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Sickness, Disability and Work
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Chapter 6

Institutional Incentives, Co-operation and Governance

Policy failure can partly result from complex institutional structures, a lack of co-operation across institutions and insufficient financial incentives for, and governing of, public institutions. In this regard, Finland and Ireland are facing particular challenges. Finland is recently promoting stronger inter-agency co-operation and there is also institutional target setting and performance management in place for the public employment service. Both are still lacking in Ireland.

Denmark and the Netherlands are much further in the process of institutional change and the strengthening of institutional accountability. The main challenge in Denmark is the enormous cross-regional difference in outcomes, while the Netherlands face a number of new challenges related to the privatisation of large parts of disability policies.

Institutional incentives play a key role. Inadequate governance of public or private service and benefit-granting institutions, lack of coherence across different systems and limited co-operation between different actors can contribute to poor outcomes of sickness and disability policies. Local institutions in particular may have insufficient incentives to focus on presumably difficult clients and instead grant a benefit. Institutions may also have strong incentives to shift people in need of help to another institution, maybe to another level of government, thereby lowering their own caseload and costs. This reduces the chances of labour market integration further and raises overall costs.

This chapter explores how the four countries are governing their disability-related institutions, and how different institutions co-operate and co-ordinate their interventions. It describes the current institutional setup and then looks at the major obstacles arising from it, especially in terms of financial incentives for the actors involved. The last part focuses on necessary and partly ongoing changes. The chapter concludes that placing more emphasis on institutional incentives, co-operation and governance would imply a more effective and efficient use of constrained public resources.

6.1. Institutional structures and regional outcomes

This section describes the responsibilities at different government levels, and especially the role municipalities in Denmark, Finland, Ireland and the Netherlands have in sickness and disability policy implementation. This is done with an eye on regional variation in outcomes which are likely to be related to the degree of discretion at the level of regional or local authorities.

A. The role of municipalities and local authorities

Denmark and Finland are two countries in which municipal authorities have an unusually large role in the administration of social and labour market policy. Municipal responsibility is matched by municipal tax collection: in both countries, some 60% of total revenues from personal income tax are collected at a sub-national level – with the exception of Switzerland and Sweden, this is the highest share of local taxation in the entire OECD (OECD, 2007b).

In Denmark, municipalities are responsible for virtually the entire social system. They run the whole benefit system, with the exception of unemployment benefits for insured workers which are administered by the labour market institutions. In this regard, municipalities are responsible for disability and sickness benefits, including sickness follow-up, as well as social assistance payments. They are also in charge of employment policy, including job-oriented rehabilitation, sheltered employment and the comprehensive flex-job wage subsidy system. Disability benefit entitlement decisions are, therefore, taken on a municipal level.

The only other important player in Denmark is, or was, the PES, with its regional and local structures. In the course of municipal reform in 2007, however, the role of the PES was

changed and its activities closely integrated with those of the municipality – through the creation of municipal job centres in which all employment services are combined, for people with and without disability. These job centres have no benefit responsibility, because for the latter purpose separate municipal benefit centres were created (Chapter 2).

Danish municipalities, however, are not in charge of the health care system, which is administered by regional authorities. Specialised medical rehabilitation used to be provided by counties, but in the course of municipal reform (when counties were abolished) this responsibility was transferred to municipalities. Since then, medical and vocational rehabilitation are better intertwined.

The situation in Finland is very different. In this country, contrary to Denmark, the high tax and social responsibility of the municipalities results to a considerable degree from their being in charge of the health care system. Through this, they bear full responsibility for medical rehabilitation. Otherwise, municipalities are only partially involved in disability policy. They are co-responsible, together with the state and its labour market authorities, for payments to the long-term unemployed and people on social assistance. Many of those are people with health problems or disability. In recent years, the two entities – the municipality and the PES – are increasingly joining forces in helping some of their clients in the new, jointly-run Labour Force Service Centres. According to nationally-set criteria, clients in these centres have to be long-term unemployed, without an acute health problem (*e.g.* drug or severe mental problems), susceptible to benefit from a multi-professional approach, with motivation to take up work and chances to find employment. There is some concern as to whether these centres are taking care of the right group of people and, such, put an end to moving people across institutions (Chapter 2).

The main actors in sickness and disability policy in Finland are the Social Insurance Institution (KELA) and the various approved private-sector pension insurance institutions (PII). The latter – pension funds, private insurance companies, foundations – may operate on a sectoral or regional or national level. In different ways, KELA and the PIIs share responsibility for benefit payments as well as vocational rehabilitation. Regarding the latter, KELA is responsible for long-term sick people, young persons with disability entering working life and generally all people with an insufficient work history, while the respective PII caters for those with sufficient work history. On the benefit side, KELA provides a benefit income-tested national pension and the PII an earnings-related pension. Sickness benefits are administered by KELA, which also reimburses employees' sickness funds. Disability benefit claims are determined by the central KELA administration and, in parallel, the respective pension insurance provider.

