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Sickness, Disability and Work
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Chapter 2

Evaluating Recent and Ongoing Reforms

The extent of policy change over the past 15 years differs widely across the four countries. Ireland is among those OECD countries which have seen the least change, largely because problems in this area have only become apparent relatively recently. The Netherlands used to stand out from other OECD countries because of the ease with which it gave out disability benefits; these days, it stands out as the most radical reformer in the OECD. Finland and Denmark also belong to the group of countries which have undertaken major reforms.

The largest difference in policy is found in the extent to which employers are seen as part of the solution. In the Netherlands, employer responsibilities and incentives were increased dramatically in the past decade whereas the Danish flexicurity policy aimed to steer change through better incentives for public authorities, especially municipalities. Finnish reforms have sought a balanced approach, with Irish reform plans looking set to be striving for a strong public role.

The magnitude of sickness and disability policy reform in Denmark, Finland, Ireland and the Netherlands in the past decade was very different, but the direction of change – towards a more active system of supports – was similar. In all four countries, better inter-agency and inter-government co-operation, better sickness follow-up and better identification of remaining work capacities are high on the agenda. One area of divergence is the degree of involvement of employers. This chapter summarises and evaluates the key elements of recent and ongoing reforms and their impact. Before this, Box 2.1 gives an overview of the countries' sickness and disability benefit schemes.

Box 2.1. **Structure of the countries' sickness and disability schemes: an overview**

Benefit systems differ across the four countries in many ways, reflecting different social protection traditions. The key characteristics are as follows:

Disability benefit schemes

In Denmark and Ireland, disability benefits are flat-rate payments, with the average payment corresponding to around 40% of net earnings in Ireland and almost 70% in Denmark. The structure of the two systems differs drastically. Denmark has only one tax-financed disability benefit which is residence based; the full benefit rate which is worth more than 90% of net earnings for a single person is paid for people with 40 years of residence. Eligibility further requires that the person is unable to work in a subsidised job, as determined by a resource profile based on health but also many other variables. The earlier existing graduation of benefits according to degree of capacity was abolished in 2003, but payments can be accumulated with earnings in a generous way.

Ireland, on the contrary, has a range of disability benefits partly contribution-based and partly means-tested and tax-financed. The three main benefits are the contribution-based invalidity pension for those permanently incapable of working; the means-tested disability allowance for those without an insurance record whose disability hinders the take-up of reasonable work; and the contribution-based illness benefit for temporary work incapacity (with no time-limit for what is seen as "temporary"; in this report, all illness benefits paid for more than two years are considered as disability benefits). Entitlement to an invalidity pension or a long-term illness benefit requires 260 weekly social insurance contributions (520 from 2 012 onwards). While assessment procedures differ, payment rates are virtually identical for all three benefits and include supplements for dependants. Like in Denmark, there is no partial benefit but various earnings disregards and taper rates for beneficiaries.

Finland and the Netherlands both have earnings-related components in their contribution-based disability insurance systems. The Finnish system consists of a statutory earnings-related part which is administered by approved private pension providers, and a nationally-administered, tax-financed, residence-based, flat-rate part. The latter is paid in full for people who have spent 80% of their adult life in the country (minimum requirement is three years of residence) but it is withdrawn for those with higher entitlements from the

Box 2.1. **Structure of the countries' sickness and disability schemes: an overview** *(cont.)*

earnings-related system. Entitlements from the latter are proportional to the insurance record, paying some 60% of earnings after 40 years of insurance; there is no minimum affiliation required and no upper benefit threshold. In practice, 20% of all recipients receive a flat-rate payment only (because of insufficient insurance records) while of the remaining 80% around half receive an earnings-related payment only. Entitlement for the two parts of the system is assessed in parallel using slightly different criteria. The earnings-related system offers a full benefit for earnings-capacity loss of at least 60% and a partial benefit for a loss of 40%-59%.

The Dutch system also has two different streams. People with full (at least 80%) and permanent earnings-capacity loss are entitled to a permanent (IVA) benefit which pays 70% of the last wage. People with a partial or temporary earnings-capacity loss are entitled to an initial wage-related (WGA) benefit for a period of 3-38 months, depending on age. After this initial period, claimants are entitled to either a lower follow-on benefit which is 70% of the statutory minimum wage multiplied by the percentage of incapacity, or – if they make use of at least 50% of their remaining capacity – a wage supplement which is equivalent to 70% of the difference between the previous wage and the assessed residual capacity (but no less than the follow-on benefit they would be entitled to). Benefits are paid irrespective of the insurance record, *i.e.* there is no minimum period of affiliation to the system. In addition, the Netherlands has a tax-financed and flat-rate (Wajong) disability benefit for people who acquired a disability before age 18. This benefit is non-contributory, has slightly different entitlement criteria and is paid at a full or a partial rate; the minimum required capacity loss is 25% and the maximum Wajong benefit (which is paid for full incapacity of at least 80%) is 70% of the statutory minimum youth wage.

One unique characteristic of the Dutch system is that the disability benefit covers all earnings-capacity losses, irrespective of the cause of the problem; hence, losses stemming from occupational injuries and diseases are covered in the same system. This is different in the three other reviewed countries, and in fact all other OECD countries, which have special systems offering protection for occupational injuries and diseases. These systems, however, are not covered in this report. One consequence is that Dutch disability benefit recipiency figures are a slight overestimation when compared to all other countries.

Sickness benefit schemes

Denmark has a tax-financed sickness benefit scheme covering the entire active population, with only minor qualifying criteria. Payments are earnings-related but with a very low maximum threshold equal to around 55% of average earnings. Benefits are paid for up to one year in 18 months, with occasional extension by up to six months. For the first 21 days, the sickness benefit is paid by the employer, thereafter by the municipality. De facto, via collective agreements, most employees receive a full-wage payment for a considerable period, typically for several weeks for blue-collar workers and often for the whole period (*i.e.* up to one year) for white-collar workers. Receipt of a partial sickness benefit is possible.

The Irish illness benefit is a compulsory social insurance scheme with flat-rate payments and supplements for dependants. It is payable for up to one year provided the person has collected 52 weekly contributions since first starting employment or 39 weekly contributions in the year preceding the claim (the requirements for a long-term claim are described above). Although Ireland has no statutory employer-paid period, most workers will also receive continued full-wage payment for between four and 26 weeks. There is no partial sickness benefit.

Box 2.1. **Structure of the countries' sickness and disability schemes: an overview** *(cont.)*

Echoing the disability benefit scheme, Finland has a universal compulsory sickness insurance scheme for all residents. Payments are earnings-related, paying around 70% of past earnings for most workers (but with a rather progressive formula). Benefits are paid for up to one year over a two-year period. There is a statutory wage payment period for the employer of nine days, but most collective agreements extend this period to 1-2 months. A 50% part-time sickness benefit can be paid after 60 days of full-benefit receipt.

In the Netherlands the sickness benefit scheme was privatised over the past 15 years. Today, employers have an obligation to pay sickness benefit to their employees for up to two years (there is no minimum qualifying period). Reinsurance with a private insurer is possible and very common especially for smaller companies. The statutory benefit level is 70% of the wage over the past two years, which is often topped up via agreements (and full-wage payment is standard during the first year). There are no partial sickness payments. In addition to the employer scheme, the old sickness benefit system (with the same 70% benefit level) continues to exist as a "safety net" for employees who do not or no longer have an employer.

More details on the countries' benefit and tax systems can be found in the Annex of Chapter 5 (Table 5.A1.1).

2.1. Denmark: strengthening responsibilities for municipalities

Ten years ago, Denmark stood out from the crowd in having a system strongly promoting reintegration of people with disability. Since then, it has not rested on its laurels, but has gone even further in search of a system that works, in both senses of the term. Outcomes in terms of labour market integration and reduction of benefit dependence, however, are generally fairly disappointing. There are still loopholes in the system and policy implementation does not live up to the intentions. One aspect behind virtually all reforms in the past 15 years was to strengthen further the role of municipalities and their incentives to implement policy as intended. This is important in view of the key role municipalities have in this country for the entire social system, including benefit grants as well as social and employment services.

