High-Level Forum, Stockholm, 14-15 May 2009

Sickness, Disability and Work

KEEPING ON TRACK IN THE ECONOMIC DOWNTURN

BACKGROUND PAPER

Organisation for Economic Co-operation and Development
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INTRODUCTION

When OECD's thematic review on *Sickness, Disability and Work: Breaking the Barriers* was launched in 2005, governments were keen to mobilise additional labour resources to address looming labour shortages, in view of population ageing and low or even negative population growth. With the recent economic downturn, the situation is reversed temporarily. The latest OECD projections from March 2009 suggest that the unemployment rate across the OECD is likely to increase to around 10% by 2010, up from around 7% in 2008 (see Annex 2, Figure A2.1). Such a scenario was inconceivable at the time the review started. The challenge has thus become even greater: Not only have governments to push forward with necessary structural reform, but they also have to devise suitable short-term measures to cushion the impacts of the crisis – in a way which as much as possible aligns with the longer-term reform agenda of getting people off disability benefits and into work.[1]

The broad objectives of this thematic review were to better understand the contributory role of institutions and policies in labour market exclusion or withdrawal of persons with health problems, to identify promising initiatives and areas for improvement. The review examined the various initiatives and structural reforms undertaken in 13 member countries in response to the growth in numbers of people claiming sickness and disability benefits in recent decades. The findings are intended to support efforts in member countries to address the associated labour market issues, burgeoning welfare burden, and to improve both individual and macroeconomic outcomes.

The purpose of this background paper is to inform debate at the High-Level Forum in Stockholm on the 14-15 May 2009. The paper consists of two sections. The first provides snapshots of key outcomes that illustrate the pressing problems in this area faced by individuals concerned and society. It compares indicators for as many OECD countries as possible, drawing on administrative and survey data. The second section summarises the policy challenges arising from these trends and important lessons learned from the individual reviews of reforms and policies in Australia, Canada, Denmark, Finland, Ireland, Luxembourg, the Netherlands, Norway, Poland, Spain, Sweden, Switzerland and the United Kingdom. The issues are discussed in light of the recent downturn in the global economy.

This paper provides a synopsis of issues that will be more comprehensively discussed in a *Synthesis Report* due in early 2010 which will include additional material from member countries that have not participated in the thematic review.

1 . Annex 1 summarises the new labour market policy challenges for OECD countries arising from the current recession and the OECD stance on the most adequate response for governments.

MAIN FINDINGS

Disability benefits are associated with poor individual outcomes

Labour force participation among people with health problems or disability remains very low	Despite the recent decade of strong economic growth and increased emphasis on employment integration, employment among persons with health problems has not increased and has even fallen in relation to other groups. At the same time, levels of unemployment are typically twice as high as for people without disability and these levels have fallen much less, if at all, over the past decade.
Persons with health problems are much more likely to experience relative income poverty	Disposable income of people with disability is on average across the OECD, 12% below national averages and as much as 20-30% in some countries. In the past decade, the relative financial position of people with disability has fallen in the majority of countries for which trend data are available.

Countries have to break the prevailing disability benefit culture and help integrate persons with partial work capacity into the labour market

Overcoming the medicalisation of labour market problems	Reduced work capacity can make a person less competitive as a jobseeker in a marketplace that may have fewer appropriate work opportunities. While these are *labour market* issues, most countries use medically-driven models to determine disability benefit entitlement that are clearly unreliable. The result is that significant numbers of people with partial work capacity are being deemed unable to work.
Moving from disability to ability	Recent trends indicate that focusing on what persons with partial work capacity *can* do and seeing them as having a meaningful labour market contribution to make results in very positive gains.
Activating persons with partial work capacity	Disability benefits contain perverse incentives that exclude persons with partial work capacity from the labour market. A number of countries are successfully using mainstream employment policy, including *activation* measures, to support persons with partial work capacity to take up work.

Extended duration on sick leave leads to high inflows into long-term disability benefits

Long-term sickness absence is high in many OECD countries	50-90% of those who take up a disability benefit do so after a period on sickness benefit. Overall, there is a fairly strong statistical correlation (R=0.6) between sickness absence levels and disability benefit inflow rates.
Some countries have recently managed to bring down the rates of inflow into disability benefit	Policy matters. Through comprehensive structural reforms, some OECD countries have been able to turn a long-standing trend around; *early intervention* has been a major element of reform. High rates of rejections of claims for disability benefit suggest that many more people apply for a disability benefit so reforming access is particularly warranted.

Reducing sickness absence from the workplace can reduce inflows into long-term disability benefits

Improving sickness monitoring practices	Public authorities that have invested in good administrative reporting systems and databases can *monitor* sickness absence in a timely way. This allows for earlier detection of sick-leave spells that heighten the risk that a worker with initially mild symptoms could eventually drift onto disability benefit.
Strengthening sickness management responsibilities of employers	Past evidence shows that some employers have downsized by transferring unwanted staff via long-term sick leave onto disability benefit, as a form of *early retirement*. This practice can be curtailed by increasing the financial liability of employers for sick-leave benefit and through experience-rating of premia.
Providing adequate supports for employers	Employers need help and expertise early in the period of their workers' sickness absence to rehabilitate and keep them attached to the labour market. There is considerable scope for public employment services to build productive working relationships in this regard, as well as to facilitate and support *employer networks* that allow placement or redeployment of workers with reduced work capacity.
Reconsidering rights legislation and employment quotas	Anti-discrimination legislation appears to be useful for persons with reduced work capacity who are already in work, but may be hindering the hiring of such persons in new jobs. Quotas are likewise being used to accommodate existing workers rather than taking on new people with partial work capacity. Circumventing legislation may be too cheap and easy for employers.
Addressing incentives for medical professionals	Guidelines that help medical professionals maximise health outcomes and minimise inappropriate sick leave could significantly reduce inflows into disability benefits. Tangible incentives to promote compliance are needed, both for doctors and for the authorities who manage the health system.

Sickness and disability benefit schemes are very costly

High public spending on benefits	On average, OECD countries spend 1.2% of GDP on disability benefits alone. This figure reaches 2% when including sickness benefits, and even 4-5% in some countries. This is almost 2.5 times as much as what is spent on unemployment benefits and represents an increase over time in a majority of countries over the past 15 years.
Widespread dependence on permanent disability benefits	More than half of OECD countries have seen a substantial growth in disability beneficiary rates in the past decade, with around 6% of the OECD-wide working-age population collecting disability benefits in 2007. The probability of returning to work after being granted a disability benefit is below 2% annually across member countries. In practice, therefore, disability benefits function like retirement pensions for the vast majority of recipients.

Measures to activate long-standing disability beneficiaries will pay big dividends, as will institutional reforms that improve the efficiency with which they are managed

Improving work incentives for current benefit recipients	Measures to activate existing disability benefit recipients can result in substantial welfare gains. This can include periodic reassessment of benefit entitlements, allowing recipients to earn reasonable amounts without cutbacks to their benefit payments, as well as guaranteeing their *right to return* to the benefit if they are unsuccessful in returning to work.
Pushing forward with institutional reform to improve service and inter-agency co-operation and co-ordination	The streamlining of agency and inter-agency processes for managing beneficiaries improves client outcomes and reduces inefficiency in general. This can include merging of public entities with similar functions, using innovative funding and other mechanisms that require them to communicate regularly and work toward common client outcomes. In this regard, a number of countries are using *one-stop-shop* models to good effect.
Improving incentives for delivery institutions	Institutions play an important role as a *substitute employer* for those who do not or no longer have an employer or for whom employer responsibility has been waived. Public servants (and those who manage them) who deal with clients need incentives to remain dedicated to the often challenging task of keeping or reattaching sickness beneficiaries or other persons with partial work capacity to the labour market.
Incorporating elements of outcome-based funding	Outcome-based funding has the potential for producing better results than outdated output- or input-based block funding. However, there are a number of challenges in administering this approach efficiently and effectively. In particular it is important to ensure that clients with partial work capacity, who are more difficult to place and retain in work, receive adequate support and resources to succeed.

There have been changes in the structural composition of the disability benefit population, with more mental-health-related problems, while people with mental illness are underrepresented in employment

Employment rates of people with mental illness are particularly low	People suffering from mental conditions are typically 30-50% less likely to be employed than those with other health problems or disability. This may be related to changes in the nature of work which has become more challenging in many sectors, making it more difficult for certain groups in the population with low skills and qualifications to compete and succeed.
An increasing share of new disability benefit claims is for mental health reasons	Mental health problems now account for a third of all new disability benefit claims on average. In some countries, this share has almost doubled in the past 10-15 years. Mental illness is systematically relatively more frequent among younger adults.

More attention to understand and address the rise in mental health problems and adequate policy responses is needed

Emphasising prevention rather than cure and getting the incentives for key actors right	Employer-friendly supports and incentives are needed to provide work environments that strengthen rather than compromise the physical or mental health of workers, and to provide training and job adjustments that help prevent health conditions from getting worse and (together with medical practitioners and health and welfare agencies) ensure sick workers remain attached to the labour market.
Addressing mental health among young adults	The growth in numbers of young adults entering into disability benefits from which they are unlikely to exit to a job has grave implications. While a number of countries are intervening to help young people with health problems enter the labour market, the existing strategies risk missing those with mental illness. Moreover, the almost automatic transfer in many countries from the school to the benefit system is highly questionable.

KEY TRENDS AND OUTCOMES

This section provides a summary of key sickness and disability trends and illustrates the main challenges that OECD countries face in this area. In particular, the:

- Insufficient labour force participation among people with health problems or disability.
- Low income of households with persons with health problems or disability.
- High cost of sickness and disability benefit schemes.
- Widespread dependence on permanent disability benefits.
- Structural shift towards beneficiaries with mental ill-health, including especially young adults.

The recent economic downturn poses special challenges for sickness and disability policy. Without adequate policy response to the above-mentioned trends, outcomes are likely to worsen.

Labour market integration of sick and disabled people is insufficient

Having a job is fundamental to social inclusion and integration, but employment opportunities of people with health problems or disability are limited.[2] On average across the OECD, their employment rates are just above 40% which is just only over a half of the rate for people without disability, which stood at close to 75% in the mid-2000s (Figure A2.2). Importantly, it appears that higher employment rates of people with disability are not systematically associated with particular employment policies. Employment *characteristics* generally differ little by disability status. However, in most OECD countries people with health problems are significantly more likely to work part-time (Figure A2.3).

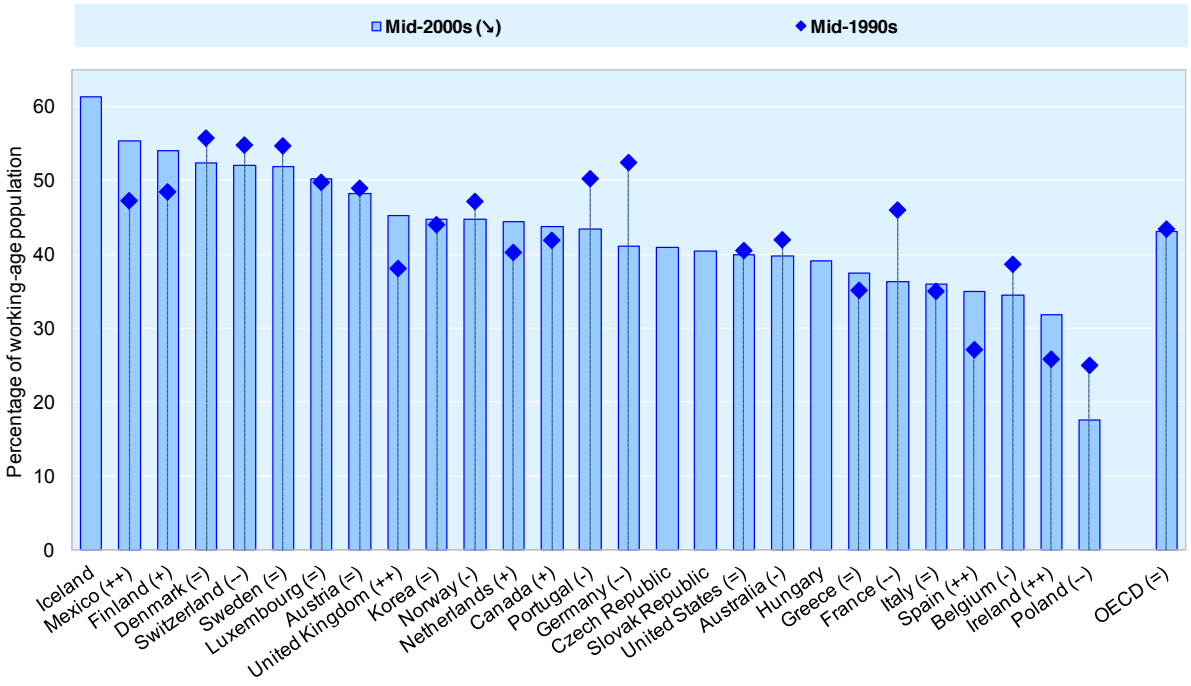
Despite increased efforts to develop and expand employment integration measures, employment levels of people with disability have not improved. Relative to their peers without disability, on average employment rates of people with disability have even fallen below 60% since the turn of the century, *i.e*. in most OECD countries individuals with health problems have not benefited to the same extent from increased growth and employment opportunities in the past decade (Figure 1).

At an average of 14% in the mid-2000s, unemployment is typically twice as high for people with disability (Figure A2.4). Across countries, low employment rates are slightly but not systematically associated with high unemployment risks. Trends in unemployment are not steady: unemployment rates of people with disability declined until 2000 but then went up again, hand-in-hand with falling employment, despite continued economic growth in most countries. This is not promising in view of the crisis which is likely to affect disadvantaged groups over-proportionally.

2. The population with disability is identified through *self-assessment* (people who report that their activities of daily living are to some degree hampered by their health situation), based on national population surveys. While survey questions are similar if not identical, cross-country comparability is restricted due to the subjective element of self-reporting and cultural differences in the interpretation of the questions.

Figure 1. **Employment rates of people with disability are low and have been falling in many countries**

Employment rates of the working-age population with disability in 27 OECD countries, mid-1990s and mid-2000s



Notes: (↘) in the legend relates to the variable for which countries are ranked from left to right in decreasing order. (++)/(--) refers to a strong increase/decline of 2% or more; (+)/(-) refers to a moderate increase/decline between 0.75% and 2%; (=) refers to a rather stable trend between -0.75% and 0.75%; percentages refer to the annual average growth rate in employment rate of persons with a disability. OECD refers to the unweighted average of the 27 countries; the mid-1990s average is an estimate based on the 23 countries for which data are available.

Source: See Annex 2 (Figure A2.2).

Low labour market integration implies lower incomes …

In most countries, people with health problems or disability have lesser financial resources. On average across the OECD, income of people with disability is 12% lower than the national average and as much as 20-30% in some countries (Figure A2.5, Panel A).[3] Income levels of people with disability are much higher than this, however, when they have a higher educational attainment or are employed (Figure A2.5, Panels B and C). Relative incomes of unemployed people with disability can be as low as 50% of the income of the entire working-age population.

