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Young persons with health conditions: measures on prevention of disability benefit dependency and activation

An overview of selected reforms, experiences and lessons from five countries

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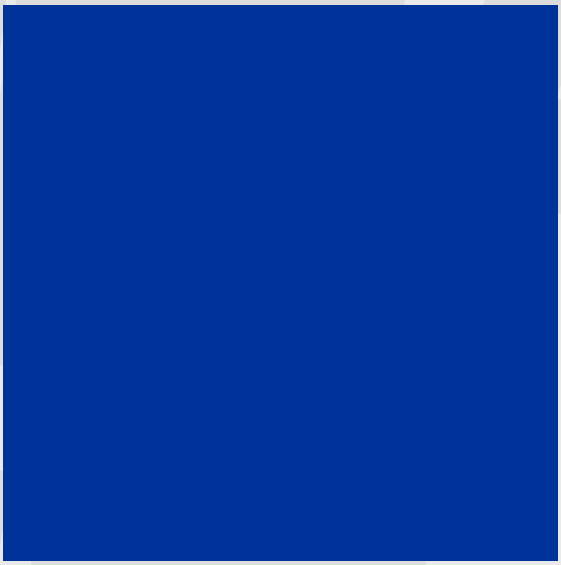

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Young persons with health conditions: measures on prevention of disability benefit dependency and activation

An overview of selected reforms, experiences and lessons from five countries

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Foreword by the Federal Social Insurance Office

Various media have reported recently on the topic of restrictions on access to invalidity pensions for young adults. As numerous statements on the further development of invalidity insurance show, the topic has also been subject to political debate. Here, other countries – in particular Denmark – were taken as examples.

In order to create a solid base of knowledge as to how such systems with a minimum pensionable age are structured and function, this report examines and presents five (pension) systems that are comparable to the Swiss system: Denmark, UK, Austria, Sweden and the Netherlands. All systems aim at integrating young people whose health is impaired into the labour market instead of paying them a pension.

Considerable caution must be exercised when comparing countries and systems, as the social security systems vary greatly in terms of their structure, financing and access entitlements. Consequently, the findings can rarely be transferred directly. Nevertheless, it can be interesting and informative to take a closer look at other countries with different, new approaches. This is particularly the case with a view to the ongoing development and optimisation of systems and processes in Switzerland.

The five European country studies show that access restrictions to invalidity pensions for young people impact heavily on other social security systems, thus influencing the interplay between numerous players such as social insurance, social welfare, educational and healthcare systems. This places high demands on inter-institutional cooperation, as the livelihoods of these young people have to be safeguarded in some way. At the same time as restricting access to pensions, the countries under consideration developed alternatives to pensions for young people with health impairments, such as ways to increase their social and professional integration and improve their education. Whether this shift in focus and the professional integration of these young people with health impairments will succeed can only be seen in several years' time, as the reforms presented in this study are almost all recent. The first results are presenting a mixed picture: several measures seem to be having a rapid effect, while others entail follow-on problems.

What stands out is that the reforms in the countries under consideration all aim at improving integration into the primary labour market and at stepping up inter-institutional cooperation, similar to the IV revisions in recent years in Switzerland. Our research studies have shown that this is not being pursued systematically enough among some of the young people with health impairments. It is not possible, on the basis of this report, to say whether pressure to step up these efforts can be increased by setting a minimum pensionable age. The further development of the IV system aims to expand the resources needed to help young people enter training and the workforce. Here too, it will take some time before we see how effective these measures are.

Stefan Ritler, Vice-Director

Head of Invalidity Insurance Domain

Vorwort des Bundesamtes für Sozialversicherungen

Zahlreiche Medien haben in jüngster Zeit das Thema der Zulassungsbeschränkung von jungen Erwachsenen zu Invalidenrenten aufgegriffen. Auch im politischen Diskurs ist das Thema präsent, wie zahlreiche Stellungnahmen zur Weiterentwicklung der Invalidenversicherung zeigen. Dabei wurde jeweils auf Beispiele anderer Länder – allen voran Dänemark – verwiesen.

Um fundiertes Wissen darüber zu schaffen, wie solche Systeme mit Mindestrentenalter ausgestaltet sind und funktionieren, wurden im vorliegenden Bericht fünf mit der Schweiz vergleichbare (Renten-)Systeme beleuchtet und dargestellt: Dänemark, Grossbritannien, Österreich, Schweden und die Niederlande. Allen Systemen gemeinsam ist das Ziel, junge, gesundheitlich beeinträchtigte Menschen im ersten Arbeitsmarkt zu integrieren, statt ihnen Renten auszurichten.

Bei Länder- und Systemvergleichen ist grundsätzlich grosse Vorsicht geboten, da sich die Sozialsysteme in ihrem Aufbau, der Finanzierungsart oder den Zugangsberechtigungen stark unterscheiden. Entsprechend können die Erkenntnisse selten direkt übertragen werden. Nichtsdestotrotz kann es interessant und lehrreich sein, andere Länder mit verschiedenen, neuen Lösungsansätzen genauer zu studieren. Dies auch gerade im Hinblick auf die stetige Weiterentwicklung und Optimierung der Systeme und Vorgehensweisen in der Schweiz.

Die fünf europäischen Länderstudien zeigen, dass Zugangseinschränkungen zu Invalidenrenten für Junge andere sozialstaatliche Einrichtungen stark tangieren und damit das Zusammenspiel zwischen zahlreichen Akteuren wie Sozialversicherungen, Sozialhilfe, Bildungs- oder Gesundheitssystem beeinflussen. Dies stellt hohe interinstitutionelle Kooperationsanforderungen, da der Lebensunterhalt dieser jungen Menschen auf irgendeine Art gesichert bleiben muss. Die betrachteten Länder bauten gleichzeitig mit der Beschränkung des Rentenzugangs für junge Personen mit gesundheitlichen Beeinträchtigungen Alternativen zur Rente aus, namentlich Angebote zur verstärkten sozialen und beruflichen Eingliederung und Bildung dieser Personen. Ob diese Fokusänderung erfolgreich sein wird und die berufliche Integration dieser gesundheitlich beeinträchtigten jungen Personen gelingen wird, lässt sich erst in einigen Jahren beantworten, denn die im Rahmen dieser Studie dargestellten Reformen sind fast durchwegs noch jüngeren Datums. Erste Resultate ergeben ein durchzogenes Bild: einige Massnahmen scheinen rasch zu greifen, andere ziehen Folgeprobleme nach sich.

Auffällig ist, dass die Reformen in den betrachteten Ländern überall auf eine verbesserte berufliche Eingliederung in den ersten Arbeitsmarkt abzielen und die verstärkte interinstitutionelle Kooperation anstreben, genau wie dies die IVG-Revisionen der letzten Jahre auch in der Schweiz anstreben. Dass dies bei einem Teil der jungen Personen mit gesundheitlichen Beeinträchtigungen noch zu wenig konsequent geschieht, haben unsere Forschungsstudien gezeigt. Ob der Druck zur Verstärkung dieser Anstrengungen durch das Festsetzen eines Mindestrentenalters tatsächlich erhöht werden kann, lässt sich mit diesem Bericht noch nicht abschliessend beurteilen. Die Weiterentwicklung der IV geht den Weg, die Mittel, um junge Menschen in die Ausbildung und die Arbeitswelt zu bringen, zu verstärken. Auch hier wird erst nach einer gewissen Zeit beurteilt werden können, wie sich diese Massnahmen auswirken werden.

Stefan Ritler, Vizedirektor

Leiter Geschäftsfeld Invalidenversicherung

Avant-propos de l’Office fédéral des assurances sociales

Depuis quelque temps, la limitation de l’accès des jeunes adultes aux rentes d’invalidité se trouve souvent sous les feux de l’actualité médiatique. La question est également débattue au niveau politique comme le montrent les nombreuses prises de position sur le développement continu de l’assurance-invalidité. La pratique à l’étranger, en particulier au Danemark, est régulièrement citée à titre d’exemple.

Pour disposer d’informations avérées sur la structure et le fonctionnement de différents modèles prévoyant un âge minimal pour l’octroi d’une rente, une étude a été menée dans cinq pays dotés d’un système de sécurité sociale comparable au nôtre : le Danemark, la Grande-Bretagne, l’Autriche, la Suède et les Pays-Bas. À l’instar de la Suisse, ces cinq pays ont pour objectif d’insérer sur le marché primaire de l’emploi les jeunes personnes atteintes dans leur santé plutôt que de leur octroyer une rente.

Il faut être très prudent lorsque l’on compare les systèmes sociaux au niveau international, car les structures, les modalités de financement et le droit aux prestations de la sécurité sociale varient beaucoup d’un pays à l’autre. Il est donc rarement possible de transposer tels quels les résultats d’études de ce genre. Cela dit, un examen approfondi des approches et solutions innovantes adoptées par d’autres pays est intéressant et particulièrement utile en vue du développement continu et de l’optimisation des assurances sociales en Suisse.

Les résultats de notre étude montrent que la limitation de l’accès des jeunes aux rentes d’invalidité influence grandement les autres institutions de l’État social et, partant, l’interaction des assurances sociales, de l’aide sociale ainsi que des systèmes de santé et d’éducation. De grands défis se posent en particulier à la coopération interinstitutionnelle, élevés, étant donné qu’il faut continuer de garantir l’existence des jeunes personnes en l’absence d’une rente. Ainsi, les cinq pays qui ont limité l’accès à la rente des jeunes atteints dans leur santé ont parallèlement renforcé leurs offres de formation et leurs mesures d’intégration sociale et professionnelle en faveur de ce groupe d’assurés. Comme ces changements sont récents, il faudra attendre plusieurs années avant de savoir s’ils produisent les effets recherchés et si les jeunes personnes concernées ont réussi à s’intégrer sur le marché du travail. Les premiers résultats donnent une image mitigée : si certaines mesures semblent être efficaces à court terme, d’autres engendrent de nouvelles difficultés.

Une conclusion intéressante est que les cinq pays ont opté pour une amélioration de l’intégration sur le marché primaire de l’emploi et un renforcement de la coopération interinstitutionnelle, deux démarches qui étaient également au cœur des révisions de l’AI réalisées ces dernières années. En Suisse, des études menées par l’OFAS ont permis de constater que les efforts d’intégration ne sont pas encore suffisamment rigoureux pour une partie des jeunes souffrant de troubles de la santé. Il n’est toutefois pas certain que l’introduction d’un âge minimal pour l’octroi d’une rente permette de remédier à cette situation. Cela ressort de la présente étude. Le développement continu de l’AI s’oriente vers un renforcement des moyens déployés pour améliorer la formation des jeunes assurés et leur intégration professionnelle. Il faudra, ici comme à l’étranger, attendre un certain temps pour juger de l’impact de ces mesures.

Stefan Ritler, vice-directeur

Responsable du domaine Assurance-invalidité

Premessa dell’Ufficio federale delle assicurazioni sociali

Recentemente numerosi media hanno ripreso il tema della limitazione della concessione di rendite d’invalidità ai giovani adulti. Questo tema è presente anche nel dibattito politico, come dimostrano molteplici pareri espressi nel quadro della consultazione sull’ulteriore sviluppo dell’assicurazione invalidità, che rimandano a esempi di altri Paesi, primo fra tutti la Danimarca.

Al fine di avere conoscenze fondate sull’organizzazione e sul funzionamento dei modelli che prevedono un’età minima per la concessione di una rendita, nel presente rapporto sono stati illustrati cinque sistemi (di rendita) comparabili a quello della Svizzera, ossia quelli di Danimarca, Regno Unito, Austria, Svezia e Paesi Bassi. L’obiettivo comune a tutti i sistemi è integrare nel mercato del lavoro primario le persone giovani con problemi di salute, invece di versare loro una rendita.

In linea di massima, il confronto fra Paesi e sistemi richiede grande prudenza, dato che i sistemi sociali sono molto diversi fra loro per struttura, modalità di finanziamento o condizioni di diritto. Pertanto le conoscenze possono essere trasferite direttamente soltanto di rado. Ciononostante può essere interessante e istruttivo studiare in modo più approfondito altri Paesi con approcci diversi e innovativi, anche e soprattutto nella prospettiva dello sviluppo e del perfezionamento costanti dei sistemi e delle procedure in Svizzera.

Gli studi sui cinque Paesi europei indicano che le limitazioni della concessione di rendite d’invalidità ai giovani toccano da vicino anche altri organi dello Stato sociale e influiscono così sull’interazione fra numerosi attori come le assicurazioni sociali, l’aiuto sociale, il sistema di formazione o il sistema sanitario. Ciò implica la necessità di un’elevata cooperazione interistituzionale, dal momento che bisogna continuare a garantire in qualche modo il sostentamento di questi giovani. Parallelamente alla limitazione della concessione di rendite ai giovani con problemi di salute, i Paesi presi in esame hanno sviluppato alternative alla rendita, in particolare strumenti volti a rafforzare la formazione e l’integrazione sociale e professionale di queste persone. Ci vorrà ancora qualche anno per sapere se questo cambiamento di prospettiva avrà successo e se l’integrazione professionale di questi giovani con problemi di salute avrà esito positivo, visto che le riforme considerate nell’ambito del presente studio sono quasi tutte di recente introduzione. I primi risultati mostrano un quadro in chiaroscuro: alcune misure sembrano efficaci in tempi rapidi, mentre altre hanno ripercussioni negative.

È significativo che tutte le riforme attuate nei Paesi presi in considerazione mirano a una migliore integrazione nel mercato del lavoro primario e a una maggiore cooperazione interistituzionale, ovvero gli stessi obiettivi perseguiti anche in Svizzera con le revisioni AI degli ultimi anni. Dagli studi svolti al riguardo è emerso che per una parte dei giovani con problemi di salute le misure sono adottate in modo ancora troppo poco sistematico. Al momento, il presente rapporto non permette di valutare in via definitiva se fissando un’età minima per la concessione di rendite aumenterebbe effettivamente la pressione per il rafforzamento degli sforzi in tal senso. L’ulteriore sviluppo dell’AI va nella direzione di potenziare i mezzi per inserire i giovani nella formazione e nel mondo del lavoro. Anche in questo caso, sarà possibile valutare gli effetti delle misure previste soltanto dopo un determinato lasso di tempo.

