Chapter 3

The Direction of Recent Disability Policy Reforms

Sickness and disability outcomes are still disappointing in most countries, with low employment rates and high benefit dependence, calling for further often unpopular reforms. In the past 10-15 years, countries have started to shift their approach away from merely paying benefits to people with disability towards helping them stay in, or return to, work. This chapter outlines the main directions of recent reforms across the OECD and explores the question whether or not changes have gone far enough to reduce benefit dependency and increase employment rates. The chapter concludes that i) *policy matters: reform has had a major impact on the observed outcomes, especially the disability beneficiary rate; and* ii) *policies are moving in the right direction, with considerable convergence of policies despite continued structural differences. However, in most countries more needs to be done.*

In 2003, the OECD report *Transforming Disability into Ability* concluded that sickness and disability policy was in dire need of comprehensive reform, probably more than any other area of social and labour market policy. To a considerable extent this conclusion still holds today, with countries struggling to overcome the high disability beneficiary rates. This does not mean, however, that nothing has changed in the past decade. On the contrary, policy measures aimed at reaching a new balance between income security and labour market integration for people with disability have started in most OECD countries. More specifically, the focus of disability policy in many cases has recently shifted from a passive towards a more employment-orientated approach.

This chapter begins by outlining recent trends in reforms of sickness and disability policy to improve labour market inclusion for people with disability. It then explores the extent to which these reforms have sufficed to change the overall policy arrangement enough so to give the strong employment message policy makers are aiming to give. This is followed by an analysis demonstrating considerable convergence of policies across the OECD, despite continuing differences. The chapter ends with a section investigating the impact of different reforms on one key outcome, the disability beneficiary rate.

3.1. Key reform trends across the OECD

There have been many changes in policies aimed at improving employment chances for people with disability and making work a more attractive option for this group of the population. These reforms can be classified under three main broad trends, as described in the following and discussed in more detail in Chapters 4-6: an expansion of employment integration measures; an improvement of the institutional set up; and a tightening of benefit schemes.

Expanding integration policy

One development in disability policy, observed in virtually all OECD countries over the past two decades, is a gradual expansion of policy and measures aimed at helping people stay in and/or re-enter the labour market. These policies can take different forms and often include a combination of measures aimed at supporting workers and employers, coupled with stronger responsibilities for companies.

Anti-discrimination legislation

Most countries have introduced *anti-discrimination legislation* to ensure equal treatment of people with disability (and other disadvantage) in job promotion, hiring and dismissal procedures. Among the first to establish such legislation were Canada in 1985 through the Canadian Charter of Rights and Freedoms and the United States with the 1990 Americans with Disabilities Act (effective 1992). In many European countries, a ban on discrimination on the basis of disability was implemented more recently as part of the EU obligation to adopt similar legislation. In some countries, legislation was first introduced softly and then strengthened gradually in terms of scope and eligibility. In the United Kingdom, for

instance, the Disability Discrimination Act was initially implemented in 1994 but the employment rights part came into force only a few years later; in another round of change, the latter was extended to cover a larger number of companies including smaller ones. Also the United States, with its latest reform, recently aims to reach a larger group of people.

Modified employment quotas

Mandatory *employment quotas* are another tool used in some OECD countries, especially in the east, west and south of Europe and in Asia, to entice employers to retain or hire people with disability or, alternatively in some of the existing regulations, subcontract with companies with a significant share of workers with disability. Several countries have recently modified their quota-levy system.[1] Recent modifications include an increase in the levy to be paid by companies not fulfilling their quota (*e.g.* France, Italy); an expansion of the quota regulation to cover the public sector (*e.g.* France, Poland); an expansion to smaller companies hitherto not covered by the regulation (*e.g.* Greece, Korea, Japan); and a broadening of the definition of disability used in the quota system to widen coverage (*e.g.* inclusion of persons with mental disorders in Japan, as from 2005).

Stronger employer incentives

Antidiscrimination legislation and employment quotas, despite recent changes, generate universal but not necessarily very strong or binding obligations for individual employers. Such obligations have been introduced in different ways in different countries. *Workplace accommodation* obligations, also for new job applicants, have often been strengthened in other legislation such as for example the Swedish Working Environment Act. Other countries have chosen to raise obligations by making employers responsible for *sickness benefit payment* for a period of varying length, *e.g.* most recently also in the Czech Republic (in exchange for reduced premia to sickness insurance). This period has been increased in steps in the Netherlands, where employers now have to pay sickness benefit for up to two years and even a third year in the case they cannot prove to have done everything to help the sick worker back into work. In some insurance systems, employers' contributions are increasingly related to the actual number of insurance cases they produce ("experience-rating of premiums"); this is true for disability benefit insurance in Finland and the Netherlands, and for various privately-provided schemes, *e.g.* in Canada and Switzerland.

Spreading of supported employment

A substantial number of countries have increased the range of employment programmes available to people with disability. Most noteworthy, *supported employment* programmes (also referred to as individual placement and support, or IPS, models) were introduced in many countries. These programmes are designed to help integrate people with disability into the regular labour market by first providing a trial workplace and then offering training and help on the job. This approach was also first introduced in the United States, where a revised programme in 1992 already included ongoing (at least twice monthly) support with site-based training and job coaching. Following the US model, several European countries have introduced supported employment-type models during the 1990s (*e.g.* the Nordic countries, Austria, Netherlands; Japan and Switzerland followed in 2002), often as a trial programme initially before being rolled-out country-wide.

Modernising sheltered employment

In the past 15 years, there has been an expansion of initiatives to help people integrate into the regular labour market. The strong focus on *sheltered employment* that many countries had taken was perceived as perpetuating the segregation of people with disability and hindering their integration into the regular labour market. In the United States, for example, sheltered employment is no longer considered as a measure of successful employment. Several countries have improved their sheltered employment regulations. Poland and Hungary, for instance, have introduced accreditation systems (as a prerequisite to receiving subsidies) to guarantee that the working environment is suitable for people with disability. Other countries have developed new forms of sheltered employment closer to the regular labour market, like the social enterprises in Finland and France; or strengthened the focus on progression into the open labour market (*e.g.* Norway which limits the share of people who can stay in sheltered employment permanently). In both cases, more emphasis is given to workers' professional development and the skills learned while in sheltered work. In the Netherlands, reforms emphasise the right to tailor-made sheltered employment which can also be offered by regular companies.

Improved wage subsidies

The main purpose of a wage subsidy – in most cases a subsidy to the employer, sometimes a subsidy given to the worker – is to change labour costs in favour of the targeted group (at the expense of others) so as to alter the composition of labour demand and create employment that would not have been possible without the subsidy. Several countries, *e.g.* Belgium and Denmark, expanded greatly *subsidised employment* for people with disability since the mid-1990s. In the latter country, generous wage subsidies (for so-called "flex-jobs") are provided for people who cannot perform their work under normal conditions, but subsidies are available only after exhaustion of rehabilitation possibilities. The effectiveness of wage subsidies depends on the degree of targeting and is typically much higher with a more restrictive system (such as in Finland) than a generous system like the Danish one, which invited large deadweight and required constant readjustment (*e.g.* a cap on the maximum subsidy) in response to sharp increases in the number of people holding such jobs, which are *de facto* subsidised part-time jobs.

Earlier vocational rehabilitation

Vocational rehabilitation operates on the supply side of the labour market. It aims to increase the productivity of people with disability by restoring and developing their skills and capabilities so they can participate in the general workforce. In recent years, a number of OECD countries have focused on increasing rehabilitation options at an early stage, as well as strengthening rehabilitation requirements. In Austria, for instance, vocational rehabilitation became compulsory in 1996 and each claim for a disability benefit is automatically treated as a request for rehabilitation. Early intervention kicks in when the present job cannot be resumed. Hungary follows, since 2008, a similar rehabilitation-before-benefit principle with a comprehensive rehabilitation process. With the fifth reform of its disability insurance, Switzerland aimed to go a step further by shifting from rehabilitation-*before*-benefit to rehabilitation-*instead-of*-a-benefit. This shift in Switzerland went hand-in-hand with the promotion of early intervention and the introduction of new measures (including job adaptation, placement and socio-professional rehabilitation). The Netherlands is an example of a country that expanded (previously largely non-existent)

vocational rehabilitation considerably in the past decade; employers must do their utmost to reintegrate sick employees and – in line with the sick-pay obligation – are responsible for retraining during the two years.

Improving the institutional setup

The expansion of employment measures was, in many cases, complemented by changes in the structure of systems and service provision to make the use of new or expanded services more effective and more likely. Financing mechanisms were also changed in a few countries to strengthen the incentives of public authorities and service providers.

