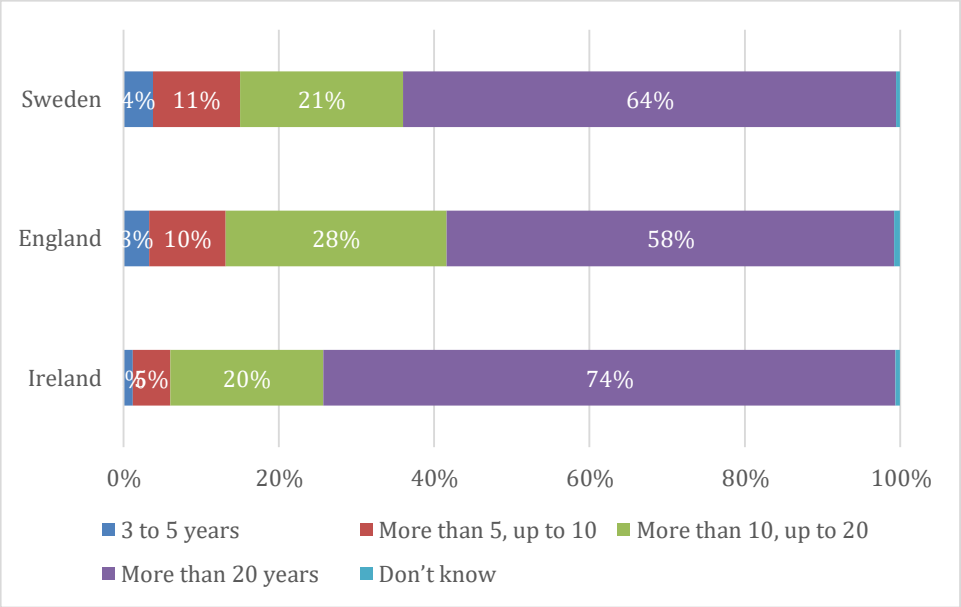
Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

Figure 2.2 Sector profile of firms sampled, by country



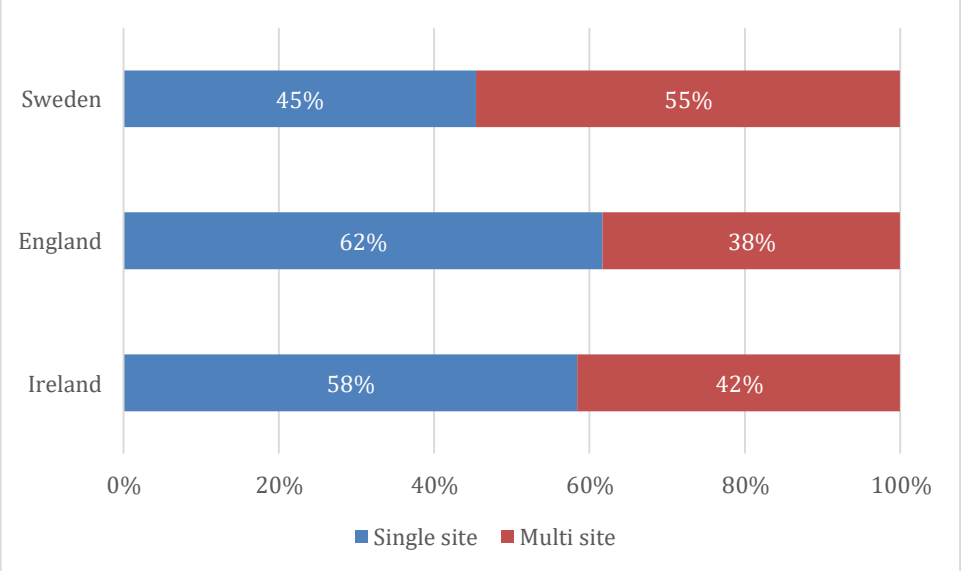
Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

Figure 2.3 Age profile of firms sampled, by country



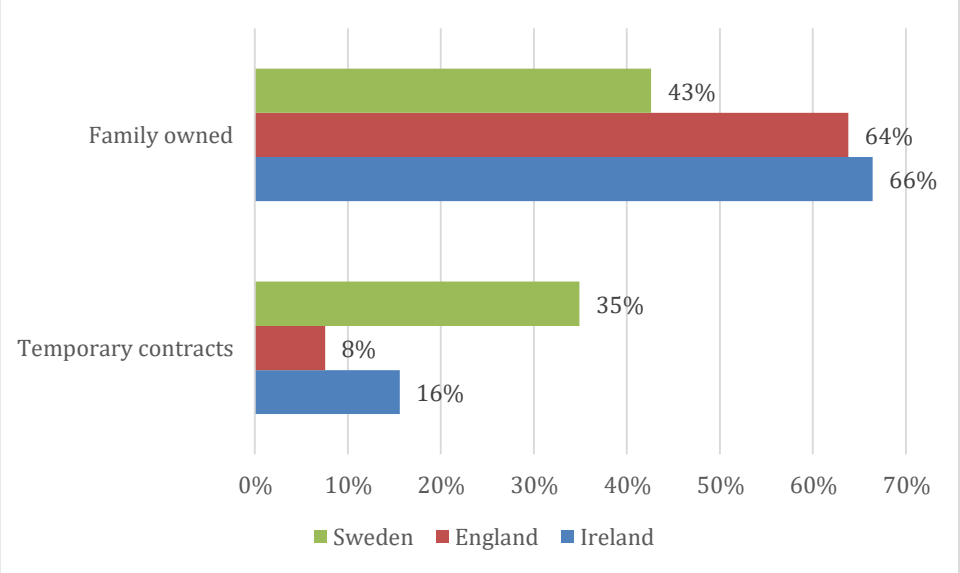
Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

Figure 2.4 Single/multi site profile of firm sample, by country



Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

Figure 2.5 Proportion of firms that are family owned and that have temporary contracts, by country



Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

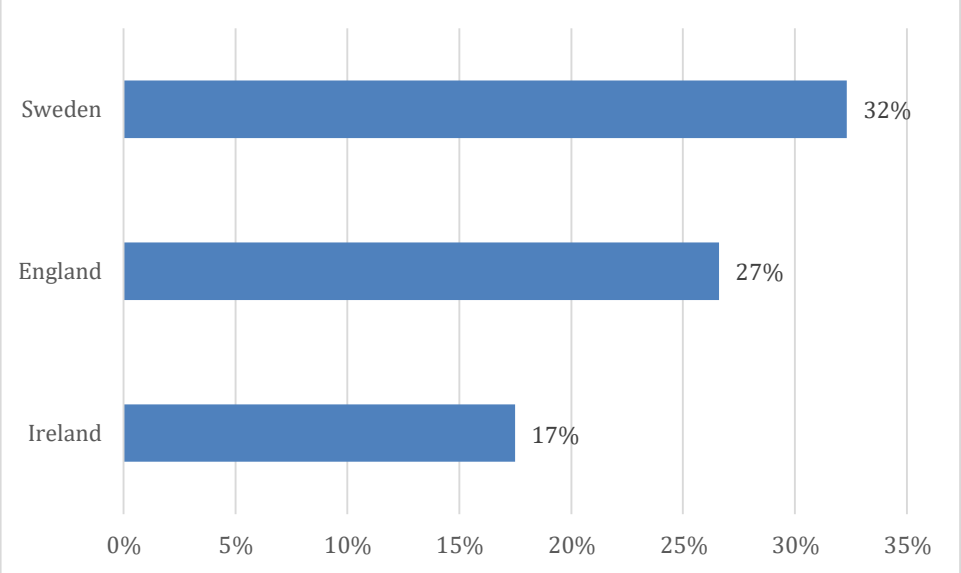
3. COMPARING EMPLOYERS' EXPERIENCE ACROSS THE THREE COUNTRIES

3.1 Mental health sickness absence

Our data show a different pattern of mental health-related sickness in Sweden compared to England and Ireland. Swedish firms are the most likely to experience mental health-related sickness absence, with 32 per cent reporting that they had at least some level of it in the 12 months leading up to the study (Figure 3.1.1). This compares to 27 per cent of English firms and only 17 per cent of Irish firms and is true of firms of all sizes.

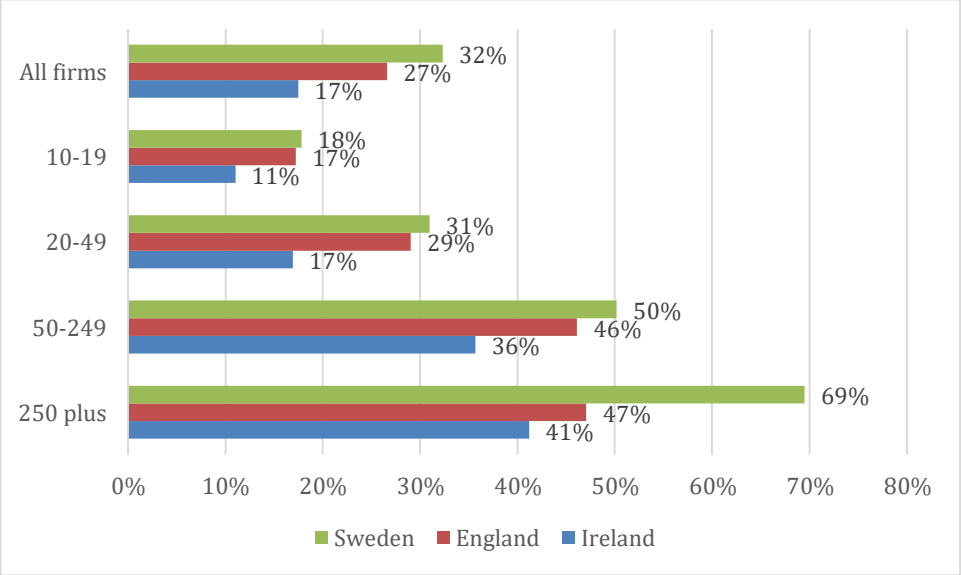
Larger firms are, in all three countries, more likely to report mental health-related sickness absence (Figure 3.1.2), which may be due to their increased likelihood of having a formal HR function to administer policies and capture data. Whereas for English and Irish firms those in the services sector have the highest reported likelihood of such absence, in Sweden the pattern is different, and hospitality and production firms report the highest levels of mental health sickness absence (Figure 3.1.3). Strikingly, as shown in Figure 3.1.4, Swedish firms are twice as likely as English and Irish firms to report long-term mental health-related absence, which is when employees are absent for more than four weeks. Nearly 90 per cent of Swedish firms with mental health sickness absence report this, compared to 38 per cent of English and 44 per cent of Irish firms. However, the proportion of firms reporting repeated mental health absences (Figure 3.1.5) is more consistent at 43 per cent for Sweden, 58 per cent for England and 43 per cent for Ireland. It is likely that the higher reporting of long-term absence in Sweden reflects underlying attitudinal and policy differences including the provision of state-funded extended sick pay and the introduction of the SED diagnosis, as discussed in section 1 above.

