# Summary

# Limited functioning

## Trend report on sickness absenteeism, incapacity for work and labour participation of people with health impairments

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Sickness absenteeism, incapacity for work and labour participation of people with health impairments have received a great deal of attention from Dutch policymakers in recent years, with several measures being implemented in a bid to reduce sickness absenteeism and the volume of disability benefits and raise the labour participation rate of this group. Over recent decades, the policy on sickness absenteeism and incapacity for work has consistently sought to strike a balance between income protection and active integration. Initially the emphasis was mainly on income protection for people who were unable to work, or work fully, due to illness, but the steep rise in the volume of social security benefits in the 1990s led to an increasing focus on reintegration into the labour market, with policy changes aimed among other things at giving employers and employees greater responsibility for that reintegration. In this fourth edition of the Trend Report we outline the trends in sickness absenteeism, incapacity for work and labour participation of people with health impairments, and investigate whether those trends are moving in the direction envisaged in the policy. As well as describing these trends, this report also devotes more specific attention to two themes: the role of employers and how people with a work-limiting disability or illness fare at the workplace. A key condition for the success of the policy is that employers make efforts to engage people with impaired health. What are working conditions like for people with health impairments who are in work? And how does their social integration compare with that of people without impairments?

The central questions addressed in this report are as follows:

- How have the sickness absenteeism, incapacity for work and labour participation rates of people with health impairments developed over the past decade?
- How willing are employers to take on people with health impairments? What developments are taking place in employers' occupational health and safety and sickness absenteeism policy, and what are employers doing to promote the sustainable employability of employees?
- How do people with health impairments fare at the workplace? Are they satisfied with their employment situation? How do the work experiences of people with and without health impairments differ?

## Reduction in sickness absenteeism and incapacity for work, but also in labour participation of people with health impairments

Sickness absenteeism and incapacity for work are largely moving in the direction envisaged by the government, but that is not the case for the labour participation rate of people with health impairments. Although sickness absenteeism rates and the number of disability benefits in payment fell over the period studied, so did the share of people with work-limiting disabilities in work, despite the heavy policy emphasis on reintegration. It should be noted that is not clear whether these trends are due to government policy or to other factors, such as the economic crisis; this report does not include a policy evaluation or impact analysis.

## Reduction in sickness absenteeism during the economic crisis

Employee sickness absenteeism rates have been falling in recent years. In 2014, employees were absent on an average of 3.7% of days when they should have been working – the lowest percentage in the entire period 2007-2014. The overall sickness absenteeism rate fell from 4.1% in 2012 to 3.7% in 2014. In 2015 it increased again to 4%. While the overall sickness absenteeism rate fell, among those aged over 55 it remained unchanged. This may be due to an increase in the average age of older workers in the later years of the period studied, and this group contains a higher proportion of employees with less robust health; the abolition of early retirement schemes may be a relevant factor here.
Sickness absenteeism rates are higher among older persons, people with a work-limiting disability, employees on permanent contracts, informal carers and employees who have recently gone through a reorganisation at work. Compared with employees, the sickness absenteeism rate among the self-employed (with or without staff) is low. One striking finding is the fall in sickness absenteeism rates during the economic crisis. It is also known from other research that fewer employees report sick when the economy is weaker. This could be due to a selection effect, where employees with high absenteeism rates are more likely to lose their jobs; a lower sickness absenteeism rate could then reflect the reduced labour participation of the more at-risk groups. Another possible explanation is a behavioural effect: employees report sick less often due to fear of losing their jobs, and go to work even when it would be better for their health to remain on sick leave.

## Reduction in disability benefits, except benefits for early disabled persons

The downward trend in the number of disability benefits has also continued in recent years. Until 2002, the number of disability benefits was on a rising trend, before falling from over 993,000 in 2002 to over 808,000 at the end of 2015. These figures relate to benefits paid under the Invalidity Insurance Act (Wet op de arbeidsongeschiktheidsverzekering – WAO), the Work and Income according to Labour Capacity Act (Wet werk en inkomen naar arbeidsvermogen – WIA), the Invalidity Insurance (Young Disabled Persons) Act (Wet arbeidsongeschiktheidsvoorziening jonggehandicapten – Wajong) and the Incapacity Insurance (Self-employed Persons) Act (Wet arbeidsongeschiktheidsverzekering zelfstandigen – WAZ). The WAZ was repealed in 2004, and the WAO was replaced by the WIA in 2006;