One-stop-shop service provision

Several countries have taken major steps towards a *one-stop-shop* benefit and service provision for people with disability. New Zealand engaged in a more co-ordinated delivery of income support and employment assistance to clients, with the merger of the Employment Service and the Work and Income Authority into the Department of Work and Income in 1998. Similarly, in the United Kingdom the creation of a new agency – Job Centre Plus – that operates on a far more customer-oriented basis provided a single point of delivery for jobs, benefits advice and support for people of working age. Norway has tried to fully merge the Public Employment Service and the National Insurance Authority into one new public administration to ensure streamlined and better co-ordinated services in order to minimise the possibility that clients are continually shuffled between agencies. Initial results are disappointing though this is mostly because such major institutional change will take a long time to deliver.

Better incentives for benefit authorities

Incentives for public institutions granting benefits or assisting persons with partial work capacity to resume employment have also been revised in several countries. Municipalities in Denmark became responsible in 1998 for both employment supports and benefit grants. Reimbursement rates from the central government are higher for active intervention so that municipalities have a vested interest in avoiding benefit payments. These reimbursement rates have been re-adjusted over the years as new policy challenges emerged; for instance, with the increased number of people on subsidised flex-jobs, the rate of reimbursement for this particular type of intervention was reduced in case of insufficient documentation in the application for a flex-job. In a similar but less developed way, and not related to disability policy as such, Dutch municipalities are given incentives to make better use of the work-related programmes available to their clients.

Outcome-based funding of services

A more recent development in some countries is a move away from *bulk funding* of employment services, provided by either public or non-profit institutions, to *outcome-based funding* of services, sometimes but not necessarily provided by private providers. To a varying degree, countries including Australia, the Netherlands and the United Kingdom have started to reimburse service providers for the actual employment outcomes (or sometimes participation outcomes) delivered, with payments often split into several components including an upfront payment and one or several payments along the road

tied to performance, when a client has achieved an outcome or stayed in employment for a predefined period.

Freedom of choice for clients

Another development in a few countries is towards giving clients seeking and in need of services the possibility to select the provider of *choice* and, more importantly, the service they need. In the United States, for a number of years disability benefit recipients are now entitled to a voucher (the so-called "ticket-to-work") which they can use for services offered by certified providers. In a similar vein, individual reintegration plans in the Netherlands allow clients to choose their own service pathway, though requiring the consent of the insurance authority; seven out of ten clients are choosing this option. A few other countries, like Germany and the Czech Republic, are experimenting with similar policies on a smaller scale.

Tightening compensation policy

Fewer countries have also implemented changes to their benefit systems, which typically take the form of a tighter access to the system in one way or another. Benefit levels remained untouched in almost all cases but assessment criteria are applied more stringently, including a stricter way of managing the sickness absence phase, the main pathway into long-term disability benefits.

More objective medical criteria

Several countries have chosen to tighten the *medical criteria* used to determine disability benefit entitlement. More particularly, countries which have hitherto relied on assessments by general practitioners have moved to a more uniform evaluation. In Spain, for instance, with the creation of the National Institute of Social Security in 1997, disability is assessed by benefit administrators based on a medical assessment performed by the institute's own doctors. Switzerland did not go as far but in a similar vein an increasing number of the medical assessments are performed by the special regional medical services operated by the cantonal authorities, introduced in 2004. Similarly, New Zealand has seen a gradual shift since the mid-1990s in the decision-making process, from eligibility determined by medical practitioners completing certificates for clients, to case-managers determining eligibility on the basis of advice from medical practitioners, interviews with the client, and other relevant assessments.

More stringent vocational criteria

In terms of *vocational assessment*, several countries are taking an ever broader perspective by considering more and more jobs in the labour market as a reference in determining disability benefit eligibility. In the Netherlands, as of 1993 eligibility for benefits requires that a person could not do any theoretically available job. Similarly, a 1994 reform in Norway, through which the labour market authorities were given the overall responsibility for employment measures, changed the system from strict own-occupation assessment to a labour market-related criterion. Implementation of such change, which is quite radical in principle, is lagging behind. Germany introduced a similar reform in 2001 but the own-occupation approach was kept for all insured older than 40 years at the time of the reform and persons entitled to a partial benefit, who do not find proper part-time work, continue to receive a full disability benefit.

Changes to benefit payments

Reforms have also affected the duration of benefit payment and the level of disability required for benefit entitlement. In Austria, Germany and Poland, disability benefits were *de facto* permanent but became strictly *temporary* – except in the case of full disability in Austria and Germany – in 1996, 2001 and 2005, respectively. In Poland, a temporary benefit is usually granted for three years and upon expiration, payments are terminated, individuals have to reapply and their case will be fully re-examined. A few countries have also modified *minimum levels of disability* required for a disability benefit entitlement. Since the early reform of 1984 in Italy, Australia and Luxembourg restricted the access to benefits for those with partially-reduced work capacity. Since 2006, eligibility to disability benefits in Australia is based on not being able to work at least 15 hours a week, instead of 30 hours prior to reform. Similarly, in the Netherlands following a reform in 2006, the then very low minimum earnings capacity loss required for a disability benefit entitlement was raised, from 15% to 35%. Finally, the generosity of the benefit itself was only modified in a handful of countries. Recent broad benefit reforms in Denmark and the Netherlands included a reduction in the level of benefit payments. Some of the countries with flat-rate payments have made efforts to equalise sickness and/or disability benefit levels with unemployment benefit levels (*e.g.* New Zealand).

Stronger work incentives

Promoting *work incentives* for people on disability benefits has also been pursued by a group of countries. This was a high priority in the United Kingdom, which introduced a special tax credit in 1999 which later on was merged into the general Working Tax Credit. In addition, a new temporary earnings supplement – the Return-to-Work-Credit – was introduced in 2003. Both credits constitute a wage top-up for people with disability in low-paid employment to ensure work pays. The biggest problem with such tax schemes, however, is the low take-up rate. The latest disability benefit reform in the Netherlands, in 2006, improves work incentives by providing what is *de facto* a permanent in-work benefit for individuals with partial or temporary disability through a wage-related benefit payment. Other countries made it easier to combine disability benefit receipt with income from work, sometimes by introducing or increasing earnings disregards (*e.g.* Ireland, New Zealand, Portugal and the Slovak Republic). In addition to the combination of work and benefits, countries have sought to promote employment of people with disability by extending the possibility to put the benefit on hold while trying work for a certain period of time and being able to return to the benefit without reassessment. Such possibility was extended to two years or more at the end of the 1990s in Finland and Norway and more recently in Canada and is now possible without any time limit in Denmark and Sweden. Finally, a few countries have introduced special rehabilitation benefits paid at a higher level than disability benefit to encourage people to take employability-improving rehabilitation measures (*e.g.* Norway and recently Hungary).

Stricter sickness absence monitoring

Several countries concluded that to tackle the number of people claiming a disability benefit it is necessary to address the issue of long-term sickness absence. These countries have increased their efforts to reduce sickness absence by making drastic modifications in their *sickness monitoring policy*. In Denmark, municipalities have been given more and more incentives to monitor absence rigorously and introduce steps for early intervention.

Since 2005, the sickness monitoring process includes the categorisation of sickness into three categories with more work-relevant focus and closer follow-up rules (every four rather than eight weeks as is used otherwise) being applied for the category most at risk. A similar mechanism was established in Spain in 2004 when a new department at the National Institute of Social Security was created with the sole purpose of better monitoring and reducing absence rates. A new monitoring tool with daily updated complete individual sickness absence histories allows online selection of cases for reviews on the basis of longer-than-expected recovery phases. In addition, in 2005 a general absence control was put in place when the duration of absence was greater than six months. Other countries, including especially the Netherlands and Sweden, have recently put in place very detailed medical guidelines for sick-leave certificates by general practitioners for a range of diagnoses so to ensure that sick workers do not stay out of work for longer than is necessary, as judged by expert opinion.

3.2. Policies converge despite continuing differences

The sickness and disability reform intensity has increased all across the OECD, and changes in policy tools and institutional reforms suggest a gradual shift in policy orientation in many cases. While policies used to be very passive, the need for better supports for people with disability to help them stay in or enter the labour market is now widely accepted.

This section explores the extent to which the many reforms and changes in policy tools described above have indeed changed the overall policy setup, by looking at the following questions:

- How much have the changes observed in the past 15 years or so influenced the generosity and accessibility of sickness and disability benefits and the nature, availability and accessibility of employment and vocational rehabilitation programmes?
- Have the observed changes resulted in a convergence in policies across the OECD, within and between groups of countries with different practices, priorities and institutional setups?

