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Current Trends in Disability Pensions in Europe

Proceedings from a seminar held in Helsinki on 8 th April 2003

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FOREWORD

In recent years there has been a growing interest in Finland in the disability pension schemes of other European countries. The Finnish Centre for Pensions has experienced this as a growing demand for information on foreign schemes. This gave us the idea to invite foreign specialists to tell us about the trends of disability pensions in their countries. The seminar on Current Trends in Disability Pensions in Europe took place in Helsinki on 8th April 2003. Close to a hundred Finnish and foreign experts from the fields of disability administration and research participated in the seminar.

This report contains the contributions presented at the seminar. We were fortunate to have excellent speakers from five different countries. Christopher Prinz presented a recent comparative study on disability policies in the OECD countries. The report searches for new policy orientations aiming at transforming disability into ability. Peter Wright described the recent changes in the UK from a historical point of view. Philip de Jong gave us an economic-policy outlook of the developments of disability pensions in the Netherlands. Catarina Svärd described the new disability pension system in Sweden from an administrative point of view. Timo Aro presented the Finnish view of work ability and functional capacity.

Our thanks are due to the speakers of the seminar for their presentations as well as for their contributions to this publication. We also like to thank Anja Kallio for the technical editing of the report and Janina Gröndahl and Maria Lindholm for editing the English language.

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OPENING REMARKS OF THE DEMOGRAPHIC, ECONOMIC AND LABOUR MARKET CONTEXTS OF DISABILITY PENSIONS

Uusitalo Hannu

Pension policy in Europe is in transition. This is not only true in the European Union Member States but also in the Central and East European countries, where the driving forces of change are partly different. In the EU countries, the major causes and motivations for reform are well known. The European population is ageing. Dependency ratios, that is the number of people over 65 in relation to the number of people in the economically active age group, are forecast to increase, although the pace and magnitude of this increase varies across countries. The growth in pension expenditure will accelerate, and the financing of pensions in a sustainable way has become a major pension policy issue. At the same time, the new challenges of providing pensions for atypical (part-time, temporary and self-employed workers) and mobile workers require new solutions. In the labour market, most European countries are now plagued by unemployment, but there is a growing concern that we may face a shortage of labour in coming decades.

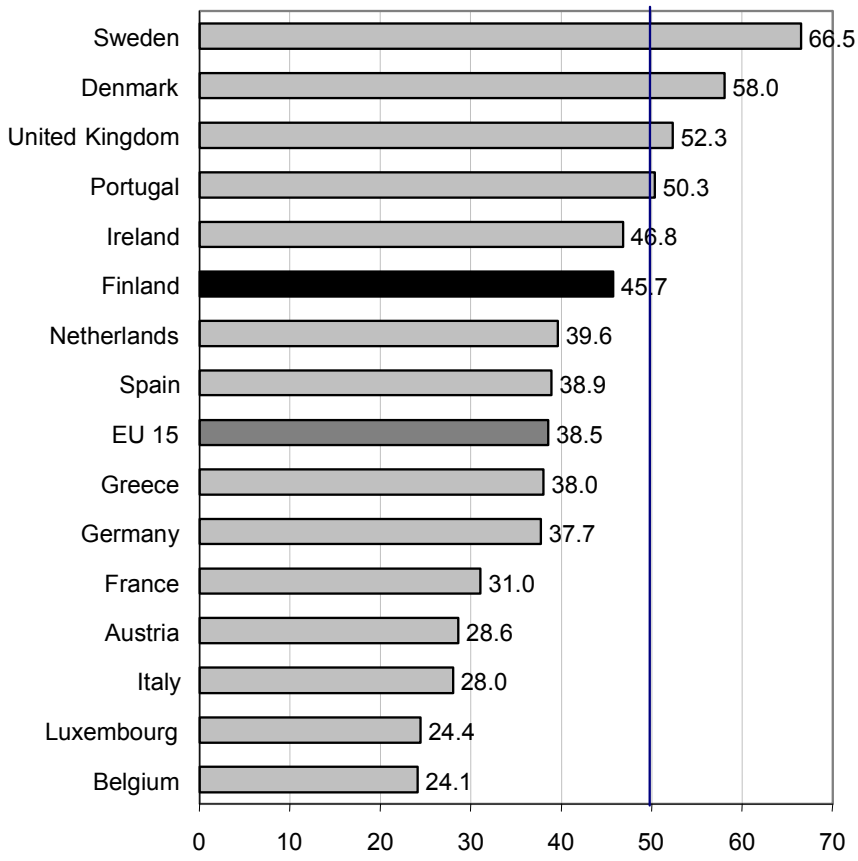
Although pension reforms are decided and carried out nationally, international impulses and pressures, such as globalisation and intensified competition, are more important than ever. At the same time, the EU has assumed the role of facilitator of pension reforms by its open method of coordination. This method has recently been applied to pension policies along with some other policy areas, such as social exclusion and health care, and the coordination will continue in the future. In this process, the EU has agreed on eleven common objectives for national pension policies under the three headings: safeguarding the capacity of the systems to meet their social objectives, maintaining their financial sustainability, and meeting changing societal needs. In the long run, the open method of coordination may prove to be more significant than most of us assumed when this process started.

In many countries, disability pensions are an important and sometimes a major route to early retirement. When pension reforms are on the political agenda, so are disability pensions. Therefore, it is only natural that the interest in disability pensions and their changes in different countries have increased considerably during recent years, in Europe in general as well as here in Finland. In Finland, the Parliament has recently passed legislation on a major reform of the statutory earnings-related pensions, which comes into effect in 2005. An important part of this reform relates to early retirement schemes. A number of EU countries (such as Denmark, Germany, the Netherlands, Greece, Luxembourg, Austria, Sweden, and the United Kingdom) have reviewed, or are in the process of reviewing, their disability pension schemes with a view to making the conditions for granting a disability pension stricter, strengthening rehabilitation measures, and offering suitable alternative work instead of granting a pension.

Labour force participation of older workers

Raising employment levels is one of the major means that the EU has outlined in order to increase the sustainability of pension systems. The Lisbon and Stockholm European Councils have set an ambitious employment goal of raising the older workers' (55-64) employment rate to 50 per cent from its current level of 38.5 per cent. The variation between the Member States is considerable. Figure 1 shows that in Sweden, the older workers' employment rate is at its own level, two-thirds of the Swedes in this age group are employed (although very often off work because of illness). At the other end, we find Belgium and Luxembourg where only one out of four in this age range is employed. Finland takes the sixth place, clearly above the EU average, but below the Lisbon and Stockholm targets.

This variation is largely due to differences in the employment rates of women. Among men, national variation is smaller. While it is clear that disability pensions are not in a major role in raising the employment rates of older workers, they are one factor towards which attention should be directed.

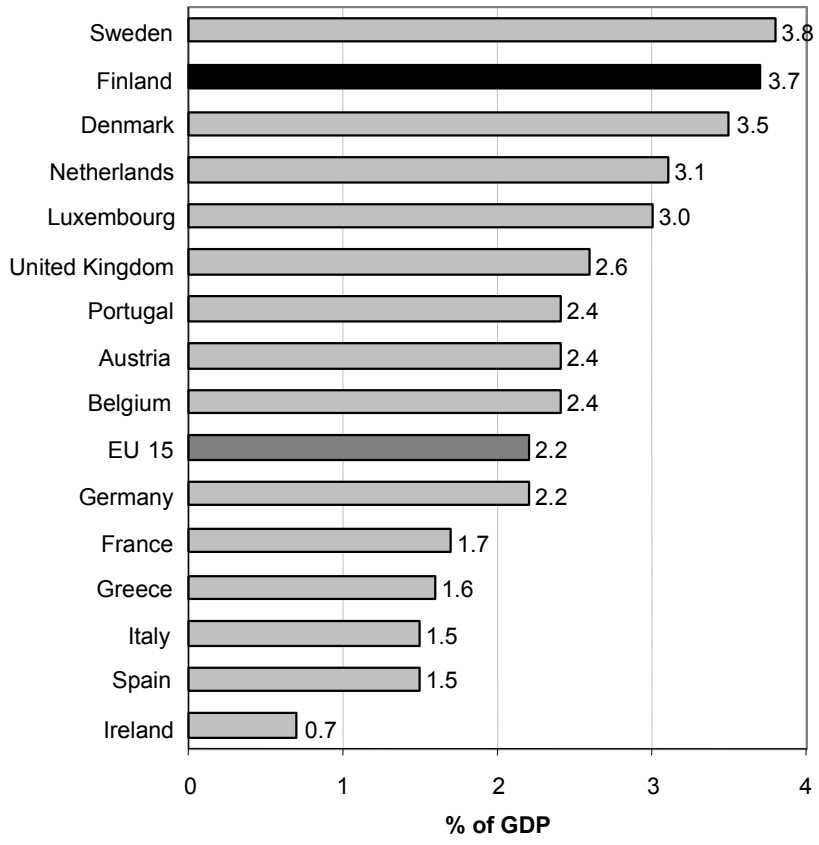


Source: Joint report by the Commission and the Council on Adequate and Sustainable Pensions, 2003.

Figure 1. Older workers' (55-64) employment rates in the EU countries, 2001, %.

Disability expenditure

Countries differ greatly as regards their disability policies. There is also considerable variation as regards public disability expenditure. The OECD study carried out by Christopher Prinz displayed such variation (Transforming Disability 2003, 17), but because Finland was not included in the OECD study, we use the EU statistics to illustrate these differences. Figure 2 shows disability expenditure as a percentage of GDP in 1999.



Source: Social Protection in Europe 2001. European Commission 2002.

Figure 2. Disability expenditure, % of GDP, 1999.

The data in Figure 2 are based on the European system of integrated social protection statistics (Esspros), provided by Eurostat. Disability expenditure includes income maintenance and support in cash or kind (except health care) for people with physical or mental disabilities who are unable to engage in economic and social activities. It also includes disability pensions, and the provision of goods and services (other than medical care) to the disabled. There are problems of comparability, but at least some provisional conclusions can be made.

Disability expenditure as a proportion of GDP varies from less than one per cent of GDP in Ireland to nearly four per cent in Sweden. The proportion of Finland's GDP spent on disability programmes is the second highest in the EU. The Nordic countries are heavy spenders, while the Southern European countries[1] and Ireland are thriftier in this spending. In any case, disability expenditure accounts for a significant proportion of the national income, especially here in the North, and therefore – in addition to employment – disability issues deserve attention in social and economic policies.

The Finnish pension reform 2005

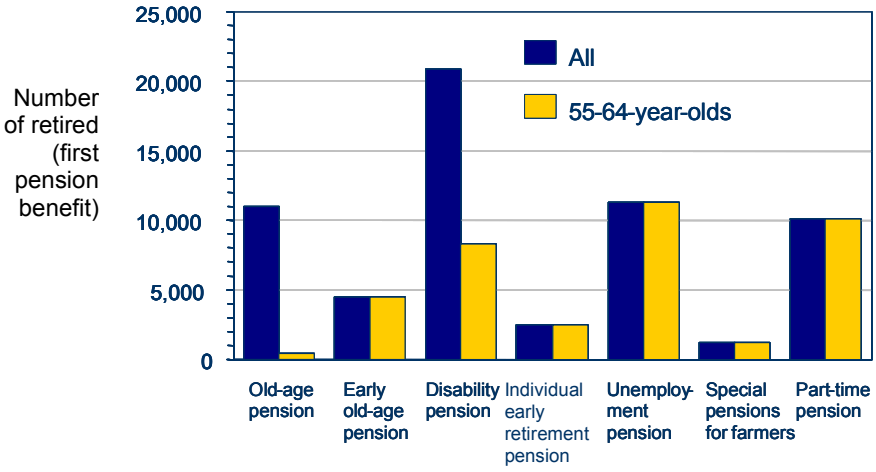
The legislated reform of the private-sector pensions in Finland will have consequences for the disability pensions. Two types of early retirement pensions will be abolished: the individual early retirement pension – a special disability pension for ageing employees – and the unemployment pension. As a partial compensation for the abolition of the individual early retirement pension, it has been agreed that in the assessment of work ability, special attention will be paid to "the vocational character of the disability in such cases where the work career is long and weariness and fatigue due to work together with ageing make continued work immoderate".

Furthermore, the age limit for the part-time pension will be raised to 58 years in 2003 for persons born in 1947 or later, and the old-age

1 Portugal is an exception, but this may be due to the fact that disability expenditure includes pensions paid to the disabled who have reached retirement age. In other countries, such pensions are included in the pension expenditure.

pension accrual will decrease during part-time pension. Instead of the current four routes to early retirement, there will be only two: the disability pension and the part-time pension. As a preventive measure, a statutory right to vocational rehabilitation is established in cases where illness, defect or injury poses a threat to work ability within the next five years.

Early retirement pensions are the major route to retirement in Finland. In the private sector, about 61,500 employees retired in 2002, and 11,000 of these retired on an ordinary old-age pension. It may be a surprise to many that the disability pension is the most common first pension benefit in Finland. For 21,000 private-sector employees, the disability pension was the first pension benefit in 2002. The unemployment pension is also more common than the ordinary old-age pension as a first pension benefit: over 11,000 private-sector employees retired on an unemployment pension in 2002. Among the 55-64-year-olds, the unemployment pension is the most common route of retirement, and the disability pension comes next (Figure 3).

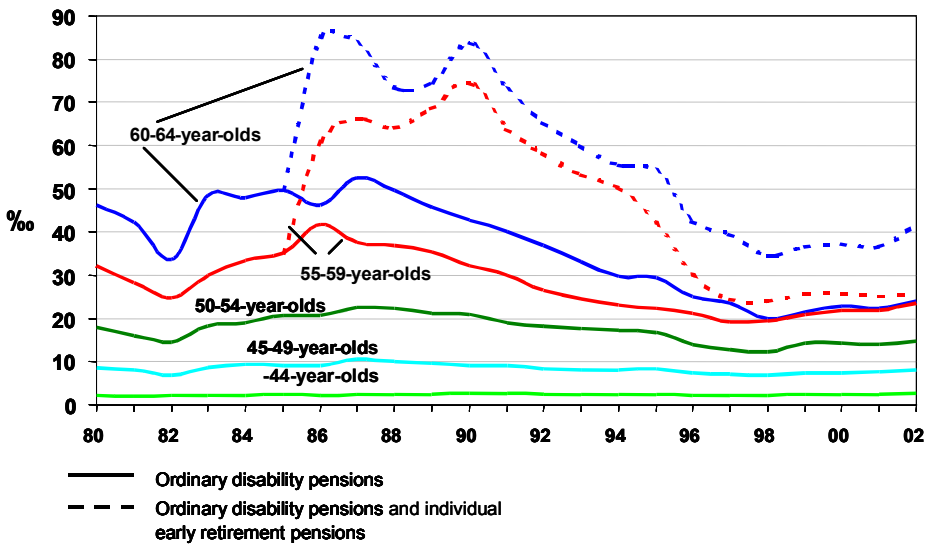


Source: Finnish Centre for Pensions.

Figure 3. The number of retired employees (first pension benefit) in the private sector according to pension type, 2002.

It should be noted that the incidence of new disability pensions, that is the proportion of employees who have been granted a disability pension in

proportion to the employees in the same age group, has increased in Finland in all age groups after 1998. The strong declining trend, which started in the latter part of the 1980s, has turned into growth (Figure 4). Although this increase is quite modest, the pension reform will further increase pressure towards disability pensions.



Source: Finnish Centre for Pensions.

Figure 4. Incidence of new disability pensions in the private sector, 1980-2002.

The closure of unemployment pension and individual early retirement pension schemes (and increasing the earliest age at which the early old-age pension can be taken from 60 to 62) will probably increase the number of persons retiring on disability pensions, and also otherwise increase pressure towards disability pension schemes. In a report published last year, it was estimated that a large majority of those employees between 60 and 62 years of age, who had taken an individual early retirement pension in the current scheme, would be found drawing a disability pension in the new scheme. In contrast, most 58- and 59-year-old employees, who had taken an individual early retirement pension in

the current scheme, are expected to continue in work until the age of 60 (Gould 2002). Similarly, the abolition of unemployment pensions will partly increase pressure towards disability pensions, while it also improves the rate of employment among the ageing labour force (Rantala 2002). Not surprisingly, similar pressures towards disability pension schemes are increased by the changes in the part-time pension scheme, although the main effect is assumed to be continuation in full-time work (Takala 2002).

In brief, since the demographic, labour market, economic and financial contexts of disability pensions are changing, there are good reasons to focuse on disability pensions. This is why the Finnish Centre for Pensions decided to arrange this seminar on disability pensions.

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DISABILITY POLICY SYSTEMS IN OECD COUNTRIES IN NEED OF REFORM

Christopher Prinz

Introduction

How the OECD countries can reconcile the twin, but potentially contradictory, goals of disability policy has yet to be resolved. One goal is to ensure that disabled citizens *are not excluded from society*: that they are encouraged and empowered to participate as fully as possible in economic and social life, and in particular to engage in gainful employment, and that they are not ousted from the labour market too easily and too early. The other goal is to ensure that those who are disabled or who become disabled *have income security*: that they are not denied the means to live decently because of disabilities which restrict their earning potential.

The OECD has recently completed a systematic analysis of a wide array of labour market and social protection programmes aimed at people with disabilities. By analysing the relationship between policies and outcomes across twenty OECD countries, it gives the reader a better understanding of the dilemmas of disability policy and of successful policy elements or packages.[1] The study concludes that a promising new disability policy approach should move closer to the philosophy of unemployment programmes by:

- emphasising activation;
- promoting tailored early intervention;
- removing disincentives to work;
- introducing a culture of mutual obligations; and,
- involving employers.

1 The following twenty countries have participated in this comparative review of working-age disability policies and outcomes: Australia, Austria, Belgium, Canada, Denmark, France, Germany, Italy, Korea, Mexico, the Netherlands, Norway, Poland, Portugal, Spain, Sweden, Switzerland, Turkey, the United Kingdom and the United States.

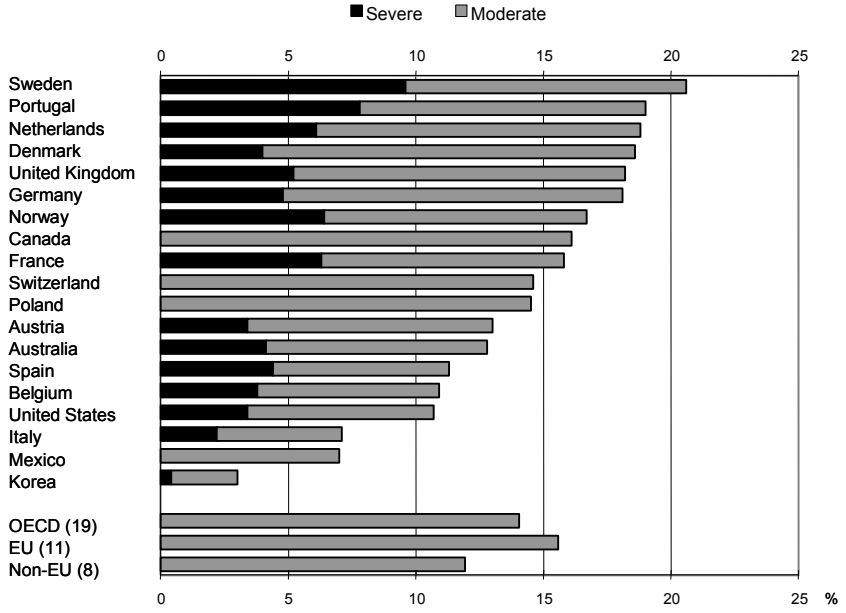
The study finds that many countries' policies already include some elements that are important components in such a new approach.

In the following, the main empirical and analytical findings and the key policy conclusions of the recent OECD report "Transforming Disability into Ability – Policies to Promote Work and Income Security for Disabled People" are highlighted.

