ISBN 978-92-64-04968-0
Sickness, Disability and Work
Breaking the Barriers – Vol. 3

Executive Summary and Policy Recommendations

Too many workers leave the labour market permanently due to health problems, and too few people with reduced work capacity are working. This is a social as well as economic tragedy that is common to virtually all OECD countries, including Denmark, Finland, Ireland and the Netherlands that are reviewed in this volume. Health-related problems, or problems labelled as such because of societies' inability to accommodate individual differences, are increasingly proving an obstacle to raising labour force participation rates and keeping public expenditures under control. Yet throughout the OECD area there is a shared paradox that needs explaining. Why it is that health is improving, yet a persistently large number of people of working age leave the workforce and rely on health-related income support? This report explores the possible factors behind this paradox in four countries; highlights the role played by institutions and policies; and puts forward a range of recommendations aimed at improving the situation (see Box 0.1 for more details on the scope of the report).

Box 0.1. **Scope of the report**

Focus of the report

The focus of the report is on how countries' benefit and employment policy systems could be enhanced so as to better match people's work capacities with their employment prospects. Therefore, the main target group of the report is people who could work but do not work, or work less than they could and often would like to. This is why emphasis is put on sickness absence monitoring and the assessment of disability; financial incentives and disincentives offered by the benefit system; and the rights and responsibilities of beneficiaries and workers with health problems, their employers and the various state authorities and municipalities in delivering and structuring benefit and employment policy. Many other aspects of policy important for the integration of people with disability into society at large are outside the scope of the report. This includes, for instance, broader issues of physical barriers and accessible transport and of attitudes of the society towards people with disability. For some groups of people with reduced work capacities these issues can be important for their labour market integration as well. Politically, these issues are much less contested than benefit and employment policies. Transportation, public buildings and private workplaces ought to be accessible for everybody, and available technical aids (*e.g.* for vision or hearing-impaired workers) be made available whenever needed, and OECD countries ought to move into this direction quickly. Non-discrimination legislation is a necessary but by no means sufficient step.

Box 0.1. **Scope of the report** *(cont.)*

Definition of disability and reduced work capacity

Identifying the target group of the report, *i.e.* working-age people with a health problem or disability, is not straightforward (working age is generally defined in this report as the age group 20-64). Disability and impaired health is not a dichotomous category but a complex concept influenced as much by personal characteristics as by "environmental" factors and barriers. Depending on the latter, a person with a health problem or disability may or may not be confronted with a reduced work capacity. The report uses two different sets of definitions, one determined by administrative procedures and the other through self-assessment. The latter and broader one is used to identify all people whose activities of daily living are to some degree, moderately or severely, hampered by their health situation. This is referred to as (self-assessed) *disability prevalence* in the working-age population. Different population surveys in the countries under review allow the identification of this group, noting that resulting prevalence rates are not fully comparable across countries and sometimes even across surveys within the same country. Some of the information for the Netherlands, however, is based on a slightly different work disability definition: People suffering from a long-lasting complaint, illness or disability, which impede carrying out or obtaining a paid job. *Administrative* definitions of disability, on the contrary, are based on often complex and more or less objective assessment procedures, always comprising medical and to some extent also work capacity elements. The main one used in the report is the definition applied by the disability benefit system (or systems, if there is more than one such scheme with different assessment procedures) with the resulting figure referred to as *disability benefit recipiency*. Another definition used occasionally is *legal disability* as determined by administrative procedures for other than benefit purposes (this concept is used in Finland for tax matters). Due to the nature and purpose of these different definitions of working-age disability, resulting figures overlap only partially.

Terminology

Throughout the report as much as possible a uniform terminology is being used. Unless noted otherwise, the term *disability benefit* is meant to include the following benefit schemes: disability pensions in Denmark; statutory earnings-related as well as national disability pensions in Finland; disability allowance, invalidity pension and illness benefit with duration of two or more years in Ireland; and the old (WAO) and the new (WIA) disability insurance benefits as well as the special benefit for people with a disability acquired before age 18 (Wajong) in the Netherlands. For a short description of these schemes, see Box 2.1.

Key lessons from the report

Work needs to be put at the heart of sickness and disability policies, for two reasons. First, in the face of an ageing population, it will be important to maintain effective labour supply. People with reduced work capacity who are highly underrepresented in today's labour markets will be an important resource in this regard. Secondly, however, improving work opportunities is also the best way to ensure that long-term sick people and those with a disability have a chance to play the role in society to which they aspire. Current policies often serve such people badly: they are trapped at the margins of society, excluded from work or marginalised into special employment categories. Helping people with disability stay or return to work should increase overall employment rates and reduce public spending, which further justifies dedicating resources and public expenditures to achieving this end.

Main challenges in Denmark, Finland, Ireland and the Netherlands

The general problem is similar in all four countries under review: large-scale labour market exclusion of people with health problems or disability on the one hand and widespread dependence on health-related benefits putting pressure on the social protection system on the other. A closer look at country-specific outcomes, however, shows that the countries are facing different key challenges, as summarised in Tables 0.1 and 0.2.

Table 0.1. **Main challenges in Denmark, Finland, Ireland and the Netherlands**

Selected key policy issues[a]	Denmark	Finland	Ireland	Netherlands
Controlling incapacity-related public spending	+++	+++	+	++++
Raising employment rates for people with health problems	++	++	++++	+++
Tackling lower incomes of households with disabled people	++	+	++++	+
Reducing the inflow into sickness and disability benefits	+++	++++	+++	++
Addressing the increase in mental health conditions	+++	+++	++	+++
Raising the outflow from permanent disability benefits	+++	+++	++	++
Strengthening co-ordination between actors and systems	++	+++	+++	++

a) The scales should be interpreted as follows: "+" minor challenge; "++" moderate challenge; "+++" substantial challenge; and "++++" formidable challenge.

Source: Authors' assessment.

Table 0.2. **Selected key outcomes in Denmark, Finland, Ireland and the Netherlands**

Selected key outcomes[a]	Denmark	Finland	Ireland	Netherlands
Spending on sickness benefits (in % of GDP)	0.9 (↔)	1.1 (↔)	0.7 (↗)	2.3 (↔)
Spending on disability benefits (in % of GDP)	1.8 (↔)	1.9 (↔)	0.7 (↗)	2.4 (↔)
Employment rate of disabled people (%)	52 (↗)	54 (↔)	37 (↘)	45 (↘)
Unemployment rate of disabled people (%)	7.6 (↘)	14.2 (↘)	7.7 (↗)	8.0 (↗)
Disabled people with less than upper secondary education (%)	35 (↘)	29 (↘)	60 (↘)	44 (↘)
Disabled workers with less than upper secondary education (%)	25 (↔)	20 (↘)	43 (↘)	31 (↘)
Disabled people below 50% of the median income (%)	12 (↗)	8 (↗)	25 (↗)	6 (↘)
Income of disabled people relative to non-disabled peers (%)	86 (↔)	89 (↔)	68 (↘)	84 (↘)
Workers on sickness absence over all workers (%)	5.2 (↗)	6.6 (↗)	4.3 (↔)	4.0 (↘)
Disability benefit inflows in 1000 of the working-age population	4.1 (↔)	9.4 (↔)	8.9 (↔)	3.7 (↘)
Disability benefit inflows with mental health problem (%)	46 (↗)	33 (↔)	. .	43 (↗)
Disability benefit recipients over age 50 (%)	64 (↘)	75 (↔)	51 (↔)	61 (↗)
Disability benefit recipients in % of the working-age population	7.1 (↔)	8.4 (↔)	6.0 (↗)	8.5 (↘)
Annual outflow from disability benefits in % of current recipients	~ 0	1	. .	3.0 (↘)
Inclusion error: non-disabled people on disability benefit (%)	35	31	47	33
Exclusion error: disabled people without benefit or work (%)	5	1	4	8

. . Data not available.

a) Figures refer to 2007 or most recent year available. Information in parentheses refers to the trend in the past few years when it is available: falling (↘), constant (↔) or rising (↗). For an explanation for the relative income poverty figure for Denmark, see the corresponding section in Chapter 1.

Source: Details on the outcome indicators are available from the analytical chapters of this report.

The main challenge in **Denmark** is the continuously high rate of dependence of the population on various health-related benefits despite a series of benefit reforms. A large and increasing share of this concerns people with mental health conditions, making up for almost one out of two new claimants. Related to this trend, the average age of new recipients is falling because more young people are successfully applying for disability benefits. The other side of the problem is that, once on disability benefit, people remain on it until retirement: the outflow from benefit into work is particularly low in Denmark. All this must be seen in the context of the overwhelming responsibility municipalities have for virtually the entire system of social benefits and employment supports; the federal government can only supervise and create incentives for policy to be implemented as intended.

Finland has a number of problems that are similar to those in Denmark: increasing long-term sickness absence and high inflow into disability benefit, with more than 40% of all cases due to mental ill-health, as well as rather low outflow from these benefits. More than in the other three countries, disability benefits are concentrated to the older population. This is partly explained by the use of disability benefits as an early retirement pathway, with every second new claimant being older than 55. Moreover, while employment rates of people with disability are high in an international comparison, as is their level of educational attainment, their unemployment rates (now 14%) are among the highest in the OECD – partly reflecting the higher overall unemployment level in Finland. Added to this is an urgent need for better co-operation across institutions resulting from the fragmented system of vocational rehabilitation.

In **Ireland**, the key challenge is the low rate of employment of people with disability, when compared with most other OECD countries, a rate which has fallen further in the past few years despite a strong economy. Partly this is a consequence of the low level of educational attainment of this group of the population, with 60% having less than upper secondary education. Low employment rates, in turn, also explain the low level of income and the high risk of poverty among households with people with disability. The second main challenge in Ireland is the lack of co-operation of the various employment policy institutions and the fragmentation of the benefit system. The number of disability benefit recipients is still lower than in the other three countries, but continues to increase as a consequence of the continued very high inflow into the many types of disability benefits.

