Work disability Prevention in the Netherlands

Chapter 14

Work Disability Prevention in the Netherlands

A Key Role for Employers

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In 2016, the Dutch sickness-absence rate (for the first two years of absence) was just below 4%, and a modest 6% of working-aged people received disability benefits (Statistics Netherlands, 2017a; Statistics Netherlands, 2017b). These figures remained fairly stable during the previous decade. However, in 1979 the sickness-absence rate peaked at 10%, and in 1990 the disability-pension rate peaked at 14% (Aarts, de Jong, & van der Veen, 2002). The miraculous drops since then can only be understood in the context of (a) Dutch labor-market characteristics, (b) increased employer involvement in work disability policy development, and (c) failures of the generous disability benefit scheme introduced in 1967. Therefore, this chapter starts with a description of the current Dutch labor-market characteristics. Next, the chapter explains how Dutch employers have historically been involved to a much larger extent than employers in other countries in the development and implementation of sick-leave policy. The positive intentions of the game-changing disability benefit scheme of 1967 are explained. Then the chapter addresses the labor-market and policy developments in the 1980s and 1990s that paved the way for a new work disability scheme, covering sickness absence and long-term disability and introduced in 2004. The new system's most striking features are that Dutch employers are required to formulate action plans within 8 weeks of workers reporting sick and must pay at least 70% of the salary during the first two years of sickness absence. The reform's successes and challenges for the Netherlands are addressed. The chapter ends by discussing the transferability of the Dutch work disability system to other countries and its sustainability in the light of the four centenary-conversation questions asked by the International Labour Organization (2016).

Current Situation

The Netherlands is a constitutional monarchy with 17 million citizens as of 2016, a fairly high labor-participation rate and productive workforce, and an unusually high proportion of part-time workers, particularly among women.

Of the 17 million citizens, in 2016 almost 13 million were of working age (15–75), and 8.5 million participated in paid work for 12 hours per week or more. Thus, the labor-force participation rate as defined by Statistics Netherlands was 66% (Statistics Netherlands, 2017b). In terms of absolute labor participation (one hour per week or more), 75% of the working-age population aged 15 to 65 participated in paid work (Trading Economics, 2017a). This participation rate has been consistent for the past 20 years (Statistics Netherlands, 2017b; Trading Economics, 2017a).

Only 9 million people were effectively available for the labor market. Those not available were spouses whose partners had paid employment, those over 65 who were officially retired and, to a lesser extent, those receiving full disability benefits. In 2016 the unemployment rate was 6%, irrespective of hours previously worked per week (Trading Economics, 2017b).

The Netherlands is a champion of part-time work, a legal right that was initially introduced in the 1980s as a work-life balance solution. Almost half of employees work less than 36 hours per week, including three-quarters of employed women (recognizing their unpaid work at home). The average dual-earner family consists of a full-time working man and a woman working 16 to 24 hours per week (with the woman caring for children under 12 for two or three days per week) (Portegijs & van den Brakel, 2016). Only 4% of part-time-employed women would prefer to work full-time, an unusually low figure compared with other OECD (Organisation for Economic Co-operation and Development) countries (OECD, in Portegijs & Keuzekamp, 2008). Mothers would like to work a few more hours, particularly when children grow older, and women's careers are limited by part-time work (Portegijs & Keuzekamp, 2008; Portegijs & van den Brakel, 2016).

Working-age people in the Netherlands are quite productive, with about 6% receiving disability benefits and a two-year sickness-absence rate of approximately 4% (Statistics Netherlands, 2017a; Statistics Netherlands, 2017b).

Short History of Dutch Employer Involvement in Sickness Leave

Dutch employers have become extremely responsible for sickness-absence guidance and payment, as established in long-standing institutional arrangements. We can distinguish three areas of institutional arrangements:

- state and professional involvement with safe and healthy workplaces and the health of workers;
- income protection for disabled workers, strongly supported by tripartite institutions; and
- healthcare, which is strictly isolated from occupational healthcare and social insurance.

First, working conditions have been protected by laws since the 19th century; a labor inspectorate was already in place by 1899. The Netherlands Society of Occupational Medicine,[1] or NVAB, was founded in 1953 (Netherlands Society of Occupational Medicine, 2017). In 1959, a law recognized the profession of occupational physician and required that organizations with more than 750 workers have their own organized occupational health program (Wolvetang, Buijs, & van Oosterom, 1997).

