Sickness, Disability and Work: Breaking the Barriers

NORWAY, POLAND AND SWITZERLAND



OECD
OECDPUBLISHING

Sickness, Disability and Work

BREAKING THE BARRIERS

Norway, Poland and Switzerland

Vol. 1

OECD

ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

The OECD is a unique forum where the governments of 30 democracies work together to address the economic, social and environmental challenges of globalisation. The OECD is also at the forefront of efforts to understand and to help governments respond to new developments and concerns, such as corporate governance, the information economy and the challenges of an ageing population. The Organisation provides a setting where governments can compare policy experiences, seek answers to common problems, identify good practice and work to co-ordinate domestic and international policies.

The OECD member countries are: Australia, Austria, Belgium, Canada, the Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, the Netherlands, New Zealand, Norway, Poland, Portugal, the Slovak Republic, Spain, Sweden, Switzerland, Turkey, the United Kingdom and the United States. The Commission of the European Communities takes part in the work of the OECD.

OECD Publishing disseminates widely the results of the Organisation's statistics gathering and research on economic, social and environmental issues, as well as the conventions, guidelines and standards agreed by its members.

This work is published on the responsibility of the Secretary-General of the OECD. The opinions expressed and arguments employed herein do not necessarily reflect the official views of the Organisation or of the governments of its member countries.

Also available in French under the title:

Maladie, invalidité et travail

SURMONTER LES OBSTACLES

Norvège, Pologne, Suisse

Vol. 1

© OECD 2006

No reproduction, copy, transmission or translation of this publication may be made without written permission. Applications should be sent to OECD Publishing: *rights@oecd.org* or by fax (33 1) 45 24 13 91. Permission to photocopy a portion of this work should be addressed to the Centre français d'exploitation du droit de copie, 20, rue des Grands-Augustins, 75006 Paris, France (*contact@cfcopies.com*) or (for US only) to Copyright Clearance Center (CCC), 222 Rosewood Drive Danvers, MA 01923, USA, fax (978) 646 8600, *info@copyright.com*.

Foreword

Sickness and disability policy should be a key economic policy concern in all OECD countries, but in fact it tends to receive less attention than it deserves. Medical conditions are increasingly proving an obstacle to raising labour force participation rates and keeping public expenditures under control. More and more people of working age rely on sickness and disability benefits as their main source of income, and the employment rates of those reporting disabling conditions are low. Unemployment has fallen to very low levels in recent years in the OECD area, yet nowhere has this drop translated into more jobs for disabled people. With increasingly stricter work requirements in unemployment and social assistance programmes, and gradual retrenchment of early retirement systems, the pressure on long-term sickness and disability benefit schemes has increased. This in turn has led to rising numbers of people of working-age drawing these benefits and more public spending on them. There is now an urgent need to address this "medicalisation" of labour market problems.

This new thematic review looks at how abilities can be matched with opportunities. It examines national policies to control and reduce the inflow into sickness and disability benefit programmes, and to assist those beneficiaries who want to reintegrate the labour market. It attempts to discover what leads a person with a health problem to withdraw from the labour market or remain outside of it, and to identify areas for further policy improvement. It follows up the 2003 OECD study Transforming Disability into Ability, *which examined the relationship between labour market and social protection programmes for people with disabilities and the outcomes of these programmes in 20 countries. That report highlighted the inherent dilemmas of disability policy and concluded that a new approach should focus on activation, tailored early intervention, improved work incentives and mutual responsibilities. Many people with health problems can work and want to work, so any policy based on the assumption that they cannot work is fundamentally flawed. Helping people to work is potentially a "win-win" policy: it helps people avoid exclusion and have higher incomes while raising the prospect of higher economic output in the long term.*

The first report in this new series examines the challenges and obstacles facing Norway, Poland and Switzerland. In particular, it looks at promising steps in those three countries toward transforming sickness and disability schemes from passive benefits to active support systems that promote work. The report consists of seven chapters. Chapter 1 sets the scale of the challenges ahead and underlines the importance of improving the employment prospects of people with health problems in and out of work. Chapter 2 discusses how better management of sickness and disability can reduce the inflow into long-term benefits. It also addresses the impact of the assessment process of those applying for a disability benefit, including the requirement to undergo rehabilitation. Chapter 3 asks how to improve outflow rates from long-term benefit recipiency, and Chapter 4 analyses how work incentives are affected by the countries' tax and benefit systems. Chapter 5 examines the issue of policy coherence and interactions with other welfare schemes. Chapter 6 discusses and evaluates past and ongoing reforms in Norway, Poland and Switzerland, and Chapter 7 suggests a number of specific recommendations for further action and reform for each country.

This publication is the first in a series of three comparative reports on sickness and disability policies in selected OECD countries. The second report, to be published in 2007, will cover Australia, Luxembourg, Spain and the United Kingdom, and the final one in 2008 will cover Denmark, Finland, Ireland and the Netherlands. The three comparative reports will be followed by a synthesis report that will summarise the lessons learned in the course of the thematic review.

Work on this review was a collaborative effort, carried out by the Employment Analysis and Policy Division and the Social Policy Division at the Directorate for Employment, Labour and Social Affairs. The report was prepared jointly by Patrik Andersson, Michael Förster and Christopher Prinz (team leader). Statistical assistance was provided by Maxime Ladaique and Clarisse Legendre, and administrative support by Anne-Laure Lecoq and Heloise Wickramanayake. Important inputs for the report were supplied by the Norwegian Ministries of Finance and of Labour and Social Inclusion, the Polish Ministry of Social Policy and the Swiss Federal Social Insurance Administration. These institutions prepared background documents, provided empirical evidence, organised fact-finding missions and commented on a draft of this report. The text was also discussed at seminars in Warsaw and Oslo in June 2006.

Table of Contents

Executive Summary and Policy Recommendations 11

Chapter 1. **Main Outcomes and Key Policy Challenges** 25

1.1. Institutional challenges faced by policy makers 26
A. Controlling sickness and disability-related public spending 26
B. Raising employment rates for people with health problems 28
C. Tackling lower incomes of households with disabled people 32
D. Reducing the inflow into sickness and disability benefits 34
E. Addressing the increasing medicalisation of labour market problems 36
F. Raising the outflow from disability benefits 39
G. Strengthening co-ordination across different benefit schemes 41
1.2. Social and economic factors 41
A. General labour market trends and requirements 41
B. Health trends and disability in the population 45
C. The impact of population ageing 46
1.3. Conclusion 49
Notes 50
Annex 1.A1. Definition and Measurement of "Disability" 51

Chapter 2. **Controlling Access to Long-term Benefits** 55

2.1. Sickness management 56
A. The persistence of sickness absence 57
B. The importance of monitoring sickness absence 59
C. Summary and conclusion 62
2.2. Disability management 63
A. From sickness to disability 63
B. Medical assessment and mental diseases 64
C. The assessment process 67
D. Summary and conclusion 69
2.3. Rehabilitation management 69
A. The rehabilitation process 69
B. Medical rehabilitation 71
C. Vocational rehabilitation 72
D. Summary and conclusion 74
Notes 74

Chapter 3. **Increasing Employment Opportunities** 77

3.1. Employment support for people with health problems 78
A. The current employment and education situation 79
B. Activation programmes for disabled people 80
C. Outcomes of vocational rehabilitation 83
D. Supported employment 84
E. Sheltered employment 86
F. Summary and conclusion 88
3.2. Improving the chances of finding and retaining a job 89
A. Protection and support of disabled people 89
B. Employers' obligations to hire disabled people 90
C. Summary and conclusion 91
3.3. Making the disability benefit scheme employment-friendly 92
A. Reassessing medical conditions and using temporary benefits 92
B. The use of partial disability benefits 94
C. Summary and conclusion 95
Notes 95

Chapter 4. **Enhancing Financial Incentives** 97

4.1. Assuring adequate incomes for people with disabilities 98
A. Relative income and poverty 98
B. Income packages and income distribution 100
C. Summary and conclusion 101
4.2. Increasing work incentives for disability benefit recipients 102
A. Overview of tax and benefit regulations for disabled people 102
B. Adequacy and generosity of replacement rates of disability benefit schemes . . 103
C. Does it pay to work? 105
D. Summary and conclusion 108
4.3. Raising employer incentives 109
A. Subsiding employers to hire people with disabilities 109
B. Subsiding the self-employment of disabled people 111
C. Experience-rating of contribution rates 112
D. Summary and conclusion 113
Notes 113
Annex 4.A1. Background Tables for Different Household Types 115

Chapter 5. **Improving Governance and Policy Coherence** 121

5.1. Incentives for benefit-granting institutions 122
A. Financing mechanisms and responsibility structures 122
B. Regional judgement in policy implementation 123
C. Monitoring benefit-granting institutions 125
D. Summary and conclusion 126
5.2. Are disability benefits a support of last resort? 127
A. The impact of disability benefit rejections 127
B. The link between unemployment and disability benefits 128

C. The link between early retirement and disability benefits 129
D. Summary and conclusion 130
5.3. Better institutional co-operation 130
A. Improving co-operation between the disability authority, the PES and local welfare agencies 130
B. Improving co-operation between the disability authority and other health-related institutions 132
C. Improving co-ordination of disability benefits and old-age pensions 134
D. Summary and conclusion 134
Notes 135

Chapter 6. **Evaluating Recent and Ongoing Reforms** 137

6.1. Norway: making the tripartite agreement a success 138
A. Efforts to reduce sickness absence 138
B. Extending the IW Agreement 140
6.2. Poland: preparing the next comprehensive steps 141
A. Successful tightening of access to benefits 141
B. Piecemeal reform of the system of employment support 142
6.3. Switzerland: bringing the "fifth revision" on track 143
A. Improving the medical tools 143
B. Efforts to reach people with work incapacity earlier 144
6.4. The impact of recent and ongoing reform 146
Notes 148

Chapter 7. **An Agenda for the Future** 149

7.1. Key problems and possible solutions in Norway 151
A. Inflow management and assessment procedures 151
B. Vocational intervention, outflow management and work incentives 153
C. Improving the institutional setup and synchronising different schemes 154
7.2. Key problems and possible solutions in Poland 155
A. Inflow management and assessment procedures 156
B. Vocational intervention, outflow management and work incentives 158
C. Improving the institutional setup and synchronising different schemes 159
7.3. Key problems and possible solutions in Switzerland 161
A. Inflow management and assessment procedures 161
B. Vocational intervention, outflow management and work incentives 163
C. Improving the institutional setup and synchronising different schemes 164
Notes 165

Bibliography 167

List of Acronyms 171

List of Boxes

0.1. Policy recommendations for Norway 15
0.2. Policy recommendations for Poland 18
0.3. Policy recommendations for Switzerland. 22
1.1. The structure of the countries' sickness and disability schemes – an overview . . 29
1.2. Computing comparable recipiency and inflow rates for Poland 37
2.1. Reassessing and monitoring sickness absences 60
2.2. Two good examples of case management to reduce absences 61
2.3. Key elements of the 2004 Social Insurance Act in Norway 62
2.4. The complexity of mental health problems 66
2.5. The special farmers' pension system (KRUS) in Poland. 67
6.1. The 2001-2005 tripartite agreement on more inclusive workplaces in Norway. . . 139
6.2. Withdrawn 2004 public expenditure reform plans in Poland 142
6.3. The planned fifth revision of the Swiss Disability Insurance Act 145
6.4. Illustration of countries' policy stances and trends 146

List of Tables

0.1. The magnitude of the policy challenge in Norway, Poland and Switzerland. 12
1.1. Growth in average disability benefits has exceeded wage growth in the past four years 30
1.2. Employment differentials in Norway and Switzerland depend on age and education. 31
1.3. One out of six inactive disabled persons wants to work 33
1.4. Incomes of disabled persons are a good tenth below the average. 33
1.5. One out of three inactive men are not looking for work because of disability. . . . 38
1.6. Mental diseases are becoming the main reason for take-up of disability benefits 39
1.7. Very few younger disabled beneficiaries succeed in leaving benefit rolls 40
1.8. Most disabled people who are moving to jobs become part-time employed 40
1.9. The labour market in 2005: Low employment and high unemployment in Poland . . 42
1.10. Disability prevalence increases with age and lower education, especially in Poland 46
1.11. Population ageing will have a larger impact on beneficiary trends in Norway and Poland 48
1.A1.1. Prevalence and benefit receipt: different disability definitions 52
1.A1.2. Poland: characteristics of disabled persons, different disability definitions and overlap 54
2.1. Sickness benefits are the main pathway to disability benefits in Norway 57
2.2. The assessment process from sickness to disability, 2005 64
2.3. People in rehabilitation have different health problems from those on disability benefits 71
2.4. Participation in medical rehabilitation is very high in Norway, especially at younger ages 72
2.5. Participation in vocational rehabilitation is extremely high in Norway 73
3.1. Outflow from disability benefits into jobs is extremely low in all countries 78
3.2. Large differences between the jobs of disabled and non-disabled people in all countries 79
3.3. Disabled people have lower levels of educational attainment 80

3.4. Almost half of all participants in vocational rehabilitation in Norway receive training . . . 82
3.5. Outcomes from vocational rehabilitation in Norway can be improved . . . 84
3.6. Temporary benefits in Norway may have lowered the entry threshold for younger people. . . . 93
3.7. Partial disability benefits are used more often in Switzerland than in Norway . . 94
4.1. Lower education triples poverty risks for disabled persons in Switzerland . . . 100
4.2. Earnings are an important income source for disabled persons in Norway. . . . 100
4.3. In Norway and Poland, incomes are distributed more evenly among disabled persons . . . 101
4.4. Gross and net replacement rates for average earners are lowest in Poland. . . . 103
4.5. Increasing working hours may penalise recipients of partial disability benefits . 108
4.6. Employers are encouraged to hire or keep disabled workers through a range of schemes . . . 110
4.A1.1. Main characteristics of disability benefit and taxation systems, as at 1 July 2004 . . . 116
4.A1.2. Net replacement rates for single persons, at three different ages, 2004. . . . 118
5.1. Regional variation in outcomes is substantial in all three countries. . . . 124
7.1. The magnitude of the policy challenge in Norway, Poland and Switzerland, 2006. . . 150

List of Figures

1.1. Spending on disability benefits is high in all three countries. . . . 27
1.2. Disability benefit recipiency rates are far above the OECD average in Norway and Poland . . . 28
1.3. Employment rates are markedly lower for disabled persons, especially in Poland. . . 31
1.4. Unemployment is high and increasing in the disabled population. . . . 32
1.5. A higher risk of poverty among disabled people in Poland and Switzerland 34
1.6. Disability benefit inflow rates have developed quite differently in the past 15 years . . . 35
1.7. Older workers are far more likely to be granted a disability benefit 35
1.8. Levels of sickness absence are high in Poland but especially high in Norway. . . . 38
1.9. Very high prevalence of mental disorders in Europe 39
1.10. Inconclusive evidence on changes in the working environment 43
1.11. Steadily improving objective health status in all three countries 47
1.12. Past trends in beneficiary numbers in Norway have been dominated by demographic changes . . . 47
1.A1.1. Self-assessed disability and benefit receipt: overlap 53
2.1. Sickness absence varies dramatically by age and by country. . . . 58
2.2. The bulk of sickness absence is long term. . . . 59
2.3. Mental diseases are most common in younger ages 65
2.4. Large variation in the inflow to disability benefits by health reason and age 65
2.5. Rehabilitation provision is substantially higher in Norway 70
3.1. Activation spending in Norway is predominantly on rehabilitation benefits 81
3.2. Disabled workers in Poland are overrepresented in sheltered employment 87
3.3. A large share of all disability beneficiaries are reassessed in Poland 92
4.1. Disabled persons with higher education levels have less income constraints . . . 99
4.2. Disability and unemployment schemes provide similar net benefits for low-income earners. . . . 104

4.3. Occupational disability benefits in Norway boost replacement rates for high-income earners 106
4.4. Taking up work can be very costly for many beneficiaries 106
4.A1.1. Net replacement rates for disability benefits, unemployment benefits and social assistance, couple households, 2004 117
4.A1.2. Average effective tax rates for disabled persons in different household situations, 2004 118
5.1. Disability benefit claims are increasingly rejected and appeals are less successful 127
5.2. The relationship between unemployment and disability benefit schemes, 1990-2004 128
5.3. Early retirement and disability benefit inflows in Norway and Poland, 1995-2004 . . . 129
6.1. Sickness absence fell in 2004 but is increasing again. 140
6.2. Comparing sickness and disability policies over time and across countries 147

ISBN 92-64-02631-2
Sickness, Disability and Work
Breaking the Barriers – Vol. 1
© OECD 2006

Executive Summary and Policy Recommendations

Too many workers leave the labour market permanently due to health problems, and too few people with a disabling condition are working. This is a social as well as economic tragedy that is common to virtually all OECD countries, including Norway, Poland and Switzerland. Health-related problems are increasingly proving an obstacle to raising labour force participation rates and keeping public expenditures under control. All three countries have very high public spending on sickness and disability benefits compared with many other OECD countries. Yet throughout the OECD area there is a shared paradox that needs explaining. Why is it that health is improving, yet more and more people of working age end up out of the workforce claiming health-related income support? This report explores the possible factors behind this paradox, highlights the role played by institutions and policies, and puts forward a range of reform recommendations aimed at improving the situation.

The essential problem in all three countries as well as elsewhere is that too little is done to avoid the flow from work to benefits and to move benefit recipients back to employment. At the same time, financial incentives to work and obligations for disabled people on benefits as well as employers are weak. The key policy challenges facing the three countries are summarised in Table 0.1.

Table 0.1. **The magnitude of the policy challenge in Norway, Poland and Switzerland**

Seven key policy challenges[a]	Norway	Poland	Switzerland
1. Controlling incapacity-related public spending	+++	+++	+++
2. Raising employment rates for people with health problems	++	++++	+
3. Tackling lower incomes of households with disabled people	+	+++	++
4. Reducing the inflow into sickness and disability benefits	++++	+	++
5. Addressing the increasing medicalisation of labour market problems	++	+	+++
6. Raising the outflow from usually permanent disability benefits	++++	+++	++++
7. Strengthening co-ordination across different benefit schemes	++	++++	+++

a) The scales should be interpreted as follows:
+ … minor challenge; ++ … moderate challenge; +++ … substantial challenge; and ++++ … formidable challenge.
Source: Authors' assessment.

Recognising the key role of policy in this field, all three countries have engaged in reform processes that are in the right direction. Poland and Norway have broadened their rehabilitation and employment policies considerably during the past 20 years, and Switzerland has followed a similar path recently with further comprehensive reform pending. They have also started to modify their benefit systems, with a view to making access tighter while ensuring adequate coverage, placing a stronger focus on temporary entitlements and strengthening re-employment opportunities and incentives.

While these reforms are likely to help improve the effectiveness of activation and integration approaches, this report shows that much more needs to be done. Efforts to

curtail flows from work to benefits and to raise participation rates of those disabled people who wish to work are still insufficient in view of the outcomes in all three countries:

- In Norway the inflow into disability benefits is particularly high with no sign of a turnaround in the trend, and sickness absence is twice the OECD average.
- In Switzerland disability benefit inflow rates started to fall in the past two years after a long period of steady increase, but this fall will not be sufficient to reduce public spending.
- In Poland the inflow into disability benefits has dropped sharply in the past six years, but substitution into other benefit schemes has been substantial, calling into question the long-run sustainability of this decline.
- In all three countries, employment rates of people with disabilities continue to be low – much lower than those of non-disabled people, especially in Poland.
- Employment rates of disabled people have tended to decline even further recently, partly reflecting changes in the work environment and population ageing, but also due to policy itself.

The reform process is reaching a critical stage in all three countries (see Chapter 6). In Norway, the tripartite agreement on "inclusive workplaces" has come to an end, and the partners to the agreement have recently negotiated the next steps. In Poland, the new government would do well to relaunch some of the public expenditure reform proposals of the previous government that were turned down by parliament. In Switzerland, a proposed fifth revision of the Disability Insurance Act is currently under discussion in parliament, with enactment scheduled for mid-2007.

Work needs to be put at the heart of sickness and disability policies, not only because of the needs of the economy but also to reflect social considerations: improving work opportunities is the best way to ensure that people on long-term sick leave or with disabilities have a chance to play the role in society to which they aspire. Such an approach should increase employment rates and reduce public spending, which further justifies dedicating resources and public expenditures to achieving this end. The starting point of this report is that the objective of policy is to ensure that people with disabilities have the opportunity to play as full a role in society, and particularly in the labour market, as they are able to. Policy discussions frequently focus on how to reduce the number of people on benefit. But the trouble with approaching sickness and disability policy from this angle alone is that it misses the point of view of people with disabilities themselves. Current policies often serve such people badly: they are trapped at the margins of society, excluded from work or marginalised into special employment categories.

Challenges and policy options for Norway

The current situation

Despite a very good general economic and labour market situation, the employment rate of disabled people in Norway is just under 45%, compared to 83% for the non-disabled population. This is a poor outcome given the sizeable investments in vocational rehabilitation and training for disabled people. These efforts have been successful in ensuring that disabled workers have the same access to continued education and training and that they are evenly

represented in all sectors of the economy, including the public sector. However, the high levels of inactivity and unemployment among disabled people remain.

Public spending on sickness and disability in Norway, at 4.1% of GDP in 2004, is more than twice the OECD average, and most of the spending is on benefits rather than measures that encourage welfare-to-work transitions and labour market inclusion. The proportion of workers moving onto sickness and disability benefits is among the highest in OECD countries. With a very high overall employment rate, today the greatest share of non-employment among working-age people in Norway is due to health reasons. Raising employment and labour force participation rates further – which is essential in order to respond to population ageing and to maintain economic growth – therefore requires, first and foremost, tackling sickness as the major reason for dropping out of the labour market.

A striking finding is that the Norwegian sickness and disability benefit system appears to contain many useful provisions, and yet outcomes and take-up are disappointing. For instance, there is an option for gradual re-entry from sickness into work and a very fine grid of partial disability benefits, but most people receive a full benefit. Further, the possibility of keeping a disability benefit upon moving into work was introduced many years ago, but outflow from benefits into work is almost nil. Likewise, no other OECD country spends nearly as much as Norway in terms of vocational rehabilitation and training to avoid inflow into long-term benefit receipt – yet disability benefit dependency is higher than anywhere else.

The key challenge for Norway, therefore, is to understand *why* the existing frameworks, which look good, are not delivering; if it is lack of enforcement and implementation, how to tackle this; and if it is wrong incentives, how to change them. Little is known about how the existing regulations and provisions available in the system are being implemented by local actors, and how implementation of policies varies across the country. Related to this is a general reluctance to apply sanctions if a particular rule is not followed, although – more than in other OECD countries – sanctions for employers, doctors and beneficiaries do exist on paper.

Key policy recommendations

Sickness absence in Norway is going to have to decrease much further if the tripartite agreement objective of a 20% decline in absence rates compared to 2001 is to be achieved, and it would have to fall much further than that to match the OECD average level. The problem of persistently high rates of inflow into disability benefits, partly a consequence of the high incidence of long-term sickness absence, also has yet to be tackled forcefully. The same holds for the disappointingly low employment rate of disabled people. Three problems in particular should be addressed in future reforms:

- Lenient assessment for disability benefit entitlements and the key role of general practitioners (GPs) in this process.
- The reasons for the little success of the costly system of vocational rehabilitation and training in avoiding new disability benefit claims.
- The near non-existence of transitions back into employment of recipients of disability benefits.

Addressing these issues means that measures and reforms will have to involve stricter obligations for the various actors and better-enforced sanctions in case of non-fulfilment of obligations. Moreover, a new balance is needed between better work incentives and tighter eligibility criteria. To bolster ongoing and planned reforms, this report makes a number of policy recommendations, summarised in Box 0.1.

Box 0.1. **Policy recommendations for Norway**

Sickness and disability assessment

First, the obligations of GPs and checking of their assessments need to be strengthened. While recent reform has helped in turning sickness in the workplace from a private to a more openly discussed matter, there is hardly any monitoring of GPs' new duty to assess functional capacity and investigate the potential of graded and active sick leave. Furthermore, assessment of long-term disability still overly relies on the GP's judgement (currently, more than 80% of all disability assessments are prepared solely by GPs). Therefore, additional measures are required:

- Frequent checks of GPs' sickness assessments by social insurance doctors, which is common practice in many other OECD countries, and actual sanctioning for non-fulfilment of duties. This should result in the GP temporarily losing the right to certify longer-term sick leave.
- A reduction of GPs' assessment and gatekeeping function in exchange for a strengthening of their guidance and assistance function, again following the general practice in most OECD countries. Gatekeeping should be transferred to the National Insurance Administration (NIA) and its specialised social insurance doctors, with increased involvement of vocational experts in the assessment process.
- More efforts should be put into using partial work capacity and partial disability benefit awards. The low share of partial awards despite the seemingly strict entry criteria for a full benefit suggests that medical assessments are too lenient.

Rehabilitation and training system

Second, reform of the rehabilitation and training system should be carried out to identify and promote successful instruments and to improve its overall effectiveness. The following measures should be considered:

- Efforts should be made to reduce the period during which people receive a medical or vocational rehabilitation benefit without receiving medical treatment or intervention and without participating in a vocational measure. It will be important to speed up the transition into a measure and to get more people who are on rehabilitation benefits into a programme.
- Medical and vocational rehabilitation, which are the responsibility of different bodies, should go hand-in-hand. This requires better co-ordination and common objectives, including the goal to restore the person's work ability.
- Geographical and occupational mobility requirements for vocational intervention should be strengthened and harmonised with those used in the unemployment benefit system. Moreover, in order to facilitate a faster return into work, the focus on employment-oriented vocational measures should be increased.

Box 0.1. **Policy recommendations for Norway** *(cont.)*

Outflow from disability benefits

Third, more should be done to raise the proportion of people on disability benefits who move to employment. Current barriers include the awarding of permanent and full benefits to most applicants, the limited possibility of combining a full benefit with labour earnings, and the limited incentives for partial benefit recipients to increase their working hours. The following measures could help promote job prospects of disability benefit recipients:

- The share of permanent disability benefit awards should be reduced further, and it should be easier to review existing entitlements. Beneficiaries who were granted a temporary benefit should be followed up and offered the support needed to return to employment.
- The same kind of attention in terms of follow-up and support should be paid to the increasing number of people whose application for a disability benefit was rejected.
- Work incentives for beneficiaries of a disability benefit need to be improved. The favourable tax treatment of permanent disability benefits in comparison to taxation of labour income should be removed, and in-work benefit payments for disabled persons taking up work or increasing their working hours should be considered.

Incentives for workers and employers

Fourth, in order to reduce the high level of sickness absence – the usual route to disability benefit – incentives for employers and employees should be changed to avoid the use of sickness benefits as a pathway to exit the labour market. Sickness benefits are currently paid at 100% of the past wage for a whole year. The incentives should in effect encourage actions to prevent health problems. Mirroring suggestions made by a government commission several years ago, measures in these areas could include the following:

- Long-term sickness benefits should be considered to be reduced to, say, 75-80% of the previous wage to increase individual's incentives to return to work. Medical and vocational rehabilitation benefits, which are often used to extend sickness benefit periods by several years, might have to be adjusted accordingly.
- The new employer obligations in relation to sickness management could be strengthened by shifting a larger part of the costs of absences onto employers. This could be done by extending the employer's current ten-day wage-payment period for sick workers to, say, 4-6 weeks, or by introducing carefully designed experience-rated premiums to the sickness benefit insurance. To avoid the consequent increases in labour costs this could be combined with a reduction in social security contributions, thereby rewarding employers investing in sickness management and prevention.

Merger of the PES and the NIA

Fifth, a number of measures should be taken to facilitate a successful merger of the PES and the NIA. This would help ensure that all persons with disabilities get the right service at the right time. These measures include:

- Governance of the merger could be improved by clearer guidelines for the institutions involved showing how to establish a joint front-line service successfully and how best to collaborate with the local social assistance authorities.
- Sufficient investments are needed for training caseworkers of the new merged institution, and for proper monitoring of the performance of local offices delivering the services, in order to assess results and identify worst performers.

SICKNESS, DISABILITY AND WORK: BREAKING THE BARRIERS – VOL. 1 – ISBN 92-64-02631-2 – © OECD 2006

Box 0.1. **Policy recommendations for Norway** *(cont.)*

Co-ordination with old-age pensions

Sixth, improvements are also needed in relation to the forthcoming reform of the old-age pension system. There is a risk that, following introduction of pension deductions for those retiring before the age of 67, more older workers will exit the labour market through the disability pension system. Co-ordination of old-age pensions and disability benefits should be based on two principles:

- Disability benefit recipients should pay full contributions to the retirement fund so as to ensure adequate old-age pension entitlements upon reaching the retirement age.
- The disability benefit formula should be adjusted to make sure those benefits do not exceed the corresponding early retirement benefit entitlements at the same age.

Challenges and policy options for Poland

The current situation

In certain areas, the situation in Poland has improved substantially in recent years. Inflow rates into disability benefits, which were higher than anywhere else among OECD countries in the early and mid-1990s, have fallen to below the OECD average. In turn, the number of disability benefit recipients has started to fall. Outflow rates from disability benefits are also higher than in most other OECD countries, including Norway and Switzerland, not least because most benefits are granted temporarily. These are important prerequisites for integration policies to be put in place more effectively.

However, Poland has extremely low levels of labour market participation of disabled people: less than one in five is in employment. The employment rate of disabled people has continued to fall during the past decade, with the attendant ongoing deterioration of their economic well-being. The take-up of vocational rehabilitation is practically nil. Instead, the traditional segregation approach is dominating. As a result, more than four in ten disabled workers are employed in Sheltered Work Enterprises, which are heavily subsidised. Moreover, if in employment, disabled people tend to have part-time, temporary jobs or to work as self-employed or family workers. They are significantly overrepresented in the agricultural sector and underrepresented in the public sector.

The employment problems of people with disabilities can be partly explained by the overall poor labour market situation in Poland, characterised by high levels of inactivity and the highest rate of unemployment in the OECD area. Further reform of sickness and disability policies, therefore, needs to be done in tandem with general labour market and product market reforms aiming at making work pay, raising labour demand and encouraging a shift from informal to formal employment so that work can become a realistic option for persons with a disability.

Key policy recommendations

The effective tightening of the access to sickness and disability benefits has failed to improve the employment rates of disabled people. This raises the question of whether the whole system of employment support for disabled people in Poland needs more fundamental reform. Some of the elements of the current system may need to be abolished

altogether or replaced by more effective instruments if a real change in policy and outcomes is to be achieved. In most cases, however, it should be possible to improve outcomes by eliminating the key weaknesses and bolstering the key strengths of the various systems currently in place. Change is therefore needed in two areas especially:

- The system of medical and vocational rehabilitation has not helped to improve the qualifications and skills of disabled people.
- The system of employment support fails to deliver the relevant support at the right time.

Changes in those two key areas must be supplemented by measures to streamline the sickness and disability assessment process further and by improved work incentives for benefit recipients. To this end, this report makes a number of policy recommendations, summarised in Box 0.2.

Box 0.2. **Policy recommendations for Poland**

Vocational rehabilitation and training

First, the system of vocational rehabilitation and training needs to be strengthened. If the causes of the negligible impact of this system are not addressed, then improving outcomes in terms of higher employment rates and lower benefit dependence of disabled people will be very difficult to achieve. It appears that eligibility criteria are too strict, labour offices have inadequate funding, and people hesitate to enter what are so far entirely voluntary vocational programmes. The following measures could be adopted:

- Eligibility criteria for participation in vocational rehabilitation should enable and encourage early intervention. Restricting vocational services to people with a legal disability certificate who are registered as unemployed or jobseekers is too limited an approach.
- The supply of well-targeted, high-quality services should be increased, and a more individualised approach in providing them should be implemented.
- If the supply of effective services is increased, some elements of obligation should also be introduced, *e.g.* in the form of moderate benefit reductions for people refusing to participate in vocational rehabilitation.

Structure of employment support

Second, a more fundamental change is needed to improve the system of employment support. Streamlining administrative structures and responsibilities might be necessary. The large number of players involved – social insurance institutions, the Public Employment Service (PES), the State Fund for the Employment and Rehabilitation of Disabled People (PFRON) and local governments – makes it difficult for a disabled person to get the right support at the right time. Reform could include the following measures:

- A one-stop-shop philosophy should be promoted and the funding structure reinforced so that responsibility and funding go hand-in-hand to help facilitate reintegration of disabled people. Local governments are probably best placed to assume this function. PFRON as a distinct institution may become redundant in a reformed system.
- Governance of local labour offices, local governments and PFRON activities should be strengthened to improve employment outcomes for disabled people. Monitoring mechanisms should be introduced in combination with target setting to ensure that funds are used and policy instruments implemented as intended.

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

- Co-ordination between the PES, which offers re-qualification programmes, and the social insurance authority, which covers the costs of a training benefit offered during this period, should be improved by giving the latter a supervisory role. One should also consider a change in the funding structure, so that the PES would benefit financially from successful placements of disabled people into paid jobs. A necessary increase in PES resources for this group of people could be achieved by opening PFRON funds for the PES, with PFRON purchasing or co-financing PES services for disabled people.

Assessment procedures

Third, reform is needed to reduce sickness absence and to maintain the current level of inflows into disability benefits after the forthcoming abolition of early retirement pathways. Further reform should streamline and improve assessment procedures. More precisely:

- Responsibility for the entire disability assessment process should be transferred to the social insurance institutions. The current separation of assessments for income support purposes (performed by the social insurance institutions) and labour market purposes (performed by local government assessment teams) is confusing, inefficient and likely to contribute to labour market exclusion.
- Rules in the special system for farmers (KRUS) should be aligned with those in the general social insurance scheme, ideally leading to a re-merging of the two schemes over the medium term. In particular, this would require changes to the contribution regulations in the KRUS scheme and in the very narrow definition of disability as the inability to continue to work on one's own farm.
- Better use should be made of existing legal possibilities for controlling sickness absences of all durations, including the first 33-day sickness period during which wage payments continue to be paid by the employer, and for penalising treating doctors who repeatedly assess "false" sickness.
- Policy should address the high proportion of successful appeals against rejected claims. As economic and non-economic costs of the latter are very high, more accurate decisions at the initial stage are important. Refused claimants should be followed up in order to prevent this group from becoming benefit recipients at a later stage or falling into poverty.

Financial incentives for workers

Fourth, financial incentives to work should be improved to promote voluntary moves into the labour market by beneficiaries who are willing and able to work. This would be achieved by the following measures:

- A smoother phase-out of disability benefits with increasing wages, instead of the current abrupt fall in the amount of benefit income in the *switch* to (more) work would eliminate uneven incentives to work. In addition, for recipients of a full benefit the possibility to try work in the regular labour market without immediately losing benefit entitlements should be introduced and encouraged by, for example, temporary in-work benefit payments.
- Other benefits, especially housing and social assistance benefits, should be reformed so that these do not create benefit traps and discourage work by beneficiaries of disability benefits in particular, but more generally as well.

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

Co-ordination with old-age pensions

Fifth, better co-ordination is needed between the reformed old-age pension and the disability benefit scheme to avoid increasing pressure on the latter in the aftermath of the upcoming phasing-out of early retirement schemes. To avoid spill-over effects in the form of a transfer of people to the more generous disability benefit scheme, reforms along the following lines should be considered:

- Benefit levels should be harmonised to ensure that the disability benefit entitlement for a person at, say, age 60 comes close to the benefit level of the old-age pension at this age.
- A clearer separation with a transparent transfer of funds is needed between disability benefit and old-age pension insurance. Ideally, regulations on contribution payments of recipients of a disability benefit to their own old-age pension accounts would be put in place, and disability benefit payments would be replaced by old-age pensions in line with the person's contribution history as soon as the person reaches the retirement age.

Wage subsidies reconsidered

Sixth, a number of measures are required to make wage subsidies as well as Sheltered Work Enterprises (SWE) more effective. In extending wage subsidies, which are financed from levies on companies not fulfilling the 6% employment quota for disabled people, to companies in the regular labour market, new challenges have arisen. If employment of disabled people were to increase as intended, the size of the fund would decline while spending on permanent wage subsidies would increase. Moreover, the strong focus on sheltered work has perpetuated the segregation of disabled workers and hindered their integration into the regular labour market. To correct these problems, further changes are needed which could include the following:

- Wage subsidies should be financed by taxes, like other public expenditure. Financing them through an earmarked contribution results in ineffective spending. In addition, were the spending to become effective, the result would be insufficient revenues to finance the expenditures.
- The prevailing privileges of SWEs – such as the income tax refund for *all* employees (including non-disabled employees) – should be further reduced in exchange for raising the resources available for skill improvements.
- To safeguard sufficient resources for people with moderate and severe health conditions, phasing-out permanent wage subsidies over time for those with a light disability working in a SWE should be considered.

Challenges and policy options for Switzerland

The current situation

Swiss policy makers are forced to act because, without further reform, the disability insurance fund as well as its current reserve fund will run into deficit in the foreseeable future. In contrast to other countries, the Swiss funding system does not allow balancing of deficits through increased government contributions. Thus, an increase in revenues is needed in order to balance the deficit accumulated in the past. In addition, very much like Norway, if Switzerland wishes to raise its future labour force potential in order to cope with

the challenges of population ageing, it would have to find ways to retain people with health problems in work and, ideally, to reintegrate people with reduced work capacity.

In general, policy outcomes in Switzerland are mixed. Inflow rates into disability benefits are still below the OECD average but they have been rather stable over time, thus contributing to a continuous increase in the number of beneficiaries. Sickness absence is relatively low, but creating major problems for the disability insurance because of inadequate co-ordination with the private sickness benefit insurances. As in Norway, disabled workers are unemployed to a higher degree – but, at 52%, their employment rate is relatively high compared to other OECD countries. Average disability benefits have increased rapidly in recent years, yet relative poverty rates among disabled people have increased as well.

A particular problem in Switzerland, more widespread than elsewhere in the OECD area, is the steep rise in mental illnesses as a cause of disability. Mental diseases have become the single most important reason for take-up of disability benefits, accounting for over 40% of the total inflow. There is much controversy about the reasons behind this development, which seems to reflect the increasing "medicalisation" of labour market and social problems. However, this preponderance of mental health problems also reveals weaknesses in the definition of disability and the assessment process.

Another special feature of the Swiss situation is the strong role of the private insurance market. Several parts of the social protection scheme fall under private insurance regulations, such as the sickness cash benefit scheme; others, despite being mandatory, are administered by privately run institutions, such as the second-pillar old-age and disability pension. The activities of these private players – which can be regulated to a certain extent but not steered directly – have a strong impact on the design and effectiveness of public policy.

Key policy recommendations

Bringing people in contact with disability insurance at an earlier stage through early identification of serious health problems is a promising approach that targets one of the key weaknesses in the Swiss system. However, the incentives for various actors to make this approach work are insufficient. The impact of the planned reform could be greatly enhanced by introducing obligations for actors in contact with the sick person at an early stage. Three aspects are particularly important for future reform:

- Sickness benefit insurers have insufficient incentives and obligations to address problems.
- Employers have insufficient incentives and obligations to bring sick employees back into work.
- Greater use should be made of vocational rehabilitation and training.

In addition, ongoing as well as future reform should continue to address work incentives, co-ordination across different schemes, and the governance of the cantonal disability offices (CDOs). This report makes a number of policy recommendations, summarised in Box 0.3.

Box 0.3. **Policy recommendations for Switzerland**

Private sickness benefit insurers

First, better balance is needed between obligations and incentives for private sickness benefit insurers. Since most people in Switzerland enter the disability benefit system after a period of sickness, the performance of these insurers is crucial. Reform affecting insurers and GPs should include the following changes:

- Private sickness benefit insurers should be obliged to introduce sickness management and a system of sickness monitoring, because they do not bear the full costs of failing to address problems. This monitoring should include the obligation to inform the public disability insurance of long or repeated absences, in order to make earlier intervention on their side possible. Monitoring should also include stronger controls of sickness absence certificates and better co-operation and exchange of information between GPs and insurance doctors.
- Individual case management introduced successfully by SUVA, the main accident insurer, could serve as a model for sickness management by private insurers. Mandatory sickness benefit insurance for all workers should be introduced (though still run by private insurance companies), to ensure that all sickness absences are managed properly.
- Retrospective payments to the private sickness benefit insurer in case a person becomes entitled to a disability benefit later on should be abolished, because these payments reduce the insurer's incentives to manage the case properly. (Retrospective payments to persons not covered by private sickness benefit insurance are a different matter.)
- GPs should be obliged to seek advice from occupational health services, which should give advice on workplace adaptation and rehabilitation opportunities. More support and training for GPs should be provided to improve their knowledge of social insurance issues.

The role of employers

Second, as regards employers, a balance will have to be sought between stronger obligations, better support and proper incentives. The experience-rated premiums recently introduced to sickness benefit insurance are a strong incentive for employers to prevent long-term absences and disabilities in order to keep premiums low. (This new system is likely to also result in stricter health screening in the recruitment phase.) Further reform and adjustments are needed, which could include the following elements:

- Employers, who only carry some of the costs of unaddressed sickness, should be required to play a part in the preparation of a plan for the reintegration of their long-term absent employees, as has become common in several OECD countries, and also to introduce a system of sickness monitoring.
- Employers should receive better support from medical and vocational specialists in managing absences. This type of support should be provided by the new so-called "agencies for early identification and assistance", which are planned to be introduced with the forthcoming reform.

Vocational rehabilitation

Third, eligibility for rehabilitation should be widened to move the system from "rehabilitation before benefits" to "rehabilitation instead of benefits". Take-up of vocational rehabilitation and training measures in Switzerland is relatively low. Strict eligibility criteria for vocational intervention probably go some way toward explaining this. Moreover, there is no use of vocational measures as a way of raising outflow from disability benefits. Therefore, the following changes should be made:

- Eligibility criteria for rehabilitation measures should be broadened to include all people with health-related difficulties in the labour market, thus moving away from assessing the legal basis of a case and toward helping people back to work. In particular, more efforts should be made to integrate people with mental conditions into the rehabilitation system.

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

- More focus should be placed on offering vocational measures to reassessed beneficiaries. Along these lines, a reassessment of the very large number of younger beneficiaries, who tend to have much higher work motivation, should be considered. Some of the newly planned measures might be particularly suitable for younger people, who often suffer from mental health conditions.

Outflow from disability benefits

Fourth, work incentives should be enhanced to raise outflows from disability benefits. OECD calculations show that marginal effective tax rates for beneficiaries taking up work are very high, especially for those with children. While the gist of the fifth revision of the Disability Insurance Act is to lower inflows into benefits, plans to improve financial incentives so as to make leaving benefits more attractive should also be implemented soon and not be postponed to after implementation of other elements of the reform. Among the changes possible are the following:

- The system of generous child supplements in the first pillar should be changed to avoid benefit traps and encourage work by beneficiaries. Consideration should also be given to introducing a means test for these supplements, because the payments constitute an important part of resources of the lower-income population.
- The use of in-work payments and temporary suspension of benefit entitlements should be considered for persons taking up work or increasing their working hours. This would encourage beneficiaries able to work to try and find another job or to work longer hours.

Inter-institutional co-operation

Fifth, ongoing but voluntary inter-institutional co-operation across different systems and institutions should be strengthened to further improve the flow of information and co-ordination of activities. This could be done through the following measures:

- Rejected disability benefit applicants should be closely followed up by the disability insurance to ensure that these people obtain the necessary support to be able to remain in or return to the labour market. The planned short-duration vocational measures aimed at preventing long-term disability should, where appropriate, be made available to rejected benefit applicants.
- To further promote successful co-operation between various institutions and insurances, it would be important to strengthen the legal underpinning of ongoing co-operation efforts. The approach taken by the canton of Solothurn is a model that other cantons should consider seriously. In this canton, under a new law local one-stop-shops and a cantonal case management office were established with legally binding cost-sharing between the disability insurance, the unemployment insurance and the communities.

Governance of cantonal offices

Sixth, governance of the disability insurance itself should be improved further. Currently there is a mismatch between funding and responsibility mechanisms, with cantonal offices granting the benefits while most funding comes from the federal level. Strengthened supervision and inspection of cantonal disability offices by the federal supervisory authority would further promote the harmonisation of practices across cantons. The following measures could be considered:

- The federal authority should have responsibility for identifying best practice and publicising such practices across cantons. It should formally signal when a canton has poor outcomes apparently due to failure to introduce best practices.
- Management through measurable targets and indicators of effectiveness, as recently introduced for the PES and currently in preparation for the CDOs, should be put in place as soon as possible, and include sanctions for non-achievement of targets. Indicators should mirror the overall approach of the insurance office and measure its success in terms of process duration as well as employment outcomes.

Last but not least, all three countries lack rigorous evaluation of most of their regulations and instruments. Particularly important is better knowledge of which type of rehabilitation and employment programmes work, and for whom. But thorough evaluation is also needed for the employment quota scheme in Poland, the recently introduced temporary disability benefit in Norway, and the new job placement efforts of the CDOs in Switzerland. Lack of evidence has led to bad policies being implemented in the past: neither the economies of the three countries nor people with disabilities can afford to have such mistakes repeated in the future.

ISBN 92-64-02631-2
Sickness, Disability and Work
Breaking the Barriers – Vol. 1
© OECD 2006

Chapter 1

Main Outcomes and Key Policy Challenges

What are the main sickness and disability policy challenges that Norway, Poland and Switzerland will need to address? A summary of the most important trends in these countries during the past 10-15 years highlights seven key objectives for policy makers. These include reducing the high inflow into and increasing the low outflow from disability benefits. In addition, there are social and economic challenges such as general labour market developments, health trends and demographic developments. These challenges need to be taken into account if sickness and disability policy systems are to be reformed successfully.

The purpose of this first chapter is to ascertain the main challenges that policy will need to address. It provides a summary of the most important sickness and disability trends in Norway, Poland and Switzerland during the past 10-15 years, and identifies the following seven key objectives for policy makers:

- Control public spending related to sickness and disability.
- Raise employment rates for people with health problems.
- Tackle lower incomes of households with disabled people.
- Reduce the inflow into sickness and disability benefits.
- Address the increasing medicalisation of labour market problems.
- Raise the outflow from disability benefits.
- Strengthen the co-ordination across different benefit schemes.

In addressing these challenges, reforms will need to be designed so as to improve outcomes in a given area (*e.g.* increasing outflows from disability benefits) without worsening other areas (*e.g.* by increasing financial insecurity, or increasing flows into alternative exit routes such as early retirement). In addition to institutional challenges, policy is facing exogenous social and economic challenges, such as general labour market developments, health trends and demographic developments, all of which affect sickness and disability policy making. These factors are also discussed in this chapter.

1.1. Institutional challenges faced by policy makers

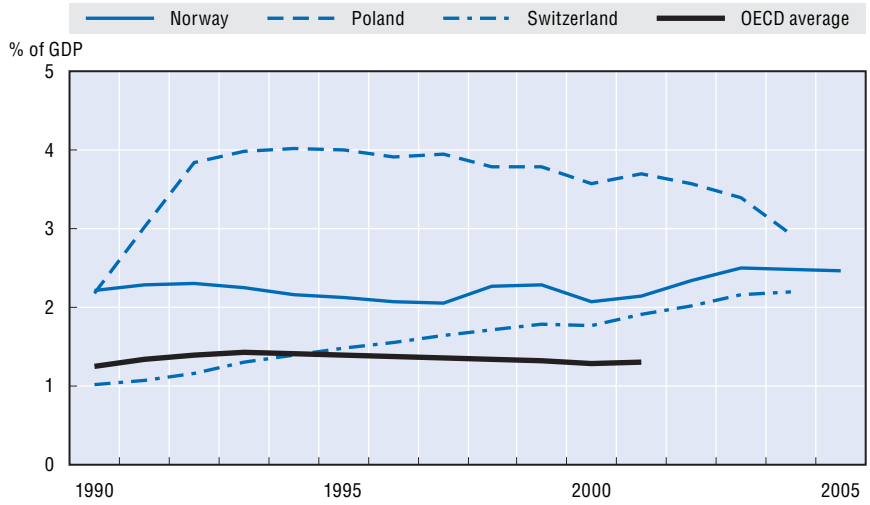
A. Controlling sickness and disability-related public spending

A first key policy concern is to moderate the very high costs of sickness and disability. In 2004, total spending in Norway, Poland and Switzerland on disability benefits alone ranged between 2.25% and 3% of GDP, compared with an OECD average of just over 1% (Figure 1.1). This has not always been the case: in Switzerland, the spending share of GDP was below the OECD average at the beginning of the 1990s but has doubled since then. In Norway, spending remained broadly stable since 1990 at 2-2.5% of GDP.[1] In Poland, the transitional recession of the early 1990s resulted in roughly a doubling of expenditure to 4% of GDP in the mid-1990s, but it has fallen sharply over the past few years.

Adding the also considerable spending on sickness benefits and other incapacity-related benefit schemes (such as occupational injury benefits) further raises total public spending on benefits alone to some 5% of GDP in Poland and Norway, and 3% in Switzerland. This is a huge commitment of resources – much higher than, for instance, these countries' commitment to unemployment benefits, which is in the order of 0.5% of GDP in Norway and Switzerland and around 1% in Poland.

In line with this, disability benefit recipiency rates among the working-age population are very high, especially in Norway and Poland with 11.4% and 10.2%, respectively, in 2005. This is roughly twice the level found across twenty OECD countries at the end of the 1990s

Figure 1.1. **Spending on disability benefits is high in all three countries**
Annual spending on public and mandatory private disability benefits, percentage of GDP, 1990-2004[a]



a) Norway: temporary and permanent disability benefit; Poland: disability benefit for employees and for farmers; Switzerland: disability benefit, supplementary benefit and mandatory occupational disability pension.

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

(OECD, 2003a) and also in Switzerland in 2005. Figure 1.2 (Panel A) shows differing trends for the three countries: in Norway and Switzerland, the recipiency rate increased steadily over the past ten years but from a much higher level in Norway. The resulting annual average growth rate in that period (which is not shown in the figure) was around 3% in Norway and almost 5% in Switzerland. In Poland, disability benefit recipiency peaked at almost 16% in the mid-1990s and has been falling since then – at a rate of 6.5% annually during the past six years.

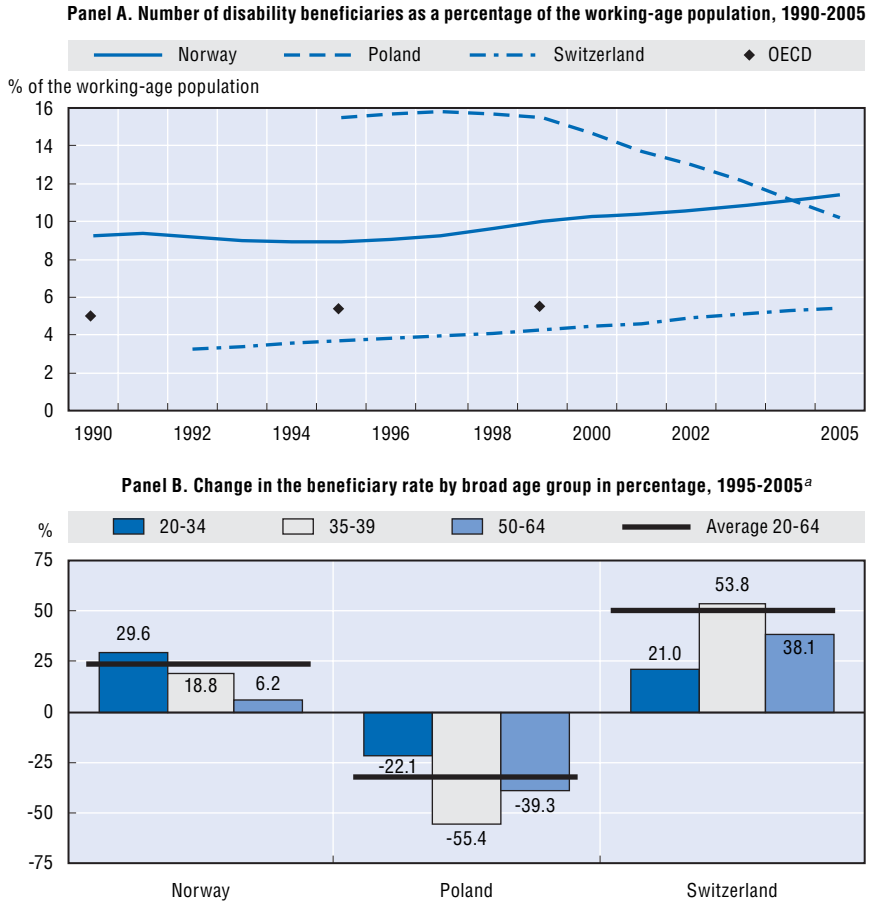
Growth in beneficiary rates over the past decade was by no means identical across age groups. In Norway, the beneficiary rate increased most among young workers aged 20-34 and very little for those over age 50 (Figure 1.2, Panel B). In Switzerland, which had the largest overall increase, the rise in the beneficiary rate was most pronounced for prime-age workers aged 35-49 and least for young workers – although even the increase among the latter was almost as large as the overall increase for Norway. The age pattern of change over the past decade in Poland "mirrors" that in Switzerland; the rapid fall in beneficiary rates in Poland affected prime-age workers more than older and especially young workers.

Differences in spending levels and beneficiary rates between the three countries as well as between these countries and other OECD countries are partly explained by cross-country differences in the characteristics of sickness and disability benefit schemes (*e.g.* access criteria, coverage rules, benefit levels) and the way these schemes are embedded into the broader social protection schemes. The structure of the schemes in Norway, Poland and Switzerland is summarised in Box 1.1. The extent to which different components of the scheme contribute to current outcomes is discussed throughout the report.