In the Netherlands, sickness and disability policy is more centralised, and, like in Denmark, very concentrated. The national employee insurance authority (UWV) is not only running the social insurance system (except for old-age and survivor pensions), but also bears responsibility for most employment services. The latter task was taken over from the previous PES a few years ago, with the latter now functioning as front office for both the UWV and the municipalities. Through the responsibility of the UWV, disability benefit decisions are taken at the national level.

Contrary to the other countries, the UWV is not providing any employment-oriented services itself but instead buying services on an emerging provider market through tendering of both individual and group reintegration trajectories. Similarly, large parts of

the social insurance system – the sickness benefit system and parts of the disability benefit system – were and are being privatised by handing over the responsibility to employers. The latter can choose to either provide benefits (and services) themselves or reinsure their risk on an emerging and diversifying insurance market.

In addition, in the Netherlands also the health care system is largely privatised, with a legal obligation for every citizen to take out insurance to cover the costs of curative care and exceptional medical expenses. Health care insurance is offered by approximately 30 insurers (some of which operating on a regional level). There is a range of conditions imposed by the lawmaker on those insurers – who are allowed to make profits – to safeguard the social nature of the system. A particular institutional challenge in the Netherlands with regard to health is the strict separation between curative doctors and insurance doctors (the latter employed by the UWV), with occupational health doctors contracted by the employers as a third group in-between the other two. A range of initiatives are ongoing to address this challenge, including *e.g.* the drafting of medical guidelines for all types of doctors which stress the importance of work for illness and recovery.

Dutch municipalities are responsible for the classic social assistance matters (benefit payment and reintegration). In recent years, the Netherlands is in the process of raising municipal accountability and co-ordinating municipal action with national authorities. Municipalities are also responsible for sheltered work, which is very widespread. Moreover, recently it was proposed to transfer the responsibility for the special disability benefit scheme for young people with disability (the Wajong scheme) to the municipal level – with the aim to improve reintegration and to avoid that municipalities continue to be seeking to transfer some of their own clients onto this scheme. This idea, however, is no longer pursued.

Policy in Ireland is highly centralised. In essence, sickness and disability matters are shared by three government departments: the DSFA, which runs most of the income support system but also some schemes designed to encourage take-up of employment (such as the Back-to-Work Allowance); the DETE, which is responsible for the system of training and employment support for people with and without disability, including vocational rehabilitation; and the DHC. The latter lost much of its previously overwhelming influence in the benefit and employment field, but kept responsibility for some types of benefits and sheltered workshops. DHC, through the Health Service Executive, also administers the medical system, including rehabilitation medicine, and kept its responsibility for rehabilitative training of people with disability (*i.e.* services targeted at developing core functional capacities). Disability benefit claims are granted on a national level.

The local dimension in Ireland is relevant in two ways. First, the Training and Employment Authority (FÁS), which administers the employment support system for the DETE, runs not only its own network of employment offices but also finances a parallel network of Local Employment Services (LES). These LES, which were established through an Economic and Social Agreement in 1996, have more flexibility than FÁS itself and they are more present locally and believed to be more accessible, especially for people with social problems. Also noteworthy is the strong Community Employment (CE) sector, financed by FÁS, which was catering for 3% of the labour force in the 1990s and, despite cutbacks, still is an important secondary labour market for more-difficult-to-place people, including people with disability. Both LES and CE are expensive but rather ineffective in terms of placing or moving people with health problems into ordinary jobs.

The second local element of policy making in Ireland is the influential and powerful community and NGO sector, the fourth social partner in this country. This sector's influence is important with respect to specialised employment services, which resisted change until now. Related to this, it is surprising that in the context of the National Disability Strategy no sectoral plan had been required from, and drawn up for, the Department of Community Affairs.

B. Regional discretion in policy implementation

Large regional disparities in the annual number of new disability benefit claimants could partly result from local discretion in decision-making. This issue is not easy to investigate across countries, given the different number and size of local entities (*e.g.* some of the municipalities in Denmark are so small that annual municipal inflow rates are meaningless) and the scarcity of data. In the following, therefore, the issue is analysed on the basis of *regional* information for Denmark, Finland and Ireland (unfortunately, no regional data are available for the Netherlands).