Second, the Netherlands can be characterized as a corporatist welfare state (Eikemo & Bambra, 2008). Its foundation is a Bismarckian welfare state, based on social insurance providing earnings-related benefits for employees and financed by a mix of employer and employee contributions, or premiums. In contrast, Beveridgean social policy is characterized by universal (for all citizens without favoring employees) provision of benefits and financed by taxes (Bonoli, 1997). Some have characterized the Netherlands as a social-democratic welfare state (Anema, Prinz, & Prins, 2013; Esping-Andersen, 1990) on the basis of its level of expenditure on welfare. However, for the purpose of this chapter, we will focus on the historically grounded divisions of responsibilities, rather than the levels of investment within the system, in line with Bambra (2007). In the 20th century, a national network of employee insurance offices was developed in the Netherlands, financed by premiums paid by employers and employees and increasingly regulated by the state. These diverse offices never offered health insurance and focused only on income provision in case of work disability. This network evolved into one national Dutch Institute for Employee Benefit Scheme,[2] which was established in 2002 (Aarts, de Jong, & van der Veen, 2002).

A typical characteristic of the Dutch corporistic welfare state is its consultative economy (Labour Foundation, 2010). The consultative economy means that decision making and policy making are based on discussion, negotiation, and bargaining, especially where work and income are concerned (Labour Foundation, 2010). This culture has been officially institutionalized since the Labour Foundation[3] was established in 1945, just after World War II. This private national consultative body comprises Dutch employers' federations and trade-union confederations and is a bipartite organization based on parity (Labour Foundation, 2010), with, to date, influential spring and autumn consultation rounds with the government. In 1950, the Social and Economic Council of the Netherlands[4] was established, representing employers and employees, and including independent experts (who are called "Crown members") (Social and Economic Council of the Netherlands, 2015). This tripartite advisory body provides recommendations on request by the government or on its own initiative. These two bodies thus do make not policies but regularly advise the government, and their advice is influential in Dutch national policy making.

Employers thus pay directly, via premiums or extension of income, for a substantial part of the welfare state, which creates a larger sense of

involvement in welfare than in a solely tax-based (Beveridge) system. Moreover, employer organizations and trade unions influence policy making at an early stage. Once developed, policies are well known to employers and employees, fit with their realities, and tend to be supported by most employers in the country, without large conflicts with employee interests. This typical Dutch incremental mode of policy development was carefully analyzed in the context of integrated healthcare for elderly citizens by Kümpers, van Raak, Hardy, & Mur. (2002). Also (although less emphasized), including experts in policy making supports the use of scientific evidence at the early stage of formulating policies.

Third, the Netherlands is characterized by its healthcare system being almost completely separate from occupational health and social insurance. Since 1903 treating physicians have been forbidden from writing sick notes for their patients. Other physicians (hired by employers or working for social insurance agencies) check the legitimacy of sickness absences and long-term disability. Since then, insurance medicine has been established as a profession, and the profession of occupational physician was officially established as early as the 1950s (Wolvetang et al., 1997). This separation of healthcare and occupational care from social insurance also encouraged employer involvement in work disability policy and practice (Prins & Bloch, 2001).

The Disability Benefit Scheme of 1967

With the introduction of the public disability benefit scheme,[5] in 1967 for all employees and in 1976 for all citizens, the Dutch welfare state was complete. The scheme covered long-term disability for the period after employment. This disability benefit scheme was linked to a sickness benefit scheme covering the first year of sickness absence, during which the employee was still employed. Both schemes did not fundamentally change until the first privatization of part of the sickness benefit scheme in 1996. The 1967 disability benefit scheme replaced diverse old laws, which only covered work risks for specific groups of employees, with a scheme that also covered social risks (not just consequences of workplace accidents) and thus loss of income due to all work disability (i.e., not being able to work due to a medical condition, regardless of its cause). The Netherlands was unique in not separating work injury from non-work injury in its disability benefit scheme. Also, the threshold for receiving benefits was only 15% loss of income, and the coverage increased incrementally, depending on the percentage of lost income, to a maximum of 80% of former income. The innovative and generous disability benefit scheme of 1967 was influenced overall by the notion of the rights to self-fulfillment and equality (Aarts et al., 2002).

Employees absent from work because of any sickness could apply for a sickness-absence benefit during the first year. During that year, the employee received healthcare treatment, and the legitimacy of their absence was monitored. Neither healthcare nor occupational health focused on restoring work ability.