these benefits are therefore no longer accessible to new applicants, but benefits already in payment continue. This downward trend is ascribed to the increased responsibility of employers to prevent absenteeism and reintegrate sick employees that ensued among other things from the implementation of the Eligibility for Permanent Invalidity Benefit (Restrictions) Act (Wet verbetering poortwachter – WVP), which was implemented in 2002, and the Continued Payment of Salary During Sickness Act (Wet verlenging loondoorbetalingsverplichting bij ziekte – WVLZ), which was implemented in 2004 (see e.g. Cuelenaere & Veerman 2011). One exception to the decline in the number of disability benefits is the volume of Wajong-benefits, which more than doubled between 2002 and 2014. The volume of these benefits continued to increase after the introduction of the new Act (nWajong) in 2010. The introduction of the Participation Act on 1 January 2015 led to a change in the Wajong, with new applications from young disabled persons with some capacity to work being placed under the Participation Act, and only young disabled persons with a full and permanent incapacity for work remaining within the 'Wajong 2015'. New applicants for benefits under the Participation Act (now administered by local authorities) fall outside the scope of this report, but will be included in the final evaluation of the Participation Act that is being carried out by the Netherlands Institute for Social Research (SCP) for the Ministry of Social Affairs and Employment.

### Decline in labour participation rate of people with health impairments

Contrasting with the positive trend in sickness absenteeism and incapacity for work, the labour participation rate of people with health impairments declined over the period studied. The percentage of employees with a partial incapacity for work (who are covered by the Resumption of Work for Partially Disabled Persons Regulation – WGA) fell from over 55% in 2008 to 43% in 2014. The share of working people in receipt of Wajong benefit also reduced, from 26% in 2008 to 22% at the end of 2014. Despite the stepping up of the reintegration policy, therefore, it is still difficult for people with a work-limiting disability to find work. One reason for this may be a change in the composition of the group, with new WIA/WGA benefit recipients increasingly consisting of older persons, people with mental health problems and people relying on benefits as a safety net (because they have no employer at the time they become unfit for work). These are all groups with a lower average chance of finding work. In absolute terms, the number of people in receipt of WGA or Wajong-benefit who are also in work has in fact increased, but this increase has been outstripped by the rise in the number of people in receiving WGA benefit, so that overall the percentage of working people with a work-limiting disability has fallen. The sickness absenteeism rate of persons with a work-limiting disability but no entitlement to disability benefit also fell in the period 2008-2014. As well as the compositional effect, the economic crisis is likely to have played a role here, given the findings in this report that when selecting employees (e.g. for a training programme or for redundancy during a reorganisation), employers attach great weight to the health of those employees in periods when the economy is doing badly.

## Reduced employer focus on health and safety policy

A key condition for raising the labour participation rate of people with health impairments is that employers are willing to make the necessary efforts for these workers. The second research question therefore addresses the degree to which employers are willing to accommodate people with health impairments, developments in employers' occupational health and safety and sickness absenteeism policy, and the measures that employers take to promote sustainable employability of workers. The findings in this report show that there is still work to be done in several areas.

First, figures from a large-scale survey of employers show a reduction in attention for occupational health and safety in the period 2008-2014. Employers carry out less frequent risk inventory and evaluation (RI&E), are less often signing a contract with a safety, health and welfare service or alternative agency, and are less often taking new measures to address safety, health and welfare risks in the workplace. The slight downward trend in compliance with most obligations (with the exception of RI&E) is in line with research based on company visits carried out by the Inspectorate SZW over the period 2008-2014 (Inspectie SZW 2015). The SCP report *Demand for labour 2015* (*Vraag naar arbeid 2015*) (Van Echtelt et al. 2015) also shows that employers gave less and less priority to staff working conditions in the period 2007-2013. Time will tell whether the reduced employer attention for safety, health and welfare policy is cyclical or structural in nature. The observed trends may also be connected to changes in the health and safety legislation in 2007, in which greater responsibility for working conditions was assigned to the 'social partners' (representatives of management and workers).

Second, the figures show that a limited proportion of employers (9%) had a specific policy in 2014 for recruiting people from vulnerable groups (including people with a chronic illness/disorder). Only 16% of employers have deliberately recruited members of this group over the last two years. The most commonly cited reason for not having a policy for vulnerable groups is that the work is unsuitable.