Empirical evidence

Working-age disability policies target a large and heterogeneous group (Figure 1). One-third of this group has severe disabilities, and people with congenital disabilities are a small minority. The diversity of this group is at the root of most of the policy challenges that face policy makers attempting to improve the living conditions of disabled people.

Disability prevalence, by severity of disability, as a percentage of 20-64 population, late 1990s

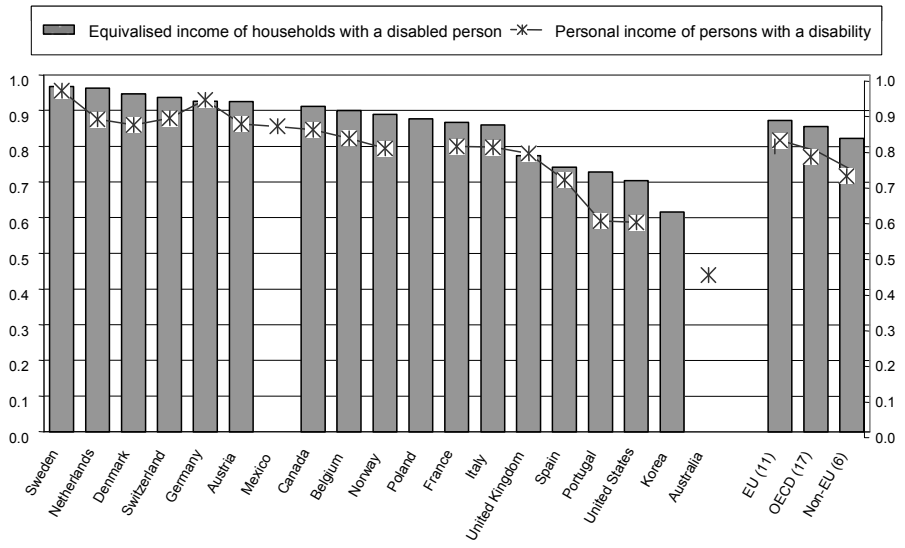


Note: Sum of "Severe" and "Moderate" for Canada, Mexico, Poland, Switzerland, and unweighted averages.
Source: OECD (2003), "Transforming Disability into Ability", Paris.

Figure 1. Average disability prevalence of 14 %, of which one-third are severely disabled.

Income security *is* high in many OECD countries: the income levels of households containing disabled people are generally broadly similar to that of the population as a whole (Figure 2). The relative economic well-being of households is correlated with the structure of the disability benefit system and the benefit level paid: countries with individual benefit entitlements for the entire disabled population (*i.e.* full population coverage) and high earnings-related insurance benefits have the highest relative incomes of disabled people, while those with a strong focus on means-tested programmes have the lowest – but public spending on benefits is considerably lower in the latter group.

Relative average income of disabled over non-disabled, for persons and households with a disabled person, late 1990s



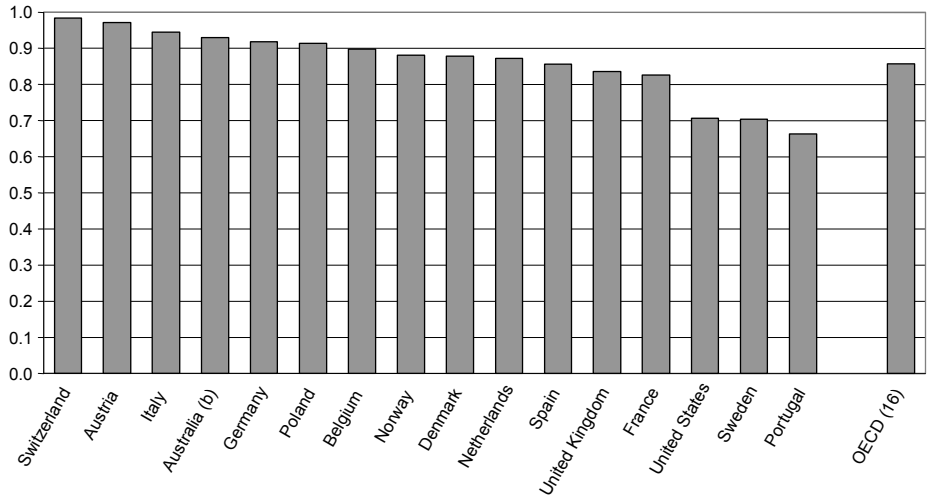
Notes: Countries are ranked in decreasing order of the ratio of equivalised incomes of households with a disabled person over those without. No personal income data for Korea and Poland, and no household income data for Australia and Mexico.
Source: OECD (2003), "Transforming Disability into Ability", Paris.

Figure 2. Successful economic intergration in many but not in all countries.

High income security is to a certain extent explained by high incomes of other household members. *Personal* incomes of disabled people depend primarily on their *work* status. Average work incomes of those disabled

people who have a job are almost as high as average work income of people without disabilities (Figure 3). Disabled people without a job have considerably lower personal financial resources.

Relative average personal[a] income from work of disabled over non-disabled persons who work, late 1990s



Note: Countries are ranked in decreasing order of the ratio.
a) Equivalised household income for Poland and Switzerland.
b) Australia: median income instead of average income.
Source: OECD (2003), "Transforming Disability into Ability", Paris.

Figure 3. Little difference in work incomes between disabled and non-disabled persons.

While employment is crucial for determining personal income resources, the employment rates of working-age disabled persons are rather *low*. This is particularly true for severely disabled people, and also generally for disabled people over age 50 and disabled people with low levels of educational attainment (Table 1). Special employment programmes for people with disabilities play a minor role in determining disabled people's employment rates in general, but in some countries such programmes seem to make an important contribution to the employment of *severely* disabled people.

As employment rates of disabled people are low, benefits also play an important role in guaranteeing income security. *Disability* benefits are the main component of benefit income for working-age people with a disability. Permanent *retirement* benefits are also an important source of

income for a considerable proportion of the working-age disabled population (either early or regular retirement, depending on the country). Unemployment benefits play a much less important role overall, despite relatively high non-employment rates among this group.

Perhaps surprisingly, recognising oneself as severely disabled does *not* necessarily imply receiving a disability benefit and vice versa. Many people on disability benefits do not claim to have a disability, while at the same time, many people who subjectively classify themselves as severely disabled and do not work receive no benefits.

Table 1. Higher relative employment rates for persons of prime working age and with higher educational attainment.

Relative employment rate of disabled over non-disabled persons, by age group, gender and educational attainment, late 1990s

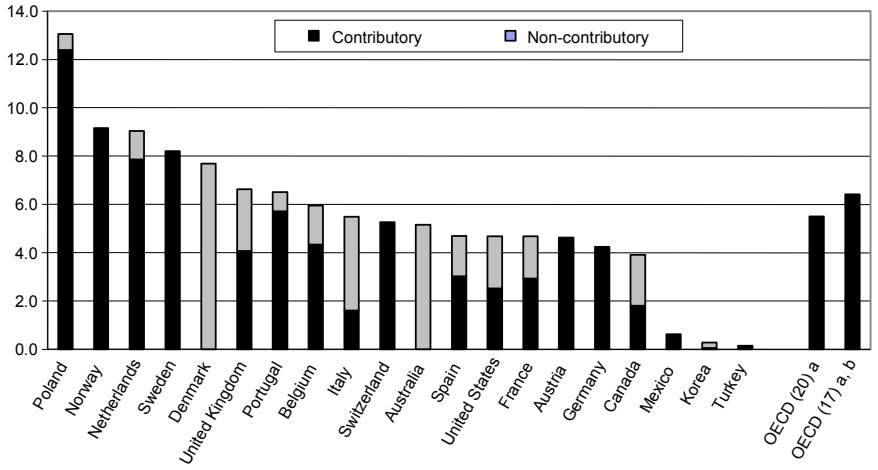
	All	Age group		Gender		Educational attainment	
	Age 20-64	20-49	50-64	Men	Women	Lower	Higher
Australia	0.55	0.66	0.45	0.54	0.56	..	..
Austria	0.60	0.85	0.55	0.60	0.59	0.49	0.67
Belgium	0.54	0.73	0.30	0.59	0.52	0.46	0.64
Canada	0.72	0.80	0.62	0.71	0.73	0.64	0.77
Denmark	0.61	0.74	0.42	0.61	0.62	0.44	0.73
France	0.72	0.83	0.67	0.75	0.69	0.71	0.83
Germany	0.67	0.84	0.65	0.69	0.62	0.57	0.71
Italy	0.60	0.84	0.52	0.59	0.63	0.48	1.02
Korea	0.74	0.82	0.66	0.66	0.69	0.73	0.89
Mexico	0.77	..	..	..	..	..	..
Netherlands	0.60	0.70	0.52	0.61	0.64	0.55	0.63
Norway	0.72	0.81	0.62	..	..	..	..
Poland	0.29	0.32	0.35	..	..	..	..
Portugal	0.59	0.70	0.56	0.59	0.62	0.58	0.85
Spain	0.41	0.53	0.36	0.43	0.37	0.41	0.57
Sweden	0.69	0.78	0.56	0.77	0.64	0.64	0.72
Switzerland	0.79	0.87	0.68	0.84	0.75	..	..
United Kingdom	0.53	0.64	0.42	0.51	0.56	0.41	0.65
United States	0.58	0.66	0.48	0.55	0.61	0.40	0.66
OECD (19)	0.62	..	..	..	..	..	..
OECD (14)[a]	0.61	0.75	0.52	0.62	0.61	0.54	0.74
EU (11)	0.60	0.74	0.50	0.61	0.59	0.52	0.73

.. Data not available.
a) Age, gender or educational attainment not available for Australia, Mexico, Norway, Poland and Switzerland.
Source: OECD (2003), "Transforming Disability into Ability", Paris.

The impact of benefit systems

Disability benefit *recipiency* rates are high in many countries (Figure 4). Nonetheless, the majority of people with disabilities (disabled according to self-assessment) do not report receipt of such benefits. Growth in disability benefit recipiency slowed recently. This is explained by reforms affecting benefit access, which have led to a stabilisation or even a decline in annual rates of benefit *inflow* in most countries, in particular since 1995.[2]

Disability benefit recipiency rates in 1999 by benefit programme, percentage of 20-64 population, late 1990s

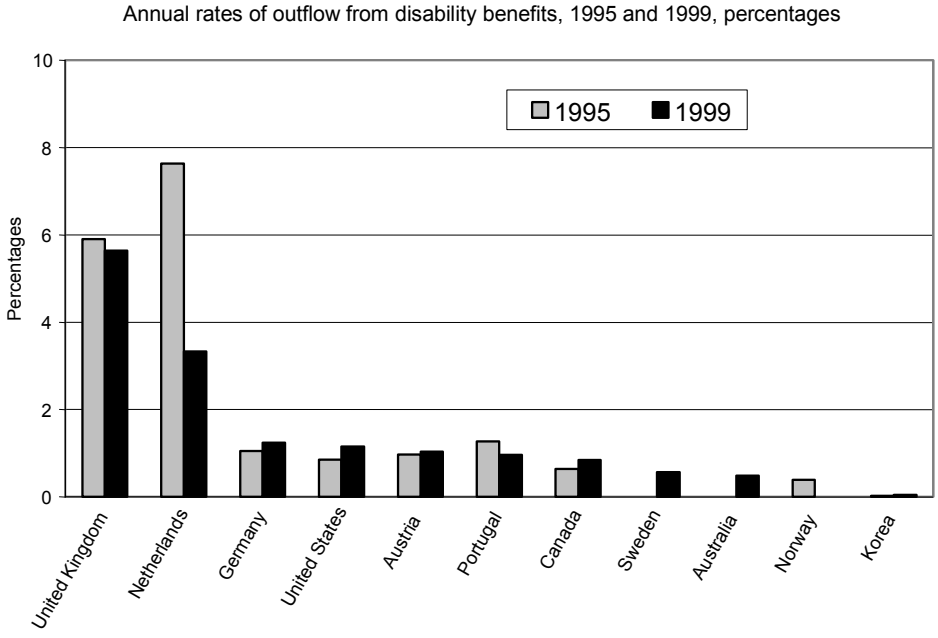


Note: The rate corrected for persons receiving both contributory and non-contributory benefits, exept for Canada (unknown).
a) Contributory and non-contributory benefits.
b) Excluding Mexico, Korea and Turkey.
Source: OECD (2003). "Transforming Disability into Ability", Paris.

Figure 4. Disability benefit recipiency rate concentrated at 5 to 7 %.

2 In this study, the term (disability) benefit recipiency is used to denote the number of people on disability benefits, while the term (disability) benefit inflow refers to the annual inflow into disability benefits. Disability prevalence, finally, is the share of disabled people in the working-age population.

Outflow from disability benefits is *very* low in virtually all countries, despite considerable cross-country differences in regulations on reviewing entitlements, the availability of partial benefits, work incentives, etc. (Figure 5). This is one reason why disability benefit recipiency rates have been rising. The low outflow partly reflects that regulations on reviewing benefit entitlements are not stringently applied and that there is a low take-up of work incentives.



Note: Countries are ranked in decreasing order of the 1999 rate.
Source: OECD (2003), "Transforming Disability into Ability", Paris.

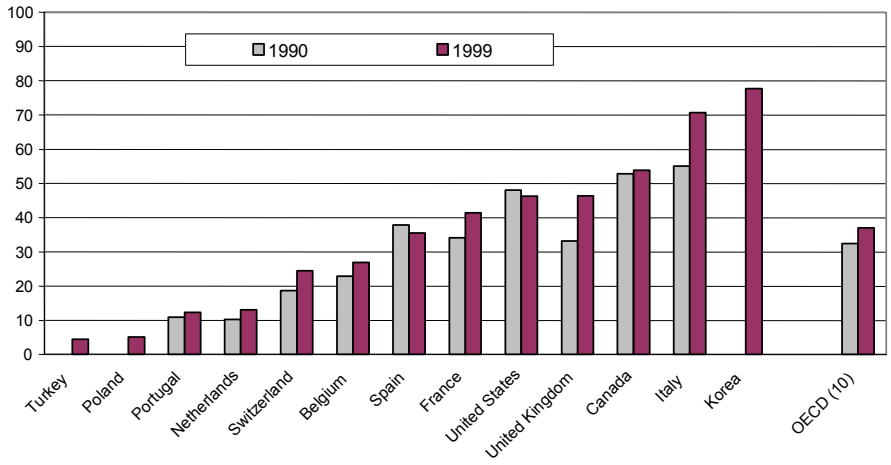
Figure 5. Low outflow rates from disability benefits.

Countries with high benefit levels generally tend to have high recipiency rates. But recently, countries with lower benefit levels have had equally high rates of inflow, and the rates of outflow have also been comparable. Similarly, countries with several grades of benefits for partial disability are among the group with high benefit recipiency rates. In these countries, one in three new awards are for partial disability.

Despite high rates of benefit recipiency, problems of exclusion from disability benefits remain, due partly to not fulfilling insurance require-

ments and partly to failing the (household) means test. In countries with a dual benefit system, *i.e.* insurance benefits for the labour force and means-tested disability benefits for those not qualifying for insurance benefits, the increasing proportion of recipients on means-tested benefits indicates an aggravation of this problem (Figure 6).

Proportion of disability benefit recipients on non-contributory benefit (only countries with a dual benefit system)



Note: Countries are ranked in increasing order of the 1999 share.
Source: OECD (2003), "Transforming Disability into Ability", Paris.

Figure 6. General increase in share of recipients on non-contributory benefits.

Women are generally under-represented on insurance programmes and over-represented on means-tested benefit programmes. This is not the case in some schemes with individual entitlement for the entire disabled population, in which women below age 45 have much higher inflow rates than men (Table 2).

Table 2. Very different gender pattern in inflows.

Ratio of female over male inflow rates in 1999, by age group

	20-34	35-44	45-54	55-59	60-64	20-64
Australia	0,52	0.61	0.87	0.76	0.17	0.60
Austria	0.81	0.79	0.59	0.24	x	0.39
Canada	0.95	1.14	0.98	0.75	0.58	0.88
Denmark	0.78	1.21	1.38	1.18	1.67	1.26
France	0.65	0.92	0.84	0.62	x	0.72
Germany	0.82	0.80	0.72	0.54	0.19	0.51
Italy	0.42	0.51	0.47	0.35	0.10	0.39
Mexico	0.36	0.31	0.26	0.20	0.16	0.20
Netherlands	2.25	1.31	0.96	0.52	0.49	1.19
Norway	1.25	1.57	1.54	1.24	0.98	1.33
Poland	0.56	0.83	0.75	0.15	0.14	0.65
Portugal	0.79	0.94	0.90	0.88	0.88	0.95
Sweden	1.40	1.64	1.45	1.20	1.00	1.27
Switzerland	1.01	1.13	1.21	0.98	0.31	0.93
United Kingdom	0.88	0.81	0.74	0.62	x	0.63
United States	0.82	0.88	0.85	0.72	0.56	0.79
OECD (16)	0.89	0.96	0.91	0.68	0.56	0.79
Netherlands (nc)	1.00	0.79	0.72	0.86	0.81	0.90
United Kingdom (nc)	0.72	0.77	0.79	0.70	3.54	0.76
United States (nc)	0.95	1.13	1.12	1.15	1.14	1.12

x Retirement age for either women, or men and women, 60 years.
nc: Non-contributory programme in a dual benefit system.
Source: OECD (2003), “Transforming Disability into Ability”, Paris.

Mental and psychological problems are responsible for between one-quarter and one-third of the disability benefit recipiency levels, and for a considerable portion of the increase in these levels (Table 3).

Table 3. One in three disability benefits due to mental conditions.

Proportion of mental illness in disability benefit stock and inflow

	Stock			Inflow		
	1990	1995	1999	1990	1995	1999
Australia (nc)	..	..	31	..	..	32
Austria	9	10	..	10	11	17
Canada	11	16	21	10	17	25
France	..	..	..	..	..	27
Germany	..	..	..	17	23	28
Netherlands	27	31	30	30	26	33
non-contritutory	36	39	46	63	53	52
Norway	28	29	29	20	23	25
Sweden	24	26	..	16	20	24
Switzerland	34	36	39	..	..	34
United Kingdom	16	17	23	13	18	26
non-contritutory	..	40	37	..	31	35
United States	27	31	31	21	23	22
non-contritutory	53	58	59	41	42	40
OECD (10)	-	-	35	-	-	32

nc: non-contritutory
.. Data not available.
Source: OECD (2003), “Transforming Disability into Ability”, Paris.

Application rates for benefits differ less across countries than do inflow rates. Benefit rejection rates vary considerably between countries, and are highest in countries with the lowest inflows (Table 4). Rates of successful appeal against benefit rejection, which are increasing in several countries, tend to be higher in countries with low rejection rates, indicating considerable differences in assessment procedures.

In a cross-country perspective, there is little evidence that high or increasing unemployment leads to high or increasing levels of disability benefit recipiency, while there is some indication that stricter access to disability benefits results in somewhat higher unemployment levels. There is also no evidence on programme interchangeability between early retirement benefits and disability benefits. On the contrary, countries in which the disability scheme is predominantly used by older workers tend to be countries with large numbers on early retirement programmes.

Table 4. Large differences in benefit rejection rates.

Proportion of rejected benefit applicants and of successful appeals

	Share of rejections among total applications			Share of successful appeals among rejected applicants		
	1990	1995	1999	1990	1995	1999
Australia	..	..	31	..	..	6
Austria	39	44	49	19	14	11
Canada	42	51	55	..	14	11
Denmark	15	13	25	47	64	51
France	..	..	25	..	..	..
Germany	32	34	38	..	..	..
Italy	..	69	68	..	..	..
Korea	30	10	23	1	3	3
Netherlands	21	42	37	41	63	12
Norway	12	17	17	23	25	26
Portugal	..	48	46	..	11	14
Spain	..	..	44	..	..	8
United States	56	52	48	..	..	..
United States (nc)	68	66	64	..	..	..
OECD (13)	..	..	39	..	..	16

.. Data not available.
nc: non-contributory benefits only.
Source: OECD (2003), “Transforming Disability into Ability”, Paris.