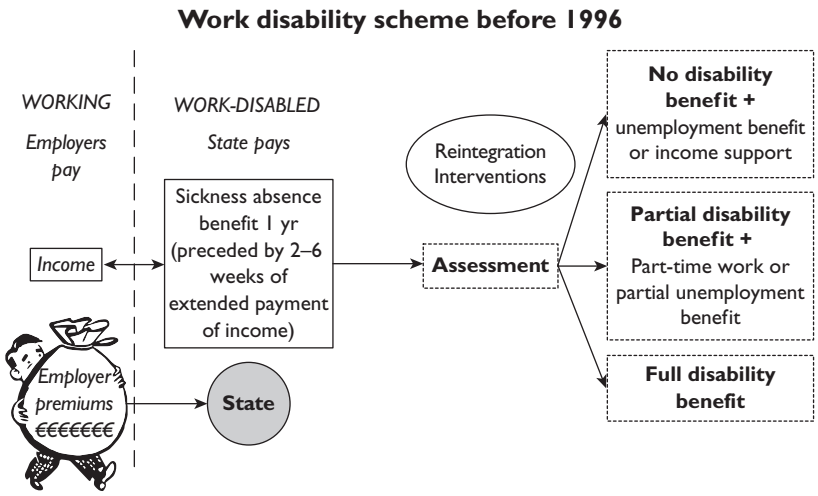

Figure 14.1 Dutch sickness-absence scheme before 1996

After one year of sickness absence earning ability, not work ability, was assessed to determine disability benefit eligibility (Aarts et al., 2002). If after one year of sickness absence an employee was not approved for the disability benefit scheme, unemployment benefits (via the Unemployment Insurance Act[6]) or income support[7] (a minimum income supplied by the state for those without income or possessions) were available. A partial disability benefit was also possible, which could be supplemented with unemployment benefits (see Figure 14.1).

Both the sickness-absence benefit and the disability benefit were financed by premiums paid by employers and employees. The premiums, in fact, also increased the employers' expenses on salaries. Most of the sickness-absence and disability benefit schemes were thus regulated and supplied by the government, but paid for by employers (see Figure 14.1).

Within the pre-1980 legislative framework, employers had ample opportunity to control sickness-absence and disability benefit costs. They could prevent sickness absence via the 1980 Working Conditions Act[8] and could perform medical examinations when hiring for jobs with high health risks. However, as will be explained below, legislation was not aimed at providing incentives for employers to reduce their sickness-absence and disability benefit costs. During the 1980s and1990s, such incentives would gradually be introduced.

"Dutch Disease" in the Netherlands Economy and Work Disability Schemes During the 1980s and 1990s

Both the sickness-absence scheme and the disability benefit scheme became far more attractive to employees than had ever been expected. In 1979,

10% of those in paid jobs were not working and were receiving sickness absence benefits. This high sickness-absence rate resulted in a large number of employees applying for disability benefits after one year of sickness absence. In 1967, it had been expected that only 200,000 people would depend on disability benefits, but seven years later, more than 300,000 were on disability benefits. In 1980, the cost of these benefits was 4% of the GDP (Aarts et al., 2002).

However, at the beginning of the 1980s, the most important problem in the Netherlands was not the high sickness-absence rate and high number of disability benefit beneficiaries, but the deep economic crisis and unemployment. The term "Dutch disease" was coined in 1977 to explain a sharp decline in the Dutch economy following overreliance on natural gas resources discovered in 1959. As a consequence, domestic industries had been neglected, causing high inflation, a drop in investment, and a loss of global competitiveness (C. W., 2014).

As a response, the government, employer organizations, and trade unions entered into what was named the Wassenaar agreement[9] in 1982. Trade unions agreed to drop their insistence on frequent wage adjustments for inflation. Employer organizations agreed to offer a shorter working week, early retirement schemes, and part-time work. With these changes, company profits were restored and full employment could be realized. Despite the feeling of victory by the three parties over the agreement, the number of people receiving disability benefits increased. The first reason was the drop in available jobs due to economic recession, which allowed the government to loosen the disability benefit assessment policy. The reduced opportunities to find other jobs were taken into account when assessing access to the disability benefit scheme, which increased the number of recipients (Arents, Cluitmans, & van der Ende, 1999).

The second reason why the number of people receiving disability benefits increased without taking immediate measures was that the high disability benefit level was masked by another typical Dutch phenomenon: very low labor participation of women at that time. Although labor participation had generally and irrespective of gender dropped from 1975 to 1985, overall expenditures on social benefits were, relative to international norms, not exceptionally high. In 1985, 20% of the population depended on some benefit, which was average compared with 11 OECD countries. However, a large proportion of the population (35%) had no personal income (mostly married women), and only 45% of the working-age Dutch population (aged 15–64) had paid work (Arents et al., 1999).

