Recent changes in Dutch disability policy

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Abstract

This article deals with disability policies in the Netherlands. We first sketch the disabled population and the benefit systems they may use. We then discuss trends and issues in disability policy. We discuss the major goals of recent policy changes: maximisation of labour force participation of the disabled, and on privatisation as a major instrument to reach these goals.

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1 Introduction

As of 2006 a new disability insurance scheme (WIA) replaces the WAO. The WAO was introduced in 1967 as a unique approach to covering earnings' loss due to long term disablement. It was unique in terms of generosity and accessibility. The WAO integrated two pre-existing schemes: one covering work injuries and occupational diseases, and one covering other causes of disability. Like everywhere else, the work injury scheme was more generous, had a fine grid of loss categories, and offered immediate full coverage. And the definition of covered risk was limited and unambiguous.

The unique step the Dutch took in 1967 was to broaden the work injury scheme to cover *all* disability contingencies, whether work-related or not. Its special features proved its weaknesses because it combined the usual generosity of a work injury scheme with a broad risk definition, including a wide range of non-specific, subjective, health complaints.

In this paper we document how the Dutch tried to cope with this unmanageable disability program. The most important reforms are summarised in Table 1. As a background we start by describing the vocationally handicapped population in the next Section. Almost 16% of the Dutch working-age population report having an impairment that limits the amount or kind of work they can do.

About half of the 1.6 million vocationally handicapped are recipients of a disability benefit. This paper deals with both groups and gives some institutional detail on benefit entitlements under the new WIA scheme. Section 3 describes the new sickness and disability benefit programs. Section 4 discusses trends in disability expenditures and beneficiaries and documents the interaction between institutional changes and disability insurance claims. In Section 5 concludes by drawing some lessons to be learned from the Dutch disability experience.

Table 1 Overview of acts and regulations on sick pay and disability insurance, results and events

Year	Government acts and regulations	Program	Events and results
1930	Sickness Benefit Act. Sectoral funds pay sickness benefits. These funds are fed by sector specific premium rates	Sick pay	
1930s 1950s	Work injury scheme General disability scheme	Disability Benefit	
1967	Dutch disability benefit scheme (WAO) introduced	Disability Benefit	Program covers employees and awards wage-related benefits to max. 80%
1975	Dutch early retirement programs emerged as an element of collective bargaining agreements between trade unions and employers		Growth of early retirement plans
1976	Disability scheme broadened with 1. those handicapped in youth entitlement from age 18 onward 2. The self-employed.	Disability Benefit	Growth in numbers. Those handicapped from youth receive flat benefits at the social minimum level. Financed out of general revenue.
1981		Disability Benefit	Total number of beneficiaries at 10 percent of the labour force
1982 and 1983	Benefit level reduced through the abolition of tax exemptions for disabled.	Disability Benefit	
1984	Earnings base (from which benefits are calculated) reduced. Incomes civil servant and statutory minimum wage are cut by 3 percent	Disability Benefit	
1985	Replacement rates lowered from 80 to 70 percent of last earnings, when fully disabled.	Disability Benefit	
1985		Disability Benefit	Top of 4.2 percent of GDP benefit expenditures
1985		Disability Benefit	From this year on woman have higher disability beneficiary incidence rates
1985	Elimination of the system of automatic indexation (adjustment) of government controlled incomes	All benefits	
Early 1990s		Disability Benefit	Policymakers define the disability issue in terms of 'moral hazard'
August 1993	Introduction 'two-phases' system – a wage-replacement phase followed by a phase with a lower, age-dependent, replacement rate. Replacement rates reduced according to age at onset disability	Disability Benefit	Sharp grow share of partial benefits
1993	Capacity defined by earnings from any job commensurate with one's residual capabilities	Disability Benefit	Percentage of partials among new awards grow
1993	Disability status of those younger than 45 reviewed according to new standards	Disability Benefit	
1994-1996		Disability Benefit	7 percent decrease beneficiary population
March 1996	Sickness Benefit Act abolished. Employers fully responsible for financing sick pay during first 12 months of sickness. Collective coverage replaced by mandating the individual employer to cover sick pay	Sick pay	Sectoral funds, fed by a sector specific premium rates, used to pay sickness benefits.

Year	Government acts and regulations	Program	Events and results
March 1996	Employers mandated to contract private provider of occupational health services to manage absenteeism. Medical doctors employed by these agencies check absence and give prognosis work resumption	Sick pay	Privatisation of the administration and management of sickness absenteeism
1990-2000		Sick pay	Sickness absence rates drop from 8 percent to 6 percent
1997	Privatisation of the 5 public Insurance Agencies	All employee benefits	Social partners (employers, employees) lose responsibility for social insurance programs
1998	Introduction of two separate premium rates, both paid by employer "polluter pays principle". First 5 years of disability benefit recipiency of new beneficiaries is paid out of levied employers premiums. Same period firms allowed to opt out of public insurance system.	Disability Benefit	Substantial impact of experience rating on DI inflow
1998	Introduction Act on Reintegration of Work Handicapped (REA)	Reintegration disabled	New target group, the work handicapped
1999		Disability Benefit	Disability benefit expenditures 4.14% of GDP
2002	5 private Insurance Agencies are integrated into one public Social Insurance Institute (SII) Reintegration is contracted out to private firms.	All employee benefits	
April 2002	Introduction of the Gatekeeper Protocol for sicklisted employees	Sick pay	
November 2002		Disability Benefit	Number of recipients coming close to the politically contentious level of one million
2003		Disability Benefit	Benefit expenditures decreased to 2.6 percent of GDP.
2003	SII pays sick pay for handicapped workers and companies pay lower disability insurance rate and are exempt from experience rating when employing such workers.	Sick pay and Disability Benefit	Introduction of the term 'no-risk policy' when hiring a disabled worker.
2003	Employers obliged to contract private reintegration firm to help disabled employee for whom no commensurate work is available within the firm to find new employment.	Reintegration	Privatisation of the administration and management of sickness absenteeism and reintegration
2003	Illness or injury entitles an insured person to a disability benefit after a mandatory waiting period of 24 months (was 12 months)	Sick pay	
2004	Self-insurance period employers extended to 24 months. (was 12)	Sick pay	
July 2004	Separate program covering self-employed has been abolished	Disability Benefit for self-employed	
October 2004	Stricter assessment rules for Disability Benefit eligibility	Disability Benefit	Start of reassessment of all current WAO-beneficiaries younger than 50 according to the stricter assessment rules
2002-2004			Disability inflow rate reduces by 40%
July 2005	Obligation employers to contract an occupational health agency is abolished	Sick pay	Firms are still mandated to contract occupational health services but may do so from separate providers
2006	Introduction of WIA, replacing WAO	Disability	

Year	Government acts and regulations	Program	Events and results
		benefit	
2004-2006		Disability benefit	Disability inflow rate drops by 50%
2006-	Dual system of financing the first ten years of WGA-benefit payment: firms may choose between the public insurer and pay an experience rated premium or become self-insured and take out private coverage	Disability benefit	28% of the firms are self-insured. They represent 51% of the wage-bill.

