Sickness, Disability and Work: Breaking the Barriers

VOL. 3: DENMARK, FINLAND, IRELAND AND THE NETHERLANDS

OECD

Sickness, Disability and Work

BREAKING THE BARRIERS

Denmark, Finland, Ireland
and the Netherlands

Vol. 3

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Foreword

Sickness and disability policies are rapidly gaining a central stage in the economic policy agenda of many OECD countries for good reasons. Medical conditions, or problems labelled as such by societies and policy systems, are increasingly proving an obstacle to raising labour force participation rates and keeping public expenditures under control. More and more people of working age rely on sickness and disability benefits as their main source of income, and the employment rates of those reporting disabling conditions are low. Strong job creation in many OECD countries, with increases in the employment-to-population ratios, has not translated into more jobs for people with disability. With increasingly stricter work requirements in unemployment and social assistance schemes and gradual retrenchment of early retirement systems, the pressure on long-term sickness and disability benefit schemes has increased. This, in turn, has led to rising numbers of people of working age drawing these benefits and more public spending on them. There is now an urgent need to address this "medicalisation" of labour market problems.

This thematic review looks at how abilities can be matched with opportunities. It examines national policies to control and reduce the inflow into sickness and disability benefit programmes, and to assist those beneficiaries who are able to work reintegrate the labour market. It attempts to discover the factors which lead a person with a health problem to withdraw from the labour market, or remain outside of it, and to identify areas for further policy improvement. Along these lines, this is a review of the employment prospects of persons with health problems or disability, not of their wider position and chances in society. This is why the report has a strong focus on benefit systems and employment policies while saying little about, for instance, broader issues of accessibility, which can be important pre-conditions for some of those people. Similarly, the main concern of the review is people who could work but do not work. Many people with health problems can work and want to work, so any policy based on the assumption that they cannot work is fundamentally flawed. Helping people to work is potentially a "win-win" policy: it helps people avoid exclusion and have higher incomes while raising the prospect of more effective labour supply and higher economic output in the long term.

The third report in this series examines the challenges and obstacles facing Denmark, Finland, Ireland and the Netherlands. In particular, it looks at promising steps in those four countries toward transforming sickness and disability schemes from passive benefits to active support systems that promote work. The report consists of six chapters and an Executive Summary of main challenges and lessons with a number of specific recommendations for further reform for each country.

Chapter 1 sets the scale of the problems by looking at current key outcomes in the four countries. Chapter 2 evaluates past and ongoing sickness and disability policy reforms. Chapter 3 discusses the role of the state in helping to reduce the inflow into long-term benefits through better sickness management and disability assessment, and in helping beneficiaries back to work through employment policies and rehabilitation measures. Chapter 4 looks at the role of employers and their incentives to retain or recruit workers with health problems. Chapter 5 analyses work incentives for individuals and how replacement rates and effective tax rates created by tax and

benefit systems affect work decisions. Chapter 6, finally, provides an analysis of institutional challenges and incentives.

This publication is the third in a series of comparative reports on sickness and disability policies in selected OECD countries. The first report, published in 2006, covered Norway, Poland and Switzerland, and the second one, published in 2007, covered Australia, Luxembourg, Spain and the United Kingdom. The three comparative reports will be followed by a synthesis report that will summarise the lessons learned in the course of the review for all OECD countries.

Work on this review was a collaborative effort, carried out jointly by the Employment Analysis and Policy Division and the Social Policy Division at the Directorate for Employment, Labour and Social Affairs. The report was prepared by Michael Förster, Ana Llena-Nozal and Christopher Prinz (team leader). Tax/benefit models were prepared by Dominique Paturot, statistical work was provided by Dana Blumin and Maxime Ladaique, and administrative support by Claire Gibbons and Sophie O'Gorman. Important inputs for the report were supplied by, among others, the Danish National Labour Market Authority (AMS), the Dutch Ministry of Social Affairs and Employment (SZW), the Finish Ministry of Social Affairs and Health (STM) and Ireland's Department of Social and Family Affairs (DSFA). These institutions prepared background documents, provided empirical evidence, organised fact-finding missions and commented on a draft of this report. The draft text was also discussed at a seminar in Dublin in June 2008.

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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.

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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).

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Chapter 1

Key Trends and Outcomes

What are the main challenges which sickness and disability policy makers in Denmark, Finland, Ireland and the Netherlands will need to address in the future? This chapter highlights the key outcomes and trends in these countries during the past 10-15 years in four areas: labour market integration of people with disability and workers with reduced work capacity; financial resources of those people; costs of sickness and disability benefits schemes; and exclusion and inclusion errors of those schemes. In addition, it addresses two macroeconomic challenges: population ageing and future labour supply shortages, and the impact of changing labour market requirements on workers' health. These external challenges need to be taken into account if sickness and disability policy systems are to be reformed successfully.

This first chapter provides a summary of the most important sickness and disability trends in Denmark, Finland, Ireland and the Netherlands during the past 10-15 years. Outcomes in the following six areas are discussed:

- Labour market integration of people with disability: employment and unemployment.
- Financial resources of people with disability: income and poverty.
- Costs of disability benefit schemes: public spending and benefit dependence.
- Exclusion and inclusion errors: disability benefit recipiency and disability prevalence.
- Demographic challenges: population ageing and future labour supply shortages.
- Impact of labour market requirements: work and health.

These key trends indicate where structural reforms in the sickness and disability area will be most needed. It will be seen that the challenges arising from these trends are not the same in the four countries. However, in addressing these challenges, reforms in all countries will need to be designed so as to improve outcomes in a given area (*e.g.* to increase outflows from disability benefits) without worsening those in other areas (*e.g.* to increase financial insecurity or flows into other benefits).

1.1. Employment and unemployment of people with disability

A. Macroeconomic environment and labour market trends

The countries reviewed share a number of common economic and social features but diverge in others (Table 1.1). All four are members of the European Union and, with a working-age population of between 2.4 and 10 million people, constitute small open economies. A considerable number of people are receiving disability benefits, around 6-8% of the working-age population in all four countries. However, the share of persons among the working-age population describing *themselves* as having a disability affecting them in their daily activities is much higher, around 14-17% in Ireland and the Netherlands and as high as 21-24% in the two Nordic countries.

All four countries have undertaken or are currently considering major sickness and disability policy reforms against the background of a favourable economic situation. During the past six years, real GDP grew continuously, employment rates increased and unemployment rates remained below OECD average or decreased in such a direction (Finland).

At 4.7%, annual growth of real GDP was particularly high in Ireland. Growth was close to OECD average in Finland (2.9%), and below that average in Denmark and the Netherlands, mainly due to a slow-down in the first three years of the decade. That said, growth is projected to slow down in all four countries over the next two years, especially in Ireland (OECD, 2008a).

Employment rates increased in all four countries in the past six years but particularly in Ireland (plus 4.5 percentage points). They are now above the OECD average of 67% in all

Table 1.1. **Favourable economic and employment trends in the past six years**
GDP and labour market indicators, 2000-2007

	Denmark	Finland	Ireland	Netherlands	OECD average
Population figures (thousands)					
Working-age population 2006[a]	3 205	3 163	2 398	9 975	
Disabled persons (self-assessed) 2006[a]	667	747	326	1 678	
Disability benefit recipients 2007[b]	235	270	155	831	
Macroeconomic indicators					
GDP per capita 2007 in USD PPPs[c]	36 192	34 226	40 716	38 554	31 684
Annual GDP growth 2000-2007 (%)[c, d]	1.7	3.1	4.7	1.8	2.9
Labour market indicators (age 15-64)					
Employment ratio					
2000	76.4	67.0	64.5	72.1	65.6
2007	77.3	70.5	69.0	74.1	66.7
Unemployment rate					
2000	4.5	9.9	4.4	3.1	6.3
2007	3.6	6.9	4.6	3.7	5.7
Long-term unemployment[e]					
2000	20.0	29.0	33.1	43.5	31.4
2007	18.2	23.0	30.3	41.7	29.1

a) Data for Denmark and Ireland refer to 2005.
b) Data for Denmark and Ireland refer to 2006.
c) Data for Ireland and the OECD average refer to 2006.
d) Data for Ireland and the OECD average refer to the period 2000-2006. The OECD average is an unweighted average.
e) Long-term unemployment is the percentage of the total unemployed who have been out of work continuously for more than one year. The 2000 figure refers to 1999 for the Netherlands.
Source: Table 1.10, OECD.Stat Reference Series and *OECD database on Labour Force Statistics*.

four countries. While the increase was less marked in the Denmark and the Netherlands, these two countries continue to have some of the highest employment ratios across the OECD area.

Unemployment rates of around 4% in Denmark, Ireland and the Netherlands are well below the OECD average. The recent small increase in unemployment in the Netherlands is projected to be reversed in the coming years and the decline in Finnish unemployment – still above OECD average but far from the two-digit levels recorded ten years ago – is projected to continue while unemployment in Ireland is expected to grow again in the next two years (OECD, 2008a). About one unemployed out of five are long-term unemployed in Denmark, one out of four in Finland, one out of three in Ireland but still almost one out of two in the Netherlands.

Current and prospective labour shortages are a main concern in all four countries. This includes expected increasing demand for skilled labour, especially in Finland. Immigrant workers accounted for an important share of recent employment growth, especially in Denmark and Ireland where this share was over 50% (OECD, 2007a). Between 2000 and 2005, the annual inflow of foreign workers has approximately doubled in each of the countries with only Ireland showing signs of a reduction at a high level in the last two years (OECD, 2007a).

Most recent OECD projections for the years up to 2009 expect the labour force participation rate to remain stable in the four countries, in line with the development of the OECD average (OECD, 2008a). Overall, while there are signs of a smoothing down in the coming years, the macroeconomic frame and the labour market situation in the first decade of the 2000s are encouraging in all four countries, setting a good basis for further reforms.

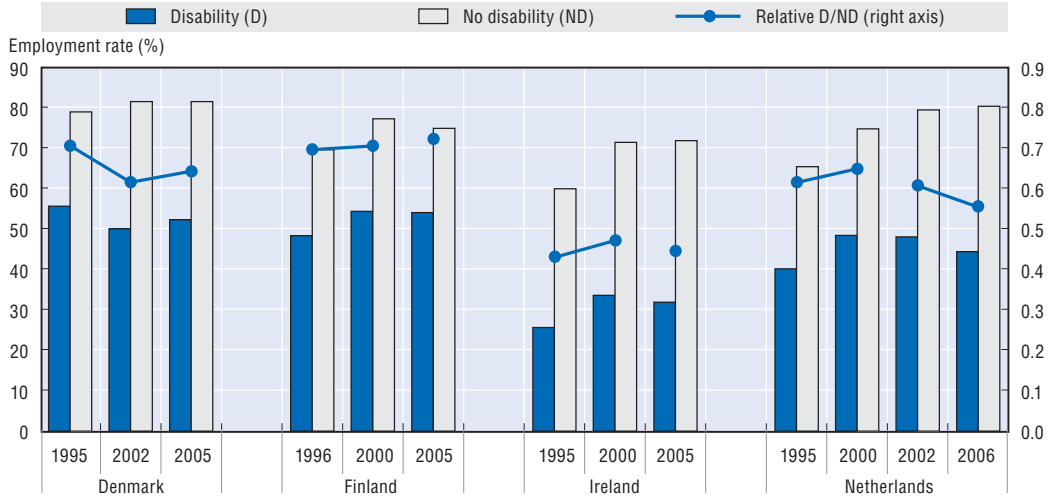
B. Employment levels

Good labour market and macroeconomic performances are likely to have "spill-over" effects on the employment integration of people with disability. It can be expected that, in a situation of enduring economic growth, high overall employment and low unemployment, persons with reduced work capacities will have greater opportunities to find a job.

Against the background of the favourable macroeconomic indicators in recent years in the four countries highlighted above, employment outcomes for people with disability are still somewhat disappointing. They have consistently lower employment rates than their peers without disability, especially in Ireland where less than one-third of them have a job.[1] For comparison, 45% of people with disability have a job in the Netherlands and 52 to 54% in the two Nordic countries (Figure 1.1). This compares to employment rates of about 50% in Luxembourg and Switzerland, 45% in Norway and the United Kingdom, 40% in Australia and less than 20% in Poland, for the countries reviewed recently (OECD, 2006b, 2007b). Employment rates of people with disability in Denmark and Finland are therefore higher than in all other countries reviewed, while Ireland has among the lowest levels.[2]

Figure 1.1. **In Denmark and Finland, one in two people with disability are employed but only one in three in Ireland**

Employment rates of people with and without disability, working age, mid-1990s to mid-2000s (percentage)[a]



a) Definition of disability on self-assessment basis: existence of a chronic health problem or disability and long-term limitations in daily life activities [Denmark, Finland, Ireland (all years), Netherlands (1995, 2000)]; "work disabled" (Netherlands 2002, 2006): suffering from a long-lasting complaint, illness or disability which impedes carrying out or obtaining a paid job.

Source: Denmark: LFS; Finland, Ireland: ECHP for 1995/96 and 2000 and national estimates based on EU-SILC for 2005; Netherlands: ECHP for 1995 and 2000, LFS for 2002 and 2006. ECHP estimates were provided by ESRI. Due to differences in data collection and definitions, results based on EU-SILC 2005 are not strictly comparable with those based on ECHP 1995 and 2000.

Also in *relative* terms – employment rates of people with over those without disability – employment performances are positively linked to the absolute employment level of people with disability. The ratio is about 0.65-0.7 in the two Nordic countries, 0.55 in the Netherlands, but 0.45 in Ireland.[3] Again, this compares to ratios of 0.6-0.7 in Luxembourg and Switzerland and 0.3 in Poland.

Trends over the past ten years also differ across the four countries. Employment rates of people with disability increased during the late 1990s rather significantly (by 6-8 percentage points) in all four countries except Denmark where they fell. In the more recent years, trends were more disappointing: employment rates among people with disability increased only slightly in Denmark, mostly due to an extension of subsidised employment, but stagnated in Finland and fell in Ireland and the Netherlands.

Age and education determine employment differentials between persons with and without disability much more than gender (Table 1.2). Employment differentials are slightly lower for men in Denmark and the Netherlands and slightly lower for women in Finland – but differences are small. On the other hand, there is a strong correlation between the relative employment rates of persons with disability and age. In Denmark, younger people with disability even have a similar employment rate than their peers without disability while employment of older people with disability is only half the level of those without. The same pattern, though less pronounced, appears in Finland and the Netherlands. Lower educational attainment is also associated with lower relative employment rates of people with disability, and gaps are similar to those of older people. On the other hand, employment rates of persons with disability with higher education still lag 15 to 30% behind those of their peers without disability. The gaps in these differentials have not become smaller over the past three to four years.

Table 1.2. **Employment differentials are much higher for older and less educated persons**

Relative employment rates of people with, over those without disability, by gender, age and education, 2002-2006[a]

		All	Gender		Age group			Educational attainment		
			Men	Women	20-34	35-49	50-64	Below secondary	Upper secondary	Tertiary
Denmark	2002	0.61	. .	. .	0.86	0.65	0.49	0.50	0.67	0.79
	2005	0.64	0.65	0.63	0.89	0.70	0.51	0.51	0.70	0.79
Finland	2005	0.72	0.71	0.74	0.86	0.82	0.62	0.58	0.78	0.84
Ireland	2005	0.44	. .	. .	. .	. .	. .	. .	. .	. .
Netherlands	2002	0.61	0.62	0.60	0.75	0.66	0.55	0.51	0.71	0.78
	2006	0.55	0.57	0.54	0.70	0.59	0.53	0.46	0.64	0.70

a) Definition of disability on self-assessment basis: see Figure 1.1.

Source: Denmark: LFS; Finland, Ireland: national estimates based on EU-SILC; Netherlands: LFS.

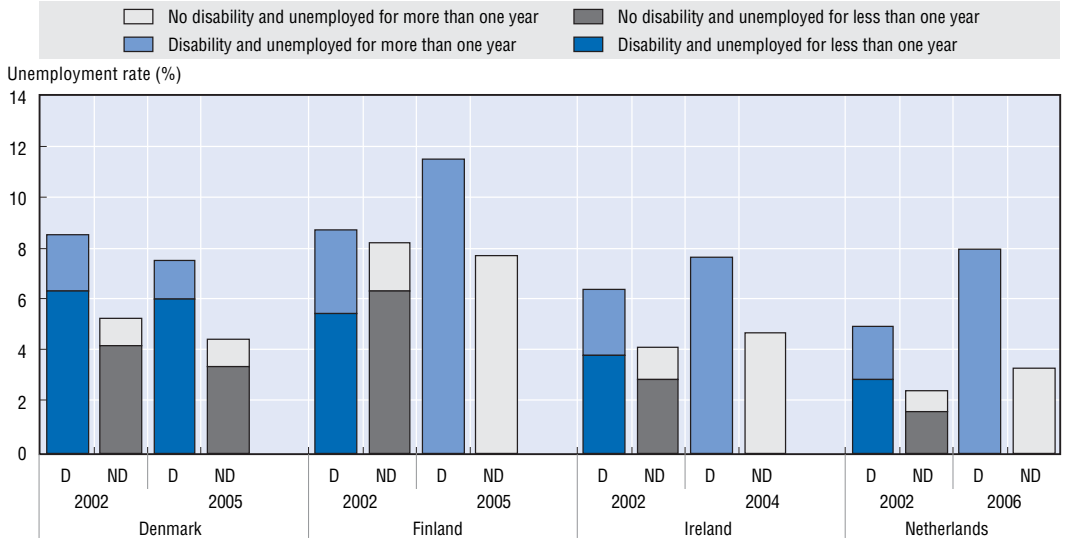
The employment outcomes discussed above refer to persons who self-assess their disability status according to standardised survey questions on health conditions and their impact on activities of daily living. Not all of these people – in fact, only a minority (see Section 1.4) – claim and receive disability benefits. Available evidence from national registers suggests that employment rates of disability benefit recipients are much lower: above 20% in the Netherlands (UWV); between 26% among younger recipients and 13% among older recipients in Denmark (Ministry for Social Welfare); and some 11% overall among recipients of earnings-related disability benefits in Finland, more precisely 5% of those receiving a full benefit and more than two-thirds of those receiving a partial benefit (preliminary results of the 2008 Disability and Work Survey of the ETK).

C. Unemployment and inactivity

Unemployment rates of persons with disability are higher than those of persons without disability in all four countries (Figure 1.2).[4] The difference is particularly pronounced in the Netherlands, where unemployment rates of people with disability are more than twice as high as those of persons without disability and where this differential has increased over the past years. At the latest date available, unemployment rates among people with disability stood at 8% in Denmark, Ireland and the Netherlands, but almost 12% in Finland. These rates have been increasing over the past years in Ireland and, particularly, Finland and the Netherlands where this trend is likely to be related to recent reforms (see Chapter 2). On the other hand, unemployment rates of persons with disability decreased in line with overall unemployment in Denmark.

Figure 1.2. **Higher and longer unemployment among the population with disability**

Unemployment rates of persons with (D) and without disability (ND), 2002 to around 2005[a]



a) Definition of disability on self-assessment basis: existence of chronic health problem and long-term limitations in daily life activities.

Source: National LFS, except for Finland 2002 (EU-LFS). No data by unemployment duration in national LFS for Finland, Ireland and Netherlands, duration shares for 2002 have been estimated on basis of EU-LFS 2002. Finland 2005: D/ND shares of unemployment estimated on the basis of EU-SILC 2005.

In general, long-term unemployment is more common among people with disability; it concerns about 20% of all unemployed persons with disability in Denmark, and about 40% in the other three countries. In Denmark the share of long-term unemployed people with disability actually fell, both absolutely and with regard to people without disability.

Despite the higher risk of unemployment, people with disability also have higher shares of inactives among the non-employed population in all four countries, ranging from 81% in Finland to 95% in Ireland, compared to 68% (Finland) to 90% (Ireland) for people without disability (Table 1.3). Related to the higher family-related inactivity of women (which is much less pronounced in Denmark), this is a better measure of disability-related labour discouragement for men for whom people with disability have 12-17 percentage point higher inactivity shares in all four countries.

Table 1.3. **Higher shares of inactivity among non-employment for people with disability**

Share of inactives in percentage of non-employed population, by gender, around 2005[a]

		All	Gender	
			Men	Women
Denmark	Disability (D)	91.0	90.4	91.4
	No disability (ND)	79.3	76.6	81.1
	D/ND	*1.15*	*1.18*	*1.13*
Finland	Disability	80.5	77.6	83.3
	No disability	68.3	61.0	74.6
	D/ND	*1.18*	*1.27*	*1.12*
Ireland	Disability	95.1	93.6	96.4
	No disability	89.8	80.7	94.4
	D/ND	*1.06*	*1.16*	*1.02*
Netherlands	Disability	93.0	91.2	94.3
	No disability	85.7	79.1	89.1
	D/ND	*1.09*	*1.15*	*1.06*

a) Definition of disability on self-assessment basis: see Figure 1.1. Data refer to 2004 for Ireland and 2006 for the Netherlands.

Source: National labour force surveys (Denmark, Ireland Netherlands); EU-SILC (Finland).

Employment policies for people with disability are targeted mostly at those who would wish to work – unemployed but also inactive persons. Some indication of the share of inactive people with disability who, despite their disadvantage, wish to take up a job is available for two countries from the EU Labour Force Survey. Table 1.4 shows that, overall, the share of working-age people with "permanent" disability reporting a wish to work is pretty low: 12% in Denmark and 7% in Finland compared with an EU average of 21%. These levels are also much lower than those found for the other seven countries reviewed in OECD (2006b, 2007b) with the exception of Luxembourg. The percentage of inactive persons with disability wishing to work further depends on age and decreases sharply for the older age group (50-64) to levels around 5%.

Table 1.4. **Only a minority of inactive persons with disability want to work**

Percentage of inactive persons permanently disabled who say they want to work, by age group, 2004/2005[a]

		Total	20-34	35-49	50-64
Denmark	Men	12.5	33.4	19.5	4.8
	Women	10.9	30.9	18.3	4.5
	Total	11.6	32.1	18.8	4.6
Finland	Men	7.0	17.2	12.0	4.5
	Women	7.0	14.6	11.5	5.1
	Total	7.0	16.1	11.8	4.8
OECD Europe[b]	Men	21.8	29.7	27.5	17.3
	Women	20.0	30.7	27.7	14.4
	Total	20.9	30.1	27.6	15.8

a) Figures refer to the average of 2004 and 2005. No data available for Ireland and the Netherlands.
b) Data are the weighted average of EU19 (excluding Ireland and the Netherlands), Iceland, Norway and Switzerland.
Source: EU Labour Force Survey 2004 and 2005.

1.2. Financial resources of people with disability: income and poverty

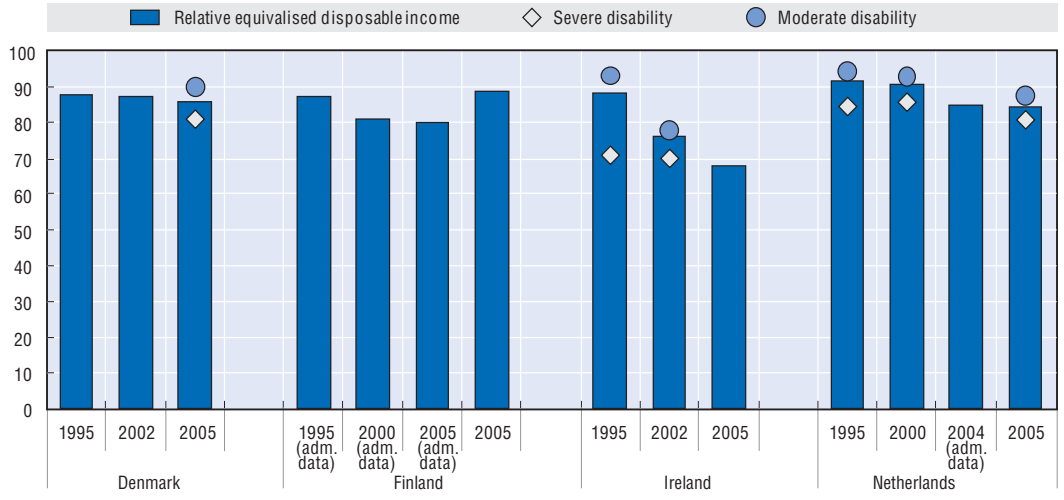
A. Relative income levels

On average, people with disability have less financial resources than those without in all four countries, but relative income levels appear to be much lower in Ireland than in the other three countries. Figure 1.3 shows trends in equivalised disposable incomes: this indicator is best suited for international comparisons, because it takes into account all household incomes net of taxes but corrects for differences in household size[5] and refers only to persons with disability. On that basis, average income levels are close to 90% of those of persons without disability in Denmark, Finland and the Netherlands, but less than 70% in Ireland. For comparison, relative incomes stand also at some 70% in Australia and the United Kingdom, 80% in Poland, and 85-90% in Luxembourg, Norway, Spain and Switzerland (OECD, 2006b, 2007b).[6] For those countries for which data are available, incomes of persons with severe disability are 7-10 percentage points below those of persons with moderate disability.

Over the past ten years, relative incomes remained pretty stable in Denmark and slightly decreased in the Netherlands while they fell considerably in Ireland, from a level similar to that of the other countries down to 68%. This suggests that Irish people with disability did not enjoy the same improvements from the booming economy as their peers without disability. This relative drop concerned predominantly the incomes of people with

Figure 1.3. **Relative income levels of persons with disability are lower in Ireland than elsewhere**

Average equivalised incomes of persons with disability over those without (percentage), 1995-2005[a, b]



a) Definition of disability on self-assessment basis (existence of chronic health problem and long-term limitations in daily life activities), except for Finland (time series 1995-2005): administrative definition (adm. data), *i.e.* persons with legal certificate giving raise to tax deductions/allowances due to disability, and for the Netherlands 2004: "work disabled" definition: suffering from a long-lasting complaint, illness or disability which impedes carrying out or obtaining a paid job.

b) Income concept: disposable household income per equivalent person, except for Netherlands 2004: disposable household income.

Source: Denmark: SFI database; regarding the estimates for Denmark, see also footnote 10; Finland: IDS (Income Distribution Statistics); Ireland: national estimates based on ECHP and EU-SILC; Netherlands: Secretariat estimates based on ECHP (1995, 2000) and EU-SILC (2005) and LFS (2004). ECHP estimates were provided by ESRI. Due to differences in data collection and definitions, results based on EU-SILC 2005 are not strictly comparable with those based on ECHP 1995 and 2000.

moderate disability which fell by some 15 points in the late 1990s while those of people with severe disability did not move much. Trend data for Finland are available only according to a much stricter administrative disability classification: persons receiving tax allowance/deductions due to work incapacity reasons. According to these data, relative incomes decreased during the late 1990s and remained stable since then.

How do these income levels compare to those of other economically vulnerable groups in the countries? For example, income levels for single parents are at about 50% of that of the total population in Ireland, about 60% in the Netherlands and 70% in the two Nordic countries (OECD average 65%). For persons aged 75 years and over, these levels are 60% in Ireland, 70% in the two Nordic countries and 85% in the Netherlands (OECD average 78%) (OECD, 2008b). Levels of relative incomes of persons with disability are, therefore, somewhat higher than those of these two groups at risk in all four countries.

Income levels of people with disability are much higher when they have a higher educational attainment Table 1.5). With tertiary education, they exceed the levels of average income of the total working-age population, especially in Finland. Also having a job is associated with income levels close to the total average level. Except for Denmark, income levels are lowest for those people with disability who are unemployed, rather than those who are inactive. Income levels of older people with disability are 15-20 points higher than for the younger except in Ireland where they do not vary across age groups.

Table 1.5. **Unemployed and lower educated people with disability have the lowest financial resources**

Income levels of people with disability in percentage of average income of working-age population, 2005[a, b]

	All	Gender		Age group			Educational attainment			Labour force status		
		Men	Women	20-34	35-49	50-64	Below secondary	Upper secondary	Tertiary	Employed	Un-employed	Inactive
Denmark	88	89	88	73	87	96	75	91	107	99	73	74
Finland	91	92	90	80	90	95	80	85	118	106	63	76
Ireland	71	69	73	74	70	71	60	80	113	93	48	62
Netherlands	87	89	86	78	84	92	80	86	104	101	69	81

a) Definition of disability on self-assessment basis (existence of chronic health problem and long-term limitations in daily life activities).

b) Income concept: disposable household income per equivalent person, except for Netherlands 2004: disposable household income.

Source: Denmark: SFI database; regarding the estimates for Denmark, see also footnote 10; Finland: IDS (Income Distribution Statistics); Ireland: national estimates based on EU-SILC; Netherlands: Secretariat' estimates based on EU-SILC.

B. Incidence of low incomes and poverty risks

To which extent do the lower income levels coupled with distributive patterns of earnings, transfers and other incomes lead to increased poverty risks among the population with disability? First, and foremost, a higher percentage of people with disability fall in the lower income deciles and a correspondingly lower percentage in the richer deciles; this picture is particularly pronounced in Ireland (Table 1.6). While, by definition, one-tenth of the total working-age population falls in the lowest decile, 22% of all persons with disability in Ireland do so compared to 10-15% in the other three countries.[7] These percentages increase to 54% among the poorest three deciles in Ireland, 42% in Denmark, 40% in the Netherlands and 37% in Finland. In Denmark, Ireland and the

Table 1.6. **More persons with disability among the lowest income deciles, especially in Ireland**

Cumulative percentages of persons with disability in lower and higher income deciles (deciles based on incomes of the total working-age population)[a, b]

		Lowest decile	Two lowest deciles	Three lowest deciles	Three highest deciles	Two highest deciles	Highest decile
Denmark	1995	14	29	41	22	15	7
	2002	16	32	43	23	15	6
	2005	15	31	42	20	13	6
Finland	1995 (adm. data)	13	29	44	19	11	6
	2000 (adm. data)	13	27	40	20	13	6
	2005 (adm. data)	13	31	45	19	11	5
	2005	12	25	37	26	17	8
Ireland	1995	13	30	43	21	12	6
	2000	19	34	47	16	11	4
	2005	22	41	54	14	9	3
Netherlands	1995	12	25	37	23	16	8
	2000	12	26	39	24	15	8
	2004 (LFS)	18	32	43	20	13	6
	2005	10	28	40	21	14	7

a) Definition of disability on self-assessment basis (see Figure 1.3).
b) Income refers to disposable household income per equivalent person (equivalence elasticity = 0.5), except for Netherlands 2004 (disposable household income).

Source: Denmark: SFI database; regarding the estimates for Denmark, see also footnote 10; Finland: IDS (Income Distribution Statistics); Ireland: national estimates based on ECHP and EU-SILC; Netherlands: Secretariat estimates based on ECHP for 1995 and 2000, EU-SILC for 2005, and LFS for 2004. ECHP estimates were provided by ESRI. Due to differences in data collection and definitions, results based on EU-SILC 2005 are not strictly comparable with those based on ECHP 1995 and 2000.

Netherlands, a greater number of persons with disability is clustered between the lowest and second-lowest decile, some 15 to 20%. In turn, just 14% of people with disability in Ireland are part of the richest 30% of the working-age population, compared to some 20% in Denmark and the Netherlands and as much as 26% in Finland.

As concerns trends, relative income positions for persons with disability have remained remarkably stable in Denmark, Finland and the Netherlands. In Ireland, on the other hand, the share of people with disability in all lower income segments has continuously increased in the decade between 1995 and 2005, with a corresponding decrease of the share in all higher income deciles.

Table 1.7 details the incidence as well as relative risks of the population with disability in the lower income segments. By convention, two low-income thresholds are shown: 50% and 60% of the median income of the total working-age population.[8] Poverty rates, defined in these terms, are lowest in the Netherlands: 6% of people with disability have incomes below 50% of median income,[9] and 12% below 60% of median income. These rates are somewhat higher in Denmark[10] and Finland, with 8-12% of persons with disability falling below the lower income cut-off, and 22-25% below the higher income cut-off. And they are substantially higher in Ireland, with 25% of people with disability having incomes less than 50% of the median and 37% less than 60%. With regard to the total working-age population, this means that disability does not increase the poverty risk under both thresholds in the Netherlands. It increases the risk in Denmark and Finland – but only under the higher poverty threshold. And it doubles the poverty risk under both thresholds in Ireland.

Table 1.7. **Being employed reduces otherwise higher poverty risks among persons with disability**

Poverty rates and relative poverty risk for persons with disability, by labour force status[a, b]

	Denmark		Finland		Ireland		Netherlands	
	1995	2005	1995	2005	1995	2005	1995	2005
	A. Low-income threshold 50% of total median income							
Poverty rate of persons with disability	10	12	4	8	12	25	9	6
Total relative risk rate	1.10	1.17	0.76	1.04	1.34	2.15	1.20	0.84
Risk rates by labour force status								
Employed	0.48	0.55	0.27	0.66	. .	0.75	. .	0.84
Unemployed	2.17	3.19	2.00	1.41	. .	3.79	. .	1.82
Inactive	1.63	1.71	0.79	1.14	. .	2.73	. .	0.78
	B. Low-income threshold 60% of total median income							
Poverty rate of persons with disability	20	25	12	22	25	37	14	12
Total relative risk rate	1.23	1.45	1.25	1.59	1.54	2.10	1.21	1.04
Risk rates by labour force status								
Employed	0.55	0.64	0.26	0.59	. .	0.88	0.81	0.80
Unemployed	2.27	2.40	2.23	1.76	. .	2.85	2.63	1.84
Inactive	1.90	2.33	1.39	1.90	1.75	2.65	1.44	1.13

a) Poverty rates: percentages of disabled persons in households with less than 50% and 60% of the median adjusted disposable income. Relative poverty risk: group-specific poverty rate divided by overall poverty rate for the working-age population.

b) Definition of disability on self-assessment basis (existence of chronic health problem and long-term limitations in daily life activities), except for Finland: administrative definition.

Source: Denmark: SFI database; regarding the estimates for Denmark, see also footnote 10; Finland: IDS (Income Distribution Statistics); Ireland: national estimates based on ECHP and EU-SILC; Netherlands: Secretariat estimates based on ECHP and EU-SILC. ECHP estimates were provided by ESRI. Due to differences in data collection and definitions, results based on EU-SILC 2005 are not strictly comparable with those based on ECHP 1995 and 2000.

The share of persons clustered between the two low-income cut-off lines of 50% and 60% median income gives some hint on the severity of the low-income situation. A higher percentage of people falling between these two benchmarks indicates that smaller increases in income are needed to push these people above the 60% poverty line. In Ireland, this concerns one-third of people with disability with low incomes, while in Denmark and the Netherlands it concerns around half and in Finland as much as 63%.

Employment is a most important factor for reducing poverty risks. In all four countries, employed persons with disability have poverty rates which are below the average of the total working-age population. This pattern is particularly pronounced in the two Nordic countries. It should be noted that employment substantially reduces poverty risks among people without disability, too. However, the counter-factual – inactivity and in particular unemployment – has a much more detrimental effect on the income position of persons with disability, especially in Denmark and Ireland.

Over the past ten years, poverty rates of persons with disability decreased in the Netherlands. They increased slightly in Denmark, but they doubled in Finland (though from a fairly low level) and in Ireland. The increase was faster than for the population without disability in the latter three countries. Furthermore, relative poverty risks increased for all groups among the population with disability, including those with below-average risks: those with a job and those with higher education (data not shown).

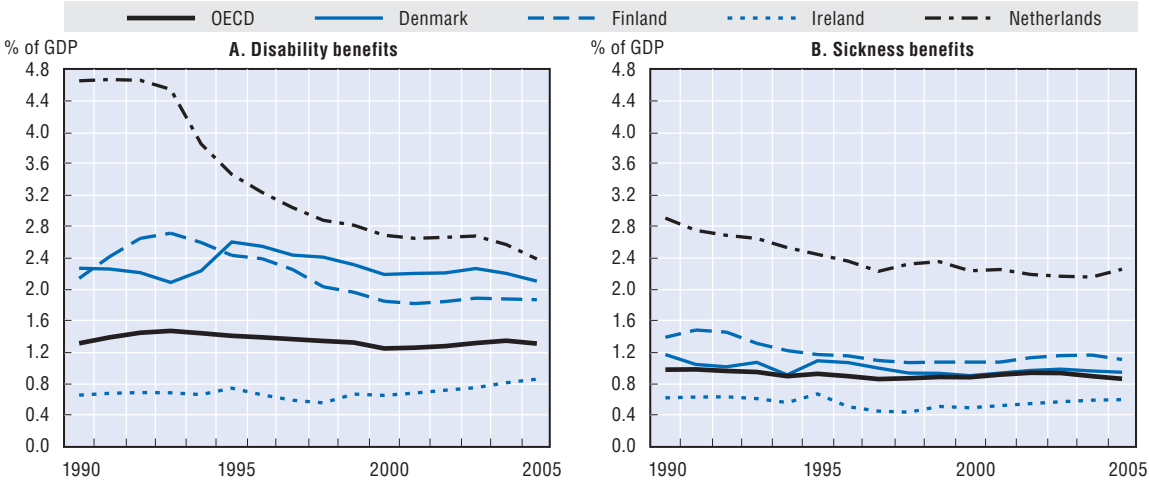
1.3. Costs of disability schemes: public spending and benefit dependence

A. Amount and composition of public spending

Moderating the high costs of sickness and disability is one of the key policy concerns – in some countries, however, more than in others. The Netherlands are outstanding in two respects: By 2005, spending on disability benefits was still significantly higher than in the other countries, with 2.4% of GDP more than double the OECD average.[11] At the same time, this country achieved to bring down spending on disability benefits by half since 1990 (Figure 1.4). This compares to spending of just below 2% of GDP in the two Nordic countries, which is also above OECD average. After a falling trend in the late 1990s, spending took up again in both countries at the beginning of the 2000s, especially in Denmark, to become stable in the more recent years. Spending was lowest and significantly below OECD average in Ireland, where it remained at a stable 0.5-0.6% of GDP throughout the 1990s and slightly took off in recent years.

Figure 1.4. **Falling trend in spending on disability benefits in the late 1990s but a slight rise lately**

Annual spending on disability[a] and sickness benefits[b], percentage of GDP, 1990-2005



a) Denmark: disability pension; Finland: disability pensions from various schemes; Ireland: invalidity pension, disability allowance and illness benefit after two years; Netherlands: disability pensions from various schemes.

b) Includes public and mandatory private spending on sickness benefits. Shares of public sickness benefit spending are 77% in Denmark, 40% in Finland, 100% in Ireland (illness benefit in the first two years and sickness benefits for civil servants); and 54% in the Netherlands.

Source: *Social Expenditure database* and data supplied by national authorities.

In the two Nordic countries, spending on sickness benefits constitutes less than half that on disability, while in Ireland and the Netherlands it is almost equal to that on disability. In Denmark, Finland and Ireland, sickness spending is rather similar to the OECD average of about 1% of GDP. Again, the Netherlands stand out with a very high spending share, twice the OECD average. Nevertheless, spending on sickness benefits showed a decreasing trend in the Netherlands while it remained rather stable around the OECD average in the other three countries.

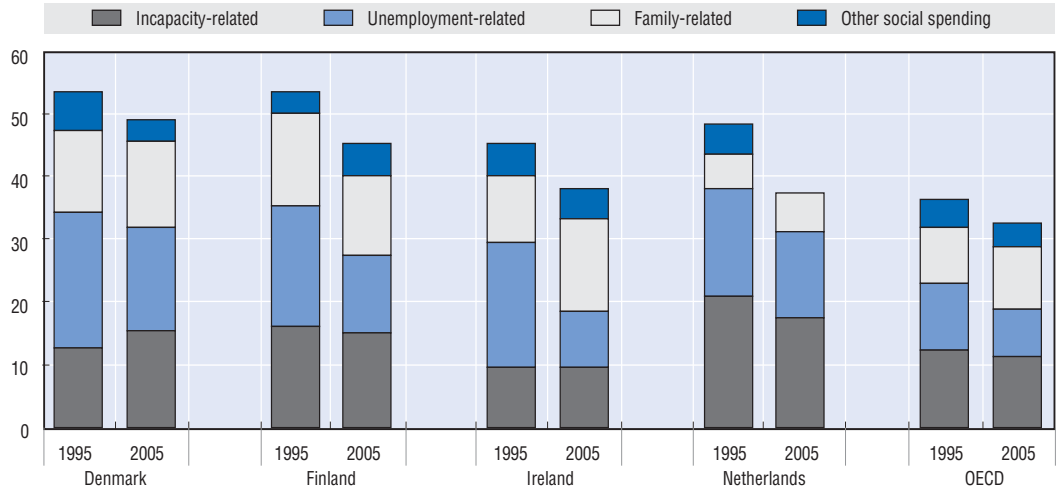
Adding expenditures on occupational injury benefits and services to those on disability and sickness benefits raises total public spending on incapacity-related schemes to around 4% of GDP in the two Nordic countries, *i.e.* a level close to that of the Netherlands,

and to 1.5% in Ireland (OECD average 2.5%). This is a considerable commitment of resources – especially when compared with other working-age related public social expenditure.

Today, incapacity-related public spending is as important as unemployment-related expenditures in Denmark (each of the two categories account for some 16-17% of total social expenditures), Finland (13-15%) and Ireland (9-10%) (Figure 1.5). This has not been the case in the past: in 1995, unemployment-related expenditures were considerably higher in these three countries. On the other hand, incapacity-related spending is much higher than unemployment- but also family-related public spending in the Netherlands: it accounts for as much as one fifth of total public social expenditures.[12]

Figure 1.5. **Incapacity-related spending increasingly as important as unemployment-related spending**

Annual non-health working-age spending,[a] by type, percentage of total public social expenditures, 1995 and 2005



a) Incapacity-related spending includes public disability and sickness benefits as well as services for people with disability. Unemployment-related spending includes unemployment benefits and active labour market programmes for the unemployed; family-related spending includes family allowances, parental leave benefits and child and childcare services; and other spending mainly includes social assistance and housing benefits.

Source: OECD Social Expenditure database.

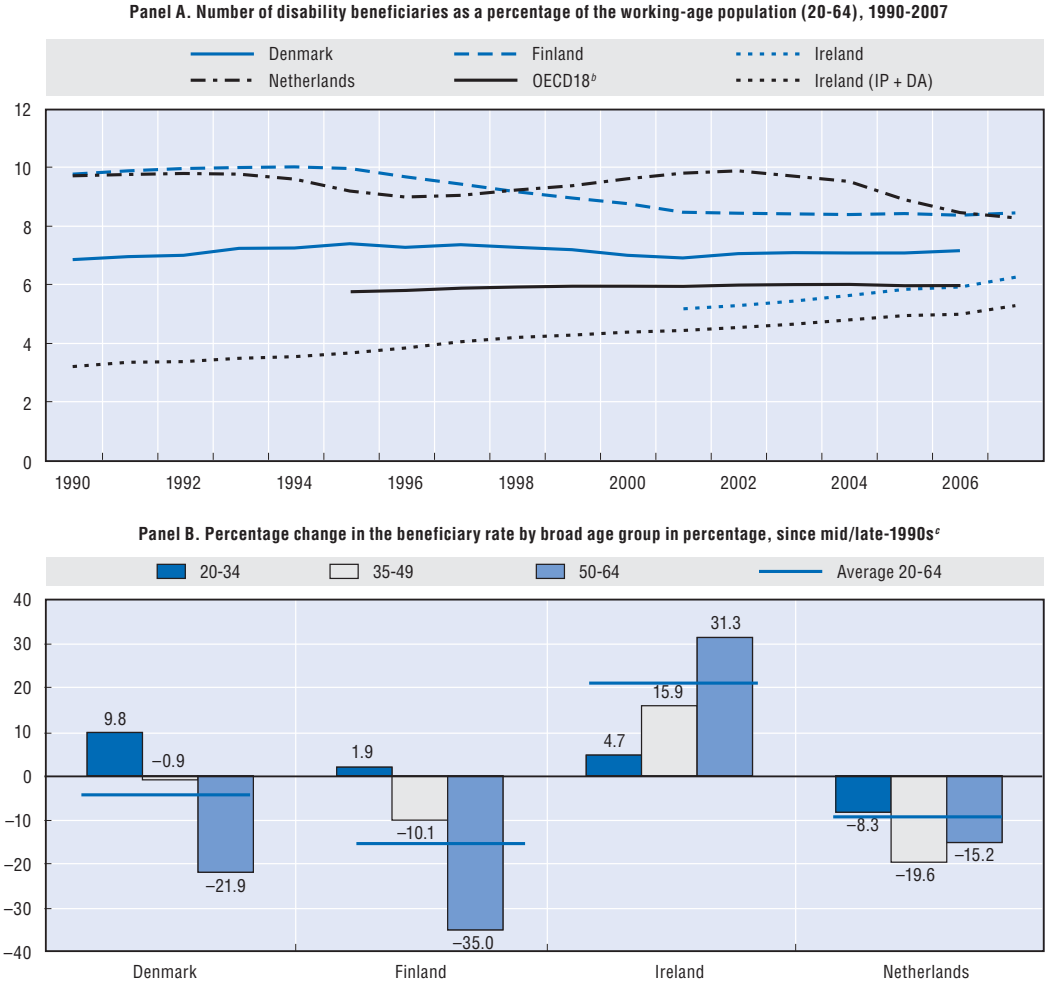
B. Trends in benefit recipiency

Trends in benefit recipiency rates among the working-age population vary across the four countries (Figure 1.6, Panel A). In Denmark, the beneficiary rate oscillated around 7% for the past 15 years. In Finland, the share of disability beneficiaries decreased from 10% to 8.5% in the late 1990s and remained stable since 2001. The Netherlands recorded a steady decrease in beneficiary rates since 2002. Ireland was the only country where disability beneficiary rates increased steadily throughout the whole period, up to currently 6%. That said, by 2007 all four countries recorded levels superior to those found across 18 OECD countries in 2006.

