



Spain 2010

Peer Review: Modernising and activating measures relating to work incapacity

Minutes



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



Peer Review: Modernising and activating measures relating to work incapacity Madrid, 4-5 February 2010

The Peer Review was hosted by the Ministry of Labour and Immigration, Spain.

Day 1

Welcome addresses

Octavio José Granado Martínez (Secretary of State for Social Security, Spain) said that Spain is at the beginning of a reform process in its social security system. The Spanish tradition is for such changes to be made by consensus among the political parties and the social partners. This has the advantage of producing comprehensive reforms, which modify cultural attitudes as well as legal and regulatory provisions. One of the most important current attitudinal tasks is to get across the idea that the social security system needs to achieve the long-term stability that comes through having more people working. Work is an economic good, but it is a scarce good which needs to be distributed. Getting more people into work helps to create a growth cycle. Excluding people from the labour market, notably on health grounds, creates more disadvantage. Spain is beginning to develop measures that avoid such exclusion. Efforts are being made to convince both employers and workers to look at people's abilities rather than their disabilities. Workplaces and attitudes that exclude people unfairly need to be changed. An early warning system has been developed to avoid employing people in occupations that could lead to future disabilities. Incentives are being created for people to change jobs if they contract either a general illness or an occupational illness. Spain is clearly committed now to achieving arrangements that include people with disabilities in the workplace rather than excluding them from it. The social security system bases the incapacity benefits on the jobs that people had before they were incapacitated. Fifty years ago, this provided reasonable security to most workers, who stayed in the same job throughout their working lives. But nowadays, what is someone's "usual" job? Is it the one they were originally trained for? Is it the one that they have spent the most years doing? Is it the job that led to their incapacity? Or is it the job that they had at the moment when they were granted incapacity benefit and excluded from the workplace? Across Europe, the various social security systems take different lines on this. Given the ageing of the population, ensuring the sustainability of the pensions system is a real challenge. So the Spanish government believes that an in-depth review of the "usual occupation" concept is needed. It is committed to looking at a benefits system that gets people into work or allows them to continue in their jobs, rather than taking them out of the labour market. Most European countries have made a start on this. The present Peer Review is an important means of sharing experience and best practice. The Spanish government will read its conclusions with great interest.

Katarina Lindahl (European Commission, DG Employment, Social Affairs and Equal Opportunities) confirmed that mutual learning is the aim of the Peer Reviews, which have been running for six years now in support of the European strategy for social protection and social inclusion. The wealth of experience drawn from some sixty such reviews has been made widely available on a dedicated website (www.peer-review-social-inclusion.eu). The reviews aim, within the framework of the Open Method of Coordination (OMC), to:

- contribute to a better understanding of Member States' policies as set out in the national strategic reports on social protection and social inclusion and, crucially, of those policies' impact
- improve the efficiency and effectiveness of the policies and of the broader strategies by learning from Member States' experiences
- facilitate the transfer of key components of policies or institutional arrangements that have proved effective.

Several evaluations have shown that Member States generally place particular emphasis on the mutual learning aspects of the OMC, as possibly its most prominent added value. The Peer Reviews are appreciated as its main mutual learning element, and the Commission wishes to further enhance this instrument.

The issue to be tackled by the present Peer Review is rendered more complex by the social dimension and the need to ensure that the baby is not thrown out with the bath water. In preparing reforms, strong consultation and involvement are needed. The impact of the current crisis makes this exercise all the more difficult. Against this backdrop, she was sure that this Review, would turn out particularly fruitful and useful.

General introduction/main issues

Dolores Santa María Ruiz (National Institute of Social Security, Spain) explained that Spain distinguishes between two kinds of incapacity: temporary and permanent. Each is regulated separately by the social security laws, but in almost every case, permanent incapacity is preceded by temporary incapacity. Temporary incapacity is defined in the Spanish Social Security Law as the situation in which the worker finds himself or herself while receiving medical treatment and being unable to work. This raises a management difficulty, as healthcare is the responsibility of Spain's 17 autonomous communities or self-governing regions. However, the incapacity benefits are provided by the State - specifically the Ministry of Labour and Immigration. So her institute, together with the work-related accident insurance mutual funds and the non-profit employer organisations which cooperate with the social security system, deals with the management of these benefits. There is a need for the benefits authorities in the various regions to decide at which point workers on temporary incapacity benefits should either go back to their jobs, having recovered their ability to work, or should be put on permanent incapacity benefit, which is managed exclusively by her institute. A second difficulty is that in 80% of cases, the benefits are paid directly by the employers, who are then able to set these amounts off against their social security payments. So why is it that in Spain, which has 6 million cases of temporary incapacity per year, with more than 25 million communications among the different regional administrations and the national social security administration, it is the doctors who have to certify that the worker is unfit for work? The doctors from the health services of the autonomous communities are also responsible for certifying on a weekly basis that the temporary incapacity has continued. However, after 12 months of incapacity, the worker goes on to a different control system, which is under the institute. So the incapacity benefit process is launched by a doctor with no hierarchical links to the ministry. But those doctors are not involved in the payments. The economic incapacity benefits are paid out of the ministry's budget, not those of the autonomous communities which employ the doctors.

Over the past five years, a series of measures have been put in place that have brought down costs, which had skyrocketed as a result of these management difficulties. In 2003-2004, the institute's spending rose by 14.5% within the space of a year. Whereas between 2007 and 2008, spending was actually reduced by 4.92%. And in the first three quarters of 2009, spending was cut by 11% compared with the same period in 2008. This reduction was, it is true, also due to the economic crisis. In uncertain times, people are more reluctant to apply for sick leave. But there was no objective reason for the previous steep increases in spending. In 2004, 9% of the rise could not be explained either by wage level increases or by increases in the number of workers. The main measures taken have been organisational ones, within the institute. It now has medical inspectors working directly for it. They form part of its multidisciplinary incapacity assessment teams. In 2004, an administrative unit was established specifically to control temporary incapacity, and in 2006, another unit was created to coordinate medical inspectors within Spain's 52 provinces. In January 2006, a regulation was brought in giving the institute the exclusive authority to determine whether a worker, after 365 days of temporary incapacity, should resume work, should spend up to 180 days more in temporary incapacity, or should begin the process of acquiring permanent incapacity status.

The results of this authority transfer have been extremely satisfactory. Of all the workers reaching the 365 days 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 injuries that might be permanent. 54% were to continue in temporary incapacity for a further 6 months. Procedural reviews were also put in place within the institute. These included the standardisation of its management procedures in the 52 provinces and the collection of information from the public health services in the 17 autonomous regions. These data include each worker's entire health record from the moment the first incapacity certificate is issued up to the point of either return to work or recognition of entitlement to permanent incapacity benefits. Assessment agreements have also been signed between the regional health services and the institute, setting annual targets for controlling the payment of incapacity benefits. Coordination with these 17 different public health systems requires constant contact between the administrations. Cooperation agreements with them have two main goals. One is to rationalise expenditure, by relating temporary incapacity payments to the actual recovery process and the needs of the job, rather than to the underlying pathology. For example, an administrative worker with a broken arm will not be professionally incapacitated for as long as somebody with the same condition in the construction industry. The other goal is to set up activity programmes, along with the 17 public health systems, to modernise and improve the management and control of temporary incapacity. One outcome is that the weekly certificates are now sent electronically to the institute. The certificates state why, in the doctor's view, the person is not yet fit for work. They also contain a diagnostic code which enables the institute's doctors to see how far the person's length of incapacity matches the norms for the sector concerned. Nonetheless, during the first 365 days, the doctor working for the autonomous region has the last word. The institute also aims to have the standard durations that it has established for different pathologies incorporated into the databases used by its own doctors and those of the autonomous regions, so that once a patient exceeds the standard time, the possible need for an assessment would be flagged up. Establishing standard durations by pathology and by job has been a complicated business, involving working groups of doctors from all the structures involved.