Stefan Ritler, vicedirettore

Capo dell’Ambito Assicurazione invalidità

Contents

The national reports will be published on the following site:
https://www.bsv.admin.ch/bsv/de/home/publikationen-und-service/publikationen/studien-gutachten.html

Abbreviations

AC	Activity Compensation programme (SE)
AtW	Access to Work programme (UK)
ESA	Employment and Support Allowance (UK)
FSIO	Federal Insurance Office Switzerland
Fit2Work	Fit to Work programme (AT)
GP	General Practitioner (“family doctor”)
IAPT	Improving Access to Individual Therapies programme (UK)
IBA	Inclusive Apprenticeship Training (“Integrative Berufs Ausbildung”)
IVG	Law on Invalidity Insurance (CH)
LSS	Act on support and service for certain disabled (“Lagen om stöd och service för vissa funktionshindrade”)
NEETs	(Persons) Not in Employment, Education or Training
NI	National Insurance (Fund) (UK)
OECD	Organization for Economic Co-Operation and Development
PES	Public Employment Services
PIP	Personal Independence Payment (UK)
PWD	Persons with disabilities
SEK	Swedish Crown (currency)
SMS	Service department in Social Ministry (“Sozialministerium Service”)
STAR	Labour Foundation (“Stichting van de Arbeid”) a national consultative body (members: representatives from social partners).
SWOT	(Analysis of) Strengths, Weaknesses, Opportunities and Threats
UWV	Employee Insurance Agency (NL)
WAJONG	Disablement Assistance Act for Handicapped Young Persons (NL)
WC	Work Choice programme (UK)
WMO	Act on Public Support (social assistance) (NL)

Summary

Background and aim of the study

There is concern on the growth of the proportion of young persons in the inflow in the disability pension scheme (in particular those with mental health related problems). Therefore, the Federal Insurance Office Switzerland is very interested to know about lessons from reforms in other countries. This study explores various reforms which actually have been implemented and - solely or substantially – focused on measures to prevent disability pension dependency (in young persons).

Methodology and products

The project has been carried out between May and October 2016. Five West European countries have been selected where relevant reforms and policy changes took place: Denmark, Sweden, Austria, United Kingdom and the Netherlands. In each country an independent expert collected information according to a common descriptive format. The products are five national reports and this comparative report. Our report includes a comparison of reforms, their backgrounds, implementation aspects, outcomes and lessons. It also contains "fact sheets" summarizing reforms, their context, impact and lessons.

Countries and reforms

The countries and selection of reforms covered in this study include:

a. *Denmark:* this country introduced age related restrictions as to claiming disability benefits and a special support programme; both were implemented January 2013;
b. *Sweden* already in 2003 introduced age restrictions for disability pension take up: persons aged under 30 were only eligible to a temporary disability benefit;
c. *Austria* recently (2014) strengthened the principle "Reha vor Pension" ("Rehabilitation goes before disability pension"), tightened eligibility criteria for disability pension, introduced a "rehabilitation allowance" and (2011) introduced prevention services;
d. *United Kingdom* introduced various measures to stop the inflow into disability benefits (by young persons and other categories). They include change of eligibility thresholds and specific activation and support programmes;
e. The *Netherlands* the special disability benefit programme for young persons with disabilities has been reformed 2010, aiming at less benefit dependency, more activation and better (special) school - labour market transfer.

Aims of reforms

Some reforms explicitly aimed to stop or reduce the inflow of *young* persons with health conditions into long term disability benefits, e.g. Sweden (2003) and Denmark (2013). In many countries reforms were motivated (too) by a *lack of success of earlier measures*. Or reforms were explicitly connected to the growth of *mental health problems* in young persons claiming disability benefits. In three countries *austerity measures* and the need for reduction of growing social insurance expenditures were also reasons for reforms.

Variations in reform measures

In many countries the strengthening of eligibility criteria for disability benefit (pension) receipt and adaptations of payment conditions is one of the reform elements. Secondly, an important reform feature includes the introduction (or improvement) of measures and provisions to support *young* persons with health conditions towards participation and employment. This may include special support programmes, early intervention during the initial stage of sickness (e.g. when receiving sickness benefits), or preventive measures like “individual” and “company” counselling (Austria).

Implementation

The *daily operation* of reforms requires considerable organizational changes, e.g. there often is a *need for new organizational structures, operational teams or case managers* and *new tools*. Secondly, in the implementation stage the *take up and utilization* of new measures often goes slowly and takes time. Thirdly, starting up the new procedures, tools or provisions often implies *initial organizational problems* like a lack of staff (or expertise), or insufficient public promotion (e.g. information campaigns) on the new services and provisions.

But also some more *basic (public) administrative complexities* or *weaknesses* have been identified, like strict separation between medical rehabilitation (often taking place during sick leave) and vocational rehabilitation (often after stabilization of health condition). Also *regional differences* or *financial responsibilities* in new cooperation structures need attention. A frequently mentioned weakness in reform design and implementation regards *the (neglected) role and needs of employers*.

Impact of reforms

a. Changing eligibility criteria for access to disability benefits in general shows to reduce applications and inflow rates of young persons (e.g. Austria, Denmark, Sweden). But (alternative) benefits still are needed for participants in an activation programme;
b. Rates on inflow into employment show to vary, depending on target group. Rates on job placement or return to work often are (very) low. But in some countries (e.g. Austria, United Kingdom) also considerably better job placement rates were found for young persons with health restrictions that were out of employment;
c. Notwithstanding, at the end of participation in a specific programme a considerable proportion of young persons with disabilities shows to be further depending on some kind of benefit, e.g. sickness benefits (Sweden) or social assistance (Austria).

Lessons on organization and coordination

Reforms do not regard just one particular benefit scheme, but “always” comprise the introduction of different measures *at the same time*. Moreover, reforms do not take place in isolation: the *institutional context* or *leading paradigms* in governmental policies may change simultaneously, like austerity measures and abolishment of sheltered workshops (example from United Kingdom). Furthermore, *new organizational structures need time* for learning to work in the new context, e.g. when applying new responsibilities, cooperation and coordination (including financial conditions). Coordination problems also were

reported from (new) multidisciplinary teams: actors from social insurance agency, employment office, health care, municipality or service providers often are attached to their own procedures, responsibilities, or “traditional” priorities in client groups. Moreover, (based on a long tradition) in some countries medical rehabilitation measures still are predominant in individual client support, compared to a low use of vocational training or job search.

Outlook

In some countries measures taken still are “too fresh” to decide on adaptations, whereas in other countries revisions or adaptations are politically considered or ongoing. Also changes in government composition may change the agenda. Adaptations often are part of wider reforms packages (focusing on employment or social inclusion policy in general, or part of reforms in social insurance). It also was noted that in some countries specific implemented reform elements will be expanded. E.g. supporting models with - evidence based - good results will on a wider scale be applied in the activation of young persons with mental health conditions (United Kingdom). And in Austria the role of prevention will be enhanced, by increasing the counselling support for employed persons who are work incapacitated (“sick listed”) and their employers.

Zusammenfassung

Hintergrund und Zielsetzungen der Studie

Der zunehmende Anteil junger Menschen (insbesondere solcher mit psychischen Problemen) bei den Neuzugängen in die Invalidenversicherung gibt Anlass zur Besorgnis. Deshalb ist das Bundesamt für Sozialversicherungen äusserst interessiert an den Erfahrungen, die andere Länder mit Reformen gemacht haben. Diese Studie befasst sich mit verschiedenen Reformen, die umgesetzt wurden und die sich ausschliesslich oder massgeblich auf Massnahmen zur Prävention der Abhängigkeit von einer IV-Rente bei jungen Menschen konzentrierten.

Methodik und Ergebnisse

Das Projekt wurde zwischen Mai und Oktober 2016 durchgeführt. Dazu wurden fünf westeuropäische Länder ausgewählt, in denen entsprechende Reformen und politische Änderungen vollzogen wurden: Dänemark, Schweden, Österreich, das Vereinigte Königreich und die Niederlande. In jedem dieser Länder sammelte ein unabhängiger Experte respektive eine unabhängige Expertin Informationen in einem einheitlichen beschreibenden Format. Das Ergebnis sind fünf Länderberichte sowie die vorliegende Vergleichsstudie, in der die Reformen, deren Hintergründe, Aspekte der Umsetzung sowie Ergebnisse und Erkenntnisse miteinander verglichen werden. Ausserdem enthält die Vergleichsstudie Fact Sheets zu den einzelnen Ländern mit einer Zusammenfassung der Reformen, Kontexte, Auswirkungen und Erkenntnisse.

Länder und Reformen

In der vorliegenden Studie werden die folgenden Länder und ausgewählten Reformen behandelt:

f. *Dänemark* führte im Januar 2013 altersabhängige Beschränkungen für den Anspruch auf Invalidenrenten sowie ein spezielles Förderprogramm ein.
g. *Schweden* setzte bereits 2003 altersabhängige Beschränkungen für den Bezug von Invalidenrenten um: Personen unter 30 Jahren haben nur vorübergehend Anspruch auf solche Leistungen.
h. *Österreich* stärkte vor wenigen Jahren (2014) den Grundsatz «Reha vor Pension», verschärfte die Kriterien für den Anspruch auf eine Invalidenrente („Invaliditätspension“) und führte ein «Rehabilitationsgeld» und Präventivdienste (2011) ein.
i. *Das Vereinigte Königreich* leitete verschiedene Massnahmen ein, um den Zustrom zur Invalidenversicherung (von jungen Menschen und anderen Kategorien) zu stoppen. Dazu gehören eine Anpassung der Schwellenwerte für den Anspruch auf IV-Renten sowie neue besondere Aktivierungs- und Förderprogramme.
j. Die *Niederlande* verfügen über ein spezielles Invaliditätsrenten-System für junge gesundheitlich beeinträchtigte oder behinderte Menschen, das 2010 einer Reform unterzogen wurde. Das Ziel bestand darin, die Abhängigkeit von Invalidenrenten zu vermindern, die Aktivierung zu stärken und den Übergang von der (Sonder-)Schule in den Arbeitsmarkt zu verbessern.

Zielsetzungen der Reformen

Einige der untersuchten Reformen zielten ausdrücklich darauf ab, den Zustrom von *jungen* Menschen mit Gesundheitsproblemen zu langfristigen finanziellen Invaliditätsleistungen (Renten) zu stoppen oder zu vermindern, so beispielsweise in Schweden (2003) und Dänemark (2013). In vielen Ländern sind die Reformen (auch) durch den *mangelnden Erfolg früherer Massnahmen* begründet oder stehen explizit im Zusammenhang mit der Zunahme von *psychischen Gesundheitsproblemen* bei jungen Menschen, die Anspruch auf Invaliditätsleistungen erheben. In drei Ländern zählten *Sparmassnahmen* und der dringende Bedarf, die wachsenden Kosten der Sozialversicherungen zu senken, ebenfalls zu den Gründen für eine Reform.

Unterschiede bei den Reformmassnahmen

In vielen Ländern gehören restriktivere Anspruchskriterien für den Bezug von Invaliditätsleistungen (Rente) sowie Anpassungen der Auszahlungsbedingungen zu den Bestandteilen der Reform. Ein weiteres wichtiges Element ist die Einführung (oder Verbesserung) von Massnahmen und Bestimmungen, mit denen *junge* Menschen mit Gesundheitsproblemen auf dem Weg hin zu einer Erwerbsbeteiligung und Beschäftigung unterstützt werden sollen. Beispiele dafür sind spezielle Förderprogramme, Frühintervention in der Anfangsphase einer Erkrankung (z. B. wenn Krankengelder bezogen werden) oder präventive Massnahmen wie etwa Beratung für Einzelpersonen und Betriebe (Österreich).

Umsetzung

Die *praktische Umsetzung* von Reformen erfordert umfassende organisatorische Anpassungen. Erstens werden oft *neue organisatorische Strukturen, Einsatzteams oder fallführende Personen (Case Managers)* sowie *neue Instrumente* benötigt. Zweitens dauert es in der Einführungsphase häufig etwas länger, bis neue Massnahmen *akzeptiert und genutzt* werden, und drittens ist die Einführung von neuen Verfahren, Instrumenten oder Bestimmungen meist mit *anfänglichen organisatorischen Problemen* wie etwa Personalmangel (oder fehlendem Fachwissen) verbunden. Zudem sind die neuen Dienstleistungen und Angebote in der Öffentlichkeit im Allgemeinen noch zu wenig bekannt (Informationskampagnen).

Hinzu kommen einige *grundlegendere Schwierigkeiten* oder *Schwächen, die mit der (öffentlichen) Verwaltung zusammenhängen*. Dazu gehört die strikte Trennung zwischen medizinischer Rehabilitation, die oft während der krankheitsbedingten Absenz erfolgt, und der beruflichen Eingliederung, die meist nach der Stabilisierung des Gesundheitszustands einsetzt. Zudem müssen *regionale Unterschiede* oder *finanzielle Zuständigkeiten* in neuen Kooperationsstrukturen beachtet werden. Eine häufig erwähnte Schwäche in der Konzeption und Umsetzung von Reformen betrifft die *Rolle und die Bedürfnisse der Arbeitgeber; beides wird vernachlässigt*.

Auswirkungen der Reformen

d. Eine Veränderung der Anspruchskriterien für Invalidenrenten führt in der Regel zu weniger Anträgen und Eintritten von jungen Menschen in dieses System (z. B. Österreich, Dänemark, Schweden). Allerdings braucht es dennoch (alternative) Leistungen für Teilnehmerinnen und Teilnehmer von Aktivierungsprogrammen.
e. Die beruflichen Eingliederungsquoten sind je nach Zielgruppe unterschiedlich hoch. Der Anteil der in den Arbeitsmarkt vermittelten oder an den Arbeitsplatz zurückkehrenden Personen ist oft (sehr) tief. In einigen Ländern (z. B. Österreich, Vereinigtes Königreich) wurden jedoch deutlich bessere Vermittlungsquoten in den Arbeitsmarkt für zuvor arbeitslose junge Menschen mit gesundheitlichen Beeinträchtigungen beobachtet.
f. Ein erheblicher Anteil der jungen gesundheitlich beeinträchtigten oder behinderten Menschen ist aber auch nach der Teilnahme an einem besonderen Förderprogramm weiterhin von einer Leistung wie etwa Krankengeld (Schweden) oder Sozialhilfe (Österreich) abhängig.

Erkenntnisse zur Organisation und Koordination

Reformen betreffen nicht nur ein einzelnes Leistungssystem, sondern schliessen immer die *gleichzeitige Einführung verschiedener Massnahmen* mit ein. Ausserdem finden Reformen nicht isoliert statt: Der *institutionelle Kontext* oder *Leitparadigmen* der Regierungspolitik können sich parallel dazu ebenfalls verändern. Dazu gehören Sparmassnahmen oder die Abschaffung von geschützten Werkstätten (Beispiel aus dem Vereinigten Königreich). *Neue organisatorische Strukturen* erfordern zudem Zeit, bis sie in einem veränderten Kontext funktionieren und wirksam werden können, etwa wenn neue Zuständigkeiten oder neue Formen der Kooperation und Koordination (einschliesslich finanzielle Bedingungen) zur Anwendung kommen. Auf Koordinationsprobleme weisen auch (neue) multidisziplinäre Teams hin: Akteurinnen und Akteure von Sozialversicherungsbehörden, Arbeitsämtern, Gesundheitsbehörden, Gemeinden oder Leistungserbringern hängen oft an ihren eigenen Verfahren, Verantwortungsbereichen oder «traditionellen» Prioritäten bezüglich der Klientengruppen. Ausserdem wird in einigen Ländern (traditionsgemäss) bei der individuellen Betreuung immer noch hauptsächlich auf medizinische Rehabilitationsmassnahmen gesetzt, während Massnahmen in den Bereichen berufliche Bildung oder Stellensuche weniger zum Einsatz kommen.