In most Western countries, employment dropped because of the economic crisis in the early 1970s, while labor forces increased because the baby boomers began entering the labor market. In all countries, an increasing number of working-age people applied for disability benefits as an alternative to (massive) unemployment. However, this shift was more pronounced

in the Netherlands. The proportion of older men (aged 55–64) who were employed dropped from a moderate 80.6% in 1970 to a striking low of 44.2% in 1997. This drop was explained primarily by the highly accessible disability benefit scheme. During this period, the proportion of older working men also dropped remarkably in Belgium, France, Finland, Germany, and Austria. Whereas in Germany and Austria disability benefit schemes also functioned as early-retirement schemes, the other countries had attractive early-retirement schemes (Aarts et al., 2002; Einerhand, Knol, Prins, & Veerman, 1995).

The third reason why work disability increased was a lack of cost awareness. The pay-as-you-go system, with employer-prepaid premiums, prevented both employers and employees from seeing the costs directly as theirs (Aarts & de Jong, 1998). The fourth reason was the striking lack of public expenditure for reintegration interventions (vocational rehabilitation), and thus low exit rates from the disability benefit scheme during the 1990s (Liedorp, 2002; Social and Economic Council of the Netherlands, 1991). Less than 0.01% of GDP was spent on reintegration interventions, compared with 0.4% in the United States, 0.10% in Sweden, and 0.15% in Germany and Switzerland (Aarts et al., 2002).

By 1990, a tremendous 14% of the Dutch labor force was on disability benefits. The prime minister used the words "The Netherlands is sick" (NRC Handelsblad, 1990), reflecting the contradiction between a prosperous country with highly educated citizens and excellent healthcare and the high number of people considered too ill to work (de Volkskrant, 1998). Finally, the state, employer organizations, and trade unions became fully determined to collaborate on this issue, affected by earlier positive experiences and new ideas about governance. During the 1980s, there was growing awareness that the state alone could not sufficiently influence social processes through strict legislation. Instead, legislation should only set the boundaries within which parties could operate, and other policy instruments, such as economic incentives, should be used (Liedorp, 2002). These new ideas, which parallel the "Third Way" (Giddens, 2001), introduced under the Clinton administration in the US and the Blair government in the UK, offered employer and employee organizations more room to influence policy.

In the Netherlands, this broadening of policy instruments resulted in a clear shift toward financial incentives for employers (Liedorp, 2002). This shift began in 1993, with sickness-absence premiums under the new Sickness Benefits Act[10] being tied to the short-term sickness rate of each organization. Next, in 1994, the government sickness-absence payment was replaced by a law mandating employers to pay at least 70% of the worker's salary during the first two (for small organizations) to six (for large organizations) weeks of sickness absence; after that, the government would take over sickness-absence payments. In 1996, the government sickness-absence payment was abandoned, and employers were mandated to pay at least 70%

of workers' salaries during the first year of work disability (Aarts et al., 2002; Liedorp, 2002). Finally, financial incentives to reduce long-term disability benefits were introduced in 1998. By then, employer premiums under the disability benefit scheme of 1967 were set according to the number of disabled employees in an organization (Liedorp, 2002). Until then, no measures had been taken to encourage return to work during the first year of sickness absence. The laws relied on employers taking responsibility themselves, prompted by financial incentives attached to preventing sickness absence and decreasing the length of sickness absences. Return-to-work interventions during sickness absence were offered by private occupational health companies, and private insurance companies who offered sickness-absence insurance to employers. Their packages came with preventive measures and return-to-work guidance to reduce the insurers' expenses.

Thus, during the 1980s and 1990s, legislation covering sickness absence and disability benefits gradually changed, with the aim of containing costs and providing incentives for employers to prevent sickness absence. At the same time, sick-listed employees also received job protection for one year. These changes in legislation were accompanied by research commissioned mostly by the government, although policy changes were often made too rapidly for their actual effects to be studied (Aarts et al., 2002).