Considerable age profiling is apparent in disability benefit programmes. In many countries, disability benefit awards are highly concentrated among people over age 45 (Table 5). This reflects the age pattern of disability prevalence, at least in part. However, taking this age structure into account, some countries turn out to have particularly high rates of benefit inflow among younger disabled people.

Table 5. Persons aged 45 and over dominate the disability benefit rolls.

Proportion of persons aged 45 and over in disability benefit stock and inflow, percentages

	Stock			Inflow		
	1990	1995	1999	1990	1995	1999
Australia (nc)	..	68	67	..	..	61
Austria	91	92	92	89	91	85
Belgium	76	73	72	..	..	..
Canada	88	84	84	80	75	75
Denmark (nc)	88	87	87	85	80	79
France	..	..	..	..	..	85
Germany	94	91	89	91	86	85
Italy	98	97	97	,,	88	88
Korea	34	58	69	..	..	..
Mexico	91	91	91	91	91	91
Netherlands	72	78	75	45	44	46
non-contritutory	17	16	19	..	..	21
Norway	79	79	78	77	72	74
Poland	..	74	78	..	59	64
Portugal	90	91	92	88	87	89
non-contributory	45	35	..	30	16	..
Spain	94	92	91	..	86	84
non-contributory	..	54	52	..	..	..
Sweden	82	72	71	85	78	75
Switzerland	68	67	67	..	..	69
United Kingdom	77	76	75	65	62	60
non-contritutory	49	45	46	..	39	40
United States	71	70	73	65	67	69
non-contritutory	..	59	63	62	63	67
OECD (19)	..	..	76	..	..	70

nc: non-contritutory benefits only.
.. Not available.
Source: OECD (2003), “Transforming Disability into Ability”, Paris.

The impact of employment policies

Even more striking is the age bias in integration programmes. Vocational rehabilitation and training is predominantly offered to people below age 45, thus partly explaining the age bias in the disability benefit programme, but sheltered and supported-type employment programmes also tend to benefit mostly young severely disabled people (Table 6).

Table 6. Few disabled persons aged 45 and over in active programmes.

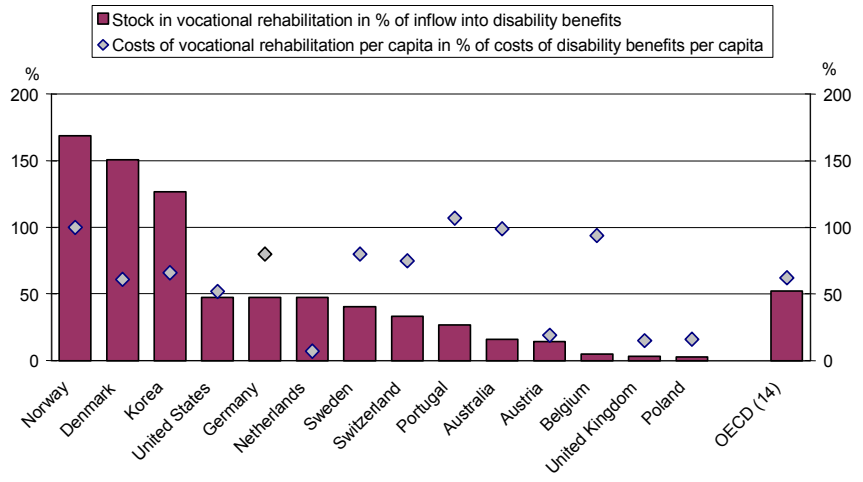
Propotion of persons aged 45 and over among persons in rehabilitation and employment programmers, percentages, 1999

	Vocational rehabilitation	Subsidised employment	Supported employment	Sheltered employment	For comparison: share in disability benefit inflow
Australia	..	..	11	20	61
Austria	14	..	..	24	85
Belgium	..	..	..	19	..
Denmark	20	47	..	..	79
France	..	55	..	..	85
Germany	..	51	..	..	85
Netherlands	32	..	..	..	46
Norway	26	30	11	41	74
Portugal	3	..	..	8	89
Spain	..	24	..	18	84
Switzerland	13	..	..	..	69
United States	25	..	..	..	69

.. Data not available.
Source: OECD (2003), “Transforming Disability into Ability”, Paris.

While the approach to vocational rehabilitation and training differs markedly between countries, this type of intervention is usually used too little, and often initiated too late (Figure 7). More can be done to involve the employers in this process. The average per capita cost for vocational rehabilitation and training is low compared with the average cost of a disability benefit. Provided that such intervention secures permanent employment, investments should pay off within a short period.

Stock in vocational rehabilitation as a ratio of disability benefits inflows[a], percentages, 1999



Note: Countries are ranked in decreasing order of the ratio of vocational rehabilitation over benefit inflow.
a) Contributory disability benefit, exept non-countributory disability scheme for Australia and Denmark.
Source: OECD (2003), "Transforming Disability into Ability", Paris.

Figure 7. More people are awarded a disability benefit than receive vocational rehabilitation services.

Countries differ markedly both in terms of the variety of special employment programmes for disabled people and the costs per participant. Where such programmes are permanent, in particular in sheltered employment, average costs can exceed the costs of per capita disability benefits. The types of employment programmes used have changed very slowly. While *sheltered* employment is increasingly seen as inappropriate and in need of being replaced by supported employment-type initiatives, empirically the protected sector remains as important as ever (Table 7).[3]

3 In this study, supported employment is defined as any form of personal assistance given at a workplace (on-the-job coaching or training) and granted to the employer or the employee. Sheltered employment is defined as employment in a segregated environment, be it in a special workshop or a social firm or in a protected job or segment in the open labour market.

Table 7. Large variation in focus and type of employment programmes.

Persons in special employment programmes for disabled persons per 1000 of the population, 1999

	All employment programmes	Subsidised employment	Supported employment	Sheltered Employment
Australia	3.4	0.2	1.6	1.5
Austria	7.0	3.6	0.7	2.7
Belgium	3.6	0.7	0.0	2.9
Denmark	5.9	3.0	0.6	2.4
France	9.5	6.3	b	3.2
Germany	4.1	0.2	0.6	3.3
Italy	0.8	0.3	b	0.6
Korea	0.3	0.1	0,0	0.2
Netherlands	9.2	b	a	9.2
Norway	7.2	2.4	0.5	4.3
Poland	12.1	2.0	x	10.1
Portugal	0.2	0.1	x	0.1
Spain	1.2	0.6	x	0.6
Sweden	16.2	10.8	0.2	5.2
Switzerland	5.6	x	x	5.6
United Kingdom	1.2	0.5	0.7	a
United States	1.1	b	1.1	A
OECD (17)	5.2	..	..	..

x No such programme up to the present.
a) Significant programme, no data available.
b) Minor programme, no data available.
Source: OECD (2003), “Transforming Disability into Ability”, Paris.

Different employment policy approaches seem to have similar effects. While legislative approaches to employment promotion differ in many respects (rights-based, obligations-based, incentives-based), all approaches tend to benefit people already in employment much more than those who are out of work and looking for a job. Proper sanctions on employers not fulfilling their obligations and adequate instruments to

enforce these sanctions are crucial for an effective employment promotion policy.

Variation in the employment rates of disabled people across participating countries is strongly correlated with variation in the employment rates of *non-disabled* people. This suggests, first, that general labour market forces have a strong impact on the employment of people with disabilities and, second, that general employment-promoting policies also foster the employment of special groups in the labour force, such as people with reduced work ability.

Finally, lessons from general active labour market policy analysis are largely applicable to the situation of people with disabilities. Some of the critique, *e.g.* regarding dead-weight or substitution effects, is less relevant, because of the permanent productivity loss of some groups of disabled people. Generally, it is necessary to balance measures affecting labour supply and labour demand.

Policy conclusions

No single country in this review can be said to have a particularly successful policy for disabled people. Nevertheless, there are differences in outcomes that appear to be related to the policy choices that countries have made. From these observations, the following policy conclusions can be recommended.

Recognise the status of disability independent of the work and income situation. Societies need to change the way they think about disability and those affected by it. The term "disabled" should no longer be equated with "unable to work". Disability should be recognised as a condition but it should be distinct from eligibility for, and receipt of, benefits, just as it should not automatically be treated as an obstacle to work. The disability status, *i.e.* the medical condition and the resulting work ability, should be re-assessed at regular intervals. The recognised disability status should remain unaffected by the type and success of intervention unless a medical review certifies changes.

Introduce a culture of mutual obligations. Most societies readily accept their obligation to make efforts to support and (re)integrate disabled persons, but it is less common to expect disabled persons themselves and, if applicable, their employers to contribute to the process as well. This change of paradigm will require fundamental rethinking and restructuring of the legal and institutional framework of disability policy in many

countries. It will only be effective if it is accompanied by a change in the attitude of all those involved in disability issues. Note that the following three recommendations are to a varying degree related to this new culture of mutual obligations.

Design individual work/benefit packages. Merely looking after the financial needs of disabled people through cash benefits is insufficient; this would still leave many excluded from the labour market and sometimes even from society, more generally. Therefore, each disabled person should be entitled to a "participation package" adapted to individual needs and capacities. This package could contain rehabilitation and vocational training, job search support, work elements from a wide range of forms of employment (regular, part-time, subsidised, sheltered) and benefits in cash or in kind. It could also in, some circumstances, contain activities that are not strictly considered work but contribute to the social integration of the disabled person.

Introduce new obligations for disabled people. Benefit receipt should in principle be conditional on participation in employment, vocational rehabilitation, and other integration measures. Active participation should be the counterpart to benefit receipt. Just as the assisting caseworker has a responsibility to help disabled persons find an occupation that corresponds to their capacity, the disabled person is expected to make an effort to participate in the labour market. Failure to do so should result in benefit sanctions. Any such sanctions would need to be administered with due regard to the basic needs of the disabled person and those of dependent family members. Furthermore, sanctions would not be justified in any case where an appropriate integration strategy had not been devised, or proves impossible to formulate, *e.g.* because of the severity or acuteness of the disability.

Involve employers in the process. Involving employers is crucial to the successful re-integration of disabled persons. Different approaches exist, ranging from moral suasion and anti-discrimination legislation to compulsory employment quotas. The effectiveness of the measures depends on the willingness of employers to help disabled persons stay in or enter work (which can be influenced through incentives aimed at raising labour demand), but also on the possibilities of circumventing legislation or paying the fines imposed for non-compliance.

Promote early intervention. Early intervention can in many cases be the most effective measure against long-term benefit dependence. As soon as a person becomes disabled, a process of tailored vocational intervention should be initiated, where appropriate including, *e.g.* job

search, rehabilitation and/or further training. Where possible, such measures should be launched while the person is in an early stage of a disease or a chronic health problem. Preventive measures at the workplace could even be delinked from being temporarily out of work.

Make cash benefits a flexible policy element. The cash part of the work/benefit package needs to reflect the disabled person's capacity to work, but it also needs to take into account whether the person has actually been able to find a job. Thus, cash benefits would have to be available with sufficient flexibility to take account both of different cases of remaining work ability and of the evolution of an individual's disability status over time. In addition, benefit entitlements should be designed such that the disabled person is not penalised for taking up work.

Reform programme administration. A more individual approach will place a wide range of new demands on disability gatekeepers, *i.e.* the people who administer entitlement for, and arrays of, active and passive interventions offered to a disabled person. Caseworkers will need an extensive knowledge of the range of available benefits and services. More time will be required to assist individuals and follow each case. Implementation of a one-stop approach will help gatekeepers to manage the full menu of available interventions, and promote equal access to all programmes for all people.

Design disability programmes as active programmes. Often, disability benefit systems function as early retirement programmes, providing a route for quasi-permanent exit from the labour market. Emphasising activation and the mutual obligations of both society and the disabled person moves disability policy closer to the underlying logic of unemployment programmes, which expect an active contribution and effort from beneficiaries. Unreformed disability programmes are likely to attract applicants who may find it difficult to comply with the stricter obligations of unemployment schemes. There is a need for a consistent strategy in disability and unemployment policy that extends the culture of mutual obligations to all labour market programmes.

DISABILITY PENSIONS IN GREAT BRITAIN

Peter Wright

The impulse to help fellow human beings unable to fend for themselves because of sickness or disability seems to be an inherent human characteristic. Neanderthal skeletons show that some individuals in the earliest known settlements can only have survived with help from their families or neighbours (Rudgley 1998, 216–7). There is also, however, an equally inbuilt unwillingness to help those whose demands reflect failing to behave as society expects. This distinction is inherent in the mediaeval and renaissance divisions between a 'deserving' or 'impotent' poor, or those poor 'by casualty'; contrasted with the 'undeserving', 'able-bodied' or 'idle' poor, sometimes referred to as 'rogues and vagabonds'. Whilst terminology and approaches have changed, this essential dichotomy has remained at the heart of UK social policy.

Prior to Tudor times, the established Roman Catholic Church supported the poor from tithes (a local tax based on the value of land, crops and herds collected by local rectors). The law of the church (canon law) therefore governed the system, rather than that of the state. Mediaeval canon law never resolved the issue of categorising the poor and the system of relieving them, because of conflicting theological approaches. Almost certainly, individual rectors decided eligibility, doubtless taking account of the views of their parishioners.

First state interventions

The state only stepped in when the church was, for one reason or another, unable to cope. The first state intervention followed the Black Death of 1349. A third of the population died; there were severe labour shortages and resulting wage inflation, and the church itself lost many priests. The government introduced strict controls of wages, prices and contracts of employment (Ziegler 1969). Once the crisis was over, the old system returned.

It fell apart in the sixteenth century when the church (and its tithes) were reformed throughout northern Europe, and nationalised in England. Co-incidental rampant inflation induced economic dislocation and extreme social unrest in both Protestant and Catholic countries. Reform proposals centred on transferring responsibility for relief from the church to local authorities, and reducing costs by ensuring clear differentiation of the two classes of the poor. Tribunals with medical members to assess sickness and disability were first proposed in 1526, in work jointly commissioned by the city of Bruges and the English King Henry VIII (Vives in Salter1926). A series of English reforming Acts culminated in three measures:

- The Poor Law Act of 1597 transferred the power to tax local citizens and relieve poverty from the church to elected local officials (the 'Overseers of the Poor');
- The Statute of Artificers of 1563 re-introduced strict control of wages and regulated work contracts in an attempt to ensure a continuing supply of cheap agricultural labour;
- The Vagrancy Act of 1597 set out those who were to be 'taken, adjudged and deemed Rogues, Vagabonds and Sturdy Beggars' if found begging, and to be 'stripped naked from the middle upwards, and be openly whipped until his or her body be bloody' and then returned to their home parish, where they were to take a job.

Similar developments in Catholic Europe revived debate on whether it was acceptable to classify the poor and restrict any from begging, and the faithful from giving them money. Eventually, a scheme proposed for the city of Ypres was referred to the Sorbonne as the guardians of canon law, and pronounced legal in 1531 provided that:

- Ecclesiastical revenues were not confiscated;
- Private individuals remained free to give to the poor if they wished, and could be encouraged to do so;
- Begging was to be allowed if public funds might be insufficient to relieve poverty.

On this basis, differentiating the treatment of the poor spread throughout Europe, encouraged by a Pragmatic Decree from the Emperor Charles V (Anon, Forma subventionis… 1926 in Salter).

Ensuing centuries saw various minor changes to a system that essentially continued until 1911 in England, and only finally disappeared in 1948. Experience showed that inhuman punishment of the idle poor simply did not work, as St Thomas More had said 'Neither ther is any punishment so horrible, that it can kepe them from stealynge, which have

no other craft, wherby to get their living (Lumby 1885). It was, nevertheless, repeatedly tried so that 'this part of English history look[s] like the history of the savages in America. Almost all severities have been inflicted, except scalping' (Burn 1764, 120). On the other hand, making poor law relief thoroughly unpleasant by making it contingent upon entering workhouses deliberately run to be uncomfortable, could drive some of the poor into work. But, the main development was the recognition of cyclical economic depressions and resulting unemployment as a concomitant of the industrial revolution. Although the division of the idle and impotent poor remained a powerful model, this meant that an idle unemployed could only be defined if there were real opportunities to work, both in general terms and for the individual who fell to be classified.

If Great Britain made no provision for a social security system between 1597 and 1911, individuals increasingly developed co-operative or friendly schemes to cover poverty due to sickness, disability or the costs of funerals by group savings. These particularly developed as Poor Law payments were reduced in the economic dislocation during and after the Napoleonic Wars. Parliament supported them by enacting appropriate base legislation, whilst resolutely refusing to enact any state social security scheme. It was the friendly schemes, together with the German guild system, which inspired Bismarck's social security system in Germany, though it was always more regulated by legislation than in Great Britain.

The National Insurance Act 1911

When Lloyd George introduced his national health insurance scheme in 1911, he deliberately copied the German model. His scheme included general practitioner services free at the time of use, and allowed citizens to choose to register with any local general practitioner who then became 'their doctor'. They would also have a free choice of a number of 'approved societies' (consisting of the old friendly societies and commercial death benefits insurers) to which they would pay contributions set by the state, and who would then pay them at least minimum levels of benefits (also set in legislation) whilst they were sick or disabled. Although the insurer formally decided whether to pay benefit, a 'certificate' from the general practitioner actually established entitlement to benefit. The benefits consisted of a flat-rate "sickness benefit" payable 'whilst rendered incapable of work by some specific disease or by bodily or mental

disablement... commencing from the fourth day after being so rendered incapable of work, and continuing for a period not exceeding twenty-six weeks', and "disablement benefit" (at a lower rate) which then became payable 'so long as rendered incapable of work by the disease or disablement' (National Insurance Act 1911).

The foremost (socialist) social researchers of the time objected that this system would prove financially unsustainable. They argued that experience in Germany, and from the friendly societies showed that free choice of a doctor who would be the benefit gatekeeper would inevitably mean lax benefit control. 'Be the intention what it may, the Government will actually be "paying the people to be ill"! Hence the problem is, not only to prevent the multiplication of illnesses caused by flagrant neglect of hygienic precautions, and how, when illness does occur, to insist on the patient co-operating in his own cure, but also how to protect the funds against malingering in all its conscious and sub-conscious forms' (Webb, Webb 1911). They summed the experience of the friendly societies as showing that:

- Every organisation insuring against sickness or unemployment experienced steadily rising numbers of claims, although the health of their members was improving;
- Cases of malingering were common, so that a whole new branch of medical practice had developed to deal with it;
- Claims control was difficult, and medical certificates from the doctors treating the claimants were often unhelpful, so that some societies required members to see their own salaried doctors (which was bitterly resented by members);
- Claims levels were affected by the organisation of the business; societies who had local branches (where members knew each other and local contributions were locally allocated to local claims after a home visit), had lower claims levels than nationally organised funds.

There is some evidence in the government papers that Lloyd George agreed with this criticism, but felt that the arrangements he had negotiated with the doctors and the friendly societies were, however imperfect, all that was practically and politically feasible (Lloyd George…1966, 364–5).

In fact, the costs of Lloyd George's scheme so exceeded expectations that an investigation into them was organised seven months after its inception. This showed that the costs for men were as predicted, but those for women (who had not been previously covered by the friendly societies) were far greater. This partly reflected women who had previously contin-

ued working despite disability because they had no other realistic choice of moving onto benefits, and partly a tendency for them not to return to work from sickness until they had completed household tasks left undone whilst they were ill. There were also weaknesses in medical certification, and the report recommended that the government should employ doctors to whom difficult cases could be referred for a second opinion (Report of the Departmental Committee… 1914). The First World War delayed implementation until 1920. The doctors of this 'Reference Service' gradually acquired wider duties of inspecting general practitioners and their practices, and became a powerful influence on the development of the specialty.