Ausblick

In gewissen Ländern sind die getroffenen Massnahmen noch «zu frisch», um schon jetzt über allfällige Anpassungen zu entscheiden. In anderen Ländern hingegen werden Revisionen oder gewisse Änderungen bereits auf politischer Ebene diskutiert oder umgesetzt. Eine neue Regierungszusammensetzung kann die Agenda ebenfalls beeinflussen. Anpassungen sind oft ein Bestandteil umfassenderer Reformpakete (die sich allgemein auf die Beschäftigungspolitik oder die Politik zur sozialen Eingliederung konzentrieren oder andere Teile von Sozialversicherungsreformen betreffen). In einigen Ländern werden spezifische, im Rahmen der Reform eingeführte Elemente zudem auf weitere Bereiche ausgedehnt. So werden beispielsweise unterstützende und fördernde Modelle, die

nachweislich gute Ergebnisse bringen, zukünftig bei der Aktivierung von jungen Menschen mit psychischen Gesundheitsproblemen breiter eingesetzt (Vereinigtes Königreich). In Österreich wird die Rolle der Prävention gestärkt, indem die beratende Unterstützung für erwerbstätige Personen, die arbeitsunfähig (krankgemeldet) sind, und ihre Arbeitgeber intensiviert wird.

Resumé

Contexte et but de l'étude

L'augmentation de la proportion de jeunes qui entrent dans le système des rentes d'invalidité inquiète. Cela vaut en particulier pour les jeunes atteints dans leur psychisme. Dans ces conditions, l'Office fédéral des assurances sociales (OFAS) est très intéressé à connaître les enseignements qui sont tirés de réformes entreprises dans d'autres pays. La présente étude examine différentes réformes mises en œuvre à l'étranger qui se focalisent entièrement ou dans une mesure importante sur des mesures visant à prévenir la dépendance (des jeunes) aux rentes d'invalidité.

Méthodologie et rapports produits

Le projet a été réalisé entre mai et octobre 2016. Les pays choisis sont cinq pays d'Europe occidentale dans lesquels un changement de cap et des réformes pertinentes ont eu lieu : le Danemark, la Suède, l'Autriche, le Royaume-Uni et les Pays-Bas. Dans chacun de ces pays, un expert indépendant a réuni des informations sur la base d'un canevas commun. Cinq rapports nationaux ont ainsi été produits, ainsi que la présente synthèse. Celle-ci compare les réformes, leur contexte, des aspects de la mise en œuvre, les effets produits et les leçons tirées. Elle contient aussi des fiches d'information par pays qui résument les réformes, leur contexte, leur impact et les enseignements.

Pays et réformes

Pays et réformes choisis pour la présente étude :

a. Le *Danemark* a introduit des restrictions d'âge pour prétendre à la rente d'invalidité et un programme de soutien spécial ; ces mesures ont été mises en œuvre en janvier 2013.
b. La *Suède* a restreint l'accès à la rente d'invalidité dès 2003 : les personnes de moins de 30 ans ne peuvent plus prétendre qu'à une allocation temporaire.
c. Récemment (2014), l'*Autriche* a renforcé le principe « la réadaptation prime la rente » (*Rehabilitation vor Pension*), durci les conditions du droit à la rente d'invalidité et introduit des indemnités de réadaptation. En 2011, elle avait introduit un dispositif de services préventifs.
d. Le *Royaume-Uni* a introduit des mesures visant à stopper l'entrée des jeunes et d'autres catégories de personnes dans le système de prestations d'invalidité. Elles incluent l'adaptation des seuils donnant droit aux prestations financières et des programmes d'activation et de soutien ciblés.
e. Les *Pays-Bas* ont réformé en 2010 leur système d'allocations d'invalidité pour les jeunes en situation de handicap. L'objectif était de réduire la dépendance aux prestations financières, de développer l'activation et de fluidifier le passage des écoles (spécialisées) vers le marché du travail.

Objectifs des réformes

L'objectif déclaré de certaines réformes était de stopper ou de réduire l'admission de *jeunes* atteints dans leur santé dans les prestations financières d'invalidité octroyées à

long terme (rentes), comme par exemple en Suède (2003) et au Danemark (2013). Dans de nombreux pays, les réformes étaient censées répondre à l'*échec de mesures antérieures* ou un rapprochement explicite a été fait entre la volonté de réforme et l'augmentation des *problèmes psychiques* chez les jeunes demandeurs de prestations d'invalidité. Dans trois pays, des *mesures d'austérité* et le besoin de réduire la croissance des dépenses des assurances sociales faisaient partie des raisons d'agir.

Différences s'agissant des mesures introduites

Dans de nombreux pays, un élément de la réforme est le durcissement des critères donnant droit aux prestations d'invalidité (rente) et l'adaptation des conditions de paiement. Un deuxième axe important est l'introduction (ou l'amélioration) des mesures de soutien pour accroître la participation sociale et l'emploi des *jeunes* atteints dans leur santé. Cela peut inclure des programmes de soutien spéciaux, l'intervention à un stade précoce de la maladie (si des indemnités maladie sont versées par ex.) ou des mesures préventives telles que des services de conseil individuel ou pour les entreprises (Autriche).

Mise en œuvre

Les réformes appellent des changements considérables pour l'accomplissement des tâches courantes. A titre d'exemple : *de nouvelles équipes de terrain ou de nouveaux gestionnaires de cas, ou encore de nouveaux outils* sont souvent *nécessaires*. Deuxièmement, *l'acceptation et l'utilisation* des nouvelles mesures est souvent lente et demande du temps. Troisièmement, la mise en place de nouvelles procédures, des nouveaux outils ou des nouvelles prestations de service est souvent accompagnée de *problèmes initiaux d'organisation*, comme par exemple : manque d'effectifs (ou d'expertise) ou sensibilisation insuffisante du public aux nouveaux services proposés (campagnes d'information, etc.).
Des *complexités* ou des *points faibles au niveau de l'administration (publique)* ont également été observées. Par exemple : le cloisonnement strict de la réadaptation médicale (qui a souvent lieu pendant le congé maladie) et de la réadaptation professionnelle (à laquelle il est souvent procédé après stabilisation de l'état de santé). Des *différences régionales* ou les *responsabilités financières* dans de nouvelles coopérations méritent attention également. Un point faible cité fréquemment est *la prise en compte (insuffisante) du rôle et des besoins des employeurs*.

Impact des réformes

a. La modification des conditions du droit aux rentes d'invalidité réduit en général les taux d'inscription et d'entrée des jeunes dans le système (ex. : Autriche, Danemark, Suède).
b. Les taux d'accès à l'emploi varient selon le groupe cible. Ces taux (ou les taux de retour au travail) sont souvent (très) bas. Mais dans certains pays (ex. : Autriche, Royaume-Uni), les taux de placement sont nettement meilleurs pour les jeunes atteints dans leur santéet sans emploi.
c. Il n'en demeure pas moins qu'une proportion considérable de jeunes en situation de handicap continue, après avoir participé à un programme spécifique, à dépendre de

certaines prestations, par exemple les indemnités maladie (Suède) ou l'aide sociale (Autriche).

Enseignements concernant l'organisation et la coordination

Aucune des réformes analysées ne se contente de modifier un seul dispositif : plusieurs programmes ou mesures sont introduits *simultanément*. De plus, les réformes n'ont pas lieu en vase clos. *Le contexte institutionnel et les paradigmes prédominants* dans les politiques gouvernementales peuvent changer en même temps (mesures d'austérité et suppression des ateliers protégés au Royaume-Uni par ex.). De plus, les nouvelles structures organisationnelles ont *besoin de temps* pour apprendre à travailler dans le nouveau cadre (nouvelles attributions, coopération et coordination [y c. conditions financières]). Des problèmes de coordination ont également été rapportés au sein des (nouvelles) équipes interdisciplinaires : les acteurs des organismes d'assurance sociale, des services de l'emploi, du système de santé, des communes ou des prestataires de services sont souvent attachés à leurs procédures, attributions ou priorités « traditionnelles » s'agissant des catégories de clients. Par ailleurs, dans certains pays (fidèles à une longue tradition), les mesures de réadaptation médicale continuent à jouer un rôle prédominant tandis que la réadaptation professionnelle ou la recherche d'emploi sont négligés dans les programmes de soutien individuel au client.

Perspective

Dans certains pays, les dernières réformes sont encore trop récentes pour décider de nouveaux réaménagements. Dans d'autres, des révisions sont en cours ou sont envisagées dans le monde politique. De plus, des changements dans la composition peuvent venir modifier l'agenda politique. Les réaménagements participent souvent d'un projet plus vaste (axé sur la politique de l'emploi ou de l'inclusion sociale en général ou nouveau train de réformes des politiques d'assurance sociale par ex.). Dans certains pays, il est prévu de développer certains éléments de réformes introduites. A titre d'exemple, on peut signaler des modèles de soutien dont l'efficacité a été prouvée seront incorporés à plus large échelle aux programmes d'activation des jeunes atteints dans leur psychisme (Royaume-Uni). En Autriche, la prévention sera revalorisée : il est prévu de développer les prestations de conseil pour les employés en incapacité de travail (congé maladie) et leurs employeurs.

Riassunto

Contesto e obiettivo dello studio

L'aumento della quota dei giovani (in particolare di quelli con problemi di salute psichica) che entrano nel sistema delle rendite dell'assicurazione invalidità è fonte di preoccupazioni. Pertanto, l'Ufficio federale delle assicurazioni sociali svizzero è particolarmente interessato a conoscere le conseguenze delle riforme attuate in altri Paesi. Il presente studio indaga diverse riforme realmente attuate e focalizzate, nella loro integralità o in modo preponderante, su misure volte a prevenire la dipendenza da una rendita d'invalidità (tra i giovani).

Metodo e prodotti

Il progetto è stato svolto da maggio a ottobre del 2016. Sono stati selezionati cinque Paesi dell'Europa occidentale nei quali hanno avuto luogo riforme e svolte politiche sul tema: Danimarca, Svezia, Austria, Regno Unito e Paesi Bassi. In ogni Paese, un esperto indipendente si è occupato di raccogliere informazioni seguendo un formato descrittivo comune. Ne sono derivati cinque rapporti nazionali e il presente rapporto comparativo. Quest'ultimo contiene un confronto fra le riforme, i contesti in cui esse si sono inserite, i diversi aspetti della loro attuazione, i risultati e gli insegnamenti che si possono trarre. Inoltre, contiene «schede informative» che riassumono riforme, contesti, impatto e insegnamenti.

Paesi e riforme

I Paesi e la selezione di riforme presi in considerazione nel presente studio sono esposti di seguito.

k. *Danimarca*: questo Paese ha introdotto restrizioni di età per la richiesta di prestazioni d'invalidità nonché uno speciale programma di assistenza, provvedimenti entrambi attuati a gennaio del 2013.
l. *Svezia*: già nel 2003 questo Paese ha introdotto restrizioni di età per la rendita d'invalidità, in quanto le persone di età inferiore ai trent'anni potevano richiedere soltanto una prestazione temporanea;
m. *Austria*: recentemente (nel 2014) il Paese ha irrigidito il principio della priorità dell'integrazione sulla rendita («Reha vor Pension»), ha reso più severe le condizioni del diritto alla rendita d'invalidità e ha introdotto un «assegno d'integrazione», dopo aver istituito (nel 2011) dei servizi di prevenzione.
n. *Regno Unito*: questo Paese ha introdotto varie misure per arrestare la presa a carico di persone (giovani e appartenenti ad altre categorie) da parte dell'assicurazione invalidità. Queste misure comprendono l'adeguamento delle soglie per aver diritto alle prestazioni nonché programmi specifici di assistenza e incentivazione del comportamento attivo.
o. *Paesi Bassi*: in questo Paese il programma speciale di prestazioni d'invalidità dedicato ai giovani interessati è stato riformato nel 2010 al fine di ridurre la dipendenza dalle prestazioni, incentivare il comportamento attivo e migliorare il passaggio dalla scuola (speciale) al mercato del lavoro.

Obiettivi delle riforme

Alcune riforme, come ad esempio quelle attuate in Svezia (2003) e in Danimarca (2013), miravano esplicitamente ad arrestare o a ridurre la presa a carico dei *giovani* con problemi di salute da parte dell'assicurazione invalidità sul lungo periodo. In diversi Paesi le riforme sono state giustificate (anche) dallo *scarso successo di misure precedenti*. In altri casi, le riforme erano esplicitamente connesse all'aumento di *malattie psichiche* tra i giovani che richiedono prestazioni d'invalidità. In tre dei Paesi presi in esame, sono state addotte come motivazioni per le riforme anche le *misure di austerità* e la necessità di ridurre le crescenti spese legate alle assicurazioni sociali.

Differenze tra le misure delle riforme

In molti Paesi, l'inasprimento dei criteri per aver diritto a una prestazione d'invalidità (rendita) e l'adeguamento delle condizioni di pagamento sono elementi importanti delle riforme. Inoltre, una caratteristica chiave delle riforme è l'introduzione (o il miglioramento) di misure e disposizioni per sostenere i *giovani* con problemi di salute in un processo di partecipazione e integrazione nel mondo del lavoro. Tra queste rientrano ad esempio programmi speciali di assistenza, l'intervento tempestivo nello stadio iniziale della malattia (p. es. in caso di ricorso a prestazioni di malattia) o misure preventive come consulenza «individuale» e «di gruppo» (Austria).

Attuazione

Innanzitutto, l'*applicazione* delle riforme *nella realtà quotidiana* richiede cambiamenti preparatori considerevoli, come ad esempio la *necessità di nuove strutture organizzative, gruppi operativi o case manager* e *nuovi strumenti*. In secondo luogo, nella fase di attuazione spesso serve tempo prima che le nuove misure siano *accettate e utilizzate*. In terzo luogo, avviare le nuove procedure, i nuovi strumenti o le nuove disposizioni spesso implica *problemi organizzativi iniziali*, come la carenza di personale (o di competenze tecniche) o una promozione pubblica insufficiente (p. es. campagne di informazione) sui nuovi servizi e provvedimenti.
Sono state altresì individuate alcune *complessità* o *debolezze di fondo a livello di amministrazione (pubblica)*, come la rigida distinzione fra riabilitazione medica, che spesso ha luogo durante le assenze per malattia, e integrazione professionale, che avviene sovente dopo la stabilizzazione dello stato di salute. Inoltre, bisogna prestare attenzione alle *differenze regionali* o alle *responsabilità finanziarie* nelle nuove strutture di cooperazione. Un punto debole spesso menzionato nell'impostazione e nell'attuazione delle riforme riguarda *il ruolo e i bisogni (spesso trascurati) dei collaboratori*.