By 2000, Dutch employers were held fully responsible for the implementation and financing of employee income protection during the first year of sickness absence. Still, the state was legally responsible for income protection of employees on sick leave. Only the legal framework had changed: the social insurance benefit was replaced by a statutory payment obligation. This change was supported by private insurers, who developed plans, with attractive premiums, that insured employers against the risk of paying sickness-absence benefits (Liedorp, 2002). These policy changes and the pace of change were totally different from other European countries with comparable economic characteristics. In Denmark, the threshold for disability benefit eligibility was higher, and participation in vocational rehabilitation was highly encouraged (Høgelund, 2003). In Sweden, employers were not required to pay sickness-absence benefits beyond the first two weeks (Liedorp, 2002). Compared with Belgium, more sickness-absence legislation was introduced in the 1980s and 1990s in the Netherlands, and it was also less permissive than the Belgian legislation (van Raak, de Rijk, & Morsa, 2005). The rapid changes in the Netherlands also constituted a drawback, as the new legislation on sickness-absence guidance to promote return to work could not be "internalized" by employees and employers. The legislation was not turned into a routine, which hampered use in practice (van Raak et al., 2005).

The New Work Disability Scheme in 2004

The new century brought with it two new laws: in 2002 the Gatekeeper Improvement Act[11] and in 2004 the Extended Payment of Income Act.

This resulted in a sickness-absence scheme that (a) obliged employers to pay at least 70% of the sick-listed employee's salary for two years (including job protection) and (b) via the gatekeeper improvement act, the requirement that employers, employees, and occupational physicians fulfill certain tasks during workers' absences to promote prompt reintegration into work. Simply stated, the two new laws meant that employers guided sickness absence and paid sickness-absence benefits directly (see Figure 14.2), thus regaining control over their expenses. Furthermore, employers, employees, and occupational physicians became the gatekeepers for access to disability benefits, in order to control the number of people receiving them. Thus, privatizing the first two years of sickness absence reduced the role of the state in controlling work disability.

Due to the "consultative economy," employers effectively contributed via bipartite and tripartite consultations to formulating these two new laws (Inspectie Werk en Inkomen, 2006). The trade unions agreed with the reforms because they no longer restricted protection of sick-listed employees' jobs to only twoyears (Høgelund, 2003). Extension of employers' payment to sick-listed employees for a maximum of two years has to be understood as the government trading employers' sickness-absence and disability benefit premiums for their payments to certain sick employees. These payments could be influenced by employers via prevention and reintegration interventions.

It is difficult to understand why the small- and medium-sized enterprises also agreed with the two new laws. Liedorp (2002) explained that, in 1996, when employers' payment of workers' sickness-absence benefits was

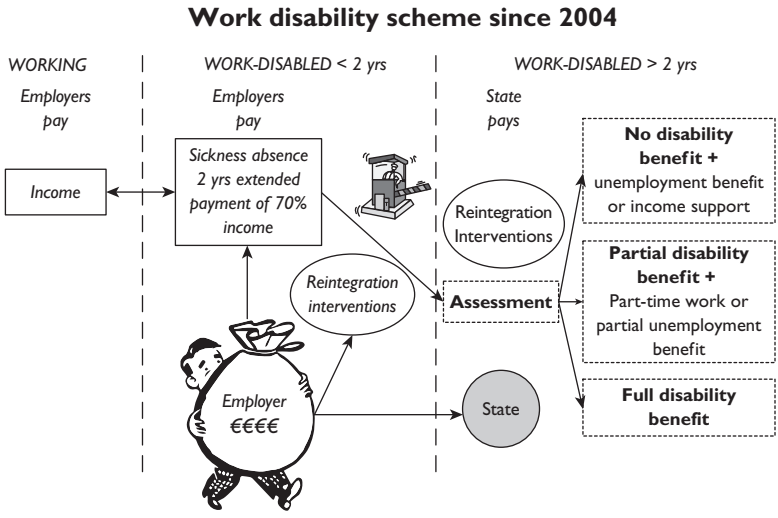

Figure 14.2 Dutch sickness-absence scheme since 2004

extended from two to six weeks, private insurance companies promised to offer employers attractive insurance rates to cover their risks of paying sickness-absence benefits. Moreover, sickness absence in small- and medium-sized enterprises has always been lower than in larger organizations (EurWORK, 2010).

