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SICKNESS AND DISABILITY SYSTEMS: COMPARING OUTCOMES AND POLICIES IN NORWAY WITH THOSE IN SWEDEN, THE NETHERLANDS AND SWITZERLAND

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Abstract/Résumé

Sickness and disability systems: comparing outcomes and policies in Norway with those in Sweden, the Netherlands and Switzerland

In Norway, sick-leave compensation and disability benefit is comprehensive and an important component of employee rights and benefits. However, despite policy attention, use of these systems is excessive; sickness absence and disability benefit recipiency levels remain extraordinarily high compared with other countries. This paper compares Norway's reform experience and policy settings with those of three countries that also have comprehensive support and that have faced similar problems: Sweden, the Netherlands and Switzerland. All four countries have made a number of changes to sick leave and disability benefit systems. However, it appears that Norway's reforms have so far been rather less successful. A broad impression in comparing the reforms is that Norway has conducted fewer measures involving reductions to entitlements and improvements in work incentives compared with the other countries.

This Working Paper relates to the 2019 OECD Economic Survey of Norway (http://www.oecd.org/economy/norway-economic-snapshot/).

JEL: I38 Government Policy, Provision and Effects of Welfare Programmes

Keywords: Keywords: sick leave, disability benefit, Norway, the Netherlands, Sweden, Switzerland

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Systèmes de maladie et d'invalidité : comparaison des résultats et des politiques en Norvège avec ceux de la Suède, des Pays-Bas et de la Suisse

En Norvège, l'indemnité de congé de maladie et les prestations d'invalidité offrent une couverture complète et constituent ainsi un élément important des droits et avantages sociaux des employés. Cependant, malgré l'attention des politiques, l'utilisation de ces systèmes est excessive; les niveaux d'absence pour maladie et le nombre de bénéficiaires à l'assurance invalidité restent extraordinairement élevés par rapport à d'autres pays. Ce document compare l'expérience de la Norvège en matière de réforme et les paramètres politiques à ceux de trois pays qui bénéficient également d'un soutien complet et qui ont rencontré des problèmes similaires: la Suède, les Pays-Bas et la Suisse. Les quatre pays ont apporté un certain nombre de modifications aux régimes de congés de maladie et d'invalidité. Cependant, il semble que les réformes de la Norvège aient été jusqu'ici un peu moins efficaces. Une impression générale en comparant les réformes est que la Norvège a mené moins de mesures impliquant des réductions de droits et des améliorations des incitations au travail par rapport aux autres pays.

Ce Document de travail a trait à l'Étude économique de l'OCDE de la Norvège (http://www.oecd.org/fr/economie/norvege-en-un-coup-d-oeil/).

JEL : I38 Government Policy, Provision and Effects of Welfare Programs

Mots-clés : congés de maladie, prestations d'invalidité, Norvège, Pays-Bas, Suède, Suisse

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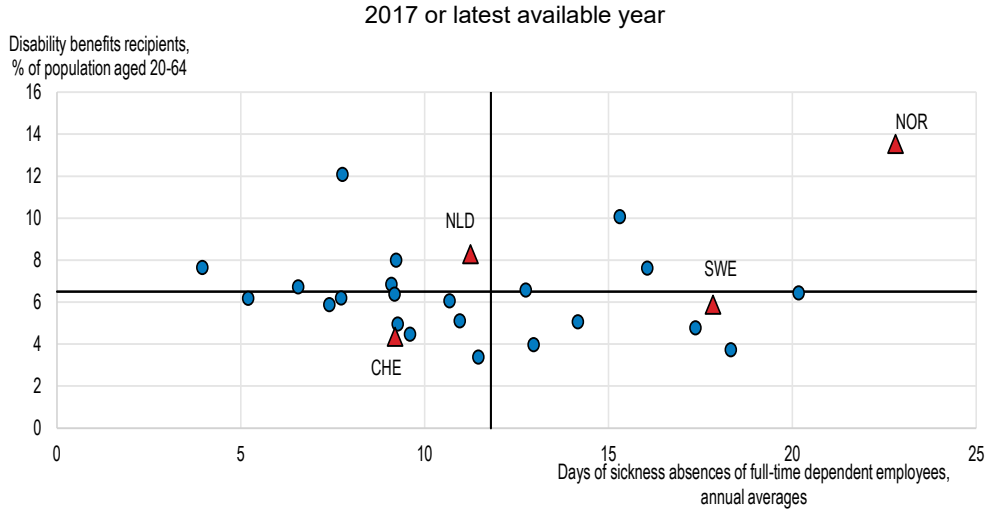
Sickness and disability systems: comparing outcomes and policies in Norway with those in Sweden, the Netherlands and Switzerland

By Philip Hemmings and Christopher Prinz[1]

Norway's sick-leave compensation and disability benefit systems provide comprehensive support and are an important component of employee rights and benefits and the wider welfare system. However, despite a good deal of policy attention, use of these systems remains excessive; sickness absence and disability benefit recipiency levels in Norway remain extraordinarily high compared with other countries (Figure 1). This is a central policy challenge, implying diminished productive capacity for the economy, reduced socio-economic inclusiveness due to disengagement from working life, and inflated fiscal costs. This paper compares Norway's reform experience and policy settings with those of three countries that also have comprehensive support and that have faced similar problems: Sweden, the Netherlands and Switzerland. The paper serves as background to an assessment of the labour market in the 2019 OECD *Economic Survey* of Norway.

Figure 1. Norway has the largest share of disability recipients and the highest number of days of sickness absences



Note: Sick-leave data are derived from the EU-labour force survey (LFS) (this includes Norway). The raw data are multiplied by a factor of 2 for all countries as it is estimated that there is, in general, a 50% underestimation in LFS-reported sickness absences compared to administrative records and health surveys. The assumption is based on analysis for some countries (Switzerland, Germany and France) of LFS data and data from health surveys and administrative sources. Disability data come from administrative sources for all countries.
Source*: OECD Social Benefit Recipients Database (SOCR), http*://www.oecd.org/els/soc/recipients.htm; and OECD estimates based on the European Labour Force Survey

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Box 1. Key findings

- Norway and the three comparator countries provide relatively generous and accessible social benefits for sickness and disability, alongside vocational rehabilitation. This approach risks high cost and weak labour market participation. All four countries have experienced this through elevated numbers on sick leave and/or on disability benefit.
- Sweden's sick leave compensation system is closest in design to that of Norway. Both countries have predominantly publicly-funded sick-leave compensation, in contrast to employer- and insurance-funded systems in the Netherlands and Switzerland. The architecture of disability benefits is similar across the four countries.
- All four countries have made a number of changes to sick leave and disability benefit systems. However, it appears that Norway's reforms have so far been rather less successful. A broad impression in comparing the reforms is that Norway has conducted fewer measures involving reductions to entitlements and improvements in work incentives compared with the other countries.
- Norway provides the most substantial compulsory guarantee for sick leave compensation among the four countries, mandating a compensation at 100% of previous salary (with a comparatively high benefit ceiling) for the one-year maximum. Sweden's and Switzerland's mandatory payout is initially set at 80% of previous salary, and in the Netherlands it is 70% of previous salary for two years.
- Norway's disability system continues to rely heavily on medical assessment by the claimant's general practitioner. The Netherlands and Switzerland feature third-party medical assessment, and in Sweden insurance doctors decide on the basis of the available medical files.
- The Swedish reform experience underscores that the level and structure of sickness benefits strongly influences benefit take-up: even small reductions (or increases) in the payment rate have a drastic impact on outcomes. It appears there is now a clearer understanding in Sweden that a tighter system with a stronger focus on work participation is a better system.
- The Dutch reform experience demonstrates that employer incentives (matched by corresponding worker incentives) matter: when premiums to sickness and disability insurance became experience rated, i.e. dependent on the employer's sickness and disability record, new benefit claims fell drastically.
- The Swiss reform experience underlines that early identification of problems and early intervention is critical to reducing disability benefit claims. It also demonstrates that shifting the assessment decision from general practitioners to a public medical authority is feasible and effective.

Background

Starting several decades ago, some countries experienced a prolonged and substantial increase in long-term sick leave and in the numbers claiming disability benefit, prompting analysis and policy measures. These trends, according to the OECD's *Breaking the Barriers* project (Box 2), partly reflected a behavioural response to policy reforms (often conducted in the 1990s) that reduced the generosity and accessibility to unemployment benefit, social assistance and early retirement, rechanneling claimants towards health-related benefits. Labour redundancy through skill-biased technological change and economic shocks, such as the 2008 economic downturn, are also thought to have been a factor.