In turn, compared with the population without disability, people with disability are at a significantly higher risk of *relative* income poverty in most OECD countries. Relative poverty risks are quite variable, however, with some countries having a risk double that of people without disability and poverty affecting more than 30% of people with disability, while in others there is little difference in poverty risks between the two population groups (Figure A2.6).

3. Working-age is defined in this report as the age group 20-64. Income is household-size-adjusted income per person, and the poverty rate is the percentage of people with disability in households with less than 60% of the median adjusted disposable income of the entire working-age population.

Over the past ten years, the relative financial situation of people with disability has deteriorated in more than half of the countries for which trends can be observed. On average, relative incomes have declined from 88% in the mid-1990s to 85% in the mid-2000s and decreases in relative incomes have even reached 20% in some cases. Likewise, poverty risks of people with disability have increased faster than for the rest of the working-age population in a majority of countries. In the current recession is highly unlikely that this trend could be turned around.

… and it is very costly for the society as a whole

Sickness and disability generate considerable costs to society. On average, OECD countries spend 1.2% of GDP on disability benefits alone and this figure reaches 2% when including sickness benefits (Table A2. 1). This is almost 2.5 times as much as what is spent on unemployment benefits. In some countries, *e.g.* the Netherlands and Norway, expenditures are much higher, close to 5% of GDP.

Disability benefit expenditures have increased in a majority of countries over the past 15 years. In certain countries, the increase has been compensated by a decrease in sickness-related expenditures. Even so, the very high disability-related costs are a large commitment of public resources. Measured as a percentage of total public social expenditure, the cost of disability is around 10% on average across the OECD, and even up to 25% in some countries. While expenditures on unemployment compensation are rising and becoming a key concern these days, expenditures on disability benefits have also risen in past recessions. It should also be borne in mind that spending on disability benefits is more difficult to control, given the permanent nature of benefits.

High benefit spending is a result of high benefit recipiency

On average, about 6% of the OECD working-age population was on disability benefits in 2007; a figure of a similar magnitude to the average OECD unemployment rate (Figure A2.7). In some countries, at close to 10% disability recipiency rates far exceed unemployment rates.[4]

Over the past two decades, disability recipiency rates across the OECD have increased only slightly on average but this masks substantial differences across countries. More than half of OECD countries, including all English-speaking countries, have seen a substantial growth in disability beneficiary rates (Figure 2). Significant declines in beneficiary rates have occurred in a few countries, following policy changes which tightened access to disability benefits one way or the other.

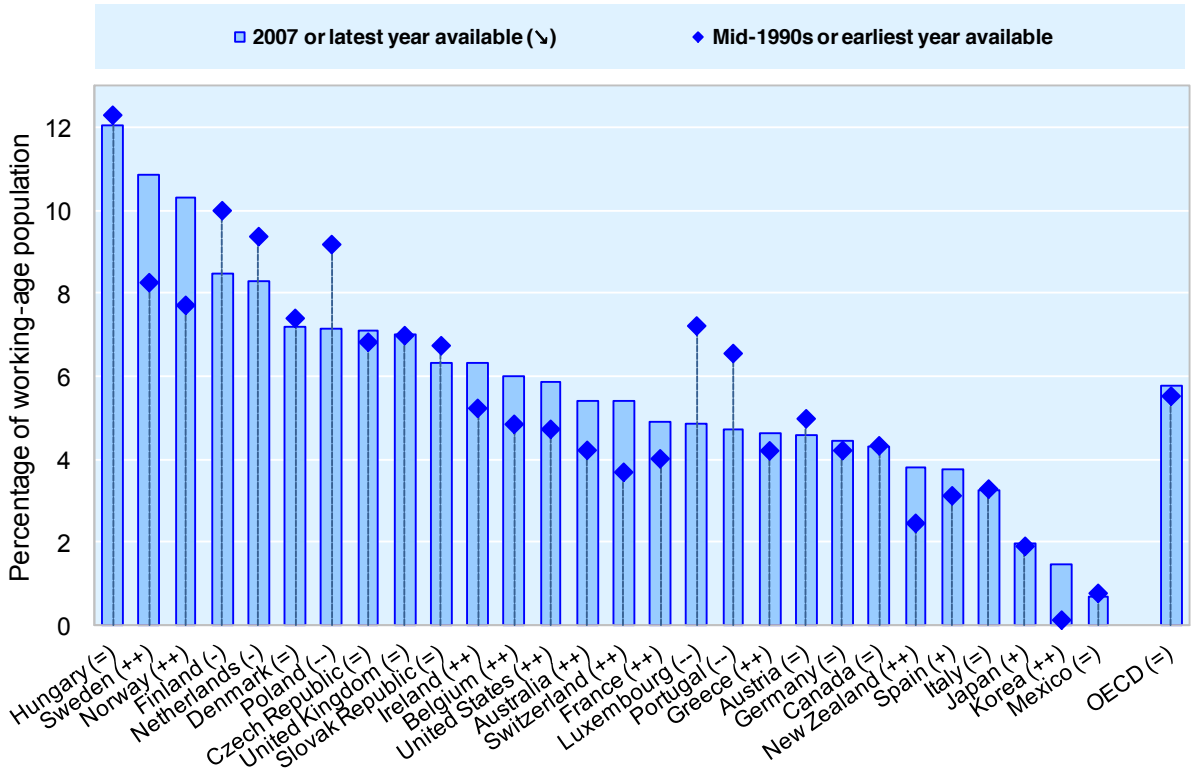
The often rapid increase in disability benefit rolls in recent decades coincided with a fall in the number of people receiving unemployment benefits (Figure A2.8). In English-speaking OECD countries in particular, the drop in unemployment beneficiaries was for a long time almost entirely compensated by a similar increase in disability beneficiaries. This suggests considerable substitution between benefit schemes, facilitated by corresponding policy, with increasingly stricter work

4. Disability benefit recipiency figures in this report reflect the aggregate of all disability benefits granted under contributory and non-contributory schemes (with Belgium, Canada, France, Germany, Greece, Ireland, Japan, Korea, Poland, Portugal, Spain, the United Kingdom and the United States having both types of schemes), full and partial disability benefits, as well as early retirement schemes specific to disability or reduced work capacity (the latter exist in Austria, Denmark, Finland and Germany). To improve comparability across countries, persons receiving sickness benefits for more than two years are also counted towards disability benefit recipiency (which matters for Ireland, New Zealand and Sweden). Special systems for civil servants (e.g. for Austria, Belgium, France and Germany) are generally not included because data are unavailable. Where persons can receive more than one disability benefit, the overlap has been taken into account where possible.

requirements in unemployment insurance and assistance schemes coupled with a lack of any such reform in disability benefit schemes. This system interdependence is also reflected in the recent developments in *Luxembourg* where falling disability beneficiary numbers (coming from stricter eligibility criteria) have led to parallel increases in the number of unemployment benefit claimants in a period of stable economic growth.

Figure 2. **Disability benefit recipiency rates are high and still increasing in many countries**

Disability benefit recipients in percent of the population aged 20-64 in 28 OECD countries, mid-1990s and latest year available[a,b]



Notes: (↘) in the legend relates to the variable for which countries are ranked from left to right in decreasing order. (++)/(--) refers to a strong increase/decline of 2% or more; (+)/(-) refers to a moderate increase/decline between 0.75% and 2%; (=) refers to a rather stable trend between -0.75% and 0.75%; percentages refer to the annual average growth rate in employment rate of persons with a disability. OECD refers to the unweighted average of the 27 countries.

a) 2004 for France; 2005 for Luxembourg; 2006 for Denmark, Italy, Japan, the Slovak Republic and the United States.

b) 1996 for Belgium and Canada; 1999 for the Netherlands; 2000 for Hungary and Italy; 2001 for Ireland; 2003 for Japan and 2004 for Poland; 1995 for all other countries.

Source: Data provided by national authorities.

Overall, changes in beneficiary rates were predominantly driven by changes in the use of disability benefits by older workers – with upwards changes of 2-3 percentage points in several cases and significant drops in countries that reformed their system (Figure A2.9). However, in many countries beneficiary rates have increased very substantially among young and prime-age workers. As a result, the average recipient is now often younger and the average duration on benefits longer.

Benefit recipiency is the result of high inflows into disability benefits and low outflows

Sickness absence levels are critical for the inflow into disability benefits, given that in most countries a majority of claimants (typically 50-90%) come into the system after a period on sickness benefit. Levels of sickness absence, measured as work-days lost, are quite different across the countries surveyed, with the OECD average at roughly 3.4%. Overall, the data show a fairly strong statistical correlation between sickness absence levels and disability benefit inflow rates (R=0.6).

Recently, some OECD countries have managed to bring down the rate of inflow into disability benefits – often hand-in-hand with a reduction in levels of long-term sickness absence.[5] However, rates of inflow remain high in most cases – in spite of relatively high rates of rejections of disability benefit claims (Figure A2.10). The high rejection rates also suggest that a much larger group of (mostly jobless) workers is trying to get on a permanent disability benefit.

Another reason for high beneficiary numbers is the permanent or quasi-permanent nature of disability benefits across most countries. Once a benefit is awarded, the probability of return to work is almost zero. For most countries for which data are available, only around 1-2% of all beneficiaries leave annually for reasons other than death or retirement (Figure A2.11).[6] More detailed data available for some countries, *e.g.* Australia, suggest that only a small minority of the outflow shown in this figure – often only some 10-20% – correspond to moves into employment.

Low outflow is partly linked to the often limited access to vocational rehabilitation and employment integration measures. On average, spending on active labour market programmes for people with disability is meagre compared to what is spent on compensation measures. Typically, only some 4-7% of total spending on disability is on integration measures and in many countries even less than this (Figure A2.12). Moreover, these percentages have not changed very much in recent years.

And, the biggest, new challenge are mental health conditions

Increasingly, inflow into disability benefits is occurring because of mental health problems. On average, one-third of inflows are related to a mental condition, rising to as high as 40-45% in some countries (Figure A2.13). Addressing the increasing prevalence of mental health problems within disability benefits requires addressing the low labour market participation of individuals with such health conditions. Data from a limited set of countries show that only one in four individuals reporting a mental health problem is in employment (Figure A2.14). This constitutes barely two-thirds or even only half of the employment rates observed for people with other health conditions.

More demanding work requirements may be leading to either more stress-related conditions, reducing the possibilities for individuals with health problems to be accommodated at the workplace or having more individuals seeking disability benefits as a way to escape demands at work. However, evidence on this topic is scant and trends in labour market conditions are mixed (Figure A2.15). The self-reported exposure of European workers to a number of stressful working conditions suggests a

5. Falling rates of inflow into disability benefits are a consequence of tighter access including closing access to disability benefit for some groups with partial work-capacity, stricter rules for assessment and broadening of employer responsibilities for sickness and disability matters and payments. In some countries, however, increases in the use of early retirement schemes as an alternative to disability benefit for older workers also play an important role in explaining falling inflow rates.

6. Exceptions to the low rate of outflow include New Zealand and the United Kingdom. Higher outflow rates in this case are a result of the larger proportion of people with short-term health problems (who would be on sickness benefit in other countries) on the disability benefit rolls in the two countries.

trend increase in psychological demands or effort for workers. At the same time, while employees who change from standard to "non-standard" employment – measured by the type of contract or working hours – generally experience a decline in their mental well-being, research has shown that they seem to be better off in terms of mental health than when they are not working at all.

KEY POLICY ISSUES

1. Overcoming a disability benefit culture

Reforms to systems and incentive structures and in policy orientation towards activation and labour market integration have had some impact on numbers of sickness and disability beneficiaries (Figure A2.8). However, the number of people with health problems benefitting from vocational rehabilitation and employment supports remains low (Figure A2.12). Not only are public systems and employers in most countries not equipped to help those with partial work capacity to secure and maintain employment, but the existing disability benefit systems seem instead to steer them into welfare dependency and labour market exclusion. That is, the benefit system itself has a *disabling* effect on people who have some productive labour to contribute to the economy.

Changes in the labour market are diminishing opportunities for persons with reduced work capacity and benefit systems are bearing the brunt of the cost. Moreover, the incentives in benefit systems have not evolved sufficiently and in many countries are contributing factors in the growth of the problem. The increasingly global nature of many industries has resulted in a shifting of production to locations wherever inputs, including labour, are cheaper. As a consequence, tolerance is falling for workers who are not highly productive in a particular job or who do not fit an ideal performance standard as the latter has become more and more narrowly defined. The end result is that workers who are not as productive due to health or other impairments are becoming priced out of the equation, and many of the niche jobs that they once occupied are disappearing.

Medicalisation of labour market problems

As shown in Figure A2.8, the fall in unemployment has been matched in many countries by a rise in disability benefit rolls, reflecting an OECD-wide trend towards accepting large numbers on disability payments in exchange for lower unemployment. People who were once managed as unemployed are now increasingly being treated as incapable of working.

Having reduced work capacity can make a person less competitive as a job seeker in a marketplace that may have fewer appropriate work opportunities as discussed earlier. This is a labour market rather than a health issue, yet the review finds most countries using medical models to manage it which are not intended or equipped to do so. The inherent problem with most public disability schemes is that entitlement is not determined according to a reliable and valid assessment of a person's labour market competitiveness. Instead, a medical practitioner with minimal or no training in the complex task of assessing how various injuries or ailments reduce labour market competitiveness, is required to estimate globally whether a person is unfit for work, including into the future. In practice, such decision-making varies considerably and unreliably across practitioners. The result being that significant numbers of people with partial work capacity and who are not wholly uncompetitive in the labour market, become deemed unable to work. The lack of planned periodic reassessment effectively seals their fate. Any adaptation that they develop over time will not be recognised. Upon receipt of a disability benefit, their formal obligation to seek employment ceases. In most benefit systems, they are also indirectly compelled to remain inactive and assert they are incapable of work in order to continue to receive payments.

The abovementioned sequence shifts the purpose of publicly-funded disability benefits, from providing a safety net for persons who are unable to secure employment because their ability to compete for work is weakened (*i.e.* a labour market issue), to compensation for permanent loss of functioning due to injury or sickness (*i.e.* a medical issue). This medicalisation of labour market problems has a number of repercussions as follows.

Symptomatic of treating labour market issues as health problems as discussed above, the review found a corresponding and disturbingly similar set of limiting attitudes and behaviours in many OECD countries toward persons with reduced work capacity. With few exceptions, an entrenched *disability benefit culture* is undermining various efforts being made to improve outcomes for persons with partial work capacity. Through this lens they are seen as incapacitated and therefore incapable of participating in all aspects of life in society – including the workforce.[7] The roots of this are partly historical in that disability schemes were originally conceived in relation to serious work-related or other physically-incapacitating health conditions. While less visible ailments are not always seen in the same way, it is generally accepted that severely disabled persons are entitled to social protection.[8] Within this mind-set, removing obligations from people unable to compete for work seemed only compassionate and humane. However, paradoxically, this prejudicial view is what sits behind the very policies that guarantee their exclusion from the labour market and predisposes them to living in or close to poverty (Figure A2.6) – and with minimal hope for improvement.

