Peer Review in Social Protection and Social Inclusion 2009

Modernising and Activating Measures relating to Work Incapacity

Madrid, 4-5 February 2010

Synthesis Report

On behalf of the
European Commission
Employment, Social Affairs
and Equal Opportunities

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in Social Protection
and Social Inclusion
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Executive summary

With the ageing of Europe's population, there is increasing concern as to the long-term sustainability of Member States' social protection and pension systems. To cope with this situation, European countries not only have to reduce early exits from the labour market, they also have to decrease the take-up of benefits. Indeed, once inactive, people find it hard to return to the labour market, and this difficulty only increases with age. Health problems and disabilities are major causes of early exits and, in turn, early exit benefits are one of the main elements on the path out of the labour market. Currently, over half of the 55–64 age group is inactive and some 20% rely on early exit benefits.

EU Member States have developed various strategic responses to address this situation and the Spanish Peer Review was organised in this context.

Spain itself is currently at the beginning of a reform process of its social security system. A major aim is to avoid situations in which people become excluded from the labour market, notably on health grounds. Efforts are being made to encourage both employers and workers to look at people's abilities rather than at their disabilities, and an early warning system has been developed to avoid placing people in occupations that could result in disabilities.

Improved management and cost containment are also key objectives of the Spanish reform as the current system, in which responsibilities are spread between the national and regional levels had resulted in management complications and a steep rise in incapacity benefit costs. The adoption of a series of cost-cutting measures over the past five years has already enabled a reduction in spending.

All the Peer countries present during the Review face similar problems to the ones presented by Spain. The questions of restricting the inflow to permanent disability schemes and of designing active measures to motivate disability benefit recipients to take up work are however addressed in different ways and rely on various measures. This was reflected in the discussions among the Peer countries.

Key lessons learned at the Peer Review meeting include:

- the need to focus on people's capabilities rather than on what they cannot do;
- the need for integrated, personalised approaches;
- the need to involve employers through effective incentives and assistance, and to promote a change in employer attitudes through information campaigns;
- the use of stepping-stones, including a mix of benefits and employment services, to promote the take-up of work;
- the removal of obstacles to employment via job carving (adjusting the workplace and the content of the job to the individual);
- the need to tackle disability at the source and focus on prevention;
- the need to manage inflows through a suitable design of benefit systems that takes into account the changing nature of incapacity;
- the importance of governance aspects, and of consultation and participation of social partners in the planning and implementation of reform.

1. Policy context at European level

With the ageing of Europe's population, there is increasing concern as to the long-term sustainability of Member States' social protection systems. To cope with this situation, European countries not only have to reduce early exits from the labour market, they also have to decrease the take-up of benefits. Indeed, once inactive, people find it hard to return to the labour market, and this difficulty only increases with age. Health problems and disabilities are major causes of early exits and, in turn, early exit benefits are one of the main elements on the path out of the labour market. Currently, over half of the 55–64 age group is inactive and some 20% rely on such early exit benefits. Overall, this age group represents more than one third of the inactive population of working age within the EU. The main reasons for inactivity include retirement, but also poor health, personal or family responsibilities, or a perception — right or wrong — that no employment is available.

Prolonging working lives and preventing early exits are vital elements of pension reform as promoted within the Open Method of Coordination on Social Protection and Social Inclusion (Social OMC). Active ageing is also an important component of the European Employment Strategy and, thus, of the Lisbon Strategy for growth and jobs.

Furthermore, the European Disability Strategy[1] is an important part of the policy framework for achieving equal treatment in employment, as is Article 5 of the Framework Employment Directive[2], which obliges employers to provide reasonable accommodation at work. The 2007 UN Convention on the Rights of Persons with Disabilities (Art. 27) also commits signatory countries to working towards the employment of people with disabilities.

1 Communication from the European Commission on establishing equal opportunities for people with disabilities: a European Action plan (COM/2003/650); Communication from the European Commission on the situation of disabled people in the enlarged European Union: the European Action plan 2006 — 2007 (COM/2005/604); Communication from the European Commission on the situation of disabled people in the European Union: the European Action Plan 2008–2009 (COM/2007/738).

2 Directive 2000/78/EC.

The employment rate among the 55–64 age group in the EU27 has increased in recent years, from 36% in 1997 to 44% in 2006. However, it still remains low in comparison with the Lisbon target of 50%, as well as by international standards. What's more, the projected increase in life expectancy, in particular of those aged 60 to 65, is likely to cause an escalation of demographic pressure on pension systems, thereby underlining the importance of increasing employment rates among 55–64-year-olds in the coming decades.

Several studies have argued that reforms to address early exits from the labour market should be designed to:

- *Restrict eligibility conditions* while creating an adequate framework for older workers' continued participation in the labour market — allowing for exceptions in the case of particularly demanding or hazardous jobs;

- *Increase incentives for employees to work longer* (namely through fiscal rules) and also for employers to hire older workers;

- *Enhance work opportunities for older workers and workers with disabilities*, with an emphasis on improving working conditions (namely by preventing health problems), developing active measures, such as training or specific programmes to assist re-entry into the labour market, and providing reasonable accommodation.

Key success factors highlighted in various studies also include taking a holistic approach to reform, obtaining broad social consensus, and ensuring the involvement and commitment of social partners and other concerned stakeholders.

A number of Member States have recently implemented reforms in line with these guidelines, including:

- *Reforms in unemployment benefits* for older workers have sought to reduce differences in eligibility conditions for older workers and those for the rest of the active population, as well as to develop active

measures in order to enhance labour market opportunities for older workers.

- *Reforms in invalidity benefits* have been aimed at facilitating the combination of work and benefits, offering retraining possibilities and improving workplace adaptation. Incentives for employers have also been strengthened in order to encourage them to hire people with reduced work capacity. At the same time, incentives for beneficiaries are being reviewed so as to reduce barriers to returning to working life. There has also been an increased focus on invalidity prevention and the professional rehabilitation of people with health problems from an early age.

- *Reforms in supplementary pension benefits* have been implemented with a view to diminishing or even putting an end to early take-up, by tightening eligibility rules and increasing awareness of the consequences of early exit on future benefit levels.

