# Sickness and Disability Policy Interventions

# 22

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This chapter provides insight into changes and effects of sickness and disability benefit policies using data comparison between various countries and the successful example of an active integration policy approach implemented in the Netherlands.

## 22.1 A Categorization and Cross-Country Comparison of Work Disability Policies

### 22.1.1 Introduction

Disability policy has become an urgent matter for governments in recent years (OECD 2010). Until two decades ago, policies of most countries were biased towards generous and easily accessible disability benefits, with less emphasis on helping people with disability return to or stay at work. The economy suffered significantly from spending on disability benefits. The onset of the global economic crisis has worsened the situation. Governments are now more focused on preventing further inflow to disability benefits and increasing labor force participation of people with disability. As the best way to fight benefit dependence is to promote reintegration into work.

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### 22.1.2 Models of Work Disability Policies

OECD (2010) distinguished three disability policy models, building on Esping-Andersen's (1990) politically based typology of three qualitatively distinct welfare state models: the social–democratic model, the liberal model, and the corporatist model. According to the OECD, the social–democratic disability policy model is characterized by a relatively generous and accessible compensation policy package and a broad and equally accessible integration policy package with a particularly strong focus on vocational rehabilitation. This policy model is potentially expensive and will not necessarily result in the highest possible labor market participation. The liberal disability policy is characterized by a much less generous compensation policy package with lower benefit levels and a much

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higher threshold to get onto benefits. This policy model is less expensive overall, but the stronger inbuilt employment incentives resulting from less generous benefits are only partly harvested with an intermediary integration policy focus. The corporatist disability policy model can be seen as intermediate in comparison to the other two models. Benefits are relatively accessible and generous, and employment programs are quite developed but not at the level of the social–democratic model. Employment and beneficiary outcomes of such a policy model can be rather mixed. In the following, the OECD typology is used to measure and compare sickness and disability policy change across OECD countries.

### 22.1.3 Two Main Disability Policy Dimensions

Two qualitative policy indicators were developed in OECD (2003) in order to make it possible to compare policies across countries and over time, each of the two reflecting one of the two major dimensions of disability policy. The first indicator covers the benefit system or compensation measures. The second indicator covers employment and integration measures. Both indicators consist of ten (unweighted) subdimensions and have an overall score ranging from 0 to 50 points. A higher score on the compensation indicator, everything else being equal, means greater system generosity. On the integration indicator, a higher score indicates a more active approach. The combination of these two indicators, or policy dimensions, characterizes a country's disability policy approach. The indicators first shown in OECD (2003) were updated for a longer period and extended to a larger number of countries in OECD (2010), allowing measurement of the extent of change in the period 1990–2007.

### 22.1.4 Three Main Trends in Sickness and Disability Policies in OECD Countries

In the past two decades, there have been policy reforms in most OECD countries aimed at reaching a new balance between compensation and labor market integration, as to improve employment chances for people with disability and reduce public expenditures. These reforms can be classified in three main broad trends: an expansion of employment integration measures, an improvement of the institutional setup, and a tightening of benefit schemes (OECD 2010).

#### 22.1.4.1 Expanding Integration Policy

In the past few decades, the disability policies of virtually all OECD countries have shifted their focus from income replacement towards a more employment-oriented approach (OECD 2010). Measures are aimed at helping people with disability to stay in, return to, or find work. These policies can take different forms and often include a combination of measures aimed at supporting workers and employers, coupled with stronger responsibilities for companies. One measure that most countries have introduced is antidiscrimination legislation to ensure equal treatment of people with disability (and other disadvantage) in employment (job promotion, hiring, and dismissal procedures) and other areas (education, mobility, etc.). Modified employment quotas (in countries that use such a quota system[1]) are another tool used to stimulate employers to retain or hire people with a disability, for instance, by reducing the number of companies excluded from the obligation to employ a certain share of workers with disability. Stronger employer incentives have been introduced in different forms to give more binding obligations for individual employers. Examples are making employers responsible for sickness benefit payment for providing (reasonable) workplace accommodation. Also, supported employment programs are introduced in many countries. These programs help to integrate people with disability into the regular labor market by first providing a trial workplace and then offering training and help on the job. Another measure is to improve and modernize sheltered employment. Basic sheltered employment was perceived as perpetuating the segregation of peo-

[1] System that obliges employers to hire a minimum proportion of employees with a disability.

ple with disability and hindering their integration into the regular labor market. Now several countries have modernized their sheltered employment regulations, for instance, by strengthening the focus on progression into the open labor market or by developing new forms of sheltered employment closer to the regular labor market. Improved wage subsidies are used to create employment for people with disability that would not have been possible without the subsidy.

#### 22.1.4.2 Improving the Institutional Setup

In addition to expanding integration policy, many countries have improved their structure of systems and service provision (OECD 2010). Several countries are providing better coordinated services by moving towards a one-stop-shop benefit and service provision for people with disability and other clients with benefit dependency. In particular, in many countries, steps are taken to increase the cooperation between the public employment service and the benefit authority or the social insurance institution, for example, by better sharing of information or cross-funding of interventions. Another measure to improve the institutional setup is by giving better incentives for benefit authorities, as done in several countries. For instance, by raising reimbursement rates for active intervention, municipalities are motivated to avoid benefit payments. A more recent development in some countries is a shift from bulk funding of employment services to outcome-based funding of services, based on actual employment outcomes. Another development in a few countries is to give clients more freedom of choice in selecting a provider and the services they need.