Figure 3.1.1 Proportion of firms reporting some level of mental health sickness absence, by country



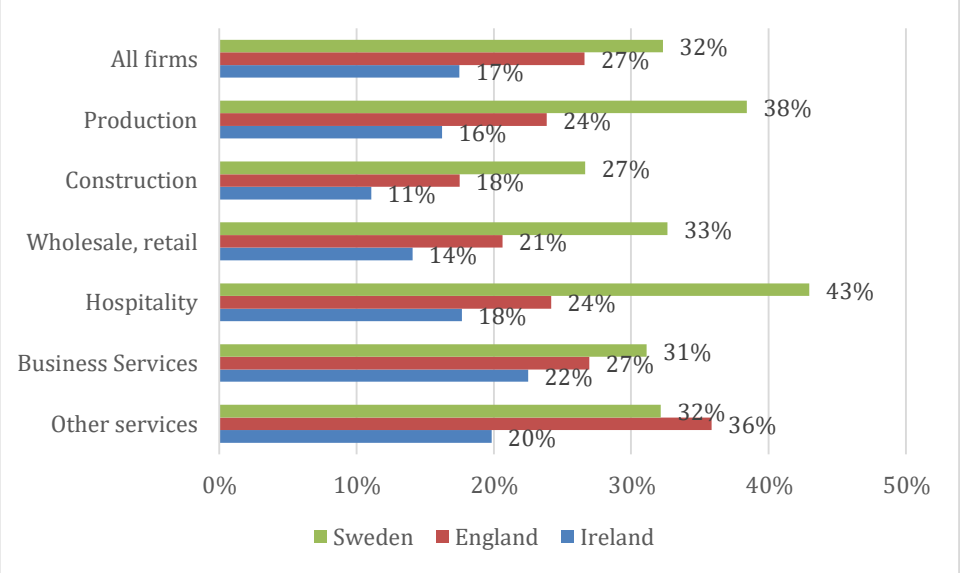
Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

Figure 3.1.2 Proportion of firms reporting some level of mental health sickness absence by size



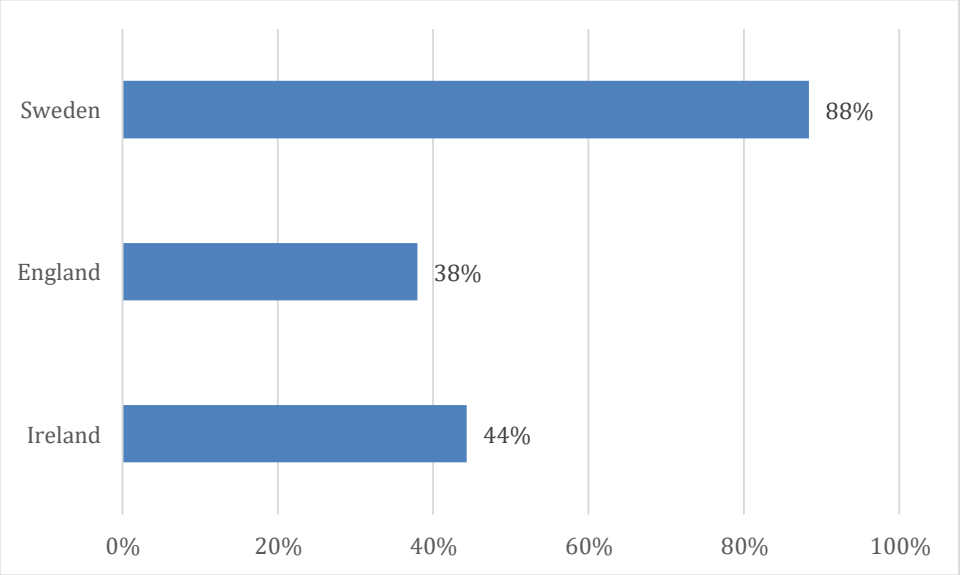
Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

Figure 3.1.3 Proportion of firms reporting some level of mental health sickness absence by sector



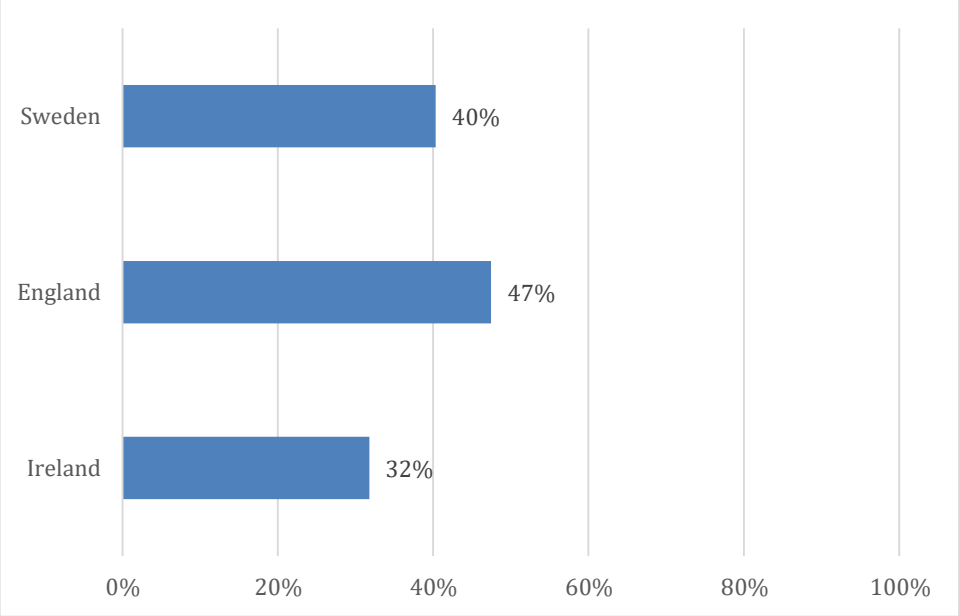
Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

Figure 3.1.4 Proportion of firms reporting some level of long term mental health sickness absence



Base: Sweden 400 firms, England 471 firms, Ireland 291 firms

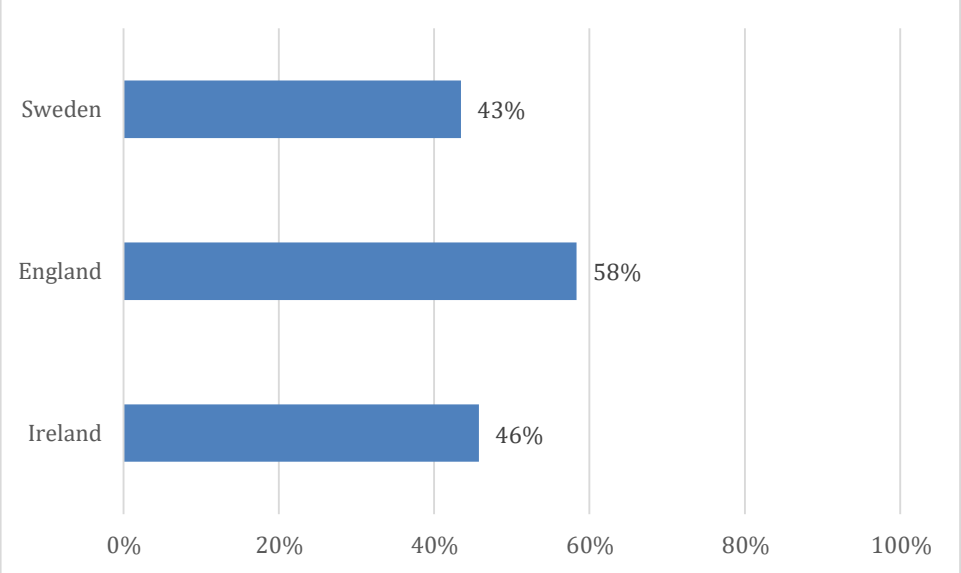
Figure 3.1.5 Proportion of firms reporting some level of repeated mental health sickness absence



Base: Sweden 400 firms, England 471 firms, Ireland 291 firms

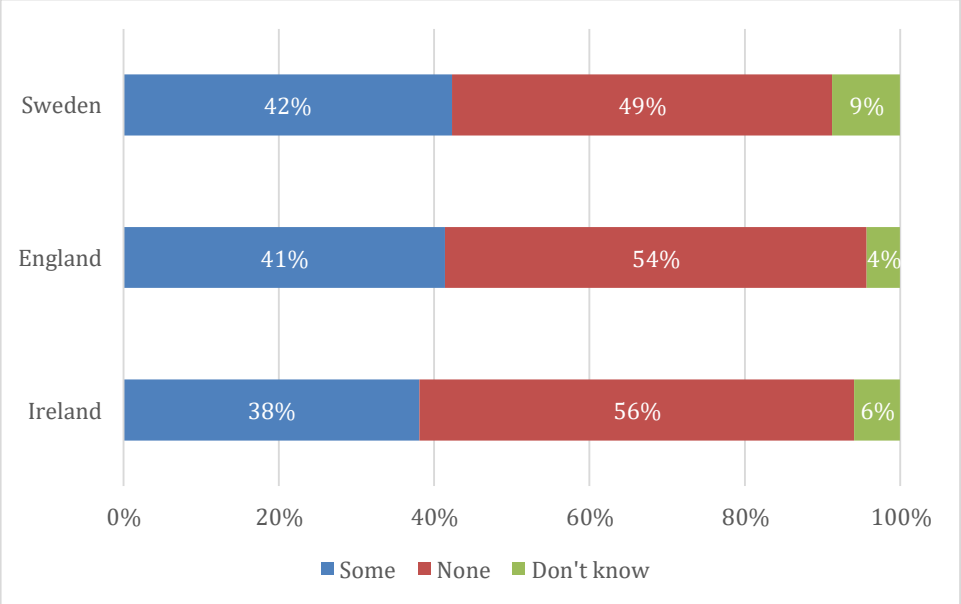
Despite being more likely to report mental health-related sickness absence, Swedish firms are less likely than English and Irish firms to say that such absence impacted on the operation or performance of their business. As shown in Figure 3.1.6, only 43 per cent of Swedish firms said they had felt the impact of mental health related absence, compared to 58 per cent of English and 46 per cent of Irish firms. Very similar levels of firms in all three countries attributed mental health sickness absence to in-work issues (Figure 3.1.7) but English firms were more likely to point to issues outside work (Figure 3.1.8) and physical illness (Figure 3.1.9) as a cause.

