SICKNESS, DISABILITY AND WORK

IMPROVING OPPORTUNITIES IN NORWAY, POLAND AND SWITZERLAND

OECD Thematic review on sickness and disability policies, Round One

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FOREWORD

1. Disability and sickness policy ought to be a key economic policy concern in many OECD countries, but tends to receive less attention than it deserves. Medical conditions appear to be posing increasing challenges 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, while employment rates of those reporting disabling conditions are low. Unemployment has fallen to very low levels in recent years in many OECD countries, yet nowhere has this drop translated into more jobs for disabled people. With increasingly stricter work requirements in unemployment and social assistance programmes in many OECD countries, and gradual retrenchment of early retirement systems, the pressure on long-term sickness and disability benefit schemes has increased. There is an ever more pressing need to move to address this "medicalisation" of labour market problems in many OECD countries.

2. This new thematic review looks at how to match abilities 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 into the labour market. The objective is to reach a better understanding of the mechanisms and policies that lead a person with a health problem to withdraw from the labour market, or to 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 their outcomes in 20 OECD countries. That report highlighted the various dilemmas of disability policy and concluded that a promising new disability policy approach should have its focus on activation, tailored early intervention, work incentives and mutual responsibilities. 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 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.

3. 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 each country in achieving a transformation of its sickness and disability schemes from passive benefit to active support systems that promote work. This report is the first in a series of three comparative reports on sickness and disability policies in selected OECD countries. The second report 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.

4. The work on this review has been carried out in collaboration between the Employment Analysis and Policy Division and the Social Policy Division at the Directorate for Employment, Labour and Social Affairs (DELSA). This report has been 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 have been given 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, by preparing a background document, providing empirical evidence, organising a fact-finding mission and commenting on a draft of this report. The latter was also discussed at seminars in Warsaw and Oslo in June 2006. This report is published on the responsibility of the Secretary-General of the OECD.

EXECUTIVE SUMMARY AND POLICY RECOMMENDATIONS

5. As in many other OECD countries, sickness and disability policy in Norway Poland and Switzerland should be a key economic policy concern. Health-related problems appear to be posing increasing challenges 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 to many other OECD countries. As elsewhere in the OECD, there is 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 claiming health-related income support? This report explores the possible factors behind this paradox, highlights the role of institutions and policies in explaining it and puts forward a range of reform recommendations aimed at improving the situation.

6. The essential problem in all three countries is that too little is done to avoid the flow from work to benefits and too little is done 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. The key policy challenges facing the three countries are summarised in the Table below.

7. Recognising the key role of policy in this field, all three countries have engaged in reform processes which go 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, putting a stronger focus on temporary entitlements and strengthening re-employment opportunities and incentives.

8. While these reforms are likely to help improve the effectiveness of the 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 still 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 the stock of beneficiaries.
- In Poland, the inflow into disability benefits has dropped sharply in the past six years, but substitution into other benefit schemes has been substantial, putting the long-run sustainability of the decline in inflows into disability in question.
- In all three countries, employment rates of people with disabilities continue to be low, especially in Poland, and much lower than those of non-disabled people.
- Employment rates of disabled people have even tended to decline recently, partly reflecting changes in the work environment and population ageing, but also due to policy itself.

Summary Table. The magnitude of the sickness and disability policy challenge ahead and illustrative key outcomes related to those challenges in Norway, Poland and Switzerland, 2004[a]

Seven key policy challenges and related key outcomes	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 income inequalities across different population groups 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 stock	++++ 0.5	+++ 2.5	++++ 1.1
#7 Strengthening the coordination 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 ++++ … very substantial challenge. *Public spending* on sickness and disability benefits excludes employer-paid wage payments in the first weeks of absence. *Relative poverty* is defined as the percentage of persons with incomes below 50% of the median income of the entire population. *Rejected disability benefits* are applications for a disability 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.

9. The reform process is reaching a critical stage in all three countries. In Norway, the tripartite agreement on "inclusive workplaces" has come to an end, and the partners to the agreement have started to negotiate the next steps. In Poland, reform plans of the new government would do well to re-launch some of the proposals of the previous government in the context of public expenditure reform 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 early 2008.

10. *Work* needs to be put at the heart of sickness and disability policies, not only because of the needs of the economy, but also reflecting 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 a diversion of resources and public expenditures to achieve 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. 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 else marginalised into special employment categories.

Challenges, recent reforms and policy options for Norway

The current situation in Norway

11. Despite a very good general economic and labour market situation, employment rates of disabled people in Norway are 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 have yet to be tackled.

12. 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 largest part of non-employment among working-age people in Norway is due to health-related 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, that sickness no longer is the major reason for dropping out of the labour market.

13. 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 there is a very fine grid of partial disability benefits, but most people receive a full benefit. Further, a possibility to keep 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, and yet the impact on re-employment chances is extremely limited.

14. The key challenge for Norway, therefore, is to understand better *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 sickness and disability benefit 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.

Recent and ongoing reforms

15. Reform over the past five years in the context of a tripartite agreement between the government and the social partners aimed at changing workplace practices in the case of prolonged and repeated sickness and reinforcing the roles of doctors and employers. Workplace Centres were established which provide, free of charge, management advice to employers. In combination with some tightening of the sickness benefit scheme, these measures started to bite in late 2004 when sickness absence fell for the first time since the early 1990s. Amendments to the sick-pay scheme in that year included an evaluation of the functional capacity of the person on sick leave by a general practitioner (GP) after eight weeks of absence and stricter sanctions on GPs who do not comply with the new rules for absence certification. The timing of the decline in absence rates suggests that the regulatory amendments have played a key role in triggering this turnaround. However, there are worrying indications that this break in trend may not be sustainable.

16. Other recent or ongoing reforms have considerable potential which could materialise if followed up closely and implemented as intended. This is especially true for the introduction of *temporary* disability

benefits, aimed at tackling the permanence of benefit entitlements. Until 2004, disability benefits were always granted permanently, today temporary entitlements are granted to about one-third of all new claimants. This is a big change though still a low share compared with other OECD countries. This reform could turn into success if a considerable part of partial entitlements do not eventually become permanent ones. At this stage, however, the data suggest that an unintended effect of this reform could be an easing of entry into disability benefits.

17. Similarly, the ongoing merger of the Public Employment Service (PES) and the National Insurance Administration (NIA) and the creation of local labour and welfare offices, which offer integrated employment and insurance services and cooperate closely with local social assistance offices, has some potential to improve the efficiency and impact of vocational measures. However, the prospective benefits of this reform will only be reaped if the organisations in question succeed in establishing an effective one-stop-shop structure and in applying a work-oriented approach all over the country.

Key policy recommendations

18. Sickness absence in Norway is going to have to fall much further if the objective of the tripartite agreement of a 20% decline in absence rates compared to 2001 is to be achieved, and would have to fall much further 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 is true for the disappointingly low employment rate of disabled people. Three problems in particular should be addressed in future reforms:

- The lenient assessment of disability benefit entitlements and the key role of GPs in this process.
- The failure of the costly system of vocational rehabilitation and training.
- The non-existence of transitions back into employment of recipients of disability benefits.

19. Addressing these issues means that measures and reforms will have to be matched by stricter obligations for the various actors and better-enforced sanctions in case of non-fulfilment. Moreover, a new balance is needed between better work incentives and tighter eligibility criteria. To achieve this and to bolster ongoing and planned reforms, this report makes a number of policy recommendations as summarised in Box 1.

Box 1 **Policy recommendations for Norway**

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

- Frequent control of GPs' sickness assessments by social insurance doctors, as is common in many other OECD countries, and actual use of sanctions for non-fulfilment of duties in the form of (temporarily) losing the right to certify longer-term sick leave.
- A reduction of GPs' assessment and gate-keeping function in exchange for a strengthening of their guidance and assistance function, following the general practice in most OECD countries. Gate-keeping should be transferred to the NIA and its specialised social insurance doctors, with an increased involvement of vocational experts in the assessment process.
- More efforts should be made to make use of partial work capacity and to raise the share of *partial* benefit awards. The low proportion of partial benefit awards despite seemingly strict entry criteria for a full benefit suggests that medical assessments are too lenient.

Second, reform of the rehabilitation and training system should be carried out to identify and promote those measures that are successful, to correct the major weaknesses in the system and to improve targeting of rehabilitative measures. The following measures should be considered in this respect:

- Programmes should be better targeted to individual needs and be used more selectively. In particular, despite recent change, many programmes are still too long.
- Medical and vocational rehabilitation, which are under the responsibility of two different bodies, should go hand-in-hand. This requires better coordination and common objectives, including the goal to restore the person's work ability.
- Geographical and occupational mobility requirements are too weak and should be harmonised with those used in the unemployment benefit system.

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 successful applicants, the limited possibility to combine 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 recipients of disability benefits:

- Efforts should be made to reduce the share of permanent disability benefit awards 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 temporary or permanent disability benefit need to be improved. The (higher) benefit level for a temporary benefit entitlement should be aligned with that for a permanent benefit. The favourable tax treatment of permanent disability benefits in comparison to taxation of labour income should be removed. In-work payments for disabled persons taking up work or increasing their working hours should be considered.

Fourth, a number of measures should be taken to ensure good conditions for 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 in terms of how to establish a joint front-line service successfully and how best to collaborate with the local social assistance authorities.
- Sufficient investments are needed in training for caseworkers of the new merged institution, and proper measurement of performance of local offices delivering the services in order to assess results and identify worst performers.

Fifth, improvements are also possible in the context of the forthcoming reform of the old-age pension system. There is a risk that, in the aftermath of the 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. Good coordination of old-age pensions and disability benefits should be based on two principles:

- Full contribution payments by disability benefit recipients to the retirement fund, to ensure adequate old-age pension entitlements upon reaching the retirement age.
- Adjustment of the disability benefit formula to make sure that disability benefit does not exceed the corresponding early retirement benefit entitlement at the same age.

Sixth, the strong focus on employers and the workplace should be continued in order to strengthen the management of absences and avoid the *automatic* transfer from long-term sick leave into disability. More support and better incentives could be provided to employers to ensure that their new obligations are being fulfilled. Measures in these areas could include the following:

- Better guidance and information should be provided to employers by the newly established local Workplace Centres, including advice on workplace adaptations and rehabilitation opportunities.
- Non-fulfilment of the employer's obligation should be penalised, *e.g.* by increasing the period during which wage payments of sick workers have to be continued or by introducing higher co-payments or experience-rated premiums to the sickness benefit insurance for employers failing to meet their obligation. Such changes could be combined with a reduction in social security contributions for employers investing in sickness management and prevention.
- Eventually, if sickness absence fails to decline to acceptable levels, reducing benefit levels – from currently 100% of the previous wage for a full year – will become unavoidable.

Challenges, recent reforms and policy options for Poland

The current situation in Poland

20. In certain areas, the situation in Poland has improved very much in recent years. Inflow rates into disability benefits, which were higher than anywhere else in the OECD in the early and mid-1990s, have fallen to below the OECD average. In turn, the stock 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.

21. However, Poland has extremely low levels of labour market participation of disabled people, with less than one in five in employment. The employment rate of disabled people has fallen further during the past decade, along with a further deterioration of their economic well-being. The take-up of vocational rehabilitation is practically nil. Instead, the traditional segregation approach is still dominant. As a result, more than four in ten of those disabled people who work are employed in Sheltered Work Enterprises, which are heavily subsidised. If in employment, disabled people tend to have part-time, temporary jobs or to work as self-employed or family workers. They are significantly over-represented in the agricultural sector and under-represented in the public sector.

22. 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. Further reform of sickness and disability policies, therefore, needs to be done in tandem with general labour- 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.

Recent and ongoing reforms

23. Recent reforms were characterised by attempts to tighten entitlement to both sickness and disability benefits while at the same time strengthening the focus on medical and vocational rehabilitation. Stricter rules for the issuing of sickness absence certificates and more control of GPs' decisions, introduced in 1998, have led to a fall in absenteeism by around one-third. Similarly, reform in the disability scheme in 1999 resulted in one of the fastest declines in benefit inflow rates – by more than 60% over just five years – ever observed in the OECD. The key elements of this reform were a new disability assessment procedure (which now, like in most other OECD countries, focuses on the applicant's inability to work) and a more restrictive approach to granting permanent disability benefits.

24. It remains to be seen, however, whether this is indeed a sustainable decline. Over the same period, inflows of older workers into early retirement as well as inflows of younger workers into social pensions increased rapidly, and the unemployment rate increased as well. The incidence of new entries into the special disability benefit scheme for farmers has also declined rapidly, although this system has not seen any changes in regulations. This suggests that substitution factors, *i.e.* a growing number of people moving into welfare benefits other than disability in response to the tightening of the disability benefit regime, made the change less painful and therefore allowed it to go faster. This, in turn, could mean that, with the abolition of early retirement in the near future, there is a great risk that the declining trend in inflows into disability benefits could turn around again very soon.

25. To prevent this risk and to contain public spending, a comprehensive public expenditure reform was prepared in 2004, but parliament rejected it. This reform proposal included, for instance, a reduction in sick-leave compensation from 80% to 70% of the last wage; a reduction in the stock of disability benefit

recipients through a re-evaluation of all pensioners under age 50/55 who had been receiving a pension for less than ten years; a strengthening of the monitoring and re-examination of recipients of a temporary disability benefit; and further steps to eliminate the more generous regulations in the special system for farmers. Since November 2005, however, to further reduce the attractiveness of labour market exit on the grounds of disability, *all* disability benefits are granted *temporarily*, typically for a period of three years, with the beneficiaries having to reapply upon expiration of the temporary entitlement.

26. In parallel to the rather effective tightening of the access into the sickness and disability benefit schemes, more possibilities were introduced for rehabilitation of benefit applicants. Due to the very low take-up, however, this change has had negligible impact. In addition, following Poland's accession to the EU, permanent wage subsidies – until then only available for workers in Sheltered Work Enterprises – became in principle available to disabled workers in all companies. So far, this broadening has had little impact. The long-established and continued focus on sheltered work does not lead to greater integration of people into the mainstream labour market, because once in sheltered work, virtually no-one leaves it. It is not a stepping-stone to better prospects, but rather a dead-end, giving people a better standard of living and some purpose in life, but falling some way short of what should be the objective of policy.

Key policy recommendations

27. The failure of the effective tightening of the access to sickness and disability benefits to improve the employment rates of disabled people in Poland raises the question whether the whole system of employment support for disabled people 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 especially in two areas:

- 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 right supports at the right time.

28. Changes in those two key areas have to be supplemented by measures to streamline the sickness and disability assessment process further and by improving work incentives for benefit recipients. To this end, this report makes a number of policy recommendations as summarised in Box 2.

Box 2 **Policy recommendations for Poland**

First, the system of vocational rehabilitation and training needs to be strengthened. Without addressing the causes of the negligible impact of this system, 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 – so far entirely voluntary – vocational programmes. These various aspects could be addressed through the following measures:

- 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 these be implemented.
- If the supply of effective services is increased, some elements of obligation should be introduced, *e.g.* in the form of moderate benefit reductions for people refusing to participate in vocational rehabilitation.

Second, a more fundamental change is needed to improve the system of employment support. More generally, streamlining administrative structures and responsibilities might be necessary. The large number of players involved – social insurance institutions, the 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. Future reform could include the following measures.

- Promoting a one-stop-shop philosophy and reinforcing the funding structure would help facilitate reintegration of disabled people. Local governments and their specialised assessment teams are best placed to assume this function. PFRON as an independent institution may be 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.
- The coordination 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 into paid jobs.

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, measures could include the following:

- The responsibility for the entire disability assessment process should be transferred to the social insurance institutions. The current separation of assessments for income support purposes (done by the social insurance institutions) and labour market purposes (done 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 penalising treating doctors who repeatedly assess "false" sickness.
- Policy should address the high proportion of benefit refusals and 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.

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 jumps in the amount of benefit income, 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 payments.
- Housing benefit should be reformed so that it does not create benefit traps and discourage work by beneficiaries of disability benefits, in particular, but more generally as well.

Fifth, better coordination is needed between the reformed old-age pension and the disability benefit scheme to avoid raising pressure on the latter in the aftermath of the upcoming phasing-out of early retirement schemes. To avoid spill-over effects to the more generous disability 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 is needed between disability benefits and old-age pensions. Regulations on contribution payments of recipients of a disability benefit to their own old-age pension accounts need to be put in place. At retirement age, disability benefit payments should be replaced by retirement payments in line with the person's contribution history.

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 all companies either fulfilling the quota or not falling under the quota rule, 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 still prevailing privileges of Sheltered Work Enterprises – such as the income tax refund for *all* employees in a SWE, 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 Sheltered Work Enterprise could be worth considering.

Challenges, recent reforms and policy options for Switzerland

The current situation in Switzerland

29. 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 keep people with health problems in work longer and, ideally, to re-integrate people with reduced work capacity into work.

30. In general, policy outcomes in Switzerland are rather 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 stock of beneficiaries. Sickness absence is relatively low, but creating large problems for the disability insurance due to systemic weaknesses. Like in Norway, disabled workers tend to be more often unemployed and working part-time, but, at 52%, their employment rate is relatively high compared to other OECD countries. Average disability benefits have increased very fast in recent years, yet relative poverty rates among disabled people have increased as well.

31. A special problem in Switzerland, more widespread than elsewhere in the OECD, 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 all inflows. There is much controversy about the reasons behind this development, which seem to reflect the increasing "medicalisation" of labour market and social problems. But it also reveals weaknesses in the definition of disability and the assessment process.

32. 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, and others, despite being mandatory, are administered by privately-run institutions, such as the second-pillar old-age and disability pension. Activities of these private players can be regulated to a certain extent, but not steered directly. The actions of these private players have a strong impact on the design and effectiveness of public policy.

Recent and ongoing reforms

33. 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 made. The newly introduced regional medical services (RAD) provide a more objective and independent medical assessment for the 10-20% most difficult cases, and force smaller cantons to collaborate with neighbouring ones. Together with the more frequent auditing of cantonal practices and the introduction of better monitoring systems, the new RADs are likely to have contributed to the fall in inflow rates in the past two years, even though this fall partly reflects an increased backlog. The impact of the provision of active job-placement services by the cantonal disability insurance offices remains to be seen.

34. Continuing reform along the lines of the planned fifth revision of the Disability Insurance Act, which aims to reduce annual inflows by 20%, will be important. The lack of intervention during the sickness phase and the late start of the reintegration process should be addressed. Tackling this through early identification of health problems to prevent long-term work incapacity, early and short-duration intervention to avoid job loss, and provision of new types of integration measures aimed at preparing people for subsequent measures is promising. The fifth revision of the Disability Insurance Act also aims to promote work incentives, but, given the importance of the issue, this part of the reform is too vague.

35. In addition to the planned and already implemented reforms, which predominantly focus on the role of the cantonal disability insurance offices (CDO) in keeping people in work and away from benefit, it is increasingly recognised that some of the problems are related to the lack of coordination and cooperation between and across different parts of the social protection system. This recognition is reflected in the recent emphasis on inter-institutional cooperation (IIZ) of two kinds:

- IIZ, focusing on cooperation between the CDO, the PES and the social assistance authorities so as to avoid so-called "carrousel effects", where people move around or are being moved around between different benefit schemes; and
- IIZ PLUS, focusing on cooperation between the CDO, the sickness benefit insurers and the work injury and accident insurers so as to enable the disability insurance to intervene earlier.

36. Both initiatives have great potential, yet there is a long way to go in implementing and further improving these voluntary agreements if carrousel effects and system inefficiencies are to be removed.

Key policy recommendations

37. Bringing people in contact with the disability insurance at an earlier stage through early identification of serious health problems is a promising approach targeting one of the key weaknesses in the Swiss system. However, 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.

38. In addition, future reform should continue to address work incentives, the coordination across different schemes and the governance of the CDOs. In this direction, this report makes a number of policy recommendations as summarised in Box 3.

Box 3 **Policy recommendations for Switzerland**

First, a 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 sickness benefit 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 should include stronger controls of sickness absence certificates and better cooperation and exchange of information between GPs and insurance doctors.
- Individual case management recently introduced successfully by SUVA, the main accident insurer, could serve as a model for sickness management by 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 should be abolished.
- GPs should be obliged to seek advice from occupational health services, which should give advice on workplace adaptations and rehabilitation opportunities. More support and training for GPs should be provided to improve their knowledge on insurance medicine.

Second, in addressing employers a balance will have to be sought between stronger obligations, better support and proper incentives. The recently introduced experience-rated premiums to the sickness benefit insurance is a strong incentive for employers to prevent long-term absences and disabilities in order to keep premiums low, though it 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 prepare a plan for the reintegration of their long-term absent employees, as has become common in several OECD countries, and 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 agencies for early identification and assistance, which are planned to be introduced with the forthcoming reform.

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. Eligibility criteria for vocational intervention probably go a long way in 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 people not entitled to a disability benefit but with health-related difficulties in the labour market, thus moving away from assessing the legal basis of a case to helping people back to work. In particular, more efforts should be made in integrating people with mental conditions into the rehabilitation system.
- The introduction of a “premature” disability assessment, planned to be put in place in parallel to the new early identification approach, should be reconsidered. This could further increase the problem of screening out of people who are not disabled according to the definition of the disability insurance but nevertheless in need of help.
- More focus should be put on offering vocational measures to re-assessed beneficiaries. Along these lines, a re-assessment of the very large stock of younger beneficiaries, who tend to have a much higher work motivation, should be considered. Some of the newly planned measures might be particularly suitable for these people, who often suffer from mental health conditions.

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. Plans in the course of the fifth revision of the Disability Insurance Act to improve financial incentives should be implemented soon and not be postponed to after the implementation of other elements of the reform. Among the possible changes are the following:

- The system of generous child supplements in the first pillar should be changed so that they do not create benefit traps and discourage work by beneficiaries. Instead of simply reducing the level of these supplements, consideration should be given to introducing a means-test, because these payments constitute an important part of resources of the lower-income population.

- The use of in-work payments and temporary benefit entitlement suspension should be considered for persons taking up work or increasing their working hours to increase the likelihood that beneficiaries able to work try to find another job.

Fifth, ongoing but voluntary inter-institutional cooperation across different systems and institutions should be strengthened. 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 cooperation between various institutions and insurances, it would be important to strengthen the legal underpinning. The approach taken by the canton of Solothurn is a model which 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.

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. Supervision and inspection of cantonal disability offices by the federal supervisory authority, thereby further promoting the harmonisation of practices across cantons, could be strengthened through the following measures:

- 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 and this appears to be due to failure to introduce best practices.
- Management through targets and indicators of effectiveness, as recently introduced for the PES, should be put in place for the CDOs as soon as possible, including sanctions for their non-achievement. Indicators should mirror the overall approach of the CDO and measure its success in terms of process duration and employment outcomes.

39. Last, but not least, all three countries lack rigorous evaluation of most of their regulations and instruments. Particularly important is better knowledge on 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 put in place in the past: neither the economies of the three countries nor people with disabilities can afford such mistakes being repeated in the future.

INTRODUCTION

40. 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 an economic tragedy which is common to virtually all OECD countries, including Norway, Poland and Switzerland. In several respects, the three countries covered in this review are facing similar challenges. For example, disability-related public spending could in the near future reach such levels that further tax increases or substantial benefit cuts may become unavoidable. They share the problem of a high proportion of working-age people on disability benefits. Norway and Poland are also among those countries with high rates of sickness absence, a problem less apparent in Switzerland, which, on the other hand, faces an unprecedented increase in mental health problems. As a result, discussions on eligibility criteria for health-related benefits, on work incentives for those on benefits and on the social exclusion of disabled people are high on the political agenda in all three countries, and reforms have either been discussed or are underway.

41. To reduce sickness and disability benefit dependency and to raise employment rates of people with health problems, it is important to confine benefits to those in need of them, be it fully or partially. This is difficult to achieve because of the inherent difficulty in identifying with much precision a person's true health status and its impact on work capacity. It is equally important to improve employment chances for both those currently working with a health impairment and those inactive but potentially able to work. Hence, further reform is needed on both the demand and supply sides. The main purpose of this report is to reflect on the different avenues for reform that will need to be pursued in the three countries in order to meet these challenges.

42. Countries need to put *work* at the heart of their sickness and disability policies, not only because of the needs of the economy, but also reflecting 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 may increase employment rates and reduce public spending, which further justifies a diversion of resources and public expenditures to achieve 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.

43. 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 could reduce the inflow into long-term benefits. It also addresses the impact of the assessment process of people applying for a disability benefit, including the requirement to undergo rehabilitation. Chapter 3 looks into the question of how to improve outflow rates from long-term benefit recipiency, and Chapter 4 analyses how work incentives – as well as hiring and firing practices – are affected by the tax and benefit system. Chapter 5 examines the difficult issue of policy coherence and interactions with other welfare schemes. Chapter 6 discusses and evaluates important past and ongoing reforms, and Chapter 7 suggests a number of specific recommendations for further action.

CHAPTER 1

MAIN OUTCOMES AND KEY CHALLENGES

44. The purpose of this chapter is to make out a set of key challenges which policy will need to address. It provides a summary of the main sickness and disability trends in Norway, Poland and Switzerland during the past 10-15 years, and identifies seven key objectives for policy makers:

- To control sickness and disability-related public spending;
- To raise employment rates for people with health problems;
- To tackle income inequalities across different population groups;
- To reduce the inflow into sickness and disability benefits;
- To address the increasing medicalisation of labour market problems;
- To raise the outflow from disability benefits; and
- To strengthen the coordination across different benefit schemes.

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

1. Institutional challenges faced by policy makers

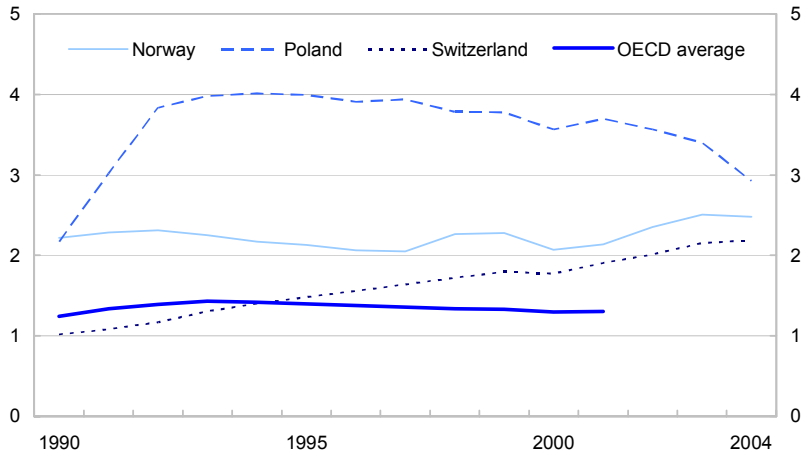
A. Controlling sickness and disability-related public spending

46. 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 2¼ and 3% of GDP, compared with an OECD average of just over 1% (Figure 1.1.). This was not always the case: in Switzerland, the spending share in 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, but it has been falling sharply over the past few years. In sum, across the three countries, there is a trend towards *convergence* in disability benefit spending in the range of 2-3% of GDP.

1. In the case of Norway, GDP figures include oil revenues. Using mainland GDP would increase spending in 2004 from 2.5% to around 3.2% of GDP.

Figure 1.1. **Convergence in annual spending on disability benefits**

Spending on 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 (2006) Social Expenditure database; data supplied by national authorities.

47. 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.

48. In line with the above picture, disability benefit recipiency rates among the working-age population are very high, especially in Norway and Poland – about 11% most recently. This is roughly twice the level found across twenty OECD countries at the end of the 1990s (OECD, 2003a) and also in Switzerland in 2004. Figure 1.2 (Panel A) shows differing trends for the three countries under review: in Norway and Switzerland, the recipiency rate increased steadily over the past ten years but from a much higher level in the former country. The annual average growth rate in that period 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 five years.

49. 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 in various chapters of the report.

50. Disability benefit recipients are predominantly older persons aged 50 to 64 years. People in this age group constitute more than half of the pool of beneficiaries in Switzerland, and more than two-thirds in Norway and Poland. Compared to many other OECD countries, Switzerland has a high share of younger and middle-aged disability benefit recipients, especially among women. The difference is particularly large for the youngest age group (20-34): these make up between 11-12% of all beneficiaries in Switzerland, but just 4-6% in Norway and Poland (Figure 1.2, Panel B).

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

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 which 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 used to have such a system, but this 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. Like in Norway, remaining years until retirement age are fully credited, which is not the case in Poland. In this country, 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%.

In all three countries, public disability benefits consist of a basic part and 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, while there also is 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.

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 so-called social pension is (since 2003) paid by the social insurance authority; contrary to social assistance payments, this is an entitlement not a discretionary benefit, and it is not means-tested.