César Gómez Garcillán (National Institute of Social Security, Spain) emphasised that incapacity is one of the various early exit modalities from the labour market. These exits, including unemployment, are all too often regarded as lifelong, thus threatening the social security system.

In Spain, the legal system includes both contributory and non-contributory provision for old age and incapacity. The contributory modality depends on the degree of incapacity of the person involved. Contributory pensions distinguish between:

- *Partial incapacity*: a reduction of not more than 33% in working capacity, which entitles the beneficiary to a lump sum.
- *Total permanent incapacity*: the worker is not able to perform the basic tasks required by his/her usual job, but may be able to do other jobs. This generally entitles the beneficiary to a lifelong pension of 55% of the calculation basis, which can be increased by 25% if there are circumstances that would make the search for another job more difficult – for example, if the worker is aged over 55. Workers aged under 60 can opt to take a lump sum instead of the lifelong pension. This can facilitate the taking up of a new, generally self-employed activity.
- *Absolute permanent incapacity*: the worker is unable to do any kind of job. Here, the lifelong pension is equivalent to 100% of the worker's calculation basis.
- *Severe invalidity*: the person is permanently unable to do any kind of job and needs help with everyday life. The lifelong pension is complemented by an allowance for outside assistance.

The institute is responsible for deciding the degree of permanent incapacity, via its regional centres. The medical services there establish an objective report, on the basis of which an expert committee assesses the impact of the impairment on the worker's capacity to perform his/her usual job and, secondly, any kind of job. The committee produces a non-binding proposal, which the institute's regional inspector takes into account when arriving at a decision. The process can be initiated by the worker, the health service or the mutual funds, but more usually by the institute – either before or at the 12-month temporary incapacity threshold. Legally, an assessment for permanent incapacity must be initiated after 18 months of temporary incapacity. The institute's decisions can be challenged through the courts, and they often are. After all, assessments of incapacity are more subjective than decisions on eligibility for other types of social benefit. Also, incapacity can change and need to be reviewed. For two years after the declaration of permanent incapacity, the employment relationship remains in legal force. After that, the employer can consider the relationship to have ended.

Each year, the institute reviews the status of some 60,000 workers – i.e. about 7% of those receiving benefits. 45% of the reviews are initiated by the institute, and the rest by the workers concerned – usually because the situation has become worse. Permanent incapacity can no longer be reviewed once the worker reaches the age of 65. After that age, incapacity benefits are replaced by retirement benefits, unless the incapacity was caused by an occupational accident or the person does not qualify for retirement benefits. The institute sets a high priority on streamlining the procedures for declaring incapacity status. People should not be left in doubt about their status for long. Thanks to new procedures introduced in 1997, the whole process now generally takes no more than 50 days, rather than 120 as in the past. Following Supreme Court rulings, the only criterion now used for reassessing the degree of permanent incapacity, once established, is whether the impairment has increased or diminished. The requirements of the job are no longer taken into account.

Today, 293,000 people in Spain are on total incapacity benefit – i.e. without the 20% supplement. Of these, about 42% have continued to work. Some 386,000 are in absolute permanent

incapacity, of which 5,000 have continued to be either employed or self-employed. There are around 300,000 people on severe incapacity benefits, some of whom are working. Another 800,000 are on retirement pensions resulting from incapacity. Per year, there are 4.4 new permanent incapacity benefit entitlements per thousand workers in dependent employment, 5.2 in self-employment and agriculture, and 3.8 in domestic service.

Several measures have been proposed to reduce early exits from the workforce on grounds of incapacity. They include making the conditions for drawing benefits stricter; 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. Weaknesses of the Spanish measures in this area include the incompatibility between working and drawing benefits. Here, the system appears unfair and could be improved. The tax-exempt status of incapacity benefits is a negative factor, as it encourages people to try to get on to those benefits rather than waiting for their retirement pensions, which are taxable. The difference between the calculation formulas for incapacity benefits and retirement pensions is a further inducement to seek incapacity status before retirement. A strength of the Spanish model is the procedures for assessing these situations. In over 60% of the appeal cases, the courts rule in favour of the institute's decisions. Also, the calculation basis for the benefits takes account of seniority at work, which means that it is now very similar to the formula for calculating retirement pensions. There are also mechanisms that facilitate progressive incorporation into the workforce, such as a comparability system between incapacity benefits and work-related earnings.

Replying to questions, **Dolores Santa María** explained that the level of incapacity benefits is related to previous salary but also to what the recipient paid into the social security system. Self-employed people can choose the level of such payments. In the case of non-occupational illnesses, the incapacity benefit is 60% of the contribution base up to the fourth day, and then 75%. For occupational accidents or illnesses, the payment is 75% of the base from the first day. Most employers top this up to 100% of salary, often by collective agreement. The trade unions achieved this during the 1980s. It does mean that workers tend to stay on incapacity leave for longer, as no loss of purchasing power is involved in most cases. **César Gómez Garcillán** said that legal entitlement to permanent incapacity benefit is not currently linked to the recipient's willingness to take part in vocational reorientation and training programmes. **Dolores Santa María** added that in 57% of cases, an employed worker will be on temporary incapacity benefit for less than 15 days. So much of the cost will be borne by the employers, who have no direct control over the granting of incapacity leave. Nor can the institute's inspection mechanisms run checks on all short-term cases. It is up to the regional health service doctors to guard against abuse.

An analysis of the compatibility between incapacity pensions and employment in Spain

Miguel Ángel Malo-Ocana (University of Salamanca, Spain) explained that one of Spain's three main types of incapacity pension is designed to be fully compatible with simultaneous remunerated work, provided that the new occupation is somewhat different to the one for which incapacity was previously declared. The two other types of disability pension are also compatible with working, but with some limitations. In studying the consequences of this, he and his colleagues drew on Spain's Longitudinal Sample of Working Lives. This contains anonymised administrative data on a representative sample of all those who have had employment-related

dealings with the social security system in a given year. The sample chosen for the present study, which is a work in progress, was of people drawing a contributory incapacity pension in 2007. It was found that 14.8% of people who were receiving an incapacity pension were also working. But this rises to 24.7% in the case of the permanent incapacity pension. The group of employed pensioners is younger than the non-employed, is predominantly male, and tends to have higher qualifications. The majority of people access a disability pension at age 55-60 in the case of men and 55-64 in the case of women. The average age of entitlement was 38.3 for pensioners who were working in 2007 and 47.2 for those who were not. In these two groups, the average age of first entry into employment was 20.1 and 24.4 respectively, while the average years of contribution to the pension scheme before entitlement were 18.2 and 22.7. The average amount of the pension was lower in the working group than in the non-working one. Econometric analysis shows that, for men, the probability of being in employment decreases as the amount of the pension increases. The same is not true of women. Other significant variables include any history of previous disabilities, whether or not the person was living alone, and the state of the labour market at the time when the pension was awarded. Analysis so far suggests that, for all the types of permanent incapacity pension, those seeking compatible employment tend to resume working shortly after becoming entitled to the pension. A longer period of transition sharply reduces the likelihood of ever achieving compatibility between a pension and a job.