Changes in beneficiary rates during the past ten years have been driven mostly by the older age groups except in the Netherlands where it has been driven by both prime-age adults and older age groups. This is in contrast to the experience of the four countries reviewed in 2007 (Australia, Luxembourg, Spain and the United Kingdom) where changes

Figure 1.6. **Disability benefit rolls are increasing in Ireland but have fallen recently in the Netherlands**

Benefit recipiency rates 1990-2007 and change in the beneficiary rate by broad age group (percentage)[a]



DA = disability allowance; IP = invalidity pension.

a) Beneficiaries: disability pension (Denmark); persons receiving statutory earnings-related pension and/or national disability pension (Finland); disability allowance, invalidity pension and persons on illness benefit for over two years (Ireland); the longer time series (IP + DA) excludes illness benefit; Wajong, WAO and WIA (Netherlands).

b) OECD18 is an unweighted average comprised of: Australia, Austria, Belgium, Denmark, Finland, Germany, Ireland, Luxembourg, the Netherlands, New Zealand, Norway, Poland, Portugal, Spain, Sweden, Switzerland, the United Kingdom and the United States.

c) Period covered is 1995-05 in Denmark, 1995-2007 in Finland, 1999-2006 in Ireland and 1999-2007 in the Netherlands.

Source: Data supplied by national authorities: Statistics Denmark (Denmark), ETK (Finland), Department of Social and Family Affairs (Ireland), MEV 2007 (Netherlands).

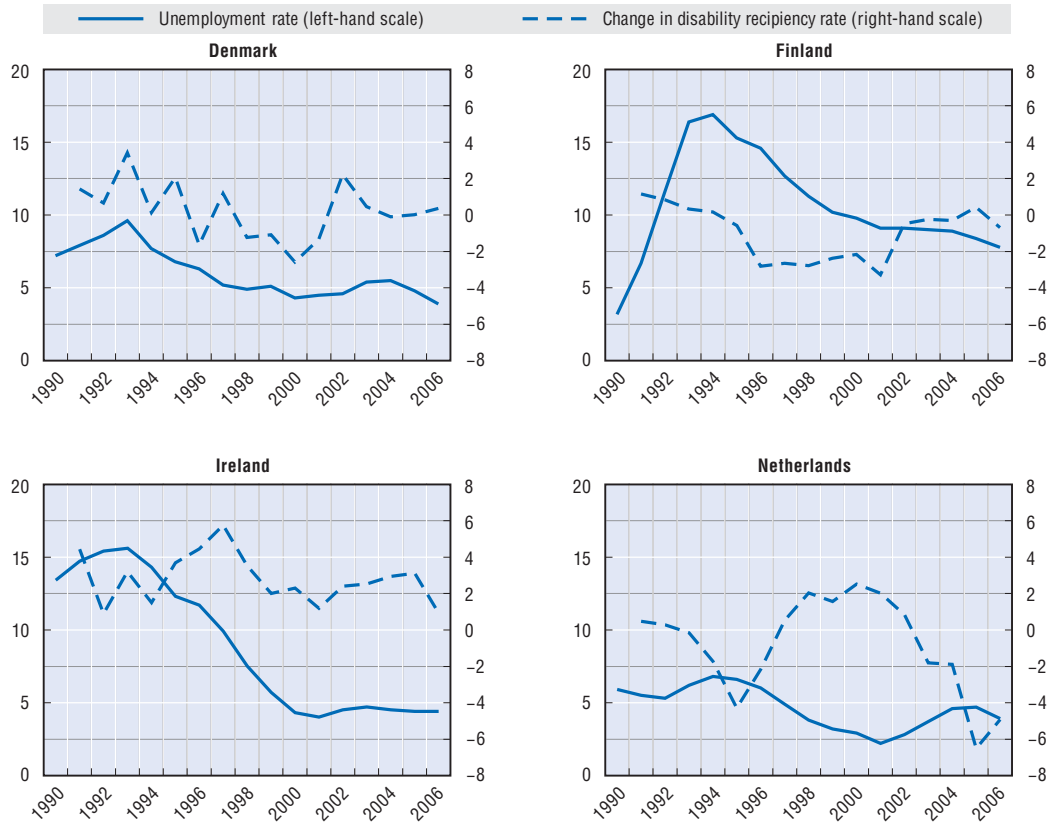
were to a larger extent attributable to younger people. For instance, in Denmark and Finland the beneficiary rate of people below 35 increased while it fell for people over 49, by as much as one-fifth (Denmark) and one-third (Finland), respectively (Figure 1.6, Panel B).

The data above do not reflect the full picture on dependency on health-related benefits in all countries. In Denmark, in particular, other benefits such as rehabilitation benefits are frequently used, with more than 11% of the working-age population receiving some type of health-related benefit – a share that is higher than in both Finland and the Netherlands and many other OECD countries.

To what extent are changes in disability recipiency rates explained by "substitution" between benefits, in particular between disability and unemployment benefits? Figure 1.7 plots the development of the unemployment rate (ILO definition) since 1990 against percentage point changes in the disability recipiency rate. This suggests that there is indeed a strong statistical relationship between these two schemes in Finland and the Netherlands, a weaker relationship in Ireland and practically no relationship (except in 2002-2003, the first year after the disability reform) in Denmark. The fall in unemployment seems to have resulted in higher disability recipiency rates to some degree, and *vice versa*.

Figure 1.7. **Some substitution between disability and unemployment in Finland and the Netherlands**

Unemployment rate and percentage point changes in disability beneficiary rate, 1990-2006[a]



a) Beneficiaries: disability pension (Denmark); persons receiving statutory earnings-related pension and/or national disability pension (Finland); disability allowance, invalidity pension and persons; Wajong, WAO and WIA (Netherlands).

Source: Data supplied by national authorities: Statistics Denmark (Denmark), ETK (Finland), Department of Social and Family Affairs (Ireland), MEV 2007 (Netherlands). OECD Labour Force Statistics.

C. Average benefit levels

The second key factor in explaining spending trends is developments in average benefit levels. It appears that trends in disability beneficiary rates are to some extent mirrored by trends in levels of average disability benefits and this contrasts the pattern identified in the four countries reviewed in OECD (2007b), Australia, Luxembourg, Spain and the United Kingdom. Table 1.8 summarises the development and relative level of average disability benefits over the period 2001 to 2006. On the one hand, in Denmark and

Table 1.8. **Average disability benefits grew faster than wages in Denmark and Ireland, but lagged behind in Finland and the Netherlands**

Annual average growth rates of average disability benefit, gross wage and take-home pay (in real values), 2001-2006[a]

	Annual average growth real values,[b] 2001-2006[c]			Disability benefit, 2006		
	Disability benefit	Gross earnings	Take-home pay	% of minimum wage	% of gross earnings	% of take-home pay
Denmark	2.3	0.8	1.6	*	41	68
Finland	0.7	2.9	3.6	*	35	50
Ireland	5.9	1.8	2.3	57	35	40
Netherlands	–1.5	0.6	–1.1	100	40	62

a) Data for Denmark refer to the disability pension, for Finland to persons receiving statutory earnings-related pension and/or national pension (full or partial), for Ireland to invalidity pension recipients and to WAO/WAZ recipients for the Netherlands. Disability benefits reported as gross values. Gross earnings refer to the average worker earnings, take-home pay to net earnings of an average worker (see OECD, 2008c).
b) Deflated with private consumer price index (PCP).
c) Years 2000-2005 for Denmark and 2000-2006 for the Netherlands.
Source: Data supplied by national authorities; OECD (2008), *Taxing Wages 2006-2007*.

especially Ireland the real average value of disability benefits increased much faster than corresponding wage indicators. In both countries the annual growth was some three times higher than that of gross earnings. Nevertheless, in Ireland, this increase in benefit levels was not sufficient to counter the drop in disposable household incomes and the rise in poverty levels.

On the other hand, in Finland and the Netherlands, the annual average growth rate of disability benefits lagged behind that of net and gross wages. In the Netherlands, the real value of WAO/WAZ payments even fell, by about 1.5 points annually between 2000 and 2006. It should be noted that changes in average benefit figures do not necessarily mirror changes in persons' income levels. Changes in average benefit levels can be the result of a number of developments: changes in the composition of beneficiaries, *e.g.* with regards to age; changes in the share of people on partial benefits; and, also, benefit reforms.

There are fewer differences as to the relative value of the average disability benefit across countries. In all four countries, the average benefit is "worth" between 35 and 40% of average gross earnings.[13] It is an open debate whether these constitute levels which can possibly lead to "benefit traps" for some of the beneficiaries (see Chapter 4). Due to different income tax regimes, there are more differences with regard to benefit levels relative to net earnings (take-home pay), which span from 40% in Ireland to 68% in Denmark. Where minimum wages exist, they are set at around the same level as the average disability benefit (Netherlands) or much higher than this (Ireland).

1.4. Exclusion and inclusion errors: disability benefit recipiency and disability prevalence

A. Understanding the concept of "disability"

The number and composition of people describing themselves as "disabled" due to a health condition is not identical to those who claim and receive an incapacity-related benefit. Estimating the extent of "disability" is therefore far from being straightforward. In contrast to the contingency "unemployment" for instance (having a job or not; searching and being available for work or not), disability status is rarely dichotomous and much more a matter of degree. Disability can be defined as a self-assessed status or else as a legal

status based on administrative sources, *e.g.* benefit receipt or holding a legal disability certificate. Often, and perhaps inaccurately so, these two definitions are referred to as "subjective" *versus* "objective" disability. All four countries under review use data and indicators derived from both self-assessed and administrative definitions.

None of the above definitions and measures is "superior" to the others; rather, they measure different though related phenomena. Throughout this report, both types of measures are analysed. In general, when mention is made of "disability prevalence", this refers to *self-reported* disability status, while "disability recipiency" (current numbers and inflows into disability) is calculated on the basis of *administrative* definitions, *i.e.* recipiency of disability benefit.

Beneficiary rates according to registers amount to between 6% (Ireland) and 8.5% (Netherlands) (column A of Table 1.9). Household surveys estimate a larger share of disability benefit recipients in the working-age population as do administrative registers, especially in Ireland (column B). In the latter country this is mainly due to the fact that the survey includes all sickness benefit recipients in the estimate. In the two Nordic countries, surveys estimate 1 to 3 percentage point higher beneficiary rates and in the Netherlands, survey estimates are even slightly lower than registers. On the other hand, "subjective" definitions on the basis of own-assessed health lead to much higher disability rates (columns D to F): between 12% in Ireland and as much as 34% in Finland. That said, due to variations in actual questions asked, even among the self-assessed category using very similar definitions, estimates may vary between surveys, as can be seen when comparing results for Finland and the Netherlands in Columns D and F. Finally, estimates for a sub-set of self-assessed disability derived via work-related status – those specifying their status as

Table 1.9. **Disability benefit receipt and disability prevalence: two different concepts**

Number of working-age persons with a disability as a percentage of the working-age population, 2005 (or closest)

	Administrative disability status			Self-assessed disability status				
	Beneficiaries (registers)	Beneficiaries (survey)	Legal status (survey)	Health definition: EU-SILC	Health definition: National LFS	Health definition (EU-LFS 2002)	Work status definition (EU-LFS)	Search for work definition (EU-LFS)
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Denmark	7.1	10.4	. .	14.0	20.7	20.6	7.1	6.4
Finland	8.4	9.6	9.9	23.6	. .	33.7	6.9	6.8
Ireland	6.0	12.1	. .	13.6	. .	11.7	3.3	0.4
Netherlands	8.5	7.2	. .	19.2	16.8	26.4	5.0	6.1

. .: Data not available.

Source and definitions: (A) Denmark (2005): disability pension; Finland (2006): persons receiving statutory earnings-related or national disability pension; Ireland (2006): disability allowance, invalidity pension and persons on illness benefit for over two years; Netherlands (2006): Wajong, WAO and WIA benefit; (B) Denmark (2005): LFS 2005, disability pension (or early retirement); Finland (2005): EU-SILC 2005, national estimates ; Ireland (2005): EU-SILC 2005, national estimates; Netherlands (2005): EU-SILC 2005, Secretariat's estimates; (C) Finland (2005): IDS (Income Distribution Statistics), Persons with legal certificate giving raise to tax deductions/allowances due to disability; (D) Denmark (2005) and Netherlands (2005): EU-SILC, Secretariats estimates; Finland (2005) and Ireland (2005): EU-SILC 2005, national estimates (persons with a chronic health problem and limited in daily activities for at least six months); (E) Denmark (2005): LFS 2005 (persons with a long-standing health problem or disability); Netherlands (2006): LFS (work disabled: suffering from a long-lasting complaint, illness or disability which impedes carrying out or obtaining a paid job); (F) EU-LFS 2002 *ad hoc* module on employment of people with disability: existence of a long-standing health problem or disability; (G) EU-LFS 2005: persons who give as main status "permanently disabled"; (H) EU-LFS 2005: persons who are not looking for work because of illness/disability.

"permanently disabled" (column G) and those not looking for work because of illness or disability (column H) – result in estimates of disability which are below administrative definitions. They range between below 1% in Ireland and 6-7% in the other three countries.

B. Exclusion and inclusion errors

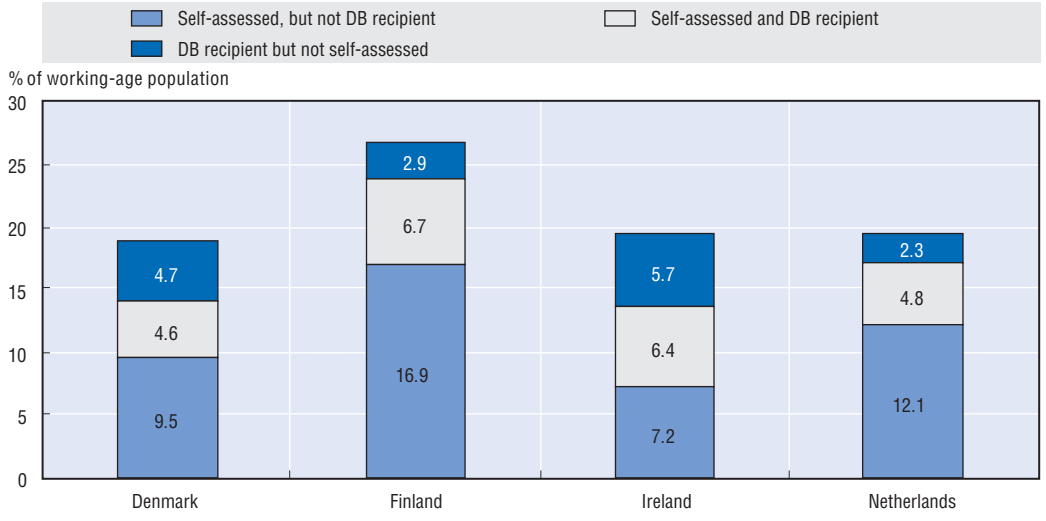
Among those who assess themselves as having a disability, many will not claim or receive disability benefits. They remain "excluded" from the benefit system, either because they are working and/or they have otherwise sufficient economic resources, *e.g.* via other household members (a central issue in family means-tested systems such as in Ireland), or else because of "true" exclusion errors such as insufficient benefit information or stigmatisation. At the same time, there may be a number of persons "included" in the benefit system who would not consider themselves as having a disability.

Figure 1.8 explores the overlap between these population groups in more detail. The total height of the bars indicates the possible extent of disability – *i.e.* people self-assessed as having a disability or disability benefit recipients, or both. This amounts to around 25% of the working-age population in Denmark and a around 20% in Finland, Ireland and the Netherlands. The middle bars show the overlap between the different disability definitions, *i.e.* people who assess themselves as having a disability and who are also on disability benefit rolls. These are between 5% and 7% of the working-age population and they constitute a minor share of the total "disability potential", namely one-third in Ireland and just one-quarter in the other three countries.

Figure 1.8 gives some first indication on the size of "inclusion" and "exclusion" errors: people on benefit registers who do not describe themselves as having a disability on the one hand (upper bars), and people who describe themselves as having a disability but do not receive benefits on the other (lower bars). At first sight, possible inclusion errors seem to be much lower than exclusion errors in three of the four countries. Around one-third of

Figure 1.8. **Many persons with disability do not receive disability benefits and many recipients do not claim to have a disability either**

Overlap between self-assessed and benefit recipient disability, 2005



DB = disability benefits.

Source: EU-SILC 2005, Secretariat's estimates (Denmark, Netherlands); and EU-SILC 2005, national estimates (Finland, Ireland).

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persons on a disability benefit consider themselves as not having a disability in Finland and the Netherlands and about half in Denmark, while a large majority of self-assessed people with disability do not receive a disability benefit in these countries (around 70%). The exception is Ireland: both the possible inclusion and exclusion errors are around 50%.

These summary indicators capture the extent of exclusion from disability benefits at large, but not necessarily "exclusion errors". People with disability may be covered by other social benefits or may have own earnings preventing them from drawing disability benefits. Table 1.10 therefore presents two additional estimates of exclusion errors, namely the share of persons with disability without any public social benefit, and, among those, people not being employed.

The share of people with disability without access to any public social benefit is between 20 and 25%. When turning to the strictest definition – those with neither benefits nor employment – the exclusion error falls to 8% in Ireland and the Netherlands, 2% in Denmark and merely 1% in Finland. These values are much lower than those found for a set of countries studied by OECD recently (OECD, 2007b). In general, when applying the strictest definition of exclusion error, those excluded are primarily women, especially in the Netherlands. There are two very different age patterns: in the two Nordic countries, the share of young people with disability increases for those who have neither access to any public benefit nor to employment, from 23% to 28% in Denmark and from 17% to 37% in Finland. On the contrary, in the other two countries only very few younger people with disability are found among those with neither a benefit nor a job (9% in Ireland, 3% in the Netherlands), and this situation concerns to a large majority older persons with disability.

Table 1.10. **Exclusion errors are low in all four countries and lowest in Finland**

Different estimates of exclusion errors, by gender, age and severity of disability, percentage shares, around 2005

Disability status			Percentage distribution						
			Men	Women	20-34	35-49	50-64	Moderate	Severe
Denmark	Total self-assessed disabled population	100	39	61	23	29	44	. .	. .
	of which:								
	– without disability benefit	67	39	61	29	29	35	. .	. .
	– without any benefit	20	43	57	24	17	60	. .	. .
	– without any benefit and not employed	2	35	65	28	20	52	. .	. .
Finland	Total self-assessed disabled population	100	48	52	17	30	52	68	32
	of which:								
	– without disability benefit	66	47	53	20	35	43	75	25
	– without any benefit	20	49	51	17	23	59	77	23
	– without any benefit and not employed	1	36	64	37	7	55	70	30
Ireland	Total self-assessed disabled population	100	47	53	18	34	47	63	37
	of which:								
	– without disability benefit	53	40	60	19	34	45	76	24
	– without any benefit	13	45	55	16	20	64	81	19
	– without any benefit and not employed	4	30	70	9	9	82	67	33
Netherlands	Total self-assessed disabled population	100	42	58	16	35	46	58	42
	of which:								
	– without disability benefit	72	39	61	20	34	42	67	33
	– without any benefit	24	45	55	19	23	58	77	23
	– without any benefit and not employed	8	12	88	3	12	85	66	34

Source: EU-SILC 2005, Secretariat's estimates.

Finally, exclusion seems to concern persons with moderate disability more than those with severe disability.

1.5. Demographic challenges: population ageing and future labour supply shortages

The number of both self-assessed persons with disability and disability benefit recipients increase strongly with age in all four countries. The process of population ageing will, therefore, "automatically" translate into higher disability rates, without any behavioural changes and other things being equal. Related to this fact are concerns about declining labour supply in the forthcoming decades due to population ageing. Mobilising under-utilised labour potential among older workers and workers with disability is sometimes seen as one of the policy answers to this challenge.

A. Effects of ageing on recent trends among disability beneficiaries

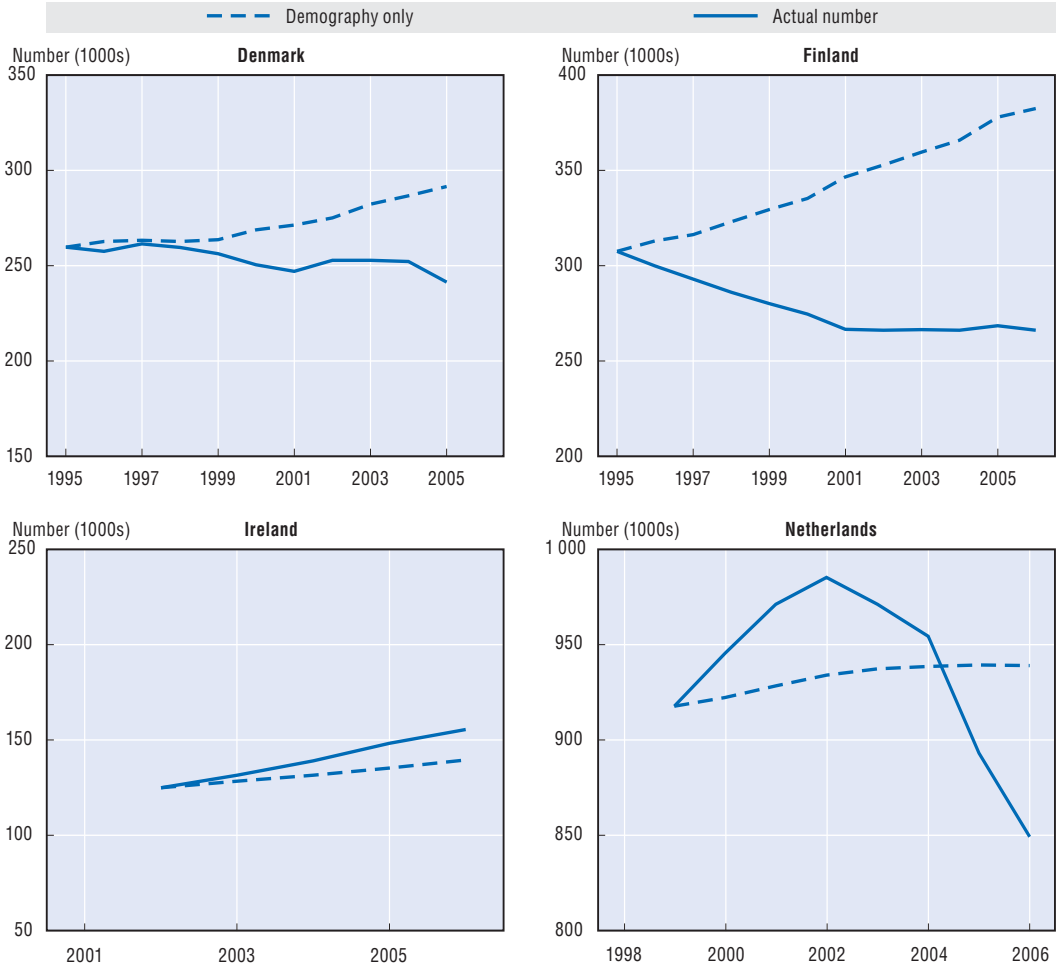
The risk of disability recipiency increases strongly with age; with people aged 50 to 64 having more than twice a probability to be in benefit receipt than the total working-age population (see Table 1.13). Differences in the age structure of the working-age population may therefore explain part of the differences in benefit recipiency rates across the four countries. Adjusting for these differences by applying an OECD average age structure would lower the actual disability recipiency rate especially in Finland (7.2% instead of 8.4%) but also in Denmark (6.6% instead of 7.1%) and the Netherlands (8.0% instead of 8.5%), but slightly increase it in Ireland which has a much younger working-age population (6.3% instead of 6.0%).

To what extent are recent trends in disability beneficiary numbers explained by changes in the population structure in each country? The "pure" effect of ageing can be explored by producing an estimated historical series of disability beneficiaries for the past decade or so for each country, multiplying 1995 (or closest) age- and gender-specific beneficiary rates by population numbers for subsequent years in each age and gender group. The difference between the estimated results and the actual beneficiary numbers is the part of the trend resulting from changes in benefit recipiency rates and therefore not explained by changes in the size of the population "at risk" but by behavioural changes, effects of policies, or both.

Demographic changes alone (dotted lines in Figure 1.9) would have continuously increased disability beneficiary rates in the past years in all countries: by some 10% in Denmark and 20% in Finland, between 1995 and 2005; by 12% in Ireland (since 2002); and by 2% in the Netherlands (since 1999). Actual developments, however, diverged largely across countries (straight lines in Figure 1.9). In Ireland, about half of the increase in beneficiary numbers since 2002 was due to changes in the population age structure, *i.e.* the relatively larger increase in the number of older workers who have a higher risk of acquiring a disability. The other half is explained by changes in the beneficiary rates themselves. The same trend appeared in the Netherlands between 1999 and 2002. However, in the past four years, actual beneficiary rates dropped substantially while the demographic pressure did not – even though the ageing trend was more favourable than in the other three countries. Likewise, in Denmark and Finland, actual beneficiary rates declined by 7% and 13%, respectively, despite the ageing of the working-age population, *i.e.* the reduction since 1995 could have been even larger in the absence of ageing.

Figure 1.9. **Recent trends in beneficiary numbers do not mirror trends in population ageing**

Observed number of disability beneficiaries and estimated number on the basis of beneficiary rates[a] in the first year available since 1995



a) The dotted lines labelled "demography only" show estimated numbers of beneficiaries under the assumption of constant age- and gender-specific beneficiary rates of 1995 (2002 for Ireland; 1999 for the Netherlands); the solid lines show the actual numbers of beneficiaries. All data refer to the age group 20-64.

Source: *OECD Population database* and beneficiary data from national insurance administrations.

B. Demographic challenges on disability policies over the coming decades

Yet another question is how disability beneficiary rates and numbers will evolve over the coming decades as a consequence of future population ageing, all other things being equal. By using national population projections,[14] future trends in disability recipiency and prevalence are estimated, again assuming for illustrative purposes that rates by age and gender remain constant from 2005 onward.

Results from these projections are summarised in Table 1.11. Both the number of beneficiaries and of persons with disability is projected to increase by roughly one-third in Ireland in the very long run, *i.e.* by 2050, but to slightly decline (5-7%) in Finland and the Netherlands and to decline by some 10% in Denmark. Overall, therefore, the demographic pressure on disability policies could well be much higher in Ireland than in the other three countries.

Table 1.11. **Population ageing will have a larger impact on beneficiary and prevalence trends in Ireland**

Projected number of disability beneficiaries and self-assessed persons with disability, 2005-2050[a] (numbers in thousands)

	Denmark		Finland		Ireland		Netherlands	
	Disability benefit recipients	Self-assessed population with disability	Disability benefit recipients	Self-assessed population with disability	Disability benefit recipients	Self-assessed population with disability	Disability benefit recipients	Self-assessed population with disability
2005	174	404	265	776	148	308	898	1 681
2010	171	397	287	798	163	337	944	1 721
2015	172	401	275	771	173	358	938	1 707
2020	172	399	266	752	184	379	943	1 695
2025	165	387	259	735	195	397	928	1 656
2030	157	371	250	719	203	410	886	1 588
2035	150	357	245	715	209	419	837	1 529
2040	148	355	254	726	210	420	818	1 516
2045	153	363	255	727	203	410	832	1 536
2050	155	367	253	722	196	399	850	1 559

a) The results refer to the age group 20-64 for all four countries.
Source: Authors' projections based on *OECD Population database* and beneficiary data from National Insurance Administrations.

Applying specific labour-market integration targets to population and labour force projections can shed some light on the possible impact of mobilising the labour potential among persons with disability. This is done in Figure 1.10 which compares projections of the total labour force (long-dotted lines, on the basis of the above population projections) with projections of the labour force augmented by estimates of persons with disability taking up work (short-dotted lines). The scenario assumes that, by 2025, all four countries will have succeeded in integrating inactive persons with disability into the labour force by an age- and gender-specific percentage which corresponds to the EU-average percentage of persons with disability wishing to work (see Table 1.4) and to double this percentage by 2050. For example, it is assumed that by 2025, 29.7% of 20-34 year old inactive men with a disability will enter the labour force and another 29.7% between 2025 and 2050. This is assumed to be phased in annually from 2005 onward.

Figure 1.10 shows that the labour market integration of all those who would wish to work would have sizeable effects on projected labour supply, although the overall effects could well be insufficient to cope with labour shortages. By 2050, the optimistic scenario would result in a labour force which is some 5 (Denmark, Finland) to 10 (Ireland, Netherlands) percentage points higher than under the constant labour force scenario. This would close the gap to the projected growth of the total population by almost 30% in the two Nordic countries, but more than 50% in Ireland and the Netherlands.

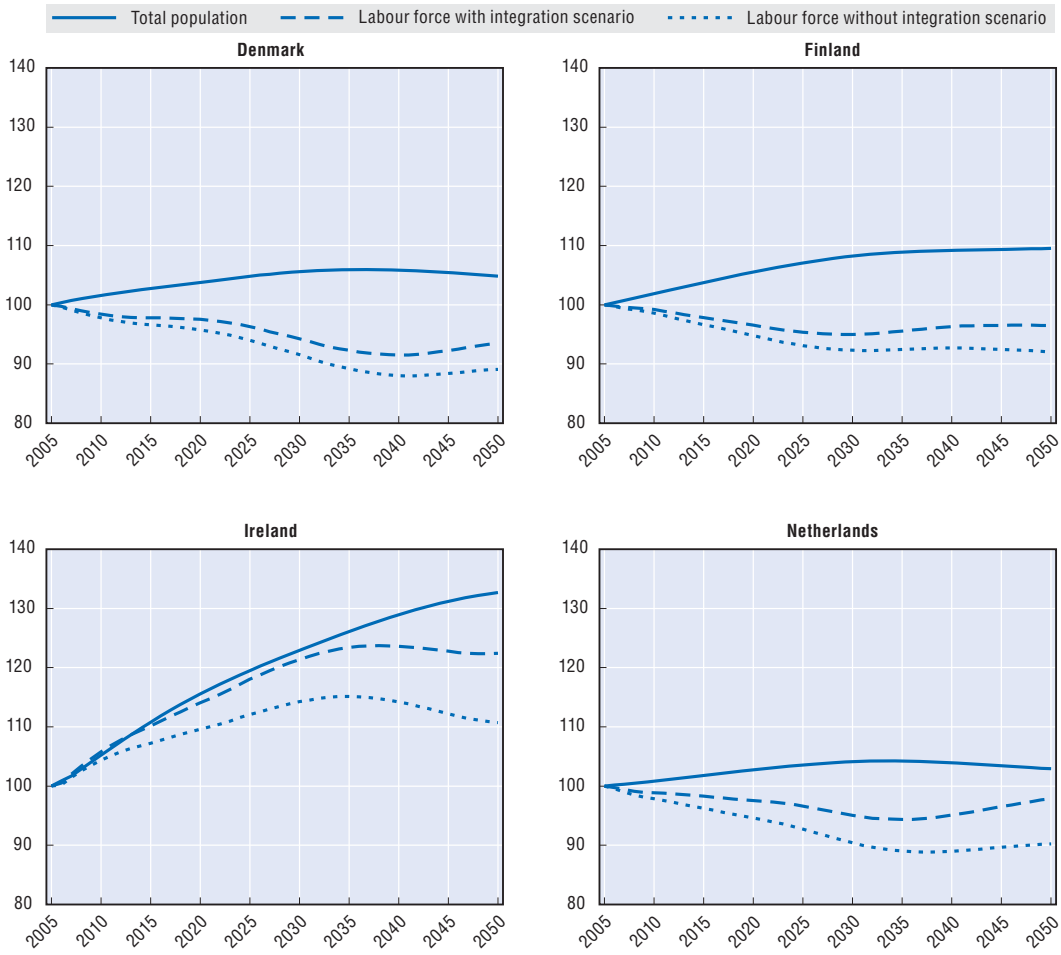
1.6. Impact of labour market requirements: work and health

A. Disability and health trends in the population

As shown above, disability based on self-assessment ("disability prevalence") concerned between 14% (Ireland) and as much as 24% (Finland) of the working-age population and, except in the Netherlands, these figures have not decreased in the past ten years. In Denmark, the prevalence rate increased by 4 percentage points, while gender, age and education differences became smaller. Disability benefit recipiency among the working-age population is lower, between 6% (Ireland) and 8.5% (Netherlands) (Table 1.12).

Figure 1.10. **Labour market integration of persons with disability would have sizeable effects in Ireland and the Netherlands**

Projected population and labour force 2005-2050 (2005 = 100), labour force under pure demographic and policy reform scenario[a]



a) The short dotted lines assume constant age- and gender-specific disability prevalence rates as at 2005. The long dotted lines assume an annual reduction of beneficiaries until 2050 corresponding to percentages of persons with disability who say they want to work, by age and gender.

Source: OECD (2006), data supplied by national authorities and *OECD Population database*.

Gender differences in self-reported disability are relatively small (Table 1.12, Panel A.). That said, at the most recent date, disabilities are slightly more prevalent among women in all four countries. There is much more of a differential across age, with disability prevalence gradually increasing by age in all four countries, and reaching 1.5 times the overall level at age 50 to 64. That said the age differential seemed to narrow slightly in the past ten years. Educational attainment is negatively linked with disability prevalence, and this link has become stronger over the years in Ireland and the Netherlands.

Relative benefit recipiency rates by age and gender are different from those for disability prevalence (Table 1.12, Panel B.): first, relative benefit recipiency rates of older workers are much higher in all four countries than for disability prevalence – at least twice the overall rate (although decreasing in the two Nordic countries in the past ten years). Second, the gender distribution is opposite in all countries except Denmark, with more

Table 1.12. **Disability prevalence is higher for women, older workers and the low-skilled**

Trends in self-assessed disability prevalence and in disability benefit recipiency by gender, age group and educational attainment, various years

		All (20-64)	Gender		Age group			Educational attainment		
			Male	Female	20-34	35-49	50-64	Below secondary	Upper secondary	Tertiary
Panel A.		Prevalence rate	Relative prevalence (overall prevalence rate = 100)							
Denmark	1995	16.4	84	115	67	90	159	161	83	71
	2005	20.7	94	106	61	90	144	144	95	70
Finland	1996	23.4	94	106	50	83	184	152	90	64
	2005	23.6	98	102	55	87	153	142	99	74
Ireland	1995	11.8	97	103	63	91	160	144	67	(45)
	2005	13.6	95	105	48	99	157	166	66	46
Netherlands	1995	17.8	92	107	63	95	161	120	101	71
	2006	16.8	91	109	53	92	155	157	88	59
Panel B.		Recipiency rate	Relative recipiency (overall recipiency rate = 100)							
Denmark	1995	7.4	83	117	21	75	280	. .	. .	. .
	2005	7.1	90	110	24	78	232	. .	. .	. .
Finland	1995	10.0	106	94	17	50	322	. .	. .	. .
	2005	8.4	105	95	20	54	249	. .	. .	. .
Ireland[a]	2001	5.2	108	92	49	86	233	. .	. .	. .
	2006	6.0	102	98	46	89	236	. .	. .	. .
Netherlands	2000	9.6	114	86	38	83	232	. .	. .	. .
	2006	8.5	109	91	37	73	226	. .	. .	. .

a) Age group 20-34 refers to ages 16-34.

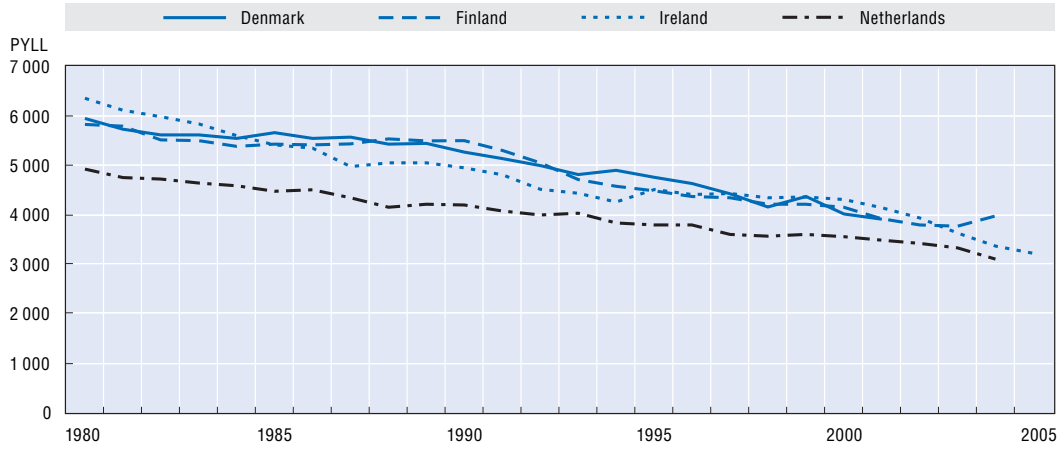
Source: Panel A: ECHP Secretariat's estimates for 1995/96; LFS (Denmark, Netherlands), and EU-SILC Secretariat's estimates (Finland, Ireland) for 2005/6; ECHP estimates provided by ESRI. Due to differences in data collection and definitions, results based on EU-SILC 2005 are not strictly comparable with those based on ECHP 1995 and 2000. Panel B: Statistics Denmark; ETK, Finland; DSFA, Ireland; and MINSZW, Netherlands.

men than women receiving a disability benefit. This suggests that, for recipiency, factors other than health seem to play a key role.

These large and persistent numbers of people with a self-assessed disability as well as disability benefit recipients have to be seen against the background of the improving "objective" health status of the population. One such indicator of this improvement is the "potential years of life lost" (PYLL). This is a summary measure of premature mortality, which provides an explicit way of weighting deaths occurring at younger ages that are, *a priori*, preventable. In all four countries this measure has fallen in the past 25 years. During the 1980s, the decrease was more pronounced in Ireland (minus 22%) than in the other countries (minus 6-15%). Since 1990, the summary measure has fallen by 25 to 30% in all four countries (Figure 1.11).

This means that subjective health or disability indicators provide quite a different trend picture of the health status than objective ones. Furthermore, developments in disability benefit receipt over time are not related to trends in either objective or subjective health indicators. Again, this suggests that these latter trends are to a considerable extent influenced by factors beyond health.

Figure 1.11. **Steadily improving health status in all four countries**
Potential years of life lost (PYLL) until age 70, per 100 000 of population, 1980-2005[a]



a) The calculation of PYLL involves summing up deaths occurring at each age and multiplying this by the number of remaining years to live up to a selected age limit. The limit of 70 years has been chosen for the calculations.

Source: *OECD Health Data 2007*, December 2007.

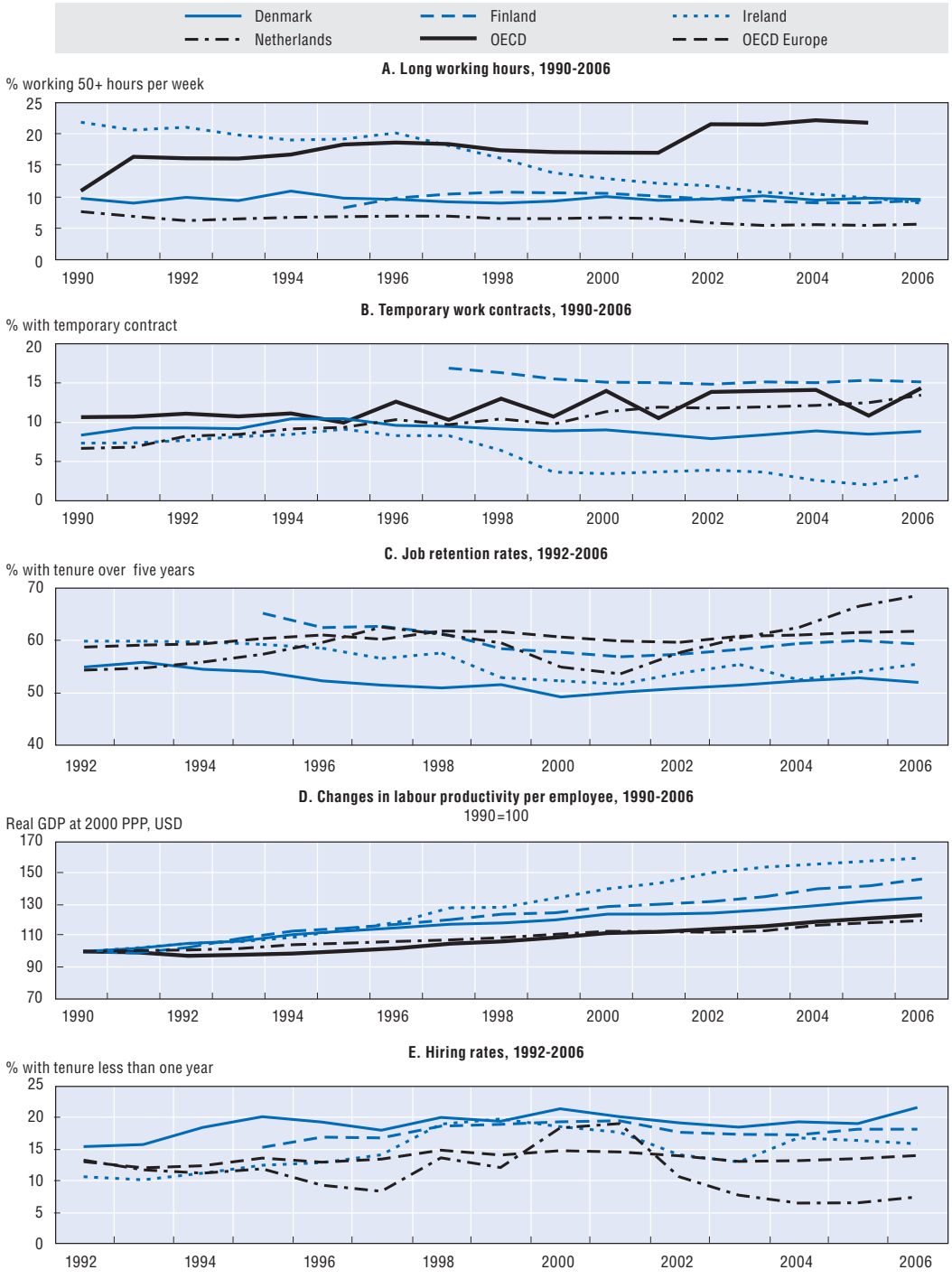
B. Labour market requirements and health

The current restructuring of the labour market in post-industrialised economies has profoundly changed labour market requirements. In the context of continuously increasing efficiency and competitiveness, permanent core employment is said to be shrinking and workloads, work pressure and job insecurity increasing. All these pressures can affect sickness and disability prevalence via two channels: first, so-called "niche jobs" become rarer, leaving less employment opportunities for people with reduced workability because of health problems and disabilities. Second, increased work pressure and falling work satisfaction themselves can create health problems of employees and lead to disability. However, being inactive or unemployed was also shown to have a negative impact on mental health in particular (OECD, 2008d).