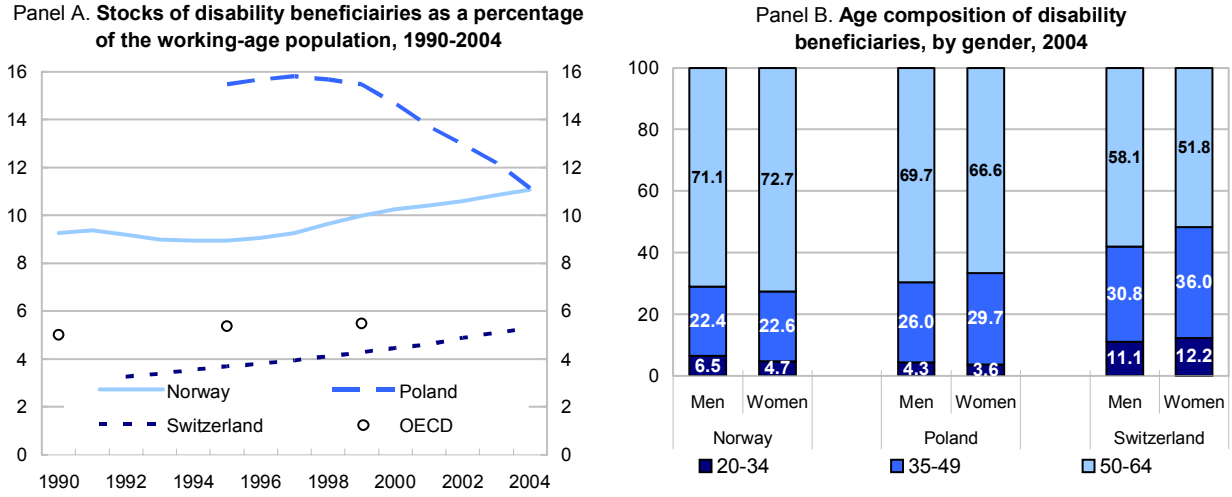
Poland and Norway also have a compulsory, contribution-financed sickness cash benefit which covers the active population. Benefits are earnings-related and covered by the insurance after a period of continued wage payment by the employer of 33 days in Poland and 16 days in Norway. Benefits are paid for up to 12 months at 100% of earnings in Norway and up to six months at 80% of earnings in Poland (with 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. In addition, 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 increasing 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.

51. Not only have beneficiary rates been growing, 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 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.

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

Benefit recipiency rates 1990-2004 and age composition of beneficiaries in 2004 (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 authorities: NIA (Norway), IV (Switzerland) and ZUS (Poland). OECD (2003a) for OECD average.

Table 1.1. **Growth in average disability benefits exceeds 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. Benefit and wage figures have been deflated with private consumption price indicator.

Source: National insurance authorities: NIA (Norway), IV (Switzerland) and ZUS (Poland).

B. Raising employment rates for people with health problems

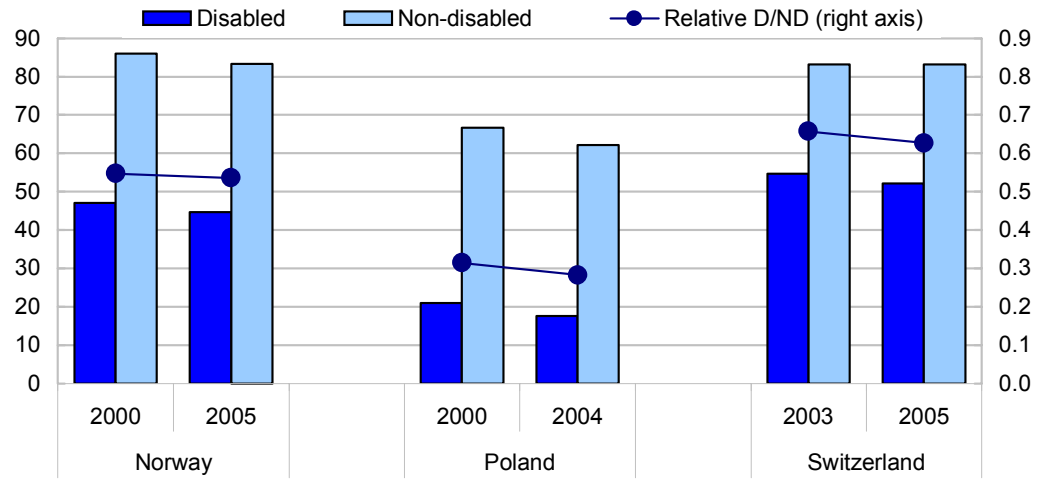
52. A second key policy concern is to improve the unsatisfactory level of labour market integration of people with disabilities. Having a job is one of the key elements for inclusion and integration in society and the economy. Depending on the degree of disability, many disabled people are able to work on the

open labour market. However, they have consistently lower employment rates than their non-disabled peers, and this difference is particularly large in Poland.

53. Indeed, with regard to employment, Poland fares much worse, both absolutely and relatively. While half of all disabled persons have a job 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 – 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 (Eurostat, 2003). Moreover, this also suggests spill-over effects of overall labour market performances: the higher the overall employment rate in the population, the higher the relative employment rates of disabled persons.

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

Employment rates of disabled and non-disabled persons of working-age, 2000-2005



Source: National labour force surveys.

54. 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 a continuation of a trend since at least 1996 – especially among severely disabled people of whom 22% had a job in 1996 compared to 16% in 2000 and only 7% in 2004.

55. It is also important to bear in mind differences in employment outcomes by gender, age and level of education. There is no 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 – but only in Switzerland and, especially, Norway. In these two countries, employment levels among disabled young people (age 20-34) and disabled persons with tertiary education are quite close to those of their non-disabled peers, between 70 and 88%. Again, Poland stands apart, with middle-aged disabled persons (age 35-49) recording lower relative employment rates than both young and older and with higher-educated disabled persons having even lower relative

2. In this as well as the next subsection, disability is a self-assessed status measured via population surveys. This is quite different from the administrative definition of disability benefit receipt (Chapter 1.2).

employment rates. However, differences are so small that one cannot detect any significant age and education differential in relative employment in Poland.[3]

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

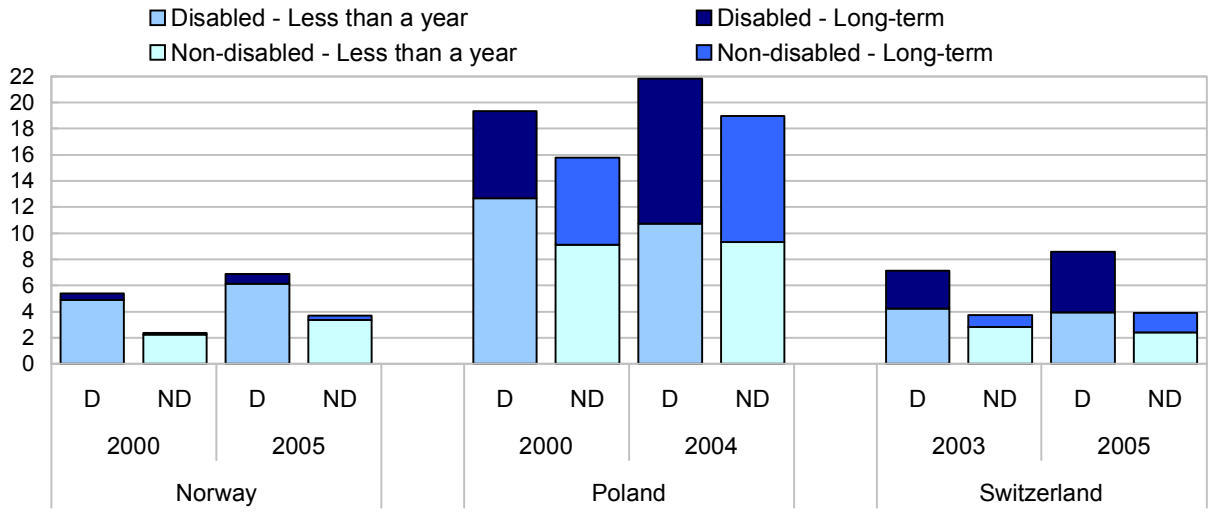
		All	Gender		Age group			Educational attainment		
			Men	Women	20-34	35-49	50-64	Below secondary	Upper secondary	Tertiary
Norway	2000	0.55	0.57	0.53	0.75	0.57	0.47	0.41	0.58	0.70
	2005	0.54	0.55	0.53	0.74	0.48	0.55	0.37	0.56	0.70
Poland	2000	0.31	0.33	0.29	0.37	0.31	0.36	0.33	0.34	0.38
	2004	0.28	0.29	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

Source: National labour force surveys.

56. Unemployment rates of disabled persons are almost twice as high as those of non-disabled persons in the low-unemployment countries 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.

Figure 1.4. **Higher and increasing unemployment among the disabled population**

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



Source: National labour force surveys.

3. That said, *absolute* employment rates among disabled higher educated persons in Poland remain higher than for lower educated (25% versus 19% for upper secondary and 14% for below that level).

57. The unemployment rate for disabled persons increased in all three countries in line with overall unemployment in the past two to five years. This may indicate increasing discrimination against disabled people on the labour market, but it also shows that there is an increasing number of disabled people who are searching for work and available for it, but cannot find any. Policy would do well in promoting employment among those disabled people who actually *wish* to work.

58. Some indication on the share of non-employed disabled people who would wish to take up a job is available from the EU labour force survey. Table 1.3 shows that the share of "permanently disabled people" who say they want to work is very similar across the three countries, some 16-18%.[4] 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.

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 average of 2002 and 2003.

Source: EU Labour Force Survey 2002 and 2003.

C. Tackling income inequalities across different population groups

59. To which extent are persons with disabilities financially worse off than others? Given their low employment rates as well as their population composition – lower educated and older people being over-represented – one would expect lower average incomes among disabled persons.

60. The best available indicator for comparing financial resources is disposable adjusted household income per person, which takes into account all income 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). Trend estimates available for Poland and Switzerland indicate that this position has worsened in recent years. In Norway, the relative income position deteriorates with increasing severity of disability. In Poland, the opposite is the case.

4. National studies for Norway report somewhat higher figures in the order of around 28% (NIFU, 2006).

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.

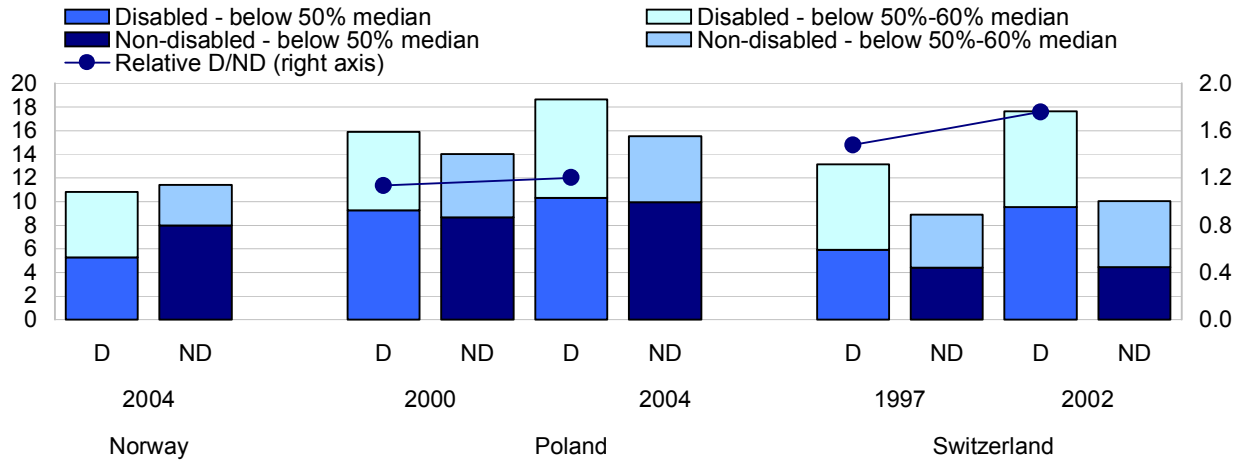
a) Income concept used is disposable household income per equivalent person (equivalence elasticity=0.5). In Poland, "moderately disabled" refers to sum of "moderately and lightly disabled".

Source: EU-SILC for Norway, Household budget survey for Poland, Health survey for Switzerland.

61. Are 10-15% below-average income levels an "achievement" or do they give reason for concern? Benchmarks for other economically vulnerable groups are as follows: the relative income levels for single parents are about 65% in Norway and Switzerland and 55% in Poland. Relative income levels for older citizens (aged 75 years and over) are 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 which are targets of social policy.

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.

62. Figure 1.5 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 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.

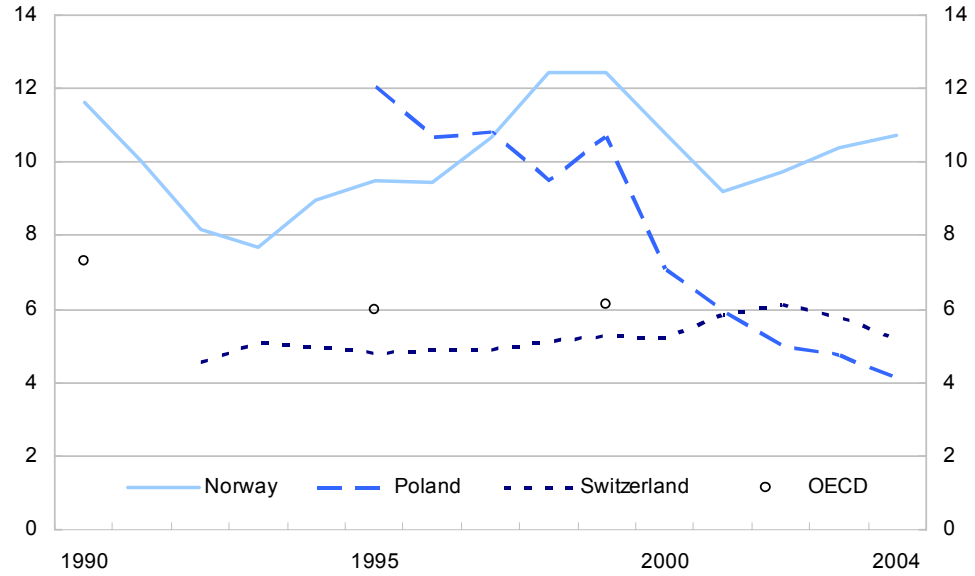
63. Trend data available for Poland and Switzerland indicate that poverty risks among disabled have increased faster than for the rest of the working-age population. This is especially the case in Switzerland: their poverty rate at the 50%-median income level increased from 6% to almost 10%.

D. Reducing the inflow into sickness and disability benefits

64. A key challenge behind the rising levels of disability benefit recipiency is the large number of people successfully *applying* for such a benefit. Movements in inflows into disability benefits over the past 10-15 years do not reflect a common pattern. In Norway, inflows – which stood at over 1% of the working-age population at the beginning of the 1990s – fluctuated considerably during the past 15 years, but the inflow rate in 2004 is not much different from the level in 1990 (Figure 1.6). In contrast, inflow rates in Poland declined continuously and steeply. They fell by two-thirds, from twice the OECD average in 1995 to a level below those of Norway and Switzerland. 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. After 2002, however, they also started to fall.

Figure 1.6. **Divergent trends in disability benefit inflow rates**

Annual inflow into disability benefit, in percentage of the working-age population, 1990-2004[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 authorities: NIA (Norway), IV (Switzerland) and ZUS (Poland). OECD (2003a) for OECD average.

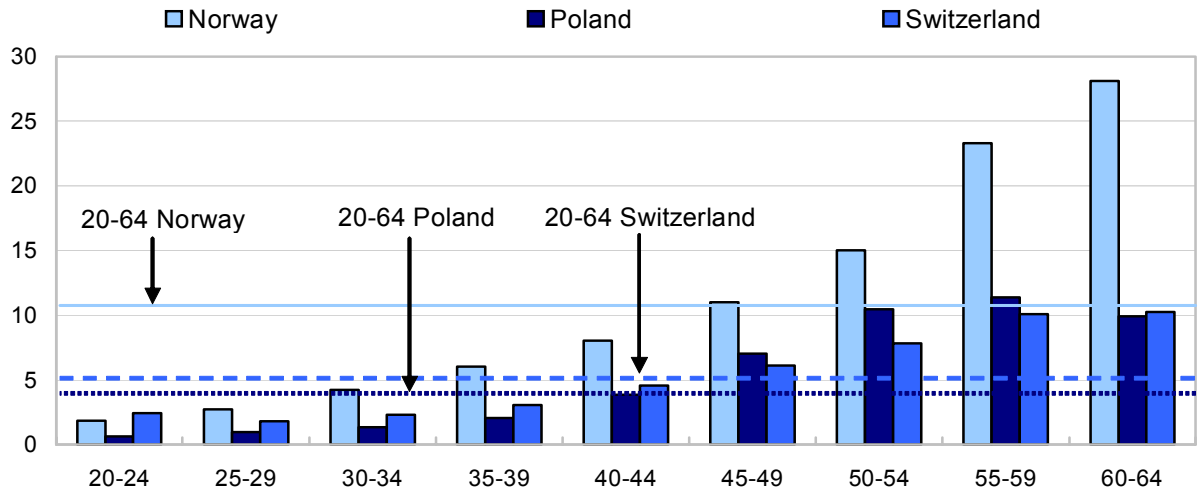
65. In all three countries, inflow rates increase steeply with age. In Norway and Poland, people in the age group 55-59, for instance, are three times as likely to be granted a disability benefit as those in the age group 40-44 (two times in Switzerland) (Figure 1.7). The result is that people in the 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 years in Poland and 47 years in Switzerland. For comparison, the average age was around 56 years across 20 OECD countries in 1999 (OECD, 2003a). This suggests that, despite the larger 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.

66. 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 a disability benefit recipient 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 larger extent driven by women's inflow rates.

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

Inflow into disability benefit in percentage 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 authorities: NIA (Norway), IV (Switzerland) and ZUS (Poland).

67. In all these comparisons, the following should be noted: For Norway and Switzerland, throughout the report stocks 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, *i.e.* different coverage rules requiring different calculation procedures, and because of limited data availability in Poland for both social pensions and the special system for farmers, disability benefit rates are computed in a different manner for Poland than for the other two countries. In this country, rates are computed as the ratio of the inflow into or the stock of people on ZUS disability benefits over the non-agricultural labour force – thus excluding 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).

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

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 to this problem of comparability chosen in OECD (2003a) was to add stocks 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 stocks 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, too. For much of the report, this is the reference used for Poland. Data for the KRUS scheme and on social pensions are only used occasionally.

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 1000, slightly lower than the figure of 4.1 per 1000 obtained when only ZUS data is used. The annual inflow rate into KRUS disability benefits (over the agricultural labour force) was 9.8 per 1000, *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 stock of KRUS benefits are aged 50-64. ZUS benefits are more evenly distributed and two-thirds of the inflow occur in the age group 40-54. The stock 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 if all three schemes had 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.

E. Addressing the increasing medicalisation of labour market problems

68. 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 percentage 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).

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		
			Male	Female	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

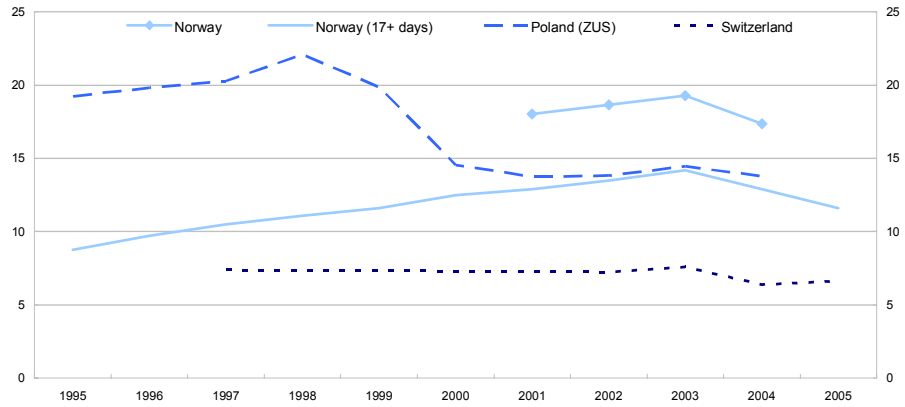
Source: EU Labour Force Survey 2006.

69. These percentages, however, are much higher in the three countries under review: almost 30% in both Norway and Poland (although it has been falling in both countries 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.

70. There are many pathways leading into disability benefit receipt. The most common one is entry via sickness absence. Long-term absence from work 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 Norway, with 17 days annually per employee in 2004 (Figure 1.8). Next comes Poland with about 14 days of absence per year (referring to the ZUS regime alone). Sickness absence is lowest in Switzerland, at about 6-7 annual days per employee.

Figure 1.8. **High level of sickness absence in Poland and especially Norway**

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



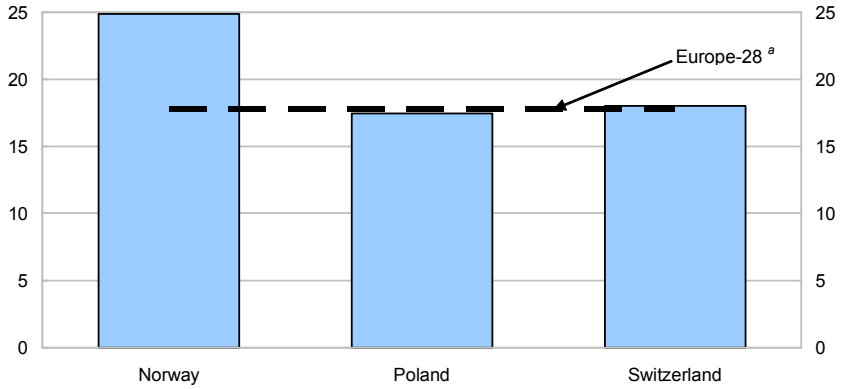
a) For Poland, ZUS benefits only.

Source: Administrative data from National Insurance Authorities 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.

71. A special and increasingly important challenge for sickness and disability policies is the increase of non-specified diseases, in particular psychological diseases such as mental disorder. It has been argued that of the ten leading causes of disability worldwide, five are psychiatric conditions (ILO, 2000). In Europe, mental illness has become the disease group with the highest share of disability-adjusted life years (DALY) lost, accounting for one quarter of all DALYs lost (Andlin-Sobocki *et al.,* 2005). Among the three countries considered here, the overall prevalence of mental disorder is highest in Norway, concerning roughly 25% 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), p. 9.

72. As a consequence, mental diseases as a reason for take-up of disability benefits also increased to very high levels. At the latest date, they accounted for 17% of all inflows in Poland, 25% in Norway and over 40% in Switzerland (Table 1.6). Their prevalence is considerably higher among women than men in both Poland and Switzerland (not so in Norway). The *growth* in mental diseases 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 benefit**

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

.. Not available.

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

Source: National insurance authorities: NIA (Norway), IV (Switzerland) and ZUS (Poland).

F. Raising the outflow from disability benefits

73. Another challenge for successful disability policies will be to find ways to increase substantially outflows from disability benefits, in particular into paid work. This key problem for disability policy is found in practically all OECD countries. While some policies had some success in the recent past with controlling inflow rates (see above), outflow rates 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 levels of younger disabled persons, aged 20-49: those are as low as 1-2%.

Table 1.7. **Very few younger disabled beneficiaries succeed to leave benefit rolls**

Outflow rates from disability benefits as a percentage of the stock of 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 authorities: NIA (Norway) and IV (Switzerland).

74. 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 driven by moves into (early) retirement and by premature death. After excluding outflows into retirement and deaths, overall outflow rates drop to 1.5% in Switzerland, 0.5% in Norway and 2.5% in Poland (Chapter 3). These rates are extremely low: once people get on disability benefit, they are very unlikely to ever leave it.

75. Another indication of the very low number of disabled people getting into the labour market successfully 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. Services are the main employer of disabled persons in Norway (over 80%), but this holds for non-disabled inactives, too. However, in Poland, a majority (57%) of those who were disabled in 2003 and found a job one year later worked in agriculture (whereas the share of all inactive persons moving to farming was only 26%). Between one-fifth (Poland) and one-quarter (Norway) of all inactive persons who got a job have higher education; this is the case of just 6% among the inactives who were disabled in both countries.

76. 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 other benefits such as social assistance, housing or family benefits) with taxation at different earnings levels can lead to situations where "it does not pay" to work or to increase working hours. Chapter 4 shows that this is a real issue in all three countries for some income groups (especially those with below average earnings) as well as family types (especially those with children), with effective tax rates for beneficiaries taking up work sometimes reaching levels close to or even above 100%.

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

Percentage of persons in employment in 2004 after having declared themselves disabled and inactive in 2003, and distribution by industry, educational attainment and full-time/part-time status, percentages adding to 100

			Distributions, in percentages								
			by industry			by educational attainement			Full-time / Part-time		
	Disabled	All inactives		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			

Source: EU Labour Force Survey 2004.

G. Strengthening the coordination across different benefit schemes

77. A last key challenge for policy makers in the three countries is the existence of a number of parallel social protection schemes, each covering different life risks, and the lack of coordination and cooperation between them. 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 the case. A younger, economically and socially disadvantaged person, for instance, with some psychological problem and who does not find a job, may end up being moved around between the different branches – the so-called "carrousel effect".

78. Moreover, reform in one scheme is typically not or not sufficiently coordinated with that in other schemes, often with detrimental impact on the disability benefit scheme. Tightening of access and stricter work testing, *e.g.* in unemployment schemes, could change preferences among potential applicants and put higher pressure on remaining unchanged schemes, such as the disability scheme. Reducing the attractiveness of one scheme, *e.g.* lowering benefits in the old-age pension scheme or phasing-out of early retirement pathways, can lift the relative attractiveness of accessing other schemes, *e.g.* retiring through the disability benefit scheme. Easing the access to temporary benefit schemes, such as sickness benefits, could put people at a distance to 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.

79. The only way to avoid disability benefit becoming a last-resort income support for those not or no longer entitled to other benefits but unable or, as the case may be, unwilling to work, is to coordinate reforms and to improve the cooperation between schemes.

2. Contextual social and economic developments

80. The institutional features described in the preceding section influence sickness and disability outcomes to a large extent. However, while institutions are subject to change and to reform, policy makers also have to cope with exogenous social and economic developments over which they have little or no discretion but which impede on sickness and disability policy making. Among these are general labour market developments, health trends and population ageing. These factors are discussed in the following.

A. Labour market trends and requirements

Unemployment trends

81. A key constraint in rapid improvement in the outcomes of disability polices 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, rising to 26% for the less-educated and 38% for those under age 25 (Table 1.9). Added to this, the incidence of long-term unemployment is also very high, 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. With such a difficult labour market situation, it is not surprising that people with health problems and disabilities face particular obstacles.

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

Employment, unemployment and long-term unemployment (percentage)

	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.

82. 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 these circumstances, general policies to increase labour demand are warranted, including 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 or relatively generous benefits also contribute to Poland's low activity rate. Labour supply policies are therefore equally important to overcome the distortions the benefit systems currently impose on the labour market.

83. Norway and Switzerland are not facing as deep labour market problems as Poland. Employment rates are among the highest in the OECD in both countries, and unemployment rates are relatively low. Nevertheless, unemployment trends are important in understanding sickness absence and disability benefit outcomes. In Switzerland, problems with the 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 those being unemployed were in this situation for over a year, and almost 60% for more than half a year; these are higher shares than are found on average across all OECD countries.

84. In Norway, falls and rises in unemployment are important because of the close relationship in this country between the unemployment rate and the rate of absence from work due to sickness.[5] From the mid-1980s until the year 2000, sickness absence has clearly increased when unemployment fell, and vice versa.[6] 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 to sickness and disability policy making.

Economic restructuring and its impact on health

85. 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 work loads, work pressure and job insecurity increasing. All these can impede on sickness and disability prevalence via two channels: first, indirectly, in that so-called "niche jobs" get rarer, leaving less employment opportunities for people with health problems and disabilities. Second, directly, in that increased work pressure and unhealthy employment relationships in themselves can create health problems of employees and lead to disability.

86. To which extent labour market restructuring and related pressures for employees have taken place, is difficult to say, as 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 average OECD country.

87. Labour productivity has increased all over the OECD as much as in Norway, Poland and Switzerland (Panel A), and rates of growth were generally higher after than before 1998 (though not in Norway). Changes in working hours, on the other hand, were very small everywhere, and the large country differences in the proportion working over 40 hours per week as an indicator of work loads very 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 as a whole, though not in Poland – where this share increased in the past five years from about 5% to 25% (Panel C). Job stability, measured through five-year job retention rates, is lower in Norway, Switzerland and also Poland than on average across the EU-15 countries, yet again, changes over time were small (Panel D). Finally, hiring rates may indicate a slight downward trend everywhere from around 17% in 2000 to around 15% in 2004 (Panel E).