Impatto delle riforme

g. In generale, le modifiche alle condizioni del diritto alle prestazioni d'invalidità si traducono in una riduzione delle richieste e dei tassi di presa a carico dei giovani (p. es. in Austria, Danimarca, Svezia). Tuttavia, restano comunque necessarie prestazioni (alternative) per i partecipanti ai programmi d'incentivazione al comportamento attivo.
h. I tassi d'integrazione nel mondo del lavoro risultano variare a seconda del gruppo target. I tassi di collocamento e rientro al lavoro sono spesso (molto) bassi, anche

se in alcuni Paesi (p. es. Austria e Regno Unito) si sono riscontrati tassi di collocamento considerevolmente migliori tra i giovani con limitazioni dovute a ragioni di salute che non erano occupati.

i. Ciononostante, al termine della partecipazione a un programma specifico, una parte consistente di giovani invalidi mostra di essere ancora dipendente da qualche tipo di prestazione, come ad esempio prestazioni di malattia (in Svezia) o assistenza sociale (in Austria).

Insegnamenti su organizzazione e coordinamento

Le riforme non riguardano soltanto un particolare tipo di prestazioni, ma prevedono «sempre» l'introduzione di diverse misure *contemporaneamente*. Inoltre, le riforme non hanno luogo in modo isolato: il *contesto istituzionale* o i *paradigmi ispiratori* delle politiche governative possono cambiare simultaneamente, come nel caso delle misure di austerità e dell'abolizione dei laboratori protetti (esempio proveniente dal Regno Unito). Va poi considerato che *serve tempo affinché le nuove strutture organizzative* imparino a operare nel nuovo contesto, ovvero con nuove responsabilità e forme di cooperazione e coordinamento inedite (comprese le condizioni finanziarie). Sono stati segnalati problemi di coordinamento anche da (nuovi) gruppi multidisciplinari: attori degli organi delle assicurazioni sociali, degli uffici del lavoro, dell'ambito sanitario o dei comuni oppure fornitori di servizi spesso vincolati alle proprie procedure, responsabilità o priorità «tradizionali» per quanto concerne le categorie di clienti. Inoltre, in alcuni Paesi (sulla base di una lunga tradizione) le misure di riabilitazione medica sono ancora predominanti nell'assistenza individuale al cliente, a fronte di un limitato ricorso alla formazione professionale o alla ricerca di impiego.

Prospettive

In alcuni Paesi le misure attuate sono ancora troppo recenti per poter parlare di adeguamenti; in altri, invece, revisioni o adeguamenti sono in fase di studio a livello politico o sono già in corso. Inoltre, i cambiamenti nella composizione del governo potrebbero modificare le priorità. Gli adeguamenti sono spesso parte di pacchetti di riforme più ampi (incentrati sull'occupazione o, in generale, sulla politica di inclusione sociale oppure parti di riforme nel settore delle assicurazioni sociali). È stato altresì rilevato che in alcuni Paesi si procederà a un ampliamento di elementi specifici attuati nel quadro delle riforme. Ad esempio, i modelli di assistenza che, sulla base di prove scientifiche, hanno mostrato buoni risultati saranno applicati su scala più ampia per incentivare il comportamento attivo dei giovani affetti da problemi psichici (Regno Unito). Infine, in Austria, verrà rafforzato il ruolo della prevenzione aumentando la consulenza destinata alle persone occupate che presentano un'incapacità al lavoro e ai loro datori di lavoro.

1 Introduction

1.1 Aim and background of the project

Currently the Swiss Law on Invalidity Insurance (IVG) is in a process of revision, which also involves discussions on options for reforms. Concern on the growth of the proportion of young persons in the inflow in the Swiss scheme (in particular with mental health related problems), made some experts propose to introduce a higher minimum age for eligibility to invalidity pensions. They referred to Denmark, that recently (2013) had introduced restrictions on the access to invalidity pensions for persons aged up to 40 years; moreover special activation measures had been introduced for this category of insured. We can add that longer ago (2003) but still operational, Sweden had introduced a special work incapacity benefit ("activity compensation") and support programme for young persons on sickness absence. These measures also were aiming to improve and speed up work resumption and prevent disability pension dependency.

FSIO (Federal Insurance Office Switzerland) is very interested to know lessons from such reforms, which are targeted on young persons, and focus on measures to prevent disability and disability pension dependency. In particular information is needed about the backgrounds and types of measures taken, how they have been conceptualized, what specific programmes or arrangements were designed, how they were implemented, what the positions of various stakeholders were, what impact the measure had and which lessons can be identified after some years of operation.

Regarding the target group and reforms to be included in the project is was required that the (new) measures should focus on young persons at working age (e.g. aged 16 – 30). Furthermore, the inquiry should only include nationwide reforms, which actually have been implemented. Pilot projects and experiments fall out of the core of the study, but could be included, e.g. as an example of "ongoing developments", after reform implementation.

1.2 Methodology

Considering the short-term need of this information, the cross-national exploration should comprise a relatively brief and concise inquiry, to provide insight into the aspects mentioned. The product of this inquiry should mainly be descriptive, not include recommendations, but rather give pros and cons in a "neutral" manner and considering the national contexts.

To this end it was crucial to select west European countries with relevant reforms. Moreover, from each selected country and reform, recent, valid and comparable information should be collected. Consequently, a common methodology and flexible use of data collection methods will be needed. Whereas for one country (Sweden) already evaluative studies were known to exist, in other countries reforms are quite "fresh" and mainly "new"

information would have to be collected (in particular on implementation and impact issues). Besides, countries may differ as to research culture, available statistics, accessibility of stakeholders, etc.

The study was carried out in a way which in the past showed to be fruitful and efficient: for each country with a reform fitting in the study a well-known "national expert" (researcher / research team) was invited to participate in the project and make a national report, whereas Rienk Prins Consultancy operated as coordinator and author of the final report.

In this design the first step regarded the selection of countries with relevant reforms (cf. Section 2.2). Secondly in the five countries selected experts were approached who were familiar with the topics and target group, had performed evaluation studies, or were active in international expert's networks. A list of the experts participating in this inquiry is included in Appendix 1.

At the start of the project national experts received a questionnaire (after having commented to a draft) which covered all the issues FSIO wanted to know. They further received a briefing ("instructions"), as well as a format for the national reports to be provided. For their inquiry experts could use a mix of research tools:

a. collection and analyses of documentation (e.g. on benefit system, reforms, implementation), statistics (e.g. inflow rates in disability benefit/pension programmes), and reports (e.g. evaluative studies, governmental policy papers, stakeholder position papers);

b. where needed (telephone) interviews were held with stakeholders involved, or other experts (e.g. disability pension administrators, policy makers). These interviews mainly aimed to identify the current situation as to strengths and weaknesses of the reform, policy evaluations, lessons learned, or reforms pending.

The project started Mid May 2016. Early July 2016 an interim report was provided, which summarized the main findings in the national reports. These initial results had a particular focus on background and content of the reforms or measures taken, implementation issues, outcomes and lessons learned. Feedback from FSIO and national experts and final versions of the national reports were the basis for the current (synthesis). In addition to the interim report here also new themes have been covered like lessons on coordination, or current (policy) developments after the start of the reforms covered. Apart from this report the national reports will be available on (www.bsv.admin.ch > Publikationen & Service > Publikationen > Studien, Gutachten...).

1.3 Elaboration of topics

In cooperation with FSIO and the national experts the issues to be covered were elaborated and transformed into a common format for data collection. National experts tried to collect information on seven aspects of the specific reform selected:

a. Backgrounds of the reform, including scope of the problem: e.g. trends in benefit dependency of young persons with health problems or disabilities;

b. Aims of the reforms and their context (institutional and legal framework);
c. Content of reforms: programmes or single measures in the field of benefits and activation;
d. Implementation, including actors involved (e.g. social security agency, employment agency, health care/rehabilitation, municipality);
e. Evaluations: impact (on benefit dependency, on labour participation), as well as opinions, viewpoints and positions of stakeholders;
f. Lessons, both on impact of measures and on implementation (e.g. legal or organizational conditions for reforms, planning lessons);
g. Outlook: ongoing (policy) developments, alternatives considered (incl. pilot projects), reforms pending, etc.

The latter theme tries to find out what happened after the "recent or less recent" implementation of the reforms: both policy developments (change of governmental priorities), positive or disappointing results, or contextual changes (e.g. economic crisis) may have put the reforms into a new perspective.

1.4 Countries and selected reforms

The study focusses on reforms and measures which were implemented nationwide and which directly or indirectly targeted at young persons with health problems. The target group may be employed (and insured) or out of employment (in education, unemployed).

The countries and selection of reform measures covered in this project include:

a. *Denmark:* introduced age related restrictions as to claiming disability benefits and a special support programme; both were implemented January 2013;

b. *Sweden* already in 2003 introduced age restrictions for disability pension take up by young insured: persons aged under 30 were only eligible to a temporary disability benefit. Furthermore, several new activation measures were provided to this group;

c. *Austria* recently (2014) strengthened the principle "Reha vor Pension" ("Rehabilitation goes before disability pension"), tightened eligibility criteria for disability pension, introduced a "rehabilitation allowance", and (2011) introduced an information and counselling service for occupational secondary prevention;

d. *United Kingdom* introduced various measures to stop the inflow into disability benefits (by young persons and other categories), including change of eligibility thresholds and specific activation and support programmes (e.g. for young persons with mental health conditions);

e. The *Netherlands* for many years had a special disability benefit programme for young persons with disabilities ("Wajong"). It was reformed 2010, aiming at less benefit dependency, more activation and better (special) school - labour market transfer.

2 Overview of reforms: their backgrounds, contents and components

2.1 Introduction

This report subsequently summarizes and discusses our findings on various aspects of the reforms. In this chapter we firstly give an overview of the types of reforms that have been selected for this inquiry. We also describe the backgrounds that lead to designing these reforms and describe their components (combination of measures) that were introduced. Their implementation (including organizational and coordination issues) will be covered in Chapter 3, whereas Chapter 4 is devoted to outcomes (impact) and lessons. Details can be found in the fact sheets and the national reports.

2.2 Overview of reforms

From the five countries covered eight reforms have been included in the study:

Denmark introduced two reforms (2013):

- In the Disability Benefit system: introduction of a higher minimum age (namely 40 years) for eligibility to disability benefits;
- In the Flex Job programme: referral of those aged under 40 with disabilities to a special activation programme (maximum duration 5 years) or to a “flex job”; Some initial findings on implementation and impact recently became available.

Sweden already in 2003 increased the minimum age for disability pension eligibility to the minimum age of 30 years. Those with reduced work capacity and aged 19-29 became eligible to an alternative benefit (the so-called “activity compensation”) with a maximum duration of three years (but with the possibility to apply for another period). Activity compensation included the right to take part in tailor made activities. After implementation some evaluation studies have been carried out.

Austria introduced a wide range of measures to prevent inflow in disability pensions and to improve job finding and job retention in young persons with disabilities. Our study concentrates on:

- Disability pension reform (2014), including strengthening eligibility criteria, as well as increased provisions for rehabilitation and prevention of disability benefit claims;
- Fit2Work programme (2011/2012): early interventions during a client’s sickness absence period, to prevent job loss and premature drop out. The programme offers individual and company counselling.

In the *United Kingdom* many reforms have been introduced, adapted and reconsidered, also due to changes in governmental priorities (e.g. austerity policies) and shifts in paradigms (e.g. “lower benefits will encourage people to move into work”). In this study we covered:

- Access to Work programme (1994, 2010): practical support for disabled people in employment aiming at job retention or self-employment;
- Work Choice Programme (2010) which aims to assist unemployed persons, who are recognized as disabled, into work.

In 2010 *the Netherlands* reformed its Disablement Assistance Act for Handicapped Young Persons ("Wajong"). The reform aimed to strengthen activation of young persosn with disabilities by introducing three sub programmes; new recipients should be assigned to one of them:

- Only benefit receipt (for those with serious disabilities and low earning capacity);
- Participation in the Employment programme, including a tailor made participation plan, services and a job offer from public employment service;
- Participation in the Education programme, for those who are still at school or studying (after age 18).

In 2015 the scheme has been revised substantially.

We have to take into account that in some countries measures not only regarded *young* persons with health conditions, but persons with disabilities *from all age groups*. Besides, some other measures focused at a wider category of young persons, including unemployed, persons with multiple problems, or those still in education. We tried to identify their relevance for young persons with health problems.

Both in the light of the recentness of reforms and availability of evaluation data, there are quite some differences across countries and reform programmes. Notwithstanding, some initial trends and conclusions as to the policies introduced and outcomes observed can be sketched.

2.3 Backgrounds of reforms

Despite considerable variations in the reforms and types of measures implemented, some general observations can be made.

1. Some reforms explicitly have been introduced with a "social insurance aim": to stop or reduce the inflow of *young* persons with health conditions into long term disability benefits: e.g. Sweden (2003) and Denmark (2013). In some other countries the new measures also targeted on "the young" with health problems, but had as major aim to improve the labour participation of more categories with health restrictions (to get and retain a job);
2. In most countries the reforms were motivated by a *lack of success of earlier measures*. Specific aims that were failed to reach: reduction of inflow into disability benefits, stop of drop out from the labour market, better use of the (remaining) working capacities of young PWD, or better accessibility and use of existing instruments and services by (young) persons with disabilities. In Austria it was noted that a basic principle of social insurance was not sufficiently realized, namely "Rehabilitation goes before Pension"; consequently reforms

should (also) contribute to timely and preventive interventions, and improved case management for the long term sick;

3. In several countries (Austria, Denmark, United Kingdom) reforms explicitly were connected to the – absolute or relative - growth of *mental health problems* in young persons claiming disability benefits, underutilization of existing instruments and labour market problems of persons with mental health conditions.

4. In two countries (Netherlands, United Kingdom) *austerity measures* and the need for reduction of growing social insurance expenditures were an - additional or underlying – objective of reforms. In Austria also the financial situation of health and pension insurance (rising costs due to sickness benefits) contributed to the awareness that reforms are needed.

In addition to these observations also more general administrative problems may be considered when preparing reforms. E.g. in Austria is was noted that discrepancies between public actors (public pension fund and public employment service) led to contradictory outcomes of assessments: many job seekers were assessed by the employment office to be unfit for work, but were capable to work according to pension fund). This implied long and double assessment procedures, in which clients were shuttled back and forth between authorities. These aspects will be covered more extendedly in the chapter (4) on lessons.

2.4 Reform components: measures taken

A common element of reforms in the countries covered is strengthening eligibility criteria for disability benefit (pension) receipt and adaptations of payment conditions. Measures may regard:

a. Introduction of a higher minimum age for benefit eligibility and replacement of the scheme by a less favourable benefit scheme. This may include: lower benefit levels, age related benefits (Sweden), fixed temporary eligibility (max. 3 or 5 years), and regular re-examinations;

b. Consequently, access to the disability benefit scheme only is available to young persons with (permanent) serious disabilities, with (permanent) low earning capacities, or if retraining is not appropriate;

c. Several countries introduced special benefits like “rehabilitation benefit” (Austria, during medical rehabilitation) or “education benefits” (Denmark, Netherlands, Sweden) to support young persons with no or un-completed (general or vocational) training.