Not only have beneficiary rates been growing, but the real average value of disability benefits increased faster than corresponding wage indicators (Table 1.1). This is true for all three countries at least for the past four years, when the annual compound growth rate of

Figure 1.2. **Disability benefit recipiency rates are far above the OECD average in Norway and Poland**

Benefit recipiency rates 1990-2005 and change in the beneficiary rate by broad age group (percentage)[a]



a) Recipiency rates for Poland exclude the special system for farmers. Working-age refers to 20-64 in Poland and Switzerland and 20-66 in Norway. OECD average refers to OECD-20.

Source: National Insurance Administrations for Norway (NIA), Poland (ZUS) and Switzerland (IV); OECD (2003a), *Transforming Disability into Ability,* for OECD average.

disability benefits exceeded that of net and gross wages by one percentage point (Norway) or half a percentage point (Poland, Switzerland). This extra growth took place also in the 1990s in Norway and Switzerland but not in Poland, where the real value of disability benefits fell by more than 1% annually between 1995 and 2000, compared with 5% net and almost 9% gross wage growth.

B. Raising employment rates for people with health problems

A second key policy concern is to improve the unsatisfactory level of labour market integration of people with disabilities. Having a job is one of the key elements for inclusion and integration in society and the economy. Many disabled people are able to work on the open labour market. However, they have consistently lower employment rates than their non-disabled peers, especially in Poland.

While half of all disabled persons work in Switzerland and slightly less than half in Norway, less than one out of five do so in Poland (Figure 1.3).[2] In *relative* terms –

SICKNESS, DISABILITY AND WORK: BREAKING THE BARRIERS – VOL. 1 – ISBN 92-64-02631-2 – © OECD 2006

Box 1.1. **The structure of the countries' sickness and disability schemes – an overview**

How are benefits paid?

The three countries' sickness and disability benefit schemes differ in the way they are embedded into the broader social protection schemes. Norway has a classical public pay-as-you-go pension scheme that covers the risks of old age, disability and widowhood. Benefit entitlements are therefore calculated in the same way for old-age pensioners and disability benefit recipients, and remaining years until the legal retirement age are fully taken into account for those becoming disabled during their working life. Poland had the same system, but that was changed in the course of its radical pension reform in 1999. Since then, old age and disability are covered in entirely different schemes, with the latter still calculated according to the previous rules. Switzerland had a separate disability insurance ever since this risk was covered by public insurance, *i.e.* since 1960, although benefits are basically calculated in the same manner as for old-age pensioners. As in Norway (but not Poland), remaining years until retirement age are fully credited. In Poland these years are only credited if the person has an insurance record of less than 25 years, and then only with a reduced accrual rate of 0.7% rather than 1.3%.

How are schemes financed?

In all three countries, public disability benefits consist of a basic as well as an earnings-related component, resulting in considerable redistribution towards lower-income groups. Public benefits are financed through a mix of contributions and taxes. In Switzerland, general taxation covers 50% of total disability spending, shared between the federal and the cantonal levels. In Poland, the general system for employees and the unemployed is financed from contributions; there is also a special system for farmers, which is largely tax-financed. The Swiss benefit system is particular, because it consists of two mandatory pillars: a public benefit which provides a minimum subsistence income and a mandatory occupational disability pension, which covers employees between a lower and upper earnings limit and the unemployed. This second pillar is entirely contribution-financed, since recently experience-rated, and administered by registered occupational pension institutes.

Who is covered for a disability benefit?

The Swiss public disability insurance covers all residents from age 18 onwards and those gainfully employed in the country, with a special benefit for those invalid from birth and before age 18 and those with less than one year of contributions. People not entitled to a second-pillar disability benefit or only to a low one can be entitled to a means-tested, tax-financed supplementary benefit. In Norway, the pension insurance covers all residents from the age of 16. Similar to Switzerland, those without or with only a low earnings-related benefit component can receive a special supplement – which, however, is not means-tested. Poland's disability benefit insurance covers the labour force with five years of contributions, with different systems for farmers and their dependants (KRUS) and the rest of the labour force (ZUS). Those not covered by this system can be entitled to a special flat-rate benefit, provided the disability has occurred before age 18 or during education. This social pension is (since 2003) paid by the social insurance authority; contrary to social assistance payments, this is an entitlement rather than a discretionary benefit, and it is not means-tested.

Box 1.1. **The structure of the countries' sickness and disability schemes – an overview** *(cont.)*

Who is covered for a sickness benefit?

Poland and Norway also have a compulsory, contribution-financed sickness cash benefit which covers the active population. Benefits are earnings-related and covered by the insurance after a period of continued wage payment by the employer of 33 days in Poland and 16 days in Norway. Benefits are paid for up to 12 months at 100% of earnings in Norway and up to six months at 80% of earnings in Poland (with a possible extension to nine months). In Switzerland, sickness benefit insurance is optional and offered by private insurance companies. In certain branches of the economy, collective labour agreements mandate employers to take out sickness benefit insurance on behalf of their employees. Also in Switzerland, employers are obliged to continue wage payments in the first weeks or even months of sickness absence; the duration of this period increases with tenure (ranging from three weeks in the first year of an employment contract to half a year after 20 years of tenure). Employers can also choose to reinsure their wage payment obligation. By and large, sickness benefits are payable for a period of up to 720 days at a level of 80% of earnings.

Table 1.1. **Growth in average disability benefits has exceeded wage growth in the past four years**

Annual average growth rates of average disability benefit, gross wage and take-home pay (in real values), 1995-2004[a]

	1995-2004	1995-2000	2000-2004
Norway			
Disability benefit	3.1	2.9	3.4
Gross earnings	2.0	1.9	2.2
Take-home pay	2.2	2.0	2.3
Poland			
Disability benefit	–0.2	–1.8	1.8
Gross earnings	5.1	8.3	1.3
Take-home pay	3.0	4.5	1.2
Switzerland			
Disability benefit	0.8	0.6	1.1
Gross earnings	0.2	–0.1	0.6
Take-home pay	0.4	0.2	0.7

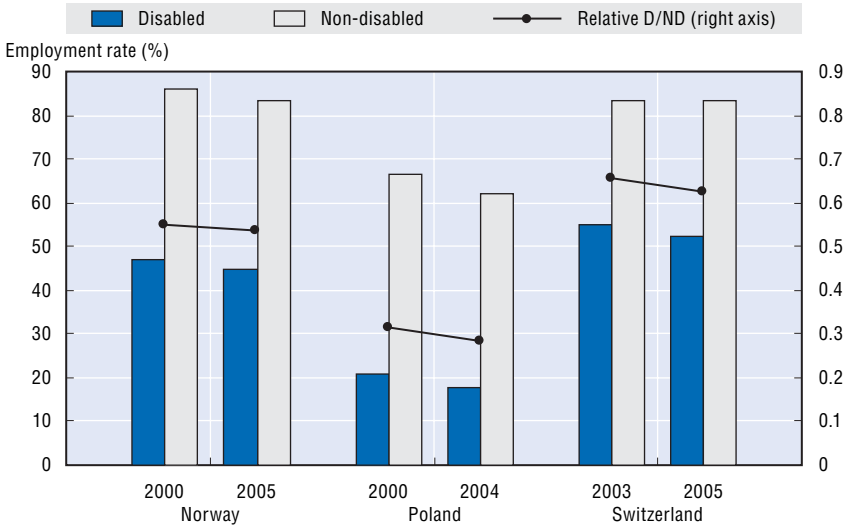
a) In Poland, disability benefit refers to ZUS disability benefit only.
Source: National Insurance Administrations for Norway (NIA), Poland (ZUS) and Switzerland (IV).

employment rates of disabled over non-disabled people – the ratio is about 0.5-0.6 in Norway and Switzerland, but less than 0.3 in Poland. Benchmarks available for EU countries show that these are two extremes on the European scale, with Norway and Switzerland on the top and Poland at the bottom**.** Moreover, this suggests spillover effects of overall labour market performance: the higher the overall employment rate in the population, the higher the relative employment rates of disabled persons.

Despite existing and new employment integration programmes and campaigns, employment rates of disabled people have been falling. Since 2000 they have fallen slightly in Norway and Switzerland and more strongly in Poland. In Poland, this is the continuation

Figure 1.3. **Employment rates are markedly lower for disabled persons, especially in Poland**

Employment rates of disabled and non-disabled persons of working age, 2000-2005 (percentage)[a]



a) The definition of disability used for Norway and Switzerland is self-assessed and for Poland it is based on those reporting having a legal disability certificate (for a discussion of definitions of disability see Annex to Chapter 1).

Source: National labour force surveys.

of a trend that began in 1996 or earlier – especially among severely disabled people, of whom 22% had a job in 1996 compared to 16% in 2000 and only 7% in 2004.

There is no real gender differential in relative employment rates in any of the three countries (Table 1.2). In turn, there is a strong correlation between relative employment rates of disabled persons and decreasing age as well as increasing education in Switzerland and, especially, Norway. In these two countries, employment rates of disabled people aged 20-34 and disabled persons with tertiary education are quite close to those of their non-disabled peers, between 70% and 88%. In Poland, there are no significant differences

Table 1.2. **Employment differentials in Norway and Switzerland depend on age and education**

Employment rate of disabled over non-disabled persons, by gender, age and education, 2000-2005[a]

		All	Gender		Age group			Educational attainment		
			Men	Women	20-34	35-49	50-64	Below secondary	Upper secondary	Tertiary
Norway	2000	0.55	0.57	0.53	0.75	0.57	0.47	0.41	0.58	0.70
	2005	0.54	0.55	0.53	0.74	0.48	0.55	0.37	0.56	0.70
Poland	2000	0.31	0.33	0.29	0.37	0.31	0.36	0.33	0.34	0.38
	2004	0.28	0.29	0.27	0.34	0.27	0.33	0.33	0.31	0.30
Switzerland	2003	0.66	0.67	0.65	0.88	0.69	0.55	0.54	0.72	0.81
	2005	0.63	0.62	0.63	0.85	0.67	0.53	0.50	0.69	0.78

a) The definition of disability used for Norway and Switzerland is self-assessed and for Poland it is based on those reporting having a legal disability certificate (for a discussion of definitions of disability see Annex to Chapter 1).

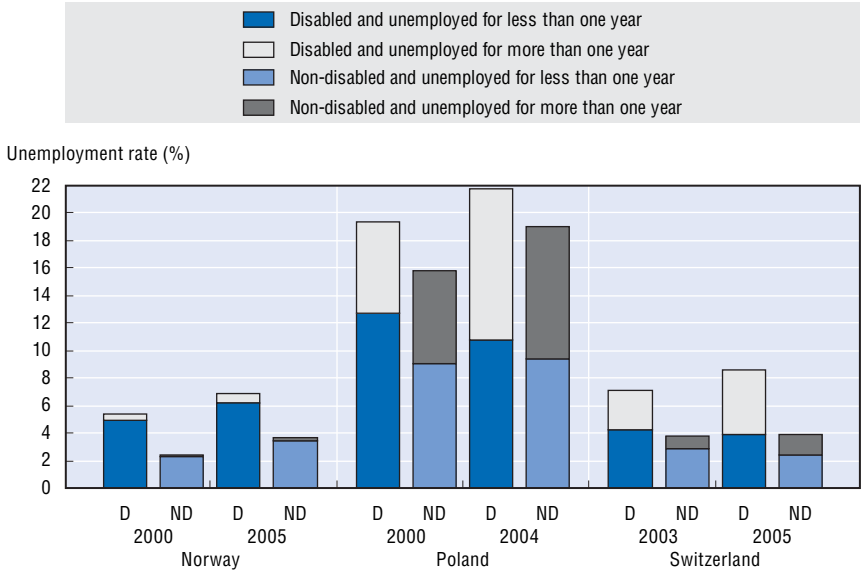
Source: National labour force surveys.

in relative employment rates for disabled people by age and education, but absolute rates are also highest for those higher-educated.

Unemployment rates of disabled persons are almost twice as high as those of non-disabled persons in Norway and Switzerland (Figure 1.4). In Poland, where the level of joblessness is much higher, there appears to be almost no difference in unemployment of disabled and non-disabled people. However, with almost four percentage points, the *absolute* difference is similar to that observed in the other two countries. Unemployment rates of disabled persons increased in all three countries in line with overall unemployment in the past two to five years, indicating that there is an increasing number of disabled people who are searching for work and available for it, but who cannot find any.

Figure 1.4. **Unemployment is high and increasing in the disabled population**

Unemployment rates of disabled and non-disabled persons of working-age, 2000-2005 (percentage)



a) The definition of disability used for Norway and Switzerland is self-assessed and for Poland it is based on those reporting having a legal disability certificate (for a discussion of definitions of disability see Annex to Chapter 1).

Source: National labour force surveys.

Some indication of the share of non-employed disabled people who wish to take up a job is available from the EU Labour Force Survey (EU-LFS). Table 1.3 shows that the share of "permanently disabled people" reporting a wish to work is very similar across the three countries, some 16-18%. But this percentage depends on age: it is about 21-23% for the middle-aged and increases to 25-33% for younger age groups. In general, more Norwegian women than men wish to work, but more Polish men than women. In Switzerland, there is no gender difference in this respect.

C. Tackling lower incomes of households with disabled people

To what extent are persons with disabilities financially worse off than others? Given their low employment rates as well as their population composition – with lower-educated and older people being overrepresented – disabled persons would seem likely to have lower average incomes. The best available indicator for comparing financial resources is disposable adjusted household income per person, which takes into account all income

Table 1.3. **One out of six inactive disabled persons wants to work**

Percentage of inactive persons permanently disabled who say they want to work, by age group, 2002/2003[a]

		Total	20-34	35-49	50-64
Norway	Men	17.2	30.1	21.7	12.4
	Women	18.7	35.6	23.2	13.3
	Total	18.0	33.0	22.5	13.0
Poland	Men	17.2	23.7	22.7	13.4
	Women	13.7	29.0	20.6	9.4
	Total	15.5	25.7	21.7	11.4
Switzerland	Men	17.7	19.8	20.7	14.8
	Women	17.4	29.5	18.9	14.7
	Total	17.6	24.6	19.9	14.7

a) Figures refer to the average of 2002 and 2003.
Source: EU Labour Force Survey, 2002 and 2003.

sources within a household and corrects for differences in household size. Disposable incomes of disabled persons are 10% below the national average in Norway and Switzerland, and 15% below average in Poland (Table 1.4). Estimates for Poland and Switzerland indicate that this position has worsened in recent years. In Norway, the relative income position deteriorates with the increasing severity of disability. In Poland, the opposite holds.

Are 10-15% below-average income levels an "achievement", or do they give reason for concern? Relative income levels for other economically vulnerable groups are often worse. For example, for single parents they are at 65% in Norway and Switzerland and 55% in Poland, and for persons aged 75 years and over they are at 65% in Norway, 80% in Switzerland and 90% in Poland (Förster and Mira d'Ercole, 2005). Levels of relative incomes of disabled persons at 85-90%, therefore, are not out of line with those of other groups that are targets of social policy.

Table 1.4. **Incomes of disabled persons are a good tenth below the average**

Levels of relative disposable income, by disability status, latest available years[a]

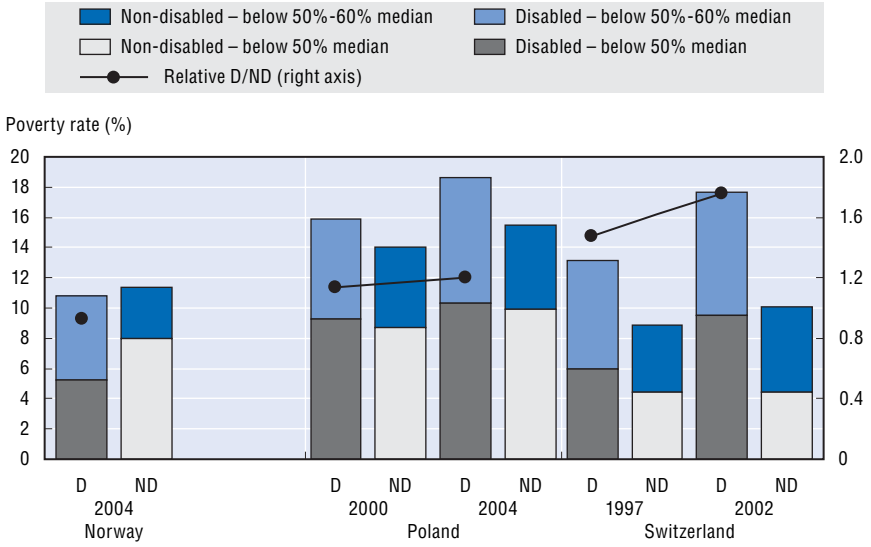
		Working-age population = 100				Entire population = 100			
		Total disabled	Severely disabled	Moderately disabled	Not disabled	Total disabled	Severely disabled	Moderately disabled	Not disabled
Norway	2004	91.1	88.1	93.0	101.9	87.5	83.9	90.0	103.1
Poland	2000	85.8	85.6	85.8	102.3	90.0	92.4	90.0	101.4
	2004	83.1	88.5	82.2	102.2	88.9	95.5	87.2	101.3
Switzerland	1997	93.6	. .	. .	101.0	91.2	. .	. .	101.7
	2002	90.2	. .	. .	101.7	88.1	. .	. .	102.5

. .: Data not available.
a) Income concept used is disposable household income per equivalent person (equivalence elasticity = 0.5). In Poland, "moderately disabled" refers to sum of "moderately and lightly disabled".
Source: EU-SILC for Norway, Household Budget Survey for Poland, Health Survey for Switzerland. For the definition of disability see Annex to Chapter 1.

Figure 1.5 (left-hand axis) shows poverty rates for disabled and non-disabled persons for two different poverty thresholds, 50% and 60% of national median income. In Norway, lower incomes of disabled people do not translate into higher poverty risks. At the 60% median threshold, poverty rates for disabled people are practically identical to those of

Figure 1.5. **A higher risk of poverty among disabled people in Poland and Switzerland**

Poverty rates by disability status, 50% and 60% median thresholds, latest available years[a]



a) Poverty rate: percentage of persons with incomes below 50% and 60% of the median income of the entire population, based on disposable household income per equivalent person (equivalence elasticity = 0.5).

Source: EU-SILC for Norway, Household Budget Survey for Poland, Health Survey for Switzerland. For the definition of disability, see Annex to Chapter 1.

non-disabled persons, and at the 50% median threshold they are even lower. The other extreme is Switzerland where, in 2002, the poverty rate for disabled people was 80% higher than for non-disabled people, as indicated by the relative N/DN poverty ratio (right-hand axis). At the 60% median threshold, poverty affects about 11% of all disabled people in Norway and 18% in Poland and Switzerland. For the 50% median threshold, this is the case for 6% of disabled people in Norway and 10% in Poland and Switzerland.

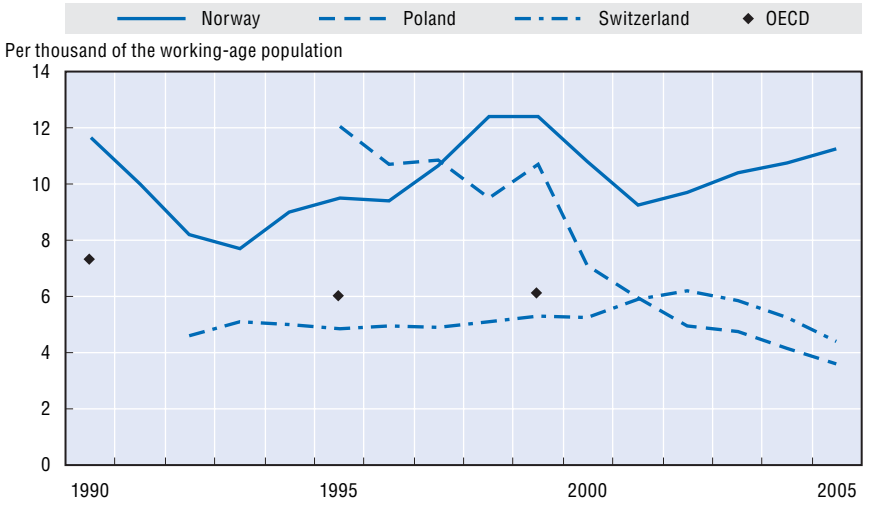
Estimates available for Poland and Switzerland indicate that poverty risks among disabled people have increased faster than for the rest of the working-age population. This is especially the case in Switzerland: their poverty rate at the 50% median income level increased from 6% to almost 10%.[3]

D. Reducing the inflow into sickness and disability benefits

A key challenge behind the rising levels of disability benefit recipiency is the large number of people successfully *applying* for such a benefit. Changes in inflows into disability benefits over the past 10-15 years do not reveal a common pattern in the three countries. In Norway, inflows – which stood at over 1% of the working-age population at the beginning of the 1990s – have fluctuated considerably during the past 15 years, but the inflow rate in 2005 is not much different from the level in 1990 (Figure 1.6). In contrast, inflow rates in Poland have declined continuously and steeply. They fell by two-thirds, from twice the OECD average in 1995 to a level significantly below that average. Inflow rates in Switzerland were at a low and also below OECD average level in the beginning of the 1990s but increased slightly during the 1990s. In the past few years, however, they also began to fall considerably.

Figure 1.6. **Disability benefit inflow rates have developed quite differently in the past 15 years**

Annual inflow into disability benefit, per thousand of the working-age population, 1990-2005[a]



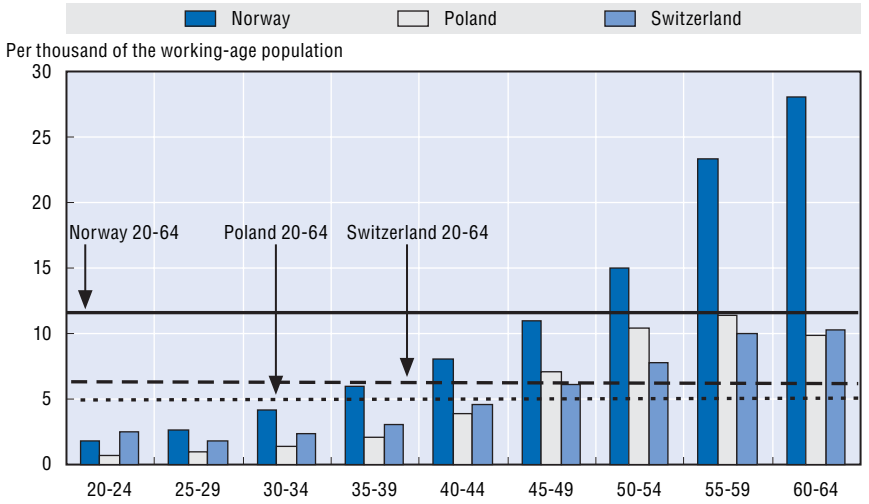
a) For Poland, inflows into ZUS disability benefits over the non-agricultural labour force. Age 20-64 for Poland and Switzerland, age 20-66 for Norway. OECD average refers to OECD-11.

Source: National Insurance Administrations for Norway (NIA), Poland (ZUS) and Switzerland (IV); OECD (2003a), *Transforming Disability into Ability*, for OECD average.

In all three countries, inflow rates increase steeply with age. In Norway and Poland, people in the age group 55-59, for instance, are three times as likely to be granted a disability benefit as those in the age group 40-44 (two times in Switzerland) (Figure 1.7). The result is that people in the 50-64 age group account for half or more than half (Norway) of the total inflow into disability benefits. The average new beneficiary is 52 years old in Norway, 48 in Poland and 47 in Switzerland. For comparison, the average age was around 56 across 20 OECD countries in 1999 (OECD, 2003a). This suggests that, despite the larger

Figure 1.7. **Older workers are far more likely to be granted a disability benefit**

Inflow into disability benefit per thousand of the working-age population, by age, 2004[a]



a) In Poland, the definition used is the inflow to a ZUS benefit over the non-agricultural labour force.

Source: National Insurance Administrations for Norway (NIA), Poland (ZUS) and Switzerland (IV).

share of older workers being granted a disability benefit, in relation to elsewhere all three countries have a relatively young population applying for such benefits. For Norway and Switzerland this is partly explained by the fact that people with congenital or youth disabilities can claim a benefit.

There are also significant gender differences across the countries. In Poland and Switzerland, men are more likely to be granted a disability benefit, by 55% in Poland and by 27% in Switzerland. On the contrary, women in Norway have a 27% higher likelihood to become disability benefit recipients than Norwegian men. Moreover, in all three countries changes in women's inflow rates were more pronounced than those for men, both upwards and downwards. Thus, trends in inflow rates shown in Figure 1.6 were to a large extent driven by women's inflow rates.

In all these comparisons, the following should be noted: For Norway and Switzerland, throughout the report the numbers of disability benefit recipients and inflows into these benefits are related to the entire working-age population to obtain inflow and recipiency rates, which is in line with the population coverage of the benefit systems in these two countries. Due to measurement issues pertaining to Poland, *i.e.* different coverage rules requiring different calculation procedures, and because of that country's limited data availability for both social pensions and the special system for farmers, disability benefit rates in Poland are computed in a different manner from the other two countries, *i.e.* as the ratio of the inflow into or the number of people on ZUS disability benefits over the non-agricultural labour force. That excludes the inactive population as well as the agricultural labour force on both sides of the fraction. The bias resulting from this approach in terms of comparability is relatively small (Box 1.2).

E. Addressing the increasing medicalisation of labour market problems

The rise of disability incidence among the working-age population in industrialised societies is often linked to the observation of an increased "medicalisation" of labour market and social problems. There is more than just anecdotal evidence for this trend. Indeed, in Europe, the share of inactive people who are not looking for work primarily because of own illness and disability nearly doubled in the past ten years, from less than 7% in 1995 to over 13% in 2005 (Table 1.5).

These shares, however, are much higher in the three countries under review and reach almost 30% in both Norway and Poland (although in both countries they are down from an even higher level in 1995), and 18.5% in Switzerland, where this share has doubled in the past decade. Inactivity because of illness or disability is more common among middle-aged and older people. Also, more men than women stop looking for work because of health reasons. The differential is particularly pronounced in Switzerland, where 12% of inactive women but 34% of men are not looking for work because of illness or disability.

There are a number of pathways leading into disability benefit receipt. The most common one is long-term sickness absence from work, which leads many people to move into disability benefits – first temporarily, then permanently. High or increasing sickness absence can, therefore, further contribute to the medicalisation of labour market problems. Levels of sickness absence are very different across the three countries. They are highest in

Box 1.2. **Computing comparable recipiency and inflow rates for Poland**

What is the problem?

Cross-country comparisons of benefit recipiency and inflow rates are affected by differences in coverage rules. The Norwegian and the Swiss disability benefit schemes cover the entire working-age population, irrespective of the activity status and the date of occurrence of a disability. But Poland has three parallel schemes covering three different groups of the population: the non-agricultural labour force (ZUS scheme), the agricultural labour force (KRUS) and the inactive population (social pensions). The first two groups have to fulfil certain contribution criteria, while for the latter group one requirement is that the disability has occurred before adulthood or during education. Therefore, a certain share of people is excluded from benefits (*e.g.* housewives who have never worked unless the disability had existed already in their childhood). For that reason, comparisons between Poland on the one hand and Switzerland and Norway on the other cannot be complete.

The solution chosen for this report

The solution to this problem of comparability chosen in OECD (2003a) was to add numbers in all different systems (or inflows into all these systems), after correction for double-counting, and relate this number to the total working-age population. Cross-country differences in outcomes are then partly explained by differences in coverage rules. For Poland this approach would imply summing up recipients of (or inflows into) ZUS disability benefits, KRUS disability benefits and social pensions. This, however, is impossible because of lack of data. A longer time series and all the necessary detail by age and gender for numbers as well as flows is only available for ZUS. Limiting the numerator to workers in the non-agricultural labour market in turn requires doing so in the denominator as well. For much of the report, that is the methodology used for Poland. Data for the KRUS scheme and on social pensions are only used occasionally.

The impact of the solution

Inflows to ZUS benefits over the non-agricultural labour force closely reflect the total inflow into all three schemes over the total population at risk. Using aggregate data for 2004 of ZUS, KRUS and social pensions in the age group 20-64 results in an inflow rate of 3.5 per 1 000, slightly lower than the figure of 4.1 per 1 000 obtained when only ZUS data are used. The annual inflow rate into KRUS disability benefits (over the agricultural labour force) was 9.8 per 1 000, *i.e.* more than twice the inflow into ZUS benefits. The inflow to ZUS accounts for close to two-thirds of the total inflow into disability benefits. However, there are large age differences between the three systems. While 80% of the inflow to social pensions occurs in the ages 20-34, close to 80% of the number of KRUS benefits are aged 50-64. ZUS benefits are more evenly distributed and two-thirds of the inflow occurs in the age group 40-54. The number of disability benefit recipients in Poland aged 20-64 amounted to almost 2.2 million in 2004. Of these, ZUS beneficiaries accounted for three-quarters, KRUS for around one-sixth and social pensions for the remaining one-tenth.

One caveat when using the ZUS scheme only is that changes would appear to be much less pronounced had all three schemes been used, because the strong decline in inflows into ZUS benefits is only partly mirrored in the KRUS scheme and stands in sharp contrast to the increased use of social pensions.

Table 1.5. **One out of three inactive men are not looking for work because of disability**

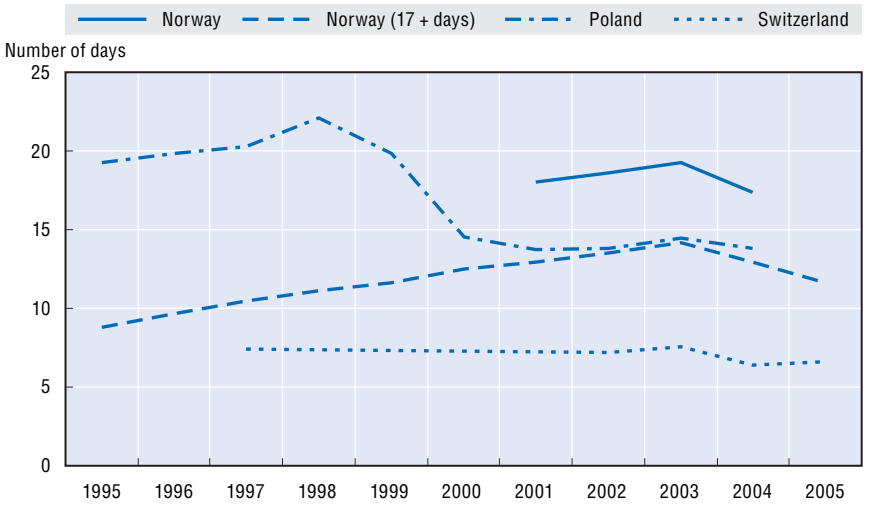
Inactive people not seeking work because of illness or disability, percentage of all inactives, mid-1990s and 2005

		All	Gender		Age group		
			Men	Women	20-34	35-49	50-64
Norway	1995	38.6	47.1	33.7	8.8	42.3	68.5
	2005	29.8	34.2	26.9	12.8	34.9	39.5
Poland	1997	36.6	48.2	30.2	7.8	48.6	50.2
	2005	28.7	39.4	22.4	7.9	42.5	36.4
Switzerland	1996	9.2	26.0	5.0	3.5	10.6	12.5
	2005	18.5	34.2	12.1	6.9	22.2	23.2
EU	1995	6.8	13.3	4.7	3.2	6.4	9.1
	2005	13.3	19.8	10.1	5.1	18.4	15.7

Source: EU Labour Force Survey, 2006 and earlier years.

Figure 1.8. **Levels of sickness absence are high in Poland but especially high in Norway**

Average annual number of days on sickness per employee, 1995-2005[a]



a) For Poland, ZUS benefits only.

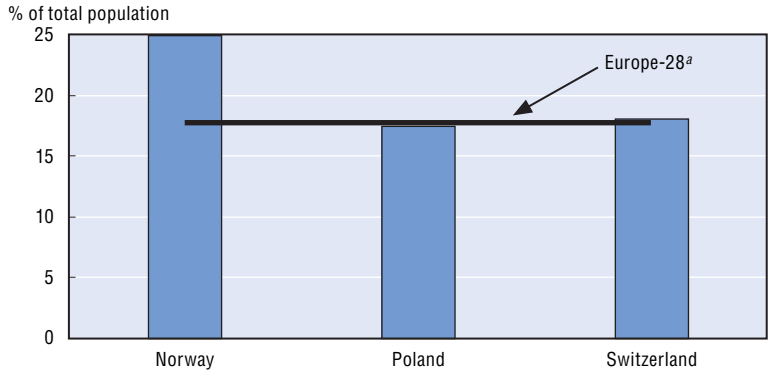
Source: National Insurance Administrations for Norway (17+ days) and Poland, National LFS for Switzerland. Norway (total): WHO (2006), European Health for All database (HFA-DB). Switzerland 1997: Observatoire suisse de la santé.

Norway, with an annual average of 17 days per employee in 2004 (Figure 1.8). Next is Poland with about 14 days of absence per year per employee (referring to the ZUS regime alone). Sickness absence is lowest in Switzerland, at about six-seven annual days per employee.

Another important challenge for sickness and disability policies is the increase of non-specified diseases, in particular mental disorders. It has been argued that of the ten leading causes of disability worldwide, five are psychiatric conditions (WHO, 2000). Among the three countries considered, the overall prevalence of mental disorder is highest in Norway, affecting roughly one-quarter of the total population. Both Poland and Switzerland are close to the European average of about 18% (Figure 1.9).

Figure 1.9. **Very high prevalence of mental disorders in Europe**

Prevalence of mental disorders, percentage of total population, 2004



a) EU-25, Iceland, Norway and Switzerland.

Source: Andlin-Sobocki *et al.* (2005), "Cost of Disorders of the Brain in Europe", *European Journal of Neurology*, Vol. 12.

As a consequence, the instances where mental diseases are cited as a reason for take-up of disability benefits have also increased to very high levels. Currently, these account for 17% of all inflows in Poland, 25% in Norway and over 40% in Switzerland (Table 1.6). In both Poland and Switzerland, mental diseases are more frequently the reason for disability benefit receipt among women than men (but not so in Norway). The *growth* in the number of times mental diseases are given as a cause for disability benefit inflow was much faster in Poland and Switzerland, especially in the second half of the 1990s.

Table 1.6. **Mental diseases are becoming the main reason for take-up of disability benefits**

Share of mental diseases among all medical reasons for inflows into disability benefits, 1990-2004[a]

	Norway			Poland			Switzerland		
	Total	Men	Women	Total	Men	Women	Total	Men	Women
1990	19.6	19.8	19.3	. .	. .	. .	. .	. .	. .
1995	22.0	21.7	22.2	12.2	9.4	16.0	28.6	25.2	34.4
2000	23.9	25.1	22.8	16.2	12.6	21.6	37.2	33.5	42.6
2004	25.4	25.7	25.1	16.9	13.5	22.9	41.0	36.7	46.6

. .: Data not available.

a) For Norway, ages 16-66 in 1990 and 1995 and 18-66 for 2000 and 2004. For Poland and Switzerland, ages 20-64.

Source: National Insurance Administrations for Norway (NIA), Poland (ZUS) and Switzerland (IV).

F. Raising the outflow from disability benefits

Another challenge for successful disability policies will be to find ways to increase outflows from disability benefits into paid work. While certain policies had some success in the recent past with controlling inflow rates, rates of outflow from benefits have been constantly decreasing over the past ten years, *e.g.* from 9-10% to just over 6% in Norway and Switzerland (Table 1.7). In both countries, outflow rates are somewhat higher among men than among women. What is most worrying, however, are the extremely low outflow rates of disabled persons aged 20-49: those are as low as 1-2%.

But these indicators concern *all* outflows from disability benefits, not only those into the labour market. Higher outflow rates among older disabled persons, therefore, are explained by transfers into early retirement and old-age pensions and by premature

Table 1.7. **Very few younger disabled beneficiaries succeed in leaving benefit rolls**

Outflow rates from disability benefits as a percentage of all beneficiaries, by gender and age, 1990-2004

		All	Gender		Age group		
			Male	Female	20-34	35-49	50-64
Norway	1990	10.0	11.9	8.4	1.0	1.5	13.1
	1995	9.6	11.2	8.5	1.8	2.7	12.6
	2000	7.2	8.2	6.4	1.2	1.7	9.5
	2004	6.6	7.3	6.1	1.2	1.4	8.7
Switzerland	1992	9.2	10.6	7.3	3.5	2.7	14.2
	1995	8.5	9.6	6.9	3.0	2.3	13.3
	2000	7.2	8.0	6.2	2.1	1.8	11.7
	2004	6.5	7.0	5.9	2.3	1.9	10.2

Source: National Insurance Administrations for Norway (NIA) and Switzerland (IV).

deaths. After excluding outflows into retirement and deaths, overall outflow rates drop to only 1.5% in Switzerland, 0.5% in Norway and 2.5% in Poland: once people get on disability benefits, they are very unlikely to ever leave them.

Another indication of the very low number of disabled people getting into the labour market is given by the share of people who were inactive in 2003 because of sickness or disability and who became employed in 2004. Evidence for Norway and Poland suggests that 3-4% of disabled persons moved into work compared to 5% of all inactives in Poland and 18% in Norway (Table 1.8). In both countries, most disabled persons who got a job worked part-time, although this is also true for non-disabled inactives moving into a job in Norway. More than one-fifth of all inactive persons who got a job have higher education; this share is much lower in both countries for disabled inactive people who found a job.

Table 1.8. **Most disabled people who are moving to jobs become part-time employed**

Share moving into employment and distribution by selected characteristics (percentages adding to 100)[a]

	Disabled	All inactives	Distribution, in percentages							
			By industry			By educational attainment			By working hours	
				Disabled	All inactives		Disabled	All inactives	Disabled	All inactives
Norway	3.7	17.6	Agriculture	8.9	3.8	Low	23.3	24.3	Full-time	31.7	37.9
			Industry	9.7	12.1	Medium	70.5	49.4	Part-time	68.3	62.1
			Services	81.4	84.1	High	6.2	26.3			
Poland	2.9	5.1	Agriculture	56.6	25.7	Low	37.1	20.5	Full-time	37.8	60.8
			Industry	14.1	19.8	Medium	56.1	58.0	Part-time	62.2	39.2
			Services	29.2	54.5	High	6.8	21.6			

a) Data refer to persons inactive in 2003 but in employment in 2004 after having declared themselves disabled.
Source: EU Labour Force Survey, 2004.

The low rate of job take-up by disabled people can be related to demand as well as supply factors. The interaction of different benefits (disability but also social assistance, housing, family, etc.) with taxation at different earnings levels can lead to situations where it does not pay to work or to increase working hours (see Chapter 4).

G. Strengthening co-ordination across different benefit schemes

The existence of a number of parallel social protection schemes, each covering different life risks, and the lack of co-ordination and co-operation among them is another key challenge facing policy makers in the three countries. Pension schemes provide replacement income for early retirees; unemployment insurance tackles joblessness; social assistance deals with poverty risks; sickness insurance compensates for short-term health problems; and disability insurance covers longer-term health conditions. However, the assumption that clients and risk groups are distinct is less and less valid. A younger, economically and socially disadvantaged person, for instance, who has some psychological problem and who does not find a job, may end up being moved around between the different schemes (see Chapter 5).

Moreover, reform in one scheme is often not sufficiently co-ordinated with that in other schemes, with a detrimental impact on the disability benefit scheme. Reducing the attractiveness of one scheme – *e.g.* lowering benefits in the old-age pension scheme, phasing-out early retirement pathways, tightening access in unemployment schemes – can raise the relative attractiveness of accessing other schemes, *e.g.* retiring through disability. Easing access to temporary benefit schemes, such as sickness benefits, could distance people from the labour market, ultimately reducing their employability and their work capacity and, in the longer run, leading to increased disability benefit applications. Phenomena like these have occurred in the past in all three countries at different times and in different ways. For instance, in Norway sickness absence and disability benefit inflows (with a two-year time lag) tend to move in parallel, and in Poland there is a strong relationship between early retirement and disability.

1.2. Social and economic factors

A. General labour market trends and requirements

Unemployment trends

A key obstacle to rapid improvement in the outcomes of disability policies in Poland is the adverse general labour market situation. In 2005, at 18%, the overall unemployment rate was higher than anywhere else in the OECD area, rising to 26% for the less-educated and 38% for those under age 25 (Table 1.9). Added to this is the high incidence of long-term unemployment, with more than two in three of those concerned being unemployed for more than six months and every second person being unemployed for at least one year. Against that background, it is not surprising that people with health problems and disabilities face particular obstacles.

Poland has not yet managed to escape the vicious circle of high non-wage labour costs, low employment in the formal economy, a large informal sector, high inactivity and high public social expenditure. Under such circumstances, general policies to increase labour demand are warranted. These could include measures to reduce both labour costs and the tax wedge for low-income workers; efforts to make active labour market policy and public employment services more effective; and more generally, a strong focus on improving the quality of education of school leavers (OECD, 2004a). However, inactivity traps created by easily accessible benefits also contribute to Poland's low activity rate. Labour supply policies are therefore equally important to overcome the distortions that the benefit systems currently impose on the labour market.

Table 1.9. **The labour market in 2005: Low employment and high unemployment in Poland**

Employment, unemployment and long-term unemployment (percentage), 2005

	Norway	Poland	Switzerland	OECD average
Employment/population ratio				
Population aged 15-64	75.2	53.0	77.2	65.3
Population aged 15-24	52.9	20.9	59.9	42.5
Population 15-64 with less than secondary education[a]	64.1	38.2	66.2	58.0
Unemployment rate				
Population aged 15-64	4.7	18.0	4.5	6.4
Population aged 15-24	12.0	37.8	8.8	13.2
Population 25-64 with less than secondary education[a]	3.9	25.9	6.1	7.9
Incidence of long-term unemployment				
6 months and over, population 15-64	25.3	71.6	59.2	47.0
12 months and over, population 15-64	9.5	52.2	38.8	32.9

a) 2003 data.

Source: National labour force surveys and OECD (2005), *Education at a Glance*, OECD, Paris.

Norway and Switzerland are not facing labour market problems as acute as Poland. Employment rates are among the highest in the OECD area in both countries, and unemployment rates are low. Nevertheless, unemployment trends are important in understanding sickness absence and disability benefit outcomes. In Switzerland, problems with disability insurance only started to emerge with the rise of unemployment in the early 1990s. In the light of this, the increase in unemployment rates in the past few years and, in particular, the very rapid increase in the share of long-term unemployment is a key concern. In 2005, almost 40% of all unemployment lasted for more than one year, and almost 60% for more than half a year; these are higher shares than are found on average across all OECD countries.

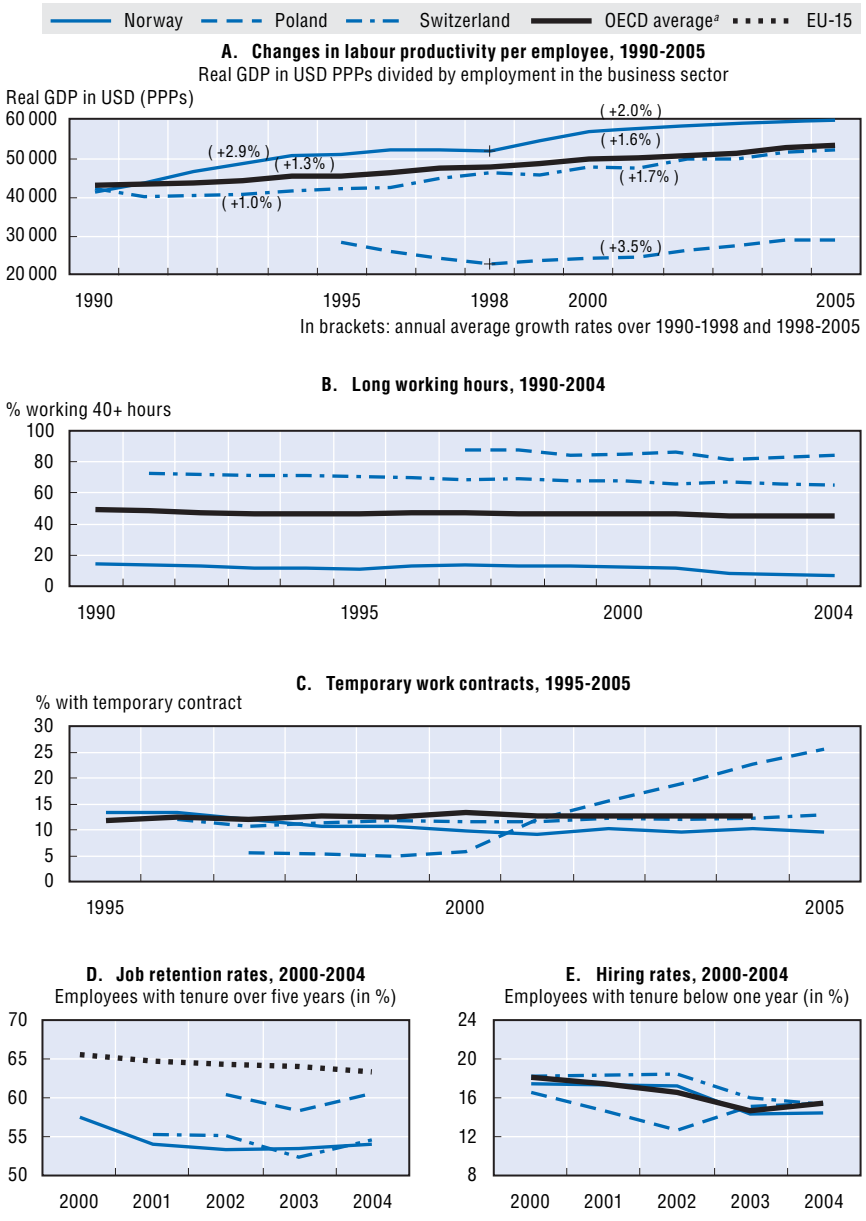
In Norway, fluctuations in unemployment rates are important because of the close relationship in that country between those rates and the rate of absence from work due to sickness.[4] From the mid-1980s until 2000, sickness absence has clearly increased when unemployment fell, and *vice versa*.[5] Long-term sickness absence, in turn, is the key pathway to disability benefit and permanent exit from the labour market in Norway (Chapter 2). Thus, the future development of unemployment is critical for sickness and disability policy making.

Economic restructuring and its impact on health

One reason often brought forward to explain the low and falling employment rates of disabled people and their high and rising dependency on health-related income support is the ongoing restructuring of labour markets and of employment relationships. In the context of continuously increasing efficiency and competitiveness, continuous core employment is said to be shrinking and workloads, work pressure and job insecurity increasing. All these can affect sickness and disability prevalence via two channels: first, so-called "niche jobs" become rarer, leaving less employment opportunities for people with reduced work ability because of health problems and disabilities. Second, increased work pressure and falling work satisfaction themselves can create health problems of employees and lead to disability.

The impact of labour market restructuring on the actual work pressure for employees is difficult to measure, because available indicators are incomplete and inconclusive. Figure 1.10 summaries some of these indicators and compares selected labour market conditions and developments in Norway, Poland and Switzerland with those for the OECD average.

Figure 1.10. **Inconclusive evidence on changes in the working environment**



a) OECD average refers to 22 countries in Panel A, 20 countries in Panels B and C, and 23 countries in Panels D and E.
Source: *OECD Economic Outlook*; OECD database on working hours; EU Labour Force Survey; national sources.

Labour productivity in Norway, Poland and Switzerland has been in line with the overall increase in the OECD area (Figure 1.10, Panel A). In Poland and Switzerland, rates of growth were higher after than before 1998. Changes in working hours, on the other hand,

were very small everywhere, and large country differences in the proportion of people working over 40 hours per week (as an indicator of workloads) have been persistent (Panel B). The share of temporary work contracts as a proxy for atypical work and job insecurity has also remained very stable in Norway, Switzerland and the OECD area as a whole, though not in Poland – where this share has increased in the past five years from 5% to 25% (Panel C). Job stability, measured through five-year job retention rates, is lower in Norway, Switzerland and also Poland than the average across the EU-15 countries – yet again, changes over time are small (Panel D). Finally, hiring rates indicate a slight downward trend everywhere from around 17% in 2000 to around 15% in 2004 (Panel E).

In sum, evidence on changes in productivity, workloads and job insecurity is inconclusive. The changes are not big enough to explain sickness and disability trends, nor are the directions of change always in line with those trends. Studies on *causal* relationships between economic restructuring and health do not obtain uniform conclusions either, although Grasdal *et al.* (2005) find that workers in downsizing firms in Norway have an increased probability of reporting sick and also of reporting longer sickness spells. Another study for Norway shows that, between 1993 and 1998, workers originally employed in downsizing and closing firms were 28% more likely to utilise disability benefits in 1999 than workers in non-downsizing firms (Statistics Norway, 2005).

Work-related stress

There is also evidence across countries about the detrimental effect of *perceived* job insecurity on individuals' health status (Domenighetti *et al.*, 1999 for Switzerland; Ferrie *et al.*, 2002 for the United Kingdom; Burgard *et al.*, 2006 for the United States). The changing work environment may have resulted in a range of "new phenomena" – such as increasing stress, burnout, workplace bullying (mobbing) and harassment – that are likely to have detrimental effects on health. The EU working conditions survey, carried out in 2000/01 covering 25 EU countries, found that about 28% of all workers were affected by work-related stress, with Poland coming very close to this average (EWCO, 2005a). National data for Switzerland report a very similar share, 27%, and point to an increasing trend since the 1980s (SECO, 2003).[6] The incidence is higher for women and younger workers. This Swiss study found a correlation between stress and the perceived workload but not between stress and the physical demands of a job.

There is some evidence from European countries that bullying, violence and harassment in the workplace have increased in the second half of the 1990s (EWCO, 2005b). Prevalence indicators increased for violence at the workplace (from 4% to 6%), intimidation (from 8% to 10%) and sexual harassment (from 1% to 3%), largely due to increases among female employees. Mobbing (workplace bullying) and its health consequences have also recently become an issue in Switzerland (SECO, 2002). Self-declared mobbing affects 4.4% of all workers. Detrimental health consequences of mobbing are quite distinct: almost half of all mobbing victims, for instance, suffer from depression while this percentage is only 14% among all other workers. As with work-related stress, there is a strong correlation between mobbing and the perceived workload, but there are no significant differences by age, gender, education or industry.

Work, joblessness and health

While too much pressure at work can result in sickness and deteriorating health, the absence of work (or from work) is even unhealthier. A survey by Waddell and Burton (2006),

based on both clinical and disability literature, suggests that work is generally good for the physical and mental well-being of healthy people, many disabled people and most people with common health problems. Joblessness can have significant adverse effects on health, while work promotes health as well as well-being and can reverse the adverse health effects of inactivity and unemployment.[7]

In addition, Waddel and Burton (2006) found broad consensus that, when possible, sick and disabled people should remain in or return to work as soon as possible, because doing so:

- Is therapeutic.
- Helps to promote recovery and rehabilitation.
- Leads to better health outcomes.
- Avoids the harmful physical/mental/social effects of long-term absence and worklessness.
- Reduces the chances of chronic disability and long-term work incapacity.

In conclusion, despite somewhat inconclusive evidence, policy makers are facing a vicious circle. Heightened requirements on the labour market seem to lead to more pressure and often more work-related stress, which in turn leads to health problems, sickness absence, disability and, eventually, dropping out of the labour market. Once out of the labour market, however, the absence of a job adversely affects health. Policies need to address this vicious circle.

B. Health trends and disability in the population

Another reason for the increasing dependence on sickness and disability programmes, partly related to labour market developments, could be a worsening of the general health status of the population. This section, however, suggests that such arguments cannot explain changes over time and differences between countries in the use of sickness and disability schemes but also that the relationship between subjective and objective health and disability indicators is complex and unclear.

Who are the people who have to cope with a disability, and how many are they? In what follows, "disability prevalence" is defined as the share of persons reporting a long-lasting health problem that hamper daily life activities. It is thus a *self-reported* disability status. This status concerned 11% of the working-age population in Poland, 13% in Norway and 15% in Switzerland (Table 1.10). While this percentage remained practically unchanged in Norway and Switzerland over the latest available five-year period, disability prevalence in Poland fell by two percentage points between 1996 and 2004.

Self-assessed disability prevalence, however, is not at all the same as the percentage of registered disability benefit claimants reported above. The overlap between these two groups of the population and target groups for policy is typically around and sometimes even below 50% (see the Annex to this chapter for a more detailed discussion on that issue). This holds for all OECD countries; during the 1990s, the OECD average for self-assessed disability prevalence was about 14% of the working-age population and disability benefit recipiency around 6% (OECD, 2003a).