#### 22.1.4.3 Tightening Compensation Policy

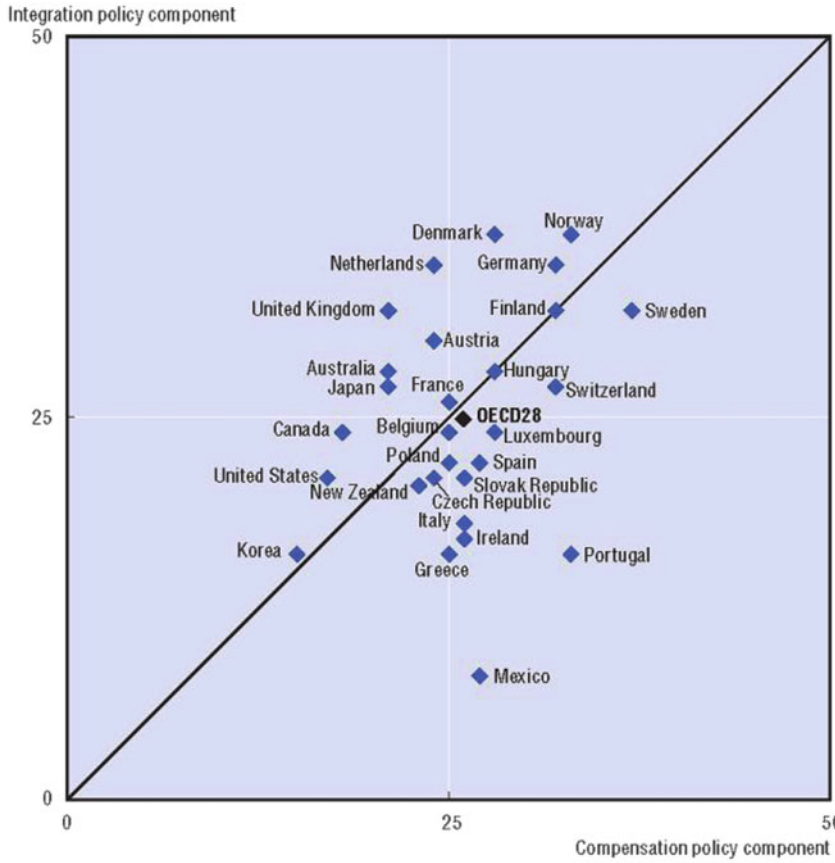
Several measures are applied to restrict the benefit systems (OECD 2010). Assessment criteria have become more stringent in some countries. A measure that is applied in several countries is to make medical criteria to determine disability benefit entitlement more consistent. Assessments by general practitioners have moved to a more uniform evaluation, in some cases through the provision of clearer sick-listing guidelines for the main diseases. Several countries are using more stringent vocational criteria to determine disability benefit eligibility. For instance, some countries changed the system from strict own-occupation assessment to a general labor market criterion. Reforms have also led to changes to benefit payments. Both the duration of payment and the level of disability or work incapacity required for benefit entitlement became more stringent in most countries. Some countries pursue promoting stronger work incentives, for instance, by introducing a tax credit and the possibility to combine disability benefit receipt with income from work. Several countries have applied stricter sickness absence monitoring to reduce long-term sickness absence.

### 22.1.5 Sickness and Disability Policy Reforms in OECD Countries: A Comparison

#### 22.1.5.1 Measuring Policy Change in the Past 15 Years

There is large variation across countries in the two policy indicators mentioned above (see Fig. 22.1). On a 50-point scale, scores on the compensation indicator range from around 20 in most English-speaking countries, Korea, and Japan to over 30 points in most of the north European countries, Portugal, Germany, and Switzerland, with a higher score representing countries with more generous and accessible benefit systems. Countries differ slightly more on the integration indicator, from around 15 points in many south European countries, Ireland, and Korea to 35 points or more in Denmark, Germany, the Netherlands, and Norway.

There is a strong correlation between the two indicators; most countries show either a low or a high score on both indicators. Only a large difference between the two indicators indicates a clear policy orientation: the higher the integration score relative to the compensation score, the more pronounced is the integration orientation of a policy setup, and vice versa. Only a few countries have a dominant indicator, focusing their policy orientation on either compensation or integration.




*Note:* The higher the score, the more generous and accessible the benefit system (X axis) and the more developed the rehabilitation and employment stance of the policy (Y axis). The maximum score is 50 on both scales. The difference between the two indices is an indication of policy orientation, *e.g.* a compensation index that is significantly higher than a country's integration index indicates a strong compensation focus, and *vice versa*.

**Fig. 22.1** Large variation in disability policy orientation across the OECD. Compensation (*x* axis) and integration (*y* axis) policy codes in 2007 for 28 OECD countries, country values on the two ordinal 50-point scales of the OECD disability policy typology indicator. *Source*: OECD (2010), *Sickness, disability and work: Breaking the barriers* (*A synthesis of findings across OECD countries*)), OECD Publishing, Paris

There has been a large shift on the two policy dimensions in many countries since 1990 (see Fig. 22.2). Changes in the integration policy score are all positive and sometimes very large, while changes in the compensation policy score are mostly negative, though less pronounced. This means that most countries shifted their policy orientation from compensation to integration and from a largely passive to a more active employment-oriented approach. However, this strong shift towards a more active disability approach does not yet seem to be reflected in the labor market outcomes of people with disability. A possible explanation is that policy implementation is lagging behind policy intentions and that policy has yet to translate into actual changes in everyday practice.

#### 22.1.5.2 Policy Clusters and Policy Convergence

These changes in disability policies across the OECD have implied convergence both within and between groups of countries (OECD 2010). A cluster analysis over the 20 subcomponents of