2 A snapshot of the Dutch vocationally handicapped population

Survey data from 2012 show that 12.3% of among 11 million working age (15-64) Dutch citizens report having (1) a chronic impairment, and (2) one that restricts their work capacity. This group is called 'Arbeidsgehandicapten' (vocationally handicapped). Compared to this average, the prevalence of handicaps is relatively high among women (14%) and the age-group 55-64 (21.6%).

The labour force participation rate of the vocationally handicapped is 41%. This is 31 percentage points lower than the national average of 72%.

The share of vocationally handicapped in the employed population is 6.6%. While on average an unusually high 38% of Dutch workers work part-time, 51% of handicapped workers do so.

These data confirm that the vocationally handicapped work less than their able-bodied peers. In other words, many handicapped workers are also handicapped financially.

3 The Dutch sickness and disability benefit schemes

3.1 Sick pay

Sick pay covers wage loss due to ill health during the mandatory waiting time for disability benefit entitlement. As of 2004, the waiting period is extended from one year to two years. So, sick pay ends after 24 months, upon which a disability benefit may be awarded, if found eligible.

High benefits, paid for by employers

Since 1996, the Dutch Civil Code stipulates that employers pay 70 percent of gross wage earnings if an employee is unable to perform his or her job because of illness or injury, irrespective of its cause. Before 1996, sectoral funds paid sickness benefits. These funds were fed by sector specific premium rates. Hence, collective coverage was replaced by mandating the individual employer to fund sick pay.

An employer sick pay, or wage continuation, period of two full years is exceptional. This two-year sick pay period applies to every Dutch employer, irrespective of size. Firms may reinsure their sick pay liability with a private insurer but are not obliged to do so. Evidently, most small and medium size firms take out private (re)insurance.

Under collective bargaining agreements between employers and employees sickness benefits are supplemented. In 2004, government and the social partners reached an agreement prescribing that the average replacement rate during the two-year sickness benefit period should not be higher than 85% of gross wages. Before 2004, the effective replacement rate was 100% of net wages during the sickness benefit year.

Employment protection

After reporting sick Dutch employees enjoy employment protection during two years. In other words, during the two-year sickness benefit period employers can only dismiss employees who consistently refuse to collaborate with reasonable work resumption plans, or pay a high (severance) indemnity. After the two-year period the labour contract can be silently dissolved.

The combination of employment protection and high replacement rates during sickness makes the sick pay option a relatively attractive one for employees – especially those who are unhappy with their work conditions, are exposed to a ‘double burden’ (combining work and family care), or have a weak attachment to the labour market.

Separation between treatment and control

The Dutch adhere to a strict separation between treatment and control. The confidential relation between a patient and his or her doctor should not be burdened with checking the medical legitimacy of absence from work. Therefore, every company is obliged to contract an occupational physician. These company doctors, who are often employed by private Occupational Health agencies, advise on prevention and management of sickness absenteeism, check the medical legitimacy of sick reports and may refer sick workers to other medical specialists. Rehabilitative health treatment, prescribed by company doctors, like low back pain therapy, psychotherapy, or conflict mediation, is not covered by regular health insurance but is paid by the employer, or his/her sick pay insurance.

The strict separation between the curative sector and occupational/social insurance medicine creates a tension. To put it strongly, the curative approach may keep sick workers endlessly in the medical process (until recovery), or may allow the sick to use an unfinished treatment as an excuse to have their leisure subsidised. From a social insurance perspective, however, one may want to control the damage (health expenditures and productivity loss) by trying to get sick workers back to work as soon as possible, even if not fully recovered. This tension has become more acute since Dutch employers are confronted with the full cost of sickness. The organisational and financial split between the curative sector and occupational medicine implies that firms who want swift treatment for their sick employees are confronted with waiting times and specialists who are – sometimes willingly – unaware of the employment status of their patients, let alone the needs of the employers of those patients.

Moreover, as of 2003, firms are obliged to contract reintegration services with private providers. These reintegration bureaus are paid to retrain and find jobs for disabled workers for whom no commensurate work is available at their current employer.

The Gatekeeper Protocol

As of April 2002, the responsibilities of a sick employee, his/her employer, and the company doctor are legally specified, and mandate a structured approach to early intervention in cases of sickness. After a maximum of six weeks of absence the company doctor has to make a first assessment of medical cause, functional limitations and give a prognosis regarding work resumption. On the basis of these data employer and employee together draft a vocational rehabilitation plan in which they specify an aim (resumption of current/other job under current / accommodated conditions) and the steps needed to reach that aim. They appoint a case-manager, and fix dates at which the plan should be evaluated, and modified if necessary. The rehabilitation

plan should be ready in the eighth week of sickness. It is binding for both parties, and one party may summon the other when considered negligent.

After 87 weeks of sickness the Public Disability Insurance Administrator (the Social Insurance Institute, or UWV)) sends a Disability Insurance application form to the sick employee. Disability Insurance claims have to be delivered before the 92nd week of sickness. Claims are only considered admissible if they are accompanied by a re-habilitation report, containing the original rehabilitation plan, and an assessment as to why the plan has not (yet) resulted in work resumption. If the report is delayed, incomplete, or proves that the reintegration efforts were insufficient the claim is not processed and the employer is obliged to continue paying sickness benefits even after the waiting period for disability benefit has elapsed.

No-risk policies

Sickness benefits for Unemployment Insurance benefit recipients, 'flexworkers', such as temporary agency workers and workers with a fixed term contract, and those working under a so-called no-risk policy are covered by a separate collective ("safety net") fund. These are workers without an employer, for whose employer the sick pay risk is considered an undue burden, or who would experience difficulties (re) enter-ing the labour market because their disabilities induce a financial risk for potential employers.

The latter group consists of those:

- who previously were disability benefit recipients;
- who were the two-year sick but not entitled to disability benefit (less than 35% disabled);
- who belong to the group targeted by the Sheltered Work Provision Act;
- who have been assessed by the Labour Office as being work handicapped;
- whose sickness is induced by pregnancy or delivery, after the statutory period of maternity leave covered by a separate Act (on Work and Care) has lapsed.