A. Assessing ability to work, not loss of ability

Prior to 2003, Denmark had a very complex disability benefit scheme consisting of several different components, depending on the degree of disability, family status and age. Payments were flat-rate and relatively high for those below average earnings. The extent and complexity of the disability benefit system was believed to contribute to its widespread use. To simplify this system was one of the main objectives of a comprehensive reform, which was implemented in 2003 but already agreed by the government and the social partners in late 2000.

In short, benefit levels were made equal for all beneficiaries and more similar to the rates of other social benefits. The new system offers only one benefit rate, payable at the level of around half of the gross average wage, corresponding to a 70% net replacement rate at average earnings. This is equal to the highest-rate regular unemployment benefit. Perhaps most importantly, the partial benefit for partial disability was abolished altogether, because the graduation of payments was found to make people act "as sick as possible".

The other main objective of the reform was to change the assessment criterion from loss-of-vocational-ability to ability-to-work, *i.e.* looking at what a person can do, not what she cannot do. More precisely, what is now being assessed is whether a person is able to support herself through either a normal job or a subsidised flex-job (Chapter 3). In assessing this, a comprehensive "resource profile" is prepared to identify people's potential. If a person is not able to perform a flex-job, a disability benefit will be granted. Otherwise, the caseworker should find her a (generously subsidised) flex-job.[1] Until such a job is found, the person is entitled to a so-called *waiting benefit*, which is paid without time limit at the level of a disability benefit.

In a nutshell, the objective of the reform was to make better use of workers' remaining work capacities. Trends after 2003 suggest that the reform was only a partial success. Not surprisingly, the number of people on subsidised flex-jobs increased rapidly. The number of people entitled to a flex-job but not able to find one, however, grew also rapidly, leading to a steady increase in the number of people receiving a waiting benefit. Moreover, people seem to be staying on such a benefit for ever longer periods. At the same time, the number of people entitled to a disability benefit did *not* fall. The overall result is that the rate of employment of people with health problems has increased, but so has the number of people receiving long-term health-related benefits.

This result is only partly surprising. With a permanent subsidy of either 50% or 67% of the corresponding full-time wage, flex-jobs are very attractive for workers and employers seeking to transform a full-time into a part-time job. But flex-jobs are also attractive for the municipality, the gatekeeper of all social benefits, because the state reimburses the costs of municipalities at different rates: at 65% for an active flex-job *versus* 35% for a passive disability benefit. Evaluation of the first three years of the new system found that a key cause for the disappointing trend is the administrative practice of municipalities. In a majority of cases flex-job eligibility is not properly documented. It appears that often the "wrong" people are transferred onto a flex-job, namely people with sufficient capacity to do a normal job, whereas those in need of a flex-job are parked on waiting benefit.

This evaluation has prompted further amendment of the system, in 2006. Municipalities will no longer get the 65% state reimbursement of the flex-job wage subsidy in cases where documentation is lacking. People on waiting benefit need to contact the job centre every three months; after six months of continued unemployment private job brokers can be involved, and after 12 months (provided flex-job eligibility criteria are still met) such brokers have to be involved. The 2006 amendment also introduced a ceiling to the flex-job subsidy, though this is still one-third more than the average full-time wage. The impact of this recent re-reform remains to be seen.

B. Tighter sickness absence monitoring

During the last few years, the Danish government has also sought to increase the number of people working and reduce public spending by measures addressing the high level of sickness absence. Initiatives to this end started with the compilation of good practice during 2003 and the programme "*This is what we do about sickness absence*" in December 2003. In early 2004, a social partner committee was set up, charged with the task of preparing proposals for modernising the sickness benefit legislation. Partly, the aim was to systematise and make coherent the many changes since the last comprehensive amendment of legislation back in 1990. These efforts culminated in new legislation effective from July 2006.

A key element of the reform is an improved follow-up of people receiving sickness benefits by municipalities. Since 1997, municipalities have been obliged to perform follow-up reviews of sick-listed people every two months; these should include the assessment of rehabilitation needs and the preparation of a retention plan. This did not stop absence rates from increasing by 30% between 1999 and 2003. With the new rules, through profiling into three categories, efforts were targeted to people with the greatest need for close and individual follow-up, *i.e.* people at risk of long-term sickness and/or loss of work ability (category 2). For them, follow-ups are now made every four weeks while for people whose return to the labour market is imminent (category 1) and those where the illness or disability is certain to be long-term or maybe terminal (category 3) follow-ups continue at eight-week intervals. At the first follow-up, the municipal authority has to decide if a follow-up plan is to be prepared, which then must be drawn up in connection with the second follow-up. The plan must include assessable targets, and the actual follow-up effort must be made transparent. A municipality will not receive any state refund should it fail to fulfil its duty to follow-up on sickness benefit cases.

The main aim of this change was to raise job retention through faster return of the sick worker into employment. This is increasingly done in a gradual way – partial sickness absence has quadrupled in the past few years. To achieve this, the strengthened follow-up procedure is complemented with new and improved support tools and regulations. Municipalities are supposed to better co-ordinate their procedures with both employers and doctors. They have to inform the workplace of relevant initiatives launched for the sick-listed person. New medical certificates for GPs with focus on the person's ability to function were introduced, and training for GPs to improve their understanding of functional ability. Better tools include an improved knowledge base for employers and municipalities, with new absence statistics for employers to compare their absence record with that of the industry average, and a new instrument for municipalities to compare their own record with that of other localities. Finally, sickness absence is now included in workplace risk assessment in the context of occupational health and safety procedures.

It is too early to assess the impact of these changes. Latest evidence suggests that absence rates continued to increase at least until 2006. Much of this increase, however, may not be related to the sickness benefit reforms. A backlog in disability benefit applications and the more stringent documentation requirements for flex-job entitlement, which led to more frequent extensions of the sickness benefit period beyond the normal duration of one year, may be explanations. However, early evaluations of the reforms point to a number of obstacles in implementing change. It appears that municipalities yet have to develop proper tools for co-operation with employers and doctors; that co-operation between municipal caseworkers and general practitioners (who are *not* under the control of the municipality) is poor; and that employers do not co-operate with general practitioners either (and therefore, for instance, do not request the new medical forms).

The disappointing sickness absence trend in the past decade, in parallel to falling unemployment, has led to a new initiative in this area. The government presented an action plan on 10 June 2008, with the aim to reduce sickness absence by 20% until 2015. Sickness absence is seen as a large burden on the economy of Denmark: every day, 150 000 people stay at home because they are ill; this is roughly three times the number of people who are unemployed. The proposals will be discussed politically in autumn 2008.

The main pillars of this action plan, which is also based on knew knowledge revealing that in many cases of illness it is possible and beneficial to come to work, are the following:

- Sickness absence prevention, including better tools for employers and better guidance and information material from the Danish Working Environment Authority.
- Early action, including a first interview after four weeks between the sick employee and the employer or, alternatively, the sick unemployed and the unemployment fund and the preparation of a retention plan in case of absence projected to last more than eight weeks.
- Activation during sickness absence, including skills upgrading and employment subsidies early on to enable a fast (gradual) return to work; strengthened financial incentives for municipalities to promote and encourage a partial return to work; and payment of sickness benefit by municipalities (rather than employers) from the first day of sickness.
- Better co-ordination of health and employment action; including replacing the current medical report about incapacity for work by a capability report; stress prevention courses for general practitioners; and guidelines for co-operation between municipalities and doctors.

C. Municipal structural reform 2007

Municipal structural reform, in 2007, was a logical complement to previous reforms aimed to strengthen the role of local governments in the sickness and disability policy system and other areas of social and labour market policy. First, counties were abolished and their responsibilities transferred to municipalities, which now are responsible for specialised rehabilitation and for arranging and administering sheltered workplaces. Secondly, many smaller municipalities were merged so as to create larger operating units (the total number of municipalities was reduced from 271 to 98).