Gender differences in self-reported disability are relatively small. Disabilities are more prevalent among women in Norway and Switzerland – as in a majority of OECD countries (see OECD, 2003a) – but more common among men in Poland (Table 1.10). There is much more of a differential across age, with disability prevalence gradually increasing by age in all three countries, and especially in Poland. However, between 1996 and 2004, disability

Table 1.10. **Disability prevalence increases with age and lower education, especially in Poland**

Trends in self-assessed disability prevalence by gender, age group and educational attainment, various years[a]

		All (20-64)	Gender		Age group			Educational attainment		
			Male	Female	20-34	35-49	50-64	Below secondary	Upper secondary	Tertiary
		Prevalence rate	Relative prevalence (overall prevalence rate = 100)							
Norway	2000	13.5	91	110	55	86	170	194	100	57
	2005	13.2	89	111	52	81	167	199	104	58
Poland	1996	13.5	105	95	21	78	250	195	74	44
	2000	12.4	106	94	22	79	239	195	84	34
	2004	11.3	109	91	28	70	229	218	88	32
Switzerland	1997	14.6	94	106	74	96	139	141	94	80
	2002	14.6	89	111	64	95	143	136	96	78

a) In Poland, disability prevalence refers to reporting of "legal disability" (see Annex to Chapter 1).
Source: National labour force surveys for Norway and Poland; national health survey for Switzerland.

prevalence among older people in Poland decreased from 34% to 26%, and it appears that this was the main contributor to falling overall prevalence. Education is also a predictor of disability prevalence, again more so in Poland where people with lower education are twice as likely to report a disability as the total working-age population, while prevalence among those with university education is below 4%.

These large and persistent numbers of people with a self-assessed disability and on disability benefit has to be seen against the background of the improving "objective" health status of the population. One such indicator of this improvement is the potential years of life lost (PYLL). This is a summary measure of premature mortality, which provides an explicit way of weighting deaths occurring at younger ages that are, *a priori*, preventable. In all three countries this measure has fallen steadily, by about one-third since 1980 and by about one-quarter since 1990. While the absolute amount of PYLL is very similar between Norway and Switzerland, it is almost double in Poland (Figure 1.11).

In conclusion, subjective health or disability indicators provide quite a different picture of the health status than objective ones. Developments in sickness absence and disability benefit receipt over time are not related to trends in either objective or subjective health indicators. This suggests that trends in sickness and disability benefit receipt are to a considerable extent influenced by factors beyond health.

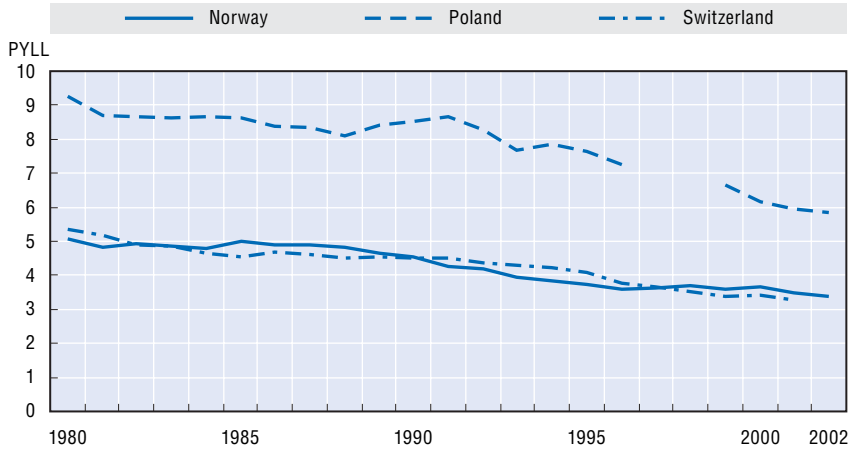
C. The impact of population ageing

A third argument sometimes brought forward for the increasing number of people on sickness and disability benefits is population ageing. As shown above, both disability prevalence and benefit recipiency increase strongly by age in all three countries. A higher share of older people among the working-age population will, therefore, translate into higher disability benefit rates, other things being equal. In Switzerland, for instance, it has been estimated that one-fifth of the annual growth in *expenditures* for disability pensions over the past decade was due to changes in the age composition (BSV, 2005).

To what extent are recent trends in disability beneficiary numbers explained by changes in the population structure? One way to explore this issue is to produce an

Figure 1.11. **Steadily improving objective health status in all three countries**

Potential years of life lost (PYLL) until age 70, percentage of population, 1980-2002[a]



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

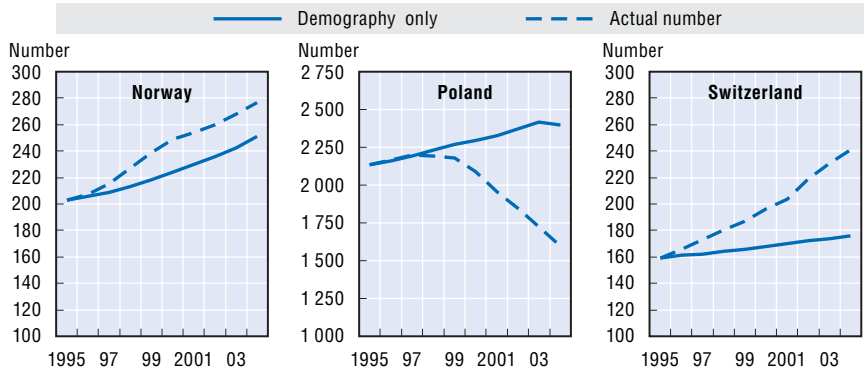
Source: OECD (2005), *OECD Health Data 2005*, OECD, Paris.

estimated historical series of beneficiaries for the past decade for each country, by multiplying 1995 age- and gender-specific beneficiary rates by population numbers in each age and gender group. The difference between the estimated results and the actual beneficiary numbers is the part of the trend resulting from changes in benefit recipiency rates and therefore not explained by changes in the size of the population "at risk".

Quite different patterns emerge for the three countries under review (Figure 1.12). In Norway, two-thirds of the 36% increase in beneficiary numbers during the period 1995-2004 was due to changes in the population age structure, *i.e.* the relatively larger increase in the number of older workers who have a higher risk of becoming disabled. The remaining third is explained by changes in the beneficiary rates themselves.

Figure 1.12. **Past trends in beneficiary numbers in Norway have been dominated by demographic changes**

Number of disability beneficiaries 1995-2004, actual and estimated, on the basis of 1995 beneficiary rates[a]



a) The solid lines labelled "demography only" show *estimated* numbers of beneficiaries under the assumption of constant age- and gender-specific beneficiary rates of 1995; the dotted lines show the *actual* numbers of beneficiaries. All data refer to the age group 20-64. For Poland, the calculation is based on ZUS pension beneficiary trends.

Source: OECD population database and beneficiary data from National Insurance Administrations.

In Switzerland, a much smaller part of the increase in disability beneficiaries is due to changes in the population structure. Since 1995 the number of beneficiaries increased by 50%, or about 80 000 people, and 20% of this increase is explained by population ageing. The pattern is again different in Poland, where population ageing would have increased the number of disability beneficiaries by some 12% but actual numbers fell by 25%, from 2.2 million in 1999 to 1.6 million in 2004. This means that the already considerable reduction would have been even larger in the absence of population ageing.

Yet another question is how disability beneficiary rates and numbers will evolve over the coming decades as a consequence of future population ageing, all other things being equal. By using national population projections, future trends in disability beneficiary numbers are estimated, again assuming for this illustrative exercise that beneficiary rates by age and gender remain constant from 2004.

Results from these projections are summarised in Table 1.11. Over the next two decades, beneficiary *rates* are projected to increase by one percentage point in Norway and Poland and one-third of a percentage point in Switzerland due to population ageing. Thereafter, they will stay more or less constant in both Norway and Switzerland but will continue to grow in Poland to be almost three percentage points higher in 2040 than in 2004. The *number* of beneficiaries is projected to increase by one-fifth in Norway in the very long run, *i.e.* by 2050, but to decrease by almost one-tenth in both Poland and Switzerland. This is mainly explained by the fact that the underlying national population scenarios project a longer-run growth of the size of the total working-age population in Norway but a fall in Poland and Switzerland. In Poland the decrease in beneficiary numbers will only occur after 2040, while in Switzerland it will already begin after 2020. Overall, therefore, the demographic pressure seems much higher in Norway and Poland.

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

Projected number of disability beneficiaries and beneficiary rates, 2004-2050[a]

	Norway		Poland		Switzerland	
	Number of persons (in thousands)	Beneficiary rates	Number of persons (in thousands)	Beneficiary rates	Number of persons (in thousands)	Beneficiary rates
2004	277	10.1	2 169	9.2	241	5.4
2010	306	10.8	2 436	9.9	249	5.5
2015	309	10.8	2 424	10.0	252	5.6
2020	318	10.9	2 287	9.9	254	5.7
2025	324	11.1	2 212	10.1	250	5.7
2030	327	11.2	2 298	10.8	239	5.7
2035	320	11.0	2 418	11.6	230	5.6
2040	314	10.8	2 421	12.0	227	5.6
2045	322	10.9	2 267	11.9	227	5.6
2050	333	11.1	2 017	11.4	225	5.6

a) The results refer to the age group 20-64 for all three countries. For Poland data are based on ZUS benefits.
Source: Authors' projection based on OECD population database and beneficiary data from National Insurance Administrations.

1.3. Conclusion

The following facts emerge from the picture above:

Benefit dependency, income and employment

- In all three countries, disability benefit spending is around 2-3% of GDP – more than double the OECD average of slightly above 1%.
- More than 5% of the working-age population in Switzerland, 10% in Poland and more than 11% in Norway receive disability benefits.
- In the past four years, average disability benefits increased faster than average earnings.
- Disabled persons have consistently lower employment rates than their non-disabled peers; the difference is particularly large in Poland. Moreover, this differential tended to grow over the past few years in all three countries.
- Unemployment is higher among disabled people. However, one in four inactive younger disabled persons in Poland and Switzerland and one in three in Norway would wish to work.
- Disposable incomes of disabled persons are 10-15% lower than for the working-age population as a whole. Poverty rates of disabled people are above the population average in Poland and Switzerland but not in Norway.

Inflows into and outflows from benefit schemes

- Rates of inflows into disability benefits are very high in Norway (at some 1% of the working-age population) and around the OECD average in Switzerland (0.6%). Due to a steep decline in the past decade, these rates have recently fallen below the OECD average in Poland (0.4%).
- The average age of new disability benefit recipients is below the OECD average, at 52 in Norway, 48 in Poland and 47 in Switzerland. Changes of inflows into disability rolls in recent years were predominantly driven by women's inflow rates.
- An increasing medicalisation of labour market and social problems has lead to high levels of sickness absenteeism, especially in Norway and Poland. Mental diseases have become the single most important reason for take-up of disability benefits, especially in Switzerland.
- As few as 1-2% of younger disabled persons succeed in leaving the disability benefit rolls for a job. Those who find a job predominantly work part-time.
- The financial gains for a disabled person taking a job or increasing working hours are often very small and sometimes non-existent, especially for those whose earnings are below average.
- In all three countries, trends in the disability benefit scheme were – in different ways and at different times – related to developments in and reforms of other benefit schemes, *e.g.* sickness benefits, unemployment benefits and early retirement pensions.

The impact of exogenous factors

- Evidence from indicators on changes in the work environment is very mixed. Increasing work-related stress in the course of raising labour market requirements may be contributing to increasing health problems, but other indicators are more ambiguous.

- Developments in sickness absence and disability benefit receipt over time are not related to trends in either objective or subjective health indicators.
- Between 10% and 18% of the working-age population declare that they are disabled. The overlap with the group of disability benefit recipients is less than 50%, indicating large inclusion as well as exclusion errors.
- During the past decade, trends in disability beneficiary numbers in Norway were strongly influenced by population ageing, while in Switzerland ageing accounted for only 20% of the increase in those numbers. In Poland, trends were driven by policy rather than by demographic factors.
- Projections of disability beneficiary numbers and rates indicate some pressure on the system arising from population ageing over the coming decades, especially in Norway and Poland.

Notes

1. In the case of Norway, GDP figures include oil revenues. Using mainland GDP only would increase spending in 2004 from 2.5% to around 3.2% of GDP.
2. In this as well as the next section, disability is a self-assessed status measured via population surveys. This is quite different from the administrative definition of disability benefit receipt (Chapter 1, Section 1.2).
3. The relatively high and increasing poverty risk of disabled persons in Switzerland is confirmed by the high and increasing proportion of those on disability benefit who receive a means-tested supplementary benefit, *e.g.* 27% in 2004 compared to only one in ten among old-age pensioners.
4. Askildsen *et al.* (2005), for instance, demonstrated the effect of unemployment on sickness spells lasting at least 15 days on the basis of panel data for the years 1990-1996 – an effect explained by the behaviour of established, fully insured workers, not by the composition of labour.
5. Since 2000, this relationship has been blurred, with a significant increase in sickness absence despite rising unemployment until 2003 and a fall in absence rates despite stable unemployment in 2004. This is likely to be a temporary phenomenon related to the strong emphasis on reform in this area in recent years (Chapter 6), because incentives as such have not changed.
6. The Swiss study estimated the overall costs of stress (medical costs and costs for foregone production due to work absence) to be around 1.2% of GDP (SECO, 2003).
7. Re-employment is associated with improved self-esteem, improved general and mental health and reduced psychological distress. The magnitude of this improvement is comparable to the adverse effect of job loss.

ANNEX 1.A1

Definition and Measurement of "Disability"

Estimating the extent of disability is not straightforward. In contrast to the contingency "unemployment" for instance (having a job or not; searching and being available for work or not), disability status is rarely dichotomous and much more a matter of degree. Much like the concept of social exclusion, disability nowadays is apprehended as a multi-dimensional and a dynamic phenomenon, going beyond physical impairments and including societal factors as well as changes over time. Two issues need to be disentangled: the different definitional approaches on the one hand and issues of measurement methods and instruments on the other.

Two broad definitions of disability

Disability can be defined as a *self-assessed* status or else as a *legal* status based on administrative sources, *e.g.* benefit receipt. Often, and perhaps inaccurately so, these two definitions are referred to as "subjective" *versus* "objective" disability. Both subjective and objective disability may be reported in error. This is plausible in the case of self-assessed disability: responses may, *inter alia*, depend on employment or benefit outcomes one wishes to explain. However, administrative records may also be reported with bias – as has recently been shown for Sweden by Johansson and Skedinger (2005), who find systematic over-reporting of disability in objective administrative data, probably explained by incentives for caseworkers to inflate their placement success.

All three countries under review use data and indicators derived from both self-assessed and administrative definitions. The Polish situation is particular insofar as there are three alternative definitions of disability available: "biological" disability (self-assessed status but restricted to physical impairments); "legal" disability (in possession of a certificate issued by local authorities which does not however necessarily make the holder eligible for a disability benefit);and receipt of a disability benefit (farmers' pension, non-farmers' pension, social pension). According to national data, 76% of "legally disabled" persons received a disability benefit in 2004.

Measurement methods and instruments

Self-assessed disability status is measured via household surveys. Although assessment is generally based on answers to questions concerning the existence of longer-lasting health problems that limit daily life activities, the detailed questions across countries and surveys usually differ. "Long-lasting", for instance, is defined as six months in Norway and as 12 months in Switzerland. Benefit recipient status can be measured

through administrative records or else through surveys. Results between the two sources are likely to differ, for two reasons: administrative records typically count cases rather than persons, which in a situation of multiple benefits can lead to double counting. On the other hand, surveys are based on responses on benefit status, which some people may not wish to reveal.

Measures and definitions used in the report

No one of the above definitions and measures is "superior" to the others; their use depends on the topic investigated (*e.g.* benefit expenditures *versus* income adequacy) but occasionally also on data availability. Throughout the report, several of the measures are analysed. In general, when mention is made of "disability prevalence", this refers to self-reported disability status, while disability benefit risk rates (inflows into disability) are calculated from administrative records. However, in the case of Poland, the "legal" disability definition is used as a proxy for disability prevalence: "biological" disability would be too restrictive (because it is limited to physical problems) and, although linked to a certificate, the "legal" status is also self-reported. In any event in comparing results across countries it should be kept in mind which precise definition is used as they often cover quite distinct population groups.

This may best be illustrated when comparing different sets of indicators for the extent of disability. Subjective definitions tend to lead to higher disability rates (Table 1.A1.1). That said, even among the self-assessed category using very similar definitions, estimates may vary between surveys, as can be seen when comparing results for Norway and Switzerland in Columns C (based on the LFS) and D (based on alternative surveys).

Table 1.A1.1. **Prevalence and benefit receipt: different disability definitions**
Number of working-age persons with a disability as percentage of the working-age population, 2004[a]

	Administrative disability status		Self-assessed disability status			
	Beneficiaries (registers)	Beneficiaries (national survey)	National LFS	Other national survey	EU-LFS (work status def.)	EU-LFS (non-search def.)
	(A)	(B)	(C)	(D)	(E)	(F)
Norway	10.6	8.3	16.3	18.0	8.1	5.8
Poland	9.6	8.6	11.3	11.6 (8.7)	8.7	8.7
Switzerland	5.3	4.0	10.3	14.6	. .	2.8

a) Sources and definitions are as follows: Col. A: National Insurance Administrations. Col. B: Poland: LFS 2004. Col. C: Norway: LFS 2005 (self-assessed disability status); Poland: LFS 2004 (persons declaring they are legally disabled); Switzerland: LFS 2004 (persons with reduced capacity due to a long-lasting health problem of more than a year). Col. D: Norway: EU-SILC 2004 (long-term illness limiting daily activities for at least six months); Poland: Household Budget Survey (HBS) 2004 [persons declaring they are legally disabled or (in brackets) biologically disabled]; Switzerland: Health Survey 2002 (persons with reduced capacity due to a long-lasting health problem of more than a year). Col. E: EULFS 2004 (persons who give as main status "permanently disabled"). Col. F: EULFS 2004 (persons who are not looking for work because of illness/disability).

These figures indicate that self-reported disability and benefit receipt are far from corresponding exactly. Figure 1.A1.1 explores the overlap between the two in more detail. The total height of the bars indicates the possible extent of disability – *i.e.* people either self-assessed disabled or benefit recipients (or holders of a legal certificate in Poland), or both. This amounts to 23% of the working-age population in Norway and 14-16% in Poland and Switzerland. The middle bars show the overlap between the different disability

definitions and allow for first hints on the size of "inclusion" and "exclusion" errors: people on benefit registers (or certificates in Poland) who do not describe themselves as disabled on the one hand, and people who describe themselves as disabled but do not receive benefits on the other.

The inclusion error seems to be higher in Poland: about 40% of persons holding a disability certificate (*i.e.* of all "legally disabled" persons) declare themselves as *not* being "biologically" disabled. The percentage of beneficiaries declaring themselves as not disabled is 35% in Norway and 25% in Switzerland. But the higher percentage in Poland is influenced by a stricter subjective definition and a larger administrative definition based on certificates rather than benefit receipt. In turn, the exclusion error seems much lower in Poland: just 17% of biologically disabled people do not hold a legal certificate, while almost half of Norwegian and a large majority of Swiss self-assessed disabled people do not receive a disability benefit.

These summary indicators capture "exclusion errors" only partially. After all, a number of self-assessed disabled people are working and therefore do not draw benefits. It would therefore be more meaningful to calculate overlap indicators for non-employed disabled people who are not eligible for other social benefits (old-age pensions in particular). This is, however, not possible with the data in hand.

Figure 1.A1.1. **Self-assessed disability and benefit receipt: overlap**

Percentage of the working-age population, 2002 (Poland and Switzerland) and 2004 (Norway)[a]



a) In Poland "recipient" refers to legal disability (*i.e.* holding a certificate) and "self-assessed" refers to biological disability.

Source: EU-SILC 2004 for Norway; Census 2002 for Poland; Health Survey 2002 for Switzerland.

For Poland, some other characteristics of the three groups of disabled people can be analysed. Table 1.A1.2 shows that persons who are biologically but not legally disabled (the "exclusion error") are more often women, lower-educated and younger. As concerns the education differential, this may well indicate problems of information advantages. Policies to better inform about eligibility rules and simplify procedures may be needed. Another finding is that those who receive a disability certificate but are not biologically disabled are much more likely to receive a "light" classification rather than those with biological disabilities (63% versus 38%).

Table 1.A1.2. **Poland: characteristics of disabled persons, different disability definitions and overlap**

Percentage shares, 2002

Disability status	Characteristics										
	Low education	Medium education	High education	Men	Women	20-34	35-49	50-64	Light	Moderate	Severe
Self-assessed	39.9	54.9	5.2	46.7	53.3	11.5	31.4	57.1	. .	. .	. .
Legally	32.8	61.5	5.7	52.0	48.0	8.5	29.5	62.0	62.5	32.0	5.5
Legally and self-assessed	39.1	56.8	4.1	54.0	46.0	10.4	29.3	60.4	38.3	19.8	3.0

Source: Population census for Poland, 2002.

ISBN 92-64-02631-2
Sickness, Disability and Work
Breaking the Barriers – Vol. 1
© OECD 2006

Chapter 2

Controlling Access to Long-term Benefits

Sickness and rehabilitation systems in Norway, Poland and Switzerland too often lead to a life-long disability benefit rather than a return to work. Particularly worrying is the high and increasing share of people with mental diseases that end up on disability benefits. In all countries possibilities to identify a health problem and to intervene at an early stage to avoid the transfer into a disability benefit are lacking. Vocational and medical rehabilitation can be important if used in the right manner. Across the three countries, rehabilitation systems vary enormously regarding the concept and criteria for eligibility. To reduce the inflow into disability benefits, it is necessary for countries to improve their assessments of health problems as early on as possible but also to have clear objectives for the medical and vocational rehabilitation systems. The aim should be to restore work ability and assist people in remaining in the labour market.

All three countries face significant challenges in terms of curbing the high and – for Norway and Switzerland – increasing number of disability benefit recipients. One way to tackle this problem is to limit the inflow into these long-term benefits. High inflow rates have several causes, such as a weak medical assessment structure, in particular during the sickness phase; insufficient or ineffective vocational rehabilitation; and imperfect work incentives. This chapter begins by discussing how improved sickness management may help reduce inflow rates. It stresses the importance of a sound medical and vocational assessment process, and argues that rehabilitation is an important instrument if used wisely. Throughout the chapter, particular emphasis is placed on the role of general practitioners (GPs) and the rights and duties for employers and employees at the various stages from work to long-term benefit dependency.

2.1. Sickness management

To begin to tackle the inflow to disability benefits, it is important to understand the steps leading to a disability benefit claim. In many countries, sickness benefits or rehabilitation are prerequisites for disability benefit receipt. In other countries, people can transfer directly from, for example, unemployment benefits. In Norway – and, despite missing evidence, most likely also in Poland and Switzerland – the main pathway to disability benefits is through a longer period of sickness absence. Therefore, sound sickness management is crucial to control that pathway. This section starts by describing various ways of obtaining disability benefits in Norway and continues by discussing short and long-term sickness absence and possible ways to reassess and monitor absence in the three countries.

According to a study by Fevang *et al.* (2004) on transitions between different benefit schemes in Norway over 1993-2000, the likelihood for people on sickness benefits to transfer to disability benefits was 11% at the start of the sickness phase, whereas 86% returned to their job. After one year on those benefits, the likelihood of moving into a disability benefit had increased to 40%. This is very similar to the result found in Table 2.1, which indicates that 42% of all new disability benefits recipients in 2004 who also received a social security benefit one year earlier transferred from the sickness benefit scheme. Medical rehabilitation is the second most important channel into disability (34%), followed by vocational rehabilitation (22%). However, most of those undergoing medical or vocational rehabilitation started their benefit career on sickness benefit.

There is also a noticeable transfer (in both directions) between unemployment benefits and sickness benefits. Fevang *et al.* (2004) confirm that people with health-related benefits were often unemployed at an earlier stage. They conclude that persons with unemployment benefits initially have a 92% probability to find a job and a 2% probability of ending up on a disability benefit. After one year on unemployment benefits, the likelihood of entering into employment is reduced to 79%, while the probability of moving into disability benefits is increased to 6%. In another study by Nordberg and Røed (2002) of new

disability benefit recipients in 2000, nearly one-quarter started as unemployed, and over 40% of all recipients were aged 20-40. These numbers illustrate that persons starting with unemployment often have (or perhaps develop) a health problem which eventually results in a disability benefit claim.

Table 2.1. **Sickness benefits are the main pathway to disability benefits in Norway**
Distribution of people on new benefits aged 20-66, 2003-04[a]

Status in 2004	Status in 2003[b]					
	Unemployment benefit	Sickness benefit	Medical rehabilitation benefit	Vocational rehabilitation	Disability pension	All benefits
Unemployment benefit	–	75.1	6.8	8.2	9.9	100.0
Sickness benefit	39.4	–	5.4	12.1	43.1	100.0
Medical rehabilitation benefit	1.8	74.0	–	17.4	6.7	100.0
Vocational rehabilitation	3.4	41.1	37.9	–	17.6	100.0
Disability pension	2.3	41.9	33.7	22.1	–	100.0
Early retirement benefit	21.0	67.0	1.3	0.0	10.7	100.0
Old age pension	4.2	5.6	0.9	0.0	89.3	100.0

a) The table should be read in the following way. Of all *new* disability benefit recipients in 2004 who were on another kind of benefit in 2003, 41.9% came from sickness benefits and 33.7% and 22.1% from medical and vocational rehabilitation, respectively; the remaining 2.3% transferred from unemployment benefits.
b) Status in 2003 refers to persons on a social security benefit at 1 January 2003. Status in 2004 refers to those persons who had a benefit at 1 January 2003 and who also had a benefit at 1 January 2004.
Source: National Insurance Administrations for Norway (NIA).

A. The persistence of sickness absence

Exceptionally high absence rates have made sickness management one of Norway's major concerns. As a result, a broad range of measures have been introduced in order to strengthen the involvement of employers as well as GPs in this process. In Switzerland, measures such as early identification are also being discussed although sickness absence is less of a problem (rates correspond to half of the EU average). In Poland, sickness absence fell sharply in 2000 – mainly because of a reform in the second half of 1999 that included stricter reporting requirements for treating doctors and a need for reassessment by social security doctors in case of prolongation of a certified absence. Based on national data, days reimbursed per employee in Poland fell from 19.2 in 1995 to 13.8 in 2004. In Norway the reverse occurred: days compensated by the National Insurance Administration rose from 7.8 days per worker and year in 1995 to 14.2 days in 2003 (the peak-level year). Added to this are around five days of employer-paid absence. In Switzerland, average sickness absence is significantly lower at 6.4 days per employee.

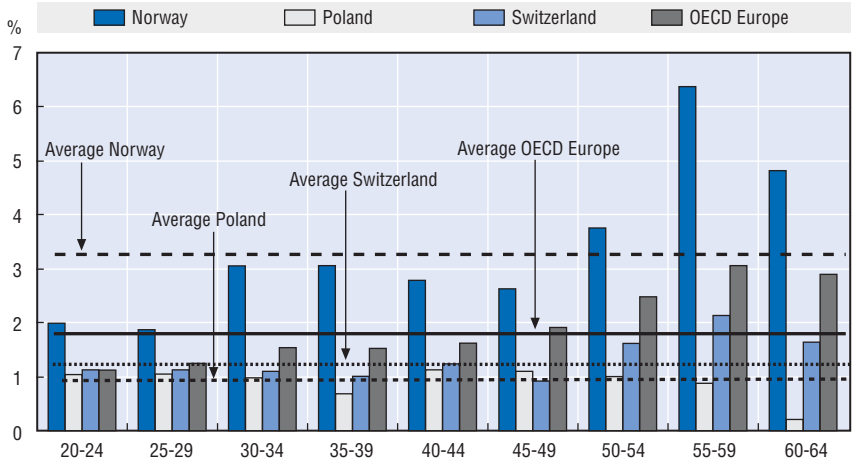
The steep upward trend in Norway was reversed in 2004, and for 2005 absence reached 11.5 days per employee, *i.e.* a fall of almost 20% compared to 2003.[1] However, this is an overestimate that does not take self-certified sick leave into account. The introduction in mid-2004 of an activity requirement within eight weeks of granting the latest sickness certificate and a mandatory evaluation of functional capacity and documentation by a GP have played an important role in reducing long-term sickness. Still, in 2004, the average sickness spell in Norway was 65 days. Muscular-skeletal diseases and mental diseases accounted for two-thirds of all absences (46% were related to muscular-skeletal diseases and 20% to mental diseases).

The reasons for the high and increasing sickness absence in Norway are not well understood. Several factors are put forward as possible explanations. One is growing labour shortages. When labour is scarce, "marginalised" workers who are more prone to be absent, *e.g.* because of poor health or social problems, are offered jobs, which may subsequently increase sickness absence. Other possible explanations are the increased efficiency that pushes people out of the labour market as well as the increase in downsizing and merging of firms. Evidence from epidemiological and clinical research shows that long-term sickness absence and disability depend more on individual and work-related psycho-social factors than on biomedical factors or the physical demands of work (Walker-Bone and Cooper, 2005).

In contrast to Poland, where it appears to be fairly constant across age groups and even falling in older ages, sickness absence increases with age in both Norway and Switzerland (Figure 2.1).[2] The Norwegian and Swiss age-sickness pattern corresponds well to the increasing disability prevalence and disability inflow rates in older ages (Chapter 1). In all three countries, however, the increase in sickness absence with age is less pronounced than the increase in disability benefits with age. This in turn may be explained by falling labour force participation rates in older ages, *i.e.* people with better health and perhaps also better jobs continue to work at older ages.

Figure 2.1. **Sickness absence varies dramatically by age and by country**

Percentage of employed in each age group, 2005[a, b]



a) Employed persons reporting not having worked at all during the week prior to the survey, due to own illness, injury or temporary disability. The average refers to averages across all age groups.

b) Certain differences in national legislation may affect the level of sickness absence. First, the duration a person can be on sickness benefits and still be accounted as employed varies between countries. Second, differences in employment protection legislation mean that absent employees in some countries are more easily laid off and therefore not accounted as employed. Statistics Norway compared how the Norwegian absence rate would change if a person on sickness benefits could only receive benefits for six months (instead of the 12 months established by legislation). Their findings show that the average absence rate in 2004 would have been 2.9% rather than 3.6%.

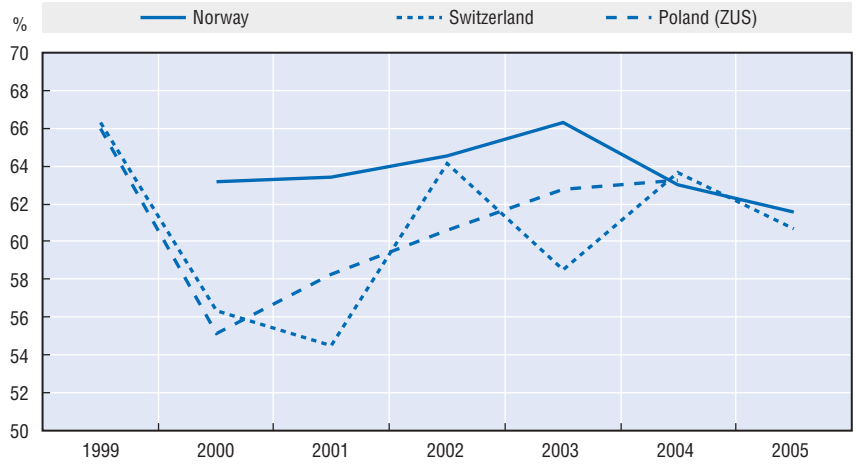
Source: EU Labour Force Survey.

Since 1999, *long-term* sickness absence (defined as absences lasting one month or longer) has developed differently in the three countries (Figure 2.2). For Norway, long-term sickness absence has followed the overall trend in absence reported in Chapter 1: when sickness absence peaked in 2003, long-term sickness accounted for two-thirds of total

sickness, higher than that in Poland and Switzerland. In Poland, long-term absence fell markedly, by 10 percentage points in 2000, in the wake of the stricter rules; the reason for the drop in Switzerland over the same period is less clear. For Norway, the trend in long-term sickness may indicate that this has been the driving force behind the steep increase in overall absence rates. In Poland and Switzerland, long-term absence has increased since 2000 without a corresponding increase in the overall absence. Currently, at around 62%, the share of long-term absence is at the same level in all three countries.

Figure 2.2. **The bulk of sickness absence is long term**

Employed persons on long-term sickness as a share of total sickness absence, 1999-2005[a, b]



a) In interpreting data on long-term sickness absence, it is important to keep in mind that sickness benefits can last up to 12 months in Norway, but only six months (with a possible extension to nine) in Poland. In Switzerland, sickness benefits can last up to two years.

b) In Norway, long-term sickness is defined as 32 days or longer and calculated as the share of total days of sickness in the third quarter each year. In Poland it is based on 34 days or longer and calculated as total days of absence. The data for Switzerland are based on the share of workers absent from work for more than one month.

Source: Statistics Norway, National Insurance Administration for Poland (ZUS); and Swiss Labour Force Survey.

B. The importance of monitoring sickness absence

Norwegian studies have found that the majority of people with a terminated sickness period lasting more than six months had already been on sickness benefits or will be on sickness benefits again. Moreover, three years after ending a period of sickness benefits for six months or longer, almost 30% of those with either a muscular-skeletal or a mental disease were receiving disability benefits (Nordberg and Røed, 2002). Monitoring and reassessing the medical condition as well as functional capacity of people on sickness benefits is costly, but will be necessary in order to identify potential disability cases and thus avoid transfers into permanent benefits.

Timing is crucial and will require close co-operation between benefit-granting institutions, GPs and employers. Measures have already been introduced in all three countries (Chapter 6) and positive outcomes have been observed in Poland, where both sickness absence and disability inflow rates have dropped markedly. In Norway, sickness absence has fallen recently, but it is still too early to judge whether this will also translate into falling disability benefit inflow rates. There are recent indications that this decline in sickness absence is reversing. Effective control of sickness absence certificates is one

Box 2.1. **Reassessing and monitoring sickness absences**

In Poland and Switzerland, a certificate from the treating doctor is required from the first day of illness. In Norway by contrast, self-declared absence is possible for up to three days (four times a year) and even up to eight days (in that case three times a year) in companies that have an agreement with the local social insurance branch. In all three countries, long-term sickness absence is assessed and reassessed by the GP.

Countries differ in the extent they control and monitor of these decisions. In Poland, checks by the public insurance are possible, including home visits, but only after expiration of the employer period, *i.e.* from day 34 onwards. In practice however, such controls are unusual and result in a termination of the sickness benefit for only around 0.2% of all sickness cases. In Switzerland, private insurers running a sickness cash benefit scheme can overturn the GP's decision. Yet, again, in practice this rarely occurs because the additional costs are covered through increased insurance premiums (Chapter 4). Norway entirely relies on the GP's decision and instead places additional obligations on both the GP and the employer. GPs have to base the sick-leave certificate on an assessment of the patient's potential to work part- or even full-time despite of the health problem (the so-called activity test).

Employers have traditionally played a very limited role in the sickness phase in all three countries. Since recently, Norwegian employers are responsible for preparing a follow-up plan (with the help of the employee and the local Workplace Centre) after eight weeks of sickness absence. Individual reintegration plans at an early stage are also going to be introduced in Switzerland. These plans will be prepared by the public authorities but require co-operation with the employer at this stage.

important element of sickness management. However, the few possibilities for control or monitoring that exist in Switzerland and Poland are rarely used (Box 2.1).

People who are unable to work or at risk of becoming unable to work because of a health impairment are frequently identified much too late – that is to say, when their health status has deteriorated seriously and their labour market attachment has weakened considerably. To improve this situation, Switzerland is planning to introduce a model where people with an impaired health status are contacted by the disability insurance authority at an early stage to examine their personal situation and assess what measures and activation would be required to maintain the existing work relationship. Clearly, early intervention requires early identification.

In practice, sickness absence is often not reported and recorded in Switzerland for several reasons, including violation of personal integrity. GPs are currently not allowed to inform employers about an employee's health situation and employers are not allowed to ask their employees the reason for their absence. The recent introduction of Bonus-Malus in the sickness benefit insurance system may have worsened the situation. Premiums to private benefit sickness insurance are experience-rated on the sickness history of the employees. Employers who report sickness cases to their insurers are likely to see an increase of their premiums, which may result in underreporting. Moreover, late intervention may also be explained by passivity on the side of private insurers. If the sickness case is continuing and the person finally obtaining a disability benefit, the insurers will be refunded from the disability insurance authority for their expenses during the sickness period.

Another way forward could be the use of better *case management*. Case management implies that every sickness case is screened for health and additional help is given to those people who are likely to go on long-term sick leave. After an identification phase, it is important to develop individual action strategies, similar to the individual action and follow-up plans in Norway. Such a screening process requires extensive information about people and their employment history but also close collaboration between all actors involved. In this respect, the Swiss main insurer for accidents, SUVA, has early rehabilitation and activation measures in place. This is also the only insurance system in Switzerland with mandatory reporting by employers of their employees' health problems. As a result, SUVA is aware of the individual's problems of returning to work at a very early stage. Box 2.2 summarises two other good examples where case management has resulted in positive outcomes, referring to the Netherlands and Denmark.

Box 2.2. **Two good examples of case management to reduce absences**

In the Netherlands in 2003, a large-scale experiment was set up in two regions. Case workers in the disability insurance administration were instructed to screen disability applications more carefully than usual. This intense screening forced employers to devote more effort in getting sick employees back to work, but it also resulted in self-screening of potential disability applicants. The outcomes were quite striking and resulted in an average fall of 13 weeks for the long-term sick and a reduced number of disability applications. Importantly, there were no spill-over effects to unemployment benefits (Jong *et al.*, 2006).

Another example of intensified case management that reduced the number of long-term sick is found in Denmark. In a study by Høgelund and Holm (2004), Danes with a sickness period longer than eight weeks who participated in case management interviews had a significantly higher likelihood of returning to work compared to those who did not participate in the interviews. However, these results were only valid when a return to the current employer was considered; no positive effects were found for employment with a new employer.

Employers' monitoring of absent employees as well as checks by social insurance offices is also a recurrent topic in Norway. Problems have partly been resolved by a new insurance act, which uses an approach that focuses on activation of the health-impaired worker (rather than just paying sickness benefits) and involves all actors in the process. The purpose of the new insurance act is to make it possible for employees on sickness benefits to resume work gradually and try out their work capacity as well as to avoid losing contact with the workplace. For this purpose, a *graded sickness benefit* is used in accordance with remaining work capacity, starting at 20% of a full benefit. *Active sick leave* is another way of staying in contact with the workplace: the employee remains on full sickness benefit (and the employer pays no salary), while performing some work tasks for the employer (Box 2.3).

Of all sickness cases in Norway that ended during the first half of 2005, 30% were graded sickness benefits and 7% were active sick leaves. The corresponding figures for the first half of 2004 were around 22% and 11%, respectively (Rikstrygdeverket, 2005). Hence, one year after this measure was enforced by the new act, the share of active sick leave had fallen while the share of graded sick leave had increased. This is in line with the aim to

Box 2.3. **Key elements of the 2004 Social Insurance Act in Norway**

The objective of the new Act is to find solutions to reduce sickness absence at each workplace. As such, the measures rely on the responsibility of the National Insurance Administration, the employees, the employers and the GPs.

The national insurance office: The national insurance office should not take on the responsibility of the employee and the employer but instead monitor and support them. The office will request a follow-up plan from the employer after a period of 12 weeks of sick leave, if the employee is not in a work-related activity. The office can also impose sanctions on employers, employees and GPs who do not comply with these requirements.

The employee: Complete inactivity at work for a period of up to eight weeks requires an extended medical certificate with documentation by the GP that provides continued significant medical grounds to prevent such activity. Within the first eight weeks of absence, the employee and the employer must draw up a plan that describes the return to work. The employees must contribute information about their own functional capacity, so that necessary measures can be implemented quickly. The employee must also agree to a dialogue with the employer on the possible reorganisation of the work situation, and participate in the solutions available to the employer and employee. If the employee refuses collaboration, the consequence can be loss of the sickness benefit.

The employer: Measures to prevent absence due to illness and the testing of functional ability must be carried out at the workplace. To avoid misuse and to improve chances for a quick return of the employee, any active sick leave must be explained and clarified. The follow-up plan prepared by the employer and the employee should include important documentation that will help further monitoring of those on sick leave in preparation for their return to work. The employer is obliged to submit the follow-up plan to the national insurance office on request. In case of non-compliance, the office can impose enforcement penalties.

The general practitioner: The GP is an important contributor to prevent sickness absence. Employees must be guided in a manner that strengthens their confidence and their motivation for being in work-related activities rather than inactivity. The GP must always assess whether there are significant medical grounds for a person to be absent from work when issuing both the initial and subsequent medical certificates. If the employee is sick for more than eight weeks an extended medical certificate must be completed. GPs who fail to follow the regulations may lose their entitlement to issue medical certificates that form the basis for social security benefits.

strengthen the focus on partial absence and to dampen potential misuse of active sick leave as a cheaper form of partial absence. This shift is also important in view of recent indications that the introduction of active sick leave several years ago may have extended the benefit period further. Results from Rikstrygdeverket (2004) show that people using active sick leave are absent up to twice as long as employees on ordinary sick leave. The study further reports that of those who used active sick leave, a larger share were absent for the whole sickness period of one year and did not return to work on a full scale afterwards.

C. Summary and conclusion

The steep upward trend in sickness absence in Norway during the past decade has placed this issue high on the political agenda. In Poland, the number of sick days has fallen

from fairly high levels. Compared to Norway and Poland, sickness absence is less of a problem in Switzerland. The issue in Switzerland is the lack of co-ordination between the disability insurance and the sickness benefit insurers.

Another issue in all three countries is the lack of monitoring and early intervention, *i.e.* of possibilities to identify a health problem and to intervene before it is too late. To tackle this problem, the Norwegian government recently introduced a new Social Insurance Act. The prospects of Norway succeeding in reducing the sickness absence will mainly depend on whether the new rules will be fully implemented and enforced. In Switzerland, early intervention takes the form of efforts to involve the disability insurance offices at an earlier stage. To facilitate early intervention, it will be important to find a solution that encourages both insurance companies and employers to start reporting sickness cases to the disability institution.

2.2. Disability management

Increasing inflow rates to disability benefits are at odds with long-term trends in the health status of populations. The assessment process for a disability benefit claim is an important factor in explaining this paradox. To better understand the process in the three countries, this section begins by describing the steps from a sickness absence to a disability benefit claim. It further examines the rapid increase in non-specific diseases and mental health problems, and ends with a discussion of different assessment methods and the importance of considering the remaining work capacity rather than the health problem itself.

A. From sickness to disability

In all three countries, a disability claim often follows a long period of sickness. As discussed earlier, Norway has recently introduced a system with early activation. Poland and (so far) Switzerland apply a less active approach. Instead, random controls can be used throughout the sickness period, but also after a disability benefit has been granted. The importance of an early activation approach is supported by evidence in Dodu (2005), who shows that entering formal employment improves the sense of well-being and social integration among people with either physical or mental disabilities. Moreover, research into the management of lower back pain finds support for a primarily work-first approach (Lee, 2005): its benefits have a physiological basis in the fact that injured muscles need to be kept in use to allow scar tissue to develop into properly aligned new muscle fibres. The study concludes that patients with muscular-skeletal disorders should be given maximum encouragement to return to work, with minimum use of a clinical approach.

Table 2.2 summarises the main steps from the moment a person becomes sick to the stage where a disability benefit is granted. The process leading to a disability benefit requires several stages and often stretches over several years, especially in Switzerland and Norway. One reason for this in Switzerland is said to be that the medical assessment tends to focus on medical recovery rather than a rapid return to the workplace. Another reason is the lack of occupational medicine expertise among assessing doctors (Bachmann and Furrer, 1999). Furthermore, in Switzerland during 2001-03, around half of all disability benefit claims had not been processed. In Norway, the backlog reached 53% in 2002 and fell to 43% in 2004. More efforts will be needed in both countries to reduce these long processing times. In Poland, the processing time appears to be systematically shorter, which may have to do with the fact that all disability benefits are granted temporarily.

Table 2.2. **The assessment process from sickness to disability, 2005**

	Norway	Poland (ZUS)[a]	Switzerland
Time scale			
1 week	Up to three days of self-declared absence (up to 8 days in inclusive workplace enterprises).	Certificate from doctor needed from first day of illness.	Certificate from doctor needed from first day of illness.
2 weeks	First medical certificate for 1-2 weeks; as of day 16, NIA pays sickness benefit.		
4 weeks		As of day 34, ZUS pays sickness benefit; controls possible any time but in practice not very frequent (2% of all cases).	*Planned: voluntary early identification of potential long-term benefit cases (currently: unknown to the IV until application for benefits/measures).*
8 weeks	Follow-up plan by the employer and the employee with support from Workplace Centres; no sanctions but control by the Labour Inspection Authority.		*Planned: individual reintegration plans at an early stage (for those identified early).*
3 months			Continued wage payment (and dismissal protection) between three weeks and six months, depending on contract duration.
6 months		End of sickness benefit payment (though extension to 9 months is possible) and application for medical rehabilitation benefit (typically granted for 24 days, but extensions are frequent).	
9 months	Dismissal possible after 6-12 months.	End of dismissal protection for workers on medical rehabilitation benefit.	
12 months	End of sickness benefit payment and application for medical rehabilitation benefit (disability benefit possible but unlikely at this stage).	Typical time for transfer into a (temporary) disability benefit, but such transfer can also occur earlier; similarly, medical rehab is still possible if needed.	Earliest possible date for transfer into disability benefit. Normally it takes 6-12 months after application to be granted a benefit, and 95% apply after more than one year.
1.5 years	Local NIA assessment as to whether medical rehabilitation needs continue (8-9 months medical rehab on average).	End of medical rehabilitation benefit payment.	
2 years	End of medical rehabilitation, start of vocational rehabilitation (if needed) with a rehabilitation allowance.		End of sickness benefit payment from voluntary private insurance (note: one-third are not covered by such insurance).
3 years	Typical time for transfer into disability benefit (but much earlier transfer possible if no prospect for improvement).	A temporary benefit is typically stopped after three years, reapplication required.	
3 years plus	Vocational rehabilitation can often stretch over several years (three years maximum since recently, two years on average).	Training pension for vocational rehab possible but rarely used (three years maximum, first granted for six months).	Vocational rehabilitation can often stretch over several years (no time limit), with a special benefit paid in this period.

a) Until September 1997 ZUS alone was responsible for all disability assessments, but from that time disability is being assessed by three different institutions. Of these, ZUS and KRUS assessments may result in disability benefits. The third institution, the local government, only grants a legal disability certificate which is, for instance, needed for special employment support.

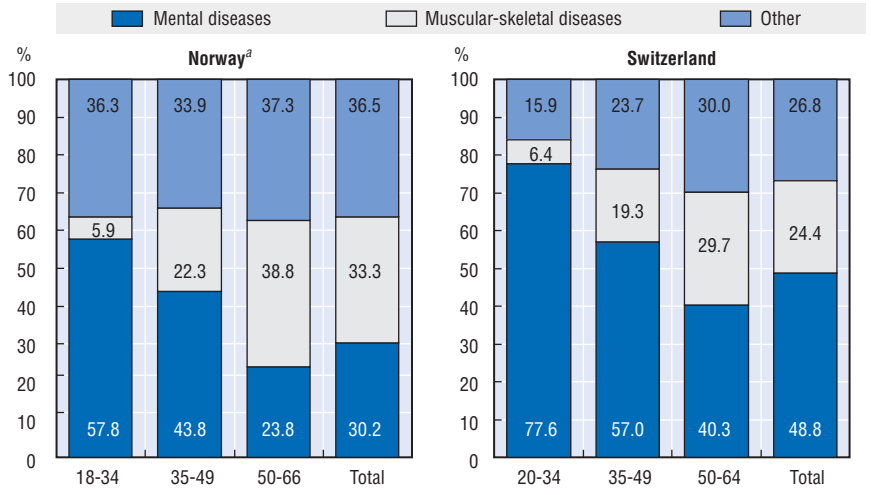
Source: Authors' compilation based on information from National Insurance Administrations for Norway (NIA), Poland (ZUS) and Switzerland (IV).

B. Medical assessment and mental diseases

In Norway and Switzerland (as throughout the OECD area), mental and muscular-skeletal diseases are the two major health problems causing disability benefit recipiency (Figure 2.3). Mental diseases cover almost half of all benefit recipients in Switzerland, compared to about one-third in Norway. Shares are systematically higher in Switzerland, but especially so in among the young age group where almost 80% of all disability benefit recipients are diagnosed with a mental disease. Still, the patterns are similar in the two countries, *i.e.* mental diseases decline with age while muscular-skeletal diseases increase.

Figure 2.3. **Mental diseases are most common in younger ages**

Percentage of major health condition by age for people on disability benefits, 2004



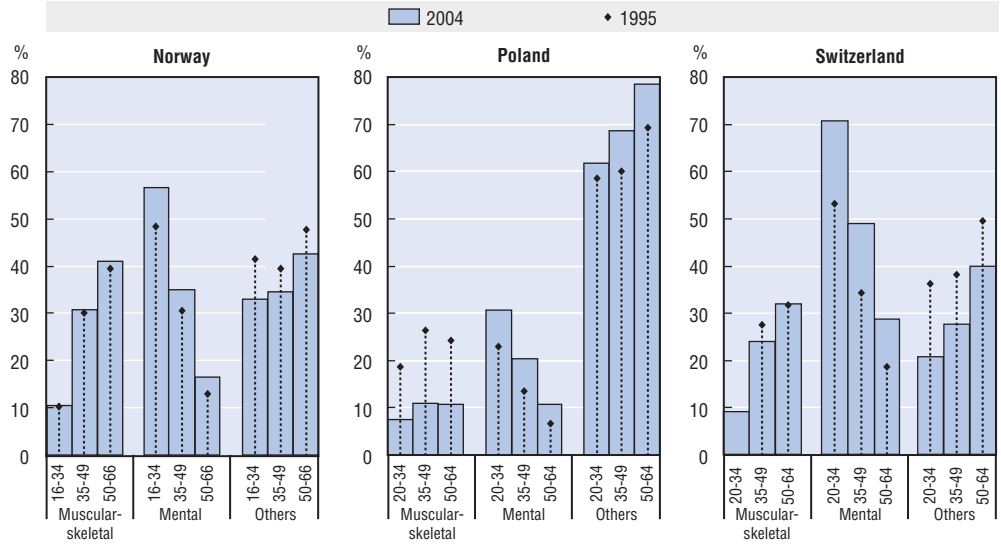
a) For Norway, the category "Other" includes: cardiovascular diseases, injuries and unspecified other diseases. For Switzerland, it includes accidents and all diseases other than mental and muscular-skeletal.

Source: National Insurance Administrations for Norway (NIA) and Switzerland (IV).

The growth in mental health problems is also reflected in the disability *inflow* data by health reason. During the past decade, mental diseases have increased considerably as a share of the total inflow in Poland: the current share is 17% compared to 12% in 1995 (Figure 2.4). Mental diseases have also overtaken muscular-skeletal diseases in numbers and are of the same order of magnitude as cancer. Still, mental health problems in Poland

Figure 2.4. **Large variation in the inflow to disability benefits by health reason and age**

Distribution of total inflow to disability benefits by health reason and age (percentages), 1995 and 2004[a]



a) For Norway, the category "Others" includes cardiovascular diseases, injuries and unspecified other diseases. For Poland, it includes cancer, nerve system diseases, circulatory system diseases and respiratory system diseases. For Switzerland, it includes accidents and all other diseases except mental and muscular-skeletal.

Source: National Insurance Administrations for Norway (NIA), Poland (ZUS) and Switzerland (IV).

are far less widespread than in Norway and Switzerland. In Norway, these problems account for one-quarter of the inflow – similar to the level in Switzerland one decade ago. Mental diseases in Switzerland have continued to rise and currently account for four out of ten new disability benefit awards. In all three countries, the share of inflow because of mental health problems is much higher for the younger age groups.

Norway introduced a National Mental Health Programme in 1998 calling for a major increase in the funding of mental health-related services as well as a major reorganisation of these services. Implementation of the programme is taking place during 1999-2008, and new laws regulating mental health services have been introduced. The overall goal for the programme is to promote independence and improve living conditions, quality of life and participation in normal activities in society for persons with mental diseases. By 2005, the service capacity and the number of persons receiving treatment had increased considerably. However, there is still some way to go when it comes to quality of treatment, access time and real impact for users, families and their associations, and where collaboration between services is concerned. So far, the programme lacks any rigorous evaluation. Nevertheless, the initiative may have contributed to halting the increase in inflow rates of people with mental diseases in Norway.

This, however, cannot fully explain the striking gap between Switzerland and Norway in the frequency of mental diseases. Another reason may be differences in definitions of mental disease (Box 2.4). This is not a well-defined group of health problems and includes categories such as social maladjustments, depression, learning difficulties, psychoses, neuroses and personality disorders. On these lines, other non-specific diseases, often pain-related, are also increasing rapidly as a cause of people receiving disability benefits. It also appears that physicians develop preferences for certain diagnoses. Whiplash, for example, has increased steeply in the German part of Switzerland and is now also increasing in the French part.

Box 2.4. **The complexity of mental health problems**

Evidence of the prevalence of mental problems in the population does not seem to be able to explain the situation in Switzerland. A study by Andlin-Sobocki *et al.* (2005) found that the frequency of brain disorders ranges from 19% to 36% in Europe. Countries such as the Netherlands, Norway, Sweden and Germany have the highest prevalence of brain disorders, whereas France, Italy and Spain have the lowest prevalence. Switzerland was found to be in a middle group of countries. However, the authors conclude that it is beyond their ability to say whether differences between countries are true or simply results of different assessment strategies to estimate their prevalence. Wittchen and Jacobi (2005) estimated the share of people aged 18-65 in the EU that had been affected by at least one mental disorder in the past 12 months to be about 27%, of which one-third had experienced more than one disorder.