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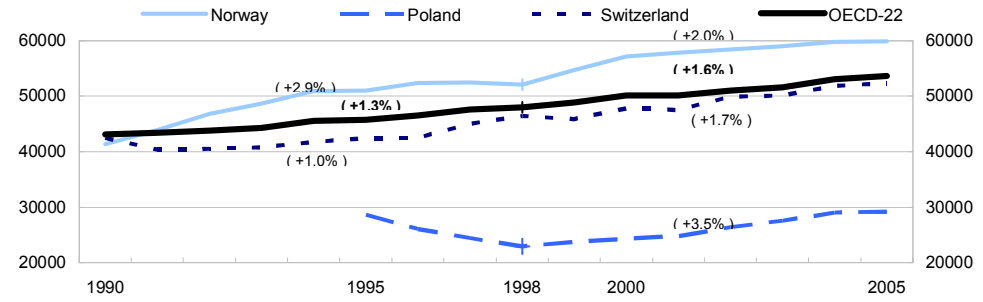
5. Askildsen *et al.* (2005), for instance, demonstrated the effect of unemployment on sickness spells lasting at least 15 days on the basis of panel data for the years 1990-1996, an effect explained by the behaviour of established, fully-insured workers, not by the composition of labour.

6. Since the year 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.

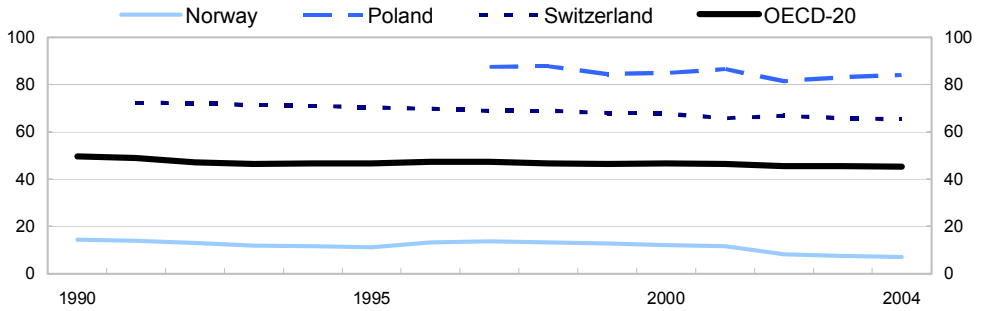
Figure 1.10. **Inconclusive evidence on changes in the working environment**

Panel A. Changes in labour productivity per employee, 1990-2005
Real GDP in US$ PPPs divided by employment in the business sector

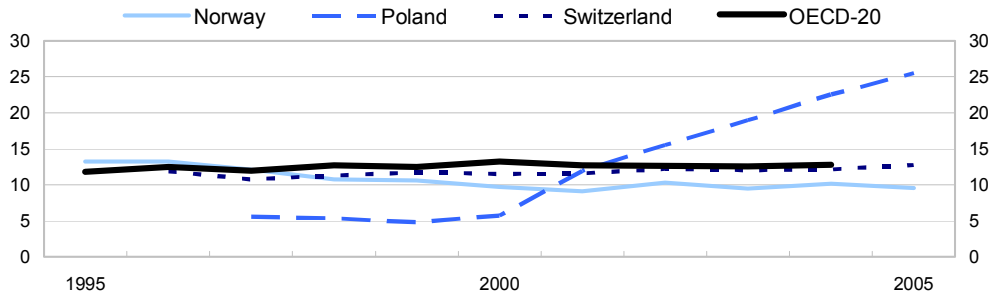


In brackets: annual average growth rates over 1990-1998 and 1998-2005.

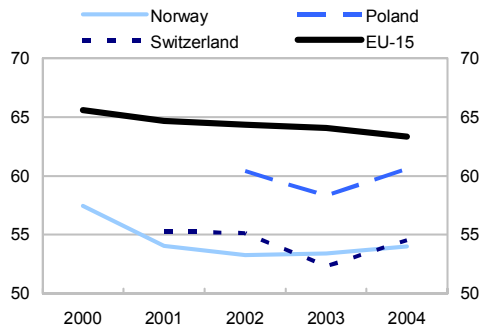
Panel B. Incidence of long working hours, 1990-2004 (percentage 40+ hours)



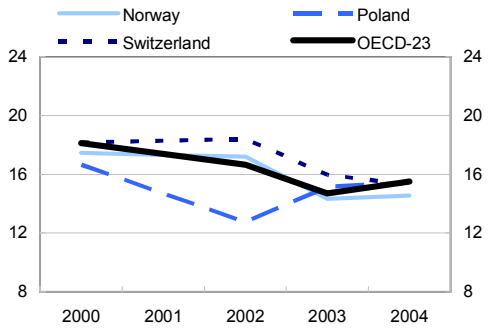
Panel C. Incidence of temporary work contracts, 1995-2005 (percentage)



Panel D. Job retention rates, 2000-2004
Employees with tenure over five years (in %)



Panel E. Hiring rates, 2000-2004
Employees with tenure below one year (in %)



Source: OECD Economic Outlook, OECD database on working hours, EU Labour Force Survey, national sources.

88. In sum, therefore, objective evidence on changes in productivity, work loads and job insecurity is inconclusive. Neither are changes big enough to explain sickness and disability trends, nor are the directions of change always in line with rising or falling rates of sickness absence or inflows into disability benefits. Studies on causal relationships between economic restructuring and health do not obtain uniform conclusions either. Grasdal, Salvanes and Vaage (2005) find that workers in downsizing firms in Norway have an increased probability of reporting sick, but also to report 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 comparable workers in non-downsizing firms (Statistics Norway, 2005). A German study (IAB, quoted in NZZ, 2006), on the other hand, found an inverse relationship between enterprises' dismissal rates and the incidence of work absence.

Work-related stress and mobbing

89. But there is also evidence from different countries about the detrimental effect of *perceived* job insecurity on individuals' perceived health status (Domenighetti *et al*., 1999 for Switzerland, Ferrie *et al*., 2002 for the United Kingdom, Burgard *et al*., 2006 for the United States). Moreover, the changing work environment has also lead to a range of "new phenomena" such as increasing stress, burn-out, mobbing and harassment which are likely to have detrimental effects on health. The EU working conditions survey, carried out in 2000/2001 and covering 25 EU countries, found that about 28% of workers were affected by work-related stress, on average, 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, 2000).[7] The incidence is higher for women and younger workers. This Swiss study found a correlation between stress and work intensity but not between stress and the physical demands of a job.

90. There is some evidence for European countries that mobbing, 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%). The lion's share of this rise is due to increases among female employees. Mobbing and its health consequences has recently also become an issue in Switzerland (SECO, 2003). Self-declared mobbing amounts to 4.4% of all workers, compared to an estimated 7.6% victims of mobbing according to objective measures.[8] Detrimental health consequences of mobbing are quite distinct: Almost half of all mobbing victims, for instance, suffer from depressions while this percentage is only 14% among non-mobbed workers. While, like for work-related stress, there is a strong correlation between mobbing and work intensity, there are no significant differences by age, gender, education or industry.

Work, worklessness and health

91. Yet, while too much pressure at work can result in sickness and deteriorating health, the absence of work (or from work) is even unhealthier. A literature survey by Waddell and Burton (2006), based on both clinical literature 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. Worklessness can have significant adverse effects on health, while work promotes health and well-being and can reverse the adverse health effects of inactivity and unemployment.[9]

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7. 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.

8. Leyman Inventory of Psychological Terrorization (LIPT).

9. 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.

92. In addition, Waddel and Burton (2006) also conclude that there is a broad consensus that, when possible, sick and disabled people should remain in or return to work as soon as possible, because it

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

93. In conclusion, despite somewhat inconclusive evidence, policy makers are facing a vicious circle. Raising 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, drop out of the labour market. Once out of the labour market, however, the absence of a job impedes adversely on the health status. Policies need to address this vicious circle.

B. Health trends and disability in the population

94. 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. The following section, however, suggests that such arguments cannot explain changes over time and differences between countries in the use of these programmes, but also that the relationship between subjective and objective health and disability indicators is complex and ambivalent.

95. First, who are the people who have to cope with a disability and how many are they? In the following, "disability prevalence" is defined as the percentage of persons reporting a long-lasting health problem which 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.

96. Self-assessed disability prevalence, however, is not at all the same as the percentage of registered disability benefit claimants reported above. Indeed, the overlap between these two groups of the population and target groups for policy is far from perfect and sometimes below 50% (see Box 1.3 at the end of 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).

97. 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 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 for disability prevalence, again more so in Poland where people with lower education are twice as likely to report a disability than the total working-age population, while prevalence among those with university education is below 4%.

Table 1.10. **Higher disability prevalence 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

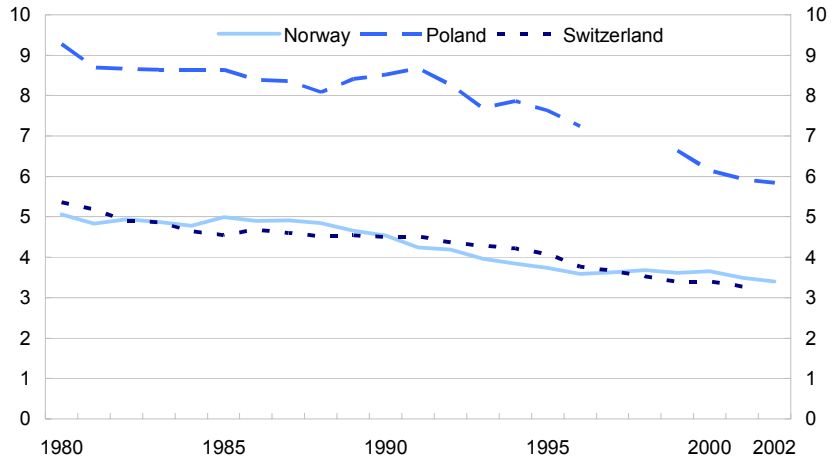
a) In Poland, disability prevalence refers to reporting of "legal disability" (see Box in the Annex to Chapter 1).

Source: National labour force surveys for Norway and Poland, national health survey for Switzerland.

98. 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 which are, a priori, preventable. In all three countries under review, 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).

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

Potential years of life lost 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 with the number of remaining years to live up to a selected age limit. The limit of 70 years has been chosen for the calculations. In order to assure cross-country and trend comparison, the PYLL measure has been standardised.

Source: OECD Health Data (2005).

99. In conclusion, therefore, subjective health or disability indicators provide quite a different picture of the health status than objective ones. This suggests that trends in sickness and disability benefit recipiency are not necessarily linked to the overall development in health.

C. The impact of population ageing

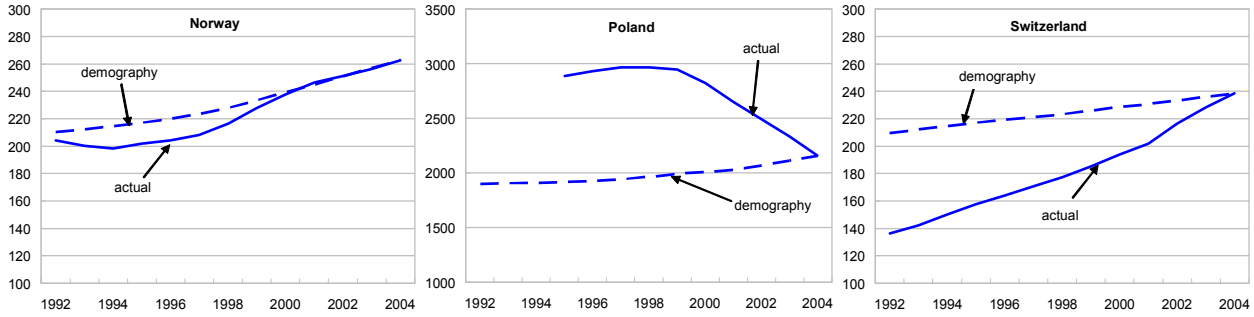
100. A third external argument sometimes brought forward for the increasing number of people on sickness and disability benefits is the ageing of the (working-age) population. As shown above, both disability prevalence and benefit recipiency increase strongly by age in all three countries, because older people are likely to have more health problems. A higher share of older people among the working-age population will, therefore, automatically lead to higher disability rates and related costs, 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 demography (BSV, 2005).

101. To which extent are recent trends in disability beneficiary rates explained by changes in the population structure? One way to explore this issue is by keeping the current age and gender structures of beneficiary rates in each country constant, applying those to historical population data and comparing the results to the actual trends in beneficiary rates and numbers. The difference between the two resulting time series is the part of the development which results from changes in benefit receipt and therefore cannot be explained by changes in the size of the population "at risk".

102. Quite different patterns emerge for the three countries under review (Figure 1.12). In Norway, the two lines move closely together, which means that much of the increase in beneficiary numbers during the past 12 years is explained by demographic changes, *i.e.* primarily ageing. During the past four years, there was practically no difference between the actual and the backward-projected beneficiary numbers.

Figure 1.12. **Beneficiary trends in Norway in the past 12 years were dominated by demographic change**

Number of disability beneficiaries 1992-2004, actual and adjusted for demographic development[a]



a) The dotted lines labelled "demography" show numbers of beneficiaries under the assumption of constant age- and gender-specific beneficiary rates of 2004, the straight lines show actual numbers of beneficiaries. Poland: trend 1992 to 2003 in KRUS and social pension beneficiaries assumed to follow the trend of ZUS pension beneficiaries.

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

103. By contrast, a much smaller part of the increase in disability beneficiaries in Switzerland is due to changes in the Swiss population structure. Since 1992, the number of beneficiaries increased by about 100 thousand, and 30% of this increase is explained by ageing. The pattern is again different in Poland. In this country, population ageing would have increased the stock of disability beneficiaries by some 10% but actual numbers fell by more than 25%, from almost 3 million to close to 2 million people. This means that the already considerable reduction would have been even larger in the absence of population ageing.

104. 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. The availability of national population projections allows to estimate future trends in disability beneficiary numbers due to population ageing alone. Again, for this crude and illustrative exercise, it is assumed that the age and gender structure of beneficiary rates of 2004 remain constant.

105. Results from these projections are summarised in Table 1.11. Projected beneficiary rates appear to move in a less spectacular way than pure numbers of beneficiaries.[10] Over the next two decades, beneficiary *rates* are projected to increase by one percentage point in Norway and Poland and half a percentage point in Switzerland due to population ageing. Over the long run, *i.e.* until 2050, the total *number* of beneficiaries is projected to increase by one-fifth in Norway but to decrease by one-tenth in both Poland and Switzerland. This is to a large extent 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. That said, a high pressure for all three countries seems to exist over the next few years when both numbers and rates are projected to increase considerably.

Table 1.11. **Population ageing will have more impact on beneficiary numbers in Norway and Poland**

Projected disability beneficiaries and beneficiary rates: effects of demographic changes, 2004-2050

	Norway		Poland		Switzerland	
	Number of persons (1000's)	Benecificary rates	Number of persons (1000's)	Benecificary rates	Number of persons (1000's)	Benecificary rates
2004	263	8.0	2158	10.9	238	5.9
2010	289	8.5	2418	12.0	247	6.1
2015	293	8.5	2406	12.3	249	6.2
2020	301	8.6	2276	12.2	252	6.3
2025	307	8.7	2201	12.3	248	6.4
2030	309	8.8	2282	13.2	236	6.3
2035	303	8.6	2398	14.2	227	6.3
2040	298	8.4	2398	14.8	225	6.2
2045	305	8.5	2248	14.8	225	6.3
2050	316	8.7	2001	14.2	223	6.3

Source: Secretariat projection based on OECD population database and beneficiary data from National Insurance Administrations.

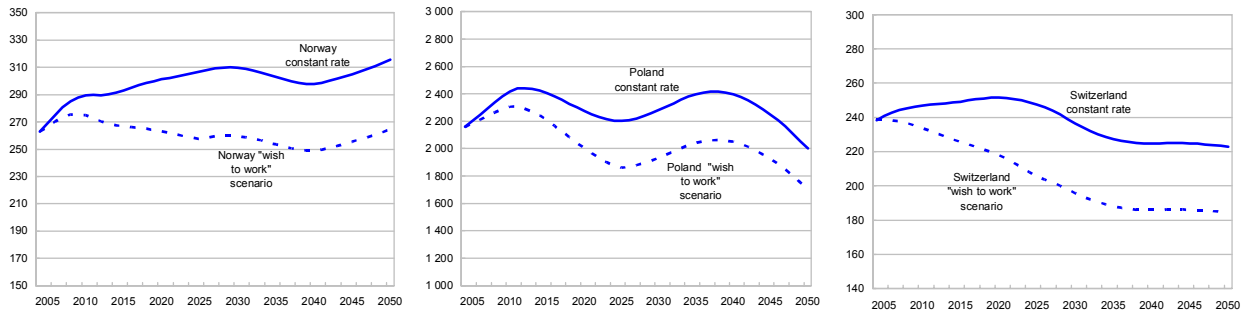
106. Applying demographic projections to forecasts of social protection beneficiaries is a useful way to point policies to current and future constraints arising from ageing and to adapt corresponding reforms. An alternative way of looking at the impact of demographic change and further needs for reform is to base projections on outcome *targets* for the future which build on characteristics and needs of the concerned population itself. This is done in Figure 1.13, which shows the development of beneficiary numbers over the next 45 years under the assumption of constant rates (straight lines) and under a policy target scenario (dotted lines). This scenario is based on actually observed wishes of disabled persons to return to work, taken from Table 1.3 above. The scenario assumes that, by 2025, all three countries will have decreased

10. Trends for beneficiary numbers and rates may even move in opposite directions. This can happen when, for instance, the weight of a "disability-prone" population group is projected to decrease but, at the same time, the total working-age population decreases even more, so that overall beneficiary rates would increase.

their age-and gender specific beneficiary rates by a percentage which corresponds to the percentage of disabled people wishing to work.[11] This reduction is assumed to be phased in annually from 2005 on.

Figure 1.13. **Disability benefit dependency will remain high if all disabled people who wish to work do so**

Projected number of disability beneficiaries 2005-2050 under a constant rates and a policy target scenario[a]



a) The straight lines assume constant age- and gender-specific disability beneficiary rates as at 2004. The dotted lines assume an annual reduction of beneficiaries until 2025 corresponding to percentages of disabled persons who say they want to work, by age and gender.

Source: Secretariat projection based on OECD population database and beneficiary data from National Insurance Administrations.

107. Figure 1.13 shows that the labour market integration of all those who would wish to work would have sizeable effects, even beyond the target date of 2025. In Norway, instead of a steady increase in three waves, beneficiary stocks would remain broadly constant and oscillate between 250 000 and 270 000. In Switzerland, the constant increase until the early 2020s would be transformed into a considerable fall, and in Poland beneficiary numbers would fall below the two million benchmark during the 2020s. That said, even when achieving the optimistic target to integrate all disabled persons who expressed wishing to work over the next 20 years, this may still not be sufficient to prevent periods of increasing disability stocks, such as the 2040s in Norway or the 2030s in Poland.

3. Conclusion from the key outcomes

108. The following stylised facts emerge from the picture drawn above:

Benefit dependency, income and employment

- Across the three countries, there is a trend towards convergence in disability benefit spending to 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 and 11% in Norway and Poland 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, and this difference is particularly large in Poland. Moreover, this differential tended to grow over the past few years in all three countries.

11. For example, it is assumed that, by 2025, the Norwegian beneficiary rate of 20-34 year old men will be 30% lower than the one which would prevail on the assumption of no change in policy effectiveness.

- Unemployment is higher among disabled people. However, one in four inactive younger disabled people 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 OECD average in Switzerland (0.6%). Due to a steep decline in the past decade, these rates have recently fallen below OECD average in Poland (0.4%).

- The average age of new disability benefit recipients is below the OECD average, at 52 years in Norway, 48 years in Poland and 47 years 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 from taking a job or increasing working hours are often very small, sometimes non-existent, especially for those earning below average earnings.

- 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, disability beneficiary rates in Norway were largely driven by population ageing, while in Switzerland ageing accounted for 30% of the increase in those rates. In Poland, developments were driven by policy rather than by demographic factors.

- Projections of disability beneficiaries indicate some pressure on the system arising from population ageing especially in the next ten years or so, especially in Norway and Poland.

Box 1.3. **Defining and measuring the extent of "disability" is a complex matter**

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 *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 with 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, also administrative records may 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 but which does not necessarily go in pair with eligibility 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 which limit daily life activities, the detailed questions across countries and surveys usually differ. "Long-lasting", for instance, is defined as 6 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 case of multiple benefits, can lead to double counting. On the other hand, surveys are based on responses on benefit status and some people may not wish to reveal their benefit status.

Measures and definitions used in the report

No one of the above definitions and measures is 'superior' to others and their use depends on the topic investigated (*e.g.* benefit expenditures versus income adequacy) and on data availability. Throughout the report, several of the above 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, as "biological" disability would be too restrictive and, although linked to a certificate, the "legal" status remains self-reported. In any event, 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 a set of different available indicators for the extent of disability. Subjective definitions tend to lead to higher disability rates (Table B.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).

Box 1.3. **Defining and measuring the extent of "disability" is a complex matter (cont.)**

Table B.1. **Prevalence and benefit receipt: different disability definitions**

Number of working-age persons with a disability in percentage of the working-age population, 2004 (or closest)

	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

Source and disability definitions:

col (A): National insurance authorities: NIA (Norway), IV (Switzerland) and ZUS (Poland).
col (B): Poland: LFS 2004.
col (C): Norway: LFS 2005-Q2 (Self-assessed disability status); Poland: LFS 2004 (persons declaring being 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 6 months); Poland: HBS 2004 (persons declaring being 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 the overlap between self-reported disability and benefit receipt is far from being perfect. Figure B.1 explores this overlap in more detail (overlap between self-assessed disability and disability benefit recipients in Norway and Switzerland; and between biological and legal disability in Poland). The total height of the bars indicate 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% to 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 (biologically disabled in Poland) on the one hand, and people who describe themselves as disabled but do not receive benefits on the other.

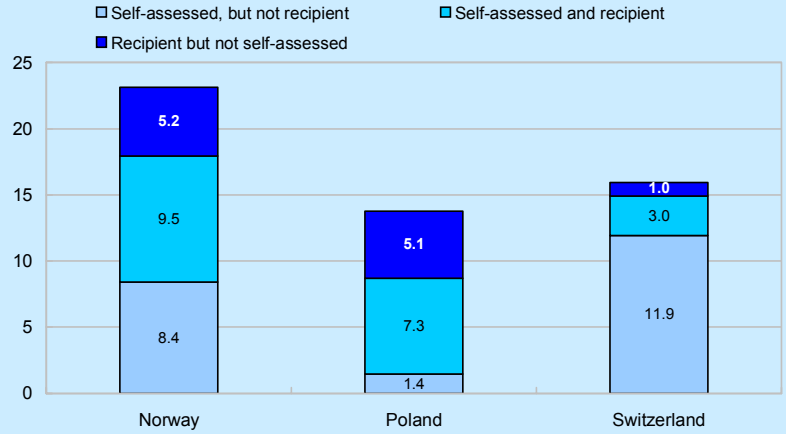
The inclusion error seems to be higher in Poland: about 40% of persons holding a disability certificate (the "legally disabled") declare themselves as *not* being "biologically" disabled, while the percentage of beneficiaries declaring themselves as not disabled is 35% in Norway and 25% in Switzerland. 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. It should be noted that the percentage of disability benefit recipients among the self-assessed disabled varies greatly across countries due to different institutional settings and different age structures (*e.g.* many older disabled people will draw a retirement rather than a disability benefit). The European Commission (2002) reports indicators for the year 1996 according to which 60-65% of severely disabled people aged 16-64 received sickness or disability benefits in Belgium, Denmark and the United Kingdom, while this percentage is below 40% in Austria, Greece, Luxembourg and Portugal (EU-14 average of 48%). More generally, 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 (in particular old-age pensions). This is, however, not possible with the data at hand.

Box 1.3. **Defining and measuring the extent of "disability" is a complex matter (cont.)**

Figure B.1. **Self-assessed disability and benefit receipt: overlap** [a]

Percent of the working-age population, 2002 (Poland and Switzerland) and 2004 (Norway)



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 in Switzerland.

For Poland, some other characteristics of the three groups of disabled people can be analysed. This shows that persons who are biologically but not legally disabled (the "exclusion error") are disproportionally women, lower educated and younger. In contrast, those legally but not biologically disabled are to a greater degree older and higher educated. As concerns the age differential, this may indicate a greater recurrence to early and old-age pensions. As concerns the education differential, this may well indicate problems of information advantages. Policies to better inform about eligibility rules and simplifying 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 B.2. **Poland: Characteristics of disabled persons, different disability definitions and overlap**

Percentage shares, 2002

	Characteristics										
Disability status	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.

CHAPTER 2

CONTROLLING THE INFLOW TO LONG-TERM BENEFITS

109. All three countries face significant challenges in terms of curbing high and – for Norway and Switzerland – increasing stocks 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 starts by discussing how an improved sickness management may help reducing inflow rates to disability benefits. It further stresses the importance of a sound medical and vocational assessment process and argues that rehabilitation is an important instrument given that it is wisely used. Throughout the chapter, particular emphasis is given to 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.

1. Sickness management

110. 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 pre-requisites 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, a sound sickness management is crucial to control the inflow to disability benefits. This section starts by describing pathways leading to a disability benefit in Norway and continues by discussing short and long-term sickness absence and possible ways to re-assess and monitor absence in the three countries.

111. 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 sickness 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 benefit 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 (with 34%), followed by vocational rehabilitation (22%). However, most of those undergoing medical or vocational rehabilitation have started their benefit career on sickness benefit.

112. 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 even over 40% of all recipients 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 a benefit in 2003, 41.9% came from sickness benefits and 33.7% and 22.1% from medical and vocational rehabilitation, respectively, while 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 in 1 January 2004.

Source: Administrative data supplied by the National Insurance Administration.

A. The persistence of sickness absence

113. 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 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, which 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.

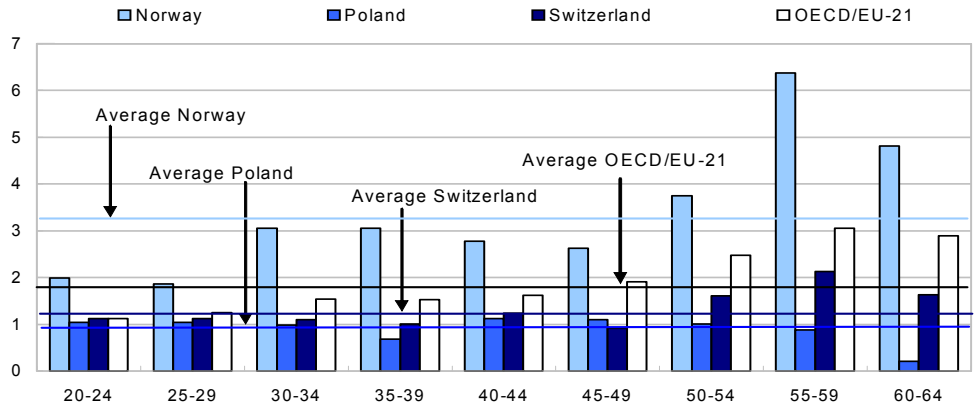
114. The steep upward trend in Norway was reversed in 2004, and for 2005 absence is projected to reach 11.5 days per employee, *i.e.* a fall of almost 20% compared to 2003. However, this is an over-estimate which does not take self-certified sick leave into account. The introduction in mid-2004 of an activity requirement within eight weeks of granting the latest sickness certificate and a mandatory evaluation of functional capacity and documentation by a GP has played an important role for 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).

115. 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 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 (Chapter 1.2). Evidence from epidemiological and clinical research shows that long-term sickness absence and disability depends more on individual and work-related psycho-social than on biomedical factors or the physical demands of work (Walker-Bone & Cooper, 2005).

116. In contrast to Poland, where sickness absence 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). 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 the incidence of sickness absence with age is less pronounced than the increase with age in disability benefits. This in turn may be explained by falling labour force participation rates in older ages, *i.e.* it is people with better health and perhaps also better jobs who continue to work in older ages.