In the **Netherlands**, despite very promising trends in the past few years following a series of very comprehensive reforms, the main challenges continue to be the large number of disability benefit recipients and the very high spending on sickness and disability benefits. Hence, a key concern is to make sure that recent trends are sustainable and not leading to other problems, including higher reapplications, in the future. There is a rapid increase in a number of risk groups for whom sustainable solutions yet have to be found, including people with (mostly mental) disability acquired before age 18 and all those (temporary) workers not covered by the considerable employer responsibilities. Another group of concern are people no longer entitled to a disability benefit due to the higher incapacity threshold, including people who lost their entitlement after reassessment.

Recent policy responses

High and sometimes further increasing dependence on sickness and disability benefits and low and sometimes falling employment rates of people with disability in the four countries under review may to some extent reflect changing labour market requirements. For instance, some have argued that workplaces are increasingly stressful and working conditions surveys find that work intensity has indeed increased. However, one important factor at work in all OECD countries is insufficient policy responses. Disability assessment procedures and benefit systems have long pushed people with reduced work capacity out of work and into long-term benefit dependency. Recognising the key role of policies and institutions in this field, all four countries have engaged recently in reform processes which generally go in the right direction.

All four countries have recently advanced, or are in the process of advancing, inter-agency as well as inter-government co-operation. This is done in recognition of problems arising from people being pushed around between different government authorities; this is not helping those people into work nor conducive to keeping social protection spending under control. In the Netherlands, the employee insurance authority is now responsible for most benefit and labour market policy matters, as are the municipalities in Denmark. Finland is yet further away from a one-stop-shop system but cross-institutional co-operation is increasingly being sought. This is similar to the situation in Ireland, where responsibilities have increasingly been bundled at two government departments. In this context, all countries except Ireland are giving municipalities a key role, and in some cases new roles.

Another more general trend in Denmark, Finland and the Netherlands is the move towards identifying people's capacity, not incapacity. In Denmark, for instance, what is being assessed to determine eligibility for a disability benefit is whether or not a person is able to support herself through either a normal job or a subsidised job – based on a comprehensive resource profile on the person's potential. The same three countries have also made significant steps in regard to better monitoring of sickness absence, so as to be able to identify problems earlier and react earlier, if necessary. Ireland is well placed to do this also, as public authorities are requesting weekly doctor certificates, but is not yet exploiting the possibilities for early intervention.

The largest difference in policy developments between the four countries probably is the extent to which employers are being involved in the reform strategy and the responsibilities they currently face. Finland and especially the Netherlands see employers as part of the solution, while Denmark and Ireland consider sickness and disability policy as an intrinsically public matter. This is why, for instance, sickness absence monitoring is in the hands of the municipalities in Denmark, but an employer obligation in the Netherlands. The latter country has also increased employer responsibilities noticeably over the past decade.

The four countries also offer some interesting lessons as regards the political economy of reform. In particular, it appears that comprehensive structural reform is only likely to happen when there is a widespread perception in the society that the status quo is no longer sustainable. This is how one could characterise the situation in the Netherlands in the mid-1990s, when public spending soared and the number of disability beneficiaries was going to approach the magical one million. Reforms have also taken place in this

country prior to then, but they were small-scale and ineffective. As of the late 1990s, the reform process gained considerable momentum which – over the past decade – led to an overhaul of the entire system, including a new institutional setup, a new disability benefit system, a new focus on vocational rehabilitation and the privatisation/outsourcing of various policy elements. No other OECD country has ever seen so many and so far-reaching reforms in this area.

Ireland is a good example of the opposite extreme. Apart from a number of shifts in responsibilities between different public authorities, the system remained virtually unchanged during the past decades. This can only be understood by the fewer number of individuals on disability benefits compared to other countries. In the past 15 years or so, however, outcomes have worsened dramatically, gradually eroding the system. Today, time seems ripe for a comprehensive reform. This can be seen by the radical shift in rhetoric over the recent years. There seems to be agreement that fiddling around with minor adjustments is not going to solve the problem. So far, little has been done but far-reaching system change is possible in the future, and also necessary.

Change in Denmark and Finland was more gradual than it was in the Netherlands. In both countries reform emphasised the expansion of integration policy with much lesser change on the benefit system side – a reform process sequence found in many countries (OECD, 2007). This is partly explained by the strong involvement in the reform process of the social partners, which in all countries tend to stay away from system retrenchment. Again, it seems that such approach can be upheld if not, or until, problems are getting too severe. Comparing Denmark and Finland, reforms on the benefit system side look more comprehensive in Denmark and more parametric in Finland, but it seems that this principle difference is largely overruled by the way reforms are being implemented.

Indeed, it is not enough to change policy unless changes are implemented rigorously, and in line with the intentions of policy makers. It is necessary to have broad support from all actors to ensure good implementation because changes in legislation often require a cultural change, *e.g.* among caseworkers of benefit-granting authorities. It appears that cultural change of this kind is still lagging behind in Denmark – as reflected in the way the flex-job scheme has been used in recent years. This is also the case in Finland and Ireland, but there it is less visible as policy has not yet changed as much. The Netherlands is probably the only of the four countries where cultural change is occurring in recent years; one example of this is the rigorous reassessment of current disability benefit entitlements. This closes the circle: Implementation is more likely to be following political intentions when a comfortable system has started to erode. Less than a decade ago, for instance, benefit reform in the Netherlands was to a large extent overruled by corresponding changes in collective agreements, which made sure to compensate any benefit losses through corresponding employer-paid top-ups. This is no longer happening to the same degree today.

Lessons from the four countries

The four countries offer interesting lessons and insights in a number of key policy areas. One concerns the importance of financial incentives for the main actors and institutions. Denmark is a forerunner in this regard as it has put in place one of the most interesting examples of how to steer the behaviour of public actors. This is done in the form of an increasingly tightened system of differentiated reimbursement of

municipalities' costs of social programmes, with higher refund from federal budgets for active than for passive intervention. Admittedly, this system was developed in response to big problems in the form of very large cross-institutional differentials in outcomes: In no other OECD country are cross-municipal differences in disability benefit recipiency rates larger. Denmark is still adjusting its system, as it has not yet really delivered, but the approach as such should be copied by other countries. Better financial incentives for main actors, social insurance institutions, public employment services and municipalities in particular, would help to ensure that policy is being implemented as intended, with effective use of public resources and efforts to reintegrate those willing and able to work.

Financial incentives, however, are only one of several important institutional aspects. First, it is necessary to get the institutional structure right. In this regard, Denmark and the Netherlands have made big progress, whereas both Finland and Ireland are still suffering from the fragmentation of their employment policy systems as well as, in the case of Ireland, the benefit system. Once the institutional set-up is sufficiently simple and transparent, the issue of institutional incentives should be addressed – an issue where Denmark has gone further than, for instance, the Netherlands. The third important element is better cross-institutional co-operation, a field in which all four countries (though Ireland to a much lesser extent) were making progress recently. Finally, good governance and monitoring of what institutions are doing, and measuring their performance with regard to some predefined standards, are important. Only then is it possible to identify weaknesses quickly, and react accordingly. In this regard, all four countries (and most other OECD countries as well) have yet to develop new approaches. Denmark has recently developed a new monitoring tool, which will allow much better benchmarking of what municipalities are doing and achieving.

Institutional incentives take new forms where responsibilities are being handed over to private actors – as was done in the Netherlands in recent years. In this country, a number of private players are involved. First, there are private rehabilitation and employment service providers. Like in other countries, *e.g.* Australia and the United Kingdom, performance of these actors is sought to be improved by a system of outcome-based funding. However, in this regard the Netherlands could still do more. The other growing markets of private actors in the Netherlands are the sickness and disability benefit insurance markets. In this case, financial incentives are supposed to regulate themselves by a system of risk-related insurance premiums. Sufficient regulation is necessary to make this work. While private insurance of this kind is becoming increasingly common in other OECD countries as well, mostly in the form of a second and/or third pillar supplementing a public system, in the Netherlands the whole first pillar has been, or is in the process of being, privatised.

Another key player for whom financial incentives matter a lot is the employer. The more responsibilities employers have the more important these incentives become. As mentioned above, Finland and especially the Netherlands have chosen to make employers responsible for large parts of the sickness and disability policy system. The new responsibilities in the Netherlands are extremely far-reaching. Not only have they to pay two years of sick-pay and the first ten (previously five) years of the costs of their workers' disability benefits, but they are also responsible for the reintegration of their workers and even for finding them a job in another company, should it be impossible to retain them in their own company. This is far beyond what employer organisations and unions in the Netherlands could have imagined until a good decade ago. The situation in Finland does

not really compare to that in the Netherlands, mainly because – contrary to the Netherlands – smaller and medium-sized companies are largely exempted from responsibilities in sickness and disability matters.

More responsibilities for employers open new chances for workers to stay in their jobs, but come with the risk of reduced hiring chances for those not, or no longer, in employment. Evidence supports this to some extent, with retention rates for people with disability being slightly higher and hiring rates slightly lower in the Netherlands and Finland (measured against their peers at the same ages without disability). This is not the case in Denmark and Ireland, which are not imposing employer obligations of this kind. The challenge then is to find the right balance between encouraging retention and encouraging hiring. This is not an easy task, although evidence shows that avoiding benefit inflow (by promoting retention) is likely to be much more successful in terms of avoiding benefit dependency than promoting exit from such benefits into the labour market – suggesting that for those with more severe health problems retention gains may well outweigh hiring losses. One response by the Dutch government (and to a lesser extent also the Finnish one) with the aim to promote employment was to exempt employers from their financial responsibilities when hiring workers on a temporary basis.

In essence, it appears that labour market regulations are not going to help enough, even though more efforts could be made especially in countries like Denmark and Ireland to prevent health problems in the first place. In any case, however, it will also be necessary to help those who have health and, therefore, labour market problems. But what is the best way to help them? Mainstreaming of employment supports is seen as one of the solutions. However, evidence shows that countries with a strict mainstreaming approach, like Finland and Ireland, fail to provide employment supports for sufficiently large numbers of people with disability. The Finnish wage subsidy system, for instance, was shown to be effective, but it is helping very few people. To the contrary, Denmark's system of heavily and permanently subsidised flex-jobs is a large-scale scheme, offering employment to some 5% of the labour force. No wonder this comes with enormous substitution and deadweight loss. The right balance needs to be found between the size and the degree of targeting of such schemes.