The impact of labour market restructuring on the actual work pressure for employees is difficult to measure, and available *objective* indicators are inconclusive (Figure 1.12). Changes in the share of employees with long working hours (as an indicator of workloads), for instance, were rather negligible in Denmark, Finland and the Netherlands, while they considerably fell in Ireland, from over 20 to below 10%. Further, their levels are below OECD average in all four countries. The share of temporary work contracts as a proxy for atypical work and job insecurity has also remained fairly stable (and again been decreasing in Ireland), as in the OECD area as a whole. Job stability, measured through five-year job retention rates, has shown a slightly increasing trend in all four countries in the past couple of years.

On the other hand, labour productivity per employee (as another indicator of work intensity) has continuously been growing and growth rates are above the level of OECD average in three of the four countries, especially in Ireland. Finally, hiring rates do not show a continuous trend in any of the countries. More recently, they have fallen significantly in the Netherlands, from almost 20% in 2000 to only 7% in 2004, which is far below the level found elsewhere.

Figure 1.12. **Inconclusive evidence on objective changes in the working environment**



Source: Panel A: *OECD database on Usual Hours Worked*, Panel B: OECD *database on Temporary Work*, Panel C and Panel E: *OECD database on Job Tenure*, Panel D: *OECD Economic Outlook No. 80*.

Comparative evidence on levels and trends in *perceived* working conditions and demands of work in EU countries suggests that the work intensity may indeed have increased. Table 1.13 shows several indicators of perceived working conditions: cognitive

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Table 1.13. **Increasing levels of perceived work intensity in most European countries**

Percentage of employed persons reporting specific working conditions, 2005 and changes since 1995[a]

	Denmark		Finland		Ireland		Netherlands		EU15	
	Level	Trend	Level	Trend	Level	Trend	Level	Trend	Level	Trend
1.a. Main job involves complex tasks	76	+++	72	=	55	=	63	+	60	=
1.b. Main job involves learning new things	89	=	90	=	76	+	83	=	74	=
2.a. Able to choose/change order of tasks	86	=	81	=	72	+	79	=	69	=
2.b. Able to choose/change speed of work	75	–	75	=	75	=	75	–	71	=
3.a. Job involves working at very high speed	34	+++	36	+++	15	+	19	=	26	+++
3.b. Job involves working to tight deadlines	35	+++	36	+++	28	+++	25	–	28	+++
4. Satisfied with working conditions in the job	93	=	85	–	87	–	88	=	84	=

a) Levels refer to year 2005. Trends refer to percentage changes 1995-2005: "+++" denotes an increase of more than 20%; "+" denotes an increase of between 5% and 20%; "=" denotes changes between –5% and +5%; "–" denotes a decrease of more than 5%; "–" denotes a decrease of more than 20%.

Source: OECD Secretariat calculations based on various waves of the European Working Conditions Survey from the European Foundation for the Improvement of Living and Working Conditions.

demands of work (items 1.a and 1.b), autonomy in the workplace (2.a and 2.b), work intensity (3.a and 3.b) and work satisfaction (4). Neither demands of work nor autonomy in the workplace have increased much in the past ten years, with the notable exception of the complexity of tasks in Denmark where the level of demands has been high already. On the other hand, work intensity increased strongly in Denmark, Finland and Ireland (as it did in the European Union as a whole) though not in the Netherlands.

This finding is important insofar as work intensity appears to be one of the key factors for stress at work. Reported levels of work-related stress are above EU15 average in Denmark, average in Finland, and below average in Ireland and the Netherlands. Persons who work under conditions of high work intensity report stress levels almost twice as high as those reported by people who do not have to work with complex tasks, at high speed or to tight deadlines (Table 1.14). The only other element that appears to be as important or even more important for the perceived level of stress resulting from work is work satisfaction: across the European Union, one in two workers who are not satisfied with the working conditions in their main job report stress at work, with results for the four countries ranging from 40% in Ireland to 68% in Denmark.[15] This is important in view of the reduction of the share of workers satisfied with their job in two countries (Finland, Ireland).

In sum, available objective evidence on changes in work requirements is somewhat inconclusive. The changes are not big enough to explain sickness and disability trends, nor are the directions of change always in line with those trends. Subjective evidence suggests that work intensity has been increasing recently, and that work intensity is positively correlated with work-related stress. Policy makers are facing a vicious circle. Heightened requirements on the labour market seem to lead to more pressure and increasing work-intensity, which in turn may lead to health problems, sickness absence, disability and, eventually, dropping out of the labour market. Once out of the labour market, however, the absence of a job adversely affects health. Policies need to address this vicious circle.

Table 1.14. **Work-related stress increases with higher work intensity and lower work satisfaction**

Share of respondents reporting stress at work, according to various working conditions, 2005[a]

	Denmark	Finland	Ireland	Netherlands	EU15
Overall	29	25	18	18	25
Whether main paid job involves complex tasks					
Yes	32	27	23	21	29
No	18	15	12	12	19
Whether main paid job involves learning new things					
Yes	29	24	20	18	26
No	20	25	10	15	21
Whether respondent can choose or change the order of tasks					
Yes	29	23	18	17	24
No	28	31	16	22	27
Whether respondent can choose or change the speed or rate of work					
Yes	27	21	18	16	24
No	35	33	17	23	28
Whether the job involves working at very high speed					
Yes	39	32	27	29	36
No	23	20	16	15	21
Whether the job involves working to tight deadlines					
Yes	34	34	29	27	37
No	26	19	13	15	20
Whether respondent is satisfied with working conditions in main paid job					
Yes	25	20	14	12	20
No	68	48	40	56	51

a) Don't knows/refusal are omitted from calculations.
Source: OECD Secretariat calculations based on 4th wave (2005) of the European Working Conditions Survey from the European Foundation for the Improvement of Living and Working Conditions.

1.7. Conclusion

The following facts emerge from the picture above:

A. Economic and labour market status of people with disability

- Against the backdrop of favourable macroeconomic indicators and high and increasing overall employment levels in the four countries under review, employment outcomes for people with disability are somewhat disappointing, especially in Ireland where only about one-third of these persons have a job, compared to almost half in the Netherlands and little over half in the two Nordic countries.
- Employment rates of people with disability have been increasing faster than those of the total working-age population in the past years only in Denmark and Finland. Unemployment is higher among people with disability, and their unemployment rate increased in Ireland and the Netherlands.
- In the past five years, average disability benefits increased faster than average earnings in Denmark and Ireland, but lagged behind in Finland and even fell in real terms in the Netherlands. By 2006, average disability benefits ranged from around 40% of average net earnings in Ireland to almost 70% in Denmark.
- Taking income sources from employment, public benefits and other household members together, average equivalised income levels of persons with disability are around 70% of those of persons without disability in Ireland, but close to 90% in Denmark, Finland and the Netherlands.

- Income poverty rates of persons with disability are lowest in the Netherlands, comparatively moderate in Denmark and Finland and very high in Ireland. Furthermore, poverty risks increased in all countries except the Netherlands.
- Employment is the single most important factor for reducing poverty risks for persons with disability below the average of the total working-age population. In contrast, unemployment – much more than inactivity – multiplies the poverty risk among persons with disability.

B. Costs of disability

- By 2005, spending on disability benefits stood at 0.7% of GDP in Ireland, little under 2% in Denmark and Finland and 2.4% in the Netherlands (which recorded a considerable fall of this share in the past ten years). This compares to a spending share of around 1.2% on average across the OECD.
- Adding expenditures on sickness and occupational injury benefits and services raises total incapacity-related public spending to 1.5% of GDP in Ireland and around 4% in the other three countries (OECD average 2.5%). This is as high as unemployment-related public expenditures in Denmark, Finland and Ireland but much higher than this in the Netherlands.
- The rate of disability beneficiaries among the working-age population is around 6% in Ireland, 7% in Denmark and 8-9% in Finland and the Netherlands – levels which exceed the OECD average of the late 1990s (5-6%).
- Since 2001, beneficiary rates have been increasing in Ireland, decreasing in the Netherlands and remained stable in the two Nordic countries. Changes in beneficiary rates during the past ten years have been larger for the older age groups in all four countries.
- Around one out of three of persons on a disability benefit consider themselves as not having a disability in Denmark, Finland and the Netherlands, compared to one out of two in Ireland. In turn, about 70% of self-assessed people with disability do not receive a disability benefit in Denmark, Finland and the Netherlands, while this is the case of 50% only in Ireland.
- The share of socially excluded people without any income from public benefits or employment is 8% of all self-assessed persons with disability in the Netherlands, 4-5% in Denmark and Ireland and just 1% in Finland. These are low proportions compared to other countries.

C. The impact of exogenous factors

- During the past years, trends in disability beneficiary numbers in Ireland and the Netherlands were strongly influenced by population ageing, explaining half of the increase since 2001 in Ireland and between 1999 and 2002 in the Netherlands. In Denmark, Finland and the Netherlands, despite demographic pressure, beneficiary numbers fell since 2002.
- Assuming constant age- and gender-specific disability beneficiary and prevalence rates, population projections for the next four decades suggest a much higher demographic pressure to disability policies in Ireland than in the other three countries.

- If 42% of inactive persons with disability were to be integrated into employment over the next 45 years (*i.e.* double the percentage of those who say they would wish to work), this would close the gap between the projected labour force and total population growth by some 30% in Denmark and Finland, but more than half in Ireland and the Netherlands.
- Increased labour market requirements may contribute to raising disability. But the evidence on this as being a significant factor behind rising disability benefit rates is mixed. During the past ten years, perceived work intensity increased significantly in Denmark, Finland and Ireland but less in the Netherlands. In all four countries, persons who work under conditions of high work intensity report above-average stress levels.

Notes

1. These estimates are based on EU-SILC 2005 data. Estimates based on alternative data sources give somewhat different pictures: results from the quarterly national household survey suggest higher employment levels of persons with disability in Ireland, namely in the order of 37% to 40% in the years 2002 to 2004. These levels are, however, still much lower than in the other three countries. Furthermore, both data sources indicate a trend decrease in the early 2000s. On the other hand, results from the Census 2002 and 2006 suggest lower employment levels, in the order of 28% to 30% but a slight increase in recent years. The main reasons for these discrepancies in findings are the somewhat different disability definitions used in the different surveys.
2. The higher employment levels of people with disability in Denmark and Finland are partly a reflection of the much higher self-assessed disability prevalence rates in these two countries (see also Section 1.4).
3. The ratio in Ireland would be 0.55 according to estimates from QNHS 2004, and 0.40 according to the 2006 census.
4. Generally, the higher unemployment rate of people with disability is an indicator of their larger disadvantages in the labour market. However, to a certain extent, it could also indicate that more people with disability who are out of work are becoming economically active by seeking work.
5. That is, household income per disabled person where income is adjusted for household size with an equivalence elasticity of 0.5. This means that total household income is divided by the square root of the household size, implying that, for instance, the income position of a four-person household is considered "equivalent" to that of two single-person households.
6. It should be noted that traditional income concepts do not adjust for specific additional costs associated with disability, *e.g.* for transport or particular equipment. Jones and O'Donnell (1995) report for the United Kingdom that physical disability has a significant effect on household fuel expenditures (plus 64%) and transport expenditures (plus 45%). Zaidi and Burchardt (2005) find that disability generates substantial additional costs of living, especially for people with disability living alone, and that these rise with severity of disability.
7. For the Netherlands, data based on the labour force survey and using a different disability definition ("work disability") and unit definition (households with persons with disability rather than persons with disability) indicate much higher percentages of persons with disability falling in the lower income deciles and, correspondingly, much higher relative poverty rates.
8. The threshold of 50% of median income is often used in OECD and other international comparisons as a yardstick for relative income poverty. The threshold of 60% is used by the European Union as a comparative yardstick for "at-risk-of-poverty".
9. Note that the alternative data source for the Netherlands (LFS, 2004) suggests a considerably higher poverty rate at that threshold, namely 14%.
10. For Denmark, information about incomes is based upon the SFI database which reports higher figures for relative income poverty than otherwise reported for Denmark (*e.g.* OECD, 2008b). The calculated share of disabled people below 50% of the median income might therefore also be overestimated.
11. The Netherlands is the only OECD country without a special system for work injuries and occupational diseases. This partly explains the higher level of spending on disability benefits.

12. The relationship would further be shifted towards higher incapacity-related spending were mandatory private sickness benefit expenditures also included.

13. Note that the value for Ireland is likely to be overestimated due to the use of the older average wage definition (APW) which tends to report lower average earnings estimates than the new definition (AW) (see OECD, 2008c).

14. The long-run demographic assumptions are as follows. Total fertility rates (children per woman): Denmark 1.9, Finland 1.85 (currently 1.84), Ireland 1.8 (1.97), Netherlands 1.75 (1.71). Female life expectancy at birth (years): Denmark 86 (currently 79.84), Finland 89.66 (82.83), Ireland 87 (80.7), Netherlands 84.19 (81.6). Net immigration (annual numbers): Denmark 2 000 (currently 5 800), Finland 10 000, Ireland 12 400 (16 360), Netherlands 23 990 (27 428).

15. National studies suggest high levels of stress but are inconclusive about trends. In Denmark, a study carried out in November 2006 by the Danish Confederation of Trade Unions reveals that 43% of public sector employees and 30% of private sector employees feel more stressed at work now than they did a year ago. At the same time, a study by the National Research Centre for the Working Environment indicates that work-related stress has in fact decreased over the past five years despite the greater awareness about work-related stress and its effect on the individual employee (EIROline, January 2007). In Finland, in a 2003 survey time pressure was reported rather or very often by 43% of all employed people, and the psychological work load was reported to be rather or very strainful by 35% (Räisänen and Honkonen, 2005).

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Chapter 2

Evaluating Recent and Ongoing Reforms

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

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

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

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

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

Disability benefit schemes

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

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

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

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

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

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

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

Sickness benefit schemes

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

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

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

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

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

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

2.1. Denmark: strengthening responsibilities for municipalities

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

A. Assessing ability to work, not loss of ability

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

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

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

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

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

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

B. Tighter sickness absence monitoring

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

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

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

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

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

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

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

C. Municipal structural reform 2007

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

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

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

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

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

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

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

2.2. Finland: moving away from retirement through disability

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

A. Continuous parametric pension reform

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

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

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

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

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

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

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

B. Promoting work capacity and strengthening rehabilitation

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

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

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

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

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

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

C. Increasing the accountability of municipalities

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

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

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

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

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

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

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

2.3. Ireland: towards systematic engagement with benefit claimants

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

A. Shifting responsibilities in the late 1990s

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

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

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

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

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

B. The National Disability Strategy 2004

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

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

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

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

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

C. From new rhetoric to new policy

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

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

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

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

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

2.4. The Netherlands: moving from rights to individual responsibilities

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

A. Progressively raising employer responsibilities

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

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

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

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

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

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

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

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

B. Enhancing the work focus of the benefit system

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

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

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

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

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

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

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

C. Reshuffling the institutional landscape

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

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

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

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

D. Moving towards private provision of services and benefits

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

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

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

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

2.5. The implications of recent and ongoing reform

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

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

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

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

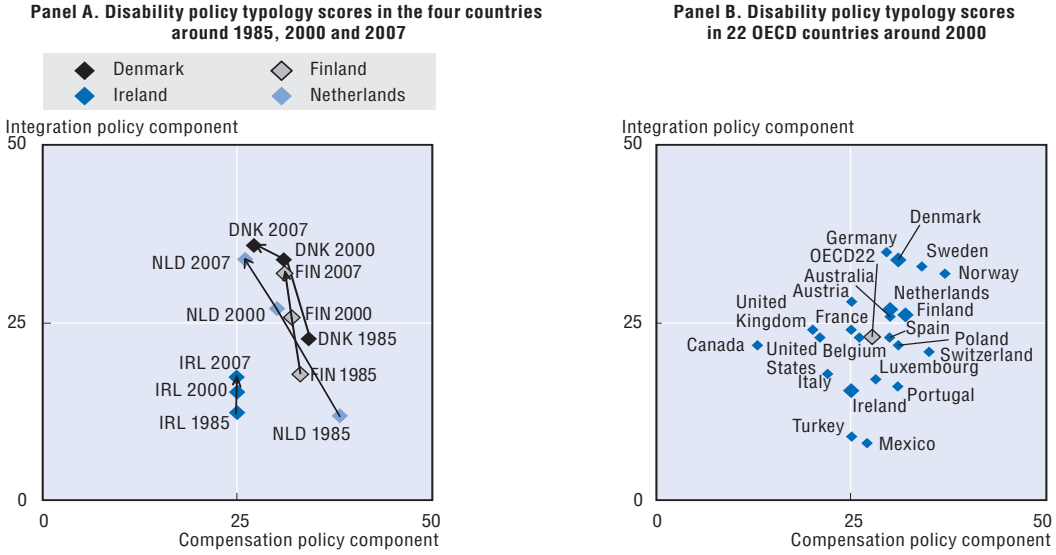
Indices in two dimensions have been developed in OECD (2003). The first is the level of compensation. The index of compensation takes into account ten policy parameters: *i)* coverage of the benefit system; *ii)* the minimum disability level; *iii)* the disability level needed to get a full disability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

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

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

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

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

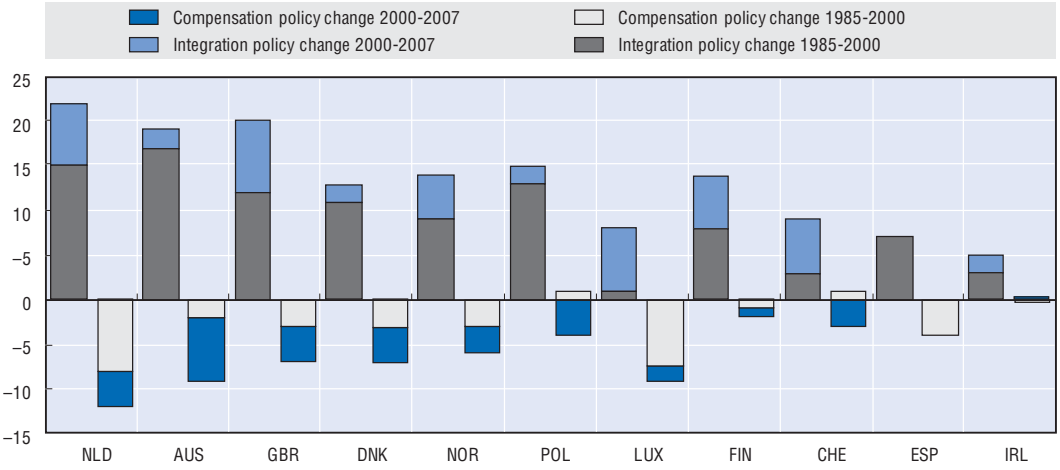


Source: Secretariat update based on information from national authorities and OECD (2003), *Transforming Disability into Ability*.

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

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

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



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

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

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

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

Notes

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

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

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Chapter 3

Into and Off Benefit: The Role of the State

Early action is important to avoid that health conditions develop into more serious problems, eventually leading to a disability benefit claim. Denmark and the Netherlands have introduced guidelines for sickness absence monitoring of workers. Such monitoring is lacking in Finland and Ireland. In addition, countries need to do more to identify and assist people with health problems when they are not regularly employed, or unemployed. The Netherlands is the only country where specific guidelines have been set up recently to address health-related work barriers of this group.

At the same time, effective re-integration measures are needed as people with disabilities experience substantial difficulties to exit disability benefits and to find sustainable employment. Denmark has taken big steps in promoting employment in the regular labour market through the use of wage-subsidies, but more can be done to prevent misuse of these "flex-jobs". On the contrary, a large proportion of people with health problems in the Netherlands remain on sheltered employment. Ireland and Finland lack systematic referral to employment services which limits the chances of activation for people with disabilities.

This chapter addresses policies to curb the inflow into disability benefits and to encourage outflow from these benefits. High and sometimes increasing disability benefit recipiency rates need to be addressed, first, by limiting entry into and, then, by promoting exit from benefits. High inflows can be tackled by improving sickness management and rehabilitation and by ensuring stricter assessment criteria. Outflow from benefits is often low, partly because of the difficulty to recover from health limitations, and partly because of low efforts to promote vocational rehabilitation and employment among recipients.

The chapter's main focus is on the role of the state and on what public policies are doing in limiting inflow and increasing outflow, and what they could be doing. As such, it does not describe in detail the role of other actors which is addressed in subsequent chapters. In particular, the role and incentives of employers are discussed in Chapter 4, and those of working and non-working individuals in Chapter 5. Chapter 6 provides a more in-depth analysis of institutional structures and incentives.

The structure of the chapter is as follows. The first section gives an overview of the process from sickness to disability in the four countries from the point of view of the state. It discusses the most frequent pathways into disability benefits and policies designed to monitor absence of sick workers and those aimed at people with health problems who are not working. This is followed by a description of the ways in which disability is being assessed and how these access criteria influence inflows into disability benefits. The second section looks at the importance of rehabilitation and activation measures to end long-term benefit dependency. The last section summarises the policy challenges that the four countries are facing in this area.

3.1. Leaving the labour market onto benefits

This section describes the various ways in which countries are monitoring sickness absence and looks at what more could be done in this field, particularly for those who are unemployed when they fall ill. A description of the different assessment criteria illustrates the challenges in controlling access to disability benefits, particularly among those with mental health problems.

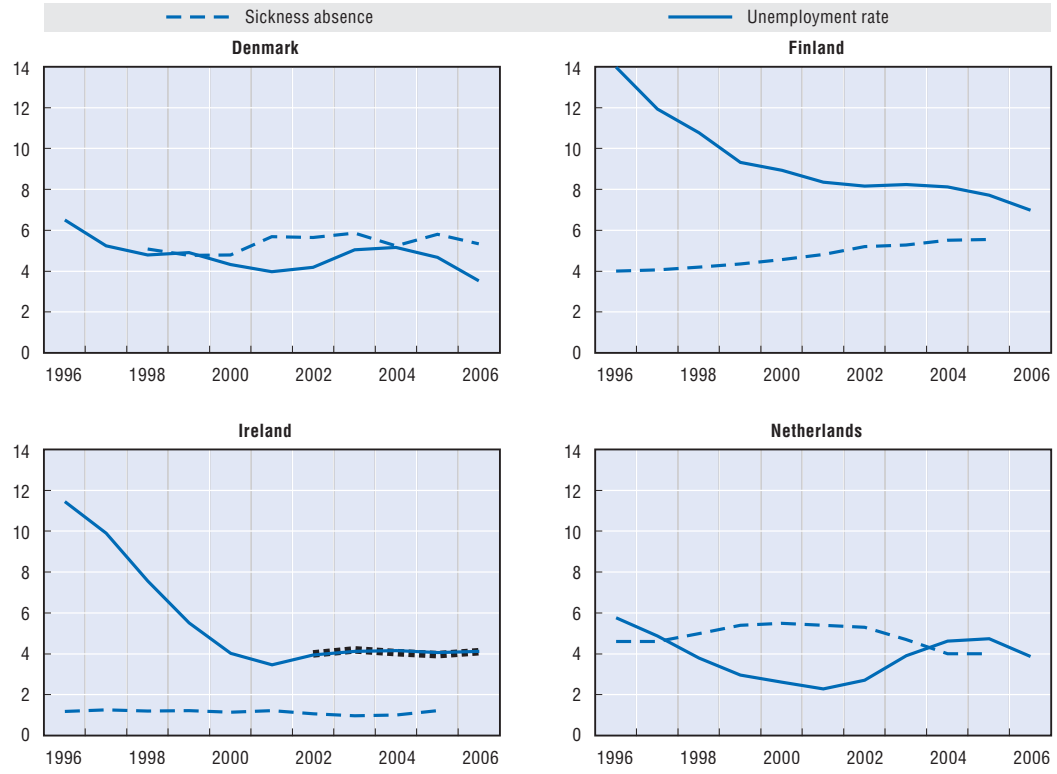
A. Health and absence monitoring of sick workers

At 4-6% of the workforce, sickness absence levels are relatively similar in the four countries under review and, since recently, are highest in Denmark and Finland. These levels are somewhat above the OECD average though not among the highest in the OECD.

Sickness absence in Denmark, Finland and most significantly in the Netherlands evolves in a countercyclical manner: sickness absence increases during times of economic expansion and decreases when unemployment is high (Figure 3.1). In the Netherlands, a 1% increase in unemployment has been found to decrease sickness absence by 0.25% (Jehoel-Gijsbers, 2007). Several economic theories provide an explanation for the relation between unemployment and sickness: firstly, during booms working conditions might get

Figure 3.1. **Sickness and unemployment are inversely related, especially in the Netherlands**

Share of workers absent from work and share of unemployed labour force (percentage), 1996-2006[a]



a) To derive the sickness absence rate, the total number of annual absence days is calculated by multiplying the number of spells by the average duration of each spell. This result is divided by the labour force resulting in the average number of days of sickness per person. These figures are further divided by the number of actual working days (statutory minimum annual leave and paid public holidays are removed) in each country. For Ireland, the long-term sickness absence series is an estimate from the EULFS giving the share of employees absent from work due to illness, injury or temporary disability *during the whole week* prior to the survey. The short-term series which is only available for 2002-2006 (black dotted line) is taken from administrative records and measures sickness absence from the *first day of absence*, as the data for the other three countries.

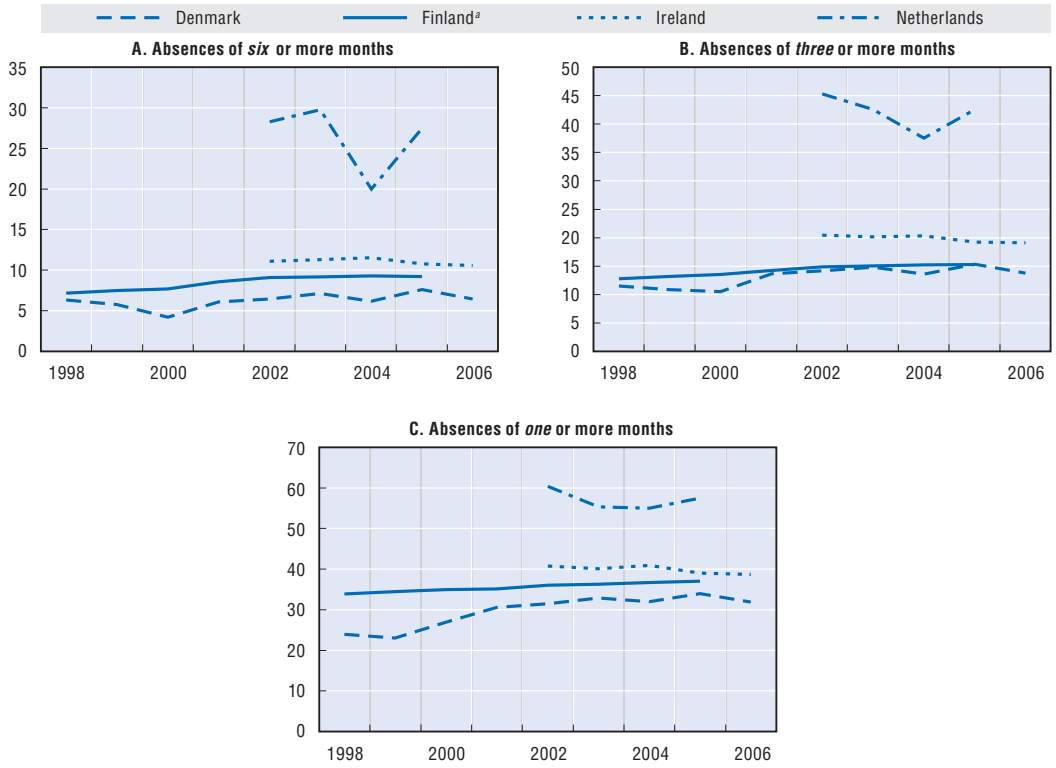
Source: For unemployment, *OECD database on Labour Force Statistics*; for sickness data, Denmark, Ministry of Employment (DREAM database); Finland, KELA; Ireland, EULFS (LFS series) and DSFA (administrative series) and the Netherlands, CBS.

worse (because of more time pressure and on-the-job stress), leading to more accidents and deteriorating health; secondly, it is also possible that during booms marginal workers with worse health enter the labour force; finally, high unemployment may have a disciplining effect on workers by increasing the fear of being laid off.

The share of long-term absences is similar in Denmark, Finland and Ireland, irrespective of the definition of long-term (Figure 3.2). The Netherlands stand out as having much higher shares of long-term absence, presumably partly due to underreporting of shorter-term absences (given that there are no public absence statistics collected any longer) and partly to the longer duration of full-wage payments in the case of absences. In Denmark and especially Finland, the increase in overall absence levels is largely driven by a slow but steady increase in longer-term absences, especially those with durations between one and three months. This in turn is believed to be partially related to a composition effect stemming from the increase in employment of more vulnerable groups, particularly

Figure 3.2. **Long-term absence is increasing in Denmark and Finland but is highest in the Netherlands**

Long-term sickness absence spells as a share of all absence spells, 1998-2006



a) For Finland, the period refers to 150 days or more.

Source: Danish Ministry of Employment (DREAM database); KELA (Finland); DSFA (Ireland) and CBS (the Netherlands).

the chronically ill. Another factor identified for Denmark is the increase in jobs with a high level of absence such as childcare workers, social and healthcare personnel (Lund *et al.*, 2007). In Ireland, on the contrary, the share of longer-term absences is falling recently.

Governments should have a strong interest in monitoring medical conditions and the work capacity of people on sickness benefits to identify potential risk cases early and avoid the transfer to long-term benefits. Eligibility checks and stricter screening have been found to increase reintegration efforts and work resumption rates during sickness absence in the Netherlands (de Jong *et al.*, 2007). Similarly, in Sweden, postponing monitoring by delaying a doctor's certificate was found to increase the duration of sickness absence (Hesselius *et al.*, 2005). Timing and an effective control of the causes for sickness absence appear to be essential elements for governments in designing their sickness management process.

To curb their high absence rates, both Denmark and the Netherlands have put in place a process of earlier intervention and absence monitoring, although performed by different actors. In the Netherlands, employers or rather the company's contracted occupational health service providers are in charge of following up workers' illnesses. In Denmark, the primary responsibility rests with the municipalities, which have an incentive in limiting long-term sickness absence because the state will not reimburse these costs after 52 weeks; during the first year, the state and the municipality share the costs on a 50/50 basis.[1] In the Netherlands, there has been a switch towards an internalisation of sickness costs, as

employers have been made responsible, since 2002, for the prevention of sickness and the reintegration of sick employees.[2] Employers are now responsible for paying the wages of sick employees for up to two years so they have strong economic incentives to limit long-term illness. Sickness management for workers without an employer is the responsibility of the national employee insurance authority, the UWV (Section 3.1.B).

In terms of the specific stages, both countries have guidelines calling for a specific plan to resume work, including activities and dates for evaluation, to be established within two to three months (Table 3.1). In the Netherlands, the plan is designed by the employer

Table 3.1. **The assessment process from sickness to disability: key dates and obligations as of 2008**

Time scale	Denmark	Finland	Ireland	Netherlands
One week		Certificate from doctor needed from first/third day of illness	Six days waiting period; DSFA starts paying illness benefit upon receiving the medical certificate	Employer needs to inform the company doctor within one week
Two/three weeks	For the first 21 days, the sickness benefit is paid by the employer, thereafter by the municipality	For the first nine days (including Saturday), statutory full salary is paid by employers, thereafter sickness allowance paid by the Social Insurance Institute (KELA)	Weekly doctor certificates required	
Four weeks	Classification into risk categories. For at-risk clients, follow-up every four weeks, for others every eight weeks	Most collective agreements stipulate a period of employers' sick pay of several weeks		
Eight weeks		After 60 days, partial sickness leave may be asked for; assessment of rehabilitation needs by KELA		Re-integration plan must be drawn. If contract ends before two years, the UWV receives this report and continues the follow-up
Three months	Establishment of follow-up plan after 16 weeks			Employer informs UWV. Planned to be shifted to week 42
Six months		KELA's consultation on rehabilitation needs and possibilities to apply for a pension. Notification to the employment pension system on the possible pension application		
Twelve months	Maximum period for sickness benefit after one year, except for chronic illness for which it can be up to two years	After 300 compensation days (including Saturdays) due to the same disease, sickness allowance ends	After one year, person can apply for an Invalidity Pension but Illness Benefit can also be continued as a long-term payment	
One year and a half				Application for disability benefit with a copy of the reintegration report in week 91
Two years				If reintegration efforts are considered sufficient, the benefit is awarded; otherwise one-year extension of employer sick pay and/or reduction of the benefit possible

Source: Compilation by authors based on information provided by national authorities.

together with the employee by week eight, and the guideline is to have periodical evaluations every six weeks. In Denmark, since July 2005, the new plan to decrease sickness absence includes the categorisation of sickness into three categories using standardised information forms with more work-relevant focus and new follow-up rules. Monitoring of sickness absence is more targeted to the category which is at risk of a long period of illness and/or of endangering the ability to work. Follow-up is made every four weeks for the more at-risk category of illness (every eight weeks for the other categories) and a follow-up plan must be established within 16 weeks.

Municipal caseworkers in Denmark are in charge of co-ordinating sickness management with employers and doctors and have at their disposal a series of tools which are, however, not always used systematically. Roundtables for dialogue with employers and physicians are one possible instrument to avoid the risk of drifting into long-term absence and to overcome issues of confidentiality in case of illness. Still, co-ordination problems remain between doctors, employers and municipalities in monitoring absence. In particular, Danish municipalities appear to be not active enough in co-operating with employers concerning the retention and work accommodation support of sick employees, despite efforts in this direction with the 2005 reform. Similarly, co-operation between caseworkers and GPs remains to be improved (Damgaard and Boll, 2007).

Specific policy changes in the area of sickness and disability have been found to have a strong impact on the level of absence. Sickness absence in the Netherlands is relatively low nowadays from a historical perspective: it has decreased from a high 10% in 1980 to 4.6% in 2006. Changes implemented before 1995, including a decrease in the percentage of reimbursement to the employer, had decreased sickness absence significantly. Most recent changes (Gatekeeper Act, Box 3.1) appear to have reduced only women's absence (Jehoel-Gijsbers, 2007) while being one of the main factors in the recent drop in the inflow into disability benefit. It is too early to evaluate the impact of recent policy changes in Denmark on overall sickness absence but a study on a small sample of employees found that the new case management interviews by municipal social workers increased the probability of return to work with the pre-sick leave employer (Hogelund and Holm, 2006).

Sickness absence is higher for individuals in their prime working age, except for men in the Netherlands. These findings go against the intuition that older individuals should be at more risk of absence due to a higher probability of health problems (although there might be a selection issue with only healthier individuals at older ages being at work). This raises the question about which factors, particularly work-related ones, are behind this phenomenon and about what governments can do to decrease absence among this age group. In all four countries, women have significantly higher rates of absence due to sickness. In addition to age and gender, education, the type of job and the sector are good predictors of absence, particularly long-term sickness absence. In the Netherlands, personal characteristics have also been found to be the best predictors of sickness absence, particularly own health, followed by the amount of time devoted to household tasks. Among work factors, the most important predictors of sickness absence are psychosocial factors, particularly the relation with managers and intimidation, as well as work pressure (Jehoel-Gijsbers, 2007).

A great deal of focus has been placed in both the Netherlands and Finland on requirements for employers to create a healthy working environment in order to prevent sickness absenteeism, work injuries and other health problems at work. Legislation in both countries obliges every company to provide occupational health services (OHS) for their

Box 3.1. **Sickness management in the Netherlands: the Gatekeeper Act**

The Gatekeeper Act from April 2002 aimed at increasing the probability of reintegration by increasing both employers and employees responsibilities in the process. The rules were adjusted after 2004 with the increased duration of the employer-covered sickness phase from one to two years. The most important component of the new measure is the strengthening of reintegration requirements. New duties of the *employer* include offering the employee a suitable job or providing the necessary workplace adaptation. The Act also gives *employees* a more important role to play in the drafting of the reintegration report. In exchange, employees must accept reasonable accommodation offers and, if employees hinder early return to work, employers have the right to suspend salary payments.

Upon application for a disability benefit, a reintegration report must record what has been done to accelerate the return to work. The report provides both medical and work-related information necessary for the UWV to make an assessment of reintegration efforts and for granting the disability benefit. Based on this report, if reintegration efforts are judged insufficient by the UWV, sanctions may be imposed on both employers and employees. In particular, the UWV may prolong the phase of mandatory wage payment during sickness for an additional year. Based on UWV's evidence, it appears that this occurs in 13% of the cases examined. Employees might also be sanctioned through the form of reduced disability benefits.

Regulations set out the minimum steps and minimum effort required from the employer, the employee and the occupational health and safety service. Guidelines include requirements for the employer to inform the OHS (*Arbodienst*) in the first week. The Arbodienst, in consultation with the sick employee, will produce an advice informing both parties about future return to work. By week eight, the employer and the employee must set the reintegration plan with concrete steps to be taken to achieve reintegration and arrangements for evaluations of progress. Current guidelines require evaluations at six week intervals. After the first year of illness, an evaluation report is drawn by the employer and the employee to summarise the reintegration efforts and the planned steps for the second year of illness. A final reintegration report is drafted by week 87 to 91 of the illness, upon filing a disability benefit claim.

employees. In the Netherlands, the role of the OHS (*Arbodienst*) is broader than in Finland and includes advice on prevention, but also management of sickness absenteeism and prescriptions for rehabilitative health treatment. Provision in Finland is also uneven because the OHS can be organised through municipal care centres or private medical centres, or services that are integrated into the enterprise (Chapter 4).

While Denmark does not include such OHS, reforms in the Working Environment Act (which include a focus on risk assessment and the effects of work environment on sickness absence) place some requirements on companies to monitor and address working environment issues. The inspection service (the Danish Working Environment Authority) visits companies unannounced and may ask them to take an advisor to solve problems in their working environment. If violations are not solved within six months, more drastic solutions may be imposed including fines or a trial. In addition, companies' assessments are published, including all violations, on the inspection's website. Future plans also include the possibility for companies to benefit from guidance services about sickness absence management and workplace retention as part of the supervisory services of the Working Environment Authority.

Sickness benefit in Finland is paid by the social insurance institution (KELA), which should assess the need for rehabilitation in the case of long-term illness after 60 working days (Table 3.1). However, because of collective bargaining agreements which extend sick pay for several weeks and the retrospective reimbursement of employer costs, KELA is not always informed. This hinders KELA in performing the follow-up and rehabilitation assessment at an early stage. In this sense, it does not appear that KELA can play an active role in monitoring sickness. This is left to employers, providing a separation between the actors bearing financial responsibility and the ones managing sickness absence. The system could promote early intervention by achieving a tighter co-ordination at the early stage of illness between the employers and the various actors involved in the sickness process: doctors providing medical certificates, the OHS, the private pension institutes and KELA.

The Irish authorities could potentially intervene early in the process of monitoring workers' sickness absence and prevent a progression to chronic disability but fails to do so. Weekly medical certificates are sent to DSFA and the benefit is immediately suspended if no certificate is received. In addition, predefined selection criteria are used to identify cases for medical review. The possibilities of the system are illustrated by the recently completed *Renaissance Project*. This project targeted a small number of illness benefit claimants suffering from low-back pain and invited them to attend a medical assessment four to six weeks from date of claim. After the examination, 67.4% were found capable of work (Cleech, 2004). Unfortunately, because of capacity constraints many claims are not examined directly by DSFA's medical assessors. There is no automatic referral at specified dates with a specific plan of action being set-up for the return to work. For this reason, people who are unable to work because of ill health are often identified far too late, upon application for an invalidity pension.

B. Health monitoring of unemployed and inactive people

To devise adequate policy responses to the high inflow into disability benefits, it is important to know more about how people enter these benefits. Unfortunately, pathways into disability benefits are poorly documented. In particular, very little information is available in Ireland about the origin of disability benefit claimants. Overall, while a large proportion of disability benefit recipients are previous sick workers – 60% in Finland and the Netherlands and 40% in Denmark, the limited information available highlights the importance of non-work-related pathways into disability.

Indeed, in Denmark and Finland, a high proportion of individuals enter disability benefit through various non-employment pathways (Table 3.2). In Denmark, a large proportion of disability benefit recipients were previous recipients of cash benefits. This category includes not only individuals on social assistance *per se* but also uninsured unemployed individuals and the long-term unemployed (who have lost their entitlement to unemployment benefits). A similar group is those waiting for flex-jobs who receive a special waiting benefit during the waiting period. Recipients of both cash benefits and the waiting benefits have increased in recent years. Direct transfers to disability from unemployment benefits are particularly high in Finland: Longitudinal estimates show that among new disability benefit recipients, a large share had been unemployed (more than one-third) during the five years prior to receiving the disability benefit and an important proportion of these individuals had also received social assistance at some point.

In addition to individuals entering disability from non-employment, there are other non-standard work pathways which are specific to the Netherlands. The number of

Table 3.2. **Sick leave is the most frequent route into disability benefit followed by non-employment**

Origin of new disability benefit claimants as a percentage of all inflows, most recent available year

Denmark	2003	2006	Finland[a]	2004	Netherlands	2006
Employed	11	7	Employed	4	Employer paid sick leave	62
Sickness benefit	44	39	Sickness allowance	60	UWV sickness benefit	38
Flex job	3	3	Unemployed	26	*Of which:*	
Waiting benefit	2	9	Study grant	1	Temping agency workers	4
Rehabilitation	3	3	Rehabilitation allowance	8	Temporary contracts	17
Social assistance	31	34	Parenthood allowance	1	Unemployed	15
Other	6	4			Other	3
Total	*100*	*100*	Total	*100*	Total	*100*

UWV: Employee Insurance Authority (Netherlands).
a) Data for Finland refer to KELA benefits only.
Source: Ministry of Social Affairs, Denmark; KELA, Finland; and UWV, the Netherlands.

disability benefit recipients coming directly from temporary employment has increased greatly in the past decade in this country (although it has stabilised recently). Non-standard work pathways include workers who do not have a regular employer because their contract is of a limited duration and ends during their illness period. The increase of temporary workers and workers with irregular employment also in Finland raises the probability for such workers to experience unemployment periods and to enter disability benefits through the unemployment route. These developments illustrate the importance of monitoring sickness not only for workers but also for non-employed individuals who receive other benefits (unemployment, social assistance) or workers who do not have a regular employer.

The Netherlands has specific rules to monitor sickness among both workers without an employer and the unemployed (the "*vangnetters*"). Because normally employers are responsible for the income support and the work reintegration measures for their employees, this group requires a special provision. The UWV is in charge of both paying a sickness benefit and setting up a rehabilitation plan according to the same guidelines as for workers with an employer. However, *de facto* this group remains at a disadvantage since reintegration appears to be most effective through partial or accommodated work within the worker's own company. For this reason, new rules were set at the end of 2006 to increase reintegration possibilities with the requirement of a stronger reintegration plan by the UWV. A tighter definition of the concept of illness and suitable work was put in place to restrict direct access to disability benefits. In addition, pilot projects are trying to establish a co-operation with temporary work agencies which could help in workplacements for people with illness and disability.

In Finland, Denmark and Ireland, potentially the process of sickness management should be similar for workers and the unemployed. This would be achieved by an automatic transfer to sickness benefit of unemployed individuals in case of illness with immediate action upon such transfer. In Denmark, municipalities recently adopted a rigorous follow-up procedure, and sickness monitoring for this group should improve. In Ireland, unemployed individuals falling ill are exempted from their activation requirements and receive illness benefit until a doctor certifies that they are fit for employment. In Finland, this transfer to sickness benefit might only occur at a late stage of unemployment because of the lack of intensive activation requirements in the first

500 days of unemployment. Relative benefit levels probably also create limited incentives for the unemployed to apply for a sickness allowance. Overall, except in the case of the Netherlands, there seems to be a lack of a specific focus on this group and a structured approach on how to monitor their sickness absence. A recent proposal in Denmark, yet to be implemented, aims to rectify the lack of sickness management among the unemployed by imposing a duty on unemployment funds to have interviews in the fourth week of sickness to check when the unemployed person can be labour market-ready again. Likewise, plans are discussed to impose upon claimants of other benefits the duty to report sick from the first day of sickness so that municipalities can provide a more effective follow-up.