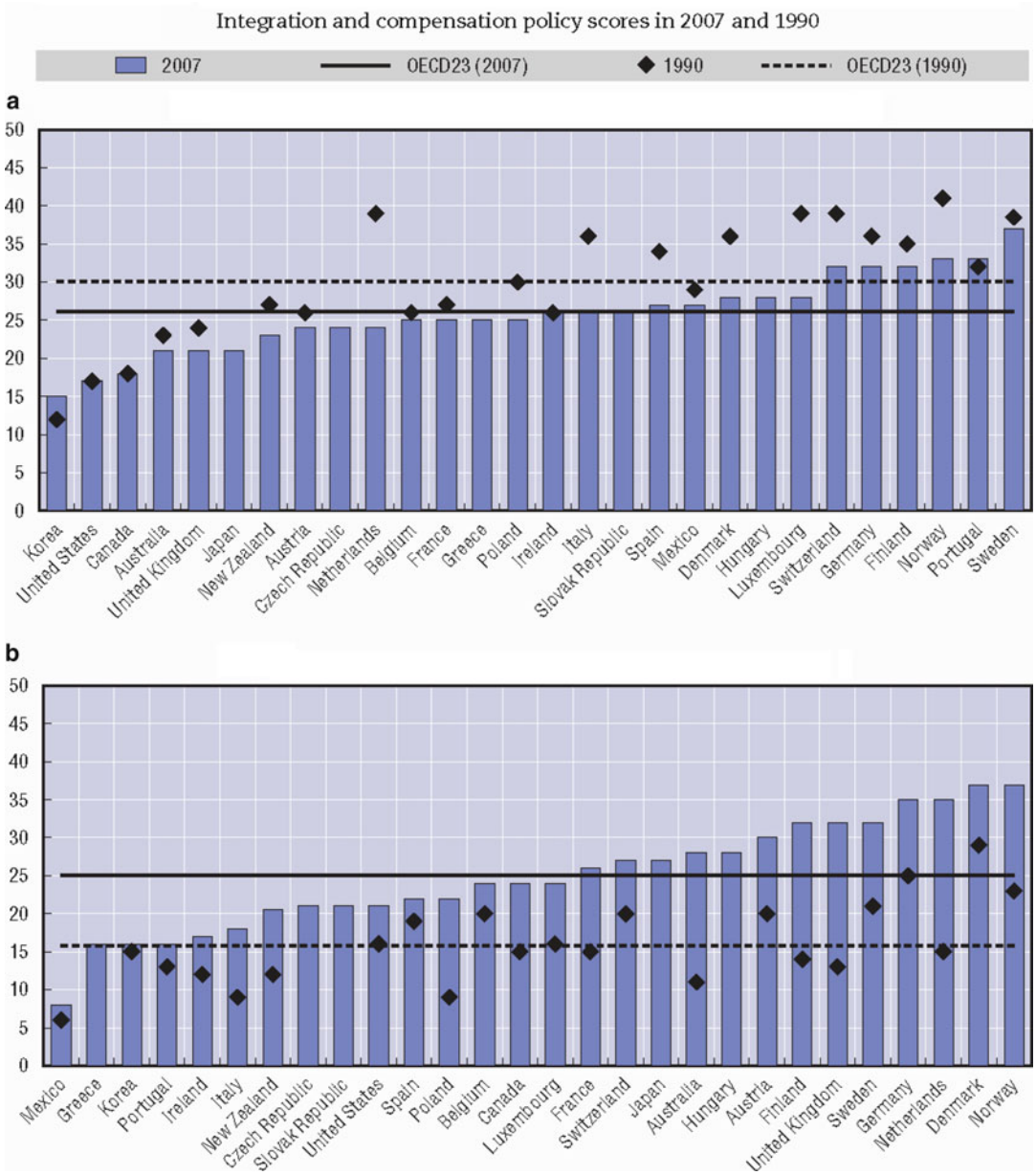



**Fig. 22.2** Disability policy is changing fast in many OECD countries. (**a**) Compensation index ranking (from least generous to most generous in 2007). (**b**) Integration index ranking (from least active to most active in 2007). *Source*: OECD (2010), *Sickness, disability and work: Breaking the barriers* (*A synthesis of findings across OECD countries*), OECD Publishing, Paris

the compensation indicator and the integration indicator identifies the three types of policies mentioned in Sect. 22.1.2 (the social–democratic model, the liberal model, and the corporatist model) and additional subgroups or variants within each main group, as elaborated in Table 22.1. The social–democratic disability policy model has two subgroups. The first includes

**Table 22.1** Three distinct disability policy models across the OECD. Results from a cluster analysis based on the OECD disability policy typology

| "Social-democratic" model (mostly north European countries) | | "Liberal" model (OECD Pacific and English-speaking countries) | | "Corporatist" model (mostly continental European countries) | | |
|---|---|---|---|---|---|---|
| Sub-group A | Sub-group B | Sub-group A | Sub-group B | Sub-group A | Sub-group B | Sub-group C |
| Denmark | Finland | Australia | Canada | Austria | France | Czech Republic |
| Netherlands | Germany | New Zealand | Japan | Belgium | Greece | Ireland |
| Switzerland | Norway | United Kingdom | Korea | Hungary | Luxembourg | Italy |
| | Sweden | | United States | | Poland | Portugal |
| | | | | | | Slovak Republic |
| | | | | | | Spain |

*Source*: OECD (2010), *Sickness, disability and work: Breaking the barriers* (*A synthesis of findings across OECD countries*), OECD Publishing, Paris

Denmark, the Netherlands, and Switzerland. It is less generous than the second subgroup on both compensation and integration, but provides better work incentives. It also has the strongest sickness absence monitoring and/or sick-pay eligibility control focus of all models. The second subgroup is the most generous in the OECD and comprises Finland, Germany, Norway, and Sweden. On the other hand, it also has the strongest employer obligations of all models.

Also within the liberal disability policy model, two subgroups can be distinguished. The first, including Australia, New Zealand, and the United Kingdom, has far better organized and coordinated and thus better accessible services. The second subgroup, including Canada, Japan, Korea, and the United States, has the most stringent eligibility criteria for a full disability benefit and the shortest sickness benefit payment duration. The corporatist disability policy model has three subgroups. The first, covering Austria, Belgium, and Hungary, has the strongest employment orientation of this policy cluster, well-developed rehabilitation and employment programs, and low benefit levels. The second subgroup comprising France, Greece, Luxembourg, and Poland has the most generous sickness and disability benefits of these three subgroups and includes temporary disability benefits and more attention to sickness absence monitoring. The third subgroup includes the Czech Republic, Ireland, Italy, Portugal, the Slovak Republic, and Spain. It has comparatively underdeveloped employment and rehabilitation policies and therefore a stronger compensation orientation even though the sickness benefit level is lower than in the other subgroups of the corporatist cluster.

However, the disability policies of the clusters characterized by the three models have all converged in the same direction in the past 20 years. All models have moved upwards on the integration policy dimension. Since the upward move is also comparable in size, differences across policy models have essentially remained unchanged. Considerable convergence is found on the compensation policy dimension; countries with more generous benefit systems have seen more downward change, whereas countries with the least generous benefit systems have seen an upward shift. In conclusion, policy models have become more similar over the past 20 years, but they still remain distinct.