A critical question is the extent to which mental disorders are recognised, treated and managed by the general and mental health care sector. Sometimes it is claimed that the problem has always been there and that old taboos concerning mental illness made it possible to keep inflow numbers relatively low. Following this argument, people with impaired mental health can now more easily find a specialist for treatment and obtain a certificate stating their incapacity to work. Still, various mental diseases (as well as muscular-skeletal diseases) that are now increasing in importance were almost unknown two decades ago. In addition, many of them may be treatable in the future.

C. The assessment process

High and increasing inflows to disability benefits (as well as extremely low outflows) cannot be explained by an overall deterioration of people's health status. Instead, one possible explanation is that disability assessment is not sufficiently well managed. During the past decade, this problem may have worsened because of increasing unemployment rates, growing needs for new skills and overall rising demands in the labour market, as well as population ageing and the increase of non-specific diseases that were relatively unknown when most of these benefit schemes were established.

Whether a person with a certain health problem is being granted a disability benefit should primarily depend on the remaining work capacity, not on the person's health problem. However, factors such as the social or personal situation, the state of the labour market, the degree of discretion for GPs and insurance officers, and moral hazard of applicants often play important roles in this decision process. In assessing the right to a disability benefit there is no uniform approach across countries, but the approach of using the remaining work capacity is winning ground over the traditional way of assessing the health problem itself. All three countries require causality between the health problem and the observed work incapacity. Obviously, a rigorous assessment process will avoid misuse and keep inflow rates at a lower level. However, strict eligibility criteria can lead to exclusions of people in need of a benefit.

The assessment of disability benefit entitlements differs significantly between the three countries, although eligibility always requires a full or partial incapacity causally linked to a medical health problem. In Norway, *work* capacity must generally be reduced by at least 50% in order to be eligible for rehabilitation benefits. In Switzerland *earnings* capacity must be reduced by at least 40% (70% for a full benefit). In Poland, total incapacity requires that a person is unable to perform *any* type of work, and partial incapacity that the person is unable to perform the *usual* work. Thus, in Poland the definition of (partial) disability relates to the applicants' own occupation, and even more so in the special system for farmers (Box 2.5), while in Switzerland the definition relates to the claimants' own earnings.

Box 2.5. **The special farmers' pension system (KRUS) in Poland**

KRUS offers farmers and their extended families a range of social insurance benefits roughly comparable to those offered by the general regime (ZUS). To be covered by the system, individuals must be: *i)* farmers owning at least one hectare of land; *ii)* members of such farmers' household who derive their income from farming or from a non-farm activity related to the agricultural land; or *iii)* inactive and dependent on a qualified farmer.

Old-age pension and disability benefit contributions to the KRUS scheme are flat rate and extremely low – less than one-third of the contribution that would be paid by a minimum-wage earner in the ZUS system. Eligible individuals whose farm is less than 2 hectares do not have to pay contributions to the unemployment benefit system but are eligible for benefits.

Benefits in the KRUS system are lower than in the ZUS system, but high relative to the contributions paid: the average KRUS benefit is around 80% of the average ZUS benefit. As a result, the KRUS system operates with a large deficit. Since 1996, registration in the system has been increasing each year (15% total). In 2002, KRUS spending amounted to 2.1% of GDP, with contributions covering only 5% of this amount.

In Norway, assessment of disability benefits is mainly carried out by GPs instead of doctors or specialists affiliated with the insurance office, as is standard in most other OECD countries. This means that insurance offices are usually not intervening or monitoring the GPs' assessments and suggestions – which may partly explain the relatively higher inflow rates to disability benefits in Norway. However, this gatekeeping function of GPs may also result in different outcomes depending on, for example, the relation between the doctor and the patient, or the number of patients the GP has. The NIA has therefore started to investigate GPs' practice with respect to certifying sick leaves (Rikstrygdeverket, 2006). It was found that GPs with a low number of patients certified a relatively lower number of sickness cases than did GPs with a larger number of patients. Also, female GPs certified fewer and shorter sickness leaves than their male colleagues. Moreover, GPs in municipalities with a high concentration of colleagues appeared to certify more sick leaves, while GPs in municipalities with relatively higher unemployment rates had a tendency to certify longer sick leaves as well as fewer graded sick leaves.

Also in Switzerland medical evidence for a disability benefit claim is compiled by GPs. This resulted (in 2004) in the creation of a special regional medical service (RAD) operated by the cantonal authorities, which can examine the medical situation of an applicant (this was not possible for the disability authorities until then). Benefit decisions in Switzerland are taken by the cantonal disability authorities. In Norway they are taken by the regional county insurance office on the basis of the remaining work capacity assessment by the local insurance office and interdisciplinary teams, which are comprised of medical and vocational experts.

In Poland, medical examinations for a benefit claim are undertaken by certified social insurance doctors. These doctors issue an assessment and can request additional medical or professional expert opinions or perform additional (clinical) tests as needed. Benefit decisions in Poland are made by the regional insurance division solely on the basis of the certified doctor's medical assessment. None of the three countries takes the actual labour market situation into account in assessing a benefit claim, although regional can and does produce significant regional diversity in outcomes (Chapter 5).[3]

Since November 2005, in Poland, benefits are only granted temporarily, but even earlier some 80% were approved only for a temporary period. Upon expiration of a temporary benefit (usually after three years) payments are terminated, individuals have to reapply and their case will be fully re-examined. In Norway, on the contrary, until 2004 all benefits were granted permanently. Since then, the insurance authority can grant either a temporary benefit if the situation is likely to improve, or a permanent benefit. Continued entitlement for the latter is automatically reassessed upon expiration of the payment. In Switzerland there is large flexibility as regards the duration of a (first-time) entitlement, and it is also possible to reassess an entitlement that was granted without a time limit. However, this is rarely done.

There is a third way to assess disability in Poland, which involves the local government.[4] This assessment is for a legal disability certificate rather than a disability benefit (although it often results in some form of support) and requires several predefined steps. First, the applicant needs a set of medical certificates from a GP or a hospital. Second, a doctor from the assessment team reviews this information and makes a decision whether to grant a disability certificate. The applicants then have to indicate if they want to work. After these steps, a second advisor reviews the case (this could be a psychologist

or a social worker). The disability certificate can be granted as severe, moderate or minor and often results in medical support or help with handicap equipment.[5] Many persons also receive social pensions at a later stage by recommendation of the assessment offices.

D. Summary and conclusion

In the three countries under study, about one-third of all disability beneficiaries have been in receipt of a benefit for ten years or longer. Mental health problems are the most widespread and fastest growing disease in younger age groups. This will most certainly extend benefit duration further and stresses the need and importance of a sound assessment process.

Many disability benefits could be avoided if health problems were detected at an early stage. The process from a sickness benefit to a disability benefit claim often stretches over several years. One important reason in all countries for the long time frame is the general lack of occupational medicine expertise among assessing doctors. Added to this, about half of all benefit applicants in Norway and Switzerland had not been processed within the first year, which indicates that the process in itself is fairly slow.

Since mental diseases are not clearly specified and not well understood, the long-term effects of these health problems are uncertain. This suggests that benefits for this disease group in particular should be granted temporarily rather than permanently. In this regard, Poland is far ahead of the two other countries.

2.3. Rehabilitation management

The stereotype of disability benefit recipients as people with severe medical conditions based on objective medical evidence such as blindness, severe neurological disease or amputation is no longer valid. Moreover, many of these health problems are potentially curable and long-term incapacity is not inevitable. This implies that, more than ever before, rehabilitation should not be a separate, second-stage intervention *after* "treatment" is completed (Waddell and Burton, 2004), but rather go hand-in-hand with the treatment of a disease. This section explores the concept and occurrence of medical and vocational rehabilitation across age and health conditions. It further discusses obligations to participate in vocational rehabilitation and how the administrative setup may affect outcomes and efficiency in the three countries.

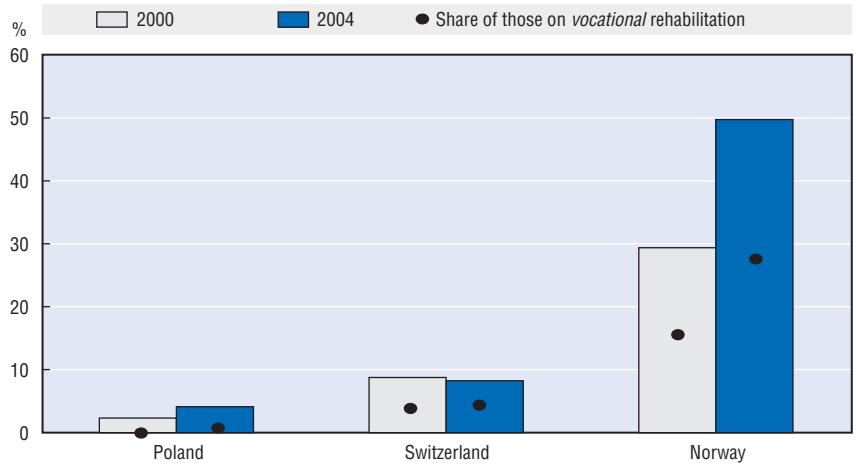
A. The rehabilitation process

Rehabilitation is a process designed to enable people with health problems to function in a normal manner, or as near to normal as possible. Whereas the objective of *vocational* rehabilitation is to assist people to remain in or return to employment, *medical* rehabilitation is generally used to restore or improve peoples' health situation because of illness or injury. Medical rehabilitation is, therefore, not necessarily meant to enhance the chances for people to return to the labour market. Participation in rehabilitation (either medical or vocational) as a share of all disability beneficiaries varies enormously, from 4% in Poland to 8% in Switzerland and 50% in Norway (Figure 2.5). In Norway and Switzerland, more than half of this is due to vocational rehabilitation, whereas in Poland rehabilitation is mainly medical.

The high and increasing frequency of rehabilitation provision in Norway can be partly explained by the broader eligibility for participation in vocational rehabilitation – which,

Figure 2.5. **Rehabilitation provision is substantially higher in Norway**

People in medical and vocational rehabilitation as a share of all disability beneficiaries, 2000 and 2004[a]



a) Medical rehabilitation in Norway is based on people receiving a medical rehabilitation allowance rather than people participating in medical rehabilitation. For Poland and Switzerland, only medical rehabilitation offered by the disability insurance is included, which excludes medical rehabilitation offered by the health insurance system.

Source: National Insurance Administrations for Norway (NIA), Poland (ZUS) and Switzerland (IV).

for instance, also includes those already on disability benefits. However, access to rehabilitation benefits does not automatically imply that people receive medical help or participate in an employment measure. *Medical* rehabilitation can be granted to persons who have exhausted their entitlements to sickness benefits when the incapacity to work has lasted one year. In the later stages of a period of rehabilitation, it may also be granted if the working capacity is reduced by 20% or more. *Vocational* rehabilitation benefits are granted to those whose ability to find work is permanently reduced by at least 50%, but vocational rehabilitation may also be used as a preventive measure when there is a risk that a person with reduced work capacity may lose the job. Medical rehabilitation programmes last on average nine months and vocational rehabilitation can last up to three years (or longer when so-called programme chains are used).

Switzerland uses a "rehabilitation before benefit" approach with an obligation for benefit applicants to undergo rehabilitation if this is needed to restore, maintain or improve work capacity. The law does not specify the eligibility criteria more precisely. Court orders have established that vocational retraining can be offered to benefit applicants with a 20% reduced earnings capacity (compared to a required reduction of 40% for receiving the lowest graded disability benefit). Job placement support by the cantonal authorities of disability insurance is open to all people with a reduced work capacity. In granting a measure, several criteria – including age, motivation, type of disability and occupation – are taken into account (Furrer *et al.*, 2003).

In Poland on the other hand, rehabilitation is not mandatory, but instead restricted both in terms of eligibility and number of programme places – especially for vocational rehabilitation.

Comparing health conditions of people in rehabilitation measures, there appears to be a much weaker focus on the group of people with mental disorders in Switzerland. Four in ten Swiss persons entering disability benefits have a mental disease, while this group only

makes up one-quarter of all participants in rehabilitation (Table 2.3). That fact is all the more surprising given that mental disorder is the fastest-growing disease in Switzerland. In Norway, the situation is the opposite: 36% of all people with a vocational rehabilitation benefit have a mental disease compared to one-quarter of the inflow into disability benefits. However, it is not clear whether these people actually participate in an employment measure or simply rely on passive benefits. Given successful outcomes from rehabilitation for the group, this difference between Norway and Switzerland may partially explain the extremely high inflow to disability benefits due to mental diseases in Switzerland.

Table 2.3. **People in rehabilitation have different health problems from those on disability benefits**

Distribution of health problems for people in rehabilitation and new disability beneficiaries, 2004 (percentages)

	Norway		Switzerland		
	Inflow to disability benefits	Vocational rehabilitation	Inflow to disability benefits	Vocational rehabilitation	Medical rehabilitation
Mental diseases[a]	25.4	35.6	41.0	23.2	26.8
Muscular-skeletal diseases	35.2	38.3	26.0	21.1	17.5
Others	39.4	26.1	33.0	55.7	55.6
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*

a) In Norway, a mental disease is defined as psychiatric problems, metabolic disorders, social maladjustment or substance abuse as well as learning difficulties.

Source: National Insurance Administration (NIA) and Public Employment Service (AETAT) for Norway, and Disability Insurance (IV) for Switzerland.

B. Medical rehabilitation

Medical rehabilitation in Norway is financed by the social security administration but carried out by the health sector. This raises two problems. First, the authority responsible for the rehabilitation does not carry the full costs, which raises issues of adjusting incentives, and secondly, medical rehabilitation is not vocationally oriented. According to the Norwegian Health Care Acts that regulate the municipal and specialist health care, "adequate rehabilitation services shall be ensured for all who need this in order to improve or maintain physical, sensory, intellectual, mental and social functioning. Rehabilitation strategies shall focus on individual goals rather than types of diagnosis". On the other hand, medical rehabilitation in Poland and Switzerland is run by both the social security administration and the health sector, and is more vocationally oriented in the former.

Those responsible for rehabilitation have no quantitative targets to, for example, reintegrate a certain share of the participants back to work. Instead, in both Norway and Poland, for the portion of medical rehabilitation that is health-care related, benefits appear to be a way of extending sickness benefits after the benefit period has expired. In Norway, such benefits can be granted for one additional year provided that the working capacity is still reduced by at least 50%, while in Poland benefits are often used by GPs as an instrument to extend sickness payments from half a year to a full year.

In both Norway and Switzerland, medical rehabilitation is most frequent in the youngest age group (Table 2.4). While it falls gradually by age in Norway, it reaches the lowest value for the prime age in Switzerland – the age group in which the inflow has been growing the fastest over the past 15 years. Overall, the share of people on medical

rehabilitation benefits as share of the inflow into disability benefits is extremely high in Norway. Judging from the high inflow rate to disability benefits, this enormous focus on medical rehabilitation does not appear to be very effective.[6] This is probably explained by the setup of the system: most Norwegians receiving a medical rehabilitation benefit are not participating in treatment.

Table 2.4. **Participation in medical rehabilitation is very high in Norway, especially at younger ages**

In percentage of inflows into disability benefits and as a share of all disability benefit recipients, 2004

	Share of the inflow				Share of current recipients			
	20-34	35-49	50-64	20-64	20-34	35-49	50-64	20-64
Norway[b]	542.0	315.8	102.4	201.1	87.9	37.3	8.7	19.5
Poland	. .	. .	. .	101.4	. .	. .	. .	3.8
Switzerland	126.1	9.7	28.2	35.1	14.3	1.0	2.7	3.4

. .: Data not available.

a) Medical rehabilitation in Norway is based on number of medical rehabilitation benefits paid by the NIA. In Poland and Switzerland, only vocationally oriented medical rehabilitation run by ZUS (Poland) and DI (for Switzerland) are reported, which underestimates the actual number on medical rehabilitation compared to Norway.

b) The age groups for Norway are 50-66 (instead of 50-64) and 20-66 (instead of 20-64).

Source: National Insurance Administrations for Norway (NIA), Poland (ZUS) and Switzerland (IV); and the Public Employment Service (AETAT) for Norway,

Since 1997, the Polish Social Insurance Administration (ZUS) provides and bears full costs of vocationally oriented medical rehabilitation, which can be prescribed at any stage of the eligibility process. The number of people involved has increased from 14 000 in 1997 to 64 000 in 2003. Available outcomes suggest that the ability to work was restored for 70% of the participants, but there is no evidence that they took up a job. The average duration of this specialised medical rehabilitation in Poland is relatively short, with 90% completing their rehabilitation within 24 days. In Switzerland, vocationally oriented medical rehabilitation lasted on average 24 days, while in Norway the average duration of medical rehabilitation was nine months; this again suggests that medical rehabilitation in Norway is to a considerable extent used as a way to extend sickness benefits.

C. Vocational rehabilitation

In Norway and Switzerland, vocational rehabilitation schemes are quasi-mandatory if the work capacity can be improved or maintained, while they are still voluntary with a very limited use in Poland. In other words, disability benefits in Norway and Switzerland are, by and large, only granted if rehabilitation has failed. In both countries, vocational measures are primarily used to maintain the participants' qualifications. In Norway, re-training to a level *below* the former job must be accepted if this is necessary for finding a "suitable job". This assessment, however, is based upon the individual's situation regarding education, age and working experience. In Switzerland, retraining for a "reasonable job" must be accepted. Whether a job is reasonable depends solely on the expected earnings after completion of a rehabilitation programme relative to the pre-disability earnings.

In Norway, the decision whether an individual should participate in vocational rehabilitation was divided between the National Insurance Administration (NIA) and the PES. The assessment by the NIA was based on medical criteria, while the PES assessment was based on labour market-related criteria. Since July 2004, the PES is fully responsible for

the assessment of the preconditions for vocational rehabilitation, the decision how to implement rehabilitation and for paying rehabilitation benefits. This is expected to speed up the transition to employment since it reduces waiting time and places the focus on employment-oriented measures at an early stage.[7]

In Switzerland, vocational rehabilitation is under the responsibility of the cantonal disability insurance office. Entitlement for vocational rehabilitation requires that the person has been assessed as disabled by the office, which also runs its own rehabilitation schemes and programmes. In Poland, vocational rehabilitation is managed by the State Fund for the Employment and Rehabilitation of Disabled People (PFRON). However, information about the number of participants as well as the content and outcomes of programmes is largely unavailable.

Vocational rehabilitation benefits are very common in Norway; these are more than three times as many participants as in Switzerland. Regardless of this difference, inflow rates to disability benefits are twice as high in Norway compared to Switzerland (the effectiveness of vocational rehabilitation is discussed in Chapter 3). In both countries the share of people on vocational rehabilitation falls steeply with age (Table 2.5). In Switzerland, older people appear to be noticeably underrepresented: while people above age 50 account for more than half of the inflow to disability benefits, they account for less than one-tenth of all participants in vocational rehabilitation, or 9% of their inflow to disability benefits. The overall share of people on vocational rehabilitation benefits in Norway on the contrary is so high that it reaches almost 80% of the inflow to disability benefits, even for those aged 50-66.

Table 2.5. **Participation in vocational rehabilitation is extremely high in Norway**
In percentage of inflows into disability benefits and as a share of all disability benefit recipients, 2004

		Share of the inflow				Share of current recipients			
		20-39	40-49	50-66	20-66	20-39	40-49	50-66	20-66
Norway	Total	958	402	78	287	144	45	7	28
	Men	1 186	484	89	324	155	51	9	33
	Women	797	348	68	256	134	41	5	24
		20-34	35-49	50-64	20-64	20-34	35-49	50-64	20-64
Switzerland	Total	191	54	9	48	22	5	1	5
	Men	248	80	10	60	27	8	1	6
	Women	131	28	6	33	16	3	1	3

Source: National Insurance Administration (NIA) and the Public Employment Service (AETAT) for Norway; Disability Insurance (IV) for Switzerland.

Following the Norwegian decision in 2004 to increase the focus on vocational rehabilitation, the number of beneficiaries has grown considerably. Part of this policy change meant that all disabled persons commencing a rehabilitation programme should have an individual action plan developed in co-operation with the PES. Two other requirements were to consider vocational rehabilitation as soon as possible and at the latest when the period of sickness benefit expired, as well as to have a new disability assessment after six months of receipt of rehabilitation benefits. This policy shift also included a time limit of medical rehabilitation to one year. As a consequence, the number of people on vocational rehabilitation benefits has increased by around 10 000 since 2003, a figure that has more or less been offset by a similar fall in the number of people on

medical rehabilitation benefits. Unfortunately, this has not transferred into an increasing number of people in employment measures, but instead only shifted people from one passive benefit to another.

In Switzerland, new measures will also be taken following implementation of the fifth revision of the Disability Insurance Act. The approach is to move away from the old concept of "rehabilitation before benefits" to a new concept of "rehabilitation instead of benefits".

D. Summary and conclusion

Medical rehabilitation is usually under the responsibility of the health sector, while vocational rehabilitation is managed by the social security administration or, as in Norway, by the PES. As a result, the two rehabilitation approaches are often completely separate. For medical rehabilitation to enable better reintegration of participants into employment these two measures should, instead of being sequential, go hand-in-hand. This is partly the case for vocationally oriented medical rehabilitation in Poland and Switzerland. Medical and vocational rehabilitation should also have common quantitative goals and objectives, and the most important one should be to restore work ability and assist people in re-entering the labour market.

Rehabilitation in general and vocational rehabilitation in particular appears to be used much more widely in Norway than in Switzerland or Poland. Since 2000, the number of people on vocational rehabilitation benefits has almost doubled in Norway while it increased by one-third in Switzerland, which indicates a firm step towards a more work-related rehabilitation policy in both countries. However, in Norway, it seems that people often use these benefits as passive income support instead of participating in employment programmes or medical treatments. Outcomes from vocational rehabilitation measures are discussed in Chapter 3.

In Poland, vocational rehabilitation is still in its infancy. It should therefore be a priority to introduce a better and more transparent system, and to broaden access to effective rehabilitation measures. This would also improve the chances that the large reduction in inflow rates will be sustainable in the long run. Also, Switzerland could further broaden the eligibility criteria for vocational rehabilitation (*e.g.* by focusing on temporary work incapacity rather than on an earnings capacity loss which in most cases requires job loss) so as to cover more people at an earlier stage and, in particular, more people with mental health problems.

Notes

1. Data from the first quarter of 2006 indicate that this downward trend has been broken and that the sickness absence is increasing again.
2. One plausible reason for these differences is that labour market participation rates fall steeply with age in Poland but much less so in Norway and Switzerland.
3. In Switzerland, a theoretical balanced labour market is used as a reference to avoid the choice between an abstract approach, with no reference to the actual labour market, and a concrete one, which takes actual job vacancies into account. The purpose of this is to ensure equal treatment of equal cases irrespective of the business cycle.
4. There are two additional disability benefit schemes, one covering the military service and one covering policemen, firemen and other uniformed services. These schemes have their own

disability definition and assessment authority and cover around 3.5% of all beneficiaries outside the agricultural labour force.

5. A *minor degree of disability* corresponds to a situation where a person has restricted ability to perform social roles or a bodily impairment that significantly reduces their ability to perform work. A *moderate degree of disability* corresponds to a situation where a person needs partial assistance to perform social roles or a situation where bodily impairments restrict work to sheltered employment. A *severe degree of disability* corresponds to a situation where a person needs long-term care and assistance to perform social roles or where the bodily impairment makes it possible to work only in sheltered employment.
6. In Poland and Switzerland, figures are based solely on the vocationally oriented medical rehabilitation run by the social security administration.
7. To further stimulate the transition back to work, certain changes have been made to the vocational rehabilitation scheme since 2004. These include: *i)* shortening of the period during which a person can receive rehabilitation benefits after having completed a vocational rehabilitation measure (from twelve to six months); *ii)* tightening of the access to rehabilitation benefits for students aged 22-26 (of whom many could participate in ordinary education); and *iii)* introducing a maximum duration of three years for rehabilitation benefits relating to education.

ISBN 92-64-02631-2
Sickness, Disability and Work
Breaking the Barriers – Vol. 1
© OECD 2006

Chapter 3

Increasing Employment Opportunities

Employment rates of people with disabilities are far below those of non-disabled persons, in Norway, Poland and Switzerland as much as elsewhere. The obvious reason for this is that severe health impairments may prevent people from working. But other reasons are a lack of relevant skills, discrimination, weak incentives to accept a job offer, and unsuccessful re-integration measures. Employment outcomes from vocational rehabilitation are often not evaluated and little is known about the optimal design of programmes or the best timing of interventions. Disabled workers sometimes have special rights in terms of employment protection legislation and often have the possibility to combine a disability benefit with labour income or to draw such benefit partially or temporarily, depending on the health problem, while employers may be required to hire a certain share of disabled workers. Again, little is known about the impact of these regulations.

With high disability benefit recipiency levels at all ages in Norway and Poland and among younger adults in Switzerland, it is necessary to increase the outflow from these long-lasting benefits into jobs. This chapter looks at ways to do so through employment programmes and measures to increase chances for people with health impairments to find a job or remain in their present occupation. It further addresses measures such as temporary and part-time benefits that may assist and encourage people to return to the labour market.

Outflow from disability benefits is extremely low and, in general, poorly documented. For example, of the total outflow in Norway, three-quarters were accounted as transfers to old-age pensions and one-fifth were due to deaths; the remainder includes transfers to employment. In Poland, half the outflow occurred because people transferred to an old-age pension, more than one-quarter were due to deaths and less than one-fifth was due to reassessments. The Swiss data only indicate total transfers and the share that transferred to an old-age pension (two-thirds). The lack of more detailed data (*e.g.* no country uses a category "transfer to employment") is telling. Given the tiny magnitude of estimated outflow rates because of an improved health situation or possible re-employment of around 0.5% in Norway, 1.4% in Switzerland and 2.5% in Poland, increasing the outflow has clearly not been an issue for policy makers so far (Table 3.1).

Table 3.1. **Outflow from disability benefits into jobs is extremely low in all countries**

In percentage of all disability benefit recipients, 2004[a]

		20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-66	Total
Norway	Total	0.8	0.5	0.8	0.6	0.6	0.6	0.5	0.4	0.3	0.5
	Men	1.0	0.6	0.9	0.6	0.6	0.6	0.6	0.5	0.4	0.5
	Women	0.5	0.4	0.6	0.6	0.7	0.7	0.5	0.4	0.3	0.4
		20-29		30-39		40-49		50-59		60-64	Total
Poland[b]	Total	4.7		3.9		4.0		2.2		0.3	2.5
	Men	5.2		3.8		3.5		2.0		0.3	2.2
	Women	3.7		4.0		4.6		2.6		0.1	2.9
		20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Total
Switzerland[c]	Total	2.4	1.5	1.6	1.2	1.1	0.9	0.9	0.8	1.1	1.1
	Men	2.4	1.4	1.5	1.0	1.0	0.9	0.8	0.9	1.2	1.0
	Women	2.5	1.7	1.7	1.4	1.2	1.0	0.9	0.8	0.8	1.1

a) Old-age pensions and deaths are excluded from the data.
b) Outflows -only refer to those reassessed by ZUS.
c) Swiss data on outflow because of deaths are unavailable and instead were imputed by using five-year age- and gender-specific death rates for Norwegian disability benefit recipients.
Source: OECD estimates based on data supplied by national authorities.

3.1. Employment support for people with health problems

Re-entering work is generally associated with improvement in income, socioeconomic status and well-being. This is partly a result of leaving the benefit system, but there is also evidence that health improvements are associated with work itself. Higher employment

rates of people on disability benefits are also vital to boost economic growth and to lower public spending. This section discusses ways to assist people with health problems to integrate (or reintegrate) into the labour market.

A. The current employment and education situation

In 2005, employment rates of self-assessed disabled persons varied dramatically between Norway and Switzerland (45% and 52%, respectively) on the one hand and Poland (18%) on the other.[1] Relative to non-disabled people, employment rates for disabled workers reached almost two-thirds in Switzerland but only one-quarter in Poland (Chapter 1). Unemployment rates are overall higher for disabled people and amounted to 7-8% in Norway and Switzerland – almost double the rate of non-disabled people. While unemployment is extremely high for all groups in Poland, it peaks for the 20- to 34-year-olds, reaching levels of 37% and 25% for disabled and non-disabled persons, respectively.

Table 3.2 gives an overview of other employment characteristics of the self-assessed disabled and non-disabled populations in the three countries. Some are worth highlighting, such as the low share of disabled Poles who work in the public sector; that

Table 3.2. **Large differences between the jobs of disabled and non-disabled people in all countries**

Employment structure and characteristics in 2005 (percentage)

	Norway				Poland[a]				Switzerland			
	20-34	35-49	50-66	Total	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total
Disability prevalence	9	13	27	16	3	8	26	11	6	9	17	10
Employment (% of population)												
Disabled	58	52	37	45	20	21	16	18	69	59	41	52
Non-disabled	78	89	82	83	57	77	49	62	81	89	78	83
Unemployment (% of labour force)												
Disabled	12	8	4	7	37	28	14	22	9	9	8	9
Non-disabled	6	3	2	4	25	15	14	19	6	3	3	4
Public sector employment[b]												
Disabled	24	36	39	35	19	15	12	14	2	5	6	5
Non-disabled	29	33	39	33	23	37	37	32	4	6	8	6
Part-time employment[c]												
Disabled	25	35	43	36	18	25	38	33	24	35	43	36
Non-disabled	22	14	15	17	10	9	12	10	19	26	27	24
Temporary employment												
Disabled	20	8	6	9	38	40	35	37	9	6	5	6
Non-disabled	17	6	3	9	34	14	11	22	11	4	4	6
Self-employed												
Disabled	7	10	12	10	17	33	41	36	7	16	22	16
Non-disabled	4	7	9	7	13	23	29	20	7	15	20	14
Share by industry												
Agriculture												
Disabled	4	3	7	5	31	39	49	41	–	–	1	0
Non-disabled	2	3	3	3	12	17	20	16	7	4	3	4
Industry												
Disabled	22	19	18	19	51	29	16	22	24	2	10	9
Non-disabled	19	22	21	21	32	30	26	30	7	8	5	7
Services												
Disabled	74	78	75	76	18	31	34	36	76	98	89	90
Non-disabled	79	75	76	77	56	54	54	55	85	88	92	88

a) For Poland, data refer to 2004.
b) For Switzerland, public administration only.
c) Part-time work is defined as less than 30 hours of work per week.
Source: Authors' estimations based on national labour force surveys.

may be explained by the fact that until recently, the public sector was not covered by the quota-levy system. Another important difference is the substantially higher share of part-time jobs among disabled workers in all countries, but also the higher shares of self-employment. Indeed, more than half of all disabled workers in Poland are either self-employed or work as a family member, compared to one in ten in Norway and one-fifth in Switzerland. Temporary employment contracts are also far more frequent among disabled workers in Poland compared to those in Norway and Switzerland. Differences can also be observed by broad industry. With a total employment share of 17%, the agricultural sector in Poland is substantially larger than in the other two countries. However, with an employment share of 40%, disabled people in Poland are strongly overrepresented in this sector, which may be partly explained by the broadening of the KRUS pension scheme noted above. Consequently, the service sector in Poland is employing far fewer disabled persons than in Norway and Switzerland.

Educational attainment is lower among the disabled compared to the non-disabled population. This is particularly the case for the *non-employed,* where the share of low-educated is almost twice as high for the disabled compared to the non-disabled group (Table 3.3). These low education levels may be an important explanation for the relatively lower employment rates among people with disabilities. The situation may have been intensified by technical progress: there is no longer a need for certain simple and menial niche jobs (as is often argued in Switzerland). However, that is not the trend in Norway, where educational attainment in the age group 20-34 is very similar for disabled and non-disabled people.

Table 3.3. **Disabled people have lower levels of educational attainment**

Level of education of non-employed disabled and non-disabled people in 2005 (percentage)[a]

Educational attainment[c]	Norway				Poland[b]				Switzerland			
	20-34	35-49	50-66	Total	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total
Low level												
Disabled	11.3	21.1	41.7	31.3	39.9	24.3	38.1	35.0	49.9	42.6	44.2	44.4
Non-disabled	9.2	17.8	37.8	22.3	12.6	19.8	29.7	19.7	23.2	25.6	30.8	26.6
Medium level												
Disabled	68.2	64.4	49.9	56.8	60.1	73.5	57.3	61.0	45.4	49.8	45.2	46.6
Non-disabled	68.0	61.5	51.0	59.8	79.5	76.5	62.4	73.3	63.7	55.6	55.1	58.4
High level												
Disabled	20.5	14.5	8.4	11.9	0.0	2.2	4.6	4.0	4.8	7.6	10.6	9.0
Non-disabled	22.8	20.7	11.3	17.9	7.9	3.7	7.9	7.0	13.1	18.9	14.1	15.0

a) Non-employed is the sum of all inactive and unemployed.
b) For Poland, data are from 2004.
c) A Low level corresponds to an educational attainment of less than upper secondary education (ISCED 0-2); a Medium level to an upper secondary education (ISCED 3-4); and a High level to a tertiary education (ISCED 5-6).
Source: Authors' estimations based on national labour force surveys.

B. Activation programmes for disabled people

General data on public spending on Active Labour Market Programmes (ALMP) show that, seen against their low level of overall unemployment, Norway and Switzerland belong to those OECD countries with a strong emphasis on rehabilitation and employment measures, with spending amounting to 1% of GDP in Norway and 0.75% in Switzerland. For

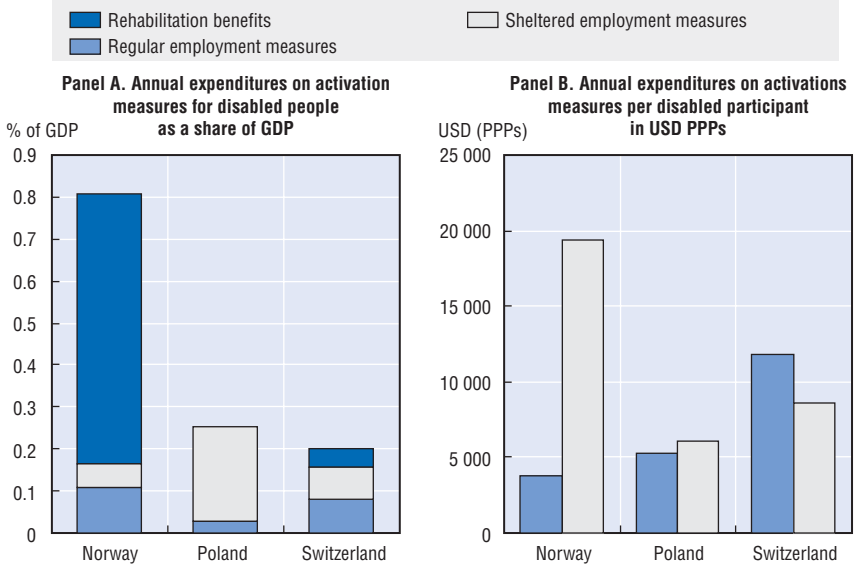
Poland the opposite holds: the unemployment rate is four times higher than in Norway and Switzerland, yet spending on ALMP is only about 0.4% of GDP.

In Norway, three-quarters of total ALPM spending is directed towards people with disabilities, while in Switzerland the same share is spent on the unemployed. This difference mirrors the gap between the two countries in the size of the inflow to disability. For Poland, activation measures are rarely used as a means to integrate disabled people into the regular labour market. Instead, 90% of Poland's spending on activation of disabled people is in the form of wage subsidies for permanent sheltered work (Figure 3.1, Panel A). In Norway, reintegration *measures* (as distinct from rehabilitation benefit spending) are predominantly focused on the regular labour market but spending shares are very similar for regular and sheltered employment measures as is the case in Switzerland. However, at around 0.1%, spending on regular employment measures for disabled people as a share of GDP is only slightly higher in Norway than in Switzerland despite almost four times as many participants. This is because by far the highest ALMP spending item in Norway is vocational rehabilitation benefits, which account for no less than 80% of total spending on activation measures for disabled people. Added to this is a similar amount spent on medical rehabilitation benefit (not shown in the figure).

Judging from Panel B in Figure 3.1, which shows annual spending on employment measures per person corrected for differences in purchasing power, it is obvious that activation programmes in Norway come at a relatively low cost. This is partly explained by the high use of regular education measures which are rather inexpensive compared to other Norwegian employment measures – but also in comparison with, for example, wage subsidies in Poland or more staff-intensive rehabilitation programmes in Switzerland. However, costs of sheltered workplaces per person involved are much higher in Norway

Figure 3.1. **Activation spending in Norway is predominantly on rehabilitation benefits**

Annual spending on ALMP measures as a share of GDP and per capita, 2003-04



ALMP: Active labour market programmes.

Source: OECD estimates based on the OECD Active Labour Market Programmes database (2005); for Norway, AETAT data on sheltered employment phase 3; for Poland, PFRON data on sheltered work; for Switzerland, administrative data on sheltered employment.

than in the other two countries. Only in Switzerland is spending per person in sheltered work lower than for activation in regular employment measures.

Vocationally disabled people in Norway can utilise a wide range of services, ranging from counselling and job-placement assistance to ordinary labour market measures. Disabled people have access to all mainstream programmes offered by the PES, but also to a range of special programmes. Measures are mostly offered on a temporary basis and can be grouped as in Table 3.4. In 2004, two-thirds of all people classified as vocationally disabled and registered at the Norwegian PES – close to 60 000 people – participated in vocational rehabilitation. However, another 30 000 were waiting either to be placed in a suitable programme or for clarification of their work ability.[2] There appears to be a clear age-targeting in the use of the various programmes: whereas prime-age people more often participate in general training measures, older participants are to a larger extent involved in sheltered work or work experience in sheltered enterprises.

Table 3.4. **Almost half of all participants in vocational rehabilitation in Norway receive training**

Distribution of programme participants by age group, 2004 (percentages)

	< 20	20-24	25-29	30-39	40-49	50-59	60-66	Total
Education in regular schools and labour market training	30.5	45.4	57.8	57.8	48.2	27.6	7.8	48.9
Work experience in regular workplaces	49.9	21.6	14.3	14.7	17.3	19.5	10.3	17.1
Work experience in sheltered enterprises	1.3	8.2	9.8	9.4	12.3	19.9	38.4	11.9
Sheltered workshops	9.0	7.1	5.3	5.6	9.7	19.4	33.2	9.1
Supported employment	5.2	10.9	5.9	4.5	4.4	4.7	2.1	5.2
Wage subsidies	1.7	2.3	2.2	2.7	3.0	3.7	3.2	2.8
Trial measures	0.1	0.3	0.5	0.7	0.9	1.4	2.2	0.8
Temporary public employment sector	0.3	1.1	0.5	0.6	0.7	1.0	1.8	0.7
Other measures	1.9	3.2	3.7	4.1	3.6	2.9	1.2	3.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Vocationally disabled that participate in a programme	*64.4*	*68.4*	*69.8*	*68.7*	*64.6*	*57.2*	*67.3*	*66.0*

Source: Administrative data from the Public Employment Service (AETAT).

Temporary wage subsidies are used rarely for vocationally disabled people in Norway irrespective of age, and indeed much less often than wage subsidies for non-disabled unemployed (OECD, 2004b and Chapter 4). Wage subsidies are understood to subsidise work carried out during normal working hours, which may limit the scope of participation for vocationally disabled people. Instead, there is a stronger focus on work experience programmes, which have more elements of adapted job training; participants can try out their capabilities and their efforts are followed up in accordance with the plan prepared for each person.

For the other two countries, there is much less evidence on the specific types of rehabilitation programmes offered to participants. Based on the limited information available, it appears as if in Poland very few employment programmes are open to or targeted to disabled people. One reason for this is that ZUS is not responsible for helping disabled people back to work.[3] Further, the Ministry of the Economy and Labour only deals with disabled people if they are unemployed, and the local PES appears not to spend much effort on re-integration of or employment measures for disabled people. Instead, the main

employment measure for disabled people goes through Sheltered Work Enterprises (SWEs), which are discussed further below. Other assistance mainly consists of permanent wage subsidies and financial aid to enable education or employment through the removal of transport barriers (Polish Ministry of Economy and Labour, 2004).

In Switzerland, the composition of programmes is going to change drastically in the future: new integration measures will be introduced with the planned fifth revision. Some of these measures will be socio-professional in nature, such as adaptation to work processes, boosting of job motivation and acquisition of social skills. Targeted occupational measures aimed at labour market integration will partly replace the old measures of career guidance, basic vocational training, professional reorientation and placements – often not the most effective instruments. These new measures will benefit people whose capacity to work has been reduced by at least 50% (*e.g.* by being on sick leave) over a minimum period of six months. It is hoped that by not requiring an earnings-capacity loss, these measures will reach people earlier than is currently the case. The measures will also be designed to reach more people with low skills and with mental health problems.

Until recently, the disability office in Switzerland did not assist disabled workers who lost their jobs but were fully employable in jobs adapted to their health problem. These people were referred to the PES. After the fourth revision of the Disability Insurance Act in 2004, the responsibility for job placement of disabled people was transferred to the disability offices, which opens up new opportunities but also raises new challenges such as training of staff and co-ordinating with the PES. According to information from the disability insurance in 2005, only 17% of the staff of the disability offices were specialists on vocational reintegration, and of these only one in four (*i.e.* 4% of the entire staff) were involved with the job placement implementation introduced in 2004.[4]

C. Outcomes of vocational rehabilitation

To understand what works and what does not work in terms of vocational rehabilitation for disabled people, more and better evaluations are needed in all countries. Often, countries lack these rigorous evaluations of their programmes, and when they exist they are usually confined to one particular scheme.

Extensive evaluations of vocational rehabilitation programmes in Norway are ambiguous and findings vary with the choice of programme evaluated; the duration of the programme; characteristics of the participants; the period elapsed following participation in the programme; and whether so-called "programme chains" are taken into account. Because persons selected into a programme are not a randomly chosen group, and since the vast majority of vocationally disabled people registered at the PES are supposed to participate in a programme, it is problematic to find proper comparison groups. Hence, some evaluations show that vocational rehabilitation has strong positive employment effects, while others show only minor effects. Generally, targeted programmes related to the labour market (*e.g.* wage subsidies), or programme chains that end with such a programme, seem to have better outcomes than, for example, general training programmes (Børing, 2004).

Based on data from 2004 on those Norwegians who had completed their rehabilitation and who did not return to vocational rehabilitation within the next 13 weeks, close to 41% obtained either a full-time or a part-time job, whereas 17% obtained a disability benefit (Table 3.5).[5] Results for men were slightly better than for women and significantly worse

for people in the age group 50 and over (the latter had an employment outcome of only 28%). Far more older participants transferred to disability benefits than younger participants. A study by Reiersen (2004) of people who had completed their vocational rehabilitation in October 2002 confirms that 40% of programme leavers obtained a job within the following 13 weeks, but also that 39% still held their job one year later.[6]

Statistics Norway is also collecting information on persons 12 months after ending a vocational rehabilitation programme. Employment outcomes from these studies amounted to only 10% in 2004, *i.e.* significantly lower than what is reported above. This may be explained by the length of the vocational intervention, with many participants continuing in another programme after ending the first one (the programme chains). However, it may also indicate that a large share of those who obtain a job after ending a rehabilitation period fail to keep their job.

Table 3.5. **Outcomes from vocational rehabilitation in Norway can be improved**
Percentage of those who completed a period of vocational rehabilitation, 2004[a]

Age	Completed rehabilitations (%)	*Of which:*						
		Full-time work (> 30 h/week)	Part-time work (< 30 h/week)	Unemployed	Long-term sick leave or rehabilitation	Disability benefits or retirement pension	Other outcomes	Total
20-29	34.9	34.0	9.8	8.4	21.9	7.0	18.8	100.0
30-39	38.0	37.2	11.0	5.2	26.4	9.0	11.3	100.0
40-49	48.2	27.7	14.6	4.5	27.8	16.1	9.4	100.0
50+	67.1	16.1	12.2	3.8	24.7	33.7	9.4	100.0
Total	44.9	28.6	12.2	5.2	25.6	16.8	11.6	100.0

a) A rehabilitation programme is seen as completed if the person does not return within 13 weeks.
Source: Administrative data from the Public Employment Service (AETAT).

Evaluations of the effectiveness of vocational rehabilitation in Switzerland are rare. A study by Buri (2000) found that of the 4 500 people who participated in vocational rehabilitation measures in 1997, 72% had not received a full pension at the end of 2000. The study showed that rehabilitation was least effective for congenital disability and most successful for people with accidents. Of all diseases, those related to mental problems accounted for around 40% of all rehabilitation cases, and muscular-skeletal diseases for another 40%. In terms of outcomes, below-average effectiveness was reported for those with mental problems (with 56% not having received a full pension three years later) and above-average effectiveness for those with muscular-skeletal problems (85%). However, the actual measure used to identify "a successful rehabilitation" (*i.e.* not being granted a *full* pension) is far from optimal. For future evaluations, efforts should be made to measure employment outcomes rather than the potential ability to take up a part-time job.

D. Supported employment

Activation programmes for disabled people are sometimes grouped according to when and if training is being offered. The following three approaches can be distinguished: *i)* "first train, then place" programmes (the nature of vocational rehabilitation and training); *ii)* "first place, then train" programmes (the nature of supported employment); and *iii)* "place-no-train" programmes (*i.e.* sheltered employment). The difference between the first two approaches is *when* in the rehabilitation process the disabled person should be

integrated into the regular labour market. The third approach differs from the other two since it advocates a segregated labour market for disabled workers with little or no training for or integration into the regular labour market.

Vocational rehabilitation measures (discussed above) often involve labour market training and education prior to a placement in the regular labour market. However, adequate working skills are often not enough for many disabled people to find or retain a job, *i.e.* the train-then-place approach may not be sufficient to successfully integrate disabled people into the regular labour market (Melvyn, 1993). As a result, the concept of supported employment was developed.

Supported employment is based on rapid placements of disabled persons in the open labour market combined with the necessary assistance; it involves coaching and training on the job. The approach assumes that with the right assistance, anyone can do a satisfactory job (Evans *et al.*, 2004). International evidence suggests that supported employment programmes are more effective than vocational rehabilitation and training (Waddell and Burton, 2006). From different experimental studies in the United States, Bond *et al.* (1997) found that on average 58% of participants in supported employment programmes with severe mental health problems obtained a job in the regular labour market compared with only 21% of those intraditional vocational rehabilitation measures.

Data from 2003 for Norway indicate that 35% of all participants that completed a supported employment programme between 2001 and 2002 obtained a job in the regular labour market. This is similar to the overall outcome from vocational rehabilitation. Participants who were placed in the private sector had a ten times greater likelihood of obtaining a permanent job than those placed in the public sector. Moreover, of the employers who agreed to take on one of these participants, the vast majority were very satisfied with the performance and assessed the person's productivity at, on average, almost two-thirds that of their ordinary employees. However, this positive judgement did not translate into a corresponding hiring of these people (Evans *et al.*, 2004).

Differences in outcomes across schemes are difficult to interpret. While supported employment programmes are often used for vocationally disabled people with a particular need for wide-ranging follow-up and support in order to obtain and retain a job, this is not the case for most other vocational rehabilitation measures. Outcomes from activation measures are also strongly affected by the timing of the measure. Corrigan (2001) concludes that supported employment will only be successful *after* the person is determined (and ready) to participate – which in fact may require some sort of pre-vocational training.

In Norway, supported employment provides extensive help in terms of competence mapping, training on work tasks, adjustment of the workplace and guidance through job-coaches. Generally, each job coach has six participants to follow up and support. The maximum length of the support is three years, but may be extended in certain cases. While in supported employment, the participant can receive a salary, a disability benefit or a training allowance. The employer also receives a subsidy to cover the wage and other specific expenses that may arise. The measure was introduced as a pilot project in 1992 and in 1996 it became one of several regular employment measures under the responsibility of the PES. In 2004 the number of participants had increased by four times compared to 1996, but still only accounted for 5% of all employment measures for vocationally disabled persons.

Neither Switzerland nor Poland has a formal supported employment programme. However, various organisations in Switzerland have been offering supported employment-type intervention for almost twenty years. *De facto,* these types of intervention (which are not referred to as supported employment) are part of either vocational rehabilitation or job placement. A study by Rüst and Debrunner (2005) classifies the existing diverse and uncoordinated programmes and identifies the major structural weaknesses of the Swiss approach. Basically, all those "coaching" programmes consist of three elements: profiling and assessment, active job placement, and post-placement coaching. The latter can be temporary or permanent, regular or on demand, and address either only the disabled worker or the worker and his or her supervisor.

Unfortunately, no data are available on the number of disabled workers benefiting from these coaching programmes or on their effectiveness. Rüst and Debrunner (2005) conclude that *i)* the variants of coaching offered in Switzerland are fairly appropriate in enabling people with considerable (mental) health problems to work on the regular labour market; and that *ii)* the impact could be improved by further clarifying and developing the concepts towards a formal supported employment programme, by promoting the skills and qualifications of job coaches and by stronger involvement on the part of employers.

E. Sheltered employment

In addition to vocational rehabilitation and supported employment measures, employment in a sheltered (*i.e.* protected) work environment is used in most OECD countries to provide work opportunities for disabled people. Often this type of work is oriented towards a therapeutic function instead of work tasks and work responsibility functions. This lead Visier (1998) to conclude that sheltered work would be more successful in integrating participants into ordinary jobs if the working conditions were more similar to those in the regular labour market.

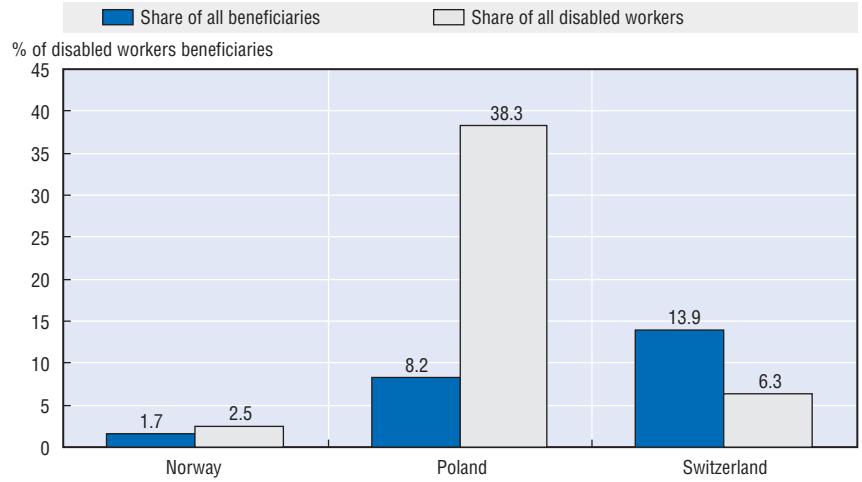
Sheltered employment differs fundamentally across the three countries, both in size and as a concept. According to Figure 3.2, sheltered employment accounts for less than 2% of the share of all disability beneficiaries in Norway, or about 2.5% of all self-assessed disabled workers. In Switzerland, sheltered work accounts for almost 14% of all beneficiaries or around 6% of all disabled workers. In Poland, the situation is quite striking: less than one-fifth of the self-assessed disabled population are working, but of those who do, almost four in ten are employed in a Sheltered Work Enterprises (SWEs).

Hence, Poland has gone furthest in developing a large-scale segregated labour market with permanently subsidised jobs, even though the concept of sheltered work is broader than in other countries.[7] Also, Switzerland has a long-standing tradition of (often permanent) sheltered employment, while in Norway it is mainly offered as a temporary solution with the objective of eventually transferring participants into the open labour market. In all three countries, sheltered employment is offered by either private or public institutions with tax-financed subsidies. In order to receive the subsidy, these institutions must follow certain rules (*e.g.* supply rehabilitation and training). Persons participating in this form of employment need to have a severe disability in Norway and Switzerland, but that requirement is less strict in Poland.

In Switzerland, access to sheltered employment is determined by the workshop management in close collaboration with the disability insurance authorities. Subsidies granted to the supplier of sheltered employment require that reintegration services are

Figure 3.2. **Disabled workers in Poland are overrepresented in sheltered employment**

In percentage, 2004[a, b]



a) Data refer to 1998 for Switzerland.

b) The share among all disabled workers is calculated as the number of people in sheltered employment divided by the number of self-assessed disabled in work. The share among all beneficiaries is simply the ratio of people in sheltered employment to the number of disability beneficiaries.

Source: OECD estimations based on the Norwegian Labour Force Survey for 2004 and 2005, and administrative data from the Public Employment Service (AETAT); the Polish Labour Force Survey for 2004 and administrative data from PFRON; and the Swiss Health Survey for 1997; and OECD (2003a), *Transforming Disability into Ability,* Paris.

offered and that at least half of the workers are disabled according to the definition of the disability insurance (which indirectly implies that most of these workers receive disability benefits).[8] These subsidies do not take into account the degree of disability or the adequacy of the institution's training and integration measures. Although the original idea was to reintegrate participants into the ordinary labour market, there is no evidence of this actually happening.