C. From sickness to disability

In all countries, a disability claim is often preceded by a long period of receipt of a sickness payment. In the Netherlands, the sickness phase has been extended to two years, while in Denmark and Finland it is shorter (one year). Ireland has no time-limit to its sickness benefit, which is very unusual in the OECD.[3] Table 3.1 summarises the main steps from the moment a person becomes sick to the stage where a disability benefit is granted. All countries except Ireland have rehabilitation requirements before a disability benefit might be considered. In addition, in Denmark, if rehabilitation efforts fail to bring a person back to ordinary employment, a flex-job must be considered before a disability benefit. Rehabilitation is meant to restore capacity after illness. While medical rehabilitation is focused on restoring health and functional capacity, vocational rehabilitation concentrates on overcoming the barriers to employment because of health reasons. However, the boundaries might sometimes be blurred. Vocational rehabilitation might include counselling, training, education, work trials/job placements and work accommodation.

Separation between financing and treatment for medical rehabilitation exists in several countries, raising concerns about assigning responsibilities for outcomes and co-operation issues (Chapter 6). In both Finland and the Netherlands, medical rehabilitation is carried out by health centres and hospitals which do not participate in the funding of either rehabilitation benefits or sickness allowance and are not necessarily geared towards work resumption. Similarly, in Ireland medical rehabilitation is the responsibility of the Health Service Executive while vocational rehabilitation is the responsibility of FÁS employment services. Ireland is currently considering introducing a bridging programme to encourage progress from medical to vocational rehabilitation. In addition, in all countries bottlenecks in the form of waiting lists might prolong the period of illness for which other actors (employers, the social insurance, and the taxpayers) pay the consequences in monetary terms.

An additional problem exists in Finland because, depending on the nature of the illness and the person's work history, pension insurance providers, KELA, the public employment services and the municipal health care authorities (*i.e.* the various rehabilitation service providers) might be involved. Doctors need to provide information on the rehabilitation details for a long sick leave but the decision-making process among the actors involved can be lengthy, delaying rehabilitation interventions. In contrast, Denmark has shifted both financial support during rehabilitation and most treatment of medical rehabilitation to municipalities.[4]

Although disability benefits are supposed to be the last resort, after all possibilities to stay in or find employment have been exhausted, in practice many factors limit

rehabilitation prior to the granting of a disability benefit. In Denmark, early intervention is sometimes prevented by the fact that individuals cannot get rehabilitation without having a documented disability. Job centres find that only work trials are possible during the sickness phase and they would like to offer individuals a wider package as is available for those on unemployment benefits or social assistance. For this reason, better opportunities will be created in the near future for individuals to receive activation offers while on sickness benefits. In the Netherlands, the fact that the disability assessment happens after two years of sickness creates a series of difficulties for reintegration. In particular, employees are reluctant to accept a new function with a lower salary because they are afraid of the implications it will have for their benefit (since a disability benefit is based on residual earnings capacity, see below). In Finland, participation in rehabilitation is voluntary and not a precondition for sickness allowance, although it is a precondition for the disability benefit. In addition, vocational rehabilitation in Finland, like medical rehabilitation, is handled by different actors and, although an act on co-operation exists, there is the potential for conflicts in deciding who is responsible for the financing of rehabilitation, the follow-up of a client and job retention.

In Denmark and Finland, partial sick leave has been introduced in order to facilitate a progressive return to work. In Finland such partial sick leave is only possible after a period of 60 days of full sickness absence. The new Danish government action plan to curb sickness absence also has a strong emphasis on maintaining the connection to the labour market and encourages gradual return to work, already after eight weeks of absence, through the use of part-time sickness leave. Recent figures show a large increase in partial absence (from 10 000 to 40 000 cases) which appears to be driven by increases in leave of absence for long-term sickness.

Disability assessment

Assessing disability requires a judgement on the severity, curability and permanence of a health condition and its limiting consequences. General practitioners (GPs) have a crucial role in the process from sickness to disability in three of the four countries reviewed (all except the Netherlands) due to their involvement in diagnosis at an early stage and the disability application process. Sickness certificates for long-term absence in Denmark and Finland require, in addition to the diagnosis, information on the functional capacity and on the possibilities to return to work. Much debate remains about relying heavily on medical discretion because GPs are often not aware of work-related issues. However, a GP's decision can be overruled either by asking for a specialist's opinion in Denmark or by an examination by the in-house medical assessors of DSFA in Ireland. In the Netherlands, on the contrary, sickness assessments are performed by company doctors who are occupational health specialists and well aware of difficulties at work. They are also better placed to discuss work accommodation and adaptation possibilities and to mediate between the employer and the employee.

To encourage early return from sickness leave and to make disability assessment more uniform, Ireland and the Netherlands are currently developing medical guidelines and protocols. Guidelines in the Netherlands aim at improving the co-operation between treating doctors and occupational health doctors by making GPs (and other medical specialists involved in the treatment) more aware of the importance of concept of work capacity and a focus on work resumption. Protocols are used by social insurance doctors (UWV) during the medical assessment of disability. They provide scientific-based evidence

about the relation between an illness, treatment and work capacity and ensure a more harmonised approach across assessments. At the moment, protocols only exist for a limited number of illnesses but they are gradually being developed for others. Similarly, in Ireland protocols will be used by the medical assessors.

In addition to the role of doctors in the assessment process, there is still much debate about the criteria for assessing the right to a disability benefit. In three of the four countries, the reasons for granting a disability benefit are not always medical but social factors and resources are also taken into account (again, the Netherlands is the exception). Besides, while Denmark considers overall work capacity left for any job, in Finland and for disability allowance in Ireland, previous qualifications and job opportunities are taken into account, allowing for a broader interpretation and looser criteria for entitlement. The Netherlands are taking an intermediary position. Like in Denmark, all job opportunities are considered; however, by using an earnings capacity criterion, previous qualification, *i.e.* income, matters.

In Denmark and the Netherlands there has been a policy shift recently where assessment is now more focused on what the person can do and on available resources with respect to the labour market, rather than looking at what people cannot do. The disability assessment is based on the loss of functions, the remaining functions left and the possible jobs that could still be performed. Disability in Denmark is assessed using a resource profile consisting of twelve elements, including labour market experience, social network and health. Health is therefore only one of many elements involved in the decision though it is a key factor in around 95% of all new cases. Health limitations are assessed by a GP, while a municipal medical specialist reviews the information provided by the doctor and can choose to ask a specialist for a second opinion. The decision on the disability assessment rests with the municipal caseworker. Recently, a large-scale trial has been launched whereby work capacity will be assessed by an interdisciplinary team.

Despite a similar logic, the criteria for assessing disability are very different in the Netherlands since it is based on earnings capacity. Disability assessment is done by specialised social insurance doctors and vocational experts who first assess whether the reintegration plan drawn by the employer and employee shows that all reintegration efforts were made but still failed in work resumption. Since the end of 2004, a double assessment procedure is possible for certain illnesses[5] whereby a second insurance doctor, independent of the first, is asked for his opinion. Functional abilities left are then matched to job requirements to assess the residual earnings capacity. The job-matching process is based on hypothetical jobs, not on actual jobs available, and there has been some criticism about the changes in requirements such as the recent decrease in the minimum number of matching jobs (from ten to three), and the lack of consideration for the availability of real part-time jobs and shift work. An individual is entitled to a disability benefit if the health condition or injury results in an earnings loss of at least 35% of the old pre-disability wage. This criteria places at a disadvantage individuals with low skills and low wages who might face serious challenges to perform work but suffer a potential loss of salary lower than 35%. The criteria have become stricter with the new law (WIA) because, for the previous disability benefit, a person was considered having a disability already if the loss was 15%. In addition, there is some concern that these employees (with less than 35% loss of capacity) are at great risk of losing their job after the two-year sick leave with little chances of re-employment afterwards.[6] Employment prospects for this group are nevertheless

encouraging: recently, employment rates have progressed from 46% in 2007 to 62% at the beginning of 2008.

Finland and Ireland each have two different assessment criteria and procedures for the disability benefit which is earnings-related on the one hand, and the national disability benefit (in Finland) or the disability allowance (in Ireland) on the other. The latter two use less precise, broader criteria which might lend themselves to inconsistencies. The definition for the earnings-related disability benefit in Finland includes the requirement of either a permanently or temporarily reduced working capacity of at least two-fifth. For the (benefit income-tested) national disability benefit, the definition of disability is related to the incapacity to engage in gainful employment as a result of an illness or injury.[7] Besides medical factors, the person's earnings capacity is taken into account as to ensure reasonable income for their age, professional skills and other circumstances, which is against the trend in most countries where disability is considered not just with respect to a person's own job but to any job, irrespective of education. Similarly, in Ireland a person is eligible for a disability allowance if, because of a disability, s/he is at disadvantage in undertaking work that would be suitable given age, experience and qualifications. The Dutch disability benefit for people who have acquired a disability before the age of 17 (Wajong) has assessment criteria that differ from those for individuals acquiring a disability during their adulthood.[8] For the Wajong, a person is eligible for a benefit if the disability resulted in an earnings loss of at least 25% in reference to the gross minimum (youth) wage.

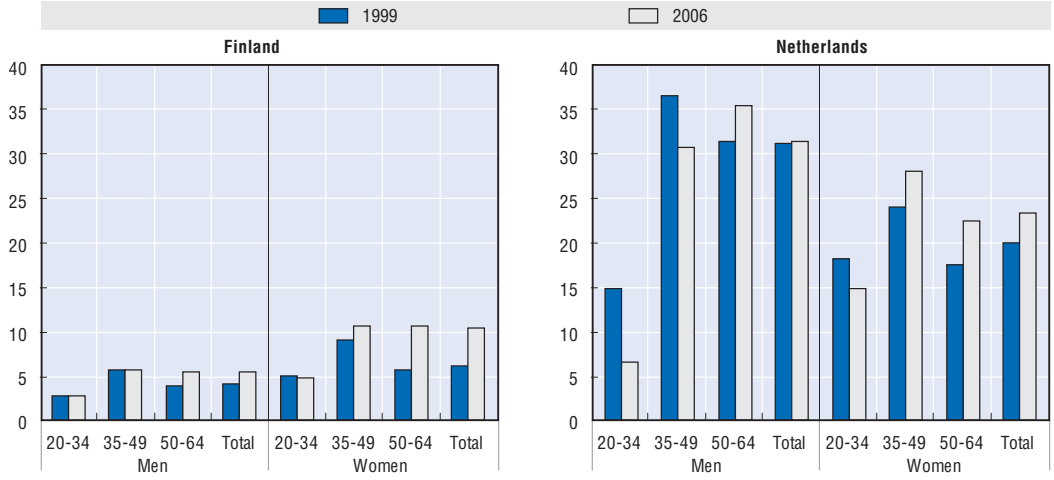
The availability of both partial and temporary disability benefits is another key difference across countries. In Denmark, disability benefits are now neither partial nor temporary, although partial benefits depending on the level of the reduced work capacity existed in the past.[9] In Ireland, temporary benefits are possible because the incapacity to perform work must be for at least a year. When the benefit is granted, it is also decided whether disability needs to be re-assessed after 12 months or 24 months, or whether it is permanent.

In Finland and the Netherlands, both partial and temporary benefits are possible (partial benefit exists for the earnings-related pension only in Finland). In practice, however, there are few cases of partial disability benefit in Finland (Figure 3.3).[10] On the other hand, the share of partial disability benefits in all disability benefits has increased for both men and women, especially in the older age group (50-64). The share of partial disability benefits is much larger in the Netherlands, though lower than in countries with comparable systems, such as Switzerland (OECD, 2006). Moreover, there has been a large decrease in partial disability among young people, who are generally awarded a Wajong benefit: because disability is based upon the minimum wage and Wajong recipients usually have functional limitations making it difficult to work, partial disability for this group is rare.

In addition, in Finland, among full disability benefit recipients, 50% get a temporary benefit for which a specific rehabilitation plan must be drawn; however, 80% of the temporary payments continue as indefinite benefits. In the Netherlands, the new disability scheme (WIA) has resulted in changes in the distribution of permanent and temporary benefits. Under the new WIA ruling, disability is judged on both its severity and permanence: one scheme exists for individuals whose capacity loss is at least 80% with no possible recovery (IVA benefit); and another scheme exists for individuals whose capacity loss is between 35% and 80% or those who are wholly incapacitated but who are likely to recover (WGA benefit). Because of the difficulty of assessing whether incapacity is

Figure 3.3. **Partial disability benefits are used more often in the Netherlands than in Finland**

Partial benefits as a share of total disability benefit recipients by age and gender, 1999 and 2006[a]



a) Data for Finland refer to earnings-related benefits only. Data for the Netherlands exclude recipients of the new WIA scheme.

Source: ETK for Finland and UWV for the Netherlands.

permanent and whether a person may recover or not, most cases under the new disability scheme are initially granted as a temporary benefit (79% of all cases). Individuals being awarded a permanent benefit have very different personal characteristics: they tend be older (80% are older than 45) and are more likely to have more serious and terminal diseases (Berendsen *et al.*, 2007). However, like in Finland, initial results suggest that the majority of temporary claims will be transformed into permanent ones over time.

D. Inflow into long-term health-related benefits

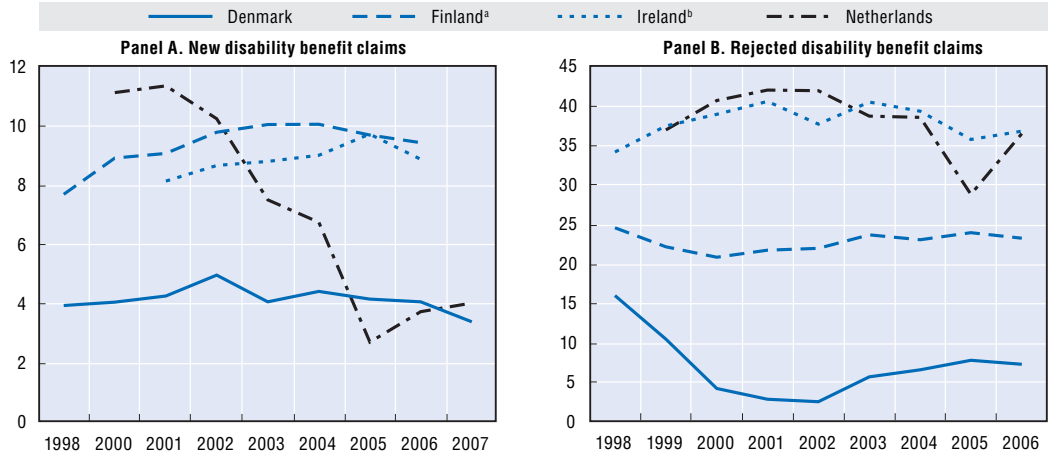
Today, the annual rate of inflow into disability benefits is around 4/1 000 in Denmark and the Netherlands but as high as 8-9/1 000 in both Finland and Ireland (Figure 3.4, Panel A). Such large differences partly reflect policy differences in managing sickness and in assessing disability. Inflow rates to disability benefits have been relatively constant over time in Denmark, but falling sharply – from a level of almost 12/1 000 in 2001 – in the Netherlands. In Ireland and Finland, inflow rates have been increasing ever since the mid-1990s, but the increase came to a halt recently.

The large differences in annual inflow rates are not reflected in the overall disability benefit recipiency rate, which is similar in all countries and still lowest in Ireland and highest in the Netherlands (Chapter 1). For Ireland, the explanation for this conundrum is the low level of the recipiency rate 15 years ago – currently Ireland is catching up fast. The large inflow in Finland is driven by a much larger inflow among the older population – *i.e.* people who stay on benefit only for a few years before reaching the retirement age of 65. Workers aged 55-64 account for almost 50% of the entire inflow in Finland compared to less than 30% in Denmark and less than 20% in the Netherlands (Figure 3.5). Moreover, new recipients are getting older on average in Finland and the Netherlands but younger in Denmark.

Available data for the four countries do not show a close correlation between disability benefit inflows and benefit rejections (Figure 3.4, Panel B). Rejection rates are particularly

Figure 3.4. **Differences in inflows are not explained by differences in rejection rates**

Disability benefit inflow rate (per 1 000 of the working-age population) and benefit rejection rate (percentage of total benefit applications), 1998-2006



a) The data for Finland cover the statutory earnings-related pension scheme only and ages 25-64.
b) Data for Ireland: the rejection rate is for the disability allowance only.
Source: Ministry of Social Affairs, Denmark; ETK, Finland; DSFA, Ireland; UWV, the Netherlands.

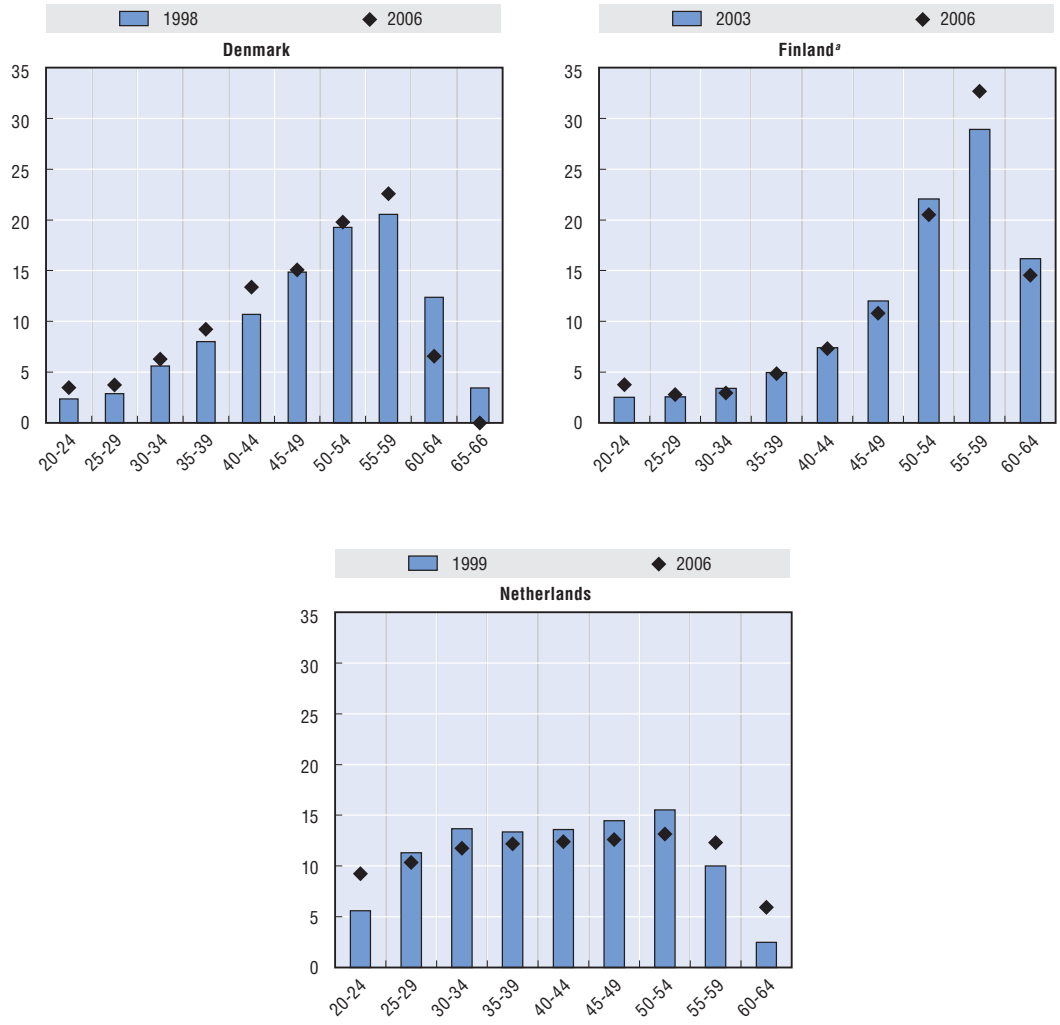
high in Ireland and the Netherlands, at close to 40% of all applicants with little variation over time, and very low and lower than ten years ago in Denmark.[11] These differences are not reflected in inflow rate levels and the evolution over time, *i.e.* differences in benefit application rates – *e.g.* between Ireland and Denmark – are even higher than in inflow rates. Similarly, the dramatic decrease in inflow rates in the Netherlands has not been a consequence of a sharply increasing share of rejections. Likewise, inflow as well as rejection rates are higher in Finland than in Denmark.

The case of the Netherlands illustrates the impact of policy changes on inflow into disability benefits. Until 2001, inflow was increasing, while there has been a sharp decrease after a series of reforms in the early 2000s. The decrease since 2001 has been larger for women, particularly those with psychological diseases, but similar for all levels of disability (Jehoel-Gijsbers, 2007). Estimates of the impact of different sickness and disability policy changes on inflow trends suggest that the gatekeeper law (increased employer responsibility for reintegration of sick employees) had the largest contribution to the fall in inflows (–42%), followed by the law lengthening employer-paid sick pay from one to two years (between –25 to –35%). The double assessment procedure with two independent assessors has helped to limit inflows for mental health reasons among prime-age and older workers.

In Denmark, inflow into disability benefits has remained constant in the last decade (although it has decreased compared with the early 1990s) in spite of all reforms, which have led to a sharp increase in the number of people referred to subsidised employment, that is, people waiting for flex-jobs and the flex-jobbers themselves.[12] Municipalities do not always document disability claims sufficiently. This is estimated at 20-25% of all cases and there is substantial cross-municipal variation in disability caseloads (Chapter 6). Both issues might partly explain the lack of success in decreasing recipiency numbers. Recent policy changes might reduce inflows by addressing both issues through efforts towards harmonisation of information and benchmarking against best practice. A new online facility has recently been developed in Denmark – which is updated on a monthly basis –

Figure 3.5. **There are large variations in the age pattern of disability benefit inflows across countries**

Inflows into disability by age as a percentage of total inflows, around 2000 and 2006



a) Data for Finland refer to the statutory earnings-related pension scheme only (this covers 80% of the inflow).

Source: Ministry of Social Affairs, Denmark; ETK, Finland and UWV for the Netherlands.

in order to facilitate comparisons across job centres on the number of recipients for the different benefits as well as on duration and costs. In addition, studies from the National Social Appeals Board imply that case-working and documentation have slowly improved since the recent reform.

In Ireland and Finland, little attention has been devoted to limiting the inflow into disability benefits. This only partially explains the rising inflows, but other changes have greatly contributed to this increase. In Finland, inflows into disability benefits are related to changes in unemployment benefits and, more recently, also to pension reform. Wide use of unemployment benefits during recession in the early-mid 1990s reduced the need for sickness and disability benefits, while in the late 1990s and early 2000s higher inflows into disability reflected a tighter administration of unemployment benefits (notably activation measures for assistance beneficiaries) and the fact that special programmes were launched to help the long-term unemployed with health problems to obtain a disability benefit (Gould,

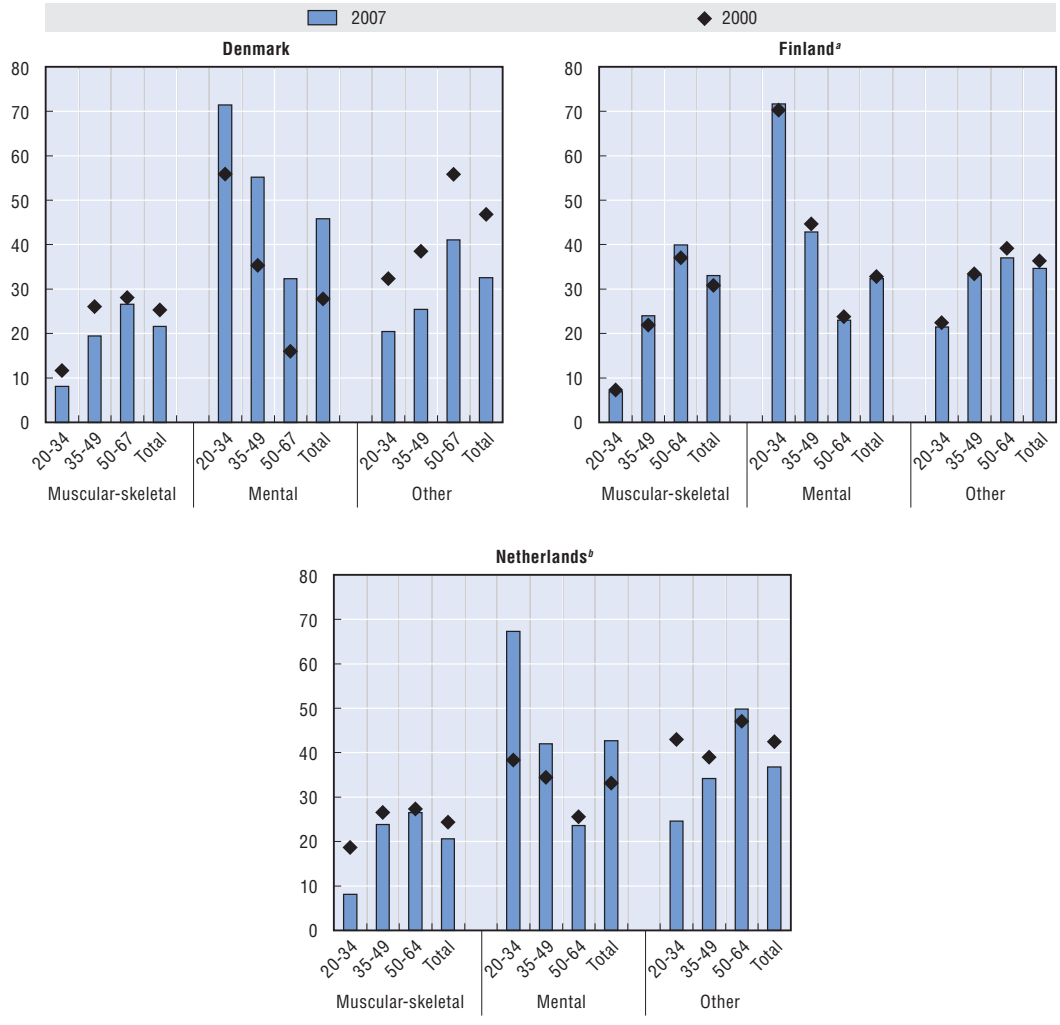
2003). In Ireland, the noticeable increase in the number of recipients of disability allowances is partly explained by changes in the administration and eligibility conditions following the transfer of responsibility from the Department of Health and Children to the DSFA.

Mental illness

The importance of tighter eligibility criteria is most evident in the case of mental diseases which have become prominent in disability benefits. Mental health problems account for more than 40% of inflows into disability benefits in Denmark and the Netherlands and close to one-third in Finland (Figure 3.6). In all three countries, shares of mental illness are systematically higher for younger and prime-age individuals, but

Figure 3.6. **Disability benefit inflows due to mental diseases are most common at younger ages**

Distribution of total inflow to disability benefits by health reason and age, around 2000 and 2007 (percentage; total in each age group = 100)



a) Data refer to 2003 and 2007.
b) Data refer to 1999 and 2007.

Source: National Social Appeals Board, Ministry of Social Affairs for Denmark; ETK for Finland and UWV for the Netherlands.

particularly for the age group 20-34: at this age, around 70% of inflows in all three countries are for mental health reasons. Inflow for mental health reasons has increased in all three countries for the younger age groups and across all age groups in Denmark. The large increase in Denmark has prompted a debate about the possibility of granting only a temporary benefit for young people with mental illness. However, other possibilities are also considered such as reassessing people on disability benefits every five years or introducing a new rehabilitation benefit. In addition, a project to improve the integration of young people at risk of mental disorders has been launched.

Explanations for the importance of mental illness are multiple and vary across countries. To a certain extent, they include the difficulty of assessing mental disabilities, the change of diagnosis and acceptance of mental ill-health, failures to help work resumption during illness and some other institutional factors, particularly in the Netherlands. According to some studies, treatment for mental diseases tends to start too late. Data from Finland show that individuals with mental illness, particularly those suffering from depression, benefit less often from rehabilitation and their return to work after rehabilitation is also less successful. Likewise, in the case of depression, disability benefits are less frequently granted on a partial basis (Gould *et al.*, 2007). In the Netherlands, additional institutional incentives exist for both municipalities and special education to encourage young people to apply for disability benefits (Box 3.2 for additional information).

Box 3.2. **Wajong: raising disability due to mental illness among the young in the Netherlands**

The Netherlands has witnessed recently a large increase in recipients of disability benefits specific for those who acquired a disability at a young age, the Wajong. The numbers have doubled between 2001 and 2006 and, currently, one in 20 18-year-olds eventually enters the Wajong benefit roll, with only 25% of them in employment (SER, 2007). 80% of the inflows are due to mental conditions and in the last years health conditions such as autism and ADHD have increased greatly (Einerhand, 2008) while inflow due to mental retardation, although still the primary diagnosis, has grown at a slower pace (mainly among the light mental handicaps).

Part of the increase of Wajong is believed to be related to changes in diagnosis and wider detection of such diseases (explaining 20% of the increase), to changes in society demanding more communication requirements, as well as to institutional incentives in the school, health care and benefit system promoting benefit dependency. In 1990, most inflow was related to physical handicaps while nowadays the majority of inflows are because of psychological problems, raising questions about changes in diagnosis, changes in stigma on psychological problems or more intolerance with respect to behavioural problems. In addition, there have been budgetary changes at the municipal level. Since 2004, municipalities are responsible for their own budget and have financial incentives to encourage young people with disability in social assistance (for which municipalities are financially responsible) to apply for a Wajong benefit; this seems to explain 20% of the Wajong increase. People with disability themselves have a financial incentive to change to a Wajong benefit since the allowance is higher than social assistance. There are also incentives to apply for a Wajong rather than a regular disability benefit, because the former has a lower entry threshold (25% rather than 35% earnings capacity loss) and no partial work requirement.

Box 3.2. **Wajong: raising disability due to mental illness among the young in the Netherlands** *(cont.)*

In addition, 40% of Wajong recipients come from special education institutions and there has been a large increase in inflow from this channel (31%). To start with, benefits for children were revised in 2000 to widen access to a larger public and they have become better known by parents of children with disability. The greater take-up of disability benefits for children increases the target group for Wajong. Additionally, increased co-operation between UWV and the special education sector has resulted in the Wajong benefit becoming more well-known. Tighter assessment criteria in 2004 had only limited impact on the number of Wajong recipients, suggesting that the type of limitations and lack of educational qualifications limit employment opportunities.

The government has launched a holistic approach which will include, in addition to changes in the benefit system, increased prevention and the promotion of a better school-to-work transition. Possible solutions considered are related to improvements in the education system in order to increase employment chances of young people with disability. In addition, the use of internships and special jobs will be stimulated. For this purpose, a new UWV centre for employers will be opened to handle specialised queries on the Wajong. The new focus will also include a more work-oriented approach after the disability assessment. Young people with disability will have participation requirements in reintegration activities and may lose their entitlement to a benefit if they do not participate or if they reject job offers. Wajong beneficiaries will initially be granted only a temporary benefit until a final assessment is made at a later stage (more precisely, at age 27 if they started receiving the benefit at age 18, later otherwise). On the other hand, the recommendation to change budgetary responsibilities so that municipalities are also responsible for Wajong (CPB, 2007) has been dropped because the municipalities are not seen to have the appropriate expertise for the reintegration of young people with disabilities.

3.2. From benefit back to work

Recognising the difficulties for people with disability to find employment and the need to help them to return to the labour market, countries have put in place a series of employment support and rehabilitation measures. The distribution of the different measures varies across countries with some putting more emphasis on access to regular employment and others focusing on vocational rehabilitation. The success of such active labour market programmes tends to be limited, partly because of low levels of engagement with people with disability, at least in some countries, and partly because of the design of the measures themselves.

A. Outflow from long-term health-related benefits

In all four countries there is a very low share of recipients leaving disability benefits for reasons other than death or retirement. In Denmark, outflow rates are virtually nil because only deprivations and withdrawals are registered. Only some 260 recipients a year suspend their disability benefit, of which, in 2006, 90 individuals started a flex-job and 170 became self-supporting. Outflow rates tend to be higher for younger people in both Finland and the Netherlands, with the exception of the very youngest in the latter who receive a Wajong benefit in most cases (Table 3.3). At 3.5% in 2003 (3% in 2006), outflow from disability benefits is relatively high in the Netherlands, in comparison with other countries reviewed

Table 3.3. **Outflows from disability benefits are relatively low**

Outflows from disability benefits as a share of all disability recipients, in percentage[a]

			20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Total
Finland	2006	Total	6.0	4.2	3.0	2.2	1.5	1.0	0.7	0.2	0.0	0.5
		Men	6.1	4.1	2.9	2.1	1.3	0.9	0.6	0.2	0.0	0.4
		Women	5.9	4.5	3.1	2.3	1.8	1.1	0.8	0.3	0.0	0.5
Netherlands[b]	2003	Total	5.2	8.5	8.5	6.8	5.5	4.3	2.8	1.5	0.4	3.5
		Men	3.4	5.6	6.4	5.6	4.4	3.4	2.2	1.3	0.4	2.4
		Women	7.0	10.5	9.9	7.8	6.6	5.3	3.5	1.9	0.4	4.8
	2006	Total	3.0	6.1	9.6	9.9	8.9	5.3	0.4	0.2	0.1	3.0
		Men	1.9	3.5	6.6	7.7	7.6	4.5	0.4	0.2	0.1	2.1
		Women	4.4	8.4	11.8	11.7	10.0	6.1	0.3	0.1	0.0	4.1

a) All outflows, excluding deaths and transfers to old-age pension.
b) Outflow data refer to those recipients whose disability benefit entitlement has been re-assessed.
Source: ETK, Finland and UWV, the Netherlands.

earlier (OECD, 2006, 2007). It has been estimated that for recent Dutch cohorts entering the benefit, 43% of new entrants[13] are no longer receiving the benefit six to seven years later (Jehoel-Gijsbers, 2007). Outflow in the Netherlands has remained fairly constant over time and it has been found that women, younger individuals and those with a disability for psychological reasons have a higher chance of exiting.

An important question concerning outflow is the destination of those exiting: are they leaving for employment or to another benefit; or are they coming back onto disability benefit a few years later? Unfortunately, as for pathways into disability, little information is available on this subject. Information from the Netherlands suggests that the majority of exits constitute a return to work (63% of outflows), while 11% move to another benefit and 9% leave the labour market (Jehoel-Gijsbers, 2007). Individuals with a full incapacity are less likely to leave the benefit for work and their work chances have diminished in recent years. On the other hand, the majority of the group exiting disability to work (85%) always had a connection to the labour market, generally through working part-time. More importantly, work resumption is not always stable: 17% of those exiting benefits for employment have lost their job again within a year (Jehoel-Gijsbers, 2007). In Denmark and Finland, the only information available is the type of benefit individuals move to when leaving the disability benefit (to another benefit) but nothing is known about the share of outflow doing such transitions. In the case of Finland, a great majority (almost 60%) move to unemployment (either with a KELA unemployment allowance or other unemployment) while in Denmark a greater share of the outflow is directed towards social assistance or other miscellaneous benefits.

Reassessment of benefit entitlement in the Netherlands

One of the main reasons why outflow rates are higher in the Netherlands is that recipients are reassessed systematically. Under the old disability regime, recipients were reassessed regularly but it appeared that 95% of them remained on benefit. Since the end of 2004, a large scale reassessment operation is under way in the Netherlands, reassessing 340 000 recipients of disability benefits under the age of 45 under the new benefit rules. With the new reassessment criteria, as many as 40% were considered fit for work or had a lower disability (*i.e.* loss of earnings capacity) than before.[14] Overall, it appears that reassessments result in the end of benefit entitlement more often for younger people,

women with low earnings and individuals with a small percentage of disability. UWV is providing reintegration plans for those not working and whose reassessment results in loss of entitlements or reduced disability benefit payment. Reassessed individuals who are not entitled to unemployment benefits may also receive a transitional benefit payable for one year. They can also benefit from so-called "bridge jobs" for which a 50% salary subsidy is available for one year.

Concerns have been raised about the results of the reassessment operation in the Netherlands and about the fact that reassessed individuals might simply be shifted to other benefits. A study following a cohort of reassessed recipients found that 50% are working after 18 months; however, only 30% of individuals previously *not* working are in employment after reassessment (Deursen, 2007). Those working tend to have better health while most work part-time and do not have a stable position; rather, they tend to hold temporary jobs. In addition, 35% of those not working do not look for work, mostly because of health reasons, 38% get unemployment benefits and 10% a temporary reintegration benefit. A large percentage, six in ten, was unsatisfied with the UWV, especially because of lack of guidance.

Overall, it appears that much more could be done in Denmark, Ireland and Finland in terms of reassessing current recipients with due consideration on how to help them to reintegrate the labour market. At the same time, large scale reassessments such as the one in the Netherlands might be constrained by regulations on benefit entitlements. This is the case, for instance, in Switzerland where removing a person's entitlement to a benefit may only be done after a very detailed proof that the health condition of the recipient has improved substantially.

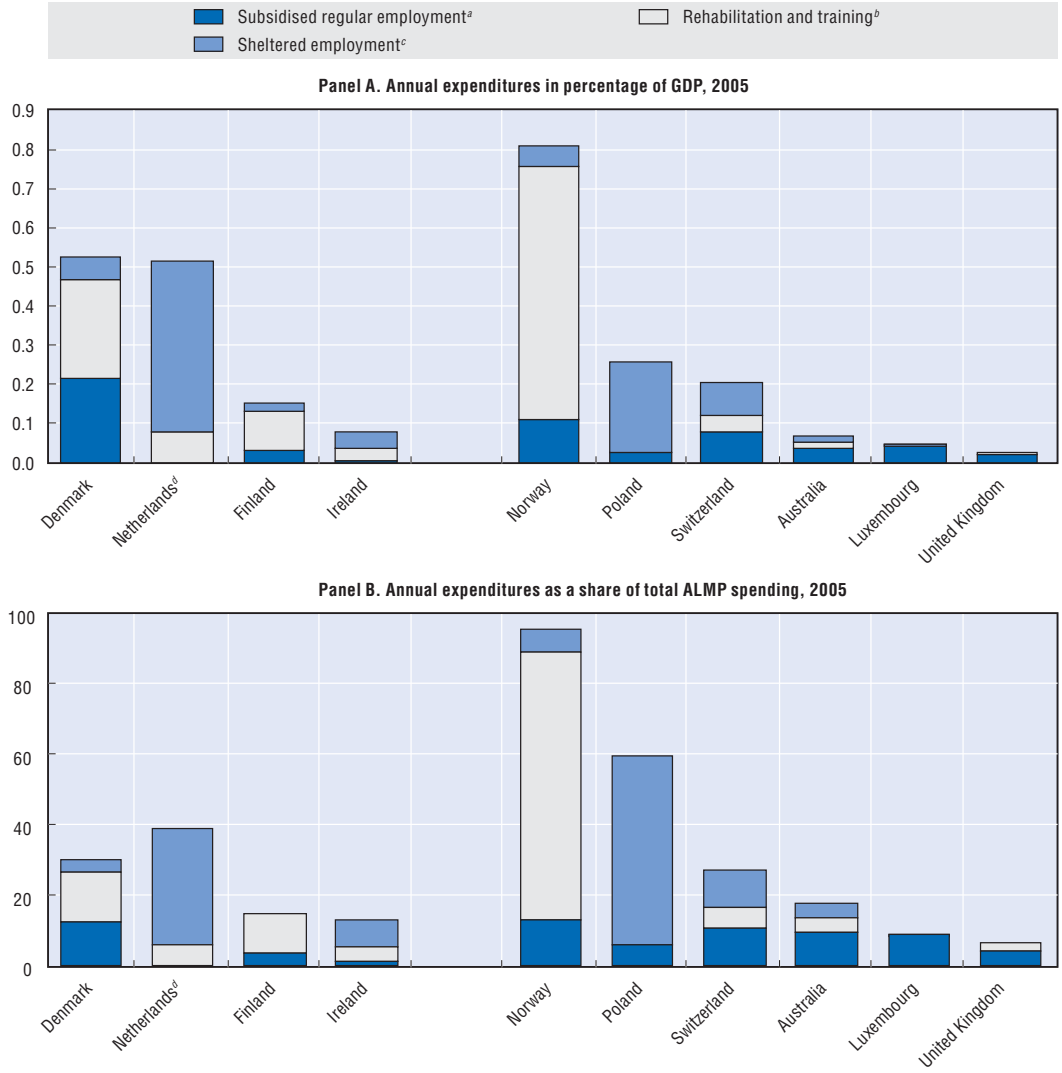
B. Active labour market programmes for people with disabilities

Active labour market programmes (ALMPs) aim to stimulate labour market inclusion (and, thus, social inclusion more broadly) of people with health problems or disability. Different countries have chosen different ways to stimulate labour demand as shown by data on public spending on ALMPs for people with disability. The data show large disparities across countries in both annual spending and the distribution of spending (Figure 3.7). Denmark and the Netherlands have comparatively high spending as a share of GDP, while Ireland and Finland have very low spending, despite high inflow into disability benefits in those two countries. As a share of total ALMP spending, the Netherlands reserves the highest percentage to people with disability (close to 40%), followed by Denmark (30%) with Ireland using the lowest relative share of ALMP for people with disability (around 12%).

In Denmark, ALMP spending for people with disabilities is mostly for subsidised (regular) employment; this contrasts with the other countries where less than 10% of expenditures are directed towards employment in the regular labour market. The Netherlands and Ireland concentrate the bulk of their expenditure on sheltered employment (85% and almost 60%, respectively). Finland targets employment measures mainly on rehabilitation. Rehabilitation measures are also important in Denmark but a large part of the rehabilitation expenditures are for vocational rehabilitation benefits (as it is the case in Norway).

The Danish focus on rehabilitation and measures to support regular employment is translated into approximately the same proportion of participants enrolling in these

Figure 3.7. **ALMP spending for people with disability is relatively high in Denmark and the Netherlands**



ALMP: Active labour market programmes.

a) Subsidised regular employment includes in Denmark: Flex-jobs; in Finland: Employment subsidy, job rotation, employment incentives, direct job creation and start-up incentives; in Ireland: Wage Subsidy Scheme and the Supported Employment Programme.

b) Rehabilitation and training includes in Denmark: rehabilitation and pre-rehabilitation; in Finland: Vocational rehabilitation and training; in Ireland: Measures offered by specialist training providers; in the Netherlands: Activities under the Act on the (re)integration in employment of the occupationally disabled (REA).

c) Sheltered employment includes in Denmark: Sheltered employment; in Finland: Employment-supporting activity of the municipalities; in Ireland: Community Employment; in the Netherlands: WSW sheltered employment.

d) Data exclude measures supporting access to regular employment.

Source: For Denmark, Statistics Denmark; for Finland, Ministry of Labour; for Ireland: FÁS Annual Reports; for the Netherlands: UWV. For the other countries, see OECD (2006) and OECD (2007).

measures (Table 3.4). In addition, Denmark is the only one among the four countries where the number of participants is actually larger than the number of disability benefit recipients. In Finland, with a relatively high proportion of expenditures on rehabilitation (64%) and much less on subsidised regular employment (22%), there is roughly the same share of participants in subsidised regular employment as in Denmark. In the Netherlands,

Table 3.4. **Training and sheltered employment are predominant in ALMP participants**

Participation in active labour market measures by type of programme (total and distribution), 2006

	Denmark[a]	Finland	Ireland[b]	Netherlands
Programme participants (in numbers)	285 897	19 272	11 986	174 766
Of which: (%)				
Subsidised regular employment	32.9	30.5	13.2	3.1
Sheltered employment	4.3	18.3	59.4	53.4
Vocational rehabilitation and training	47.9	51.2	27.4	38.7
Job coach/Job guidance	14.9	. .	. .	2.4
Other	. .	. .	. .	2.4
For comparison: programme participants as a share of current disability pension recipients	*123.0*	*7.2*	7.7	*20.6*

ALMP: Active labour market programmes.

a) Data refer to 2005.

b) Sheltered employment participants refer to "starts" and regular employment includes 1 254 participants in 2004 due to the unavailability of more recent data.

The definitions for the type of programmes are the same as for Figure 3.7.

Source: Finland, Ministry of Labour; Ireland, FÁS and Indecon report, Denmark, Danish Ministry of Employment DREAM database; Netherlands UWV.

a great deal of expenditures is concentrated in sheltered employment though serving only half of all ALMP participants while in Ireland the proportion spent on sheltered employment is similar to the relative number of participants.