- *Reforms in taxation* have aimed to encourage employers to hire older workers and to increase incentives for employees to stay in work.

In addition to reforming their pensions and benefits systems, some Member States have focused their efforts on improving the participation of older workers in lifelong learning, promoting health in the workplace, improving public employment services, and combating age discrimination through stricter legislation and age awareness campaigns.

Many Member States have or are working towards developing a one-stop shop approach, in which single points of contact provide both workers with disabilities and employers with an overview of all available supportive measures and channel clients to the appropriate organisations. Such an approach is considered useful in encouraging employers to take on ageing workers disabilities, so long as the single points of contact are largely publicised both among businesses and the community of people with disabilities.

A number of lessons can be learnt from the higher-performing countries and the Spanish Peer Review was held within this context. However, one problem encountered when evaluating and comparing policies and reforms is that disability policies target an extremely heterogeneous group, with definitions of disability varying widely across the EU and the OECD. Even within one country, there may be various definitions depending on the background of the specific legislation (e.g. social insurance vs. labour market legislation) or on the legislative body (e.g. national vs. regional legislation). The overall snapshot of the prevalence of disability will vary according to the definition used. Many statistics are based on self-reporting. According to such data, around 15% of the workforce suffers from one type of disability or another. There appears to be ample evidence that self-reported disability indicators provide a reasonably trustworthy image of a person's objective health status. Nevertheless, the use of self-reported data for international comparisons is contested by some, who argue that greater stigma is attached to disability in some countries than in others.

The analysis of disability policies in Member States leads to a number of observations. First of all, it is noticeable that most disability programmes have several functions, one of which is early retirement. In some countries, it may be less stigmatising to be out of work for health reasons than due to unemployment. They also provide a tool for managing labour market difficulties, such as downsizing, lay-offs or restructuring. And yet, over the years, studies have shown that people with disabilities often can work and want to work. Not necessarily full-time or on normal terms — they may require some adjustments — but the use of assistive technology has improved the opportunities for many people with disabilities to enter the workforce. The practice of designing policies on the assumption that people with disabilities are not able to work may therefore be erroneous.

Another observation is that, in general, there is a low outflow from people on disability benefits. This is down to a number of reasons. First of all, the level of education plays an important role. Indeed, disability prevalence rates are significantly higher among those with low educational attainment, who are often employed in more physically demanding occupations. What's more, people with disabilities are not always properly included in educational and

training systems. A second issue is age. In many countries, disability benefit awards are highly concentrated among people over the age of 50. In part, this reflects the age pattern of disability prevalence, but there also seems to be an age bias inherent to many integration programmes, with vocational rehabilitation and training predominantly offered to people below the age of 45.

These flaws in the design of disability policies have led to a situation in which working-age people with a disability most often rely on disability benefits or permanent retirement benefits as their most important source of income. Unemployment benefits play a much less important role overall, despite the relatively high non-employment rates in this group.

In light of this situation, studies in this area have come up with a number of recommendations:

- It is necessary to *distinguish between disability status and work and income situation*. The term "disabled" should no longer be equated with "unable to work". Disability should be recognised as a condition but it should be distinct from eligibility for, and receipt of, benefits, just as it should not automatically be treated as an obstacle to work. The disability status, i.e. the medical condition and the resulting work capacity, should be re-assessed at regular intervals.

- It is important to *design individual work/benefit packages*. It is not enough to only care for the financial needs of disabled people through cash benefits, as this will leave many excluded from the labour market and sometimes even from society. Each disabled person should be entitled to a "participation package", adapted to his or her individual needs and capacities. Such packages should contain rehabilitation and vocational training, job-search support and work opportunities within a wide range of employment forms (regular, part-time, subsidised or sheltered).

- *Benefit receipt should in principle be conditional* on participation in employment, vocational rehabilitation and other integration measures.

- *Involving the social partners* is crucial to the successful reintegration of disabled persons. The effectiveness of measures will depend on the willingness of employers to help disabled people stay in or enter work and make the necessary workplace adjustments.

- *Early intervention* is of critical importance.

- There is a need to *reform programme administration* in many countries, as it is often under-coordinated and fragmented.

- *Disability programmes should be designed as active programmes*. Often, disability benefit systems effectively function as early retirement programmes, providing a route for quasi-permanent exit from the labour market. Emphasising activation and the mutual obligations of both society and the disabled person will move disability policy closer to the underlying logic of unemployment programmes, which expect an active contribution and effort from beneficiaries.

If unreformed, disability programmes are likely to attract applicants that find it difficult to comply with the stricter obligations of unemployment schemes. A consistent strategy should be applied to both disability and unemployment policies, with a view to extending the culture of mutual obligations to all labour market programmes.

2. Policy and the situation in the host country — Spain

Spain is at the start of a reform process of its social security system. A major aim is to avoid situations in which people are excluded from the labour market, notably on health grounds. Efforts are being made to encourage both employers and workers to look at people's abilities rather than at their disabilities, and an early warning system has been developed to avoid placing people in occupations that could result in disabilities.

Improved management and cost containment are also important elements of the reform. The Spanish system distinguishes between temporary and permanent work incapacity. For the first twelve months, temporary incapacity status is recognised, on a medical basis, through weekly certification by the doctor treating the person concerned. This raises management issues as incapacity benefits are paid out of the national budget, but the decision that opens the payment is taken by doctors answerable to the 17 autonomous regional healthcare systems. These management complications have resulted in a steep rise in incapacity benefit costs. In 2003–2004, spending by the National Institute of Social Security increased by 14.5%. However, thanks to the adoption of a series of measures to cut costs over the past five years, spending went down by 4.92% between 2007 and 2008.

One important measure involved the creation of multidisciplinary incapacity assessment teams that include medical inspectors working directly for the National Institute. What's more, the Institute has signed assessment agreements with the regional health services, setting annual targets for controlling incapacity benefit payments.