Labour market policy across the OECD has moved towards a stronger employment orientation in the past decade, so it is a serious issue that disability schemes continue to be very passive when it comes to expectations for persons with partial work capacity. While the outcomes evidence makes it clear that this is not good policy, nor humane or compassionate, many policy makers are reticent about the perceived unpopularity of introducing expectations or removing life-long and obligation-free entitlement to benefits for persons with partial work capacity. This fear is compounded by the fact that disability benefits are also seen by some recipients as lifetime pensions and a more attractive working-age benefit than unemployment benefits.[9] This lack of willingness to act is especially concerning in light of the surge in younger persons with health problems now finding their way onto disability benefits in many OECD countries (Figure A2.13).

7. Severe physical impairments now accounts for a relative minority of new disability benefit claims compared to other causes, especially mental and musculoskeletal health problems. The modern reality is that the vast majority of health problems labelled as disabilities, do not render an individual severely incapacitated, but rather impair functioning in a fixed or episodic fashion. This means affected workers can continue to work if there is sufficient flexibility for them at the workplace to alter their duties or periodically reduce working hours when symptoms flare up. It is concerning to find that some employers and public agencies continue to act as though disability means incapacitation. Their inability to move beyond outdated ideas limits the possibilities for those with health problems to work and develop careers.

8. The invisibility of the most common forms of disability that benefits are claimed for (mental health and musculoskeletal problems) also affects integration in the labour market. While employers and co-workers may be willing to accept a worker who produces less because of an overtly visible problem, this is much harder when it comes to a mental health issue or episodic back pain that can be less generously interpreted as malingering. There may also be concerns about accommodating a person with mental health problems and the potential disturbance to the workplace and productivity.

9. First, this is because job-search requirements and other forms of activation elements have been strengthened in unemployment benefit systems. Second, disability benefits pay more generously in many countries than unemployment benefits and are perceived as more socially acceptable. That is, the stigma of perceived laziness sometimes used to characterise long-standing recipients of unemployment benefits is not applied to those on disability benefits.

From disability to ability

The review did however note a slow shift in fundamental conceptualisation from *disability* to *ability* starting in a small number countries, which is refocusing operational policy around what people with health problems can still do at work and developing supports and entitlements that empower them in this regard. In the longer run, opting out of the labour market needs to cease as an option, except for the small minority with very marginal capacity and even then, most beneficiaries should be periodically reassessed to see if they can return to the labour market in future. Setting aside the economic gains arising from the activation of the majority of the current pool of claimants with mental health and musculoskeletal problems, this would send an important social message letting these persons know that their community has not written them off but rather views them as potentially having useful work capacity to contribute. Such a change in orientation shifts existing supports and resources to rehabilitating people back to part or full-time work (versus supporting them to stay at home). There seems no justifiable reason for a person with partial work capacity to be told to remain indefinitely at home on a public benefit.

There are encouraging signs in a number of countries of new thinking in terms of *partial work capacity* rather than incapacity. However, progress has been slow because most are still hamstrung by the disability benefit culture discussed earlier. The work capacity issue is also closely tied to socio-political ideologies about the purposes of social protection. Member countries each have to find a way forward that works in their respective jurisdictions. By way of example, the *Australian* approach has been to trial automatic referral of unemployed who are sick and temporarily unable to work, to a job capacity assessment that establishes what they can still do. *Sweden* is a nation with an historically strong ethos of social protection and it is seeking to tackle the capacity assessment challenge through a Work Capacity Commission tasked with receiving submissions and providing a forum for public discussion.

The disability scheme in *Denmark* which was reformed in 2003 incorporates a most fundamental conceptual shift. Disability assessment is now focused on what a person can do rather than their loss of capacity; more precisely, the extent to which a person is able to carry out a subsidised job (a so-called "flex-job"). A disability benefit is only granted where capacity is held to be permanently reduced to the extent that a flex-job cannot be performed, and participation in rehabilitation would not help to restore this capacity. In determining capacity, a comprehensive individual resource profile is being put together which includes measures of health, social and labour market proximity criteria. In this respect, Denmark is a best-practice example within the OECD.

New approaches for supporting people with partial work capacity

It should be of paramount concern to all OECD countries that the vast majority of persons with partial work capacity who take up disability benefits never return to the labour market. Data from various countries suggests that after being on disability benefits for a year, statistically more recipients are dying than returning to employment. The interim April 2007 OECD Issues Paper on *New Ways of Addressing Partial Work Capacity* discusses structural reforms now being taken in a number of countries to better identify such persons and help ensure they remain attached to the labour market through careful tailoring of welfare and other supports.

In *Denmark*, following the policy change described above, people who used to qualify for a disability benefit now either receive a flex-job subsidy or (as long as they are unemployed) a special unemployment or waiting benefit, which is set at the level of a disability benefit. The situation is similar in *Luxembourg* where after 2002, people with remaining work capacity who were receiving sickness benefits were shifted on to job-search support in the form of a clearly-defined

"redeployment" procedure which can have two outcomes: employment with a permanent payment to compensate for any difference between previous and new earnings, or unemployment in which case they receive a waiting allowance set at the level of disability benefit.

The revised disability benefit system that came into operation in the *Netherlands* in 2006 has similar features. Workers with an assessed earnings incapacity of 35-79% receive a wage supplement depending on the amount of remaining work capacity actually used, or (if not working) a flat-rate payment which is considerably lower than the former disability benefit used to be. Workers with an earnings capacity reduction of 15-34% can no longer receive a disability benefit; in case of job loss they are, after exhaustion of sickness benefits, managed like other unemployed. Welfare reform introduced in *Australia* in 2006 has been along similar lines where people with significant work capacity who can work 15-29 hours per week are no longer entitled to a disability benefit; but are instead classed as regular unemployed and supported and obligated to seek (part-time) work.

Activating persons with partial work capacity

The previous discussion raises important issues about the purpose and unintended but perverse outcomes arising from disability benefit schemes. Though both disability and unemployment benefits offer an income replacement to working-age people without a job who are in many cases able to work, disability schemes differ drastically in how they operate and the outcomes they produce. Unemployment benefits are paid so long as a beneficiary engages in job-search activities, training or other obligatory activation measures. In most countries, this is not the case for a person on disability benefits, who tends to be viewed as both incapacitated and inactive, irrespective of their actual work capacity. This is clearly counterproductive and undesirable.

When viewed in terms of competitiveness in the labour market, the distinction between persons with partial work capacity and the long-term unemployed becomes increasingly blurred. As beneficiaries, they are arguably indistinguishable. In response, some countries are beginning to explore approaches for managing persons with partial work capacity as mainstream unemployed, in order to remove the disincentives inherent in current disability benefit schemes and thereby improve labour market, welfare spending and individual outcomes. The general idea being to offer a basic safety-net benefit to the entire working-age population, with contingency payments to cover costs of managing various individual health conditions or other problems that limit a person's work capacity.

The *United Kingdom* has recently taken a small step which shows what is possible when a person with partial work capacity is viewed as having something meaningful to offer. It has introduced a new Employment and Support Allowance in late 2008 to replace the existing disability benefits (both contributory Incapacity Benefit and non-contributory Income Support). For clients assessed as being able to work in some capacity, the new benefit works essentially as an unemployment benefit, albeit paid at a slightly higher rate, recognising the additional obligation to engage in a mandatory work-related interview regime where sanctions ensue for non-attendance. *New Zealand* is another country that has been looking actively at the virtues of integrating its working-age benefits.

While this is an important area of reform with considerable potential upside benefits, the long-standing nature of existing systems warrants careful consideration of local conditions, mores and timing issues. For instance, such a shift may be technically and politically more difficult in countries in which disability benefits are integrated into the old-age pension scheme. However, *Sweden* has demonstrated that even this is possible to disentangle, albeit as part of a major reform of its pension scheme.

Obligations for new benefit recipients

Voluntary participation does not facilitate the motivation necessary for successful transition and retention in employment for more than a small number of beneficiaries with partial work capacity evident in the low numbers of people in most OECD countries accessing voluntary reintegration programmes. Tying obligations to benefit receipt appears to be much more effective in activating benefit claimants. Politically it makes good sense to start introducing participation requirements with new benefit claimants who have yet to adjust to being paid to remain inactive. Such requirements could take various forms, ranging from periodic contact with case managers to mandatory vocational rehabilitation and, ultimately, a requirement to accept suitable work. Steps along these lines are being taken in a number of countries to establish a more sustainable balance between beneficiary rights and responsibilities. The *United Kingdom's* Pathways-to-work process represents one such example. The main feature of the new process is a series of six-monthly, mandatory work-focused interviews, usually starting eight weeks after the benefit claim, aiming for a personal action plan.[10]

Switzerland is also in the process of introducing new responsibilities for persons with health conditions that could lead them to taking up disability benefits. Under a reform adopted in 2008, these persons are now obliged (as the legislation states) to participate in "measures designed to reduce the costs for society arising from their disability"; obligations are listed explicitly, together with sanctions for non-compliance. Similarly, in *Luxembourg*, people with partial work capacity are now obliged to enrol in training and reintegration measures.

Responsibilities for current benefit recipients

Participation requirements are an important element of an improved strategy, but most countries have so far shied away from steps to activate the potentially large number of inactive disability beneficiaries and little emphasis is being given to reassessing benefit entitlement. On the contrary, most countries have elected to grandfather those already on benefit at the time of reform. The probability that these people will never be reactivated, irrespective of their actual work capacity, is high.

Nevertheless, available evidence suggests that reforms activating existing recipients can be successful – even though the context of a recession and rising unemployment may not be the ideal time to implement such change. The *Netherlands* is the only country which recently reassessed entitlements of large parts of its stock of beneficiaries (basically all those under age 50). Benefit dependency was reduced significantly after the reassessment and the majority of former beneficiaries moved back into work.

Needless to say, it is a big step for beneficiaries who have adapted to receiving social benefits for life to contemplate returning to the workforce and risk the security of their benefits. Countries will need to plan carefully to allay their fears. *Sweden* has recently implemented promising reforms which could be looked into by other countries concerned about activating their existing stocks of long-term disability benefit claimants. Permanent disability beneficiaries can earn up to around EUR 4,000 per year before their benefit starts to reduce progressively. Most importantly, they can cease work and resume their disability benefit at any time without a new reassessment. This policy may also support those whose ability to cope with incapacity improves over time, and it is especially likely to suit persons with episodic health conditions. Reform of this type is particularly well-suited in the current economic climate. It gives beneficiaries a safe means of trying to re-enter the labour market, without having to fear failing in the attempt and so having to endure another long and drawn-out assessment process to regain benefit entitlement.

10. Any action taken in response to these interviews, however, is still non-compulsory.

2. Strengthening incentives for employers and medical professionals

Addressing the weaknesses of existing benefit schemes is important but not sufficient. The review of member countries also found that responsibilities and financial incentives for key players involved in the management of workers with health problems needs much greater attention. This includes especially employers and medical practitioners (who are the subject of this section) but also the authorities granting benefits and/or providing employment services (see subsequent section).

Employers play an instrumental role. There are three main aims for involving them in a tangible way. First, they are uniquely well placed to monitor absences (which in and of itself reduces inappropriate sick leave), seek occupational health advice and develop, together with the employee, a rehabilitation and work retention strategy. Secondly, because they exist to maximise profit, they are very sensitive to financial incentives that encourage them to fulfil their responsibilities, *e.g.* having to carry substantial costs of not managing sickness matters adequately. And thirdly, they need to get early and easily accessible financial and non-financial support to help sick workers return to work as soon as possible.

Prevention

Having a job is generally good for a person's health while being unemployed or inactive has detrimental effects on health, especially mental health. However, the nature of work in many sectors has become more challenging, making it more and more difficult for certain groups in the population, especially those with low skills and qualifications, to compete and succeed. As illustrated in Figure A2.15, through the growth in service industries, more workers are working longer hours and more frequently outside "normal" hours; more jobs are involving high work intensity and complex tasks; while work contracts are less secure; and fewer workers report high work satisfaction – all of these indicators being correlated with stress and, in turn, inferior health.

Employers need supports and incentives to offer work environments that do not undermine the physical or mental health of workers, and to provide training and job adjustments that help prevent a condition from deteriorating and ensure the worker remains attached to the labour market. Achieving this requires making supports more employer-friendly and reconsidering the role of and incentives for employers, and to a certain extent also the role of medical practitioners, in the early phases of ill-health.

Finland has addressed these issues very actively. To prevent sickness absenteeism, work injuries and other health problems at work, considerably greater emphasis has been placed on employers' legal obligations to purchase private or community-run preventive occupational health services and create healthy working environments. These services help ensure regular monitoring in workplaces, action programmes assessing and minimising workplace risks, early detection of reduced work capacity and other strategies to prevent disability. Public subsidies are available to support employers. *Sweden* is currently in the process of re-establishing its system of occupational health services, such that services match the new responsibilities that employers have.

Sickness monitoring practices

Mechanisms for early identification of at-risk cases are needed but these are lacking. However, some countries have recently started to put in place more rigorous, systematic and continuous systems to monitor sickness absences to help prevent long labour market interruptions and exits developing from initially mild symptoms.

Sickness absence monitoring can be done in a variety of forms. In *Spain*, for instance, the National Social Security Institute has hundreds of doctors whose sole role is to monitor and reassess ongoing sickness cases. This is possible by way of a very rich administrative database with complete sickness absence histories, including information on the employee, the employer, the cause for the absence and the full medical history. These medical inspectors who can terminate a sickness benefit when appropriate, control people with absences longer than the average for a specific sickness, specified by very detailed lists for all possible diseases. In *Luxembourg*, to give another example, a formalised procedure kicks in as soon as a person reaches six weeks of absence within the last 16 weeks. Workers and their attending general practitioner have to provide prescribed information to the public control unit for social security institutions, which in turn is supposed to evaluate all the information and make a statement regarding the person's work ability; this can lead to termination of sickness benefit payment.

Other countries use prescribed follow-up procedures. In *Denmark*, for example, municipalities which are responsible for all benefit matters have to follow-up every four weeks in case of an absence classified as at risk of leading to long-term illness or loss of work capacity, and every eight weeks otherwise. Within 16 weeks, a follow-up plan must be established by the worker and the caseworker. Other countries have very strict sick-note rules – in *Ireland*, for instance, a sick worker is required to renew the sick-note every week – but are yet to use this information for systematic follow-ups.

Sickness management responsibilities of employers

When faced with economic hardship, businesses look to cutting costs including through reducing their workforces. Past evidence shows that some employers have downsized by transferring unwanted staff via long-term sick leave onto disability benefit, often as a form of early retirement. The problem with this as discussed earlier, is that affected workers almost never return to the workforce. In the current deep recession, countries that allow this to be repeated will see a burgeoning permanent welfare burden and loss of labour force capacity that is unlikely ever to be regained.