Disability benefits

The government nationalised sickness and disability benefit payments in 1948. The basic structure was unchanged, but Disablement Benefit was increased to the level of Sickness Benefit, and became payable indefinitely. Invalidity Benefit replaced Disablement Benefit in 1971. Although the basic rate was unchanged, supplementary payments to younger recipients made it more generous for many whose sickness persisted beyond six months. In addition it was both payable and tax free after retirement, up to age 70 for men and 65 for women.

Sickness absence rates rose progressively. Occupational physicians noted what was happening, and investigated the reasons. In general, they found that social issues determined whether employees took time off which was attributed to sickness, rather than true health problems. At first, the government simply observed and analysed the trends. It then decided to try and persuade employers to do more to try and get their sick employees back to work. The responsibility of paying Sickness Benefit was transferred to employers who were required to pay “Statutory Sick Pay” (SSP). Initially, the cost of SSP was refunded by the government. Later re-imbursement was phased out, except for small employers facing unusually heavy costs.

By 1994, the numbers on Invalidity Benefit had doubled, as had its cost. The government investigated the situation, with the following findings:

1. The benefit gateway had loosened through case law. Since 1911, the basic entitlement to benefit had been that it was payable 'whilst rendered incapable of work by some specific disease or by bodily

or mental disablement'. Case law had recognised that this should mean being incapable of one's own job for no longer than about six months. After that time, a looser test of any kind of work should be used. But, developing case law meant any kind of work had become 'work which he (or she) might reasonably be expected to do', so introducing non-medical factors. Finally, further case law required that any kind of work had to be justified by quoting examples of the jobs the individual could be expected to do, so he or she could appeal against the decision.

2. Certificates from treating clinicians remained unreliable, particularly about the ability to do any type of work.
3. Inflow to benefit had remained relatively constant; the increased numbers were due to reduced outflows; once on benefit, recipients tended to remain there.
4. Industrial re-structuring had lead to many low-skilled, middle aged men losing jobs based on physical work, and they had moved onto benefit. They had poor job prospects and social factors largely underpinned their benefit entitlement. For exemple, 60 per cent of benefit recipients had musculo-skeletal problems and 40 per cent back pain, and many benefit recipients with back pain had no discernible disability;
5. There was no evidence that the health of the population was worsening (Figure 1) to explain the increasing numbers on benefits for sickness and disability (and this continues to be the case);

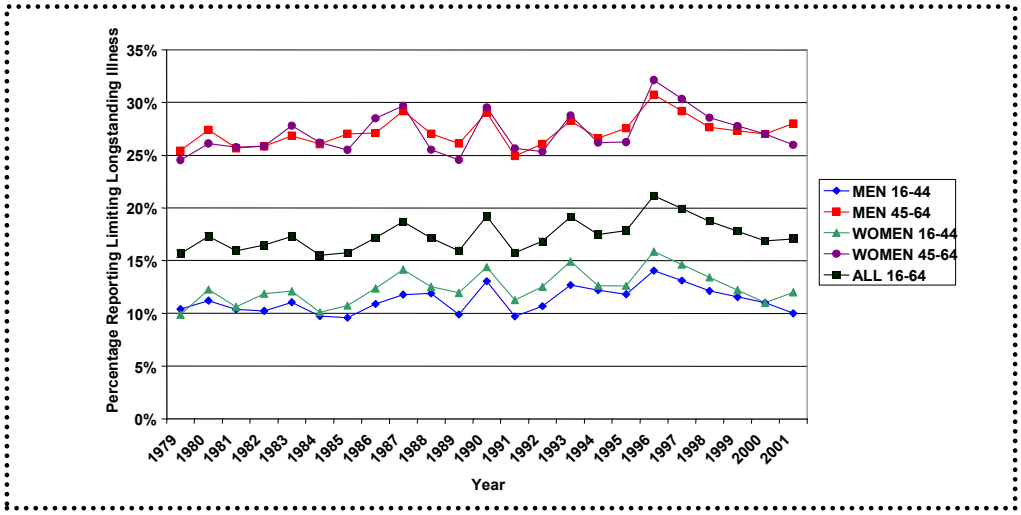


Figure 1. Proportion of People Reporting a Limiting Longstanding Illness.

The All-Work Test

The response was to introduce a new Incapacity Benefit from 1995, replacing Invalidity Benefit. It has the following features. It applies from the beginning of the second six months of absence, when the ability to do any form of work becomes the formal test. Although information is obtained from treating clinicians, any medical statement or certificate they provide is no longer accepted as evidence of incapacity. A social security doctor applies a test instead. The test considers medical factors only, in the form of disabilities and abilities; non-medical social factors are not considered. The benefit is considerably less generous and no longer extends over the age of 65 years.

A formal test "The All-Work Test" (AWT) replaced the opinion of the treating clinician. Designed with the help of a panel of 80 independent experts[1], the requirements set out for the new test were that it should be medically based; clear and simple; fair, objective, and readily understandable; devised to reduce the role of GPs; and arranged to allow expert consideration of the medical factors and evidence.

The resulting AWT defined 14 physical and sensory areas relevant to the issue of capacity to work (Table 1). Within each of these categories AWT defined a list of 'descriptors' giving an ascending scale of ability/disability. It assigned a numerical score to each descriptor within its category which related to similar scores in other categories (Table 2).

Table 1. AWT: 14 physical/sensory functional areas.

Five lower limb; rising from sitting, standing, walking, walking up stairs, bending and kneeling
One trunk; sitting in a chair without arms
Three upper limb; reaching, lifting and carrying, manual dexterity
Three sensory; speech, hearing, vision
Two 'loss of control'; seizures, incontinence

1 Consisting of people with disabilities; professionals expert in assessing disability; occupational physicians; general practitioners; representatives of organisations for people with disabilities; and social security doctors.

Table 2. AWT: Example of scores.

Rising from sitting - cannot rise from sitting to standing (15 points) - cannot rise from sitting to standing without holding on to something (7 points) - sometimes cannot rise from sitting to standing without holding on to something (3 points) - no problems with rising from sitting (0 points)

AWT defined four areas of mental health relevant to capacity for work; daily living, completion of tasks, coping with pressure, and interaction with other people. The test set a series of descriptions of mental health with yes/no answers and point scores for each answer reflecting the capacity for work. It provided a formula for summing the scores to give a final figure, and a scale to determine whether a score implied that it would not be reasonable to expect someone to seek work. Furthermore, AWT defined a series of conditions which implied that someone was so clearly incapacitated that the test should not be applied ("exemptions") (for example, that they had a severe mental health problem requiring hospital care, were tetraplegic or registered blind). It also defined a list of situations where return to work was unreasonable ("non-functional descriptors") (for example, that they were due to have a major operation or therapeutic procedure within the next 3 months). Finally, AWT defined the evidence required to decide that an exemption or non-functional descriptor applied. The new test was applied retrospectively to those who had moved onto Invalidity Benefit after its introduction was announced, and prospectively to new benefit claimants.

The results of retrospective application of the test were relatively poor. Following re-examined recipients (not those over 58 years of age on 13 April 1995 and who had been on benefit since 1 December 1993) showed that half claimed a new benefit within six months, most within three. Those unemployed before claiming Invalidity Benefit were more likely to claim a benefit. Also disallowed claimants were more likely to claim; 40 per cent had a live claim for IB at 12 months. 19 per cent got work immediately, rising to 23 per cent at 12 to 18 months.

The test was far more effective in reducing benefit inflow. Figure 2 shows the effect on the numbers of benefit recipients.

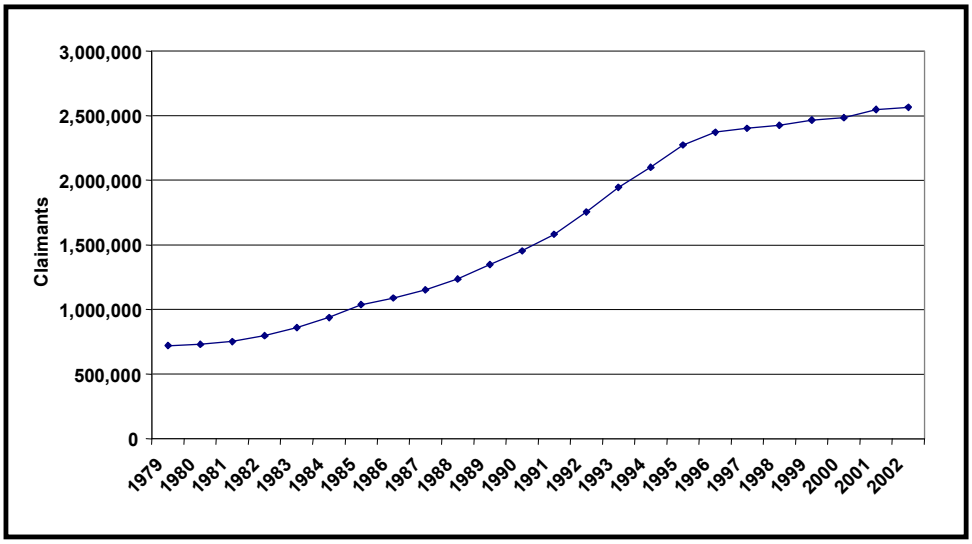


Figure 2. Working Age Claimants of Incapacity-Related Benefits (Excluding IB Short-Term Lower Cases): 1979-2002.

Numbers fell after introduction of the test, but then began to increase again, although at a far slower rate. This trend became apparent just as the UK elected a new Labour government in 1997. It faces an unprecedented and successful economic and labour market situation (Table 3). Therefore any major expansion of the workforce can only come from those currently on sickness and disability benefits, or from immigration.

Table 3. The Labour Government: Economic and labour market situation.

- ILO unemployment rate 1.46 million (5%);
- Claimant unemployed 935,300;
- About 1 million job vacancies;
- 2.9 million on income replacement benefits for sickness and disability; 1.2 million say they would like to work; 400,000 available for work within two weeks.

The government has therefore become extremely active in promoting the return to work of those on sickness and disability benefits. Its main messages are: “Work is the best form of welfare for people of working age”, and “Work for those who can, security for those who cannot”. The fallowing measures are used:

- Increase services to help those without work find a job, and widen conditionality. All benefit recipients of working age to have help to return to work from a personal adviser;
- Strengthen Disability Discrimination Act;
- Make work pay: National Minimum Wage, Employment Tax Credit (tops up low earnings).

In parallel, there have been changes to the AWT. It has been subsumed into the Personal Capability Assessment (PCA). Whereas AWT concentrated on incapacity, PCA focuses on residual ability. It includes advice to the Personal Adviser on any previous work-related problems, personal and work-related capability, work restrictions\limitations, possible workplace adaptation, and help and support back into some from of work.

Other initiatives include the Job Retention and Rehabilitation Pilots. These are a randomised controlled trial, comparing the outcomes for four groups; health or workplace service boosts, or both, and a control group. Subjects are between 6 weeks and 6 months of going off sick. This is an attempt to reach subjects who are on SSP, still have an employer, and might be got back to work as opposed to moving onto benefit. The Incapacity Benefit Pilots will be a trial of healthcare boosts for those first claiming Incapacity Benefit (i.e. at six months after leaving work). They are coupled with mandatory work-focussed interviews with new specially trained advisers.

The views expressed are those of the author and do not necessarily represent those of the Department for Work and Pensions or the government of the United Kingdom.

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NEW DIRECTIONS IN DISABILITY (BENEFIT) POLICY: THE DUTCH EXPERIENCE

Philip R. de Jong

Introduction

This paper reviews the Dutch disability benefit system and some other programmes that are part of a national policy towards persons with disabilities. It starts with a short description of the sickness and disability benefit programmes.[1] Section 3 discusses trends in disability expenditures and beneficiaries in order to illustrate what is at issue. In Section 4 I give an overview of the changes that took place in the last ten years, their efficacy, and proposals that have recently been debated. The conclusion is that Holland is moving from a wayward system to a more balanced one using elements that the OECD suggests in its new publication on disability policy.

The Dutch sickness and disability schemes

Sick pay

When a Dutch worker is unable to perform his or her job because of illness or injury, irrespective of its cause, he or she is entitled to sick pay. Sick pay replaces 70 per cent of gross wage earnings but most collective bargaining agreements between employers and employees stipulate that

1 A broader description of the Dutch system of social welfare programmes can be found in Prinz, 2003.

sickness benefits are supplemented to the level of net earnings. Sick pay ends after 12 months.

As of 1996, the employer is fully responsible for financing sick pay. He may reinsure his sick pay liability with a private insurer but is not obliged to do so. Employers are mandated to contract with a private provider of occupational health services to manage absenteeism. Doctors employed by these occupational health agencies check whether the absence from work is legitimate and give a prognosis concerning work resumption.

Small firms may be unable to offer a commensurate job if an employee is afflicted by a disability that prevents him from doing his old job. In that case a reintegration service organisation should mediate towards placement in a new firm. As of 2003 employers are obliged to subscribe to the services of a private reintegration organisation to help disabled employees for whom no commensurate work is available within the firm.

Disability

Under the Dutch ruling any illness or injury entitles an insured person to a disability benefit after a mandatory waiting period of 12 months. While other OECD countries make a distinction between whether the impairment occurred on the job or elsewhere, only the *consequence* of impairment is relevant for the Dutch disability insurance programme.

Three separate benefit programmes targeting different social groups provide compensation for loss of earning capacity due to long-term or permanent disablement. The first, and by far the biggest, programme covers employees, and awards wage-related benefits. The other two address the self-employed and those handicapped from youth. These provide flat-rate benefits at the social minimum level. Youth handicapped are entitled to a benefit from age 18 onwards. Otherwise, the design and administration of these two programmes are the same as for the wage-related programme.

The degree of disablement is assessed by consideration of the disabled worker's residual earning capacity. Capacity is defined by the earnings flowing from any job commensurate with one's residual capabilities as a per centage of earnings. The degree of disablement is the complement of the residual earning capacity and defines the benefit level. The Disability Insurance programme for employees has seven disability classes. The minimum loss of earning capacity entitling to a benefit is

fifteen per cent. Wage replacement rates range from 14 per cent of covered earnings in the 15 to 25 per cent disablement category to 70 per cent in the 80 to 100 per cent category.

The other two disability schemes – for self-employed and youth handicapped – have six disability categories: they skip the first category so that entitlement starts at a degree of disability of 25 per cent. The wage base here is the minimum wage and so the benefit at full disablement is 70 per cent of the minimum wage.[2]

Partial benefits can be combined with labor earnings up to the level of the pre-disability wage. If recipients of a partial benefit are unable to find gainful employment they are entitled to a partial unemployment benefit. Combination of disability and unemployment benefits never replaces more than 70 per cent of earnings lost.

Wage-related benefits are based on age and earnings. The disability benefit period is cut in two, chronologically linked parts. The first is a short-term wage-related benefit replacing 70 per cent of before-tax earnings. The duration of this wage-related benefit depends on the age at the onset of disablement. It varies from zero for those under age 33 to six years for those whose disability started at aged 58 or beyond. Hence, workers age 58 and older keep their 70 per cent replacement rate until the statutory pension age of 65. For older workers the accrual of pension rights related to one's last job continues after entering the disability rolls. In addition, most pension plans do not require disability beneficiaries to pay pension premiums. Such contract rules discourage re-entry into the labour market by creating a gap in pension accrual rights, and make the disability system an alternative early retirement option.[3]

The second part is a so-called follow-up benefit with a lower income base and, hence, a lower replacement rate with respect to the pre-disability wage. During the follow-up period, the income base for benefit

2 In 2003 the minimum wage equals €16,189.63 per year.

3 Dutch early retirement programmes have no statutory basis; they emerged as an element of collective bargaining agreements between trade unions and employers in 1975. The tremendous growth of early retirement plans since, the expected fiscal pressure of an ageing workforce, and benefits being paid out of pay-as-you-go funds, called for changes in these actuarially unbalanced programmes. An increasing number of these –collectively bargained – plans are now being transformed into capital funded flexible pension schemes with a much closer link between contributions and pension rights. These changes are likely to boost the interest in the disability benefit option.

calculation is the minimum wage *plus* a supplement depending on the age at onset according to the formula: 2.0 per cent ∗ [age at onset – 15]∗[wage – minimum wage]. Age serves as a proxy for work history, or "insurance years", introducing a quasi-pension element into the disability system. Most collective bargaining agreements cover the gap between the lower replacement rates in the follow-up period and the 70 per cent replacement rate during the first period of disablement (including the 'sickness year'). The effective replacement rate when fully disabled, therefore, stays at 70 per cent in most cases.

Disability benefits are capped by a maximum amount of covered earnings which equals about €43,000 per annum (in 2003). This is also the maximum amount of income taxable for disability (and unemployment) insurance.

Trends and Issues

In May 2002 the British weekly Economist commented on the Dutch economy in an opinion article titled "Going Dutch". It wrote: "(...) it is the very need for consensus that has inhibited further reforms to the much-abused and excessively generous disability system, which pays out to a ludicrous one in seven Dutch people of working age." In the eyes of this commentator the Dutch disability experience is a clear illustration of the negative side of the much-praised culture of consensus and tolerance in Holland.

What happened really?

The data collected as part of the OECD disability policy project both confirms and refutes the stereotype of the Dutch disability system given by this quote. According to Table 2.1 of the OECD report Holland is still among the big spenders on disability benefits but it is not the biggest spending country anymore, as it was in 1990. In 1999 broad disability

benefit expenditures were 4.14 per cent of GDP, which is 28 per cent lower than in 1991.[4]

Figure 1 shows the trend in the number of persons receiving a disability benefit as a per centage of the labour force (including disability beneficiaries),[5] and disability benefit expenditures as a per centage of GDP. Disability benefits are here defined in a narrow sense, including both benefits from contributory and non-contributory disability schemes. From a 1985 top of 4.2 per cent of GDP disability benefit expenditures decreased to 2.6 per cent in 2001.

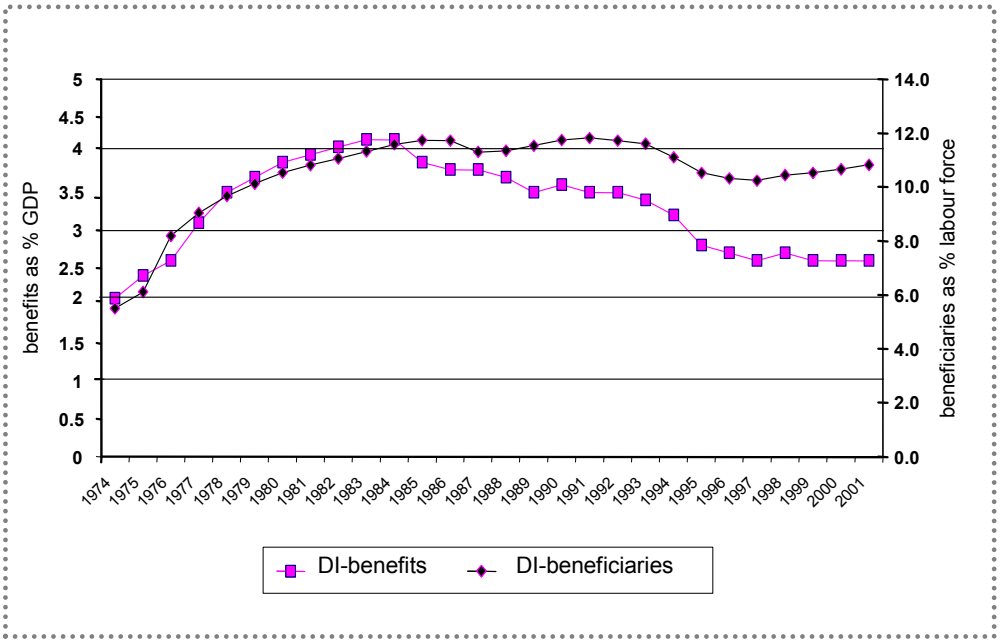

Figure 1. DI-benefits as % of GDP and DI-beneficiaries as % of the labour force, 1974-2001.