One of the key elements for good rehabilitation and employment service is better targeting of supports to the actual needs of the person seeking and needing help. Heterogeneous problems need individual solutions. In this regard, Ireland is planning a major reform, which, however, will only deliver if sufficient resources are being made available. Often countries (not only Ireland) operate with too small a number of caseworkers, who are not in a position to deal with every client on an individual basis. There is plenty of information available on what an adequate caseload would be. However, there is a second necessary element: Corresponding participation requirements for those with partial work capacity. Evaluations in other countries, but also in Ireland, have shown that purely voluntary approaches are unlikely to go very far, not the least because clients doubt that employment services have much to offer. More individualised, improved support needs to go hand-in-hand with at least modest participation requirements similar to those in the unemployment scheme, in turn justifying more resources for this purpose. Experiences from the United Kingdom show that regular mandatory caseworker contact, with a strong work focus, could be a first step in this direction – even if the subsequent engagement process was to remain voluntary. All this requires a comprehensive change in approach (from insurance to activation) on the side of both institutions and individuals.

At the same time, it appears that various forms of traditional sheltered employment continue to exist, especially in Ireland (as Community Employment) and in the Netherlands, despite many efforts to scale down these schemes. The issue to what extent such forms of segregated employment continue to be needed is another open question, but their persistence despite changes in rhetoric (preferring supported employment *i.e.* full integration into the regular labour market) suggests that it is unlikely that they will disappear in the nearer future. Instead, intermediary solutions are likely to be growing in the future, combining market features with some form of shelter, or security. This could be a solution, provided there is sufficient transition between this form of employment and regular jobs. Social enterprises in Finland are potentially one example of this, even though their scale is small and transitions into regular employment unsatisfactory. The Danish flex-jobs could become a good example once they are being used by those most in need of support, as originally intended.

Challenges and policy options for Denmark

The current situation

Denmark has a very high overall employment rate of over 77% and a low rate of unemployment of around 3.6% in 2007 (down from 5.7% in 2003). A further increase in structural employment would only be possible by mobilising dormant labour reserves, including especially people with disability. Their employment rate is only around 52% – which is low relative to the rate of their peers without disability, of over 80%, but relatively high in an OECD perspective. In the period 2002-2005, this rate increased by 2 percentage points (following a similar decrease in the period 1995-2002), with most of this improvement being due to the growth in subsidised employment.

This recent trend must be seen against the increase during the past six years in the proportion of working-age people receiving health-related transfer payments from 9.6% to 11.2% – a very high share in an international comparison. Most of this increase concerns three different groups: people on long-term sickness benefits; people employed on a flex-job (a generously and permanently subsidised job for people with reduced work capacity who cannot obtain a job on normal conditions), and people waiting to be placed in a flex-job and receiving a special unemployment benefit (or waiting benefit) in the meantime. The number of people on permanent disability benefit is high but very stable over time, at slightly above 7% of the working-age population.

Behind these trends are two interconnected challenges for the future: first, the increase in the number of young people aged 20-34 receiving a disability benefit (with a 10% increase in the recipiency rate since the mid-1990s) and, secondly, the increasing share of people with mental health conditions on such benefits (which account for 46% of the total inflow into disability benefits in 2007, compared to 26% in 1999). Mental illness is also the greatest challenge for employment policy, with those people having the lowest employment rates. Thus, this trend might also partly explain the recent increase in Denmark in poverty rates of people with disability, which are now some 20% higher than for people without disability.

In conclusion, the recent developments show that a comprehensive disability benefit reform, initiated in 2000 and implemented in 2003, which changed the assessment of disability from a focus on loss-of-ability to ability-to-work and abolished the partial benefit

and the different benefit rates, has not yet unfolded its potential. The rapid increase in the number of people entitled to flex-jobs, without a drop in the numbers qualifying for a disability benefit,[1] suggests that it is often people who used to work in non-subsidised jobs who are attracted by these subsidised jobs. Outcomes also indicate that recent initiatives to reduce sickness absence – through which a model structure was introduced on how authorities ought to follow-up on people who are sick – have so far not delivered.

Partly the problem in Denmark is one of policy implementation, with large parts of social and labour market policy being administered at the municipal level. Indeed, in no other OECD country are there larger differences in disability benefit award rates across municipalities than in Denmark, with a minimum-to-maximum ratio of 1:3 even at the much broader county level. As Denmark is a small country, this is unlikely to be explained by cross-municipal differences in health. This is why the government is trying to steer municipal practices through a system of graded rates of reimbursement of municipal costs – with higher reimbursement by federal funds for active intervention (such as vocational rehabilitation) as a financial incentive to avoid granting long-term, permanent benefits.

Key policy recommendations

The system of financial steering of municipal practices, however, is not new and apparently insufficient. In recognition of this, further reform has taken place in 2006 and 2007 in a number of areas, including the introduction of a better and user-friendly benchmarking tool for municipalities to measure outcomes and compare own practices with those of their neighbours. This should make it easier for poor performing municipalities to learn from the best performers. An amendment of the 2003 benefit reform, in 2006, aims to avoid the frequent referral to flex-jobs without adequate documentation of the fulfilment of eligibility conditions. This was found to be one of the main reasons for the recent (and at this magnitude unexpected) increase in the number of flex-job awards. The effect of this correction, which also lowered the maximum flex-job subsidy, remains to be seen.

This amendment is complemented by structural changes that aim to strengthen even further the employment orientation of the Danish system, which already includes a very comprehensive vocational rehabilitation programme and a far-reaching system of supported employment. First, through municipal structural reform counties were abolished and the 271 municipalities merged into a total of 98. Secondly, new municipal job centres were created, jointly run by the municipality and the PES, which function as a single entry point for employment services for employers and all citizens – thus fostering the employment function of municipalities and their co-operation with the labour market authorities. Again, it is too early to judge the effects of these changes; one expectation is that cross-regional differences in outcomes will become smaller.

More needs to be done to better understand the partial failure of the current system and recent reforms. To bolster most recent and ongoing changes, the Danish government should consider the following policy recommendations, as summarised in Box 0.2.

Box 0.2. **Policy recommendations for Denmark**

The recent reforms have the potential to help reduce benefit dependency and increase employment integration of people with health problems or disability. However, there are still a number of areas which ought to be addressed to further improve policy implementation and to redress the remaining weaknesses of the policy system. Four challenges, in particular, should be taken up in future reforms:

- The restricted influence municipalities have on certain matters, *e.g.* medical assessment.
- The only recently introduced monitoring of municipal policy implementation.
- The limited co-ordination across actors, one of the causes of high sickness absence.
- The increasing number of (young) disability-benefit recipients with mental illness.

Bestow municipalities with the power needed to deliver better outcomes

Maybe the most outstanding feature of Danish policy setting is the overwhelming role of municipalities, which administer almost the entire social and employment system. It is the municipality which grants or refuses a sickness benefit, a disability benefit, a flex-job or any other employment or training measure. That said, some elements of the current responsibility structure are not conducive to optimal outcomes. For instance, general practitioners who are not under the remits of the municipality still play a key role. To make this system fully functional and consistent, even more power will have to be given to the municipalities. In view of this, the following measures should be considered:

- *Strengthen the medical powers of municipal job centres*. Involve municipal doctors early on, ideally in the first eight weeks of absence. In particular, some systematic control of GP certificates and more second opinions at an earlier stage are needed, while making it possible or easier for medical consultants in the job centre to overrule GPs. Eventually, consider following the Swiss model – *i.e.* to establish a regional medical service for a group of neighbouring municipalities, which would take care of all the necessary medical assessments.
- *Resource job centres adequately*. Secure resources for job centres and stimulate investment in competence enhancement of caseworkers. Sufficient resources are needed for comprehensive sickness follow-up, which should be more than an administrative procedure. Evaluate the capacity of the 14 pilot job centres under full municipal control *vis-à-vis* the job centres operated jointly by the municipality and the PES; if the pilot centres turn out to be more effective, full responsibility for employment matters should be given to the municipalities.
- *Move towards a streamlined one-stop-shop service*. Evaluate the recent splitting of employment and benefit matters and take action, including *e.g.* merging job and benefit centres, if necessary. Improve the seamless co-operation between job centres and benefit centres. Consider merging the municipal benefit centres (which deliver cash benefits and sickness benefits) with the municipal welfare offices (which are responsible for disability benefits and other payments).

Better support municipal policy implementation

With the overwhelming responsibilities of the now 98 municipalities, a main problem in Denmark is the large discrepancy between legislation and implementation. This is reflected in large cross-municipal differences in disability benefit awards. The government has chosen to steer municipal policy implementation through financial incentives, but these do not seem to be sufficient to generate the expected behaviour: Poor performers could do better and make more efforts to learn from good practices in other municipalities. This is why a new performance management system was put in place in the course of recent reforms of the employment system.