Given that entry into disability benefits is preceded in most cases by a period of long-term sick leave, an effective means of curtailing the incentive to downsize in this way is to transfer a larger share of financial liability for sickness benefits to employers. This is the case in the *Netherlands*, where employers now pay the costs of sickness benefits for as long as two years during which workers generally cannot be dismissed.[11] They are also responsible for monitoring absences of their workforce, following a series of predefined steps. Sanctions which can be as much as paying sickness benefit for a full third year ensue for employers who fail to fulfil this responsibility. Other countries, such as *the United Kingdom* and *Luxembourg*, have also recently increased the responsibility of employers for sickness benefit payments (to six and three months, respectively) albeit with lesser sickness management obligations, while some other countries, like *Switzerland*, have always had a period of continued wage-payment of several months.

Disability management responsibilities of employers

Some countries go even further than making employers responsible, not only financially, for managing sickness in an early stage or throughout the legal sick-pay period. Mirroring similar rules in work injury or workers' compensation schemes in many OECD countries, there is an increasing tendency of shifting costs of general disability onto employers to a larger extent. Basically, this is happening in two ways: either as a public policy choice or by private insurers.

11. Dutch employers can choose to reinsure their risk with a private insurer.

In *the Netherlands*, experience-rated premiums to the public disability insurance were first introduced in 1998; since 2003, employers have to pay for most of the costs of the first five years of disability benefit receipt of their former workers. This system change was one of the key explanatory factors for the recent sharp fall in the rates of inflow into disability benefits. With the latest benefit reform the system was changed yet again, so that now employers are de facto paying for even ten years for those with a partial earnings incapacity but no longer for those with full and permanent incapacity. A similar system in *Finland*, affecting large firms only, implies that companies may have to pay up to 80% of the total disability benefit bill of their workers in case of job loss as a result of disability. *Switzerland* and *Canada* are seeing similar trends but in this case coming from the private insurance sector which is gaining importance.[12] Adjusting insurance premiums to take account of employers' experience in this case is driven by the aim to control the rising costs of these private insurance schemes.

This new development in financing regulations raises a number of issues. There is a risk that without a proper regulatory framework, which is lacking in the Swiss case, the potential negative aspects of this shift – in the form of reduced hiring opportunities for sick and disabled people – outweigh the gains. This can be minimised with careful design of the system, *e.g.* in the form of exemptions for employers hiring a chronically sick or a disabled person – as exists in the *Netherlands* and since recently also in *Finland*. It is not desirable to penalise employers willing to engage workers with health problems, but it is desirable to hold responsible those employers who generate more sick and disabled workers than other employers in similar circumstances, *e.g.* in the same sector, for the extra costs involved.

Adequate supports for employers

Stronger responsibilities for employers need to be matched by *better supports* from public employment agencies and the like to help employers fulfil their obligations. Employers vary in their expertise and experience in managing sick workers and it is impractical to expect them to find all solutions themselves. They also, understandably, shy away from cumbersome administrative procedures and contacts. There is a strong case for a partnership approach to working with employers given the all-round benefits that arise from keeping people in work and off benefits.

Public employment services in most countries facilitate networks of employers who are "willing" to assist with the placement of jobseekers who are difficult to place, *e.g.* because of reduced work capacity. While there is room for greater involvement by employment services in this regard, what in many cases is lacking altogether is support for employers at the critical early period of sick leave use to help retain the employee in work. One good-practice example of partnership can be found in *Norway*, where a personal contact officer for each employer (who subscribes to the "Inclusive Workplace" network) is assigned at the respective local workplace centre to build a working relationship through which helpful information can be made available in a timely way to employers.

In some countries employer-run circles or networks have developed with the aim of redeploying workers who are no longer suited to a job because of illness or injury with other firms, without the involvement of public authorities. Such networks can be found in *Sweden*, mostly on a sectoral basis and in *the Netherlands*, where these fast-growing networks are organised on a regional basis. The

12. Anecdotal evidence from Canada suggests that the use of private providers of insurance for sickness and disability risk may be very effective. Having a vested financial interest in avoiding the liability arising from long-term sick leave and disability, they immediately and proactively intervene as soon as a worker becomes sick to find ways of helping them resume work and overcome illness quickly.

potential exists for workers to be transferred across sectors where it is less likely for a worker to experience the same workplace factors that may have contributed to their sickness absence. The growth of these networks in the Netherlands has been a pragmatic response on the part of employers to minimising their individual exposure to the costs of long-term sickness absence. Transferring to employers this responsibility created a strong mutual interest among them to be willing to hire workers from other companies in exchange for the possibility of redeploying their own workers who develop problems that may leave the employer with a large wage bill for another ten years, possibly with little if any productive output.

Rights legislation and employment quotas

Anti-discrimination legislation and other legal instruments also influence employer practices. Most countries have introduced anti-discrimination legislation to ensure equal treatment of people with disability (and other disadvantage) in job promotion, hiring and dismissal procedures. Such legislation is strongest and most established in *Australia*, the *United Kingdom* and the *United States*, but since 2006 all EU member states are obliged to adopt similar legislation. The differences between regulations can be manifold and include aspects such as coverage (*e.g.* whether or not they also affect smaller companies, like they do since recently in the United Kingdom) and degree of enforcement.

However, it is not clear that the use of legislation to protect the rights of persons with disability is working as effectively as intended. While workers in existing employment may be enjoying greater protection, such legislation may be hindering the hiring of workers with reduced work capacity because employers fear that they will face undue difficulties in terminating employment if they cannot be successfully accommodated. Research on this matter, mainly from the United States, is ambiguous and on balance probably discouraging, even though the gradual fall in (relative) employment rates of people with disability since the mid-1990s cannot easily causally be linked to the introduction of such legislation.

Some countries are using an employment quota for the employment of people with disability, and these schemes are generally better enforced and somewhat easier to evaluate. The idea in this case is to compel employers to employ a certain share of (administratively registered) people with disability – ranging from 6% of the workforce in *Poland* to 2-4% in *Luxembourg* and *Spain* – and to put levies on companies not fulfilling their quota. The impact on employment of people with disability, however, is small with the levies sometimes being perceived to be government revenue rising.

There is no robust evaluation available on any of the employment quota schemes in the countries reviewed. Evaluations on the impact of a similar scheme in *Austria*, one of the countries with relatively high quota enforcement, are highly discouraging: somewhat similar to the finding on the effect of anti-discrimination legislation, the quota seems to generate some job retention for workers developing a disability at the expense of keeping jobseekers with disability further away from the labour market, with the net employment effect on balance being negative. The essential problem may be one of incentives insofar as there is no practical way of preventing an employer from filling their quota with existing staff who have low productivity because of existing problems, rather than taking on new workers with reduced work capacity who they perceive to be less productive and may require greater management input. As noted earlier, employers are facing greater financial pressures in many sectors. It is foreseeable that they will tend to seek ways of complying with the letter of the law while circumventing the underlying policy intent if they perceive the latter could reduce their competitiveness and jeopardise their survival.

Incentives for medical professionals

Medical professionals who assess sickness and disability claims are key actors in this policy area. As has been observed in many countries, there is considerable variability in the decisions they make about sick leave, particularly in the duration granted. In most countries client demand (for more rather than less leave) is the only overt incentive in play. On the unsubstantiated presumption in most countries that whatever they decide is medically appropriate, general practitioners cannot be rewarded nor sanctioned for awarding more or less leave by the systems they serve. The work of the National Board of Health and Welfare in *Sweden* shows that there are practitioners who unwittingly authorise more sick leave than is necessary, in cases actually diminishing health outcomes.[13] In this country, guidelines are now provided to assessing medical professionals to maximise health outcomes and minimise inappropriate sick leave. Implementing this approach in other countries is likely to achieve similar improvements in practice and better health and labour market outcomes.

Recognising that inappropriately long sick leave incurs costs for employers or the public purse and risks labour market detachment, it is important that countries explore ways of improving incentives for medical practitioners to help sick workers to return to their jobs as soon as possible. One way of doing this is to monitor individual practitioners' practices and, in a first step, to make them aware of the problems caused by unnecessarily sick listing and, in a second step, to impose sanctions including in the extreme, the temporary suspension of sick-listing authorisation.

At a broader systems level, the authorities who administer the regional or national health care entities that licence or employ or in some other way fund the medical practitioners who grant sick leave, should have an intrinsic financial interest in managing their system in ways that promote employment rather than create the unnecessary inactivity that contributes to labour market detachment. One avenue to this may be through transferring a component of the liability for public expenditure on sick leave from employment or social security budgets to the health sector. In doing so, health system authorities who manage medical practitioners have an incentive to encourage them to keep the duration and corresponding cost of sick leave to the minimum necessary for good health outcomes.

3. The necessity for institutional reform

The thematic review found that countries willing to address, rather than shy away from, fundamental reform enjoyed the greatest improvements, particularly where there is convergence of policy objectives – from passive support to active employment and an inclusion orientation – and, convergence in the tools and instruments used to achieve them. Making a difference is possible and each country has interesting elements of policy to offer that others can learn from.

However, the review also observed that employment supports for people with health problems are poorly administered in most countries, often hard to access and typically offered too late. As a consequence, not all groups that could be helped are being helped. Moreover, rehabilitation and employment supports are often haphazardly integrated into the overall system. They are not sufficiently co-ordinated with benefit eligibility and the work-capacity assessment process.

13. For example, it was found that workers meeting the criteria for Generalised Anxiety Disorder have a better prognosis if they stay at work rather than at home because in isolation they are more likely to ruminate excessively and further deteriorate. Likewise, four weeks recuperative leave following coronary surgery tends to have a better prognosis because becoming active (within prescribed limits) after this time supports healing and adjustment.

Service and agency co-operation and co-ordination

Perhaps the most common problem affecting the performance of government is ensuring efficient flows of information and co-operation between public sector agencies and across layers of government to achieve common client goals. In countries like Switzerland and Canada, constitutional demarcation creates barriers to co-ordination and flow of information between municipal, regional/cantonal/provincial and state authorities. One attempt at resolving this is to clarify and agree on respective responsibilities and commit to sharing of specific information necessary to achieve common client outcomes. One such example is the *Australian* Commonwealth State Territory Disability Agreements which define the roles of the different government layers in the provision of services for disabled people. Similar mutual agreements between federal and provincial/territorial powers exist in *Canada*, thereby overruling or re-specifying in more detail the sharing of responsibilities laid down in the constitution.

When it comes to actual service delivery, persons with partial work capacity invariably face a complex and fragmented system of supports. This problem is common to most areas of social service delivery and a range of approaches has been tried to improve the quality of services provided and to keep the focus on employment outcomes. *Norway*, for instance, has merged the Public Employment Service and the National Insurance Authority into one new public administration to ensure streamlined and better co-ordinated services in order to minimise the possibility that clients are continually shuffled between agencies. Initial results are disappointing though this is mostly because such major institutional change will take much longer to deliver. A similar merger took place in the *United Kingdom* a few years earlier, creating a new agency – Job Centre Plus – that operates on a far more customer-oriented basis and provides a single point of delivery for jobs, benefits advice and support for people of working-age. In this case, results seem to have improved.

A number of other countries are using *one-stop-shop* elements of sorts to ensure that people with disability receive the right service at the right time. More recently, *Sweden* for instance has tasked its Social Insurance Agency with managing funds set aside for the vocational rehabilitation of workers that is the responsibility of its Public Employment Service. This has required the two agencies to work jointly, at all levels, to develop common plans and focus on client outcomes.

Incentives for delivery institutions

Policy makers are used to thinking about incentives for shaping the preferences and behaviours of private providers and clients. However, consideration needs also to be given to general and specific incentives for public institutions granting benefits or assisting persons with partial work capacity to resume employment. Public authorities have an important role in monitoring and managing sickness, acting in this regard as a *substitute employer* for those who do not or no longer have an employer or for whom employer responsibility has been waived.

The challenge here is that granting of a disability benefit reduces the administrative burden for public servants. Compared with an unemployment beneficiary who has to be continually followed up to ensure they are actively engaging in job-seeking activities or required training, a client on disability benefits usually requires no such monitoring or sanctioning. OECD countries use a myriad of systems to manage such persons and will have to find opportunities for setting agency incentives to ensure it is in the interest of frontline workers to help people with partial work capacity return to work. The *Danish* social system provides an interesting example in this regard. Municipalities responsible for both employment supports and benefit grants in this country, receive higher reimbursement from the state for active intervention and therefore have a vested interest in avoiding passive payments.

Outcome-based funding

Some countries have opted to promote privately operated (for-profit and not-for-profit) job brokers and service providers to increase vocational rehabilitation and employment service capacity and efficiency using outcome-based funding approaches. One of the key challenges is setting remuneration correctly because profit but also public-service-driven providers are likely to favour clients who are easiest to work with and place, and actively disengage with those costing more to serve. *Australia* and the *United Kingdom* have sought to ensure that less competitive jobseekers attract higher placement fees and place some – though generally not yet enough – weight on the sustainability of employment outcomes. Also, clients vary considerably in what they need from providers to make the transition into and maintain employment, which in turn requires investment in time and other resources by providers to recruit, retain, train and develop staff to deliver quality services. The current evidence is equivocal in that the approach has stimulated a growth in provider capacity but there are challenges in making sure that harder-to-place clients are receiving the support they need.

Notwithstanding these issues, if outcome-based funding can be shown to provide better and more sustainable employment outcomes, this approach should not be limited to private service providers. Countries relying on public employment services and community and disability organisations should seek ways to stimulate better outcomes by remunerating them on the basis of their success in placing workers with reduced work capacity. Outdated output-based (and even more so input-based) block funding is less likely to lead to sustainable employment and to promote innovative practices to achieve this.

Mental health and young people

The surge in mental health problems in recent decades is a complex OECD-wide phenomenon. As shown in Figure A2.14, having a mental illness markedly lowers the likelihood of employment. The challenge for countries seems at least three-fold. Firstly, they have to provide mental health services that help affected persons feel well enough to participate in the labour market. This is not going to be easy given the extreme heterogeneity in mental disorders, though the sick-leave guidelines recently implemented in Sweden show that medical practitioners can help keep affected persons attached to the labour market. Secondly, it is important to overcome the stigma associated with mental health problems in the workforce. Many employers are still concerned that they do not know how to work with such employees. Mental illness is in most cases an invisible malady and fellow workers may not be as willing to accommodate reduced productivity and any other special needs in the way that they might with a new colleague who has an obvious physical impairment. Finally, they need to understand and address the drivers of inflows into labour market detachment due to mental health, which includes looking at the changing face of work itself.

While the structural reforms discussed earlier have helped reduce the numbers of sickness and disability beneficiaries in some countries, recent data indicates that the problem is shifting to take root among younger people. The numbers in this group have doubled in a number of countries, with mental health now accounting for around two-thirds of persons under age 35 claiming disability benefits. This has grave implications because the vast majority of those people are unlikely ever to work again. The scenario of a young person, aged 20 with clinical depression, becoming eligible for disability benefits is disturbing to say the least – because it means being paid to stay at home on benefits for around 40 years, squandering a life of otherwise productive participation in the labour market and missing the many benefits that come with that. While a number of countries are intervening to help young people transition into the workplace, the existing strategies do not explicitly prioritise mental health or look at working conditions of entry-level jobs they are likely to take-up. The existing interventions risk capturing those more likely to find work anyway and miss others with mental health problems or lower school qualifications.