Box 2. OECD work on sickness and disability system reform

OECD has long been advocating reform of sickness and disability benefit systems, notably in the Breaking the Barriers project headed by the Education, Labour and Social Affairs Directorate. Building on an initial cross-country assessment in 2003 (OECD, 2003), this project comprised 13 country-level reports (including Norway, Sweden, the Netherlands and Switzerland) and culminated in a synthesis report in 2010 (OECD, 2010). Breaking the Barriers underscored the importance of ensuring financial incentives, not only among individuals but also among employers and the other actors involved in sick leave compensation and disability benefit (e.g. benefit authorities and employment services).

In many OECD countries, mental illness has increasingly become the reason for sick leave and disability benefit claims. Picking up on this issue the OECD's Mental Health and Work project has included reviews of Norway and the three comparator countries that feature in this paper. The synthesis paper for this project (OECD, 2015) underscores that mental ill-health occurs throughout society and across age groups, significantly affects education and employment outcomes but is often under-treated and has significant stigma attached to it. Invariably, intervention comes too late, key stakeholders are left out and co-ordination between institutions and integration of services is poor. The policy solutions extend beyond sickness leave and disability systems, though they are necessarily part of it. The report notes that high levels of mental ill-health are found across all working-age benefit claimants, including recipients of unemployment benefit and social assistance--so many people with mental ill-health are not even passing through the sick leave and disability system.

Many systems for sick leave compensation and disability benefit were not initially oriented towards return to work. Policy design envisaged comparatively small numbers on long-term sick leave or disability benefit, with the individuals involved having demonstrably little or no capacity for return to work. Thus, neither individuals, employers nor government agencies were strongly motivated or steered towards rehabilitation and labour market reintegration. Table 1 summarises the archetypal problems faced by policies. Annex A lists operational measures suggested by the *Breaking the Barriers* project that can be taken to tackle the issues.

Gathering sufficient public support for reforms to sick leave compensation and disability benefit systems is often difficult, especially when reforms affect workers' and/or employers' costs and incentives. Measures may be seen insensitive and questioning individuals' integrity. For instance, cutting benefit entitlement for new disability claimants, or bringing in new medical assessments can be risky politically. Therefore, such type of measures are less common than positive inducements, such as optional training and rehabilitation programmes and employer wage subsidies to hire people with disabilities. Norway probably struggles more than other countries in implementing and justifying entitlement-cutting measures due to its oil-wealth. As successive OECD *Economic Survey*s have pointed out, this is a general challenge for structural reform in Norway.

Table 1. Classic weaknesses and potential solutions in sick leave and disability benefit systems

	Classic weak points in systems	Potential solutions
Individuals	Excess policy focus on supporting individuals out of work, rather than on return to work	Assess work capacity not disability Move to an activation approach Make disability benefit (generally) a transitory payment Make work pay from an individual perspective
Employers and medical professionals	Employers not sufficiently engaged in policy process, despite potential role in monitoring health status and preventative measures Medical-profession incentives not geared to rehabilitation or to working with other stakeholders	Strengthen the role of employers, especially in sick leave compensation Provide better support for employers, such as advice on workplace adjustment for disabled workers, wage subsidies or similar financial support Gear medical assessment around work potential and rehabilitation More medical-certification guidance for general practitioners More checking/control of sickness certificates
Government agencies	Low take up of rehabilitation programmes Poor co-ordination	Improve cross-agency co-ordination, such as between benefit administration and medical practitioners and between benefit administration and employment services Engage with clients systematically and in a tailored way Ensure agencies have financial incentives to rehabilitate those on long-term sick leave and disability, e.g. by changing the funding mechanism

Source: Based on OECD *Breaking* the *Barriers* synthesis report (OECD 2010)

Similarities and differences in overall policy design

Breaking the Barriers (OECD, 2010) classifies the sickness and disability systems of all four countries being *socio-democratic* (as opposed to *liberal* or *corporatist*) (Box 3), echoing the countries' approaches to welfare policy in general. Socio-democratic systems are characterised by, first, relatively generous and accessible compensation policy for sickness and disability; and, second, substantial efforts towards integration, with strong focus on vocational rehabilitation. Thus, the systems generally provide good support for those who can and want to work, but also considerable incentives to apply for, or remain on, long-term benefits. High cost and excessive use are the greatest risks; in other words, there is a risk that accessibility and payment generosity draw many people into benefits and weaken the effectiveness of rehabilitation. This risk has materialized for all four countries studied here.

Box 3. Liberal and Corporatist approaches to sickness and disability

Other policy approaches to sickness and disability can differ markedly from Norway and the comparison countries chosen for this study. Countries that fall under the liberal model (such as Australia, Japan, the United Kingdom, and the United States), are characterised by less generous and less accessible compensation and less well developed employment and rehabilitation measures. The corporatist model (largely comprising European countries such as France, Italy, Spain, and Poland) lies somewhere in between. Access to and levels of benefits are higher and closer to the socio-democratic model but support for employment and rehabilitation is not as strongly developed.

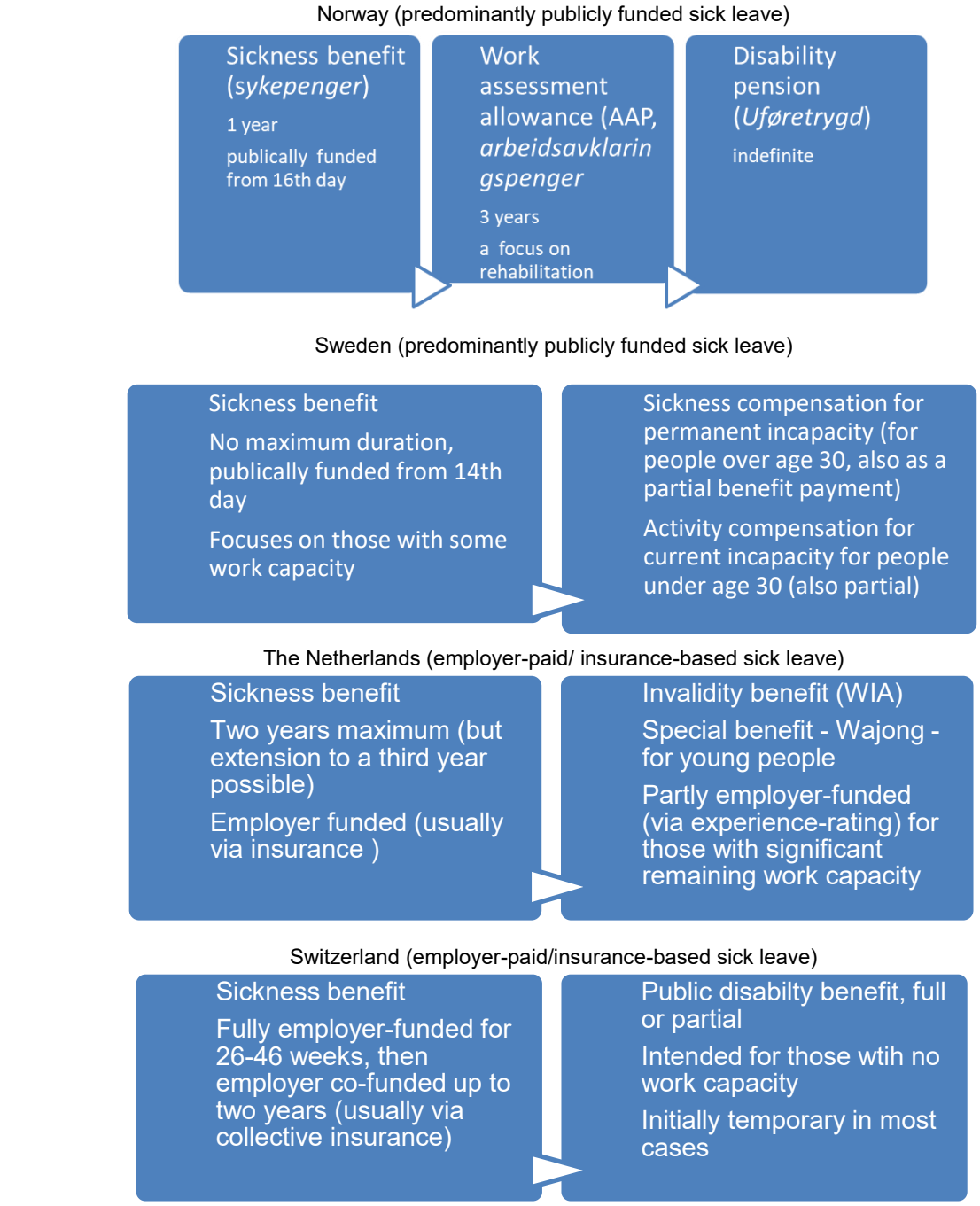
Source: OECD (2010)