Box 0.2. **Policy recommendations for Denmark** *(cont.)*

In view of the power of the municipalities, the improvement of outcomes could be supported by the following measures:

- *Empower municipal caseworkers*. While leaving sufficient room for experimentation and innovation, better guidelines are needed for municipal caseworkers on how to achieve good results in managing job insertion, sickness follow-up and flex-job follow-up. Specific outcome targets for job centres should be set, based on results achieved by best performers (*e.g.* in terms of absence follow-up and numbers leaving long-term benefits). Sanctions in case of municipal underperformance should be used carefully but consistently.
- *Strengthen cross-municipal good-practice sharing and learning*. The new, regularly updated benchmarking tool *jobsindstats.dk* should be exploited systematically. This tool should allow analysing and understanding better the large and persistent outcome differences across municipalities. Coherently better outcomes can also be achieved by a larger focus on country-wide dissemination of municipal good practices.
- *Closely monitor the flex-job scheme numbers and changes*. Despite a number of changes to the system in 2006, flex-jobs remain an attractive solution for municipalities, employers and employees alike. Procedures in the case of retention in the same job should be tight to avoid that people able to work under normal conditions are granted a flex-job subsidy. Some element of self-insurance might be warranted to prevent overuse of the system: the salary under a flex-job should be lower than for an unsubsidised job. Moreover, the maximum flex-job wage subsidy will need to be scaled down further. People on waiting benefit, waiting to be placed in a flex-job, should be activated to prevent this new payment from becoming another permanent non-active benefit or a stepping stone before a disability benefit is being granted.
- *Further improve financial incentives for municipalities*. Changes over the years aimed to improve incentives of municipalities to focus on labour market integration. Yet, outcomes suggest that this has not gone far enough. For instance, the reimbursement rate (of 65%) for the municipal costs of flex-jobs is still too high. Similarly, reimbursement should be waived for badly documented disability benefit awards. Another option would be to consider lower reimbursement for the municipality, and lower subsidies for workers and employers, for flex-jobs offered to the *own* workforce so as to stimulate the creation of new flex-jobs for workers who have not previously worked in the company.

Improve co-ordination of municipalities with other actors

More power for the municipalities combined with stringent performance management still misses a third element: the limited co-ordination of municipal action with other actors. This is particularly striking with regard to sickness absence. Despite a very good sickness monitoring system in theory, absence levels are high and increasing, and job retention of sick workers is low. This is partly related to the Danish flexicurity approach, with easy firing of sick workers, but at least partly also to structural weaknesses. Employers and municipalities follow a parallel but hardly co-ordinated monitoring approach, and general practitioners are detached from this process altogether. In improving co-ordination across actors, the following issues should be addressed:

- *Improve co-operation with employers*. In seeking to lower absence rates and raise job retention, municipalities need better links with employers. In particular, they should involve employers in the preparation of their follow-up plan. More pressure needs to be put on municipalities to develop co-operation tools, and more should be done to make that roundtables involving caseworkers, employers and doctors are being used on a regular basis. For instance, reimbursement of municipal sickness benefit payments by the state could be lower if no roundtable had been organised. Such change would be even more effective were financial incentives for employers also being considered

Box 0.2. **Policy recommendations for Denmark** *(cont.)*

so as to stimulate their participation in these roundtables. Moreover, employers should have a one-stop access to the public system, ideally with individual workplace contacts in the respective municipal job centre.

- *Tackle the high level of sickness absence*. Little is known about the high level and recent increase in long-term absence. More research in this regard would be crucial. Every effort should be made to reactivate people faster, fully or partially – by following-up as early as possible. The recent action plan of the Danish government contains a large number of promising proposals which should be implemented swiftly. For instance, the range of support available at an early stage will need to be broadened. If all this turns out to be insufficient, the sickness benefit level should be reconsidered and topping-up payments via collective agreements be regulated (*e.g.* limited to 80% of the wage), as is increasingly common in the OECD. More generally, collective and co-operation agreements should be used to address absence matters. Of particular importance is to monitor and better manage sicknesses of the unemployed, with increased co-operation between municipalities and the unemployment benefit insurance funds.

Address the high disability benefit recipiency of (young) people with mental illness

A big challenge in Denmark is the increasing dependence on disability benefits of young adults aged 20-34 and the increasing share of mental illness as a cause of long-term benefit receipt. There is also a correlation between the two trends because three in four benefit grants for young adults are for mental health reasons. This development is going on for a while and has not been tackled yet. It is especially problematic in view of the permanent nature of disability benefit claims. While the reasons for this OECD-wide phenomenon are not very well understood, a few system changes could help improve the situation. The following changes should be considered:

- *Tackle the high inflow into disability benefit by young adults*. Disability benefits are quite generous especially for young people with reduced work capacity and limited, if any, work experience. This is also a group that is difficult to bring closer to the labour market, because most of them are suffering from mental ill-health. These people would be helped by better work incentives and better-targeted supports, in exchange for tighter participation requirements. There is currently a discussion in Denmark on how best to help those people, including *e.g.* the abolition of disability benefits for people under a certain age or the granting of temporary payments for this group, regular reassessments after five years or the introduction of a new rehabilitation benefit. The pros and cons of any of these approaches should be considered very carefully. In this context, the practicalities of a single working-age benefit are worth further discussion; with the latest benefit reform, benefit level differences across various payments have become very small, for instance.
- *Address the high share of disability benefits caused by mental illness*. First, earlier screening and treatment of mental health problems would help to stop these problems from creating long-term labour market barriers. Secondly, better identification of people's skills and capacity would be needed, with a job certificate for each person with disability, including information on *e.g.* wage subsidy entitlements. Thirdly, active labour market programmes will need to better allow for the needs of people with mental health conditions. New approaches should take account of work as a factor which is good for mental health. Partial return to work – which is increasingly encouraged in Denmark – might be particularly adequate for this group.
- *Consider policies to raise the outflow from disability benefits*. People on permanent disability benefits could be a new target group for policy. Tools to stimulate the outflow from benefits should include the promotion of existing benefit suspension regulations (which allow for suspension of benefit entitlement without a time limit) and regular and more structured reassessments of current entitlements. Through the reimbursement system, municipalities should receive special rewards for each long-term beneficiary brought back to the labour market on a sustainable basis.

Challenges and policy options for Finland

The current situation

Finland's labour market does not look very strong compared to the other Nordic countries. The overall employment rate at 70% in 2007 is still lower than in these countries, while the unemployment rate is much higher, at almost 7%. These levels are indeed closer to the OECD average, which can be explained at least in part by Finland having been struck very hard by the collapse of the Soviet Union in the early 1990s and the subsequent sharp decrease of exports to Russia and its neighbours. Indeed, unemployment peaked at almost 17% in 1994 – it has fallen fast since, and continued to fall fast in the past three years, but has not reached the low level of the late 1980s and early 1990s yet.

However, the benefit system also seems to contribute to high inactivity. The system provides for too small a wedge between work and benefit income and too limited possibilities to combine both – in short, not helping to raise labour supply sufficiently, and fast enough. The share of working-age people receiving a disability benefit was 8.4% in 2007, a high level which remained unchanged in the past five years but is below the 10% peak in the crisis year 1994. However, unemployment also affects people with disability far more often than those without disability.

Sickness absence is also high in Finland, with 5.5% of all workdays lost for this reason, and it has been increasing gradually during the past decade. Much of this increase is due to the increase in long-term absence; absence days of more than three months have increased by almost 50% in the past ten years, compared to a 15% increase for absence days of less than one month. The inflow into disability benefit also continues to be very high, giving little hope for a reduction in overall beneficiary numbers. A very large part of new disability benefit recipients is accounted for by workers over age 55, to a certain extent reflecting the tradition in Finland of using disability benefits as an early-retirement pathway.

Despite the continuously high level of unemployment and health-related inactivity, however, labour shortages are arising in certain branches of the economy. This is the result of a skill mismatch, which in turn is related to the very fast shift in the economic structure towards a globalised service economy. Low labour supply and arising labour shortages in parts of the economy will be further exacerbated by population ageing – one of Finland's current key policy concerns and the driving force for the strong labour market focus of sickness and disability policy.

This must be seen against a level of employment of people with disability of around 54% – a relatively high level in international comparison, partly explained by more people considering themselves as having a chronic health problem or disability (almost one in four of all people in the working-age population, compared to one in six in most other OECD countries); the employment rate of those with more severe problems is around 40%. On the other hand, more than 30% of those having partial work capacity and receiving a partial disability benefit are not in work. Some 33 000 of those currently on an earnings-related disability benefit were found to be willing and able to work, at least occasionally; this is 19% of the current caseload and around 1% of the total labour force.

Key policy recommendations

What is the Finnish government doing in response to these challenges? A major pension reform in 2005, following a series of smaller reforms in the 1990s, made it more attractive for older workers to continue working beyond age 63. This is hoped to rise the average effective age at retirement by 2-3 years. The impact of this reform on the disability benefit system, which is an integral part of the pension scheme, and thus on retirement on the grounds of disability, however, is small. The abolition of a special, own-occupation assessment based, early retirement pension for workers over age 58 with ill-health was compensated by easier entry into regular disability benefits for those over age 60 (now also with own-occupation assessment) – so that the overall disability benefit inflow and recipiency rates remained virtually the same.

In addition, the government is aiming to address work disincentive issues more broadly, through a comprehensive reform, or overhaul, of the social protection system. The ultimate goal of this reform, the details of which are not known at this stage, is to better exploit the work potential of those currently inactive and, usually, on benefit. This effort is likely to result in changes to unemployment benefits, maybe including a reduction in payment over the duration of unemployment, as has become common in many OECD countries. The effect on disability benefits remains to be seen.

Following the downsizing of the network of sheltered work centres during the economic recession in the early 1990s, active labour market policy in Finland started to adopt new approaches to support people with disability. Since the mid-1990s, the European Social Fund has also contributed to the implementation of new projects targeting both long-term unemployed and jobseekers with disability. The take-up of schemes for the latter group, however, was and still is low, and the focus of the PES is only shifting away from fighting structural unemployment very slowly. One major challenge is the large number of different actors responsible for people with disability. The newly established Labour Force Service Centres are a first step to improve cross-institutional co-operation by bringing the PES and the municipality closer together. However, these centres predominantly help people with a combination of labour market and social problems, with only one-third of the clients having a health problem.

To reduce benefit dependency and improve employment chances of people with health problems or disability, much more will need to be done. To this end, the Finnish government should consider the following policy recommendations, as summarised in Box 0.3. Moreover, measures in those areas could be helped by streamlining the assessment of disability and work capacity.

Box 0.3. **Policy recommendations for Finland**

Ongoing and recent reforms in Finland have shied away from addressing the situation of people with disability more forcefully. Changes are needed in a number of areas, including the following in particular:

- The fragmentation of the system of vocational rehabilitation.
- The limited focus of the mainstreamed Public Employment Service on the participation and integration of people with long-term health problems or disability.