Effects of privatising sick pay

Sickness absence rates dropped from 8 percent in 1990 to 6 percent in 2000 – a 25 percent drop.[1] Both these years represent a cyclical top and comparison between these, therefore, controls for the influence of the business cycle on absenteeism. At least part of this large drop can be ascribed to privatisation, and its associated incen-tives. This favourable result is obtained despite the fact that about 80 percent of all firms took out some form of private insurance to cover their sickness liabilities.

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1 T.J. Veerman en J.J.M. Besseling, *Prikkels en privatisering*, The Hague: EBI, 2001, p.60.

There appears to be a strong negative relationship between firm size and insurance coverage: while firms with less than 20 employees have a coverage rate of about 83%, only 25 percent of those with 100 or more workers buy insurance. Larger firms also choose a larger coinsurance period or buy a stop-loss arrangement.[2] To avoid adverse selection insurance companies stipulate that no employee be excluded from coverage under a sick pay policy which the employer buys. Insurers also demand that firms contract occupational health agencies, and stipulate which set of services is to be contracted. Econometric analysis shows that the insurance status of a firm had no adverse effect on its consecutive absence record.[3] This suggests that, apart from experience rating, sick pay insurers use other instruments as well to control damages.

Surprisingly enough, privatisation did not induce a surge in conflicts between sick workers and employers refusing to continue payment of their wages. This could have been the result of the fact that the privatisation was enacted in a boom period. But also the 2000-2004 recession did not lead to significant trouble.

3.2 Disability (WIA) benefits

The WIA ruling started in 2006. It replaced the comprehensive disability benefit scheme – WAO, which is dealt with in the next Section. The new scheme is more work-oriented as it emphasises the use of residual capacity instead of compensating incapacity. The Social Insurance Institute administrates both the disability and unemployment insurance programs.

Eligibility rules

Under the Dutch ruling any illness or injury entitles an insured person to a disability benefit after a mandatory waiting period of 24 months. While other OECD countries make a distinction by whether the impairment occurred on the job or elsewhere, only the *consequence* of impairment is relevant for the Dutch disability insurance program.

Under the new (WIA) ruling the degree of disablement is measured by considering two factors: severity and permanence. A disabled worker's residual earning capacity indicates severity. It is defined by the earnings flowing from any regular job commensurate with one's residual capacity, as a percentage of earnings, irrespective of

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2 T.J. Veerman, E.I.L.M Schellekens, J.F.L.M.M. Dagevos, J.A. Duvekot, F. Marcelissen. P.G.M. Molenaar-Cox, W*erkgevers over ziekteverzuim, Arbo en reïntegratie*, The Hague, EBI, 2001, pp.22-27.

3 Ph.R. de Jong and M. Lindeboom, “Privatisation of Sickness Insurance: Evidence from the Netherlands”, *Swedish Economic Policy Review* 11 (2004), pp. 11-33.

education, work history, or acquired status. A job is regular if it pays at least the statutory minimum wage.

The degree of disablement is the complement of the residual earning capacity and determines for which of *two schemes* an applicant is eligible. If the capacity loss is 80% or more, *and* there is no foreseeable potential for any degree of recovery, the claimant is awarded a so-called *IVA* (full and permanent disability) benefit.

If capacity loss is anywhere between 35 and 80%, *or* 80% or more, but with prospects for recovery, he/she is entitled to a so-called *WGA*-(partial or temporary full disability) benefit. If capacity loss is less than 80% the WGA-benefit is primarily a wage-subsidy scheme because it covers 70% of the difference between the new wage and the old, pre-disability wage. For those who are without work the unemployment insurance rules apply and the WGA benefit shrinks eventually to one based on the minimum wage (see below).[4]

Assessment
Disability assessment is done by specialised social insurance doctors and vocational experts, employed by the Social Insurance Institute - the so-called gatekeepers of disability insurance. Before a disability benefit claim is processed the reintegration plan, which concludes the Gatekeeper Protocol, is checked. If the plan convincingly shows why work resumption during the two sickness years has failed, the plan provides the gatekeepers with a first picture of the medical and vocational problems of the claimant. The social insurance doctor then proceeds by judging the general medical condition of the claimant. If the current medical status allows for the presence of functional capacities an inventory of such capacities is made.
In 2010, among about 32,000 new awards, 77% were judged to have some capacity to function in paid (open) employment. The other 23% had no functional capacities at the moment of adjudication, for instance because they were bedridden, or in a treatment program. Such medically fully disabled cases are always reviewed later, at an appropriate moment to see if the claimant is recovered and capacities are regained.

For those with residual capacities, the vocational expert feeds this list of functional capacities to an algorithm representing the Dutch labour market, *i.e.,* a catalogue of regular jobs, and the physical and mental requirements to do those jobs. The algorithm produces a list of jobs that are commensurate with the claimant's capacities, and their wage rates. Only if at least three different types of jobs are found, each of which can be found in three places on the Dutch labour market, the residual capacity

4 The statutory minimum wage is €19,500 per year (in 2014).

of the claimant is assessed. This is called the “three-by-three rule”. If the limitations are such that they don’t meet this rule, the claimant is considered fully disabled. The vocational expert uses this list to assess one’s residual earning capacity. In his assessment he may take account of vocational factors, such as age and knowledge of the Dutch language. Whether there are any vacancies among commensurate jobs is irrelevant.

The outcome of this two-step process is a degree of disablement which is not only dependent on the medically caused functional limitations but also on earnings. If earnings are at, or just above, the minimum wage a relatively small loss of functional capacity may lead to a residual capacity at a level lower than the minimum wage. In that case regular jobs are not commensurate which one’s residual capacity and the claimant is considered fully disabled. If, on the other hand the residual capacity allows for work in a low-wage job the earnings loss is often smaller than 35% and the claimant is denied a benefit.

Permanence of disability is established in the last phase of the adjudication process. The crucial aspect to establish permanence is whether medical treatment could eventually reduce functional limitations entailing full disablement. Only if such prospects are absent, permanence can be concluded.

Benefit calculation
An IVA (full and permanent disability) benefit equals 75% of gross earnings.

The WGA (partial or temporary disability) benefit is cut in two, chronologically linked, parts. The first is a short-term wage-related benefit replacing 70 percent of the difference between the pre-disability wage and *the new wage*, if employed. For those without employment the WGA-benefit replaces 70% of the pre-disability wage. The duration of the wage-related benefit depends on work history and age and is the same as the rules for the duration of unemployment insurance benefit.[5]

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5 Coverage for unemployment insurance benefits requires gainful employment for at least 26 weeks during the 36 weeks before unemployment – the so-called ‘weeks requirement’. If a dismissed employee has been employed for at least four years during the five years preceding the year of dismissal the ‘years requirement’ is also met. If only the ‘weeks’ requirement is met, entitlement ends after three months. If both requirements are met, duration of the earnings-related benefit depends on a combination of age and one’s work record since 1998, with a minimum of four months and a maximum of 36 months. During the first two months the replacement rate is 75%, and 70% thereafter. For those who are not entitled to unemployment insurance benefits, or who exhaust their entitlement, means-tested social assistance is available. As of 2015, the maximum duration is 24 months.