4 'Broad' includes disability benefits, sick pay and work injury benefits.

5 The labour force is measureds in full time equivalents (*i.e.*, corrected for part-timers); disability beneficiaries are measures in full benefit equivalents (*i.e.*, corrected for partial benefits).

At the same time, however, the relative number of beneficiaries stayed at 11 per cent of the labour force – the level it had reached in 1981, after the disability explosion of the 1970s. In absolute terms, the number of disability beneficiaries grew continuously from 475,000 in 1976 to 921,000 in 1993.[6] Changes in the definition of disability and in the way benefits are calculated drastically reduced the number of new awards. Moreover, part of the current beneficiaries was reviewed using the new, more stringent definition. This increased the number of benefit terminations and, on balance, led to a 7 per cent drop in the number of beneficiaries, to 855,000 in 1996. From then on the numbers started growing again, and reached 979,000 in November 2002, coming close to the politically contentious level of one million disabled.

Benefit cuts

The Figure 1 above shows that the reduction in spending on disability benefits was not caused by a smaller number of beneficiaries. Logically, then, the average benefit must have gone down. First, over the 25 years covered by the Figure 1 cutting statutory benefits appeared to be the only policy measure to reduce the financial burden of an otherwise uncontrollable programme. In the early 1980s benefits lost 25 per cent of their purchasing power by a series of substantial retrenchments. First, levying social insurance contributions on benefit income changed the calculation of after tax benefit amounts. In 1982 and 1983, the after-tax DI-benefit level was reduced through the abolition of certain tax exemptions for the disabled. In 1984, the earnings base from which benefits were calculated was reduced. Moreover, all incomes under government control – transfers, civil servant salaries, and the statutory minimum wage – suffered a 3 per cent nominal cut. Finally, in 1985, (before tax) replacement rates were lowered from 80 to 70 per cent of the last earnings, when fully disabled. These direct cuts were accompanied by the elimination of the system of automatic indexation (adjustment) of government controlled incomes.

6 In 1976 the disability scheme was broadened. From then on it also included those handicapped in youth and the self-employed. The absolute numbers quoted are not corrected for partial benefits.

Benefits were cut again in August 1993, when statutory replacement rates were reduced according to the age at the onset of disability. As a result, benefits lost another 20 per cent of their real value between 1985 and 1995. This loss contrasts sharply with per capita GDP, which increased by one third during the same period.

Partial benefits

Second, after the changes of 1993 the share of partial benefits grew sharply. By these changes the notion of suitable work was eliminated from the definition of disability. Capacity is since defined by the earnings flowing from any job commensurate with one's residual capabilities as a per centage of pre-disability usual earnings. The degree of disablement is the complement of the residual earning capacity and defines the benefit level. Before 1994, only jobs that were compatible with one's training and work history could be taken into consideration in the assessment of residual capacity. This new ruling made the per centage of partials among new awards grow from 19 per cent in 1990 to 45 per cent in 2001.

Two thirds of partial benefit awardees work. For them, and their employers, the benefit acts as a wage subsidy. Research has shown that partial beneficiaries differ from full beneficiaries in many respects: They are older, better educated, more often male, married and main breadwinner, have a longer tenure with their current employer and work in financially healthy companies (de Jong, Thio 2002). In short, Dutch partial beneficiaries are socially and economically better off. The data suggest that partial benefits are often used to offer older employees easier work conditions and act as a partial early retirement scheme.

The average beneficiary has changed

Over the past three decades the typical new disability beneficiary changed from an older male industry worker with a long work record in physically strenuous work into a younger female employee in the service industry with a relatively short labour market record. As 57 per cent of Dutch women work part-time their wages and their disability benefits are lower (OECD 2002). An increasing proportion of women among disability entrants, therefore, implies lower benefits, other things equal.

Figure 2 displays the disability beneficiary incidence rate for men and women. Women had lower rates until 1985, and have higher ones ever since. More importantly, the gap between the two incidence rates increased continuously from 1983, when the female rate was 15 per cent lower than that of men, till 1998 when women had a 80 per cent higher risk of becoming dependent on disability benefits. It has stayed at that level since.

In absolute terms the total number of disability beneficiaries increased by six per cent between 1991 and 2001. While the male beneficiary volume decreased by 13 per cent, its female counterpart increased by 43 per cent.

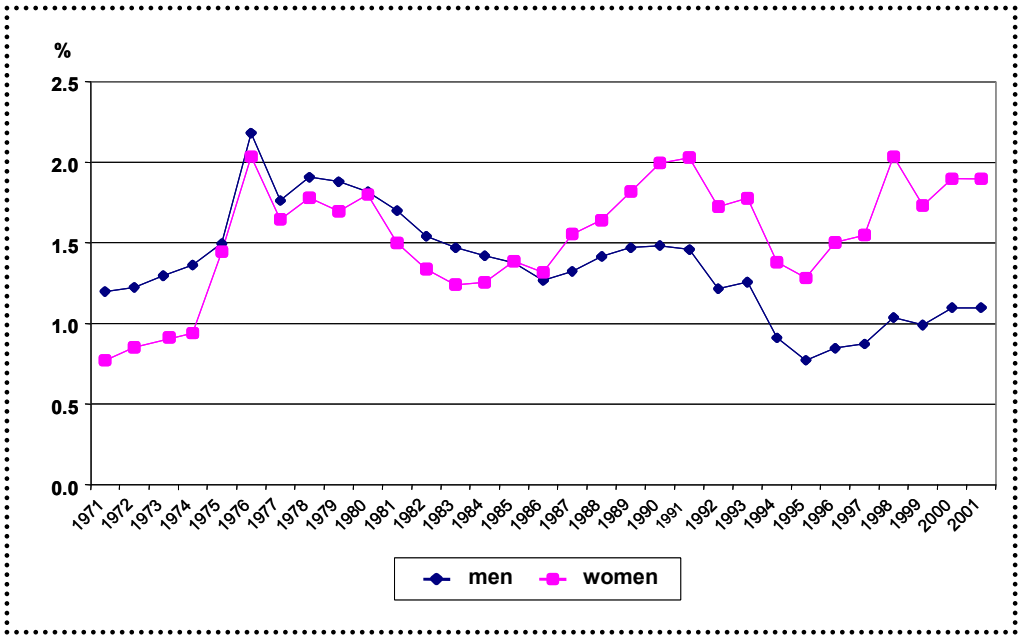

Figure 2. New beneficiaries as % of the labour force by gender, 1971-2001.

The sharp increase in female disability was matched by an equally strong growth of the labour force participation of mothers. Traditionally, Holland had very low labour force participation rates of married women. In the 1970s three out of four women stopped working after the birth of the first child. Twenty years later only one third stops. In other words, the traditional single-earner model has been replaced by that where husbands work full-time and wives have part-time jobs. For lack of sufficient child care facilities this social change has been accommodated by the disability

scheme. Disability benefits allowed market production to be replaced by home production without a sharp drop in household income. The feminisation of disability benefit dependency illustrates how an income-oriented disability policy invites to put the strains of dual earnership in medical terms.

New policies: privatisation and reintegration

Enhanced incentives…

In the early 1990s Dutch policymakers turned to defining the disability issue in terms of 'moral hazard'. They concluded that the system lacked appropriate incentives for the three parties directly involved: employees, employers and system administrators.

…for employees

Employees were hit by benefit cuts in 1993, when the 'two-phases' system was introduced – a wage-replacement phase followed by a phase with a lower, age-dependent, replacement rate (see above). Although collective bargaining agreements correct the gap between the lower rate in the second phase and that in the first phase for most employees these supplements came in the place of supplements on the standard 70 per cent replacement rate up to 100 per cent of the net wage. All in all, the effective rate went down for most employees.

As part of the 1993 amendments the definition of disability under the Disability Insurance Act became stricter. The loss of earning capacity used to be assessed against work that was considered suitable with respect to someone's education and achieved level of functioning. If a disability would prevent employment in suitable work one was considered fully disabled. As of August 1993, the extent of disablement is assessed by considering the complete labour market, instead of the parts that are suitable. This is one of the reasons why the share of partial benefits increased sharply. Moreover, the disability status of all beneficiaries who were younger than 45 was reviewed according to the new standards. These reviews led to a surge in terminations and reductions of benefits.

The 1993 amendments also affected the incidence of new disability awards (see Figure 2). The decrease in awards may well be the combined result of increased stringency of the gatekeeper and lower application rates because disability benefits lost part of their financial appeal due to lower benefits and stricter eligibility requirements. But the benefit cuts, together with a booming economy and an increasingly tight labour market during the last six years, also changed the face of disability. Better paid workers with long careers tried to avoid becoming fully dependent on disability benefits as they had better opportunities in the labour market. Secondary breadwinners and low-wage workers would lose less when going on disability and are therefore strongly over-represented among the current disability entrants.

A smaller number of awards and a steep increase of benefit terminations resulted in a 7 per cent decrease of the disability beneficiary population over the three years between 1994-1996. So far these were the only years in which the number of beneficiaries declined since the introduction of the comprehensive disability insurance scheme in 1967.

…and for employers

Sickness benefits were privatised

In March 1996, the Sickness Benefit Act was abolished. Under this Act sick pay was collectively financed through sector specific insurance funds. These funds were administrated by public agencies. By abolishing this Act employers became responsible for coverage of sick pay during the first 12 months of illness, after which Disability Insurance takes over. Under the Civil Code, firms are obliged to continue payment of 70 per cent of earnings during illness. They may choose freely whether they want to bear their sick pay risk themselves or have (part of) it covered by a private insurer.

This is a remarkable change. A fully regulated monopoly market to which private insurers had no access has been transformed into a deregulated one on which private insurers freely bid for contracts with firms that seek to insure their sick pay liabilities. Firms are legally mandated to contract with a private occupational health agency and buy a package of services including prevention and monitoring of sick spells. These new mandates seek to reduce absenteeism and inflow into the disability benefit programme by confronting firms with its full cost. Invest-

ment in prevention and reduction of illness is profitable as it reduces avoidable costs of absenteeism.

Sickness absence rates dropped from 8 per cent in 1990 to 6 per cent in 2000 – a 25 per cent drop (Veerman, Besseling 2001, 60). Both these years represent a cyclical top and a comparison between these, therefore, controls the influence of the business cycle on absenteeism. At least part of this large drop can be ascribed to privatisation, and its associated incentives. This favourable result is obtained despite the fact that about 80 per cent of all firms took out some from of private insurance to cover their sickness liabilities.

There appears to be a strong negative relationship between firm size and insurance coverage: while firms with less than 20 employees have a coverage rate of about 83 per cent, only 25 per cent of those with 100 or more workers buy insurance. Larger firms also choose a larger coinsurance period or buy a stop-loss arrangement (Veerman et al. 2001, 22-27). To avoid adverse selection insurance companies stipulate that no employee be excluded from coverage under a sick pay policy which the employer buys. Insurers also demand that firms contract occupational health agencies, and stipulate which set of services is to be contracted.

A parliamentary majority expected that privatisation of sickness benefits would make the labour market less accessible for people with disabilities because employers would check the health status of job applicants more strictly. To counter that problem an act banning medical examinations as part of an application procedure was introduced. Survey data show that selection on the basis of health risks has not increased due to privatisation: in 1999 about one third of firms report that they scrutinise applicants sharply on health. The same share did so in around 1990. To what extent this result is due to the Act on Medical Examinations is unclear (de Vos et al. 2001).

Surprisingly enough privatisation did not induce a surge in conflicts between sick workers and employers refusing to continue payment of their wages. This may also be the result of the fact that the privatisation was enacted in a boom period. The current recession may be used to test to what extent private financing of sickness benefits is weatherproof.

Disability contribution rates are experience rated

Since 1998 experience rating of firms is gradually phased into the disability insurance scheme. Pre-1998 benefits are still funded by the existing uniform pay-as-you-go contribution rates but as of 1998 the first five years of disability benefit recipiency of new beneficiaries is paid out of

premiums that are levied according to the "polluter pays principle." If an employee is awarded a disability benefit, the firm will face a higher contribution rate, and vice versa if a firm employs a disability beneficiary. Moreover, firms are allowed to opt out of the public insurance system, but only with respect to the coverage of the first five years of benefit recipiency.

The disability insurance scheme for employees is now financed by levying two separate premium rates, both paid by the employer. The first is a uniform pay-as-you-go rate covering the benefits of those that were already on the rolls before 1998. Five years after its start –*i.e.*, from 2003 – the pay-as-you-go rate also covers benefits that started after 1997 and last more than five years. Over the past five years this rate has gone down from 7.55 per cent to 5.05 per cent of taxable wage (up to €43,000 per year).

The second rate covers the first five years of benefit recipiency and is differentiated according to the firm-specific disability risk. To calculate the risk in year t the total expenditures on disability benefits of the firm's disabled employees in year t-2 is taken and expressed as a per centage of the average wage-bill over the past five-year period. This firm-specific risk determines the differentiated rate. The average risk rate has increased from 0.30 per cent in 1998 to 2.38 per cent in 2003. As of 2003 only firms with a wage -bill of more than €600,000 pay differentiated rates. These rates are limited by a lower and an upper bound. The upper bound increased from 1.12 per cent in 1998 to 8.52 per cent in 2003.

Five years after the inception of experience rating the system can be considered mature. The uniform pay-as-you-go rate is expected to stay at about the current level of 5 per cent of taxable wages. What the average risk rate will do strongly depends on how the inflow rates develop.

At the end of 2001 only 0.9 per cent of Dutch firms had opted out of this public financing scheme and had chosen to self-insure the risk of paying the first five years of disability benefit payment (first six years if one includes the sickness benefit year). These firms account for 5.6 per cent of total wages because, naturally, 'large' employers (with a wage -bill larger than €600,000) are over-represented among the self-insured. In the public pay-as-you-go division of disability insurance only 12 per cent are large firms. Among the self-insured 25 per cent are large.

Whether experience rating has reduced the inflow rates is yet unknown. The phase-in stage of differentiated premiums has just ended, and the period since those rates are 'biting' is still short.

….but not for the gatekeepers of the programme

In the debate on disability policy the focus gradually shifted from the programme itself toward the programme administrators. In 1993, a multi-party parliamentary committee investigated the operations of the then existing Insurance Agencies which were organised by sector of industry and held a legally protected monopoly with regard to the administration of sickness, disability and unemployment insurance benefits. The committee devoted special attention to the administration of the disability insurance scheme. The committee publicly interrogated a vast number of current and former administrators, civil servants, and politicians. The picture that emerged from the nightly televised summaries was devastating for the image of the Insurance Agencies. What most suspected, and what had already been shown by research, was now publicly confirmed. The committee's report created broad political support for drastic changes regarding, in particular, the dominant, and autonomous, position of the trade unions and employers' representatives in the management of social insurance.

In 1995, as a result of the committee's recommendations, an independent supervisory body was set up. It publishes annual reports on the efficiency and legality of the administration of the social insurance programs. In 1997, the public Insurance Agencies that were run by the social partners were privatised, and regrouped themselves into five organisations. Next to their traditional tasks in administering public (unemployment and disability) insurance programmes, they set up a range of private activities, offering medical and vocational rehabilitation, and occupational health and employment services.

The original plan was to create a competitive market on which these five agencies, as well as new entrants to this market, would compete for contracts with companies or groups of companies to administer wage-replacing unemployment and disability insurance. The trend was towards offering 'full-service packages' that would cover the legally mandated social insurance liabilities as well as pensions, health insurance and outplacement of redundant employees.

The public debate on this model of private delivery of social insurance disclosed several problems. A competitive insurance market for mandatory coverage of disability risks could be viable, and efficient, if private insurers would be allowed to control all the links in the "insurance chain": running from drafting policies, calculating premiums, administering indemnities, controlling damages and managing claims. Insurers could

offer firms tailor-made packages by varying elements such as the extent of co-insurance and the intensity of damage control through prevention, swift rehabilitation and monitoring activities. One crucial element in this chain is the assessment of the degree of disablement. A political majority was unwilling to subject disability assessment to the business interest of private insurers. As a consequence, a hybrid model was proposed in which the whole chain was privatised except disability assessment, which was to be done by a separate public (medical) agency.

Second, while disability is a privately insurable risk, unemployment is not. Privatisation of unemployment insurance would not obtain a (socially) efficient market. Apart from the insurmountable problem of risk dependency, employers would only be interested in the cheapest unemployment insurance administration contract because they would not profit from investment in quick re-employment of workers after they became redundant. Putting disability and unemployment risks in one basket, therefore, would result in a (socially) sub-optimal outcome.

Third, private agencies that cover mandatory (public) insurance are likely to offer additional, related, insurance services, such as health insurance, pensions. To the extent that the portability of such employee benefit packages is limited, employees are locked in to the firm. Likewise, firms may find it difficult to change providers of employee benefits.

And, finally, private agencies that get data on covered workers because they run public schemes may abuse those for other commercial activities, *e.g.*, risk selection for health insurance. Similarly, they may use money from mandatory, public, insurance for their private business. Auditing such hybrid organisations is complex, controversial, and expensive.

For these, and other, reasons a political majority pulled the plug on this privatisation plan in the summer of 1999. In 2002 the Social Insurance Institute was established to run the disability and unemployment insurance schemes as a so-called quango (quasi-autonomous non-governmental organisation) under contract with the Ministry of Social Affairs and Employment. Only rehabilitation (reintegration into paid work) is contracted out to private firms. This could offer an opportunity for the existing occupational health service companies that now do the management of sickness benefit claims to broaden their scope.

Reintegration

REA-provisions

In contrast to countries with a similarly broad social welfare system the Dutch disability programme used to lack effective mandates regarding vocational rehabilitation and a rehabilitation infrastructure to support such mandates. This was increasingly felt as a system failure. In July 1998 the Act on Reintegration of Work Handicapped Persons (REA) introduced a new target group. Under this Act the set of provisions in kind and subsidies that previously were scattered over a number of schemes were added together and made consistent.

Work handicapped persons are all those:

- that have a disability that reduces their productive capacity, and
- are entitled to a disability benefit, or those that have lost their entitlement less than five years ago;
- are entitled to provision in kind or subsidy to maintain or restore their productivity, or those that have lost their entitlement to such provision less than five years ago;
- belong to the group targeted by the Sheltered Work Provision Act;
- do not belong to any of the aforementioned groups but have been assessed (through medical examination at a social insurance agency) as being work handicapped.

The status of work handicapped is allowed for five years, after which it has to be re-established. REA excludes all those work handicapped persons that have an employment contract, unless they have reached the limit of 12 months of illness, with or without a disability insurance award, and those that have not reached this limit but are unable to resume with their current employer.

In 2000 about 1.2 million persons (12 per cent of the working age (18-64) population) were counted as work handicapped. Of those 79 per cent are benefit recipients; 34 per cent of the work handicapped population are employed. Work handicapped are older than the average employee: 61 per cent are older than 45 against 28 per cent of all employees.

As of 2002 REA covers the following types of provisions:

1. Work handicapped employees may be entitled to education, training, mobility provisions, trial placement and personal assistance and certain therapies (like stress and RSI training) to maintain or restore their productivity
2. Companies pay a lower disability insurance rate and are exempt from experience rating for handicapped workers. The sickness benefits of handicapped workers are covered collectively so that their employers do not bear the financial risk of continued wage payment if they would fall ill.
3. Companies are entitled to subsidies that cover the cost of accommodation of the work place.

In 2001 57,000 REA-provisions were awarded to employees, and about 50,000 to employers. As employees, or their employers, often get more than one provision the number of employees that get a provision is much less than the total number of provisions given in 2001 (107,000). But even if this sum would be the number of workers getting a REA-provision it is small compared with a target group of 800,000 non-working handicapped.