Figure 2.1. **Incidence of sickness absence varies across both age and countries**

Percent of employed in each age group, 2005[a]



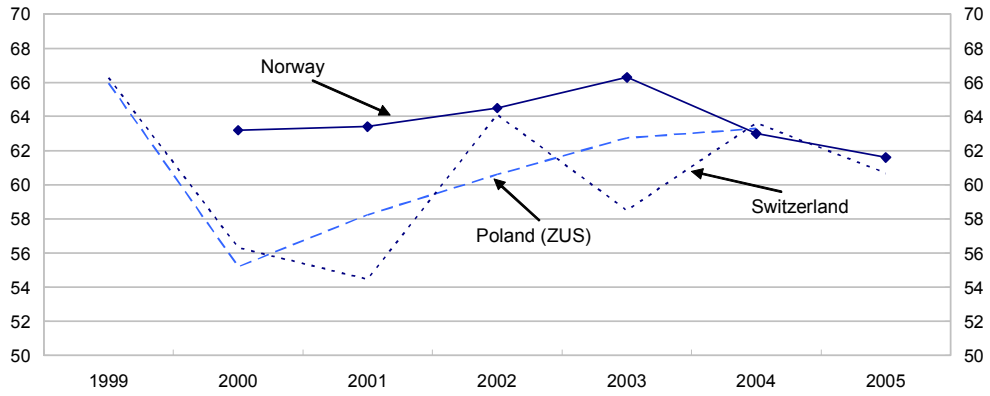
a) Employed persons reporting not having worked at all during the week prior to the survey, due to own illness, injury or temporary disability. The average refers to averages across all age groups.

Source: EULFS.

117. 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 as already reported in Chapter 1: when sickness absence peaked in 2003, long-term sickness accounted for two-thirds of total sickness, higher than in Poland and Switzerland. In Poland, long-term absence fell markedly, by 10 percentage points in 2000, as an effect of the stricter rules, while 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 incidence. 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 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 months) 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 being absent from work for more than one month.

Source: Statistics Norway, Administrative data from ZUS (Poland) and Swiss labour force survey.

B. The importance of monitoring sickness absence

118. 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 re-assessing medical conditions 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.

119. Timing is crucial and will require close cooperation 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 indications recently that this decline in sickness absence is being reversed. Effective control of sickness absence certificates is one 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).

Box 2.1. **Re-assessing and monitoring sickness absences**

In Poland and Switzerland, a certificate from the treating doctor is required from the first day of illness. In Norway, in contrast, self-declared absence is possible for up to three days (four times a year) and even up to eight days (in this case three times a year) in companies with an agreement with the local social insurance branch. In all three countries, long-term sickness absence is assessed and re-assessed by the GP. Countries differ in the extent of control and monitoring of these decisions. In Poland, controls by the public insurance are possible, including home visits, but only after expiration of the employer period, *i.e.* from day 34 onwards. However, in practice 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 control 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 supposed to prepare a follow-up plan (with the help of the employee and the local Workplace Centre) after a period of eight weeks of sickness absence of an employee. 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 cooperation with the employer at this stage.

120. 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, *i.e.* often 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 on 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.

121. 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 for the reason of their absence. The recent introduction of the Bonus-Malus system in the sickness benefit insurance system may have deteriorated the situation further. Premiums to private benefit sickness insurances 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 under-reporting. 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.

122. Another way forward could be the use of better *case management*. Case management implies that every sickness case is screened for health reason and that 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 2003, in the Netherlands, 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 usually. 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 such interview. 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.

123. Employers' monitoring of absent employees as well as check-ups 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 to a larger extent 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 loosing contact with the work place. 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 where the employee remains on full sickness benefit (and the employer pays no salary), while performing some work tasks for the employer (Box 2.3).

124. 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 on active sick leave had fallen, while the share on graded sick leave had increased. This is in line with the aim to 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 without returning to work on a full scale afterwards.

C. Summary and conclusion

125. 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 coordination between the disability insurance and the sickness benefit insurers.

126. Another issue in all three countries is the lack of monitoring and early intervention, *i.e.* 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 for Norway to succeed in reducing the sickness absence will merely 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.

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

The objective of the new Act is to find solutions at each workplace. As such, the measures of graded and active sick leave rely on the responsibility of both the National insurance office, the employees, the employers and the GPs.

The National insurance office: The National insurance office should not take over 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 non-work-related activity within 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 reorganization of the work situation and participate in the solutions available to the employer and employee. If the employee refuses collaboration, the consequence can be a 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 in order to help further monitoring of those on sick leave in preparation for returning 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.

2. Disability management

127. Increasing inflow rates to disability benefits are at odds with long-term trends in the health status of populations. The assessment process of a disability benefit claim is an important factor for explaining this paradox. To better understand this process in the three countries, this section begins by describing the persistence of disability benefits and the steps from a sickness absence to a disability benefit claim. It further examines the fast 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.

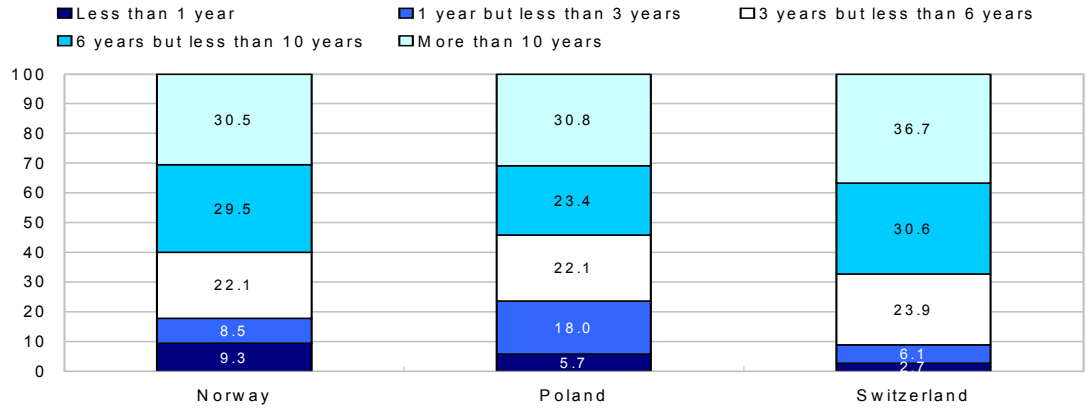
A. The persistence of disability benefits

128. In past years, in Norway and Switzerland, inflow rates have fallen or stabilised in older age groups but instead increased in younger and prime age groups. If this trend is allowed to continue, the average duration of a benefit period will increase further from already high levels (Figure 2.3). In all three countries about one-third of all recipients of disability benefits have been on benefits longer than ten years, while far more than half have been on benefits for more than six years. In Switzerland, more than 40% in the age group 35-49 have been on disability benefits for more than ten years – a higher share

than in the oldest age group (not shown in the figure). Similarly, over one-quarter of recipients aged 20-34 in Switzerland have been in receipt of benefits for ten years or longer (compared to 15% in Norway).

Figure 2.3. **Disability benefits are persistent in all countries**

Percentage of recipients in each duration group over all recipients aged 20-64, 2004[a]



a) For Norway the duration used is: less than one year, at least one year but less than two years, at least two years but less than five years, at least five years but less than ten years and ten years and over. Moreover, the distribution is based on recipients aged 20-66.

Source: The Norwegian National Insurance Authority (NIA), the Polish National Insurance Authority for the non-agricultural sector (ZUS) and the Swiss Disability Insurance (IV).

129. Country differences in benefit periods shorter than one year are mainly explained by variations in inflow rates. Since these have fallen dramatically in Poland in the past few years, the relatively larger share of beneficiaries with periods of one to three years is expected to fall further. The opposite is expected to take place in Norway and Switzerland since inflow rates in younger age groups are increasing faster than in older age groups. Except for these fluctuations, the pattern is fairly similar in the three countries. Somewhat simplified, one could say that relatively low shares of short-term recipiency are a result of successful inflow management, while high shares of long-term recipiency result from low outflow rates. As such, Switzerland, for example, could be said to be successful in terms of keeping inflows low, but less successful in terms of raising outflows. Norway does not appear to be very successful in controlling either inflow or outflow, which is surprising given their much stronger focus on re-integration measures (see below).

B. From sickness to disability

130. In all three countries, a disability claim often follows a longer 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 Dodo (2005), who shows that entering formal employment improves the sense of well-being and social integration among people with both physical and mental disabilities. Moreover, research into the management of lower back pain finds support for a primarily work-first approach (Lee, 2005). The benefits of work-first approaches to this condition 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 little use of a clinical approach.

131. 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 be related to 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 3 days of self-declared absence (up to 8 days in IW-firms)	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 3 weeks and 6 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 NIS 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 since then 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: Secretariat's compilation based on information from the Norwegian National Insurance Authority (NIA), the Polish National Insurance Authority for non-agricultural sector (ZUS) and the Swiss Disability Insurance (IV).

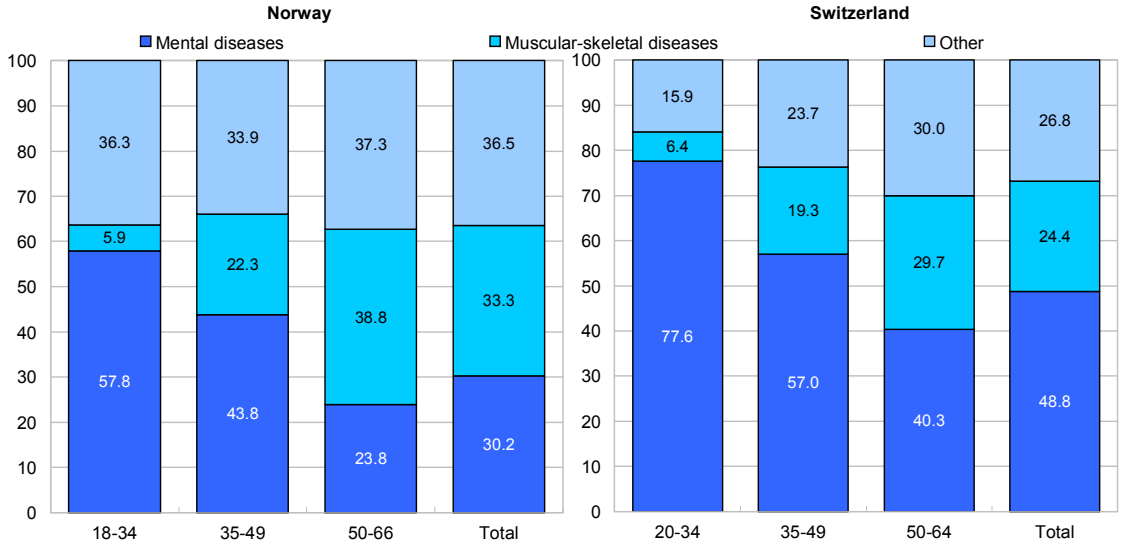
C. Medical assessment and mental diseases

132. In Norway and Switzerland (as throughout the OECD), mental and muscular-skeletal diseases are the two major health problems causing disability benefit recipiency (Figure 2.4). Mental diseases cover almost half of all 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% 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 2.4. **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 "Others" include: cardiovascular diseases, injuries and unspecified other diseases. For Switzerland, it includes accidents and all diseases other than mental and muscular-skeletal.

Source: Norwegian National Insurance Authority (NIA), Swiss Disability Insurance (IV).

133. The growth in mental health prevalence 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 2.5). Mental diseases have also overtaken muscular-skeletal diseases in numbers and are of the same magnitude as cancer. Still, mental health problems in Poland are far less widespread than in Norway and Switzerland. In Norway, mental health 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 benefits awards. In all three countries, the share of inflow because of mental health problems is much higher for the younger age groups.

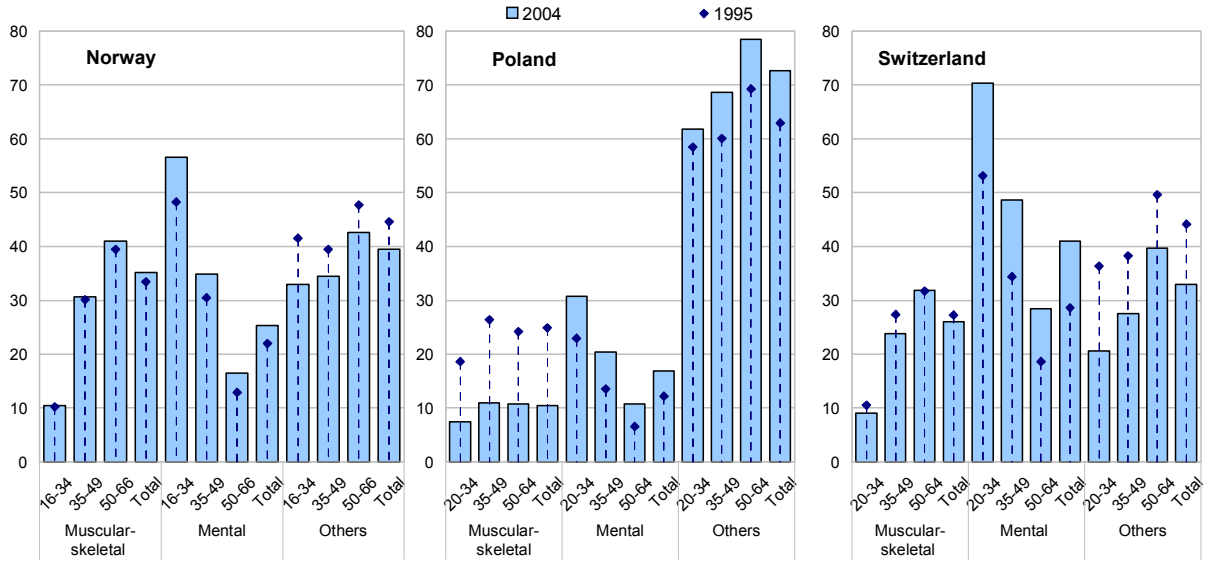
134. On these lines, Norway, in 1998, introduced a National Mental Health Programme, calling for a major increase in the funding of mental health-related services, as well as a major reorganisation of these services. Implementation of the programme is taking place during 1999-2008 and new laws regulating mental health services have been introduced. The overall goal for the programme is to promote independence, 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 getting treatment had increased considerably. However there is still a way to go when it comes to quality of treatment, access-time, 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.

135. This, however, cannot fully explain the striking gap between Switzerland and Norway in the incidence 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, etc. On these lines, other non-specific diseases, often pain-related, are also increasing fast as a cause of people getting 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.

Figure 2.5. **Large variation in the inflow to disability benefits by health reason and age**

Percentage of total inflow to disability benefits in each age group, 1995 and 2004[a]



a) For Norway, the category "Others" include: Cardiovascular diseases, Injuries and unspecified other diseases. For Poland it includes: Cancer, Nerve system diseases, Circulatory system diseases, Respiratory system diseases. For Switzerland it includes Accidents and all other diseases of which mental and muscular-skeletal.

Source: Norwegian National Insurance Authority (NIA), Polish National Insurance Authority for non-agricultural sector (ZUS), Swiss Disability Insurance (IV).

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

Evidence on 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 to what extent mental disorders are recognized, 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.

D. The assessment process

136. 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.

137. 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, often 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 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 strict and 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.

138. 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 a quarter (100% for a full benefit), while 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 of 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 a large deficit. Since 1996, registration in the system has been increasing each year, by 15% in total since that time. In 2002, KRUS spending amounted to 2.1% of GDP with contributions covering only 5% of this amount.

139. In Norway and Switzerland, medical evidence for a disability benefit claim is compiled by GPs. Benefit decisions in Switzerland are taken by the cantonal disability authorities, while in Norway these 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 both countries, additional medical experts are increasingly involved. In Switzerland, 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). In Poland, medical examinations for a benefit claim are undertaken by certified social insurance doctors. These doctors issue an assessment individually 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 large regional discretion can and does produce significant regional diversity in outcomes (Chapter 5).[12]

140. In Poland, since November 2005, benefits are only granted temporarily, but even earlier some 80% were approved for only a temporary period. Upon expiration of a temporary benefit (usually after three years), payments are terminated, individuals have to re-apply 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 either grant a temporary benefit, if the situation is likely to improve, or a permanent benefit. Continued entitlement for the latter is automatically re-assessed 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 re-assess an entitlement that was granted without a time limit. However, this is rarely done.

141. There is a third way to assess disability in Poland which goes through the local government (*poviat*).[13] This assessment is for a legal disability certificate rather than a disability benefit (although it often results in some forms of support) and requires several pre-defined 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 to grant a disability certificate. The applicants then have to indicate their interest to work. After these steps, a second advisor goes through 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.[14] Many persons also receive social pensions at a later stage by recommendation of the assessment offices.

E. Summary and conclusion

142. 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.

143. Many disability benefits would 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

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12. 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.

13. Poviat is a local administrative unit set up in 1999. Currently, the Polish territory is divided into 16 Voivodships, 308 Poviats and 65 cities with Poviat status.

14. A *minor degree of disability* corresponds to a situation where a person has restricted ability to perform social roles or with a body impairment that significantly reduces the 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.

important reason in all countries 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.

144. Since mental diseases are not clearly specified and not well understood, 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

3. Rehabilitation management

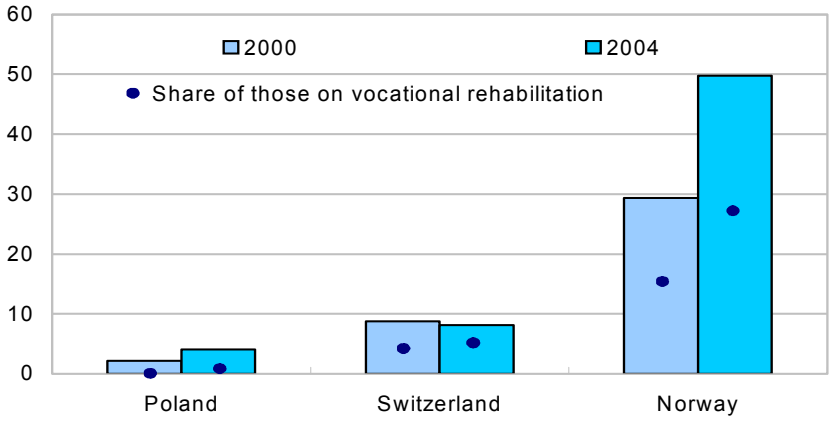
145. The stereotype of disability benefit recipients as people with severe medical conditions based on objective medical evidence such as blindness, severe neurological disease or amputation is no longer valid. Moreover, many of these health problems are potentially curable and long-term incapacity is 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 incidence 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

146. Rehabilitation is a process designed to enable people with health problems to function in a normal or as near-normal manner as possible. Whereas the objective of *vocational* rehabilitation is to assist people to remain 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 the stock of disability beneficiaries varies enormously, from 4% in Poland to 8% in Switzerland and 50% in Norway (Figure 2.6). In Norway and Switzerland, more than half of this is due to vocational rehabilitation, whereas in Poland the main part is medical rehabilitation.

Figure 2.6. **Incidence of rehabilitation is substantially higher in Norway**

People in medical and vocational rehabilitation as a share of the stock of 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; thus excluding medical rehabilitation offered by the health insurance system.

Source: Norwegian National Insurance Authority (NIA), Polish National Insurance Authority for the non-agricultural sector (ZUS), Swiss Disability Insurance (IV).

147. The high and increasing incidence of rehabilitation in Norway can be explained by the broader eligibility for participation in vocational rehabilitation, which, for instance, also includes those already on disability benefits. Access criteria also imply that *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 only 20% or more. *Vocational* rehabilitation is granted to those whose ability to find employment is permanently reduced by at least 50%, but 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).

148. With less than one in ten of all disability benefit recipients participating in rehabilitation in Poland and Switzerland, access is much more restricted compared to Norway. Switzerland uses a "rehabilitation before benefit approach" with an obligation for benefit applicants to undergo a rehabilitation measure if this is needed to restore, maintain or improve work capacity. However, rehabilitation programmes are only offered to persons who would otherwise be eligible for a disability benefit. In granting a measure, several criteria – including age, motivation, type of disability, and occupation – are being taken into account (Furrer *et al.*, 2003). On the contrary, rehabilitation is not mandatory in Poland, but rather restricted both in terms of eligibility and number of programme places – especially for vocational rehabilitation.

149. 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). The fact that so few people with a mental disorder undergo any rehabilitation is surprising since it is the fastest-growing disease. In Norway, the situation is the opposite and 36% of all people undergoing vocational rehabilitation have a mental disease compared to one-quarter of the inflow into disability benefits. Given successful outcomes from rehabilitation for this 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. **Health problems for people in rehabilitation are different from those on disability benefits**

Health problem distribution for rehabilitation and the inflow to disability benefits, 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 people with psychiatric problems, metabolic disorders, social maladjustment, substance abuse as well as learning difficulties.

Source: Norwegian National Insurance Authority (NIA) and Swiss Disability Insurance (IV).

B. Medical rehabilitation

150. 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 to be 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 contrary, medical rehabilitation in Poland and Switzerland is run by both the social security administration and the health sector. The former part is more vocationally oriented than the medical rehabilitation in the health sector.

151. There are no quantitative targets for those responsible for rehabilitation to, for example, re-integrate a certain share of the participants back to work. Instead, in both Norway and Poland (for the health-care related medical rehabilitation), medical rehabilitation benefits appear to be a way to extend 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.

152. In both Norway and Switzerland, medical rehabilitation is most frequent in the youngest age group (Table 2.4). While the incidence 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 incidence of medical rehabilitation as share of the inflow into disability benefits is extremely high in Norway; around two and a half persons receive medical rehabilitation for each person that is being granted a disability benefit. Judging from the high inflow rate to disability benefits, this enormous focus on medical rehabilitation does not appear to be very effective.[15]

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

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

	Share of the inflow				Share of the stock			
	20-34	*35-49*	*50-64*	*20-64*	*20-34*	*35-49*	*50-64*	*20-64*
Norway[b]	1021.9	405.0	56.5	240.1	165.7	47.9	4.8	23.2
Poland	..	..	..	101.4	..	..	..	3.8
Switzerland	126.1	9.7	28.2	35.1	14.3	1.0	2.7	3.4

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 underestimate 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: Norwegian National Insurance Authority (NIA), Polish National Insurance Authority for non-agricultural sector (ZUS), Swiss Disability Insurance (IV).

153. 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. Moreover, 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 lasted nine months.

15. In Poland and Switzerland, figures are solely based on the vocationally-oriented medical rehabilitation run by the social security administration.

C. Vocational rehabilitation

154. 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, re-training 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.

155. 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 and for the decision how to implement rehabilitation. 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.

156. 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 are largely unavailable.

157. Vocational rehabilitation and training is very frequent in Norway, with around seven 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 incidence of vocational rehabilitation falls steeply with age (Table 2.5). In Switzerland, older people appear to be noticeably under-represented: 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. On the contrary, the overall incidence of vocational rehabilitation in Norway is so high that the ratio of participants over the inflow to disability benefits is almost 80% even for those aged 50-66.

Table 2.5. **Also participation in vocational rehabilitation is extremely high in Norway**

Percent of inflows into disability benefits and as share of all beneficiaries, 2004

		Share of the inflow				Share of the stock			
		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: The public employment service, AETAT, for Norway and the Disability Insurance, IV, for Switzerland.

158. After the Norwegian decision, in 2004, to increase the focus on vocational rehabilitation further, the number of participants 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 cooperation 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 included also a time-limitation of medical rehabilitation to one year. As a consequence, the increased participation in vocational rehabilitation since 2003 (of around 10 000 persons) has more or less been offset by a similar fall in the number on medical rehabilitation. As a result, the number of participants in vocational rehabilitation is currently of the same size as the sum of all registered unemployed and ALMP participants.

159. In Switzerland, new measures will also be taken after the 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

160. As a general rule, medical rehabilitation is 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 separated. For medical rehabilitation to enable better re-integration of participants into employment, instead of being sequential, these two measures should 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, where the most important one should be to restore work ability and assist people in re-entering the labour market.

161. Rehabilitation in general and vocational rehabilitation in particular is used much more widely in Norway than in Switzerland and Poland. Since 2000, the number of people on vocational rehabilitation 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. Where this change has improved or is going to improve outcomes is discussed in Chapter 3.

162. In Poland, vocational rehabilitation is still in its infancy. It should be a priority for Poland to introduce a better and more transparent vocational rehabilitation system, and to broaden access to effective rehabilitation measures. This would also improve chances that the large reduction in inflow rates will be sustainable in the long run. Also Switzerland should reconsider the eligibility criteria for vocational rehabilitation measures, which are only offered to those people who would otherwise qualify for disability benefits. Moreover, the fact that so few people in Switzerland with a mental disorder undergo any form of rehabilitation is a major concern.

CHAPTER 3

INCREASING EMPLOYMENT OPPORTUNITIES

163. 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 raise outflow rates from disability benefits 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.

164. 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 because of re-assessments. 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 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 are only referring to those being re-assessed 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.

1. Employment support for people with health impairments

165. Re-entering work is generally associated with improvement in income, socio-economic 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. On the contrary, interventions which simply force beneficiaries off benefits are more likely to harm their health and well-being (Waddell and Burton, 2006). 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. It starts off by exploring the current employment and education situation of disabled people in the three countries.

A. The current employment and education situation

166. 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 (with 18%) on the other. 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 20-34 year olds reaching levels of 37% and 25% for disabled and non-disabled persons, respectively.

167. Table 3.2 gives an overview of other employment characteristics of the self-assessed disabled and non-disabled populations in the three countries. Some observations are worth highlighting, such as the low share of disabled Poles that work in the public sector, which 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. There are also some main differences 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 over-represented 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.

168. 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. This situation may have been intensified by technical progress where there is no longer a need for certain simple and menial niche jobs (as is often argued in Switzerland). However, in Norway, this trend may be reversed because educational attainment in the age group 20-34 is very similar for disabled and non-disabled people.

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
Family workers												
Disabled	1	0	1	0	15	8	17	14	1	1	4	2
Non-disabled	0	0	0	0	6	3	4	4	1	1	2	2
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: OECD estimations based on national labour force surveys.

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]

	Norway				Poland[b]				Switzerland			
Educational attainment[c]	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: OECD estimations based on national labour force surveys.

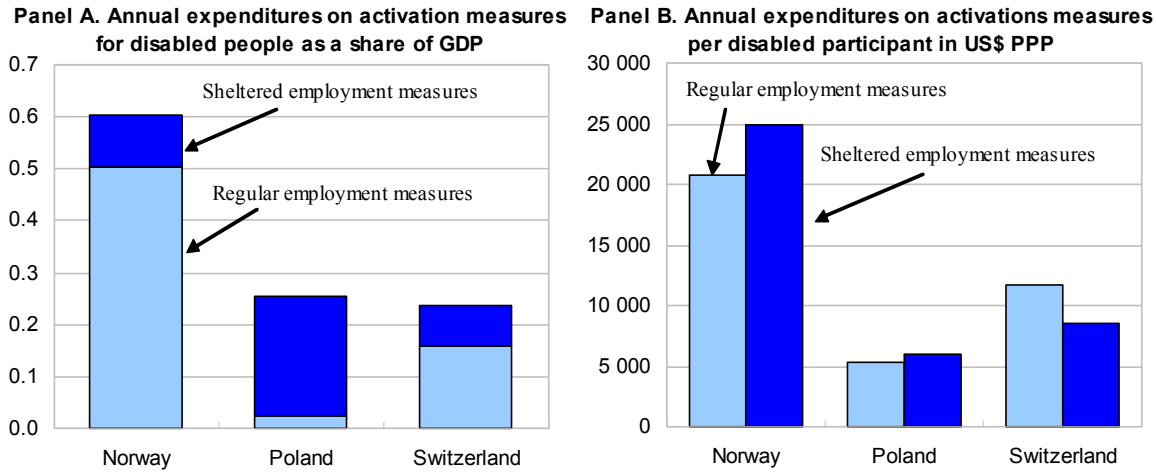
B. Activation programmes for disabled persons

169. 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 0.7-0.8% of GDP. For Poland the opposite holds: the unemployment rate is more than four times higher than in Norway and Switzerland, yet spending on ALMP is only about 0.15% of GDP.

170. 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 benefits and the eligibility criteria for participation in vocational rehabilitation. 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 directed towards permanent sheltered work (Figure 3.1, Panel A). In Switzerland and especially in Norway, reintegration measures are predominantly focused on the regular labour market.

Figure 3.1. **Spending on ALMP in Poland is directed towards the sheltered sector**

In percentage, 2003-04



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.

171. Annual spending on employment measures per person, corrected for differences in purchasing power, is also much higher in Norway compared to Poland and Switzerland (Figure 3.1, Panel B). Measures such as work experience in Norway (discussed below) are staff-intensive and relatively more costly compared to, for example, wage subsidies in Poland which amount to around 70% of the minimum wage. However, costs of a sheltered workplace are also much higher in Norway than in the other two countries. Only in Switzerland is spending per person in sheltered work lower than for activation in regular employment measures. Overall, the spending-per-capita differences across countries are extraordinarily large: Norway spends five times as much as Poland and 2.5 times as much as Switzerland.