In all four countries employment services have been mainstreamed, although in the Netherlands and Ireland there is a co-existence of a fully mainstreamed process with partially specialised services. All job centres in Denmark have a key person to deal with people with disability and, if more specialised knowledge is required, guidance might be sought from a specialised regional centre. No special advisors for jobseekers with disability exist in Ireland and Finland, although Finland's public employment services include vocational guidance psychologists and rehabilitation advisors which are available for all job-seekers but might have reasonable knowledge of useful measures for people with disability. In Ireland, clients are often referred to external companies of specialised services: 90% of training is outsourced to specialist training providers and FÁS fails to improve integration of people with disability within a regular training environment. On the other hand, mainstreamed services have been criticised in Finland for not leading to employment in the open labour market because of the high caseload and the lack of specific support needed by people with disability after employment is found.

C. Vocational rehabilitation

In all countries, except Denmark, vocational rehabilitation tends to be contracted out to private rehabilitation providers. Multiple training providers increase the risk of dispersion in the quality of services and of lack of accountability. In the case of Finland, KELA does not provide rehabilitation services directly but purchases it from 60 different rehabilitation centres. In addition, the strong focus on vocational rehabilitation might be due in part to the high importance attached to the principle that every person has the right to rehabilitation. Partly this is a result of the PES not being involved at the beginning of the setting-up of back-to-work strategies for people with disabilities. Most rehabilitation in Ireland (80%) is provided by specialist training providers (STPs) which receive funding through a capitation per Whole-Time Equivalent (WTE) training place.

Rehabilitation in the Netherlands is also carried out through private providers on behalf of the UWV. Funding arrangements are markedly different from Ireland since reintegration activities constitute a "quasi-market" where providers bid for contracts with the UWV. A large share of providers is organised in a branch association, BoraBorea, which acts as a pressure group and also grants a quality seal. Reintegration is contracted out either as a general tender for whole groups of clients and services or per person for the "Individual reintegration plans" (IRO); the latter have increased greatly and today constitute some 70% of all reintegration trajectories. Service providers bear a risk because of the financial system ("no cure, less pay") and because previous performance is taken into account.

Individual reintegration plans (IROs) have proven to be more successful, first, in terms of client satisfaction, but also, more importantly, in terms of outcomes. In part, this might be due to a selection effect, with clients who are closer to the labour market being more likely to choose an IRO. IROs were introduced in the Netherlands in 2004 in an effort to increase tailoring of reintegration activities and give individuals the possibility to decide on the best means for their own reintegration. Such reintegration plans offer more choices in terms of the provider to be used in view of the special needs of the client and more opportunities for further education and training. There are, on the other hand, certain limitations to IROs in terms of duration (two years) and a total maximum cost. Based on UWV's evaluation, it appears that individual trajectories are more satisfactory for clients but also more costly and requiring more intensive support, which is not always available due to a shortage of reintegration coaches. In addition, while the success rate is twice as high for people using IROs, such clients often have higher education and a lower degree of disability.

While monitoring and evaluation of reintegration services have improved greatly, there is a lack of knowledge about effectiveness of private providers in the Netherlands and benchmarking measures are underused. Procedures have improved, as well as choice of participants, together with targeting of the more difficult to place (SZW, 2007). Lack of adequate competition remains a concern because companies with good results are not necessarily growing at the expense of those with poorer results (Groot *et al*., 2006). In addition, the tender mechanism is blamed for causing a race to the bottom in terms of price of contracts, resulting in companies not having the means to place people and often offering cheaper trajectories. UWV has attempted to reverse this by engaging in longer-term contracts which allow reintegration companies to invest (SZW, 2007). At the same time, IROs have paved the way for a multitude of companies to enter the field with an enormous growth of companies specialised in reintegration (*Maandblad Reintegratie*, 2005).

In general, outcomes of vocational rehabilitation of sick employees in terms of increasing chances of work are mixed. Outcomes in Ireland remain poor with every second participant either not completing a course or just starting another one; less than a third of participants find a job upon completion and only 6.6% does so in the open labour market (Table 3.5). Furthermore, partly because of the structure for provision, rehabilitation measures suffer from a lack of occupational focus: more in-work type training opportunities as well as bridging programmes could be provided. In Finland, in contrast, 65% of rehabilitees under the earnings-related pension scheme are in employment afterwards. In Denmark a high proportion of rehabilitees becomes unemployed and, similarly, in the Netherlands job placement remains low. To a certain extent, good placement outcomes in Finland appear to be partly driven by creaming or selection effects since the numbers of individuals in rehabilitation are fairly low, although not in

Table 3.5. **Vocational rehabilitation leads to employment for a minority of participants, except in Finland**

Employment outcomes as a share of all rehabilitation participants, 2006

	Outcome	20-34	35-49	50-64	Total	Men	Women
Denmark	Employment	35.6	36.7	24.5	34.8	39.1	32.0
	Unemployment	41.4	40.1	39.6	40.6	37.1	42.9
	Early retirement and light job	4.4	5.0	11.9	5.5	6.1	5.1
	Education	4.8	1.6	0.2	2.9	2.6	3.1
	Flexjob	4.6	7.3	16.2	7.1	7.7	6.7
	Sick day and maternity day benefits	6.8	7.6	5.9	7.0	5.0	8.3
	Other	2.4	1.7	1.7	2.1	2.4	1.8
		100.0	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*

	Outcome	< 35	35-44	45-54	55-67	Total	Men	Women
Finland	Employment	73.3	72.1	64.1	53.4	65.9	66.0	65.9
	Education or unemployment	4.3	5.8	5.5	4.7	5.4	5.9	5.0
	Full disability pension	7.5	7.4	10.8	14.9	10.0	9.9	10.1
	Partial disability pension	2.4	3.3	7.5	9.9	6.1	5.8	6.3
	Other	12.5	11.4	12.0	17.0	12.6	12.5	12.7
		100.0	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*

	Outcome					Total		
Ireland	Employment	. .	. .	. .	. .	30.0	. .	. .
	Of which:							
	Open employment	. .	. .	. .	. .	6.6	. .	. .
	Sheltered employment	. .	. .	. .	. .	23.4	. .	. .
	Progression further education/ training	. .	. .	. .	. .	32.0	. .	. .
	Cease to attend due to medical problem	. .	. .	. .	. .	18.0	. .	. .
	Other	. .	. .	. .	. .	20.0	. .	. .
		. .	. .	. .	. .	*100.0*	. .	. .

	Outcome	20-34	35-49	50-64	Total	Men	Women
Netherlands	Employment	44.6	46.5	40.3	44.7	46.1	43.1
	Unemployment	43.5	43.1	48.6	44.4	41.2	48.0
	Modular service, unsuccessful	3.0	2.3	2.3	2.5	2.9	2.0
	Modular service, successful	8.9	8.1	8.8	8.4	9.8	6.8
		100.0	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*

Source: Denmark, The Danish Labour Market Authority; Finland, ETK; Ireland, "Study of Efficiency and Effectiveness of Vocational Training Services and Rehabilitative Training Services for People with Disabilities provided by Specialist Training Providers", Indecon; and the Netherlands, UWV.

comparison to Ireland. It is possible that a large share of the participants in vocational rehabilitation (under the earnings-related scheme) are employed in regular labour markets and typically in permanent contracts before (and during) rehabilitation.[15]

Many studies have investigated the impact of rehabilitation and find that the effects differ by the type of measure used. Educational measures seem to have limited effect on the return to work because the negative locking-in effects (reduced search intensity during rehabilitation) cancel the positive impact on human capital after completing rehabilitation (Hogelund and Holm, 2003). On the other hand, recent assessments considering long-term effects of training show the existence of positive results in different European countries, although in this case the sample is not restricted to people with disability (Kluve, 2006).

Nevertheless, rehabilitation has been found to have more positive effects for individuals who are further away from the labour market and workplace rehabilitation appears to be most effective in return to work of sick people (Frolich *et al*., 2004).

D. Supports to regular employment

With the exception of Denmark, supportive measures helping people with disability to access the open labour market have low take-up. Countries should consider to expand private sector incentive programmes since they have been found, relative to training programmes, to perform better in increasing employment prospects (Kluve, 2006). Most countries provide a range of measures to facilitate regular employment including job coaching, wage subsidies to compensate for the lower productivity and/or adapted hours, subsidies for workplace adaptation, transportation and personal assistance. In Ireland there are, however, no specific supports to address the personal assistance needs of people with disability in the workplace. Because of the multiplicity of actors involved in engaging with people with disability, the division of responsibility for personal assistance remains unclear – personal assistants are funded by DHC while work-related measures should be under the responsibility of DETE – and no funding is provided for this activity.

Only temporary, wage subsidy schemes for people with disability are available in Finland and in the Netherlands. This is in line with findings from earlier research showing that temporary targeted wage subsidies (instead of general wage subsidies) appear to be most effective in job creation (Martin and Grubb, 2001). In the Netherlands, a wage subsidy scheme does not exist for those declared disabled under the WIA: the disability benefit for those having a partial disability (WGA) becomes in essence a wage supplement compensating for the difference between the previous wage and the work-related actual income. Individuals under the old disability scheme and those on a Wajong benefit are also entitled for a wage supplement for a limited duration. In addition, for people with disability who have been reassessed, a special wage subsidy has been created for up to one year. Wage subsidies are available from public employment services in Finland for two years for a person with disability (or three years in the case of working in a social enterprise). Lack of flexibility in the funding has been blamed for the low usage of the scheme and the system was reformed in 2006 to simplify it. The subsidy is currently composed of a basic subsidy equivalent to the unemployment benefit and a supplementary subsidy ranging from 60% to 90% of the basic subsidy for the hard-to-place individuals. Job retention appears to be low and individuals remain no longer in employment after the withdrawal of the subsidy.

Danish policy is heavily oriented towards employment in the ordinary labour market. To facilitate job placement, an initiative to provide work-certificates for people with disability has been set up in order to describe what the applicants can do in a job context and what compensation measures are available. Use of the wage-subsidy scheme – flex-job scheme – is high and has increased greatly in recent years (by more than 200% since 2003). In order to qualify for a wage subsidy, the person must have a permanent impairment of the ability to work and be unable to retain a job on normal conditions. In addition, all other rehabilitation and activation measures must have been exhausted. There are reasons to believe that the popularity of flex-jobs hide substitution problems with ordinary jobs because employers, employees and municipalities all benefit from transferring individuals to flex-jobs. Indeed, employees work reduced hours but are paid a full wage, employers receive a subsidy which can be used to hire an additional person and municipalities are

generously reimbursed by the state. The majority of flex-jobs were allocated to individuals previously working at the firm rather than hiring an external person. For this reason, the flex-job programme was modified in 2006 by putting a wage limit on the flex-job and increasing requirements on municipalities to provide documentation before allocating a flex-job.[16] In addition, to reduce the number of persons on a waiting benefit while waiting for a flex-job, active contact with the job centre is required and, after one year, private providers might be called upon to find a suitable job. Progression from flex-jobs to ordinary employment remains low (less than 1%).

In contrast, subsidised jobs are used by an extremely low share of people with disability in Ireland. The Wage Subsidy Scheme includes a subsidy to compensate for the employee's lower productivity, and additional compensation for employers designed to compensate for the extra management and supervisory costs. Disincentives are partly related to the benefit system (Chapter 5) but also to the lack of clarity in the scheme design. Wage subsidies are incompatible with keeping benefits (except the Back-to-Work Allowance) and many people with disability do not join because they fear losing their secondary benefits, especially the medical card (which they are allowed to keep for up to three years). The subsidy depends on the level of productivity deficit but the definition of productivity is not very clear and not related to the assessment of disability (as in the Netherlands), making it difficult to quantify its level. In addition, the wage subsidy does not encompass whether work might be undertaken under specific conditions such as reduced hours or shifts and requires at least 21 hours of work per week.

In order to facilitate employment of people with disability, multiagency initiatives have been set up in Ireland and Finland but challenges remain in the design to improve outcomes. The Midlands pilot in Ireland raised concerns about the lack of referral and information-sharing across agencies – failure to activate related to the fact that services offered lacked relevance to the individual's situation and aspirations. Problems of tailoring are to be blamed for the lack of success: the Midlands project shows that people were not interested to participate in activation because they felt that the PES had nothing to offer (FÁS, 2006).[17] Labour force service centres (LAFOS) have been created in Finland since 2002 with staff drawn 50% from public employment services and 50% from municipalities. They are supposed to concentrate on unemployed individuals who are difficult to place and could benefit from a multi-disciplinary approach and from more regular meetings than are usual at the PES. On the other hand, because of the restrictive criteria set for clients, many disadvantaged clients such as people with mental health problems are not serviced by the LAFOS.

E. Sheltered employment

In all four countries the provision of sheltered employment is organised in a decentralised manner, at the local level, although the size and organisation differs greatly. Indeed, sheltered employment constitutes the most important active labour market programme in the Netherlands in terms of both expenditures and the number of participants while it is relatively small in Finland and Denmark (in terms of the share of participants). In the Netherlands, most participants work at sheltered employment companies (78%) but sheltered employment in a regular company has increased greatly in recent years (by 37% in 2006). Sheltered employment and Community Employment (CE) are the main employment measures in Ireland. A major difference between the two schemes is that sheltered employment does not have the re-integration into the open labour market

as its main goal, while CE does and is more focused on addressing long-term unemployment.

Sheltered workshops and companies tend to be organised at the level of the community in all countries because the workshops traditionally performed tasks in the interest of local community and the nature of the work was determined by local demands. Before the municipal reform, responsibility for sheltered employment in Denmark was divided between municipalities and regions but since 2007 municipalities are in charge of the full management. In Ireland, the origins of both sheltered and Community Employment are related to the provision by voluntary organisations and community associations. As a result, they rely heavily on volunteers to manage the enterprise and to contribute to the production and have a non-profit orientation (O'Hara and O'Shaughnessy, 2004). Financing and overall responsibility of sheltered employment belongs to the DHC while CE receives a budget from FÁS. In the Netherlands and Finland, sheltered employment was financed mostly by the state and municipalities had to cover the financial losses if the statutory aid was not sufficient. To simplify finances and reduce waiting lists in the Netherlands, the budget is, since 2008, based on the number of individuals referred to sheltered employment instead of a fixed subsidy by placement.

To be eligible for sheltered employment, countries require that people are unable to work in regular employment. Placement tends to be voluntary without a systematic structure of engagement. In the Netherlands, the target group comprises people who, due to physical, mental or psychological limitations, will only be able to undertake work under adapted conditions. To ensure an independent assessment and consider other possibilities in regular employment, the request is examined by the Centre for Work and Income and not by the municipalities.[18] In spite of a discussion about the lack of information about the possibilities to do sheltered work and the absence of systematic referral, the system remains voluntary. There are no sanctions if individuals do not request to work or if they refuse a placement while on the waiting list, although they will be removed from the programme after the refusal. Instead, individual rights have increased with the requirements for municipalities to provide an appropriate place within a year. In Denmark and Ireland, eligibility is also possible for individuals experiencing social difficulties which prevent them from maintaining a regular job. In Ireland, individuals express their interest to FÁS or their local employment services and eligibility is based on age and the length of time as a benefit recipient (unemployment, disability, social welfare).

The composition and evolution of participants on sheltered employment varies across the countries. In general, the number of participants appears to have increased slightly. In the Netherlands there has been stagnation since the municipal reform of 2004: numbers increased by 1-2% per year between 1998 and 2004 and the increase was limited to 0.1% in 2006. The waiting list has increased at the same time, reaching 20 000 individuals who await placement. In Ireland, though overall participation rates in CE fell significantly, the proportionate share of people with disability on the scheme has increased from 7.4% in 1998 to 23% in 2007. Participants differ likewise in their source of income. In the Netherlands, participation in sheltered employment is regulated by special collective agreements and participants receive a wage equivalent to regular employment (above the minimum wage) and the same holds for social enterprises in Finland. In Ireland and Denmark, individuals in sheltered workshops generally use their benefit as their main source of income and the salary received is perceived as a complement. In addition, in

Ireland the legal status of workers remains a controversial issue since they have no guarantee of a minimum wage, a legal contract of employment or employment protection.

Overall there has been an emphasis on shifting away from sheltered workshops towards other forms of sheltered employment such as sheltered external employment and social enterprises. Likewise, all countries are focusing on workers progression towards the open labour market and pay more attention to skills learned and useful training during sheltered employment. In Ireland, CE has developed a more structured approach to facilitate progression including, since recently, a training component delivering a certificate. The Irish DETE is also investigating how sheltered workshops could have a more commercial potential. In the Netherlands, reforms emphasize the right to more tailor-made sheltered employment and municipalities will receive a bonus in the case of sheltered employment in the form of coaching by regular companies. Similarly, in Denmark and Finland the trend is to arrange sheltered employment in enterprises that operate in the ordinary labour market; the 2007 Finnish reform increasing the wage subsidy for social enterprises should be seen in this context.[19]

Sheltered employment has been considered as a stepping-stone into the ordinary labour market but in reality in most countries progression is very low. For instance, total transition to a regular job is estimated at below 10% in Ireland (from CE) and a 4% in the Netherlands. Ireland has set limits to the length of time individuals can be in CE to encourage progression but individuals are often offered another type of CE. It has been suggested that the scheme does little to raise employment prospects of participants and training might be a better option for enhancing the chances to get a regular job (O'Connell, 2001). The question remains, however, to what extent it can constitute a transitional form of employment for people with disability and to what extent there is a need for a sort of secondary labour market. To at certain extent, progression goals create a dilemma with the very own requirements to qualify for sheltered employment, *i.e.* an inability to work in the regular labour market. The second question is whether production by sheltered workshops within a competitive environment is compatible with rehabilitative work or social integration. Indeed, it appears that in the Netherlands, selection is occurring in order to prevent monetary losses and individuals with a higher degree of disability remain on the waiting list for a longer period of time.

3.3. Conclusion

While Dutch policy is more focused on promoting job retention and reducing disability benefit inflow, Danish policy places more emphasis on activation of people with disability and providing different types of employment measures before a disability benefit is being granted. A concern remains towards inclusion of people with disability in Ireland and Finland because many people do not have a chance to participate in mainstreamed ALMP measures. Both countries use a more passive approach towards employment of people with disability, with some focus on rehabilitation and skills acquisition.

Ireland has only recently moved away from a traditional role of providing income support for people with disability. Only nowadays Ireland is in the process of developing an integrated approach to activation with systematic identification of employment potential, with DSFA facilitators determining referral options (Social and Economic Participation Programme). This has the potential to solve the current lack of systematic engagement with people with disability who only enrol in active labour market programmes if they choose to contact directly the different agencies involved. Currently, there is little follow-up

upon completion of a programme and no progress monitoring. Partly this is due to a lack of resources, and partly this is a result of the division of responsibilities for rehabilitation and the segmentation of vocational rehabilitation among different specialist training providers. It is important that such segmentation does not hinder the progression from medical to vocational rehabilitation, preventing people with disability from acquiring the skills to successfully participate in the labour market. Likewise, tools for progression and employment-related targets need to be in place to provide adequate monitoring.

Similarly, in Finland people with disability are not systematically referred to the public employment services. Labour force service centres, with multi-professional co-operation between the employment office and the municipality (and with some involvement of the social insurance authority), combine different services and support solutions and would have the potential to help with the reintegration of people with disability. However, these centres are mostly focused on the long-term unemployed with social problems. One of the institutions in charge of sickness and disability policy should take the lead in referring people with disability to the appropriate agencies and in monitoring progress towards vocational rehabilitation and employment (Chapter 6). This is particularly important in the case of rehabilitation since many players are involved in determining needs and payments. As for Ireland, quantitative targets on outcomes and placement rates should be considered for people with disability. Better measurement of both outcomes and clients' level of disadvantage remains a precondition for targeting.

In Denmark and the Netherlands incentives and mechanisms are in place to provide ALMPs to people with disability but more can be done in terms of evaluation and efficiency. Job centres in Denmark have a great potential to monitor outcomes of actions with a tool for benchmarking across municipalities and targets which could be extended to people with disability. In the Netherlands, the outcome focus of payments could be strengthened and more efforts should be made in ensuring quality checks for providers. Besides, in spite of all innovative reforms and efforts to increase work incentives in the Netherlands, the strong focus on sheltered employment remains and more could be done to increase regular employment of people with disability.

Notes

1. Plans for future reforms to promote active efforts by municipalities include raising reimbursement rates for municipalities from 50% to 65% if the sick person has partially recovered or has accepted an activation offer of more than 10 hours per week; otherwise the reimbursement is *reduced* to 35%.
2. The responsibility was shifted to employers in 1996, but strengthened considerably in 2002 (gatekeeper protocol), 2003 (reintegration firms for jobs with other employer) and 2004 (two-year sick pay – see Chapter 2 for more detail).
3. Empirically, one in five recipients of illness benefit in Ireland receive such payment for more than one year.
4. Specialised rehabilitation was previously the responsibility of counties. With the municipal reform (effective as from 1 January 2007), the responsibility was transferred to the municipalities.
5. The list of illness is drawn together by the UWV and the Ministry of Social Affairs and includes among others chronic back pain, psychological diseases, whiplash, RSI and chronic tiredness.
6. The group with < 35% reduction in earnings incapacity is quite large, constituting 17 315 individuals in 2006 in comparison to the 18 007 who have been awarded either an IVA or WGA benefit in 2006.
7. Because of the two parallel assessments, co-operation between the two institutions exists in order to prevent that a different decision is reached for the two benefits.

8. The Dutch benefit for early disability (Wajong) is for individuals who have acquired a disability before the age of 17 or after the age of 17 but before the age of 30 and who have been a student for at least six months in the year prior to the occupational disability.
9. The Danish flex-job subsidies, which are available at two levels (one-half and two-thirds of the previous wage), partly fulfil the role of partial disability benefits in other countries.
10. The low percentage of partial disability benefits in Finland is in part explained by the fact that part-time work opportunities remain limited and authorities granting benefits are concerned that people cannot make a living with only a partial payment.
11. Part of the explanation for low rejection rates in Denmark is that the figures do not include people who are not considered for a disability benefit because they have not exhausted all activation, rehabilitation, treatment and other measures before they can be considered for the application of the benefit.
12. Workers in flex-jobs have increased from 13 000 in 2003 to 41 500 in 2006. The number of individuals waiting for a flex-job increased from 1 400 to 12 700 in the same period.
13. The 43% corresponds to the outflow of new entrants over a recent seven-year period, including transfers into retirement, while 3% corresponds to the share of annual outflows of all current recipients excluding transfers to old-age pensions.
14. Reassessing disability recipients could therefore lead to larger outflows in other countries, particularly in Ireland, where reassessment is not done systematically; it was estimated that among those individuals called for reassessment, roughly 35% were found able to work.
15. The figures for Finland only include participants of ETK vocational rehabilitation measures since no comparable statistics concerning KELA, traffic and accident insurances or other providers are available.
16. According to the Danish Board of Appeals, prior to this reform, 50% of the cases were not well documented.
17. The Irish pilot also showed that awarding a disability allowance before an assessment was done on ability to progress had a major demotivating effect as beneficiaries became dependant on benefits and were reluctant to join a program for fear of losing them.
18. Before eligibility to sheltered employment in the Netherlands was done by commissions at the municipal level and it was found that criteria were not applied in a uniform manner across municipalities. In addition, there was concern about the influence of municipalities in the decisions.
19. To be considered a social enterprise in Finland, at least 30% of the company's personnel must have a disability or be long-term unemployed. Legislation was modified in 2007 to facilitate employment in social enterprises by increasing the maximum amount of wage subsidy by 60% and extending the maximum duration by an additional year. The latest changes appear to have stimulated the creation of social enterprises from very low numbers (two new social enterprises are being created per week).

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Chapter 4

Job Retention and Recruitment: Involving Employers

Employment rates of people with disability are far below those of people without disability. Partly this is because low recruitment due to a lack of appropriate skills and partly because employers may have an incentive to encourage early exit from the labour market for people with health problems. Employment protection legislation (EPL) meant to protect workers can create additional deterrents for employers to hire. More stringent EPL in Finland and the Netherlands could be contributing to labour market duality and to lower hiring of people with disability. This contrasts with Denmark and Ireland where employers have fewer obligations to retain workers but where the labour market favours easier return to work.

Different forms of financial incentives have been put in place as additional incentives to employers in all countries. Wage subsidies have successfully increased employment in Finland but they appear to have created substitution effects in Denmark. In the Netherlands, employers are exempted from carrying the costs of disability benefits and from paying wage during sickness when hiring a person with a longstanding illness. Overall employers are often discouraged by administrative hurdles and more could be done in this area in all poor countries.

Employment rates of people with disability remain at a low level, in spite of efforts to improve them. Promoting increased participation of people with disability through stricter requirements and financial incentives, together with more widespread activation programmes, might not be enough to change this. The role of employers is also crucial in raising employment of people with disability and employers need to be convinced of the importance of employing and retaining people with health problems. However, in many cases, significant obligations for employers towards people with a longstanding illness or disability, together with concerns about the implications in terms of the company's productivity and costs, act as deterrents to employment.

This chapter looks at the challenge of promoting employment of people with disability predominantly through the eyes of employers. First, the analysis looks at which groups of people employers do or do not retain or recruit, with an emphasis on young and older workers. Secondly, the chapter surveys the systems in place to enforce job retention of workers with health problems and how these affect employers, with emphasis on the hiring-retention dilemma. The last section discusses possibilities to overcome this dilemma through a variety of ways to engage with employers so as to improve retention and recruitment chances.

4.1. Labour demand and skill mismatches

In spite of labour shortages in some of the countries, high inactivity is found among people with self-assessed disability who wish to work and could be filling employment gaps. This section provides an overview of employment characteristics of people with disability and discusses how the lack of qualifications makes employing people with disability less attractive in the eye of employers. Skill mismatches are particularly problematic for younger workers but also for older workers who are no longer fit for a demanding and changing labour market. The section also surveys how disincentives in the social security system discourage employers from hiring and retaining older workers with health problems.

A. Is low employment of people with disability a result of low hiring and low skills?

Relative to people without disability, employment rates are much lower for people with disability in all countries (Chapter 1 and Table 4.1). The gap is particularly large in Ireland and the Netherlands where employment rates are almost half of people without disability compared to 70% in Finland. Additionally, the gap in employment between people with disability and without is substantially higher for older age groups (50-64) in all countries. Unemployment rates are also higher for people with disability; especially in Denmark and the Netherlands where they are twice as high. Ireland has the lowest employment rates for people with disability while Finland has the highest unemployment rate (also among those without disability).

Table 4.1. **Employment characteristics of people with disability differ from those without disability**

Employment structures and characteristics, by age and disability status, percentage, latest available year[a]

	Denmark				Finland				Ireland				Netherlands			
	20-34	35-49	50-64	**Total**	20-34	35-49	50-64	**Total**	20-34	35-49	50-64	**Total**	20-34	35-49	50-64	**Total**
Employment (% of population)																
Disabled	65	65	39	**52**	57	70	44	**54**	53	49	30	**41**	58	52	34	**44**
Non-disabled	73	93	77	**82**	66	86	71	**75**	78	79	63	**75**	83	87	64	**79**
Unemployment (% of labour force)																
Disabled	9	8	7	**8**	14	13	15	**14**	10	5	4	**6**	. .	. .	. .	**8**
Non-disabled	6	4	4	**4**	10	8	12	**10**	5	3	3	**4**	. .	. .	. .	**4**
Part-time employment[b]																
Disabled	21	19	24	**21**	12	7	15	**11**	19	26	30	**25**	27	29	32	**29**
Non-disabled	15	7	10	**10**	11	5	10	**8**	12	20	22	**17**	26	32	30	**29**
Temporary employment																
Disabled	17	5	5	**8**	29	9	7	**13**	6	4	4	**5**	19	7	4	**10**
Non-disabled	14	4	4	**8**	29	10	8	**17**	5	3	3	**4**	18	7	6	**11**
Self-employed																
Disabled	2	9	13	**9**	9	14	17	**14**	7	19	30	**19**	6	10	16	**11**
Non-disabled	5	8	12	**8**	7	13	17	**12**	8	21	29	**17**	7	13	17	**11**
Share by industry																
Agriculture																
Disabled	3	3	4	**3**	5	6	8	**7**	4	7	15	**9**	1	2	4	**2**
Non-disabled	3	2	4	**3**	3	5	7	**5**	4	6	11	**6**	2	3	4	**3**
Industry																
Disabled	22	25	22	**23**	25	26	26	**26**	28	22	22	**24**	21	25	27	**25**
Non-disabled	23	25	23	**24**	28	28	27	**28**	31	27	24	**28**	20	21	21	**21**
Services																
Disabled	75	72	74	**74**	70	68	66	**68**	68	71	63	**67**	78	72	69	**73**
Non-disabled	73	72	73	**73**	69	67	66	**67**	65	66	65	**65**	78	77	74	**77**
Hiring rate[c]																
Disabled	38	19	. .	**20**	34	12	. .	**15**	27	15	. .	**18**	29	15	. .	**17**
Non-disabled	35	16	9	**21**	36	14	9	**21**	26	13	10	**19**	32	18	13	**23**
Job retention rate[d]																
Disabled	20	46	76	**50**	24	68	81	**64**	31	55	67	**51**	30	58	79	**56**
Non-disabled	22	55	75	**48**	22	64	79	**52**	30	62	71	**48**	27	57	76	**48**

a) Definition of disability on self-assessment basis. Employment and unemployment for Denmark, Finland and the Netherlands refer to 2005, employment characteristics to 2002.
b) Part-time work is defined as less than 30 hours per week.
c) The hiring rate is calculated as the share of employees with tenure less than one year.
d) Job retention rate is defined as the share of employees with tenure with the same employer for five years or longer.
Source: OECD calculations based on EULFS (2002) *ad hoc* module on disabled persons, except employment and unemployment for Denmark (LFS 2005), Finland (SILC 2005) and the Netherlands (LFS 2005).

In terms of employment characteristics, there are few significant differences for people with disability. There are no notable differences by sector of employment or in the share of self-employed. Persons with disability do not appear to be overrepresented in temporary employment in Denmark, Finland and the Netherlands while they are slightly so in Ireland. The most substantial difference in terms of employment characteristics is the higher share of part-time jobs among people with disability. In Denmark, Ireland and Finland, this holds for all age groups. The largest gap in part-time employment occurs in Denmark, particularly among the older age group. In Ireland, in contrast, the largest difference in part-time employment is found among young adults. Fewer restrictions on employers to retain workers with health problems could partly explain the large part-time

work shares among people with disability in these two countries (Section 4.2). In the Netherlands there is a high part-time share among all groups, with or without disability.

There are large differences in the hiring rate between people with disability and those without in Finland and the Netherlands (Table 4.1). The greater reluctance of employers to hire people with disability could be related to certain employer obligations (see Section 4.2). On the other hand, a closer look at the break-down by age groups reveals that, partly, the gap is an age effect. In line with the finding of, and explanations, for hiring rate differences, job retention rates are higher among people with disability, in both the Netherlands and especially Finland. In Denmark and Ireland, retention rates are lower for people with disability in the mid-age range.

Poor overall labour market outcomes for people with disability are partly a result of their lower qualifications. In all four countries, educational attainment of people with disability is on average much lower (Table 4.2). The share of people with disability having tertiary education is only two-thirds of people with no disability in Denmark and Finland and close to one-half in the Netherlands and Ireland. Much higher shares of people with disability have only primary education, particularly in Ireland (60% or almost twice the share for those without disability). The education gap tends to be higher among younger individuals, except in Denmark. Lower educational outcomes for people with disability, especially among younger individuals, are partly explained by the fact that their disability was acquired at a young age, thus hampering them in their educational career (Gannon and Nolan, 2006).

Educational levels of people with disability compare best to those of inactive people without disabilities, who have the lowest level of qualifications among people without disability. In fact, except in the Netherlands, people with disability have even lower qualifications than inactives without disability. Employed individuals with disability have relatively better qualifications, particularly in Finland where the share of tertiary education reaches 80% of that of employees without disability.

B. Older workers and early retirement practices

As can be seen in Figure 4.1, Panel A, the age distribution of disability benefit recipiency is biased towards older age groups. A strong bias exists in all countries but it is particularly important in Finland where those aged 50 and over constitute more than 70% of all disability benefit recipients. Part of the age bias is a consequence of the age gradient of health problems, as shown in Chapter 1 and reflected in age-specific disability prevalence rates. Another explanation for the age bias is the use of disability benefits as an early retirement pathway. This is most apparent in Finland where most of the inflows into disability also occur among the older age-group (Figure 4.1, Panel B). On the contrary, new disability benefit recipients are distributed equally across age in the Netherlands.

Early retirement is not just a labour supply issue but a labour demand one as well, since firms may be interested in their older workers to stop working for several reasons and may choose not to act as partial gatekeepers to the benefit system. The structure of employers' social security contributions tends to make employment of older workers more expensive. Wages tend to grow with age or length of service and, in certain countries, wage systems are built on seniority. High wages and labour costs for older workers should reflect higher productivity associated with experience. However, beyond a certain age, wages might exceed relative productivity, particularly in comparison with younger workers. This

Table 4.2. **Qualification levels of people with disability are lagging far behind, especially in Ireland**

Distribution (in percentage) of all people in each category by age and educational attainment, most recent year available

Panel A. People with disability

	Employed				Unemployed				Inactive				Total			
	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total
Denmark																
Less than upper secondary	26	25	24	25	34	20	47	33	35	49	48	47	29	32	38	35
Upper secondary	50	48	49	49	52	63	42	53	55	42	38	41	51	47	43	46
Tertiary	24	27	27	26	13	17	11	14	10	9	13	12	19	21	19	20
	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Finland																
Less than upper secondary	9	12	30	20	48	24	44	38	33	31	46	41	21	17	39	29
Upper secondary	63	54	41	50	44	60	43	49	58	53	39	44	60	54	40	48
Tertiary	27	34	29	31	8	16	13	13	9	16	15	14	19	28	21	23
	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Ireland																
Less than upper secondary	28	37	60	43	47	69	67	58	61	70	78	73	42	54	72	60
Upper secondary	46	35	23	34	43	21	22	32	30	24	16	20	39	29	18	26
Tertiary	27	27	16	23	10	9	10	10	9	6	6	7	19	17	9	14
	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Netherlands																
Less than upper secondary	24	30	36	31	. .	. .	. .	. .	52	52	57	55	36	40	49	44
Upper secondary	56	47	41	47	. .	. .	. .	. .	41	36	31	34	49	42	35	40
Tertiary	20	23	23	22	. .	. .	. .	. .	7	11	12	11	15	18	16	16
	100	100	100	100	. .	. .	. .	. .	100	100	100	100	100	100	100	100

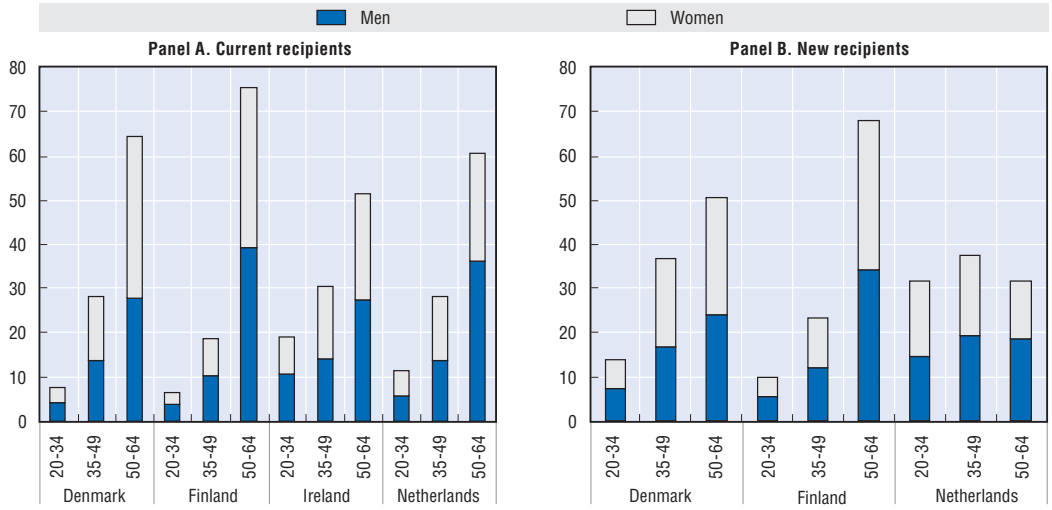
Panel B. People without disability

	Employed				Unemployed				Inactive				Total			
	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total
Denmark																
Less than upper secondary	18	17	23	19	30	25	35	30	20	31	42	30	19	18	27	21
Upper secondary	49	49	46	48	38	48	42	42	68	51	43	56	52	49	45	49
Tertiary	33	34	31	33	32	27	23	28	13	18	16	14	28	33	28	30
	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Finland																
Less than upper secondary	10	12	26	15	24	19	43	29	15	19	46	26	12	13	32	18
Upper secondary	58	45	37	47	57	64	41	54	70	45	27	53	61	47	35	48
Tertiary	33	43	37	38	19	16	16	17	15	35	26	22	27	41	33	34
	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Ireland																
Less than upper secondary	17	32	50	29	40	57	66	49	24	49	67	47	19	36	56	33
Upper secondary	47	40	28	41	39	29	23	34	56	38	23	39	48	39	26	40
Tertiary	36	28	22	30	21	14	11	17	20	13	10	14	32	25	17	26
	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Netherlands																
Less than upper secondary	17	22	29	22	. .	. .	. .	. .	30	41	49	42	20	24	36	26
Upper secondary	50	45	37	45	. .	. .	. .	. .	53	42	33	40	51	45	36	44
Tertiary	32	33	34	33	. .	. .	. .	. .	17	18	18	17	30	31	28	30
	100	100	100	100	. .	. .	. .	. .	100	100	100	100	100	100	100	100

Source: For Denmark and the Netherlands, LFS 2005; Finland: EU-SILC 2005; Ireland, EULFS 2002 *ad hoc* module on disabled persons.

Figure 4.1. **Disability benefit population is significantly biased toward older age groups**

Distribution of current and new disability benefit recipients, by age and gender (as a percentage of the total), 2006[a]



a) Data for Denmark refer to 2005. No data available on inflows by age for Ireland.

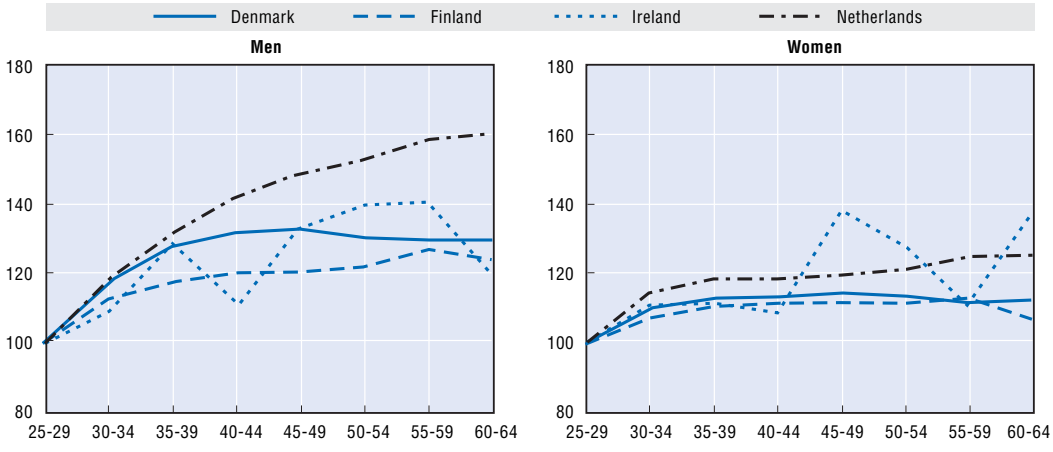
Source: Ministry of Social Affairs Denmark; ETK for Finland; DSFA for Ireland and UWV for the Netherlands.

becomes a more relevant issue if older workers have not benefited from training and their skills become obsolete or because they typically tend to be less educated than younger generations.

Institutional practices place a higher burden on older workers in Finland and the Netherlands. Social security contributions are particularly high for older workers in these two countries where the systems of experience-rating make employers' contribution to disability benefits rise with the age of the workforce in the company (see Section 4.2.B). In Denmark there is little evidence of seniority wages (Figure 4.2) and age does not appear to be a significant barrier to the employment of older workers, similarly to Ireland. In

Figure 4.2. **Earnings profiles rise steeply by age in the Netherlands only**

Relative average earnings by age and gender (earnings at age 25-29 = 100), latest available year



Source: Statistics Denmark; Statistics Finland; Ireland, Level of Living Survey; and the Netherlands, CBS, Enquête werkgelegenheid en lonen.

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

contrast, most collective agreements in the Netherlands include seniority-related pay. On the other hand, the extent of age-discrimination towards older workers has decreased greatly in Ireland, Finland and the Netherlands while it has increased in Denmark, according to a regular EU-wide survey. Incidence of age discrimination remains highest in Finland with 5.9% of workers aged 50 to 64 in 2005 reporting having experienced discrimination (down from 9.2% in 2000) and is lowest in Ireland with only 0.6% of workers suffering from it (Table 4.3).

Table 4.3. **Age-discrimination is highest in Finland and lowest in Ireland**
Share of persons experiencing age discrimination by age groups, 1995-2005
Employees aged 50-64

	1995	2000	2005
Denmark	3.8	1.0	4.4
Finland	5.5	9.2	5.9
Ireland	2.6	2.5	0.6
Netherlands	6.8	7.4	4.2
EU19 average[a]	5.4	5.6	4.9

a) Unweighted average.
Source: OECD calculations based on the European Working Condition Survey (EWCS).

Early retirement schemes were previously widespread in the Netherlands but early exit routes have been gradually tightened, including disability benefits. Reforms in the early retirement schemes have generated positive labour supply effects (Euwals *et al.*, 2006). Disability benefits used to be a more attractive early retirement pathway than unemployment benefits because of the lack of job-search obligations and the fact that pension rights were accrued during disability and not during unemployment (van Oorschot, 2007). However, from around age 60, older workers in the Netherlands tend to exit the labour market on the grounds of early retirement rather than disability, which partly explains the age pattern of disability benefit inflows. It is possible that with reforms in early retirement schemes other exit routes become more attractive but eligibility to the new disability scheme has also become much stricter. At the same time, experience-rating of disability benefits appears to have discouraged employers to use benefits as a form of early retirement, despite seniority pay. This can be seen from the very significant decrease in disability benefit inflows in the past few years (Chapter 3).

Likewise, in Finland, early retirement practices were common and there is a danger that disability benefits are used as an early retirement pathway as other pathways have now been, or are being gradually abolished. In 2002, 75% of 60-64-year-olds were receiving some form of early retirement benefits, 40% of which were disability benefits (Hakola and Uusitalo, 2005). Recent pension reforms in 2005 terminated the early retirement pension (the special pension for those with reduced work capacity in their own occupation) and phased out the unemployment pension. Previously, the social security system enabled the unemployed to withdraw from the labour market from the age of 55 with unemployment benefits until old-age retirement but the entry age for this so-called "unemployment tunnel" has been delayed by two years. The 2000 reform had already changed experience-rating of unemployment benefits and the evaluation showed that firms reduced the lay-offs of the aged because of this (Hakola and Uusitalo, 2005). Although no similar evaluation has been performed for the use of experience-rating in disability benefits, there is a possibility that this might also reduce early exit from the labour market. Besides, to avoid

that disability benefits are used as early retirement the government wishes for such benefits to be granted on a temporary basis at first. Still, in many cases temporary benefits are later transformed into indefinite payments (80% of the cases). Moreover, the system still allows for "social factors" (as opposed to just medical conditions) to play a role after the age of 60 when assessing eligibility for a disability benefit.

It is necessary to ensure that future jobs are available for those older workers whose early retirement options are progressively abolished, and to promote their employability. Hiring rates for older workers remain at a much lower level in all four countries. Several policies of premium discounts and subsidies have been put in place to encourage both hiring and retention of older workers in Denmark, Finland and the Netherlands. A low-wage subsidy for older workers consisting of a payroll tax subsidy for fulltime workers aged 54 and above was set up in Finland in 2006. The subsidy appears to have increased employment among blue-collar workers by significantly decreasing exit from employment (Huttunen *et al.*, 2008). Flex-jobs in Denmark should also contribute to employment of older workers, although they are not specifically targeted to that age group. Employers in the Netherlands are since recently exempted from disability premiums in case of hiring or retaining older workers (Section 4.3.B) but the results of this policy remain yet to be evaluated.