ANNEX 1
LABOUR MARKET POLICY IN LIGHT OF THE GLOBAL ECONOMIC DOWNTURN

The sustained growth over the past decade in the world economy is now over and policy needs to change and adapt to suit a period of recession. While countries are taking measures to cushion some of the impacts of the downturn on consumer and business confidence and labour demand, they must also act to minimise damage to their economies as they ride out the immediate storm and commence rebuilding in earnest to pull themselves and the global economy out of the present situation.

It is now broadly accepted that many more workers in all parts of the world will lose their jobs because of the downturn: the latest OECD projections suggest that unemployment in the OECD area could increase by 25 million over the level at the end of 2007. The high-profile closure of long-standing or large-scale businesses in many OECD countries has been the subject of considerable media attention and caused a deep psychological impact on many communities. People are anxious to know that help will be forthcoming if it is needed; either as income support to stay out of poverty or as re-employment assistance to find whatever other work they can. Having already made significant contributions to various stimulus and bail-out measures, the pressure is now also building on governments to spend much more on safety-net welfare and active labour market measures.

It is cautionary to observe in previous economic downturns that panicked responses to such social and political pressure in some countries sowed the seeds for major structural problems that both delayed their later recovery and held them back long after the global economy improved. In this context, Santayana's axiom 'those who do not learn from history are condemned to repeat it' remains more apt than ever. It is of paramount importance that safety-net welfare intended to protect those made redundant by the downturn avoids the mistakes of the past, chief among which was moving people from unemployment to other benefits that led to their permanent exclusion from the labour market. Categorising jobless people as long-term sick or disabled expediently reduces official unemployment statistics and, while this may be an attractive option politically insofar as it reduces electoral pressure over rising unemployment, it causes much more significant problems in the medium and longer term and ought to be avoided at all costs. In this regard, countries should also consider the Swedish reforms to regulations governing assessment of sickness and disability by medical professionals. Heading into recession there will be increasing pressure to help people access sickness and disability insurance and welfare schemes. Reforms and incentives to minimise the granting of inappropriate sick leave are merited at any time, but particularly so at present.

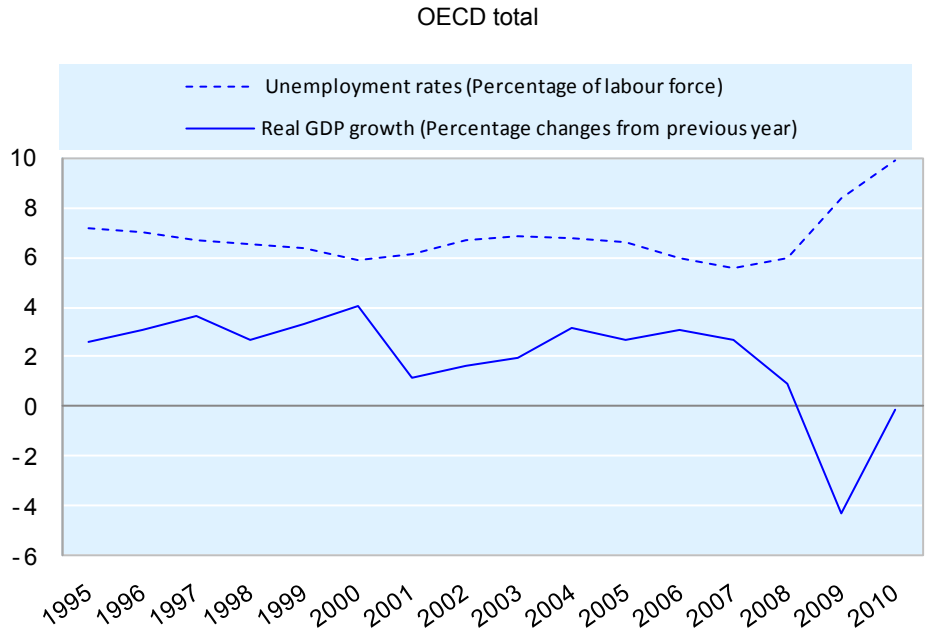
Under a range of past policy regimes, many OECD countries – especially some of the English-speaking and the Nordic countries – allowed large numbers of working-age adults easy access into disability benefits with minimal or no obligation to seek work. This, in turn, allowed companies to downsize their workforces by shifting older workers onto disability schemes with high replacement rates as a form of early retirement. Since then it has proven extraordinarily difficult to get any of these recipients back into sustained employment. Short-term thinking in these countries saddled their economies with huge and permanent welfare burdens and loss of productive labour force capacity that was, with hindsight, avoidable. Given the additional problems of an ageing population and rising mental health problems affecting especially but not only young adults, these old strategies are no longer tenable.

It is inevitable that countries will want to spend more supporting workers who lose their jobs due to the downturn. Moreover, if the recession is very deep and prolonged there is a serious risk that many people become trapped on unemployment benefits, and thereby susceptible to disabling mental health problems over time. As we know from existing data, many of these never return to work even after their health conditions improve. So, rather than waste scarce resources on guaranteed inactivity and risk the slippery slope to labour market exclusion, governments could look at directing their investment toward temporarily funded schemes that protect their labour supply and make unemployment and disability benefits a last resort. Some short to medium-term options in this regard could include public works schemes; subsidies to short-time working; wage subsidies *e.g.* in the form of cuts to payroll or other employee insurance contributions; and retraining and other education subsidies to help persons who have lost or who cannot find new employment to broaden or develop new skills that improve their employability.

Looking forward, many countries will seek to protect people who lose their jobs from poverty through various income protection measures. However, a key lesson from previous downturns is that these need to be temporary (albeit lasting a number of years) and with built-in or planned obsolescence, such that they cease to apply when the economy picks up. Failing to tie these measures to economic conditions risks creating incentives for people to stay out of work when demand for labour starts to grow again.

ANNEX 2
SUPPORTING FIGURES AND TABLES

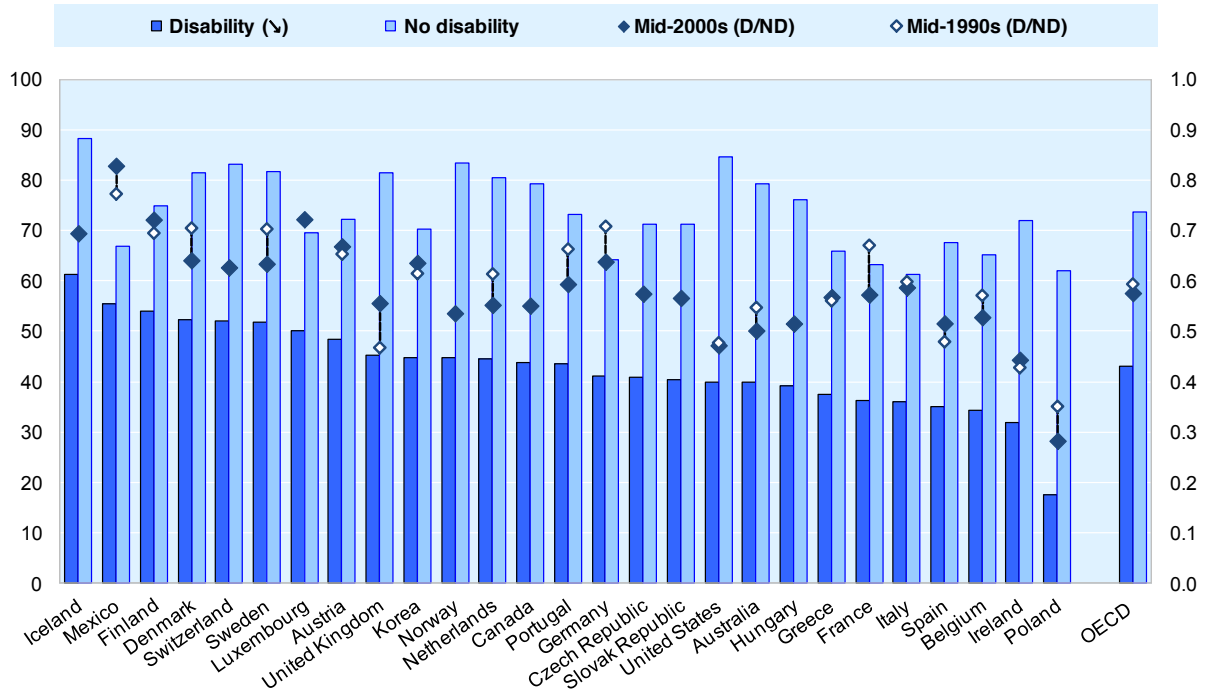
Figure A2.1. **After a period of decreasing unemployment, a bleak economic outlook is forecast**



Source: *OECD Economic Outlook Interim Report*, March 2009.

Figure A2.2. **People with disability are far less likely to be employed all over the OECD**

Employment rates by disability status in the mid-2000s (left axis) and trends in relative employment rates since the mid-1990s (people with disability over those without, right axis)

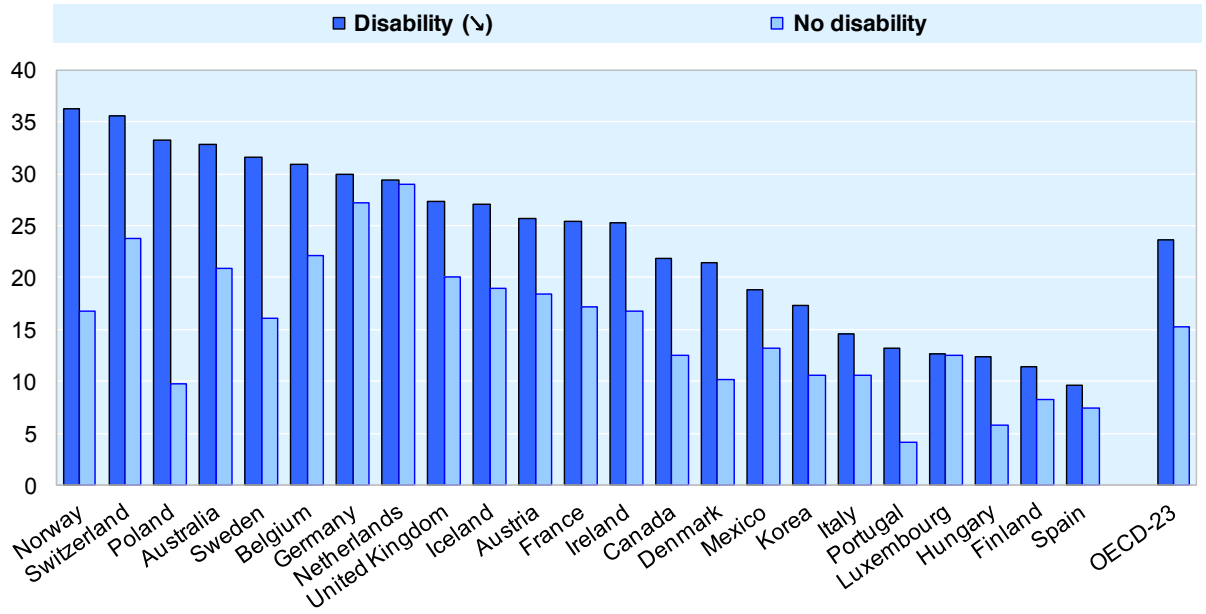


Notes: Throughout this annex, (↘) in the legend relates to the variable for which countries are ranked in decreasing order from left to right. OECD refers to an unweighted average for 27 countries for employment rates and 19 countries for trends in relative employment rates.

Source: EU-SILC 2005 (wave 2) and ECHP 1995 (Wave 2), except: Australia: SDAC (Survey of Disability and Carers) 2003 and 1998; Canada: PALS (Participation and Activity Limitation Survey) 2006; Denmark: LFS 2005 and 1995; Finland: ECHP 1996; Korea: National Survey on Persons with Disabilities, 2005 and 1995; Luxembourg: EU-SILC 2004; Mexico: ENESS (National Survey of Employment), 2004 and 1996; Netherlands: LFS 2006 and 1995; Norway: LFS 2005; Poland: LFS 2004 and 1996; Spain: EU-SILC 2004; Sweden: ECHP 1997; Switzerland: LFS 2005; United Kingdom: LFS 2006 and 1998; United States: SIPP (Survey of Income and Program Participation) 2004 and 1996 (waves 4 core data).

Figure A2.3. **When employed, people with disability work part-time more often than others**

Share of part-time employment in total employment by disability status in the 2000s[a]

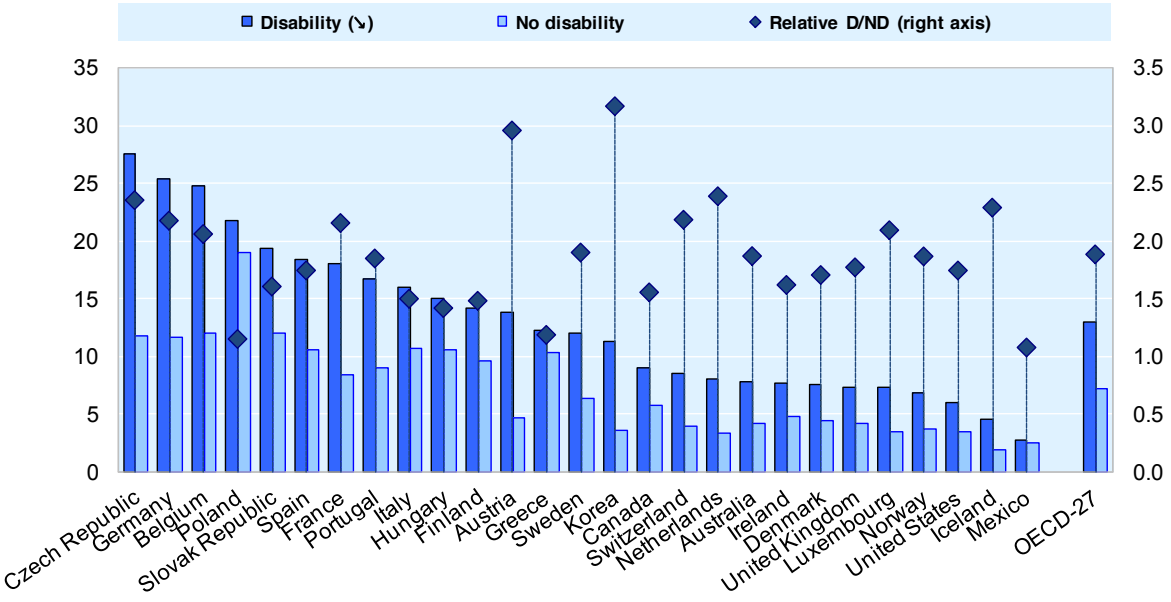


a) Part-time employment refers to persons who usually work less than 30 hours per week in their main job.

Source: See sources for the mid-2000s in Figure A2.2.