The second part is a so-called follow-up benefit with stricter rules. It looks at the difference between the pre-disability wage and *the residual earning capacity* as assessed by the Social Insurance Institute. If the disabled employee fully uses his/her residual capacity the new wage is 100% or more of the assessed capacity and the WGA-benefit does not change. If only part of the residual capacity is used the replacement rate drops correspondingly (see Box 1 for an example).

Box 1 Example of WGA benefit calculation

A 40 year old employee is assessed as being 50% disabled. His pre-disability wage was €2,000 per month. So, his assessed residual capacity is *€1,000.*

I. He works and earns €1.000. His wage related and follow-up benefit WGA-benefit is €700.

II. He works and earns €600. His wage-related benefit is €980. His follow-up benefit is €700.

III. He works and earns € 400. His wage-related benefit is €1,120. His follow-up benefit is 70% x 50% x €1,378.65 = €482.50.

IV. He is unemployed. His wage-related benefit is €1,400. His follow-up benefit is 70% x 50% x €1,378.65 = €482.50.

Table 2 Earnings and WGA benefit for an employee with a pre-disability wage of €2,000 per month who is 50% disabled

	Labour earnings	Wage-related benefit	Follow-up benefit	Total earnings		
				First part	Second part	Replacement rate
I.	1,000	700	700	1,700	1,700	0.85
II.	600	980	700	1,580	1,300	0.65
III.	400	1,120	482.5	1,520	882.5	0.44
IV.	0	1,400	482.5	1,400	482.5	0.24

If the new wage is between 50 and 100% of the assessed capacity the WGA benefit equals 70% of the difference between the pre-disability wage and the residual earning capacity. If the new wage is less than 50% of the assessed capacity the WGA-benefit is based on the minimum wage level so as to penalise a disabled worker for not working enough.[6]

The same 'penalty' applies to unemployed partially disabled workers. After lapse of the wage-related unemployment insurance benefit, they keep a WGA-benefit which equals [70% x degree of disability x minimum wage]. If this minimal benefit is below the social minimum that applies to the household to which the unemployed disabled belongs, he/she is entitled to a supplement. This supplement is tested against

6 In 2006 the before-tax minimum wage equals €16,543.80 per year, or €1,378.65 per month.

household labour income, not household wealth, or investment income, like under social assistance.

Disability and unemployment insurance benefits are capped by a maximum amount of covered earnings equalling € 44,400 per annum. This is also the maximum amount of income taxable for disability (and unemployment) insurance.

Financing WIA benefits

IVA benefits are paid for by a uniform pay-as-you-go premium rate. To finance the first 10 years of WGA benefit recipiency firms have the possibility to choose between the Social Insurance Institute - the public insurer – or to opt out of the public pay-as you-go system and buy a WGA-insurance policy from a private insurer. Evidently, private coverage induces full experience rating at the level of the individual firm. To make the playing field between a public disability insurer, who calculates pay-as-you-go premium rates, and a private insurer, who is obliged to prefund its benefit liabilities, the Social Insurance Institute also uses premiums that follow the polluter-pays-principle. It differentiates premiums according to a firm's risk, which is based on the disability benefit expenditures ("damages") it has caused over the previous five years. The premium differentiation grid differs according to firm size: firms with a taxable wage-bill less than 755 thousand euro (25 times the average wage) are small firms.[7] The premium grid for small firms runs from 0,48% to 1,59% of the taxable wage bill, and for other ("large") firms from 0,13% to 2,12% (in 2012). The average premium is 0,5%.

These differentiated premium rate fund the first ten years of WGA benefit recipiency. This implies that Dutch firms run a financial risk that extends to 12 years in cases of sickness and disability. Private insurers offer combinations of sickness and disability benefit insurance that cover this 12 year period. Such insurance packages may also cover re-integration efforts that are a firm's responsibility if it chooses to leave the public system. 38% of the large firms, and 29% of small firms, have opted out of public insurance because they get a better deal from private insurers.[8] In terms of employees the market share of private insurers is about 50% of the wage bill. To the extent that opting out mainly concerns low risk firms this dual system may fuel a crowding-out process which may result in a situation where most firms have left the public insurer and only a group of high-risk firms are stuck with the public option.

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[7] The taxable wage is defined by the maximum insured wage. In 2012 this € 50,064 per year.

[8] Jan-Maarten van Sonsbeek, Michiel Rovers and Saskia Mangoendimono, 2012. "De duale markt voor WGA-verzekeringen", *ESB*, 97 (4639 and 4640).

Reassessing WAO beneficiaries
In 2004, a parliamentary majority supported the proposal to make the eligibility standards for WAO *and* WIA benefits stricter. For instance, full disability on medical grounds can only be concluded if a claimant is institutionalised or incapable to perform regular activities of daily living independently. Regarding the vocational part of disability determination pre-onset work patterns – such as part-time work - are not taken into account anymore, unless there are medical constraints. Lack of common skills, such as command of the Dutch language or basic use of a computer, are disregarded.

Introduction of a new social insurance arrangement creates the issue of what to do with the current beneficiary population. Between October 2004 and December 2007 all (300,000) WAO beneficiaries younger than 45 are being re-assessed using these stricter standards. This campaign started with the youngest cohorts and ended with the 45-49 year olds in 2007. 39% of the benefits were terminated or reduced, and among this group about 60% were working three years after their benefit status was reviewed.

Other disability programs
Up until July 2004 a separate disability benefit program for self-employed workers existed. It was introduced in 1976, awarded social minimum benefits, and was funded by a uniform contribution rate. At the end of 2011, there were 26.000 benefit recipients left. Because there are no new enrolments the program will gradually disappear.

A second program addresses those handicapped from youth – the so-called Wajong scheme. This scheme, too, provides flat benefits at the social minimum level, financed out of general revenue. Eligible youth handicapped are entitled to a benefit from age 18 onwards. At the end of 2011 it had 207.000 beneficiaries. Almost all beneficiaries are judged to be fully disabled, not so much because they have no earnings capacity but because their earning capacity is lower than the relatively high minimum hourly wage rate in the Netherlands. Hence, while about 75% are capable of doing productive work in the labour market, employers do not hire them, because all employees must be paid the statutory minimum wage. At the current inflow rates, the Wajong program is estimated to grow to 400,000 beneficiaries by 2040 (see Figure 3).[9]

[9] See Burkhauser, Daly and De Jong, 2008. "Curing the Dutch Disease: Lessons for United States Disability Policy", MRRC Working Paper, Michigan, for a fuller discussion of the Wajong scheme.