A second component of reforms does not predominantly focus on benefits (eligibility, level), but includes the introduction or improvement of measures to support young persons with health conditions towards participation and employment, e.g.:

a. Reforming the support process, by creating a special support team (e.g. rehabilitation team);

b. Introduction of special support programmes including (multidisciplinary) assessment of needs and capacities, “tailor made” individual packages to improve education, increase vocational capacities, job search, in-work support, etc.;

c. Making existing provisions more accessible to (young) PWD: e.g. Denmark: better access to flex jobs (temporarily subsidized jobs); and Austria: (earlier) placement in rehabilitation hospitals or ambulant rehabilitation;

d. More early intervention during the initial stage of the person’s sickness process (when receiving sickness benefits). Austria’s Fit2Work programme provides (voluntary) “individual counselling” to employees sick listed over 6 weeks and/or unemployed with health problems;

e. The same programme includes “company counselling”: information, advice and support for employers, team training for coping with mental burdens at work, etc. Reforms in Austria, Netherlands and the United Kingdom involve various types of support for employers engaging PWD in apprenticeships or jobs;

f. A few countries (Austria, United Kingdom) report special health support programmes for young (and older) people with mental health conditions (e.g. in United Kingdom: IAPT: “Improving Access to Psychological Therapies”).

Finally, two countries explicitly extended their repertoire of measures for young persons with disabilities *in schools*, in their last year of education, or after having completed school. Austria introduced special teams (“clearing teams”) and apprenticeships training programmes for disabled young persons at school age. The Netherlands replaced eligibility to disability benefit by referring certain categories of young persons with disabilities to specific support measures aiming at a better school- labour market transfer.

3 Implementation and organization

3.1 Introduction

In this section we explore various aspects related to the implementation of reforms. Implementation often requires changes on an administrative level: shift of responsibilities of stakeholders involved, creation of new institutions, new funding, cooperation agreements, etc. On the other hand on operational level also many challenges have to be met, e.g. in the area of training staff, available service providers, information campaigns (to promote acceptation of reforms or use of the programmes), or monitoring daily practices and indicators.

3.2 Implementation

As to the implementation of reforms three aspects can be identified in the national reports, which are related to the "daily operation" of the new programme(s).

Firstly, *the need for new operational teams or case workers and new tools*. In most countries reforms have been implemented by creating new structures, instruments, procedures and responsibilities. Some elements yield for various reforms:

a. Creation of a new team or organization, e.g. Rehabilitation team (Denmark) Coordinating Agency (Sweden), Competency Centers (Austria), often with a multidisciplinary composition. Its tasks are to perform and/or coordinate the (new) measures;

b. Better assessment of needs and demand in various areas, like education, vocational training, health, but maybe also debt management, healthy life style promotion and assessment of eligibility to (specific) benefit;

c. Creation of tailor made individual programmes covering measures in these areas, including planning and monitoring of progress.

Secondly, *take up and utilization* of the newly implemented measures: there is a large variety across countries about data on take up of new measures by the target groups. For Denmark it was concluded that some parts of the support programmes did not meet the targets of the first year (e.g. individual plans), whereas other elements (e.g. flex jobs) were widely used from the beginning

Thirdly, several reports indicated that starting up the new procedures, tools or provisions went slowly, due to *initial organizational problems* like lack of staff (or expertise), or insufficient public promotion (e.g. information campaigns) on the new services and provisions.

Finally, it should be noted that also variations may be found *within a country* as to coordination tasks. E.g. in Denmark the teams that organize the reform (resource process) may differ per municipality: in some communities special resource *teams* or resource centers have been created, whereas on others coordinating *case workers* are operating

form the employment agency (where they have been placed). Evaluations show that case workers operating in a special resource team are more content and can more easily deal with challenges and (organizational) bottle necks than those not working in a team.

3.3 Cooperation and coordination

But also some more basic administrative complexities or weaknesses have been identified in the countries that designed and implemented reforms. We do not cover here financial aspects of reforms, but experiences with coordination issues and cooperation structures. Reforms often require a new or adapted institutional structure e.g. due to a shift of responsibilities or new tasks to be performed (and financed). The national reports mention various factors or conditions that show to complicate or restrict the (initial) implementation of the reforms.

The countries and reforms investigated both show some common organizational problems (which yield across several countries) and specific “country bound” findings.

3.3.1 Some common (roots of) implementation problems

Reforms often face the *consequences of historical borders*: e.g. the strict separation between medical rehabilitation (takes often place during sick leave) and vocational rehabilitation (often: after stabilization of health condition). It is advocated that especially person with mental health conditions need integrated medical and vocational services. In Austria - during the reform - pilot projects have been developed to provide such integrated services. Also from several countries it was reported that a better communication and cooperation with the (mental) health care providers is crucial for young clients with mental health conditions

In many countries *the social system is fragmented*, including more or less independence of self-administered public bodies, which may restrict new cooperation relationships as imposed by the reform. Furthermore, institutions involved in reforms may differ as to viewpoints on who should do which tasks (e.g. assessments, benefit payment, service provision, enforcement): source out of do it themselves. Finally, also regional differences may complicate cooperation. Examples mentioned regard regional differences in available medical or mental health services or in - public or private - service providers for rehabilitation, vocational training, individual counselling, etc.

From Austria is it is reported that *a central steering group* (representatives from ministries of health and social affairs, social insurance institutions, public employment services) shows to be crucial in linking these institutional stakeholders together, but also for addressing cooperation issues emerging from daily operations in the field.

Some reports (e.g. from Austria) show that *alertness on old failures* also is needed: without meaningful cooperation there is a risk that new rehabilitation measures may turn into a stepping stone on the way to permanent disability benefit (as was the case in the past with the temporary disability benefit).

It may be concluded that many reforms showed to require *better communication and collaboration* between stakeholders:

- *within* public social insurance: e.g. disability pension fund and health insurance fund may need better cooperation for early detection of high risk groups, or to improve early intervention, and
- *between* social insurance (e.g. disability pension fund) and other actors, e.g. health care providers (rehabilitation), employment office (labour reintegration), and service providers (e.g. training, debt management, life style counselling).

3.3.2 …but also many cross national variations

New cooperation structures may differ as to scope: some reforms only require reshuffling of one or a few tasks, whereas other imply a re-organization of various activities like assessments (e.g. as to care needs, or regarding work capacity and labour competencies), design and implementation of personal plans for clients, monitoring, etc.

Sweden is the only country where – already a decade ago – *"financial coordination*" explicitly has been introduced as a political measure in the field of labour market rehabilitation. Its target group are individuals (from all age categories) with multiple problems or needs (e.g. somatic, mental, social, vocational). These clients are in need of coordinated services from two or more organizations, which are participating (financially, and in staff provision) in the coordination agency. This agency, working on regional or local level, comprises experts from the social insurance agency, the public employment service, municipalities and county councils. The purposes of financial coordination are the following:

a. The individual should reach or improve work ability;
b. Avoid unnecessary vicious circles or grey areas between authorities;
c. Develop well-functioning collaboration between authorities;
d. Achieve a more effective use of resources in the whole system.

In 2015 there were 80 agencies in 241 of Sweden's municipalities.

In some countries also *the local context and civil societies* show to be very important. Swedish experiences indicate that in municipalities where non-governmental organizations (like sport clubs, churches and voluntary associations) are available, have many opportunities for clients to participate in activities. Rural areas often offer less opportunities to be active in terms of participation in courses, training and exercises. In this country it also was found that good access to internships with employers (in the private and public sector) also means more choices for clients.

However, in the United Kingdom public social insurance bodies are not the major actors in reforms, but government and various large and small *private providers*. The latter are being commissioned by government to perform coordination tasks, and to provide services for PWD (e.g. assessments, assistance to finding employment and in-work support). Organizational principles governing this way of implementation include: an im-

portant role for “prime providers” (large private organizations), minimum service prescription guidelines and large or long term contracts. But in this country cooperation and coordination also has been affected by conflicts and contested developments, e.g. the closing of (Remploy) sheltered workshops and redundancy of 1700 workers.

An important restriction in the evaluation how reforms have been implemented lays in (unforeseen) *“intervening developments”.* E.g. in the Netherlands the restructuring (2012) of the administrations of employment services and social insurance agencies (UWV) had a structural negative effect on cooperation between social insurance bodies and the municipalities. The number of social insurance offices was reduced from 98 to 30; moreover, there was a change from an integrated to a complementary service provision, as well as a quick change to electronic service provision (“E Desk”). Problems with digitalization and IT systems stressed the cooperation between stakeholders and service provision to clients (client satisfaction rates dropped considerably between 2010 and 2013).

Finally, an often mentioned weakness in reform design regards *the role and the needs of employers*. In designing new programmes the (potential) employer often is not sufficiently considered, or his role is poorly developed. This was – for instance – found for Austria: also an OECD study identified this weakness, but this is not unique for this country: new (training and employment related) services to young persons still seem to be more “supply oriented” rather than (labour market) “demand driven”.

In the Netherlands, however, employers (organizations) received a structural role in the employment of (young) PWD. The social insurance agency, social partners and the Labour Foundation (STAR) promoted the use of collective agreements between employers’ organizations and labour unions to encourage employers to employ young people with disabilities. The proportion of all collective agreements which include such special programmes to employ youth with disabilities increased from 19% in 2010 to 46% in 2014.

4 Reforms: impact, lessons and further developments

4.1 Introduction

In this chapter we summarize the insights from the national studies as to into the impact of the reforms, both as to benefit dependency and participation into employment or social inclusion. We further summarize the lessons noted in these countries on outcomes and implementation. Moreover, for most countries the policy developments do not stop after implementation of a reform, or evaluation of outcomes; so we also shortly sketch some recent developments that are related to our topic.

4.2 Impact

The information provided in the national reports on impact of reforms (take up, employment, benefit dependency, and implementation) varies considerably across countries and programmes. This is not only due to the (very) recent character of some reforms, which restricts empirically based insights. Countries also differ as to research efforts and monitoring (statistics) of the operation and outcomes of the new programmes introduced. We firstly list major findings, listed per country (details can be found in the national reports).

Denmark:

- Statistical figures show a considerable drop in inflow in the disability benefits scheme after introduction of the reform;
- First years of implementation showed a low take up of the support programme (except: transfer to flex jobs);
- Initial data show: after completion of the new programme (resource process) only 2% of clients had found a job in the open labour market, 14% found a flex job, and about 50% were granted a disability benefit;
- The new programme managed to provide more tailor made support;
- The start of implementation showed to be too hastily; more time was needed for preparations and start up;
- During programme operation waiting periods arose, due to poor functioning or slow creation of rehabilitation teams;
- Case workers noted there is a need for more awareness in clients on their own active role for activation and employment.

Sweden:

- There was a drop in inflow into disability benefits programme, after the reform;
- A continuous rise in number of clients flowing in the new programme; moreover now 90% of participants are diagnosed with mental health conditions; this change in morbidity pattern was not expected;

- Only a small share of clients enter the labour market; many stay afterwards in the public health insurance scheme and continue to be dependent on benefits (e.g. social assistance);
- After some years factors like time pressures and budget constraints affected the operation of the programmes: consequently, staff attention shifted from activation support to benefit provision;
- Tailor made programmes show large variations: they vary as to content and local availability of expertise (currently most common activity is probably: doing sports…).

Austria:

- After the reform a serious decline was noted in benefit applications and in numbers entering the disability benefit schemes (drop by 70%);
- When persons aged under 30 were eligible their disability pensions mostly were temporal with re-assessment (before reform); after re-assessment in most cases the disability pensions were not continued anymore (after reform);
- The higher inflow of young persons into rehabilitation is mainly concentrated in medical rehabilitation, not in vocational rehabilitation programmes as required occupational protection is lacking in most cases;
- Still not optimal cooperation between various authorities complicates the service provision to clients;
- Prevention: very low take up of individual counselling of sick listed persons (provided by social security institutions and PES); individual counselling: seems to be favourable to persons with mental health conditions and for labour (re) integration;
- Initial support needs continuation: less than 50% complete a case management after the stage of preliminary individual counselling;
- Company counselling shows to have impact: it may change employer attitudes (e.g. as to health maintenance, contracting persons with disabilities);
- Evaluation of the inclusive apprenticeship programme for young persons with disabilities shows: two-third of those who completed their training were employed afterwards (by the same employer).

United Kingdom:

- Low uptake of the new programme (for young persons in employment) but figures are increasing;
- Clients appreciate: 1) the tailor made support in the work place and 2) taking account of their own opinions and demands;
- Despite lack of data according disabled persons organizations have the opinion that the programme pays out;
- Positive changes were found in employer attitudes towards employment of PWD, their productivity, sickness absence, etc.;
- Regarding the programme for persons out of employment: favourable outcomes were found as to job placement (57% of initial participants had found a job);
- Several weaknesses have been identified in programme administration and operation (e.g. quality and quantity of work done, disability assessments);

- Public conflicts and media behavior (e.g. as to PWD, benefits abuse, suicide among clients with mental health conditions) affect discussions on reforms.

Netherlands:

- Substantial decrease in the category of clients relying on disability benefit receipt; substantially higher rejection of applications and 40% lower inflow (in initial years);
- Only a small proportion of the persons entering the employment sub programme found a job in the open labour market;
- The employment sub programme provided little support for young persons with mental health conditions; one of the reasons: multidisciplinary (IPS) support is comparatively expensive;
- Poor results were identified in program operation, including mismatches between the three sub programmes: benefit, employment, and education;
- “Cherry picking” methods were applied in the selection of clients for employment support;
- Job offers provided by the administrator to clients (as part of employment programme): often did not meet employer needs;
- Employers show positive opinions on wage subsidies (to compensate for lower productivity);
- The reform (and reorganizations in other tasks and responsibilities) created a considerable administrative burden for administrators (integrated social insurance agency/ employment office).

4.3 Some initial lessons

4.3.1 Reforms: benefit dependency and employment

Disregarding the specific programmes described and the variation in empirical evidence demonstrated in the national reports, some general lessons can be listed.

As to outcomes of reforms four conclusions can be drawn:

a. Changing the eligibility criteria for access to disability benefits in general shows to reduce application and inflow rates of young insured or young clients (Austria, Denmark, Sweden);
b. Income support still is needed during participation in an activation programme. Several countries (e.g. Sweden, Denmark, Netherlands) indicate that dependency on those benefit schemes may last long (client participation for these programmes may last up to 3 or 5 years in some countries);
c. Rates on inflow into employment from these specific programmes show to vary, depending on target group. Whereas it was found for several reforms that rates on entering a job or returning to work are (very) poor, in some countries (Austria, United Kingdom) also considerably better job placement rates were found. These regarded programmes targeting at young persons with health restrictions that were out of employment;

d. Notwithstanding, for all countries it was noted that at the end of the specific programme participation a considerable proportion of young persons with disabilities shows to be further depending on some kind of benefits, e.g. sickness benefits (Sweden) or social assistance (Austria).

4.3.2 Some basic features of reforms

Reforms do not only regard a change in one particular scheme, but "always" comprise a change in more programmes, or the introduction of different measures *at the same time*. This not only complicates evaluation of success to specific programme elements, but shows to create various challenges to the stakeholders involved, who have to implement and operate the new approach.