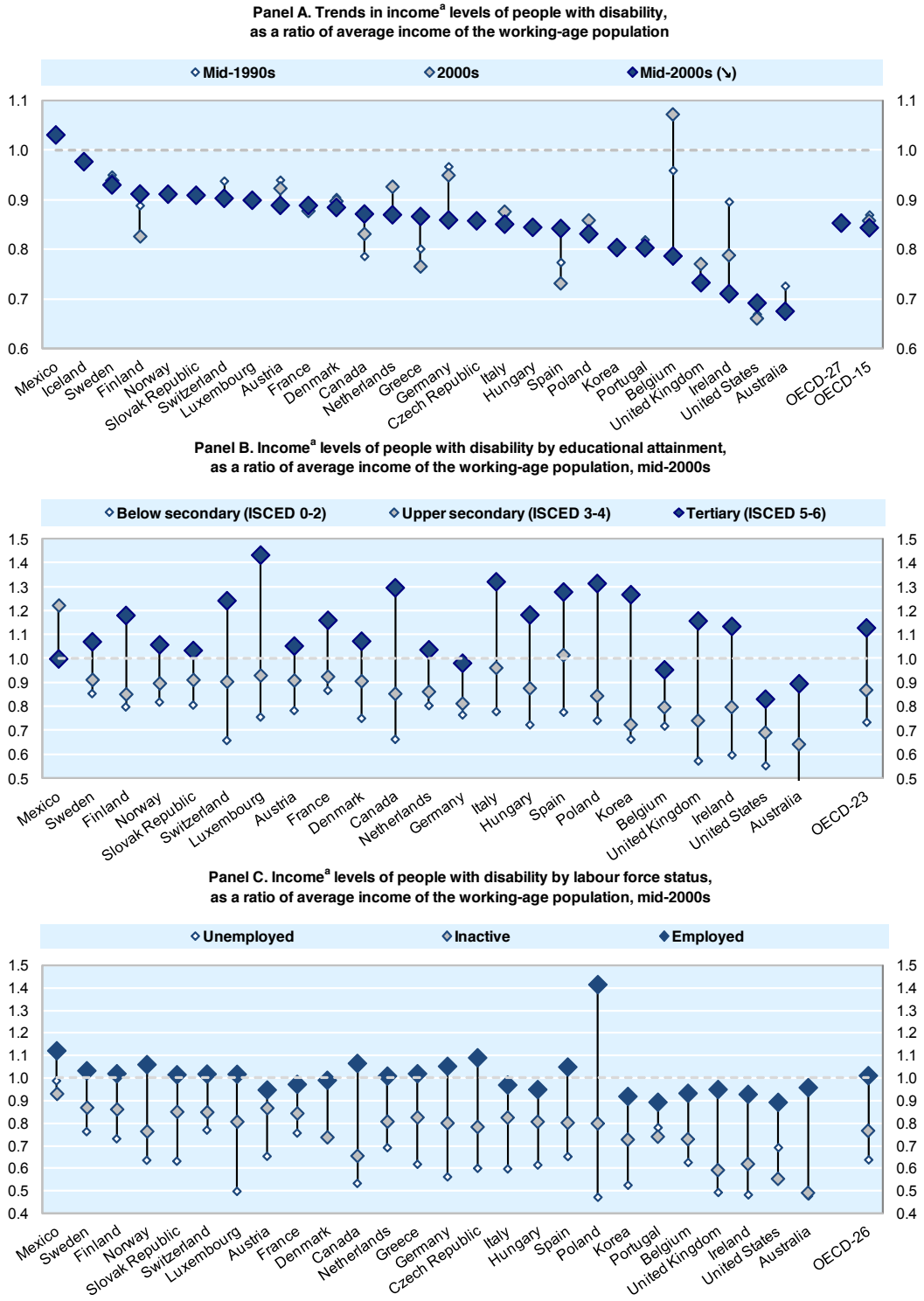
Figure A2.4. **People with disability are twice as likely to be unemployed, even in good times**

Unemployment rates by disability status (left axis)
and relative unemployment rates (people with disability over those without) in the mid-2000s



Source: See sources for the mid-2000s in Figure A2.2.

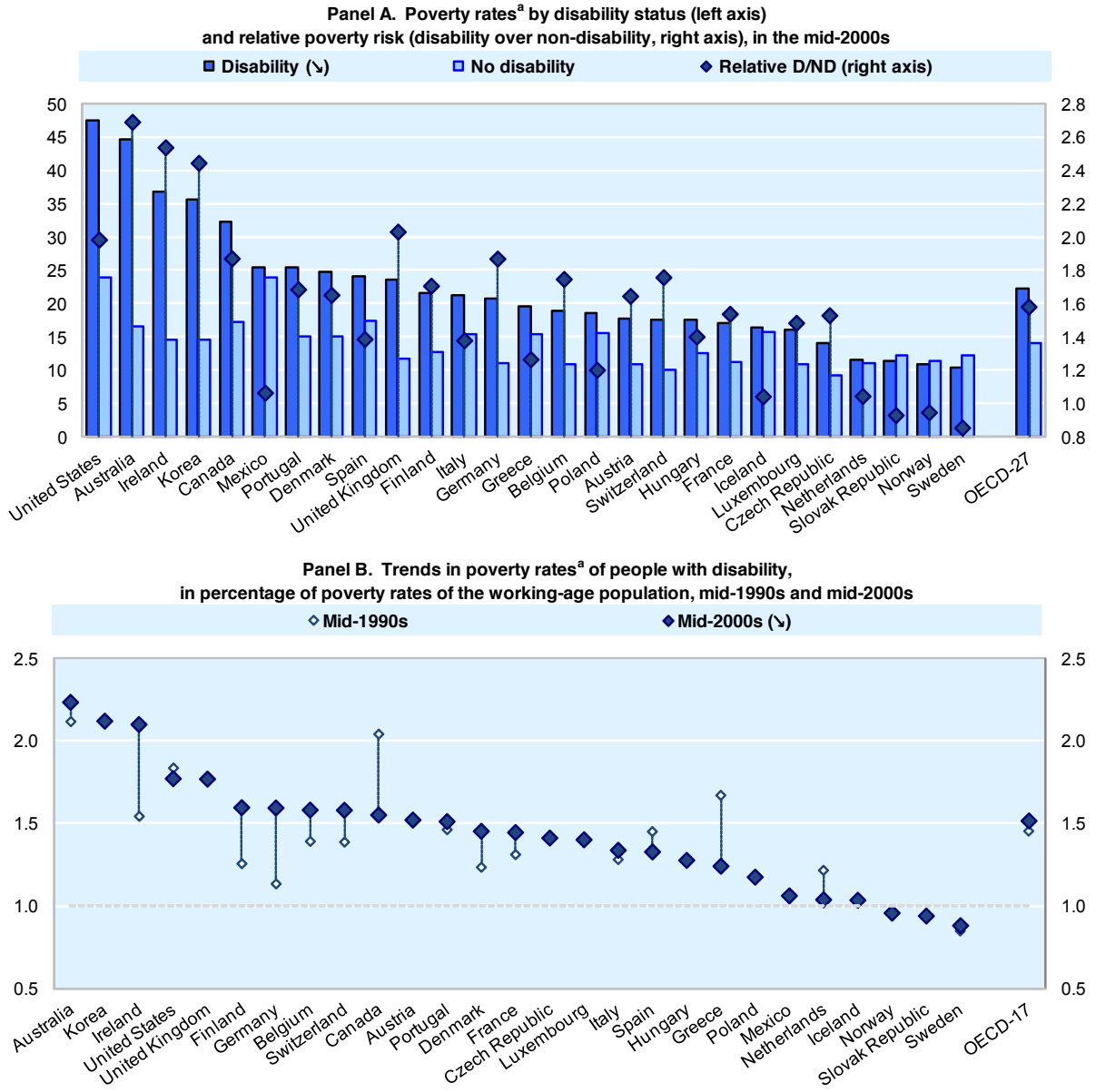
Figure A2.5. **Incomes of people with disability are relatively low, unless they are highly-educated and have a job**



a) Income refers to household-size equivalised disposable income per person.

Source: See sources in Figure A2.6.

Figure A2.6. **People with disability are at greater risk of living in or near poverty**



a) Poverty rates: percentages of people with disability in households with less than 60% of the median adjusted disposable income.

Source: EU-SILC 2005 (wave 2) and ECHP 2000, 1995 (waves 7, 2), except: Australia: SDAC (Survey of Disability and Carers) 2003 and 1998; Canada: SLID (Survey of Labour and Income Dynamics) 2005, 2000 and 1995; Denmark: SFI database 2005, 2002, 1995; Finland: IDS database 2005, 2000, 1995; Korea: Korean Welfare Panel Study, 2006; Luxembourg: EU-SILC 2004; Mexico: ENESS (National Survey of Employment), 2004, 2000, 1996; Norway: EU-SILC 2004; Poland: HBS (Household Budget Survey) 2004, 2000; Spain: EU-SILC 2004; Sweden: ECHP 1997; Switzerland: SHS (Swiss Health Survey) 2002, 1997; United Kingdom: FRS (Family Resource Survey) 2004, 2002; United States: SIPP (Survey of Income and Program Participation) 2004, 2001, 1996 (waves 4 core data).

Table A2.1. **Incapacity-related spending is much higher than unemployment-related spending**

Trends in expenditure on disability and sickness programmes, in percentage of GDP, 1990, 2000 and 2005, and in percentage of unemployment benefit spending and total public social spending, 2005

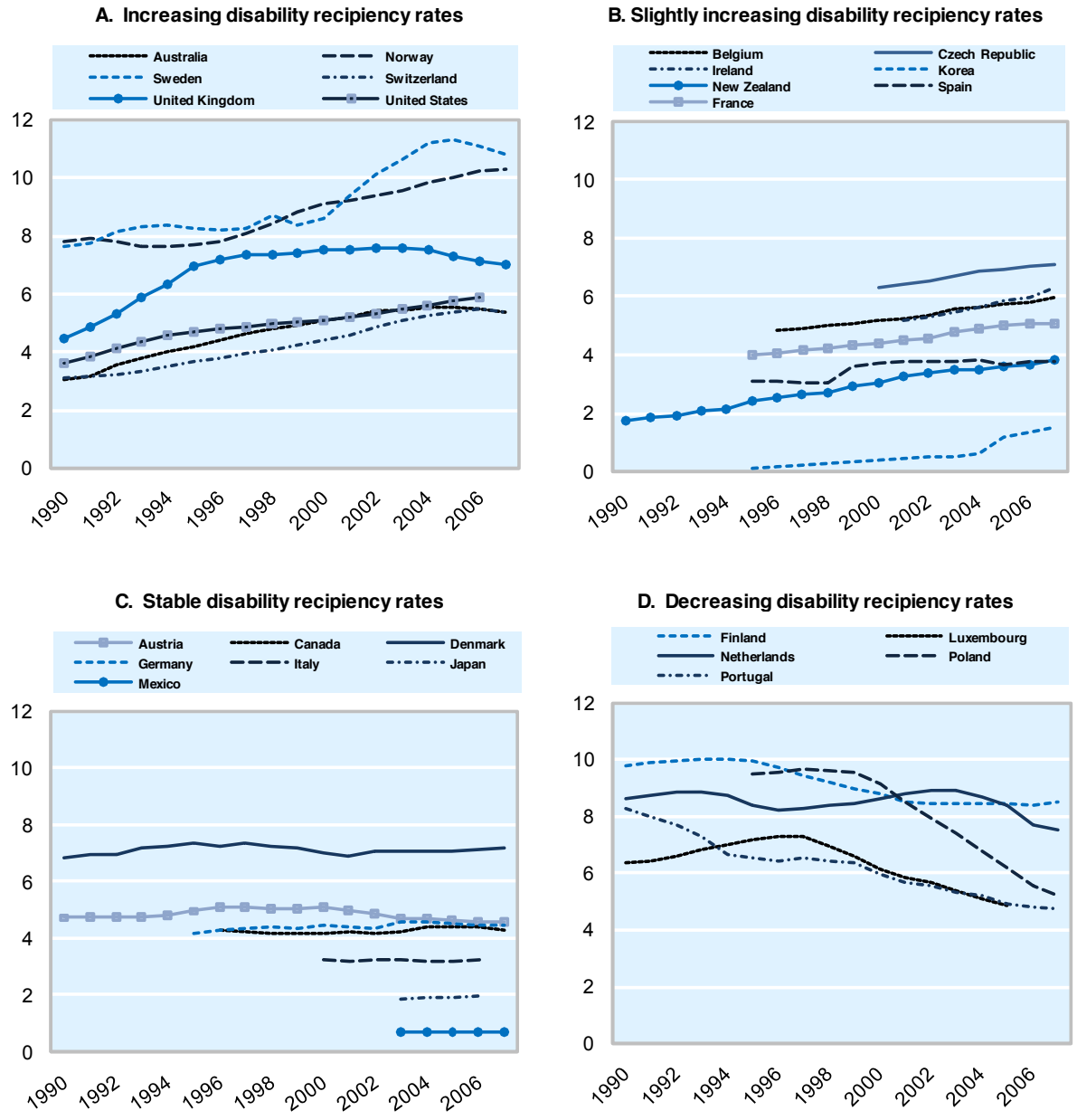
	Disability			Sickness			Disability and sickness				
	% GDP			% GDP			% GDP			% Unemployment	% Public social spending
	1990	2000	2005	1990	2000	2005	1990	2000	2005	2005	2005
Australia	1.1	1.2	1.3	0.5	1.8	1.3	1.6	3.0	2.5	463	15
Austria	1.8	1.1	1.3	1.3	1.1	1.0	3.1	2.3	2.4	221	9
Belgium	1.4	1.2	1.4	1.4	0.7	0.7	2.8	1.9	2.1	72	8
Canada	0.4	0.4	0.4	0.0	0.0	0.0	0.4	0.4	0.4	65	2
Czech Republic	1.2	1.1	1.1	1.0	1.2	1.0	2.3	2.3	2.1	355	11
Denmark	1.6	1.5	1.8	1.4	1.1	1.3	2.9	2.6	3.1	231	11
Finland	2.1	1.8	1.9	1.5	1.2	1.2	3.6	3.0	3.1	194	12
France	0.9	0.8	0.9	0.6	0.7	0.8	1.6	1.5	1.6	99	6
Germany	0.8	1.0	0.9	1.9	1.6	1.3	2.7	2.5	2.2	148	8
Greece	1.0	0.7	0.7	0.8	0.7	0.6	1.9	1.4	1.3	329	6
Hungary	..	0.2	0.2	..	0.7	0.7	..	1.0	0.9	190	4
Iceland	0.9	1.7	2.2	1.5	1.4	1.5	2.3	3.1	3.6	1 183	22
Ireland	0.5	0.6	0.7	0.8	0.6	0.7	1.3	1.1	1.5	163	9
Italy	1.2	0.9	0.8	0.9	0.7	0.5	2.1	1.6	1.3	324	5
Japan	0.3	0.3	0.3	0.1	0.1	0.1	0.4	0.4	0.4	125	2
Korea	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	104	3
Luxembourg	2.0	1.7	1.6	0.6	0.6	0.9	2.6	2.3	2.5	324	11
Mexico	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	..	..
Netherlands	4.7	2.7	2.4	2.9	2.2	2.3	7.6	4.9	4.6	303	22
New Zealand	0.6	0.9	1.0	0.3	0.3	0.3	0.9	1.2	1.3	302	7
Norway	2.5	2.3	2.6	2.6	2.7	2.4	5.1	5.1	4.9	960	23
Poland	2.1	2.2	1.6	0.7	0.7	0.6	2.8	3.0	2.3	821	11
Portugal	1.7	1.8	1.8	0.0	0.0	0.0	1.7	1.8	1.8	157	8
Slovak Republic	..	0.9	0.9	..	1.0	0.3	..	1.9	1.2	672	7
Spain	1.2	1.2	1.1	1.0	1.0	1.1	2.2	2.2	2.2	103	11
Sweden	1.9	2.1	2.5	3.1	2.0	1.7	5.0	4.1	4.2	353	14
Switzerland	1.0	1.8	2.1	1.2	1.1	1.0	2.2	2.8	3.2	339	16
Turkey	0.1	0.2	0.1	0.1	0.0	0.0	0.1	0.2	0.1	232	1
United Kingdom	1.6	2.1	1.8	0.6	0.7	0.5	2.2	2.8	2.3	904	11
United States	0.5	0.6	0.7	0.8	0.6	0.7	1.3	1.2	1.4	483	9
OECD	1.3	1.2	1.2	1.0	0.9	0.8	2.3	2.1	2.0	248	10

Notes: .. : Data not available. Disability category refers to public and private disability benefits; sickness category refers to public and mandatory private paid sick-leave programmes (both occupational injury and other sickness daily allowances).