Employers Pay For and Guide Sickness Absence

The combination of employers paying for and guiding sickness absence was thus considered self-evident in the Netherlands. The Gatekeeper Improvement Act was developed to address the lack of early intervention and cooperation by employers during sickness absence. Hertogh, Putman, & Urban (2001) analyzed how sickness absence for mental health problems, the most common reason for sickness absence, was in fact a "one-way-ticket to a disability benefit" (p. 11). Other Dutch studies revealed a similar lack of cooperation in return to work during the first year of sickness absence (de Rijk, van Raak, & van der Made, 2007; van Raak et al., 2005). The Gatekeeper Improvement Act of 2002 was expected to change this pattern, due to three main measures: (a) employers and occupational physicians became gatekeepers for entering the disability benefit scheme, (b) employers, employees, and occupational physicians now have responsibilities under the Act for the steps listed below during periods of sickness absence, and (c) these responsibilities are checked by the social insurance agency and, if necessary, sanctioned (e.g., with benefit reductions for employees or fines for employers) (OECD, 2007; Reijenga, Veerman, & van den Berg, 2006). The following steps must be followed during a sickness absence:

1 The employee contacts the employer on the first day of sickness absence.
2 Within six weeks, a certified occupational physician, hired by the employer, has to provide an analysis of the work (dis)ability problem.
3 Within eight weeks, the employer and employee formulate a reintegration plan, including work modifications and gradual return to work.
4 If the employee is not reintegrated after one year, the employer is obliged to offer a suitable job in another organization (in practice, this is often facilitated by a reintegration agency).
5 If the employee is not reintegrated after two years, the employee can apply to the social insurance agency for disability benefits.

From an international perspective, it might still be difficult to understand why employers so easily accepted their responsibility for ill employees for a period of two years. It is important to note that, immediately after introduction of the Gatekeeper Improvement Act in 2002, the one-year employer obligation seemed arbitrary. Moreover, policy makers increasingly focused

on an incentive structure that promoted participation in paid work rather than income protection (OECD, 2007) and concluded that more than a year of exploring work modifications, other jobs within the organization, and jobs elsewhere was needed to prevent entry into the disability benefit scheme. It was expected that extending employer payment of sickness-absence benefits for another year would reduce the number of disability benefit beneficiaries. Meanwhile, new plans for stricter thresholds for entering the disability benefit scheme were being prepared. Thus, employers expected that lower disability benefit premiums would outweigh the extended period of sickness-absence payments.

Successes in the New Work Disability Scheme

The new work disability system promoted by the Gatekeeper Improvement Act and the Extended Payment of Income Act had immediate, significant effects. Sickness absence dropped and, since the Act on extended wage payment included job protection and most employees worked under permanent contracts in the first decade of this century, the drop implies that more employees kept their work and income. This drop was related to the number and type of actions taken during the period of sickness absence, also confirming the effectiveness of the new act. Moreover, the health of employees returning to work did not deteriorate (Inspectie Werk en Inkomen, 2006). Further, the number of new disability benefit claimants dropped from 8.4 per 1,000 employees in 2004 to 4.5 per 1,000 employees in 2006 (Jehoel-Gijsbers & Linder, 2007). As a result of both economic development and the new legislation, expenditures for sickness absence and disability benefits decreased remarkably, as shown in Figure 14.3 (OECD, 2010).

Compared with other countries, the Netherlands' drop in new disability benefit claimants was large (OECD, 2010). The relationship between the drop in new sickness-absence and new disability benefit claimants was also stronger than in other countries, confirming the gatekeeper role of the new Act (OECD, 2010). Although the largest decrease in sickness absence had already taken place in the 1980s, due to the economic crisis and reduction in physically harmful jobs (Einerhand et al., 1995), these figures confirm the contribution of the Gatekeeper Improvement Act to increasing return-to-work rates during sickness absence without harming employees' health.

It soon appeared that the Gatekeeper Improvement Act was particularly successful in reducing sickness absence in formerly underserved populations, specifically women and immigrants (Jehoel-Gijsbers & Linder, 2007). Apparently, the Gatekeeper Improvement Act and the Extended Payment of Income Act stimulated employers in sectors offering precarious and demanding work, such as cleaning, to offer the same guidance and standards of sickness absence already present in sectors employing traditional white male breadwinners. The gatekeeper improvement act's flexibility regarding