#### 22.1.5.3 Effects on Disability Benefit Rolls

The impact of these policy changes on the number of people claiming disability benefit has been explored with a multivariate regression analysis (OECD 2010). Results show a positive effect of compensation measures on the number of disability beneficiaries. Integration policy change had only a very small effect on recipients' disability benefit rates.

The specific subcomponents of compensation and integration policy were explored in detail in OECD (2010). Benefit accessibility and generosity were positively associated with disability beneficiary rates, as was a more generous sickness policy. Moreover, the more stringent medical and vocational assessment appeared to be

correlated with an increasing beneficiary caseload. This may be due to the fact that such changes take a while to be implemented properly or due to the difference between legislation and actual implementation. Employment programs, vocational rehabilitation, and changes in work incentives were all correlated with a decreasing number of persons receiving a disability benefit. Antidiscrimination legislation, on the other hand, is associated with higher shares of disability benefit recipients. An explanation for this might be that such legislation, while protecting workers in existing employment, may hinder the hiring of workers with disability.

## 22.2 Understanding Cross-Country Differences in the Return to Work of Long-Term Sick-Listed Workers

### 22.2.1 Introduction

The OECD methodology and analysis improve our understanding of broad policy trends and their impact on outcomes on a macro-level, especially on the number of people receiving disability benefits, but cannot reveal the effect of individual policy measures and the way they are implemented on the labor market integration or reintegration of disabled workers. There are very few studies which try to compare the effect of policy measures on actual return to work (RTW) across countries. One such study, a multinational cohort study to evaluate the effect of integration and compensation measures in six different countries/jurisdictions, was initiated several years ago by the International Social Security Agency (ISSA) (Bloch and Prins 2001). Integration measures were defined in this study as healthcare interventions and workplace interventions. Chronic low back pain (LBP) was used as an example due to its high prevalence of disability benefits claimants in most countries. The study was conducted in Denmark, Germany, Israel, the Netherlands, Sweden, and the USA (states of New Jersey and California). Two-year follow-up data from 2,825 claimants sick-listed for 3 months due to chronic LBP were collected and analyzed. Because all national cohort studies had a common core design comprising several identical basic features, it was possible to collapse the datasets into a homogenous standardized dataset for multinational analysis.

### 22.2.2 Description of the Compensation Measures for RTW in Six Countries

In general, there were three different arrangements in those countries for claimants based on (compulsory) wage replacement, sickness benefits, and (temporary or permanent) disability benefits or pensions for long-term work disability. Main characteristics of the compensation systems of the involved countries between 1994 and 1997 were defined into compensation measures by the members of all national research teams before the onset of the study. The compensation measures were dichotomized as present or absent in a specific compensation system (see Table 22.2).

The start of payment of a benefit or wage replacement after filing the claim varied between 0 days in most countries and one waiting day in Israel and Sweden and 1 week in the USA.

Countries differed in the administrative procedure to legitimate a sickness benefit claim. In all countries except the Netherlands, a medical certificate was needed, mostly from a treating physician to filter inappropriate claims. In the countries, the moment of eligibility assessment for a work disability pension was very different, from starting very early after the claim onset up to after 1 year in the Netherlands. In order to evaluate the effect of an early or late entitlement to long-term disability benefits or rehabilitation, the countries were dichotomized in early entitlement or late entitlement (i.e., >3 months after the start of claim). Also the degree of work incapacity required to be eligible for disability benefits was very different among countries, ranging from 15% in the Netherlands to 100% in the USA. Most countries required a high threshold of 50% work incapacity or more to be eligible for a disability benefit. There were clear differences

**Table 22.2** Compensation policy variables (1994–1997) defined by the international panel (derived and modified from Bloch and Prins 2001)

| | DNK | GER | ISR | NLD | SWE | USA |
|---|---|---|---|---|---|---|
| Income loss[a] | + | + | + | − | + | + |
| Waiting days[b] | − | − | + | − | + | + |
| Medical certicates needed for a sickness benefit[c] | − | + | + | − | + | + |
| High minimum (≥50%) of work incapacity needed for a long term disability benefit[d] | + | + | − | − | − | + |
| Risk of dismissal[e] | + | − | + | − | + | + |
| No or late entitlement to a long term disability benefit[f] | − | − | + | + | − | + |

*DNK* Denmark; *GER* Germany; *ISR* Israel; *NLD* The Netherlands; *SWE* Sweden; *USA* United States, + present, − absent
[a]Income loss when reporting sick (financial incentive)
[b]No compensation of initial days of sickness absence
[c]A medical certificate needed that should filter inappropriate claims
[d]High minimum degree (≥50%) of work incapacity needed to be eligible for full a partial disability benefits
[e]Risk of dismissal: no legal obstacles—i.e., no job protection—to dismiss long–term incapacitated employees
[f]No or late (>3 months after the start of claim) entitlement to long term disability benefits or rehabilitation
*Source: Journal of Occupational Rehabilitation*, Anema et al. (2009)

among countries regarding the risk of dismissal during sickness absence: the Netherlands and Germany had a long fixed period of protection against dismissal, whereas the other countries had no legal obstacles to dismiss long-term incapacitated employees.

### 22.2.3 Differences in Applied Healthcare Interventions for RTW in the Six Countries

There were large differences in the applied healthcare interventions to improve RTW in the six countries. It was also surprising that each country had specific popular treatments for chronic back pain. The USA had the highest frequency for surgery (35.1%), Israel and Denmark for pain relieving medication (86.9% and 78.9%, respectively), and Germany for passive treatment like medicinal baths (in 67%) and manipulation (41.7%). In Sweden, acupuncture (31%) was very popular. Active treatments were popular in the USA and the Netherlands (exercise therapy, 63.0%) and in Germany and Denmark (back schools, 28%). All interventions were categorized in surgery, active treatments (consisting of training/gymnastics and back schools) and passive treatments (consisting of pain relieving medication, massage, heat/cold and electric therapy, medicinal baths, manipulation, and acupuncture). The differences in frequencies of medical interventions between countries were all significant ($p \leq 0.001$). Summarizing, there was a wide variety of healthcare interventions applied in the countries. Some treatments were common in all countries, but there were also very specific frequently used interventions in each country that are not commonly used in the other countries (Table 22.3).