Source: *OECD Social Expenditure database* (*www.oecd.org/els/social/expenditure*).

Figure A2.7. **Disability benefit rolls have evolved differently across the OECD, reflecting policy choices**

Number of disability benefit recipients aged 20-64 as a share of the working-age population[a]

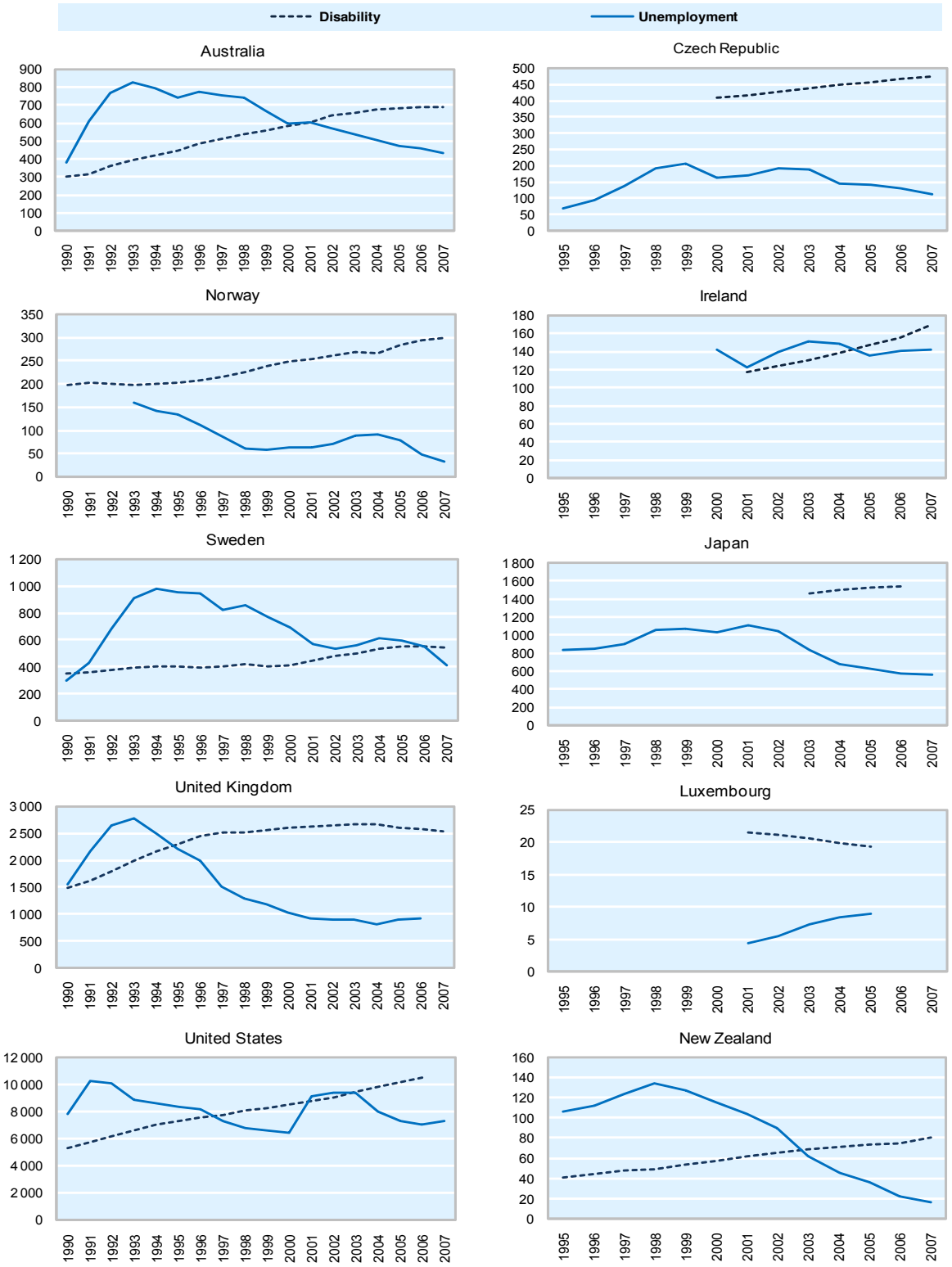


a) Data for Austria and Germany would be approximately one percentage point higher if civil servant schemes were included. Data for the Netherlands cover ages 15-64. Data for Poland refer to the employee contributory scheme only; were the farmers' contributory scheme and the non-contributory scheme included, the rate would be two percentage points higher.

Source: Data provided by national authorities.

Figure A2.8. **Opposite trends for unemployment and disability beneficiaries highlight substitution effects**

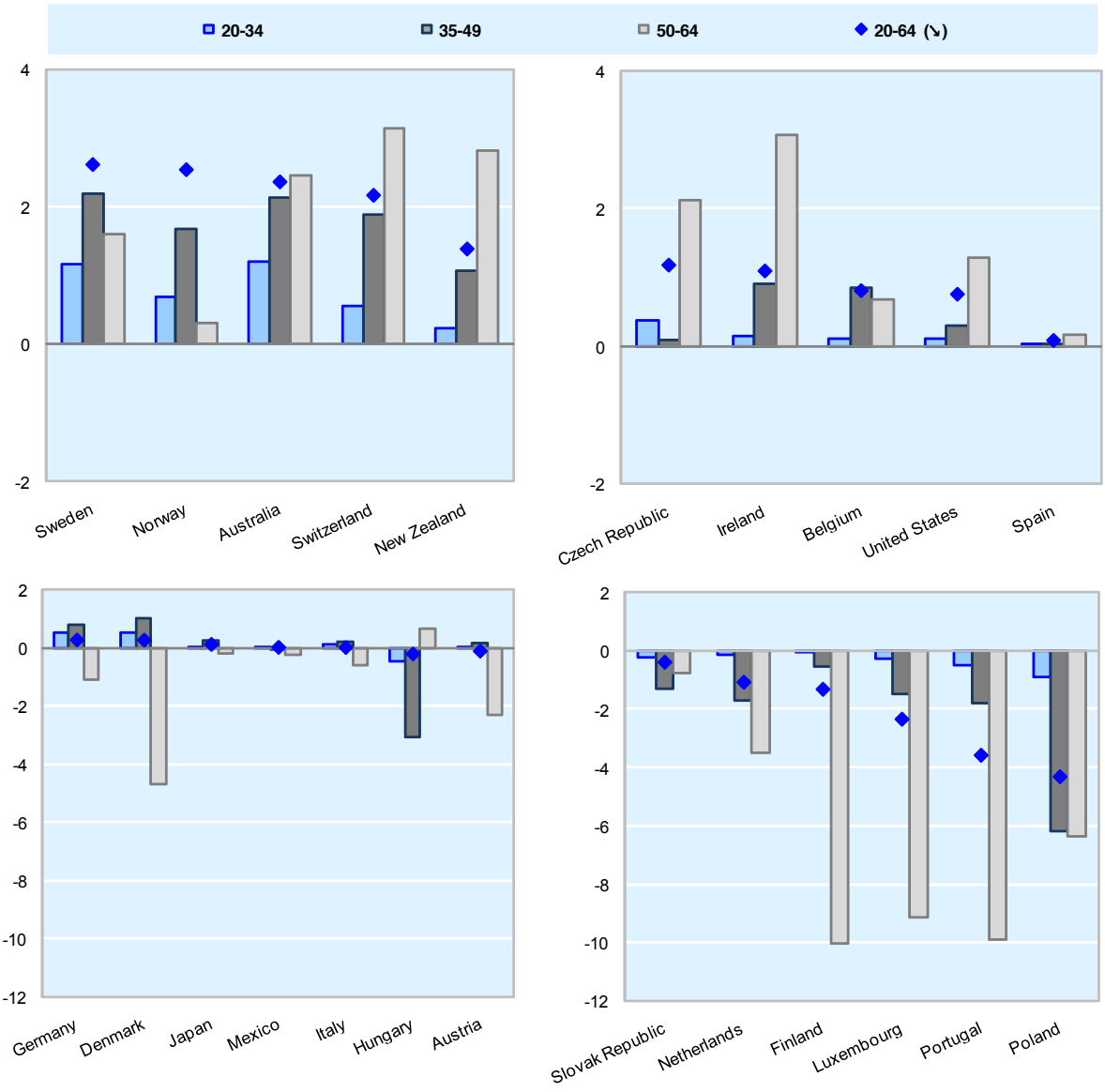
Unemployment and disability beneficiaries in thousands of persons, 1990-2007



Source: Data supplied by national authorities and the *OECD Active Labour Market database*.

Figure A2.9. **Older workers dominate the disability benefit rolls, as well as trends over time**

Percentage point change in disability beneficiary rates by age groups, 1990-2007[a,b]



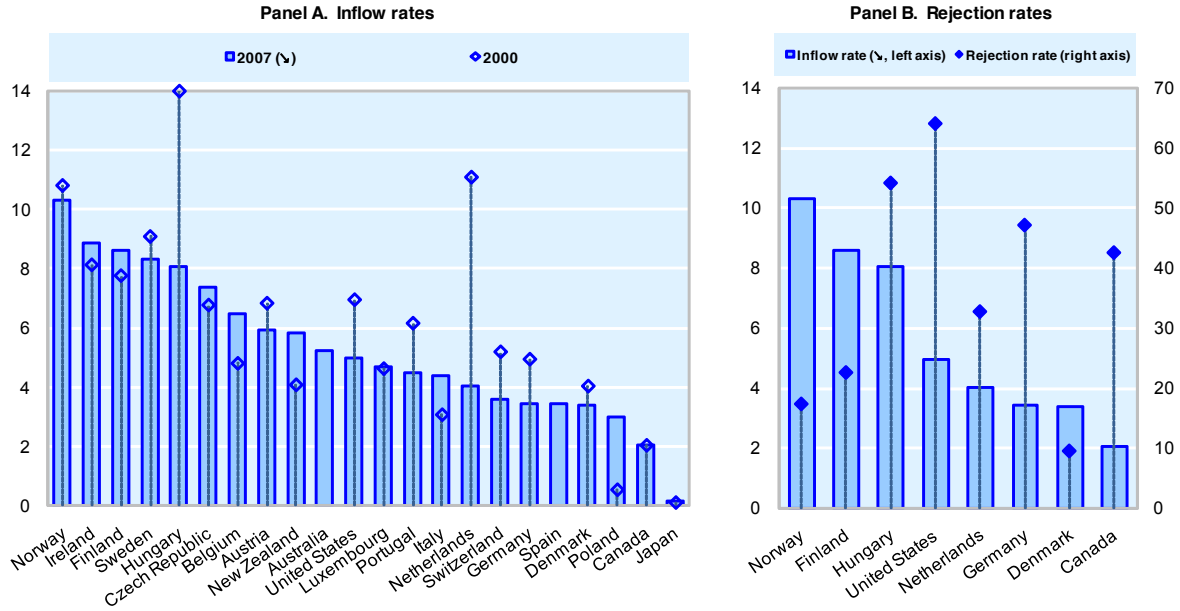
a) 1990-2005 for Denmark; 1992-2007 for Switzerland; 1995-2005 for Luxembourg; 1995-2006 for the Slovak Republic;1995-2007 for Germany, New Zealand and Poland (employee contributory scheme only) and Sweden; 1999-2007 for the Netherlands; 2000-2006 for Italy and the United States (contributory scheme only); 2000-2007 for Hungary; 2001-2007 for Ireland; 2003-2006 for Japan; 2003-2007 for Mexico; and 2005-2007 for Spain.

b) Belgium refers to the contributory pension only.

Source: Data provided by national authorities.

Figure A2.10. **Some countries have recently managed to reduce inflows into disability benefits**

Disability benefit inflows in per cent of the working-age population, 2000 and 2007, and share of rejected applicants[a,b]

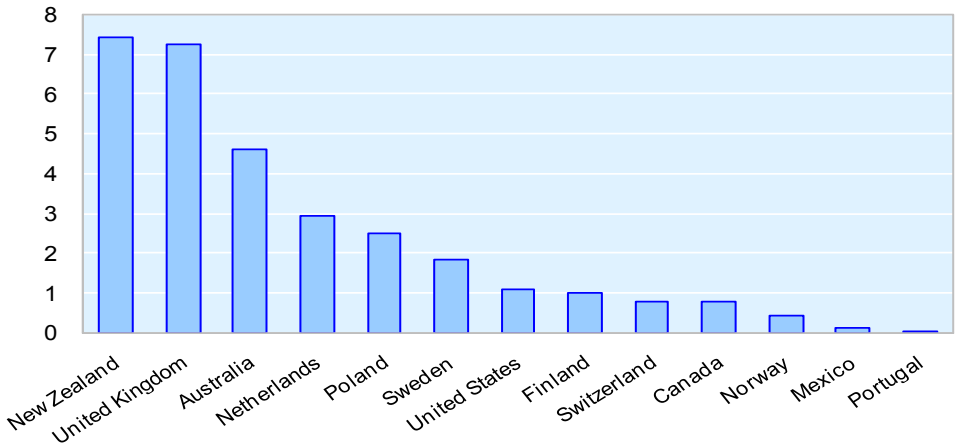


a) Data for Ireland refer to 2001 and 2006; Luxembourg to 2005; Canada, Italy and Japan to 2006.
b) Austria excludes civil servants. Canada refers to the contributory pension only. Germany includes civil servants and excludes the non-contributory pension and early retirement for the severely disabled. Spain covers the contributory benefit only.