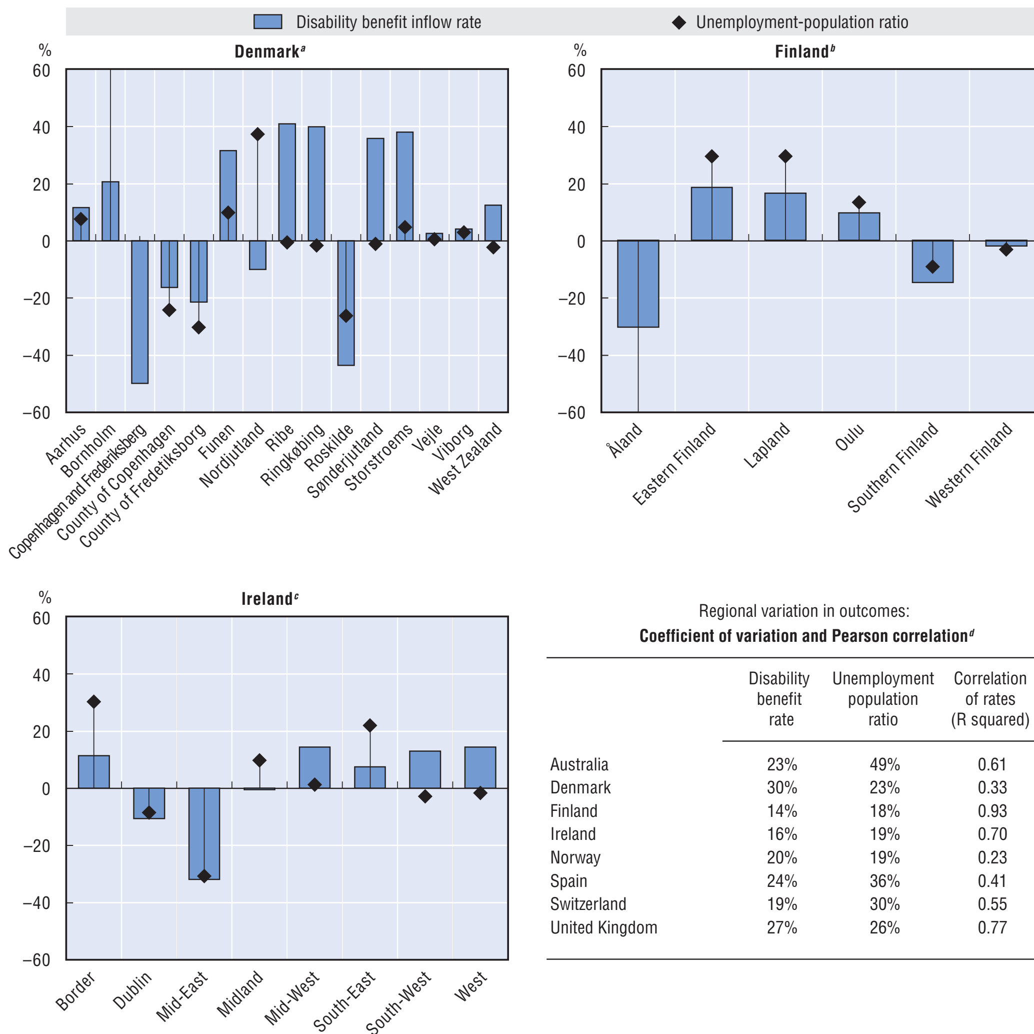
The table in Figure 6.1 shows that regional disparities in disability benefit rates are much larger in Denmark, the only country in which benefit decisions are made on the municipal level, than they are in Finland and Ireland. In six of the fifteen Danish regions is the disability benefit inflow rate 40% higher or lower than on average across the country. The coefficient of variation is 30%, compared to only half of this value in the other two countries. This is also higher than in any other of the previously reviewed countries. Moreover, contrary to all other countries in this and previous review rounds, regional disparities in disability benefit rates in Denmark are much *larger* than regional disparities in unemployment-population ratios. It is hoped that the municipal structural reform in the 2007 through the creation of larger operating units will reduce cross-regional differences (Chapter 2).

The finding above suggests that local decision-making indeed has an impact on the likelihood of benefit grants, beyond and above the regional economic conditions as measured through regional unemployment differentials. This is further confirmed by the correlation between regional disability and unemployment rates. Disability and unemployment are statistically closely correlated in both Finland and Ireland, with correlation coefficients of 0.93 and 0.70, respectively. This association is much lower in Denmark. This could suggest that local authorities are granting disability benefits more frequently in some regions, thereby (unwillingly) reducing the unemployment rate, and *vice versa* . However, this is pure speculation because no research is available for Denmark on the extent to which local or regional disparities are caused by differences in policy implementation.

The very similar variation in unemployment and disability rates in both Ireland and Finland confirms findings in previously reviewed countries, including Australia, Switzerland and the United Kingdom. This finding could also have different explanations. The close association could be due to external factors, which affect disability and unemployment benefit authorities in a similar way; or due to the fact that long-term unemployment is often deteriorating health (OECD, 2008) and leading to disability benefit claims; or simply due to comparable problems of regional consistency and harmonised policy implementation for disability and unemployment benefit decision-takers; or a combination of all these factors.

Figure 6.1. **Regional variation in outcomes is most pronounced in Denmark**

Differences in percentage between the regional rate and the overall rate in the country, 2006



Regional variation in outcomes:

Coefficient of variation and Pearson correlation[d]

	Disability benefit rate	Unemployment population ratio	Correlation of rates (R squared)
Australia	23%	49%	0.61
Denmark	30%	23%	0.33
Finland	14%	18%	0.93
Ireland	16%	19%	0.70
Norway	20%	19%	0.23
Spain	24%	36%	0.41
Switzerland	19%	30%	0.55
United Kingdom	27%	26%	0.77

a) Danish data on unemployment-population ratios are from 2005.

b) Finnish data refer to unemployment-related benefits paid by KELA. The calculation of the coefficient of variation excludes the small region of Aland (an outlier in which only 0.5% of the population live).

c) Irish data refer to the current number of disability allowance recipients. No region-specific data are available for new disability allowance recipients or for new or current recipients of invalidity pensions and illness benefits.

d) Data for Ireland, Norway, Spain and Switzerland refer to *current* disability benefit recipients, data for all other countries to *new* disability benefit recipients.