To measure the extent of change and convergence in disability policy in the period 1990 to 2007, this section draws on the policy typology developed in OECD (2003). This typology is based on two qualitative policy indicators, which capture a comprehensive selection of disability-related policies and allow for comparisons across countries and over time. The first indicator provides an overall assessment of policy features related to the benefit system whereas the second captures the intensity of integration measures for benefit recipients and those applying for benefits (see Box 3.1 for further details).

Measuring policy change in the past 15 years

There is significant variation across countries in both policy indicators (Figures 3.1 and 3.2). Scores on the first dimension, encapsulating the benefit or compensation policy tools, range from around or below 20 in most of the English-speaking countries, Korea and Japan (countries with the least generous and least accessible benefit systems) to over 30 in most of the Nordic countries, Portugal, Germany and Switzerland. Scores on the second dimension, summarising employment-oriented or integration policy tools, span a slightly broader range; from around 15 in many south-European countries, Ireland and Korea (and

Box 3.1. **OECD disability policy indicators**

Two disability policy indicators are constructed: the first covers compensation measures or benefit programmes, and the second employment or integration measures. These indicators were originally constructed for *Transforming Disability into Ability* (OECD, 2003) for two years, 1985 and 2000. They have been extended to cover the whole period between 1990 and 2007 and have been slightly modified for the purpose of the regression analysis presented later in this chapter. Each of the two indicators is composed of ten sub-components. Each sub-component is measured according to a predefined quantitative and/or qualitative scale, resulting in a certain number of points, ranging from zero to five points for each sub-component. The criteria for each sub-component are spelled out in detail in Annex 3.A1, and the country-specific scores in Annex 3.A2. The points for each sub-component are added to obtain the overall score for each indicator; hence, each sub-component receives the same weight. Tests for correlation and internal consistency have been performed and have revealed no particular problems with the chosen sub-components.

The compensation dimension is split into the following ten sub-components: *i) coverage; ii)* minimum *degree of incapacity* needed for benefit entitlement; *iii)* degree of incapacity needed *for a full benefit*; *iv) disability benefit level* (in terms of replacement rate for average earnings with a continuous work record); *v) permanence of benefits* (from strictly permanent to strictly temporary); *vi) medical assessment* (from exclusive responsibility of treating doctors to that of teams of insurance doctors); *vii) vocational assessment* (from strict own-occupation assessment to all jobs available); *viii) sickness benefit level* (distinguishing short- and long-term sickness absence); *ix) sickness benefit duration* (including the period of continued wage payment); and *x) sickness monitoring* (from no checks on sickness absence to strict steps for monitoring and early intervention). A higher score means greater system generosity, with 50 being the score for maximum generosity.

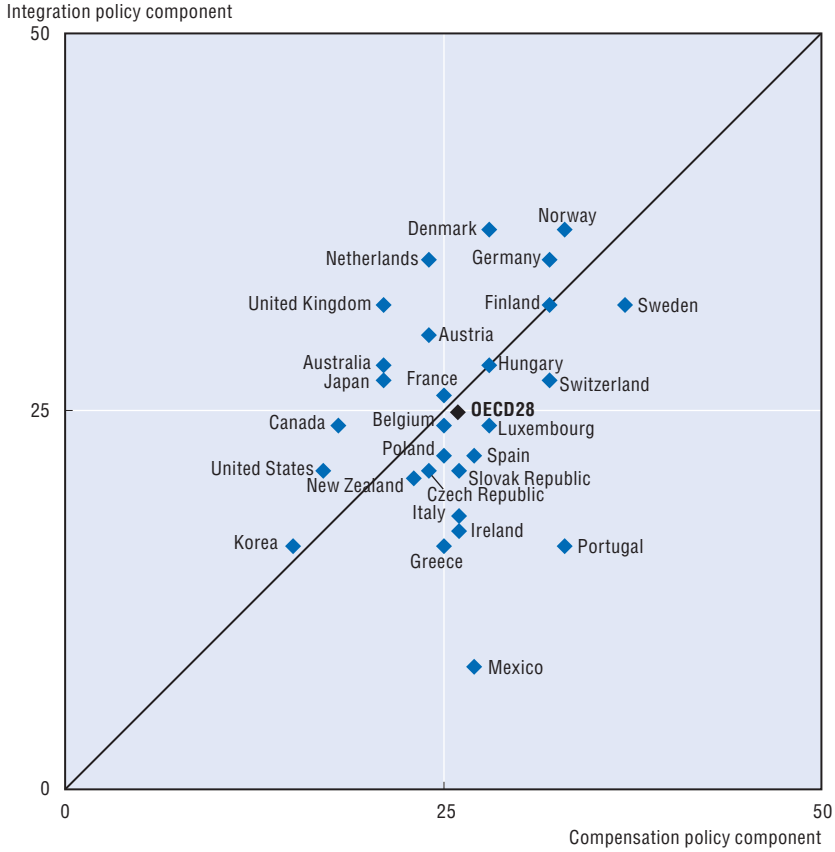
The integration dimension distinguishes the following ten sub-dimensions: *i) coverage consistency* (access to different programmes and possibility to combine them); *ii) assessment structure* (responsibility and consistency); *iii) anti-discrimination legislation* covering employer responsibility for work retention and accommodation; *iv) supported employment* programme (extent, permanence and flexibility); *v) subsidised employment* programme (extent, permanence and flexibility); *vi) sheltered employment* sector (extent and transitory nature); *vii) vocational rehabilitation* programme (obligation and extent of spending); *viii) timing of rehabilitation* (from early intervention to late intervention only for disability benefit recipients); *ix) benefit suspension* regulations (from considerable duration to non-existent); and *x)* additional *work incentives* (including possibilities to combine work and benefit receipt). Again, a higher score indicates a more active approach, with 50 being the possible maximum score.

half this value in Mexico) to 35 points or more in Denmark, Germany, the Netherlands and Norway.

The ranking of countries on the two indicators shows some resemblance, with several of the 28 countries covered in this study having either a high or a low score on both policy dimensions. Countries with high scores on both scales have a comparatively strong integration policy in place, but the generosity and accessibility of benefits is likely to devalue the potential of these policies. Similarly, some countries have very stringent

Figure 3.1. **Large variation in disability policy orientation across the OECD**

Compensation (X axis) and integration (Y axis) policy codes in 2007 for 28 OECD countries, country values on the two ordinal 50-point scales of the OECD disability policy typology indicator



Note: The higher the score, the more generous and accessible the benefit system (X axis) and the more developed the rehabilitation and employment stance of the policy (Y axis). The maximum score is 50 on both scales. The difference between the two indices is an indication of policy orientation, *e.g.* a compensation index that is significantly higher than a country's integration index indicates a strong compensation focus, and *vice versa*.

Source: OECD estimates based on information from national authorities as well as OECD (2006, 2007 and 2008), *Sickness, Disability and Work: Breaking the Barriers* (Vol. 1-3), OECD Publishing, Paris.