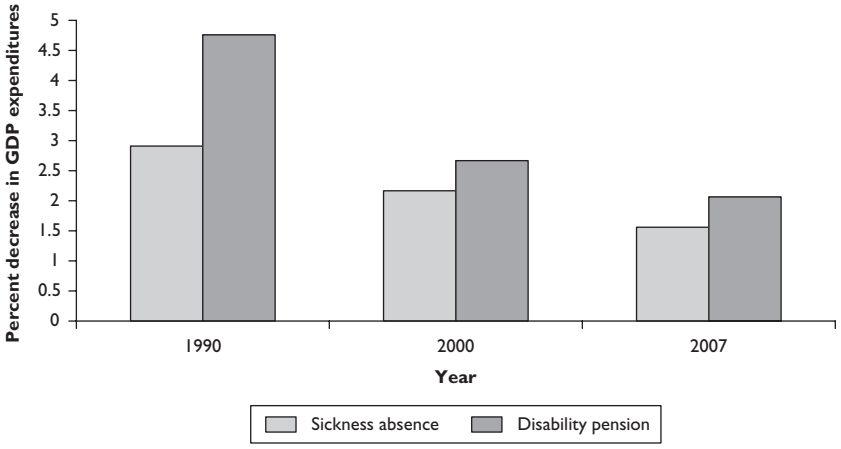

Figure 14.3 Drop in sickness-absence and disability-pension expenditures, as a percentage of GDP. Based on data from Table 2.1 in OECD (2010), Sickness, disability and work: Breaking the barriers. A synthesis of findings across OECD countries.

changing reintegration plans allows employees to try new opportunities for returning to work if an initial option fails. This flexibility is important, as a Canadian study showed how fixed reintegration plans hamper, rather than encourage, return to work, because the course of illness is often capricious and unpredictable (Maiwald, Meershoek, de Rijk, & Nijhuis, 2013).

Challenges with the Dutch Work Disability Scheme

Despite its clear success, the Gatekeeper Improvement Act is not a magic solution. Hoefsmit, de Rijk, Houkes, & Nijhuis (2013) showed that the Act does not remove distrust between employers and employees, particularly not during the second year of sickness absence when employers' tolerance in accepting their employee's sickness absence often expires. Further, Hoefsmit, Boumans, Houkes, & Nijhuis (2016) and Hoefsmit, Houkes et al. (2016) demonstrated that employers are still in need of additional, more detailed roadmaps. In cases of conflict between employers and employees, the Gatekeeper Improvement Act does not decrease, and might even extend, the length of sickness absence (Inspectie Werk en Inkomen, 2006). In addition, if mental health problems that lead to sickness absence are caused by workplaces, the Act does not support effective return to work, as shown by Verdonk, de Rijk, Klinge, & van Dijk-de Vries, A (2008). In these cases, requiring sick-listed employees to wait a year before switching to another workplace is unnecessarily long.

A further challenge is that employers and occupational physicians might not have the time and financial resources to adequately support employees on sickness absence (Her Majesty's Dutch Medical Association, 2016; Social and Economic Council of the Netherlands, 2014). Small- and medium-sized companies, especially, complain about the risk of paying employees sickness-absence benefits for the extra year, and the state secretary for Social Affairs and Employment expressed concern about the potential for employers to select healthier employees (Ascher, 2016). Due to the separation of occupational health and healthcare, employers cannot rely on support from healthcare services. Moreover, effective and fast treatment of work disability is not available in the case of conditions requiring large amounts of care and medication (Prins & Bloch, 2001).

While the Gatekeeper Improvement Act and the Extended Payment of Income Act favor disabled people who are already employed, other disabled groups of working age are underserved. The acts favor insiders, not outsiders. First, the Gatekeeper Improvement Act is seldom applied to sick unemployed people or those who work for temporary agencies (Inspectie Werk en Inkomen, 2006).

Second, due to the hesitancy of employers to hire people with health problems (even though selection on the basis of health is officially forbidden), the number of unemployed disabled people has increased. Even with the earlier changes in legislation, when employers became directly responsible for an additional six weeks of employee sickness-absence benefits, this hesitancy was observed (Høgelund, 2003). In the Netherlands, the gap in employment rates between disabled and nondisabled people is among the largest in Europe (Eurostat, 2014). These unemployed disabled people have a relatively high risk of poverty. Although about a quarter of unemployed, working-age, disabled Dutch people are poor, only 5% of nondisabled unemployed people are. Poverty is less prevalent among Dutch unemployed disabled people than in, for example, the United Kingdom (35.4%) and Belgium (35.7%) but far more prevalent than in, for example, France (17.1%) and Sweden (18.2%) (Eurostat, 2015). This is also related to the increased threshold for receiving disability benefits (35% loss of earning capacity instead of 15%) after 2004. The number of people with work disability who are not receiving disability benefits (but, instead, temporary unemployment benefits or income support) and who are not finding work has thus increased in the last decade (Statistics Netherlands, 2017b).