In Norway, sheltered employment is considered an employment programme for those with special needs due to physical, psychological or social problems, and covers almost one-tenth of all employment measures towards vocationally disabled people. The scheme is divided into three phases: *Phase 1* tests the participants' work ability; *Phase 2* covers increased practical and formal skills through adapted training and work experience; and *Phase 3* offers permanently adapted work for those with very limited chances of getting a job in the regular labour market. Whereas Phase 1 may last up to eight weeks, Phase 2 can last up to two years. The regulations also state that, each year, one-quarter of all participants in Phase 2 have to leave the programme. There is no time limitation in Phase 3; however, the possibilities of obtaining an ordinary job should be considered regularly. The enterprise performing this function, a so-called Labour Market Enterprise (LME), must follow relatively strict rules such as having rehabilitation as the primary activity, not paying any dividend, retaining any profit in the enterprise to benefit rehabilitation, and having at least half of the total number of approved places in Phase 2. With around 40% of all sheltered employment in Norway, the Association of Vocational Rehabilitation Enterprises is the largest supplier of this form of employment measure. In the first half of 2005, 37% of those who left Phase 2 got a job (60% left with an active solution, *i.e.* including training or education). These positive outcomes are presumably an

effect of the higher spending (*e.g.* more staff-intensive) compared to regular employment measures as was shown in Figure 3.1 above.

In Poland, sheltered work is largely a dead-end; almost no one ever transfers to the regular labour market. Employers with an employment share of disabled people of at least 40% can apply to become a SWE. If they also meet other requirements such as providing a suitable work environment for disabled people and providing training and rehabilitation programmes, these enterprises receive a subsidy. The subsidy is paid by PFRON and ranges from 50% of the minimum wage for people with minor disabilities to 110% for people with moderate disability and 130% for people with severe disability. The SWEs are privately run companies that compete on the open market. Until 2004, they also received generous tax exemptions but these were abolished largely as a result of compliance with EU regulations on competition. Still, they are privileged in that they receive an income-tax refund for *all* employees in their company – including their non-disabled employees. Judging in terms of mainstreaming workers with disabilities into ordinary enterprises, however, SWEs have not achieved success sufficient to justify their cost (Hoopengardner, 2001).

F. Summary and conclusion

Employment rates for disabled people in all three countries are far below those of non-disabled persons. One obvious reason for this is severe health impairments that may prevent people from working. Other reasons may be lack of relevant skills, discrimination or weak incentives to accept a job offer. An additional reason is the lack of success of reintegration measures.

Norway offers a wide range of programmes to disabled persons. Some 85% of these are vocational rehabilitation measures or "first train, then place" programmes, which cover a large share of the disabled population. Switzerland's approach is similar to Norway's, but less far-reaching in terms of coverage. It also places a slightly greater focus on sheltered work. Poland has a very limited range of reintegration measures and is mainly offering "place-no-train" programmes, including permanent wage subsidies to employers in the open labour market. Supported employment, or "first place, then train" programmes, are rarely used in Norway and Switzerland and non-existent in Poland.

Employment outcomes from these measures are often weakly documented. In Norway, where such evaluations exist, outcomes are ambiguous. The focus in Poland on sheltered work with no objective of reintegrating people into the regular labour market has also created a strongly segregated labour market of disabled persons.

Even with the relative lack of "place-then-train" programmes, the limited available evidence points towards relatively good outcomes. In Norway, outcomes are surprisingly high considering that participants are more severely disabled compared to participants in most other programmes. This may be explained by the fact that Norway has taken this measure a step further: almost two-thirds of the participants had completed at least one rehabilitation programme prior to entering supported employment. In this sense, Norway offers a mix of vocational rehabilitation and supported employment. This may be a very successful approach; a redirection of funding from vocational rehabilitation and sheltered employment to supported employment should be considered.

Weak outcomes may be linked not only to the programmes themselves but also to their timing. Evidence from Switzerland suggests that the likelihood of reintegrating a person is around 80% if the case is identified during the first three months of absence,

compared to only 20% after one year of absence (NZZ, 2006). This finding is supported by Waddell and Burton (2004), who argue that the best period for effective rehabilitation is between one and six months after a non-work period. To take maximum advantage of this window, rehabilitation should be an integral part of good clinical and occupational management. Another crucial factor for successful reintegration or job retention is to ensure that employment or rehabilitation measures are well targeted and adapted to the person participating in the programme. It is therefore also important to have rigorous evaluations of what works, and for whom.

3.2. Improving the chances of finding and retaining a job

While employment programmes and rehabilitation measures may help people with health problems find a job, other barriers, such as discrimination and the work environment, may work in opposite directions. Hence, protecting disabled workers by introducing or strengthening discrimination legislation and assisting them by using employment quotas or stricter employment protection are other instruments used. However, along with these employers' obligations it is also important to consider measures that encourage hiring and retention through, for example, the use of subsidised work accommodation schemes and personalised support from the social insurance institution. This section discusses different ways of protecting disabled workers (by, for example, the Work Environment Act in Norway and the quota-levy system in Poland), as well as measures to support employers to hire and retain them.

A. Protection and support of disabled people

In January 2006, a new Worker Protection and Working Environment Act (WPA) came in force in Norway. For the most part the act was a continuation of the main rules following from the WPA of 1977. However, there were also some new provisions such as the implementation of the EU Directive 2000/78, providing that direct and indirect discrimination on grounds of political views, membership of a trade union, sexual orientation, disability or age are prohibited. From 2004, Poland also has far-reaching discrimination legislation. As an amendment to the Labour Code, any form of discrimination in employment is forbidden. This holds for hiring and firing practices, terms of employment and access to training. In 2004 the Swiss Constitution introduced a provision of legal measures to prevent discrimination against people with disabilities; the measures establish general conditions that make it easier for disabled people to take an active role in society and to undertake training. The Swiss legislation is different from that in Norway and Poland since it does not cover conditions such as hiring and firing.

A key objective of the new WPA in Norway is to ease access to the labour market for persons with disabilities. The new act therefore introduced a softening of the rules regulating *temporary* employment but at the same time increased the special *protection* period against dismissal in the event of illness or disability from six to twelve months. The Swiss Law of Obligations provides much shorter legal protection against dismissal of people who become incapacitated. The protection period depends mainly on job tenure as follows: employment durations less than one year cannot be terminated during the first month from the onset of the illness; between the second and fifth year, this period is extended to three months; and for tenure longer than five years it rises to six months. In Poland, dismissal of people in the event of illness or disability is only possible after

exhaustion of sickness benefits. With additional protection during the first three months in medical rehabilitation, this period could be stretched to a total of nine months.

Disabled workers in Poland have special rights. For example, workers with moderate or severe disabilities have only to work 35 hours per week (compared to 40 hours for people with minor or no disabilities).[9] There are other special rules such as ten additional days of paid vacation per year and the right to an additional 30-minute break per day to participate in, for example, training. Moreover, disabled workers do not have to work night shifts or overtime.

Poland is the only country of the three that uses a quota-levy system.[10] Until recently, the system covered only private companies with 25 or more employees; these need to have a workforce share of disabled persons of at least 6% (full-time equivalents).[11] The level of disability is irrelevant and a person with a severe disability has the same "weight" as a person with a minor disability. Companies that comply with the rules receive a permanent wage subsidy for each disabled employee corresponding to 35% of the minimum wage for minor disabled persons, 77% for moderate disabled persons and 91% for the severely disabled (the subsidy is 90% for people with mental diseases, epilepsy and blindness). Companies that are *not* complying with the quota-levy system not only lose the wage subsidy for all of their disabled workers but also must pay a levy amounting to 40.65% of the average national wage for each disabled person below the 6% target. Levies are collected by PFRON and are mainly used to subsidise SWEs.

Despite these strong incentives to hire disabled persons, 70% of all regular companies under the quota system fail to comply with the rules. This suggests that there are some fundamental problems with the scheme. Obviously, one could argue that the levy is not sufficiently high as far as employers are concerned and that the disadvantages of hiring a person with even a minor disability are larger than the cost of paying the levy. However, this is probably not true. Instead, there are indications that employers lack information regarding the rules and therefore treat the levy as just another wage tax. Another explanation could be low incentives to take up work or the competition with young and highly-qualified unemployed persons for whom high wage subsidies also exist. Whatever the reason, the system is not very successful in its present form.

B. Employers' obligations to hire disabled people

Adjusting the work environment is another way to assist disabled workers to remain in work or to facilitate their re-entrance to the labour market. To this end, in 2003 Poland introduced a work accommodation subsidy for enterprises employing disabled persons. Subsidies are granted for both new hires and current employees who become disabled. In 2004, only 489 enterprises received such an accommodation subsidy, with an average subsidy of PLN 23 000. One reason for the low take-up of these subsidies is the high administrative costs of applying for the subsidy. Another reason was said to be, again, the lack of information. This argument apparently also holds for Switzerland, where employers can also be reimbursed for their costs of workplace adaptation.

Norwegian regulations place a much larger responsibility on the employer, but hardly any financial responsibility. They must ensure implementation of systematic preventive work and adaptation, including the responsibility to follow up and make adjustments for employees on sick leave. Moreover, if an employee suffers from reduced work capacity as result of an accident, illness or the like, the employer shall, to the extent possible,

implement the necessary measures to enable the employee to retain the job. This could be special adaptation of the work, working hours, alteration of technical appliances or rehabilitation. Grants to employers are available if expenses exceed NOK 30 000.

An important example of a non-financial measure to support employers is furnished by the Workplace Centres in Norway. The core activities of these centres are to improve employer/worker relationships and to support a dialogue on how to reintegrate absent employees. To do so, companies are offered a contact person who is familiar with the company and the situation. This consultation service is free of charge to employers that signed an agreement with the local insurance office (Chapter 6) and includes tailor-made services, such as co-ordination with vocational training centres, help with applications for work accommodation subsidies and more general matters such as management guidance. These Workplace Centres are much appreciated by employers and appear to be successful in terms of disseminating good practice across companies. It is unclear whether measures like these have any significant effect on the disability inflow rate but they are a valuable complement to the integration approach of disabled persons, which could in the longer perspective help reduce prejudices against disabled workers.

C. Summary and conclusion

Poland is the only country in the comparison that has special rights for disabled people. At the same time, employment rates of disabled people are by far the lowest among the three countries (but also in the OECD area as a whole). One important reason is that this protection is not followed up by additional support to disabled persons who work or try to find a job. Another barrier is said to be inaccessible infrastructure, including public transport. A third reason often mentioned is the relatively lower educational attainment as a result of restricted access to education and training. Special rules for disabled people *in* employment may also contribute to lowering the hire of disabled jobseekers by increasing the stigma of disabled people more generally. It is unclear whether Poland's quota-levy system for the employment of disabled people adds to this problem or not.

On the other hand, employment protection in Switzerland is among the most flexible in the OECD area (OECD, 2004c). Switzerland also lacks strong discrimination legislation and employment quotas. However, disabled people in Switzerland have the highest employment rate of the three countries (and one of the highest in the OECD area). Whether this is a result of fewer negative stereotypes, a better integration approach that encourages disabled people to participate in the labour market, or a more flexible labour market with easy hiring and firing is difficult to say. Probably all these factors contribute to the outcome.

In Poland there are indications that employers are unaware of the rules regarding the quota-levy system and that the administrative cost of applying for the work-accommodation subsidy is too large. Similar indications are found in Switzerland, where employers report a general lack of knowledge regarding possible financial and non-financial assistance to hire or retain disabled workers. This suggests that raising awareness about existing measures (primarily targeting small and medium-sized companies) and limiting administrative barriers could be more important than introducing new measures.

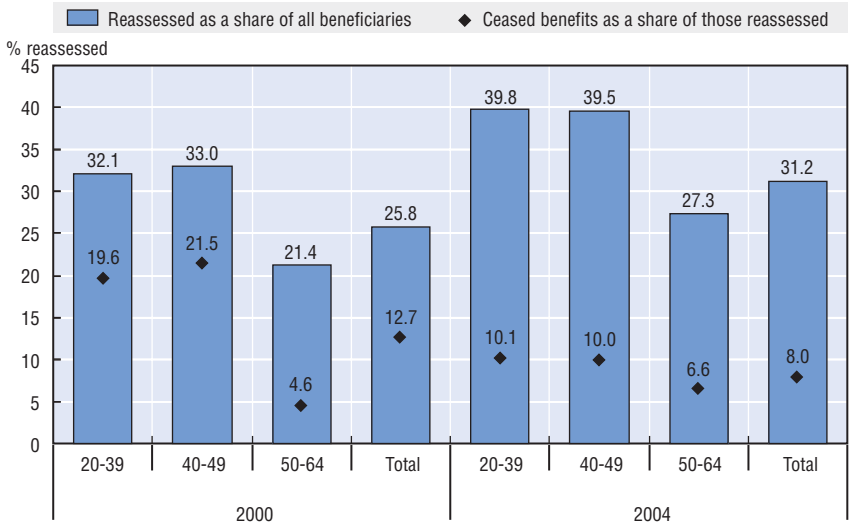
3.3. Making the disability benefit scheme employment-friendly

While reform in Poland has proved very successful in terms of reducing inflows and raising outflows, low outflows remain a key problem in both Norway and Switzerland. One way forward is to improve the process of identifying beneficiaries potentially able to work. This is usually done by reassessing the health situation of those currently receiving disability benefits. In countries where this is not already the case, such a decision would probably be unpopular and perhaps also go against legislation regarding permanent benefits. Countries therefore often grant temporary and partial benefits. This section explores different ways to reassess disability benefits. It discusses temporary benefits and the importance of maintaining strict eligibility for them. It further examines the use of partial benefits and efforts to encourage people already on benefits to take up a job.

A. Reassessing medical conditions and using temporary benefits

Poland has gone furthest in the use of temporary entitlements, at least as far as non-agricultural social insurance (ZUS) is concerned. From November 2005, all benefits are being granted temporarily for the first three years. After this period, benefits are terminated; all individuals have to reapply and their health situation is fully re-examined. However, even before this rule was introduced, about 80% of all benefits were granted temporarily and reassessments of existing benefits took place frequently. In 2004, about one-third of all benefits were reassessed (an increase from one-quarter in 2000), and of these 8% were withdrawn (a decline from 13% in 2000). This corresponds to a termination of 2.5% of all disability benefits – slightly lower than the corresponding share of 3.3% in 2000 (Figure 3.3).

Figure 3.3. **A large share of all disability beneficiaries are reassessed in Poland**
In percentage, 2000 and 2004



Source: National Insurance Administration for the non-agricultural sector (ZUS).

There is no possibility of reassessing the individual's health situation in Norway after a permanent benefit has been granted. Instead, in 2004 a parallel system of temporary disability benefits was introduced, thereby creating the possibility to review the medical

assessment after a certain period for people who have the prospects of returning to work. Temporary entitlements are granted for a period from one to four years, after which they are reassessed; benefits may be prolonged for a new period of up to four years. Permanent disability benefits (full or partial) will only be granted to those who, having undergone appropriate rehabilitation, are judged to be without prospects of going back to work in the future.

In 2005, one year after their introduction, these temporary disability benefits in Norway accounted for around 36% of the total inflow, an increase from 28% in 2004. However, their use varies across age groups; they accounted for about three-quarters of the total inflow in the age group 25-44, while they were hardly ever granted to people over 55 years of age (Table 3.6). Concerns have been raised because the total inflow for certain age groups has increased since the new benefit was introduced. Indeed, compared to 2003 (one year prior to introduction), the total inflow rate in the age group 20-39 increased substantially. This may be an indication that the entry threshold for granting a disability benefit has been lowered. It will be important to monitor these developments closely.

Table 3.6. **Temporary benefits in Norway may have lowered the entry threshold for younger people**

In percentage by age group, 2005

	New temporary benefits as share of all new disability benefits	Distribution of new *temporary* benefits	Distribution of new *permanent* benefits	Change in total inflow rates from 2003 to 2005
18-19	11.3	0.5	2.4	28.2
20-24	49.8	3.0	1.7	47.1
25-29	72.9	5.8	1.2	45.5
30-34	77.8	10.7	1.7	60.0
35-39	76.0	15.7	2.8	43.8
40-44	73.0	18.9	3.9	24.0
45-49	61.9	19.7	6.8	12.7
50-54	44.2	18.0	12.7	0.0
55-59	11.9	7.1	29.5	–5.7
60-64	1.1	0.6	31.3	–14.1
65-67	0.1	0.0	6.1	–2.2
Total	35.9	*100.0*	*100.0*	*8.2*

Source: National Insurance Administration (NIA) and Statistics Norway.

In Switzerland all benefits can be reassessed at any time, but outcomes in terms of returns to work are disappointing. For example, in 2003, close to 45 000 benefit recipients, or almost 20% of all beneficiaries, were reassessed. After this reassessment, however, 82% of all reassessed entitlements retained their previous benefit, 11% were increased (*e.g.* from a quarter to a half benefit), 3% were reduced and only 4% were ceased. In other words, less than 1% of all disability benefits were terminated, and among these job reintegration probably only played a small part. In terms of benefit periods, there is a great deal of flexibility in Switzerland. Still, disability benefits are usually granted permanently if the health problem is assumed to be permanent or likely to persist in the longer term.

If ex-beneficiaries do not return to work but move between different benefits, they often experience deterioration in mental health, quality of life and overall well-being. Indeed, interventions that encourage and support beneficiaries to come off benefits and that successfully assist them back into work are likely to improve their health and well-

being. On the contrary, interventions that simply force beneficiaries off benefits are more likely to harm their health and well-being (Waddell and Burton, 2006). Unfortunately, there is no information available in Norway, Poland or Switzerland on the work and benefit career of former beneficiaries who lost their entitlement after reassessment.

B. The use of partial disability benefits

Granting a partial disability benefit is another way of encouraging people to remain in work to some degree or return to employment. Such benefits are often granted to people with minor disabilities or whose capacity to work is only reduced partially. In Norway, a partial benefit is granted in all cases where less than 100% of the work capacity is lost. In Poland the benefit is granted to people who can work but are not able to continue in their former occupation. In Switzerland, a partial entitlement requires that the earnings capacity be reduced by more than 40% but less than 70%. Based on these definitions, the Norwegian rules for a full benefit entitlement appear to be by far the strictest.

However, a comparison of the use of full and partial benefits reveals a different picture. In Norway, 20% of all benefits are partial compared to 27% in Switzerland, while in Poland, the corresponding share is 54% (not shown in the table below).[12] The difference between Norwegian and Swiss inflows into full benefits is even substantially higher, reaching 13 percentage points in 2004 – a further widening compared to 1995, when both countries had similar shares (Table 3.7).

In 2004, Switzerland introduced a three-quarter disability benefit for those with 60-69% work incapacity. This was done to increase the likelihood that reassessed full-benefit recipients could be brought back into work. The measure was in addition to the already existing one-quarter (40-49%), one half (50-59%) and *full* benefit (70% or more earnings incapacity). In Norway, the grid of partial benefits is even narrower and can be graded by 5% intervals from 50% to 95% of the full benefit. However, it would seem the grid is underused: instead, the vast majority receives either a half benefit (around one-quarter of the inflow) or a full benefit (72% of the inflow).

Table 3.7. **Partial disability benefits are used more often in Switzerland than in Norway**

In percentage by age and degree of disability, 1995 and 2004

	1995				2004			
	20-34	35-49	50-66	Total	20-34	35-49	50-66	Total
Norway								
25% to 49%	0.2	0.2	0.1	0.1	0.4	1.0	0.3	0.5
50% to 74%	19.5	31.0	25.7	26.3	14.0	28.0	24.9	24.4
75% to 99%	3.2	4.6	7.2	5.9	2.2	3.0	3.9	3.5
100%	76.3	61.8	66.3	66.4	83.4	68.0	70.9	71.6
	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total
Switzerland[a]								
40% to 49%	4.7	6.0	4.9	5.2	4.7	9.5	9.0	8.6
50% to 59%	21.7	31.4	29.3	28.7	17.3	25.6	26.3	24.9
60% to 69%	–	–	–	–	5.7	9.2	9.5	8.9
70% to 100%	73.5	62.5	64.4	65.3	72.4	55.7	55.3	57.7

a) In 1995, the degree of disability corresponded to 40-49%, 50-66% and 67-100%.
Source: National Insurance Administration for Norway (NIA) and for Switzerland (IV).

In 2005, another attempt to render the disability benefit scheme in Norway more re-employment friendly was made by offering beneficiaries in five counties the possibility of working for three years without jeopardising entitlements – the so-called *disability benefit as a wage subsidy scheme*.[13] As the name indicates, the employer receives the recipient's disability benefit as a wage subsidy (up to a ceiling of 90% of the salary) for up to three years. The objective of this pilot project was to engage 600 participants before the end of 2005, but in October that same year only 54 persons were working and another 50 persons waiting for a job. The scheme was evaluated in order to understand the reasons behind the very low take-up (ECON, 2006). Outcomes from that evaluation indicated: *i)* a lack of interest among disability benefit recipients (mainly because of weak economic incentives and support for formal employment); *ii)* a lack of interest among employers; and *iii)* regulatory restrictions (*e.g.* the scheme was only available to those who received a disability benefit before 2004).

C. Summary and conclusion

Attempts to convince people to move *voluntarily* from benefits to employment seem to meet with little success – thus the importance of reassessing the health status of disability benefit recipients. However, reassessing large shares of disability beneficiaries (as in Switzerland and Poland) or restricting the inflow to permanent benefits through temporary benefits (as in Norway and Poland) are only meaningful if people resume work, at least partly. Moreover, if eligibility for partial or temporary benefits is (relatively speaking) less strict, these benefits may contradict their purpose and in fact increase inflow rates and, hence, reduce total labour supply. There are indications that this could be the case for younger recipients of temporary disability benefits in Norway.

Also, partial benefits appear to be problematic in Norway. Despite the stricter medical requirement for full benefits, the share of recipients on partial benefits is much lower than in Switzerland. Temporary and partial benefits in Norway should return to their stated purposes by using a more coherent benefit assessment method. Moreover, better targeted assistance to find employment should be offered to those people who lose their benefits. This is especially important in Poland where such support is less sought and where termination of benefits is more frequent. There will also be an increasing need to provide adequate support to those on temporary benefits in all three countries, in order to avoid an automatic conversion into permanent benefits.

Increasing outflow rates is a complicated matter; certain fundamentals need to be in place in order to obtain successful outcomes. One such factor is financial incentive to work, a topic discussed in Chapter 4. As long as disability benefit recipients lack economic incentives to take up employment (*e.g.* because of too-high replacement rates or too-high marginal effective tax rates), or employers lack incentives to hire and retain people with disabilities – outflow rates will most certainly remain low.

Notes

1. For Norway and Switzerland, disability is defined as a self-assessed, long-lasting health problem that hampers the person in his/her activities of daily living, while in Poland a person is classified as disabled if he/she declares to hold a legal disability certificate. The bias resulting from this difference in definitions should be small, not only because both definitions are self-assessed but also because so many people in Poland have the legal certificate (see Annex to Chapter 1 for more details on this).

2. The maximum length of a temporary programme is three years. However, after completing one programme, participants often qualify for another programme, leading to so-called "programme chains", which means that the total period on vocational rehabilitation may last even longer.
3. In 1997 the training pension was introduced. This can be granted for up to three years for re-qualification of skills (financed by ZUS and provided by the PES). However, take-up is extremely low and in 2004 only 830 persons used it. The reason for the low take-up is a combination of restricted eligibility, the limited number of PES programme places, and potential candidates fear of losing the disability benefit.
4. The coexistence of several institutions responsible for job placement (private placement agencies, PES, disability offices, social welfare offices, private insurance companies, NGOs) makes the system complex. It remains to be seen whether the recent change will improve the situation for disabled people.
5. This outcome is slightly lower than the target of 45% set by the PES. Results are based on a voluntary questionnaire sent to former programme participants 2-3 months after they have ended a programme.
6. Whether an outcome of 40% is sufficient to produce a positive net employment effect is impossible to judge without more rigorous evaluation involving a comparable non-treatment group.
7. In addition to these widespread SWEs, Poland operates Vocational Activity Enterprises (for rehabilitation purposes) and Occupational Therapy Workshops (for people with severe intellectual disabilities). These are more similar in nature to sheltered workshops in, for instance, Central European countries. The number of participants, however, is very low.
8. Subsidies to institutions offering sheltered work make up almost one-fifth of the total expenditure of the disability insurance.
9. A person classified with severe or moderate disability is only *allowed* to work in the open labour market after obtaining an approval of the National Labour Inspectorate.
10. Between 2005 and 2007, the Norwegian government has been compelled to ensure that at least 5% of all new employees are persons whose functional capacity is impaired (including employees with vocational disabilities, in rehabilitation schemes and on disability benefits).
11. The system was recently introduced in the public sector. To meet the 6% requirement, the quota will be gradually raised from its current level of 3% over the next few years.
12. No detailed data are available for Poland.
13. A very similar system was launched in Sweden in 2000. The scheme was far from a success and 12 months after its introduction only 0.5% of all disability benefit recipients signed up, of whom one-third returned to benefits after three months, *i.e.* when it was no longer possible to receive both the disability benefit and a salary from the job (OECD, 2003b).

ISBN 92-64-02631-2
Sickness, Disability and Work
Breaking the Barriers – Vol. 1
© OECD 2006

Chapter 4

Enhancing Financial Incentives

On average, people with disabilities are financially worse off than their non-disabled peers. In Poland and Switzerland, they also have a higher risk of being poor. Disability benefits and other public social transfers contribute to alleviate income inequalities, in particular in Norway. At the same time, the current design of these benefits, in combination with income taxation, creates financial disincentives for certain groups of disabled people to take up work. This particularly affects partially disabled persons who wish to return to part-time or full-time work, and more generally those with lower incomes and those with children. Despite a range of subsidies in place in all three countries, disincentives also exist for employers who wish to hire or retain disabled workers.

Are current disability policies – in particular, benefit policies – successful in preventing large financial losses and poverty risks for people who become disabled? Also, are these policies balanced enough to avoid "benefit traps", *i.e.* situations in which a possible take-up of work actually penalises the persons who intended to do so? Is there any impact of policies designed to increase incentives on the employers' side? This chapter looks at the income adequacy/work incentives dilemma. Its structure is modelled after the triple policy goal in this area, namely: to assure adequate incomes for people with disabilities; to increase work incentives for benefit recipients; and to enhance or, in many cases, establish incentives for employers to offer jobs to disabled people.

4.1. Assuring adequate incomes for people with disabilities

Average contributory disability benefits in Norway, Poland and Switzerland are set at around 40-60% of average national earnings. Disability benefits, however, are just one of many possible income resources for a disabled person; others include public benefits, own earnings, capital income, income from savings and private transfers. Furthermore, the resources of other household members with whom the disabled person is living contribute to (or, in their absence, put a burden on) their economic well-being.

A. Relative income and poverty

Disposable income levels of disabled people are between 10% and 15% below the average of the working-age population in all three countries (see Chapter 1).[1] Poverty rates of disabled people are lower in Norway (6-11% depending on the reference income) than in either Poland or Switzerland (10-18%).[2] The fact that average income levels of disabled people in Switzerland are at the same (relatively high) level as in Norway but poverty rates are at the same (high) level as in Poland suggests that incomes of disabled people are more unequally distributed in Switzerland – a feature which may be related to the importance of private provisions in the frame of the Swiss three-tier disability benefit system.

It should be noted that traditional income concepts such as the one used here do not take into account specific consumption costs associated with disability, *e.g.* for transport or special equipment. National studies using disability-adjusted equivalence scales find lower income and higher poverty levels among the disabled population (*e.g.* Jones and O'Donnell, 1995; and Zaidi and Burchardt, 2005 for the United Kingdom). Income estimates for disabled persons presented here are, therefore, likely to be underestimates.

Financial well-being and poverty differ among age groups and educational levels attained. Income levels are lower among younger and older and among lower-educated people. While this is true for both disabled and non-disabled persons, the benefit system evens out age- and education-specific income differentials between these two groups, in particular in Poland.

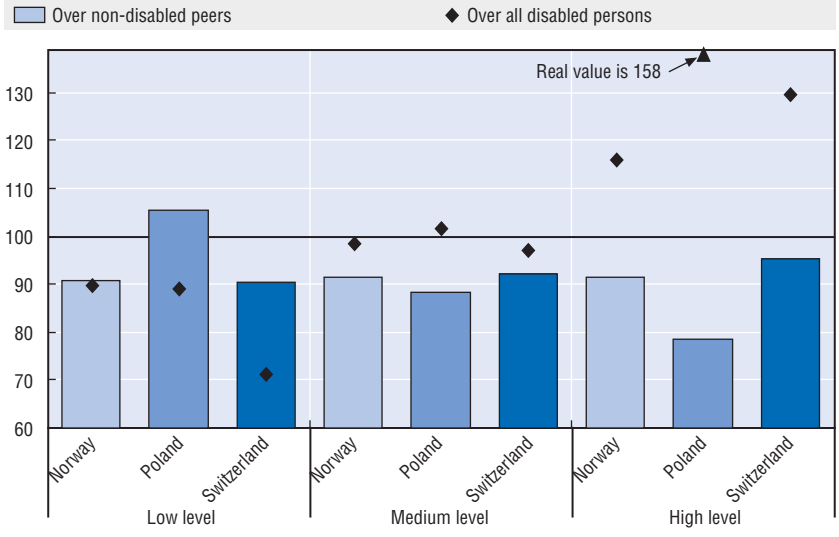
In Norway, relative poverty risks fall with increasing age, with 20- to 29-year-old disabled persons having a poverty risk more than double that of non-disabled. Poverty risks

also fall by age in Poland – except for below-average risks for the youngest group, which may partly be due to income protective effects of social pensions that are mostly received by younger disabled people. Relative risks *increase* by age in Switzerland: the oldest (60-64 years) among the disabled population of working-age have the highest relative poverty risk.

The degree to which income levels of disabled persons correlate with educational attainment varies by country (Figure 4.1). The income losses from lower education and the gain from higher education are more pronounced in Poland and Switzerland than in Norway. These differentials are, however, even stronger for non-disabled people, particularly in Poland where incomes of disabled persons with lower education are actually higher than those of their non-disabled peers.

Figure 4.1. **Disabled persons with higher education levels have less income constraints**

Relative average incomes of disabled persons by educational levels, 2002-2004[a, b]



a) Income refers to disposable household income per equivalent person (equivalence elasticity = 0.5). Columns refer to average incomes of disabled people relative to the incomes of non-disabled people in each education category. Diamonds refer to average education-specific income levels relative to total disabled population. In Poland, estimates for higher-educated people (triangles) are based on a small sample size and should, therefore, be treated with care.

b) A low level corresponds to an educational attainment of less than upper secondary education (ISCED 0-2); a medium level to an upper secondary education (ISCED 3-4); and a high level to a tertiary education (ISCED 5-6).

Source: EU-SILC 2004 for Norway, Household Budget Survey 2004 for Poland and Health Survey 2002 for Switzerland.

In terms of poverty, relative risks decrease by level of education, although this is again less pronounced in Norway than in the other two countries: in Poland, a lower education level increases the poverty risk by one and a half times, and in Switzerland by three times (Table 4.1). In contrast, those disabled persons who have a tertiary education generally have lower poverty risks than the total working-age population, including the non-disabled.

Table 4.1. **Lower education triples poverty risks for disabled persons in Switzerland**

Poverty rates and relative poverty risk for disabled persons, by level of education[a]

	Norway 2004	Poland 2004	Switzerland 2002
Poverty rate	11	19	18
Relative risk rate	0.96	1.17	1.58
Relative risk rate by education			
Lower education	1.17	1.52	3.05
Upper secondary education	0.91	1.06	1.21
Higher education	0.72	0.22	1.05

a) Poverty rates: percentages of persons in households with less than 60% of the median adjusted disposable income. Relative poverty risk: group-specific poverty rate divided by overall poverty rate for the working-age population (20-64 in Poland and Switzerland, 20-66 in Norway).

Source: EU-SILC 2004 for Norway, Household Budget Survey 2004 for Poland and Health Survey 2002 for Switzerland.

B. Income packages and income distribution

Disabled people rely on a range of financial sources, but to a different degree than their non-disabled peers. First and foremost, labour income plays an important role. In Norway, the labour market contributes as much as two-thirds to the income of disabled persons, but in Poland the share is just above one-third (Table 4.2). Second, public social transfers are an important source of income; their share in total income of disabled persons is about twice that for the total working-age population. Moreover, the share of transfers in total incomes increased in the past four years in Poland, more so for disabled people than for the total working-age population, reflecting very low and falling employment rates in that country. Disability and sickness benefits make up for some 60% of all transfer income of disabled people in both Norway and Poland. Third, while other income sources such as capital income or private transfers may top up the financial resources of disabled persons, they play a much more modest role on average.

Table 4.2. **Earnings are an important income source for disabled persons in Norway**

Income composition by disability status, 2004[a]

		Disabled people	Non-disabled people	Total working-age
Norway	Labour income	67	83	80
	Capital income, private transfers	4	7	6
	Public social transfers	29	10	13
	Of which: Disability benefit	18	3	5
	Sickness benefit	3	1	1
	Old-age pension	5	2	3
	Other benefits	3	4	4
Poland	Labour income	34	72	68
	Capital income, private transfers	2	3	3
	Public social transfers	64	25	29
	Of which: Disability/sickness benefit	37	4	7
	Other benefits	26	21	22

a) In Norway, disability benefit includes rehabilitation benefit; old-age pension includes early retirement pension (AFP). Other benefits include unemployment benefits, family benefits and social assistance. No data are available for Switzerland.

Source: EU-SILC 2004 for Norway and Household Budget Survey 2004 for Poland.

Given the prominent share of disability benefits in the income package of disabled people, an important question concerns their redistributive features and the extent to which they provide income security for persons at the lower end of the distribution. Disability benefits have a higher redistributive impact in Norway than in the other two countries.[3] In Poland, disability benefits show a slight middle-income bias, in that both poorer and richer people receive somewhat lower shares than those with medium incomes. That said, social benefits alleviate inequalities of other income sources in all three countries. Labour incomes, for instance, are distributed much more unequally than total net incomes, and this is particularly the case for disabled persons (Table 4.3).

Table 4.3. **In Norway and Poland, incomes are distributed more evenly among disabled persons**

Gini coefficients of income concentration by disability status, various years

		Net income			Labour income		
		Disabled people	Non-disabled people	Total	Disabled people	Non-disabled people	Total
Norway	2004	0.22	0.26	0.25	0.38	0.29	0.31
Poland	2000	0.30	0.31	0.31	0.50	0.39	0.41
	2004	0.27	0.32	0.32	0.53	0.41	0.42
Switzerland	1997	0.24	0.24	0.24	. .	. .	. .
	2002	0.27	0.27	0.27	. .	. .	. .

. .: Data not available.

a) The Gini coefficient is a measure of income inequality, ranging from 0 (perfect equality) to 1 (perfect inequality). All income components refer to household income equivalised for household size and composition.

Source: EU-SILC for Norway, Household Budget Survey for Poland and Health Survey for Switzerland.

Given the stronger reliance on benefits, one would expect a more equal income distribution among disabled than among non-disabled persons. This is indeed the case in Norway and in Poland (2004): the Gini coefficient of income inequality among disabled persons is four to five percentage points lower. In Switzerland there is no difference in inequality between disabled and non-disabled people. This partly explains the relatively higher poverty rates in Switzerland despite comparatively high average incomes among the disabled population.

C. Summary and conclusion

In all three countries, average disposable income levels of disabled persons are below the average of the total working-age population; in Poland and Switzerland, relative income poverty among disabled persons is also higher and has been increasing recently. In Switzerland, the higher poverty rates are primarily due to a more unequal income distribution among disabled people. In Poland, the higher poverty levels are mainly linked to the low employment rates of disabled people.

Public social transfers, among them disability benefits, contribute to alleviating income inequalities, in particular in Norway. This is due to a number of regulations built into the different disability benefit systems such as minima and maxima benefits as well as (sometimes means-tested) supplementary benefits.

All three countries have anti-poverty programmes in place, although these are not regular and do not include concrete objectives and targets.[4] Moreover, no particular measures are targeted at persons with disabilities but there is a tendency to "mainstream" that population group into general programmes. This is a promising approach especially

for younger disabled persons, provided such programmes are training and employment-related. However, given the profile of poverty among disabled people, which is concentrated on older people and those with low education, targeted programmes that go beyond employment objectives may also be needed.

4.2. Increasing work incentives for disability benefit recipients

This section looks at *financial* work incentives and disincentives for disabled persons through the tax/benefit scheme. Non-financial incentives – *e.g.* stemming from eligibility criteria for various benefits and programmes, their maximum duration and the extent of follow-up of persons on such schemes – are discussed in previous chapters. Here, the net income effects of two types of transitions are considered:

- The transition from work to inactivity, *i.e.* levels of replacement income – measured by net replacement rates (NRR) – when becoming partially or totally disabled.
- The transition from inactivity into work, *i.e.* the extent to which gains in earnings are "taxed away" through a combination of reduced benefits and higher taxes, when taking up work – expressed as average effective tax rates (AETR) – or when increasing hours of work – measured through marginal effective tax rates (METR).

A note of caution is needed when referring to "disability benefit traps" and when interpreting the results below. First, a certain number of disability beneficiaries cannot be expected to take up work under any circumstances. The labour supply elasticity to changes in tax/benefit features will be much lower than for unemployed or other inactive persons. Secondly, estimates are based on the assumption that a person passes from employment *directly* to disability benefits. Typically, however, intermediate periods of sickness will precede disability, and sickness benefit regulations and replacement rates will influence decisions to return to work. That said, shorter sickness spells have little impact on earnings, as there is a system of continuous wage payment in all three countries. In Poland, employers are only obliged to pay 80% of the regular wage in this period, but many employers opt to pay the full wage. Also, benefits paid in case of longer-term sickness absence, which often leads to a disability claim, are very high in all three countries (and even 100% of past earnings in Norway and for many people in Poland and Switzerland).

A. Overview of tax and benefit regulations for disabled people

The disability benefit systems as well as taxation differ considerably across the three countries (see Annex Table 4.A1.1). On the benefit side, this has to do with different social protection traditions, with Norway adopting a universalistic system, Poland a continental-European-type earnings-related system and Switzerland a three-tier system (see also Chapter 1 and Box 1.1). On the tax side, the differences have to do with much more decentralised taxation in Switzerland than in the other two countries and the tax base being family income compared with essentially individual income in both Norway and Poland.

Regulations for accumulating earnings with disability benefits differ greatly. The Norwegian rules include an earnings disregard up to the so-called "basic amount" (at about 20% of the average wage). If earnings exceed this amount, the disability grade is adjusted accordingly. In Poland too, a disability benefit recipient may earn a certain amount without losing his or her benefit – 70% of the national average wage. With earnings between 70 and 130% of the average wage, benefits are reduced by a flat-rate amount, and earnings above 130% lead to total loss of the benefit. In Switzerland there is no earnings disregard, and disability benefits are graduated out in 25% steps with increasing earnings.

Table 4.4 compares the tax/benefit position of a 40-year-old single person with average earnings when working and after going on full disability benefit. The first column for each country describes the steps from gross to net earnings for a working person. In all three countries, about 30% of gross income is "taxed away": in Switzerland and Poland this is done mainly through social security contributions, while in Norway the share between central and local taxes and social security contributions is more balanced.

Table 4.4. **Gross and net replacement rates for average earners are lowest in Poland**
The tax/benefit position of a single person at average earnings and when out of work on disability benefit, USD Purchasing Power Parities (PPPs), 2004[a]

	Norway			Poland			Switzerland	
	Working	Temporary disability benefit	Permanent disability benefit	Working	Partial disability benefit	Total disability benefit	Working	Disability benefit
A1. Gross earnings	33 433			14 526			36 405	
A2. Taxable benefits								
Disability insurance	0	22 066	17 636	0	5 090	6 787	0	21 416
B. Income tax and social security contributions								
Central government income tax	3 045	1 422	1 212	2 090	1 934	2 579	366	99
Income tax credit	–	–	–	1 205	684	816	–	–
Local taxes	3 943	1 841	1 570	–	–	–	3 135	1 573
Social security contributions	2 608	1 721	529	3 692	420	560	6 324	1 600
Total income tax and social security contributions	9 595	4 984	3 311	4 577	1 670	2 323	9 825	3 272
C. Non-taxable means-tested benefits								
Housing benefits	0	0	0	0	1 471	0	0	0
D. Net income out of work (A-B+C)		17 082	14 325		4 891	4 464		18 144
E. Net income in work	23 837			9 949			26 580	
F. Gross replacement rate (A2/A1)		66%	53%		35%	47%		59%
G. Net replacement rate (D/E)		72%	60%		49%	45%		68%

a) Average earnings refer to average production worker wage (APW): NOK 317 101 in Norway, PLN 26 584 in Poland and CHF 64 419 in Switzerland. Estimates refer to a 40-year-old single person with an earnings history of 22 years at average earnings. Figures assume that there is no waiting period between employment and the benefit situation.
Source: Special module of OECD tax/benefit model. Information provided by national authorities.

The second and third columns for each country in this table look at the tax/benefit position of the same person when moving from work to a full disability benefit entitlement. The tax weight on benefits is somewhat lower than for workers, primarily due to lower social security contributions. *Gross* replacement rates, *i.e.* gross benefit levels with regard to former gross earnings, range from around one-third for partial disability benefits in Poland to two-thirds for temporary disability benefits in Norway. *Net* replacement rates are generally higher than gross replacement rates.[5]

Net replacement rates for single persons are lower in Poland (45-50%) than in Norway or Switzerland (60-70%). This difference is further accentuated when comparing *absolute* levels of earnings and benefits, expressed in USD in purchasing power parities.[6] Levels of average earnings in Poland are about 60% lower than in Norway and Switzerland, and benefit levels are about 70% lower. This must be kept in mind when considering generosity *versus* adequacy of the different schemes.

B. Adequacy and generosity of replacement rates of disability benefit schemes

Net replacement rates (NRRs) compare the income situation when moving from paid work to inactivity. They thus provide indicators of both the adequacy and generosity of

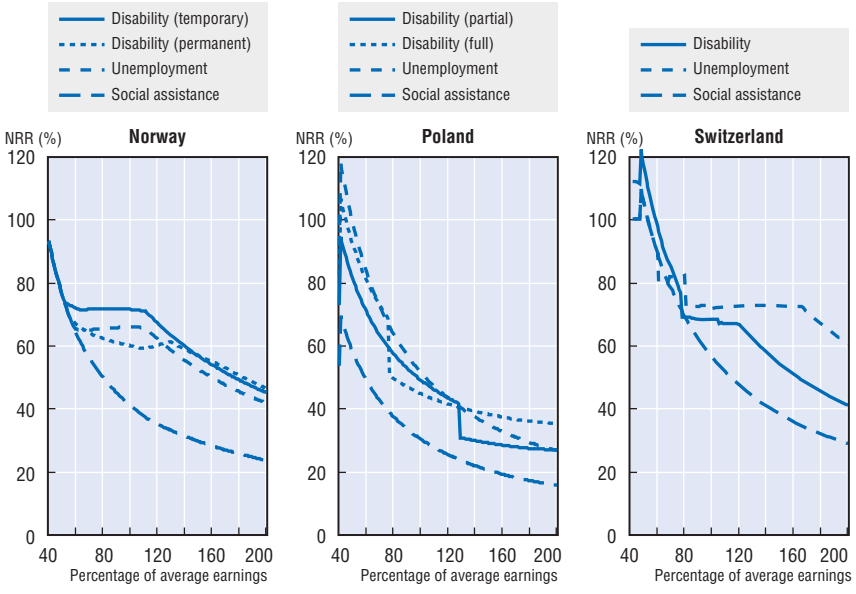
disability benefit schemes. Low NRR for people who become totally incapacitated for work in the midst of their professional career may raise concerns about poverty and social exclusion, especially if the persons have caring obligations towards children. However, a majority of disabled persons are not fully incapacitated for work but experience problems of staying in the labour market. In the case of NRRs approaching 100%, such schemes may become an attractive alternative to employment (for both employees and employers). Indeed, recent OECD work suggests a positive correlation between scores on a synthetic "benefit generosity indicator" and both beneficiary rates and disability benefit inflows (OECD, 2003a).

How do disability benefits compare in terms of replacing earned income with regard to two other main income support schemes in case of inactivity: unemployment benefit and social assistance? Typically these schemes have been distinct, serving different groups of people. However, there is some evidence that many persons with health problems – to which social and employment problems often are added – are being shifted and, at the end, trapped between increasingly tightened schemes. Figure 4.2 compares NRRs from disability, unemployment and social assistance benefit schemes for single persons (results for other household types and ages are given in Annex Figure 4.A1.1). The following key findings emerge:

- For former earnings above half the average national wage, unemployment and disability benefits are fairly similar and both provide higher NRRs than social assistance, especially in Norway. In Poland, due to their flat-rate nature, NRRs of unemployment benefits are higher at the lowest earnings levels and then fall steeply. In contrast, NRRs

Figure 4.2. **Disability and unemployment schemes provide similar net benefits for low-income earners**

Net replacement rates for disability benefits, unemployment benefits and social assistance, single person, 2004[a]



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

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

of unemployment are higher than for disability benefits in Switzerland above average earnings.

- In general, NRRs for disability benefits are considerably higher when there are children present in the household – for example, at average earnings, 15-20 percentage points higher than for singles in Norway and Poland, and 30 percentage points higher in Switzerland, where they reach 100%. This is due to general child benefits and family allowances, but also to special child supplements within the disability benefit system.[7]
- The interplay of different benefits, minima and maxima, income-test thresholds and taxation causes several "notches" in the NRR for disability beneficiaries as former earnings increase. In Norway, due to the amount of the maximum benefit, temporary disability benefits display higher NRRs than permanent ones in the segment that lies between half to one and a half former average earnings. In Poland and Switzerland, withdrawal of means-tested benefits (social assistance payments, housing allowance, supplementary benefit) at specific income levels drive NRRs up at some earnings levels and down at others.
- In general, disability benefits do not increase with age. The main exception is Switzerland, where *e.g.* persons aged 50 have considerably higher NRRs at higher earnings levels than those aged 40, essentially due to the second-pillar benefits that play a greater role above average earnings.

These NRRs are based on compulsory disability benefits and therefore underestimate the income situation of those disabled persons who are eligible for additional payments from voluntary, complementary schemes. The latter are especially important for persons with average and higher previous earnings in Norway and Switzerland.[8]

A recent tax/benefit analysis undertaken by the Norwegian Ministry of Finance illustrates this for the largest occupational pension scheme, that for public-sector employees (SPK). Above average earnings, SPK raises the NRR to a constant level of 75% for temporary beneficiaries and to 80% for permanent beneficiaries (Figure 4.3). In Switzerland, calculations undertaken by the insurer Swiss-Re (2005) shows that taking account of complementary insurance going beyond the minimum in the frame of the second-tier disability benefit can increase NRRs well above 60%.

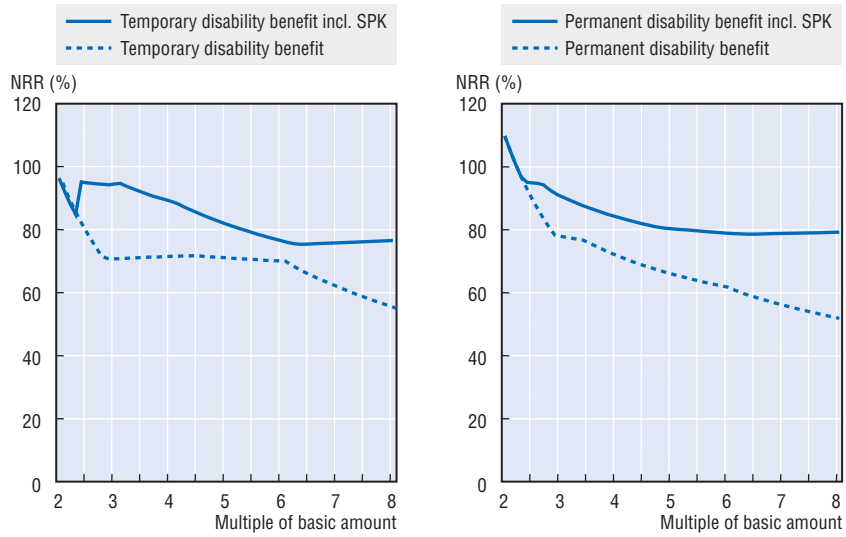
C. Does it pay to work?

Once inactive, what are the financial consequences linked to a return to work? As argued above, this question will concern only part of the disabled population drawing benefits, in particular those on temporary or partial benefits. Taking up work should be financially attractive for those considering this step. Figure 4.4 (and Annex Figure 4.A1.2) demonstrates that this is not always the case:

- In Norway, when returning to a lower-paid or part-time job that pays less than 70% of average earnings, average effective tax rates (AETRs) are between 50% and 75%. At 70% of average earnings, AETRs jump to very high levels close to and above 100%, due to complete withdrawal of benefits. Only when earning well above average earnings do AETRs return to somewhat lower levels.
- Full disability benefit recipients in Poland face the lowest AETRs across the three countries. However, due to the earnings disregard, which is reduced at about 70% and suspended at about 130% of average earnings, disability benefit recipients returning to work at 80% of former earnings are penalised with regard to those returning to work at

Figure 4.3. **Occupational disability benefits in Norway boost replacement rates for high-income earners**

Net replacement rates for temporary and permanent disability benefits, with and without public sector occupational pensions, 2006[a]



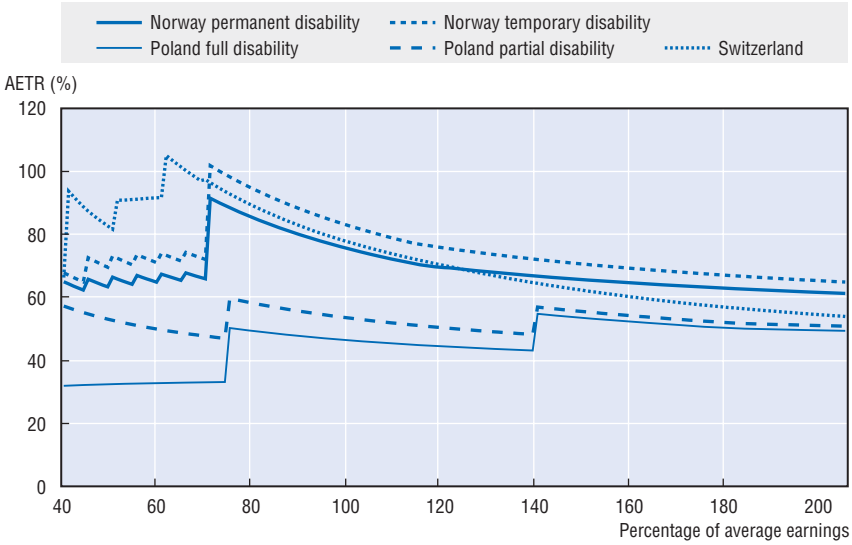
a) Net replacement rates (NRRs): ratio of household net income after becoming inactive and receiving temporary disability benefit (Panel A) and permanent disability benefit (Panel B). Average earnings amount roughly to five so-called basic amounts.

SPK: Norway's Occupational Pension Scheme for public sector employees.

Source: Norwegian Ministry of Finance (2006).

Figure 4.4. **Taking up work can be very costly for many beneficiaries**

Average effective tax rates for a 40-year-old disabled single person, 2004[a]



a) Average effective tax rate (AETR) is the percentage of earnings that is taxed away via increased taxes and reduced benefits when taking up work. Take-up of work at between 40% and 200% of average production worker wage (APW). The person is assumed to be on disability benefit after having worked at 100% of APW.

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

SICKNESS, DISABILITY AND WORK: BREAKING THE BARRIERS – VOL. 1 – ISBN 92-64-02631-2 – © OECD 2006

either 50% or 100% of former earnings. The same pattern can be observed for partial disability benefit recipients in Poland.

- In Switzerland, effective taxation is lowest when returning to a job with very low earnings, below one-third of the average wage. This is because earnings can be accumulated without benefit loss including means-tested supplements up to the first graduation step. However, when returning to the former earnings level (*i.e.* average earnings), AETRs are at about 80% for disabled persons without children and close to 100% for those with children.
- The household composition can influence financial work incentives. In Norway and Poland, AETRs are highest for disabled persons who live with an inactive spouse and without children, for both types of disability benefits considered. In turn, in Switzerland, couples with children with a working spouse have to face considerably higher AETRs when the disabled partner returns to work. In this constellation, AETRs exceed 100% in the range between 40% and 100% of average earnings. The high level of effective taxation for couples with children is due to the child supplement which is paid without a means test.

The discussion above has focused on *inactive* disability benefit recipients and the consequences when taking up work. A different yet important question arises for those disabled persons who are *in* work drawing a partial disability benefit and considering working more hours. Table 4.5 considers the financial consequences of increasing working hours for a disabled person, in four steps: from 0 to 10 hours (marginal work), from 10 to 20 hours (part-time), from 20 to 30 hours (considerable part-time) and from 30 to 40 hours (full-time). The person is assumed to have worked at average earnings before having become disabled and again to be taking up work at this earnings level and receiving a partial disability benefit, if eligible.

There are several "zones" of increases in working hours which actually penalise disabled persons who work more, *i.e.* with marginal effective tax rates over 100%. They therefore encourage persons to stay in their current benefit position despite their wish to become more active due to, for instance, improvements in their health condition. Such "zones" typically occur when a disability benefit is suspended – taking account of other benefit reductions and taxation:

- In Norway, a move from 20 to 30 weekly hours of work results in net income losses in all three household constellations considered.[9] However, marginal effective tax rates (METRs) are also very high when disabled persons move from marginal to part-time work. The very low net gain in income despite doubling gross earnings is due to decreases in the partial disability benefit and increases in social security contributions and, in particular, taxes.
- In Poland, disability benefit recipients face lower METRs when increasing work in ten-hourly steps until reaching full-time work because of the earnings disregard. There are, however, higher effective taxes around the 30-hour zone because that is where the full earnings disregard is reduced by a flat-rate amount (about one-quarter of net national wage). This encourages disabled people who are able to increase work to move to full-time directly or else to rather marginal increases.
- In Switzerland, disabled persons considering increasing their work from 10 to 20 hours or further from 20 to 30 hours are financially penalised, and heavily penalised when they have children. This also holds for increases from 10 to 30 weekly hours directly (data not shown).