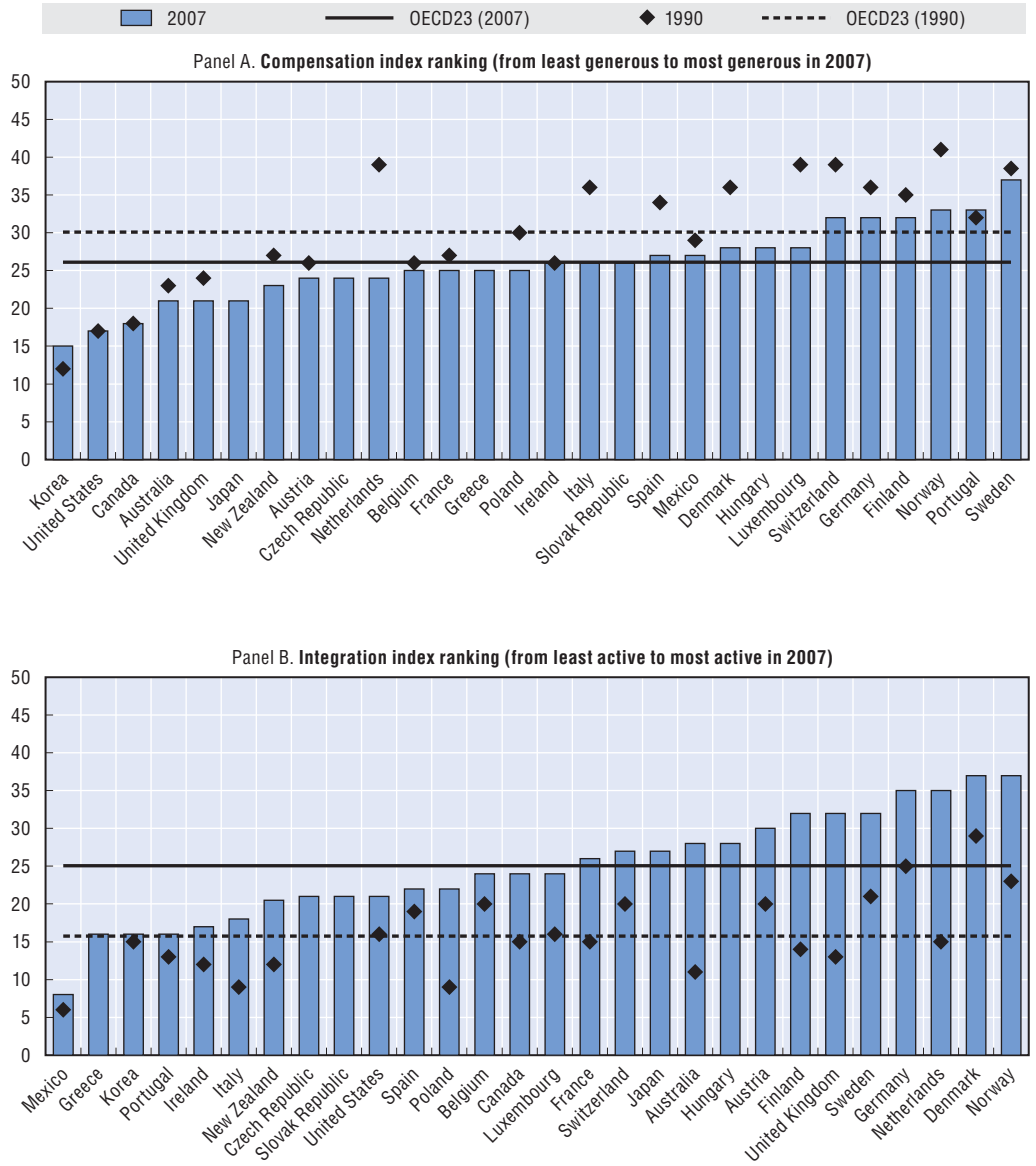
benefit schemes and mediocre payments levels, but the lack of stronger employment policies still implies a relatively passive policy setup.

The *difference* between the two scores could be interpreted as a measure of policy orientation: The higher the integration score relative to the compensation score, the more pronounced is the integration orientation of a policy setup, and *vice versa*. On this account, only a few countries seem to have a more dominant – either compensation or integration – focus in their policies. Portugal and Mexico, followed by Greece, Ireland and Italy, have the strongest compensation orientations. On the other side of the spectrum are the Netherlands and the United Kingdom, followed by Denmark, Canada, Australia, Japan and Austria, with the strongest integration orientations in their policy setup.

Figure 3.2 shows how the various reforms and changes in policy tools since 1990 have changed the scores on the two dimensions of the policy typology. The picture arising from this chart is very clear. Sickness and disability policy reforms across the OECD during the past 15 years have led to a strong shift in policy in many countries. Changes in the integration policy score are all positive and sometimes very large, while changes in the

Figure 3.2. **Disability policy is changing fast in many OECD countries**

Integration and compensation policy scores in 2007 and 1990



Source: OECD estimates based on information from national authorities as well as OECD (2006, 2007 and 2008), *Sickness, Disability and Work: Breaking the Barriers* (Vol. 1-3), OECD Publishing, Paris.

compensation policy score are predominantly negative, though on average less pronounced. As a result, most countries have seen a – sometimes very considerable – shift in policy orientation from compensation to integration, *i.e.* from a largely passive to a more active disability policy.

In two-thirds of the countries, integration scores have increased by over five points, and the Netherlands, the United Kingdom, Finland and Australia recorded increases of over 15 points.[2] The latter are large changes on a 50-point scale in a period of only 15-20 years. Similarly, two-thirds of the countries have experienced at least some decline of their compensation scores, with the largest drops of 10 points or more observed in the

Netherlands, Luxembourg and Italy. On the contrary, little change occurred in Korea and the Southern European countries.

This big shift in policy orientation towards a more employment-oriented approach does not or not yet seem to be reflected in the labour market outcomes of people with disability. This has several co-existing explanations, which are elaborated in more detail in subsequent chapters. First, it appears that policy implementation is lagging behind policy intentions. The big shift in rhetoric and policy has yet to translate in many cases to an actual shift in everyday practice of doctors, caseworkers, benefit-granting authorities and service providers. This will require very significant additional change addressing the financial incentives of the main stakeholders. Moreover, the policy shift has not been accompanied to the necessary degree by a corresponding shift in resources – contributing to the very low take-up in most cases of new and modified services. This suggests that the shift to a more active stance as identified by the policy typology is probably somewhat exaggerated.

Policy clusters and policy convergence

Do these changes imply that policies have converged across the OECD, or do we continue to find very distinct groups of countries with different sets of disability policies? These questions are explored in the following, concluding that convergence is found both within and between groups of countries.

A cluster analysis over the 20 sub-dimensions of the OECD disability policy typology identifies three main groups or types of policies, with additional subgroups within these, as elaborated in Table 3.1.[3] Each policy model is characterised by a particular set of policies, or policy packages. The dissimilarity of the three emerging models is much larger than that of the subgroups within each of them.

This classification has strong common characteristics with welfare typologies and welfare regime taxonomies developed elsewhere. For instance, the three policy types identified above largely overlap with those associated with the "liberal", the "corporatist" and the "social-democratic" welfare regimes described in Esping-Andersen's seminal 1990 paper. However, there are also a number of interesting exceptions of countries falling into "unexpected" models, or policy clusters. Germany and Switzerland are not usually seen as having the same welfare policy approach as the Nordic countries; whereas Ireland's disability policy seems somewhat distinct from that of the other English-speaking countries.[4]

Table 3.1. **Three distinct disability policy models across the OECD**

Results from a cluster analysis based on the OECD disability policy typology

"Social-democratic" model (mostly north European countries)		"Liberal" model (OECD Pacific and English-speaking countries)		"Corporatist" model (mostly continental European countries)		
Sub-group A	Sub-group B	Sub-group A	Sub-group B	Sub-group A	Sub-group B	Sub-group C
Denmark	Finland	Australia	Canada	Austria	France	Czech Republic
Netherlands	Germany	New Zealand	Japan	Belgium	Greece	Ireland
Switzerland	Norway	United Kingdom	Korea	Hungary	Luxembourg	Italy
	Sweden		United States		Poland	Portugal
						Slovak Republic
						Spain

Source: OECD calculations.

The *Social-democratic* disability policy model is broadly characterised by *i)* a relatively generous and accessible compensation policy package, with largely universal benefit coverage, a low entry threshold for a partial disability benefit and generous sickness and disability benefits; and *ii)* a broad and equally accessible integration policy package, with particularly strong focus on vocational rehabilitation. It provides good supports for those who can and want to work, but also considerable incentives to apply for, or remain on, long-term benefits. Such policy is potentially expensive and will not necessarily result in the highest possible labour market participation. Two variants of this model are distinguished in Box 3.2.

The *Liberal* disability policy model is characterised by a much less generous compensation policy setup compared with the other policy models, with lower benefit levels and a much higher threshold to get onto benefits, including an assessment of work capacity with regard to any job on the labour market. Absence monitoring is not well developed. Employment policies are on an intermediary level and vocational rehabilitation is, by and large, relatively underdeveloped; but work incentives are strong and benefit

Box 3.2. **Several variants of the three main disability policy models**

The *Social-democratic* policy model comes in two variants. One group, including Denmark, Switzerland and the Netherlands, is less generous than the other one on both policy dimensions (benefits and employment supports are less accessible) but provides better work incentives. It also has the strongest sickness absence monitoring and/or sick-pay eligibility control focus of all models and sub-models. Germany, according to this typology, belongs to the second Nordic sub-model, together with Finland, Sweden and Norway. This sub-model is the most generous in the OECD (with full population coverage, low entry thresholds, high benefits, generous benefit suspension, comprehensive employment and vocational rehabilitation programmes), but also has the strongest employer obligations of all models and sub-models.

The *Liberal* policy model also has two variants. One, covering Australia, New Zealand and the United Kingdom, has far better organised and co-ordinated and thus better accessible services. Benefit levels are even lower for this than for the other subgroup but benefit coverage is almost universal. The other sub-model, comprising Canada and the United States on the one hand and Japan and Korea on the other, has the most stringent eligibility criteria for a full disability benefit, including the most rigid reference to all jobs available in the labour market, and the shortest sickness benefit payment duration, compared with all other models and sub-models.