Source: National Social Appeals Board and Statistics Denmark for Denmark, ETK and KELA for Finland and DSFA for Ireland. For other countries, OECD (2006) and OECD (2007a)

6.2. Institutional and financial challenges

As much as weak incentives for employees and employers can be an obstacle to better policy outcomes, this is also true for the institutions and decision makers involved. This section discusses the financial incentives resulting from the institutional structure and the main challenges with regard to the fragmentation of parts of the system, especially in Finland and Ireland.

A. Financing and monitoring mechanisms

The outcomes presented above demonstrate the importance of institutional incentives created by the underlying financing mechanisms. Denmark is trying to address this issue already for more than 15 years, and more forcefully since 1999. Since then, the national government is trying to influence local authorities by differentiated repayment of their costs, *i.e.* by giving financial incentives rather than monitoring actions. Reimbursement rates for spending on active interventions are higher than for passive benefit payments. More precisely, the municipalities' costs for employment-near measures – such as vocational rehabilitation and flex-job wage subsidies – are reimbursed at 65%, costs for long-term disability benefits at 35%, and costs for long-term sickness benefits (*i.e.* sickness over one year) at 0%. Anecdotal evidence suggests that municipalities do react to this system, even though outcomes do not appear to reflect this. Until now, however, various loopholes had existed which have undermined the logic of the payment scheme – such as the high 65% reimbursement rate for people receiving a special waiting benefit while waiting to be placed in a flex-job.

The Danish financing mechanism, which has a lot of potential if only put in place rigorously, has no direct counterpart in the other three countries. Certainly this is true for Ireland, where all financing is centralised. The challenge in this case is to monitor public institutions adequately to ensure that resources are used effectively and efficiently. This is particularly relevant for FÁS budgets. In reality, FÁS outsources most of its services for people with disability to specialist providers, which receive stable annual bulk funding with limited monitoring of what they are doing, and achieving. There is also very little known about the efficiency of the dual service structure – with LES offices operated in parallel to the FÁS offices. Similarly, Community Employment, which is by far the largest of the non-specialised FÁS schemes for people with disability, has developed a life of its own, providing a steady funding for certain community services, yet without monitoring the long-term value for the people concerned and, thus, for FÁS and the taxpayer.

The situation in Finland is again different. KELA (which is governed by a special body appointed by parliament) and the PES (which is run directly by the Ministry of Employment and the Economy) are two big national organisations operating through district offices (in the case of KELA) and local offices (in the case of the PES). Funding streams are complex, which large parts of the funds coming from the government directly in both cases. KELA funding includes contributions from public and private employers, and PES funding both voluntary employee and mandatory employer contributions and municipal payments. This funding structure calls for good monitoring and governance. In the case of the PES, for instance, the Ministry of Employment and the Economy negotiates yearly objectives, regional targets and budgets with special regional bodies which, in turn, negotiate targets and budgets with local PES offices. The rigour of this process is difficult to judge.

Furthermore, the new cost-sharing in Finland between municipalities and the state for both the long-term unemployed and the indefinite-duration assistance benefit recipients has pros and cons. On the one hand, this makes it less appealing to shift people from one status to the other, but on the other hand the municipality is relieved of parts of the costs at the margin. Such, this type of cost-sharing might be an insufficient incentive for Finnish municipalities to make a real effort for more difficult clients. This is one reason for why the Netherlands, through welfare reform, has made local governments fully responsible for those costs.

Developments in the Netherlands are partly into the direction of the Danish approach. Municipalities are now facing a two-tiered budget, with one part of the disbursement reserved for benefit payments and another part for work-related measures. Unused parts of the latter stream have to be returned to the national government. Such, like in Denmark, municipalities should be persuaded to employ a more active approach to their clients.

More important from the point of view of sickness and disability policy, however, are the funding streams related to the privatisation of sickness and disability policies. The UWV, which receives its funding both through employer contributions and, for the Wajong scheme, from the government, is buying reintegration trajectories on a "no cure-less pay" principle. This should help to ensure the survival of only the best providers (in the first tender this was not the case, which is why apparently a lot of mediocre providers had been able to make money with very poor outcomes). The low turnout for some of the UWV clients suggests that this mechanism could be improved.