Third, whilst employers increasingly see the importance of employees continuing to work for longer, they are not taking concomitant steps to achieve this. The number of measures taken to accommodate less able workers (reduced working hours, lighter duties, more flexible work, etc.) is reducing. Whilst this is in line with the government's aim of reducing publicly funded measures to accommodate these workers, cutting the costs of older workers and thus making them more attractive to employers (TK 2015/2016b), the flipside is that only limited staff development measures are being taken for these workers (e.g. training, transfer to other roles, etc.) – precisely the measures that the government expects from employers.

## Health an important selection criterion for employers

While employers have reduced the attention they devote to occupational safety, health and welfare, the health of their employees is an important element in their opinion of those employees and the opportunities they offer them. A vignette study using an experimental approach was used to present different choices to employers showed sickness

absenteeism and health complaints to be the most influential factors in the decision on retaining an employee or offering them a permanent contract. Characteristics such as excellent functioning and age are less important for employers' decisions on retaining an employee than health (given the same human capital characteristics).

One point which needs to be taken into consideration here is the flexibilisation of labour relations. The figures show that among temporary employees, those who have been sick or who are in poorer health are more likely to be out of work after two years than healthy employees, mainly because they have become unemployed. The maxim of 'survival of the fittest' thus appears to be a prominent characteristic of a flexible labour market. In reality, a flexible labour market should actually offer more opportunities to people from vulnerable groups, because employers can avoid risks by not immediately offering permanent contracts. However, if health is an important selection criterion for retaining employees, people with health impairments will be at a permanent disadvantage on the labour market. This is understandable from the perspective of employers because of the costs of absenteeism, and it may be that measures aimed at reducing these risks, such as no-risk arrangements or discounts or exemptions from social insurance premiums, could provide some mitigation. Many employers are however unfamiliar with these schemes (Van Echtelt et al. 2015). Increasing that familiarity could increase their use and lead to a greater willingness by employers to recruit or retain people with health impairments.
On the other hand, too much should not be expected of this: the last edition of the Trend Report (Versantvoort & Van Echtelt 2012) concluded on the basis of a literature review that, despite the financial mitigation measures, the high transaction costs meant that employees with health impairments were no more attractive to employers. It is sometimes thought that the stricter obligations placed on employers have reduced their willingness to recruit people with health impairments. For example, the period of compulsory continuation of salary payments is much longer in the Netherlands (two years) than elsewhere in Europe (generally a few weeks or months), and it is argued that it is difficult for smaller employers, in particular, to afford this. It is also argued that it makes employers reluctant to offer permanent contracts, especially to employees from a group with a higher risk, such as older persons and people with health impairments. Although the measure appears to have made a positive contribution to reducing sickness absenteeism and the volume of disability benefits, one unintended side-effect may be that it acts as an impediment to the labour participation of people with impairments. In this context, the Minister of Social Affairs and Employment asked the Social and Economic Council of the Netherlands (SER) to produce a report on an integrated system for the continued payment of salary for both employees and self-employed workers, which will be published in the autumn of 2016 (SER 2016; TK 2015/2016a). The position of self-employed workers who become sick has been attracting increasing attention in recent years as the proportion of workers with self-employed status grows.

## Health also a reason for people to choose not to work

Current Dutch government policy leans heavily on the idea that working is good for people and that everyone, healthy or less healthy, should be able to participate in the labour market. Doing paid work has increasingly become the norm, with only people with a total and permanent incapacity for work (recipients of benefit under the Full Invalidity Benefit Regulations – IVA) and some recipients of Wajong-benefit not being expected to perform paid work. Nonetheless, it can be quite a challenge for some people to participate in the labour market despite their illness or disability, for example because it saps much of their energy or because they work under less favourable conditions. It is also possible that they are poorly treated by employers (or colleagues).

The third research question addressed in this report is concerned with how people with health impairments fare at the workplace. The statistics show first that poor health is a reason for not working for a substantial proportion of the population. If we leave out people in receipt of disability benefit, we find that almost one in ten people aged between 15 and 64 years have a work-limiting disability, i.e. their self-reported health status is an obstacle to performing or obtaining work. This figure is particularly high among those in receipt of social assistance benefit (48%) and unemployment benefit (12%). People not currently working frequently cite their subjective health status as a reason for not looking for work; almost a quarter (23%) of non-workers not in receipt of disability benefit and not looking for work cite poor health as the main reason. This group thus believe that paid work in and of itself will be too much for them, or that the demands placed on them by an employer will ultimately prove to be too severe.
Second, workers with a work-limiting disability would relatively often like to work fewer hours and retire early, in other words their desired working hours and retirement age more often differ from the actual situation than for people without a work-limiting disability. While they do participate, therefore, they would evidently prefer to do so less, perhaps because they find their work relatively strenuous. Paid work is found to contribute positively to the happiness of people both with and without a work-limiting disability, but this relationship is weaker for those with than those without a work-limiting disability.