Moreover, reforms do not take place in isolation: the *institutional context or leading paradigms* in governmental policies may change simultaneously. This is particularly visible in the United Kingdom (e.g. austerity measures, abolishment of sheltered workshops) and the Netherlands (decentralization of activation tasks to municipalities and - at the same time- budget cuts).

New organizational structures or organizations need time for learning to work in the new context. All country reports included in this study demonstrate various problems that have to be addressed when applying an activation programme for (young) persons with disabilities. Frequently mentioned issues are:

a. Distribution of responsibilities, cooperation and coordination (including financial conditions). To increase efficiency and prevent unnecessary vicious circles or grey areas between authorities some coordination needs priority. Only in Sweden this issue ("financial coordination") has been addressed from the beginning;

b. Coordination problems also may arise when (new) multidisciplinary teams have to be created, which should integrate their services, set priorities. E.g. when actors come from social insurance, employment office, health care or municipality they may be attached to their own responsibilities, or "traditional" priorities as to client groups;

c. Availability and expertise of service providers affect programme operations: in some countries regional differences as to available experts and facilities may reduce the speed of the reform, or may lead to waiting lists;

d. Based on a long tradition in some countries it was found that medical rehabilitation measures receive more attention in individual client programmes, than vocational rehabilitation and training or job search activities;

e. Finally in most countries – when implementing reforms - "intervening factors and conditions" have to be taken into account. Simultaneous reorganizations in related task areas, reduction of funds, public conflicts and media behavior, etc. may seriously restrict the stakeholders involved in shaping the reform.

The local context is very important too. Not only – as mentioned before – regarding the supporting experts and services that are available. But also regarding the question to what extend the local labor market is willing to contract PWD. OECD noted – also for countries included in our study – that in many activation programmes the role and involvement of employers is underdeveloped. With the exception of one programme in Austria (Fit2work) in many programmes early involvement of employers and in-company support to employers and supervisors is lacking. On the other hand, in many programmes also some financial incentives are available for employers to contract PWD (e.g. wage subsidies, subsidies for work place adaptations). However, some national reports also suggest:

a. that financial incentives (e.g. wage subsidies) do not seem to affect employer decisions on hiring personnel with disabilities;

b. several programmes (e.g. those focusing on internships) lead to a more positive attitude in employers to engage persons with disabilities.

4.4 Outlook

In some countries the reforms described here are “too fresh” to discuss fundamentally the need for substantial adaptations (e.g. Austria, Denmark). Moreover, authorities realize implementation needs time. In other countries, however, the reforms explored here, already have been made subject of revision, adaptations or are politically being reconsidered. The national reports also include a section on such developments.

Consequently, when summarizing “ongoing developments” in the area of activation of young persons with health problems a few developments may be noted.

Firstly, as was mentioned before (cf. Section 2.3) changes in leading political ideologies or governmental composition may change the political agenda. Alternatives promoted then often are related to viewpoints on the tasks of government, individual responsibility and/or empowerment, the role of financial incentives. Both in the report on the United Kingdom and the Netherlands such societal developments have been mentioned to affect discussions on further reforms;

Secondly, many programmes show to be subject of adaptations in the light of their current poor outcomes (as to employment rates), or when considering the “substitution processes” that are ongoing (referral from one benefit programme to the other). From several countries it was reported that politicians and other stakeholders want adaptations (e.g. Sweden). These often are included in reforms packages, affecting a wider context (e.g. employment or social inclusion policy in general, or further reforms in social insurance policies);

Thirdly, there also are programmes or programme elements mentioned in our study that will be expanded (as has been reported for Austria and the United Kingdom). As in several countries young persons with mental health conditions need more attention, “new” supporting models with evidence based good results will - on a wider scale - be used in

activation programmes. An example from the United Kingdom: the IAPT approach: “Improving Access to Psychological Therapies”. Moreover, some country reports mention the increase of national budgets for mental health care (e.g. Sweden). In Austria the role of prevention will be enhanced by increasing the (counselling) support for employed persons who are work incapacitated (“sick listed”);

Finally, some national reports inform about regional experiments and pilot projects that are ongoing to improve the service provision to young persons with disabilities. They may regard models for young persons in school age to improve efforts to find a job (e.g. Austria). Or they may focus on new forms of multidisciplinary cooperation, be it in “rehabilitation teams” (e.g. Austria), or be it in “coordinating offices” (e.g. Sweden).

Fact sheets

Next pages include fact sheets which summarize main facts and findings on the reforms covered in the national reports. The fact sheets for each country vary as to size. Some fact sheets include programmes that apply to young persons with health conditions both in employment and out of employment. Some other fact sheets separate between these categories of clients: they show specific measures, some only targeting on young persons out of employment (e.g. Netherlands) and other that only focus at persons with health restrictions (included the young) who are in employment. Detailed information can be found in the underlying national reports.

4.5 Fact sheet Denmark

Introduction: selected contextual facts on Denmark

- Number of inhabitants: 5,6 million persons
- Employment rate (age group 20-64, 2015):76.5%
- Unemployment rate (August 2016): 6.2%
- Unemployment rate (Aged < 25 years, August 2016): 10.8%
- Social systems applicable to young persons with health restrictions or handicap:

  (1) Disability benefit and (2) “Resource Process”.
- Their coverage: income replacement;
- Number of persons covered: In 2013 239.817 persons received disability benefits but after the reform this number has dropped to 215.590 in 2015 (Source: Statistics Denmark);
- Responsible actors: the municipality handles and grants the disability benefit but the monthly payment to the pension is done by Payment Denmark (Payment Denmark is a public authority);
- Financing of benefits and services: disability benefits and other social benefits are taxation based in Denmark. Government reimburses the municipalities when a person is transferred from disability benefit into a job (see the Danish National Report for further information about the reimbursement mechanism and reimbursement rates).

1. Reforms: Key Data

Name:	Reform of disability benefit system and Reform of Flex job scheme.
Target:	Restriction of disability benefit for claimants under 40 (in employment or out employment) and replacement by a programme in which the claimant receives multidisciplinary support. Aim: better integration of health, employment and social services for people with multiple problems, to bring them back into the labour market or education and prevent claiming disability benefit.
Introduced:	1 January 2013.

2. Backgrounds

- A major earlier reform (2003) to reduce inflow into the disability benefit system and to support partially disabled persons with a flex job subsidy was not successful: inflow into disability benefit remained high and the flex job scheme drew regular workers into subsidized jobs;
- When considering new reforms special attention was paid on two facts: too many young persons and too many people with mental illnesses are not employed;
- the flex job scheme should become more accessible to persons with severe health problems and be more attractive for people working fewer hours with severe health problems;
- The flex job scheme provides for subsidized labour. If a flex job recipient by the municipality is deemed to have a working intensity (or working capacity) of 50 percent and works 20 hours per week the employer must pay for ten hours; in addition the recipient receives benefits for the last 10 hours per week.

3. Contents (measures, provisions, etc.)

The reform not only focusses on *young* persons but persons from 18-40 years old. Reform elements regard:

a. A (so called) “resource process”: when aged under 40 the claimant cannot receive a disability benefit (when suffering from severe disability). Instead a support programme is granted, which may include many areas of support;
b. Support to the client be employed in a flex job (temporary subsidized job, maximally 5 years). If working in a flex job for 5 years the clients work ability should be tested to see if it has changed (for better or worse). If further placement is not successful, the claimant is eligible to unemployment benefit;
c. Education benefit is provided to persons under 30 with no education.

4. Implementation

- Young clients (often with multiple problems) must firstly have their work capacities assessed by a multidisciplinary “rehabilitation team”, operating in the municipality organization;
- The team consists of case workers (from social services, employment, education) and a health system coordinator;
- Subsequently the job center can grant a disability benefit (in case of serious disability), a flex job or a rehabilitation plan;
- The rehabilitation plan may include educational, employment, health, and other kinds of support (e.g. physiotherapy, meetings with psychologists). The client should play an active role in shaping and fulfilling the rehabilitation plan;

- In addition to these measures and provisions the client may receive sickness benefit (when eligible) or a monthly benefit on social assistance level. There is no age limit to receiving these types of benefits;
- In case of being aged under 30 and having no education the client may receive an educational benefit (as the government wanted to make strong incentives for young people to start on an education);
- This support process may last for max. 5 years. This both regards the resource process and flex job scheme, where after 5 years work ability is to be tested again;
- Furthermore, the reform envisages better coordination of health, employment and social services. Municipalities vary as to the way this coordination is shaped (e.g. by making use of separate teams, or by appointing a coordinating case worker).

5. Impact

Outcomes:

- Initially it was aimed to start 14,500 support programmers in the first year of implementation (2013). But take up did not deliver and was limited in 2013 to 2,298 resource processes granted. In 2014 9,929 people were granted a resource process;
- Since the implementation of the reform the number of people in flex jobs has increased by approx. 54,000 persons in the fourth quarter of 2012 to 58,000 persons in the third quarter of 2014;
- Statistical figures show that the number of new people being granted disability benefit has been falling since 2009. In the period 2009 to 2012 the number decreased from 17,102 to 14,621; after the reform was implemented the figure declined further to 5,743;
- In 2015 609 resource processes had finished and 14 had found a way back into the labour market. 314 were granted a disability benefit and 84 were transferred to the flex job scheme. None started an education. They did not fall out of the system, but have to try a new approach in the resource process.

6. Lessons

- Politicians have been criticized for not being able to transform the 19,000 established resource processes - at a cost of DKK 630million - into more ordinary jobs. Of the 19,000 established resource processes only 130 ordinary jobs were created;
- The job centres and municipalities all see a big potential in the reform and the new measures but they still find it difficult to navigate in the new settings and are still learning how to best work and use the expertise in the rehabilitation teams;
- Evaluation reports all show that the implementation has taken a longer time than expected and that the municipalities are still learning to operate in the new employment paradigm.
- Other implementation lessons:

- Waiting periods come up, due to the functioning of the rehabilitation teams;
- Coordination in the rehab team (with experts from several disciplines/organizations) is challenging, due to differences in priorities, commitment, etc.;
- The new programme gives good opportunities for tailor made support;
- There is a need for more information and awareness in a client on his/her own role.

4.6 Fact sheet Sweden

Introduction: selected contextual facts on Sweden

- Number of inhabitants: 9,7 million persons
- Employment rate (age group 20-64, 2015): 80.5%
- Unemployment rate (August 2016): 7.0%
- Unemployment rate (Aged < 25 years, August 2016): 20.4%
- Social systems applicable to young persons with health restrictions or disability: there is a range of different systems for this heterogeneous category. Activity Compensation is a crucial one since it provides financial stability for those assessed with a longstanding medically caused incapacity for work. Another important system is regulated in LSS (Lagen om stöd och service för vissa funktionshindrade: Act on support and service for certain disabled). LSS provides different kinds of services and is administrated by the municipalities;
- Their coverage: Income replacement is the norm in the Swedish social security system. Activity compensation comes in two different parts: firstly: building on the principle of income replacement. The second part is a guaranteed compensation for those who lack insured income;
- Number of persons covered: The different parts of the Swedish social insurance systems are either residence-based or work-based. As AC is divided in terms of level of compensation, it has one part that is work-based and another one that is residence-based. As a conclusion, everyone aged between 19 and 29 years of age living in Sweden is covered (about 1,2 million);
- Responsible actors: The Swedish Social Insurance Agency (Försäkringskassan) is responsible for Activity Compensation;
- Financing of benefits and services: The Swedish social insurance is financed by social fees and by taxes. As an example, in 2014 the income from social fees was 117 billion SEK and the income from taxes was 91 billion SEK.

1. Reforms: Key Data

Name:	“Activity Compensation” (AC);
Target:	Young persons aged 19-29 (in or out of employment), whose work capacity is reduced by at least 25% due to a long standing medical cause;
Introduced:	January 1, 2003, still operational.

2. Backgrounds

- There is no concern for growing number of young individuals on disability pension, but about the (stable! number of) younger beneficiaries (aged 16-29) and the urge for meaningful activities for young persons with severe disabilities;
- Therefore, there is a need for a separate system for youth with medically caused incapacity for work: AC replaced the disability pension system to insure against financial poverty, for persons aged 19-29;
- Minimum age for admission is 19 years ("prolonged adolescence"), as almost no one in Sweden is gainfully employed at the age of 16. Persons aged between 16 and 19 are expected to be in the educational system;
- Major aims: provide financial security (when illness or injury makes employment impossible) and enhance and make use of remaining capacity for work in disability to encourage social engagement through participation in activities outside the home.

3. Contents (measures, provisions, etc.)

- Two types :
  a. "Income based AC": age related benefits (varying from € 840 at age 19, till € 940 (before tax) for persons who are assessed by the Swedish social insurance body and having a longstanding, medically caused, incapacity for work. This type includes the right to measures to increase work ability and to take part in activities;
  b. "AC for prolonged schooling": benefits automatically granted to persons who need extra time to finish school. They automatically receive benefits, without having to prove their incapacity for work;
- Consequently, permanent disability benefit no longer is available for young persons;
- AC is granted for max. 3 years, but recipients can re-apply (until age 29). AC clients are regularly re-examined on eligibility, after max. 3 years.

4. Implementation

- AC is carried out by "coordinating agencies" in which four stakeholders work together: Social Insurance Agency, Public Employment Service, Municipalities and County Councils;
- Purpose of these coordinating agencies is to provide "tailor made" support: help client to improve work ability; avoid unnecessary vicious circles or grey areas between authorities; develop well-functioning collaboration between authorities; more effective use of resources;
- Many agencies created the function of "activity coordinator"; this role differs from the traditional "bureaucratic" role of approving/rejecting applications for AC; however, later benefit provision/management became main task (again).
- Young persons with health restrictions or disabilities have deliberately been prioritized by these agencies.

5. Impact

- The number of AC recipients grows continuously. As an example, the number of recipients was 16,246 in 2005 and 37,599 in 2015. The annual inflow rates are larger than the outflow rates;
- A small share of clients enter the labour market; the aim of AC to make it easier for young persons to take up work after a period of long term disability/disease has not been fulfilled;
- Those diagnosed with mental health disorders now stand for nearly 90 percent of the group with AC, while the intended target-group (persons with severe disability originating from birth) only represents a small minority. This shift in distribution of types of disabilities was not expected an the begin of the measure;
- The growth of numbers of AC clients and changes in the morbidity pattern may have various backgrounds: increase of number of pupils in special schools; changes in health status among the young; revisions in diagnostic manuals and habits by physicians; changing labour market (temporary employment, unstable relations); or changes in societal norms and attitudes as to mental health problems.
- Since the activities should be tailor-made very different kinds of activities can be carried out. Doing sports (at a gym) is probably the most common activity.
- A majority of the clients stay in the public health insurance system or return after a time with social assistance. Only a very small share enter the labour market: approximately six individuals out of ten go directly to permanent sickness allowance when they reach age 30;
- Since the eligible criteria have been made stricter for Sickness Compensation, many persons experience a gap when turning 30. They do not qualify anymore for Sickness Compensation but still have an incapacity for work.