A major objective of the reform was to improve the co-operation between the municipalities and the public employment service (PES). This was done through the creation of new *job centres* (in every municipality) in which all employment services are bundled. This job centre, which is run jointly by the municipality and the PES (replacing the previously existing independent services of the two entities), is a single entry point for all employment services for all those in search of service or workers. This change prompted an institutional reorganisation of the PES at national, regional and local level, including *a)* the establishment of four employment regions the task of which is to monitor labour market developments and to follow-up on the effect and results of the aggregate employment action of all job centres by way of individual dialogue with each job centre; and *b)* the creation of employment councils at local and regional level, which have an advisory role, to ensure the involvement of the social partners in monitoring employment services and labour markets.

One objective behind the creation of joint job centres was to mainstream the employment integration of people with health problems. In each job centre one key person is appointed as a disability specialist, who is the primary contact for those concerned and a resource for colleagues. This specialist should disseminate knowledge across the job centre and liaise with key persons in other job centres to ensure uniform knowledge across the country. In addition, caseworkers can draw from the expertise of one specialised job

centre with eight specialists, based in Vejle, and a recently established knowledge network run by the Danish Council of Organisations of People with Disability.

Politically the new structure was a compromise solution. The original aim was to hand over the full responsibility for employment supports to the municipalities, in addition to their responsibility for the social system. In order to test the potential of such far-reaching reform, or the ability of the municipalities to take full responsibility for employment services, 14 pilot job centres have been created which are exclusively municipality-run without the PES being involved. It remains to be seen whether or not these centres can better solve job-oriented and social problems side by side.

To further strengthen the employment focus of the new job centres, Denmark has chosen a somewhat unusual route: benefit matters were separated from employment supports, as a signal that caseworkers should focus on employment potential only. This is unusual to the extent that recent developments across the OECD point in the direction of full one-stop-shop centres which are responsible for all matters. In Denmark, instead, municipal benefit centres were put in place. In fact, there are now three benefit centres in each municipality: one run by the labour market institutions (dealing with unemployment benefits for insured unemployed), and two run by the municipality – one for sickness benefits and means-tested social assistance payments for the non-insured unemployed, and one for disability benefits and various disability-compensating payments.

It remains to be seen what outcomes the new management structures are going to deliver. Comprehensive evaluation is ongoing, especially with an eye on comparing the jointly-run job centres with the pilot job centres run by 14 municipalities. No doubt many countries will be interested to see the impact of the move away from a one-stop-shop service, towards a situation where clients have to move back and forth between the job centre and the responsible benefit centre.

2.2. Finland: moving away from retirement through disability

Policy development in Finland could be described as typical of many other countries. Starting from a rather passive benefit-oriented system 20 years ago, employment support policies were gradually expanded. Despite the increasing focus on rehabilitation, the view that many people with a long-term health problem or disability can and should be integrated into the labour market has only spread very slowly. The driving force behind change was the objective to prevent disability and maintain people's work capacity for as long as possible so as to postpone retirement. Sickness and disability benefit schemes remained largely unchanged, thus reducing the potential of the new labour market policies. Discussions about the impact of this uneven policy approach have only started recently.

A. Continuous parametric pension reform

In Finland, as in many other OECD countries, disability benefits are an integral part of the pension system. In these countries, pension reform automatically impacts on the disability benefit system. In 2005, Finland went through a broad pension reform which was in many ways a continuation of reforms in earlier years. Like earlier changes, the main aim of the reform was to make working longer more attractive.

To achieve this, a drastic change in accrual rates was put in place to remove the existing penalty for working longer (OECD, 2004). Between ages 63 and 67, the accrual rate

is now 4.5% per year, while it is 1.9% for ages 53-62 and 1.5% for ages 18-52. At the same time, the ceiling for the maximum pension – of 60% of pensionable earnings – was removed to make sure that this high accrual rate from age 63 onwards results in higher benefit entitlement. This policy was a continuation of a change introduced in 1994, when accrual rates for ages 60 and over were increased from 1.5% to 2.5%. The accrual rate for *granted* years of service between the onset of disability and age 63, when the disability benefit entitlement is replaced by an old-age pension, is 1.5% for years up to age 49 and 1.3% for ages 50-62. This is a slight improvement over the situation prior to 2005, when it was 1.2% for ages 50-59 and 0.8% above age 60.[2]

Other important changes with the 2005 pension reform include the abolition or phasing-out of some of the remaining early retirement pathways. In particular, individual early retirement was brought to an end. This was introduced in 1986 as a special kind of disability benefit with less stringent medical criteria for sick people over age 55. For this benefit, work capacity only had to be reduced permanently to such an extent that the person could not continue their current job or occupation (*i.e.* own-occupation assessment), taking current working conditions into account. Contrary to an ordinary disability benefit, other jobs would not be considered. Following very widespread use of the individual early retirement scheme soon after its introduction, the minimum entitlement age was raised to 58 years in 1994 and further to 60 years in 2000, after which the use dropped quickly because at this age other retirement pathways were relatively more attractive or more easily accessible.

The longer-term impact of these reforms on the inflow into the ordinary disability benefit system is complex. First, many of those who previously accessed individual early retirement pensions will now successfully apply for an ordinary disability benefit, in particular because the 2005 reform at the same time relaxed the medical criteria for disability benefit entitlement for people over age 60. The slightly higher accrual rates for granted years especially above age 60 increase entitlements slightly (*e.g.* the replacement rate for a person who started to work at age 20 and leaves on disability benefit at age 50 was *de facto* raised from 59.4% to 61.9%), thereby reducing somewhat the difference to the potential replacement rate of those continuing to work until age 63. However, people unable to work beyond age 63 face a significant penalty*vis-à-vis*those continuing to work until age 68, who could raise their pension entitlement by one-third by working another five years.

Substitution onto disability benefit could also arise in the medium term due to the phasing out of the unemployment pension over the period 2009-2014. This benefit is currently available for people born before 1950 who have reached age 60, have been unemployed for a long period and have had a paid job for at least five of the past 15 years. The impact of the phasing-out of this scheme, however, is likely to be limited, because the so-called unemployment *tunnel* – *i.e.* continued unemployment benefit payment until retirement age – is maintained and extended up to age 65.[3]

In conclusion, therefore, it appears that, through the 2005 pension reforms, significant but by no means sufficient steps were made to reduce the use of early retirement.[4] In particular, the use of disability benefits is more likely to increase rather than decrease in the future as a consequence of these reforms.

B. Promoting work capacity and strengthening rehabilitation

Continuous pension reform over the past 15 years was complemented by continuous efforts by the Finish government to promote workers' health, skills and work ability and to improve working conditions. After the end of the economic recession in the mid-1990s, a series of programmes was introduced to this extent, including the Workplace Development Programme and its extension (1996-2003, 2004-2009), the National Programme on Ageing Workers (1998-2002), the National Well-Being at Work Programme (2000-2003), the VETO programme (2003-2007), the NOSTE programme (2003-2009) and, most recently, the MASTO project (initiated in 2008) which aims to tackle depression as a cause of work incapacity through prevention, treatment and rehabilitation.

Partly, the strong concern for work ability is probably a consequence of Finland's long tradition of early retirement on the grounds of disability. Initiatives and projects in this field are quite diverse. What most initiatives have in common is their focus on workplaces and the involvement of various actors, typically including one or several government departments and the social partners. Important elements of these initiatives are the promotion of good practice, the provision of expert support to workplaces striving for improvements in working life, and the development of a better research base. The ultimate goal of all these programmes was and is that older workers can fully participate in working life and leave the labour market later than they used to do.

Projects and initiatives often involve soft measures, including attempts to change the attitudes of workers and employers alike, the causal impact of which is difficult to establish. Programme evaluations show only relatively small improvements in working conditions (OECD, 2004). However, on a macro-level, during the past ten years employment rates for workers aged 55-64 have increased much faster in Finland than in most of the OECD.