## People with health impairments face worse conditions at the workplace

This report also highlights the relatively unfavourable social and other circumstances of people with a work-limiting disability: 16% of workers with a visible illness or disability sometimes or frequently encounter antisocial treatment at the workplace, compared with 9% of (visibly) healthy workers. Examples include their opinions being ignored, exaggeratedly careful checking of their work, removal of responsibilities or being assigned unpleasant tasks, making jokes, or being subjected to accusations, sarcastic comments or insults. They also report that they are given fewer opportunities at work than colleagues with equivalent training and experience. For example, they feel more often than people without impairments that they earn less (32% versus 23%), are less likely to be promoted (34% versus 22%), are offered fewer development opportunities (30% versus 17%) and receive less

training (25% versus 15%). These differences remain after controlling for differences in background characteristics, such as age and education level.

People with a visible illness or disability more often suffer emotional and physical exhaustion due to their work: 13% feel completely exhausted by their work at least once a week, compared with 8% of people without a visible illness or disability. This is connected to the greater dissatisfaction with work and unhappiness with their lives felt by people with visible illnesses or disabilities. Strikingly (and worryingly from the perspective of the commitment to equal opportunities), while people with health impairments more often feel disadvantaged and bullied at work, they less often look for other work than people without impairments. It may be that people with health impairments factor in the worse working conditions and expect to encounter similar situations in a different workplace, or feel they have less chance of finding other work. A lack of energy or some other aspect of their illness/disability may also hold them back from applying for other jobs. Further research in this area is needed to obtain a more precise answer.

### Focus areas and risk factors

Sickness absenteeism and the volume of disability benefits have been falling in the Netherlands in recent years. Whilst these are positive trends, there are a number of points to consider for the future. Changes on the labour market warrant attention because of their potential impact on sickness absenteeism and incapacity for work. As well as the flexibilisation of labour relations referred to earlier, the principal changes are population ageing, the growth in the percentage of working informal carers and the rise in the number of mental health complaints.

The raising of the retirement age and population ageing means the number of older workers is growing: older persons account for an ever-increasing share of the working population. However, advancing age increases the risk of chronic illnesses and disabilities, raising the prospect of higher average sickness absenteeism rates in the years ahead. It is not so much that older workers take sick leave more often, but more that their length of absence tends to be greater than their younger counterparts. It is therefore reasonable to assume that a further increase in the labour participation rate of older persons and the raising of the retirement age will lead to an increase in sickness absenteeism in the future. There is already a good deal of policy attention for sustainable employability, with the aim of ensuring that people can remain active on the labour market until retirement age; good health is a key factor here (STAR 2013; TK 2013/2014). The government is keen to see a reduction in the use of collective measures to accommodate older workers, such as days off, shorter working hours and exemption from certain activities, though doubts are sometimes cast on the desirability of this aim (see e.g. De Lange & Van Dartel 2015). Such measures may still be needed for individual employees to prevent the raising of the retirement age pushing more people onto disability benefits.

The sickness absenteeism rate is also relatively high among informal carers. This can be explained partly by age: informal carers are relatively often aged over 45. The government wants people to take more responsibility for caring for loved ones; this aim is expressed among other things in the Social Support Act (Wmo), which was implemented in 2007. While the share of people combining paid work with providing informal care has risen over the last decade (Josten & De Boer 2015), an unintended side-effect of this policy could be an increase in the people suffering from fatigue. Research has shown that people who combine informal caregiving with working suffer more 'combination stress', mental fatigue and higher sickness absenteeism (see e.g. Broese van Groenou et al. 2015; Josten & De Boer 2015). Although the percentage of people combining paid work with informal care is still relatively low, they are a growing group. And although not yet visible, it is possible that sickness absenteeism in this group will rise in the future.
The combination of paid work and care has been on the policy agenda for some time, especially as regards caring for young children. However, combination stress is not limited to young families in the 'rush-hour' of their lives, but is increasingly prevalent among older employees who are caring for a loved one. Flexible working and leave arrangements have recently been made more generous, but it has not been demonstrated unambiguously that flexible working hours and working from home actually reduce combination stress (Mattijssen et al. 2016). Some studies find a positive effect, while others find a neutral or even a negative effect. Research does however stress the importance of the social aspects within a labour organisation and of a good and lasting employee-employer relationship. Social support from the employee's superior has for example been shown to be an important factor in reducing combination stress (Broese van Groenou et al. 2015; Mattijssen et al. 2016).