In January 2006, a Regulation was adopted giving the Institute the exclusive authority to determine the status of workers that have been on temporary incapacity for 365 days. The Institute can decide that a worker should resume work, spend up to 180 more days on temporary incapacity benefits, or begin the process of acquiring permanent incapacity status. Among all the workers that reached the 365-day threshold in 2009, the Institute determined that 30% had recovered their capacity to work, 16% were to be reassessed for

permanent incapacity in view of cognitive or physical problems that might be permanent, and 54% were to continue on temporary incapacity benefits for a further 6 months.

In cases of permanent incapacity, the Institute is responsible for determining the degree of incapacity, which in turn defines the benefits payable. The process for obtaining recognition of permanent incapacity can be launched either before or on reaching the 365-day threshold but, by law, it must be initiated by the end of the 18 months period of temporary incapacity at the latest. Following Supreme Court rulings, the only criterion that may now be used when reassessing the degree of permanent incapacity, once established, is whether the impairment has increased or diminished. Job requirements are no longer taken into account.

Another objective of the reform process was to link temporary incapacity benefits to people's recovery process and job needs, rather than to their underlying pathology. Recovery standards are being set for different sectors, taking into account the fact that, for example, an administrative worker who breaks an arm is likely to be vocationally incapacitated for a shorter time than a worker in the construction sector. The Institute can then check whether the length of incapacity matches sectoral norms, based on the diagnostic codes placed on the weekly medical certificates of patients, which are transmitted electronically to the Institute.

Several measures have also been proposed to reduce early exits from the labour force on grounds of incapacity. These include the strengthening of conditions for obtaining benefits; policies for the occupational rehabilitation of beneficiaries; multidisciplinary training programmes to encourage re-adaptation, especially for people with lower skills levels; job-search training; and incentives for companies to hire people with permanent incapacities.

The Spanish reform process could learn from previous Peer Reviews in Finland (active ageing strategies to strengthen social inclusion, 2007) and Sweden (integrated services in rehabilitation: coordination of organisation and financing, 2006).

3. Policy and the situation in the Peer countries

All the Peer countries present during the Review face similar problems to the ones presented by Spain. The issues of restricting the inflow to permanent disability schemes and of designing active measures to motivate disability benefit recipients to take up work are however addressed in different ways and rely on various measures. This was reflected in the discussions among the Peer countries.[3]

In **France**, several benefits are available to adults of working age faced with disabilities. These may be connected with working life (invalidity pensions, pensions for employment injuries and occupational diseases) or not (allowance for disabled adults). On the other hand, measures to support integration or reintegration into employment cover all people with disabilities, whether in or out of work. The two most important categories of benefits are the invalidity pension, which is provided for by social security legislation, and the allowance for disabled adults (AAH), which falls under the legislation on social assistance and action. About 0.6 million people currently receive invalidity pensions, while almost 850,000 people receive the allowance for disabled adults.

The aim of invalidity pensions is to provide a replacement income to workers whose capacity for work has been reduced by at least 66%. Pensions are granted by the sickness insurance fund after the degree of invalidity has been assessed by a medical officer from the social security fund. The size of the pensions varies according to the residual working or earning capacity.

The allowance for adults with disabilities (AAH) seeks to provide a minimum income to persons suffering from a permanent incapacity of at least 80% and, under certain conditions, of between 50 and 80%. Permanent incapacity is assessed by the Commission for Rights and Autonomy of People with Disabilities (CDAPH). The AAH is a supplementary, non-contributory social minimum income that is means-tested and financed from the State budget through the family allowance fund.

3 For more information on the countries' situations see the respective comments papers for this Peer Review, published at: http://www.Peer-review-social-inclusion.eu/Peer-reviews/2009/modernising-and-activating-measures-relating-to-work-incapacity

Both the invalidity pension and the allowance for disabled adults are granted on a temporary basis, and may be revised under quite strict assessment and review conditions. Recipients of invalidity pensions are, on average, rather old (the average age for first receiving an invalidity pension is 52 years) and suffering from serious illnesses.

Whichever the category of financial compensation applicable to their disability, disabled people also have access to a range of general and specialised support mechanisms. Jobseekers with disabilities are supported in their search by the general employment service (Pôle Emploi) and by the Cap Emploi, a specialist placement network for workers with disabilities. Specific support measures are financed by the State.

For those people who wish, and are able, to do so, it is possible to combine invalidity or disability benefits with a job: currently around 20 % of invalidity pension recipients and AAH beneficiaries have a job (8 % in normal employment and 12 % in sheltered employment). What's more, French employment legislation imposes an employment obligation on employers so that each company with more than 20 employees is bound to employ persons recognised as "workers with disabilities" as 6% of the workforce.

Lithuania has passed a number of major reforms in the field of social integration policy for the disabled. A new Law on Social Integration of the Disabled entered into force in 2005.

The Law sets the country's model of social integration for the disabled closer to the models of other EU Member States, with a legal enforcement of equal rights and opportunities for the disabled in society. It introduces new systems for assessing disability and working capacity levels, with a greater focus on working capacity than in the previously used invalidity assessment tests.

The assessment of disability and working capacity levels is conducted by the Disability and Working Capacity Assessment Authority at the Ministry of Social Security and Labour. The working capacity of an individual is defined as a percentage, in 5 per cent increments. For example, if an individual is

assessed to be of 0–25% working capacity, he/she is considered incapable of work.

The Law also regulates access to vocational rehabilitation schemes. Once the Assessment Authority has confirmed an individual's need for vocational rehabilitation, the person in question will have to apply to the Local Labour Exchange Office in their place of residence, which will in turn issue a reference for the institution providing vocational rehabilitation services. An individually tailored vocational rehabilitation programme is then elaborated for the individual and the scheduled services are provided. Once the vocational rehabilitation programme is completed, the person returns to the Disability and Working Capacity Assessment Authority for a final assessment of his/her working capacity level. Persons participating in such a vocational rehabilitation programme receive a vocational rehabilitation benefit.

The most common type of social security for disability is the State social insurance pension for work incapacity (known as the "disability pension" until 1 July 2005). Pensions for work incapacity are paid to individuals who, on the day their work incapacity level is established, have been insured under the state social insurance for pensions for a minimum period.