Sweden's sick leave compensation system is closest in design to that of Norway. Both have predominantly public-funded sick-leave compensation, in contrast to the systems in the Netherlands and Switzerland that are funded entirely by employers and private insurance.[2] In the latter two countries employers, therefore, have strong incentives to prevent sick leave in order to curb premium or insurance costs. In the Netherlands "experience rating" of the insurance premiums adds to incentives, i.e. the premiums vary depending on claims. The similarity between Norway and Sweden and that between the Netherlands and Switzerland is illustrated in Figure 2, which shows the progression of an individual transitioning out of the labour force initially via sick leave and then onto disability benefit. In Norway and Sweden, sick leave compensation switches from being funded by the employer to being publicly funded after a comparatively short period (from the 16th day in Norway, 14th day in Sweden). In contrast, sick-leave compensation remains the responsibility of employers for much longer in the Netherlands and Switzerland (in both cases generally up to two years) and many employers choose to take out insurance to cover sick leave compensation.

As regards disability support, Norway differs from the other three countries as it has a separated temporary benefit (the AAP) preceding disability benefit. The AAP arose from a consolidation of temporary disability benefit schemes (see below) and aims to limit numbers ending up on the Disability Benefit. Systems in other countries often contain equivalent mechanisms embedded within regular disability benefit, so Norway is not quite so unique as may appear. In other respects, the broad structure of disability benefit is similar across the four countries.

[2] The role of private insurance in the Netherlands and particularly in Switzerland is complex. In the Netherlands, many employers, especially larger ones, pay sick leave compensation directly (i.e. they do not reinsure). In Switzerland, the legal employer obligation ends after 26-46 weeks, depending on the canton, but many collective agreements mandate or encourage employers to also offer subsequent sickness daily benefit insurance. Where this is not the case, people will typically take out their own insurance, which is more costly than collective employer insurance.

Figure 2. Basic structure of sickness and disability benefit schemes in Norway, Sweden, the Netherlands and Switzerland



Source: OECD Secretariat

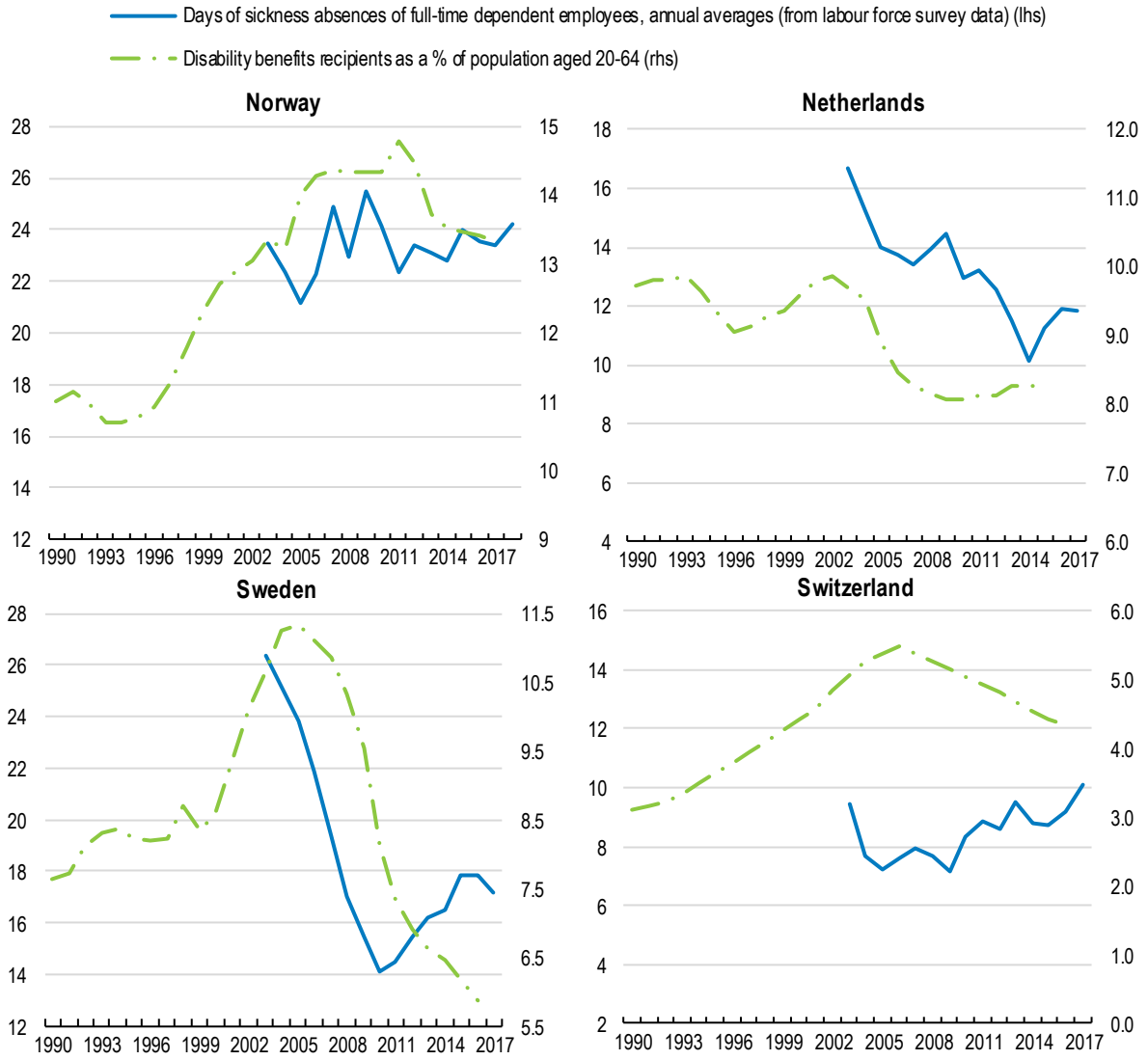
Norway has been rather less successful in terms of outcomes

All four countries show some successes in reducing sick leave absence and disability-benefit recipiency according to OECD data (Figure 3, Box 4). Success is most apparent in disability recipiency. Sickness-absence data show more mixed patterns and interpretation is more difficult because of greater cyclical influence of sickness absence (Box 5), less data (shorter time series) and greater year-on-year fluctuation.

Considering each country in turn, the data suggest:

- Sweden: Substantial falls in both disability recipiency and sickness absence. Disability recipiency has fallen from over 11% of the working-age population to around 6%. The rise in sickness absence in recent years is likely to be a least partially cyclical (but this also probably applies to the preceding decline).
- Switzerland: Falls in disability recipiency since the mid-2000s, from around 5.5% to 4.5% of the working-age population. Sickness absence has, however been rising, though again cyclical factors may be at play. Some observers consider that the recent sickness-absence increase may partly reflect that private insurers (mistakenly, as it turns out) cut back on early intervention measures in the belief that an increased focus by government on early intervention in the disability benefit would decrease need for their own measures.
- The Netherlands: Fall in disability recipiency in the early to mid-2000s, from nearly 10% to 8% of the working-age population but with some increase thereafter. Sick leave absence shows a substantial drop; it started falling even before the global financial crisis.
- Norway: Disability recipiency on a downward track since around 2010 (due to a decline in the share receiving the temporary AAP benefit) but still on a level much higher than in the other countries. Sickness absence is either stable or declining, depending on the indicator used. OECD estimates of the number of days of absence among full-time dependent employees based on labour-force survey data show no long-term change. However, administrative data from the OECD's Health Status database and directly from Statistics Norway indicate some decline in the average number of days of sick leave (see Box 4 and Figure 4).