172. 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 mainly 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, or close to 60 000 people,

participated in vocational rehabilitation. Another 30 000 were either waiting to be placed in a suitable programme or for clarification of their work ability.[16] In terms of all participants, 'Education in regular school and labour market training' is by far the most frequently used programme, accounting for half of all participants. Next in size are 'Work experience in regular workplaces' and 'Work experience in sheltered workplaces' with 17% and 12%, respectively. There appears to be a clear age-targeting of these programmes: whereas prime-age people participate more often in training measures, older participants are to a larger extent involved in 'Work experience in sheltered enterprises' and 'Sheltered workshops'.

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 AETAT (Norwegian public employment service).

173. Temporary 'Wage subsidies' are used rarely and, indeed, much less often than for non-disabled unemployed (OECD, 2004b and Chapter 4). These 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 schemes'. These measures have more elements of adapted job training where participants can try out their capabilities and their efforts are followed-up in accordance with the plan prepared for each person.

174. 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-ordination 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 of which only one in four (*i.e.* 4% of the entire staff) were involved with the job-placement implementation introduced in 2004.[17]

175. With the planned fifth revision, Switzerland will introduce new integration measures. These measures will be socio-professional in nature, such as adaptation to work processes, boosting of job

16. The maximum length of a temporary programme is three years. However, after completing one programme, participants are often qualifying for another programme, so-called "programme chains", which means that the total period on vocational rehabilitation may last even longer.

17. The co-existence 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.

motivation, stabilising of the personality 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 earning capacity has been reduced to at least 50% over a minimum period of six months. Thus, they are hoped to reach people earlier than is currently the case. In addition, these measures are also designed to reach more people with low skills and with mental health problems.

176. Based on the limited available information, it appears as if in Poland very few employment programmes are available for or targeted to disabled people. One reason for this is that ZUS is not responsible to help disabled people back to work.[18] 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 or employment measures of disabled people. Instead, the main employment measure for disabled people goes through Sheltered Work Establishments (SWEs), which are discussed further below. Other assistance mainly consists of permanent wage subsidies and financial aid to enabling education or employment through the removal of transport barriers (Ministry of Economy and Labour, 2004).

C. Outcomes of vocational rehabilitation

177. To understand what works and what does not 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 these exist, they are usually confined to one particular scheme.

178. Extensive evaluations of vocational rehabilitation programmes in Norway are ambiguous and findings vary with the choice of the programme evaluated; the duration of the programme; characteristics of the participants; the elapsed period after participation in the programme; and whether so-called "programme chains" are being accounted for. 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, 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).

179. Based on data from 2004 of 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).[19] Results for men were slightly better than for women and significantly worse for people in the age group 50 and over with an employment outcome of only 28%. Older participants transferred to disability benefits to a much higher extent compared to younger participants.

180. 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,

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18. 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, limited PES programme places and a fear of losing the disability benefit.

19. 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 two to three months after they have ended a programme.

i.e. significantly lower than those reported by the PES. This may be explained by the length of the vocational intervention, with many participants continuing in another programme after ending the first one (so-called programme chains). However, it may also indicate that a large share of those who obtain a job after ending a rehabilitation period fail in keeping 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 (>30h/week)	Part-time work (<30h/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 AETAT (Norwegian public employment service).

181. 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

182. 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 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 and integration into the regular labour market.

183. 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 in the regular labour market (Melvyn, 1993). As a result, the concept of supported employment was developed.

184. Supported employment is based on rapid placements of disabled persons in the open labour market combined with necessary assistance, involving coaching and training on the job. As such, the approach assumes that, with the right assistance, anyone can do a satisfactory job (Evans, Frøyland and

Spjelkavik, 2004). International evidence suggests that supported employment programmes are relatively 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 programs with severe mental health problems obtained a job in the regular labour market compared with only 21% of those in traditional vocational rehabilitation measures.

185. 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 higher chance to obtain 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 their productivity to, on average, almost two-thirds of their ordinary employees. However, this positive judgement did not translate into a corresponding hiring of these people (Evans, Frøyland and Spjelkavik, 2004).

186. 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 may not be 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.

187. 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 for 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.

188. Neither Switzerland nor Poland have a formal supported employment programme. However, various organisations in Switzerland are 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.

189. Unfortunately, no data are available on the number of disabled workers benefiting from those coaching programmes nor on their effectiveness. Rüst and Debrunner (2005) conclude (i) that the variants of coaching offered in Switzerland are by and large quite appropriate in enabling people with considerable (mental) health problems to work on the regular labour market, but (ii) that 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 of employers.

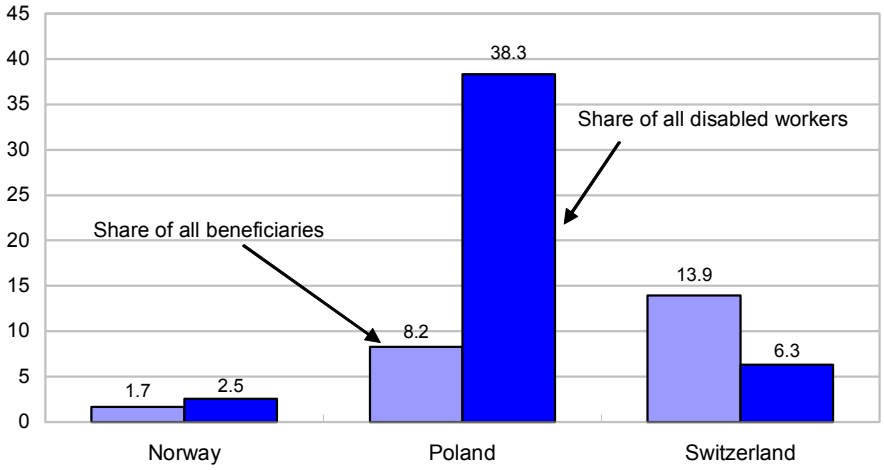
E. Sheltered employment

190. In addition to vocational rehabilitation and supported employment measures, employment in a sheltered work environment is used to provide work opportunities for disabled people in most OECD countries. Sheltered employment is a form of support for people with more severe problems who are offered work in a protected environment. Often sheltered 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.

191. 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 the stock of 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 Establishment (SWE).

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) Participants in sheltered employment as a share of all disabled workers are calculated as people in sheltered employment over the self-assessed disabled in work. Participants in sheltered employment as a share of all beneficiaries are simply the ratio between people in sheltered employment and the stock of disability beneficiaries.

Source: OECD estimations based on the Norwegian Labour force survey for 2004 and 2005 and administrative data from AETAT; Polish Labour force survey for 2004 and administrative data from PFRON; and Swiss Health Survey for 1997 and OECD (2003a).

192. Hence, Poland has gone furthest in developing a large-scale segregated labour market with permanently-subsidized jobs. 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 to transfer 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 have certain rules they need to follow (*e.g.* supplying 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.

193. 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 re-integration services are 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).[20] These subsidies lack differentiation on the basis of the degree of disability and the adequacy of the institution's training and integration measures. Although the original idea was to re-integrate participants into the ordinary labour market, there is no evidence of this actually happening.

194. 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, possibilities to obtain an ordinary job should be considered regularly. The enterprise, 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 Enterprise 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).

195. In Poland, sheltered work is largely a dead-end and almost no-one ever transfers to the regular labour market. Employers with an employment share of at least 40% disabled people can apply to become a SWE. If they also meet some 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 complying with EU regulations on competition. Still, they are privileged by receiving 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, SWEs have not achieved success sufficient to justify their cost (Hoopengardner, 2001).

F. Summary and conclusion

196. 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 for these relatively lower employment rates is unsuccessful re-integration measures.

197. Norway offers a wide range of programmes to disabled persons. Some 85% of these measures are vocational rehabilitation 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

20. Subsidies to institutions offering sheltered work make up almost one-fifth of the total expenditure of the disability insurance.

also places a slightly larger focus on sheltered work. Poland, has a very limited coverage of re-integration 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.

198. Employment outcomes from these measures are often weakly documented. In Norway, where such evaluations exist, outcomes are ambiguous but generally show that employment outcomes are fairly low. The focus in Poland on sheltered work with no purpose to re-integrate people into the regular labour market has also created a strongly segregated labour market of disabled persons.

199. None of the three countries use supported employment programmes or 'first place, then train' programmes to a wider extent, although 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 since 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 and, therefore, a redirection of funding from vocational rehabilitation and sheltered employment to supported employment should be considered.

200. Weak outcomes may not only be linked to the programmes themselves but also to their timing. Evidence from Switzerland suggests that the likelihood of re-integrating 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 re-integration 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.

2. Improving chances to find and retain a job

201. While employment programmes and rehabilitation measures may help people with health problems to 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 or 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 by, 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

202. 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. Since 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 also 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 disabled people. It aims to prevent discrimination against people with disabilities and establishes general conditions which 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 for conditions such as hiring and firing.

203. A key objective of the new WPA in Norway is to ease the 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.

204. Disabled workers in Poland themselves have special rights. For example, workers with moderate or severe disabilities have only to work for 35 hours per week (compared to 40 hours for people with minor or no disabilities).[21] There are also other special rules such as ten additional days of paid vacation per year and the right to an additional 30-minutes break per day to participate in, for example, training. Moreover, disabled workers do not have to work night shifts or overtime.

205. Poland is the only country of the three that uses a quota-levy system.[22] Until recently, the system covered only private companies with 25 or more employees, which must employ at least 6% disabled workers (full-time equivalents) of their workforce.[23] 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 they must also 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.

206. 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 even with 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 that low incentives to take up work or that they have to compete with young and

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21. 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.

22. 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).

23. 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.

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

207. 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 both for new hires and current employees who become disabled. In 2004, only 489 enterprises received such an accommodation subsidy, with an average subsidy of ZL 23 000. One reason for the low take-up of these subsidies is high administrative costs to apply for the subsidy. Another reason was, again, said to be the lack of information. This argument apparently also holds for Switzerland, where employers can also be reimbursed for their costs of workplace adaptation.

208. Norwegian regulations place a much larger responsibility on the employer. 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.

209. An important example of a non-financial measure to support employers is through 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 re-integrate 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 coordination with vocational training centres, help with applications for work accommodation subsidies but also more general matters like 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 it is 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

210. 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 for this 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 non-accessible infrastructure, including public transport. A third reason often mentioned is the relatively lower educational attainment as a result of restricted access for disabled people to education and training. Special rules for disabled people *in* employment may also contribute to lower the hiring 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.

211. On the contrary, employment protection in Switzerland is among the most flexible in the OECD (OECD, 2004c). Switzerland is also lacking 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). 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 the combination of all these factors contributes to the outcome.

212. In Poland, there are indications that employers are unaware of 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. Making the disability benefit scheme employment-friendly

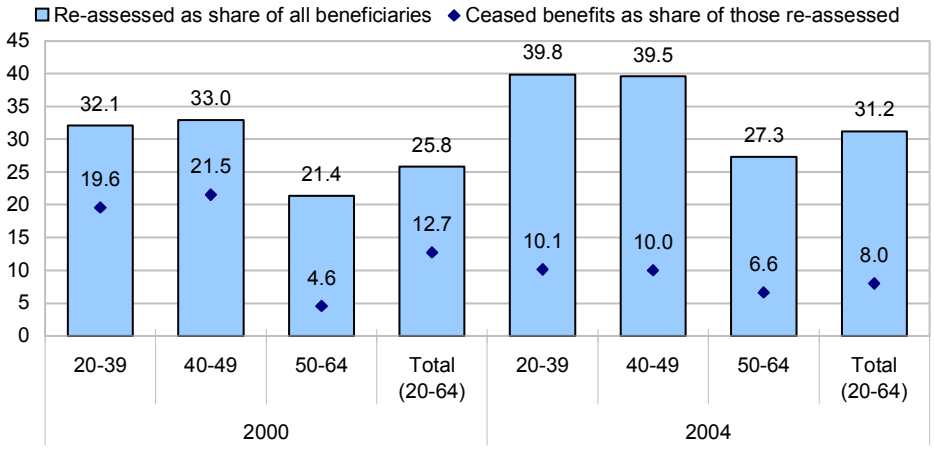
213. While reform in Poland has proven to be very successful in terms of reducing inflows and raising outflows, low outflows remain a key problem in both Norway and Switzerland. One way forward is to improve the identification of beneficiaries potentially able to work. This is usually done by re-assessing 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 are therefore often granting temporary and partial benefits. This section explores different ways to re-assess disability benefits. It discusses temporary disability benefits and the importance of maintaining strict eligibility for these benefits. It further examines the use of partial benefits and efforts to encourage people already on benefits to take up a job.

A. Re-assessing medical conditions and using temporary benefits

214. Poland has gone the furthest in the use of temporary entitlements, at least as far as the non-agricultural social insurance (ZUS) is concerned. Since November 2005, all benefits are being granted temporarily for the first three years. After this period, benefits are terminated and all individuals have to re-apply and their health situation will be fully re-examined. However, even before this rule was introduced about 80% of all benefits were granted temporarily and re-assessments of existing benefits took place frequently. In 2004, about one-third of all benefits were re-assessed (an increase from one-quarter in 2000), of which 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 the stock of disability beneficiaries are re-assessed in Poland**

In percentage, 2000 and 2004



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

215. There is no possibility to re-assess 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. Thereafter, the benefit will be re-assessed to consider whether the person is capable of returning to work. If this is still unclear, the benefit may be prolonged for a new period up to four years. Permanent disability benefits (full or partial) will only be granted to those who, after having undergone appropriate rehabilitation, are judged to be without prospects of going back to work in the future.

216. In 2005, one year after its introduction, temporary disability benefits in Norway accounted for around 36% of the total inflow, an increase from 28% in 2004. However, the use of these benefits varies across age groups and accounted for about three-quarters of the total inflow in the age group 25-44, while such benefits are 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 before temporary benefits were introduced), 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 Authority and Statistics Norway.

217. In Switzerland, all benefits can be re-assessed 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 the entire stock of beneficiaries, were re-assessed. After this reassessment, however, 82% retained their previous benefit, 11% of all re-assessed entitlements 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, of which job reintegration was probably only a small part. In terms of benefit periods, there is large 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.

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

improve their health and well-being. On the contrary, interventions which 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 and Switzerland on the work and benefit career of former beneficiaries who lost their entitlement after re-assessment.

B. The use of partial disability benefits

219. Granting a partial disability benefit is another way of encouraging people to (partially) remain in or return to employment. Such benefits are often granted to people with minor disabilities or when the incapacity 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, this benefit is granted to people who can work, but are not able to keep their former occupation. In Switzerland, a partial entitlement requires that the earnings capacity is 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 (Table 3.7). 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).[24] The difference between Norwegian and Swiss inflows to full benefits is even substantially higher and reached 13 percentage points in 2004; a further widening compared to 1995 when both countries had similar shares.

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

	Stocks				Inflows							
	2004				1995				2004			
Norway	18-34	35-49	50-66	Total	20-34	35-49	50-66	Total	20-34	35-49	50-66	Total
Less than 25%	0.0	0.1	0.0	0.0	0.8	2.4	0.7	1.2	0.0	0.0	0.0	0.0
25% to 49%	0.2	0.5	0.2	0.2	0.2	0.2	0.1	0.1	0.4	1.0	0.3	0.5
50% to 74%	8.4	18.9	16.1	16.3	19.5	31.0	25.7	26.3	14.0	28.0	24.9	24.4
75% to 99%	1.8	2.7	4.3	3.8	3.2	4.6	7.2	5.9	2.2	3.0	3.9	3.5
100%	89.6	77.8	79.4	79.6	76.3	61.8	66.3	66.4	83.4	68.0	70.9	71.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Switzerland[a]	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total
40% to 49%	2.5	4.3	4.0	3.9	4.7	6.0	4.9	5.2	4.7	9.5	9.0	8.6
50% to 59%	10.1	16.6	18.0	16.6	21.7	31.4	29.3	28.7	17.3	25.6	26.3	24.9
60% to 69%	4.9	5.8	7.0	6.4	..	..	..	..	5.7	9.2	9.5	8.9
70% to 100%	82.4	73.4	71.1	73.2	73.5	62.5	64.4	65.3	72.4	55.7	55.3	57.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

a) In 1995, the degree of disability corresponded to 40-49%, 50-66% and 67-100%.

Source: The Norwegian National Insurance Authority (NIA) and the Swiss Disability Insurance (IV).

220. In 2004, Switzerland introduced a three-quarter disability benefit for those with 60-69% work incapacity. This was done to increase the likelihood that re-assessed full-benefit recipients could be brought back into work. This introduction was made 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. Still, it seems to be used much too little. Instead, the vast majority receives either a half benefit (around one-quarter of the inflow) or a full benefit (72% of the inflow).

24. No detailed data are available for Poland. However, because of the different definitions of "partial disability", comparability is restricted.

221. In 2005, another attempt to make the disability benefit scheme in Norway more re-employment friendly was made by offering beneficiaries in five counties the possibility to work for three years without jeopardizing entitlements, the so-called *disability benefit as a wage subsidy scheme*.[25] 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 the 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 this 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

222. There seems to be little success in convincing people to move *voluntarily* from benefits to employment. Therefore, re-assessing the health status of disability benefit recipients is very important. However, re-assessing large shares of the stock (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 less strict, these benefits may contradict their purpose and instead 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.

223. 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. Therefore, temporary and partial benefits in Norway should return to their stated purposes by using a more coherent benefit assessment method. Moreover, enhanced assistance to find employment should be given to those people who lose their benefits. This is especially important in Poland where such support is relatively less used 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.

224. Increasing outflow rates is a complicated matter and certain fundamentals need to be in place in order to obtain successful outcomes. One such factor is financial incentives to work, which are 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.

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25. 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 which 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).

CHAPTER 4

ENHANCING FINANCIAL INCENTIVES

225. Are current disability policies, in particular benefit policies, successful in preventing large financial losses and poverty risks for people who get disabled? At the same time, 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. It is structured along 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.

1. Assuring adequate incomes for people with disabilities

A. Relative income and poverty among disabled persons

226. Average contributory disability benefits in Norway, Poland and Switzerland are set at around 40-58% of average national earnings. Disability benefits, however, are just one of many possible income resources for a disabled person: other public benefits, own earnings, capital income, income from savings and private transfers all play an additional important role. Furthermore, the resources of other household members the disabled person is living with contribute to (or, in their absence, put a burden on) the economic well-being of disabled persons.

227. Disposable income levels of disabled people are between 15% (Poland) and 10% (Norway, Switzerland) below the average of the working-age population, and they were slightly declining in recent years (see Chapter 1).[26] Poverty rates of disabled people are much lower in Norway (6-11% depending on the reference income) than in both Poland and Switzerland (10% - 18%).[27] 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.

228. It should be noted that traditional income concepts such as the one used here ("square-root equivalence scale") 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

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26. 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).

27. These estimates refer to *monetary* poverty which covers only one – though important – element of poverty and social exclusion. Non-monetary poverty among disability beneficiaries in Switzerland has recently been estimated at around 20 percent, with half of these persons being under a monetary poverty threshold (Gredig *et al.* 2005).

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.

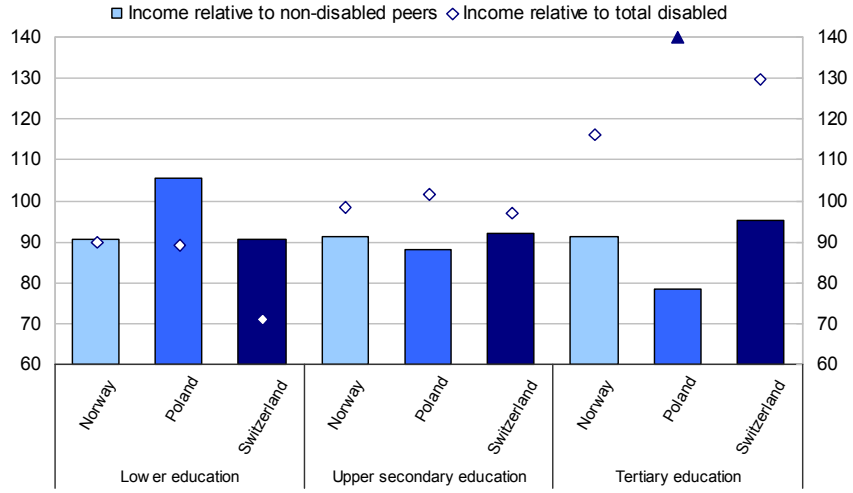
229. Financial well-being and poverty differ, however, between age groups and educational levels attained. Income levels are lower among younger and older and among lower-educated people. While this is true for both disabled and non-disabled persons, the benefit system evens out age- and education-specific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

230. In Norway, relative poverty risks are falling with increasing age, with the youngest among the disabled persons (20-29 years) having a poverty risk more than double that 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. In turn, relative risks *increase* by age in Switzerland where the oldest (60-64 years) among the disabled population of working-age have the highest relative poverty risk.

231. 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. **Higher educated disabled persons have less income constraints**

Education-specific average incomes of disabled persons, 2002-2004[a]



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

Source: EU-SILC 2004 for Norway, Household budget survey 2004 for Poland, Health survey 2002 for Switzerland.

232. In terms of poverty, relative risks decrease by level of education, although this is less pronounced in Norway than in the other two countries: in Poland, lower education 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 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, respectively. 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, Health survey 2002 for Switzerland.

B. Income packages and income distribution

233. 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.[28] 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).[29] 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 transfer share in incomes increased in the past four years in Poland, more so for disabled than the total working-age population, reflecting very low and falling employment rates in this country. Among social transfers received by disabled persons, 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.

234. Given the prominent share of disability benefits in the income package of disabled people, an important question refers to their redistributive features and to which extent 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.[30] 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 due to 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).

28. This could be own earnings of disabled persons as well as earnings of others household members.

29. No data are available for Switzerland.

30. This refers to the overall impact of these benefits among the total working-age population in 2000 (Förster and Mira d'Ercole 2005).

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

Income composition by disability status, 2004[a]

	Disabled	Not disabled	Total working-age
Norway			
Labour income	67	83	80
Capital income, private transfer	4	7	6
Public social transfers	29	10	13
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 transfer	2	3	3
Public social transfers	64	25	29
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.

Source: EU-SILC 2004 for Norway, Household budget survey 2004 for Poland.

235. 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 4 to 5 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.

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

Gini coefficients of income concentration, by disability status, various years[a]

		Net income			Labour income		
		Disabled	Not disabled	Total	Disabled	Not disabled	Total
Norway	2004	0.22	0.26	0.25	0.38	0.29	0.31
Poland	2000	0.29	0.31	0.31	0.49	0.39	0.41
	2004	0.27	0.32	0.32	0.49	0.41	0.42
Switzerland	1997	0.24	0.24	0.24	..	..	..
	2002	0.27	0.27	0.27	..	..	..

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

Source: EU-SILC for Norway, Household budget survey for Poland, Health survey for Switzerland.

C. Summary and conclusion

236. In all three countries, average disposable income levels of disabled persons are below the average of the total working-age population, and in Poland and Switzerland relative income poverty among disabled persons is also lower. 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.

237. Public social transfers and, 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 benefits systems such as minima and maxima pensions as well as (sometimes means-tested) supplementary benefits.

238. All three countries have anti-poverty programmes in place, although those are not regular and neither do they include concrete objectives and targets.[31] In addition, no particular measures are targeted at the population with disabilities but there is rather a tendency to "mainstream" this 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 going beyond employment objectives may also be needed.

2. Increasing work incentives for disability benefit recipients

239. This section looks at financial work incentives and disincentives for disabled persons through the tax/benefit scheme. 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).

240. 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. Second, estimates are based on the assumption that a person leaves 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. But also benefits paid in case of longer-term sickness, which often leads to a disability benefit claim, are very high (and even 100% of past earnings in Norway and for many people in Poland and Switzerland).

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31. The Norwegian White Paper outlining the plan of action for combating poverty for 2002-05 (Report No. 6 to the Storting, 2002). The Polish Social Strategy Plan for 2007-2013 which includes disability as one of seven priorities. The Swiss "first national poverty conference" in 2003 which included one cluster on the impact of poverty on the health status (soziale sicherheit, 2003).

A. Overview of tax and benefit regulations for disabled persons

241. The disability benefit systems as well as taxation differ considerably across the three countries (see Annex Table 4.A.1). On the benefit side, this has to do with different social protection traditions, with Norway relying on a universalistic system, Poland on a continental-European type earnings-related system and Switzerland on a three-tier system (see also Chapter 1 and Box 1.1). On the tax side, it has to do with a 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.

242. For instance, the three countries have very different approaches to the graduation of partial disability benefits, which are most refined in Norway while Poland only distinguishes the inability to perform any work (total disability) from the inability to perform one's usual work (partial disability). In Switzerland, there is a four-fold graduation system in the first-pillar disability insurance, but only a two-fold graduation in the second-pillar which also requires a higher minimum degree of earnings capacity loss (50% rather than 40%). Expanding or reducing the range of graduation is an important reform issue as this may lead to opposing effects, depending on the implementation rules. Introducing additional graduations may, on the one hand, reduce the inflow into "full" or higher-rated disability benefits. Evidence suggests that this may have happened recently in Switzerland after introduction of a three-quarter benefit in 2004. However, it may "attract" new applicants as well, especially if this goes in pair with a lowering of the minimum loss of work capacity.

243. A most important question for work incentives are regulations for accumulating earnings with disability benefits. Again, country approaches 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. Also in Poland, a partial 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.

244. Table 4.4 compares the tax/benefit position of a 40-years-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 predominantly via social security contributions, while in Norway the share between central taxes, local taxes and social security contributions is more balanced.

245. 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.[32] The tax weight on benefits is somewhat lighter 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 generally are higher than gross replacement rates.[33]

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32. While the "typical" transition would be from work to sickness before moving to disability benefits, the earnings from former work are likely to remain the financial benchmark for the person.

33. The exception is 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 mid-way between the partial and the total disability benefit of a former average earner (PLN 9 300 and PLN 12 400, respectively).

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, US$ Purchasing Power Parities (PPP), 2004[a]

	Norway			Poland			Switzerland	
	Working	Temporary disability benefit	Permanent disability benefit	Working	Partial disabtiliy benefit	Total disability benefit	Working	Disability benefit
A.1 Gross earnings	33 433			14 526			36 405	
A.2 Taxable benefits								
Disability Insurance	0	22 066	17 636	0	5 090	6 787	0	21 416
B. Income tax and 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): 317101 NOK in Norway, 26584 PLN in Poland and 64419 CHF in Switzerland. Estimates refer to a 40-years-old single person with an earnings history of 22 years at average earnings. Figures assume that there is no waiting period between in work and the benefit situation.

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

246. 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.[34] 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

247. Net replacement rates compare the income situation when moving from paid work to inactivity. They thus provide indicators of both the adequacy and the generosity of disability benefit schemes considered. On the one hand, low replacement rates 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. On the other hand, a majority of disabled persons is not fully incapacitated for work but experiences problems of staying in the labour market. In the case of replacement rates 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).

248. 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,

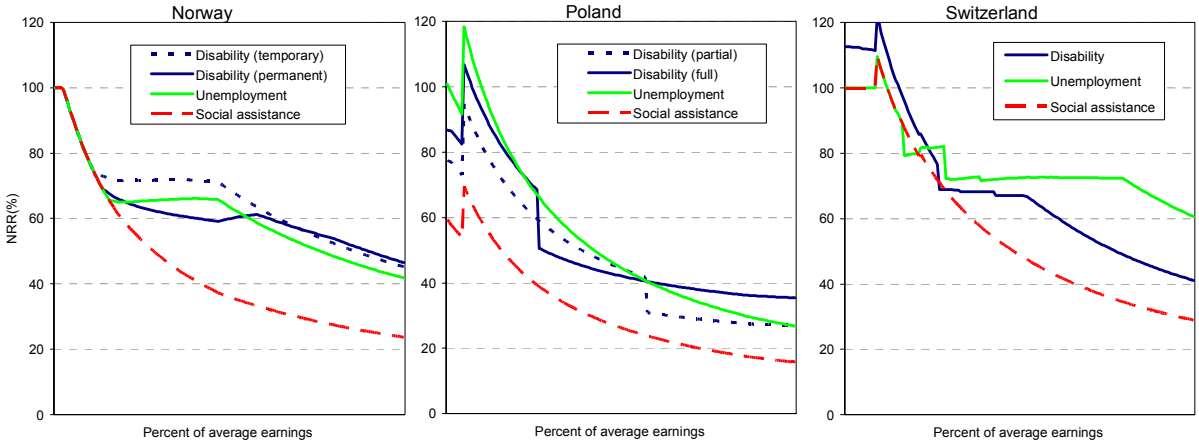
34. It should be noted that, of the three countries covered in this report, Norway and Switzerland belong to the "top five" OECD countries in terms of GDP per capita in PPPs while Poland ranks third lowest.

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 accumulated – are being shifted and, at the end, trapped between increasingly tightened schemes – a phenomenon referred to as *carrousel effect*. Disability insurance increasingly acts as a benefit of last resort in this carrousel.