Workplace and work ability programmes complement a very strong system of occupational health services (OHS), which is provided by the employer with partial cost reimbursement by the Social Insurance Institution. While OHS became statutory in the late 1970s to tackle problems with the primary care sector, OHS requirements were broadened in 2001 to include workplace and health surveillance and the aims of the services made much clearer. With the reform, the focus has shifted from broadening the coverage towards improving the quality of OHS through better co-operation of OHS with both employers and employees. In addition, extra budget has been made available to train sufficient numbers of OHS professionals (*e.g.* the number of graduated occupational health physicians has almost doubled in the past three years).

The effectiveness of the OHS system was facilitated through a parallel reform, in 2004, of the vocational rehabilitation system. Reform was supposed to encourage earlier identification and intervention by making rehabilitation a subjective legal right for workers still in employment but at risk of work-capacity loss. The institutional complexity and fragmentation of the rehabilitation system, however, remained untouched. In 2007, the early-intervention approach was further strengthened by the introduction of a partial sickness allowance so as to facilitate the return to work. Entitlement involves both a medical certificate and a contract between the employer and the employee, to demonstrate the need for a partial, or phased, return and the actual reduction in working time and pay (which have to be reduced by 40-60%).

Workplace-oriented interventions are complemented by a long-established system of experience-rated employer premiums to both the disability and the unemployment benefit scheme. Current rules exempt smaller companies with a wage sum of less than EUR 1.5 million, while employer costs rise gradually to 80% of the total benefit costs for large companies with a wage sum of more than EUR 24 million (thresholds are adjusted annually). After the harmonisation of the rules, in 2000, unintended effects which made lay-offs the more attractive option for companies with over 525 employees, and disability retirements the more attractive option for those with between 51 and 525 employees have disappeared. However, disincentives to hire disadvantaged workers remained. This was one of the reasons for the recent reform of the wage subsidy scheme, in 2006, which suffered from low take-up. With the reform, among other things, the duration during which a wage subsidy can be paid was increased to up to two years for people with disability hired by an ordinary company and up to three years for those hired by a social enterprise.

C. Increasing the accountability of municipalities

Municipalities in Finland have wide-ranging responsibilities in the sphere of health and social services, including employment services, matched by the right to tax the income of citizens. Overall, municipal income tax adds up to some 60% of total income tax collected in Finland (OECD, 2007b), and it also covers some 60% of total municipal spending. Of the remaining 40% of municipal outlays, one-third is covered through state budgets and 7% through citizen fees. However, there is considerable variation across municipalities, with some of them facing low and falling tax income at the same time as high and rising spending needs.

Recent reforms have been designed to strengthen the accountability of local communities, to improve the matching of responsibilities and resources and to strengthen the co-operation of local and state authorities. Since 2006, the municipality and the state share equally the costs for benefit payments for both the long-term unemployed (people unemployed for more than 500 days) and clients of municipal social assistance.

Another potentially important change was the creation, over 2004-2006, of a net of 39 Labour Force Service Centres (LAFOS), now available in 80% of the country. These are jointly operated by the municipality and the public employment service, occasionally with the involvement of the national social insurance institution. The five-stage process followed in the LAFOS operation is as follows: *i)* map obstacles for employment; *ii)* work on removing obstacles; *iii)* offer individualised support (weekly meetings); *iv)* continue support after placement, especially for people on wage subsidies; *v)* if employment solution fails, find a pension solution. The plan is to provide better-integrated employment and social support services for disadvantaged clients, and to address the problems of people moving, or being moved, around between short-term employment, unemployment and social assistance. Initial results on pathways following LAFOS intervention, however, show that the 20% open employment target is not achieved. Outcomes include the following (multiple outcomes possible): 3% disability benefit, 78% medical consultation, 17% rehabilitation and life management (mostly debt advice), 13% labour market training, 17% subsidised work, 10% open employment, and 15% job coaching.

Potentially these centres could help reduce the flow of long-term unemployed or social assistance clients onto disability benefit rolls. This is important in view of the “screenings” organised by labour market and municipal authorities and aimed at helping people to

access disability benefits in case of work incapacity caused by disability. These screenings started in the late 1990s and became a requirement after legislative reform in 2002, through which municipalities became responsible for organising work and other activities for people with disability. Initial evidence, however, suggests that the LAFOS face considerable institutional obstacles: municipalities and employment services still tend to operate two parallel services under one roof, each with their own manager and reporting to their "mother" authority, rather than one united package of assistance.

Moreover, recent changes are unable to solve some of the structural problems. In reality, many small municipalities face considerable difficulties in providing the services they are responsible for, even though they can choose to produce services themselves, to arrange services in co-operation with neighbouring communities, or to buy services from other municipalities. There are currently some 400 municipalities, with an overall population of just over five million. A reform of the system of local government will take place in the period 2007-2013, aiming to build a sound structural and financial basis for municipal services. The intention is to secure the required standard of service quality, effectiveness, availability, efficiency and technological advancement.

Ideally, smaller municipalities would be merged into larger operating units, but – contrary to Denmark – it was considered impossible to impose such change. Instead, framework legislation was implemented which obliges municipalities to report to the government on how they are going to modify their services. More specifically, co-operation obligations are being considered so to reach the critical mass (of around 20 000 inhabitants) for efficient services. First trends show that only 13 of the 400 municipalities have ignored their reporting obligation; however, while municipalities increased co-operation on health services, they shy away from more co-operation on social services.

2.3. Ireland: towards systematic engagement with benefit claimants

Irish disability policy remained essentially unchanged until relatively recently. This may be related to developments in the Irish economy, which was facing other more urgent problems until it took off in the 1990s. Reforms began to emerge from the mid-1990s when mainstreaming became a key objective in European policy circles and the *Report of the Commission on the Status of People with Disabilities in Ireland* was published. This led eventually to the formulation of the Irish Disability Strategy, in 2004, whereby policy rhetoric changed more comprehensively. Consensus was created on the need for further reform, although what exactly should be done will yet have to be agreed upon.

A. Shifting responsibilities in the late 1990s

Until the mid-1990s, disability issues in Ireland were seen as a very special matter to be dealt with by a specialist government department (the Department of Health and Children, DHC) and specialist service providers. One result of this approach was, and still is, that Ireland has a large number of different health-related benefit schemes and a very complex and differentiated system of employment supports. In the second half of the 1990s, driven by the aim to mainstream public services, the first important steps were made so as to improve the coherence of this fragmented system.

First, in 1996, the Department of Social and Family Affairs (DSFA) became responsible for most benefit payments with the transfer of disability allowance (formerly known as Disabled Persons' Maintenance Allowance) to that department. This payment was formerly

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administered by the regional Health Boards and the rules for eligibility were often applied unevenly across the country. Since, eligibility criteria have been set down in legislation and are now applied uniformly across Ireland. Secondly, in 2000, policy responsibility for vocational training of people with disability was transferred to the Department of Enterprise, Trade and Employment (DETE). Since then, the Training and Employment Authority (FÁS), the Irish PES, is formally in charge of the training and employment support needs of all unemployed people, including people with disabilities.

However, responsibility structures remain complicated. The number of health-related benefits has not changed, and some benefits continue to be under the responsibility of the Health Service Executive.[5] With ongoing reform, some of the problems are going to be resolved in the medium term: Provision was made in legislation in 2008 for the transfer of further payments to DSFA, one payment (Infectious Disease Maintenance Allowance) will be abolished in 2009 and the integration of the remaining payments with existing DSFA payments will be pursued following their transfer to DSFA. Problems caused by the structure of employment supports may continue much longer. First, DHC has kept responsibility for rehabilitative training of people with disability and for sheltered workshops. Secondly, some of the inherited structures remained untouched, despite the shift in departmental responsibility. This holds true in particular for the system of specialist training supports; the existing private, non-profit providers continue to satisfy some 80% of all training needs and to receive annual bulk funding, now from FÁS.