In response to questions, he said it would be possible to determine if a person is still working in the same company as before, by means of code identifiers in the database. This has not been done so far, but it would be a good issue to address. The relationship between incapacity benefit and part-time working could also be a fruitful field of study. Although the database is a rich one, it does lack a number of variables that are crucial to an understanding of the labour market – such as skills and education levels. More analysis of the differences between men's and women's roles as breadwinners for households is also needed. He felt it is a positive thing that people in Spain can combine incapacity benefits with employment. It helps to integrate them into society. We need to focus on what people can do, not on what they can't. Most of us are physically and mentally unsuited to working as astronauts, but that does not mean that we are incapacitated for every other kind of job. Of course, not all kinds of incapacity are compatible with working. So the question is: where do we draw the line? For incapacitated people's own good, and the good of society as a whole, the pension system should not discourage them from working.

César Gómez Garcillán commented that the Spanish assessment system looks at the degree of people's incapacity to continue in their current job. It does not evaluate their residual capacity to do other things. If they have residual skills, it is quite understandable that they should seek employment while drawing benefit. After all, their pension will usually represent just 53% of their previous contribution base. Only about 5,000 of the 386,000 people currently receiving incapacity pensions are working. Technological advances will enable more of them to do a job in future.

Modernising and activating measures relating to work incapacity – presentation of the discussion paper

Steinar Widding (Thematic Expert – Work Research Institute, Norway) said all European countries face the tasks of reducing both early exits from the labour market and the early take-up of benefits. This problem is related to the ageing of Europe's population, which has created concern over the long-term sustainability of the social protection system. Once inactive, a person

will have difficulty in returning to the labour market, and this difficulty increases with age. Health problems and disabilities are important reasons for early exits, and early exit benefits are one of the main elements of the path out of the labour market. Take-up of these benefits often accounts for some 20% of the population aged 55-64, who make up more than one-third of the inactive people of working age within the EU. Currently, over half of the 55-64 age group are inactive, due mainly to retirement but also to poor health, to personal or family responsibilities, or to the perception – right or wrong – that no employment is available. The European Disability Strategy is an important part of the policy framework for achieving equal treatment in employment, as is Article 5 of the Framework Employment Directive, which obliges the employer to provide reasonable accommodation at work. Active ageing is an important component of the EU's Lisbon Strategy, and the 2007 UN Convention on the Rights of Persons with Disabilities (Art. 27) commits signatory countries to work towards the employment of people with disabilities.

The employment rate of the 55-64 age group has increased in recent years, from 36% in 1997 in EU27 to 44% in 2006. However, it still remains below the Lisbon target of 50%. The projected increase in life expectancy, in particular at 60 or 65, is seen as a key driving force of future demographic pressure on pension systems, which underlines the need to increase employment rates among 55-64-year-olds in the coming decades. The labour market participation of older people in Europe remains low by international standards.

EU Member States have been developing various strategic responses to the ageing population and its impact on the labour market. A number have adopted substantial reform programmes for the pension and benefit systems. Others have strengthened their reform efforts, while some remain at an early stage of the process. In addition to pension reforms, improvements in the participation of older workers in lifelong learning, promotion of better health in the workplace, improvements in public employment services, stricter legislation banning age discrimination in employment, and age awareness campaigns have been among the recent approaches.

A number of lessons can be learnt from the higher-performing countries. Success factors highlighted in various studies include a holistic approach to reform, a broad social consensus, and the involvement and commitment of the social partners and other concerned stakeholders. A one-stop shop approach is helpful for employers willing to employ ageing workers with disabilities. Such a contact point should have an overview of all available supportive measures and channel its clients to the appropriate organisations. The one-stop shop, which many Member States have implemented or are implementing, should be made well known to business as well as to the community of people with disabilities.

Several studies have argued that reforms to address early exit paths 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* (notably through fiscal rules) and also for employers to hire older workers and not rely on early exit schemes
- *Enhance work opportunities for older workers and workers with disabilities*. Important aspects include improving working conditions (notably 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.

A number of reforms have been implemented recently by Member States:

- *Reforms of unemployment benefits* for older workers have in particular been aimed at reducing the differences between eligibility conditions for older workers and those for the whole active population, and at developing active measures in order to enhance labour market opportunities for older workers.
- *Reforms of invalidity benefits* have in particular aimed at offering better possibilities to combine benefits and work, retraining, and improved workplace adaptation. Also, incentives have been strengthened for employers to hire people with reduced work capacity, while incentives for beneficiaries could also be reviewed in order to reduce barriers to returning to working life. Invalidity prevention and the professional rehabilitation of people with health problems are considered to be important contributions, which must start from an early age.
- *Reforms of supplementary pension benefits* are taking place in order to diminish or even stop early take-up, by tightening eligibility rules and increasing awareness of the consequences of early exit on future benefit levels.
- *Reforms of taxation* aim at increasing incentives for employees to postpone or avoid taking early exit benefits, and for employers to hire older workers.

One problem is that disability policies target an extremely heterogeneous group. Definitions of disability vary 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 picture of the prevalence of disability will vary according to the definition used, but there is ample evidence that self-reported disability indicators are a reasonable predictor of a person's objective health status. On the basis of such self-reporting, about 15% of the workforce claim one or other type of disability.

Disability programmes may 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, rather than due to unemployment. They may also be a tool for managing labour market difficulties, such as downsizing, lay-offs or restructuring. However, studies over the years have shown that people with disabilities can work and want to work. This will not necessarily be full-time work on normal terms. It may have to be adjusted. Assistive technology has improved the opportunities for many people with disabilities to enter the workforce. Designing policies on the assumption that people with disabilities are not able to work may therefore be erroneous.

In general, there is a low outflow from disability benefits. The level of education plays an important role. Disability prevalence rates are significantly higher in groups with low educational attainment, notably because they are often employed in physically more demanding occupations. Another problem is the considerable age profiling in disability benefit programmes. 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 overall age bias in integration programmes: vocational rehabilitation and training are predominantly offered to people below the age of 45. Meanwhile, the complexity of jobs and flexibility

requirements are constantly increasing, and people with disabilities are not always well included in educational systems. Disability benefits are the main component of benefit income for working-age people with a disability. Permanent retirement benefits are also an important source of income for a considerable proportion of the working-age disabled population – either early or regular retirement, depending on the country. Unemployment benefits play a much less important role overall, despite the relatively high non-employment rates in this group. Return-to-work or rehabilitation measures commonly used in EU Member States include tax incentives, quotas, flexitime regimes, telework, partial work benefits, retraining, counselling and coaching, internships in enterprises, and workplace adjustment.

Some recommendations and lessons can be drawn from the studies made in this area:

- *Recognise the status of disability independently of the 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.
- *Design individual work/benefit packages.* It will not be enough only to look after 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 individual needs and capacities. This package should contain rehabilitation and vocational training, job search support and work elements from a wide range of forms of employment (regular, part-time, subsidised, 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 the measures depends on the willingness of employers to help disabled people to stay in or enter work and make the necessary workplace adjustments.
- *Early intervention* is critically important.
- In many countries, there is a need to *reform programme administration*, which is often uncoordinated and fragmented.
- *Design disability programmes as active programmes.* Often, disability benefit systems 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 moves disability policy closer to the underlying logic of unemployment programmes, which expect an active contribution and effort from beneficiaries.

Unreformed disability programmes are likely to attract applicants who may find it difficult to comply with the stricter obligations of unemployment schemes. There is a need for a consistent strategy in disability and unemployment policy that extends the culture of mutual obligations to all labour market programmes. He suggested that the lessons learnt from Peer Reviews in Finland (active ageing strategies to strengthen social inclusion, 2007) and Sweden (integrated services in rehabilitation: coordination of organisation and financing, 2006) could assist the Spanish reforms.