4 Trends and their underlying causes

4.1 Trends

For long the Dutch disability scheme was excessively generous and open to unintended use. The data in the first publication of a larger OECD disability policy project[10] shows that Holland is still among the big spenders of disability benefits but it is not the biggest spending country anymore, as it was in 1990.

Figure 1 shows the trend in the number of persons receiving a disability benefit as a percentage of the labour force (including disability beneficiaries),[11] and disability benefit expenditures as a percentage of GDP. Disability benefits include both benefits from contributory and non-contributory disability schemes. From a 1985 top of 4 per cent of GDP disability benefit expenditures decreased to 2 per cent in 2010.

At the same time, however, the relative number of beneficiaries is still 8.5% of the labour force. In absolute terms, the number of disability beneficiaries grew continuously from 475,000 in 1976 to 921,000 in 1993.[12] As of 1994, changes in the definition of disability and in the way benefits are calculated drastically reduced the number of new awards. Moreover, part of the current beneficiaries was reviewed using a new, more stringent definition, as was done later, in 2004. This increased the number of benefit terminations and, on balance, led to a 7 percent drop in the number of beneficiaries, to 855,000 in 1996. From then on the numbers started growing again, and reached 993,000 at the end of 2002, coming very close to the politically contentious level of one million disabled.[13] From 2003 onwards the number of beneficiaries declined thanks to a number of measures, culminating in the introduction of the new disability (WIA) scheme in 2006. Currently, it stands at about 800,000 of which 55% are beneficiaries from the previous WAO scheme and 25% belong to the Wajong scheme for youth handicapped.

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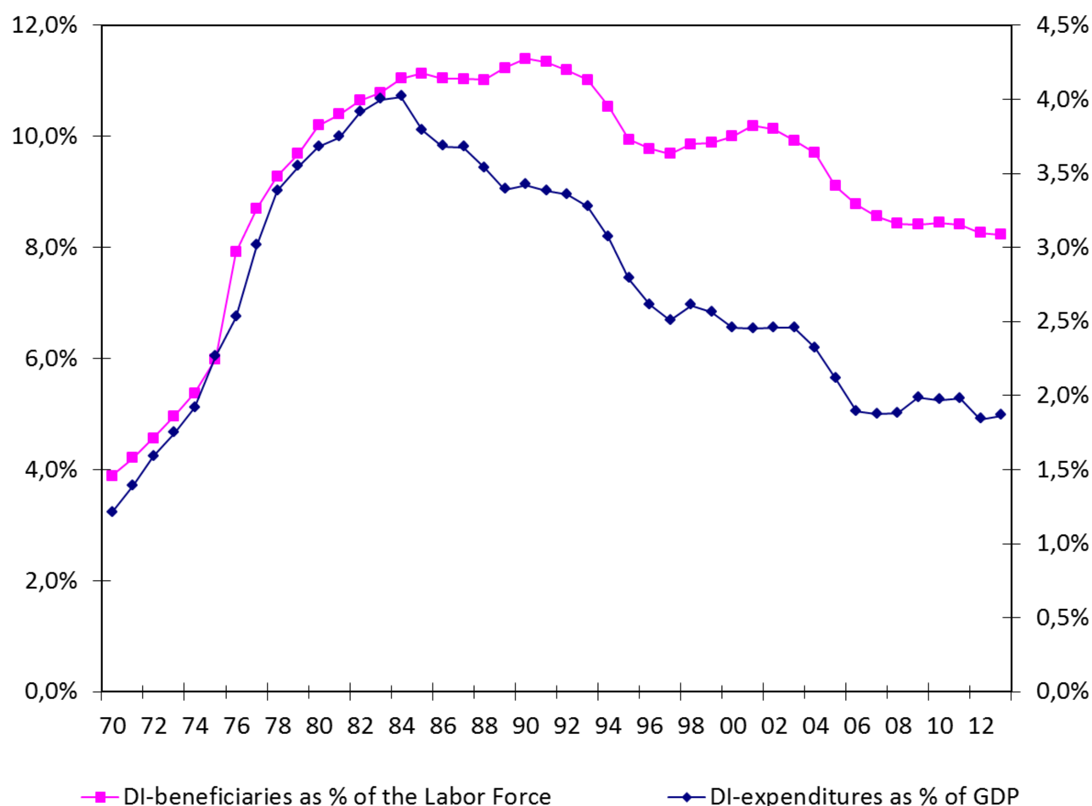
10 *Transforming Disability into Ability,* Paris, OECD, 2003.

11 Disability beneficiaries are measured in full benefit equivalents (*i.e.*, corrected for partial benefits).

12 In 1976 the disability scheme was broadened. From then on it also included those handicapped in youth and the self-employed. The absolute numbers quoted are not corrected for partial benefits.

13 In 1990, when the number of beneficiaries was 880.000, then Prime minister Lubbers declared that he would resign if the rolls would reach the one million beneficiary point.

Figure 1 DI beneficiaries as a percentage of the labour force (left axis) and DI-benefit expenditures as percentage of GDP (right axis), 1970-2013



Sources: CBS, UWV

Figure 1 above shows that, up until 2003, the reduction in spending on disability benefits was not caused by a smaller number of beneficiaries. Logically, then, the average benefit must have gone down. Three factors have reduced the average benefit amount: statutory benefit cuts; more stringent eligibility standards; and changes in the profile of the enrolees, as the disability entry rates of women, mostly working parttime, significantly increased between 1985 and 1993, and, from then on, stayed at a higher level than that of men (see Figure 2).

4.2 Benefit cuts

Over the 40 years covered by Figure 1, benefit cuts were regularly used to reduce the financial burden of an otherwise uncontrollable program. In the early 1980s benefits lost 25% of their purchasing power by a series of substantial retrenchments. First, levying social insurance contributions on benefit income changed the calculation of after tax benefit amounts. In 1982 and 1983, the after-tax DI-benefit level was reduced through the abolition of certain tax exemptions for the disabled. In 1984, the earnings base from which benefits were calculated was reduced. Moreover, all incomes under government con-

trol - transfers, civil servant salaries, and the statutory minimum wage - suffered a 3 percent nominal cut. Finally, in 1985, (before tax) replacement rates were lowered from 80 to 70 percent of last earnings, when fully disabled. These direct cuts were accompanied by the elimination of the system of automatic indexation (adjustment) of government controlled incomes. In August 1993, benefits were cut again when statutory replacement rates were reduced according to age at the onset of disability. As a result, benefits lost another 20 percent of their real value between 1985 and 1995. This loss contrasts sharply with per capita GDP, which increased by one third during the same period. To summarise, the *after-tax* replacement rate for an average worker who becomes fully disabled dropped from about 90% in the 1967-1980 period, to 85% between 1980 and 1994, to 75% from 1994 onwards.