Moreover, survey data on cohorts of those that reached the disability insurance waiting period of twelve months of illness in 2001 show that the instruments are used selectively in a sense that suggests a certain extent of dead-weight loss: REA helps those that are in a relatively favourable position more often than others. The group that gets a relatively large amount of support from REA is very similar to those that get partial disability benefits: they are better educated, they have longer tenure, they are more often breadwinners, and work for large, financially healthy, firms (Jehoel-Gijsbers, van Deursen 2003). The report on this survey concludes that the introduction of REA has not (yet?) led to a significant improvement of the reintegration process.

Reintegration plans

This conclusion is based on a study of workers who are long-term ill but still have an employment contract with their current employer. In that case, the employer and his occupational health agency make the application for a REA provision. Concerning disability beneficiaries REA provisions are usually part of a reintegration (back-to-work) plan drafted by vocational experts of the Social Insurance Institute. These plans may be compared with the `individual participation packages' proposed by the OECD. On the

one hand beneficiaries can influence the design of the plan by stating their preferences for certain REA provisions and lines of work. On the other hand, beneficiaries are legally mandated to take all steps necessary to restore their productive capacities. Therefore, those that are offered a plan cannot refuse to co-operate, unless they can prove that they already are on the road back to work.

The Social Insurance Institute contracts with private reintegration service organisations to execute reintegration plans. This is done by parcelling out groups (plots) of beneficiaries to organisations with the best offer in terms of price, successful placement record and professionalism. These plans are financed out of the REA -budget, and cover both the reintegration instruments and the effort of the reintegration service. In 2001 about 50,000 reintegration plans were contracted for the work handicapped. About half of these concern disability beneficiaries; the others are unemployed disabled (with or without an unemployment transfer income). In other words, plans were made for about 2.5 per cent of the disability beneficiary population. According to contract 35 per cent (17,500 of 50,000 plans) should result in successful placements (employment for at least six months).

Reintegration reports

As of April 2002, the responsibilities of the sick employee, his/her employer, and the occupational health service are legally specified, and mandate a structured approach to early intervention in cases of illness. After a maximum of six weeks of absence the occupational (health service) doctor has to make a first assessment of medical cause, functional limitations and give a prognosis regarding work resumption. On the basis of these data employer and employee together draft a vocational rehabilitation plan in which they specify an aim (resumption of current/other job under current/accommodated conditions) and the steps needed to reach that aim. They appoint a case -manager, and fix dates at which the plan should be evaluated, and modified if necessary. The rehabilitation plan should be ready in the eighth week of illness. It is binding for both parties, and one party may summon the other when considered negligent.

After 35 weeks of illness the Social Insurance Institute sends a Disability Insurance application form to the sick employee. Disability Insurance claims have to be delivered before the 40th week of illness. Claims are only considered admissible if they are accompanied by a rehabilitation

report, containing the original rehabilitation plan, and an assessment as to why the plan has not (yet) resulted in work resumption. If the report is delayed, incomplete, or proves that the reintegration efforts were insufficient the claim is not processed and the employer is obliged to continue paying sickness benefits even after twelve months.

This is a serious step in the direction of mutuality of rights and responsibilities both in the relationship between employer and employee, and of both parties in their relationship with the state, represented by the Social Insurance Institute. Employees who consistently refuse to cooperate with their employer to execute the plan can be dismissed. To that end the labour law has been changed, because until now an absolute dismissal ban was in force for the first two years following the onset of disability.[7] Employers can be sanctioned by a one-year extension of the payment period of sickness benefits if proven at fault. And employees may be penalised by cutting their disability insurance benefit.

The Donner report

In May 2001 a National Advisory Commission on Disability proposed to drastically revise the current scheme. After its chairman it is called the Donner Commission. The proposal takes the mutual responsibility of employer and employee to promote work resumption and prevent benefit dependency as a starting point. The employer is obliged to take care of the necessary accommodation of the current job, or to offer another job, inside or outside his firm. The employee has to provide the medical information necessary to adapt employment conditions, and has to accept any job offer earning at least 70 per cent of his previous wage.

The sufficiency of the return to work efforts of employer and employee are to be judged by the Social Insurance Institute. Insufficiency will be sanctioned. If the employer is held liable he will have to continue payment of sickness benefit, until he has taken the steps judged necessary by the Institute. If the employee proves unwilling to collaborate with

7 A comparison among 10 European welfare states, the United States and Japan, shows that the Dutch system of job protection during sickness (still) is much stronger than in any of the twelve countries (Bakkum, Desczka 2002, 15-16.

reasonable plans and job offers the employer may dismiss him/her. The latter rules have already been effected by the introduction of the reintegration report in April 2002, except that the Donner commission proposed to make the waiting period before a benefit claim can be filed flexible with a minimum period of three months.

This system of mutual obligations to promote swift work resumption is underscored by a new risk definition under Disability Insurance. People are only awarded a disability benefit if they can be considered permanently and severely disabled. Partial disability is no longer covered by the public Disability Insurance programme. Expectations are that this alone will reduce the inflow rate by two thirds. Only if the inflow rate declines significantly the benefit under this new system can go back to its pre-1993 level of 70 per cent of earnings.

Disabled workers who, under this strict regime, are not eligible for disability benefit and who, despite reasonable efforts of their employer and themselves, are unable to find commensurate work can claim unemployment benefit.

One of the main goals of this blueprint is to emphasise that workers who have fallen ill should do everything reasonable to go back to work as soon as possible. To that end they can appeal to broad support from their employers. Employers who remain negligent have to continue paying sickness benefit for an unlimited duration. This sanction should replace experience rating of the firm-specific disability risk. Those that are eligible for disability benefit are presumably left without any residual earning work ability, and are therefore not subject to rehabilitation mandates.

The SER proposals

The Donner proposals met with fierce opposition. Although the central recommendation to restrict the Disability Insurance programme to the permanently and fully disabled and to privatise partial disability was broadly accepted, the fact that many of those who are now entitled to disability benefit may become unemployed and end up on social assistance was equally broadly considered unacceptable. Others noted that by doing away with experience rating, together with the possibility of eventually higher replacement rates, would bring the system back to its pre-1993 state and would reinstate all the wrong incentives the system got rid of over the past years. A third form of criticism concerned the concept, definition and implementation of full and permanent disablement. The

gatekeepers of the programme would never be able to apply such a strict standard, especially under the pressure of disabled workers claiming a benefit, which would soon turn out to be higher than any other transfer income.

The Donner proposals were send to the Social-Economic Council (SER) – the advisory body the Government has to consult in matters of social and labour market policy. This Council consists of trade unions' and employers' representatives and independent Crown Members. These three parties have equal shares in the Council.

The SER accepted major parts of the Donner report but modified two crucial elements:

1. Benefits were to compensate 75 per cent of lost earnings. The trade unions demanded this as a *quid-pro-quo* for the employers' bonus: elimination of experience rating.
2. Partial disability would be eliminated from Disability Insurance but a new system was proposed in which two classes of partial disability would remain: those who are not fully disabled but suffer a loss of capacity of more than 35 per cent and those that have a limitation which reduces capacity by less than 35 per cent.

The first group would get a supplement on their wage if they were employed. Firms would be legally obliged to take out private insurance to cover these supplements. In case of unemployment they would be entitled to a benefit which eventually would go down to the level of the social minimum but which would remain (until age 65) an insurance entitlement without means tests. The second group (with a capacity loss of less than 35 per cent) would be entitled to support from their employer to stay in employment. In case of unemployment they would be treated as regular unemployed who eventually end up on means tested welfare.

The Government considered this mollification of the Donner proposals as undue. It argued that the mandatory private insurance system for those in the 35-100 disability class would work adversely. At least two of the three parties involved in this game (employers and private insurers) were expected to prefer unemployment over claiming a wage supplement – damages which could be avoided by making the employee redundant. But compared to a partial disability benefit under the current system the unemployment option was in many cases an improvement, too.

Government proposals

The Government takes a stand close to the Donner proposals. Four new amendments are currently being prepared:

1. A Bill is drafted in which the mandatory waiting period is extended from one to two years. This extends the sickness benefit payment period for employers but reduces the burden of experience rating correspondingly.
2. The definition and operationalisation of the disability criterion proposed by Donner is under serious study both by physicians and lawyers.
3. An element, which is neither part of the Donner nor the SER proposals, is the introduction of an employment record requirement before one is covered by Disability Insurance. The current coalition is in favour of the introduction of such an additional requirement.[8]
4. If one were to choose a Donner type criterion ILO treaty 121 ratified by the Dutch government requires that those that would get partially disabled due to a work-related accident or occupational disease are covered by social insurance. Government has drafted a Bill to cover work-related risks by mandating employers to contract private insurers. The need to do so would only be enhanced by the introduction of a contribution record requirement.

All in all, 'Donner' would bring the Dutch disability benefit system in many respects back into the international mainstream. But in other respects it remains unique: it keeps its heavy employer mandates and reinforces elements of mutuality.

8 An element, which makes the Dutch disability programme more accessible than those elsewhere, is the absence of a required contribution period before a worker is fully covered. Such absence is natural under a Work Injury scheme, because a construction worker, who falls from a scaffold on the first day on the job, has to be covered. But general disability benefit programmes in other countries all require a certain contribution payment period, which may run up to 5 years, before full coverage is obtained (Bakkum, Desczka 2002, 33-36).

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WORK ABILITY AND FUNCTIONAL CAPACITY – THE FINNISH POINT OF VIEW

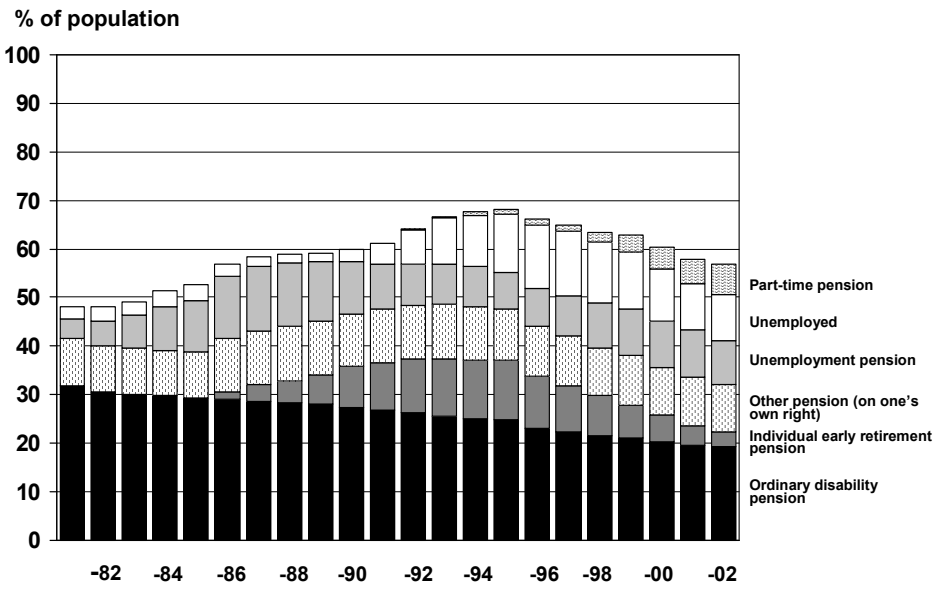
Timo Aro

Over the past ten years, working life has undergone a major change in Finland. First, the country experienced the deepest economic recession since the war years followed by a severe unemployment problem. The decade was also marked by a rapid process of internationalisation of large companies and record growth in the national product, which, however, did not bring about a decline in unemployment, as expected. Meanwhile, membership of the European Union and the common monetary union has significantly affected economic planning and operational options. Over the past three years, the share markets have continued to decline for the longest period in decades.

A whole new sector, information technology, emerged in Finland and grew into international proportions. Working life has changed. Most workers use IT tools in their work, and there is a growing number of Finns who could be rightly considered knowledge workers. More and more people use symbols instead of only machines and equipment, they work together and for each other, creating information and knowledge-related services. Human capital has become a significant competitive advantage.

Finnish society is being moulded by a change in its population structure, and a continuing high rate of unemployment. Our workforce is ageing rapidly and the move from working life to different types of early retirement pensions among the older age groups is common and takes place at an early age (Figure 1). An increasing number of contracts of employment are fragmented and often short-term. This has given cause for concern and caused psychological symptoms. Coping with pension expenditure and the health and medical care costs related to the change in the age structure of the population have become a key challenge for the Finnish economic and social policy. A twofold employment situation presents another challenge. Our unemployment has become structural and is at risk of remaining permanently high. There are almost 300,000 unemployed jobseekers and their number seems to continue to grow due to the

weak economic development internationally. On the other hand, labour shortage will become more common in the next few years when the large post-war age groups retire.

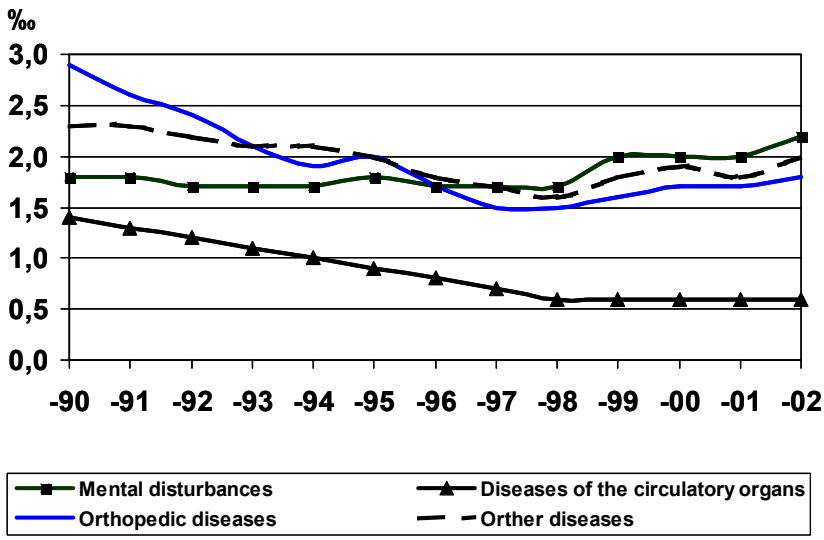


Source: Finnish Centre for Pensions.

Figure 1. Proportion of 55-64-year-old pensioners and unemployed persons in 1981-2002.

New stress factors in workplaces

Finland is a country where the pace of work is hectic. Studies show that a good half of all workers feel that the hectic pace is stressful and has an adverse effect on their work. Of the working-aged population, one in every five lives under the threat of layoff, notice or unemployment. Mental health problems now rank first as the reason for retiring on a disability pension before musculoskeletal diseases (Figure 2). Improving the psychological atmosphere of workplaces, the work pace, and stress management will be important parts of personnel management in the future. Studies show that fair management practices reduce job-related stress symptoms and reduce the amount of sick leave.



Source: Finnish Centre for Pensions.

Figure 2. Age-adjusted private-sector disability pensions (new awards) beginning in 1990-2002, by important disease group.

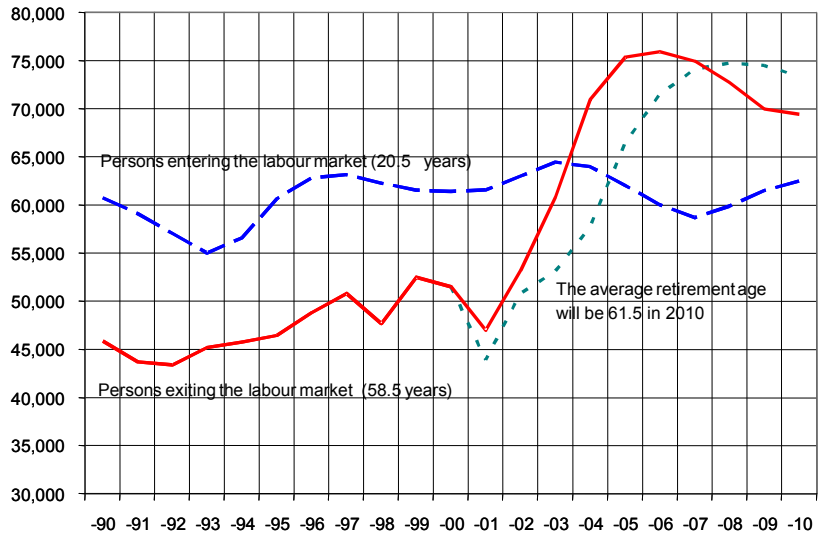
Traditionally, discussions about working life and occupational health have focused on factors that constitute a risk to health at work. Less attention has been paid to how being part of a working community can promote the worker's health and well-being. Research findings show, however, that a wide-ranging workplace health promotion programme together with high-quality occupational health and work protection schemes enhance health, work ability and business economics.

Ageing population and availability of work-force

In the next few years, the ageing of the large post-war age groups, longer life expectancy, early retirement, and long-term unemployment will have an adverse effect on the dependency ratio. The weakening dependency

ratio is not only a Finnish phenomenon, but in Finland there are, however, certain additional factors related to the situation. The population is ageing faster in Finland than in many other western countries. On the other hand, it would seem that ageing entails a move out of the workforce more often in Finland than in other countries. The estimated retirement age is 59 years, and people tend to move out of the workforce a year earlier. According to the Finnish Centre for Pensions, the retirement age has not risen significantly in the last few years.

The size of the working-age population has continued to increase rapidly throughout the post-war period. From 1945 to 2009, the working-age population will have grown by one million. In the present decade, the growth will be down to 5,000 a year and will centre on people aged over 55. As of 2010, the size of the working-age population will decline and by 2030, the number will have dropped to 400,000, i.e. a fall of 20,000 persons a year on average. In addition, even before the decline in the size of the working-age population, there will be a drop in the availability of labour already this year (Figure 3).



Source: Ministry of labour.

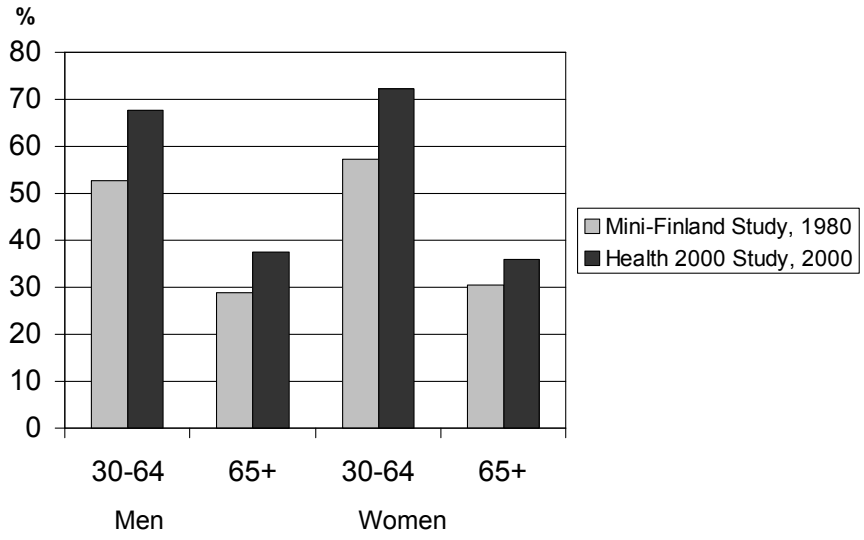
Figure 3. Change in potential labour market supply 1990-2010.

The changes in the size of the working-age population are so significant and sudden that they will have a major effect on the labour market.

Another problem connected with the ageing of the Finnish population is education. The educational level of the post-war generation is low, and therefore, their potential for entering the labour market is relatively bleak. The situation looks bad for ageing workers for the next ten years at least, as the demands of work continue to increase.