### 22.2.4 Differences in Applied Workplace Interventions for RTW in the Six Countries

In the six countries, the social security, employers, and labor market organizations had various sets of workplace interventions that could be applied. The legal and social security framework in a country determined the repertoire of workplace interventions. This resulted in large differences in the frequency of applied workplace interventions. Popular in most countries was adaptation in working hours, job redesign, and workplace adaptation. Changes in number and/or pattern of working hours such as different shifts, less or more hours ("partial work resumption"), and more variation in hours were defined as adaptation in working hours. Job redesign was defined as change of job tasks, including minor changes such as not having

**Table 22.3** Medical and work interventions applied for % of claimants ($N = 2.825$) sick listed 3–4 months due to low back pain in six countries, during 2 years since the start of sick leave

| *N* | DNK 563 (%) | GER 358 (%) | ISR 316 (%) | NLD 426 (%) | SWE 374 (%) | USA 460 (%) | TOTAL 2,825 (%) |
|---|---|---|---|---|---|---|---|
| *Medical intervention* | | | | | | | |
| Surgery | 12.7 | 10.7 | 15.6 | 23.7 | 9.2 | 35.1 | 17.5 |
| Pain relieving medication | 78.9 | 58.5 | 86.9 | 67.0 | 62.6 | 72.1 | 70.4 |
| Passive treatment | 1.9 | 41.7 | 6.4 | 7.5 | 5.2 | 7.4 | 10.7 |
| Exercise therapy | 57.5 | 47.6 | 29.7 | 63.0 | 36.8 | 73.1 | 51.9 |
| Back schools | 28.5 | 28.8 | 3.7 | 12.4 | 27.8 | 14.0 | 20.6 |
| *Work intervention* | | | | | | | |
| Adaptation workplace | 11.0 | 2.7 | 10.1 | 23.9 | 9.0 | 15.1 | 11.9 |
| Job redesign | 27.6 | 6.1 | 43.7 | 35.4 | 10.0 | 27.5 | 23.7 |
| Working hours adaptation | 20.5 | 6.6 | 39.8 | 49.2 | 9.8 | 28.9 | 24.2 |
| Job/vocational training | 16.1 | 5.6 | 5.8 | 7.7 | 18.0 | 12.8 | 12.0 |
| Therapeutic work resumption | 1.6 | 1.0 | 0.9 | 59.7 | 19.8 | 4.3 | 14.6 |

*DNK* Denmark; *GER* Germany; *ISR* Israel; *NLD* The Netherlands; *SWE* Sweden; *USA* United States
*Source*: *Journal of Occupational Rehabilitation*, Anema et al. (2009)

to carry things. Finally, workplace adaptation included any technical aids, such as a different chair or desk/table, special tools, a lifting aid, and an adapted transport during work.

In the Netherlands, the frequency of "adaptation of the workplace" (23.9%), "working hours adaptation" (49.2%), and "therapeutic work resumption" (60.0%) was highest. The latter intervention comprising RTW with ongoing benefits or wage replacement was almost unique to the Netherlands. High frequencies for work interventions were also found in the Israeli (job redesign, 43.7%) and in the Swedish cohorts (job training, 18.0%). In Germany, the frequencies of workplace interventions were the lowest for all types of workplace interventions. The differences in frequencies of workplace interventions between countries were all significant ($p \leq 0.001$).

### 22.2.5 Effects of Integration and Policy Measures on RTW

A total of 851 out of 2,825 claimants (34.1%) in the six countries had a sustainable RTW at 2 years after the first day of sick leave. Figure 22.3 demonstrates the curves for work disability duration until sustainable RTW stratified for countries. As shown, sustainable RTW after 2 years varied considerably between countries (log rank test $p < 0.001$): ranging from 22% of the claimants in the German cohort to 62% of the claimants in the Dutch cohort. Sustainable RTW was found in 31%, 39%, 49%, and 49% of the claimants in the Danish, Swedish, American, and Israeli cohort, respectively. In addition, RTW patterns in the first and second year varied between countries: from gradual change over 2 years (Denmark, USA, Israel) compared to steep decline in the first year and no changes in the second year (the Netherlands, Sweden, and Germany).

The impact of compensation measures, healthcare interventions, and workplace interventions on sustainable RTW of people claiming a disability benefit was explored with a multivariate regression analysis. The differences between the countries in these measures explained to a large extent the observed differences between countries in duration until sustainable RTW. The variance in work interventions between countries (more workplace adaptation, job redesign, working hours adaptation, and therapeutic work resumption led to more and earlier RTW) accounted for 26% of the variance in (differences in) RTW. The cross-country variance in healthcare interventions (earlier surgery, pain medication, and exercise therapy led to more and earlier RTW) contributed to 18% of the explained variance in

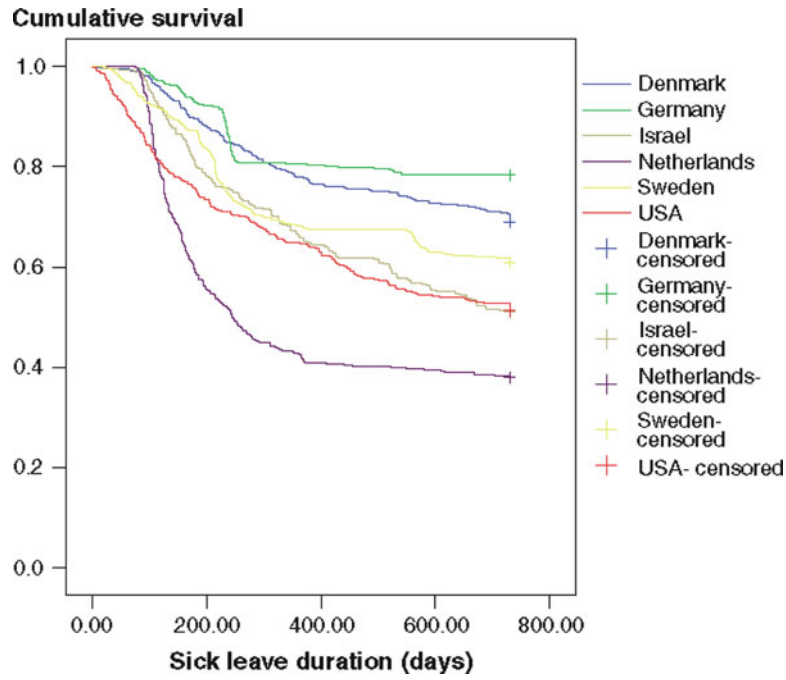



**Fig. 22.3** Survival curves of work disabilty duration until sustainable RTW for workers in six countries sick listed 3–4 months due to LBP. *Source: Journal of Occupational Rehabilitation*, Anema et al. (2009)