Figure 3.1.6 Proportion of firms reporting that mental health sickness absence impacted on their business



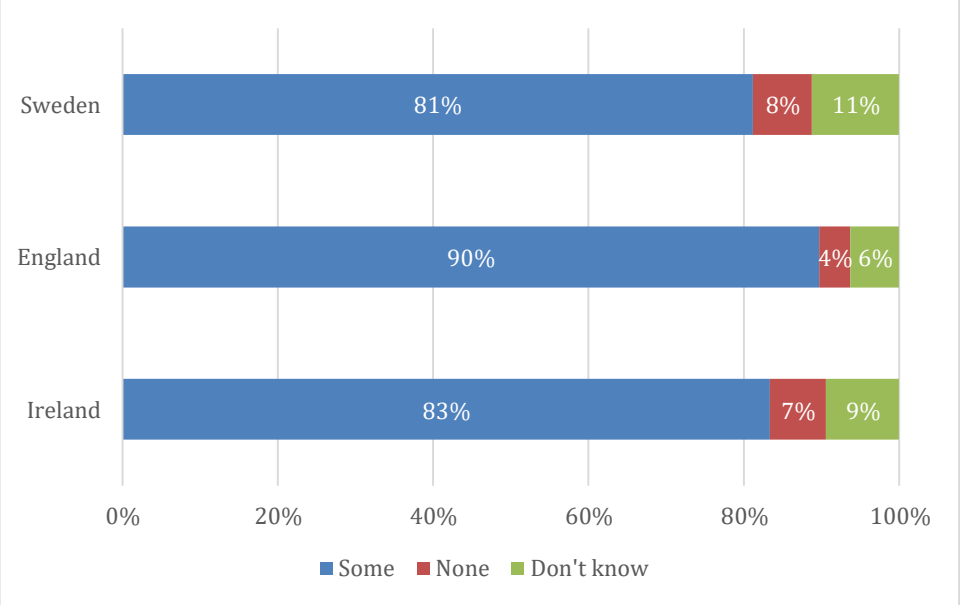
Base: Sweden 400 firms, England 471 firms, Ireland 291 firms

Figure 3.1.7 Proportion of firms attributing mental health sickness absence to in-work issues



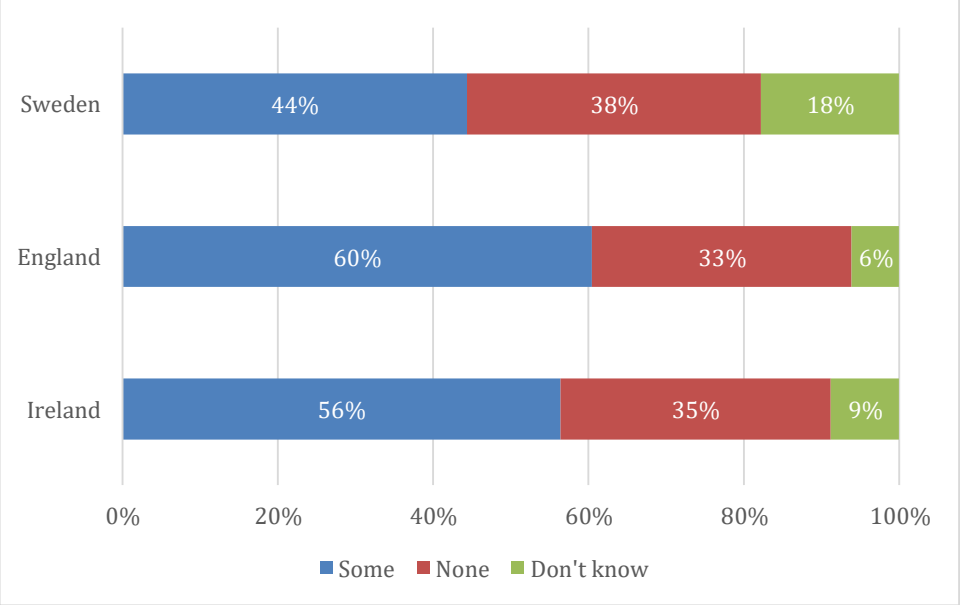
Base: Sweden 400 firms, England 471 firms, Ireland 291 firms

Figure 3.1.8 Proportion of firms attributing mental health sickness absence to outside-work issues



Base: Sweden 400 firms, England 471 firms, Ireland 291 firms

Figure 3.1.9 Proportion of firms attributing mental health sickness absence to physical illness issues



Base: Sweden 400 firms, England 471 firms, Ireland 291 firms

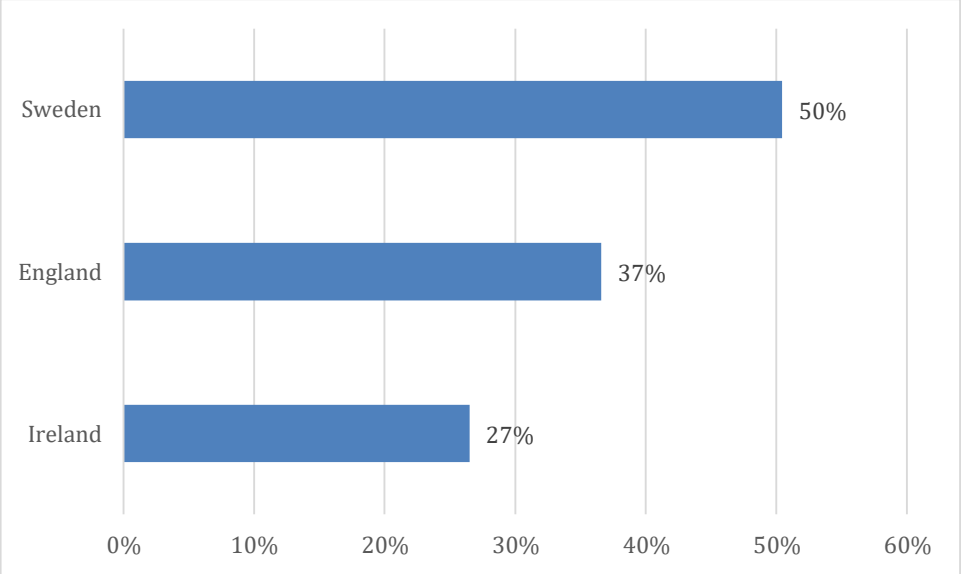
In summary, Swedish firms report different patterns of mental health-related absence than their English and Irish counterparts, with more firms experiencing mental health absence overall, and a much greater likelihood of long-term mental health absence. This suggests a different approach towards absence linked to mental health problems, possibly driven by different prevailing attitudes and enabled by a social security system that centrally funds extended sickness leave. It is possible that this difference removes the imperative to try to minimise mental health absence and instils instead an approach that seeks to manage it appropriately, even if that implies extended sick leave. Despite a higher likelihood of absence, and of extended absence, Swedish firms are significantly less likely than English and Irish firms to feel that mental health absence impacts their operations, which suggests that their approach may drive positive firm-level outcomes.

3.2 Presenteeism

Presenteeism – when employees are working when unwell or are routinely working beyond their contracted hours – has increased significantly over the past two years in England. In 2023, 37 per cent of firms reported some level of presenteeism compared to only 21 per cent in the previous year (ERC, 2023). Fewer Irish firms than English report preseenteeism, but it is more prevalent in Swedish firms, with 50 per cent of those surveyed saying they had experienced it in the previous 12 months (Figure 3.2.1). In all three countries, presenteeism is more likely to be reported by larger firms (Figure 3.2.2) but whereas in England and Ireland it is more prevalent in services firms, in Sweden hospitality firms are most likely to experience it (Figure 3.2.3).

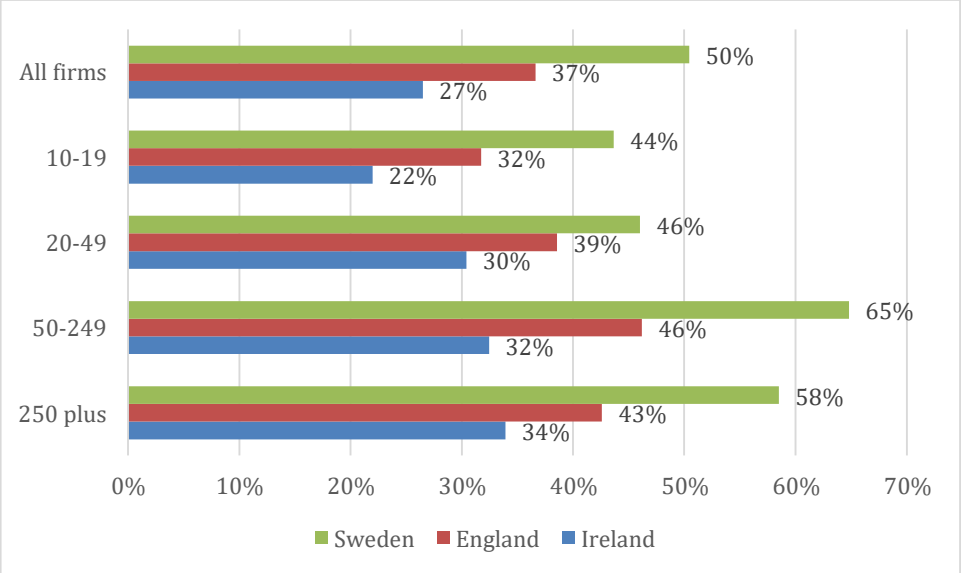
Patterns of presenteeism appear to vary by country, with Swedish firms much less likely to report working beyond contracted hours, possibly due to working hours legislation which enshrines a 40 hour working week in law, and much more likely to report employees working when ill. Irish firms are less likely to report that presenteeism is due to employees working when ill than firms in England and Sweden (Figure 3.2.4). The main reason for presenteeism given by Swedish firms is the desire to earn more money, but for firms in both England and Ireland, it is to meet deadlines, and Irish firms are the most likely to attribute presenteeism to staff shortages (Figure 3.2.5). The majority - 83 per cent - of Swedish firms say that they are taking steps to address presenteeism, compared to 68 and 70 per cent of English and Irish firms respectively (Figure 3.2.6). In all countries, the most common step taken is to send unwell employees home, but while 15 per cent of Swedish firms report that they reinforce messages about a good work-life balance, only 9 per cent of Irish and English firms do so (Figure 3.2.7).