Box 0.3. **Policy recommendations for Finland** *(cont.)*

- The widespread use of disability benefits as an early retirement tool.
- The potential, and the remaining challenges, of the strong employer responsibilities.

Streamline the fragmented vocational rehabilitation system

The system of activation and vocational rehabilitation is highly fragmented, with a number of different actors responsible for different groups of the population at different points in time. Key players are the PES for unemployed jobseekers with disability, the general and occupational health care system for people with long-term illness, the accident and motor liability insurance institutions for people with work and traffic accidents, respectively, the authorised pension insurance institutions for workers with sufficient work history, and the social insurance institution for those with limited work history and those not covered by anyone else. Municipalities also play a residual role. Just to understand who is supposed to do what for whom at what stage is almost impossible – for any potential client, but also for the authorities involved. The following measures would improve the situation:

- *Raise the accountability of actors*. The current system of rehabilitation service provision has to be simplified. Changing the funding streams would be an option; different possibilities for doing this should be explored by the Advisory Board for Rehabilitation. To increase the transparency of the system and avoid that people are being shifted around between the various authorities, two concepts should be promoted. First, it would be important to create a single entry point into the system for those concerned. Secondly, once a person is in the system, one authority should carry responsibility for the case from the beginning to the end so as to ensure effective services.
- *Improve the co-operation of rehabilitation authorities*. At the very minimum, the 2003 Act on Co-operation on Client Services within Rehabilitation should be further developed and include binding co-operation between rehabilitation authorities. This should contain earlier and ongoing, clearly-regulated information exchange between the authorities involved, including the private pension providers, to ensure timely intervention. Better co-operation and information exchange with the PES is particularly important (certainly for KELA but also for the private pension providers) so that PES activities are not coming too late. There is also a need for better co-operation with the occupational health service sector in preparing a rehabilitation plan.
- *Introduce a mutual responsibilities framework*. People with disability should be obliged to take part in rehabilitation activities as a condition of benefit receipt if an improvement in work capacity is likely. Consistent with the enhanced responsibilities for rehabilitation institutions, the currently existing right to vocational rehabilitation for the individual should be matched by corresponding participation requirements. Reform in Switzerland in 2005 could serve as a yardstick on how this could be done.
- *Streamline the rehabilitation benefit system*. In line with efficiency improvements in vocational rehabilitation responsibility, the various rehabilitation benefits and allowances should be merged into a single payment.

Increase the focus of the PES on people with disability

During the 1990s, the main aim of the PES was to fight the high rate of unemployment. Much less attention was given to unemployed people with health problems or disability and this is still very much the picture of today. Disability benefit recipients, for example, would generally have difficulties in accessing services offered by the PES. This situation is mirrored in the newly-established Labour Force Service Centres (LAFOS), which were set-up for clients in need of integrated, more intense case-managed support, but due to resource constraints are not able to serve all potential customers. The

Box 0.3. **Policy recommendations for Finland** *(cont.)*

following measures would help to raise the take-up of mainstreamed services by people with ill-health or disability:

- *Ease access of people with disability to PES measures*. Improve access to and take-up of mainstream services of the PES for those groups which are underrepresented, including long-term sick unemployed, (partial) disability benefit recipients willing and able to work, self-employed with health problems and denied disability benefit applicants. This will require more financial and staff resources for the PES.
- *Improve PES governance*. There is a lack of (and lack of interest in) monitoring and evaluating programmes offered by the PES, especially since funding by the European Social Fund has stopped. In a first step, better measurement is needed of outcomes of services for different client groups (especially but not only groups with different levels of disadvantage). In a second step, quantitative targets on outcomes and placement rates should be considered for various groups of people with reduced work capacity.
- *Strengthen the Labour Force Service Centres*. Better integrate the municipal and the PES part of the LAFOS and involve KELA as an equal partner so that its rehabilitation expertise can be fully exploited. Evaluate the different operation methods put in place in the 39 LAFOS across the country to identify the most promising approach. Make sure that people with health problems can access these integrated services. More generally, consider using the LAFOS approach (multi-professional team; post-placement and job-to-job support) for all clients who are disadvantaged and out of work for, say, at least six months.
- *Promote the use of wage subsidies*. Evaluate the wage subsidy scheme to better understand *i)* the impact of the reform of the system in 2006, *ii)* the causes of the limited use of the scheme for people with disability and *iii)* the low take-up of the pay subsidy voucher, which is given to jobseekers directly. Modify the system in line with the findings of these evaluations. For instance, make sure that PES caseworkers encourage the use of the scheme and that the administrative procedure is not seen as an unnecessary burden by employers.

Address the widespread use of disability benefits as an early retirement tool

Every year, one in hundred working-age people in Finland leave the labour market via disability benefit. 47% of all new recipients are in the age group 55-64 (compared to 18% in the Netherlands and 29% in Denmark), with the inflow rate for the 55-59 age group being seven times higher than for the 35-39 age group, for instance. As a result, more than one in four of all 60-64 year olds receive a disability benefit – demonstrating that this scheme continues to be used as an early retirement instrument. Pension reforms have addressed the issue of early labour market exit more broadly, but with little attention to the disability benefit system. The following measures would complement hitherto benefit reforms and help avoid shifts onto disability benefit in the course of the also needed phasing-out of the "unemployment tunnel" (*i.e.* the easier access for the unemployed over age 57 to continued unemployment payments, followed by early retirement from age 62):

- *Modernise work capacity assessments*. Assessments should put a stronger focus on remaining work capacity, and less on medical conditions. The same disability assessment should be used for workers of all age groups: the easier access for those aged 60-64 is a strong invitation to retire on the grounds of disability. Similarly, public sector employees – local government as well as state employees, together around 20% of the workforce – should be assessed on the same grounds rather than on an own-occupation basis.
- *Bring labour market flexibility in line with capacity assessment*. Partial disability benefit for people with partial work capacity should be granted irrespective of the actual availability of a part-time job, while allowing for a combination of partial disability with partial unemployment benefit.

Box 0.3. **Policy recommendations for Finland** *(cont.)*

Problems of workers with reduced work capacity should be addressed in collective agreements, including aspects of lower working hours and lower wages. This could, for instance, include regulations allowing a partial return to work in case of partial recovery from an accident or illness. In line with this, it may also be necessary to make public *partial* sickness allowance accessible earlier (*i.e.* not only after a period of 60 days of full sickness allowance receipt).

- *Make work pay*. Pay more attention to the incentives created by the disability benefit system in combination with the various disability and tax allowances. For instance, a gradual phase-out of disability benefit when earnings exceed allowed limits, for both full and partial benefits, would make it more attractive to combine benefit and work income. To further stimulate job-search efforts, in-work payments targeted to low-wage earners with disability could be considered. Evaluate the system of tax deductions to see if they are an effective instrument to compensate for the higher costs of disability.

Consolidate the extensive employer responsibilities

By way of a comprehensive system of occupational health care and experience-rating of employer premiums to the disability benefit scheme, employers are involved very much in sickness and disability policy. Challenges arise from hiring disincentives stemming from the experience-rating system and from the large variation in, and the unequal access to, occupational health services (OHS). OHS schemes vary considerably across industries and firms, and large parts of self-employed, farmers and workers in SME's are not covered. To address some of these issues, including the situation of unemployed people, the following measures should be considered:

- *Expand occupational health care*. OHS coverage should be raised nearer to 100% and the quality of services improved. Raising coverage would mean to make OHS mandatory for entrepreneurs and self-employed and to put in place an OHS-like system for the part of the working-age population without a job. The *Work Health Clinics* pilot, which also draws on experience from the farmer's pension pilot, should develop a model on how this could be done. Improving OHS quality could be done by giving higher priority in these services to effective sickness and rehabilitation management. For SMEs, it would be important that OHS operate more closely at the workplace, with regular workplace visits.
- *Strengthen the experience-rating system*. More should be done to better understand the impact of the experience-rating system in place for financing disability benefits. Consider new measures to counterbalance the reduced hiring incentives arising from the scheme, such as targeted payroll-tax reductions for employers hiring people with disability. The Dutch "no-risk policy" could serve as a model on how to design such policy. Some form of experience-rating for SMEs could also be considered, at least for a limited number of years of disability benefit payment, to raise small employers' interest in good sickness management.
- *Improve sickness management*. Sickness management guidelines currently developed by the Ministry of Social Affairs should be disseminated, and employer awareness risen about workplace responsibility for sickness monitoring and management. Mandatory notification of employers to KELA upon day 60 should be enforced; no reimbursement of sick pay should be granted without notification; retrospective reimbursement (which explains the much delayed reporting to KELA by the employers concerned) should be abolished. GPs should be trained about the potential of early action so as to prevent long-term absences.
- *Improve the situation of sick unemployed*. Better sickness management is needed for people without an employer. Unemployed who are sick and unable to fulfil their job-search requirements should be obliged to report sick so to be geared towards a sickness management and early intervention process and avoid worsening of their health. This will require more resources in the short run to reduce costs in the long run.

SICKNESS, DISABILITY AND WORK: BREAKING THE BARRIERS – VOL. 3 – ISBN 978-92-64-04968-0 – © OECD 2008

Challenges and policy options for Ireland

The current situation

Ireland has gone through a long period of sustained economic growth: around 9% per annum in the 1995-2000 period and 4.7% per annum since 2000. Only very recently is there a sign of a slowdown. The strong and protracted economic expansion has translated into enormous job creation. Due to both population growth (owing to high fertility in the past and significant immigration more recently) as well as economic growth, the labour force has almost doubled within slightly more than two decades. Disappointingly, however, job growth has not translated into higher employment rates of people with disability: this rate has actually fallen in the most recent past and now stands at 32-37% (depending on the data source used), which is only half the rate of people without disability.