- In all three countries, METRs return to "normal" levels of 30-40% when moving from 30 weekly hours to full-time work, *i.e.* once all disability payments have been suspended.

Table 4.5. **Increasing working hours may penalise recipients of partial disability benefits**

Marginal effective tax rates for those receiving full or partial disability benefits, 2004[a]

		Increase in weekly working hours			
		From 0 to 10	From 10 to 20	From 20 to 30	From 30 to 40
Norway	Single	62	85	146	*36*
	Couple without children (spouse inactive)	67	85	167	*36*
	Couple with children (spouse earning 2/3 of APW)	53	86	151	*36*
Poland	Single	71	35	73	35
	Couple without children (spouse inactive)	75	35	73	35
	Couple with children (spouse earning 2/3 of APW)	43	50	73	35
Switzerland	Single	26	138	113	*31*
	Couple without children (spouse inactive)	58	130	110	*41*
	Couple with children (spouse earning 2/3 of APW)	19	197	154	*31*

a) Average earnings refer to average production worker wage (APW). Marginal effective tax rate (METR) is the percentage of earnings that is taxed away via increased taxes and reduced benefits when increasing working hours. The hourly wage is at the APW level throughout. The person is assumed to be on partial disability benefit, provided such benefit exists, after having worked at APW earnings. Estimates refer to a 40-year-old single person with an earnings history of 22 years at APW earnings. Figures in italics refer to situations where no more partial disability benefits are granted.

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

D. Summary and conclusion

The different tax/benefit systems produce a number of "disability benefit traps" for disabled persons taking up work, especially part-time or considerable part-time work of 30 hours a week. Financial disincentives typically arise when graduation steps change or disability or other benefits are suspended. The problem is even greater for disabled persons who already combine a partial disability benefit with a half-time job and increase working hours. In Poland, more than three-quarters of their increase in gross earnings would be taxed away, and in Norway and Switzerland they would face a METR over 100%.

One way to improve work incentives would be to reduce disability benefit levels. This, however, is in conflict with the equity objectives of the schemes and the fact that many of the beneficiaries cannot be expected to work. Raising the net return from earnings would be another way to make work more attractive for disability beneficiaries. This can be achieved through different approaches or a mix of them:

- Current regulations for earnings disregards could be refined by a better phasing-out of benefits against earnings.
- Graduation of partial benefits could be further refined to facilitate a smoother phase-in of income from work.
- The possibility of applying a means test to special supplements (*e.g.* for children) could be considered. Proportional supplements to disability benefits create significant disincentives to take up work or increase working hours.
- Particular disincentive problems arise in the earnings segments where disability benefits are suspended fully. Such breaks could be tackled with carefully designed in-work benefits for disability beneficiaries taking up work.

- Finally, better co-ordination of different benefit schemes is needed. The current design of social assistance, family and housing benefits in Poland, for instance, clearly leads to conflicting incentives for disability beneficiaries.

4.3. Raising employer incentives

The financial consequences for *employers* who keep or hire persons with disabilities need to be taken into account for successful integration and reintegration policies. A study by the Central Statistical Office for 2004 showed that only 5% of Polish employers would consider employing a disabled person, despite a range of subsidies and other incentives in place. Similarly, a study in Switzerland concluded that only 13% of those with a new disability in 2001/02 were retained by their employer afterwards (Baumgartner *et al.,* 2004). The following section discusses the different instruments currently in place in the three countries to encourage employers to hire and retain disabled workers, as summarised in Table 4.6.

A. Subsiding employers to hire people with disabilities

There are two different but not mutually exclusive reasons why subsidies to employers may be an appropriate measure to increase employment among disabled people. One is to *compensate* employers for the possible lower productivity from a disabled employee. This can be important in the presence of wage rigidities, *i.e.* the absence of downwards wage flexibility. The other is to *encourage* employers who would otherwise not hire disabled persons, thus giving disabled people opportunities in the labour market and a chance to prove their ability by making it financially attractive for an employer to hire them rather than a non-disabled person.

Wage subsidies

In Norway, wage subsidies are less often used for vocationally disabled workers than they are for the non-disabled unemployed. In addition to the regular wage subsidy scheme, which covers half of the wage costs for a period of one year, there is also a pilot project targeting disabled people with muscular-skeletal or mental disorders who have undergone rehabilitation. The duration and level of the wage refund are more generous than in the regular scheme and there are discussions to generalise this scheme to all vocationally disabled people for a maximum of three years.

In Switzerland, the condition that the disabled person has to be placed by the cantonal office of the disability insurance in order to qualify for a wage subsidy, together with the lack of employer knowledge of its existence, is believed to account for the fact that this measure is currently not much used (DOK, 2004). However, it is planned to extend the system of wage subsidies during the probationary period along the lines of the current regulations in place in the unemployment insurance system, with degressive subsidies of 60%, 40% and 20% of the wage. A further extension in coverage to all disabled persons – not only those placed by the cantonal offices – may well prove an effective policy change. There is also a subsidy to wage costs for assistance services supplied by third persons (*e.g.* reading to blind persons). In practice, many applications for such subsidies are turned down by the disability insurance.

Among the three countries, the system of wage (and related) subsidies in Poland is the most extensive. Accounting for one-third of the total PFRON budget in 2004, direct and permanent wage subsidies, most of which go to Sheltered Work Enterprises, are the single

Table 4.6. **Employers are encouraged to hire or keep disabled workers through a range of schemes**

Summary of incentive measures available to employers, 2006

	Norway	Poland	Switzerland
Direct wage subsidy	50% of wages for up to 12 months, for all vulnerable groups of jobseekers, including vocationally disabled jobseekers.	For SWEs: flat-rate subsidies, percentages of minimum wage: 130% for severely disabled, 110% for moderately disabled and 50% for lightly disabled. Annual extension possible.	Subsidy to the wage during the probationary period (up to six months), for disabled persons who have been placed by a DI office.
	Pilot project in five counties: disability benefit used as a wage subsidy (employer receives DI benefit as wage subsidy up to 90% of salary, up to three years).	For enterprises with less than 25 employees and enterprises with 25 or more employees that fulfil the 6% quota: flat rate subsidies, percentages of minimum wage: 91% for severely disabled, 77% for moderately disabled and 35% for lightly disabled. Annual extension possible.	"Try-and-hire" pilot project of Swiss NGOs: loan of disabled persons for a probationary period.
Indirect wage subsidy	Support for assistance in the job situation.	Subsidy for persons employed to assist the disabled employee (minimum wage times the ratio of hours worked of assistance to hours worked by the disabled person).	Reimbursement of wage costs for assistance services of third persons, up to CHF 1 583 (25% of average wage).
Lower employers' social security contributions and taxation		For SWEs: lower social contributions and lower taxation. For enterprises with 25 or more employees which fulfil the 6% quota: reimbursement of employers' old age pension contribution for severely and moderately disabled persons, and for employers' accident insurance contribution for lightly disabled persons.	
Subsidies for workplace modification and equipment	Support for investment costs.	Subsidy for workplace modification and equipment for disabled persons employed for a minimum of 36 months, up to 20 times the average wage.	Reimbursement of total costs for equipment needed as well as for adaptation of workplace, if "simple and useful".
Experience rating of sickness and disability contributions			In the second-pillar disability insurance as well as the voluntary sickness benefit insurance, individual regulations.
Continuous wage payment in case of sickness absence	17 days.	33 days (at 80% of the regular wage).	15-230 days, depending on tenure.

SWEs: Sheltered Work Enterprises.

Source: Authors' compilation based on information provided by national authorities.

most important item (Polish Ministry of Social Policy, 2005). The fact that, among larger enterprises, only those fulfilling the quota are eligible for direct wage subsidies introduces considerable inequality into the system: enterprises that would like to hire a disabled person but do not fulfil the quota not only will not receive any wage subsidy but also will be required to pay a levy to PFRON. From 2004, Poland also has an additional wage subsidy for persons assisting the disabled worker. Unlike the direct wage subsidy, this new subsidy is available to all enterprises.

Three aspects or design features are particularly important in the context of wage subsidies: their level, their duration, and their targeting. In terms of levels, wage subsidies sometimes reach 100%. This is the case, for instance, with a pilot project in Norway where the disability benefit can be used as a wage subsidy, and with the "try-and-hire" model of some Swiss NGOs.[10] This is a very costly model and applies particularly to severely

disabled persons with a "supported employment" philosophy (see Chapter 3). In most cases, however, wage subsidies are limited to a certain fraction of the wage costs.

A most controversial issue is the time limit of wage subsidies. A temporary subsidy could be seen as an employment or training measure permitting disabled people to return to the open labour market because it encourages employers to hire them. A permanent subsidy could be justified whenever it is designed to compensate the employer for his or her employee's permanently reduced productivity or work capacity. The third important issue for all forms of wage subsidies is the adequate targeting to particular risk groups to avoid deadweight loss and, related to this, a close monitoring of outcomes, especially for relatively generous and quasi-permanent schemes such as the one currently in place in Poland.

Differentiation of social security contributions and taxes

This measure exists only in Poland and seems overly complex (Table 4.6). In Switzerland, there has been some discussion about the possibility of introducing reduced taxation and employers' social security contribution rates for newly hired disabled persons for up to two or, alternatively, five years. There are, however, concerns that a partial or complete elimination of social contributions (5.05%) alone would not be sufficient to increase incentives and that implementation of new taxation rules would be overly complex (all cantonal tax laws would need to be changed). In Norway, a reduction in employers' contribution rates for older workers has been introduced in the frame of the IW Agreement. However, nothing comparable exists for disabled workers.

Subsidies for workplace modification and equipment

Adapted and adequate workplaces are a prerequisite for successful (re-)integration of disabled people into their job. Subsidies to employers to modify workplaces, ranging from additional equipment to structural adaptation, exist in all three countries. However, they do not seem to be used to a greater extent than wage subsidies. In Poland for instance, this measure did not enjoy popularity among employers: in 2004, the scheme subsidised the adaptation of less than 500 workstations, at an average cost of PLN 24 335 (about 10 times the average wage).

It should be noted that subsidies for workplace modification in all three countries not only concern new hires but also apply to disabled persons already employed. Further, some laws actually request employers to provide adequate work accommodation for their disabled employees. The fact that subsidies for work accommodation are not used to a greater extent may also have to do with the often time-consuming administrative procedures (which are not reimbursed): for low-cost adaptations of workplaces, administrative procedures seem to outweigh the benefits.

B. Subsiding the self-employment of disabled people

For some disabled people, self-employment is an attractive alternative for generating earnings and reintegrating into the labour market. In Norway and Switzerland, take-up of self-employment by unemployed persons is supported in the frame of general PES programmes. Only Poland has a special support scheme for disabled persons for self-employment start-ups (including farms), consisting of three measures (Table 4.6). Again, however, take-up of these measures is marginal and has in fact declined rapidly in recent years. About 1 000 disabled persons received a subsidised loan for start-up of self-employment in 2000, about

600 in 2002 and again in 2003 and just 164 in 2004 (Polish Ministry of Social Policy, 2005). The reasons for this low take-up and decline are unclear and warrant investigation.

C. Experience-rating of contribution rates

There is some debate in all three countries about whether to introduce or expand elements of experience-rating of contributions to disability benefit and related schemes, *i.e.* to raise contributions for those employers or sectors of the economy that "generate" a large number of people drawing these benefits. The idea behind such "bonus/malus" schemes is to place more responsibility on employers in keeping sickness absence and disability inflow at a low level. Experience-rating exists already in many work injury and accident insurance companies across the OECD area, including in Poland.[11] According to the Polish Labour Inspectorate, this system has helped in reducing the number of work accidents.

Experience-rating has recently been introduced in the Swiss second-pillar disability insurance as well as in the private sickness benefit insurance, and most insurance companies apply this approach to their clients. Regulations vary widely and depend on the size of the company as well as the duration of the insurance contract. Premiums are usually calculated on the basis of the company's record in the past three-five years, which creates a considerable degree of arbitrariness for smaller companies.[12]

The issue of introducing similar experience-rating in the first-pillar disability insurance is now under debate. Employers' and employees' organisations, however, share some concerns, especially regarding the lack of transparency of the system due to the multitude of regulations. The fact that, via the whole enterprise, all other employees contribute to higher premiums in case of increased sickness or disability cases may diminish solidarity with colleagues who have health problems. Finally, while experience-rating of contributions may well have increased the responsibilities of Swiss employers towards the health management in their firms, it is likely to create adverse effects when it comes to new hires of disabled persons.[13] If the newly hired disabled workers have more or longer periods of sickness or disability than the firm average, this will increase the firm's premiums but also those of their colleagues.

One way to deal with this issue would be to lower employers' premiums for new hires of disabled persons – as is done in the Netherlands, the only OECD country that uses experience-rating in its public disability insurance. The fifth revision of the Disability Insurance Act in Switzerland indeed includes such a clause (BSV, 2005). However, this regulation is formulated as a "possibility" and not specified in any concrete manner; rather, it is intended to first collect experiences in a number of pilot projects over the next few years (BSV, 2005).[14]

One particular aspect of experience-rating concerns the different rules governing the length of continuous wage payment in case of sickness by employers, before social (or private) insurance pays sickness benefits. The longer this period, the more responsible individual employers are being held for health management and the reintegration of their employees in the workplace in case of sickness. In Norway, at 17 days, this period is very short – shorter than in Poland, with 33 days. The period is much longer in Switzerland, where it varies between 15 and 230 days depending on the tenure of the employee. It should be noted that in Switzerland the employer can reinsure against this longer wage-payment period.

D. Summary and conclusion

In Switzerland, all political parties in parliament agree on the need to encourage employers to hire disabled employees, *e.g.* via favourable tax treatment. At the same time there is general agreement that forcing employers to take more financial responsibility, *e.g.* through a quota-levy system, would not work. There is also reluctance to implement experience-rating any further, at least at this stage, because that would increase employers' obligations. In Poland and particularly in Norway, social partnership and tripartite agreements play a very important role influencing employers' decisions. The IW Agreement in Norway, for instance, is largely based on measures to create a "cultural change" permitting longer-lasting inclusion of people with health problems in firms – with and without concrete financial support measures. To a lesser degree, this is also the role of the tripartite commission in Poland.

Direct and indirect wage subsidies can be powerful tools to create financial incentives among employers, and there are programmes of this type in all three countries reviewed. It is too early to evaluate outcomes of experience-rating of sickness insurance premiums as recently introduced in Switzerland.[15] The measure does however show considerable potential for better health management and thus early prevention of possible disabilities. On the other hand, however, experience-rated insurance premiums could constitute a barrier for the hiring of disabled persons currently outside the labour market because of the higher risk of premium increases. Equalising mechanisms would be needed to ensure that the benefits are reaped and the dangers kept under control.

In all three countries there is a general belief that while the law provides a number of rules and regulations that financially support employers who retain or hire disabled persons, in general these measures are not sufficiently used, if indeed they are used at all. In turn, employers' organisations and NGOs complain about the lack of information on such measures, especially in Poland and Switzerland, as well as about the complexity and frequent amendments of regulations.[16] Advertising campaigns and a simplification of rules would likely encourage greater take-up.

Notes

1. Disposable income is defined as total net household income per person adjusted for household size with an equivalent scale corresponding to the square root of the household size (elasticity = 0.5).
2. These estimates refer to *monetary* poverty. Non-monetary poverty among disability beneficiaries in Switzerland has recently been estimated at around 20%; half of these persons are under a monetary poverty threshold (Gredig *et al.,* 2005).
3. This refers to the overall impact of these benefits among the total working-age population in 2000 (Förster and Mira d'Ercole 2005).
4. The Norwegian White Paper outlining the plan of action for combating poverty for 2002-05; the Polish Social Strategy Plan for 2007-2013 which includes disability as one of seven priorities; and the Swiss "first national poverty conference" in 2003 with a working group on the impact of poverty on the health status.
5. The exception is in Poland where the gross replacement rate is lower than the net rate for partial disability benefits but the opposite holds for the total disability benefits. This is due to the interaction with the housing benefit which is means tested at a level midway between the partial and the total disability benefit of a former average earner (PLN 9 300 and PLN 12 400, respectively).
6. It should be noted that, of the three countries covered in this report, Norway and Switzerland belong to the "top five" OECD countries in terms of GDP per capita in PPPs, while Poland ranks third lowest.

7. In Norway, these supplements are flat-rate and means-tested and therefore play a role in the lowest income segment. In Switzerland they are proportional to the basic disability benefit and, therefore, also important for higher income earners.
8. In Norway, about half of all employees are covered by the second-pillar occupational disability benefit (*tjenestepensjon*). In Switzerland, second-pillar provident institutions often offer over-compulsory insurance, *i.e.* to insure the salary above the compulsory maximum (*Überobligatorium*).
9. This occurs because the disability benefit is suspended beyond 50% work capacity. Together with the earnings disregard of around 20% of average earnings, this means that benefits stop at about 70% of average earnings, except the flat-rate family benefit for dependant children in the household.
10. This corresponds to a loan of disabled persons to an enterprise for a probationary period where the persons remain under contract and are paid by the NGO.
11. Contribution rates to accident insurance are differentiated according to a formula that takes into account the number of injuries, the number of fatal accidents and the number of persons working under hazardous conditions. This indicator is recalculated annually but the contribution rates are valid for three years.
12. The case of the medium-sized Enterprise Z in the canton of Zurich is telling: Z, employing 40 people, is producing office furniture for the domestic market. As the industry is covered by a collective labour agreement, Z has to take out daily allowance insurance as a collective insurance contract. During 2002, four employees had health problems that led to longer-term sickness absences. In turn, the insurer doubled the premiums from 0.75% to 1.5% of the payroll and there was a risk for the enterprise of losing the insurance. The sickness cases have been reduced considerably since, but it will take another two years to return to initial values of contributions.
13. Anecdotal evidence suggests that roughly half of the reduction in sickness absences in firms actively responding to the new challenge is due to better sickness prevention of current employees and the other half to better health screening in the recruitment phase.
14. Such a model has also been proposed by the Swiss umbrella organisation of disability NGOs (DOK, 2004). To simplify matters, this model proposes reimbursement of 20% of the annual wage of the disabled person should they be absent for more than 30 days, for a maximum of two years.
15. Some evidence is available for other OECD countries. Koning (2004) estimates the *ex post* effect of the experience-rating system – introduced into the disability scheme in the Netherlands in 1998 – to amount to a 15% reduction of inflows after one year. This concerned predominantly larger enterprises; no substantial impact was found for employers with less than 25 workers.
16. A survey among 1 600 Swiss enterprises revealed that only one-quarter of them are informed about existing financial subsidies and 10-20% about non-financial measures (Baumgartner *et al.*, 2004). Larger enterprises and those employing disabled persons are considerably better informed about the existing schemes.

ANNEX 4.A1

Background Tables for Different Household Types

Income positions when persons are in work and when they are out of work are strongly influenced by the level and design of taxation and available benefits and their interaction with personal and household incomes. The analysis in Chapter 4 is based on estimations from an additional module to the OECD tax/benefit model (OECD, 2004d), for different groups of disabled people: those living alone, those living with (working or inactive) spouses and those living with spouses and children.

Table 4.A1.1 summarises the main features of the three countries' disability benefit systems, their taxation and the rules for combining benefits with labour earnings.[1] It also describes those parts of the system not taken into account in the model calculations, mainly because they are not "standard" for the typical households examined. For the most part this concerns the occupational disability benefit in Norway, which covers about half of all workers in that country; the social pensions for persons with congenital disabilities in Poland; and third-pillar private insurance in Switzerland.

Figure 4.A1.1 complements the results for single persons shown in Figure 4.2, with estimates on net replacement rates for disability benefits, unemployment benefits and social assistance for two other household types: a disabled person living with an inactive spouse and a disabled person living with a lower-wage earning spouse and two children. Table 4.A1.2 shows NRRs for single disabled persons at three different ages. Figure 4.A1.2 presents average effective tax rates for different household types.

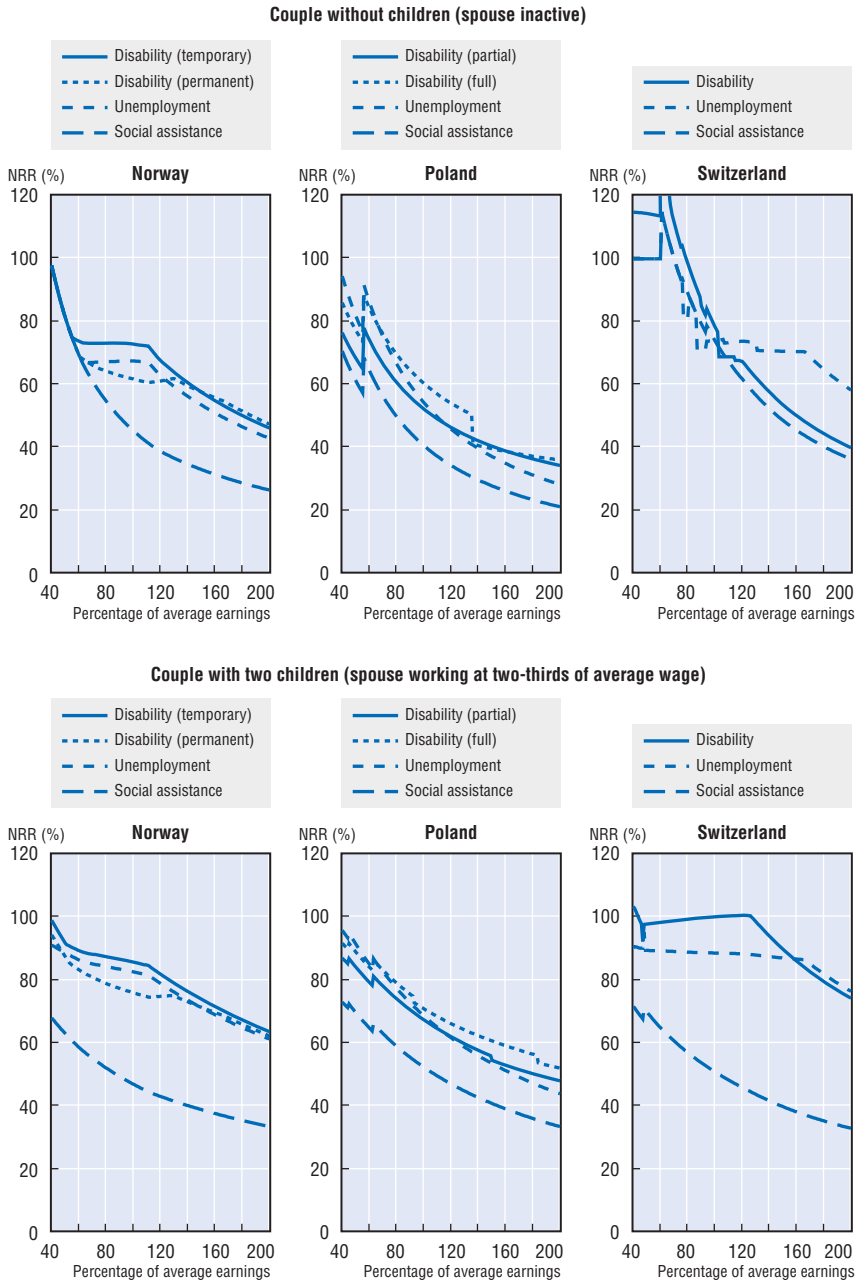
It should be noted that the incentive indicators presented in Chapter 4 do not take into account a range of monetary and non-monetary policy instruments available to support work-related expenses. In Norway, a basic benefit (*grunnstonad*) is granted if disability involves significant extra expenses (*e.g.* in case of extra expenses for transport to/from work).[2] In Poland, transportation costs are subsidised for some groups of disabled persons, but via reduced ticket prices for public transportation and independently of whether it is transport to work. And the Swiss first-pillar disability insurance reimburses equipment for transportation in order to "develop personal independence, regardless of earnings capacity". Although these measures are not specifically targeted at in-work situations, they compensate for costs that would not arise if the person were not working. In addition, the Polish labour law specifies some special rights for disabled employees. If monetised, these privileges would lower the effective tax rates faced by disabled persons taking up work. In Switzerland, auxiliary equipment (hearing aids, guide dogs, motor vehicles, special tools, etc.) is provided for reasons that explicitly include "engaging in paid employment" and "training purposes".

Table 4.A1.1. **Main characteristics of disability benefit and taxation systems, as at 1 July 2004**

	Norway	Poland	Switzerland
Benefit schemes (covered in model)	Temporary disability benefit (*tidsbegrenset uførestønad*).	Full invalidity benefit (*renta z tytułu całkowitej niezdolności do pracy*) if unable to perform any type of work.	First pillar of invalidity benefit (AI, *assurance invalidité*), universal.
	Permanent disability benefit (*varig uførepensjon*), consisting of first-pillar basic pension (*grunnpensjon*) and earnings-related supplementary pension (*tilleggspensjon*).	Partial invalidity benefit (*renta z tytułu częściowej niezdolnosci do pracy*) if unable to perform usual work but capable of a different job.	Earnings-related second pillar of invalidity benefit (PP, *prévoyance professionnelle*), compulsory above a certain salary level.
Special supplements (covered)	Special supplement (*saertillegg*), if no or low supplementary pension. Child supplement (*barnetillegg*), means-tested for permanent disability pensioners.	No special supplements.	Means-tested supplementary benefit to the first pillar to cover basic needs (*prestation complémentaire*). Child supplement.
Graduation of benefits	Calculated in 5% steps, with reduced earnings capacity by at least 50%.	No.	First pillar: 1/4, 1/2, 3/4 and full pension for capacity reduction of 40%, 50%, 60% and 70%, respectively. Second pillar until 2004: 1/2 pension for capacity reduction between 50% and 67%. Second pillar from 2005: same as first pillar.
Benefit schemes (not covered)	Non-mandatory occupational disability pension (*tjenestepensjon*).	Social pension (*renta socjalna*) for persons whose invalidity began before age 18.	Voluntary private third-pillar disability insurance.
Special supplements (not covered)	Basic benefit (*grunnstønad*) for extra expenses. Attendance benefit (*hjelpestønad*) for special attention needs or nursing. Spouses supplement, for spouses over age 60 (*ektefelletillegg*).	Medical care supplement (*dodatek pielegnacyjny*) for persons who require assistance from another person.	"Helplessness" allowance (*allocation pour impotent*). Exceptional pension (*rente extraordinaire*).
Taxation of benefits	Yes, but tax limitation rules and special deduction.	Yes, no special relief.	Yes, no special relief.
Social security contributions	Lower social security contributions for permanent disability benefit.	Benefits not subject to social security contributions for retirement, disability or sickness, but subject to health care contributions.	Not subject to social security contributions except compulsory health insurance if not recipient of supplementary benefit.
Accumulation of benefits with earnings	Yes, for graded benefits. No reduction in benefits up to one "basic amount" (*grunnbeløpet*). Sum of the benefit and earnings must not exceed the earnings before disability	Yes, for both partial and full benefit. No reduction in benefits up to 70% of average national wage, partial reduction until 130 %, suspension of benefits above 130% average national wage	Yes, for graded benefits
Combination with other benefits	Allowed with social assistance but not with national insurance benefits.	Allowed with social assistance, parental leave, family or housing benefits but not with retirement pensions, injury benefits or unemployment benefits.	Reduction in benefits where, added to injury or second-pillar benefits, they exceed 90% of income which beneficiary is deemed to have lost.

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

Figure 4.A1.1. **Net replacement rates for disability benefits, unemployment benefits and social assistance, couple households, 2004**[a]



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

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

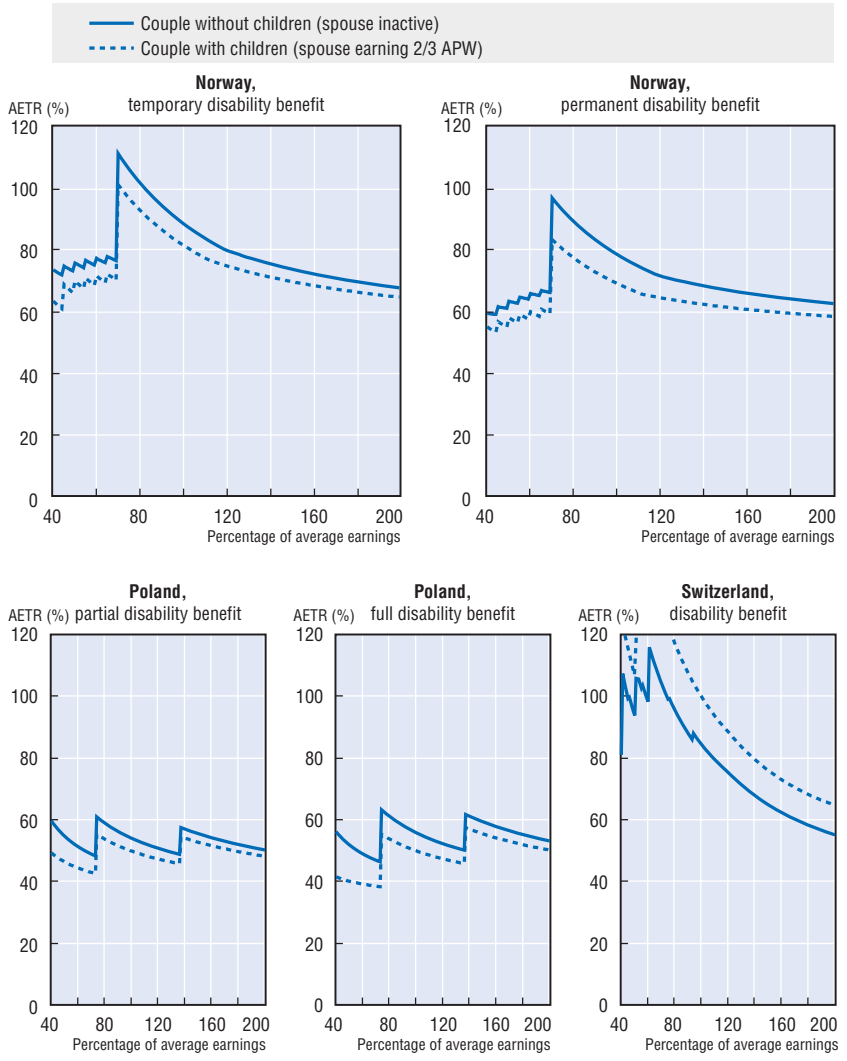
Table 4.A1.2. **Net replacement rates for single persons, at three different ages, 2004**[a]

	Age	Former earnings level, percentage of average earnings			
		50%	67%	100%	150%
Norway	30	76	65	60	57
	40	76	65	60	57
	50	76	65	60	57
Poland	30	89	71	40	34
	40	92	75	45	38
	50	98	62	53	47
Switzerland	30	116	86	65	51
	40	117	87	68	54
	50	118	85	93	78

a) Net replacement rates (NRRs): ratio of household net income after becoming inactive and receiving disability benefit to household net income when earning 50%, 67%, 100% and 150% of average earnings. Estimates refer to a single person with a full earnings history from age 18.

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

Figure 4.A1.2. **Average effective tax rates for disabled persons in different household situations, 2004**[a]



a) Average effective tax rate (AETR): percentage of earnings that is taxed away via increased taxes and reduced benefits when taking up work. Take-up of work at between 40-200% of average earnings (APW). Estimates refer to a 40-year-old person with an earnings history of 22 years at average earnings.

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

SICKNESS, DISABILITY AND WORK: BREAKING THE BARRIERS – VOL. 1 – ISBN 92-64-02631-2 – © OECD 2006

Notes

1. A detailed description of the country-specific parameters of the disability systems that have been used for the models is available at *www.oecd.org/els/disability*.
2. In 2005, 18% of Norwegian disability pensioners received an annual basic benefit of between NOK 6 636 and NOK 33 240.

ISBN 92-64-02631-2
Sickness, Disability and Work
Breaking the Barriers – Vol. 1
© OECD 2006

Chapter 5

Improving Governance and Policy Coherence

Policy failures often result from poor implementation of rules at the local level, a lack of coherence across different benefit schemes and an absence of co-operation between different actors. Norway, Poland and Switzerland are no exceptions in this regard. In all three countries, for instance, there is a mismatch between decision-making and financial responsibility, with funding coming from central sources and decisions on benefit awards or employment programmes being taken at the local level. Norway is addressing this mismatch and the lack of co-operation across institutions by merging the public employment service and the social insurance administration. Switzerland tackles the problem through improved governance of cantonal actors, broadened responsibilities of the disability insurance and new inter-institutional co-operation activities. In Poland, governance rules and the channels of co-operation have yet to be adapted to the recent devolution of certain responsibilities to regional and local levels.

Imperfect governance of service and benefit-granting institutions, lack of coherence across different systems, and inadequate co-operation among different actors can contribute to poor outcomes of sickness and disability policies. Local institutions may have little or no incentive to focus on difficult and time-consuming cases and instead grant a benefit. Institutions at different government levels may also have strong incentives to shift people in need of help to another institution, thereby lowering their caseload and costs. This reduces the chances of labour market integration further, and raises overall costs.

This chapter explores how the three countries are dealing with governance of their local disability institutions and policy implementation judgement at the regional level, but also with co-ordination and co-operation *across* different institutions. It discusses how disability benefits have developed in relation to unemployment benefits and early retirement schemes, and how changes in these schemes have influenced and may continue to influence disability trends. It identifies good practices of cross-institutional and cross-governmental co-operation as well as loopholes in policy co-ordination. The chapter concludes that placing more emphasis on governance and policy coherence would result in more effective and more efficient use of scarce public resources.

5.1. Incentives for benefit-granting institutions

If weak incentives sometimes fail to influence employees and employers, they can also prove an obstacle to better policy outcomes with regard to the institutions and actors involved in decision making. This section briefly describes the financing and decision mechanisms in Norway, Poland and Switzerland, regional variation in outcomes resulting from implementation judgement at the level of regional authorities, and ways and means used to monitor and supervise the decision process. It ends with a general conclusion on how to improve the incentives for granting institutions to deliver good outcomes.

A. Financing mechanisms and responsibility structures

Incentives for service and benefit-granting institutions crucially depend on the extent to which funding structures match decision structures. In this regard, the systems in all three countries have major weaknesses. In Poland, disability benefits are almost exclusively financed from national government revenues, be it through social security contributions (for ZUS benefits), other taxes on labour (for activation measures offered by the PES or PFRON), or general taxes (for KRUS benefits and social pensions). Decisions on granting a benefit or offering participation in an employment-related measure, on the other hand, are by and large taken at the regional or local level. Disability benefits are granted by an insurance officer in one of the regional divisions of the relevant social insurance institution; social pensions are granted at the local government level, following the recommendation of the local disability assessment team. Employment and rehabilitation programmes, to the extent they exist, are run by local labour offices (PES-funded schemes) and by municipal centres for the employment of persons with disabilities (PFRON-funded schemes).

This structure gives local and regional decision makers little incentive to use funds effectively or to focus on sustainable employment outcomes. Local labour offices, for instance, have little incentive to register jobseekers with difficulties in the labour market, such as people with a disability, even though the social insurance institution can cover the daily expenses of a disabled person participating in a vocational programme (by granting a temporary training pension). The problematic decision structure in Poland is also reflected in the extremely high proportion of appeals against rejected first-time disability benefit applications, much higher than anywhere else in the OECD. Of these appeals, almost half are turned into an entitlement in the end, compared to only around 10% in most other OECD countries.[1] This is an expensive way of trying to keep inflows low.

In Switzerland, disability policy is financed almost exclusively through the Swiss disability insurance, which in turn receives half of its funding from social security contributions and the other half from general taxation. Of the latter, three-quarters stem from national and one-quarter from cantonal government revenues. Thus, only about one-eighth is financed through cantonal resources – yet it is precisely interdisciplinary teams at the cantonal disability offices that take most of the decisions.[2] Insurance officers in these teams are also responsible for offering or refusing a medical or vocational rehabilitation measure and for granting subsidies to institutions and organisations that, for instance, offer sheltered work.

Labour market policy in Switzerland is also characterised by a mismatch between decision making and financial responsibility. That is because the same situation arises for the PES, which is also financed from social security contributions but operating on a cantonal level. The large share of federal resources for disability policy making in Switzerland contrasts with a low share of income tax collected at this level, with most income tax being collected at cantonal and municipal levels. This suggests that there is room for reconsideration of the current funding and decision streams. To some extent that rethinking is taking place in the course of the ongoing changes to the financial equalisation mechanism, with cantons becoming responsible for the financing of the institutions offering services for disabled people (including sheltered work institutions). However, this change affects only some 20% of total spending of the cantonal disability offices.

In Norway, sickness and disability policy, as well as labour market policy more generally, is predominantly funded through tax on labour in the form of non-earmarked social security contributions. Decision making, however, is in the hands of local and regional actors, with all employment and vocational rehabilitation programmes operating under the responsibility of the PES and all other social insurance benefits under the responsibility of the NIA. The social insurance administration is obliged to operate on the municipal level, although permanent disability benefit decisions are formally taken by the county following the assessment of the local NIA officer. The PES operates on a regional level. It is free to determine the size of its operational units, which are larger than municipalities but much smaller than counties. This financing structure does not lend itself to strong incentives for local and regional actors to use public resources efficiently; granting a benefit to a more difficult-to-integrate client would be a relief to the caseworker with seemingly no detrimental impact on either the caseworker or the local office's budget.

B. Regional judgement in policy implementation

The fact that there are regional disparities in policy outcomes suggests that there is a problem that needs to be tackled. In Switzerland, the share of disability benefit recipients in the working-age population varies from less than 4% in three German-speaking cantons to

over 7% in Ticino and Jura and even 9% in the city of Basel**.** The resulting coefficient of variation is 23%, which is slightly larger than that computed for Norway (20%) and Poland (19%) (Table 5.1). In Norway, there are basically two groups of counties: those in the North with recipiency rates of 12.5-14%, and Oslo and its neighbouring counties with rates below 10%.

Table 5.1. **Regional variation in outcomes is substantial in all three countries**
Minimum rate, maximum rate and coefficient of variation for each indicator, 2004

	Norway	Poland	Switzerland
Disability benefit recipiency[b]			
Minimum	7.8	3.5	3.7
Maximum	14.0	7.0	9.1
Coefficient of variation	20%	19%	23%
Vocational rehabilitation[c]			
Minimum	2.1	. .	0.4
Maximum	4.3	. .	1.3
Coefficient of variation	24%	. .	32%
Unemployment rate			
Minimum	2.7	14.6	1.2
Maximum	5.7	24.9	7.1
Coefficient of variation	19%	16%	30%

. .: Data not available.
a) Calculations are based on outcomes for 19 Norwegian counties, 16 Polish *voivoidships* and 26 Swiss cantons.
b) Benefit recipiency rate in Norway and Switzerland, legally disabled with a severe or moderate disability in Poland.
c) PES-registered vocationally disabled persons in Norway, participants in a vocational measure in Switzerland. No data are available for Poland.
Source: National Insurance Administrations for Norway (NIA), Poland (ZUS) and Switzerland (IV).

Benefit recipiency rates are a reflection of past policy. Available evidence suggests that in both Norway and Switzerland, the rate of participation in vocational rehabilitation – a better reflection of differences in current policies shows even more regional disparity.

Regional variation can be a reflection of differences in the way policy is implemented (internal factor), but also of differences in economic and labour market conditions (external factors). With reference to the former, it is quite plausible that the data for Switzerland indicate higher variation across *cantons* than is found across *counties* in Norway and *voivoidships* in Poland. This is because the canton is the key unit for policy implementation, while actual variation across municipalities in Poland and Norway – the level at which most of the implementation judgement would arise – is partially levelled out on a regional level. Available evidence for Switzerland suggests that one-third of the regional variation in disability benefit recipiency rates is a consequence of differences in policy implementation at the cantonal level – *e.g.* different ways of interpreting the law and, thereby, of granting or rejecting a benefit, and varying emphasis on vocational reintegration (Spycher *et al.*, 2004).

Comparing disability with unemployment outcomes across regions suggests that the external factor, *i.e.* economic conditions, might play an important role as well. In Switzerland, cross-cantonal variation in unemployment rates is almost as large as cross-cantonal variation in the use of vocational rehabilitation, while in Norway and Poland the unemployment rate shows lower regional variance (Table 5.1). This similarity in regional variation of the unemployment and disability systems could either be explained by external factors, which affect officers in both the disability insurance and the PES, or by comparable problems of regional consistency and harmonised policy implementation in

PES offices, which in all three countries operate at the same (or almost the same) regional level as the disability insurance.

C. Monitoring benefit-granting institutions

A strong system of supervision and control is one way to minimise implementation judgement of policy makers at the regional and local level. This requires a clear definition of the role of the supervisory authority and an adequate set of tools for this authority to fulfil its role and to follow up on actors or institutions violating the rules or otherwise failing to achieve their goals. In this regard, Switzerland seems to be ahead of the other two countries.

In all three countries, local and regional insurance offices are monitored and supervised by the national insurance office. The same is true for the PES: local and regional offices are monitored by the national authority. In Norway and Switzerland, where these institutions are responsible for the bulk of disability policy, the whole issue of control and monitoring therefore boils down to how the national insurance office and the national PES fulfil their roles. In Poland the situation is more complex because several different institutions and government layers supervise the implementation of disability policies.

In Switzerland, divergent policy implementation at the level of cantonal disability offices is partly responsible for divergent outcomes. Harmonisation of cantonal differences through improved monitoring by the national supervisory body, the Federal Office of Social Insurance (BSV), has therefore become a driving force for policy change. Various improvements have been implemented over recent years. These include a better reporting and monitoring system that has strengthened competition between cantons for good outcomes, and a more frequent procedure of control over cantonal decision processes; that control now takes place annually rather than only every third year.

In addition, steps are currently being taken to improve the governance of cantonal disability offices (CDOs) by introducing target agreements between the BSV and the CDO, similar to the agreements recently introduced between the cantonal PES offices and their supervisory body. Fulfilment of the agreements between the BSV and the CDOs is to be measured on the basis of a set of outcome-oriented indicators (yet to be developed) on the effectiveness of the CDO. Indeed, while for the PES this kind of management-by-objectives has become common in most OECD countries, it is still quite an innovative approach for national disability insurance administrations. With these administrations moving away from being a benefit-granting institution to being a service institution, however, it seems appropriate to apply the management approach of the PES.

In Norway, a rather different approach is currently being taken by the PES and the National Insurance Administration (NIA). The PES introduced management-by-objectives almost 20 years ago, accompanied by decentralisation and increased policy discretion for regional and local PES offices (Mosley *et al.*, 2001). The majority of the operational targets (which include special targets contained in measures for and participation of disabled people), however, are process- rather than outcome-related, and financial transfers to local offices are not linked to performance requirements. Thus, even if management-by-objectives has helped to change the culture of the PES, which is applying a declared work focus, it has probably not reduced regional variation in outcomes. This is also explained by a general guiding principle for service delivery used in this large and sparsely populated country, which is to give all Norwegians – irrespective of whether they live in a city or in an isolated rural community – the same access to all services. The principle may be a

hindrance to a stronger focus on inspection of appropriate policy implementation at the regional and local level.

The NIA, on the contrary, is still largely functioning as a benefit authority; supervision from the national level to harmonise outcomes across regions is not a central issue for this organisation. With the PES now fully responsible for the integration of disabled people in Norway, the management culture of the NIA has become even more different from that of the PES. This will be a major challenge for the ongoing merger of the two institutions.

In Poland, improved governance of the regional social insurance authorities and the local labour offices through management-by-objectives does not appear to be a key concern. The situation is also more complex than in Norway and Switzerland, because in addition other governance issues arise. With administrative reform in the 1990s, responsibility for supervision and control of issues related to persons with disabilities was transferred to the regional government level (*voivoidship*). This includes the supervision of local government actors who determine a person's degree of disability or grant sheltered work enterprise status to a company, but also supervision of local labour offices. While this administrative change was, among other things, intended to improve compliance with the rules, the Polish system implies that funding, supervision and implementation of policy is now taking place at three different levels – national, regional and local. Strong co-operation across government boundaries is needed to turn this into an effective structure.

PFRON, which manages the revenues from the employment quota scheme, also has a supervisory role. Employers who receive wage subsidies for an employee must report activities regarding their disabled workers to PFRON. This applies to employers in the open labour market, who can receive these subsidies since 2004, and to Sheltered Work Enterprises (SWEs). However, PFRON's monitoring possibilities are both limited and rarely applied. This is why the issue of misuse of wage subsidies by some SWEs is reported in the media repeatedly. Moreover, large portions of the PFRON funds are transferred to the local government level directly, and the agency has little or no control over the use of these funds. There is in fact little control of PFRON itself, a national institution operating in parallel with the regional governments.

D. Summary and conclusion

In all three countries, financing structures do not really match the decision structures. By and large, funding of disability-related policies comes from central sources while decisions on benefit awards or employment programmes are taken at the local level. Regional variation in outcomes could be an indication of individual judgement on the part of regional officers in the decision process. That would support the "lacking incentives for decision makers" argument, at least partially.

There are two ways to improve the situation. First, the financing mechanism could be adjusted in order to reflect the decision structure, thereby establishing direct implications of bad case management and over-generous use of benefits at the local or regional level. This would require a more comprehensive change in financing structures because large parts of current public spending for disability policies come from social security contributions. Alternatively, ways should be sought to improve governance of regional and local actors through better supervision and control from the national government, the national social insurance institution and the national PES. This could help eliminate

regional variation in outcomes determined by divergent policy implementation. That process is under way in Switzerland, while Poland has not yet addressed the issue.

5.2. Are disability benefits a support of last resort?

Lack of incentives for and weak governance of benefit-granting institutions may not only create regional disparities in disability benefit outcomes, but also cause substitution and carousel effects between benefit schemes. For example, if rule changes in one scheme are not co-ordinated with those in other schemes, expected outcomes may well be partially or fully offset by developments in those other schemes. This section discusses available evidence on substitution and carousel effects, as well as the issue of co-ordination of and co-operation across different schemes.

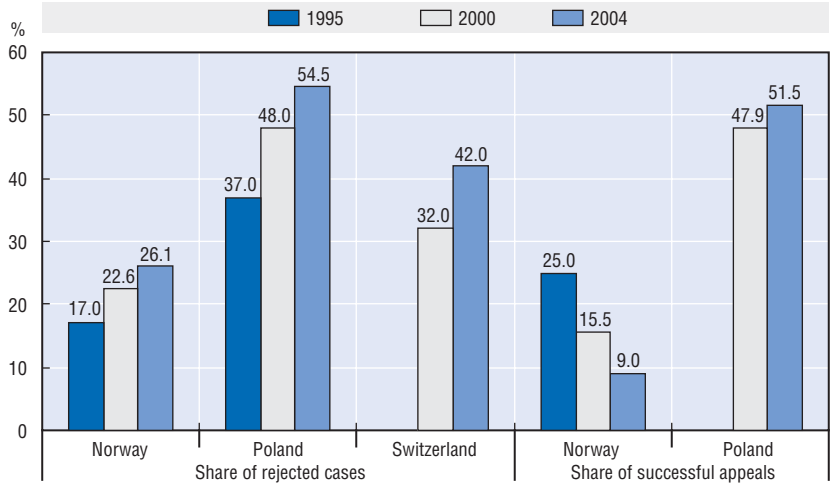
A. The impact of disability benefit rejections

Rejections of the claims of disability benefit applicants who do not fulfil the requirements can help explain why inflow rates to disability benefits differ substantially across countries. Countries with low inflow rates appear to have high rejection rates and *vice versa*. This is also the case for the three countries. While Norway has the lowest rejection rate but the highest disability benefit inflow rate, Poland has the highest rejection rate and the lowest inflow rate (Figure 5.1). Disability benefit rejections have increased in all three countries, which explains part of Poland's success in reducing the inflow and Switzerland's relatively stable inflow rates. In Norway, the situation could have worsened further in recent years had rejection rates not risen.

To measure the impact of rejection rates, they need to be seen against the share of successful appeals. In 2004 the latter amounted to 51% in Poland, five times higher than in Norway.[3] Correcting the disability benefit inflow rates for both rejection rates and rates of successful appeals shows that 14 per 1 000 of the Norwegian working-age population applied for a disability benefit in 2004. In Poland and Switzerland, the corresponding

Figure 5.1. **Disability benefit claims are increasingly rejected and appeals are less successful**

Rejected cases as a share of claims and successful appeals as a share of rejections, 1995, 2000 and 2004[a]



a) For Switzerland, figures refer to 2003 and 2005 rather than 2000 and 2004.

Source: For Norway, fiscal state budget 2004 and 2005, Ministry of Labour and Social Affairs; for Poland, the National Insurance Administration for the non-agricultural sector (ZUS); and for Switzerland, the Swiss Disability Insurance (IV).

shares of disability benefit applications amounted to 5.6 and 7.6 per 1 000, respectively.[4] These rates should be compared to the respective inflow rates of 10.7 per 1 000 in Norway, 4.1 in Poland and 5.2 in Switzerland.

Ideally, disability benefit inflow rates should be low and benefit rejection rates as well as appeal rates close to zero. Taking both successful appeals and rejections into account reveals that one-quarter of all applicants in Norway and Poland and almost one-third in Switzerland end up without a benefit. Most of these applicants will, at the time of rejection, most certainly have lost their job. Unless they find a new job, they are likely to transfer to another scheme – be it unemployment benefits, rehabilitation measures or social welfare benefits – and possibly end up on disability benefits in the long run.

High rejection rates, especially in combination with high rates of appeals, may also signal an overly strict or complex assessment process. On the other hand, low rejection rates in combination with high inflow rates can indicate a lax assessment procedure. This may be a plausible description of the situation in Norway (especially for older people) and a reason why the overall share of applicants is twice as high there as in Poland and Switzerland.

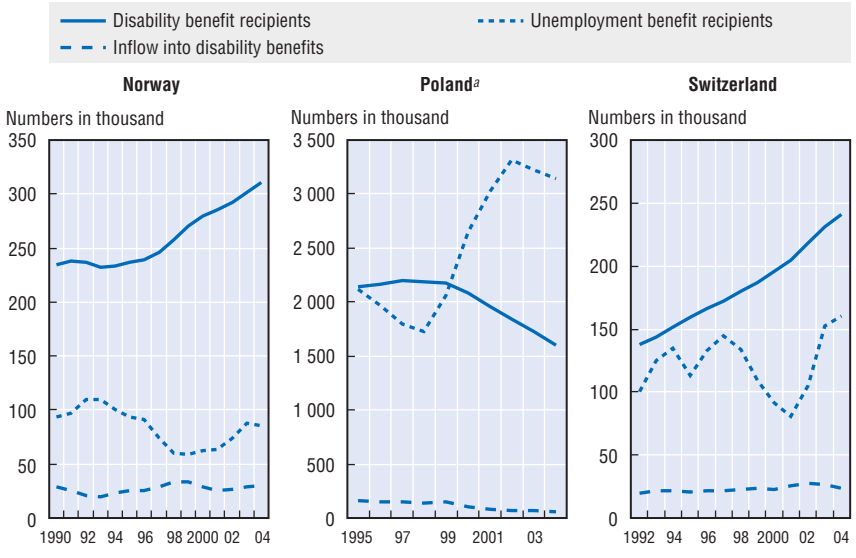
B. The link between unemployment and disability benefits

An increased inflow to disability benefits can also be driven by, for example, imposing stricter obligations for the unemployed, *e.g.* through stricter work-testing and tighter regional and occupational mobility requirements in the unemployment benefit system and social assistance scheme. The opposite may also hold, where a strengthening in medical and vocational assessments for granting disability benefits can increase the number of claimants of unemployment benefits or social assistance payments.

Figure 5.2 shows how the relationship between the unemployment and the disability benefit programme has developed during the past 10-15 years in the three countries.

Figure 5.2. **The relationship between unemployment and disability benefit schemes, 1990-2004**

Unemployment benefit recipients, disability benefit recipients and inflow into disability benefits, in thousands



a) Disability benefits are based on ZUS benefits.

Source: National Insurance Administrations for Norway (NIA), Poland (ZUS) and Switzerland (IV).

Judging from the results, the relationship between the two appears to be fairly close in Poland and somewhat less so in Norway, while there is no such relationship in Switzerland. In Norway and Poland, a fall in the number of new recipients in one of the two benefits tends to be (at least partly) offset by an increase in the other. This is especially so in Poland after 1999, when reform of the disability benefit scheme took place. But until 2001 this inverse relationship was also observable in Norway.

If people tend to substitute disability benefits for unemployment benefits, then one would expect a higher rate of disability benefit recipients in regions where unemployment is higher. This is only partially supported by the data. In Switzerland and Norway (if the county of Oslo is excluded), regions with higher disability benefit recipiency levels tend to have higher unemployment rates. For Poland, no systematic relationship on a regional level is found between disability and unemployment, which confirms earlier findings from Hoopengardner (2001).