Figure 3.2.1 Proportion of firms reporting some level of presenteeism, by country



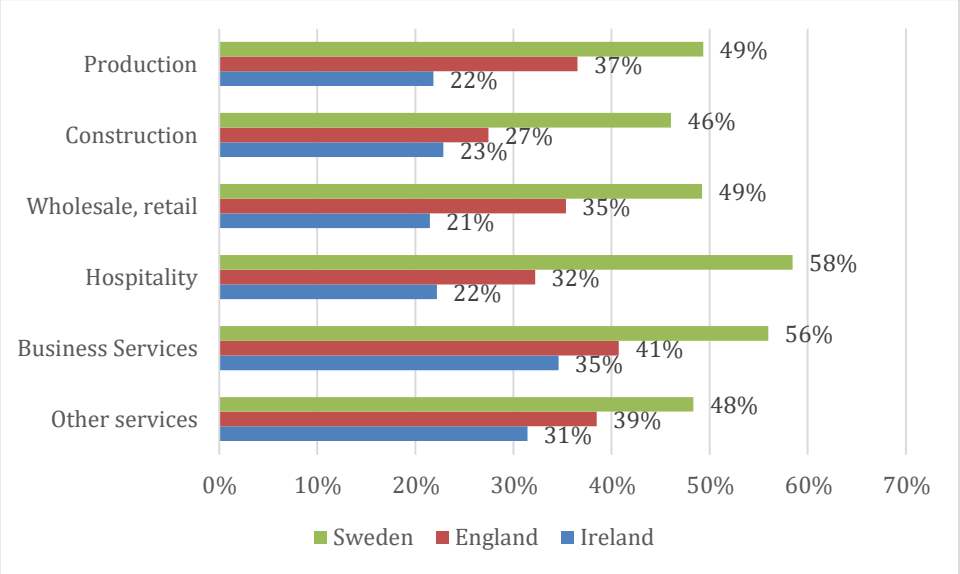
Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

Figure 3.2.2 Proportion of firms reporting some level of presenteeism, by size



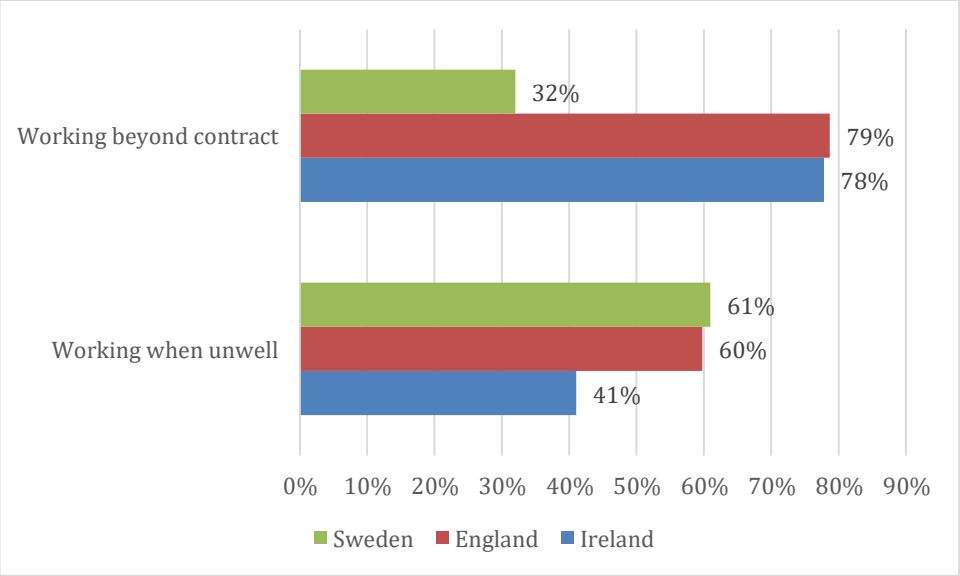
Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

Figure 3.2.3 Proportion of firms reporting some level of presenteeism, by sector



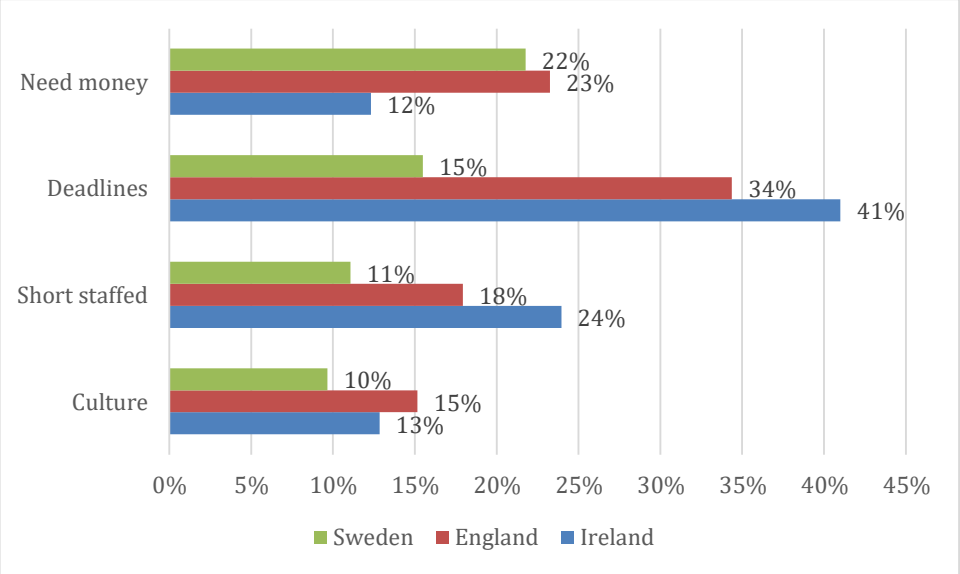
Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

Figure 3.2.4 Type of presenteeism reported, by country



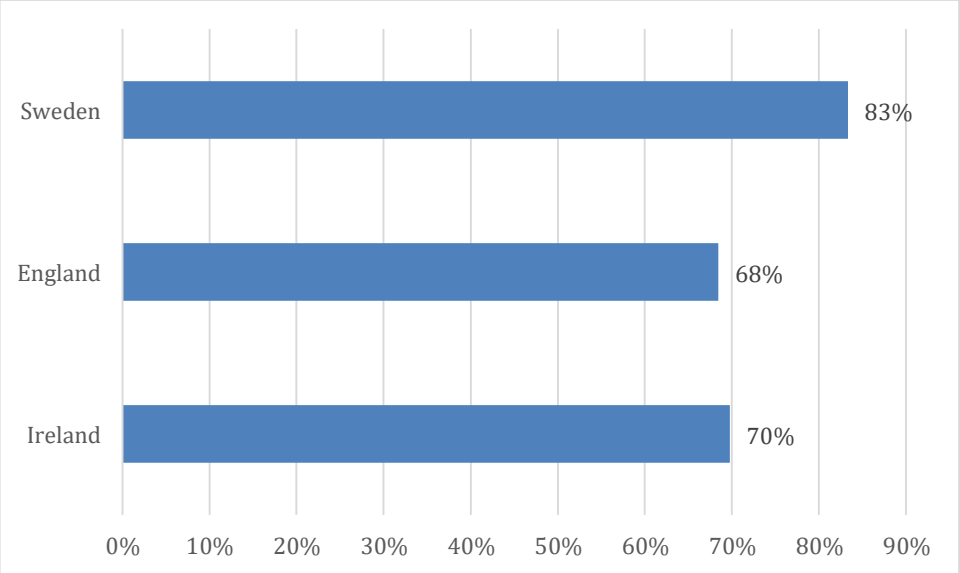
Base: Sweden 543 firms, England 692 firms, Ireland 417 firms

Figure 3.2.5 Reasons given for presenteeism, by country



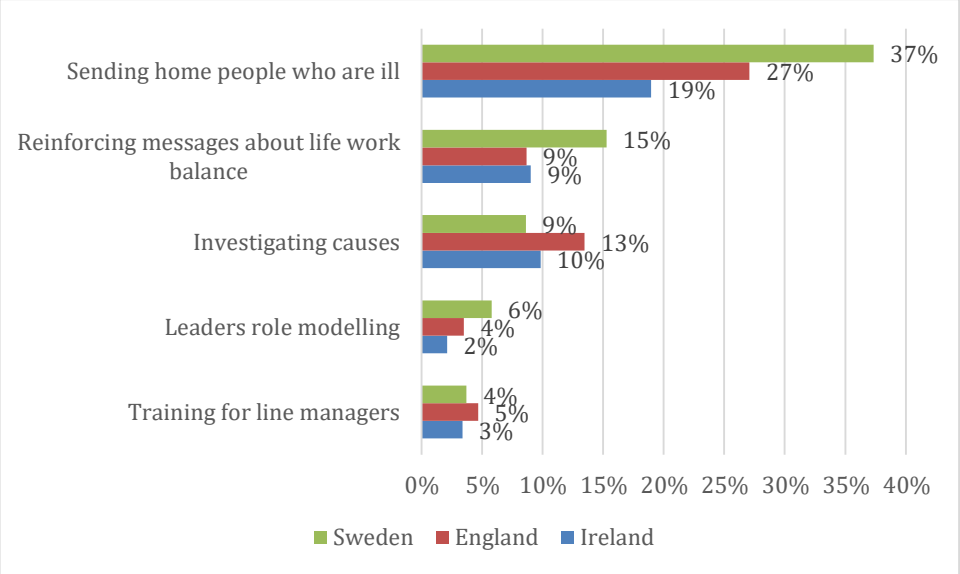
Base: Sweden 543 firms, England 692 firms, Ireland 417 firms

Figure 3.2.6 Proportion of firms reporting that they take steps to address presenteeism, by country