Within the *Corporatist* policy model, three subgroups can be distinguished. Policies in the first group, including Austria, Belgium and Hungary, stand out in having well developed rehabilitation as well as employment programmes coupled with lower benefit levels, thus having a stronger employment orientation than the other countries in this policy cluster. The countries in the second subgroup, France, Greece, Luxembourg and Poland, pay the most generous sickness and disability benefits of all the countries in the Corporatist cluster; other distinguishing policy features include a focus on temporary disability benefits, more attention to sickness absence monitoring and a lack of benefit suspension possibilities. The third and biggest subgroup, covering the Czech Republic, Ireland, Italy, Portugal, the Slovak Republic and Spain, has comparatively underdeveloped employment and rehabilitation policies. This makes for a stronger compensation orientation even though the sickness benefit level is lower than in the other subgroups of this cluster (but with longer sickness benefit payment duration).

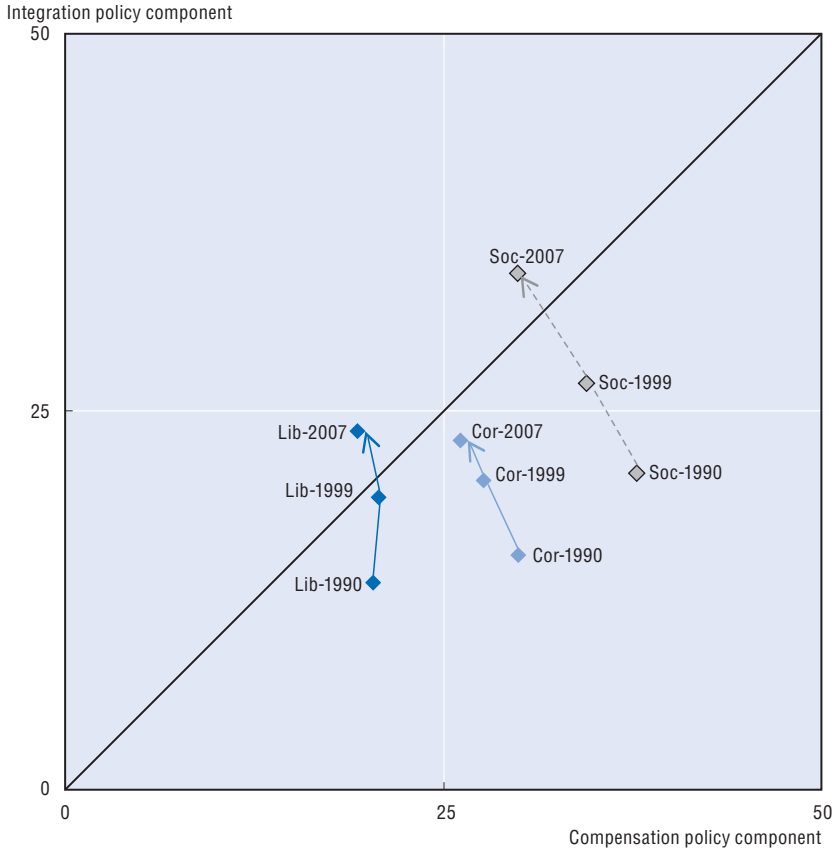
suspension rules very flexible. This policy setup is less expensive overall but the stronger inbuilt employment incentives resulting from less generous benefits are only partly harvested with an intermediary integration policy focus. Again, two sub-groups of this model are distinguished in Box 3.2.

The *Corporatist* disability policy model can be interpreted as intermediate, relative to the other two models. Benefits are relatively accessible and relatively generous but not at the level of the Nordic model. Similarly, employment programmes are quite developed but the focus on vocational rehabilitation and supported employment is not nearly as strong as in the Nordic model. Employment and beneficiary outcomes of such a setup can be rather mixed. Outstanding system features are a relatively strong focus on own-occupation assessment in many of the countries in this group and a lower population coverage, but also limited benefit flexibility and work incentives features. The Corporatist model covers a large number of countries mostly in the south, east and west of Europe with considerable differences in their policy setup, as described in Box 3.2.

Figures 3.3 shows how policy has changed for the groups of countries identified through cluster analysis. On the integration policy dimension, policy is moving in largely

Figure 3.3. **Disability policy is converging in the same direction**

Changes in integration and compensation policy scores 1990-1999 and 1999-2007 for the three policy models: Social-democratic (Soc), Liberal (Lib) and Corporatist (Cor)



Source: OECD estimates based on information from national authorities as well as OECD (2006, 2007 and 2008), *Sickness, Disability and Work: Breaking the Barriers* (Vol. 1-3), OECD Publishing, Paris.

the same direction in all models and sub-models. Since the upwards move is also comparable in size, differences across policy models have essentially remained unchanged. Thus, there is convergence in trends but not in indicator levels. On the compensation policy dimension, however, considerable convergence is found, due to differences in both the extent and direction of change. Countries belonging to a model with more generous benefit systems have seen more downward change, and the least generous group back in 1990 has even seen an upward shift. In conclusion, therefore, policy models remained distinct but they are more similar now than some 15-20 years ago.

3.3. The effect of policy changes on disability benefit rolls

The key question for policy makers is whether the reforms they are legislating and implementing are having the intended effect of lowering benefit dependency and raising employment of people with disability. This section investigates the potential impact of the different reforms introduced in the disability system in the past 10-20 years on one key outcome, the number of working-age people claiming disability benefit.[5] Features of the sickness and disability benefit system potentially play a major role in depressing labour force participation. They can reduce the willingness to work or engage in job search not only for current beneficiaries but also for current jobholders with or without disability, by modifying the relative advantage of working *versus* not working. Similarly, the new integration approach with expanded, more accessible employment services and at times more mandatory elements of rehabilitation can have the opposite effect of making the non-work option less attractive and less likely.

The results of a multivariate regression show that the overall compensation features of disability policy matter as they are positively related to the resulting number of disability beneficiaries (Table 3.1, model I).[6] The effect of compensation policy holds after controlling for a range of economic conditions, although it is significantly reduced (compare model I, with/without controls).[7] At the same time, integration policy taken as a whole has only a very modest and non-significant effect on resulting disability benefit recipiency rates. This confirms that policy implementation is lagging behind policy change in regard to its employment-oriented components.

Model II while controlling for the same economic conditions looks into the impact on beneficiary outcomes of the specific elements of compensation and integration policy. In line with previous findings (OECD, 2003), it appears that changes in accessibility to disability benefit programmes and benefit generosity are both positively associated with disability beneficiary rates. This is also confirmed by single-country experiences, with a sharp drop in beneficiary rolls in the aftermath of a reform introducing a much more restrictive approach to granting permanent disability benefits (Poland after 1999) or much stricter access to disability benefit for people with partially-reduced work capacity (Luxembourg after 1997).

A more generous and lenient sickness policy (combined "sickness policy indicator" in Table 3.2) also contributes to higher disability beneficiary levels. The link in this case is often a longer-term sickness absence, which then leads to a disability benefit claim. This finding is in line with other studies, for instance, for Sweden on a strong positive relationship between the sick-leave compensation rate and the resulting absence level (Hesselius and Persson, 2007), or the Netherlands where the increasing sickness absence

Table 3.2. **What explains changes in disability benefit recipiency rates?**

Fixed-effect regression coefficients[a, b, c]

	Model I		Model II	Model III
	No controls	With controls		
Indicators				
Compensation indicator	0.117**	0.081**		
Integration indicator	–0.007	–0.011		
Detailed policy indicators				
Benefit accessibility/generosity			0.184***	0.185***
Medical and vocational assessment			–0.160***	–0.149***
Sickness indicator			0.245***	0.211***
Anti-discrimination legislation			0.172**	0.131*
Vocational rehabilitation programme			–0.239*	–0.216*
Sheltered/Subsidised/Supported			–0.115***	–0.117***
Incentives indicator			–0.125***	–0.152***
Gross replacement rates (UB)				–3.604*
Constant	–0.102	–4.945	–10.002***	–3.806
Observations	330	300	300	277
R-squared	0.928	0.938	0.958	0.956

*, **, ***: statistically significant at the 10%, 5%, 1% level, respectively.

a) The dependent variable is annual disability beneficiary rates in 19 OECD countries (Australia, Austria, Belgium, Canada, Denmark, Finland, Germany, Ireland, Korea, Luxembourg, the Netherlands, Norway, Poland, Portugal, Spain, Sweden, Switzerland, the United Kingdom and the United States) in the period 1990-2007. The following years are included for each country: 1994-2007 for Austria; 1990-2007 for Australia, Belgium, Denmark, Finland, the United Kingdom, Ireland, Netherlands, Norway, Portugal and Sweden; 1996-2006 for Canada; 1996-2007 for Switzerland; 1995-2007 for Germany and Spain; 1995-2006 for Korea; 1990-2005 for Luxembourg; and 1990-2006 for the United States.

b) All regressions also include year and country dummies and are weighted by population size. Female labour force participation rates, the share of people aged 55 and above in the population and the share of employment in manufacturing are used as controls for economic conditions and demographic trends. In particular, the share of jobs in manufacturing is also used as a proxy for structural changes in the economy. GDP per capita is capturing a wealth effect. Gross replacement rates for unemployment are used as a crude measure of alternative benefit options only in model III. Differences in the sample size are explained by the non-availability of certain economic indicators and gross replacement rates for some of the countries.

c) The detailed policy indicators used in this table group the sub-components described in Annex 3.A1 into meaningful sub-indicators. Benefit accessibility/generosity includes coverage; minimum disability level; disability level for a full benefit; maximum benefit level; and permanence of benefits. Medical and vocational assessment includes those two components, whereas the sickness indicator includes sickness benefit level; sickness benefit duration; and sickness monitoring. The choice of these sub-components is based on the low correlation that exists between them and the fact that they cover a broad range of elements. Because of the lack of available yearly time series, integration coverage and institutional assessment are not included.