6. Lessons

Implementation: some evaluation studies and other investigations have been carried out which indicated:

a. The role of the “activity coordinator” changed into “personal administrator”; consequently: less emphasis was put on the programme of activities;
b. Due to time pressures in operating the scheme, the provision of benefits was prioritized, instead of planning activities to increase work capacity; Moreover, there often was a lack of contacts between coordinator and AC clients;
c. The local context is decisive: not only regarding what supporting services or measures can be offered (in the light of availability of sports clubs, evening schools etc.). But also as to what extent the local labour market is willing to let persons with disabilities in (e.g. internships);

d. Due to the gap between AC and sickness compensation, reaching the age of 30 is associated with anxiety, since eligibility criteria are stricter for sickness compensation;

e. Lock in effects were noted since many young persons who are on AC think that it is risky to try out studies or work (“Will they cut my benefit? What if I will not manage being employed?”);

f. New proposals for adaptations (from Ministry) envisage to facilitate for people with AC to combine work/studies with AC.

4.7 Fact sheet Austria

Introduction: selected contextual facts on Austria

- Number of inhabitants: 8.6 million persons
- Employment rate (age group 20-64, 2015):74.3%
- Unemployment rate (August 2016): 6.2%
- Unemployment rate (Aged < 25 years, August 2016): 10.6%
- Social systems applicable to young persons with health restrictions or handicap:

  (1) Pension Insurance (disability pensions, funding of medical rehabilitation and retraining[1]), (2) Unemployment insurance (realization of retraining), health insurance (realization of medical rehabilitation). (3) Occupational secondary prevention scheme fit2work organized and funded by SMS (Sozialministerium Service), (4) Accident Insurance, (5) Labour Inspection, (6). Programmes for those not in employment, in most cases organized and funded by SMS and PES.
- Their coverage:
- Pension Insurance: Income Replacement and funding of rehabilitation measures.
- PES: Income replacement, retraining and activation measures.
- Health Insurance: Income Replacement, medical rehabilitation and control of sickness leaves.
- Number of persons covered: stock of disability pensions < 30 2014: 1,302.
- Responsible actors:
- Pension Insurance, PES, Health Insurance: central government and social partners but with local and regional offices;
- Fit2work: central government, social partners and social security authorities.
- Programmes for those not in employment: in most cases central government and PES.
- Financing of benefits and services
- Contribution-based: Disability pension, rehabilitation benefit (during “medical rehabilitation”), retraining benefit, sickness benefit, unemployment benefits.
- Retraining and rehabilitation benefit paid by Pension Insurance.
- Sickness Benefit paid by Health Insurance.
- Unemployment benefits paid by PES.

[1] Retraining not very relevant for young persons as in most cases no occupational protection and thus, not eligible.

Young persons (with health conditions) in employment

1. Reforms: Key Data

Name: (1) Disability pension reform;

(2) Introduction of Fit2Work.

Target: (1) Enforcement principle rehabilitation before benefit;

(2) early prevention of job loss and premature drop-out from working life due to health reasons.

Introduced: (1) January 2014

(2) individual counselling 2011; counselling for companies 2012.

2. Backgrounds

- Earlier measures (principle “Rehabilitation before Benefit” and granting only temporary benefits to [young] claimants) showed little impact; authorities intervened too late.
- Concern about the steep rise in numbers of persons with mental health conditions claiming sickness, disability or unemployment benefits. Moreover: long durations of sickness absence when caused by mental health conditions

3. Contents (measures, provisions, etc.)

Reform of Disability Pension Scheme (for cohorts born 1964 and later), without minimum age (lowest inflow age can be 15 years, namely when client was allowed to work):

a. Strengthening eligibility criteria for claiming disability pensions, namely granted only if totally unable to work and retraining not appropriate
b. Extended rehabilitation provisions; introduction of rehabilitation benefit (during medical rehabilitation)
c. Pension fund administration assesses work capacity of clients from public employment service and other insurance institutions.

Fit2Work: early intervention measures during sickness absence and unemployment, namely:

a. (Voluntary) individual counselling of employees (when sick listed over 6 weeks) or unemployed with health problems;
b. Company counselling: information, advice and support for employers on early warning signs for groups at risk; team training for coping with mental burdens; changes in activities, processes, working time, etc.

4. Implementation

Disability Pension Reform:

a. Introduction of “competence centers” at pension insurance for performing assessments for employment office, etc. Development of tools, e.g. “career potential analysis” for evaluating clients’ interests, working capacity, etc. as a basis for counselling by the employment office

b. Abolishment of temporary pensions; application for pension is “converted” into application for rehabilitation.

c. Extended application of and funds for medical rehabilitation.

Fit2Work:

a. Individual counselling (invitation by sick funds for employees sick listed over 6 weeks or unemployed, and carried out by (private) professionals in occupational medicine, psychology and social work

b. Company counselling (primarily carried out by counsellors contracted by Vocational Education and Rehabilitation Centre): 3-8 days provided, depending on company size. Subjects: advice and information (implementation early warning system, inclusion delegate, measures for groups at risk)

5. Impact

Disability pensions: findings after 1-2 years:

- Decline in number of applications in 2014: decline in inflow by persons under 30: – 69.5%;
- Stock of disability recipients aged under 30: dropped 48.3%, as almost all pensions granted were temporarily with re-assessment;
- After reform for this age group in almost all re-assessments the disability pension was not granted anymore (intensification of principle: “reha before pension”);
- In first two years: the savings in disability pension payment approximately equal expenditures for rehabilitation and labour market integration;
- The higher inflow of young persons in rehabilitation mainly seems to be on medical rehabilitation, not on vocational rehabilitation; retraining benefit is only granted in a few cases (when occupational protection was acquired) (2015).

Fit2work: (only) initial results:

a. 42% of fit2work users suffer from mental disorders, while 37% have a physical health complaint;

b. Individual counselling: mostly used: general information;

c. Low take up: only 4% of clients invited by default in written form by health insurance participate in counselling; but also: considerable take up by unemployed and access through GPs (general practitioners) or self-referrals;

d. Individual counselling seems to improve mental health conditions of participants and (re)integration;

e. Company counselling shows change of attitude towards health maintenance of existing employees and new employment of persons with disabilities.

6. Lessons (only initial lessons as reforms are fresh)

Disability pension (administration):

- Still separation between medical and vocational rehabilitation, but in case of mental health conditions integrated services are needed;
- Retraining programmes should be better adapted to the needs of the labour market and should be opened to young persons with mental disorders;
- A system with separate authorities for assessment, enforcement and benefit payment complicates cooperation;
- OECD concluded: Austrian reform lacks a strategy to involve employers, and employment offices often need better understanding of the needs of employers who engage workers with chronic health conditions.

Fit2work:

- OECD: better coordination needed of individual counselling and case management with mental health care system and general practitioners;
- Invitation policy to individual counselling should be improved;
- Relatively poor follow-up of preliminary individual counselling by case management (less than 50%).

Young persons with health conditions but out of employment

In the light of available information and multitude of programmes (not all targeted at young PWD) this fact sheet is less extended.

Reform 1 Clearing

1. Reform: Key Data

- Introduced: 2001 and amended 2004, replaced by *Youth Coaching* targeting at all young at risk in 2012;
- Target group: young persons (age not specified) with disabilities including those who completed school;

- Aim: secure best possible transformation between school and occupation and introduction to the labour market;
- Funding: special fund from federal government, European Social Fund and other.

2. Contents (measures, provisions, etc.)

A clearing team develops, with the young person concerned – an individual package of measures for (next to) last school year, including:

- Profile of predispositions and abilities, SWOT-analysis;
- Determination and planning of need for post training;
- Identification of occupational perspectives, career-/evolution-plan;
- Networking and cross references by involvement of interface-stakeholders

Support is provided by social workers, school psychologists, psycho-pedagogues and student advisors for children with mental and behavioral problems.

3. Impact

- 24% of programme participants were able to attain a regular employment contract or an apprenticeship in the first labour market. In addition, in the follow-up of the Clearing programme 29% were carried for in another programme (“Occupational Training Assistance”) or prepared in a pre-apprenticeship;
- The programme was chosen as best-practice-model for peer reviews by the European Commission.

Reform 2 Inclusive Apprenticeship Training (“Integrative Berufsausbildung”/IBA)

1. Reform: Key Data

- Introduced: 2003 and amended 2010;
- Target group: young persons (age not specified) with disabilities which have special education needs, and have not completed their education or face other job placement barriers, and are not able to attend regular apprenticeship;
- Aim: enable entry into the labour market.

2. Contents (measures, provisions, etc.)

- Apprentices receive targeted assistance (from employment office or service department in ministry of social affairs), both social and psychological, to ensure that they complete their training, financed by the Social Ministry Service;
- Funds (from public employment service) available for employers that offer inclusive apprenticeship places in the first labour market; as well as funds for additional necessary costs (e.g. wage costs, adaptations of work places.

3. Impact

- High completion rates;
- Evaluation studies showed: two thirds of those who completed their training were employed by the same employer afterwards.

Other reforms focusing on a part of young NEETS (Not in Employment, Education or Training)

Target groups: several categories of disadvantaged youth, including youth with disabilities and health impairments. Most important programmes:

1. Youth coaching: since 2013 nationwide, all youth at risk of dropping out below 19 years (in case of disability or special education needs: under age 25);
2. Apprenticeship Guarantee: the target group are young people who have completed their education but cannot find a regular apprenticeship and those who have pulled out of an apprenticeship. The purpose of the measure is to secure the best possible transition between school and occupation and the introduction to the labour market;
3. Education/Training Fit: nationwide low threshold education for youth under 21 years (under age 24 if disabled);
4. Factory Schools: nontraditional schooling schemes for preparation of education/ training, to become acquainted with different education/ training paths and for the deferred acquisition of skills and qualifications. The target group consists of 15-25 years old who leave school without qualifications and social skills and cannot cope with school, apprenticeships or work in their current form. All over the country 60 Factory Schools with approximately 3,000 places for 4,000 youth are available.

4.8 Fact sheet United Kingdom

Introduction: selected contextual facts on the United Kingdom

- Number of inhabitants: 64.9 million persons
- Employment rate (age group 20-64, 2015): 76.8%
- Unemployment rate (August 2016): 4.8%
- Unemployment rate (Aged < 25 years, August 2016): 14.6%
- Social systems applicable to young persons with health restrictions or handicap:

  (1) Services, devices and assistance : e.g. personal budgets (payment for personal assistance and adaptations)

  (2) Disabled Facilities Grant – adaptations to the home
  (Note: the above allowances are particularly relevant for people who have physical impairments);
  (3) Access to Work: a special scheme of service provision targeting people with mental health conditions;
  (4) Employment and Support Allowance (ESA) – income replacement;
  (5) Universal Credit (currently being phased in) which will replace 6 benefits, including ESA (see below);
  (6) Personal Independence Payment (PIP) – compensation for additional costs of impairment;
  (7) Housing benefit – help with housing costs for people on a low income.

- Their coverage: income replacement and services
- Number of persons covered:

  PIP claimants 2016 – 3.62 million;
  Housing Benefit 2016 4.68 million;
  Universal Credit 2016 - 303,839 (this benefit is being phased in therefore figures lower) of which 120,000 (40%) are in employment and 183,144 (60%) are not in employment;
  Employment Support Allowance and Incapacity Benefit 2016- 2.49 million claimants;
  Access to Work – annually about 12,000 new entrants.

- Responsible actors: Job Centre Plus administers payments for income replacement benefits but funding is from national sources, from the Department for Work and Pensions.

- Financing of benefits and services: The system is both taxation and insurance based. There are contributory, non-contributory and social assistance benefits. *Contributory benefits* and their associated costs are funded by the National Insurance Fund, which is financed by compulsory contributions based on current income and paid by most workers and employers. The benefits cover old-age, bereavement, incapacity, maternity, and unemployment and are mostly paid at a flat rate.

  Non-contributory benefits are financed from general taxation and are paid on the basis of individual circumstances (e.g. related to disability, children).

  Social assistance benefits such as Housing Benefit, income-based Jobseekers Allowance, income-based Employment and Support Allowance and Income Support (for people who are not working) and Pension are also funded from general taxation and act as a safety net. The National Health Service provides universal health care, which is financed from taxation and the NI Fund and is not dependent on a contribution record.

Young persons (with health conditions) in employment

1. Reform 1: Key Data

Name: Access to Work programme (AtW)

Target: Practical support at work for disabled people (in employment) with aim of job retention or self-employment

Introduced: 1994, reformed 2010

AtW is not specifically restricted to young persons, but the report focusses – as much as possible – on this category of young clients and those with mental health conditions.

2. Backgrounds

- Austerity measures to reduce public expenditures on sickness and disability;
- Assumption behind new policies: restricting benefits will encourage people to move into work;
- Criticism that, despite formally being eligible, in early days the programme (from 1994) only supported a limited number of persons namely those with physical and sensory impairments (and not people with mental health problems, and intellectual, cognitive and developmental impairments);
- Shift of provision of sheltered employment to supporting individuals in open employment: reduction of funding for sheltered workshops, consequently: closing of many factories with sheltered workshops.

3. Contents (measures, provisions, etc.)

- Eligible: anyone over age 16, as long as in employment and not in receipt of out of work benefits;
- Practical support: in the workplace, like: personal assistance, adaptations to equipment, fares to work, support worker or job coach, a support service if absent from work (or finding it difficult to work), disability awareness training for colleagues;
- Workplace Mental Health Service is funded by the AtW programme: special scheme for people with mental health conditions, administered by Remploy (former sheltered workshop provider);
- Personal Independent Payments (PIPs) replaced the Disability Living Allowance as main benefit for compensation of additional costs of living with a disability;
- Related reform in other domains: health support for young (and older) people with mental health conditions: IAPT programme ("Improving Access to Psychological Therapies").

4. Implementation

- Main actors involved: eligible job applicants, local agencies (Job Centre Plus) of Department of Work and Pensions, employers, other workers in the place of employment and contracted service providers (e.g. job coaches, assessors);
- It is administered locally; local partnerships are considered very important;
- Assessors (independent specialists, contracted by Job Centre Plus) determine through a work place visit what is required and contract service providers;
- Monitoring the project concluded: poor knowledge on application process, inadequate publicity by actors other than the Department of Work and Pensions;
- Recent budget restrictions led to considerable objections by PWD, in particular from deaf persons, who rely on sigh interpreters, the costs of which are relatively high.

5. Impact

- Uptake of AtW has increased but numbers remain very low;
- Programme participants with mental ill health are underrepresented, making up only 4% of service users (2013-2014). Data on the use of the AtW programme by young people with mental health conditions is limited;
- AtW: highly valued by disabled people as it provides support in the workplace, which is tailored to their job; and they have a say in what kind of assistance they receive; Evaluations show AtW levels the playing field, as PWD enjoy same opportunities for jobs and success in work compared to non-disabled employees;

- Also general studies on success of return to work measures indicate that individually tailored support yields the best results;
- Earlier evaluation of AtW (2009) showed employers become more knowledgeable to support their employees in employment and reported increase of productivity, reduction of sickness absence, etc.;
- According to disabled people (organizations) and some research: AtW pays for itself by 1.48 times because of the taxes paid and welfare benefits payments saved. However the Minister has disputed this figure, so it should be considered as indicative;
- OECD has expressed concern at the lack of support (early intervention) in early stage of sickness absence to prevent long term work incapacity.