Base: Sweden 543 firms, England 692 firms, Ireland 417 firms

Figure 3.2.7 Steps taken to address presenteeism, by country



Base: Sweden 450 firms, England 451 firms, Ireland 294 firms

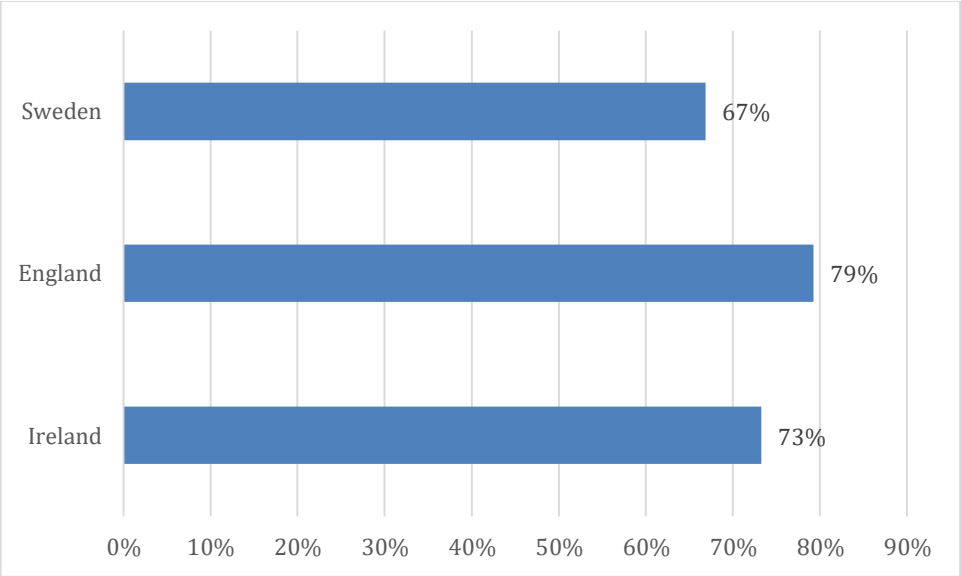
To summarise, Swedish firms are significantly more likely to report presenteeism than their English and Irish counterparts, and they also report different patterns of presenteeism. Swedish firms are considerably less likely to report working beyond contracted hours, which is the main form of presenteeism reported by English and Irish firms. As noted above, this may reflect cultural values in Sweden, which attach greater importance to work-life balance, or legislation limiting working hours. Swedish firms are more likely to report working when ill. The reasons given for presenteeism vary among the three countries. In Sweden, it is much less likely to be attributed to the need to meet deadlines, because of being short-staffed or because of workplace culture, whereas in England and Ireland, deadlines are the major cited cause for presenteeism. Swedish firms are more likely to say they are addressing presenteeism and are most likely to say that they are doing so by sending home people who are ill. They are also more likely than English and Irish firms to say that they reinforce messages about work-life balance, again potentially reflecting different cultural attitudes.

3.3 Addressing mental health in the workplace

A smaller proportion of firms in Sweden express the view that employers ought to address mental health issues at work (Figure 3.3.1). Yet Swedish firms are significantly more likely than those in England and Ireland to report that they have adopted mental health initiatives of some kind (Figure 3.3.2), with 78 per cent of Swedish versus 52 per cent of English and 46 per cent of Irish firms offering them. In all three countries, larger firms are more likely to have adopted initiatives (Figure 3.3.3) but while English and Irish firms show some sectoral

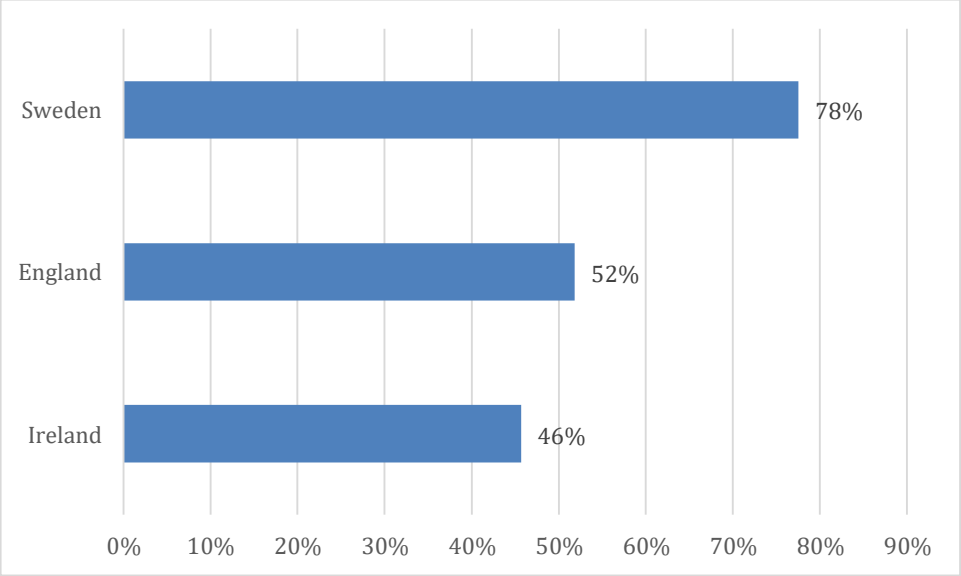
variation in their uptake of initiatives, Swedish adoption of mental health initiatives is much more consistent across business sectors (Figure 3.3.4).

Figure 3.3.1 Proportion of firms disagreeing that mental health is a personal issue and not one which should be addressed at work, by country



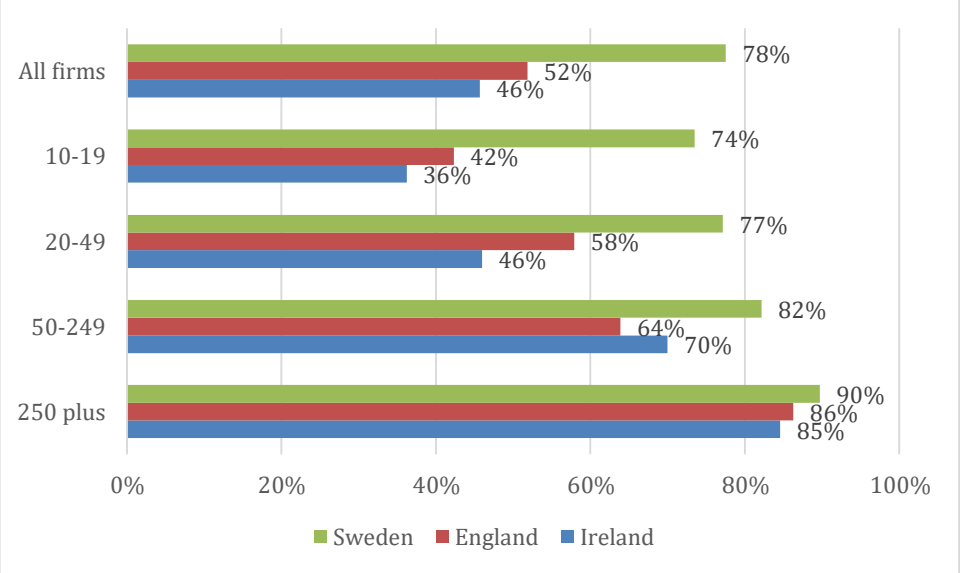
Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

3.3.2 Proportion of firms reporting that they have adopted MH initiatives of some kind, by country



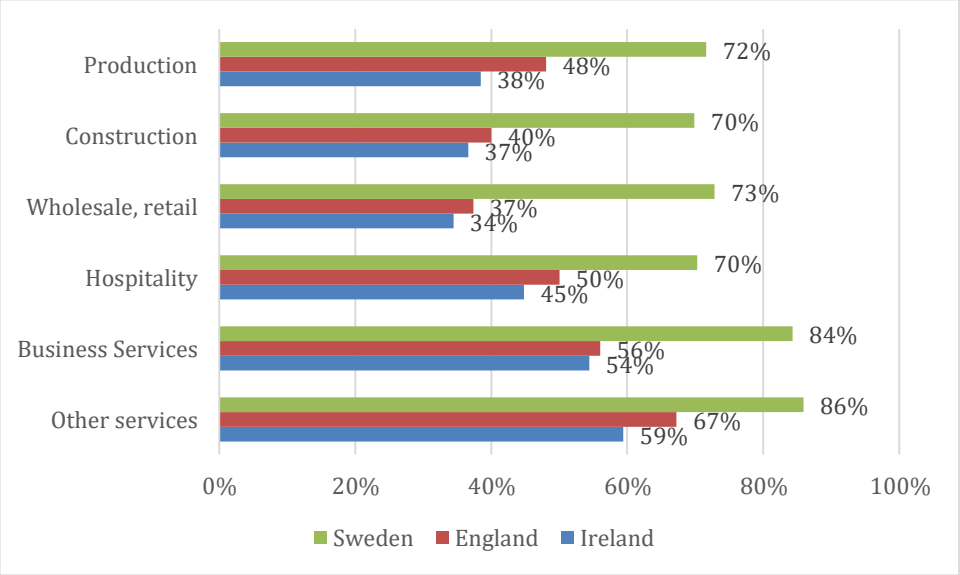
Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

3.3.3 Proportion of firms reporting that they have adopted MH initiatives of some kind, by size



Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

3.3.4 Proportion of firms reporting that they have adopted MH initiatives of some kind, by sector



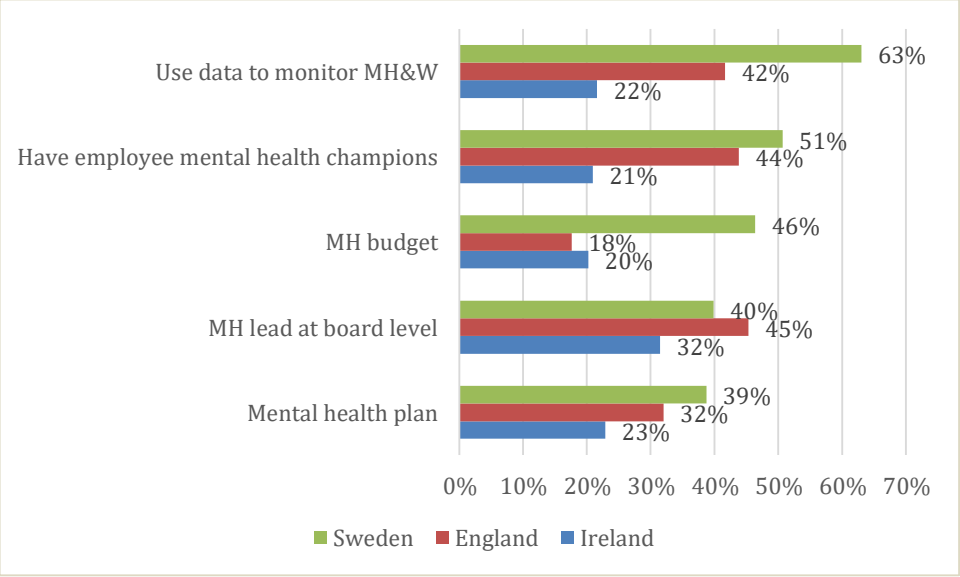
Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

To evaluate the adoption of initiatives in more detail, we divide them into four categories of workplace mental health and wellbeing activities - strategic or policy initiatives, skills training and monitoring activities, workplace practices to reduce risk and investments in employee wellbeing. Different patterns of adoption of these groups of initiatives in the three countries under study are evident. Swedish firms report higher levels of adoption of strategic or policy initiatives (Figure 3.3.5) and of investments in employee wellbeing

(Figure 3.3.8) than firms in England and Ireland. English firms, on the other hand, are the most likely to adopt all the initiatives classified as skills training and monitoring activities (Figure 3.3.6). Swedish firms are the lowest adopters of training and monitoring activities. All three countries evidence high uptake of workplace practices to reduce risk (Figure 3.3.7) which are primarily initiatives that do not require financial investment. Irish firms are the most likely to say that they would like to offer more initiatives, with 71 per cent of respondent firms expressing this view compared to 61 per cent in England and 59 per cent in Sweden (Figure 3.3.9).