Discussion

Teodoras Medaiskis (Vilnius University, Lithuania) advocated a policy based not only cash benefits but also on social services for disabled people. If somebody has no legs but is good at using computers, that person will be more in need of services (transportation, workplace adaptation etc.) than of cash. **Steinar Widding** very much agreed. Four years ago, Norway brought in a one-stop shop that was supposed to deliver services in a more coordinated manner. But that did not happen, because the services were internally uncoordinated. **Tom Dominique** (General Inspectorate of Social Security, Luxembourg) suggested that the whole discussion is complicated by different terminologies. While the underlying problems are much the same, a glossary is needed so that each country's system of benefits and pensions can be clearly understood by others.

Jan Spooren (EPR - European Platform for Rehabilitation) argued that a shift is needed from income replacement benefits to services *and* allowances to compensate for the extra cost of being disabled. He strongly disagreed with the idea of using self-reporting as a main indicator of disability. A study had shown that, if people in Finland are asked whether they are disabled, about 33% say that they are, whereas in Malta the corresponding figure is 7-8%. This is not an objective difference but a cultural one. Notably, greater stigma is attached to disability in some countries than in others. He advocated using the culturally neutral ICF concept (International Classification of Functioning, Disability and Health) developed by the World Health Organisation. His organisation's members, who provide rehabilitation services to people with disabilities and other disadvantaged groups, increasingly address the employers. So they see the employer as the client. In many countries, support is available for the employers but they cannot access it. So the service providers are tending to bridge that gap. The EPR has developed a distance learning tool for employers on disability issues. Amongst other things, it enables them to calculate the cost of absenteeism. **Steinar Widding** agreed that employers need assistance in this field. Most employers in Europe are small and medium-sized enterprises (SMEs), so the intermediaries do have an important role to play. The "rehabilitation industry" has tended not to address the employers enough. On the ICF, he pointed out that not many countries have chosen to use it, so the definitions are still rather fragmented. But it is certainly one possible point of departure for a more standardised definition. That would require a very broad policy discussion.

Robert Anderson (Eurofound – European Foundation for the Improvement of Living and Working Conditions) felt that the discussion should not focus on disability alone, but should look more broadly at the EU's measures for active inclusion. These have three components: income, social services and employment guidance. 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? As most workers develop any disabilities during the course of their working life, it is during their working life that there are opportunities to prevent poorer health and retain workers in employment. So clearly, employers are a very important player in this. More specifically, it is their human resource managers and occupational health professionals who should be involved in retention, reorientation and return to work. We need to think carefully about the opportunities that have been missed to involve those workplace professionals. **Nicole Legrain** (AGE – the European Older People's Platform) emphasised the need to consider the psychological environment in the workplace. Many people leave work due to psychological factors such as stress, company reorganisation, monotonous tasks and a lack of autonomy. Ageing should be taken into account as a natural phenomenon when employers define their human resource strategies. This will help to solve the problem of early retirement, as well as the integration of

people with disabilities into the workplace. It 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. Relevant wage policies should also be considered which will promote greater flexibility and so counter the argument that employers cannot afford to employ older people and people with disabilities. 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 and should seek to change the attitudes of potential employers to ensure they engage and value older people and remove discriminatory barriers to their participation in the workplace. Managers need to be trained and coached about working with older or disabled employees, and managers should be encouraged to express any difficulties about dealing with these sections of the population.

Neil McIvor (Department of Work and Pensions, United Kingdom) agreed on the need for a better integration of the health and employment service aspects, as well as a more individualised approach. But this means that we need very clearly defined goals. Otherwise, a sum of money allocated for an individual might be spent purely on health improvement, rather than on a back-to-work strategy that would include health improvement. Unless we also tackle the demand side, in other words the employers' willingness to hire these people, there will never be the flow out of the benefits system that we hope to see. We should be clear about what adjustments employers are expected to make, but suggested a safety net for SMEs, including advice and perhaps some funding. Fluctuating health conditions, such as those presented by some people with mental disabilities, pose a particular challenge for the employers. This problem is currently being looked at in the UK. He supported the use of self-reporting as an indicator of the number of disabled people in society and in employment, but not as a gateway to benefits or pensions. **César Gómez Garcillán** pointed out that Spain makes a clear distinction between work incapacity and disability, which is much more broadly defined. So it should be borne in mind that not all of the disability provisions in Spain, such as transport assistance, would be described in detail during this Review, which was about incapacity. **Marcel Einerhand** (Ministry of Social Affairs and Employment, The Netherlands) disliked subjective measurements of disability. Self-reporting may have a role nationally, but it does not produce reliable international comparisons. Mental disability is a large part of the inflow into the dutch disability scheme. People are now considered to be mentally disabled who ten or twenty years ago would have not have diagnosed as mentally disabled. The increased inflow of youngsters into disability in the Netherlands may be caused by better diagnostics and by different demands of society. Also, the Dutch experience is that if access to disability benefits is reduced, there is a risk that people move over to other parts of the social security system. 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. The ICF is a holistic measurement of incapacity, and its use would therefore promote holistic solutions. Employers need financial incentives to hire people with disabilities, but should also be financially penalised for not taking on their responsibilities.

In the discussions so far, **Katarina Lindahl** had detected a strong emphasis on the need for holistic approaches and coordination. The emphasis on services is one that the Commission shares, having worked for some time on supporting Member States' active inclusion strategies. The skills to achieve coordination and deliver a personalised approach still need to be developed. The broader issue of the non-inclusiveness of labour markets in general also needs to be tackled. She suggested that prevention should receive more consideration in the discussions. **Daniel**

Schmidt (European Commission, DG Employment, Social Affairs and Equal Opportunities) said studies show that overall achievement, in terms of obtaining the employment of people with disabilities, is still rather low, despite all the efforts at the European and national levels. Yet most people with disabilities want to work. Combining work with benefits is certainly a worthwhile aim, as it helps people back into working life. On European level, the lack of comparable statistics is problematic. Not only that every country has its own definition of disability also official recognition of disability is mostly connected with a benefit claim. However, a new statistical module on disability is currently developed by Eurostat.

Dolores Santa María felt there might be a case for a category of partial temporary incapacity – a status not currently recognised in Spain. **Patrik Andersson** (Ministry of Health and Social Affairs, Sweden) wondered if the “one-stop shop” concept may be moving us towards a single “out of work” benefit which will take no account of the reasons for being out of work (incapacity or unemployment). **Teresa Quílez Félez** (Ministry of Labour and Immigration, Spain) suggested that more data on all illnesses influenced by work, and not just those classified as occupational, could help to prevent incapacity. Spain is beginning to develop more information on health variables such as age and gender, but there is a need to know what factors were influencing the person's health at the time of diagnosis. We also need to analyse how a worker's reaction to incapacity is influenced by the benefits received. The statistical curves for total incapacity show that, as the worker reaches the age where there is a possibility of going on to other benefits, the probability of being on incapacity benefit decreases. **Teodoras Medaiskis** pointed out that not all services to incapacitated people can be converted from kind into cash. This is particularly the case for people with mental disabilities, who need regular counselling.

