



Spain 2010

Peer Review: Modernising and activating measures relating to work incapacity

Short Report



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



Held in Madrid (Spain) on 4-5 February 2010, the Peer Review was hosted by the Spanish Ministry of Labour and Immigration. In addition to the host country, nine peer countries were represented: France, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Romania, Sweden and the United Kingdom. Represented as stakeholders were AGE (the European Older People's Platform) and EPR (the European Platform for Rehabilitation). Taking part for the European Commission were representatives of DG Employment, Social Affairs and Equal Opportunities, "Inclusion", "Social Protection" and "Integration of people with disabilities" Units.

1. The policy under review

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

The Spanish system distinguishes between temporary and permanent incapacity for work. In the first 12 months, temporary incapacity status is recognised on a medical basis, through weekly certification by the doctor treating the person concerned. This raises a management difficulty because the incapacity benefits are paid out of a national budget, but the decision that launches the payment is taken by doctors answerable to the 17 autonomous regional healthcare systems. Over the past five years, a series of new measures has reduced the cost of incapacity benefits, which had risen steeply as a result of these management complications. During 2003-2004, spending by the National Institute of Social Security increased by 14.5%, whereas between 2007 and 2008, it went down by 4.92%.

One reform is that the institute now has medical inspectors working directly for it. They form part of its multidisciplinary incapacity assessment teams. 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. Of all the workers reaching the 365-day threshold in 2009, the institute determined that 30% had recovered their capacity to work, 16% were to be reassessed for permanent incapacity in view of cognitive or physical problems that might be permanent, and 54% were to continue in temporary incapacity for a further 6 months. Assessment agreements have been signed between the regional health services and the institute, setting annual targets for controlling the payment of incapacity benefits. Another goal is to relate temporary incapacity benefits to the recovery process and the needs of the job rather than to the underlying pathology. Norms are being set for different sectors. For example, an administrative worker who breaks an arm is likely to be vocationally incapacitated for a shorter time than a worker in the construction sector. The weekly certificates are now electronically transmitted to the institute. They include a diagnostic code, enabling the institute to check if the length of incapacity matches the sectoral norms.

In cases of permanent incapacity, the institute is responsible for deciding the degree of incapacity, which determines the benefits payable. The process for recognition of permanent incapacity can be launched either before or at the 365-day threshold, but by law it must be initiated at the latest after 18 months of temporary incapacity. 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. Several measures have been proposed in Spain to reduce early exits from the labour force 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.

2. Lessons learned

Among the main points to emerge from the Peer Review:

- The focus should be on people's **capabilities** rather than on what they cannot do. That principle should be borne in mind at a time when most EU Member States are reflecting on how to modernise their social protection systems.
- **Personalised approaches** to the management of incapacity are needed. One size does not fit all. This needs to be combined with appropriate coordination between the services and other actors involved.
- **Stepping-stones** from incapacity to employment may include the social economy, possibilities for combining work with the drawing of benefits, and trial periods with fall-back provisions.
- **Job carving** (adjusting the workplace and the content of the job to the individual) can help to remove obstacles to employment.
- **Prevention**, by reducing occupational accidents and illnesses and heading off potential causes of unemployment, can help to tackle incapacity at source.
- **Inflow management** is a major issue. 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 reassessment. In the Spanish case, the tax-exempt status of incapacity benefits may encourage people to seek them rather than waiting for their retirement pensions, which are taxable.
- **The nature of incapacity is changing.** In the OECD countries, mental health problems are the fastest-growing reason for incapacity claims. The proportion of incapacitated young workers is also increasing. One gender factor is the particular problems faced by female carers with impairments if they seek to rejoin the labour force. Policies need to take account of all these aspects.
- **Participation by social partners** in the planning and implementation of reform should be ensured, possibly through tripartite structures.
- **Employer involvement** is essential. Effective incentives are needed to change employers' attitudes to disability and encourage them to hire and retain incapacitated workers. Assistance will sometimes be required to make the necessary changes in the workplace, especially in the case of employers with no previous experience of these issues. This may entail the

involvement of specialised personnel. There are now training and certification schemes for disability managers and back-to-work managers. Employer involvement is imperative as only they - together with the employee - know where the latter can perform best. But in particular smaller employers (SMEs), who are providing the majority of employment in Europe, may need additional help with resources. On the other hand, if too much of the responsibility is assigned to the employers, they may become reluctant to hire people with potential future problems. In this case, the medical screening of job applicants may become an issue.

- **Governance aspects**, such as increased involvement of relevant stakeholders, emerge as vital – to raise awareness, foster a shared understanding of what reforms aim to achieve, address misperceptions and attitudes blocking progress. More attention needs to be given to monitoring and evaluating the impact and effectiveness of reforms.
- There have been several **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 (first training people and then attempting to place them on the labour market) over “place-train” approach (on-the-job training) up to more comprehensive “supported employment” concepts which clearly aim at integration into open paid employment with adequate support in various forms. While the emergence of private service providers for the rehabilitation and job placement of incapacitated people can bring benefits, there is a need to prevent “cherry-picking” – a concentration on the easiest and cheapest placement cases rather than on those in greatest need of help.
- **Active inclusion strategies** are particularly relevant to the incapacity debate, as they aim, through integrated, comprehensive approaches encompassing a link to the labour market, adequate income support and access to quality services, both to reach the people who are furthest from the labour market and to fight poverty. A good job is the best safeguard against poverty and exclusion, while it must also be recognised that working is not an option for everyone. The EU will pursue this approach through its social Open Method of Coordination (OMC).