Additional measures need to be implemented to increase training possibilities of older workers. In Ireland, the Back-to-Education Initiative provides flexible learning opportunities for people wishing to combine work and part-time education. Priority is given to people with low qualifications and fees are waived for recipients of the different welfare allowances. In addition, the National Training Fund finances a wide range of training initiatives for Irish employees. However, these policies do not target older workers and empirically appear to benefit mostly young early-school-leavers, particularly through apprenticeships. A previous tax credit for training of employees above the age of 40 was available in the Netherlands but it was abolished in 2004 as the findings suggested that it only resulted in postponing of training (Leuven and Oosterbeek, 2004). Such a policy measure could be reconsidered, with some modifications, as well as spreading the use of individual learning accounts.

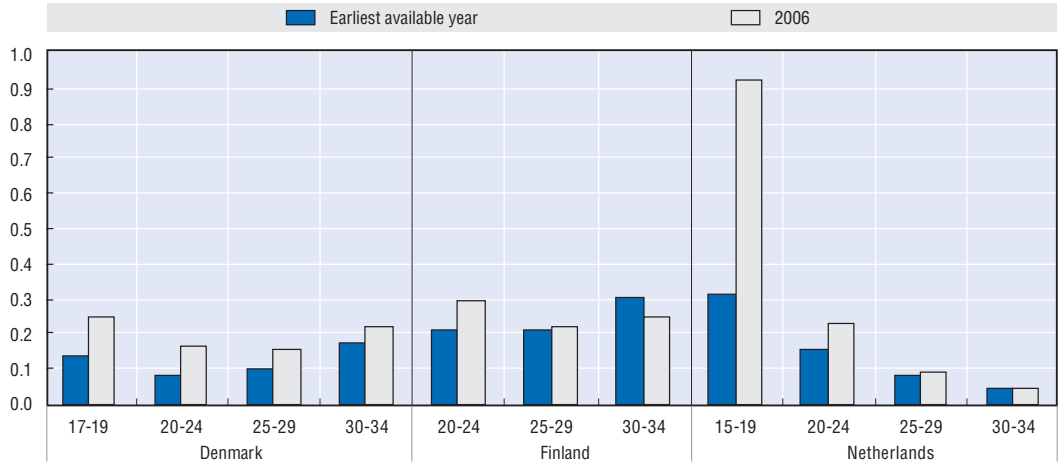
C. Young people with limited work experience

Although the disability population tends to be biased against older age groups, recent years have seen large increases in the inflow into disability benefits by young people. As shown in Chapter 3, inflows of people 45 and above have remained stable or declined in all four countries in the last decade (except those aged 55-59). In the same period, the greatest increases in inflows have been among the young. When looking in detail at the 15 to 34-year-olds, it appears that the youngest age group among them has experienced the largest increment in inflows. This is particularly striking forthe Netherlands among 15 to 19-years-olds but also holds for Denmark and Finland (Figure 4.3).

Large proportions of youth who are neither in employment nor at school partly reflects difficulties in the school-to-work transition caused by a skill mismatch. A relatively high proportion of youth leave school without qualifications, particularly when they have health problems, and their skills are not always well suited to the requirements of the labour market (Quintini *et al.*, 2007). Young people face difficulties finding initial employment and one year after completing their initial education, a majority of them are more likely to be unemployed or inactive in Ireland, and, particularly, in Finland, where the

Figure 4.3. **Inflows have increased most among the youngest everywhere**

New disability benefit claims in percentage of the population in each age group, around 2000 and 2006[a, b]



a) 1998 for Denmark, 2003 for Finland and 1999 for the Netherlands.

b) For the Netherlands, data refer to the Wajong scheme only.

Source: Ministry of Social Affairs Denmark; ETK, Finland and UWV for the Netherlands.

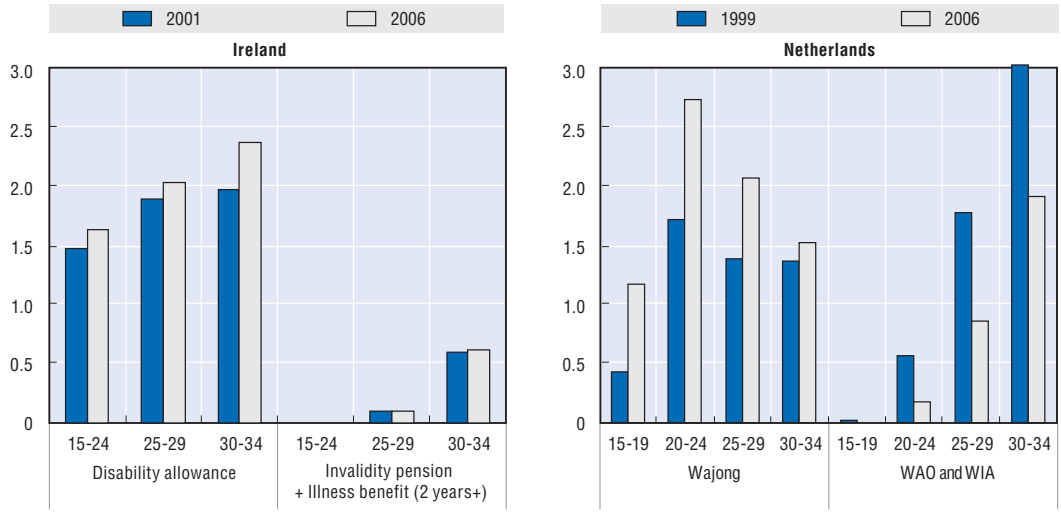
school-to-work transition is relatively long (OECD, 2008). Such young people with low or no qualifications can become trapped into spells of unemployment and inactivity and progression to stable employment is constrained.

On the other hand, the sharp increase in disability benefits for youth appears to be more related to incentives within the benefit system than to employer practices. Younger people are kept away from the labour market and move directly from the education system into benefit dependency, especially in the Netherlands and Ireland. Increases in disability recipiency rates in the Netherlands are highest among the youngest age groups and for the Wajong scheme, for which beneficiaries must have acquired a disability before the age of 18 (Figure 4.4). Some degree of substitution is taking place in recent years between the Wajong scheme and the WAO/WIA scheme: the data show large decreases in recipients of WAO/WIA benefits at age 20-34 while there have been large increases in Wajong recipients. A large share of Wajong recipients comes from the special education system whose population has also been increasing in recent years. Families are encouraged to apply for Wajong benefits immediately after school (see Chapter 3 for more explanation on Wajong).

Similarly, most disability benefit recipients below age 35 in Ireland receive a disability allowance, for which there are no previous social security contribution requirements and much loser eligibility criteria.[1] Very few of them receive an invalidity pension. Dependency on benefits can start at an early age as disability allowance can be obtained from age 16. Disability allowance is often perceived by parents as a care-type payment, especially because it follows on from the payment of the disability care allowance which is paid up to age 16. Families having children with disability are greatly dependent on carers' benefits as often one of the parents is not working when taking care of the child. Additional benefits such as the medical card further encourage families to apply for a disability allowance as soon as the child is eligible.

Figure 4.4. **Young beneficiaries are more likely to receive a non-contributory disability benefit than in past years**

Disability benefit recipients in percentage of the population in each age group, around 2000 and 2006



Source: Ireland, DSFA and UWV for the Netherlands.

Ensuring that youth leave education with the required qualifications together with having effective active labour market strategies are important reforms to curb the inflow into disability by young adults and increase transitions to employment. To improve education possibilities, recent proposals in Ireland argue that the age of eligibility to disability allowance should be postponed to promote further school enrolment. In addition, to ensure that young people do not leave school without proper qualifications, an enhanced use of internships has been suggested in the Netherlands as a way to improve signalling to employers and to increase employment chances. Another policy to encourage hiring of unskilled youth is also in place in the Netherlands since 2005. The youth-specific no-risk policy guarantees a refund of wages (by municipalities) during sickness absence for employers providing on-the-job training to acquire certified qualifications (for a maximum training period of two years). The results so far are not very encouraging: It appears that employers make little use of it largely because of the high administrative burden (Van Poppel *et al.*, 2008).

Modifying access to benefits for young people is also likely to reduce incentives to withdraw from the labour market. This is in line with current policies in Denmark and Finland where rehabilitation must be tried first before obtaining a disability benefit. Disability benefits cannot be obtained before the age of 20 in Finland, after rehabilitation possibilities have been exhausted. In Denmark, various options are currently under discussion to curb the use of disability benefits by young adults, including a higher minimum age of eligibility. A recent reform in the Netherlands (*leerwerkplicht wet*) makes it mandatory to either study or work until age 27. For the moment, the reform will curtail access to social assistance until the age of 27 while no such restriction is planned for disability benefits (although significant changes are planned for the Wajong scheme – see Chapter 3). For youth with health problems who do not qualify for Wajong benefits, participation in either work or study is proportional to their capacity as a result of their health limitations. Similar policies could be considered in Ireland for potential applicants of the disability allowance.

Granting only temporary disability benefits to young people has been under discussion in Denmark and the Netherlands. In the Netherlands, it has been approved recently that Wajong beneficiaries will receive a temporary benefit initially and there will be a reassessment at a later stage to determine the permanence of the condition. This reform is also considered in Denmark in particular for youth having mental health problems which might be cured with timely treatment so that they might have a chance to rejoin the labour market at a later stage. However, experience from other countries (Germany, Norway) has shown that, first, most temporary benefits are being transformed into permanent ones, and secondly, that the threshold for granting a disability benefit might fall, thus accentuating the problem. A careful strategy of follow-up, treatment and rehabilitation needs to be in place, to prevent that temporary benefits are not just postponing the acquisition of a permanent payment.

4.2. Employer responsibility for sick workers

Employment rates of people with disability are low not only because such workers might have acquired lower human capital and are therefore less attractive to employers, or because the benefit system encourages early exit from the labour market for both workers and employers; employment protection legislation (EPL) might also make it unattractive for employers to hire and/or retain such workers. This section reviews the legislation in place to protect workers in case of illness, with an emphasis on the far-reaching regulations existing in Finland and the Netherlands, and the potential employment implications of these mechanisms.

A. Employment protection and other legislation

Barriers like discrimination may prevent people with health problems from developing their full employment potential. Protecting such workers through certain legislation has been a major policy instrument but it has the potential to generate negative side effects. Sick-pay regulations increase the cost of labour and higher costs of adjustment are generated by dismissal severance pay as well as restrictions on dismissal. When hiring a new worker, a firm needs to take into account such future costs and this may have negative implications on hiring. The net impact of EPL on aggregate employment and unemployment is ambiguous, although empirical findings show that EPL might influence the demographic composition of employment with certain disadvantaged groups, particularly the low-skilled and those suffering from long-term illnesses, being more at risk of losing out in terms of lower employment (OECD, 2004).

Lose employment protection legislation in Denmark and Ireland contrasts with that in the Netherlands where strong responsibilities of employers in terms of sickness monitoring and rehabilitation have been implemented, with Finland standing in between. A similar conclusion holds for dismissal regulations, while anti-discrimination legislation has been introduced with similar provisions in the four countries.

Sick-pay and sickness monitoring obligations

Employers' responsibility in terms of sick pay is low in Ireland, Denmark and Finland but, in practice, provisions are often extended through the use of collective agreements in all countries. In Ireland, no statutory sick pay exists, which implies low costs during sickness, and does not provide thus a deterrent to hire workers with a history of illness. The length of time during which employers are responsible for wage payment during

illness is three weeks in Denmark, longer than in Finland where it is only nine days. In Ireland, despite the absence of any statutory obligation, many organisations operate sick-pay schemes and the details of the scheme should be included in the employee's contract. In the case of the Irish public sector, employees receive their full wage for six months and a half wage for another six, while in the private sector full wage payments range from four to 26 weeks of sickness leave per year. Many collective agreements in Denmark and Finland also extend sick pay regulations for several months depending on the sector. In Finland, public sector employees have full pay for the first two months and 75% pay for the following months. It is estimated that in Denmark 28% of blue-collar workers have wage payments for four weeks and for many white-collar workers wages are paid during the whole sick leave period of one year (*source*: Confederation of Danish employers). The provision of sick pay by employers has an impact on the public sickness management process as co-operation with public authorities does not always occur and the authorities are not always informed that a sickness spell has started or turned into a long-term problem.

In the Netherlands, which is already having a long period of employer-provided sick pay, collective agreements extend the generosity of payments. Employers are required to pay at least 70% of wages during two years of sickness but collective agreements often include a topping-up. An agreement between the government and the social partners in 2005 stipulated that such supplement should be limited to 170% of wages over the total two-year period. The typical distribution of payments is that 100% of wages are paid in the first and 70% in the second year.

In terms of sickness management, the legislation in place guarantees extensive public responsibility during sickness in Ireland and Denmark, with limited responsibility of employers, in contrast to the Netherlands. In Ireland, there are no statutory duties on employers to facilitate a sick person's return to work. Similarly to Denmark, sickness monitoring is in the hands of the public administration, the DSFA in the case of Ireland, and municipalities in the case of Denmark. Also in Denmark employers have little contact with the public service to follow-up on the process of illness and reintegration, although they are entitled to request information on the illness from the doctors following the employees' consent. Round tables between employers, municipalities and GPs are one possible instrument to manage absence but in practice they appear to be seldom used, particularly because there are no obligations for employers to participate. Recognising the crucial role of employers, the Danish government has put forward a proposal to increase employers' involvement in the sickness management process. Guidelines will be designed to stimulate the use of employer-employee talks, not later than in the fourth week of illness, and the design of retention plans at the workplace.

Although sickness management is voluntary for employers in Finland, extensive regulations are in place to reduce sickness absence by improving the work environment through occupational health services (Section 4.2.B). Such obligations exist in the Netherlands as well, including the obligation for employers to do their utmost to facilitate reintegration during the two years of sickness absence. These requirements also include the responsibility to finance rehabilitation services. Sickness absence regulations place quite a burden on Dutch employers, particularly because if they do not satisfy all reintegration steps, they might have to pay an additional year of wages (see Chapter 3 for steps during sickness).

Dismissal regulations

As in the case of sick pay, employment protection legislation is weaker in Denmark and Ireland in terms of dismissal regulations. In both countries dismissal is possible in case of absence from work during illness and because of the illness. In Denmark, a worker can in theory be dismissed any time, also during the 21-days wage-payment period, but collective agreements usually stipulate additional regulations so that dismissal is only possible after a leave of 120 days for many workers.

In Finland and the Netherlands layoff on the grounds of illness is generally considered an unfair dismissal procedure. Only in exceptional circumstances, can an employee be fired during the first two years of sickness in the Netherlands. Such an exception is made when, for instance, an employee refuses to collaborate in reintegration efforts. Employers may also request a dismissal when workers are regularly ill and overall production is affected; yet, the procedure can be lengthy and complicated, particularly if the dismissal application is done via the Centre for Work and Income (CWI).[2] Dutch dismissal procedures are amongst the most rigid within the OECD as prior consent is required from either the CWI or the court and minimum statutory periods of notice are relatively long in case of long tenure (four months notice) while severance payments are generous for permanent contracts. Dismissal during illness is allowed in Finland only if it has resulted in a substantial and long-term impairment of the employees' work capacity. This could occur before the end of the sickness allowance period (of one year) and the application for a disability benefit.

Little research exists on the effects of dismissal regulation but the findings suggest that it is more common to be fired during an illness in Denmark than in the Netherlands. Dutch job protection legislation appears to limit the rate at which employers dismiss their sick-listed employees: in Denmark almost 60% of them were dismissed during their illness compared to 11% in the Netherlands (Hogelund, 2004). In addition, since the extension of the employer-provided wage-payment period to two years, firing of people with disability has decreased from 18 700 to 5 700 per year (CBS, 2008).[3]

Anti-discrimination legislation

All four countries have introduced similar anti-discrimination legislation or modified it, following the adoption of an EU Directive on Equal Treatment. The most important provisions are that direct or indirect discrimination on the basis of disability, among other criteria, is outlawed and that people have a right to equal treatment in terms of employment and training. A key legal concept in anti-discrimination legislation is "reasonable accommodation". An employer must do what is reasonable to adapt the workplace, including adjustment and modification of equipment, and the work environment to provide access to the place of work, and/or to modify the job content, working time and work organisation to facilitate the employment of individuals with disability. The obligation of reasonable accommodation contains the prerequisite that the person is the best candidate for the job once these adaptations have been made and that adaptations do not impose unreasonable costs to the employer. In the case of the Netherlands, instead of reasonable accommodation, the provision introduces the concept of *effective* accommodation which implies that the accommodation is appropriate and necessary, and must have the pursued effect, but should not result in a disproportionate burden to the employer.

Anti-discrimination legislation has become an essential instrument for promoting workers' rights and changing attitudes towards people with disability; however, whether such legislation helps increasing employment of people with disability remains inconclusive. As for other aspects of employment protection, anti-discrimination clauses might reduce hiring because of anticipated increases in costs due to accommodation and increased chances of lawsuit. Evidence from the effects of anti-discrimination legislation in other countries (mainly the United States) is mixed in terms of employment outcomes of people with disability. Several recent empirical studies have suggested that the effect of the American with Disabilities Act had resulted in lower employment rates for people with disability (DeLeire, 2000; Acemoglu and Angrist, 2001) but when pre-existing trends in employment were controlled for, no effect was found (Beegle and Stock, 2003). Yet, it appears that requirements on reasonable accommodation did result in a short-term decline in the employment of people with disability (Jolls and Prescott, 2004).

B. Unusual employer obligations in Finland and the Netherlands

Additional obligations have been imposed upon employers in Finland and the Netherlands with a view to provide economic incentives for cost internalisation in the presence of occupational health and safety externalities. Negative health externalities can appear if costs of on-the-job injuries and illnesses are born by families and communities while companies do not take into account such social costs in their profit calculations. Under perfect competition, labour markets should generate a compensating wage differential for additional health and safety costs from the job *i.e.* employers with poor health and safety records will provide higher wages to attract workers. However, in imperfect markets it is unlikely that workers will have sufficient information about risks and no such wage differential will be provided to compensate for higher risk of illness. Without any incentives for regulation, companies might therefore provide only a minimal level of safety and compensation to workers.

Experience-rating of employers' premiums to the disability benefit scheme and occupational health services (OHS) are two pillars of an incentive system mutually reinforcing each other to make companies financially responsible for the prevention of long-term health problems. Legislation on OHS might be inefficient if there is a lack of monitoring and enforcement. However, as companies' premiums are related to disability benefit inflows, there are strong economic incentives to invest and put in place an OHS to improve health and safety records and enhance prevention.

Occupational health systems

Employers in Finland and the Netherlands are required by law to organise and pay for preventive occupational health services but certain differences exist between the two countries in the structure and nature of these services. In Finland, occupational health services can be organised in several ways: through municipal health care centres or private medical centres, or services that are integrated into the enterprise or jointly offered by several enterprises. A majority of companies organise OHS through municipal health centres (37% of the workforce) or private medical centres (39% of the workforce) rather than having own OHS in the company. Employers fund the OHS but they are entitled to reimbursement for necessary and reasonable costs by the Social Insurance Institution (KELA).[4] In the Netherlands, companies were previously required to have an in-house OHS

with certified company doctors. The new 2007 law allows for a greater degree of customisation and flexibility in organising an OHS.

OHS have the same broad goal of improving health and safety but different tasks are performed in both countries. In Finland, the OHS places an emphasis on regular monitoring of workplaces, including an action programme assessing risks and early detection of reduced work capacity, together with ways of minimising workplace risks and preventing workers to develop a disability. In addition, the OHS provide regular health examination of employees and also have a broader medical approach, considering risks that are not workplace-related. This is reflected in the composition of OHS staff with a more medical orientation in Finland (physicians, nurses, physiotherapists). Many OHS perform optional curative services (which are not compulsory according to legislation): 93% of the employees received such services. This has lead to increases in the number of employee visits to occupational health physicians while visits to health centre physicians have declined (Lehto and Sutela, 2006).

OHS legislation in the Netherlands includes not only monitoring of working conditions but also a compulsory active sickness absence policy. Compulsory preventive activities are very detailed and require an annual risk inventory and evaluation. A company doctor must support sickness absence policy including reintegration activities, periodical monitoring of work-related health and treatment of work-related illness. In contrast, less than half of Finnish OHS offer services facilitating the return to work after sick leave (Kivisto *et al.*, 2007). Since 2007, changes in Dutch legislation have removed a certain number of additional obligations such as the requirement to have in-house set times for consultation with the company doctor; instead access to expert advice for employees can be organised in other ways suitable for the company. Risk analysis and evaluation is not compulsory for small companies with up to 25 workers (instead of ten in the previous legislation). At the same time, Health and Safety Convenants, representing agreements between employers' organisations, trade unions and the government, have also been agreed to extend current legislation on occupational safety and health and provide additional instruments for the return to work. Sick leave appears to have declined more rapidly in branches having endorsed such convenants than in sectors without a convenant: from 33.7% to 10.9% between 1999 and 2005 (Veerman *et al.*, 2007). Partly, however, this is because it is those branches with the highest initial absence rates that have agreed on a convenant – a finding mirrored in similar initiatives in Norway (OECD, 2006).

A great degree of monitoring and evaluation of OHS results exist in both countries. The Finnish Ministry of Social Affairs and Health, together with the Occupational Safety and Health Inspectorates, supervises the occupational health service and safety system. Almost 30 000 inspections are carried out annually and inspectorates may oblige employers to redress problems in occupational health and safety. In addition, regular OHS surveys, as well as working conditions and workability surveys, monitor health and work environment outcomes. In Finland, the number of occupational accidents and diseases has greatly fallen over time; for instance, the frequency of accidents has dropped by a third during the last 20 years (Ministry of Social Affairs and Health, 2004). There is widespread implementation of OHS regulations with, for example, more than two out of three people reporting extensive activities for the maintenance or promotion of workability at their workplace (Lehto and Sutela, 2006). Similarly, in the Netherlands, yearly OHS reports document compliance with regulations and results. The labour inspection controls whether companies have contracted OHS and that the company-appointed workers in

charge of prevention have sufficient expertise to oversee daily health and safety. Furthermore, the labour inspection has the power to ask for improvements in standards or to impose fines in case of serious violations.

System-wide inequalities are present in Finland within the OHS structure. First, there are inequalities in terms of coverage: while the majority of employees are covered by OHS (close to 90%), coverage is much lower among small and medium enterprises as well as self-employed entrepreneurs. A new model of OHS, the Work Health Clinic, is being developed to provide wider coverage and improve OHS for the self-employed, those with temporary contracts and those who are on-off work. Secondly, there is considerable variation in resources, activities and outcomes between the different service models, but even greater within a given type of OHS, reaching up to two- to three-fold differences in manpower and performance indicators (Rasanen *et al.*, 1997). In particular, physicians in rural and semi-rural municipal centres have many other duties aside OHS and have a much higher ratio of employees served per full time physician. Recent changes in the Dutch OHS legislation might give rise to similar inequalities with a proliferation of external OHS.

Experience-rating systems

Experience-rating of premiums aims at giving employers discretion for their action while preventing that they impose costs on others; the causes of occupational diseases and disability are difficult to identify, however, creating several challenges for the design of appropriate incentives. In particular, individuals' own characteristics are an important component of disability risks. Employers pay a premium that is based to a certain extent on their individual disability record but it can be argued that they should not be held responsible for the full disability risk. Because of this, a certain number of issues have to be taken into account in the design of premiums especially for small employers, the appropriate time window for disability risk, and the responsibility for disability claims in the case of multiple employers. Finland and the Netherlands have chosen different ways to address these issues.

In both Finland and the Netherlands the degree of experience-rating depends on both risk and firm size. Experience-rated premiums are set in two stages: first, firms are categorised into rate groups defined according to the underlying risk. The risk ratio depends partially on the age of the employees as disability risks tend to rise with age. A base rate is established for each group and then the rate is modified according to firm's own experience to calculate the disability premium. In addition, both countries limit the extent to which small employers are affected by experience-rating because of the fact that non-controllable disability risks will have high implications for their costs. Employers cannot control all risks of injuries and illnesses but, in the case of large employers, the law of large numbers helps to ensure that disability rates reflect average risks related to the work environment. For small employers, on the other hand, it is questionable whether a rate adjustment based on random events outside employer's control offers employers incentives to increase workplace safety (Hyatt and Thomason, 1998). For this reason, premiums for large employers are highly related to their individual disability risk experience while for small employers premiums are less (or not at all) dependent on the company's experience.

In Finland small employers are not subject to experience-rating while they are in the Netherlands. Small employers in Finland[5] (wage sum of less than 1.5 million) pay a fixed-rate basic contribution independent of person's age. The contribution of medium-size

employers is determined partly according to basic contribution and partly according to the risk category contribution, with the share of the latter increasing linearly with the wage sum. For large employers (wage sum of more than 24 million), the contribution is based fully on the category contribution. In the Netherlands, for a short period, small employers were not experience-rated but with the new public part of the WIA system (Box 4.1), also their premiums are experience-rated, although the maximum rate on individual risk is lower than for larger firms. Indeed, a small firm (with a wage sum up to 25 times the average wage) pays a maximum of two times the average premium while a large company may pay a maximum of four times that premium.[6]

In neither Finland nor the Netherlands, the measure of disability experience makes a distinction by the severity of cases. The system is based on number of claims while the appropriate time window for experience-rating is different in the two countries. Experience-rated premiums are based on total disability costs according to the number of disability cases in previous years. In the Netherlands, the calculations were determined by looking at the last five years while in Finland it was decided to have a shorter time span with only two years. A short-time span in which firms' efforts to improve workplace health and safety are reflected immediately in firm specific rates likely to be more effective in influencing employer behaviour. However, because disability claims will span over a long period of time, assessing claim experience over a short period will not include all costs attributable to the employer (Hyatt and Thomason, 1998). In addition, for some diseases there is a long latency period which raises issues of attribution, particularly in the case of workers who switch employers.

Cost liability in Finland is divided between the pension providers in proportion to the earnings while in the Netherlands the last employer is responsible, with some exceptions in both countries. In Finland, pension providers have a reserve for each employer to cover the costs of disability for two years. In addition, experience-rating is limited to permanent disability benefits and does not apply to temporary benefits (cash-rehabilitation benefits). The cost of a disability benefit is shared across companies proportionally to the earnings for the two years preceding the onset of disability except in the case of employees with low earnings or occasional employers where the disability cost will be financed via pooling. Similarly, in the Netherlands employers are not experienced-rated for temporary workers or unemployed individuals (*vangnetters*) who acquire a disability. WIA benefit costs in the case of *vangnetters* are financed through sectoral or national funds.

In terms of the impact of experience-rating, very few studies are available but they suggest that it has resulted in a certain degree of internalisation of disability costs by employers. Several studies examining the effect of experience-rating in North America, mainly on work injuries and unemployment but also on disability, found that firms responded by attempting to reduce claim costs (Hyatt and Thomason, 1998). An evaluation of experience-rating of the Dutch disability insurance (WAO) has found that the impact was substantial, reducing disability benefit inflow by 15% (Koning, 2005). It appears that premium rate increases were partly unanticipated by employers in the first phase which triggered them to increase prevention and occupational health care activities over time. At the same time, the impact of experience-rating on small employers was more limited.

Some unexpected consequences of experience-rating have also emerged in the Netherlands but policy has been adjusted accordingly. With the introduction of differentiated premiums in the WAO, there was a possibility to opt out from the public

Box 4.1. **Changes in experience-rating in the Netherlands: from WAO to WIA**

Experience-rating was introduced in the Netherlands in 1998 with a new public disability scheme (WAO). The premiums included a basic uniform contribution based on the average risk for the category and a differentiated contribution set according to the number of disability cases occurring in companies. Employers were responsible for the first years of a person's disability benefits. Large employers were subject to a maximum premium which was set much higher than for smaller firms. As from 2003, small firms with less than 25 employees were no longer subject to individual experience-rating, instead the premium for these firms is only differentiated by sector.

Employers were allowed to opt out of the public system of financing disability benefits by either switching to private insurance or financing the disability benefits themselves. If a firm opts out, the benefit administration and reintegration activities are financed privately, although the claim assessment and the benefit level are defined by public statutory bodies. In 2004, the possibility to opt out was abolished for small and medium-sized firms to prevent that companies with low risk opt out because this is financially more attractive.

With the introduction of the WIA in 2006, which will gradually replace the WAO, the disability benefit is divided into the IVA (for full and permanent disability) and the WGA (for temporary and/or partial disability). Substantial differences exist in the financing regulations between the IVA and the WGA. The IVA is financed publicly while, for the WGA, companies have the choice between public and private financing. There is no experience-rating for the IVA, although this possibility was considered in preparing the reform, because this system covers only long-term illness, where the risk is difficult to be influenced by employers' actions. On the contrary, for the WGA reintegration and joint responsibility of employer and employee are more appropriate. Since 2008, there is no more experience-rating for the WAO: employers pay a basic contribution and a uniform individual premium. From that date, employers cannot choose to opt out from either the WAO or the IVA.

For the WGA, only employers who choose to insure within the public system are subject to experience-rating, both small and large companies. Minimum and maximum premiums depend on the size of the company based on the wage-sum. Up to 50% of the WGA-premium contributions can be shared between employers and employees if both parties agree. Employers were originally responsible for financing four years of disability benefits and in 2007 this was extended to ten years. There is the possibility for the employer to opt out of the WGA system or to choose a private insurer; employers who had chosen to opt out from the WAO, were automatically considered as opting out in the new system. Private insurance will typically also set premiums according to experience, but there are no regulations on this. In 2007, it was decided by the new coalition government that the WGA will be fully private in the future but the final decision on privatisation has been postponed until after evaluation of the new system.

The new WIA regulations have promoted the development of a disability insurance market. In addition to private insurance for the WGA premiums, both companies and employees also choose to take insurance to compensate for the loss of income during disability or full insurance packages. The latter include health and safety, sickness absence, reintegration activities and disability matters. Additional top-up insurances include the WGA-gap insurance (to cover the difference between the wage supplement and the follow-on benefit), long-term disability supplement and WIA salary supplement, and insurance for those with less than 35% work capacity loss; such insurances are common for high-income groups, and currently many collective agreements aim to close benefit gaps.

system. The policy of permitting opting out aimed at increasing choice for companies while at the same time increasing effectiveness by offering options outside the public monopoly. As a result of the opting out option, adverse selection was observed with high risk firms tending to remain publicly insured while low risk (cross-subsidising) firms tended to opt out. A dynamic implication of adverse selection was that public premiums were set to increase, providing more incentives for adverse selection (Deelen, 2006). Policy changes aimed to redress this situation by closing the possibility to opt out for small and medium-sized firms. The new WIA disability system tried to limit the possibilities of adverse selection by making it more risky to opt out since the period in which employers are responsible for disability premiums was extended to ten years.

C. The hiring versus *retention dilemma*

In Finland and, particularly, the Netherlands, assigning high responsibility for employers in the field of sickness and disability leads to high costs for employers who have to finance significant parts of the overall disability benefit costs. This makes investments in work environment and the retention of employees more attractive, as reflected in higher retention rates (Table 4.1). Dutch policy tends to support work retention of sick employees more than Danish policy, for instance, with a greater proportion of sick employees returning to work with their employers in the Netherlands (72%) than in Denmark (40%) (Veerman, 2001). This is partially related to the fact that employment legislation makes it relatively easier to dismiss sick-listed employees in Denmark (Section 4.2.A).

At the same time, because of the feared financial implications of such obligations, employers might become reluctant to hire new employees, particularly those with a history of illnesses. The Danish flexicurity model contains little obligations to retain workers but employers are more prone to hiring. Emphasis in Denmark is placed on increasing the employability of workers through a strong approach to vocational rehabilitation within the public system. As a consequence, while the dismissal of sick employees appears to have no negative impact on the return to work in Denmark, it has a strong negative impact in the Netherlands (Hogelund, 2004).

Reintegration obligations and costs in terms of disability premiums in the Netherlands (as well as other employment protection legislation) might thus be leading to an insider-outsider problem. Indeed, temporary employment shares have increased in the past ten years while hiring rates have fallen since 2000 (Chapter 1). Employers have strong incentives to circumvent their obligations by increasing the share of temporary workers for whom they have no reintegration obligations upon expiration of the contract, nor are they experience-rated for this group. With the increase in temporary employment they are thus partially reversing the transfer of responsibilities back to the public system. In a similar manner, the possibility that non-employed individuals, with health problems, have lower chances to get a job, may increase the problem of outsiders. This hypothesis is partially confirmed in by lower hiring rates of people with, although marginally so when comparing each age group (Table 4.1). In comparison, the impact of experience-rating appears to be more limited in this respect in Finland because small employers, which constitute a large part of all firms, are exempted from experience-rating. In addition, circumventing obligations through the use of temporary employment is a less important issue because employers are exempted from experience-rating only for short-term temporary contracts with earnings below EUR 14 000 for the last two years.

4.3. Different ways to stimulate job creation and job retention

This section discusses promising avenues for raising employers' involvement in order to stimulate labour demand for workers with disability. One possibility, the least interventionist, is to create an appropriate framework for employers' initiatives to make the labour market more inclusive and to support employers' initiatives after their initial developments. Still, employers might not be sufficiently active and such initiatives might remain limited or have a limited impact on employment levels. Without added financial incentives, employers might not generate new employment opportunities for people with disability. At the same time, employers are looking for other types of support aside financial incentives, particularly, for a simplification of the hiring process.

A. Public stimulus to employers' initiatives in reintegration

The Danish government has attempted to raise employers' involvement in the integration of those difficult to place not by imposing obligations but by promoting the concept of corporate social responsibility. At the same time, employers in the Netherlands have organised themselves in networks to increase the chances of workers' reintegration and the Ministry of Social Affairs and the Social Insurance Institution (UWV) are sponsoring their development.

Corporate social responsibility

The concept of corporate social responsibility (CSR) in Denmark has been initiated by the government and aims at promoting a more inclusive labour market. As such, CSR is not perceived as a means to remedy problems related to large corporations and market imperfections in a variety of areas such as environment and rights of workers. Rather, CSR in Denmark is seen within the context of imperfections in the welfare system and as a way to encourage companies to take a more active role in integrating people from welfare who still have work capacity left (Holt, 2000). The campaign was launched in 1994 by the Ministry of Social Affairs based on promoting the idea that the private sector will be better at integrating the long-term unemployed and people with disability than the public sector. It constituted a shift from a supply-side approach to a demand-side intervention and was part of a broader change of state-market relations and public-private partnerships. In addition, it promotes the idea of a transitional labour market, bridging from non-employment and preventing exclusion so that companies internalise responsibilities for the hard to place groups and increase job-creation within a flexible work environment (Bredgaard, 2004).

The CSR campaign has relied mainly on voluntary participation of companies but contains a certain number of economic incentives for companies as well as in-built social dialogue and monitoring devices. Public subsidies have been put in place to provide financial incentives for companies to hire workers on special terms for a temporary phase during job training or rehabilitation, or with permanent subsidies for flex-jobs. A partnership for social cohesion was developed to establish a public-private dialogue and co-ordination committees were set up with representatives from the local authorities, companies, social partners and general practitioners. In addition, social indicators were developed to measure corporate social responsibility and a report is published yearly to investigate the efforts of companies. Publicity is given to good examples and prizes are also allocated. While voluntary participation is stressed, the political side has emphasized that

without such co-operation from companies other actions – such as quotas – might be imposed (Holt, 2000).

Has the CSR campaign delivered in terms of integration and, in that case, what is the companies' main motivation for adhering to CSR? Surveys show positive developments in companies' CSR performance measured by positive expectations of workers about the efforts made in the workplace towards people with illnesses and disabilities, in particular in terms of help during rehabilitation, increased retention and reintegration of workers under special terms (Boll and Kruhoffer, 2002; Mahler and Pedersen, 2005). Still, many limitations exist in the adoption of CSR by the majority of companies. It appears that companies tend to adhere to the concept based mainly on profit-maximising objectives, that is, companies invest in CSR because they believe that gains can be obtained through reputation enhancement, recruiting and retaining best skilled labour during periods of labour shortages. CSR is thus linked to the firm's business differentiation strategies and corporate image.

The Dutch employer networks

Originally, the "gatekeeper centres" developed as an independent initiative of companies in the North Holland region and the initiative is now up-scaled throughout the country, given its success. This first network developed as a regional and intersectoral labour market instrument to exchange sick employees. The network grew towards broader objectives of exchanging knowledge and experience with human resources policy. National employers' organisations are supporting an extension of the network to stimulate the growth of similar networks across the country. An employers' forum has developed a website to stimulate the exchange of information and knowledge about factors contributing to a successful network. Several governmental institutions including the UWV support this initiative and have facilitated funds for brainstorming groups while the Ministry of Social Affairs provides temporary subsidies for the starting phase of support activities.[7] The idea is that several smaller networks where workers can rotate should co-exist throughout the country.

Obligations to reintegrate sick employees have created a heavy burden for Dutch employers and networks have developed to help companies meet their obligations. For many small companies, reintegration activities might prove a very difficult task because of lack of opportunities to provide other jobs for their sick employees. Reintegration networks give companies the chance to find placement options for sick employees within other companies. They provide many advantages for companies in this respect: such networks 1) increase control of placement of sick workers and chances of reintegration; 2) help saving costs by reintegrating workers before the end of two years and without the need to outsource reintegration; 3) help creating vacancies in the company and allow companies savings on disability benefits; and 4) prevent dismissal conflicts.

The networks operate through the voluntary co-operation of companies but need nevertheless a functional structure to operate efficiently. Administrative structures need to be in place to make the matching process feasible and companies need to comply with not only sending sick employees but accepting sick employees from other companies. The matching process is organised differently across networks: through a consultant, through intercompany meetings or through an electronic vacancy database. Additionally, a follow-up process evaluating the results of the matching is essential as well as regular meetings to discuss new external or internal challenges. Because of difficulties to reintegrate

employees within similar types of jobs, the networks are most effective when organised with sufficient diversity and scale at regional level rather than at branch level. While they are non-profit, networks need to generate sufficient resources to provide a functional structure. Such resources also contribute to increased prevention by having funds contributing to workers' employability as well as effective health management. The networks may also act as mediators for buying jointly vocational rehabilitation instruments.

B. Labour market policy

With the purpose of encouraging employers to increase the hiring of people with disability, governments in the four countries have developed a series of financial incentives, mainly in the form of wage subsidies, but also including premium discounts and the waving of sick-pay obligations in the Netherlands. Financial measures have resulted in a different degree of success depending on the country. This section describes the different approaches and some of their shortcomings in mobilising employers. To a certain extent, employers' views reflect the opinion that subsidies are not enough. This section also sketches other initiatives which could help employers in raising employment levels of people with disability.

A "second" labour market?

Subsidised employment schemes aim at increasing employment of disadvantaged groups in the labour market – people with disability, in this case – but their impact is ambiguous. The main purpose of the subsidies is trying to alter the composition of labour demand and creating employment that would not have been possible without the subsidies by changing labour costs in a favourable way for the targeted group (at the expense of others). Wage subsidies may also help people with disability to increase their human capital, obtain work experience and skills which can be transferable to non-subsidised jobs (Martin and Grubb, 2001). Such schemes might have several negative indirect effects. For instance, they might be inefficient and generate a deadweight loss because hiring would have occurred in the absence of the program as well. Worse even, they might generate substitution effects as the jobs created by the program replace jobs for other categories or even displace jobs elsewhere in the economy, as a result of a distortion in competition giving comparative advantage to firms with wage subsidy. In terms of the net employment effects (general equilibrium) positive externalities might still occur if they create employment for people with disability previously not in work who, by getting hired and becoming "insiders", help reduce wage pressure (Lee, 2005).

Evaluation studies of wage subsidies find successful outcomes in Finland while there is some evidence of substitution effects in Denmark. The flex-job scheme in Denmark has produced only modest employment effects and has only significantly raised employment probabilities for people with disability in the mid-age range. In addition, it appears that 52% of firms would have employed workers on ordinary terms if the subsidy scheme had not existed (Datta Gupta and Larsen, 2007). In contrast, the wage subsidy program in Finland appears to have stimulated employment in subsidised firms and finds no sign of distorted competition or crowding out of employment in non-subsidised firms (Kangasharju, 2005). Wage subsidies in Finland were on the other hand not especially targeted towards people with disability but towards the long-term unemployed. The Wage Subsidy Scheme in Ireland was introduced only recently, in 2005, and no econometric

evaluation of the employment effects has been performed yet. Given the low number of workers benefiting from the scheme (Chapter 3), it is unlikely that it has resulted in large substitution effects. Previous empirical analysis of a similar subsidy for the long-term unemployed in Ireland (Employment Incentive Scheme) found modest substitution effects but large deadweight losses since such workers would have found employment without the subsidy (Marx, 2005).

The effectiveness of a wage subsidy scheme is partially related to appropriate targeting and scheme design. To reduce windfall effects the programme needs tight targeting but targeting on characteristics may result in negative views of employers on the productivity of these groups and generate stigmas (Lee, 2005). The downside will be that employers may only be willing to hire from this group if they receive a subsidy. Highly-targeted programmes might have low take-up. This is, for instance, one of the concerns with the Irish Wage Subsidy Scheme. Employers appear to have little information about the programme and they are deterred by the complexity of the application procedure. On the other hand, if the subsidy is too high there will be a high demand for subsidised workers – as can be seen in Denmark. The extent to which a wage subsidy scheme leads to substitution depends, first, on whether it covers more than the productivity deficit and the reservation wage of workers and, secondly, on the extent to which these workers are substitutable in production. Recent reforms in Denmark limiting the subsidy ceiling suggest that substitution effects were related to over-generous subsidies and that many flex-jobbers were previous employees. Close monitoring is therefore necessary to ensure that employers do not abuse subsidies. Some studies show that wage subsidies combined with training lengthen job tenure and are a promising avenue to raise human capital and strengthen ties between the employer and employee (OECD, 2003).

Other financial incentives: the Dutch no-risk policy and premium discount

Aside from wage subsidies, other forms of financial incentives are possible to promote employment among people with disability. An example is available in the Netherlands where the government has introduced several policies to alleviate the burden of employers. The policy provisions aim at decreasing the financial implications in terms of extra costs of sickness and disability that hiring workers with higher sickness risk will imply. Provisions include a no-risk policy, premium discounts, and other forms of additional compensation.

The no-risk policy introduced in 2003 (and extended in 2005) limits financial risks by removing employers' obligation to pay the costs during the sickness phase for an employee with a disability. The UWV fully covers the costs of sickness benefits for such workers during the two years of illness. In addition, employers do not have to pay higher premiums for disability for the employees covered by the no-risk policy (or the benefit if they have opted out). Categories eligible for the no-risk policy include persons who are entitled to a disability benefit (WIA, WAO, Wajong), those who fall under the less than 35% category after two years of illness,[8] and individuals who are eligible for sheltered employment (or qualified by the CWI as having a functional limitation). The no-risk policy is applicable for new employees as well as for own employees after the two-year sickness period. It holds for five years but can be extended if the person is at serious risk of illness. In the case of Wajong and those eligible for sheltered employment, there is no time limit, *i.e.* the exemption covers the entire working life of the employee.

Disability premium discounts are also available when employers hire workers from the same target group as for the no-risk policy. Discounts from the yearly total disability

benefit premium are available for a maximum of three years in case of hiring a new employee with a disability. In case of retaining an employee, the discount holds for one year only and is not available for those with less than 35% disability. The premium discount depends partially on the wage of the employee since the amount will be substantially reduced if the employee earns less than 50% of the minimum wage. On the other hand, an additional premium discount is available for individuals with a Wajong benefit. Furthermore, hiring a person who is 50 years or older or keeping an employee older than 54.5 carries an additional financial advantage: employers do not pay the basic WIA premium for such employees.

Additional subsidies to accommodate people with disability are also financed by the UWV to further stimulate employers in hiring and retaining sick employees. Subsidies are mainly directed at adapting the workplace for individuals with a visual, hearing or motor handicap. Such subsidies are higher for employees earning more than 50% the minimum wage and for own employees to encourage retention. In addition to workplace adaptation, the UWV provides funding for job coaches.

Additional ways to generate labour demand

Beyond providing financial incentives to employers, public employment services (PES) may successfully affect the re-employment chances of people with disability by building more effective networks with employers. It has been found that caseworkers who maintain strong active contacts with employers achieve higher employment rates, especially for low-skilled clients. Such positive employment effects are persistent and appear to generate placements into stable jobs as increased employment is observed three years afterwards (Behncke *et al*., 2007). This could be the result of increased information on vacancies, skill requirements or labour market needs – particularly informal knowledge of potential vacancies. Employers are increasingly using a variety of recruitment channels and in most countries not all vacancies are known to the PES; the PES vacancy share in Finland, for instance, is about 60% while it is much lower than this in Ireland and the Netherlands; only in Denmark it is still 100%. At the same time, PES effectiveness in placements may also be affected by marketing specific programmes and services to employers. It appears, for instance, that one of the reasons for the low take-up of the wage subsidy scheme in Ireland is the lack of engagement with employers and insufficient knowledge about the programme details.