Health and work ability of working people

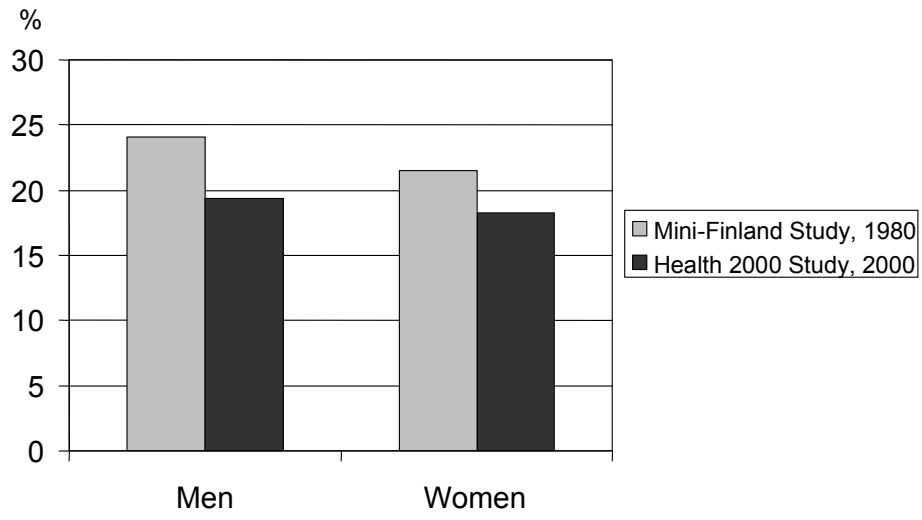
The health of the working-age population has improved. Particularly, people in the age group 55-64 years feel that they are now in better health. Long-term morbidity has also declined in the age group 45-64 years (Figure 4). The longer life expectancy of both men and women is also proof of this favourable trend.



Source: Aromaa, Koskinen 2002.

Figure 4. Age-adjusted prevalence of good or moderate health (employee´s own concept) (%).

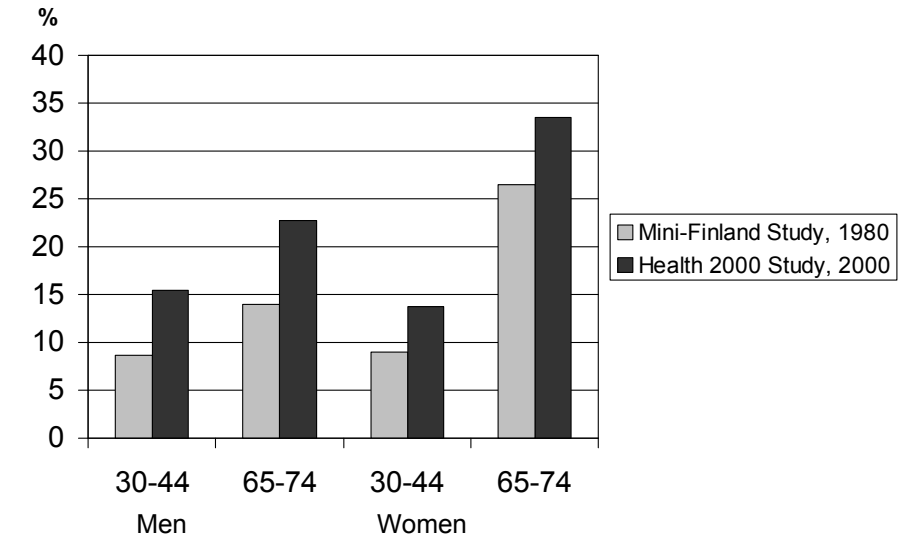
On the basis of the findings of the recently published study Health 2000, the majority of the working-age population considered themselves able to work (80%), and particularly the work ability of men had improved. On the other hand, only slightly over 50 per cent of the persons aged 55-64 considered themselves able to work (Figure 5). If the favourable trend continues, more workers in the smaller age groups will be able to stay in work longer as far as their health is concerned.



Source: Aromaa, Koskinen 2002.

Figure 5. Partly or totally disabled (own concept) among the 30-64-year-olds.

The trend in health-promoting lifestyle factors has been favourable, with the exception of increasing alcohol consumption, a large number of smokers, and a growing problem of obesity (Figure 6). On the basis of research findings, it would appear that the lifestyle risk factors vis-à-vis sick leaves include drinking, smoking, obesity, and a lack of exercise, which means that much still remains to be done in public health promotion work in Finland (Table 1).



Source: Aromaa, Koskinen 2002.

Figure 6. Prevalence of fatness (BMI >0 ≥ 30), %.

Table 1. Work community often to blame for absence from work due to illness.

Risk factor	Men N=1490	Women N=4952
Factors related to lifestyle	Risk coefficient	Risk coefficient
Overweight (BMI 25-30)	1.27	1.39
Fatness (BMI >30)	1.79	1.75
Official smoker	1.13	1.19
Excessive use of alcohol	1.47	1.02
Lack of physical activity	1.48	1.18

Source: Kauppinen et al. 2000.

As regards chronic diseases, i.e. arteriosclerosis, the low-back syndrome, arthrosis, and particularly arthrosis affecting women's knee joints have declined significantly, probably due to a decline in physically strenuous work. Increasing obesity may, however, in the future subject a growing number of working-age people to diseases affecting their joints. Asthma has also become increasingly common. Of the diseases of the respiratory organs, the incidence of chronic bronchitis has changed according to smoking habits so that it has declined among men and increased among women.

Mental health problems, particularly mood disorders, burn out, and alcohol dependency are considered to be more common than before. In the light of research findings it would seem, however, that with the exception of alcohol dependency, mental health problems today are about as common as they were 20 years ago. Although psychological symptoms that weaken the mental well-being continue to be common (incidence 20-25 per cent of the population), severe cases of depression are clearly more rare now (5 per cent of the population). The results show incontrovertibly, however, that mental health problems are a major public health risk, the prevention of which is one of the most important challenges for our health policy, and is the reason why workplace health promotion must be carried out effectively. Although disability pensions granted on the basis of mental health problems have become more commonplace in the 1990s, recent studies give reason to assume that retirement related to mental disorders will no longer increase. An unfavourable increase may, however, continue as a result of insufficient resources in the health care sector. It may also be that the demands set for our general psychological fitness by information-intensive work will lead to a steady increase in pensions granted on the basis of mental health problems. Recent questionnaires show that job-related mental stress is a common cause for premature retirement.

Assessment of work ability with respect to insurance medicine

In the sphere of pension insurance legislation, attention given to work ability has usually focused on the absence of work ability or functional capacity, in other words: assessing disability for work or limitations on work ability. Such thinking is a consequence of the need to assess the

examined person's right to financial benefits on the basis of various insurance policies. Although disability for work is defined in a number of different ways in legislation, the general, widely applied, principle in Finland complies with the Employees' Pensions Act (TEL): "An employee whose work ability can be estimated to be continuously reduced by at least two fifths for a minimum of one year as a result of illness, deficiency, or disablement is eligible for a disability pension. In assessing reduction in work ability, the employee's remaining capacity to earn income through work available to him/her and reasonably considered to suit him/her in view of his/her previous training, previous activity, age, living conditions, and other such issues are taken into account."

In the national pension scheme, the definition of disability for work is roughly in keeping with the Employees' Pensions Act. In the national pension scheme, however, a pension is always granted to blind and physically handicapped people, and to people permanently so helpless that they cannot manage without another person's help.

Although pension legislation only defines the concept of disability for work, insurance practice has extensively applied concepts related to remaining work ability in recent years, and tried to promote ways of medical or vocational rehabilitation to improve the remaining work ability, and to modify work tasks so that they allow people to cope with their jobs in spite of reduced work ability due to illness.

In the Finnish legislation, it is emphasised that disability for work means a medically assessed disability caused by illness, deficiency or disablement. In the sphere of pension insurance, the application of pension legislation and thus the definition of disability for work has been assigned to authorised pension providers. The solutions that the pension providers have arrived at are juridical decisions based on existing law and its established interpretations. When work ability is being assessed, both the attending physician and the insurance physician aim at a just, and often also unanimous, solution for the person in question. Divergent views concerning the disability of a person applying for compensation usually arise from the fact that the insurance company has the opportunity to assess work ability in the light of different kinds of information and often has more extensive information than the physician who examines and treats the person concerned, and writes a statement concerning this person. It may also happen that the information acquired by the attending physician on a patient is not made sufficiently available for assessment to the insurance physician. However, differences between a physician's

assessment of work ability and the insurance company's decision are unusual.

Risk of work disability

Employees at risk of disability may be entitled to vocational rehabilitation (Table 2). The pension legislation taking effect on 1 January 2004 allows increasingly close cooperation between the occupational health care, the

Table 2. Vocational rehabilitation - Mission.

Why do we have vocational rehabilitation?

- to promote the general target of increasing the percentage of employed persons in the working-age population
- to postpone the average retirement age in the long term and thereby relieve the pressure on future pension payments.

Social Insurance Institution and the authorised pension provider in a situation where the occupational health care has discovered that illness is threatening the employee's work ability. Hence, ageing employees in particular would have better opportunities to continue working longer than now, and rehabilitation could support those whose opportunities to continue working have been materially reduced by deteriorating health. This sets major requirements for assessing the threat of disability accurately in occupational health care.

In assessing the risk of disability, the occupational health care should analyse the employee's functional capacity and its expected trend in the near future (Figure 7). Employees will be entitled to appropriate occupational rehabilitation if the criteria listed in Table 3 are met. Sickness means a diagnosed illness for which the potential for treatment and medical rehabilitation have been taken into account. The near future means an approximate period of five years. Work ability is at risk in a situation where, at the time of assessment, the employee's disability due to illness would make him/her eligible for a disability pension in the near

future unless rehabilitation is undertaken. The likelihood of such disability is assessed with a scale applied in occupational disease diagnostics (very likely, likely, possible, unlikely and very unlikely).

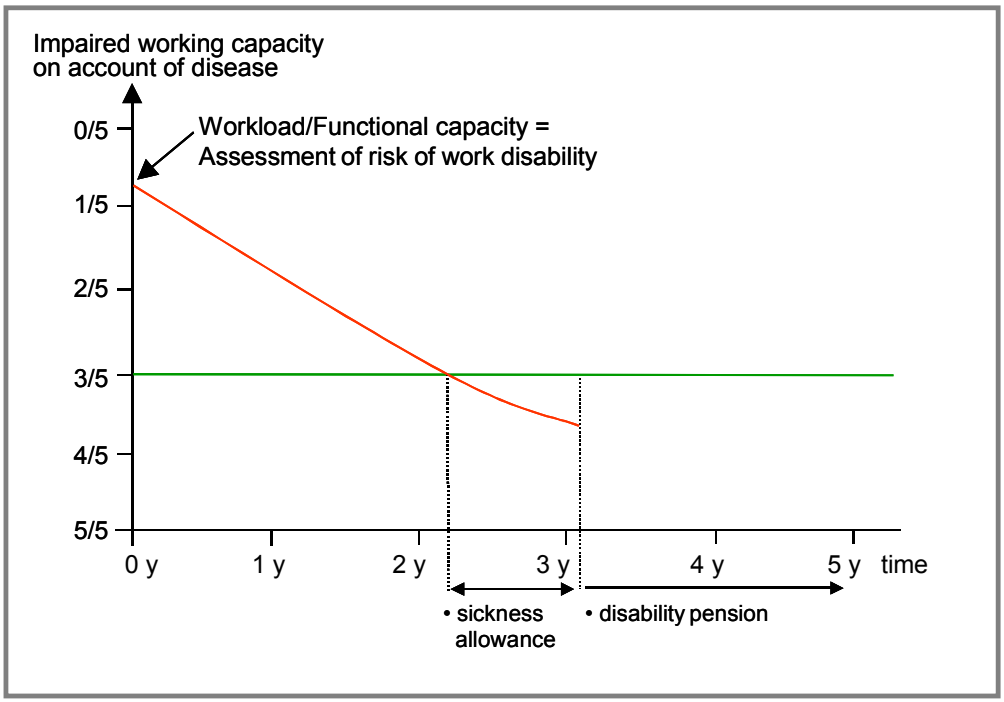


Figure 7. Risk of work disability.

Table 3. Risk of work disability.

- Employees are entitled to obtain appropriate vocational rehabilitation to prevent work disability or to improve their working and earning capacity, if

- they have confirmed desease, defect or handicap that will likely place them at *risk of disability* in the near future.
    - A confirmed desease, defect or handicap means a disease diagnosed by a physician and registered by him or her in accordance whith the ICD disease classification system.

- The likelihood of work disability is assessed using the scale for diagnosing occupational diseases: 1. highly likely, 2. likely, 3. possible, 4. unlikely, and 5. highly unlikely.

- Work disability (the risk) refers to a situation where the employee would be granted full or partial disability pension.

- The near future refers to a period of approximately five years.

- Assessment of whether rehabilitation is reasonable takes the following considerations into account:
    - The employees' age, occupation, previous work, education and work experience.
    - Whether the rehabilitation applied for is likely to enable the applicants to continue in or return to work suited to their health.

- Reasonable assessment also includes the consideration of whether rehabilitation is likely to bring savings in pension expenditure.

If the aim is that the applicant is able to continue in his /her previous job, the objective is to improve his/her *functional capacity* by medical care or medical rehabilitation. If the aim is to modify the requirements of the previous job and thus improve the applicant's *work ability,* the key issue is vocational rehabilitation. Then assessment must be made as to what

possibilities there are for the employee to transfer to a job that corresponds more closely to his/her functional capacity by improving the employee's current professional skill and expertise (Figure 8). It is important that the occupational health care in cooperation with the employee make a realistic plan including specific targets, which both the employee and the occupational health expert understand in the same way and to which both can commit themselves unequivocally.

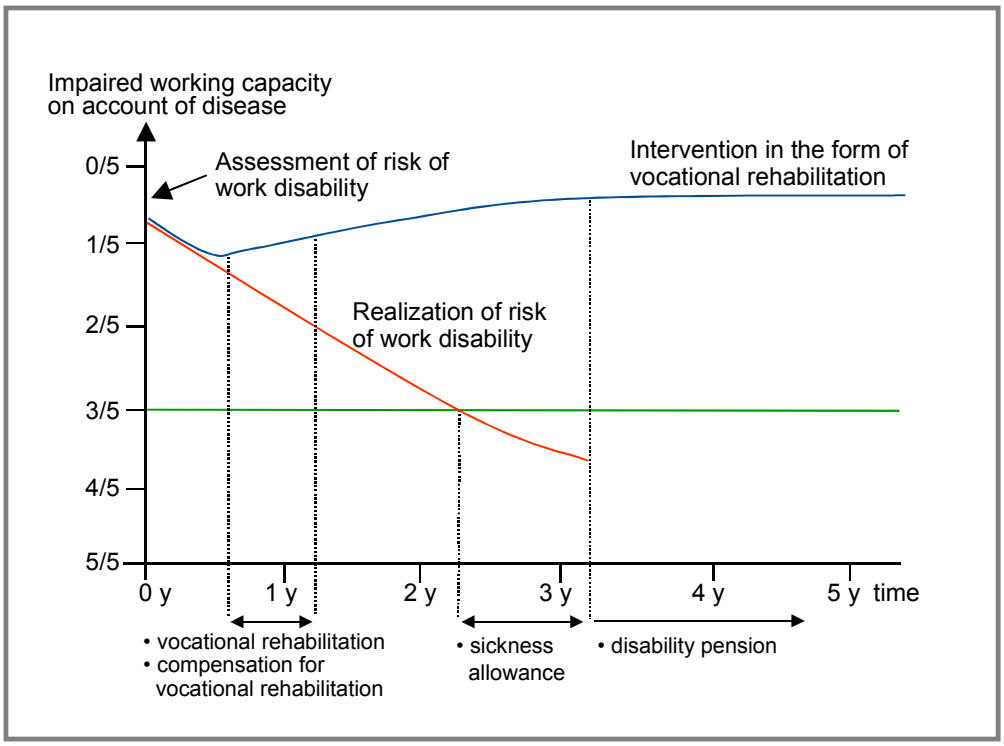


Figure 8. Assessment of risk of work disability.

If the balance in work ability is disturbed by changes related to the organisation of the work, social working conditions, workplace values, the supervisors' management and operating methods or lack of expertise and professional skill as well as the various subjective symptoms that the employee suffers from, responsibility for activities to promote work ability is taken on by the personnel administration, the supervisors and the occupational health care. If this balance is disturbed by an illness, deficiency or disablement appropriately diagnosed and treated by the

occupational health care or the public health services, action can be taken in cooperation with the Social Insurance Institution and the authorised pension provider.

Summary

In the next few years, the key challenges for Finland's economic and social policy will be the growing pension and care service expenses caused by its ageing population. The still increasing unemployment figures combined with an impending scarcity of labour and the relatively early average retirement age are other issues that need to be addressed.

Disability for work continues to be the most common reason for retiring in Finland, followed by unemployment. The old-age pension is only the third most common reason for retirement. As the steadily improving public health does not seem to be reflected in people's willingness to stay longer in work, our welfare state is now making every effort to focus on the development of working life and the promotion of work ability.

Maintaining the core of our welfare state requires a significant rise in the employment rate of our working-age population. A key tool for achieving this goal is to defer retirement by 2-3 years. This will require further development of both workplace health promotion efforts and the earnings-related pension scheme.

Working life should be developed to make staying in work a genuine alternative to retirement. In information society workplaces, the staff is a key competitive factor, the efficiency, expertise and well-being of which must be developed in a balanced manner. If a company focuses on efficiency only, it will result in growing dissatisfaction among customers, and in ill feeling, burn out and a wish to retire among staff. Lacking a continued focus on research, education and expertise presents a risk of expertise and jobs leaving the country. If we abandon the targets we have set for staff well-being, we will face work-related illnesses and other problems in the staff's health and work ability.

The private-sector pension reform that will take effect in 2005 will create the preconditions for competitiveness and productivity in Finnish working life. The reform will provide a flexible retirement age and pension accrual that will encourage people to stay in work. The retirement age will vary from 62 to 68 years, and the 60 per cent ceiling on pensions will be abolished. Preparations will be made to provide for a longer lifetime and growing pension contributions through increased funding and higher

worker contributions from the age of 53 onwards. The new system will gradually adjust the amount of pensions to today's longer lifespan.

Vocational rehabilitation within the earnings-related pension scheme will be revised as of the beginning of 2004 when it will become a comparable benefit to the old disability pension. The reform seeks to promote work ability and prolong working careers. The estimate given in the pension reform was that the effective retirement age could be raised by two years by 2015 and by three years by 2050 .

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SICKNESS COMPENSATION AND ACTIVITY COMPENSATION – THE REFORMED DISABILITY PENSION SYSTEM

Catarina Svärd

As from January 1st this year a new social security benefit has come into force, namely the sickness and activity compensation. This benefit has replaced the former invalidity or disability pension.

The terms *disability pension* and *temporary disability pension* are replaced by *activity compensation* for people aged 19–29 and *sickness compensation or time-limited compensation* for those aged 30–64.

These benefits (activity compensation and sickness compensation) are a part of the sickness insurance system.

Thus invalidity or disability pension is from now on no longer a part of the pension system, meaning that sickness and activity compensation is considered to be a part of the sickness insurance system.

The changes are a result of reforms in the old-age pension system and the abolishing of the national basic pension and supplementary pension system (ATP). The tax regulations relating to a specific basic income tax deduction for pensioners (SGA) have also been abolished. Under the new system, the benefits are taxed in the same way as other income. As a result, the gross amount of these benefits has increased to compensate the individual, but as a rule, the net amount has remained the same.

The new system does not involve any changes to the basic grounds for entitlement to compensation. As before, compensation may be granted to persons whose work ability is reduced for medical reasons, either permanently or for a long period (at least one year), by at least one quarter. Compensation is still payable at 100 per cent, 75 per cent, 50 per cent or 25 per cent of the full rate (or one quarter, half, three quarters and full compensation).

Sickness compensation and activity compensation

The new rules apply to sickness compensation and activity compensation granted from 1 January 2003. Certain transitional provisions apply.