Unemployment rates have also fallen rapidly in the late 1990s, but stayed at around 4-4.5% ever since 2001. This fall in unemployment was a consequence of economic development but also of tighter unemployment benefit rules and better case management of the long-term unemployed (not including those on disability payments). People with self-assessed disability, however, have a higher likelihood to be unemployed and long-term unemployment in particular is more frequent.

Moreover, like in many other OECD countries, part of the decline in unemployment was offset by an increase in the number of recipients of long-term sickness and disability benefits. Numbers on these benefits have more than doubled since 1990, partly explained by improvements in qualifying conditions after 1996, with a general shift from short to long-term payments and from insurance to non-contributory, assistance-type entitlements. The share of working-age people on such long-term sickness and disability payments gradually increased from 4% in 1990 to 5% in 1998 and to 6.3% in 2007, thus having surpassed the OECD average of around 5.5%. Given the continuously high rate of annual inflow into those schemes, this share is set to continue to increase.

Related to their low employment rate and the high dependence on public income support payments (which are all flat-rate at around 30% of the average wage), poverty rates of people with disability are very high – exceeding the levels of people without disability by a factor of 2.5 or more on both a relative and an absolute poverty measure. Even on the latter more restrictive measure, which in Ireland is referred as "consistent poverty", one in six people with disability are income poor.

Key policy recommendations

Ireland has just started to react to the increase in exclusion related to poor health and disability. Compared to most other OECD countries, systems and structures in place are still quite traditional, passive and reactive. The Department of Social and Family Affairs (DSFA) had been given the responsibility for most benefit payments more than a decade ago, and employment matters were mainstreamed in 2000 when the Irish Public Employment Service (FÁS) became responsible for the training and employment support of people with disability as well. Yet, this has changed relatively little in real life: The benefit system remained highly fragmented, and employment supports continued to be predominantly in the form of either specialised training offered by specialist providers or

Community Employment in a sheltered environment, both rarely leading into open employment.

It has to be said, however, that many of the current problems are well recognised and various changes planned or at least discussed. In the context of the National Disability Strategy, launched in late 2004, some of the main current challenges are in focus. The DSFA is planning to develop a customer-oriented active case management approach for all working-age people on social welfare payments, whether they are unemployed, lone parents or people with disability, which will be initiated upon benefit claim application. In addition, an ESF-funded proposal aims at developing employment strategies for people on disability welfare payments. This is in parallel to initiatives by the Department of Enterprise, Trade and Employment (DETE) to develop a comprehensive employment strategy for people with disability, with caseloading of new registrants and enhanced service effectiveness.

Taken together, these changes have a lot of potential, in particular if they were implemented in a mutually supportive manner. With employment and benefit matters remaining in the hands of two different departments, effective inter-departmental and inter-agency co-operation will be crucial. This is particular important in view of the case management approach to be introduced by the DSFA: this new process should not get in conflict with the National Employment Action Plan used by FÁS for the activation of the unemployed, which has a very similar rationale. The jointly-agreed co-operation protocols between various government departments, including DSFA and DETE, recognise the need for collaboration for the first time. The next step will be to implement these plans and to develop the details of how different departments and agencies are going to co-ordinate their actions.

The time is ripe for comprehensive reform. In this process, the Irish government should consider the following policy recommendations, as summarised in Box 0.4, which also elaborates the essential criteria for implementing planned changes successfully. All this would be greatly helped by further developing the evidence base to facilitate policy making.

Box 0.4. **Policy recommendations for Ireland**

Current reform plans are very ambitious. Implementing this shift from new rhetoric to new policy will not be easy because a series of changes to various components of the policy system will be needed to improve outcomes. Forthcoming reforms should especially address the following issues:

- The lack of systematic engagement with people with chronic health problems or disability.
- The fragmentation of employment supports and the little attention given by the Public Employment Service to people with long-term health problems or disability.
- The fragmentation of the benefit system and the limited consideration given to remaining work capacity in assessing eligibility for long-term disability-type benefits.
- Poor incentives for people with health problems to seek work and for employers to retain or hire them.

Introduce systematic engagement with customers

Systematic engagement with people with health problems or disability is lacking, even though major changes are likely to be forthcoming. Currently, employment services are fairly detached from the benefit application process, and the take-up of services is on an entirely voluntary basis.

Box 0.4. **Policy recommendations for Ireland** *(cont.)*

Unsurprisingly, therefore, the take-up of employment and training measures is very low, with few new claimants of disability-related payments ever having received any services. The following should be done:

- *Implement the planned framework of systematic engagement as quickly and rigorously as possible***.** The planned customer-oriented intensive engagement with the DSFA upon claim application has the potential to change the nature of the system radically. The new approach should include *i)* profiling at application stage including, if needed, profiling in stages for people more distant from the labour market, *ii)* early identification of support needs, with timely referral to FÁS, and *iii)* systematic outcome monitoring with the aim to adjust and improve the system accordingly. Experience with the *Renaissance* pilot could be useful in determining the details and success features of the engagement process.
- *Resource this new process adequately*. For the system to deliver also for people with health problems or disability, it will be important that the new engagement procedure is applied with rigor to all benefit applicants. This will most certainly require more resources for DSFA than currently planned: Assuming that the maximum clientele a caseworker can realistically serve is around 100, there is a need for around 150-200 facilitators in total (rather than the current 40 plus approved 30 additional facilitators) to put this system in place.
- *Put strong emphasis on linkage points*. Systematic engagement can only deliver if the DSFA collaborates closely with other actors. Particularly important is the co-operation with FÁS, which should function as the only focal point for training and active labour market policy (see below). Referral to FÁS should come as early as possible, and DSFA should be informed regularly about the progress being made so to take necessary further steps, including work capacity assessments when indicated. This will help avoid duplication of the work of FÁS advisors and DSFA facilitators.
- *Extend activation and conditionality approach to disability payments*. Unless some form of conditionality was brought into the process (which is not planned), outcomes are likely to be disappointing. This was clear from the failure of a recent local pre-pilot, with similar engagement elements. In a first step, a mandatory interview process (along UK's *Pathways-to-Work* scheme) should be introduced. In a second step, further participation requirements will be needed, at least for some groups. Notably, young benefit claimants and recipients (in particular those claiming disability allowance which is non-contributory) should have education and training participation requirements.

Boost the quality of employment support for people with disability

Despite a commitment to "mainstream" employment services, which goes back almost a decade, more than 80% of all services offered to people with disability are specialist services. Too often, these are seen as an end in itself, rather than a means to an end, *i.e.* a transfer into open employment. There is a lack of monitoring of what the providers of these services are doing. People with disability can enter the employment support system through different doors, with the results of the activation process depending on which door, or institution, initially chosen. This situation should be changed by implementing the following reforms:

- *Move towards a one-stop-shop approach***.** FÁS should be the only entry point for individuals seeking training and employment services; today one can enter the system through either FÁS, the local employment service (LES), the Health Service Executive, or a specialist training provider (STP). Direct course recruitment by a STP without agreement by FÁS, for example, should be disallowed. Generally, FÁS should assess needs and refer the person to the most appropriate entity or provider network. This one-stop-shop, or gateway, structure would be a necessary complement to the systematic engagement process of the DSFA.

Box 0.4. **Policy recommendations for Ireland** *(cont.)*

- *Improve performance management*. Much can be done to improve the performance of FÁS and LES offices and the services provided by STPs – with STPs and LES receiving direct funding by FÁS. Supervision and monitoring should include the introduction of measurable disability-related output and outcome targets for FÁS at national and regional level and for the local FÁS and LES offices and the STPs. DETE should set the overall objectives, while FÁS should administer funds and manage and monitor the use of those funds. Moreover, the disability competence of FÁS and LES staff should be developed in order to translate the mainstream rhetoric into mainstreaming of services; maybe by having one specialist caseworker in each office, as in Denmark. Good governance also requires the development of an evaluation culture, *e.g.* by reserving a certain share of the budget for each programme for impact measurement.
- *Boost the quality of specialist services and build bridges to mainstream support***.** Specialist training by private, non-profit providers should be improved by a system of certification of providers and stringently applied quality-assurance regulations. The current annual bulk funding should be replaced by outcome-based funding of services, at least in part, with provider accountability as a way of promoting outcomes in a competitive provider market. In addition, new pathways will have to be developed from rehabilitative into mainstream training and further on into employment. The forthcoming pilot bridging programme between rehabilitative and vocational training is a first step in this direction. Following the one-stop-shop approach, there should be automatic flags to FÁS upon completion of rehabilitative training with a STP and automatic re-referral to FÁS after the end of a training programme so that FÁS can make an independent assessment of further needs.
- *Strengthen FÁS' work with employers*. FÁS should also be the single point of entry for employers seeking to retain a worker with health problems or to hire a person with disability. Employers should be provided with a contact person in their responsible FÁS office. FÁS caseworkers should make efforts to improve the quality of matching of job requirements and jobseekers' abilities to help increase the number of placements of people with disability.

Modernise the benefit system and the disability assessment process

There is a range of different health-related payments which can be received on a long-term basis. Benefits are categorised as to whether or not the person had a sufficient insurance record, a long-term disability, a work-related condition, a special type of disability, or a combination of these. This multiplicity creates inefficiencies which in turn lead to ineffective policies. Assessment procedures in place to determine eligibility to the various payments differ and very little attention is given in granting benefits to the claimants' remaining work capacity. The following changes should be considered to make the system more coherent and work-focused:

- *Transfer benefit responsibility to the DSFA*. In line with a recent Government decision, in a first step the responsibility for those benefits which are still managed by the DHC should be transferred to the DSFA as quickly as possible, so to have all benefits bundled in one institution. This shift should affect the Infectious Diseases Maintenance, the Blind Welfare and the Mobility Allowance, but also the Supplementary Welfare Allowance (Ireland's social assistance payment, which is administered by the Health Service Executive).
- *Rationalise sickness and disability benefit schemes*. In a second step, some of the existing payments should be merged. With the same type of systematic engagement by the DSFA for all benefit claimants, a single disability-related long-term benefit would be the most appropriate solution in the longer run. This could also be a stepping stone towards a single working-age benefit, irrespective of the contingency causing labour force exit, as is currently under discussion in a number of OECD countries. Alternatively, a single means-tested payment for all people of working age could be aimed for, as has been called for on a number of occasions (*e.g.* in the 2004 *Review of the Illness and Disability Payment Schemes*).