A one-stop-shop not only for workers but also for employers could facilitate employment of people with disability. In Ireland, FÁS places a big emphasis on customised training programmes by incorporating employers' needs because they believe that the involvement of employers results in real gains in employment. Certain employment offices succeeded in placing a large number of unemployed customers by negotiating with employers that pre-placement training targeted to the needs of the company will be provided in advance by FÁS. In addition, employers often cite high administrative burdens as reasons for the low use of certain programmes such as the no-risk policy for youth in the Netherlands. There is a strong demand for a comprehensive package of services when hiring people with disability. Employers wish to outsource the administrative burden of finding out which possibilities exist for combining a certain number of hours of work or a certain wage with benefits, for instance. Intermediaries would also allow employers to hire people with disability with a trial period before considering whether they wish to extend the contract into a permanent one. Finally, the provision of job coaches for the new employees was also signaled as a successful necessary element.

Additional flexibility in the labour market is often cited by employers as another solution to encourage employment of people with disability. Promoting opportunities to work part-time, particularly in Ireland and Finland, is supported by employers as a way to raise employment levels of those with reduced work capacity. In these two countries, employers also believe that wage subsidies are not used often enough because of the lack of flexible design.

Although this section has outlined ways to involve employers, the question is to what extent generating enough labour demand for people with disability is possible within the regular labour market. Employment policies for people with disability view sheltered employment as a form of transitional employment. At the same time, for many people with disability, sheltered employment or working in a sheltered environment of some form might be the only realistic option of labour market participation. There might be limited scope for mobilising employers in the face of labour market changes with increased work pressure and more service-oriented jobs. The latter also raises the question as to whether the ambitious Dutch "Plan 200 000" aiming to creating 200 000 additional jobs for excluded groups (people with disability and people on long-term benefits) could deliver without taking into account carefully the design of the wage subsidies, the ways to engage with employers and expectations about integrating such large numbers within the regular labour market. A similar concern may be applied to the targets from the Irish government to raise the employment of people with disability to 45% by 2016.

Notes

1. Partly, this is because entitlement to invalidity pension requires 260 paid social security contributions, which is equal to five years of employment. From 2012 this requirement is due to rise to 520 paid contributions.
2. The Netherlands has a dual dismissal system and dismissal can be requested either via the CWI or through the courts. Dismissal via the CWI is usually longer but carries lower costs; it is traditionally the preferred route for small and medium enterprises. Dismissal through court has become increasingly more important over time.
3. Not all of the decrease in the number of dismissals in the Netherlands is explained by reintegration obligations because of the gatekeeper protocol; overall firing has decreased in the same period because of improved economic prospects for companies.
4. The reimbursement rate for OHS costs in Finland is 60% for preventive occupation health services and 50% for optional curative services.
5. In Finland, since 2006 the size of the employer is defined on the total wage sum and no longer on the number of employees. The wage sum limits are revised yearly with an index.
6. In 2007, in the Netherlands average premiums were set at 0.75% of the payroll for the WGA and at 5.63% for the WAO and IVA combined. Average costs in Finland amount to 2% of the wage sum.
7. A special subsidy is also available to improve the reintegration opportunities of the group with less than 35% disability.
8. The no-risk policy holds for the group with less than 35% within five years after their disability has been evaluated.

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Chapter 5

The Individual's Perspective: Financial Incentives for Taking up Work

One of the main objectives of current disability benefit reforms in all four countries is to increase incentives for persons with disability to take up or to remain in work. Disability and other public benefits are an important source of income for people with disability, especially in lower income groups. While these benefits are particularly targeted in Ireland, they provide lower net replacement rates than in the other three countries.

The design of these benefits in combination with income taxation can create work disincentives. Average effective taxation is high in all four countries and reaches 70% to 90% with a few exceptions. Different in-work benefit elements are operated to overcome this problem but are either too small in size (Finland), have a take-up problem (Ireland) or are effective only for higher-income groups (Netherlands).

The prime aim of disability benefit policies – in conjunction with other benefit policies – is to prevent large financial losses and poverty risks for people who experience long-lasting health problems or disability. At the same time, governments need to ensure that these policies are balanced enough so as to avoid "benefit traps", *i.e.* situations in which a possible take-up of work actually penalises the persons who intended to do so. This chapter looks at this income adequacy/work incentives dilemma. It shows that, in a non-negligible number of constellations, benefit systems fail to achieve one or the other objective and highlights examples and suggestions to avoid such situations. The first section looks at the "attraction" and adequacy of disability benefits *versus* other working-age benefits, in particular unemployment and social assistance benefits. Section two analyses financial consequences for people with disability when taking up work and discusses incentives for persons on partial disability benefits. The last section concludes.

5.1. The "attraction" of disability benefits

A. The relative importance of disability benefits and their distribution

Average gross disability benefits are around 35% to 41% of average national gross earnings in the four countries under review (Chapter 1). Persons with disability rely, however, on a multitude of income sources: Other public benefits often play a major role, but other sources also include own earnings, capital income, and income from savings and private transfers. Furthermore, the resources of other household members with whom the person with a disability is living contribute to (or, in their absence, put a burden on) their economic well-being.

This "income package" differs, however, between countries. In all countries, labour income plays by far the most important role, accounting for as much as 78% of the income of persons with disability in Denmark and 58% to 65% in the other three countries (Table 5.1). The share of labour income in total incomes remained stable in Ireland and very slightly decreased in Denmark and the Netherlands in the past ten years. In Ireland and the Netherlands, this is in contrast to the development for persons without disability: their labour income share increased by 4 to 6 percentage points (no comparable trend data are available for Finland).[1]

Second, public social transfers are an important source of income for persons with disability. Their share in total income is about three times that for persons without disability. It should be noted that various non-disability related public benefits such as old-age pensions and family benefits are as important as disability benefits – the latter account for less than half of all transfer income of people with disability in all countries (data not shown). Total public transfers make up for 18% of all income of people with disability in Denmark, 33% in Ireland and 40% in the Netherlands. The low figure (13%) for Finland is explained by the fact that all earnings-related pensions are counted within "private transfers and capital income".[2] This income source, together with "other income" is less important in the other three countries and the share decreased in Ireland and the Netherlands.

Table 5.1. **Earnings constitute four-fifths of income for persons with disability in Denmark**

Income composition by disability and employment status, 2005 and changes since 1995[a]

	Employed with disability		Not employed with disability		All people with disability		No disability	
	Level 2005	Change 1995-2005	Level 2005	Change 1995-2005	Level 2005	Change 1995-2005	Level 2005	Change 1995-2005
Denmark								
Labour income	94	1	46	–6	78	–2	90	–3
Public social transfers	3	–9	47	–1	18	–6	6	–5
Private transfers, capital, other income	3	8	7	7	4	8	4	8
Finland								
Labour income	83	. .	35	. .	65	. .	78	. .
Public social transfers	7	. .	24	. .	13	. .	9	. .
Private transfers, capital, other income	10	. .	42	. .	21	. .	13	. .
Ireland								
Labour income	85	–1	48	2	64	1	86	6
Public social transfers	13	3	49	4	33	2	11	–4
Private transfers, capital, other income	2	–2	3	–5	3	–4	2	–3
Netherlands								
Labour income	85	2	38	1	58	–3	84	4
Public social transfers	13	–1	60	3	40	5	14	–2
Private transfers, capital, other income	2	–2	3	–3	2	–2	2	–2

a) Income concept used is disposable household income per equivalent person.

Source: Denmark: SFI database; Finland: IDS (Income Distribution Statistics); Ireland: national estimates based on ECHP (1995) and EU-SILC (2005); Netherlands: Secretariat estimates based on ECHP (1995) and EU-SILC (2005).

Among the population with disability, the "income package" differs significantly between those who have a job and those who do not. As a matter of fact, the income shares of employed persons with disability are almost identical to those of the population without disability, in all four countries, with earnings shares in total income of between 83% and 94%. This underlines the crucial importance of employment. While public policy often focuses on benefits, succeeding in increasing employment seems the best way to economic security for many people with a disability.

On the other hand, benefits and transfers constitute almost half of the disposable household income of non-employed persons with disability in Denmark and Ireland, and more than half in the Netherlands and Finland (if earnings-related pensions are counted with benefits). Given the sizeable share of public transfers and in particular disability benefits in the income package of people with disability, an important question concerns their redistributive features and the extent to which they provide income security for persons at the lower end of the distribution. Turning first to all public social transfers taken together (right-hand panel in Table 5.2), a little over one-third of those are going to the bottom quintile, while between 7% (Denmark) and 12% (Ireland, Netherlands) are accruing to the top quintile. This makes all three countries considerably more redistributive in terms of public transfers than other OECD countries: on average across 21 OECD countries, the share of transfers going to the bottom quintile is less than one and a half times the one going to the top quintile. It is around three times as high in Ireland and the Netherlands and almost five times as high in Denmark.

Table 5.2. **Disability benefits are more redistributive in Ireland than elsewhere**
Shares of disability benefits and total public social transfers going to lowest and highest income quintiles, 2000-2005[a]

		Disability benefit			All public social transfers		
		(1) Lowest quintile	(2) Highest quintile	(1)/(2)	(1) Lowest quintile	(2) Highest quintile	(1)/(2)
Denmark	2000	30	7	4.3	37	8	4.8
	2005	27	6	4.5	36	7	4.9
Ireland	2000	47	7	6.6	35	10	3.4
	2004	45	7	6.4	33	12	2.7
Netherlands	2000	30	10	3.0	37	9	4.0
	2004	27	12	2.3	35	12	3.0
OECD-21	Around 2000	27	16	1.7	30	17	1.8
	Around 2005	25	16	1.6	24	19	1.3

a) Income concept: disposable household income per equivalent person. Disability benefit includes all disability-related public transfers.
Source: Computations from OECD income distribution questionnaire.

In Denmark and the Netherlands (as well as on OECD average), this pattern is quite similar for disability benefits though they seem to have a slightly smaller redistributive impact than all benefits taken together. It is very different in Ireland where almost half of disability benefits accrue to the bottom quintile and the bottom-to-top ratio reaches 6.4. This is partly due to the fact that disability allowance (included in the figure) is means-tested and other disability payments are flat-rate. Except in Denmark, the redistributive impact of both disability benefits and all public transfers has become smaller over the past five years. That said, even if less progressively distributed, disability and other social benefits alleviate inequalities of other income sources, especially those of market incomes, in all countries.[3]

B. The tax/benefit position of persons with disability

The disability benefit and tax systems share some common features across the four countries but differ considerably in other aspects (see Annex Table 5.A1.1 and Box 2.1 in Chapter 2). This has to do with different social protection histories and traditions. Denmark is the only country with one single benefit for people with disability – a consequence of a reform in 2003 through which the hitherto complex benefit system was simplified considerably (Chapter 2). As is the case of all other social benefits in this country, it is financed through taxes and has universal coverage. In addition, persons with partial work capacity queuing for a flex-job are entitled to a waiting benefit, the payment rates of which are closely linked to unemployment benefit. Finland operates a dual system with a tax-financed and universal national disability pension and an earnings-related contribution-based statutory disability pension. The two schemes are integrated and counted against each other.[4] The universal schemes in the two Nordic countries (disability pension in Denmark and national pension in Finland) provide flat-rate benefits up to a certain income level (differentiated by household type).

Ireland operates two major disability-related benefits – invalidity pension which is contribution-based and covers employed people only, and a non-taxable means-tested benefit with universal coverage, disability allowance. Ireland also has an illness benefit which can be received without time limit.[5] The three schemes provide quite similar flat-rate benefit rates. The main scheme in the Netherlands, WIA (as well as the former WAO)

is contribution-based and covers employees only. It consists of two provisions: a benefit for persons with at least 80% permanent disability (IVA) with rates related to past earnings up to a maximum; and a return-to-work benefit (WGA) for people with partial work capacity. This benefit is initially wage-related and, after some time, transforms into either a follow-up benefit (if the person is not working) or a wage supplement (if working "sufficiently"). The Netherlands also has a special and universal scheme for young people with disability, called Wajong. Among the four countries, Finland and the Netherlands operate genuine partial (and graduated) disability benefits, although the Danish flex-job scheme (which is available at two different capacity levels) serves a similar purpose.

Table 5.3 compares the tax/benefit position of a 40-year-old single person with average earnings when working and after going on full disability benefit. The first column for each country describes the steps from gross to net earnings for a working person. With 15%, the burden of taxation is considerably lower in Ireland than in the other three countries (between 30% in Finland and 40% in Denmark). The weight of social security contributions to total taxation is lowest in Denmark. In Finland and the Netherlands, they contribute about one-third to the total tax burden, an order of magnitude found in many Continental European countries. In the Netherlands, however, social security contributions are much more important than direct income taxes. In the two Nordic countries, especially in Finland, local income taxes play a more significant role than central government taxes.

The second column for each country in Table 5.3 looks at the tax/benefit position of a single person after having moved from work to a full disability benefit. The third and fourth columns show the position of a person who moved from work to other types of disability benefits. The tax weight on benefits is much lower than for workers, and zero in the case of disability allowance in Ireland due to non-taxation of benefits. *Gross* replacement rates, *i.e.* gross benefit levels with regard to former gross earnings, are therefore lower than *net* replacement rates. In all countries, tax credits are used to ease the tax burden of disability beneficiaries and they are particularly important in Ireland.

In Denmark, Finland and the Netherlands, full disability benefits replace about two-thirds or more of former earnings in the case of a single person who used to earn an average wage. With 72%, the net replacement rate is highest for a Dutch person on initial WGA benefit.[6] The rate is 69% for Finnish recipients of earnings-related disability pensions and 66% for a Danish disability pensioner. In Ireland, net replacement rates are considerably lower – 54 to 55% – and they are practically identical between the three different schemes. This is not the case in the Netherlands, where the follow-on benefit of the WGA disability payment provides a 16 percentage point lower rate than the initial payment. That said, the net replacement rate of the follow-on benefit is still in the order of the Irish full benefit replacement rates.

Also in terms of *absolute* levels of regular benefits, expressed in USD in purchasing power parities, these are lowest in Ireland (a little below USD 14 000), around USD 15 000 to 16 000 in the two Nordic countries, and highest in the Netherlands (close to USD 20 000).

C. Adequacy and generosity of replacement rates

Net replacement rates (NRRs) compare the income situation when moving from paid work to inactivity. They thus provide indicators of both the adequacy and generosity of disability benefit schemes. Low NRRs for people who become totally incapacitated for work in the midst of their professional career may raise concerns about poverty and social

Table 5.3. **Gross and net replacement rates for main disability schemes are lower in Ireland**

The tax/benefit position of a single person at average earnings and when out of work on disability benefits, USD Purchasing Power Parities (PPP), 2006[a]

		Denmark			Finland		Ireland				Netherlands		
		Working single person	Disability pension	Waiting benefit	Working single person	Disability pension	Working single person	Illness benefit	Invalidity pension	Disability allowance	Working single person	Full disability benefit (WGA)[b]	Follow-on benefit (WGA)[b]
A.1	**Gross earnings**	38 581			34 615		29 698				43 023		
A.2	**Taxable benefits**												
	Disability benefits		20 226	18 400		21 809		8 546	9 227			30 116	10 194
	Social assistance benefits[c]												3 283
	Total taxable benefits		20 226	18 400		21 809						30 116	13 477
B.	**Income tax and social security contributions**	0	0	0	0	0	0	0	0		0	0	0
	State taxable income (after allowances, deductions, credits)	33 425	20 226	18 286	32 019	21 809	29 698	8 546	9 227		43 846	31 343	10 857
	State income tax	2 204	1 108	1 002	3 107	1 116	5 940	1 709	1 845		5 983	1 665	266
	Local taxable income (after allowances, deductions, credits)	33 425	20 226	18 286	28 827	21 809							
	Local income tax	9 646	5 246	4 599	5 304	4 013							
	Tax credits	246	246	246	162	119	3 093	1 616	1 616		268	160	160
	Social security contributions	4 305		114	2 339	327	1 520				9 787	8 920	2 061
	Total income tax and social security contributions	15 909	6 108	5 469	10 588	5 337	4 367	93	230		15 502	10 426	2 168
C.	**Non-taxable benefits**												
	Disability benefits									8 943			
	Housing benefits	409	1 075	1 075				5 270	4 589	4 873			4 211
	Total non-taxable benefits	409	1 075	1 075				5 270	4 589	13 816			4 211
D.	**Net income out of work (A – B + C)**		15 192	14 006		16 472		13 722	13 586	13 816		19 690	15 521
E.	**Net income in work (A1-B)**	23 081			24 027		25 331				27 521		
F.	**Gross replacement rate [(A2 + C)/A1]**		**55%**	**50%**		**63%**		**47%**	**47%**	**47%**		**70%**	**41%**
G.	**Net replacement rate (D/E)**		**66%**	**61%**		**69%**		**54%**	**54%**	**55%**		**72%**	**56%**

a) Average earnings refer to average wage (AW): DKK 330 900 in Denmark, EUR 33 543 in Finland, EUR 38 491 in the Netherlands and to average production worker wage (APW) in Ireland where AW is not available: EUR 29 960. Estimates refer to a 40 year-old single person with an earnings history of 22 years at average earnings. Figures assume that there is no waiting period between employment and the benefit situation.

b) WGA: person assumed to have 79% work incapacity and to receive top-up social assistance payments.

c) Net rates.

Source: Special module of OECD tax/benefit model. Information provided by national authorities.

exclusion, especially if the persons have caring obligations towards children. However, a majority of persons with disability are not fully incapacitated for work but experience problems of staying in the labour market. In the case of NRRs approaching or exceeding 100%, such schemes may become an attractive alternative to employment (for both employees and employers looking to adjust workforce size without causing labour discontent). Indeed, past OECD work suggests a positive correlation between scores on a synthetic "benefit generosity indicator" and both beneficiary rates and disability benefit inflows (OECD, 2003).

Countries have different disability schemes in place. They can be differentiated by whether or not the work capacity loss or disability is permanent, such as illness benefit and invalidity pension in Ireland, or by degree of work incapacity, such as the waiting benefit in Denmark or WGA in the Netherlands. In addition, there are special schemes for persons not covered otherwise such as disability allowance in Ireland.[7] A first issue is how these disability schemes compare to each other in terms of replacing earned income. Figure 5.1 compares NRRs for a single person (results for other household types are shown in Annex Figure 5.A1.1).

How do the different disability schemes fare compared to each other?

In Denmark and the Netherlands, NRRs for single persons are higher for those who receive disability benefit and WGA than for those on waiting benefit and WGA follow-on benefit, respectively. That said, in Denmark the difference is not particularly pronounced (except for persons with low former earnings) and in the case of couples, NRRs for disability benefits and waiting benefits are practically identical. In the Netherlands, the estimates shown for WGA follow-on benefits assume that the person is not receiving any top-up social assistance payments and are therefore between 20 and 30 percentage points lower than the initial WGA benefit. In practice, many people on WGA follow-on benefit will apply for and receive such top-ups (to which they are entitled) and increase their NRRs to the levels of social assistance, *i.e.* identical to WGA for former earnings up to 60% of average wage and 15 to 20 percentage points lower for earnings higher than that. It should also be noted that differences in NRRs between regular and partial or short-term disability benefits have been reported to be higher (between 20 to 40 percentage points) in other OECD countries reviewed recently, Spain and the United Kingdom (OECD, 2007). In Ireland, the three different schemes (IB, IP and DA) provide almost identical NRRs.

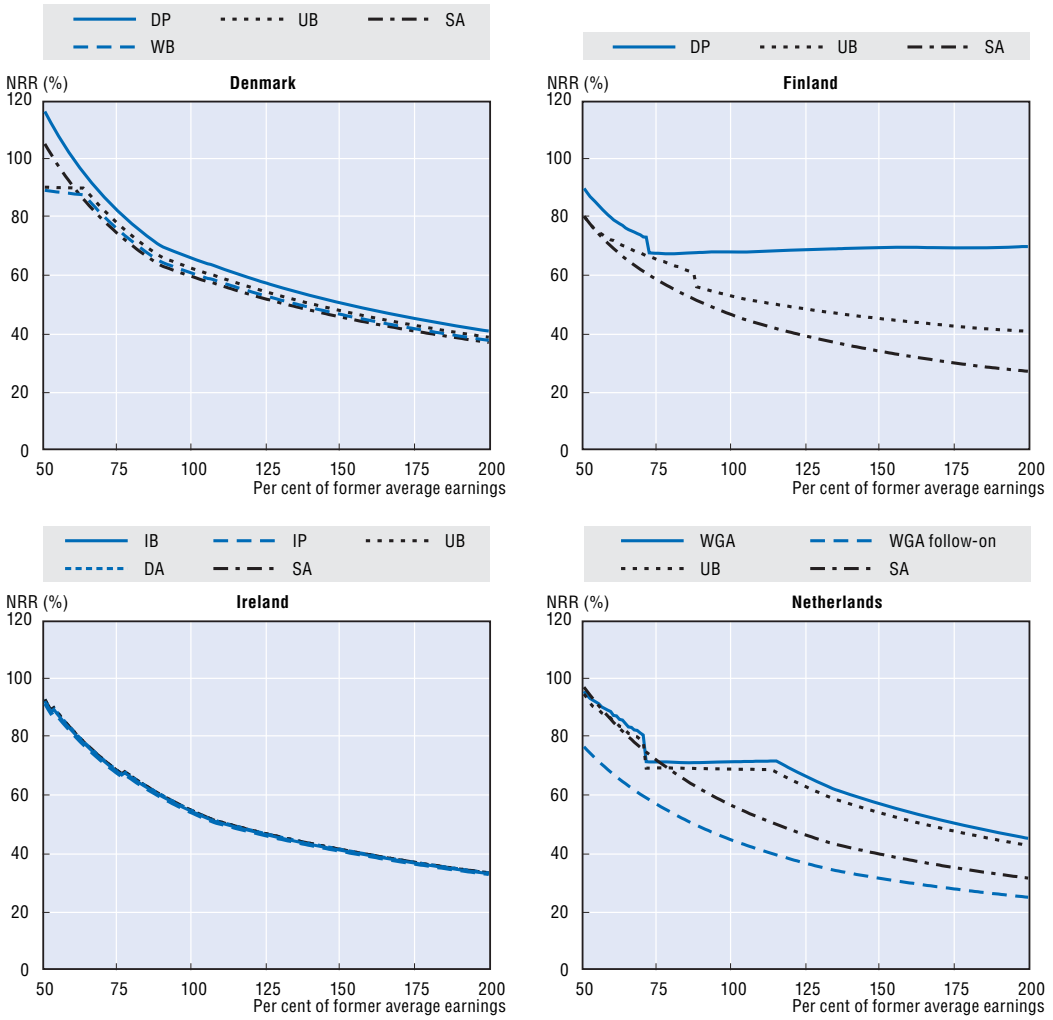
A second issue is how disability benefits compare, in terms of replacing earned income, with other main income support schemes for those of working-age: unemployment benefit and social assistance. In theory, these schemes have been distinct, serving different groups of people. However, there is some evidence that many persons with health problems – to which social and employment problems often are added – are being shifted around and, in the end, trapped between increasingly tightened schemes. Figure 5.1 also compares NRRs for disability, unemployment and social assistance benefit schemes.

How do main disability schemes compare with other benefit schemes for the working-age population?

In Denmark (except for former low wage earners), Ireland and the Netherlands, unemployment and disability benefits have almost identical replacement features throughout the whole earnings range considered (half to double the average wage). In many cases, NRRs for disability benefits are a few percentage points higher than for

Figure 5.1. **Disability and unemployment schemes provide similar net replacement incomes, except in Finland**

Net replacement rates for disability benefits, unemployment benefits and social assistance, single person 40 years old, 2006[a, b, c]



a) Net replacement rates (NRR): ratio of household net income after becoming inactive and receiving disability benefit or unemployment benefit or social assistance to household net income when earning 50% through 200% of average earnings. Estimates refer to a 40-year-old single person with a full earnings history since age 18.

b) DA = disability allowance; DP = disability pension; IB = illness benefit; IP = invalidity pension; SA = social assistance; UB = unemployment benefit; WB = waiting benefit; WGA = initial disability benefit in the Netherlands; WGA follow-on = subsequent disability benefit in the Netherlands.

c) WGA: person assumed to have 79% work incapacity, without receiving top-up social assistance payments.

Source: Special module of OECD tax/benefit model. Information provided by national authorities.

unemployed persons, and in a few cases, they are substantially higher: for former low-wage earners in Denmark (*i.e.* below approximately 60% of the average wage), and for two-earner couples with two children in the Netherlands. The pattern is quite different in Finland. There, NRRs for disability and unemployment benefits are quite similar only up to around a former earnings level of two-thirds the average wage – around 70%-80% for singles and one-earner couples and 90% for two-earner couples. Starting from two-thirds of average wage, NRRs for unemployment beneficiaries are gradually falling to 40% (in the case of single persons) but remain at a constant 70% for disability benefit recipients. This

is due to the earnings-related nature of the disability benefit in Finland and the fact that there exists no maximum benefit.

Only in Finland and the Netherlands, both unemployment and disability benefits provide higher NRRs than regular social assistance, and even in these two countries this is not the case for former lower wage levels. In Denmark, NRRs for social assistance recipients are only marginally lower. In all four countries, NRRs for social assistance recipients tend to be lower, however, as soon as there is a second earner in the family.

NRR features for singles and one-earner couples in Ireland are unique as all working-age benefits – social assistance, unemployment benefit and the three disability benefits considered – provide almost identical NRRs. This is partly due to housing benefit top-ups which are paid throughout the whole earnings range. That said, estimates excluding housing costs also result in very similar NRRs across the schemes.

How does family structure affect benefit entitlements?

NRRs for disability benefits can be considerably higher when there are children present in the household. For instance, in the area around former average earnings, they are some 10-15 percentage points higher than for singles in all four countries. This is due to general child benefits and family allowances, but also to special child supplements within the disability benefit system as is the case in Finland and Ireland.

NRRs for disability benefits for inactive childless couples are quite similar to those for singles. The major exception is Ireland where NRRs are significantly higher for inactive couples than for singles throughout the whole earnings range. This is due to benefit supplements for dependent (*i.e.* inactive) spouses, on the one hand, and lower taxation on the other.

The interplay of different benefits, minima and maxima, income-test thresholds and taxation may cause several "spikes" in the NRRs for disability beneficiaries as former earnings increase. Withdrawal of means-tested benefits (social assistance payments, housing benefits) and differences in tax rules at specific income levels can drive NRRs up at some earnings levels and down at others. For example in Finland, "spikes" appear at around 70% of average earnings (for disability benefit) and 90% of average earnings (for unemployment benefits) when housing benefit entitlements stop.[8] This is also the reason for the sudden fall of NRRs for disability and unemployment benefits in the Netherlands, at around 70% average wage. The two smaller breaks in the Irish NRR lines are due to taxation for working people: until around half the average wage they do not pay income taxes, and until around three quarters of average wage, they do not pay health insurance contributions.

It should be noted that the model estimates presented here do not take into account a number of special and individualised monetary benefits and related or derived in-kind benefits. In Denmark this concerns, for instance, a cash benefit designed to compensate additional expenses on the grounds of specific handicaps (*merudgiftsydelse*). In Finland, there exist allowances for specific health conditions (*e.g.* nutrition grants) but also a special disability allowance for non-beneficiaries to compensate for hardship arising from illnesses. In Ireland, the receipt of disability payments is linked to access to a free medical card.[9] These transfers and services may increase the "net worth" of disability benefits for some recipients and are not reflected in the NRR figures above.

To sum up, income from work dominates the household income package of people with disabilities. For those who are inactive and on benefit, regulations on taxes and transfers determine net replacement rates. The latter tend to be lower in Ireland than in the other countries. Moreover, disability benefits generally provide net replacement income similar to unemployment benefits in Denmark, Ireland and the Netherlands and, except for former lower wage earners, considerably higher net replacement income in Finland. Except in Denmark, the redistributive impact of disability benefits has become considerably smaller over the past five years.

5.2. Work incentives and disincentives for disability benefit recipients

This section looks at *financial* work incentives and disincentives for persons with disability through the tax/benefit scheme. Non-financial incentives – *e.g.* stemming from eligibility and duration criteria for various benefits and programmes and the extent of follow-up and activation policies towards persons on such schemes – are discussed elsewhere in the review. Here, the net income effects of transitions into or within work are considered. That is, the transition from inactivity into work, *i.e.* the extent to which gains in earnings are "taxed away" through a combination of reduced benefits and higher taxes, when taking up work – expressed as average effective tax rates (AETR) – or when increasing hours of work – measured through marginal effective tax rates (METR).

A. Does it pay to work?

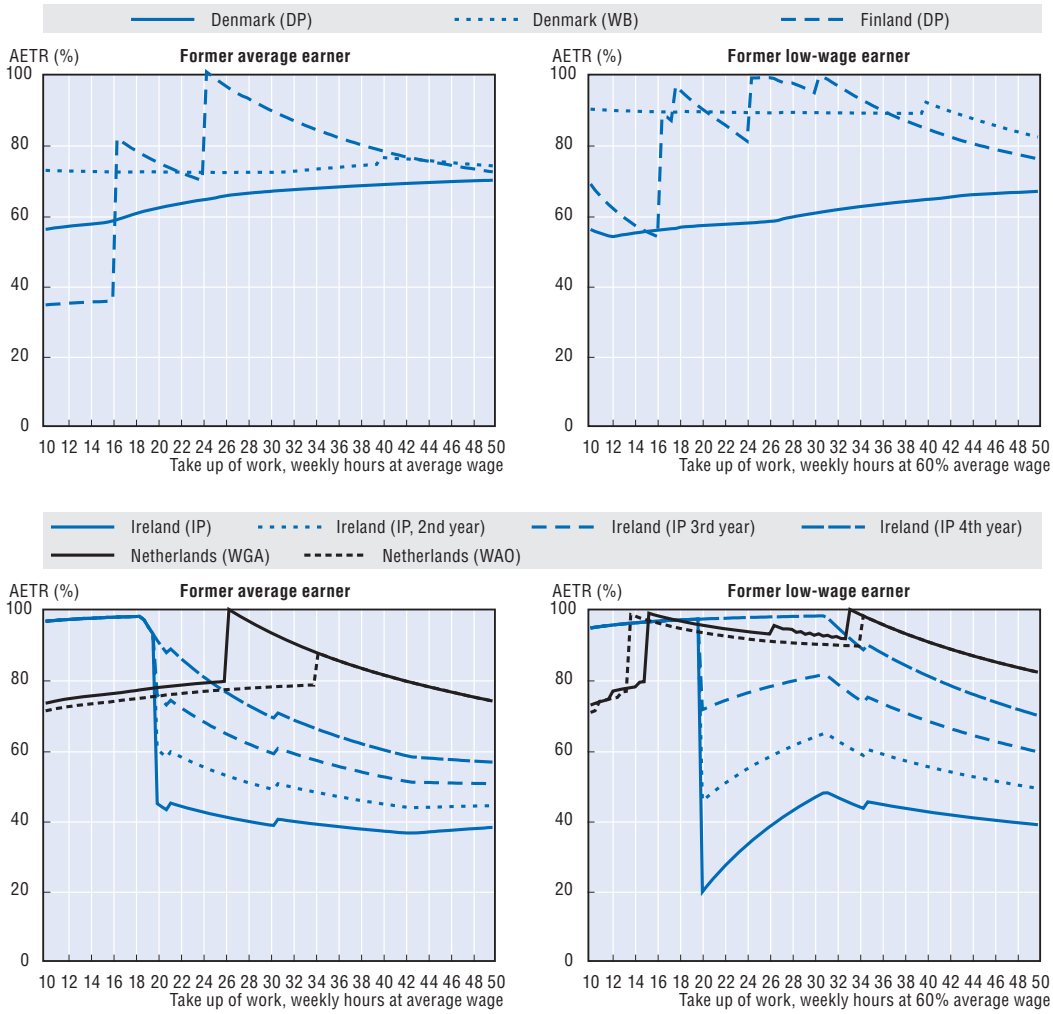
Once inactive and on disability benefit, what are the financial consequences of a return to work? This question will be particularly relevant for those people with remaining work capacities, in particular those on temporary or partial benefits. Partial benefits notably exist in Finland and the Netherlands, and the first set of considerations below is based on the realistic assumption that people on partial benefits are combining these with work.[10] Taking up work should be financially attractive for those considering this step. This is, however, not always the case. Figure 5.2 shows average effective tax rates embedded in the countries' main disability schemes, for single persons with two different earnings histories: those who were on average wage prior to acquiring a disability, and those who were on low wages.[11] It is assumed that persons return to a job at the same wage rate but for varying working hours up to the former wage level.[12] The following key findings emerge.

Denmark is the only country, in which effective taxation for disability beneficiaries is almost independent from the amount of work taken up: between six and seven Danish Crowns are "taxed away" for every ten Crowns earned (Figure 5.2). This is due to a smooth interplay between a gradual phase-out of disability benefit,[13] comprehensive taxation and top-up of housing benefits at a broader range of lower earnings levels (until about two-thirds of average earnings). At around 70-75%, average taxation for people on waiting benefits is slightly higher when they were average earners, but considerably higher when they were low-wage earners: close to 90%. This is due to the fact that waiting benefits are calculated according to unemployment benefits[14] and, for low-wage earners, they are tapered away by the same absolute but a higher relative size than for average earners. When taking up work at the former wage level, waiting benefits are suspended, creating a small increase in AETRs at the level of full-time work (40 hours).

Average taxation for disability beneficiaries in Finland is relatively low, some 30%, but only up to engaging in work for 16 hours (*i.e.* 40% of their former earnings level). At that

Figure 5.2. **Taking up work pays in Denmark and especially Ireland**

Average effective tax rates for a 40-year-old single person with disability, 2006[a, b]



a) Average effective tax rate (AETR) is the percentage of earnings that is taxed away via increased taxes and reduced benefits when taking up work. Take-up of work at 10 and 50 hours weekly work, at average wage AW (Panel A) or low wage (Panel B). The person is assumed to be on disability benefit after having worked at 100% of AW (Panel A) or at low wage (Panel B). Irish data where AW estimates are not available are based on average production worker wage APW. Low wages defined as 60% of AW/APW. Estimates refer to a 40-year-old person with a full earnings history since age 18.

b) DP = disability pension; IP = invalidity pension; WAO = former disability benefit in the Netherlands; WB = waiting benefit; WGA = current disability benefit in the Netherlands.

Source: Special module of OECD tax/benefit model. Information provided by national authorities.

stage, the full disability benefit is transformed into a partial one and the AETR doubles to some 80%[15] (Figure 5.2). A second such jump in AETR arises when the person works more than 24 hours (60%) as they then lose benefit entitlement altogether. At that stage, work does not pay at all and the AETR returns only to 80% when taking up a full-time job. For former low-wage earners, even working for less than 16 hours is somewhat less attractive than for average earners. This has to do with a *relatively* higher starting level of net income when out of work due, *inter alia*, to housing benefits.

Finland operates an employment-conditional benefit in the form of an "earned income allowance". While this benefit is available to all persons taking up work, there is also a special tax allowance and a tax credit targeted for persons with disabilities in Finland. Nonetheless, these instruments impede only very little if at all on effective taxation, hence, incentives to work. In-work benefits, for instance, constitute just some 3-4% of net income for both former average and low-income earners should they take up work for 16 hours.

In contrast, in-work benefits seem to have more potential in Ireland. Recipients of working-age benefits, including all disability-related payments are entitled to a Back-to-Work Allowance (BTWA) should they take up work for at least 20 hours. This causes the AETR to drop from a level close to 100% to some 45% for former average earners and a low 20% for low-wage earners, at take up of half-time work (Figure 5.2). AETRs for average earners then decrease further except for two small increases when income taxation and health insurance contributions set in, respectively. Effective taxation is 40% when taking up full-time work. On the other hand, AETRs for low-wage earners increase in the band of 20 to 32 hours of work, mainly because of housing benefits being phased out. The AETR is 43% when they take up full-time work.

However, to the difference of the Finish in-work benefits, the Irish Back-to-Work Allowance is limited in time and phased out rather substantially. It entitles to 75% of the former benefit in the first year, 50% in the second and 25% in the third year. Figure 5.2 also shows that this phase out leads to 10 percentage point increases in AETRs per year for former average earners. After the third year, they face a 60% AETR when taking up full-time work. The situation is worse for former low-age earners. The yearly increase in AETRs is much more pronounced, and after the third year, a former low-wage earner faces AETRs between 80% and 100% when taking up part-time or full-time work. This time limitation and phase-out may therefore explain the low take-up of these in-work benefits in Ireland: less than 1% of all recipients of disability payments make use of the BTWA.

In the Netherlands, effective taxation is high. People on initial WGA benefit considering to take up work will see EUR 7 to 8 being taxed away for every EUR 10 gain in gross earnings. Above 65% of former earnings (corresponding to 26 hours of work), persons will lose their WGA benefit and AETRs reach a level of 100%. At full-time work, the level is still around 80%. Compared to the former WAO initial benefit, AETRs are similarly high with the only exception that the jump in AETR levels for WAO occurs later, namely at 85% of former earnings (34 hours of work). This is linked to the change in the minimum threshold for benefit recipiency, from 15% (WAO) to 35% (WGA). For former low-wage earners peaks in AETRs occur already earlier, at around 14 to 15 hours. This is due to the suspension of housing benefits at these earnings levels. When out of work, these constitute some 18% of net income of disability beneficiaries.[16]

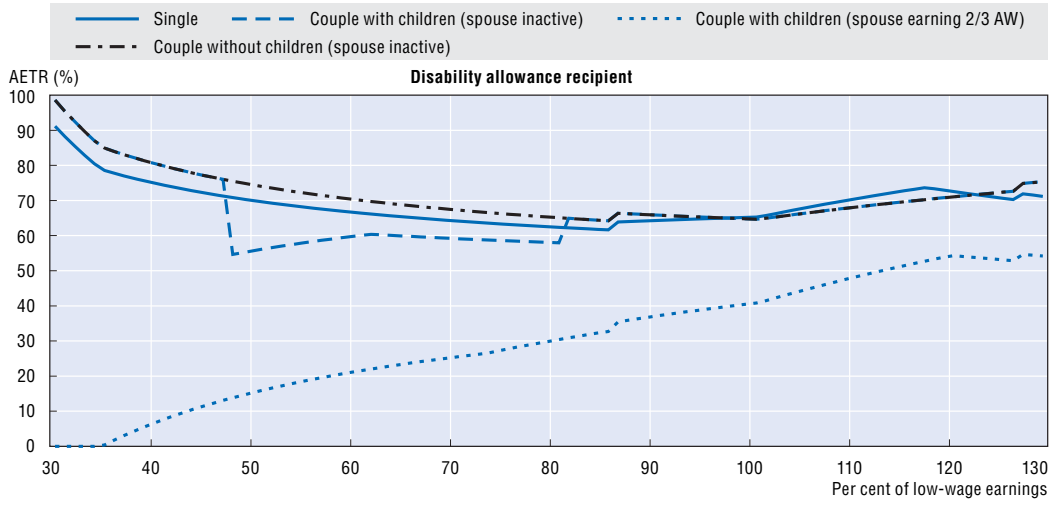
Household composition can influence financial work incentives for disability beneficiaries, especially in case of withdrawal of child or family-related benefits, or different earnings disregards depending on the activity of the partner. This issue plays a significant role only in Ireland. In the other three countries, AETRs for different household constellations are practically identical, with the exception of single parents, who face slightly higher AETRs in the two Nordic countries and slightly lower ones in the Netherlands.

In Ireland, to the contrary, AETRs are generally lower for persons with disability who live in households with children, in the area between half-time and full-time work. This is partly due to the Family Income Supplement (FIS), operated in this country. FIS is an employment-conditional benefit for parents working at least 19 hours per week[17] which pays 60% of the difference between the net family income and a specified earnings limit, with a minimum supplement of EUR 20 per week. The earnings limit varies with the number of children and ranges from EUR 465 to 905; hence, FIS is focused at low-wage earners. The FIS take-up rate is estimated to be as low as 30-40%, but the payment has the potential to play a much greater role in making work pay and raising family income: it has been estimated that achieving a full take-up of FIS would lead to a 3 percentage point reduction in the key at-risk-of-poverty indicator (Callan *et al.*, 2006).

For instance, when taking up half-time work at low wages, AETRs for disability allowance (DA) recipients with an inactive spouse and two children fall by 20 percentage points from about 75% to 55% (Figure 5.3). AETRs remain on a lower level for these one-earner couples until FIS is phased out, at around the level of four days work per week. Note that AETRs for DA recipients with children whose partners are working (at two-thirds of the average wage in this case) are also very low and, indeed, below 40% up to full-time work. This is not due to FIS but to the fact that the *initial* disability allowance is significantly lower for these families because they do not receive (inactive) spouses supplement or housing benefit; two-earner couples have therefore less to lose' when taking up work. Both family types with children benefit from the DA earnings disregard but this is counted against housing benefits and spouse supplement in the case of one-earner couples. Nevertheless, the design of FIS could serve as a model for in-work benefits to improve work incentives for single persons with disability in the lower earnings range, not only for Ireland.

Figure 5.3. **Irish low-wage families with children have stronger incentives to work**

Average effective tax rates for a 40-year-old single person with disability, former low-wage earner, 2006[a]



a) Average effective tax rate (AETR) is the percentage of earnings that is taxed away via increased taxes and reduced benefits when taking up work. Take-up of work at between 30 and 130% of low wage, with the latter defined as 60% of APW. Estimates refer to a 40-year-old person with a full low-wage earnings history since age 18. Children are aged 4 and 6.

Source: Special module of OECD tax/benefit model. Information provided by national authorities.

B. Mobilising remaining work capacities

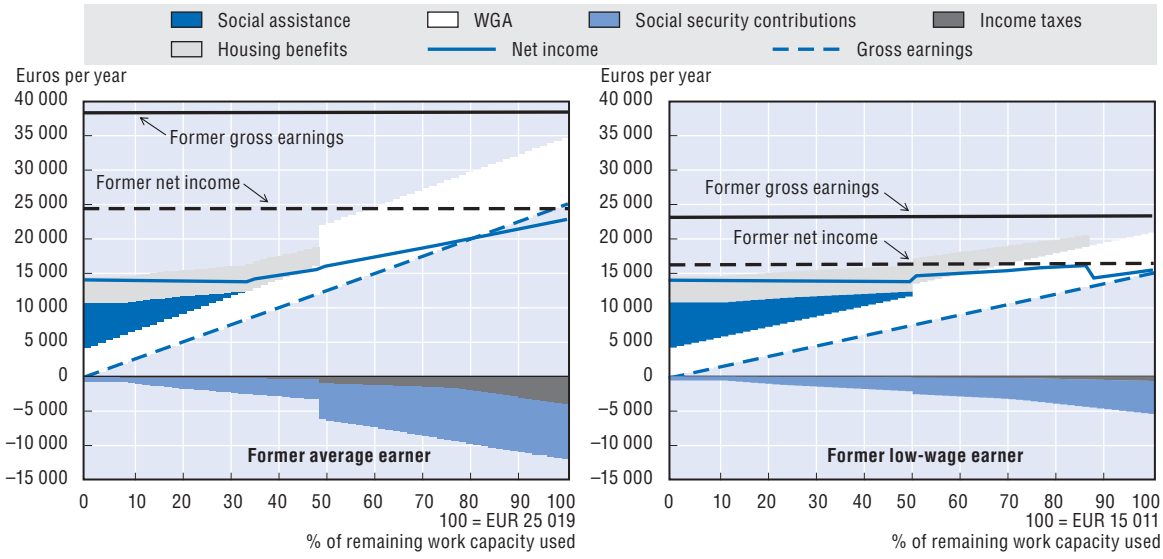
The considerations above refer to people on a full disability benefit who consider taking up work, at different working hours, corresponding to earnings levels between 25% and 125% of their former earnings. This implies that, when taking up work at a more substantive range, their disability benefits will be transformed into partial benefits (Finland, Netherlands), phased out (Denmark), or suspended (Ireland). It is thus assumed that persons who increase their earnings capacity correspondingly decrease their disability degree. Another relevant issue concerns persons on partial disability benefits with a fixed disability degree who consider making use of part or all of their remaining work capacities.