Source: OECD estimates based on *OECD Economic Outlook Database*, *OECD Labour Force Statistics*, Labour Force Survey for Australia and *OECD STAN Database* for all other countries. Disability beneficiary rates are OECD Secretariat estimates based on information provided by national authorities as well as OECD (2006, 2007 and 2008), *Sickness, Disability and Work: Breaking the Barriers* (Vol. 1-3), OECD Publishing, Paris.

monitoring responsibilities of the employer were found to be one of the main factors in the recent drop in the number of new disability benefit claims (Jehoel-Gijsbers, 2007).

The recently tightened way in which disability is assessed – in some case more stringent medical, in others tighter vocational assessment – appears to be correlated with an increasing beneficiary caseload. This is in contradiction with observations from specific countries like Switzerland, for example, where the introduction of new regional medical services providing more uniform and qualitatively better disability assessments throughout the country was shown to have contributed to the fall in new disability benefit claims as of 2004. However, capturing the effect of changes in the assessment process is

notoriously difficult, not only because such changes take a while to be implemented properly, but also because of the difference in many cases between legislation (on which the indicator is based) and actual implementation.[8]

With respect to integration, the expansion of employment programmes and vocational rehabilitation is correlated with a decreasing number of persons receiving a disability benefit. The same is true for changes in work incentives which are also associated with reduced levels of disability benefit recipiency rates. This confirms findings for the United Kingdom according to which the recent reversal in the upward trend in disability beneficiaries is related to a range of policies focusing on labour market integration – including the New Deal for Disabled People rolled out nationally as of 2001 (which *e.g.* includes the use of unpaid work trials and temporary job-match payments for part-time work); the mandatory work-focused interviews eight weeks after the initial benefit claim introduced in the mid-2000s; and a new although temporary earnings supplement for incapacity benefit recipients moving into paid work.

Anti-discrimination legislation, on the other hand, is associated with higher shares of disability benefit recipients. Again, this is not dissimilar from evidence elsewhere (mainly for the United States) showing mixed results in terms of employment outcomes for people with disability (*e.g.* Begle and Stock, 2003; Jolls and Prescott, 2004). One plausible explanation is that such legislation, while protecting workers in existing employment, may hinder the hiring of workers with health problems, even though the Americans with Disabilities Act also protects job applicants with disability.

The regression analysis shows that some elements of disability policy reform are associated with a change in disability beneficiary rates. However, these beneficiary rates are also related to policies in other areas, in particular the availability of other working-age benefits such as for example unemployment benefit (Bound and Burkhauser, 1999). Adding into the model's equation gross replacement rates for unemployment benefits, as a crude measure of alternative benefit options, does not alter significantly the results (Table 3.2, model III). A more generous unemployment benefit is associated with lower disability beneficiary rates (significant at the 10% level), confirming findings discussed earlier in the report according to which increases in disability benefit rolls coincided with a fall in the number of people receiving unemployment benefit.[9]

3.4. The political economy of reform

Sickness and disability system reform is a huge task, for several reasons. First, the underlying policy goals are potentially contradictory: to provide income security during periods of short or long-term work incapacity, while at the same time helping people to stay in the labour market or to enable them to return to it as quickly as possible. Second and partly related to this, the group of people to be helped is extremely heterogeneous, requiring a wide range of different forms of incentives, supports and services to be provided by one and the same system. Third, the group of stakeholders involved is broader than in other policy fields; not only are social and employment issues at stake but the medical sector is also involved, both in assessing eligibility and in rehabilitating workers. Fourth, changing one parameter of the system (*e.g.* eligibility assessment) can have complex effects on other parameters (*e.g.* early intervention). Finally, reforms of *other* social assistance and social insurance systems often have a major impact on sickness and disability benefits, which have become in several cases the "benefit of last resort".

For these reasons, it is difficult to make structural system reform happen. Successful change not only needs the right elements of reform but also has to pay sufficient attention to the way in which reform is being argued, designed and put in place.[10] Only rigorous implementation of reform can guarantee its intention will be followed and outcomes improved. It is too easy for stakeholders to continue business as usual, and there are incentives in the system for stakeholders to err on the side of leniency when granting a benefit.[11] Therefore, structural reform needs a change in attitudes and mind-sets of all the actors involved at different stages. In turn, this makes the study of sickness and disability reform paths and processes and of the political economy of system reform particularly interesting.

An issue that arises when governments are considering comprehensive reform is the ability to communicate clearly and convincingly to stakeholders both the need for reform and the desirability of the proposed solutions. The rigor and quality of the analysis underlying a reform can affect both the prospects for its adoption and the implementation and the quality of the policy itself. At any given moment, the political context will also influence the reception by the general public, by stakeholders and by policy elites of any particular piece of analysis and policy recommendation. Drawing on Prinz and Tompson (2009), Box 3.3 exemplifies some of these problems by looking at the reform pathways in selected OECD countries – demonstrating the iterations of reform in most cases.

Box 3.3. **Policy process lessons from selected OECD countries**

Switzerland, after 40 years of little change in its disability policy regime, undertook a series of increasingly successful reforms in recent years. To a considerable degree, these reforms were motivated by accusations of widespread benefit fraud that, although never proven, triggered a more thorough public debate. Public discussion of the issue became increasingly intense in response to the steady increase in numbers of beneficiaries and the fast rise in the deficit of public disability insurance. These helped to convince most stakeholders of the need for reform. At the same time, new data were being collected and a large body of new scientific evidence was being produced. Much attention was paid to benchmarking outcomes and policies against other OECD countries. Placed in a comparative context, policies, institutions and practices that seemed normal until then came to be looked at through a more critical lens. Such discussion made it possible to generate consensus on the direction of reform, its main characteristic being a new focus on early identification and intervention in order to prevent people flowing onto long-term disability benefit.

Norway has yet to undertake major reform, despite the highest sickness absence and disability beneficiary rates in the OECD. A Royal Commission report in 2000 presented far-reaching reform proposals, especially regarding the benefit system and the incentives for workers and employers, but successive governments have left it to the social partners to solve the problems the Commission identified. This approach has brought very limited success so far: Sickness absence has not really fallen and disability beneficiary rates continued to increase. Government shied away from more comprehensive structural reform, even though an increasing body of national evidence suggests that such change is needed to alter the incentives facing the key players in the system. Hence, the need for change and also the direction of necessary reform is well recognised by most experts but the political culture of consensus-driven reform (via social dialogue) hinders enactment of some unavoidable but unpopular system restructuring. A renewed tripartite agreement aims to strengthen further the focus on partial sickness absence and closer follow-up during sick leaves.

Box 3.3. **Policy process lessons from selected OECD countries** *(cont.)*

Australia has experienced steady economic growth since the early 1990s. However, as unemployment was falling, the disability beneficiary rate was rising, and at a roughly similar rate. What is more, this happened despite an important reform in 1991 that provided significant resources and introduced a series of new programmes to promote the employment of people with disability. Much of the reform effort since then has involved attempts to expand the more successful elements of labour market programmes to assist people with reduced work capacity to find work. This idea encountered lots of resistance, but the accumulation of a growing body of national evidence supporting such change enabled the government to introduce a comprehensive welfare-to-work reform in 2006. Under the new arrangements, many of those with partially-reduced work capacity are now treated like the regular unemployed, with corresponding part-time work, job-search and participation requirements. However, adoption of this very contentious reform was made possible only by leaving untouched the entitlements of those already on a disability benefit.