The new allowances consist of both protection according to the loss of income principle in the form of income-related sickness compensation or activity compensation, and basic protection in the form of guaranteed compensation.

In other words, the sickness and the activity compensation are divided into two parts, one income-related and one residence-based. The income-related part is meant to be a compensation for the loss of income and the residence-based part is a basic benefit intended for those who have little or no income-related benefit. The Swedish government finances the residence-based compensation and the income-related compensation is financed by employers.

- Sickness compensation is granted to insured persons between the ages of 30 and 64
- Activity compensation is granted to insured persons between the ages of 19 and 29

Sickness compensation can either be granted for an indefinite period or a limited period. Activity compensation is always paid for a limited period of a maximum of three years at a time.

Insurance requirements for entitlement to sickness and activity compensation

According to the Social Insurance Act, the right to social insurance allowance is dependent on whether you are resident or gainfully employed in Sweden. Social insurance comprises residence-based insurance relating to guaranteed amount and allowance, and work-based insurance relating to loss of income. If you work in Sweden, you are covered by work-based insurance, regardless of where you live. If you are resident in Sweden, you are insured for residence-based benefits. You are considered resident here if you have your permanent domicile in Sweden. If you are resident in Sweden but leave the country you will still be considered

resident here if your stay abroad is estimated to last no longer than one year.

Income-related sickness compensation and activity compensation

Income-related compensation is based on the qualifying income, which is the average of the three highest annual incomes earned during a given period prior to the date on which the risk materialised (framework period). The length of the framework period depends on the age of the insured at the time of materialisation of the risk. The framework period varies between 5 and 8 years.

The framework period for insured aged 53 or above at the time of materialisation of the risk is 5 years. For insured aged 50, 51 or 52, the framework period is 6 years, for those aged 47, 48 or 49 it is 7 years and for insured aged 46 or less it is 8 years.

The right to receive income-related compensation requires that the person is insured in Sweden for work-based benefits at the time of the materialisation of the risk and that is when the capacity for work is reduced by at least 25 per cent and the reduction is assessed to last for at least one year.

The right to receive anything from income-related insurance also requires a minimum of one year with income within the framework period.

The size of the compensation is, in other words, not related to how long a person has been insured in Sweden. Neither is it possible to include as a basis for calculation income earned before the onset of the framework period.

In certain cases, special rules apply to the calculation of income-related activity compensation.

Concerning persons aged 19–29 years there are two alternative ways of calculating the compensation. These two alternative ways are there for this group or these persons to have a fair chance of having a decent income when depending on the activity compensation.

If it is more advantageous for the beneficiary, the qualifying income for income-related activity compensation may be calculated using the average of the two highest gross annual incomes during a framework

period of three years, instead of the principal rule. For persons aged 19–29, the number of years of income from work are often few, and a framework period of three years may therefore be more advantageous.

The income-related compensation is paid at 64 per cent of the individual's qualifying income up to 7.5 times the price base amount.

The 7.5 price base amounts is the ceiling for sickness insurance benefits. The price base amount for 2003 is SEK38,600. In other words the person's qualifying income can not be higher than SEK289,500 (7.5 x 38,600). In 2003, the maximum income-related compensation is SEK185,280 a year (0.64 x 289,000).

The income-related sickness and activity compensation is co-ordinated with foreign benefits which correspond to sickness and activity compensation.

The paid income-related compensation gives old-age pension rights.

Income-related compensation can be paid out no matter where in the world the beneficiary decides to live.

Guaranteed compensation and guaranteed level

This compensation is dependent on insurance periods, in this case periods of residence.

The right to guaranteed compensation and the size of the compensation depend on how many insured years in Sweden the person can claim. At least three insured years are needed to qualify for compensation and the compensation will be proportionally reduced for anyone with an insurance period of less than 40 years. Like the right to receive income-related compensation requires that the person is insured in Sweden for residence-based benefits at the time of the materialisation of the risk

Since this residence-based compensation is meant to be granted to those who have little or no income-related compensation it will only be paid in certain cases.

Guaranteed compensation is payable to those without or with a low income-related compensation, either in full, or as a top-up to reach the minimum guaranteed level. Thus this residence-based compensation is integrated with the person's income-related compensation as well as with foreign invalidity benefits.

This guaranteed level is the same for married and unmarried individuals. The guaranteed level is age-related and amounts to 2.10 price base amounts for those under the age of 21, increasing successively every other year to 2.35 price base amounts by 29 years of age and 2.40 price base amounts for those aged 30 or older. The price base amount for 2003 is SEK38,600.

In 2003, the maximum guaranteed compensation is SEK92,640 (2.40 x 38,600).

Guaranteed compensation is payable to individuals residing in Sweden, but also to those living in the EU/EEA area or in a country with which Sweden has reached a special agreement.

Indexed sickness and activity compensation

The allowances offer a standard protection as they will be recalculated annually in relation to changes in the price base amount. The benefits are adjusted upwards using the price base amount. The price base amount for 2003 is SEK38,600. Several other social insurance benefits are linked to the price base amount. This means that the benefits maintain their value as general price levels change

The beneficiary can also obtain a housing supplement for pensioners when he receives sickness or activity compensation.

The conversion from disability pension system to income-related sickness compensation and guaranteed compensation

The transition took place like this. Everybody who during December 2002 was receiving a disability pension and who should have this right if there were no new legislation in January 2003 had their pension transformed into sickness compensation. Parenthetical information is that in December 2002 there were almost 489,000 persons with permanent or temporary disability pensions.

For persons already receiving a disability pension when the new system entered into force on 1 January 2003, these benefits were

converted into income-related sickness compensation and guaranteed compensation. Persons below the age of 30 received sickness compensation instead of a disability pension.

On the whole, the benefits were raised but they also became subject to higher tax. An adjustment amount ensured that the net compensation (compensation after tax) remained more or less the same after the changes had been introduced. Calculations were based on the last month of compensation according to the regulations in December 2002. The calculated amount was after that frozen. Later changes such as a person's civil status can not affect the size of the compensation. Certain transitional provisions apply.

Special rules for activity compensation

Activity compensation can be granted for at the most three years at a time. After which an assessment of the person's continued right to compensation is made.

There are special rules for activity compensation. The age group 19–29 can be receiving activity compensation at the most three years at a time and at the same levels as I mentioned earlier.

A person in this age group with a disability also has a right to full activity compensation without any special assessment of his capacity for work if the person in question has not been able to complete his compulsory or secondary school education by the turn of the mid-year during which he turns 19 and this is due to the disability. This means that there has to be a direct connection between the disability and the unfinished studies.

The reason why the compensation to persons under 30 is called activity compensation is among other things that this age group shall be offered to participate in activities. What is meant by an activity? According to the legislator an activity is an activity which can be supposed to have a positive effect on the insured person's work ability. The final aim is that these activities should make the persons mentally ready to enter the labour market, but in the beginning the activity could be merely a support for the persons to adapt to or learn to cope with their illness or disability.

Thus unlike the disability pension system, activity compensation should stimulate activity without jeopardising the individual's economic security.

Social insurance offices should examine whether individuals who have been granted activity compensation can take part in activities that could have a positive effect on their state of health or physical or mental capacity for work. This serves to increase an individual's prospects of taking part in working life. In consultation with the insured individual, the social insurance office should plan and coordinate the various activities that the individual has chosen so as to make the best use of his development potential. Costs arising from participating in these activities may be reimbursed. It could be costs due to journeys, literature, participation fees etc.

Since this is a brand new compensation or benefit the Swedish social security has little experience whatsoever how these matters are dealt with regionally or locally throughout Sweden.

Dormant compensation

The beneficiary can test his capacity for work

The National Insurance Act makes it possible to leave the sickness compensation dormant during one year to start with.

Persons who have been granted sickness compensation for at least one year should be entitled to test their capacity for work for one year without losing their compensation rights.

This requires that the insured person has received the benefit for a minimum of one year. After that he may try to work and during this dormant time he may without any administrative complications receive the compensation if he didn't succeed in working.

The intention is that the insured will have the opportunity to try and work without the risk of the right to compensation to cease during this time. Thus the right to the compensation remains and very little administrative procedure is required to have the compensation paid out again. During this time of dormant compensation it is not necessary to make a new consideration as to the right to receive the compensation. An interesting thing is that during the first three months you are allowed to receive both your sickness or activity compensation and your salary.

The period of one year may be prolonged another two years. But after the last period of two years it is necessary for the social insurance offices to make a new consideration as to the right to receive the compensation.

There are special rules for activity compensation. Persons aged 19-29 who have been granted activity compensation are entitled to test their capacity for work for the entire remaining period for which the benefit has been granted, as from one year from the decision, without losing their right to compensation, in other words the maximum period is two years.

In December 2002 there were 2,328 persons having their compensations dormant. Something like 30 per cent quit having dormant compensation after a certain time, which means that they get the compensation back after having tried to work.

In order to further encourage people on sickness compensation to test their capacity to work, the period the benefit is dormant without the holder losing entitlement to it has been extended from one to at the most two years. The new rules were introduced in July this year.

CLOSING WORDS

Jukka Kivekäs

At the time when Finland joined the European Union in 1995, some sceptics reported fears that joining would mean crude harmonising of the Finnish legislation on social security and pensions with other EU countries by obligatory directives. The past ten years have shown that this has not been the case. Instead, there has been rapidly increased interest to know and understand the legislation, the practice as well as the processes applied in different countries.

The need for knowledge is especially high when there are amendments under way in one's own country, which is the case in the Finnish pension scheme at present. Thus, the Seminar on Current Trends of Disability Pensions in Europe is very well timed, and the presentations at the seminar have made us more acquainted with some reforms in Europe and perhaps also with the purpose and meaning of the reforms.

In many European countries, there are quite a lot of amendments under way or being planned right now. The problems pressuring countries to carry out pension reforms are very similar. Among the politicians and also among the economists, there is a shared worry about the increased number of persons retiring early, which evidently means increased pension costs when the large baby-boom cohorts born after the Second World War reach the typical age for early retirement. For example, in Finland the purpose of postponing the average retirement age has been mentioned in the policy of our last three Governments.

Also, changes in the labour market make the amendments necessary. Most of the pension schemes are built on the idea of a single long-term employment, which nowadays is no longer the prevalent situation. Instead, there is a great shift towards atypical work with different kinds of problems concerning the pension scheme. There are also many predictions according to which the lack of skilled workers, which is small at present, will become even greater in many European countries, and the question how the skilled workers currently in employment can be kept in work a few years longer has been raised.

The reforms seem to have some common features. First of all, the aim to postpone the retirement age seems to be the most important one. There is also a clear trend to move the focus of the system, at least

somewhat, from a passive benefit programme to a flexible labour market programme. This means to change the idea of disability benefits to more integrative, active parts of the social policy. Also, the relationships of the pension organisations and the reintegrative professionals, for example, the occupational health care, rehabilitation service providers, and the employment offices have become much more active and co-operative. This is especially true if the reintegration policy includes some kind of early interventions, which also seem to be common features in many reforms. So far, the pension organisations have been rather passive and only paid for the consequences of the various situations in which the work ability of the worker has declined.

An interesting feature is also the trend of outsourcing the reintegration services to private companies. Some of them may be social enterprises, whereas others are operating on clearly commercial principles.

In many countries, there are specific activity programmes for certain groups under threat of marginalisation. For example, the long-term unemployed, or young people with handicaps or major social problems hindering them to integrate into the open market may have the right to certain benefits, which in many cases, however, may include some kind of responsibility to work or take part in some activation programme, as well.

The policy makers have been very creative in building up the principles for encouraging such integration processes. Of course, there are many cultural and societal factors that explain the wide variation in the methods. Basically, the methods encourage people to stay on in working life (economic incentives to the employee or the employer), help employees and employers with reintegration (reintegration services), or make it more difficult to receive a disability pension (Table 1).

Table 1. Possible ways to encourage reintegration.

Employee
- Greater benefits during periods of active rehabilitation
- Decreasing benefits for periods of long-term disability
Employer
- Economic incentives
- Obligations of reintegration and prevention
Reintegration services
Disability legislation
- Definition of disability
- Procedure of assessment

In most countries, disability assessment is of special importance and comes under public criticism. Applying medical facts to the legal frameworks of benefit legislation is certainly not easy and involves a lot of discretion. The use and the role of specialised medical professionals, the insurance physicians, seem to vary from country to country. The criticism does not focus that much on the definition of disability, but instead on the procedure of assessment. The facts Mr Prinz told us about the OECD study, that most of the disabled people do not receive disability benefits and that 35 per cent of the benefit recipients do not regard themselves as disabled, are interesting. Does this explain that there is drastic failure in the assessment procedure? Or, is it just a fact we have to accept as the best we can do?

Current trends in social policy and civil rights also make some demands on the disability assessment procedure. The legal demands are legitimacy and justice so that the procedure would be and be perceived as fair, and treat all the applicants in the same way. The assessment procedure should also be accurate so that those who are entitled to benefits can be distinguished from those who are not. The rapid changes in legislation give rise also to demands on flexibility and effectiveness. Perhaps the most difficult demand to satisfy is having more transparency in the procedure. So far, the assessment procedure has been rather closed, and making it more transparent and easier to understand also for the applicant seems to be a difficult question for pension officers both to accept and organise.

The shift in the diagnoses behind disability pensions has put demands on making better tools for disability assessment, especially concerning mental diseases. In many countries, there is a trend to produce some standardised procedures or tools for disability assessment, and in that case the use of the functional capacity based on the ILO International Classification of Functioning, Disability and Health is a very interesting one.

To put the message of the whole seminar in a nutshell, one could say that there is a tendency to change the focus of pension organisations' disability policy from passive benefit programmes to more active labour market programmes, and thus, a whole new sector, Disability Management, can be seen as a business strategy of early intervention and reintegration for employees, employers, insurance companies as well as for the whole society.

SUMMARY AND CONCLUSIONS

Raija Gould and Sini Laitinen-Kuikka

In this report, current trends of disability pensions have been examined from both a broad comparative perspective and from the perspective of some single countries. The country descriptions again had different interests, from historic to economic-policy and administrative. Disability pensions forming a growing national economic burden was the central motive behind all these examinations.

In his opening remarks, Hannu Uusitalo described the increase of expenditures on disability pensions in different EU countries. Disability pensions form part of a larger problem: early withdrawal from the labour market and the economic burden of early and long retirement. This problem is not only in the interest of national governments but also of the EU as a community. In the single market, imbalances in the public finances of one member country are seen as a threat also to other member countries. This is the main reason why the EU has paid so much attention to the reform of the pension systems in the past few years.

The targets of the common pension policy of the EU are not only financial, however. A new balance between economic, employment and social policies has been striven for since the Lisbon Summit in spring 2000. In ten years the EU should become not only the most competitive area in the world but also an area with better jobs and better social cohesion. The role of the social security systems in this aim is to support a change from a passive to a more active social policy. The principles of an active social policy are described in the articles of this report.

In his article, Peter Wright brought up the dilemma of an active social policy from a historical perspective. Discussion on the mutual obligations of the individual and the society (here the social security system) easily leads the thoughts to the 18th century thought of deserving and undeserving poor. This dichotomy again is based on the idea of human beings mainly as independent and rational players. When examining disability this dilemma is aggravated.

The OECD report reviewed here by Christopher Prinz brings up the dilemma of an active social policy very concretely. It describes the twin but potentially contradictory goals of disability policies: integration into employment and compensation for the loss of earnings capacity. The

economic tension between these two goals becomes even more prominent by the target of the financial sustainability of the pension system. By recommending, for instance, to emphasize activation, mutual obligations and removal of disincentives to work, the conclusions of the OECD report place the ideology of disability policy close to the philosophy of unemployment programmes. Passive compensation is insufficient; benefits should instead be interweaved in individually designed participation packages.

The new approach of disability policies presented in the OECD report is based on the idea of encouraging participation in economic and social life. By preferring in-work benefits to passive compensation and by setting new obligations for people with decreased work ability, the new policy approach suggests active participation as a precondition for benefit receipt.

The new proposals to reform the Dutch disability benefit system follow the same line of thought. As Philip de Jong points out, under the new system disability benefits would be awarded only to people who have no residual work ability. Those with decreased work ability, who do not qualify for disability benefits, would be entitled to broad rehabilitative support from their employers. The same message is also clearly pronounced in the slogan of the British government, “work is the best form of welfare for people of working age” (see the article by Peter Wright).

From the point of view of the individual, the work-oriented disability policy strives to give an opportunity for employment and social participation through work. If it functions well, this policy line will strengthen the citizenship rights and empowerment of people with disabilities.

However, as the OECD report states, activation approaches tend to benefit people already in employment much more than those who are out of work. A successful integration process requires that the disabled person is able and motivated to negotiate about his or her own life policies with the gate-keepers of the various activation programmes. It presupposes that there is some room for choice in his life situation. Those most vulnerable to marginalisation, for example workers with very loose labour market attachment, may not gain by the integrative policies. Moreover, people with so-called new disabilities, such as depression, exhaustion, ambiguous pains, and problems with learning and coping, may find their lives even more difficult under the pressures of activation obligations.

From the economic point of view the justification of integration policies does not emerge from social rights; it is based on the avoidance of the cost of non-social policy (see Palola 2003, 224). A categorization of

ideal type strategies to achieve cost control reflects the relationship of the basic motives of disability policy reforms and activation policy. According to Overbye (2004) there are three ideal type strategies to achieve cost control in disability schemes. First there is the basic model, which means broad coverage accompanied by low benefits. In this model, cost control to some extent takes care of itself through low demand. The second model is the dual one: generous benefits for a core labour force but low benefits for marginal groups. Here the cost control is built into the rules limiting coverage. The third model, the encompassing model, includes broad coverage and generous benefits. In this model, cost control is exercised either through strict medical gate-keeping or extensive activation policies.

In the Nordic countries, the encompassing model is the prevailing one. To avoid overtightening the restrictive, gate keeping, emphasis has been put on integrative measures. Cost control is thus achieved by avoiding the costs of non-integrative policy. Both, in Finland and Sweden, the latest disability pension reforms have emphasized the activation element. In her article, Catarina Svärd describes the Swedish activation compensation – a new benefit for the young disabled. The activities under this compensation aim at supporting the person's coping abilities and mentally preparing him or her for entry into working life. Timo Aro discusses the integrative trends of the Finnish pension reform: the right to vocational rehabilitation and the efforts of early intervention by assessing the risk of inability to work.

Aro further describes in his article how working life has become more hectic and stressful, and the threat of lay-off or unemployment is imminent. Mental health problems rank first as the reason for granting a disability pension, which, according to the OECD study, is the case in most other European countries, too.

The qualitative change in inability to work – in particular the emerging of mental and psychological problems – calls for a broad concept of work ability. In the context of assessing work ability for benefit claims, the concept of work disability is based on illness. This illness-based concept mainly concentrates on the loss of work ability, but recently, however, a new and more integration-prone approach has been introduced. The British Personal Capability Assessment as well as the Finnish functional capacity approach focus on residual ability instead of emphasizing the incapacity.

Yet, for the purpose of preventing inability to work, the strictly medically based concept is not sufficient. The context of prevention calls for a

multidimensional notion of work ability. Besides health such dimensions as coping and exhaustion, control over work, participation and motivation are needed to capture the complexity of well-being at work. A good working life will evolve from the interactions of these dimensions on the level of the worker himself, the work process, workplace community and the organization as a whole.

Researchers of the new EU social policy have made their first outlines of a new European welfare state. Esping-Andersen and his colleagues search for the elements of a good society from the life cycle perspective of citizens (2002). The focus is on the possibilities and resources the society gives to the individuals. A good society is a society where citizens have equal opportunities and life chances. In disability policy this would mean that attention is paid not only to the integration of disabled persons into working life but also on the quality of working life. Employees' health and well-being should be one factor when the ground rules of a company are decided.

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