In conclusion, therefore, the responsibility shifts started in the second half of the 1990s are "unfinished" business. Mainstreamed services are as yet far from being a reality for all people.

B. The National Disability Strategy 2004

The launch of the National Disability Strategy (NDS), in September 2004, was a concerted effort by the Irish Government to underpin the participation of people with disability in society. The NDS built on previous equality legislation (Employment Equality Act 1998, Equal Status Act 2000, Equality Act 2004) and carried further the policy of mainstreaming. One key element of the strategy is the subsequent Disability Act 2005, a crosscutting piece of legislation aimed to improve access to mainstream public services, including physical access to public buildings and infrastructure, for people with disability. Other important elements are legislation aimed to transform special needs education policy, and legislation putting in place a personal advocacy service for people with disability.

One of the most important elements of the NDS are the sectoral plans that were developed for six government departments, setting out how they will deliver specific services for people with disability. Those departments are Social and Family Affairs; Enterprise, Trade and Employment; Health and Children; Transport; Communications, Energy and Natural Resources; and Environment, Heritage and Local Government. These plans specify objectives as well as actions. Some plans include quantitative targets, such as DETE's aim to raise the employment rate of people with disability from 37% to 45% by 2016. The plans also include arrangements for complaints, monitoring and review procedures.

Typically, the sectoral plans set out in detail the arrangements proposed for the implementation of certain parts of the Disability Act. For the sectoral plan of the DHC, for instance, this refers to a statutory entitlement for people with disability to an independent

assessment of their health and education needs. For the sectoral plan of the DETE, accessible employment services are a key objective, by further embedding the mainstreaming concept across the range of services delivered by the department and its agencies. Another key element of the plan of the DETE is to develop a comprehensive employment strategy for people with disability, a key pillar of which is enhanced effectiveness of employment and vocational training programmes. The most important areas of the sectoral plan of the DSFA address some of the key weaknesses of the current Irish system: the lack of systematic engagement with benefit claimants; the fragmentation of benefit schemes; benefit traps and employment disincentives; and information gaps caused by insufficient data.

Most importantly, the sectoral plans also recognise the need for effective cross-departmental co-operation if the goals set out in the plans are to be achieved. This has led to the signing of specific protocols between various departments. One such protocol has been agreed between DSFA and DHC with the aim to ensure that income supports and associated benefits do not create financial barriers to people with disability taking up employment. Protocols are also being developed to provide a strategic framework for inter-departmental and inter-agency co-operation between DHC, DETE, HSE and FÁS in order to improve the vocational training landscape. Most recently, in January 2008, the Office for Disability and Mental Health was established, reflecting the government's commitment to develop a more coherent and integrated response to the needs of people with disability, to facilitate cross-agency and cross-departmental co-operation and to strengthen the client orientation of services.

C. From new rhetoric to new policy

The sectoral plans of DSFA, DETE and DHC and the co-operation protocols have a lot of potential. In particular, they show that the need for reform more broadly and the key areas which need reform have been identified and agreed upon. This is promising in view of the fragmented system of income as well as employment supports. However, it remains to be seen how and how fast action will be taken. Agreeing on objectives is a first necessary step, which does not do away with the structural problems that lie behind some of the policy failures. Obstacles to implement change and to translate the expression of intentions into actual action remain.

Probably the most important planned reform is the development, under the Irish Government's National Development Plan 2007-2013, of a "Social and Economic Programme – people of working age" which includes the objective of promoting participation and social inclusion through activation measures aimed at people of working age. This programme involves engaging with all people of working age in a similar way, whether they are unemployed, lone parents, or people with disability. The aim is to facilitate progression regardless of the circumstances that led the person to require income maintenance. An active case management approach is proposed that will support those on long-term social welfare payments into education, training and employment. This would consist of segmentation or customer-profiling at the first point of engagement with DSFA (typically at claim application), systematic identification of the customer's potential, early and active intervention where needed, referral to the agency best placed to meet the needs of the customer, identification of training and other support needs, and regular monitoring of the outcome.

In line with this, in late 2006 the DSFA also submitted a proposal entitled "Supporting Economic Participation by People with Disabilities" with the aim to develop and test a comprehensive employment strategy on individual case management of people on disability welfare payments. The proposal has since received formal funding approval from the ESF and will soon be piloted in the town of Mullingar. Should this pilot prove successful it may be used as a template for intervention with disability benefit claimants elsewhere. Both of these projects will be informed by experiences from earlier pilots for certain groups of beneficiaries or specific disease categories, and the reasons for the partial failure of some of these. One such pilot was the Midlands Project, a multi-agency initiative implemented during 2005 to test the capacity of an integrated approach to delivering training and employment supports to young recipients of disability allowance. This initiative failed to the extent that only a small share of the target group participated in the voluntary programme. Another interesting pilot was the Renaissance Project, implemented in 2003, which looked at the impact of early intervention for people on illness benefit diagnosed with lower back pain. In this case, early referral to a more comprehensive medical assessment at 4-6 weeks from the date of benefit claim has proven to be able to reduce considerably the move into a chronic stage of disease.[6]

The lessons of all these pilots will have to be taken into account in developing the sectoral plans and the inter-agency protocols further. While pilots are a good way to progress policy, it appears that actual change is slow. The rich vocational training strategy of FÁS is a good example in this regard. Soon after the transfer of new responsibilities to FÁS, the effectiveness and efficiency of the new setting was reviewed. In 2003, an independent evaluation report with a large number of recommendations was prepared, which triggered the development of the new FÁS strategy, in 2006. This strategy is now an integral part of DETE's sectoral plan; it is implemented currently by FÁS, including for instance changes in flexibility in the way mainline training is delivered.

One example of a specific change in line with the DSFA's sectoral plan is the amendment of the disability allowance disregard, in 2006, through which benefits are phased out more gradually for people taking up rehabilitative work. Since then, the number of claimants availing of the disregard has increased by over 40% (from 6 500 to 9 300). However, this only corresponds to an increase in the proportion of working beneficiaries from 8% to just over 10% as the total number of beneficiaries increased by 13% in the same period. Hence, this appears to be a minor change in view of the dramatic and well-recognised work disincentives in the Irish benefit scheme.

2.4. The Netherlands: moving from rights to individual responsibilities

Sickness and disability policy in the Netherlands has gone through an unparalleled series of reforms over the past 15 years. The consultation process with the social partners (known as the Dutch Polder model) and the advice of the Socio-Economic Council were critical elements in this process. In short, reforms were characterised by a shift of responsibilities to employers and employees and the outsourcing/privatisation of employment services as well as, partially, sickness and disability benefits. Despite comprehensive change, for many years outcomes remained disappointing: the number of disability beneficiaries continued to approach the magical limit of one million. In the past five years, however, outcomes changed rapidly. The challenge now is to make this change sustainable.

A. Progressively raising employer responsibilities

In the early 1990s, agreement was reached that reducing the use of the disability benefit scheme will require incentives for employers not to use the system as a workforce-adjustment instrument. As a first step, the costs of sickness absences were gradually shifted onto employers. In 1992, premiums to the sickness benefit scheme were experience-rated. Then, in 1994, employers became responsible for paying the first six weeks of sickness absence. Stimulated by the success of this change in terms of falling rates of sickness absence, only two years later employers became responsible for carrying the entire cost of the, back then, one-year sick-pay period.

This change, in 1996, was coupled with a broader shift towards privatising sickness management. Employers were obliged to contract private providers of occupational health services to manage absenteeism. Even though sickness absence fell in return, however, flows into the disability benefit scheme did not. To respond to this trend, in 1998, premiums to the disability system were also experience-rated for the first five years of benefit receipt of new recipients. Employers could also choose to opt out of the system and pay the costs for these five years themselves directly, with the possibility of reinsuring this risk (see below).