The *United Kingdom*, too, has seen a significant part of the rapid fall in unemployment since 1993 offset by increased use of disability benefits – with the result that the share of the working-age population on such benefits far exceeded the OECD average. This has generated a vast literature on various elements of the system, including a series of evaluations of the impact of interventions of all kinds showing, *inter alia*, that employment programmes could be effective also for people with reduced work capacity and work was generally good for people's health. The accumulation of an evidence base enabled the government to push forward with reform, often using trials and pilots in an initial stage, and including a proposal to move in the direction of a single working-age benefit. Reliance on pilot programmes means that the universal or comprehensive roll-out of an initiative is evidence-based, even though the effectiveness might be less pronounced on a nationwide scale.

In *Sweden*, since the beginning of the 1990s successive governments have tried to tackle the problem of rapidly rising expenditure on sickness benefits, as well as the concomitant growth in the number of work days lost as a result of sickness. During the 1990s, these efforts – triggered by an acute fiscal crisis – were ineffective; a series of reforms or reform attempts were either reversed or blocked. Back then, there was no consensus on the need for reform. Since 2002, however, there have been renewed attempts at sickness insurance reform, recently with very impressive results. There are many reasons for the frustration of reform efforts in the 1990s and the – so far – promising outcomes observed since 2002. These include a gradual shift in the political consensus from a commitment to passive income assistance with respect to people with disability to the application of the kind of mutual-obligations approach already used with respect to unemployed people. There is also a strong case for arguing that the more recent reforms were possible because the failed reforms of the 1990s gave rise to a large and sophisticated body of empirical work on the weaknesses in the sickness insurance system.

The *Netherlands*, finally, has long had one of the most generous disability insurance systems in the OECD. By 2000, around 11% of the working-age population was drawing disability benefits. A major reform to the system was agreed by the government and the social partners in 2003-04, and took effect in 2006. The reform, which applied only to persons who suffered disability in 2004 or later, reduced the inflow into the disability benefit scheme from the 70 000-100 000 per year that had prevailed over the preceding decade, to some 40 000 in 2007 and 2008 – a major accomplishment. Those already receiving benefits at the time of the reform continued to receive benefits defined under the old rules, but most of those younger than age 45 have had their entitlement re-assessed under the criteria used in the new system. Again, there is a strong case for arguing that the success of the latest reforms which have changed the incentives facing employers and employees drastically was made possible by the (failed) earlier reform which, building on fast growing new scientific evidence, have created a consensus for the need for change.

3.5. Conclusion

This chapter finds that sickness and disability policy is changing in most OECD countries, and in largely the same direction. To a varying degree and at varying speed, countries are transforming their systems gradually in a search for a better balance in the provision of income support and work incentives. Most countries have expanded considerably the array of employment supports available for people with chronic health problems or disability, and some countries have also – to a lesser extent – started to control more stringently access to hitherto easy – to-get sickness and disability benefits. The chapter also finds evidence of some convergence in policies even though distinct policy models continue to exist.

However, despite a number of efforts, in most countries reforms have not gone far enough to change sufficiently the continuously disappointing outcomes in terms of low employment and high rates of benefit dependency. The message given by many systems to workers, employers and public authorities administering the system continues to be slightly contradictory in terms of whether or not employment is seen as the best way to tackle disability. The lack of more far-reaching reform in several countries is to a considerable degree the consequence of the difficult policy process involved in changing a passive system that was designed for a narrow group and is now serving a highly heterogeneous target group.

The good news on which further structural reform should build is that policy matters: Countries which embarked on comprehensive reform involving both the benefit and the employment support system have seen the biggest changes in outcomes.

Notes

1. Quota-levy systems aim to influence labour demand by mandating employers to employ a certain share of workers with disability, typically in the range of 2%-7% of the company workforce. However, systems allow employers to opt out by contributing money (a levy) to a special fund. These funds usually disperse resources to workers with disability, service providers, and employers.
2. It should be kept in mind that not each and every single policy change has an impact on the indicator values and also that the indicator is more sensitive to some types of changes than others. Hence, these results should be taken as indicative of the overall size of change in each country.
3. Cluster analysis is a method to group data (in this case, a series of policy typology scores) into subsets or "clusters", such that those within each cluster are more closely related (or more similar) to one another than objects assigned to different clusters. Cluster analysis discovers structures in data without explaining why they exist. The estimates are based on hierarchical clustering using the classic complete linkage method whereby distance between groups is defined as the distance between the most distant pair of objects. Hierarchical clustering means that more and more objects are being aggregated together into larger and larger clusters of increasingly dissimilar elements.
4. A classification like this obtained through cluster analysis should be interpreted carefully. It can help identify broad commonalities and differences but can also react very sensitively to small changes in indicator values in one or several countries.
5. Due to data limitations, the dependent variable used is the total disability benefit caseload not the flow of new claimants of disability benefits which reacts more sensitively to policy change. However, flow data are not available for a long enough period for a large enough number of countries.
6. The analysis describes multivariate correlations between changes in system and policy features and changes in the beneficiary caseload. Results cannot be interpreted as causal, again because of data limitations.

7. Several sensitivity tests have been performed, based on disaggregated data by gender and age and excluding one country at a time. Labour market factors may play an important role in explaining changes in disability recipiency rates since decreases in work options, or work options that are low paid, are found to be a major explanation for lower participation rates for the low-skilled and higher applications to disability benefits (Autor and Duggan, 2003; Faggio and Nickell, 2005). Labour demand and alternative benefit options (such as early retirement) are *not* controlled for in this analysis because of the lack of appropriate indicators. Unemployment rates could be used as a proxy for labour demand conditions, but they may capture more general economic change more than the relative attractiveness of unemployment *versus* disability benefits. Concerns about using time-series data for such analysis exist (Disney and Webb, 1991) and would be particularly problematic given the short time-span and the cross-country nature of the data.
8. Taking the example of the Netherlands, changes in the definition of disability reduced the number of new benefit awards by 7% in 1993. However, the slowdown was reversed at the end of the 1990s and the number on disability rolls reached almost 1 million in 2002. The reversal is believed to be partly attributed to a more lenient interpretation of the assessment rules.
9. The causality between disability and other beneficiary trends can also be influenced by policy decisions, for instance, easier access to unemployment benefit during a downturn reducing the need for disability benefit in the short run, or stricter application of entitlement rules for social assistance payments contributing to a shift of some people onto disability benefit, as has been shown for Finland (Gould, 2003).
10. The right timing of reform can be another critical parameter. The coincidence of a jobs crisis does not appear to be the best moment to embark on structural reform but this report tries to argue why ongoing disability reform cannot be halted at this stage in view of the long-term structural risks (of a higher structural disability beneficiary rate) and challenges (of a falling labour force).
11. This problem is closely related to the challenge of assessing work capacity. Ideally, a system should neither deny benefits to people who deserve them (exclusion error) nor award benefits to those who do not (inclusion error). Both errors involve welfare losses, but the consequences of exclusion errors are likely to be more serious for those administering the system: deserving applicants who are denied benefit may contest the decision, whereas undeserving applicants who are awarded benefits will not draw attention to themselves. Moreover, doctors and others involved in screening are likely to face more serious consequences if they are found to have denied assistance to a genuinely needy individual, who then suffers further health problems or loss of capacity as a result. The agents administering the system thus have incentives to err on the side of leniency and grant the benefit of doubt.

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ANNEX 3.A1

Table 3.A1.1. **OECD disability policy typology: classification of the indicator scores**

DIMENSION	*5 points*	*4 points*	*3 points*	*2 points*	*1 point*	*0 points*
X. Compensation						
X1. Population coverage	Total population (residents)	Some of those out of the labour force (*e.g.* congenital)	Labour force plus means-tested non-contrib. scheme	Labour force with voluntary self-insurance	Labour force	Employees
X2. Minimum required disability or work incapacity level	0-25%	26-40%	41-55%	56-70%	71-85%	86-100%
X3. Disability or work incapacity level for full benefit	< 50%	50-61%	62-73%	74-85%	86-99%	100%
X4. Maximum disability benefit payment level	RR > = 75%, reasonable minimum	RR > = 75%, minimum not specified	75 > RR > = 50%, reasonable minimum	75 > RR > = 50%, minimum not specified	RR < 50%, reasonable minimum	RR < 50%, minimum not specified
X5. Permanence of benefit payments	Strictly permanent	De facto permanent	Self-reported review only	Regulated review procedure	Strictly temporary, unless fully (= 100%) disabled	Strictly temporary in all cases
X6. Medical assessment criteria	Treating doctor exclusively	Treating doctor predominantly	Insurance doctor predominantly	Insurance doctor exclusively	Team of experts in the insurance	Insurance team and two-step procedure
X7. Vocational assessment criteria	Strict own or usual occupation assessment	Reference is made to one's previous earnings	Own-occupation assessment for partial benefits	Current labour market conditions are taken into account	All jobs available taken into account, leniently applied	All jobs available taken into account, strictly applied
X8. Sickness benefit payment level	RR = 100% also for long-term sickness absence	RR = 100% (short-term) > = 75% (long-term) sickness absence	RR > = 75% (short-term) > = 50% (long-term) sickness absence	75 > RR > = 50% for any type of sickness absence	RR > = 50% (short-term) < 50% (long-term) sickness absence	RR < 50% also for short-term sickness absence
X9. Sickness benefit payment duration	One year or more, short or no wage payment period	One year or more, significant wage payment period	Six-twelve months, short or no wage payment period	Six-twelve months, significant wage payment period	Less than six months, short or no wage payment period	Less than six months, significant wage payment period
X10. Sickness absence monitoring	Lenient sickness certificate requirements	Sickness certificate and occupational health service with risk prevention	Frequent sickness certificates	Strict follow-up steps with early intervention and risk profiling, but no sanctions	Strict controls of sickness certificate with own assessment of illness if necessary	Strict follow-up steps with early intervention and risk profiling, including sanctions

Note: RR = replacement rate.