Third, in the Netherlands, self-employed people are not covered in cases of sickness absence and disability, except by income support. Depending on their age, family situation, other income, and assets, income support adds from 70% to 100% of minimum wage. The self-employed population is relatively large in the Netherlands, comprising about 10% of those with paid work (Social and Economic Council of the Netherlands, 2010).

Is the Dutch Work Disability System Transferable to Other Countries?

A major drawback of the Gatekeeper Improvement Act and the Extended Payment of Income Act is, thus, that they favor employees, who are the only group that is guaranteed to receive 70% of their former income over two years of work disability and whose jobs are protected. This insider/outsider phenomenon, related to the Dutch Bismarckian welfare state, should not be transferred to other countries. The question as to whether the Gatekeeper Improvement Act can be transferred at all can be answered with a "Yes, but." As explained above, this Act is highly beneficial for the group it was meant to serve (employees), and it seemed to be particularly good at providing those who were traditionally underserved regarding sickness-absence guidance (Jehoel-Gijsbers & Linder, 2007). But even for employees, the Act will only be effective if:

- the organization has a sense of urgency about reducing sickness absence;
- occupational physicians are available, who are trained to translate disease into functional limitations that can be communicated to employers without harming employees' privacy; and
- the necessary skills, or even culture, for multidisciplinary cooperation are available among employers, occupational physicians, and other stakeholders, such as treating physicians.

It is doubtful that the Extended Payment of Income Act could be transferred to other countries. Requiring that employers directly pay sickness-absence benefits for two years is only possible in the context of a corporatist welfare state, a consultative economy, and protection of employees' jobs when they are on sick leave. However, encouraging employers to take some financial responsibility for sick leave will certainly help reduce the length of sickness absence.

The Issue of Sustainability

To conclude, the two acts are highly effective for the group they were designed to serve, and their effectiveness was enabled by sociopolitical and economic developments in the Netherlands over the past five decades. However, the acts' sustainability is questionable; it depends on whether employers can still be given a key role when the labor market becomes more diverse, flexible, and unstable.

In 2017, the Social and Economic Council of the Netherlands published a memorandum, entitled "The Future of Work in the Netherlands," in reaction to the four centenary-conversation questions asked by the International Labour Organization (2016):

1 Work and Society: What role will work have in our society over the next century?

   According to the memorandum, an important challenge will be to increase the relatively low labor-participation rate and hours worked per week of low-skilled women and immigrants.

2 Decent Jobs for All: How do we guarantee employment and employee protection over the next century?

   Globalization and technologization can offer chances to improve the quality of work but can also threaten basic work values. Specific to the Netherlands, says the memorandum, is the increase of flexible employment relationships that differ from those for permanent employees. The two acts are not applied to sick unemployed people and those who work for temporary agencies (Inspectie Werk en Inkomen, 2006), and the acts do not cover the situation of employees with temporary contracts that end during the first two years of sickness absence. Equal opportunities need to be provided for low- and high-skilled citizens, and the government has to provide an appropriate interpretation of the concept of solidarity across citizens.

3 The Organization of Work and Production: How will production processes change, and what effect will this have on employment and employee protection?

   According to the memorandum, new risks for sickness absence might develop among employees not able to keep up with the high pace of change in production processes.

4 The Governance of Work: How do we exercise governance over work, nationally and internationally?

   According to the memorandum, globalization should not lead to a downward spiral in employment and social security of employees.

These four areas of new developments imply that, increasingly, Dutch employers are confronted with unpredictable costs and employees with unpredictable risks, while the government has to better protect vulnerable workers and small employers, and find new ways to create solidarity. The Dutch consultative economy will be challenged and has to find ways to develop a more universal welfare state; that is, a welfare state with the same provisions for all citizens irrespective of having (had) an employer or not, one that upholds human rights and enables fulfilling jobs for all working-age adults. Although the consultative economy will help find answers through its integration of diverse perspectives, Dutch employers will not likely play the key role in the welfare state that they did in recent decades.

Notes

1 Nederlandse Vereniging voor Arbeids- en Bedrijfsgeneeskunde.
2 Uitvoeringsorgaan Werknemers Verzekeringen.

3 Stichting van de Arbeid.
4 Sociaal-Economische Raad.
5 Wet op de ArbeidsOngeschiktheidsverzekering.
6 Werkloosheids Wet.
7 Bijstand.
8 Arbeidsomstandighedenwet.
9 Akkoord van Wassenaar.
10 Ziektewet.
11 Wet Verbetering Poortwachter.

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