Several years later, it turned out that this change did have a very positive impact. However, in the beginning very little changed, also because experience-rated premiums were phased-in over a five year transition period. This is why further far-reaching change had been introduced with the *gatekeeper protocol* in 2002. Through this, sickness management responsibilities became much more regulated. Two years later, the sickness period was extended from one to two years, and so was the period during which employers bear full responsibility and costs. Moreover, if they fail to fulfil their obligations, the period of employer-paid sick-pay can be prolonged by at most a third year. In practice, one in eight employers with a worker reaching the two-year limit has to pay longer than foreseen.

With the changes in 2002 and 2004, employers (together with the employee) now have to prepare a written reintegration plan after eight weeks, which specifies activities and the date of periodical evaluation; an evaluation report after one year, with details about the activities for the second year of illness; and a reintegration report towards the end of the two-year period, which summarises the efforts and the reasons for their failure.

With the new benefit system which came in place as of 2006, finally, employers are now fully responsible for the reintegration of sick workers with capacity losses of less than 35%, *i.e.* workers who no longer are entitled to a disability benefit. Experience-rating of disability insurance premiums was also strengthened for people with partial or temporary disability, but it was removed for those with full and permanent disability. It is also possible to opt out of the public scheme for people with partial disability (earnings-capacity loss of 35-79%), in which case the employer becomes fully responsible for those people as well, regarding both benefit payments and work reintegration.

All these changes have contributed to the remarkable drop in the number of new disability benefit claims in the Netherlands in the past few years. However, they also seem to have contributed to the declining employment rate of people with disability. For those who are unemployed, it became more difficult to be hired into a new job. Changes in employment practices – with more and more people being hired on temporary contracts so as to circumvent the intensified sickness-related employment protection – are another reaction of employers. To tackle these problems, for 2009 the government anticipates the

introduction of wage subsidies for hiring persons on disability benefit and additional premium discounts for hiring older beneficiaries.

Earlier responses to the problem of low employment of people with disability include the introduction of the so-called "no-risk policy" in 2003, with further extensions in 2006. The aim of this is to make hiring people with health problems or increased health risks more attractive. Through this policy, for a predefined group of newly-hired workers the state (through the social insurance authority) bears full costs and responsibility in case of illness. In most cases, this holds for the first five years of a new work contract, *e.g.* for disability benefit recipients and, since recently, employees with less than 35% assessed disability after two years of sickness who are not able to continue working with their employer. Only in some cases, the no-risk exemption is permanent, *e.g.* for recipients of a Wajong benefit. The no-risk policy and the increase in temporary contracts have led to a very sharp increase in recent years in the number of people who, in case of sickness, are under the responsibility of the social insurance authority. This new reality has yet to be addressed more forcefully.

B. Enhancing the work focus of the benefit system

Already in the early 1990s, the government had concluded that shifts in employer incentives need a complementary change in incentives for workers so as to enhance the activation nature of the entire system. In view of this, the disability benefit scheme was changed comprehensively in 1994. The main aim of this change was to reduce the benefit level in relation to age. Benefit entitlement was split in two periods, a first period in which payments are related to own earnings and a second period in which they are partly calculated in relation to the minimum wage. The length of the first period increases with age. Also in 1994, a decision was made to reassess large parts of the stock of disability benefit recipients on the grounds of slightly revised access criteria following the abolition of own-occupation assessment in the same year.

These changes almost 15 years ago, however, remained without a long-lasting effect. First, the benefit reform was largely offset by corresponding top-ups of benefit payments by employers via collective agreements. Secondly, while many beneficiaries lost their entitlement after the reassessment in the mid-1990s, many of them had – often successfully – reapplied during the following years, so that benefit recipiency rates in 2000-2002 were back to the level prior to reform.

Ten years later, therefore, a renewed effort was made to change the incentives of workers. In 2004, another round of reassessments was started for people under age 50 (later on limited to those under age 45), which will be completed by 2009. Again, this was done on the basis of stricter access criteria, including putting even less weight on the actual availability of jobs. Evidence suggests that reassessments are leading to benefit cuts, or even loss, in 40% of all cases. The challenge is to help those people, who, depending on their work history, may be entitled to unemployment benefit, back into work – to avoid a large number of disability benefit applications in the years to come.

In 2005, following the extension of the sick-pay period to two years, an agreement was reached with the social partners so to raise the incentives for workers to do their best to get back into work. In the large majority of collective agreements, sickness benefits are no longer topped up to full wages for the entire two-year period. Rather, a 170%-rule was

established: the replacement rate is now 170% over two years in most cases (typically 100% in the first and 70% in the second year).

As of 2006, a new disability benefit scheme was enacted; this was agreed upon two years earlier, thus affecting everyone who reported sick as from January 1, 2004. The key aim of this reform is to identify those people who are *not* able to work and to strengthen work incentives for those who can. The first group receives a higher public benefit, provided the capacity loss is permanent, and no reintegration efforts are being made for them. The second group is subject to a number of changes aimed to better exploit their remaining work capacity. The actual impact of this reform remains to be seen, but it certainly has considerable potential.

First, during the second period of benefit payment, entitlements for the second group will be flat-rate in relation to the minimum wage, unless the person uses at least half of her remaining capacity. In case of a capacity loss of 60%, for instance, the person would have to work at least 20% (*i.e.* half of the remaining potential of 40%) in which case she would be entitled to a wage supplement covering 70% of the wage loss.[7] A weakness of this regulation is that it will only matter for people who used to earn significantly more than the minimum wage. Secondly, with work capacity losses of between 15% and 34%, people no longer qualify for a disability benefit. Thirdly, topping-up disability benefit entitlements is no longer as frequent as it was. Available evidence suggests that top-ups are common in one in three collective agreements, restricted to a period between one and five years, and almost never guaranteeing a top-up to the full previous wage.

C. Reshuffling the institutional landscape

Changes in employer and employee incentives were also complemented by changes in the institutional setting. In 2002, a national employee insurance administration was created, which is responsible for the (remaining) benefit matters and most reintegration affairs. This institution, the UWV, replaced five previously existing private branch insurance agencies, which in turn were only founded in 1997 by replacing the then existing five employee-insurance organisations which were fully controlled by the social partners. In short, therefore, institutional reform removed, in two steps, the responsibility of the social partners for running the social insurance system.

In the course of foundation of the UWV, the public employment service was dismantled. Most employment services, for both workers with disability and the regular unemployed, were integrated into the UWV, with only minor activities for the easy-to-place unemployed remaining in a separate work and income agency (CWI) under the control of the social partners. Municipalities are responsible for the integration of social assistance clients as well as non-beneficiaries. This duty was reinforced with reform, in 2004, through which total budgets for local governments were split into two streams: a work component, which can only be used for activation measures, and a benefit component, which is at the municipality's free disposal.

Ever since 2002, various efforts are ongoing to better integrate the UWV and the CWI. Already since 2002, CWI functions as a one-stop-shop front office for both the UWV and the municipalities and in this function, for instance, refers benefit applicants to the relevant benefit agency. In recent years, shared premises are being created, in which the three organisations are also regionally accommodated together – in practice in some, but

not all, cases with one management only. The purpose of all this is to increase client-orientation of services. For 2009, a full merger of the UWV and the CWI is planned.

D. Moving towards private provision of services and benefits

Changes in the institutional structure went hand-in-hand with an increased outsourcing of employment services. From its creation in 2002, the UWV was required to outsource reintegration services to private, often for-profit, companies. This is still the case today for people with disability, while for the regular unemployed UWV is now allowed to provide its own services as well. Payments follow a "no cure, less pay" principle (typically 20% upfront payment, 30% after six months and 50% after successful placement).

A main focus of the reforms in the past years is to tailor reintegration services to individual needs. To this end, in 2004, a new option was introduced to allow people with disability to design their own individual reintegration plans (IRO). The role of the UWV is to assess the content of the IRO and, in case of approval, to arrange the plan with a private company. IROs are contracted out one by one, and payment is based on the result obtained by the company (usually 50% upfront and 50% when a person has a job for at least six months). Initial evidence suggests that the new IROs deliver better outcomes, though it remains to be seen whether or not this is due to selection effects.