RTW. Finally, cross-country differences in compensation measures contributed also to the observed differences in sustainable RTW. For the following compensation measures in countries, an effect on earlier sustainable RTW was found: no or late timing of entitlement (>3 months after onset of the claim) to a long-term disability benefit ($p<0.001$) and no high minimum (less than 50%) degree of work incapacity needed for a long-term partial disability benefit ($p<0.001$). The model including various compensation policy measures explained 48% of the variance in RTW between countries.

The main implication of this study is that integration measures, particularly workplace interventions, are effective on RTW. Integration measures should be supported by effective compensation measures, that is, flexible (partial) disability benefits adapted to the individual needs and capacities of the claimant. A delicate balance between those integration and compensation measures seemed to stimulate RTW. Surprisingly the effect on RTW seems to be independent of the underlying political welfare model. Participating countries with a liberal disability welfare policy, like the USA and Israel, seemed to stimulate RTW better than the participating countries with a social–democratic disability policy like Sweden, Denmark, and Germany, which had a much lower RTW rate. The social–democratic policy model in the Netherlands was a positive exception with a largest RTW rate. The implementation of the successful Dutch policy changes in the last decade will be elaborated in the final part of this chapter to understand their possible influence on these positive effects on RTW.

## 22.3 Lessons on Sickness Absence and Disability from the Netherlands

### 22.3.1 Sickness Absence Policy Reforms and Current Sickness Absence Policies

In the Netherlands in the 1980s and 1990s, about 9–10% of working days were lost due to sickness absence. This increased social security expenditures, not only in the sickness benefit scheme but

**Table 22.4** Overview of reforms in sickness absence policy in the Netherlands

| |
|---|
| 1994: sickness: 2–6 weeks full wage payment |
| • Next year: 20% reduction in sickness days |
| 1996: sickness: maximum 52 weeks full wage payment |
| • Impact on sickness absence rates: poor |
| 2002: Improved Gatekeeper Law: return-to-work policy: compulsory |
| 2004: Wage payment during sickness: maximum 2 years |
| • First year: minimally 70% of wage (≥80–100%)<br>• Second year: 70% (≥80%)<br>• Impact on sickness absence: substantial |

also in the disability benefit arrangement, as many long-term sick persons entered the disability benefit rolls after 1 year, namely after termination of sickness benefits.

In that period, the Dutch *sickness* benefits amounted 70% of wages, but in most sectors, social partners agreed to top up benefits to 90 or 100% of wages (with a maximum). Moreover, the two waiting days without income replacement had been abolished in most collective labor agreements. Another feature is that, due to ethical considerations, Dutch treating physicians refused to provide certificates for work absence, arguing that this might interfere with the doctor–patient relationship. Consequently, the main actor to control the phenomenon was the sickness benefit administrator governed by representatives of employers and labor unions.

Since 1994, several measures were taken to reduce sickness absence levels. These measures and their impact are listed in Table 22.4.

In January 1994, a compulsory wage payment period was introduced, including maximally 2 weeks per episode for small employers and maximally 6 weeks for large employers. Due to its success (sickness absence dropped by 20%) from March 1996, the wage payment period was extended: the employers were legally obliged to pay full wages to their sick employees for a maximum of 52 weeks. Public sickness benefits remained available for a small category of employees, namely, those with a temporary labor contract, and for personnel victim of bankruptcy.

As Dutch labor law prohibits dismissal during sickness, the only way to limit the employer's financial risk was to try to have the sick employee returned to work as quickly as possible.

The employer can insure the financial risk of wage payment in the private insurance market, but he/she also was free to pay the costs himself or herself. Monitoring of sickness absence, checking of work incapacity, and initiating return-to-work measures were then laid in the hands of the occupational health services. Employers were obliged by law to contract these services, either in-company or as an external (private) service.

In 2002, the Improved Gatekeeper Law came into force, with the aim to reduce long-term sickness absence especially by reducing the inflow in the disability benefit scheme. The law required the provision of a work resumption plan, agreed upon by employer and employee (Table 22.5).

The 2004 law extended compulsory wage payment from 1 to 2 years. Since then, in a detailed and stepwise way, the actions employer and employee have to take in case of sickness absence have been prescribed. Major elements of these procedures are shown in Table 22.5.

### 22.3.2 Policy Efforts to Reduce High Number Work Disability Pensions in the Netherlands

For a long time, the Netherlands also had one of the most generous disability insurance systems in the OECD. "Medical" eligibility criteria only regarded the loss of functional capacities in the light of the original job. Moreover, the threshold for entering the scheme was low: a minimum of 15–25% loss of work capacity qualified for a partial benefit. However, in some periods, regulations allowed provision of full benefit (70% of last wage, often topped up in collective labor agreements) in case the client with partial disability could no longer return to the labor market. Administrative criteria were limited: sickness benefit receipt for 1 year automatically led to transfer to the disability claim procedures, and no further minimum insurance periods were requested.