Carlota García-Rodrigo Menéndez (Ibermutuamur, Spain) said that Spain's occupational accident and illness mutual insurance funds have been working for more than a hundred years to bring incapacity rates down. This requires an integrated approach ranging from prevention to medical treatment, benefits payments, rehabilitation and physiotherapy, and finally re-adaptation and reinsertion or alternative employment. The regulations should be adjusted to give the mutual funds a higher-profile role at each stage of the process. The representative of **CCOO** (Comisiones Obreras, Spain) doubted that a single, universal definition of disability would be a good idea at the present time, as the degree of training and workplace access available to people with disabilities varies greatly from country to country. In Spain, a law has been in force for more than twenty years now that compels companies with more than 20 employees to have at least 2% of their workforce composed of disabled people. The trade unions have been pushing to get this law respected, but with very relative success, even though Spain does have quite high economic incentives for employers to hire workers with disabilities. More coordination is needed between the organisations involved. When an employer offers a job requiring a certain set of skills, the public employment services do not match that vacancy up with an appropriate disabled worker. **Thibault Lambert** (AGEFIPH – Association nationale de gestion du Fonds pour l'insertion professionnelle des personnes handicapées, France) emphasised that only a small proportion of people with disabilities (in France, about 15%) are born disabled. Most disabilities are acquired during the working life, so there is a large proportion of persons with disabilities after the age of 50. Employment rates differ greatly from one country to another because retirement policies and differences in labour participation according to gender differ greatly too. France has two different services, one that helps people to find a job and one that helps people to retain a job. His own organisation has a budget based mainly on a levy system. When keeping somebody over 50 in employment involves redesigning the job or the working times, his fund helps to finance part of the wages.

Tom Dominique suggested that, realistically, the labour market in general will have to be improved if the employment chances of incapacitated people are to be increased.

Access to employment, retention and reintegration of people with work incapacities

Robert Anderson (Eurofound) said the link between ill-health and employment is being emphasised more in EU policy documents. The first key document came from the 2003 preparations for a summit on the reasons for the low employment rates of older workers. It placed emphasis on the health problems of older workers. Since then, a series of Commission and Council reports have highlighted poor health as a barrier to employment and economic growth. In particular, the 2007 Communication on social protection for those furthest from the labour market was a key document promoting active inclusion. These documents are coming not only from the Directorates-General concerned with employment, but also from those dealing with the economy and public health, as well as the general economic discussions of the European Council. In 2008, reference is made to the European Pact on Mental Health – a sign of a growing awareness that mental health is the biggest new challenge in work incapacity. Today, the OECD estimates that about 30-45% of the new inflow into disability benefits is people with mental health problems. Are our disability schemes and activation measures really 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. Many of the younger recipients subsequently go on to long-term benefits, effectively removing them from the labour force. Eurofound conducts surveys of health and disability in the general population, but also the European Working Conditions Survey, looking at health and risks in employment by age group and gender. The Foundation's database on active strategies for an ageing workforce contains 200 company studies. It has just launched a new report on active inclusion for young people with disabilities. He also pointed out that some of the people suffering disadvantage in employment are not those receiving incapacity benefits but those caring for them.

He suggested that the issue of reintegration has been relatively neglected. New European data are urgently needed, and he hoped that the 2011 Labour Force Survey will provide these. The OECD estimates that the employment rates of people with mental health problems are generally no more than half of those for people with other health problems. Recent German data also show a continuous increase in early exits for reasons of mental ill-health. Employer reluctance and the general employment situation account for some of the rise in exclusion on mental ill-health grounds, but so do improvements in diagnosis, changes in eligibility rules, and a passive response to the employment problems of young people with disabilities. We need to think more about 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. On the retention of older workers in employment, he pointed to the Finnish example of promoting their working capacity and skills but also matching human resource policies to them – notably as regards reconciling work with non-work responsibilities, such as caring for ailing spouses or parents.

Most incapacity prevention activities will happen in the workplace, but necessarily with the support of community services. Two Eurofound studies on preventive measures in the workplace are available on its website (<http://www.eurofound.europa.eu>). The key elements of good practice in age and disability management are relatively well understood, but are inconsistently applied.

Companies are now paying more attention to the promotion of health and well-being, but not necessarily for all groups within the workforce. There is often little attention to the specific needs of lower-skilled workers and of women. Active disability and age management are still rarely mentioned by the companies surveyed in Europe. Few companies are taking active steps to bring people back after long-term sickness. We need to address the absence of positive attitudes among health professionals and employers, the low expectations among workers, and the lack of appropriate resources in many workplaces. Coordinated and focussed system responses are needed, not only from public authorities, but also from and in companies, and from and in community services.

Answering questions, he emphasised that when companies do introduce good practice in this field, it is usually because there is a business case for doing so – for example, a shortage of workers or a wish to avoid losing the skills of their existing workforce. That business case should be built upon. Simply raising awareness of demographic ageing may not do much good. A recent survey showed that only 6% of companies are preparing for demographic change. Economic incentives could play a role here, but SMEs in particular need support in order to do what they generally want to do – i.e. retain or reintegrate their staff. Documenting good practice is also very important here. In some Member States, the social economy is an important source of employment for people with health problems.

Discussions/experiences by the peer countries

Neil McIvor felt that getting employers with positive attitudes to talk to other employers is much more effective than diktats from central government. The UK Government supports a forum for inter-employer dialogue on this issue. **Jan Spooren** emphasised that many different employment types are available to people with disabilities, ranging from occupational therapy through sheltered workshops, supported employment and the social economy to the open labour market. While the ultimate goal should be to bring everyone into the open labour market, this is not a realistic option for some types and degrees of disability. The risk with sheltered workshops and social enterprises is that they may seek to retain people who could otherwise move on to the open labour market, as they are their most productive workers. **Thibault Lambert** pointed out that, while large companies can redeploy incapacitated people to other tasks, SMEs may not have that option. In such cases, solutions have to be sought outside the enterprise concerned. **Peter Skogman Thoursie** (IFAU – Institute for Labour Market Policy Evaluation, Sweden) said the Swedish benefits system is very much based on compensating for a loss of income. This means that young people without an employment record behind them will receive only the basic amount, and will be at risk of poverty if they remain out of work.

Irina Badea (Ministry of Labour, Family and Social Protection, Romania) said her ministry has just launched a project to support employment both of incapacitated people and of those disabled since childhood. This will be a big challenge, as Romanian employers are very reluctant to employ people with disabilities. Many Romanians, including the families of those concerned, still think that people with disabilities are unable to do anything, and the disabled people themselves often prefer just to stay at home and draw a pension. The government's hope is that, many years from now, it will become possible to employ people with disabilities on the open labour market. Another project aims to develop social enterprises. Some such enterprises are already run by NGOs, but without any legislative basis.

Grażyna Wawrzyńczyk-Kaplińska (ZUS – Polish Social Insurance Institution) said Poland had very high expenditures on sickness and disability benefits during the 1990s. This was due both to high unemployment and to the disability assessment system, which placed high importance on biological factors rather than work incapacity. So reforms were introduced aimed at tightening the entitlement conditions for benefits and focussing on returns to the labour market. Incapacity for work is now the criterion. Medical rehabilitation is offered, with good results, but Poland's efforts at vocational rehabilitation have been less successful, due mainly to very low take-up. **Agnieszka Szatanowska** (ZUS) added that, while the calculation basis for retirement pensions has recently been changed, this is not the case for incapacity benefits. This may mean that the benefits will be higher than pensions, and this issue will have to be tackled in the coming years.