4.3 Partial benefits

After the changes of 1993 the share of partial benefits grew sharply. By these changes the notion of suitable work was eliminated from the definition of disability. Capacity is since defined by the earnings flowing from any job commensurate with one's residual capabilities as a percentage of pre-disability usual earnings. Before 1994, only jobs that were compatible with one's training and work history could be taken into consideration in the assessment of residual capacity. This ruling made the percentage of partial benefits among new awards grow from 20% in 1990 to 40% in 2004.

Due to the recession the share of partial benefit awardees that work decreased from 68% in 2008 to 62% in 2012. For them, and their employers, the benefit acts as a wage subsidy. Research has shown that partial beneficiaries differ from full beneficiaries in many respects: They are older, better schooled, more often male, married and main breadwinner, have a longer tenure with their current employer and work in large, financially healthy firms.[14] In short, Dutch partial beneficiaries are socially and economically better off. The data suggest that partial benefits are often used to offer older employees easier work conditions and act as a partial early retirement scheme.

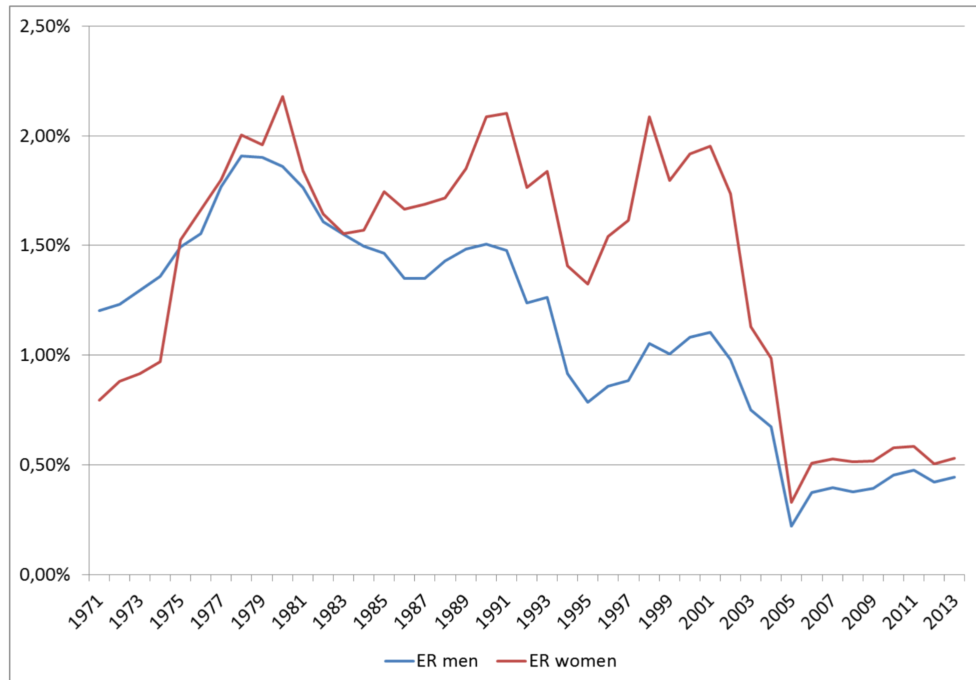
4.4 The average beneficiary changed between 1985 and 2005

Over the past three decades the typical new disability beneficiary changed from an older male industry worker with a long work record in physically strenuous work into a younger female employee in the service industry with a relatively short labour market record. As 57 percent of Dutch women work part-time their wages and their

14 Philip de Jong and Vincent Thio, “Donner versus Veldkamp”, APE report 53, October 2002 (in Dutch).

D.I.-benefits are lower.[15] An increasing proportion of women among D.I.-entrants, therefore, implies lower benefits, other things equal.

Figure 2 DI Inflows as a percentage of the labour force (Inflow Rates, IR) for men and women, 1971-2013 (WAO/WIA inflows)



Source: UWV, CBS Statline

Figure 2 displays the inflow rates for men and women into the contributory WAO/WIA scheme for employees. Women had lower rates until 1985, and have higher ones ever since. More importantly, the gap between the two incidence rates increased from 1983, when the female rate was 15% lower than that of men, till 1998, when women had a 98% higher chance of becoming dependent on disability benefits. It stayed at about that level until 2002.

The sharp increase in the female disability incidence was matched by an equally strong growth of the labour force participation of mothers. Traditionally, The Netherlands had very low labour force participation rates among mothers. In the 1970s three out four women stopped working after the birth of their first child. Twenty years later only one third stops. In other words, the traditional single-earner model was replaced by one where husbands work full-time and wives have part-time jobs. For lack of sufficient child care facilities this social change has been accommodated by the disability scheme. Disability benefits allowed to let market production be replaced by home production without a sharp drop in household income. The femini-

15 *OECD Employment Outlook,* Paris, 2002, p. 69.

sation of disability benefit dependency illustrates how an income oriented disability policy invites to put the strains of dual earnership in medical terms. When, from 2002 onwards, policies changed the gender gap in inflow rates decreased significantly, from a 77% higher rate in 2002 to a 27% higher rate in 2010.

4.5 Sharply decreasing inflow rates

Between 2002 and 2010 the inflow rate decreased sharply, from 1.3% to 0.5% of the labour force. Four factors have contributed to this drop. First, the Gatekeeper Protocol in combination with the financial incentive for firms to contain sickness absence reduced sickness duration and the number of DI claims. Second, experience rating for firms was already introduced under the former WAO scheme, and proved effective.[16] Third, eligibility criteria became stricter under the new WIA scheme, and this stringent approach was in force as of October 2004. And fourth, the new disability benefit program offers less generous benefits as it intends to replace generosity and accessibility by an emphasis on residual capacity and penalties for those who are negligent in terms of reintegration effort. This new approach may have discouraged workers from following the 'disability route'.

Van Sonsbeek & Gradus decomposed the 70% drop in inflows between 1999 and 2009. [17]They attribute 22 points to the Gatekeeper protocol, 13 points to experience rating, 13 points to increased stringency, and 23 points to the less generous WIA scheme.

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[16] Pierre Koning, 2009. "Experience rating and the inflow into disability insurance", *De Economist*, 157 (3), pp. 315-335.