Related reforms: results in the main support for young people with mental health conditions (IAPT):

- Targets were to treat 15% of target group with anxiety or depression, and a recovery rate (which means: they were out of the health system, not: got a job) of 50% of those who completed treatment;
- First target was met (15.6%) but second not (45.4%).

6. Lessons

- Lack of information on the programme restricts take up (there also is a need for broader perspectives e.g. across government departments and budgets);
- Need for early intervention strategies for young persons in employment with mental health conditions;
- Support that is tailored to individuals and their specific circumstance is more effective than general non-targeted approaches;
- Many reports note the one – sided nature of research and policy. Very little effort on the demand side of the equation e.g. promotion of mental health friendly work practices.

Young persons (with health conditions) out of employment

1. Reform 2: Key Data

Name: Work Choice Programme (WC)

Target: Practical support to assist unemployed persons who are recognized as disabled (under the Equality Act 2010) into work

Introduced: October 2010

Work Choice programme participants should be of working age (minimum: 16 years), but the report focusses – as much as possible – on the category of young clients.

2. Backgrounds

WC replaces earlier programmes. Due to a change of government with a different outlook WC was introduced. It was the aim to change the relationship of the Department with service providers, increase competition between service providers, increasing opportunities for new providers (in summary: to introduce greater privatization of services).

3. Contents (measures, provisions, etc.)

- Applicants must have a long term health condition that affects their work capacity and must be able to work at least 16 hours/week (after receiving skills development support and advices) and need support in work;
- Services offered: pre-employment advice and support, followed by short to medium term in-work support for employee and employer for up to 2 years;
- The work choice wage incentive for young disable people was introduced July 2012 but the scheme ended August 2014 following uncertain results in evaluation.

4. Implementation

- Department for Work and Pensions organizes the contracts with “prime providers” (large organizations) which sub contract providers on local and regional basis (e.g.: for profit providers, social enterprises, charities);
- Other elements: outcome based funding for work choice providers are paid at various stages of the employment process, and paid according to outcomes achieved), minimum service prescription (to allow innovations in local providers) and larger contracts;
- Support contains 3 stages: assessments, assisting with finding employment, in-work support;
- Implementation involved considerable restructuring which went parallel to another (contested) development: the closure of sheltered workshops.

5. Impact (as assessed in various evaluation studies and other reports)

- Of those starting WC 57.3% had found a job (2014), which is very favorable compared to the earlier (Work) Programme for this target group. Best outcomes are for PWD with more skills; better results also have been reported for internships;
- Public conflicts, media behavior (e.g. as to characterizations of disabled people in the media), including many well documented cases of failures: people declared fit for work who have died shortly after being assessed; increased suicide rates among clients with mental health conditions;
- Weaknesses in the administration of the WC programme and elements criticized regard: the quality and quantity of work done, leadership skills and integrity of senior public staff, and increasing costs of administration (e.g. assessments);

- Impact of weaknesses in the process preceding WC participation: the disability assessments (made by private medical assessment company) before entering a benefit or support programme. The organization and methods of evaluation have been heavily criticized by various groups and authorities (incl. General Accounting Office);
- The reforms have been contested at a number of levels and several discrepancies were found: e.g. people with mental health conditions were 3 times more sanctioned than helped to find a job. Sanctions increased client's problems as to finding a job, continue training, homelessness, etc.;
- Currently shift to more coercion to look for work and use of psychological strategies. Activities are intended to modify attitudes, beliefs and personality, in order to put pressure on clients, e.g. by interpreting failure in the job market as an individual failing, and imposing sanctions (cut of benefits) when certain actions are done by the client;
- Research shows: benefit cuts reduce chances of finding a job;
- Most measures still are supplier side oriented.

6. Lessons

- Wage incentives (for employers to employ a young person) were abolished 2014 as it did not make a difference to the employment rate. Employers reported the £2,275 payment did not really make a difference in hiring decisions. Also some objected to paperwork and bureaucracy involved;
- Young persons with mental health conditions need more help than other categories of clients;
- Incentive payments to providers do not stimulate assistance for those who need most help (creaming, parking);
- There is well established research evidence (OECD) of the effectiveness of IPS (Individual Placement and support model. The Work Choice organizations that used this approach had better results. This kind of assistance straddles pre-work and support in work. However initiatives still remain small scale;
- Difficult to connect changes in employment or placement rates to elements in programmes. Besides, evaluation studies not automatically lead to implement changes.

4.9 Fact sheet The Netherlands

Introduction: selected contextual facts on the Netherlands

- Number of inhabitants: 16.9 million persons
- Employment rate (age group 20-64, 2015): 76.4%
- Unemployment rate (August 2016): 5.8%
- Unemployment rate (Aged < 25 years, August 2016): 11.3%
- Social systems applicable to young persons with health restrictions or handicap:

A. Income replacement:

- Disablement Assistance Act for Handicapped Young Persons (Wajong);
- Act on public support (WMO) = social assistance;

B. Other:

- Special financing for education;
- Programmes in the field of special children day care, psychotherapeutic centres for children and youngsters (GGZ), Exceptional Medical Expenses Insurance (AWBZ);
- Support for (better) transportation;
- Regulation (compensation) for costs of children with a disability, living at their parents' home (TOG).

- Their coverage: income replacement and services;
- Number of persons covered: Total Wajong population 250,600 (Old Wajong 183,900 and new Wajong 2010 66,700) and people receiving WMO social assistance income 411,000 (end of 2014);
- Responsible actors: since 2015: Ministry of Social Affairs and Employment is responsible and the Employee Insurance Agency (UWV) provides the Wajong benefit and instruments and the municipalities provide public support (WMO);
- Financing of benefits and services: The Disablement fund handicapped young persons (Arbeidsongeschiktheidsfonds jonggehandicapten) finances Wajong benefits and (re-) employment services. This fund is fully financed by state contribution. Social assistance (WMO) is also financed by state contribution. UWV (Wajong) and municipality (WMO) pay for the respective measures.

1. Reform: Key Data

Name:	Reform of Disablement Assistance Act for Handicapped Young Persons ("Wajong").
Target:	Increase labour participation of young persons with disabilities, in or out of employment (From the age of 18 to 27, young people admitted to the Wajong work programme receive intensive assistance in finding and

keeping employment. Remaining earning capacity is (re-)assessed at the age of 27 for a permanent Wajong-benefit until aged 67).

Introduced: January 2010.

2. Background

- Continuously increasing numbers of young PWD depending on disability benefit, but also having (partial) working capacities. . In 2001 a total of 6,200 Wajong-benefits where granted and in 2009 the inflow was16,700. That year 5% of the people aged 18 was claiming and receiving this disability benefit. The total of 200,000 recipients costed 2 billion Euro each year and was expected to double in 2040;
- In 2009 24% claimants were working. 9% for a regular employer and 15% at a social firm. It was estimated that 66% of the total Wajong population was able to do (some) work;
- Activation of young PWD because most of them are still developing at that age; moreover: work is considered to be good for health and participation in society;
- Consequently: more focus needed on what people can do instead of **in**capacities.

3. Contents (measures, provisions, etc.)

- Wajong dates from 1986 and is provided by the semi-public Employee Insurance Agency UWV. The new Wajong was introduced in 2010 only for the new inflow of young PWD. The stock of recipients keep their eligibility to the Old Wajong, that mainly is providing benefits. In the old and new Wajong it is possible to be employed and receive an additional benefit. Entering the new Wajong in 2010 the claimant may qualify for:
  a. (only) benefit receipt (in case of serious disabilities leading to inability to earn < 35% of statutory minimum wage), *or*
  b. employment programme, based on participation plan and an employment offer from employment office (and supporting partial benefits can be combined with labour earnings), *or*
  c. education programme (for those who still are at school or start study between age 18 and 27 years (including a supporting benefit maximum of 35% of the minimum wage)
- The Ministry of Social Affairs and Employment is responsible and the UWV provides the benefit and instruments and funding for young PWD that want to and do work and for their employers;
- Increased use of individual reintegration plans, centered on possibilities, rights, obligations and prospects for work. When the client is eligible: obligation to cooperate with reintegration plan and to accept ‘suitable work’;
- Stronger financial incentives for clients to take up work (namely rewards for working more hours, cutting benefits when not cooperating);
- Promotion of a better school-to-work transition and work-orientated education;

- Improving support for employers by newly created 'work trials' without pay, wage dispensation, subsidies to install 'non-transportable facilities, regional employment service centers;
- Culture change programme: changing attitudes of parents, teachers, health care workers, municipalities, employees and employers towards young people with disabilities.

4. Implementation

- was achieved by working groups lead by the social insurance body UWV

Initial implementation problems as assessed in initial studies:

a. 54% entered the work programme. The research department of UWV later found that less than halve of them (26% of new claimants) had possibilities of working in regular employment, now or in the future.

b. Focus of the majority of the reintegration efforts was only on these 26%.

c. Job offers from employers did not match with selected candidates: the administrator (UWV) could hardly deliver young applicants who were in the Wajong 2010 work programme and were able to do the work in vacancies.

d. Matching young PWD with suitable regular jobs was too much work for UWV due to imposed staff reductions (austerity measures).

5. Impact

- In 2010 the inflow of young PWD into the new scheme changed considerably:

a. In 2010 7,000 (40%) of the applications were rejected compared to 33% in 2009;

b. inflow dropped from 17 500 to 10 500 in the new programme. However, in 2014 this changed to a higher number of 15 200. UWV explained this as the result of higher youth unemployment and efforts by municipalities to move unemployed young people with disabilities from WMO income assistance into the Wajong;

c. in the first years after implementation: only 13% of inflow entered the (only) benefit programme, 54% entered the employment (sub-) scheme and 34% entered the education programme;

- From the young people entering in the Wajong work programme in 2010, 62% have a developmental disorder, 27% have a psychological illness and 11% have a physical illness. Within the group with developmental disorders, we mainly see individuals with (very) slight mental impairments (29%), a disorder that falls within the autistic spectrum (13%) and people with an attention deficit disorder (ADHD) (10%). In the study programme the ones with slight to moderate learning disabilities are over represented;
- In the years after introduction only a few hundred from the new Wajong 2010 work scheme group found employment in regular jobs. The numbers were much better

for young PWD in the old Wajong. Although the total numbers of recipients of old and new Wajong entering employment in regular jobs went up from 2,800 in 2010 to 8,000 in 2014, the majority was receiving the Old Wajong. UWV explained that this was caused by the younger age of the new inflow.

- The total employment rate (of persons having a job while receiving additional benefits from the old or new scheme) went down: from 25% (2009) to 22% (2014), of which half have a job in regular employment (open labour market).
- Sustainability of employment: almost all contracts are temporary. Earlier studies showed 50% of (former) Wajong recipients have lost their job one year later.

Implementation

- Wage subsidy and wage dispensation (employer pays under minimum wage for employees with disability benefit), job coaching and work trial are the provisions for employers that mostly support placement;
- Employers are satisfied with the wage subsidy (to compensate for lower productivity of Wajong clients entering a job;
- Within 35 region “Work Squares” (“werkpleinen”) were created to facilitate contacts between client, social insurance and employers with vacancies.
- Several experts concluded that the new Wajong employment programme did not provide employment support and job offers to young persons with mental health conditions. IPS based approaches (Individual Placement and Support) were not applied; one of the reasons mentioned: they are costly and require support from various experts (multidisciplinary;
- Government and social partners were convinced that the many different employment strategies would not result in more jobs for young PWD. In the opinion of parliament, employers, social firms and municipalities the social insurance administrator (UWV) failed in activating young PWD both in in the old and new Wajong 2010;
- Labour unions and the administrator of the New scheme (2010) fear that many young PWD with disappear from benefit and activation programme rolls, and will be without any help. However, municipalities and local health and care organisations as well as employers are positive toward the newly (2015) reformed programme.

6. Lessons

- In the first year of the new Wajong 2010 there was a 10% drop in the total inflow so expectations were high. In 2013 there was again a growth in Wajong benefit dependency The number of new inflow that was employed or found employment dropped and those who found work had less long contracts. According UWV this had to do with the crisis and high youth unemployment at that time.
- In order to improve placement from 2010 on UWV worked hard to make agreements with municipalities, (local) employers, health and education institutions to create networks to reduce early school dropping and stimulate job creation for young people with disabilities.
- With the aim to enhance the role of employers and to stimulate employment of PWD public and private employers voluntarily agreed in collective labour agreements to provide 125,000 jobs for PWD by the year 2020.
- The financial crisis and shrinking state budgets resulted in a change of governmental policy views on how to cut spending on health services and income benefits. Neo liberal views resulted after 2010 into a policy that health, social welfare and benefit systems should be decentralised. In 2015 municipalities received full responsibility for the youth mental health care and for the participation of young people with disabilities who are not fully unfit for work. However in the process that led to this decentralisation the social insurance agency UWV lost control over the networks (with schools, employers) they had invested in heavily. Municipalities were less interested while they had to concentrate on (other) new obligations;
- After only five years the Wajong changed again in 2015. From the new inflow only the fully disabled who are permanent unfit for work receive a new Wajong 2015 benefit. The inflow in 2015 reduced by 75%.

Appendix: List of national experts and coordinator

Denmark: Tobias Carstensen MSc worked for three years as a researcher in a private research institute and made research into long-term absence from the labour market due to sickness and disability beneficiaries with psychical disabilities and their attachment to the labour market. He is now working as an archivist at National Archives Denmark.

Austria: Michael Fuchs MSc is a researcher at the European Centre for Social Welfare Policy and Research in Vienna since 2000. He has coordinated and has been engaged in several international and national research projects related to labour market policy, social security and social inclusion commissioned by European Commission, World Bank and WHO as well as Federal Ministries and local governments in Austria.

United Kingdom: Dr Sarah Woodin is an independent researcher and Research Associate with the University of Leeds (UK). She has worked on many national and transnational research projects concerned with social policy particularly in the fields of social policy, employment, disability and gender (e.g. Academic Network of European Disability Experts (ANED), Fundamental Rights Agency (FRA), Daphne programme).

Sweden: Dr. Sara Hultqvist is working for Nordic Centre for Welfare and Social Issues in Stockholm, providing the Nordic Council of Ministers with research based reports concearning social insurance in the Nordic countries. She is also a lecturer at the School of Social Work, Lund University.

Netherlands: Edwin Luitzen De Vos MSc is owner of Champ research and consultancy (Amsterdam, Netherlands). He published on social security, employment, inclusion and active labour market policies. He does research on behalf of European organisations (EuroFound, TAIEX) and the ILO and is active member of expert groups on disability and work (GLADNET, LEVERHULM, EHESP, DSiN).

Coordination: Dr. Rienk Prins worked until 2014 as senior researcher/consultant at AStri Policy and Consultancy Group (Leiden, Netherlands). He coordinated various cross national studies in the field of social security, disability policy and labour integration, and used his consultancy experiences in projects for World Bank, OECD and EU.

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