Marcel Einerhand described Dutch reforms that have produced a decrease in inflow rates and hence, longer-term, in the number of people on benefits. This was achieved mainly by shifting the burden of risk from the State to the level at which the risk can best be influenced. The employer is the person who can most effectively help an employee to get back to work. So the employers were given the responsibility of paying for the benefit. In 1996, the first requirements for employers to pay for sickness benefits were introduced: two weeks in the case of small companies, six weeks for larger employers. This was later increased to one year, and then to two years in 2005. In money terms, the difference between one year and two is small, as few people are on sick leave for more than a year. But the increase does leave more time for reintegration, while encouraging employers to avoid long-term sick leave. There is now also a risk-rated disability system divided into three categories: full permanent disability, partial disability and temporary disability. It includes 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 reduced. Employers can opt out of the system altogether and take out private insurance 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. Other incentives include a gatekeeper law that can lead to fines on employers who do not make any reintegration efforts during the first two years. Also, benefits-drawing employees who make no such efforts during that period are subject to dismissal. 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. Answering questions, he agreed that strong social partnership in the Netherlands had helped in putting this system into place. The reforms have not led to medical screening of potential employees prior to hiring, as this practice was outlawed when the reforms were brought in. If older people (50-65) 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. Regarding the large increase in the number of young people categorised as disabled (now 1 in 20 in the Netherlands), he suggested that modern society is too ready to write youngsters off as incapacitated. But the precise reasons for the rise are not yet known, and this poses the biggest challenge for the future of the Dutch system. **Erik Swart** (Workers Insurance Authority, Netherlands) explained that, while Dutch doctors are not expected to give the employers details of anybody's medical condition, they are required to tell the employer what the person can still do. The employer is then required to find suitable tasks within the enterprise or, failing that, to contact other employers. The Workers Insurance Authority assesses whether the employer and the worker have made all appropriate efforts in this regard.

Lidia Pola (European Commission, DG Employment, Social Affairs and Equal Opportunities) said that sickness and health are not absolutes. There are degrees of incapacity, and systems need to recognise this. 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. This is one way of bringing benefits recipients out of the black economy. Meanwhile, as the employers are clearly key to the incapacity issue, she suggested that they should be more closely involved in discussions such as the present Peer Review. **Jan Spooren** believed that, while the privatisation of reintegration services can certainly bring down their cost, there are also some risks. The quality will tend to go down, the public authorities may lose control of reintegration policy and practice, and payment by results means that service providers may cherry-pick the least difficult cases rather than helping those most in need. Possible ways of avoiding these problems include focussing tenders on particular groups (e.g. with the same syndrome or disability) and building quality specifications into the tenders.

Thibault Lambert explained that France has revised the levies attached to its quota system for the employment of people with disabilities. For enterprises with no disabled employees, the increase would be particularly steep – three times the previous level. However, following representations from the employers' organisations, the implementation of this new regulation has been postponed for branches employing between 20 and 50 employees for a new period of six months. France has also been helping people with disabilities who are already employed to achieve promotion through additional qualifications. This is seen as one way of overcoming the retention problem. **Tom Dominique** felt that an integrated approach like the Dutch one is the key to reforms. The solutions will vary according to national circumstances, but we should all pick out the key lessons from other countries' experience. One common element is the role of the doctors. The basis for medical assessments will need to be discussed with them.

Neil McIvor reported that the UK has radically changed its incapacity benefits system recently. Many companies have Occupational Sick Pay schemes drawn into their employment contracts, for example allowing individuals to receive full pay for the first 6 months of absence and half pay for a further 6 months subject to a maximum of 12 months paid sick leave in any four year period, dependent on an individual number of years service.

The Government also has a Statutory Sick Pay scheme, which is a measure of earnings replacement for employees who are off work because of sickness. Employers are liable to pay this to all their employees who satisfy all the qualifying conditions when they are off work sick. Employers can choose to opt out of fully operating the SSP scheme in favour of their own occupational sick pay.

People who reached the end of the statutory sick pay period without returning to work used to be able to apply for incapacity benefit. The name and the process of that benefit were changed in October 2008 to the Employment and Support Allowance. 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 are receiving incapacity-related benefits, but some people on jobseekers' allowances and lone parent benefits also have health conditions or a disability. One of the most important change to the employment and support allowance was that anyone claiming it now enters an assessment period during which the money received will be exactly the same as the basic unemployment benefit. Within about 14 weeks, the aim is to give all applicants an independent medical assessment, called the Work Capability Assessment. It focuses on what

somebody can do, rather than what they can't do. The assessment will either find the person fit for work, in which case they go on to the normal unemployment benefit, or for "work-related activity" aimed at getting back into employment (which will be the case for most of those concerned), or into a "support group", meaning that the person has a limited capability for work related activity and is not required to do any work related activity as a condition of receiving the benefit, although people in this category may volunteer to do so. In October 2009, the first statistics on the work capability assessment were published. Of those claiming benefit, around 38% were found fit for work, 11% were in the "work-related activity" group, and further 5% were in the "support" group. Most of the others had come off the benefit within the 14-week period. Special arrangements exist for those who have genuine difficulties in attending for assessment or understanding the system. The changes have meant that the case-load of people on incapacity benefit of Employment Support Allowance is different. They are further from the labour market, so the original Pathways to Work programme for them will need to be looked at again. Pathways to Work is delivered by private providers in 60% of the country who receive outcome based payments for placing each person in a job, and then an additional payment if the person stays in the job for at least 13 weeks. There is an argument that this tends to encourage cherry-picking. The future dilemma will be whether to focus on getting the fastest and least expensive results or concentrate on the more difficult, and therefore more costly, cases, so bringing greater long-term benefits. One approach being considered in the UK for the long term unemployed is incremental payments to the reinsertion providers: they would, for example, receive more per head for the second hundred people placed than for the first hundred. This would be 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. A programme called Access to Work can help to fund the extra costs faced by disabled workers, such as support workers, extra travel to work costs or workplace adaptation, but only if it is over and above what could be reasonably expected of the employer. The programme is currently being developed to better focus on those with the most severe barriers to work, such as mental health conditions and learning disabilities, and to increase the contributions of larger employers so that more funds are available to help smaller employers.

Day 2

NGO statements

Jan Spooren suggested a typology of activation measures for people with disabilities:

- *Social orientation addressing people with disabilities.* These address mainly the individual needs and capacities of those concerned. Vocational services include job training and personality training. Allowances compensate for the extra expense of being disabled, such as the cost of transport, technical aids and personal assistance.
- *Social orientation addressing employers.* These measures include obligations (anti-discrimination legislation and the duty to make reasonable accommodation for people with disabilities) and incentives (on-the-job support, which still needs further development and financing; and the relatively new area of disability management – training employers, human resource personnel and work colleagues about disability issues).
- *Economic orientation addressing people with disabilities.* The main aim here is to ensure the

financial sustainability of social protection systems. The conditions for receiving a disability pension are being tightened in some countries, which are also introducing post-rehabilitation assessment and periodic re-assessment, linked to measures to improve people's situation. This is a recognition that disability is not necessarily lifelong. The situation can change. However, he warned against the negative effects of subjecting people to reassessment if they are really never likely to be able to work. Another recent trend is an obligation to involve oneself in work-related activities or rehabilitation. A positive measure is to allow for flexible employment schemes. This includes "job carving" – the redesign of tasks to match the worker's abilities. Flexible time schedules, including part-time work, should also be recognised as a way of permitting people with disabilities to work. Combining (partial) benefits with work income should be permitted. Some countries still do not allow people on benefits to engage in any employment. This is a real disincentive to their entering the labour market, as it is then seen as a gamble. If employment does not work out, it should be possible to fall back on to benefits without having to go through the whole procedure again. The "benefit trap" is another problem. Financially, it should be worth people's while to find employment. In the case of people with disabilities, this also entails tackling issues such as transport.

- *Economic orientation addressing employers.* Positive measures include grants to compensate for the lower productivity of people with disabilities and for the extra costs to the employer (alterations to buildings, special IT etc.). Legal quotas for the employment of people with disabilities work well in many countries, but can be stigmatising: people are then being employed in order to avoid a fine, rather than for what they can contribute. Also, employers sometimes justifiably complain that people with disabilities are not being equipped with the skills needed in order to make them employable. There must also be sufficient flexibility on the labour market. If employers are saddled with all the costs when the employment of a person with disabilities does not work out, then they will be very reluctant to employ such people.