Requirements to contract with private services also exist for employers, including those who opt out of the public system, as described above. In addition, the shift of sick pay and partly disability benefit responsibilities to employers has led to the creation of new private insurance products. Private sickness insurance was blooming soon after the 1996 reform (when employers became responsible for a full year of sick pay). Today, most small companies have some kind of private reinsurance for compulsory sick pay, while most large companies do not (coverage rates vary from 86% for firms with 0-4 employees to 10% for those with more than 100 employees). Insurance products range from conventional insurance, where all is managed by the insurance company, to stop-loss insurance, which only covers excessive costs. By and large, the market seems to be functional.

The disability insurance market has been growing, albeit slowly, ever since 1998, when employers were allowed to opt out of the public system for a certain period of time. There were two types of products: those covering the risk for employers who chose to opt out of the public system, and those offering top-up payments for employees. With the latest benefit reform in 2007, the disability insurance market is again in the process of change. The range of insurance products is expanding, including a new salary-supplement insurance for workers with minor disability, *i.e.* people not "disabled" enough to qualify for a disability benefit but also not able to earn the same salary as before. The long-term impact of the latest reform on the insurance market, as well as the impact of the market's reaction on the outcomes of the reform itself, is yet to be seen. The current *partial* privatisation – with voluntary opting out of the public system for partial disabilities and no opting out for full and permanent disabilities – might well turn out to need further adjustment.

2.5. The implications of recent and ongoing reform

The countries covered in this review demonstrate that unfavourable outcomes – such as excessive disability benefit dependence – are a driving force for change. At the same time, sickness and disability policy reforms during the past 20 years are essential

explanatory factors for the current outcomes in each country. OECD (2003) developed two indices of policy – one on *integration policy* and the other on *compensation policy* – in order to illustrate and compare countries' policy stances and to assess broad trends in policy development (Box 2.2).

Box 2.2. **Illustration of countries' policy stances and reform trends**

So many different dimensions of policy matter when assessing the overall stance of a system that it is easy to get swamped in details. This is particularly the case when looking at trends over time. In order to get a reasonable overview of what is happening in policy both over time and across countries, an index of the various policy parameters can be useful.

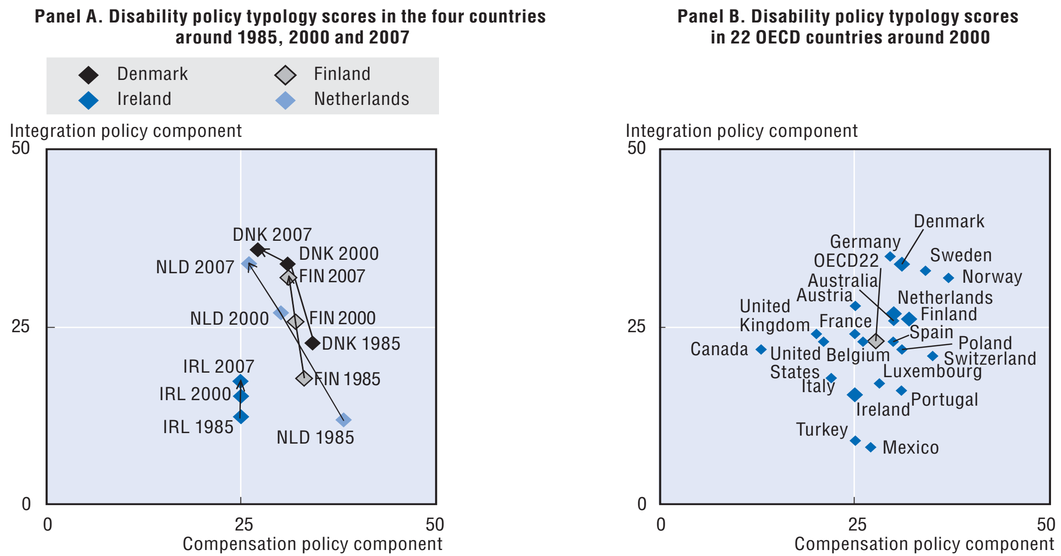
Indices in two dimensions have been developed in OECD (2003). The first is the level of compensation. The index of compensation takes into account ten policy parameters: *i)* coverage of the benefit system; *ii)* the minimum disability level; *iii)* the disability level needed to get a full disability benefit; *iv)* the maximum benefit level at average earnings; *v)* the permanence of benefits; *vi)* the medical assessment; *vii)* the vocational assessment; *viii)* the sickness benefit level; *ix)* the sickness benefit duration; and *x)* the unemployment benefit level and duration in comparison with disability benefits. Each country is ranked on a scale of zero to five on each of these categories. No attempt is made to assess which of these categories is most important; all have equal weight. A country which has a high total score in the compensation dimension is "generous" in supporting people with disabilities who are not working.

The second dimension is that of integration. Again, ten policy parameters are taken into account: *i)* access to different programmes; *ii)* the consistency of the assessment structure; *iii)* employer responsibility; *iv)* supported employment programmes; *v)* subsidised employment programmes; *vi)* the sheltered employment sector; *vii)* vocational rehabilitation programmes; *viii)* the timing of rehabilitation; *ix)* benefit suspension regulations; and *x)* work incentives. As with the compensation dimension, each of these categories is rated from zero to five and assigned equal weight. A country which has a higher integration score is one which has a more active policy in ensuring that people with disabilities can find work. [Details of the points attached to each aspect of policy and the policy stance of 20 OECD countries in 1985 and 2000 can be found in OECD (2003)].

According to this policy typology, compared with the OECD average in 2000, Denmark, Finland and the Netherlands all had above-average reintegration scores, indicative of a stronger set of activation policies. However, all three countries also had above-average compensation scores, reflecting a more generous and easily accessible benefit system (Figure 2.1, Panel B). As already argued in OECD (2003), the latter may well be an obstacle to better outcomes from reintegration. Ireland is an opposite example, with scores on both dimensions being lower than in the hypothetical average OECD country in 2000, and much lower than in the other three reviewed countries.

Figure 2.1 (Panel A) also shows policy trends, both before and after 2000. Overall, in all four countries the increase in integration scores (*i.e.* the strengthening of integration policy elements) outweighs the decrease in compensation scores (*i.e.* the tightening of the benefit scheme). This is characteristic of reform in most OECD countries. Ireland has not seen any significant benefit reform, not the least because the system is already among the least

Figure 2.1. **Comparing sickness and disability policies across time and countries**

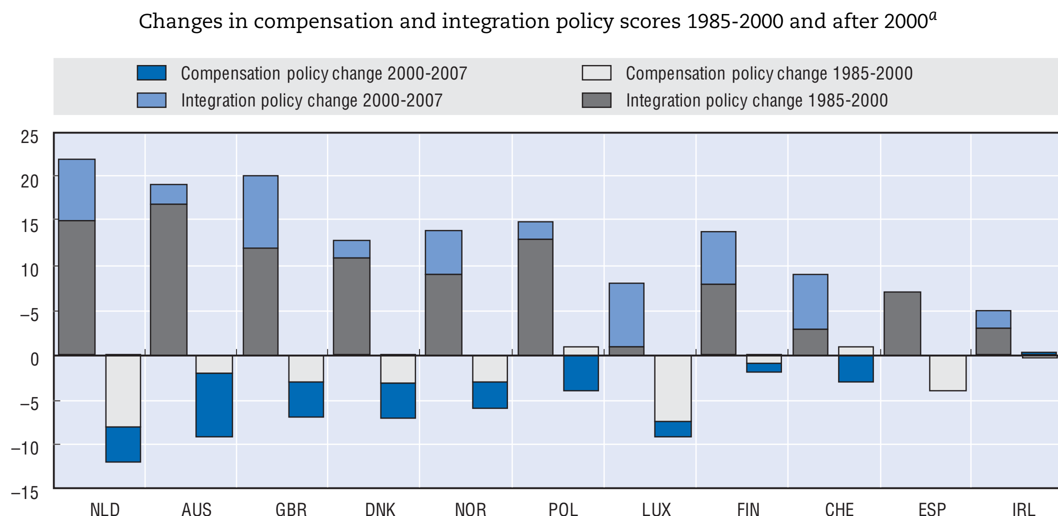


Source: Secretariat update based on information from national authorities and OECD (2003), *Transforming Disability into Ability*.

generous and accessible. But also the shift towards activation was minor compared to the other three, and in fact all other, reviewed countries. The Netherlands has gone through the largest transformation: starting from an extremely generous as well as passive system in 1985, today policy is as integration-oriented as in the Nordic countries and the benefit system score as low as the Irish one. Indeed, the reform intensity in the Netherlands was much larger than in any other OECD country (Figure 2.2).