Since 2004, the Government has undertaken efforts to link social assistance benefits to participation in active labour market programmes. These programmes mainly target the long-term unemployed. Two main laws — the Law on Employment Promotion and the Law on Social enterprises — have been implemented with a view to integrating the most vulnerable groups of persons into the labour market. The laws provide for subsidised employment and support to employers who create new jobs and hire unemployed disabled persons under open-ended contracts or who adapt existing workplaces to the disability needs of the unemployed person.

Luxembourg provides two types of disability-related benefits: sickness cash benefits and disability benefits.

Sickness cash benefits provide insured persons with the full wage that they would have earned if they had continued to work, for a period of up to 52 weeks. Payments end if a disability pension is granted, if the individual is

re-directed towards another benefit scheme, or in the case of a failure to comply with control measures. To improve the follow-up of people presenting long-term sickness episodes, the assessment procedure requires a detailed medical report on the health condition, at the latest for the tenth week of absence from work over a twenty week period. Failing this, the sickness leave allowance is not granted any more.

Disability pensions are calculated in the same way as retirement pensions, with a basic component and an earnings-related component, which can be artificially augmented in the case of disability before the age of 55. Eligible beneficiaries consist of individuals who, as a result of prolonged disease or infirmity, have suffered a reduction in working capacity that prevents them from exercising the profession which they exercised most recently or another activity corresponding to their strengths and skills.

Special procedures have been elaborated for assessing disability benefit claims. These include compulsory medical assessments and examinations, benefit decision-making, retesting of disability benefit entitlements and the possibility of disability-related benefit suspension and work incentives. Indeed, the worker must remain available for employment, and the allowance is only payable for as long as appropriate work has not been found for the recipient.

As of 2002, new laws designed, on the one hand, to speed up the prescribed procedures in the realm of social security by coordinating them with rules safeguarding the right to work and, on the other hand, to supplement the protective mechanism with occupational-reintegration measures for workers unfit to resume their previous duties, were implemented.

In 2008 the General Inspectorate of Social Security (IGSS) conducted an evaluation of existing measures for the professional reintegration of people with reduced work capacity. The major conclusions of the evaluation process related to the need to strengthen internal redeployment processes, to carry out periodic revaluations of the degree of impairment, to standardise work capacity evaluations and to improve policies aimed at preventing disabilities.

In the early 1990s, public spending on sickness and disability benefits in **Poland** was significant, largely due to the difficult labour market situation and high rates of unemployment. Disability pensions were perceived as an alternative to unemployment benefits and many people applied for them. In order to improve control over health-related expenditure, Poland undertook a series of reforms towards the end of the 1990s. These reforms were characterised by attempts to tighten the entitlement conditions for benefits, while also strengthening the focus on return to the labour market. Introduced in 1997, the reforms resulted in very rapid decline in the benefit inflow rate — of more than 50% in over just 6 years. The outflow rate from disability benefits also declined significantly, halving the number of pensioners over 10 years.

However, the vocational rehabilitation schemes were not successful. This was largely related to supply-side constraints, as few suitable programmes were offered by labour offices. In addition, the voluntary nature of these programmes has resulted in few people being interested in participating. The system of vocational rehabilitation thus needs to be strengthened so as to supply high-quality services according to a more individualised approach. Some elements of obligation should also be introduced, e.g. in the form of moderate benefit reductions for people refusing to participate in vocational rehabilitation. Moreover, stronger incentives for permanent education should be provided, flexible forms of work should be promoted, and limits on disabled people's earnings should be abolished as they discourage people from returning to work.

In 2004, the harmonisation of **Romania's** legislation with EU law led to development of rules on professional and vocational evaluation for persons with disabilities. Romanian legislation takes a rights-based approach to the social integration and inclusion of persons with disabilities. The main normative act regulating the rights of persons with disabilities, as well as the method of evaluation, is Law 448/2006 regarding the protection and promotion of the rights of persons with disabilities.

The definition of disability that is incorporated into Law 448/2006 is based on the WHO International Classification of Functioning, Health and Disability.

Social benefits for adults with disability are granted upon request or ex officio, as the case may be, based on documentary evidence.

According to the law, the Commission for the Evaluation of Disabled Adults is responsible for determining the degree of disability and for granting certificates of disability that open the door to a number of rights and benefits, including professional information and counselling services, labour mediation and professional training, provided by the territorial agencies for employment or other authorised services. The Commission for the Evaluation of Disabled Adults may decide that classification within a disability degree is permanent or that it should be re-evaluated annually, according to the situation.

Romania has set up various schemes aimed at facilitating the integration of people with disabilities into the labour market. These include quota systems, financial support for people with disabilities, fiscal advantages for employers, etc. A project entitled "Equal opportunities on the labour market", sponsored by the European Social Fund, was launched in 2008 to address the situation of people with disabilities. The project will run until April 2011 and concentrate on developing vocational rehabilitation services for persons with disabilities in order to facilitate their integration into the labour market.

In **Sweden**, the severe economic downturn in the early 1990s marked a turning point in disability policy. Unemployment rates jumped from below 2% in the late 1980s to 8–10% and remained at that level until 1998. The number of people on sickness and disability benefits also increased significantly at the time, so that more than 20% of the working-age population were in fact on social insurance benefits — compared to around 10% during the 1970s and 1980s. And, as sickness leave offered the main pathway into disability benefits, increasing levels of long-term sickness absence gradually translated into increasing levels of disability beneficiaries. In fact, the annual inflow onto disability benefits more than doubled between 1998 and 2004. As a consequence, the share of working-age population living off either sickness or disability benefits peaked at 14% in 2004 — the highest level in the whole of the OECD.

Several reforms were implemented to handle this situation: the Social Insurance Administration went through a comprehensive reorganisation; a new "sick-listing" process was introduced to reduce the inflow into long-term sickness benefits; the gateway into disability benefits was tightened to reduce the inflow onto these benefits; measures to encourage employers to hire people with a reduced work capacity were introduced; and rehabilitation measures were improved.