Figure 3. Some clear successes in reducing disability benefit rolls, with less clear trends for sick-leave absence

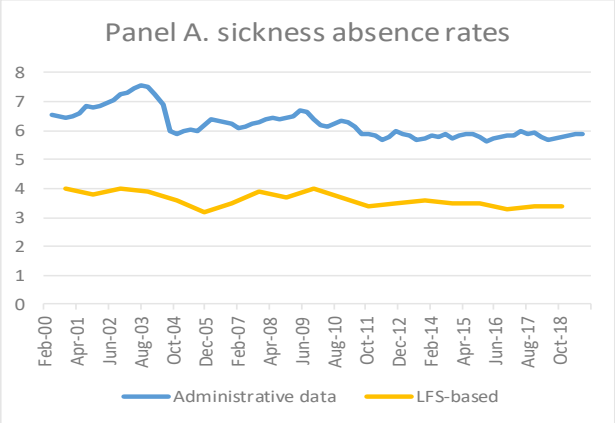


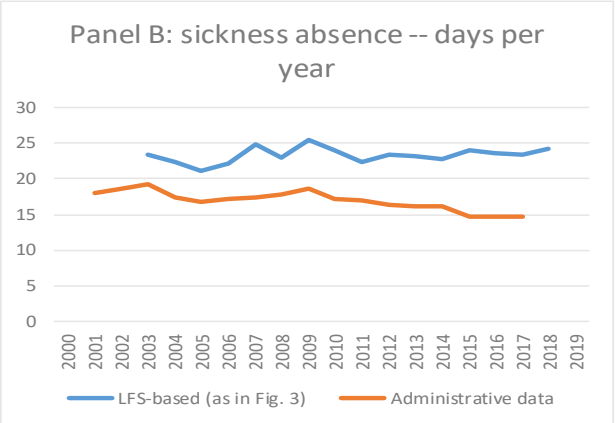
Note: See note in Figure 1. For Norway, disability data prior to 2010 do not include temporary disability benefit claimants (there were several schemes operating at that time). Instead, the figure includes an estimate of temporary disability claimants to be more consistent with post-2010 data. The estimates are based on a simple data splice. Specifically, each data point for 2009 and before was multiplied by 1.3, which is the ratio of the 2010 data point (14.3%) to the 2009 data point (10.6%). The adjustment therefore comprises only a level shift in the data for 2009 and before and implicitly assumes a constant proportion of those on temporary schemes.
Source: *OECD Disability Recipiency Database (unpublished), OECD Sickness Leave Database (unpublished).* OECD Health Statistics 2019,

Box 4. Data on sickness absences and disability benefit caseloads

- There are two types of data on sickness absences from work available at the OECD and another set of data on disability benefit caseloads:
- Estimates on sickness absences from work are derived from labour force survey questions on the reasons of full- or part-week absences from work during the survey reference week. Absence from work due to ill health is one of the answer categories in these questions. This information can be used to generate an estimate of the incidence of sick leave (the percentage of employees on sick leave on average over the year)—as shown in Panel A of Figure 4. It can also be used to estimate the average number of sick days per employee per year on the basis of the number of hours lost due to sickness absences. Figure 3 and Figure 4 (Panel B) in this paper shows unpublished OECD estimates of sick days per employee per year. The main advantage of sick leave indicators from labour-force surveys is that they are comparable across countries and consistent over time, and so are good for benchmarking the magnitude and intensity of sickness absences from work and assessing trends. On the other hand, estimates of sickness absences are suspected to be downward biased as the reporting in labour force surveys is limited to the "main reasons" for part-week or full-week absences. A comparison with alternative social security data for three countries (France, Germany and Switzerland) found some 45% to 60% under-reporting of hours lost due to illness in labour-force surveys, largely associated with an under-reporting of part-week absences (Ahmad, N. et al., 2003). Accordingly, the OECD estimates of the average number of sick days double the original data for all countries to account for a 50% under-reporting of sickness absences in labour force surveys (see footnote to Figure 3). As the adjustment for this bias is consistent across countries, this should not affect international comparability of the estimates of the number of days of sickness absences of employees.
- Administrative data on sick leave are also available in many countries. For instance, Figure 4 shows sickness absence rates and sickness days per year based on administrative records on public sick leave compensation. The administrative data in Panel B are taken from the OECD's Health Statistics database, which includes a mix of administrative data (as is the case for Norway and Sweden) and survey based data (as is the case for Switzerland and the Netherlands). Cross-country comparability between administrative and self-reported data is limited. Comparability issues also arise across administrative data that are subject to different reporting rules across countries (i.e. limited often to only compensated sickness absence days) that may also change over time. Moreover, sickness absence based on administrative data may appear greater in countries with longer duration of sick leave compensation.

Figure 4. Different measures of sickness absence for Norway





Notes and sources: Panel A: Administrative data show the number of person-days on sickness among 16-69 year olds as a share of total contractual person days based on sickness absence certificates data. The data are seasonal and influenza adjusted, From the 1st quarter of 2015, statistics on sickness absence are based on a new data source (A-ordningen). The seasonal and influenza adjusted series are adjusted for this break. Source: Statistics Norway
Panel A: LFS data show the number of persons temporarily absent from employment as a percentage of employment. Source: Statistics Norway
Panel B: Administrative data show calculation of the average number of sickness absence days per year per employee based upon sickness absence certificates data. Source: OECD Health Statistics database.
Panel B: LFS data, see note to Figure 1. Source: OECD Sickness Leave Database, unpublished

- Disability benefits caseload data give the number of disability benefit recipients in a country, typically shown as a share of the population aged 20-64. Similar to administrative data on sickness absences, cross-country differences in disability benefit caseloads in part reflect differences in how systems are operated. For instance, countries with a comparatively quicker transition to disability benefits – e.g. because of more lenient grants for temporary disability benefits – will tend to record a higher incidence of disability benefit claims, while for those with a longer mandatory sickness absence period prior to a disability benefit claim the opposite might be found. Data include beneficiaries who are working.

Box 5. Cyclical and demographic influences on sick leave and disability recipiency

At least in recent history, Norway's sickness absence shows little sign of a consistent reaction to economic conditions (sick leave is sometimes found to be pro-cyclical, one explanation being that those vulnerable to sick leave may be concentrated in the "cyclical" segment of the labour market). Figure 5 compares sickness absence with the rate of unemployment. From 2001-2003 both unemployment and sickness absence increased, from 2005-2007 unemployment declined and sickness absence increased somewhat. Over the global financial crisis, there was a strong increase in unemployment and an increase in sickness absence. From 2014 until 2016, there was a strong increase in unemployment, but fairly small changes in sickness absence. Unsurprisingly, over the entire period there is practically no statistical correlation between sickness absence and unemployment (the correlation coefficient is around -0.1).

Figure 5. No consistent reaction in sickness absence to the business cycle in recent times

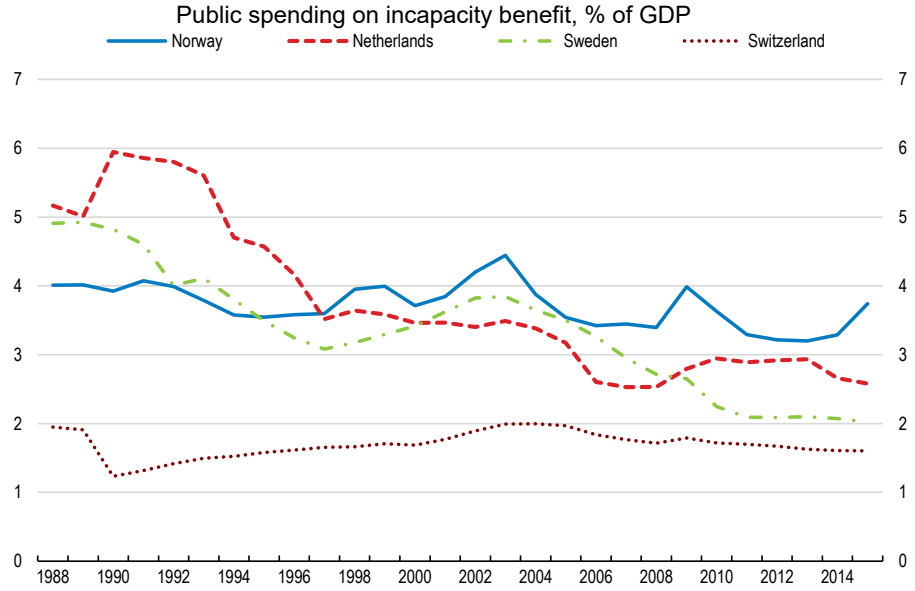
Note: see footnote to Figure 4.
Source: Unemployment rate, OECD data. Sickness absence, *Statistics Norway*

Cyclical influence on disability benefit is also possible. *Breaking the Barriers* found for some countries small counter-cyclical responses in benefit rates to changes in the output gap. The anti-cyclicality ties up with disability benefit acting as a (long-term) unemployment benefit. Linked to this, some recessions appear to have prompted a permanent increase in disability benefit levels—underscoring the problem of disability often being a one-way street out of the labour force.