Box 0.4. **Policy recommendations for Ireland** *(cont.)*

- *Strengthen the assessment process***.** Alongside the integration of various types of long-term disability-type payments, but also if such integration does not take place, the assessment of disability should be improved. In particular, rather than merely testing benefit eligibility requirements, the focus on remaining work capacity should be strengthened. The Australian Job Capacity Assessment could be taken as a reference in this regard. There is lots of untapped employment potential of claimants of long-term payments which could be better identified by a more stringent and better developed medical and vocational assessment. This will have to be built into the systematic engagement process of the DSFA. Moreover, more emphasis should be put on more-clearly defined reassessments for all groups of benefits.
- *Reconsider the current illness benefit regulations*. In relation to the above recommendations, particular attention should be given to the structure of illness benefit, which many people are receiving on a long-term basis. Paying sickness benefit without time limitation is very unusual across the OECD, for good reasons. There is a great risk that those people will never return to the labour market, and this risk is particularly strong for unemployed people on such benefit. Illness benefit payments should be limited to, say, one year: people would have to apply for a long-term benefit thereafter, thus being channelled through a comprehensive work capacity assessment (as recommended above) at that time.

Improve financial incentives for workers and raise the involvement of employers

Strong work disincentives for people on disability benefits arise from the loss of secondary benefits upon moving into work. The main secondary benefit coming with income support entitlement is the Medical Card which guarantees free health care for the entire family. A number of changes were done recently to alleviate this problem, *e.g.* it is now possible to keep the Medical Card for three years after having moved into work. However, behaviour has not really changed, partly because recent changes were insufficient to overcome the psychological barriers arising from a fear to lose secondary benefits. At the same time, the potential of *employers* being part of the solution for raising labour market participation of people with health problems or disability is largely untapped. The following changes would help to improve employment outcomes:

- *Improve access to health care*. Access to health care is a main issue in Ireland, because of the entitlement to a free Medical Card for recipients of disability payments. About half of the Irish population is covered by private health insurance and some 30% are entitled to the Medical Card, leaving a considerable share of the population uncovered. The problem of incentives to stay on benefits because of fear of losing the Medical Card will have to be addressed more forcefully. One solution, currently under consideration in the DHC, would be making entitlement to a Medical Card independent of benefit status, thus giving people permanent access to the card once assessed as having a disability.
- *Improve work incentives*. In addition, work incentives will have to be addressed more broadly. Policy to this end should include better promotion of existing regulations (such as the income disregard for disability allowance recipients and the rather effective Back-to-Work Allowance) and better integration of these tools with *e.g.* the Wage Subsidy Scheme which is targeted at employers. Permanent in-work payments would be the most appropriate tool for encouraging people to use their remaining work capacities. The Family Income Supplement, which is effective in improving work incentives for low-income families with children, is one example of how this could be done – provided take-up of such payment can be raised to a satisfactory level.
- *Promote partial return to work*. Another issue in relation to work incentives is the general lack of flexibility for work which could better accommodate people's health problem or disability. Labour agreements should address this issue. The potential of a partial return to work for recipients

Box 0.4. **Policy recommendations for Ireland** *(cont.)*

of shorter-term payments (illness benefit in particular) should be explored; *e.g.* by broadening the exemption scheme so as to include jobs with the previous employer, in combination with a reduced illness benefit payment rate. Denmark and Finland, for example, are promoting partial sickness absence (payments) recently with some success.

- *Address the low level of income of people with disability.* Evaluate the range of assistance currently available to mitigate the additional costs incurred by people with a disability. Consider introducing more adequate payments to compensate these costs so as to reduce the high level of income poverty of this population group. Any such payments should be independent of the work status and separate from income support payments. The results of the ongoing needs assessment process underway in the DHC should be used to determine the appropriate level of such cost-of-disability payments.
- *Strengthen the involvement of employers*. Seek ways to involve employers in the planned process of systematic engagement of the DSFA, *e.g.* by including them into the preparation of a return-to-work or rehabilitation plan, with some rewards for those employers participating in the process. Investigate the potential of strengthening the financial incentives for employers *e.g.* by introducing a mandatory period of employer-provided sick-pay – some private-sector firms do this already and public-sector employees have very generous sick-pay regulations.

Challenges and policy options for the Netherlands

The current situation

When it comes to sickness and disability, no other OECD country has such an interesting story to tell as the Netherlands. First, sickness absence fell from 10% in the late 1980s to only 4% today. More recently, the inflow into disability benefit also dropped remarkably, from almost 12 per 1 000 in 2001 (and in fact during most of the two decades prior to the turn of the century) to around four per 1 000 in 2007. Eventually, from 2005 onwards, the total number of people on disability benefit also started to fall. This success is a consequence of a series of very comprehensive reforms, characterised by a shift of responsibilities to employers and employees, a tightening in benefit eligibility and generosity, and a (partial) privatisation of hitherto public schemes.

In the 1980s and 1990s, the country was the world champion in disability benefit recipiency. This poor starting position to a considerable extent helps to explain the widespread perception of the need for a comprehensive reform. However, compared to most other OECD countries the level of disability benefit recipiency today is still very high, and it remains to be seen where the disability benefit *inflows* will converge to in the medium to longer run. Following the sudden drop in inflows after reform, the inflow rate is creeping up gradually: in 2007, it was 50% higher than in 2005; however, this is still 40% below the 2004 and 65% below the 2001 level. That said, in the past three years the inflow level was so low that the "success" of the reform could become its worst enemy, with the government being pushed into re-establishing the earlier system generosity, at least partly.

Another uncertainty comes from the large-scale systematic reassessment of those already on disability benefit, the success of which is also contributing to the recent developments. Through this process, which started in 2004 and will be completed in the

first quarter of 2009, one-third of all recipients are either getting their entitlement reduced or losing eligibility altogether. Analysis suggests that many of those are moving into work (62% are in work one and a half year later, including those already in work before the reassessment) but the quality and stability of these new jobs are often low. Earlier large-scale reassessments of this kind (like in the United States in the mid-1980s and also in the Netherlands in the mid-1990s) have resulted in larger inflows into disability benefit in subsequent years. Until now, the data do not indicate a similar effect in the current operation and the numbers finding work keep increasing. However, this will have to be monitored over a longer period.

The flip side of the Dutch success story is the persistently low level of employment of people with disability, which has fallen further in 2002-2005 in the course of reform, both in absolute terms, from 47% to 44%, and relative to that of people without disability (the figures for 2006 show no further decline). Over the same period, the rate of unemployment of people with disability has increased by 3 percentage points, from 5% to 8%, while it increased by less than 1 percentage point for people without disability. These figures may indicate that people with disability are more vulnerable on the labour market in times of a weakening economy, an effect that may be increased by the remarkable financial responsibility employers have for their employees. There is no research available on this issue, however.

Also in terms of benefit recipiency, one trend is striking: the fast increase in the number of young people under age 25 receiving disability benefits. The number of 15-19 year olds on such benefit has almost tripled in the period 1999-2006, and in the 20-24 age group it increased by more than a quarter. Almost all of those people are receiving a Wajong benefit, *i.e.* a special largely unreformed disability benefit for people with disability acquired before age 18. Partly this increase reflects a shift of people from municipal social assistance onto national social insurance records, partly reduced non take-up and partly a broader failure of society and schools to integrate people with autism and Attention-Deficit Hyperactivity Disorder (ADHD)[2] – the two fastest growing subgroups. In May 2008 the Dutch Government announced plans to restructure the Wajong benefit. For most of the applicants, final assessment will be delayed until age 27. The main objective is to focus on work and assistance needed to get into work.

Key policy recommendations

The Dutch government is well aware of the low employment rate of people with disability and is trying to tackle this issue in several ways. One is the further improvement of the reintegration market, a market which was created a few years ago when reintegration became a main policy issue. Improvements mainly relate to better, outcome-based, funding arrangements. Another recent response is the further streamlining of employment policy responsibilities, with the employee insurance authority (UWV) having become the main actor and with strengthened co-operation between this authority, the former PES and the municipal authorities. In 2009, the UWV and the PES will be merged fully to further improve the match between labour supply and labour demand.

A third riposte to the low employment rate of people with disability is the further extension of the so-called "no-risk policy", *i.e.* the number of cases in which employers are exempt from their far-reaching responsibilities, either temporarily (*e.g.* if hiring a sick

worker) or permanently (*e.g.* if hiring a person receiving a Wajong benefit). This will be complemented by new hiring subsidies in 2009. Finally, the most recent benefit reform, which came into force in 2006, will also tackle the low employment rate of people with reduced work capacity. The main aim of this reform is to improve work incentives for those people who are able to work: people with 15-34% earnings capacity loss are no longer entitled to a disability benefit and for those with 35-79% earnings capacity loss (or full but temporary capacity loss) the benefit level will depend on the amount of remaining capacity actually used in the labour market.

Some of these recent reforms and the last benefit reform in particular have also created new challenges for some sub-groups of the population, such as people no longer qualifying for a disability benefit, people who lost their benefit entitlement and people on benefit willing but unable to find a job matching their capacity. Further adjustments are necessary. To this effect, the government of the Netherlands should consider the following policy recommendations, as summarised in Box 0.5. Also important are further studies on the long-term impact of recent and ongoing reforms.

Box 0.5. **Policy recommendations for the Netherlands**

Although the Netherlands have gone through so many reforms in the past decade and are still discussing other actions, and although many of the recent changes will need to settle down to unfold their impact, a number of further adjustments seem necessary. These should cover the following areas:

- The fast increase in a number of risk groups ("Vangnetters" and "Wajongers").
- The still insufficient co-operation between the UWV and other actors.
- New inequality issues arising from reformed regulations.
- The remaining weaknesses of the private reintegration and insurance markets.