Equally important are the financial incentives for employers and private insurers, with the latter collecting their funds through experience-rated employer premiums. Evidence suggests that this system has contributed to the good outcomes in recent years, with sickness absence levels having reached a historical low, and disability benefit inflows having fallen by over 50%. With the most recent benefit reform, however, the disability insurance market is now under transformation, with a range of new products being offered, including a top-up payment for people who do not qualify for a disability benefit any longer. It is far too early to tell whether the new system is going to function well. In particular, the *partial* privatisation of the benefit scheme is likely to create adverse incentives. Employers and even more so private insurers have an interest to see people move from temporary or partial disability to full and permanent disability, because benefit payments for the latter are taken over by the public system. Whether this will ensure optimal reintegration efforts remains to be seen.

B. Fragmentation of benefit systems and activation schemes

Related to responsibility and funding structures, another challenge yet to be tackled in some of the countries is the complexity and fragmentation of existing systems. Challenges are found with respect to both benefit schemes and employment and rehabilitation systems.

Regarding the benefit system, the most pronounced fragmentation is found in Ireland, with eight different types of health-related benefits, all of which can be received on a long-term basis. Benefits are categorised as to whether or not the person has a sufficient insurance record, a long-term disability, a work-related condition, a special type of disability (blindness), or a combination of these. Benefit levels differ little across the schemes, but eligibility criteria and assessment procedures are different. In particular, little attention is given to remaining work capacity as an entitlement criterion for such payments. Also noteworthy, each of these benefits is run by a different unit in one of the two departments responsible for benefit payments (DSFA and DHC), units which, for instance, use entirely different IT systems to keep track of claims and payments.

Benefit complexity in Finland results from the dual, parallel system of national pensions and earnings-related pensions. Empirically, 40% of all claimants have entitlements from both schemes, 20% have a national pension only and 40% (with a tendency to increase) have only an earnings-related pension. A challenge arises from the fact that assessment procedures are parallel, though similar, and that appeals procedures

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in case of benefit denial are parallel and also dissimilar. Added to this, there is a partial earnings-related but no partial national pension.

Another issue in Finland is the disintegration of the vocational rehabilitation system, which involves five main actors: the municipalities through their responsibility for health care (vocational rehabilitation in the period of sickness), the accident and motor liability insurance institutions (for work and traffic accidents), the authorised pension providers (incapacity and sufficient work history), the Social Insurance Institution (incapacity and insufficient work history) and the PES (unemployed and jobseekers with disability). The benefit paid during the period of vocational rehabilitation and the contracted organisations involved in service provision vary accordingly.

Ireland has a much less developed system of vocational rehabilitation, but employment services for people with disability are also far from being integrated. Some schemes are run by the DSFA, others by FÁS (through its mainstream employment service), with no co-ordination between them. Moreover, FÁS contracts out most of the services for people with disability, notably all specialised services, and rehabilitative training is under the remit of the DHC and HSE.

System fragmentation is not a big issue in the other two countries, where one institution carries responsibility for most sickness and disability policy matters. The Danish municipalities inherently co-ordinate their benefits and services, and through the recent creation of municipal job centres also co-operate closely with the PES. Similarly, the Dutch employee insurance authority bears responsibility for both benefit and reintegration matters ever since the quasi-abolition of the PES. The main difference between the two countries is that municipalities in Denmark organise and run most schemes themselves, whereas the UWV in the Netherlands purchases services on a private market and handed over large parts of the benefit responsibility to employers and private insurers.

To a certain extent, though, the Netherlands suffers from having a special system for young people with disability (the Wajong scheme). This system is now operated under different conditions because it has not followed the same reform path as the ordinary disability benefit scheme. This is important in view of the rapid increase in the number of young people on Wajong benefits. Such increase is also found in other OECD countries, notably Denmark, but in the Netherlands it predominantly concerns people in the 18-24 age groups who are moving from special education onto benefit (Chapter 4).

An issue in Denmark is the introduction of a special waiting benefit (sometimes referred to as unemployment allowance) for people not entitled to a disability benefit and waiting to be placed in a flex-job. The number of people receiving this benefit has increased rapidly, because the supply of flex-jobs could not keep pace with the growing demand. More particular, people remain on waiting benefit for ever longer periods, thus *de facto* turning the benefit into an *alternative* disability benefit.

6.3. Better incentives, co-operation and governance

To improve employment outcomes and to avoid shifting people between different authorities and schemes will require institutional change. This subsection discusses what Denmark, Finland, Ireland and the Netherlands could be doing, and are partly in the process of doing, to this end. It highlights four key aspects: a simpler structure, better incentives for disability-related institutions, better co-operation across institutions and between various levels of government, and better monitoring and governance of the action

taken and outcomes achieved by the various institutions. Institutional change is probably the most difficult step for a country, because it requires a dismantling of historically grown structures and traditions and a change in the behaviour of actors.

A. Streamlining fragmented systems

A first step in improving the institutional setup is to bring down the complexity of the system by reducing the number of parallel streams. There is no good argument to run schemes with a similar, even though not necessarily identical, purpose. Such situation is confusing for people and often also institutions, and can act as a barrier to better outcomes.