At the beginning of the 1980s, sickness and disability rates in the **Netherlands** rose exponentially to become the highest in the world (the "Dutch Disease"). At the same time, the country was experiencing a deep economic crisis. This marked the start of a long reform process, which seems to be paying off, although it is still ongoing.

The most important changes in the field of sickness and disability in the past 10–15 years include:

- Privatisation of sickness schemes so that employers are obliged to pay for sickness benefits for two years. Initially, employers were only required to pay benefits for two weeks in the case of small companies, and six weeks for larger employers. This was later increased to one year, and then to two years in 2005. In monetary terms, the difference between one or two years is small, as few people are on sick leave for more than a year. But the increase allows more time for reintegration, while encouraging employers to avoid long-term sick leave.

- Option for employers to opt out of the disability scheme if they take up a private insurance that enables them to cover the risk of paying up to 12 years' worth of salary in incapacity benefits. About 20% of companies have chosen to do so.

- Strong reintegration incentives: Employers are responsible for the reintegration of sick employees, under the "Gatekeeper law", which can lead to fines on employers who do not make any reintegration efforts during the first two years. Also, benefit-receiving employees who make no reintegration efforts during the two-year period are subject to dismissal.

- Adoption of the New Disability Act (WIA), introducing a risk-rated disability system that distinguishes between three categories of disability: full permanent disability, partial disability and temporary disability.

- Strong incentives for employees to use their remaining work capacity: For example, a 50% incapacity initially gives an entitlement to 50% of the benefit, but if the person does not seek 50% employment, the benefit will be sharply reduced.

- Experience rating in the social contributions of employers;

- Stricter eligibility conditions for benefits;

- Reassessment of disability benefit claimants under the age of 50;

- More focus on reintegration instruments (mostly by private companies). Many reintegration services have been privatised, and the service providers receive a bonus if the reintegration is successful. The methods are not prescribed. They are paid by results.

The strong social partnership in the Netherlands had helped to put this system into place. The reforms have not led to the medical screening of potential employees prior to hiring, as this practice was outlawed when the reforms were brought in. If older people (aged 50–55) enter an employer's workforce, the employer receives additional compensation. If the employer hires a person with disabilities, a special "no-risk policy" means that the government — rather than the employer — pays any subsequent sickness or incapacity benefits for that person.

As a result of this comprehensive reform process, the new inflow into disability benefits has gone down from 100,000 in 2000 to roughly 35,000 for the past three years. Furthermore, a larger number of persons have been reassessed and are using their remaining work capacity.

The **UK** has radically changed its benefits system recently. In October 2008, UK incapacity benefits were replaced by an "Employment and Support Allowance" for all new customers. Those words were carefully chosen.

The number of incapacity benefit recipients had rocketed in the 1980s and 1990s, peaking at just under 2.8 million out of a working-age population of about 35.5 million in November 2003. Currently, around 2.6 million receive incapacity-related benefits, but some people on jobseekers' allowances and lone parent benefits also have health conditions or a disability. A key element of the new benefit programme is the introduction of a new, more accurate, medical assessment — the Work Capability Assessment, which includes a work-focused health-related assessment, carried out by independent healthcare professionals. During the assessment period, the sum received by applicants will be exactly the same as the basic unemployment benefit.

The aim of the assessment is to identify what people can do — not only what they cannot — in order to provide them with the most appropriate support. Individuals will either be assessed as:

- being "fit for work", in which case they go on to the normal unemployment benefit;
- having a "limited capability for work", in which case they receive a higher rate of benefit than the normal unemployment benefit and are mandated to engage with pathways aimed at getting back into work-related activities;
- having a "limited capability for work-related activity", in which case they receive a higher rate of benefit entitlement overall and are exempted from mandatory participation in back-to-work activities, although they may choose to take up the assistance and support on offer if they wish.

The plan is to transfer all existing incapacity benefits customers to the Employment and Support Allowance scheme as of October 2010. The first statistics on the work capability assessment scheme were published in October 2009. Of those claiming benefits, around 38% were found fit for work, 11% were in the "work-related activity" group, and further 5% were in the "support" group for people with severe disabilities. Most of the others had come off the benefit within the 14-week assessment period. Special

arrangements exist for those who have genuine difficulties in attending the assessment or are intellectually incapable of understanding the system.

A wide range of Active Labour Market Policies, specifically designed for disabled people and those with health problems, are on offer in the UK. The most important programmes are: "Pathways to Work" — a back-to-work programme available to all customers claiming incapacity benefits — "Work Preparation" — a series of short courses (generally over six weeks) delivered by the public, private and voluntary sectors to help disabled people with complex barriers prepare for employment by building their confidence, identifying suitable types of work, offering work experience and providing support — and "WORKSTEP" — a programme that delivers mainstream jobs (around 2,500 people are in Supported Businesses) and encourages individuals to progress to 'open' unsupported employment where appropriate. As of October 2010, the WORKSTEP and Work Preparation programmes will be replaced with a single scheme called "Work Choice".

4. European stakeholders' contributions

The European Platform for Rehabilitation' (EPR) — a network of leading European providers of rehabilitation services to people with disabilities and other disadvantaged groups — stressed the need for a broad range of services to help disabled people enter into or return to work. In terms of delivery modes, a distinction can be made between generic mainstream services, specialised and customised services for people with disabilities, and a combination of these, which can be qualified as "inclusive mainstream services".

Improving workability for elderly workers — who are more at risk of disability — is key, and the focus should first of all be on the work itself, rather than on the person, through improving workloads and the work environment. Only as a second and third step, should the accent be on optimising the work community and organisation, improving the functional capacity of elderly workers and promoting their professional skills.

According to the EPR, the following typology of activation measures should be available to people with disabilities:

- *Social orientation addressing people with disabilities*, focussing mainly on the individual needs and capacities of those concerned (e.g. vocational services, allowances to compensate for the extra expense of being disabled, etc.);
- *Social orientation addressing employers*, including obligations and incentives;
- *Economic orientation addressing people with disabilities*, aimed at ensuring the financial sustainability of social protection systems (e.g. tightening of assessment thresholds, introduction of obligations to participate work-related activities or rehabilitation, flexible employment schemes, combination of benefits and work income, trial periods and possibility to fall back on benefits without having to go through the whole procedure again, avoidance of benefit trap);

Economic orientation addressing employers (e.g. grants to compensate lower productivity and costs, legal quotas for the employment of people with disabilities).