Figure 2.2. **The Netherlands are the reform champion, but little has changed in Ireland**

Changes in compensation and integration policy scores 1985-2000 and after 2000[a]



a) Countries are ranked by the decreasing sum of absolute changes between 1985 and 2007.

Source: Secretariat estimates based on information from national authorities as well as OECD (2006) and OECD (2007a), *Sickness, Disability and Work: Breaking the Barriers* (Vol. 1 and Vol. 2), Paris.

More than in other countries, in the Netherlands benefit and employment system reform went hand-in-hand. This was different in Denmark, where benefit reform followed only after comprehensive extension of employment support schemes. Such sequencing of reforms was also found in several other OECD countries, including Australia and Poland. With the recent benefit reform, however, Denmark has gone further in changing its benefit system than most other OECD countries. This bolsters the positive work focus which governments in most countries have been trying to follow and which is also in the interests of the majority of those on the benefit. In Finland, where the integration orientation was strengthened as much as in Denmark, on the contrary, a broader change on the compensation dimension is still lacking.

In conclusion, Ireland belongs to those OECD countries where the compensation policy score by far exceeds the integration policy score. In Finland, the compensation score is still high relative to the integration score – noting, however, that this typology says little about both the implementation of regulations and the effectiveness of policies. Such a situation was characteristic for almost all OECD countries in 1985, but ever fewer of them today. This suggests that there is scope for further policy change in those two countries in particular, and especially in Ireland. Denmark and the Netherlands have recently become examples of countries with a higher integration than compensation score, *i.e.* a strong employment orientation coupled with an increasingly tighter benefit system. Such an approach bears considerable potential for better employment outcomes in the future.

Notes

1. Prior to reform, it was not only easier to receive a disability benefit (benefit eligibility at 50% capacity loss was abolished) and to receive a flex-job subsidy (subsidy eligibility at one-third capacity loss was abolished), but there also was an overlapping area between one-third and two-thirds capacity loss at which the municipality could "chose" to grant either a disability benefit or a flex-job.
2. Another change with the 2005 pension reform is the switch towards taking lifetime earnings as the reference for calculating benefit entitlements. This change was complemented by more generous indexation of previous earnings, which are now predominantly wage indexed. Prior to 2005, reference earnings were the last ten years of each employment contract, with entitlements calculated for each employment contract separately. Reference earnings for granted years, from the onset of disability to retirement age, are the average earnings during the five years before the disability commenced. Prior to 2005, last earnings were taken as the calculation base for these granted years. Finally, the reform also introduced a life-expectancy coefficient through which benefit entitlements will be adjusted automatically to life expectancy changes from 2009 onwards.
3. This is usually called unemployment tunnel, or pipeline, because unemployed over age 57 are *de facto* confronted with very limited, if any, job-search requirements. From age 62, they can choose to retire on an old-age pension without actuarial reduction.
4. This is further substantiated by continued generous subsidising of part-time pensions for workers aged 58 and over, who reduce their earnings to between 35% and 70% of previous full-time earnings and working hours to 16-28 hours a week. The part-time pension system compensates 50% of the income loss, while old-age pension rights accrue as if the person would have continued full-time work.
5. The Health Service Executive (HSE) was established in January 2005 and is responsible for providing health and personal social services in Ireland within available resources.
6. During the Renaissance pilot, more than three in four claimants left the benefit after intervention, with some 90% of those returning to paid employment. Following the successful piloting of the project, it has now been extended to 16 000 claims (from 1 600 in the pilot) while DSFA is also considering extending the early intervention process it uses to assess claimants with other conditions, such as those with mental health problems.

7. The original plan of the reform was to expect people to use 100% of their remaining capacity to be entitled to a wage supplement, but this was watered down in the process of political negotiations. Similarly, the group "not-able-to-work" (which is entitled to a higher benefit) is now defined as those whose earnings capacity is reduced by 80% or more, rather than those people unable to work at all.

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List of Acronyms

ADHD	Attention-Deficit Hyperactivity Disorder
AETR	Average Effective Tax Rate
ALMP	Active Labour Market Programmes
AMS	Danish National Labour Market Authority
AW (APW)	Average Worker (Average Production Worker Wage)
BTWA	Back-to-Work Allowance
BVG	Shared One-Stop-Shop Premises of Different Actors (Netherlands)
CBS	Statistics Netherlands
CE	Community Employment
CPB	Bureau for Economic Policy Analysis (Netherlands)
CSR	Corporate Social Responsibility
CWI	Work and Income Agency (Netherlands)
DA	Disability allowance
DB	Disability benefits
DETE	Department of Enterprise Trade and Employment (Ireland)
DHC	Department of Health and Children (Ireland)
DSFA	Department of Social and Family Affairs (Ireland)
ECHP	European Community Household Panel
EFILWC	European Foundation for the Improvement of Living and Working Conditions
EPL	Employment Protection Legislation
ESF	European Social Fund
ESRI	Economic and Social Research Institute (Ireland)
ETK	Finnish Centre for Pensions (Finland)
EU	European Union
EULFS	European Union Labour Force Survey
EUR	Euros
EU-SILC	European Union Statistics on Income and Living Conditions
EWCS	European Working Conditions Survey
FÁS	Public Employment Service and Training Authority (Ireland)
GDP	Gross Domestic Product
GP	General Practitioner
IB	Illness benefits
IDS	Income Distribution Statistics (Finland)
IP	Invalidity pensions
IRO	Individual Reintegration Plan (Netherlands)
IVA	Income Provision Scheme for People Fully Occupationally Disabled (Netherlands)
KELA	Social insurance institution (Finland)

LAFOS	Labour Force Service Centres (Finland)
LES	Local Employment Service (Ireland)
LFS	Labour Force Survey
METR	Marginal Effective Tax Rates
MEV	Macro Economic Outlook (Netherlands)
MISSOC	Mutual Information System on Social Protection in the EU Member States
NDS	National Disability Strategy (Ireland)
NRR	Net Replacement Rate
OECD	Organisation for Economic Co-operation and Development
OHS	Occupational Health Services
PES	Public Employment Service
PPP	Purchasing Power Parities
QNHS	Quarterly National Household Survey (Ireland)
REA	Act on the Reintegration of the Occupationally Disabled (Netherlands)
SER	Social and Economic Council (Netherlands)
SFI	National Centre for Social Research (Denmark)
SME	Small and Medium Enterprises
STM	Ministry of Social Affairs and Health (Finland)
STP	Specialist Training Provider (Ireland)
SZW	Ministry of Social Affairs and Employment (Netherlands)
USD	United States Dollar
UWV	Employee Insurance Authority (Netherlands)
Wajong	Work-Disability Provision for Young Disabled Act (Netherlands)
WAO	Disability Insurance Act (Netherlands)
WAZ	Self-employed Person's Disablement Benefits Act (Netherlands)
WGA	Return to Work Scheme for the Partially Disabled (Netherlands)
WIA	Labour Capacity Act (Netherlands)

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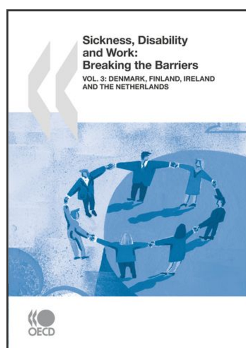

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