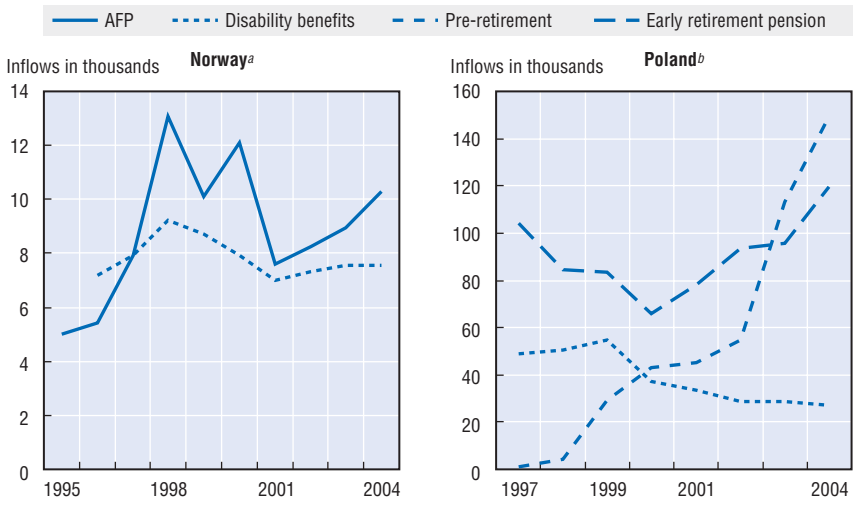
C. The link between early retirement and disability benefits

There are indications that at least part of Poland's success in reducing disability benefit inflows, following system reform in 1999, is due to higher uptake of early retirement pensions and pre-retirement allowances. To explore this argument further, inflows into early retirement are compared with inflows into disability benefits for people in age groups eligible for early retirement benefits in both Norway and Poland (Switzerland has no official early retirement scheme).

In Poland, there seems to be a very strong relation between the two after the restricted access to disability benefits in 1999 (Figure 5.3). This is indicated by a fall in the inflow to

Figure 5.3. **Early retirement and disability benefit inflows in Norway and Poland, 1995-2004**

New beneficiaries in thousands



AFP: Norway's Early Retirement Pension Agreement.

a) Inflow to disability benefits for those in the age group 60-66.

b) Inflow to disability benefits for those aged 50-64. Early retirement pensions refer to ZUS pensions which will be phased out as from 2008 in line with the phasing-in of the 1999 pension reform. Flat-rate pre-retirement benefits (which are similar to unemployment benefits although paid by ZUS since 2005) do not include pre-retirement allowances, which were abolished in 2002.

Source: For Norway, National Insurance Administration (NIA) and Statistics Norway; for Poland, Polish Ministry of Economy and Labour (2005) and the National Insurance Administration for the non-agricultural sector (ZUS).

disability benefits in the age group 50-64 over this period, together with an enormous increase in the inflow into early retirement pensions and pre-retirement allowances. If this link for Poland also works in the opposite direction, which is quite likely, any possible effect of closing or limiting the access to early retirement (which is due to happen in the near future) could be significantly dampened by higher inflows into disability of older people currently eligible for early retirement.

The relationship in Norway is less clear but, contrary to Poland, suggests that the increased inflow into early retirement benefits (AFP) has not affected the inflow of workers aged 60-66 into the disability benefit scheme in the direction expected. If anything, it appears to have further facilitated the use of disability benefits for older workers.

D. Summary and conclusion

To avoid carousel effects, with many people eventually ending up on the disability benefit rolls, social insurance institutions in all three countries should make efforts to monitor closely the further work and health career of rejected applicants. This is not done currently; benefit institutions are not even aware of second- or third-time applications. Close monitoring in this case also means providing the necessary support to these rejected applicants, who for instance will often not be eligible for vocational rehabilitation and training. It would also be important to have a better understanding of why these people have applied for a disability benefit, and why they are reapplying repeatedly.

Poland deserves praise for its substantial reduction of disability benefit inflow rates. However, more effort is required to avoid some of the existing substitution effects between the disability and other benefit schemes. Currently there appears to be a close inverse link between disability benefits on the one hand and unemployment benefits and early retirement pensions on the other. Norway also faces some substitution problems, while in both Switzerland and Norway there is a close link across regions between disability and unemployment benefits.

5.3. Better institutional co-operation

Better co-operation across institutions and among various levels of government is necessary to improve employment outcomes and to avoid shifting people between different benefit schemes. This section highlights recent efforts and continuing problems in the three countries. First, it looks at the way the disability administration co-operates with the PES and the local social assistance agencies in order to eliminate carousel effects. Secondly, it addresses the issue of co-operation across various institutions responsible for health-related matters. Finally, it discusses the question of how disability policy could be adjusted to far-reaching old-age pension reforms.

A. Improving co-operation between the disability authority, the PES and local welfare agencies

It is an OECD-wide phenomenon that local PES offices try to shed difficult-to-integrate unemployed workers with health problems from their caseloads by shifting them to other institutions. Similarly, local social assistance offices in many OECD countries, including the countries covered in this report, try to transfer disabled people from their caseloads into national disability benefit programmes. In doing so they would often help the person apply for such benefits. Local officers have two reasons for trying to discard certain clients. First, there are financial causes: the more people that are transferred elsewhere, the lower

the costs. This argument is particularly valid for transfers across government borderlines. Secondly, there are operational motives. A transfer of the most difficult-to-integrate clients implies that only those who are easier to integrate remain, thereby improving outcomes and thus performance at the level of the individual caseworker as well as the local service office.

The disability benefit insurance is in a weak position in this carousel phenomenon. In many OECD countries, including Norway and Switzerland and until recently also Poland, disability benefit is increasingly becoming a benefit of last resort, *i.e.* a benefit for those people of working age unable to succeed in the labour market but not entitled to work-tested unemployment and social assistance benefits. There are two mutually inclusive policy responses to this dilemma. One is to remodel the disability benefit programme into an employment support programme, very much along the lines of an unemployment benefit programme with a strong focus on activation measures. The three countries have all implemented some steps in this direction (Chapter 6). The other necessary response, which ideally should complement the first, is to drastically improve the co-ordination and co-operation across institutions.

In this respect, Norway has instituted comprehensive changes with considerable potential. In late 2002 a government white paper to parliament proposed merging the PES with the NIA to form a new central government agency and to establish a new Employment and Welfare Administration (EWA) at the local level. In 2006 parliament approved the legislation and the local EWA offices will be put in place gradually over the years 2006-2009. These one-stop-shops will offer all the employment and insurance services of the two organisations and co-operate closely with the local social assistance office. The objective is to develop a more effective employment and welfare system and to provide client-oriented services. Currently, co-ordination of services has to cut across administrative borderlines as well as government levels. This merger would most certainly improve the labour market integration of disabled people, who are now being serviced by the PES (for employment and vocational rehabilitation purposes) and the NIA (for benefit purposes).

In 2005, 17 pilot agencies with all three institutions under one roof were set up in several Norwegian counties. In this pilot phase, the agencies still appear to function more like a front desk with three different officers sitting next to each other and operating on the basis of different legislation and separate IT systems. Added to this are different management styles and performance monitoring approaches, different philosophies (with the NIA offices operating as benefit authorities and the PES offices as activation agencies) and different expectations of clients. Aligning these differences is a challenge and will require strong leadership and clear guidelines.

Currently, clients in need of services from at least two of the agencies often fall between chairs. These are the customers on whom particular emphasis is being put in the pilot agencies, with the aim of developing common tools for co-operation (around 8% of all customers need service from all three agencies, and 16% from two of the agencies). It is already a big step forward to have a co-operation platform where all three agencies meet to find a joint solution, with the work focus centre stage. Shifting clients around is being made more difficult, as is benefit shopping for the customers.

For several years now, Switzerland has also been very active in addressing carousel effects by improving inter-institutional co-operation between the PES, the cantonal disability offices and the municipal social assistance authorities. The philosophy of this

new co-operation, generally referred to as IIZ, is to encourage individual actors to co-ordinate their activities, to make their own actions more transparent and to share information with other institutions. There is support among these institutions that IIZ is needed. There is also support from the national government, which for instance has published an IIZ handbook summarising experiences so far.

However, a key weakness of IIZ is its *voluntary* nature: it is up to each canton and each municipality to decide whether and to what extent it participates in IIZ projects. As a consequence there are large cantonal differences in the way IIZ is implemented. For instance, in some cantons all three partners are involved, while in others co-operation is limited to particular aspects. The common denominator is a new focus on mutual exchange of information and ways to regulate co-operation. One good-practice model was developed by the canton of Solothurn: in mid-2005 a new law was enacted that established one-stop-shop offices in each municipality and one case-management office for the whole canton. The latter should take care of persons with multiple problems, *i.e.* cases that would typically fall under the responsibility of several institutions. The strength of the law is the mutually agreed and legally binding cost-sharing between the communities, the unemployment insurance and the disability insurance, which are covering 40%, 40% and 20% of the entire costs of co-operation, respectively.

Another promising initiative in the context of the new inter-institutional co-operation, launched during 2006, is IIZ-MAMAC. MAMAC, which is shorthand for medical-vocational assessment for case management, aims at making IIZ work through *i)* a joint assessment of a person's work capacity that is binding for all institutions; *ii)* jointly agreed reintegration measures; and *iii)* making one of the three institutions responsible for managing a particular case throughout the entire process. The target group for this project are people for whom there is no clear evidence as to whether they are sick because they are excluded from the labour market or whether they do not work because they are sick or disabled. Again, while the national government aims to implement IIZ-MAMAC in all cantons over the next four years, at this stage participation in the new initiative is entirely voluntary for the cantons and municipalities.

In Poland, no country-wide efforts are made to improve co-operation between labour offices, the social security administration and the municipal welfare services, or to introduce one-stop-shops for clients in need of help. Some municipalities, however, are trying to improve co-operation across institutions and government levels. In Warsaw City, for example, new social service centres have been established that harmonise and bundle information and knowledge to help disabled people navigate through the complex system of support.

B. Improving co-operation between the disability authority and other health-related institutions

There is also a need for better co-operation between the disability scheme and other health-related benefit or integration schemes in all three countries. The integration of sickness and disability benefit schemes and of medical and vocational rehabilitation schemes is discussed in Chapters 2 and 3. The key messages from the analysis in these chapters are the need for closer integration of procedures, for instance through similar assessment procedures for longer-term sickness and disability cases, and the harmonisation of objectives, for instance with a stronger work orientation for vocational as well as medical rehabilitation. In Poland currently, sickness and disability seem to be better

linked than in Norway and Switzerland. However, some voices in policy circles have recently suggested de-coupling sickness from disability and linking or merging sickness cash benefit insurance with health care insurance. This would clearly be a step in the wrong direction, weakening the functioning of and the control over the sickness benefit scheme and thereby unnecessarily easing the transfer from sickness into disability. It is true that sickness and health care are merged into one system in many OECD countries, but this is not an example Poland should follow. In this respect, those countries could learn from Poland.

Switzerland faces additional problems because of the strong role of private insurers in the entire social protection scheme, which means that these actors also have to be included. Various efforts have recently been made in Switzerland to improve co-operation between the disability insurance and those insurers typically involved at an earlier stage, the sickness benefit insurers, the accident insurers and the pension funds offering occupational disability pensions. This type of inter-institutional co-operation is being referred to as IIZ PLUS. Promoting IIZ PLUS is particularly important in the course of ensuring early identification of people on sick leave who might need support in the form of job counselling and placement or other reintegration measures – the key objectives of the fifth revision of the Swiss disability insurance act. As with IIZ initiatives, however, legally binding steps to advance IIZ PLUS are lacking. Instead, co-operation is encouraged on a voluntary basis and support given through the development of manuals of good practice.

The manual on co-operation between the disability insurance and the sickness benefit insurers, developed by the BSV together with representatives of the private insurance sector, is a good example. The manual proposes that the sickness benefit insurers, while collaborating with the disability benefit insurance, classify their recipients into four categories: *i)* simple cases which do not need any intervention by the disability insurance; *ii)* cases with good prospects that would gain from a close collaboration between the two parts, wherein the disability insurance would have to provide information on reintegration needs between three and eight months after the work incapacity has commenced; *iii)* difficult cases with low reintegration potential, where collaboration with the disability insurance is inevitable; and *iv)* cases where a disability benefit is unavoidable and will result in a benefit claim after eight months of sickness absence. This procedure is going to be implemented through an agreement between the national disability insurance authority and the private sickness benefit insurers. The agreement is binding for the BSV, but voluntary for the sickness benefit insurers; however, once the latter have signed the contract, they are obliged to follow its principles. To facilitate collaboration, standardised forms are being introduced jointly and the sickness benefit insurers are also expected to provide standardised medical files that contain information about sick employees and their occupation. Hence, again, transparency and exchange of information at an early stage are seen as the key to success.

Co-operation of the disability insurance with the accident insurers in general and with SUVA (the main accident insurer in Switzerland) is also being promoted. Currently, this type of co-operation is also on a voluntary basis. There are several examples of good practice in certain cantonal disability offices that work closely with the local SUVA offices, *e.g.* through a temporary exchange of staff and regular automatic transfer of information – all designed to ensure that the disability insurance is aware of difficult cases as early as possible.

C. Improving co-ordination of disability benefits and old-age pensions

A third issue in the context of policy co-ordination and coherence is the adaptation of disability benefit schemes in response to planned and completed old-age pension reform. This is a major challenge in Poland, where a comprehensive old-age pension reform was implemented several years ago. Norway is currently discussing a far-reaching pension reform, while Switzerland has avoided many of the mistakes of pension policy making in many OECD countries. Influenced by the strong work ethic in the country, the Swiss population never developed an early retirement expectation, which has helped avoid use of disability benefits as an early retirement pathway.

The situation in Norway is quite unusual. Although disability benefit receipt has long been relatively high for the population aged 60 and over, an early retirement culture was only established with the introduction of the collectively-agreed and publicly subsidised early retirement scheme (AFP) in 1989. The introduction of this scheme and its successive extensions to younger age groups have not reduced the pressure on the disability benefit scheme: disability benefit recipiency rates for those aged 60 and over did not show the slightest decline. The impact on the disability benefit scheme of any changes to the old-age pension or the AFP scheme remains to be seen. With older workers in Norway now expecting to retire early, stricter access to early retirement or old-age pension cuts before age 67 could well increase pressure on the disability scheme.

This will soon become an issue for disability policy making, because a comprehensive change in Norway's old-age pension scheme is forthcoming.[5] In response to this reform, both the AFP scheme and the disability benefit scheme will have to be modified. In mid-2005, a Disability Pension Commission was set up to consider possible reform of the disability pension scheme. The main considerations for this new Commission are: *i)* to propose measures to adapt disability benefit entitlements so that these will not counteract or distort the work incentives in the new old-age pension scheme; *ii)* to form an opinion on whether the permanent disability benefit should continue to follow the old-age pension or be separated from the latter and instead be integrated with the temporary disability benefit; and *iii)* to discuss how to calculate the old-age pension for people who have received a disability benefit. The Commission is to submit a report to the government in Spring 2007.

In Poland, on the contrary, no efforts were made so far to adjust the disability benefit formula, although a comprehensive reform of the pension system was implemented as early as 1999.[6] The transition rules of the reform imply that those older than 57 in 2006 still all retire on the basis of the old Polish pension scheme. That in turn implies that adjustments of the disability benefit formula, which uses the defined-benefit formula of the non-reformed pension scheme, is gradually becoming pressing. This is particularly evident from the discussion in the previous section, where it was shown that the very rapid drop in inflows to the disability benefit scheme since 1999 was accompanied by an equally rapid rise in the use of early retirement benefits. The moment workers fall under the rules of the reformed old-age pension scheme, the pressure on the disability benefit scheme will increase. The phasing-out of early retirement pathways during the same period will further exacerbate this pressure.

D. Summary and conclusion

The need for coherent policies and better co-ordination and co-operation across institutions is a recurrent issue for sickness and disability policies, which face the dilemma

of providing adequate benefits to those in need without weakening work incentives for those able to work. Co-operation across institutions to ensure more effective and efficient use of scarce public resources has become a key issue over recent years in both Norway and Switzerland, but less so in Poland.

Switzerland is most active in ensuring good governance of its cantonal disability institutions, and is also taking important steps to improve co-operation of these institutions with the cantonal PES and the local social assistance agencies on the one hand and with the sickness benefit and work injury insurers on the other. Given the administrative setup and the key role of private insurers, this co-operation is needed urgently, but it is also going to be very hard to achieve. The major weakness of the recent efforts is the lack of obligation for any of the actors involved.

Norway is tackling the need for better co-operation through a comprehensive merger of its key institutions, the PES and the NIA, in close collaboration with the municipal social assistance offices. This is a long-term project that is unlikely to deliver good outcomes easily and quickly, and which therefore needs very strong leadership to be implemented successfully. The merger could also be used more explicitly to improve governance and supervision of these institutions.

For Poland, good governance and coherent policy making are issues that need to be brought to the top of the policy agenda. The recent sharp fall in inflows to disability benefits masks the need for better monitoring of operating institutions and better co-operation of the social insurance institutions with other institutions, especially the PES. Moreover, the disability benefit system still has to be adjusted to the reformed old-age pension system, especially in view of the forthcoming phasing-out of early retirement schemes.

Notes

1. The higher rate of successful appeals in Poland is partly explained by the fact that new (medical) evidence can be taken into account for the court decision.
2. Including the costs of mandatory occupational disability benefits, which are entirely contribution-financed; that further reduces the share of the total financial burden of cantonal government.
3. Data for Poland refer to the ZUS system only. In the KRUS system, disability benefit inflow rates are twice as high as in the ZUS system, but only 3% of the decisions were appealed.
4. No information is available on the share of successful appeals in Switzerland. The estimation assumes that this rate corresponds to the OECD average in 1999 of 16%. The average rejection rate across the OECD area in 1999 was 39%, and thus very similar to the rate of 38% observed in Switzerland for 2004 (OECD, 2003a).
5. In late 2004, the Norwegian government issued a white paper setting out a strategy for a reformed pension system with a flexible retirement age, which should consist of three components: *i)* an earnings-related pension that depends to a greater degree than today on the individual's lifetime income and labour force participation; *ii)* a targeted minimum pension guarantee, tax-financed and tested against benefits from the reformed income-related pension; and *iii)* a compulsory occupational pension with a notional defined-contribution formula similar to other notional account systems. In 2005, the general rules of that new scheme were adopted by parliament.
6. The new pension system in Poland consists of three components: *i)* a mandatory notional defined-contribution scheme; *ii)* a mandatory pre-funded second tier consisting of individual, privately managed savings accounts; and *iii)* a minimum pension guaranteed by the state for those meeting age and contribution conditions. Workers born after 1968 became members of both mandatory components of the new system; those born before 1949 remained in the old, non-reformed scheme; and those born between 1949 and 1968 could choose to participate only in the first reformed tier or in the full new system.

ISBN 92-64-02631-2
Sickness, Disability and Work
Breaking the Barriers – Vol. 1
© OECD 2006

Chapter 6

Evaluating Recent and Ongoing Reforms

Sickness and disability policy in Norway, Poland and Switzerland is reaching a critical moment. In Norway, a tripartite agreement on more inclusive workplaces has recently been prolonged despite the obvious failure of its predecessor. In Poland, the new government is preparing several disability reform bills on a range of subjects. In Switzerland, forthcoming comprehensive change aims at making contact as early as possible with people at risk of having to claim a disability benefit. Seen in a twenty-year perspective, the focus on work as a central object of disability policies has intensified in all three countries, as in most other OECD countries. Benefit schemes, however, have just recently started to be reformed. Relative to the OECD average, all three countries still have generous and easily accessible sickness and disability benefit schemes.

Sickness and disability policy in Norway, Poland and Switzerland is reaching a critical moment. In Norway, despite very little improvement, the tripartite agreement on more inclusive workplaces has recently been prolonged another four years (2006-09). In Switzerland, the proposed fifth revision of the Disability Insurance Act is currently being discussed in parliament, with enactment expected for mid-2007. In Poland, the new government is currently seeking an alternative to the comprehensive reform plans of the previous government, which were rejected by parliament. This chapter summarises and evaluates the key elements of recent and ongoing reforms in the three countries.

6.1. Norway: making the tripartite agreement a success

In 1999, the government established a Royal Commission to propose reforms to the sickness and disability benefit scheme. The report of that Commission, submitted in late 2000, contained proposals for far-reaching changes, some of which were put in place in the years that followed. Among them was a temporary disability benefit, introduced as an alternative to the permanent benefit. In 2005, one year after its introduction, one-third of all new claims were awarded temporarily. Many of the Commission's other proposals, however, were strongly opposed by the social partners – in particular the plan to introduce a 20% co-payment by the employer for the entire sickness benefit period and to reduce the benefit from its current 100% to 80% of the last wage in the first 16 days. Considering the failure of recent initiatives, however, sooner or later a relaunch of the Commission's proposals might become unavoidable.

A. Efforts to reduce sickness absence

Rather than implementing the Commission's proposals, the Norwegian government decided on a different and – in an international perspective – quite unusual route, namely to shift a portion of the responsibility for solving these issues to the social partners. With the aim of reducing the outflow from the labour market into health-related benefits and early retirement schemes, a tripartite agreement was signed for 2001-05 between the government and the social partners to co-operate on strengthening active measures at the workplace – the so-called IW Agreement. The main idea behind this is that the workplace is the main arena where progress should be made (Box 6.1).

Several measures were implemented to achieve the agreement's objective to reduce sickness absence rates, including mandatory preparation of a follow-up plan for each employee after eight weeks of absence. The most important instrument appears to be the possibility for enterprises to enter into a co-operation agreement with the National Insurance Administration (NIA). IW enterprises, which by now cover some 60% of the labour force, benefit from a number of special regulations and from support from the newly established Workplace Centres of the NIA. Service from these centres can be comprehensive and include, for instance, tailored management and organisational development assistance.

Box 6.1. **The 2001-2005 tripartite agreement on more inclusive workplaces in Norway**

The three specific objectives of this tripartite agreement are:

- To reduce sickness absence by at least 20% from its level in the second quarter of 2001.
- To secure employment for a greater number of people with disabilities.
- To extend working life.

The social partners have the main responsibility for reaching these objectives. The government plays a supportive role as a provider of economic incentives to those employers that make serious efforts to achieve the stated targets. The idea of the agreement is that employers and employees in individual workplaces will co-operate closely in investigating the reasons for the employee's absence and early retirement and in developing appropriate solutions.

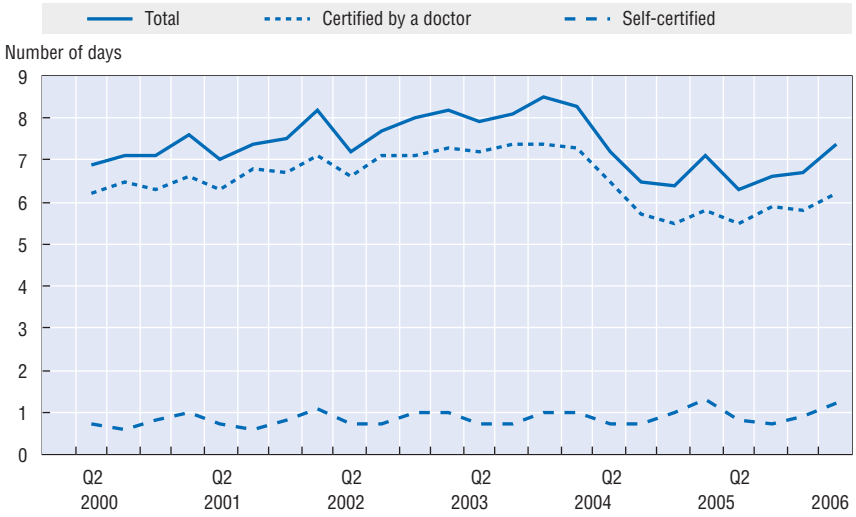
Every enterprise can sign a contract with its local social security office to become recognised as an "inclusive workplace enterprise" (IW enterprise). IW enterprises have a regular contact person at the newly established local Workplace Centre of the NIA who assists them in taking necessary actions and follows up employees on sick leave. When an employee is unable to continue working due to sickness or bad health, the employer is obliged to supply training in collaboration with the authorities so the person can be qualified for another job in the company.

Workers are obliged to inform the firm about their health situation while on sick leave, so that relevant measures can be implemented as quickly as possible. They should have a dialogue with the employer concerning changes in work tasks, participation in training or other measures necessary to continue working. In order to place more responsibility on employees and employers, workers in IW enterprises have the right to take uncertified sick leave for an extended period.

Results from a mid-term evaluation of the tripartite agreement in late 2003 were disappointing. Sickness absence had continued its increase since the mid-1990s. While the government and the social partners agreed to uphold the agreement for the full period, mainly because the IW concept has gained considerable support in the Norwegian workplace, restrictive amendments to the sick-pay scheme came into force in mid-2004. These included an evaluation of the functional capacity of the person on sick leave by a GP within eight weeks and stricter sanctions on GPs who do not comply with the new rules for sickness absence certification.

In response to these changes, in the second half of 2004 sickness absence rates suddenly dropped sharply (Figure 6.1). In the second quarter of 2005, absence rates were around 10% below the level of the reference quarter for the IW Agreement (the second quarter of 2001). Thus, around half of the targeted decline had been achieved. However, over the past year sickness absence accelerated again, and in early 2006 absence rates were almost as high as in early 2001. Compared to five years ago, doctor-certified absences had fallen by some 6% but self-certified absences had increased by 20%. Moreover, there is almost no difference in the trends in absence rates in IW enterprises and in firms that have not signed a co-operation agreement with the NIA. Sectoral differences are also relatively small, with the largest declines typically reported in sectors where sickness absence levels had been highest. On the whole, therefore, absence is going to need to fall much further if it is to get back to what used to be normal in the 1980s and early 1990s.

Figure 6.1. **Sickness absence fell in 2004 but is increasing again**
Full-time equivalent sickness absence days for employees, quarterly data 2000-2006



Source: Statistics Norway in co-operation with the National Insurance Administration (NIA).

In the medium term, the co-operation agreements of enterprises with the local NIA offices may help to set off a change in sickness management practices. Today, employers are encouraged and expected to engage in a dialogue with their employees on health problems and possible solutions at the workplace. In this process, managers can rely on support from the Workplace Centre, which is entirely free to the employer. The total costs of these Workplace Centres are small in relation to the potential savings they could produce. Total direct costs in 2004/05 were close to NOK 200 million, some 20% of which is a reallocation from PES funds. This compares with NIA costs for one day of sickness absence in the order of around NOK 400 million. Thus, the additional costs of the Workplace Centres could be offset by merely a half-day reduction in total sickness absence across Norway.

B. Extending the IW Agreement

Despite the obvious failure of the tripartite agreement to achieve its objectives (sickness absence is almost as high as it was five years ago, the employment rate of disabled persons has dropped further, and the retirement age has fallen), a follow-up agreement was signed in December 2005 for the period 2006 to 2009. In the future a stronger focus shall be put on inclusion and integration of people *outside* the labour market. However, the objectives of this follow-up deal are either disappointing or yet to be determined. In particular, the non-achieved target of a 20% reduction in sickness absence has simply been extrapolated to the end of 2009, and it is hoped that the expected retirement age will be raised by six months over the same period. Targets on reducing the share of disabled people transferring from work into inactivity, on increasing the share of people moving from disability benefits back to employment, and on increasing the share of people on long-term sickness benefit who start vocational rehabilitation will be set before the end of 2006. Whether the agreement could develop into a successful initiative very much depends on these specific targets.

Outcomes in relation to the agreement's objectives shall be analysed twice a year, and adjustments may be made if outcomes are disappointing. A full evaluation of the agreement is planned for 2009. It is also possible to terminate the agreement if achieving the objectives proves impossible. However, the follow-up agreement also stresses that "the government will not propose any changes to the current sickness scheme during the period of the agreement, neither for employers nor for employees, unless all actors agree to do so". In view of the disappointing outcomes so far, this standstill promise might become a big obstacle. Again, the government has given away much of its powers to the social partners and has little possibility of influencing outcomes.

6.2. Poland: preparing the next comprehensive steps

In Poland, reform in recent years was characterised by attempts to tighten entitlement to both sickness and disability benefits while at the same time gradually strengthening the focus on medical as well as vocational rehabilitation. So far, the latter has had very little impact.

A. Successful tightening of access to benefits

Stricter rules for the issuing of sickness absence certificates and more control of GPs' decisions were introduced in 1998. By 2000, absenteeism fell by one-third and has remained constant since then. Inflow into disability benefits also started to fall very sharply after 1999, and continues to do so. The two key changes responsible for this decline are the introduction of a new disability assessment procedure and a more restrictive approach to granting permanent disability benefits. However, it remains to be seen whether this is indeed a sustainable and long-lasting decline. Over the same period, inflow into early retirement increased very rapidly, and the unemployment rate increased as well.

These changes in the disability benefit system came in parallel with the takeover of the disability assessment for farmers by KRUS (the special system for farmers and their dependants) in 1997. Despite a lack of equivalent change in the procedures and rules for farmers, inflow into that scheme also fell, though not as much as the inflow to the general disability benefit scheme. This suggests that more awareness and changing practices on the side of GPs as well as a substitution element – *i.e.* a growing number of people moving into welfare benefits other than disability in response to the tightening of the disability benefit regime – have been the key explanatory factors of recent change. This in turn could mean that with phasing-out of early retirement in the near future, there is a great risk that the declining trend in inflows into ZUS as well as KRUS disability benefits could turn around again very soon.

Despite the steep fall in inflows to disability benefits, the number of people receiving such benefits is still very large; consequently, spending on disability benefits is very high. The previous government therefore suggested a reassessment of those receiving permanent disability benefits under the age of 55 (age 50 for women). This proposal was made in the context of a more comprehensive public expenditure reform aimed at improving work incentives and lowering public social spending. But parliament rejected the reform in late 2004 so that most of the recommendations were not enacted or, if so, only partially. One measure implemented in 2004 was a reduction in the replacement rate for long-term sickness absences of more than three months, from 100% to 80% of the past wage. Reform plans of the new government would do well to relaunch some of the proposals made in 2004 (Box 6.2).

Box 6.2. **Withdrawn 2004 public expenditure reform plans in Poland**

In 2004, the Polish authorities were considering a number of labour market reforms aimed at increasing labour supply, reducing work disincentives, getting beneficiaries back into work and (thereby) lowering public spending on passive social benefit programmes. Many of these changes concerned the disability benefit scheme (both the ZUS and the KRUS scheme).

The plans for the sickness and disability benefit system included:

- A reduction in sick leave compensation from 80% to 70% of wages.
- A reduction in the number of categories of disability pensions.
- A reduction in the current number of disability benefit recipients through a re-evaluation of all long-term recipients under the age of 55 (men) and 50 (women).
- A return to a system whose benefits are more closely linked to past earnings and more closely related to the extent a disability limits a worker's earnings potential.
- An automatic transfer from disability to the old-age pension scheme upon reaching the retirement age.
- A strengthening of the monitoring and re-examination of temporary disability benefits.

Parallel plans for the farmers' disability benefit system included:

- A redefinition of eligibility criteria so as to harmonise them with the ZUS criteria.
- A reduction of benefit levels and an increase in contribution rates in the KRUS scheme so as to reduce differences between the KRUS and ZUS systems.
- An introduction of contribution subsidies for farmers with lower earnings.
- The creation of a rehabilitation allowance similar to the training pension in the ZUS scheme to help farmers return to work after prolonged periods of sickness.
- More generally, further attempts to eliminate misuse of the KRUS scheme.

B. Piecemeal reform of the system of employment support

In parallel with the tightening of the sickness and disability benefit schemes, more possibilities were introduced for rehabilitation of benefit applicants. First, benefit authorities were given responsibility for medical rehabilitation aimed at reducing the likelihood and duration of disability benefit receipt (ZUS since 1995, KRUS since 1997). In a second step, possibilities for vocational rehabilitation were introduced (ZUS since 1997, KRUS since 2005). The latter change, however, has not yet had much impact, with only 2% of the applicants for a disability benefit ever receiving a so-called training pension for purposes of re-qualification. Reasons for the low take-up include stringent eligibility criteria, a limited number of places on re-qualification programmes, and applicants' fear of loss of entitlement to long-term benefits.

As effective as the tightening of access to sickness and disability benefits was, this has not prevented a further drop in the employment rates of disabled people. The continued focus on subsidised work outside the open labour market, with generous wage subsidies and tax relief to Sheltered Work Enterprises (SWE), has not brought disabled people closer to the open labour market. In particular, subsidies have so far benefited employers more than employees, as they allowed them to hire very cheap labour with (in many cases) only mild disabilities.

Recent policy change in the course of Poland's accession to the EU has opened the generous and permanent wage subsidy scheme to employers in the regular labour market (rather than restricting it to SWEs). This has led to a slight increase in the number of firms voluntarily employing disabled people and the number of workers with a disability employed in these companies. However, the change also brought new challenges for the future, because companies that fall under the quota regulation are eligible for wage subsidies for *all* their disabled workers, and because wage subsidies are paid out of the funds collected from employers *not* fulfilling the quota. If more employers were to hire disabled people, the size of the fund would decline while wage subsidy spending would increase. These rules could only be maintained if the intention to raise the employment rate of disabled people remained unfulfilled.

The entire system of employment support for disabled people, as regulated under the act on employment and vocational rehabilitation of disabled people, appears to be ineffective. Neither generous wage subsidies nor the employment quota scheme have brought disabled people closer to the labour market. Two key aspects in this context are governance and stability of the system. With some 40 amendments of the respective legislation since its introduction in 1991, employers have limited trust in the system and tend to avoid dealing with the administration. Instead, most prefer to pay the relatively high levy (of around 40% of the average national wage per worker not employed). This results in very large revenues for PFRON, in turn raising the issue of governance of these funds. PFRON is perceived as a rather passive institution, as is the PES when it comes to jobseekers with health problems or disabilities. Both agencies contribute little to fight the low level of inactivity of this population group. Improving this situation is the key challenge for the future.

6.3. Switzerland: bringing the "fifth revision" on track

Based on an assessment of the years 1985-2000, OECD (2003a) identified Switzerland as the country that had undergone the fewest changes in the area of sickness and disability policy throughout the OECD area. That is no longer the case. Following a discussion process on comprehensive reform steps that began in the mid-1990s, the fourth revision of the Swiss Disability Insurance Act finally came into force in 2004. Preparations for the fifth revision had by then already begun.

A. Improving the medical tools

The three new key elements introduced with the fourth revision were the following:

- The introduction of regional medical services (RAD) to provide more uniform and qualitatively better disability assessments throughout the country.
- The upgrading of active job placement services by the cantonal offices of the disability insurance, with an entitlement to active jobseeking assistance and better advice to employers.
- The introduction of a three-quarter benefit (for those with 60-69% reduced earnings capacity) so as to increase the likelihood of retested full-benefit recipients moving back into work.

The provision of active job placement services by the cantonal disability insurance offices (CDO) is potentially an important change requiring major investments for its full implementation. In particular, more and differently qualified case managers or job brokers

are needed for this service. So far, only a small part of these investments have been made. The new job placement service of the CDOs is in addition to and independent from similar services offered by the PES, which raises issues of efficiency and co-ordination. It is argued that only the CDO case manager has the necessary know-how to solve the many problems disabled people are facing in getting back into work, while the PES tends to treat even those people with only mild health problems as very difficult if not hopeless cases. Against this, however, stands the network with employers and other labour market players used by the PES caseworkers. It remains to be seen whether building a new placement structure is the most effective and most efficient way to go.

Perhaps the most important change in the course of the fourth revision was the introduction of the regional medical services (RAD), which are independent from the CDO in terms of their core activities, but administratively under CDO supervision. Today there are ten RADs throughout Switzerland, in most cases set up in co-operation between several CDOs.[1] The objective of this change was twofold: to provide a more objective and independent medical assessment for the 10-20% of cases that are most difficult, and to force smaller cantons to collaborate with neighbouring cantons. Both should contribute to a harmonisation of the assessment process across Switzerland. Together with more frequent auditing of CDO practices and the introduction of better monitoring systems, the new RADs are likely to have contributed to the recent fall in inflow rates into the disability benefit scheme by roughly 9% in 2003-04 and by a similar amount in 2004-05. However, part of this decline is the result of an increase in backlogs.

B. Efforts to reach people with work incapacity earlier

While the fourth revision improved the medical tools of the disability insurance, the fifth revision aims to supplement the necessary social and vocational tools, thereby completing the process started with the 2004 reform (Box 6.3). As in Norway, a major problem in Switzerland is the lack of intervention during the sickness phase and the late start of any reintegration process. When people turn to the CDO, they have typically been out of work for many months and often have lost their job. The key focus of the planned revision, therefore, is to get in contact as early as possible with people at risk of obtaining a disability benefit later on. This should be done through three steps, all of them under the responsibility of the CDO: *i)* early identification of health problems, ideally after a period of four weeks, to prevent long-term work incapacity; *ii)* early and short-duration intervention, if needed, to avoid job loss (*i.e.* relatively cheap but effective intervention that does not require a comprehensive assessment process, for instance adaptation of the workplace); and *iii)* provision of new types of integration measures predominantly aimed at preparing people for subsequent vocational rehabilitation and reintegration and targeted to persons who had been at least 50% work-incapacitated for a period of at least six months.

It is hoped that each year around 20 000 people will be identified early,[2] with 10 000 of them participating in early intervention measures and 5 000 in new preparatory integration measures – thereby resulting in the targeted 30% decline in the annual inflow into disability benefits. Whether this target will be achieved remains to be seen. According to the plan, all players – the disabled workers themselves, their employers, their doctors, their relatives, the private health insurer, the private sickness benefit insurer, etc. – are allowed to inform the disability insurance of a potential case where intervention might be needed. All of this is however voluntary, which is why it will be crucial to get the incentives right for all key actors involved, including the 26 CDOs themselves.

Box 6.3. **The planned fifth revision of the Swiss Disability Insurance Act**

The fifth revision of the act aims to reduce the deficit of the insurance system by reducing the annual inflow into disability benefits by 30% (from its 2003 level), removing negative incentives with regard to taking up rehabilitation and work, and making a substantial contribution to improving the financial health of the system through austerity measures. The main changes proposed to the parliament are:

Curbing the rise in the inflow into disability benefits

- Early identification (after four weeks) of potential work incapacity to prevent disability.
- Early intervention to avoid job loss.
- New integration measures to prepare for vocational rehabilitation and reintegration.
- Strengthening the obligation to co-operate, including new sanctions.
- Stricter access to disability benefits through a modified definition of disability.
- Abolition as far as possible of retrospective payment of disability benefit (which can only be paid six months after registration with the IV).
- Increase in the statutory minimum contribution period from one to three years.

Correcting negative incentives

- Further adjustments to the system of daily allowances for rehabilitation purposes.
- Prevention of loss of income in case of employment take-up.

Austerity measures

- Waiving the career supplement for new disability benefit recipients under the age of 40.
- Shift of medical rehabilitation without a work perspective to the health insurance system.
- Abolition of supplements for spouses of all current benefit recipients (*i.e.* not only for new cases, as under the fourth revision).

There are also new risks arising from this new approach, which ought to be monitored closely. Early identification bears the danger that "medicalisation" of labour market problems will take place at an even earlier stage. It is hoped to counteract this in two ways: firstly, by rapid clarification within a period of six months of whether persons are eligible for disability benefits (which in turn should function as a deterrent for application), while making access to benefits more stringent; and secondly, by providing early integration-oriented intervention where needed. The premature assessment of probable entitlements has pros and cons. It aims to overcome the long duration of the full disability assessment process, and hence is a compromise between precision and speed, with the latter regarded as crucial. However, there is a risk that this premature assessment will be used by caseworkers to screen ineligible people early and to put less focus on efforts to reintegrate them. This would be detrimental to the idea of prevention of disability through early identification and early intervention.

The fifth revision also aims to correct negative work incentives. Apart from some adjustments to the system of rehabilitation benefits, however, this part of the reform is rather vague. The baseline is that no one should receive a benefit higher than the previous income, and no one should lose income in the case of taking up work. OECD tax-benefit model results show that weak work incentives are a major issue in the Swiss system that

need to be addressed more forcefully, also to ensure that other parts of the reform will succeed (Chapter 4).

Even the targeted 30% decline of the disability benefit inflow, were it to be achieved on a sustainable path, would not suffice to reduce the rapidly growing deficit of the disability insurance. Therefore, the fifth revision is almost certainly going to be supplemented by revenue-side measures: an increase in the contribution rate to the disability insurance from 1.4% to 1.5%, and – more importantly in terms of its effect – a targeted increase in value-added tax in the order of 0.8%. While the latter is scheduled to be temporary and withdrawn once the deficit has come under control, estimates suggest that it will certainly have to be maintained for a period of around 20 years or so. Given the many responsibilities of the disability insurance, revenue-side measures are indeed justified and necessary.

6.4. The impact of recent and ongoing reform

Reforms to the sickness and disability policy system undertaken in the past 20 years, as well as insufficient reform of the disability benefit system in most cases, are essential factors for current outcomes in each country. OECD (2003a) developed two indices of policy – one on integration policy and the other on compensation policy – in order to illustrate and compare countries' policy stances and to assess broad trends in policy development (Box 6.4).

Box 6.4. **Illustration of countries' policy stances and trends**

Many different dimensions of policy need to be considered when assessing the overall stance of a system. In order to get a reasonable overview of what is happening in policy both over time and across countries, an index of the various policy parameters can be useful.

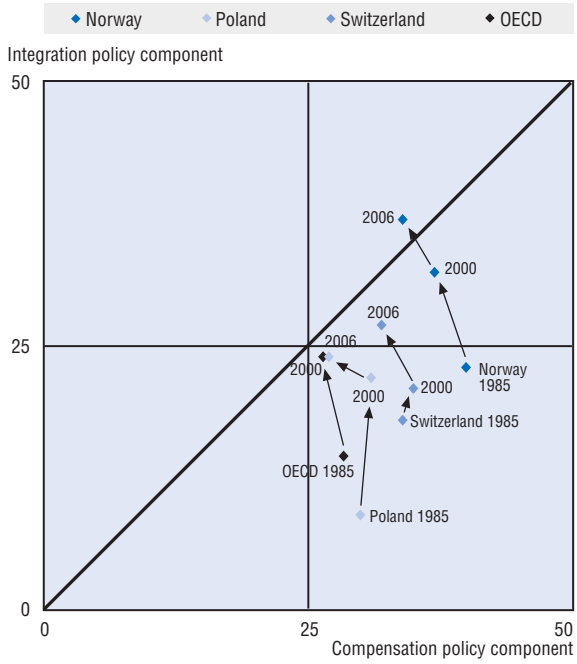
Indices in two dimensions have been developed in OECD (2003a). The first is the level of compensation. The index of compensation takes into account ten policy parameters: *i)* coverage of the benefit system; *ii)* the minimum disability level; *iii)* the disability level needed to get a full disability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

The second dimension is that of integration. Again, ten parameters are taken into account: *i)* access to different programmes; *ii)* the consistency of the assessment structure; *iii)* employer responsibility; *iv)* supported employment programmes; *v)* subsidised employment programmes; *vi)* the sheltered employment sector; *vii)* vocational rehabilitation programmes; *viii)* the timing of rehabilitation; *ix)* benefit suspension regulations; and *x)* work incentives. As with the compensation dimension, each of these sub-dimensions is rated from zero to five and assigned equal weight. A country that has a higher integration score is one that has a more active policy in ensuring that people with disabilities can find work.

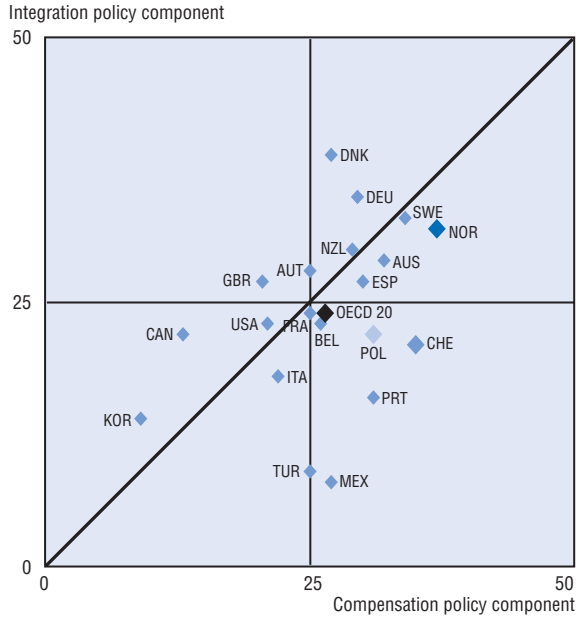
According to this policy typology, compared with the OECD average in 2000, all three countries covered in this review were characterised by a relatively generous and accessible disability benefit system (Figure 6.2, Panel B). Norway also stood out as one of

Figure 6.2. **Comparing sickness and disability policies over time and across countries**

Panel A. Disability policy typology in the three countries around 1985, 2000 and 2006



Panel B. Disability policy typology in 20 OECD countries around 2000



Source: Authors' update based on OECD (2003a), *Transforming Disability into Ability*, OECD, Paris.

the countries with a particularly strong integration policy focus, similar to other Nordic countries, while Poland and Switzerland were found slightly below average on this account.

Throughout the OECD area, *integration* policy elements have been strengthened, sometimes considerably, with a strong convergence in policy objectives. OECD (2003a) estimated on average across 20 countries a 10-point increase on the 50-point integration policy dimension over the 15-year period from 1985-2000 (Figure 6.2, Panel A). This change contrasts with a relative lack of reform of *compensation* policy; benefit programmes have remained virtually unchanged in most cases. In theory, there is nothing wrong with a policy stance that increases the integration focus of disability policy without substantially changing the compensation package. In practice, however, there are dangers in following such an approach. Other benefits – such as unemployment, social assistance, early retirement – have often become less generous (more often by restricting access than by reducing benefit levels). The near absence of any such reforms in disability benefit schemes bears the risk that the latter stands out all the more as being the last-resort benefit, to which those who do not wish to work or those whom benefit officers despair of activating gravitate. This undermines the more positive work focus that governments have been trying to follow and that is in the interests of the majority of those on the benefit.

Norway, Poland and Switzerland are no exception to this general trend in the period 1985-2000, even though Switzerland had hardly instituted any reform in that time frame. However, continued policy adjustments in the past few years in all three countries, taking ongoing reform into account, suggests that the situation is changing. First, the work focus has continued to spread since 2000 (Figure 6.2, Panel A). In this relatively short period, the shift was strongest in Switzerland and least pronounced in Poland. As a consequence, the overall change in the three countries during the last 20 years had been similar (10-15 points on the 50-point scale). Secondly, all three countries have also seen a tightening in their sickness and disability benefit schemes (mostly a tightening in access), resulting in a three to four-point decline on the compensation policy scale. This could help improve the effectiveness of the integration approach.

Relative to the OECD average in 2000, all three countries nevertheless still appear to be having generous and accessible sickness and disability benefit schemes. Furthermore, despite reform, Poland and Switzerland still have a much less developed integration policy focus when compared to Norway – noting that this typology of policies says nothing about their implementation or effectiveness. This suggests that there is room for further change, and also that any such change should take both the integration and the compensation side of the sickness and disability policy package into account. In the next and final chapter of this report, more detailed recommendations are made as to the direction and particulars of further promising reform steps.

Notes

1. The new RADs are not replacing the specialised medical assessment centres (MEDAS), which continue to handle particularly complex cases. A MEDAS assessment, a service connected with a hospital, takes two years – on average much longer than a normal application procedure.
2. Compared with an inflow into disability benefits of around 25 000 in 2004, and an estimated number of around 200 000 people who have longer-term sickness absences of more than four weeks.

ISBN 92-64-02631-2
Sickness, Disability and Work
Breaking the Barriers – Vol. 1
© OECD 2006

Chapter 7

An Agenda for the Future

What are the most promising avenues of reform in Norway, Poland and Switzerland? All three countries are facing high costs because of high or increasing numbers of people receiving sickness and disability benefits. Too few people with health problems find employment. In all three countries, too little is done to avoid the outflow from work to benefits and to help benefit recipients to move back into employment. At the same time, financial incentives to work and obligations for disabled people on benefits as well as employers responsabilities to retain or hire people with disabilities are too weak. Many people with health problems can work, and want to work. Having a policy based around an assumption that they cannot work is fundamentally flawed. Improving the situation will require broad-reaching reforms in all three countries.

All three countries reviewed have to put up with high public costs associated with high or increasing numbers of people receiving sickness and disability benefits and low rates of employment of people with health problems. In all cases, broad-reaching reforms will be needed to improve current outcomes. The different nature of the underlying problems, such as the persistently high rates of inflow into sickness and disability benefits in Norway, the rapid rise of non-specific and mental diseases in Switzerland or the dysfunctional, segregated labour market in Poland, means that different cures are called for. Even so, the three countries also face a number of challenges common to all schemes. One example is the lack of proper sickness prevention and monitoring, which results in considerable delay of adequate intervention for most people in need of help – a delay that is very costly in the long run. This chapter discusses promising avenues of reform for the three countries.

In Chapter 1, seven key policy challenges were identified where reforms are most needed. Based on the analysis of policies and outcomes in Norway, Poland and Switzerland in Chapters 2-5, all three countries are facing strong pressure on public spending for incapacity-related programmes. Other than that, the policy challenges differ (Table 7.1). The key issues in Norway are to reduce the very high inflow into sickness and disability benefits and to raise the negligible outflow from disability. The latter also holds for Switzerland. The main challenges in Poland, on the other hand, are to raise the very low rate of employment of disabled people and, as in Switzerland, to strengthen the

Table 7.1. **The magnitude of the policy challenge in Norway, Poland and Switzerland, 2006**

Seven key policy challenges and related key outcomes[a, b]	Norway	Poland	Switzerland
1. Controlling incapacity-related public spending	+++	+++	+++
Public spending on sickness and disability benefits, in % of GDP	4.1	3.6	2.7
2. Raising employment rates for people with health problems	++	++++	+
Employment rate of disabled people of working age (percentage)	44.7	17.6	52.1
3. Tackling lower incomes of households with disabled people	+	+++	++
Relative poverty of disabled people of working age (percentage)	5.4	10.3	9.5
4. Reducing the inflow into sickness and disability benefits	++++	+	++
Rate of inflow into disability benefit, in % of population at risk	1.1	0.4	0.5
5. Addressing the increasing medicalisation of labour market problems	++	+	+++
Inflow into disability benefit due to mental problems (percentage)	25.4	16.9	41.0
6. Raising the outflow from usually permanent disability benefits	++++	+++	++++
Rate of outflow from disability benefit into work, in % of recipients	0.5	2.5	1.1
7. Strengthening co-ordination across different benefit schemes	++	++++	+++
Rejected disability benefits, in % of all applications	26.1	54.5	42.0

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

b) *Public spending* on sickness and disability benefits excludes employer-paid wage payments in the first weeks of absence. *Relative poverty* is defined as the share of persons with incomes below 50% of the median income of the entire population. *Rejected disability benefits* are applications for a benefit turned down by the benefit administration due to non-eligibility.

Source: Authors' assessment. Outcome indicators are replicated from the various analytical chapters of this report.

co-ordination between different benefit schemes and employment support measures. Switzerland also faces serious challenges because of the increasing medicalisation of labour market problems, visible in the rapid increase in mental and non-specific health problems.

7.1. Key problems and possible solutions in Norway

While an affluent country like Norway may be able to afford high public spending on sickness and disability benefits, the outcomes are unacceptable in the longer run. With the highest rate of inflow into sickness and disability benefits in the entire OECD area in tandem with rather high overall levels of labour market participation, today the major share of inactivity among the working-age population is due to health-related problems. Raising employment and labour force participation rates further – which is essential in order to respond to population ageing and to maintain economic growth – therefore requires, first and foremost, that sickness no longer be the major reason for dropping out of the labour market.

While recent changes in the context of the IW Agreement have started to make inroads into the problem of persistently high rates of inflow into long-term disability benefits, much more needs to be done. In the following, ways are identified to improve the outcomes of the proposed follow-up agreement. In addition to efforts to lower sickness absence, measures should seek to reduce disability benefit inflow rates and to increase labour market reintegration of those currently on benefits or otherwise inactive due to a health problem.

A specific challenge in Norway is that while the system contains many promising elements, their take-up is low and outcomes are poor. The key, therefore, is to understand better *why* the existing frameworks (which look good) are not delivering; if the reason is lack of enforcement and implementation, how to tackle this; and if it is wrong incentives, how to change them. Indeed, very little is known about how the existing provisions and regulations are being implemented by local actors.

A. Inflow management and assessment procedures

During the past decade, Norwegian sickness and disability policy making aimed at shortening benefit duration and intensifying follow-up, while leaving benefit levels unchanged. However, this policy principle has not been followed fully in the past few years, and it will be difficult to continue it in the future if outcomes are to be improved. To begin with, in order to implement this policy principle fully, measures and reforms would have to be matched by *stricter mutual obligations* and *better-enforced sanctions* in case of non-fulfilment. In addition, for future reforms, a new balance should be sought between better work incentives and tighter eligibility criteria.

Sickness absence is a good example. Criteria for long-term absence were tightened and more obligations introduced, especially for GPs and employers (see below). In doing so, the IW approach was a first important step helping to lift sickness from a private matter to a more openly discussed issue. However, reform stopped halfway. Since 2004, GPs are obliged to assess functional capacity and to investigate the potential of graded and active sick leave, but there is hardly any control of GPs in this regard. Sanctions for non-fulfilment of duties – in the form of (temporarily) losing the right to certify longer-term sick leave, thereby affecting GPs' income and reputation – are possible and desirable**,** but they are not

applied. *Frequent control* of GPs' sickness assessments by social insurance doctors, as is common in many OECD countries, and actual use of sanctions could strengthen the system significantly.