The modernisation of vocational reintegration services means that the providers have to do more and better with the same resources. Two paradigm shifts are involved here: from the medical to the social model of disability, and from public programming regulation to market-based regulation. These are realities that the service providers must face up to. They are too defensive in their discussions with society, including the Commission. They should instead devote their energies to making the new set-up work as well as possible. Service providers and policy-makers should invest in the training of professionals. All the other pathways are not possible without strong expertise. Those pathways are explained in detail, with practical examples, in the EPR Charter on modernisation of disability-related health and social services (http://www.epr.eu/images/EPR/documents/policy_documents/charter.pdf).

Nicole Legrain said AGE was commenting on the basis of its member organisations' responses to the Peer Review documents. Mobilising the human capital that exists among older workers is essential for the long-term sustainability of our social protection systems. A more positive image of their value must be promoted. Policies to support a more active transition period from paid employment to old-age dependency are urgently needed, and the transferability of such policies between EU Member States should be carefully examined. She 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? Pressures for changes to disability protection exist in

Member States, due to concerns about growing costs, demographic ageing, increasing dependency rates and the issue of long-term sustainability. AGE is concerned about the situation of older workers on long-term sick leave who are legitimate claimants of disability benefits but whose expectation of a successful return to the labour market is very low. Support measures should be implemented to help them back into jobs adapted to their capacities, but not to force them into poor-quality jobs. It must be ensured that individuals can access state benefits when they have a legitimate claim. 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 these workers to stay longer in employment? A strategy is needed that combines actions to create quality jobs for older workers, and provide incentives and support to them, with efforts to change the attitudes of potential employers. All employers, both public and private, should have a duty to challenge ageist assumptions. 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. Evidence shows that worker productivity does not decrease with age, as declining physical capacity is compensated by qualities and skills acquired through experience. 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? Real gains are to be made not by forcing people to wait longer for their pensions (often in unemployment or on incapacity benefits), but by enabling them to work productively as long as they wish and then move into a productive and active retirement period which may include paid employment. The main aim of active ageing policies should be to make the labour market age-neutral or age-friendly. Training on this for employment offices and counsellors would be useful. But older workers' needs and capacities vary. Hence the need for flexibility. Many older people are keen to return to work. Closer cooperation is needed on this between the employment, social affairs and health sectors. Social protection systems should be adapted to enable older workers to remain at work for longer, but without curtailing their rights. 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.

Ms Legrain suggested three issues for further consideration: How far can current national policies have a bearing on the activity or inactivity of seniors? How can we ensure the removal of public policy and legal barriers to more flexible forms of employment? How can working environments be adapted so that they are more age-friendly and disability-friendly?

Discussions/experiences by the peer countries *(continued)*

Neil McIvor said the UK has recently introduced a guarantee that anyone going back into work will be at least £40 a week better off.. A new initiative called Invest to Save that is expected to roll out in 2011 would pay the providers a portion of the savings made by the State when people are got back into work. This 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 that the Government only pays for the additional outcomes.

Tom Dominique recalled that, up to 1996, Luxembourg had faced a steep increase in the numbers going into its disability scheme and out of the labour market. In 1996, the 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 now received nothing apart from social assistance. So the legal provisions were partially reformed in 2002, but this led to much more complicated structures, and streamlining measures are now planned. One main focus now is to give people a trial period in employment. There will also be efforts to make employment more flexible, notably by reducing work times. Medical assessment will be oriented more towards what a person is capable of doing, where applicable. He emphasised the need for an integrated approach. Reforms must not just shift people from one benefits scheme to another.

Olivier Bachellery (Ministry of Health and Sport, France) wondered if the financial responsabilisation 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.

Erik Swart doubted that this problem will arise, as the insurance company will press the employer to reintegrate the person concerned as soon as possible.

Outlining the reforms in the Swedish sickness and disability scheme, **Patrik Andersson** noted that the upward curve of benefits payments in the latter decades of the twentieth century had been similar to those described for other countries, or even steeper. As Sweden had never had an early retirement scheme, the only early ways out of the labour market had been to take a reduced pension or to qualify for disability benefit. Previously, too, disability benefit had sometimes been granted as a way around labour market problems. The situation peaked around 2004, when 14-15% of the population were on sickness or disability benefits. In 2006, the incoming government decided to change the rules. The overall goal was to increase the incentives for all stakeholders. An upper limit of two and a half years was set on sickness benefits, for which there had previously been no timeframe. During the first 90 days of sickness benefit, the person is assessed for an ability to return to the same job as before. If that is not possible, the employer is to take the necessary measures to provide some other type of job. If the employer cannot provide a suitable job within 180 days, the person will be assessed against all possible jobs on the labour market. This is quite new. If no suitable jobs are found on the labour market, the person will be transferred to the unemployment scheme. As regards Swedish disability benefit, he explained that the gateway has been narrowed. Today, this benefit is granted only to those who have a permanent reduction of their work capacity. That reduction must be such as to make it impossible for the person to return to the labour market through rehabilitation. Today, about 11% of the population draw disability benefit. People had been afraid that attempting to work might lay them open to reassessment, so the government said that those who had been drawing disability benefit before July 2008 could work as much as they liked, without ever being reassessed. The success of this strategy will be evaluated soon. People can earn up to €4,000 a year without loss of benefit. After that, there is a taper rate of 50%. The employers have been assigned greater responsibility for rehabilitating sick workers. Incentives to employers for hiring people who are on long-term sickness or disability benefits include reductions in social security contributions. Cooperation between the national insurance authority, the health sector and local social assistance offices has been stepped up, and a right to some kind of rehabilitation within three months has been introduced. The sickness notes completed by GPs now include the

patient's employment possibilities. The social and health insurances have developed a list of the expected average durations of different sicknesses. If a GP's sick note exceeds the average duration, a justification has to be given. The occupational health service is also being strengthened, and great importance is attached to this. **Peter Skogman Thoursie** added that the decrease in the numbers on benefits actually began in 2004, before the changes. The previous government had concentrated on changing attitudes, and this seems to have had an effect. Recently, there has been considerable debate in Sweden about the reforms. This highlights the need to achieve a political consensus on reforms of this scope.

Jan Spooren described a model developed by EPR to investigate how employers decide whether to hire a person with a disability. Four main domains impact on that decision: *system drivers* (legislation, regulations, policies, quotas, incentives and support services); *socio-economic drivers* (the general labour market situation, the behaviour of competitors, trade union pressure, and the company's economic situation); *internal drivers* (the employer's strategy on diversity etc, the nature of the firm's production, previous experience of employing people with disabilities, and the firm's size and sector); *personal drivers* (the attitudes and experiences of the managers taking the decision, and the skills of the person with the disability). These factors lead to an employment threshold, and an EPR survey has produced figures on this. The importance of the drivers differs greatly from country to country, and also between SMEs and large companies.

Many speakers stressed the importance of broad consultation with stakeholders when planning reforms – notably with disabled people's organisations and the social partners. In **France**, there is now a legal requirement on firms with more than 50 employees to sign collective agreements or action plans with the trade unions on the employment of older people and people with disabilities, 11 February 2005 Act.

An increase in the proportion of women on incapacity benefits was noted. However, most peer countries do not intend to take gender-specific measures in this field. A further discussion point was the decline in the number of low-skilled, low-paid jobs available in Europe, and the possible impact of this on the employment of people with disabilities. Generally, it was agreed that a return to low-quality jobs would not be either a feasible or a desirable solution. Rather, there is a need to ensure that people with disabilities acquire up-to-date skills.