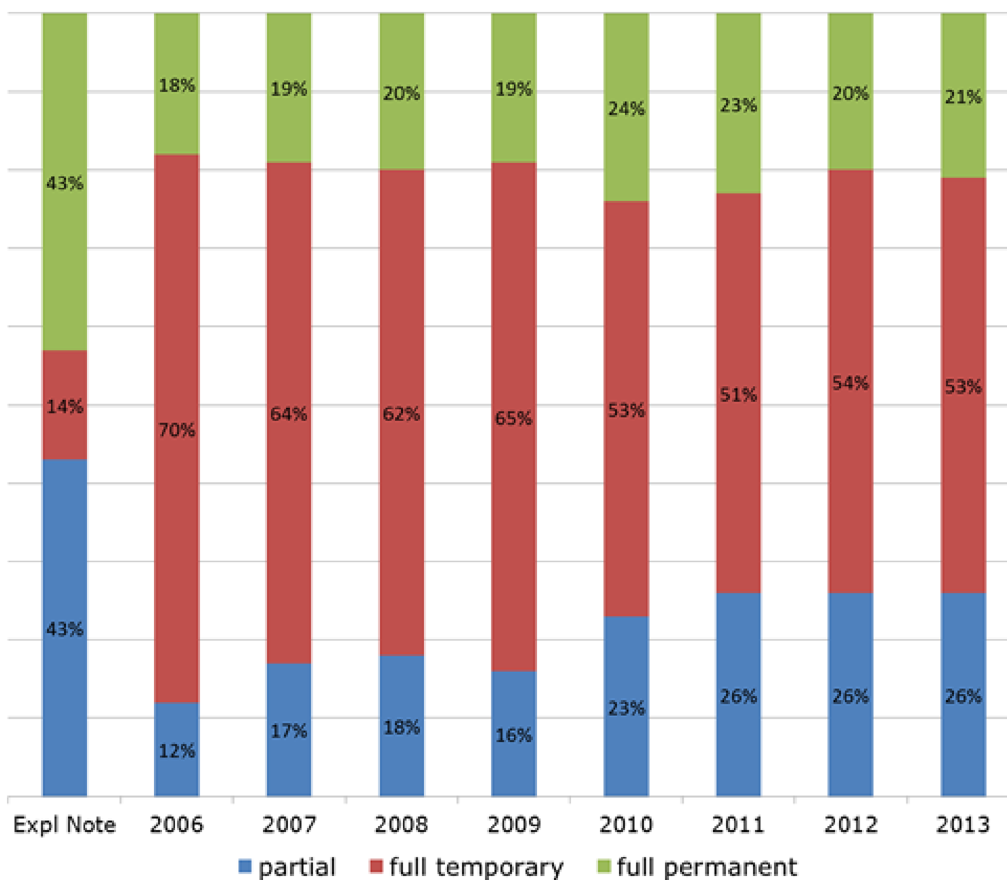
[17] J-M van Sonsbeek & R. Gradus, 2011. "Estimating the Effects of Recent Disability Reforms in The Netherlands," Tinbergen Institute Discussion Papers 11-121/3, Tinbergen Institute, Amsterdam.

5 Outcomes of the new WIA scheme

Extent of disablement

About 1% of the insured population files a WIA claim at the end of the second year of sickness. The denial rate is about 45%. Figure 3 shows how the awards are distributed. In 2013, 21% pertains to the IVA scheme for those that are not expected ever to return to paid work. The other 79% get an award under the WGA scheme of whom about a third is assessed as partially, and two-thirds as fully disabled but with a prospect of recovery.

Figure 3 Composition of WIA-awards by degree of disablement, 2006-2013



Source: UWV Kwantitatieve informatie, 2007 -2014

These outcomes are in stark contrast with expectations when the bill was drafted. According to its Explanatory Note the government expected that only 14% of DI entries would be assessed as fully but not permanently disabled. From the start of the WIA scheme this group turned out to be the largest.

Conversely the share of partial WGA awards is much smaller than expected. The complex system of incentives that is designed to promote full use of residual capacity of the partially disabled, as illustrated in Box 1 and Table 2, now only applies to 26% of WIA awards, and to 20% of all current WIA beneficiaries. The share of partial benefits is lower than was expected because of the preventive effects of the Gatekeeper protocol, that promotes re-integration efforts for workers who are able to work.[18] The relatively large share of fully disabled under the WGA scheme is partly the outcome of the same process of (self) selection that directs those without residual capacities towards the WIA. For another part, it reflects the strict rules that steer admissions to the IVA program for those who are permanently fully disabled. If those that are considered fully but not permanently disabled do not regain any capacity to work in the coming years, they will probably move to the IVA scheme. Pressures to do so may both come from beneficiaries, but also from employers and insurers who can stop paying for WGA benefits if beneficiaries move to the IVA scheme because IVA benefits are funded by a uniform pay-as-you-go rate.

Diagnosis

Table 2 indicates how the new system works: IVA-benefits are targeted towards those with severe medical conditions who have no prospect of recovery. For the other categories the medical picture more resembles that of the usual disability beneficiary population, with a smaller share of serious, potentially lethal conditions, and a larger share of non-specific disorders.

Table 3 Diagnoses by disability benefit category, 2006

	IVA-benefit	**WGA – full benefit**	**WGA – partial benefit**	**denials**
Cancers	18%	7%	7%	3%
stroke (CVA)	12%	2%	3%	1%
neurological diseases	15%	3%	4%	1%
cardiovascular diseases	4%	1%	2%	1%
respiratory diseases	3%	1%	2%	1%
psychiatric disorders	3%	2%	1%	0%
sub-total	56%	17%	19%	8%
other mental disorders	9%	40%	36%	27%
other diseases	36%	43%	44%	65%
total	100%	100%	100%	100%

Source: UWV, Kwartaal Verkenning, 2007 II, p.28

[18] See Tom Everhardt and Philip de Jong, 2011. “Return to Work After Long Term Sickness: The Role of Employer bases Interventions”, *De Economist,* 159 (3), pp. 361-380.

Contingent workers ("safety-netters")
Until 2014 workers who are entitled to sickness benefits but have no employer to pay for it were paid out of a so-called safety-net fund. This fund is administrated by the Social Insurance Institute (UWV in Dutch). This group consists of:

- employees whose labor contact ends during a sick spell: either because they have a fixed term contract or are made redundant;
- the vast majority of temporary agency workers ("temps") whose contract ends when they call in sick;
- Unemployment Insurance beneficiaries.

UWV takes on the benefit payment, accommodation, rehabilitation and job mediation tasks that employers do for workers whose contract continues during sickness.