249. Figure 4.2 compares net replacement rates from disability, unemployment and social assistance benefit schemes for single persons (results for other household types and ages are given in Annex Figure 4.A.1). The following key findings emerge:

Figure 4.2. **For lower wage earners, disability and unemployment schemes provide similar net benefits**

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



a) Net replacement rates: ratio of household net income after becoming inactive and receiving disability benefit, unemployment benefit or social assistance, respectively, to household net income when earning 33% 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.

- Above former earnings of half the average national wage, unemployment and disability benefits provide higher NRRs than social assistance and fairly similar ones, 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 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, *e.g.* 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.[35]

- 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 maximum benefit, temporary disability benefits display higher NRRs than

35. In Norway, these supplements are flat-rate and means-tested and therefore play a role in the lowest income segment. In Switzerland, these are proportional to the basic disability benefit and, therefore, also important for higher income earners.

permanent ones in the segment between half to one and a half former average earnings. In Poland and Switzerland, withdrawal of means-tested benefits (social assistance, housing allowance, supplementary benefit) at specific income levels drive NRRS up at some earnings levels and down at others.

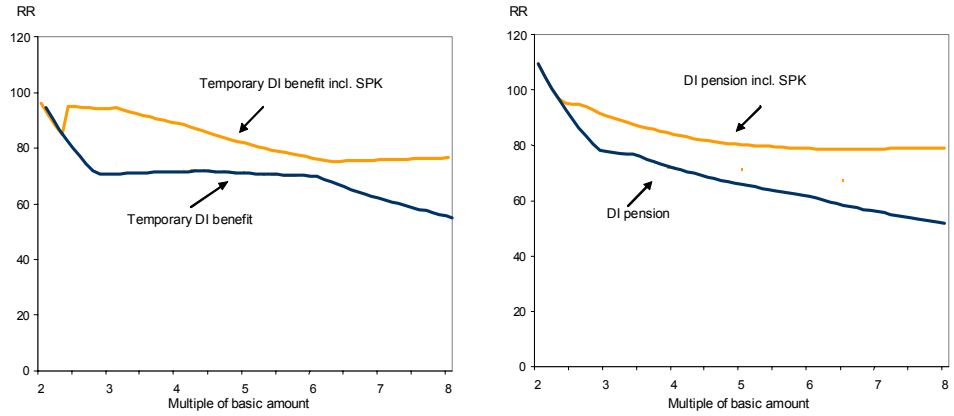
- In general, disability benefit rules do not follow a "seniority principle", *i.e.* NRRs are not increasing with age. The main exception is Switzerland, where *e.g.* persons aged 50 have considerably higher NRRs at higher earnings levels than those aged 40, essentially due to the second-pillar benefits which play a greater role above average earnings.

250. 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. These are especially important for persons with average and higher previous earnings in Norway and Switzerland.[36]

251. A recent tax/benefit analysis undertaken by the Norwegian Finance Ministry illustrates this for the largest occupational pension scheme, the scheme 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) show that taking account of complementary insurance going beyond the minimum in the frame of the second-tier disability benefit can increase NRRs also for high-income earners well above 60%.

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

Net replacement rates for temporary and permanent disability benefits in Norway, with and without state occupational pensions, 2006[a]



a) Net replacement rates: 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.

Source: Norwegian Ministry for Labour and Social Affairs (2006).

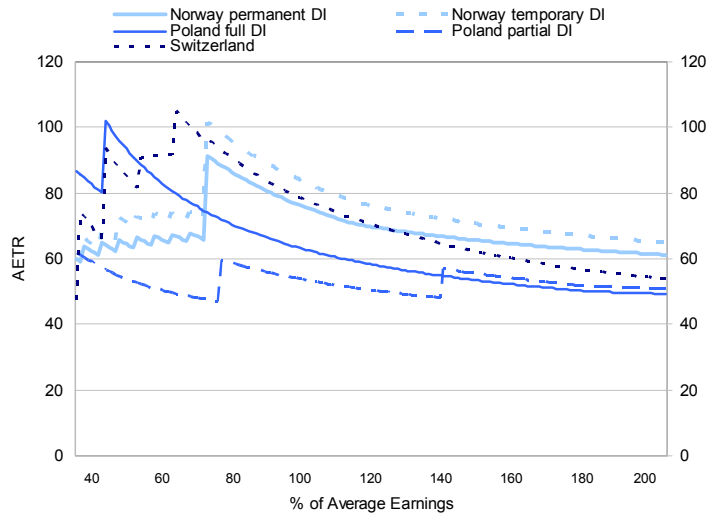
36. In Norway, about half of all employees are covered by the second-pillar occupational disability benefit (*tjenestepensjon*). In Switzerland it is very common that second-pillar provident institutions practice over-compulsory insurance, *i.e.* that they insure a salary beyond the compulsory maximum (*Überobligatorium*).

C. Does it pay to work?

252. 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. Therefore, taking up part-time or full-time work should be financially attractive for those who are considering this step. Figure 4.4 (and Annex Figure 4.A.2) demonstrate that this is not always the case:

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 33% 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.

- In Norway, AETRs are higher for temporary than for permanent disability benefits, though one would expect recipients of the former to be more likely to consider returning to work. When returning to a lower-paid (or part-time) job which pays less than 70% of average earnings, 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.

- Polish *partial* disability benefit recipients 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 either 60% or 100% of former earnings. As there is no such earnings disregard for *full* disability benefit recipients in Poland, AETRs are much higher up to two-thirds of average earnings.

- 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.

253. 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 ("graduated") disability benefit and who are considering to work 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 (half-time work), from 20 to 30 hours (part-time work) and from 30 to 40 hours (full-time work). The person is assumed to have worked at average earnings before having become disabled and again taking up work at this earnings level and receiving graded pensions, if eligible.

254. 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%, and 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:

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

Marginal effective tax rates for beneficiaries of full or partial disability benefits, 2004[a]

			Increase in working time			
			0>>10 hours marginal work	10>>20 hours half-time work	20>>30 hours part-time work	30>>40 hours full-time work
Norway	Temporary disability benefit	Single	62	85	146	*36*
		Couple without children (spouse inactive)	67	85	167	*36*
		Couple with children (spouse earning 2/3 APW)	53	86	151	*36*
Poland	Partial disability benefit	Single	71	35	73	35
		Couple without children (spouse inactive)	75	35	73	35
		Couple with children (spouse earning 2/3 APW)	43	50	73	35
Switzerland	Full Disability benefit	Single	26	138	113	*31*
		Couple without children (spouse inactive)	58	130	110	*41*
		Couple with children (spouse earning 2/3 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, if available after having worked at APW earnings. Estimates refer to a 40-years 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.

- In Norway, a move from half-time to part-time work results in net income losses, in all three household constellations considered.[37] However, METRs are also very high when disabled persons move from marginal to half-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, partial disability benefit recipients face lower METRs when increasing work in 10-hour steps until full-time work because of the earnings disregard. There are, however, higher effective taxes around the part-time zone because this is where the full earnings disregard is reduced by a flat-rate amount (about one-quarter of net national wage). This encourages those 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 marginal to half-time work or from half-time to part-time work are financially penalised, and heavily penalised when they have children. This also holds for increases from marginal to part-time work directly (data not shown).

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

D. Summary and conclusion

255. The different tax/benefit systems embed a number of "disability benefit traps" for those disabled persons who consider taking up work, especially half-time or part-time work. Financial disincentives typically arise when graduation steps change or disability or other benefits are suspended. The problems are even larger when considering disabled persons who already combine a partial disability benefit with a half-time job and wish to 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 even face a METR in excess of 100%.

256. The solution to these benefit traps cannot, of course, simply consist in reducing disability benefit levels, given the equity objectives of the schemes and the fact that many of the beneficiaries cannot be expected to work. There are alternative ways to make work for disability beneficiaries more attractive, namely by raising the net return from earnings. This can be achieved via different approaches or a mix of them:

- The current regulations for earnings disregards could be refined by a better phasing out of counting benefits against earnings. The earnings disregard could also be expanded to full disability benefit recipients.

- Graduation of benefits could be refined and should be harmonised in cases where different graduation systems exist, such as in Switzerland.

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37. 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.

- The possibility to apply 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, a better coordination of different benefit schemes is needed. The current design of family and housing benefits in Poland, for instance, clearly lead to conflicting incentives for disability beneficiaries.

3. Rising employer incentives

257. While the issue of work incentives for disability beneficiaries and how best to design schemes to avoid benefit traps has recently received much attention by policy makers, this seems to be less the case when it comes to *employers'* incentives. However, the financial consequences for employers of keeping disabled employees or of hiring persons with disabilities need to be taken into account for successful integration and re-integration policies. A study by the Polish Central Statistical Office for the year 2004 has shown that just 5% of Polish employers would consider employing a disabled person, despite a range of subsidies and other incentives in place. Similarly, a recent study in Switzerland concluded that only 13% of those with a new disability in 2001/2002 were retained by their employer (Baumgartner, 2004). The following section discusses the different instruments which are currently in place in the three countries, as summarised in Table 4.6, and points to existing problems of take-up and potential solutions.

A. Subsiding employers to hire people with disabilities

258. 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 reason is to *compensate* employers for the lower productivity of some of their disabled employees. This can be important in the presence of wage rigidities, *i.e.* the absence of downwards wage flexibility, and can help to protect the minimum earnings levels for those people with reduced work capacity.

- Another reason is to *encourage* employers who otherwise would not hire disabled persons to do so, 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 a disabled rather than a non-disabled person.

Wage subsidies

259. 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 the 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 with a maximum duration of three years.

260. In Switzerland, the condition that the disabled person 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.

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 job seekers, including vocationally disabled	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 6 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 3 years)	For enterprises with less than 25 employees and enterprises with 25 or more employees which 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 1583 (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 as for adaptation of work place, if "simple and useful"
Subsidies for take-up of self-employment		Amortisation of a loan up to 30 times average wage, in case self-employment lasts for 2 years at least Reimbursement of half of interest payments for continuing economic activity Partial reimbursement of social contributions for first start-ups (75% of pension contributions for severely disabled, 50% of pension contributions for moderately disabled and 50% of accident insurance contribution for lightly disabled)	
Experience rating of sickness and disablity contributions			In the second-pillar disability insurance as well as the voluntary sickness benefit insurance, individual regulations
Continous wage payment in case of sickness absence	17 days	33 days	15-230 days, depending on tenure

Source: OECD.

261. Among the three countries, the system of wage subsidies – and related subsidies – in Poland is the most extensive. Accounting for one-third of the total PFRON budget in 2004, direct wage subsidies, most of which going to Sheltered Work Enterprises, are the single most important item (Polish Ministry of

Labour and Social Welfare, 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 which would like to hire a disabled person but do not fulfil the quota not only will not receive any wage subsidy but are required to pay a levy to PFRON. This creates adverse incentives. Since 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.

262. In some cases, the wage subsidy may reach 100%. This is the case, for instance, of a pilot project in Norway where the disability benefit can be used as a wage subsidy, and of the "try-and-hire" model of some Swiss NGOs.[38] Of course, this is a very costly model and applies particularly for severely disabled persons with a "supported employment" philosophy (see Chapter 3).

263. A most important and also controversial issue is the time limitation 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, and thus most appropriate for encouraging employers to hire a disabled worker. 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.

264. Finally, another important issue for all forms of wage subsidies is administration, control and close monitoring of outcomes, especially for relatively generous and quasi-permanent schemes such as the one currently in place in Poland. Administration of differentiated regulations is costly but absence of close control can create incentives for fictive employment.[39]

Differentiation of social security contributions and taxes

265. This measure exists only in Poland where it seems overly complex (again 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

266. Adapted and adequate work places constitute a prerequisite for a successful (re)integration of disabled people in their job. Subsidies to employers to modify work places, ranging from additional equipment to structural adaptation of work places 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).

267. It should be noted that subsidies for workplace modification in all three countries not only concern new hires but also apply to already employed disabled persons. Further, some laws actually

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38. 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.

39. Golinowska and Piętka (2003) quote studies by the Polish Statistical Office for the mid-1990s that up to 10% of Polish old-age and disability pensioners work in the shadow economy.

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 self-employment of disabled people

268. For some disabled people, self-employment is an attractive alternative for generating earnings and getting reintegrated 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 (again Table 4.6). Again, however, the take-up of these measures is marginal and, moreover, 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 2003 and just 164 in 2004 (Polish Ministry of Labour and Social Welfare, 2005). The reasons for this low take-up and decline are unclear and warrant investigation.

C. Experience-rating of contribution rates

269. 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, which "generate" a large number of people drawing these benefits. The idea behind such "bonus/malus" schemes is to increase individual employer's economic interest to keep sickness absence and disability at a low level. Experience-rating already exists in many work injury and accident insurances across the OECD, including in Poland.[40] According to the Polish Labour Inspectorate, this system has helped in reducing the number and rates of work accidents.

270. The possibility for 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 3-5 years, which creates a considerable degree of arbitrariness for smaller companies.[41]

271. The issue of introducing similar experience-rating also in the first-pillar disability insurance is now under debate. Employers' and employees' organisations, however, share some concerns, especially on 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 premia in case of increased sickness or disability cases may lead to a de-solidarisation with colleagues who have health problems. Finally, while experience-rating of contributions may well have increased the responsibilities of Swiss employers towards better health

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40. Contribution rates to accident insurance are differentiated according to a formula which takes into account the number of injuries, the number of fatal accidents and the number of persons working under hazardous conditions. This indicator is re-calculated on an annual basis but the contribution rates are valid for three years.

41. To illustrate this, the case of the medium-sized enterprise Z. in the canton of Zurich is enlightening: Z. is producing office furniture for the domestic market, employing 40 people. 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 which led to longer-term sickness absences. In turn, the insurer doubled the premia from 0.75% to 1.5% of the pay-roll and there was a risk for the enterprise of falling out of the insurance. The sickness cases have been reduced considerably since but it will take another two years to return to initial values of contributions.

management in their firms, it is likely to create adverse effects when it comes to new hires of disabled persons.[42] These are usually more likely to have periods of sickness or disability, thereby increasing the firm's premia but also those of their (potential) future colleagues.

272. One way to deal with this issue would be to reimburse employers' increases in premia caused by new hires of disabled persons, and the fifth revision of the disability insurance in Switzerland includes such a regulation (BSV, 2005). However, this regulation is formulated as a "possibility" and not specified in a concrete manner; rather, it is intended to collect experiences in a number of pilot projects over the next years (BSV, 2005b).[43]

273. One particular form of experience-rating is the different rules concerning 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 made for health management and the re-integration of their employees in the workplace in case of sickness. In Norway, this period is shorter (17 days) than in Poland (33 days), while it is between 15 and 230 days in Switzerland, depending on tenure of the employee – noting that in Switzerland the employer can re-insure against this longer wage payment periods.

D. Summary and conclusion

274. When it comes to policy measures directed towards employers, political culture and history need to be taken into account. In Switzerland, for instance, all political parties represented in parliament agree to enhance measures encouraging employers to hire disabled employees, *e.g.* via favourable tax treatment. On the other hand, there is a general agreement that a quota system cannot be implemented in Switzerland. There is also reluctance towards implementation of experience-rating beyond the existing elements, because this would increase employers' obligations. In Poland and, in particular, in Norway, social partnership and tripartite agreements play a very important role influencing employers' decisions. The Inclusive Workplace 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.

275. Direct and indirect wage subsidies can be a powerful tool to create financial incentives among employers to hire persons with health problems, and there are programmes of this type in all three countries reviewed. Experiences with experience-rating of premiums as recently introduced in Switzerland are inconclusive.[44] On the one hand, this system provides incentives to employers for a better health management and early prevention of possible disabilities, thereby increasing integration of their disabled

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42. Anecdotal evidence suggests that roughly half of the reduction in sickness absences in firms actively responding to the new challenge are due to better sickness prevention of current employees and the other half to better health screening in the recruitment phase.

43. Such a model has also been proposed by the Swiss umbrella organisation of disability NGOs (DOK, 2004). As it would be very complex to calculate each reimbursement case, this model proposes reimbursement of 20% of the annual wage of the disabled person should s/he be absent for more than 30 days, for a maximum of two years.

44. Some evidence is available for other OECD countries. Koning (2004) estimates the ex-post effect of the experience-rating system – introduced in 1998 into the disability scheme in the Netherlands – to amount to a 15% reduction of inflows after one year. This concerned predominantly larger enterprises while no substantial impact was found for employers with less than 25 workers.

employees. On the other hand, this may well constitute a barrier for hiring disabled persons because of the higher risk of premia increases.

276. In all three countries, there is a general feeling that the law provides a number of rules and regulations which financially support employers who retain or hire disabled persons – but that in general, these measures are not sufficiently used, if 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 the frequent amendments of regulations.[45] There seems to be some room for advertising campaigns and for simplification of rules to encourage greater take-up.

45. 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 (BSV, 2004). Larger enterprises and those employing disabled persons are considerably better informed about the existing schemes.

ANNEX TO CHAPTER 4

277. The income positions when in work and when out of work are strongly influenced by the level and the 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, 2004), for different groups of disabled people: those living alone, those living with (working or not-working) spouses and those living with spouses and children.

278. Table 4.A.1 resumes the main features of the three countries' disability benefit systems, their taxation as well as the rules for combining benefits with labour earnings.[46] It also describes those parts of the system which were not taken into account in the model calculations, mainly because they are not "standard" for the typical households examined. This concerns foremost the occupational disability benefit in Norway which covers about half of all workers in this country, the social pensions for persons with congenital disabilities in Poland and the third-pillar private insurance in Switzerland. The other special supplements not taken into account concern a much lower number of disabled persons.

279. Figure 4.A.1 complements net replacement rates for disability benefits, unemployment benefits and social assistance for single persons from Figure 4.2 with estimates 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.A.2 shows NRRs for single disabled persons at three different ages. Figure 4.A.2 presents average effective tax rates for different household types.

280. 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 from/to work).[47] 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 not in work. In addition, the Polish labour law specifies some special rights for disabled employees. If monetised, these privileges would consequently lower the effective tax rates faced by disabled persons taking up work.[48] 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".

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

47. In 2005, 18% of Norwegian disability pensioners received an annual basic benefit of between 6636 NOK and 33 240 NOK.

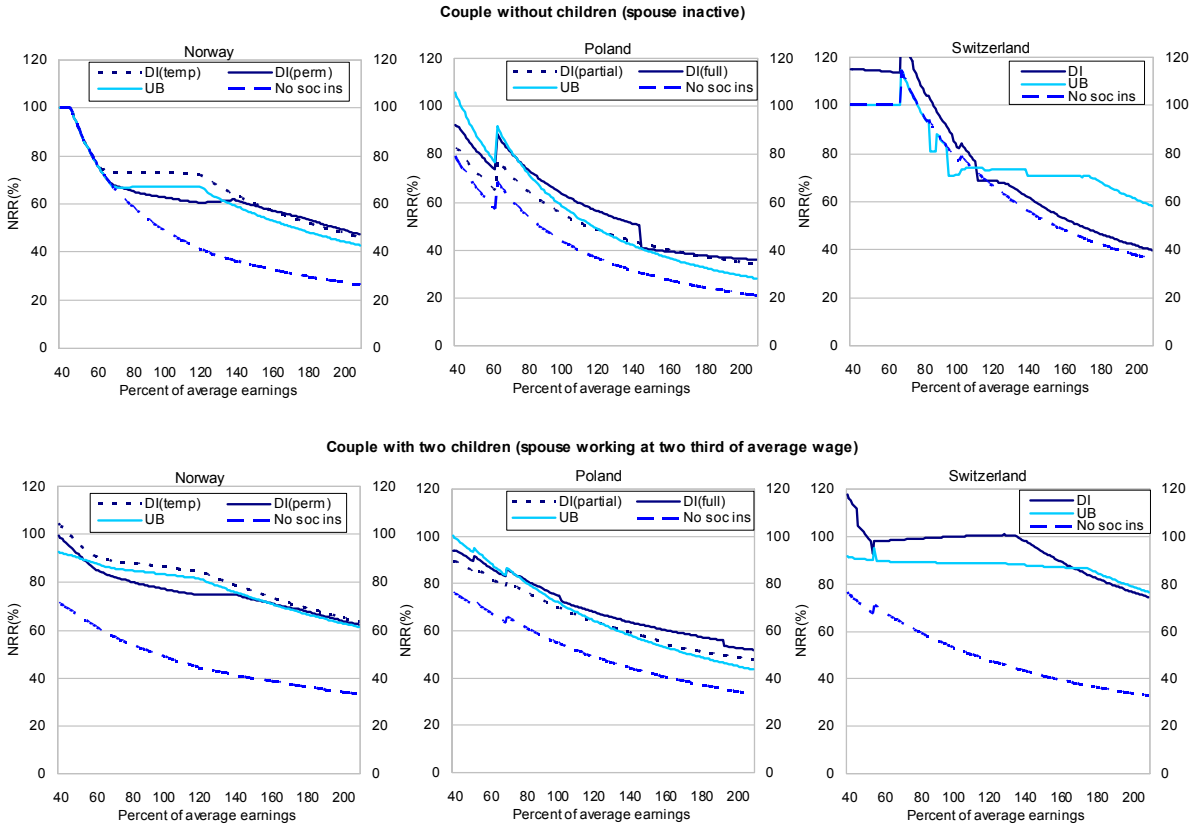
48. Whether these privileges are an effective instrument for raising disabled persons' employment is, however, questionable (see Chapter 3).

Table 4.A.1. **Main characteristics of disability benefit and taxation systems, 2004**

	NORWAY	POLAND	SWITZERLAND
Benefit schemes (covered in model)	Temporary disability benefit (tidsbegrenset uførestønad) Permanent disability benefit (varig uførepensjon), consisting of first-pillar basic pension (grunnpensjon) and earnings-related supplementary pension (tilleggspensjon)	Full invalidity benefit (renta z tytułu całkowitej niezdolności do pracyn) if unable to perform any type of work Partial invalidity benefit (renta z tytułu częściowej niezdolnosci do pracy) if unable to perform usual work but capable of a different job	Federal disability insurance benefit, consisting of two pillars: First pillar of invalidity benefit (AI, assurance invalidité), universal 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 (préstation 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: 1/2 pension for capacity reduction between 50% and 67%
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 b*enefit (grunnstønad) for extra 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). Extraordinary pension (rente extraordinaire).
Taxation of benefits	Yes, with 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 partial 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, unemployment allowance, parental leave, family and housing benefits but not with retirement pensions, injury benefits and unemployment benefits	Reduction in benefits where, added to other incomes, they exceed 90% of income which beneficiary is deemed to have lost

Source: OECD (2004), MISSOC (2005), information provided by national authorities.

Figure 4.A.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, unemployment benefit or social assistance, respectively, 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. Percent of average earnings refer to pre-disability earnings of the first earner.

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

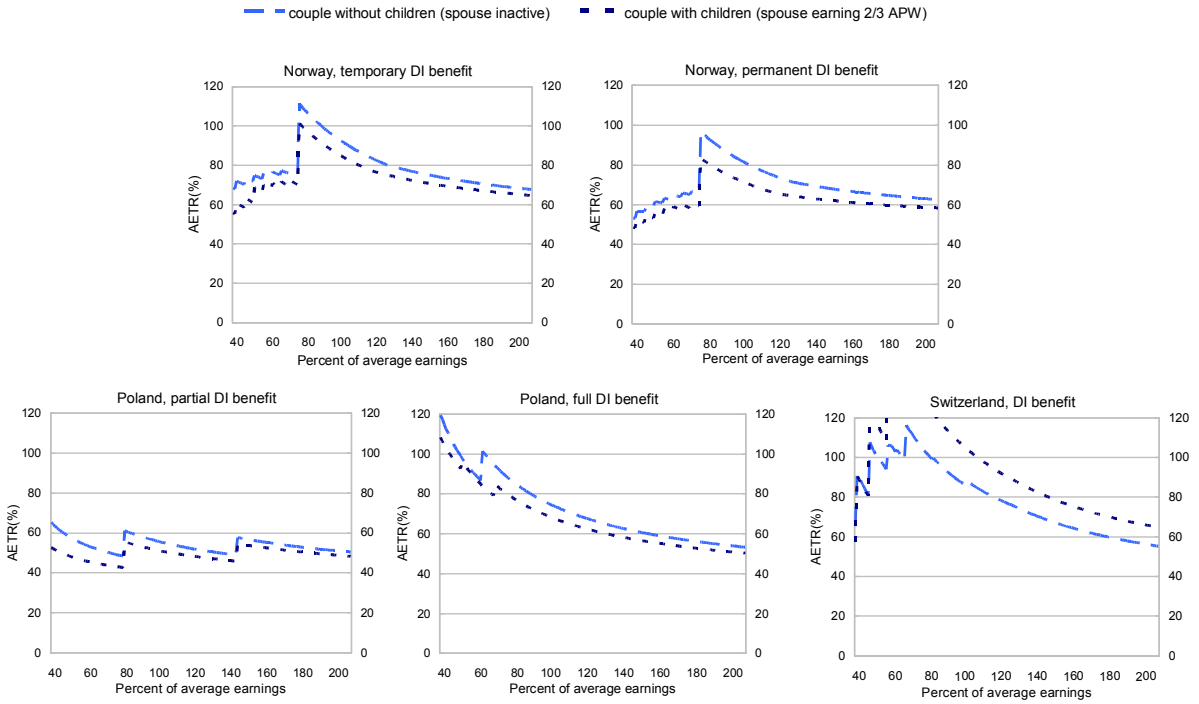
Table 4.A.2. **Net replacement rates for single persons, at three different ages, 2004**[a]

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

a) Net replacement rates: 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, respectively. Estimates refer to a single person with a full earnings history since age 18.

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

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



a) Average effective tax rate: 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.

CHAPTER 5

IMPROVING GOVERNANCE AND POLICY COHERENCE

281. Imperfect governance of service and benefit-granting institutions, lack of coherence across different systems, and inadequate cooperation between different actors can also contribute to poor outcomes of sickness and disability policies. Local institutions may have little or no incentives 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.

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

1. Incentives for granting institutions

283. As much as weak incentives for employees and employers can be an obstacle to better policy outcomes, this is also true for the institutions and 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 discretion 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

284. 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 contrary, 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 respective social insurance institution, and 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 employment of persons with disabilities (PFRON-funded schemes).

285. This structure provides a weak incentive for local and regional decision makers to use funds effectively and to focus on sustainable employment outcomes. Local labour offices, for instance, have a feeble 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 undergoing a vocational programme (by granting a temporary training pension). The problematic decision structure 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 around 10% in most other OECD countries (see below). This is an expensive way of trying to keep inflows low.

286. In Switzerland, disability policy is almost exclusively financed 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 while most of the decisions are being taken by the cantonal disability offices.[49] Disability benefit decisions are made by an interdisciplinary team at the cantonal office. 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 which, for instance, offer sheltered work.

287. Labour market policy in Switzerland is also characterised by a mismatch between decision making and financial responsibility, 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. Partly, this is being done 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.

288. 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 being under the responsibility of the PES. The social insurance administration is obliged to operate on the municipal level, although benefit decisions are formally taken by the county based on the assessment of the local officer. The PES operates on a regional level. It is free to determine the adequate size of its operational units, which are larger than municipalities but much smaller than counties. Again, this financing structure does not lend itself to strong incentives for local and regional actors to use public resources efficiently.

B. Regional discretion in policy implementation

289. One way of identifying problems of discretion at the local and regional level is to look at regional variation in policy outcomes. Regional disparities suggest that there is a problem yet 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 Basel-City. The resulting coefficient of variation is 23%, which is slightly larger than that computed for Norway (20%) and

49. Including the costs of mandatory occupational disability benefits, which are entirely contribution-financed, further reduces the share of the total financial burden of cantonal government.

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[a]

	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%

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 authorities.

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

291. Regional variation can be a reflection of differences in policy implementation (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 policy discretion 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 in interpreting the law and, thereby, using the possibilities to grant or to reject a benefit and a rather different emphasis on vocational reintegration (Spycher *et al*., 2004)).

292. 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 (again Table 5.1). This similarity in regional variation of the unemployment and the disability system could either be explained by external factors, which affect officers in both the disability insurance and the PES, or by comparable problems of regional discretion 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 granting institutions

293. A strong system of supervision and control is one way to minimise discretion 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.

294. 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, where local and regional offices are being 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.

295. 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 were implemented over recent years, including a better reporting and monitoring system, which has strengthened competition between cantons for good outcomes, and a more frequent procedure of control over cantonal decision processes, control which is now taking place annually rather than only every third year.

296. In addition, steps are currently being made to improve the governance of cantonal disability offices (CDOs) further through the introduction of 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 planned to be measured on the basis of a set of outcome-oriented indicators (which are 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, this is still quite an innovative approach for national disability insurance administrations. With these administrations moving away from being a benefit-granting to being a service institution, however, it seems very appropriate to apply the management approach of the PES.