Given that many individuals' health problems emerge with age, population ageing is also a driver of sick leave and especially disability trends. The evidence suggests this effect accounts for some but by no means all of the upward trends. Calculations based on age-specific disability rates in *Breaking the Barriers* showed that for Norway demographics accounted for only 0.8 percentage points out of the 2.4% total growth in the number of beneficiaries from the early 1990s, i.e. roughly one third of the increase. For Sweden, this demographic effect was estimated at 0.5 percentage points; for the Netherlands, 0.3 percentage points; and for Switzerland, 0.6 percentage points. It is reasonable to assume that the same broad conclusion can be reached for sick-leave trends, as older workers on average typically have more absence days (with fewer absences but longer durations when absent). Update of these calculations was beyond the scope of this study (disability rates by age group are not readily available) but it seems likely demographics are playing more or less the same role in explaining disability rates.

Comparison of public spending on sick leave and disability benefits (together, incapacity-related benefits) using the OECD's Social Expenditure Database (SOCX) also points to somewhat less successful progress in Norway's outcomes. Public spending on these benefits as a percentage of GDP in Norway has been trending down slowly since the early 2000s (Figure 6). This is also the case for Switzerland but at a much lower overall spending level. Sweden and the Netherlands have experienced more substantial declines for longer periods. In Sweden, spending on incapacity benefit was around 5% of GDP in 1990 and is only around 2% in the latest available data. In both Sweden and the Netherlands, much of the decline in social spending occurred in the early 1990s and was a consequence of sharp declines in sickness benefit claims at that time. Those declines were driven by the sickness benefit cuts in Sweden (see "Examples of Reform" section below) and for the Netherlands the transfer of sickness benefits from the state to the employers (also see below).

Figure 6. Spending on incapacity benefit: substantial reduction in the Netherlands and Sweden



Source: OECD SOCX Database

How do sick-leave compensation rules compare?

The role of employers

As described above, Norway's sick-leave compensation has a relatively short employer-funded phase, and a prolonged public-funded phase, similar to Sweden. Meanwhile, compensation in Switzerland and the Netherlands is predominantly employer funded and typically via private-sector sick leave insurance.

There are various *a priori* strengths and weaknesses to the public-provision and insurance approaches to sick leave. Under public provision, policy levers are more direct but employers have comparatively little incentive to engage in preventative measures or rehabilitation. Indeed, employers (in co-ordination with employees) might use the system as a means of cutting back on wage costs during times of slack. In contrast, in principle, the insurance-based systems of the Netherlands and Switzerland should stimulate much stronger engagement from employers, and/or the insurers, in terms of monitoring health status and providing preventative measures and rehabilitation.

Size and scope of sick-pay compensation

In all four countries the sick-leave compensation system guarantees individuals an amount, at least initially, equal to their regular salary or at least a substantial percentage of it. This sets them apart from countries where national legislation provides lighter guarantees and sick-leave compensation is more determined by individual employer policy and/or collective agreement.

Norway provides the most substantial compulsory guarantee among the four countries, mandating compensation at 100% of previous salary (up to a ceiling) for the one-year maximum duration (Table 2). Sweden's mandatory payout is initially 80% of previous salary (though top-up to the legally-set maximum of 90% is common, Table 2), and in the Netherlands, it is 70% of previous salary for two years, often topped up by employers, through collective agreements, to 100% during the first year (with a legal maximum of 170% over two years). Switzerland mandates continued wage payment at 80% (again, often topped up by employers, through collective agreements, to 100%) for the first few weeks of sick leave, the length depending on canton and tenure (26-46 weeks). This is typically followed by 80% compensation via voluntary private insurance, co-funded by workers and employers and often through collective employer insurance.

Norway's payout ceiling also reflects a high priority on ensuring substantial across-the-board sick-leave compensation. The state-funded payout is calculated up to the equivalent of 110% of the national average salary, which implies the system guarantees a majority of employees receive full salary when on sick leave (because wage distributions are skewed, the mean wage is always above the median wage). Norway's payout ceiling contrasts starkly with Sweden, where the state compensation ceiling is set at only 60-65% of the average wage (though, as mentioned above, top-up payments are common). Norway's payout ceiling is more akin to the Netherlands where the ceiling is roughly 120% of the average wage.

Table 2. Comparing sick leave compensation levels and rules

Describes typical case

Norway	Sweden	Netherlands	Switzerland (2)
100% of salary (for one year) - ceiling on state payment is 6 times the National Insurance Basic amount ("G") this is roughly equivalent to 110% of the average wage (1) - top-up payments employers can (and often do) pay more than the ceiling during the initial phase so that above-ceiling earners receive 100% previous salary	**Around 80% of salary for first year, 75% thereafter (multi-year)** - ceiling on state payout is roughly equivalent to 60-65% of average wage (1) - top-up payments possible via collective agreement or insurance. However, these are only up to a ceiling of 90% of previous salary. - one day "waiting period" (i.e. no pay out) - first payment may take up to 30 days due to processing	**At least 70% of salary (for two years), often topped up to 100% during the first year** - maximum duration is three years if employers have not done enough to facilitate a return to work (as a sanction) - ceiling to obligatory payment applies that is roughly equivalent to 120% of average wage (1) - payment must be at least minimum wage (statutory payment of 70% for low wage workers) - employers can apply up to two waiting days	**80-100% of salary for a few weeks , generally 80% thereafter** - initial period varies by tenure, from 3 weeks to 26 weeks, and by canton (up to 46 weeks maximum) - insurance arrangements beyond the wage-payment period and initial level of pay (80/100%) depends on collective agreement - pay out from sickness-pay insurance is generally around 80% of previous salary (premiums paid by employer and employee, former must pay at least half of the premium)

Notes:
1. Payment ceilings as a percentage of the previous wage are OECD calculations.
2. The Swiss sick pay system is rather complex. The first period ranges from three weeks for people with tenure of less than one year to 26 weeks for those with tenure of 20 years or more (and up to 46 weeks in some cantons for even longer tenure). Thereafter, the situation differs widely across collective agreements. Many Swiss workers will have sick pay insurance for up to two years in total via collective employer insurance, co-funded by employer and employee premiums.
Source: OECD Secretariat

Eligibility requirements

Medical certification rules influence patterns of sick leave and there are trade-offs in terms of policy design. Early medical certification, for instance, may contain short-term abuse of sick leave but imposes appointment demand on the medical system and may undesirably prompt GPs to sign individuals off work for prolonged periods. Employers often have some discretion on medical certification, reflecting that they typical fund at least initial phases of sick leave.

In Norway, the employer is entitled to require a medical certificate from a doctor after three days but under particular workplace agreements, employees can take up to 16 days of sick leave through self-certification (Table 3). Critically, throughout sick leave, certification is only by the claimant's general practitioner. Other systems often require third-party medical control or verification once sick leave extends beyond a certain period. For instance, in the Netherlands long-term sick leave requires certification by a company-assigned occupational doctor.

Examination of the eligibility conditions underlines that there are many avenues for influencing access and compensation. Among the four countries, examples include:

- Waiting periods (i.e. an initial period where there is no (mandatory) compensation) feature in the sick-leave arrangements for Sweden (one day waiting period) and the Netherlands (employers can apply up to two days waiting period). Waiting periods will discourage some from taking sick leave in the first place but may also push some into extending sick leave, so the overall impact on sick leave (and compensation costs) is an empirical question.
- Increasingly stringent rules for incapacity assessment as sick leave lengthens. In Sweden, eligibility for sick leave compensation beyond 90 days requires the person is assessed as unable to do their normal work *or* any other job your employer can offer. Beyond 180 days, this is expanded to being unable to do work in any position on the normal job market.
- Absence guidelines for doctors. Both Sweden and the Netherlands operate sick-listing guidelines for general practitioners (developed by doctors for doctors), which prescribe the optimal length of leave for the major physical and mental illnesses. A doctor would have to justify deviating from the general guideline. Norway has also introduced guidance for doctors.
- Strong obligations for employers and employees, with strictly enforced sanctions. In the Netherlands, employers and sick employees have to make every effort to enable a swift return to work. Sanctions are harsh (benefit cuts for employees, a third year of sick pay for the employer) and widely used.