AGE — the European Older People's Platform — addressed three main questions:

- *How can the main inflow paths to disability be handled in such a way that legitimate claimants and those in need are not rejected?* Support measures should be implemented to help older workers on long sick leave back into jobs adapted to their capacities, but not to force them into poor-quality jobs. Information on entitlements needs to be improved through one-stop shops.

- *How can conditions for older workers be improved in such a way that they motivate and enable the workers to stay longer in employment?* More emphasis should be placed on retraining and skills updating, improved workplace health and safety standards, adaptive ergonomics, better age management, and employment policies that take a life-cycle, age-neutral approach to work. To raise the employment rate of older workers, employment contracts need to be more flexible, and intergenerational mentoring should be encouraged.

- *Which additional aspects of prevention besides training, education and accommodation/improvement of working conditions should be taken into consideration in the design of integration measures?* The main aim of active ageing policies should be to make the labour market age-neutral or age-friendly. Training for employment offices and counsellors on this would be useful. Closer cooperation is needed between the employment, social affairs and health sectors. Trade unions and a substantial number of older people will have to be convinced of the need to extend working lives, and attitudes among potential employers will need to be changed.

5. Discussions at the Peer Review meeting

Discussions during the meeting highlighted a number of general and more specific issues.

Varying definitions and measurements of disability

Overall, it was agreed that sickness and health are not absolutes: There are degrees of incapacity, and systems need to recognise this. However, the difficulties relating to the definition and measurement of disability were underscored by participants. Indeed, disability is a fluid concept and people who, ten or twenty years ago, would have been regarded as normal are now considered to be mentally disabled. Subjective measurements of disability were thus considered particularly problematic. While self-reporting may have a role nationally, it does not produce reliable international comparisons. The EPR pointed to a study that showed that, when people in Finland were asked whether they were disabled, about 33% said that they are, whereas in Malta the corresponding figure was 7–8%. Also, in the Netherlands, for instance, 50% of those currently on the benefits system for very disabled persons do not feel disabled. They feel that they could work. Another statistical problem is that, in most countries, people are not officially recognised as disabled unless they are receiving disability benefits. To address this problem, the EPR advocated using the culturally neutral ICF concept (International Classification of Functioning, Disability and Health) developed by the World Health Organisation, although it acknowledged that this would require a very broad policy discussion.

In recent years, the steep rise in disability claimants across the EU has led to a tightening of eligibility criteria in most countries. In 1996, Luxembourg's Social Security Court ruled that, in order to receive the disability pension, a person must be fully incapable of work. This legal decision produced a steep decrease in benefits payments, but it caused problems for some people on long-term sick leave, who then received nothing other than social assistance. These legal provisions were partially reformed in 2002, but this led to much more complicated structures, and streamlining measures are now planned.

The Dutch experience also shows that if access to disability benefits is reduced, people will simply move over to other parts of the social security system. Reforms must therefore ensure they do not just shift people from one benefits scheme to another and this requires an integrated approach.

Providing the right mix

It was stressed that a shift is required from income replacement benefits alone to a mix of services and allowances in order to best compensate for the extra cost of being disabled, while encouraging labour-market participation. Studies show that overall employment levels of people with disabilities have remained low, despite all the efforts at the European and national levels, and despite the fact that many people with disabilities want to work. Combining employment measures and benefits is certainly a worthwhile aim, as it helps people back into working life.

The link between ill-health and employment is being emphasised more and more in EU policy documents. The first key document dates back to the 2003 preparations for a European Summit on the link between the ageing of the workforce and the decrease in employment rates, in which a great emphasis was placed on the health problems faced by older workers. Since then, a series of Commission and Council reports have highlighted poor health as an important barrier to employment and economic growth. The consultations in 2006 and 2007 on the active inclusion of those furthest away from the labour market and the subsequent Commission Recommendation on this issue, which was endorsed by the Council in December 2008, are initiatives of key relevance in this context. These documents were elaborated not only by the Directorates-General in charge of employment, but also by those dealing with the economy and public health.

In light of these developments, Peer Reviewers noted that the discussion should not focus on disability alone, but should be considered in light of the broader issue of the non-inclusiveness of labour markets, taking into account the EU's recommendations on active inclusion. These have three components, namely: income, provision of quality social services and employment guidance. The questions that need to be asked are: "How do we

put ill-health on the agenda of the employment services, and how do we put return to work on the agenda of the health services?"

Getting employers involved

As most disabilities are developed during the course of working life, it was argued that the workplace and employers play an important role in addressing the link between employment and ill-health.

There are numerous opportunities to prevent poorer health and to retain workers in employment during their working life. Yet, in many countries, the role of employers has been neglected and, where support is available for employers, it is often difficult to access it. As a result, there is a tendency for service providers to bridge the gap. Seeing as most employers in Europe are small and medium-sized enterprises (SMEs), intermediaries do have an important role to play. Nevertheless, reviewers stressed the need to think carefully about the opportunities that have been missed to involve workplace professionals and, in particular, their human resource managers and occupational health professionals, in retention, reorientation and return to work.

The Dutch reforms are based on the very premise that the employer is the person who can most effectively help an employee to get back to work and employers have thus been given the responsibility of paying for the benefit. The idea is that employers therefore not only need financial incentives to hire people with disabilities, they should also be financially penalised for not taking on their responsibilities. This shift in the burden of risk from the State to the level at which the risk can best be influenced has also produced a decrease in inflow rates and hence, longer-term, in the number of people on benefits. It was asked if the financial responsibilisation of employers, as aimed at in the Dutch reforms, might not be reduced if the employers can take out private insurance to cover their benefits payment risks, but it seems that this problem is unlikely to arise, as the insurance company will press the employer to reintegrate the person concerned as soon as possible.

Although the key elements of good practice in age and disability management are relatively well understood throughout the EU, they are inconsistently applied. While companies do now pay more attention to the promotion of health and well-being, little attention continues to be paid to the specific needs of certain groups within the workforce, such as lower-skilled workers or women.