Ireland is a clear case for benefit rationalisation. In line with a recent Government decision, in a first step the responsibility for those benefits which are still managed by the DHC (such as Infectious Diseases Maintenance Allowance, Blind Welfare Allowance and Mobility Allowance, but also Supplementary Welfare Allowance) should be transferred to the DSFA as quickly as possible. In a second step, some of these payments should be merged, or abolished. For instance, all means-tested disability payments could be merged with the current disability allowance. Similarly, long-term illness benefit should be merged with the invalidity pension, as there are no distinguishing features between eligibility for both schemes, in terms of contingencies covered, medical criteria, levels of incapacity for work needed, or levels of support required (see the 2004 *Report of the Working Group of the Review of the Illness and Disability Payment Schemes*). In this case, illness benefit should remain as a short-term payment for no more than one year, as in other OECD countries.

Equally important in the context of streamlining the Irish benefit system is to address the different assessment procedures and entitlement criteria for the three main long-term disability benefits. Generally, remaining work capacity should be given more attention in determining eligibility for long-term payments, thus strengthening the current medically-focused criteria. Currently, access to illness benefit (the Irish sickness benefit, which many people receive for more than five years) and disability allowance, seems to require much loser criteria than is common across the OECD. This is reflected in the very high inflow rates to these payments.

Assessment procedures in Finland could also benefit from streamlining. There is no plausible advantage of having two parallel assessments by the Social Insurance Institution and the approved pension insurance providers. At best, the two assessments lead to the same decision – empirically this seems to be the case in the majority of cases (unless the latter grant a partial benefit which does not exist in the national scheme). Bigger problems can arise when an appeal is filed against a rejected claim, because appeals procedures are entirely different. This is not an efficient solution.

Even more streamlining seems necessary in Finland in regard to the imperfectly arranged system of vocational rehabilitation. Depending on which institution is taking responsibility, not only are different services offered but also different eligibility criteria used and different types of benefits paid (including full or partial rehabilitation allowance, full or partial rehabilitation cash benefit, per diem allowance, but also sickness as well as unemployment benefit). Some of the special rehabilitation payments are equal to a regular disability benefit with a 33% increment (earnings-related scheme) or a 10% increment (national pension scheme). Such complexity is not conducive to a scheme which aims to maintain or improve the employability of workers with health problems.

B. Increasing institutional incentives

A second step in improving the institutional setup is to ensure good financial incentives for all disability-related institutions and actors. If each and every player has the right incentives, this could improve outcomes accordingly and it should help to minimise the frequent shifting of people across institutions – even in the absence of better co-operation across institutions.

Denmark has gone very far in terms of steering outcomes through institutional incentives. Admittedly, this is also more straightforward in a country where policy is very much concentrated in the hands of one institution, the municipality. The example of Denmark also shows the political economy constraints: it took around 15 years from the first big step in this direction in 1992 (when reimbursement rates for disability benefits were lowered to those for rehabilitation benefits, *i.e.* until then passive action was reimbursed more generously) to reform in 2006 which eventually closed all escape options for the municipality. Only since then is there no possibility for municipalities to shift people on a quasi-permanent passive payment with relatively high reimbursement from the state (the last such possibility was the 65% reimbursement which was granted for all people on waiting benefit, *i.e.* waiting for a flex-job; today, flex-job eligibility must be adequately justified and documented, and even then state reimbursement is discontinued after one year).

Pending outcomes from this last reform, however, even in Denmark steering municipalities' behaviour through further strengthened incentives would be possible. For instance, roundtables for dialogue between employers, job-centre caseworkers, physicians and employees to improve early identification and intervention have proven quite effective but are rarely taking place. Lower sickness benefit reimbursement rates for municipalities in the absence of such roundtables could induce more efforts to make them happen – all the more so, if corresponding incentives would be put in place for both employers (through differentiated sickness benefit co-financing) and physicians (through differentiated remuneration). Another possibility would be to consider lower reimbursement for the municipality and lower subsidies for workers and employers in case of flex-jobs offered for the own workforce (the most common situation today) so as to stimulate the creation of new flex-jobs for workers who have not previously worked in the company.

The Netherlands might also consider going further down the Danish route. The recent change in the way municipal budgets are being determined is a first step in this direction. This could be further strengthened *e.g.* by gradually shifting funding from the benefit stream to the work stream. This could help improve the incentives for municipalities to engage with the UWV and the CWI in the shared premises (see below). However, this would also require municipal budget security beyond the current promise to keep budgets largely unchanged until 2011/2012. This strengthening of municipal accountability would have made particular sense in combination with the above mentioned (but recently rejected) transfer of the Wajong scheme to the municipal authorities.

Other than this, the Netherlands should seek to improve the financial incentives for the UWV. For instance, incentives should be developed to make it more attractive for the UWV to facilitate the *regional gatekeeper centres* by providing the necessary infrastructure. These centres are regional employer networks created in response to the employers' obligation to find a job in another company for a sick worker unable to continue working in the company. Incentives could also be improved so that the UWV better fulfils its role as a

quasi-employer in terms of sickness monitoring and management of workers without an employer, or with an employer who is exempt from the sick-pay regulation. This group in particular could benefit from investments by the UWV in better co-operation between caseworkers and employers. However, the UWV should also make an effort to be involved with employers and private insurers for all other workers, because failure of reintegration of workers during the first two years can become very costly for the UWV.