297. 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 on 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. Management-by-objectives has, therefore, helped to change the culture of the PES, which is applying a declared work focus. However, 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. This principle may be a hindrance to a stronger focus on inspection of appropriate policy implementation at the regional and local level.

298. The NIA, on the contrary, is still largely functioning as a benefit authority, with supervision from the national level to harmonise outcomes across regions not being a central issue for this organisation. With the PES having become 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 (see below).

299. 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 some other governance issues arise. With administrative reform in the 1990s, the 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 disability degree 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 – the national, the regional and the local level. Strong cooperation across government boundaries is needed to turn this into an effective structure.

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

D. Summary and conclusion

301. In all three countries, financing structures do not match the decision structures very well. 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 the discretion by regional officers in the decision process, thus supporting the "lacking incentives for decision makers" argument, at least partially.

302. 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. Switzerland is in the process of doing this while Poland has not yet addressed this issue.

2. Disability benefit as a support of last resort?

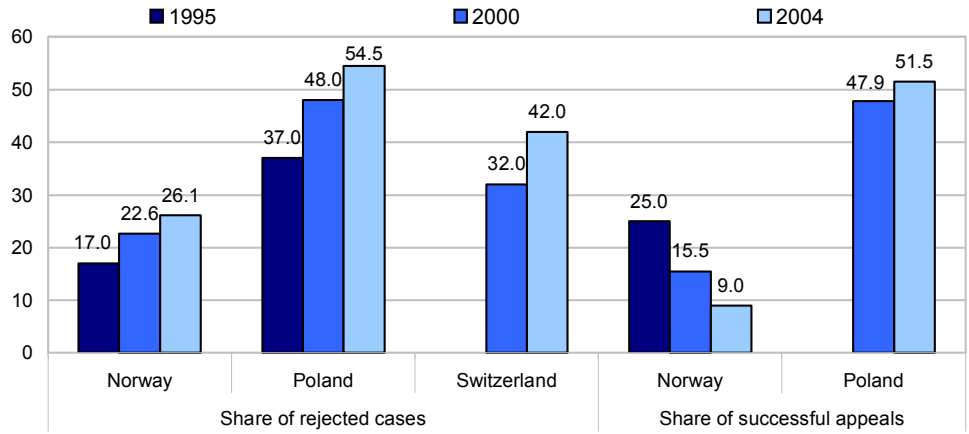
303. Lack of incentives for and weak governance of benefit-granting institutions may not only create regional disparities in disability benefit outcomes, but it may also cause substitution and carrousel effects between benefit schemes. For example, if changes in rules in one scheme are not coordinated with those in other schemes, expected outcomes may well be partially or fully offset by developments in other schemes. This section discusses available evidence on substitution and carrousel effects, leading to a discussion of the issue of coordination of and cooperation across different schemes in the subsequent section.

A. The impact of disability benefit rejections

304. The claims of disability benefit applicants who do not fulfil the requirements for obtaining a benefit are usually rejected. These rejections 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 to disability benefits and Switzerland's relatively stable inflow rates. In Norway, the situation could have worsened further in recent years had rejection rates not risen.

Figure 5.1. **Disability benefit rejection rates and successful appeals, 1995, 2000 and 2004**

Rejected cases as share of all claimants and successful appeals as share of all rejected cases[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 Authority for the non-agricultural sector (ZUS); and for Switzerland, the Swiss Disability Insurance (IV).

305. To measure the impact of disability benefit rejection rates, these have to be seen against the share of successful appeals against rejected benefit claims. In 2004, successful appeals amounted to 51% in Poland; five times higher than in Norway.[50] Correcting the disability benefit inflow rates for both rejection rates and rates of successful appeals, shows that 14 per 1000 of the Norwegian working-age population applied for a disability benefit in 2004. In Poland and Switzerland, the corresponding shares of disability benefit applications amounted to 5.6 and 7.6 per 1000, respectively.[51] These rates should be compared to the respective inflow rates of 10.7 per 1000 in Norway, 4.1 in Poland and 5.2 in Switzerland.

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50. 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 against. This indicates that it could be easier to obtain a KRUS disability benefit compared to a ZUS benefit, which is also indirectly confirmed by the looser disability definition of being unable to work on one's own farm.

51. No information is available on the share of successful appeals in Switzerland. This estimation, therefore, assumes that the rate of successful appeals in Switzerland corresponds to the OECD average in 1999 of 16%. The average rejection rate across the OECD in 1999 was 39% and, thus, very similar to the rate of 38% observed in Switzerland for 2004 (OECD, 2003a).

306. 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 implies 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 these people 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.

307. High rejection rates, especially in combination with high rates of appeals, may also indicate a too strict or very 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 Norwegian situation (especially for older people) and a reason why the overall share of applicants is twice as high as in Poland and Switzerland.

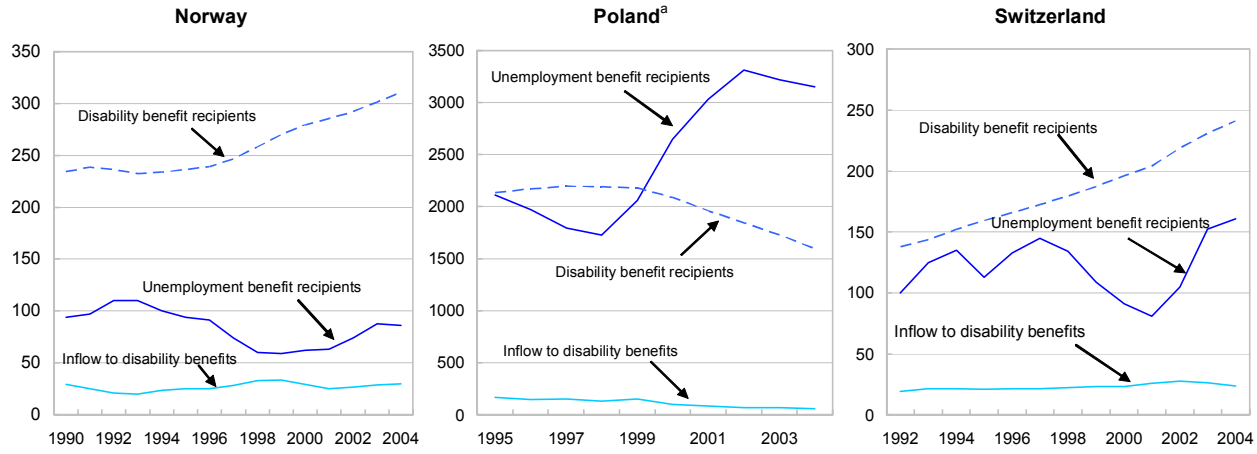
B. The link between unemployment and disability

308. 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 enhanced regional and occupational mobility requirements in the unemployment benefit system and the 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.

309. 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. Judging from the results, there appears to be a fairly close relationship between the two benefit schemes 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 benefit. This is especially clear in Poland after 1999 when the reform of the disability benefit scheme took place. But until 2001 this inverse relationship was also observable in Norway.

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]



a) Disability benefits are based on ZUS benefits.

Source: National Insurance Administration and National Labour Force Surveys.

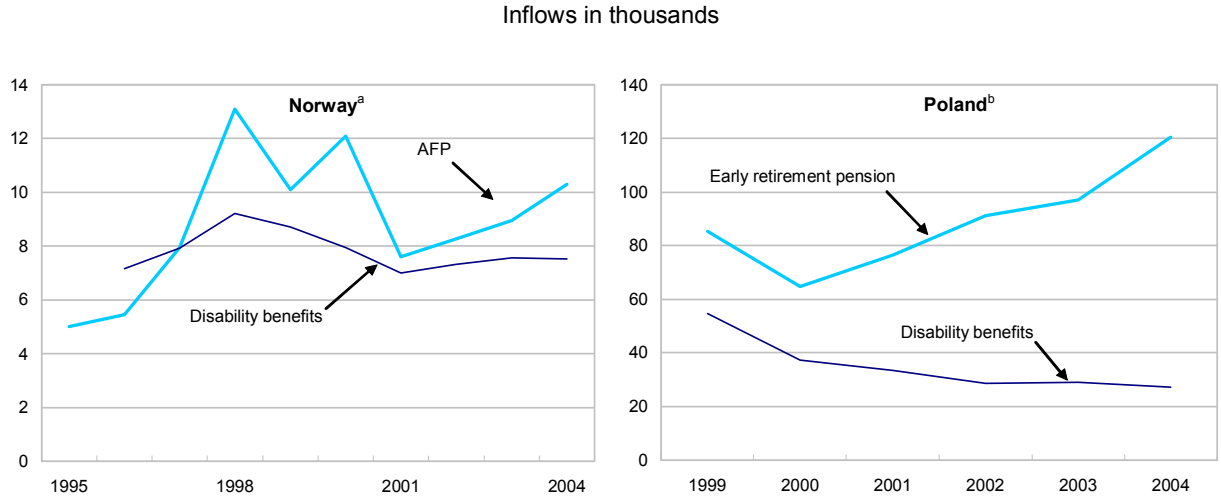
310. If people tend to substitute disability benefits for unemployment benefits, then one would expect a higher rate of disability benefit recipients in regions where unemployment is higher. This is only partially supported by the data. In Switzerland and Norway (if the county of Oslo is excluded), regions 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

311. 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. 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).

312. In Poland, there seems to be a very strong relation in the use of these two benefits after the restricted access to disability benefits in 1999 (Figure 5.3). This is indicated by a fall of almost 30 000 people in the inflow to disability benefits in the age group 50-64 over this five-year period, together with an increase in the inflow into early retirement pensions by more than 35 000. 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 will happen in the near future) could be significantly dampened by higher inflows into disability of older people currently eligible for early retirement.

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



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

b) Inflow to disability benefits for those aged 50-64. For inflow to early retirement pensions, only ZUS early retirement pensions are used, *i.e.* pre-retirement benefits and pre-retirement allowance through the unemployment system are excluded from the data.

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

313. 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 expected direction. If at all, it appears to have further facilitated the use of disability benefits for older workers.

D. Summary and conclusion

314. To avoid carrousel effects with many people eventually ending up on the disability benefit rolls, social insurance institutions in all three countries should make efforts to closely monitor the further work and health career of rejected applicants. This is not done currently, with benefit institutions not even being 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 applying for such a benefit repeatedly.

315. Poland deserves praise for their 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 also a close link across regions between disability and unemployment benefits.

3. Better institutional cooperation

316. Better cooperation across institutions and between 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 Norway, Poland and Switzerland. First, it looks at the way the disability authority cooperates with the PES and the local social assistance agencies in order to eliminate carrousel effects. Secondly, it addresses the issue of cooperation 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 cooperation between the disability authority, the PES and the local welfare agencies

317. 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 this, they would often help the person in applying for such benefits. Local officers have two reasons for trying to discard some of their clients with health impairments to other bodies. First, there are financial causes: the more people that are being 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.

318. The disability benefit insurance is in a weak position in this carrousel 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 coordination and cooperation across institutions.

319. In this respect, Norway has started very comprehensive changes with considerable potential. In late 2002, a government white paper to the parliament proposed to merge the PES with the NIA into a new central government agency and to establish new local labour and welfare offices (called NAV). This one-stop-shop would offer all employment and insurance services of the two organisations and cooperate closely with the local social assistance office. The objective is to develop a more effective employment and welfare system and to provide more client-oriented services. Currently, coordination 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).

320. In 2005, 17 pilot agencies with all three institutions under one roof were set up in several Norwegian counties. In this pilot phase, these 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.

321. Currently, clients in need of services from at least two of these agencies often fall between chairs. It is these customers on whom particular emphasis is being put in the pilot agencies, with the aim to develop common tools for cooperation (around 8% of all customers need service from all three agencies, and 16% from two of the agencies). The cooperation platform where all three agencies meet to find a joint solution, with the work focus centre stage, is already a big step forward, because shifting clients around is being made more difficult. Similarly, benefit shopping is becoming more difficult for the customers.

322. Switzerland is, since several years, also very active in addressing carrousel effects by improving the inter-institutional cooperation between the PES, the cantonal disability offices and the municipal social assistance authorities. The philosophy of this new cooperation, generally referred to as IIZ, is to encourage individual actors to coordinate their activities, to make their own actions more transparent and to share information with other institutions. There is strong support among these institutions that IIZ is needed. There is also support from the national government, which, for instance, has published an IIZ handbook that summarises experiences made so far but also through different types of support to those actors willing to improve cooperation.

323. 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 being implemented. For instance, in some cantons all three partners are involved, while in others cooperation is limited to certain particular aspects. The common denominator is a new focus on mutual exchange of information and ways to regulate cooperation. One good-practice model was developed by the canton of Solothurn. In this canton, in mid 2005 a new law was enacted which 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 which 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 cooperation, respectively.

324. Another promising initiative in the context of the new inter-institutional cooperation, 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 which is binding for all institutions; *ii)* jointly agreed re-integration measures; and *iii)* one of the three institutions being made 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 this new initiative is entirely voluntary for the cantons and municipalities.

325. In Poland, no country-wide efforts are taken to improve cooperation 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 cooperation across institutions and government levels. In Warsaw City, for example, new social service centres have been established which harmonise and bundle information and knowledge to help disabled people navigate through the complex system of support.

B. Improving cooperation between the disability authority and other health-related schemes

326. There is also a need for better cooperation between the disability 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 Chapter 2 and Chapter 3. 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.

327. On these lines, various efforts have recently been taken in Switzerland to improve cooperation 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 cooperation 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, cooperation is encouraged on a voluntary basis and support given through the development of manuals of good practice.

328. The manual on cooperation 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 ("normal-care cases") that would gain from a close collaboration between the two parts, where the disability insurance is supposed to provide information on reintegration needs between three and eight months after the work incapacity has commenced; *iii*) difficult ("best-care") 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.

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

C. Improving coordination of disability benefits and old-age pensions

330. A third issue in the context of policy coordination 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 that has implemented a comprehensive old-age pension reform 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. Promoted by the strong work ethic in the country, the Swiss population never developed an early retirement expectation, which has helped to avoid the use of disability benefits as an early retirement pathway.

331. 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 extension to younger age groups has 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 the pressure on the disability scheme.

332. This will soon become an issue for disability policy making because a comprehensive change in Norway's old-age pension scheme is forthcoming.[52] In response to this reform, both the AFP scheme and the disability benefit scheme will have to be adapted. 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 disability benefit scheme should continue to follow the old-age pension scheme or be separated from it and 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 supposed to submit a report to the government in late 2006.

333. 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 already in 1999.[53] The transition

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52. 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 to a greater degree than today depends on 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.

53. The new pension system in Poland is a reflection of the reforms in several other European countries over recent years and 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,

rules of that reform imply that those older than 57 years in 2006 still all retire on the basis of the old Polish pension scheme. This, 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

334. The need for coherent policies and better coordination and cooperation 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. Cooperation 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.

335. Switzerland is most active in ensuring good governance of its cantonal disability institutions, and it is also taking important steps in improving cooperation 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 cooperation 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 obligations for any of the actors involved.

336. Norway is tackling the need for better cooperation through a comprehensive merger of its key institutions, the PES and the NIA. This is a long-term project which 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.

337. For Poland, good governance and coherent policy making are issues that need to be brought up to the fore of the policy agenda. The recent sharp fall in inflows to disability benefits masks the need for better monitoring of operating institutions and better cooperation 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.

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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.

CHAPTER 6

EVALUATING RECENT AND ONGOING REFORMS

338. Sickness and disability policy in Norway, Poland and Switzerland is reaching a critical moment. In Norway, the tripartite agreement on more inclusive workplaces has come to an end, and the partners to the agreement have started to negotiate the next steps. In Switzerland, the proposed fifth revision of the Disability Insurance Act is currently being discussed in parliament, and enactment is expected for early 2008. In Poland, the new government must find 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.

1. Norway: Making the tripartite agreement a success

339. Seven years ago, the government established a Royal Commission to propose reforms to the sickness and disability benefit scheme. The report of that Commission, submitted in September 2000, contained proposals for far-reaching changes, some of which were put in place in the subsequent years. Among them was a somewhat more generous 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.

A. Reducing sickness absence

340. 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 parts 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 2001-2005 between the government and the social partners to cooperate 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).

341. Several measures were implemented to achieve the agreement's objective to reduce sickness absence rates, including the 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 cooperation 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 tripartite agreement on a more inclusive workplace 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 larger number of people with disabilities; and
- To extend working life.

The social partners have the main responsibility to reach 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 cooperate closely in investigating the reasons for the employee's absence and early retirement and for developing appropriate solutions.

To reduce the sickness absence rate, earlier workplace-related interventions are being introduced in combination with better methods to follow-up on persons on sick leave. Companies are also introducing a "work ability index" to measure the ability employees have in spite of sickness. Further, the government has increased the reimbursement of companies' expenditures for purchasing health care services and rehabilitation. To improve the employment prospects of persons with limited work capacity, the government has introduced wage subsidies for employers who hire disabled people and a special subsidy for adapting workplaces to the needs of these workers.

Every enterprise can sign a contract with its local social security office to become recognized as an "inclusive workplace enterprise" (IW-company). The National Insurance Service has organised new Workplace Centres in all of Norway's counties to assist the IW-companies. Such companies have a regular contact person at the Workplace Centre to help them in taking necessary actions and to follow up employees on sick leave. In addition, the health services in IW-enterprises are given a special refund rate from the National Health Service for efforts to bring employees on extended sick leave or disability benefits back to work.

Firms that sign such a contract with their social security office must commit themselves to work systematically to meet the objectives. When an employee is unable to continue her or his job 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.

Employees are obliged to inform the firm about their own functional capacity when on sick leave, so that relevant measures can be implemented as quickly as possible. The employee should also agree to have a dialogue with the employer concerning changes in work tasks, participation in training or other necessary measures to continue working. In general, the employee should cooperate with the employer in adapting the workplace as required. Employees in IW-enterprises have the right to take sick leave without a doctor's certificate for an extended period of eight calendar days per period of sick absence, with a total upper limit of 24 days per year. The reason for introducing this rule is to place more responsibility on the employee and the employer since doctors often prescribe sickness certificates for longer periods than is usually necessary.

342. Results from a mid-term evaluation of the tripartite agreement in late 2003 were disappointing. Sickness absence had continued its almost linear 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:

- The introduction of an activity requirement within eight weeks of granting the latest sickness certificate (unless medical reasons clearly exclude workplace attendance).
- An evaluation of the functional capacity of the person on sick leave by a medical practitioner within eight weeks.
- Stricter sanctions on medical practitioners who do not comply with the new rules for sickness absence certification.

343. In the second half of 2004, sickness absence rates dropped sharply, though they seem to have stabilised again one year later at a lower level. In the second quarter of 2005, sickness absence rates were around 10% below the level of the reference quarter for the IW-agreement (second quarter of 2001). Thus, around half of the targeted decline has been achieved. However, this decline has yet to prove to be long-lasting because data suggest that sickness absence is reaccelerating lately. Moreover, there is almost no difference in the trends in absence rates in IW-enterprises and those which have not signed a cooperation 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, absence is going to have to fall much further if it is to get back to what used to be normal in the 1980s and early 1990s.

344. The timing of the decline in sickness absence rates and the similarity in trends in IW- and other companies suggest that the regulatory amendments have played the key role in triggering a turnaround in the absence trend or at least stopping absence rates from increasing further.[54] However, it is not known which element of the 2004 sick-pay reform has played the crucial role in the reduction of sickness absence.

B. Promoting new management practices

345. The cooperation agreements of enterprises with the local office of the NIA have indeed set off a change in sickness management practices, although such change is difficult to measure empirically. In contrast to just a few years ago, sickness absence no longer seems to be a private matter between the employee and his or her doctor. Today, employers are encouraged and expected to engage in a dialogue with their employees on health problems and possible solutions at the workplace (see the good-practice example in Box 6.2).

Box 6.2. **New management practices can lower sickness absence**

The example of the Bjørkelangen branch of Norgesbuss Bærum og Romerike AS shows how a new management style and the support from the county Workplace Centre can influence the behaviour of employees.

The success story of this small branch of a large company, with some 50 workers, which is running a school bus service in the east of Norway and an hourly express service from Lillestrøm to Oslo, is remarkable. In 2002, the branch was undergoing a very difficult time, including a merger with another company. At this time, working conditions and the relationship between staff and management were very poor; "it was hell going to work", as some of the workers said. In the last quarter of 2003, the company recorded total sickness absences of 15.2%. A completely new management style was introduced to improve relations with the workforce and to raise the quality of work. This new approach was initiated with a joint exercise for all employees (in which they practised for a catastrophe situation) and an open-door policy so to shorten the distance between staff and management and take up matters immediately as they arise. Another important element was that all managers were required to drive a bus themselves every day (even if only for two hours).

Within a year, management and its employees have been able to create a unique working environment. The company won the Oslo Working Environment Prize for 2003 and then became an IW-firm in 2004. By the last quarter of 2004, sickness absence had fallen to 3%, a drop of some 80% within just one year. This has been achieved through the contact with the county Workplace Centre and a joint effort to intervene early – with the involvement of a physiotherapist and the use of the active sick leave system – with the objective to make sure that workers continue to be involved closely. Overall, the branch has saved over two person-years during the time it has been an IW-enterprise and is now serving as a good-practice model.

54. It remains to be seen to what extent the recent trend is at least partly a cyclical effect. A fall in the rate of unemployment could well push the rate of sickness absences upwards again.

346. In this process, human resource managers can rely on support from the new county Workplace Centres of the NIA, which are well received by these managers. These services are entirely free to the employer. The total costs of these Workplace Centres are small in relation to the potential savings they produce: Total direct costs in 2004/2005 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 are offset by merely a half-day reduction in total sickness absence across Norway (not taking into account indirect benefits through increased production and productivity).

347. Cultural change brought about through this development, however, may well be two-sided. While sickness no longer seems to be a private matter, there is anecdotal evidence based on the findings of an in-depth qualitative study of 16 IW-enterprises that recruitment of people with health problems has fallen in some of them. Hence, while recent changes might have raised the awareness about health issues and thus helped to make sickness management a priority at the company level, this might be happening at the expense of stronger health screening in the recruitment process. This problem will also have to be monitored very closely.

2. Poland: Preparing the next comprehensive steps

348. In Poland, reform in recent years was characterised by attempts to tighten entitlement to both sickness and disability benefits while at the same time strengthening the focus on medical as well as vocational rehabilitation. Were these reforms successful?

A. Successful tightening of access to benefits

349. Stricter rules for the issuing of sickness absence certificates and more control of doctors' decisions were introduced in 1998. Within two years, absenteeism fell by one-third from its high pre-reform level 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 were the introduction of a new disability assessment procedure, with one approved social security doctor having to assess the applicant's inability to work, and a more restrictive approach to granting permanent disability benefits. Temporary benefits, which are granted in most cases, are stopped after three years, and the recipient must reapply and re-qualify for the benefit. 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.

350. These changes in the disability benefit system came in parallel with the take-over of the disability assessment for farmers by KRUS (the special system for farmers and their dependants) in 1997. Despite a lack of equivalent changes 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 and substitution factors, *i.e.* a growing number of people moving into welfare benefits other than disability in response to the tightening of the disability benefit regime, might have been the key explanatory factors of recent change. This, in turn, could mean that with abolition 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.

351. Despite the steep fall in inflows to disability benefits, the stock of people receiving such benefits is still very large and, consequently, spending on disability benefits very high. The previous government, therefore, suggested to reassess the stock of recipients of 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 to improve work incentives and to lower public social spending. But parliament rejected the reform in late 2004. Reform plans of the new government would do well to re-launch some of the proposals made in 2004 (Box 6.3).

Box 6.3. **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 stock of disability benefit recipients through a re-evaluation of all long-term disability benefit 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 less generous 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 the 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

352. In parallel to 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 (which are offered by the PES), and applicant's fear of loss of entitlement to long-term benefits. Major efforts will have to be made to make the vocational rehabilitation scheme functional.

353. 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. This is a major concern, partly driven by poor labour market conditions in general, but it is partly related to disability policy, too. 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.

354. Recent policy change in the course of Poland's accession to the EU has broadened the wage subsidy scheme considerably. Today, wage subsidies for employing disabled people are available to all employers (except for companies with more than 25 employees not fulfilling the 6% employment quota),

although subsidies are lower than those for SWE companies. Compared with other OECD countries wage subsidies are high, and they are paid permanently. The broadening of the wage subsidy scheme has led to a slight increase in the number of firms voluntarily employing disabled people (*i.e.* firms with less than 25 employees that do not fall under the quota) and the number of workers with a disability employed in these companies.

355. However, this change also brought new challenges for the future. Companies that fall under the quota regulation are eligible for wage subsidies for *all* their disabled workers, not only those in excess of the quota. 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 at the same time wage subsidy spending would increase. This situation could quickly become unsustainable; the current rules could only be maintained if the policy intention – namely to raise the rate of employment of disabled people – remains unfulfilled.

356. The entire system of employment support for disabled people, as regulated under the act on employment and vocational rehabilitation of disabled people (AEVR), appears to be ineffective. Generous wage subsidies for SWE companies, often larger than the actual wages paid, have not helped to raise the employment rate of disabled people, nor has the employment quota. Two key aspects in this context are governance and stability of the rehabilitation system. With some 40 amendments of the AEVR since its introduction in 1991, employers have limited trust in the system and tend to avoid dealing with the administration. Instead, most employers prefer to pay the relatively high levy (of around 40% of 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. SWE companies, which receive the bulk of the fund's spending, have very limited reporting requirements, and PFRON has limited control possibilities that are not used much. 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.

3. Switzerland: Bringing the "fifth revision" on track

357. Based on an assessment of 1985-2000, OECD (2003a) identified Switzerland as the country which had undergone the least changes in the area of sickness and disability policy throughout the OECD. This has changed drastically since. Having started a discussion process on comprehensive reform steps in the mid-1990s, the fourth revision of the Swiss Disability Insurance Act finally came into force in 2004. Preparations for the fifth revision were by then already begun.

A. Improving the medical tools

358. The three new key elements introduced with the fourth revision were the following (Box 6.4): regional medical services (RAD); active job placement services in the cantonal offices of the disability insurance; and a three-quarter benefit (for those with 60-69% work incapacity). The latter was a surprising step, given that only a few years earlier, in 1999, the government unsuccessfully tried to abolish the quarter benefit. The new three-quarter benefit was designed to increase the likelihood of re-tested full-benefit recipients to move back into work, because it lowered the required earnings capacity needed for this to happen from one-third to one-fourth.

359. 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 to put this service in place. So far, only a small part of these investments have been made. The new job placement service of the CDO is in addition to, and completely independent from, similar services offered by the PES, which raises issues of

efficiency and coordination. 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 the PES caseworkers usually have, which is lacking in the CDO. It remains to be seen whether building an entirely new placement structure is indeed the most effective and most efficient way to go.

Box 6.4. **The fourth revision of the Swiss Disability Insurance Act**

The fourth revision had several objectives, such as contributing to the financial consolidation of the disability insurance, providing a better targeted set of benefits and services, and strengthening the supervisory role of the confederation. The main changes to the system were the following:

Contributing to the financial consolidation

- Abolition of benefit supplements for spouses and of hardship pensions;
- Creation of a right to claim supplementary benefits for recipients of quarter pensions;
- Greater cost control through the introduction of demand planning for institutions working with the disabled; and
- Legal basis for the funding of research work.

Providing a better targeted set of benefits and services

- Introduction of a standard care allowance (replacing the existing miscellaneous care and support benefits) to encourage independence and foster self-determination;
- Redesign of the system of daily allowances paid during the rehabilitation phase (*e.g.* more transparent and not dependent on marital status);
- Extension of benefits for further occupational training (coverage of invalidity-related supplementary costs of further occupational training);
- Introduction of a three-quarter disability benefit to provide greater incentives for beneficiaries to take up gainful employment; and
- Upgrading job-placement services by the disability insurance offices (with an entitlement to active job-seeking assistance and advice on how to keep existing jobs; and with better advice and information to employers on their workers' rehabilitation and insurance rights).

Strengthening the supervisory role of the confederation

- Introduction of regional medical services, spanning over several cantons, to provide more uniform and qualitatively better disability assessments throughout the country; and
- Annual audit of the accounts of the cantonal disability insurance offices (rather than every 3-5 years), based on a sample of complete dossiers.

360. Maybe 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 their supervision. Today there are ten RADs throughout Switzerland, in most cases set up in cooperation between several CDOs.[55] The objective of this change was twofold: to provide a more objective and independent medical assessment for the 10-20% most difficult cases, 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

55. The new RADs are not replacing the specialised medical assessment centres (MEDAS), which continue to take care of particularly complex cases. A MEDAS assessment, a service connected with a hospital, takes two years, on average, much longer than a normal application procedure.

inflow rates into the disability benefit scheme by roughly 9% each in 2003-2004 and 2004-2005. However, part of this decline is the result of an increase in backlogs.