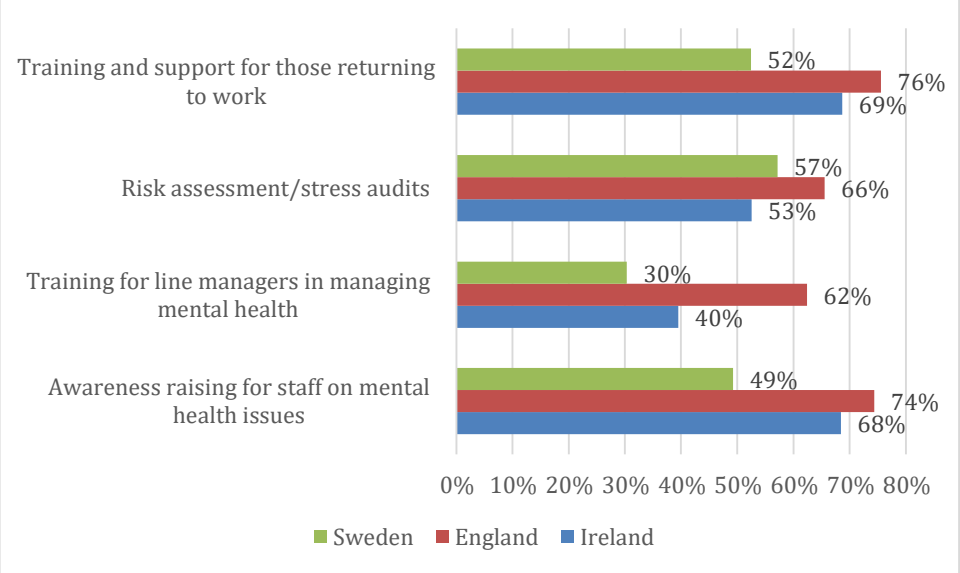
Around 40 per cent of English and Swedish firms and 33 per cent of Irish firms say that they evaluate their mental health and wellbeing initiatives (Figure 3.3.10) and they identify a range of outcomes. More than three-quarters of firms in all three countries say that their initiatives led to greater job satisfaction and better management of mental health in the workplace, and more than 60 per cent in all countries said that the initiatives helped to improve staff retention. Swedish firms were significantly less likely than English and Irish firms to identify business performance and customer service improvements (Figure 3.3.11).

3.3.5 Proportion of firms reporting that they have adopted strategic or policy MH initiatives, by country



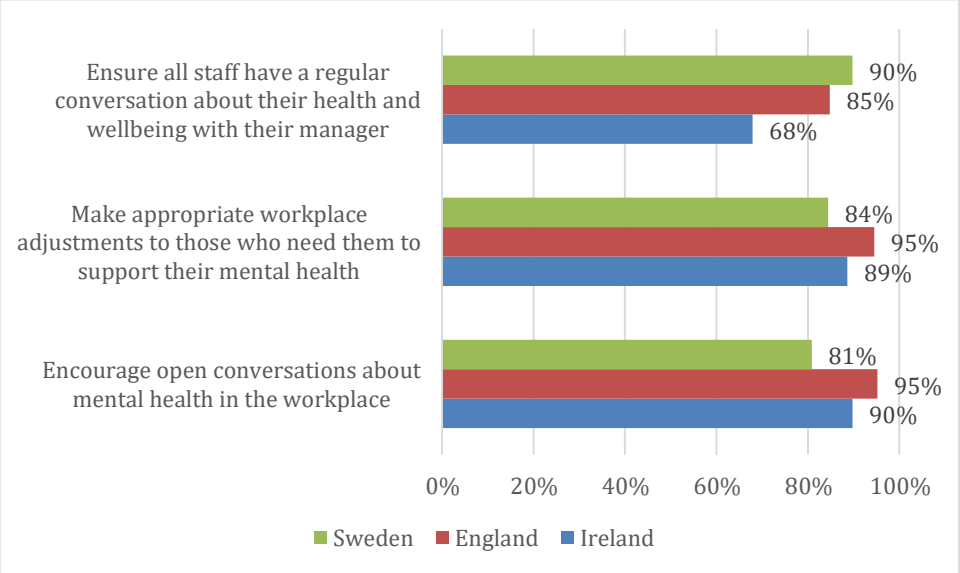
Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

Figure 3.3.6 Proportion of firms reporting that they have adopted skills training or monitoring MH initiatives, by country



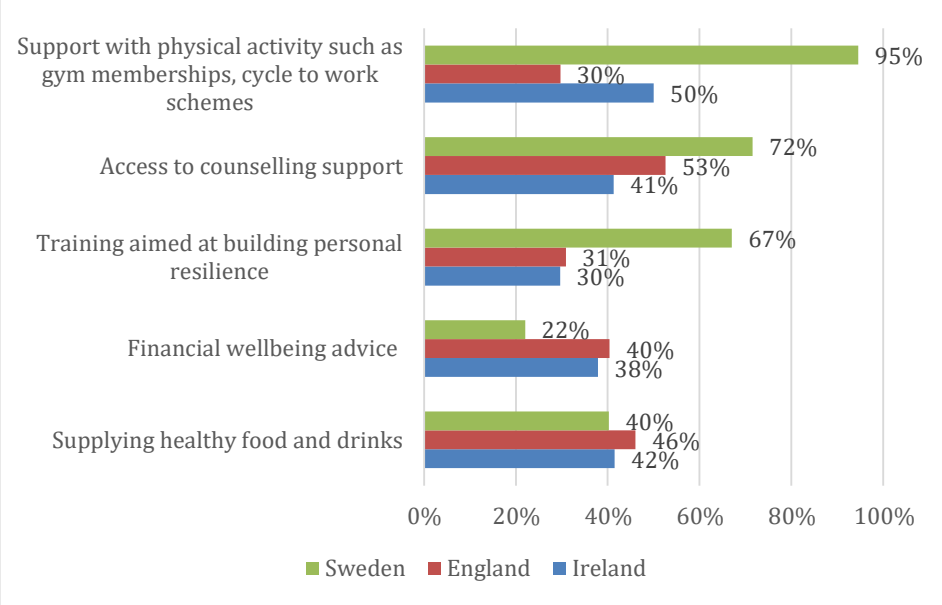
Base: Sweden 784 firms, England 970 firms, Ireland 722 firms

Figure 3.3.7 Proportion of firms reporting that they have adopted workplace practices to reduce risk factors, by country



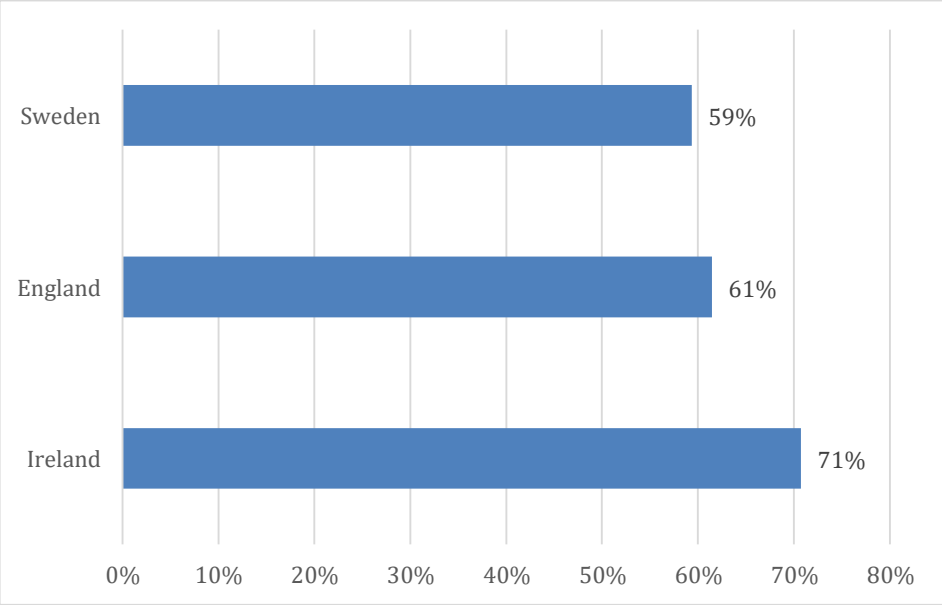
Base: Sweden 784 firms, England 970 firms, Ireland 722 firms

Figure 3.3.8 Proportion of firms reporting that they have adopted investments in employee wellbeing, by country



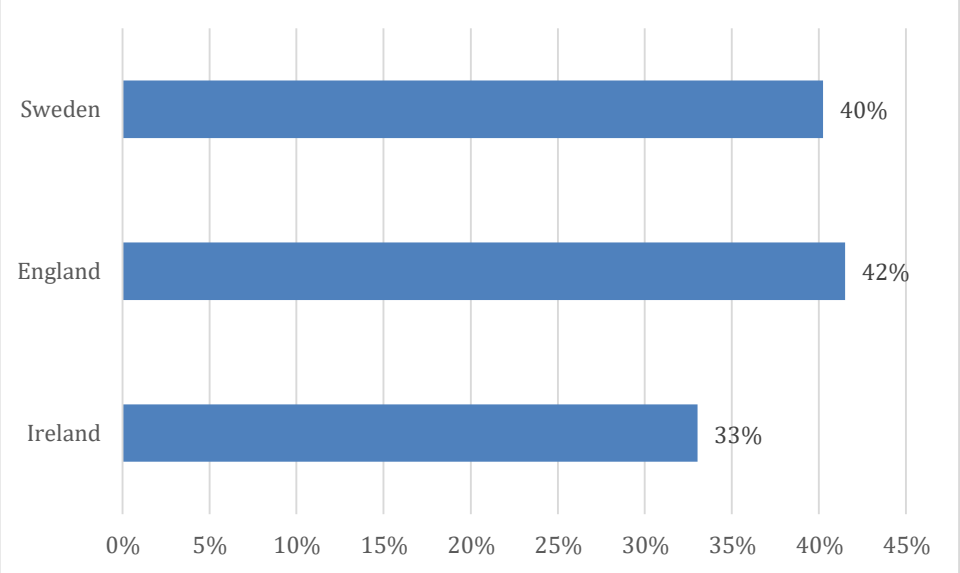
Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

Figure 3.3.9 Proportion of firms that would like to offer more mental health and wellbeing support to employees, by country