What's more, according to Eurofound studies on preventive measures in the workplace and the European Working Conditions Survey (available on the Eurofound website http://www.eurofound.europa.eu), active disability management and rehabilitation measures are still a rare phenomenon among the companies surveyed in Europe. Few companies take active steps to bring people back to work after long-term sickness.

Addressing the absence of positive attitudes among health professionals and employers, as well as the low expectations among workers and the lack of appropriate resources in many workplaces, will be essential. Coordinated and focused system responses are needed, not only from public authorities, but also from and within both companies and community services. Indeed, it was mentioned that getting employers with positive attitudes to talk to other employers is much more effective than diktats from central government. In the UK, a forum for inter-employer dialogue has been set up.

The psychological environment prevalent in the workplace was underscored as playing an important part. Many people leave work due to psychological factors such as stress, permanent reorganisation, monotonous tasks and a lack of autonomy. Most exits from the labour market do not happen suddenly. The warning signs often appear much earlier (disputes with bosses, repeated cycles of employment followed by unemployment etc.) and earlier intervention may prevent a later recourse to incapacity benefits. Employers should take into account health issues and ageing when defining their human resource strategies. This will help to solve the problem of early retirement, as well as the integration of people with mental disabilities into the workplace. Such an approach would mean looking at what people can do rather than what they cannot do. It would also mean anticipating the ageing phenomenon by planning for greater mobility between tasks during the employment period, in order to avoid disability later on. Similarly, the

development of flexible working times would benefit all workers. Human resource strategies should give more weight to qualitative targets and performance assessments, rather than just quantitative ones. Managers need to be trained and coached about relations with older or disabled employees, and the managers should be encouraged to express their psychological difficulties about dealing with these populations. There should also be a reflection surrounding wage policies and their suitability in promoting greater flexibility and in countering the argument that employers cannot afford to employ older people and people with disabilities.

Promoting reintegration

Peer Reviewers pointed out that the issue of reintegration has been overly neglected. New European data on this topic is urgently needed.

Reforms are currently focused on giving people a trial period in employment. Efforts are also being made to make employment more flexible, notably by reducing work times. And medical assessments are being oriented more towards what a person is capable of doing, where applicable. Nevertheless, more consideration should be given to issues such as motivation, employer attitudes and capacities, economic factors and system factors, but also the way services are delivered both to the benefits recipients and to employers.

The UK has recently introduced a guarantee that anyone going back into work will be better off by at least £40 a week. The policy will not cost much as that is already the case for most people returning to work. A new initiative that it is expected to be rolled out in 2011 would involve paying the employment providers a portion of the savings made by the State when people re-enter the workforce. This however entails modelling the "deadweight" (the proportion of claimants who would in any case have found work) in advance and building it into the contracts with the providers, so it is quite a high-risk strategy.

With regard to the retention and reintegration of older workers in employment, it was pointed out that the Finnish system might provide a good example in terms of promoting working capacity and skills, as well as of matching

human resource policies to them — notably as regards reconciling work and non-work responsibilities, such as caring for ailing spouses or parents.

A further discussion point related to the decline in the number of low-skilled, low-paid jobs available in Europe, and the possible impact of this phenomenon on the employment of people with disabilities. It was however generally agreed that a return to low-quality jobs would be neither a feasible nor a desirable solution. Rather, there is a need to ensure that people with disabilities acquire up-to-date skills.

Also, reintegration may not always entail a return to salaried employment. There may be a case for supporting efforts by partially incapacitated people to become self-employed. Indeed, this would be one way of bringing benefits recipients out of the black economy.

The rise in mental health problems

The OECD estimates that, today, roughly 30–45% of the new inflow into disability benefits is composed of people with mental health problems. This raises the question of whether our disability schemes and activation measures are suitably designed for them.

This population is also younger and predominantly female, whereas the previous population of benefit recipients was more likely to be older and male. Indeed, an increase in the proportion of women on incapacity benefits has been noted but most Peer countries do not intend to take gender-specific measures in this field. Many of these younger recipients become dependent on long-term benefits, effectively removing them from the labour force.

The OECD estimates that employment rates among people with mental health problems are generally less than half those of people with other health problems. Recent German data also shows a rapid increase in early exits for reasons of mental ill-health. Employer reluctance and the general employment situation account for some of the rise in unemployment on mental ill-health grounds, but so do improvements in diagnosis, changes in

eligibility rules and the tendency of government policies to concentrate on the elderly, rather than on the problems of young people with disabilities.

Lastly, it was pointed out that it is not only those people receiving incapacity benefits that are suffering a disadvantage in the labour market, but also some of those caring for them.

Setting priorities

A particular dilemma in future policymaking in many of the Peer countries will be whether to focus on getting the fastest and least expensive results or to concentrate on the more difficult, and therefore more costly, cases, thereby achieving greater long-term benefits.

One approach being considered in the UK is the use of incremental payments for providers of reinsertion opportunities. These would, for example, receive more per head for the second hundred people placed than for the first hundred. This would serve as an inducement to tackle the more difficult cases. Another idea is to take more account of motivation when measuring a person's distance from the labour market. Furthermore, a programme called "Access to Work" helps to fund workplace adaptation measures that are considered over and above what could be reasonably expected of the employer. Consideration is being given to using part of this fund to hold open jobs for people with fluctuating conditions, for example by hiring agency workers to replace them temporarily when needed.

Stakeholder consultation

Last but not least, many speakers stressed the importance of broad consultation with stakeholders when planning reforms — notably with disabled people's organisations and the social partners.

6. Conclusions and lessons learned

The question of inflow management was a major issue in Peer Review discussions: How do we design systems in such a way as to motivate benefits recipients to seek work?

One important factor relates to the level of benefits compared to wages. Periodic reassessments of individuals are also essential as the degree of incapacity may change over time and reformed schemes tend to be increasingly oriented towards temporary benefit entitlement.