The assessment of long-term disability still relies too heavily on treating doctors (today, more than 80% of all disability assessments are prepared solely by GPs). Following the general practice in most OECD countries, treating doctors' assessment and gatekeeping functions should be reduced in exchange for strengthening their guidance and assistance functions. Efforts within the IW Agreement instead seem to be strengthening the gatekeeping function, which is too demanding for the GPs and also undesirable for the patients who lose their medical advocates. The medical *assessment and gatekeeping functions* for disability benefit eligibility should, therefore, be handed over to the NIA and its specialised insurance doctors.

Furthermore, in the transition from work to sickness and disability, a stronger emphasis should be placed on *functional and vocational assessment*. The obligatory functional assessment by the GP after eight weeks of sickness absence is a step into the right direction, but for this to be done properly vocational experts need to be involved. They could be experts employed or contracted by the NIA (as would seem appropriate for the assessment of disability) or a special occupational health service available to the GP to provide occupational health advice as well as advice on workplace adaptations and rehabilitation opportunities. In this context there is also an urgent need to evaluate the use and impact of graded and active sick leave, to understand the extent to which these regulations contribute to the high absence rate or to recent improvements.

Better management of sickness absences can only be achieved through the strong *involvement of employers*. Along these lines, the recent establishment of independent workplace centres – which supply services to employers through dedicated contact persons – in every region in Norway is an innovative and promising approach. To strengthen this new structure, the advisers should approach managers more proactively and disseminate good management practice in terms of sickness prevention and monitoring. In a second step, the role of these workplace centres in increasing the *hiring* rates of disabled people should be reinforced.

Another important change to improve sickness management is the new obligation for employers to prepare a *follow-up plan*. This could be promoted further in various ways. First, it is necessary to evaluate the impact of this new obligation. Secondly, employers may need more support in fulfilling their obligation. To the extent possible, support should include guidance by the patient's doctor or the above-mentioned occupational health service. Thirdly, in exchange for providing better guidance and information, fulfilment of the employer's obligation to prepare such a follow-up plan should be checked, and non-fulfilment sanctioned with financial consequences.

However, implementing these suggestions may not be enough to reduce sickness absence rates further. The replacement rate of 100% for 12 months and the short employer-paid period of 16 days are not conducive to further change. Therefore, a better balance between financial incentives and enforcement of obligations, for employees as well as employers, should be pursued. *Employee incentives* could be strengthened through lower replacement rates (of maybe 75-80%) for long-term absences. Better *incentives for employers* could be achieved either through a longer period (of maybe 4-6 weeks) during which they would have to continue wage payments in case of sickness absence, or through more

flexible, experience-rated premiums to the sickness benefit insurance. To avoid increases in labour costs, such change could be combined with a reduction in social security contributions, thereby rewarding employers investing in sickness management and prevention.

B. Vocational intervention, outflow management and work incentives

Vocational interventions are another way to prevent long-term work incapacity and disability. Vocational rehabilitation and training is used widely in Norway, but this has not helped to reduce the very high inflow into disability benefits. More evaluation is needed to understand the reasons for this lack of success – including evaluation of the recent changes to the rehabilitation system, which introduced new duration limits. It is important to uncover which of the available programmes are most appropriate for whom, and to distinguish successful programme chains from those that merely contribute to postponing the disability benefit award. Indeed, it appears that many people are "sitting" on a rehabilitation benefit and waiting to be placed in a programme. Efforts should be made to speed up the transition into a measure and to get more people on rehabilitation benefit into a programme. Geographical and occupational mobility requirements are too weak and the durations of many programmes still too long. Employment outcomes could be improved through a stronger focus on employment-oriented measures, thereby reducing the current dominance of education measures.

In addition, better integration of medical and vocational rehabilitation is needed. In Norway, medical rehabilitation is the responsibility of the health sector, while vocational rehabilitation is under the responsibility of the PES. *Closer co-operation* between the different actors and common objectives are needed, including to goal to restore the work capacity, to ensure that medical and vocational rehabilitation go hand-in-hand, ultimately improving the labour market outcomes of the entire rehabilitation process. Moreover, as with vocational rehabilitation, many people are "sitting" on a medical rehabilitation benefit without actually receiving any treatment or intervention. The duration of medical rehabilitation benefit receipt should therefore be reduced further, *i.e.* limited to the time actually needed to restore or improve the health status of the person concerned. This will further accelerate the transition into vocational rehabilitation and, thus, the transition into work.

Given the large share of the population on disability benefit, the Norwegian government should also concentrate on measures to *increase outflows* from benefits into work. One element of this could be a re-evaluation of the work potential of current beneficiaries of a permanent disability benefit, at least of those still far from retirement age. Reassessing the work capacity of beneficiaries and cutting or withdrawing benefits from those with sufficient work capacity, however, are not ends in themselves. Examples of similar retesting exercises in the United States (in the mid-1980s) and the Netherlands (in the mid-1990s) have shown that those people (*i.e.* people who were assessed to be able to work but cannot simply return because they have lost their job) nevertheless often tend to end up on disability benefits. They therefore have to be provided with special support. That support should include tailored job-search and placement services and, if needed, vocational rehabilitation and retraining, but also a secure benefit payment until successful reintegration into the labour market.

Already in 2004, a *temporary disability benefit* was introduced to reduce permanent exits from work. The impact of this measure could be enhanced in various ways. First, it is too

early to rule out that the major effect of this change is an easing of entry into disability benefits, as indicated by rapid increases in the inflow among those around age 30. Further evaluations should therefore focus on the likelihood of returns to work and transfers of those on temporary benefit to a permanent disability benefit, as well as on practices in awarding a temporary entitlement. Secondly, it is of key importance to follow up those people granted a temporary benefit, for they are likely to need additional support to return to employment. There is little evidence so far that such follow-up and assistance are taking place. Thirdly, at around one-third, the share of people granted a temporary rather than permanent disability benefit is low from an international perspective. Far more people should have the potential to improve their health situation and thus their work capacity. The authorities should aim to reduce further the share of permanent disability benefit awards.

Similarly, the share of beneficiaries receiving a *partial disability benefit* is very low, despite a very fine grid of partial benefits. In Switzerland, for instance, a much larger proportion of disability benefit awards are partial, although the Swiss system grants a full benefit for a 70% work capacity reduction; Norway on the other hand requires a 100% work capacity reduction for a full entitlement. This suggests that far more emphasis could be placed on how partial benefits are awarded, and on efforts to move beneficiaries with a full benefit into partial work via a stronger focus on partial payments.

In order to raise outflow rates, *work incentives* for beneficiaries of a temporary or permanent disability benefit need to be improved. Currently, a full benefit can only be combined with marginal earnings, and for people with a partial benefit additional earnings would quickly result in a reduced benefit. This should become more flexible in order to make the transition into work more attractive. One problem is the higher benefit level for a temporary benefit, which further reduces work incentives for those likely to have a higher chance to return to work. This difference from the level of a permanent disability benefit should be removed. Another problem is the favourable tax treatment of permanent benefits in comparison to taxation of labour income, which should also be removed. In-work payments for beneficiaries taking up work or increasing their working hours could also be considered. In this context, the ongoing pilot projects where disability benefits are used as temporary wage subsidies (for up to three years) are a promising method. The reasons for the low use of this regulation should be analysed carefully and actions taken in response to raise the take-up.

Those people whose application for a *disability benefit was rejected* are another group to which national authorities should pay particular attention. Often these people do not get the necessary help to remain in or return to work. In light of the recent increase in rejection rates, this is becoming ever more important. For other countries, it has been shown that rejected applicants often end up on disability benefit in the long run.

C. Improving the institutional setup and synchronising different schemes

The *original IW Agreement*, which ran from 2001 to the end of 2005, has recently been extended for another four years (2006-09) even though it has not achieved any of its objectives. Rightly, the new agreement puts a stronger focus on the labour market integration of (disabled) people outside the labour market. However, the objectives of the follow-up agreement are unimpressive and in addition have been left open in most cases. In order for the new agreement to contribute to improving outcomes, targets on disabled people moving from work into inactivity and on transfers from disability benefits back to

work will need to be ambitious. Moreover, additional action on the legislative side should be taken as soon as targets are missed. This holds especially for the target to reduce sickness absence, which is likely to need complementary changes in the sickness benefit system. This is unlikely to happen, though, because unfortunately the government has again accepted a veto on systemic reform and promised to refrain from changing the sickness scheme without agreement from all partners.

With the forthcoming *reform of the old-age pension system* yet to be agreed in detail, it will be difficult to leave disability benefit levels unchanged. An increase in the disability benefit inflow among older workers following introduction of old-age pension deductions for those retiring before the age of 67, as foreseen in the reform, is very likely. Good co-ordination of old-age pensions and disability benefits should be based on two principles. First, full contribution payments by disability benefit recipients should be made to the retirement fund during periods of benefit receipt to ensure adequate old-age pension entitlements upon reaching the retirement age. Second, the disability benefit formula should be adjusted so that disability benefit does not exceed the corresponding early retirement benefit entitlement at the same age. That implies that the collectively agreed early retirement scheme needs to be integrated into the forthcoming reform of the pension system as well.

The *merger of the PES and the NIA*, at national as well as local level, could help ensure that all persons with disabilities get the right service at the right time. Through integration of the social welfare offices, it could also reduce the risks of carousel effects between different support sectors. However, clearer guidelines for the institutions involved are needed to establish a joint front-line service successfully. The different management styles and approaches of the PES and the NIA will have to be harmonised to achieve a uniform, work-oriented approach throughout the country. Clearer guidelines will be needed for co-operation with the local social assistance agencies. Managing the merger would also mean that targets will have to be set for the achievement of certain goals. Sufficient investments are also needed for proper training for caseworkers of the new merged institution and to harmonise the IT systems of the different institutions.

Better governance of the local NIA (or soon EWA) offices, which lack financial incentives to deliver good work outcomes, is also needed. Incentives for the PES through target agreements have been introduced quite successfully in many OECD countries. This approach is still much less common for social insurance agencies. The PES/NIA merger in Norway should be used as an opportunity to introduce better supervisory mechanisms. Only with proper tools and indicators to measure the performance of local offices delivering the services is it possible to implement competition for best practice, thereby putting pressure on worst performers to strive for better outcomes. In this regard, Norway might be able to benefit from the experience in Switzerland, where a similar plan to introduce better supervision through target agreements and effectiveness indicators is being pursued. In a second step, financial incentives for local EWA offices delivering services to people having problems on the labour market will need to be improved.

7.2. Key problems and possible solutions in Poland

Poland is facing extremely low levels of labour market participation of disabled people, with less than one in five employed. Since 1990, benefit and employment support schemes were changed substantially but by and large unsuccessfully, partly due to the overall poor

labour market situation. The new work-oriented elements of the Polish system appear to exist on paper only, with almost zero take-up of, for instance, vocational rehabilitation. This is explained by a number of factors, including a lack of interest among people with health problems and a lack of availability of appropriate programmes. Instead, the traditional segregation approach is still dominant. As a result, more than one in three disabled people are working in sheltered work enterprises. If in employment, disabled people tend to have part-time, temporary jobs or to work self-employed or as family workers. They are highly overrepresented in the agricultural sector and underrepresented in the public sector.

Some of the policy changes in the past decade, however, have been successful. Inflow rates into disability benefits, higher than anywhere else in the OECD area in the early and mid-1990s, have fallen rapidly ever since and are now below the OECD average. Outflow rates from mainly temporary disability benefits are also higher than in most other countries, including Norway and Switzerland. These are important prerequisites for integration policies to be put in place more forcefully and effectively. Also needed are general labour market and product market policy reforms aimed at making work pay and raising labour demand so that work can become a realistic option for persons with a disability.[1]

Various possible solutions are discussed below that could make the entire Polish sickness and disability system more functional. Indirectly, some of these measures could also encourage a shift from informal to formal employment, as many beneficiaries of disability benefit currently work in the informal economy. Some of the elements of the current system probably need to be abolished or replaced altogether if a real change in policy and outcomes is to be achieved. In most cases, however, the suggested policy changes focus on how to eliminate key weaknesses and bolster key strengths of the various systems currently in place.

A. Inflow management and assessment procedures

Despite reforms that successfully reduced *sickness absences*, absenteeism is still higher than in a majority of OECD countries. Partly this is explained by relatively high sickness benefit payments, often topped up to 100% of former earnings. To maintain these high benefit levels, it will be necessary to tighten access further. In particular, ZUS should be given the possibility to control work incapacity more forcefully in an early phase – including the first, 33-day sickness period during which wage payments continue to be paid by the employer. Moreover, better use should be made of existing legal possibilities for checking sickness absences of all durations and sanctioning treating doctors who repeatedly assess "false" sickness. In addition, more focus should be placed on *sickness monitoring*, in close co-operation with employers who should be given the necessary assistance and information to support the insurance institution in doing this.

Inflow into disability benefits has fallen remarkably in the past few years in response to changes in the assessment process. However, this outcome was in part the result of an increased use of early retirement for people over age 50 and an increased inflow of younger age groups into social pensions. More analysis is needed to understand better the causes of the rapid decline in inflow rates. To some extent the decline is also explained by swift increases in benefit rejection rates. To ensure that inflow rates remain low in the future, it will be important to monitor and follow up on people who had been refused a disability benefit, in order to prevent this group from becoming disability benefit recipients at a later stage. Many of these people are likely to need some help remaining in or re-entering the labour market, *e.g.* in the form of workplace adjustments.

Appeals against rejected benefit claims are also very high in number and the proportion of successful appeals is on the rise, which raises further concerns. With almost every second rejected benefit being turned into an entitlement (compared to some 10% in most other OECD countries), the exclusion error is far too high in the assessment phase. As the economic and non-economic costs of such a high share of erroneous decisions are very high, the benefit assessment procedure should be improved to ensure more accurate decisions in the first place.

More generally, the current *disability assessment structure* may need to be reconsidered. The separation of assessments for pension purposes (performed by ZUS and KRUS) and labour market purposes (performed by local governments) is confusing, inefficient and likely to contribute to labour market exclusion. Instead, responsibility for the entire assessment process (*i.e.* for benefits as well as for disability certificates) should be transferred to the social insurance institutions. The local government assessment teams should continue to be involved, offering occupational guidance for persons with disabilities – as should local labour offices, offering placement support.

Further, rules in the KRUS system, the *special system for farmers*, should be aligned with those in the ZUS scheme, leading to a re-merging of the two schemes in the long run. In particular, this would require changes to the contribution regulations in the KRUS scheme and restricted access to KRUS benefits through changes in the very narrow definition of disability as the inability to continue to work on one's own farm. Many of those unable to continue working on their own farm could almost certainly work in other sectors of the economy. In line with this, a strong focus should be placed on efforts to reintegrate potential as well as current KRUS disability beneficiaries into other sectors of the economy. This could be accomplished through increased and compulsory use of medical rehabilitation as well as vocational rehabilitation and retraining.

Similarly, the ZUS *definition of partial disability* – the inability to continue working in one's own profession – invites disability benefit application. Workers are advised not to look for a job in another occupation in order to prevent losing eligibility for a disability benefit. More than half of the annual inflow into disability benefits in Poland is through such a partial entitlement. This type of "own-occupation" assessment has been abolished in recent years in most OECD countries where it had been in place, and it should also be abolished in Poland. Instead, introducing a reduced disability benefit could be considered for workers whose capacity is only partially reduced. Designing such reduced benefit as an in-work payment rather than out-of-work benefit could help avoid later increases in the inflow rate. However, this would also require more tailored job-search and reintegration support for those people assessed as partially disabled.

Medical rehabilitation is another area where improvements would be possible and desirable. First, better co-ordination is needed between the health and the disability insurance. ZUS and KRUS use a more work-oriented approach, while the health insurance applies a strictly clinical approach aimed at recovery. Better co-ordination could be achieved through an improved quality and flow of medical files provided for disability benefit applications, with doctors being rewarded for taking more time for the examination. Secondly, earlier medical rehabilitation during the sickness absence phase should be promoted. Thirdly, costs of medical rehabilitation can be reduced by increasing the use of less costly out-patient rehabilitation. Finally, co-ordination of preventive activities should be enhanced, with more preventive responsibility given to ZUS and KRUS.

B. Vocational intervention, outflow management and work incentives

Vocational rehabilitation and training is still almost non-existent. While comprehensive regulations were introduced as long as a decade ago, take-up is virtually nil. If the causes of this failure are not ascertained, improving outcomes in terms of higher employment rates and lower benefit dependence of disabled people will be difficult to achieve. Indeed, given the observed lower educational attainment levels of disabled people in Poland, coupled with the segregated labour market policy approach, improving the skills and qualification levels of disabled people will be crucial. As a first step, it is important to understand why vocational training is currently not requested. It appears that eligibility criteria are too strict, labour offices have inadequate funding and people hesitate to enter the programmes. All these aspects need to be addressed individually. For instance, restricting vocational services to people with a legal disability certificate who are registered as unemployed or jobseekers is too limited an approach. Instead, access criteria should enable and stimulate early and then often short-duration intervention.

Furthermore, vocational intervention is entirely *voluntary* and only granted upon request of the individual, provided he or she is eligible. Experience across the OECD has shown that take-up of rehabilitation and training is very low when it is voluntary, especially for people who have been out of work for a longer period. Hence, some elements of compulsion should be introduced, for instance in the form of moderate benefit reductions for people refusing vocational intervention. Such coercion will also be necessary in order to help reduce the high incidence of informal employment in Poland. However, this will require a sufficient supply of well-targeted, high-quality services, and a more individualised approach in providing these. Otherwise, introducing more obligations for people with health problems would not seem justified or be unlikely to prove acceptable to the Polish electorate.

Despite recent success in reducing benefit inflows, the number of disability benefit recipients in Poland is still so large that effective curbing of public spending and better labour market integration of disabled people requires *re-evaluating the work potential* of current beneficiaries. To do this most effectively, the focus should be on people younger than 50 and with, for example, a disability benefit duration of less than ten years, *i.e.* those groups with the largest chances of successful reintegration. To avoid these people ending up on disability benefits in the long run, they need to be provided with special support, including – if needed – vocational rehabilitation and retraining. This support could include some transitional payment conditional on fulfilment of job-search activities, *i.e.* a special unemployment benefit.

To promote voluntary moves into the labour market of beneficiaries willing and able to work, *work incentives* should be enhanced. The current abrupt jumps in the amount of benefit income allow considerable additional earnings for some but not for all groups. As such, work is not sufficiently attractive for many of those able to find informal work. A smoother phase-out of disability benefits with an increasing wage would eliminate these uneven incentives. In addition, the possibility of working in the regular labour market without losing benefit entitlements should be introduced and encouraged by, for example, in-work payments. Finally, the relationship between the phase-out of disability and other benefits (*e.g.* housing and social assistance benefits) should be analysed more closely. OECD tax-benefit model calculations seem to indicate that these benefits create major benefit traps and income spikes.

Another area of concern is the ineffective *employment quota* (compliance stands at around 30%) and the role of PFRON, the Fund for Employment and Vocational Rehabilitation of Disabled People. The relatively high quota of 6% of the workforce and the comparatively high sanction raises labour costs further, thereby reducing the employment chances of vulnerable groups such as disabled people. To improve the situation, further differentiation of fines and subsidies could be introduced, *e.g.* by degree of disability and educational level of the disabled person, and by relating fines to the *average* wage in the company (rather than the nationwide average) and subsidies to the *actual* wage of the person employed. Moreover, further efforts could be made to raise the level of employment of disabled people in the public sector, which in most countries is a frontrunner in terms of their reintegration.

In 2004, the *wage subsidy scheme* – financed through PFRON funds – was extended to all companies in the Polish economy. Since then, even companies that fall under the employment quota regulation (those with more than 25 employees) and that fulfil the quota receive a subsidy for *every* disabled employee. As was shown above, the new system is fiscally unsustainable. Wage subsidies should be financed by taxes, like other public expenditure since financing them through an earmarked contribution results in ineffective spending. Moreover, the variation in wage subsidy levels by severity of disability should be further increased so to reach a larger share of people with a severe or moderate disability (today the majority of subsidised employment concerns people with a light disability).

The strong focus on *Sheltered Work Enterprises* (SWE) has perpetuated the segregation of disabled workers and hindered their transfer and integration into the open labour market. In addition, there are indications that SWEs are recruiting disabled workers from the open labour market rather than helping reintegrate disabled people on disability benefits or otherwise inactive. For all those reasons, the ever prevailing privileges of SWEs – such as the income tax refund for all employees in a SWE, also for their non-disabled employees – should be reduced so that more resources can be used for skill improvements. In addition, the higher wage subsidies for SWEs could be linked to observed rates of transfers into the open labour market: the higher the transfer rate, the higher the subsidy. Further, to safeguard sufficient resources for people with moderate and severe health conditions, phasing-out permanent wage subsidies over time for those with a light disability working in a SWE could be worth considering.

Privileged *employment conditions* for disabled workers (shorter work hours, longer annual leave entitlements, longer daily breaks, exemption from night work) are considered by employers as obstacles to their hiring of people with health problems. In light of the limited difference these regulations probably make for disabled workers, their abolition should be considered to remove barriers to employment as well as reducing negative stereotypes and prejudices.

C. Improving the institutional setup and synchronising different schemes

The comprehensive *reform of the old-age pension system* in 1999 has so far not led to a higher inflow into disability benefits for older workers. The main explanation for this is the rapid increase in the use of early retirement pathways in the past few years. Given the rapid ageing of the population, this is not sustainable; in the near future, these early retirement schemes are going to be phased out (already the case for the ZUS scheme by 2007). The pressure on the disability benefit scheme will then most certainly increase, especially because disability benefits are more generous than old-age pensions. To avoid spillover effects, reforms of the disability benefit scheme are unavoidable. As for Norway, the starting point for such reform

should be to harmonise benefit levels to ensure that the disability benefit entitlement for a person at, say, age 60 comes close to the benefit level of the old-age pension at this age.

In addition, a clear separation with a transparent transfer of funds is needed between *disability benefit and old-age pension* insurance. Only from 2004, beneficiaries reaching the retirement age are transferred to the old-age pension system, which has helped in creating a better environment for future changes. However, with an unchanged disability benefit formula, the forthcoming maturing of the 1999 pension reform will lead to a situation where older workers will have incentives to seek retirement on the grounds of disability. Therefore, clear regulations need to be put in place that determine contribution payments of recipients of a disability benefit to their own old-age pension accounts. Upon reaching retirement age, disability benefit payments should be stopped and replaced by retirement payments in line with the person's contribution history.

Active labour market measures of the PES and its local labour offices tend to be ineffective. This is crucial because the PES is also responsible for activation of disabled people, even though most programmes are mainstreamed rather than targeted to people with disabilities. To improve outcomes of PES interventions for disabled people, governance of local labour offices should be improved. Monitoring mechanisms should be introduced in combination with target setting, as has been done in recent years throughout much of the OECD area. Special targets for disabled people (as well as other vulnerable groups) would help ensure that sufficient resources are being used for these groups. More generally, the PES will need more resources for disabled people to improve its impact. This could be achieved by opening PFRON funds for the PES, with PFRON purchasing or co-financing PES services for disabled people that have a long-term impact on employment stability.

Also important is a *better co-ordination* between the PES on the one hand and the social insurance authorities (ZUS and KRUS) on the other. Currently, ZUS is paying people for taking up vocational training, while re-qualification programmes are offered by the PES. ZUS has no control or supervision over the programmes and the selection of programme participants, although it finances much of the costs and therefore has a stronger interest in the success of any such programme. This could be greatly improved by better co-operation between ZUS and the PES, *e.g.* by giving ZUS a supervising role. Instead, or in addition, a change in the funding structure could also be considered so that the PES would benefit financially from successful placements into paid jobs.

More generally, *streamlining administrative structures* and responsibilities should be considered. The large number of players involved makes it difficult for a disabled person to get the right support at the right time. Promoting a one-stop-shop philosophy and reinforcing the funding structure so that funding and responsibility go hand-in-hand could help facilitate reintegration of disabled people and lower overall spending. In view of Poland's decentralisation process, local governments are probably best placed to assume this function. PFRON as an independent institution may be redundant in a reformed system. In the short run, PFRON should become more efficient as it is needed as a funding institution to recuperate matching funds from the European Social Fund. In the long run however, the important functions of this organisation could instead be transferred to local governments, which receive a large amount of the PFRON funds unconditionally in any case. With such a transfer, incentives for local governments would have to be improved with stricter consequences of policy failure. At the same time, streamlining the supervision procedures of local governments would also limit wide latitudes of judgement in policy implementation.

7.3. Key problems and possible solutions in Switzerland

Swiss policy makers are forced to act because the disability insurance fund as well as its current reserve fund will run into deficit in the foreseeable future.[2] The medicalisation of labour market problems and the steep rise in non-specific, often mental illnesses has reached a level that calls for more comprehensive reconsideration of the current policy setup. This implies that reforms of the disability insurance itself are not sufficient. Further reform has to address problems in the co-ordination of different social security schemes, be they mandatory public, mandatory private or voluntary private systems.

As a result of worsening disability outcomes, and after a long phase of policy stability, the reform process is gaining momentum. With the fourth revision of the Disability Insurance Act, a major first step in the right direction was taken. Continuing reform along the lines of the planned fifth revision, to be implemented as from mid-2007, will be necessary to tackle the remaining structural problems in the system. However, much of the planned change only affects the way the disability insurance becomes involved and its possible responses rather than the role of other actors and the way disability insurance co-operates with other agencies and insurances. Following up on initiatives taken in the course of the recently established inter-institutional co-operation will, therefore, be equally important.

Proposals are made below to help ensure full-fledged implementation of the fourth revision and to enhance the impact of the forthcoming fifth revision. Possible weaknesses in the current version of the reform proposal are also addressed. In addition, suggestions are made to enhance the impact of initiatives to improve inter-institutional co-operation and governance of the public disability insurance.

A. Inflow management and assessment procedures

The fifth revision aims to reduce the annual inflow into disability benefits by 30%. It is hoped this will be achieved by bringing people into contact with the disability insurance at an earlier stage – ideally, after four weeks of sickness absence or work incapacity, rather than after a year or more as is currently the case. *Earlier identification* of serious health problems indeed has major potential to reduce the inflow to disability benefits. However, the incentives for various actors to make this approach work are insufficient. The impact of the planned reform could be greatly enhanced by introducing obligations for actors in contact with the sick person at an early stage. In particular, employers and sickness benefit insurers should be obliged to introduce sickness management, including a system of sickness monitoring. Today, even basic sickness absence statistics are lacking.

Better *sickness management* would require more knowledge about the reasons for absences, and thus more information from sick employees and their doctors. Moreover, for employers to contribute to the preparation of a plan for reintegration of their absent employees as an important element in managing absences, support from medical and vocational specialists is also needed. This type of support can and should be provided by the new "agencies for early identification and assistance", which are planned to be introduced with the forthcoming reform. Employers would benefit from having a unique contact person in the agency who could provide the necessary assistance – as is the case with the new local Workplace Centres of the Norwegian social insurance authority.

An element recently introduced to both the sickness benefit insurance and the disability component of the mandatory occupational pension is *experience-rated premiums*. The result of this is that an increase in the number of long-term sickness absences

translates into higher premiums for the employer. This is a strong incentive to prevent long-term absences and disabilities. However, it is important to evaluate the effects of this change since it may also result in stricter health screening in the recruitment phase. Depending on the findings, corrections may be needed – *e.g.* in the form of contributions from the disability insurance to the increased costs of an employer willing to hire a disabled person – to minimise any negative impacts of the new funding mechanism on the employment chances of sick or disabled people without a job. Furthermore, extending experience-rating to the contributions to public disability insurance – as was done successfully in the Netherlands several years ago – could be considered, but again with certain mechanisms to counteract disincentives for employers to hire people with health problems.

To oblige *private sickness benefit insurers* to implement sickness monitoring and sickness management will also require a few changes. First of all, this monitoring should include the obligation to inform the public disability insurance of long or repeated absences – so as to make earlier intervention on their side possible. Another element would be to strengthen the incentives to monitor absences properly. This would in particular require abolishing retrospective payments to the sickness benefit insurer in case a person becomes entitled to a disability benefit. These payments are an incentive not to care about people on longer-term sick leave. In addition, sickness assessment controls by private sickness benefit insurers and collaboration and exchange of information between GPs who assess work incapacity and insurance doctors should be promoted. Individual case management recently introduced successfully by SUVA, the main accident insurer, could serve as a model for management of sickness benefit insurers.

To improve the impact of this new focus on sickness management, introducing *mandatory sickness benefit insurance* for all workers (though still run by private insurance companies) should be considered. Otherwise, there is a danger that workers not covered by the voluntary sickness benefit insurance (currently about one-third of the labour force) would fail to be identified early enough. Full coverage in the (private) sickness benefit insurance as well as the (public) disability insurance would also help improve co-operation between the two insurance systems.

Related to these reforms, the medical tools in both the sickness and disability assessment phase could be further improved. The new regional medical services (RAD) make it possible for the disability insurance to conduct its own *medical assessment* of those applying for a disability benefit. However, the large majority of those applying continue to be assessed on the basis of the existing medical files only. The dominant role of GPs, especially in the sickness assessment process, has remained untouched. Improvements could include better co-ordination on the medical side between the disability insurance and the private sickness benefit insurers at an early stage. In particular, more control of the GPs' assessment and, if needed, overturning of the decision should be introduced after a few weeks of absence.

In addition, *support and training for GPs* is necessary to improve their knowledge of social insurance issues. However, some obligations should also be introduced for GPs in terms of seeking advice from occupational health services. These should be available for GPs in assessing the patient's condition (*i.e.* the nature and level of incapacity and the kind of work that can still be performed) and give advice on workplace adaptations and rehabilitation opportunities. Involving occupational specialists in the assessment process

is particularly important for the rapidly increasing mental, pain- and stress-related health problems. GPs would also benefit from feedback from the benefit authority on their assessments and the ultimate outcome in terms of disability benefit awards.

B. Vocational intervention, outflow management and work incentives

Despite the "rehabilitation-before-benefits" principle, take-up of *vocational rehabilitation and training* measures in Switzerland is relatively low – much lower than, for instance, in Norway. Eligibility criteria for vocational intervention should be broadened to include all people with health-related difficulties in the labour market rather than only those with reduced earnings capacity, as this typically implies that the person has lost the job and that intervention is coming late. Moreover, the criteria currently imply more restrictive access to vocational rehabilitation and training for people with low pre-disability earnings, many of whom have low qualifications. This is because in Switzerland disability is defined as earnings-capacity reduction, and thus discriminates against people with lower pre-disability earnings. Broadening access criteria would imply moving away from assessing the legal basis of a case to helping people back into work.

Vocational rehabilitation and training could also be a way of raising the outflow from disability benefits. In line with the eligibility arguments described above, it is important to go ahead with plans to introduce *new and innovative low-key measures* that are often of relatively short duration and less costly. As planned, particular focus should be given to measures targeted at people with low skills and/or with mental health conditions for whom the existing measures are insufficient. The new measures should aim at preparing these people for other forms of support or intervention. As in other countries, little is known about the impact of existing vocational programmes. In Switzerland, the only information available is the share of people not on a *full* benefit after completion of a measure, while nothing is known about actual transitions back to work or regarding longer-term work and earnings careers. With the introduction of new vocational programmes, rigorous evaluation of rehabilitation measures is becoming even more important.

Policy should also address the large *number of young disability beneficiaries*. Compared to other countries, a much larger proportion of those on disability benefits in Switzerland are younger than 35 (12% compared to around 4% in Norway and Poland). Moreover, 80% of those drawing a disability benefit in the 20-34 age group are doing so for mental health reasons. Many of these people should not be granted a *de facto* permanent benefit, because young people in particular have a relatively high integration potential and most of them also wish to work. A first step in addressing this issue would be to reassess beneficiaries below a certain age (maybe age 40-45), and to give those assessed as capable of working, at least partially, special support to achieve their potential. In addition, a mandatory full reassessment after a few years could be introduced for all future inflows, especially those younger than 50 years.

Phased or *partial re-entry* into work should also be considered for people on sick leave for more than four weeks. Introducing partial sickness benefit for the recovery phase – similar to the system of graded sick leave in Norway – may help some workers reintegrate earlier and in the longer term reduce inflows to disability benefit. This would lower costs as well as limit loss of skills.

Further, to raise outflows from disability benefits, *work incentives* should be enhanced. OECD tax-benefit model calculations show that effective tax rates for beneficiaries taking

up work are very high, especially for those with children. There are various plans in the course of the fifth revision to improve financial incentives, which should be implemented vigorously and not postponed until after the implementation of the other reform elements. For instance, the earnings disregard, mentioned as a general possibility in this reform proposal, should be specified and introduced. Moreover, it will be important to modify the system of child supplements in the first pillar to improve work incentives. As a minimum, these supplements – which constitute an important part of resources of the lower-income population – should be means-tested. That in turn will require some in-work payments for certain groups of beneficiaries to make work attractive. Other than this, a better phase-out of benefits in line with increased earnings from work should be developed to avoid breaks in effective tax rates, in particular breaks resulting from the different graduation system of partial benefits in the first and second pillars.

C. Improving the institutional setup and synchronising different schemes

A particular problem in Switzerland is the so-called *carousel effects*. One measure to reduce these problems is for the disability insurance to monitor closely and follow up rejected benefit applicants. With large increases in the rejection rate in recent years, this issue is becoming ever more important. The follow-up would aim to make sure these people obtain the necessary support to be able to remain in or return to the labour market. The issue is particularly pressing in connection with the planned short-duration measures that aim at preventing long-term disability. These new measures should also be available to those people whose claim for a disability benefit is rejected.

To address carousel effects, attempts have been made to improve *inter-institutional co-operation* between various institutions. The key weakness of many of these initiatives is their voluntary nature. To promote successful co-operation further, it would be important to strengthen the legal underpinning. The "Solothurn model" is a promising example in this direction, one that should be exported to other cantons.

The ongoing introduction of a *new job placement structure* in each cantonal disability office (CDO) must also be seen against the background of insufficient inter-institutional co-operation. The structure is being introduced because the placement efforts and success of the PES are considered inadequate when it comes to people with disabilities, not the least because the PES first and foremost aims at rapid rather than sustainable reintegration. It remains to be seen whether the CDO will be more effective in this regard. Major investments are needed for hiring enough sufficiently qualified case workers. In addition, better co-operation should be sought with the cantonal PES so as to combine efficiently CDO knowledge about particular needs of disabled people with PES expertise about the needs of employers, as well as co-ordination with NGOs that are specialised in job placement for difficult-to-place groups. Otherwise, building yet another network of contacts with employers could be costly and, in the worst case, hinder rather than promote inter-institutional co-operation.

Governance of the disability insurance itself should also be improved. Currently, there is a mismatch between funding and responsibility mechanisms, with cantonal offices granting the benefits while most funding comes from the federal level. There are various possibilities to improve supervision and inspection of CDOs by the federal supervisory authority, thereby further promoting the harmonisation of practices across cantons. The federal authority should have responsibility for identifying and publicising best practice. It

should formally signal when a canton has poor outcomes and this appears to be due to failure to introduce best practices.

A major ongoing reform to improve governance is the planned introduction of *management through targets* and indicators of effectiveness, as recently introduced for the PES as well. This should be introduced for the CDOs as soon as possible, with clear targets and sanctions for their non-achievement. In doing so, the same indicators should be used for all CDOs, adjusted to account for cantonal differences in industrial structure and levels of unemployment. Indicators should mirror the overall approach and success of the CDO and could include *i)* the share of all applications that have received an active measure within a certain period – say, three months; *ii)* the share of all first applications that end with a partial or a full disability benefit award; *iii)* the average duration from first application to a disability benefit award; *iv)* the average process duration for those cases reintegrated successfully; and *v)* the number and share of people successfully transferred from a full to a partial disability benefit and from any benefit into work, including information on the stability of employment.

One other problem in Switzerland is the rapid increase in the proportion of new disability benefit claimants who are entitled to *supplementary benefits*. Levels of poverty among disabled people of working age are relatively high in Switzerland and have been increasing – despite their high levels of employment compared to other OECD countries. More analysis is required to fully understand this development so as to identify the most appropriate policy response. One explanation could be the minimum threshold for coverage of second-pillar occupational disability entitlements. Until recently it was at about 35-40% of average earnings, and thereby excluded significant parts of the labour force (currently about 30%), especially women who frequently work part-time. It remains to be seen what impact the recent lowering of this threshold to 25-30% of average earnings will have. Abolishing the lower limit altogether to cover the entire labour force might need to be considered.

Finally, it is crucial to make further efforts to *improve the database* in the areas of sickness absence and occupational disability benefits. In these spheres, available information is insufficient for good and evidence-based policy making. That areas with poor statistics are administered by private insurance companies is no argument for not obliging them to provide urgently needed evidence.

Notes

1. General labour market and product market policy reforms are discussed in detail in the 2006 Edition of the *OECD Employment Outlook* which is devoted to the reassessment of the OECD Jobs Strategy. The focus there is on coherence between labour costs and labour market developments; competition in product markets; adoption of working-time arrangements; and employment protection legislation conducive to labour market dynamism.
2. In 2004, outlays exceeded revenues by 17% and the cumulated deficit has reached CHF 6 billion. This corresponds to over 60% of the annual revenues of the disability insurance. If nothing is done, the gap is projected to rise to more than 150% by 2010. The reserve fund of the old-age pension insurance has covered that deficit until now, but the reserve is estimated to be run down by 2012 (BSV estimates).

ISBN 92-64-02631-2
Sickness, Disability and Work: Breaking the Barriers – Vol. 1
Norway, Poland and Switzerland
© OECD 2006

Bibliography

Andlin-Sobocki, P., B. Jönsson, H.U. Wittchen and J. Olesen (2005), "Cost of Disorders of the Brain in Europe", *European Journal of Neurology*, Vol. 12, Suppl. 1, pp. 1-27.

Askildsen, J.E., E. Bratberg and O.A. Nilsen (2005), "Unemployment, Labour Force Composition and Sickness Absence: A Panel Study", *Health Economics*, Vol. 14, No. 11, pp. 1087-1101.

Bachmann, R. and C. Furrer (1999), "Die ärztliche Beurteilung und ihre Bedeutung im Entscheidverfahren über einen Rentenanspruch in der Eidgenössischen Invalidenversicherung" [The medical assessment and its relevance in the process of granting benefits in the Swiss disability insurance], Forschungbericht Nr. 6/99 im Auftrag des BSV, Bern.

Baumgartner, E., S. Greiwe and T. Schwarb (2004), "Die berufliche Integration von behinderten Personen in der Schweiz" [Labour market integration of disabled persons in Switzerland], Forschungsbericht Nr. 5/04, BSV, Bern.

Bond, G.R., R.E. Drake, K.T. Mueser and D.R. Becker (1997), "An Update on Supported Employment for People with Severe Mental Illness", *Psychiatric Services,* Vol. 48, pp. 335-346.

Børing, P. (2004), "Norsk og annen nordisk forskning om yrkesrettet attføring" [Norwegian and other Nordic research on vocational rehabilitation], NIFU Working Paper 8/2004, Oslo.

BSV (2005), "Botschaft über die 5. Revision des Bundesgesetzes über die Invalidenversicherung" [Information about the fifth revision of the Federal Disability Insurance Act], *www.bsv.admin.ch/iv/projekte/d/Botschaft_5te.pdf*.

Burgard, S., J. Brand and J. House (2006), "Job Insecurity and Health in the United States", PSC Research Report, No. 06-595, Population Studies Center, University of Michigan.

Buri, M. (2000), "Wirksamkeit beruflicher Massnahmen der Invalienversicherung" [The effectiveness of vocational interventions of the disability insurance], *Soziale Sicherheit* 6/2000, pp. 327-330.

Corrigan, P.W. (2001), "Place-Then-Train: An Alternative Paradigm for Psychiatric Disabilities", *Clinical Psychology: Science and Practice*, Vol. 8, pp. 334-349.

Dodu, N. (2005), "Is Employment Good for Well-Being?", *JOPED*, Spring, pp. 17-33.

DOK (2004), "Anreize für Arbeitgeber zur Beschäftigung von Menschen mit Behinderung" [Incentives for employers to employ workers with a disability], Bericht einer Arbeitsgruppe der DOK.

Domenighetti, G., B. D'Avanzo and B. Bisig (1999), "Health Effects of Job Insecurity among Employees in Switzerland", Lausanne University, Cahier de recherche, No. 9907.

ECON (2006), "Uførepensjon som lønnstilskudd: Årsaker til lavt omfang" [Disability benefits as a wage subsidy: Reasons for low take-up], Rapport 2006-010, Oslo.

Evans, M., K. Frøyland and Ø. Spjelkavik (2004), "Supported Employment in Norway – a National Mainstream Programme", The Work Research Institute, Occasional Papers, No. 6/04, Oslo.

EWCO (2005a), "Managing the Risk of Work-related Stress", *www.eurofound.eu.int/ewco/2005/02/EU0502NU02.htm*.

EWCO (2005b), "Violence, Bullying and Harassment in the Workplace", *www.eurofound.eu.int/ewco/reports/TN0406TR01/TN0406TR01.pdf*.

Ferrie, J., M. Shipley, S. Stansfeld and M. Marmot (2002), "Effects of Chronic Job Insecurity and Change in Job Security on Self Reported Health, Minor Psychiatric Morbidity, Physiological Measures, and Health Related Behaviours in British Civil Servants: The Whitehall II Study", *Journal of Epidemiology and Community Health*, Vol. 56, pp. 450-454.

Fevang, E., K. Roed, L. Westlie and T. Zhang (2004), "Veier inn i, rundt i, og ut av det norske trygde- og sosialhjelpssystemet" [Ways in, between and out from the Norwegian social security system], Ragnar Frisch Centre for Economic Research, Rapport 6/2004, Oslo.

Förster, M.F. and M. Mira d'Ercole (2005), "Income Distribution and Poverty in OECD Countries in the Second Half of the 1990s", OECD Social, Employment and Migration Working Paper, No. 22, OECD, Paris.

Furrer, C., O. Bieri and R. Bachmann (2003), "Berufliche Wiedereingliederung in der Eidgenössischen Invalidenversicherung" [Vocational reintegration in the Swiss disability insurance], Schlussbericht des Interface Institut für Politikstudien, Luzern.

Grasdal, A., K. Salvanes and K. Vaage (2005), "Industry Restructuring and Sickness Absenteeism. A Microeconometric Analysis Using Matched Employer-Employee Data", mimeo, Department of Economics, University of Bergen.

Gredig, D., S. Deringer, M. Hirtz, R. Page and H. Zwicky (2005), *Menschen mit Behinderungen in der Schweiz* [Persons with disabilities in Switzerland], Verlag Rüegger, Zürich.

Høgelund, J. and A. Holm (2004), "Case Management and Returns to Work of Disabled Employees", Centre for Applied Microeconometrics, University of Copenhagen.

Hoopengardner, T. (2001), "Disability and Work in Poland", Social Protection Discussion Paper Series No. 0101, World Bank, Washington, DC.

Johansson, P. and P. Skedinger (2005), "Are Objective, Official Measures of Disability Reliable?", IFAU Working Paper, No. 2005-14, Institute for Labour Market Policy Evaluation, Uppsala.

Jones, A. and O. O'Donnell (1995), "Equivalence Scales and the Costs of Disability", *Journal of Public Economics*, Vol. 56, pp. 273-289.

Jong, P., M. Lindeboom and B. Klaauw (2006), "Screening Disability Insurance Applications", IZA DP, No. 1981.

Koning, P. (2004), "Estimating the Impact of Experience Rating on the Inflow into Disability Insurance in the Netherlands", CPB Discussion Paper, No. 37, The Hague.

Lee, D. (2005), "Musculoskeletal Disorders, Case Management and Rehabilitation: A Review", *JOPED*, Spring, pp. 59-72.

Melvyn, P. (1993), "Social Integration and Vocational Rehabilitation for Persons with Mental Disabilities", Eurosocial Report Series, Vol. 44, Vienna.

Mosley, H., H. Schütz and N. Breyer (2001), "Management by Objectives in European Public Employment Services", Discussion Paper FS I 01-203, Wissenschaftszentrum Berlin für Sozialforschung, Berlin.

Nordberg, M. and K. Røed (2002), "Utstøting fra arbeidsmarkedet og tiltaksapparatets rolle" [Exclusions from the labour market and the role of activation programmes], Ragnar Frisch Centre for Economic Research, Report 2/2002, Oslo.

NZZ (Neue Zürcher Zeitung, Internationale Ausgabe) (2006), p. 33, 17 January.

OECD (2003a), *Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled People*, OECD, Paris.

OECD (2003b), *Ageing and Employment Policies: Sweden*, OECD, Paris.

OECD (2004a), *Economic Survey: Poland*, OECD, Paris.

OECD (2004b), *Ageing and Employment Policies: Norway*, OECD, Paris.

OECD (2004c), *Employment Outlook*, OECD, Paris.

OECD (2004d), *Benefits and Wages, 2004 Edition*, OECD, Paris.

OECD (2006), *Boosting Jobs and Incomes: A reassessment of the OECD Jobs Strategy*, OECD, Paris.

Polish Ministry of Economy and Labour (2004), "Poland 2004 report: Labour Market and Social Security", Warsaw.

Polish Ministry of Economy and Labour (2005), *Employment in Poland 2005*, M. Bukowski (ed.), Department of Economic Analyses and Forecasts, Warsaw.

Polish Ministry of Social Policy (2005), "Report on the Implementation of the European Social Charter", Edition 2003/04, Warsaw.

Reiersen, T (2004), "Oppfølgingsundersøkelse blant arbeidssøkere som sluttet å melde seg ved Aetat høsten 2002. Del 1: Tilpassing på arbeidsmarkedet et år etter" [A follow-up survey of jobseekers who stopped registering at the PES, Autumn 2002. Part 1: Their situation in the labour market one year later], Aetat Arbeidsdirektoratet, Report No. 01/2004, Oslo.

Rikstrygdeverket (2004), "Effekt av aktiv sykemelding, 2002-2003" [The effect of active sick leave, 2002-2003], Report No. 03/2004, Oslo.

Rikstrygdeverket (2005), "Folketrygden Nøkkeltall 1. halvår 2005" [Social security scheme in figures 1. half of 2005], Report No. 03/2005, Oslo.

Rikstrygdeverket (2006), *Fastlegers sykemeldings- praksis I: Variasjoner* [Variation of GPs' practices in certifying sickness absence I], Report No. 05/2006, Oslo.

Rüst, T. and A. Debrunner (2005), "Supported Employment", Modelle unterstützter Beschäftigung bei psychischer Beeinträchtigung [Models of supported employment in case of mental disorders], NFP 45, Probleme des Sozialstaates, Verlag Ruegger, Zürich.

SECO (2002), "Mobbing und andere psychosoziale Spannungen am Arbeitsplatz in der Schweiz" [Workplace bullying and other psychosocial challenges at work in Switzerland], Conditions de travail No. 3 (11.2002), State Secretariat for Economic Affairs, Bern.

SECO (2003), "Les coûts du stress en Suisse" [The costs of stress in Switzerland], Conditions de travail No. 5 (03.2003), State Secretariat for Economic Affairs, Bern.

Spycher, S., J. Baillod, J. Guggisberg and M. Schär Moser (2004), "Analyse der kantonalen Unterschiede innerhalb der Invalidenversicherung" [Analysis of cross-cantonal differences in the disability insurance], Kurzfassung einer Studie im Rahmen des NFP 45, Büro BASS und büro a&o, Bern.

Statistics Norway (2005), "The Effect of Plant Downsizing on Disability Pension Utilisation", Discussion Papers, No. 435, Oslo.

Swiss-Re (2005), "Ersatzquoten-Apéro", presentation of a model for replacement rates of Swiss disability pensions, prepared by M. Knöpfel.

Visier, L. (1998), "Sheltered Employment for Persons with Disabilities", *International Labour Review,* Vol. 137, No. 3.

Waddell, G. and K. Burton (2004), *Concepts of Rehabilitation for the Management of Common Health Problems*, commissioned by The Corp Medical Group, Department for Work and Pensions, London.

Waddell, G. and A.K. Burton (2006), "Is Work Good for Your Health and Well-being?", commissioned by the Department for Work and Pensions, London.

Walker-Bone, K. and C. Cooper (2005), "Hard Work Never Hurt Anyone – Or Did It? A Review of Occupational Associations with Soft Tissue Musculoskeletal Disorders of the Neck and Upper Limb", *Ann Rheum Dis,* Vol. 64, pp. 1391-1396.

WHO (2000), "Measuring and reporting on the health of populations", EB107/8 note, Geneva.

Wittchen, H. and F. Jacobi (2005), "Size and Burden of Mental Disorders in Europe – A Critical Review and Appraisal of 27 Studies", *European Neuropsychopharmacology*, Vol. 15, pp. 357 – 376.

Zaidi, A. and T. Burchardt (2005), "Comparing Incomes When Needs Differ", *Review of Income and Wealth*, Vol. 51-1, pp. 89-114.

List of Acronyms

AETAT	Norway's Public Employment Service (*Arbeidsdirektoratet*)
AETR	Average Effective Tax Rate
AFP	Norway's Early Retirement Pension Agreement (*Avtalefestet pensjonsordning*)
ALMP	Active Labour Market Programme
APW	Average Production Worker
BSV	Switzerland's Federal Social Insurance Office (*Bundesamt für Sozialversicherung*)
CDO	Switzerland's Cantonal Disability Office
CHF	Swiss Franc
EU-LFS	European Union Labor Force Survey
EU-SILC	European Union Statistics on Income and Living Conditions
EWA	Norway's Employment and Welfare Administration
GDP	Gross Domestic Product
GP	General Practitioner
GRR	Gross Replacement Rate
IT	Information Technology
IW Agreement	Norway's Inclusive Workplace Agreement
IIZ	Switzerland's Inter-Institutional Co-operation (*Interinstitutionelle Zusammenarbeit*)
IV	Switzerland's Disability Insurance (*Schweizerische Invalidenversicherung*)
KRUS	Poland's Social Security Institution for Farmers (*Kasa Rolniczego Ubezpieczenia Społecznego*)
LME	Norway's Labour Market Enterprise
MAMAC	Switzerland's Medical-Vocational Asssessment for Case Management (*Medizinisch-arbeitsmarktliche Assessments im Rahmen des Case Management*)
MEDAS	Switzerland's Medical Assessment Centre (*Medizinische Abklärungsstellen*)
METR	Marginal Effective Tax Rate
NGO	Non Governmental Organisation
NIA	National Insurance Administration
NOK	Norwegian Krona
NRR	Net Replacement Rate
PES	Public Employment Service
PFRON	Poland's State Fund for the Employment and Rehabilitation of Disabled People (*Państwowy Fundusz Rehabilitacji Osób Niepełnosprawnych*)
PLN	Polish Zloty
PPP	Purchasing Power Parity
PYLL	Potential Years of Life Lost

RAD	Switzerland's Regional Medical Service (*Regionaler Ärztlicher Dienst*)
SECO	Switzerland's State Secretariat for Economic Affairs (*Staatssekretariat für Wirtschaft*)
SPK	Norway's Occupational Pension Scheme for Public Sector Employees (*Statens Pensjonskasse*)
SUVA	Switzerland's Main Work Accident Insurer (*Schweizerische Unfallversicherungsanstalt*)
SWE	Poland's Sheltered Work Enterprise
USD	United States Dollar
VAT	Value-Added Tax
WPA	Norway's Worker Protection and Working Environment Act
ZUS	Poland's Social Security Institution for Employees (*Zakład Ubezpieczeń Społecznych*)

OECD PUBLICATIONS, 2, rue André-Pascal, 75775 PARIS CEDEX 16
PRINTED IN FRANCE
(81 2006 09 1 P) ISBN 92-64-02631-2 – No. 55239 2006

Sickness, Disability and Work: Breaking the Barriers

NORWAY, POLAND AND SWITZERLAND

Too many workers leave the labour market permanently due to health problems, and yet too many people with a disabling condition are denied the opportunity to work. This is a social and economic tragedy common to virtually all OECD countries, and an apparent paradox that needs explaining. Why is it that health is improving, yet more and more people of working age end up out of the workforce relying on long-term sickness and disability benefits?

This first report in a new OECD series on sickness, disability and work explores the possible factors behind this paradox. It looks specifically at the cases of Norway, Poland and Switzerland, and highlights the role of institutions and policies. A range of reform recommendations is put forward.

In all three countries, too little is done to avoid the flow from work to benefits and to move benefit recipients back to employment. At the same time, financial incentives to work and obligations for disabled people on benefits as well as employers are too weak. Many people with health problems can work, and want to work, so having a policy based around an assumption that they cannot work is fundamentally flawed. Helping those people to work is potentially a true "win-win" policy: it helps people avoid exclusion and have higher incomes, at the same time as raising the prospect of higher economic output in the long term.

www.oecd.org/els/disability

The full text of this book is available on line via these links:

http://www.sourceoecd.org/employment/9264026312
http://www.sourceoecd.org/socialissues/9264026312

Those with access to all OECD books on line should use this link:

http://www.sourceoecd.org/9264026312

SourceOECD is the OECD's online library of books, periodicals and statistical databases. For more information about this award-winning service and free trials ask your librarian, or write to us at **SourceOECD@oecd.org**.

wwwoecd.org

OECD

OECDPUBLISHING

ISBN 92-64-02631-2
81 2006 09 1 P

9 789264 026315