Table 3. Comparing sick leave eligibility requirements and rehabilitation elements

Describes typical case

Norway	Sweden	Netherlands	Switzerland
- Employer entitled to require a medical certificate after 3 days. Under workplace agreements, the entire 16-day employer funded phase can be based on self-declaration. - NAV requires return-to-work plan after 4 weeks (drawn up by employee and employer) - Expanded medical certification required (from beneficiary's GP) after 8 weeks	- Medical certificates required after 7 days and again after 14 days (the latter for eligibility to publicly funded benefit). -- Eligibility is based on a widening range of job capacity over time, to be assessed by the Social Insurance Agency against their own job (first 90 days), any job of the employer (next 90 days), and any job in the labour market (after first 180 days)	- Longer term sickness (six weeks and longer) must be reported and monitored by a company-assigned doctor - Strict obligations for employers to provide any rehabilitation necessary for a quick return to work - Strict obligations for employees to take part in reintegration offers by the employer	- First medical certificate generally required after third day - Subsequent certificates as mandated through the last certificate - After 30 days, a low-threshold disability eligibility test can be required (with the aim to make clear to many that such eligibility will not arise) - Reintegration measures offered by private insurers vary substantially

Source: OECD Secretariat

How do rules for long-term support compare?

Disability-type benefit typically provides the second phase of support for workers with long-term health problems. In the past one or two decades, many countries have been orienting disability benefit systems towards encouraging employment. The individuals' level of disability (and compensation) is now increasingly graded in terms of work capacity specifically, not capacity in some broader sense. Previously, disability benefits often had no provisions for employment, indeed in some cases paid employment was not allowed at all for beneficiaries. In a similar vein, reforms have focused support services for those claiming a disability benefit increasingly on rehabilitation into employment, often accompanied by employer subsidy programmes.

Size and scope of compensation

In all four countries, longer-term compensation is similar to that for sick leave in that it is linked to previous earnings (with floors and ceilings) but the payout is generally smaller. Norway appears to be less exceptional than is the case for sick leave, paying out two-thirds of previous salary for the duration of the AAP and the Disability Benefit (Table 4). Sweden has practically the same compensation rate (though, as for sick leave, the compensation ceiling is lower than in Norway). Compensation for long-term support in the Netherlands is a little higher (70%, and even 75% for those fully and permanently unable to work), while for Switzerland it is a little lower (60%).

Systems in all four countries also have redistributive features implying that low earners face significantly higher income replacement rates. Moreover, all four countries allow very young people to apply for a disability benefit (typically from age 18 onwards). Special provisions often apply. For instance, in Sweden the eligibility criteria are stricter for those aged under 30 and in the Netherlands there is a separate scheme for people with congenital disability or a disability occurring in childhood and youth. Despite special arrangements, it often remains the case that the disability benefit payments are high compared to the earnings capacity of many young people, making it relatively generous to some. This is a particular challenge in regard to mental health problems, which are increasingly dominating the disability rolls in all OECD countries. Mental health problems tend to start very early in life and, thus, affect young people and young disability benefit claimants in particular (Box 6). The recent rise in disability rolls among young people in many OECD countries is an issue that has yet to be addressed: all four countries compared in this paper have seen some success from its reforms for older claimants while claimant numbers keep rising among young adults (OECD, 2015).

Box 6. Mental health: the biggest and a rising challenge for disability benefit systems across the OECD

In most OECD countries, mental health has become the biggest driver of new disability benefit claims, contrary to the situation one or two decades ago, when muscular-skeletal health problems dominated the disability rolls. The mental health issue is inseparably connected with the youth issue: among young adults, the share of claimants with mental health problems is particularly high, often reaching 80% and more.

OECD work on mental health identified and emphasized a number of unique characteristics of mental health claimants, calling for a better policy response. Claimants with mental health problems are different: they are not only younger but they also have much poorer employment records and are much further away from the labour market when claiming a benefit. Benefit authorities also apply a different

approach: such claimants a more likely to be granted a full benefit, more likely to be granted a temporary benefit initially, less likely to be denied a benefit, and less likely to leave benefit once receiving it. Existing assessment tools and support services are often inappropriate for this group.

The share of mental health claims is rising almost everywhere, irrespective of whether total benefit rolls are still increasing or declining in countries that have gone through structural reform. Norway is an exception insofar as the share of mental health claims has remained more stable over time, and middle-ranking compared to other countries. The reasons for this deviating trend are unknown but may plausibly be related to the fact that it is still easier in Norway, compared to most other OECD countries, to receive disability benefits for other health reasons. If this is true, any more structural system reform in Norway is likely to lead to a similar shift to a higher share of mental health claims, implying that it will be important to be prepared for this shift.

Source: OECD (2012a), OECD (2013) and OECD (2015).

The comparatively narrower differences in compensation for long-term disability support imply stronger consensus (compared with sick leave) on the appropriate level of compensation---at least across the four countries under consideration here. The narrower differences also suggest that compensation is not the key reason for Norway's continuing high claimant numbers compared with other countries. Rather, these high claimant numbers are explained by the large number of people on long-term sick leave and the relative ease with which they can enter temporary disability payments (i.e. AAP); payments which end in a permanent disability payment in most cases. This is confirmed by cross-country data showing that Norway has the lowest benefit rejection rate of all OECD countries and one of the lowest rate of outflow from disability benefits because of lacking reassessments (OECD, 2010).

Table 4. Comparing long-term disability benefit compensation levels and rules

Typical case for an (ex) employee (1)

Norway	Sweden	The Netherlands	Switzerland
AAP (up to 3 years), and Disability Benefit 66% of salary - ceiling on state payment same as sickness benefit, i.e. around 110% of average wage (1) - top-up payments: additional pay outs from occupational disability pension scheme are possible - reference wage for benefit calculation: -- AAP: average earnings in year prior to illness -- Disability Benefit: average of three best-paid years in the five years before illness	**Sickness or Activity Compensation: 64.7%** of a reference income - reference income is the pension-based past income - ceiling is equivalent to about 55% of the average wage (1) - almost universal occupational pension coverage for those earning above the ceiling	**Work and Income (WIA) benefit: 70%/75%** - Return to Work scheme (WGA): Pay-related benefit (2): 75% of previous salary first two months, 70% thereafter - in the 70% phase, the benefit may be cut if the person's actual working hours do not reflect assessed work capacity - Full Invalidity Benefit (IVA): 75% of previous earnings with ceiling of EUR 209 per day. - authorities can demand payments from the employer if they consider insufficient efforts were made to avoid a claim	**Disability pension: around 60% of covered earnings** - a public first pillar guarantees subsistence income (maximum equals two times the minimum) - a mandatory second pillar (occupational pension) guarantees a reasonable living standard - payment of a means-tested supplement for those not entitled to a second-pillar benefit

Notes:
1. Payment ceilings as % of previous wage are OECD calculations.
2. Netherlands. The WGA has three payment schemes: 1) Pay-related benefit that applies to those previously employed and lasts up to two years, 2) "pay supplementing benefit" and 3) "follow up benefit" that applies after two years and to those not previously employed (or with low earnings).
Source: OECD Secretariat

Eligibility conditions

In terms of eligibility conditions for a disability benefit, all four countries illustrate the shift towards a work-orientated approach. This is reflected in eligibility criteria based on capacity (or incapacity) to work or earn. For instance, Sweden requires at least 25% permanent incapacity for work (Table 5). In the Netherlands, access to the WIA benefit requires individuals to be assessed as only being able to earn 65% or less than their previous income and in Switzerland, earnings capacity must be reduced by 40%. Furthermore, all countries facilitate partial as well as full return to work.

Other devices are in place to strengthen work orientation. For instance, Norway's AAP benefit requires individuals to develop a return-to-work plan in consultation with the Labour and Welfare Administration (NAV) officials.[3] In Sweden, individuals are reassessed every three years, while in the Netherlands the authorities can demand compensation from employers if they think insufficient efforts were made during the sick-leave phase of benefits. Switzerland uses a strict rehab-before-benefit principle: a disability benefit can only be granted to an individual if all medical and vocational rehabilitation efforts have been tried and have failed.