**Table 22.5** Protocol included in "Improved Gatekeeper Law"

| | |
|---|---|
| Day 1 | Employee reports sick with employer; employer informs occupational health service (OHS) or occupational physician |
| Week 6 | Occupational physician makes a "problem analysis" (identifies problems, explores solutions) |
| Week 8 | Employer and employee make an "action plan" (RTW return-to-work plan) |
| Every 6 weeks | Regular contact employer–employee |
| Week 42 | Employer informs social security agency of work incapacity of employee |
| Week 44 | Social security agency informs employer and employee of their obligations |
| Week 47–52 | Employer and employee evaluate progress and adapt plan if needed; plan (now) should include actions for work resumption with another employer |
| Week 87 | Employee receives disability benefit claim form, employer receives request for wage data, etc. from social security agency |
| Week 91 | Employer and employee make "reintegration report" and send in with disability benefit claim to social security agency |
| Month 24 | Social security agency evaluates employers and employee's efforts to work resumption, before starting disability claim process |
| Week 104 | In case of assessment of full or partial loss of work capacity, start disability benefit (or extended wage payment, in case of insufficient actions taken to labor reintegration) |

By 2000, around 11% of the working-age population was drawing disability benefits. A major reform to the system was agreed by the government and the social partners in 2003–2004, and took effect in 2006. The reform, which applied only to persons who suffered disability in 2004 or later, reduced the inflow into the disability benefit scheme from 70,000 to 100,000 per year that had prevailed over the preceding decade to some 40,000 in 2007 and 2008—a major accomplishment. Those already receiving benefits at the time of the reform continued to receive benefits defined under the old rules. However, most of those younger than age 45 have had their entitlement reassessed under the criteria used in the new system. Again, there is a strong case for arguing that the success of the latest reforms, which have changed the incentives facing employers and employees drastically, was made possible by the (failed) earlier reform which, building on fast growing new scientific evidence, created a consensus for the need for change.

### 22.3.3 Impact and Evaluation

Several evaluative studies (de Jong et al. 2010) were held to assess the implementation and impact of measures taken in the field of sickness absence management and disability benefit dependency. For several stakeholders, it could be concluded that the measures in general affected their attitude and behavior.

Employers indicated (which was partly confirmed in employee surveys) that they had become more aware of the costs of sickness and disability. They also had become more interested in human resource policy and working conditions. Moreover, they also had learned that they themselves have possibilities and tools to lower sickness absence. On the other hand, the new procedures also led to complaints about the paper work and the time they (or their supervisors) had to spend on sickness absence management.

Employee surveys showed also a positive impact on employee's opinions. Workers had become more aware of their own responsibilities during sickness absence and that an active role is requested for recovery and work resumption. They also learned that long-term sickness and disability benefit dependency would imply serious loss of income. But also negative consequences of the new scheme were reported: a substantial minority also reported fear related to pressures (from their employer or occupational physician) to be forced to RTW too early.

Healthcare professionals (apart from the occupational physicians) became slowly familiar with

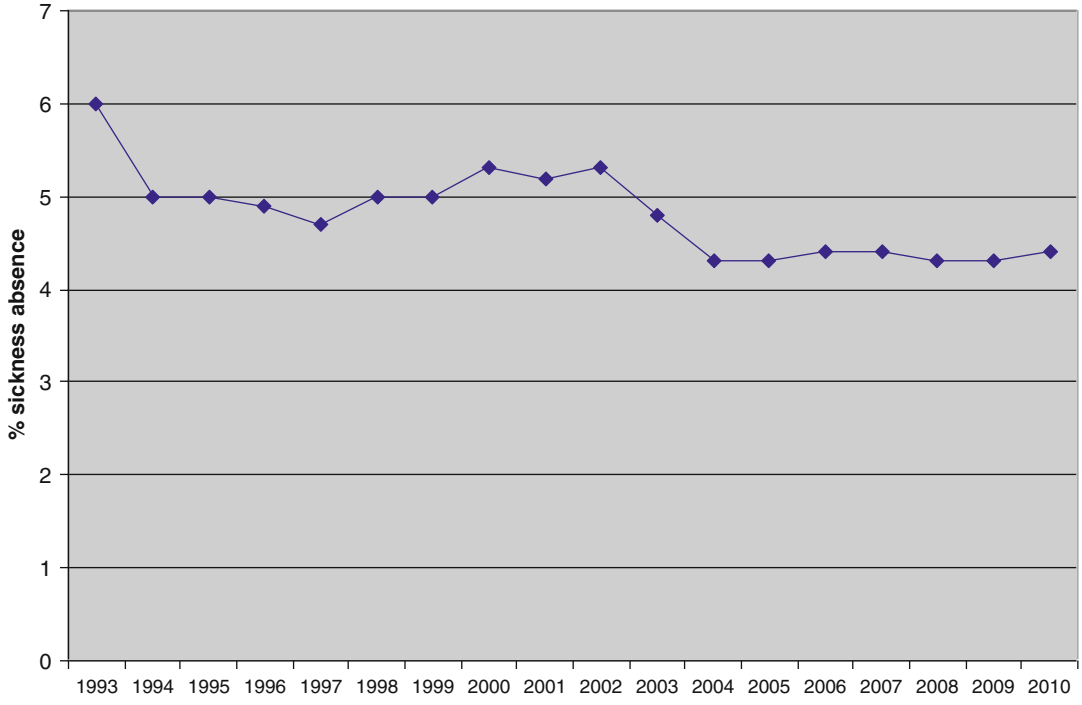



**Fig. 22.4** Percentage of working days lost due to sickness absence in the Netherlands between 1993 and 2010. *Source*: Centraal Bureau voor de Statistiek, StatLine 2012, Den Haag/Heerlen