Source: Data provided by national authorities.

Figure A2.11. **People almost never leave a longer-term disability benefit for employment**

Annual outflows from disability benefits as a share of all disability benefit recipients, 2007[a,b]

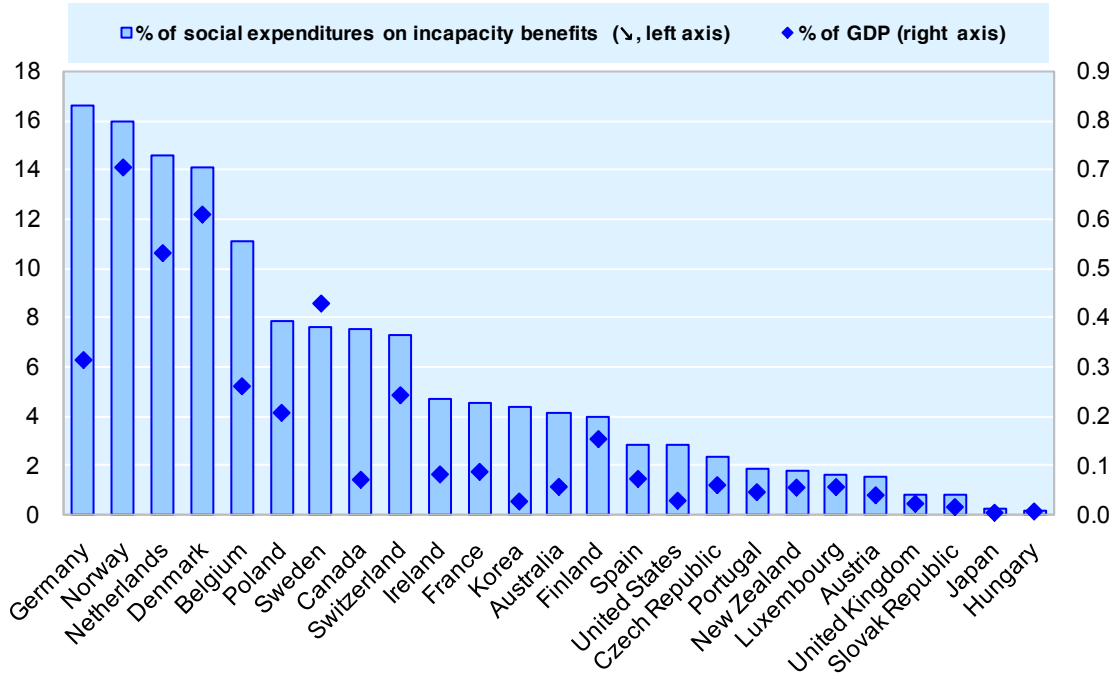


a) Outflows include moves into employment and into other inactivity as well as loss of eligibility, but exclude deaths and transfers into old-age pension.
b) Data refer to 2004 for Luxembourg, 2005 for Australia and the United Kingdom and 2006 for Finland. Data for Canada and the United States refer to contributory pensions only; data for Poland to the contributory farmers' scheme; and data for the United Kingdom to the Long-term Incapacity Benefit.

Source: Data provided by national authorities.

Figure A2.12. **Not enough resources go to ALMPs in comparison with what is spent on compensation**

Active labour market spending on employment programmes and vocational rehabilitation, 2005[a,b]

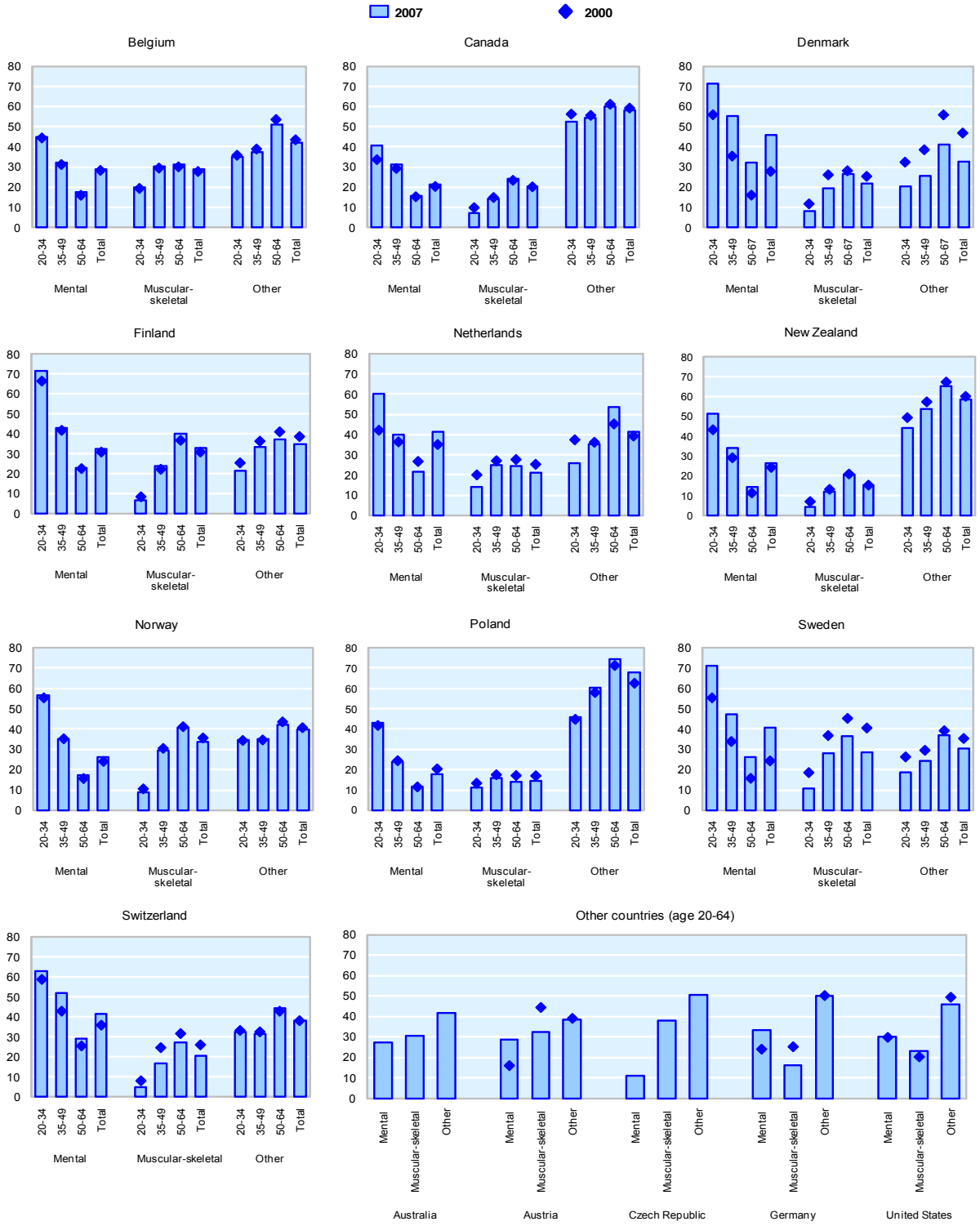


a) 2004 for Denmark, Portugal and Spain; 2006 for Australia, Belgium, Canada, Ireland, New Zealand, Poland and Sweden (spending on incapacity benefits) and the United States.
b) Incapacity benefit spending includes spending on sickness and disability benefits.

Source: *OECD ALMP database*, *OECD SOCX database* and data provided by national authorities.

Figure A2.13. **More and more inflows into disability benefit because of mental health conditions**

Inflows into disability by health condition as a percentage of all inflows by age group, 2000-2007[a]

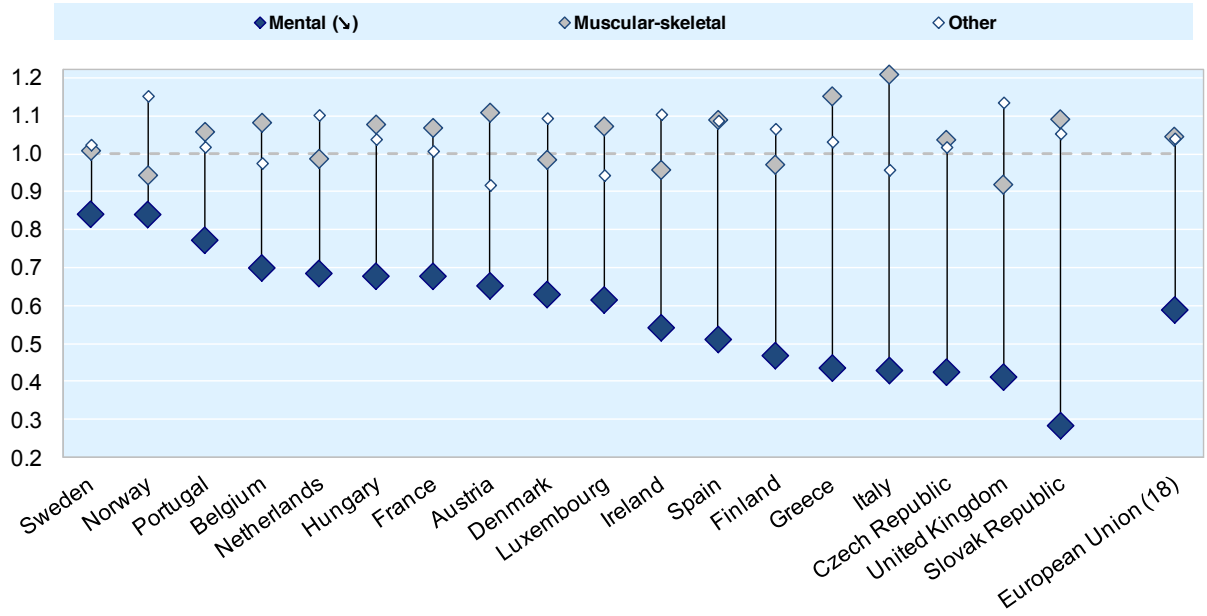


a) Data for Canada refer to 2001 and 2006; data for the United States refer to 2006 and (contrary to data in previous figures) do not account for the overlap in contributory and non-contributory benefit receipt.

Source: Data supplied by national authorities.

Figure A2.14. **Employment rates of people with mental health conditions are particularly low**

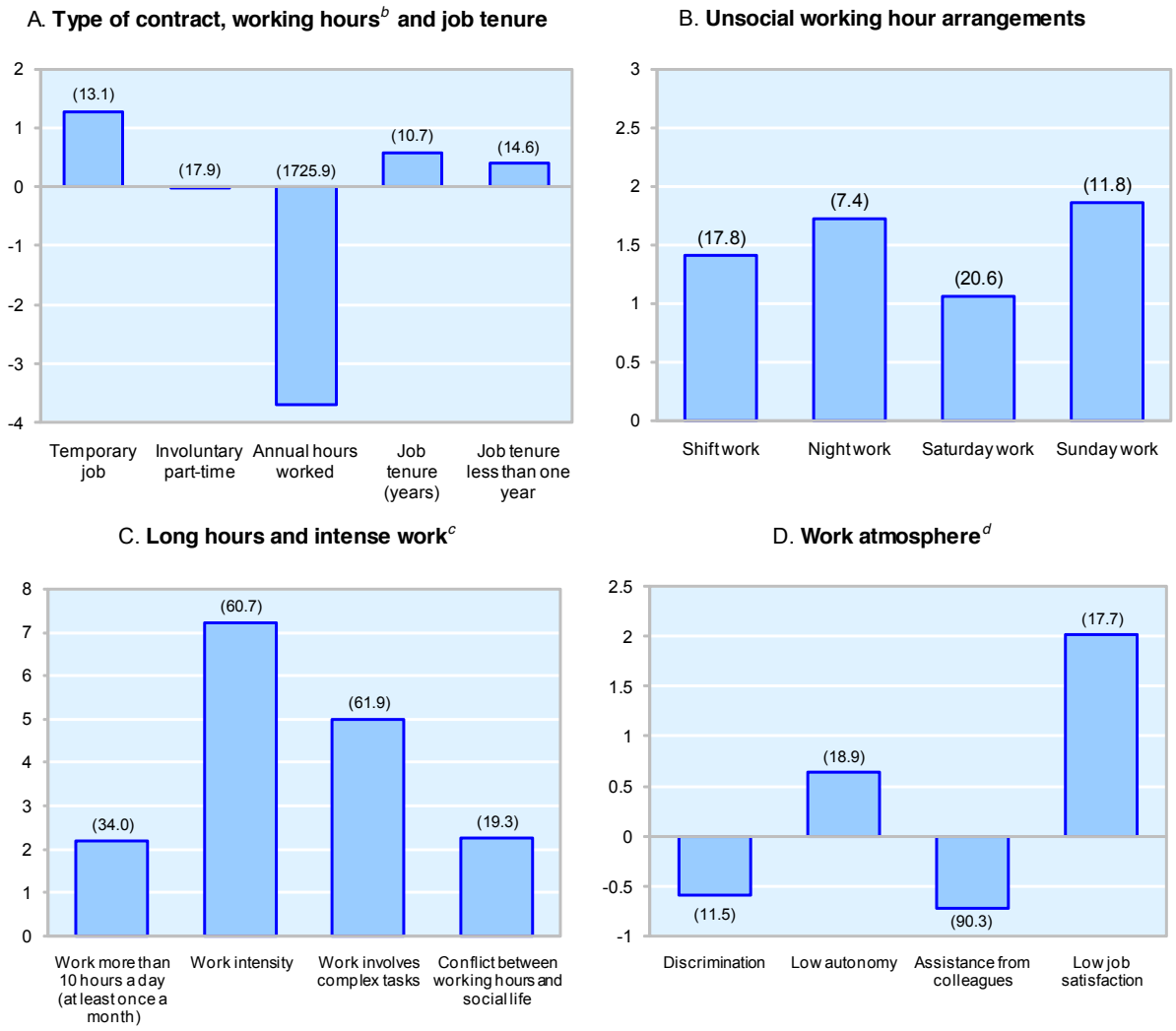
Employment rates by health condition, as a ratio of the employment rate of all people with disability, 2002



Source: European Labour Force Survey (2002), Ad-hoc module on employment of people with disability.

Figure A2.15. **Today, many more workers are reporting high work intensity**

Percentage-point changes, 1995-2006, unweighted average of OECD countries[a]



a) Values within parenthesis are the OECD average in the last year.
b) Percentage change for average annual hours worked.
c) 2000-2005 for the share of employees working more than 10 hours a day (at least once a month) and for those experiencing difficulties in reconciling working hours and family or social commitments outside work; 1990-2005 for work intensity; and 1995-2005 for work involves complex tasks.
d) 1995-2005 instead of 1995-2006.

Source: OECD calculations based on the *OECD database on Labour Force Statistics* for panel A; the European Labour Force Survey (EULFS) for panel B; and the European Working Conditions Survey (EWCS) for panels C and D. For further details on variables and definitions, see OECD (2008), *Employment Outlook*, Chapter 4.