Table 5. Comparing long-term disability benefit eligibility conditions

Typical case for an (ex) employee

Norway	Sweden	The Netherlands	Switzerland
- 50% or less work capacity required for AAP, also 40% less income capacity for Disability Benefit if transferring from AAP (50% otherwise). - Work capacity assessed by the beneficiary's GP. - Required to engage in a return-to-work plan with NAV officials. - Work is possible under both AAP and Disability; benefit-earnings formulae structured so that work pays.	Sickness or Activity Compensation: - At least 25% permanent incapacity for work (in case of those over 30 years). - Assessment by the Social Insurance Agency with renewed investigation every three years. - Benefit suspension possible for people who want to try work (no reapplication required).	WIA benefit: - must be assessed as only being able to earn 65% or less of previous income - Return to Work scheme (WGA): for those assessed as between 35 and 80% incapacity - Full Invalidity Benefit (IVA) for those assessed with over 80% incapacity - The authorities can demand payments from the employer if they consider insufficient efforts were made to avoid a claim	**Disability Pension** - At least 40% earnings incapacity for one year for a quarter benefit, and 70% for a full benefit. - For inactive claimants, incapacity is related to current activity (e.g. education, housework). - Initial assessment by GP, increasingly checked by insurance doctors from regional medical service. - Disability benefit is only granted if all rehabilitation efforts have failed. - -

Source: OECD Secretariat

Assessing the relative depth and success of the work-oriented approaches to disability support across the four countries is difficult to gauge. Comparing the numerical work capacity requirements is probably unwise because these are framed differently across countries and their meaning in terms of ill-health depends on the processes and guidance involved in assigning them. Medical assessment requirements and processes are obviously a key influence on the number and composition of those receiving long-term support for ill-

[3] The NAV (*Arbeids og velferdsetaten*) provides both benefit administration and employment services and collaborates closely with local authorities, with the aim to provide better integrated supports and services. While this merger of two previously rather isolated authorities was a long and difficult process, it is an example that other countries are trying to follow (OECD, 2015).

health. Medical conditions vary hugely, as do the mental and physical demands of different jobs, so assessing the degree of incapacity for employment is inevitably an inexact science. The most important question, however, is how stringently rehabilitation and return-to-work efforts are followed and how strictly the corresponding regulations are applied. In all countries, there are also significant regional disparities related to differences in the way the law is interpreted. This raises a number of issues that go beyond the scope of this paper, such as the institutional structure and the regulations in place to supervise and monitor regional and local decisions.

Key episodes in past reform

All four countries have made changes to sickness leave and disability benefit systems in an effort to shift towards a more work-orientated system that sees fewer individuals permanently exiting from the labour market due to health issues. Norway has largely progressed through minor adjustments to its benefit rules although it has introduced significant institutional changes, merging its benefit authority and the employment service. There has also been a series of tripartite agreements aiming to reduce sick leave, though this has not been hugely successful. Adjustments to Sweden's and the Netherlands' sick leave and disability systems in the mid-2000s, on the contrary, have been very significant. Switzerland's reform of medical assessment has been an important step, though there were substantial changes to the system on other fronts too.

A broad impression in comparing the reforms is that Norway has conducted fewer measures involving reductions to entitlements compared with the other countries. In the examples below, reform in Sweden included tightening eligibility, in the Netherlands reform included reassessing eligibility for all those aged under 45 on disability benefit, and Switzerland moved away from solely general-practitioner based medical assessments.

Norway

Consolidation of temporary disability benefit (2010). In 2010, three different benefits (vocational and medical rehabilitation benefit and temporary disability benefit) were combined into one, the Work Assessment Allowance (WAA).[4] Under the WAA, medical and vocational support towards rehabilitation is provided to those eligible (inter alia, work capacity must be assessed as being reduced by at least 50%). The benefit rate is 66% of the last income, or the average of the last three years, which is similar to the level of a disability benefit. Supplementary allowances are provided to cover expenses related to participating in vocational measures.

Inclusive Working Life Agreements (2001 onwards). To date, reform in sick leave compensation has largely arisen from a series of agreements between the government, employers and unions (the Inclusive Working Life (IA) Agreements). However, the agreements' impact on the incidence of sick leave has been disappointing. Reliance largely on individual employer and sector-level actions to address sick leave, without substantial reform to the sick-leave compensation rules themselves may be one reason for the limited impact. The agreements have always contained a clause that precludes government-initiated changes to the sickness benefit system while the agreement is place.

[4] The merger of these three benefits was a response to rather disappointing developments after the introduction of the temporary disability benefit in 2003, which has led to a significant increase in disability benefit claims. Through the temporary track, receiving a disability benefit became easier; however, eventually virtually all temporary claims turned into permanent ones and the idea that temporary claimants would return to the labour market never materialised.

Sweden

Sick-leave compensation reform (1990s). Pushed by a major economic downturn in the early 1990s, Sweden embarked on a series of sickness benefit reforms as part of a broader attempt to curb public spending. This included the introduction of a 14-day sick-pay period covered by employers (1992). In addition there were significant changes to compensation:

- Before 1991, sickness benefits replaced 100% of earnings for 90 days and 95% thereafter, with no time limit. As of 1993, there was no payment on the first day of sickness absence (i.e. one "waiting day"), compensation then varied over time: 75% of previous earnings (days 2 and 3 of absence), 90% (until day 90), 80% (to the end of first year) and 70% thereafter. This reform promoted a sharp drop in absence spells, especially in short-term absences, but also a small increase in the duration per spell (Johansson and Palme, 2004; Henrekson and Persson, 2004).
- When the economy recovered in the late 1990s, sick-pay rates were increased, to 90% of the previous wage until the end of the first year and 80% thereafter. This led to a significant rise in absence rates, especially longer-term absences (Hesslius and Persson, 2007). Overall, the cost of being absent significantly affected absence behaviour.

Sickness and disability reform (mid 2000s). Starting in 2006, Sweden undertook a series of reforms to sickness and disability policies, which contributed to further considerable drops in both sickness absence rates and disability claims. These reforms included (*Economic Survey* of Sweden, OECD 2012b) among other things the introduction of:

- Institutional restructuring which led to more rigorous implementation of existing regulations and more process and outcome consistency across the country.
- Requirements for individuals on sick leave to consider a wider scope of jobs as sick leave lengthens (the current version of this is described below).
- A 2.5-year ceiling on the duration of sick leave compensation (previously there was no limit on duration).
- More stringent disability-pension entitlement criteria.
- Medical guidelines for the 90 most frequent medical conditions, prescribing recommended periods of sickness absence likely to produce a good health and work outcome (developed on the basis of empirical data on the typical absence period).

The Netherlands

Privatisation of sickness insurance (1990s). Driven by a widespread understanding that sickness levels were intolerably high, the Netherlands went through a major reform, which started in the early 1990s and led to the full privatisation of the previously publicly administrated and collectively financed sickness benefit scheme. In 1992, hitherto uniform premiums were changed to reflect a firm's actual absence rate. In 1994, payment of benefits during the first six weeks became the responsibility of the employer; and as of 1996, employers were responsible for sick pay for the then entire 52-week period. Sickness absence rates dropped from 8.1% in 1992 to 4.6% in 1997. The reform process produced the current system in which government sets the major rules (including the covered risk, the insured population, the insured wage, the replacement rate) in a system that operates in large part like a private insurance as most small companies choose to insure their sick-pay liabilities. The Netherlands still provides for a public sickness benefit for people without an employer (e.g. fixed-term workers, unemployed) or for whom employers are exempt from their sick-pay obligation (e.g. people hired from long-term sickness or disability status). As privatisation induced a political debate on discrimination by firms against hiring people with an excessive sick-pay risk, medical checks to select job candidates on the basis of their health were banned.

Sickness reforms in 2002 and 2004. Additional regulation brought more rules regarding employers' sickness management and reintegration responsibilities. New obligations included offering the employee a suitable job or providing the workplace adaptations (which employees must accept). Reforms also extended the sick-pay period from one year to two years and obliged employers to prepare a reintegration report on all actions taken (work-related or medical) to facilitate and accelerate the return to work. Insufficient reintegration efforts by employers can prolong the sick-pay period by another year.