A strikingly high proportion of new recipients of certain disability benefits (WGA) are people with mental health issues, and their number increased relatively sharply in the period 2008-2014. The figures also show that employers consider socio-psychological aspects to be far and away the most important employment risk; pressure of work is for example cited by almost half of employers as a major risk, and that percentage increased over the period 2010-2014. It is therefore surprising that employers take relatively few steps to address this problem. Research also shows that employers often find it difficult to tackle this issue (TNO 2012). The government recognises the problem and has placed psychosocial work stress explicitly on the agenda as part of its Sustainable Employability policy programme. One of the aims is to make employers and employees more aware of the risks and make it acceptable to discuss this issue in the workplace. Early identification is key here. To address this, the Inspectorate SZW recently launched a practical tool (the website www.werkdrukenongewenstgedrag.zelfinspectie.nl) to enable employers to assess whether pressure of work is being adequately assessed within their organisation (Inspectie SZW 2016). It is however debatable whether such measures offer sufficient counterweight to social trends that lead to ever-increasing pressure on employees, such as the growing percentage of working informal carers referred to earlier (see Van Echtelt 2014).

There has also been a sharp rise in the number of young people receiving Wajong-benefit because of a development disorder, such as an intellectual disability. It may be that the demands placed on the individual by society make it more difficult to function adequately at school and on the labour market without support (Woittiez et al. 2014). There is sometimes an implicit assumption that vulnerable groups (e.g. recipients of Wajong-benefit) will eventually no longer need support at work as they gain experience and become more accustomed to their jobs. In reality, however, a proportion of this group will require structural and longer-term support in order to be able to remain in work (see e.g. Horssen et al. 2009). Since the implementation of the Participation Act, recipients of Wajong-benefit who have some labour capacity come under the responsibility of local authorities. Time will tell whether those local authorities deploy (and have available) sufficient resources to meet this need for continuing support.

## Conclusion

This report outlines trends in sickness absenteeism, incapacity for work and labour participation of people with health impairments, but also makes clear that the statistics need to be placed in a broader context and cannot be seen in isolation from other developments on the labour market. In itself, a low absenteeism rate is a good thing, but it may also indicate a selection effect on the part of employers (employees with high absenteeism rates are more likely to lose their jobs) or employees continuing to work whilst they are ill (presenteeism). The reduction in the volume of disability benefits is in line with government policy, but begs the question of how people fare on the labour market if the stricter access criteria mean they are not or no longer eligible for benefit but perhaps still experience impediments due to their health.

Despite the reintegration policy, trends in the labour participation of people with health impairments remain a concern. While the policy is aimed at creating an inclusive labour market, the participation figures in recent years point to a situation that is more akin to 'survival of the fittest'. When the economic picture improves, there is also likely to be more room on the labour market for people with health impairments. Nonetheless, there are also structural trends on the labour market which warrant attention, such as the role of health in a flexible labour market and the working conditions of people with health impairments.

Recent policy changes, such as the implementation of the Participation Act and the Occupational Disability (Employment Targets and Quotas) Act (Wet banenafspraak en quotum arbeidsbeperkten) are mainly targeted at recipients of Wajong-benefit and people who are unable to earning minimum wage without support. People in receipt of a partial disability benefit based on the WIA (Work and Income according to Labour Capacity Act) and WAO (Invalidity Insurance Act) are for example not counted for the purposes of the Occupational Disability (Employment Targets and Quotas) Act, but can still experience obstacles on the labour market. The same applies for people with work-limiting disabilities who are not in

receipt of disability benefit. The statistics show that health is an important motive for a substantial proportion of non-workers who are not in receipt of disability benefit not to participate in the labour market. If the government wishes to raise the labour participation rate further, it will have to focus not only on people who cannot earn the minimum wage without support, but also on other groups for whom health is an important reason for not participating in the labour market.

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