Table 3.A1.1. **OECD disability policy typology: classification of the indicator scores** *(cont.)*

DIMENSION	*5 points*	*4 points*	*3 points*	*2 points*	*1 point*	*0 points*
Y. Integration						
Y1. Consistency across supports in coverage rules	All programmes accessible	Minor discrepancy, flexible mixture	Minor discrepancy, restricted mixture	Major discrepancy, flexible mixture	Major discrepancy, restricted mixture	Strong differences in eligibility
Y2. Complexity of the benefits and supports systems	Same agency for assessment for all programmes	One agency for integration, benefits co-ordinated	Same agency for benefits and vocational rehabilitation	One agency for integration, benefits not co-ordinated	Different agencies for most programmes	Different agencies for all kinds of assessments
Y3. Employer obligations for their employees and new hires	Major obligations towards employees and new applicants	Major obligations towards employees, less for applicants	Some obligations towards employees and new applicants	Some obligations towards employees, none for applicants	No obligations at all, but dismissal protection	No obligations of any kind
Y4. Supported employment programmes	Strong programme, permanent option	Strong programme, only time-limited	Intermediary, also permanent	Intermediary, only time-limited	Very limited programme	Not existent
Y5. Subsidised employment programmes	Strong and flexible programme, with a permanent option	Strong and flexible programme, but time-limited	Intermediary, either permanent or flexible	Intermediary, neither permanent nor flexible	Very limited programme	Not existent
Y6. Sheltered employment programmes	Strong focus, with significant transition rates	Strong focus, but largely permanent employment	Intermediary focus, with some "new" attempts	Intermediary focus, "traditional" programme	Very limited programme	Not existent
Y7. Comprehensiveness of vocational rehabilitation	Compulsory rehabilitation with large spending	Compulsory rehabilitation with low spending	Intermediary view, relatively large spending	Intermediary view, relatively low spending	Voluntary rehabilitation with large spending	Voluntary rehabilitation with low spending
Y8. Timing of vocational rehabilitation	In theory and practice any time (*e.g.* still at work)	In theory any time, in practice not really early	Early intervention increasingly encouraged	Generally *de facto* relatively late intervention	After long-term sickness or for disability recipients	Only for disability benefit recipients
Y9. Disability benefit suspension option	Two years or more	At least one but less than two years	More than three but less than 12 months	Up to three months	Some, but not for disability benefits	None
Y10. Work incentives for beneficiaries	Permanent in-work benefit provided	Benefit continued for a considerable (trial) period	Income beyond pre-disability level allowed	Income up to pre-disability level, also partial benefit	Income up to pre-disability level, no partial benefit	Some additional income allowed

Note: RR = replacement rate.

ANNEX 3.A2

Table 3.A2.1. **OECD disability policy typology: country scores around 2007**

Panel A. Compensation policy dimension (values from 0-5 for each sub-component and 0-50 for the total)

	1	2	3	4	5	6	7	8	9	10	Sum
	Benefit system coverage	Minimum disability benefit	Level for full disability	Disability benefit generosity	Disability benefit permanence	Medical assessment rules	Vocational assessment rules	Sickness benefit generosity	Sickness benefit duration	Sickness benefit monitoring	
Australia	4	1	2	1	2	3	1	1	1	5	21
Austria	2	3	4	2	1	1	4	3	2	2	24
Belgium	3	2	3	1	4	2	4	2	2	2	25
Canada	3	1	1	1	4	1	0	1	1	5	18
Czech Republic	1	4	3	3	0	2	1	0	5	5	24
Denmark	5	2	1	3	4	4	2	4	3	0	28
Finland	5	4	4	3	2	3	2	3	3	3	32
France	3	2	1	3	1	2	4	2	5	2	25
Germany	3	5	3	2	1	3	2	4	4	5	32
Greece	3	3	2	5	2	1	3	2	2	2	25
Hungary	1	3	2	3	2	1	4	3	5	4	28
Ireland	3	1	2	1	4	3	2	1	5	4	26
Italy	3	2	0	3	1	1	3	3	5	5	26
Japan	4	1	0	1	2	2	0	2	5	4	21
Korea	3	3	0	1	2	1	0	0	1	4	15
Luxembourg	2	1	2	5	3	2	2	5	4	2	28
Mexico	0	3	4	0	3	2	5	2	3	5	27
Netherlands	4	4	2	3	2	1	0	4	4	0	24
New Zealand	5	1	2	1	2	3	1	1	5	2	23
Norway	5	3	2	4	2	4	2	5	4	2	33
Poland	3	3	4	4	0	1	3	3	2	2	25
Portugal	3	2	3	5	4	1	4	1	5	5	33
Slovak Republic	1	4	3	2	4	2	1	2	5	2	26
Spain	3	4	1	4	5	0	3	2	4	1	27
Sweden	5	5	1	5	4	3	1	4	4	5	37
Switzerland	5	4	3	3	4	3	2	3	4	1	32
United Kingdom	3	1	2	1	2	3	1	1	2	5	21
United States	3	0	1	3	2	4	0	3	0	1	17
OECD average (28)	3.1	2.6	2.1	2.6	2.5	2.1	2.0	2.4	3.4	3.0	25.8

Table 3.A2.1. **OECD disability policy typology: country scores around 2007** *(cont.)*

Panel B. Integration policy dimension (values from 0-5 for each sub-component and 0-50 for the total)

	1	2	3	4	5	6	7	8	9	10	Sum
	Access to employment programmes	Agency responsibility structure	Degree of employer responsibility	Supported employment programme	Subsidised employment programme	Sheltered employment programme	Vocational rehabilitation programme	Vocational rehabilitation timing	Benefit suspension rules	Work incentives rules	
Australia	4	5	3	1	2	3	1	3	5	1	28
Austria	2	3	3	4	4	2	5	4	0	3	30
Belgium	3	3	3	1	5	2	2	3	2	0	24
Canada	1	1	3	3	2	2	1	2	5	4	24
Czech Republic	3	1	4	1	1	3	1	4	0	3	21
Denmark	4	4	2	3	5	2	5	4	5	3	37
Finland	2	2	4	3	3	3	4	4	5	2	32
France	3	2	3	3	5	4	1	2	0	3	26
Germany	4	0	4	5	4	3	5	5	3	2	35
Greece	3	2	3	0	2	3	0	1	0	2	16
Hungary	2	3	4	3	3	2	3	2	4	2	28
Ireland	3	2	2	1	3	2	0	1	1	2	17
Italy	4	2	4	1	1	2	0	2	0	2	18
Japan	3	1	1	3	3	2	2	4	5	3	27
Korea	0	1	1	2	3	2	1	2	1	3	16
Luxembourg	2	4	3	2	4	3	2	3	0	1	24
Mexico	2	2	0	0	0	0	0	1	0	3	8
Netherlands	4	4	4	2	2	4	4	4	2	5	35
New Zealand	3	5	2	2	2	1	0	0	3	3	21
Norway	4	5	4	2	4	4	5	4	5	0	37
Poland	4	2	2	0	3	4	2	2	0	3	22
Portugal	3	2	2	1	2	2	1	1	1	1	16
Slovak Republic	3	2	4	2	2	3	0	2	0	3	21
Spain	4	3	3	1	2	3	2	2	0	2	22
Sweden	3	4	5	2	4	3	3	3	5	0	32
Switzerland	4	4	2	1	1	3	5	4	0	3	27
United Kingdom	4	4	4	3	1	2	1	3	5	5	32
United States	0	0	3	4	1	2	1	1	5	4	21
OECD average (28)	2.9	2.6	2.9	2.0	2.6	2.5	2.0	2.6	2.2	2.4	24.9