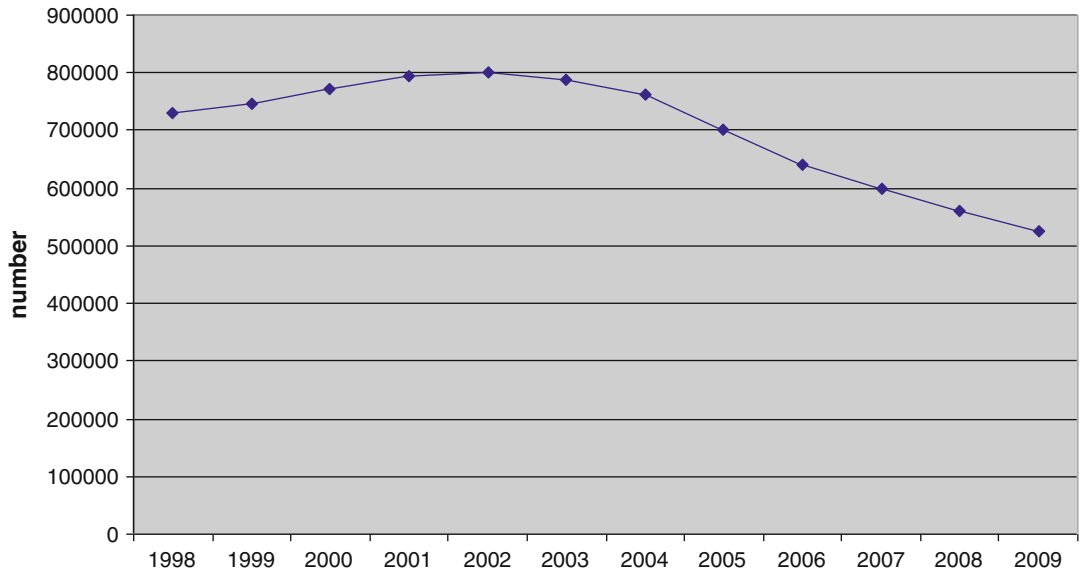



**Fig. 22.5** Number of disability benefit recipients in the Netherlands between 1998 and 2009. *Source*: Centraal Bureau voor de Statistiek, StatLine 2012, Den Haag/Heerlen

the new procedures and resisted initially to the viewpoint that in many cases work resumption can start before full recovery and—when feasible—the goal might be partial work resumption. They further expressed objections against "de-medicalization" and too strong emphasis on the behavioral side of sickness absence of their patients. Physicians having a social medicine specialty (occupational physicians and social insurance physician) were the strongest advocates of the new approach.

### 22.3.4 Summarizing: Pillars of Dutch Sickness Absence and Disability Policy

In conclusion, the aims of current Dutch policies towards sickness absence and disability benefit dependency were initially the reduction of public expenditures (sickness benefits and disability benefits). In due course, a second objective was added, that is, to keep more people in employment because of future labor force deficits and the need to keep social services and healthcare system financially sustainable. Underlying the changes was a paradigm shift in relation to work incapacity and RTW. Instead of focusing on *in*capacities, the *remaining* capacities should be addressed when thinking of and acting on sickness absence management and disability prevention. Consequently, instead of aiming at work resumption after full recovery, a stepwise approach should be used when feasible. Within this framework, partial work resumption can occur during recovery and as soon as possible. This change required a shift of responsibilities. Income replacement in case of sickness would no longer be provided by an (anonymous) administrator in social security, but instead by the employer whose expenditures might function as incentive to actively engage in work reintegration. Measures to address sickness absence were laid in the hands of the two main stakeholders: the employer and employee. Service provision (rehabilitation, labor reintegration) was no longer a monopoly of public agencies. These agencies now had to compete with new (private) providers of labor reintegration and other services.

It should not be forgotten that certain additional conditions supported the change in attitude and behavior of employer and workers. These supporting policies include compulsory workplace occupational safety and health services. Every employer is required to contract an occupational health service both to advise the worker and employer on sickness absence management and disability prevention and also for services relating to "regular" occupational health and safety activities. Another supporting policy is increased flexibility in the provision of return-to-work measures. OHS providers now have more budgetary opportunities to select reintegration measures that are more custom made financed by the Dutch Employee Benefit Schemes (UWV). Workers received the right to have a personal budget to make their own plan for labor reintegration (with a current, former, or new employer). Finally, preemployment medical examinations are restricted, as has been the case for many years. These assessments have been forbidden (with some exceptions) in order to avoid employer discrimination against less healthy workers.

The current Dutch policies resulted in a substantial drop of the percentage lost working days and in the number of work disability benefit pensions in the Netherlands after abolishment of sickness benefits for initial period of sick leave and the introduction of 2–6 weeks wage payment from the employer (2003–2004). Also, a substantial drop occurred after introduction of the revised gatekeeper model (2002–2004).

## 22.4 Conclusion

This chapter provides an overview of changes in sickness benefit and disability policies in the OECD countries in the last 15 years. Although there is still a large variation in sickness benefit and disability policies between OECD countries, disability policies all converged in the same direction in the past 20 years. Considerable convergence is found on the compensation policies; countries with more generous benefit systems have seen more downward change, whereas countries with the least generous benefit systems have seen an upward shift. In addition, most

countries shifted their policy orientation from compensation to integration and from a largely passive to a more active employment-oriented approach. The OECD study showed a positive effect of compensation measures on the number of disability beneficiaries. However, the change in integration policies had only a very small effect on disability benefit recipiency rates. A possible explanation is that policy implementation is lagging behind policy intentions and that policy has yet to translate in actual changes in everyday practice. It might also be that policies were not effective to change behavior or that there is resistance to implementation, for example, due to unexpected side effects.

A comparative six-country study initiated by International Social Security Agency (ISSA) evaluated the implementation and effectiveness of integration and compensation measures on sustainable RTW of workers on long-term sick leave due to LBP. It showed that countries with an active integration policy approach as well as countries with a strict compensation policy approach were successful. Work interventions were the most effective component of a successful integration policy approach. The Dutch integration policy approach is a good example of the success of implementing work interventions by introducing appropriate incentives for employers. Finally, Dutch policy changes in the last decade on sickness benefits level and disability compensation rates led to positive effects on RTW rates.

## 22.5 Note

An important part of this chapter including figures and tables is based on research published previously with permission of the publishers:

– Section 22.1 of this chapter draw heavily on OECD (2010): *Sickness, disability and work: Breaking the barriers* (*A synthesis of findings across OECD countries*), a report that summarizes the results of a 4-year OECD project led by Christopher Prinz. The opinions expressed and arguments employed herein are those of the author and do not necessarily reflect the official views of the OECD or of the governments of its member countries.
– Section 22.2 of this chapter draw heavily on a paper *Can Cross Country Differences in Return-to-Work After Chronic Occupational Back Pain be Explained*? *An Exploratory Analysis on Disability Policies in a Six Country Cohort Study*, published in *Journal of Occupational Rehabilitation* in 2009. Authors: J. R. Anema, A. J. M. Schellart, J. D. Cassidy, P. Loisel, T. J. Veerman, A. J. van der Beek.

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