B. Trying to reach people with work incapacity earlier

361. 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 6.5). 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 a person turns to the CDO, he or she has typically been out of work for many months and often has lost his or her job. The key focus of the planned revision, therefore, is to get in contact as early as possible with people at risk of drawing disability benefit payments 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, targeted to persons who had been at least 50% work-incapacitated for a period of at least six months.

Box 6.5. **The planned fifth revision of the Swiss Disability Insurance Act**

The fifth revision of the disability insurance act aims to reduce the deficit of the insurance system by reducing the annual inflow by 20% (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 cooperate, including new sanctions;
- Stricter access to disability benefits through a modified definition of disability;
- Abolition of retrospective payment of disability benefit and reintegration measures; and
- 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; and
- 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 the entire stock of benefit recipients (*i.e.* not only for new cases as under the fourth revision).

362. It is hoped that each year around 20 000 people will be identified early,[56] with 10 000 of them participating in early intervention measures and 5 000 in new preparatory integration measures – thereby resulting in the targeted 20% 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. However, all of this is voluntary which is why it will be crucial to get the incentives right for all key actors involved, including the 26 CDOs themselves.

363. In addition, there are also new risks arising from this new approach, which ought to be monitored very closely. Early identification bears the danger that "medicalisation" of labour market problems takes place at an even earlier stage. This is hoped to be counteracted 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. While misuse of integration-oriented measures is rare, the "quick-and-dirty" premature assessment of probable entitlements has pros and cons. The aim of this first assessment, which is only done on the basis of the existing medical files without any further medical tests, is to overcome the long duration of the full and comprehensive disability assessment process. Hence, it is a compromise between precision and speed, with the latter regarded as crucial. However, there is a big risk that this premature assessment will be used to screen ineligible people early and to refuse any support to them on the grounds of lack of eligibility. This would be detrimental to the idea of prevention of disability through early identification and early intervention.

364. The fifth revision of the Disability Insurance Act also aims to correct negative work incentives. Apart from the planned 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).

C. Looking beyond disability insurance

365. Even the targeted 20% 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 be 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.

366. In addition to the planned and already implemented revisions of the disability insurance act, which predominantly focus on the role of the CDO in keeping people in work and away from benefit, it is increasingly recognised that some of the problems are related to the lack of coordination and cooperation between and across different parts of the social protection scheme. This recognition is reflected in the recent emphasis on inter-institutional cooperation of two kinds: IIZ, focusing on cooperation between the CDO, the PES and the social assistance authorities so to avoid carrousel effects; and IIZ PLUS, focusing

56. Compared with an inflow into disability benefits of around 25 000 in 2003-04, and an estimated number of around 200 000 people who have sickness absences of more than 4 weeks.

on cooperation between the CDO, the sickness benefit insurers and the work injury and accident insurers (Chapter 5). While IIZ has been further stimulated with the implementation of the fourth revision, IIZ PLUS will become crucial in the course of implementation of the fifth revision.

4. The impact of recent and ongoing reform

367. Reforms to the sickness and disability policy approach undertaken in the past 20 years as well as the lack of a particular type of reform are essential explanatory factors for the 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 6.6).

Box 6.6. **Illustration of countries' policy stances and trends**

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

Indices in two dimensions have been developed in OECD (2003a). The first is the level of compensation. The index of compensation takes into account 10 policy parameters: *i)* coverage of the benefit system; *ii)* the minimum disability level; *iii)* the disability level needed to get a full disability benefit; *iv)* the maximum benefit level at average earnings; *v)* the permanence of benefits; *vi)* the medical assessment; *vii)* the vocational assessment; *viii)* the sickness benefit level; *ix)* the sickness benefit duration; and *x)* the unemployment benefit level and duration in comparison with disability benefits. Each country is ranked on a scale of zero to five on each of these categories. No attempt is made to assess which of these categories is most important; all have equal weight. A country which has a high total score in the compensation dimension is 'generous' in supporting people with disabilities who are not working.

The second dimension is that of integration. Again, ten sub-dimensions 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 which has a higher integration score is one which has a more active policy in ensuring that people with disabilities can find work. [Details of the points attached to each aspect of policy and the policy stance of 20 OECD countries in 1985 and 2000 can be found in OECD (2003a)].

368. According to this policy typology, compared with the OECD average in the year 2000, all three countries covered in this review were characterised by a relatively generous and accessible disability benefit system (Figure 6.1, right-hand side). At the same time, Norway also stood out as one of 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.

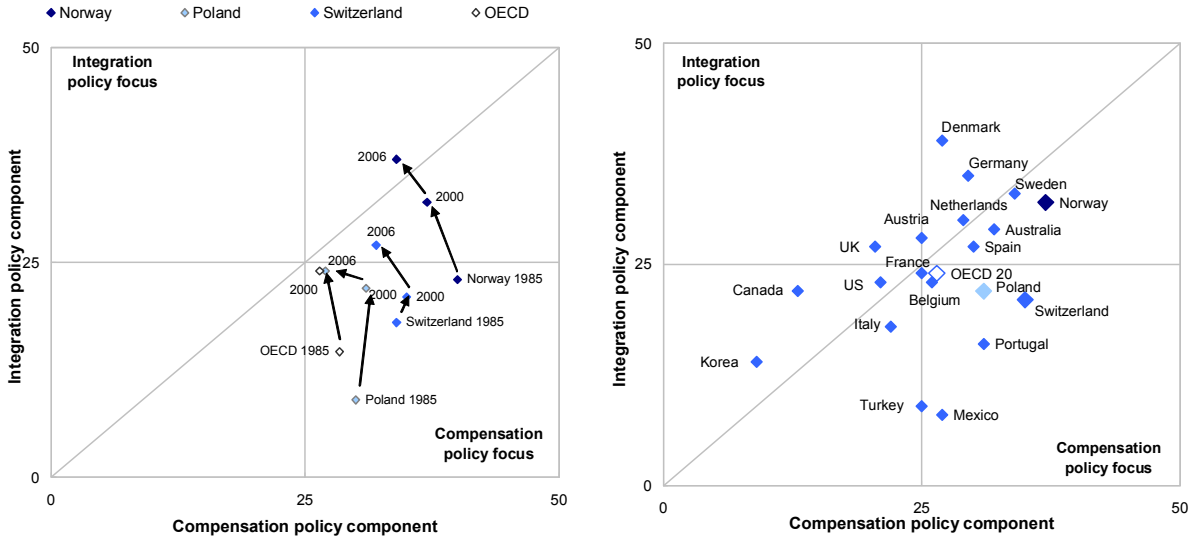
369. Throughout the OECD, *integration* policy elements have been strengthened, sometimes considerably, with a strong convergence in policy objectives. On average across twenty countries, OECD (2003a) estimated a 10-point increase on the 50-point integration policy dimension over the fifteen-year period from 1985-2000 (Figure 6.1, left-hand side). This change contrasts with a relative lack of reform on the *compensation* policy dimension; benefit programmes have remained virtually unchanged in most cases. In theory, there is nothing wrong with a policy stance which 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 rather 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 gravitate those who do not wish to work or those who benefit officers despair of activating. This undermines the more positive work focus which governments have been trying to follow and which is in the interests of the majority of those on the benefit.

Figure 6.1. **Comparing sickness and disability policies across time and countries**

Left-hand side: Disability policy typology in the three countries around 1985, 2000 and 2006

Right-hand side: Disability policy typology in 20 OECD countries around 2000



Source: Secretariat update based on OECD (2003a), *Transforming Disability into Ability*.

370. Norway, Poland and Switzerland are no exception to this general trend in the period 1985-2000, even though Switzerland had hardly gone through any reform in that period. However, continued policy change 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 6.1, left-hand side). In this relatively short period, the shift was strongest in Switzerland and least pronounced in Poland, implying that the overall change 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 3-4 point decline on the compensation policy scale. This could help improve the effectiveness of the integration approach.

371. Relative to the OECD average in 2000, nevertheless all three countries still appear to be having relatively 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 the implementation and the effectiveness of policies. 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.

CHAPTER 7

AN AGENDA FOR THE FUTURE

372. 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, is calling for different cures. Even so, the three countries also face a number of challenges common to all schemes, for instance 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 which is very costly in the long run. This chapter discusses promising avenues of reform for the three countries.

373. 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 on incapacity-related programmes. Other than this, policy challenges differ (Table 7.1). The key issues in Norway are to reduce the very high inflow into sickness and disability and to raise the negligible outflow from disability benefits. 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, like in Switzerland, to strengthen the coordination 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.

Table 7.1. **The magnitude of the policy challenge in Norway, Poland and Switzerland, 2006**[a]

Seven key policy challenges	Norway	Poland	Switzerland
#1 Controlling incapacity-related public spending	+++	+++	+++
#2 Raising employment rates for people with health problems	++	++++	+
#3 Tackling income inequalities across different population groups	+	+++	++
#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 the coordination across different benefit schemes	++	++++	+++

a) The scales should be interpreted as follows: + … minor challenge; ++ … moderate challenge; +++ ... big challenge; and ++++ … very big challenge.

Source: Authors' assessment.

1. Key problems and possible solutions in Norway

374. 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 in tandem with rather high overall levels of labour market participation, today the largest part 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 is the major reason for dropping out of the labour market.

375. 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 any possible successor to the IW-agreement, which should do more than aim to lower sickness absence further. Measures should also 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. In addition, proposals are made to reinforce and complement ongoing and planned reforms.

376. A specific problem in Norway is that the system contains many promising elements but their take-up is low and outcomes are poor. The key challenge, therefore, is to understand better *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. Indeed, very little is known about how the existing provisions and regulations are being implemented by local actors

A. Inflow management and assessment procedures

377. 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 in addition it will be difficult to continue it in the future if outcomes are to be improved. To begin with, in order to fully implement this policy principle, measures and reforms would have to be matched by stricter mutual obligations and better-enforced sanctions in case of non-fulfilment. In addition, however, for future reforms a new balance should be sought between better work incentives and tighter eligibility criteria.

378. 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 matters from a private matter to a more openly discussed issue. However, reform stopped half-way. 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, 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.

379. The assessment of long-term disability still relies too much 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 gate-keeping function should be reduced in exchange for strengthening their guidance and assistance function. Efforts within the IW-agreement instead seem to be strengthening the gate-keeping function, which is too demanding for the GPs and also undesirable for the patients who lose their medical advocates. The medical assessment and gate-keeping function for disability

benefit eligibility should, therefore, be handed over to the national insurance authority (NIA) and its specialised insurance doctors.

380. Furthermore, in the transition from work to sickness and disability, a stronger focus should be put 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. These 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 give occupational health advice as well as advice on workplace adaptations and on 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 the recent improvements.

381. Better management of sickness absences can only be achieved through a strong involvement of employers. Along these lines, the recent setting-up 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, these 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 with regard to the objective to increase *hiring* rates of disabled people should be reinforced.

382. Another important change to improve sickness management is the new obligation for employers to prepare a follow-up plan. This could also 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 through financial consequences.

383. 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 through a longer period (of maybe 4-6 weeks) during which employers 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

384. Vocational interventions are another way to prevent disability benefit inflow. Vocational rehabilitation and training is used widely in Norway, but the results are disappointing. 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 many available programmes are most appropriate for whom, and to distinguish successful programme chains from those that merely contribute to postponing the disability benefit award. Programmes should be better targeted to individual needs and be used more selectively. Geographical and occupational mobility requirements are too weak and durations of many programmes still too long. A stronger focus could be put on low-cost, short-duration programmes, as planned to be introduced in Switzerland.

385. In addition, better integration of medical and vocational rehabilitation is needed. In Norway, medical rehabilitation is in the responsibility of the health sector, while vocational rehabilitation is under the responsibility of the PES. Closer cooperation 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.

386. Given the large share of the population on disability benefit, the Norwegian government should also concentrate on measures to tackle 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 further away from the retirement age. Re-assessing the work capacity of beneficiaries and cutting or withdrawing benefits from those with sufficient work capacity, however, is not an end in itself. Examples of similar re-testing exercises in the United States (in the mid-1980s) and the Netherlands (in the mid-1990s) have shown that those people, nevertheless, often tend to end up on disability benefits. Therefore, special support has to be provided to these people, including 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.

387. 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. Badly needed evaluations should therefore focus on the likelihood of returns to work and transfers to a permanent disability benefit of those with a temporary benefit, but also on practices in awarding a temporary benefit. Secondly, it is of key importance to follow-up those people granted a temporary benefit – people who are likely to need additional support to return to employment. There is no evidence so far that such follow-up and assistance is taking place. Thirdly, at around one-third, the share of people granted the temporary rather than a permanent disability benefit is low in international perspective. Far more people should have the potential to improve their health situation and, thus, their work capacity. Therefore, the authorities should aim to reduce the share of permanent disability benefit awards further.

388. Similarly, the share of beneficiaries with 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 already for a 70% work capacity reduction whereas Norway 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 by a stronger focus on partial payments.

389. 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 to 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) is a promising attempt. The reasons for the low use of this regulation should be analysed carefully and actions taken in response to raise the take-up significantly.

390. 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

391. The IW-agreement, which ran over 2001-05, will be extended but the details are not yet arranged. On the basis of the experience during the past five years, a follow-up agreement should include the following features: *(i)* the agreement should be a motor for change; therefore, no veto on systemic reform should be accepted; *(ii)* it must be more focused on increasing the labour force participation of disabled people; *(iii)* it needs quantitative and action-oriented targets for all its objectives, with clearer specified obligations for all involved parties (employees, employers, the government, the social partners, doctors), *i.e.* who will do what and when; *(iv)* it also needs clearer formulation of the consequences of non-fulfilment of obligations and non-achievement of targets; *(v)* and, finally, the follow-up agreement should make an effort to provide the necessary support to all employers, not only IW-companies.

392. With the forthcoming reform of the old-age pension system yet to be agreed in its details, it will also be difficult to leave disability benefit levels unchanged. An increase in the disability benefit inflow among older workers in the aftermath of the introduction of old-age pension deductions for those retiring before the age of 67, as foreseen in the reform, is very likely. Good coordination 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 to make sure that disability benefit does not exceed the corresponding early retirement benefit entitlement at the same age. In turn, this implies that the collectively-agreed early retirement scheme needs to be integrated into the forthcoming reform of the pension system as well.

393. The merger of the PES and the NIA, at national as well as local levels, could help ensure that all persons with disabilities get the right service at the right time. Through the integration of the social welfare offices, it could also reduce the risks of carrousel 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 the cooperation 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.

394. Better governance of the local NIA (or soon NAV) 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 indicators of effectiveness is being pursued. In a second step, financial incentives for local NAV offices delivering services to people having problems on the labour market will need to be improved.

2. Key problems and possible solutions in Poland

395. Poland is facing extremely low levels of labour market participation of disabled people, with less than one in five of them being 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 as self-employed or family workers. They are highly overrepresented in the agricultural sector and underrepresented in the public sector.

396. 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 in the early and mid-1990s, have fallen rapidly ever since and are now below the OECD average. Outflow rates from by and large 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. This needs to be done in tandem with general labour- and product market policy reforms aiming at making work pay and raising labour demand so that work can become a realistic option for persons with a disability.[57]

397. In the following, various possible solutions are discussed that could make the whole Polish sickness and disability system more functional. Indirectly, some of these measures could also encourage a shift from informal to formal employment, with many beneficiaries of disability benefit currently working in the informal economy. Some of the elements of the current system should probably 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 to bolster key strengths of the various systems currently in place.

A. Inflow management and assessment procedures

398. 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 which are 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 controlling 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 cooperation with employers who should be given the necessary assistance and information to support the insurance institution in doing this.

399. 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 above age 50 and an increased inflow to social pensions for younger age groups.

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57. General labour- and product market policy reforms are discussed in detail in the *Reassessment of the OECD Jobs Strategy* (OECD, 2006a), with a focus on coherence between labour costs and labour market developments, competition in product markets, and adoption of working-time arrangements and employment protection legislation conducive to labour market dynamism.

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 rapid 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 to remain in or re-enter the labour market, *e.g.* in the form of workplace adjustments.

400. Appeals against rejected benefit claims are also very high 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 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.

401. More generally, the current disability assessment structure may have to be reconsidered. The separation of assessments for pension purposes (done by ZUS and KRUS) and labour market purposes (done by local governments) is confusing, inefficient and likely to contribute to labour market exclusion. Instead, the 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 through occupational guidance for persons with disabilities, and local labour offices through placement support.

402. Further, rules in the KRUS system 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 ability 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 put on efforts to reintegrate potential as well as current KRUS disability beneficiaries into other sectors of the economy through increased and more compulsory use of medical rehabilitation as well as vocational rehabilitation and retraining (see also further below).

403. 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 work capacity is only partially reduced. Designing such reduced benefit as an in-work payment rather than out-of-work benefit could avoid increases in the inflow rate in the aftermath of such change. However, this would also require more tailored job-search and reintegration support to those people assessed to be partially disabled.

404. Medical rehabilitation is another area where improvements would be possible and desirable. First, better coordination 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 coordination could be achieved through an improved quality and flow of medical files provided for disability benefit applications, with doctors needing more time for the examination. Secondly, earlier medical rehabilitation during the sickness absence phase should also be promoted. Thirdly, costs of medical rehabilitation can be reduced by increasing the use of less costly out-patient rehabilitation. Finally, coordination of preventive activities should be enhanced, with more preventive responsibility given to ZUS and KRUS.

B. Vocational intervention, outflow management and work incentives

405. 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. Without addressing the causes of this failure, 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 currently vocational training is not requested. It appears that eligibility criteria are too strict, labour offices have inadequate funding and people hesitate to enter vocational programmes. All these aspects need to be addressed. 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.

406. 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 contribute to a reduction in 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.

407. Despite recent success in reducing benefit inflows, the stock 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. In doing 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, special support has to be provided to them, including tailored job-search and placement services and, 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 provide income support as well as job-search incentives during the transition back into the labour force.

408. To promote voluntary moves into the labour market of beneficiaries who are 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, it 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 to work. In addition, the possibility to try work 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 housing and disability benefit should be analysed more closely. OECD tax-benefit model calculations seem to indicate that housing benefits create major benefit traps and income spikes.

409. 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, more 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, more 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 reintegration of disabled people.

410. In 2004, the wage subsidy scheme – financed through PFRON funds – was extended to all companies in the Polish economy. Since then, even companies which fall under the employment quota regulation (those with more than 25 employees) and which 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. 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 (while today the majority of subsidised employment concerns people with a light disability).

411. The strong focus on sheltered work enterprises (SWE) has perpetuated the segregation of disabled workers and hindered their integration into the open labour market. Insufficient efforts are made to facilitate the transfer of sheltered workers 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 still prevailing privileges of SWEs – such as the income tax refund for all employees in a SWE, also for their non-disabled employees – should be further reduced so that more resources can be used for skills 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.

412. 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 hire people with health problems. In the light of the limited difference these regulations probably make for disabled workers, abolition of these rules 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

413. The comprehensive reform of the old-age pension system in 1999 has not so far 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. In the light of rapid ageing of the population, this is not sustainable; in the near future, these early retirement schemes are going to be phased out (this is already the case for the ZUS scheme by 2007). At that moment, the pressure on the disability benefit scheme will most certainly increase, especially because disability benefits are more generous than old-age pensions. To avoid spill-over 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.

414. In addition, a clear separation is needed between disability benefits and old-age pensions. Only since 2004, beneficiaries reaching the retirement age are transferred to the old-age system, but they still keep their higher disability benefit. This has not made it less attractive for older workers to seek retirement on grounds of disability. Instead, clear regulations need to be put in place which 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.

415. 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. 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 to improve its impact. However, services should not be delivered when they do not have a long-term impact on employment stability.

416. Also important is a better coordination 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 this, although they finance it and therefore have a stronger interest in the success of any such programme. This could be greatly improved by better cooperation between ZUS and the PES, *e.g.* by giving ZUS a supervising role. Instead, or in addition, one could also consider a change in the funding structure so that the PES would benefit financially from successful placements into paid jobs.

417. 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 could help facilitate reintegration of disabled people and lower overall spending. Local governments and their specialised assessment teams are best placed to assume this function. PFRON as an independent institution may be redundant in a reformed system. The important functions of this organisation could instead be transferred to local governments, which receive a large amount of the PFRON funds unconditionally anyway. With such a transfer, incentives for local governments would have to be improved by stricter consequences of policy failure. At the same time, streamlining the supervision procedures of local governments would also limit the discretion in policy implementation.

3. Key problems and possible solutions in Switzerland

418. 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.[58] The medicalisation of labour market problems and the steep rise in non-specific, often mental, illnesses has reached a level which 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 coordination of different social security schemes, be they mandatory public, mandatory private or voluntary private systems.

419. 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 made. Continuing reform along the lines of the planned fifth revision, to be implemented as from 2008, 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 the responses it can take rather than the role of other actors and the way the disability insurance cooperates

58. In 2004, outlays exceeded revenues by 17% and the cumulated deficit has reached CHF 6 billion. This corresponds to more than 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 was estimated to be run down by 2012 (BSV estimates).

with other agencies and insurances. Following up on initiatives taken in the course of the recently established inter-institutional cooperation will, therefore, be equally important.

420. In the following, proposals are made 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 underpin the impact of initiatives to improve inter-institutional cooperation and governance of the public disability insurance.

A. Inflow management and assessment procedures

421. The fifth revision aims to reduce the annual inflow into disability benefits by 20%. This is hoped to be achieved by bringing people in contact with the disability insurance at an earlier stage – ideally after a few months of sickness absence but no later than after eight months, rather than after a year or more as is currently the case. Earlier identification of serious health problems indeed has a major potential to reduce the inflow to disability benefits. However, 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 in 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.

422. 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 prepare 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. For this to be successful, employers would benefit from having a unique contact person in the agency who could provide the necessary assistance – as is the case in the new local Workplace Centres of the Norwegian social insurance authority.

423. 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 employment chances of sick or disabled people without a job. Furthermore, extending experience-rating to the contributions to the 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.

424. To oblige private sickness benefit insurers to implement sickness monitoring and sickness management will also require a few changes. One element would be to strengthen the incentives to do this properly. This would in particular require abolishing retrospective payments to the sickness benefit insurer in case a person becomes entitled to a disability benefit. This regulation is 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. Finally, individual case management recently introduced successfully by SUVA, the main accident insurer, could serve as a model for sickness management of sickness benefit insurers.

425. 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 the cooperation between the two insurance systems.

426. Related to these reforms, several changes would be feasible that could further improve the medical tools in both the sickness and the disability assessment phase. The new regional medical services (RAD) make it possible for the disability insurance to conduct its own medical assessment for 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, remained untouched. Improvements could include better coordination between the new RAD and the sickness benefit insurers by giving the latter access to the service of the RAD at an early stage *i.e.* in the sickness absence phase. This would imply more control of the decision of the GP's assessment and should be introduced after around 4-6 weeks of absence.

427. In addition, support and training for GPs is necessary to improve their knowledge of insurance medicine. 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

428. 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 probably go a long way in explaining this. Access to vocational programmes is only possible for people who are disabled according to the definition of the disability insurance, *i.e.* people who, without any further measure, would qualify for a disability benefit. Such an approach avoids misuse of these programmes, but is not good enough to avoid long-term disability. Moreover, access criteria imply more restrictive access to vocational rehabilitation and training for people with low pre-disability earnings, many of whom with low qualifications. This is because in Switzerland disability is defined as earnings-capacity reduction, thereby discriminating against people with lower pre-disability earnings. The eligibility for rehabilitation measures should therefore be broadened, including people not entitled to a disability benefit but with difficulties in the labour market because of a health problem. This would imply moving away from assessing the legal basis of a case to helping people back into work.

429. Similarly, the planned "premature" disability assessment (to be introduced in parallel to the new early identification approach) could become an obstacle by screening out people who are not disabled according to the definition of the disability insurance (*i.e.* not entitled to a disability benefit) but nevertheless in need of help. The problem of hasty refusal of integration measures, as described above, could thus increase. The result would be that more people are shifted to the unemployment insurance – an outcome that is in sharp conflict with ongoing measures to reduce "carrousel effects". This would also make the recently introduced RAD less effective because many people would be assessed on the basis of the existing medical files only, maybe even more than in the past. Thus, the planned premature assessment would also be in conflict with the objectives of the fourth revision of the disability insurance act. Such, introducing this "quick-and-dirty" benefit eligibility assessment may be at odds with other objectives and may also be unnecessary altogether.

430. 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 the plans to introduce new and innovative low-key measures which 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 portfolio is insufficient. These 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 introduction of new vocational programmes, rigorous evaluation of rehabilitation measures is becoming even more important.

431. Policy should also address the large stock of young disability beneficiaries. Compared to other countries, a much larger proportion of those on disability benefits in Switzerland are younger than 35 years (12% compared to around 4% in Norway and Poland). Moreover, 80% of those in the 20-34 age group are drawing a disability benefit 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 to address this issue would be to reassess the stock of 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 re-assessment after a few years could be introduced for all future inflows, especially those younger than 50 years.

432. 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 to reintegrate earlier and in the longer-term reduce inflows to disability benefit. This would lower costs as well as limit loss of skills.

433. 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 elements of the reform. 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. This, 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

434. A particular problem in Switzerland is the so-called carrousel 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. This 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. This 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.

435. To address carrousel effects, attempts have been made to improve inter-institutional cooperation between various institutions. The key weakness of many of these initiatives is its voluntary nature. To

further promote successful cooperation, it would be important to strengthen the legal underpinning. The "Solothurn model" is a promising example in this direction, which should be exported to other cantons.

436. 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 cooperation. Such structure is being introduced because 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 cooperation should be sought with the cantonal PES so as to combine efficiently the CDO knowledge about particular needs of disabled people and the PES expertise about needs of employers, as well as coordination 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 cooperation.

437. 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 best practice and publicising such practices across cantons. It should formally signal when a canton has poor outcomes and this appears to be due to failure to introduce best practices.

438. 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 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.

439. 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 relatively 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 at about 35-40% of average earnings, thereby excluding 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.

440. 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 those administered by private insurances is no argument for not obliging them to provide urgently needed evidence.

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LIST OF ACRONYMS

AETAT	Norwegian Public Employment Service (Arbeidsdirektoratet)
AETR	Average Effective Tax Rates
AEVR	Act on Employment and Vocational Rehabilitation (of disabled people)
AFP	Norwegian early retirement pension agreement (Avtalefestet pensjonsordning)
ALMP	Active Labour Market Programmes
APW	Average Production Worker wage
BSV	Swiss Federal Social Insurance Office (Bundesamt für Sozialversicherung)
CDO	Cantonal Disability Offices
DALY	Disability Adjusted Life Year
EU-LFS	European Union Labor Force Survey
EU-SILC	European Union Statistics on Income and Living Conditions
GPs	General Practioners
HBS	Household Budget Survey
ICF	International Classification of Functioning, Disability and Health
ILO	International Labour Organisation
IT	Information Technology
IW agreement	Inclusive Workplace Agreement
IIZ	Inter-institutional cooperation (Interinstitutionelle Zusammenarbeit)
IV	Disability Insurance (Schweizerische Invalidenversicherung)
KRUS	Polish social security institution for farmers (Kasa Rolniczego Ubezpieczenia Społecznego)
LME	Labour Market Enterprise
MAMAC	Medical-vocational assessment for case management (Medizinisch-arbeitsmarktliche Assessments im Rahmen des Case Management)
MEDAS	Medical assessment centres (Medizinische Abklärungsstellen)
METR	Marginal Effective Tax Rates
NAV	Norway's New Labour and Welfare Offices (Ny arbeids- og velferdsforvaltning)
NGO	Non Governmental Organisation
NIA	National Insurance Authority/National Insurance Administration
NOK	Norwegian Kroner
NRR	Net Replacement Rates
PES	Public Employment Service
PFRON	State Fund for the Employment and Rehabilitation of Disabled People (Państwowy Fundusz Rehabilitacji Osób Niepełnosprawnych)
POVIAT	Municipalities in Poland
PPP	Purchasing Power Parities
PYLL	Potential Years of Life Lost
RAD	Regional Medical Service (Regionaler Ärztlicher Dienst)
SECO	State Secretariat for Economic Affairs (Staatssekretariat für Wirtschaft)
SPK	Occupational pension scheme for public sector employees (Statens Pensjonskasse)
SUVA	Main Swiss Work Accident Insurer (Schweizerische Unfallversicherungsanstalt)
SWE	Sheltered Work Enterprises
VAT	Value Added Tax
WHO	World Health Organisation
WPA	Worker Protection and working environment Act
ZUS	Polish social security institution for employees (Zakład Ubezpieczeń Społecznych)