Disability benefit reform (early 2000s). A major reform was agreed between the government and the social partners in 2003-04, and took effect in 2006. The reform focused on reducing inflows to disability benefit, and was certainly successful in this regard. Inflows to disability benefit dropped substantially; from around 70 000-100 000 per year prior to reform to some 40 000 in 2007 and 2008. Measures taken included:

- Reassessment of entitlement for those aged under 45 years to align with new assessment criteria (a reassessment had also been carried out in 1994).
- An increase in the minimum work capacity reduction required to be entitled to a disability benefit, from 15% to 35%.[5]
- Stronger employee incentives, such as benefit cuts for people with partial work capacity who are not using at least half of their capacity in the labour market (e.g. someone classified as having 60% work capacity but only working less than 30% would be penalized by a reduction in benefit entitlement).

A modification of experience rating in the disability system (i.e. premiums which depend on the number of disability claims in the company), which was first introduced in 1998, as an incentive for employers to prevent long-term disability.

Switzerland

Medical assessment reform (early 2000s). In 2004, as part of a revision of invalidity insurance law Switzerland established the Regional Medical Services (RAD, Regionalärztliche Dienste). RAD support the disability insurance authority in assessing work capacity and thus benefit entitlement – a task previously, in the main, carried out by a claimant's general practitioner. A preliminary evaluation (Wapf and Peters, 2007) found that the introduction of RAD led to an improved quality and homogeneity of medical decisions, with more cooperation between physicians across different disciplines and a better alignment with the requirements of the disability insurance. Liebert (2019) concludes that external medical assessment has reduced disability insurance uptake by around 14-23% and for mental health conditions even by 30%. However, Wapf and Peters found that the reform did not shorten the time needed to take decisions. Also staffing the RAD has proved a challenge, requiring attracting regular physicians to work as medical insurance professionals. This is something to be aware of for any country considering similar reform.

Disability benefit reform (2003-2016). Over a prolonged period, the government substantially altered the disability insurance system through a series of reforms geared at early intervention. The reforms (also summarized in the 2019 *Economic Survey of Iceland*; OECD, 2019):

- Clarified and tightened the eligibility criteria for disability benefits;

[5] The 15% threshold for a partial disability benefit in the Netherlands was comparatively low in international comparison and stemmed from the fact that the system covers both work injury and general disability, which is unusual (countries generally have a separate work-injury compensation scheme). The threshold increase to 35% means that the minimum threshold for a work injury became unusually high in international comparison.

- Reduced implicit tax rates by partially decoupling additional labour income from disability benefits;
- Improved the detection of people at risk of becoming disabled, including a new form of low-threshold application to disability insurance;
- Set up early intervention measures to secure job retention or to support job search, including vocational training and active job placement;
- Introduced substantial wage subsidies for employers hiring disability benefit claimants.

Conclusion: What can Norway learn from the selected countries?

Learning from policies and experiences in other countries is critical, even where systems seem to differ. Invariably, the basic challenges are the same in all countries. For sickness and disability benefit systems, these challenges include:

- how to assess who should be entitled to what types of services and benefits, and how to prevent unnecessary benefit claims;
- how much to pay in order to find a good balance between securing adequate incomes and providing sufficient incentives to seek work; and
- how much employer co-payment to seek to encourage sufficient preventive and return-to-work efforts.

For Norway, the relevance of policy reform from the three selected countries – Sweden, the Netherlands, and Switzerland – is helped by relatively small differences in the structure and objectives of these countries' sickness and disability schemes. The key lessons for Norway from this four-country comparison are as follows:

- More than anything else, the **Dutch case demonstrates that employer incentives are critical** and that support for a reform that increases employer costs for sickness and disability can be obtained when all parties agree that the outcomes are inacceptable and unsustainable. This was certainly the case in the Netherlands in the 1990s. The example of the Netherlands also shows that employee incentives must match those of the employer and that any policy and new regulations must be enforced rigorously and sanctions be applied strictly.
- The **Swiss case** is especially interesting for two reasons: first, it shows that **medical assessment reform is possible** in which decisions are gradually transferred from general practitioners to a public authority, regional medical services in the Swiss case, to control medical files. Secondly, it shows that **greater early identification of problems, matched with new early intervention services, is critical**. Losing time is costly because a return to work is unlikely as soon as workers have shifted their mindset to inactivity. More recent reform in Switzerland targeted at disability beneficiaries (not discussed in this paper), also shows that bringing long-term beneficiaries back into the labour market is much less promising.
- The **Swedish system** is the one most similar to the Norwegian, and lessons therefore most easily transferable. One key lesson from Sweden is that **employee incentives and enforced regulations can work very effectively**. When sick pay was reduced in the 1990s, in the course of a severe economic downturn, absence rates fell dramatically; even just a 10 percentage-point decrease in the sick pay compensation rate had an enormous effect. When sick pay regulations were overhauled ten years ago, with new eligibility criteria that support a much swifter return to the labour market, sickness trends underwent further dramatic change. Thus, the other Swedish lesson is that a cultural shift is possible: the degree of change in sickness and disability in Sweden in the past decade is unparalleled.

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Annex A. Measures that can improve sick leave and disability benefit systems, based on the 2010 OECD report "Sickness Disability and Work: Breaking the Barriers"

Desirable policy direction	Toolbox: specific measures that can be taken
	Individuals
Focus on work capacity not disability	• Focus disability medical assessment on work capacity. One approach is for those with (indisputably) full and permanent work incapacity to remain on a passive disability type benefit, and ramp-up activating and encouraging work among others • Widen scope of jobs that claimants must consider as sick leave/disability lengthens • Introduce option of partial return to work from sick leave
Move to an activation approach	• Introduce a phase of temporary disability benefit with strong focus on vocational rehabilitation • Combine partial benefits with work availability requirements • Convert partial disability benefit into an in-work payment • Direct some with partial work capacity onto unemployment benefit • Shift towards universal benefit (e.g. replace existing disability and unemployment benefit with a single benefit)
Make work pay through adjustment to benefits and taxation	• Direct reduction in compensation/benefit amounts. • Introduce in-work benefits (or expand existing ones) • Disability benefit suspension rules: allowing recipients to try out work without losing benefit entitlement or need for reapplication • Tweak benefit rules (e.g. tapering) and/or taxation to minimise numbers on disability facing weak financial incentive to enter employment or weak incentives to increase hours if already working
	Employers and medical professionals
Encourage employers to retain sick/disabled employees (instead of letting them transition out of employment)	• Supported employment: programmes of trial work placement with training and other on-the-job support • Improve sheltered employment, such as improving service-provider accreditation • Strengthen occupational health services • Mandate more sickness monitoring • Shift financial liability for compensation onto employers • Stronger anti-discrimination legislation, tighter enforcement of employment quotas where they exist • Employer subsidies: for covering cost associated (accommodation subsidies) or wage subsidies • Mitigating hiring risks e.g. removing or reducing employers' sick-leave compensation responsibilities when hiring disabled persons • Awareness campaigns (for instance regarding potential returns for employers to monitoring and preventative measures) • Facilitating employer networks
Stronger employment focus by medical professions involved in the sick leave and disability systems	• Medical sick-leave guidelines for doctors, including recommended lengths of absence • Systematic control of sickness certificates • Clearer administrative procedures • For disability benefit increase the medical powers of the benefit-granting institution (lowering relevance of practioner's assessment) • Financial incentives/sanctions for doctors • Incentivise the medical system in a top down way by shifting some of the financial cost for sick-leave compensation or sick leave benefit to the medical system.
	Public agencies providing services
Improve cross-agency co-ordination	• Integrated gateways to benefits and services (one-stop shops) • Streamlining systems • Better matching agency funding with responsibilities • More monitoring of regional and local authority policy implementation • Stronger outcome measurement and evaluation of programmes

Engage with clients systematically and in a tailored way	• Widening access to programmes
	• Early identification of problems:
	  ○ monitoring of sick leave,
	  ○ health monitoring of unemployed and inactive individuals,
	  ○ early intervention to head off disability claims
	• Better tailored services:
	  ○ client profiling for user services,
	  ○ flexibility in service provision,
	  ○ review balance between channelling disabled into generic employment services ("mainstreaming") and providing specialised services for disabled
	review balance between employment experience and training in programmes

Improving private agency performance	• Outcome-based funding • Performance ratings and competition • Voucher systems

Source: Based on the *Sickness, Disability and Work: Breaking the Barriers* synthesis report (OECD, 2010)