This question is particularly relevant in the Netherlands which introduced a new system of wage supplements to encourage people with partial earnings capacity loss to take up work in the limits of their remaining work capacity. Once the initial WGA benefit is exhausted,[18] the person is entitled to either a (lower) follow-on benefit or a wage supplement in case she is working at least at half of her residual earnings capacity. Figure 5.4 shows an example for a single person with a remaining work capacity of 65% – the new threshold for entering the WGA system – and two different earnings histories: average and low-wage earnings before disability occurred. The full residual earnings capacity therefore is EUR 25 000 in the first case and EUR 15 000 in the second. The horizontal axis denotes the percentage of capacity being used: from 50% remaining capacity being used, the WGA follow-on benefit is being replaced by the more generous WGA wage supplement. If the person were to use more than 100% of her remaining capacity, all WGA payments would be suspended.

Figure 5.4 shows that the WGA wage supplement helps making work pay although the interplay with income taxes and other benefits considerably attenuates the role of these

Figure 5.4. **The Dutch WGA wage supplement provides weaker work incentives for former low-wage earners**

Gross and net income of a single person with 65% remaining work capacity, by percentage of work capacity used, Netherlands, 2006[a]



WGA = Follow-on disability benefit or wage supplement.

a) Low wages defined as 60% of AW.

Source: Special module of OECD tax/benefit model. Information provided by national authorities.

supplements, especially for lower-wage earners. For a former average earner with 65% remaining work capacity, using at least half of the remaining capacity would provide a net replacement income of between 65% and 90% (if using her entire remaining capacity). If not working or using less than half of her capacity, the replacement rate is somewhat but not substantially lower, 56-60%. This is due to top-ups of housing benefit and social assistance at the bottom of the income ladder and higher income taxes and contributions at the upper part. The important role of housing benefit becomes clear when considering a former low-wage earner. In that case, the replacement rate would increase only slightly (from 85 to 90% and more) when using more than half of the remaining work capacity and there would even be a temporary decrease in the earnings range when housing benefit gets suspended.

That said, the important feature of the new measure is that it helps to avoid that additional Euros earned lead to only marginal increases, or even reductions, in net income because of loss of disability benefit, at least for average earners. Ways need to be found that the effectiveness of WGA wage supplements do not remain restricted to the mid-income range and, indeed, higher than average earners up to the maximum daily wage which is the cap for this supplement (around 120% of average wage).

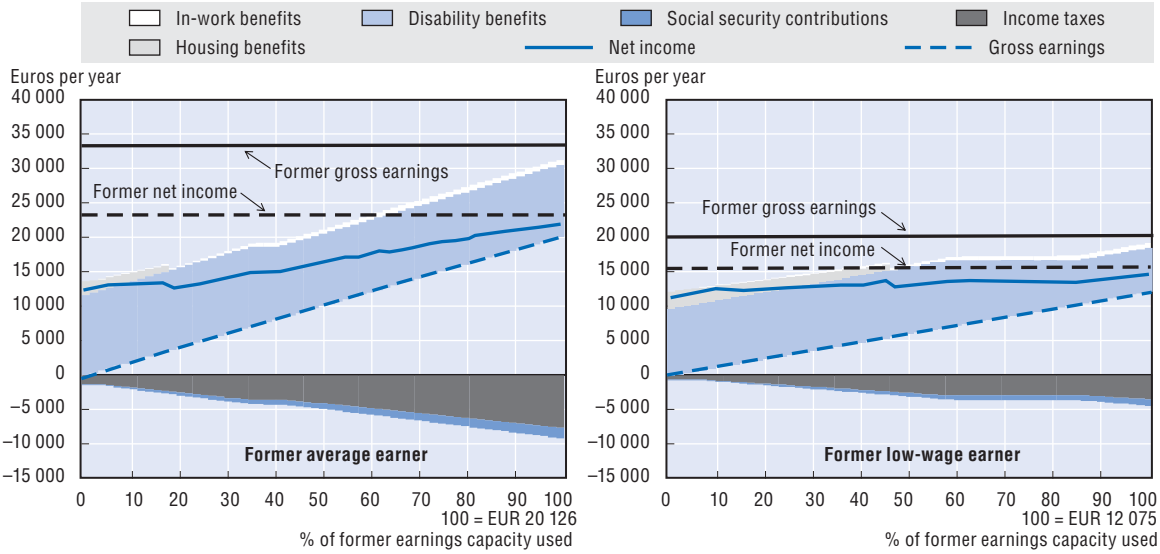
The situation is somewhat similar for Finnish partial disability beneficiaries although benefit regulations are different. The threshold for a partial benefit is 60% of remaining work capacity. National and earnings-related pensions are combined and the amount of the national pension is reduced by 50% of the earnings-related pension. When taking up work, the earnings-related pension part is paid independent of the amount worked (up to reaching full capacity level). On the other hand, the national pension part is counted against earnings but with an annual earnings disregard of EUR 7 064.

Figure 5.5 shows that for a former average earner on partial disability benefit, the net replacement rate is about 50% and for a former low-wage earner it is 70%. In both cases, these rates increase up to 95% when making use of the full remaining work capacity. Again, housing benefits play an important role in the lower income part and even causing a slight fall in net income at around 18% (average earner) and 45% (low-wage earner) of remaining work capacity. Between 38 and 42% of remaining capacity (average earner) and 60 and 88% (low-wage earner), the net income function becomes flat (*i.e.* additional gross earnings would not increase net income), as the earnings disregard for national pension is phased out at the first point and the national pension part in the second. Ways should be found to reward increasing work effort in these areas by giving, for instance, a greater role to (existing) in-work benefits.

The situation is different in Ireland. In this country, no partial disability scheme exists. However, in order to mobilise remaining partial work capacities, earnings disregards for disability allowance recipients who take up rehabilitative employment have been introduced recently. Recipients can work and have the first EUR 120 earnings per week disregarded entirely, plus 50% of earnings between EUR 120 and EUR 350.[19] Figure 5.6 shows that this disregard can be very effective: AETRs for former average earners now are significantly lower, up to 28 hours of weekly work. The effects are even more pronounced for former low-wage earners: without disregards, AETRs were 100% up to half-time work and beyond, but now they are in the range of 60-80%. This may explain the relative success of this measure: about 10% of disability allowance recipients availed of earnings disregards for rehabilitative work in 2007.

Figure 5.5. **High earnings disregards in the Finnish partial disability benefit, especially for former average earners**

Gross and net income of a single person with 60% remaining work capacity, by percentage of work capacity used, Finland, 2006[a]

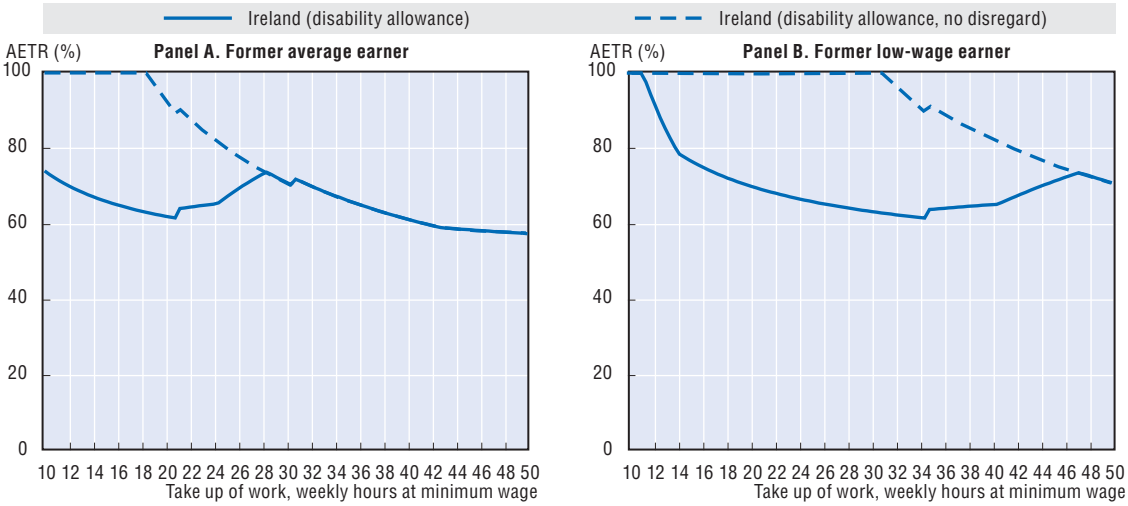


a) Low wages defined as 60% of AW.

Source: Special module of OECD tax/benefit model. Information provided by national authorities.

Figure 5.6. **The disability allowance earnings disregard in Ireland can be very effective, especially for low-wage earners**

Average effective tax rates for a 40-year-old single person in receipt of disability allowance, 2005[a]



a) Average effective tax rate (AETR) is the percentage of earnings that is taxed away via increased taxes and reduced benefits when taking up work. Take-up of work at 1 and 50 hours weekly work, at average wage (Panel A) or low wage (Panel B). The person is assumed to be on disability benefit after having worked at 100% of AW (Panel A) or at low wage (Panel B). Irish data where AW estimates are not available are based on average production worker wage APW. Low wages defined as 60% of AW/APW. Estimates refer to a 40-year-old person with a full earnings history since age 18.

Source: Special module of OECD tax/benefit model. Information provided by national authorities.

C. The impact of increasing work efforts

The discussion above has focused on *inactive* disability benefit recipients and the consequences when taking up work. A different yet important question arises for those persons who are *in* work already, possibly drawing a (partial) disability benefit, and considering to work more hours. Table 5.4 shows the financial consequences of increasing working hours for a person with disability, in four steps: from 0 to 10 hours (marginal work), from 10 to 20 hours (part-time), from 20 to 30 hours (considerable part-time) and from 30 to 40 hours (full-time). Again, two cases are considered: the person is assumed to have worked at average or low-wage earnings before the onset of disability and again to be taking up work at this hourly earnings level and receiving a partial disability benefit, if eligible.

First, there are several "zones" where working more hardly pays, *i.e.* with marginal effective tax rates close to or over 100%. In such cases, persons are encouraged to stay in their current benefit position despite their wish to become more active due to, for instance, improvements in their health condition. Such "zones" often occur when a disability benefit is suspended – taking account of other benefit reductions and taxation. Only in Denmark there are no such specific "zones" and METRs are constantly between 56 and 76% because a (gradually decreasing) disability benefit is paid throughout the whole earnings range.

Second, increasing working hours does in general not seem to be more attractive – in that less of additional earnings are "taxed away" – for low-wage than average wage earners. Low-wage earners may even face much higher METRs, especially in cases when increasing working hours lead to a loss of other social benefits, such as housing benefit. This is, for instance, the case in Ireland when changing from part-time to considerable part-time work and in the Netherlands for changes from marginal to part-time work and, for average earners, from part-time to considerable part-time work.

Third, in Finland and, to a lesser degree in Denmark and the Netherlands, engaging in little work entails comparatively lower METRs than increasing the number of hours worked, hence the issue seems to be one of a low-wage (poverty) trap more than of an

Table 5.4. **Increasing working hours may penalise workers with disability**
Marginal effective tax rates for those receiving full or partial disability benefits, percentage of earnings, 2006[a]

		Increase in working time			
		0 >>> 10 hours	10 >>> 20 hours	20 >>> 30 hours	30 >>> 40 hours
Denmark (DP)	Average earner	56	68	76	75
	Low-wage earner	56	58	68	76
Finland (DP)	Average earner	34	116	*120*	*43*
	Low-wage earner	69	111	*104*	*54*
Ireland (IP)	Average earner	*97*	*–7*	*27*	*32*
	Low-wage earner	*95*	*–55*	*100*	*31*
Netherlands (WGA)	Average earner	74	82	*126*	*46*
	Low-wage earner	73	118	*87*	*86*

DP = disability pension; IP = invalidity pension; WGA = initial disability benefit.

a) Average earnings refer to average wage (AW), except for Ireland where they refer to average production worker wage (APW). Low wages defined as 60% of AW/APW. Marginal effective tax rate (METR) is the percentage of earnings that is taxed away via increased taxes and reduced benefits when increasing working hours. The hourly wage is at the AW level (first line) or national low-wage wage level (second line). The person is assumed to be on full or partial disability benefit, provided such benefit exists. Ireland: persons on IP are assumed to be entitled to Back-To-Work-Allowance (1st year). Estimates refer to a 40-year-old single person with an earnings history of 22 years at AW respectively low-wage earnings. Figures in italics refer to situations where no more disability benefits are granted.

Source: Special module of OECD tax/benefit model. Information provided by national authorities.

inactivity trap. In Ireland, however, it is the opposite. For people on either invalidity pension or illness benefit, it does not pay to take up work for one or two days a week because disability payments are suspended and the Back-to-Work Allowance is not available at this earnings range. In turn, when out of work, net income is toped up considerably with housing benefits (about one-third of net income). However, at exactly half-time work take-up, METRs are slightly negative for average earners and considerably negative for low-wage earners establishing a huge incentive to take up work at this level. This effect flattens out over the years when BTWA is gradually reduced, or phased-out: METRs for low-wage earners are slightly negative after two years, some 45% after three years and close to 100% when they are no longer eligible for this in-work benefit.

5.3. Conclusion

Taxes and benefits determine the adequacy of public net transfers provided to people with disability but also the financial awards for those who take up work, in particular those with partial work capacity. Across full disability regimes, net replacement rates are lower in Ireland than in the other three countries: for single former average earners, they amount to some 55% in Ireland and to some 70% in Denmark, Finland and the Netherlands.

Ireland has the most fragmented system of disability-related benefits in operation. Nevertheless, judged in terms of outcomes, despite different benefit rates and taxation, net replacement rates of illness benefit, invalidity pension and disability allowance are identical, throughout the whole earnings range and across different household types. This suggests that there is room for unifying some of these payments.

In the short run, *i.e.* upon leaving the labour market, regular disability benefits appear to be more "attractive" than unemployment benefits only in Finland (except for the lower income range). In the other countries, they provide net replacement rates slightly below those of unemployment benefits. However, disability benefits are expected to provide a much more "permanent" source of replacement income than unemployment benefits.

The step to paid work can be costly for a person with disability ("inactivity trap"), as can be the decision to increase working hours or earnings ("low-wage trap"). The level of average effective taxation is indeed high in the four countries and can reach 70 to 90% for both average and low-wage earners. In Denmark, average effective tax rates are somewhat lower, especially for low-wage earners and more constant along the earnings range – but they still exceed 50%. Only Finnish disability beneficiaries who take up work for less than two days per week and Irish disability payment recipients who take up work for at least 20 hours will be able to keep more than half of their additional gross earnings.

In-work benefits exist in Finland and Ireland but are much more important in size in the latter country. Nevertheless, there seems to be a take-up problem, perhaps related to the temporary nature of BTWA in Ireland. Another employment-conditional benefit for families with children, the Family Income Supplement, has a considerable potential, too.

Earnings disregards are another inroad for boosting work incentives, especially among people with partial work capacities. The new wage-supplement for people with partial work capacity in the Netherlands seems to be an effective tool, but only for former average-wage earners. In Finland, earnings disregards ensure that net replacement rates increase considerably when people make use of their full remaining work capacity but less so when working less. In Ireland, a recently introduced earnings disregard for DA recipients lowers effective tax rates, especially among low-wage earners.

Notes

1. For Finland, trend data are only available for the more restrictive definition of "administrative" disability status, *i.e.* for persons who are eligible for tax allowances due to a disability degree of between 30% and 100%. These data suggest that the labour income share has increased by 4 percentage points during the past ten years for people with disability and by 6 percentage points for people without disability.
2. If one assumes a similar share of capital income in Finland as in the other countries, the transfer share in Finland would be similar to the one in Ireland.
3. This refers to the overall impact of these benefits among the total working-age population in 2000 (Förster and Mira d'Ercole, 2005).
4. In 2006, about 40% of all disability beneficiaries combined both types of payments. This share was more than double prior to 1996 when the national disability pension became fully pension-income tested.
5. Throughout this report, this scheme is classified as a sickness benefit in the first two years of benefit receipt, and as another disability benefit after these two years.
6. The initial WGA benefit provides the same replacement income as the full disability benefit for fully and permanently incapacitated persons (IVA).
7. The national pension in Finland has the same role. Currently, about 20% of Finnish disability beneficiaries receive a national pension only.
8. There are no such spikes in the case of two-earner couples since these families are not eligible for housing benefits throughout the whole earnings range.
9. Under the medical card assessment guidelines, persons whose weekly incomes are derived solely from DSFA or HSE payments, even if these exceed the stated threshold, qualify for a medical card.
10. This also implies that persons taking up work beyond the minimum threshold for claiming disability benefits (*e.g.* 35% in the Netherlands, or 40% in Finland) are assumed to lose these benefits.
11. Low wages are defined as 60% of average wage in each country. This comes quite close to the level of the minimum wage in Ireland, and the higher sectoral minimum wage rates applied in Denmark and Finland. The minimum wage level in the Netherlands is lower, about 40% of average earnings.
12. Above that level, it is assumed that people receive higher wage rates.
13. In the case of a single former average earner, the disability pension is completely phased out only at 1.9 times average earnings.
14. It should be noted that both disability beneficiaries and people on waiting benefit face lower effective taxation than unemployment beneficiaries in Denmark.
15. The model assumes identity between 40% of full-time hours and 40% of earnings – the threshold for partial disability benefit in Finland.
16. Housing benefits may indeed influence the interpretation of results. The OECD models assume that the person is eligible for housing benefit and that the costs for rent amount to 20% of average earnings. Alternative calculations assuming no housing benefit entitlements show that AETRs would be slightly lower for the Netherlands (2 to 5 percentage points), but 10 to 20 percentage points lower in Ireland. On the other hand, this would have no effect on indicators in Denmark and Finland.
17. Married or cohabiting couples can add their hours together.
18. This depends on the individual's employment record and varies between 6 and 60 months. In the example of the OECD model, the WGA duration would be two years.
19. The disregard applies to rehabilitative work only, as certified by medical evidence from the treating doctor.

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ANNEX 5.A1

Background Tables for Different Household Types

Income positions when persons are in work and when they are out of work are strongly influenced by the level and design of taxation and available benefits and their interaction with personal and household incomes. The analysis in Chapter 5 is based on estimations from an additional module to the OECD tax/benefit model (OECD, 2007b), for different groups of people with disability: those living alone, those living with inactive spouses and those living with working spouses (with and without children for all three constellations).

Table 5.A1.1 summarises the main features of the four countries' disability benefit systems, their taxation and the rules for combining benefits with labour earnings.* Figure 5.A1.1 complements the results for single persons shown in Figure 5.1, with estimates on net replacement rates for disability benefits, unemployment benefits and social assistance for two other household types: a person with disability living with an inactive spouse and one living with a spouse earning two-thirds of an average wage (in both cases having two children).

* A detailed description of the country-specific parameters of the disability systems that have been used for the models is available at *www.oecd.org/els/disability*.

Table 5.A1.1. **Main characteristics of disability benefit and taxation systems, as at 1 July 2006**

	DENMARK	FINLAND	IRELAND	NETHERLANDS
Benefit schemes (covered in model)	1. Disability pension (*Førtidspension*). Tax financed universal protection scheme for all inhabitants.	1. Statutory earnings-related pension (*Työeläke*): contribution based, covering all economically active persons (employees, self-employed, farmers).	1. Invalidity pension (IP). Social insurance scheme financed by contributions for employees with flat-rate benefits.	1. Before 2006: WAO (*Wet op de ArbeidsongeschiktheidsverzekEring*): employees with at least 15% earnings incapacity. Since 2006: WIA (*Wet Werk en Inkomen naar Arbeidsvermogen*): employees with at least 35% earnings incapacity, consists of two parts: WGA, IVA.
	2. Waiting allowance (*Ledighedsydelse*): allowance for people waiting on flex-job.	2. National pension (*Kansaneläke*): universal coverage guaranteeing a minimum pension.	2. Disability allowance (DA). Universal scheme for persons substantially handicapped in undertaking work of a kind which, if not suffering from that disability, would be suited to age, experience and qualifications.	2. WGA (*Regeling Werkhervatting Gedeeltelijk Arbeidsgehandicapten*): persons with temporary or partial disability, transforming after some time into follow-up benefit (if not sufficiently working) or wage supplement (if sufficiently working).
			3. Illness benefit (IB, formerly Disability benefit, DB).	3. IVA (*Regeling Inkomensvoorziening Volledig Arbeidsongeschikten*): persons with permanent and full disability (80%).
Benefit formula	1. Disability pension: up to certain income level, DKK 177 636 (EUR 23 823)/year for persons living alone and DKK 150 984 (EUR 20 248) for married or co-habiting pensioners.	1. Statutory earnings-related pension: accrued pension amount increased with accrual for projected pensionable service up to retirement age (minimum earnings EUR 13 358.40 during 10 years preceding the contingency). Accrual rate on annual earnings: 1.5% between age 18-52, 1.9% between age 53-62 and 4.5% between age 63-68. Accrual rates for projected service: 1.5% until age 50 and 1.3% between ages 50-63. Calculation basis: earnings during the five years preceding the contingency. For pensioners who are in employment, accrual rate is 1.5% of earnings. Accrual rate for unpaid periods 1.5%.	1. IP: Flat-rate amounts depending on age. • EUR 171.30 per week, if aged under 65. • EUR 193.30 per week if aged between 65 and 80 years. • EUR 203.30 per week if recipient is aged 80 or over.	1. WAO (before 2006): • Initial benefit: daily allowance between 14% and 70% of the daily wage (pre-disability wage up to maximum daily wage) depending on the incapacity level. Ceiling: EUR 170.33/day. • Continuing benefit: for each year above age 15, 2% of the difference between the previous wage (maximum EUR 170.33/day) and the minimum wage is added to this minimum wage.

Table 5.A1.1. **Main characteristics of disability benefit and taxation systems, as at 1 July 2006** *(cont.)*

	DENMARK	FINLAND	IRELAND	NETHERLANDS
	2. Waiting allowance: between 91% and 82% of the highest unemployment benefit, *i.e.* DKK 3 035 and DKK 2 735/week. Ceiling: average individual income during past 12 months.	2. National pension: full amount between EUR 432.44 and EUR 510.80 according to marital status and municipality. A full pension if resident of Finland, 80% of time after age 16 and before pension starts. Otherwise pension is adjusted to the length of residence. Reduced by 50% of the amount of the Statutory earnings-related pension and other Finnish and foreign pensions when annual total exceeds EUR 567.	2. DA: • Personal rate: EUR 165.80 per week.	2. WGA (since 2006): • Initial benefit: 70% of the (maximum) daily wage (pre-disability wage up to the maximum daily wage) if not working and 70% of the difference between the (maximum) daily wage and the individual's work-related income if working. • WGA follow-on benefit: 70% of the statutory minimum wage multiplied by the percentage of incapacity. If monthly wage is less than the statutory minimum wage, WGA follow-on benefit will be 70% of the daily wage, multiplied by the percentage of incapacity. • Wage supplement: 70% of the difference between the (maximum) daily wage and assessed residual capacity (pre-disability wage multiplied by percentage of incapacity). Wage-related WGA benefit may not be less than the level of the WGA follow-on benefit.
			3. IB: • Personal rate: EUR 165.80 per week.	3. IVA (since 2006): 70% of the last earned wage. Ceiling: EUR 170.33 per day.
Minima/maxima	– Minimum pension: 1/40 of the above mentioned amounts. – Maximum pension: full rate (40/40) of the above mentioned amounts.	No minima, no maxima.	IB: minimum amount is EUR 74.50 per week when weekly earnings are below EUR 80.	WIA/WAO: No minimum benefits. Maxima: see above.
Special supplements (covered)	No supplements for dependants.	Children: National pension (*Kansaneläke*): Child increase EUR 18.68 per month and child under the age of 16.	1. IP: supplements for dependants. Spouse aged under 66 years: EUR 122.20 per week, aged 66 years and over: EUR 149.30 per week. For each child: EUR 19.30 per week. 2. DA: increase for a qualified adult: EUR 110.00; Increase for each qualified child: EUR 16.80. Where a claimant's spouse or partner is not a qualified adult, increases in respect of qualified children are generally payable at half-rate, depending on the exact circumstances. 3. IB: increase for a qualified adult: EUR110.00; increase for each qualified child: EUR16.80. An additional allowance of EUR7.70 is payable to recipients of IP and DA who are living alone.	No supplements for dependants.

Table 5.A1.1. **Main characteristics of disability benefit and taxation systems, as at 1 July 2006** *(cont.)*

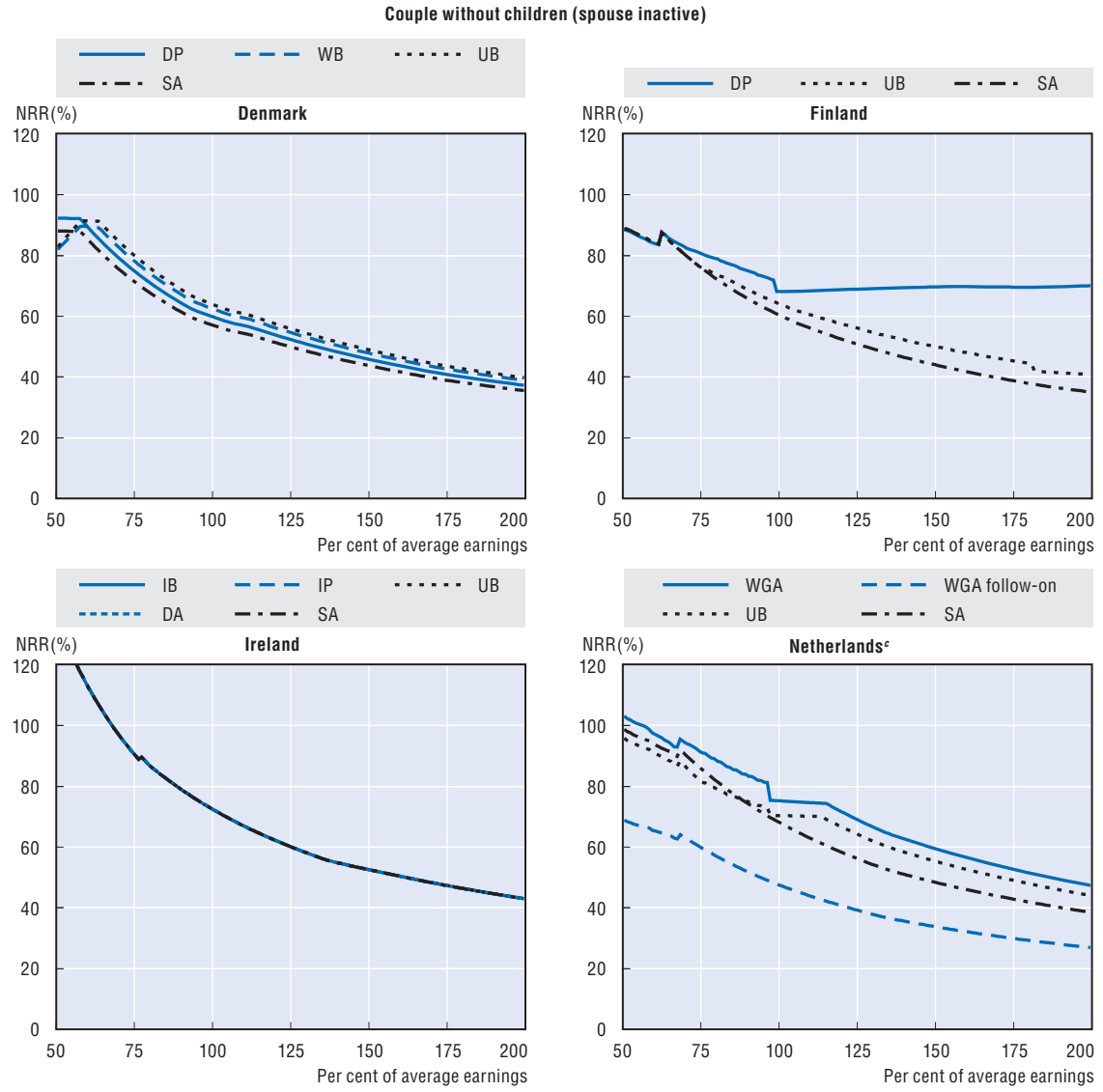
	DENMARK	FINLAND	IRELAND	NETHERLANDS
Graduation of benefits	No	Yes, for earnings-related pension: partial disability pension (*Osatyökyvyttömyyseläke*): 50% of the full disability pension.	No	Yes
Benefit schemes (not covered)	Cash benefit to compensate additional expenses on the grounds of the handicap (*Merudgiftsydelse*). The amount is fixed for each individual case, taking into account the expenses to be expected. Minimum DKK 6 000 (EUR 805) per year.	• Pensioners & acute care allowance (*Eläkkeensaajien Hoitotuki*): Payable to compensate for costs arising from home care or other special expenses caused by illness or injury. • Pensioners & acute housing allowance (*Eläkkeensaajien Asumistuki*). • Disability allowance (*Vammaistuki*) for non-pensioners: for 16-64 year old persons who are not in receipt of a pension but whose healthis weakened through illness or injury to compensate for hardship, necessary services etc. • Dietary grant EUR 21 per month, compensates celiacs for some of the additional cost of gluten-free nutrition. • Cash rehabilitation benefit/subsidy = time-limited disability pension (*Kuntoutustuki*) or rehabilitation allowance (*Kuntoutusraha*).	• Free travel. recipients may also qualify for fuel allowance, electricity allowance, T.V. licence and telephone rental allowance. • Carer's allowance (since 1990), carer's benefit scheme (since 2000), people caring on a fulltime basis for invalidity pensioners.	Wajong (*Wet Arbeidsongeschiktheidsvoorziening Jonggehandicapten*), Disablement Assistance for Handicapped Young Persons. The basis for this benefit is the statutory gross minimum (youth) wage per month excluding holiday allowance, divided by 21.
Taxation of benefits	Pensions are subject to taxation. General taxation rules. No special relief for pensions.	Pensions taxed as other earnings. Small pensions are entitled to a special pension deduction. If the income consists of national pension only, no income tax is paid. Disability allowance, Pensioners & acute care allowance and Pensioners & acute housing allowance are not taxed. Amounts of full pension deduction for pension income/year: • Local taxes: Single person EUR 6 950; married person EUR 5 960. • Government taxes: EUR 1 460 for all. When pension is higher than the full pension deduction amount, the deduction is reduced by 70% of the exceeding amount. No deduction when pension is higher than: • Local taxes: Single person EUR 16 877; married person EUR 14 473. The amount of pension deduction cannot exceed the amount of pension income. • Government taxes: EUR 3 545.	IP: pensions (including supplements for adult and child dependants) are subject to taxation, without any special relief for pensions. DA: not taxable. IB: taxed after six weeks payment in any tax year (including supplement for adult dependants but excluding supplements for child dependants).	Pensions are subject to taxation. General taxation rules.

Table 5.A1.1. **Main characteristics of disability benefit and taxation systems, as at 1 July 2006** *(cont.)*

	DENMARK	FINLAND	IRELAND	NETHERLANDS
Social security contributions	Disability pension: no social security contributions. Waiting allowance: contributions to the supplementary pension scheme (ATP).	Sickness insurance premium for pensioners is 1.5% of taxable income. No other contributions.	No social security contributions.	WIA/WAO/Wajong: social insurance contributions for the General Surviving Relatives Act (ANW), the General Exceptional Medical Expenses Act (AWBZ), the General Old-Age Pensions Act (AOW) and the Health Insurance Act (ZVW). The contributions deducted for health have to be refunded by the body that administers the payment of the pension. Furthermore from the WAO-benefit contributions for the Unemployment Benefit Act (WW) are deducted and from Wajong a contribution that equals the WW-contribution.
Accumulation of benefits with earnings	Accumulation possible, but with benefit reduction.	• National pension (*Kansaneläke*): pension withdrawn if the take up of work similar to former activity. The pension can be suspended for 6-24 months if the pensioner finds employment. • Statutory earnings-related pension (*Työeläke*): within certain limits, the pensioner is allowed to work while receiving the pension. In the case of full disability pension, if earnings are 40% but not 60% of the pensionable salary, the full disability pension is changed to a Partial disability pension. If earnings exceed 60% of the pensionable salary, the pension is withdrawn.	IP: accumulation with earnings from work is not possible. Invalidity pension requires permanent full incapacity. DA: weekly income disregard of EUR 120. 50% of earnings between EUR 120 and EUR 350 will also be disregarded.	If a beneficiary finds suitable employment, the disablement category, in which she/he has been classed, may change, depending on what he/she earns doing this work. This means that the rate of benefit may be revised.
Tax credits	No special relief for pensions.		No special relief for pensions.	Tax benefits to supplement income or alleviate the burden of the costs for health care (special costs of not insured care (*e.g.* dental care), costs of insurance benefits, diet, transport, facilities, etc.). Tax deductions for a person having excessive health care costs. Specific tax deduction for people on Wajong benefits.
Combination with other benefits	Accumulation is not possible concerning benefits targeted at covering the same maintenance need.	Only one pension from National Pension Scheme may be paid. If combined with a statutory earnings-related pensionor employment injuries & acute or occupational diseases & acute pension, the national pension is reduced. The statutory earnings-related pension is secondary to the employment accident insurance benefit, and only the part of earnings-related pension in excess of the compensation under employment accident insurance is payable. The same applies to compensations under the motor liability insurance. The disability pension (*Työkyvyttömyyseläke*) is not usually granted until the sickness benefit has been paid for the maximum period. This does not apply to the individual early retirement pension.	IP is not payable with any pension under the social welfare acts with the exception of Disablement Benefit (Occupational Injury Benefit). DA is not payable with any pension under the social welfare acts with the exception of Disablement Benefit (Occupational Injury Benefit). One-Parent Family Payment (single parents) claimants may accumulate their One-Parent Family Payment with half the personal rate of IB. IP, DA and IB claimants are eligible for Back-to-Work Allowance and Back-to-Education Allowance schemes.	If disability benefits, together with any unemployment benefits, are lower than the social minimum, a supplement can be claimed under the Supplementary Benefit Act (*Toeslagenwet*, TW) (means tested).

Source: OECD (2007b), MISSOC and information provided by national authorities.

Figure 5.A1.1. **Net replacement rates for disability benefits, unemployment benefits and social assistance, couple households, 2006**[a, b]



a) Net replacement rates: ratio of household net income after becoming inactive and receiving disability benefit or unemployment benefit or social assistance to household net income when earning 50-200% of average earnings. Estimates refer to a 40-year-old person with an earnings history of 22 years at average earnings. Percentage of average earnings refers to pre-disability earnings of the first earner.

b) DA = disability allowance; DP = disability pension; IB = illness benefit; IP = invalidity pension; SA = social assistance; UB = unemployment benefit; WB = waiting benefit; WGA = initial disability benefit in the Netherlands; WGA follow-on = subsequent disability benefit in the Netherlands.

c) WGA: person assumed to have 79% work incapacity, without receiving top-up social assistance payments.

Source: Special module of OECD tax/benefit model. Information provided by national authorities.

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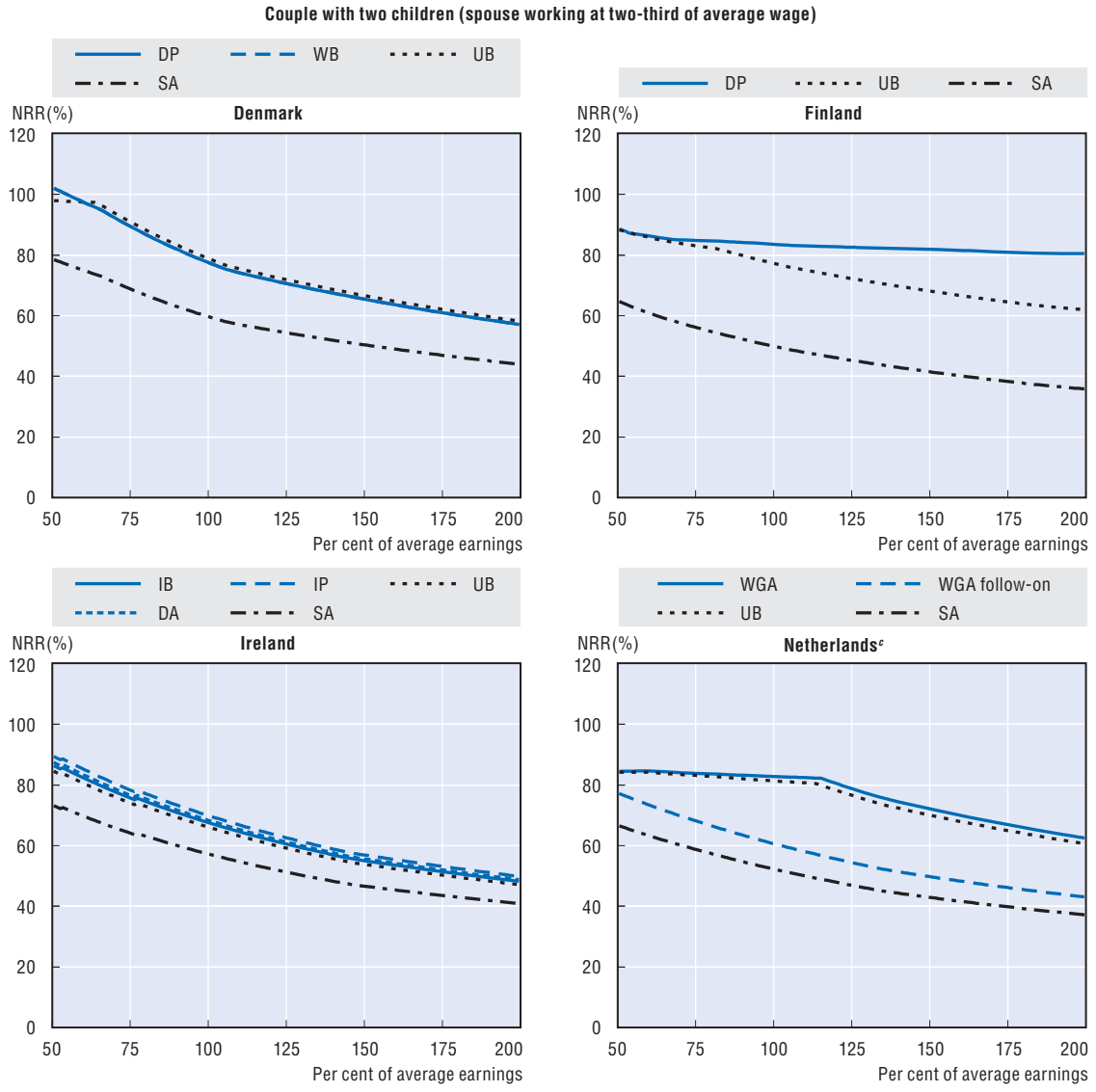
Figure 5.A1.1. **Net replacement rates for disability benefits, unemployment benefits and social assistance, couple households, 2006**[a, b] *(cont.)*



a) Net replacement rates: ratio of household net income after becoming inactive and receiving disability benefit or unemployment benefit or social assistance to household net income when earning 50-200% of average earnings. Estimates refer to a 40-year-old person with an earnings history of 22 years at average earnings. Percentage of average earnings refers to pre-disability earnings of the first earner.

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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).

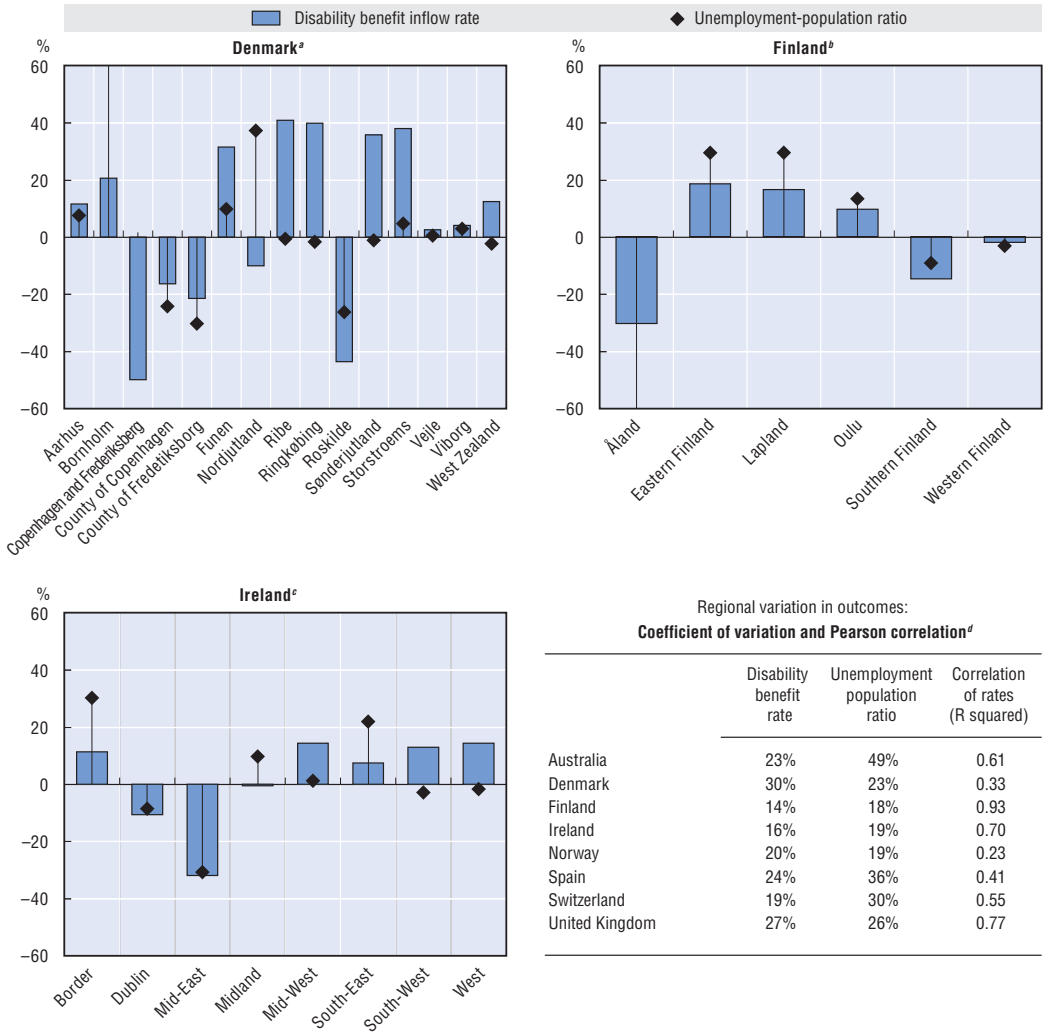
The table in Figure 6.1 shows that regional disparities in disability benefit rates are much larger in Denmark, the only country in which benefit decisions are made on the municipal level, than they are in Finland and Ireland. In six of the fifteen Danish regions is the disability benefit inflow rate 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

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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Sickness, Disability and Work: Breaking the Barriers

VOL. 3: DENMARK, FINLAND, IRELAND AND THE NETHERLANDS

Too many workers leave the labour market permanently owing to health problems, and yet too many people with reduced work capacity are denied the opportunity to work. This is a social and economic tragedy common to virtually all OECD countries, and an apparent paradox that needs explaining. Why is it that the average health status is improving, yet a persistently large number of people of working age leave the workforce to rely on long-term sickness and disability benefits?

This third report in the OECD series *Sickness, Disability and Work* explores the possible factors behind this paradox. It looks specifically at the cases of Denmark, Finland, Ireland and the Netherlands, and highlights the roles of institutions and policies. A range of reform recommendations is put forward to deal with specific challenges facing the four countries.

Experiences in the four countries offer some lessons on the importance of financial incentives for the main actors: private and public institutions (including public employment services, social insurance institutions and municipalities), employers, and workers. Good incentives will help to achieve the necessary shift in mentality, from providing insurance to activation, to promote better co-operation across actors, and to foster reform and system implementation in line with policy intentions. This should improve outcomes.

Despite a range of good-practice elements in this regard, in all four countries more can be done to avoid the flow onto benefits and to move benefit recipients back to employment. Many people with health problems or reduced work capacity can work, and want to do so. Helping those people is potentially a true "win-win" policy: it helps them avoid exclusion and have higher incomes, while raising the prospect of higher economic output in the long term.

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