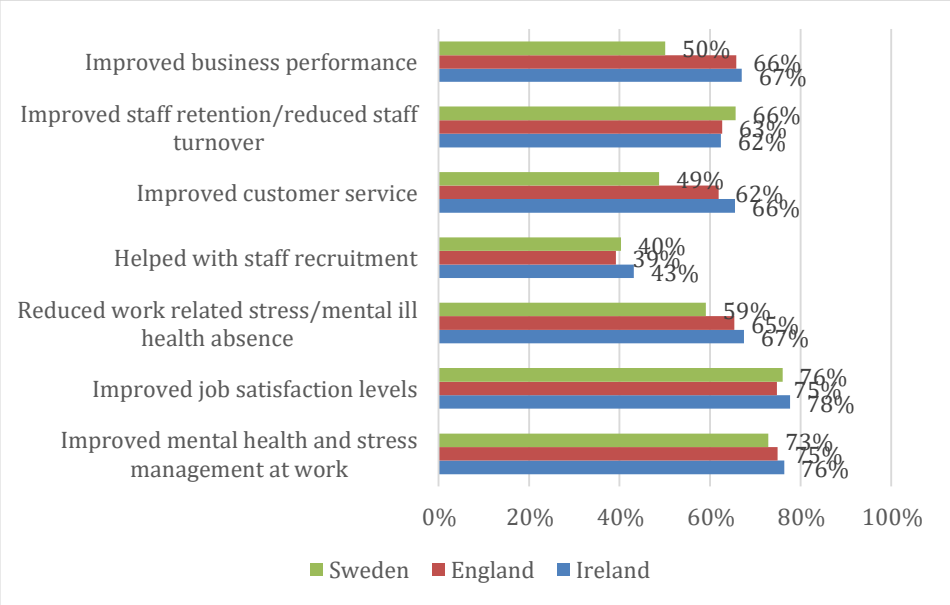
Base: Sweden 1,000 firms, England 1,902 firms, Ireland 1,501 firms

Figure 3.3.10 Proportion of firms that evaluate their mental health & wellbeing initiatives, by country



Base: Sweden 902 firms, England 1,379 firms, Ireland 941 firms

Figure 3.3.11 Reported impacts of mental health & wellbeing initiatives, by country



Base: Sweden 902 firms, England 1,379 firms, Ireland 941 firms

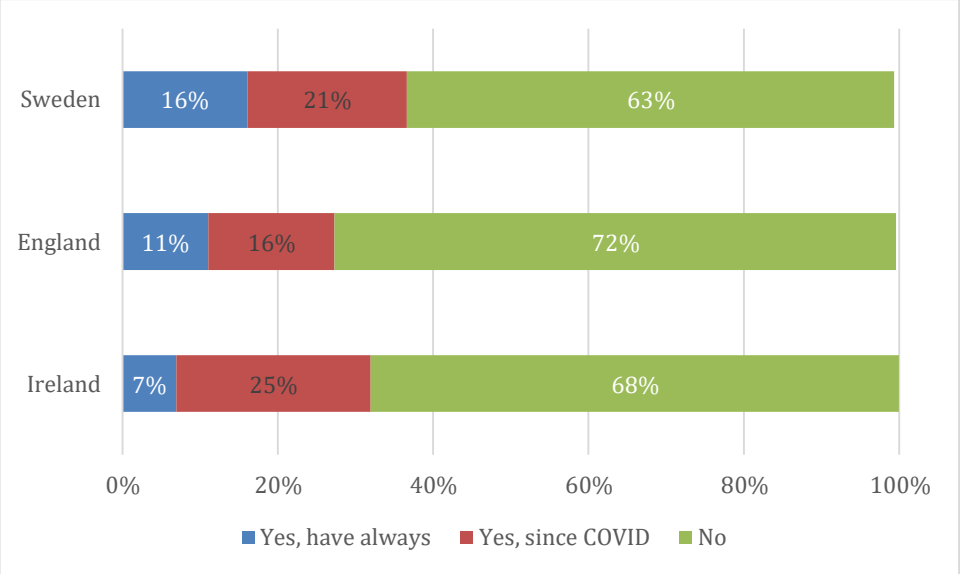
In summary, although fewer employers in Sweden express the view that they ought to address mental health issues at work, more firms adopt initiatives to address these issues than in England and Ireland and this adoption is more consistent across sectors. This suggests a more embedded approach to dealing with workplace mental health in Sweden, driven by underlying cultural norms. Swedish firms have strikingly different patterns of adoption of initiatives and are much more focused on strategic or policy initiatives and

investments in employee wellbeing than firms in England and Ireland. For example, they are twice as likely to have a budget for mental health activities and they are much more likely to offer resilience training and counselling support. Arguably, this difference evidences a greater emphasis in Swedish firms on initiatives designed to prevent mental health problems than in English or Irish firms. Large proportions of firms in all three countries report the adoption of no-cost practices to address workplace mental health, which potentially implies a burden for line managers. Swedish firms are significantly less likely to say that they train line managers in dealing with mental health issues than firms in England and Ireland. Firms in all three countries say that their initiatives lead to better job satisfaction, mental health management and staff retention, but Swedish firms are significantly less likely to identify business performance and customer service improvements.

3.4 Remote working

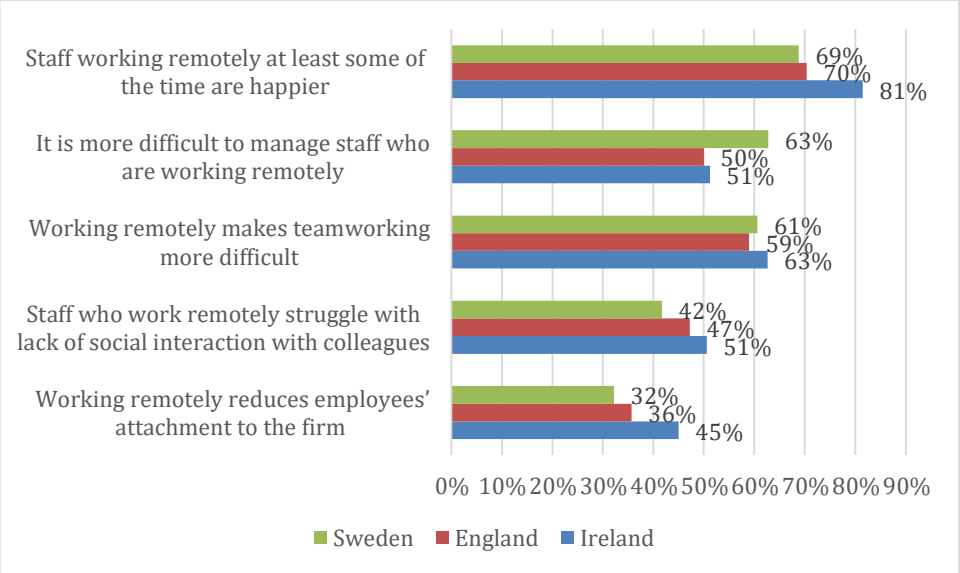
Employers in Sweden, England and Ireland report some variance in the adoption of home working as shown in Figure 3.4.1. Swedish firms were more likely to have had some level of remote working pre-pandemic - 16 per cent of Swedish firms reported this compared to 11 per cent and 7 per cent of English and Irish firms respectively. Irish firms were the most likely to have introduced remote working since the pandemic. Overall, 27 per cent of English firms, 32 per cent of Irish firms and 37 per cent of Swedish firms say that they now have employees working from home. Reflecting on the impacts of remote working, Swedish firms are the least likely to point to reduced employee attachment to the business and employees struggling due to lack of interaction with others but are the most likely to say that it is more difficult to manage remote staff. Irish firms are the most likely to say that remote-working employees are happier (Figure 3.4.2). More Irish firms say that they encourage remote-working employees to maintain a clear distance between work and home (63 per cent compared to 59 per cent of English and 51 per cent of Swedish firms – see Figure 3.4.3). There is also some variation in how firms encourage this work-life balance, with Swedish firms more likely to adopt role modelling behaviour from managers as well as formal methods such as time sheets and formal conversations than English and Irish firms, and the latter more likely to discourage employees from responding to emails outside working hours and use informal conversations (Figure 3.4.4).

Figure 3.4.1 Proportion of firms with employees working from home, by country



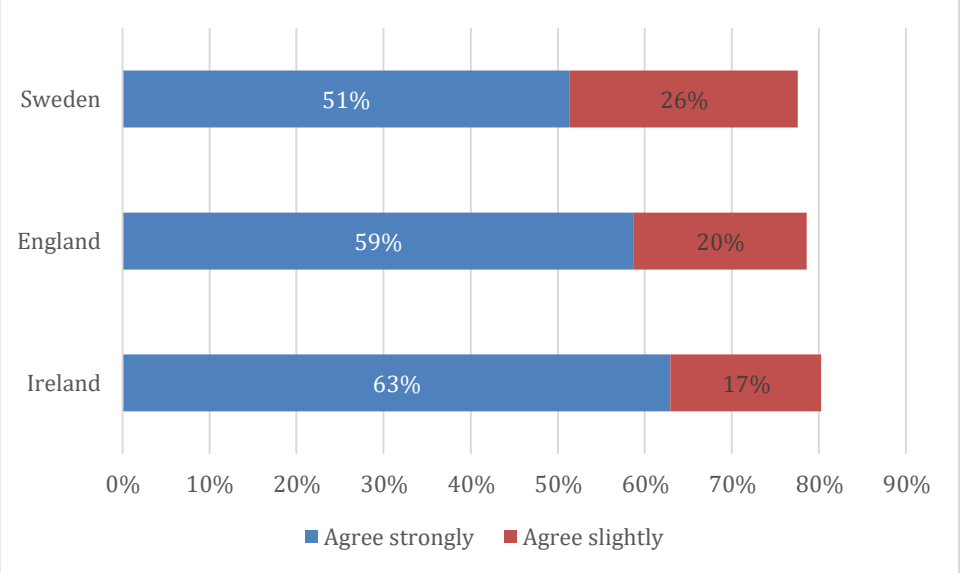
Base: Sweden 1,000 firms, England 1,894 firms, Ireland 1,499 firms

Figure 3.4.2 Proportion of firms agreeing with the following statements about remote working, by country