Finland and Ireland have less experience with financial incentives for institutions but should also consider them in the course of streamlining their systems. In Finland, the Social Insurance Institution (KELA) bears major responsibility for sickness follow-up, especially in cases where employers do little in this regard. Even more important is KELA's role in regard to sickness management for those workers not covered by an employer-chosen occupational health service and for unemployed people. Incentives should be developed so as to ensure the early preparation of a rehabilitation plan for those people. The current Work Health Clinic pilot should help identify promising ways of OHS-type support for such workers and the unemployed (Chapter 4).

Similarly, better incentives and guidelines are needed to ensure that the Labour Force Service Centres (LAFOS) fulfil their role. This could be done by targeting funds for the PES (and also KELA) for this purpose, while broadening the group of people to be served by this intensive case management. Obviously, this will also require a different approach towards municipalities, which should benefit from putting more resources into the LAFOS. The current situation – with the LAFOS merely being a co-operation network without its own budget – makes for a fragile system.

A main challenge in Ireland currently is the lack of systematic and coherent engagement with clients, which is further complicated by the multitude of actors involved. Available resources for the DSFA should be concentrated and targeted to a rapid implementation of the planned *Social and Economic Programme – people of working age*, meant to implement what is currently lacking. This would mean to invest into a larger network of DSFA facilitators at the expense of currently existing double and triple structures (for the various benefits operated in parallel).

C. Promoting one-stop-shop service delivery

A third step in improving the institutional setup is to improve the co-operation across institutions and between various levels of government and, in particular, to ensure that clients do not face any institutional obstacles. Joint operation of services in the form of a one-stop-shop, for instance, would also be a way to reduce the attractiveness of shifting people across institutions.

The countries under review have gone along the one-stop-shop route to rather different degrees. The Danish job centres, which were created in all municipalities, are the single entry point for employment and rehabilitation services, operated jointly by the PES and the municipality. However, the new division of labour between the job centre and the different benefit centres implies that better co-operation on employment services by the PES and the municipality is sought while at the same time moving away from the previous municipal one-stop-shop service. Partly this is a consequence of the fact that the labour market institutions always had run the unemployment benefit scheme, and continue to do so. Seamless co-operation across municipal job and benefit centres is yet to be achieved. In the long run, integration of all benefit matters would seem adequate.

The Netherlands are in the process of merging the previous PES (since 2002, CWI) with the UWV. Similar mergers of the employment service and the social insurance institution have recently taken place in several other OECD countries, *e.g.* Norway (OECD, 2006) and the United Kingdom (OECD, 2007a). To some extent, the Netherlands has gone further in this regard by also integrating municipalities, with the CWI functioning as a front office to both the UWV and the municipality. More recently, a real one-stop-shop with further improved service delivery is being put in place – so-called shared premises, in which the three entities are also accommodated under one roof. However, there is still a long way to go, especially in regard to the integration of municipalities on an equal footing. The situation is almost the opposite of the one in Denmark: in the Netherlands, the one-stop-shop idea is in the forefront, but joint profiling is so far only done in six regional pilot areas, *i.e.* in one in ten of the 60 shared premises (and in some regions there is not even a shared premise yet).

Finland's Labour Force Service Centres are another interesting example of cross-agency co-operation. Like in Denmark, these LAFOS are operated jointly by the PES and the municipality, with the aim to provide better-integrated employment as well as social support services. However, there are some differences to the Danish solution. First, the Finnish LAFOS are only meant to cater for certain groups of disadvantaged, long-term unemployed people. Secondly, the degree of co-operation in each centre varies considerably. Moreover, the Social Insurance Institution which is responsible for benefit matters but also for vocational rehabilitation is only on board occasionally. Hence, these LAFOS can only be a very first step towards integrated service (and benefit) provision. For the fragmented system of vocational rehabilitation, it would be very important to create a single entry point and to appoint one authority which carries responsibility for a case from the beginning to the end so as to ensure effective services. The very minimum would be better-regulated and earlier information exchange between rehabilitation authorities, including the private pension providers.

There is nothing like a one-stop-shop service currently in Ireland. FÁS, the Irish PES, would be the institution that should act as a single entry point for individuals with health problems seeking training and employment services. The fact that people in Ireland can enter the system through different doors (FÁS, the parallel Local Employment Service, the Health Service Executive or a specialist training provider) implies that people may be offered very different reintegration trajectories in comparable situations. Due to the lack of integration of services, there are no bridges from specialist services into mainstream services and further on into employment. Similarly, FÁS should be a single entry point for employers seeking to obtain service or hire a person with disability. The above-mentioned (planned) systematic customer profiling and case management by the DSFA also requires an active and modern FÁS, which would be the focal point for activation in this new system: receiving referrals from the DSFA; referring clients further to the most appropriate (either mainstream or specialised) service; and re-referring them back to the DSFA where and when needed.