It is also important to distinguish between health and employment problems, and to decide which to focus on. Incapacity schemes sometimes confuse the two. Systems should be designed to take into account variables such as the increase in the number of young incapacitated people, the growing importance of mental health problems among the grounds for incapacity, and the gender dimension, as women with impairments may face particular difficulty in re-entering the labour market.

Flexibility is considered an important design principle for schemes. Integrated approaches and one-stop shop models were among the models discussed and it was particularly underscored that approaches need to be personalised: one size does not fit all. In many countries, rehabilitation structures are quite fragmented and require better coordination.

The Dutch model, with its new system of risk-sharing, aroused strong interest. It was nevertheless pointed out that if too much of a burden is placed on the employers, they will pull out and it will become even more difficult to get people back into the labour market. The Dutch example also highlighted the fact that reforms take time — 25 years, in the Dutch case.

Another issue is the question of prioritisation: Who should schemes address first and foremost, those who are easiest and cheapest to get back into work, or the more difficult cases that will entail greater expense? When moving people into jobs, what kind of jobs are we talking about: Quality jobs or low-skilled ones? What consideration should be given to the skills match?

Should temporary, part-time or flexible work be considered legitimate? And what about informal or unpaid work?

Lately, there have been a number of paradigm shifts in the provision of incapacity benefits — from medical to social models; from public programming to market-based solutions; and perhaps also from "train-place" approaches (in which people first receive training before it is attempted to place them on the labour market) to "place-train" approaches (implying on-the-job training). So far, Norway's experience of "place-train" has been quite positive.

In more or less all EU countries, a noticeable trend is the shift from looking at people's incapacities to focusing instead on what they *can* do.

The involvement of employers is essential, and effective incentives are needed to change their behaviour to hiring disabled people. In some cases, assistance will be required to make the necessary changes in the workplace, especially in the case of employers who do not have previous experience of dealing with people with disabilities. This may entail specialised personnel. There are now training and certification schemes for disability managers and back-to-work managers. But smaller employers will have fewer resources and may need a different approach. In any case, if too much of the responsibility is assigned to the employers, they may become reluctant to employ people with potential future problems and medical screening may become an issue. False perceptions relating to incapacitated people among employers need to be tackled. Awareness campaigns like those in the UK and the Netherlands are one way of achieving this. Skills upgrades are needed for service providers and for others who may be involved in the return to work, such as occupational health personnel.

The Peer Review revealed that there is a great deal of knowledge relating to good practices that work. However, good practices tend to come with a "best before" date. They need to be used fairly fast. The key question is thus how to translate what is already known into action. This will require the involvement of the social partners, possibly through tripartite models. Also, action learning structures might provide an efficient means of obtaining the necessary commitment from stakeholder groups.

The key lessons that emerged from this Peer Review include:

- The focus should be on people's **capabilities** rather than on what they cannot do. This principle should be borne in mind at a time when most EU Member States are reflecting on how to modernise their social protection systems.

- **Personalised approaches** to the management of incapacity are needed. One size does not fit all. This should be combined with appropriate coordination between the services and other actors involved.

- **Stepping-stones** from incapacity to employment may include the social economy, possibilities for combining work with benefits, and trial periods with fall-back provisions.

- **Job carving** (adjusting the workplace and the content of the job to the individual) can help to remove obstacles to employment.

- **Prevention**, by reducing occupational accidents and illnesses and heading off potential causes of unemployment, can help to tackle incapacity at source.

- **Inflow management** is a major issue and systems need to be designed in such a way as to motivate benefits recipients to seek work. Key factors here include the level of benefits compared to wages and the periodic assessment of incapacity levels. In the Spanish case, the tax-exempt status of incapacity benefits may encourage people to seek them rather than waiting for their retirement pensions, which are taxable.

- **The nature of incapacity is changing**. In OECD countries, mental health problems are the fastest-growing reason for incapacity claims. The share of incapacitated young workers is also increasing, as is the proportion of women with disabilities out of work. A particular gender issue relates to the problems faced by female carers with

impairments who seek to rejoin the labour force. Policies should take account of all these aspects.

- **Participation by social partners** in the planning and implementation of reform should be ensured, possibly through tripartite structures.

- **Employer involvement** is essential. Effective incentives are needed to change employers' attitudes to disability and encourage them to hire and retain incapacitated workers. Some employers may also require assistance to make the necessary changes in the workplace, especially smaller employers (SMEs), who currently provide the majority of employment in Europe.

- While the emergence of private service providers for the rehabilitation and job placement of incapacitated people can bring benefits, there is a need to **prevent "cherry-picking"** — a concentration on the easiest and cheapest placement cases rather than on those in greatest need of help.

- **Governance aspects**, such as increased involvement of relevant stakeholders, emerge as vital to raise awareness, to foster a shared understanding of what reforms aim to achieve, and to address misperceptions and attitudes blocking progress. More attention needs to be given to monitoring and evaluating the impact and effectiveness of reforms.

- **Active inclusion strategies** are particularly relevant to the incapacity debate, as they aim both to reach the people who are furthest from the labour market and to fight poverty. A good job is the best safeguard against poverty and exclusion. The EU will pursue this approach through its social Open Method of Coordination (OMC) and the European Employment Strategy.

http://www.peer-review-social-inclusion.eu

Modernising and activating measures relating to work incapacity

Host country: **Spain**

Peer countries: **France, Lithuania, Luxembourg, Malta, Poland, Romania, Sweden, The Netherlands, United Kingdom**

As Spain embarks on a review of some of its social security policies, the issue of social protection for people suffering from sickness or disability has emerged as an important theme.

Many Member States have addressed the same issue in recent years but it remains firmly on the policy agenda. Efforts to reform incapacity schemes, therefore, are still concerned to find the best means of defining permanent incapacity or incapacity for work, of preventing abuse and the costs associated with this and of designing activation measures to help people with disabilities into employment. On the one hand, it is important to ensure that people who really need income and other support are able to receive it; on the other hand, it is equally important that those who are able to work are not forced into an early exit from the labour market. Moreover, the current economic crisis adds a new dimension to consider.

The Peer Review will provide a valuable opportunity to share recent national experience in this area and to assess the outcomes of some of the policies that have been implemented.