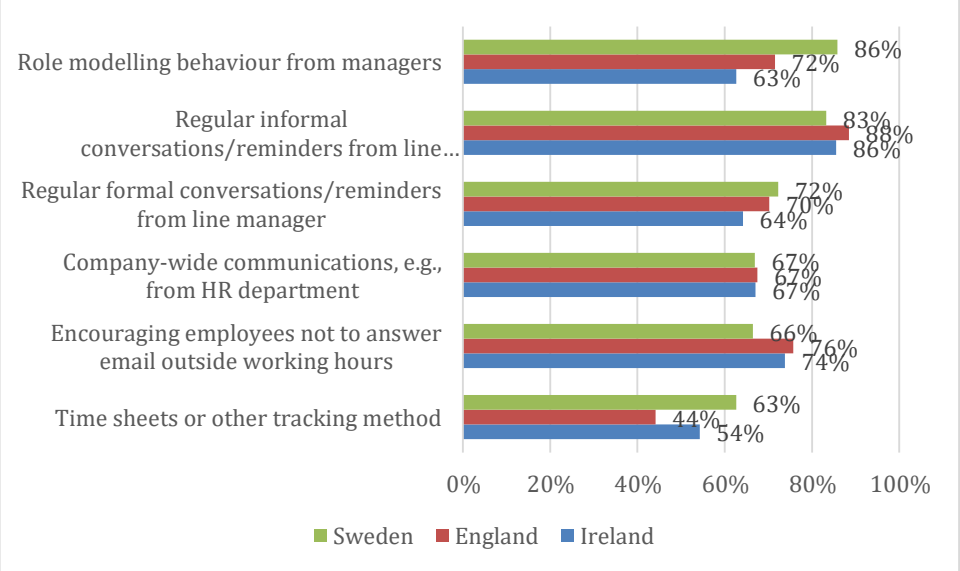
Base: Sweden 378 firms, England 565 firms, Ireland 507 firms

Figure 3.4.3 Proportion of firms agreeing that their company encourages employees working at home to maintain a clear distinction between work and leisure time, by country



Base: Sweden 378 firms, England 565 firms, Ireland 507 firms

Figure 3.4.4 How firms encourage a clear distinction between work and leisure for those working remotely, by country



Base: Sweden 295 firms, England 438 firms, Ireland 404 firms

To summarise, we see different levels of remote working in the three countries, with Swedish firms more likely to have had some level of remote working pre-pandemic and Irish firms most likely to have introduced remote working since the pandemic. 27 per cent of English firms, 32 per cent of Irish firms and 37 per cent of Swedish firms currently report remote working. Perhaps because remote working was more embedded pre-pandemic in

Sweden, Swedish employers articulate fewer concerns about the impacts related to employee work attachment and social interaction. Swedish firms are more likely to use manager role modelling and formal interactions to encourage a good work-life balance for remote workers, while English and Irish firms use more informal interactions.

4: KEY FINDINGS AND IMPLICATIONS

4.1 Key findings

Our comparative data reveals some striking differences between employer experiences of, and approaches towards, workplace mental health issues. First, Swedish firms report different patterns of mental health-related absence than their English and Irish counterparts. They are more likely to experience mental health-related sickness absence, despite similar levels of mental ill-health in the three countries, which suggests that Swedish employees may be more willing to disclose mental health issues to their employer than their English and Irish counterparts. This may reflect different attitudes towards mental ill-health in the three countries, which could mean that stigma attached to these problems leads to under-reporting of mental health issues by English and Irish employers. More than ninety per cent of Swedish firms that do experience mental health-related absence report that at least some of it is long-term, i.e., for four weeks or more. This compares to 38 per cent of English and 44 per cent of Irish firms, and suggests a fundamentally different approach to the management of workplace mental health in Sweden, as evidenced by the adoption of stress-induced exhaustion disorder (SED) as a diagnosis and greater emphasis on taking sufficient time to deal with an issue.

Second, despite being more likely to experience mental health absence, Swedish firms are less likely to say that such absence impacts their business operations, which suggests that managing, rather than attempting to minimise, mental health-related absence may be a strategically beneficial approach for employers. It is important to note here, however, that the availability of extended government-funded sickness absence pay may play a part in enabling this approach.

Third, Swedish firms are more likely than English and Irish firms to report that they experienced presenteeism in the previous twelve months. Half of Swedish firms reported presenteeism compared to 37 and 27 per cent of English and Irish firms respectively. Here again, different patterns can be observed, with Swedish firms much less likely to report working beyond contracted hours, probably because of working time legislation, and more likely to report working when unwell. In Sweden, presenteeism is much less likely to be attributed to the need to meet deadlines or to mitigate staff shortages than in England and Ireland. Swedish firms are also much less likely to point to firm-level cultural reasons for presenteeism. Swedish firms are more likely than their English and Irish counterparts to say that they are addressing presenteeism, and they are more likely to do so by sending unwell people home, and by reinforcing messages about work-life balance. Again, it seems

plausible that underlying cultural factors, notably attitudes towards the importance of work-life balance, and regulatory differences related to working time legislation, may be shaping Swedish employer experiences.

Fourth, fewer employers in Sweden express the view that they ought to address mental health issues at work, but more Swedish firms adopt initiatives to address these issues than in England and Ireland and this adoption is more consistent across sectors. This suggests that managing mental health is an embedded practice that Swedish employers believe is expected of them. While similar proportions of Swedish English and Irish firms adopt no-cost practices such as encouraging open conversations about mental health in the workplace, Swedish firms are much more likely to adopt strategic or policy initiatives and investments in employee wellbeing. For example, they are twice as likely to have a budget for mental health activities. This suggests a more embedded approach to dealing with workplace mental health in Sweden, with a strong focus on leader buy-in and general employee wellbeing. Strategic/policy and wellbeing initiatives are also, by their nature, more focused on the prevention of issues. Finally, when it comes to remote working, 27 per cent of English firms, 32 per cent of Irish firms and 37 per cent of Swedish firms currently report remote working. Swedish firms are more likely to have had some level of remote working pre-pandemic and perhaps for this reason, Swedish employers articulate fewer concerns about the impacts related to employee work attachment and social interaction. This may also explain why Swedish firms are more likely to use manager role modelling and formal interactions to encourage a good work-life balance for remote workers, while English and Irish firms are more likely to use more informal interactions.

4.2 Implications for policy and practice

Drawing on these findings, we identify some tentative implications for policy and practice related to the management of workplace mental health. First, although Sweden, England and Ireland have remarkably similar levels of mental health problems (as shown in Figure 1.1), Swedish firms are more likely to report more mental health-related sickness absence, which implies that Swedish employees are more willing to disclose these issues to their employer, and that mental health issues may be being under-reported in England and Ireland. This may be because stigma attached to mental health issues is more pervasive in England and Ireland than in Sweden. Swedish employers are also much more likely to report long-term absence, which indicates that taking time away from work to manage these issues, and taking more lengthy periods of absence where necessary, is a more established approach in Sweden. The Swedish government's unilateral adoption of the SED diagnosis, and the acknowledgement that recovery from SED requires time,

exemplifies this approach. Despite a greater likelihood of mental health absence, however, Swedish firms are less likely to report the impacts of absence than their English and Irish counterparts, which suggests that their approach may be more successful in addressing the issues, and that approaches that discourage absence or encourage shorter absences are potentially less effective in managing workplace mental health problems. This implies that a greater firm-level focus on giving employees the time away that they need to deal with mental health issues, rather than attempting to minimise absence due to mental health issues, may be a more effective way of managing these challenges, and may pay dividends in the medium to long term. Further research into the benefits of managing rather than minimising mental health-related absence is needed, to provide clear evidence of the efficacy of this approach. In terms of practice, communicating this message to employers would be a good first step, and providing guidance and support to help them establish and transition to new protocols and procedures would be helpful, particularly in addressing stigma related to mental health issues and encouraging employees to disclose issues they may have. Policy support would also be helpful, given that Swedish employers have access to considerable levels of government-funded sick pay which are not currently available in England or Ireland.

Secondly, presenteeism is an issue in all three countries, although we observe different underlying reasons and divergent approaches to its management. It is striking that in Sweden, employers are significantly less likely to report working beyond contracted hours, and they are also much more likely to say that they are addressing presenteeism, by sending unwell home employees home and reinforcing messages about work-life balance. It seems likely that the considerably lower reporting of working beyond contracted hours in Sweden reflects a culture that prioritises a good work-life balance and working hours legislation. Swedish employer responses to presenteeism also seem to reflect this priority. Nevertheless, although Sweden evidences less working beyond contracted hours, Swedish employers do report similar levels of working when ill as those in England and Ireland. Prior research has linked presenteeism with stress and burnout in individuals (e.g., Cooper & Lu, 2018), which inevitably impacts the mental health of employees as well as firm-level performance. So, at the employer level, adopting practices to discourage working beyond contracted hours and working when unwell would appear to be the right thing to do. Employers may need encouragement and support to help them find ways to ensure that their employees feel able to take sick leave when necessary, and that they do not feel pressured into routinely working additional hours. When it comes to the latter, English and Irish employers could look to the approaches adopted by Swedish firms, notably reinforcing messages about work-life balance and leaders role modelling this behaviour.

Third, Swedish firms appear to be much more committed to strategic/policy and employee wellbeing initiatives to address workplace mental health issues, whereas English and Irish employers are more focused on training and monitoring initiatives. Given the differing reported outcomes – notably that Swedish firms report fewer impacts of mental health absence – the Swedish model might have something to offer employers in England and Ireland. Committing to senior-level engagement through, for example, the establishment of a mental health budget and a mental health plan seems likely to raise the profile of these issues within the firm, to ensure that business leaders are aware of the potential impacts of mental health issues and of the likely benefits of addressing them. Providing well-being investments like counselling support and resilience training may help to give employees the personal skills and resources they need to proactively manage their general health and wellbeing, potentially reducing the likelihood of a crisis event. Given the plethora and variety of mental health initiatives available, providing employers with guidance on the different types of initiatives available to them, and on the advantages that each offers, may help them to make informed judgements about what would work best for their business, to deliver the best firm- and individual- level outcomes. This would help them to evaluate the vast array of potential initiatives, to select those which would be the most appropriate for them.

Finally, to manage the challenges of remote working, employers will need to find effective ways to encourage a good work-life balance for their remote employees. Here again, given that remote working appears already to be more embedded in Sweden, and that Swedish employers seem to report fewer social interaction and detachment challenges related to it, practices prevalent in many of the Swedish firms we surveyed may be relevant for firms in England and Ireland. In particular, English and Irish employers could consider engaging in more formal ways of reminding employees to prioritise their home life, rather than relying on informal conversations. They could also consider encouraging managers to role model behaviour designed to ensure a clear work-life separation. Initiatives to support employers might include guidance to clarify the importance of psychologically detaching from work when working remotely, and suggestions for ways of embedding formal practices designed to ensure that managers are confidently able to provide as much support to employees who are working remotely as they are to those working in-person.

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