D. Improving governance and service quality

A fourth step in improving the institutional setup is to improve monitoring and governance of the various institutions, in terms of both process and achieved outcomes. This would be of particular importance, of course, if none of the other three steps are taken.

Ireland faces a major issue in governing public institutions. Performance management does not seem to be sufficiently developed. This would be of particular importance for the mainstreamed system of employment services. Without performance targets related to people with health problems and disability, FÁS is unlikely to make sufficient efforts to make sure those people can access services. Good supervision and monitoring would require measurable disability-related targets from the DETE to FÁS and within FÁS from the national entity to the regions and from the regions to the local offices. Good governing would also be needed to address the historically grown separation of specialist service providers. These should continue to offer such service but under supervision and control of FÁS, not through annual bulk funds. Only then could the quality of services, measures and providers be ensured, and improved, and the transition into mainstream services increased.

Like with the Irish FÁS, good governance and monitoring is needed in Finland for both the PES and KELA. For the PES, yearly targets and budgets are being negotiated already, but with little explicit focus on the unemployed with a health problem or disability. Again, this would be important in the context of mainstreamed services. Moreover, the experience of countries where PES management is similarly decentralised (such as Switzerland) suggests that performance indicators and performance management can play a more important role. Added to this, performance management has yet to be put in place for KELA; Switzerland, which is in the process of developing this for its cantonal disability insurance authorities, could again serve as a benchmark (OECD, 2006).

In the Netherlands, much of the governance issues were transformed into privatisation and outsourcing issues. A key governance issue in this country is to improve the quality of private for-profit services. Some other OECD countries do this through a rigorous system of licensing, others, especially Australia, through a comprehensive system of quality measurement and certification (OECD, 2007a). Neither exists in the Netherlands, where a credibility check is the only control in the tender process, although many providers are registered with a branch association which grants a quality seal. Policy could strengthen ongoing quality developments further by elaborating the outcome-focus of payments to private providers and by monitoring the adequacy of the rapidly increasing individual reintegration trajectories (including, as is currently planned, more guidance responsibility for the UWV in developing these trajectories). These individual measures were shown to be more effective, but also more costly – and not always cost-effective, given that on average only more motivated and more employable clients are choosing these trajectories.

Quality of private sickness and disability benefit insurance is another important issue in the Netherlands. Little regulation, governance and monitoring is found in this regard. By transferring responsibilities to employers, it is basically left to the manager to seek a proper insurer and, by shopping around between different insurance products, help to improve the quality of contracts and crowd-out bad insurers, or products. Public guidance and monitoring in this regard would mean to set guidelines *e.g.* on the sickness and disability management approach to be employed by the insurers, or on how and how quickly insurance premiums have to be adjusted to the employer's recent sickness and disability experience. Also important are steps to increase the transparency of the insurance market (this is important for disability insurance, which is in transformation) as well as competition (this is an issue for sickness insurance, with five big insurers sharing 80% of the market). The lack of regulations in this regard is surprising in view of the

comprehensive regulations for the private health care market (Ministry of Health, Welfare and Sport, 2005).

In Denmark, the situation is quite different from the other countries. Governance and quality control by the national government must be seen in the light of the innovative financing regulation, *i.e.* the differentiated reimbursement rates for municipal action. To a certain extent, this regulation reduces the need for better monitoring, for two reasons: first, because municipalities bear responsibility for virtually all benefit payments and employment policies, and, secondly, because of the political accountability of the municipalities. However, financial incentives alone are not enough. This is why, in the course of the establishment of a new employment service system in 2007, new management and follow-up tools were put in place. The overall management philosophy is that job centres with good results will have a larger degree of freedom with regard to planning and implementing their own approach, whereas those with poor results will experience closer follow-up, including sanctions.

Today, the Danish employment service system uses four monitoring and follow-up tools:

- Annual targets set by the minister for employment, with one of the three targets for 2009 being that each "job centre must ensure that the number of sickness benefit periods exceeding 26 weeks will be reduced compared to the previous year."
- Annual employment plans on employment action to be taken in the following year in response to the major challenges, prepared by each job centre.
- Jobindsats.dk, a continuously updated internet portal with the latest employment action figures allowing job centres, employment regions and the ministry to compare actions at local level on a wide range of indicators; and
- Performance audits which are used as a basis for managerial discussions between the public administration, local politicians and social partners; these audits are also used to evaluate employment action of the past year and to plan future employment action.

The efficiency of this performance management system is yet to be seen. A continuous evaluation of the new employment system is to be undertaken until 2010.

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List of Acronyms

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

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

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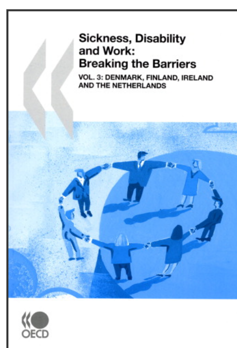

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