Respond to the increase in the number of "Vangnetters" and "Wajongers"

The share in the inflow into disability benefits of those who have not received employer-paid sick pay for two years prior to being granted a disability benefit has increased to 40%. This group (the "Vangnetters") includes people on temporary contracts who lost their job during the two years, but also people still employed but with a *no-risk* label. The UWV has the same responsibilities for these workers as employers have for theirs. Another group increasing very rapidly in size are those receiving a special disability benefit on the grounds of a disability acquired before age 18 (the "Wajongers"). To some extent this increase seems to be the result of the inability of families and schools to cope with the increasing demands of society (thus requiring changes *e.g.* in the special education system, which are beyond the scope of this report). A third group to which the UWV will have to pay more attention are those reassessed and taken off the disability benefit caseload. The following measures should be taken into account:

- *Better assist public sickness benefit clients*. UWV should make its role as a quasi-employer transparent and increase internal incentives to improve results. In particular, UWV caseworkers should follow the gatekeeper protocol rigorously, with strong reintegration plans and tight participation requirements for sick people early on. Seek contact with employer networks and temporary work agencies. For those who still have an employer (*i.e.* the no-risk group), joint employer-UWV responsibility calls for a strong co-operation of the caseworker with the worker's line manager to ensure a fast return to work. To achieve better results, outcomes of the activation of sickness benefit clients should be monitored, targets specified, and the introduction of (soft) sanctions considered for local UWV offices that perform badly. This will

Box 0.5. **Policy recommendations for the Netherlands** *(cont.)*

require a stronger role for the central UWV, which should, in a first step, publish the outcomes of local offices on its website.

- *Tackle the increase in Wajong beneficiaries*. Restructure the Wajong benefit into an active payment by focusing on the work capacity of (potential) claimants, while increasing participation requirements and improving reintegration supports. Assess Wajong benefit claims in regard to *work* rather than earnings capacity, because most applicants have no previous earnings experience. Apply the logic of the WIA benefit reform, which distinguishes full benefits for people with full and permanent capacity loss from wage subsidies for people with partial or temporary loss, to the Wajong scheme. Consider to reassess those on Wajong benefit currently, at least those under age 30, according to the proposed new criteria, with an activation strategy for those no longer entitled to a full benefit. Increase work incentives for those on Wajong benefit, *e.g.* in the form of (probably permanent) in-work payments.
- *Address problems of reassessed beneficiaries*. For those reassessed and taken off the disability benefit roll, introduce a systematic follow-up procedure to ensure that as many of them as possible are being helped early on to find a job or retain their job. This should be done for those who move onto unemployment benefit and those who do not, and include those reassessed in the past few years. Again, in the context of this follow-up, strong links with local employer networks should be built. The new transitional benefit for those moving off disability benefit should be coupled with clear participation and job-search requirements. Monitor the effects of the recently introduced "transition jobs" on employment outcomes. Consider using a similar systematic follow-up approach also for those found ineligible upon disability benefit application, to avoid reapplications.

Enhance co-operation of the UWV with other actors

Following various institutional reforms, today the public employee insurance authority – the UWV – is the main public player in Dutch sickness and disability policy. It carries overall responsibility for both labour market and benefit policy to the extent this is not a duty of the employer. Yet, for the UWV to be able to fulfil its roles and obligations, good co-operation is needed with employers and employer networks on the one hand and other public authorities on the other. The following measures should help to progress further in this regard:

- *Improve co-operation with employers*. Better exploit the monitoring potential of the obligation for employers to notify the UWV of long-term absences, because a sick person not entitled to a disability benefit after two years of sick pay is likely to rely on public support in the long term. Employer-UWV co-operation is particularly important for sick people on temporary contracts, for whom notification obligations should be stricter and come earlier. When a temporary contract ends, reintegration plans should be checked rigorously and employer obligations upheld if indicated by the dossier.
- *Improve hiring instruments and incentives*. Support employers and employees to facilitate job changes *during* the two-year sick-pay period. Introduce options for employers to hire a worker from another company during the sickness period to avoid that people are out of work for too long – while taking measures to avoid misuse of such regulation. This will require some form of assessment of the worker's remaining capacity, and regulations could vary according to the assessed capacity level.
- *Improve institutional co-operation at various levels*. Integrate the Centre for Work and Income (the former PES) into the UWV at all levels to facilitate the most adequate service at the right moment for all clients. Further develop the shared premises (BVGs) and, in particular, ensure that municipalities are an equal partner in the operation. Evaluate the joint profiling involving all partners, which is currently tested in six regional pilots; and apply this approach in all BVGs if the evaluation results are good. Improve the co-operation of the BVGs with the private reintegration providers; with the private temporary work agencies; and with the local employer networks (*e.g.* by providing the necessary infrastructure for those networks).

Box 0.5. **Policy recommendations for the Netherlands** *(cont.)*

Address new inequalities

In the course of the many reforms of the past some inequality issues have come to the fore. These include inequalities between those with slightly below and slightly above 35% of earnings capacity loss (due to the new threshold in the benefit system); between those able and unable to find work corresponding to their remaining partial earnings capacity (due to the new work incentives in the benefit system); and between different economic sectors (due to differences in the way collective agreements respond to reform). These issues are not discussed very much. The following measures would address some of the underlying problems:

- *Address the situation of those with less than 35% capacity loss*. Further in-depth follow-up studies should be undertaken, especially by the social partners who bear responsibility for the employment and rehabilitation of those who are less than 35% incapacitated, to better understand the long-term impact of recent benefit reform on this group, both first-time applicants and reassessed clients. Continue ongoing pilots, involving UWV's vocational experts, aimed at good coaching so as to avoid long-term problems for this group.
- *Monitor the new work requirement for those with partial earnings capacity loss*. Evaluate the impact on beneficiaries' income position of the requirement to use at least 50% of the remaining earnings capacity; in particular, the extent to which the economic cycle influences people's ability to find a corresponding job. If indicated by the results of this evaluation, consider additional measures to improve work opportunities for those actively looking for and willing to accept a job.
- *Monitor differences across economic sectors*. Monitor the extent of topping-up of sickness and disability benefits to be able to identify the need for additional reform promptly, *i.e.* to avoid that intentions of reform are countered by collective agreements, as was the case in the late 1990s. For instance, consider ruling out through legislation the possibility to top-up sickness benefits to more than 85% of the previous wage (or 170% over the first two years), or, if necessary, less than this, as was done in Sweden recently; such top-ups are much less common today than previously but still possible.

Monitor and refine the reintegration and insurance markets

Since the privatisation of reintegration services, some 1 700 providers appeared on the market. The UWV monitors placement results of reintegration services provided in larger contracts, but knows little about the quality of services provided in the context of the increasingly important individual reintegration plans – which account for 70% of all reintegration measures. Recently the funding arrangement has changed somewhat ("no cure, less pay"). However, neither is there a quality control nor a licensing process for new providers. As regards the insurance market, challenges relate to transparency and competition. Currently, five big insurers share 80% of the sick-pay reinsurance market, with a lot of co-operation between them. This is good for transparency but not for competition. The opposite holds for the disability insurance market, which is only developing now to large scale. At this stage, it is difficult for an employer to know what type of disability insurance he needs and where the best offer can be found. The following measures would help to develop the markets further:

- *Further develop the reintegration market*. Introduce a certification process for new providers; the current credibility check is insufficient. Strengthen and further elaborate the outcome-focus of payments, with a stronger focus on the sustainability of jobs and transitions into better jobs. Continuously monitor outcomes to ensure quality standards (*e.g.* through an approach similar to Australia's Star Ratings system). Better monitor the adequacy and efficiency of the individual reintegration plans; in this regard, give more guidance responsibility to the UWV, as is currently planned.

Box 0.5. **Policy recommendations for the Netherlands** *(cont.)*

- *Promote transparency and competition*. Ensure transparency of the sickness and, especially, disability insurance market, in terms of both *costs* (*i.e.* premiums and adjustment mechanisms) and *benefits* (such as the sickness and disability management offered by the insurer). Make sure there is sufficient competition between insurers so to get the best quality – via good sickness and disability management – for a fair price.
- *Improve insurance market regulations*. Consider introducing guidelines for private insurers on how (quickly) premiums have to be adjusted to the recent disability experience of the employer. Seek ways for the UWV (upon becoming responsible for a worker) to benefit from previous casework and needs assessments done by private sickness insurers. Monitor the impact of the *partial* privatisation of the disability benefit scheme (with a public system for those with full and permanent loss of earnings capacity) so to be able to react quickly if insurers are not doing enough to avoid that a partial capacity loss develops into a full one, and a temporary problem into a permanent one.

Notes

1. Adding the numbers qualifying for a waiting benefit to the numbers qualifying for a disability benefit, the total number of new claims of long-term disability-type benefits even increased in Denmark after the benefit reform in 2003.
2. ADHD is a neuro-behavioural developmental disorder affecting around 5% of the world's population under the age of 19. It typically presents itself during childhood and is characterised by a persistent pattern of inattention and/or hyperactivity, as well as forgetfulness, impulsivity and distractibility. About 60% of children diagnosed with ADHD retain the condition as adults. ADHD is more frequent among boys than girls and is currently considered to be a persistent and chronic condition for which no medical cure is available (Polanczyk *et al.*, 2007).

Bibliography

OECD (2007), *Sickness, Disability and Work: Breaking the Barriers – Vol. 2: Australia, Luxembourg, Spain and the United Kingdom*, OECD, Paris.

Polanczyk, G., M.S. de Lima, B.L. Horta, J. Biederman and L.A. Rohde (2007), "The Worldwide Prevalence of ADHD: A Systematic Review and Meta Regression Analysis", *American Journal of Psychiatry*, Vol. 164, No. 6, pp. 942-948.

ISBN 978-92-64-04968-0
Sickness, Disability and Work
Breaking the Barriers – Vol. 3

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)

Table of Contents

Boxes

Tables

Figures