Relevance and key learning elements for peer countries and stakeholder representatives

Steinar Widding said inflow management had been a major issue at this Peer Review. How do we design systems in such a way as to motivate benefits recipients to seek work? One factor is the level of benefits compared to wages. Also, incapacity may change over time, so there may be a case for periodic reassessments of cases. Reformed schemes are tending to be oriented more towards temporary benefit entitlement. There is a need to distinguish between health problems and employment problems, and to decide which to focus on. Incapacity schemes sometimes confuse the two. Variables include the increase in the number of young incapacitated people. There is also a gender dimension, as female carers with impairments may face particular difficulty in re-entering the labour market. The design of systems should bear this in mind. Account must also be taken of the growing importance of mental health problems among the grounds for incapacity. Design models discussed had included the integrated approach and the one-stop shop model. Approaches need to be personalised. One size does not fit all. In many countries, the rehabilitation structures are quite fragmented and need better coordination. Flexibility is an

important design principle for schemes. The Dutch model, with its new system of risk-sharing, had aroused interest. Certainly, if too much of a burden is placed on the employers, they will pull out and it will become more difficult to get people back into the labour market. The Dutch example had also shown that reforms take time – 25 years, in the Dutch case. Another issue is who should be prioritised: those who are easiest and cheapest to get back into work, or the more difficult cases who will entail greater expense? When we want to move people into jobs, what kind of jobs are we talking about? Quality jobs or low-skilled ones? What is the skills match? Should temporary, part-time or flexible work be considered legitimate? And what about informal or unpaid work? Especially in the present context of growing private sector service provision, the need to prevent cherry-picking should be borne in mind. There have been a number of paradigm shifts in incapacity provisions: from the medical to the social model; from public programming to market-based solutions; and perhaps also from a “train-place” approach (training people and then attempting to place them on the labour market) to a “place-train” approach (on-the-job training). So far, Norway’s experience of “place-train” has been quite positive. In more or less all EU countries, he noted a trend away from looking at people’s incapacities and towards focussing on what they *can* do. The involvement of employers is essential, and effective incentives are needed to change their behaviour in this regard. Assistance will sometimes 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, so medical screening may become an issue here. False perceptions of 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 had shown that a lot of knowledge exists about good practices that work. But good practices tend to come with a “best before” date. They need to be used fairly fast. So the question is how to translate what we already know into action. It is important to involve the social partners in this, possibly through tripartite models. A commitment is needed from stakeholder groups, and action learning structures might be an efficient way of achieving this. He recalled the recommendations of the EU and the OECD:

- Recognise the status of disability, independent of the work and income situation
- Design individual work/benefit packages
- Introduce new obligations for disabled people
- Involve employers in the process
- Promote early intervention
- Make cash benefits a flexible policy element
- Reform programme administration
- Design disability programmes as active programmes.

Closing remarks

Katarina Lindahl thanked the Spanish Government for hosting this Peer Review on a very complex issue. The discussion had been eclectic and far from conclusive, but extremely interesting. There were a host of elements which everyone could pick up in continuing to work on these issues. She also thanked the participants, experts, stakeholders and organisers for their contributions.

This Peer Review had taken place in the context of the reflection in all Member States about how to modernise social protection systems. The situations and approaches vary considerably, but there are many impressive efforts going on and many aspects that we can all learn from. She noted the Spanish suggestion at the outset that the leitmotiv for further reflection should be to focus on people's capabilities rather than what they cannot do. The general relevance of active inclusion strategies had been highlighted, also as a framework for approaching this issue. The idea of active inclusion is to reach the people who are furthest from the labour market, and to do so through a strategy that can also serve as a tool for fighting poverty. A good job is the best safeguard against poverty and exclusion. Policies have to be made to function together across a range of fields, notably in order to ensure a link to the labour market. The discussions had brought out the role of the social economy as a possible stepping-stone, the need to provide possibilities for combining work and benefits, and the need to allow for trial periods and provide a fall-back. Access to services had also been a thread running through the debate, as had ensuring adequate income support while permitting people to take steps towards employment – but also for people who really cannot work. Integrated, coordinated policies are needed, and all stakeholders should be brought together, including the service providers, in order to achieve personalised approaches. Employers also need incentives and support, so that they take on disabled workers. The key role of the employers in the Dutch reform had been emphasised. "Job carving" (adjusting both the workplace and the content of the job to the individual) can help to remove obstacles. More development would be important of the youth, gender and mental health elements in the discussion. Prevention has an important role to play in reducing disability and permanent alienation from the labour market. The need to involve the actors in preparing and implementing the reforms had been emphasised. This implies wide communication on the rationale for the reforms and the dissemination of good practice. There had been less discussion of the need to monitor and evaluate what actually comes out of these reforms. Ideally, there should be more *ex ante* consideration of their impact on different groups.

The Commission will certainly have opportunities to build on the lessons learnt at the Peer Review and pick up on the many pointers for further reflection. This will be done in the framework of the social OMC, where one of the objectives is to achieve financially sustainable and socially adequate pension systems. Longer working lives are a key element in that. Active ageing is a priority under the employment strategy, and there is a new disability strategy in preparation. She encouraged the participants to pass on the lessons learnt from this Peer Review, so that they have a lasting impact.

Aurelio Fernández (Chair, EU Social Protection Committee) said the core of the discussion on the social dimension of the future 2020 European Strategy is the joint articulation of the activation mechanisms for consolidating social protection systems. The Informal Council of EU labour and social affairs ministers held in Barcelona looked at the constraints on policy coordination in this sphere. This Peer Review had examined that issue, and a wide diversity of national policy packages had been seen. The challenge ahead is to fit these national packages together in the most consistent way possible. The Peer Reviews are an important element in the work of the

Social Protection Committee. Mechanisms are being established within the Committee to assess both the effectiveness of the various national policies and the impact of the current economic crisis. The Peer Review findings will feed into this process, which can lead on to recommendations to the Council of Ministers.

Fidel Ferreras Alonso (Director General, National Institute of Social Security, Spain) recalled that social security has long been controversial in the countries of the EU. This is because the issues have become more complex. The criteria for entitlement to a widow's pension or a retirement pension are clear. In the case of incapacity benefit, they are much less obvious. Do we look only at medical criteria, or at psychosocial criteria, or also at workplace and occupational criteria? Every EU country takes at least one of these elements into account when defining incapacity, but the emphasis varies, and historically it has tended to shift when the labour market situation changes. When employment declines and the numbers on incapacity benefits increase, the medical criteria come to predominate and we lose sight of the psychosocial aspects in particular. Ideally, the three elements should be combined. Currently, all over Europe, there is also a growing trend to look at income, whether from benefits, from earnings or from both. Statistics show that mental disorders are now the main cause of incapacity, followed by musculoskeletal complaints and cardiovascular illness. Why has Europe become so stressed at work? Pensions are only part of the solution. Reinsertion is just as important, and facilitating people's return to the labour market must be a priority task for government.

Miguel Ángel Díaz Peña (Director General, Ministry of Labour and Immigration, Spain) said that examining social protection systems will, within the mechanism of the Open Method of Coordination (OMC), be a priority during the Spanish EU presidency. The Member States' experiences in this field are diverse, which is why it is so useful to compare them. Spain's social security reforms have passed through a stakeholder consultation phase under the country's Toledo Pact, are now undergoing parliamentary scrutiny and will be subject to further analysis by the social partners. It is hoped that agreed conclusions will be reached within a few months. The incapacity issue has two main facets: the gateway to the benefits, and their possible compatibility with a return to work. An issue that has surfaced recently in Spain is the shortage of data. Closer cooperation among the various agencies is one solution to this. Spain is also placing greater emphasis on prevention. This Peer Review had given Spain a great deal of material for reflection, and he hoped that was also the case for the other participants.