While the share of workers who end up as safety netters during sickness is 25% of the employed population they account for 50% of all DI-entries. In other words, their probability to enter DI is three times as big as that for "regular" employees. [19]

Two factors, among others, contribute to this vast difference. The first is that safety netters by definition lack an employment contract and an employer to return to. They have to rely on jobs at other firms which are much harder to obtain in, or after, a sick spell. Second, UWV is not subject to the financial and administrative incentives that firms face.

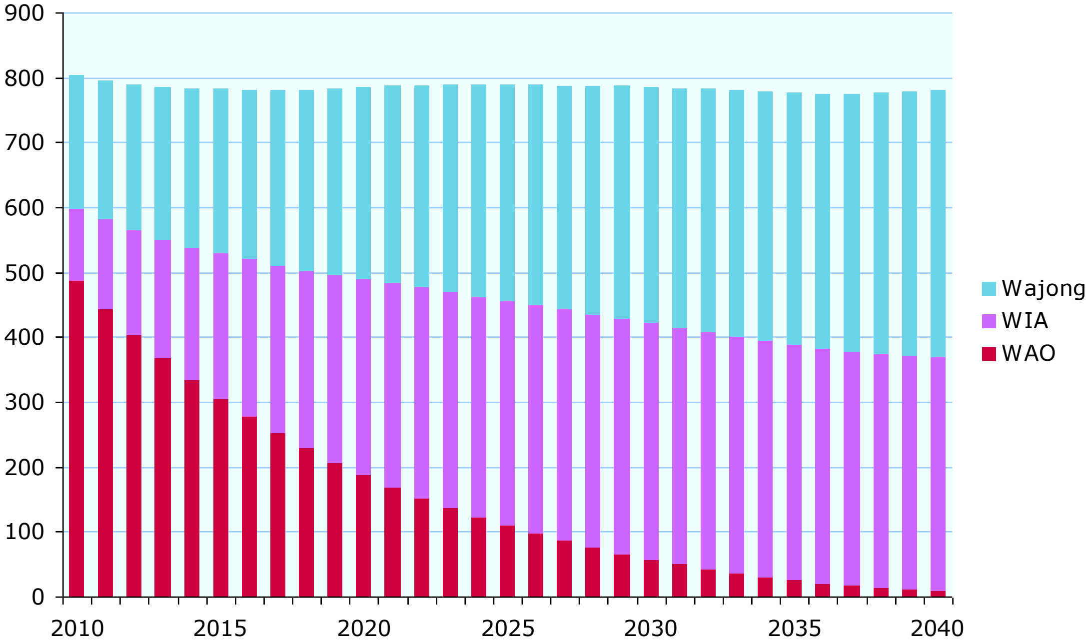
From 2014 on, new legislation seeks to emulate the successes of the reform measures for regular employees for workers whose contact ends during sickness. Depending on their size Dutch firms now have to bear the full cost of sickness benefits and experience rated DI benefits for these workers as well.

Forecasts
At the end of 2011, the stock of disability beneficiaries from all former and existing disability programs was 815,310. According to forecasts by the Ministry of Social Affairs and Employment this stock will hardly go down despite the success of the WIA. The contributory part (WAO + WIA) is expected to go down from 600 thousand to 380 thousand. But this drop is nullified by the expected growth of youth handicapped, if they would continue on the current trajectory. But this is not likely to happen. A new Bill is sent to parliament which introduces eligibility criteria for Wajong benefits that are comparable to the IVA criteria for employees. Youth handicapped with the capacity to earn at least 20% of the minimum wage are only entitled to means tested welfare benefits. To promote their employment firms can pay

[19] See Philp de Jong and Tom Everhardt, "Return to work after long term sickness. The role of public versus private interventions". Paper for the OECD conference Labor Activation in Times of High Unemployment, November 2011.

them according to their productive capacity, which are by definition below minimum wages. These are then supplemented by partial benefits.

Figuur 1 Trend in disability benefits (x 1000), at end of year 2010-2040



Source: R. Alblas, B. Ouwehand en J.-M. van Sonsbeek, 2010. "Langetermijn raming Arbeidsongeschiktheidsregelingen", Ministry Social Affairs & Employment.

6 Lessons

The *first* lesson that can be learned from the Dutch disability experience is that social disability insurance is often used as a provision to accommodate social change. A good illustration is the increase in female incidence rates. The disability benefit scheme supported Dutch households in their transformation from a traditional single breadwinner type to a modern dual earner family. Similar uses of disability benefit schemes can be seen in Eastern Europe to soften the pains of transition to a market economy.

The backside of using disability benefits as a 'soft' child care or unemployment provision is that it hides the lack of targeted, more cost-effective, provisions, and postpones their introduction. Meanwhile huge unfunded financial liabilities are created given the long average duration of disability benefit dependency. The Dutch case is a good illustration both of the size of such liabilities and of the political problems to change an entitlement oriented disability policy.

Nevertheless, under pressure of an ageing workforce the Dutch government took a series of drastic steps from 1993 onwards. The *second* lesson is that many of these steps proved successful. In particular mandating that sickness and disability risks are borne where they can best be influenced – *i.e.,* at the level of the firm – proved to be a fruitful approach. But the fact that the management of absenteeism was strongly helped by the legally binding Gatekeeper protocol, which emphasises work resumption and prevention of long-term disablement, shows that private provision of social insurance also needs rules and regulations in order to balance market efficiency and the social goals of disability policy.

The large impact of the Gatekeeper Protocol also indicates that creating a competitive market by legislation requires additional instruments to get the desired efficient results. The two cases of privatisation that were part of the many changes that the Dutch sick pay and disability benefit programs underwent illustrate this point. These cases are: private provision of occupational health, and reintegration and job mediation services. Previously, both were supplied by public monopolies (social insurance administration and public employment service). The Dutch legislator mandated firms to contract these services from private providers. But employers had difficulties in finding out what kind of package they needed and where they could get a good offer. The fact that firms were obliged to purchase something, anything, that met the legal standards also invited inferior, or even fraudulent, providers to offer there services. Hence, the call for quality standards and certification.

A *third* lesson to be drawn from the Dutch experience is that the special features of the disability benefit scheme also proved to be its weakness. In 1967, the Dutch chose to integrate the general disability benefit scheme and the work injury scheme. They took the most generous of the two – the work injury scheme - as the model for a social insurance program that covered all disability risks, independent of their cause. From the work injury scheme the fine grid of seven disability classes was taken. Applying this grid to all kinds of disability contingencies, among which an increasing number of diffuse complaints, made the system weak and uncontrollable.

The new WIA scheme purports to cover only those that have hardly any productive capacity left, and to provide other workers with disabilities with strong incentives to remain active. The results for the first eight years of the operation of the new scheme show that inflow rates have dropped substantially to levels that are reasonable by international standards. The incentive structure that steers the behaviour of employers and long-term sick employees proves to work.